



An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta
National Economic & Social Council

Well-being Matters: A Social Report for Ireland

Volume II

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Well-being Matters

A Social Report for Ireland

Volume II

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Abbreviations

ADHEA

Association for
Higher Education
Access and Disability

AISTEAR

The Framework for
Early Learning

CMHT

Community Mental
Health Team

CRC

Convention on the
Rights of the Child

CSO

Central Statistics
Office

CV

Curriculum Vitae

DISTAT

United Nations
Disability Statistics
Database

DOEHLG

Department of
Environment,
Heritage and Local
Government

EQLS

European Quality
of Life Survey

ESRI

Economic and Social
Research Institute

EU

European Union

EU-SILC

European Union
– Survey on Income
and Living Conditions

FÁS

The Irish Training
and Employment
Authority

GDP

Gross Domestic
Product

GP

General Practitioner

HBSC

Health Behaviour in
School Aged Children

HIQA

Health Information
and Quality Authority

HSE

Health Services
Executive

IBEC

Irish Business
and Employers
Confederation

ICF

International
Classification of
Functioning

ICTU

Irish Congress of
Trade Unions

ILO

International Labour
Organisation

ISCI

An International
Society for Child
Indicators

NCAOP

National Council
on Ageing and
Older People

NCCA

National Council
for Curriculum and
Assessment

NCO

National Children's
Office

NDS

National Disability
Survey

NESC

National Economic
and Social Council

NESF

National Economic
and Social Forum

NGO

Non-Governmental
Organisation

OECD

Organisation for
Economic Co-
operation and
Development

OMC

Office of the Minister
for Children

OMCYA

Office of the Minister
for Children and
Youth Affairs

PISA

Programme for
International Student
Assessment

QNHS

Quarterly National
Household Survey

RIS

Refugee Information
Service

SLÁN

Survey of Lifestyles,
Attitudes and
Nutrition

SSIA

Special Savings
Investment Account

TILDA

The Irish Longitudinal
Study of Ageing

UK

United Kingdom

UN

United Nations

UNECE

United Nations
Economic
Commission
for Europe

UNICEF

United Nations
Children's Fund

USA

United States
of America

WHO

World Health
Organisation

WHODAS

World Health
Organisation
Disability Assessment
Schedule

MHADIE

Measuring Health
and Disability in
Europe

Structure of the Report *Well-being Matters*

The report *Well-being Matters* comprises 4 parts in 2 volumes.

Volume I comprises 3 parts.

Part I, *Thinking about Well-being*, contains two chapters. Chapter 1 explains why well-being matters. Chapter 2 reviews the well-being literature to arrive at an understanding of well-being which is used throughout the report.

Part II, *Reporting Well-being*, also contains two chapters, Chapter 3 on expressing well-being through social reporting, and Chapter 4 which provides an overview of well-being trends in Ireland over the last ten to twenty years.

Part III, *Recasting Well-being in Ireland*, contains one chapter which recaps on the approach to well-being used throughout the report, summarises the key well-being trends, sets out the well-being implications and suggests a number of policy directions.

The recession has clearly impacted on economic and social progress and on people's well-being in the last year. The impact of the recession is considered where data have become available, and is dealt with more specifically in Chapters 1 and 5.

Volume II comprises one part.

Part IV, *Charting Well-being in the Policy Framework* contains four chapters, each relating to a life cycle stage as set out in the policy framework document *Towards 2016: children, people of working age, older people and people with disabilities*. Each of the four chapters explores meanings of well-being in relation to the particular population group, documents key well-being trends, relates these to the policy framework and comments on policy directions, data and indicator gaps.

At the start of each of the four parts of the report a short synopsis of what is contained in that part is provided. The last section of Chapter 1 also contains an overview summary of what is contained in the overall report.

PART IV

Charting
Well-being
in the Policy
Framework

Part IV of the report documents well-being trends and comments on them in relation to the policy framework, *Towards 2016*. The four chapters in this Part address each of the life cycle groups specified in the developmental welfare state: children, people of working age, older people and people with disabilities. People with disabilities are included as a population group with particular needs across the life cycle.

Each of the four chapters is informed by the understanding of well-being as defined in Chapter 2, Volume I, that is:

Well-being is a positive physical, social and mental state. It requires that basic needs are met, that individuals have a sense of purpose, that they feel able to achieve important goals, to participate in society and to live the lives they value and have reason to value.

It is enhanced by conditions that include supportive personal relationships, strong and inclusive communities, good health, financial and personal security, meaningful and rewarding work, a healthy and attractive environment and values of democracy and social justice.

Public policy's role is to place the individual at the centre of policy development and delivery, by assessing the risks facing him/her, and ensuring the supports are available to him/her to address those risks at key stages in his/her life.

Each chapter follows a similar structure. First, relevant literature, international frameworks and national strategies on well-being for the life cycle group are presented. Second, work on the assessment of well-being, in particular the use of social indicators, is discussed, the relevant high level goals from *Towards 2016* are documented, and an indicator framework for the chapter is presented. The third section in each chapter provides a context by briefly setting out the demographic trends and social spending.

The fourth section applies the well-being framework derived in Chapter 2 (Volume I), presenting the information across each of the six domains of well-being:

- ◆ Economic resources;
- ◆ Work and participation;¹
- ◆ Relationships and care;

1. As noted earlier, while the term 'participation' is used here to describe participation in work and education, participation in one's community and in decision-making are also important to well-being.

- ◆ Community and environment;
- ◆ Health; and
- ◆ Democracy and values.

For each of these well-being domains Ireland's progress is examined in an international context. Attention is also paid to the well-being of sub groups of the population on these domains. Acknowledgement of the diversity of the population reflects the unique combinations of well-being domains for individuals and their collective permutations.

A developmental welfare state provides an appropriate policy response by offering a standard service on the one hand, tailored to individual needs on the other. Following through on this approach, for each well-being domain the main relevant policy commitments and actions under each well-being domain is presented, with a brief commentary on the capacity of the policy framework to improve well-being outcomes. Comment is also made on indicator and data gaps.

A final section in each chapter seeks to start a dialogue on policy monitoring by providing an example of how indicators can inform the policy cycle.

6

Children

The true measure of a nation’s standing is how well it attends to its children – their health and safety, their material security, their education and socialisation, and their sense of being loved, valued, and included in the families and societies into which they are born (Unicef, 2007: 1).

6.1 Understanding Children’s Well-Being

There is a large body of literature specific to children’s well-being. The discourse is well summarised by Hanafin *et al.* (2007) in their article on ‘Achieving Consensus in Developing a National Set of Child well-being Indicators’. Child well-being reflects understandings of general well-being, as discussed in chapter 2. Thus, the definition of general well-being, cited at the outset of Part IV in this Volume, holds for children and is in line with the vision of the Irish National Children’s Strategy. The National Children’s Strategy takes a ‘whole child’ perspective and is congruent with the principles of the UN Convention on the Rights of the Child. The Strategy’s vision is:

An Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own; where all children are cherished and supported by family and the wider society; where they enjoy a fulfilling childhood and realise their potential. (Department of Health and Children, 2000c: 4).

Ireland is a signatory of the UN Convention of the Rights of the Child (1989). The convention is a broad statement of children’s rights and provides an internationally agreed framework of minimum standards necessary for the well-being of every child and young person under 18.

The Convention on the Rights of the Child (CRC) brings together children’s civil, political, social, economic and cultural rights.² The rights defined in the CRC are seen as necessary for the development and dignity of the child. There are 41 ‘substantive articles’ which set out the rights of children and the corresponding obligations of governments. Four of the articles are known as ‘general principles’:

- ◆ Article 2 – non discrimination;
- ◆ Article 3 – best interests of the child;

2. Details on the Convention of the Rights of the Child can be located on the Children’s Rights Website at www.childrensrights.ie

- ◆ Article 6 – the right to life, survival and development; and
- ◆ Article 12 – respect for the views of the child.

The remainder of articles 1-41 each detail a different right. These can be grouped under 4 main themes:

- ◆ *Survival Rights*: recognise the child's right to life and basic needs. They encompass nutrition, shelter, an adequate standard of living and access to healthcare.
- ◆ *Developmental Rights*: outline what children require to reach their full potential. These include things like education, play, leisure and cultural activities.
- ◆ *Protection Rights*: require that children are protected from abuse, neglect and exploitation.
- ◆ *Participation Rights*: which acknowledge that children should be able to play an active role in decisions affecting their lives.

The CRC promotes a holistic view of the child (Bradshaw *et al.*, 2006; Hanafan *et al.*, 2007). This perspective sees the child as 'an active agent' who has the 'capacity' to influence their own life and to form positive relationships while being supported by their families and communities, and through formal supports and services. This is very much in line with Sen's focus on capabilities and the sense of 'agency' where people, including children, can act and bring about change and whose achievements can be judged according to their own values and objectives (Sen, 1999: 19).

This understanding of child well-being also reflects the multidimensional nature of children's lives. It goes beyond economic well-being to encapsulate health and physical well-being, education and cognitive well-being, social, emotional and behavioural development, relationships with the family, the community and wider society, as well as participation and a sense of values and social justice. Such an approach to well-being places the child at the centre and recognises their capabilities to fashion their own lives. It accepts children being citizens in their own right, but also recognises that children are dependent on their families, schools, communities and wider societies. Even though current thinking emphasises the need to focus on children's well-being in the here and now, this is balanced by an argument (political and economic) to invest in children's futures by focusing on their families, schools, and future employment prospects (Bradshaw *et al.*, 2006; Hanafin *et al.*, 2007).

Children's rights proponents stress the importance of positive outcomes for children. Bradshaw *et al.*, (2006: 8), drawing on Sen's work (Sen, 1999), refers to the conditions for child well-being to be understood in terms of 'capabilities', which can influence children's lives today and their life chances in the future. This understanding is particularly important for children from disadvantaged backgrounds where supporting and liberating children's capabilities can stem inter-generational poverty and inequality.

In summary, children's well-being is understood as being multidimensional. It is influenced by the child's own capabilities as well as those of his/her family, friends and peers. External factors such as the community and environment within which the child lives, the school they attend, the provision of health and social services, and the wider political, economic and social circumstances within which they live and develop, including the cultural and social values pertaining in the society, influence a child's well-being. Central to current understandings of child well-being is the role and perspective of the child themselves.

6.2 Assessing Children's Well-being

Development of Child Well-being Indicators

Based on this broad understanding of children's well-being many have addressed the question of how to assess it. Leaders in this field include Asher Ben-Arieh and Jonathon Bradshaw. They, among others, have developed social indicators of children's well-being, (and more recently a summary index). Much of the literature on social indicators is summarised by Hanafin and Brooks (2005), Hanafin *et al.*, (2007) and Hanafin and Brooks (2009).³

Efforts to assess and monitor children's well-being have developed rapidly over the last 25 years. Ben-Arieh (2008) has argued that the study and use of children's social indicators has seen five major developments over this time. These have been:

- ◆ *From survival to well-being.* While indicators of child morbidity and mortality are still important they are not sufficient to capture the more encompassing ideal of child well-being. Broader indicators on the state and quality of children's lives are now being developed.
- ◆ *From negative to positive.* Traditionally indicators focussed on deficits in children's lives, such as lack of income, possessions and opportunity. The emphasis is now on trying to portray positive aspects of children's lives, 'indicators of sparkle, satisfaction and well-being'. These are recognised as being more difficult to measure, but are seen as important.
- ◆ *From well-becoming to well-being:* Much attention has been given to the development of children into well-functioning productive adults, through investing in children now for future gains. There is now recognition of the need to also focus on the well-being of children in childhood. Hence the emphasis on aspects of children's lives such as their relationships and current activities. The relative emphasis on well-being versus well-becoming has implications for child and family policy.
- ◆ *From traditional to 'new' domains:* This development is a reflection of the previous three, with a particular reference to the Convention on the Rights of the Child and a broader interdisciplinary approach. These indicators seek to capture things like 'spiritual and moral well-being', 'identity and self care' and 'children's right to a voice' (cited in Hanafin and Brooks, 2005: 23).

3. An International Society for Child Indicators (ISCI) has been established to contribute to improving the well-being of the world's children. The ISCI 'Seeks to build a network of individuals dedicated to improving measures and data resources, advancing the data analysis, exploring theoretical issues and publicising and disseminating information on the status of children'. They held an inaugural conference in the USA in June 2007 and launched a Quarterly *Child Indicators Research Journal* in 2008. For more information see www.childindicators.org

- ◆ Towards a composite index of well-being: recent work has concentrated on developing a 'single summary number' (Ben-Arieh, 2008: 11) to capture the well-being of children. Unicef, in particular, (see Appendix C) has developed and utilised this approach to compare trends across countries.

These developments 'can be attributed to the emergence of new normative and conceptual theories as well as methodological advancements' (Ben-Arieh, 2008: 5). Three main 'normative or theoretical changes' have influenced thinking in developments on child indicators. These are: (i) 'the normative concept of children's rights'; (ii) the recognition of 'childhood as a stage in and of itself'; and (iii) ecological theories of child development (see Bronfenbrenner's bio-ecological model in Appendix B). These conceptual developments have been mirrored by similar methodological advances: (i) the importance of a 'subjective perspective'; (ii) the 'child as a unit of observation'; and (iii) the utilisation of a wider spectrum of data sources, including administrative data.

Development of Indicators in Child Well-being in Ireland

Ireland has been to the forefront of some of these developments. In 2005, Nicgabhainn and Sixsmith (see Hanafin and Brooks, 2005: 38; Hanafin *et al.*, 2007) undertook research on 'children's understandings of well-being' to elicit the views of more than 250 children aged 8-19 on what well-being meant to them. While they identified similar items to adults they emphasised different priorities. For instance, the children highlighted relationships as most important to their well-being, particularly with their family and friends. This has been borne out in other surveys by Barnardos (2007) and the Ombudsman for Children (2007).

The NCCA has completed a comprehensive overview of literature and research on well-being in relation to adolescence and post-primary schooling (O'Brien, 2008). A number of themes in relation to education and well-being are drawn out. These include the need for educational provision to espouse principles of well-being, the recognition of the realities of relationships and of care, and the development of skills and cultural tools to participate in society. The review emphasises the importance of self efficacy which is highly influential in relation to capability and motivation.

The development of indicators of child well-being which reflect conceptual understandings has been limited by the availability of data, particularly comparative and duration data. An indicator of well-being has been defined as 'a measure of behaviour, condition or status that can be tracked over time, across people and/or geographic units' (Child Trends, 1997: 11, cited in Hanafin and Brooks, 2005: 22).

Fitzgerald (2004) examined the availability of data in Ireland for the construction of child well-being indicators. She concluded that Ireland has international standard data on population, employment status of parents, household living conditions and maternal and infant health. Ireland has data gaps in relation to disability, and children at risk of violence. Ireland's qualitative data are also limited in respect of relationships, parenting skills and children's use of time. Information on younger children, in particular, is limited. Some of these data gaps will be addressed through the National Longitudinal Study of Children currently underway.

Many indicators of child well-being have now been developed. Hanafin and Brooks (2005: 30) identified more than 2,500 child well-being indicators, drawn from eighty datasets. Commentators on indicators (Palmer and Rahman (2002), National Economic and Social Council (2002)) advise the selection of a 'manageable number of indicators' (Palmer and Rahman, 2002: 12). This is important for three reasons:

- ◆ A small number of indicators keep the project manageable and focused;
- ◆ A small number of indicators have a greater chance of acceptance in the policy arena; and
- ◆ A small number of indicators, which are readily understood, are more likely to become part of a generalised understanding than a more exhaustive list. (National Economic and Social Council, 2002: 6-7).

Limiting the number of indicators requires criteria for their selection. Various criteria have been advanced for the selection of indicators and indicator sets (for a summary of this work see Hanafin and Brooks (2005) and Bradshaw *et al.* (2006 and 2007). There appears to be four over-riding criteria for indicator selection:

- i. *Aspects of well-being*: that the indicators and indicator set cover the understanding of child well-being as comprehensively as possible.
- ii. *Capacity for disaggregation*: that child well-being can be compared across child and geographic groupings eg. age and gender of children, national and international comparisons.
- iii. *Availability and robustness of the data*: the availability of high quality, timely data which can be compared across countries and over time.
- iv. *Relevance*: that the information on children's well-being has resonance with policy makers, practitioners and others concerned with children's well-being.

The most comprehensive and up-to-date overview of the well-being of Irish children is contained in the Office of the Minister for Children and Youth Affairs' publication *State of the Nation's Children: Ireland 2008*. The report presents information on 56 indicators, organised in 4 parts:

- ◆ The socio-demographic situation of children in Ireland;
- ◆ Children's relationships with their parents and peers;
- ◆ Outcomes of children's lives (education, health and social, emotional and behavioural); and
- ◆ Formal and informal supports for children.

The *State of the Nation's Children: Ireland 2008* report is based on the national set of child well-being indicators developed in 2005 (Hanafin and Brooks, 2005; Hanafin *et al.*, 2007) which were considered by multiple stakeholders, including children, to be important. The indicators are informed by a holistic and up-to-date view of children's well-being. The 2008 report is an updated version of the original *State of the Nation's Children: Ireland 2006* report. Further information on children's

well-being has been produced by a wide range of bodies including the Central Statistics Office, the Economic and Social Research Institute, various government departments, state agencies, and academics, particularly the Children's Research Centre in Trinity College. The information base continues to be developed and will be substantially added to by the National Longitudinal Study of Children. Initial findings of this survey for 9 year olds have now been published (*Growing up in Ireland*, July 2009).

The Policy Context

The purpose of the examination of children's well-being in this report is to summarise some of the key trends and link these to the policy framework, particularly *Towards 2016*, with a view to identifying areas for policy reflection, information and indicator gaps. The trends identified under each of the six well-being domains, using a variety of indicators, are discussed in relation to the key high level goals for child well-being specified in *Towards 2016* and related priority actions. The vision and seven high level goals for children are as follows:

Towards 2016 Vision and High Level Goals

An Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own; where all children are cherished and supported by family and the wider society; where they enjoy a fulfilling childhood and realise their potential.

Ireland has ratified the UN Convention on the Rights of the Child and is committed to its implementation in our laws and policies.

To achieve this vision, the Government and social partners will work together over the next ten years towards the following long-term goals for children in Ireland:

- ◆ Every child should grow up in a family with access to sufficient resources, supports and services, to nurture and care for the child, and foster the child's development and full and equal participation in society;
- ◆ Every family should be able to access childcare services which are appropriate to the circumstances and needs of their children;
- ◆ Every child should leave primary school literate and numerate;
- ◆ Every student should complete a senior cycle or equivalent programme, (including ICT) appropriate to their capacity and interests;
- ◆ Every child should have access to world-class health, personal social services and suitable accommodation;
- ◆ Every child should have access to quality play, sport, recreation and cultural activities to enrich their experience of childhood; and
- ◆ Every child and young person will have access to appropriate participation in local and national decision-making.

The Indicator Framework

Taking all of these factors into account (conceptual understanding of child well-being, availability of data, and the policy framework) the following indicator framework is used to examine child well-being in Ireland, see Table 6.1.

Table 6.1 Construction of Child Well-being

Domains	Components	Indicators
Economic Resources	<i>Income</i>	Income inequality
	<i>Poverty</i>	Income poverty Consistent poverty
	<i>Deprivation</i>	Low family affluence
Work and Participation	<i>Work</i>	Jobless households
	<i>Early education</i>	Benchmarks in early childhood services
	<i>Educational achievement</i>	Literacy in reading, mathematics & science
	<i>Participation</i>	% of full-time and part-time students
	<i>Potential</i>	Not in education or employment
	<i>School Well-being</i>	Like school
Relationships and Care	<i>Marital breakdown</i>	Children in divorced/separated households Children in care
	<i>Family structure</i>	Lone parent families
	<i>Family relations</i>	Eating main meal together Parents talking to children Pets
	<i>Peer Relations</i>	3 or more friends Spend 4 or more evenings with friends Electronic media
	<i>Care</i>	Child carers
	Community and Environment	<i>Accommodation</i>
<i>Community</i>		Community and charity groups
<i>Environment</i>		Environmental awareness Deaths from accidents and injuries Good places to spend free time
Health		<i>Health at birth</i>
	<i>Immunisation</i>	Measles / DPT3 / Polio immunisation
	<i>Risk behaviours</i>	Smoking cigarettes
		Getting drunk
		Using cannabis
		Births to girls aged 10-17
	<i>Healthy behaviours</i>	Eat breakfast
		Physically active
	<i>Health assessment</i>	Rating health as fair or poor Access to health services
<i>Mental well-being</i>	Feeling lonely	
	Mental illness	
	Youth suicide	
Democracy and Values	<i>Exercising democracy</i>	Participation in making school rules Access to the internet
	<i>Threats</i>	Feeling safe
		Being bullied
		Domestic violence
	<i>Rights and equality</i>	Child abuse Being treated fairly Discrimination against children

These domains and indicators seek to capture the main elements of children's well-being. In relation to economic resources information on income, poverty and deprivation is presented, with a focus on low income and deprived families. As for adults participation in meaningful activity is important for child well-being. There are two main elements to this domain: the first is the extent to which the child's family is engaged in paid employment – with a focus on jobless households which have been shown to be unfavourable to children's well-being. The second element is the child's participation in education, where a number of indicators are presented including early education, educational participation, achievement, and future potential as well as school well-being.

The third domain looks at relationships which children themselves view as central to their well-being. Positive and negative indicators are presented, including children in divorced or separated households, children in care, lone parent families, children with caring responsibilities, and relationships with family members and peers. The fourth domain explores the child's local community and environment. Information is presented on housing indicators, community participation and the quality of the child's local environment.

Health is the fifth domain and covers many elements of a child's life from birth to late teenage years. Indicators are presented on health at birth, immunisation, through to risk behaviour such as smoking and drinking to healthy behaviours such as eating fruit and being active. Indicators are also included on mental well-being and children's own rating of their health.

The final domain is democracy and values and indicators here capture children's involvement in decision making, threats to their well-being and experiences of discrimination and abuse (as a contravention of their rights).

In international work, especially by Unicef and Jonathon Bradshaw, a composite index has been developed to measure children's well-being. The composite index is not used in this report but the main findings are presented in Appendix C and reference is made to some of the key findings, where relevant, throughout this chapter on children's well-being.

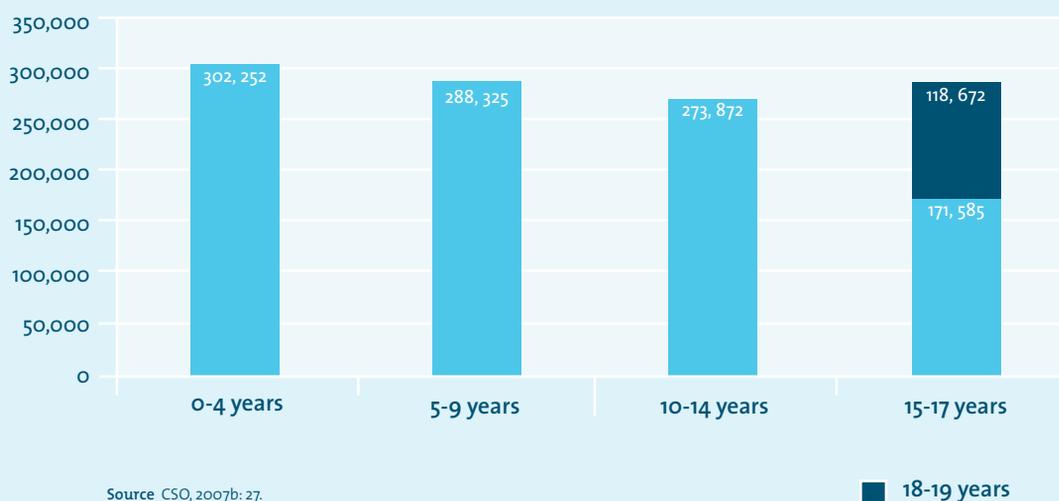
This chapter draws heavily on the *State of the Nation's Children* reports as the most up to date and comprehensive data source on children's well-being in Ireland. In some places information is drawn from other sources and referenced accordingly.

6.3 The Context for Children's Well-being in Ireland

Composition of the Child Population

Ireland has 1,036,034 children aged under 18 (2006), 51 per cent of whom are boys and 49 per cent girls. Children and young people under 18 make up 24 per cent of the Irish population. The age profile of Ireland's children is illustrated in Figure 6.1

Figure 6.1 Number of Children in the State by Age Group, 2006



In 2006, 62,800 children were non-Irish nationals, representing 6 per cent of the total child population in Ireland. The number of non-Irish national children has increased by almost 60 per cent over the period 2002-2006. Some 30 per cent of non-Irish national children live in Dublin, and a further 10 per cent live in Cork. Almost one-third of non-Irish national children reported their nationality as British or Northern Irish. Eight per cent of non-Irish children reported their nationality as Polish, the next most common nationality after British/Northern Irish. Other common nationalities for non-Irish national children were Nigerian, Lithuanian and American. Some 1.1 per cent of all children are Traveller children (CSO, Census 2006). Traveller children under the age of 18 account for almost fifty per cent of the total Traveller population in Ireland.

In May 2009, there were 2,235 children whose families were seeking asylum and who were living in Direct Provision⁴ (Reception and Integration Agency, 2009). In 2006, there were 569 children who were separated from their families who were seeking asylum, with one in three (35 per cent) of these children less than ten years old. Fifty eight per cent of the separated children seeking asylum were subsequently reunited with their families and 38 per cent were placed in the care of the HSE⁵ (OMCYA, 2008a).

4. Direct Provision is a support system for asylum-seekers whereby all accommodation costs together with the cost of three main meals and snacks, heat, light, laundry, maintenance, etc are paid directly by the state. In addition, asylum seekers in receipt of direct provision are paid €19.10 per adult and €9.60 per child per week.

5. The outcomes for the remainder are not known.

Many children in vulnerable situations come within the care of the HSE. In 2006, the number of children in the care of the HSE was 5,247, 88 per cent of whom lived in foster family homes. The number of children who, following a report to the Social Work Department in the HSE, had an initial assessment for a child welfare and protection concern was 12,520.

Some 35,900 young people have a disability, which is 3.5 per cent of people aged 0-17 (CSO, 2008d, National Disability Survey, 2006). In 2007, there were 7,802 young people under the age of 18 registered as having an intellectual disability, and 8,373 registered as having a physical and/or sensory disability (OMCYA, 2008a – based on figures supplied from the HRB Disability Databases⁶). In 2006, there were 398 admissions to hospital for psychiatric care among children, with young people aged 15-17 accounting for 84 per cent of these admissions (OMCYA, 2008a).

Quantitative information is not available on the sexual orientation of young people in Ireland. Research by the UK Government estimated that 5-7 per cent of the population aged 16 and over were lesbian, gay or bisexual (LGB) (UK Department of Trade and Enterprise, 2004). Applying this statistic to Ireland it could be expected that 5,000-8,000 sixteen and seventeen year olds are LGB. Most studies confirm that self-realisation of one's sexual identity occurs in the adolescent years: this can be a difficult time for many young people, but especially so for young people identifying as LGB.

While the proportion of young people in the population as a whole has consistently decreased over the last 25 years, Ireland still has a relatively high proportion of young people compared to most other European countries. However, even with a recent rise in births, the fertility rate⁷ for Ireland was 1.9 in 2006, which is below the replacement level of 2.1 (CSO, 2007h: 75). Factors affecting the fertility rate include postponement of childbearing and women having fewer children. The mean age of Irish women at childbearing has remained stable over the past ten years and is now 30.6 (Eurostat, 2006). Tax and welfare, and labour market policies can directly or indirectly affect fertility patterns, through influencing decisions on whether and when to have children. Particularly important here are supports for children directly and policies enabling families to combine family and work.

Family Benefits

According to the OECD (OECD, 2007c) Ireland invests just above average on family benefits in cash, services and tax breaks, see Figure 6.2.⁸ Ireland is one of the higher spenders on cash benefits but one of the smallest on services for children. This finding is borne out by other work of this nature by Bradshaw and Finch (2002)

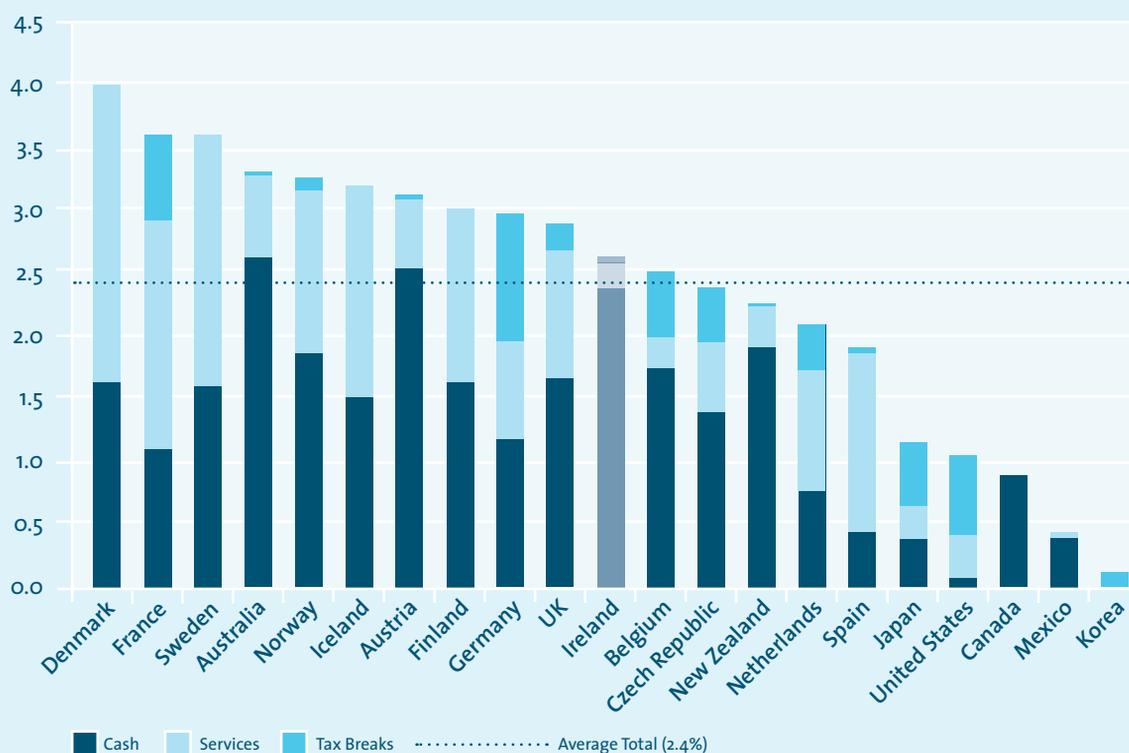
6. The Health Research Board holds two registers of disability: The National Intellectual Disability Database and the National Physical and Sensory Database. The National Intellectual Disability Database (NIDD) was established in 1995 to provide a comprehensive and accurate information base for decision-making in relation to the planning, funding and management of services for people with an intellectual disability. Currently, there is approximately 95 per cent coverage on the NIDD database. The National Physical and Sensory Disability Database (NPSDD) was piloted in 2000/1 and national implementation began in 2002 to provide a comprehensive and accurate information base for decision-making in relation to the planning, funding and management of services for people with a physical and/or sensory disability. Currently, there is approximately 65 per cent coverage on the NPSDD database. Participation in these databases is voluntary and only includes those in receipt of, or requiring, specialised disability services; therefore they do not necessarily include all young people living in Ireland who have a physical and/or sensory disability or an intellectual disability. In general, where people with profound, severe or moderate intellectual disabilities also have physical or sensory disabilities, they are registered on the NIDD, and consequently not included on the NPSDD.

7. Total period fertility rate (TPFR) estimates the number of children who would be born to each female over her lifetime on the basis of current birth patterns.

8. The OECD use GDP rather than GNP or GNI.

and Timonen (2003, 2005). Bradshaw and Finch found that while Ireland was ranked 5th of 22 countries when child related taxes and benefits were taken into account, it fell to joint 11th (with the USA) when housing, childcare, health and education costs were taken into account.⁹ The balance between income supports and service provision for children is the subject of ongoing debate in the current economic climate. This issue is addressed throughout the chapter in the various sections charting trends across the well-being domains and the associated policy commitments. What is clear, however, is that there are many children and families in vulnerable situations, and for these families good service provision with adequate income supports is vital to their well-being. NESC, in its Developmental Welfare State approach, has emphasised the ‘radical development of services as the single most important route to improving social protection (NESC, 2005a: xix).

Figure 6.2 Public Spending on Family Benefits, International Comparisons, 2003
Percentage of GDP



Source OECD (2007) Social Expenditure Database

Note 'Public spending' presented here is that exclusively for families (child payments and allowances, parental leave benefits and childcare support). Spending in other social policy areas such as health and housing also assists families but is not recorded here.

9. It is noted that the Early Childcare Supplement was introduced after this study was undertaken and there have been increases in other areas of child income support. There have been further changes in child income supports since the onset of the recession.

Happiness and Life Satisfaction

Before examining the six domains of child well-being employed in this report it is useful to have an overview of how children view their lives. Two measures, drawn from the Health Behaviour in School-aged Children (HBSC) survey, can be used.¹⁰ The first measure asks children if they are happy with their life. The survey found that 50 per cent of children in Ireland reported being 'very happy' in 2006, a 10 per cent increase since 1998. Boys (55.4 per cent) are happier than girls (48.5 per cent) and being 'very happy' declines with age, from 62.3 per cent of 10-11 year old boys and 63.5 per cent of 10-11 year old girls to 40.8 per cent of 15-17 year old boys and 33 per cent of 15-17 year old girls (HBSC, 2006). There is little variation across social class.

The second measure is self-reported life satisfaction. Eighty three per cent of 15 year olds in Ireland (boys and girls) report high life satisfaction, ranking 16th among 32 countries in Europe and North America. The Netherlands ranks highest at 90 per cent, and Turkey lowest at 63 per cent, with Ireland being mid-range. As reported by the authors of HBSC Ireland (Walsh, Clerkin and Nic Gabhainn, 2002) strong family and peer relationships are associated with self-rated happiness and life satisfaction. They argue that attention should focus on children who rate their happiness and life satisfaction as being poor, with emphasis being placed on identifying and addressing the underlying reasons. The following sections of this chapter will attempt to do this across the main domains of child well-being employed in this social report.

6.4 Economic Resources

6.4.1 Measuring the Economic Well-being of Children in Ireland

Economic resources are a fundamental element of child and family well-being. The economic well-being dimension is considered using three components: income, poverty and deprivation.

Income Inequality

The income component is assessed using an indicator on income inequality. Figure 6.3 shows that Ireland has a disproportionately large number of children towards the bottom of the income distribution. If the distribution was equal there would be twenty per cent of children in each income quintile. The graphic shows that 45.3 per cent of children are in the bottom two quintiles.

10. The Health Behaviour in School-aged Children (HBSC) survey is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study aims to gain new insight into, and understanding of, young people's health and well-being, health behaviours and their social context. HBSC was initiated in 1982, and there are now 43 participating countries and regions, worldwide. The first cross-national survey was conducted in 1983/84, the second in 1985/86 and, since then, data have been collected every four years using a common research protocol. The most recent survey, the seventh in the series, was conducted in 2005/6. The Irish data are collected and analysed by the Health Promotion Research Centre at NUI Galway, where Dr. Saoirse nic Gabhainn is the Principal Investigator. Ireland joined the HBSC network in 1994 and conducted the first survey of Irish school children in 1998. The 2006 survey is the third time of Ireland's involvement in the international collaboration, collecting information on school-going children aged 10-18. References throughout this chapter to HBSC 2006 refer to this survey. Articles/reports using analysed data are referred to by author name and date. Further information is available at www.hbsc.org and www.nuigalway.ie/hbsc.

Figure 6.3 Children Across Income Quintiles, 2007



Source CSO, 2008b: 32-33.

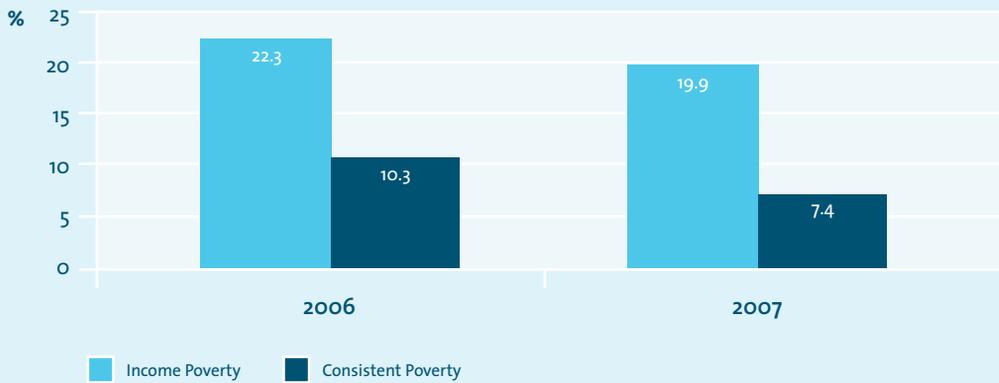
Countries with the greatest degree of income inequality, in general, tend to have the highest rates of child poverty. Esping-Anderson has emphasised this point in his discussion on a current 'era of inequalities' (Vleminckx & Smeeding, 2001: vii). Applying a life cycle approach he notes that 'this new inegalitarian thrust is worrisome because it coincides with a sharp shift in the distribution of social risks across citizens' life course, from the old to the young, and most problematic of all, to families with children'. A key concern is the 'economic vulnerability' of families.

Poverty

The second component examines the economic vulnerability of families by presenting indicators for income poverty and the Irish measure of consistent poverty. Using the EU-SILC at-risk-of-poverty measure, (the percentage of children living in homes with equivalent disposable income below 60 per cent of the national median), 19.9 per cent¹¹ of children in Ireland in 2007 were at risk of income poverty, falling from 22.3 per cent in 2006. Some 7.4 per cent of children in Ireland were in consistent poverty in 2007, compared to 10.3 per cent in 2006, see figure 6.4. Poverty among children is higher than poverty among the working age population and higher than poverty among older people.

11. Including SSIA income. If SSIA income is excluded 19.0 per cent of children were at-risk-of-poverty in 2007. For further elaboration of the influence of SSIA income on poverty rates, see Chapter 4 and EU-SILC 2007 (CSO, 2008b).

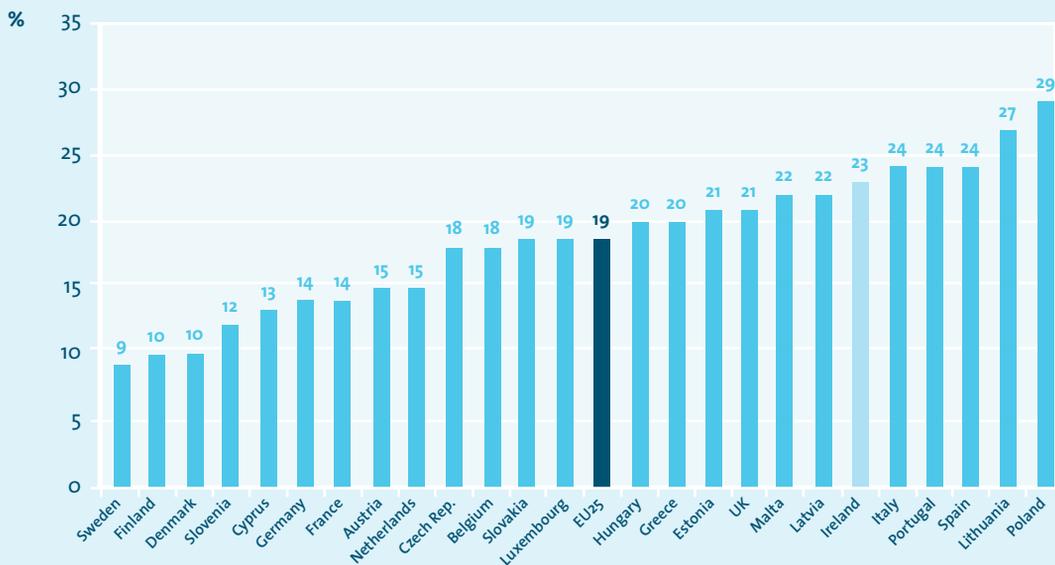
Figure 6.4 Child Poverty in Ireland, 2006 and 2007



Source CSO, EU-SILC publications.

In European terms Ireland has a high level of child poverty even though we have experienced strong economic growth and have in place a national anti-poverty strategy and national children's strategy with child poverty reduction targets, see Figure 6.5. In the face of an economic recession renewed emphasis will be required to ensure we continue to reduce child poverty and meet the child poverty reduction targets.

Figure 6.5 At-Risk-of-Poverty Rates for Children, EU25 Comparisons, 2005



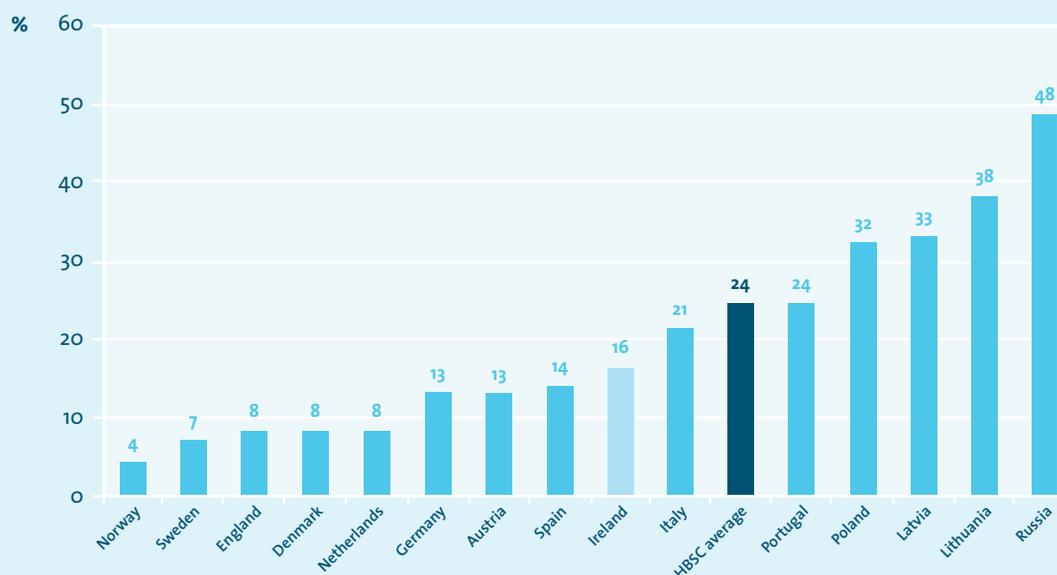
Source EU-SILC, 2005

Important elements of child poverty are its depth and duration as well as the links between income poverty, deprivation, social exclusion and inter-generational poverty. Research on some of these issues has been carried out in Ireland by Layte *et al.*, 2006. They found that that 17 per cent of Irish children have spent 5 to 8 years in income poverty. The households within which children live influence the amount of time spent in childhood poverty, with younger children and children in larger families spending the longest time in poverty. The duration of child poverty is affected by their parents' employment and educational status, the number of working adults in the household and the household's dependence on social welfare.

Low Family Affluence

While the level of income tells us where households with children sit in relation to the overall population and enables us to make comparisons between countries it does not necessarily tell us the extent to which children have access to basic items within the household. The third component of the economic resources domain is deprivation. This is assessed using the indicator 'percentage of children reporting low family affluence' from the World Health Organisation's (WHO) survey of *Health Behaviour in School-age Children (HBSC)*. Low family affluence records absence of vehicles, holidays, computers and own bedroom.

Figure 6.6 Low Family Affluence, Selected Countries, 2006



Source HBSC, 2008:15.

On this measure of deprivation, 16 per cent of children in Ireland live in families with low family affluence, see Figure 6.6. This is below the HBS average of 24 per cent. Countries with less than 10 per cent of low affluence families are Norway, Sweden, England, Denmark and the Netherlands. Those countries with the highest percentage of low affluence families (more than 30 per cent) are Poland, Latvia, Lithuania and Russia.

Summary

Ireland has relatively high levels of child poverty with one in five at risk of income poverty. Irish rates of child poverty are high in European terms and in comparison with other life cycle groups (working age adults and older people) in Ireland. The inequality of the income distribution is a contributory factor, along with parents' employment and education levels, the number of working adults in the household and the family's dependence on social welfare payments. Seven per cent of children in Ireland live in consistent poverty and 16 per cent live in families with low levels of affluence. Some of these families experience economic vulnerabilities with some children (especially in larger and/or lone parent families) spending much of their childhood in poverty.

6.4.2 Ireland's Policy Framework on Economic Well-being for Children

The current policy framework *Towards 2016* contains a number of commitments on economic resources for children. Overall, the social partners to the agreement are committed that:

'Every child shall grow up in a family with access to sufficient resources, supports and services, to nurture and care for the child, and foster the child's development and full and equal participation in society'.

Specific priority actions towards meeting this objective include:

- ◆ Combined value of child income support to be set at 33-35 per cent of the minimum adult social welfare payment; and
- ◆ Assisting families on low incomes through new or reformed mechanisms such as a second tier child income support.

Ireland has a policy mix of non-income related payments, means-tested payments and income supports for low income workers to support the well-being of children in general and children who are disadvantaged, in particular. The extent and value of this support has increased substantially in recent years, particularly through substantive increases in Child Benefit, and the introduction of the Early Childcare Supplement. However, the Early Childcare Supplement will be abolished at the end of 2009, and replaced with a free pre-school year of Early Childhood Care and Education for all children between the ages of 3 years and 3 months and 4 years and 6 months. Revisions have been made to the Family Income Supplement to improve the financial situation of low income families, although take-up still remains an issue. Despite these increases and improvements, child poverty in Ireland has remained stubbornly high.

6.4.3 Commentary on Economic Well-being for Children

Research by Unicef (2005) found that the greater the proportion of GDP devoted to supporting families with children the lower the risk of children growing up in poverty. However, they found no fixed ratio between the two, so that children's economic well-being depends not only on 'the level of government support but on the manner of its dispensation and on the priorities governing its allocation' (Unicef, 2005: 23).

Bradshaw and Finch (2002: 183) argue that while the wealth of nation's matters, particularly the equality of the income distribution, ultimately it is the effectiveness of policies which determines children's well-being. They state 'that it is not the level of wealth of a nation, nor the character of its labour market, nor the level of earnings but rather its social expenditure and especially the share of its social expenditure going to families ... that determines the child benefit package. ... The level of the child benefit package achieved is also associated with success in reducing market-generated levels of child poverty.'

In their analysis of 'what works best in reducing child poverty: a benefit or work strategy?', Whiteford and Adema of the OECD (Whiteford and Adema, 2007: 4) conclude that 'the fact that all countries with very low child poverty rates (less than 5%) combine low levels of family joblessness and effective redistribution policies supports the view that successful anti-poverty strategies should seek a balanced approach combining improved benefits where necessary and improved incentives to work'.

This is also the message from Frazer and Marlier (2007: 59) who examined policies to promote the social inclusion of children across the EU. They identify the need for an adequate balance of employment, tax and social protection policies to ensure an adequate income for families with children. Specifically they argue for the need to increase opportunities for parents to earn a decent income from work and for this to be supported by tax and social welfare policies that support families with children. Subsidised services for families and children on a low income are also important. These issues are addressed in the following sections.

In monitoring progress on addressing children's economic well-being, and child poverty in particular, there is a need to continue to improve our information sources. Firstly, it would be useful to consistently present data for 0-17 year olds. The CSO's presentation of this information in their recent EU-SILC results is welcome (CSO, 2008). Secondly, it would be useful to know how income is distributed within the household and how and what proportion is allocated to children and promotion of their well-being. There are qualitative data which provide insights, but this whole area could be improved.

Thirdly, further information on deprivation would also help as would the duration and depth of poverty. The National Longitudinal Study of Children *Growing up in Ireland* will provide some insights in this regard but other survey and administrative data could also contribute to our knowledge on the nature and extent of poverty and deprivation among children. While current indicators of child economic well-being in Ireland are able to provide the required indicators for international and European comparisons, further work on child deprivation indicators would be useful.

It would also be relevant to track the percentage of GDP/GNP/GNI spent on children's economic well-being, particularly on child income supports, and to plot this against child poverty rates, using a number of the relevant measures.

Summary

Child poverty remains high in Ireland despite the unprecedented economic growth in the 1990s and early 2000s, with associated increases in child income support rates. Based on the evidence assessed for this report, the policies being pursued in Ireland should be purposely reviewed. Fruitful areas for consideration include the interaction and appropriate policy mix of tax, welfare, employment, housing, family and childcare policies in order to find the optimal balance to promote children's economic well-being. A number of policy proposals and research reports already exist, which warrant further consideration with a view to an integrated approach to their implementation, for example see NES, 2008a. In particular, the position of children and families vulnerable to poverty, including families incurring additional costs of disability, warrants further consideration, especially in the light of the economic recession and large increases in unemployment. As proposed throughout this report, more tailored approaches are required, with the balance between income support and service provision critical. Furthermore, it will be important to monitor birth rate trends so that future needs and provision can be adequately planned and catered for.

6.5 Work and Participation

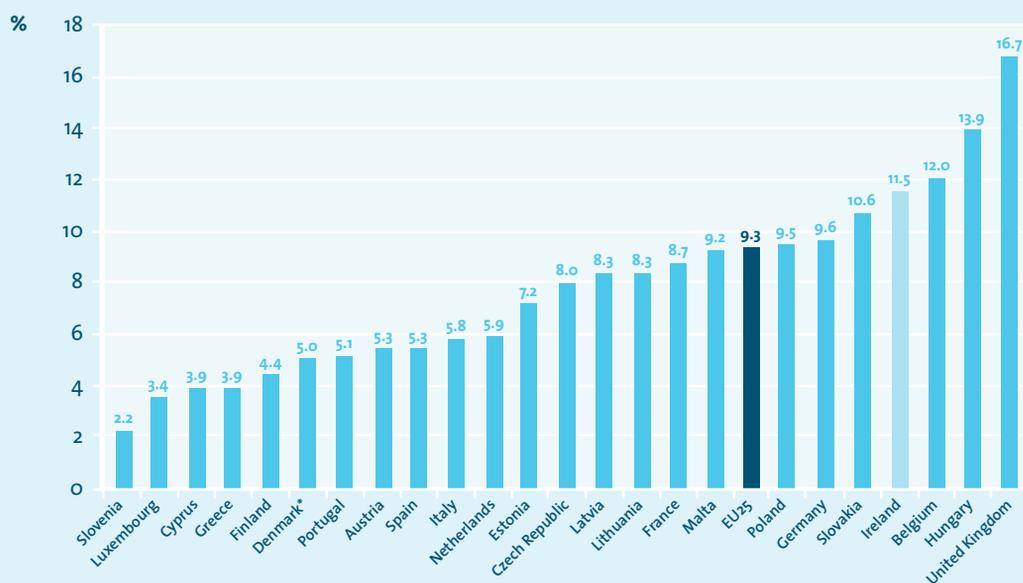
6.5.1 Measuring the Work and Participation of Ireland's Children

Participation in meaningful activity is central to the current and future well-being of children and young people. The participation of their family in work or other meaningful activity also impacts on the well-being of the child and the family unit. The work and participation dimension of children's well-being is measured using 6 components: work, early education and development, educational achievement, educational participation, potential, and school well-being.

Jobless Households

The first component, work, is measured by the percentage of children living in families without an employed adult. Many studies have found an association between joblessness and child poverty. Jobless households have a particularly high poverty risk, being dependent in the main on social welfare benefits. A child growing up in a jobless household is also at a disadvantage in being unconnected to the world of work. Using Eurostat figures for 2007, 11.5 per cent of children in Ireland live in households where no-one is in paid employment compared to an EU25 average of 9.3 per cent, see Figure 6.7. In Ireland, six out of ten children in jobless households are in income poverty (below the 60 per cent threshold) compared to one in ten children in households where at least one adult is working (Dunne *et al*, 2007: 23). While the proportion of jobless households fell during the Celtic Tiger years of strong employment growth, the increase in jobless households in the economic recession is of concern.

Figure 6.7 Children Living in Jobless Households, EU Comparisons, 2007



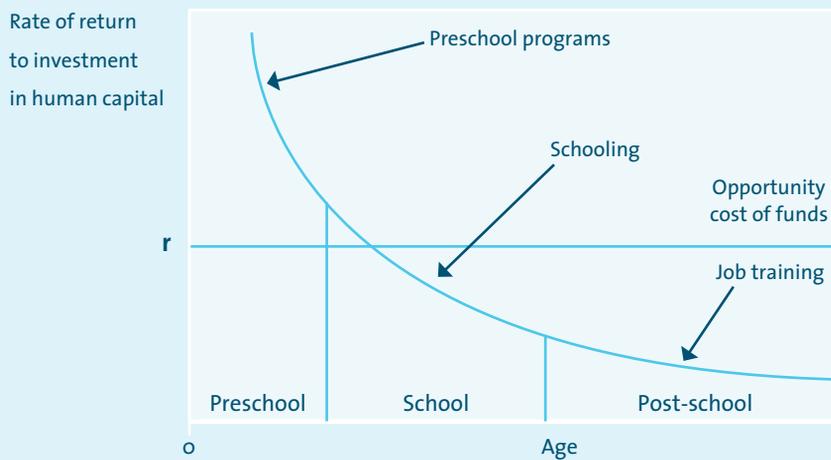
Source Eurostat LFS, 2007.
*Figures for 2006.

Early Childhood Development

The second component of participation is early childhood education and development. Giving children a good start in life, especially children from a disadvantaged background, stands them in good stead for the rest of their life. From both child well-being and economic viewpoints research shows that high quality early education programmes for all children, but particularly for children living in poverty, contributes to children's intellectual and social development and to their school success and economic performance in adulthood. A number of longitudinal studies have shown rates of return from \$4 to \$17 for every dollar invested.¹²

12. See Unicef, 2008; pp 10-11 which describes the Abecedarian Project in North Carolina, United States where returns of \$4 for every dollar invested were estimated. Similarly, the Perry Pre-school Project in Michigan, United States which ran from 1962 to 1967 found in a 2006 evaluation of individuals involved in the project (at age 40) a benefit-cost ratio at more than \$8 for every dollar invested. Indeed, Schweinhart's research (2004) has shown that 'long-term effects are lifetime effects. The cost benefit analysis showed a \$17 dollar return on each dollar invested' (cited in NESF, 2005: 4).

Figure 6.8 Rates of Return to the Same Investment Made in a Person of a Given Ability at Different Ages



Source Cunha et al. (2005), *Interpreting the Evidence on Life Cycle Skill Formation*

Figure 6.8, which shows the rates of return to investment in human capital at different stages in the life cycle, demonstrates clearly the high rates of return for pre-school programmes, particularly in comparison to school and post-school programmes.

Across the developed world a transition in early childhood care and education has been taking place. As documented by Unicef (Child Care Transition, 2008a) and the OECD (Starting Strong II, 2006b) 'out of home' child care is increasing for a number of reasons: a majority of women of working and child bearing age are now working outside the home; governments are encouraging women into the workforce; and pre-school education is increasingly seen as an investment in future academic and career success. It has been estimated that approximately 80 per cent of the OECD countries' three to six year olds are in some form of 'out of home' early childhood education and care (Unicef, 2008a: 3). A related development is neuroscience research which has demonstrated the importance of loving, stable, secure and stimulating relationships with caregivers in the earliest months and years of life for a child's development (Unicef, 2008a: 1 & 6-7).

Data on the care and education of young children are limited. In an attempt to address this deficit Unicef (2008a) has proposed a set of ten internationally applicable 'benchmarks' for quality early childhood care and education.¹³ These ten benchmarks cover the areas of: policy framework (1 and 2), access (3 and 4), quality (5, 6, 7 and 8) and supporting context (9 and 10). The ten benchmarks are:

13. Unicef note that this is very much a first attempt to establish benchmarks for early childhood services. The benchmarks are very much determined by the availability of internationally comparable data. For example, data on children younger than four or five years old, and data on informal childcare arrangements are limited. No outcome indicators are included. Future work is expected to focus on agreeing common definitions, more sensitive indicators, better data and measuring the extent of the disparities between children's abilities at point of entry into the formal education system.

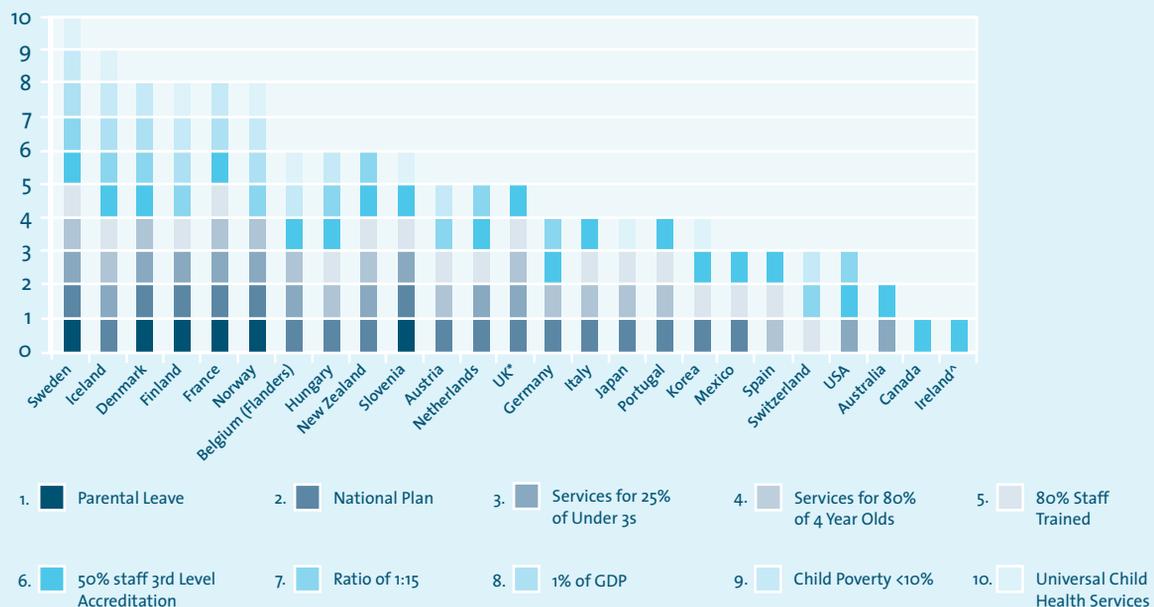
1. *A minimum entitlement to paid parental leave* measured by one parent being entitled to leave of at least a year (including pre-natal leave) at 50 per cent of salary (subject to upper and lower limits).
2. *A national plan with priority for disadvantaged children* measured by the proxy of whether governments have drawn up a plan for the organisation and financing of early childhood services.
3. *A minimum level of childcare provision for under threes* measured by subsidised and regulated childcare services being available for at least 25 per cent of children under the age of three.
4. *A minimum level of access for four year olds* measured by at least 80 per cent of four year olds participating in publicly subsidised and accredited early childhood services for a minimum of 15 hours per week.
5. *A minimum level of training for all staff* measured by at least 80 per cent of staff who have significant contact with young children, including 'home-based' child carers having relevant training, including at least an induction course.
6. *A minimum proportion of staff with a higher level of education and training* measured by at least 50 per cent of staff in early education centres supported and accredited by governmental agencies having a minimum of three years tertiary education with a recognised qualification in early childhood studies or related field.
7. *A minimum staff to children ratio* measured by the ratio of no more than 15 pre-school children (four to five year olds) to 1 trained staff, and that group size should not be greater than 24.
8. *A minimum level of public funding* measured by at least 1 per cent of GDP to be spent on early childhood education and care (for children aged 0-6).
9. *A low level of child poverty* measured by less than 10 per cent of children in families in which income is less than 50 per cent median equivalised disposable income.
10. *Universal outreach* measured by the proxy of the extent to which basic child health services have been made available to the most marginalised and difficult-to-reach families. A country is expected to fulfil two of three requirements to reach this benchmark: a) the rate of infant mortality is less than 4 per 1,000 live births; b) the proportion of babies born with a low birthweight (below 2,500 grams) is less than 6 per cent; and c) the immunisation rate for 12 to 23 month-olds (averaged over measles, polio and DPT3 vaccination) is higher than 95 per cent.

Figure 6.9 presents the extent to which each of 25 OECD countries meet these benchmarks, as assessed by Unicef in 2007/early 2008. Only Sweden meets all ten. According to Unicef, Ireland fares particularly badly, meeting only one of the ten benchmarks: having at least 50 per cent of staff in accredited early education services tertiary educated with a relevant qualification. Looking specifically at GDP spend on early childhood care and education, in 2003, Ireland spent 0.2 per cent of GDP on these services, compared to an OECD average of 0.7 per cent of GDP. On this measure, Ireland ranks 27th or second lowest of 28 OECD countries.

Unicef has qualified their findings, stating that the measures are ‘crude’, reflecting the availability and quality of data. The Irish Office of the Minister for Children and Youth Affairs (OMCYA, 2008b) has updated the information used by Unicef (data was supplied in 2007) finding that Ireland now meets at least 4 out of the 10 benchmarks with progress being made in the other areas. The following benchmarks have now been met:

1. *Parental leave* – Irish women are entitled to 26 weeks paid maternity leave (together with 16 weeks unpaid maternity leave), which is equivalent to 52 weeks at 50 per cent of salary.
2. *National plan* – The National Childcare Strategy, together with the DEIS¹⁴ Programme and the National Childcare Investment Programme, contains specific measures to deal with disadvantage.
3. *A low level of child poverty* – 7.9 per cent of children aged under 6 in Ireland are below the poverty line (set at 50 per cent of median equivalised disposable income), which is below the 10 per cent threshold set by Unicef.
4. *Universal child health services* – Ireland now meets two of the three requirements of this benchmark: infant mortality is 3.7 infant deaths per 1,000 (below the benchmark of 4); and 5.7 per cent of babies were born with a low birth weight (below the benchmark of 6).

Figure 6.9 Benchmarks on Early Childhood Services, International Comparisons, 2008



Source Unicef, 2008: 2

* Data for the UK refer to England only.

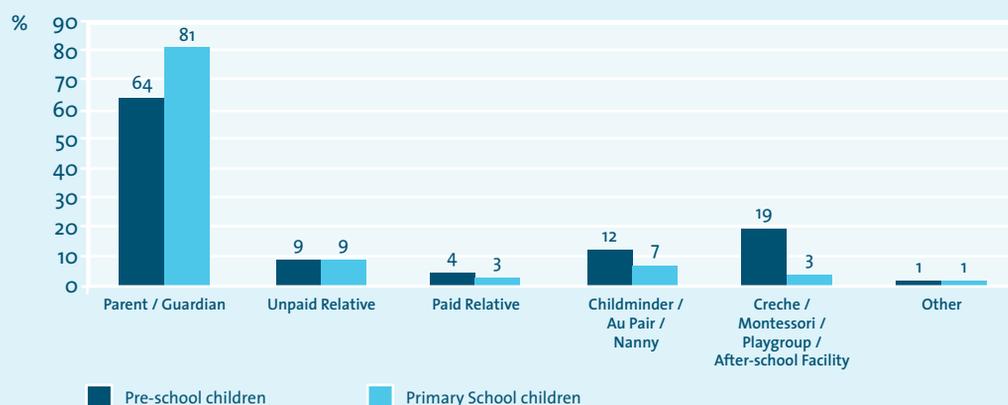
^ Data for Ireland have since been updated by the Office of the Minister for Children and Youth Affairs, showing that Ireland now meets at least 4 of the benchmarks – see update in the text.

14. DEIS is Delivering Equality of Opportunity in Schools. The DEIS programme is focused on addressing the educational needs of children and young people from disadvantaged communities, from pre-school through to second level.

In addition, the OMCYA, accepting that some targets have not been achieved, has stated that progress has been made on all the benchmark areas. For example, 72 per cent of childcare staff have a childcare relevant qualification (benchmark 80 per cent), and 30 per cent of employees in the childcare and early childhood education sector possess a third level qualification (benchmark 50 per cent). A further point made by the OMCYA is that the majority of Irish parents choose to care for their children themselves or have them cared for by a relative. Unicef provides the caveat that their benchmarks offer no measure of parental involvement in early childhood services. However, they do make the point that new knowledge about the early childhood period shows that ‘care without education is not care’ (Unicef, 2008a: 8).

Figure 6.10 shows the types of childcare used by pre-school and primary school children aged 0-12 years in Ireland (CSO, 2009a). In 2007, three quarters (75 per cent) of all children aged 0-12 were cared for by their parents, with primary school children (81 per cent) more likely to be cared for by their parents than pre-school children (64 per cent). However, between 2002 and 2007 the proportion of households using non-parental childcare for pre-school children increased from 42 per cent to 48 per cent for pre-school children, while the proportion using non-parental childcare for primary school children remained unchanged at 25 per cent. The main types of non-parental childcare used by pre-school children were crèche/montessori/playgroup (19 per cent), followed by childminder/au pair/nanny (12 per cent), unpaid relative (9 per cent) and then paid relative (4 per cent). Unpaid relative (9 per cent) and childminder/au pair/nanny (7 per cent) were the most popular forms of non-parental childcare used by primary school children. Overall, pre-school children spent an average of 24 hours per week in non-parental childcare. Information from the OECD showed that in Ireland 10 to 15 per cent of 0-3 year olds had access to regulated services, while 56 per cent of children aged 3-6 years were enrolled in public pre-primary schools (OECD, 2006b: 351).¹⁵

Figure 6.10 Types of Childcare Used by Children Aged 0-12 Years by School Going Status, 2007



Source CSO QNHS Q4 2007 Childcare Module

15. It is noted that many children aged 4 to 5 in Ireland are in Infant Classes in Primary Schools and are thus classified as in Primary Education.

Almost two thirds (65 per cent) of children who lived in lone parent households where the parent worked full-time and 58 per cent of children who lived in couple households where both parents worked full-time used non-parental childcare.

The average weekly expenditure by households who used paid childcare for their children aged 12 years and under was €144 in 2007,¹⁶ rising to €192 in the Dublin region. The National Children's Nurseries Association survey (2008) of their members¹⁷ showed that the average national price for childcare in Ireland in 2008 was €174 per week (ranging from €222 per week in South Dublin to €126 in Cavan). The costs of childcare in Ireland have been estimated to be in the order of 17 to 20 per cent of earnings, compared to a European average of 8 per cent (McWilliams, 2007).

For families on average or lower earnings internationally comparable data from the OECD (2004) showed that childcare costs are higher in Ireland than anywhere else in the OECD (NESC, 2008b: 225). Unicef noted that for children under 3 in the Nordic countries services are organised at community level and are highly subsidised, with parents paying no more than 10 to 15 per cent of the costs, with fees waived completely for low income families. By comparison, in English-speaking countries with market-oriented approaches, including Ireland, parents often have to bear the full costs for children under three (Unicef, 2008: 20). The Community Childcare Subvention Scheme (CCSC) subsidises childcare costs for low paid and disadvantaged parents in 865 community based not-for-profit childcare facilities. The average weekly fee for parents using the CCSC services was €83 in 2008.¹⁸ The CCSC, which was introduced in 2007, has been subject to a number of ongoing issues since its introduction.

Features of Irish early childhood care and education, in addition to its historic lack of investment and its relative expense, are its availability and 'proliferation of settings' (Harvey, 2007: 33). Settings for early childhood education and care include crèches, playgroups, nurseries, pre-schools, naoinraí, after-school and early start centres. As is evident from the information presented above, Ireland's current early childhood system is notable for the large role of the family and informal care, and the emerging roles of the private and not-for-profit sectors. 'In effect, a two-tier system is developing with publicly-subsidised early childcare focused on some socially disadvantaged children, while the majority of families purchase services that range from the developmentally excellent to those that simply 'park' children while their parents work' (NESC, 2008: 225).

16. This figure is based on the 26 per cent of households who used paid childcare in the QNHS, Childcare Module, Q4, 2007.

17. The National Children's Nurseries Association (NCNA) is a membership organisation for providers of quality full day care and after school care for children and represents approximately 800 providers of childcare in Ireland. NCNA members provide childcare services for 40,361 children and employ 8,988 staff.

18. Parental fees charged under the scheme for July-December 2008 for full daycare, ranged from an average of: €40 for parents in Band A (social welfare recipients and CE workers); €70 for parents in Band B (low income working families on FIS, other employed adults who had been on Band A last year and FAS trainees); €95 for parents in Band C (lower to middle income families above the FIS threshold, generally those holding a GP visit card or medical card); €140 for parents in Band D (middle to higher income parents).

Diversity in child care provision is not unusual (Unicef, 2008), but the cost, availability and quality of childcare is critical, especially for disadvantaged children. In Ireland, when asked, 60 per cent of parents disagreed with the statement '*I have access to high quality, affordable childcare in my community*' (CSO, 2009: 21). When asked if there was an alternative type of childcare they would like to use, 20 per cent of households wanted an alternative type of childcare for their pre-school children and 15 per cent wanted an alternative type for their primary school children. For pre-school children the most common reason for not using an alternative was cost/financial, while for primary school children the most commonly stated reasons were lack of availability and cost/financial reasons.

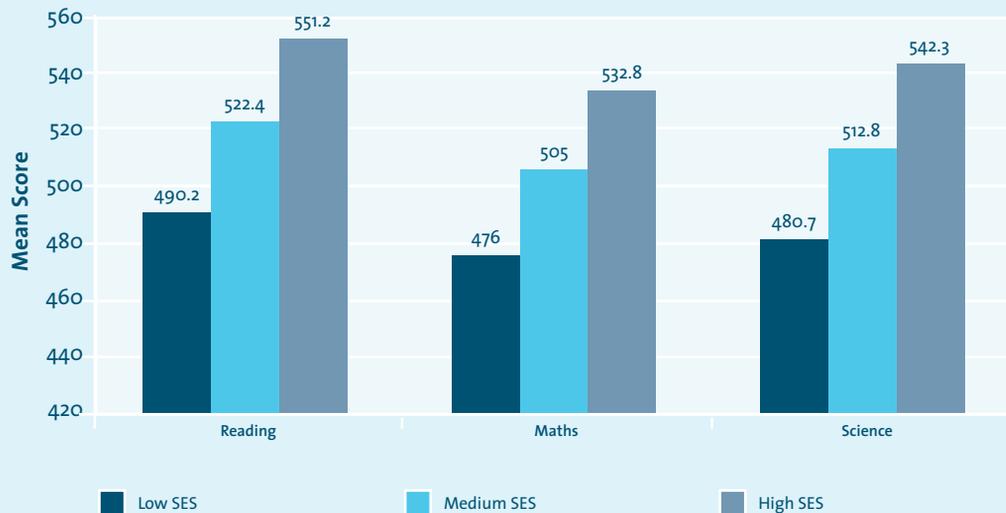
Educational Achievement

The third component of participation is educational achievement. The UN Convention on the Rights of the Child, Article 29 states that 'The development of the child's personality, talents and mental and physical abilities to their fullest potential' is the challenge to the education system, in the development of children's educational well-being. The indicators presented here relate to achievement at age 15 in reading, mathematics and science.

The OECD's *Programme of International Student Assessment (PISA)* measures the abilities of 15 year olds. The analysis from the PISA 2006 (published December 2007) shows children in Ireland doing very well on reading literacy, placed 5th on the OECD ranking behind Korea, Finland, Canada and New Zealand. Ireland has also improved its performance on science – now slightly but significantly above average, and remains average on mathematics. Finland is the top OECD performer on science by a long way and is also the top OECD performer on mathematics (OECD, 2007d).

In Ireland, there is a strong gradation by social class across the three fields, as illustrated in Figure 6.11. For reading, maths and science pupils in the lowest social class category perform considerably less well than those in the highest social class category. In relation to reading achievement, Eivers *et al.*, (2005) found that in disadvantaged primary schools up to 30 per cent of pupils have 'serious reading difficulties'. An important element of educational performance is the extent to which education systems can prevent low achieving pupils falling too far below the average. A Unicef study (2002) found that the 'best education systems allow high achievers to reach their potential, while at the same time not allowing others to fall too far behind'.

Figure 6.11 Educational Achievement by Social Class, Ireland, 2006



Source OMCYA, 2008a: 81, 84, 87.

Participation in Education

The fourth component of the work and participation domain of children's well-being is participation in education measured by the percentage of 15 to 19 year olds who remain in education. Remaining in education helps to better equip young people with the skills necessary to progress in today's society, gives them better opportunities for the future, and contributes to the overall economic success of the country. Ireland performs above the OECD average on this measure with 88 per cent of Irish 15-19 year olds remaining in education in 2006 compared to the OECD average of 82 per cent (OECD, 2008c: 344). The top performer was Belgium with participation rates at 95 per cent, followed closely by Poland and Greece with participation rates of 93 per cent.

The Irish 2007 School Leavers' Survey report¹⁹ (Byrne *et al.*, 2008) provides more detailed analysis for Ireland. The analysis showed that school leavers from unemployed backgrounds were most likely to leave school with no qualifications (12 per cent) while the percentage of those from farming, professional, employer/manager, intermediate non-manual or manual backgrounds who did so was 2 per cent or lower.²⁰ Overall, 14.1 per cent of respondents to the survey left school before taking the Leaving Certificate.²¹ 'School factors' (62 per cent) and 'economic or work factors' (60 per cent) were the main reasons given, followed by 'family factors' (14 per cent) and 'health factors' (5 per cent)²² (Byrne *et al.*, 2008: 13).

19. The report is based on the 2007 School Leavers' Survey, representing school leavers who left school in the academic year 2004/05.

20. Although not specifically identified in the survey the retention rate of members of the Traveller community in the education system is low, with 63 per cent of Travellers having ceased their full time education before the age of 15.

21. Includes Leaving Certificate Established, Leaving Certificate Applied and Leaving Certificate Vocational.

22. These factors are not mutually exclusive – respondents could indicate more than one reason and many did so.

Young People's Potential

Young people's potential (or rather potential limitation), captured by the transition to employment, is the fifth component of the participation domain of children's well-being. The indicator used is the percentage of 15 to 19 year olds not in education or employment. The proportion of young people in Ireland who were not in education or employment in 2006 was low at 5 per cent (compared to an OECD average of 6.5 per cent) (OECD, 2009b: 80-81).²³

Whether Young People Like School

The sixth and final component of the participation domain is young people's own assessment of whether they like school. Some 24 per cent of young people in Ireland aged 11, 13 and 15 stated they 'liked school a lot' in comparison with an HBSC average of 28 per cent (HBSC, 2006). Across the countries surveyed, including Ireland, girls tend to like school more than boys and liking school declines with age for both boys and girls. There is little variation by social class.

Summary

In 2007, just over 10 per cent (11.5 per cent) of the children in Ireland lived in households where no-one was in paid employment. This proportion is likely to have increased in light of the economic recession. These children have a high risk of poverty. In relation to early childhood care and education, the evidence shows that high quality early education programmes for children, especially children from disadvantaged backgrounds, contribute to their intellectual and social development. Ireland does not score well on an international assessment of early childhood services, although recent progress has been made. Continued investment in childcare provision is critical for the current and future well-being of children, the economy and wider society, with issues of provision, standards and affordability continuing to require attention, especially in the current economic climate.

With regard to educational achievement, in international comparisons of 15 year olds, Ireland performs well on literacy and science and average on mathematics. However, pupils in lower socio-economic groups perform considerably less well than others. Overall, about one quarter of young people aged 11, 13 and 15 said they liked school a lot. By international standards a relatively high proportion of 15-19 year olds remain on in education in Ireland. Again, there is a social class gradient, with more than 10 per cent (12 per cent) of young people from unemployed backgrounds likely to leave education with no qualifications. Nevertheless, in 2006, the proportion of 15-19 year olds not in education or employment was relatively low. The impact of the recession will limit employment opportunities for school leavers, at least in the short-term.

23. It is worth noting that in the second quarter of 2008, 11 per cent of the population aged 18-24 were defined as early school leavers, that is, persons aged 18-24 who have completed their education and whose highest level of education attained is lower secondary or below. The proportion of male early school leavers was nearly double the proportion of female early school leavers (15 per cent compared with 8 per cent). Just over half of all early school leavers were employed in Q2 2008 (52 per cent). Over one in five were unemployed (21 per cent) and 28 per cent were defined as not being economically active. Early school leavers have a lower rate of employment compared with other persons aged 18-24 (52 per cent compared with 61 per cent) and a higher unemployment rate (21 per cent compared with 5 per cent) (CSO, 2008e: 3).

Overall, a key challenge is to ensure that our education system can meet the needs of all children by reducing educational disadvantage. The emphasis should be on improving the provision of early childhood care and education as well as reducing the numbers of children living in jobless households.

6.5.2 Ireland's Policy Framework for Work and Participation for Children

The policy framework *Towards 2016* contains a number of commitments on participation for children. Relevant high level goals include:

- ◆ Every child should grow up in a family with access to sufficient resources, supports and services, to nurture and care for the child, and foster the child's development and full and equal participation in society;
- ◆ Every family should be able to access childcare services which are appropriate to the circumstances and needs of their children;
- ◆ Every child should leave primary school literate and numerate; and
- ◆ Every student should complete a senior cycle or equivalent programme, (including ICT) appropriate to their capacity and interests.

A family with sufficient resources implies access to income – in the majority of cases this will be through paid employment. Hence, the emphasis on reducing the number of children growing up in jobless households. This issue is dealt with further in the next chapter on people of working age where there is a specific focus on employment.

In relation to early education and care, *Towards 2016*, together with the NAP inclusion 2007-2016 and the National Development Plan 2007-2013, contains many 'priority actions'. The overall policy goal is to 'develop an infrastructure to provide quality, affordable childcare and to work towards increasing the supply of childcare places (of all types) by 100,000 over this period. ... This is to meet the Barcelona targets of making childcare available to 90 per cent of children between 3 and the mandatory school age (6) and 33 per cent of children aged under 3 years by 2010' (*Towards 2016*, 2006b: 41-42).

Specific policy actions include new childcare places, training in childcare, a national quality framework, a national standardised inspection service, provision of after school facilities, targeting the early childhood needs of disadvantaged children, and improving maternity leave entitlements.

On educational achievement and participation Ireland has a broad ranging policy approach to promoting educational well-being and to targeting educational disadvantage in particular. The overriding objectives, as articulated in *Towards 2016* are: 'Continued improvements in the standard and quality of education and to promote best practice in classrooms, schools, colleges and other centres for education, ... to prioritise the educational needs of children and young people from disadvantaged communities by supporting schools and their communities to achieve equality in terms of educational participation and outcomes in line with national norms, ... and to reduce early school leaving to 10% by 2010.'²⁴

24. Early school leaving in Ireland is 11.5 per cent as reported in the Labour Force Survey, 2007, Eurostat. The early school leaving rate in EU25 is 15 per cent. Early school leavers are the percentage of the population aged 18-24 who have at most lower secondary education and are not in further education or training.

High level goals are to:

- ◆ Halve the proportion of pupils with serious literacy difficulties in primary schools serving disadvantaged communities from 27-30% to less than 15% by 2016; and
- ◆ Work to ensure that the proportion of the population aged 20-24 completing upper second level education or equivalent will exceed 90% by 2013.

There are many priority actions identified to achieve these objectives, including:

- ◆ To tackle literacy and numeracy in primary schools;
- ◆ A reduction in the number of children per classroom teacher at primary level to 27:1 in 2007/8 (20:1 in junior classes and 24:1 in senior classes in disadvantaged urban primary schools) and resources for special needs pupils;
- ◆ An integrated approach to support attendance and retention in schools, including an additional 100 posts by 2009 (for the National Educational Welfare Board and the National Educational Psychological Service) to address absenteeism, early school leaving, behavioural problems and special needs;
- ◆ Fostering an inclusive school environment through admission policies;
- ◆ Future provision of schools to recognise the diverse nature of pupil enrolment, including the provision of an extra 550 language support teachers by 2009 and support for the integration of international children at primary and second level; and
- ◆ An additional 1,000 places for Youthreach by 2009 and recognition through a national framework of qualifications.

Other initiatives relate to curricula developments, special needs services, services for Traveller children, Community Training Centres, school transport, technology enhancements, anti-racism proposals and resources for youth work.

A key element of the policy approach to educational well-being, particularly for disadvantaged children, is DEIS – ‘Delivering Equality of Opportunity in Schools’. DEIS identifies levels of disadvantage in schools and provides an integrated programme of support to schools identified as disadvantaged.

An immediate impact of the economic recession has been to curtail many of these commitments. Work by the ESRI (Smyth and McCoy, 2009) has assessed the impacts that the main changes in educational expenditure arising from the Supplementary Budget 2009 and from the April 2009 Budget are likely to have on disadvantaged young people. While funding on the DEIS programme has been ‘ring-fenced’, there are many disadvantaged young people who are attending non-DEIS schools. Therefore, measures such as abolition of the book grant scheme for non-DEIS schools, the reduced capitation grant for Travellers, and the reduced curricular programme grants are likely to have a disproportionate impact on disadvantaged students, especially those who attend non-DEIS schools (Smyth and McCoy, 2009: 58).

6.5.3 Commentary on Work and Participation for Children

Children in households where no-one is working have lower levels of child well-being, across a range of indicators. Unicef (2007) has noted that countries with high levels of child well-being are those countries with employment policies that reconcile work and family life with non-income related supports for children. Whiteford and Adema of the OECD (Whiteford and Adema, 2007: 4) conclude that low levels of family joblessness along with effective redistribution policies improve children's well-being. Frazer and Marlier (2007: 59) also emphasise this point arguing for the need to increase opportunities for parents to earn a decent income from work to promote the social inclusion of children. The issue of employment will be discussed further in the next chapter on the well-being of people of working age. Suffice to say here that in the current economic recession a key strategy must be to keep unemployment as low as possible and to have programmes and pathways to support people into employment.

In relation to early education and care international and Irish evidence has demonstrated the benefits of a positive environment for children early on in their lives. This is particularly the case for children who are disadvantaged (OECD, 2004 and NESF, 2005). The quality of childcare is paramount and Hanafin and Brooks (2005) highlight the findings of a review of the international literature by the UK National Audit Office in 2003, which showed that 'high quality childcare for disadvantaged children in the first three years of life resulted in benefits in the areas of cognitive, language and social development'. Conversely, low quality childcare had no or negative effects.

The recent review of childcare by Unicef shows that Ireland performs very poorly across 10 benchmarks of early childhood care and education and notes that in some countries early childhood services are 'often muddled in purpose, uneven in access, patchy in quality, and lacking systematic monitoring of access, quality, staff-to-children ratios, or staff training and qualification' (Unicef, 2008a: 13). Unfortunately, many of these findings have historically applied to early childhood services in Ireland, although progress is now being made with a number of benchmarks having recently been achieved.

Some of the most significant findings from the Unicef (2008a) research are:

- ◆ The importance of one to one interaction in the first year of life, implying the need for provision of adequately paid (for example, 50 per cent of salary) parental leave for the first year of the baby's life. This approach suggests supports to employers are required.
- ◆ In educational childcare settings, the development of social skills and an awareness of the emotions, needs and rights of others are as important as the development of cognitive and linguistic skills.
- ◆ The importance of quality in the provision of childcare, for all children, but especially for disadvantaged children. This requires recognising the importance of early childhood development and raising the status of child care as a profession, with appropriate recognition and remuneration.

In relation to the quality of early childhood care and education the Centre for Early Childhood Development and Education²⁵ has produced *Siolta* – a national quality framework for early education in Ireland. *Siolta* has been developed through evidence-based research and the engagement of a wide range of stakeholders in the early childhood care and education sector in Ireland. The framework recognises that early education takes place in a wide range of settings in Ireland and that young children have needs for both education and care and that the focus can never be exclusively on either. *Siolta* contains twelve principles of quality and sixteen national standards of quality.

The National Council for Curriculum and Assessment (NCCA) is also finalising a curriculum framework for early childhood education – Framework for Early Learning (AISTEAR). The framework will be for adults who support children’s learning from birth to six years (parents and families, childminders, practitioners in ‘out of home’ settings). The framework views children as unique individuals who are active, capable and competent learners in their communities, and focuses on the four themes of well-being, identity and belonging, communicating, and exploring and thinking. Using these themes the framework seeks to develop children’s skills (walking, climbing, writing, etc.), dispositions (eg. curiosity, concentration, resilience), and attitudes and values (respect for others, positive attitudes to learning and to life). It is intended that the Framework for Early Learning will help early childhood settings meet a number of the standards set out in *Siolta*. The challenge is now to implement and monitor these frameworks.

Reviews of best practice have identified the need for expanding provision of early childhood care and education in Ireland towards universal access with targeted interventions, improving quality, having adequate investment and good co-ordination (OECD, 2004 and NESF, 2005). The NESC has previously argued (NESC, 2005a) that an approach that provides services for everyone but with a differential subsidy structure, which enables families at different income levels to access the same service (‘tailored universalism’) would optimise the coverage and quality of early childhood care and education services.

For education at primary and second level, the international evidence shows that there are a broad range of approaches and initiatives to improve educational performance, yet there is great variation in performance and educational outcomes. Between May 2006 and May 2007 McKinsey and Company carried out research to identify the key elements of best performing school systems (McKinsey & Company, 2007). They particularly focused on the world’s top ten best performing school systems, based on the OECD PISA results. They found that despite increases in spending and ‘well-intentioned reform efforts’, the performance and outcomes of many school systems had not improved. The overriding feature in the best performing school systems was high quality teachers and high quality instruction to every child.

25. The Centre for Early Childhood Development and Education has now been abolished.

This means ‘getting the right people to become teachers’, ‘developing these people into effective instructors’, and ‘putting in place systems and targeted support to ensure that every child is able to benefit from excellent instruction’. This approach is also applicable to early childhood care and education, and should be complemented by an approach which supports the learner to embark on a journey of life-long learning.

McKinsey found that these elements produced better outcomes than reforms such as funding of schools, governance of schools, curriculum standards, assessment and testing, class size, and school admissions. Unicef reflect this view in reporting that there is no simple relationship between the level of educational disadvantage in a country and educational spending per pupil or pupil-teacher ratios (Unicef, 2002). Unicef argue that educational achievement is strongly related to the occupational and economic background of a child’s parents. This is supported by other studies, including the Canadian Longitudinal Study of Children, which found that the educational level of the mother had a strong impact on child development (Government of Canada, 2003). This leads to the conclusion that reform in the school system needs to be complemented by supports for families and communities, particularly those from disadvantaged backgrounds.

In their research on combating educational disadvantage Smyth and McCoy (2009) came to similar conclusions, claiming that social class background and parental education are significantly associated with a range of educational outcomes among young people in Ireland. They stressed the importance of pre-school education and argued that school targeting alone cannot address the needs of all children and young people. In her review of well-being and post-primary schooling O’Brien (2008: 170) contended that a broader conception of schooling is required as an over-emphasis on ‘the academic’ and on achievement has an ill-being effect for some individuals and groups of young people. She concluded that the ‘climate and culture’ of schools, what they teach, how they organise and assess, and the sets of relations between students and staff are central to the well-being of young people.

In conclusion, Ireland has a broad range of policy initiatives relating to educational well-being, particularly for disadvantaged children. However, there needs to be greater coherence between these policy initiatives across and between the various levels of education. Four key areas could usefully be reviewed in the context of implementing current commitments. These are:

- ◆ More coherent and improved provision of early childhood care and education. The introduction of the Early Childhood Care and Education Scheme is welcome but consideration is required with regard to its implementation.²⁶ Early childhood care and education is critical for the well-being of children today and the future of our society and economy;

26. For example, concerns have been raised with regard to the capacity to deliver it throughout the country, and the capitation grant available, given the variability in costs throughout the country. It is encouraging that the scheme is linked to the implementation of *Síolta* and *AISTEAR*, with an emphasis on providing a quality pre-school year for children.

- ◆ Whilst recognising the quality of our education system for many children and young people, the need to ensure delivery of a quality education to **all** children;
- ◆ The need to reduce literacy difficulties in disadvantaged primary schools;²⁷ and,
- ◆ Enhanced support for disadvantaged families and communities.

6.6 Relationships and Care

6.6.1 Measuring Relationships and Care Among Ireland's Children

Five components are used to measure relationships and care: marital breakdown (divorced/separated parents, children in care), family structure (lone parents), family relationships (eating and talking together, pets), peer relationships (3 or more friends, evenings with friends, contact through electronic media), and care (child carers). Relationships with people and animals, and the activities within the context of these relationships, gives children a sense of belonging, being safe, loved, valued and being cared for (NicGabhainn and Sixsmith, 2005: 64).

Research by McKeown *et al.* (2003: 12) on family well-being found that the type of family a child or young person lives in – one parent, two parent, married parents, co-habiting parents, separated or single parents – has limited impact on family well-being. The key factors shaping the physical and psychological well-being of parents and children was found to be family processes, particularly the ability to resolve conflicts and arguments, and the personality traits of the parents.²⁸

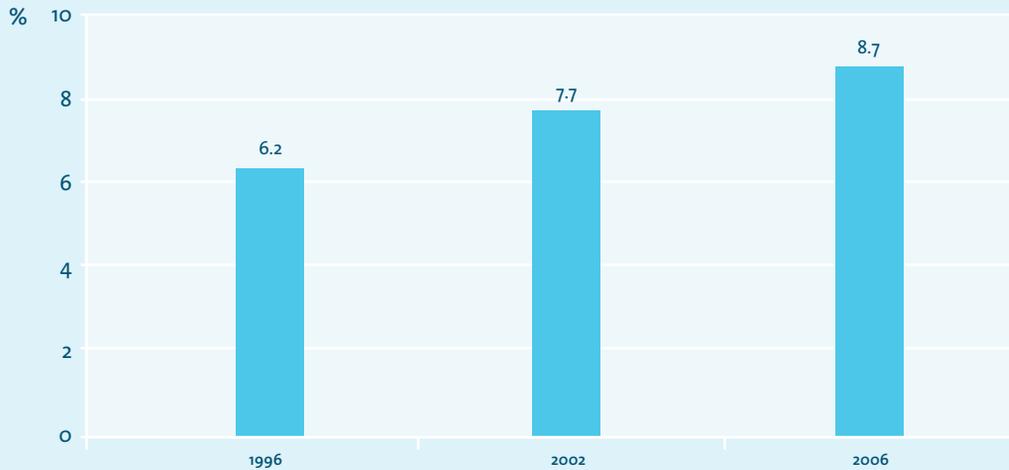
Children in Divorced and Separated Households

The inability to resolve conflicts can lead to poor family relationships and marital breakdown. The first component of the relationships and care domain of children's well-being is children in divorced/separated households. Some 62,405 separated and divorced households contained children in 2006; increasing from 38,988 in 1996. Of households containing children in 2006, 8.2 per cent were separated or divorced households; in 1996, 6.2 per cent of households containing children were classified as separated/divorced households, see Figure 6.12.

27. The Department of Education and Science are monitoring progress towards meeting targets set and the NESF is undertaking a project on child literacy and social inclusion, with a focus on policy implementation.

28. The findings of the research by McKeown *et al.* (2003) are at variance with some of the other international research on family well-being, which has attributed greater weight to the influence of family structures on well-being. There is a view that the wider social acceptance of relationship types and structures may also have an influence on child and family well-being. Therefore, the mediation of cultural norms and the presence of significant institutional structures are relevant to the impact of family structures and relationships on the well-being of the family (Healy, 2005).

Figure 6.12 Percentage of Households Containing Children who were Classified as Separated or Divorced Households, Various Years²⁹



Source Census tables

Children in Care

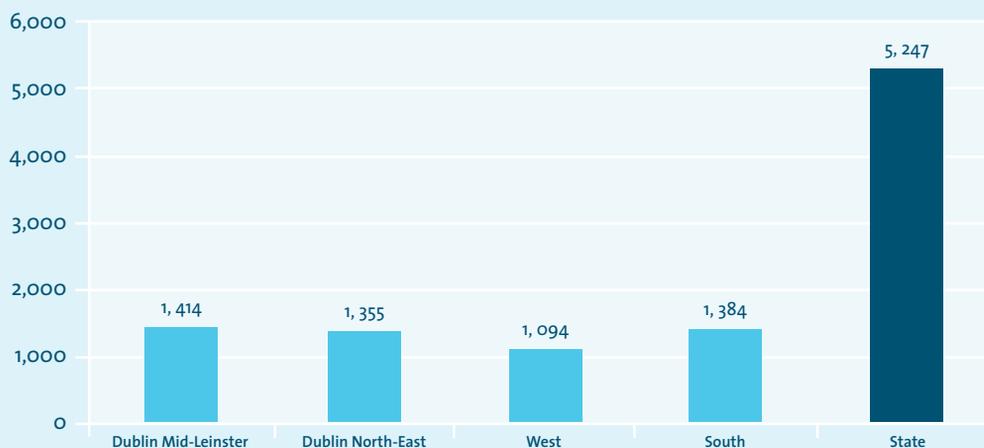
Where parents are unable to look after their children, for a variety of reasons, they are placed in the care of the State. In 2006, 5,247 children were in the care of the Health Service Executive (HSE), equating to an overall rate of 50.6 per 10,000 children, see Figure 6.13.³⁰ There are no significant differences by gender. Almost 90 per cent of children in care live in foster family homes, 28.2 per cent of whom are in foster family homes with relatives. Less than 10 per cent of all children in care are placed in residential care settings and nearly 40 per cent of children in the care of the HSE are in care for 5 years or more.³¹

29. Figures and percentages are calculated from various census tables, specifically 'Private households by composition and size and sex and marital status'. Household types 'with children (of any age)' are summed to provide total households with children. Households with children (of any age) classified as separated/divorced are presented as a percentage of total households with children.

30. As noted earlier, in 2006 there were 569 children who were separated from their families who were seeking asylum, 214 of whom were placed in the care of the HSE.

31. Figures are from the Childcare Interim Dataset, HSE, cited in OMCYA, 2008a: 205-207.

Figure 6.13 The Number of Children who were in the Care of the HSE, 2006.

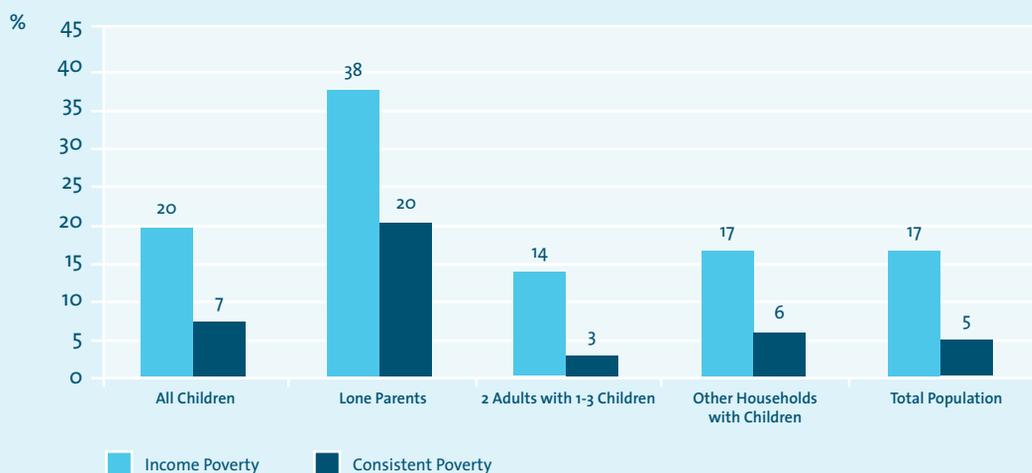


Source OMCYA, 2008a: 205.

Lone Parent Families

The second component of the relationships and care domain is family structure. The indicator is lone parent families. It is acknowledged that many children who grow up in lone parent families are secure and happy, and that there are some two-parent families where relationships may not be conducive to supporting their children’s well-being. However, statistical analyses across a range of countries show that, in general, children in lone parent families have a greater risk of poorer health, early school leaving, low skills, low pay, and poverty. Information on children living in poor households by family type is presented in Figure 6.14.

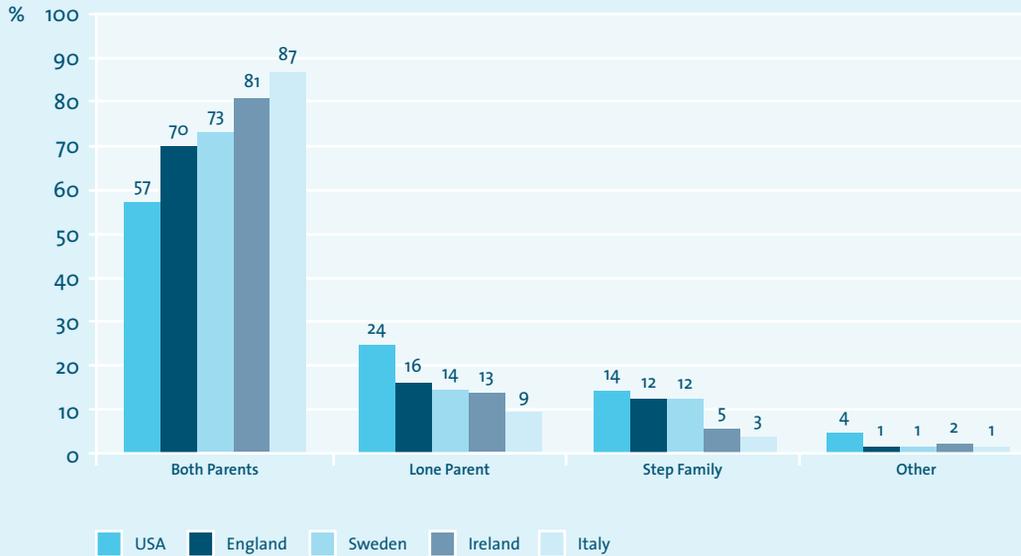
Figure 6.14 Children Living in Poor Households, 2007



Source CSO, 2008b, EU-SILC, 2007.

The proportion of children in Ireland reporting that they live in lone parent families is 13 per cent, compared to an HBSC average of 15 per cent (HBSC, 2006),³² see Figure 6.15. Some 81 per cent of children in Ireland reported living with both parents, 5 per cent in step families and 2 per cent reported living in other family units.^{33,34}

Figure 6.15 Percentages of Young People Reporting Primary Family Living Arrangements, Selected Countries, 2006



Source HBSC, 2006: 185.

Family Relationships

The third component in the relationships and care domain is family relationships. This component is measured by: the percentage of children who report eating the main meal of the day with parents more than once a week (PISA, 2006); the percentage of children who report that parents spend time 'just talking' to them (PISA, 2006); and the percentage of children who have a pet (HBSC, 2006). These measures are an attempt to determine the quality of family relationships. Some 75 per cent of 15 year olds ate their main meal with their parents more than once a week and 65 per cent stated that their parents spent time talking to them. In 2006, both of these items were only asked in Ireland; accordingly, there is no international

32. It should be noted that this information is based on HBSC data collected for 40 OECD countries. Young people were asked about their family living arrangements and who they lived with most of the time. For Ireland, the proportion of young people 'self reporting' living in single parent families is lower than the proportion recorded in the 2006 Census of Population.

33. 'Other' denotes, for instance, children normally living in a foster home or those being cared for by non-parental members. It is noted that figures are not available for the number of children in families of same-sex parents, although it is recognised that this information would be useful, especially in the context of recognising the rights of children in various family forms.

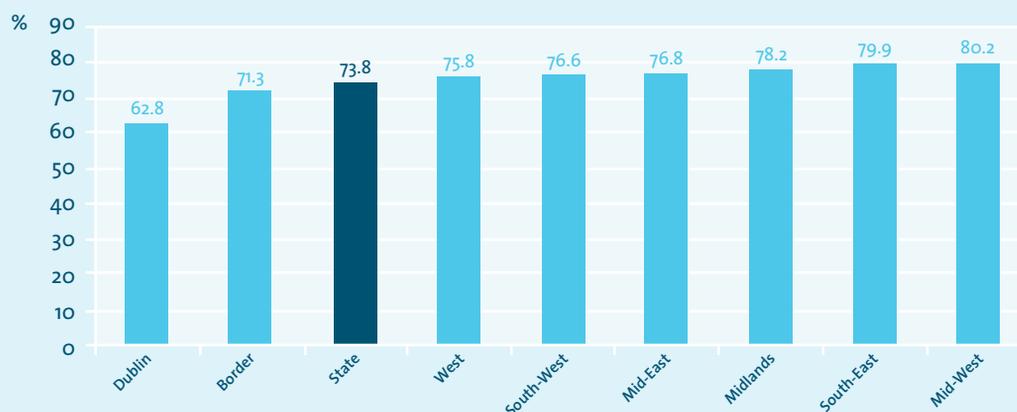
34. The initial results of the Growing up in Ireland Study (July 2009) showed that 76 per cent of 9 year olds lived with biological parents; 18 per cent lived in lone parent families with one biological parent, a further 4 per cent lived with one biological parent and his/her spouse or partner; and 2 per cent lived in other types of families, for example with adoptive parents, foster parents and grandparents.

comparison available.³⁵ In Ireland, there is little differentiation across social class, although on both indicators children from lower social classes record slightly lower scores. More girls than boys report that their parents spend time talking to them and eat a main meal with them more than once a week.³⁶

Having a Pet

NicGabhainn and Sixsmith (2005) highlight the importance of children's relationships with pets and animals as an aid to children's physical, social and emotional development. In 2008, the State of the Nations Children report included for the first time data on children aged 9-17 who report having a pet of their own or a pet in their family (OMCYA, 2008a, based on HBSC, 2006). Some 74 per cent of children reported having a pet, the figure being a little higher for girls than for boys. Slightly more children in social classes 1 and 2 report having a pet (76 per cent) than children from social classes 5 and 6 (74 per cent). There were differences by region, with children living in Dublin least likely (63 per cent) to have a family pet, while children in the Mid-West region were most likely (80 per cent) to own a pet, see Figure 6.16.³⁷ This item was only asked in Ireland; accordingly, there is no international comparison available.

Figure 6.16 Percentage of Children Aged 9-17 who Report Having a Family Pet, 2006



Source OMCYA, 2008: 64, based on HBSC, 2006.

35. In 2000, 77 per cent of Irish 15 year olds ate their main meal with their parents more than once a week (OECD average 79 per cent), and 62 per cent of Irish 15 year olds reported that their parents spent time 'just talking to them' (OECD average 63 per cent).

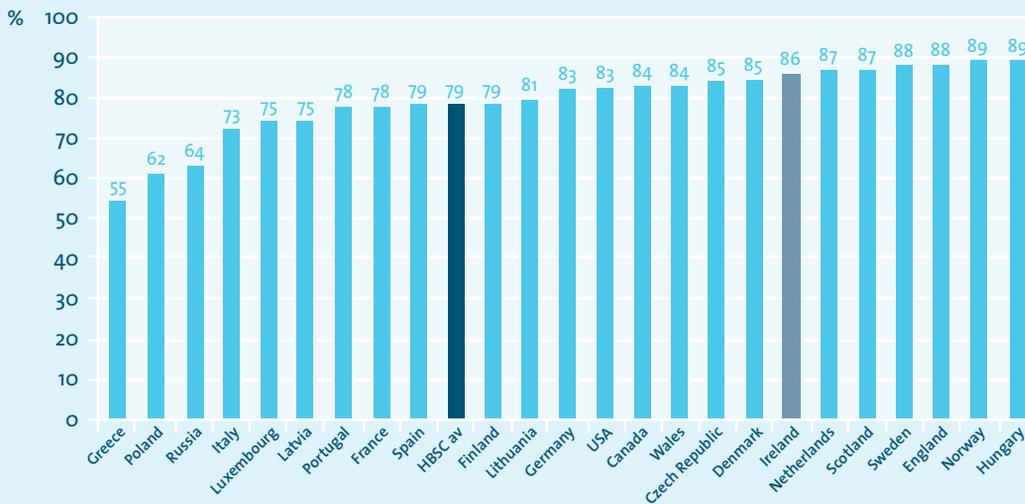
36. In the Growing up in Ireland study (July 2009) just under three quarters (72 per cent) of parents of 9 year olds said that they sat down to eat a meal with their 9 year old every day and 77 per cent said they talked about things together every day.

37. In the Growing up in Ireland study (July 2009) about two thirds of 9 year olds said they had a least one pet in the family. Nearly half (47 per cent) said they had a family dog.

Peer Relationships

Children's relationships with their friends comprise the fourth component of the relationships and care dimension of children's well-being, measured by the percentage of Irish children who report having 3 or more friends of the same gender (HBSC, 2006). Some 86.4 per cent of Irish children (aged 11, 13 and 15) reported having 3 or more friends of the same gender. This is above the average of 79 per cent for the 41 countries that responded to this HBSC question, see Figure 6.17. Overall, children in Ireland ranked 7th. Within Ireland, there were no differences across social class.

Figure 6.17 Percentage of Children who Report To Have Three or More Friends of the Same Gender, by Selected Countries, 2006



Source OMCYA, 2008a: 61, based on HBSC, 2006.

It has been estimated that adolescents spend a third of their waking time with their peers or friends (Brown and Klute, 2003). A new peer relationship indicator from the HBSC Survey in 2006 focuses on 11, 13 and 15 year olds who spend four or more evenings per week out with friends. The time which adolescents spend with friends in the evenings has been strongly linked to adolescent risk behaviour, most notably substance abuse (Settertobulte and Matos, 2004; Del Carmen Granado Alcon, Pedersen and Carrasco Gonzalez, 2002). However, Berndt notes that peer contact is important for the development of protective factors and has positive as well as potentially negative outcomes (Berndt, 1999). Some 42 per cent of 11, 13 and 15 year olds in Ireland spend four or more evenings out with friends, compared to an average of 26 per cent of 11, 13 and 15 year olds of the countries included in the survey. Boys are more likely to spend evenings with their friends than girls, see Figure 6.18.

Figure 6.18 Percentage of 11, 13 and 15 Year Olds who Spend Four or More Evenings per Week Out with Friends, 2006.



Source HBSC, 2006: 34.

Electronic Media

The third indicator in the peer relationships component of the relationships and care domain is contact through the medium of electronic media: text messages, telephone calls and activity on the internet. Contact through electronic media has come to the fore in recent years and is associated with both positive and negative outcomes. Negative outcomes include detracting from school work and household duties, lower levels of self-rated health, obesity, loneliness and social isolation, and violence or hostility (Prezza *et al.*, 2004; Punamaki *et al.*, 2006; Kuntsche, 2004; Kautiainen *et al.*, 2005; Kraut *et al.*, 1998). Positive influences include improved cognition and school performance and improved social relations with known peers (Gross *et al.*, 2002).

In 2006, girls were more likely to use mobile phones and boys were more likely to use the internet. In Ireland, 61 per cent of 15 year old boys had daily electronic media contact with friends compared to an HBSC average of 56 per cent. Electronic media contact was lower for 15 year old girls in Ireland at 36 per cent, compared to an HBSC average of 43 per cent (HBSC, 2008: 37-39).

Child Carers

The fifth component of the relationships and care domain is care provision, using an indicator of child carers. In the 2006 census, there were 11,269 carers aged 15-24 years, 5,165 males and 6,104 females. There are no available statistics on the number of child carers 0-17 in Ireland. However, of the carers aged 15-24 years old, 8,079 had 'child status' in their household, 3,861 of whom were males and 4,218 were females. The responsibilities of young carers have been defined as 'providing practical and personal care and emotional support for the cared-for person. Providing such care

may undermine other aspects of their lives, as, for example, social and educational opportunities, career prospects and health' (Halpenny and Gilligan, 2004: 13).³⁸

Summary

Relationships are central to child well-being and are valued highly by children themselves. Positive indicators of relationships are eating and talking together with family members, having friends and pets. Risks to good relationships and well-being include living in disruptive and conflictual families, in poor families, living in care, having burdensome caring responsibilities, spending a lot of time outside the home in the evenings and high levels of contact through electronic media. On the indicators used Ireland performs relatively well. However, one fifth of children live in lone parent families which have a high risk of poverty, and the number of children in separated/divorced families is growing, albeit from a low base. Boys in Ireland tend to spend an above average amount of time out with friends in the evening and a relatively large amount of time communicating through electronic media.

6.6.2. Ireland's Policy Framework on Relationships and Care

Ireland has recognised the importance of family relationships through its family policy, based on the *Commission on the Family* which reported in 1998. Given the increasing diversity and complexity in family types there is an ongoing challenge to ensure the needs of children are met adequately and fairly, particularly in the transition from one family type to another. *Towards 2016* states that 'the Government and the social partners recognise the central importance of the family unit to the lives of children and the need to strengthen the system of supports available to children and their families'.

Specific identified priority actions towards meeting this objective include:

- ◆ Enhanced policies to promote family formation and support family life;
- ◆ Focusing on children in lone parent households and larger families through reviewing support for lone parents and re-focusing family income supplement in favour of larger families with low earnings;
- ◆ Strengthening services under the Teen Parent Support Initiative;
- ◆ The development of Family Support Initiatives;
- ◆ Enhancing maternity leave entitlements;
- ◆ A study of the extent to which children undertake inappropriate care roles with the subsequent development of a programme of in-home supports; and
- ◆ Establishing the Social Services Inspectorate (SSI), which inspects children's residential and foster care services, on a statutory basis.

The Government has published a discussion paper on *Proposals for Supporting Lone Parents* (Government of Ireland, 2006a).

38. The Office of the Minister for Children and Youth Affairs has commissioned research from the Child and Family Research Centre at the National University of Ireland in Galway on young carers. The aim of the research is to examine mechanisms through which young carers (15-17 years old) can be identified, to assess the impact of caring on their lives and the ways in which they can be assisted. It has been commissioned in response to an acknowledgement that young carers are a hidden group in society who need to be identified and encouraged to avail of services. The research will examine national and international best practice and make recommendations for the development of services in Ireland for young people in situations of caring. The research is due to be completed in 2009.

6.6.3 Commentary on Relationships and Care

Policies for improving family and peer relationships tend to transcend policies in other areas. Most policy approaches recognise the importance of stable family relationships for children. McKeown *et al.* (2003: 13) espouse the need for measures which develop and support relationship skills – ‘all families, irrespective of type, need these skills if parents and children are to experience well-being’. At the same time, interventions to support families also need to acknowledge the influence of parents’ psychological traits and the broader socio-economic circumstances of the family. The development of Family Support Initiatives is important in this regard.

Policies which promote a work-life balance and flexible working arrangements, along with good childcare provision, contribute towards good family relationships. Specific initiatives are targeted towards lone parent families, in particular, who tend to have a high risk of poverty. Most policies in this area support lone parents into the work force through a range of childcare, education and training, and income supports. Some improvements have been made to income supports for lone parents in recent years but further work requires to be done to take forward the proposals in the Government’s Green paper on Lone Parents.

In terms of specific initiatives to support children’s well-being, the Office of the Minister for Children and Youth Affairs (OMCYA) is testing models of best practice which promote integrated, locally-led delivery of children’s services for children experiencing multiple disadvantages. An evaluation framework is being developed to identify the key learning from these models.

An agenda for the provision of health and social services for children was published in 2007, based on supporting the child within the family and within the local community. Its purpose is to provide guidance and assistance to people working in the children’s health and social services system (Government of Ireland, 2008a: 132).

The Report of the Commission to Inquire into Child Abuse (the Ryan Report) was published on 20th May 2009 (see www.childabusecommission.ie). It details ‘the litany of terrible wrongs inflicted on our children’, who were placed by the State in residential institutions run by religious orders. These were the most disadvantaged, abandoned and neglected children who, placed in the care of the State, were subject to ‘abuse of all types – physical, sexual, neglect and emotional’. The Ryan Report documents the extent and nature of the abuse in 5 volumes, totalling some 2,500 pages. The Government has accepted all the recommendations of the Commission and has committed itself to their implementation (Office of the Minister for Children and Youth Affairs, 2009a). It is clear that, as stated in the Government’s Implementation Plan, ‘the lessons of the past must impact on current attitudes, policies and practices to strengthen the central place of children in our society and to provide for the care and protection of all our children’.

In relation to information on children’s relationships and care it would be useful to have better data on the lives and relationships of children living in different family forms.

6.7 Community and Environment

6.7.1 Measuring the Community and Environmental Well-being of Ireland's Children

The community and environment within which children live affects their well-being. The community and environmental well-being of Ireland's children is measured using three components: accommodation, community and environment.

Housing Need

The first component, accommodation, is measured by housing need and youth homelessness. One of the most pressing issues in Ireland in relation to housing has been its availability, particularly for low-income households with children. The 2008 Assessment of Housing Needs carried out by the Department of Environment, Heritage and Local Government shows that in 2008 there were 27,704 households with children in need of social housing, up from 22,335 in 2005. Some 55 per cent of households with children in need of social housing were households with one child; a further quarter (27 per cent) were households with two children.

Youth Homelessness

The second indicator is youth homelessness. Youth homelessness is the most extreme form of housing deprivation. Children and young people who are homeless are vulnerable to exploitation, victimisation and criminality, experience acute housing need and are at risk of moving into adult homelessness (Mayock, Corr and O'Sullivan, 2008). There is a wide range of different reasons for young people's homelessness, including child abuse, family problems or emotional/behavioural problems. Some 449 children were homeless and in HSE care in 2006, see Figure 6.19. There were no significant differences by gender. In terms of age, 55 per cent of homeless youths were aged 16-17 and a further 28 per cent were aged 14-15 years old. The remaining 17 per cent of homeless children were aged 13 or under, with 9 per cent under 12 years old.

Figure 6.19 Number of Children who Appeared to the HSE to be Homeless, 2006.



Williams and Gorby (2002) highlight that homelessness has a tendency to be underreported, so that youth homelessness could well be higher than these figures suggest. For example, the most recent *Counted In* (2008) survey of homelessness in the Dublin region found 576 child dependents living with their families within homeless services, suggesting at least 1,000 children in Ireland who are homeless, either in families or in HSE care (Homeless Agency, 2008). Furthermore, research conducted by Focus Ireland on a sample of 44 young people leaving state care found that two thirds had experienced homelessness within two years of leaving HSE care (Kelleher *et al.*, 2000).

Community Participation

The second component of the community and environmental domain of children's well-being is community participation. In this report community participation for children is measured by the proportion of children and young people who are members of community and charity groups. Almost one-third of young people aged 12-18 are members of one or more groups (NCO, 2005). The groups include youth clubs, choirs and charities or voluntary groups. Girls report greater participation in groups than boys, as do rural dwellers over urban dwellers and younger adolescents are more likely to participate in groups than older adolescents.

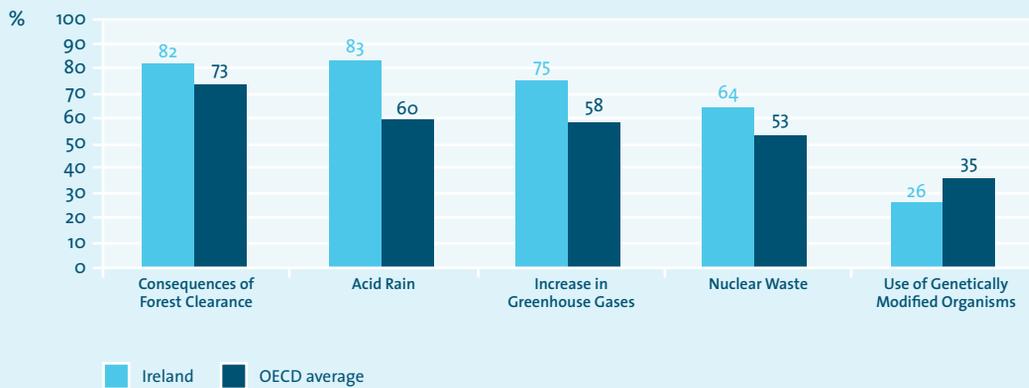
Environment

The third component of the community and environment domain of children's well-being is their surrounding environment. This aspect of children's well-being is captured by three indicators: environmental awareness; deaths from accidents and injuries; and the availability of good places to spend free time.

Environmental Awareness

In the 2006 PISA survey students were asked if they were 'familiar with or knew something about' five environmental issues. Overall, Ireland had one of the top awareness levels of environmental issues. The results, comparing Ireland with the OECD average, are presented in Figure 6.20. More than 80 per cent of student respondents in Ireland were familiar with the consequences of forest clearance and acid rain on the environment. Three quarters knew something about the increase of greenhouse gases in the atmosphere and nearly two thirds were aware of the impact of nuclear waste. For all these environmental issues the level of awareness in Ireland was higher than the average awareness across the OECD. Just a quarter of students in Ireland were aware of the use of genetically modified organisms, compared to a third of students across the OECD.

Figure 6.20 Percentage of Students who Report That They are Familiar With or Know Something About Environmental Issues, OECD & Ireland, 2006



Source PISA 2006, results at www.pisa.oecd.org

In research undertaken by the Office of the Minister for Children and Youth Affairs, young people aged between 12-18 years were asked whether enough people respected the environment and helped to keep it clean and safe (OMCYA, 2006b: 22). The majority of respondents (70 per cent) felt that enough people do not respect the environment or help to keep it clean and safe. Less than 2 per cent of the children and young people surveyed agreed with the statement. One respondent, a girl aged 16, remarked:

‘Children should grow up in a clean and unpolluted environment because pollution can affect children’s long-term health and affect them in later life. Growing up in a clean environment also shows children how important it is to keep the environment tidy and it also shows how much better the world is as a clean and unpolluted place’ (OMCYA, 2006b: 23).

Deaths from Accidents and Injuries

The second indicator on the environment component is deaths from accidents and injuries per 100,000 under nineteen year olds. The indicator seeks to measure the overall level of safety for young people. Drawing on comparative information from the World Health Organisation’s Mortality Database Ireland ranks mid-table with 15 deaths from accidents per 100,000 young people compared to an average of 14.3, see Figure 6.21. Sweden, United Kingdom, the Netherlands and Italy are the best performers with less than 10 deaths per 100,000. The risks associated with child accidents are poverty, low maternal education, low maternal age at birth, single parenthood, poor housing, poor family relationships and drug or alcohol abuse (Unicef, 2007: 14).

Figure 6.21 Deaths from Accidents and Injuries per 100,000 Under 19 Years, International Comparisons, 2005³⁹



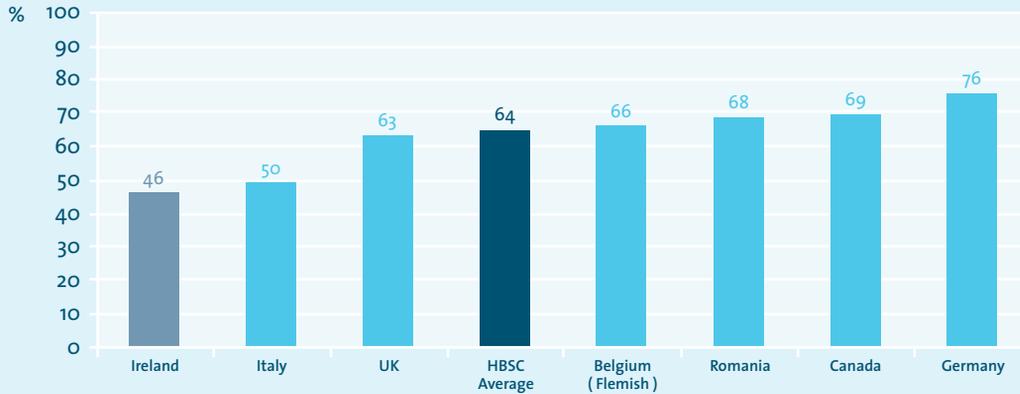
Source Unicef, 2007: 43.

Good Places to Spend Free Time

The third indicator on the environment component is the availability of good places for young people to spend their free time. In 2006, 42.2 per cent of children and young people in Ireland, who were aged 10-17, felt that there were good places in their area to spend their free time, with 55 per cent of 10-11 year olds and 33 per cent of 15-17 year olds in agreement (OMCYA, 2008a: 181). Using 11, 13 and 15 year olds to draw international comparisons from the 2006 HBSC survey, Ireland (45.7 per cent) is well below the HBSC average of 64.3 per cent, see Figure 6.22. Of the seven countries that used this indicator in 2006, children from Germany topped the poll with 75.7 per cent; Ireland ranked 7th and last.

39. Data were downloaded by Unicef in 2005 and the data presented are the average of the last three years available. Data were combined for all kinds of accidental deaths into one variable.

Figure 6.22 Percentage of Young People Aged 11, 13 and 15 who Report That There are Good Places in Their Area to Spend Their Free Time, by Country,⁴⁰ 2006



Source OMCYA, 2008: 183.

Within Ireland, the indicator varies on a geographical basis with children in Dublin (58.4 per cent) most likely to report good places in their area to spend their free time, compared to children in the West (33.4 per cent). Throughout Ireland boys and younger children were more likely to report that there were good places to spend their free time than girls and 15-17 year olds. Some 45 per cent of young people in social classes 5 and 6 reported having good places to spend their free time compared to 39 per cent of those in social classes 1 and 2. In their work on understanding well-being, Nic Gabhainn and Sixsmith (2005) found that a well-designed environment is important for ensuring the physical and emotional well-being of the whole community, including children. This is especially relevant for young people from disadvantaged backgrounds who may be more reliant on their immediate environment. The accessibility of local environments is important for young people with disabilities.

Summary

The community and environment is important for the well-being of children and young people. The indicators employed here relate to housing, community and environment. There is substantial housing need for households with children and an urgency to end youth homelessness, with some homeless young people being less than 12 years old. One third of young people participate in community and charity groups, with the rate of participation declining as they get older. Young people have an awareness of environmental issues and feel that environmental conditions can be improved. Unsafe environments can lead to deaths from accidents and injuries and on this indicator Ireland is above international averages, with 15 deaths per 100,000 young people attributable to accidents. Ireland is below international averages on having good places in the area for children to spend their free time, with less than half of those surveyed in Ireland stating there were such places.

40. Data are only available for 7 countries

6.7.2 Ireland's Policy Framework on Community and Environmental Well-being

The policy response to community and environmental issues for children is the goal that every child should have access to suitable accommodation, and access to quality play, sport, recreation and cultural activities (*Towards 2016*). Specific actions relate to:

- ◆ Publishing a National Recreation Policy to complement the National Play Policy;
- ◆ Expanding the Young People's Facilities and Services Fund;
- ◆ Implementing the Youth Homelessness Strategy, and developing closer links between the youth and adult homeless forums; and
- ◆ Continued development and support for the youth work sector and, in that context, further resources to be provided to progress implementation of the National Youth Work Development Plan and the Youth Work Act, 2001, on a phased and prioritised basis.

The OMCYA has responsibility for co-ordinating the implementation and monitoring of these initiatives. Local authorities have day-to-day responsibility for the provision of social housing and the quality of local environments, including play facilities.

6.7.3 Commentary on Community and Environmental Well-being

Provision of affordable and/or social housing for low income families with children is a key issue. Suitable accommodation is required which is safe, has adequate space, is of good quality and has adjacent safe areas for children to play. The most extreme housing deprivation is child and youth homelessness. This is a priority to be addressed. The recession may limit resources for some of the housing commitments, but with vacant properties and skilled labour available, in some locations it should be possible to find imaginative ways to match provision and need. Youth homelessness is a complex issue, with a range of supports required, as well as the provision of accommodation.

In relation to community participation one third of children are members of community and charity groups. In their review of children's civic participation Bradshaw *et al.*(2007) note that civic participation develops children's skills in communication and networking as well as accumulating knowledge, experience and civic awareness, and building children's confidence and self esteem. This can work well in disadvantaged communities where community development and youth projects are supported.

It is notable that young people are aware of and concerned about environmental issues. There is a need to do more to respect and protect our environment, especially as it will directly impact on our children's futures. The number of child deaths from injuries and accidents, within and outside the home, needs to be reduced. Play is important in children's development, and thus the importance of good and safe places for children to play and for young people to 'hang out'. Good planning has a role to play in the provision of positive environments for young people.

Better data are required on children's play patterns and the availability of appropriate facilities. Monitoring the implementation of the national play policy and national recreation policy will be instructive in this regard. More detailed information on children and young people's involvement in community and voluntary activities would also be useful, as would closer monitoring of child and youth homelessness.

6.8 Health

6.8.1 Measuring the Health of Ireland's Children

Health is the fifth domain of children's well-being. The health domain comprises 6 components covering aspects of children's health from birth to late teenage years. The 6 components are: health at birth, immunisation, risk behaviours, healthy behaviours, health assessment and mental well-being.

Infant Mortality Rate

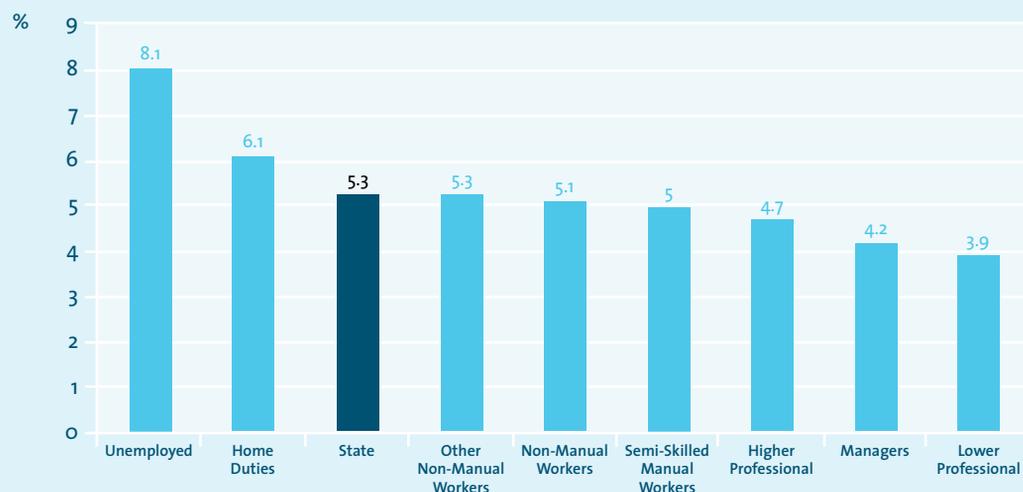
Health at birth is measured by two indicators: the number of infants dying before age 1 per 1,000 births and percentage of infants born with low birth weight (<2,500g⁴¹). 'A society that manages ... to reduce infant deaths below 5 per 1,000 live births is clearly a society that has the capacity and commitment to deliver other critical components of child health' (Unicef, 2007: 13). Ireland recorded a level of 3.7 infant deaths per 1,000 live births in 2006, a reduction of 5.2 percentage points since 1986. Romania reported the highest infant mortality rate amongst the EU27 with 13.9 deaths per 1,000 infants, while Luxembourg reported the lowest mortality rate of 2.5 per 1,000 births. This was closely followed by Sweden and Finland, both with infant mortality rates of 2.8 per 1,000 live births (OMCYA, 2008a: 17).

Low Birth Weight

Using data from 2004 for international comparisons, Ireland performs reasonably well on low birth weight rate, holding a rank of seventh among 30 OECD nations. Ireland's low birth weight rate was 4.9 per cent compared to the OECD average of 6.6 per cent (OECD, 2007e: 39). A low birth weight not only affects a child's well-being in the early days and weeks of life but also can influence physical, mental and behaviour development throughout childhood. A child's birth weight is influenced by their mother's well-being and behaviour. Children born to teenage mothers, mothers who smoke, abuse alcohol or drugs during pregnancy, mothers who do not attend antenatal clinics, and mothers in lower socio-economic groups have a higher risk of a low birth weight (Institute of Public Health, 2005). Across social classes, the highest proportion of low weight babies in Ireland are born to mothers who are unemployed, see Figure 6.23.

41. 5.5 pounds.

Figure 6.23 Percentage of Low Weight Babies by Occupation of Mother, Ireland, 2005⁴²



Source OMCYA, 2008: 95.

Immunisation

The comprehensiveness of preventative health services can be measured by immunisation levels. Immunisation is the second component of the health domain. The percentage of children aged 24 months immunised against measles, DPT₃ (diphtheria, pertussis, tetanus) and polio is the indicator used to measure this aspect of child health. The *State of the Nation's Children: Ireland 2008* report showed that, in 2006, 86 per cent of the relevant age group in Ireland had received the measles-containing vaccine, 91 per cent had received the DPT₃ vaccine and 91 per cent had received the polio vaccine. Ireland remains below the World Health Organisation's target of 95 per cent immunisation for children.

Risk Behaviours

The third component in the health domain of children's well-being is risk behaviours. Children's health is known to be influenced by the socio-economic conditions within which children live. It is in this context that Unicef notes (2007: 27), 'In ways that are not fully understood, they (risk behaviours) indicate problems and pressures facing a significant number of young people ... reflecting ... their unpreparedness and inability to cope with such pressures'. There are 7 indicators in this component – 3 relating to use of tobacco, alcohol and cannabis, 2 relating to risky sexual activity, with the 6th indicator measuring the teenage fertility rate, and the 7th the risk of being overweight or obese.

42. Occupational categories where percentages were based on less than 100 births have been omitted in this figure (i.e. 'Unskilled Manual Workers', 'Other Agricultural Occupations and Fishermen', 'Farmers and Farm Managers', 'Skilled Manual Workers' and 'Salaried Employees').

Smoking Cigarettes

The tobacco use indicator employed is the percentage of young people aged 11, 13 and 15 who smoke cigarettes at least once per week. Some 9.2 per cent of Irish young people in these age groups do so, compared to an HBSC average of 8.1 per cent. There is little difference between boys and girls but smoking increases with age, see Figure 6.24 and is also higher among children in lower social classes. On an international comparison of 40 countries and regions asking this question, children in Ireland were ranked 24th, with Sweden reporting the lowest percentage of 3.5 per cent of children smoking cigarettes every week. Tobacco use is the leading cause of preventable death in the world (WHO, 2003). Smoking tobacco is addictive and is a high risk activity for young people.

Figure 6.24 Percentage of Young People Aged 11, 13 and 15 who Smoke Cigarettes at Least Once a Week, International and Irish Comparison, 2006



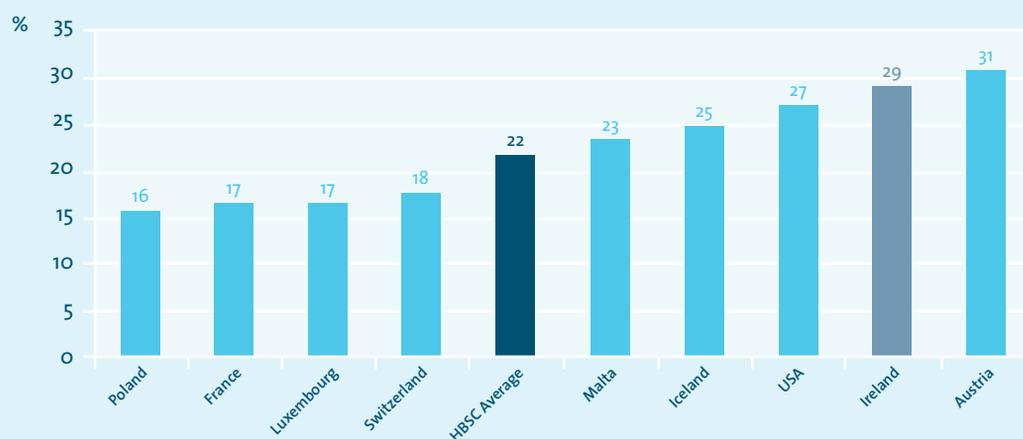
Source HBSC, 2006: 121.

Getting Drunk

The second indicator on risk behaviour is the percentage of young people who have been drunk at least once in the last thirty days. In 2006, 20.4 per cent of all children aged 10-17 reported being drunk at least once in the last thirty days (OMCYA, 2008a: 135). More than one third of 15-17 year olds (38 per cent) had been drunk, with slightly higher rates for boys than girls across all age groups. There was little variation across social class. Alcohol consumption among 10-17 year olds was highest in Dublin with 27.4 per cent of young people living in the Dublin region reporting being drunk in the last thirty days, compared to 13 per cent of young people in the South-West of Ireland.

For the purpose of international comparisons, the percentage of young people aged 15 years old who have been drunk at least once in the last 30 days is used to capture alcohol use. In 2006, 29 per cent Irish 15 year olds had been drunk at least once in the last thirty days, compared to an HBSC average of 21.7 per cent, see Figure 6.25. Overall, Irish children ranked second highest behind Austria at 30.6 per cent (OMCYA, 2008a: 136).

Figure 6.25 Percentage of Children Aged 15 who Report Having Been Drunk at Least Once in the Last Thirty Days, by Country, 2006



Source OMCYA, 2008a: 137.

High alcohol use among young people poses a high risk to themselves and wider society both now and in the future. It has been reported by the Strategic Task Force on Alcohol (Department of Health and Children, 2004b: 14)⁴³ that alcohol causes 1 in 4 deaths of all young men in Europe aged between 15 and 29 years. The majority of these deaths result from injuries (unintentional and intentional). For young men, alcohol contributes to nearly half of all deaths from motor vehicle accidents, over one third of poisonings, drownings, homicide and falls, and in one fifth of suicides. For young women (aged 15 to 29) alcohol contributes to about one in three of all deaths from poisonings, drownings and homicide and one in five deaths from motor vehicle accidents and falls.

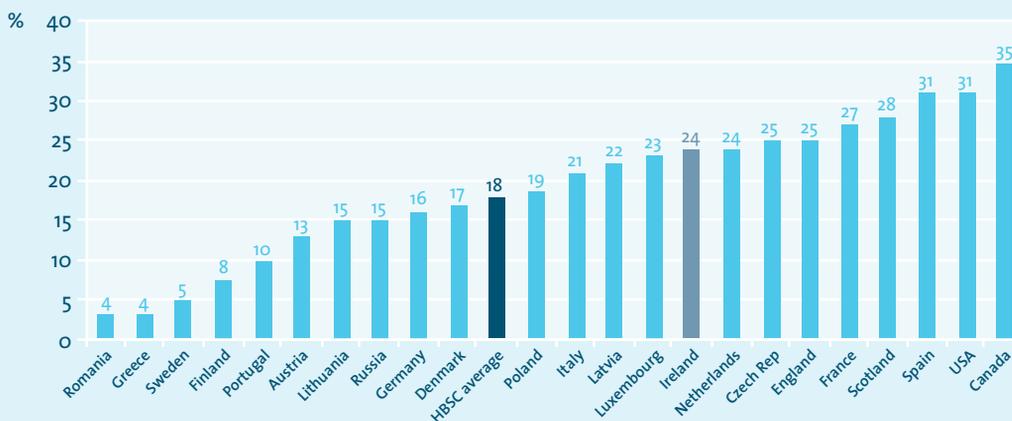
In Ireland, it has been estimated that the overall alcohol related cost imposed on Irish society (not just by young people) was €2.65 billion in 2003 (Byrne, 2004). This figure comprised loss of output due to alcohol related absences from work (€1,050m), alcohol related transfer payments (€523m), healthcare costs (€433m), cost of road accidents (€322), taxes not received on lost output (€210m), and cost of alcohol related crime (€147m).

⁴³ Based on research by Rehm, J., Room, R. & M. Monteiro (2003) 'Alcohol as a risk factor for burden of disease' in World Health Organisation (Eds.) *Comparative Quantification for Health Risks: Global and Regions Burden of Disease Due to Selected Major Risk Factors*. Geneva: World Health Organisation.

Using cannabis

There are many different indicators to report on the use of drugs by children and young people. The State of the Nations Children Report uses the proportion of children aged 10-17 who report having used cannabis at least once in their lifetime. In 2006, 15.7 per cent of children in Ireland aged 10-17 reported that they had used cannabis, which indicates an increase of 3.6 percentage points on figures from 2002. More boys had taken cannabis than girls. Again drug use increased with age, with almost 30 per cent of 15-17 year olds having taken cannabis at least once in their lifetime (OMCYA, 2008a: 138). There was little variation across social classes. There was some regional variation, with 20.3 per cent of young people in Dublin having taken cannabis, compared to 11.9 per cent in the South-West of Ireland. Taking 15 year olds for the purpose of international comparisons, 23.5 per cent of children in Ireland reported taking cannabis, compared to an HBSC average of 18 per cent, see Figure 6.26. Among the 39 countries and regions which used this HBSC item, Ireland was ranked 12th highest; Romania had the lowest percentage at 3.5 per cent, while Canada had the highest at 34.5 per cent.

Figure 6.26 Percentage of Children Aged 15 Who Report Having Taken Cannabis at Least Once in Their Lifetime, Selected Countries, 2006



Source OMCYA, 2008a: 140.

Like smoking and drinking, illicit drug use is a high-risk activity for young people, with a risk of immediate harm to themselves and those they come in contact with, as well as being addictive and having potentially harmful consequences over the longer term. For these three risk behaviours, there is little variation across gender or social classes, although they are increasing behaviours for girls. They also tend to increase with age.

Sexual Activity

Other indicators of risk behaviour for children and young people are indicators of sexual activity, for example, the percentage of 15 year olds who have had sexual intercourse and/or the percentage who have used a condom. These data are not available for Ireland. This is an information gap as knowledge of condom use is important in putting in place measures to reduce sexually transmitted diseases and HIV/AIDs, as well as reducing unplanned pregnancies. The Irish Survey on Sexual Health and Relationships (ISSHR, 2004/05) includes a retrospective account of the age at which individuals had first intercourse for those now aged 18 and over. Seventeen was reported as the median age for first intercourse for both men and women now aged 18–24. Some 31 per cent of men and 22.3 per cent of women aged 18–24 reported having had sex before the age of 17 (Crisis Pregnancy Agency, 2008).

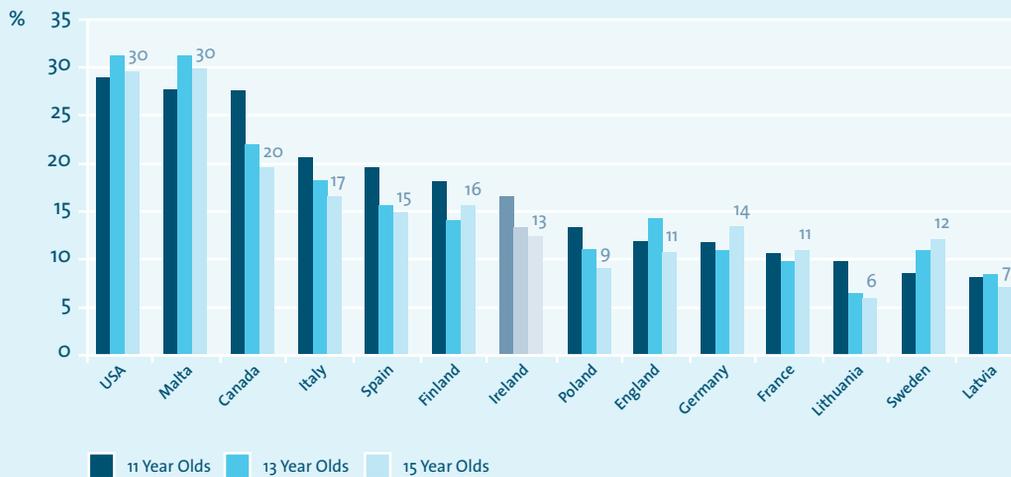
Births to Girls Aged 10-17

An associated indicator is the number of births to girls aged 10-17. Although the total number of births in Ireland increased in 2006, the number of births to girls aged 10-17 stood at 577, a reduction of 202 births on figures from 2002 (OMCYA, 2008a: 142). Births to girls aged 10-17 accounted for 0.9 per cent of all births in Ireland in 2006, with 10 babies born to girls aged 10-14. Almost 35 per cent of births to girls aged 10-17 took place in Dublin, with 9.5 per cent of births taking place in Cork. Teenage pregnancy is associated with an increased risk of poor economic and health outcomes for both mother and child. Poor outcomes include low birth weight, a higher risk of poor health and infant mortality, and higher than average rates of post natal depression (NHS Centre for Reviews and Dissemination (1997) and Social Exclusion Unit (1999) cited in OMCYA, 2008a: 142).

Being Overweight or Obese

The percentage of children who are overweight or obese is the seventh indicator in the risk behaviours component of the health domain of children's well-being. Childhood obesity is particularly detrimental to future health and well-being. The World Health Organisation has recognised that the numbers of children who are overweight or obese have reached epidemic proportions in most industrialised countries (WHO, 2004). In 2006, 14 per cent of 11, 13 and 15 year old Irish children reported being overweight or obese (HBSC, 2006: 77). The HBSC average was 13 per cent, with children from the United States most likely to report being overweight or obese (30 per cent), closely followed by Maltese children (29 per cent), see Figure 6.27.

Figure 6.27 Percentage of Children Aged 11, 13 and 15 years who Report Being Overweight or Obese, Selected Countries, 2006.



Source HBSC, 2006: 76.

Note Numbers shown on the graph are for 15 year olds.

In Ireland, boys are more likely than girls to report being overweight or obese despite being more likely to take part in physical exercise, emphasising the importance of good nutrition as well as physical exercise. Girls are more likely to have a negative body image and engage in weight reduction behaviour (HBSC, 2006). Some 33 per cent of Irish 11, 13 and 15 year old girls think that they are too fat, compared to 22 per cent of boys. Body image plays an important role in mental health and psychological well-being (Williams and Currie, 2000; Ge *et al.*, 2001). There is a significant gender difference for 15 year olds in Ireland, with twice as many 15 year old girls having a negative body image as 15 year old boys (HBSC, 2006: 81).

Healthy Behaviours – Eating Breakfast

The fourth component of the health domain for children is healthy behaviours. This component measures the positive health behaviours of eating breakfast and taking physical exercise. Using the indicator of the percentage of children aged 9-17 who report eating breakfast on 5 or more days per week, in 2006, 76 per cent of children in Ireland did so. Boys are more likely to eat breakfast than girls, younger children than older children and those in the higher social classes compared to those in the lower social classes. Within Ireland, 70 per cent of young people in the Midlands report eating breakfast compared to 79 per cent in the West. Other regions fall within these levels (OMCYA, 2008a: 160-161). Comparing Ireland internationally, using the responses for 11, 13 and 15 year olds, 78.2 per cent of young people of these ages in Ireland report eating breakfast, which is above the HBSC average (72.2 per cent) and places Ireland 10th among the 39 countries and regions that used this HBSC item, see figure 6.28. Eating a breakfast has been shown to be important to nutrient intake and to help children concentrate in school.

Figure 6.28 Percentage of Children Aged 11, 13 and 15 who Report having Eaten Breakfast on Five or More Days per Week, Selected Countries, 2006



Source OMCYA, 2008a: 140.

Physical Exercise

The second indicator in the healthy behaviours component is physical exercise. This is measured by the percentage of children aged 9-17 who report being physically active for at least 60 minutes per day on more than 4 days per week. The World Health Organisation recommends participation in moderate intensity physical exercise for an hour a day. In Ireland, in 2006, just over half of 9-17 year olds (55 per cent) were physically active for at least one hour on more than four days per week. Physical activity was higher among boys and younger children. There was little variation across social classes and the level of activity increased between 2002 and 2006, from 48 per cent to 55 per cent (OMCYA, 2008a: 154). Taking only 11, 13 and 15 year olds for the purpose of international comparison, Ireland was the highest scoring country on this measure with 59 per cent of young people exercising to this level more than 4 days per week (HBSC, 2006). The HBSC average was 42.6 per cent, see Figure 6.29.

Figure 6.29 Percentage of Children Aged 11, 13 and 15 who Report Being Physically Active for At Least 60 Minutes per Day on More Than Four Days per Week, Selected Countries, 2006



Source OMCYA, 2008a: 156.

Rating Health as 'Fair or Poor'

The fifth component of the health domain is health assessment, based on two indicators: the percentage of 15 year olds who rate their health as 'fair or poor' and access to health services. On the first indicator Irish scores are in line with the HBSC (2005/6) averages – 20 per cent of 15 year old girls and 15 per cent of 15 year old boys rated their health as 'fair or poor' compared to an HBSC average of 23 per cent and 13 per cent, respectively. In general, fair or poor health is more commonly reported by older (15 year olds) than younger children (11 year olds), and by girls than boys at all ages. Low family affluence is significantly associated with higher levels of fair or poor health (HBSC International Report, 2008: 59). Self rated health, as a subjective indicator, has been found to be predictive of objective health outcomes in adults and is therefore held as a more appropriate measure of adolescent health than traditional morbidity and mortality measures. Self rated health has been associated with a wide range of factors including: symptoms of anxiety and depression; and with school and family factors, such as, academic achievement, positive school experiences, bullying, family structure and communication with parents (HBSC International Report, 2008: 59).

Access to Health Services

On the second indicator, access to health services for children, the measure used is the number of children on hospital waiting lists. In April 2008, 2,537 children were known to be on hospital waiting lists (OMCYA, 2008a: 200). Some 39 per cent of these children had been waiting for 3-6 months, 42 per cent for 6-12 months and 19 per cent for more than a year. Most (85 per cent) were awaiting surgical treatment, the remaining 15 per cent medical treatment. Access to basic healthcare is central to the well-being of children in their lives as children and for their health

and well-being as adults. Access can depend on the availability of the service and being able to pay for the service. Long waiting times for health care can have long-term implications. Medical cards provide important access to primary health care services for low income families and their children. Some 32.5 per cent of children under 16 years of age have access to a medical card, and 45.5 per cent have access to private medical insurance (CSO, 2007).

Mental Well-being

The sixth and final component of the health domain is mental well-being. In consultations with 277 young people aged between 12 and 18 in autumn 2008 at venues throughout the country, young people identified the key factors which ‘helped’ and ‘hurt’ their mental health (OMCYA, 2009f). ‘Being judged for how you look’ and the pressures associated with school and the exam system were the two most significant areas of ‘hurt’ in relation to teenage mental health, with other issues cited as having a negative impact including the death of a close family member or friend, the lack of facilities and the effects of peer pressure. The main factors which were identified as ‘helping’ young people’s mental health was having a safe space, such as a youth cafe, to ‘hang out’ with friends, having less homework especially at weekends, and less reliance on exams.

Feeling Lonely

Mental well-being is assessed here using three indicators: the percentage of students who feel lonely, young people with mental illness and youth suicide. Some 4.6 per cent of 15 year old students in Ireland agreed with the statement ‘I feel lonely’ (PISA, 2003), compared to an average of 7.4 per cent across OECD countries, see Figure 6.30. Japan is an outlier with nearly a third (29.8 per cent) of 15 year olds agreeing that they were lonely. Fifteen year olds were least likely to feel lonely in the Netherlands, Spain and Ireland.

Figure 6.30 Percentage of 15 Year Old Students who Agree With the Statement ‘I Feel Lonely’, Selected Countries, 2003



Source PISA, 2003: 156.

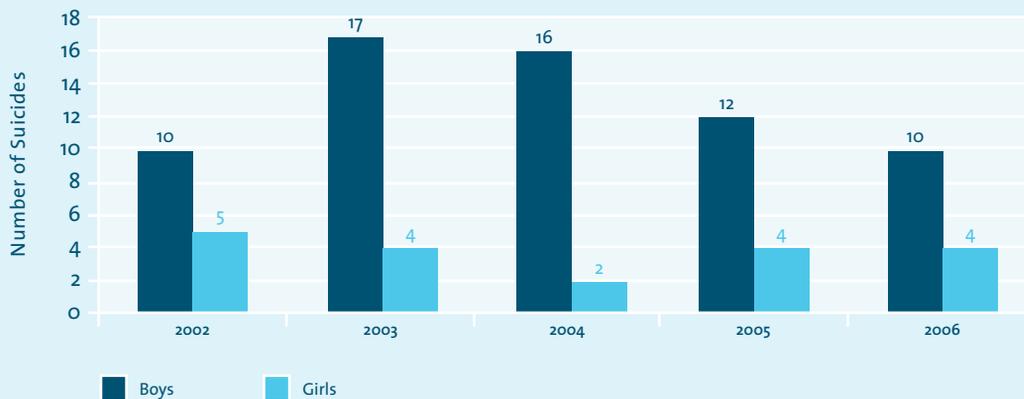
Admissions to Psychiatric Hospitals

The second indicator in the mental well-being domain is mental illness measured by the number of admissions to psychiatric hospitals. In 2006, 398 children aged 5-17 were admitted to psychiatric hospitals, 84 per cent of whom were aged 15-17 (OMCYA, 2008a: 208). The number of admissions to psychiatric hospitals was higher for boys than girls. The most common reason for admission to hospital was for depressive disorders (29.6 per cent). Alcoholic disorders accounted for 4.3 per cent of admissions and drug dependence for 5.8 per cent of admissions.

Youth Suicide

Extreme negative feelings and mental illness can sometimes result in deliberate self-harm and the taking of one's own life. The third indicator in the mental well-being component of the health domain is youth suicide among children and young people aged 10-17. In 2006, there were 14 suicides among this age group. The number of suicides for boys was 10, down from a high of 17 in 2003. The number of suicides among boys (10) was over twice that for girls (4), see figure 6.31. In 2006, suicide accounted for 14.7 per cent of all deaths for children and young people aged 10-17. Even though the numbers of children and young people affected by mental illness and suicide are relatively small, these events have traumatic and lasting debilitating effects on the young people and their families and friends.

Figure 6.31 Number of Suicides by Gender for Children and Young People Aged 10-17, 2002-2006



Source OMCYA, 2008a: 149.

Self Harm

Deliberate self harm is often associated with mental ill-health and risk of suicide. In their survey of young people's mental health the National Suicide Research Foundation (Sullivan *et al.*, 2004) found that a lifetime history of self harm was reported by 12 per cent of the teenagers surveyed, and that nearly half (46 per cent) had done so more than once. Girls were three times more likely to harm themselves than boys. Self cutting and drug overdose were the most common methods used by the young people. Results from the 2008 Annual Report of the National Registry of Self Harm (National Suicide Research Foundation, 2009), which records persons presenting to hospital emergency departments as a result of deliberate self harm, identified the peak rate for women as the 15-19 year old age group at 639 per 100,000, and the peak rate for men as the 20-24 age group at 433 per 100,000. In other words, 1 in every 156 adolescent girls was treated in hospital as a result of deliberate self harm, and 1 in every 233 men in the 20-24 years age group.

The National Suicide Research Foundation (2009) has noted that the recent significant increase in deliberate self harm among young adult men may reflect mental health and social problems associated with the economic downturn. From their lifestyle and coping survey (2007) reasons identified as increasing the risk of self harm included having relationship problems, family difficulties, being bullied, being in trouble with the police, having worries about their sexual orientation, having close friends or family who had taken their own life, and having been physically or sexually abused.

In their study of the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) people (Mayock *et al.*, 2009) found heightened levels of psychological distress arising from stigmatisation and harassment, leading to significant levels of self harm and suicide risk. Over a quarter (27 per cent) of the sample had self harmed at least once, with 16 years of age being the average age for the onset of self harm. Some 18 per cent of the respondents had attempted suicide, half of whom said this was related to their LGBT identity. Seventeen and a half years was the average age of the first suicide attempt.

Summary

Health is a central component of children and young people's well-being. The indicators used here relate to health at birth, immunisation, risk and healthy behaviours, health assessment and mental well-being. Ireland fares relatively well on health at birth with levels of child mortality below the 5 infant deaths per 1,000 live births yardstick, and low birth weight rates below the OECD average. A child's birth weight is influenced primarily by their mother's behaviour and well-being. Ireland remains below the WHO's target of 95 per cent immunisation for children, an important preventative health service measure.

On risk behaviours, just under 10 per cent of young people smoke every day, one fifth have been drunk at least once in the last thirty days and 16 per cent report that they have used cannabis at least once in their life time. For these three risk behaviours there is little variation across gender or social class, although they are increasing behaviours for girls. They also tend to increase with age. Ireland is above international averages for these three risk behaviours, with long-term implications

for health and well-being. Irish data are not available for risky sexual activity, however, in 2006 there were 577 births to girls aged 10-17. The final risk factor used here, overweight and obesity, showed that 14 per cent of young people in Ireland reported being overweight or obese, in line with international averages. Boys are more likely to be overweight than girls, although girls are more likely to have a negative body image.

With regard to healthy behaviours, three quarters of children in Ireland eat breakfast and just over a half are physically active for at least one hour or more on four days per week. Ireland is the most physically active country in the international survey. Both breakfast eating and physical activity in Ireland are higher among boys than girls and among younger than older children. In relation to health assessment one fifth of 15 year olds rate their health as only 'fair or poor'. Access to basic health services remains a serious issue in Ireland with 2,537 children on hospital waiting lists in 2008, one fifth of them for more than one year.

On mental well-being just under 5 per cent of 15 year olds feel lonely, 398 children and young people aged 5-17 were admitted to psychiatric hospitals (2006) and 14 young people took their own life. Boys are more at risk of mental ill-health than girls. However, girls are three times more likely to self harm than boys. The economic downturn has been associated with an increase in self harm and suicide risk. Young people who are lesbian, gay, bisexual or transgender have been identified as having a high risk of self harm and suicide risk, associated with their LGBT identity.

6.8.2 Ireland's Policy Framework for Children's Health

Ireland's policy approach to children's health in *Towards 2016* (2006: 41 & 44) is that 'every child should have access to world-class health and personal social services' and 'to deliver tangible improvements in the health outcomes for children over a ten year period'. This is to involve prevention, early intervention and treatment services within the health sector, as well as policies in other areas such as education, income support, accommodation, childcare, food and the environment, plus addressing lifestyle related risk factors.

Specific priority actions towards meeting these objectives include:

- ◆ *Health services* - a review of secondary care paediatric services outside Dublin;
- ◆ *Immunisation* - to achieve the WHO target of 95 per cent immunisation;
- ◆ *Risk Behaviours* - to address lifestyle factors through a new Health Promotion Policy, the implementation of the National Alcohol policy, and through monitoring prevalence trends of smoking and substance use;
- ◆ *Nutrition* - launching a National Nutrition Policy to address children's food poverty and obesity; developing a national database to monitor prevalence trends of growth, overweight and obesity; and expansion of the School Meals programme;

- ◆ *Physical activity* - recognition of the importance of recreation, sport and physical activity for the balanced and healthy development of children through increased support for sports infrastructure and sporting organisations; promoting sport in education settings; and a more integrated approach to meeting needs at local level, in line with the National Recreation Policy and National Play Policy. There was a target to increase by 3 per cent the numbers of children taking part in sport between 2006 and 2008; and
- ◆ *Mental health* - 1 child and adolescent community mental health team (CMHT) per 100,000 by 2008 and 2 CMHTs per 100,000 by 2013.

A previous target (2002) to reduce the gap in low birth weight rates between children from the lowest and highest socio-economic group by 10 per cent has not been included (Government of Ireland, 2002). There has been difficulty in getting baseline data for this measure. Nevertheless it is a critical indicator in improving child well-being.

In relation to a multidimensional response a 'cross-departmental team, chaired by the Office of the Minister for Children, is developing an initiative to test models of best practice which promote integrated, locally-led, strategic planning for children's services' (*Towards 2016*, 2006b: 38). These 'models of best practice' will focus specifically on disadvantaged children and young people, their families and their communities.

The *Towards 2016 Fourth Progress Report* (2008) states that progress is being made on the child and adolescent community health teams although the target has not yet been met and there is still some way to go before these teams will be fully operational. Immunisation rates have not yet met the WHO target of 95 per cent but now stand at more than 90 per cent for most vaccinations. A National Nutrition Policy has been drafted and progress has been made in developing a database for monitoring trends of growth in overweight and obesity. Despite substantial expansion of the School Meals Scheme demand continues to exceed expectation (Government of Ireland, 2008a: 125). In relation to the Health Promotion Policy, it has been decided that, as many of the determinants of health lie outside the remit of the health sector, an Inter-Departmental approach is the most appropriate way to progress health promotion issues comprehensively.

6.8.3 Commentary on Children's Health

Policy approaches for improving children's health focus on improving access to health services, particularly primary care services and preventative measures. There is also recognition of the inter-relatedness of health with other dimensions of well-being so that policies to address poverty, mother's well-being, education, housing, nutrition and the environment are also important.

Finland is a country which is acknowledged as having a health system with good health outcomes for children. Finland has a comprehensive health care system with a focus on maternity and child health clinics, as well as pupil welfare systems. Pupil welfare services include school nurses, dental care and specialists such as psychologists and speech therapists. In municipal health centres, which provide primary health care for everyone, children and young people under the age of 18 are entitled to free appointments with health centre GPs (Jalava, 2007: 18).

The United Kingdom, which has a high profile commitment to 'end child poverty in a generation', emphasises narrowing health inequalities. They too recognise the influence of other policy areas on improving health outcomes as well as focusing on 'hard to reach' families (Bradshaw and Bennett, 2007: 18).

There is a myriad of policy approaches for minimising risky and harmful behaviours among children and young people. Many of these are included under the broader gambit of health and education policies. In many countries there is a specific emphasis on the promotion of sport and recreation. Some countries promote positive behaviours through their youth sector policies, whereas in other countries policies relating to areas like physical activity and good nutrition are categorised as of lower priority than what are seen as more pressing needs. There tends to be an emphasis on older rather than younger children, which reflects an approach of reaction to problems rather than preventative approaches. Best practice would suggest a long-term co-ordinated approach to promoting positive behaviours is required, with an emphasis on prevention and early intervention.

The policy response in Ireland is currently focused on a multidimensional and preventative approach, which is the stance adopted by the best performing countries on this measure. It would seem to be important to continue this approach, as much as possible in the context of the recession, for the long-term benefit of our children. Implementation of policy commitments remains a challenge in a number of areas, for example, implementation of the recommendations of the Strategic Task Force on Alcohol. While 'value for money' must remain a key criterion, especially in the economic recession, attention needs to remain focused on the delivery of front-line services and preventative measures.

Further consideration could be given to alternative approaches to promoting and ensuring access to primary care provision, particularly for low income and disadvantaged families. For example, given the high and increasing rates of deliberate self harm among those aged 10-14 years there is a need to prioritise evidence-based mental health programmes for children and adolescents, as well as special mental health programmes. Policies which attempt to change behaviours take time, so it is important to monitor progress on an ongoing basis. Key policy areas for the promotion of positive behaviours are education, health, sport, nutrition and youth policy more broadly.

A focus on improved services for children, particularly for disadvantaged young people, with an emphasis on prevention and early intervention is very much in line with the recommendations of the Developmental Welfare State and the need for Ireland to enhance its service delivery.

In relation to monitoring progress on children's health there is a wealth of information and indicators, both nationally and internationally, some of which are presented in this report. However, there remain some gaps. Information could be improved on health inequalities across socio-economic groups to see if progress is being made on narrowing the current gaps. A further consideration is information on the impact of a sick or disabled child on family income. Information on sexual activity and condom use for young people is not available in Ireland, yet these are seen as important indicators of young people's health internationally. Good validity and reliability tests are required for data collected on behaviours. Further work could be done on exploring the linkages between the various risk behaviours, which would help to inform more integrated policy responses.

6.9 Democracy and Values

6.9.1 Measuring Democracy and Values Among Ireland's Children

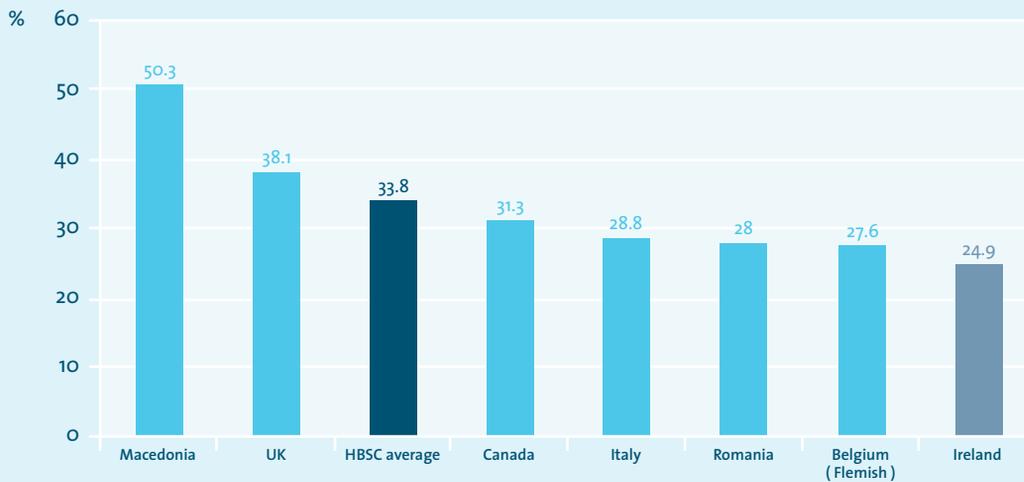
The final domain is democracy and values and indicators here capture children's involvement in decision-making, their experiences of violence, discrimination and abuse (as a contravention of their rights). Three components are used to measure democracy and values: exercising democracy; threats to well-being; and rights and equality.

Participation in Making School Rules

Two indicators measure the first component, exercising democracy: participation in making school rules; and access to the internet. As noted in the *State of the Nation's Children: Ireland 2008* report 'effective student participation in school decision-making contributes to the improvement of school practices and builds the confidence and self esteem of students' (OMCYA, 2008a: 122). In 2006, just over one-fifth (22.5 per cent) of young people aged 9-17 in Ireland reported that students in their schools participate in making the school rules. Interestingly, participation was higher among young children and children from lower social classes. There was little difference in participation by gender. Geographically, participation was highest in the Dublin region at 28.1 per cent and lowest in the Mid-West at 17.2 per cent. Taking 11, 13 and 15 year olds only for the purpose of international comparison, of the 7 countries who used this indicator in the HBSC, Ireland came last, 8.9 percentage points below the HBSC average of 33.8 per cent, see figure 6.32.⁴⁴ Half of students in Macedonia, the highest scoring country, reported that students in their school participated in making the school rules. The UK also scored highly.

44. HBSC survey data are drawn from self-report, self completion questionnaires completed by children in schools. Thus, they are subject to potential biases in relation to self presentation and memory.

Figure 6.32 Percentage of Children who Report That Students at Their School Participate in Making the School Rules, by Country, 2006

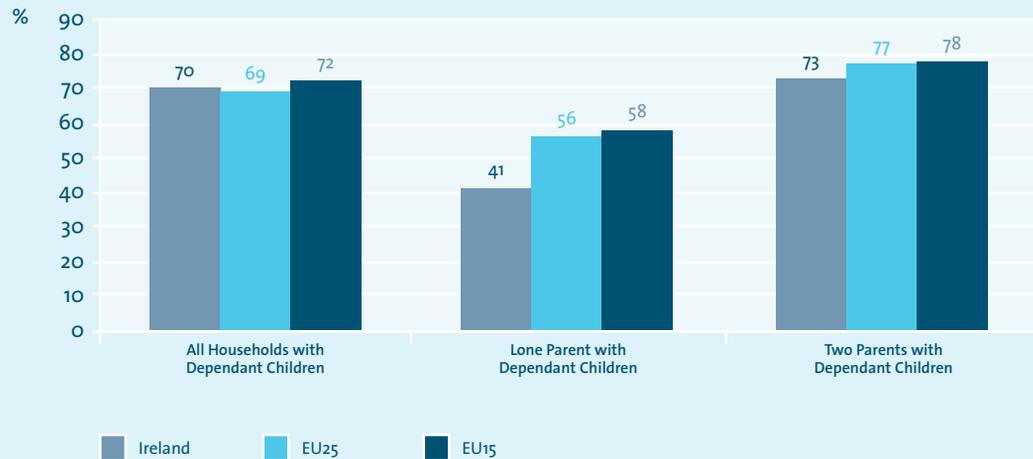


Source OMCYA, 2008a: 124.

Access to the Internet

The second indicator on the exercising democracy component is access to the internet. Electronic communication is important for young people to have access to informational resources, especially with regard to self-learning. Adequate security safeguards are required to ensure children and young people do not access inappropriate material on-line. As noted earlier, balance may also be required in the use of the internet to ensure that electronic communication does not replace human contact with friends. Using Eurostat figures (2007), 70 per cent of Irish households with dependent children had access to the internet, which was close to the EU15 average of 72 per cent. However, only 41 per cent of lone parent households had internet access. This was well below the EU15 average of 58 per cent. Two-parent households fared better at 73 per cent, coming fairly close to the EU15 average of 78 per cent, see Figure 6.33.

Figure 6.33 Access to the Internet, by Household Type, EU and Irish Comparisons, 2007.



Source Eurostat, 2007.

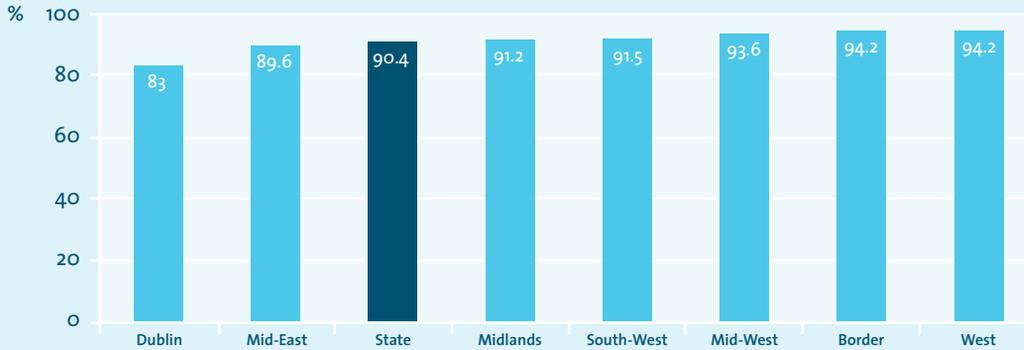
Threats to Well-being

The second component of the democracy and values domain of children's well-being is threats, which contravene young people's experiences of trust and values. Three indicators are used in this component: feeling safe in the area you live in; being bullied; and domestic violence.

Feeling Safe

A sense of safety in the local community is an important facet of children's well-being. Using an indicator from the *State of the Nation's Children: Ireland 2008* report, 90 per cent of children report feeling safe in the area where they live. There are no differences by age or gender, with small differences attributed to social class: lower social classes feel less safe. Across the country, children and young people living in the Border and West regions of Ireland were most likely to report feeling safe in the area where they live, whereas children and young people in the Dublin area were the least likely to report feeling safe, see Figure 6.34. When taking only 11, 13 and 15 year old children for international comparisons, Ireland's average of 91.2 per cent feeling safe in the area where they live is slightly higher than the HBSC average of 89.5 per cent, with Belgium (Flemish) ranked first for this indicator at 93 per cent. Of the eight countries using this indicator, Ireland ranked 3rd (OMCYA, 2008a: 180).

Figure 6.34 Children who Report Feeling Safe in the Area Where They Live, by Region, 2006



Source OMCYA, 2008a: 179.

Being Bullied

The second indicator on the experiences of violence component is the percentage of young people who report to having been bullied at school. Understanding and preventing bullying during childhood has important implications for the well-being of children, as well as the long-term well-being of society.⁴⁵ In international comparisons, Ireland ranks 14th of the 39 countries and regions responding, with 25.9 per cent of 11, 13 and 15 year old children reporting having been bullied in the past couple of months, see figure 6.35. This is below the HBSC average of 32 per cent. Children in Spain (ranked 1st at 13.6 per cent) were least likely to have been bullied in school, while more than half of the children in Lithuania (ranked 39th at 56.3 per cent) reported being bullied in school in the past few months (OMCYA, 2008a: 67).

Figure 6.35 Percentage of Children who Report to Having Been Bullied in School in the Past Couple of Months, by Selected Country, 2006



Source OMCYA, 2008a: 67.

45. Based on work by O'Moore, A.M. (2000) 'Critical Issues for teacher training to counter bullying and victimisation in Ireland', *Aggressive Behaviour*, Vol. 26, 99-111, cited in OMCYA, 2008a: 65.

Looking at Ireland in more detail, one quarter (24.5 per cent) of children and young people aged 9-17 in Ireland report to having been bullied at least once in the last few months (OMCYA, 2008a: 65, based on HBSC data for 2006). Bullying is higher among younger children. There is little variation by gender, across social classes or throughout the country. The information is not presented by ethnicity, nationality, disability or sexual orientation, which would be useful additions. In a study carried out by the anti-bullying centre at Trinity College, Dublin, Minton *et al.*, (2006) found that half of lesbian, gay and bisexual young people had been bullied in school in the past three months, compared to 16 per cent of the general youth population.

Experience of Domestic Violence

The third indicator in the threats to well-being component is children's experience of domestic violence. Information on children who have experienced domestic violence is limited, although the report *Health Statistics 2005: Children in Care and Child Abuse Cases* (Department of Health and Children, 2006) records domestic violence in just 0.5 per cent of cases as being the principal reason for the admission of children to care. However, many of the other reasons given, for example, physical, sexual and emotional abuse, and parents unable to cope may relate to domestic violence. The *State of the Nation's Children: Ireland 2008* report (Office of the Minister for Children and Youth Affairs, 2008a) notes that there is an increasing awareness of the impact of domestic violence on children and the impact this can have on them throughout their lives. In 2007, the Office of the Minister for Children and Youth Affairs published in-depth research into the experiences of children living with domestic violence, through talking to children on their experiences of domestic violence and the types of services they found useful (Hogan and O'Reilly, 2007).⁴⁶ In domestic violence situations the children themselves may be the subject of violence, but more often they are living in a household where someone (usually their mother) is suffering abuse from a violent partner.

Some of the key findings from the research were:

- ◆ Some children had been assaulted as part of the violence;
- ◆ For many children witnessing and overhearing a man's violence was an enormous stress, especially when they felt helpless in protecting their mother;
- ◆ Young children in refuges missed their fathers, despite his violence;
- ◆ Teenagers were less likely to miss their fathers, especially where he had been seeking to 'control' the family;
- ◆ Where the mother was the perpetrator of domestic violence, similar to situations where a man was the perpetrator, children lived in fear and shame;
- ◆ The use of mobile phones to send threatening and abusive messages; and
- ◆ 'Crisis and chaos' were identified in the lives of children who experienced domestic violence.

There were a range of poor outcomes from these experiences including poor relationships with their parents, unplanned pregnancies, drug and alcohol abuse, behavioural problems, physical health problems and dropping out of school.

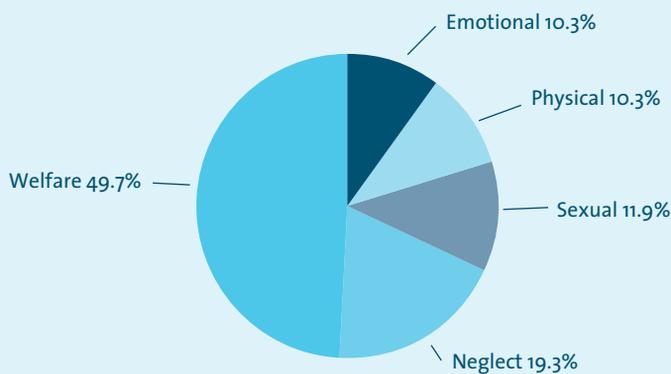
⁴⁶ 22 children who had experienced domestic violence were interviewed ranging in age from 5-21 years.

Child Abuse

The third component of the democracy and values domain is rights and equality. Three indicators are used to capture this component, which document contravention of rights and equality: child abuse; being treated unfairly; and discrimination. Children have the right to be protected from abuse, neglect and exploitation under the UN Convention on the Rights of the Child. The Report of the Commission to Inquire into Child Abuse (The Ryan Report, 2009) has documented ‘harrowing accounts’ of the lives of children who were abused in institutions run by the religious orders, having been placed there by the State. The Commission found that physical and emotional abuse and neglect were features of the institutions and that sexual abuse occurred in many of them. In particular, the Commission found ‘a disturbing level of emotional abuse suffered by disadvantaged, neglected and abandoned children’. The religious orders, the Department of Education, the Government and wider society all failed to address the abuse. Following publication of the Commission’s report in May 2009, the Taoiseach reiterated an apology, made in May 1999 on behalf of the Government, the State and all the citizens of Ireland, to the victims of childhood abuse for the ‘collective failure to intervene, to detect their pain or to come to their rescue’. The Government has accepted all the recommendations of the Commission, and is committed to their implementation. An implementation plan was published in July 2009 (OMCYA, 2009).

Abuse and neglect can have serious effects on children, including undermining child well-being, with long-term effects leading to problems in adult life (Hooper, 2002). In 2006, there were 12,520 children who had an initial assessment for a child welfare and protection concern (OMCYA, 2008a: 118). This represents 120.8 out of every 10,000 children in Ireland. Almost half of all reported cases in 2006 were related to the welfare of children, while 19.3 per cent reported neglect and 11.9 per cent sexual abuse, see figure 6.36.

Figure 6.36 Percentage of Reported Cases for Initial Assessment of Child Welfare and Protection Concerns, 2006 ⁴⁷



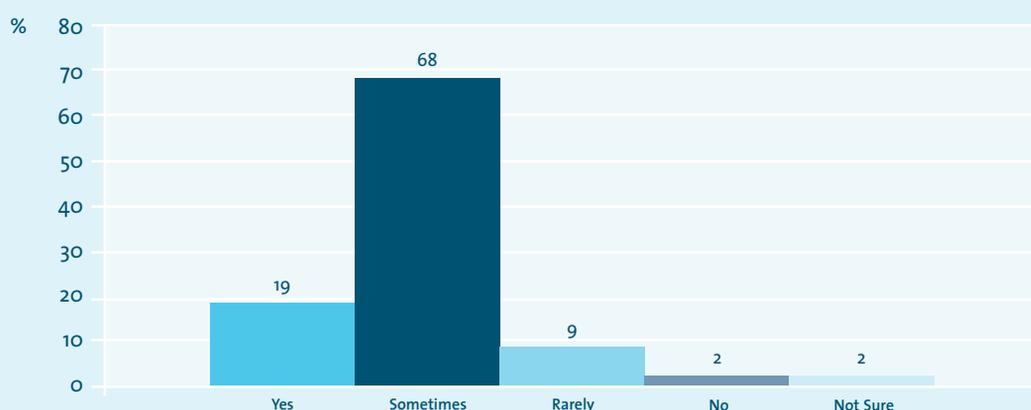
Source OMCYA, 2008a: 119.

⁴⁷ The number of children who had an initial assessment for child welfare and protection concerns is an important measure of the incidence of child abuse and neglect in Ireland. It should be noted, however, that these rates are affected by a number of factors other than the actual incidence of abuse and neglect, and some caution is thus required in drawing conclusions concerning the overall prevalence of abuse and neglect for the following reasons. First, some cases of abuse and neglect are never reported. Secondly, some incidents are reported more than once and several reports may relate to a single family. Thirdly, reports tend to increase for reasons unrelated to the actual prevalence of abuse and neglect, such as a highly publicised case or public awareness campaign (OMCYA, 2008a: 119).

Being Treated Unfairly

The second indicator on the rights and equality component is the extent to which young people believe they are being treated unfairly. ‘How we see it’, a survey by the Office of the Minister for Children and Youth Affairs in 2006,⁴⁸ reported on the extent to which children and young people aged between twelve and eighteen felt they were being treated unfairly. Figure 6.37 shows that 87 per cent of the children surveyed felt that children and young people are not treated fairly either all of the time or sometimes.

Figure 6.37 Are Children and Young People Treated Unfairly? 2006



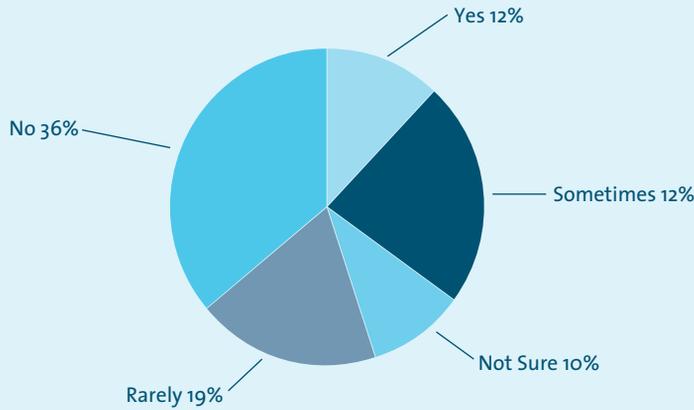
Source OMCYA, 2006b: 16.

Discrimination

The third indicator on rights and equality is the extent to which young people think that society does enough to help children and young people who are being discriminated against. Figure 6.38 shows that just over a third (35 per cent) of respondents felt that society does enough all of the time or sometimes to counter such discrimination compared to more than half (55 per cent) saying that it does not or rarely does. Ten per cent were not sure (OMCYA, 2006b).

48. The survey was completed by 117 young people aged from 12 to 18 who attended the 2006 Dáil na nÓg. The young people were from each of the 34 local authority Comhairlí na nÓg areas. Of the total number of respondents 21 per cent were aged 12-14, almost three quarters (73 per cent) were aged 15-17, while 6 per cent were aged 18. Approximately two thirds of respondents were female, one third male.

Figure 6.38 Does Society Provide Enough Help to Children and Young People who are being Discriminated Against? 2006



Source OMCYA, 2006b: 17.

To address discrimination against children and young people, the young people themselves felt that children should be educated on the way society is changing in order to have a better and more informed attitude towards others within the new Irish multicultural society. A sixteen year old male respondent to the survey suggested what was required was to: *'Set up youth groups where all young people from different backgrounds are brought together to get to know about each other. Have cultures and different religions taught in schools more, so young people can understand people more'* (OMCYA, 2006b: 17).

Information on racism among children is not currently available, but would be a useful addition, given our increasing racial and cultural diversity. Discrimination against Traveller children in the education system has been documented (ITM, 2004: 13). Pavee Point (2005) argues that a lack of visibility of Traveller culture within the school system may lead to feelings of isolation experienced by Traveller children. The lack of interaction between Traveller and settled children and lack of respect for cultural identity may provide a fertile ground for discrimination. The promotion of intercultural policy can play an important role in combating discrimination and racism.

Young people can also be subject to negative stereotyping. In his research on inequality and the stereotyping of young people Devlin (2006) found that the media, in particular, were prone to stereotyping young people in very negative ways by associating 'youth' with crime, deviance, delinquency, drug and alcohol problems, sexual promiscuity and general disorderliness. Such stereotyping can be damaging to the status of the group in question, diminishing the relationships between the stereotyped group and other groups in society, based on assumptions rather than realities.

It is worth noting that ‘No person is simply defined, nor is any community homogeneous. An individual’s experience of racism is informed by a multiplicity of factors, including gender, age, sexual orientation, religion, disability and marital or family status’ (Equality Authority, 2003).

Summary

Democracy and values is an important dimension of children’s well-being. The components presented here relate to children’s ability to exercise democracy, threats to their well-being, and experiences of discrimination. Just over one fifth of young people aged 9-17 report that students in their school participate in making the school rules. This is low by international standards where the average is one third. The exercise of democracy was also measured by access to the internet – 70 per cent of households with dependent children in Ireland had access to the internet, which was close to the EU15 average. It is notable that only 41 per cent of lone parents in Ireland had such access.

On the threats component, 90 per cent of children in Ireland feel safe in the area where they live, slightly above the international average. However, one quarter of children and young people aged 9-17 in Ireland report to having been bullied in the last few months. Despite this figure seeming high, it is below the international average of one third of children who have been bullied. Nevertheless, there are sub groups of the population who are more likely to be bullied, for example, the experience of being bullied is well above national averages for lesbian, gay, bisexual and transgendered young people. While the proportion of children formally reporting domestic violence is low, an OMCYA report documents the harrowing and frightening experience of children living in violent households, from the perspective of the young people themselves.

In line with the UN Convention on Children’s Rights, children have the right to be protected from abuse, neglect and exploitation. The ‘Ryan Report’ has documented a ‘litany of abuses’ against children who were placed by the State in residential institutions run by the religious orders (www.childabusecommission.ie). In 2006, 121 children in every 10,000 children in Ireland (12,520 children) had an initial assessment for a child welfare or child protection concern. At a broader level, in a young people’s survey, 87 per cent of respondents felt that young people are not treated fairly and that society does not do enough to help children and young people who are being discriminated against. Future challenges include addressing the negative stereotyping of young people and promoting interculturalism.

6.9.2 Policy Framework on Democracy and Values

The Irish National Children’s Strategy places great emphasis on ‘giving children a voice’ and *Towards 2016* ‘shares a vision of an Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own’ and has the long-term goal that ‘every child and young person will have access to appropriate participation in local and national decision making’ (*Towards 2016*, 2006b: 41). Specific innovative measures to achieve this include the establishment by the OMCYA of a Comhairle na nÓg Implementation group to develop Comhairli na nÓg throughout the country. The initiative is to be complemented by specific participation projects with statutory bodies and NGOs.

Dáil na nÓg and the establishment of a Child and Youth Forum are important and useful developments. How effective these structures will be in improving outcomes for children has yet to be assessed. Indicators of the effective participation of children and young people have yet to be adequately developed.

Other priorities include: actions to promote anti-racism and the participation of international children and young people, minority groups and Travellers in education; support for youth work; and the establishment of a new Irish Justice Service.

6.9.3 Commentary on Democracy and Values

Accepting a ‘whole child’ approach to children’s well-being requires the inclusion of children’s views. This is clearly an area for further development, in terms of effective indicators and subsequent data collection. The influence of children’s views on policy making is an area warranting further exploration.

Mechanisms to progress a ‘whole child approach’ and ensure that children’s rights are upheld include the important role of the Ombudsman for Children as well as initiatives to promote active citizenship and participation in a knowledge society, integration and intercultural guidelines and action. The Framework for Early Learning (Aistear), as well as Civic, Social and Political Education (CPSE) and Social, Personal and Health Education (SPHE) and associated initiatives, offer potential to promote active citizenship and values of social solidarity, but they need to have greater priority within the education system.

The democracy and values domain is one which is central to the recognition of the rights of the child as well as providing a sound foundation for the future of our society. Data and indicators for monitoring this aspect of children’s well-being remain limited and could usefully be developed.

6.10 Conclusion

This chapter provides an overview of children’s well-being in Ireland using the well-being framework developed for this social report. It sets out key trends across the domains of: economic resources; work and participation; relationships and care; community and environment; health; and democracy and values. It seeks to link these trends to the current policy framework, paying particular attention to the 10 year social partnership agreement 2006-2015 *Towards 2016*, which provides an important long-term policy backdrop despite the dramatic and unpredicted changed economic circumstances which have succeeded the agreement of the framework. Comments are made on the extent to which the key trends and policy commitments are aligned, and the availability of data and appropriate indicators.

Demographically, Ireland has one million children, which is just under one quarter of the population. Despite having a relatively youthful population and having one of the higher fertility rates in the EU, Ireland’s reproduction rate remains below replacement level. One of the key changes in Ireland’s youth population in recent years has been its increasing diversity, with non-Irish nationals now making up 6 per cent of the child population. One per cent of all children are Traveller children.

Some 3.5 per cent of people aged 0-17 have a disability. In terms of state supports for children, by international comparisons, Ireland is one of the higher spenders on cash benefits but one of the smallest on services for children. The balance between income supports and service provision for children is the subject of ongoing debate in the current economic climate. Half of children in Ireland state that they are 'happy' with four fifths of 15 year olds reporting a high level of satisfaction with their lives.

With respect to *economic resources* Ireland has a high level of child poverty with one in five children at risk of income poverty. The inequality of the income distribution is a contributory factor, along with parents' education level, jobless households and the family's dependence on social welfare payments. Seven per cent of children live in consistent poverty and 16 per cent of children live in families with low levels of affluence. To improve the economic outlook for children in Ireland an appropriate policy mix of tax, welfare, employment, family and childcare policies is required. In particular, the position of children and families vulnerable to poverty, including families incurring additional costs of disability, warrants further consideration, especially in light of the economic recession and large increases in unemployment. As proposed throughout this report, the balance between income support and service provision is critical.

In relation to *participation*, in 2007, just over 10 per cent of children lived in households where no-one was in paid employment. These children have a high risk of poverty, and the proportion of these households is likely to have increased as a result of the economic recession. The main emphasis in this domain is on education and early childhood development. Ireland does not score well on an international assessment of early childhood services, although recent progress has been made. High quality early education programmes for children, especially children from disadvantaged backgrounds, contribute to their intellectual and social development.

With regard to educational achievement, in international comparisons, Ireland performs well on literacy and science, and average on mathematics. However, children in lower socio-economic groups perform considerably less well than others. By international standards a relatively high proportion of 15-19 year olds remain on in education in Ireland, but again, there is a social class gradient with young people from unemployed backgrounds more likely to leave education with no qualifications. The key challenge is to ensure that our education system can meet the needs of all children by reducing educational disadvantage. The emphasis should be on improving the provision of early childhood care and education, as well as reducing the numbers of children living in jobless households.

Relationships are central to child well-being and are valued highly by children themselves. Positive indicators of relationships include eating and talking together with family members, and having friends and pets. Risks to good relationships and well-being include living in disruptive and conflictual families, in poor families, living in care, having burdensome caring responsibilities, spending a lot of time outside the home in the evenings and contact through electronic media substituting for personal social interaction. On the indicators examined Ireland does reasonably well. However, one fifth of children in Ireland live in lone parent families which

have a high risk of poverty, and the number of children in separated/divorced families is growing, albeit from a low base. Boys in Ireland tend to spend an above average amount of time being out with friends in the evening and a relatively large amount of time communicating through electronic media. Policies for improving family and peer relationships tend to transcend policies in other areas. However, most policy approaches acknowledge the importance of stable family relationships for children within a diversity of family forms.

With regard to the **community and environment** a substantial housing need has been identified for households with children. There is an urgency to end youth homelessness, with some homeless young people being less than 12 years old. In relation to community participation, one third of young people participate in community and charity groups, with the rate of participation declining as they get older. Young people have an awareness of environmental issues and feel that environmental conditions can be improved. Unsafe environments can lead to deaths from accidents and injuries and on this indicator Ireland is above international averages, with 15 deaths per 100,000 young people attributable to accidents. Ireland is below international averages on having good places in the area for children to spend their free time, with less than half of those surveyed in Ireland stating there were such places.

Health is a central component of children's well-being. By international standards Ireland has a good record on child mortality and low birth weights, but remains below the WHO's target of 95 per cent immunisation for children. In relation to risk behaviours Ireland is above international averages for smoking, drinking and using cannabis. With regard to overweight and obesity, 14 per cent of young people in Ireland reported being overweight or obese, in line with international averages. Ireland ranks highly on healthy behaviours such as eating breakfast and taking part in physical activity. One fifth of 15 year olds rate their health as only 'fair or poor'. Access to basic health services remains a serious issue with 2,537 children on hospital waiting lists in 2008, one fifth of them for more than one year.

On mental well-being just under 5 per cent of 15 year olds feel lonely, 398 children and young people aged 5-17 were admitted to psychiatric hospitals (2006) and 14 young people took their own life in 2006. Boys are more at risk of mental ill-health than girls. However, girls are three times more likely to self harm than boys. The economic downturn has been associated with an increase in self harm and suicide risk. Young people who are lesbian, gay, bisexual or transgender have been identified as having a high risk of self harm and suicide risk, associated with their LGBT identity. The policy response is currently focused on a multidimensional and preventative approach. It would seem important to continue this approach, as much as possible in the context of the recession, for the long-term benefit of our children.

Democracy and values are an important aspect of children's well-being. Just over one fifth of young people report that students in their school participate in making the school rules, which is low by international standards. Accessing information is an important element of exercising democracy and 70 per cent of households with children had access to the internet, which was close to the EU15 average. Children's rights can be contravened by threats to their well-being and one quarter of young people in Ireland report to having been bullied in the last few months. Some

sub groups of the population are more likely to be bullied than others, with for example, the experience of being bullied well above national averages for LGBT young people. Data on exposure to domestic violence is difficult to collect but it is notable that in 2006, 12,520 children had an initial assessment for a child welfare or child protection concern. The ‘Ryan Report’ has documented a ‘litany of abuses’ against children who were placed by the State in residential institutions run by the religious orders.

At a broader level, many young people feel that they are not treated fairly and that society does not do enough to help children and young people who are being discriminated against. Challenges include addressing the negative stereotyping of young people and promoting interculturalism.

This summary overview addresses diversity among the child population in a limited way. It is acknowledged that there are gender, age, class, geographic, economic status, disability, sexual orientation, and ethnic and cultural differences on many of the indicators.⁴⁹ However, it is evident that the prevention and reduction of poverty and disadvantage is central to children’s well-being, as it affects many other aspects of children’s lives, such as health, development, education, future opportunities and how they feel about themselves. In many instances current policy approaches may need to be reviewed, with an eye to how they can be tailored to meet the needs of young people in particular circumstances or vulnerable situations.

6.11 Policy Monitoring

This analysis raises the challenge of how we can better monitor progress on the design and implementation of policies to assess their outcomes, specifically the linkage and interaction between national level policy goals and local level implementation and delivery. In Chapter 3 (Volume I) we set out a model for the potential role of social indicators in the policy cycle. Here we present an example of how this might work in practice and as a starting point for the development of a ‘performance dialogue’ between policy designers, policy deliverers, and policy receivers (bearing in mind that there may not be clear demarcations between these groups).

For example, as shown in Table 6.2, the Department of Education and Science has the policy goal (strategy) that every child should leave school literate. (This goal is reiterated in *Towards 2016*).⁵⁰ Diagnostic indicators can identify children who have low levels of literacy and are unlikely to leave school literate, for example, who are these children, where are they, why are they leaving school illiterate. The inputs to address illiteracy in schools include budgets, staff, training, curriculum development, as well as additional supports, such as speech and language teachers and therapists, special needs assistants, family supports, and so on. At this stage, building on the diagnostic indicators, baseline indicators can be established, setting out the number of children with low levels of literacy by socio-economic status, equality grounds, early childhood setting, school, and area.

49. The *State of the Nation’s Children: Ireland 2008* report provides detailed analysis on children’s well-being.

50. NESF is currently undertaking a project on child literacy and social inclusion, see www.nesf.ie

Table 6.2 Reading Literacy Example

Policy Cycle	Indicators
Strategy Every child should leave school literate	Diagnostic Children with low literacy levels – who, where, why.
Inputs Budget Staff Training Curriculum development Additional supports	Baseline No. children with low literacy disaggregated by socio-economic status, equality grounds, school, area
Outputs No. children receiving additional supports No. staff focusing on improving literacy No. partnerships	Performance Reading levels of children Institutional ‘helpers’ and ‘hinderers’
Outcomes Young people leaving the education system able to fulfil literacy functions	Systemic Reading literacy achievement aged 15, using international benchmark

Subsequently outputs would be recorded, such as, the number of children receiving additional supports, the number of staff focusing on improving literacy, ‘partnerships’ involved, for example, between the educational setting and the family and/or local community. The contribution of these outputs to the overall policy goal would be assessed using performance indicators, such as the reading levels of children, and institutional ‘helpers’ and ‘hinderers’. This information is particularly useful when assessed against the baseline indicators. The systemic indicator measures reading achievement at age 15, using an international benchmark such as the PISA (*Programme of International Student Assessment*) information collected by the OECD. This would indicate progress towards the ultimate outcome of young people leaving the education system able to fulfil literacy functions.

This work requires to be further developed but is just one example of how policy commitments can be assessed against desired outcomes, informed by a framework to promote children’s well-being. Most of the data would be gathered and collated by the schools and Department of Education and Science, or the relevant agencies. The publicly available information would be the systemic indicator measuring outcomes. In particular, the diagnostic information is most useful to those at the ‘coal face’ who are trying to address literacy through their services. Further examples are provided for other life cycle stages in the following chapters.

7

People of Working Age

7.1 Understanding the Well-being of People of Working Age

In adopting a life cycle approach, a key cohort in terms of size and contribution is people of working age. This chapter examines the well-being and key characteristics of this life cycle group. The working age cohort comprises individuals aged 18 to 64. In this stage of the life cycle people are forming and re-forming families and households, participating in society through employment or a range of other activities, and accumulating wealth. The contribution and well-being of the working age cohort are influenced by their childhood experiences and also their preparation for older age.

A key characteristic of the working age life cycle group is their diversity. The age group spans 46 years and can be sub divided into ‘young adults’ (18-29) and ‘anchor adults’ (30-64). A key feature of young adults is their *transitions* – into the labour market, into independent living and into parenthood. Anchor adults are characterised by their *responsibilities* – mortgage, child rearing, eldercare, saving for retirement (National Economic and Social Council, 2005a: 226). This chapter seeks to assess the impact of these transitional and responsibility aspects on the well-being of working age people. Where appropriate, attention is drawn to sub groups where their well-being is adversely affected, bearing in mind the uncertain connection between individual and collective well-being, as well as the prevalence of many social deficits even at a time when there has been an overall positive trend in collective well-being across the domains (see Chapter 4, Volume I).

There is no specific literature relating to the well-being of the ‘working age’ population. Most of the general well-being literature spans the life course, with much of it related to the working age population – in relation to standard of living, quality of life and general happiness. Many of the well-being discourses reviewed in Chapter 2 *Understanding Well-being* (Volume I) are relevant to the working age population.

In line with the other three life cycle chapters (Volume II, Part 4), it is useful to situate the life cycle group in the context of the overarching human rights framework. In the case of people of working age, the Universal Declaration of Human Rights, to which Ireland is a signatory, recognises the importance of fundamental rights—to freedom; to equal treatment; to security; to relationships and social opportunities; to development; to material possessions; to work, education and health; to leisure; to an adequate standard of living—for all human beings.

7.2 Assessing the Well-being of People of Working Age

Unlike for children, few people have given attention to how the well-being of people of working age should be assessed. There are many indicators of well-being for the population as a whole, as well as sets of indicators dealing with particular aspects of well-being such as the health of the working population and work-life balance. These indicator sets will inform the indicators used in this report.

The Policy Context

The context within which the well-being of people of working age is being assessed is the current policy framework, particularly *Towards 2016*. This policy context also informs the indicator set used. The vision and seven high level goals for people of working age are as follows:

Towards 2016 Vision and High Level Goals

An Ireland where all people of working age have sufficient income and opportunity to participate as fully as possible in economic and social life and where all individuals and their families are supported by a range of quality public services to enhance their quality of life and well-being.

To achieve this vision, the Government and social partners will work together over the next ten years towards the following long-term goals for people of working age in Ireland:

- ◆ Every person of working age should be encouraged and supported to participate fully in social, civic and economic life.
- ◆ Every person of working age would have access to lifelong learning, a sense of personal security in a changing work environment and an opportunity to balance work and family commitments consistent with business needs.
- ◆ Every person of working age would have an income level to sustain an acceptable standard of living and to enable them to provide for an adequate income in retirement.
- ◆ Every person of working age on welfare will have access to supports towards progression and inclusion, access to quality work and learning opportunities, encouraging a greater degree of self-reliance and self-sufficiency.
- ◆ Every person, irrespective of background or gender, would enjoy equality of opportunity and freedom from discrimination.
- ◆ Every family would have access to health and social care, affordable accommodation appropriate to their needs and a well functioning public transport system.
- ◆ Every person with caring responsibilities would have access to appropriate supports to enable them to meet these responsibilities alongside employment and other commitments.

Unlike the other life cycle groups there is no specific strategy, or central co-ordinating office to address issues specific to people of working age. However, a number of other strategies are clearly applicable to this group, for example, the National Women's Strategy, National Strategy for Social Inclusion, National Skills Strategy, and the 'Migration Nation' Statement in an Integration Strategy.

The Indicator Framework

Taking into account the overall conceptual framework, the policy context and the availability of data and indicators, the following indicator framework is used to examine the well-being of people of working age (based on the well-being indicator framework developed in Chapter 2, Volume I), see Table 7.1.

Table 7.1 Construction of the Well-being of People of Working Age

Domains	Components	Indicators
Economic Resources	<i>Income</i>	Income distribution Pension provision
	<i>Poverty</i>	Income poverty Consistent poverty Economic pressures
	<i>Work and Participation</i>	<i>Work</i> Labour force participation rate Employment rates by family status Principal economic status
	<i>Work life balance</i>	Part time employment Combining paid and unpaid work Satisfaction with work and free time
	<i>Unemployment</i>	Unemployment by age and gender Unemployment by nationality Jobseeker claimants
	<i>Educational participation</i>	Educational qualifications of the unemployed Life-long learning
	<i>Relationships and Care</i>	<i>Family structure</i> Marital status Age at birth of first child Household composition Lone parenthood
	<i>Family relations</i>	Satisfaction with family life
	<i>Caring</i>	Work and caring balance Recipients of carers payments
	<i>Community and Environment</i>	<i>Accommodation</i> Occupation of mortgage borrowers Housing need by employment status Homelessness
	<i>Community</i>	Practical help from neighbours Involvement in voluntary activities Attendance at arts events
	<i>Environment</i>	Environmental actions Means of travel to work
	<i>Health</i>	<i>General health</i> Sick-related absences from work Attending a GP
	<i>Risk behaviours</i>	Smoking Alcohol consumption Overweight / obese
	<i>Healthy behaviours</i>	Physical exercise Nutrition
	<i>Health assessment</i>	Perception of good health
	<i>Mental well-being</i>	Psychological distress
Democracy and Values	<i>Exercising democracy</i>	Satisfaction with the demographic process Tensions between groups in society Trade union membership
	<i>Threats</i>	Victims of crime Perception of crime
	<i>Equality</i>	Workplace discrimination Intercultural dialogue

These domains and indicators attempt to capture the main elements of the well-being of people of working age. Particular attention is given to the two main sub groups within this life cycle group—‘young adults’ (18-29) who are in a transitional phase of their lives, and ‘anchor adults’ (30-64) who are characterised by their responsibilities—where the data allow.

Many of the indicators used in Chapter 4 *An Overview Picture of well-being in Ireland* (Volume I) are relevant for the working age population and are therefore not duplicated in this chapter. We have sought here to use indicators which specifically reflect the well-being of people of working age and sub groups within this diverse life cycle group.

With regard to economic resources information is presented on income distribution and pension provision for people in employment. Poverty among working age people is also examined, including a focus on a number of economic pressures.

Participation in meaningful activity is central to human flourishing and well-being. The work/participation domain presents indicators on the labour force participation rate, the employment rates of 20 to 44 year olds by family status and principal economic status by gender. To assess work-life balance indicators are presented on part-time employment rates, on hours spent doing unpaid work by those in employment, and on men and women’s satisfaction with their work and leisure time. In relation to unemployment indicators are provided on unemployment with regard to age, gender and nationality. Information is also provided on recipients of selected social welfare benefits. A fourth component on educational participation documents the educational qualifications of people who are unemployed and proportions involved in life-long learning.

Relationships are central for people of working age and indicators are presented on marital status, births by age of mother, household composition and the age profile of mothers with children under 15. Information is also provided on satisfaction with family life, the balance between working and caring and recipients of carers’ payments.

The community and environment within which people live impact on their well-being and indicators on the occupation of mortgage borrowers, housing need by employment status, and homelessness are provided in relation to accommodation. With regard to the community within which people live indicators are presented on getting practical help from neighbours, involvement in voluntary activities and attendance at arts events. Environmental concerns are covered by environmental actions and means of travel to work.

In relation to the health of working age people general health issues are covered by sick-related absences from work and attending a GP. A number of indicators on risk and healthy behaviours are presented including smoking, alcohol consumption, being overweight or obese, taking physical exercise and good nutrition. The section also includes information on people’s perception of their health as well as their mental well-being.

The final domain examined is democracy and values. The focus here is on exercising democracy which is described by indicators on people's satisfaction with the demographic process, perception of tensions between different groups and trade union membership. Threats, which have a negative impact on well-being, are assessed by indicators on victims of crime and perception of crime as a very serious problem. Finally, in relation to equality, indicators are presented on workplace discrimination and intercultural dialogue.

In the following sections information is presented for each of the six domains in the well-being framework, with a commentary on how the key trends relate to the policy context, highlighting information gaps. The next section presents contextual information on people of working age.

7.3 The Context for the Working Age Population in Ireland

Composition of the Working Age Population

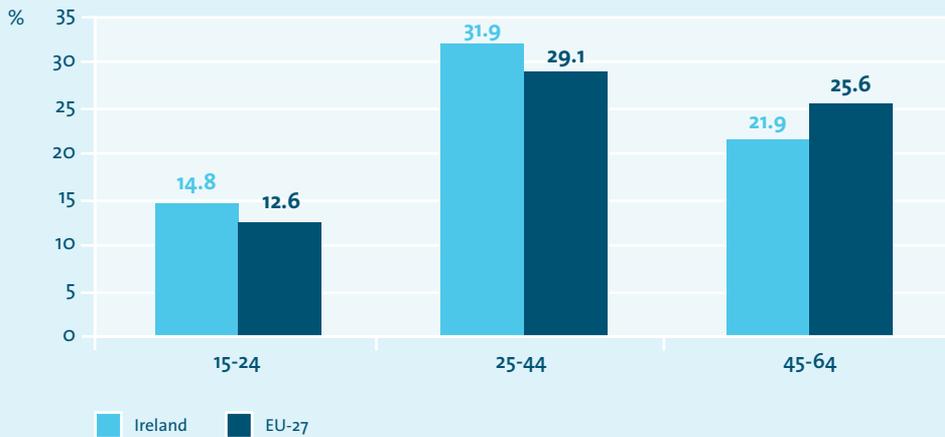
In 2006 there were 2,735,888 people aged 18 to 64 in Ireland (Census, 2006). In comparison to other European states, the working age population as a percentage of the total population in Ireland in 2004 stood at 68.3 per cent, which was slightly above the EU27 average of 67.3 per cent (Eurostat, 2004). The most recent Irish figures showed a growth in the working age population, to 73.2 per cent (Census, 2006). Within Ireland, the working age population as a proportion of the total population is dispersed throughout the regions, with almost 30 per cent of all working age persons resident in the Dublin region (Census, 2006).

Compared to other European countries, Ireland has a young demographic profile, see Figure 7.1 overleaf. Correspondingly, Ireland's overall age dependency ratio⁵¹ of 45.8 per cent is lower than the EU27 average of 48.6 per cent. As noted in Chapter 4 (Volume I) this is a positive demographic profile with a relatively large working age sector and a youthful population, reflecting the observation that 'the current absolute and proportionate importance of the working age population is greater than at any point in the past' (Government of Ireland, 2007c: 16).

Ireland has one of the most gender balanced populations in the European Union – there are 100 women per 100 men in Ireland for the total population. However, the ratio of men to women in the population decreases with age, from 105 men per 100 women in the 0-19 age group down to 45 men per 100 women in the 85+ age group. The EU27 average is 105, with countries such as Estonia and Latvia both having 115 women per 100 men (Eurostat, 2007).

51. Aged 0-14 and 65+ as a proportion of the population aged 15-64.

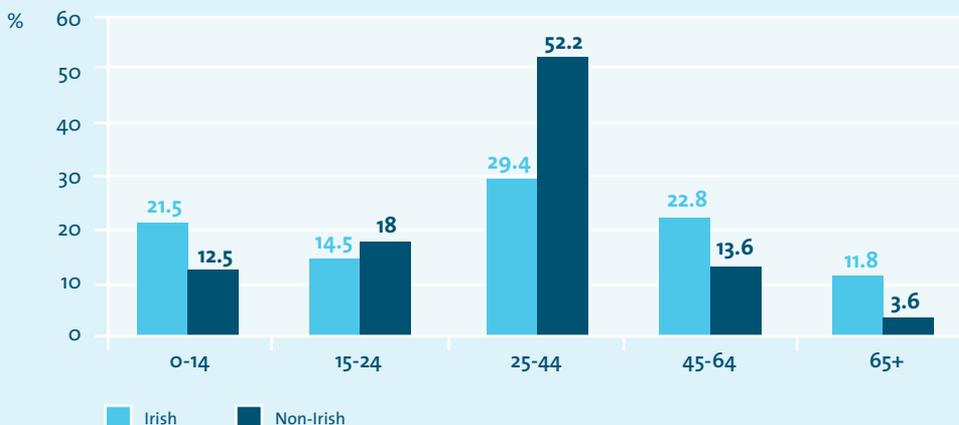
Figure 7.1 Percentage of the Population in Age Groups, EU Comparison, 2007



Source Eurostat, 2008

A key feature of the working age life cycle group is their diversity. In Chapter 4 (Volume I) we stated that 11 per cent of the overall population comprised non-Irish nationals. The non-Irish population has a very different age profile to that of the native Irish population, see Figure 7.2. Non-Irish nationals are dominated by people in the 25 to 44 year old age group. Thus, the non-Irish population has a predominance of people of working age which will also be reflected in other domains such as labour force participation rates and levels of educational achievement. The Irish Traveller community (estimated at 22,435 Travellers in Ireland, 0.5 per cent of the population, Census, 2006) have a young age profile, with 41 per cent under 15, one fifth aged 15 to 24, one quarter 25-44, 10 per cent aged 45-64 and only 3 per cent aged 65 and over.

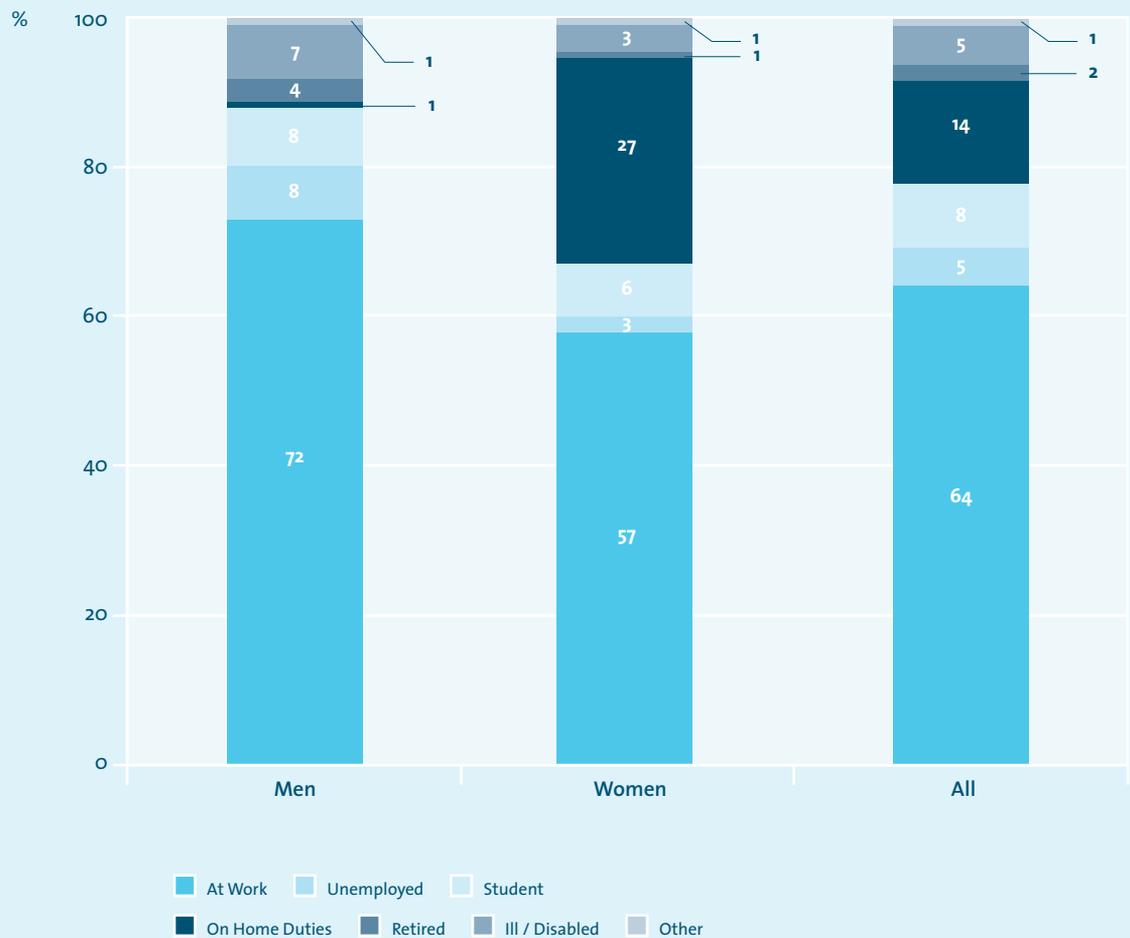
Figure 7.2 Age Profile of the Population by Nationality, 2006



Source Census, 2006, presented in Government of Ireland, 2008b: 44

The socio-economic status of the working age population also displays heterogeneity, see Figure 7.3. In 2005, while two thirds of people of working age (18-64) were at work (72 per cent of men and 57 per cent of women), more than one quarter of women were ‘on home duties’, and relatively small percentages were students, unemployed, ill or disabled and retired. It is noted that these data are somewhat dated and the proportion who are now unemployed will have increased. These figures are presented here to illustrate the diversity in the socio-economic status of people of working age.

Figure 7.3 Socio-economic Status of People of Working Age (18-64), 2005



Source EU-SILC, 2005, presented in Government of Ireland, 2008b:18

Social Expenditure

In relation to social expenditure on the working age population, in 2003, Ireland's income support expenditure stood at 5.6 per cent of GDP, which was slightly above the OECD average of 5.0 per cent, see figure 7.4 (OECD, 2007c). At the end of 2008, there were 510,507 recipients of income support benefits for people of working age, showing a 29 per cent increase over 2007⁵² (Department of Social and Family Affairs, 2009b). Further details are provided in the relevant sections of this chapter.

Figure 7.4 Income Support to the Working Age Population as a Percentage of GDP Across Selected OECD Countries, 2003



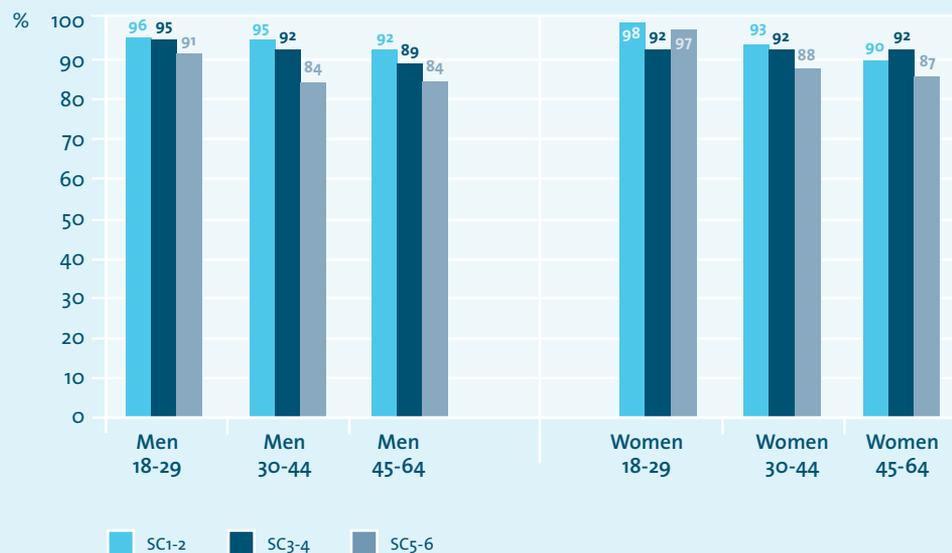
Source OECD, 2007c

Quality of Life

Prior to examining the six domains of well-being for people of working age, it is useful to capture people's overall satisfaction with life. The indicator used here is based on the SLÁN 2007 survey which asked respondents to rate their quality of life on a five point scale from 'very good' to 'very poor' (Morgan *et al.*, 2008). The percentage of respondents, by age, gender and social class, reporting their quality of life to be good or very good is presented in Figure 7.5.

52. Benefits to people of working age include: Adoptive Benefit, Back to Work Allowance Employee, Back to Work Enterprise Allowance – Self Employed First Year, Back to Work Enterprise Allowance – Self Employed Years 2-4, Back to Education Allowance, Carer's Benefit, Carer's Allowance, Deserted Wife's Benefit, Deserted Wife's Allowance, Farm Assist, Health and Safety Benefit, Illness Benefit, Jobseekers Benefit, Jobseekers Allowance, Maternity Benefit, One-Parent Family Payment, Part-Time Job Incentive Scheme, Pre-Retirement Allowance, Prisoner's Wife's Allowance, Widow/er's (Non-Contributory) Pension.

Figure 7.5 Percentage of Respondents Reporting Their Quality of Life as 'Good' or 'Very Good', by Age, Gender and Social Class,⁵³ 2007



Source Morgan et al., 2008: 41 (SLÁN, 2007)

Overall, levels of satisfaction were very high with 90 per cent of respondents citing their quality of life to be 'good' or 'very good'. Responses were similar for men and women. Higher percentages of younger respondents and people in the higher social classes reported having a 'good' or 'very good' quality of life. Unskilled or semi-skilled men aged 30 to 64 had the lowest satisfaction levels, even though these were still high at 84 per cent.

7.4 Economic Resources

7.4.1 Measuring the Economic Well-being of Working Age People

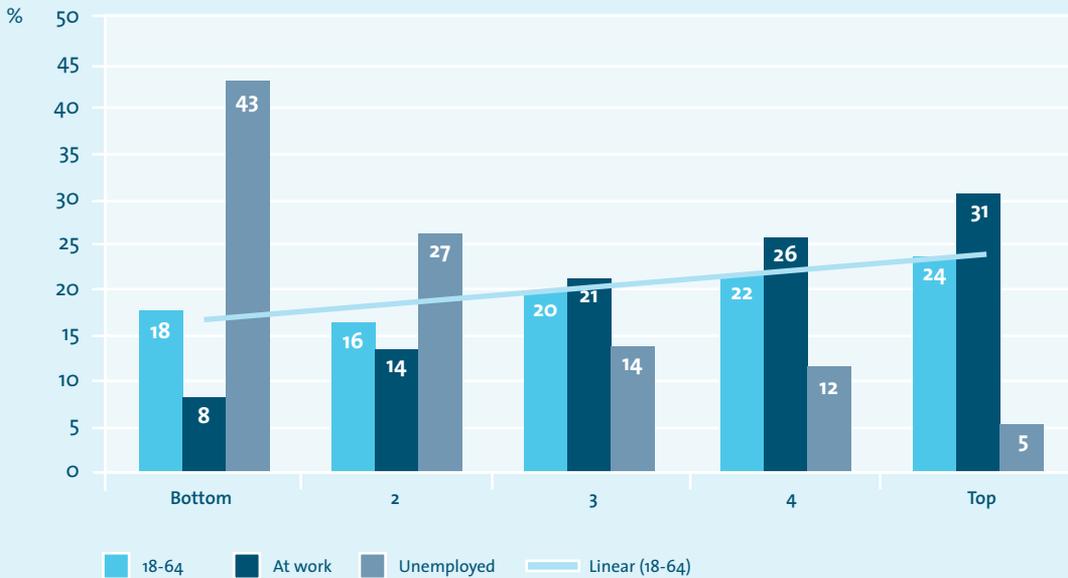
Under the economic well-being domain we examine two components: income and poverty. A certain level of income to achieve an adequate standard of living is fundamental to well-being in a developed society such as Ireland. Two indicators are used to measure the income of working age people: income distribution and pension provision.

53. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

Income Distribution

The average net equivalised income per person aged 18-64 in Ireland in 2007 was €25,192 per annum (€484.46 per week) compared to €23,610 per annum (€454.03 per week) for the total population (CSO, 2008b: 13). In terms of well-being incomes relative to others matter as much as the absolute amount (Layard, 2005: 41) – ‘a wealthy man is one who earns \$100 a year more than his wife’s sister’s husband’.⁵⁴ Figure 7.6 shows the income distribution for 18-64 year olds across income quintiles, along with the total population who are at work and the total population who are unemployed. The working age population are spread fairly evenly across the income distribution with a tendency towards the higher quintiles. This trend is accentuated for people at work, and therefore earning. People who are unemployed and reliant on state benefits cluster towards the bottom of the income distribution.

Figure 7.6 The Distribution of 18-64 Year Olds, People at Work and the Unemployed Across Net Equivalised Income Quintiles, 2007



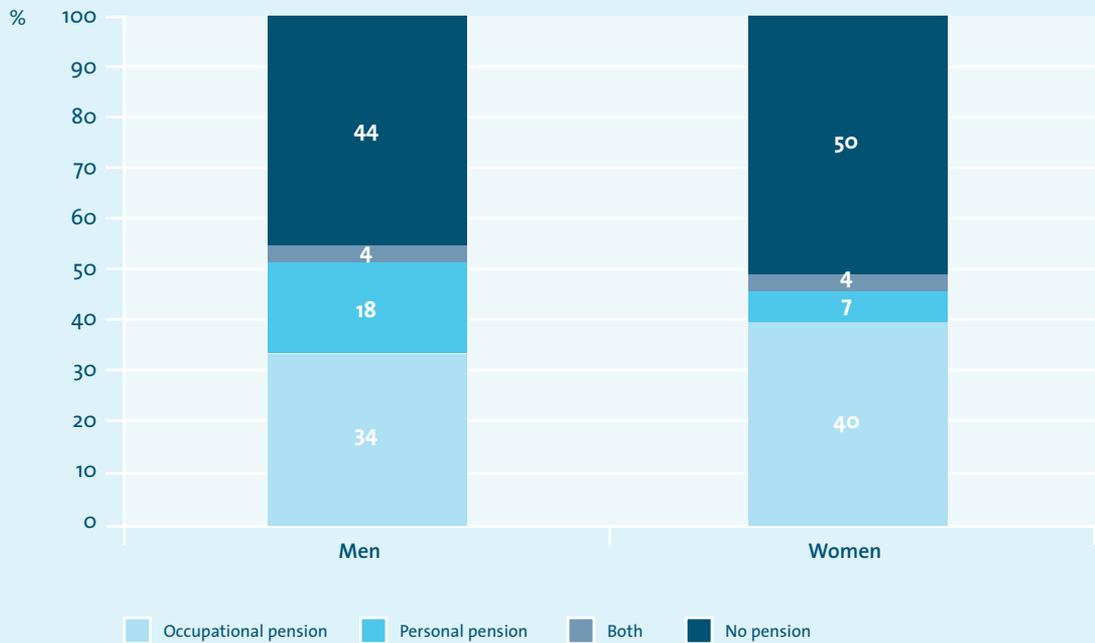
Source CSO, 2008b: 32-33 (EU-SILC, 2007)

54. Mencken, H.L., quoted in Layard, 2005: 41.

Pension Provision

Making provision for future income in retirement assists in ‘smoothing’ income across the life cycle. The second indicator on the income component of working age well-being is pension provision, measured by pension coverage for people in employment, see Figure 7.7. This figure shows that half of women and 44 per cent of men aged 20-69 and in employment have no pension provision other than the state pension. This will have implications for their future well-being. When asked what their expected main source of income would be in retirement four out of ten transitional adults (20-29) said occupational or personal pension, 16 per cent said state social welfare pension, while one third said they didn’t know. When asked the same question just over half of anchor adults (30-65) said occupational or personal pension, one fifth said state social welfare pension and just under ten per cent didn’t know (Department of Social and Family Affairs, 2007: 42). These data do not take into account the impact of the recession on pensions.

Figure 7.7 Pension Coverage of People Aged 20-69 in Employment, 2008

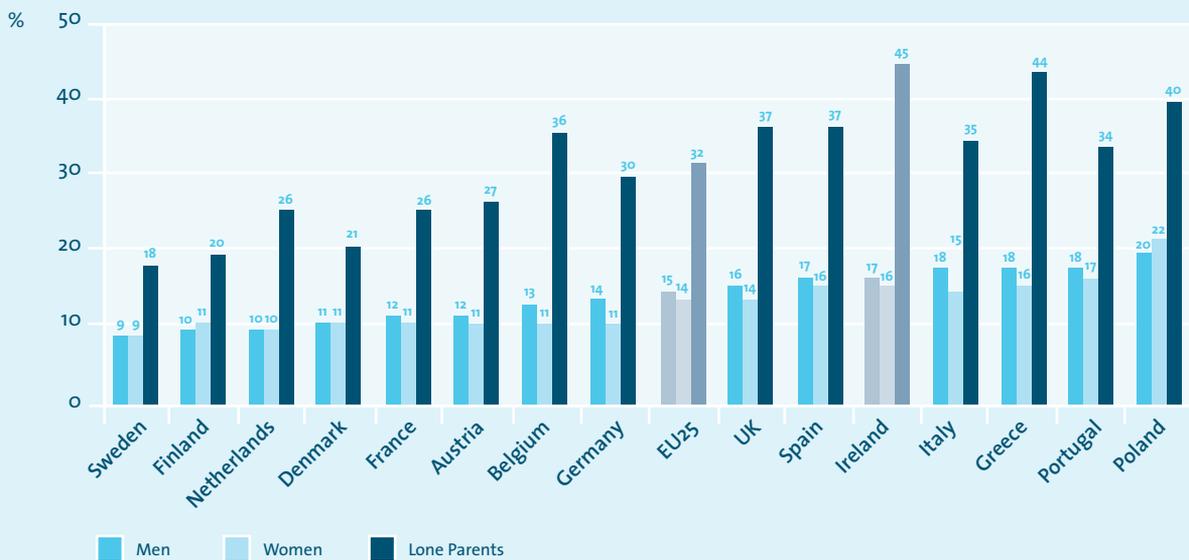


Source CSO, 2008f (QNHS)

Income Poverty

The second component examined in the economic well-being domain is poverty. Three indicators are used to measure poverty among the working age population: income poverty, consistent poverty, and economic pressures. The risk of income poverty for both men and women aged 16-64 in Ireland at 17 per cent and 16 per cent respectively was above the EU average (2005), see Figure 7.8. As for most member states, there was little difference in the poverty risk for men and women.

Figure 7.8 Percentage in Income Poverty Among Working Age Men and Women and Lone Parents, Selected EU Comparisons, 2005



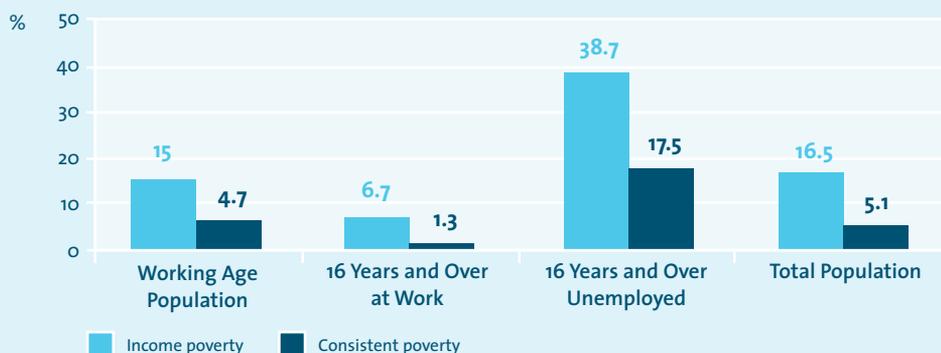
Source: EUSILC, 2005

One of the highest risk groups across all countries was lone parents, with lone parents in Ireland having the highest risk of poverty at 45 per cent (2005), well above the EU25 average of 32 per cent. The Scandinavian countries had the lowest risk of poverty for lone parents, although this was still relatively high at around 20 per cent.

Consistent Poverty

The Irish government also uses the consistent poverty measure to capture deprivation along with income poverty. Figure 7.9 shows proportions of the working age population in income and consistent poverty. Some 4.7 per cent of the working age population were in consistent poverty in 2007, compared to 5.1 per cent of the total population (CSO, 2008b: 13). Comparable figures for income poverty, sometimes referred to as 'at-risk-of-poverty', were 15 per cent compared to 16.5 per cent. Some 17.5 per cent of those aged 16 years and over who were unemployed were in consistent poverty (38.7 per cent at-risk-of-poverty), compared to 1.3 per cent of those who are in work (6.7 per cent at-risk-of-poverty), see Figure 7.9.

Figure 7.9 Income and Consistent Poverty for the Working Age Population / Those Aged 16 Years and Over, Ireland, 2007⁵⁵



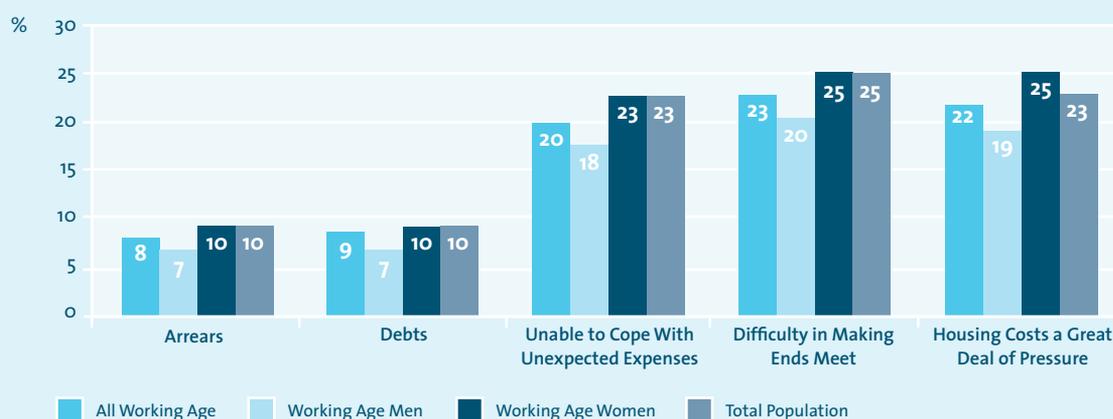
Source CSO, 2008b: 13.

While work is clearly important in reducing poverty, and therefore contributing to economic and social well-being, as noted in Chapter 4 (Volume I) having a job does not necessarily lift people out of poverty. Even though the risk of income poverty for people who are employed is relatively low, at 6.7 per cent, much of the concern relates to workers whose earnings are too low to keep their families out of poverty. Those most at risk of being ‘working poor’ are farmers, self employed, and those working part-time, mainly women.

Economic Pressures

The third indicator on the income component is economic pressures for the working age population. Figure 7.10 shows the response of working age people to subjective assessments of their economic circumstances (asked in 2005, well before the onset of the recession).

Figure 7.10 Economic Pressures for the Working Age Population (18-64), 2005



Source Callan *et al.*, 2007: 25, (based on EU-SILC, 2005)

55. Figures include SSIA income.

In general, the working age population reported a lower level of economic pressures than the total population. Working age women reported a higher level of economic pressure than working age men, with one quarter of working age women having difficulty in making ends meet. Lone parents, in particular, had difficulty coping with unexpected expenses and in making ends meet (65 and 60 per cent respectively, Callan *et al.*, 2007: 48) – 85 per cent of lone parents are women. It is notable that housing costs were seen as a great pressure in 2005 – this figure is likely to have increased in light of the recession.

Figures released by the Department of Social and Family Affairs at the end of July 2009 show that there were almost 14,000 people in receipt of mortgage interest supplement (compared to 8,000 at the end of 2008) and recipients of rents supplement⁵⁶ rose to 91,000 (a 50 per cent increase since the end of 2007), (www.welfare.ie). The increase in the scale of debt is also reflected in the increased numbers of people using the services of the Money Advice and Budgeting Service (MABS).⁵⁷ MABS has dealt with 10,000 new clients this year (2009), with an average debt of €15,000 per client (www.mabs.ie).

Summary

An adequate level of income is required to meet basic needs and thereafter, in terms of well-being, the level of income relative to others becomes more significant. Incomes for people of working age are relatively high compared to other life cycle groups, but the diversity within this life cycle group is notable. For example, as expected, many people in work have relatively high incomes compared to people who are unemployed. Even though the working age population is in a position to prepare for older age, half of women and 44 per cent of men in paid employment have no pension provision other than the state pension.

Economic well-being was also examined in relation to poverty. Of particular concern was the level of poverty among lone parents (who are mainly women) and people who are unemployed. While being in a job brings many benefits it is not necessarily a guarantee of lifting people out of poverty. About 7 per cent of paid workers in Ireland are at risk of poverty, and just under a third (31 per cent) of all households at risk of poverty are headed by a person in employment. A significant minority of people of working age (up to one quarter of women of working age) had a difficulty in making ends meet (data precede the recession).

7.4.2 Ireland's Policy Framework on Economic Well-being

In relation to the economic well-being of people of working age *Towards 2016*, Ireland's ten year policy framework agreed by the social partners, has the long term goal that:

Every person of working age would have an income level to sustain an acceptable standard of living and to enable them to provide for an adequate income in retirement.

56. Rent Supplement is paid to people who cannot afford to pay their rent.

57. MABS is a national, free, confidential service for people in debt or in danger of getting into debt.

Specific identified priority actions towards meeting this objective include:

- ◆ Ensuring that social protection adequately supports all people of working age, whether in the labour force or out of it; and
- ◆ Maintaining €150 per week in 2002 terms for the lowest social welfare payments, uprated, over the course of the agreement; this has been updated in the National Action Plan for Social Inclusion to €185.80 per week in 2007 terms – this rate to be maintained to 2016.^{58, 59}

Other commitments contained in the National Action Plan for Social Inclusion 2007-2016 (Government of Ireland, 2007b) include:

- ◆ The role of the Family Income Supplement scheme as an income support for low income working families is to be reviewed;
- ◆ Expenditure of €214 million is to be spent on the Rural Social Scheme (RSS) between 2007 and 2016 to benefit some 2,600 households of low income farmers and fishermen; and
- ◆ Improvements are to be made in the social welfare system relating to part-time and atypical workers. Lone parents and other parents on low income will receive particular attention.

The National Action Plan for Social Inclusion also contains proposals on financial inclusion.

7.4.3 Commentary on Economic Well-being

The policy commitments on the economic well-being of the working age population emphasise the importance of income adequacy now and in the future. The underpinning rationale is the importance of work and emphasis is placed on supports to assist people into the labour force as well as the provision of an adequate social welfare system for those who cannot work in the paid labour force for various reasons. In the context of the recession there is an ongoing challenge to maintain income at levels which will keep people out of poverty, at the same time as supporting people into education, training and/or work. Attention will need to be paid to those groups at particular risk of poverty and economic stress – people who have become unemployed and those who have been unemployed for some time, lone parents, and low paid workers (especially where they are the only wage earner in a large household). At the same time, consideration needs to be given to replacement rates, and the importance of providing people with an incentive to work.⁶⁰

Pension provision is especially challenging for the future given the relatively low levels of pension coverage among the working population, and the large losses in pensions experienced by many as a result of the recession. The current scenario points to the need for immediate reform of Irish pension policy.⁶¹ This issue is dealt with further in the next chapter on the well-being of older people.

58. An alternative expression of this target is 30 per cent of Gross Average Industrial Earnings (GAIE).

59. It is noted that Job Seekers Allowance for 18 and 19 year olds was reduced to €100 per week in the Supplementary Budget of April 2009. Payments for Asylum Seekers are €19.10 per week per adult and €9.60 per child. Asylum Seekers have their accommodation and meals provided.

60. OECD data have shown that replacement rates for people on long-term unemployment benefits in Ireland are comparatively high.

61. It is noted that the Government has recently introduced measures to support workers in pension schemes.

One of the key issues to be addressed is increasing levels of debt and indebtedness, leading to heightened levels of economic stress, which have a detrimental impact on well-being. The economic crisis has caused debt problems for many people, especially with respect to housing debt. While a number of initiatives have been taken—by individuals, creditors, and the State—there has been difficulty in dealing with the scale of demand. As proposed by Stamp in his exploratory analysis of the financial difficulties among those living below the poverty line, a policy framework is required to deal with over-indebtedness holistically, humanely and appropriately (Stamp, 2009: 38).

Summarising, an adequate income is required to meet basic needs and reduce financial stress and poverty. For this age group (18-64) particular attention needs to be paid to the economic, social and mental benefits of work. The next section looks further at the importance of participation on well-being.

7.5 Work and Participation

7.5.1 Measuring Work and Participation for Ireland's Working Age Population⁶²

A central tenet of well-being is to engage in meaningful activity. In modern society such engagement or participation can take a number of forms: paid work, unpaid work, education and training, and leisure. All of these are important for individual and societal well-being. Often the challenge is attaining a balance between them and supporting choices which optimise well-being.

Eighteen to sixty four year olds, that is, people of working age, are often thought of as the 'engine of the economy' – contributing to the productivity of the economy, raising children, caring for others and preparing for their old age. In the recession, some of these aspects of participation are more difficult with people becoming unemployed, and school leavers and graduates finding it difficult to get jobs.

Paid Work

This section will present indicators on four components: work; work-life balance; unemployment; and participation in education. The first component of the work and participation domain is paid work. The importance of work for well-being is emphasised in the literature, especially 'meaningful' or 'fulfilling' work, where you have some control over what you do (Layard, 2005: 68). Work brings economic benefits, provides social interaction and psychological benefits through the feeling and reality of contributing to society. Research by the National Economic and Social Forum (NESF, 2007b) documented the benefits of work for mental health and social inclusion.

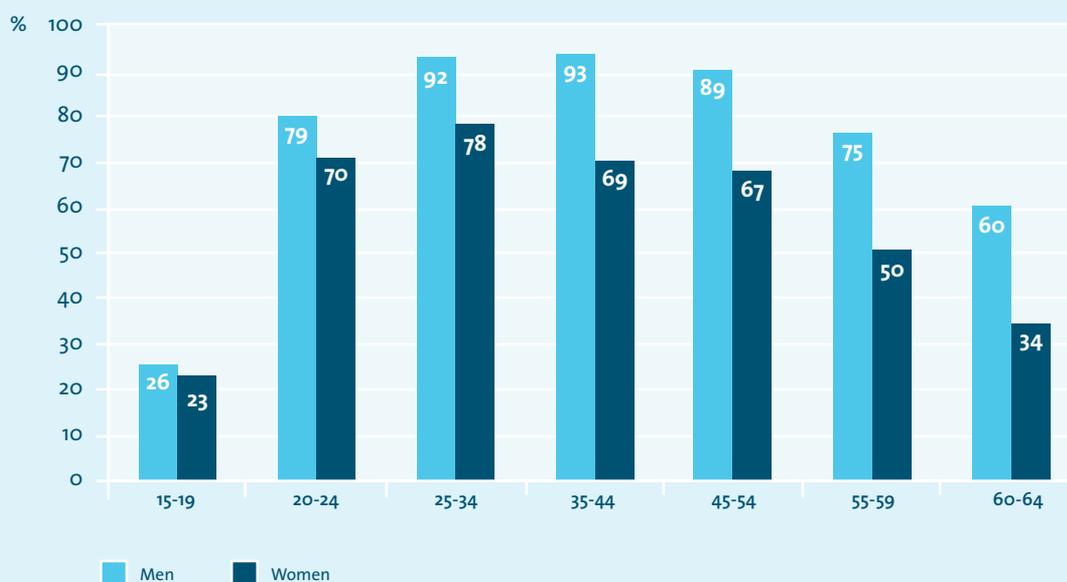
62. As noted in Chapter 2, the terminology can only capture the essence of the various domains of well-being. Therefore while 'participation' is the term used to describe participation in paid work and education, participation in one's community and in decision-making is also important to well-being. These dimensions of participation are captured in the 'community and environment' and 'democracy and values' domains.

To assess the work component the following three indicators are used: labour force participation rate; employment rates by family status; and principal economic status.

Labour Force Participation Rate

Figure 7.11 shows the labour force participation rate by gender and age group for 2008. The labour force participation rate (percentage of cohort in the labour force (employed or unemployed)) for men is over 89 per cent in the age groups 25 to 54. For women the highest participation rate was in the 25 to 34 year old age group at 78 per cent, falling to 34 per cent for 60 to 64 year olds. Overall, women represented 43 per cent of the work force in 2008 (CSO, 2009: 13).

Figure 7.11 Labour Force Participation Rate (ILO) by Age Group, 2008

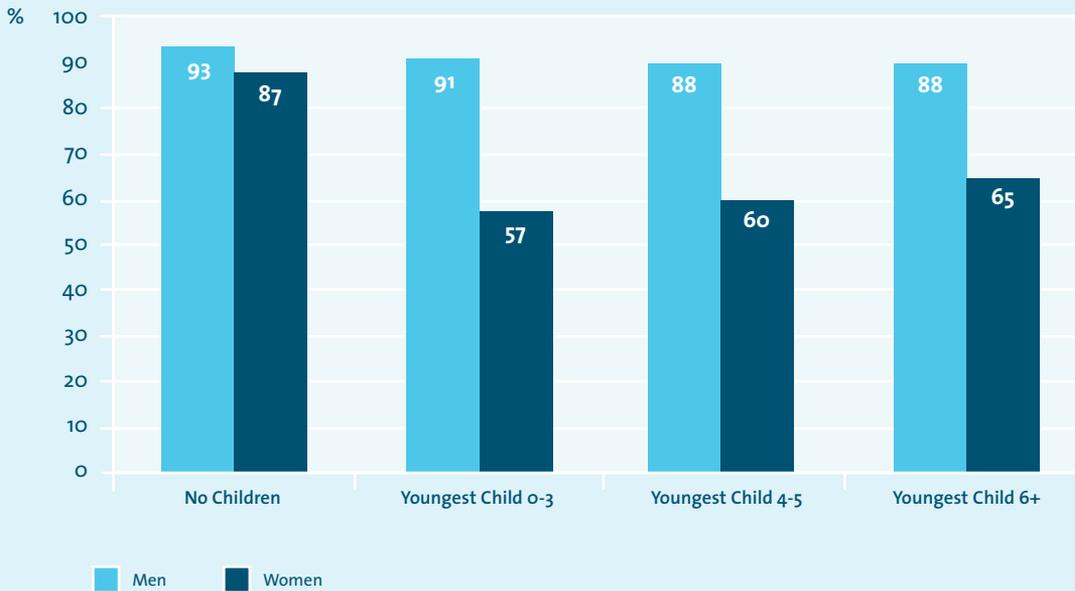


Source CSO, 2009: 13 (CSO QNHS March – May 2008)

Employment Rates by Family Status

When we examine the employment rates of people aged 20 to 44 by family status, we note that the presence of children clearly has an effect on women's employment, see figure 7.12. In 2008, the employment rate of women aged 20 to 44 was 66 per cent. The rate varied from 87 per cent for women with no children to 57 per cent for women whose youngest child was aged between 0 and 3 years old.

Figure 7.12 Employment Rates of People Aged 20-44 by Family Status, 2008

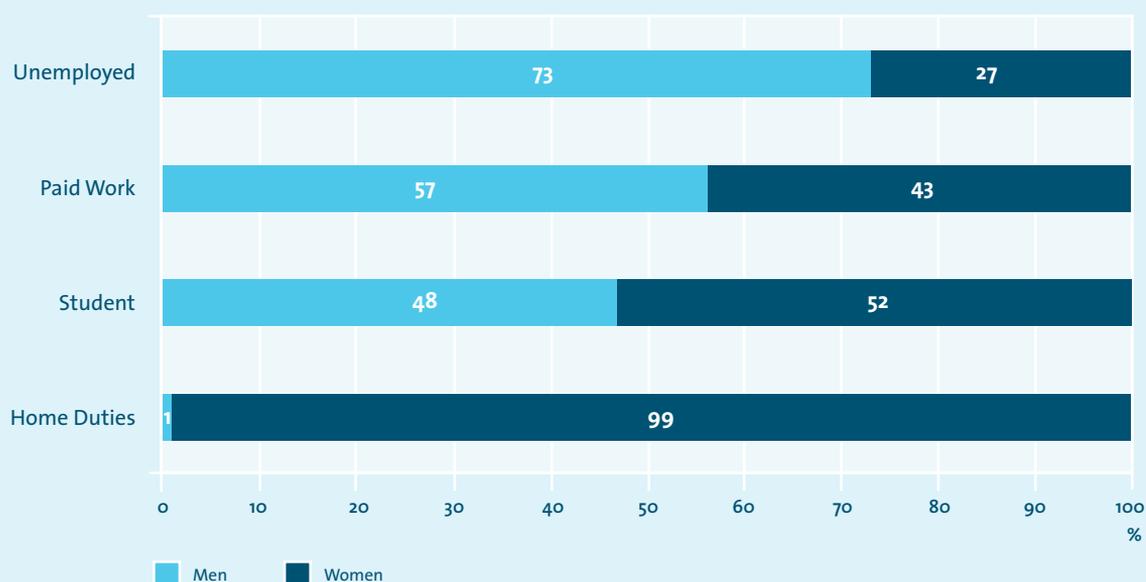


Source CSO, 2009:14 (CSO QNHS March – May 2008)

Principal Economic Status

The third indicator is principal economic status. Just over half of women aged 15 years and over (52 per cent) describe themselves as members of the labour force (in work or unemployed) compared to 72 per cent of men. Of those not in the labour force in 2008, 61 per cent of women were looking after the home or family, compared to just 1.4 per cent of men (CSO, 2009: 25). Figure 7.13 shows principal economic status by gender in 2008. Women comprise 43 per cent of people in paid employment and more than half (52 per cent) of students. While they make up under a third of the unemployed (27 per cent in 2008), they are primarily responsible for looking after the home or family (99 per cent)—of those looking after the home or family only 1 per cent are men.

Figure 7.13 Principal Economic Status by Gender, 2008



Source CSO, 2009: 25 (CSO QNHS March – May 2008)

Work-Life Balance

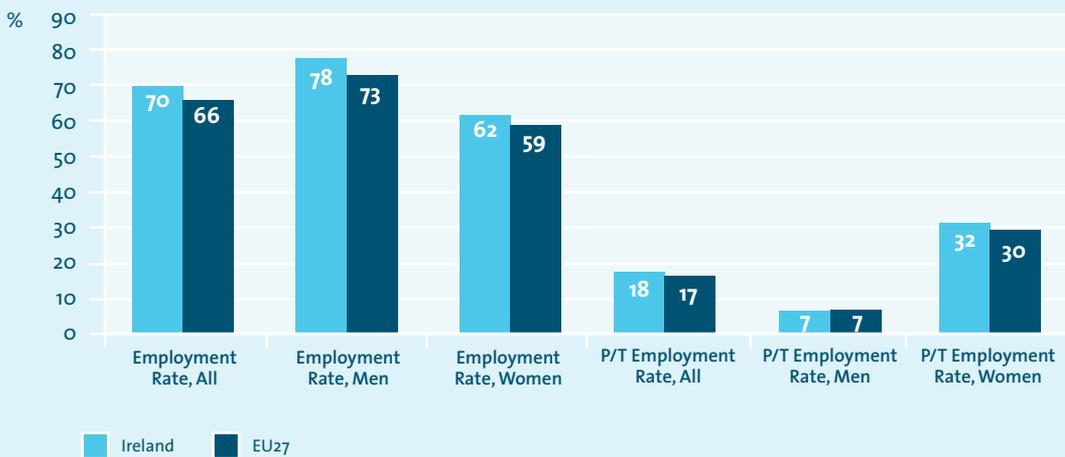
The second component in the work and participation domain is work-life balance. One of the challenges of modern life is reconciling paid work and private life, especially for women, who often have to ‘adapt their professional choices to their personal circumstances’ (European Foundation, 2009: 30). Flexibility and choice in these arrangements tend to have positive well-being outcomes, but where this is lacking stressful outcomes can ensue with a potentially negative impact on well-being. The indicators to assess work-life balance are: part-time employment; combining paid and unpaid work; and satisfaction with work and free time.

Part-Time Employment

The first indicator is part-time employment. Figure 7.14 shows employment rates and part-time employment for Ireland compared to the EU27 average (2007). The first point to notice is that employment rates in Ireland mirrored the EU27 with marginally higher rates in Ireland. Secondly, similar to some of the previous graphs employment rates were higher for men than for women. Thirdly, and of most interest in this section, is the part-time employment rates. In 2007, about 17 per cent of workers across the EU27 (2007) were in a part-time job, with the comparable figure for Ireland being 18 per cent. Fourthly, the proportions of workers who work part-time were markedly different between men (7 per cent of the work force in Ireland) and women (32 per cent of the work force in Ireland) (European Foundation, 2009: 23). There was also great variation across countries with 75 per cent of the female workforce in Holland working part-time, and Germany, Norway and the UK having more than 40 per cent of the female work force working part-time.

On average, in Ireland, women were in paid work for 31.3 hours per week, with men working 40.3 hours per week. Put another way – women represented 80 per cent of persons who worked a maximum of 19 hours per week in paid employment, and men made up 77 per cent of persons who worked 40 hours and over (CSO, 2009: 17). Fifthly, younger workers are more likely to work part-time. In Ireland in 2007, 25 per cent of 15-24 year old workers were in a part-time job, compared to 18 per cent of all workers (15-64 year olds) (Eurostat LFS 3/2007).

Figure 7.14 Employment Rates and Part-Time Employment, 15-64 Year Olds, Ireland and EU27, 2007



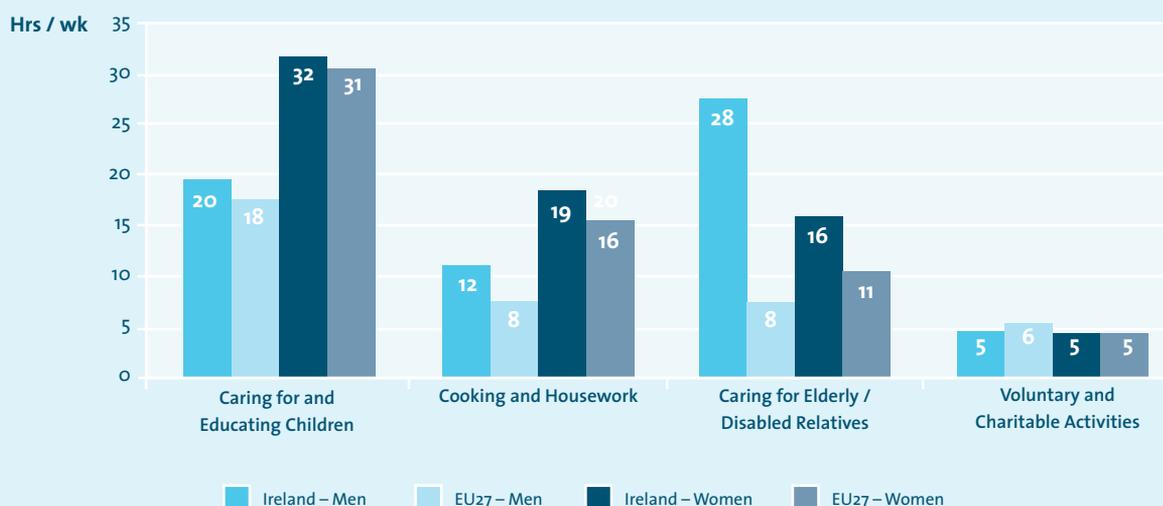
Source: European Foundation, 2009:23 (Eurostat Labour Force Survey (LFS) 3/2007)

Combining Paid and Unpaid Work

The second indicator is combining paid and unpaid work. Caring responsibilities, housework and voluntary activities add to the time spent in paid employment. Figure 7.15 presents information on the hours per week spent on doing unpaid work, by those in employment, comparing Ireland with EU27.⁶³ The most common activity was caring for children, then cooking and housework, followed by caring for elderly/disabled relatives, and voluntary and charitable activities. Apart from voluntary and charitable activities (where only 5 hours per week for both men and women in Ireland were spent in these activities) women tended to spend more hours per week on caring and housework activities than men. An outlier here is the time men in Ireland spent on caring for elderly/disabled relatives – but this figure may be unreliable because it is based on only a small number of cases, see figure note. In general, the hours spent on all these activities in Ireland, for both men and women, tends to be just above the EU27 average (with the exception of men caring for elderly/disabled relatives).

63. Information of this nature is not currently available for people not in paid employment.

Figure 7.15 Hours per Week Spent Doing Unpaid Work by Those in Employment, by Gender, Ireland and EU27, 2007



Source: European Foundation, 2009: 23 (Eurostat Labour Force Survey 3/2007)

Figure Note The 'caring for elderly/disabled relatives, Ireland – men' is an unusually high figure (28 hours per week) and may be unreliable because it is based on only a small number of cases. The next highest number of hours spent by men on caring for elderly/disabled relatives was 12 hours, spent by both Slovenians and Slovaks. The EU27 average was 8 hours. In addition, Ireland was one of only 5 countries where the hours spent by men on caring for elderly / disabled relatives was greater than for women, and in these cases the difference was between 1 and 5 percentage points (not 16 percentage points as is the case shown here for Ireland).

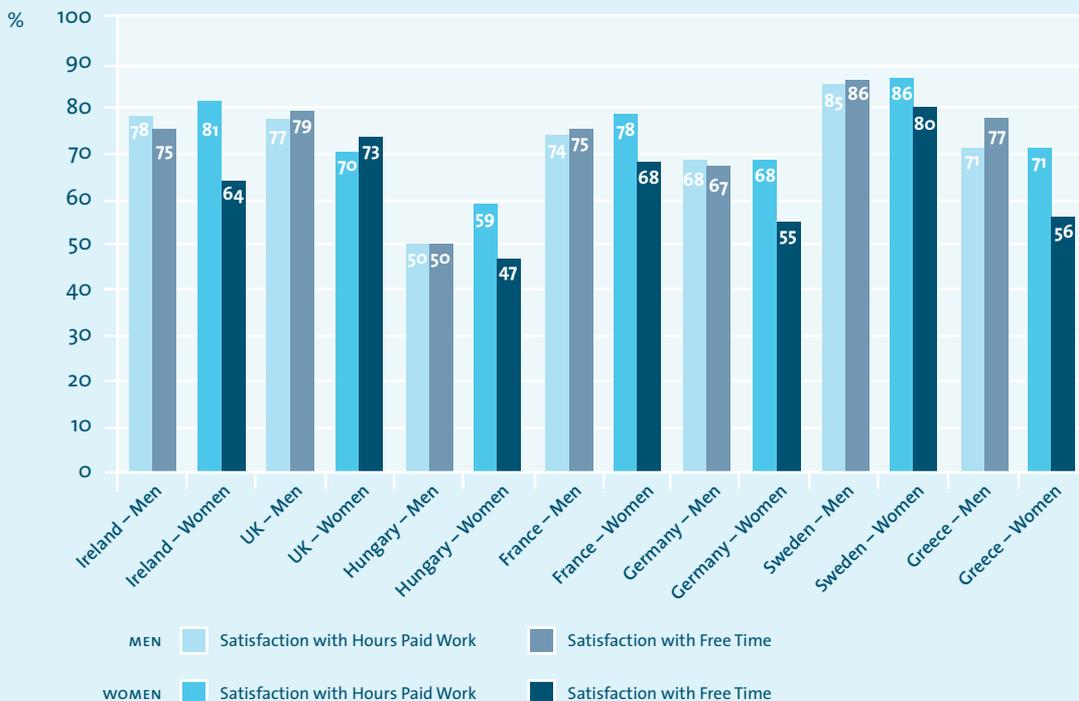
These findings are in line with the Eurostat time use survey and subsequent survey for Ireland carried out and analysed by the ESRI (Eurostat, 2005; McGinnity & Russell, 2007). McGinnity and Russell's work was informed by international literature which suggests that employment growth has led to less leisure time, sometimes referred to as 'time poverty' (reference is made to the work of Schor, 1991; Robinson and Godbey, 1997; Gershuny, 2000; Jacobs and Gerson, 2004). While the opportunity to make a contribution through paid or unpaid work has been found to contribute to well-being, if this leads people to being rushed or stressed as they try to balance increasingly busy lives, their mental and physical health, and subsequently their well-being, can deteriorate.

McGinnity and Russell (2007) found Ireland was distinctive in its time use patterns in a number of ways. Women in Ireland had a comparatively high level of unpaid work, whereas men in Ireland had a low level of unpaid work. Conversely, Irish men had a high level of free time, whereas Irish women had a high level of 'committed time' (paid and unpaid work and travel). McGinnity and Russell (2007: 349) found that high levels of committed time can lead to subjective feelings of 'time pressure'.

Satisfaction With Work and Free Time

The third indicator for work-life balance is satisfaction with work and leisure. Figure 7.16 presents findings on satisfaction with work and leisure time (European Foundation, 2007). These findings show that Swedes were most satisfied with the hours they spent on paid work and with their own free time and Hungarians were the least satisfied. Ireland had relatively high satisfaction levels, with 78 per cent of men and 81 per cent of women being satisfied with their hours of paid work. However, women in Ireland were less satisfied with their free time with 64 per cent saying they were satisfied compared to 75 per cent of Irish men.

Figure 7.16 Satisfaction with Work and Leisure for Men and Women, Selected European Countries, 2003



Source: European Foundation for the Improvement of Living and Working Conditions, 2007: 62

Throughout Europe contemporary working life, which requires flexible labour, treats men and women differently (European Commission, 2006). Women often have to choose between having children or a career due to lack of flexible working arrangements and/or inadequate care services, gender stereotyping and an unequal share of family responsibilities (European Foundation, 2009: 30). In general, women have responded by tending to choose to work part-time if possible, while men often choose to work long hours. These scenarios can lead to a conflict between working time and the time available to spend with the family. The well-being literature points to the importance for well-being of engagement in meaningful activity and affective relationships – yet if the demands of paid and unpaid work are high they can put strain on family relationships.

Approaches to achieving a better work-life balance, in the context of the recession, include possibilities of a greater sharing of paid and unpaid work (requiring co-operation between employers, employees, the social welfare system, service providers and families). While greater balance between working and other activities, including family life, tends to support positive well-being the most detrimental impact on well-being is lack of job security, in particular loss of a job and unemployment. 'That is why unemployment is such a disaster: it reduces income but it also reduces happiness directly by destroying the self respect and social relationships created by work' (Layard, 2005: 67).

Unemployment

The third component on the work and participation domain is unemployment. In the context of the recession unemployment is likely to have one of the most negative impacts on individual and societal well-being. Because of the speed of the recession, it is hard to document the current situation as it is continually changing and there is a data lag in collecting, analysing and presenting information on unemployment. Unemployment is especially damaging for people of working age as this is the stage of people's lives where they engage in employment, at least for some part of this stage of the life cycle.

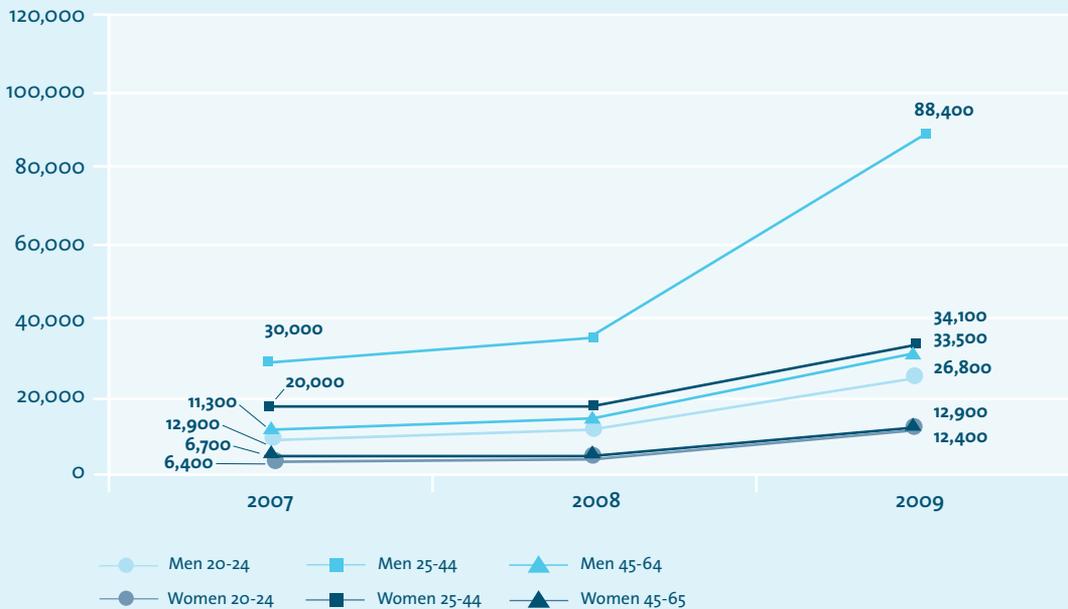
Unemployment By Age and Gender

Three indicators are presented under the unemployment component: unemployment by age and gender; unemployment by nationality; and Jobseeker claimants. In July 2009, the number of people on the seasonally adjusted Live Register was 423,400 persons, an increase of 197,500 from July 2008 (CSO, 2009d). The Live Register standardised 'unemployment rate' was 12.2 per cent. It should be borne in mind that the Live Register does not directly measure unemployment as it includes part-time workers (those who work up to three days per week), seasonal and casual workers.

Unemployment is measured by the Quarterly National Household Survey (QNHS) and the most recent information available at time of going to press was for Quarter 1, 2009. Some 222,800 people were unemployed in Q1 2009, 158,400 of whom were men and 64,500 were women. This was an increase of 113,400 or 104 per cent over the year. The unemployment rate increased from 4.9 per cent to 10.2 per cent over the year – the male unemployment rate was 12.8 per cent and the female rate 6.8 per cent. Increases in unemployment have taken place throughout the country with increases of 32,900 (+104 per cent) and 80,500 (+104 per cent) in the numbers unemployed in the last year in the Border, Midland and Western and in the Southern and Eastern regions respectively. Throughout the country 158,500 job losses have been recorded between Q1 2008 and Q1 2009. Some 72,200 of these have been in construction, 30,300 in the wholesale and retail trade, and repair of motor vehicles and motorcycles, and 19,600 in industry.

Figure 7.17 shows numbers of men and women who were unemployed in Q1 2007, Q1 2008 and Q1 2009 by age group. What is evident immediately is the large increase in the numbers unemployed from Q1 2008 to Q1 2009, for all categories, but especially for men aged 25-44 where there has been an increase from 36,300 to 88,400 (143 per cent increase) over that time period. The graph also shows that more than twice as many men as women were unemployed (158,400 compared to 64,500 in Q1 2009). The largest age group unemployed were 25 to 44 year olds for both men and women. However, the highest unemployment rates were in the youngest age groups with one quarter (26 per cent; 32 per cent for men and 18 per cent for women) in the 15 to 19 year old age group unemployed, and 18 per cent (24 per cent for men and 12 per cent for women) in the 20-24 age group unemployed, compared to a national unemployment rate of 10.2 per cent.⁶⁴

Figure 7.17 Unemployed Men and Women by Age, Q1 2007, Q1 2008, Q1 2009



Source CSO, QNHS, Q1 2009

Long-term unemployment⁶⁵ has also been increasing with the overall long-term unemployment rate increasing from 1.3 per cent in Q1 2008 to 2.2 per cent in Q1 2009. Overall, in Q1 2009 there were 49,100 people who were unemployed for more than one year, with three times as many men as women in this category (38,400 compared to 10,700). Half of the long-term unemployed (25,100) were in the 25-44 age category. Long-term unemployment can be difficult to address as people become detached from the labour force, which can be a disempowering experience. It is a waste of human capital and detrimental to individual, family and collective well-being.

64. It is noted that labour force participation rates (people in the labour force who are employed or unemployed) for younger age groups are lower than for other age groups, as many are in education. For example, the participation rate for 15-19 year olds was 20 per cent, and for 20-24 year olds 71 per cent compared to 84 per cent and 80 per cent for 25-34 year olds and 35-44 year olds, respectively.

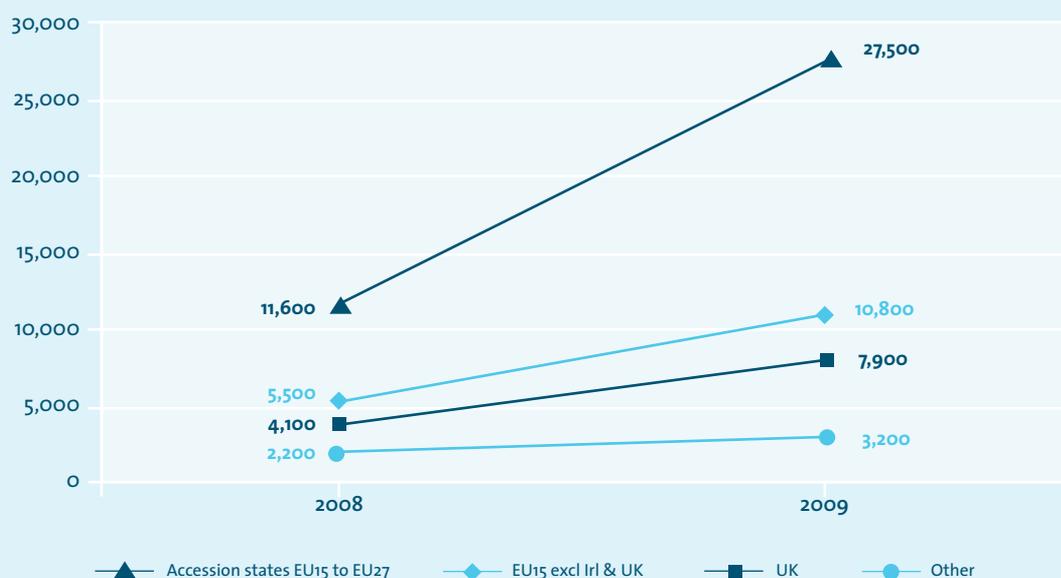
65. Defined as being unemployed for one year or more. The long-term unemployment rate is the number of persons unemployed for one year or more expressed as a percentage of the total labour force.

While there is understandable concern for the large numbers of people who have become unemployed as a result of the economic recession, the needs of people who were previously at risk of long-term unemployment, for example, lone parents, people with disabilities, and people with low educational levels and skills continue to need to be addressed.

Unemployment and Nationality⁶⁶

An emerging issue is the number of non-Irish nationals who are becoming unemployed. In the early 2000s Ireland was reliant on immigrant labour to meet labour market demands. Many people, especially from the EU accession states, came to Ireland, some with their families during that period. Now that things have changed they may find themselves in very different circumstances. This scenario has implications for the individuals involved and their families as well as for the Irish state in supporting their integration into Irish society. The second indicator in the unemployment component of the work and participation domain is unemployment by nationality.

Figure 7.18 Unemployment and Non-Irish Nationals, Q1 2008 and Q1 2009



Source: CSO, QNHS Q1 2009

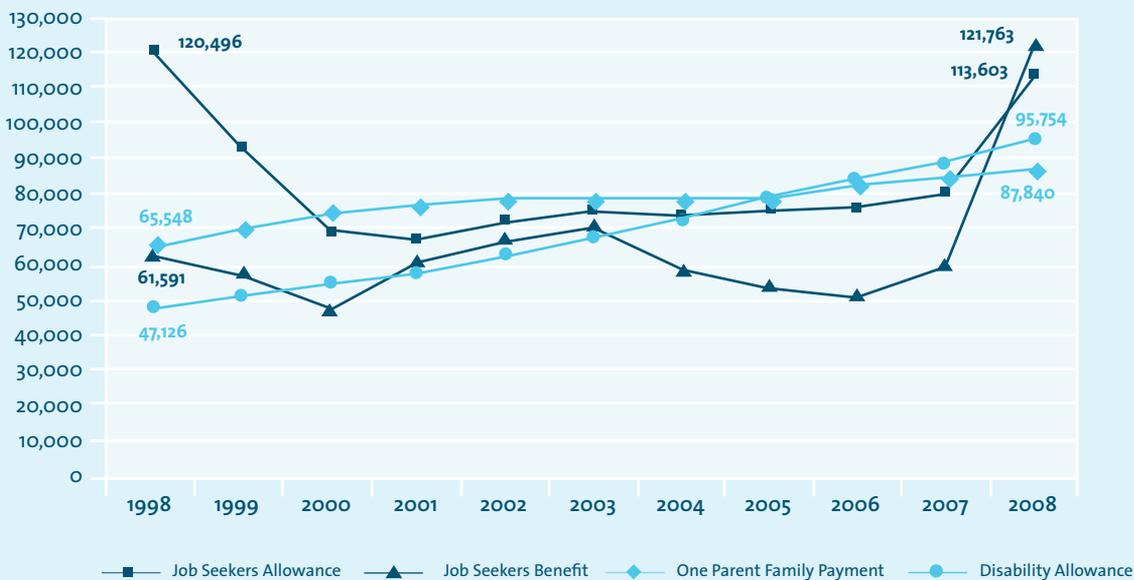
Figure 7.18 shows the number of non-Irish nationals who were unemployed in Q1 2008 and Q1 2009. The graph shows that the numbers unemployed increased for all non-Irish nationals over the period. The increase in non-Irish nationals from the accession states was particularly striking, increasing from 11,600 to 27,500 over the period, or a 137 per cent increase. The increase for all non-Irish nationals over that period was 111 per cent, compared to an increase of 101 per cent for Irish nationals.

66. It is noted that changes have been made to the work permit system, applying from the 1st June 2009. These changes apply to new applicants, and include exclusions to certain categories of employment, including jobs with a salary of less than €30,000 per year (with some exceptions).

Jobseeker Claimants

The third indicator on the unemployment component is Jobseeker claimants. People who are unemployed are entitled to Jobseekers Benefit or Jobseekers Allowance subject to meeting certain conditions. Trends in the numbers receiving these two payments over the decade 1998 to 2008 are shown in Figure 7.19. The graph shows Jobseekers Benefit (insurance based) recipients declining from 1998 to 2000, then gradually increasing to 2003, declining again to 2006 and then showing an increase in 2007 to 59,167 recipients and then a 105 per cent increase to 121,763 in 2008. Jobseekers Allowance (means tested) was received by twice as many people as Jobseekers Benefit in 1998 (120,496 compared to 61,591) but fell substantially to 2001, and since then has shown a gradual increase to 2007, with 80,268 receiving the allowance in 2007, followed by a 41 per cent increase to 113,603 in 2008.

Figure 7.19 Recipients of Selected Social Welfare Benefits, 1998-2008



Source: Department of Social and Family Affairs, 2009b

With large increases in the numbers becoming unemployed in 2008 (see Figures 7.17 and 7.18) substantial increases in the numbers receiving both these Jobseeker payments can be expected. Other substantive payments to people of working age, also shown in Figure 7.19, are Disability Allowance⁶⁷ and One Parent Family Payment. Both these payments have substantially increased in the decade from 1998 to 2008 – One Parent Family Payment by 34 per cent and Disability Allowance by 103 per cent. The implications of the increase in Disability Payments are considered in more detail in Chapter 9 and well-being issues relating to lone parents are dealt with in more detail in other sections of this chapter.

67. Disability Allowance (means tested) is a payment to people aged 16 to 65 who have a disability that is expected to last at least a year (95,754 recipients in 2008). There are two other payments for people who are ill or disabled which have large numbers of recipients. Illness Benefit (insurance payment) is for people who cannot work due to illness (73,609 recipients in 2008) and Invalidity Pension (insurance payment) is for people who are permanently incapable of work because of an illness or incapacity (53,725 recipients in 2008).

A key point running through this chapter is the relative proportions of the working age population who are in paid work, who are unemployed, who are looking after the home/family, who are students and the numbers who are in receipt of income supports. People who are facing various contingencies in their lives are entitled to income supports and associated services. However, the well-being literature indicates that meaningful engagement is central to individual well-being, as well as being of societal benefit. A significant challenge is to provide people who are or become unemployed with opportunities and choices to engage in meaningful activity.

Educational Participation

Education and training are one way of keeping engaged and as well as contributing to cognitive well-being and providing options to take up employment opportunities when they become available. The fourth component on the work and participation domain is educational participation. Two indicators are presented: educational qualifications of the unemployed and participation in life-long learning.

Educational Qualifications of the Unemployed

Figure 7.20 presents information on the educational qualifications of people who were unemployed, by gender, in Q1 2009. The graph shows that 37 per cent of unemployed men have a qualification at lower secondary level or below, and 17 per cent a third level degree or above. By comparison, unemployed women are more qualified – with 30 per cent educated to degree level or higher, and 18 per cent with a qualification at lower secondary or below. There has been a change in the educational profile of the unemployed over the last year, with an increase in the proportion of people who are unemployed and educated to third level – a small increase of 16 to 17 per cent for men, but a much larger increase from 21 per cent to 30 per cent for women. As shown earlier, more than twice as many men as women were unemployed in Q1 2009 (158,400 *vis-à-vis* 64,500). Many women aged 15 and over (47 per cent) are not in the labour force (compared to 29 per cent of men).

Figure 7.20 Educational Qualifications of People Aged 15 to 64 who are Unemployed, Q1 2009

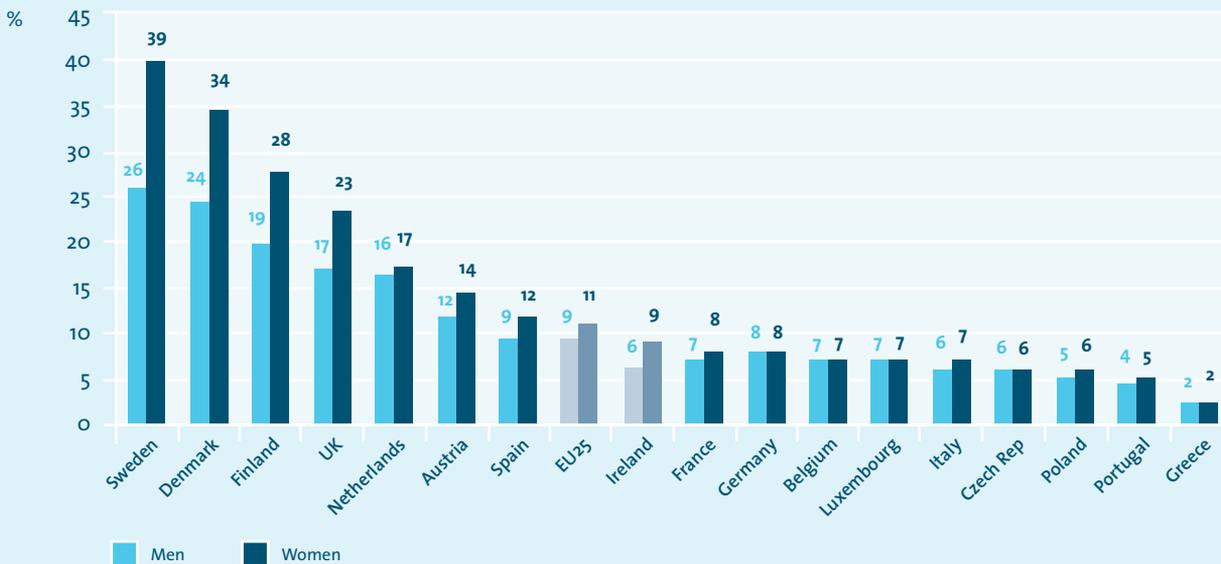


Source CSO, QNHS Q1 2009 Table 23

Life-long Learning

The second indicator on the educational participation component is life-long learning. In 2007, only 7.6 per cent of Irish people aged 25 to 64 were in receipt of education and training (either formal or non formal). Figure 7.21 shows that, like most European countries, Irish women were more likely to be in life-long learning than men: 9 per cent compared to 6.2 per cent. Ireland was just below the EU average on this measure, with the Scandinavian countries and the UK having the highest participation levels in life-long learning.

Figure 7.21 Life-long Learning by Gender⁶⁸, Selected EU Comparisons, 2007



Source: Eurostat LFS, sourced directly

People in employment are most likely to be engaged in life-long learning. Of all men participating in life-long learning 81 per cent were in employment; only 3 per cent were unemployed and 17 per cent were not economically active. The corresponding figures for women were 68 per cent in employment, 2 per cent unemployed and 30 per cent not economically active (CSO, QNHS, 2005). People with higher levels of educational attainment are more likely to participate in life-long learning than people with lower educational attainment. For example, the OECD showed that while the participation rate of 25-64 year olds in non-formal job-related education and training for Ireland overall was 11 per cent, for those with a third level education it was 20 per cent, compared to 5 per cent for those with only a lower secondary education (OECD, 2007g: 353).

68. Life-long learners are people aged 25 to 64 in receipt of education (either formal or non formal) in the four weeks prior to the survey.

Life-long learning is a way for people to improve their knowledge and skills throughout their life. In the recession there may be a tendency for employers and the state to cut back on supports for life-long learning. This would be short-sighted as in the long-run individuals who are flourishing improve their own well-being as well as making a contribution to their organisations and wider society. Some employers have taken innovative approaches to supporting such choices for their employees during the recession, for example, through career break options and flexible working arrangements. However, barriers exist to participation in further education. For example, a survey of young people aged 18-25⁶⁹ found that the biggest barrier in returning to study was the cost, with 'overall cost' and 'part-time fees' being a particular issue for people in lower socio-economic groups (National Youth Council of Ireland, 2009). There is a challenge for educational providers to engage with potential life-long learners, with a need for flexibility along with tailored approaches to delivery.

Summary

In summary, participation is important for well-being, especially meaningful and fulfilling work. The labour force participation rate for men aged fifteen and over in quarter 1 2009 was 71 per cent and for women 53 per cent. Participation rates were highest in the 25-34 age group at 91 per cent for men and 77 per cent for women. Women's employment rates are affected by the presence of children. The employment rate for women with no children at 87 per cent in 2008 was comparable to men (93 per cent), but dropped to 57 per cent where the youngest child was less than 3. Of people aged 15 and over who were not in the labour force, nearly two thirds of women were looking after the home or family, compared to just 1 per cent of men.

In seeking to balance work and life women often have 'to adapt their professional choices to their personal circumstances'. For example, in Ireland 32 per cent of women work part-time compared to 7 per cent of men.⁷⁰ For those in employment women tend to spend more hours per week on unpaid work such as caring for children and housework activities than men. In an examination of time use patterns Irish women had a high level of committed time in paid and unpaid work; by contrast Irish men had a high level of free time and relatively little time spent in unpaid work. While more than three quarters of both Irish men and women were relatively satisfied with their hours of paid work, only two thirds of Irish women were satisfied with their free time, (compared to three quarters of men).

Unemployment has one of the worst negative impacts on well-being, which is particularly worrying in the context of the recession. There has been a large increase in the numbers of people who are unemployed – for men and women of all ages, but especially men aged 25-44. Although numbers are smaller, unemployment rates are high in the younger age groups. Long-term unemployment is also showing an increase. In line with trends for Irish nationals, the numbers of non-Irish nationals who are unemployed have also shown large increases, with people from the Accession States showing a 137 per cent increase.

69. A questionnaire survey of a representative quota sample of 1,000 young people aged 18-25 was undertaken in July to September 2008.

70. Younger workers are also more likely to work part-time.

People who become unemployed are entitled to Jobseeker payments. There have been significant increases in these payments between 2007 and 2008, with Jobseekers Benefit increasing by 105 per cent to 121,763 recipients, and Jobseekers Allowance increasing by 41 per cent to 113,603 recipients. Many people of working age are also in receipt of payments because they are parenting alone or because they have an illness or disability. While people who face various contingencies in their lives are entitled to income supports and associated services, a significant challenge is to provide people who are, or become unemployed, with opportunities and choices to engage in meaningful activity.

Educational participation and achievement make an important contribution towards well-being both in terms of their intrinsic benefits and also because they contribute to economic well-being and advancement. The highest qualification of 37 per cent of unemployed men is lower secondary or below. Unemployed women are better qualified: for 18 per cent their highest qualification is lower secondary or below, while 30 per cent have a degree, compared to 17 per cent of men. To some extent this reflects the increasing unemployment rates among graduates which are an aspect of the economic recession. Participation of adults (25-64 year olds) in education (referred to as life-long learning) is relatively low in Ireland: 8 per cent compared to an EU average of 11 per cent. Overall, women do better on all of these measures than men. People who are in employment are the most likely to be participating in adult education, although a substantial proportion (30 per cent) of female life-long learners are not economically active. People who participate in life-long learning tend to be those who are already relatively well qualified. Cost barriers have been identified, especially for those in the lower socio-economic groups. The current economic climate presents a challenge to education providers to provide flexible and tailored education and training responses.

7.5.2 Ireland's Policy Framework for Work and Participation

Ireland's policy documents contain many proposals to enhance the participation of the working age population, into work in particular, but also in relation to other aspects of life and community. *Towards 2016* contains the following long term goals:

Every person of working age should be encouraged and supported to participate fully in social, civic and economic life; and have an opportunity to balance work and family commitments consistent with business needs; and ... every person of working age on welfare will have access to supports towards progression and inclusion, access to quality work and learning opportunities, encouraging a greater degree of self-reliance and self-sufficiency; and ... every person of working age would have access to lifelong learning.

Bearing in mind that *Towards 2016* was drawn up before the recession, many of its aspirations and these long-term goals remain relevant. For example, in delivering on these long-term goals the achievement of a balance between flexibility and security is seen as important. There is a wide range of priority actions proposed to meet the long-term goals, including a greater focus on activation and participation through an integrated approach across a number of relevant programmes including the National and Local Employment Services, the National Employment Action Plan, the High Supports Process, the Bridging/Foundation Programme, the Pathways to Employment processes, and the Social and Family Support Service. There will be a focus on the long-term unemployed, youth unemployed (16-24 years old), and those furthest from the labour market, including certain women workers, lone parents, people with disabilities and those who have been engaged in a programme but remain unemployed. A number of specific initiatives are proposed including an active case management service, funded through the NDP's social and economic participation investment programme.

Education and training goals for people of working age are supported by policies that are focussed on ensuring that Ireland has a fully trained, well-educated workforce. There is a broad array of priority actions towards meeting these objectives including: increasing participation in life-long learning among low skilled and low paid members of the workforce; focusing on adults from disadvantaged communities and backgrounds, including people in rural areas; improving literacy; implementing a national skills strategy; developing apprenticeship training; and development of community services and related programmes.

The Government has prioritised an expansion of opportunities in adult and further education, with a particular focus on the low skilled. The National Skills Strategy contains the long-term target for some 500,000 workers to increase their levels of educational attainment by at least one level of the National Framework of Qualifications. The immediate priority is to provide, to the greatest extent possible and with limited resources, for the needs of the increasing numbers of people who are now unemployed. There is a particular focus on the education, training and employment needs of young adults (18-29 year olds) in *Towards 2016*.⁷¹

Many of these initiatives are underpinned by investment from the National Development Plan where there is a strong focus on the development of human capital as well as social inclusion. The emphasis in the NDP is on upskilling the work force, on supporting further and higher education, and in providing supports for people at risk of social exclusion including people who are unemployed, people with disabilities, lone parents, Travellers, ex-offenders, women, older workers, part-time workers and migrants.

The National Action Plan for Social Inclusion 2007-2016 emphasises improving literacy among the working age population, the provision of second chance education, and the provision of 550 teachers for language supports to support the integration of newcomers.

71. It is noted that Jobseekers Allowance for 18 and 19 year olds was reduced to €100 per week in the Supplementary Budget of April 2009.

7.5.3 Commentary on Work and Participation

In the context of the recession the focus needs to be on creating jobs, retaining jobs and providing an immediate and tailored response to people who become or are unemployed. Such a response will require the relevant organisations (for example, the Departments of Enterprise, Trade and Employment, Social and Family Affairs, Education and Science, FÁS and other relevant agencies) to work together to provide a menu of options and supports to people who are unemployed or at risk of becoming unemployed. A range of initiatives are already underway, but there is a challenge to meet the scale of the response required, especially in the context of an overall reduction in public expenditure.

The recession does, however, provide a context for a medium to longer term view of addressing a range of issues, as reflected in this analysis and ambitioned in *Towards 2016*. This includes things like:

- ◆ Providing a range of education and training opportunities for people;
- ◆ Developing an appropriate Irish flexicurity system;⁷²
- ◆ Improving work-life balance for both women and men;
- ◆ Working to ensure appropriate integration of non-Irish nationals;
- ◆ Retaining graduates through the provision of relevant and meaningful opportunities; and
- ◆ Further innovative measures.

While the challenge of encouraging and supporting the participation of working age people during a recession is not to be under-estimated it does provide an opportunity to address structural and institutional weaknesses and to re-organise our systems to be more flexible and tailored, but at the same time supportive, to meet the diverse range of needs. Such an approach would be beneficial to the well-being of individuals and to wider society.

7.6 Relationships and Care

7.6.1 Measuring the Relationships and Care of Working Age People

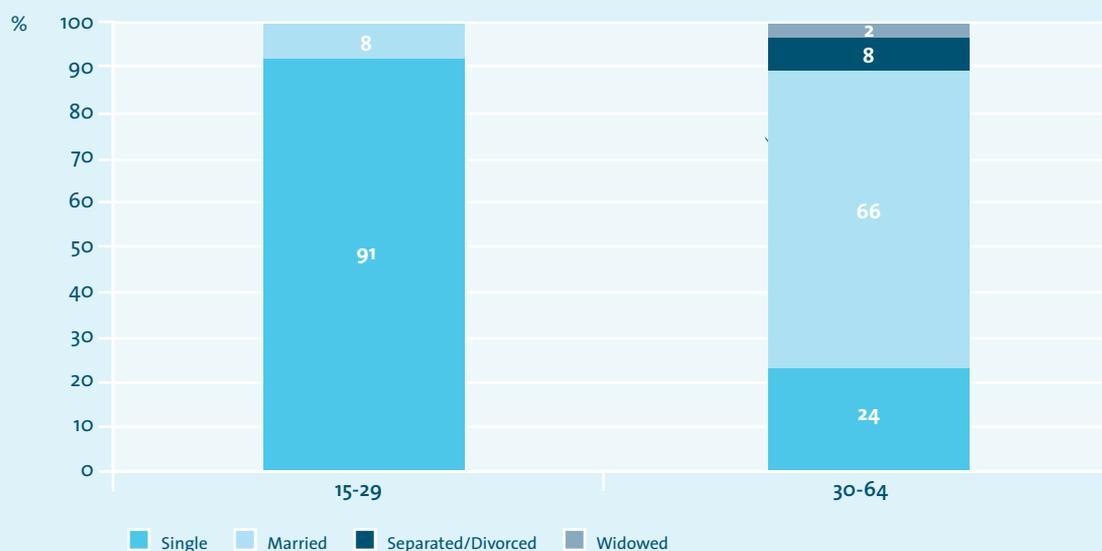
The ability to engage in and maintain relationships is a key component of well-being for people of working age. This aspect of well-being will be explored under three headings: family structure, family relations and caring. Four indicators are presented under the family structure component: marital status of young adults and anchor adults; births by age of mother; household composition; and lone parents by age.

72. The labour market model of flexicurity proposed by NESC combines three core elements: freedom under employment legislation for enterprises to adjust their staffing needs as they see fit but for enterprises that have the technological, marketing and management capabilities capable of complementing this freedom to successfully capture new markets; high levels of income replacement for a sufficient period of time for workers who become unemployed, which enables them to search for employment effectively and not be forced to take new jobs below their capabilities; active labour market programmes, in which employers, training and educational institutions participate, that genuinely enhances participants' skills and which people who wish to continue claiming compensation for their unemployment after the exhaustion of their entitlement to unemployment benefit are obliged to participate. As noted in previous NESC reports 'the flexicurity model does not come cheap' but it is argued that its components and the relationships between them are particularly well-suited to Ireland's labour market in the 21st Century.

Marital Status

Within the working age life cycle group, there is a distinction between young transitional adults (18-29) and older anchor adults (30-64) with regard to relationships and family formation. In general, people are entering marriage later in life; this is reflected in both marital status and household composition. In 2006, the average age of first marriage for women was 31.0 and 33.1 for men. Since 1991 the average age has increased by 4.1 years for women, and 3.4 years for men. Figure 7.22 shows that young transitional adults, in this graph those aged 15-29, are largely single, with less than 10 per cent of young adults who are married, predominately within the 25-29 cohort. Anchor adults (30-64) are a more heterogeneous group: although two thirds of anchor adults are married, there remains a substantial cohort of single persons and a growing number of divorced persons within this age group (this reflects the legalization of divorce in the State in 1997). Less than 1 per cent of transitional adults are separated, divorced or widowed, compared to 10 per cent of anchor adults.

Figure 7.22 Percentage of Persons in Age Group Classified by Marital Status, 2006



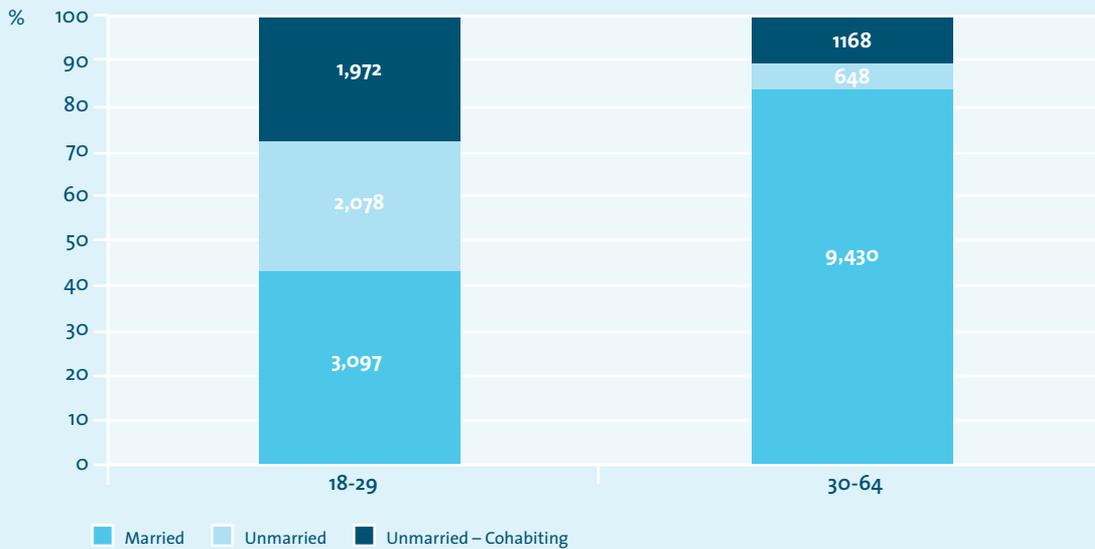
Source: Census, 2006

Note: Percentages may not add to 100 due to rounding.

Age at Birth of First Child

The second indicator on the family structure component is age of mother at the birth of her first child. The average age is 28.9 years (CSO, 2007h). Married mothers account for 68 per cent of all births and unmarried mothers account for 32 per cent, of which 17 per cent are resident in the same address as the father of the child (cohabiting). Almost 40 per cent of all births are to women in the young transitional age cohort, of which 44 per cent are married mothers, almost 30 per cent are unmarried mothers, and over a quarter are unmarried but cohabiting mothers, see Figure 7.23. Anchor age women account for just over 60 per cent of all births, of which almost 85 per cent are married mothers, over 10 per cent are unmarried but cohabiting mothers and 5 per cent are unmarried mothers. Across all age groups, a sub group of women aged 30-34 account for the largest number of children born, with over a third of all births in Ireland.

Figure 7.23 Percentage of Births Classified by the Age of Mother, 2007



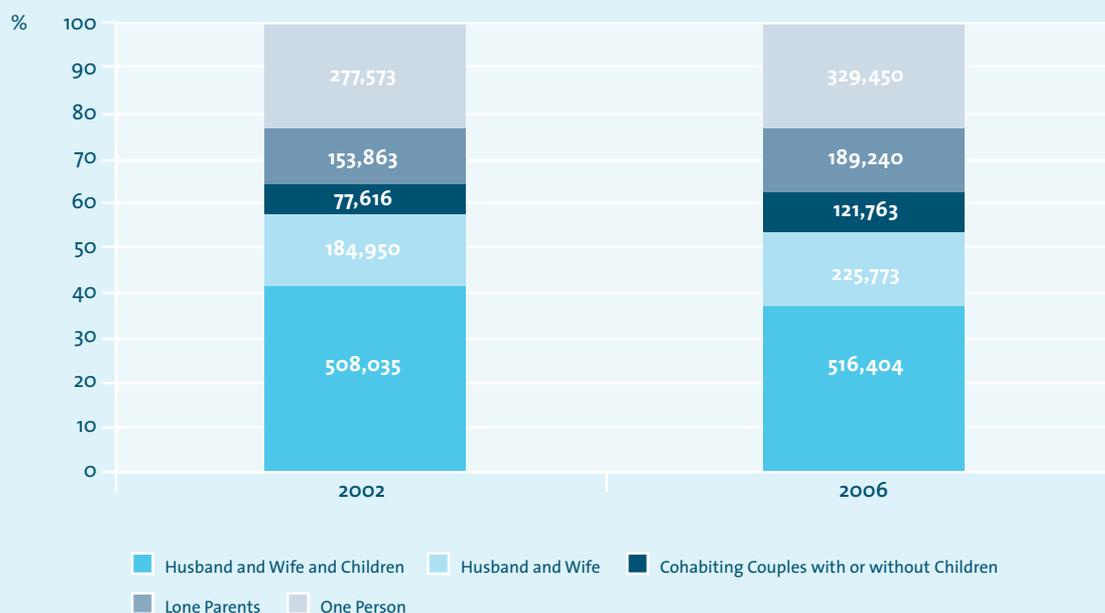
Source CSO, 2007h

There is a distinctive trend within the young adult cohort, with a majority of births taking place outside of marriage. Many of these births outside of marriage are to those cohabiting with a partner. In the Nordic states, cohabitation has grown to such an extent that there are more first births within cohabiting unions than marital unions (Kiernan, 2001). There is distinct variation in the incidence of cohabitation across Europe, with Ireland traditionally placed near the bottom of the scale. However, in relation to extra-marital births, an indicator which is intimately linked to cohabitation rates, the proportion in Ireland rose from 8 per cent in 1985 to 32 per cent in 2006 (Census, 2006).

Household Composition

The third indicator on the family structure component is household composition, which has been changing in Ireland over time. In 2006, the most common household type was a husband and wife with children (of any age); followed by one person households, husband and wife without children, lone parents and then cohabiting couples, see Figure 7.24. Although there has been an increase in the absolute number of husband and wife households, there has been a relative decrease in the number of households of a husband and wife with children. Correspondingly, there has been an increase in the proportion of cohabiting households, both with and without children. In the 2006 Census, cohabiting couples with or without children accounted for 11.6 per cent of all family units, which was an increase of 8.4 percentage points on the 2002 Census; a majority of these households were without children (63.8 per cent).

Figure 7.24 Percentage of Private Households Classified by Type, 2006



Source Census, 2002, 2006.

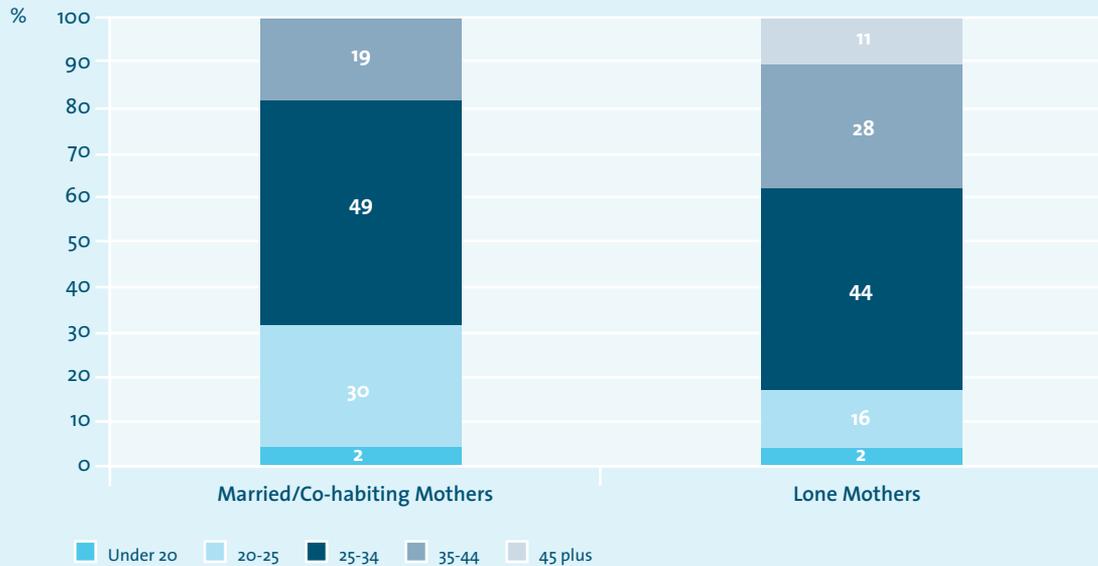
Cohabiting couples are not formerly recognised in the Irish Constitution. This includes both heterosexual and same-sex couples. Heterosexual cohabiting couples, however, have the choice of entering marriage if they wish to do so, either for the first time or after divorce/widowhood. In doing so, they can afford themselves the constitutional protection offered to families based upon marriage. Same-sex couples are not afforded such a choice. However, in June 2009, the Government published the Civil Partnership Bill 2009 which provides for the registration of civil partnerships for same-sex couples, bestowing rights and duties in relation to maintenance, shared home, succession and pension.⁷³ Legal recognition of these arrangements promotes their acceptance and inclusion, as well as providing protection – attributes which contribute to positive well-being.

Lone Parenthood

The fourth indicator on the family structure component is lone parenthood by age. The age profile of mothers with children under 15 years of age in 2006 is provided in Figure 7.25. Some 44 per cent of lone mothers with children under 15 are aged between 25 and 34, with 28 per cent aged 35 to 44. Contrary to popular perception, less than 2 per cent of lone mothers are under 20 years of age, with 18 per cent age 25 or less. Even so, lone mothers tend to be younger than married or cohabiting mothers with children under 15. The age profile of lone mothers reflects their routes into lone motherhood, with those who become lone mothers through marital breakdown or widowhood older than those who have never married. Lone parents are more likely to have smaller families with 6 out of 10 lone parent families having only one child, compared to 3 out of 10 families with two parents living together (Government of Ireland, 2007c).

73. The Bill also provides for a cohabitant's redress scheme for same-sex and opposite-sex couples, and legal recognition to cohabitant agreements to enable cohabitants to regulate their joint financial affairs.

Figure 7.25 Age Profile of Mothers with Children Under 15 Years, 2006

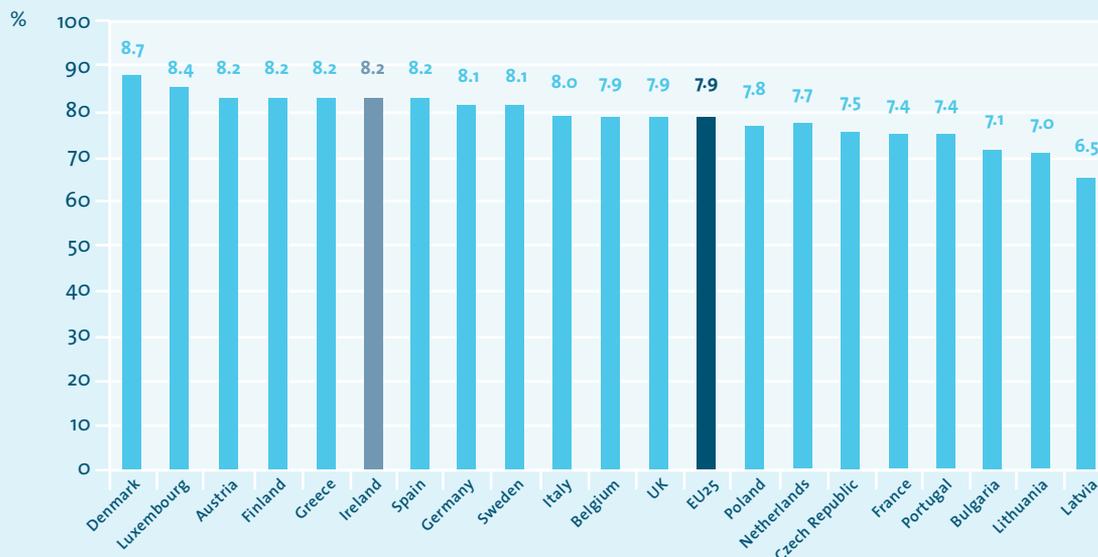


Source: Government of Ireland (2007c: 34, based on QNHS, Q2, 2006)

Satisfaction with Family Life

The second component in the relationships and care domain is family relations, illustrated by the indicator satisfaction with family life. Figure 7.26 shows that on a scale of 1 to 10, where 1 is ‘very dissatisfied’ and 10 is ‘very satisfied’ an EU25 average of nearly 8 out of 10 Europeans were satisfied with their family life, in 2003. The most satisfied were the Danes (averaging 8.7 on the scale), with the Irish also highly satisfied with family life at 8.2. Least satisfied were the Latvians at 6.5.

Figure 7.26 Satisfaction with Family Life,⁷⁴ Selected EU Comparisons, 2003



Source: Government of Ireland (2007c: 34, based on QNHS, Q2, 2006)

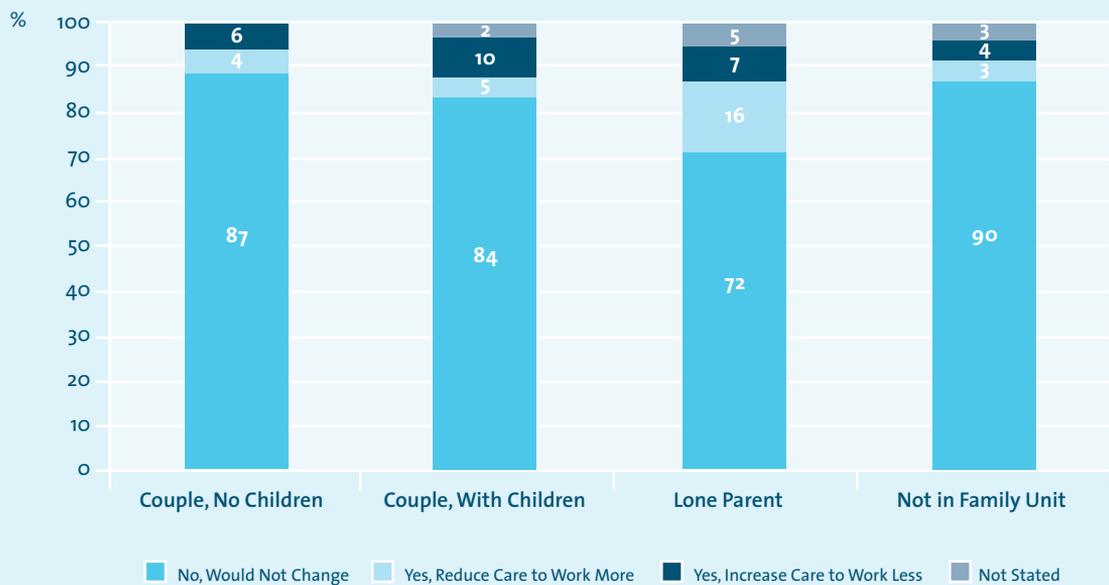
74. Mean value on a scale from 1 ‘very dissatisfied’ to 10 ‘very satisfied’ with family life.

Work and Caring Balance

Caring is the third component of the relationships and care domain. Two indicators are presented: work and caring balance; and recipients of carers benefits. In relation to the work and caring balance, as part of a QNHS module in 2005 (Q2) the CSO asked people aged 15 to 64 with caring responsibilities⁷⁵ whether or not they would change the balance between work and caring. Ten per cent of women said they would like to increase care to work less, compared to 8 per cent of men, and 9 per cent of women said they would like to reduce care to work more compared to 2 per cent of men.

Figure 7.27 presents the results on whether there is a desire to change the work / caring balance by family status. The figure shows that by and large, in 2005, (more than 80 per cent) couples with or without children, and those not in a family unit, did not want to change their work/caring balance. However, more than one fifth of lone parents would have liked to change this balance, in the main (16 per cent) to work more. Nearly 10 per cent of couples with children indicated that would like to increase their care and work less.

Figure 7.27 Whether Want to Change the Balance Between Work and Caring by Family Status, 2005



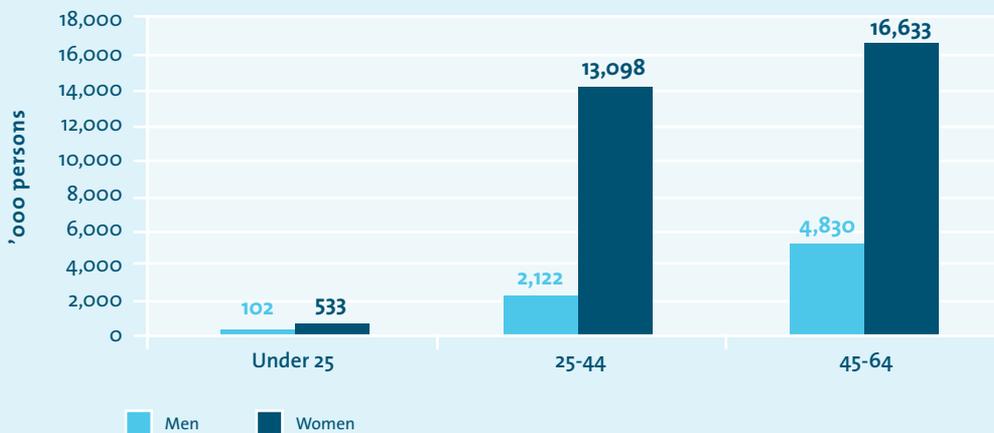
Source CSO, QNHS, Q2, 2005

75. Caring responsibilities included having children aged less than 15 living in the household, providing unpaid childcare for children 'other than your own or those of your spouse/partner', and providing unpaid care for ill, disabled or elderly relatives/friends aged 15 and over.

Recipients of Carers Payments

The second indicator in the caring component of the relationships and care domain is recipients of carers payments⁷⁶ by age (for under 65 year olds). Caring work is defined as the provision of assistance and support, on an unpaid basis, to family members, relatives or friends who need such care because of disability, old age or long term illness. In this context it does not include caring for children, unless they are disabled or have a long term illness. In 2008 there were 37,318 recipients of Carers Payments who were under the age of 65 – 94 per cent of whom were in receipt of Carers Allowance and 6 per cent in receipt of Carers Benefit. Figure 7.28 shows that 81 per cent of carers under 65 in receipt of a carers payment were women, more than half (55 per cent) of whom were aged 45 to 64.

Figure 7.28 Recipients of Carers Allowance and Carers Benefit by Age and Gender, 2008



Source: Department of Social and Family Affairs (2009b: 54), *Statistical Information on Social Welfare Services, 2008*

Despite there being a large increase in the numbers of recipients of carers payments (nearly trebling from 16,528 in 2000 to 45,818 for all recipients of carers payments),⁷⁷ this only represents between one quarter and one third of the total number of carers (161,000). People in receipt of carers payments receive a maximum of €221.20 per week (for caring for one person).⁷⁸

76. There are two main carers payments. Carers Benefit is a social insurance payment for people who have left paid employment to look after someone who requires full-time care. Carers Allowance is a means tested payment for carers who look after someone on a full-time basis. In September 2007, a half-rate Carers Allowance was introduced for people who were caring for another person and in receipt of another social welfare payment. There were 15,790 recipients of half rate Carers Allowance at the end of 2008.

77. Includes recipients aged 65 and over.

78. This is for people in receipt of Carers Benefit. (If caring for more than one person they can receive up to €331.80 per week). People in receipt of Carers Allowance receive €220.50 per week (if under 66 years of age; people caring for more than one person receive €330.75 per week). People in receipt of half-rate Carers Allowance receive €110.25 per week (if under 66 years of age; people caring for more than one person receive €165.37 per week).

Carers make a huge contribution to the people being cared for, care which would otherwise have to be provided by the state or community and voluntary sector. Providing care and receiving care can be a demanding and emotional experience affecting people's well-being. For the individual and collective well-being of carers, those being cared for, and their families it would be appropriate to develop comprehensive and tailored packages of care, involving family members, the state, the community and voluntary sector and private providers. Some of these issues are considered further in the following sections, and in the next two chapters.

Summary

Relationships have a strong influence on well-being. Stable affective relationships have a beneficial impact on well-being, whereas disharmony and severing of relationships can greatly disimprove well-being. The trends analysed show that people are getting married later in life. Young transitional adults are mainly single; whereas anchor adults have more diverse relationships, with the majority married, but substantial proportions single and separated/divorced/widowed. The average age for a woman to have her first child is 28.9. Sixty per cent of all births are to anchor age women. In the transitional age group more than half of births are to women who are single or cohabiting.

These changes are reflected in the changing composition of households. There has been an increase in the proportion of cohabiting households, both with and without children, including an increase in the recorded number of same-sex couples. The largest household type continues to be husband and wife with children, making up 37 per cent of all households. Lone parenthood has been increasing, and lone mothers tend to be younger than married or cohabiting women. In general, Irish people are satisfied with family life.

In relation to caring, more than one fifth of lone parents said they would like to change their work/caring balance, in the main (16 per cent) to work more. Nearly 10 per cent of couples with children would like to increase their care and work less. There are 161,000 carers in Ireland, who provide assistance and support, on an unpaid basis, to family members, relatives or friends who need such care because of disability, old age or long term illness, just under 30 per cent of whom are in receipt of a carers payment. Many carers combine caring roles with paid employment or unpaid responsibilities in the home. The majority of carers and those in receipt of carers' payments are women. Carers provide an invaluable service to those they care for, but it is a demanding and emotional responsibility.

7.6.2 Ireland's Policy Framework for Relationships and Care

The policy framework, *Towards 2016*, makes reference to caring responsibilities, and contains the long-term goal that:

Every person with caring responsibilities would have access to appropriate supports to enable them to meet these responsibilities alongside employment and other commitments.

Specific priority actions include:

- ◆ Development of a National Carers Strategy;
- ◆ Improvements to Carers Allowance, Carers Benefit and the Respite Care Grant;
- ◆ Training and improved supports for carers; and
- ◆ Provision for Family Support Services.

7.6.3 Commentary on Relationships and Care for People of Working Age

The literature on well-being emphasises the importance of relationships. While relationships are often seen as private and separate from the State, the State has an important role in monitoring trends so that policy and legislation can respond to or support these changing trends. Publications by the Department of Social and Family Affairs on analysing family trends in Ireland and in setting out the government supports available are useful in this regard.

Security, recognition and equality with regard to relationships are important dimensions in supporting positive well-being. The trends show the increasing diversity of families in Ireland, especially the increase in cohabitation, including same-sex partnerships. The civil partnership legislation goes some way towards providing security and recognition for same-sex couples.

Towards 2016 makes a number of commitments to support carers. Some of these commitments have been deferred in the context of the recession, including the proposed National Carers Strategy. It is important to take stock of the role of carers, their contribution to individual and collective well-being, and the impact that caring can have on their own health and well-being. The provision of comprehensive tailored packages of care is worthy of further consideration.

There is potential to improve our knowledge base on carers, and on those requiring care, and to collect additional information on the formation and re(formation) of relationships, with associated legal, economic and social implications. This information would help us to better understand the dynamics of changing trends and to ensure appropriate supports and legislation are in place.

7.7 Community and Environment

7.7.1 Measuring the Community and Environmental Well-being of People of Working Age in Ireland

People's living circumstances impact on their well-being. This section will present indicators on three components: accommodation, community, and environment. The first component is accommodation. Accommodation is a basic need affecting the quality of people's lives, as well as being a key component of social integration.

Accommodation

Three indicators will be presented on accommodation: occupation of mortgage borrowers; housing need; and homelessness. With the rapidity of the recession it is difficult to get a full up-to-date picture of its effect on housing and the impact this is having on people's well-being. In chapter 4 (Volume I) we noted the large reliance on home ownership in Ireland,⁷⁹ and increases in the number of housing loans and their value. The recession has had a number of repercussions with a potential impact on people's well-being. While it is difficult to get aggregated definitive information (as changes have been occurring rapidly), it has been estimated that 7-15 per cent of mortgage holders could now be in negative equity.⁸⁰ One outcome of the recession and negative equity is risk of mortgage arrears and home repossession. The main reason given for mortgage accounts falling into arrears is unforeseen circumstances, such as marital/relationship breakdown, unemployment or illness. Other reasons cited are related to poor financial management or mismanagement (Irish Financial Regulator, 2009).⁸¹ Another aspect of the housing boom followed by recession is the number of vacant properties in the State. The 2006 Census showed 266,322 unoccupied properties (a vacancy rate of 15 per cent).⁸² This figure does not take into account the impact of the recession.

Occupation of Mortgage Holders

The indicator employed here is occupation of mortgage owners, see Figure 7.29. Even though data are only provided up to 2004 the graph shows that professionals, managers and employers continue to make up the highest proportion of mortgage borrowers (for both new and second hand houses). However, the proportion of borrowers in salaried and non-manual employment has more than doubled between 2001 and 2004, making up one third of borrowers in 2004. This information is useful in assessing the types of occupation most hit by the recession and therefore who is most likely to be at risk of stress in relation to their housing.

Information is available on the age profile of mortgage borrowers for 2007.⁸³ People aged under 30 (transition adults) comprised 58 per cent of first time buyers in 2007; and made up one fifth of former owner occupiers⁸⁴ (Department of Environment, Heritage and Local Government, *Housing Statistics, 2008*, at www.environ.ie).

79. Ireland has traditionally had high levels of home ownership – 82 per cent in 2000, compared to an EU15 average of 63 per cent (CSO, 2003: 55). The 2006 Census of Population in Ireland showed that owner occupiers made up 77 per cent of private households.

80. Ronan Lyons, Economist with Daft and Gerard O'Neill, Chairman of Amarach Research, at www.daft.ie, accessed May 2009.

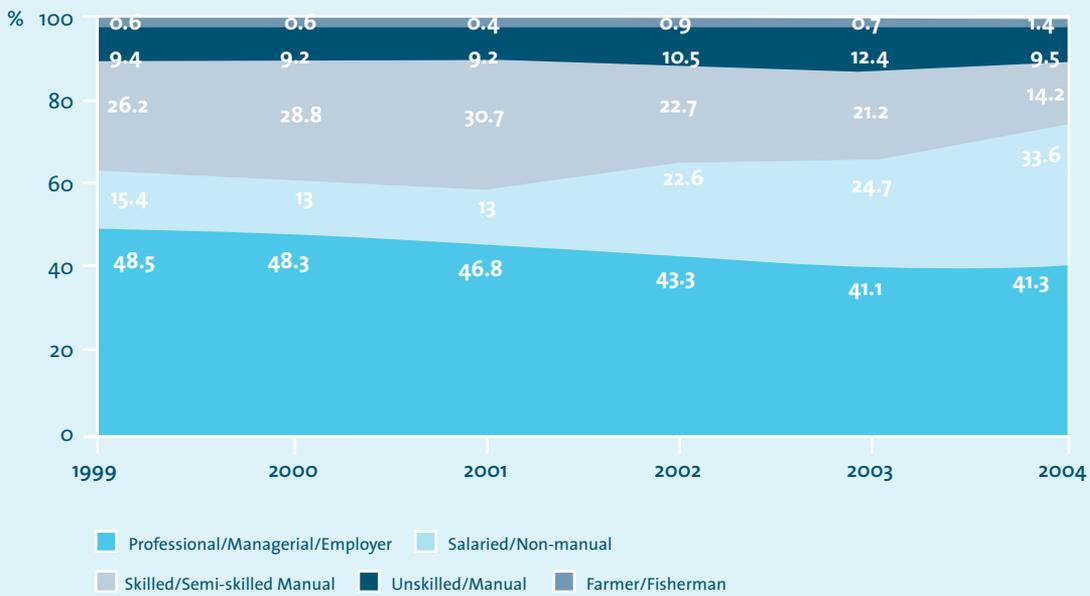
81. Irish Financial Regulator's website accessed May 2009, at www.financialregulator.ie

82. This figure of 266,322 comprises 174,935 vacant houses, 41,598 vacant flats and 49,789 holiday homes, at www.cso.ie, accessed May 2009.

83. The range of ages has been derived from an analysis of mortgage loan payments data as supplied by mortgage lenders and only refers to the year in which the loan was drawn down.

84. Former owner occupier also includes residential investors.

Figure 7.29 Occupation of Mortgage Borrowers, 1999-2004

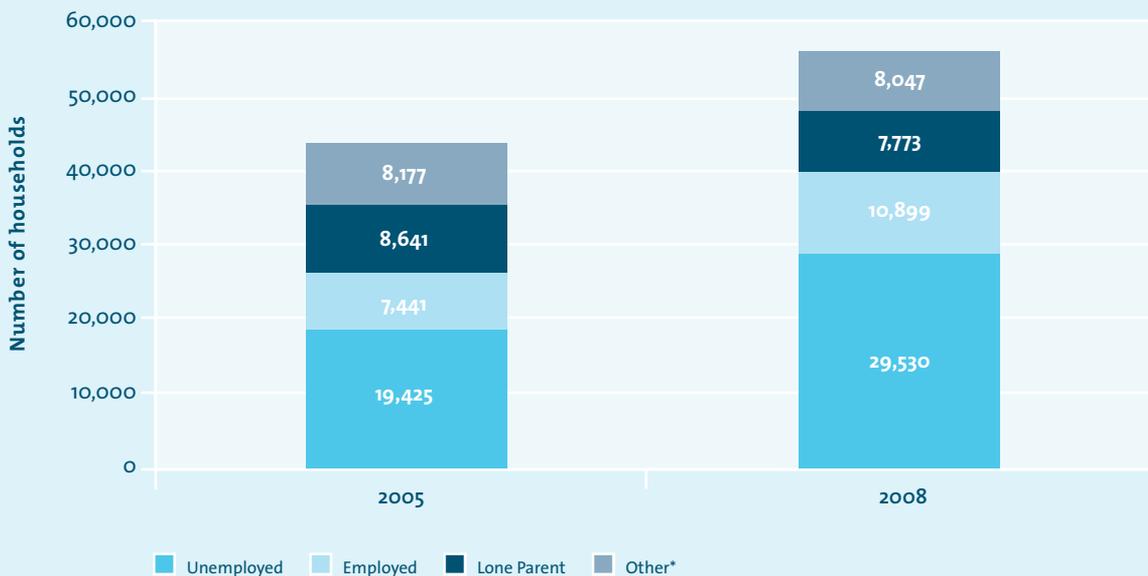


Source: Department of Environment, Heritage and Local Government, *Housing Statistics, 2008*, at www.environ.ie

Housing Need

The second indicator on the accommodation component is housing need by employment status, presented in Figure 7.30.

Figure 7.30 Housing Need by Employment Status, 2005 and 2008



Source: Department of Environment, Heritage and Local Government, *Local Authority Assessment of Social Housing Need*, at www.environ.ie

Note: Other* includes pensioners, people employed on FÁS/Back to Work Schemes, Homemakers and other miscellaneous categories.

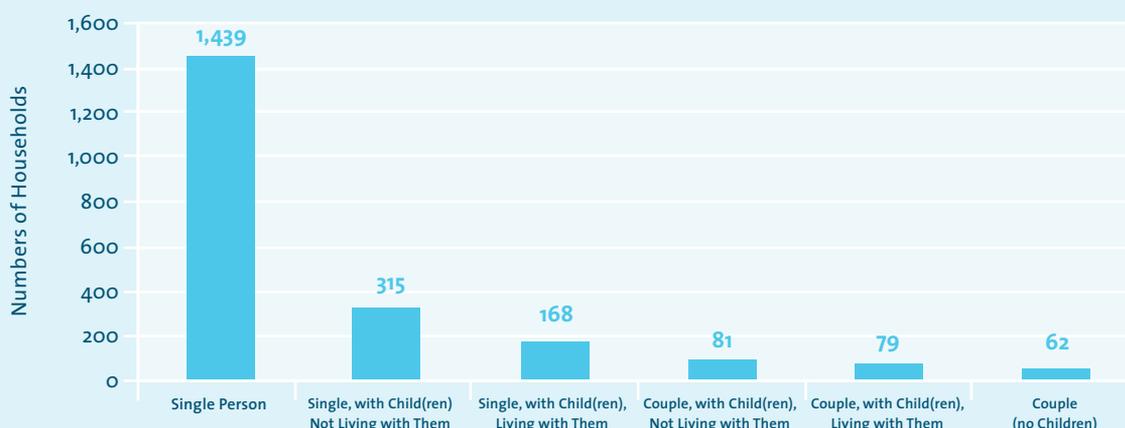
Figure 7.30 shows that housing need increased by 29 per cent between 2005 and 2008 – from 43,684 households saying they required accommodation in 2005 to 56,249 in 2008. The number of people on the housing list who were unemployed increased by more than 50 per cent from 19,425 to 29,530. The number of employed people on the housing list also increased, by 46 per cent from 7,441 to 10,899. In the context of the recession the numbers in need of housing are likely to increase, especially given the increase in numbers of people who have become unemployed.

Homelessness

The third indicator on the accommodation component is homelessness. Being homeless is the most severe form of housing need and has serious implications for people's well-being. The 2008 local authority assessment of social housing need across the country recorded 1,394 households as homeless (Department of Environment, Heritage and Local Government, at www.environ.ie). This figure seems low, as a survey of all homeless services in Dublin (March 2008) recorded 2,144 households in homeless services – resident in homeless accommodation, resident in long-term supported accommodation for people who were previously homeless or else sleeping rough (Homeless Agency, *Counted In*, 2008). Most of the adults in homeless services (84 per cent) were Irish nationals, but nearly 1 in 6 (16 per cent) were non-Irish nationals.⁸⁵

Figure 7.31 shows the type of households experiencing homelessness in Dublin. It is clear that people who are homeless are largely single. They are also mainly men – men made up 68 per cent of people in homeless services. The average age for all homeless services' users was 39 years old. Some 28 per cent of homeless adults in Dublin were aged 18-29, 68 per cent were aged 30-64 and 4 per cent were aged over 65. In general, anyone over the age of fifty who has had a prolonged experience of homelessness is vulnerable to many of the physical health problems associated with older age. As noted in the previous chapter, and shown here in Figure 7.31, there are about 250 people who are using homeless services who have children living with them. Many people who are homeless identify that they have children, but that they are not currently living with them.

Figure 7.31 Type of Households Experiencing Homelessness, Dublin, 2008



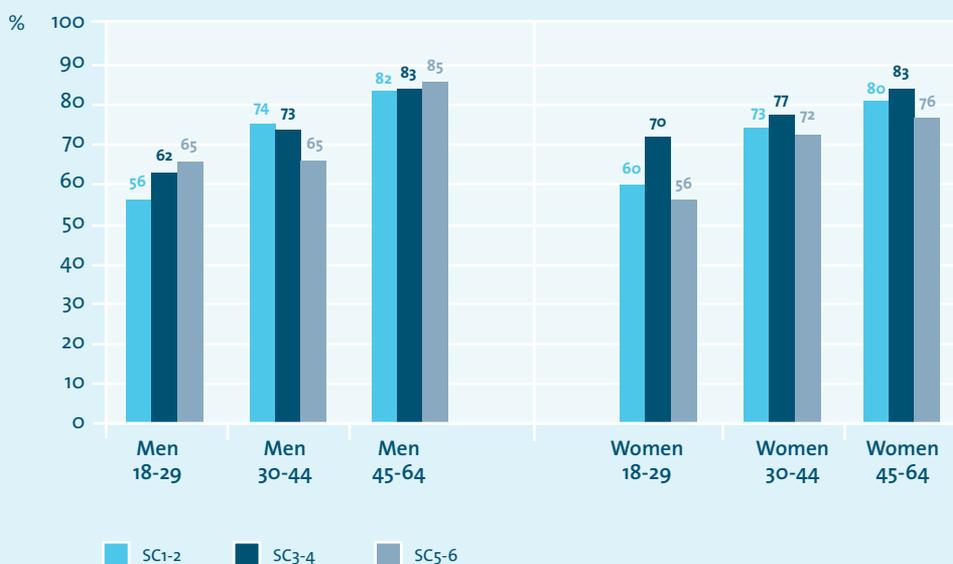
Source CSO, QNHS Q4 2008, Table 23

85. Non-Irish nationals make up 11 per cent of the total population.

Community – Getting Practical Help from Neighbours

The second component of the community and environment domain is community. Social interaction, support from those around you, and participation in community activities, sometimes referred to as social capital, are beneficial to well-being. Three indicators are presented: practical help from neighbours; involvement in voluntary activities; and participation in arts events. Figure 7.32 shows that three quarters of respondents to the 2007 survey of lifestyle, attitudes and nutrition in Ireland (SLÁN) found it ‘easy’ or ‘very easy’ to get practical help from neighbours. There were few gender or social class differences but older respondents were more likely to report finding it easy to get help from neighbours than younger ones.

Figure 7.32 Percentage of Respondents who Report finding it ‘Easy’ or ‘Very Easy’ to get Practical Help from Neighbours, by Age, Gender and Social Class,⁸⁶ 2007



Source: Morgan *et al.*, 2008: 94 (SLÁN, 2007)

Involvement in Voluntary Activities

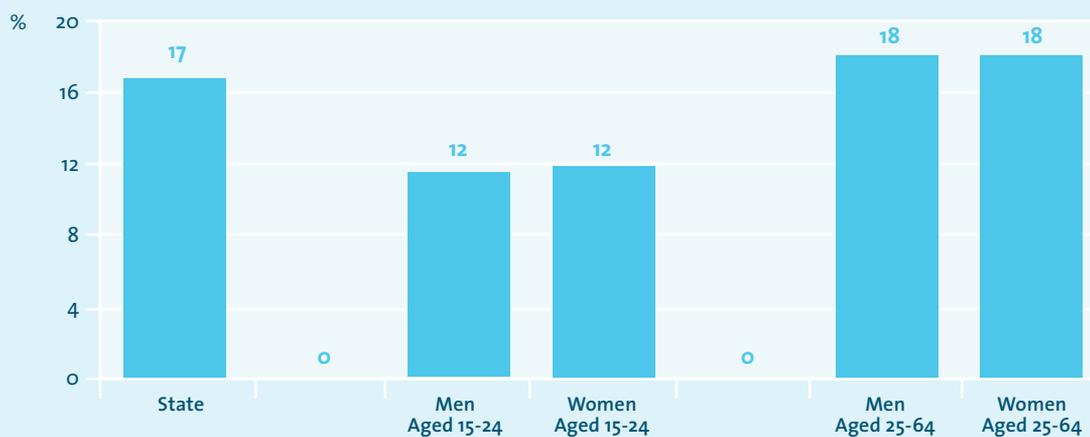
The second indicator used for the community component is involvement in voluntary activities. Using data from the 2006 Census Figure 7.33 illustrates the proportions of the population aged 15-64 involved in a range of voluntary activities.⁸⁷ The figure shows that less than one in five (16.6 per cent) of 15 to 64 year olds are involved in voluntary activities. Mature adults (25-64) are more likely to be involved in voluntary activities (18 per cent) than people who are at a transitional stage in their lives (15-24 year olds – 11.6 per cent). There is little variation between men and women overall, although there is some variation across activity.

86. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

87. Involvement is defined as attending meetings, being a committee member, or taking responsibility for some activity. It excludes attendance at mass or church services (CSO, 2009e).

Women are more likely to be involved in voluntary work with a social or charitable organisation or with a religious group or the church, whereas men are more likely to be helping with a sporting organisation. In terms of building social capital and supporting well-being there is clearly potential to build on the level of voluntary activity across the working age population, especially among young adults.

Figure 7.33 Involvement in Voluntary Activities, 2006



Source CSO, 2007a (Census, 2006)

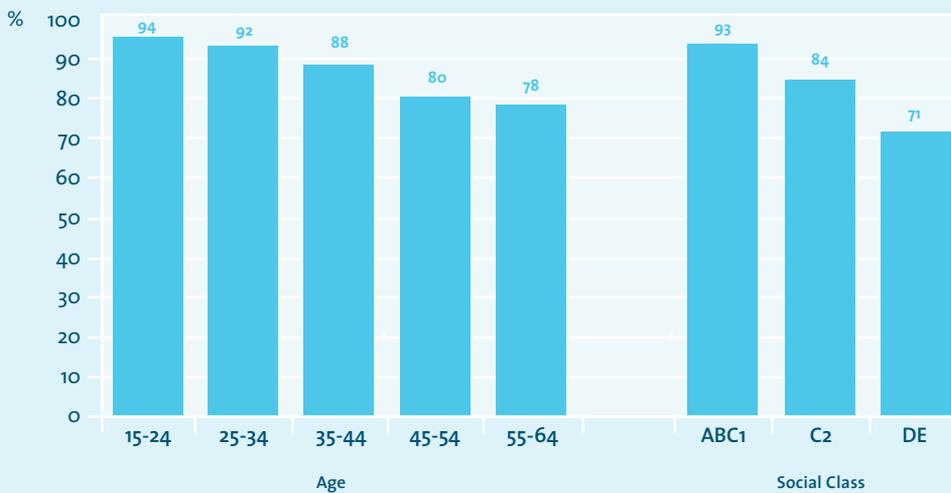
Regarding international comparisons, the Taskforce on Active Citizenship (2007) reported that Ireland is average to slightly below average in terms of reported group membership and volunteering across OECD countries. Even though the evidence is limited, they also noted that Ireland is rich in terms of informal social networks, compared to many other economically developed countries. The Taskforce on Active Citizenship noted the important role voluntary and community organisations play in promoting community involvement and building social capital.

The ESRI has documented the social value of sport in building social capital (Delaney and Fahey, 2005). They reported that sport plays an important role in bringing people together, counteracting loneliness and social isolation, in forming networks and in strengthening communities. Many people continue to volunteer in sport, attend sports events or socialise in their sports club after they have stopped actively playing sport.

Attendance at Arts Events

Involvement in the arts contributes to and strengthens social capital, which is, in turn, associated with higher economic growth, greater social equality, and increased levels of well-being and life satisfaction (NESF, 2007: 107). Participation in the arts can also play an important role in providing intellectual and emotional stimulation, as well as marking significant events in life and expressing communal meanings. Figure 7.34 shows attendance at arts events by social class. The chart shows that more than 70 per cent of the population aged over 15 attended arts events but that there is a gradation by social class and age. People in the higher social class groupings have higher levels of attendance at arts events than those in the lower social class groupings and younger people have higher attendance rates than older people. Variations in attendance at arts events are attributable to a range of barriers such as economic costs, poor transport, lack of literacy, and social and psychological barriers (NESF, 2007).

Figure 7.34 Attendance at Arts Events by Age and Social Class, 2006⁸⁸



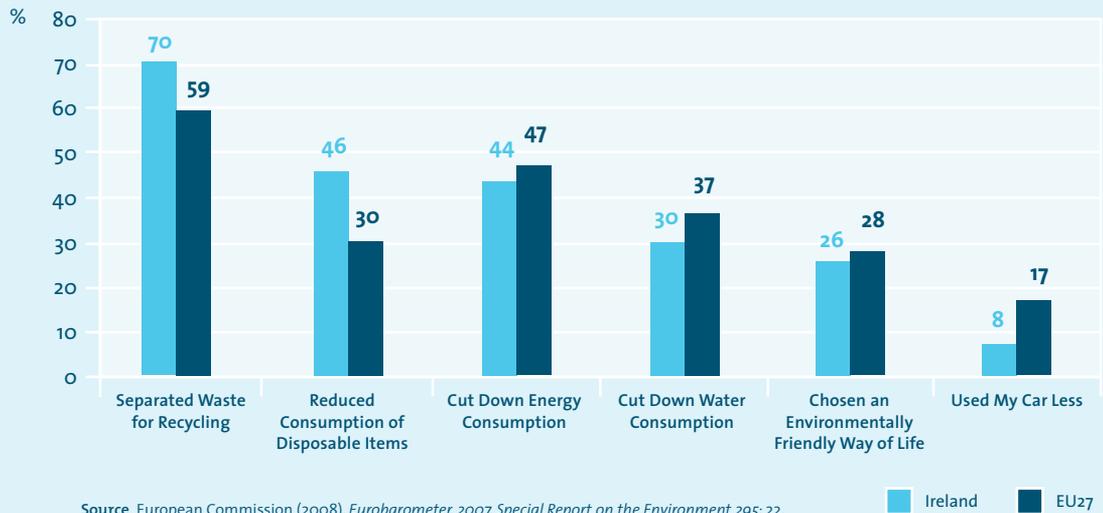
Source NESF, 2007

Environmental Actions

The third component on the community and environment domain is environment. The environment within which we live can affect our health and well-being. Two indicators are presented for the environment component: environmental actions and means of travel to work. Actions which citizens in Ireland have undertaken to improve the environment are presented in Figure 7.35, based on results from a Eurobarometer survey (European Commission, 2008). On the plus side, respondents to the Eurobarometer in Ireland were above the EU27 average for recycling and reducing consumption of disposable items. However, we are less likely to cut down on our energy and water consumption or choose an environmentally friendly way of travelling. In particular, we are much less likely to use our cars less.

88. Arts events include plays, classical concerts, art exhibitions, ballet, traditional Irish or folk music, rock/pop music, film, street theatre/spectacle, musicals, variety shows, stand-up comedy, circus, art-house film, contemporary dance, other dance, jazz/blues, country & western music, world music, other live music, readings and 'other' arts events. ABC1 includes upper middle class, middle class and lower middle class; C2 consists of the skilled working class; and DE the semi-skilled and unskilled working class.

Figure 7.35 Have You Done Any of the Following During the Past Month for Environmental Reasons, EU Comparisons, 2007

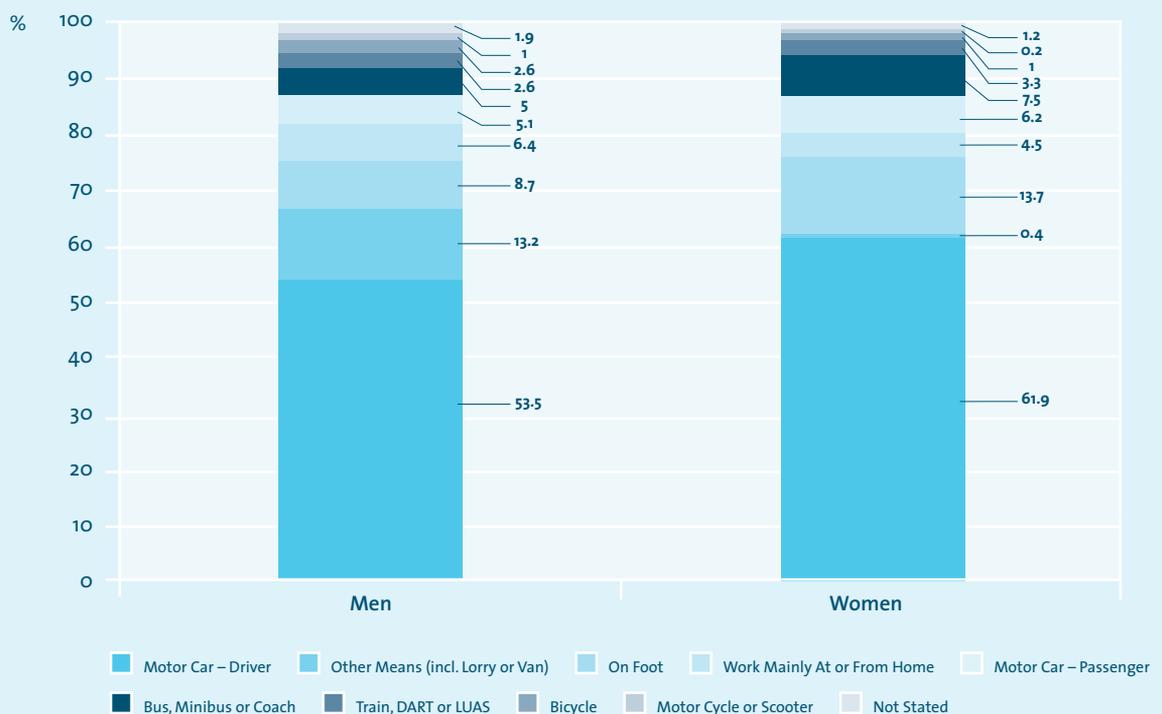


Source: European Commission (2008), Eurobarometer, 2007, Special Report on the Environment 295: 22.

Travel to Work

When we examine the means of travel to work in 2006, see Figure 7.36, it is clear how dependent we are on our cars with 62 per cent of women and 53 per cent of men driving their cars to work. The next most important mode of transport for women was walking at 14 per cent and ‘other means, including lorry or van’ for men at 13 per cent. Only 11 per cent of women and 8 per cent of men used public transport.

Figure 7.36 Means of Travel to Work by Gender, 2006



Source: Census, 2006.

Summary

Ireland has traditionally had high levels of home ownership. The recession has impacted on the housing market leaving some people having difficulty making mortgage repayments. In terms of the occupation of mortgage holders, professionals, managers and employers make up 40 per cent of the total with salaried and non-manual employees making up one third of borrowers. The numbers of people in need of housing has increased in recent years, with 56,249 households on local authority waiting lists in 2008. The numbers of people on the housing lists who are unemployed has increased, but so too has the numbers of people who have a job. In the context of the recession the numbers of people requiring social housing is likely to increase, especially with increasing numbers of people becoming unemployed. The most extreme form of housing need is being homeless, with 1,394 people recorded as homeless in 2008. More detailed information from Dublin (2008) showed that two thirds of the homeless population were men, mostly single, and with an average age of 39 years old.

Social interaction and community participation are important for well-being. Three quarters of respondents to a national survey reported that it was easy to get help from neighbours. With regard to community participation, one in six of 15 to 64 year olds is involved in voluntary activities, with 25-64 year olds more likely to be involved than 15 to 24 year olds. While there was little difference in the level of involvement between men and women overall, women are more likely to be involved in charitable or religious work, whereas men are more likely to help in sporting organisations. Participation in arts events also supports social capital - more than 70 per cent of people have attended arts events, with higher attendances by higher social class groups and young people. At a more general level, community and voluntary sector organisations play an important role in supporting community involvement and building social capital.

On the environment, people in Ireland tend to take more environmental actions than the EU average in recycling and reducing consumption of disposable items but are less likely to cut down on energy or water consumption or chose environmental ways of travelling. For example, 62 per cent of women and 53 per cent of men drive to work with less than 10 per cent using public transport.

7.7.2 Ireland's Policy Framework for Community and Environment

Towards 2016 has a range of goals and actions relating to accommodation, community, and the environment. The following long-term goals are articulated:

Every person of working age should be encouraged and supported to participate fully in social, civic and economic life ... and Every family would have access to ... affordable accommodation appropriate to their needs and a well functioning public transport system.

Priority actions include:

- ◆ Delivery of the Housing Policy Framework: Building Sustainable Communities, with a focus on: the elimination of homelessness; assessment of need and enhanced delivery of social and affordable housing, including working towards the provision of an additional 73,000 social housing units as recommended by NESC; full implementation of the Rental Accommodation Scheme; and implementation of the Local Authority Traveller accommodation programmes. There will be a particular focus on young adults (18-29) who are the key household formation group and as such may experience challenges in accessing housing/accommodation.
- ◆ Promoting environmental sustainability through: mainstreaming environmental considerations into policy formulation and better enforcement; implementation of a climate change strategy; investment in environmental infrastructure, such as water treatment and supplies and recycling facilities; and increasing environmental awareness.
- ◆ Improving the transport infrastructure through: Transport 21 in the Greater Dublin Area, with a particular focus on improving the public transport network; a national investment programme in public transport; and consolidation and expansion of the Rural Transport Initiative.

Many of these housing/accommodation, environmental and public transport initiatives are to be underpinned by investment allocated in the National Development Plan. The National Action Plan for Social Inclusion 2007-2016 also addresses all of these issues with a particular focus on people at risk of social exclusion.

Some of these projects are likely to be deferred or curtailed because of the economic recession.

7.7.3 Commentary on Community and Environmental Well-being

With respect to housing there remains a considerable level of housing need. This need is likely to increase and become more urgent in the recession, both in relation to dealing with 'distressed mortgages' and in providing social housing for those who need it. The tools available, and scale of the response required, are areas requiring urgent attention. The commitment to deliver the proposals in the 'housing policy framework: building sustainable communities' are welcome, but there is an urgency to meet the needs of people who are in difficulties as a result of the recession as well as to continue to meet the needs of particularly vulnerable groups, such as people who are homeless, people leaving institutional care and Travellers. The community and voluntary sector have an important role to play here, in supporting the implementation of commitments in a comprehensive, efficient and integrated manner.

While a relatively high level of neighbourhood support is indicated there is scope for encouragement of participation in community and voluntary activities, at both an individual and community level. Community activity provides important opportunities for social interaction and development and can have a particularly beneficial impact in disadvantaged communities, where additional supports for community development may be required. There is the potential to develop a policy framework for supporting community and voluntary activity, including the recruitment, training and management of volunteers.

Accessibility to work, shops, family and social activities is an important aspect of social well-being and provision of public transport also promotes more environmentally sustainable transport options for people. However, it is clear that much remains to be done to promote the use of more environmentally friendly modes of transport, as well as increasing environmental awareness more widely.

7.8 Health

7.8.1 Measuring the Health of Working Age People

Good health is a fundamental component of well-being. In chapter 4 we presented trends for life expectancy at birth (81.5 for women and 76.7 for men) and healthy life years (64.1 for women and 62.9 for men). In this chapter, under the health domain, we present information across five components: general health; risk behaviours; healthy behaviours; health assessment; and mental well-being. Under the general health component we present two indicators: sick-related absences from work and attending a GP.

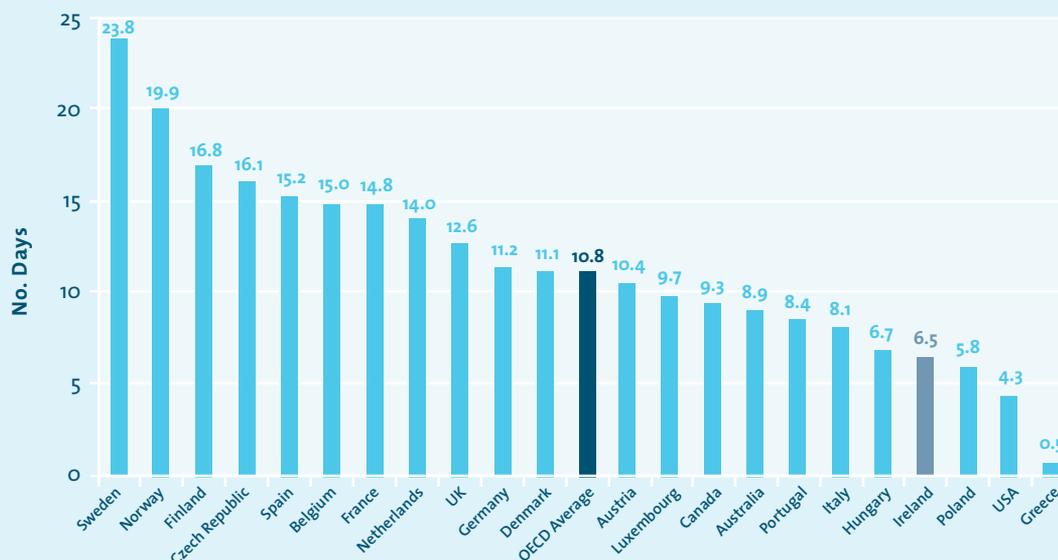
Sick-related Absences from Work

Figure 7.38 shows sick-related absences from work across selected OECD countries. Sick-related absences from work provide information about loss of labour supply as well as potential expenditures arising from sickness absences from work. They also provide evidence about workers' state of health, the extent of their job satisfaction and integration into the workplace (OECD, 2007a: 94). The indicator used here measures full-time employees who declare themselves temporarily absent from their job due to sickness. The measure is the average number of days lost per year by each worker in 2005.⁸⁹ The average number of days lost in Ireland at 6.5 was relatively low, compared to an OECD average of 10.8. The highest number of days lost was 23.8 in Sweden and the lowest in Greece at less than 1 day.⁹⁰ Women tend to be more prone to sickness absences than men – with 7.3 days absent from work in Ireland (OECD average is 12.9; Sweden is 31). Sick-related absences from work, when of long duration, may also lead to permanent withdrawals from the labour market (OECD, 2007a: 94). The share of respondents reporting labour market inactivity because of sickness and permanent disability rises with age.

89. There is no internationally agreed definition of sickness absences nor a unique data source to be used for international comparisons. The data used here have been compiled by the OECD from the European Labour Force Survey for 22 countries and national surveys for other countries, using data for 2005.

90. It is noted that factors influencing sick absences can include employment policy and legislation, work practices, the nature of the country's health system and cultural issues.

Figure 7.37 Sick-related Absences from Work, Selected OECD Countries, 2005



Source: OECD, 2007a: 95 (based on labour force surveys)

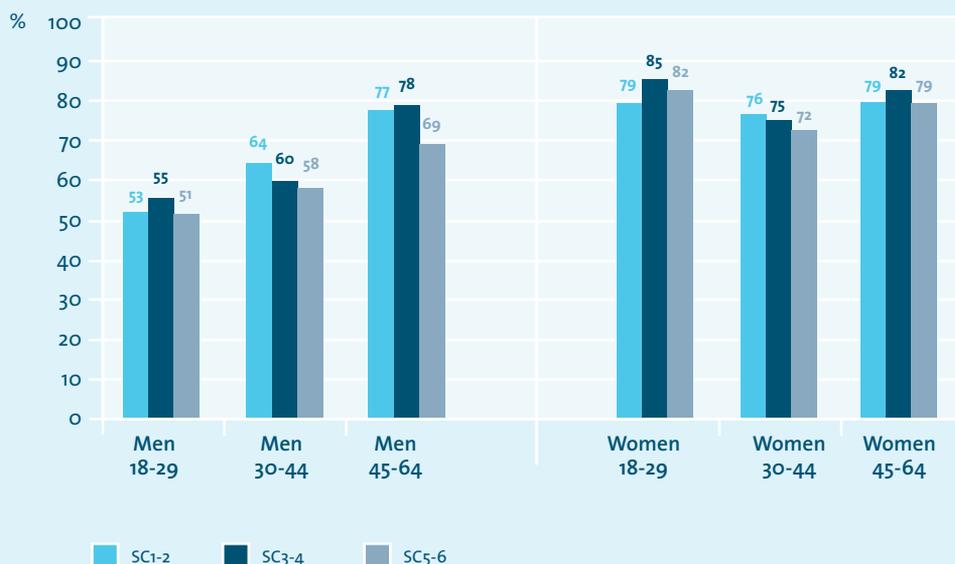
While a breakdown of the nature of the sickness related to being absent from work is not provided here, there has been increasing awareness in recent years of a high incidence of mental ill-health in the workplace (NESF, 2007b). Some studies have found that workers are more likely to be absent from work because of stress and anxiety than because of physical illness or injury. Causes of work place stress have been cited as cuts in staffing levels, rapid change in the work environment, long working hours, and bullying. Women may experience greater work stress as they often have greater responsibility for caring and domestic work (see section 7.5 of this chapter), as well as less control and discretion in the workplace (NESF, 2007: 91). There is a stigma attached to mental ill-health with an associated fear of disclosure. The evidence to date suggests that employers would welcome guidance and information on dealing with mental ill-health and promoting positive mental health. This may be even more challenging in a climate of economic recession.

Attending a GP

The second indicator on the general health component is attending a general practitioner (GP). Figure 7.38 shows the proportion of respondents in the SLÁN 2007 survey who had attended a general practitioner in the previous 12 months (Morgan *et al.*, 2008). Overall, 74 per cent of respondents had attended a GP, with a higher percentage of women (80 per cent) reporting attendance than men (67 per cent). For men, attendance increased with age but this age difference was not discernable for working age women. From this evidence there were no discernible social class differences (Morgan *et al.*, 2008: 38). In 2006 one fifth of 16 to 24 year olds had a medical card, rising to 30 per cent for 50 to 64 year olds. Some 42 per cent of 16 to 24 year olds had private health insurance, rising to 53 per cent for 50 to 64 year olds (CSO, 2007c: 23).

In 2007, over one quarter (27 per cent) of all adults aged 18 and over had neither a medical card nor private health insurance (CSO, 2008c: 1). Fifteen per cent of people at risk of poverty and 3 per cent of people living in consistent poverty had neither a medical card nor private health insurance (CSO, 2008b).

Figure 7.38 Percentage of Respondents who Reported Attending a GP within the Previous 12 Months, by Age, Gender and Social Class,⁹¹ 2007



Source Morgan *et al.*, 2008:94 (SLÁN, 2007)

Possession of a medical card has been found to be an important determinant of utilisation of GP services (Layte *et al.*, 2007). Examining GP visiting rates across the income distribution Nolan and Nolan (2005: 11) found that visiting rates were twice as high towards the bottom of the income distribution as towards the top, compared to other European countries where the ratio was 1.5. Ireland also stood out in relation to a sharp drop in visiting ratio from the second to the third decile, with the average number of visits falling from 6.6 to 3.6. Layte *et al.*,’s (2007: xxiii) analysis shows that having a higher income (among those without a medical card) made the probability of a visit to the GP in the year more likely, but high income does not increase the frequency with which a person visits a GP. They suggest that having a lower level of income significantly decreases the chance that a person will seek out any GP care at all rather than suppressing the frequency of visiting.

91. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

The cost may deter some people from visiting a GP even when they are sick. For example, the National Youth Council of Ireland reported that 20 per cent of 18-25 year olds did not attend the doctor when they were sick due to financial costs (National Youth Council of Ireland, 2009: 20). The proportion of people at risk of poverty who do not have a medical card or health insurance is worrying in this regard. An associated problem may be the ability to access a GP. For instance, many Travellers (up to 17 per cent) have experienced difficulty in registering with a GP, as in some areas only a small number of GPs provide services to Travellers (Department of Health and Children, 2002: 68).⁹²

Risk Behaviours

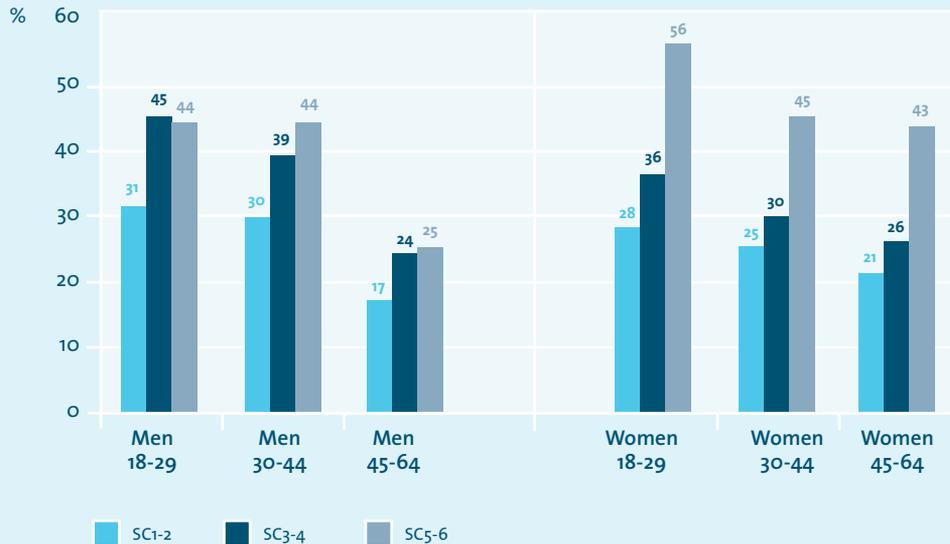
The second component in the health domain is risk behaviours. People's behaviours affect their well-being. The choices people have, and consequently their behaviours, are influenced by their socio-economic conditions, and other factors including the behaviour of their peers. Under the risk behaviour component we present three indicators: smoking; alcohol consumption; and being overweight/obese. We draw on the results of the 2007 SLÁN survey (survey of lifestyle, attitudes and nutrition).

Smoking

Figure 7.39 shows the percentage of smokers in 2007 by age, gender and social class. Overall, 29 per cent of the population report being cigarette smokers, and in general, men are more likely to smoke than women: 31 per cent compared to 27 per cent. There are higher rates of smoking among younger people (18-29) and those in semi-skilled and unskilled occupational groups. It is striking that more than half (56 per cent) of women aged 18-29 in semi-skilled and unskilled occupational groups smoke. This is worrying given the detrimental effect of smoking on health and the potential damaging impact on children. Smoking has declined in recent years (1998-2007) for most groups except for semi-skilled and unskilled women (Morgan *et al.*, 2008: 75).

92. An All-Ireland Traveller Health Study 'Our Geels' was initiated in autumn 2008.

Figure 7.39 Percentage of Smokers by Age, Gender and Social Class,⁹³ 2007



Source Morgan *et al.*, 2008: 75 (SLÁN, 2007)

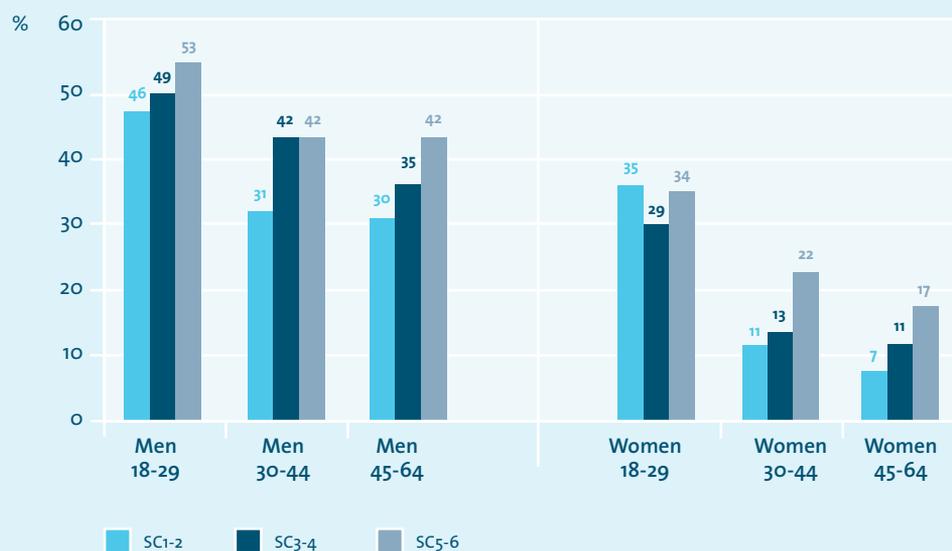
Alcohol Consumption

In relation to alcohol consumption, respondents who reported they drank alcohol were asked how often they had 6 or more 'standard'⁹⁴ drinks on one or more occasions per week, see Figure 7.40. Overall, more than one quarter (28 per cent) of those asked reported drinking to this level with a greater proportion of men (38 per cent) than women (17 per cent) consuming 6 or more 'standard' drinks per week. Younger people drink more heavily than their older counterparts, and people in semi-skilled and unskilled occupations tend to drink more than other social class groups. It is notable, however, that among women it is young professionals who are the heaviest drinkers, with more than a third (35 per cent) reporting that they had 6 or more drinks on one or more occasions in the last week. In general, the proportion of the population consuming this level of alcohol has fallen over the last 5 years, although it should be noted that there is a tendency to under-report the level of alcohol consumption (Morgan *et al.*, 2008: 81). Drinking alcohol can affect the health and well-being of the individuals involved as well as the health and safety of others, especially if operating machinery or driving. Heavy drinking can put a strain on relationships especially if it leads to financial stress or abuse.

93. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

94. A 'standard' drink is defined as one unit of alcohol, eg. half pint or glass of beer, cider or lager; a single measure of spirits; a single glass of wine, sherry or port; or a bottle of alcopop (long neck).

Figure 7.40 Percentage of Drinkers who Reported Having Six or More 'Standard' Drinks on One or More Occasions per Week, by Age, Gender and Social Class, 2007



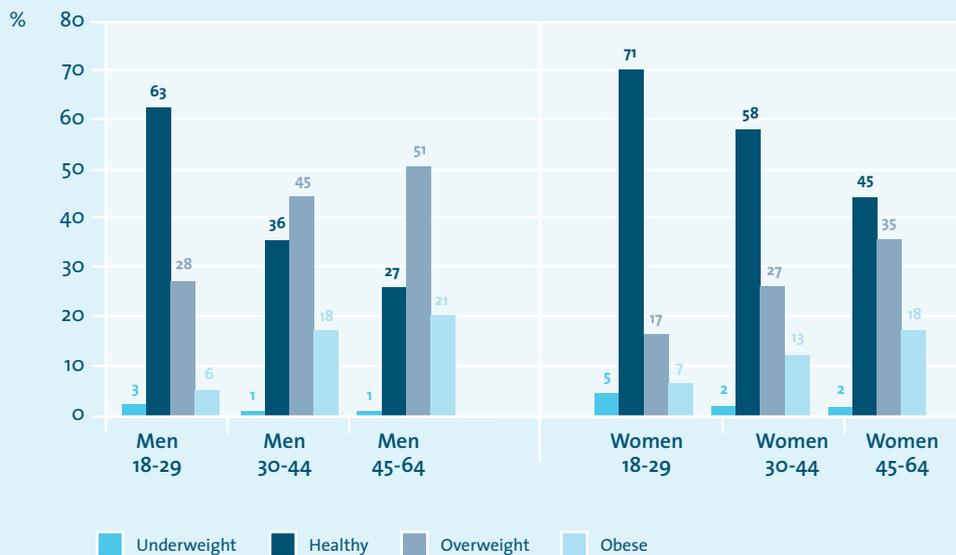
Source Morgan *et al.*, 2008: 81 (SLÁN, 2007)

Being Overweight or Obese

The third risk indicator examined is being overweight or obese. The results are shown in Figure 7.41. More than one third (36 per cent) of respondents reported themselves as being overweight and 14 per cent reported being obese.⁹⁵ Men are more likely to be overweight (43 per cent) or obese (16 per cent) than women (28 per cent overweight and 13 per cent obese). Being overweight or obese was found to increase with age, for both men and women. The percentage of the population reporting being overweight has increased in recent years (2002 to 2007), while those reporting being obese has stayed the same (Morgan *et al.*, 2008: 99).

95. As part of the SLÁN data collection exercise BMI (Body Mass Index) was also independently measured for a sub sample of respondents. In line with other international studies the self reported data tended to underestimate prevalence of being overweight or obese compared to the independently measured data.

Figure 7.41 Body Weight by Age and Gender, 2007



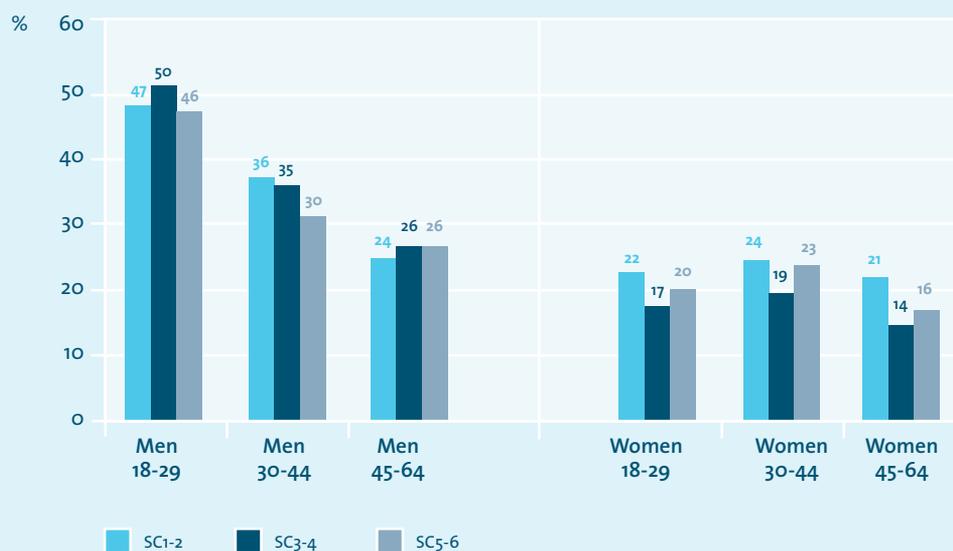
Source Morgan *et al.*, 2008: 99 (SLÁN, 2007)

Being overweight or obese can contribute to health problems. SLÁN also collected data (measured by a nurse) on obesity, blood pressure and cholesterol levels for a sub sample of respondents aged 45 years and over. Some 82 per cent of these respondents were found to have raised cholesterol; 60 per cent had raised blood pressure; and 32 per cent were obese. Some 18 per cent had all three cardiovascular risk factors.

Healthy Behaviours – Physical Exercise

The third component on the health domain is healthy behaviours. Two indicators are presented: physical activity and nutrition. Healthy behaviours such as physical exercise and good nutrition can reduce health risk factors and promote good health and well-being. Figure 7.42 shows the percentage of respondents in the SLÁN survey with high physical activity scores – over 10,000 steps per day. Overall, 24 per cent of respondents had high activity scores, with twice as many men (32 per cent) having this level of activity compared to women (16 per cent). Younger men had higher levels of physical activity and this decreased with age; contrasting with a lower level of physical activity by women across all age groups. There was little variation by social class. Some 22 per cent of respondents were inactive. Reasons given for inactivity were lack of time (41 per cent) followed by injury/disability or a medical condition (18 per cent) (Morgan *et al.*, 2008: 52).

Figure 7.42 Percentage of Respondents with High Physical Activity (IPAQ⁹⁶) Scores by Age, Gender and Social Class, 2007



Source Morgan *et al.*, 2008: 51 (SLÁN, 2007)

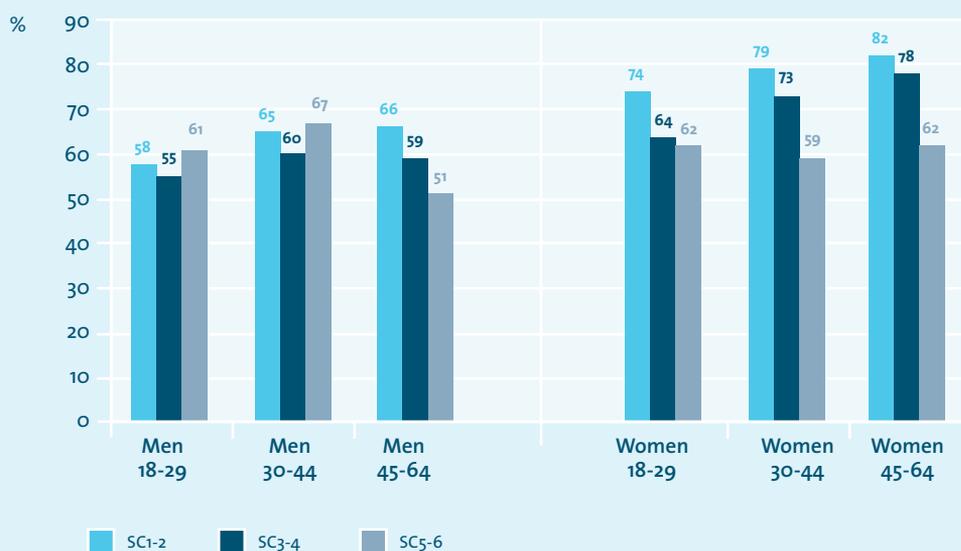
Research by the ESRI (Lunn and Layte, 2008) found that the number of people engaged in exercise activities increased ‘dramatically’ over the last twenty years. Younger people today are more likely to participate in sport than the previous generation. The tendency is to play team sports in youth and to participate in individual sports (walking, aerobics, swimming, jogging, going to the gym) in adulthood. The ESRI identified gender and socio-economic trends. Girls are less likely to play team sports than boys but adult women are as likely as adult men to participate in sport, particularly individual sport. The ESRI found a gap between socio-economic groups, with lower socio-economic groups less likely to participate in sport, and that this gap endures across the life cycle.

Nutrition

Diet also plays an important role in maintaining a healthy life style. Healthy eating is guided by the ‘Food Pyramid’ which recommends 5 or more daily servings of fruit and vegetables. Figure 7.43 presents the percentage of respondents to the SLÁN survey consuming 5 or more daily servings of fruit and vegetables. Overall, 65 per cent of respondents reported this consumption level, with women (71 per cent) more likely to consume at least 5 daily servings than men (59 per cent). There is a slight variation with age – younger age groups are less likely to consume this level of fruit and vegetables. There is also a small gradation by social class where professionals are more likely to consume fruit and vegetables than those in semi or unskilled occupations (Morgan *et al.*, 2008: 64).

96. IPAQ is the International Physical Activity Questionnaire.

Figure 7.43 Percentage of Respondents Consuming Five or More Daily Servings of Fruit and Vegetables, by Age, Gender and Social Class, 2007

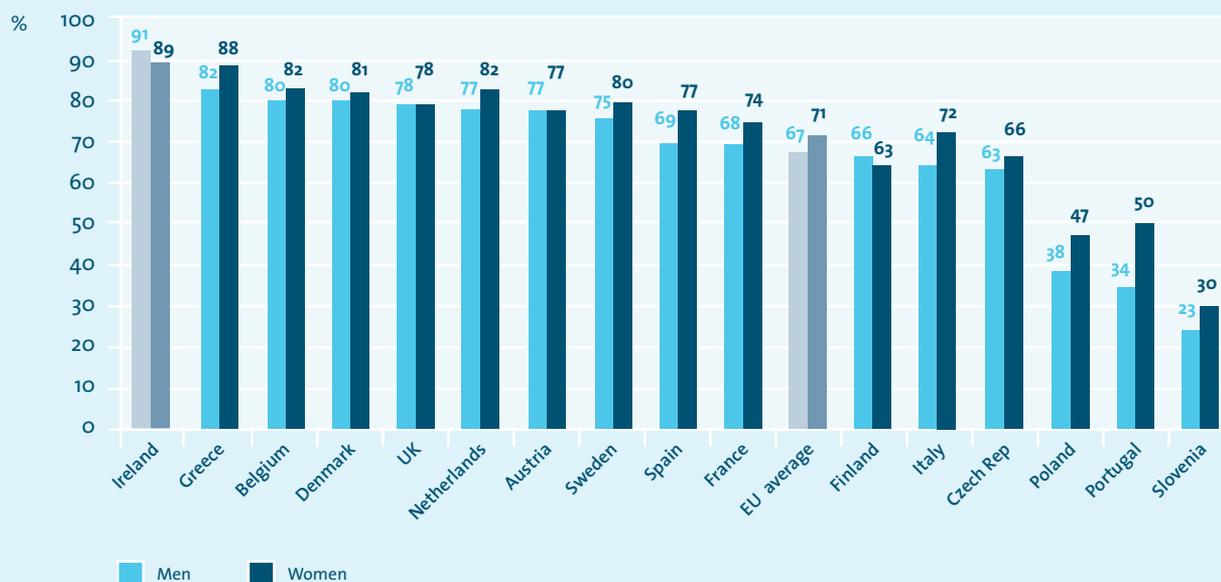


Source Morgan *et al.*, 2008:64 (SLÁN, 2007)

Perception of Health

The fourth component on the health domain is health assessment, measured by an indicator on perception of good health. Figure 7.44 presents information on the percentage of 25 to 64 year old men and women in European countries who perceived themselves to be in good health (2004). Some 91 per cent of Irish men and 89 per cent of Irish women believed they were in good health, higher than any other European nation. Similar percentages for Ireland were found in a more recent survey of self perceived health status undertaken by the CSO in 2007 (CSO, 2008c: 2).

Figure 7.44 Percentage of Men and Women Aged 25-64 Who Perceive Themselves to be in Good Health, EU Comparisons, 2004

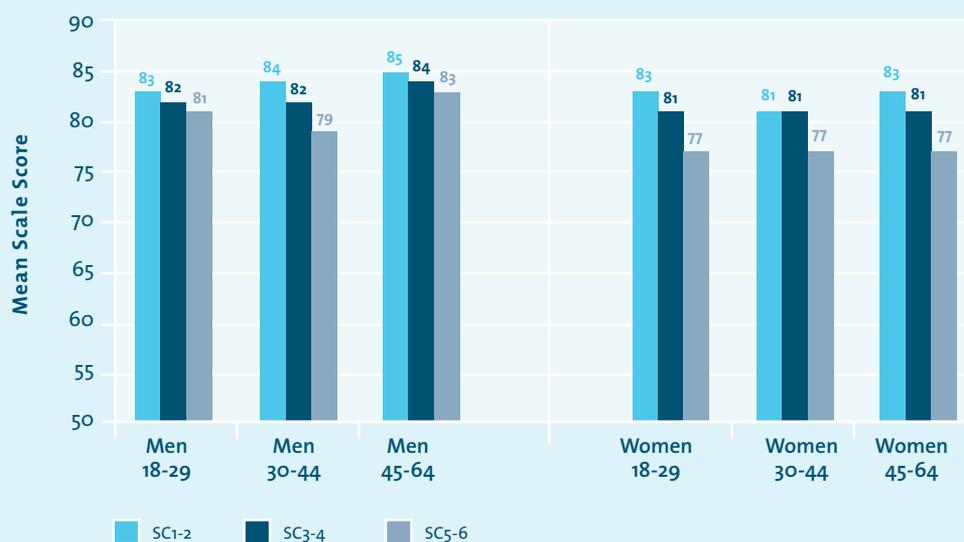


Source Eurostat Health Interview Surveys

Mental Well-being – Psychological Distress

The fifth component on the health domain is mental well-being. The indicator used to measure mental well-being is psychological distress, drawing again from the SLÁN survey, 2007. Respondents were asked questions such as whether they felt ‘particularly nervous’ or ‘downhearted and miserable’ in the previous four weeks. Higher scores indicate less psychological distress. The results are presented in Figure 7.45. The average score was 82 suggesting relatively low levels of psychological distress. There is little variation across age groups or gender (men scored 83 and women 81), while professionals had higher scores than those in semi-skilled and unskilled occupations. Mental health problems are still seen as stigmatising — two thirds of respondents would not want people to know if they were having mental health problems (Morgan *et al.*, 2008: 3).

Figure 7.45 Mean Score on Mental Health Index Scale, by Age, Gender and Social Class⁹⁷
(Higher scores indicate less psychological stress)



Source Morgan *et al.*, 2008: 75 (SLÁN, 2007)

Summary

Full-time employees in Ireland were absent from work for an average of 6.5 days per year due to sickness. This was relatively low, compared to an OECD average of 10.8 days. There has been an increasing awareness in recent years of a high incidence of mental ill-health in the workplace. Causes of workplace stress have been cited as cuts in staffing levels, rapid change in the work environment, long working hours, and bullying. The economic recession can be expected to add to workplace stress.

Three quarters of respondents to the SLÁN 2007 survey had attended a GP in the last year, with women more likely to attend than men. The cost may deter or prevent some people attending a GP – 24 per cent of the population has a medical card, 44 per cent has private health insurance, 5 per cent has both, and just over one quarter (27 per cent) has neither, including 15 per cent of people at risk of poverty. Some people may have difficulty accessing GP services in their area.

In general, men and women in Ireland aged 25-64 perceive themselves to be in good health. In relation to mental health relatively low levels of psychological distress were identified by the SLÁN survey (2007). People in semi-skilled and skilled occupations were more likely to experience psychological distress than people in professional occupations. It should be noted that this survey preceded the onset of the economic recession.

97. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

People's behaviours can promote healthy living or put their health at risk. The choices people have, and consequently their behaviours, are influenced by their socio-economic conditions. Risk behaviours include smoking, consuming excessive alcohol and being overweight. Some 29 per cent of the working age population smoke and some 28 per cent consume excessive alcohol with rates for both generally higher for men, young people and people in semi-skilled or unskilled occupations. The prevalence of both smoking and excessive drinking has declined slightly in recent years, up to 2007 (the most recent year for which data are available). Half of the working age population have weight issues with 36 per cent being overweight and 14 per cent obese. Some 59 per cent of working age men are overweight or obese compared to 41 per cent of working age women.

Smoking, drinking excessively and being overweight have a negative impact on health. Exercise and good nutrition can help – although conversely, lack of exercise and poor nutrition can contribute to being overweight and to poor health. One quarter of the working age population has high physical activity levels with men having higher activity levels than women. Some 22 per cent of the working age population are inactive with time being given as the main reason for inactivity. Levels of physical activity have increased in recent years and the nature of activity has also changed, especially for women, with a preference for individual activities such as swimming, walking and going to the gym rather than team sports. Unskilled socio-economic groups are less likely to participate in physical activity than professional socio-economic groups. In relation to diet, two thirds of the working age population eat 5 or more servings of fruit and vegetables every day, with women, older adults and professionals more likely to eat healthily.

7.8.2 Ireland's Policy Framework for Health

Towards 2016 contains the long-term goal that:

Every family would have access to health and social care.

Specific actions include improvements in health care provision, particularly primary care. This will entail: a person-centred primary care service delivered through multi-disciplinary teams and networks; service development and delivery informed by needs assessment; reductions in waiting times for public patients; an increase in acute hospital bed capacity, with a focus on public beds for public patients; development of a high quality community-based mental health service; improved support for people on low incomes to access health services, including a review of medical cards; a strategic integrated approach to rehabilitation services to support people back into employment; and development of palliative care.

Towards 2016 does not contain a long-term goal on behaviours and life style issues for working age people, but does contain health promotion actions and focuses attention on the needs of young adults (18-29). On health promotion there is a commitment to work in partnership to develop specific community and sectoral initiatives to encourage healthy eating and access to healthy food and physical activity among adults, especially for people living in areas of disadvantage. For young adults there are actions related to combating substance abuse, reducing alcohol related harm, and implementing the *National Strategy for Action on Suicide Prevention*.

The National Development Plan contains commitments to provide investment towards the provision of sport and recreational facilities on a nationwide basis to contribute, as a preventative measure, to a healthier nation conscious of the benefits of a healthy and active lifestyle. There are also resources available for local and community development, including the drugs strategy and young people's facilities and services fund. The recession has led to a reduction in the resources allocated to some of these initiatives.

7.8.3 Commentary on Health for Working Age Adults

The indicators employed to assess health well-being show Ireland to be a relatively healthy nation and to have a positive attitude towards their health. Indicators have not been employed to show the efficiency and effectiveness of the health service, as an overall indicator to measure this aspect of access to health and quality of provision is not yet available.⁹⁸ The commitments to improve health care provision, particularly primary care are welcomed, but the challenge is in delivering these commitments in a timely, integrated, user-oriented fashion, especially in the context of a recession. An ongoing challenge is to find an appropriate balance between preventative and curative health measures.

In terms of reducing risk behaviours and promoting healthy behaviours there is an important message in relation to reducing smoking and excessive alcohol consumption, promoting healthy eating and taking exercise to address health concerns related to being overweight and to engender good health and well-being. The policy framework recognises these issues.

Nevertheless, there is an ongoing need to address issues related to the availability and affordability of healthy food and the provision of affordable facilities to encourage physical exercise. There is scope to encourage and support volunteering with regard to physical activity, as identified earlier, but attention also needs to be given to the identified lack of time and supporting a positive work-life balance.

⁹⁸. There are many indicators on aspects of the health service but an overall indicator has not yet been developed. Work is ongoing between the Department of Health and Children and the Central Statistics Office to develop a set of health accounts.

7.9 Democracy and Values

7.9.1 Measuring Democracy and Values for People of Working Age

The sixth domain is democracy and values. The exercise of democracy, living in a peaceful and safe society, lack of discrimination and a sense of inclusion contribute to individual and collective well-being. In this section we present three components: exercising democracy; threats; and equality.

Satisfaction with the Democratic Process

Three indicators are presented for exercising democracy: satisfaction with the democratic process; tensions between people and trade union membership. The OECD has analysed data from the Eurobarometer surveys for 1980-2005 on satisfaction with the democratic process (OECD, 2007a).⁹⁹ The findings are presented in Figure 7.46 for selected countries.

Figure 7.46 Percentage of Respondents that are either 'Satisfied' or 'Very Satisfied' with the Democratic Process, EU Comparisons, 1980-2005



Source: OECD, 2007a: 113 (<http://dx.doi.org/10.1787/020765758801>)

99. 'Satisfaction with the democratic process' refers to the way democracy works in their particular country. As well as relating to the role of political institutions (government and parliament) and public administration it includes citizen involvement and participation in public affairs and reforms to make public services more open, transparent and client-oriented.

The graphic shows that 71 per cent of Irish respondents were happy with the democratic process in 2005 – this had increased from less than 50 per cent in the 1980s, with a large increase in the 1990s. The Danes were the most satisfied with the democratic process (92 per cent in 2005), while less than half of Italians (44 per cent in 2005) were happy with their democratic process, although this had been improving in recent years from a low of 20 per cent in 1995. Most countries have seen an improvement over the years – but this was not the case in Germany where satisfaction had declined from 78 per cent in 1990 to 53 per cent in 2005. France also saw a decline from 2000 to 2005.

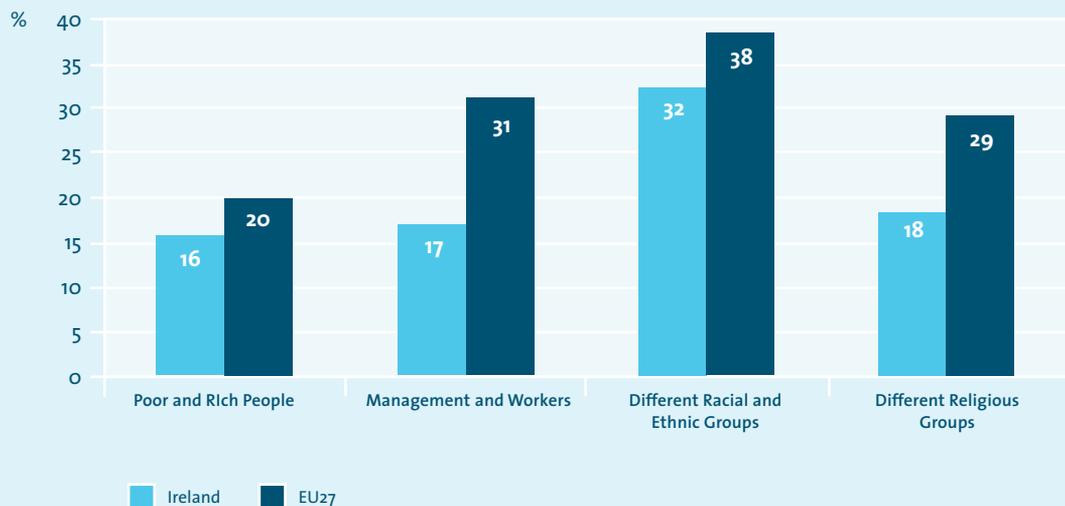
The global economic crisis may have influenced people's satisfaction with the democratic process, but data are not yet available to assess the nature or extent of any change. The OECD (2007a: 112) note that citizens often ask for more involvement and participation in public affairs. They suggest that trends in satisfaction with the democratic process may reflect the extent to which countries are introducing reforms to make public services more open, transparent and user-friendly. A 'democratic audit' undertaken by TASC (2007)¹⁰⁰ reported that Ireland has a high level of stated public commitment to democratic values, a largely free, fair and representative electoral system and that citizens are largely well protected by the rule of law. However, there has been a declining voter turn out, there are low levels of party political activism and engagement, a weak system of parliamentary oversight of public bodies, and limited democracy at local level. Work is currently being undertaken by the NESF to explore local participatory governance in Ireland.

Tensions Between Groups in Society

The second indicator on the exercising democracy component is tensions between people, see Figure 7.47. In the European Quality of Life Survey people were asked to rate the level of tension between the various groupings presented in Figure 7.47 (European Foundation, 2009). Across the EU27 less than one third of respondents perceived a lot of tension between rich and poor people, management and workers and different religious groups. Nearly 4 in 10 respondents perceived a lot of tension between different racial groups. In Ireland, fewer respondents than at EU27 level felt there was a lot of tension between the various groupings: less than 20 per cent perceiving a lot of tension between rich and poor, management and workers and different religious groupings, with one third perceiving a lot of tension between different racial and ethnic groups. It should be borne in mind that the survey was undertaken in 2007, before the economic recession. The recession has the potential to heighten tensions between different groupings in society if not sensitively managed.

100. The democratic audit was initiated in 2004 and reported in 2007. Seventy different questions were used as measures and the answers derived from many and varied sources, including government statistics, international surveys, legislation, NGO information, and academic analyses.

Figure 7.47 Respondents Perceiving a Lot of Tension Between Groups in Society, EU Comparisons, 2007

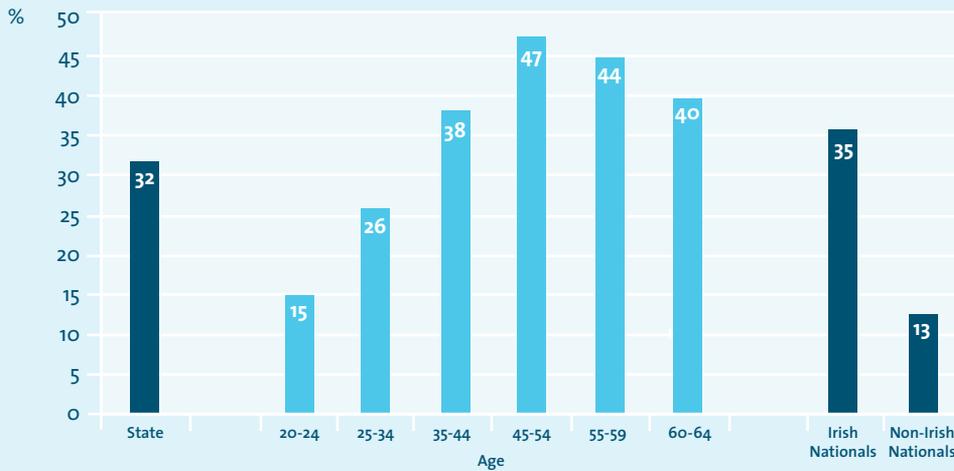


Source: European Foundation, 2009: 58 (EQLS, 2007)

Trade Union Membership

One area where people of working age can exercise democracy is in relation to trade union membership. Trade union membership is an important element of the relationship between management and workers and has made a significant contribution to industrial peace. Relationships between employers and workers have become all the more important in a recession. Figure 7.48 presents the percentage of employees who are union members by age and nationality. Just under one third (31.5 per cent) of employees were members of a trade union in 2007 – this proportion had fallen from 37.4 per cent in 2003. Full-time employees (34.6 per cent) are more likely to be members of a trade union than part-time employees (19 per cent). Across age groups younger people are less likely to be members of trade unions with about a quarter of under 35 year olds belonging to a union. Nearly half (47 per cent) of 45-54 year olds were members of a trade union. Trade union membership is low among non-Irish nationals with only 13 per cent claiming trade union membership. Membership levels also varied greatly according to economic sector. Just over 79 per cent of employees in the public administration and defence sectors had trade union membership, compared to only 8 per cent in the hotels and restaurants, and agriculture, forestry and fishing sectors.

Figure 7.48 Percentage of Employees Who Are Trade Union Members, by Age and Nationality, 2007



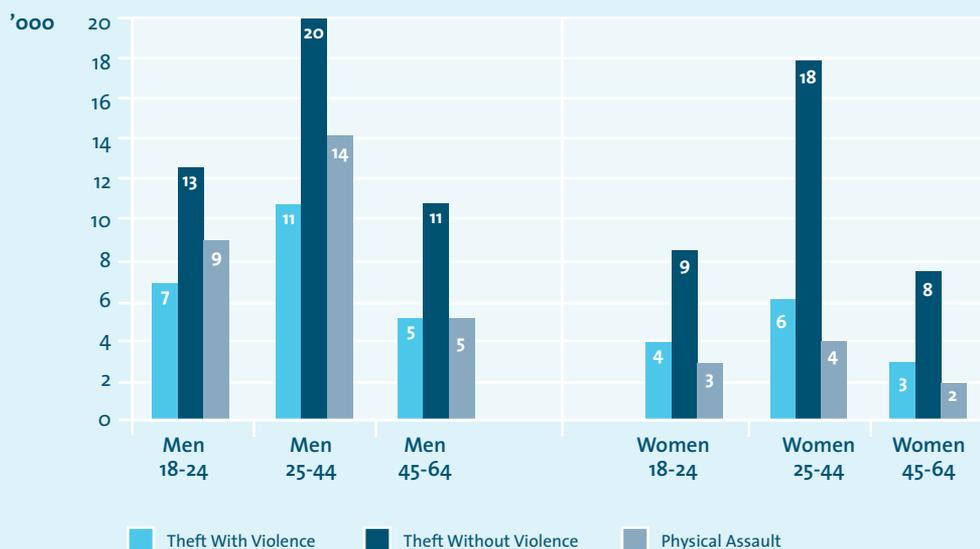
Source: CSO, 2008g (QHNS Q2 2007).

Victims of Crime

The second component of the democracy and values domain is threats which undermine well-being. In Chapter 4 we presented indicators on recorded crime incidents, trends in numbers of victims of crime, people's perception of safety and domestic violence. Here two indicators are presented for people of working age: victims of crime; and perception of crime. Figure 7.49 presents information on victims of crime by age, gender and type of crime for 2006 (before the economic recession). Men are more likely to be victims of crime than women, and people (whether men or women) in the 25 to 44 age group are most likely to be victims of crime. The most common crime is theft without violence—some 82,500 people were a victim of this crime¹⁰¹ (2.8 per cent of men and 2.3 per cent of women). It is notable that 3.9 per cent of 18-24 year old men were the victims of physical assault, compared to 1.8 per cent of men overall and 0.5 per cent of women overall (CSO, 2007j: 5).

101. Includes 5,300 people aged 65 and over who were victims of this crime, as well as the 77,200 people aged 18-64.

Figure 7.49 Victims of Crime by Age, Gender and Type of Crime, 2006



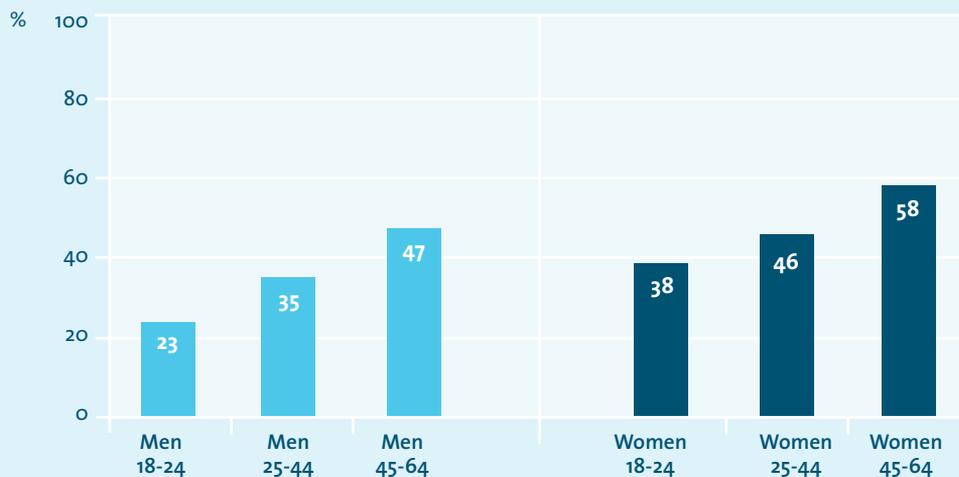
Source CSO, 2007j; 5 (QNHS, 2006)¹⁰²

Perception of Crime

The second indicator presented on threats is perception of crime, see Figure 7.50. Overall, in Ireland in 2006, 46 per cent of people aged 18 and over thought crime was a very serious problem. Women were more likely to think this than men (52 per cent compared to 40 per cent) and perceptions of crime being a very serious problem increased with age, with 58 per cent of 45-64 year old women considering this to be the case.

102. The collection, interpretation and presentation of crime statistics is complex. Crime statistics can be provided from administrative sources eg. garda statistics or from surveys. Garda statistics can only reflect crimes which become known to them or are reported to them, but they are generally the most up to date. Crime statistics can also be collected through crime and victimisation surveys. The results presented here are from the CSO Crime and Victimisation Survey carried out as a QNHS module in 2006. The CSO survey asks people aged 18 and over about crime. It does not include questions on domestic violence or sexual assault. The EU International Crime Survey asks people aged 16 and over and includes domestic violence and sexual assault. Crime rates are slightly higher from this source as it is likely that those in their late teens can be more vulnerable than average to some crime types. The CSO is likely to include those 16 and over in future Crime and Victimisation surveys and will also ask about sexual and domestic assault (including the offer of specific supports, if required).

Figure 7.50 Perception of Crime as a Very Serious Problem, by Age and Gender, 2006



Source CSO, 2007j: 22 (QNHS, 2006)

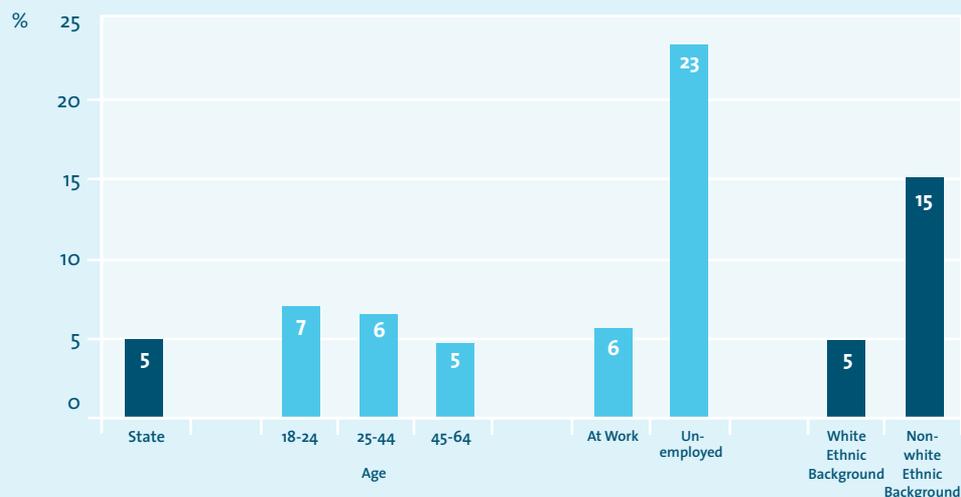
Workplace Discrimination

The third component on the democracy and rights domain is equality. In Chapter 4 we presented indicators on the gender wage gap, women in decision-making, and experience of discrimination by ethnic minorities. Here we present two indicators: workplace discrimination; and intercultural dialogue. Treating people less favourably or unfairly because of certain characteristics can have a detrimental affect on their well-being. Findings from a special module of the Irish QNHS on equality in 2004 found that 5 per cent of the Irish population aged 18 and over experienced work-related discrimination in the past two years, see Figure 7.51. Work-related discrimination relates to discrimination 'in the workplace' or when 'looking for work'. Some 23 per cent of unemployed people and 15 per cent of people from a non-white ethnic background experienced work-related discrimination. Seven per cent of 18-24 year olds experienced work-related discrimination compared to 5 per cent of 45-64 year olds (CSO, 2005).

In relation to the grounds for discrimination 51 per cent reported work-related discrimination on the grounds of race / skin colour / ethnic group / nationality. Some 38 per cent reported 'other' grounds, which included sexual orientation, membership of the Traveller community, and religious beliefs. Age and gender grounds were cited by 38 and 37 per cent of respondents reporting discrimination, respectively, with disability and family status cited by 35 per cent and 32 per cent, respectively.¹⁰³

103. It should be noted that multiple responses were allowed for grounds of discrimination.

Figure 7.51 Experience of Work-related Discrimination Experienced in the Last Two Years, 2004



Source CSO, 2005 (QHNS, Q4, 2004)

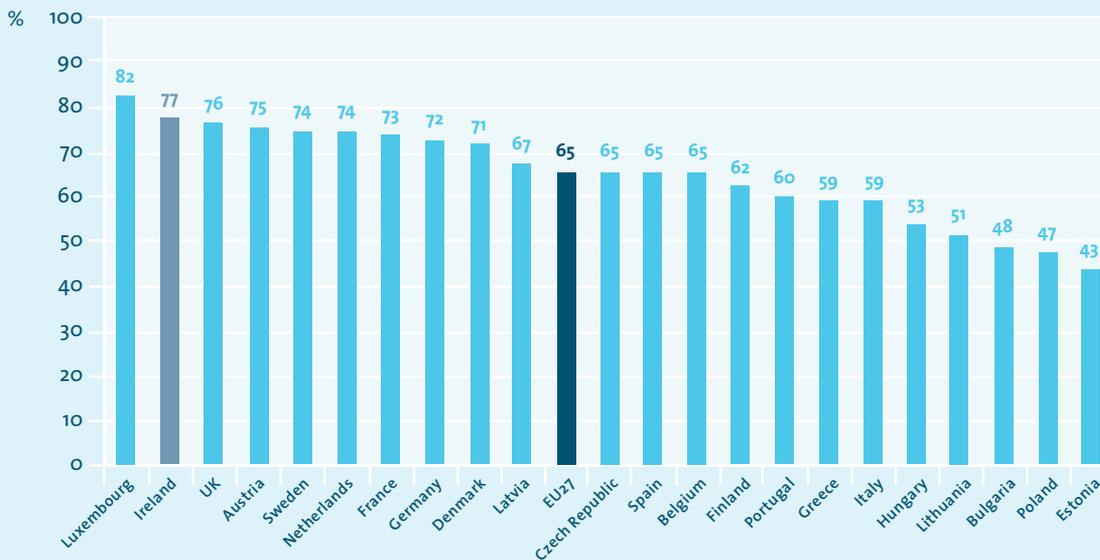
Further analysis of the QHNS Equality module by Russell *et al.*, (2008) provides a deeper understanding of discrimination. The authors note that respondents of black ethnicity have the highest risk of discrimination, in accessing services, as well as in looking for work. Unemployed people have a high risk of discrimination, but the unemployed are not currently covered by the equality legislation. This information was collected and analysed before the onset of the recession.

More recent research by the ESRI, published by the Equality Authority (McGinnity *et al.*, 2009) found that job candidates with Irish names were more than twice as likely to be called to interview for advertised jobs than candidates with identifiably non-Irish names, even though both submitted equivalent CVs. The authors concluded that the extent of discrimination observed in the experiment contradicts any notions of equality in terms of access to employment. They note that individuals with minority backgrounds do not have equal access to the Irish labour market if they are being screened out at the first stage of recruitment, and therefore that the skills of immigrants are not being used to their full potential.

Intercultural Dialogue

The second indicator on the equality component of the democracy and values domain is intercultural dialogue. A flash eurobarometer survey on intercultural dialogue in Europe, carried out in November 2007, found that almost three quarters of EU citizens believe that people with a different background (ethnic, religious or national) enrich the cultural life of their country (European Commission, 2007b). Across Europe, Irish and Luxembourgish respondents agreed most that the presence of people from various backgrounds enriched the cultural life of their nation. The survey also found that day to day interaction among people of different cultures is now a reality, see Figure 7.52. Two thirds (65 per cent) of respondents in the EU27 were able to recall any interaction with at least one person either of a different religion, ethnic background or nationality (either EU or non-EU) other than their own in the seven days prior to being interviewed. The member states that had the highest percentages of citizens having interaction were Luxembourg (82 per cent) and Ireland (77 per cent), followed by the UK and Austria.

Figure 7.52 Percentage of Respondents Having Any Interaction With At Least One Person of a Different Culture, Selected EU Countries, 2007



Source: European Commission (2007b), Flash Eurobarometer 217

Summary

Seventy per cent of Irish people are satisfied with the democratic process. Satisfaction with the democratic process in Ireland has been increasing over the last 25 years and Ireland has one of the highest satisfaction levels in Europe, behind the Nordic states. The global economic crisis may have influenced people's satisfaction with the democratic process, but data are not yet available to assess the nature or extent of any change. Other evidence suggests that democracy is more limited at local level.

Just under 20 per cent of people in Ireland perceived a lot of tension between rich and poor, between management and workers and between different religious groups, while one third thought that there was a lot of tension between different racial and ethnic groups. Overall, people in Ireland thought there was less tension between the various groupings than across the EU27 as a whole. The survey was undertaken before the onset of the recession.

In 2007, just under one third of employees were members of a trade union, showing a decline from earlier years. Part-time, younger and non-Irish nationals were less likely to be trade union members than full-time, older and Irish national employees.

In relation to threats to well-being men are more likely to be victims of crime than women, and people (whether men or women) in the 25-44 age group are most likely to be victims of crime. In 2006, 46 per cent of people aged 18 and over thought crime was a very serious problem. Women were more likely to think this than men and perceptions of crime being a very serious problem increased with age.

Discrimination in the work place or in looking for work can impact negatively on people's well-being. Some 5 per cent of the population has experienced work-related discrimination, with the unemployed and people from a non-white ethnic background experiencing substantially higher levels of discrimination. Recent research (McGinnity *et al.*, 2009) found that job candidates with Irish names were more than twice as likely to be called to interview for advertised jobs than candidates with identifiably non-Irish names, even though both submitted equivalent CVs. In relation to intercultural dialogue almost three quarters of EU citizens believe that people with a different background (ethnic, religious or national) enrich the cultural life of their nation. At 77 per cent, Ireland is the second highest EU27 country (after Luxembourg) to have an interaction with at least one person of a culture other than their own in the last seven days.

7.9.2 Ireland's Policy Framework for Democracy and Values

The national partnership agreement *Towards 2016* states that the achievement of a fairer society and equality for all citizens is a key principle of the partnership approach, noting that the achievement of true equality requires a holistic approach and a society-wide understanding of the complementary roles and skills of both men and women. *Towards 2016* contains the long-term goal that:

Every person, irrespective of background or gender, would enjoy equality of opportunity and freedom from discrimination.

Specific actions are to promote greater gender equality, to support and strengthen equality actions across the nine grounds, and to improve data on equality. Innovative measures include the integration of migrant communities, promotion of information and communications technology, and an integrated approach to providing services and supports to Travellers.

7.9.3 Commentary on Democracy and Values

The exercise of democracy and confidence in the fairness of the institutions of the state are important for the individual and collective well-being of people of working age. Equality and inclusion are central in this regard. The policy commitments in *Towards 2016* recognise this.

However, in order to deliver on these commitments in the context of the recession there is a need: for renewed confidence in the democratic process and the institutions of the state; for the social partners to work together in the spirit of partnership and respect; to address the blight of discrimination; and to ensure the safety of citizens. Ireland has become a multi-cultural country, and while the evidence suggests that there is relative harmony between Irish and non-Irish nationals, there is a need for ongoing work to ensure the promotion of intercultural policy, especially where there may be competition for services and jobs.

As recognised in *Towards 2016* there is an ongoing need to continue to improve data and monitoring in the areas of equality and inclusion to ensure that the long-term goals of equality of opportunity and freedom from discrimination are met.

7.10 Conclusion

This chapter has provided an overview of the well-being of people of working age across six aspects of their lives: economic resources, work and participation, relationships and care, community and environment, health, and democracy and values. As in the previous chapter it seeks to link these trends to the policy framework, *Towards 2016* in particular, and to comment on policy and data issues arising.

Demographically, in 2006 there were more than 2.7 million people of working age (aged between 18 and 64) in Ireland, which was nearly three quarters of the population (73.2 per cent). The working age population is very diverse, but two key groups have been identified: young people in a transitional phase of their lives (18-29 year olds) and mature or ‘anchor’ adults (30-64 year olds) characterised by their responsibilities and contributions to their families, their communities and to society. Within these broad categories there is much diversity. In relation to social expenditure, Ireland’s income support to the working age population as a percentage of GDP stood at 5.6 per cent, which was slightly above the OECD average of 5.0 per cent (2003). In 2008, there were more than 500,000 recipients of income support benefits for people of working age, an increase of 29 per cent over 2007. With regard to their satisfaction with life, 90 per cent of the working age population reported their life as good (2007).

Key elements of *economic well-being* are having an adequate level of income to participate in Irish society, to be able to participate on a par with your peers, and to be able to provide for yourself and your family now and in the future. Incomes for people of working age are relatively high compared to other life cycle groups but the diversity within this group is notable. While the majority of the working age population should be in a position to prepare for older age, half of women in paid employment and two fifths of men in work have no pension provision other than the state pension. Economic well-being was also examined in relation to poverty. Even though the majority of working age people have an adequate income there are particular sub groups of the population at risk of poverty, particularly lone parents (mainly women) and people who are unemployed. A job is not a guarantee of lifting people out of poverty as about 7 per cent of people who are working are at risk of poverty, and just under one third of all households at risk of poverty are headed by a person in employment. A significant minority of people of working age (up to one quarter of women of working age) have difficulty in making ends meet.

In the context of the recession there is an ongoing challenge to maintain income at levels which will keep people out of poverty, at the same time as supporting people into education, training and work. Consideration needs to be given to replacement rates, and the importance of providing people with an incentive to work. One of the key issues to be addressed is the increase in debt and indebtedness, leading to heightened levels of economic stress, which have a detrimental impact on well-being.

Work and participation are important for well-being with the extrinsic and intrinsic rewards such participation brings. Nearly three quarters of men (71 per cent) and just over half of women (53 per cent) aged 15 and over participate in the labour force. Women's employment rates are affected by the presence of children. In seeking to balance work and life women often have to 'adapt their professional choices to their personal circumstances', for example, by working part-time, and spending considerable time on unpaid work such as caring for children and housework. For instance, while more than three quarters of both Irish men and women are relatively satisfied with their hours of paid work, only two thirds of Irish women are satisfied with their free time, (compared to three quarters of men).

Unemployment has one of the worst negative impacts on well-being, which is particularly worrying in the context of the recession. There has been a large increase in the numbers of people who are unemployed – for men and women of all ages, but especially men aged 25-44, and non-Irish nationals. Unemployment rates are particularly high in the younger age groups. Long-term unemployment is also showing an increase. Increases in unemployment are reflected in substantial increases in the numbers of people claiming Jobseeker payments. While people who face various contingencies in their lives are entitled to income supports and associated services, a significant challenge is to provide people who are, or become unemployed, with opportunities and choices to engage in meaningful activity.

Participation in education and training has the immediate benefits of achievement but also provides a currency to become established in the workplace and to progress in life. The highest qualification of 37 per cent of unemployed men is lower secondary or below. Unemployed women are better qualified – 18 per cent have lower secondary or below as their highest qualification, while 30 per cent have a degree compared to 17 per cent of men. To some extent this reflects the increasing unemployment rates among graduates, which is an aspect of the economic recession. Participation in life-long learning is relatively low at 8 per cent and most of these participants are already in work. People who participate in life-long learning tend to be those who are already relatively well qualified. Cost barriers have been identified, especially for those in the lower socio-economic groups. A notable feature of educational achievement and participation is the extent to which women achieve better and participate more than men, yet women get lower rewards from the labour market and have greater demands on their time.

In the context of the recession, the overall challenge is on creating and retaining jobs, and providing an immediate and tailored response to people who become or are unemployed. A range of initiatives are already underway, but there is a challenge to meet the scale of the response required, especially in the context of an overall reduction in public expenditure. While the challenge of encouraging and supporting the participation of working age people during a recession is not to be under-estimated it does provide an opportunity to address structural and institutional weaknesses and to re-organise our systems to be more flexible and tailored, but at the same time supportive, to meet the diverse range of needs. Such an approach would be beneficial to the well-being of individuals and to wider society.

Relationships and care have a strong influence on well-being. Stable affective relationships have a beneficial impact on well-being while disharmony and the severing of relationships can have a very damaging effect. The nature of relationships in Ireland has changed: people are choosing to cohabit as a relationship choice or as a precursor to marriage; people are separating/divorcing and forming new relationships; people are having children later in life; and more people are parenting alone, by choice or circumstance. Policy needs to adapt to these changed circumstances to ensure that people have security and supports for themselves and their families when they need them. In general, Irish people are satisfied with family life.

Caring is an important aspect of well-being in society – both for the carer and those being cared for. In relation to caring, more than one fifth of lone parents said they would like to change their work/caring balance, in the main to work more. Nearly 10 per cent of couples with children would like to increase their care and work less. Focusing on caring in relation to disability, illness and old age there are 161,000 carers in Ireland, just under 30 per cent of whom are in receipt of a carers payment. Many carers combine caring roles with paid employment or unpaid responsibilities in the home. The majority of carers and those in receipt of carers payments are women. Carers provide an invaluable service to those they care for, but it is a demanding and emotional responsibility.

People's living circumstances, and their *community and environment*, affect their well-being. The recession has impacted on the housing market leaving some people having difficulty making mortgage repayments. In terms of the occupation of mortgage holders, professionals, managers and employers make up 40 per cent of the total with salaried and non-manual employees making up one third of borrowers. The numbers of people in need of housing has increased in recent years, with 56,249 households on local authority waiting lists in 2008. The numbers of people on the housing lists who are unemployed has increased, but so too has the numbers of people who have a job. In the context of the recession the numbers of people requiring social housing is likely to increase, especially with increasing numbers of people becoming unemployed. The tools available, and the scale of the response required, are both areas requiring urgent attention. The most extreme form of housing need is being homeless, with 1,394 people recorded as homeless in 2008. More detailed information from Dublin (2008) showed that two thirds of the homeless population were men, mostly single, and with an average age of 39 years old.

Social interaction and community participation are important for well-being. Three quarters of respondents to a national survey reported that it was easy to get help from neighbours. With regard to community participation, one in six of 15 to 64 year olds is involved in voluntary activities, with 25-64 year olds more likely to be involved than 15 to 24 year olds. While there was little difference in the level of involvement between men and women overall, women are more likely to be involved in charitable or religious work, whereas men are more likely to help in sporting organisations. Participation in arts events also supports social capital – more than 70 per cent of people have attended arts events, with higher attendances by higher social class groups and young people. At a more general level, community and voluntary sector organisations play an important role in supporting community involvement and building social capital. There is potential to develop a policy framework for supporting community and voluntary activity, including the recruitment, training and management of volunteers.

On the environment, people in Ireland tend to take more environmental actions than the EU average in recycling and reducing consumption of disposable items but are less likely to cut down on energy or water consumption or chose environmental ways of travelling.

Good *health* is a fundamental component of well-being. Men and women in Ireland perceive themselves to be in good health with relatively low levels of psychological distress. Full-time employees were absent from work for an average of 6.5 days per year due to sickness, which was low compared to the OECD average. There has been an increasing awareness in recent years of a high incidence of mental ill-health in the workplace. Causes of workplace stress have been cited as cuts in staffing levels, rapid change in the work environment, long working hours, and bullying. In a national survey relatively low levels of psychological stress were found among the working age population. People in semi-skilled and skilled occupations were more likely to experience psychological stress. The economic recession is likely to increase levels of stress among the working age population.

Three quarters of the population had attended a GP in the last year with women more likely to attend than men. The cost may deter or prevent some people attending a GP – 24 per cent of the population has a medical card, 44 per cent has private health insurance, 5 per cent has both and just over one quarter has neither, including 15 per cent of people at risk of poverty. Some people may have difficulty accessing GPs in their area.

People's behaviours can promote healthy living or put their health at risk. The choices people have, and consequently their behaviours, are influenced by their socio-economic conditions. Some 29 per cent of the working age population smoke, 28 per cent drink excessively and half the working age population have weight issues with 36 per cent being overweight and 14 per cent obese. Exercise and good nutrition can promote healthy living – two thirds of the working age population eat at least five helpings of fruit and vegetables daily and one quarter have high physical activity levels. Some 22 per cent of the working age population are inactive with 'time' being given as the main reason for not engaging in physical activity.

With regard to *democracy and values* 70 per cent of the population are satisfied with the Irish democratic process. The global economic crisis may have influenced people's satisfaction with the democratic process, but data are not yet available to assess the nature of extent of any change. Other evidence suggests that democracy is more limited at local level.

Just under 20 per cent of people in Ireland perceive a lot of tension between rich and poor, between management and workers and between different religious groups, while one third think that there is a lot of tension between different racial and ethnic groups. In 2007 just under one third of employees were members of a trade union, showing a decline from earlier years. With regard to intercultural dialogue, more than three quarters of people in Ireland had an interaction with at least one person of a culture other than their own in the last seven days. Some 5 per cent of the population has experienced work-related discrimination, with the unemployed and people from a non-white ethnic background experiencing higher levels of discrimination.

In relation to threats to well-being men are more likely than women to be victims of crime, and people (men and women) in the 25-44 age group are most likely to be victims of a crime. In 2006, 46 per cent of people aged 18 and over thought crime was a very serious problem in Ireland.

Throughout this analysis there are a number of emerging issues. The first is the impact of the economic recession on people of working age, with increasing unemployment the most serious issue, requiring a wide range of activation measures at an appropriate scale to deal with the problem. This issue is dealt with more explicitly in Chapter 5 (Volume I). The second issue is the demands made on many women – as they balance work and life requirements, bring up children (sometimes on their own), work in lower paid jobs – yet are better qualified, more likely to participate in education, and less likely to engage in risky behaviours. The third issue is the need for people of working age to adapt to change, particularly young adults. There are changes taking place in the nature of their relationships and family structures, in relation to the economy and with regard to their social environment.

For those who can adapt there are opportunities they can avail of, but for those who are not in a position to change or find it more difficult to adapt, life can be intimidating, potentially leading to risk behaviours or to poorer physical and mental well-being. Fourthly, there are clearly people who are vulnerable within the working age population and some of them have been identified in this analysis: people who are poorly educated, low skilled, unemployed, homeless, leaving institutional care, of a non-white ethnic background, members of the Travelling community, lone parents and people who are in low paid insecure jobs. The policy framework, and the relevant institutions, need to target and support these people to ensure they can avail of opportunities to overcome their difficulties and to realise their potential.

7.11 Policy Monitoring

As in the previous chapter we return to monitoring the implementation of policy commitments through the use of indicators throughout the policy cycle. How this might happen was set out in Chapter 3, (Volume I).

For example, as shown in Table 7.2, *Towards 2016* contains the goal (strategy) that every person of working age would have an opportunity to balance work and family commitments consistent with business needs. Diagnostic indicators could identify who is trying to balance work and family commitments, for example, dual earner households, lone parents – how many there are, where they are and what are their requirements, as well as issues emerging as the result of the economic recession. The inputs would include the recommendations of the National Framework Committee for Work-Life Balance policies, any policy or legislative changes required, funding, promotion of any agreed initiatives with employers and trade unions, a range of improved options to support caring (for children, people with disabilities and older people), as well as actions taken as a result of the recession. At this stage, building on the diagnostic indicators, baseline indicators can be established, setting out the number of people requiring a change to their work-life balance arrangements and a record of the current situation.

Subsequently outputs would be recorded, such as the number of flexible working arrangements available, and the numbers of people (women and men) availing of flexible working arrangements. The contribution of these outputs to the overall policy goal would be assessed using performance indicators such as recording the number of changes which have taken place, as well as institutional arrangements which have ‘helped’ to provide opportunities for people to balance work and family commitments, and those institutional arrangements which have ‘hindered’ the process. This information is particularly useful when assessed against the baseline indicators.

Table 7.2 Supports for People of Working Age Example

Policy Cycle	Indicators
<p>Strategy</p> <p>To ensure opportunities to balance work and family commitments consistent with business needs</p>	<p>Diagnostic</p> <p>People who are trying to balance work and family commitments – who, how many, where, what are their requirements, and impact of the economic recession</p>
<p>Inputs</p> <p>Work of the National Framework Committee for Work-Life Balance Policies</p> <p>Policy (legislative) change</p> <p>Budget</p> <p>Promotion with employers & trade unions</p> <p>Improved caring options</p>	<p>Baseline</p> <p>No. of people requiring a change to their work-life balance arrangements</p> <p>Record of current situation</p>
<p>Outputs</p> <p>No. of flexible working arrangements available</p> <p>Nos. (both men and women) availing of flexible working arrangements</p>	<p>Performance</p> <p>Record of changes</p> <p>Institutional ‘helpers’ and ‘hinderers’</p>
<p>Outcomes</p> <p>People having a better balance of work-life balance arrangements</p>	<p>Systemic</p> <p>More equal sharing of ‘committed time’ and ‘non-committed time’ between men and women and in line with European best practice</p>

The systemic indicator would employ a time use survey to measure the amount of time allocated to different activities, with a view to identifying the ratio of ‘committed’ to ‘non-committed’ or free time. This indicator could be complemented by an indicator measuring satisfaction with hours of paid work and satisfaction with free time (an update of the current analysis carried out by the European Foundation for the Improvement of Living and Working Conditions).

A key factor in monitoring quality outcomes is the availability of good quality, timely data. While there is a vast array of information on the working age population, information could be improved in relation to: access to primary health care, access to and use of public transport; satisfaction with care arrangements (for both carers and cared for) and well as the ability to disaggregate information by age, gender, family status, marital status, ethnicity, socio-economic status, employment status, disability, membership of the Travelling community, sexual orientation and religion. An essential requirement to improving our analysis and hence understanding of the working age population is the need to match and link data, as recommended in the 2003 report of the Steering Group on Social and Equality Statistics, *Developing Irish Social and Equality Statistics to Meet Quality Needs*. These data sources then need to be applied to monitoring progress on policy actions and measuring outcomes.

8

Older People

8.1 Understanding the Well-being of Older People

Only in this century (1900s) has human civilisation made it possible for most people in western societies to reach the age of 70 and over. Therefore, the shaping of what is possible in old age does not have a long tradition. As a society, we are only at the beginning of a learning process about old age. In this sense, old age is still young, its potential is not fully realised, and institutions, norms and resources advantageous for old age still need to be developed (Baltes and Mayer, 1999).

This chapter examines the key characteristics and well-being of older people. There is no common agreement on the definition of an older person. The OECD refers to 'older workers' as those who are 50 and over. The UN and WHO use the age of 60 and over to describe older people. In many countries the 'official' age of retirement from the work force and entitlement to pensions is 65 and over. For the purposes of this report an older person is taken to be someone who is 65 and over. This is the age used in the Irish Developmental Welfare State and the current policy framework of *Towards 2016*. In some cases 60 plus and 50 plus are used, where statistics are only available at these cut off points. These instances are noted.

While there are a number of discourses on 'ageing' there is no agreed definition of older people's well-being. A number of concepts are in use such as 'healthy ageing', 'active ageing', 'positive ageing', 'productive ageing', 'successful ageing', 'a society for all ages' and 'an age friendly society'. What all of these concepts have in common is that they promote older age as an active and participative stage in a person's life, based on human rights. Human rights discourses are making an important contribution to understanding the well-being of older people, (Townsend, 2007).

The UN maintains the rights of older people to a positive ageing experience, and sets out *principles for older people*, based on the Universal Declaration of Human Rights. These are: independence; participation; care; self-fulfilment; and dignity.

Current thinking on older people's well-being highlights the contribution which older people make, sometimes referred to as 'productive ageing':

The social and economic contribution of older persons reaches beyond their economic activities. They often play crucial roles in families and in the community. They make many valuable contributions that are not measured in economic terms: care for family members, productive subsistence work, household maintenance and voluntary activities in the community. Moreover, these roles contribute to the preparation of the future labour force. All these contributions, including those made through unpaid work in all sectors by persons of all ages, particularly women, should be recognised (*Madrid International Plan of Action on Ageing*, 2002: para 23, cited in NCAOP, 2005a: 22).

There have been a number of significant international developments in older people's well-being. These are summarised in Table 8.1.

Table 8.1 International Developments on Ageing

Year	Organisation	Development
1982	UN	Vienna International Plan of Action on Ageing
1991	UN	Principles for Older Persons
1995	UN	Copenhagen World Summit on Social Development
1999	UN	International Year of Older Persons
	WHO	World Health Day on Active Ageing
	EU	Towards a Europe for All Ages: Promoting Prosperity and Inter-generational Solidarity
2002	WHO	Active Ageing: A Policy Framework
	UN	Madrid International Plan of Action
	UN	Regional Implementation Strategy
2007	UN	A Society for All Ages: Challenges and Opportunities

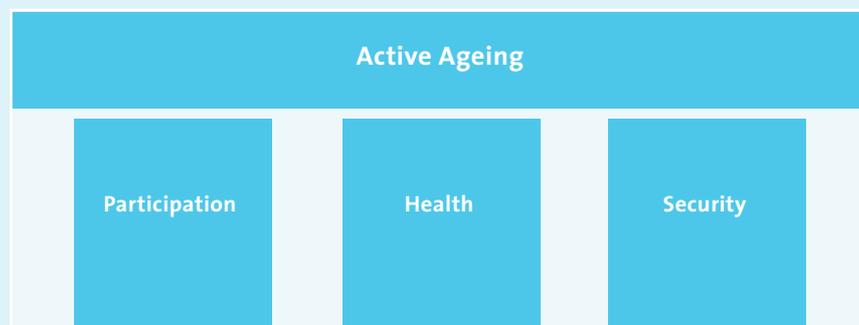
Source Based on a table in National Council on Ageing and Older People (NCAOP), 2005a: 20.

The trend from a passive 'needs-based' approach to an active independent participative approach is reflected in these international developments. For example, in 1995 the WHO renamed its 'Health of the Elderly Programme' to 'Ageing and Health', and then in 2000 to 'Ageing and Life Course'. The new names indicate 'an important change in orientation' from a 'compartmentalised' approach to a 'life course perspective'. The aim of the WHO programme is 'the attainment of the best possible quality of life for as long as possible for the largest number of people' (WHO, 2002: 54).

This approach, adopted in the International Year of Older Persons (1999), is sometimes referred to as ‘a society for all ages’. Such an ‘age-integrated’ society supports the participation of all citizens and is ‘characterised by relationships of reciprocity, solidarity and equity between the generations’ (National Council on Ageing and Older People (NCAOP), 2005a: 21).

At the UN Second World Assembly on Ageing in Madrid in 2002 the Madrid International Plan of Action on Ageing was adopted. This Plan, which has been endorsed by Ireland, is based on the WHO concept of ‘active ageing’, defined as ‘the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’ (World Health Organisation, 2002: 12). This approach is sometimes denoted as the three pillars of active ageing, as illustrated in Figure 8.1.

Figure 8.1 Policy Framework for Active Ageing



Source WHO, (2002) *Active Ageing: A Policy Framework*.

The first pillar recognises the importance of full participation and integration of all older people into society. Taking a participation approach includes adopting a democratic approach to consumer consultation and decision-making processes, including how services are developed, structured and provided, and ensuring policies are aware of age, gender and disability issues. The second pillar on health focuses on health promotion, disease prevention and equitable access to quality primary healthcare and long-term care, ideally in a continuum of care. The third pillar on security seeks to protect older people against poverty through social protection and pension systems, labour market policies, life-long learning and good information systems (NCAOP, 2005a: 39-41). The ‘three pillar’ approach recognises the heterogeneity of the older population and the importance of supportive environments and interventions throughout a person’s life.

The OECD defines ‘active ageing’ as ‘the capacity of people, as they grow older, to lead productive lives in the society and the economy. This means that they can make flexible choices in the way they spend time over life – in learning, in work, in leisure and in care-giving’ (OECD, 1998: 84).

The Australian Office of Ageing uses the term 'positive ageing' to denote:

an individual, community, public and private sector approach to ageing that aims to maintain and improve the physical, emotional and mental well-being of older people. It extends beyond the health and community service sectors, as the well-being of older people is affected by many different factors including socio-economic status, family and broader social interactions, employment, housing and transport. Social attitudes and perceptions of ageing can also strongly influence the well-being of older people, whether through direct discrimination or through negative attitudes and images (cited in NCAOP, 2005a: 22).

These understandings of well-being are in line with the definition and concept of well-being employed in this report. They capture the idea of an 'age-friendly' society which is person-centred and which does not impose social constructs on individuals (NCAOP, 2005a: 27).

Much of the debate on older people has been in the context of 'demographics' and the consequences of 'demographic ageing'. People are now living longer, having fewer children and retiring earlier than in previous generations. In future, these trends will have implications for labour markets, social security and health care systems as well as on the structure of our society. Much of the commentary describes this as the 'demographic time-bomb', conceptualised as a large ageing and dependent population. In contrast, the 'active ageing' discourse sees this as an opportunity. Older people today are better educated and in better health than ever before. Many make an ongoing and valuable contribution to society in paid and voluntary capacities. The challenge is for the institutional frameworks to overcome the challenges of an ageing population and tap into the opportunities provided by an actively ageing population.

These sentiments are captured in the *Madrid International Plan of Action on Ageing*:

A positive view of ageing is an integral aspect of the International Plan of Action on Ageing, 2002. Recognition of the authority, wisdom, dignity and restraint that comes with a lifetime of experience has been a normal feature of the respect accorded to the old through-out history. These values are often neglected in some societies and older persons are disproportionately portrayed as a drain on the economy, with their escalating need for health and support services. Although healthy ageing is naturally an increasingly important issue for older persons, public focus on the scale and cost of healthcare, pensions and other services have sometimes fostered a negative image of ageing. Images of older persons as attractive, diverse and creative individuals making vital contributions should compete for the public's attention. Older women are particularly affected by misleading and negative stereotypes; instead of being portrayed in ways that reflect their contributions, strengths, resourcefulness and humanity, they are often depicted as weak and dependent. This reinforces exclusionary practices at the local and national levels (UN, 2002, *Madrid International Plan of Action on Ageing*: para 102).

The United Nations Economic Commission for Europe (UNECE) has translated the Madrid Plan into a Regional Action Plan (RIS), which sets out ten specific commitments adopted by countries, including Ireland. These ten commitments are:

- i. Mainstreaming Ageing;
- ii. Integration and Participation;
- iii. Economic Growth;
- iv. Social Protection;
- v. Labour Markets;
- vi. Education and Life-long Learning;
- vii. Quality of Life, Health and Well-being;
- viii. Gender Approach;
- ix. Caregivers, Inter- and Intra- Generational Solidarity; and
- x. Implementation and Follow Up.

Progress on the implementation of the RIS was reviewed at an UNECE Ministerial Conference on Ageing held in Leon, Spain in November 2007. An Irish delegation attended this conference. The Ministerial Declaration *A Society for All Ages: Challenges and Opportunities* was adopted. The Declaration noted that progress has been made across the ten commitments of the RIS but that much more remains to be done.¹⁰⁴ The Declaration restated the commitment of an ultimate goal of a society for all ages that relies on respect for human rights, on protection against age discrimination, on social cohesion, and on equal opportunities for men and women of all ages. The principles of independent living, participation, care, self-fulfilment and dignity have also been reaffirmed (Economic and Social Council, 2008: 6).

As part of this work the European Centre, Vienna has been commissioned by UNECE to provide technical and scientific support for monitoring RIS. Part of their work has focused on the development of measurable indicators for older people.¹⁰⁵

104. The Ministerial Declaration noted that, in many countries, improvements had been observed in care for older persons, an increase in retirement age, and an alleviation of poverty in old age. Achievements in implementing the Regional Strategy also included better national and local level co-ordination and closer involvement of citizens in ageing-related policy making. Areas identified for improvement included greater support for older people in need of care, involving a better balance between paid work and family life and co-ordination between care providers, such as the public sector, the private sector, the family and civil society. Specifically, policies need to be developed to address the growing number of people with health-related problems. Economic growth and a life course perspective were seen as important in achieving a society for all ages. In relation to Ireland, ageism in all its manifestations was seen as the most important challenge to be overcome to ensure that Ireland becomes a society for all ages.

105. In developing 'indicators of achievement' the European Centre in Vienna has drawn on policy briefs and background papers prepared by international experts for a workshop in April 2004 on 'Sustainable Ageing Societies: Indicators for Effective Policy-Making' which were subsequently published in Marin, B. & A. Zaidi (Eds.) (2007) *Mainstreaming Ageing: Indicators to Monitor Sustainable Policies*. Aldershot: Ashgate. Thirty indicators (with 105 subdivisions) are proposed to monitor the RIS, presented under four topics: demography (6 indicators) – basic dimensions and population ageing (9 subdivisions), longevity (3 subdivisions), fertility (2 subdivisions), migration (1 subdivision), health (1 subdivision), disruption in cohort flows (1 subdivision); income and wealth (7 indicators) – income status (2 subdivisions), income distribution and composition (2 subdivisions), poverty (4 subdivisions), minimum income protection for older persons (4 subdivisions), wealth (3 subdivisions), income and wealth mobility (1 subdivision), pension indicator (1 subdivision); labour market and labour market participation (6 indicators) – participation rates (10 subdivisions), average effective retirement age and flexible retirement (8 subdivisions), unemployment reduction (4 subdivisions), employability of older workers (2 subdivisions), ageing migrants (4 subdivisions), eliminating age barriers and discrimination in recruitment and employment of older workers (3 subdivisions); social protection and financial sustainability (11 indicators) – adequate minimum income (5 subdivisions), social justice and inequality (6 subdivisions), relationship between contributions and benefits (2 subdivisions), public and total pension spending (6 subdivisions), age-related public expenditure (2 subdivisions), sustainability of public finances (2 subdivisions), (dis-)incentives for early retirement (5 subdivisions), (system-related) dependency ratios (3 subdivisions), life-time allocation (3 subdivisions), private pension provision (2 subdivisions), gender, reconciliation of work and family life (4 subdivisions). The publication presents charts for 46 indicators for selected countries.

8.2 Assessing Older People's Well-being

Based on the understanding of older people's well-being described above a number of elements seem to be important in the assessment of their well-being. These include:

- ◆ **Multidimensionality** – indicators which reflect the range of influences on older people's lives. Thus, not only are material well-being and health important but also an older person's relationships and their ability to contribute to and participate in their communities and societies.
- ◆ **Active participation** – the assessment of older people's well-being needs to reflect the older person's ability to shape their lives rather than as passive recipients of state provided services. The views of older people themselves are important.
- ◆ **Diversity** – any assessment of older people's well-being needs to acknowledge the heterogeneity of the older population. Key attributes are socio-economic status, gender, age within the older population, family and marital status, sexual orientation, as well as ethnicity and religion.

The move towards a 'new paradigm' of active ageing is 'one that views older people as active participants in an age-related society and as active contributors as well as beneficiaries of development' (WHO, 2002: 43). This requires addressing a number of challenges including:

- ◆ Our attitudes and understanding of ageing and older people, in particular addressing ageism and the concept of dependency models;
- ◆ Ensuring policies, institutions and standards are appropriate for an active ageing population;
- ◆ Engaging with and involving older people; and
- ◆ Improving our knowledge and information on older people.

There is work which contributes towards our knowledge of older people's well-being. As noted in the previous section, under the *Regional Implementation Framework of the Madrid International Plan on Ageing*, the European Centre in Vienna is developing indicators to monitor sustainable policies (Marin and Zaida, 2007).

In Ireland, the CSO has produced an indicator report on 'Ageing in Ireland' (CSO, 2007i). This report provides a recent picture of the lives of older people in Ireland in relation to demographics, health and care, accommodation, economic situation and lifestyles. The Office for Social Inclusion has also produced a social portrait of older people in Ireland (Fahey *et al.*, 2007).

The Policy Context

In this social report the intention is to summarise the key trends of older people's well-being across the six domains in the well-being framework, and to link these to the current policy framework, *Towards 2016*. The vision and four high level goals for older people in Ireland, as specified in *Towards 2016*, are:

Towards 2016 Vision and High level Goals

An Ireland which provides the supports, where necessary, to enable older people to maintain their health and well-being, as well as to live active and full lives, in an independent way in their own homes and communities for as long as possible.

The long-term goals, in the context of increased longevity and greater possibilities and expectations for quality of life of older people, are:

- ◆ Every older person would be encouraged and supported to participate to the greatest extent possible in social and civic life;
- ◆ Every older person would have access to an income which is sufficient to sustain an acceptable standard of living;
- ◆ 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; and
- ◆ Every older person would, in conformity with their needs and conscious of the high level of disability and disabling conditions amongst this group, have access to a spectrum of care services stretching from support for self care through support for family and informal carers to formal care in the home, the community or in residential settings. Such care services should ensure the person has opportunities for civic and social engagement at community level.

To support the implementation of these commitments an Office for Older People has been established in the Department of Health and Children, with a Minister of State for Older People (and Health Promotion). This office has responsibility for 'long-stay charges' and services for older people. A national longitudinal study of ageing (TILDA) is underway, with the first results expected in late 2009.

The Indicator Framework

For the purposes of this social report we have constructed a framework of key indicators reflecting, as far as possible, older people's well-being, see Table 8.2.

Table 8.2 Construction of Older People's Well-being

Domains	Components	Indicators
Economic Resources	<i>Income</i>	Income composition
		State pension
		Net pension replacement rate
	<i>Poverty</i>	Income poverty by gender
		Consistent poverty
	<i>Deprivation</i>	Deprivation
Work and Participation	<i>Work</i>	Labour force status
		Average exit age from the labour force
	<i>Education</i>	Level of educational attainment
Relationships and Care	<i>Family Structure</i>	Marital status
		Living arrangements
		Living alone
		Loneliness
	<i>Caring</i>	Carers
<i>Institutions</i>	Resident in nursing homes and hospitals	
Community and Environment	<i>Housing</i>	Housing problems
		Housing need
	<i>Community</i>	Practical help from neighbours
		Community and voluntary activities
	<i>Environment</i>	Pollution and noise
	<i>Transport</i>	Quality of public transport
Health	<i>Life expectancy</i>	Life expectancy at 65
	<i>Health status</i>	Prevalence of disability
		Mental health
		Access to health services
		Perception of health
	<i>Risk behaviours</i>	Smoking cigarettes
		Drinking alcohol
		Overweight / obese
	<i>Healthy behaviours</i>	Physical exercise
		Nutrition
Democracy and Values	<i>Exercising democracy</i>	Intergenerational solidarity
		Voter participation
		Use of ICT
	<i>Threats</i>	Crime victimisation
		Perception of crime
		Poor treatment, neglect, abuse
	<i>Equality</i>	Age discrimination

These domains and indicators provide an assessment of older people's well-being. In relation to economic well-being information is presented on income, poverty and deprivation, including heating deprivation. Pensions are an important source of income for older people and particular attention is paid to the adequacy of pensions to prevent poverty and income replacement elements. Pension provision for older people is especially important in the context of the economic crisis.

Participation in meaningful activity is important throughout life. In the work and participation domain information is presented on labour force status and average age of exit from the labour force, as well as level of educational attainment. Relevant issues here are age of retirement and correlations between educational attainment, socio-economic status and well-being among older people. Unfortunately information is not yet available on the allocation of time between market and non-market activities, given the important role many old people play in looking after grandchildren and helping and caring for others.

Relationships are important for well-being throughout life and play a central role in the well-being of older people. In this domain information is presented on family structures, with marital status, living arrangements, the number of older people living alone, and loneliness being the key indicators used. Addressing loneliness among older people is a key factor in their well-being. As people age, care in the community or for some, in institutions, can take on a more significant role in their lives, and indicators are presented on caring and institutional arrangements.

The fourth domain is community and environment. Four components are presented here: on housing, with indicators on housing problems and housing need; on community, with indicators on getting practical help from neighbours and involvement in community and voluntary activities; on environment, with an indicator on pollution and noise; and on transport, with an indicator on the quality of public transport.

Health is a critical element of older people's well-being with four components presented. These include indicators on life expectancy, the prevalence of disability, mental health status, access to health services, and people's perceptions of their health. People's behaviours, in association with their socio-economic status and cultural influences, can impact on their health and indicators are presented for smoking, drinking, exercise, nutrition and older people's weight.

On the final domain of democracy and values, indicators are provided on the government's role in promoting an understanding between the young and the old, on voter participation, on older people's use of ICT and on the extent of older age discrimination. Crime and abuse contravene people's rights and undermine dignity and well-being: indicators are presented on crime victimisation, perception of crime, and the extent of poor treatment, neglect and abuse.

The following sections of this chapter present the key trends on each of the domains of the well-being framework, setting these against current policy commitments and actions, with an associated commentary. The following section sets out the context for older people in Ireland.

8.3 The Context for Older People's Well-being in Ireland

Composition of the Older Population

In 2006, there were 467,900 people aged 65 and over in Ireland which accounted for 11 per cent of the population (CSO, 2007i). Compared to other European countries Ireland has a relatively small proportion of its population aged 65 and over: 11 per cent compared to an EU27 average of 16.8 per cent, see Figure 8.2. In contrast, Italy and Germany have nearly a fifth of their population aged 65 and over. There is great variation within Ireland, however, with only 3.3 per cent of the Traveller Community aged 65 and over, 9.5 per cent of UK nationals, 1.1 per cent of 'other' EU nationals and 1.8 per cent of 'other non-Irish nationals' (CSO, Census 2006).

Figure 8.2 Percentage of the Population 65 and Over, EU Comparison, 2006



Source CSO, 2007i: 11 (Eurostat, CSO Census of Population)

Women tend to live longer than men, therefore the proportion of women outnumber the proportion of men as populations age. In Ireland there are 79 men for every 100 women aged 65 and over. Despite this, Ireland had one of the most gender balanced populations in the EU in 2006, see Figure 8.3. Across the EU there was on average 70 men for every 100 women aged 65 and over, with Estonia and Latvia having less than 50 men per 100 women (CSO, 2007e).

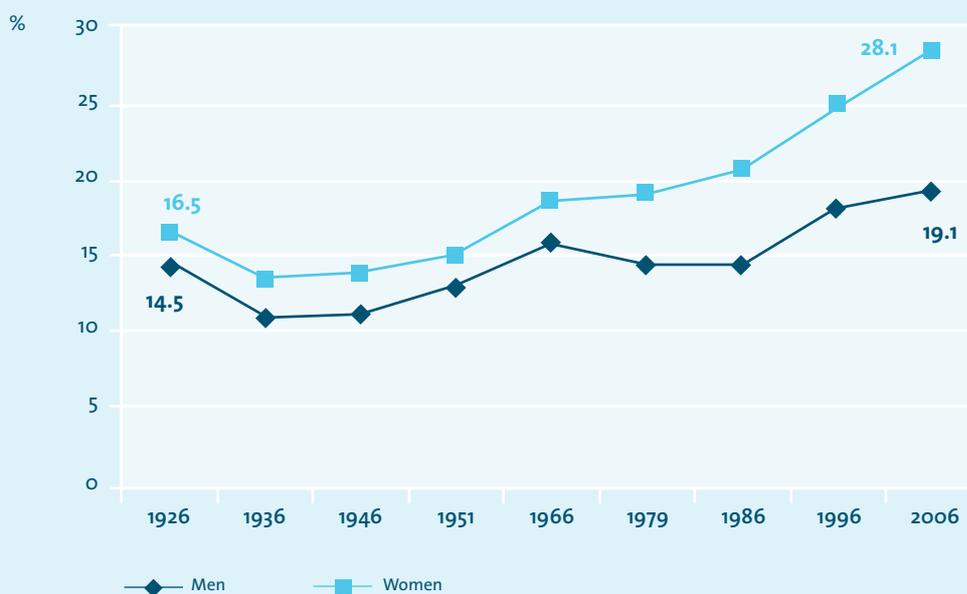
Figure 8.3 Men per 100 Women, EU Comparison, 2006



Source CSO, 2007e: 23 (Eurostat, CSO Census of Population)

As people live to be older the number of people aged 80 and over has been increasing. In 1926, in Ireland people aged 80 and over made up 15.6 per cent of the over 65 year olds. Eighty years later, in 2006, this proportion had increased to 24.1 per cent. The trend applies to both men and women, but is accentuated for women, see Figure 8.4 (CSO, 2007i).

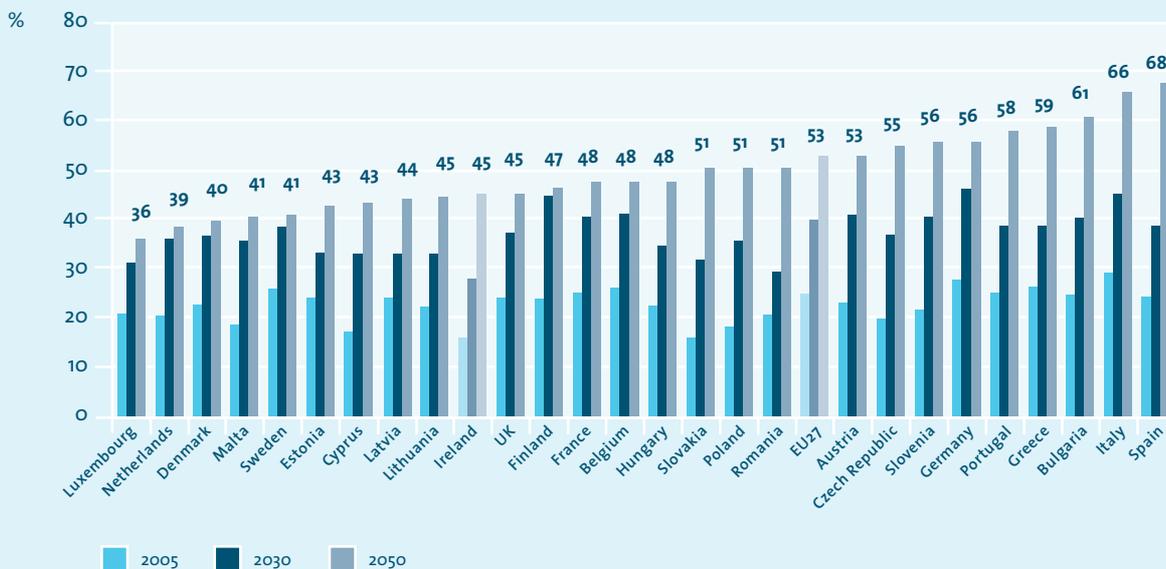
Figure 8.4 Persons Aged 80 and Over as a Percentage of the Over 65's, 1926–2006



Source CSO, 2007i: 13 (Census of Population)

The proportion of the population aged 65 and over is set to increase in the years ahead. By comparative standards Ireland has a relatively low proportion of its population aged over 65 as a proportion of the working age population (15-64s), at 16.8 per cent.¹⁰⁶ However, the 65s and over as a proportion of the working age population is projected to increase to 28 per cent by 2030 and to 45 per cent by 2050. Even though Ireland currently has one of the lowest 'age dependency ratios' in the EU, this is set to change and will be nearer the average by 2050, see Figure 8.5. The Pensioner Support Ratio (the ratio of the number of people working to the number of people over pension age) is estimated to decline from 5.6 in 2006 to 1.8 in 2061 (Department of Social and Family Affairs, 2007: iv).

Figure 8.5 Age Dependency Ratio (65+ as a Percentage of 15-64), EU Comparison, 2005, 2030 & 2050



Source Eurostat, sourced directly.

Note Figures presented on the graph are for 2050

Population projections carried out for an actuarial review of the social insurance fund (Government of Ireland, 2007: 12) estimate that the number of people aged 65 and over is expected to increase dramatically over the period to 2061, rising by 285 per cent from 472,000 in 2006 to just over 1.8 million by 2061. This is compared with a 24 per cent growth in the working age population over the same period. The main conclusion of the actuarial review is that the social insurance fund's surplus will be exhausted by 2016. By 2021, the annual shortfall is projected to be €2.8 billion (1.1 per cent of GNP), increasing to over €35 billion by 2061 (6.4 per cent of GNP).¹⁰⁷

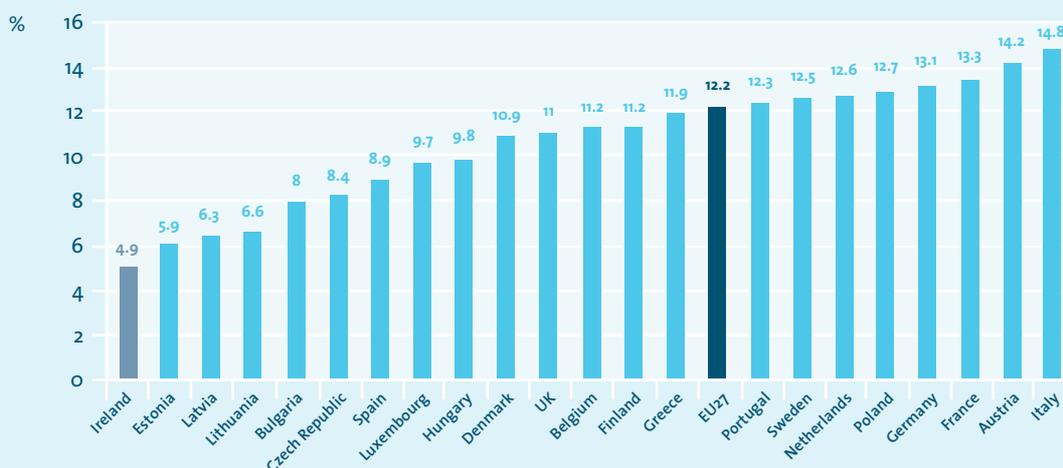
106. It is worth noting that the age dependency ratio is 18.6 per cent for rural areas, compared to 14.6 per cent for urban areas, (CSO, 2007: 12, data for 2006). Older people have an above average share of the population in the Border, Mid-West, South-East, South-West and West regions. The greater Dublin area has below its average share of older people in its population but still contains just over one quarter of all those aged 65 and over (Fahey *et al.*, 2007: 13).

107. It is noted that it is difficult to forecast accurately, especially over long time periods. Assumptions on migration and economic growth in particular are subject to variability over time.

Expenditure on Pensions

In 2005, the proportion of GDP spent on pensions in Ireland was comparatively small at 4.9 per cent, see Figure 8.6. There were a number of reasons for this including Ireland’s proportionately smaller older population and fact that the expenditure does not include tax reliefs which were estimated to cost €2.9 billion in 2006 (Department of Family and Social Affairs, 2007: 106). However, as noted above, there are concerns about the adequacy and sustainability of Ireland’s pensions in the future. Many of these issues are raised in the Green Paper on Pensions (Department of Family and Social Affairs, 2007), and are dealt with in the next section of this report.

Figure 8.6 Expenditure on Pensions as a Percentage of GDP, Selected EU Countries, 2005



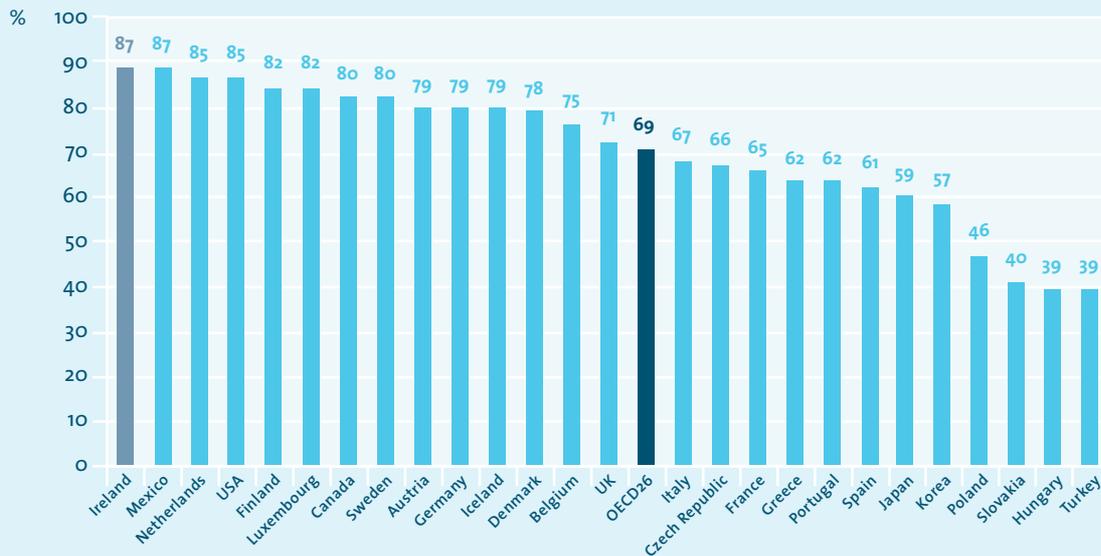
Source Eurostat, sourced directly.¹⁰⁸

Life Satisfaction and Quality of Life

As in previous chapters, before considering each of the six domains of well-being, we present the level of satisfaction with life in general of people aged 65 and over. The graph presented here, see Figure 8.7, is the OECD indicator of the share of those aged 65 and over who report a high level of life satisfaction (OECD, 2007a). Along with Mexicans, 87 per cent of older people in Ireland report a high level of life satisfaction, compared to an OECD average of 69 per cent. The least satisfied are Turkish and Hungarian older people.

¹⁰⁸ The ‘pensions’ aggregate comprises part of periodic cash benefits under the disability, old-age, survivors and unemployment functions. It is defined as the sum of the following social benefits: disability pension, early retirement due to reduced capacity to work, old age pension, anticipated old age pension, partial pension, survivors’ pension, early retirement benefit for labour market reasons. The figure for Portugal is for 2004.

Figure 8.7 Life Satisfaction, OECD Comparisons, 2006



Source OECD (2007: 115) *Society at a Glance: OECD Social Indicators 2006*

Within Ireland, the SLÁN 2007 survey asked respondents to rate their quality of life on a five point scale from 'very good' to 'very poor'. They found that 82 per cent of people aged 65 and over rated their quality of life as 'good' or 'very good'. This was slightly below the population as a whole, where overall, 90 per cent of people rated their life as 'good' or 'very good'. For the over 65s there was little difference between men and women, and in line with other age groups, those in higher social classes tended to rate their quality of life slightly higher than those in lower social classes (Morgan *et al.*, 2008: 41).

The next six sections of this chapter assess the well-being of older people in Ireland across the six domains of well-being: economic resources, work and participation, relationships and care, community and environment, health, and democracy and values. Cutting across these six domains are the needs of older people in vulnerable situations who need additional attention and support. This includes those living on low incomes, those who are living alone and may be isolated, the very old and the very sick and disabled. As communities of new Irish from different ethnic origins age this will add a new dimension to our older population and communities. Our services need to be able to identify and support vulnerable older people and our data systems need to be able to monitor their well-being.

8.4 Economic Resources

One of the current concerns in relation to the economic resources of older people is pensions – their adequacy, their income replacement capacity and their sustainability. With losses in pensions funds incurred as part of the global credit crunch many companies are now unable to fulfil their pension obligations.¹⁰⁹ This situation has implications for current and future pensioners and is of immediate and urgent concern. There are also a broader range of pension issues outlined in the Government’s Green Paper on Pensions, published in 2007 (Department of Family and Social Affairs, 2007).

8.4.1 Measuring the Economic Well-being of Older People

Under the economic well-being domain we examine 3 components: income, poverty, and deprivation. The indicators reflect the overall picture but data are not yet available to reveal some of the more recent changes. Income is a fundamental component of economic well-being. Four indicators are used to assess the income levels of older people. These are: income composition; state pension; net pension replacement rate; and income distribution.

Income Composition

The income of single people aged 65 and over mainly comprises social welfare pensions (62 per cent), occupational/personal pensions (20 per cent), income from work and self employment (7 per cent), other direct income (investment etc.) (5 per cent) and other benefits (6 per cent), see Figure 8.8 (Department of Social and Family Affairs, 2007: 38). These percentages vary slightly by age and gender, with the younger age group (65-69) and men having more income from work and occupational/private pensions than the older age group (75+) and women. The 70-74 age group has a comparatively large proportion of income from occupational/private pensions. For all groups more than half (and for women and those age 75 and over two thirds) of income is from social welfare pensions (Department of Social and Family Affairs, 2007: 38).¹¹⁰ More recent data from the Study of Health and Retirement in Europe (SHARE), 2008, found that 40 per cent of male retirees had occupational pensions, compared to only 26 per cent of female retirees (Gannon and Rabb, 2009). The composition of pensioner incomes may change as a result of the recession, with the likelihood of a higher reliance on social welfare pensions.

109. Ireland’s private pension funds have been heavily hit by the financial crisis, with real losses of 37.5 per cent in 2008, which is the worst investment performance for private pensions in 30 OECD countries. Investment losses in Ireland were the largest because of the large share of equities in pension-fund portfolios: around two thirds of assets before the crisis hit, compared with an average of 36 per cent in the 20 OECD countries where data are available (OECD, 2009c).

110. In 2005 the average total gross income for single pensioners was €253.11, varying from €289.27 for men and €283.51 for 65-69 year olds to €235.51 for women and €241.47 for over 75 year olds (Department of Social and Family Affairs, 2007: 38).

Figure 8.8 Composition of Single Pensioner Incomes by Age and Gender, 2005



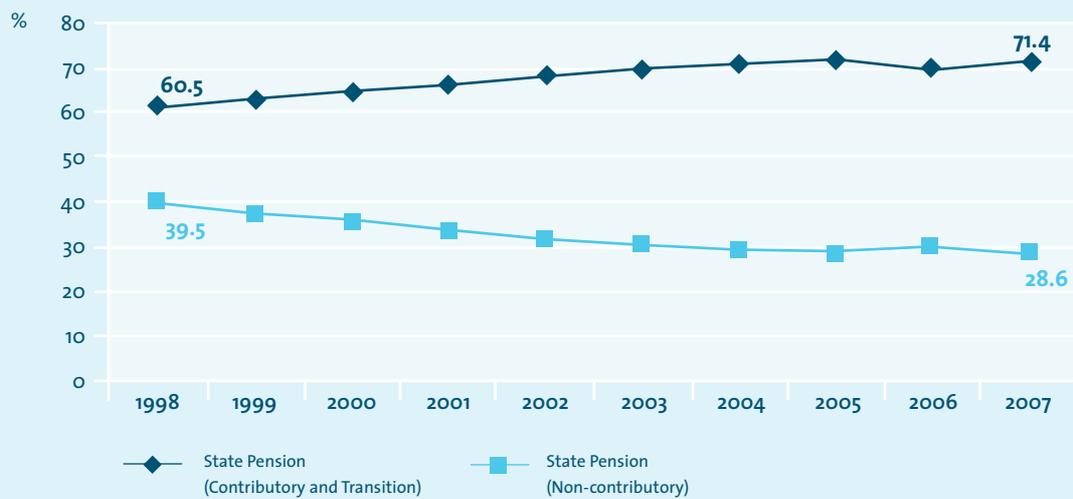
Source: Department of Social and Family Affairs, 2007: 38 (based on special analysis of 2005 EU-SILC survey)

State Pension

As shown in Figure 8.8 social welfare pensions are the main source of income for Irish pensioners. About 32 per cent of pensioner units have income from occupational or personal pensions, but relatively few pensioners in the bottom four deciles have incomes from these sources (Department of Social and Family Affairs, 2007). There are two main types of social welfare pension in Ireland: the contributory pension (state and transition)¹¹¹ and non-contributory (state). In 2009, the state pension (contributory and transition) is €230.30 per week (€240.30 for 80 years and over) and the state pension (non-contributory) is €219 per week (€229 for 80 year olds and over). More than two thirds of state pension recipients now receive the contributory (and transition) pension, as coverage of the social insurance system has increased, see Figure 8.9. Pensioners may also be entitled to receive other benefits, depending on their circumstances, such as a living alone allowance, free travel, electricity or gas allowance, telephone allowance, free television licence, fuel allowance and a medical card.

111. Transitional state pensions are paid to people aged 65 who have made social insurance contributions. Contributory state pensions are paid to people aged 66 and over who have made social insurance contributions.

Figure 8.9 Recipients of State Pension by Pension Type, 1998-2007



Source Department of Social and Family Affairs, 2009: 28

Net Pension Replacement Rate

As pensions make up the largest proportion of the income of people over 65 it is useful to look at the ‘net pension replacement rates’.¹¹² The old age pension replacement rate is a measure of how effectively a pension system provides income during retirement to replace earnings, which is the main source of income prior to retirement. The net pension replacement rate takes into account personal tax and social security contributions. It is the net replacement rate that matters to individuals as this is what determines their standard of living during retirement relative to when working.

Using OECD data for male workers at average (mean) earnings the net replacement rate across OECD countries from mandatory pensions is on average 70 per cent (OECD, 2007b: 34). There is substantial variation across countries. Ireland (38.5 per cent), along with Mexico, Japan, UK and New Zealand has one of the lowest rates, see Figure 8.10. The male net pension replacement rate for low earners (half of mean earnings) in Ireland is 66 per cent and 23 per cent for high earners (twice average earnings). Two factors are relevant here – Ireland has a flat rate public pension scheme and the effect of taxes and contributions on low earners is ‘more muted’ because they pay less in taxes and contributions than those on average earnings (OECD, 2007b: 84). It should be noted that supplementary pensions are not included in the Irish calculations, since the methodology only covers mandatory schemes (Department of Social and Family Affairs, 2007: 53). Ireland is currently the only Member State in the EU without some form of compulsory income-related pension provision for a majority of workers (European Commission, 2006a: 188).

112. The net pension replacement rate is defined as the individual net pension entitlement divided by net pre-retirement earnings, taking account of personal income taxes and social security contributions paid by workers and pensioners.

Figure 8.10 Male Net Pension Replacement Rate at Average (Mean) Earnings, OECD Comparison, 2007



Source OECD 2007b: 35 (based on OECD Pension Models)

Income Distribution

Within Ireland the average annual equivalised disposable income for a person aged 65 and over in 2007 was €353.86 per week, compared to €454.03 for all individuals, and €484.46 for a person aged 18-64 (CSO, 2008b: 13). When we divide the income distribution into ‘income deciles’ (10 equal segments from lowest to highest income) we see that older people are over-represented in the second and third deciles (net equivalised weekly incomes of €198 to €278) and under-represented across the rest of the income distribution, see Figure 8.11. This reflects their dependence on a fixed income.¹¹³

Figure 8.11 Income Distribution Across Deciles by Life Cycle Age, 2007



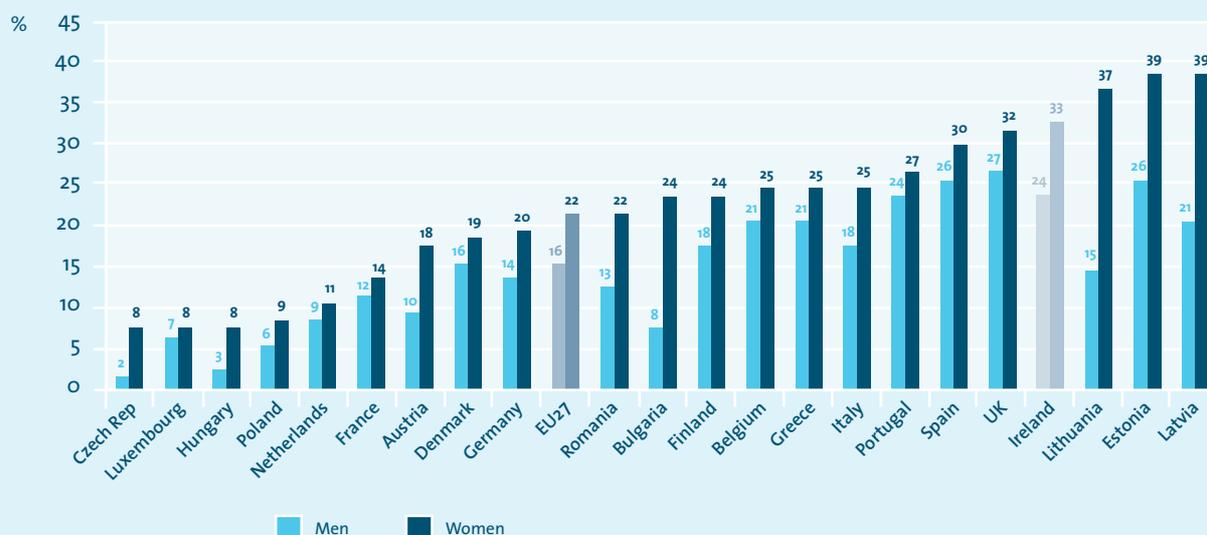
Source CSO, 2008: 32-33 (based on EU-SILC 2007).

Notes 1. Risk of poverty threshold = €228.65 per week, based on equivalised net disposable income.
2. Figures shown on the graph are for 65+

¹¹³ Living on a fixed income can limit consumption decisions especially in relation to unexpected or discretionary expenditures. Attention tends to be focused on covering basic items such as food, clothing and heating, with price sensitivities in relation to these items.

The second component examined in the economic well-being domain is poverty. Two indicators are presented: income poverty by gender and consistent poverty. Using income poverty (which is the risk of poverty after social welfare transfers), Ireland has a relatively high income poverty rate, with 24 per cent of older men (65+) and 33 per cent of older women (65+) at risk of poverty. This is compared to an EU27 average of 16 per cent for older men and 22 per cent for older women, see Figure 8.12. Across the EU older women have higher poverty rates than men. Women live longer than men and, in general, receive lower pension rates. While this gap is evident in Ireland it is much less than other countries such as Bulgaria, Lithuania, Estonia and Latvia.

Figure 8.12 Percentage Income Poverty among 65 Year Olds and Over, Selected EU Comparison, 2007



Source Eurostat, sourced directly

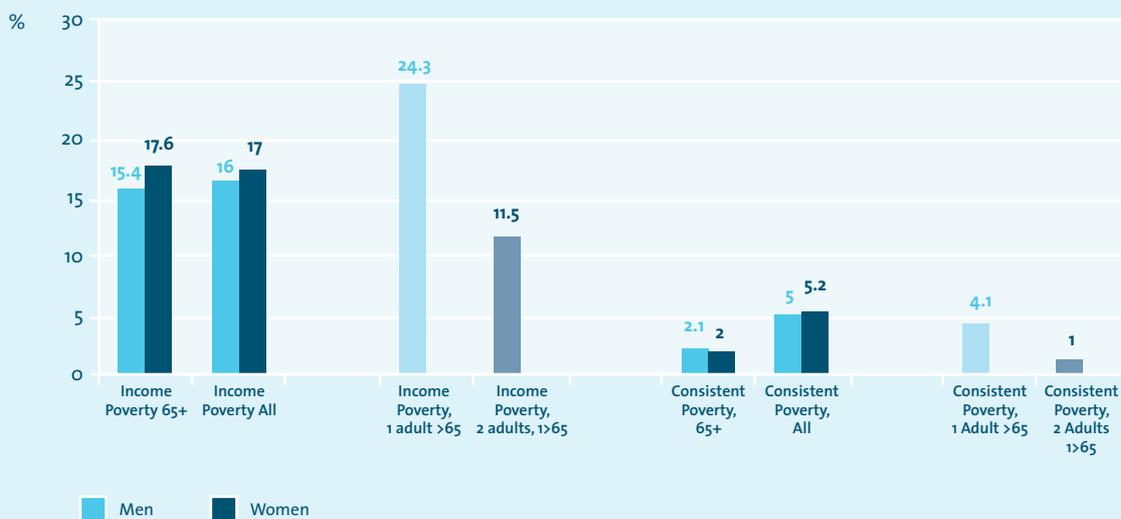
Within Ireland (using the national definition of income and national equivalence scale, rather than the European definitions and scales) 16.6 per cent of older people were at risk of income poverty in 2007, compared to 15 per cent of 18-64 year olds.¹¹⁴ Older men and women have similar poverty rates on this measure at 15.4 and 17.6 per cent respectively (2007), see Figure 8.13. The risk of poverty for older adults living alone is higher at 24.3 per cent, whereas for 2 adults living together, one of whom is over 65, the risk 11.5 per cent. Poverty rates for older people are very dependent on pension rates.

114. These figures include Special Savings Investment Account (SSIA) income. SSIA income averaged €743 net equivalised disposable income in 2007 (3.2 per cent). People living in households with 2 adults at least one of whom was 65 or over had relatively high average income from SSIA's at €937 or 5.1 per cent. Older people living alone had one of the lowest levels of SSIA income at €443 or 2.8 per cent. The risk of poverty threshold falls when it is recalculated excluding SSIA income. The impact of this recalculation is greatest for older people living alone as their income did not increase much as a result of SSIA's but the threshold was lower when SSIA income was excluded so that their risk of poverty rate decreased relative to the new threshold (from 24.3 per cent to 17.6 per cent), CSO (2008b: 11-12).

Consistent Poverty

Income poverty tells only part of the story of the economic well-being of older people. In Ireland, consistent poverty (living on a low income and experiencing deprivation) is the official poverty measure used. In 2007, only 2.0 per cent of 65 year olds and older were living in consistent poverty compared to 4.7 per cent of 18-64 year olds, see Figure 8.13. Rates are similar for men and women at 2.1 and 2.0 per cent respectively. For people over 65 living alone the risk of consistent poverty is slightly higher at 4.1 per cent, but only 1 per cent for 2 adult households where one of the adults is aged over 65. Progress has been made in reducing rates of consistent poverty among older people—these low rates are to be welcomed and efforts should be made to maintain them, especially in the context of the economic recession.

Figure 8.13 At-Risk-of-Poverty and Consistent Poverty Rates Among People Aged 65 and Over, 2007



Source: CSO, 2008b, based on EU-SILC 2007.

Deprivation

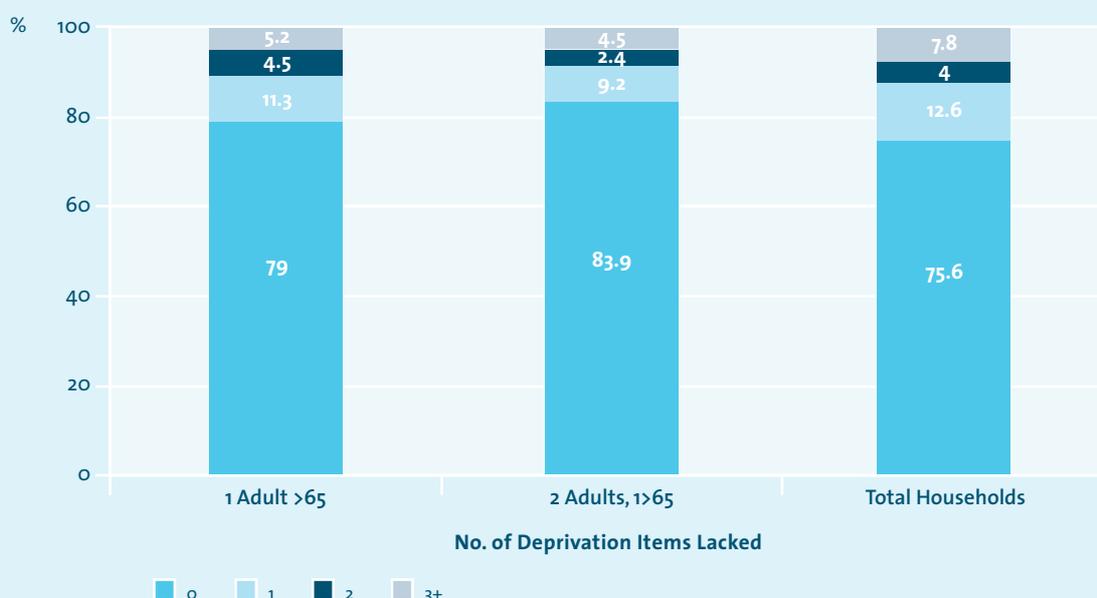
The third component on the economic resources domain is deprivation where two indicators are presented: the deprivation element of the consistent poverty measure is explored in more detail; and fuel poverty. Deprivation is measured in Ireland using deprivation indicators.¹¹⁵ Deprivation among the older population is low, reflecting accumulation of assets over their lifetime and high rates of home ownership in

¹¹⁵ 11 basic deprivation indicators are used:

- i. Without heating at some stage in the past year due to lack of money;
- ii. Unable to afford a morning, afternoon or evening out in the last fortnight for entertainment;
- iii. Unable to afford two pairs of strong shoes;
- iv. Unable to afford a roast once a week;
- v. Unable to afford a meal with meat, chicken or fish (or vegetarian equivalent) every second day;
- vi. Unable to afford new (not second hand) shoes;
- vii. Unable to afford a warm waterproof coat;
- viii. Unable to keep the house adequately warm;
- ix. Unable to replace worn out furniture;
- x. Unable to afford to have family or friends for a drink or meal once a month; and
- xi. Unable to afford to buy presents for family or friends at least once a year.

Ireland. In addition, many older people in Ireland have access to the ‘free schemes’ (electricity allowance, fuel allowance, telephone rental, television licence, free gas and free travel). In 2007, 79 per cent of one adult households where the adult was over 65 and 84 per cent of two adult households where at least one of the adults was aged over 65 experienced none of the 11 deprivation indicators, compared to 76 per cent of all households, see Figure 8.14. Less than 5 per cent of one and two person households containing a person aged 65 and over were deprived of 3 or more items, in comparison with 8 per cent of all households. Nevertheless, households containing older persons who lack three or four basic amenities can be left in a very vulnerable position with potential risks to their health.

Figure 8.14 Deprivation Among Older People, 2007

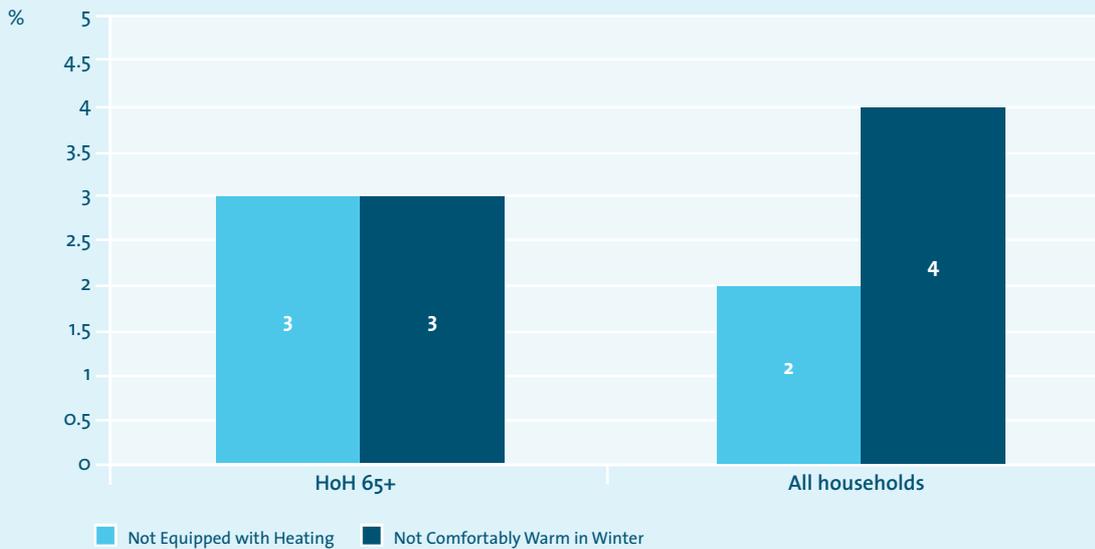


Source CSO, 2008b: 23 (based on EU SILC 2007)

Heating Deprivation

A key deprivation for some older people is lack of heating. Figure 8.15 shows the percentage of head of households aged 65 and over who live in accommodation not equipped with heating and those who cannot keep their accommodation comfortably warm in winter, compared to the general population. The figure shows that the level of heating deprivation in Ireland in 2007 was relatively low with less than 4 per cent of households who were not able to keep their accommodation adequately warm. The proportion of 65 year olds was slightly lower at 3 per cent. While these relatively low levels of heating deprivation among the older population is welcome, for those who do experience heating deprivation there is a risk to their health (McAvoy, 2007).

Figure 8.15 Heating Deprivation Among Households Headed by People Aged 65 and Over in Ireland, 2007



Source: CSO, 2009f (based on EU-SILC 2007).

Summary

More than four fifths of the income of people aged 65 and over comes from pensions (62 per cent from social welfare pensions and 20 per cent from occupational/personal pensions). Older men tend to have higher incomes than older women, and income declines with age. More than two thirds of state pension recipients receive the state contributory (and transition) pension. Pensioners may be entitled to receive a number of other benefits, depending on their circumstances, sometimes referred to as the 'free schemes'. Ireland has a relatively low male net replacement rate¹¹⁶ at 38.5 per cent, compared to an OECD average of 70 per cent. Supplementary pensions are not included in this figure.

Across the income distribution people aged 65 and over are over-represented in the second and third deciles, reflecting their dependence on a fixed income. Using EU poverty measures older people in Ireland, and women in particular, have a relatively high risk of income poverty at 24 per cent for men and 33 per cent for women, compared to EU27 averages of 16 and 22, per cent respectively. However, using the Irish measure of consistent poverty, poverty levels are low for older people at less than 2 per cent. This low rate of consistent poverty is mirrored in the low levels of deprivation among older people, where 80 per cent of older person households do not experience deprivation. Nevertheless, the 20 per cent of older person households who are deprived of one or more basic items are potentially vulnerable with possible risks to their health, in particular the 3 per cent of older person households who experience heating deprivation.

¹¹⁶ The old age pension replacement rate is a measure of how effectively a pension system provides income during retirement to replace earnings, which are the main source of income prior to retirement.

8.4.2 Ireland's Policy Framework for the Economic Well-being of Older People

Ireland's policy framework is spelt out in *Towards 2016* for the 10 years from 2007 to 2016. In relation to the economic well-being of older people *Towards 2016* contains a number of commitments. Overall, the social partners to the agreement are committed that:

Every older person would have access to an income which is sufficient to sustain an acceptable standard of living.

Specific identified priority actions towards meeting this objective include:

- ◆ A review of national pensions' policy to enhance pension provision and income supports;
- ◆ Enhancement of social welfare pensions, through increasing the personal rate and raising the level of the qualified adult allowances for pensioner spouses to the level of the state non-contributory pension;
- ◆ To provide an adequate income in retirement, related to pre-retirement income, as far as possible. A target of 50 per cent of pre-retirement income in retirement was suggested in the National Pensions Policy Initiative in 1998 (NPPI), drawing on all sources of income;
- ◆ Enhancing the level of occupational and pension private coverage – to at least 70 per cent of those aged 30 and over (from 59 per cent), as suggested in the NPPI;
- ◆ Recognising the role and economic contribution of spouses working on the farm in the social insurance system;
- ◆ Administering payments on an individual basis; and
- ◆ An action research project (undertaken by Sustainable Energy Ireland and the Combat Poverty Agency) to improve heating systems and insulation in older dwellings.

These initiatives are complemented by a number of supporting documents, most notably the National Action Plan for Social Inclusion 2007-2016, and the Green Paper on Pensions.

8.4.3 Commentary on the Economic Well-being of Older People

Two key things are necessary to ensure older people's economic well-being: an adequate state pension and adequate provision of occupational and/or personal pensions during working age. These factors reflect not only a person's economic fortunes over their life course, but also security for their future (Banks *et al.*, 2006: 1). On income indicators Ireland's pension replacement rate is relatively low by international standards and the level of income poverty comparatively high. Coverage of occupational and personal pensions is lower than the targets set by pensions' policy.

Policy commitments acknowledge the need to address these issues and the Green Paper on Pensions provides a comprehensive overview with options for reform. Particular attention needs to be paid to vulnerable older people on low incomes. Many women are disadvantaged in relation to access to adequate pensions. Further consideration should be given to reforms which meet the needs of women as well as men (National Women's Council of Ireland, 2008).

In the light of the economic recession the need to address the pensions issue has become urgent and even more important. As stated earlier, the OECD has identified that Ireland has the worst investment performance for private pensions among the OECD countries, and has also a comparatively high level of income poverty among pensioners. Ireland has a high reliance on tax incentives, but these are expensive and are not well targeted on lower earners or younger workers (OECD, 2009c). It would seem useful, in light of this analysis and the recession, to give consideration to three overriding goals – poverty prevention, income replacement and sustainability. As suggested by NESC (2009: 93), a fundamental reform of pensions policy is required with the move towards a universal state pension proposed. This would include a significant increase in the state pension available on a universal basis, the option of a contributory element and significant reform of the existing system of tax reliefs. Any proposal needs to take into consideration the funding challenges associated with public pension provision, as outlined earlier.

8.5 Work and Participation

8.5.1 Measuring Older People's Work and Participation

Participation in meaningful activity is a fundamental element of well-being. For many this involves participation in paid and unpaid work, and participation in education.¹¹⁷ For older people there may be less opportunity to participate in these activities.¹¹⁸ Here we present two components: work and education.

Two indicators are used to assess the work component for older people: the labour force status (ILO) of people aged 65 and over; and the average exit age from the labour force.

Labour Force Status

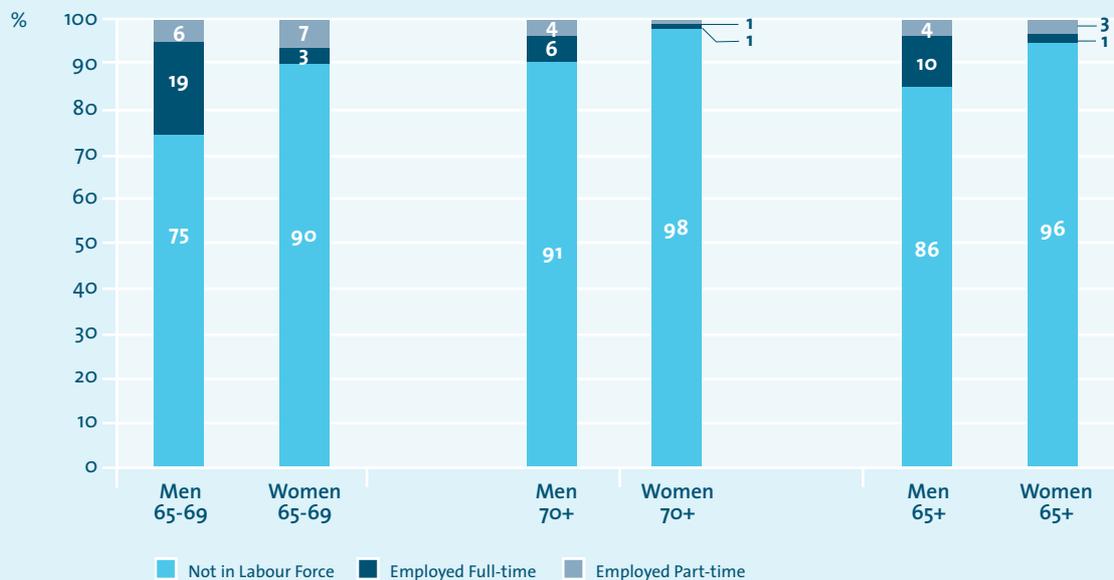
The majority of people aged 65 and over are not in the labour force – 85 per cent of men and 96 per cent of women aged 65 and over, see Figure 8.16. As expected, participation in the labour force declines with age with one quarter of 65-69 year old men in employment compared to 9 per cent of over 70 year old men; the comparative figures for women are 10 per cent compared to 2 per cent. Older women in employment are more likely to be in part-time work, compared to older men who are more likely to be in full-time work.

117. As noted in earlier chapters, participation in one's community and in decision making is also important to well-being. These dimensions of participation are captured in 'Community and environment' and 'Democracy and values'.

118. There are a number of reasons why such opportunities may not be available to older people, including ageism.

In relation to European comparisons older people (65 and over) in Ireland have an overall employment rate of 8.7 per cent (14.4 for men and 4.2 for women) which is above the EU27 average of 4.4 per cent (6.6 for men and 2.8 for women). Despite being above the EU27 average the Irish employment rate is substantially below some other countries, notably Iceland (34), Portugal (18.3 per cent), Romania (15.2 per cent) and Norway (13.6 per cent). In Ireland, nearly half of the men over 65 in employment were engaged in agriculture, fishing and forestry, the majority of whom were self employed farmers. Women over 65 were spread across sectors, with a small concentration in the health and retail sectors.

Figure 8.16 Labour Force Status of over 65 Year Olds, 2006¹¹⁹



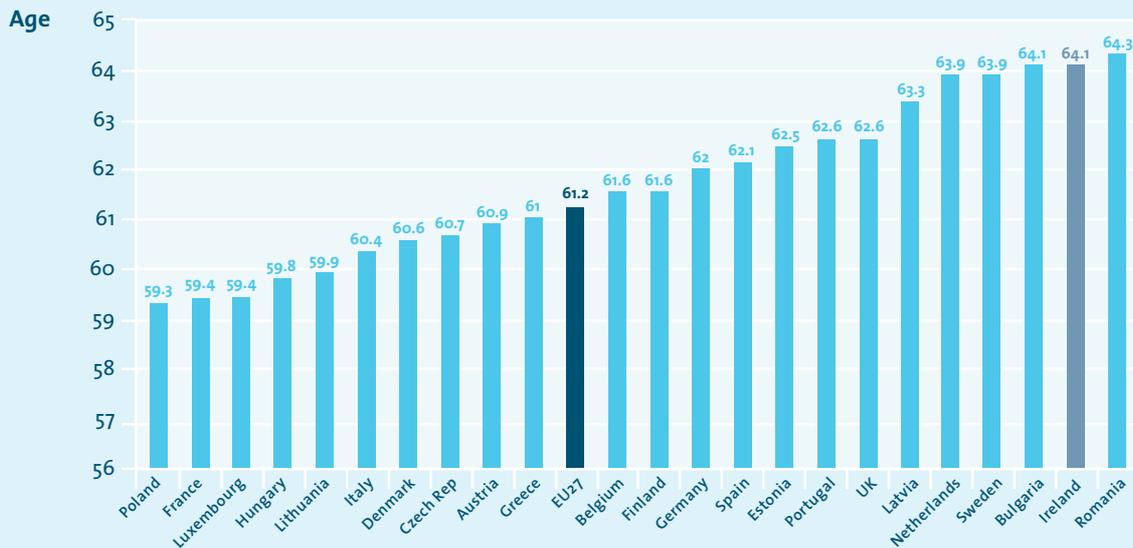
Source: CSO 2007i: 24 (based on QNHS).

Average Exit Age from the Labour Force

The second indicator on the work component of the work and participation domain is average exit age from the labour force. The average exit age in Ireland is 64.1, above the EU27 average of 61.2, see Figure 8.17. Romania has the highest exit age at 64.3 with Poland the lowest at 59.3. The exit rate for women in Ireland is 64.7, compared to an exit rate of 63.5 for men. Variability across countries in retirement age, pension policies and culture is reflected in the disparities in employment rates and exit ages.

119. The economic recession may be impacting on the employment status of older workers.

Figure 8.17 Average Exit Age from the Labour Force, Selected EU Comparison, 2007¹²⁰



Source Eurostat, Labour Force Survey, accessed directly.

Information from the English Longitudinal Study of Ageing (ELSA) showed that those at the two extremes of the income distribution were less likely to work than those in the middle. People at the bottom were less likely to work because of ill health or lack of work, whereas those at the top did not necessarily need the income from work (Banks *et al.*, 2006: 2). Overall these findings indicate a need for greater flexibility on the part of employees, employers and government on retirement age and the balance between working and retiring.

Research undertaken in 2000 by the National Council on Ageing and Older People on preferences for employment and retirement among older people aged 55-69 years found that many of them wished to change their employment status: 70 per cent of those working expressed a preference to retire more gradually than is the current norm, 37 per cent wished to retire as soon as possible, while 26 per cent of those not employed wanted to take up work (NCAOP, 2005c: 14).

More recent information from the Survey of Health, Ageing and Retirement in Europe (SHARE), Ireland, (2008) provides the main reasons for retirement for people aged 50 and older. Some 20 per cent gave their own ill health as a reason for early retirement, with a further 5 per cent saying they retired because of the poor health of a relative or friend. More than one in five women stated that their main reason for retiring was to spend more time with their family (just over 5 per cent of men gave this reason). The main reason given by men (37 per cent) was that they were eligible for a pension (18 per cent of women gave this reason). Some ten per cent of both men and women retired to 'enjoy life' (Harmon *et al.*, 2008: 19).

120. Data for Luxembourg and Hungary are for 2005, and for Bulgaria, Ireland, Lithuania and Romania for 2006.

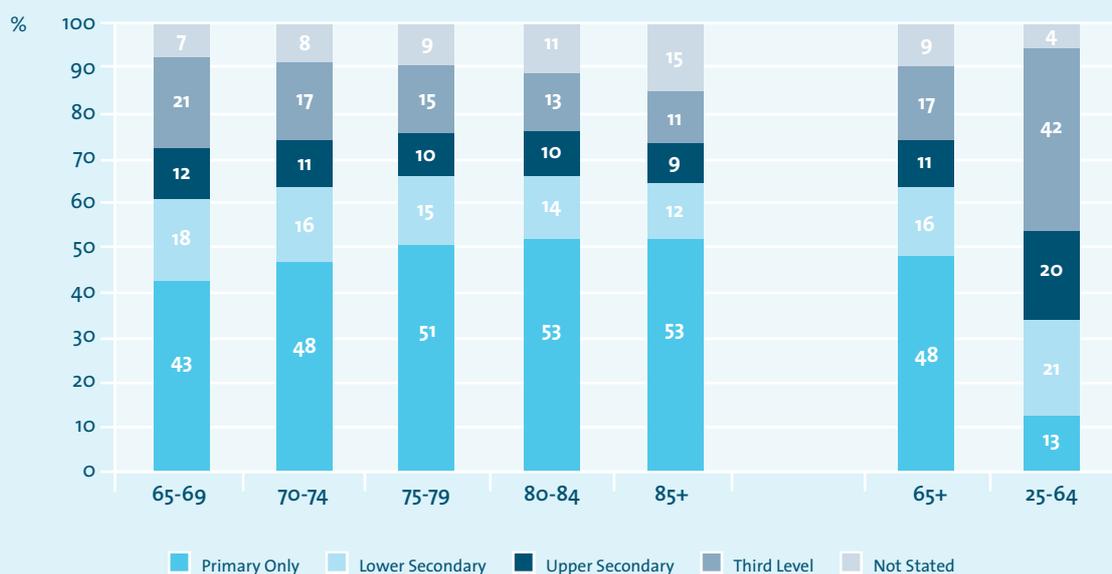
Time Use

Ideally in this domain we would like to present an indicator on the allocation of time to market and non-market activities by older people. This information is included in the SHARE but is not yet analysed and publicly available for Ireland. For example, for the countries¹²¹ analysed in the SHARE report (Borsch-Supan *et al.*, 2005) about one quarter of people aged 65 and over spend time looking after their grandchildren and about one in five provide help to relatives outside the household, friends and neighbours. Less than 10 per cent are involved in ‘market work’. This information would be useful for Ireland, given the role of older people in helping and caring for others.

Level of Educational Attainment

The second component is education with one indicator presented: level of educational attainment. Primary or no formal education was the highest level of education attained for just under half (48.1 per cent) of people aged 65 and over in 2006, see Figure 8.18 (CSO, 2007i: 31). Some 16 per cent had achieved lower second level, 11 per cent upper second level and 16 per cent third level. As expected, the level of education achieved is much lower for 65 year olds and older than for the working age population (25-64). Older age groups had the lowest levels of attainment with more than half of people over the age of 75 having primary as their highest level of education.

Figure 8.18 Level of Educational Attainment of Persons Aged 65 and Over, 2006



Source CSO 2007i: 31 (based on 2006 Census)

121. Sweden, Denmark, Germany, Netherlands, France, Switzerland, Austria, Italy, Spain and Greece.

Information on current participation in education by older people is limited. The 2004 Quarterly National Household Survey (QNHS) reported that almost one third of those questioned aged 60 and over had received ‘informal education’ during the previous twelve months. Informal education includes reading professional books and magazines, educational broadcasting, library visits and the internet (NCAOP, 2005c: 14).

Educational attainment is a good indicator of socio-economic status and has been correlated with a number of aspects of well-being among older people by the team analysing the Irish SHARE data (Harmon *et al.*, 2008). These researchers found a significant education gradient in cognitive function, numeracy, life satisfaction and self-reported health.

Summary

Participation in meaningful activity is central to well-being. About 14 per cent of men aged 65 and over and 4 per cent of women aged 65 and over are in the labour force. Just under half of the men are self employed farmers. On average people in Ireland leave the labour market at 64.1 years of age, which is above the EU average of 61.2. The main reasons given for retiring were eligibility for a pension, ill-health and to spend more time with the family (women mainly). Research by the National Council for Ageing and Older People found that a majority of those working would like to retire more gradually than is currently the case. A number of studies indicate that there is a need for greater flexibility with respect to retirement age and more balance between working and retiring.

Information on how older people spend their time is limited in Ireland. European research found that up to one quarter of people aged 65 and over spend time looking after their grandchildren and about one in five provide help to relatives outside the household, friends and neighbours. With regard to education, older people have lower levels of educational attainment than the population generally. This has implications for their health and well-being.

8.5.2 Ireland’s Policy Framework for the Work and Participation of Older People

A key objective for the government and social partners is to maximise the opportunities for older people to participate in education, employment and other aspects of economic and social life (*Towards 2016*, 2006: 64).

Specific identified priority actions include:

- ◆ Encouraging the continuing participation of older people in the labour market, including training, the phasing out of the Pre-Retirement Allowance (PRETA) and promotion of a ‘cultural mindset change’.
- ◆ Targeted adult and community educational opportunities, related to life-long learning;¹²² and
- ◆ Support to get involved in family literacy projects in bringing their ‘knowledge, skills and experience to bear’.

122. There is no upper age limit for access to Adult and Further Education programmes provided by the Department of Education and Science, except for Youthreach (early school leavers) and VTOS (21 to 64 years). These programmes include: Post Leaving Certificate courses, Back to Education Initiative (BTEI), Adult Literacy and Community Education. Some 8 per cent of BTEI participants in 2008 were aged 65 and over, and in 2007, 14 per cent of people availing of adult literacy tuition were aged 55 and over.

These proposals are also supported in the National Action Plan for Social Inclusion. There is discussion in the Green Paper on Pensions on the arguments for greater work flexibility in older age.

8.5.3 Commentary on the Work and Participation Well-being of Older People

The main message in terms of participation in work, education and other activities for older people is for greater flexibility in relation to when people can retire and also how people retire. While views are mixed about whether people want to retire earlier or later depending in their circumstances, there is a desire for greater flexibility in making this decision and in a more gradual withdrawal from the labour force, with the possibility of balancing working and other roles. The desire to work longer and have greater flexibility in relation to retirement is likely to increase as people live longer. It is useful to bear in mind that one of the main reasons people retire at the moment is because of their eligibility for a pension, although many also retire because of ill-health.

People aged 65 and over have a wealth of expertise and experience to offer, both in the workplace and outside it. A notable feature is the diversity of the older population and how they spend their time. Older people are actively involved in activities such as caring for grandchildren, helping others and participating in voluntary activities (see later sections of this chapter). These valuable contributions to society and to their own well-being also need to be recognised. At the moment data are limited on these activities – it would be useful to have more detailed information on the contribution older people make to their families, communities and to wider society.

Information on older people's involvement in education and training activities is also limited. However, in general, older people's educational levels are lower than the rest of the population, due to intergenerational changes in the opportunities to avail of education and in the recognition of its value and in its provision. Greater opportunities for older people to engage in education and other developmental activities would be beneficial to their well-being. Up-to-date information on older people's literacy levels would also be useful, as well as the extent of their participation in 'life-long learning' and how they value this.

8.6 Relationships and Care

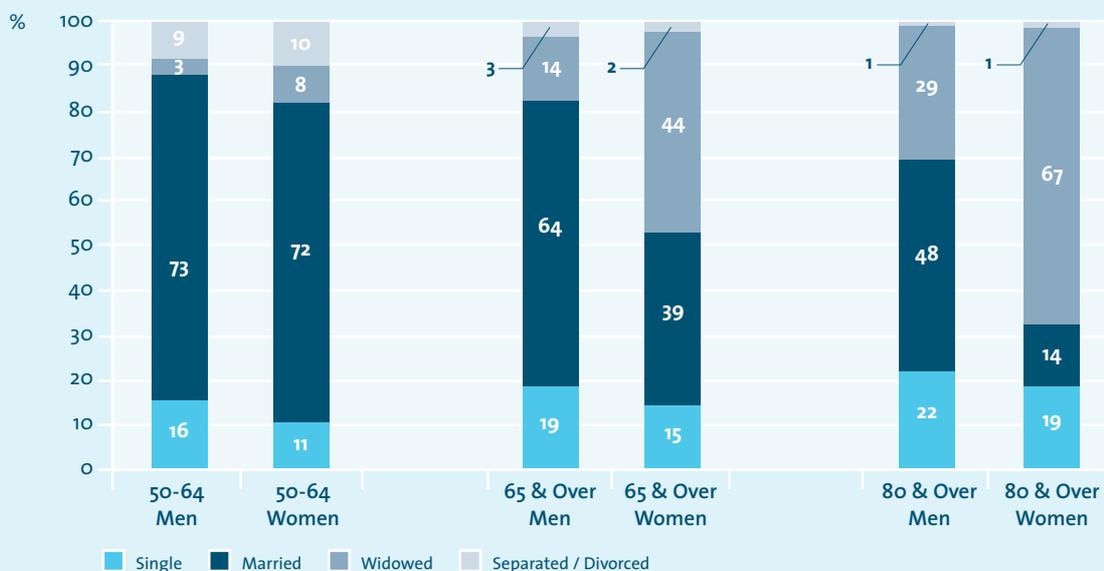
8.6.1 Measuring the Relationships and Care of Older People

People's relationships and their care are important to their overall well-being. The quality of people's relationships, in particular, contributes to their sense of well-being and ability to cope. Under the relationships and care domain we have 3 components: family structure; caring; and institutions.

Marital Status

Under family structure there are four indicators: marital status, living arrangements, living alone, and loneliness. Figure 8.19 presents information on the marital status of men and women over 50. Over 70 per cent of both men and women in the 50-64 year old age group are married. This proportion reduces hugely, for women in particular, as they get older: two fifths of women aged 65 and over are widowed; while for the over 80s two thirds of women are widowed, as are just under one third of men. These trends reflect higher female life expectancy and probable age differences at time of marriage (CSO, 2007i: 15). The proportion of older people who are widowed or single has implications for their living arrangements and for the provision of services and supports as people age.¹²³

Figure 8.19 Marital Status of People Aged 65 and Over, 2006



Source: CSO 2007i: 15 (based on 2006 Census)

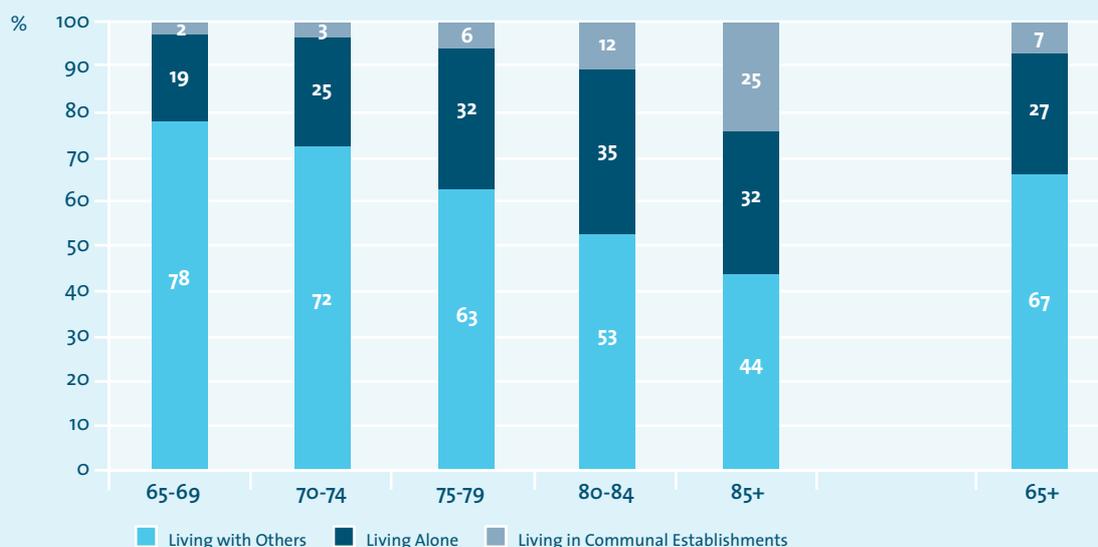
Living Arrangements

Figure 8.20 shows the living arrangements of older people in Ireland. Two thirds of people aged 65 and over live in private households with others, 27 per cent live alone and 7 per cent live in communal establishments. The proportion living in private households with others declines with age, with the proportions living alone and then in communal establishments increasing with age, so that for people aged 85 and over, less than half live with others, nearly one third live alone and one quarter live in communal establishments. This is over twice the rate for 80-84 year olds in communal establishments.¹²⁴

123. Although there is no specific research in Ireland on the circumstances of older lesbian and gay people, research in the USA has shown that older lesbians and gay men are more likely to live alone, and less likely to have a life partner or children than is the case for the older population in general. This can translate into lack of traditional support networks. This lack of support, along with lack of legal recognition of their relationships, is a contributory factor in many older gay and lesbian people growing older alone, which can be compounded by difficulties in relation to pensions rights, succession, next of kin status and provision of care services (these issues are being addressed in the Civil Partnership Bill 2009).

124. In terms of numbers, there were 452,925 people aged 65 and over in Ireland in 2006. 301,088 of these lived in private households with others, 121,157 lived alone and 30,680 lived in communal establishments.

Figure 8.20 Living Arrangements of People Aged 65 and over, 2006



Source CSO 2007i: 31 (based on 2006 Census)

Living Alone

As the population lives longer and with changing household patterns it is perhaps inevitable that more older people will live alone. This has consequences, both for the well-being of older people, and for wider society in providing supports to enable older people to live independently for as long as possible. Figure 8.21 presents information on European comparisons of people aged 65 and over who were living alone in 2001. The graph shows that 21 per cent of older men and 32 per cent of older women in Ireland lived alone, which was above the European average for men (16.2 per cent) and below the average for women (38 per cent).¹²⁵ Greece had the lowest number of older people living alone and Denmark had the highest. Some of these variations reflect the culture of the country.

Figure 8.21 Per Cent of People Aged 65 and over Living Alone, EU Comparisons, 2001



Source Eurostat, sourced directly.

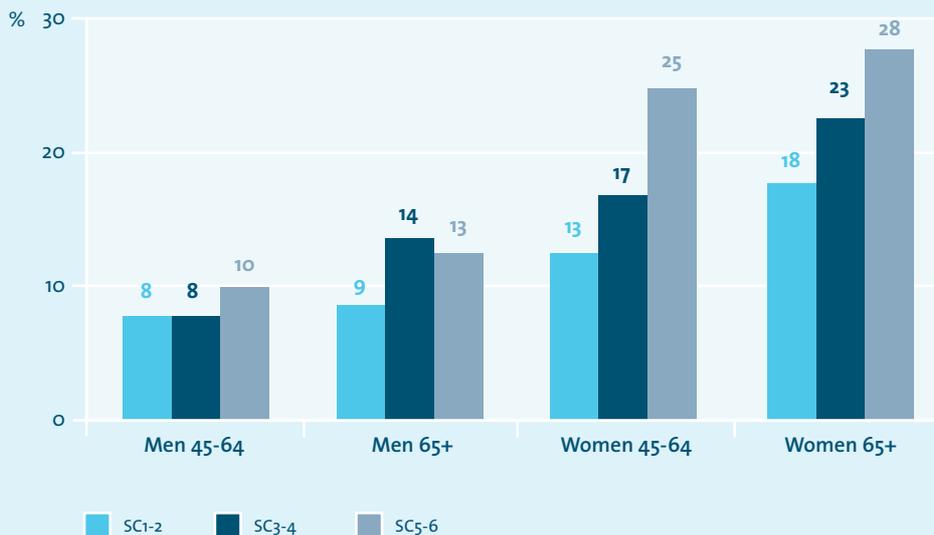
125. These figures are for 2001 and compare with 27 per cent for both men and women in Ireland in 2006, see Figure 8.20.

Loneliness

The National Council on Ageing and Older People has projected that in future greater percentages of our older people will live alone. Their research has found that 11 per cent of older people have minimal social contacts and a limited social network (NCAOP, 2005c). Data from ELSA shows that there is a 'socio-economic gradient in loneliness' with people on lower incomes most likely to be lonely. Factors reducing the likelihood of loneliness include having children living nearby and having friends. People aged 80 and over are the most vulnerable to loneliness (Banks *et al.*, 2006).

The Irish SLÁN survey (2007) asked respondents if they often felt lonely in the last four weeks. Just under one in five (17 per cent) of people aged 65 and over said they felt lonely, compared to 13 per cent of 30-64 year olds, see Figure 8.22. Women were more likely to be lonely than men and people in lower social classes were more likely to be lonely. For example, 28 per cent of women aged 65 and over in social classes 5 and 6 said they felt lonely compared to 18 per cent of women in the same age group in social classes 1 and 2 (Morgan *et al.*, 2008: 94). People who are widowed (any age) are about five times more likely to feel lonely than those who are married or cohabiting.

Figure 8.22 Percentage of Respondents who Answered 'Yes' to the Question 'Have you often felt lonely in the last 4 weeks?' by Gender and Social Class,¹²⁶ 2007



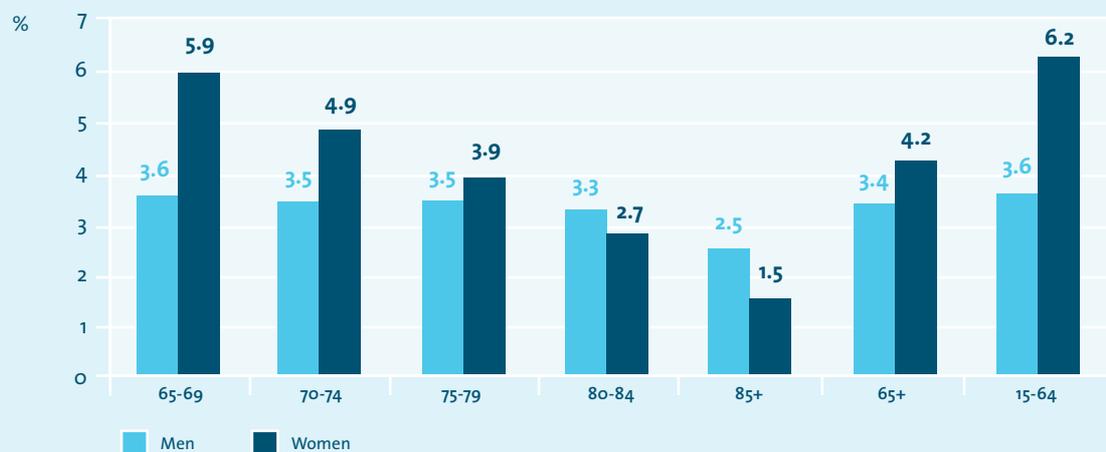
Source Morgan *et al.*, 2008: 94 (SLÁN, 2007)

126. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

Carers

The second component of the relationships and care domain is care. Data are limited on the supports provided for older people. For this reason we have used the proportion of persons aged 65 and over who are carers. Some 3.9 per cent of people aged 65 and over are carers (an estimate of about 18,000 older people), compared to 4.9 per cent of the 15-64 age group. A higher proportion of women than men are carers, although for those who are over 80 the proportion of men caring is higher than women, see Figure 8.23. In 2006, 37 per cent of carers aged 65 and over provided up to 14 hours of unpaid help per week; and half (49 per cent) provided 43 or more hours per week (CSO, 2007i: 20). Some 5,244 people aged 65 and over received carers payments (Carers Benefit and Carers Allowance) in 2007, with nearly four times as many women as men in receipt of the payments (Department of Social and Family Affairs, 2009: 52).¹²⁷ As stated in Chapter 4, many carers feel isolated and undervalued, as well as being emotionally stressed by the caring responsibility (Equality Authority, 2005; O’Sullivan, 2008).

Figure 8.23 Percentage of Persons Aged 65 and Over who are Carers, by Age, 2006



Source CSO Census of Population, 2006.

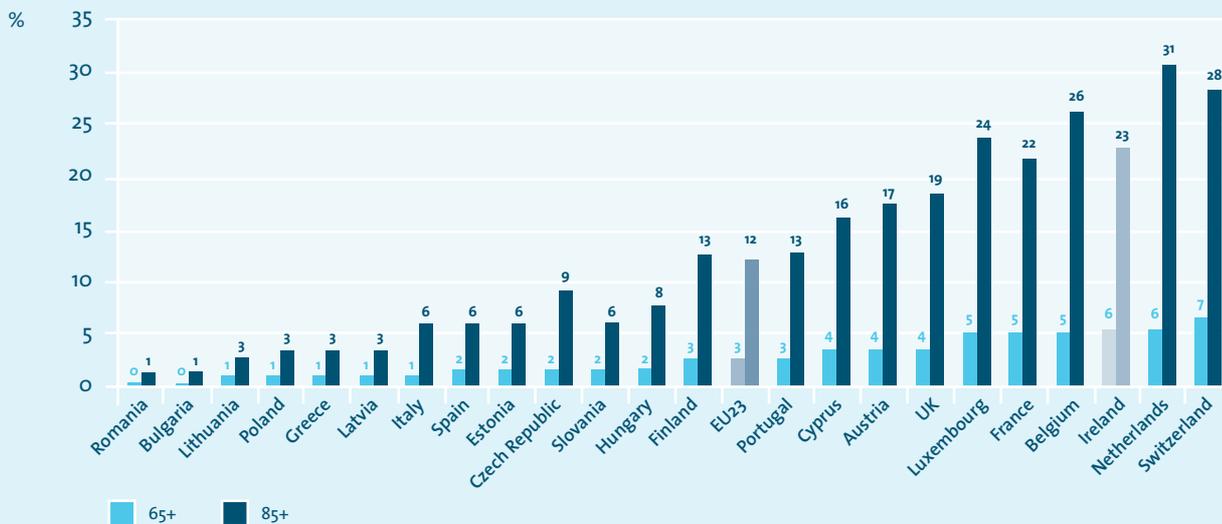
A study undertaken by Garavan *et al.* in 2001 for the National Council on Ageing and Older People reported that 12 per cent of older people living in the community usually needed help with one or more daily tasks. Research on carers by O’Shea (2000) stated that there were 97,000 households in Ireland that contained a carer who was looking after a person aged 65 or over who either lived with them or in another house. An earlier study by Fahey *et al.* (1994) found that nine out of ten carers were relatives, mostly women. The National Council on Ageing and Older People state that the evidence indicates that the population of older people requiring home care is expected to rise, while the number of carers available is predicted to fall over the next ten years (NCAOP, 2005b). There are a number of reasons for this: the ratio of women aged 45-68 (the majority of carers) to the number of people over 70 will decline; the increasing proportion of women in the workforce; increased geographic separation of families; and changing family patterns.

¹²⁷ There are two main carers payments. Carers Benefit is a social insurance payment for people who have left employment to look after someone who requires full-time care. Carers Allowance is a means tested payment for carers who look after someone on a full-time basis. In September 2007, a half-rate Carers Allowance was introduced for people who were caring for another person and in receipt of another social welfare payment. There were 15,790 recipients of half-rate Carers Allowance at the end of 2008 (all ages).

Resident in Nursing Homes and Hospitals

The third component on the relationships and care domain is institutions measured using the indicator of the percentage of 65 year olds and over, and 85 year olds and over, who are resident in nursing homes and hospitals. Figure 8.24 shows that in Ireland 5.6 per cent of people aged 65 and over were in nursing homes and hospitals¹²⁸ compared to an EU average of 2.9 per cent. In Ireland, this proportion increased to 22.7 per cent (16.4 per cent for men and 25.5 per cent for women) for 85 year olds and over, compared to an EU average of 12.4 per cent. Ireland has a relatively high proportion of its older population in institutional care, although these figures need to be taken in an overall context of the options and supports available for older people as well as cultural influences.

Figure 8.24 Percentage of Older People in Nursing Homes and Hospitals, EU Comparisons, 2001



Source CSO, 2007i: 22 (based on Eurostat data).

Women represented two thirds of all nursing home and hospital residents aged 65 and over, and three quarters of residents aged 85 and over (CSO, 2007i: 22). In 2005, almost half of patients aged 65 and over in long-stay units were in private units, with 36 per cent in public units and 16 per cent in voluntary units.

Research by the National Council on Ageing and Older People found that in Ireland the main reasons for admission to long-stay care were chronic illness, mental infirmity, physical disability and social reasons (NCAOP, 2005c: 17). They also found that 87 per cent of older people questioned would prefer to remain in their own homes with family members taking care of their needs, supplemented by health care services where necessary (NCAOP, 2005c: 17).

¹²⁸The data used here for EU comparative purposes are for 2001. For Ireland more up to date figures are available - in 2006, 5.5 per cent of people aged 65 and over were in nursing homes and hospitals; 4.1 per cent for men and 6.7 per cent for women).

While institutional care (nursing homes and hospitals) will be required for some older people, the objective for older people's well-being should be to support people in their own homes and neighbourhoods for as long as possible. Where required, institutional settings should provide a positive, supportive and empowering environment for older people. One element of care is to ensure dignity at the end of life, where the wishes of the dying person and their relatives and friends are respected, and where people are treated sensitively and with humanity.

Summary

Relationships and care are an important part of older people's well-being. While living independently in their own homes is many older people's preferred option there is a risk of isolation and loneliness. Two fifths of women over 65 and two thirds of women over 80 are widowed. Just over a quarter of the over 65s live alone – one fifth of older men and one third of older women. Some 17 per cent of the over 65s feel lonely, with women and people in lower social classes more likely to be lonely.

The proportion of older people living alone is likely to increase in future as the population ages and with changing family structures. This will increase the need for caring supports. Although information on carers is limited we know that 4 per cent of older people are themselves carers. We also know that a large proportion of carers are women relatives of the older person, and that the number of women carers available for this role in future is likely to decline. Most older people desire to live independently for as long as possible. However, Ireland has a relatively high proportion of its older population in institutional care. While the health and needs of older people need to be taken into account, we should be aspiring to improve family and community supports to enable older people to live independently for as long as possible.

8.6.2 Ireland's Policy Framework on Relationships and Care for Older People

Ireland's policy approach to older people's long term care in *Towards 2016* spells out long term goals for supporting independence for as long as possible, as well as support for a 'spectrum of care services stretching from support for self-care through support for family and informal carers to formal care in the home, the community or in residential settings'.

Specific priority actions towards meeting this objective include:

- ◆ A comprehensive 'infrastructure of long-term care services for older people' with additional resources and agreed, applied standards. This would include community and home-based care, sheltered housing options and quality residential care. Commitments are made in relation to the financial model to be employed;
- ◆ The application of a national standardised needs assessment, to ensure the delivery of relevant public services in an integrated manner around the needs of the care recipient;
- ◆ Home support packages are being piloted to test best models of delivery;
- ◆ Community intervention teams will assist in supporting transitions to and from hospital and support community-based services; and
- ◆ Appropriate and equitable levels of co-payment.

Towards 2016 recognises the ‘important role of family and informal care’. Specifically, there is a ‘new emphasis on home and day care’. This will include ‘national protocols for case management for home care packages’. ‘Home support packages’, which are being piloted, are to provide for a ‘broad range of support personnel in addition to personal and social services’. In addition, ‘community intervention teams will assist in preventing avoidable hospital admission and the facilitation of early discharge from hospitals’.

The National Development Plan 2007-2013 *Transforming Ireland* has committed €4.7 billion to a ‘Living at Home’ Programme and €5 billion to a ‘Residential Care Programme’. The Living at Home programme provides resources for home care packages, home helps, meals-on-wheels, community intervention teams and respite/day care services to enable older people to live independently in their homes and communities for as long as possible. The Residential Care programme will go towards providing services for people in long-stay residential institutions.

The Nursing Homes Support Scheme, ‘A Fair Deal’ was published in December 2006, setting out the co-payment arrangements for nursing home care. The Nursing Homes Support Scheme Bill 2008 was published in October 2008, giving effect to government policy. The Home Care Package scheme has been operational since 2006 with approximately 11,000 people benefiting per year at a cost of €110 million. The National Quality Standards for Residential Care Settings have been drafted but, at the time of going to press, have yet to be approved and implemented.

7.6.3 Commentary on the Relationships and Care of Older People

The indicators used to assess relationships and care show that most older people indicate that they wish to live independently in their own homes for as long as possible. This will require carers and supports to cater for their physical, mental and emotional well-being as an increasing number of older people will live alone, with the risk of isolation and loneliness. In designing and implementing care supports for older people we need to value the contribution and role older people play in our society and place their articulated needs at the centre of any response, as set out in the policy documents referred to above. The aspiration is for a continuum of care from support for self care through to institutional care. In this regard there is a need for greater coherence and consistency in the provision of existing services, and which can react to changes in the circumstances of older people.

The policy response has placed much emphasis on ‘home support packages’. The provision of these packages, in consultation with the older person and their family, will be critical in providing supports for older people in future, many of whom are themselves in caring roles. The NESF has undertaken an assessment of the implementation of the Home Care Package Scheme (NESF, forthcoming) and initial findings indicate that while many people find the home care packages very beneficial, there are difficulties in their implementation, including limited information provision, variability in eligibility criteria, access to the scheme and in the amounts paid. The Department of Health and Children is also undertaking a comprehensive evaluation of the scheme.

Also relevant to the care of older people is the proposed National Carers Strategy, which has been deferred in the context of the economic recession.

The policy aspirations to support older people's well-being through social services is comprehensive – the key is to ensure that older people are aware of the choices available, and can exercise choice in their care arrangements through the availability of appropriate care, access to that care, its affordability and to ensure that adequate standards are met.¹²⁹ To deliver on these aspirations will be challenging in the current economic climate. However, we need to find ways to ensure that older people's care needs are met, preferably in the community for most older people. We also need to ensure that people have the right to die with dignity. These issues require ongoing attention, as the numbers of older people increase and the number of family carers decrease.

The legal recognition of committed and intimate relationships can make a significant contribution to older people's well-being. Such recognition is important regarding decisions about care, but also in relation to next of kin status, succession rights, tax, and pension rights. For some long term partnerships, for example, for same-sex couples, such legal recognition and subsequent protection has not existed.¹³⁰ The lack of such recognition and protection can contribute to insecurity, loneliness and undermine well-being.

Finally, better data and information are required to identify people's needs, and in consultation with older people and their families, to ensure appropriate provision. Currently, our information and data systems on the needs and desires of older people and their families in relation to living circumstances and family supports are limited. Information systems could be enhanced through taking a person-centred approach to data collection, shared by the main service providers. The longitudinal study of older people, TILDA, can add to this information base, as it will track the lives of older people over time. Ongoing monitoring of the commitments in *Towards 2016* is required. Further research on the choices people have in relation to their long term care needs would be useful, including their knowledge of options available, and on the appropriateness, quality, and cost of services available.

8.7 Community and Environment

8.7.1 Measuring Older People's Community and Environmental Well-being

The accommodation, community and environment in which older people live affect their well-being. Some of these aspects have been touched on in the previous section. In this domain we examine 4 components: accommodation, community, environment and transport. Two indicators are employed to assess older people's accommodation: the percentage of retired people with three or more housing problems and housing need. The data (from Eurostat) is available by socio-economic status and hence the 'retired' population is taken as a proxy for older people.¹³¹ The data are for 2001, and hence rather dated, but they do provide an overview of housing quality among the older population. More up-to-date information is also provided for Ireland.

129. Attention to regulations and standards for care provided in the home (paid and unpaid) and in institutions is required. This issue is dealt with further in section 8.9.

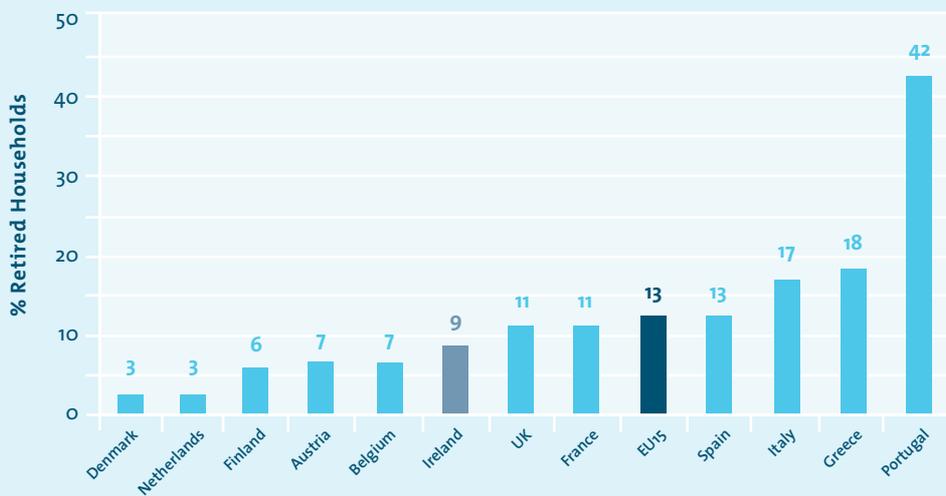
130. The Civil Partnership Bill 2009 provides for the registration of civil partnerships for same-sex couples, bestowing rights and duties in relation to maintenance, shared home, succession and pension.

131. It is noted that there may be some variation between the population aged 65 and over and the retired population. For example, there are people who retire before they reach age 65, some people may identify as unemployed rather than retired, and some women may identify as working in the home rather than as retired.

Housing Problems

Some 8.6 per cent of retired households in Ireland stated they had housing problems. This compares to an EU average of 12.6 per cent. Retired households in Portugal had the most problems, while retired households in Denmark and the Netherlands had the least problems, see Figure 8.25. More recent data for Ireland (2007) shows that 12 per cent of retired households in Ireland and 13 per cent of heads of households aged 65 and over were dissatisfied with their dwelling, compared to 17 per cent of heads of households across all age groups (CSO, 2009f: 6). Older heads of household were more likely to be satisfied with their accommodation than younger households.¹³²

Figure 8.25 Percentage of Retired Households With 3 or More Housing Problems, EU Comparisons, 2001



Source Eurostat, accessed directly.

Housing Need

In relation to housing need, applicants for social housing who were aged 61 and over made up 6 per cent (3,469 applicants) of those assessed as in need of housing in 2008 (www.environ.ie). The absolute numbers of older people requiring social housing have increased from 2005 (3,075 applicants), but make up a slightly smaller proportion of all applicants for social housing (was 7 per cent in 2005). The 2008 assessment of homelessness in Dublin (Homeless Agency, 2008) showed that 4 per cent of adults in homeless services (90) were aged 65 and over, with 21 per cent of homeless adults in Dublin aged over 50. The Homeless Agency note that anyone over 50 who has a prolonged experience of homelessness is vulnerable to many of the physical health problems associated with older age.

¹³² More than one in five of heads of household under 35 years of age were dissatisfied with their dwelling.

Voluntary housing associations¹³³ play a complementary role to local authorities in providing housing for those who cannot meet their own accommodation needs. Housing associations have developed more than 7,000 housing units for older people over the last 20 years (Irish Council for Social Housing, 2005). An Irish Council for Social Housing (ICSH) survey (2004) of 79 housing associations providing housing for older people revealed 3,165 units of accommodation in low support group housing or high support sheltered housing,¹³⁴ with a wide variety of care and support services. At that time (2004) the research identified a further 84 housing associations with plans to develop schemes for older people, which would provide an additional 2,413 units of accommodation (ICSH, 2005). Both group housing schemes and sheltered housing are part of the 'assisted independent living' options and are important elements in the continuum of care for older people. They provide options for older people to remain in their communities rather than having to go into institutions prematurely because of a lack of other options. Sheltered housing covers two policy areas – the provision of housing and the delivery of care. Capital funding has been provided for the provision of housing but the care element has been more difficult to deliver (ICSH, 2005).

Community

The second component examined in relation to community and environment is community. Local support and participation in social activities has been shown to be important for general well-being, especially so for people who may not have the social interaction of work-related activities. Two indicators are used: practical help from neighbours and involvement in voluntary and community activities.

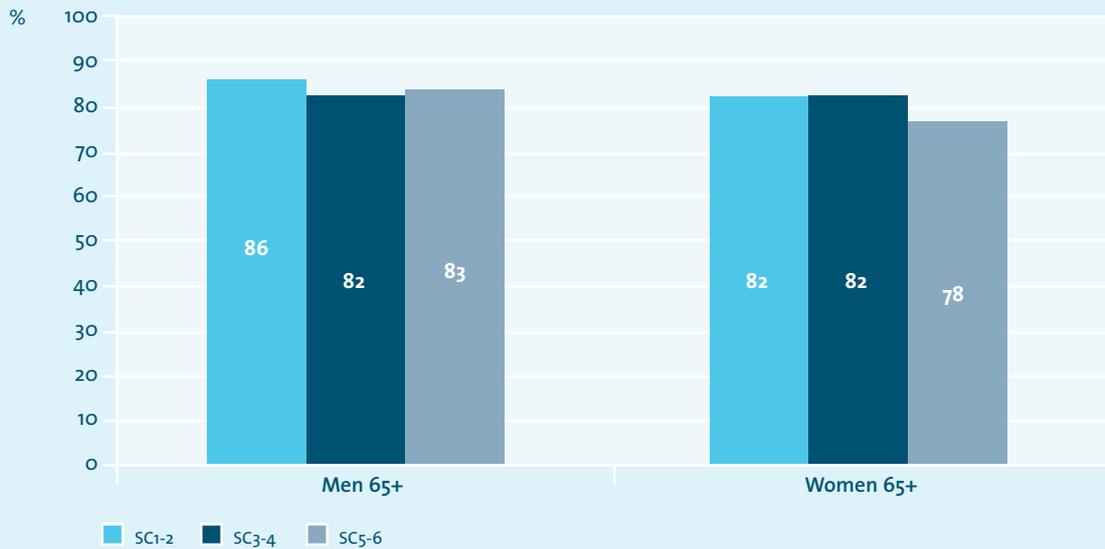
Practical Help From Neighbours

Figure 8.26 shows that four out of five 65 year olds and over who were respondents to the Irish 2007 survey of lifestyle, attitudes and nutrition in Ireland (SLÁN) reported finding it 'easy' or 'very easy' to get practical help from neighbours. There is few gender or social class differences. The Irish SHARE analysis presented levels of social support among older age groups. They found that 22 per cent of respondents aged 50 and over had received help in the last twelve months, with more help received as people get older – 20 per cent for 50-59 year olds and 41 per cent of over 80 year olds receiving help. Conversely, the level of help provided declines with age – with 40 per cent of 50-59 year olds providing help and 16 per cent of the over 80s providing help. Overall, 34 per cent of people provided help (Harmon *et al.*, 2008: 24-25)

133. Housing associations are non-profit organisations established to relieve housing need and are Approved Bodies under legislation (Section 6 of the 1992 Housing Act).

134. Low support housing refers to small group schemes, usually consisting of around 10 units, for relatively active older people, with a limited number of additional services and staff. Sheltered housing can be described as a type of supportive housing service for persons who are too frail or vulnerable to remain in their own homes but who do not need hospitalisation. Sheltered housing schemes provide a high level of support to tenants with a wide degree of on-site facilities, alarms and care staff.

Figure 8.26 Percentage of Respondents Aged 65 and Over who Reported Finding it 'Easy' or 'Very Easy' to Get Practical Help from Neighbours, by Gender and Social Class,¹³⁵ 2007



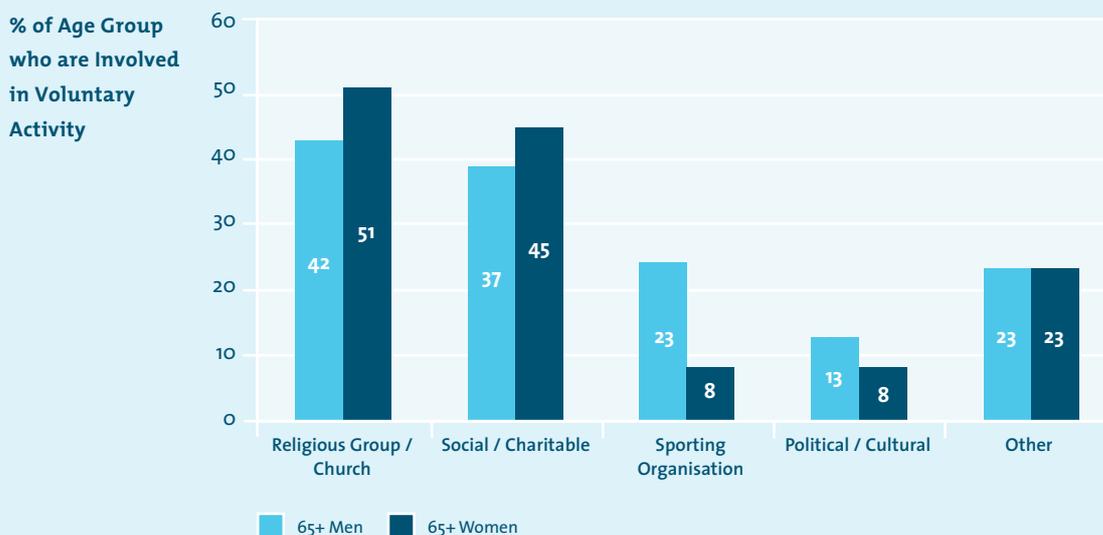
Source: Morgan *et al.*, 2008: 94 (SLÁN, 2007)

Community and Voluntary Activities

The second indicator is involvement in community and voluntary activities. Participation in societal activities is beneficial to older people's well-being as well as making a valuable contribution to society. A National Council on Ageing and Older People survey found that 86 per cent of older people interviewed felt that society does not recognise the contribution made by older people (NCAOP, 2005c: 17). In 2006 some 15.5 per cent of men and 14.5 per cent of women aged 65 and over were involved in voluntary work (Census of Population). This is in comparison to 20.2 per cent and 22 per cent of 55-64 year olds, respectively. The main activities engaged in are religious groups or the church (46.7 per cent), and social or charitable organisations (41.4 per cent), see Figure 8.27.

¹³⁵ SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

Figure 8.27 Persons Aged 65 and over by Type of Voluntary Work, 2006



Source CSO Census of Population, 2006

The SLÁN survey also asked people whether they regularly attended one or more community activities, such as sports clubs, political parties, trade unions, environmental groups, parent-children associations, tenant groups, neighbourhood safety, religious or voluntary activities, evening classes and social clubs. Just under half (47 per cent) of respondents who were 65 years old and over reported regularly attending one or more of these community activities. There was little difference in attendance between men and women but involvement in community activities was more common among the higher social classes (Morgan *et al.*, 2008: 95).

The SHARE survey also asked about participation in social activities. They found older people were most likely to be involved in religious activities – more than one third of those aged 60 and over were engaged in such activities. For all other activities participation declined with age, for example, about one quarter of 60 to 80 year olds participated in social/sports activities, compared to 11 per cent of over 80s who did so, (Harmon *et al.*, 2008: 31).

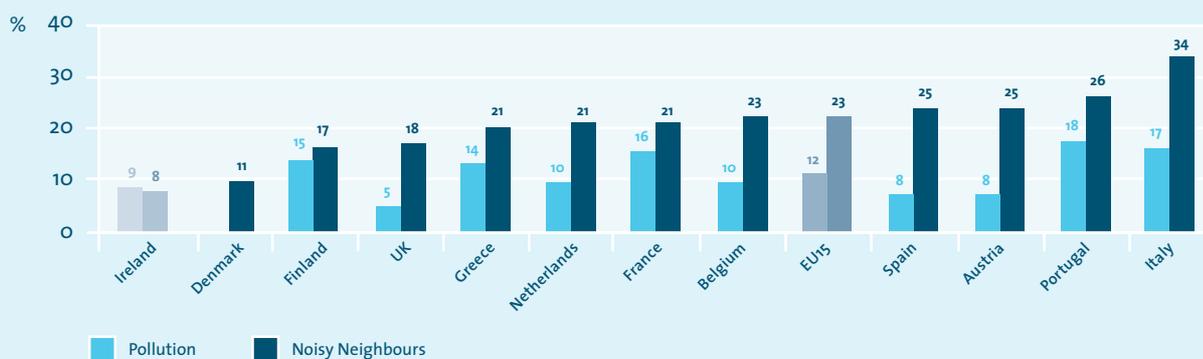
The CSO (2009e) has recently reported on community involvement. They report that 35 per cent of 65-74 year olds and 23 per cent of 75 year olds and over were actively involved in a voluntary or community group compared to 28 per cent of all persons aged 15 and over. In relation to participation in group activities, 69 per cent of 65 year olds and over participated in such activities compared to 65 per cent of everyone aged 15 and over. Some 23 per cent of 65 to 74 year olds participated in informal unpaid charity work, in line with the general population aged 15 and over at 24 per cent. Over 75 year olds were less likely to participate in informal unpaid charity work at 12 per cent.

In summary, there is a wide range of voluntary and community involvement, with levels of participation depending on the nature of the activity. Participation of people aged 65 and over is generally in line with the overall population, although as expected, levels of participation decline for the over 70s. Despite involvement in a wide range of activities there is capacity to increase levels of participation, given the important role of voluntary and community organisations in promoting community development and building social capital, and the benefits to individual well-being.

Environment – Pollution and Noise

The third component is environment. The indicator employed to examine the quality of the immediate environment is the percentage of retired households experiencing pollution from traffic or industry and noise from neighbours or outside, using data from Eurostat, 2001. On both measures Ireland does well with only 8.5 per cent of retired households in Ireland saying they experienced pollution, below the EU average of 11.6 per cent. Retired households in Ireland were least likely to experience noise from neighbours or outside, at 8.4 per cent compared to an EU average of 23.3 per cent, see Figure 8.28. It is noted that design features in the built environment have an important bearing on the quality of life for older people, for example, the provision of public seating, road crossings, the state of footpaths, and street lighting. Data are not currently available to assess the quality of the built environment.

Figure 8.28 Environmental Issues, Retired Households, EU Comparisons, 2001



Source: Eurostat, accessed directly.

Note: Data on 'Pollution' not available for Denmark.

Transport

Transport is the fourth component identified under the domain of community and environment. Mobility and access to transport is fundamental to an older persons' well-being and to support their independence. Good public transport systems play a central role and older people can travel for free on public transport systems in Ireland. However, public transport systems are still limited in many areas, especially rural areas, and information on availability of, and access to, public transport is limited, both in Ireland and internationally. The indicator used here is the views of 65 year olds and over on the quality of public transport, from the European Quality of Life Survey, 2003.

Respondents were asked to score the quality of the national public transport service on a scale of 1 ‘very poor quality’ to 10 ‘very high quality’. The results are presented in Figure 8.29. Older people in Ireland scored the quality of public transport here just below the EU25 average at 6.1. The EU25 average was 6.4. The quality of public transport was ranked highest by older people in Finland and Luxembourg and lowest in Portugal and the Czech Republic.

Figure 8.29 Views on the Quality of Public Transport by 65 Year Olds and Over, EU Comparisons, 2003¹³¹



Source: European Foundation for the Improvement of Living and Working Conditions, 2004 (based on European Quality of Life Survey, 2003).

As people age they become more reliant on public and other forms of transport as their ability to drive themselves declines. For example, while 84 per cent of men and 55 per cent of women aged 60 to 69 held a full drivers licence in 2006, only 44 per cent of men and 13 per cent of women aged 80 and over did so. Lack of appropriate transport can be a barrier to health, shopping, social engagement, wider participation and learning. Just over one third (35 per cent) of heads of household aged 65 and over had difficulty accessing public transport compared to 26 per cent of all heads of household. One quarter of older heads of household had difficulty accessing a shop that sells groceries or a post office (23 per cent and 26 per cent, respectively), compared to 16 per cent and 12 per cent, respectively, of all heads of households (CSO, 2009e: 22). Older women are particularly vulnerable and their share of the population is likely to increase in future years (see section 8.3). Access to transport is especially critical in rural areas where conventional transport services may be limited and people may have difficulty getting to the bus stop. Non-conventional services, such as the Rural Transport Programme, can play an important role here.¹³⁷ There is also scope for other innovative approaches to be developed.

¹³⁶. Data should be treated with caution as some cell sizes may be small.

¹³⁷. The Rural Transport Programme is being reviewed by the Department of Transport.

Summary

Just under 10 per cent of older people had housing problems and just over 10 per cent of older people were dissatisfied with their housing. In the order of 3,500 older households are in need of social housing and about one fifth of homeless adults in Dublin are aged over 50. The provision of group housing schemes and sheltered housing by housing associations plays an important role in assisting independent living for older people.

In relation to community supports about four out of five older people (aged 65 and over) found it easy to get practical help from neighbours. Older people are involved in a wide range of community and voluntary activities, with levels of involvement in line with the general population. Much of the involvement of older people is related to religious activities, but also with social and charitable organisations. Lower social class groups and the very old tend to be less involved in these activities.

On environmental issues, less than 10 per cent of retired households experienced pollution from traffic or industry, or noise from neighbours or outside. The design of the built environment can contribute to the quality of life for older people, but data are not available to assess the quality of the built environment. In relation to transport people aged 65 and over rated the quality of public transport in Ireland as average. Transport is fundamental to the well-being and independence of older people in providing access to essential services and activities. Specific needs have been identified for older people living in rural areas, with non-conventional and innovative transport services having a role to play in meeting those needs.

8.7.2 Ireland's Policy Framework on the Community and Environment for Older People

The vision of an Ireland where older people can live active and full lives contains the high level goals that 'every older person would be encouraged and supported to participate to the greatest extent possible in social and civic life' and that 'every older person should have adequate support to enable them to live independently in their own homes for as long as possible. This includes access to housing, transport.' (*Towards 2016*).

Specific priority actions are:

- ◆ To ensure availability of a mix of dwelling types (integrated housing and care services) of good design across all tenures;
- ◆ For older people on low incomes: grant schemes, social housing and sheltered housing options;
- ◆ Housing Action Plans to address special needs and specify the role of the voluntary and co-operative housing sector;
- ◆ Inter-agency co-operation to cater for care needs in accommodation;
- ◆ A reform of the grant schemes for older people in private housing;
- ◆ Services to provide enhanced home security and energy conservation, including improved heating systems and insulation; and
- ◆ Further development of the rural transport initiative (RTI) to support community-based living.

8.7.3 Commentary on the Community and Environment for Older People

There are a number of areas requiring consideration in relation to the community and environment for older people. While the quality of accommodation for older people has generally improved in recent years and most people are satisfied with their accommodation there are about ten per cent of the older population with housing needs which require to be addressed. In addition, urgent attention needs to be given to older people who are homeless, particularly given the associated health risks. The importance of inter-agency cooperation is emphasised—between and within, public, private and voluntary service providers—to provide sustainable housing along with the provision of care supports, where required.

Older people make a valuable contribution to their families, communities and society through their voluntary and community work, which can also contribute to their own well-being. Their role often goes unrecognised, but should be more widely acknowledged and valued. More detailed information on their involvement in community and voluntary activities, and the benefits to them and their communities, would help to elaborate on this aspect of older people's lives and well-being.

Improving the community and environment for older people is primarily a function of integrated planning and service provision, complemented by specific supports to address particular needs. Many of these needs are identified in the policy framework, but attention needs to focus on the most vulnerable 10 to 20 per cent or so of older households.

An example of a positive scheme is the 'Action Plan' to promote more 'age-friendly' transport services, a joint initiative of the Equality Authority, the Health Service Executive and the National Council on Ageing and Older People, which has secured the support of the main bus and rail transport providers. The plan is designed to 'combat ageism and promote equality for older people accessing transport services'. Key features of the plan include ongoing consultation with older customers, staff training and 'age-friendly customer service practices'. The plan notes that 'transport is essential to the well-being and quality of life of older people in rural and urban areas' (McGivern, 2006). Evaluation of the implementation of the initiatives in this plan will be important to provide feedback on the success or otherwise of the services. Similarly, the provision of non-conventional transport services, such as the Rural Transport Programme, play an important role in providing access for older people to essential services and facilities and in promoting independent living.

It would be useful to have more data available by age and socio-economic group to be able to analyse, in more detail, the impact of community and environmental factors on the well-being of older people. Additional indicators could also be considered, such as distance to nearest bus stop or shop.

8.8 Health

8.8.1 Measuring the Health of Ireland's Older People

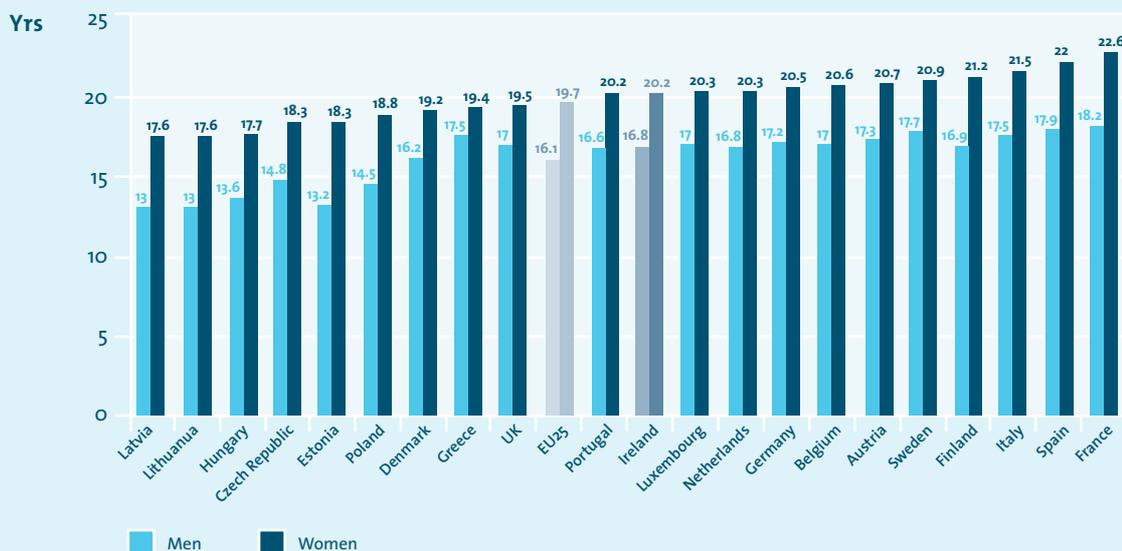
The health of older people is fundamental to their well-being and, along with pensions, receives the most attention. While people's susceptibility to ill-health increases with age, with the provision of anticipatory care, appropriate diagnosis, treatment and rehabilitation older people's well-being can be enhanced. Technological advancements will also add to people's abilities to manage their lives as they age.

Under the domain of health we examine 4 components: life expectancy, health status, risk behaviours and healthy behaviours. With advances in medicine and improved knowledge about the various aspects for enhanced well-being people are living longer. This has implications for people as they grow older, for their families, for communities and for public policy. In chapter 4 we presented a graph on life expectancy from birth for the period 1985 to 2006. Here we present information on life expectancy at age 65, which is relevant for older people as well as policy makers and service providers.

Life Expectancy at Age 65

Using data from Eurostat, Figure 8.30 shows that life expectancy for men and women at 65 in Ireland is just above the European average. Life expectancy at 65 for women in Ireland is 20.2 years; for men it is 16.8 years,¹³⁸ compared to 19.7 for women and 16.1 for men in the EU25. In Ireland there is great variation within the population. For example, Traveller men live 9.9 years less than settled men and Traveller women live 11.9 years less than settled women (www.pavepoint.ie).

Figure 8.30 Life Expectancy at 65, Selected EU Comparisons, 2006



Source Eurostat, accessed directly.

Note Figures for Italy are 2004, and for UK 2005. The EU25 figures are calculated as a simple average of the 25 EU countries.

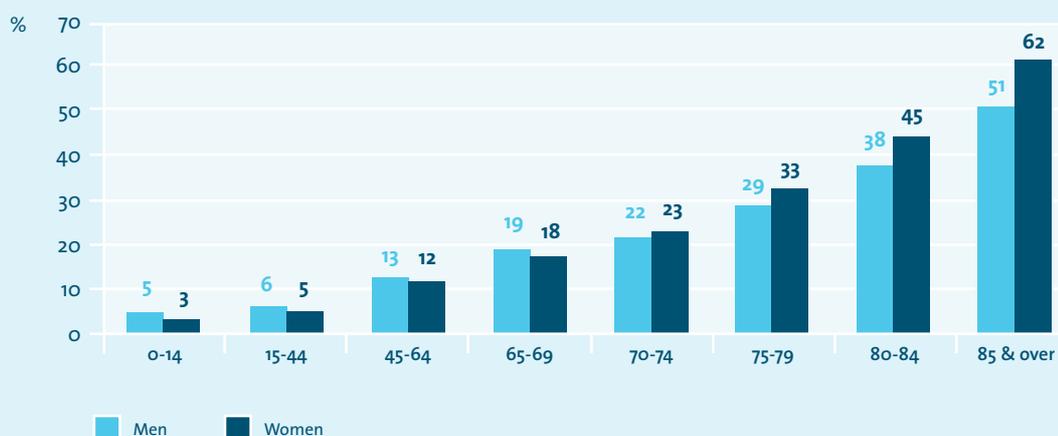
138. The Irish Life Tables produced by the CSO estimate life expectancy at 65 for males as 16.6 and for women as 19.8 provided for the period 2005-2007.

As well as a long life a healthy or disability-free life contributes to the well-being of older people. In chapter 4 we presented information on healthy life years from birth – which was 65 for women and 63.3 for men in Ireland (2006). The findings from the English Longitudinal Study of Ageing (ELSA) demonstrate a link between health and wealth, with higher income groups in general having better health and lower income groups having poorer health (Banks *et al.*, 2006). Socio-economic circumstances, genetics, cultural factors and peer influences, as well as risk and healthy behaviours, impact on people’s health throughout life. These issues, as well as the role of preventative measures, are addressed throughout this chapter, as well as in other chapters of this report.

Prevalence of Disability

The second component in the health domain is health status. The first indicator presented in this component is the prevalence of disability. Data from the Irish 2006 census show that 29.5 per cent of persons aged 65 and over indicated they had a disability compared to 9.3 per cent of all persons (CSO, 2007a: 19). Disability increases with age, varying from 18.7 per cent of 65-69 year olds to 58.6 per cent of the 85 and over age group, see Figure 8.31. In the older age groups women have a higher prevalence of disability than men.

Figure 8.31 Prevalence of Disability by Age, 2006



Source CSO, 2007i: 19 (based on Census data).

The first results of the National Disability Survey, 2006 (CSO, 2008d) show that people aged 65-74 have on average 2.6 disabilities per person and people aged 75 and over have 2.8 disabilities per person. For both these older age groups the most frequently reported disability was mobility and dexterity problems, at 83 per cent of all persons with disabilities in the 75 and over age group and 70 per cent of the 65-74 age group. Pain was the next most frequently reported disability, with 59 per cent of the 65-74 year old age group and 48 per cent of the 75 and over age group reporting pain. For both conditions the most commonly cited cause was arthritis (all age groups) – for 25 per cent of those with a mobility/dexterity problem and 34 per cent of those with a pain disability. These conditions, and pain in particular, have a debilitating effect on well-being.

Some 62 per cent of people aged 65 and over report having a chronic illness (Health Service Executive, 2009a: 83). Chronic illnesses are long term conditions which can be treated and controlled but not cured. They include things like heart disease, respiratory disease, asthma, some cancers, musculoskeletal diseases, dementia and mental health problems. Generally these conditions are acquired as one gets older and people may suffer from more than one condition. Living with a chronic illness can have a negative impact on the quality of people's lives. Just over one fifth of people with a chronic illness or health problem are at risk of poverty. Chronic diseases are responsible for about 60 per cent of deaths. The most common cause of death in those aged 65 and over is cardiovascular disease, followed by cancer and respiratory diseases (CSO, 2007i: 18).

Mental Health

The second indicator in the health status component is mental health. The measure used here is the mental health index, which is a measure of psychological distress. The index is constructed from the responses to questions such as whether people felt 'particularly nervous' or 'downhearted and miserable' in the previous 4 weeks. Higher scores indicate less psychological distress (from 0-100), (Morgan, *et al.*, 2008: 45). The overall mean score for the population of 18 and over was 82, representing relatively low levels of psychological distress in the population generally. People aged 65 and over tended to have slightly higher average scores (less psychological distress) than people aged 45-64, see Figure 8.32. People in lower social class groups tended to have slightly lower scores, indicating higher levels of psychological stress.

Figure 8.32 Mean Score on Mental Health Index Scale, by Gender and Social Class,¹³⁹ 2007
(Higher Scores Indicate Less Psychological Stress)



Source: Morgan *et al.*, 2008: 45 (SLÁN, 2007)

139. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

Poor levels of social support and experiencing loneliness are strongly associated with higher levels of psychological distress (Barry *et al.*, 2009: 3). As stated in earlier chapters there is a stigma attached to mental health problems, and they impact negatively on people's quality of life and sense of well-being. Mental health problems affect not only the individual themselves, but can impact on family members and friends. Limitations in social and physical activities as a result of mental health problems can lead to social isolation and further health problems (Tedstone Doherty *et al.*, 2008: 11).

Research by the Health Research Board (Tedstone Doherty *et al.*, 2008: 11) emphasised the role played by GPs in the care and treatment of people who are experiencing psychological distress. The research cites the important role played by good primary care services in the UK where a 'stepped care model' for the treatment of common mental health problems, with access to counsellors and psychologists within the primary care service, can significantly reduce referrals to secondary mental health services. Such an approach is not yet available in Ireland.

Access to Health Services

The third indicator in the health status component is access to health services, measured by attendance at a GP. Figure 8.33, based on SLÁN data, shows that older respondents have higher attendance rates at GPs, with women tending to attend GPs slightly more than men. There is little difference across social class. The CSO's health status and health service utilisation survey (QNHS Q3 2007) found similar results, with 65-69 year olds having an average of 4 consultations with their GP in the last 12 months, and 70 year olds and over having 5.2 consultations (CSO, 2008c). This compared to 2.8 consultations for 45 to 54 year olds. In 2007, 38 per cent of 65-69 year olds and 62 per cent of 70 year olds and over had a medical card;¹⁴⁰ 41 per cent of 65-69 year olds and only 3 per cent of 70 year olds and over had private health insurance. Some 11 per cent of 65-69 year olds had neither (only 1 per cent of 70 year olds and over had neither).

140. Entitlement to a medical card was available to all persons aged 70 and over from July 1st 2001. This automatic entitlement ended on 31st December 2008 and has been replaced by a means tested scheme from 1st January 2009 where everyone aged 70 and over will be entitled to a Medical Card if their weekly gross income is below €700 for a single person and €1,400 for a couple.

Figure 8.33 Percentage of Respondents who Reported Attending a GP within the Previous 12 Months, by Gender and Social Class,¹⁴¹ 2007



Source: Morgan *et al.*, 2008: 38 (SLÁN, 2007)

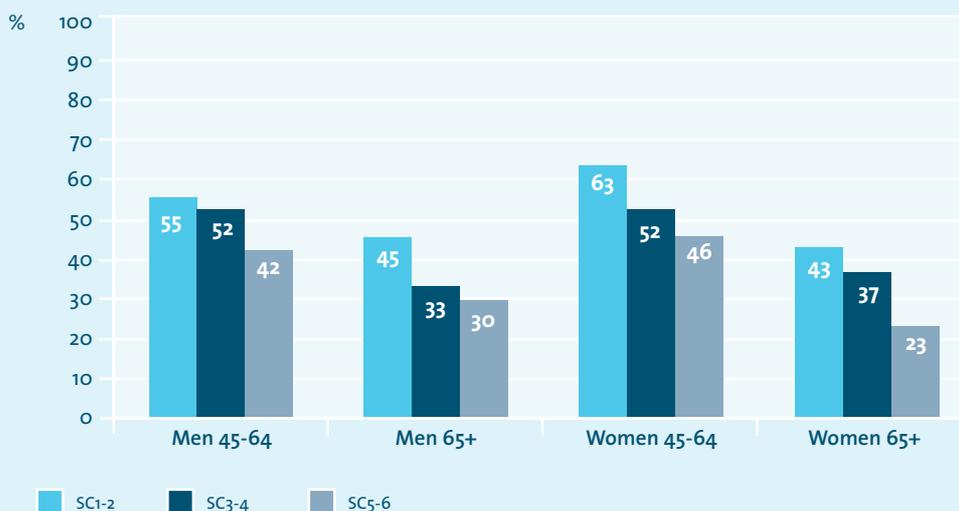
As also noted in the previous chapter possession of a medical card has been found to be an important determinant of utilisation of GP services—those without a medical card had 2.3 visits on average, rising to 6 for those with a medical card (Layte *et al.*, 2007: xxiii). The reasons for this are complex, but the higher level of GP utilisation among medical card holders can be partly explained by their higher age and worse physical and mental health, as well as other factors. Layte *et al.*'s (2007: xxiii) analysis showed that having a higher income (among those without a medical card) made the probability of a visit to the GP in the year more likely, but high income does not increase the frequency with which a person visits a GP. The researchers suggest that having a lower level of income significantly decreases the chance that a person will seek out any GP care at all rather than suppressing the frequency of visiting. The cost of attending a GP (for those without a medical card) is a factor in accessing health services; as well as the ability to access such services. Some 29 per cent of heads of household aged 65 and over reported having difficulty accessing a GP, compared to 19 per cent of heads of households across all age groups (CSO, 2009e: 22).

Perception of Health

The fourth indicator of this component is older people's perception of their health. As expected, older people were less likely to rate their health as 'very good' or 'excellent' than younger people, see Figure 8.34, based on SLÁN data. Only one third (34 per cent) of people aged 65 and over rated their health as 'very good' or 'excellent' compared to an average of 58 per cent across age groups. There were no gender differences but people in lower social classes were less likely to perceive their health as 'very good' or 'excellent'.

141. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

Figure 8.34 Percentage of Respondents Rating Their Health as ‘Excellent’ or ‘Very Good’ by Gender and Social Class,¹⁴² 2007



Source Morgan *et al.*, 2008: 34 (SLÁN, 2007)

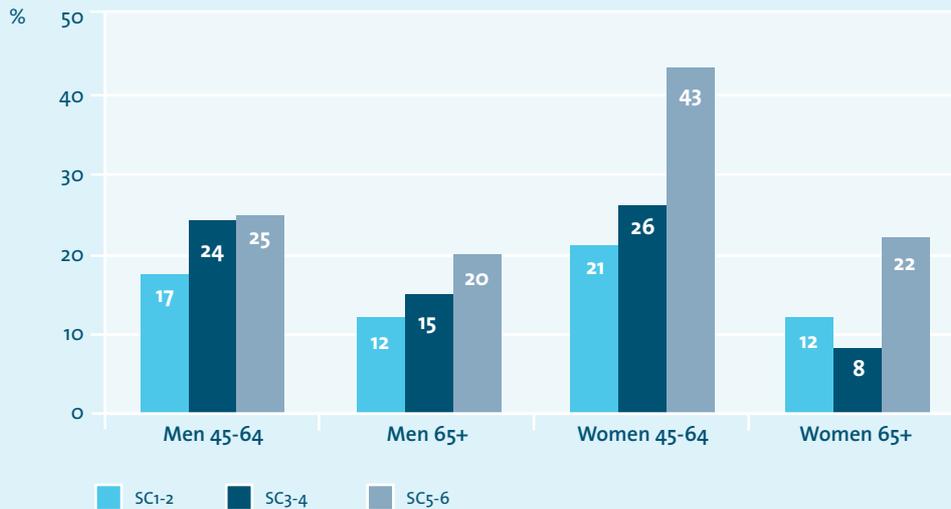
Risk Behaviours

The third component in the health domain is risk behaviours. Health behaviours are one of the factors affecting health outcomes. Health behaviours are a product of individual choice conditioned by other factors such as levels of education, income, peer behaviours and cultural beliefs. Three indicators are used to assess risk behaviour – smoking cigarettes, drinking alcohol, and being overweight or obese.

Smoking Cigarettes

Figure 8.35 presents information from the SLÁN survey on the percentage of smokers in 2007. Overall in the population 29 per cent of respondents reported being current cigarette smokers, but for 65 year olds and over it was only 14 per cent (25 per cent for 45-65 year olds). For the over 65s rates of smoking were higher for men than women (17 per cent compared to 13 per cent). There was a big social class gradient with 20 per cent of over 65 year old men in social classes 5 and 6 smoking compared to 12 per cent in social classes 1 and 2. The difference was more marked for women with nearly twice as many women over 65 in social classes 5 and 6 (22 per cent) smoking as in social classes 1 and 2 (12 per cent).

142. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

Figure 8.35 Percentage of Smokers, by Gender and Social Class,¹⁴³ 2007

Source Morgan *et al.*, 2008: 75 (SLÁN, 2007)

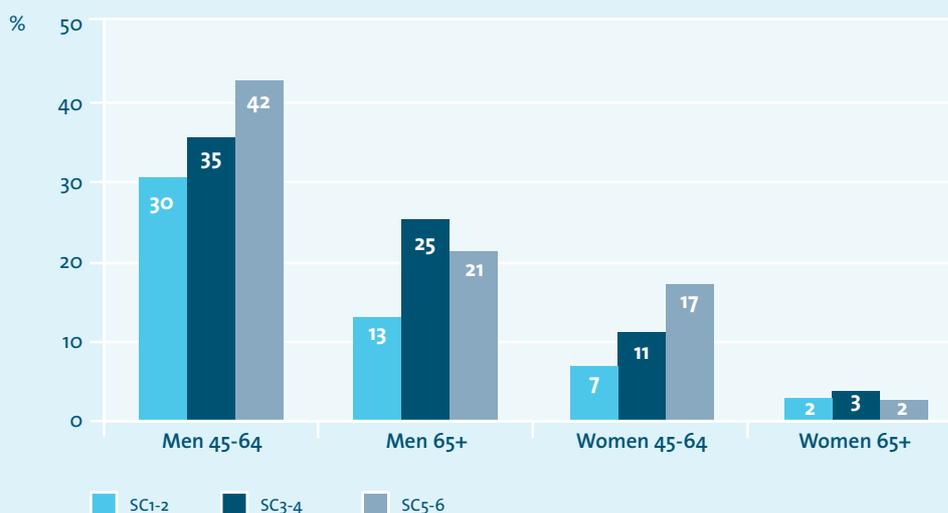
Drinking alcohol

In relation to drinking alcohol, 12 per cent of people aged 65 and over reported drinking 6 or more 'standard' drinks on one or more occasions per week, compared to 28 per cent in the population overall, see figure 8.36.¹⁴⁴ Older women, in particular, were less likely to drink to this level. While across the population generally, people in social classes 5 and 6 have higher levels of alcohol consumption, this is less evident in the older age groups. The National Council on Ageing and Older People note that 'the level of alcohol problems among older people is unknown as they often go unrecognised... 11.5 per cent of those in the 64-74 age group and 4.8 per cent of those aged 75 and over who were admitted to psychiatric hospitals in 2000 suffered from alcoholic disorders' (NCAOP, 2005c: 16).

143. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

144. A 'standard' drink is defined as one unit of alcohol eg. half pint or glass of beer, cider or lager; a single measure of spirits; a single glass of wine, sherry or port; or a bottle or alcopop (long neck).

Figure 8.36 Percentage of Drinkers who Reported having 6 or more ‘Standard’ Drinks on One or More Occasions per Week, by Gender and Social Class,¹⁴⁵ 2007



Source Morgan *et al.*, 2008: 81 (SLÁN, 2007)

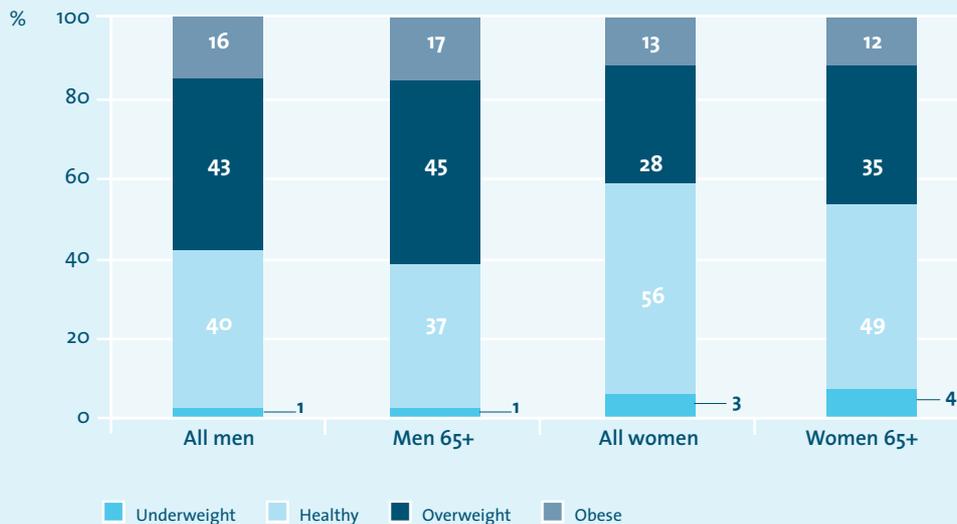
Overweight / Obese

The third indicator on the risk behaviours component is being overweight or obese. Overall, 36 per cent of the population is classified as overweight and 14 per cent obese – higher percentages of men were overweight (43 per cent of all men compared to 28 per cent of all women) and obese (16 per cent of all men compared to 13 per cent for all women), see Figure 8.37. These trends are accentuated for older people – 45 per cent of older men and 35 per cent of older women self reported as being overweight and 17 per cent of older men and 12 per cent of older women as obese.¹⁴⁶ As mentioned in the previous chapter SLÁN also collected data (measured by a nurse) on cholesterol levels, blood pressure and obesity. Of the sample of 65 year olds and over who participated in these tests, more than four out of five (83 per cent) had raised cholesterol, three quarters (74 per cent) had high blood pressure and nearly one third (30 per cent) were obese.

¹⁴⁵ SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

¹⁴⁶ As part of the SLÁN data collection exercise BMI (Body Mass Index) was also independently measured for a sub sample of respondents. In line with other international studies the self reported data tended to underestimate prevalence of being overweight or obese compared to the independently measured data.

Figure 8.37 Body Weight of 65 Year Olds and Over, by Gender, 2007



Source: Morgan *et al.*, 2008:99 (SLÁN, 2007)

Healthy Behaviours – Physical Exercise

The fourth component on the health domain is healthy behaviours. There are two indicators in this component – physical exercise and nutrition. Figure 8.38 shows the percentage of respondents aged 65 and over, compared to those aged 45-64, in the SLÁN survey, with high physical activity scores (over 10,000 steps per day). Overall in the population a quarter (24 per cent) of respondents had high physical activity scores, with twice as many men (32 per cent) having this level of activity compared to women (16 per cent). High levels of physical activity decline with age, with just 10 per cent of 65 year olds and over participating in physical activity to this level, with lower levels for older women than older men. There was little difference across social class. The main reason given for physical inactivity among the older population (aged 65 and over) was an injury, disability or medical condition (44 per cent of physically inactive over 65s); one quarter (24 per cent) gave ‘other’ reasons and 17 per cent were not interested. Research by the National Council of Ageing and Older People (2005c) reported that 78 per cent of people aged 55 and over felt that they exercised sufficiently.

Figure 8.38 Percentage of Respondents with High Physical Activity (IPAQ¹⁴⁷) Scores, by Gender and Social Class,¹⁴⁸ 2007



Source Morgan *et al.*, 2008: 51 (SLÁN, 2007)

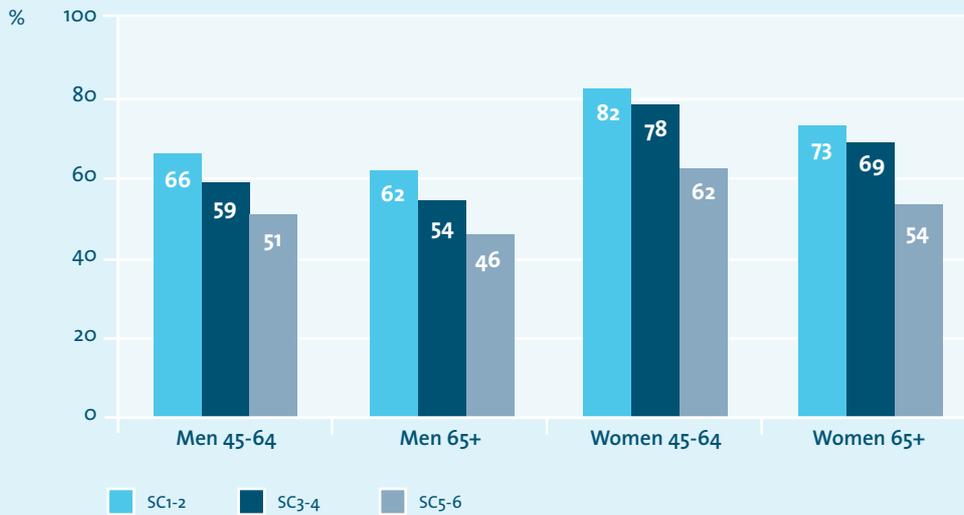
Nutrition

Diet is also important in contributing to good health and well-being. Figure 8.39 presents the percentage of respondents aged 45-64 and over 65 to the SLÁN survey (2007) who reported consuming 5 or more daily portions of fruit and vegetables, as recommended in the ‘Food Pyramid’. Overall, two thirds (65 per cent) of respondents reported consuming 5 or more daily servings of fruit and vegetables. Women (71 per cent) were more likely to consume this level of fruit and vegetables than men (59 per cent). People aged 65 and over, at 59 per cent, consumed less than the average, see Figure 8.39. There is a social class gradient with respondents in the higher social classes more likely to eat 5 or more daily servings of fruit and vegetables. Research undertaken by the National Council on Ageing and Older People (2005c) found that one third of people in Ireland over the age of 55 do not eat the recommended daily servings of dairy, fruit, vegetables, meat and fish and just over half believed that they could be eating more healthily.

147. IPAQ is the International Physical Activity Questionnaire.

148. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

Figure 8.39 Percentage of Respondents Consuming 5 or More Daily Servings of Fruit and Vegetables, by Gender and Social Class, ¹⁴⁹ 2007



Source Morgan *et al.*, 2008: 64 (SLÁN, 2007)

Summary

The health of older people is fundamental to their well-being. While people's susceptibility to ill-health increases with age, preventative measures such as healthy behaviours, along with the provision of anticipatory care, appropriate diagnosis, treatment and rehabilitation, and technological advancements can enhance older people's health and well-being. Average life expectancy for 65 year old women is 20.2 years and for 65 year old men is 16.8 years, although there are differences within the population. These life expectancy rates are above the EU25 average in both cases. There is a link between health and wealth with higher income groups, in general, having better health than lower income groups. As well as a longer life, a healthy life is also important to well-being. Just under 30 per cent of people aged 65 and over have a disability (the chances of having a disability increases with age) and just less than two thirds (62 per cent) of older people have a chronic illness. These conditions can have a debilitating effect on people's health and well-being especially if associated with pain. Nevertheless, older people tend to have lower levels of psychological distress than the population in general, although people in the lower social class groups do record higher levels of stress. Psychological distress can be associated with loneliness and lack of social support.

The role of primary care is important. As might be expected, older people have higher attendance rates at GPs than the population generally, with women attending GPs more than men. A number of factors, in addition to health needs, influence attendance at a GP, including having a medical card, cost, and being able to access a GP. Some 29 per cent of heads of household aged 65 and over reported having difficulty in accessing a GP. About one third of older people rated their health as 'very good' or 'excellent' (compared to 58 per cent of the population generally).

149. SC1-2 are higher (professional and managerial) social classes; SC3-4 are non-manual and skilled manual; SC5-6 are semi-skilled and unskilled.

Health behaviours can affect people's health and are influenced by people's socio-economic circumstances and cultural beliefs, as well as individual choice. Being a non-smoker, moderating alcohol intake, eating healthily, taking exercise and maintaining a healthy weight all contribute to health and well-being generally and reduce the risk of ill-health and disease in older ages. Older people have lower smoking and drinking rates than the population generally, but have lower levels of physical activity (in many cases because of a medical condition or disability), consume slightly less fruit and vegetables, and are more likely to be overweight or obese. There are some gender and social class differences.

8.8.2 Ireland's Policy Framework on the Health of Older People

The national partnership agreement *Towards 2016* contains the long term goal that:

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 (services)

Priority actions include ensuring that older people will be provided with the appropriate access to a full range of health services to suit their needs, including primary care, acute care and mental health care.

The health care actions for older people are to be supported by a number of strategic policy frameworks, including the *Health Strategy: Quality and Fairness: A Health System for You* (2001) and *Primary Care: A New Direction* (2001). Also relevant are the National Mental Health Strategy 2006 *A Vision for Change*, the National Plan for Social Inclusion 2007-2016, the National Development Plan and strategies related to various aspects of health, for example, the national strategy for cancer control (see www.dohc.ie and www.hse.ie).

The National Health Promotion Strategy (2000-2005) sets out four objectives in relation to older people: (i) to consult older people on promoting positive mental health; (ii) to implement community-based programmes such as 'Being Well' and 'Go for Life'; (iii) to implement the recommendations of a food and nutrition policy for older people and the recommendation of 'Building Healthier Hearts'; and (iv) to implement the health promotion strategy for older people 'Adding years to life and life to years'. The health promotion work addresses issues of nutrition and exercise, through the local authorities and community-based programmes. These initiatives are complemented by national policies on smoking, drinking, drug misuse, safety and injury prevention (Department of Health and Children, 2000a, www.dohc.ie).

8.8.3 Commentary on the Health of Older People

There are three main points to make in relation to the health of older people. The first is that people in Ireland are living longer and this is to be welcomed, especially from a positive ageing perspective. Older people are less likely to engage in behaviours that damage their health, such as smoking and excessive drinking. Nevertheless, health outcomes for older people could be improved through improved diet and greater levels of physical activity. People's health in older age is also influenced by their behaviours throughout life so the conclusions of chapters 6 and 7 are also relevant here. In particular, there are associations between people's socio-economic circumstances, their health behaviours and their health outcomes, which could be further addressed.

The second point is that, despite longer lives and active ageing, health does decline with age, especially in relation to the onset of chronic illness and disability. The pain and limitations associated with some of these conditions can be debilitating in relation to health and well-being. Conditions with a high prevalence which impact on older people's well-being include: cardio-vascular disease, cancers, musculoskeletal disease, respiratory conditions and diabetes. Older people are also subject to falls, which are a major cause of fatal injuries in older people. The analysis points to the importance of primary care and supports in the community, including the use of technology.

The third point is the importance of good data to assess need and to monitor improvements. The SLÁN survey is a particularly rich data source, providing breakdowns across a number of dimensions, including age. The analysis of TILDA will further contribute to our information base on the health and care needs of older people.

8.9 Democracy and Values

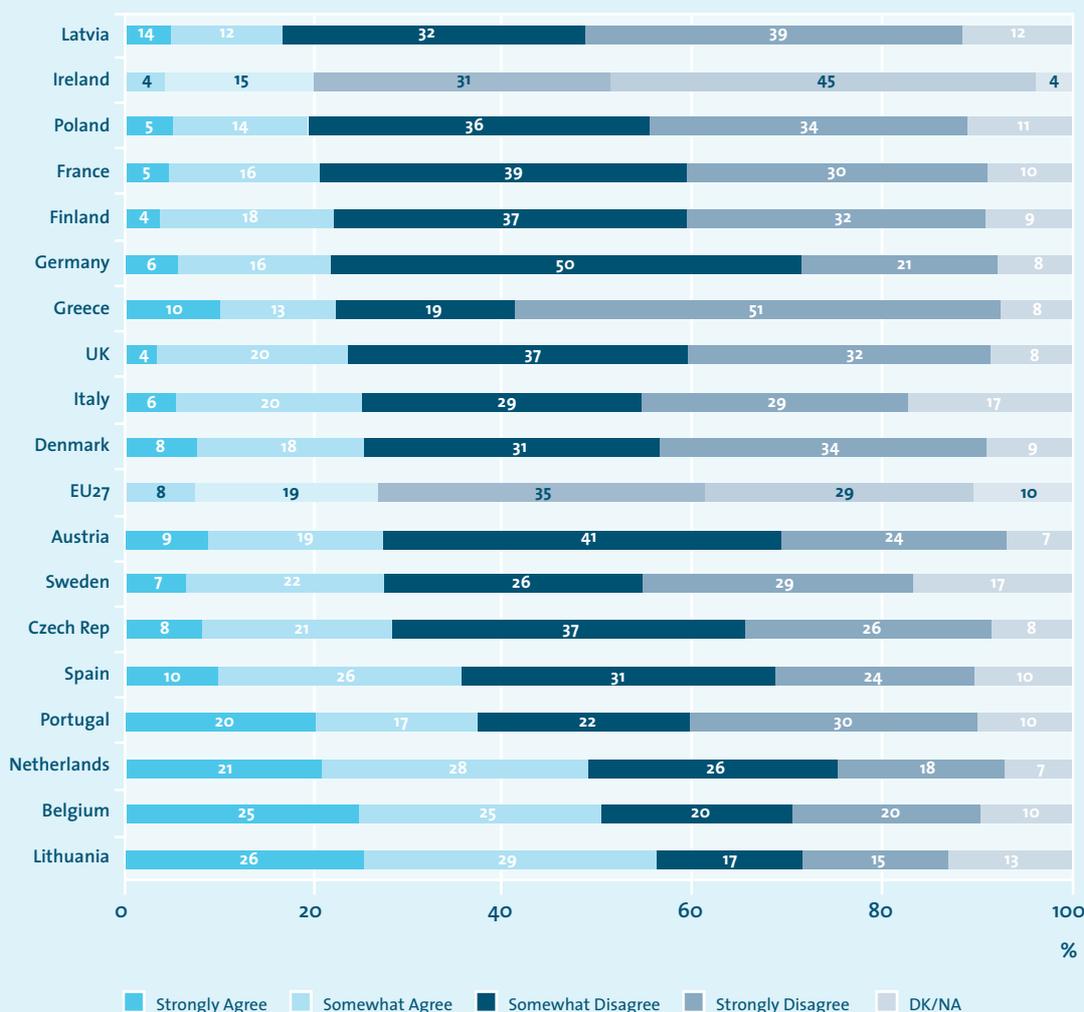
8.9.1 Measuring Democracy and Values for Older People

The sixth domain is democracy and values. As stated previously, living in an open and transparent democracy which is inclusive, safe, fair, and where people are valued is conducive to well-being. In this section there are 3 components: exercising democracy, threats and equality. Under the exercising democracy component we present 3 indicators: intergenerational solidarity, voter participation and internet usage.

Intergenerational Solidarity

The European Commission recently carried out a Eurobarometer survey on intergenerational solidarity (European Commission, 2009). One of the questions asked was whether people agreed that the government was doing a good job in promoting a better understanding between the young and the old. The results for selected EU countries are presented in Figure 8.40. Across the EU27 just over a quarter of the respondents agreed (27 per cent) that their government was doing a good job promoting intergenerational understanding (8 per cent strongly agreeing and 19 per cent somewhat agreeing). The proportion of respondents holding this view in Ireland was much lower with less than 1 in 5 (19 per cent) agreeing that the government was doing a good job promoting a better understanding between the young and the old (4 per cent strongly agreeing and 15 per cent somewhat agreeing). This is one of the lowest levels of agreement across the EU. Only in Lithuania and Belgium did more than half of respondents agree that their government was doing well in promoting intergenerational understanding.

Figure 8.40 'The Government is Doing a Good Job in Promoting a Better Understanding Between the Young and the Old', Selected EU Countries, 2009

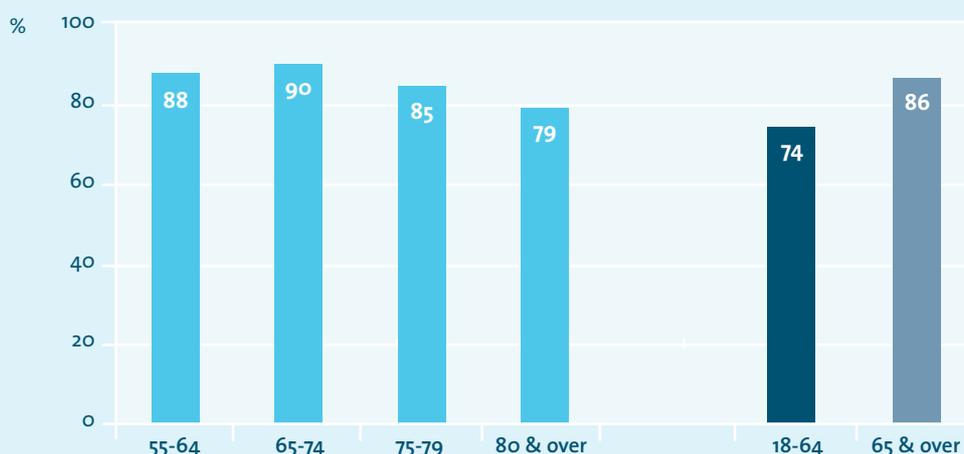


Source: European Commission, Flash Eurobarometer, 2009.

Voter Participation

The second indicator in the exercising democracy component is voter participation. Voting among the older population is traditionally higher than for the rest of the population. Figure 8.41 shows voter participation in the general election of May 2002. Some 86.3 per cent of people aged 65 and over voted in this election, compared to 74 per cent of the 18-64 year old population. Some 90 per cent of 65-74 year olds voted, declining to 79 per cent for 80 year olds and over. The main reason given by those aged 65 and over who did not vote was illness or disability (43 per cent). Other reasons included being away, having no interest or disillusioned (CSO, 2007i: 29).

Figure 8.41 Voter Participation in the General Election, May 2002



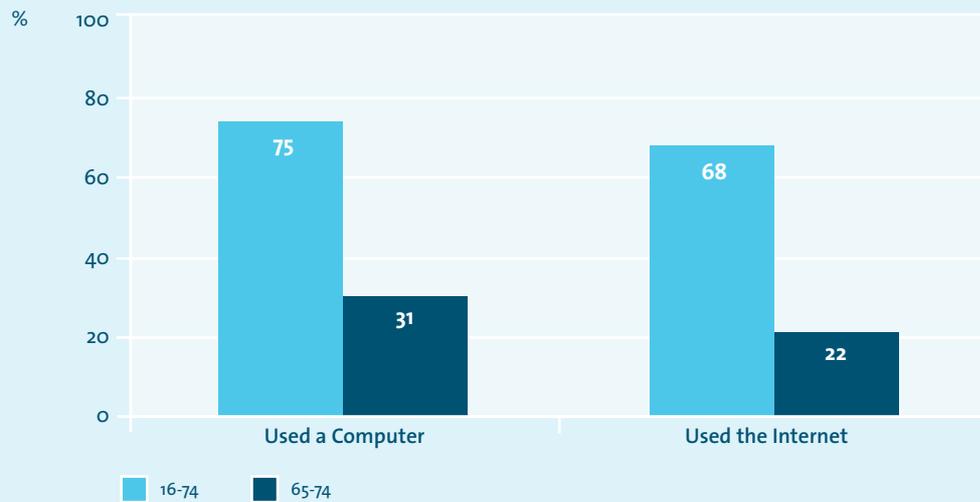
Source CSO, 2007i: 29.

Use of ICT

Access to the internet and use of computers are increasingly required for full participation in modern society. Figure 8.42 shows the percentage of people aged 65-74 who have used a computer or the internet.¹⁵⁰ Some 31 per cent of people aged 65-74 years have used a computer compared to three quarters of the whole population (16-74 year olds); there is a similar gap in internet usage – just one in five (21 per cent) of 65-74 year olds having used the internet compared to two thirds (68 per cent) of the population (CSO, 2009c). Given the advance of new technologies it would be expected that older people would have a lower usage than the population as a whole. Nevertheless, efforts are required to ensure that older populations do not ‘get left behind’ or excluded from technological developments. This is particularly important in relation to the provision and accessibility of information on public services.

150. Results are from the CSO QNHS Q1 2008. The information is based on a sub-sample of the QNHS and may be subject to some sampling and survey errors due to sample size.

Figure 8.42 Computer and Internet Use, 2008

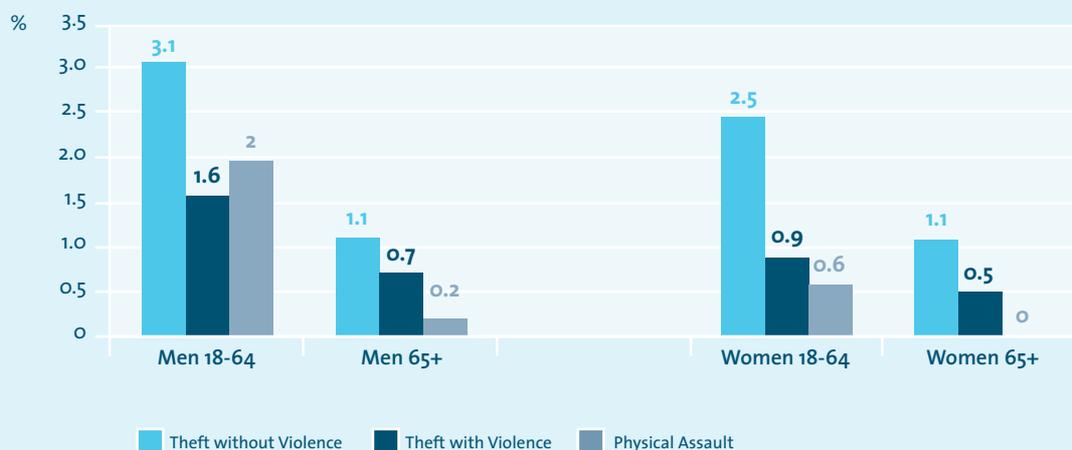


Source CSO, 2009c: 35

Threats – Crime Victimization

The second component of the democracy and values domain is threats which undermine well-being. Three indicators are presented: victims of crime, perceptions of crime and poor treatment, neglect and abuse. Figure 8.43 presents crime victimisation rates in Ireland in 2006, comparing those aged 65 and over with the rest of the population aged 18 to 64. Crime victimisation rates are low among older people in Ireland with 1 per cent of older people experiencing theft without violence and less than 1 per cent experiencing theft with violence and physical assault. However, for the individuals involved and their families this can be a traumatic experience.

Figure 8.43 Crime Victimization Rates, by Age and Gender, 2006



Source CSO, 2007i: 30 (CSO QNHS Crime and Victimization Module).

Perception of Crime

The fear of crime is borne out in data on perceptions of crime, where 63 per cent of older people perceived that crime was a 'very serious problem' in Ireland, 28.3 per cent a 'serious problem' and 8 per cent a 'fairly serious problem', see Figure 8.44. Less than 1 per cent thought that it was 'not a serious problem' (CSO, 2007i: 30). Older people were more likely to think that crime was a 'very serious problem' than people aged 18-64, 42.9 per cent of whom thought so.

Figure 8.44 Perceptions of Crime, 2006



Source CSO, 2007i:30 (CSO QNHS Crime and Victimisation Module).

Poor Treatment, Neglect, Abuse

The third indicator is poor treatment, neglect and abuse. Elder abuse is clearly detrimental to older people's well-being, but data are limited, especially as it can often be hidden. International research indicates that anywhere between 3 and 5 per cent of older people may be subject to abuse (HSE, 2009b: 5). In Ireland this would mean that between 14,000 and 23,000 older people suffer abuse. In reality, the reporting of abuse is usually lower than this at 1 to 2 per cent. The number of abuse cases reported to the HSE in 2008 was 1,840, up from 927 in 2007 (HSE, 2009b).

The Eurobarometer survey asks people aged 15 and over if 'in their opinion, poor treatment, neglect and even abuse of dependent elderly people is very widespread, fairly widespread, fairly rare or very rare in their country' (European Commission, 2007a). Figure 8.45 displays the results of the percentages who believe poor treatment, neglect and abuse to be widespread (very and fairly widespread).

Figure 8.45 Widespread Poor Treatment, Neglect and Abuse of Dependent Older People, EU Comparisons, 2007



Source European Commission, 2007a (Eurobarometer).

Nearly one third (32 per cent) of the adult population (those aged 15 and over) believe that poor treatment, neglect and abuse of older people is widespread in Ireland. While this figure may seem high it is below the EU average of 47 per cent. A shocking 86 per cent of the Romanian population believe poor treatment to be widespread. In contrast, less than one in five believe this to be the case in Sweden.

A survey (June 2008) carried out for the HSE by Millward Brown (HSE, 2009b: 64-66) reported that over half of the adult population believed that elder abuse was widespread, and was even higher following the media activity related to World Elder Abuse Awareness Day on 15th June 2008. There was general consensus among the respondents that older people are more vulnerable as they age, leading to a dependence on others which can provide an environment conducive to abuse. However, 40 per cent of respondents referred to deficits in the structure of society which allows abuse to occur, including the isolation of older people, resultant loneliness, poverty and the fact that many families are too busy to take care of older people.

The Eurobarometer survey found that people with experience of the care system were most inclined to feel that poor treatment, neglect and abuse of dependent older people was widespread (European Commission, 2007a). For example, more than half of people who were ‘severely limited’, people who had personal experience of the long-term care system, people who currently pay or have paid in the past for the care of their parents, and people with a parent in a nursing home held the view of widespread poor treatment, neglect and abuse. This is a serious issue for our care system, given that these are the views of people who have interacted directly with caring institutions.

When asked about forms of maltreatment, more than three quarters of Irish respondents believed that dependent elderly people were exposed to poor living conditions (EU average was 70 per cent), while 74 per cent believed there was lack of attention to physical needs (EU average was 67 per cent). Two thirds responded that dependent elderly people were exposed to inadequate care, psychological abuse and abuse of property, in line with EU averages. One half of respondents thought that there was a risk of exposure of physical abuse while 31 per cent thought there was the risk of sexual assault and abuse, again in line with EU averages (European Commission, 2007a).

In Ireland, HSE records show that, of referrals in 2008, 26 per cent comprised psychological abuse, 20 per cent self neglect, 19 per cent neglect, 16 per cent financial abuse, and 12 per cent physical abuse. Sexual abuse made up 1 per cent of referrals, as did discrimination. Other categories accounted for the remaining 5 per cent (HSE, 2009b: 28).

Respondents to the Eurobarometer survey were asked who was most likely to carry out poor treatment, neglect or abuse of dependent older people. In Ireland, 31 per cent thought this was most likely to be staff in a care home and care workers, home helps and nurses working in the person's own home (29 per cent), in line with EU averages. Some 16 per cent thought that the children of an elderly person would be most likely to carry out such treatment (EU average was 23 per cent) and 11 per cent thought hospital staff and nurses (EU average was 11 per cent). Less than 10 per cent of respondents in Ireland thought that the spouse or partner of an elderly person, siblings or acquaintances were most likely to carry out poor treatment, neglect or abuse (European Commission, 2007a).

HSE records show that the predominant alleged perpetrators of elder abuse have been reported as those that have the closest relationship to the person, that is, son/daughter in 43 per cent of cases, partner/spouse in 17 per cent of cases and other relative in 12 per cent of cases (HSE, 2009b: 32).

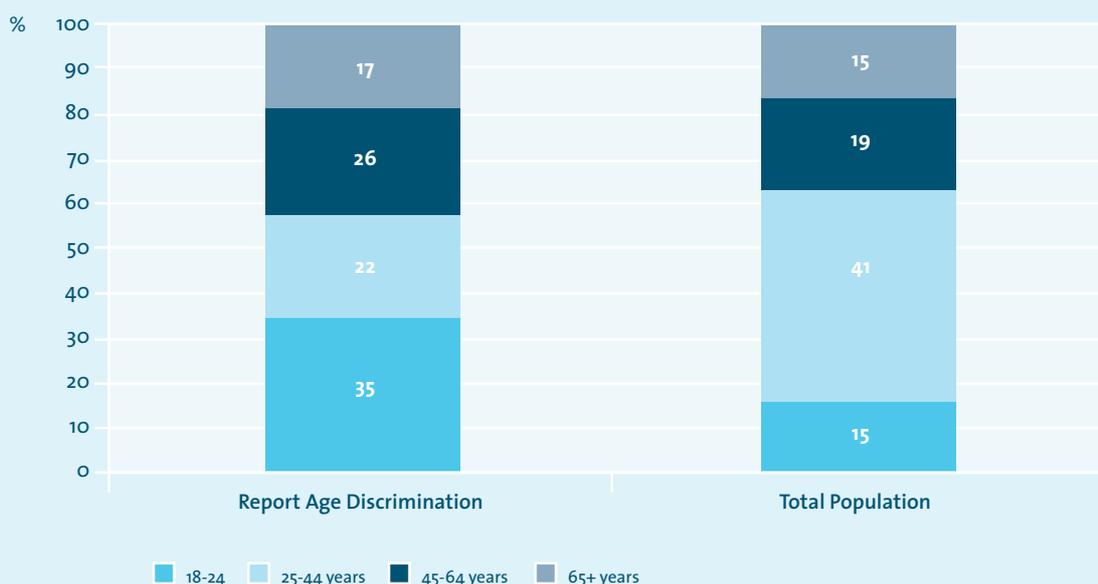
When presented with a number of options and asked about the two best ways to prevent poor treatment, neglect and abuse 29 per cent of Irish respondents to the Eurobarometer survey answered 'better training of carers, whether they are family or professionals', 27 per cent answered 'give an income to those who have to give up working or reduce their working time to care for a dependent person', 25 per cent said 'tougher regulations and standards', 24 per cent stated 'severe punishment for those who abuse dependent elderly people', and 21 per cent said 'strict controls carried out by a government agency'. Other responses (less than 20 per cent) included 'better income for professional carers' (19 per cent), 'more involvement of relatives, family doctors or GPs, social workers or religious people in the organisation of care' (19 per cent) and 'less work pressure on professional carers' (10 per cent) (European Commission, 2007a).

Equality – Age Discrimination

The third component on the democracy and values domain is equality and the indicator presented here is age discrimination. Discrimination undermines equality in society and may ‘exacerbate social cleavages and weaken social solidarity’ (Russell *et al.*, 2008: ix). In an analysis of the first national survey of experiences of discrimination in Ireland (survey carried out by the CSO in 2004, analysed by the ESRI and published by the Equality Authority in Russell *et al.*, 2008), 12 per cent of the population aged 18 years and over said that they had been discriminated against in the preceding two years. Some 9 per cent reported discrimination in accessing services and 7 per cent reported work-related discrimination. Of the nine grounds covered by equality legislation, age related discrimination was the most commonly reported (19 per cent of all reported grounds).

Figure 8.46 presents information on the age composition of those who report age-related discrimination as against the total population. The graph shows that the youngest age group (18-24) makes up the largest proportion of those reporting age discrimination. Russell *et al.* (2008: 34) note that ‘surprisingly, those aged over 65 years are not over-represented among those reporting age discrimination – they make up 17 per cent of that group compared to 15 per cent of the population’ and that ‘it is disproportionately the young, not the old, who experience age-related discrimination in Ireland’.

Figure 8.46 Age Composition of Those who Reported Age-related Discrimination and of The Total Population, 2004



Source Russell *et al.*, 2008: 34 (based on analysis of CSO QHNS 2004 Equality Module).

Russell *et al.*, (2008) explored age discrimination in relation to both the labour market and access to services. They concluded (2008: 77) that those aged 65 and over were less likely to have experienced work-related discrimination than other age groups, and suggest that one possibility is that older workers who experience discrimination in the labour market are more likely to withdraw and become discouraged. People aged 65 and over are also less likely to report subjective discrimination in shops/pubs/restaurants, financial services, education, and housing, and report the same low levels of discrimination as the youngest age group (under 25) in relation to health. The authors note that the low level of health-related discrimination for this group was not anticipated and may reflect reluctance among older people to interpret unequal treatment as discriminatory. They base this suggestion on the information that older people have a relatively low level of knowledge about their rights under Irish equality law, and that this lack of knowledge may partly explain their greater reluctance to take action in response to any discrimination they experience.

Summary

Only one in five respondents to a Eurobarometer survey agreed that the Irish government was doing a good job promoting a better understanding between the young and the old. In relation to exercising democracy, a relatively high proportion of Ireland's older people vote, compared to the rest of the population. With respect to accessing information older people lag some way behind the rest of the population with just under a third of people aged 65-74 having used a computer and just one in five having used the internet. This has implications for older people's ability to access information on services, which is increasingly available electronically.

Crime, fear of crime and abuse can have an undermining influence on the well-being of older people and their families. Despite less than 1 per cent of older people being victims of crime, there is a fear of crime among this age group, with more than 90 per cent perceiving crime as a serious or very serious problem. International evidence suggests that 3 to 5 per cent of older people are subject to abuse even though only 1 to 2 per cent of older people report abuse. However, there is a need to increase awareness of the abuse of older people as it is often hidden. Between one third to one half of the adult population thought that poor treatment, neglect and abuse of older people was widespread in Ireland. With regard to age discrimination there was little evidence of older age discrimination in a CSO survey on equality.

8.9.2 Ireland's Policy Framework for Democracy and Values for Older People

Towards 2016 contains a number of priority actions to promote the well-being of older people which are relevant to this domain. These include:

- ◆ The establishment, on a statutory basis, of the Social Services Inspectorate which will have an inspectorate role for public and private nursing homes;
- ◆ The implementation, by the HSE, of a standardised approach to inspection and reporting of private nursing homes;
- ◆ The implementation of the recommendations contained in the report on Elder Abuse by the National Implementation Group on Elder Abuse;

- ◆ Support in the use of information and communications technology; and
- ◆ Public information campaigns to tackle ageism.

The Department of Community, Rural and Gaeltacht Affairs did run a scheme of ‘Community Support for Older People’, which was designed to support initiatives to improve the security of vulnerable older people. This included physical security, such as locks and security lighting as well as ‘socially monitored alarm systems’. This scheme is currently suspended.

8.9.3 Commentary on Democracy and Values for Older People

While the majority of older people in Ireland lead full and active lives and are generally held in high esteem there are some older people who are vulnerable and subject to abuse or in some cases are the victims of crime. Every effort must be made to protect vulnerable older people, whether in residential settings or in the community. The current policy framework recognises these needs and proposes a range of initiatives to address current shortcomings. Every effort must be made to follow through and implement the proposals in full, even in the context of limited financial resources. The setting, implementation and monitoring of standards, which respect the dignity of the older person, is critical in this regard.

Secondly, older people play an active role in our democracy having one of the highest levels of voter participation. We need to ensure that they are supported to continue to participate using modern electronic methods. ICT use plays an increasingly significant part in people’s lives. We need to ensure that the facilities are available to older people, for example, in their homes, libraries, community centres as well as training provided to support the use of ICT facilities. Awareness campaigns to promote active ageing are also helpful in this regard and the publication of a National Positive Ageing Strategy will be a positive development.

Finally, while improvements have been made in data on older people’s participation, for example, through the equality module of the QNHS and through the collection and collation of statistics on elder abuse and use of ICT, this information needs to be collected and updated on an ongoing basis.

8.10 Conclusion

This chapter has provided an overview of the well-being of older people in Ireland across six aspects of their lives: economic resources, work and participation, relationships and care, community and environment, health, and democracy and values.

In relation to *demography*, there are just under half a million older people in Ireland, which is 11 per cent of the population. Across Europe, Ireland has the lowest proportion of its population over the age of 65, but this is set to change in future. By 2050 it is anticipated that ‘age dependency’ (65s and over as a proportion of the working age population) will have increased to 45 per cent (from 17 per cent in 2005). The over 80s will contribute to much of this increase, as people live longer, and the proportion of women will increase relative to men. Some 87 per cent of older people report a high level of satisfaction with their lives.

Much of current international debate on older people is in relation to the 'demographic time bomb' and 'burden of ageing'. While the proportion of older people will increase it is important to recognise the contribution and experience of older people. The older population is very diverse in terms of age, health, wealth, circumstances and well-being. A proportion of older people (10 to 20 per cent) are disadvantaged and vulnerable. While it is necessary to ensure a good standard of living for all of our older people through good services and adequate levels of income, it will be important to tailor services and supports for those who are most disadvantaged. Improved data and information are required to identify those who may have difficulties and to ensure that adequate supports for these older people and their families are available.

With regard to their *economic resources* more than four fifths of the income of people aged 65 and over comes from pensions (62 per cent from social welfare pensions and 20 per cent from occupational/personal pensions). Older men tend to have higher incomes than older women and income declines with age. Ireland has a relatively low male net pension replacement rate. Across the income distribution people aged 65 and over are over-represented in the second and third deciles, reflecting their dependence on a fixed income. Using EU income poverty measures older people in Ireland, and women in particular, have a relatively high risk of income poverty. However, using the Irish measure, consistent poverty levels are low for older people at less than 2 per cent, reflecting low levels of deprivation, including heating deprivation.

In light of the economic recession the need to address the pensions issue has become more urgent and even more important. The OECD has identified that Ireland has the worst investment performance for private pensions among OECD countries, along with a high reliance on tax incentives, which are expensive and not well targeted (OECD, 2009c). It would be useful, in the light of this analysis and the recession, to give consideration to three overriding goals – poverty prevention, income replacement and sustainability. A fundamental reform of the pension system may be required with a move towards a more universal state pension, taking into account the funding challenges associated with public pension provision.

Work and participation are central to well-being. About 14 per cent of men aged 65 and over and 4 per cent of women aged 65 and over are in the labour force. Just under half of the men are self employed farmers. On average people in Ireland leave the labour market at 64.1 years of age, with the main reasons being their eligibility for a pension, ill health or to spend more time with the family (mainly women). While views are mixed about whether people want to retire earlier or later, depending on their circumstances, there is a desire for greater flexibility in making this decision and in a more gradual withdrawal from the labour force. Information on how older people spend their time is limited in Ireland. However, we know from studies in other countries that older people are actively involved in activities such as caring for grandchildren, helping others and participating in voluntary activities. One point of note is that older people's educational levels are lower than the rest of the population, due to intergenerational changes in the opportunities to avail of education, and in the recognition of its value and in its provision. Lower levels of education have implications for older people's health and well-being.

Relationships and care are important elements of older people's well-being. While living independently in their own homes is most people's preferred option there is the risk of isolation and loneliness. Two fifths of women over 65 and two thirds of women over 80 are widowed. One fifth of older men and one third of older women live alone. Nearly one in five of the over 65s feel lonely, with women and people in lower social classes more likely to be lonely. The proportion of older people living alone in future is likely to rise, and this will increase the need for caring supports. Although information on carers is limited we know that 4 per cent of older people are themselves carers. We also know that a large proportion of carers are women relatives of the older person and that the number of women carers available for this role in the future is likely to decline. Ireland has a relatively high proportion of older people in institutional care. While the health and needs of older people need to be taken into account we should be aspiring to improve family and community supports to enable people to live independently for as long as possible.

In designing and implementing care supports for older people we need to value the contribution and role older people play in our society and place their articulated needs at the centre of any response. The key is to ensure that older people are aware of the choices available, and can exercise choice in their care arrangements through the availability of appropriate care, access to that care, its affordability and to ensure that standards are met. To deliver on these aspirations will be challenging in the current economic climate.

With regard to their **community and environment** just under 10 per cent of older people had housing problems and just over 10 per cent were dissatisfied with their housing. In the order of 3,500 older households are in need of social housing. While the provision of group housing schemes and sheltered housing by housing associations plays an important role in assisting independent living for older people, urgent attention needs to be given to addressing the needs of homeless older people, and in providing integrated responses to the accommodation and care needs of older people.

In relation to community and voluntary activities about four out of five older people found it easy to get help from neighbours. Older people are involved in a wide range of community and voluntary activities, with levels of involvement in line with the general population. Much of the involvement of older people is related to religious activities, but also with charitable and social organisations. Older people make a valuable contribution to their families, communities and society through their voluntary and community work.

On environmental issues, less than 10 per cent of retired households experienced pollution from traffic or industry, or noise from neighbours or outside. While data are not currently available on access to the built environment, it is important to note that the design of the built environment can contribute to the quality of life for older people. In relation to transport, people aged 65 and over rated the quality of public transport in Ireland as average. Transport is fundamental to the well-being and independence of older people, in providing access to essential services and activities. Specific needs have been identified for older people living in rural areas and non-conventional and innovative transport services can play a role in meeting those needs. It would be useful to have more data available by age and

socio-economic group to be able to analyse in more detail the impact of community and environmental factors on the well-being of older people. Additional indicators could also be considered such as distance to the nearest bus stop or shop.

Health is fundamental to the well-being of older people. While people's susceptibility to ill-health increases with age, preventative measures such as healthy behaviours, along with the provision of anticipatory care, appropriate diagnosis, treatment and rehabilitation, and technological advancements can enhance older people's health and well-being. Average life expectancy for 65 year old women is 20.2 years and for 65 year old men is 16.8 years, although there is great variation within the population. As well as a long life a healthy life is important to well-being. Just under 30 per cent of people aged 65 and over have a disability (the chances of having a disability increases with age) and just less than two thirds of older people have a chronic illness. These conditions can have a debilitating effect on people's health and well-being, especially if associated with pain. Nevertheless, older people tend to have lower levels of psychological distress than the population in general, although people in the lower social class groups record higher levels of stress. Psychological distress can be associated with loneliness and lack of social support.

The role of primary care is important in the lives of older people and as might be expected older people have higher attendance rates at GPs than the population generally, with women attending GPs more than men. A number of factors, in addition to health needs, influence attendance at a GP, including having a medical card, cost, and being able to access a GP. Some 29 per cent of heads of household aged 65 and over reported having difficulty in accessing a GP. About one third of older people rated their health as 'very good' or 'excellent' (compared to 58 per cent of the total population). Health behaviours, influenced by people's socio-economic circumstances and cultural beliefs, can affect people's health. Older people have lower smoking and drinking rates than the population generally, but have lower levels of physical activity (in many cases because of a medical condition or disability), consume slightly less fruit and vegetables and are more likely to be overweight or obese.

In relation to **democracy and values** only one in five respondents to a Eurobarometer survey agreed that the Irish government was doing a good job promoting a better understanding between the young and the old. A relatively high proportion of Ireland's older people vote, compared to the rest of the population, but with regard to accessing electronic information older people lag some way behind the rest of the population with just under a third of people aged 65-74 having used a computer and just one in five having used the internet. This has implications for older people's ability to access information on services, which is increasingly available electronically.

Crime and fear of crime can have an undermining influence on the well-being of older people and their families. Despite less than 1 per cent of older people being victims of crime, there is a fear of crime among this age group, with more than 90 per cent perceiving crime as a serious or very serious problem.

International evidence suggests that 3 to 5 per cent of older people are subject to abuse even though only 1 to 2 per cent of older people report abuse. However, there is a need to increase awareness of the abuse of older people as it is often hidden.

Between one third to one half of the adult population thought that poor treatment, neglect and abuse of older people was widespread in Ireland. With regard to age discrimination there was little evidence of older age discrimination in a CSO survey on equality.

8.11 Policy Monitoring

As in Chapters 6 and 7, in this chapter we address monitoring the implementation of policy commitments through the use of indicators in the policy cycle. More details as to how this might happen were provided in Chapter 3.

For older people this relationship can be illustrated using an example, see Table 8.3. *Towards 2016* and the Department of Health and Children both have the policy goal (strategy) to support older people to live in their own homes as long as possible. Diagnostic indicators identify older people who are in need of supports to live at home independently, for example, who are these older people, where are they, what are their family circumstances, what supports do they require, and is living at home in their own homes the optimal approach. The inputs to support older people in their homes to live independently include budgets and staff, as well as physical adaptations and in some cases medical and social supports. At this stage, building on the diagnostic indicators, baseline indicators can be established, setting out the number of older people in need of support disaggregated by socio-economic status, equality grounds, living arrangements, supports required and area.

Subsequently outputs would be recorded, such as, the number of older people receiving home help services, the number of older people receiving home care packages, and the number of older people receiving other supports. The contribution of these outputs to the overall policy goal would be assessed using performance indicators, such as the number of older people in receipt of supports enabling them to remain in their own homes and institutional ‘helpers’ and ‘hinderers’. This information is particularly useful when assessed against the baseline indicators.

The systemic indicator measures the percentage of older people in nursing homes and hospitals, which is an international bench mark indicator. A reduction in this percentage is an indicator of success as the preference of most older people is to receive care at home, if possible. This indicator could usefully be complemented by an indicator which measured the satisfaction of older people with the supports provided. Clearly, there is a qualification attached to this – there will always be a small proportion of the older population who will require care in an institutional setting. A person-centred approach, however, gives the older person that choice.

Table 8.3 Supports for Older People Example

Policy Cycle	Indicators
Strategy To support older people to remain at home for as long as possible	Diagnostic Older people in need of supports to help them live at home independently – who, where, what supports required
Inputs Budget Staff Physical, medical and social supports	Baseline No. older people in need of support disaggregated by socio-economic status, equality grounds, living arrangements, supports required, area
Outputs No. people receiving home help services No. people receiving home care packages No. people receiving other supports	Performance No. older people in receipt of supports enabling them to remain in their own homes Institutional ‘helpers’ and ‘hinderers’
Outcomes Quality community and home care services for those who require them	Systemic Per cent of older people in nursing homes and hospitals below the EU average ¹⁵¹

A key factor in monitoring quality outcomes is the availability of good quality timely data. To date, information on older people’s well-being has been limited; the decision to undertake the Irish Longitudinal Study on Ageing (TILDA) seeks to address this. An essential requirement to improving our analysis, and hence understanding of ageing, is the need to match and link data, as recommended in the 2003 report of the Steering Group on Social and Equality Statistics, *Developing Irish Social and Equality Statistics to Meet Quality Needs*. These data sources then need to be applied to monitoring progress on policy actions and measuring outcomes. The SLÁN survey is a useful resource in this regard. The SHARE (Survey of Health Ageing and Retirement in Europe) also has the potential to make a valuable contribution to our knowledge and understanding of ageing issues.

This chapter has sought to report on systemic indicators for older people’s well-being and to relate these to policy objectives. Achievement of the ultimate outcomes will depend on the actions of a number of actors. The report seeks to reflect this multidimensional cross-cutting approach but not to address a wide range of issues in detail. This can be done within Departments and agencies, through the use of diagnostic, baseline and performance indicators. In this overall context, the report seeks to identify, describe and interpret the well-being of older people in Ireland across a range of systemic indicators.

¹⁵¹. Ideally a new indicator would be developed which would measure the satisfaction of older people with the supports provided

9

People With Disabilities

9.1 Understanding the Well-being of People with Disabilities

Introduction

This chapter assesses the well-being of people with disabilities, in line with the framework adopted in the national partnership agreement *Towards 2016* and associated policy frameworks, for example, the National Development Plan and National Action Plan for Social Inclusion. The National Disability Strategy (NDS) is the key policy driver in advancing the well-being of people with disabilities.

The NDS is a significant milestone in recognising the place of persons with disabilities in Irish society and of the State's responsibilities in ensuring they participate on an equal basis with other citizens (NESC, 2005b: 168). The disability infrastructure under construction adopts a developmental welfare state approach through individual assessments of need, individual service statements, government departments' sectoral plans, multi-annual funding, accessibility plans at local authority level, and the development and monitoring of codes of practice through the National Disability Authority, and the setting and monitoring of standards, including through the Social Services Inspectorate by the Health Information and Quality Authority (HIQA). The aspirations of tailoring services to meet the needs of people with disabilities, and of balancing and inter-connecting service provision and income supports, plus the stated intention of integrating institutional arrangements all present a developmental approach conducive to promoting the well-being of people with disabilities. Such an approach recognises the diversity of people with disabilities. While progress is being made challenges in the wider policy process and public service environment, along with curtailments due to the recession, are making implementation difficult and impacting on service provision for people with disabilities.

The policy framework of *Towards 2016* states that the life cycle approach 'adopts the perspective of the person as the centre piece of social policy development'. The 'disability lifecycle' is set out in addition to the three chronological lifecycle stages (children, people of working age, older people), where people with disabilities will, 'in accordance with the policy of mainstreaming, ... benefit from measures at all stages of the lifecycle' (Government of Ireland, 2006b: 40). This mainstreaming approach includes setting out a vision for people with disabilities, along with priority actions, governance arrangements and monitoring mechanisms.

As the implementation of *Towards 2016* and the National Disability Strategy progresses, there may be merit in future social reports of including people with disabilities within the three life cycle stages, in line with a mainstreaming approach. However, in this report, as in the current policy framework, people with disabilities are given specific attention.

Understandings of Disability

Understandings of disability have evolved over recent decades. A number of different models have informed these understandings. Historically the ‘medical’ model focused on an individual’s impairment and viewed disability as a problem inherent in the person. Using this model the focus was on medical care and health policy in trying either to ‘cure’ the person with the disability or to address the disability through medical treatment or assistive technologies. Medical professionals dominated thinking and policy approaches to enhance the well-being of people with disabilities.

The ‘medical’ model has been contested for many years, especially by people with disabilities, and in the 1970s an alternative model, the ‘social’ model, emerged. The ‘social’ model of disability challenges the individualistic focus of the medical model and presents disability as a social issue. The social model became the ‘dominant paradigm’ for understanding and researching disability by ‘redefining disability in terms of disabling environment, repositioning disabled people as citizens with rights, and reconfiguring the responsibilities for creating, sustaining and overcoming disablism’ (Dewsbury *et al.*, 2004: 145). The central tenet of this approach is that disability is created by society through the construction of disabling barriers. The social model of disability is described by Oliver as:

It does not deny the problem of disability but locates it squarely within society. It is not individual limitations, of whatever kind, which are the cause of the problem but society’s failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation (Oliver, 1996: 32).

The societal barriers manifest themselves in a number of ways, through inaccessible environments, negative and ill informed attitudes, and exclusion from participation in social and economic spheres such as education, employment, leisure and culture. In the social model interventions for people with disabilities require social action, at individual, community and societal level. The social model is underpinned by a human rights perspective of ensuring equal access for everyone.

The social model of disability is also contested. A major criticism is that it does not adequately take the individual into account or recognise the diversity of impairments and disabilities and how these are experienced. Even though the social model still dominates much thinking on disability, the current model is a ‘biopsychosocial’ model which views disability as the interaction between the individual and his/her environment.

This new understanding of disability derives from the International Classification of Functioning, Disability and Health (ICF), formally approved by the World Health Organisation (WHO) in 2001. The ICF classification has been officially endorsed by 191 countries, including Ireland, as the standard to describe and measure disability. The ICF provides a 'holistic framework which views disability as the interaction between the individual (reduced functioning and activity limitation) and his/her environment.' This reflects a multidimensional concept of disability relating to 'body function, activity limitations, participation restrictions and environmental factors' (O'Donovan and Doyle, 2006: 1).¹⁵²

Understandings of disability in Ireland have been informed by international disability instruments. The most recent of these is the UN Convention on the Rights of Persons with Disabilities which was adopted by the UN General Assembly in December 2006. Ireland became a signatory to the Convention in March 2007. The Convention aims to promote, protect and ensure full and equal enjoyment of all human rights by people with disabilities. It marks a shift in thinking about disability from a medical and welfare concern to a human rights and equality issue. It covers a number of areas such as accessibility, personal mobility, health, education, employment, participation and equality. States who ratify the Convention undertake to promote the rights of people with disabilities.

At European level the Council of Europe adopted the Disability Action Plan 2006-2015 in April 2006. The Disability Action Plan contains a range of actions in relation to accessibility, participation, education, employment and information. In particular, it focuses on the needs of women and children with disabilities. It also highlights the needs of people with severe disabilities who require a high level of support. Member States are encouraged to promote the rights and full participation of people with disabilities through the integration of actions in the Action Plan into their legislation, policy and practice.

The European Union has a 6 year action plan to promote equal opportunities for people with disabilities (2004-2010). This action plan aims to implement the Directive on equal treatment in employment and occupation, mainstream disability issues in relevant policies and improve accessibility to goods, services and the built environment. This action plan builds on initiatives such as the Amsterdam Treaty, the European Charter of Fundamental Rights, anti-discrimination Directives, and the European Year of People with Disabilities 2003.

The Treaty of Amsterdam (1999), which had an emphasis on citizenship and the rights of individuals, introduced Article 13 making it possible to combat discrimination on the grounds of disability. The European Charter of Fundamental Rights reaffirms the protection of people with disabilities on the basis of equality before the law as well as promoting the rights of people with disabilities to independence, social and occupation integration and participation in society.

152. The International Classification of Functioning, Disability and Health (ICF) is used in the National Physical and Sensory Disability Database (NPSDD), a national service planning database for people with disabilities, managed by the Health Research Board in Ireland, on behalf of the Department of Health and Children. The NPSDD was established in 2002.

Disability in Ireland

Within Ireland much progress has been made in creating a policy framework for promoting the rights of people with disabilities. These are contained in the National Disability Strategy which was launched in September 2004. The strategy, preceded by a highly participative process, sets out to promote the participation of people with disabilities in Irish society. Key elements of the strategy are legislation, sectoral plans and multi-annual funding, specifically:

- ◆ Education for Persons with Special Educational Needs Act 2004;
- ◆ The Disability Act 2005;
- ◆ The Citizens Information Act 2007;
- ◆ Sectoral Plans prepared by six Government departments; and
- ◆ A multi-annual investment programme (€900m) targeted at high-priority disability support services.

The Disability Act (2005) defines disability as:

A substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in the social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment (Disability Act, 2005: S2(1)).

The Disability Act (2005) provides for service statements based on individual assessments of need, codes of practice for access to buildings and services, six sectoral plans, a 3 per cent target for employment of people with disabilities in the public service, as well as conditions for genetic testing and standards of universal design. The sectoral plans prepared by 6 government departments, ('Health and Children', 'Social and Family Affairs', 'Transport', 'Communications, Energy and Natural Resources', 'Environment, Heritage and Local Government' and 'Enterprise, Trade and Employment') set out for each of the Departments and the public bodies under their aegis a programme of measures to be taken in relation to the provision of services for people with disabilities. The plans are linked to Departmental statements of strategy and business plans and seek to address cross-departmental issues in a coherent way.

The Citizens' Information Act 2007 authorises the Citizens Information Board to provide a personal advocacy service for people with disabilities. The Education for Persons with Special Educational Needs Act 2004 established the National Council for Special Education and provides for assessment of need, along with the preparation and implementation of Individual Education Plans for children with special educational needs, including the involvement of parents.

To oversee the implementation of the National Disability Strategy an Office for Disability and Mental Health was established in January 2008 in the Department of Health and Children. The office supports the Minister of State for Disability and Mental Health. It is tasked with co-ordinating a 'whole-of-government' approach and, in addition to work in the health area, it has a remit to work closely with the Departments of Education and Science, Enterprise Trade and Employment, the HSE,

the National Disability Authority and recognised disability groups. Progress on the implementation of the National Disability Strategy is monitored by the Senior Officials Group on Disability which reports to the Cabinet Committee on Social Inclusion. A National Disability Strategy Stakeholder Monitoring Group, comprising the Senior Officials Group on Disability, a Disability Stakeholders Group and the National Disability Authority, has also been established to monitor progress on the overall implementation of the strategy. The National Disability Authority provides advice on disability policy and practice, complemented by organisations in the community and voluntary sector who have important advocacy and service delivery roles.

The promotion of the well-being of people with disabilities in Irish policy and practice is informed by the following principles:

- ◆ Dignity for the person;
- ◆ Independence and individual autonomy;
- ◆ Equality of opportunity;
- ◆ Respect for difference;
- ◆ Participation; and
- ◆ Accessibility.

These principles are very much in line with the understanding of well-being employed throughout this report. In this chapter a person with a disability is a person of any age with an impairment which limits their functioning and activities in relation to participation in their environment.

9.2 Assessing the Well-being of People with Disabilities

Comparative Monitoring at International Level

The UN Disability Rapporteur has stated that:

The principles of full participation and inclusion, which are the dominant ideas in modern disability policy, strongly favour building effective monitoring of the human rights of persons with disabilities as an integral part of existing monitoring mechanisms (Report of the Special Rapporteur of the UN Commission for Social Development, 2000-2002).

Nevertheless, the monitoring of the well-being of people with disabilities has been limited. In 1990 the UN published a *Disability Statistics Compendium*. This publication was based on the national statistics available in DISTAT, which is the United Nations Disability Statistics Database, established in 1988. DISTAT contains disability statistics from the national household surveys, population censuses, and population or civil registration systems of 55 countries. The *Disability Statistics Compendium* provides national data on a range of topics in relation to people with disabilities, including: age, sex, residence, educational attainment, economic activity, marital status, household characteristics, causes of impairment and special aids used.

Irish data were included from the 1981 Population Census – on the basis of people with disabilities who were not economically active, presented by age and gender. There were 4,266 non-economically active disabled men per 100,000 population and 2,650 non-economically active disabled women per 100,000 population identified at that time. For both men and women prevalence increased with age. However, given the variability of the data sources and the variation in definitions of disability used it is not possible to make meaningful cross-country comparisons, even using this dated data. An updated compendium has not been published but up-to-date statistics are available on a country-by-country basis from the DISTAT database. Up-to-date information for Ireland is not included and the use of the material carries the qualification that ‘due to the differences in concepts and methods to identify people with disabilities prevalence rates should not be compared across countries’.¹⁵³

Under the auspices of the UN Statistics Division the Washington Group on Disability Statistics has been established to promote the co-ordination of disability statistics throughout the world. Specifically, the focus is on the design of disability measures suitable for censuses and national surveys. The World Health Organisation’s (WHO) International Classification of Functioning, Disability and Health (ICF) has been accepted as the basic framework for this work. The Washington Group comprises representatives of national statistical offices, international organisations and non-governmental organisations. It was established in 2001. Ireland is a member of the Group and hosted the seventh meeting in September 2007 (the CSO with assistance from the National Disability Authority).

At OECD level there is limited information on disability. The focus is on receipt of sickness and disability benefits, using information from labour force surveys. These data are limited in a number of ways – they do not distinguish between sickness and disability, they only relate to people in the workforce, and to those in receipt of benefits.

There are limited statistics on disability at European Union level. Information relates to social expenditure on disability payments, and employment of people with a long-standing health problem or disability (special module of the Labour Force Survey, 2002). There is also limited information on ‘people outside the labour force’ who are ‘inactive’ because of illness or disability. The European Community Household Panel survey (ECHP) asked if people were hampered in their daily activities because of chronic ill-health or disability. This survey ceased in 2001 and was replaced by EU-SILC (Survey of Income and Living Conditions) in 2003 which does not include a specific disability question (questions are included on health and inability to work due to illness or disability). There is a European Consortium, Measuring Health and Disability in Europe (in which the Irish National Disability Authority is a partner), which is considering application of the ICF approach at European level.

¹⁵³. See <http://unstats.un.org/unsd/demographic/sconcerns/disability/disab2.asp>

Monitoring Disability in Ireland

In Ireland information on disability has been sparse and incomprehensive. The National Statistics Board (2003) noted that less than a quarter of social and equality data sources could be disaggregated by a disability indicator. Added to this is the variation in the various definitions of disability applied to the data, for example, in relation to illness, impairment, and/or restriction. The National Intellectual Disability Database and the National Physical and Sensory Disability Database, both held by the Health Research Board, are important information sources which hold disability information (on those registered with them). Disability information is also available from the Census, some surveys and administrative records, including patient registries.

The 2006 Census contained questions on disability (building on earlier questions in the 2002 Census). These questions identified people who have a long-lasting condition which gives them difficulty in doing a specified number of activities. The results were published in 2007, (CSO, 2007d). More importantly, however, the 2006 Census was followed up by Ireland's first National Disability Survey (NDS), which was carried out in the autumn of 2006. The NDS questionnaires were based on the social model of disability which defines disability as the outcome of the interaction between a person with an impairment and the environmental and attitudinal barriers s/he may face (CSO, 2008d: 8).

The NDS includes information on disabled adults and children, people living in private households and people living in institutions. The first set of results have been published (2008), providing information on the prevalence of disability, information on nine disability types by age, gender, region, level of severity, age of onset, cause of the disability and aids used. A subsequent report (not yet published) will present data on education, work, transport, the built environment and social participation for people with disabilities. The NDS will provide the most comprehensive data on disability in Ireland to date, (for further details on this information source, see Appendix D).

The Policy Context

Using the format employed throughout this report, the key trends with regard to the well-being of people with disabilities are summarised, using available information, across the six domains of the well-being framework, and these trends are then linked to the policy framework, *Towards 2016*. *Towards 2016* lucidly summarises the main policy commitments and priority actions for people with disabilities, as articulated in the National Disability Strategy. The vision and five high level goals for people with disabilities in Ireland, as specified in *Towards 2016* are set out in the box below.

Towards 2016 Vision and High Level Goals

An Ireland where people with disabilities have, to the greatest extent possible, the opportunity to live a full life with their families and as part of their local community, free from discrimination.

The long-term goals to improve the quality of life of people with disabilities are:

- ◆ Every person with a disability would have access to an income which is sufficient to sustain an acceptable standard of living;
- ◆ Every person with a disability would, in conformity with their needs and abilities, have access to appropriate care, health, education, employment and training, and social services;
- ◆ Every person with a disability would have access to public spaces, buildings, transport, information, advocacy and other public services and appropriate housing;
- ◆ Every person with a disability would be supported to enable them, as far as possible, to lead full and independent lives, to participate in work and in society and to maximise their potential; and
- ◆ Carers would be acknowledged and supported in their caring role.

The Indicator Framework

There is recognition of the importance of monitoring the status and well-being of people with disabilities.¹⁵⁴ However, the reality of monitoring has been difficult given the definitional and data constraints outlined above. For this chapter the indicator framework used has been informed by a number of factors: the availability of data, work on indicators undertaken by the National Disability Authority,¹⁵⁵ the policy commitments set out in *Towards 2016*, and the well-being framework and indicators used in this report for children, people of working age and older people.

The National Disability Authority (NDA) provides a good articulation of the key issues in choosing an indicator set (National Disability Authority, 2005a). It has proposed 26 indicators across 17 domains (see Appendix E). The domains are based on information from key disability documents, a pilot survey, general social indicators, and specific disability concerns. In particular, it draws on the work of the Commission on the Status of People with Disabilities (1996), the UN Standard Rules (1993),¹⁵⁶ and WHO's International Classification of Functioning, Disability and Health (ICF) (2001), (see Appendix F). International comparisons are not used by the NDA based on the view that there are differences in how people perceive whether they are disabled or not across countries. The indicators suggested by the NDA are

¹⁵⁴ See documentation from the National Disability Strategy, National Disability Authority and National Statistics Board.

¹⁵⁵ The National Disability Authority has published a report on *How Far Towards Equality? Measuring How Equally People with Disabilities are Included in Irish Society*. In this report attention is paid to developments in data collection and disability indicators (National Disability Authority, 2005a).

¹⁵⁶ The UN Standard Rules on the Equalisation of Opportunities for People with Disabilities were adopted by the UN in 1993. Under these rules member states are to collect and disseminate information on the living conditions of people with disabilities and to monitor and evaluate the implementation of national programmes and services concerning the equalisation of opportunities for people with disabilities.

‘outcome-focused’ with the purpose of identifying whether ‘disparities between people with disabilities and others are widening or narrowing’ (National Disability Authority, 2005: 97). Data are not yet available for all of these so they cannot be comprehensively included in this report. However, where data are available, many of the indicators are included within the well-being framework employed here.

Table 9.1 Construction of the Well-being of People with Disabilities

Domains	Components	Indicators
Economic resources	<i>Income</i>	Income
		Distribution of income
		Social class
	<i>Poverty</i>	Income poverty rate
		Consistent poverty rate
		<i>Deprivation</i>
Work and Participation	<i>Work</i>	Employment rate
		Employment in the public service
		Proportion of people with intellectual disabilities in open employment
		Proportion of people with disabilities who are ‘not in the labour force’
	<i>Education</i>	Percentage of pupils with disabilities in mainstream schools
		Age at which education ceased
Relationships and Care	<i>Living arrangements</i>	Proportion 30-44 living in parental home
		Proportion living in communal establishments
	<i>Family structure</i>	Proportion aged 45-64 by marital status
	<i>Social life</i>	Proportion with afternoon/evening out in previous fortnight, that costs money
	<i>Care</i>	Proportion of disabled households with a carer in the household
	Community and Environment	<i>Community</i>
<i>Accommodation</i>		Housing tenure
		Housing need
<i>Environment</i>		Access to the built environment
<i>Transport</i>		Proportion with a car
Health	<i>Health Status</i>	Hampered in daily activities
		Illness associated with disability
	<i>Supports</i>	Use of aids/services
	<i>Behaviours</i>	Smoking
		Physical activity
Democracy and Values	<i>Exercising democracy</i>	Proportion saying they would vote
		Access to ICT
	<i>Threats</i>	No specific indicator
	<i>Equality</i>	Discrimination Attitudes to people with disabilities

The framework of key indicators for people with disabilities, based on the six well-being domains employed throughout this report, is presented in Table 9.1.

These domains and indicators provide an assessment of the well-being of people with disabilities. With regard to economic well-being information is provided on income, poverty and deprivation. This section includes a consideration of the social class of people with disabilities, as it reflects many other dimensions of their lives and impacts on their well-being.

The work and participation domain presents indicators on work and education. The work component considers various dimensions of employment and the attachment of people with disabilities to the labour force. The education component compares the educational attainment of people with disabilities with the population in general. Education and access to knowledge is an important element of well-being in and of itself, as well as providing a sense of achievement and options for employment, which all contribute to human flourishing and well-being.

In the relationships and care domain indicators are presented on living arrangements, family structure, social life and care. As we are social beings good relationships have been identified as important for everyone's well-being, but they are particularly critical for those people with disabilities who may have some dependence on others for daily living needs. As with other population groups these needs are diverse, depending on the nature and level of severity of the person's disability and their living circumstances. With the information available the indicators seek to capture some of these dimensions.

The fourth domain is community and environment. Indicators are presented on participation in an organisation, accommodation, access to the built environment and transport. Access and participation are central to the well-being of people with disabilities and, even though the data are limited, there is an attempt to capture the key features of this domain.

To some extent, health and disability are inter-linked, and the fifth domain presents indicators on health status, the use of aids and services, and health behaviours, including smoking and physical activity. While many people with a disability enjoy good health, for some their disability is linked to illness. The provision of supports, services and aids can help to address the health and disability needs of people enabling them to maximise their abilities and capabilities.

The sixth domain is democracy and values. As in other chapters we sought to present indicators on exercising democracy (voting and access to ICT), threats and equality. Unfortunately there is not currently data available to present an indicator on threats/safety so we can only capture the democracy and equality components of this domain.

The following sections present the key trends on each of the domains of the well-being framework, set these against the current policy commitments and actions and then provide a short commentary on key issues emerging, including data shortcomings. The following section sets out the context for people with disabilities in Ireland.

9.3 The Context for People with Disabilities in Ireland

Composition of the Population of People with Disabilities

In 2006, there were 325,800 people with a disability in Ireland, which accounted for 8.1 per cent of the population (CSO, 2008d).¹⁵⁷ The definition of disability employed to arrive at this estimate is 'the outcome of the interaction between a person with an impairment and environmental and attitudinal barriers s/he may face' (CSO, 2008d: 8).

Disability is highly correlated with age: 3.5 per cent of people aged less than 18 have a disability compared to 37.7 per cent of those aged 75 and over. For those aged less than 18, males are more likely to have a disability than females, whereas in the over 75s women have higher rates of disability than men (CSO, 2008d), see Figure 9.1.

Figure 9.1 Prevalence of Disability by Age and Sex, 2006



Source Census 2008d:18 (based on National Disability Survey).

Figure 9.2 presents information on disability by region. The navy bars show the disability prevalence rate per 1,000 population for each of the eight planning regions. While the Mid-East region has the lowest prevalence rates at 66 people with disabilities per 1,000 of the population, and the Mid-West the highest rates at 87 per thousand, there is relatively little variation in the prevalence of disability across the country. The blue bars show age-standardised disability ratios by region. Age-standardised rates allow comparisons between populations with different

¹⁵⁷ The information presented here is based on the National Disability Survey 'Census Disability' sample. An additional sample taken from the general population yielded a disability rate of 10.4 per cent, giving an overall disability prevalence of 18.5 per cent (about 780,000 people with disabilities). A disability prevalence of 18.5 per cent is comparable to disability rates in other national disability samples. However, the CSO has recommended using the 'census disability' prevalence rate of 8.1 per cent, as it is more reliable. For a description of how these estimates are arrived at, see Appendix D.

age structures.¹⁵⁸ The Mid-East region shows disability rates below what would be expected based on the age composition of the population in the region while the Mid-West, Dublin and the South-East have slightly higher rates than their population structure would suggest (CSO, 2008d: 19).

Figure 9.2 Prevalence of Disability and Age-standardised Disability Ratios by Region, 2006



Source Census 2008d: 19 (based on National Disability Survey).

Figure 9.3 presents information on prevalence of disability by nationality. The prevalence of disability is lower among the non-Irish population at 5.8 per cent compared to the Irish population at 9.8 per cent. The highest disability prevalence rate is among people from the UK at 11.6 per cent. These prevalence rates reflect the age structures among the various nationalities, see Chapter 4.

Figure 9.3 Prevalence of Disability by Nationality, 2006¹⁵⁹



Source Census 2007d: 47 (based on 2006 Census).

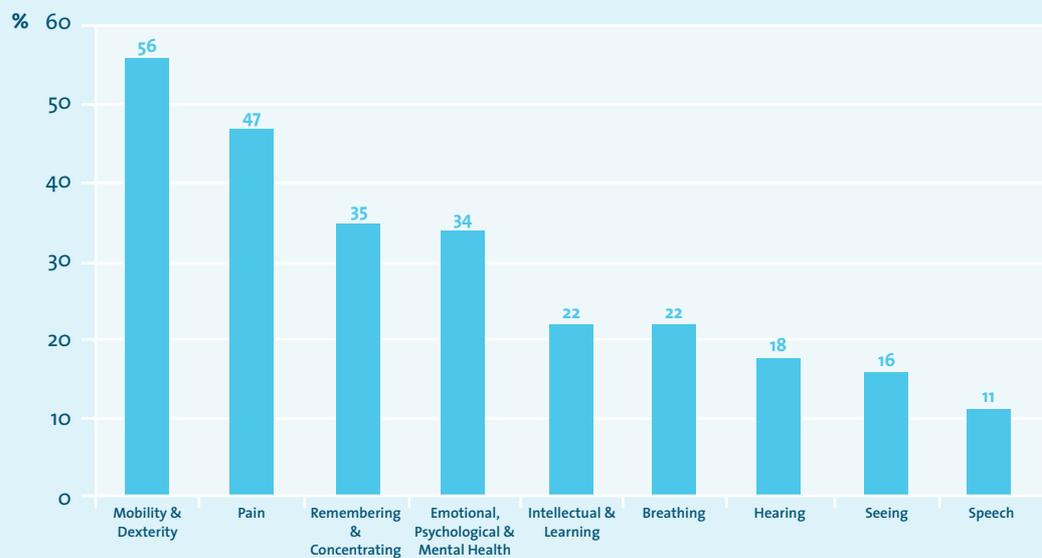
¹⁵⁸ A ratio of more than 100 indicates a greater likelihood of having a disability than would be expected in that region on the basis of its age distribution alone. Conversely, a ratio of less than 100 indicates that the population of the region are less likely to have a disability than would be expected from the age composition of the region.

¹⁵⁹ The information in this table is based on information reported in the Census of Population, 2006 (The information is not yet available from the National Disability Survey).

The information presented above demonstrates the diversity of the population of people with disabilities, in terms of age, gender and nationality. People with disabilities are also heterogeneous in relation to their ethnicity and cultural background, family and marital status, sexual orientation and religion. Acknowledgement of these multiple identities is important in relation to the potential for people to be disadvantaged with regard to their disability and also in respect of other characteristics—sometimes referred to as ‘double disadvantage’. These issues are addressed in more detail throughout this chapter, with equality and discrimination issues given specific attention in section 9.9 on democracy and values.

The population of people with disabilities is also diverse in relation to types and severity of disability. The distribution of disability types within the population reporting a disability is illustrated in Figure 9.4. Mobility and dexterity was the most frequently reported disability type, with 56 per cent of all persons with a disability reporting this type of disability. The next highest categories were pain (47 per cent), remembering and concentrating (35 per cent) and emotional, psychological and mental health (34 per cent). Speech was the least frequently reported at 11 per cent of those with a disability (CSO, 2008d: 21).

Figure 9.4 Types of Disability, 2006

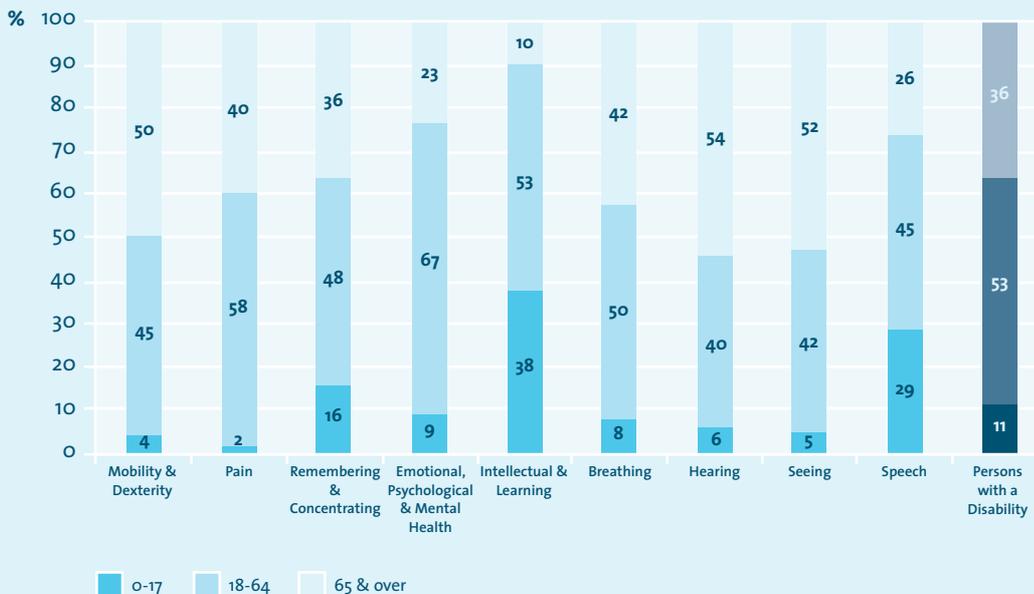


Source Census 2008d: 21 (based on National Disability Survey).

Figure 9.5 shows the age distribution by disability type. Overall 11 per cent of persons with a disability were in the 0-17 age group, while just over a third were 65 and over (see right hand bar in graph). There is some variation in this pattern. For example, persons reporting an intellectual and learning disability have a higher representation in the younger age groups with 38 per cent in the 0-17 age group and a further 53 per cent in the 18-64 age group. People with speech difficulties also had a higher representation in the younger age groups with people aged 0-17

accounting for 29 per cent of people experiencing this type of disability and 45 per cent aged 18-64. Over two thirds of those experiencing emotional, psychological and mental health disabilities were aged 18-64. Persons aged 65 and over comprised more than half of those with mobility/dexterity, hearing and seeing disabilities.

Figure 9.5 Age Profile of Types of Disability, 2006



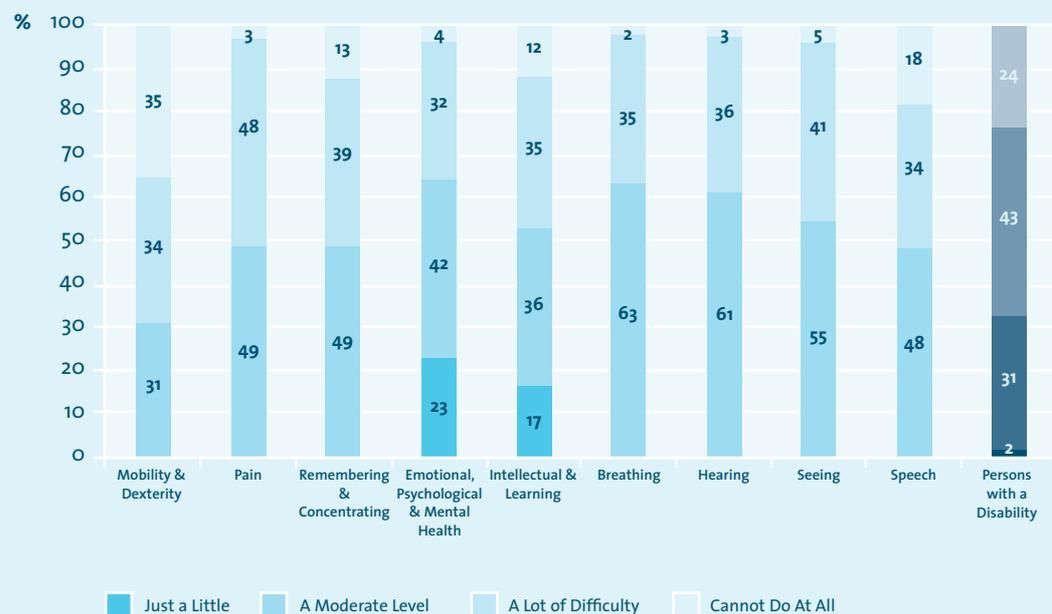
Source Census 2008d: 24 (based on National Disability Survey).

The distribution of different types of disabilities varies within age groups. For older age groups the most frequently reported disability was mobility and dexterity (83 per cent of all persons with a disability in the 75 and over age group and 70 per cent of the 65-74 age group). The profile of disabilities among children is different from other age groups. Three quarters of 0-17 year olds with disabilities reported intellectual and learning difficulties, and half reported difficulties remembering and concentrating. Although speech was the least reported disability overall (11 per cent of people with a disability) it was reported by just over a quarter (28 per cent) of those in the 0-17 age group (CSO, 2008d: 24).

On average, people with disabilities have 2.6 disabilities per person. This varies from 2.3 for 18-34 year olds to 2.5 for 0-17 year olds to 2.8 for those aged 75 and over.

Figure 9.6 shows the level of difficulty in doing everyday activities by disability type.¹⁶⁰ A third of those with a disability reported a moderate or lower level of difficulty (see right hand bar in the graph). A further 43 per cent reported their highest level of difficulty as 'a lot of difficulty', while just less than a quarter reported 'cannot do at all' under at least one disability type. Mobility and dexterity had approximately equal proportions experiencing a moderate and a lot of difficulty, and had the largest proportion of persons reporting 'cannot do at all' at 35 per cent. Apart from this group, the largest proportions of persons who were not able to do everyday activities at all were those with speech disabilities (18 per cent), remembering and concentrating (13 per cent) and intellectual and learning (12 per cent), (CSO, 2008d: 27).

Figure 9.6 Profile of Level of Difficulty by Disability Types, 2006



Source Census 2008d: 27 (based on National Disability Survey).

Social Expenditure

Many people with disabilities are dependent on a social security payment. It is possible to make international comparisons using Eurostat data. Figure 9.7 shows that Ireland has a relatively low expenditure on disability payments as a proportion of total expenditure on social benefits. Disability payments comprise 5.4 per cent of benefit expenditure in Ireland, just above Greece at 4.7 per cent and below the EU27 average of 7.5 per cent. The highest expenditures are in the Nordic countries. However, when sickness benefits are also included, Ireland's expenditure on sickness and disability benefits increases to 46.5 per cent of total social benefits, the highest proportion of expenditure on these benefits across the EU27 in 2006, and well above the EU27 average of 36.7 per cent.

160. For each disability type one or more filter questions were used to determine whether a respondent experienced this type of disability. Filter questions asked the extent to which the respondent experienced difficulty in everyday activities due to that particular disability type. Details of the questions asked are given in Appendix G.

In terms of PPS expenditure¹⁶¹ Ireland spent 314PPS per head of population on disability payments compared to an EU27 average of 457PPS in 2006. However, when sickness benefits were also included Ireland's expenditure per head of population increased to 2,725PPS per head, compared to an EU27 average of 2,240PPS.

Figure 9.7 Percentage of Expenditure on Disability Benefits, and Sickness and Disability Benefits, as a Percentage of Expenditure on Total Social Benefits, Selected EU Countries, 2006¹⁶²



Source Eurostat, accessed directly.

Ireland's expenditure on disability/illness payments has increased substantially in recent years. A review of illness and disability payment schemes (Government of Ireland, 2004) showed that total expenditure on illness/disability payments almost quadrupled between 1982 and 2002, with expenditure having more than doubled since 1995. Overall government spending on disability specific services in 2008 as reported by Government Departments, was some €6.5 billion.¹⁶³ The Departments of Social and Family Affairs (43 per cent), Health and Children (38 per cent), and Education and Science (15 per cent) made up the bulk of this expenditure.

Figure 9.8 shows the number of disability beneficiaries as a percentage of the working age population (20-64) for selected OECD countries. Disability beneficiary rates in Ireland have been increasing throughout the noughties up to an all time high of 6.3 per cent in 2007. While this means that Ireland has now reached

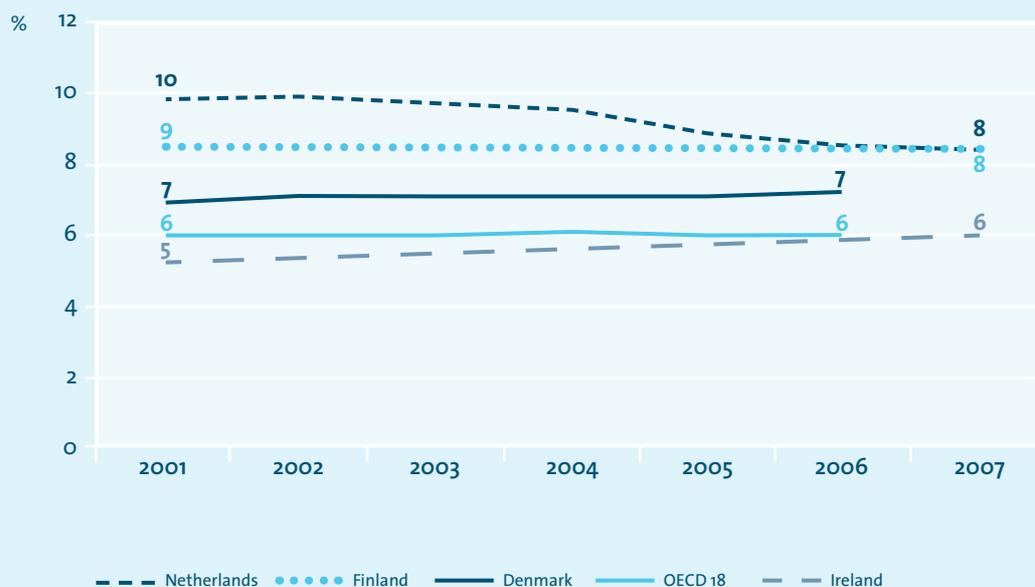
161. PPS expenditure is Purchasing Power Standards. These present comparative expenditures independent of national currencies and taking differences in price levels into account.

162. Disability Benefits refer to income maintenance and support in cash and kind (except health care) in connection with the inability of physically or mentally disabled people to engage in economic and social activities. Sickness Benefits refer to income maintenance and support in cash in connection with physical or mental illness, excluding disability.

163. This is a provisional figure. The corresponding figure for 2007 was €6.3b, and the provisional estimate for 2009 is €6.9b. Figures supplied by the Department of Finance, June 2009.

the OECD-18 average, it is still below the levels of the other countries shown: Denmark, Finland and the Netherlands. What is most notable, however, is the trend direction – increasing for Ireland, while remaining stable or declining for the other countries shown.¹⁶⁴

Figure 9.8 Disability Beneficiaries as a Percentage of the Working Age Population (20-64), Selected OECD Countries, 2001-2007¹⁶⁵



Source OECD (2008b: 54)

Note Data are not available for 2007 for Denmark and OECD 18.

The composition of disability payments expenditure in Ireland has changed since the 1980s, with longer term payments now making up nearly two thirds of expenditure compared to one third in 1982. The proportion of social insurance payments to means-tested payments has also reduced, social insurance payments making up 67 per cent of payments in 2002, compared to 88 per cent in 1982. Overall, payments are fairly evenly distributed between those under 50 years of age and those over 50. The gender breakdown reflects that of the general population. There is, however, significant variation between some of the payment schemes.

¹⁶⁴. The OECD provides a number of reasons for this trend in Ireland. The main reason given is the increased number of older people (under 65) in the population (there were just over 800,000 45-64 year olds in 2001, increasing to 950,000 in 2007). Associated reasons are the extent of activation (which has been relatively low in Ireland) and a perceived increase in work intensity, resulting in above-average stress levels being reported.

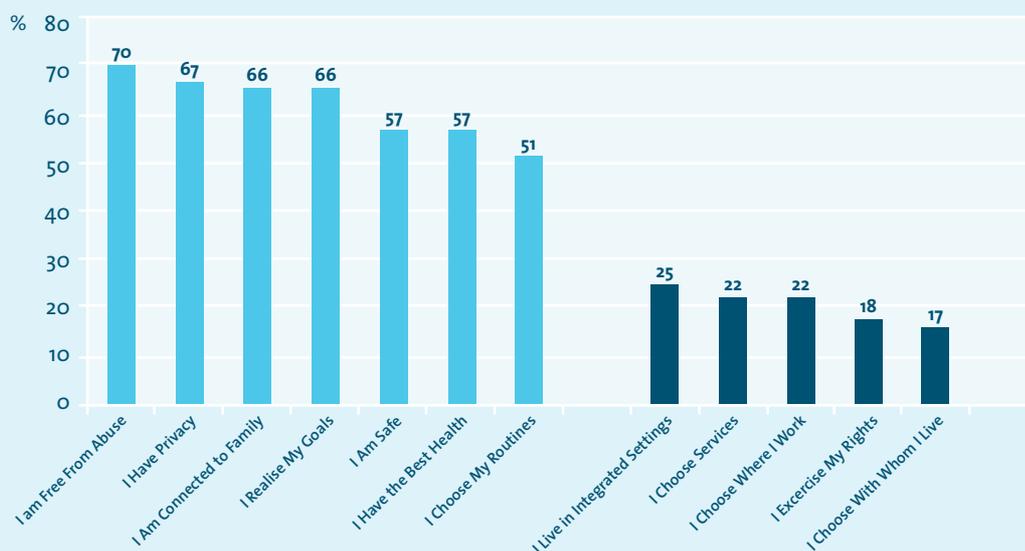
¹⁶⁵. Beneficiaries for Ireland include Disability Allowance, Invalidity Pension and persons on Illness Benefit for over two years. Beneficiaries for the other countries are: Denmark (Disability Pension), Finland (persons receiving statutory Earnings-related Pension and/or National Disability Pension); Netherlands (Wajong, WAO and WIA).

Quality of Life – Personal Outcomes

In previous chapters, at the end of the context section we included information on the level of satisfaction with life for the population group being considered, that is for children, for people of working age and for older people. Unfortunately, for people with disabilities this information is not available. Instead, information is presented on the quality of life of people with disabilities in Ireland based on a study of personal outcome measures.¹⁶⁶ Twenty three different dimensions of a person's quality of life were measured. The survey, based on a sample of 300 people with disabilities¹⁶⁷ who regularly used a disability service, reported an average of 10 out of 23 personal outcomes fully present at the time of the study (March - June 2007).

It should be noted that the study is not representative of people with disabilities. It is based on a specific sample of people who have used specialist disability services. However, in the absence of other information, the results are presented to provide an indication of the quality of life of people with disabilities in Ireland. The outcomes most often present, and outcomes least often present, are shown in Figure 9.9.

Figure 9.9 Personal Outcomes Most Often Present, and Least Often Present, in a Sample of People with Disabilities, 2007



Source McCormack & Farrell (2007: 5)

166. Personal outcomes are those outcomes that are important to the person. Twenty three outcomes measures are used in the Personal Outcomes Measure (POM) which has been used across the English speaking world. These are: *My Self*: 1. I am connected to my family 2. I have intimate relationships 3. I am safe 4. I have the best possible health 5. I exercise my rights 6. I am treated fairly 7. I am free from abuse and neglect 8. I have continuity and security in my life 9. I decide when to share personal information *My World* 10. I choose where and with whom I live 11. I choose where I work 12. I choose my daily routine 13. I have time, space and opportunity for privacy 14. I use my environment 15. I live in integrated environments 16. I interact with other members of the community 17. I perform different social roles 18. I choose services *My Dreams* 19. I choose my personal goals 20. I realise my personal goals 21. I participate in the life of the community 22. I have friends 23. I am respected.

167. Of the sample of 300 people with disabilities who took part in the study, 256 had intellectual disabilities, 31 had physical disabilities, and 13 were on the autistic spectrum. The sample was from 27 service providers throughout the country. The sample of 300 represents more than 5,000 adults with disabilities regularly availing of specialist services across the country. Fifty eight per cent of the sample were male and 58 per cent were 35 years of age or older.

Seventy per cent of participants reported that they were free from abuse, neglect and exploitation, with two thirds reporting that they have adequate privacy, are connected to their family and can realise their goals. Over half of participants reported that they choose their own routines, that they have the best possible health and that they are safe. On the other hand, only one participant in six had a choice about where and with whom they lived, and less than one in five had all their rights respected. Less than a quarter had any choices about where they worked, or choices in relation to their personal services such as a hairdresser, dentist or doctor. Consistent with this, only one in four experienced life in ordinary settings, such as living in ordinary housing, working in ordinary work places and being in ordinary leisure places. While there was considerable variation, a quarter of the participants in the survey had five or less of the 23 outcomes present (McCormack & Farrell, 2007: 4-5). The remainder of this chapter will explore some of these issues in more detail across the six well-being domains.

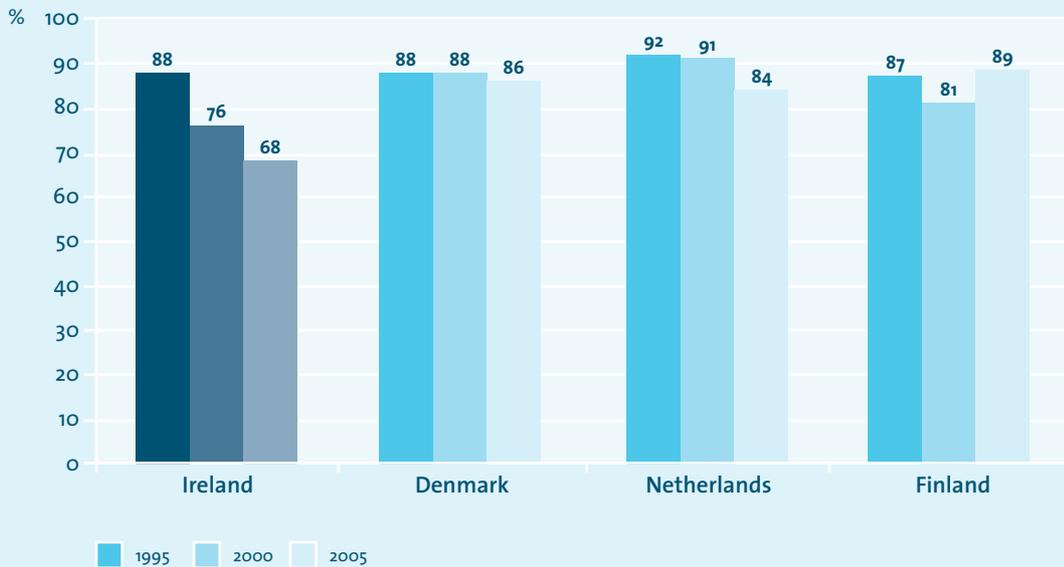
9.4 Economic Resources

9.4.1 Measuring the Economic Well-being of People with Disabilities

Income

Under the economic well-being domain 3 components are measured: income, poverty and deprivation. For income, there are three indicators used: income levels, distribution of income and social class. Figure 9.10 presents information on average equivalised incomes of people with a disability as a percentage of those without for Ireland, Denmark, Netherlands and Finland for 1995, 2000 and 2005. On average people with disabilities have a lower level of income than those without, and this is especially the case for Ireland: in 2005 average income levels for people with disabilities were close to 90 per cent of those without a disability in Denmark, the Netherlands and Finland, but only 70 per cent in Ireland (OECD, 2008b). For comparative purposes (and drawing on other OECD studies) relative incomes also stand at 70 per cent in Australia and the UK, 80 per cent in Poland, and 85-90 per cent in Luxembourg, Norway, Spain and Switzerland (OECD, 2006c; 2007f). For countries where data are available the incomes of people with a severe disability are 7 to 10 percentage points below those of people with a moderate disability. The levels of income do not take into account the extra costs of disability which can be considerable, for example, in relation to heating, transport, medication, aids and adaptations, and diet.

Figure 9.10 Incomes of People with Disabilities as a Percentage of the Incomes of People without a Disability, Selected OECD Countries, 1995-2005¹⁶⁸



Source OECD (2008b: 48)

Over the ten year period 1995-2005 the incomes of people with disabilities compared to the non-disabled in Ireland fell considerably, from a level similar to that of the other countries presented in Figure 9.10, to 68 per cent, suggesting that Irish people with disabilities did not enjoy the same benefits of the Celtic tiger economy as their non-disabled peers. This relative drop mainly related to the incomes of people with a moderate disability which fell by some 15 percentage points in the late 1990s, while those of people with a severe disability did not move much. For most countries, the income levels of people with a disability are much higher when they have higher educational attainment and when they have a job. These issues will be dealt with further in the next section on participation.

Distribution of Income

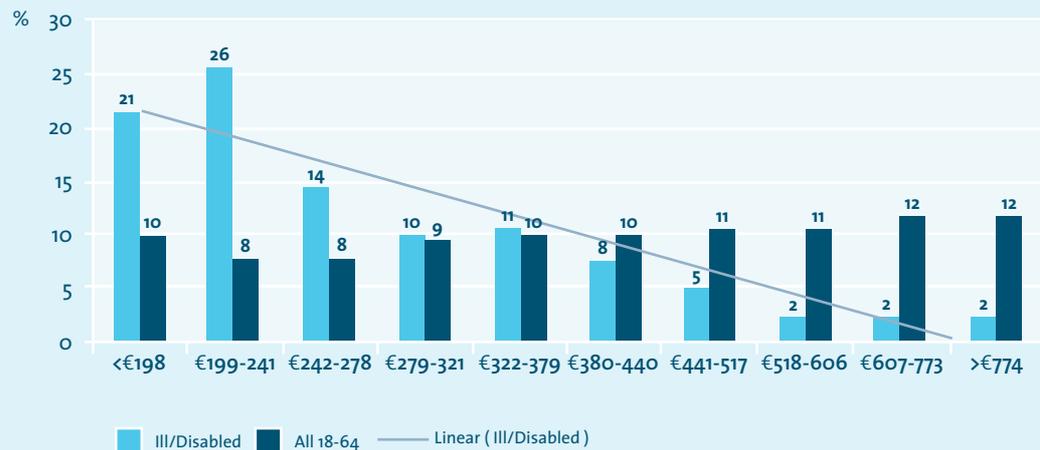
The spread of people with disabilities across the income distribution in Ireland is shown in Figure 9.11, drawing on EU-SILC, 2007.¹⁶⁹ A comparison is made between the disabled and non-disabled population using net equivalised income for people who gave their 'principal economic status' as 'not at work due to illness or disability' compared all people aged 18-64. This figure shows that the income of people who are categorised as being 'not at work due to illness or disability' is concentrated in the lower income deciles, particularly in deciles one and two. This measure under-estimates the income

¹⁶⁸. Disability is defined on the basis of self assessment (existence of a chronic health problem and long-term limitations in daily life activities), except for Finland (1995 & 2000) where an administrative definition is used ie. persons with a legal certificate giving rise to tax deductions/allowances due to disability. Note also that for Denmark the data shown as 2000 are actually for 2002.

¹⁶⁹. Includes SSIA income. For people not at work due to illness or disability SSIA income comprised 1.7 per cent of average annual disposable income, compared to 3.3 per cent for all 18-64 year olds.

of people with disabilities as it does not take into account disabled people who are in work (approximately 37 to 42 per cent of people with disabilities, depending on definitions and sources).¹⁷⁰

Figure 9.11 The Distribution of People Not at Work Due to Illness or Disability and All 18-64 Year Olds Across Net Equivalised Income Deciles, 2007



Source CSO, 2008b:32-33 (EU-SILC, 2007)

Using another measure, the average annual equivalised income after social transfers for those who said they had a chronic illness or health problem was €20,367 in 2007 compared to €24,898 for those who do not (CSO, 2008b). Again, it should be emphasised that people with a disability do not necessarily have a chronic illness or health problem and vice versa. Nevertheless, it is apparent from these two measures that people with disabilities tend to have lower incomes than the population in general.

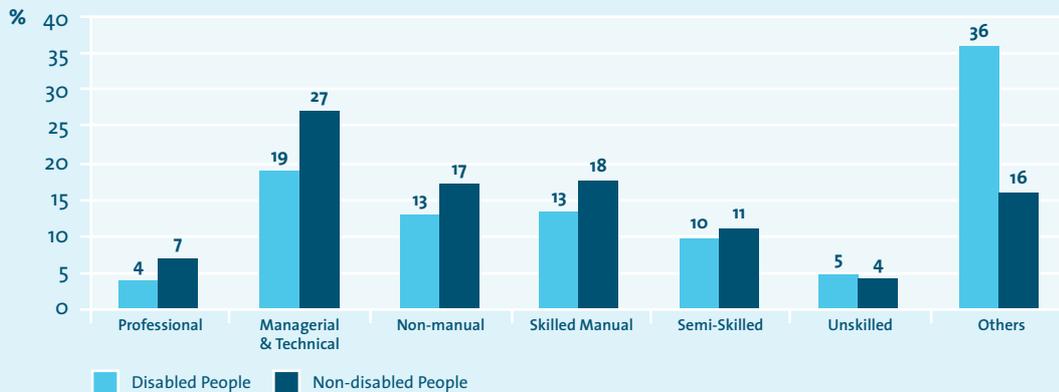
Social Class

One of the reasons for lower incomes becomes clearer when we examine information on social class from the 2006 Census, see Figure 9.12. Two trends are immediately apparent: first, that compared to the non-disabled population people with disabilities are under-represented in all the social class groups except the unskilled; and secondly, more than one third of people with disabilities (36 per cent) are classified as 'Other' ie. where occupational status is not stated.¹⁷¹

170. Using the ILO classification from the QNHS Q1 2004, 37 per cent of persons aged 15-64 with a disability/longstanding health problem were in employment. Using the PES classification in the 2006 Census, only 36 per cent of disabled people with a disability were classified as 'unable to work due to permanent sickness or disability'. Fifty per cent were in the labour force (42 per cent at work and 8 per cent unemployed), with a further 11 per cent not in the labour force but looking after home/family.

171. It should be noted that members of a family unit who are deemed to be dependent are classified to the social class of the person on whom they are deemed to be dependent. If the head of a family has never worked or is permanently sick or disabled or their occupation is not known they are assigned to the social class of the principal earner in the family. If there is no such earner they are assigned to the 'Other' category.

Figure 9.12 Percentage of Disabled and Non-disabled People Across Social Class Groups, 2006

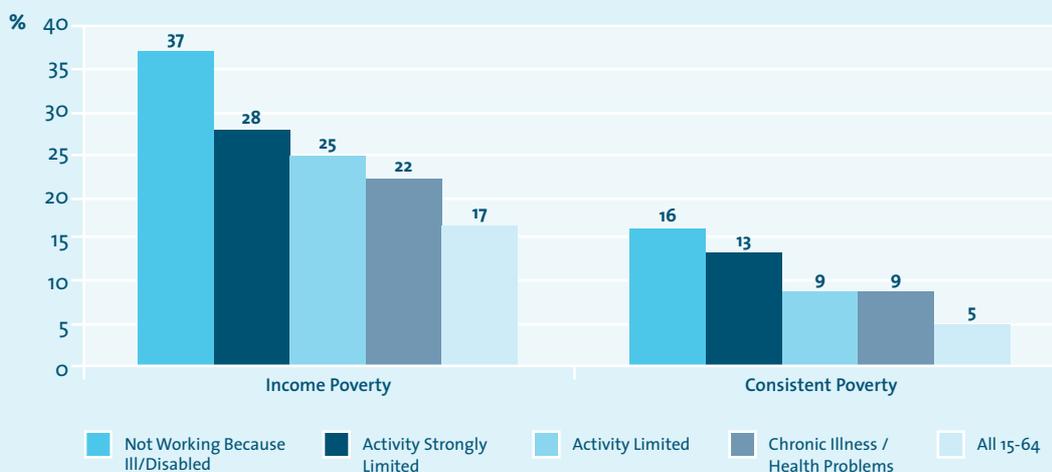


Source: Census 2006

Poverty

Having lower incomes and lower social class would be expected to place people with disabilities at greater risk of poverty. This is borne out when poverty rates for people with disabilities are examined, see Figure 9.13. People who are not at work due to illness or disability, people whose activities are limited because of a health problem and people with a chronic illness all have higher rates of both income poverty and consistent poverty than the population in general. Thirty seven per cent of people who are not working because of an illness or disability are at risk of poverty and 16 per cent are living in consistent poverty, compared to 16.5 per cent and 5 per cent for the general population, respectively. People with disabilities have one of the highest risks of both income poverty and consistent poverty, along with people who are unemployed and lone parents.

Figure 9.13 Poverty Rates for People with Disabilities, 2007¹⁷²



Source: CSO, 2008b (EU-SILC, 2007)

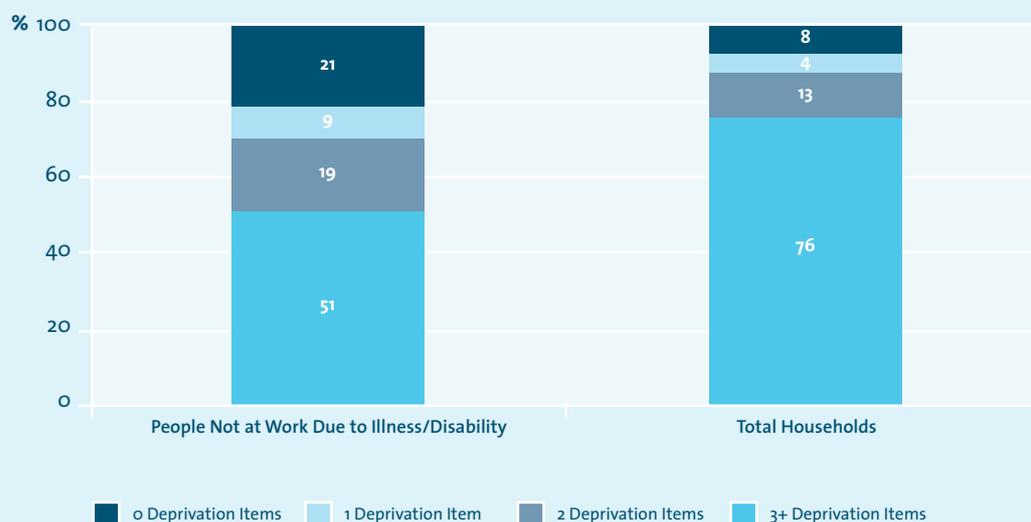
172. A number of statistics are presented here as there is no one statistic for people with a disability. Not working because ill/disabled denotes labour force status as being unable to work due to illness or disability. Many disabled people may be working or otherwise occupied. Activity strongly limited/limited denotes people who were strongly limited in their usual activities in the last six months due to a health problem – this may not apply to some disabled people. The case is similar for people with a chronic illness or health problem, although 93 per cent of people whose labour force status is ill/disabled record having a chronic health problem. Figures include SSIA income – see footnote 169 and notes in earlier chapters (4, 6, 7 & 8).

Work by Gannon and Nolan (2005), using information from the 2001 Living in Ireland Survey¹⁷³ found that 38 per cent of adults with a chronic illness or disability were at risk of income poverty, which was more than twice the rate for other adults. Similarly, their consistent poverty rate was more than twice the rate for other adults at 7 per cent. The experience of being hampered severely in their daily activities increased the risk of income poverty to 50 per cent and consistent poverty to 16 per cent. If people with chronic illness or disabilities are not hampered in their daily activities they have similar poverty rates to other adults. Subsequent work by Gannon and Nolan (2006) found that the onset of disability resulted in an increase of 7 percentage points in the probability of being in income poverty.

Deprivation

The third component on the economic resources domain is deprivation. Figure 9.14 shows that the level of deprivation among individuals defining themselves as not at work due to an illness or disability is much higher than among the population generally. For example, just over half (51 per cent) of ill/disabled individuals reported no deprivation indicators compared to three quarters of the overall population (76 per cent), while one in five people (21 per cent) not at work due to illness or disability reported three or more deprivation indicators compared to 8 per cent of the total population.

Figure 9.14 Deprivation among People with Disabilities, 2007¹⁷⁴



Source Figures supplied by the CSO, June 2009, (based on EU-SILC, 2007).

173. The Living in Ireland Survey has information on whether adults reported having a chronic or long standing illness or disability, and if so, whether this hampers them severely, to some extent or not at all in their daily life.

174. The figure shows the number of deprivation items among individuals who stated that they were not at work due to an illness or disability. It is a self defined status (principal economic status). It does not cover all people with a disability or all households headed by or containing a person with a disability. Nevertheless, it provides an indication of the level of deprivation experienced by people with disabilities.

Further examination of the data shows that people not at work due to illness or disability were two to three times more likely to experience deprivation across the deprivation indicators than the general population. For example, nearly one third (32 per cent) of people not at work due to illness or disability were unable to replace any worn out furniture compared to 13 per cent of all individuals. Likewise, one in five (20 per cent) could not afford to have family or friends for a drink or a meal once a month and 17 per cent were unable to afford new (not second hand) clothes, compared to 10 per cent and 5 per cent, respectively, of all individuals.

Summary

People with disabilities have incomes about 70 per cent of the level of income of people without a disability. People with disabilities tend to be concentrated in the lower income deciles of the income distribution and in lower social class groups. People with disabilities also have extra costs, for example, in relation to medication, aids and adaptations, heating and transport.¹⁷⁵ As a result of all of these factors the risk of both income poverty and consistent poverty for people with disabilities is high – about twice the rate for the general population. They also experience much higher levels of deprivation than the population generally.

9.5.2 Ireland's Policy Framework on Economic Well-being for People with Disabilities

Ireland's policy framework is spelt out in the National Disability Strategy with key commitments reiterated in *Towards 2016* for the 10 years from 2007 to 2016. In relation to the economic well-being of people with disabilities *Towards 2016* contains a number of commitments. Overall, the social partners to the agreement are committed that:

Every person with a disability would have access to an income which is sufficient to sustain an acceptable standard of living.

Specific identified priority actions towards meeting this objective include:

- ◆ Ensuring adequate levels of income for people with disabilities by working for the enhancement and integration of supports in line with overall social welfare commitments and targets. This is to include a rationalisation of existing allowances for people with disabilities in the context of the Government's policy of mainstreaming and the proposed transfer of functions from the HSE to the Department of Social and Family Affairs.
- ◆ Considering issues around the cost of disability following the development of a needs assessment system provided for under Part 2 of the Disability Act, 2005.

These commitments are reiterated and developed in the sectoral plans of the Departments of Social and Family Affairs and Health and Children.

Specifically there are commitments to:

- ◆ Develop protocols to provide a strategic framework for inter-departmental and inter-agency co-operation between the Departments of Health and Children and Enterprise, Trade and Employment, the HSE and FAS.

¹⁷⁵ Some payments, grants and schemes are available to assist with these costs. For example, the Disabled Drivers and Disabled Passengers Scheme provides a range of tax reliefs linked to the purchase and use of vehicles by disabled drivers and disabled passengers in Ireland. There is a mobility allowance and mobility aids grant scheme. Diet and heating supplements are available and there are housing adaptation grants. These issues are dealt with in more detail in later sections of this chapter.

- ◆ A protocol has been agreed between the Departments of Health and Children and Social and Family Affairs to ensure that social welfare benefits do not create disincentives to taking up employment – this includes retention of a medical card for 3 years on taking up employment.
- ◆ The Department of Social and Family Affairs is also committed to developing a data strategy to address information gaps on disability.

At least 235,000 people with disabilities are in receipt of a social welfare benefit,¹⁷⁶ see Table 9.2. Some 71 per cent of these are in receipt of payments of €204.30 per week, which is below the 2007 poverty line of €228.65.¹⁷⁷

Table 9.2 People with Disabilities in Receipt of Social Welfare Payments

Payments	Number of Recipients, 2008	Weekly Personal Rate, 2009
Disability Allowance	90,500	204.30
Illness Benefit	74,600	204.30
Invalidity Pension	53,900	209.80 – 240.30
Disablement Pension	13,000	235.40
Blind Pension	1,500	204.30
Occupational Injury Benefit	1,400	204.30
Total	234,900	

Source Department of Social and Family Affairs, Budget Fact Sheets 2008 & 2009.

9.5.3 Commentary on Economic Well-being

Currently many people with disabilities rely on social welfare for their income. People with disabilities have a high risk of poverty. For those who have to rely on income support, social welfare payments need to be adequate to prevent poverty. In addition, many people with disabilities face additional costs in day to day living, such as technical aids, adaptations and equipment, care assistance, medical bills, extra heating, special diet and higher transport costs. There is no explicit recognition of these extra costs in the social welfare payment structure, although schemes and grants are available to assist with some of these costs. There have been a number of attempts to estimate the extra costs of disability but this has proved difficult given the diverse needs of the disabled population and there has been no agreement on how they should be addressed (Indecon, 2004). The commitment to consider issues around the costs of disability following the development of a needs assessment system is welcomed, although it is recognised that implementation of this measure may be difficult in short-term, given the constrained economic climate.

The wide ranging policy commitments in the National Disability Strategy and *Towards 2016* (as well as the National Development Plan and the National Action Plan for Social Inclusion) are very positive but there remains a challenge in ensuring

¹⁷⁶. This is a minimum number who are on the main disability payments. There may be others who have a disability who may be on other payments such as the Pre-Retirement Allowance, State Pension, Widow/Widowers Pension, Job Seekers Payments, One Parent Family Payment or Farm Assist.

¹⁷⁷. It is acknowledged that some of these benefit recipients may be in households with other sources of income, or may be in receipt of secondary benefits. The calculation of the poverty threshold includes SSIA income.

their full implementation. Improved data on people with disabilities is required to establish adequate indicators (baseline, performance, systemic and diagnostic) for monitoring progress, with a focus on improving outcomes for people with disabilities. The National Disability Authority is currently developing an ‘indicator suite’ to monitor the NDS. As acknowledged in *Towards 2016* this work needs to be supported by the development of more comprehensive information and research on disability from a range of bodies and sources.

The OECD has recently reviewed disability policy in Ireland (OECD, 2008b). In respect of the economic resources of people with disabilities their main observations relate to the fragmentation of the benefit system and the limited consideration given to remaining work capacity in assessing eligibility for long-term disability-type payments. They also note that there are poor incentives for people with health problems to seek work and for employers to retain or hire them (OECD, 2008b: 30). They suggest that benefit responsibility should be transferred to the Department of Social and Family Affairs (as already decided by the Government) and that sickness and disability benefit schemes be rationalised. The OECD also suggests that more adequate payments should be introduced to mitigate the additional costs associated with disability, and to reduce poverty among people with disabilities. A related issue is more coherent and flexible supports and incentives to facilitate people with disabilities into employment, which is addressed in the next section.

Budget 2009 brought about a number of changes in disability payments. People now have to have paid 104 social insurance contributions (twice the previous amount) to qualify for Illness Benefit. In addition, there is a new limit of two years on the duration of Illness Benefit. This benefit is intended as income replacement for insured persons during short spells of illness or incapacity, but there had been no limit on the amount of time the benefit was paid to people who had full contribution records. This change is in line with the OECD recommendation (see above; OECD, 2008b: 33) that ‘paying sickness benefit without time limitation is very unusual across the OECD, for good reasons’, the reasons being that there is a great risk that people in such circumstances will never return to the labour market.¹⁷⁸

9.5 Work and Participation

9.5.1 Measuring the Work and Participation of People with Disabilities

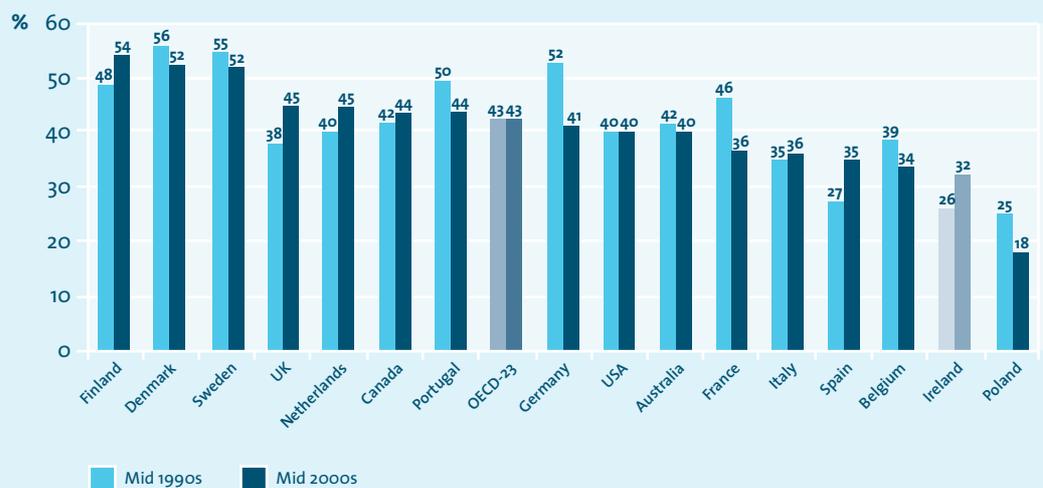
We have seen throughout this report that employment, and participation more broadly, is important for people’s well-being. This ‘sense of purpose’ for ‘human flourishing’ is also important for people with disabilities by focusing on abilities and capabilities. In this section we present two components: employment and education. With regard to employment there are four indicators: employment rate; employment in the public service; the proportion of people with intellectual disabilities in open employment; and proportion of people with disabilities who are not in the labour force.

¹⁷⁸ Budget 2009 also introduced a change to the Disability Allowance, raising the qualifying age from 16 to 18 (and replacing it with Domiciliary Care Allowance for this age group), on the basis that receiving the payment at age 16 could lead to welfare dependency and disincentives to taking up education, training or employment opportunities. This change was subsequently reversed, with the existing arrangement continuing pending completion a full review of the scheme.

Employment Rates

Figure 9.15 presents employment rates of the working age population with disabilities in selected OECD countries in the mid-1990s and mid-2000s. The employment rate of people with disabilities in Ireland is one of the lowest in the OECD at 32 per cent in 2005, compared to an OECD-23 average of 43 per cent (OECD, 2009a). However, in Ireland the rate has increased from 26 per cent in the mid-1990s, which is a positive trend, contrary to many other OECD countries where the employment rate of people with disabilities has been falling.

Figure 9.15 Employment Rates of the Working Age Population with Disabilities, Selected OECD Countries, Mid-1990s and Mid-2000s¹⁷⁹



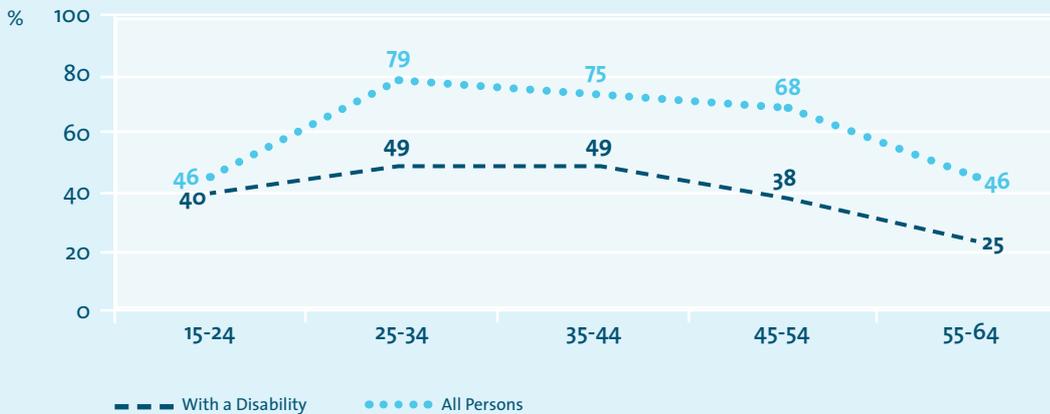
Source OECD, 2009a: 12

Further detail for Ireland is available from the Disability Module of the Quarterly National Household Survey Q1 2004.¹⁸⁰ This survey showed just over 37 per cent of all persons aged 15 to 64 with a disability or long standing health problem were in employment, compared with an overall rate of 64 per cent for the total population, see Figure 9.16. Across age groups the employment profile of people with disabilities is similar to the overall population with highest rates in the 25-34 age group, although it is here that the gap is widest between disabled people and the general population.

179. Working age here is defined as 20-64. The population with a disability is identified through self assessment (people who report that their activities of daily living are to some degree hampered by their health situation), based on national population surveys. While survey questions are similar, if not identical, cross country comparability is restricted due to the subjective element of self-reporting and cultural differences in the interpretation of the questions.

180. The QNHS uses the ILO Economic Status classification. This defines 15 to 64 year olds as being in employment if they worked in the week before the survey for one hour or more for payment or profit and all persons who had a job but were not at work because of illness, holidays etc. People are described as unemployed if, in the week before the survey, they were without work and were available for work, and in the previous four weeks had taken specific steps to find work. The labour force comprises persons employed plus unemployed. Everyone else is classified as inactive (not in the labour force).

Figure 9.16 Percentage in Employment Aged 15-64, 2004



Source CSO 2004 (QNHS Q1 2004 Disability Update)

Persons reporting a disability/health problem worked on average 34.9 hours per week compared to 36.8 hours per week for the overall population (CSO, 2004: 1). The OECD notes that in most countries people with 'health problems' are significantly more likely to work part-time (OECD, 2009a: 11). Hours worked affects earnings levels. Gannon and Nolan (2005: 10) found that while there was little difference between the average earnings of all male employees and the average earnings of male employees with a disability, women with a disability did have lower weekly earnings, primarily because they worked fewer hours per week.¹⁸¹ There is an earnings gap between those whose disability hampers daily activities and those whose disability does not. Disability also has an indirect impact on earnings as it may have an effect on the level of education attained (see below) and on years of work experience.

Gannon and Nolan also found (2006: 9) that the onset of disability for adults of working age led to a decline of about 20 percentage points in the probability of being in employment, especially if the person was hampered in his/her daily activities. Conversely, when an adult moved from reporting disability to not reporting disability there was an increase of about 7 percentage points in the probability of his/her being in employment.

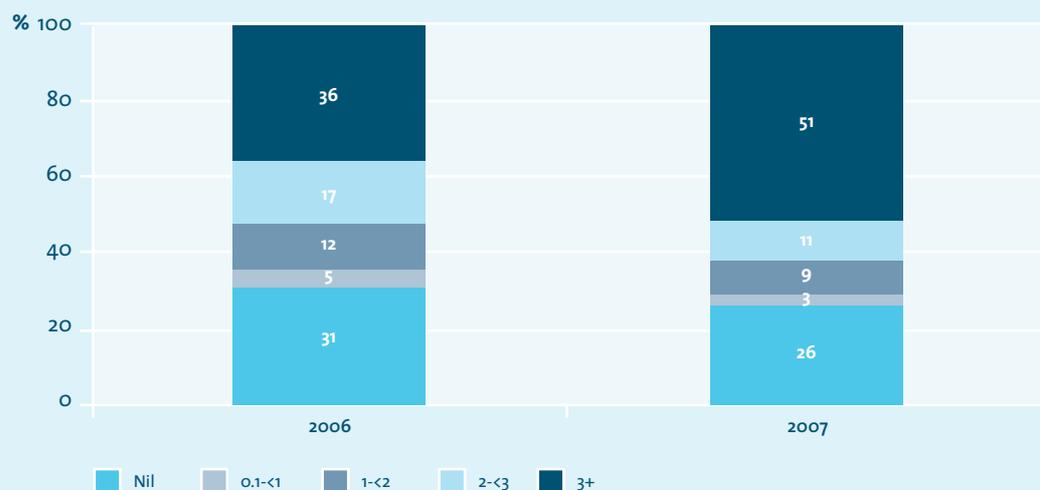
Employment in the Public Service

Since 1977 there has been an informal requirement for public bodies to employ a minimum quota of 3 per cent of people with disabilities. The Disability Act 2005 has now put this informal requirement into law, along with the obligation to take all reasonable measures to comply with the law. Monitoring the employment of people with disabilities in the public service has been fraught with difficulties, including defining disability, disclosing disability, promoting a positive environment for people with disabilities and reporting on the proportion of people with disabilities in the workforce. The NDA has produced two reports on compliance with the 3 per cent quota in the public service (National Disability Authority, 2006a & 2007a).

181. Disabled women's hourly earnings were actually somewhat higher than average. Thus, the picture is quite complex. When the age and education profile of women in employment and reporting a chronic illness or disability is looked at in more detail, it is found that they are older and more highly educated than the (much larger) group of women employees without a disability with whom they are being compared. Unfortunately, limited sample size did not allow more sophisticated statistical analysis of this data (Gannon and Nolan, 2005: 41).

Figure 9.17 shows that, in 2007, just over half (51 per cent) of public service organisations had achieved this target, up from just over one third (36 per cent) in 2006. Part of the explanation for the increase is improved monitoring, as well as a more proactive approach to the employment of people with disabilities.¹⁸² Overall, the government departments and other public bodies which responded to the NDA monitoring request in 2007 had a workforce of 238,833 of which 2.5 per cent (5,879) were reported as having a disability. The best performing parts of the public sector were the government departments and local government organisations where 87 per cent and 77 per cent, respectively, had reached or exceeded the target. The NDA found a direct link between certain types of proactive activities, such as having a specific policy on employing people with disabilities or carrying out an access audit, as resulting in organisations being more likely to achieve or exceed the 3 per cent employment target. The size of organisation was also a factor with larger organisations, on average, more likely to achieve the target. Achieving the target is likely to become more difficult in the current economic climate, with restricted public sector recruitment.

Figure 9.17 Percentage of Public Sector Organisations Achieving the 3 Percent Employment Target, 2007



Source National Disability Authority, 2007:26

Employment of People with a Mental, Nervous or Emotional Disability

The QNHS Q1 2004 showed that only 14 per cent of people with a mental, nervous or emotional disability were in work, which was considerably lower than for any of the other disability groups considered, for example, speech impediment 27 per cent, back or neck disability 42 per cent. Research undertaken by Millward Brown IMS for the NESF (NESF, 2007b: 5) on mental health in the workplace found that there is a stigma attached to mental ill health in the workplace and that 'there are difficulties and risks in disclosing mental ill-health to colleagues and employers, which may have a direct and adverse impact on job prospects'. The research notes

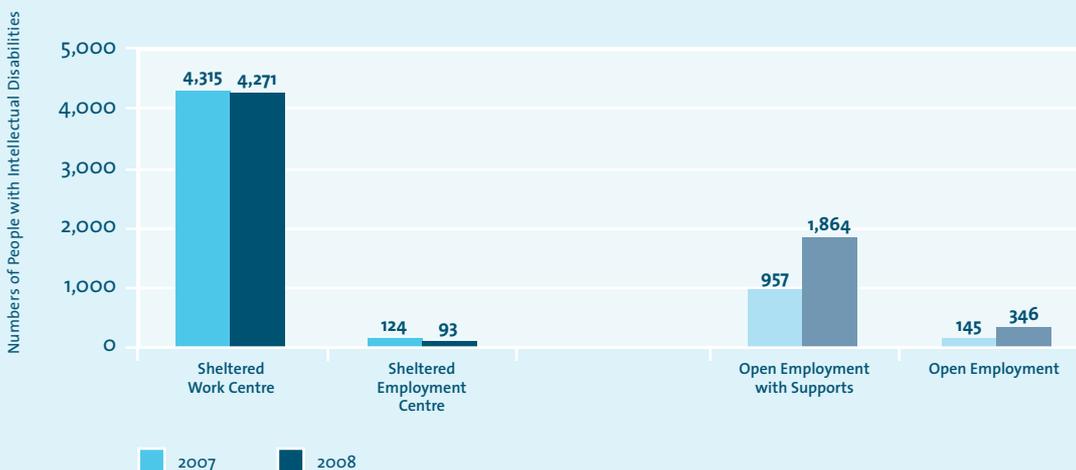
182. As a result the data for the 2 years are not directly comparable.

the lack of policy and guidelines currently in place and that both employers and employees need greater support in this area. Likewise, the OECD (2009a: 10) has found that people suffering from mental health conditions are typically 30 to 50 per cent less likely to be employed than those with other health problems or disability. The OECD also notes that mental health problems now account for one third of all new disability benefit claims on average.

Employment of People with Intellectual Disabilities

People with intellectual disabilities are often in supported or sheltered work settings (National Disability Authority, 2005a: 64). The National Intellectual Disability Database provides information on the employment of people with intellectual disabilities, who are registered on the database.¹⁸³ Of the 17,278 people aged 18 and over who were registered on the database (2008) and availing of day services 6,574 are in some form of employment (38 per cent): 25 per cent in sheltered centres, and 13 per cent in an open employment setting – see Figure 9.18. The numbers in open employment doubled between 2007 and 2008. For those in ‘sheltered work’ there is no entitlement to a minimum wage and earnings are nominal (National Disability Authority, 2005: 64).¹⁸⁴ The HSE is undertaking a review of day service provision for adults with a disability—‘Progressing a Modern Person Centred Service’.

Figure 9.18 Employment Status of People with Intellectual Disabilities, 2007 & 2008



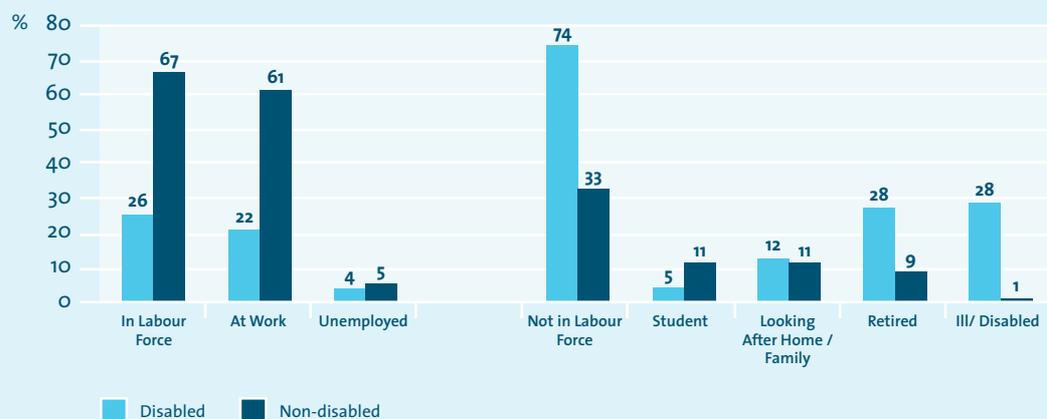
Source: National Intellectual Database, 2007, Table 3.6.

¹⁸³ The database includes people with an intellectual disability who are assessed as being in receipt of, or in need of, an intellectual disability service. It should be noted that people who are not users of disability services are not included on this database; these are mainly people with mild disabilities.

¹⁸⁴ Sheltered work for people with disabilities is provided (or arranged) by the HSE. People may be entitled to benefits/allowances, in full or in part, while engaged in sheltered work. Various income disregards apply under these schemes.

A large proportion of people with disabilities are not in the labour force. Figure 9.19 shows the economic status of the disabled population aged 15 and over compared to the non-disabled population, from the 2006 Census.¹⁸⁵ Nearly three quarters of disabled people are not in the labour force, the majority being retired (28 per cent) or permanently sick or disabled (28 per cent). Similar proportions of the disabled and non-disabled population are looking after the home or family (11 per cent), while only 5 per cent are students compared to 11 per cent of the non-disabled population.¹⁸⁶

Figure 9.19 Economic Status of Disabled and Non-disabled Population, 2006



Source Census 2006

Education

The second component of the work and participation domain is education. The educational well-being of people with disabilities is assessed using three indicators: the percentage of pupils with disabilities in mainstream schools; age at which education ceased; and the highest level of qualifications achieved. Education is a key influence on life chances, as well as providing people with opportunities for enhancing confidence and self discovery. Supporting educational participation and improving education outcomes are fundamental for the well-being of people with disabilities. The thrust of current policy is for greater mainstreaming of children with disabilities within the education system.

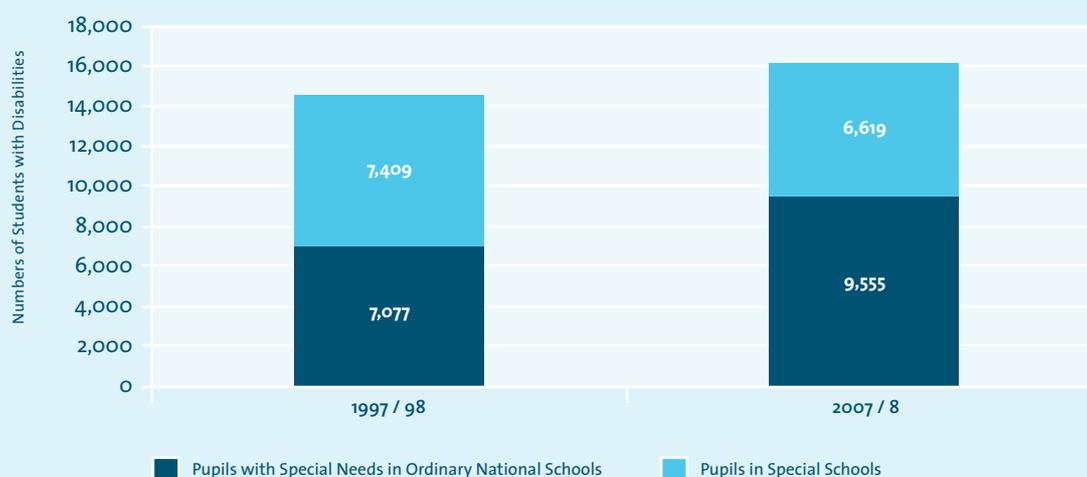
Pupils with Disabilities in Mainstream Schools

At first level students with disabilities are educated in mainstream primary schools with supports, in special classes attached to mainstream primary schools and in special schools. Historically, a high proportion of children with disabilities were educated in special schools, but in line with current thinking, the focus is now in supporting children in mainstream schools as far as is possible. Figure 9.20 presents the number of pupils with special needs in ordinary national schools and in special schools, comparing 1997/98 with 2007/8.

¹⁸⁵ Using Principal Economic Status. Respondents are asked how they would describe their present principal economic status on the basis of the following response categories: working for payment or profit; looking for first regular job; unemployed; student or pupil; looking after home/family; retired from employment; unable to work due to permanent sickness or disability; other.

¹⁸⁶ Time use data for people with disabilities is not available but would be useful to determine how people with disabilities spend their time and their levels of satisfaction in this regard.

Figure 9.20 Students with Disabilities at First Level, 1997/98 and 2007/08



Source Department of Education and Science (2008), *Education Statistics 2007/8*

Figure 9.20 shows that the proportion of children with disabilities educated in ordinary national schools compared with special schools has increased over the ten year period from 1997/8 to 2007/8, from 49 per cent to 59 per cent. Beyond first-level age, children with disabilities either enter mainstream second level schools (for which comparable figures are not currently available) or are in special schools. A study by AHEAD¹⁸⁷ in 1997/98 found that at second level most schools reported having a small number of children with disabilities, with higher proportions found in schools with special education units and in vocational schools (cited in National Disability Authority, 2005a: 40).¹⁸⁸ Overall, these data indicate a trend towards the greater integration of children with disabilities in mainstream schools.

As might be expected the proportion of primary age children who are in special schools depends, to some extent, on the type and severity of their disability. Children with mild general learning disabilities or speech and language disorders are more likely to be in special classes in national schools than in special schools. Children with more severe learning disabilities, who have profound hearing and sight impairments, are emotionally disturbed or have multiple disabilities are more likely to be in special schools (National Disability Authority, 2005a: 40).

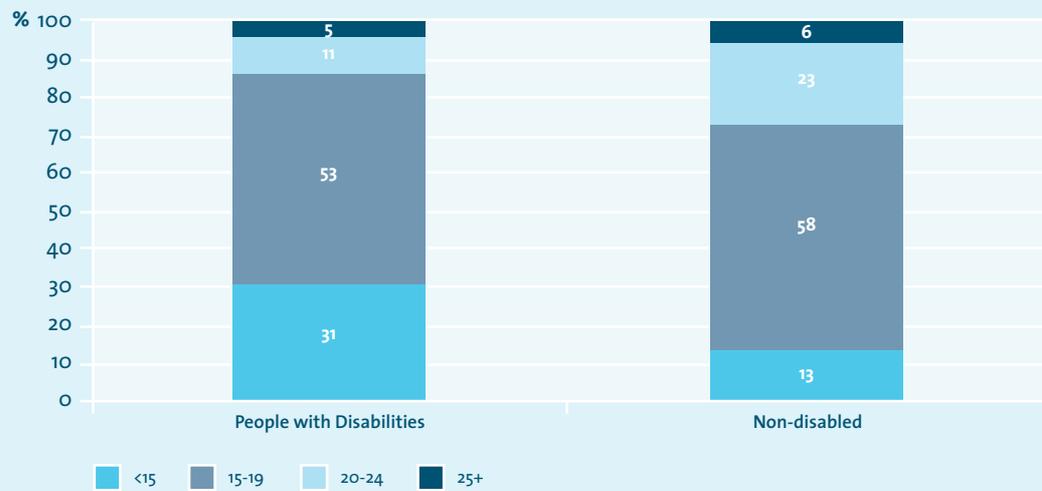
Age at Which Education Ceased

Future life chances are, to a large degree, determined by educational attainment. The next two indicators attempt to shed some light on these opportunities for people with disabilities. Figure 9.21 shows the age at which education ceased for people with disabilities compared to the non-disabled population. People with disabilities finish their education earlier than the non-disabled population, with 31 per cent ceasing before the age of 15, compared to 13 per cent of this age group who do not have disabilities. Using data on Principal Economic Status, 75 per cent of people with disabilities aged 15-19 are classified as students compared to 78 per cent of the non-disabled population.

¹⁸⁷ AHEAD is the Association of Higher Education Access and Disability organisation. It is a registered charity working to promote full access to, participation in, benefit from, and contribution to third level education by people with disabilities in Ireland, north and south.

¹⁸⁸ It is noted that there are a growing number of special classes attached to mainstream schools at second level.

Figure 9.21 Age at which Education Ceased, 2006

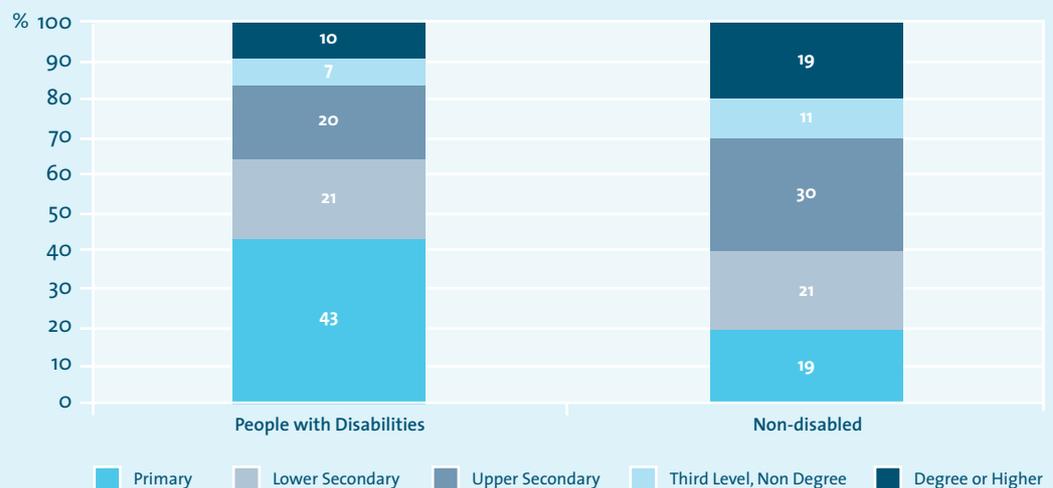


Source Census 2006

Highest Level of Education Achieved

When we examine the highest level of qualifications achieved people with disabilities have lower levels of qualifications than the non-disabled population, see Figure 9.22. Some 43 per cent of people with disabilities have only achieved primary level education compared to 19 per cent of the non-disabled population. Conversely, only 17 per cent of the disabled population have a third level qualification compared to 30 per cent of the non-disabled population. Age is a factor here as disability increases with age and the older population tend to have a lower overall level of qualification than the non-disabled population. However, people with a disability are less likely to have a third level education than the overall population across all age groups. In the 25-44 age group, only 28 per cent of people with a disability have completed third level education compared to 43 per cent of all persons in that age group (CSO, 2007d: 28).

Figure 9.22 Highest Level of Qualification Achieved, 2006



Source Census 2006

Work by Gannon and Nolan, using data from the Living in Ireland survey, reinforces these findings (Gannon and Nolan, 2005 & 2006). They found that having a disability or chronic illness in childhood can treble the risk of leaving school with no qualifications. People who became disabled as adults also have lower levels of education than the general population, indicating that those with lower levels of education are more susceptible to disability or chronic illness.

Summary

The participation of people with disabilities in the labour force is much lower than that of the non-disabled population. Three quarters of people with a disability are not in the labour force: one third of these are categorised as ill or disabled, one third are retired and the remaining one third are looking after the family or home or are in education. Employment rates for people with a disability are low at between 32 and 37 per cent of the working population in Ireland (depending on definitions used) and is one of the lowest rates in the OECD. People with health problems are more likely than the general population to be working part-time. The type of employment for people with disabilities has an impact on their earnings, as seen in the previous section.

Just over half of public service organisations meet the 3 per cent quota of employing people with a disability. Organisations with proactive measures such as disability policies or access audits are more likely to meet or exceed the target. However, achieving the target is likely to become more difficult in the current economic climate, with restricted public sector recruitment. There are particular employment difficulties for people with mental ill-health, with a stigma attached to this type of disability. Across the OECD the numbers of people with mental ill-health have been increasing. People with intellectual disabilities are least likely to participate in the labour market, with only a very small proportion in open employment (6 per cent), and about one quarter in sheltered work.

People with disabilities have poorer educational outcomes than the population in general, which affects their life chances. This is in evidence throughout the education system. While there is evidence of a greater integration of people with disabilities into the mainstream education system, in many cases supports are required to improve their educational experiences and outcomes.

9.5.2 Ireland's Policy Framework for the Work and Participation of People with Disabilities

Ireland's policy framework is spelt out in the National Disability Strategy with key commitments reiterated in *Towards 2016* for the 10 years from 2007 to 2016. In relation to the work and participation of people with disabilities *Towards 2016* contains a number of commitments. Overall, the social partners to the agreement are committed that:

Every person with a disability would, in conformity with their needs and abilities, have access to appropriate ... education, employment and training.

Specific identified priority actions towards meeting this objective include:

- ◆ The elaboration of a comprehensive employment strategy for people with disabilities including:

- Vocational training and employment services for people with disabilities;
 - Addressing disincentives and considering extension of the NEAP FÁS referral process to people with disabilities;
 - Public service employment;
 - Promoting awareness regarding the employment of people with disabilities; and
 - Drawing on the materials of the Workway Initiative.¹⁸⁹
- ◆ Developing a strategic integrated approach to rehabilitation services within the context of a Multi-Annual Investment Programme with a view to supporting people back into employment, as appropriate, through early intervention and enhanced service provision.

These commitments are reiterated and developed in the sectoral plans of the Departments of Social and Family Affairs, Enterprise, Trade and Employment and Health and Children. Specifically there are commitments to:

- ◆ Develop protocols to provide a strategic framework for inter-departmental and inter-agency co-operation between the Department of Health and Children, the Department of Enterprise, Trade and Employment, the HSE and FÁS.
- ◆ A protocol has been agreed between the Department of Health and Children and the Department of Social and Family Affairs to ensure that social welfare benefits do not create disincentives to taking up employment – this includes retention of a medical card for 3 years on taking up employment.
- ◆ The Department of Enterprise, Trade and Employment is committed to developing a comprehensive employment strategy as specified above.
- ◆ The Department of Social and Family Affairs is committed to the development of a systematic engagement with all people of working age, specifically including people with disabilities. This includes commitments in the National Action Plan for Social Inclusion.

The National Action Plan for Social Inclusion 2007-2016 contains a target to raise the employment rate of people with disabilities from 37 per cent to 45 per cent by 2016 and to increase the overall participation rate of people with disabilities in education, training and employment to 50 per cent by 2016. The Department of Enterprise, Trade and Employment's sectoral plan also contains these commitments. Improved data will be required to monitor these developments.

There is no statutory requirement for the Department of Education and Science to produce a sectoral plan. The Education for People with Special Needs Act 2004, which is premised on the rights of people with disabilities for assessment and an individual education plan, sets out the State's obligation to provide education for people with special educational needs, in an inclusive environment. This requires the provision of education to children with special educational needs to the same level as to those who do not have such requirements, with the ambition that

¹⁸⁹. The Workway Initiative is a joint IBEC and ICTU initiative to promote the employment of people with disabilities in the private sector. From 2002-2005 four regional Workway networks addressed the complex and challenging barriers that people with disabilities face in accessing and staying in employment. In the course of their work they developed a wide range of practical materials for people with disabilities, employers and trade union representatives.

children with special needs can leave school with the skills necessary to participate to the level of their capacity. The focus is on supporting people to live independent and fulfilled lives. In general, there is a focus on supporting children in mainstream education, where possible. It should also be noted that there is a constitutional right to education.

The National Council for Special Education has published an Implementation Report on the phased implementation of the Education for Persons with Special Educational Needs Act. The report finds that up to 18 per cent of school going children may have special educational needs. The report identifies areas where investment is needed, with a particular emphasis on teacher training and support for schools.¹⁹⁰

There is provision for people with disabilities in the further education sector. The participation of people with disabilities is encouraged by making available supports that may be required, and the offer of specific programmes and special initiatives.¹⁹¹

The economic climate is impacting on the ability to deliver on a number of these commitments at the present time. For example, the Back to Work Allowance has been closed to new entrants since the 1st May 2009 and there have been reductions in budgets for Special Needs Assistants in schools and in the National Education Psychological Service.

9.5.3 Commentary on the Work and Participation of People with Disabilities

Employment

It is clear from the analysis that those who can access the labour market and have an earned income have a higher standard of living. The policy instruments recognise this and there is a focus on encouraging people with disabilities into the labour force, depending on the developmental capacity of each individual. Participation in the labour force provides financial benefits but also the advantages of gainful activity. Lack of work is generally harmful to health, including: higher mortality; poorer general health; poorer mental health; and higher medical consultation, medication consumption and hospital admission rates (Goodbody Economic Consultants, 2008: iii).

In their study of sickness, disability and work in Ireland, the OECD (2008b: 29) note that Ireland's systems and structures to address poor health and disability in relation to work and income support are 'still quite traditional, passive and reactive'. In particular: there is a lack of systematic engagement with people with chronic health problems or disability; there is a very fragmented and complex system of employment supports with little attention given to people with long-term health problems or disability; little consideration is given to remaining work capacity in assessing eligibility for long-term disability benefits; and there are poor incentives for people with health problems or disability to seek work and for employers to retain or hire them.

190. The National Disability Authority has also carried out two reports on education and disability (NDA, 2006b & 2007b). These reports found that there was strong support for the principle of inclusion in the mainstream but that further work was required to support the implementation of this commitment, including, in particular, supports for teachers and pupils. The ethos of the school and the management of resources were important related issues.

191. People with disabilities may access: Post Leaving Certificate Courses, Vocational Training Opportunities Scheme, Youthreach, Back to Education Initiative, Adult Literacy, and Community Education. Examples of specific initiatives include the 'stepping forward' programme offered by Dun Laoghaire VEC, and the Access (Rehabilitative Training) programme offered by the National Learning Network.

The OECD has identified as key challenges for Ireland the low rate of employment for people with a disability and the lack of co-operation of the various employment policy institutions. For example, despite policy responsibility for vocational training of people with a disability transferring to the Department of Enterprise, Trade and Employment and other training and employment supports to FÁS, responsibility for rehabilitative training and sheltered workshops remains with the Department of Health and Children. Many other structures remain unchanged, for example, the system of specialist training support through private non-profit providers, who receive funding from FÁS.

Indecon (2007) has carried out a review of the efficiency and effectiveness of vocational training services and rehabilitative training services for people with disabilities provided by specialist training organisations. They reported that there are 57 separate agencies providing rehabilitative training and 38 providing vocational training.¹⁹² People with mental health and intellectual disabilities are the two major disability groups served by the rehabilitation training provided, while ‘depressive disorder’ and ‘physical medical disability’ are the major disability groups in vocational training. The main conclusions of the review were the importance of training schemes having links to other activities, such as job search and job coaching, the creation of individualised training packages, and the need for evaluation and feedback from people with disabilities themselves. Feedback in the Indecon study indicated that training was effective in terms of outcomes, health and social gain, training delivery / standards and certification, but that funding and the availability of places was inadequate.

The OECD criticised the sheltered employment scheme in Ireland for its lack of ambition in relation to progression, potentially to the open labour market, and noted that the legal status of workers in sheltered employment in Ireland remains a controversial issue as there is no guarantee of a minimum wage, a legal contract of employment or employment protection (OECD, 2008b: 125). At a more general level, the OECD has called for greater streamlining of services in Ireland, with greater flexibility and consideration of more part-time options. The need to work with, and support, employers is also acknowledged. The role of employers was also recognised in the Goodbody (2008) review of the wage subsidy scheme, along with the importance of the medical card to people with disabilities.

In a study of chronic illness, acquired disability and employment, WRC Social and Economic Consultants (2008) found that there is a need to support both employment retention and employment reintegration.¹⁹³ The longer a person is absent from work the less likely they are to retain their employment or reintegrate back into employment. For this reason early intervention is advocated as is the need to identify the particular needs of the population of Illness Benefit recipients (the focus of the study) so as to be able to ‘better tailor responses to their particular and individual needs’ along the lines proposed in the developmental welfare state and in the National Disability Strategy (WRC Social and Economic Consultants, 2008: xxii). It is recognised that the retention and reintegration of people in receipt of long term Illness Benefit will be even more challenging in the current economic and employment context.

192. Rehabilitative Training focuses on the enhancement of an individual's core functional skills, life skills and social skills. The level of outcome from Rehabilitative Training is not predetermined but is dependent on the developmental capacity of each individual. Vocational Training focuses on the attainment of a predetermined level of competence in a specific employable skill (Indecon, 2007: ii).

193. The processes involved in assisting an employee who is absent from work due to the onset of chronic illness or acquired disability (CIAD) to return to work in his/her job or to another job with his/her employer is referred to as employee retention. The process involved in assisting a person with a CIAD who has lost their former employment to take up employment with an employer other than their former employer is referred to as employment reintegration (WRC Social and Economic Consultants, 2008: viii).

In order to access the labour force many people with disabilities require supports, incentives and flexibility as they strive to overcome the many barriers that can make their participation in the labour market difficult. The sectoral plans of the Departments of Social and Family Affairs, Enterprise, Trade and Employment, and Health and Children, and the co-operation protocols, offer a lot of potential. But structural barriers remain and the main challenge, in the recession, will be to retain a focus on the development of a tailored case management approach for people with disabilities to enable them to realise their potential to the greatest extent possible, with the associated longer term benefits to themselves and society. The ongoing monitoring of progress and outcomes, including the development of appropriate indicators, will be important in this regard.

The evaluation of the 'Midlands Pilot'¹⁹⁴ (WRC Consultants, 2006) examined issues in relation to the capacity of young people (aged 16 to 25) on Disability Allowance viewed as 'capable of progression'. The evaluation concluded that there was a need to recognise the diversity of the young people's circumstances and needs, and to move from a predominantly passive system of income support combined with a voluntary take up of services to a system that proactively engages with people with disabilities to provide a full range of services in relation to education, training and employment. Such a system needs to use an assessment method that is oriented towards identifying capacities for work, and the supports required to realise these capacities, rather than being tied to eligibility requirements for Disability Allowance. The evaluation pointed to the need for an individualised tailored approach, a much greater level of inter-agency co-operation, more consideration of part-time options and the challenges of finding suitable and available jobs.

Education

The overview of the educational well-being of people with disabilities has shown that the educational achievement of people with disabilities is still well below the mainstream average. There is recognition of the need to address this in current policy commitments, although this analysis and other studies show that there is still some way to go. There is a need to ensure that adequate supports are available from an early age so that children and young people with special educational needs can receive an education which maximises their potential and provides opportunities for their well-being now and in the future. The continued provision of supports is coming under pressure in the current economic climate but it would seem unwise, despite short-term pressures, to pull back on the progress made thus far, not only for the young people and their families, but also for the longer-term benefits of their contribution to society.

Monitoring

In order to monitor progress on whether the gap between the educational outcomes for people with disabilities and the population in general is narrowing improved

¹⁹⁴ The 'Midlands Pilot' was a multi-agency initiative designed to respond to the increasing number of young people (between the ages of 16 and 25) applying for Disability Allowance. The agencies involved included FÁS (in the context of vocational training and employment support), Department of Social and Family Affairs (in respect of income and employment support schemes and/or benefit retention mechanisms) and the Health Service Executive (in the context of rehabilitative training and supports). The pilot project took place in the 'midlands region' comprising counties Longford, Laois, Offaly and Westmeath. The specific objectives of the pilot were to: a) provide an integrated point of contact for the target group, and subsequently an integrated examination of their training and support potential; b) facilitate participation in training and employment supports by addressing the needs of a group with high risks of poverty; c) reduce social welfare dependency and create economic independence for disabled people; d) examine the nature and extent of existing supports used by various statutory agencies to assist disabled people's progression towards employment; and e) analyse and benchmark the outcomes of the pilot against previous approaches. The 'Midlands Pilot' was implemented in 2005 and evaluated by WRC Social and Economic Consultants in 2006.

data are required to track the performance of people with disabilities. The NCSE is engaged in a significant programme of research which is guided by a framework that incorporates educational outcomes for children with special education needs as one of its central themes. Information on the participation of people with disabilities more broadly is also required. For example, it would be useful to have time use data to monitor the various activities people with disabilities are engaged in, the time allocated to these activities and their satisfaction levels with how they spend their time, bearing in mind the importance of participation and sense of purpose to well-being. Data such as these can contribute to an overall monitoring system and performance dialogue (see section 9.11).

9.6 Relationships and Care

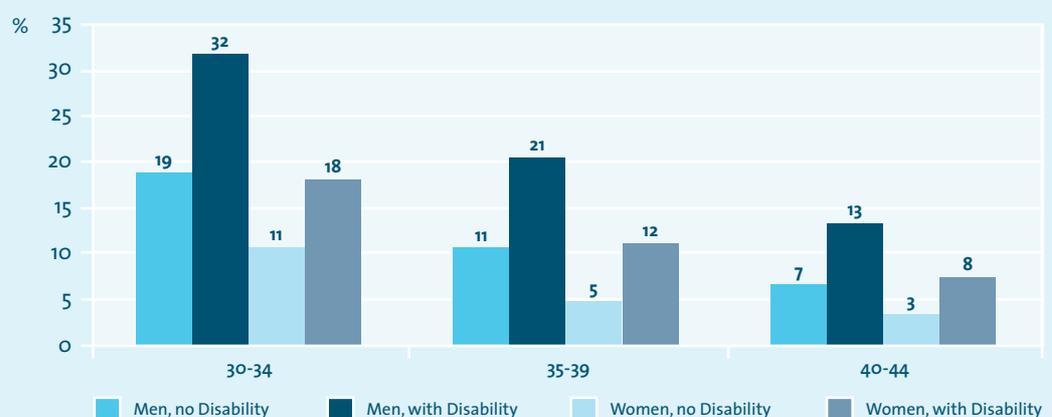
9.6.1 Measuring the Relationships and Care of People with Disabilities

Relationships are an important element of well-being for everyone. To assess relationships for people with disabilities their living arrangements are examined, as well as family structure, social life and care. On the first component of living arrangements two indicators are used: the proportion of 30-44 year olds living in the parental home, and the proportion living in communal establishments.

Proportion of 30-44 year olds Living in the Parental Home

Figure 9.23 shows the proportion of 30-44 year olds living in the parental home for disabled and non-disabled men and women. As stated earlier (see Chapter 7 in particular), when people are in their thirties they are likely to have made transitions in relation to career development and household formation. It is clear from the graphic that for people with disabilities this is less likely to be the case. People with disabilities are twice as likely to live in the parental home from age 30 to 44 as their non-disabled peers. Men, with and without disabilities, are more likely to live in the parental home than disabled and non-disabled women.

Figure 9.23 Proportion of 30-44 Year Olds Living in the Parental Home, 2002¹⁹⁵



Source NDA, 2005a: 77, Table 7.2

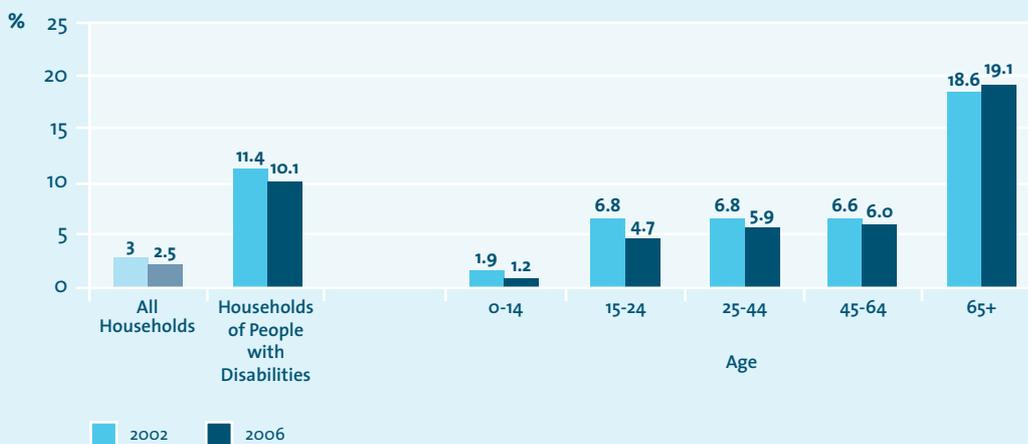
195. This information is based on a special tabulation of the 2002 Census. This information is not yet publicly available from the 2006 Census / National Disability Survey.

People with disabilities may have fewer options to live independently than non-disabled people given care requirements in relation to their disability, their lower education, employment rates and income levels, the high cost of housing and waiting lists for suitable local authority housing. The insufficiency of care supports and options may also make it more difficult for people with disabilities to leave the parental home. People's care requirements can also influence the nature of their relationships and determine their ability to form relationships outside the parental home. The NDA (2005a: 76) has reported that people with learning difficulties and those who have difficulty in dressing or leaving home alone are least likely to move out of the parental home before the age of forty.

Living in Communal Establishments

The second indicator under the living arrangements component of the relationships and care domain is the percentage of people living in communal establishments, see Figure 9.24. While the majority of people with disabilities live in private households (90 per cent) a substantial minority (10 per cent) live in communal establishments. People with disabilities are more likely than the general population to live in communal establishments: 10 per cent compared to 2.5 per cent. There has been a slight decline in the proportion of people with disabilities living in communal establishments between 2002 and 2006, from 11 to 10 per cent. This decline is reflected across age groups except for those aged 65 and over. The likelihood of living in a communal establishment increases with age: only 1 per cent of children aged 14 and under with a disability live in a communal establishment, 5 to 6 per cent of 15-64 year olds do so, and this increases to 19 per cent of the over 65s. Some 82 per cent of people with disabilities living in a communal establishment live in a hospital, nursing home or children's home. The available evidence highlights the desire of people with disabilities to live independently, where possible. The data indicate a move in this direction, but a requirement is the provision of adequate supports.

Figure 9.24 Percentage of Disabled People Living in Communal Establishments, 2002 and 2006

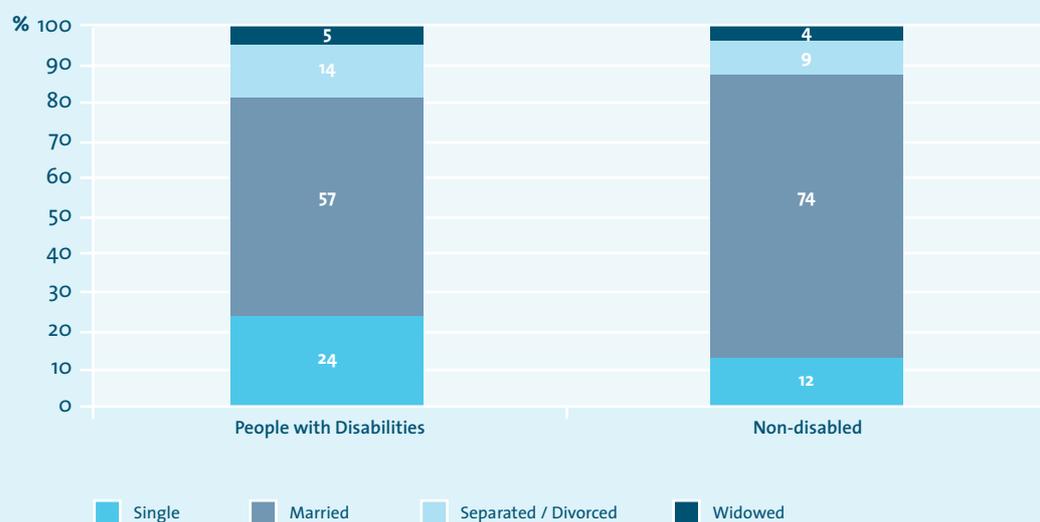


Source Census 2002 and 2006

Family Structure

The second component on the relationships and care domain is family structure and the indicator is the proportion of 45-64 year olds by marital status, see Figure 9.25. This graphic shows that even though the majority of people with a disability in this age group are married (57 per cent) they are twice as likely to be single, fifty per cent more likely to be separated or divorced and slightly more likely to be widowed than people without a disability. The importance of affective and supportive relationships for well-being has been highlighted throughout this report, so that the higher levels of separation, divorce and widowhood for people with a disability would be a concern, especially as conflictual relationships and loss of a partner are known to be particularly detrimental to well-being. Social supports can be important in these instances and the next indicators presented relate to social outings and carers.

Figure 9.25 Marital Status of 45-64 year olds, 2006

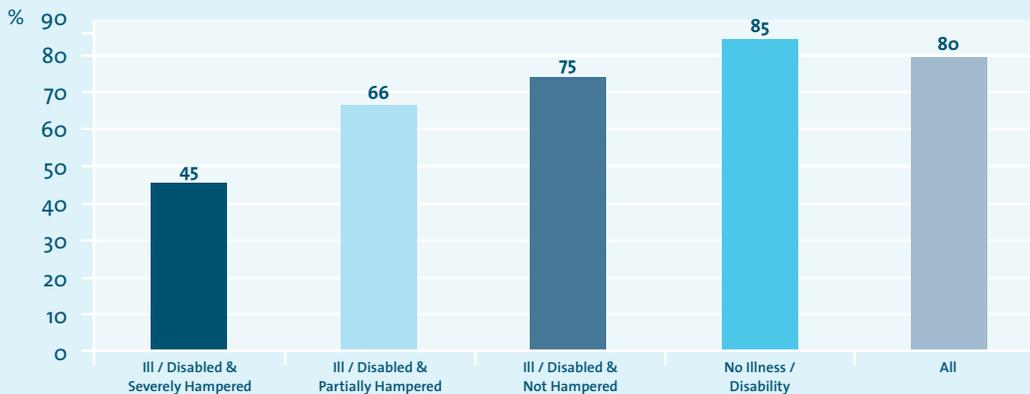


Source Census 2006.

Social Outing

The third component of the relationships and care domain is social life and the indicator here is having an afternoon or evening out for entertainment in the last fortnight which costs money. Figure 9.26 shows that people who are severely hampered by their disability are less likely to have an afternoon or evening out for entertainment, at 45 per cent, than those who are not hampered by their chronic illness or disability, at 75 per cent. Some 85 per cent of people without a disability had such a social outing in the last fortnight. When asked why they did not have an afternoon or evening out responses varied by the extent to which their disability limited them in participating in such activities. Nearly half of those who were severely hampered said their illness/disability was the main reason preventing them going out. Other reasons provided were that they did not want to or could not afford to. Not wanting to go out was the main reason given by the majority of the other groups. There may be an age factor here as people with disabilities have an older age profile, but disability and access are also contributory factors.

Figure 9.26 Percentage having a Social Outing, 2001¹⁹⁶

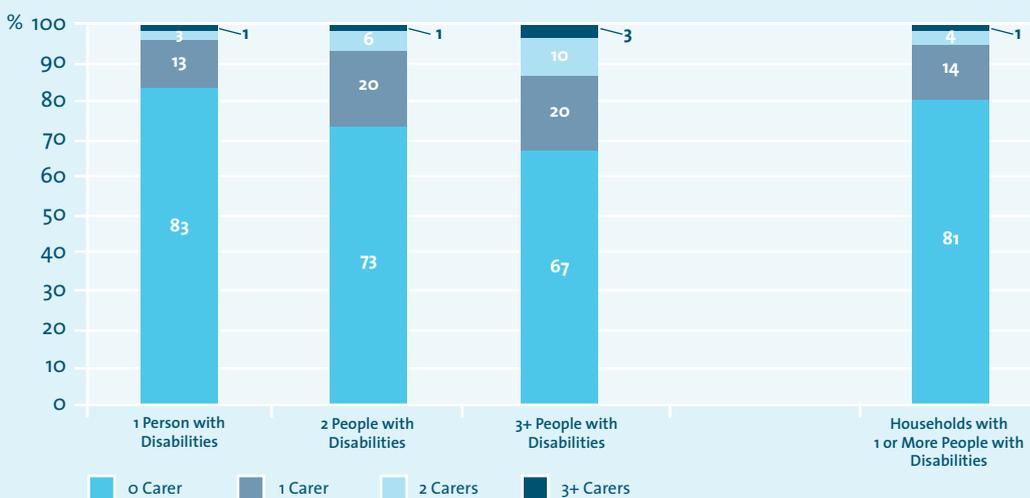


Source Gannon and Nolan, 2005, Table 6.4 (based on *Living in Ireland Survey, 2001*)

Carers in Households with People with Disabilities

The fourth component on the relationships and care domain is care and the indicator is carers in the household, as presented in Figure 9.27. The figure shows that four fifths of households containing one or more people with disabilities does not contain a carer. This varies from 83 per cent of households containing one person with a disability to two thirds of households containing 3 or more people with a disability who do not have a carer in the household. One third of households containing three or more people with a disability contains one or more carers, compared to less than one in five households containing one person with a disability. While this information provides an indication of the number of carers in households containing people with disabilities it does not provide information on the nature of the caring relationship, caring requirements or other supports available. Further information on carers and caring will become available on publication of the second set of results from the National Disability Survey.¹⁹⁷

Figure 9.27 Carers in Households with People with Disabilities, 2006



Source CSO 2007d: 164 (Census, 2006)

196. More up-to-date information is available from EU-SILC 2007, but this is limited to people not at work due to illness or disability who have been unable to afford a morning, afternoon or evening out in the last fortnight. Some 16 per cent of people not at work due to illness or disability have not been able to afford such an outing compared to 8 per cent of the overall population.

197. A research study is also underway at the National Institute for Intellectual Disability on carers of people with an intellectual disability.

Summary

Relationships are important for well-being. The information presented here indicates that the quality of relationships for people with disabilities still falls some way below the population in general. People with a disability are less likely to be independent, and thus more likely to be living in the parental home in middle age, more likely to be living in communal establishments, more likely to be single or separated/divorced in middle age, and less likely to socialise than people without a disability. In terms of care, only one fifth of households containing at least one person with a disability have a carer in the household.

9.6.2 Ireland's Policy Framework for Relationships and Care

Towards 2016 contains the vision statement that 'people with disabilities (will) have, to the greatest extent possible, the opportunity to live a full life with their families and as part of their local community, free from discrimination', and the high level goals that 'every person with a disability would, in conformity with their needs and abilities, have access to appropriate care' and that 'carers would be acknowledged and supported in their caring role'.

Priority actions include person-centred supports to enable people to live in a community setting, where appropriate.

9.6.3 Commentary on Relationships and Care

Throughout this report the importance of affective and supportive relationships for people's well-being is recognised. Information on the relationships of people with disabilities is limited, yet this is an important element of their well-being. This limited analysis has shown that there is scope for enriching the relationships of people with disabilities. While personal choice is a central tenet in this domain the enhancement of other aspects of the lives of people with disabilities will provide opportunities for improving their relationships, for example through education, employment, supports and access.

In section 3 of this chapter we presented information on personal outcomes for people with disabilities. Of the twenty three 'personal outcome' measures used, six relate to relationships—being connected to family, having intimate relationships, having friends, interacting with other members of the community, choosing with whom I live, and being respected—emphasising the importance of this aspect of people's lives for their overall quality of life and well-being.

The provision of care is also important for many people with disabilities, especially in relation to enabling the choice to live independently. There is an ongoing debate in respect of supports for people with disabilities with regard to independent living, especially in relation to person-centred services, self-directed services and direct payments.¹⁹⁸ While direct payments are not currently a feature of Irish social care provision they have been introduced in other European countries. The provision of care and the role of carers is an important dimension in the lives of many people with disabilities. The government has been preparing a Carers Strategy, which is currently deferred in the context of the economic crisis. However, in the longer

198. Direct payments are a form of social care whereby cash is paid to individuals with assessed care needs to enable them to employ, either directly or indirectly, individuals to assist them with their everyday tasks. Direct payments are made in lieu of the care service being provided in the more traditional service-provider based way. Direct payments operate in a number of EU countries including Britain, Sweden, Austria, Finland, Belgium, Holland and Germany.

term it will be important to consider aspects of this strategy with respect to the care needs of people with disabilities.

Data can be improved in this domain, initially through further analysis of the National Disability Survey, but also on an ongoing basis through improved administrative statistics and surveys of people with disabilities and their organisations.

9.7 Community and Environment

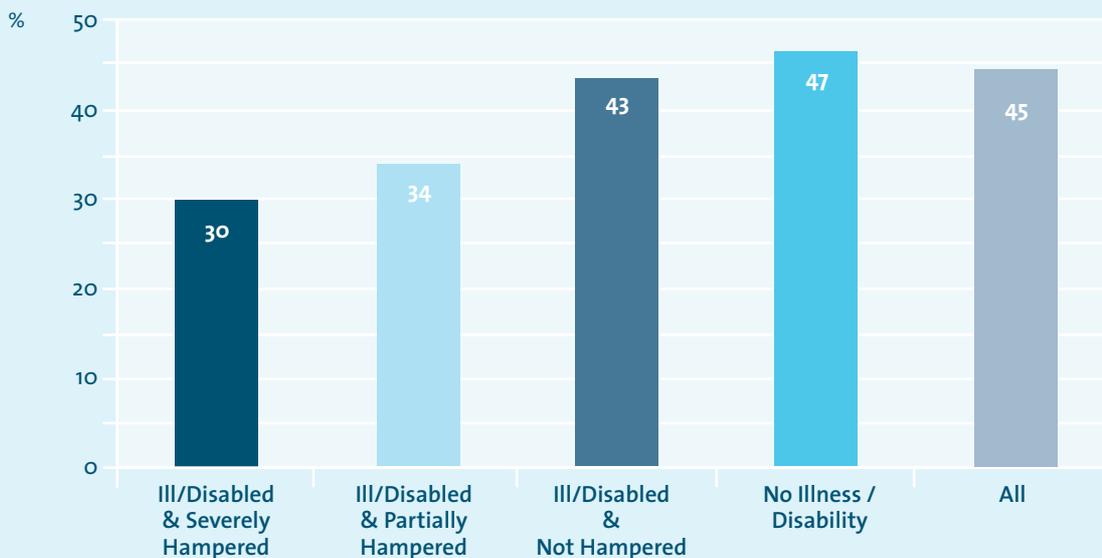
9.7.1 Measuring the Community and Environmental Well-being for People with Disabilities

The community and environment in which people with disabilities live impacts on their well-being. This section presents information on four components: community, accommodation, environment and transport.

Community Participation

The first component examined is community participation presented by an indicator on the proportion of people with a disability belonging to a club or organisation. Figure 9.28 shows that people who have a disability which severely hampers them in their daily activities are less likely to belong to a club than those who are less hampered or who are unhampered. Some 30 per cent of people with a severely hampering disability participate in a club or organisation compared to 43 per cent of those who have a disability but are unhampered. In this survey (Living in Ireland, 2001) nearly half (47 per cent) of people without a disability report belonging to a club or organisation.

Figure 9.28 People with Disabilities who Belong to a Club/Organisation, 2001



Accommodation, Environment and Transport Indicators

The second, third and fourth components on the community and environment domain relate to accommodation, the environment and transport. The UN Standard Rules, the Commission on the Status of People with Disabilities and the ICF (see Appendix F) all cite accessibility, mobility and transport as vital for the participation of people with disabilities. Despite this, the indicators and data available to measure these aspects of well-being are limited for people with disabilities. In particular, it is not possible to get a fully comprehensive assessment of accommodation requirements or to measure access to the environment or public transport accessibility/use at present. Thus, more limited indicators and information are presented to highlight the relevant issues. The next report of the National Disability Survey 2006 will provide information on many of the indicators in this domain.

Accommodation

The second component is accommodation, measured by an indicator on housing tenure. The Commission on the Status of People with Disabilities defined housing as ‘the base from which people participate in society and can reflect as well as dictate their level of participation’ (Commission on the Status of People with Disabilities, 1996). The Commission noted that the way we organise housing may restrict choices, make people dependent on family members, or even lead to a person being removed from their local community and being placed in institutional care. The indicator presented here is housing tenure, which is limited in terms of the needs of people with disabilities, but it does provide an overview of the housing situation and is supplemented with other information.

Housing Tenure

Figure 9.29 compares housing tenure for the disabled and non-disabled populations. The figure shows that owner occupation is the largest category for both people with disabilities and the non-disabled population at just under 80 per cent. People with disabilities are more likely to own their home outright, reflecting their age profile. Some 12 per cent of people with disabilities rent their home from the local authority compared to 7 per cent of non-disabled people, whereas non-disabled people are more likely to rent privately (10 per cent compared to 6 per cent).

Figure 9.29 Housing Tenure, 2006



Source: Census 2006

Housing Adaptations

A key issue for many people with disabilities is the requirement to adapt their home to meet their needs. Until November 2007 a Disabled Persons Grant was available from the local authorities for this purpose. In 2006, some 6,669 grants were paid. In their review of the operation of the Disabled Persons Grant scheme (NDA, 2006c) the National Disability Authority noted that the distribution of Disabled Persons' Grants had not been uniform across Ireland and bore little relationship to the proportion of people with physical disabilities living in each area. They found inconsistencies in eligibility criteria and payment protocols. These issues have been recognised in the Department of Environment, Heritage and Local Government's Statement on Housing Policy (*Delivering Homes: Sustaining Communities*, 2007), and a new improved scheme introduced. People with a disability can now apply to their local authority for a Housing Adaptation Grant or a Mobility Aids Grant (mainly for older people with disabilities). The same means test now applies in every local authority area. In 2007, some 10,393 houses were adapted – local authorities paid 9,588 individual grants to private householders under these schemes and carried out works of adaptation to 805 local authority rented dwellings (www.environ.ie). However, some disability groups have stated that the introduction of means testing and a reduction in the individual amounts paid may mean it will difficult for some disabled people, particularly those on low incomes who require adaptations to their homes, to avail of the grants.

Housing Need

In relation to housing need for people with disabilities, the local authority housing needs assessment undertaken in 2008 showed that 1,155 people with disabilities were in need of housing, up from 480 in 2005. The assessment also showed that 8,059 people required housing for medical or compassionate reasons, 715 people leaving institutional care needed housing, and 4,965 people were involuntarily sharing—some of these people may have disabilities. In the previous section we noted that a relatively high proportion of 30-44 year olds with disabilities were living in the parental home. The 2008 assessment of housing need shows that 5,810 people in need of housing were currently living with their parents—some of them may be people with disabilities.

As for older people, voluntary housing associations provide accommodation for people with disabilities. An Irish Council of Social Housing (ICSH) Survey (2006/7) showed that housing associations are providing more than 2,000 units for people with disabilities, with wide variation in the number of units provided in different parts of the country. Just over half of the units house people with an intellectual disability and one quarter provide for people with physical disabilities. Housing associations provide practical and functional support to tenants which facilitates them to live independently in the community. Health, personal and social supports are often as important as the housing provision. Challenges raised by respondents to the survey included: the importance of the housing needs assessment in providing a gateway to people with special needs to access social housing; funding limits for adaptations including for assistive technologies; the need to link housing provision with care dimensions, including greater coherence between providers; and greater consideration given to lifetime adaptable housing (ICSH, 2007).

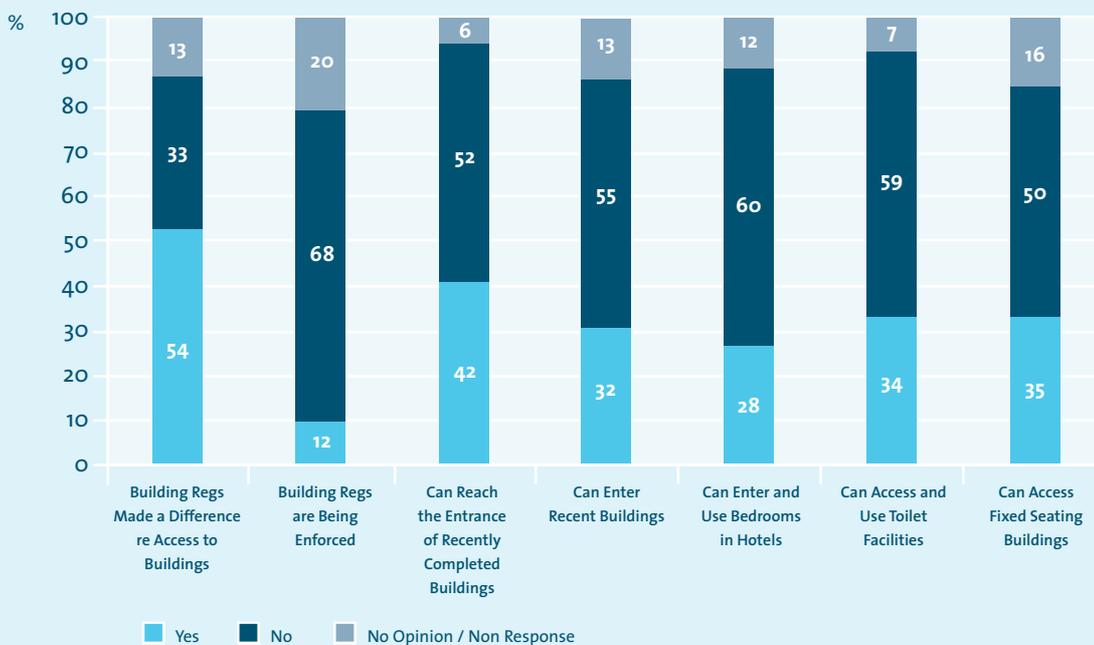
Accessibility of the Built Environment

The third component on this domain is environment and ideally an indicator would be presented on access to the built and natural environment. Local audits have shown that many environments and buildings present barriers for people with disabilities. These include undished footpaths, stepped entrances, steep ramps, inaccessible toilets, narrow doorways, lack of lifts and poor signage (NDA, 2005a: 30). The Disability Act (2005) requires local authorities and public bodies to address these issues by 2015 (through implementation of Part M of the Building Regulations).

Here, until the second set of results of the National Disability Survey 2006 is published, the interim indicator presented is compliance with Part M of the building regulations. Part M of the building regulations deals with access for people with disabilities, defined as 'people who have an impairment of hearing or sight or an impairment which limits their ability to walk, or which restricts them to a wheelchair' (NDA, 2005b: 8).

Figure 9.30 (based on a survey of 109 people with disabilities undertaken for the NDA) shows that, despite Part M of the building regulations access to, and use of, recently constructed non-residential buildings remains difficult for people with disabilities. For example, even though just over half of the respondents thought that having building regulations made a difference to the accessibility of non-residential buildings, only 12 per cent thought they were being enforced. This view is borne out by their experience where just two out of five can generally reach the main entrance of recently completed buildings (other than dwellings), the main problems being parking, gravel paths, steps, and ramps that are too steep. Only a third could generally, safely and independently, enter recently completed buildings (other than dwellings), the main problems being door type, door size/width, and the location of intercoms.

Figure 9.30 Accessibility of the Built Environment, 2004¹⁹⁹



Source: National Disability Authority, 2005b.

Given the number of new hotels built during the economic boom, it is disappointing that less than one third of respondents were generally able to access and use bedrooms in hotels and guest houses built in the last ten years. The main problems were the size and layout of the bedrooms and bathrooms. Only a third of respondents to the survey were able to access and use the toilet facilities in recently completed buildings, the main problems being the size of cubicles and the direction and location of door opening. Again, just over a third of respondents could, most of the

199. The information presented in this graph is based on a survey of people with disabilities to assess the effectiveness of Part M and whether they were able to access and use the buildings to which the regulation applied. It is not a representative survey but illustrative of the views of people with disabilities. The information was captured through a questionnaire. The results are based on the responses of 109 people with disabilities, spread throughout the country and across disability types. The questionnaire was supplemented with qualitative information. The information presented relates to recent buildings (built in the last 10 years) and to non-residential buildings.

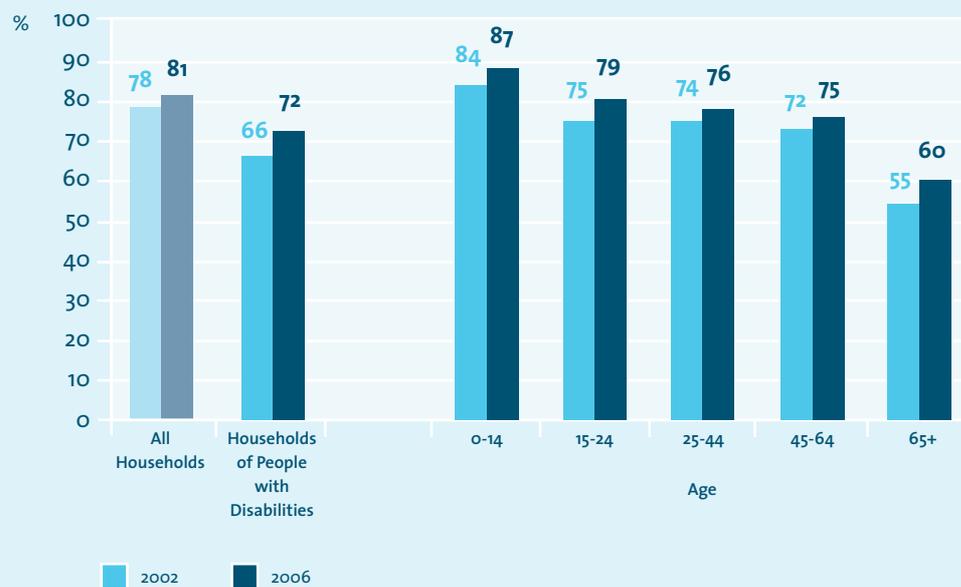
time, safely and independently access recent buildings containing fixed seating for audiences or spectators, such as theatres, cinemas, concert halls, lecture theatres and sports stadia. The main problems were insufficient spaces and the position of wheelchair spaces, as well as lack of support for blind and deaf people.

While insightful, this indicator on access to the environment is rather limited and information on this important aspect of well-being should be developed in future, for example, to include access to other built environments, access to the natural environment and landscape, as well as access issues for other types of disability (Part M relates only to hearing, sight and mobility impairments).

Transport – Access to a Car

The fourth component of the community and environment domain is transport. Again, information and indicators are limited. The indicator presented is people with disabilities living in households with at least one car, see Figure 9.31.

Figure 9.31 Percentage of People with Disabilities with Access to a Car, 2002 & 2006



Source: Census 2002 and 2006

Figure 9.31 shows that people with disabilities are less likely to live in a household with access to a car than the population generally, 72 per cent compared to 81 per cent. This gap appears to be narrowing – reducing from 12 percentage points to 9 between 2002 and 2006. Older people with disabilities are less likely to live in households with a car than disabled young people. A NDA survey (TNS-mrbi, 2004)²⁰⁰ found that just under half of adults with disabilities drive a car regularly compared to about three quarters of non-disabled people. While there are no data on the reasons the NDA suggests that the cost of a car, impairments and difficulty getting insurance may be possible reasons (NDA, 2005a: 34).²⁰¹

For those without access to a car (28 per cent of all people with disabilities aged 15 and over; 40 per cent of people with disabilities aged 65 and over) they are dependent on other household members/neighbours/friends for lifts or other forms of transport, such as public transport or taxis. While information is not available on the use of these forms of transport or their accessibility, the NDA suggests that difficulties include availability of public transport, getting to the access point and difficulties getting into the vehicle (NDA, 2005a: 35). The NDA survey (TNS-mrbi, 2004) found that, overall, nearly one quarter (23 per cent) of adults with disabilities have neither access to public transport nor regularly drive a car. This is compared to just 5 per cent non-disabled adults.

Summary

The community and environment are key elements of well-being for people with disabilities. People with disabilities are less likely to belong to an organisation and have access to a car than the general population. There is evidence of housing need among people with disabilities – both in relation to availability of housing and the need to adapt their current accommodation. Even though access to non-residential buildings has improved as a result of Part M of the building regulations many barriers continue to exist for people with disabilities in accessing and using buildings. A key issue is the limited information available in relation to this domain for people with disabilities. Some of these data shortcomings will be addressed with the publication of the second set of results from the National Disability Survey, 2006.

9.7.2 Ireland's Policy Framework for the Community and Environmental Well-being of People with Disabilities

Towards 2016 contains the long-term goal that:

Every person with a disability would have access to public spaces, buildings, transport, information, advocacy and other public services and appropriate housing.

Specific priority actions include 'evolving building standards' to improve the accessibility of the housing stock. A National Housing Strategy is to be developed as recommended in the NESC *Housing in Ireland* Report (2004), under the aegis of the Housing Forum. There is a commitment to undertake an assessment of housing

200. The research was carried out on the TNS-mrbi's omnibus survey (PhoneBus), which is a nationally representative survey of 1,000 adults aged 15 years and over. The survey was carried out in November 2004 using a quota sample (age, sex, social class, region) representative of the national population. The survey included people with disabilities, people without disabilities, and people who have a disabled person in their household. An additional 302 'booster interviews' were conducted to yield a disabled sub sample of 500.

201. The Disabled Drivers and Disabled Passengers Scheme provide a range of tax reliefs linked to the purchase and use of vehicles by disabled drivers and disabled passengers in Ireland.

needs, in line with the Disability Act, 2005. Accessible public transport services are to be addressed in the Department of Transport's Sectoral Plan.

The National Development Plan *Transforming Ireland 2007-2013* makes provision for funding for provision of accessible facilities, including access audits and implementation plans by the local authorities.

The sectoral plans of the Departments of Transport, Environment, Heritage and Local Government, and Communications, Energy and Natural Resources are relevant to participation and access for people with disabilities. These plans contain a broad range of measures. Their implementation and the monitoring of progress towards the achievement of targets will be critical to further the independence and well-being of people with disabilities.

9.7.3 Commentary on the Community and Environmental Well-being of People with Disabilities

There is a level of housing need among people with disabilities, in relation to access to appropriate housing and adaptations to their existing accommodation. Tailored housing and housing supports are required for people with disabilities, as identified in the NESC report on Housing (2004). Research published by the National Disability Authority, based on an international review, found that in most cases people with intellectual disabilities enjoy a better quality of life if they live in individual houses located throughout the community rather than in housing schemes or clusters exclusively for people with intellectual disabilities (National Disability Authority, 2009).

The built environment limits the access and independence of many people with disabilities and further work is required by local authorities and public bodies to ensure that people with disabilities are able to access and use new buildings. People with disabilities are also less likely to have access to a car and so are more likely to be reliant on public transport. However, although improvements have been made, there remain concerns about the availability and accessibility of public transport, especially in the current economic climate. People with disabilities do not participate to the same extent in clubs and organisations as others. Reasons advanced include age, level of disability, income and education levels.

Comprehensive commitments have been made to improve accessibility and mobility for people with disabilities to enable them to participate in civic, economic and social life to the fullest extent possible. Nevertheless, many shortcomings have been identified and current plans has to be fully implemented if accessibility is to be significantly improved. The Centre for Excellence in Universal Design in the National Disability Authority has an important role to play in setting standards and in supporting local authorities to improve access for people with disabilities.

To date, information to monitor the well-being of people with disabilities in relation to community participation, accommodation needs, access to the environment and transport has been limited. The results, when available, from the National Disability Survey 2006 will provide an important baseline. Supplemented by administrative statistics and specific surveys, there is the potential to greatly improve data and monitoring in respect of this aspect of the lives and well-being of people with disabilities.

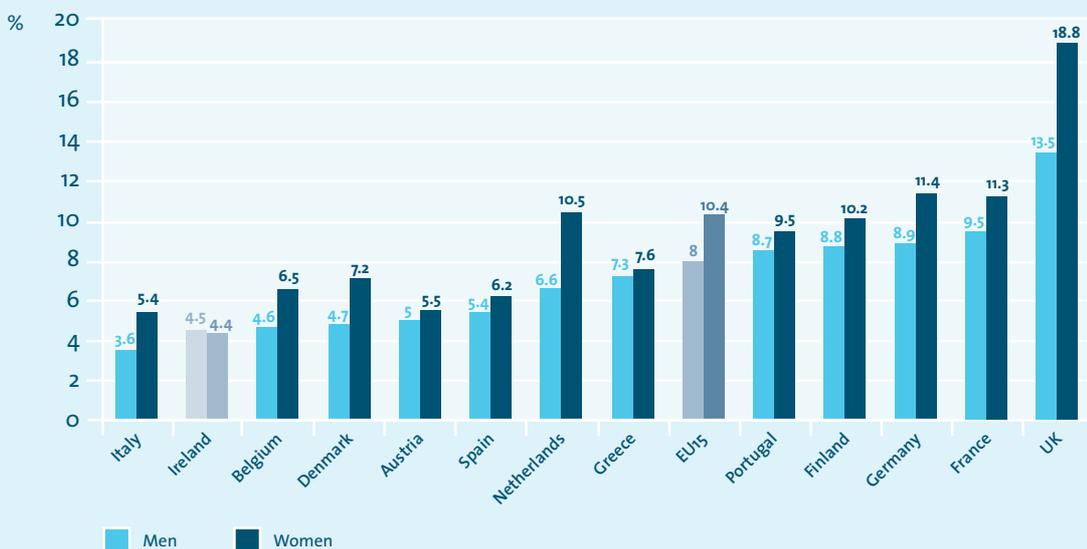
9.8 Health

9.8.1 Measuring the Health of People with Disabilities

Health Status – Hampered in Daily Activities

Good health is a fundamental element of well-being. Information is limited on the health status and behaviours of people with disabilities. It would be useful to have comparative information on life expectancy for a number of disability types, on disabled people's views of their health status, and on the impact of disability on people's mental health. In the absence of more comprehensive and disability-specific information, data are presented on three components under the health domain: health status, supports and behaviours. Two indicators are presented under health status: hampered in daily activities, and illness associated with disability. The first indicator is a comparative indicator on the percentage of the population aged 15 and over who have restrictions on everyday activities caused by a health problem. This provides an overview of the situation regarding difficulties faced in daily life and the potential need for assistance. The information is drawn from the European Community Household Panel (ECHP) 2001, and the results are presented in Figure 9.32.

Figure 9.32 Percentage Hampered in Daily Activities because of Chronic Conditions, Selected EU Countries, 2001



Source: European Community Household Panel, 2001

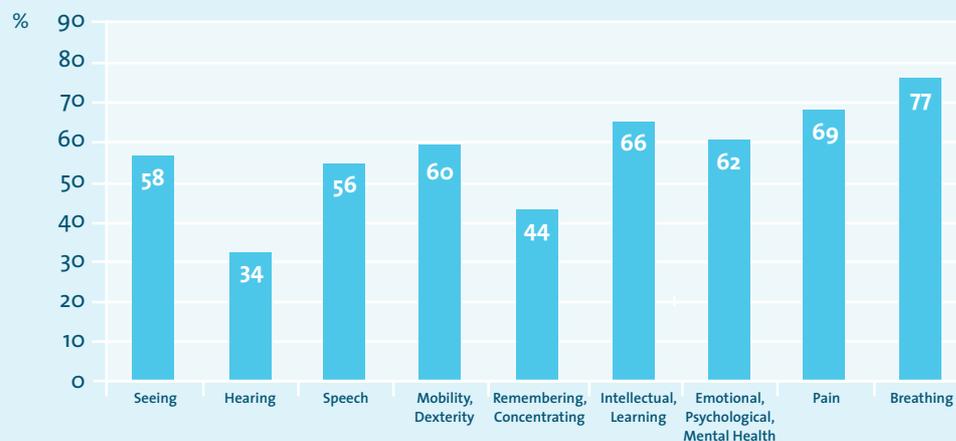
The chart shows that the percentage reporting being hampered in their daily activities is low in Ireland at 4.5 per cent for men and 4.4 per cent for women. In most countries women are slightly more likely to be hampered in their daily activities than men. This is not unexpected as women live longer than men and disability increases with age. Ireland is unusual in that the proportions are similar for both men and women. It may reflect Ireland's relatively youthful population, although the proportions for Italy are also low.

The data are now a little dated but more up-to-date comparative data are not currently available.²⁰² The EU-SILC survey of 2006 (CSO, 2007c) shows that, in Ireland, one quarter of the population aged 16 years and over has a chronic illness or health problem. The National Disability Survey 2006 (CSO, 2008d) provides more detailed information on disability types, severity of disability and causes of disability. Some of this information was presented earlier in the chapter in the context section.

Illness Associated with Disability

The second indicator presented here, illness associated with disability, also draws on these data. Figure 9.33 presents data on people with a disability reporting an illness by disability type. The graphic shows that persons reporting an illness associated with their disability range from one third of those with hearing disabilities²⁰³ to three quarters of those with breathing disabilities.²⁰⁴ For most disability types more than half report an illness which is associated with their disability, except for hearing, and remembering and concentrating²⁰⁵ (just under a half at 44 per cent). The National Disability Survey also provides information on the main illnesses associated with the disability types, for example, for breathing disabilities the main illness is asthma, for pain and mobility/dexterity disabilities it is arthritis and for emotional, psychological and mental health disabilities it is depression.

Figure 9.33 Percentage of People with a Disability Reporting an Illness by Disability Type, 2006



Source CSO, 2008d (National Disability Survey, 2006)

202. Information from the World Health Organisation Disability Assessment Schedule II (WHODAS II), the Measuring Activity and Participation (MAP), and Measuring Health and Disability in Europe (MHADIE) instruments will, in time, provide comparative data.

203. Illnesses reported for hearing disability are conductive deafness (7 per cent), sensorineural deafness (5 per cent), other (12 per cent), unspecified condition/don't know (10 per cent).

204. Illnesses reported for breathing disability are asthma (31 per cent), cardiovascular disease (16 per cent), bronchitis (7 per cent), chronic obstructive pulmonary disease (7 per cent), emphysema (4 per cent), cystic fibrosis (1 per cent), other (10 per cent), unspecified condition/don't know (1 per cent).

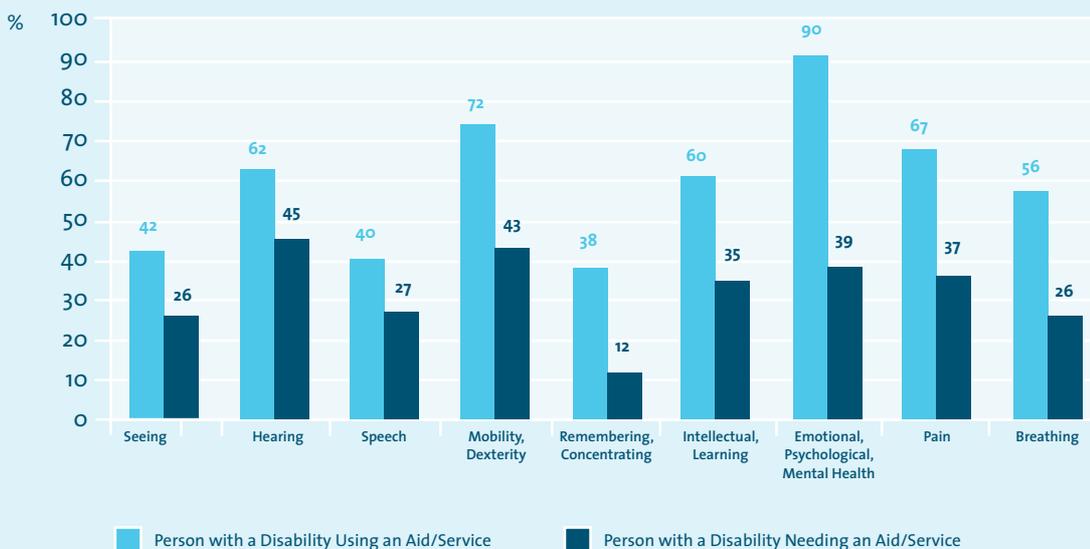
205. Illnesses reported for remembering and concentrating disability are alzheimer's disease or dementia (9 per cent), stroke or hemiplegia (5 per cent), epilepsy (4 per cent), traumatic or acquired brain injury (2 per cent), other (21 per cent), unspecified condition/don't know (3 per cent).

Use of Aids/Services

The second component of the health domain captures aids and services for people with disabilities. The National Disability Survey (2006) records aids/services used by people with a disability, and aids/services that they say they need, for each disability type, see Figure 9.34. The use of aids, and whether or not additional aids are required, is based on self assessment. The figure shows that, on average, about half of people with disabilities use some kind of aid, ranging from less than two in five for people with remembering and concentrating disabilities to 90 per cent of those with emotional, psychological and mental health disabilities. The National Disability Survey provides information on the types of aids and services used, for example, for people with emotional, psychological and mental health disabilities three quarters used medical services, such as a GP or community nurse and 70 per cent used medication. For people with mobility and dexterity disabilities nearly half used walking aids and a third used grab bars.

The figure also shows that about one third of people with disabilities reported that they needed an aid or service, varying from 12 per cent of those with remembering and concentrating disabilities to more than 40 per cent of those with hearing disabilities (45 per cent) and mobility/dexterity disabilities (43 per cent). The types of aids/services needed were hearing aids, phone related devices and visual or vibrating alarms for people with hearing disabilities; and grab bars, physiotherapy, lifts and stair lifts, and occupational therapy for people with mobility and dexterity disabilities.

Figure 9.34 Percentage of Persons with a Disability Using an Aid/Service and Percentage Saying They Needed an Aid/Service, 2006²⁰⁶



Source CSO, 2008d (National Disability Survey, 2006).

206. Based on self assessment. The graph shows, for example, that of persons with a seeing disability 42 per cent use at least one aid/service and 26 per cent say they needed an aid/service that they did not have. People having or using aids/services could say they needed another aid/service.

The National Physical and Sensory Disability Database (NPSDD), compiled by the HRB, also contains information on the service needs of people with a physical/sensory disability.²⁰⁷ The latest report (Doyle *et al.*, 2009) analyses just over 27,000 cases on the database (In December 2008 there were just under 30,000 people registered on the database, but the analysis does not include people aged 66 and over (2,600), who are the responsibility of Older People's Services, rather than Disability Services). Participation in the NPSDD is voluntary and therefore does not include a proportion of people who have a physical or sensory disability who have opted not to be included in the database. The information on service use and service need is indicative rather than fully comprehensive.

Information from the database indicates that 83 per cent of those (aged under 66) on the database were in receipt of therapeutic intervention and rehabilitation services, nearly two thirds were using at least one technical aid or appliance and just over half were in receipt of day services and activities. Some 10 per cent were availing of planned respite services and only 3 per cent were availing of residential services. In terms of service needs half of those (aged under 66) on the database (13,848 people) required assessment for therapeutic intervention and rehabilitation services, one third (9,413) requested at least one technical aid or appliance and one quarter (6,587) required assessment for personal assistance and support services. Some 4,242 people required assessment for respite services, 3,244 people required day services or activities, 3,804 people required an alternative or additional service to their existing services, and 730 people required residential services. There were waiting lists for most of these services for people who had been assessed.

The National Intellectual Disability Database²⁰⁸ provides information on service provision and requirements for people with intellectual disabilities. It is a comprehensive and accurate database. In December 2008 there were 26,023 people registered on the database, representing a prevalence rate of 6.14 per 1,000 population.²⁰⁹ Analysis of the information (Kelly *et al.*, 2009) reports that 98 per cent of the people registered on the database are in receipt of services (25,433 people); 1 per cent are not availing of services and do not require services (301 people); and 1 per cent (289 people) are without services but require them. Trends show that more people now live in group homes within their communities than in residential services. The number of people with an intellectual disability (inappropriately) accommodated in psychiatric hospitals was 308 in December 2008. Some 64 per cent of those registered (16,708 individuals) live at home with parents, siblings, relatives or foster parents. Issues for the future include requirements for more full-time residential places as people with intellectual disabilities are living longer (often outliving their carers), more residential support services and more day programmes. 188 people living in psychiatric hospitals require transfer to more appropriate locations. It has also been identified that 11,823 people receiving services require alternative, additional or enhanced services.

207. The objective of the National Physical and Sensory Disability Database is to provide an overview of the specialised health and personal social service needs of people with a physical, sensory and/or speech and language disability. The latest report (Doyle, *et al.*, 2009) is based on monitoring current service provision and future service requirements over a five year period.

208. The National Intellectual Disability Database is a register of people with an intellectual disability. Detailed trends in demand for services for children aged 0-5 and for those aged 50 years and over using data from the database is available in separate publications.

209. The administrative prevalence rate for mild intellectual disability was 2.02 per 1,000 and the prevalence rate for moderate, severe and profound intellectual disability was 3.61 per 1,000.

All of this information, from the various information sources, provides an overview of the level of services, aids and supports used by people with disabilities and the level of need for services and supports. While this varies considerably by disability type, severity and other factors, it is clear that there is a significant level of need for services and supports for people with disabilities which would contribute to their overall quality of life and well-being.

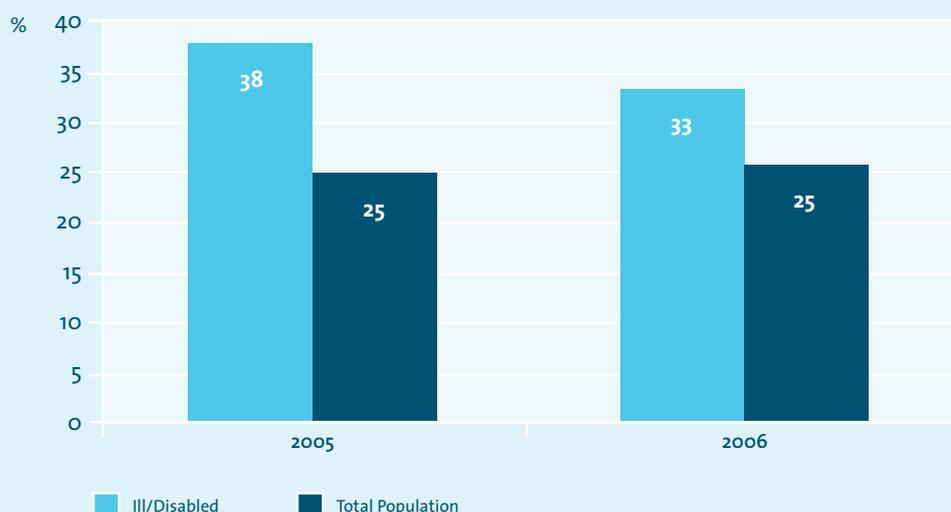
Health Behaviours

The third component on the health domain is behaviours. As information on the behaviours of people with disabilities is limited only two indicators are presented here: the proportion of people with disabilities who smoke (risk behaviour); and the proportion of people with disabilities who have participated in physical exercise in the last 12 months (healthy behaviour). As noted throughout this report people's behaviours are influenced by their economic and social circumstances, peer behaviours and cultural factors.

Risk Behaviour - Smoking

Figure 9.35 presents information on the proportion of people who are ill or disabled and who smoke. Using data from the EU-SILC survey (2006), 33 per cent of a sub group of people with disabilities (those whose principal economic status is 'ill/disabled')²¹⁰ smoke compared to one quarter of the population. While this gap appears to be reducing there is still a substantial proportion of this group of disabled people who smoke. An NDA survey (TNS-mrbi, 2004) found little difference in smoking habits between disabled and non-disabled respondents, with 25 per cent of adults with disabilities stating that they smoked compared to 23 per cent of non-disabled respondents. Smoking can contribute to illness and disability.

Figure 9.35 Proportion of People who are Ill or Disabled and who Smoke, 2006



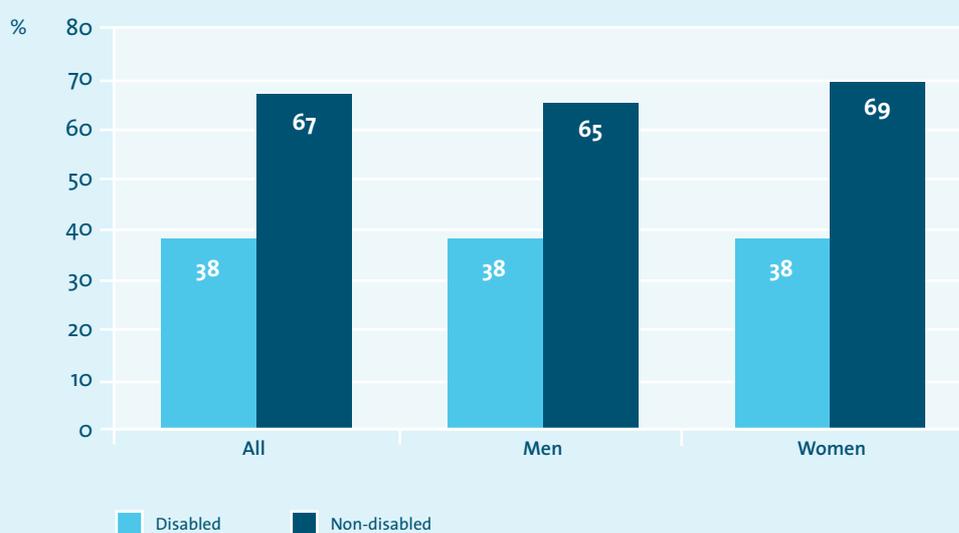
Source CSO, 2007c (EU-SILC, 2006)

210. This does not include disabled people who may be working, or who may be classified as retired, in home duties, studying or in the 'other' category.

Healthy Behaviour – Physical Activity

The second indicator on this component is physical exercise. Figure 9.36 shows that 38 per cent of people with disabilities (all people with a disability or long-standing health problem) take part in physical exercise, compared to 67 per cent of the non disabled population.^{211, 212} There is little variation by gender. The main reasons given by people with disabilities for non participation are their disability and age. For those people with disabilities who do participate their main motivation is improving their health (CSO, 2007k).

Figure 9.36 Proportion of People with Disabilities Participating in Physical Activities, 2006



Source CSO, 2007k (QNHS Q3, 2006 Sport and Physical Exercise).

Summary

Health is a fundamental element of well-being. Using an EU measure, the proportion of the Irish population aged 15 and over who are hampered in their daily living activities is comparatively low at less than 5 per cent. Using more up-to-date Irish data, one quarter of the population aged 16 and over has a chronic illness or health problem. For most disability types, more than half of people with a disability report an illness associated with their disability, from one third of those with a hearing disability to three quarters of those with a breathing disability.

In relation to supports for people with disabilities, about half of people with disabilities use some kind of aid or service, ranging from two in five for people with remembering and concentrating disabilities to 90 per cent of those with emotional, psychological and mental health disabilities. About one third of people reported that

211. Disability here is defined as a disability or long standing (6 months) health problem, including: blindness, deafness or a severe vision or hearing impairment; a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting or carrying; a learning or intellectual disability, a psychological or emotional condition; other, including chronic illness.

212. The NDA (TNS-mrbi, 2004) survey also asked respondents about engaging in physical exercise one or more times per week and found that 62 per cent of people with disabilities were likely to take part in exercise to this level compared to 84 per cent of the non-disabled population.

they needed an aid or service, varying from 12 per cent of those with remembering and concentrating disabilities to more than 40 per cent of those with hearing and mobility/dexterity disabilities. The National Intellectual Disability Database and the National Physical and Sensory Disability Database provide detailed information on the service needs of people with a disability. All of this information indicates that there is a substantial need for additional services, supports and aids.

With regard to risky and healthy behaviours one third of people classified as ill or disabled smoke (not including people with disabilities who are working or are classified as retired, in home duties, studying), which is higher than the total population. Smoking can contribute to poor health and disability. Just over one-third of people with disabilities (all those with a disability or long-standing health problem) participate in physical activities (compared to two-thirds of the total population). The main reasons for not participating in physical activity are due to their disability and their age. It would be useful to have more comprehensive data on people with disabilities' perceptions of their health, on their healthy and risk behaviours, and on the impact of their disability on their mental health.

9.8.2 Ireland's Policy Framework for the Health of People with Disabilities

Ireland's policy approach to the health needs of people with disabilities in *Towards 2016* spells out long-term goals for:

Every person with a disability would, in conformity with their needs and abilities, have access to appropriate ... health ... and social services.

Specific priority actions towards meeting this objective include:

- ◆ Assessment for, and access to, appropriate health ... services including residential care, community-based care and mental health services. This will include 'person-centred' supports for long-stay residents in psychiatric hospitals and for 'adults with significant disabilities, having regard to the range of support needs which they require, eg. nursing, personal assistance, respite, rehabilitation, day activities etc'.
- ◆ Establishing on a statutory basis the Social Services Inspectorate (SSI), as part of the Health Information and Quality Authority (HIQA).
- ◆ National Standards are to be introduced in respect of specialist health services for people with disabilities.

There is a focus on supporting people in the community, where possible.

Progress has been made on a number of these commitments through the sectoral plan of the Department of Health and Children, which has been reviewed (see Department of Health and Children, 2007). On this basis a number of new targets have been set and some targets revised. The emphasis in this plan is in putting in place the procedures and structures to implement the priority actions. The use of the money in the Multi-Annual Investment Programme and the role of the HSE are critical in ensuring delivery on the major commitments. The Health Information and Quality Authority (HIQA) was formally established in May 2007, with the Office of the Chief Inspector of Social Services established within HIQA. HIQA has an important role in relation to the setting and monitoring of standards.

Towards 2016 does not make specific reference to behaviours and lifestyle issues for people with disabilities. However, general health promotion policies also apply to people with disabilities and they need to take the particular situation of people with disabilities into account. Likewise, in line with a mainstreaming approach, the recommendations of the Expert Group on Mental Health Policy, published in *A Vision for Change*, need to take into account people with disabilities.

The Special Olympics movement promotes physical exercise to enhance the well-being of people with intellectual disabilities, and Ireland's hosting of the world event in 2003 helped to raise the profile of the capabilities and needs of athletes with disabilities. Special Olympics is complemented by specific sporting competitions for people with physical and sensory disabilities. However, these are competitive events and more needs to be done to promote healthy lifestyles with and for people with disabilities in general.

9.8.3 Commentary on the Health and Well-being of People with Disabilities

The policy framework for health and social supports for people with disabilities is comprehensive and ambitious. However, as shown in the analysis, many needs remain to be met. The challenge is to meet these needs, both in terms of quantity and quality, especially in the context of limited resources. The implementation of a 'person-centred' tailored approach and the setting and monitoring of standards are important dimensions of these commitments.

The HRB databases on intellectual and physical and sensory disability are the main sources of information on the service usage and service needs of people with a disability, along with the results of the National Disability Survey. However, information on the health status, health behaviours and health needs of people with disabilities is limited. The requirement for comprehensive and up-to-date information is important in encouraging and supporting people with disabilities into mainstream services. The development and use of MAP, WHODAS II and MHADIE (mentioned earlier)²¹³ will be useful in this regard. In addition, health promotion documents should recognise the requirements of people with disabilities.

9.9 Democracy and Values

9.9.1 Measuring Democracy and Values for People with Disabilities

In the democracy and values domain we are concerned with people's ability to participate in the democracy, to be safe, and to be treated fairly and respected. These issues are important for people's well-being. In this section there are three components: exercising democracy, threats and equality. Under the exercising democracy component two indicators are presented: the proportion of people with disabilities saying they would vote, and access to ICT.

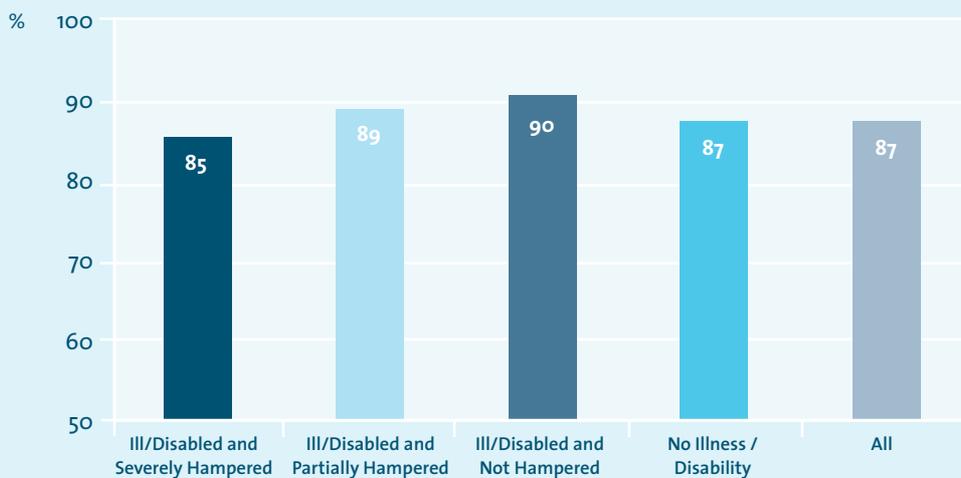
213. MAP is Measuring Activity and Participation; WHODAS II is World Health Organisation Disability Assessment Schedule II; and MHADIE is Measuring Health and Disability in Europe.

Voting Intention

Figure 9.37 shows that people with disabilities, whether hampered or not, have a high level of voting intention. Some 90 per cent of those who are disabled but who are not hampered by their impairment stated their intention to vote, higher than the non-disabled population. People who are severely hampered by their impairments also have high voting intentions at 85 per cent (Gannon and Nolan, 2005). It is relevant that, as we saw earlier, the profile of people with disabilities is older than the profile of the population generally and that older people have a higher propensity to vote than younger people (see Chapter 8).

It should be noted that voting eligibility and/or intention does not always translate into voting action. Some 76 per cent of those eligible to vote in the May 2002 general election stated that they had voted (CSO, QNHS, 2002). The voting practices of people with disabilities were not specifically identified but of the respondents to the survey who said they had not voted 6.8 per cent gave illness or disability as the reason (see also Chapter 8).

Figure 9.37 People with Disabilities who Said They Would Vote in a General Election, 2001



Source: Gannon and Nolan, 2005: Table 6.6 (Living in Ireland Survey, 2001)

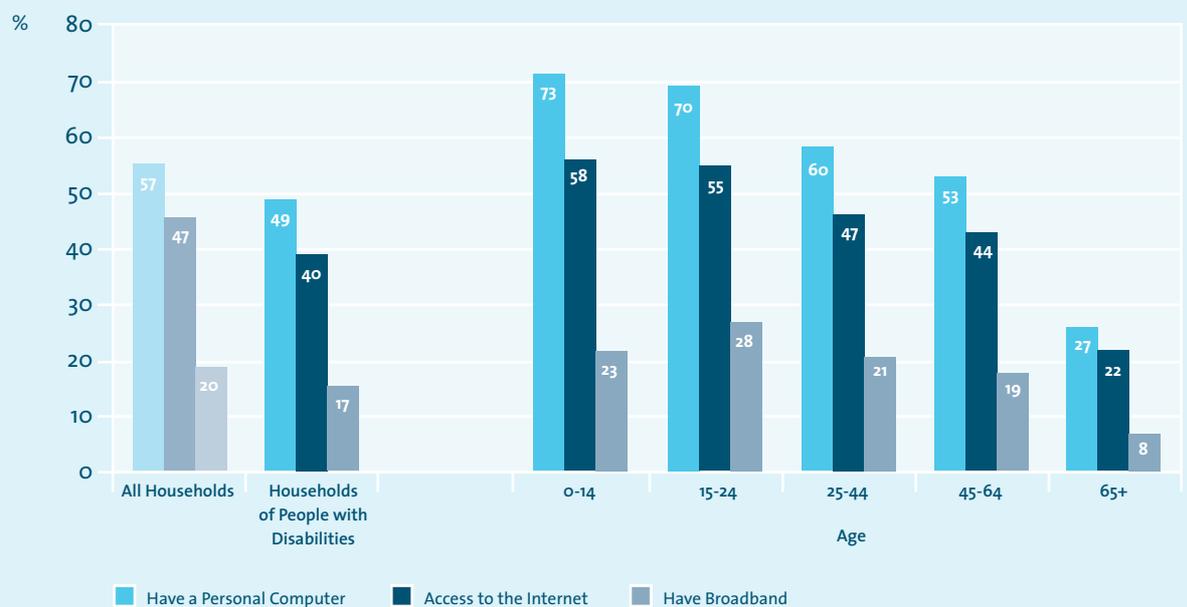
Access to ICT

The second indicator in the exercising democracy component of the democracy and values domain is access to ICT. This indicator comprises having access to a personal computer, the internet and broadband. In today's world access to computers and the internet are an increasingly important participation and inclusion route, especially for people who may have restricted mobility or limited access to facilities and activities outside their home/accommodation. Access to a computer and access to the internet provide opportunities for accessing information, shopping, banking, social interaction and even dating. Computers and the internet can also provide a

platform for assistive technology, which can improve the lives and well-being of many people with disabilities.

Figure 9.38 shows that people with disabilities tend to live in households where computer ownership and internet access is lower than in households in the population generally. There is less variation in relation to Broadband, except for older people with disabilities. This probably reflects the availability of Broadband. Differentiation by age is also apparent for computer availability and internet access, with younger people with disabilities much more likely to be in households with a computer and to have access to the internet than older disabled people.

Figure 9.38 Percentage of Disabled People having a Personal Computer, Access to the Internet, and Broadband, 2006



Source: Census 2006

Threats

The second component of the democracy and values domain is threats. Unfortunately, no indicator is currently available to measure the extent to which people with disabilities are victims of crime, their perception of crime or the extent to which they have experienced domestic or institutional violence or abuse. In section 3 of this chapter we presented information on personal outcomes for people with disabilities. A number of the personal outcome measures relate to safety: 'I am free from abuse and neglect' and 'I am safe'. It is encouraging that these were among the outcomes most often present, but the fact that they are not mentioned as personal outcomes in all cases gives cause for concern. Recently, the Chief Executive of Inclusion Ireland (Irish Times, 10th June 2009) raised issues about the abuse of people with disabilities in institutional care. She referred specifically to the Ryan Report on Institutional Abuse which highlighted the fact that children

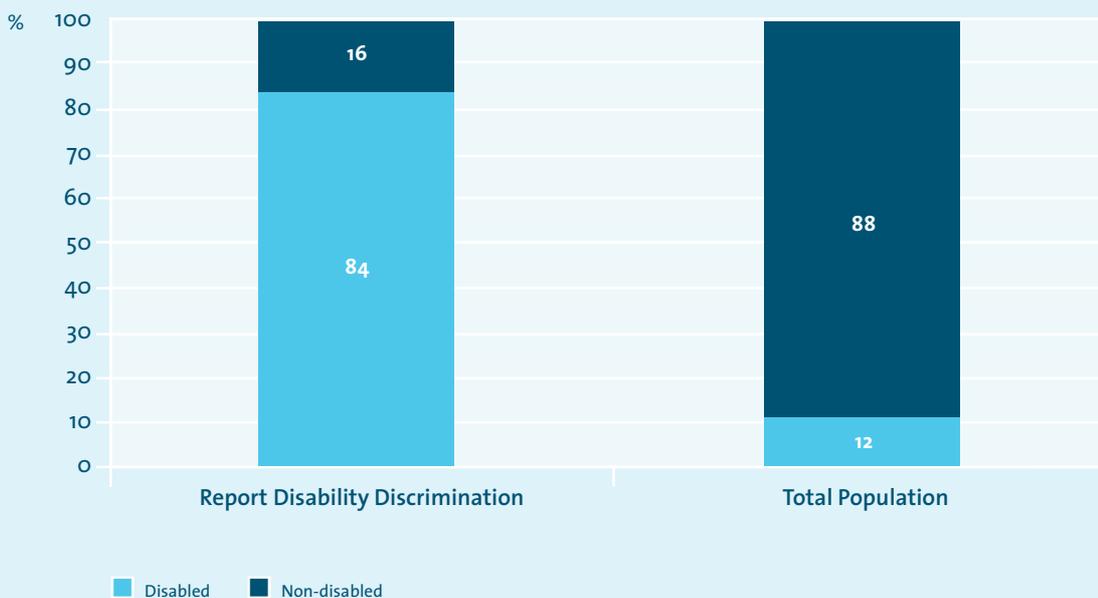
with intellectual disabilities and sensory impairments were especially vulnerable and most at risk. A key issue is the setting and monitoring of standards for disabled children and adults in residential services, along with the available resources to ensure their implementation.

The National Disability Authority has addressed the subject of violence against people with disabilities, hosting a conference in November 2004. Issues discussed at the conference included: a level of cultural and social tolerance of violence against people with disabilities, the vulnerability of many people with disabilities, the power relationships at play in dependent relationships, the fear of the consequences of disclosure, and institutional violence. The lack of research in this field was raised, as was the need to take into account the diversity of people with disabilities, including their gender, ethnicity and sexual orientation. The National Disability Authority is currently undertaking a study into the abuse of people with disabilities.

Discrimination

The third component on the democracy and values domain is equality. Two indicators are presented: discrimination against people with a disability and attitudes to people with disabilities. As stated earlier discrimination undermines equality in society and weakens social solidarity. Figure 9.39 shows that, unsurprisingly, disabled respondents are more likely to report discrimination on the grounds of disability: 84 per cent of those reporting discrimination on the grounds of disability were disabled. This compares to just under 12 per cent of the total population who report having a disability.

Figure 9.39 Disability Status of Those Reporting Discrimination on the Grounds of Disability and of the Total Population, 2004



Source Russell *et al.*, 2008:37 (based on analysis of CSO QNHS 2004 Equality Module).

In relation to work-related discrimination and discrimination in accessing services Russell *et al.* (2008: 79) found that disability was one of the strongest predictors of discrimination risk. For instance, people with disabilities were significantly more likely to perceive discrimination in all but one of the nine work and service domains²¹⁴ than those without a disability (education was the exception). Disability had the strongest effect in relation to accessing health services and using transport services, where people with disabilities were over five times more likely to perceive problems of discrimination. In using shops/pubs/restaurants and financial services, and in obtaining housing and accessing public services other than education, health and housing people with disabilities were more than twice as likely to perceive discrimination as non-disabled people. Disability also had a strong effect on work-related discrimination with people with disabilities 2.8 times more likely to perceive discrimination than others.

For people with disabilities discrimination was not limited to one-off incidences but was more a regular part of their lives than for most other groups. For those people with disabilities who had experienced discrimination just over one third said it had a serious impact on their lives. Discrimination can seriously undermine well-being. The study also found that a significant deficit in knowledge of their rights exists with just under one third of disabled respondents having no knowledge of their rights under the law.

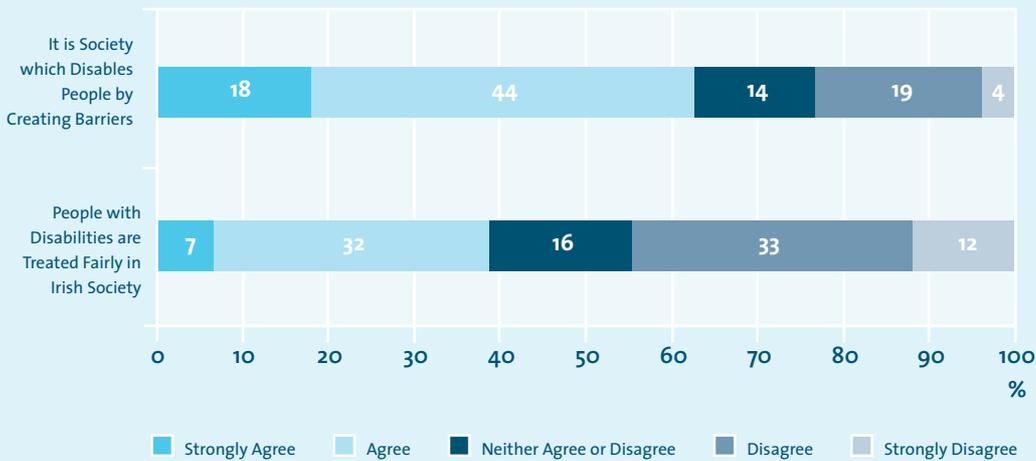
Attitudes to People with Disabilities

The second indicator in the equality component of the democracy and values domain is attitudes to disability. The information presented is based on a public attitudes survey undertaken by the National Disability Authority in 2006 (National Disability Authority, 2007c). Figure 9.40 shows 45 per cent of respondents to the survey disagreed or strongly disagreed with the statement that people with disabilities are treated fairly in Irish society. 39 per cent agreed or strongly agreed with it. Respondents that knew someone with a disability were more likely to disagree with the statement, but there was no significant difference between people with and without a disability.

When asked if it is society which disables people by creating barriers nearly two thirds of respondents to the survey (62 per cent) agreed or strongly agreed with this statement, see Figure 9.40. Respondents that had a disability or knew someone with a disability were more likely to agree with this statement. Disability groups in the community and voluntary sector play an important democratic and advocacy role in creating awareness and raising issues around disability.

214. The nine work and service domains are: while looking for work; using transport services; in shops, pubs or restaurants; using services of banks and insurance; in relation to education; accessing health services; obtaining housing or accommodation; in the workplace; accessing other public services.

Figure 9.40 Attitudes to People with Disabilities, 2006



Source: National Disability Authority, 2007c

Summary

A high proportion of people with disabilities intend to exercise their right to vote. In relation to access to information and communications technology half of households with someone with a disability have a computer and 40 per cent have access to the internet, which is below the level of access for the population generally. Younger people with disabilities have greater access to ICT than older people with disabilities. In today's world, access to ICT plays an important role in providing access to information, services, and social interaction, as well as in providing a platform for assistive technology.

With regard to threats, information is not available on the extent to which people with disabilities are victims of crime, their perception of crime or the extent to which they have experienced domestic or institutional violence or abuse. Disability organisations have raised issues in relation to the abuse of people with disabilities and the need to set and monitor standards for people with disabilities.

Disability is one of the strongest determinants of discrimination risk, as people with disabilities perceive discrimination in relation to accessing a number of services and in work situations. For a third of those experiencing discrimination it has had a serious impact on their lives. Just under half (45 per cent) of respondents in a public attitudes survey thought that people with disabilities were not treated fairly in Irish society, and nearly two thirds thought that society disables people by creating barriers. Disability groups play an important role in raising issues relating to disability.

9.9.2 Ireland's Policy Framework for Democracy and Values

Towards 2016 contains the vision that:

People with disabilities have, to the greatest extent possible, the opportunity to live a full life ... free from discrimination.

And the long-term goals that:

Every person with a disability would have access to ... information, advocacy and other public services ... and that Every person with a disability would be supported to enable them, as far as possible, to lead full and independent lives, to participate in ... society and to maximise their potential.

Priority actions include the establishment of the Social Services Inspectorate (SSI) as part of HIQA and that national standards will be introduced, as discussed in section 9.8 of this chapter. There is also a commitment to the development of information and advocacy services for people with disabilities. Under the Citizens Information Act 2007, the Citizens Information Board has a mandate to provide advocacy for people with disabilities.

The sectoral plans of the Departments of Social and Family Affairs, Health and Children and Communications, Energy and Natural Resources are relevant to the participation and safety of people with disabilities. These plans contain a broad range of measures: their implementation, and the monitoring of progress towards the achievement of targets, will be critical.

9.9.3 Commentary on Democracy and Values for People with Disabilities

The ability to participate in the democracy, to have access to good information, to be safe, to be respected, to be treated with dignity and fairly, and to have your rights upheld makes an important contribution to well-being. In this context, the commitments to a personal advocacy service and to the implementation of standards in communal establishments is welcome. Yet, people with disabilities do not participate in society to the same extent as others on a number of indicators. Access to ICT is an important mechanism to facilitate participation, along with ensuring existing barriers are removed, and that people with disabilities are not discriminated against. The current disability legislation provides for redress but only a minority of people with disabilities are aware of it. As shown in section 9.9.1 people with disabilities experience and perceive discrimination in accessing work and services. In addressing these issues there is a need to recognise the diversity of people with disabilities, and the possibility of double disadvantage, in relation to disability and other equality grounds, such as gender, age, ethnicity and culture, and sexual orientation.

A key concern has been identified in relation to the safety of people with disabilities, especially those who are most vulnerable. Data are limited in this area but from what information does exist diverse needs and vulnerabilities have been identified. The need to ensure that people with disabilities are free from maltreatment, abuse and neglect needs to be a priority, despite the economic crisis and resource constraints. Finally, information on this domain is limited and incomplete, and attention could be given to the collection and analysis of information on the safety, in particular, of people with disabilities. The dearth of information in this area supports the case for a national information strategy for people with disabilities.

9.10 Conclusion

This chapter has provided an overview of the well-being of people with disabilities in Ireland across six aspects of their lives: economic resources, work and participation, relationships and care, community and environment, health, and democracy and values. As stated at the outset, people with disabilities are a distinct population group who transcend the life cycle of children with disabilities, people of working age with disabilities and older people with disabilities. Within the life cycle framework, and in this report, people with disabilities are considered specifically and separately in line with a mainstreaming approach, where people with disabilities should benefit from measures across all stages of the life cycle.

Demographically, people with disabilities make up just under ten per cent (8 per cent) of the population (325,800 people). Disability is highly correlated with age with just over a third of people with disabilities aged 65 and over. Mobility/dexterity and pain are the most frequently reported disability types. There is some variation in disability type by age. For example, persons reporting an intellectual and learning disability were mainly in the younger age groups, as were people with speech disabilities. Over two thirds of those experiencing emotional, psychological and mental health disabilities were aged between 18 and 64, while the most frequently reported disability for older age groups was mobility and dexterity. Ireland's expenditure on disability benefits has increased substantially in recent years. Overall, government spending on disability specific services in 2008, as reported by Government Departments was some €6.5 billion. Information is not available on people with disabilities' satisfaction with life. However, using an illustrative 'personal outcomes measure', based on a sample of 300 people with disabilities who regularly used a disability service, on average, just under than half of the desired outcomes were present.

With regard to **economic resources** people with disabilities have incomes about 70 per cent of the level of people without a disability. People with disabilities tend to be concentrated in the lower income deciles and in the lower social class groups. They often have extra costs associated with their disabilities. As a result of all of these factors the risk of both income poverty and consistent poverty for people with disabilities is high—about twice the rate for the general population. They also experience much higher levels of deprivation than the population generally. Currently, many people with disabilities rely on social welfare benefits for their income. These benefits do not take into account the extra costs associated with having a disability, although there are grants and schemes available to assist with some of these costs. A recent OECD review has pointed to the fragmentation of the benefit system for people with disabilities and the limited consideration given to work capacity. The OECD suggests that more adequate payments should be introduced to mitigate the additional costs associated with disability, and to reduce poverty among people with disabilities. The government has set out a number of proposed reforms in this area and recently introduced some changes.

Having a sense of purpose through **work and participation** contributes to well-being. The participation of people with disabilities in the labour force is much lower than that of the non-disabled population. Three quarters of people with disabilities are not in the labour force: one third of these are categorised as ill or disabled, one third

are retired and the remaining one third are looking after the family or home or are in education. Employment rates for people with disabilities are low at 32 to 37 per cent of the working population in Ireland (depending on the definition used), which is one of the lowest rates in the OECD. Just over half of public sector organisations meet the 3 per cent quota of employing people with a disability. Organisations with proactive measures such as disability policies or access audits are more likely to meet or exceed the target. However, achieving the target is likely to become more difficult in the current economic climate, with restricted public sector recruitment. There are particular employment difficulties for people with mental ill health, whose numbers have been increasing, and for people with intellectual disabilities who are least likely to participate in the labour market. People with disabilities also have poorer educational outcomes than the population in general, despite their increasing integration into the mainstream education system. In many cases supports are required to improve their educational experiences and outcomes.

The OECD has identified key challenges for Ireland in relation to the low rate of employment for people with a disability and the lack of coordination between the various policy institutions. They describe the Irish system as ‘still quite traditional, passive and reactive’ citing the lack of systematic engagement with people with disabilities, and the fragmented and complex system of employment supports. These issues are echoed by a number of Irish studies on disability and employment schemes and supports. The government has set out commitments for change but structural barriers remain. The main challenge in the recession will be to retain a focus on the development of a tailored case management approach for people with disabilities to enable them to realise their potential to the greatest extent possible, with the associated longer term benefits for themselves and society. Likewise, in relation to education it would seem unwise to withdraw supports for children with disabilities and undo the progress made to date on improving educational outcomes for children with disabilities, which still remain below the mainstream average.

Relationships and care are important for well-being. The available information shows that the quality of relationships for many people with disabilities still falls some way below the population in general. People with disabilities are less likely to be independent, and thus more likely to be living in the parental home in middle age, more likely to be living in communal establishments, more likely to be single or separated/divorced in middle age, and less likely to socialise than people without a disability. In terms of care, only one fifth of households containing at least one person with a disability has a carer in the household. While personal choice is a central tenet of this domain the enhancement of other aspects of the lives of people with disabilities will provide opportunities for improving their relationships, for example through education, employment, supports and access. Further consideration is required in relation to the care needs of people with disabilities, especially in enabling the choice to live independently.

The ***community and environment*** are key elements of well-being for people with disabilities. People with disabilities are less likely to belong to an organisation and have access to a car than the general population. There is evidence of housing need for people with disabilities—both in relation to availability of housing and the need to adapt their current accommodation. Even though access to non-residential

buildings has improved as a result of Part M of the building regulations many barriers continue to exist for people with disabilities in accessing and using buildings. Comprehensive commitments have been made to improve accessibility and mobility for people with disabilities to enable them to participate in civic, economic and social life to the fullest extent possible. Nevertheless, many shortcomings have been identified and current plans will have to be fully implemented if accessibility is to be significantly improved.

Health is a fundamental element of well-being. More than half of people with a disability report an illness associated with their disability, from one third of those with a hearing disability to three quarters of those with a breathing disability. In relation to supports, about half of people with disabilities use some kind of aid or service, ranging from two in five of people with remembering and concentrating disabilities to 90 per cent of those with emotional, psychological and mental health disabilities. About one third of people reported that they needed an aid or service, varying from 12 per cent of those with remembering and concentrating disabilities to more than 40 per cent of those with hearing and mobility/dexterity disabilities. With regard to risk and healthy behaviours one third of people classified as ill or disabled smoke (not including people with disabilities who are working or are classified as retired, in home duties, studying), which is higher than the total population. Smoking can contribute to poor health and disability. Just over one third of people with disabilities (all those with a disability or long-standing health problem) participate in physical activities (compared to two thirds of the total population).

Despite the policy framework for health and social supports for people with disabilities being comprehensive and ambitious many needs remain to be met. The challenge is to meet these needs, both in terms of quantity and quality, especially in the context of limited resources. The implementation of a 'person-centred' tailored approach and the setting and monitoring of standards are important dimensions of these commitments.

In relation to **democracy and values** a high proportion of people with disabilities intend to exercise their right to vote. With regard to access to ICT, half of households with someone with a disability have a computer and 40 per cent have access to the internet, which is below the level of access for the population generally. In today's world, access to ICT plays an important role in providing access to information, services, and social interaction, as well as providing a platform for assistive technology.

In terms of the contravention of rights, disability is one of the strongest determinants of discrimination risk, as people with disabilities perceive discrimination in relation to accessing a number of services, and in work situations. Just under half (45 per cent) of respondents in a public attitudes survey thought that people with disabilities were not treated fairly in Irish society, and nearly two thirds thought that society disables people by creating barriers. Disability groups play an important role in raising issues relating to disability.

Unfortunately, information is not available on the extent to which people with disabilities are the victims of crime, their perception of crime or the extent to which they have experienced domestic or institutional violence or abuse. The need

to ensure that people with disabilities are free from maltreatment, abuse and neglect needs to be a priority, despite the economic crisis and resource constraints. The commitments to a personal advocacy service and to the implementation of standards in communal establishments, though overdue, are welcome.

A key point to note throughout this analysis is the diversity of people with a disability – in terms of their age, gender, socio-economic status, race/ethnicity, religion, family status, living arrangements, marital status, sexual orientation, and the nature and severity of their disability. Thus, in terms of policy responses there is a knowledge requirement as to their needs, which is attuned to this diversity and complexity. This knowledge calls for a tailored, flexible, person-centred approach, where the person's views are taken into consideration, in line with the approach proposed in the developmental welfare state.

The delivery of such an approach requires good data, at both the local and national levels, to monitor overall trends and outcomes. At present there are information gaps in a number of the well-being domains, most notably in relation to access, safety from crime and abuse, health, behaviours, relationships and participation, and in some of these areas the views of people with disabilities would be particularly useful. There is a commitment to improve the information base in relation to people with disabilities and the National Disability Survey makes a substantial contribution in this regard. A case can be made for the development of a national information strategy for people with disabilities.

The National Intellectual Disability Database and the National Physical and Sensory Disability Database also offer potential for the collation of data on the service needs of people with disabilities. In these databases information is supplied by local service providers and by the HSE. The data are collated and analysed by the Health Research Board. Their work is based on internationally endorsed understandings, definitions and standards of disability. There is ongoing work to improve the quantity and quality of the information. The information can be used to inform services at the local level as well as to assess national trends. The information could be usefully cross-referenced to other data sources, such as the National Disability Survey, building on links already made.

9.11 Policy Monitoring

As in previous chapters we return to monitoring the implementation of policy commitments through the use of indicators throughout the policy cycle.

As stated at the outset of this chapter NESC has stressed the importance of data and monitoring for people with disabilities. *Towards 2016* has also emphasised the importance of research and data for monitoring progress. The development of surveys, databases and administrative records, along with reviews of the sectoral plans and the overall National Disability Strategy, will contribute to our knowledge base on the well-being of people with disabilities, and identify areas for improvement.²¹⁵

215. The National Disability Authority is currently developing an 'indicator suite' to monitor the National Disability Strategy.

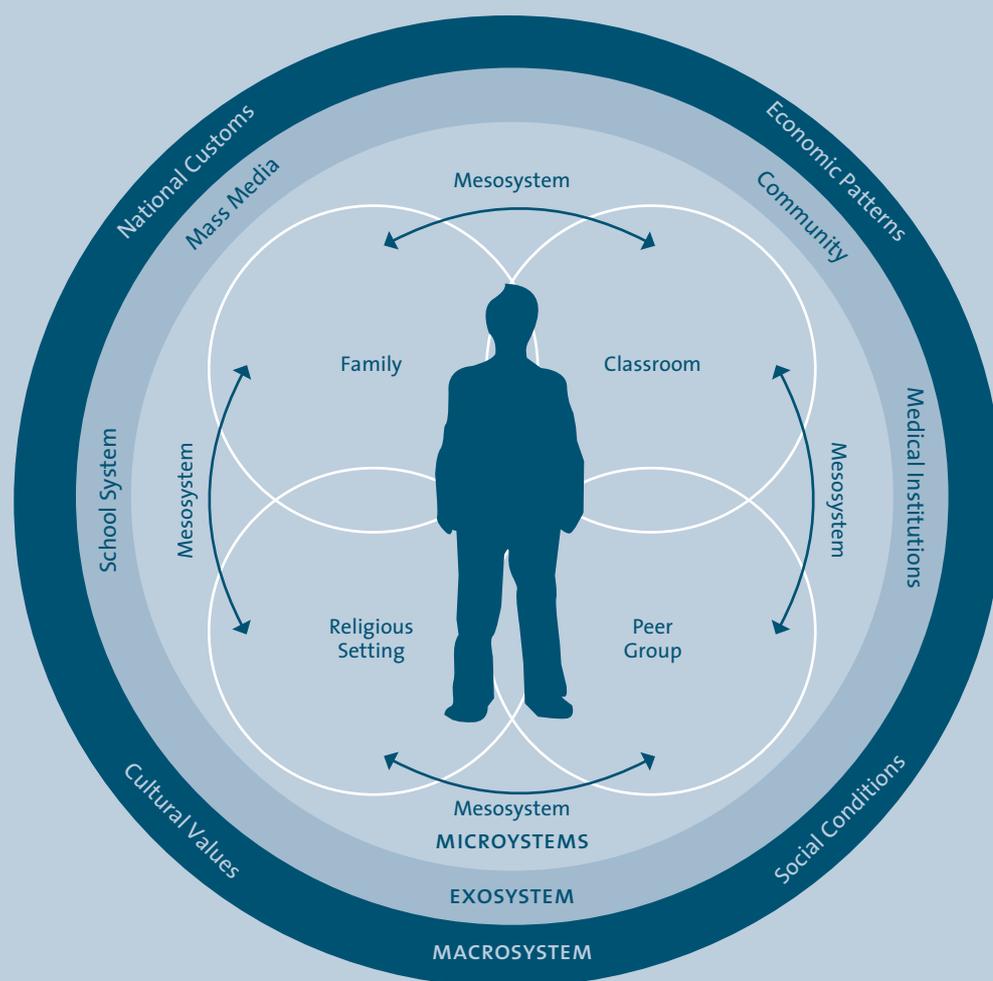
An example is used here to illustrate the relationship between the policy cycle and the use of indicators (see Chapter 3) for people with disabilities, see Table 9.3. *Towards 2016* contains the goal that every person with a disability would have access to an income which is sufficient to sustain an acceptable standard of living. Diagnostic indicators can identify those people who do not have access to an adequate income and the reasons why, for instance, their employment status, level of income and their costs. Inputs, such as income supports, education, training, employment, and accessibility supports, should seek to address gaps in order to improve their income. Baseline indicators would measure this and performance indicators would measure the change. Expected outputs would be more people with disabilities in education, training and employment. More flexibility in employment opportunities could also be an output. The outcome sought is a reduction in the number of people with disabilities living in poverty and this could be measured using the systemic indicator that for people with disabilities the risk of poverty is similar to the non-disabled population.

Table 9.3 Supports for People with Disabilities Example

Policy Cycle	Indicators
<p>Strategy To ensure every person with a disability has access to an income sufficient to sustain an acceptable standard of living</p>	<p>Diagnostic Employment status of people with disabilities Income sources of people with disabilities Costs of people with disabilities</p>
<p>Inputs Income supports Supports for people to access education, training and employment Improved service provision</p>	<p>Baseline % of people with disabilities in poverty Educational level of people with disabilities Employment rates of people with disabilities</p>
<p>Outputs No. of disabled people in post second level education and training No. of disabled people in employment</p>	<p>Performance Change in educational level of people with disabilities Change in employment rates of people with disabilities Ability of people with disabilities to make ends meet Institutional 'helpers' and 'hinders'</p>
<p>Outcomes Reduction in the number of people with disabilities in poverty</p>	<p>Systemic % of people with disabilities in poverty same or lower than the non-disabled population</p>

B

Appendix B Bronfenbrenner's Ecological Model of Child Development



Bronfenbrenner's bioecological model of human development (Bradshaw *et al.*, 2006: 9) describes child development on the basis of 'four concentric circles of environmental influence'. The child is at the centre. The child interacts directly with their family but also with other networks and institutions such as friends, school, childcare and health care. This is known as the *microsystem*, and has the greatest influence on children's lives. Outside of this is the *mesosystem*, which describes interactions between the various parties in the microsystem eg. parents' interaction with schools. The next system up is the society within which families live. This is the *exosystem* and includes the local community, services and employment. The outside sphere is the *macrosystem* which refers to the economic and political context. These systems 'are dynamic and interdependent, influencing each other and changing over time'.

C

Appendix C
Unicef's Summary of Child
Well-being Across 21 Countries

Unicef has provided a summary framework to measure children's well-being (Unicef, 2007). The Unicef assessment is informed by the Convention on the Rights of the Child, as far as the data allows. 'It stresses the positive, whilst emphasising both the rights and responsibilities of children and families' (Unicef, 2007: 40). The Unicef summary framework of child well-being is made up of 40 variables, in 18 components, in 6 domains. The domains are not aggregated into an index. Bradshaw *et al.* (2007) argue that this maintains the transparency of the various aspects of child well-being, which is reflected in differences in the domains across countries.

The Unicef summary results are presented in Table C1. The assessment uses six dimensions to measure child well-being: material well-being, health and safety, educational well-being, family and peer relationships, behaviour and risks, and subjective well-being. Using the summary measure of child well-being Ireland ranks 9th of the 21 countries analysed. The best performing countries are the Nordic nations and the worst performers are the UK and USA. Ireland performs well on behaviours and risks (4th – health behaviours such as eating and exercising, risk behaviours such as smoking, drinking, sexual activity, and experience of violence), on subjective well-being (5th – how young people themselves rate their health, school life and personal well-being), on educational well-being (7th – school achievement, staying in education and making the transition to employment) and family and peer relationships (7th – family structure, family relationships and peer relationships). Ireland does less well on material well-being (19th – relative income poverty, households without jobs and reported deprivation) and children's health and safety (19th – health below the age of 1, preventative health services and safety from accidents and injuries), arguably the most fundamental aspects of children's well-being.

Table C1 Child Well-being Across 21 Countries

Dimensions of Child Well-being	Average Ranking	Material Well-being	Health and Safety	Educational Well-being	Family and Peer Relationships	Behaviours and Risks	Subjective Well-being
Netherlands	4.2	10	2	6	3	3	1
Sweden	5.0	1	1	5	15	1	7
Denmark	7.2	4	4	8	9	6	12
Finland	7.5	3	3	4	17	7	11
Spain	8.0	12	6	15	8	5	2
Switzerland	8.3	5	9	14	4	12	6
Norway	8.7	2	8	11	10	13	8
Italy	10.0	14	5	20	1	10	10
Ireland	10.2	19	19	7	7	4	5
Belgium	10.7	7	16	1	5	19	16
Germany	11.2	13	11	10	13	11	9
Canada	11.8	6	13	2	18	17	15
Greece	11.8	15	18	16	11	8	3
Poland	12.3	21	15	3	14	2	19
Czech Republic	12.5	11	10	9	19	9	17
France	13.0	9	7	18	12	14	18
Portugal	13.7	16	14	21	2	15	14
Austria	13.8	8	20	19	16	16	4
Hungary	14.5	20	17	13	6	18	13
United States	18.0	17	21	12	20	20	-
United Kingdom	18.2	18	12	17	21	21	20

Source Unicef (2007) *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries*.
Unicef: Innocenti Research Centre, Report Card 7.

D

Appendix D Explanation of National Disability Survey Results

The 2006 Census of Population included two questions on disability – first, whether or not you had any long lasting conditions, and the second one, based on the ‘yes’ answer to the first question, on difficulties with specified activities because of the condition(s). Based on a ‘yes’ answer to the first question, 9.3 per cent of the population (393,800 persons) reported a disability.

Later in 2006 a more detailed survey of disability, the National Disability Survey (NDS), was carried out to establish the prevalence, severity and impact of disabilities and to provide more detail on the characteristics and circumstances of people with disabilities. The NDS included nine different disabilities (seeing, hearing, speech, mobility and dexterity, remembering and concentrating, intellectual and learning, emotional, psychological and mental health, pain, and breathing), some of which were not included in the Census (speech, pain and breathing).

The design of the NDS involved two separate processes. The main approach was to select a sample from among those persons who reported a disability in the Census (the ‘Census disability’ sample). Interviews were conducted with 14,518 individuals (13,868 in private households and 650 in communal establishments).

A second and smaller, sample of 1,551 individuals (the ‘General Population’ sample) was drawn from households who did not report a disability on their Census form. The purpose of this sample was to explore the extent to which the broader NDS definition would identify disability not picked up in the Census. As this is a smaller sample of a bigger population the estimates of disability are much less precise than for the ‘Census disability’ sample.

The ‘Census disability’ sample yielded a disability prevalence of 8.1 per cent. The ‘general population’ sample produced a disability prevalence of 10.4 per cent, giving an overall disability prevalence of 18.5 per cent. However, the CSO has recommended using the ‘Census disability’ prevalence rate of 8.1 per cent, as it is more reliable.

There are a number of reasons for the variations between the two samples. The ‘Census disability’ sample set a threshold of disability, through the use of a filter question to determine the level of disability experienced. Five levels of difficulty were used: no difficulty, just a little, a moderate level, a lot of difficulty, cannot do at all. If the respondent replied that they had ‘no difficulty’ or ‘just a little’ they were not included, except for intellectual and learning difficulties, and emotional, psychological and mental health difficulties where persons replying that they

had 'just a little difficulty' were included. Also, in the Census people self-reported their disability whereas the NDS used personal interviewing so that in a small proportion of cases the status of some people changed from what had been recorded on the Census. As stated earlier, the 'general population' sample included people not included in the Census, but who were subsequently identified as having a disability, predominantly those disabilities not covered in the Census such as pain and breathing difficulties.

This information is summarised in the table below. Further details are provided in the report on the disability survey, see CSO, 2008d.

Survey	Sample size	Target Population	Disability Rate	Comments
Census of Population				
	-	4,239,848	9.3%	<ul style="list-style-type: none"> ◆ Based on 2 questions in 2006 Census, included if answer 'yes' to first one ◆ Self report
National Disability Survey (NDS)				
Census Disability Sample	14,518	370,500	8.1%	<ul style="list-style-type: none"> ◆ Sample of those saying 'yes' in 2006 Census ◆ Personal interview ◆ Includes pain, speech & breathing ◆ Threshold of disability set ◆ Includes communal establishments as well as private households ◆ Robust sample
General Population Sample	1,551	3,700,000	10.4%	<ul style="list-style-type: none"> ◆ Sample of those saying 'no' in 2006 census ◆ Personal interview ◆ Includes pain, speech & breathing ◆ Estimates imprecise
Total	16,069	4,070,500	18.5%	<ul style="list-style-type: none"> ◆ Sum of 'census disability' and 'general population' ◆ Comparable disability rates to other national disability samples

E

Appendix E Disability Indicators Proposed by the NDA

Domain	Indicator	Potential Data Source
Independent access to transport	<i>Proportion with a car</i>	Census: EU-SILC
	<i>Proportion who can use public transport</i>	To be developed
Employment	<i>Employment rate</i>	QNHS
Income	<i>Equivalised household income</i>	EU-SILC
	<i>Proportion at risk of poverty</i>	EU-SILC
Education	<i>Proportion aged 15-19 in education</i>	Census, QNHS
	<i>Proportion aged 25-29 by highest level of qualifications received</i>	Census, QNHS
Housing	<i>Proportion aged 35-39 living in parental home</i>	Census
	<i>Proportion living in residential care</i>	Census
Health	<i>Comparative life expectancy in Ireland and OECD for certain conditions eg. cystic fibrosis</i>	Vital statistics
	<i>Proportion visiting dentist</i>	EU-SILC
	<i>Proportion eating fruit/vegetables</i>	SLÁN
Supports	<i>Waiting list for aids/appliances</i>	Physical and Sensory database
	<i>Waiting list for personal care</i>	Physical and Sensory database
Household and family	<i>Proportion aged 40-45 in different marital categories</i>	Census
Social life	<i>Proportion with morning / afternoon / evening out in previous fortnight, that costs money</i>	EU-SILC
Accessibility	<i>Proportion of footpaths which have been dished</i>	Monitoring of Sectoral Plan, DOEHLG
	<i>Proportion of supermarkets accessible</i>	To be developed
Mainstream opportunities	<i>Ratio of people with disabilities in open employment to total number of people with disabilities at work</i>	QNHS + returns for sheltered employment
	<i>Ratio of pupils with disabilities in mainstream schools to total pupils</i>	Education statistics
Attitudes	<i>Proportion of public comfortable with a disabled person as a neighbour</i>	To be developed
Civic participation	<i>Proportion voting in last election</i>	QNHS voting module or European Social Survey
Communications	<i>Access to computer / internet</i>	Census
Safety	<i>Feeling safe at home</i>	To be developed
Friendship	<i>Proportion in disability services with 3 or more friends</i>	To be developed
Independence	<i>Proportion in disability services who exercise choice in their lives</i>	Audit Tool, National standards

F

Appendix F Domains Covered in Key Disability Classifications

UN Standard Rules, 1993	Commission on the Status of People with Disabilities, 1996	WHO International Classification of Functioning, Disability and Health (ICF), 2001
Accessibility	Access, transport and mobility	Mobility
Education	Education	Education, learning
	Health	
Employment	Work and training	Work and employment
Income	Income	Economic life
Family life and personal integrity	Sexuality and relationships	Interpersonal relationships
Culture	Arts and culture; media	
Recreation and sports	Sports, leisure and recreation	Recreation and leisure
Religion	Religious practice	Religion
	Housing	Domestic life
	Technology and communications	Communication
		Self care
		Community life; political life and citizenship

G

Appendix G Questions Asked to Ascertain Level of Difficulty in Doing Everyday Tasks

In relation to their disability(ies) respondents were asked about difficulties that have lasted, or are expected to last, six months or more or that regularly occur. For each of these questions respondents were asked if they had 'no difficulty', 'just a little difficulty', 'a moderate level of difficulty' or 'cannot do at all'. To obtain an overall severity score persons were coded to the highest level of difficulty recorded in the filter questions relating to that disability.

Seeing (Wearing your glasses/contact lens), do you have difficulty seeing?

Hearing (Using your hearing aid), do you have difficulty hearing?

Speech Do others generally have difficulty understanding you when you speak?

Mobility and Dexterity Do you have difficulty -

- i. Moving around inside your home?
- ii. Going outside your home?
- iii. Walking a longer distance, eg. walking for about 15 minutes?
- iv. Using your hands and fingers eg. picking up small objects or opening and closing containers?

Remembering and concentrating

- i. Do you have difficulty remembering to do important things?
- ii. Do you often forget where you put things?
- iii. Do you have difficulty concentrating on doing something for 10 minutes?

Intellectual and Learning

- i. Do you have any difficulty with intellectual functions due to a condition such as acquired brain injury, Down Syndrome, brain damage at birth?
- ii. Do you have any difficulty with interpersonal skills due to any condition such as autistic spectrum disorders?
- iii. Do you have any difficulty in learning everyday skills such as reading, writing, using simple tools, learning the rules of the game due to a condition such as ADHD (Attention Deficit Hyperactive Disorder) or dyslexia?

Emotional, Psychological and Mental Health Because of any emotional, psychological or mental health difficulties, do you have difficulty in the amount or kind of everyday activities you can do? (These conditions include depressive illnesses, anxiety or panic disorders, schizophrenia, alcohol or drug addictions, eating disorders such as anorexia, bulimia).

Pain Because of constant or recurrent pain, do you have difficulty in the amount or the kind of everyday activities you can do?

Breathing Because of a breathing difficulty, do you have difficulty in the amount or kind of everyday activities you can do?

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