

Enhancing the Quality of Life of Older People Reliant on the State Pension

M. Hodgins, V. McKenna and M. D'Eath

**Health Promotion Research Centre
NUI Galway**



Executive Summary

Background

About one fifth of older people continue to live in income poverty and just under 4% in consistent poverty (CSO, 2006). The implications of this are not solely monetary in nature and a broader understanding of the experiences of these older people is needed.

The aims of this study were to

- identify and explore non-monetary factors that affect the quality of life of older people living in poverty
- analyse the efficacy of existing policy from the perspective of older people
- build on existing evidence and to inform an evidence-based policy making process

Specific objectives were to

- consult with older people, living alone and on state pension, in order to identify what they consider to be non-monetary factors that influence quality of life
- explore, in particular, the perceived importance of health, social and community supports and housing condition in achieving positive health and quality of life
- explore the experience of social exclusion and how it impacts on health and quality of life
- review existing health, housing, and social welfare policy with regard to provisions for older people
- make recommendations for policies which will enhance the quality of life of older people in poverty

Methods

The study employed qualitative methods. A semi-structured interview guide was developed using the Quality of Life framework developed by the Centre for

Health Promotion at the University of Toronto in Canada (1996) with special reference to the measure developed especially for older people *Quality of Life profile: Seniors*. Maximum variation, a form of purposive sampling, was used. The sample comprised 40 older people (ie over 65 years) who are reliant on the state pension and live alone, and included both men and women in urban and rural settings. Ethical approval for the study was awarded by the National University of Ireland Galway Ethics Committee. All participants were identified and accessed via 'gatekeepers' in the voluntary and statutory health and social service organisations. All interviews were tape-recorded and transcribed verbatim. Two validation exercises were set up, in both rural and urban centres where larger volumes of older people had participated in the interviews. The exercises focused on validating the final themes from the dataset.

Findings

Twenty four of the participants were women and 16 were men, and ranged in age from 66-100. On balance there were more rural than urban participants and more over the age of 75, than under. Only two participants (male) were separated, and of the balance, 60% were widowed and 40% single. More than half participants owned their own house and eight were in social or voluntary housing projects.

Being

Findings in this section relate to the areas of physical wellbeing (health, mobility, and exercise levels), psychological well-being (worry/stress, self control, attitude towards life) and spiritual being (things to look forward to in life, feeling peaceful)

Physical Being

The majority of participants recounted health difficulties. Poor health detracted from quality of life in two ways; pain and discomfort, and the loss of function which in turn led to the loss of enjoyable pastimes. Participants were philosophical about their compromised health, pointing out that it could be worse. The sense was that a certain amount of disability and discomfort could be expected with age. Participants consistently described their health in

the context of mobility. Great importance was placed on being able to get out, about, and around the house.

Psychological Being

Participants identified a number of things that create sadness in their lives and that worry them. Sadness was almost exclusively discussed in the context of loss; the loss of a spouse or a sibling. Worries were described as part of parcel of everyday life and while participants admitted to worrying about many things, it was evident that they strove to maintain a positive attitude to life. Worries included the situations of various family members, their health, their children being 'well reared', or their work situations. The importance of striving to maintain a positive attitude was very evident across the data set. Participants described their efforts to be positive and stay positive. This was considered to be vital to a sense of well-being.

Spiritual Being

While there was considerable variation across interviews regarding psychological well-being, participants were more consistent in their discussions of what they had to look forward to in life and whether they felt peaceful. Almost all participants claimed to be peaceful or at peace with themselves, and for most this was a positive state of affairs. The things that participants, particularly women, looked forward to were mundane yet of worth; family visits or day centre outings, weekends away with children or grandchildren, mass, shopping trips. The way in which the older people spoke of these events revealed their significance and their life-affirming nature. The men looked forward to family events but also sport and TV.

Belonging

Belonging is concerned with the fit between individuals and their various environments. It encompasses physical belonging, social belonging and community belonging.

Physical Belonging

Physical belonging refers to the relationship people have with their physical environments, including feelings of safety and privacy in their home and community. Participants mentioned a number of aspects of their physical living environment in positive terms; quietness, being in a country setting and convenience to facilities. Most participants felt safe in their surroundings. Factors that contributed to this were being in the countryside, perceiving the area to be low in crime, having and using door locks and the general area being well lit.

In terms of warmth, comfort and maintenance there was a lot of variation in participants' experiences. For maintenance, participants referred to help from family members such as sons and nephews, and occasionally tradespersons. While participants in the main expressed satisfaction overall with their living situations, there were a number of difficulties in relation to physical aspects of accommodation such as stairs and bathrooms and with heating. While few seemed to have difficulty keeping warm in their house comfort either came with a cost or required a 'heat rationing' strategy. Those who mentioned storage heaters seemed to have greatest comfort without burdensome expense.

Social Belonging

Social belonging consists of meaningful relationships with others, for example family, friends and neighbours. Outcomes in this domain were good. Connections with neighbours and family were of great importance for participants and in the main, strong. When asked to talk in general terms about their neighbourhood, most did so in a positive way in terms of the neighbours and the people around them. Having people around whom could be relied on to help was valued highly.

Family was very important to participants. Participants described where their various family members lived, when they could visit or be visited and clearly placed a high value on this aspect of their lives. In some cases family could not maintain as much contact as the older person would have liked. It was

apparent that this was a source of sadness although borne with the stoicism seen elsewhere in the interviews. Family members were an important source of practical support.

Participants described other social activities that did not rely on family, for example organized social activities and outings or trips in day centres or ARAs, and trips to mass, the shops and for a few of the men, to the pub. This type of social activity was also important and well appreciated. Opportunities for social activities could be lost due to lack of transport. Social activities were not always sought by participants. Older age can bring a freedom of not having to engage socially. Throughout the interviews, few participants expressed loneliness but where it did exist it seriously detracted from life quality.

Community Belonging

Community belonging refers to the connections people have with resources typically available to members of their community and society, including information about and access to health and social services, recreational programmes, sources of adequate income, and community events. In general, participants considered themselves to have a sense of belonging within their community.

Health and social services

In relation to health and social services, participants were asked about GP, hospital and home help services. Positive comments about GPs referred to "*having time for you*", being nice, kind, and providing a good service. A number of participants discussed the perceived reluctance of GPs to make house calls. This was frustrating for older people and was exacerbated by general transport and mobility difficulties. Structured activities (Day Centres, Senior Citizens, 'Old Folks' Clubs, ARAs) were described, unanimously, in positive terms.

Income Adequacy

The strongest impression emerging from the interview data in respect of income adequacy is the way in which the attitude of the older people

mitigates the financial hardship in which they live. Almost all participants reported some level difficulty with money, yet this often had to be probed. The older people interviewed appeared to be stoic in their willingness to 'manage' their limited means, justifying their difficulties with an acceptance that this was not a time of life for extravagance, combined with grateful testimony that things can be or were worse for others, including parents. Participants employed a number of management strategies to cope with their small pensions. These included being prudent in their spending and reliance on secondary benefits. Participants relied on family for a number of practicalities such as house maintenance and social activities. Families also provide financial assistance, often in an informal manner. Many of the participants pointed out that they had no money for 'extras' and this was borne with characteristic forbearance. The most particular difficulty older people faced was with regard to affording fuel.

Becoming

Becoming, in the Toronto QoL Model, is about the purposeful activities in which individuals engage as a way of realizing their goals, aspirations and hopes.

Practical Becoming

Practical becoming refers to purposeful activities, such as housework and self-care and paid or voluntary work that are typically done on a regular basis. Participants readily outlined daily routines, including housework, gardening and visits to friends, family or mass. The women elaborated more on their daily routine, and more references were made to housework. The activities provide a structure for the day.

Leisure Becoming

This aspect of 'Becoming' includes activities that promote relaxation, enjoyment and recreation, for example games, hobbies and holidays that do not have an obvious instrumental value. Participants gave plenty of examples of things undertaken for enjoyment: TV, listening to the radio, crosswords, reading, knitting, bingo and visits to the pub. Otherwise,

enjoyment was not always evident. Solitary activities only go so far in providing recreation. Non-engagement in community-based leisure activities was usually construed as a choice, rather than as a function of low income. Findings do indicate however that getting out more would clearly afford more opportunities for quality of life outcomes in this domain.

Growth Becoming

'Growth becoming' encompasses activities that promote the development of skills and knowledge, which can include either formal or informal learning. It also incorporates adapting to changes in life. Participants had few examples of activities undertaken to maintain their physical and mental skills. Exercise, particularly walking was mentioned as was reading and doing crosswords. With regard to adjusting to life's changes, there were participants who took reasonably positive perspectives, accepting their life and its natural course.

Overall Influences on Quality of Life

Participants commented in an overall manner on what things make life good and what things make life not so good. The responses to these questions were broadly consistent with both the literature and findings in the earlier parts of the interview.

Things that make life good for the older people were family, and health and being able to get out and about. Family was important both in terms of the practical and emotional support they provided; knowing that they care and caring for them. Health was identified both in a general sense but most particularly in respect of maintaining independence and the freedom to get out and about. Participants found it harder to identify what made life not so good. The few who felt they could respond to this question referred to sickness, not having enough money in the purse and loneliness.

Discussion and Conclusions

The vast majority of participants in the study either stated they found it difficult to manage with their pension or that they 'managed', through using careful money management strategies. Older people were very careful to

avoid being in debt and this may account for their own 'playing down' of living with a low income or in poverty.

Repeatedly, through the interviews, attitudes of forbearance and acceptance are evident. Older people were found to express attitudes of stoicism in the face of financial difficulty. This same tendency has been noted in a recent study on older people's perspectives of living in poverty, part of the Growing Older study series in the UK (Sharf *et al.*, 2006). The significance of perspective is illustrated by the discussions on spending. The prudent spending described by older people in the study essentially means that older people deny themselves items that they consider a luxury, for example holidays, new furniture, or a new suit of clothes. This is discussed in the context of generational effects and specific intergenerational comparisons.

The stoic perspective of older people has to be considered carefully in the context of policy responses to this kind of information. Older people's perceptions of circumstances must be taken into account in planning appropriate policy responses. The uncomplaining stoical perspective articulated by older people masks difficulty making ends meet and cloaks hardships that would be very real to other population groups. The 'grateful testimony' found in the study does not mean that older people have sufficient money; it simply means that they are reluctant and unable, perhaps given their life experiences, to articulate need in this respect. As such, policy makers need to make provision for adequate social welfare pension payments that clearly exceed the poverty threshold. Older people's perceptions of circumstances and low expectations, which may be evidence of internalism ageism, must be taken into account in planning appropriate policy responses.

The study throws light on the discrepancy between the high rates of income poverty and low rates of consistent poverty noted in previous research. The perspective of older people and their tendency to contextualise their experiences of living on a low income may lead to a denial of unaffordability of items used as indicators of deprivation. In the study it was apparent that older people have a unique perspective or what qualifies as need and as luxury. It is possible that notions of un-affordability are conflated with old age. Further, low

expectations, combined with use of family and other informal supports, may lead older people to downplay 'un-affordability' of items.

Family

The findings of this study highlight the immense importance of social contact in the lives of older people. Families provide practical support with home maintenance, gardening, housework, finance and opportunities for social activities. In this way families can cushion older people from financial hardship. The findings mirror previous studies in that the majority of older people were socially integrated with having close relationships with family friends or neighbours, and a minority were experiencing loneliness. The need for a comprehensive befriending service available across communities is evident.

From a policy perspective, this 'invisible' level of support is not available to all, and should not be assumed. Those without family members available to them, or whom feel embarrassed asking family for support will become hidden victims of poverty.

Social Exclusion

There was little evidence of social exclusion in this study, despite the fact that older people were living on low incomes and finding it hard to manage. The older people did not wish for other social opportunities other than those provided or facilitated by family although this may have been due to low expectations. With an awareness of the possibilities that could be open to older people in terms of social and lifelong learning opportunities, financial barriers may well become relevant.

The population of older people would benefit from a formal social needs assessment and appropriate service provision. This could include the development and promotion of locally based befriending schemes to ensure that the social connectedness of older people living alone is facilitated. Family support may not always be available and is no substitute for a comprehensive social service.

Well-being and Outlook

Older people interviewed here displayed stoicism and an attitude of acceptance. Expectations for a 'good life', or a life in which one enjoys 'all the important possibilities' seemed to be attenuated as a function of comparisons with previous times, and the hypothetical possibility of not being mobile or independent. Older people were buoyant but had low expectations, echoing the findings of Hill *et al.*, (2006) and Scharf *et al.*, (2006).

Home and Neighbourhood

The erosion of community and depletion of social capital, often lamented in the media, was not a typical experience for most participants, although it should be noted that older people living in extreme isolation who are not in contact with services were not reached in this study. Many of those interviewed spoke of good neighbours, community belonging and connectedness. Neighbours provided essential community support and an opportunity for older people to reciprocate support, and for some a connectedness with the past, which contributes to a sense of well-being. However, for a few, the stunted community, characterised by few people did exist and were associated with changes over time such as the death of one's peers and the increasingly busy lives of people. This clearly detracted from life quality.

The study findings reinforce previous work on housing deprivation. Although broadly expressing satisfaction with living arrangements participants did disclose difficulties in relation to stairs, bathroom and in particular getting work done.

Public transport difficulties exist for older people, a finding that reinforces those of earlier studies. Given the role of transport in getting out and about and its role in turn in contributing to well-being and a sense of independence, this is an area that requires attention in the case of older people living in or at risk for poverty. None of the rural based participants mentioned using the Rural Transport Initiative. Participants used taxis for attending doctor/hospital appointments, for going into town and for social activities

commented on the high price. Not having access to public transport adds considerably to living expenses and thus limited income interacts with transport deficit to detract from life quality.

Health and access to Health Services

The older people in this study described a range of ailments, with varying degrees of compromised mobility although many were, by their own appraisal, reasonably healthy. Those with chronic ill-health found it did limit their ability to enjoy life and spoke with regret of their diminished capacity for exercise. Attitudes of forbearance and low expectations were evident again here, with participants giving grateful testimony that they were still around and emphasising what they can do rather than what they can't.

Access to and satisfaction with health care services was also variable. Participants were generally satisfied with Home Help and Meals on Wheels services, and these services would seem to be important in protecting older people from more severe levels of financial hardship. Older people living alone need to be fully informed and supported to access information relevant to their entitlements to community based health and social services. A more proactive approach, tailored to the specific needs of older people and easily accessible would be of benefit.

Many of the older people in this study utilised their local day care service and highlighted its importance in terms of both practical and social support. Day Centres appear to be vital in terms of maintaining and promoting social connectedness, promoting physical activity and importantly as a source of practical support and information.

Satisfaction with medically-oriented services was poorer than social services. Given that acute and GP services are now free at point of access to most older people, income did not feature as an interacting factor. Most who had had hospital visits were positive about the experience, although the perceived unwillingness on the part of the GPs to undertake home visits was noted. Mobility and financial barriers can then be encountered.

Chapter 1

INTRODUCTION

1.1 Study rationale

Population ageing, an international phenomenon, will lead to an increase in the proportion of older people (i.e those over 65 years of age) in the population in Ireland from 11.1% in 2002 to between 14.8 % and 15.3% by 2021 (NCAOP, 2005). Providing an environment that maximizes the potential for a good quality of life for older people poses a substantial challenge to policy makers today. While it can be argued that, in general, older people in Ireland have shared the gains in prosperity witnessed in recent years, it is evident that particular issues need to be addressed at a national level. Life expectancy at 65 remains below both the EU-25 average, and unacceptable proportions of the older population live in or at risk of poverty. The latter concern is the subject of this report.

Poverty has been an issue for Irish policy makers throughout the past decade. Data collected through successive sweeps of the 'Living in Ireland' survey, revealed alarmingly high levels of poverty during the 1990's. Levels of poverty increased throughout the decade, resulting in Ireland's income poverty rates being higher than the EU average in 1999 (*NAPS/incl* 2003-2005). In 1994, for example, 15.6% of Irish people were income poor, rising to 21.9% by 2001 (*ibid.*). Income poverty is defined by The Combat Poverty Agency as the proportion of people living in households where their disposable income is below the threshold of 60% of the national average disposable income. It is the definition employed throughout this report.

The effects of unprecedented economic growth, taken with the commitment of successive governments to reducing poverty, through the publication of the *National Anti-Poverty Strategy (NAPS)* in 1997 and subsequent strategies, appears to have had a positive impact. We are now witnessing a drop in both income poverty rates, from 21.9% in 2001 to 18.5% in 2005 (CSO, 2005,

2006) and consistent poverty rates from 9.4% in 2003 to 7% in 2005. The figure of 7% is far from the 2002 target of 2%. Consistent poverty is defined as the percentage of people who are living on a lower than normal income and who lack certain basic essential items such as warm coat, sufficient food or adequate heating and thereby experiencing a lower standard of living than the rest of society.

The situation of older people within this national picture has been of particular concern for some time. The report *Income Deprivation and Wellbeing among Older Irish People* highlighted the fact that elderly households are at greater risk of income poverty than other population groups, and figures in this respect were 'extremely high and worrying' (Layte *et al.*, 1999; p.3). Between 1998 and 2001, older people experienced the greatest increase in income poverty. By 2001 44.1% of older people lived in relative income poverty (*NAPS/incl*, 2003-2005). Whilst this figure has consistently dropped since 2002, latest figures indicate that one fifth (20.1%) of older people continue to live in income poverty¹.

Certain sub-groups of older people are particularly vulnerable for income poverty - women, those living alone, those living in rural areas, and those on Old-Age Non-Contributory pensions, Widows' Contributory and Non-Contributory pensions (Layte *et al.*, 1999; *NAPS/incl*, 2003-2005). Women may be especially vulnerable due to the cumulative effects of unequal pay and/or treatment regarding access to paid work, tax arrangements and inheritance practices. Living alone presents particular challenges in respect of reliance on the state pension and housing deprivation. The extreme difficulties of lone single female pensioners were recently highlighted in relation to managing on a budget for minimum essentials (VPSJ, 2006). Older people in rural areas are more likely to experience housing and secondary deprivation, and transport difficulties (Layte *et al.*, 1999).

The impact of social transfers on poverty is most marked for older people (CSO, 2004), reflecting the fact that older people are highly reliant on social welfare pension incomes, especially those living alone. The value of pension

¹ Detailed figures on income and consistent poverty appear in Chapter 2, p. 31. 36

has fallen relative to Gross Average Industrial Earnings in recent years (Prunty, 2007), and state pension payment rates typically have not crossed the poverty threshold.

Debates on poverty and income levels have repeatedly made the point that the implications of living in or at risk for poverty are complex and not solely monetary in nature. As demonstrated by Daly and Leonard (2002) families living on a low income experience knock-on difficulties in terms of health, leisure, social relationships and marginalization. Living on a low income pervades many aspects of family life, and the daily struggle to make ends meet takes its toll in numerous and mutual ways. With regard to older people, less is known about the lived experience of poverty and reliance on the state pension. It is apparent that at a time when older people are more at risk for income poverty than children and adults 18-64 years, they are least at risk for deprivation (*NAPS/incl*, 2003-2005). Further, despite being a greater risk for income poverty older people are not at greater risk for social isolation (Layte *et al.*, 1999) than the general population. The role of secondary benefits, high rates of owner occupancy and family support have been offered as candidates explaining the weak links between income and living standards (O'Shea and Conboy, 2003). Yet, the availability of secondary benefits does not automatically lead to uptake, the adequacy of secondary benefits is unknown and older people are more likely than other population groups to experience housing deprivation including dampness, rotting, and inadequate heating (Layte *et al.*, 1999). The way, in which non-cash benefits improve or impact on older people's daily lives, how access to health and social care services and social and family support interact with available financial or community resources, and the role of individual attitudes and expectations are, as yet, unknown.

Quality of life, as an outcome of health and social policy interventions, could reasonably be expected to have improved for older people, in line with reductions in income poverty. Indeed this is the case, as Sheily and Kelleher (2004) report, in their comparison of data from the two National Lifestyle Surveys. In 1998, 73.3% older people reported good or very good Quality of Life rising to 78.1% in 2002. However, specific contradictions to this general

effect appeared for sub-groups (ibid.). Further, the complexity and possible unreliability of assessing life quality with standardised measures has been noted (e.g. Hendrey and McVittie, 2004; Felce and Perry, 1995).

Thus, surveys, while rendering reliable 'hard' data, do not always reveal the complexities and nuances of people's lives. It is clear that there is a need to move from a narrow focus on income to a broader understanding of the experiences of older people who are at risk for poverty, taking into account their social and family supports, their perceived access to services, social inclusion and general expectations.

Both poverty research and quality of life research draw chiefly on quantitative data and the actual experiences of people as they live their lives on low incomes, their perceptions of their ability to manage money, the significance of other welfare benefits and the extent to which appraisals of quality of life are linked to attitudes, expectations, and the process of social comparison is an under-researched area. Qualitative research, defined by Bryman (1998), as 'the way in which people being studied understand and interpret their social reality' (p.8) lends itself to these questions and is the main method of investigation employed in this study.

1.2 Policy Context

The policy response to income poverty and generally and to the particular situation of older people can be seen in the adoption of the ten year Government plan for poverty reduction, the *National Anti-Poverty Strategy (NAPS)* in 1997. The NAPS is a ten-year programme of action that aims to bring about a substantial reduction of overall poverty and inequality in Irish society.

The NAPS has had five areas of focus from the outset: income adequacy, unemployment, educational disadvantage, disadvantaged rural areas and rural poverty, thus taking a broad view of poverty, its determinants and its consequences. It has provided an important policy focus for addressing poverty and related inequality in Irish society. The subsequent Programme for Prosperity

and Fairness and subsequent documents (*NAPs/incl 2003-2005; Building an Inclusive Society 2002; Sustaining Progress, 2003-2005 Social Partnership Agreement*) have continued to highlight the need for specific actions in respect of income poverty and the non-monetary aspects of living in or at risk of poverty, in particular the need for social inclusion.

Most recently, a new ten year social partnership agreement has been laid out in '*Towards 2016*' (Department of the Taoiseach, 2006). This agreement adopts a lifecycle framework to address key social challenges 'by assessing the risks and hazards which the individual person faces and the supports available to them at each stage in the life cycle' (p.40). It claims to place the person at the centre of social policy development and to facilitate joined-up policy making. Priority actions are identified for older people that include enhancing pension provision and income support in addition to health service actions and promotion education and employment opportunities for older people. *The National Development Plan (Department of Finance, 2007)* and the latest *National Action Plan for Social Inclusion 2007-2013* are both driven off *Towards 2016* and reflect the lifecycle approach taken within it.

1.3 Aims of the Present Study

The aims of this study are to

- To identify and explore non-monetary factors that affect the quality of life of older people living in poverty
- To analyse the efficacy of existing policy from the perspective of older people
- To build on existing evidence and to inform an evidence-based policy making process

1.3.1 Specific Objectives

- To consult with older people, living alone and on state pension, in order to identify what they consider to be non-monetary factors that influence quality of life

- To explore, in particular, the perceived importance of health, social and community supports and housing condition in achieving positive health and quality of life
- To explore the experience of social exclusion and how it impacts on health and quality of life
- To review existing health, housing, and social welfare policy with regard to provisions for older people
- To make recommendations for policies which will enhance the quality of life of older people in poverty

1.3.2 Structure of the Report

The report begins with a general introduction to the study, placing the work in context. Chapter 2 commences with a discussion of Quality of Life, including the various interpretations of the construct, approaches made to its study and measurement challenges. The Toronto model, which underpins this study, is described in some detail. A summary of the key determinants of life quality in older people is provided, including social relationships, well-being and outlook, health, home and neighbourhood, social activities as well as income. Each of these is then discussed in the context of research findings and policy issues.

In Chapter 3, the methodology is outlined, including the justification for employing a qualitative approach and a semi-structured interview schedule. The approach taken to sampling is described, and a profile of the final sample given. The main results of the interviews are laid out in Chapter 4, using the framework contained within the Toronto model, being belonging and becoming. Overall influences of quality of life are also reported in this chapter.

Chapter 5 explores the participant profile in the context of the study criteria and their experiences with regard to income poverty. The non-monetary determinants of quality of life for older people, as described in Chapter 2, are discussed in the context of living on a low income. Finally, the efficacy of policy with regard to improving life quality for older people particularly for those on a low income is discussed and recommendations for policies which will enhance the quality of life of older people in poverty are made.

Chapter 2

QUALITY of LIFE of OLDER PEOPLE

2.1 Quality of Life

'Quality of life' is a term that has immediate resonance for many people. Although popularised and widely used, it is often poorly defined (Rogerson, 1995; Zissi and Barry, 2004; Walker, 2004), leading to conceptual confusion and limiting practical application. To some, quality of life is a synonym for happiness; it represents the 'good' life, and is measured by how happy or satisfied one is with life. To others, it is a measure used in the study of health care representing one year of full-health life, while to the fictional character Elisabeth Serafin it is "*....some property which is in one way or another promoted or enhanced by washing machines...*"². It is hard to deny the truth in any of these interpretations, even that of Serafin, yet clearly none captures the totality of the quality of life construct. As Day and Jankey (1996) point out, the difficulty in defining quality of life is very like the difficulty faced by the seven blind men in the Indian fable, each trying to describe an elephant according to the part of it they could feel. Researchers, health and social service practitioners and the public may not share a common understanding of the concept, despite identifying with it (Hendry and McVittie, 2004), although all grasp something of its essence. Despite proliferating research interest in the topic, many researchers do not define quality of life, one review claiming that in 75 articles on quality of life, only 11 actually defined the construct (Gill and Feinstein, 1994). Quality of Life is clearly a complex construct, multi-level and amorphous (Bowling, *et al.*, 2002) with attendant measurement challenges.

Two particular measurement issues that have been the subject of much discussion and debate in the quality of life literature are the relative importance of subjective appraisals and objective indicators, and the high scores obtained on quantitative measurement instruments.

²From the novel of Michael Frayn, "A Landing in the Sun" (1991), cited in Bowling, A. (2001) Measuring Disease.

Early approaches to Quality of Life assessment focused principally on objective indicators, such as housing employment, housing, education or illness. In recent years reliance on these objective indicators has been challenged on the basis that they take no account of the value or otherwise that any individual may place on any of the specified indicators. Taylor and Bogdan (1996), for example, unambiguously state: "*Quality of life is a matter of subjective experience. The concept has no meaning apart from what a person feels and experiences*" (p.11). As a result, subjective assessment or appraisals, ranging from one item measures of life satisfaction to multi-item scales of self reported life quality have been introduced and employed.

However, subjective appraisals of life quality are not unproblematic. They do not correlate well with objective assessments (Raphael, 1996, Felce, 1997). Felce (1997) suggests that well-being may owe more to internal temperament than to external conditions. In this context, Zissi and Barry note that subjectively assessed life satisfaction bears only a modest, if any, relationship with objectively assessed, demographic variables. They demonstrate that, for mental health populations, concepts such as self-concept and perceived autonomy act as mediators between objective indicators and quality of life (Zissi and Barry, 2004).

Relatedly, studies have shown that people can report high levels of satisfaction while living under life conditions that by objective assessment would be deemed deprived. Scores on generic Quality of Life indices are frequently inflated, displaying average subjective appraisal scores within the range of 70-80%, irrespective of objective individual circumstances. While overwhelming adverse life events may cause a dip in this level, psychological mechanisms, such as adaptation, social comparison and selective attention, work to effect a restoration of the average level. The way in which any individual makes a subjective an assessment may be affected by their expectations, experiences, cultural values and sense of empowerment. In relation to older people, this difference between subjective and objective assessment is sometimes called the 'satisfaction paradox' and may be linked to reduced expectations from prior generations. The phenomenon is especially worrying when Quality of Life

is measured in marginalised populations (Raphael, 1996), and findings should be interpreted in this light.

These difficulties can be addressed with particular measurement strategies. Inclusion of both subjective and objective indicators is now usually recommended, and within this assessments of domain-specific aspects of life. Augmenting quantitative data with qualitative is advocated as a way of informing the interpretation of high ratings, exploring the perceived importance of specific domains in relation to one another and the role of attitudes and expectations. Recently, more studies employing qualitative approaches have been seen in the literature.

Within the proliferation of debates, discussions and studies, three broad approaches, all of which include both subjective and objective measurement, can be discerned: the social/psychological indicators approach, the medical approach, and the comprehensive approach. These are consistent with the three models outlined by Lindstrom (1992).

2.1.1 The Social/Psychological Indicators Approach

With a view to identifying how to improve the quality of life of whole nations, policy makers have focused on measuring and comparing countries along selected, measurable indicators considered indicators of a 'good life' for residents. This approach has been harnessed in the service of political campaigners – providing proof or otherwise of the success of government policies and programmes, employing both economic and social indicators, for example rates of unemployment, crime, housing, education retention level, public safety, and transport. Indicators are selected by experts and are usually external and objectively assessed. They often reflect researcher interests and therefore are not always comparable. More recently, subjective or psychological indicators can be included: aggregated individual level assessments of life satisfaction, satisfaction with friends, well-being, and alienation.

2.1.2 The Medical/Health Approach

Originating from the realisation that medical interventions, although aiming to increase quantity of life, may do so at the expense of life quality, perhaps involving ongoing pain, discomfort or side effects, this medical approach assesses individual responses to illness and medical interventions. Initially only focusing on the physical domain of life, work in this area has expanded to include mental and social aspects of life. For example, the work of specific researchers such as Bowling and O'Boyle would be in keeping with this approach, taking a broader and more holistic view of health, and including subjective assessments of life quality in addition to specific illness-related indicators. Quality of life within this approach has been used to reflect primarily aspects of quality of life that relate to health, and thus, more recently researchers in this tradition use the term health-related quality of life.

2.1.3 The Comprehensive Approach

The comprehensive approach takes the view that Quality of Life is a broad construct, encompassing other constructs such as happiness, life satisfaction and indeed all aspects of life (WHOQoL, 1995; Brown *et al.*, 1996; Day and Jankey, 1996; Raphael, 2001). In this way Quality of Life is simply how good life is for an individual, a group or a population. Practitioners and researchers in this tradition take the view that quality of life must encompass all dimensions of life, and consequently map out broad domains of human experience such as emotional, social and physical well-being, and then attempt to identify key indicators of life quality within these dimensions. These indicators are usually based on literature searching and consultation with the populations of interest, allowing for the concerns of any one population to be built into the measure and render a relevant and accurate interpretation of life quality of that group. For example, 'privacy' would be relevant for those in long term residential care, as would 'social support' for community dwelling older people. Measurement, therefore, allows individuals, groups or populations to be compared on these broad indices, or compared over time. The comprehensive approach to Quality of Life study lends itself easily to the assessment of care environments, to benchmark population group/client quality of life to population norms, or to evaluate specific policies or programmes. It is the approach adopted in this study.

Specifically, the model offered by the Centre for Health Promotion Studies, University of Toronto (Brown, *et al.*, 1996), one of the few conceptual models of life quality, underpins this study of quality of life of older people living in poverty. Quality of life as defined by this research team is the degree to which a person enjoys the important possibilities of his or her life. The principles that underpin their approach are outlined in Table 2.1. Three broad areas of life are seen to be common to all humans and essential to human experiences – being, belonging and becoming. These are then broken down across the physical, social and psychological life domains to yield nine components (Brown *et al.*, 1996). The model contains both broad determinants of life quality, and a set of ‘moderating variables’ that are seen to moderate the effects of the determinants. Broad, system factor determinants include family, neighbourhood, workplace, as well as personal determinants such as somatic illness, perceptions, and experiences. Moderating conditions are those which influence whether quality of life outcomes become more positive or negative, for example: perceived control of the important possibilities of ones life, access to resources, opportunities/chances for change and enhancement and so on (see Figure 2.1). For example, a person/persons might live in poor quality housing (determinant), but the degree to which they perceive themselves to have control over this will then moderate their quality of life outcomes in either a more positive or negative direction (Raeburn and Rootman, 1996).

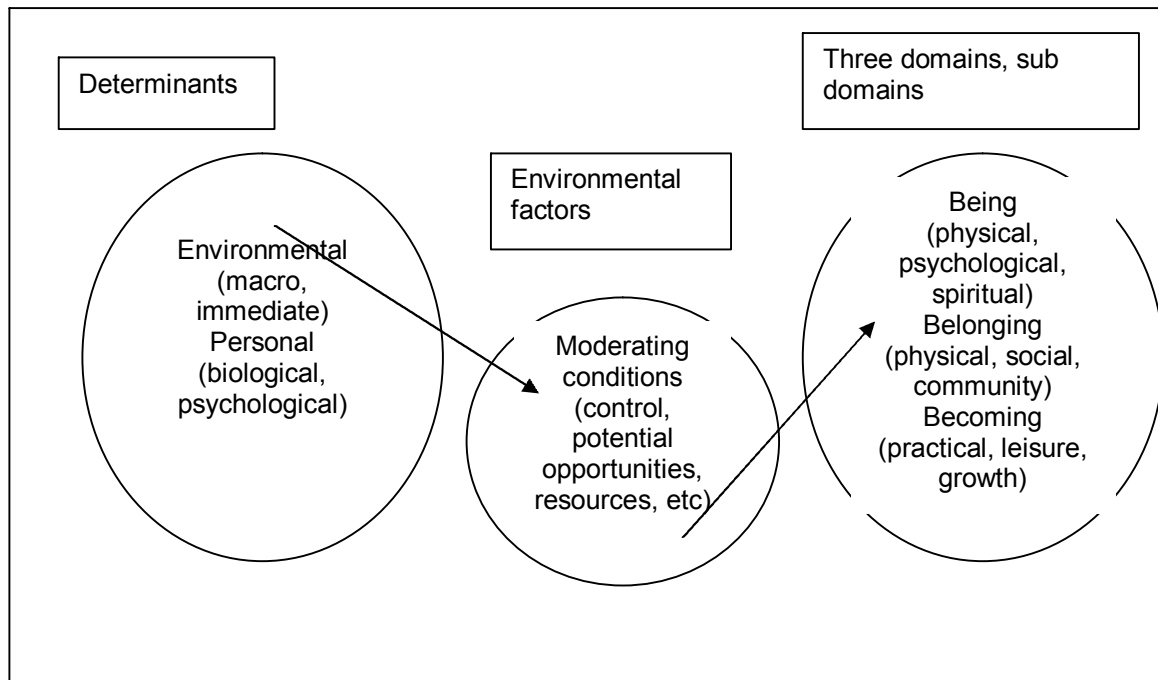
The Centre for Health Promotion studies in Toronto has devised a number of self-report measures based on this model, for use with specific populations, for example young persons, persons with a disability and older people ('Seniors version'). The Seniors measure has been psychometrically validated and may be used for screening purposes (Raphael, 1995).

The approach is broadly positivistic, includes both objective and subjective assessment, and distinguishes between determinants, moderators and outcomes in Quality of Life study. The approach is distinguishable from those taken in the medical field in that it is not applied in a post-event situation. Its practical applications are more in the realm of social diagnosis, or in design of environments to generally promote life quality and health, and in the holistic understanding of the term.

Table 2.1: Principles underpinning Toronto Quality of Life model

Quality of Life is a multidimensional construct
Every individual is biopsychosocial in nature (i.e. has physical, psychological and social aspects) and is in continual interaction with their environment
Because Quality of Life arises out of this complex person-environment interaction, a holistic approach is necessary for understanding it
The components of Quality of Life are the same for people with and without disabilities
Quality of Life is a dynamic constellation of interacting components. Thus it can change for individuals over their lifetime
Although the basic components of Quality of Life are the same for all people, the meaning attached to Quality of Life will differ to varying degrees from one person to another. This is because individuals attach differing relative importance to the basic components of Quality of Life and have differing opportunities/constraints within their lives.
Quality of Life takes account of the health of the individual, assuming a broad definition of health (e.g. World Health Organisation, 1946) and a social model of health
The perspectives of the individual are important in understanding their Quality of Life.

Figure 2.1: Toronto Quality of Life Model



2.2 Quality of Life of Older People

Older people are receiving increasing attention within Quality of Life research, no doubt driven in part by expectations of increased numbers of older people in the population coupled with concerns about the costs of service provision in this respect (Bowling *et al.*, 2002). Medical approaches, which stress functionality and are underpinned by pathological and ageist assumptions are still dominant (Walker, 2004). More recently, comprehensive approaches have found voice in the literature, drawing on personal histories and older people's own constructions of what gives or detracts from quality in their lives. These approaches have greater potential for promoting healthy ageing. The EQUAL initiative, within the seven-year Growing Older programme in the UK is a good example, focusing as it does on prolonging activity, participation in society and quality of life in old age (Walker, 2004).

Studies that have employed global self-rating scales of Quality of Life have been used to compare total scores with other population groups, or to explore relationships with demographic variables. Such studies demonstrate social class, age and gender effects. Social class does bear a negative relationship

with Quality of Life, although it does not display a strong relationship consistently (Smith *et al.*, 2004). Farquhar (1995) demonstrated that social deprivation does lead to poorer overall Quality of Life scores, but is probably confounded by age: for example 25% (of 85 yrs+) and 6% (of 65-84yrs) of samples in an area of high deprivation in the south east of England rated their Quality of Life very negatively, compared to 3% (of 65-84yrs) in a middle income area. Higher ratings of life quality are associated with higher educational attainment (Sheily and Kelleher, 2004).

Studies have explored the determinants of Quality of Life in various ways. Two methodologies predominate - identifying the variables (objective and subjective) that correlate with scores on Quality of Life measures, and qualitative studies, which employ interviews, from which key themes emerge. Even with these two very different methodologies, the determinants of Quality of Life in older people are fairly consistent across studies (see Table 2.2).

While health is important to older people in constructing and articulating their ideas about life quality, it is evident that there is more to Quality of Life than health (Bowling *et al.*, 2002, Hendry and McVittie, 2004). The need for broad based investigations, encompassing all aspects of life, not just those related to service provision, is abundantly clear from these studies. While determinants such as social relationships of finance are typically listed as 'separate' determinants, it is evident that they are interactive and dynamic. This interlinking of different realms of experience is not unsurprising but does have implications for the creation of measurement instruments that are rarely developed to capture the organic and overlapping nature of the construct (Hendry and McVittie, 2004). Qualitative methods hold more promise in this respect.

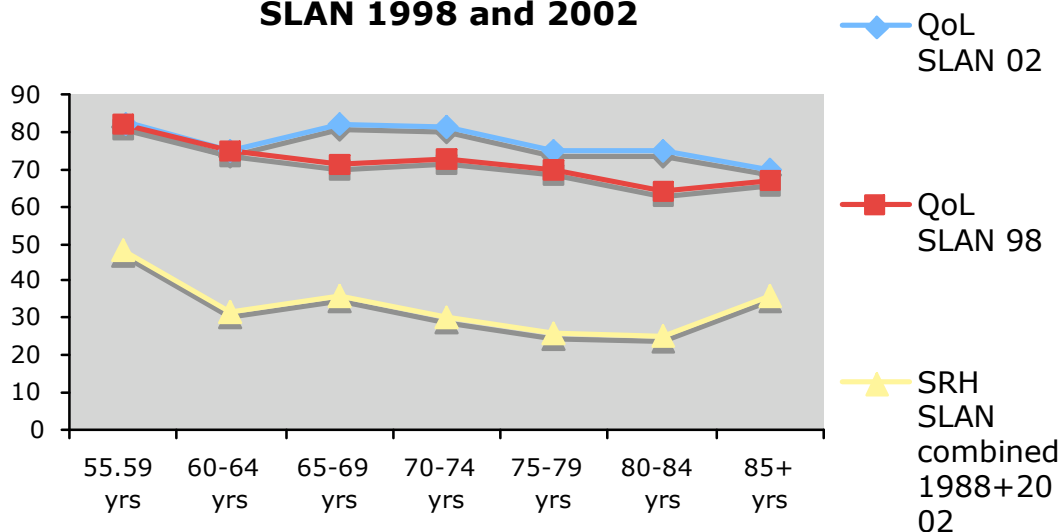
Table 2.2: Summary of studies exploring Quality of Life in older people

Farquhar, 1995	Gabriel and Bowling, 2004	Wilhelmson et al., 2005	Murphy et al., 2007		Bowling et al., 2002	Smith et al., 2004	
<i>QoL themes emerging from interviews (UK) in order of frequency of mention</i>	<i>QoL themes emerging from interviews (UK) in order of frequency of mention</i>	<i>QoL themes emerging from interviews (Scandinavia) in order of frequency of mention</i>	<i>QoL domains emerging from interviews (Irish older people with a disability)</i>		<i>Independent predictors of global QoL using regression analysis (UK)</i>	<i>Independent predictors of Life Satisfaction using regression analysis (UK residents, deprived areas)</i>	
Family	Social relationships with family, friend, neighbours	Social relations	Health		Social comparison and expectations	Loneliness	
Activities	Home and neighbourhood	Health	Environment		Personality and psychological characteristics	Perception of own health	
Other social contacts	Psychological well-being and outlook	Activities	Sense of Self		Health and functional status	Feeling isolated from society	
Health	Social activities and hobbies	Functional ability	Social connectedness		Social capital	Ability to manage financially	
Material circumstances	Health	Living in own home	Income			Satisfaction with neighbourhood	
	Financial circumstances	Personal finances				Perception of poverty over time	
	Independence	Personal belief and attitudes				Satisfaction with accommodation	
						Community integration	

2.3 Quality of Life of Older People in Ireland

There is no evidence at the present time that Quality of Life for older people in Ireland is very different to that of older people in the UK, or elsewhere. Quality of Life has increased for older people between the two National Lifestyle Surveys (which employed a global self-rating scale) with 73.3% reporting good or very good Quality of Life in 1998 and 78.1% doing so in 2002 (Sheily and Kelleher, 2004), consistent with the level reported in the HeSSOP 1 study (78%) (Garavan *et al.*, 2001). Further, there is an age effect, with people 55-59 reporting higher level of life quality, although this effect disappears at very old age. There were no gender differences in the 1998 survey, although in 2002 women rated their Quality of Life significantly better than men. Interestingly, Quality of Life is rated considerably higher than health, indicating that these are two different constructs. While Quality of Life ratings decrease slightly over 80 years, self rated health (SRH) rating actually rise to the same level as 20 years previously (see Figure 2.2) (Sheily and Kelleher, 2004).

FIGURE 2.2: Percentage reporting good/very good Quality of Life SLAN 1998 and 2002



McGrat Source: Sheily and Kelleher, 2004 and interview data on a small sample of older people in the West of Ireland, revealed determinants of life

quality consistent with those in international studies, with only two themes not apparent elsewhere: ageism and fear of institutionalisation. In this context, it is worth noting the finding of Garavan *et al.*, (2001) that while older people have clear preferences and ideas about long-term care, very few have articulated these or discussed them with family. More recently, Murphy *et al.* (2007) have explored quality of life in older people with a disability in Ireland. Again, similar domains emerged in this study (see Table 2.2).

A study on Quality of Life of Older people in Long-Stay Settings in Ireland included a qualitative study of resident and staff perceptions of Quality of Life in long-stay settings. Four themes were identified, two of which (personal identity, connectedness to family and community) related to less tangible, broader environmental factors in determining life quality for residents (Murphy *et al.*, 2006).

Quality of life research has important potential for optimising the ageing process (Raphael, 1996). 'Healthy ageing' is the term used to describe health promotion policies for older people. It is concerned primarily with increasing the quantity and quality of life of older people. A survey of over 300 healthy ageing projects around the country (O'Shea, 2003) found that almost half were social in nature (social interaction, public attitudes, retirement issues and income support); 20% focused on lifestyle and behavioural issues (physical activities, smoking, drinking, nutrition and diet); 17% projects related to physical environments (transport, housing, security). Additional projects focused on specific diseases (10%) and accidents and suicide (6%). Findings from this research suggest that current policy needs to be re-adjusted in favour of greater public support for projects in the social environment (O'Shea 2003). The area of social interaction and integration and the needs of those living alone and rural older people were ranked as priority areas for further work if additional funding were made available (O'Shea, 2003).

2.4 Determinants of Quality of Life in older people in Ireland

Key determinants of Quality of Life of Older people will now be considered. For each determinant, the main findings in the literature will be reported, a critique of policy interventions will be provided where possible, and the particular case of older people in poverty will be explored. Although income is clearly a monetary aspect of life quality it will be presented first in order to provide a context for exploring the non-monetary aspects of life quality for those older people living in poverty.

2.4.1 Income - Older People in Income Poverty

Having enough money at the least for basic requirements, and the freedom not to have to worry about money is an important determinant of Quality of Life of older people (Bowling et al., 2002; Gabriel and Bowling, 2004) and particularly so for older people in deprived neighbourhoods (Smith *et al.*, 2004). The interactive nature of the various determinants of Quality of Life is well demonstrated here, with money not only permitting basic material necessities, but also enabling participation in life generally, attending social events, or purchasing practical help (Gabriel and Bowling, 2004). Money is important in defending against being dependent on others and facilitates social contact through activities and events.

It is therefore disturbing to find that older people are a population group at greater risk than other population sub-groups for income poverty. The situation has been assessed at EU level, revealing that about 13 million older people are at risk of poverty in the 25 member states. Ireland has the second highest poverty risk rate³, at 21 percentage points above the EU-15 average.⁴ Further, using EUROSTAT indicators only Ireland and two other countries experience income poverty rates for older people twice as high as for the population aged 16-64 (Zaidi, 2006).

Layte *et al.*, (1999) drew attention to the seriousness of older people's

³ Terminology used by Zaidi (2006) to mean 60% of median income poverty threshold

⁴ Based on EUROSTAT data. Figures are not easily comparable to Irish data.

poverty-risk in Ireland in 1999, reporting that 'considering solely income, the position of the elderly population has worsened dramatically since 1987, relative to the non-elderly' (p.6). At this time just one third of older people were living in income poverty, and this figure rose to 44.1% in 2001. The most up-to-date data on poverty in Ireland is contained in the results of the recent EU Survey on Income and Living Conditions (EU-SILC) for 2005, published by the Central Statistics Office (CSO) in November 2006. Although still higher for those over 65 years than for other sub-groups, relative income poverty has decreased for older people since 2003, and especially between 2004 and 2005, bringing it closer to, but still higher than income poverty rates in the total population. Older rural dwellers, older women and most particularly, those living alone are at greater risk (Prunty, 2007) (see Tables 2.3 and 2.4).

Table 2.3: Income Poverty Rates General Population and Over 65s

	2003	2004	2005
General population (all)	19.7	19.4	18.5
Children	21.0	21.2	21.2
15-64 years	17.6	17.6	17.4
Over 65s	29.8	27.1	20.1

Based on EU SILC data, CSO (2005, 2006)

Table 2.4: Gender, dwelling and living alone Income Poverty Rates

	2003	2004	2005
All Over 65s	29.8	27.1	20.1
Males/Females	26.4/32.3	25.8/28.2	20.3/19.9
Urban/rural dwellers	-	21.5/33.2	-
Lives alone/not alone	-	37.1/21.4	-

Based on EU SILC data, CSO (2005, 2006) and Prunty (2007)

The heavy reliance of older people on the state pension is clearly a feature of this inequitable situation. Only one third of older people have an occupational

or private pension (Stratton 2005), and if no account was taken of social transfers the income poverty rate for older people would be 88% (CSO, 2006). Analysis of rates of pay for the State Pensions vis-à-vis poverty thresholds, where available, reveals that pensions consistently fall below the threshold (see Table 2.5). The reason why many older people do not experience income poverty is due in part to the various secondary benefits such as a medical card, electricity and telephone allowances and free travel that supplement the basic pension payments.

Table 2.5: Payment rates of State Pensions vis-à-vis Poverty Thresholds

Year	Highest rate State (Contributory) pension	Highest rate State (Non-Contributory) pension	Increment for 80+ years	Poverty threshold	Difference Contributory rate and poverty threshold	Difference Non-Contributory rate and poverty threshold
2003	157.30	144.00	6.40	175.77	-18.47	-31.77
2004	167.30	154.00	6.40	185.51	-18.21	-31.51
2005	179.30	166.00	6.40	192.74	-13.44	-26.74
2006	193.30	182.00	10.00	Not available		
2007	209.30	200.00	10.00			

Those on State Pension (Contributory) fare better than those on State Non-Contributory pensions. This was recently demonstrated in the findings of a study employing a consensual budget standard methodology⁵, which found that, within older person household income scenarios (couples and lone pensioners, on Contributory and Non-Contributory pensions, with and without a car) the only couple income scenario where the income was higher than budget costs was a couple on a Contributory pension without a car (VPSJ, 2006).

⁵ People living in various household types, together, through a series of focus groups, develop budgets for food, household good, fuel etc., based on their own experience (Minimum Essential Budgets). This is then considered against real income, based on objective welfare payment data. For further information see VPSJ, (2006)

When income is divided into deciles (ten groups each containing an equal number of persons) and labelled according to average weekly household income, 7.5% of older people were in the lowest decile, and over half of all older persons in the second and third lowest deciles, indicating that almost 60% of older people have incomes below or very close to the poverty threshold. This compares to only 30% in the general population.

Pension policy and social welfare policy are relevant to address income poverty, and subsequent Quality of Life of older people. Pension policy in recent years has been characterized by a drive to increase reliance on privately funded pensions, and in particular voluntary/individual pension arrangements (Stewart, 2006). This is evident in the introduction of Personal Retirement Savings Accounts (PRSAs) and on-going tax relief on both PRSAs and occupational pensions.

Personal Retirement Savings Accounts are a supplementary pension measure to assist in providing a retirement income close to pre-retirement levels. A PRSA is a contract between an individual and an authorised PRSA provider in the form of an investment account. The Pensions Board and the Revenue Commissioners are jointly responsible for the product approval process (The Pensions Board, 2006). Employers who do not operate a pension scheme are required to put in place arrangements for employees to access PRSAs on request.

Neither of these policy approaches is likely to reduce relative income poverty in older people or improve income inequity between older and younger people generally. With regard to PRSAs, Stratton (2005) reports that they have met with little success, being poorly incentivised and not mandatory on the part of employers. They are unlikely to substantially increase private pensions coverage among people on lower incomes, who realistically cannot put aside needed finance on a weekly or monthly basis. McCashin (2006) also draws attention to the possibility that the means test for the State Pension (Non-Contributory) may actually act as a disincentive, deterring people from embarking on a PRSA.

Tax supports underpinning occupational pensions are generous and now rival the costs of state pensions (McCashin, 2006). This strategy has not in fact increased private coverage for the majority of workers, as levels of coverage have changed little between 1985 and 2005 (Hughes, 2006). Tax reliefs clearly favour higher earners and thus contribute to rather than reduce current inequity.

With regard to income adequacy for older people, pension policy has not sought to substantially strengthen the state pension system, which it is argued, is required to create better living conditions and life quality. Costs to the exchequer are reasons given for the resistance to any measure other than traditional marginal increases in state pension payments. Yet we are not encouraged to look at the costs of state pension payments vis-à-vis the costs of lost revenue from tax relief on private and occupational pensions, which are in fact quite similar (Stratton, 2005). As such, pension policy is inherently inequitable, redistributing state resources away from the less well off, toward the better off who secure maximum benefit from tax relief (Stewart, 2006).

Social welfare policy measures have focused on increasing social welfare payments in real terms to allow an acceptable level of living relative to society. Successive budgets have contained marginal increases in the state pension, although these are highly unlikely to have a positive impact on poverty on old age (see Table 2.7). While personal rates of payment for state pensions have increased steadily and have reached the target of €200 per week, in 2007, as planned in 2002 (Department of the Taoiseach, 2002), this target is not particularly generous, given the consistent shortfall between pensions pay-out rates and the poverty threshold. Further, since this target was set based on 2002 estimates, it is fair to point out that it may be inadequate in today's terms. It is only €8/15 above the 2005 poverty threshold. According to Prunty (2007) the value of the pension has fallen relative to Gross Average Industrial Earnings in recent years, for example in 1987 the Contributory Pension was worth 38% of average earnings whereas by 2005 it had fallen to 31%. The commitment to increasing the level of the qualified adult allowance for pensioner spouses (*NAPS/incl, 2003-2005*) has yet to be realised, although the

latest NAPs commits to achieving this by 2009 (*NAPS/incl 2007-2016*). The new Social Partnership Agreement, *Towards 2016* which adopts a life cycle approach prioritises increases in income supports for older people, with the aim of providing an adequate income in retirement which, as far as possible, is related to pre-retirement income (Department of the Taoiseach, 2006).

2.4.1.1 Older People and Deprivation

The implications of living in or at risk for poverty are a complex and not solely monetary in nature. Consistent poverty, the official Government definition of poverty, measures income but also recognizes the enforced lack of non-monetary, material goods, in the form of an indicators of deprivation. This measure of poverty is thought to better capture the cumulative effects of poverty, by assessing whether people have certain items considered necessary to ensure a basic standard of living, such as a substantial meal for at least one day in the past two weeks, two pairs of strong shoes, a roast once a week, or a warm waterproof coat.

In contrast to their higher levels of income poverty, older people are less likely than other population groups to experience deprivation by this measure, both in Irish studies and in the UK (Layte et al., 1999; Prunty, 2007; Dominy and Kempson, 2006) (see Table 2.6). Within the older person population, gender differences in measures of consistent poverty are very small. There are significant effects however for education levels and living alone. Those living alone have a consistent poverty level of 5.3% compared to 2.2% for those living with others (Prunty, 2007)⁶.

Recently, in the light of the changing nature of Irish society a new set of deprivation indicators has been agreed. Older people have higher rates of deprivation on these new indicators, but are still consistently lower than other populations groups on each item (see Table 2.7).

⁶ All consistent poverty figures quoted are from 'Older People in Poverty in Ireland: An analysis of EU-SILC 2004' (Prunty, 2007) unless otherwise stated.

Table 2.6: Consistent Poverty Rates

	2003	2004	2005
General population	8.8	6.8	7.0
All Over 65s	5.8	3.3	3.7
Over 65 - Males /Females	*/6.7	3.8/3.0	3.6/3.8
Over 65 - Lower education/higher education	*	4.0/0.8	*
Over 65 - Lives alone/not alone	*	5.3%/2.2%	*

Source: EU SILC data, CSO (2004, 2005, 2006), Prunty, 2007.

* Data not available

Table 2.7: New Deprivation Indicators by Population Group

	Unable to.....				
	...keep house adequately warm	...buy presents for friends/family once a year	...replace worn out furniture	...have friends/family around for a drink once a month	...have an evening/afternoon out in past 2 weeks
0-14 yrs	4.2%	5.2%	17.9%	15.7%	Not available
15-64 yrs	3.1%	4.4%	12.4%	10.5%	8.3%
65+ yrs	2.8%	4.1%	11.4%	7.9%	5.1%

Source: EU-SILC 2004 data (Prunty, 2007)

Older people are also less likely than the 15-64 year population to have utility bills in arrears, to have burdensome debt repayments, to report great difficulty in making ends meet or to have difficulty with unexpected expenses.

One general area that older people are marginally more deprived in is saving

some income regularly, where 59.8% have difficulty with this compared to 58.9% of those aged 15-64.

Thus, older people generally appear to avoid the worst excesses of deprivation although the mechanisms by which they do so are unclear. Some light is thrown on this question in the work of Dominy and Kempson (2006) who report that under-identification of older people who say they go without things because they can't afford them is at least in part due to their having items even if not able to afford to purchase the items themselves (i.e. from another source), and an unwillingness to admit not being able to afford items.

Non-cash transfers and secondary benefits may also play a role in protecting older people although the difficulties imputing a cash value on these has been acknowledged previously (Layte *et al.*, 1999), and uptake may be less than complete, given that people must not only be aware of their existence but understanding of the often complex criteria that govern eligibility.

2.4.2 Social Relationships

Given the interactive and dynamic nature of the determinants of life quality it is not appropriate to select one determinant out as being of primary importance. Yet it is difficult to ignore the fact that when rank ordered for perceived importance, social relationships consistently receives high or highest ranking (e.g. Farquhar, 1995; Bowling *et al.*, 2002; Gabriel and Bowling, 2004; Wilhelmson *et al.*, 2005), and when compared in terms of the degree of correlation with Life Satisfaction measures, 'social relationships' typically has a strong relationship (Smith *et al.*, 2004). Social relationships refers to contact and interaction with family members, friends and neighbours, opportunities to engage with others and both accept and give social support. Contact and connectedness with family, friends and neighbours acts as an enabler of life quality and, conversely, loneliness and isolation act detract from quality of life. On entry to long-stay facilities, social interaction continues to be an important factor in Quality of Life (Kane, 2001; Age and Opportunity, 2003; Murphy *et al.*, 2006). Participants in the study on Quality of Life of older with a disability also identified social contact and social networks as important to their quality of life. In this study, participants noted with regret the demise of practices

such as 'visiting' which were seen to facilitate companionship, fun and social connectedness (Murphy *et al.*, 2007).

Getting out and about is also of fundamental importance to quality of life (Walker, 2006; Tracey *et al.*, 2005), as it facilitates social contact. Older people strive to maintain their independence and ability to get out and about (Holland *et al.*, 2005). Contact with family, friends and neighbours help sustain a sense of emotional well-being, through both the provision of companionship, information, practical support and the opportunity to reciprocate and provide care and affection. Activities with others provide cognitive stimulation and thus contribute to a sense of well-being. Movement and mobility and thus health and transport impact on getting out and about and thus social contact. Holland *et al.*, (2005) who have explored key studies within the UK Growing Older research programme describe getting out and about as crucial to facilitating a person's sense of their social world, and consequently to their quality of life (*ibid.*). The interactive nature of the determinants of life quality is well illustrated in this. Getting out and about, even within narrow geographic confines, is essential to social contact. Mobility is critical in getting out and about. Health or ill-health, in turn, determines mobility and movement. Access and transport are environmental determinants that interact with health factors.

The research literature on the topic of loneliness emphasizes that the constructs of social isolation, loneliness and the experience of living alone are not synonymous. Social isolation refers to the quantity of social contact in the community and can be objectively measured, while loneliness refers to the subjective experience of being without social interaction or companionship (Townsend, 1973). Measures of loneliness are more useful in the context of social relationships and life quality, as people can still experience this even with objectively indicated social contact. The two terms are often used interchangeably (Victor *et al.*, 2002) and older people themselves may not quickly differentiate the two constructs (Tracey *et al.*, 2004).

The view is widespread that older age is associated with loneliness although the evidence to support this is sparse. Consistently, about three quarters of the older person population report not being or never being lonely in UK

studies and this figure is fairly stable over time (*ibid.*). Irish studies report similar prevalence, with figures ranging from 14% (Commission of the European Communities, 1993), through 10% (Garavan *et al.*, 2001) to 7% (Power, 1980) reporting feelings of loneliness. In the most comprehensive study to date on loneliness in Irish older people, 10% report moderate social loneliness, and 7.2% moderate family loneliness (Tracey *et al.*, 2004). The majority of respondents in this survey had regular contact with friends, family or neighbours. Overall, 73.2% were in locally integrated support networks (*ibid.*) clarifying that older people in Ireland are not at any greater risk of social isolation than the national population (Fahey and Murray, 1994; Layte, *et al.*, 1999).

Although older people in Ireland are less likely to live alone than their EU peers (Layte *et al.*, 1999), 25.8% do so (Stratton, 2004). Living alone, while not synonymous with either social isolation or loneliness, is associated with both. Living alone is also associated with higher risk of income poverty and those in this situation are likely to be very needy in material, social and emotional terms.

Policy relevant to promoting social contact, addressing loneliness where it exists and reducing the risk of loneliness in the community include transport policy and supporting community involvement through community group activities.

With regard to private vehicle ownership, older people are less likely than younger adults to own a car, especially if they live alone (Holland *et al.*, 2005). While there are many reasons why older people choose not to own cars, finance is definitely an issue. Watson and Williams (2003) report that access to a private vehicle is a problem for many older people with 58% of households of one person 65 or over not being able to afford a car or van.

Public transport therefore is particularly important for older people. Poor local transport services detract from quality of life for older people (Gabriel and Bowling, 2004). A lack of efficient and appropriate transport systems, particularly in rural areas, can potentially impact in a positive way on

loneliness and social isolation. The introduction of the Free Travel Pass, during the 1970s, is a policy intervention of relevance. The Free Travel Scheme enables those who aged 66 or over and reside permanently in the state, to travel for free on both public transport services and the public transport services offered by a large number of private operators in various parts of the country. Certain incapacitated people can also get a Companion Free Travel Pass if they are medically assessed as unfit to travel alone. Recently the scheme has been extended to include travel within Northern Ireland. The Free travel scheme has the potential to enhance quality of life substantially for older people.

Yet to have effect local transport services need to be available and accessible. The evidence, however, is to the contrary. The need to improve access and the limitations of current supports with regard to the Free Travel scheme have been reported repeatedly (e.g. Brenner and Shelley, 1998; Ruddle *et al.*, 1998; Garavan *et al.*, 2001; O'Shea, 2003; Stratton, 2004; Murphy *et al.*, 2007). When asked to identify problems in their neighbourhoods, the problem most frequently mentioned by older people (25% of respondents) was poor public transport (Garavan *et al.*, 2001). Typically bus and train services are limited in rural areas. Similarly, Murphy *et al.*, (2007) found that for older people with a disability in rural areas, most had a travel pass but few had much use of it. In short, a free travel pass is of little use if the bus only comes once a week, if you live too far from the bus stop to walk, or if it cannot take your mobility aid.

Older people living in or at risk for poverty are particularly disadvantaged. For those that do own cars the associated costs put considerable strain on daily finances as evidenced by minimum essential budget study (VPSJ, 2006). For those that rely on public transport which is inadequate, the only alternatives are taxis or hackneys, which have no incentive to reduce fares for pensioners.

A policy that has the potential to address the limitations of the Free Travel Scheme is the Rural Transport Initiative (RTI). The RTI was launched in 2001, funded under the 2000-2006 *National Development Plan* (NDP) by the Department of Transport. The overall objective of the RTI is to address social

exclusion in rural Ireland. Its focus has, therefore, been to target the most vulnerable groups in rural society, including older people and to ensure that they are provided with effective access to services and social activities. The aim of the initiative is *"to encourage innovative community-based initiatives to provide transport services in rural areas, with a view to addressing the issue of social exclusion in rural Ireland, which is caused by lack of access to transport"* (ADM Ltd., 2002). The initiative aims at local participation both in relation to needs assessment and the use local knowledge and expertise in the development of public transport services. The use of free travel passes, on RTI assisted services, is central to its success in addressing social exclusion in that it enables equality of access for those who are less well-off. Findings from an evaluation of the initiative (pilot) indicate that older women are the most frequent users of the service (75%) and that shopping (61%) and leisure activities (34%) were found to be the main travel purposes of passengers. Pension collection and other services (21%) and health appointments were also identified as important uses. Users of the service cited independence and social contact as the most important impacts of the service on their lives (ADM, 2004).

Finally, facilitating community services and activities that would enhance socialization opportunities for older people has been recommended through the reduction in public liability costs for community groups for older people and a wider dissemination of information on grants and funds available for the development of such activities (Tracey *et al.*, 2004).

2.4.3 Well-being and outlook

Having a positive attitude, an acceptance of life and one's situation, realistic expectations, staying good-humoured, being optimistic all surface as determinants of Quality of Life of older people. On the other hand, negative feelings such as worry and fear (of ageing, loss of mobility, being depressed) have the potential to reduce Quality of Life.

According to Hendry and McVittie this is not just a passive determinant of life quality but is an active strategy that older people employ in order to 'manage' quality in their life as they experience it (Hendry and McVittie, 2004). It is

consistent with the finding that older people place importance on being optimistic and not 'feeling sorry for themselves'. For some, this in the context of past experiences, having memories of life before the welfare state, or the experience of war. It can include actively seeking pursuits that are thought to maintain mental agility (e.g. adult education classes, crosswords) and in short, is a coping strategy (Gabriel and Bowling, 2004).

It is not something that policy makers, as a rule address. Policies in the area of housing, health and welfare could be expected to have an indirect effect on this determinant of quality of life. At the present time we know very little about this determinant of life quality in Irish older people. This study will, in some measure, address this deficit.

2.4.4 Home and Neighbourhood

This determinant of Quality of Life refers to having good neighbours, being close to family, security, and being able to live comfortably in one's own home. Neighbours can provide practical help with lifts and shopping and this can often be reciprocated, perhaps through feeding pets or keeping an 'eye out' when people are away, thus minimizing feelings of dependence. It includes a pleasant environment to walk in or look out on, and access to amenities, and frequent, accessible public transport (Gabriel and Bowling, 2004). Having good neighbours facilitates security and perhaps mobility and therefore can play a role in allowing an older person to remain in their own home. Having one's own home is an important determinant of quality of life for older people (Gabriel and Bowling, 2004; Wilhelmson *et al.*, 2005).

Many aspects of both social and environmental policy have relevance for this determinant of quality of life - environmental planning, rural and urban development, local defence and housing. The following discussion will be confined to housing policy.

Owning one's home is not a priority issue for older people in Ireland, with home ownership within the general population (83%) and the older population (87%) being high by European standards (60% on average) (Stratton, 2004). Housing maintenance and comfort are really the key areas of concern

regarding this determinant of life quality in older Irish people. The 'downside of home ownership is that older people's houses tend to be older than the general housing stock and lack the facilities of newer homes' (ibid. p. 16). Older people, generally, are at greater risk than other population groups for housing deprivation, especially those in rural areas (Layte, *et al.*, 1999; Prunty, 2007), on each of six housing deprivation indicators (see Table 2.8). When asked what they liked least about their accommodation, the greatest cause for dissatisfaction concerns the condition of the dwelling and problems regarding maintenance (Stratton, 2004).

Table 2.8: Housing Deprivation by Age Group

	Bath/ shower	Central heating	Hot Water	Running water	Damp walls	Too dark	Toilet
0-14 yrs	.4%	6.7%	.9%	.6%	13.1%	6.9%	.4%
15-64 yrs	1%	7.6%	1.5%	.9%	13.2%	6%	.6%
65+ yrs	2.5%	17.7%	4.2%	1.3%	15.5%	5.4%	1.2%

Source: EU-SILC 2004 data (Prunty, 2007)

Stratton's analysis of housing policy in Ireland points out that local housing authority strategies are mainly concerned with issues of supply and demand, and therefore can miss out on the needs of older people who wish to remain in their own homes, but require assistance with repairs. Various housing supports are in place (see Table 2.9) and while these effectively target those who are deemed to be of limited means, the absence of information is a problem for older people in availing of the schemes (The Equality Authority, 2002). The application process itself can be difficult to manage for older people and the grants are based on restricted, annual budgets that rarely meet demand. Housing needs will not be met if one fails the means test. As a consequence those with needs but still not in a position to pay for repairs maintenance or adaptations may remain disadvantaged, with a resultant impact on health, independence and Quality of Life. Stratton concludes that housing supports should be proportionate to needs (Stratton, 2004). Consistency in

administration, and the extent to which schemes dovetail with each other, has also been raised as an issue (NESF, 2005).

Even for those who secure grant assistance, related issues such as accessing and dealing with tradespersons and security are not explored in the literature, nor addressed by policy makers. New measures for addressing housing need in older people include protocols for interagency collaboration in housing where there is a care dimension and proposal for improved targeting (NAPS/Inclusion, 2007-2016) are unlikely to fully address this need.

Table 2.9: Summary of Housing Supports available to Older People

Support	Administered by	Conditions
Social and affordable housing	Local authority	On housing list, satisfies a means test, unable to secure a commercial mortgage
Rent Supplement	Dept Social and Family Affairs	Living in private residential accommodation and unable to provide for the cost of n accommodation from their own resources
House Improvements Loan	Local Authority	Income limits apply, Maximum €20,000
Grant for Home Improvements/Home Improvements Scheme	HSE through local health office	Based on approval by an Occupational Therapist, for disability-related adaptation. Up to 90% of coat of adaptation for private housing, 100% for local authority housing
Essential Repairs Grants	Local authority	Maximum €9,530
Home Improvements Scheme	Task Force on Special Housing Aid for Elderly (Regional Health Authorities)	
Household Benefits Package	Dept Social and Family Affairs	Over 70 or under 70 and in receipt of state pension and living alone. ESB/Gas, telephone and TV license allowance
Fuel Scheme	Dept Social and Family Affairs	Living alone and Income limits apply
Home insulation	Dept of Environment and Local	Living alone Assistance with insulation of doors, windows and attics

	Government through Energy Action	
--	--	--

Source: Stratton, 2004

2.4.5 Independence, Health and Access to Health Services

Health, and in particular mobility, is clearly a particularly important factor in life quality. Perceiving one's health to be good will in and of itself enhance psychological well-being. Poorer health may reduce mobility, functional ability, independence and, in turn, mental health (McAvoy, 2001). The physical and mental health of older people in Ireland has been described in detail elsewhere (e.g. Fahey and Murray, 1994; Keogh and Roche, 1996; Brenner and Shelley, 1998; Layte, *et al.*, 1999; Sheily and Kelleher, 2004). In short, life expectancy has improved for older people in Ireland steadily from 1950 to the present time, although life expectancy at 65 it is still lower than the EU-25 average (O'Shea and Conboy, 2005). In 1997 life expectancy for older people in Ireland was lowest in the 15 EU countries (*Quality and Fairness*, 2001) for both men and women. In a healthy life expectancy survey, Ireland was ranked 22nd for males and 23rd for females out of a total of 23 countries surveyed, in terms of time spent in poor health (WHO, 2001).

The principal causes of death are cardiovascular disease, cancer and respiratory disease. Although a majority of older people do not suffer from chronic illness, certain illnesses are more common in old age, for example Diabetes, Arthritis, Osteoporosis and Parkinson's disease (Brenner and Shelley, 1998). Almost one quarter of Older Irish people experience depression, and 5 - 6% of those over 65 experience dementia (Keogh and Roche, 1996). The suicide rate has increased in both the general population and for those over 65 (Brenner and Shelley, 1998). Approximately one third of older people rate their health as excellent or very good (Sheily and Kelleher, 2004).

Key policy initiatives with regard to health of older people include general health service policy and other policy initiatives that indirectly affect the wider determinants of health. Health service policy will be considered here. As it happens, most policy specific to older people in Ireland has been, essentially, health service policy. For example, the 'basis of official policy' for older people in Ireland, according to O'Loughlin (1999) is the report *The Years Ahead - A Policy for the Elderly* (1988). The main focus of *The Years Ahead* is to enable older people to live in dignity and independence in the community where possible and to ensure adequate and appropriate care in

an environment close to their home. This commitment persists throughout subsequent health policy documents in respect of older people through to the current national health strategy, *Quality and Fairness - a Health System for You*. *Quality and Fairness* promises an action plan which focuses on a co-ordinated approach to meeting the needs of older people, as well as attention to eligibility for long-term care and the operation of subvention schemes (*Quality and Fairness*, 2001).

With regard to community and primary care, the GP is a pivotal health professional for older people (Garavan *et al.*, 2001) and community based social care services such as home help and meals-on-wheels play an important role in maintaining health, independence and psychological well-being. Both the review of the implementation of *The Years Ahead* (Ruddle *et al.*, 1997) and a recent report of the National Economic and Social Forum (2006) notes that this key policy objective of successive Governments, to keep older people living independently in their own homes and communities for as long as possible, has not been reflected on the ground. This is due mainly to 'an under-developed community care system that does not afford older people independence or autonomy' (NESF, 2006, p.iv). The Home Help Service is a case in point. Without any clear legislative entitlement to basic services necessary for living in the community (as exists for GP and hospital based services), it is unlikely that adequate funding will be provided (Lundstrom and McKeown, 1994; The Equality Authority, 2002). Just under 10% of older adults take advantage of home help services, compared to 13% in the United Kingdom. Clearly, the provision of important services such as home help and home nursing are needed on a much more comprehensive level than currently exists, in order to offer older people a real choice in terms of continuing to live in their own homes.

Day centres can provide a range of benefits (social; psychological; physical) to older people. They may act as significant social outlets for older people who might otherwise have very little social contact (Equality Authority 2004). Day centres can also be an important central source of information of relevance for older people. Typically, transport services are provided for access to the

centres, although in rural areas, older people may have to depend on local transport, which may limit access (Ruddle *et al.*, 1997).

With regard to older people living in or at risk for poverty, the link between poverty and ill-health is well established. Substantial health inequalities, favouring those in higher income and educational groups, have been reported in terms of both health behaviours (SLAN, 1998, 2004) and a range of mortality and morbidity indicators (IPH, 2000). Older people in poverty are more likely to have a chronic illness and to report that their activities are limited by a health problem (Prunty, 2007). Negative relationships between social deprivation and a range of health indicators, as well as general quality of life within the population of older people have been reported (Sheily and Kelleher, 2004). Specifically, higher income is associated with higher levels of self-rated health, lower levels of mobility limitation due to ill-health, and physical activity. Higher educational attainment is associated with higher self-rated health and better nutrition.

A key policy initiative in respect of older people in poverty is the availability of the medical card. The medical card entitles holders to free GP services, prescribed drugs and medicines, public hospital services, dental services, optical services, aural services, maternity and infant care services and a range of community care and personal social services. The medical card is means tested, with weekly income limits (€184.00 for a single person, €266.50 for a married couple) in place. Older people below the agreed income limits have been eligible for medical cards, since their introduction in 1970. However since 2001 eligibility has been extended to all persons over the age of 70. This means, in effect, that only those between the ages of 65 and 70 and just above the income threshold, will be disadvantaged in respect of financial barriers to primary care.

Since GP services are particularly important for older people, reducing financial barriers is a significant policy intervention. Older people living in poverty should not be disadvantaged with regard to access. However inequalities may still persist. According to Garavan *et al.*, (2001) direct personal payments,

made for services actually covered by the medical card were reported by older people, and this tendency has increased between the first and second HeSSOP studies (O'Hanlon *et al.*, 2005). Clearly, broader cultural factors in part override policy implementation on the ground, in this case with a negative impact for poorer older people.

Regarding acute services, while entitlement is not, theoretically, an issue, older people have been highlighted as suffering disproportionately from the shortfalls in Accident and Emergency services. One in ten older persons visited A & E in one year (O'Hanlon *et al.*, 2005) and Wren and Tussing report that it is common for those 'of advanced age to spend up to five days on trolleys' (Tussing and Wren, 2006, p. 218). Further older people have been victims of the prejudice seen in the characterisation of older patients as 'bed-blockers'. It is well acknowledged that within the two-tiered health system, those who can afford private insurance can purchase more rapid access to specialist care. Older people are less likely to have private health insurance (48% of those over 65 years of age, compared to 60% of those between 45 and 64 years of age) (Tussing and Wren, 2006).

2.6 Chapter Summary

In this chapter the definition and measurement of Quality of Life has been explored. The Toronto model, which underpins this study is outlined. A summary of the literature pertaining to quality of life and older people is provided, highlighting the main determinants of life quality that have consistently emerged across studies on differing populations and employing differing methodologies. The determinants (income, social relations, well-being and outlook, home and neighbourhood, independence, health and access to health services) are then explored in respect of available information on older people in Ireland. A critical appraisal of key policy interventions, with a particular focus on older people living in poverty is included.

Chapter 3

STUDY DESIGN AND METHODS

3.1 Introduction

This research sought to identify and explore non-monetary factors that affect the quality of life of older people living in poverty as described by older people, to examine how well existing policies are working from the perspective of older people and to make recommendations for policies which will enhance the quality of life of older people in poverty. The study employed qualitative methods.

3.2 Qualitative methods

Both poverty research and quality of life research draw chiefly on quantitative data. While providing important information regarding levels and trends, 'hard' data does not explore and expose the complexities of people's lives. Qualitative research, being concerned with 'the way in which people being studied understand and interpret their social reality' (Bryman, 1988, p. 8) is more likely to address this deficit in research. There is a need to conduct studies which yield a broader understanding of the experiences of older people who are at risk for poverty, taking into account the actual experiences of people as they live their lives on low incomes, their perceptions of their ability to manage money, the significance of other welfare benefits and the extent to which appraisals of quality of life are linked to attitudes, past experiences and expectations. In this way the context of the relationship between the individual and society, which is important in quality of life studies with older people (Bond and Corner, 2004), can be explored. Qualitative methods are better placed to capture the dynamic interplay between the various determinants of life quality highlighted by Hendry and McVittie (2004).

3.3 Interviews

The interview is the most widely used method of generating data in qualitative research (Nunokoosing, 2005). The basic principle of interviewing is to provide a framework within which respondents can express their understanding in their own terms (Patton, 2002). Interviews range from totally structured to totally unstructured. These are described as follows;

...at one extreme we have the fully structured interview, with predetermined set questions asked, and have the responses recorded on a standardized schedule (effectively a questionnaire where the interviewer fills in the responses), through semi-structured interview, where the interviewer has worked out a set of questions in advance, but is free to modify their order based upon her perception of what seems most appropriate in the context of the 'conversation', can change the way they are worded, give explanations, leave out particular questions which seem inappropriate with a particular interviewee or include additional ones, to the unstructured (completely informal) interview, where the interviewer has a general area of interest and concern, but lets the conversation develop within this area". (Robson, 1999, p. 231)

Previous studies exploring quality of life in older people have employed both semi-structured (Smith *et al.*, 2004, Noone, 2004; Wilhelmson *et al.*, 2004; Moriarity and Butt, 2004; Hendry and McVittie, 2004; Scharf *et al.*, 2003; Murphy *et al.*, 2007) and unstructured (Farquhar, 1995; Gabriel and Bowling, 2004) interviews.

The main advantages of employing a semi-structured interview are that the instrument permits the researcher to address a number of set objectives or topics, but permits flexibility in the ordering of questions or topics, and in making judgments about the appropriateness of certain questions or topics for individual interviewees. Semi structured interviews allow the researcher to keep the interview 'on track', while remaining flexible. This was the approach deemed appropriate here.

3.3.1 Study instrument

The interview schedule was developed by the research team using the Quality of Life framework developed by the Centre for Health Promotion at the University of Toronto in Canada (1996) with special reference to the measure developed especially for older people *Quality of Life profile: Seniors*. The framework sets out nine specific areas of life that are considered to be an important part of lives of all people within the three areas of Being, Belonging and Becoming (see Figure 2.1). These three areas were the main structural contribution to the interview. Thus, the data collection was consistent with a comprehensive approach to Quality of Life, taking the view that Quality of Life is a broad construct, encompassing happiness, life satisfaction and well-being. The interview schedule focused on the lived experiences of the older people in relation to their social, health and community support needs and experiences and their current housing conditions. Additional information for the instrument was included based on a review of relevant literature, in particular the work of Gabriel and Bowling (2004), Layte, *et al.*, (1999) and O'Hanlon *et al.*, (2005).

3.4 Sample

In qualitative research, the fundamental process of sampling is dependent on the selection of information rich cases (Patton, 2002). As such qualitative sampling strategies do not aim to identify a statistically representative set of respondents (Pope *et al.*, 2000). The focus is on purposefully selecting individuals (from the population of older people) that display important characteristics to be studied. For the purpose of this study, the sample comprised older people who are reliant on state pensions and live alone, in the 65-74 year old and the 75+ year's age groups. The sample included men and women in both urban and rural settings.

The method of sampling used is a form of purposive sampling known as maximum variation (Kuzel, 1992). This form of sampling deliberately includes varying phenomena that are based on prior knowledge of important

characteristics of the group. The aim is to be able to include participants from across a wide and heterogeneous group. Maximum variation sampling employs contrasting sampling categories, which are conceptually relevant to the research aim. This technique requires the establishment of a series of sampling categories and then employing a purposive snowballing technique to identify someone who meets the criteria for each category. In this way a diverse sample can be obtained, which although not representative in the statistical sense, permits the exploration and illumination of aspects of experience that is typically the objective of such sampling techniques (Minichellio *et al.*, 1995). The 'snowballing technique', a variation of purposive sampling is advocated when participants are not easily accessible (Holloway and Wheeler, 1996).

3.4.1 Sample size

In qualitative research, sample size is largely a function of the purpose of the enquiry, the quality of the participants and the sampling strategy used (Polit and Hungler, 1999). Morse (1994) suggests that from 30-50 interviews should be carried out. In order to meet the informational needs of the study as well as keeping with the designated timeframe of six months, the final sample comprised 40 older people who are living alone and are reliant on state pension, included men and women, both urban and rural dwellers and reflected a diversity of ages.⁷

3.5 Pilot

The interview schedule was piloted with three older people who met the participant profile (lived alone; receipt of the state pension and in the 65-74 or the 75+ age group). All attended a voluntary day centre in an urban area. None of the pilot participants took part in the general study. As the interviews for the overall study sample were to be conducted by 2 separate interviewers (A and B), each read through the interview schedule in detail and familiarised themselves with the appropriate prompts prior to conducting the pilot.

⁷ Forty two older people were interviewed but two interviews were disregarded, as it emerged in the course of the interview that the participant was not on the state pension (1) or not living alone (1).

Interviewer A sat in on the interview conducted by interviewer B and visa versa to ensure further standardisation of the interview process. Following each pilot interview, the participants was asked questions on the content and clarity of the interview and interviewers compared notes and discussed any changes that needed to be made, both to the content and/or the interview techniques. One of the interviews was transcribed to allow planning for transcription time and costs for the general study.

3.6 Ethical Considerations

Ethical approval was awarded by the National University of Ireland, Galway Ethics Committee. In keeping with best practice research guidelines, detailed *Participant Information* sheets were drawn up which detailed the purpose of the study, what was involved for the participant and emphasised the right to withdraw at any time. Confidentiality and anonymity was assured. All participants also signed individual consent forms prior to the commencement of interviews.

3.7 Participants

In both urban and rural locations, participants were accessed via a range of 'gatekeepers' from voluntary and statutory health and social service organisations. For ethical reasons it was not possible for the researchers to directly identify participants, nor for organisations to identify participants to the research team. For purposes of privacy, 'living in poverty' was interpreted in the study as being dependent on the State Contributory or Non-Contributory Pension. This allowed gatekeepers to identify potential participants without seeking further personal information. Gatekeepers were aware however of the overall context of the study.

In keeping with the informational needs of the study and the time limitations, a number of rural areas of the HSE West were identified and contact made with the Public Health Nursing Services and Community Care Services and.

contact details for a range of day care centres, social services and community based groups, working with older people, were provided, representing both the statutory and voluntary sectors. For urban participants, contact was made with HSE Community Development Projects and voluntary organisations in order to identify potential participants in a number of locations.

Initial contact was made with the Nurse Manager or Manager of the organisation and the purpose of the study explained, including the criteria to guide the selection of suitable participants. Information on the research project in writing and a copy of the Participant Information (PI) Sheet was then sent to the organisation. Organisation staff agreed to identify suitable participants and provide them with a PI sheet to read. In instances where the older person was unable to read the PI sheet, a member of staff read it on their behalf. Researchers followed up with the organisation after one week to confirm number of participants volunteering to participate.

3.7.1 Participant Profile

Forty valid interviews were recorded. The final sample is outlined in Figure 3.1. The gender ratio was determined as 24 female and 16 male, to reflect the higher proportion of older women living in poverty (Layte *et al.*, 1999). The participants ranged in age from 66 to 100. On balance there were more rural than urban participants and more participants over the age of 75, than under. Only two participants (male) were separated, and of the balance, 25 were widowed and 13 single. For those from rural areas, women were more likely to be widowed and men more likely to be single. More than half participants owned their own house, most particularly women. Eight participants were in social or voluntary housing projects, six of which were in urban settings (see appendix 1). Four participants were car owners, three rural and one urban.

Table 3.1: Sample

	Urban (n)	Rural (n)	Total
<i>Age group 1</i> <i>(65-74 years)</i>	F (4)	F (5)	9
	M (3)	M (3)	6
<i>Age group 2</i> <i>(75 and more)</i>	F (7)	F (8)	15
	M (3)	M (7)	10
Total	17	23	40

3.6 Data Analysis

All interviews were tape-recorded and transcribed verbatim. All members of the research team read through the transcripts. The first level analysis involved looking at common themes in the dataset, categorised by the Being, Belonging and Becoming framework (see Table 3.2 below). Second level analysis then identified overarching themes that emerged in the dataset. In keeping with the principles of qualitative research, the analysis did not seek to draw comparisons between different aspects of the sample (such as rural-urban or gender comparisons). Some general but non-exhaustive codes were developed prior to data collection through the specified aims and objectives of the research.

The basis of the process of data analysis in this study follows a general template analysis style (Miller and Crabtree, 1992). This involves the generation of themes, patterns and interrelationships in an interpretive process. A template or analysis guide (based on the interview schedule) was applied to the text. The template was derived from the a priori coding as well as theory, pre-existing knowledge and summary reading of the text. Application of the template is intended to identify meaningful units or parts. Several iterations of text and template took place until the point of data saturation was reached and no new revisions were identified.

Table 3.2: Three Domains and Nine sub-components of Quality of Life Field

BEING		
	Physical	<i>Body and health</i>
	Psychological	<i>Thoughts and feelings</i>
	Spiritual	<i>Beliefs and values</i>
BELONGING		
	Physical	<i>Where I live and spend my time</i>
	Social	<i>The people around me</i>
	Community	<i>Access to community resources</i>
Becoming		
	Practical	<i>Daily things I do</i>
	Leisure	<i>Things I do for enjoyment</i>
	Growth	<i>Things I do to cope and change</i>

(Adapted from Centre for Health Promotion, University of Toronto, 1996)

3.7 Authentication of data

In qualitative research, respondent validation or ‘member checking’ is used to compare the researcher’s account with those of the research participants in order to establish the level of correspondence between the two sets (Mays and Pope, 2000). Two validation exercises were set up, in both rural and urban centres where larger volumes of older people had participated in the interviews (total of nineteen persons). The exercises focused on validating the final themes from the dataset.

An urban Day Centre, through which some of the participants had been recruited, agreed to host a validation session. Six people whom had been interviewed during the data collection phase attended the session. In a ‘round table’ format, the researcher presented the key findings which had emerged from the interview data. As the findings were presented the group were asked their opinions on these, whether they felt that they were indicative of their experiences and whether they believed that the data accurately represented the general situation of older people. The participants engaged enthusiastically with the validation process and affirmed that the findings were robust. When asked to consider whether any important aspects were omitted from the findings the participants did not identify any gaps.

At the rural centre, none of the older people were able to participate on the day, due to illness on the day and changed circumstances since the original interviews were conducted. In this instance the overall findings were presented and discussed with a health professional who had acted as a gatekeeper, and had assisted with recruitment. Based on her experience with participants, she agreed that the findings accurately reflected the situation of older people.

Chapter 4

FINDINGS

4.1 Introduction

This chapter describes the findings from the interviews with older people. The findings are presented in five sections. In the following three sections (4.2 to 4.4) the key themes are presented within the Being, Belonging and Becoming framework which incorporate the nine areas of life outlined previously. Section 4.5 reports the findings for the overall influence on quality of life. Section 4.6 explores older people's perspectives on policy, both in summary and through employing three 'cases' in which interviewees gave explicit comments on the adequacy of policy interventions for older people.

4.2 Being

Findings in this section relate to the areas of physical wellbeing (health, mobility, and exercise levels), psychological well-being (worry/stress, self control, attitude towards life) and spiritual being (things to look forward to in life, feeling peaceful).

4.2.1 Physical Being

Most participants recounted health difficulties. These included cancer, diabetes, heart complaints, arthritis, hip replacements and depression. From any objective perspective, health is poor for the older people interviewed in the study. There were participants who acknowledged and lamented the health difficulties they had. Poor health detracted from quality of life in two ways; pain and discomfort, and the loss of function which in turn led to the loss of enjoyable pastimes. For example an 84 year old woman explained

I had my hip done three years ago I found it a little bit hard to walk I do, I don't go out much....I can't walk for too far..... I was alright until I had my hip done, my left hip done. I was fine up to that.

Urban female respondent, aged 84 years⁸

Another 66 year old who had had a stroke described her situation:

A year and four months over it. I spent eight months in the hospice and a year over in the hospital for the rest of the time..... Good and bad, I get good days, and I get very bad days, I get very depressed because I'm living on, trying to manage. Although I have a home help comes into me. They were supposed to give me someone who will come out and bring me for a drive, because I can't go out on my own....I'm on twenty two tablets a day. Eleven at night and eleven some in the afternoon.

Urban female respondent, aged 66 years.

She went on to explain how her life was affected by the stroke:

No, I don't go anywhere, not since the stroke. I used. I used to get on the bus, go into town, after my husband (died) the doctor told me to get out as much as I could. Now that has stopped. I'd go into town, spend most of my time looking around. Go in, meet somebody and have a chat with them. I can't do that now. Someone is after clipping my wings off. My wings are clipped.

Urban female respondent, aged 66 years.

Somewhat similarly, an 83 year old man described how an accident had affected his health and his life quality:

I got this bash with the car you know, that's what has me the way I am. She smashed my legs, I was eight weeks unconscious. Three years ago....Medical men and all said it was a miracle like. They couldn't explain how I came out. I can walk around the house maybe with the walking aid or crutches a small piece. I wouldn't be able to manage without the wheelchair, it's one of those

⁸ All identifying place names have been altered; e.g. named hospitals replaced with 'the hospital', and place names replaced with 'Ballytown'.

things. Getting out of my house now.....I get from the house to the car with the crutches you see and then I get in the car and they bring me to wherever I am going with them.There's nothing I can do about it. That's it do you see. Quality of life is gone and that's it. I'm a cripple in other words. And I was an active man in every way do you know. Destroyed. Destroyed my whole life.

Rural male respondent, aged 83 years.

Another lady who had broken her hand a year prior to the interview described her trips back and forth to the hospital, and how her injury prevented her enjoying a favourite hobby:

R: I broke this hand makin' a cup of tea twelve months ago and ah now it's grand to what it was. That's me wrist (shows interviewer) and I was only makin' a cup of tea. I tripped over the mat but I went out to the Hospital and they put wires in it and put the plaster. I went out after a fortnight - I was in for two days - went out after a fortnight, they x-rayed it. The wires were after breakin' and the fingers was gone so they x-rayed it again, the wires were after breakin' away. I had to go in at 8 o'clock in the morning and be operated on again. They rejoined the wires and let me again after another two days and then back for another x-ray. No the wires broke again. All the fingers - there were nothin' to hold the fingers, the wires or anything so I got in a plate so that was three times that they cut off all the plasters and put in a plate.

I: That must have been terrible for you?

P: The plate wasn't, no. I had no use in those fingers and I used to knit. I loved knittin', crocheting, embroiderin'. I loved all that but I have use back in those now (shows interviewer) but I have none in those, I can't knit any more because I can't hold the thread. Those little things, I used to make everything, Arans, crocheting, bed covers, covers for beds, everything, can't do that now....

Urban female respondent, aged 71 years.

Yet, not all described their health as poor. Participants were philosophical about their compromised health, pointing out that it could be worse. The sense was that a certain amount of disability and discomfort could be expected with age. The man who had become 'crippled' by the accident above reminded us:

However, sure we won't live forever. At eighty three I've the better part of it gone anyway. I'm lucky to live to that you see. Most of my contemporaries are dead. That's it.

Rural male respondent, aged 83 years.

Others were more generally accepting of poor health in old age:

I wouldn't say it's the very best, but what can you expect at eighty eight. I'm able to walk and I wouldn't do a marathon, but I'm able to get up and do the little things around the house, get my breakfast ready so I suppose I should be very thankful.

Urban female respondent, aged 88 years.

'Tis me own fault that it impairs my mobility with the emphysema, but it's me own bloody fault, with the smoking and I must say it's me own fault and I'm 75, not 21 any more. Like that annoys me when people, they expect to be fit till they are 110 like you know.....

Urban male respondent, aged 75 years.

A 70 year old lady who was a wheelchair user for three years and constantly in need of oxygen pointed out:

Gosh, if I didn't have the oxygen I wouldn't be able to breathe up to a couple of years ago. It fouls up your mouth your ears your nose, everything. But there are people worse off now.

Urban female respondent, aged 70 years.

Another gentleman was proud of his ability to survive an aneurism plus cancer twice, while another emphasised how a walking aid gave her independence.

Yeah, I've done very good actually yeah. They call me the bionic man actually, that's what one of the doctorscalls me, 'here comes the bionic man' (laughs), that's what he calls me!

Urban male respondent, aged 73 years.

The way it is is if I could walk like everyone else I'd have no problems but the health nurse – that girl comes down here and she got me a walkie and when I goes any place I brings me walkie so I's quite independent. I can do me own shopping – the walkie, now you know what it's like – it folds in and you can sit on the bus and come home.

Urban female respondent, aged 71 years.

The importance of mobility was evident throughout the interviews. When mobility was lost or compromised, participants noted this in negative terms.

I only, there is a stairs in the house that I'm selling at the moment, but I don't use the stairs. I do walk down the stairs alright but I find it very difficult to get up the stairs. So I'm kind of going to live on the flat, a bungalow.

Urban female respondent, aged 82 years.

I can't walk anywhere, here in fact, say walking around town and I'm tired in two minutes, just cannot get down town I can't come back up and especially with that hill.... but I'm bad on the legsit's arthritis I think.

Rural female respondent, aged 66 years.

Conversely, contributing to the 'philosophical' acceptance of health difficulties was the retention of mobility. Participants consistently described their health in the context of mobility. Great importance was placed on being able to get out, about, and around the house.

For me age, I'm not too bad...no major problems... I do walk alright

Rural male respondent, aged 81 years.

It's good (health) really, I've cholesterol and blood pressure and my eyes are not the best at the minute but I'm waiting to go in to see about those, I haven't any complaints. I can get around, I love to go for walks, I love to walk, I tidy my own house and I weed my own garden.

Rural female respondent, aged 79 years.

Participants were keen to take exercise, where possible or in whatever way possible. Examples were given of exercise undertaken as part of a day centre programme, or adapting exercise to physical limitations:

I have a broken collar bone. I can exercise my legs. Well when I'm in bed I go on my bicycle, keeping myself fit.

Urban female respondent, aged 88 years.

While two participants mentioned cycling short distances, walking was clearly the most favoured form of exercise. Even with some health difficulty, walking was possible with a stick. Other forms of exercise, such as yoga or aqua aerobics were mentioned but only by female participants.

Participants explained how they exercised to maintain health generally, or specifically to improve mobility.

Well, the yoga now I feel is very good because I fell you see and hurt my shoulder there. And as sure as God it's helping and that's the truth and that's a fact.

Urban female respondent, aged 90 years.

You know when you're walking up the stairs? Like this (demonstrates) like this and do this on the first and second step and eventually you'll get to the top of the stairs. Like to keep moving, don't do much sittin' down. If you sit down you'll only get stiff.

Urban female respondent, aged 71 years.

I collect the papers every day and walk there every day and back. Yeah. Five minutes there and five minutes back. Otherwise I never have pneumatic pains and my joints are perfect.

Urban male respondent, aged 75 years.

Exercise could also be part of an active strategy to maintain general well-being:

And I love to walk, you know walk to town too, unless I had to go home with messages, I have the car for that. I'm just on the road to Ballytown, about half a mile, so I try and walk in most days if I can just for the walk, as I say I don't use the old car at all only for to carry messages.....I'm alright like that, its great.

Rural female respondent, aged 70 years.

I walk, I do a good bit of walking, I always feel I have to get out at some time of the day to go for a walk, it could be this time of the day, it could be in the evening time or I could even go if the night was dry So I think that's what helps me to be keeping healthy too you know. And in the active retirement then we go every Tuesday to aqua aerobics, we go around half past 9, we get a bus down there so that's every, one day in the week like. And it might be an effort like to be organised and get there but it's worth it, after I feel it does me good.

Rural female respondent, aged 71 years.

4.2.2 Psychological Being

Participants identified a number of things that create sadness in their lives and that worry them. Sadness was almost exclusively discussed in the context of loss; particularly the loss of a spouse or a sibling. Loss was difficult to cope with and this was poignantly expressed by participants as follows;

R: Well, since M (wife) died, I changed completely like you know. Well I feel I sort of couldn't get over it really. Apart from that I'm doing all right you know but I never really got over it.

I: You were very close?

P: Yeah, but apart from that I'll be all right. I didn't get over it for some reason or other. I was bad for a couple of years. I was, I got a bad fit of depression and everything for years, but I came out of it.....Definitely, you know. That's the only thing.

Urban male respondent, aged 71 years.

Peaceful enough you know, not fully now but often times lonely and that, you'd be on your own, when you wouldn't have a family of your own to phone

you or ring you or anything like that, its hard really and then my brother, my youngest brother died a month ago, he was in America and he was to come home and he used to always ring me so often and advise me and talk about things and I miss him an awful lot, now I will miss him an awful lot because he was there in the background always, do you know what I mean....he wasn't married and he was to come home to live next year and I was looking forward to him being near me you know and buy a house somewhere around you know but all that is dead now.

Rural female respondent, aged 78 years.

Worries were described as part and parcel of everyday life and while participants admitted to worrying about many things, it was evident that they strove to maintain a positive attitude to life. Worries included the situations of various family members, their health, their children being 'well reared', or their work situations. Only one male participant discussed worries involving his family whereas several of the women discussed worries concerning their family members, for example a daughter whom had had cancer and another whose daughter had recently given birth to twins. Only one participant, an 82 year old widow, worried a lot about paying bills and managing money. Another, a 75 year old man living in social housing attributed the absence of worry to the fact that he could manage financially;

No, I do worry, about well I got a bill this morning from NTL for the television. And that bothers me, the last time I was up in the post office I didn't have the bill with me to pay x amount off it do you know what I mean, so it's built up and that bothers me. That's about it. I do worry about bills.

Urban female respondent, aged 82 years.

Generally speaking compared with what other people have to worry about, I don't have worries at all. I have no money burdens at all. I live according to my measure and I don't have any bills. I don't owe a penny and I don't have a car. I gave up the car. My clothes, I have enough clothes and I get the food here at a reasonable price and the rent is reasonable. Ah no, I don't have great worries at all.

Urban male respondent, aged 75 years.

The importance of striving to maintain a positive attitude was very evident across the data set. Participants described their efforts to be positive and stay positive. This was considered to be vital to a sense of well-being. For example the 82 year old lady above described how she 'managed' her bill worries:

I don't have control over bills. I will go to bed at night, I will sleep, as I say, if I'm going to worry, I'll worry tomorrow about it. Not going to worry tonight.

Urban female respondent, aged 82 years.

Others outlined broader approaches to maintaining well-being:

Not really, it's just not easy, you know. You're OK one day and part of the day and things will hit you in other parts but you have to fight it out and there's no other way out of out because you just can't sit down in the corner because if you do you're there and you won't get out you know ...

Rural female respondent, aged 72 years.

The way it is, I wouldn't go around with a long face on me. You have to make the best of a bad job and you can't go around moanin' and groanin' I'll settle for small things, like comin' down here, goin' to City House, goin' for the spins, goin' for me little drop.....Well there's no point in coddin' yourself about things.

Urban female respondent, aged 71 years.

This participant went on to explain how her faith assisted her in being positive and accepting the small and simple things in life. The 66 year old woman who had experienced a stroke, while acknowledging the importance of being an active manager of one's own well-being was not finding it easy to do so:

Well I've got to try and think positive because if I don't I'm going to go downhill again. Do you know what I mean? I push myself put it that way. I've got to. My family's away from me and I do get nervous living on my own.

Urban female respondent, aged 66 years.

4.2.3 Spiritual Being

While there was considerable variation across interviews regarding psychological well-being, participants were more consistent in their discussions of what they had to look forward to in life and whether they felt peaceful. Almost all participants claimed to be peaceful or at peace with themselves, and for most this was a positive state of affairs. One gentleman reported positively that he had "terrible peace", while another pointed out that:

If I were too peaceful I wouldn't like that because that means I would be lethargic about things. You must be a little passionate about things and I'm passionate about a lot of things.

Urban male respondent, aged 75 years.

An 82 year old woman described the source of her spiritual peace, although her physical health limited her ability to fully express this:

Yes I do. I do believe in God and I say my prayers and I don't get to mass because I can't walk very well, I'd have to bring a walking aid, and I don't like the walking aid.

Urban female respondent, aged 82 years.

The things that participants, particularly women, looked forward to were everyday activities such as family visits or day centre outings, weekends away with children or grandchildren, mass, shopping trips. The way in which the older people spoke of these events revealed their significance and their life-affirming nature. The men looked forward to family events but also sport and TV.

I look forward to my family coming. That's the main thing you know? They are very good to me. I look forward to seeing them coming. And they do come.

Urban female respondent, aged 84 years.

Well I look forward to them coming home on holidays and I look forward to going for a game of bingo or I look forward to quite a lot of things, like going in doing the bit of shopping into Ballytown, yeah.

Rural female respondent, aged 75 years.

I look forward to seeing my grandchildren, do you know? And seein' them getting on in life and that. They take me up, I've a son up in Co. D and I've a daughter up in K. They brought me up for the christenings and confirmations and that you know? So I, I get around you see. I look forward to them. Good power to them. Visiting and all that.

Rural male respondent, aged 83 years.

Few looked beyond the everyday events, with only one participant looking forward to 'heaven' and another accepting that death is in the future, and while it is not be something to look forward to, for him it is also represents the cycle of life.

4.3 Belonging

Belonging, according to Renwick and Brown (1996) is concerned with the fit between individuals and their various environments. It encompasses physical belonging, social belonging and community belonging.

4.3.1 Physical Belonging

Physical belonging refers to the relationship people have with their physical environments, including feelings of safety and privacy in their home and community. Rural participants mentioned a number of aspects of their physical living environment in positive terms; quietness, being in a country setting and convenience to facilities:

Oh it is, it's a grand spot, the view of the sea and the view of the mountains

Rural male respondent, aged 86 years.

I do (like living here) because its terribly convenient, you have churches, post office you've buses which is a great asset to me, getting a bus and I can go to Ballytown and see my sister and come down again, cost me nothing really and I spend a few days with her but that's how I find it, whereas if you were a few miles out you'd have to call a hackney to take you in. When you come off the bus you've no worry, just cross the road.

Rural female respondent, aged 72 years.

Generally participants felt safe in their surroundings. Factors that contributed to this were being in the countryside, perceiving the area to be low in crime, having and using door locks and the general area being well lit. There is a sense in the data that older people did not want to acknowledge any vulnerability, as opposed to having objective reasons for feeling safe. A 76 year old gentleman who used oxygen 16 hours a day and had no security or personal alarm tells us:

R: Oh yes, I never heard or seen anything wrong here. Well we have help here because/. we back on to each other so nobody can come in the back. Which is fantastic; yeah, yeah.

I: If anyone wanted to come in it had to be through the front?

P: Which would be very difficult as well wouldn't it?

Urban male respondent, aged 76 years.

This lady, a widow of 78 lives in a rural area. She sees no need to dispense with the practice of leaving her key in the door.

Oh I feel safe in it.....sure they're always at me, I never, rarely ever (go out to) put a key in the door, I have the key left in the door and they come in and someone would come in and say you have the key in the door again. And I said, if I hadn't the key in the door now how would you come in I said, you wouldn't come in to me and I wouldn't know there was anyone had come. But they said it's very, they're telling me, always warning me but thank god nothing happened yet anyhow.

Rural female respondent, aged 78 years.

Consistent with this few participants had security, smoke or personal alarms (see charts in Appendix 1). Smoke alarms were the most common, with just over half of participants (21) possessing one. Security alarms were the least common with only 8 in the sample, 5 of which were in the houses of women in urban settings. None of the rural women in the sample had a security alarm. Generally, however the women were more likely to have alarms. One lady who did not have a personal alarm did not see the need. Yet for others

there was uncertainty about how personal alarms are secured and how to arrange the process. Two participants asked the interviewer for one.

I don't know how would I... (go about getting a personal alarm)... I know...some of the people that has them and they'd say I should get it

Rural male respondent, aged 81 years.

Well if I could get one yes, I wouldn't mind, the sitting room now is the only place I have no smoke alarm, in the sitting room, but I would like some kind of, eh, you know, people break in, if you had some type of an alarm you know that...

Urban male respondent, aged 73 years.

Two participants mentioned the cost of the personal alarm, one unsure whether the cost was justified;

I think it was eighty euros the last time, I press a button if I needed something. But I never need it at all. It's there in the bedroom. I don't bother with it.

Rural male respondent, aged 83 years.

Supported housing seems to affords the greatest level of security:

'Tis great (security), 'tis great to know that there are wardens on, that you have security, that's something no matter how I agree with it or whatever, that you can get into your bed at night with an easy mind.

Urban female respondent, aged 70 years.

In terms of warmth, comfort and maintenance there was a lot of variation in participants' experiences. For maintenance, participants referred to help from family members such as sons and nephews, and occasionally tradespersons. While participants in the main expressed satisfaction overall with their living situations, there were a number of difficulties in relation to physical aspects of accommodation. Stairs for example could present a problem. One gentleman explained how he wanted to have a new toilet installed - outside - in order to avoid using the stairs during the day. Bathrooms presented others

types of problems; a low sink that over flows easily, and safe access to the bath or the shower. The two accounts below indicate the difficulties these participants had with their bathroom accommodation and subsequently with trying to get the necessary adjustments made. It appears that the cost of the necessary alteration was an issue one of these women.

Well I got the central heating in, I'd have liked a shower in but they never, I'm looking for it years. Oh yes, we'll come and do it and then they never come back. I got fed up. Yes.....they gave me a grant you know, it was the, what's the word? It was approved, but whatever the blooming fellas were to do, they never came back. My son said they have bigger jobs to do and they can't be bothered. Ah I said, Ah forget about it.I have a basin, that's all. What's the use in worrying? I kept myself clean all these years in a basin of water. What's the use? No use in worrying.

Urban female respondent, aged 90 years⁹.

Yes, well I don't need anything at the moment..... only the bath is the only thing, has me troubled, is to be able to get a shower. If I got into the bath - I used to always get into the bath, but as I got on in years, and was handicapped with my legs - I couldn't get out of it, and I have no one here to help me. My son put a bar on the side, but that wouldn't help me, it would bring me up but I might slip.... and even putting a chair in the bath wouldn't help me, I'd have to get it over the bath...we were in touch with them about it (installing a shower in addition to the bath) and it's not passed yet, the council I think it is, you have to make an application in. So they are up to look at it, the person was, and they said they have to wait and see if it's passed. Plans to do it. I think what they mean is, amount it's going to cost, you would have to pay a little yourself and they pay the balance.

Urban female respondent, aged 90 years¹⁰.

Another lady, 78, in a rural area had a very difficult time with flooding, and similarly, with local authority assistance:

I have awful flooding outside the house and I do be terrified of that, the last awful big floods was 7 or 8 years ago, it came into the house at 12 o'clock at

⁹ Respondent no. 10

¹⁰ Respondent no. 6

night and I had to get a lad, there was muck spreaders, oh there was a foot or foot and a half in the house, all the bottom of the house was destroyed and wet, ah it was destroyed and I had to get a man then in the middle of the night to siphon it away you knowI never got a penny, I applied for it and they told me that, one lad said to me I shoulda taken a photograph of it and I said how I could I take a photograph of the flood, in the middle of the night I said, that finished me then, I didn't go any further, I said I won't get anything out of it.... Yeah terrible hard, you can't really, its very hard for a widow to get anything.....

Rural female respondent, aged 78 years.

The other difficulty was with heating. Few older people admitted to have difficulty actually keeping warm in their house. They reported using either turf, central heating, gas or electric heaters. However 'heat rationing' strategies were mentioned, such as only heating the downstairs part of the house. Difficulty meeting costs was clearly an issue.

Ah yeah it's fairly warm. I heat it by coal. I have no central heating because I don't like central heating. Well it's cheaper than turf. Probably cheaper than oil. Well everything is expensive nowadays ...

Rural male respondent, aged 75 years.

A stove, I've oil, they put it in 5 or 6 years go, it was turf then and it was very hard to bring home the turf and put it into a shed and I'd have to do all that myself you know and then we put in oil. The oil is dear now, it's going up and up all the time you know but oil is in twice a year, I suppose it will be €800 or €900

Rural female respondent, aged 78 years.

The few who mentioned storage heaters seemed to have greatest comfort without burdensome expense. These participants were in either local authority, private rented accommodation or supported housing arrangements.

P: *'Tis lovely, 'tis beautiful. Ah 'tis lovely.*

Int: *And is it warm?*

P: *Yea. I have the storage heater on. The storage heater comes in at night time. They're great yea and when 'tis warm I leave the bedroom doors and doors open. Plenty of heat there. I don't mind the cold anyway..... Sure I only wear a shirt in winter. I'd never wear anything else. Only a shirt, that's all, only a shirt.*

Urban male respondent, aged 71 years.

Oh it's quite warm. Because there's a storage heater in the living room and then there's another wall heater, you know, on the wall in the bedroom. So it's quite warm. It's not really expensive. Then of course I have the fire, I have the range and I can turn the fire on. And when I put on the fire I don't need to put on the storage heating. Because the range keeps the house warm and it warms the water then like as well, you know, which is good.

Rural female respondent, aged 71 years.

4.3.2 Social Belonging

Social belonging consists of meaningful relationships with others, for example family, friends and neighbours. Outcomes in this domain were good for this group of older people. Connections with neighbours and family were of great importance for participants and in the main, strong. When asked to talk in general terms about their neighbourhood, most did so predominantly in terms of the neighbours and the people around them, and did so in a positive way. Having people around on whom they could rely to help was valued highly. Neighbours who called in daily were described, and who would help out with putting in light bulbs, giving lifts to shops and so on. The women in particular discussed the 'minding' support given by neighbours;

I've gorgeous people around me, right next door stuck on to me I have a nurse and she's married to a tradesman, she's nursing in Ballytown she'd be in the door like a shot,....and then I have another across the road from me and she comes, they're the only two that come into me but I don't want anymore, that's enough.

Rural female respondent, aged 76 years.

Oh yes, well the alarm, I've given two neighbours a name on it if I want them, if I wanted anyone now, they'd come over to me, anytime, even if I had no

alarm or anything, they always keep an eye on me..... When she'd see the light on she'd say, "were you up, was there something wrong?" Which is good to have, a neighbour like that.

Urban female respondent, aged 90 years.

R: ...my neighbour on the corner, my lovely neighbour died, but her son was there. I never see him, he doesn't bother me but he's there if I want him. On this side is B H, she's the loveliest person under the sun. I've lovely neighbours.

I: So you like your neighbourhood?

R: I love my neighbours, I really do

Urban female respondent, aged 84 years.

A connectedness with the past was also important:

I've no friends of mine living there but my neighbours are friends, they're there since, there's young and old in it you know, yeah there's young and old and the young ones are lovely I must say and even the little children, I've seen children grow up there since I came in, I've seen them grow up and go away and get married and now some of them have children of their own and I never ever had a bit of trouble

Rural female respondent, aged 79 years.

.....and I'm very lucky I have no noise down here plus the fact that the girl that's opposite in the hall, I knew her mother well, I grew up with her mother and the girl that's over ahead of me, again I knew her mother so you know....

Urban male respondent, aged 73 years.

Family was very important to participants, and for most participants there was evidence of meaningful relationships with family members. Participants described where their various family members lived, when they could visit or be visited and clearly placed a high value on this aspect of their lives.

I have my two sisters married in Ballytown. They are just down the road from me, about 10 minutes down the road so that's nice....Oh I see them quite often, maybe about 3 times a week. I go and visit them and they come and visit me.

Rural female respondent, aged 71 years.

R: *The eldest is living across the bridge ... and D is down in Ballytown, about 30 miles down there.*

I: *And he comes over every day?*

R: *Yea he does he drives up and down.....Oh G would ring me every night, every night without fail and D would ring me, he has a family now but he would ring me regular and I see the children.*

Urban male respondent, aged 71 years.

Oh yes of course yeah, oh god yeah, very much (can count on family), actually the girl now that went to South America she left me hershe said, she left me her car she said; 'dad you might want to go out for a spin or something like that', you know and..... another girl there that's Y, she would be the youngest, I still call her the young one, but she just text me there,to see how I was, that's everything, oh yeah, I must say they're very good to me, not good for asking for money though (laughed then coughed).

Urban male respondent, aged 73 years.

In some cases family could not maintain as much contact as the older person would have liked. It was apparent that this was a source of sadness. For example a 90 year old widow told us;

They (family) come when they can, across to me, its expensive you know. They come when they can. One is just back, she was at home with her husband she had to come home but you see, not really to see me, he came home to see his brother who was having an operation.... They came home to see that he'd have help when he was home. He's seventy eight. They were here four days then went back up. They were dog tired. J, she had her knees done and she's only kind of getting over it you know? She won't be home for a while. The other girl might be home in August, you have to live in hope.

Urban female respondent, aged 90 years.

Another 87 year old, also a widow said similarly;

No, they're all out, the husband and wife has to work and the kiddies have to go to school. And then they have their own life. They have to go and collect

them from school and home again, take off their uniform. By the time you get that done. And I understand that.

Urban female respondent, aged 87 years.

Family members were an important source of practical support. This could 'double' as social visiting and emotional support, and families also provide the opportunity for reciprocity:

Well my daughter will call off and on and she might be coming to leave them to me for a few hours or something like that or for half the day maybe because she's kind of doing part time work from home now like herself.

Rural female respondent, aged 71 years.

Families were an important source of social activity. Participants talked about family members taking them out for afternoon or away for weekends:

...if they were going to Ballytown for a day I'd go with them, we'd visit the other members of the family and my daughter brought me up to the new shopping centre last week just to see it.

Rural female respondent, aged 70 years.

R: At the weekend I goes off for a drink. I meets me sisters and we goes off. Nearly every day.

I: So you are great friends altogether?

R: I'd be lost without her. Well, we go for a weekend if they are goin' any place. And they have cars and their daughters have cars and we tour round the weekend wherever they're goin' I go. But they have their ups and downs just the same.

Urban female respondent, aged 71 years.

Participants described other social activities that did not rely on family, for example organized social activities and outings or trips in day centres or Active Retirement Association activities, trips to mass, the shops and for a few of the men, to the pub. This type of social activity was also important and well appreciated:

I'd go to the old folks, tomorrow night, or tonight, up in the convent here, there's a nun that takes the old folk, I was going there before I joined this, I know the nun because she was from home, she asked me to go up so that's why I was going there and they do have a dancing session and tea and sandwiches afterwards.

Rural female respondent, aged 76 years.

The active retirement ...it's great, yeah it's grand, we meet every Wednesday night and you meet people and you talk to them, its grand and then the Irish class, go up to that, there's always a crowd there. I don't get out that often now but I get out once a week with them.....we were away for 4 days there we went on tours every day. That's another thing I took up since I joined the active retirement, golf, its great because we got lessons in golf and we used to go up, all summer.

Rural female respondent, aged 70 years.

A 90 year old gentleman, living in a voluntary housing project explained about the social club that runs at weekends:

Oh it's in the community centre, St. F....., yeah its run very well, it's on every Friday and, it's Saturday and Sunday night..... Sing along Saturday and Sunday, dance and all, bar and all.

Urban male respondent, aged 90 years.

Opportunities for social activities could be lost due to lack of transport:

I: Do you get the chance to go visiting at all?

R: Well I don't really because you see I've no transport and I live on the outskirts of the town you know which means if I went into the town, sure all my friends are gone you know.

Rural female respondent, aged 83 years.

My daughters come in the car, they come and take me. Otherwise I wouldn't get there.

Urban female respondent, aged 84 years.

Social activities were not always sought by participants. It was pointed out that older age can bring a freedom of not having to engage socially. Three single older people outlined how they were comfortable with their lack of social life:

Int: *Would you like to go to any sort of social groups now?*

P: *No, not now. I don't like to be tied to a time to go here a time to go there, I enjoy my freedom.*

Urban female respondent, aged 88 years.

R: *My sisters – once every five months, she'd drive down from Cork and we'd go for a meal in a hotel. I wouldn't be particularly looking forward to seeing them. I'm very content on my own maybe. I'm not a recluse now, but I'm very content with my own company. Sometimes we might have lunch together or we might have a chat and that's about it, maybe sometimes I might go for a drive with them, you know.....No, I'm, I'm a private sort of person, you know, if there was such thing as a wedding or films I go to them. I enjoy that all right.*

I: *But that's as much as you want?*

R: *That's about how much now. When you get over the 60 you kind of settle.*

Rural male respondent, aged 74 years.

I'm a bit of a loner. I love my own company. I don't need people that much. I can be happy for a weekend in my apartment there, but I have my Lyric FM – I love classical music, all my records, I can write my letters, study my languages, go for a little walk around the block. I don't meet anybody. We need people but some people need them all the time. I don't need that. I have three sisters, one of them got married, the other two didn't but they stay in their own houses. They like to come and visit but they like to do their own thing, make their own decisions, the freedom of being alone is great too.

Urban male respondent, aged 75 years.

Across the data set, few participants expressed loneliness but where it did exist it seriously detracted from life quality. An eighty one year woman, who lived in rural area experienced loneliness. Widowed for 20 years with no children, she explained how she found it difficult to get out due to arthritis.

She felt the main stress in her life was being alone, and this made it difficult to be positive. She described her neighbourhood and her visits to day care:

Home on Saturday, their own jobs done. You can't expect them (to be around you). You see they are all working now and all the old ones are gone. Long gone.

Well there isn't many here you know? A house here and a house there you know. They all do their own business it's not like one time running out to visit one another, that day is gone. We used to play cards at one time, but the gang that played the cards are all gone to God.

Rural female respondent, aged 81 years.

A single gentleman also living in rural area and 81 years of age described his biggest problem as being "on my own...you know, lack of company" and having no one to talk to. Having returned from England he felt he had never adjusted. He found it difficult to be positive and felt he had little to look forward to. Lack of transport exacerbated the problem, as his main form of transport was a bicycle. On the subject of getting out and visiting:

R: *Well it's not so easy. I do go into a, I do go into an odd house, but only for a very short visit.*

I: *Mmm.*

R: *It's not like one time that you'd go in visiting*

I: *Why's that, you think that times have changed?*

R: *Oh they have changed a lot....Of course you couldn't go in everywhere, it was...there are big changes. One time you used to go visiting and stay all night, ah stay for...*

Rural male respondent, aged 81 years.

An 82 year old widow who lived in a city, also found herself lonely at times. A lack of companionship made it difficult to go to social events or join groups:

Maybe I just didn't know about them. I'd just feel like to go somewhere, to go with somebody. Do you know what I mean? Going on my own is difficult. The summer evenings like is fine.

Urban female respondent, aged 82 years.

This lady had one son whom she saw regularly and went shopping with, although this still did not seem to be sufficient to keep loneliness at bay:

I have a brother living around the corner from me, just a way off, not on my avenue, he's on C..... Terrace. I have my son. I don't see my brother very often. It's a bit distant. That's it really.

Urban female respondent, aged 82 years.

4.3.3 Community Belonging

Community belonging refers to the connections people have with resources typically available to members of their community and society. This includes information about and access to health and social services, recreational programmes, sources of adequate income, and community events. In general, participants considered themselves to have a sense of belonging within their community:

Well everybody knows me, it's true. Its no use going around with a long face all the time, I'm always laughing, whether I'm dead or alive.

Urban female respondent, aged 90 years.

4.3.3.1 Health and social services

In relation to health and social services, participants were asked about GP, hospital and home help services. Positive comments about GPs referred to "*having time for you*", being nice, kind, and providing a good service. A number of participants were particularly negative about the perceived reluctance of GPs to make house calls. This is exacerbated by mobility difficulties.

No, I'm not happy. I find it very hard. Especially when I'm on prescriptions, he won't answer the phone. I find it, I never kind of, expect him to come to the house. He's not very helpful about it. That's one reason. That's about the only one. He doesn't bother to come. If I had to have my prescription every month, I'm ringing and ringing, they just don't answer the phone. I keep at it until I do get them.... No, he'll come....he'll come around when he's seeing somebody else.

Urban female respondent, aged 84 years.

P: *Well we have a long time queuing anyway*

Int: *And, would he come out to you now if you needed him to, or would you have to go into the clinic, or?*

P: *Oh, I'd have to go into the clinic. He doesn't like coming out, ah, I've had (health problem) oh it'd be years ago, and I phoned him, and I, I couldn't go into him, and I phoned him, and he didn't come out. And the next day I phoned again, I said I'm poorly.*

He came out the second day, but he said he forgot, but he, he doesn't like going out as I said.

Rural male respondent, aged 81 years.

I have to go to her, and it's a long walk up S Road and I'm not able for that. Ah she doesn't like the idea of the house. It would have to be a real emergency. No one to help me. So I do it myself while I can. But in this heat.

Urban female respondent, aged 90 years.

This 90 year old lady also found the service to be poor:

This morning when I rang the doctor. When they should have been there, it was twenty past nine. I kept saying oh my god she mustn't be in today. I persevered and all of a sudden someone answered. She said hold on a minute. They left me twenty minutes. As a matter of fact, they didn't ring me back, I was waiting so long I hung up and rang back, couldn't get through at all, and I said there must be something wrong with the phone. Anyway after a long time, she did ring back and I told her what happened. Oh she said there was something wrong with the line you know. Then she told me the doctor was on holiday, I said again, she only came back last week.

Urban female respondent, aged 90 years.

Home visits are much appreciated when they occur. A 70 year old described her GP in the following manner:

R: *Ahhhh a saint of a man. He'd say, 'you shouldn't even come out because you might pick up something from the rest. I'll go into you', which he used to do but it's not fair to him because that could be at half eight at night and him*

after just finishing up in the surgery and he wouldn't have even gone home then. But he's a lovely gentleman....

I: And he'd come out to you any night?

R: No bother to him any night.

Urban female respondent, aged 70 years

Lack of continuity was another negative aspect of the GP service:

Not great my doctor, the doctor I went to died, Dr. O..... ,and since then I've changed several times, you know they're sent out for 6 months, you know this practice effort or whatever and that's all you'd have and then they're changed again, you have no comfort when you haven't the same one, I was going to change altogether and then when the knee came up, the doctor in Ballytown sent the letter out I said I better stick where I am..... because they don't have your history or anything, when your going they're trying to find it in that whatever you call it, computer and that takes ages no comfort with that you know.

Rural female respondent, aged 71 years.

Almost half of the interviewees had had a hospital experience in the past year. These were not discussed in detail in the main, although one participant described how positive his experience was, despite a wait for treatment:

P: Brilliant. I was examined in February and it was November I got a terrible pain and I couldn't walk or I couldn't talk and I went down in the ambulance. But otherwise I might be still waiting for it. I was waiting the nine months. It wasn't terrible painful but it was there. One night I got it bad and I wasn't able to turn and I had to get someone to ring for me.

Int: But your experience in the hospital was ok?

P: Oh yea, I couldn't praise them high enough. I was there in the A and E and they were busy there, it was one o'clock in the morning, and they were up to their eyes but they were coaxing me are you all right there, we'll get you a doctor now in a minute, we can't give you an injection yet, they were over to me every five minutes. I couldn't praise them enough.

Urban male respondent, aged 71 years.

Specific negative experiences included insensitivity around making an appointment and an inappropriate referral to a nursing home. In the following case the short notice combined with the difficulties posed by getting to the hospital for an early appointment was a very a frustrating experience. Her only alternative to public transport was a taxi which was well beyond her reach, financially.

But I was sent ... to have this X-Ray or a scan, and they asked, they want me in for twenty past nine, there's no way I can get into Ballytown (48 miles) for twenty past nine, you know to get out on to that road as well.....so I rang my own doctor and they said the same thing.... I had to sign two forms, which I think is a bit awkward, I mean I only got the phone call this morning, could I go in tomorrow to have it done, I could cancel it but then I could wait maybe two or three months more for it and I don't want that. We had hell to sort it the way out, but... what annoyed me more was to get to Ballytown from here ... I can't afford a taxi that's sort of a price, it's about two hundred pounds to go there and then you have to come back.

Rural female respondent, aged 66 years.

The following quotation is another illustration of the type of negative experience an older person can have with hospital services. This lady felt that a decision was made to place her residential care on the basis of practical difficulty that could have been resolved with a modification to her bathroom. She seems to feel that a doctor who was more familiar with her general health and accommodation would not have made this 'snap' decision.

R:in hospital you see and it depends on who you meet the night you go in. This doctor outside, he sent me out to the (Nursing Home) on the C Road. I was lying on a bed. I was out there for eight months lying on a bed.

I: What were you there for eight months for?

R: Because this doctor sent me out because I wasn't able...he asked me a question and I was telling the truth, the shower was in the bath in our apartments in the old part of the building and when I said I couldn't get into the bath for a shower he sent me to this nursing home and I hated it, lying on a bed for eight months, looking out the window on to the square with all the

houses and they couldn't bring you up a wheelchair...And you got your tea at half four in the evening. It nearly did me in.

Urban female respondent, aged 70 years.

The Home Help Service was generally appreciated by those in receipt of it. Home helps assist with a wide variety of tasks, though family back-up is also mentioned:

I have a home help; a girl comes to me five days a week. Little girl. Now she does, she'd bathe my feet now in the morning and she'd get my breakfast in the morning and help me to get dressed and that and tidy a bit around for me. Now, I don't have her on Saturdays and Sundays do you see, she's only five days. That's the thing about it. On those days, I try and manage myself or if M or S are around, come into me. And that's about it. I try and get on with it myself.

My family picks up for me. I haven't a bad family. This is the part about my family. They're always coming with something and they never come empty handed. M on Saturday and Sundays, she'd bring me up for my dinner.

Rural male respondent, aged 83 years.

The Meals on Wheels was less favoured, at least by the women interviewed. It was also a service that some interviewees stated they had to pay for.

I was getting the meals on wheels, it was alright at the beginning but then that girl, I never met the woman, she retired, and another girl came in.....it wasn't satisfactory, the chops were hard, very hard.

Urban female respondent, aged 87 years.

Oh no I wouldn't have that, (M on W) well, I saw a neighbour, he was out one day and I saw when he went out and I saw....I wouldn't like that. I don't mind boiling the potato myself or an egg maybe or whatever.

Urban female respondent, aged 90 years.

Structured activities (Day Centres, Senior Citizens, 'Old Folks' Clubs, Active Retirement Association) were described, unanimously, in positive terms. Those who attended Day Centres found them to offer enjoyable and stimulating activities, and the opportunity for socializing, company and

gossip. Even the gentleman who didn't go in for "that physiotherapy, clapping your feet and clapping your arms" claimed he enjoyed the centre as he could sit and read the paper.

I like this day care centre. My mother and father, they never had anything like this. I'm satisfied with what I'm doing. I'm quite satisfied coming here on a Monday and going there. That's plenty for me. Of course I am, I'm very pleased

Urban female respondent, aged 84 years.

R: *I love it, I love coming here. I do.*

I: *What sort of stuff do you do here?*

R: *I do painting, art, painting and that. They took us out last week to R Castle, we'd a lovely day out, it was lovely it was. You know? First time I was ever been on any outings here you know.*

P: *Would you like to come more often?*

Int: *Well I wouldn't mind another day like maybe. A Friday or something. I'm quite happy like. The people here are very nice and there's not enough they can do for you. Every one of them. M... is A1, the one in charge.*

Urban female respondent, aged 66 years.

Active retirement here, there's always bits and pieces on, we have tours and its very good, well really and truly it got me a long way because I was very down when it started I have to say, I lost my husband suddenly and it took me a while to get over it. But I found that it was a great help.

Well more or less this club has our life ticking over, we look forward to going on tours and we were away last week for a few days you know, down in Ballytown which was great really and truly.there was 50 of us which was great because you don't do those things on your own, you know you have a club....I don't know but I just found the active retirement the most important because most nights we have something like a game of cards, we'll always have speakers,...we had them out from the health board as regards what we should eat and what we should do and another night for exercise, it's really very good you know.

Rural female respondent, aged 72 years.

4.3.3.2 Income Adequacy

Participants were recruited to the study on the basis of being in receipt of the state pension. The interview probed issues of income adequacy, about how easy or difficult it is to manage on the pension and explored difficulties where identified. While all participants clarified that they were in receipt of the state pension, not all volunteered information about whether it was the contributory or non-contributory pension. Of those that did seven were on the Contributory and seven on the Non-Contributory.

On reading through the interview data, the strongest impression emerging in respect of income adequacy is the way in which the attitude of the older people mitigates the financial hardship in which they live. Almost all participants reported some level difficulty with money, yet this often had to be probed. The older people interviewed appeared to be stoic in their willingness to 'manage' their limited means, justifying their difficulties with an acceptance that this was not a time of life for extravagance, combined with grateful testimony that things can be or were worse for others, included their own parents.

Those who managed well included a gentleman on the non-contributory pension and a woman in a supported housing arrangement:

R: Oh the pension is good, I'm getting the what do you call pension, the high pension, I am, now with the fuel and all its €221.23 or something. Yeah something like that now it is, because I'm on the, I had stamps and I'm on the high pension....

I: So it's easy enough to live on that?

R: Oh it is.

Rural male respondent, aged 86 years.

You can't complain, no, I could live and I could save then there wouldn't be much for spending too but I've got all, everything I want in the flat and the name of television and that, all the things and my phone is the most important thing, eh, I have everything I need in it really.

Rural female respondent, aged 66 years.

The majority of participants however employed a number of management strategies to cope with their small pensions. These included being prudent in their spending:

I'm doing ok, I've me own plan, the clothes I have and apart from the few fags I have enough grub but it's a very – I don't I never go on holidays, I never go to restaurant or bring a bottle of wine, so I can live on what I earn, survive on what I have, but you have to live a very frugal kind of life. But I'm not cribbing about that because I'm very happy with what I have.

Urban male respondent, aged 75 years.

Well I suppose I have to be thrifty or economical like you know, I notice it's the winter months its more expensive than in summer time, your using more central heating and the sitting room every night but I would a few nights in the week if I had visitors calling or something like that. You have oil to get and then I have the house insured and that falls due in November alright and I often remember my husband saying the same thing to me, he used to always hate the month of November.

Rural female respondent, aged 71 years.

Well, no, not so bad now, I suppose so far. So far I'm going alright. You know, I, I, I, don't go mad or anything with spending, like you know. I go by the, the old, the old saying, look after the pennies and the pounds will look after themselves. I've heard it often. Look after the pennies and the pounds will look after themselves.Oh, if I, well if I went mad, if I went buying everything, probably buying a load of things of it, then I'd have no money. But it, but it's fine to me anyway, because they'd be no good to me.

Rural male respondent, aged 65 years.

Managing payments to bills on a weekly on monthly basis:

No, what I usually do, I don't know if everybody does it, if I go for my pension, I always pay about twenty of gas and twenty of electricity, and when I get the bills, they aren't so bad, so that's the way. I don't let it build up because I don't think I'd be able for those bills when they come in.

Urban female respondent, aged 90 years.

But I manage. Like I told you I pay so much off the phone bill and telecom. What I really hate is that NTL. It's ridiculous really. What they are looking

for now is 43 euros, no 42.89 the full extent, every two months and nothing on it if I'm in for a night...and I haven't looked at those sports in years. If they come I'm not paying it this time. I got the letter last week and they can come if they like.

Urban female respondent, aged 70 years.

Management included reliance on secondary benefits:

P: It's easy enough, you know, when there's only one you know.

Int: You don't find it that difficult.

P: Well you don't because well I get gas free and the heat and all that.And mm you know free phone and all. It does (help), it all adds up.

Rural male respondent, aged 83 years.

Well that's all I have. I don't really (find it a struggle) no, I have a free TV licence and we get, from October to April we get an extra €10 towards our coal, towards our fuel and we have a good lot of units on electricity, when you live on your own you don't really.

Rural female respondent, aged 79 years.

It was important to participants not to be in debt. This 90 year old, on a Widows pension, outlined her approach to money management:

P: Well as I say, when I'm on my own, but you see, when you take so much out of and pay each thing, in the post office, the only big bill I have is the aerial bill and the insurance on the house, that's it for me. Other than that I have no debt anywhere.

Int: So you manage?

P: Manage yes, make the best of it, obviously when it comes, I don't owe anyone any money.

Int: And that's important is it?

P: Oh yes, I want to keep it that way.

Urban female respondent, aged 90 years.

As mentioned above, participants relied on family for a number of practicalities such as house maintenance and social activities. Families also

provide financial assistance, often in an informal, even non-obvious manner. For example, in conversation a 90 year gentleman who reported that he was OK for food since he got the Meals on Wheels, his daughter intervened to point out that he cooked for himself at weekends, with meat her sister brought down each Saturday and Sunday. Similarly, two other women reported assistance:

I used to use this range in the winter do you see, light it with oil but really if the weather was very, very cold now you'd have to leave it on from the time you'd get up until you go to bed and you'd want maybe €500 to fill the tank and I could never do that at the one time, I might put in a couple and the lads (sons) would put in a few hundred Euro.

Rural female respondent, aged 72 years.

And ah, my sister lives in M... she sends down a dinner, you know any time I'm there.....Potato and vegetable and mince and chicken and chop it up

Rural female respondent, aged 80 years.

Many of the participants pointed out that they had no money for 'extras'. This was borne with characteristic forbearance:

Well if you wanted to go for a little holiday now to have that extra little bit of money to go for the holiday, we went, the active retirement went for a holiday last week and you know you pay for the hotel and pay for your mid day meal and you have to pay, if you see anything that suits you in the clothes you'd be tempted to buy and all that, that bit of independence, you know what I mean, when you want it or when you see you know, that you can't really...

Rural female respondent, aged 78 years.

There are plenty things honestly speakin'. To begin with I could do with blinds. I could do with new curtains. I could do with a new armchair in particular, but I can't have 'em because I have to save up from item to item. The curtains come first, the sink comes second, the blinds will come whenever I get around to them. It could take 2 years or 1 year...

Urban female respondent, aged 71 years.

I think it's alright anyway, (current income) I'm not a person who wants

grandeur. And I don't smoke, that takes an awful lot of money. I'm glad I didn't smoke. ...Ah yes, couldn't expect anything different
Urban female respondent, aged 90 years.

Older people were not just stinting on extras - limited means meant it was difficult to respond to unpredictable situations or expenses. This lady, one of the few who runs a car found she was due to pay a parking ticket just prior to the interview. The €40 required placed her under considerable strain:

I can't wait for Friday morning to get up to the post office ...because by the time I pay for a little bit of petrol for the car and you know there's oil and the usual things or the life insurance and the tax and insurance on the car and there's all those things to be paid for and now look I've go to and give €40 for that and by jingos that's breaking my heart.
Rural female respondent, aged 70 years.

Participants expressed different views on their current pension in relation to the amount received and it's relevance to living costs. One participant who had resided in England for some of his life commented that the pension available in Ireland as well as the availability of services is better than the supports available to older people living in England.

I'll say this, this country is a lot better than England for older people. Over in England old age, what you're entitled to, and their pensions are less than here, a good bit less
Rural male respondent, aged 81 years.

This opinion was reiterated by another participant:

I think we are very well looked after in this country, with the pension, free travel, milk, no TV license to pay. Our pensioners are much better looked after than in England. They don't get any free allowances as regards TV licences or anything like that.
Urban male respondent, aged 75 years.

However this same participant did point out that on the pension

You have to live a very frugal kind of life. I never go on holidays, I never go to a restaurant or bring a bottle of wine....so I can survive on what I have.

Urban male respondent, aged 75 years.

Two participants stated explicitly that they would like to see an increase in the pension. The most particular difficulty older people faced was with regard to affording fuel. Participants were very mindful of the specific costs of fuel and the relevance of increasing costs within the tight margins of their weekly budgets.

Fuel yeah, that is my biggest draw now do you know, saving up to that you know, really what I do is now on a Friday when I get it, I give off so much from my ESB bill and so much on my phone bill, maybe €5 each Friday and when it comes there might, in 2 months I might even have a bonus, credit.

Rural female respondent, aged 72 years.

I: *And do you feel that you are able to manage?*

R: *Barely now. I have no bank account or anything but it's getting me through. But when it comes to the pinch when I sees the gas bill and the phone bill well I have nothing left for me self but I put up with it as long as I get a little bit to eat and cigarettes I'm alright.*

When discussing fuel this 71 year old woman commented:

It's goin' up! Everythin' is gone up. You'd be afraid now...this week the mornin's is cold and I only leave it on for an hour and I'm doin' something then like goin' down the town and I'll put it on again in the night for another while because what runs in me head is the bill ...only for that I'd have it on all day, yea. I haves the pipes on all day.

Urban female respondent, aged 71 years.

These two gentlemen found both fuel and food costs high:

Well it's hard. Yeah, we can't buy the proper food that we need, food is very expensive and electricity is very expensive..... Yes and there it's for the

television, the pipe television you know the pipe?... That's forty every two months.

Urban male respondent, aged 76 years.

It is very (expensive), yeah, and now with the thirty three percent too as well.....but again to the fruit, yeah it all depends on where you buy your fruit, you know, some, Dunnes is very expensive, well sometimes if I go to that place in M..... Street.

I order to collect my dinner here, then the, I collect my dinner here, in the summers they cook the dinners you know, meats and that

Oh I do yeah (pay for Meals on Wheels), gone up too actually, their gone up another Euro, although fairly good value for four Euro you know, they, but sometimesI find it very hard, I mean food is as you know yourself... but you know food now, groceries and stuff like that, gas and, now I have free electricity all right but I mean....you know you live from week to week, I was always a fairly good saver you know I used to save a few bob here and there so you know, eh, yeah I find it very hard to survive on the pension actually you know.

Urban male respondent, aged 73 years.

For some the willingness to take a positive view was in the context of earlier hardship. This lady recalls some details of her childhood:

...what they used to get years ago. I remember it well, my father god rest him had seven of us to look after when my mother died. He usually gave five shillings to her and the labour and fifteen to himself, and as soon as she died the five shillings stopped. Then we got the shilling each. He put me down as housekeeper you know. He got the five pound. But things were very bad in those days. You wouldn't understand. People don't believe it. You know. People were very very poor years ago. I mean they're too well off today.

Urban female respondent, aged 90 years.

The gentleman below considers current provision generous:

It (the first Old Age pension) was 5 shillings a week in 1908 and it meant that (you) could buy butter and eggs and tea. Up to that period people had no support at all. How well off we are now compared to that.

Urban male respondent, aged 75 years.

4.4 Becoming

Becoming, in the Toronto Quality of Life Model, is about the purposeful activities in which individuals engage as a way of realizing their goals, aspirations and hopes (ibid.).

4.4.1 Practical Becoming

Practical becoming refers to purposeful activities, such as housework and self-care and paid or voluntary work that are typically done on a regular basis. Participants readily outlined daily routine. Activities undertaken included housework, gardening and visits to friends, family or mass. The women interviewed elaborated more on their daily routine, and more references were made to housework. Housework was a clearly purposeful activity for the women, as was gardening. The activities provide a structure for the day. The following two accounts are typical:

I get up in the morning, if I've anywhere to go I get up early, if I don't I stay in bed until Ryan is nearly finished.... then I get up and I do my tidying up, have a cup of tea and if I have any bit of washing to do, if I have anywhere to go I go, usually I go for a walk then, if it's a lovely day I'll go out in the garden or go for a walk, that's the way I do my day and I love to read at night, I love to read and I love the telly, I love all the soaps.

Rural female respondent, aged 79 years.

My daily routine now I'd get up at about 8 o'clock, I'd come down and make a cup of tea and I'd go back up to bed again and turn on the radio and listen to all the news and then I'd have my breakfast and then the first thing I do every morning is I go for a walk, I just go into town and if I have to get any little thing in the supermarket, I can carry something light, I'll get it and I'll come home. Then I'll do a bit of house work, sheds trying to clean them out which there's no end to and cut the lawns so I'd only do a bit at a time because its hard, it might take the whole week to cut all the back and all the

front but if the lads are home at the weekend, if it was a dry weekend they'd cut it all and be saying don't be cutting it but I can't bear to see the grass high. And I always did a little bit of painting in the house myself....so if there's things to be done....I keep myself busy, that's what I do.

Rural female respondent, aged 70 years.

This lady, a wheelchair user, with very limited mobility lived in supported housing. Despite her disability, the assistance she has enables her to describe the routine in terms that suggested a degree of independence and control:

Well, I wake up very early, and like I said himself (warden) come over with the porridge to me. I'm still in bed at this point. Then he puts on a kettle of water and I have a wash. I can't get into the bath, you see, but one of the ladies if she is in early will give me what you might call a bed bath and I wash myself, deodorant, put on me clean clothes and he comes back at about nine o'clock and I have a cup of boiling water, 'tis better for you than tea. Then the carer, the home help would come in and she wouldn't be there for long. And time passes in and then we might come down here then at half eleven or quarter to twelve usually every day and we'd read the newspapers at the end of the dining room, they get the papers in for everyone, the residents to read and then we have the lunch, and if it is a bad day he'll bring me up to me own apartment, well every day he'll bring me up to me own apartment for an hour or so and he decides then, 'tis up to him, I don't say are you going anywhere. If he decides then, like I said the three of us go off then, F.... and I, off to Ballytown.

Urban female respondent, aged 70 years.

The men did not describe their housework in quite the same detail, but again there was evidence of regular daily routines and purposeful activity.

I get up about ten o'clock and lazily have my breakfast and do the dishes, the one or two dishes and I'd, if the day was anyway fine I might go into town and if it's anyway like it today, like today I go down the field for a walk and come home and I go to bed, I do have to rest a bit in the afternoon a bit, come home and go to bed, I get up then and I used to went down in the field in the evening as well for a half an hour or so, you know just walk

around I have the dinner in the evening and then I sit in and watch telly and that's it, and if anybody calls well and good you know.

Urban male respondent, aged 73 years.

4.4.2 Leisure Becoming

This aspect of 'Becoming' includes activities that promote relaxation, enjoyment and recreation, for example games, hobbies and holidays. They do not have an obvious instrumental value. Participants gave plenty of examples of things undertaken for enjoyment: TV, listening to the radio, crosswords, reading, knitting, bingo and visits to the pub. For example this 75 year old single gentleman had plenty of activities that afforded enjoyment:

I learn Russian every night. I teach myself from books. I have great pronunciation now. I have a great ear for sounds, I'm not boasting now. I do, I fly through those (crosswords) - this is the one I did this week.... The Sunday Times, the Sunday Independent, the letters in the Irish Times are an education. The way they can formulate their letters. And I used to love Kevin Myers.

Urban male respondent, aged 75 years.

Others however were not quite as engaged by solitary activities:

I look at the television a while at night. I listen to the radio. All the news. I'm not too bad.

Rural female respondent, aged 77 years.

Watch television, radio and television that's all I have to pass the time with when the winter comes, that's all.

Rural male respondent, aged 86 years.

Enjoyment? For enjoyment, well I go to an odd film that's all.

Urban male respondent, aged 73 years.

Otherwise, enjoyment was not always evident. For some, solitary activities only go so far in providing recreation. The comments below indicate that

getting out more would clearly afford more opportunities for quality of life outcomes in this domain.

R: To tell you the truth, I don't do a lot for enjoyment, I used to do it before I came to this age. I used to dances and I used to go out playing bingo and a few things like that. At the moment there's nothing here to keep you. I'd like to be able to go out to some places, but I can't go, I wouldn't go out at night. I'm afraid of coming in at night. I don't feel that I would be able to socialise that much.

I: So you think it's your age that's against you?

R: Yes it is, I couldn't. I wouldn't be able to keep it up. I'm too tired. I'm just living an ordinary life now. Making the best of what I can.

Urban female respondent, aged 90 years.

Watching soaps... I do like to read, not a lot because I fall asleep reading, but I do read yes. ... I'd like to go out more, I would really yes.

Urban female respondent, aged 90 years.

Just listen to the music on the TV and Radio. I wouldn't get much enjoyment around here now. There isn't many people left here. Ah it is different to what it was years ago. I don't know, people have gone down, you know gone down more than half in the last 20 years

Rural male respondent, aged 83 years.

Sure what only watch the auld telly. Nothing else for it.

Rural females respondent, aged 81 years.

Participants rarely went on holiday, unless arranged by ARAs or Senior Citizens. This could be due either to lack of money or mobility difficulties. The 71 year old who had a mobility impairment did not relish going on holiday with others, perceiving her need for assistance to impact negatively on others enjoyment.

I probably wouldn't have too many holidays but I can live, pay my rent and my food and a few things like that.

Rural male respondent, aged 74 years.

I used to go on holidays every year. I used to go to Norway and every place, you name it, but I can't do that now. Now do you see? Now. That is slowing me down. I have regrets over that and I love now going off and I loved all me friends but I wouldn't have them linked to meThey say come, come but I know me self that I'd be an encumbrance on them and I don't want that. I don't want anyone saying 'are you all right? Come on now I'll help you.' I don't want that. I want to do me own thing.

Urban female respondent, aged 71 years.

4.4.3 Growth Becoming

Finally, 'growth becoming' encompasses activities that promote the development of skills, knowledge, which can include either formal or informal learning. It also incorporates adapting to changes in life. Participants had few examples of activities undertaken to maintain their physical and mental skills. Exercise, particularly walking was mentioned as was reading and crosswords. With regard to adjusting to life's changes, there were participants who took a reasonably positive perspective, accepting their life and its natural course: The following 83 year old widower, for example, was very philosophical:

Ah well I have, I really have, I'm taking them. You must accept life as it comes to you girleen you know. Take the good with the bad. And if you don't do that well then you're fighting a losing battle because you're going around with a chip on your shoulder and you're a nuisance to everyone and they detest the sight of you do you see?Oh no no no. You get nothing out of crying do you see. You just have to live with it. My biggest challenge I suppose is really, I suppose, to accept what I have. To accept it and to welcome it with open arms. That's my attitude to it do you see. I say thank god like there's a lot of fellas dead. I'm still alive.

Rural male respondent, aged 83 years.

Most others however spoke with acceptance, tempered with resignation:

The way it is, as you're getting on in life, you haven't the same interests as you would when you were a younger person. We used to be flying off every

night, going places. When you get on you don't do those things. You just make the best of them. To be alive at this age...

Urban female respondent, aged 90 years.

Living alone was the biggest challenge, now being honest, it's living alone and those it's just, I find it very, very hard, but as I said the kids are around and anything like that but still it's not the same, when you leave your own home

.....

Urban male respondent, aged 73 years.

4.5 Overall Influences on Quality of Life

The interview asked participants to comment in an overall manner on what things make life good and what things make life not so good. The responses to these questions were broadly consistent with both the literature and findings in the earlier parts of the interview.

Things that make life good for the older people were family, and health and being able to get out and about. Family was important both in terms of the practical and emotional support they provided; knowing that they care and caring for them. One gentleman summed this up saying:

All I can say is if I'm free worrying about this and that's the two lads. If the two lads are all right the two grandchildren are. If they are all right I am all right.

Urban male respondent, aged 71 years.

Health was identified both in a general sense but most particularly in respect of maintaining independence and the freedom to get out and about. The following comments are typical:

Being able to move, being able to go out you know and keep the legs going, I mean if my legs go I'm lost, cause I do like going places,.....My daughter rings me most nights, and some comes to see me you know, I couldn't say in any problems in that way.

Rural female respondent, aged 66 years.

I'm 70 now and I'm in reasonably good health, I'm able to get around. Ah yeah, I have control, haven't lost my marbles yet anyway.

Rural female respondent, aged 70 years.

Make my life good, well I couldn't see, that's a hard question to answer, as I said before to be able to go around and talk to the neighbours and walk around and enjoy life, I couldn't put it any plainer.

Rural male respondent, aged 86 years.

The Day Centre was mentioned as being the one thing that makes life good.

Coming in here is one thing, meeting people, that's the one thing, that's about it

Rural male respondent, aged 75 years.

R: *What are the good things in your life?*

I: *Coming here*

R: *Its great to have isn't it?*

R: *Oh Lord it is I would be finished altogether if it wasn't for coming in here. It's a great place*

Rural female respondent, aged 81 years.

Apart from the 90 year old gentleman who said that "a few shillings in your pocket and a gargle" made life good, money was not mentioned in this part of the interview.

Participants found it harder to identify what made life not so good. The few who felt they could respond to this question referred to sickness, not having enough money in the purse and loneliness. Answers were short and not elaborated upon.

4.6 Policy from the Perspective of Older People

Few of the older people in the study gave explicit comments on policy. Those who did are highlighted in the adjacent box inserts as 'case studies'. Others, in their general comments touched on policy in an oblique way. With regard to social welfare policy, only a few were actually satisfied with the amount of the pension combined with secondary benefits. Others ranged from those who voiced an acceptance of it, in the context of their own ability to apply careful budgeting strategies, to those who found it hard to manage.

The fact the many resorted to family support in respect of maintenance and repairs makes it difficult to assess perspectives on housing policy across the entire data set. However those that did need to secure assistance found it difficult to do so through the available channels.

Health service policy allows older people free access to all hospital services, and to all GP services, once they reach the age of 70 (90% of the sample). Access generally was not an issue for older people although reluctance to undertake house visits on the part of some GPs was definitely a concern. The policy of paying capitation fees per patient, regardless of the number or location of visits is relevant here. This may only be addressed with a significantly different financing mechanism for primary care.

Older people were happy with the absence of payments for medical services. The only service requiring payment was Meals on Wheels, which costs 4 euro a week in some areas. A few women in the study were not impressed with the quality of the meals in the service. Greater inclusion of older people in planning and devising meals might address this.

Transport policy has not served the interests of older people sufficiently, in their view. Free passes are useful only if public transport is locally accessible, frequent and accessible to those with mobility aids. Those in remote rural areas are particularly disadvantaged. No one in this study mentioned the RTI, which it seems requires greater penetration.

BOX A

'A' is 73 years old, separated and living in a supported accommodation. He has had a number of life threatening illnesses but had come through each despite predictions to the contrary, and is left with chronic respiratory difficulties that limit his mobility. He describes himself as having a positive attitude but is critical of the difficulties he encounters trying to secure entitlements from the *'health board or the social welfare people'*. He perceives that newcomers to the welfare system, *'refugees'*, are granted entitlements with ease, compared to himself and his family. 'A' finds heating expensive and is critical of a recent rise in fuel costs that make it difficult for him to heat his apartment. He pays for Meals on Wheels, which he considers to be reasonably good value at 4 euro though notes that it has recently *'gone up another euro'*. He has contact with his family, who either visit or bring him out regularly. His family help him with shopping, and he likes a quiet life.

When asked about the necessities for a good life he answers *'well a rise in the old pension for a start'*, as he feels that heating is expensive. He is cynical about social welfare provision, pointing out that even with a rise in a pension of 10 or 15 euro, it will be taken back in another form, *'so in other words you gain nothing'*. He doesn't think the fact that it's an election year makes any difference to how the government will treat older people with regard to pensions. 'A' finds it hard to survive on the pension, even with the free electricity. He feels the pension forces him to live from week to week despite having been *'a fairly good saver'* in earlier years.

'A' has a home help one hour a week but found this difficult to obtain, and notes it will be reviewed again soon. He is happy with GP and hospital services but is not overly confident that older people can in fact access the social services they require.

Box B

'B' is a 66 year woman, who has poor health on account of having suffered a stroke. 'B' has had a number bereavements and struggles with depression.

She is on the Non-Contributory Widows pension, and finds it very hard to manage. She thinks the pension should be increased - *'more money than what we are getting'*. She finds she is always *'owing bills'* and suffers from the cold. She is critical of the social welfare system:

No, I don't think it's enough. I think we should be getting more than what we are getting. It's very hard and you get all these people coming into the country and they're getting, I've nothing against people but they're getting....

'B' is critical of the housing and social service system in respect of the restrictions placed on supports available, the limited amount of support given, and the gaps in provision that, she feels, leave her unsafe and lonely. For example she finds she is not eligible for accommodation adapted to her needs, as she owns her own house. She is cynical about this, describing herself as *'an awful eejit'*, not to 'play' the system and have to rented a place that wasn't her own when applying.

She is hoping to have her house modified to take in a downstairs toilet. The grant assistance for the modification is very limited, and she is having trouble getting the work undertaken:

You think for instance, I had to get a place downstairs (toilet) and they gave me a grant of eighteen and the thing is going to cost thirty seven because there's two shores in the bath. Just for a toilet and a shower? Nothing else. Tiles and things. Now I'm getting it done by a proper firm. I'm waiting over a year, best part of, six or eight months. When I was in the hospital..... they gave me this commode at home. This girl comes in and that and all. It's terrible. It's degrading so the sooner I get this the better. I'd be delighted when it's done and I'm saying I wouldn't bother if I just had a little place around me. That I could get. Just a small place.

She has a home help and speaks very positively about this person. However being only entitled to one hour a day at the weekend is a serious limitation when she is so disabled. 'B' has been refused a travel companion on the grounds that she is not deemed 'permanently' disabled, nor blind. She is critical of a system that makes these distinctions and sees the system as giving her no option to become isolated.

She does not feel secure or safe in her house, especially because she is mobility impaired. She feels that the health services are not aware of the specifics of her situation, and would feel more secure if her living area had higher boundary fences or if she had an intercom or a personal alarm. 'B' thinks her need will not be met within current provision. She compares the situation here to that in the North, where people are readily informed of their entitlements.

Box C

'C' is 75 year gentleman who lives in supported accommodation. He is single and other than emphysema keeps good health.

He was made redundant 15 years ago and his financial situation deteriorated considerable at that time, moving from private accommodation to local authority and not being able to afford to run a car. He considers the social welfare system to favour the needs of 'foreigners' over people such as himself.

He is on the Contributory pension and manages given that he is 'a very abstemious guy'. He receives an electricity allowance that is adequate to his needs, and in fact considers pension provision to be good especially in comparison to past times:

I think we are very well looked after in this country, with the pension, free travel, milk, no tv licence to pay. No, people are so well off now, you know what I mean, my father told me he remembers the first old age pension, he was born in 1892, and 1908 the first time the British Government introduced the old age pension... It was 5 shillings a week in 1908 and it meant that she could buy butter and eggs and tea. Up to that period people had no support at all.....

He does concede that it's good but only insofar as you can 'live a frugal kind of life'. 'C' also considers pension provision better here than in the UK, where people do not receive the same secondary benefits. On the subject of health policy, 'C' is very positive:

I've a medical card and all that is paid for by the state. Sure that's fantastic and we don't appreciate that you know. You know you never hear anyone saying it's nothing. Like Mary Harney is doing her best.

4.7 Chapter Summary

In this chapter the main findings have been outlined, using the framework within the Toronto Quality of Life model. Outcomes in the 'being', 'belonging' and 'becoming' and domains have been identified. The chapter concludes with findings regarding older peoples perspectives on policy that effects their lives.

Chapter 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The focus of the study is the quality of life of older people reliant on the state pension. According to the most up-to-date data on poverty in Ireland, income poverty remains higher for those over 65 years than for other sub-groups. Older rural dwellers, older women and most particularly, those living alone are at greater risk (Prunty, 2007). The heavy reliance of older people on the state pension clearly contributes to this situation. Only one third of older people have an occupational or private pension (Stratton 2005).

Older people on the state pension were therefore, the target sample for the study. Semi-structured interviews were conducted with a purposive sample of 40 older people. All participants were living alone and reliant on either the State (Contributory), State (Non-Contributory) or State Widow/er pension. The framework within the Toronto Quality of Life model was employed to inform the data collection process, with particular attention being paid to health, social and community supports, social exclusion and housing condition in achieving positive health and quality of life.

This chapter will first explore the participant profile in the context of the study criteria and explore their experiences with regard to living on a low income. In the following sections the non-monetary determinants of quality of life for older people, as identified in the literature and as described in Chapter 2, will be discussed in the context of living on a low income. Finally, the efficacy of policy with regard to improving life quality for older people particularly for

those on a low income will be discussed and recommendations for policies which will enhance the quality of life of older people in poverty made.

5.2 Living on a low income

Living on a low income is unquestionably associated with poor quality of life outcomes. Many studies attest to the relationship with broad quality of life and health outcomes and indicators of poverty and deprivation (e.g. Townsend *et al.*, 1988; Daly, 1989; Millar *et al.*, 1992). Most recently a study of family life on a low income in Ireland, which interviewed 30 families, 80% of which were below the 60% poverty line, revealed a picture of families 'faced with extreme financial and other deprivations which place enormous pressures on their management and parenting skills and which expose their children to social exclusion and various at-risk behaviours' (Daly and Leonard, 2002 p.xx1). The study, undertaken on a sample of the nation's poorest households revealed that almost all income was absorbed by basic necessities, and many of the families were not able to manage financially without falling into debt.

Despite the fact that older people are at greater risk than other population sub-groups for income poverty, very little is known about the quality of life of older people who live on a low income. Large scale quantitative studies have been undertaken, for example as part of the 'Growing Older' programme in Britain, (e.g. Smith *et al.*, 2004; Fletcher *et al.*, 2002) but few studies explore the lived experience of poverty in older people using qualitative data. This study, in part, addresses this deficit.

The older people in this study were recruited on the basis of being reliant on the State (Contributory or Non-Contributory) pension. None were on occupational pensions. At the time of writing, the difference between the two pensions was negligible, at €11.30 (personal rate). 'Gatekeepers' who identified participants for interview, while not required to probe about their financial circumstances, were made aware of the study brief and thus even though some participants were on the State Contributory Pension, which is not

means tested, there was no evidence within the sample of wealth or generous means.

The vast majority of participants in the study either stated they found it difficult to manage with their pension or that they 'managed', through using careful money management strategies. Only four participants appeared to have no real challenge in managing money, two of which were in supported housing situations. The accounts here were in many ways consistent with those reported elsewhere (e.g. Daly and Leonard, 2002; Dominy and Kempson, 2006; Hill *et al.*, 2006). In the study on families, very careful money management was evident with children's needs being prioritised and substantial constraint being placed on spending generally (Daly and Leonard, 2002). Here, similar money management strategies were in evidence. Older people manage by paying off utility bills, on a weekly or monthly basis and not allowing debt accumulate. Careful spending, such as the prioritising food and utility bills, described by Dominy and Kempson as 'protected expenditure', was in evidence in this study also. Older people were very careful to avoid being in debt and this may account for their own 'playing down' of poverty. As with the family study, older people here were at times confronted with financial emergencies, which placed them under pressure. What is revealing is what constituted an emergency - an unexpected parking fine of €40, and forgetting to bring a bill to the post office, thereby allowing debt to build up, causing stress.

Other accounts of living in poverty, for example Daly and Leonard (2002) and Daly, (1989) reveal the extreme hardship and negative emotional experiences of families and women on the margins, giving meaning to the phrase 'grinding' poverty. For example, in the 1989 study the women report feelings of inferiority, powerlessness and isolation, and in the 2002 study, for the families interviewed it was apparent that hardship cast a constant shadow with strain, worry and depression being a feature of daily life. Graham, in the UK has painted a similar picture in her qualitative work on women's experiences of hardship and health (e.g. Graham, 1993).

However, while it true that the older people interviewed here experience difficulty with money and managing the pension, the same sense of desperation and privation is not present. Indeed, the most striking finding in the study regarding the lived experience of older people living on a low income is their perspective and their approach to life. Repeatedly, through the interviews, attitudes of forbearance and acceptance are evident. For example, the participants point out that 'it could be worse' or that they 'are not cribbing' about what they have. This same tendency was noted in a recent study on older people's perspectives of living in poverty, in which older people were found to express attitudes of stoicism in the face of financial difficulty (Sharf *et al.*, 2006). A number of factors might contribute to this finding.

Firstly, the reality of their lives is very different. Not being at a stage of life where it is necessary to provide for others, relieves an individual of some of the stress and constant anxiety of making ends meet. These older people are not catering for others needier or more vulnerable than themselves. It is worth noting that although older people living with a spouse are less at risk of income poverty than those living alone (Prunty, 2007) their lived experience of a low income may be different, as they will be managing money with the needs of others in mind. Neither do older people have the emotional drain, evident in other studies, of worrying about how living on a low income will effect the life chances of young children, nor the guilt associated with not giving children what their friends or others have. Therefore, their experience of low income is qualitatively different than that of families. Further, the study here did not distinguish between those who are deemed poor due to the inadequacy of the pension and those who would have been in income poverty for much of their adult lives, as well as now. If samples from each group were compared, their lived experiences may be quite different.

Secondly, it may be a function of the type of social comparisons undertaken by the older people in this study. Participants did engage in social comparison in reflecting on their financial situation, which is not uncommon in quality of life studies, and was also noted by Daly and Leonard (2002). Comparisons were made, however, with past generations, rather than peers or young people. This same tendency was noted also in a recent qualitative study in

the UK on a cross section of older people found that those on lower income raised the importance of money less often than those who were in higher income groups, and suggested that perceptions of 'not being badly off' were the result of comparisons to earlier stages of life when people had less, and were evidence of resilience to living on a constrained income (Hill *et al.*, 2007). Poverty prior to the welfare state was particularly harrowing and deeply stigmatised. Despite Ireland's neutrality in the Second World War, the early 1940s saw acute deprivation among certain sections of the population, along with high levels of potentially fatal infectious diseases such as tuberculosis (Barrington, 1987). Ireland missed out on the period of economic prosperity experienced by other western societies in the 1950s and early 1960s and the re-orientation to the welfare state did not take place until at least 1960 (McLaughlin, 1993). Thus intergenerational comparisons will lead to less negative appraisals of current situations than might be expected. Further, past memories or recollections of very lean times may also lead this cohort of older people to distance themselves from the label of 'poverty'. The tendency not to see oneself as deprived or 'in-poverty' was noted by Scharf *et al.*, (2006). Similar tendencies among older people to 'contextualise' disability experiences were noted by Murphy *et al.*, (2007).

The significant of perspective is illustrated by the discussions on spending. The prudent spending described by older people in the study essentially means that older people deny themselves items that they consider a luxury, for example holidays, new furniture, or a new suit of clothes. Dominy and Kempson similarly reported that clothing, leisure and holidays were areas older people cut back on for financial reasons. For many people in society however, these items are not actually luxury items, and hardly constitute 'going mad', as one gentleman in the study implied. Another lady, happy that she doesn't smoke as it would cost her too much, states this in the context of not being 'a person who likes grandeur'. Those that described their prudence in spending (see page 79-80) were quick to emphasise that it was not a problem and were accepting of the situation. Low expectations for material comforts and 'extras' were evident. This may say more about the way in which older age has been portrayed in society generally than individual need satisfaction.

The stoic perspective of older people has to be considered carefully in the context of policy responses to this kind of information. The kind of grateful testimony found in the study does not mean that older people have sufficient money; it simply means that they are reluctant and unable, perhaps given their life experiences, to articulate need or rights in this respect. Older people's perceptions of circumstances must be taken into account in planning appropriate policy responses. The fact that they are uncomplaining and resigned to having less underscores the need to be proactive in improving access to finance and in particular pension provision.

The one area where there was evidence of privation was in relation to fuel. Heating costs were difficult to meet and participants resorted to heat rationing strategies, such as only heating one part of the house. Some described their homes as cold or slow to heat up. This is consistent both with the high levels of fuel poverty reported by Healy (2003) and with the prioritising of household expenditure reported by Dominy and Kempson (2006).

The study throws further light on the discrepancy between the high rates of income poverty and low rates of consistent poverty noted in previous research (e.g. Layte *et al.*, 1999; Prunty, 2007; Dominy and Kempson, 2006). The tendency within participants to minimise the negative aspects of living on a low income may lead them to interpret indicators differently. For example, deciding at what point furniture is sufficiently worn to require replacing may differ for populations of different ages. Older people may in fact have furniture replaced for them by friends or family, as Dominy and Kempson found, thereby masking un-affordability. Being unable to buy presents for friends and family does not distinguish between buying presents that intended recipients might require or want, and buying small tokens, inexpensive but symbolic. Older people may well claim to go without items and consider it due to old age, rather than the fact that they cannot afford them. The accounts in this study certainly indicated that older people prefer to perceive themselves as managing, albeit with few needs, rather than not being able to afford things. Older people's social activities were not necessarily limited by finance, as many social events were those provided by family or day centres or organisations.

5.3 Social relationships

It is generally accepted that engagement with life defined by the maintenance of social relationships and productive activities is a key factor for 'successful ageing' (Sheldon, 1948; Townsend, 1957, 1968; Victor, *et al.*, 2004). Consistent with other studies on quality of life of older people, the findings of this study clearly indicate the immense importance of social contact in the lives of older people (e.g. Farquhar, 1994; Bowling, 1995; Treacy *et al.*, 2004; Wilhelmson *et al.*, 2005; O'Hanlon *et al.*, 2005; Walker 2006; Hill *et al.*, 2007; Murphy *et al.*, 2007). The study contributes to an understanding of the role social relationships play in enhancing life quality. Social contact was discussed in terms of family, friends and neighbours. Family is discussed below, and friends and neighbours in below in section 5.5, Home and Neighbourhood.

5.3.1 Family

The importance of family cannot be overstated in the lives of these older people. Families played a pivotal role in terms of life quality. For most participants there was evidence of meaningful relationships with family members, describing where family members lived, when they could visit or be visited and how they interacted with them. This was expressed in a number of ways. When discussing what was looked forward to family visits or trips were frequently mentioned, and in this way family contributed to spiritual being, in the Toronto framework. The achievements of grandchildren were a source of pride and could also present opportunities to provide practical help through child minding. Where family could not maintain as much contact as the older person would have liked it was a source of sadness. It is interesting to contrast this stoicism with that evident in discussions of frugal spending and money management. The latter were more positive, more successful in terms of optimism, than the former. There was a wistfulness and sadness about family not having enough time and sense of trying to rationalise limited visiting, rather than phlegmatically accepting it. This is consistent with the finding of Hill *et al.*, (2007) that respondents in

their study generally placed more importance on social networks than economic resources.

Although estimates of the degree of either social interaction or loneliness were not possible in this study, the findings mirror those of Tracey *et al.*, (2004) and McGrath (2005) in that the majority of older people were socially integrated with having close relationships with family friends or neighbours, and a minority were experiencing loneliness. However, as with the Tracy *et al.*, study, for these it impacted very negatively on quality of life in respect of emotional well-being. The findings contrast somewhat with those of Scharf *et al.*, (2003) which revealed levels of social isolation of 20%. Although numerical estimates were not possible in the present study, it is unlikely that those who could be so described amounted to one fifth of the sample.

Bereavement could be seen to contribute to loneliness. It has been noted in the literature that older people who are less well off but whom receive no support from family and friends are worse off than those that have support. While there was no evidence in this study that loneliness per se was aggravated by being on a low income, there was no evidence to the contrary. Two interviewees who were clearly lonely, a widow and a single gentleman, gave accounts that indicated their lives were very limited in general.

The need for a comprehensive befriending service available across communities is evident. Although some participants spoke of 'having no one to talk to' it is interesting to note that none of the participants reported contact with any such service. Promoting the development of local befriending schemes is highlighted as an important preventative and low-level community support in the NESF's *Caring for Older People report* (2005). UK-based research has demonstrated the effectiveness of home-visiting programmes for older people that focus on health promotion and preventative care. These programmes follow a similar model to home-visit schemes for mothers and young children (Elkan *et al.*, 2001).

Consistent with other accounts (e.g. Dominy and Kempton, 2006) families provided practical support for example with home maintenance, gardening, housework, and for some, finance. Families also provided opportunities for social activities, through family events and holidays, playing a major role in social support. In this way families clearly play a role in cushioning older people from financial hardship, and helping both directly and indirectly to stave off actual privation. From a policy perspective, it must be borne in mind that this 'invisible' level of support is not available to all, and should not be assumed. Family support is by its nature informal and subject to a range of emotional and practical confounding factors. Those without family members available to them, or who feel embarrassed asking family for support will become hidden victims of poverty.

5.3.2 Social Exclusion

Social exclusion is described as a process whereby certain individuals are pushed to the edge of society and prevented from participating fully in society by virtue of their poverty or lack of basic competencies and life long learning opportunities as well as social and community networks and activities (Combat Poverty, 2007). There was little explicit evidence of social exclusion, as so described, in this study, despite the fact that older people were living on low incomes and finding it hard to manage. Older people described social activities, mostly in relation to family events or visiting, and structured services such as Day Centres, Active Retirement Associations and Senior Citizens. In this way low income was not a barrier to social activities. The older people did not wish for other social opportunities typically, although this may have been due to low expectations. With higher expectations, and an awareness of the possibilities that could be open to older people in terms of social and lifelong learning opportunities, financial barriers may well become relevant.

That said, it true to say that leisure pursuits were confined to passive activities such as watching TV and reading. In this the study findings were similar to the families study in their tendency to highlight what may seem to others to be trivial pleasures (Daly and Leonard, 2002). It may also be case, as with deprivation indicators that older people prefer to construe non-

engagement in wider community-based activities as due to their age, rather than un-affordability. Certainly, solitary activities while filling time could also be something of a compromise when it came to enjoyment.

It should also be pointed out that the recruitment strategy in this study, employing 'gatekeepers' in health and social services to identify potential participants meant that older people living in extreme isolation who are not in contact with services were not reached. Social exclusion might be a reality for such a group of older people.

5.4 Well-being and outlook

Older people interviewed here, as discussed above, displayed stoicism and an attitude of acceptance. Expectations for a 'good life', or a life in which one enjoys 'all the important possibilities' seemed to be attenuated as a function of comparisons with previous times, and the hypothetical possibility of not being mobile or independent. Their stoicism was employed to counter worries or concerns about money and about ageing and illness generally, and specifically about money worries. Many of the older participants in this study compared their present day situation to extreme hardships experienced in their earlier lives and concluded that they now enjoyed a better quality of life. Older people were buoyant but had low expectations, echoing the findings of Hill *et al.*, (2006) and Scharf *et al.*, (2006).

Consistent with the findings of Hendry and McVittie (2004) the philosophical perspective evident in interviews is part of an active strategy to maintain well-being, not just the outcome of life experiences. Participants explained their position they strove to maintain a positive attitude to life. One gentleman was at pains to explain how, when stiffening up in the cold, puts on electric fires in order not to give in and go to bed. He passes his 'philosophy' onto the interviewer - 'Girleen, don't go up to the bed. Keep out of it'.

The daily routine of older people can be seen to contribute to well-being.

Almost all participants readily outlined their daily routine, including housework, gardening and visits to friends, family or mass. The activities provide a structure for the day.

5.5 Home and Neighbourhood

While media accounts frequently bemoan the erosion of community and depletion of social capital, this was not the experience of most participants. Many still spoke of good neighbours, community belonging and connectedness. When asked to talk in general terms about their neighbourhood, most of the participants did so in terms of the neighbours and the people around them. A positive feature of neighbourhoods was having people around who could be relied on. Neighbours who called in daily were described, and who would help out with practical tasks including transport. Neighbours were often described as friends. Neighbours provided essential community support and an opportunity for older people to reciprocate support, for example, through watching out for post or feeding pets. Living in the same neighbourhood for many years gives a connectedness with the past, which contributes to a sense of well-being.

However, for a few, the stunted, sequestered community does exist. These neighbourhoods were discussed in terms of a lack of people and community and were associated with changes over time such as the death of one's peers and the increasingly busy lives of people. This clearly detracted from life quality for participants who so described their community. Findings are consistent here with those of Murphy *et al.*, (2007).

With regard to safety, participants generally were very positive. Most felt safe in their community and few possessed security alarms. Yet at the same time, there was uncertainty about the process of applying for a personal alarm and it seemed that more might utilise alarms if information about the costs and process were more readily available. It is possible that costs were a factor contributing to the low levels of alarms, yet again, the participants tended to emphasise the fact that they were sufficiently safe. It is possible that older

people do not wish to acknowledge vulnerability, in the same way as they do not want to concede they cannot afford items. Interestingly, the older people in McGrath's (2005) study in a rural setting discussed safety in more negative terms. It may be that the focus group discussion permitted more disclosure of concerns in this regard. The participant who explained how she left her key in the door as this enabled people to come and visit her may well be trading off social contact against safety, and this possibility could be explored in a more specific study. The findings contrast again with those of Sharf in which a large proportion of older people felt unsafe in their community and many indeed had been victims of crime. Their study, carried out in deprived areas in three UK cities, highlights the differences between living on a low income due to low pensions payment rates and living in an environment characterised by deprivation.

The study findings reinforce previous work on housing deprivation. Although broadly expressing satisfaction with living arrangements participants did disclose difficulties in relation to stairs, bathroom and in particular getting work done. The difficulties experienced with maintenance related to getting work done or getting financial assistance for repairs. There is clearly a need for a service which assists older people with grant applications.

The study, in using the state pension as a proxy for poverty, does not focus particularly on older people who live in deprived neighbourhoods as, for example, the work of Scharf and associates with the UK 'Growing Older' programme does. As such, the potentially negative impact of living in poverty over time and living in an environment in which others also live in poverty cannot be explored.

Seven of the participants lived in supported housing arrangements. These participants had good quality of life in many respects but particularly with regard to their homes. All felt very safe with either wardens or personal alarms supplied. It was these participants that spoke of storage heaters and their satisfaction with this arrangement. Securing a place in such a facility was thought to be a godsend and it was clear that these amenities have the potential to greatly enhance quality of life for older people.

It did emerge in the course of the study that public transport difficulties exist for older people. This finding reinforces those of earlier studies (e.g. Ruddle *et al.*, 1998; Garavan *et al.*, 2001; O'Shea, 2003; McGrath, 2005; Murphy *et al.*, 2007) that bus and train services are limited, particularly in rural areas. Given the role of transport in getting out and about and its role in turn in contributing to well-being and a sense of independence, this is an area that requires attention generally, but critically, in the case of older people living in or at risk for poverty. In this study only a small proportion of participants owned and used their own car (3) while the remainder used public transport, taxis and/or reliant on transport from family or neighbours. It is worth noting that none of the rural based participants mentioned using the Rural Transport Initiative. Participants used taxis for attending doctor/hospital appointments, for going into town and for social activities commented on the high price. Taxis, though used out of necessity, are clearly not an affordable option for older people in poverty and force them to use already limited resources on a service that should be available publicly. Not having access to public transport adds considerably to living expenses and thus limited income interacts with transport deficit to detract from life quality.

5.6 Health and access to Health Services

As outlined in chapter 2, health is an important determinant of quality of life both directly and also indirectly, through its influence on mobility and, in turn, getting out and about and socialising. The older people in this study described a range of ailments, with varying degrees of compromised mobility, consistent with the findings of Dominy and Kempson (2006) and Hill *et al.*, (2007), although many characterised their health as 'fairly good' and were, by their own appraisal, reasonably healthy. Ill-health required participants to make adjustments to their life, which had emotional, social and financial implications. Loss of enjoyable pastimes was an issue, as was reduced ability to move around one's environment. Those with chronic ill-health found it did limit their ability to enjoy life and spoke with regret of their diminished capacity for exercise. Attitudes of forbearance and low expectations were

evident again here, with participants giving grateful testimony that they were still around and emphasising what they can do rather than what they can't. In the study on older people with a disability, similar optimistic perspectives were found, as older people viewed their ill-health in a comparative context, with those who were perceived to be worse off (Murphy *et al.*, 2007).

Access to, and satisfaction with health care services was variable. Participants were generally satisfied with Home Help services and findings did not reveal how the service could be improved. With regard to Meals on Wheels services, meals perhaps could be more palatable. These services generally would seem to be important in protecting older people from deeper levels of financial hardship, although Meals on Wheels does carry a cost which although low, may be significant for those on a low income.

Many of the older people in this study utilised their local day care service and highlighted its importance in terms of both practical and social support. Participants varied in the number of days they attended the service and some would like to increase attendance but were cognisant of limited places available. It was clear that participants placed a very high value on this service, one participant claiming that she 'lives for it'. Day Centres appear to be vital in terms of maintaining and promoting social connectedness, promoting physical activity and importantly as a source of practical support and information.

Satisfaction with medically-oriented services was poorer than social services. Given that acute and GP services are now free at point of access to most older people, income did not feature as an interacting factor with the exception of one incident, in which a changed appointment left the interviewee in a position where she could not attend her appointment without considerable cost. A taxi was the only means of transport to the hospital, some distance away. While most who had had hospital visits were positive about the experience, it was with regard to GP visits that older people had the most difficulty. A perceived unwillingness on the part of the GP to undertake home visits was noted, leaving older people to find their own way to the surgery. Mobility and financial barriers can then be encountered.

5.7 Conclusions

The primary aim of this study was to identify and explore non-monetary factors that affect the quality of life of older people living in poverty, through consulting with older people. To this end the study interviewed 40 older people aged between 66 and 100, who were reliant on the State pension, which was used as the indicator of poverty. The interview guide was based on the Toronto Quality of Life framework, which encompasses aspects of physical health, psychological well-being and social and community belonging and opportunities for growth and development.

5.8.1 Enhancing Quality of Life through Income Adequacy

The older people interviewed can be said to be either on a low income or living in poverty. Almost all older people in the study either found it difficult to manage with their pension or 'managed' through the application of budgeting strategies. Consistent with other studies on either life quality or financial management in older people (e.g. Dominy and Kempson 2006; Scharf *et al.*, 2003), older people appear to minimise hardship and distance themselves from the label of poverty. The older people, while describing careful money management strategies and prudence in spending display a stoicism about constitutes the essentials in life. They give grateful testimony to what they have in relation to past generations, and have low expectations with regard to what life could be offering them in old age. This is confirmed in the quality of life literature. The lived experiences of older people on a low income and living alone in this study are qualitatively different to those of women and families in poverty. In light of this, policy makers need to make provision for adequate social welfare pension payments that clearly exceed the poverty threshold. The uncomplaining stoical perspective articulated by older people masks difficulty making ends meet and cloaks hardships that would be very real to other population groups.

With regard to social welfare policy, it is evident that secondary benefits are important in supplementing income for older people living alone. However,

given the particular difficulties experienced by older people in respect of fuel costs, it is evident that the fuel allowance needs to be increased and adjusted regularly in the context of unstable fuel prices.

The study calls for a re-think of the indicators of deprivation. Previous research has shown that while older people are the population group most at risk for income poverty, they are least at risk for deprivation. However the deprivation indicators which require that people agree or disagree as to whether they can afford certain items, may not capture actual deprivation in older people. The particular evaluations of older people and their tendency to contextualise their experiences of living on a low income may lead to a denial of unaffordability of items used as indicators of deprivation. In the study it was apparent that older people have a unique perspective on what qualifies as need and as luxury. It is very possible that notions of un-affordability are conflated with old age. Further, low expectations, combined with use of family and other informal supports, may lead older people to downplay 'un-affordability' of items.

5.8.2 Enhancing Quality of Life through Social, Community and Health Determinants

In the context of poverty research, the point has frequently been made that poverty is more complex than the amount of money coming into the household or individual pocket. Poverty is about more than money because others goods, services and the opportunity for enjoyment, recreation and life affirming experiences require access to money. Similar arguments have been made in the quality of life research. Hendry and McVittie (2004) found in their study of quality of life in older people that although questions were put based on discrete topics, the participants did not view quality of life as falling into distinct domains. They tended to link the various aspects in their own experiences, and their comment revealed that one 'domain' has implications for others domains. Different aspects of quality of life were inextricably interlinked. The quality of life of older people living in on a low income can be much improved by addressing the broad determinants of health and well-being.

The informal support provided by families, in respect of practical help, housework and meals, finance can be seen to protect older people from extreme hardship. However this level of support cannot and should not be assumed. Such informal systems are neither comprehensive nor systematic and the population of older people would benefit from a more formal social needs assessment and appropriate service provision. For example, the development and promotion of locally based befriending schemes need to be supported to ensure that the social connectedness of older people living alone is facilitated. Bereavement support is another service that could be developed to meet the needs of older people living alone. In addition to providing social support, social services can also be a source of information and practical support to older people who are living alone.

Given the low expectations of older people in the study it is worth considering how models and images of positive ageing can be promoted more comprehensively throughout the community. Positive models of ageing underpin the valuable work of a number of importance agencies and organisations of and for older people but it argued here that these models need to be promoted across the entire population rather than just the older community, emphasising the opportunities and freedoms old age offers. As it now stands, the tendency to see older people primarily in terms of their 'problems' underpins much policy. The majority of health policy documents outline the need for disease prevention, nursing care, the expansion of services generally and beds in particular and access to services. Health promotion and in particular the concept of salutogenesis (factors that create and maintain health) has much to offer in respect of positive models of ageing.

Access to Primary care services are of particular importance to older people, and this study confirms that removing financial barriers to the services is a positive development. However hidden barriers may still exist, in the form of having to pay for transport to attend the surgery. Measures to assist older people access GPs could include taxi vouchers, or providing incentives for home visits.

The provision of appropriate, affordable and accessible transport is a crucial need for older people. A lack of access to transport can impact negatively on social participation rates and independence of older people. In relation to accessing public transport in rural areas more information about the existing Rural Transport Initiative is required. For older people with diminished mobility the use of private transport (taxis) may be more appropriate. However the affordability of taxis is a real issue for those on fixed social welfare pensions. In this regard additional transport initiatives need to be explored such as the provision of taxi vouchers.

It was apparent from study findings that older people have difficult accessing information about entitlements and at times, actual services and grant assistance. Older people living alone need to be fully informed and supported to access information relevant to their entitlements to community based schemes. A more proactive approach, tailored to the specific needs of older people and easily accessible would be of benefit. In this regard the role of the Citizens Advice Centre could be explored and considered for expansion, for example, by continuing to develop and expand the provision this service on an outreach basis.

Although the nature of the data collected here does not permit discrete comparisons, it appears that those who live in supported housing arrangements have a more positive experience, particularly with regard to comfort and safety and social contact. Even where rent is a cost that individuals must meet, others provisions cushion the older persons from financial hardship. More extended provision of these housing arrangements would greatly enhance life quality for older people living alone, and at risk for or in poverty.

5.8.3 Future Research

This study, in using the State pension as an indicator of low income, did not distinguish between older people who are on a low income or in poverty by virtue of low pension payments, or who have lived much of their lives on low incomes or in poverty. Future research could identify these sub samples for comparison. Relatedly, the lived experiences of older people living with a

spouse should be given research consideration. In the light of findings from other poverty studies, the need to provide for and care for another might lead to a different experience of deprivation, despite lower risk of income poverty.

Older people living in extreme isolation who are not in contact with services were not reached in this study. Further research needs to explore different methodologies in order to obtain a qualitative perspective on their everyday experiences. Any such research needs to be ethically appropriate in terms of identifying and engaging with this group of older people. Door to door data collection may only be appropriate in some areas and the safety and security issues in relation to both older people and research teams needs consideration in this context.

The importance of social contacts, networks and connectedness has emerged in this study, and reinforces that of other quality of life studies. A comprehensive social needs assessment across the diverse older person population would provide a basis of policy making, in which broad quality of life issues would be the fore and the specific needs of different sub groups of older people could be addressed. Such a study would inform policy making consistent with the life cycle approach underpinning the current partnership agreement (Towards 2016) and The National Action Plan for Social Inclusion 2007 - 2016.

REFERENCES

Age and Opportunity (2003) *Home from Home? The views of Residents on Social Gain and Quality of Life: A Study in Three Care Centres for Older People*. Dublin: Age and Opportunity.

Area Development Management Ltd (2002) *Rural Transport Initiative*. Retrieved March 22nd 2007 from <http://www.adm.ie/Pages/rti/overview.htm>

Area Development Management Limited (2004) *External Evaluation of the Rural Transport Initiative*. Retrieved December 5th 2006 from <http://www.adm.ie/Pages/rti/publications/RTI%20External%20Evaluation%20-%20Final%20Report0704.pdf>

Barrington, R. (1987). *Health Medicine and Politics in Ireland 1900-1970*. Dublin: Institute of Public Administration

Bond, J. & Corner, L. (2004) *Quality of Life and Older People*. Maidenhead: Open University Press.

Bowling, A. (2001) *Measuring Disease: A Review of Disease Specific Quality of Life Measurement Scales*. Buckingham: Open University Press.

Bowling, A. (2002) *Research Methods in Health (2nd ed)*. Buckingham: Open University Press.

Bowling, A., Bannister, D., Sutton, S., Evans, O. & Windsor, J. (2002) A multidimensional model of the quality of life in older age. *Ageing and Mental Health*, 6(4), 355-371.

Brown, I., Renwick, R. & Nagler, M. (1996) The Centrality of Quality of Life in Health Promotion and Rehabilitation. In R. Renwick, I. Brown & I. Nagler (Eds.), *Quality of Life in Health Promotion and Rehabilitation: Conceptual Approaches, Issues and Applications*. Thousand Oaks: Sage Publications.

Bryman, A. (1998) *Quantity and Quality in Social Research*. London: Unwin Hyman.

Brenner, H. and Shelley, E. (1998) *Adding Years to Life and Life to Years...: A Health Promotion Strategy for Older People*. Dublin: National Council on Ageing and Older People.

Central Statistics Office (2003) *Principle Demographic Results - Census 2002*. Cork: Central Statistics Office.

Central Statistics Office (2005) *EU Survey on Income and Living Conditions EU-SILC 2004 (with revised 2003 estimates)*. Retrieved March 2nd 2007 from <http://www.cso.ie/releasespublications/>

Central Statistics Office (2006) *EU Survey on Income and Living Conditions EU-SILC 2005*. Retrieved March 2nd 2007 from <http://www.cso.ie/releasespublications/>

Commission of the European Communities, 1993 cited in Tracey, P., Butler, M., Byrne, A., Drennan., J., Fealy, G., Frazer, K., and Irving, K. (2004) *Loneliness and Social Isolation among Older Irish People*. Dublin: National Council on Ageing and Older People

Crabtree, B & Miller, W (1992) *Doing Qualitative Research*. Newbury Park: Sage Publications.

Daly, M. (1989) *Women and Poverty*. Dublin: Combat Poverty Agency

Daly, M. & Leonard, M. (2002) *Against All Odds: Family Life on a Low Income in Ireland*. Dublin: Combat Poverty Agency/ Institute of Public Administration.

Day, H., and Jankey, S. (1996) Lessons from the literature: toward a holistic model of quality of life. In R. Renwick, I. Brown & I. Nagler (Eds.) *Quality of Life in Health Promotion and Rehabilitation: Conceptual Approaches, Issues and Applications*. Thousand Oaks: Sage Publications.

Department of Finance (2006) *Budget 2007 (online)*. Available: <http://www.budget.gov.ie/> (December 7th 2006)

Department of Health (1988) *The Years Ahead: A Policy for the Elderly. Report of the Working Group on the Services for the Elderly*. Dublin: The Stationary Office.

Department of Health and Children (2001) *Quality and Fairness: A Health System for You*. Dublin: The Stationary Office.

Department of the Taoiseach (2002) *Building an Inclusive Society: Review of the National Anti-Poverty Strategy under the Programme for Prosperity and Fairness*. Dublin: The Stationary Office.

Department of the Taoiseach (2003) *Sustaining Progress: Social Partnership Agreement 2003-2005*. Dublin: The Stationary Office.

Department of the Taoiseach (2006) *Towards 2016: Ten Year Framework Social Partnership Agreement 2006-2015*. Dublin: The Stationary Office.

Department of the Taoiseach (2002) *An Agreed Programme for Government between Fianna Fáil and the Progressive Democrats*. Dublin: The Stationary Office.

Department of Finance (2000) *National Development Plan 2000-2006*. Dublin: The Stationary Office.

Department of Finance (2007) *National Development Plan 2007-2013*. Dublin: The Stationary Office.

Dominy., N. and Kempson, E., (2006) Understanding Older People's Experiences of Poverty and material Deprivation Norwich: Corporate Document Services, UK Government Dept for Work and Pensions

Elkan, R., Kendrick, D., Dewey, M., Hewitt, M., Robinson, J., Blair, M., Williams, D. and Brummell, K. (2001) Cited in National Economic and Social Forum (2005) *Care for Older People*. National Economic and Social Forum: Dublin.

Fahey, T. & Murray, M. (1994) *Health and Autonomy among the over-65s in Ireland*. Dublin: National Council for the Elderly.

Farquhar, M. (1995) Elderly People's Definitions of Quality of Life. *Social Science & Medicine*, 41(10), 1439-1446.

Felce, D. & Perry, J. (1995) Quality of life: its definition and measurement. *Research in Developmental Disabilities*, 16, 51-74.

Felce, D. (1997) Defining and applying the concept of quality of life. *Journal of Intellectual Disability Research*, 41,126–135.

Fletcher, A., Jones, D., Bulpitt, C. & Tulloch, A. (2002) The MRC trial of assessment and management of older people in the community: objectives design and interventions. *BMC Health Services Research*, 2(21), 21

Gabriel, Z. & Bowling, A. (2004) Quality of life from the perspectives of older people. *Ageing & Society*, 24, 675-691.

Garavan, R., Winder, R. & McGee, H. (2001) *Health and Social Services for Older people (HeSSOP)*. Dublin: National Council on Ageing and Older People.

Gill, T. & Feinstein, A. (1994) A critical appraisal of the quality of quality of life instruments. *Journal of the American Medical Association* 272:619-626.

Graham, H. (1993) *Hardship and Health in Women's Lives*. Brighton:Harvester Wheatsheaf

Healy, J. (2003). *Fuel Poverty and Policy in Ireland and the European Union*. Dublin: CPA. Cited in O'Shea & Conboy (2005).

Hendry, F. & McVittie, C. (2004) Is quality of life a health concept? Measuring and understanding life experiences of older people. *Qualitative Health Research*, 14, 961-975.

Hill, K., Kellard, K., Middleton, S., Cox L., and Pound., E. (2007) *Understanding resources in later life: views and experiences of older people* York: Joseph Rowntree Foundation.

Hodgins, M. & Kelleher, C. (1998). *Health and Well-Being in Social Care Workers*. In: *Women's Studies Review*. Vol.5. Galway: NUI Galway.

Holland, C., Kellahaer, L., Peace, S., Scharf, T., Breeze, E., Gow, J., and Gilhooley, M (2005) *Getting Out and About in A. Walker* (Editor) *Understanding Quality of Life in Old Age* Maidenhead: Open University Press.

Holloway, I. & Wheeler, S. (1996) *Qualitative Research for Nurses*. Oxford: Blackwell Science.

Hughes, G. (2006) *Pension Tax Reliefs and Equity*, In J. Stewart (Ed.), *For Richer For Poorer - An Investigation of the Irish Pension System*. Dublin: New Island Books

Institute of Public Health (2000) *Inequalities in Mortality 1989-1998: A Report on All-Ireland Mortality Data*. Dublin: Institute of Public Health.

Kane, R. (2001) Long-term care and a Good Quality of Life: Bringing them closer together. *The Gerontologist*, 41, 293-304.

Keogh, F. & Roche, A. (1996) *Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment*. Dublin: National Council for the Elderly.

Kuzel, A (1992) Sampling in qualitative inquiry. In B. Crabtree & W. Miller (Eds.), *Doing Qualitative Research*. Newbury Park: Sage Publications.

Layte, R. Fahey, T. & Whelan, C. (1999) *Income, Deprivation and Well-being among older Irish people*. Dublin: National Council on Ageing and Older People.

Lindstrom, B. (1992). Quality of Life: A model for Evaluating Health for All. Conceptual considerations and policy implications. *Sozial und Praventivmedizin*, 37, 301-306

Lundstrom, F. & McKeown, K. (1994) *Home Help Services for Elderly People in Ireland*. Dublin: National Council for the Elderly.

Mays, N. & Pope, C. (2000) Qualitative research in health care: assessing quality in qualitative research. *British Medical Journal*, 320, 50-52.

McAvoy, H. (2001) A prospective comparative study of the influence of day-care on the quality of life and health of older people. Galway: National University of Ireland, Unpublished dissertation.

McCashin, A. (2006) *The State Pension - Towards a Basic Income for the Elderly*. In J. Stewart. *For Richer For Poorer - An Investigation of the Irish Pension System*. Dublin: New Island Books.

McGrath, M. (2005). *Enhancing Quality of Life in Older People*. Unpublished Masters Thesis. Galway: NUI Galway.

McLaughlin, E. (1993). Ireland: Catholic Corporatism, in A. Cochrane and J. Clarke (Editors) *Comparing Welfare States* London: Sage

Miles, M. & Huberman, A. (1994) *An expanded source book for qualitative data analysis*. Thousand Oaks: Sage Publications.

Miller, W. & Crabtree, B. (1992) Overview of qualitative research methods. In B. Crabtree & W. Miller (Eds.), *Doing Qualitative Research*. London: Sage Publications.

Millar, J., Leeper, S. & Davies, C. (1992) *Lone Parents Poverty and Public Policy in Ireland*. Dublin: Combat Poverty Agency.

Minichellio, V., Aroni, R., Timewell, E. & Alexander, L. (1995) *In-depth Interviewing: Principles, Techniques, Analysis*. Melbourne: Longman Cheshire.

Morse, J.M. (1994) Qualitative research: fact or fantasy? In J.M. Morse (Ed.), *Critical Issues in Qualitative Research*. Thousand Oaks: Sage Publications.

Murphy, K., O'Shea, E., Cooney, A., Shiel, A. & Hodgins, M. (2006) *Improving Quality of Life for Older People in Long-Stay Care Settings in Ireland*. Dublin: National Council on Ageing and Older People.

Murphy, K., O'Shea, E., Cooney, A., & Casey, D. (2007) *The Quality of Life of Older People with a Disability in Ireland*. Dublin: National Council on Ageing and Older People.

Department of Social and Family Affairs (2003) *National Action Plan Against Poverty and Social Exclusion 2003-2005*. Dublin: The Stationary Office.

Department of Social and Family Affairs (2003) NAPS/incl: *National Action Plan for Social Inclusion 2007-2016*. Dublin: The Stationary Office.

National Council on Ageing and Older People (2005) *An Age Friendly Society - A Position Paper*. Dublin: National Council on Ageing and Older People.

National Economic and Social Forum (2005) *Care for Older People*. Dublin: National Economic and Social Forum.

Noone, P. (2004) The meaning of well-being for Older People. Unpublished Masters Thesis. Galway: NUI Galway.

Nunukoosing, K. (2005) The problems with interviews. *Qualitative Health Research*, 15(5), 698-706.

O'Hanlon, A., McGee, H., Barker, M., Garavan, R., Hickey, A., Conroy, R. & O'Neill, D. (2005) *Health and Social Services for Older People II (HeSSOP II): Changing Profiles from 2000 to 2004*. Dublin: National Council on Ageing and Older People.

O'Loughlin, A (1999) Social policy and older people in Ireland. In S. Quin, P. Kennedy, A. O'Donnell & G. Keily (Eds.), *Contemporary Irish Social Policy*. Dublin: University College Dublin Press.

- O'Shea, E. (2003) *Healthy ageing in Ireland: policy, practice and evaluation*. Dublin: National Council on Ageing and Older People.
- O'Shea, E. & Conboy, P. (2005). *Planning for an Ageing Population: Strategic Considerations*. Dublin: National Council on Ageing and Older People.
- Patton, Q.M. (2002) *Qualitative Research and Evaluation Methods*. Thousand Oaks: Sage Publications.
- Pearson, M. Pension Reforms: What was overlooked? Presented at IFA Conference, Copenhagen May 2006.
- Polit, D.E. & Hungler, B.P. (1999) *Nursing Research: Principles and Methods*. Philadelphia: Lippincott.
- Pope, C., Ziebland, S. & Mays, N. (2000) Qualitative research in health care: Analysing qualitative data. *BMJ*, 320, 114-116.
- Power, B. (1980). Old and Alone in Ireland: A Report on a Survey of Old People Living Alone. Dublin: Society of St. Vincent de Paul.
- Prunty, M. (2007) *Older People in Poverty in Ireland: An analysis of EU-SILC 2004*. Retrieved April 24th 2007 from http://www.cpa.ie/publications/workingpapers/2007-02_WP_OlderPeopleInPovertyInIreland.pdf
- Raphael, D. (1995) The quality of life seniors living in the community - a conceptualisation with implications for public health practice. *Canadian Journal of Public Health*, 86, 228-233
- Raphael, D. (1996) Defining quality of life: eleven debates concerning its measurement. In R. Renwick, I. Brown & I. Nagler (Eds.), *Quality of Life in Health Promotion and Rehabilitation: Conceptual Approaches, Issues and Applications*. Thousand Oaks: Sage Publications.
- Raphael, D. (2001) Evaluation of Quality-of-Life Initiatives in Health Promotion. In I. Rootman, M. Goodstadt, B. Hyndman, D. McQueen, L. Potvin, J. Springett & E. Ziglio (Eds.), *Evaluation in Health Promotion: Principles and Perspectives*. Copenhagen: WHO Regional Publications.
- Raeburn, J. and Rootman, I, (1996). Quality of life and health promotion. In I. Brown, R. Renwick & I. Nagler (Eds.), *Quality of Life in Health Promotion and Rehabilitation*. London: Sage Publications.
- Renwick, R. & Brown, I. (1996) The Centre for Health Promotion's Conceptual Approach to Quality of Life. In I. Brown, R. Renwick, & I. Nagler (Eds.), *Quality of Life in Health Promotion and Rehabilitation*. Sage Publications.
- Rogerson, R. (1995) Environmental and health-related quality of life: conceptual and methodological similarities. *Social Science and Medicine*, 41, 10, 1373-1382

Robson, C. (2002). *Real World Research* (2nd ed). Malden: MA: Blackwell Publishing.

Ruddle, H., Donoghue, F., Mulvihill, R. (1998) *The Years Ahead report: A Review of the Implementation of its Recommendations*. Dublin: National Council on Ageing and Older People

Schallock, R.L., Brown, I., Brown, R., Cummins, R.A., Felce, D., Matikka, L., Keith, K.D. & Parmenter, T, (2002) Conceptualization, Measurement, and Application of Quality of Life for Persons With Intellectual Disabilities: Report of an International Panel of Experts. *Mental Retardation*, 40(6), 457-470.

Scharf, T., Phillipson, C., Smith, A,m and Kingston, P. (2003) *Older People in Deprived Neighbourhoods: Social Exclusion and Quality of Life in Old Age*. GO Findings, Growing Older Programme: University of Sheffield

Scharf, T., Bartlam, B., Hislop, J., Bernard, M. Dunning, A., and Sim, J. (2006) *Necessities of Life: Older People's Experiences of Poverty*. Keele: Help the Aged

Sheily, F. & Kelleher, C. (2004) *Older people in Ireland: A profile of Health Status, Lifestyle and Socio-Economic Factors from SLAN*. Dublin: National Council on Ageing and Older People.

Sidorenko, A., and Walker, A. (2004) cited in Walker, A (2006). Extending quality of life: policy prescriptions from the growing older programme, *Journal of Social policy* 35 (3): 437-454.

SLAN (1998) *The National Health and Lifestyle Surveys*. Dublin Dept. of Health and Children and Galway: Centre for Health Promotion Studies

SLAN (2004) *The National Health and Lifestyle Surveys*. Dublin Dept. of Health and Children and Galway: Centre for Health Promotion Studies

Smith, A.E., Sim, J., Scharf, T. & Phillipson, C. (2004). Determinants of quality of life amongst older people in deprived neighbourhoods. *Ageing and Society*, 24, 793-814.

Stratton, D. (2004) *The Housing Needs of Older People*. Dublin: Age Action Ireland.

Stratton, D. (2005). Looking after our ageing population - the case for pension reform. *Action on Poverty Today*, 11, 4-5

Stewart, J. (2006) *Incomes of Retired Persons in Ireland*. In J. Stewart (Ed.), *For Richer For Poorer - An Investigation of the Irish Pension System*. Dublin: New Island Books

Taylor, S. & Bogdan, R. (1996). Quality of life and the individual's perspective. In R. L. Schallock (Ed.), *Quality of life: Conceptualization and measurement* (Vol. I). Washington, DC: American Association on Mental Retardation.

The Equality Authority (2002) Implementing Equality for Older People. Retrieved December 5th 2006 from <http://www.equality.ie/index.asp?ACTIVEGROUP=2&locID=107&docID=-1>

The Pensions Board (2006) Personal Retirement Savings Accounts (PRSAs). Retrieved March 11th 2006) from <http://www.pensionsboard.ie/eng/index.asp?locID=40&docID=-1>

Townsend, P. (1957). *The Family Life of Old People*. London: Routledge and Kegan

Townsend, P., Davidson, N. & Whitehead, M. (1988) *Inequalities in Health: The Black Report and the Health Divide*. Harmondsworth: Penguin.

Treacy, P., Butler, M., Byrne, A., Drennan, J., Fealy, G; Frazer, K. & Irving, K. (2004) *Loneliness and Social Isolation among Older Irish People*. Dublin: National Council on Ageing and Older People.

Tussing, D., and Wren, M.A., (2006) *How Ireland Cares*. Dublin: New Island

Unit for Health Status and Health Gain (2005) *Report for Advisory Group on Consultative Study*. (Unpublished).

Victor, C., Bowling, C., and Bond, J. (2002) Cited in Treacy, P., Butler, M., Byrne, A., Drennan, J., Fealy, G; Frazer, K. & Irving, K. (2004) *Loneliness and Social Isolation among Older Irish People*. Dublin: National Council on Ageing and Older People.

Vincentian Partnership for Social Justice (2006) *Minimum Essential Budgets for Six Households*.

Walker, A. (2006). Extending quality of life: policy prescriptions from the growing older programme. *Journal of Social Policy*, 35(3), 437-454.

Walker, A. (2004) The ESRC Growing Older research programme 1999-2004. *Ageing & Society*, 24, 657-674.

Watson, D. and Williams, J. (2003) Irish National Survey of Housing Quality 2001-2002. Dublin ESRI, Cited in O'Shea, E. and Conboy, P. (2005). *Planning for an Ageing Population: Strategic Considerations*. Dublin: National Council on Ageing and Older People.

WHOQOL Group (1995) The World Health Organisation Quality of Life Assessment (WHOQOL): Position Paper from the World Health Organisation. *Social Science & Medicine*, 41(10), 1403-1409.

Wilhelmson, K., Andersson, C., Waern, M. & Allebeck, P. (2005) Elderly people's perspectives on quality of life. *Ageing and Society*, 25, 585-600.

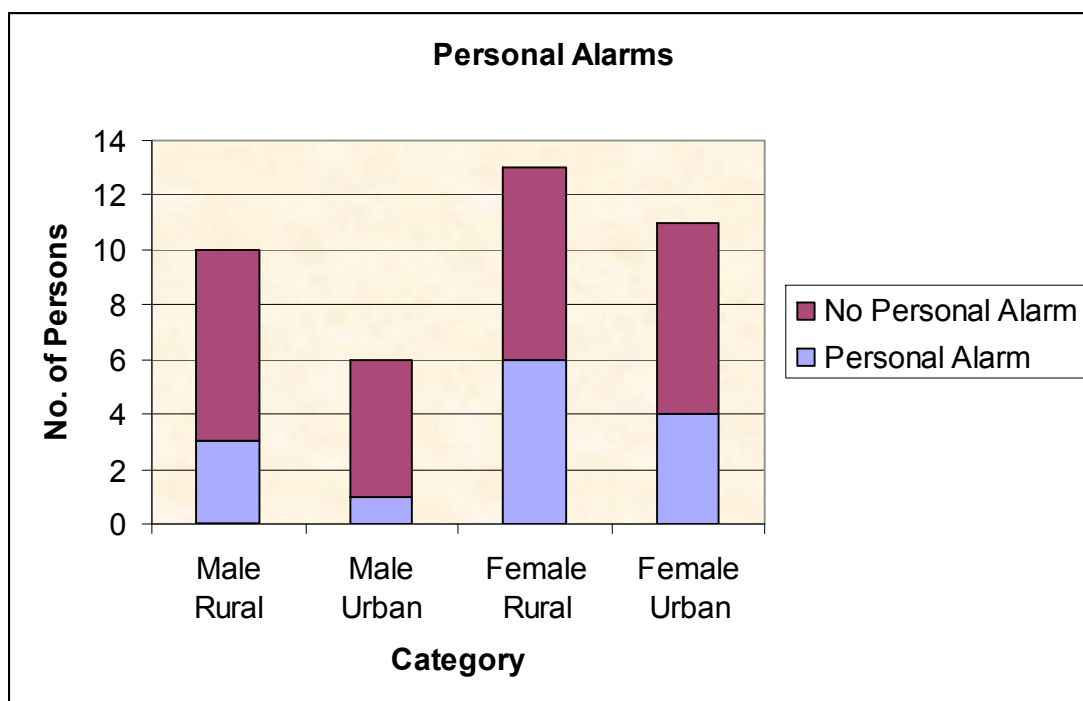
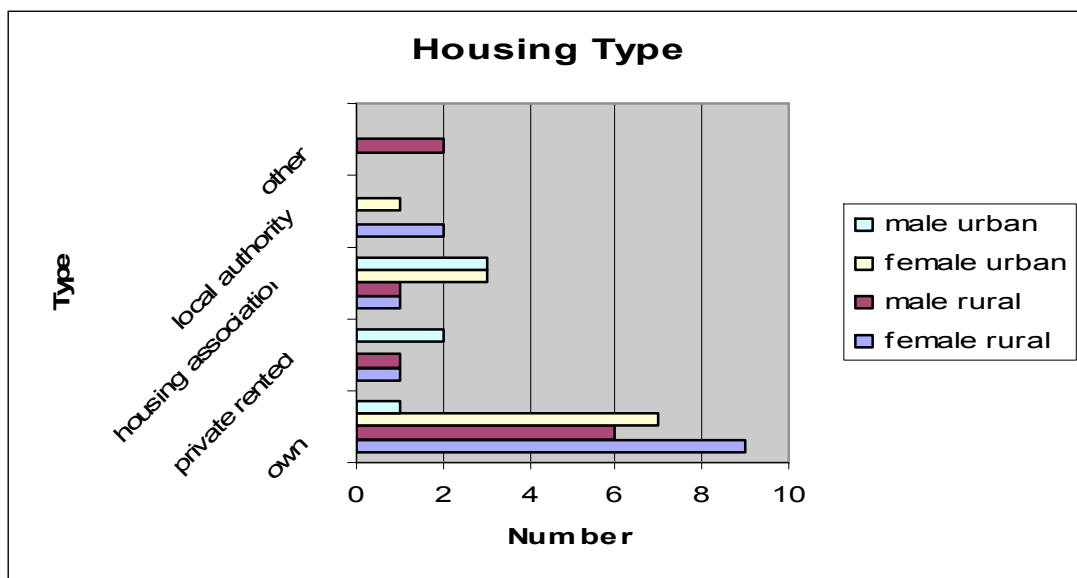
World Health Organisation (1946). *Constitution*. Geneva: World Health Organisation.

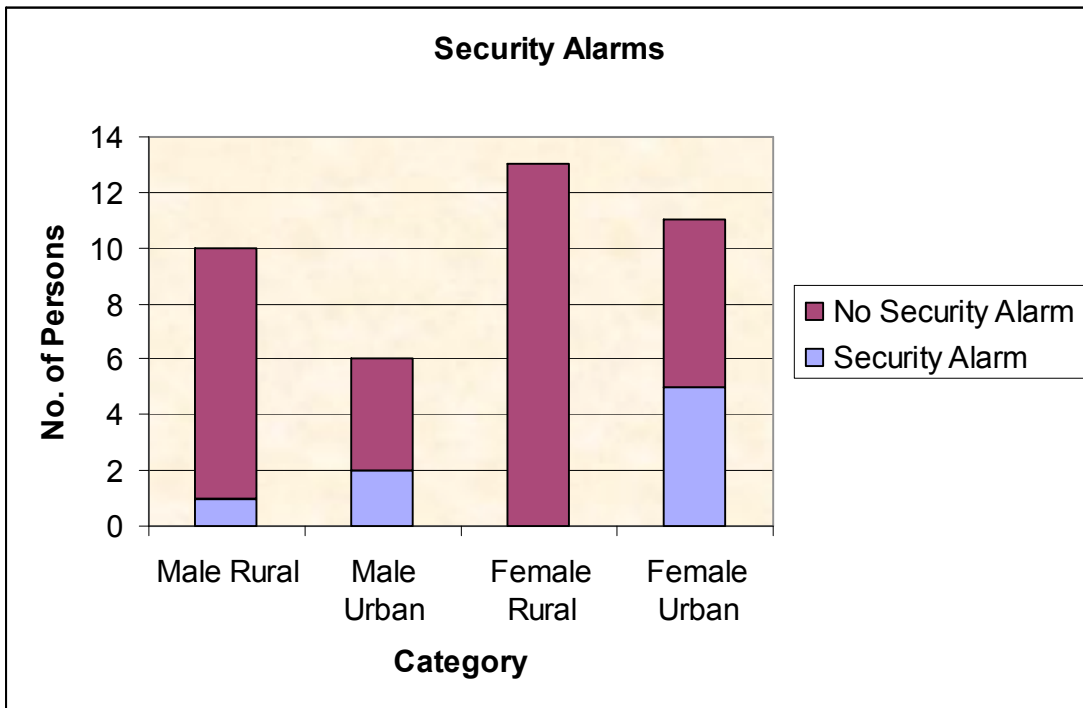
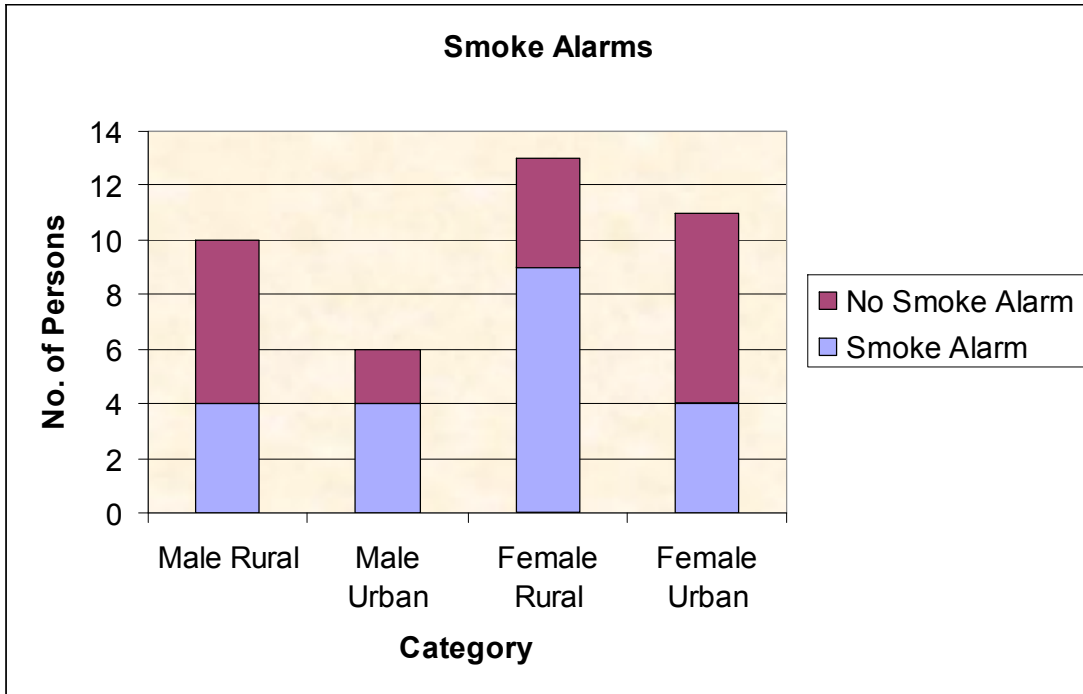
World Health Organisation (2001) cited on http://www.atlanticphilanthropies.org/ageing/republic_of_ireland, retrived 2nd April 2007

Zaidi, A. (2006) Poverty of Elderly People in EU25. European Centre for Social Welfare Policy and Research

Zissi, A. & Barry, M. (2004) Well-Being and Satisfaction as Components of Quality of Life in Mental Disorders. In H. Katsching, H. Freeman, and N. Sartorius (Eds.), *Quality of Life I Mental Disorders*. Chichester: Wiley and Sons.

Appendix 1





GLOSSARY

Adaptation	The process of changing to fit new circumstances or conditions
Consistent Poverty	The 'Consistent Poverty' measure was developed by the Economic and Social Research Institute (ESRI) to identify those people who are in relative income poverty (i.e., receiving below 60% of median income) <u>and</u> who are also deprived of certain items that Irish people consider are necessary to ensure a basic standard of living. These deprivation items include: no substantial meal for at least one day in the past two weeks due to lack of money; without heating at some stage in the past year due to lack of money; experience of debt problems arising from ordinary living expenses ; unable to afford two pairs of strong shoes; unable to afford a roast once a week; unable to afford a meal with meat, chicken or fish (or vegetarian equivalent) every second day; unable to afford new (not second-hand) clothes; unable to afford a warm waterproof coat. Persons at risk of poverty who experience deprivation in relation to at least one of these eight items are regarded as being in consistent poverty.
Contributory Pension	The State Pension (Contributory) is payable to people in Ireland from the age of 66 who have enough social insurance contributions. It is not means tested and applicants may have income from any other source while receiving it. It is taxable. The Social Welfare Law Reform and Pensions Act 2006 changed the name of the Old Age Contributory Pension to State Pension (Contributory). <i>http://www.citizensinformation.ie/categories/social-welfare/social-welfare-payments/older-and-retired-people/oap_contributory, retrieved March 2007</i>
Fuel Poverty	Being unable to afford adequate levels of heating. This is

	one of a number of indicators of deprivation used to define consistent poverty.
Income Poverty	Relative income poverty is having an income that is less than what is regarded as acceptable by general society, giving a lower than normal standard of living. It is called 'relative' because it is measured by how much less it is relative to what the majority of people enjoy. The 60 percent relative income poverty line is 60 per cent of the disposable income of the average household.
Income deciles	Measuring and comparing the relative income of different groups by dividing the total population into tenths.
National Development Plan (NDP)	The Irish Government's strategy for allocating EU Structural Funds and other public monies aimed at stimulating long term growth and a fairer distribution of resources across the whole economy.
Non-Contributory Pension	The State Pension (Non-Contributory) may be paid from age 66 to people in Ireland who do not qualify for a State Pension (Contributory). <i>http://www.citizensinformation.ie/categories/social-welfare/social-welfare-payments/older-and-retired-people/oap_contributory retrieved March 2007</i>
Poverty	People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by Irish society generally. Because of their poverty they may experience multiple disadvantage through unemployment, low income, poor housing, inadequate health care and barriers to education. They are often excluded and marginalised from participating in activities that are the norm for other people.
Poverty lines	From a base of average household income, poverty lines show the number of households and families falling below a certain income level and how far below that level they are. Poverty lines are usually set at 40%, 50% and 60% of the

	average income.
Qualitative Research	The gathering and analysing of data based on interviewees' own perceptions or experiences in order to provide insight into their beliefs about their circumstances rather than measurable data.
Quality of Life	The degree to which a person enjoys the important possibilities of his or her life (Brown, Renwick and Nagler, 1996)
Salutogenesis	Salutogenesis is the opposite of pathogenesis. The salutogenic model of health focuses on the causes of global well-being rather than the etiology of specific disease processes
Selective attention	The process or state of consciousness which involves focusing on a specific aspect of a situation while ignoring other aspects
Social Comparison	The process of judging our own performance or abilities with reference to others.
Social Exclusion	Social exclusion is a process whereby certain individuals are pushed to the edge of society and prevented from participating fully by virtue of their poverty or lack of basic competencies and life long learning opportunities as well as social and community networks and activities. They have little access to power and decision-making bodies and thus often feel powerless and unable to take control over the decisions that effect their day-to-day lives
Somatic Illness	An illness or illnesses relating to or affecting the body, especially the body as considered to be separate to the mind

