

7

Health And Social Care Utilisation

Charles Normand, Yumiko Kamiya, Virpi Timonen and Brendan Whelan

Contents

7.1	Introduction.....	204
7.2	Medical card and health insurance coverage.....	205
7.3	Use of medical services.....	208
7.4	Utilisation of other state care services	213
7.5	Disability and sources of care.....	214
7.6	Prevalence of impairments in ADL and IADL by age and sex.....	214
7.7	State provision of meals, home help, and personal care.....	215
7.8	Primary source of help for those with disability.....	216
7.9.	Conclusions.....	217

7

Health And Social Care Utilisation

Key findings

- Nearly all (97%) of those aged 80 or over have medical cards that exempt them from paying fees for primary care and hospital care. This compares with 91% for people in their 70s and 30% of those in their 50s.
- Nearly 60% of people between 50 and 69 have private medical insurance, dropping to 46% for those in their 70s and 32% of those over 80.
- The likelihood of being a user of GP care rises slightly with age, but is similar for all those over 70.
- The likelihood of having a hospital admission is similar for different ages over 60, but the length of stay increases slightly with age, and people over 80 are lower users of outpatient services than those in their 60s and 70s.
- The prevalence of disabilities rises with age from less than 10% of those between 50 and 64 to nearly 30% of those over 75.
- People with impairments in activities of daily living (ADL) and instrumental activities of daily living (IADL) receive on average 118 hours of help per month.
- The most common primary helper for this group is the recipients' spouse, this represents a large contribution by older adults into the care of older adults.
- Only 3.5% of people over 50 receive state provided home help services.
- Of those with both ADL and IADL impairments, 12% do not receive formal or informal help and these people constitute a potentially very vulnerable group.

7.1 Introduction

Access to health services depends both on medical need and the presence or absence of financial or other barriers. Some medical needs are related to age – in particular it is common for older people to have one or more chronic conditions, and the treatment and care of these conditions may be complicated by frailty or multimorbidity. This first analysis of the patterns of use of health services looks in particular at the roles of age and eligibility status on use of services. We begin by considering the usage of the main healthcare services – general practitioners (GPs) and hospitals and then go on to deal with formal and informal social care.

Entitlement to health care that is free or subsidised at the point of use in Ireland ('Entitlement Status') falls into four main categories – those with rights only to

the main state funded services, those who have supplementary private insurance, those with medical cards (which give free access in primary and community care, exemption from co-payments in public hospitals and free drugs) and those with both private insurance and medical cards. The entitlements for those with private medical insurance vary depending on the policy that is chosen, but generally allow quicker access to some hospital services and exemption from co-payments in hospitals. Uptake of full medical cards is close to 100% of those who meet the criteria. The income threshold for medical cards is higher for those over 70. There is a small additional category – a card giving rights to free GP care but not the other benefits, called the GP visit card. This is available for people with incomes up to 50% above the medical card limit. The uptake of the GP visit card is much lower than for the medical card but accurate data on the uptake are not available.

In this section those with main state cover only are described as having ‘no additional cover’, and those with both private insurance and medical cards are described as having ‘dual cover’.

The TILDA survey data have been weighted to be fully representative of the older population. However, the survey in the first wave did not include those who are in residential care. Although this covers only around 2% of those over 50, it represents a larger proportion of those in older age categories and people in residential care typically have more chronic disease. This means that the findings may understate to a small extent the use of health services, particularly in the older part of the over 50s population. It is popularly believed that the ageing of the population will significantly increase the demands on the health sector. Studies in several countries have questioned the importance of age, and point to the large increase in use of services in the last six months of life (1). The data from TILDA presented in this chapter support the finding that age alone is not a particularly important determinant of health service utilisation.

7.2 Medical card and health insurance coverage – the patterns of entitlement to health services free at the point of use in Ireland

Health services in Ireland are funded mainly from taxation, which provides around 80% of total health spending (2). However, nearly half of the population has supplementary private insurance that mainly covers in-patient services, and contributes around 8% of total health care resources. Most of the population pay out-of-pocket for primary and community services and for drugs (up to a monthly maximum), and this represents around 12% of total health care expenditure (2). These services are free for those with medical cards.

Table 7.1 shows the patterns of health care coverage for those over 50 by age group. Entitlements are issued on the basis of income (and in a few cases particular health needs) but were available to all people over the age of 70 from 2001 to 2008. For the purposes of presenting these numbers, the small proportion (less than 5% of card holders over 50 years of age) with GP visit cards are included in the medical card category.

Table 7.1: Health care entitlement status by age

	Not Covered		Health Insurance only		Medical Card only		Dual Cover		Total	All Medical Cards		All Health Insurance		Number in Sample	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI		%	95% CI	%	95% CI	%	
50-59	19	(17-20)	51	(49-53)	25	(23-27)	5	(4-6)	100	30	(28-33)	56	(54-59)		3271
60-64	10	(9-12)	50	(47-53)	31	(28-34)	9	(7-11)	100	40	(36-43)	59	(56-62)		1393
65-69	10	(8-12)	41	(37-44)	33	(30-36)	17	(14-19)	100	49	(46-53)	57	(54-62)		1197
70-79	1	(1-2)	8	(7-9)	53	(49-56)	38	(35-41)	100	91	(89-92)	46	(43-50)		168
>=80	0	(0-1)	3	(2-4)	68	(64-72)	29	(25-33)	100	97	(95-98)	32	(28-36)		63
Total	11	(10-12)	37	(35-38)	36	(35-38)	16	(15-17)	100	52	(52-54)	53	(51-55)		8172

Some interesting patterns can be found. Despite the recent decision to withdraw the automatic entitlement to medical cards from those over 70, it remains the case that over 90% of those between 70 and 79 retained the cards, and almost all of those over 80 still have medical cards. Dual cover is rare in those between 50 and 59 but is more common in those in their 70s.

Those between 50 and 59 have similar entitlements to those estimated for people under 50 (2), although there is a slightly higher proportion with private health insurance. Around 60% of people in their 60s have private insurance – suggesting there may be a cohort entering the older age groups who have had and retain private cover. For those between 60 and 69 there is no apparent effect of the statutory retirement age on the proportions with private insurance but the proportion having dual cover is higher in those between 65 and 69. Private insurance cover for those over 80 is much lower at 32%.

Entitlement status may provide some insight into the patterns of health service use reported on the next page. To explore this in more detail it is necessary to look at entitlement status, age and socio-economic status, all of which affect use of health and social care. Table 7.2 shows the patterns of those with private insurance, those with medical cards (including those with dual cover) and those with neither.

Table 7.2: Characteristics of the population aged 50 and over by entitlement status

	Not covered %	Medical card %	Medical insurance %	Total %
Gender				
Male	57	43	52	48
Female	43	57	48	52
Highest education achieved				
Primary/none	34	55	15	38
Secondary	52	35	52	43
Third/higher	15	9	33	19
Household type				
Living alone	16	32	12	23
Living with spouse only	30	39	40	38
Living with others	54	29	48	39
Employment status				
At work	61	14	59	35
Retired	12	48	24	35
Other	26	38	18	29
Self-rated physical health				
Excellent	15	9	22	14
Very good	29	22	35	28
Good	35	34	31	33
Fair	17	26	10	19
Poor	3	8	2	6

The patterns are not surprising. Those with no additional entitlements typically report themselves as healthier than those with medical cards, but slightly less healthy than those with private insurance only. They are likely to be working and to have at least secondary education.

Those with medical cards are generally older, are least likely to be in good health, and are much less likely to be working. The majority of those with medical cards have only primary education, which is partly explained by their age. They are also the most likely group to be living alone.

Those with private insurance have the highest levels of education, are likely to be working and have the best self-rated health. They are the least likely to be living alone. Although complex causal relationships may underlie these figures it is clear that private insurance cover is concentrated in the part of the over 50 population with the lowest needs for care, as it is in the population as a whole (2).

Table 7.3 shows the patterns of self-rated health by age group. As expected this shows some decline in health status with age, but most people still consider themselves in good health in each age group.

Table 7.3: Self-rated health status by age

	Excellent		Very Good		Good		Fair		Poor		Total	Number in sample
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI		
50-59	18	(17-20)	30	(29-32)	31	(30-33)	16	(15-17)	4	(4-5)	100	3273
60-64	14	(12-16)	30	(28-33)	33	(30-35)	18	(16-20)	6	(4-7)	100	1394
65-69	13	(11-15)	25	(22-28)	35	(32-38)	20	(18-23)	7	(5-8)	100	1198
70-79	10	(8-11)	24	(21-26)	35	(33-38)	25	(23-27)	7	(6-8)	100	1681
>=80	9	(7-11)	26	(23-30)	33	(29-37)	25	(22-29)	7	(5-9)	100	631
Total	14	(13-15)	28	(27-29)	33	(32-34)	19	(18-20)	6	(5-6)	100	8177

Note. CI = confidence interval; Missing observations = 0.01%

When these are collapsed into two categories – good and poor – the proportions declaring themselves to be in good health fall from 79% of those in their 50s to 68% for those in their 80s.

7.3 Use of medical services

Table 7.4 shows the patterns of use of different types of health services by entitlement status and self-rated health. The percentages are for those who used the services at least once in the previous year. For the purposes of this presentation the five categories of self-rated health have been collapsed into two – those who consider their health good or better, and those who consider their health to be fair or poor.

Table 7.4: Percentage of persons who utilised different types of healthcare, classified by entitlement status and self-rated health

	GP visit		Outpatient Clinic Attendance		Emergency Department Attendance		Hospital Admission	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Good health								
Not covered	71.1	(67.3-74.7)	26.1	(22.7-29.8)	11.2	(9.0-13.9)	4.6	(3.2-6.5)
Medical insurance	80.9	(79.1-82.5)	33.4	(31.4-35.5)	10.2	(9.0-11.5)	8.3	(7.3-9.4)
Medical card	91.6	(90.4-92.7)	35.3	(33.2-37.4)	12.0	(10.8-13.2)	10.7	(9.6-11.9)
Total	84.6	(83.5-85.6)	33.4	(31.9-34.9)	11.1	(10.3-12.0)	9.0	(8.3-9.7)
Poor health								
Not covered	86.7	(80.3-91.2)	51.8	(44.2-59.3)	21.2	(15.3-28.5)	11.2	(7.0-17.3)
Medical insurance	92.5	(89.2-94.9)	62.3	(57.0-67.3)	23.4	(19.4-28.0)	22.4	(18.5-26.9)
Medical card	97.6	(96.5-98.4)	61.3	(58.3-64.2)	27.7	(25.1-30.6)	26.8	(24.3-29.4)
Total	95.7	(94.6-96.6)	60.7	(58.1-63.1)	26.4	(24.2-28.6)	24.6	(22.5-26.8)
Total								
Not covered	74.3	(71.0-77.3)	31.3	(28.1-34.7)	13.2	(11.0-15.8)	5.9	(4.4-7.8)
Medical insurance	82.3	(80.7-83.8)	36.9	(35.0-39.0)	11.8	(10.6-13.0)	10.1	(9.0-11.2)
Medical card	93.7	(92.8-94.5)	44.3	(42.5-46.2)	17.5	(16.2-18.8)	16.3	(15.2-17.5)
Total	87.4	(86.5-88.2)	40.2	(38.8-41.6)	14.9	(14.1-15.8)	12.9	(12.1-13.7)

People with no additional cover and those with private insurance only are similar in terms of the age distribution, and the likelihood of being employed. However, those with private insurance are wealthier and have higher levels of education and are on average in better health. The expectation might, therefore, be that those with private insurance would make less use of health services than those with no additional cover. The opposite is the case for all types of care as discussed in more detail below. Those with medical cards are in general the oldest and sickest part of the over 50 population, and as would be expected are the highest users of services in all categories.

The most interesting comparisons are for those who declare themselves as being in poor health, where failure to access services may be more serious. For those in poor health, having a medical card makes attendance at the GP more likely. For those without medical cards, the deterrent effect of paying the full cost fee (reported in most cases to be €50 per visit) appears to be stronger in the no additional cover group than the private insurance group (probably due to the generally lower

incomes of those with no additional cover compared to those with private insurance only).

Those in poor health with no additional cover are also less likely to go to the emergency department which may in part be because without a GP referral this incurs a €100 fee. Similarly, those with no additional cover are less likely to go to outpatient services, which again require referral by a GP or hospital doctor. In some cases it is likely that those with private insurance are going to private outpatient appointments, where getting an appointment is usually easier and waiting times are typically shorter. This suggests that for outpatient services there are more barriers to access for those with no additional cover than for the rest of the population.

Those in poor health who have a medical card are most likely to have a hospital admission, and those with no additional entitlements are the least likely. The higher rates of inpatient admission for those with private insurance compared to those with no additional cover may be because those with insurance can opt to go to private hospitals where thresholds for admission are sometimes lower than in public hospitals.

Table 7.5 shows the patterns of use of health services classified by age group and self-rated health. Again the figures shown refer to the percentage who availed of the service in question at least once in the past year. Although it is widely believed that age is a major factor in the use of services, a more complicated pattern emerges.

Table 7.5: Percentage of persons who utilised different types of healthcare, classified by age group and self-rated health

	GP visit		Outpatient Clinic Attendance		Emergency Department Attendance		Hospital Admission	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Good health								
50-59	77.4	(75.6-79.2)	29.4	(27.5-31.4)	10.3	(9.1-11.6)	7.2	(6.3-8.3)
60-69	86.8	(85.0-88.4)	36.5	(34.1-38.9)	11.7	(10.2-13.3)	9.3	(8.0-10.6)
70-79	93.3	(91.7-94.6)	37.9	(35.0-40.9)	11.7	(10.0-13.8)	11.8	(10.0-13.8)
>=80	95.3	(92.7-97.0)	32.6	(28.1-37.5)	11.8	(9.1-15.2)	10.8	(8.2-14.1)
Total	84.6	(83.5-85.7)	33.4	(31.9-34.9)	11.1	(10.3-12.0)	9.0	(8.3-9.7)
Poor health								
50-59	93.6	(91.3-95.3)	60.5	(56.5-64.4)	28.5	(24.9-32.5)	23.3	(20.0-27.0)
60-69	96.4	(94.5-97.6)	63.9	(59.9-67.8)	25.1	(21.7-28.8)	23.8	(20.4-27.6)
70-79	97.8	(95.8-98.8)	63.8	(58.8-68.5)	27.3	(23.2-31.8)	26.9	(23.0-31.2)
>=80	95.7	(91.6-97.8)	45.3	(37.8-53.0)	21.6	(16.2-28.3)	25.2	(19.4-31.9)
Total	95.7	(94.6-96.6)	60.7	(58.1-63.1)	26.4	(24.2-28.6)	24.6	(22.5-26.8)
Total								
50-59	80.7	(79.1-82.1)	35.7	(33.9-37.5)	14.0	(12.7-15.3)	10.5	(9.4-11.7)
60-69	89.2	(87.8-90.5)	43.3	(41.2-45.5)	15.0	(13.6-16.6)	12.9	(11.6-14.3)
70-79	94.7	(93.5-95.7)	46.1	(43.4-48.8)	16.7	(14.8-18.7)	16.6	(14.8-18.5)
>=80	95.4	(93.4-96.9)	36.7	(32.7-40.8)	14.9	(12.3-18.1)	15.4	(12.8-18.5)
Total	87.4	(86.5-88.2)	40.2	(38.8-41.6)	14.9	(14.1-15.8)	12.9	(12.1-13.7)

For those in poor health, there is very little apparent effect of age on the likelihood of using GP services or having a hospital admission. Use of outpatient services is only slightly higher for the 70-79 age group compared to the 50-59 age group, and those over 80 are the least likely to be users of outpatient services. There is only a small increase in the likelihood of having a hospital admission between those in their 50s and 60s and those in their 70s, and there is no difference in the likelihood of using hospital inpatient services between those aged 70-79 and those over 80.

For those who consider themselves to be in good health the patterns are broadly similar, with GP visits rising slowly with age, but no difference between those in their 70s and those over 80. There is no change in the rate of attendance at emergency departments with age. The likelihood of using outpatient services rises between those in their 50s and those in their 60s, but then peaks and falls. There is an increase overall in hospital admissions from the 50s to the 70s, but this is also small, and mainly reflects the larger numbers who report that they are in poor health (see Table 7.3).

There is also evidence that those in older age categories who are hospitalised spend more days in hospital. Table 7.6 shows patterns of number of days in hospital for those hospitalised, and the greater number of long stays in those over 80 suggests that these include many whose discharge is delayed by lack of suitable alternative care. Although those over 80 are less likely to have a hospital admission than those between 70 and 79, the longer stays means that the bed days (and therefore the likely cost) are similar. It is interesting, however, to note that for all age groups there are some people with long stays, and in all age categories at least 10% of those hospitalised spent 20 days or more in hospital.

Table 7.6: Number of nights in hospital for those hospitalised in the past year, classified by age

	1-4 Nights		5-9 Nights		10-14 Nights		15-19 Nights		20-29 Nights		30-39 Nights		40+ Nights		Total	Number in sample
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI		
50-59	54	(48-60)	25	(20-30)	9	(7-13)	2	(1-4)	5	(3-8)	2	(1-4)	3	(1-4)	100	334
60-64	44	(36-52)	27	(20-35)	15	(10-21)	5	(2-10)	5	(2-10)	1	(0-5)	4	(0-5)	100	160
65-69	43	(36-51)	35	(27-43)	10	(6-16)	1	(0-4)	7	(4-12)	2	(1-6)	2	(1-6)	100	171
70-79	40	(34-46)	25	(20-31)	14	(10-19)	4	(2-7)	8	(5-12)	3	(2-7)	6	(2-7)	100	282
>=80	35	(25-46)	25	(17-35)	16	(10-25)	3	(1-8)	10	(5-18)	5	(2-12)	6	(2-12)	100	96
Total	45	(42-48)	27	(24-30)	12	(10-14)	3	(2-4)	7	(5-8)	3	(2-4)	4	(2-4)	100	1043

Note: CI = confidence interval; Missing observations = 0.29%

What is striking is the small difference in number of days in hospital for those hospitalised between those in their 70s and those in their 80s. The survey does not include those normally resident in nursing homes or hospital. Those normally in residential care are likely to display different patterns of service use since they are typically more dependent, but may also be less vulnerable since some of the support they need is available within the nursing home or hospital.

7.4 Utilisation of other state care services

We now turn to care services other than those provided by GPs and hospitals. Respondents were asked which other state services they had utilised in the past year, excluding services where the respondent had paid more than a nominal amount. Table 7.7 shows how these other state provided health and social care services are utilised by people over 50. The utilisation rates vary from 13% for optician services to less than 1% for speech and language therapy, social workers and respite services. There is a strong age gradient: about 31% of the youngest age group avail of at least one of the services listed compared with 60% of those aged 80 or over. It is still striking that as many as 40% of the oldest age group did not avail of any of the services in the past year. The final column of the table shows the percentage of respondents receiving each service who reported that they were satisfied with it. The levels of satisfaction are very high.

Table 7.7: Percentage of the population availing of different social services in the past year, classified by age, and percentage satisfied with the service

	Age group 50-59	Age group 60-69	Age group 70-79	Age group >=80	Total	Satisfied with service
	%	%	%	%	%	%
Public Health or Community Nurse	2.2	3.7	11.8	24.9	6.6	90
Occupational therapy	0.9	1.3	2.2	3.2	1.5	93
Chiropody services	1.3	2.2	9.8	15.6	4.5	88
Physiotherapy services	3.9	5.1	7	6.9	5.2	88
Speech and language therapist	0.2	0.2	0.4	0.2	0.2	93
Social work services	0.3	0.1	0.4	0	0.3	89
Psychological/counselling services	1.4	0.5	0.6	0.1	0.8	94
Home help	0.5	1.3	6.2	19.2	3.5	94
Personal care attendant	0.1	0.2	0.9	3.3	0.6	95
Meals-on-Wheels	0.1	0.3	2.4	3.3	0.9	94
Day centre services	0.3	0.6	1.6	6.8	1.2	97
Optician service	7.9	10.7	20.9	18.5	12.3	96
Dental services	9.8	11.6	12.0	8.7	10.7	92
Hearing services	0.8	1.4	2.9	5.3	1.8	86
Dietician services	1.1	1.6	2.3	0.3	1.5	95
Respite services	0.2	0.3	0.8	1.1	0.5	90

7.5 Disability and sources of care

The following section broadens the definition of care to cover help received from both formal and informal sources. Informal help refers to unpaid assistance offered by family, friends, and neighbours. Formal services refer to various paid services, whether provided by the state or by private or non-profit organisations, such as those considered in the preceding section. We focus in particular on the relationship between care received and care need, as indicated by two widely used measures of one's capacity to carry out normal daily activities. The overall prevalence of disability is first discussed and we then go on to consider the relationship between disability and three of the state provided formal services mentioned above. The final section examines the extent and sources of informal care and how receipt of care varies with disability type.

7.6 Prevalence of impairments in ADL and IADL by age and sex

This section describes the prevalence of disability in the Irish population aged 50 and over. Disability is here defined as difficulty in carrying out normal daily activities, referred to as activities of daily living (ADL) and instrumental activities of daily living (IADL). ADL are the basic tasks of everyday life that pertain to personal care, such as eating, bathing, dressing, toileting, and moving about. The original ADL scale was developed by Katz and colleagues (3) who described ADL as 'activities which people perform habitually and universally'. IADL are activities performed by a person in order to live independently in a community setting, such as managing money, shopping, using the telephone, housekeeping, preparing meals, and taking medications correctly. The IADL scale used in TILDA is derived from a set of validated questions developed by Lawton and Brody (4).

Table 7.8 shows the proportions of the population with limitations in ADL only, IADL only and having both ADL and IADL limitations. Overall, 12% of men and 14% of women aged 50 and over have at least one such disability. There is a clear age gradient as the prevalence is greater at older ages and in each age group, women are more likely to have limitations than men. The prevalence of limitations in the oldest age group is 23% for men (9% with ADL only, 6% with IADL only and 8% with IADL and ADL difficulties), while for women it is 32% (6% with ADL only, 12% with IADL only and 14% with IADL and ADL difficulties).

Table 7.8: Prevalence of disability by age and sex

	Not disabled		ADL disability only		IADL disability only		IADL and ADL disability		Total	Number in sample
	%	95% CI	%	95% CI	%	95% CI	%	95% CI		
Male										
50-64	92	(91-93)	4	(4-5)	2	(1-3)	2	(1-2)	100	2,081
65-74	88	(86-90)	7	(5-9)	2	(1-3)	3	(2-5)	100	1,070
>=75	77	(73-80)	9	(7-12)	6	(4-8)	8	(6-11)	100	598
Total	89	(87-90)	6	(5-7)	3	(2-3)	3	(2-4)	100	3,749
Female										
50-64	92	(90-93)	3	(2-4)	3	(2-4)	3	(2-3)	100	2,587
65-74	87	(85-89)	5	(4-7)	4	(3-5)	4	(3-5)	100	1,093
>=75	68	(65-72)	6	(4-8)	12	(10-15)	14	(11-17)	100	749
Total	86	(84-87)	4	(3-5)	5	(4-6)	5	(5-6)	100	4,429
Total										
50-64	92	(91-93)	4	(3-4)	2	(2-3)	2	(2-3)	100	4,668
65-74	87	(86-89)	6	(5-7)	3	(2-4)	4	(3-5)	100	2,163
>=75	72	(69-74)	7	(6-9)	10	(8-12)	11	(10-14)	100	1,347
Total	87	(86-88)	5	(4-5)	4	(3-4)	4	(4-5)	100	8,178

Note: CI = confidence interval; Missing observations = 0.00%

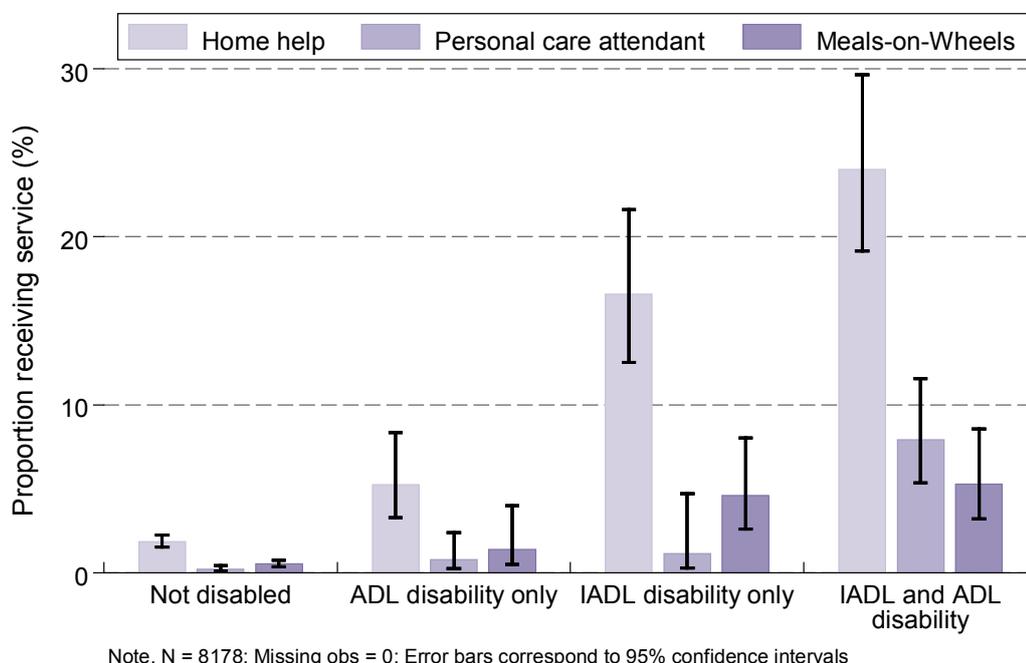
7.7 State provision of meals, home help, and personal care

This section examines the proportions of community living older people who receive three types of state-provided home services: home helps (also referred to as home care workers whose tasks are mainly oriented to household tasks i.e., help with IADL); meals services (most commonly meals-on-wheels) and the services provided by personal care attendants (typically help with ADL and some nursing).

Table 7.7 showed that 3.5% of older people received home help services in the past year, while 1% of the population had the help of a state-provided personal care attendant and around 1% received meals on wheels. Figure 7.1 illustrates this use by the reported level of disability. Some use of services in the past year was made by individuals with no reported impairments in ADLs or IADLs. This may reflect the temporary nature of the impairment that led to the allocation of the service, or that the service had been provided on the basis of a judgement including factors other than an individual's disability. Among those with impairments in both ADLs and

IADLs, these services were used by 24%, 8% and 5% of people respectively.

Figure 7.1: Percentage of the population receiving home help service, meals on wheels and personal care attendant services by level of disability



7.8 Primary source of help for those with disability

TILDA respondents with disabilities were asked to identify up to twelve formal and informal helpers, and to specify which of these was their primary carer. Of those with only ADL limitations, 83% did not receive any help, 13% were primarily helped by their spouse, 3.5% by a child, and 0.5% by a non-family member. The proportion of those who did not receive any help is high, but it should be noted that 80% of those with only ADL difficulties reported 'difficulties with dressing, including putting on shoes'. The fact that they did not report any difficulties with IADL suggests that these individuals have difficulties for example in bending down to put on shoes or lacing them, but no major problems that would impact on their ability to live independently.

Of those with IADL limitations, 26% received no help, 28% were primarily helped by a spouse, 26% by a child, 5% by relatives other than spouse and children, and 14% by non-family members. For those with combined IADL and ADL limitations, 12% did not receive any help, 33% were primarily helped by a spouse, 31% by children, 3% by other relatives, and 20% by non-family members.

The category “non-family members” includes both informal carers such as neighbours and friends and formal carers such as those paid privately, those paid by the state and those provided by non-profit bodies. The relatively low numbers in this “non-family” category emphasises the heavy predominance of informal sources, and in particular spouses and children in providing care for older people.

7.9 Conclusions

The patterns of entitlements and use of health services shows some influence of entitlement on use of services, and some effects of age, but overall it is clear that age has only modest effects on patterns of service use compared to self-reported health status. Despite the widely held belief that ageing will lead to large increases in the demands for hospital care which will be hard to accommodate, the evidence from TILDA suggests that increased demands will be modest, and will be driven primarily by the health of the population as opposed to the age structure. As found in other studies (1,5) the most pressing effects of ageing are likely to be on demands for a range of community-based health and social care services.

As the population ages, planning for formal and informal care becomes a major policy issue. The results presented above show that 12% of men and 14% of women aged 50 and over have at least one limitation in daily activities. For those with limitations in daily and instrumental daily activities, the principal source of help is family members.

The severity of impairments in instrumental and daily activities is associated with the number of hours of care. Preliminary analysis suggests that people with both ADL and IADL difficulties receive on average 118 hours of help per month (data not shown) and this will be the focus of detailed further investigation. As the most common primary helper for this group is the care recipient’s spouse, this represents a large contribution by older adults into the care of other older adults, a finding that calls for further research and policy interventions for the growing number of older carers (6).

For only 5% of people with ADL difficulties only, 13% of people with IADL difficulties only and 20% of people with both ADL and IADL the primary source of personal care was a non-family member. Some of these helpers are friends and neighbours, and some are formal (i.e. paid) care workers. The 12% who do not receive any help from formal or informal sources despite having both ADL and IADL difficulties constitute a potentially very vulnerable group, and further analysis of TILDA data will enable us to characterise this population, with the view to enabling the planning of services targeted at them.

Only a minority of older people with ADL and IADL difficulties receive formal care from the State, such as home help and meals-on-wheels. Four per cent of people over 50 received some state-provided home help services in the past year.

A full examination of the relationship between need for care and the factors that determine the allocation of services in the population is beyond the scope of this report but will be the subject of future analyses.

References

1. Mcgrail K, Green B, Barer ML, Evans RG, Hertzman C, Normand C. Age, costs of acute and long-term care and proximity to death: evidence for 1987-88 and 1994-95 in British Columbia. *Age Ageing*. 2000 ;29(3):249-253.
2. Report of the Expert Group on Resource Allocation and Financing in the Health Sector (Ruane Report). Dublin: DOHC; 2010.
3. Katz S, Ford AB, Moskowitz RW, Jackson BA, Jaffe MW. Studies of illness in the aged, the index of ADL: A standardized measure of biological and psychosocial function. *JAMA*. 1963 21;185:914-919.
4. Lawton MP, Brody EM. Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist*. 1969;9(3 Part 1):179-186.
5. Werblow A, Felder S, Zweifel P. Population ageing and health care expenditure: a school of "red herrings"? *Health Econ*. 2007 Oct;16(10):1109-1126.
6. Wren M-A. The Older Carer [Internet]. SPARC; 2010. Available from: http://sparc.tcd.ie/docs/The_Older_Carer.pdf