WPPU Working Paper No.3

Lives of Older People in Ireland

Utilising the *Well-being Framework* for Ireland to describe people's lives

Fiachra Kennedy

Well-being Public Policy Unit

August 2023

This paper has been prepared by staff in the Department of Public Expenditure, NDP Delivery & Reform. The views presented in this paper are those of the author alone and do not represent the official views of the Department or Minister.

In *Programme for Government - Our Shared Future*, the Government set out its commitment to develop a set of well-being indices to create a well-rounded, holistic view of how Irish society is faring. Furthermore, the Government is committed to ensuring that this framework will be utilised in a systematic way across government policymaking at local and national levels in setting budgetary priorities, evaluating programmes and reporting progress; as an important complement to existing economic measurement tools.

The purpose of this series of working papers is to utilise the initial *Well-being Framework for Ireland* to examine the relationship between public policy and well-being, in particular, locate and understand well-being within the policy environment in Ireland.

Contents

Executive Summary	4
1. Introduction	8
2. Public Policy and Well-being	11
3. Well-being and Ageing	15
4. Well-being and the Lives of Older People in Ireland	18
4.1 Approach to Describing Well-being and Ageing	18
4.2 Ageing and Subjective Well-being	20
4.3 Ageing and Health	24
4.4 Ageing and Participation in All Aspects of Life	29
4.5 Ageing with Being Confident and Secure	35
5. Discussion	43
6. Concluding Comments	47
Appendix A – National Goals and Objectives of the National Positive Ageing Strategy	48
Bibliography	50

Figure 1 – Well-being Framework and the Lives of Older People in Ireland	19
Figure 2 – Differences over time in Older People's Health	25
Figure 3 – Older People's Health relative to People in General	27
Figure 4 – Differences between Older People in terms of their Health	28
Figure 5 – Differences over time in Older People's Participation in Aspects of Life	30
Figure 6 – Older People's Participation in All Aspects of Life relative to People in General	32
Figure 7 – Differences between Older People in terms of their Participation in All Aspects of Life	32
Figure 8 – Differences over time in Older People's Confidence and Security	36
Figure 9 – Older People's Confidence and Security relative to People in General	37
Figure 10 – Differences between Older People in terms of their Confidence and Security	38

Table 1 – Well-being Framework for Ireland	13

Box 1 – Age-Friendly Cities and Communities	41

Executive Summary

Over the course of the last few decades, life in Ireland has undergone many significant changes. Perhaps one of the most significant is that Irish people are living longer lives, and that these additional years are increasingly being lived in good health. As the World Health Organization recognises, population ageing across the globe is "one of humanity's greatest triumphs".

From a public policy perspective, population ageing presents significant challenges for governments, especially in terms of prioritising limited public resources. Furthermore, policy consideration of ageing often tends to emphasise people's health.

However, if the benefits of increased life expectancy are to be fully realised, there is a need to utilise a broader perspective that focuses on how life is lived in older age. Since the 1980s, there has been an international effort to reframe ageing as presenting opportunities for new beginnings and as a time of new possibilities. There are a range of different approaches to conceptualising ageing that go beyond the familiar focus on health such as "healthy ageing", "active ageing", "positive ageing" and "successful ageing". The challenge for governments is to enact public policies that can ensure that additional years are not just lived in health, but that people have opportunities to live in ways that they find meaningful and of value to themselves, their families, their communities and society.

In Ireland, the *National Positive Ageing Strategy* (2013) sets out a vision that will:

- Prepare properly for individual and population ageing;
- Enable and support all ages and older people to enjoy physical and mental health and wellbeing to their full potential;
- Promote and respect older people's engagement in economic, social, cultural, community and family life; and
- Foster better solidarity between generations.

In this working paper, to develop an understanding of what is meant by well-being in older age, the broad range of interrelated factors encompassed by the various conceptualisations of ageing are presented in terms of the initial *Well-being Framework for Ireland*.

The *Well-being Framework* is grounded in Sen's capability approach ("capabilities of persons to lead the kinds of lives they value – and have reason to value") and sets out a vision of "enabling all our people to live fulfilled lives now and into the future". The multidimensional Framework has been presented in the first and second reports of the Interdepartmental Working Group (IDWG).[1]

[1] See: https://www.gov.ie/en/campaigns/1fb9b-a-well-being-framework-for-ireland-join-the-conversation/ Over time, the *Framework* will be refined as understanding of well-being as an issue in an Irish policy context deepens, and experience of utilising it broadens. The Second Report has suggested that a formal review of the Framework be undertaken in 4-5 years time, in line with international best practice.

The reason for adopting a well-being perspective is that it offers a multi-dimensional approach that can contribute to the development of a shared understanding of what makes for better lives both in terms of a particular case (older people) or the general context (different cohorts in society, or policies or programmes that focus on a particular policy challenge or cohort in society). By also considering equality, the well-being perspective is not simply concerned with change over time, but seeks to address differences between groups of people. As an approach to public policy, a well-being perspective focuses on providing opportunities for people to change or progress their lives, and more targeted interventions in cases when opportunity may have been denied by the context in which a person lives (e.g., by poverty or deprivation).

This working paper seeks to describe the well-being of older people by addressing three questions:

- How has the well-being of older people changed over the course the last two decades?
- How does the well-being of older people compare to that of people in general?
- How does well-being differ between groups of older people?

Well-being of Older People in Ireland

The analysis shows that, in many ways, the well-being of older people living in Ireland today is much improved on what it was for those of a similar age living in Ireland at the turn of the millennium. There have been some notable improvements in terms of their:

- Being healthy (e.g., increased life expectancy and healthy life years);
- Participating in all aspects of life (e.g., increased economic activity and income from employment, reduced likelihood of in-work at-risk of poverty); and

- Ageing with confidence and security (e.g. increased income, reduced likelihood of poverty, less likely to report problems with crime, pollution or noise in the area where they live).

More generally, it should also be acknowledged that since the 1990s a series of societal changes have enhanced equality, and these are likely to have contributed to improved well-being amongst older people.

In some aspects of life older people tend to be:

- Better-off than people in general (e.g., more likely to be satisfied with time use, less likely to experience poverty, greater net wealth, less likely to be a victim of crime or report that crime, pollution or noise is a problem where they live); or

- At least be similar to people in general (e.g., as likely to get together with family or friends, contribute to their local communities and society).

However, the analysis also shows that, in other aspects of life, older people tend to be:

- Worse-off than people in general (e.g., more likely to experience health problems such as long-standing medical conditions or disability, to be severely limited in everyday activities because of a health problem, less likely to be employed, more likely to be providing care and for longer hours, more likely to report being worried about being a victim of crime).

Furthermore, older people living in Ireland are not a homogenous group and there are differences in terms of age (e.g., having a disability and being severely limited in everyday activities, being admitted to hospital as an inpatient, being economically active, participating in local community, society and cultural activities as well as attending sporting events, number of hours devoted to caring for another), sex (e.g., caring and hours caring), household composition (e.g., income and wealth, experience of poverty) and affluence (e.g., quality of house and keeping it adequately warm, housing costs).

Concluding Comments

Clearly, there have been some significant improvements in well-being. However, it is also clear that despite these improvements, some aspects of older people's well-being are less than those of people in general, and for some older people their well-being is less than that of other older people.

While the *Well-being Framework* does not provide any conclusive or simple answers about the well-being of older people living in Ireland, its development is part of a wider effort to enhance public policy in Ireland. Its application:

- Provides an opportunity to mainstream the notion of ageing within the policy environment by articulating clearly what it means to enhance well-being through the adoption of a multi-dimension approach to thinking about what people do (i.e., work, volunteer, express their voice, attend events, highlight social issues) and what people want to be (i.e., being able to meet their current and future needs, being secure at home and when they are out-and-about).

- Offers an opportunity to consider how to frame policy goals and, in particular, highlights the need to go beyond improvements over time to include efforts to reduce differences

between older people and people in general and between different cohorts of older people.

- Helps frame the various services that are delivered, from the reasonably straightforward interventions and services that are provided to a diverse group of people to the more specialised or longer-term interventions and services provided to a targeted group of people.

- Creates opportunities for each stage of the policy making cycle to consider the available evidence, whether setting out the rationale for the intervention, selecting between potential policy interventions, reviewing an existing programme or intervention to determine how it might be enhanced.

- Brings to the fore questions of co-ordination and cooperation with other policy areas that may shape the effectiveness of a service or intervention.

What is set out in this working paper is one initial way of utilising the *Well-being Framework* to examine an issue of public policy concern. Others may seek to build on the approach set out in this working paper in order to draw on the wealth of policy expertise within a particular public service organisation and across relevant policy communities, develop a more substantive understanding of the relationship between well-being and relevant policies and programmes, and examine broader, more extensive sets of data.

Introduction[2]

When thinking about older age there may be a tendency to focus on people's health. After all, health is an important aspect of how people live their lives as it both shapes the opportunities they have to do that which they value, and is shaped by the broad range of experiences they encounter over the course of their lives. However, over the last four decades or so, there has been an international movement toward seeing people's later years as a time of new beginnings and of new possibilities.[3] Gibney et al. (2018: 10) have noted that the World Health Organization has:

> identified population ageing as one of humanity's greatest triumphs and greatest challenges… countries can afford to get old if governments, international organisations and civil society enact 'active ageing' policies and programmes that enhance the health, participation and security of older citizens.

In Ireland, the *National Positive Ageing Strategy* sets out a vision for Irish society as one for all ages that:

> …celebrates and prepares properly for individual and population ageing. It will enable and support all ages and older people to enjoy physical and mental health and wellbeing to their full potential. It will promote and respect older people's engagement in economic, social, cultural, community and family life, and foster better solidarity between generations. It will be a society in which the equality, independence, participation, care, self-fulfilment and dignity of older people are pursued at all times.[4]

Furthermore, the *Programme for Government – Our Shared Future* sets out a vision of creating an age-friendly Ireland. The inclusion of older people in the core framework for policy and service delivery ensures that ageing is not just a health issue but requires a whole-of-government approach to address a range of social, economic and environmental factors that affect the lives of ageing citizens.

All of this suggests that any approach to understanding the lives of older people should be concerned not only with a person's mental and physical health, but with how people meet their basic needs, have a sense of purpose and efficacy, participate in society, and find value in the lives that they live.[5]

This working paper utilises the *Well-being Framework for Ireland* to describe the lives of older people in Ireland.[6] In general terms, the *Well-being Framework* provides a multi-dimensional

---

[2] The author is grateful to Dr. Emer Coveney (Age Friendly Ireland) and colleagues in the Department of Health for their comments on earlier drafts of this paper. The author is also like to acknowledge the comments made by those who attended the IGEES Strategic Policy Discussion on the Lives of Older People in Ireland (30 March 2023).

[3] For instance, the UN First World Assembly on Ageing (1982); UN Principles for Older Persons (1991); International Year of Older Persons (1999); UN Second World Assembly on Ageing, the Madrid International Plan of Action on Ageing (2002); Europe 2020 - Innovation Union (2010); the European Innovation Partnership on Active and Healthy Ageing (2011); European Year for Active Ageing and Solidarity between Generations (2012).

[4] Department of Health, 2013a: 18.

[5] Department of Health: 2013b: 9; Diener, 2006: 156; Dolan, 2014; Ryan and Deci, 2001; Ryff and Singer, 2008; Stiglitz, Sen and Fitoussi, 2009.

[6] In June 2022, the Government published *Understanding Life in Ireland: The Well-being Framework. Second Report*. This develops builds on an initial report that was published in July 2021, *First Report*

structure that can contribute to the development of a shared understanding of what makes for better lives. In order to support the development of a quantitative description of the well-being of older people living in Ireland, this working paper firstly, discusses how the notion of well-being in older age can be informed by key conceptualisations of ageing (i.e., healthy ageing, active ageing, positive ageing and successful ageing).

The working paper then utilises the *Well-being Framework* to frame a description of how the lives of older people in Ireland have changed since the turn of the millennium. Furthermore, the working paper draws on the *Well-being Framework's* focus on equality to identify how the experiences of older people differ from those of people in general, and from each other (i.e., how the well-being of some groups of older people may be better than that of others).

The analysis shows that, in many ways, the well-being of older people living in Ireland today is much improved on what it was for those of a similar age living in Ireland at the turn of the millennium. There have been some notable improvements in terms of their being healthy (e.g., increased life expectancy and healthy life years), participating in all aspects of life (e.g., increased economic activity and income from employment, reduced likelihood of in-work at-risk of poverty) and ageing with confidence and security (e.g. increased income, reduced likelihood of poverty, less likely to report problems with crime, pollution or noise in the area where they live). More generally, it should also be acknowledged that since the 1990s a series of societal changes have enhanced equality, and these are likely to have contributed to improved well-being amongst older people.

In some aspects of life older people tend to be better-off than people in general (e.g., more likely to be satisfied with time use, less likely to experience poverty, greater net wealth, less likely to be a victim of crime or report that crime, pollution or noise is a problem where they live), or at least be similar to people in general (e.g., as likely to get together with family or friends, contribute to their local communities and society). However, the analysis also shows that, in other aspects of life, older people tend to be worse-off than people in general (e.g., more likely to experience health problems such as long-standing medical conditions or disability, to be severely limited in everyday activities because of a health problem, less likely to be employed, more likely to be providing care and for longer hours, more likely to report being worried about being a victim of crime).

Furthermore, older people living in Ireland are not a homogenous group and there are differences in terms of age (e.g., having a disability and being severely limited in everyday activities, being admitted to hospital as an inpatient, being economically active, participating in local community, society and cultural activities as well as attending sporting events, number of hours devoted to caring for another), sex (e.g., caring and hours caring), household composition (e.g., income and wealth, experience of poverty) and affluence (e.g., quality of house and keeping it adequately warm, housing costs).

What this introductory overview highlights is the complexity of trying to understand the well-being of people. Not only is well-being difficult to define and measure (often involving multiple indicators across numerous dimensions), any effort to draw conclusions is highly dependent on the perspective adopted. If the question focuses on how well-being has changed over time, then for the most part the well-being of older people is much improved on what it was two decades ago. However, if the question seeks to compare older people with people in general, or within the group of older people, then what might have been seen as an improvement over time becomes an issue whereby older people are less well-off than people in general, or some older people are less well-off than others.

---

on a Well-being Framework for Ireland. Both of these reports and other relevant materials are available at: https://www.gov.ie/en/campaigns/1fb9b-a-well-being-framework-for-ireland-join-the-conversation/

Public policy that seeks to address the issue of ageing is focusing on a complex policy area. The benefit of adopting a well-being perspective is that it will support and inform a broad understanding of people's experiences. This will help identify and define policy challenges, create opportunities to explore how the various aspects of the policy challenge relate to each other, and examine how public policy can be designed and implemented in a way that will enhance well-being in older age.

What is set out in this working paper is one initial way of utilising the *Well-being Framework* to examine an issue of public policy concern. Others may seek to build on the approach set out in this working paper in order to draw on the wealth of policy expertise within a particular public service organisation and across relevant policy communities, develop a more substantive understanding of the relationship between well-being and relevant policies and programmes, and examine broader, more extensive sets of data (e.g., TILDA's longitudinal data, National Dementia Registry that is being rolled out by the HSE).[7] For instance, by focusing on cohorts of older people with specific needs, such as dementia or palliative care, a well-being perspective may help inform discussions of how public policy could enhance their well-being.

[7] In *Programme for Government – Our Shared Future*, the Government set out a commitment not simply to develop a set of well-being indices to create a well-round, holistic view of how Irish society is fairing but to utilising it in a systematic way across government policy making. As the *First Report* notes, if the *Framework* is to fulfil the ambition of improving public policy and decision-making, then it is important to develop a knowledge base around well-being as a policy objective and integrate well-being into the various stages of the policy making process. The overall intention of utilising the *Well-being Framework* to examine public policy is to inform efforts to: deliver more effective public services; use data to describe policy challenges and progress made in addressing these challenges; focus attention on questions around differences in people's experiences; enhance strategic alignment and identify opportunities for coordination and co-operation across Departments and Agencies; and inform the development of bespoke sectoral specific strategies including sectoral-focussed well-being frameworks. Over time, the *Well-being Framework*, and its potential to contribute to policy-making in Ireland, could be further refined by building on the insights derived from policy analysis and the experiences of those who have sought to utilise the well-being perspective.

2. Public Policy and Well-being

Over the last decade or so there has been an increasing focus on the issue of "well-being". The increased salience of well-being is in part associated with the acknowledgment that economic growth, while important in terms of generating the resources necessary to provide key public services, is limited as a measure of how society and people are progressing (i.e., it is more a means to an end, than an end in itself). This increased focus has been particularly evident in the development of well-being frameworks, most notably by the OECD and New Zealand.

In general terms, the notion of well-being is associated with people feeling satisfied, happy or comfortable with their lives. The OECD (2013) offers an inclusive definition of subjective well-being as "good mental states, including all of the various evaluations, positive and negative, that people make of their lives and the affective reactions of people to their experiences."[8] Rather than something that is associated with "happiness", this definition seeks to encompass the full range of different aspects of subjective well-being, in particular how people experience and evaluate their life as a whole.[9]

While subjective well-being is an important element of well-being, it is not sufficient. In particular, it does not consider the conditions under which "well-being" was achieved. The availability of resources does not ensure that people are able to convert them into well-being (e.g., two people with similar means may achieve or reveal very different levels of life satisfaction).[10]

The approach to well-being that informed the development of the *Well-being Framework* is based on Sen's capability approach. The capability approach focuses on the "capabilities of persons to lead the kind of lives they value – and have reason to value".[11] It focuses attention on the broad range of human "functionings"[12], that is, people's:

- "beings" - the kind of person someone is able to be (e.g., being well-nourished, being educated); and

- "doings" - the activities that a person is able to undertake (e.g., working, caring for someone, voting).[13]

From a public policy perspective, the capability approach focuses attention on describing people's lives and the challenges they face. It also emphasis how policy can create

[8] Diener et al., 2006.
[9] This approach to well-being is often seen as encompassing *life evaluation or satisfaction* (a reflective assessment on a person's "life as a whole" or some specific aspect of it); *affect* (a person's feelings or emotional states, typically measured with reference to a particular moment in time (or shortly after the experiences have occurred); *eudaimonia or flourishing* (a sense of meaning and purpose in life, or good psychological functioning). (Stiglitz, Sen and Fitoussi, 2009; Hardoon, Hey and Brunetti, 2020)
[10] Sen, 2005; Robeyns and Byskov, 2020; Cronin de Chavez et al., 2005.
[11] Sen, 1999: 18.
[12] Functionings or "beings and doings" are the various observable activities and states that constitute a human life, that is, they make the lives of human beings both "human" (i.e., in contrast to other forms of life) and "lives" (i.e., in contrast to inanimate objects). (Sen, 1992: 39)
[13] It is worth acknowledging that such distinctions are not always clear-cut. Some functionings may be described as a "being" (e.g., a person *is* housed in a warm house) or a "doing" (e.g. a person *consumes* energy to keep their house warm). In other cases, functionings are more clearly a "being" (e.g., being healthy) or a "doing" (e.g., driving a car).

opportunities for people to change or progress their lives, or intervene in a more targeted manner when opportunities may be at risk of being denied by factors such as poverty or deprivation.

In terms of thinking about how to go about creating opportunities for people "to be" and "to do", the capability approach emphases how the individual is dependent on (or constrained by) their own abilities as well as how people interact with each other in society and the environment where people live. The extent to which an individual can convert goods and services (i.e., "means"[14]) into "beings and doings" (i.e., "ends") may be constrained by *personal conversion factors* (a person's own internal abilities such as metabolism, physical condition, sex, reading skills); *social conversion factors* (factors associated with the society in which the person lives such as public policies, social norms, practices that unfairly discriminate, societal hierarchies, or power relations related to, for instance, class, gender, race, sexual orientation, gender identity); and *environmental conversion factors* (factors that emerge from the physical or built environment where a person lives). However, that people are dependent on each other and can draw benefits from the environment where they live, suggests that these factors should not simply be seen as constraining people, but as ways of enabling people to enhance their lives.[15]

The consideration of human diversity focuses attention on questions of "justice" (e.g., bringing people above a given threshold; assuring equality of opportunity).[16] The recognition of differences between people highlights the need to look beyond average conditions (societal wide estimates) to consider *horizontal inequalities* (gaps between population groups); *vertical inequalities* (gaps between those at the top and those at the bottom of the achievement scale in each dimension); and *deprivations* (the share of the population falling below a given threshold of achievement).

Finally, the capability approach is concerned with the practical task of identifying a range of dimensions that ought to be examined (simultaneously) when considering what enhances well-being. This approach recognises and seeks to take account of how people pursue a diversity of "beings and doings". It encourages the consideration of a broad range of information in the policy making process.[17]

The first and second reports of the Interdepartmental Working Group (IDWG) have set out an initial multidimensional well-being framework. Over time, the *Framework* will be refined as

---

[14] The capability approach considers whether or not the person has the required "means" necessary to achieve what they want to be and what they want to do. Means are seen as having an instrumental valuation (i.e., help achieve a particular end) rather than an intrinsic valuation (i.e., desirable in and of themselves). For example, are people able to be healthy *and* do they have the means or resources for this capability (e.g., access to medical services, clean water and adequate sanitation). It does not assume that financial resources are the most important means to achieve all ends. (Money or economic growth are not valued for their own sake but for the contribution they make to resourcing services that are important to people being healthy.) In some cases, the most important "means" may be financial but in other cases non-financial means may be important (e.g., provision of public goods, role of political institutions, social norms or cultural practices). (Stiglitz, Sen and Fitoussi, 2009; Robeyns and Byskov, 2020)

[15] Dean, 2009; Taylor, 2011.

[16] Stiglitz, Sen and Fitoussi, 2009; Alkire, 2002; Robeyns, 2003.

[17] The capability approach offers a flexible, open-ended and underspecified framework and advises against the idea of a pre-determined canonical list of capabilities that are selected by reference to theory only. Within any given country or society, such a pre-determined approach would ignore the important role of an open or public deliberative process in identifying those aspects of well-being that bear most directly on people's living conditions. Furthermore, such a canonical list would deny the possibility of progress over time in social understanding. (Sen, 1987, 1993 and 2005; Nussbaum, 1999 and 2000; Stiglitz, Sen and Fitoussi, 2009; Robeyns and Byskov, 2020; White, 2005.)

understanding of well-being as an issue in an Irish policy context deepens, and experience of utilising it broadens. Table 1 provides a summary of the concepts involved, in particular, drawing out the notion of public policy as creating opportunities for people to meet certain needs.

Table 1 – Well-being Framework for Ireland

Dimensions	Well-being as Public Policy
Subjective Well-being	The cognitive and affective responses of individuals to their immediate circumstances as well as to retrospective and prospective reflections of how their life is progressing.
Mental & Physical Health	The physical and mental factors that shape the ability of the individual to engage in economic, social, cultural, community and family life.
Income & Wealth	The financial resources that shape the range of feasible choices available to an individual to meet their day-to-day needs and wants and the opportunity to mitigate personal, economic and societal risks and vulnerabilities.
Knowledge, Skills & Innovation	The cognitive and motor skills acquired and developed over the course of a person's life that shape their ability to achieve material or economic progress and meet needs relating to esteem (e.g. feeling of accomplishment) and self-actualisation (e.g., achieving full potential) as well as cope with and address change in their lived experience and in society more generally.
Housing & the Built Environment	The physical infrastructure that shapes the ability of an individual to meet physiological needs (e.g., shelter), safety needs (e.g. personal security) and social belonging needs (e.g., a space for family, intimacy and a sense of connection). The built environment refers to the infrastructure and services (e.g., street furniture, accessible transport) that provide people with the opportunity to move freely and easily within their own local area and beyond.
Environment, Climate & Biodiversity	The nature of the place in which an individual lives and works shapes their ability to meet physiological needs (e.g., clean water and air) as well as more transcendental needs (e.g., relating to and interacting with nature). Humans can also hold considerable influence over the environment and can impact it positively (e.g., sustainable living, low carbon lifestyles in food, transport, energy use, etc; conscious consumer, limits waste etc.) or negatively (e.g., pollution, climate change, biodiversity loss).
Safety & Security	The social, cultural, natural and institutional factors that shape the ability of an individual to live life and engage in activities without fear of harm from other people and to mitigate risks and impacts associated with infrastructural, mechanical and natural hazards.
Work & Job Quality	The productive activities (both paid and unpaid) that shape how an individual progresses (i.e., develop their skills and abilities, fulfil their personal ambitions) as well as building and supporting their self-esteem and informing their sense of contributing to society more generally.

Time Use	The efforts of an individual to both meet and combine the demands that others place on their tie (e.g., work, family and other caring commitments), and meet their own needs (e.g., personal care and development), subject to the constraint of a fixed quantity of time available in any single day.
Connections, Community & Participation	The opportunities that an individual has for engaging with other people and sharing activities in order to meet their basic needs and their psychological and self-fulfilment needs.
Civic Engagement, Trust & Cultural Expression	The rights and opportunities that an individual has to express their voice, and participate and contribute to the functioning of their society. This dimension also includes incidences or feelings of discrimination alongside the freedom to express cultural, personal or political views. The opportunities that people have to express their voice will in part be shaped by trust in public governance (e.g., its institutions, rules and norms) and how this fosters cooperation between people.

3. Well-being and Ageing

People in Ireland are living longer lives. In the 45 years between 1971 and 2016, the number of people living in Ireland aged 65 years or older increased by 93% to about 637,570; having only increased by 21% in the 45 years between 1926 and 1971.[18] It is projected that by 2046, when those born in 1981 will be 65 years of age, there will be some 1.4 million people aged 65 years or older (accounting for between a fifth and a quarter of the total population).

While increasing life expectancy is often associated with policy concerns around morbidity and infirmity[19] as well as the wider potential public expenditure consequences of an ageing society, if the benefits of increased life expectancy are to be fully realised there is a need to focus on how life is lived in older age. In addition to focusing on people's health, it is also important to have a broad understanding of people's experiences (to identify policy challenges and how these may related to each other) and how older people can have opportunities to both develop themselves and continue contributing to society (how public policy can enhance well-being in older age).[20] The 2022 Rome Ministerial Declaration of the Member States of the United Nations Economic Commission for Europe, *A Sustainable World for All Ages*, set out goals that are intended to realise a sustainable world for all ages and solidarity and equal opportunities throughout life:

- Promoting active and healthy ageing throughout life;
- Ensuring access to long-term care and support for carers and families; and
- Mainstreaming ageing to advance a society for all ages.

The *Decade of Ageing* (2021-2030) is a United Nations global collaboration that brings together governments, civil society, international agencies and other stakeholders to improve the lives of older people, their families and the communities in which they live. In order to

---

[18] The increase in the number of older people is especially evident amongst those aged 85 years or older: by 41% between 1926 (14,860) and 1971 (20,930); and 223% between 1971 and 2016 (67,555). By 2046, those born in 1961 will be 85 years of age, by which time it is projected that there will be some 256,000 people aged 85 years or older.

[19] Wren et al., 2017.

[20] The World Health Organization (WHO) has been central to policy initiatives that have sought to develop societies in ways that support older people in continuing to lead active and healthy lives. In particular, the WHO (2002, 2015) has set out a framework that provides a roadmap for involving multiple agencies in designing multi-sectoral active ageing policies (i.e., recognise and address factors that affect how people and populations age; adopt a life-course perspective; and promote intergenerational solidarity in developing policies to respond to population ageing). (See also: Department of Health. 2013a: 63-64; Baltes and Baltes, 1990.) For instance, the WHO Regional Committee for Europe has set out a *Strategy and Action Plan for Healthy Ageing in Europe, 2012–2020*. Within this it has set out four strategic priority areas for action that help people to stay active as long as possible (including in the labour market) and actions to protect the health and well-being of people with (multiple) chronic conditions or at risk of frailty: healthy ageing over the life-course; supportive environments; health and long-term care systems fit for ageing populations; and strengthening the evidence base and research. The Strategy and Action Plan also suggests five priority interventions: promoting physical activity, falls prevention; vaccination of older people and infectious disease prevention in health care settings; public support to informal care-giving, with a focus on home care; and geriatric and gerontological capacity-building among the health and social care workforce. Finally, it sets out additional supporting interventions that link healthy ageing to its wider social context: prevention of social isolation and social exclusion; prevention of elder maltreatment; and quality of care strategies for older people including dementia care and palliative care for long-term care patients.

achieve this it focuses on changing how people think about age and ageing and seeks to address four areas for action:

- Age-friendly environments – better places in which to grow, live, work play and age and are created by removing physical and social barriers and implementing policies, systems, services, products and technologies that address the social determinants of healthy ageing and enable people (even when they lose capacity) to continue to do the things they value;

- Combatting ageism – despite the many contributions of older people to society, negative attitudes such as stereotyping, prejudice and discrimination towards people on the basis of their age can have deleterious effects on the health and well-being of older people;

- Integrated care – Older people require non-discriminatory access to good-quality health services in a way that ensures that these services do not contribute to financial hardship; and

- Long-term care – Limitations in the ability of older people to care for themselves and to participate in society are associated with declines in physical and mental capacity and may be alleviated by access to rehabilitation, assistive technologies, and supportive and inclusive environments. Access to good-quality long-term care is essential for such people to maintain their functional ability, enjoy basic human rights and live with dignity.

There are a number of different approaches to conceptualising ageing and they encompass many of the elements of the multi-dimensional well-being approach. Each of these approaches present ageing in a way that goes beyond the familiar focus on physical and mental health[21]:

- *Healthy ageing* focuses on optimising opportunities for physical, social and mental health in order to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life;

- *Active ageing* emphasises people's continued participation in all aspects of their communities (e.g. social, economic, cultural, spiritual and civic affairs) and not just the ability to be physically active or to participate in the labour force;[22]

- *Positive ageing* moves beyond a concern with a person's physical, emotional and mental well-being to include social attitudes and perceptions of ageing that can influence the well-being of older people, whether through direct discrimination or through negative attitudes and images; and

- *Successful ageing* accounts for the dynamic or life-cycle element of ageing as it is concerned with the ability of people to adapt to the transitions experienced by the ageing person; preventing or reducing the negative impacts on their quality of life.[23]

These various approaches are essentially seeking to mainstream ageing within the public policy environment highlighting how ageing is not simply about health services but requires a whole-of-government approach to address a range of social, economic and environmental

[21] Department of Health. 2013a: 63-64; Department of Health, 2015a: 2-3; Baltes and Baltes, 1990.
[22] Bass, Caro and Chen, 1993; OECD, 1998.
[23] Depp and Jeste, 2006; Montross et al., 2006.

factors that influence the opportunities people have to live lives they value and have reason to value.

In Ireland, these various perspectives of ageing are evident in the national goals set out in the whole-of-government *National Positive Ageing Strategy*[24] (See Appendix A.):

- The first goal is concerned with removing barriers and providing opportunities for people to be involved in all aspects of life. In particular, this goal references employment and education, active citizenship and volunteering, engagement and participation in their local communities and enabling people to "get out and about".

- The second goal is concerned with supporting people's physical and mental health and well-being. In particular, it focuses on preventing and reducing disability and chronic illness and promoting the development and delivery of high quality care services and supports.

- The third goal is concerned with enabling people to age with confidence, security and dignity in their own homes and communities. To this end it focuses on people's income and standard of living, the quality of their homes, the accessibility of public spaces, transport and buildings, and their feelings of safety and security both within and outside their homes and families.

[24] Department of Health, 2013a: 20-21.

4. Well-being and the Lives of Older People in Ireland

4.1 Approach to Describing Well-being and Ageing

In order to understand what is meant by well-being in older age, this working paper draws on the broad range of interrelated factors that have been highlighted by the various conceptualisations of ageing: health, participation in all aspects of life and ageing with confidence and security. Figure 1 presents an initial effort to link these elements to the various dimensions of the *Well-being Framework*. It also sets out indicators that are used to describe the well-being of older people living in Ireland.

However, Figure 1 does not reflect the full complexity of this policy area. There are likely to be important links between the various dimensions. For example, policies that are primarily focused on improving physical and mental health outcomes may also seek to remove barriers to participation (e.g., engage in physical, social and intellectual activities) and support people to continue living in their own homes and communities for as long as possible.

Furthermore, Figure 1 does not present an explicit link between these aspects of ageing and subjective well-being. This is not to suggest that there is no such link. Instead, the opposite is very much the case. Subjective well-being is probably best seen as a consequence of how people evaluate and react to the various elements of their lives (i.e., a product of one or more to the other well-being dimensions).[25]

Finally, while this working paper is not in a position to address the following directly, it should be noted that an understanding of well-being in older age is not simply about people's current circumstances and behaviours, but includes the accumulation of positive and negative effects of social, economic and environmental conditions throughout their lives (i.e. the circumstances in which people are born, grow up, live, work and age).[26]

This working paper seeks to describe the well-being of older people by addressing three questions: How has the well-being of older people changed over the course the last two decades? How does the well-being of older people compare to that of people in general? How does well-being differ between groups of older people?

The first question is addressed by comparing the well-being of older people today (i.e., the three most recent years that data is available, or the most recent year) with the well-being of older people at the turn of the millennium (the three years closest to 2000 or earliest year since 2000 for which data is available). The analysis presents information on whether older people today are more likely than older people 20 years ago "to be" or "to do" something. In order to be able to examine the degree of change that has occurred over time, the analysis compares

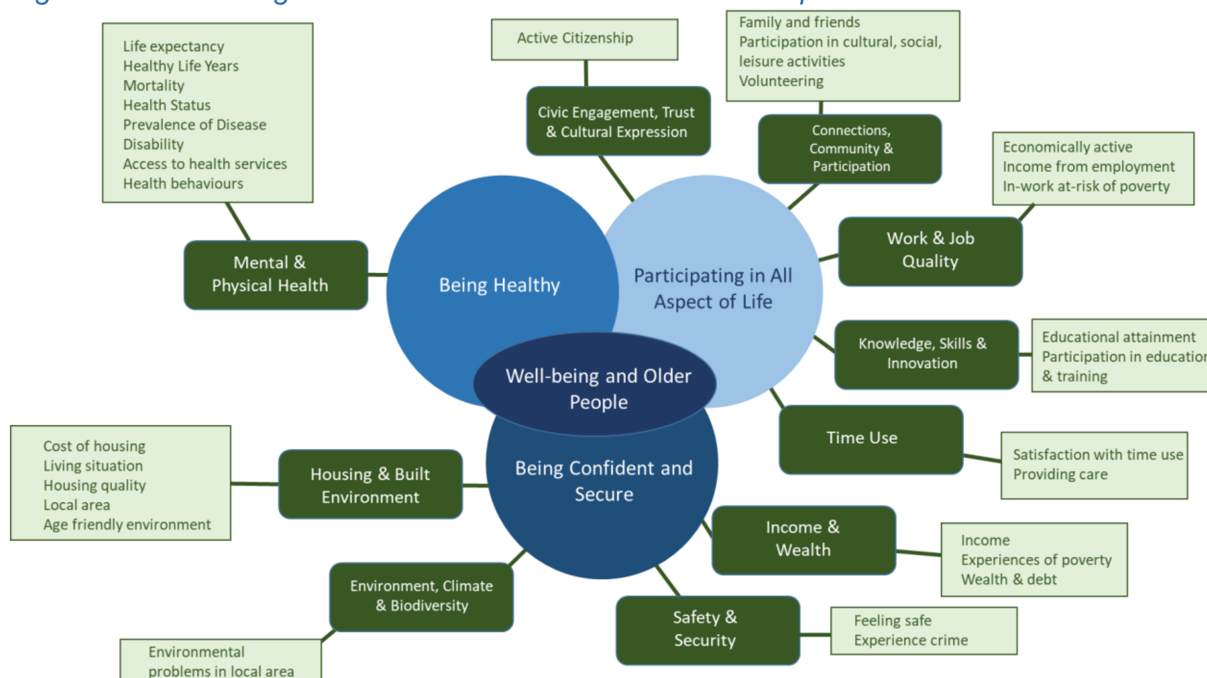
---

[25] OECD, 2013a; Diener et al., 2006; Stiglitz, Sen and Fitoussi, 2009; Hardoon, Hey and Brunetti, 2020.

[26] Both the *National Positive Ageing Strategy* and *Healthy Ireland* promote a life course approach to health and well-being in older age. Gibney et al. (2018: 11) have observed that the implementation of the *National Positive Ageing Strategy* is an essential part of creating the vision set out in *Healthy Ireland* of a society in which "every individual and sector of society can play their part in achieving a healthy Ireland" and "…everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported and at every level of society and is everyone's responsibility. (Department of Health, 2013b: 6) Within its vision, *Healthy Ireland* emphasises: the need for public policy to focus on health and well-being over the life-course and across the broader determinants of health; and personal and collective responsibility for protecting health and preventing disease. Amongst its high-level goals, *Healthy Ireland* intends to increase the proportion of people who are healthy at all stages of life and reduce health inequalities.

standardised scores.[27] In this working paper, strong change is associated with a change of two or more standard deviations.[28]

Figure 1 – Well-being Framework and the Lives of Older People in Ireland



The second question is addressed by comparing the "youngest" cohort of older people with "people in general". Depending on the indicator, the "youngest" cohort of older people tends to refer to people aged either 65-69 years or people aged 65-74 years. "People in general" depends on definitions of the wider population associated with particular indicators. For each indicator, the analysis presents a ratio that describes whether older people are more or less likely than people in general "to be" or "to do" something.

The third question is addressed by comparing different groups of older people with each other. Based on the available data, these groups are described in terms of age, affluence, household composition, economic status or sex. This analysis also presents a ratio that describes whether or not one group of older people are more or less likely than their counterparts "to be" or "to do" something.

The ratios used to address the second and third questions compare three-year nominal averages if data is available. The discussion of the data does not set out a single rule to identify strong differences.

For the most part the indicators used in this working paper have been sourced from the Central Statistics Office and Eurostat online databases. Where relevant the empirical analysis references indicators published by the *Healthy Ireland Survey*[29] and the *Healthy and Positive*

[27] Transform the indicators to a common scale with a mean of zero and a standard deviation of one (z-scores).
[28] While the selection of two standard deviations is arbitrary, it is worth noting change of this magnitude in observed values. Others may wish to utilise more or less onerous levels of variation in determining the extent of change.
[29] The annual *Healthy Ireland Survey* collects data on the adult population as a whole in order to support the monitoring and assessment of the various policy initiatives *Healthy Ireland Framework*.

Ageing Initiative (HaPAI) *Survey*[30]. Furthermore, the analysis is also supplemented by research published by *The Irish Longitudinal Study on Ageing* (TILDA). TILDA is a nationally representative longitudinal survey of the older population in Ireland. The research that has been published by TILDA provides a comprehensive picture of the characteristics and contributions of older persons in Ireland.

4.2 Ageing and Subjective Well-being

The *Well-being Framework for Ireland* presents the Subjective Well-being dimension in terms of the cognitive and affective responses of individuals to their immediate circumstances as well as retrospective and prospective reflections of how their life is progressing.[31] Subjective well-being seeks to include a broad range of aspects to how people experience and evaluate their life as a whole: life evaluation or satisfaction; affect (feelings or emotional states); and eudaimonia (or sense of flourishing).

Subjective well-being in older age can be presented in terms of quality of life. The World Health Organization has defined quality of life in terms of (author's emphasis):

> the individual's *perception* of their position in life in the context of the culture and value systems in which they live and *in relation to* their goals, expectations, standards and concerns. It is a broad ranging concept *affected in a complex way* by a person's physical health, psychological state, level of independence and their relationships to salient features of their environment.[32]

Quality of life is a multi-dimensional concept encompassing not only a person's physical health but also their psychological well-being, social functioning and participation in the world around them. It is not simply about a person's health. It is not uncommon for older people to rate their quality of life as good even when they have a serious illness or disability.[33] Quality of life focuses on a person's ability to participate actively in the place where they live, live in a way that allows them to fulfil their potential, derive happiness or enjoyment, and be free from the unwanted interference of others.[34]

How people think about old age can influence well-being.[35] Older people who have a positive view of ageing are more likely to engage in preventive health behaviour, have fewer functional limitations and live longer.[36] Robertson and colleagues have examined how negative attitudes towards ageing can effect health in later life and have shown that older adults with negative attitudes towards ageing exhibited a decline in walking speed and cognitive abilities over time even when controlling for health, medications, mood, life circumstances and other health

[30] The *Healthy and Positive Ageing Initiative* (HaPAI) *Survey* completed 10,540 interviews of community-dwelling members of the population aged 55 years and older who were living in private households in 20 local authority areas. The survey was carried out to provide evidence about the experiences and preferences of older people and to identify the gaps in services and supports needed to allow them to age positively in their local communities.

[31] The OECD (2013a) offers an inclusive definition of subjective well-being as "good mental states, including all of the various evaluations, positive and negative, that people make of their lives and the affective reactions of people to their experiences." See also Diener et al., 2006.

[32] World Health Organization Quality of Life Group,1997: 1.

[33] McGarrigle and Ward, 2018; McGee, Morgan, Hickey, Burke and Savva, 2011; Bowling and Dieppe, 2005.

[34] Sen (1999) emphasises whether or not a person has the necessary capabilities or opportunities to lead the kind of life they value (e.g. are they well nourished, mobile, take part in community life).

[35] McGee, Morgan, Hickey, Burke and Savva, 2011.

[36] Levy and Myers, 2004; Levy, Slade and Kasl, 2002; Levy, Slade, Kunkel and Kasl, 2002.

changes over the same period of time.[37] Robertson and Kenny (2015) have found that negative attitudes towards ageing affect the interaction of different health conditions. In particular, amongst TILDA participants those who were frail but with positive attitudes towards ageing had the same level of cognitive ability as their non-frail peers while those who were frail with negative attitudes towards ageing had worse cognitive ability.

While the available data is limited in terms of identifying trends over time, in Ireland, overall life satisfaction amongst older people is as strong, if not stronger than it is amongst other age cohorts, and would appear to be more stable. In 2018, net overall life satisfaction amongst those age 65 years or older (+36.4 percentage points) was similar to people in general (+35.7 percentage points).[38] Older people (46.4%) were slightly more likely to report high levels of overall life satisfaction than people in general (44.4%), but were also slightly more likely to report low levels of overall life satisfaction (10%) than people in general (8.7%). Comparing 2013 and 2018, there has been little change in net life satisfaction reported by those in the oldest age cohort, but the younger age cohorts had notable smaller net overall life satisfaction scores in the immediate aftermath of the economic and financial crisis.[39]

In TILDA, quality of life is conceptualised in terms of needs satisfaction and is measured along four domains of "control" and "autonomy" (prerequisites for an individual's free participation in society) and "self-realisation" and "pleasure" (active and self-reflexive aspects of living that bring reward and happiness to people in later life).[40]

McGee et al. (2011) have found that overall, older people in Ireland feel that they experience high levels of quality of life:

- Control refers to a person's ability to actively participate in their environment. To a large degree, older Irish people feel they are free to plan for their futures and rarely feel that what happens to them is out of their control, that they are left out of things or that their age prevents them from doing things they like to do;

- Autonomy refers to the right of the individual to be free from the unwanted interference of others. To a large degree, older Irish people feel that they can do the things that they want to do and they rarely feel that family responsibilities or their health prevents them from doing what they want to do;

- Self-realisation refers to the fulfilment of one's potential. To a large degree, older Irish people feel full of energy and feel optimistic about the future and positive about the past; and

- Pleasure refers to the sense of happiness or enjoyment derived from engaging with life. To a large degree, older Irish people feel that life has meaning, look forward to each day, enjoy the things that they do and the company of others and look back on their life with a sense of happiness.

Research utilising the TILDA data has shown that quality of life is associated with a range of different factors including some that are encompassed by dimensions of the *Well-being Framework*[41]:

[37] Robertson, Savva, King-Kallimanis and Kenny, 2015; Robertson, King-Kallimanis, and Kenny, 2015.
[38] Net difference is percentage scoring 9-10 on a scale minus percentage scoring 0-5 on a scale.
[39] Central Statistics Office, WBA37
[40] McGee, Morgan, Hickey, Burke and Savva, 2011.
[41] McGarrigle and Ward, 2018; McGee, Morgan, Hickey, Burke and Savva, 2011; Ward, McGarrigle and Kenny, 2018; Ward, 2019.

- Age – The evidence suggests that quality of life does not decrease linearly with age but instead increases to a peak at 68 years and then starts to gradually decline;

- Marital status - Those who were married have a higher quality of life than those who were separated or divorced;

- Education - Those who had tertiary education have a higher quality of life than those whose highest level of education was primary level;

- Self-rate health status - Those who rated their health as either excellent or good have higher quality of life than those who rated their health as either fair or poor;

- Wealth - Those in the most well-off quartile have a higher quality of life than those in the least well-off quartile;

- Social integration – There was a positive association between social integration and quality of life with social isolation being associated with lower quality of life. The quality of these relationships is also important in that people who reported having positive supportive relationships with friends were also more likely to report a higher quality of life relative to those with less supportive relationships. As such then, quality of life in older age is not just about having active social interactions it is also about having quality relationships (i.e. both quantity and quality are important);

- Chronic conditions – There was a negative association between the number of chronic conditions and quality of life; and

- Disability - For both disability in terms of "activities of daily living" (e.g. washing, eating and toileting that are essential to daily life) and "instrumental activities of daily living" (e.g. preparing meals, managing money and household chores that are important in maintaining independence), quality of life decreased with increasing numbers of limitations.

- Retirement has little impact on people's quality of life.

McGee et al. (2011: 274-281) have examined attitudes to ageing amongst older people in Ireland. Their approach focused on the multifaceted nature of the ageing process, taking account of both positive and negative aspects of older people's views:

- *Timeline* – awareness of ageing and variation in experience of the process over time.[42] People were slightly more likely to go through phases of feeling old than to be constantly conscious of it, but they did not perceive it to be strongly one or the other. Those aged 75 years or older and those with the lowest levels of formal education were more likely than their counterparts to be constantly conscious of feeling old.

- *Consequences* – beliefs about the positive and negative impacts of ageing on one's life.[43] A majority of older people acknowledged the positive aspects of ageing with

[42] This dimension is divided in "timeline-chronic" (the extent to which awareness of one's age or ageing is constant, e.g., 'I always classify myself as old') and "timeline- cyclical" (the extent to which one experiences variation in awareness of ageing, e.g., 'I go through phases of feeling old').
[43] This dimension is divided into "consequences-positive" (awareness of the benefits of ageing, e.g., 'As I get older I get wiser') and "consequences-negative" (awareness of the downsides of ageing, e.g., 'Getting older makes everything a lot harder for me').

86% agreeing that they appreciate things more and 72% feeling that they continue to grow as a person.

While the negative aspects of ageing have less of an impact, it is nonetheless worth noting that just over half felt that age restricts what they can do (53%) while just over a quarter felt that they do not cope so well with problems that arise (28%). Those who were more likely to have negative beliefs about the impact of ageing on their lives were people aged 75 years or older, those with the lowest formal education qualifications, people who rate their health as either fair or poor and those who live alone.

- *Control* – beliefs about one's power over both the positive and negative aspects of ageing.[44] In large part, older people believed they have control over the positive experiences of ageing with 87% believing that they can determine to live life to the full and 84% believing that they can determine the positive aspects of ageing.

  There was also a sense that they have considerable control over negative aspects of ageing as 56% disagreed that they have no control over the impact of ageing on their social life, but 60% agreed that they cannot control slowing down with age. The people who were least likely to feel that they have control over the negative aspects of ageing were those who are aged 75 years or older, those with the lowest levels of formal education, the least well off and those who live alone.

- *Emotional representations* – emotional responses to ageing, (e.g., 'I get depressed when I think about getting older').

  The data suggests that people did not have strong emotional responses to ageing.

[44] This dimension is divided into "control-positive" (perceived control over positive experiences of ageing, e.g. 'The quality of my social life in later years depends on me.') and "control-negative" (perceived control over negative experiences of ageing, e.g. 'How mobile I am in later life is not up to me').

4.3 Ageing and Health

Health is an important element of an individual's well-being both as a dimension of well-being and as a factor that can influence the ability of people to live independently[45] (e.g., their ability to continue working, volunteer in their communities, meet and socialise with others, be able to look after their own needs and wants). The Mental & Physical Health dimension of *Well-being Framework* is concerned with those physical and mental factors that shape the ability of the individual to engage in economic, social, cultural, community and family life. This is similar to the healthy ageing approach that focuses on optimising opportunities for physical, social and mental health in order to enable older people to take an active part in society and to enjoy an independent and good quality of life. Along similar lines, the notions of active ageing and positive ageing seek to go beyond a singular focus on health in older age to focus on participation and how people think about older age. The notion of successful ageing introduces a life-cycle element that brings to the fore a concern with how people transition across various stages of life and how experiences in younger years can impact on the quality of life in older years.[46]

Over the course of the last two decades there has been a strong improvement in older people's self-perceived health status and this is associated with strong increases in the number of healthy life years at 65 years of age as well as continuing increases in life expectancy at older ages (Period Life Expectancy, PLE) and decreases in mortality rates. (See Figure 2.)

How people perceive their own health is regarded as a good indicator of overall well-being. There is an association between poor self-rated health and future disease, functional decline, use of healthcare services and mortality.[47] Compared to 2005-07, net self-perceived health status has increased by 13 percentage points amongst people aged 75 years or older and by 5.7 percentage points amongst people aged 65-74 years. The share of people reporting "good" or "very good" health has increased from 53% to 63.4% amongst people aged 75 years or older and from 65.3% to 71.3% amongst people aged 65-74 years. The share of people reporting "bad" or "very bad" health has decreased from 11.2% to 8.7% amongst people aged 75 years or older and has remained more or less unchanged amongst people aged 65-74 years (about 6%).[48]

Healthy life years refers to the number of years that a person can expect to live in a healthy condition without severe or moderate health problems. As such, it acts as a proxy for both the duration and quality of life (it is sometimes referred to as disability-free life expectancy).[49] The number of healthy life years at 65 years has increased from an average of 9.4 years in 2004-06 to average of 12.8 years in 2018-20.[50]

In Ireland, there has been an increasing trend in life expectancy at birth since 1926. However, these improvements in life expectancy were not evident across all age groups. It was not until 1991 that life expectancy for older males surpassed that achieved in 1926.

Since the turn of the millennium, there have been notable improvements in life expectancy for both males and females at 65 years and at 75 years. The increases have been greater amongst males (+1.7 years at 65 years and +1.1 years at 75 years) than females (+1.2 years

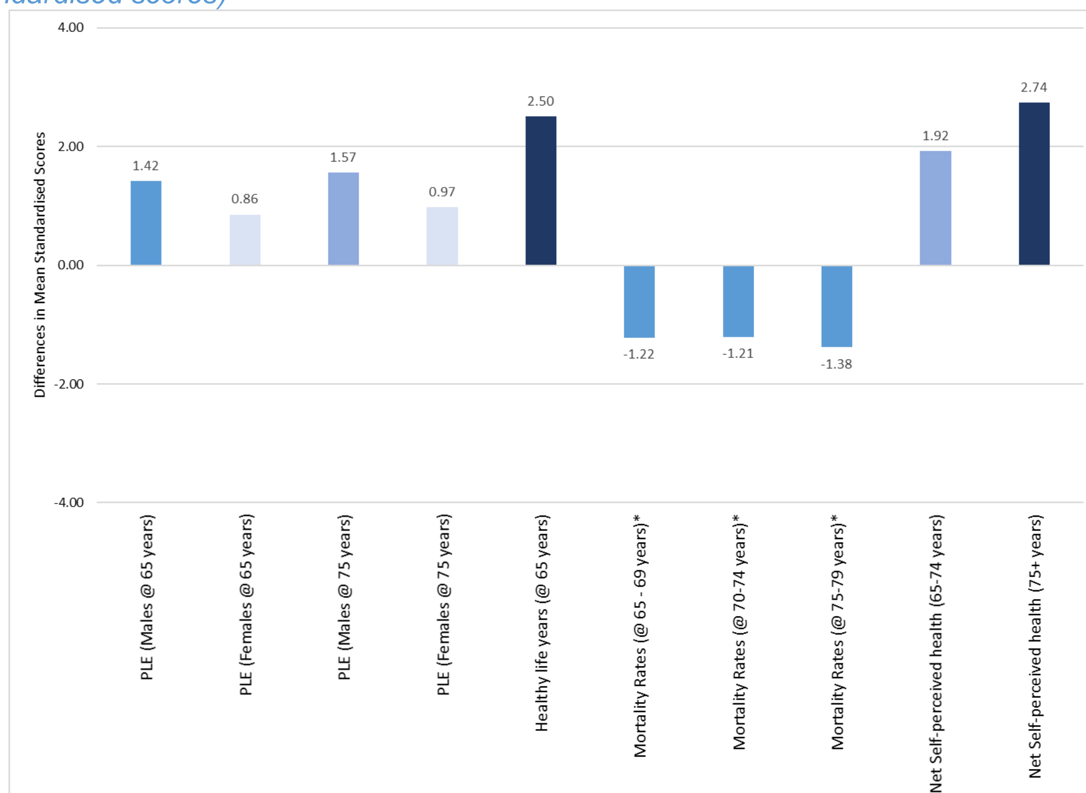
---

[45] Eurostat, 2020.
[46] Department of Health, 2013a and 2013b.
[47] Donoghue, O'Connell and Kenny, 2016; Idler and Benyamini, 1997; DeSalvo, Bloser, Reynolds et al., 2006; Lee, 2000.
[48] Eurostat, HLTH_SILC_10.
[49] Eurostat, 2020.
[50] Eurostat, HLTH_HLYE.

at 65 years and +0.8 years at 75 years) though female life expectancy is still of longer duration (by 3.2 years at 65 years and 2.3 years at 75 years).[51]

In addition to increasing life expectancy and healthy life years, mortality rates per 100,000 population have also decreased for those aged 65-79 years. Amongst people aged 65-69 years, mortality rates have decreased from an average of 1,875 in 2000-02 to an average of 1,105 in 2015-17 (-41%). The mortality rate amongst people aged 70-74 years have decreased by 39.7% (from an average of 3,210 to an average of 1,935) and amongst people aged 75-79 years by 37.6% (from an average of 5,520 to an average of 3,440).[52]

Figure 2 – Differences over time in Older People's Health (differences in average standardised scores)



* Expected negative trend

While there have been some notable improvements in the health of older people living in Ireland, they are more likely than people in general to experience a health challenge or disability, be severely limited in everyday activities, and access medical services. Older people are also more likely than people in general to have lower net self-perceived health status and mortality rates are higher. While older people are less likely than people in general to drink alcohol excessively, they are more likely to be overweight or obese and less likely to consume recommended daily amounts of fruit and vegetables. (See Figures 3 and 4.)

Amongst people aged 65-74 years average net self-perceived health status (+65-percentage points) was lower than that for people in general (+78-percentage points). The share of people in general (83%) who reported "good" or "very good" health was about 12-percentage points greater than the share of people aged 65-74 years who did so; people in general were a little less likely than older people to report "bad" or "very bad" health.

---

[51] Central Statistics Office, VSA30.
[52] Central Statistics Office, DHA13.

Within the population of older people, the net self-perceived health status of people aged 75 years or older was less than that of people aged 65-74 years. The share of the oldest group of older people reporting "good" or "very good" health was about eight percentage points lower than it was amongst those aged 65-74 years while the share reporting "bad" or "very bad" health was about three percentage points higher. It is also worth noting that for both cohorts of older people, net self-perceived health status is associated with affluence. The least affluent group of older people were less likely than the most affluent group to report "good" or "very good" health and were more likely to report "bad" or "very bad" health. These differences in net self-perceived health status were notably greater for those aged 65-74 years (32 percentage points) than those aged 75 years or older (11 percentage points).

The prevalence and incidence of poor health increases as people age. Compared to people in general, older people were more likely to report having a long-standing medical condition (43% as compared with 26% in 2019) and a disability (21% as compared with 12% in 2015).[53] Research published by TILDA has shown that as people age there are increases in the prevalence of cardiovascular and non-cardiovascular conditions, and frailty.[54] Within the cohort of older people, people aged 75 years or older were more likely than those aged 65-74 years to have a disability and were somewhat more likely to report having a long-standing medical condition.

As people age there tends to be increased demand for health services. In 2019, people aged 65-74 years were more likely than people in general to report visiting a GP (89% as compared with 76%) and medical or surgical consultant within the last 12 months (40% as compared with 31%). Along similar lines, though the available data is not very recent (2015), this group of older people was more likely than people in general to report being admitted to hospital as a day-patient (21% as compared with 16%) and as an inpatient (14% as compared with 11%).[55] People aged 75 years or older were somewhat more likely than those aged 65-74 years to visit a medical or surgical consultant or be admitted to hospital as an inpatient.

People's quality of life can be undermined by reduced physical health and disability.[56] While there are many types of disability, a distinction is often drawn between those that impact on "activities of daily living" (e.g. washing, eating and toileting that are essential to daily life) and "instrumental activities of daily living" (e.g. preparing meals, managing money and household chores that are important in maintaining independence). Older people were more likely than people in general to report that a health problem was a contributing factor in their being severally limited in everyday activities (8% as compared with 5% in 2019).[57] Within the cohort of older people, people aged 75 years or older were more likely than those aged 65-74 years to be severely limited in everyday activities by a health problem.

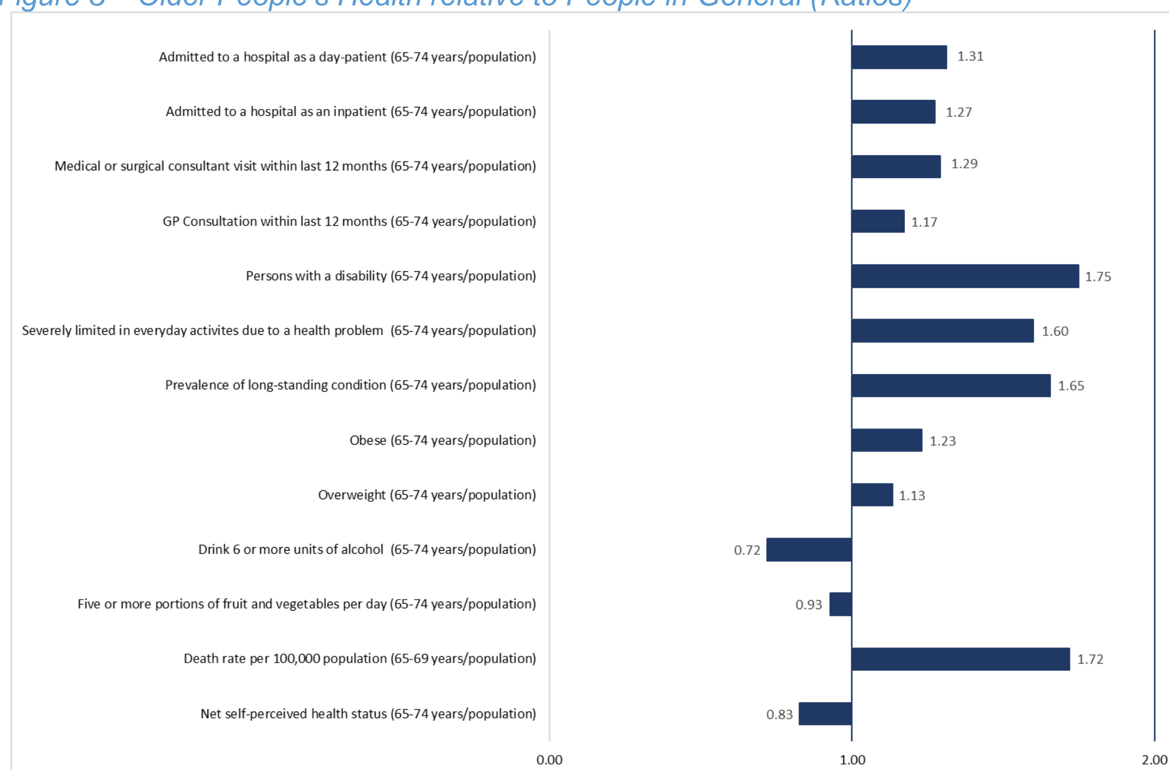
As people age, mortality rates increase and the average mortality rate in 2015-17 for people aged 65-69 years (1,105 per 100,000 population) was notably greater than it was for people in general (640 per 100,000 population). The mortality rate amongst people aged 75-79 years was about three times greater than it was amongst those ten years their junior.

While people may not expect to be in perfect health throughout the whole of their lives, an important aspect of increased longevity is that most of those additional years are lived in good health. This broader context suggests that health is about more than the absence of disease. Behavioural health refers to modifiable risk factors (e.g., smoking, alcohol consumption and

[53] Central Statistics Office, IH009 IH217 IH030.
[54] McNicholas and Laird, 2018; O'Halloran et al., 2020; O'Halloran and O'Shea, 2018.
[55] Central Statistics Office, IH044 IH225 IH117
[56] George, 2010; Stegenga et al, 2012.
[57] Central Statistics Office, IH023 IH222.

diet) that can have a negative influence on health and contribute to chronic disease.[58] The impact of these behaviours is not only associated with current behaviour but is also related to the cumulative effect of these behaviours over the course of a lifetime. Smoking is a well-known risk factor for a variety of conditions, in particular, cardiovascular and lung diseases and plays a role in other non-life-threatening chronic conditions such as cataracts and osteoporosis.[59] The cumulative effects of smoking over the life course means that the disease burden falls disproportionately on older people.[60] The *HaPAI Survey* (2018: 62) has reported that 18% of those aged 55 years or older were current smokers with 29% of respondents reporting that they were former smokers. The *Healthy Ireland Surveys* report that the prevalence of smoking amongst people aged 65 years or older (10%) was less than it was for the population as a whole (18%).[61] Within the older cohort, smoking was more prevalent amongst people aged 65-74 years (13%) than people aged 75 years or older (8%).[62]

Figure 3 – Older People's Health relative to People in General (Ratios)



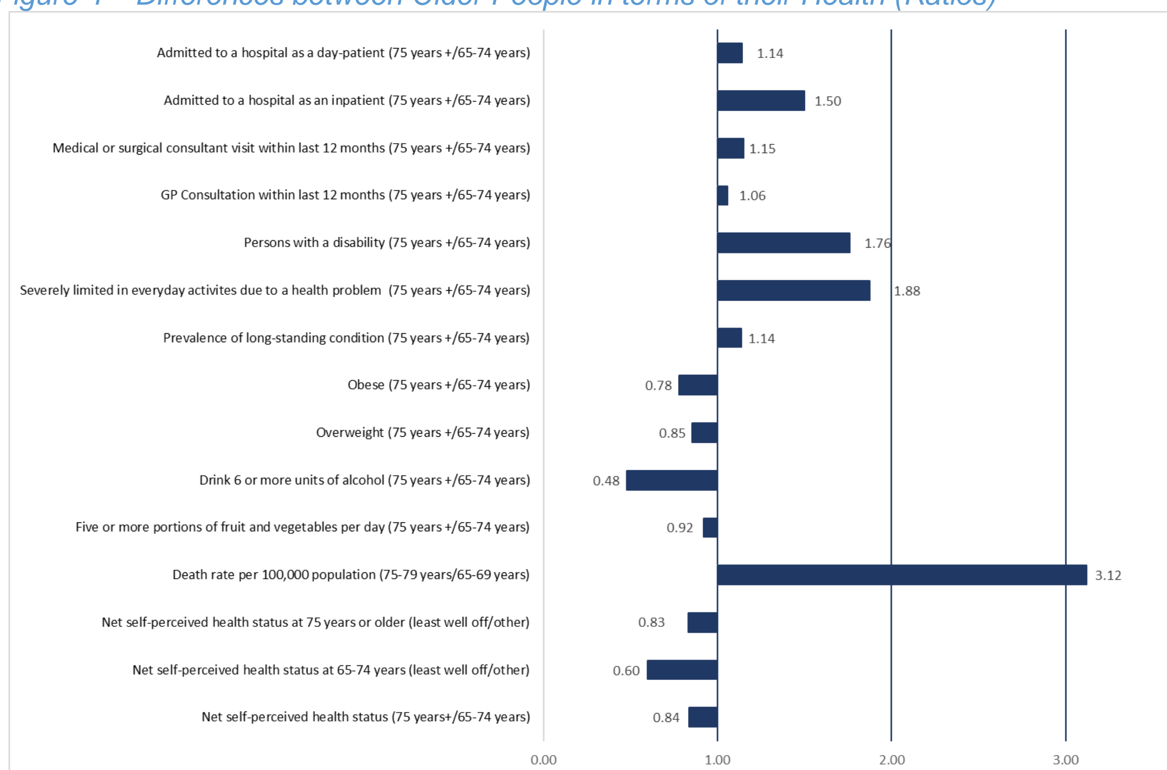
The World Health Organization has reported that the harmful use of alcohol is a causal factor for more than 200 diseases and injury conditions and can cause death and disability relatively early in life.[63] In Ireland in 2019, people aged 65-74 years (23%) were less likely than people in general (32%) to report drinking more than six units of alcohol at least once a month, but not every week.[64] That said, the *Healthy Ireland Survey* (2018: 12-13) has shown that the prevalence of weekly alcohol consumption increases until people are aged 55-64 years (66%) and then starts to decrease (63% amongst people aged 65-74 years and 53% amongst people aged 75 years or older).

---

[58] McNicholas and Laird, 2018.
[59] Wald and Hackshaw, 1996.
[60] Hudson, Madden and Mosca, 2015.
[61] Healthy Ireland Survey, 2021: 4.
[62] Healthy Ireland Survey, 2018: 8-9.
[63] World Health Organization, 2014.
[64] Central Statistics Office, IH089 IH302.

People aged 65-74 years were somewhat more likely than people in general to be overweight (34% as compared with 30%) and obese (32% as compared with 26%).[65] While it is notable that people aged 75 years or older were less likely than those aged 65-74 years to be overweight or obese, they were also less likely to eat the recommended daily amounts of fruit and vegetables.[66] The findings of the *Healthy Ireland Survey* (2019: 7) suggest that in Ireland the share of people achieving the minimum amount of activity recommended by the *National Guidelines on Physical Activity for Ireland* declines as people age. While 46% of the population had achieved the minimum 150 minutes of moderate activity each week, 35% of people aged 55-64 years did so, as did 33% of people aged 65-74 years and 18% of people aged 75 years or older.

Figure 4 – Differences between Older People in terms of their Health (Ratios)



[65] Central Statistics Office, IH096 IH308.
[66] Central Statistics Office, IH074 IH297.

4.4 Ageing and Participation in All Aspects of Life

Another perspective on ageing is that older people have opportunities to participate in all aspects of life. The approach adopted here utilises a number of different dimensions from the *Well-being Framework* to describe older people's participation in the labour force, education and activities in their local communities and society as well as the demands that are placed on their time, especially caring for others.

The available indicators that describe long-term change in participation by older people tend to focus on the areas of employment and education. (See Figure 5.) The Work & Job Quality dimension of the *Well-being Framework* is concerned with ensuring that people have opportunities to develop their skills and abilities so that they can fulfil personal ambitions, build and support their self-esteem and inform their sense of contributing to society more generally. When thinking about older people and employment, there may be a perception that people retire after 40 years of paid employment with their income to come from a pension or retirement fund. However, although low, there is an increasing number of people who continue to work beyond retirement age. While some may be choosing to continue working because of the satisfaction they derive from doing so, others may have to do so out of necessity (e.g., they are concerned they will not have sufficient income to meet their day-to-day needs (current and/or future)). People's experiences of work and job quality when they are younger can impact on their well-being in older age. A person's ability to prepare financially for later life can be hindered by experiences of unemployment[67] or poor quality working conditions.[68] These types of experiences as well as inadequate financial preparation can impact on people's standard of living in older age and levels of social engagement and physical activity.[69] It is also worth acknowledging that some older people may have retired from their employment, but that this may not have been their preferred course of action (e.g., retired from paid employment sooner than intended because of illness or disability, or a need to provide care to another).[70]

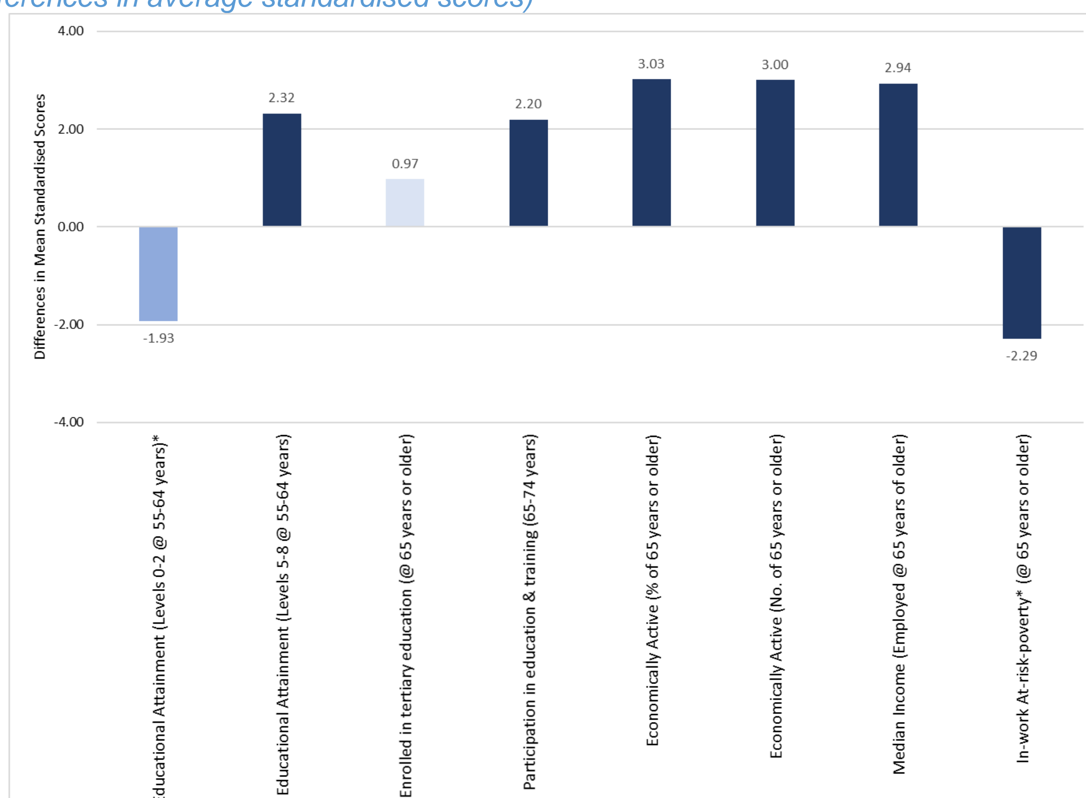
The Knowledge, Skills & Innovation dimension of the *Well-being Framework* is concerned with ensuring that people have the opportunity to develop skills (both cognitive and motor) to meet their needs relating to self-actualisation (e.g., achieving full potential) and esteem (e.g., feeling of accomplishment), cope with and address change (both in their day-to-day lives and in society more generally), and achieve material and economic progress. While participation in full-time formal education tends to be associated with younger years, learning is a dynamic process that presents people with opportunities across the whole of the life-cycle. There are increasing opportunities for people to attend adult education or third level courses, and lifelong learning provides people, including older people, with the opportunity to lead more active and fulfilling lives through improving their knowledge and skills, increasing their productivity and extending their careers.[71] In this context it is also important to note that educational attainment can impact on people's well-being in later years. For instance, amongst older people educational attainment is associated with quality of life (i.e., people who had tertiary education

[67] Unemployment can impact on people's physical and mental health through increased tobacco use and alcohol consumption; poor housing conditions and inadequate diet; stress around debt and poverty, social withdrawal and family disruption. (Waldron and Lye, 1989; Popovici and French, 2013; Brand, 2014; Drewnowski and Specter, 2004; Gallo et al., 1999; Marmot Review Team, 2011)
[68] Poor work conditions (e.g., exposure to hazards and the physical impact of manual labour) can impact on physical health. (Marmot Review Team, 2010)
[69] Allen, and Daly, 2016; Allen, Daly and Institute of Health Equity, 2016; Allen, 2008; Institute of Health Equity, 2004; Roberts and Bell, 2015.
[70] Eurostat, 2020.
[71] Eurostat, 2020.

tend to have a higher quality of life than those who at best had primary level education[72]). Similarly, educational attainment is associated with overall levels of cognitive performance (i.e., individuals who had more years of formal education consistently performed better on the cognitive performance tasks than those who had received less education[73]).

In terms of older people's participation in the labour force, the number of people aged 65 years or older who are economically active has increased from an average 34,800 in 2000-02 to an average of 93,200 in 2019-21. Relative to population size, the share of people aged 65 years or older who are economically active has increased from an average of 8.1% in 2000-02 to an average of 12.9% in 2019-21.[74]

Figure 5 – Differences over time in Older People's Participation in Aspects of Life (differences in average standardised scores)



* Expected negative trend

While there has been an increasing trend in participation in employment amongst older people, from Figure 6 it is evident that people aged 65-69 years have tended to be a lot less likely than people in general to be economically active (an average of 25.2% as compared with an average of 62.2% amongst people aged 15 years or older). From Figure 7 it is also evident that labour market participation decreases substantially when people reach the age of 70 years (an average of 12.1% amongst people aged 70-74 years and 4.4% amongst those aged 75 years or older).[75]

Older people's continued participation in the labour market has been associated with a number of benefits: increasing income and decreasing likelihood of in-work at-risk of poverty. Median equivalised net income of older people in employment has increased from an average of

[72] McGarrigle and Ward, 2018; McGee, Morgan, Hickey, Burke and Savva, 2011; Ward, McGarrigle and Kenny, 2018.
[73] Feeney and Tobin, 2018.
[74] Eurostat, LFSA_AGAN LFSA_ARGAN.
[75] Eurostat, LFSA_ARGAN.

€17,925 in 2004-06 to an average of €34,050 in 2019-21.[76] Furthermore, the median equivalised net income of older people still in employment was slightly greater than for people in general (an average of €32,170 amongst employed persons aged 16-64 years) and was notable higher than that of people aged 65 years or older who have retired (an average of €23,210).

Over the same period, the risk of a person aged 65 years or older being at risk of poverty while in employment has decreased from an average of 19% in 2003-05 to an average of 3.5% in 2019-21.[77] Furthermore, older people aged 65-69 years (average of 3.5%) were slightly less likely than people in general to experience in-work at-risk of poverty (an average of 4.9% amongst people aged 18 years or older).[78]

All of this change has occurred at a time when there has been a notable change in the distribution of educational qualifications amongst people aged 55-64 years. Since the turn of the millennium the share of people aged 55-64 years with highest levels of educational qualifications has increased from an average of 13.7% in 2000-02 to 34.2% in 2019-21 while the share with the lowest levels has decreased from an average of 63.9% to an average of 29.1%.[79] However, within the working age population, older cohorts were more likely than younger cohorts to have lower levels of educational attainment. In 2019-21, the average share of people aged 55-64 years with low levels of educational attainment was 29.1% as compared with 19.4% amongst people in general (i.e., people aged 15-64 years).[80] The average share of people aged 55-64 years with tertiary education was 34.2% as compared with 42.9% amongst people in general.[81]

While there have been important changes in the distribution of educational qualifications associated with age, the share of older people who had recently participated in education and training remains small (though there has been an upward trend from 1.7% in 2004-06 to 4.8% in 2019-21)[82] and the number of people aged 65 years or older enrolled in tertiary education has remained in and around 400.[83]

The Time Use dimension of the *Well-being Framework* is concerned with ensuring that people have the opportunity to meet and combine the demands that others place on them (e.g., work, family and other caring commitments) and meet their own needs (e.g., personal care and development).

In general terms, net satisfaction with time use was more likely to be stronger amongst people living in both one- or two-adult older households than it was amongst people in general (i.e., all household compositions). In particular, older people were a lot more likely than people in general to be satisfied with time use (about 57% as compared with 34.7%) and a lot less likely to be dissatisfied with time use (about 7% as compared with 18.8%).[84]

[76] Eurostat, ILC_DI05.
[77] Eurostat, ILC_IW01.
[78] Eurostat, ILC_IW01.
[79] Eurostat, EDAT_LFSE_03.
[80] It is also worth noting that in 2019-21 the share of people with low levels of educational attainment was 5% amongst people aged 20-24 years, 6.4% amongst 25-34 years and 8.8% amongst 35-44 years.
[81] Eurostat, EDAT_LFSE_03.
[82] Eurostat, TRNG_LFS_01.
[83] Eurostat, EDUC_UOE_ENRT02.
[84] Central Statistics Office, WBA40.

Figure 6 – Older People and Participation in All Aspects of Life relative to People in General (Ratios)

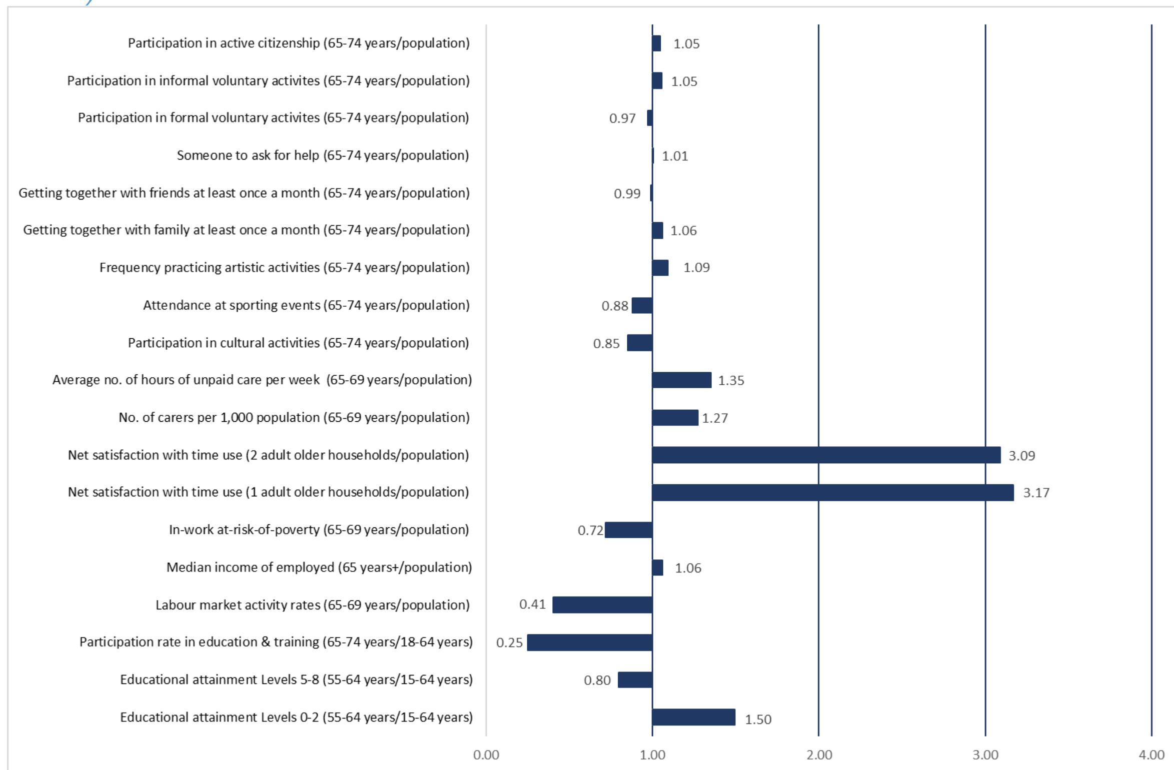
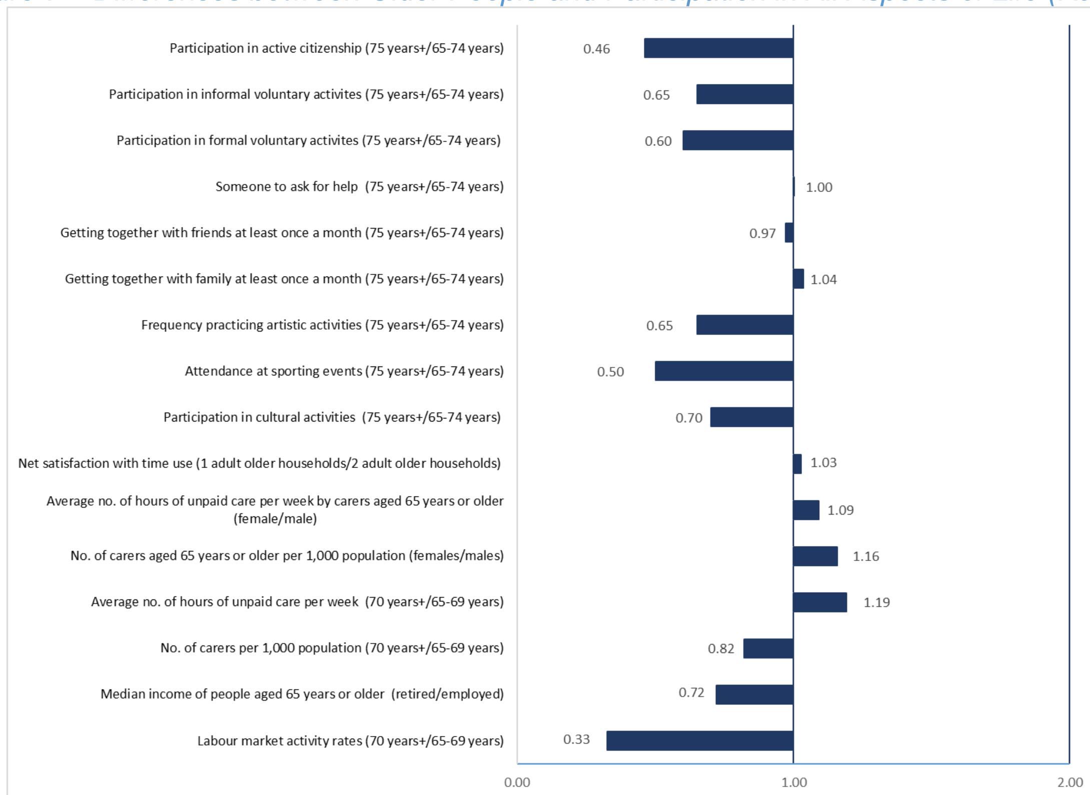


Figure 7 – Differences between Older People and Participation in All Aspects of Life (Ratios)



The provision of care is a particular demand on a person's time. In some cases, an older person may have a caring role for a partner. In other cases, caring is an example of intergenerational solidarity such as an older person caring for their grandchildren or, given increasing longevity, caring for a parent.[85] While a caring role can provide a person with a sense of purpose and self-esteem, it should be acknowledged that the duration and intensity of caring can impact on the health of the carer as well as their working lives and longer-term financial security. People who are involved in providing informal care for relatives and others may be at risk themselves of poor health, especially stress and depression.[86]

Based on data from 2016 Census, there were 52.2 carers per 1,000 population aged 65-69 years as compared with 41.0 carer per 1,000 population of all ages. Furthermore, carers aged 65-69 years have provided notably more hours of unpaid care (52.3 hours) than people in general (38.7 hours). Amongst those aged 65 years or older, the number of female carers was greater than the number of male carers (61 as compared with 43.4 per 1,000 population aged 65 years of older) and they have provided slightly more hours of unpaid care (55.3 hours as compared with 47.9 hours). It is also worth noting that while the number of carers aged 75 years or older (42.9 per 1,000 population) was less than those aged 65-74 years, the number of hours of care they have provided is greater (62.4 hours).[87]

The Connections, Community & Participation dimension of the *Well-being Framework* is concerned with the opportunities that an individual has for engaging with other people and sharing activities in order to meet their basic needs as well as psychological and self-fulfilment needs. This dimension includes family connections, community connections, volunteering and participation in community activities as well as the quality and quantity of time spent engaging with other people.

The Civic Engagement, Trust & Cultural Expression dimension of the *Well-being Framework* is concerned with the rights and opportunities that an individual has to express their voice, and participate and contribute to the functioning of society. It encompasses the extent to which people can shape the community where they live, are free both to express cultural, personal or political views and from incidence or feelings of discrimination. The opportunities that people have to express their voice will in part be shaped by trust in public governance (e.g., its institutions, rules and norms) and how this fosters cooperation between people.

When older people retire, some use the additional free time to engage in a range of voluntary activities, participate in other types of activities within their community, engage in active citizenship and share their experience, skills and talents.[88] Engaging with other people, and the quality of these relationships, has been shown to have positive implications for people's health and well-being.[89] Social engagement is protective against cognitive decline and dementia and can influence levels of physical activity, healthy eating, and other positive health

---

[85] Eurostat, 2020.

[86] Schulz and Sherwood, 2008; Heisler et al, 2012; Winter, Bouldin and Andresen, 2010. The *Irish Health Survey – Carers and Social Supports* found that carers were somewhat more likely than non-carers to report the prevalence of a long-standing condition, some level of limitation with regards to everyday activities and feelings of depression. (Central Statistics Office IH110, IH184)

[87] Central Statistics Office, E9044 E9058. The Census data presents the nominal number of carers. Census 2016 data on the number of people in each age group was used to calculated the number of carers per age cohort.

[88] Eurostat, 2020.

[89] Seeman, 1996; Nieminen, Harkanen, Martelin et al., 2015; Holt-Lunstad, Smith and Layton, 2010; Wahrendorf and Siegrist, 2010; Windsor and Anstey, 2010; McMunn, Nazroo, Wahrendorf et al., 2009; Santini, Koyanagi, Tyrovolas and Haro, 2015.

behaviours.[90] It has been posited that this is a consequence of positive emotions and a buffering of the harmful effects of stress.[91]

On the other hand, low levels of social engagement are held to have a similar impact on people's health as established risk factors such as physical inactivity, obesity, smoking and high blood pressure.[92] In older adults, loneliness has been associated with declines in physical, mental and cognitive health and increased risk of mortality.[93] Feelings of loneliness encompass missing close personal relationships (emotional loneliness) and wider social interaction, and reflect a deficit between a person's desired quality and quantity of engagement with others and the day-to-day reality of their engagement with others.[94]

Volunteering is an important source of social engagement and there is evidence of benefits in terms of physical, psychological and social well-being. For instance, quality of life increases with increasing frequency of volunteering and older adults who volunteer for at least 100 hours a year show slower declines in self-rated health and physical functioning, slower increases in depression levels and lower mortality rates compared to those who volunteered for less than 100 hours a year.[95] In addition, cultural participation can provide people with an opportunity to engage with other people and the world around them, promoting feelings of belonging and contributing to well-being.[96]

There were only some slight differences between the share of older people and people in general who reported engaging with family or friends or participating in their local communities (volunteer, active citizenship). While there were little or no differences between the various cohorts of older people in terms of getting together with family and friends, people aged 75 years or older were a lot less likely than those aged 65-74 years to have reported participating in their local communities. People aged 65-74 years were somewhat less likely than people in general to have reported participating in cultural activities (58.8% as compared with 69.1% of people aged 16 years or older) or attending sporting events (38.3% as compared with 43.5%). Furthermore, with increasing age the likelihood of participation in cultural activities and attending sporting events tends to decrease.[97]

---

[90] Allen and Daly, 2016: 3-4.
[91] Berkman, Glass, Brissette and Seeman, 2000.
[92] Holt-Lunstad, 2017; Donoghue, O'Connell and Kenny, 2016; House, Robbins and Metzner, 1982.
[93] Holt-Lunstad, 2017; Donoghue, O'Connell and Kenny, 2016; Hawkley and Cacioppo, 2010; Hawkley, Thisted and Cacioppo, 2009.
[94] Victor, Scambler, Bowling and Bond, 2005.
[95] Ward, Gibney and Mosca, 2018.; Donoghue, O'Connell and Kenny, 2016; Lum and Lightfoot, 2005.
[96] Eurostat, 2020.
[97] Eurostat, ILC_SCP03 ILC_SCP07 ILC_SCP09 ILC_SCP19.

4.5 Ageing and Being Confident and Secure

The final perspective on well-being in older age focuses on people ageing with confidence and security. The approach adopted here utilises a number of different dimensions from the *Well-being Framework* to describe the material resources that can provide older people with confidence about being able to meet their day-to-day needs both now and into the future, and the quality of the places where they live that can provide a sense of security about being able to meet their physical and social needs in their own homes and when they are out and about in their local area.

The Income & Wealth dimension of the *Well-being Framework* is concerned with ensuring that people have the opportunity to meet their day-to-day needs and wants as well as to mitigate personal, economic and societal risks and vulnerabilities. In terms of income, retirement is a key point of transition in a person's life. While pensions help protect people from poverty, pension inadequacy may result in a reduction in living standards compared to what was experienced during working lives, or relative to pre-retirement expectations. Financial insecurity may contribute to experiencing poverty and social exclusion as well as illness, disability or frailty.[98] Research published by TILDA has shown that older people in the most well-off quartile have a higher quality of life than those in the least well-off quartile.[99]

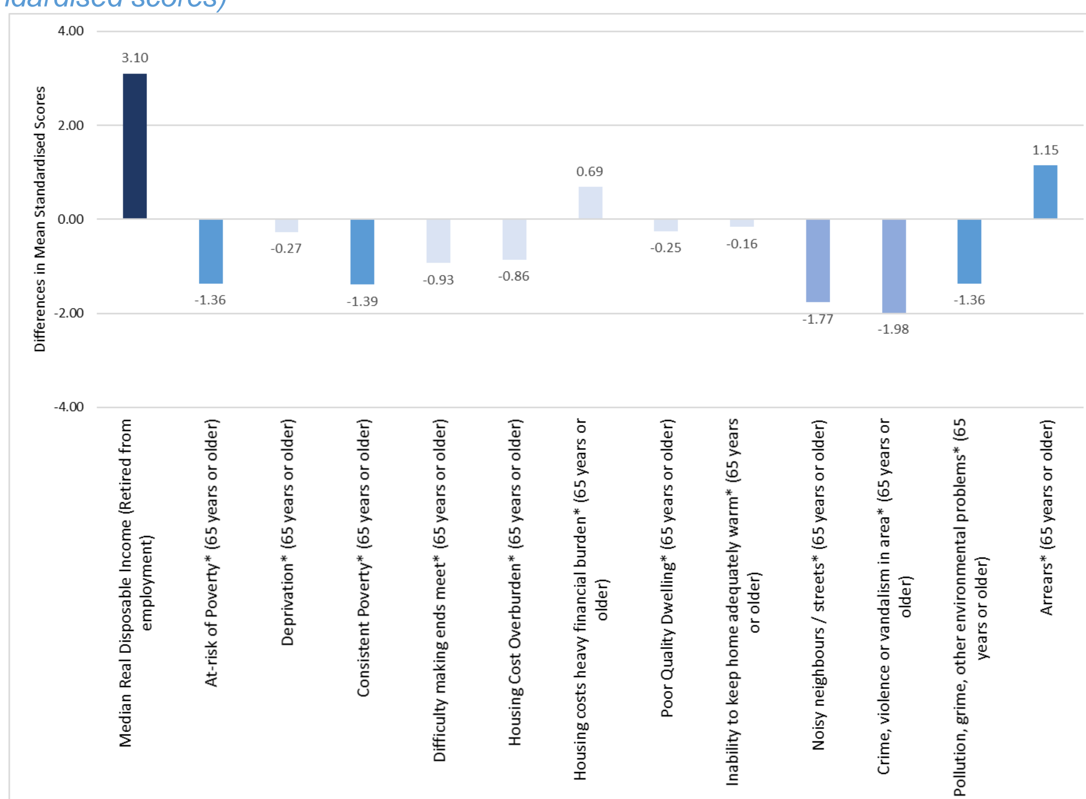
In terms of the material resources that older people have available, median real disposable income in households where the reference person has retired from employment have increased from an average of €21,495 in 2004-06 to an average of €29,990 in 2020-22 (+39.5%).

In 2017-19, median real household disposable income of retired households were notably less than that of all households (average of €29,420 as compared with an average of €45,540). Household composition is an important factor in differentiating between older households as median disposable income of one-adult older retired households (average of €17,320) was less than half of that of two-adult older retired households (€38,480).[100]

Over the same period, there was a notable decrease in the share of older people who were at-risk of poverty[101] (from 20% in 2004-06 to 13.6% in 2020-22). However, it is worth noting that in the years prior to the pandemic the average share of older people who were at risk of poverty was 10.2% (2017-19). Furthermore, prior to the pandemic, older households were a lot less likely than people in general to be at-risk of poverty (14.2% in 2017-19), but this was not the case in 2020-22 when the share of people in general at-risk of poverty was 12.6%.

[98] Eurostat, 2020.
[99] McGarrigle and Ward, 2018; McGee, Morgan, Hickey, Burke and Savva, 2011; Ward, McGarrigle and Kenny, 2018.
[100] Central Statistics Office, SIA14 SIA16
[101] The share of persons with an equivalised income below 60% of the national median income.

Figure 8 – Differences over time in Older People's Confidence and Security (Average standardised scores)



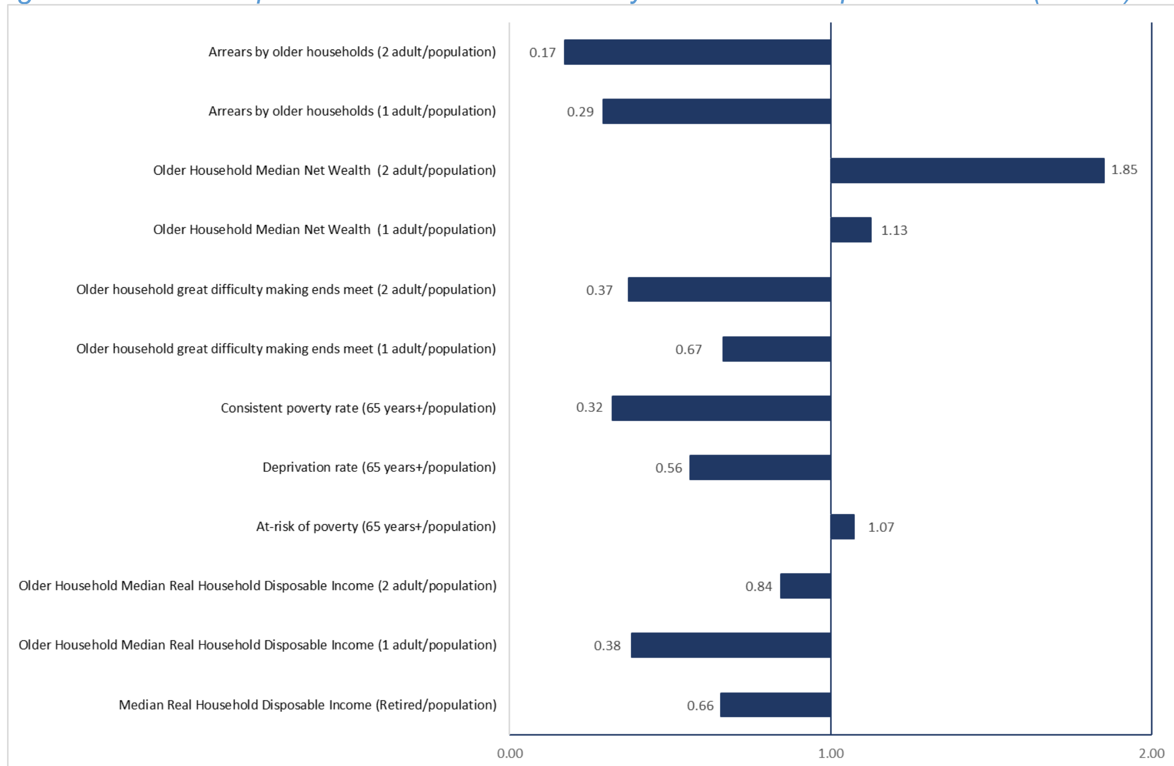
* Expected negative trend

There have also been reductions in deprivation[102] and consistent poverty[103] rates amongst older people, but these have been of a much smaller magnitude. Older households were less likely than people in general to experience deprivation and consistent poverty or to experience great difficulty making ends meet. That said, it should be noted that household composition was important as one-adult older households were more likely than two-adult older households to experience poverty or encounter difficulties making ends meet.[104]

In this context it is worth noting two trends that while small are not in the expected direction. Firstly, the likelihood of older households being in arrears with payments has increased from an average of about 1.9% in 2003-05 to an average of about 3.4% in 2019-21.[105] Secondly, there has been an increase in the share of older households reporting that housing costs were imposing a heavy financial burden, from 11.9% in 2003-05 to about 14.5% in 2018-20.[106]

[102] Deprivation rate is the share of persons who are excluded and marginalised from consuming goods and services (11 list items) which are considered the norm for other people in society due to an inability to afford them.
[103] Consistent poverty rate is the share of persons identified as being at risk of poverty and who are living in households deprived of two or more of the eleven basic deprivation items.
[104] Central Statistics Office, SIA12 SIA13 SIA55.
[105] Eurostat, ILC_MDES05.
[106] Eurostat, ILC_MDED04.

Figure 9 –Older People's Confidence and Security relative to People in General (Ratios)



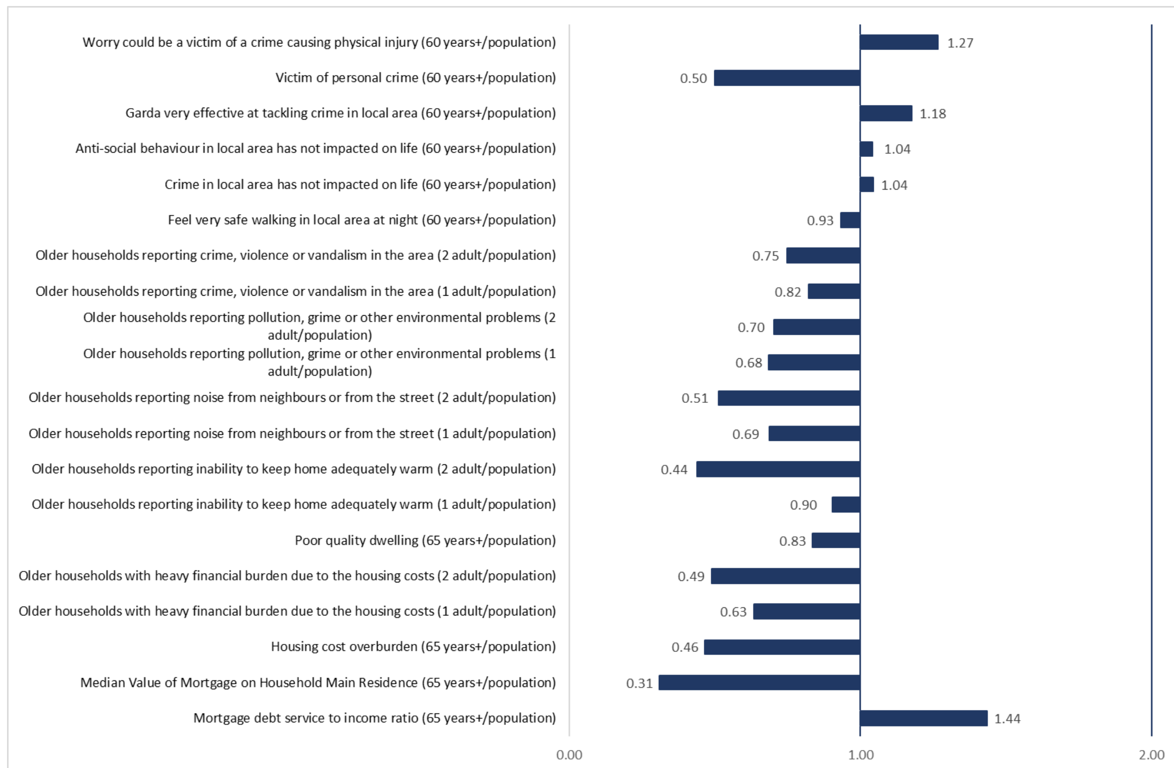
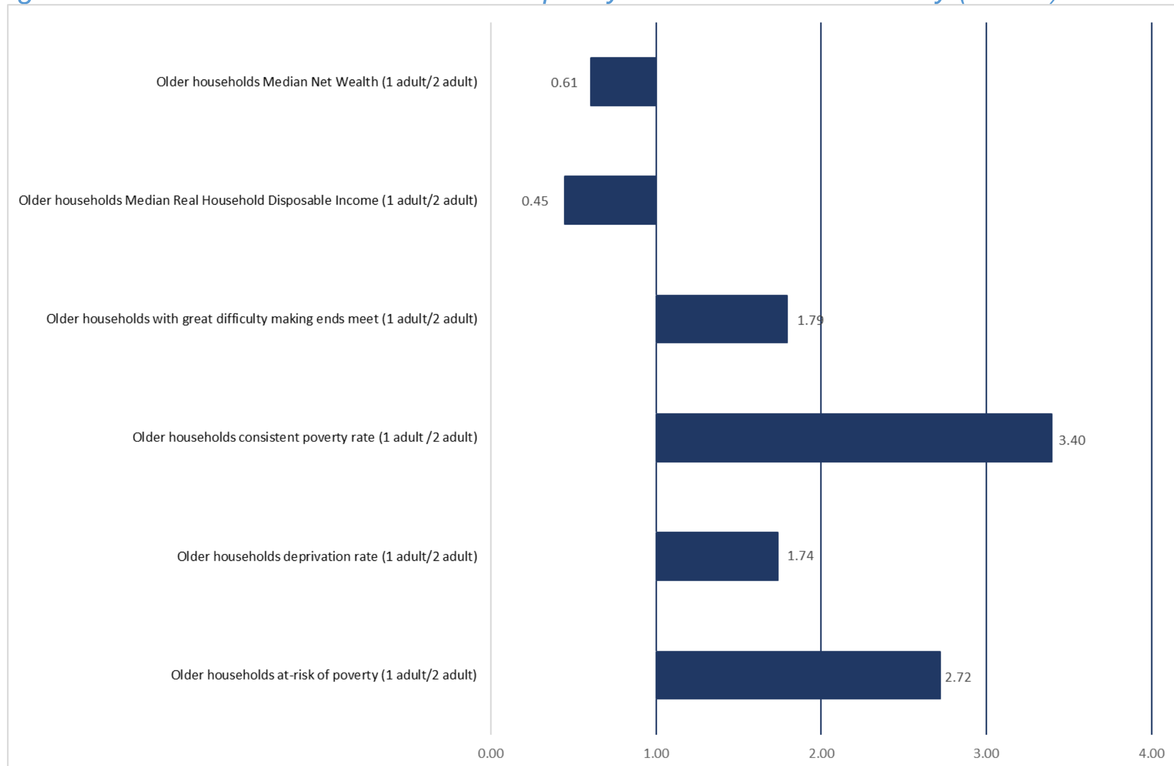
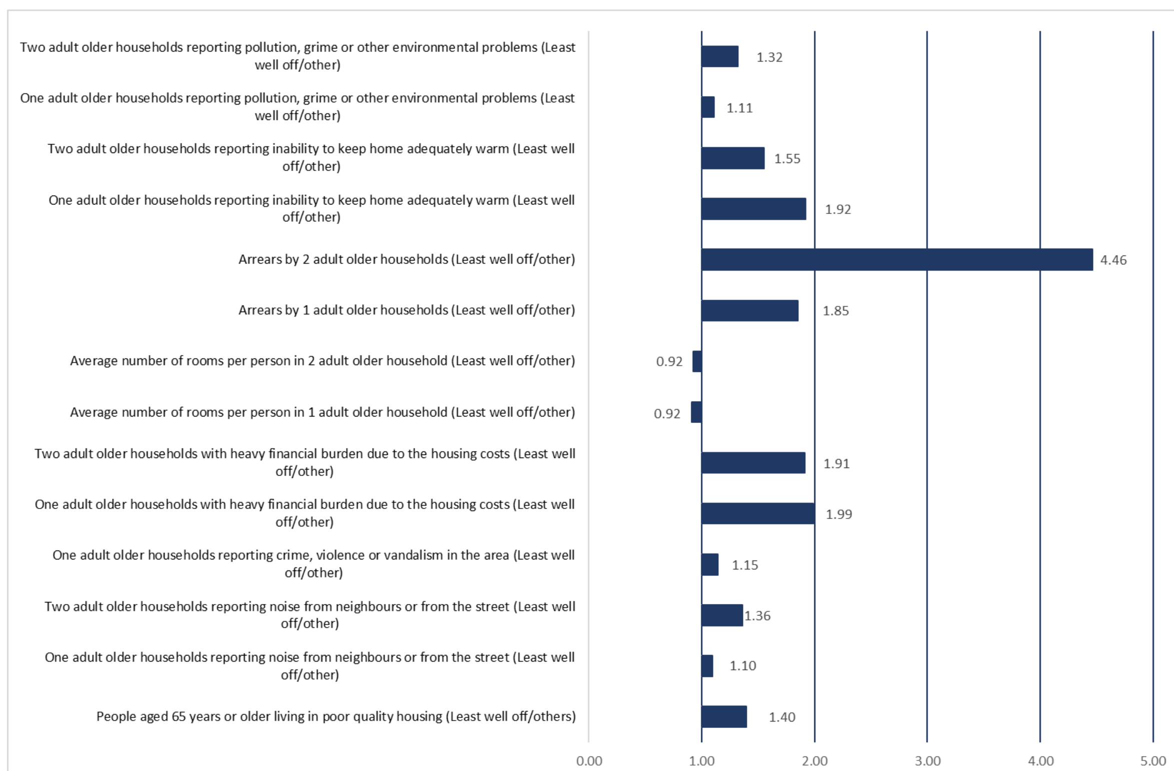


Figure 10 – Difference between Older People by Confidence and Security (Ratios)





Household wealth was another aspect of resources available to people. Older households had greater median net wealth than people in general and this was associated with household composition. Two-adult older households had a higher median net wealth (€330,400) than one-adult older households (€200,700), but both of these were greater than the median net wealth of households in general (€178,400).[107]

In Ireland, people aged 65 years or older were more likely to own than rent their home. On average, in 2019-21, 93% of two-adult older households and 83% of one-adult older households owned their home. Of these, over 95% had no outstanding mortgage. This compares with 69% of households in general who owned their home, of which 51% had no outstanding mortgage.[108] The median value of any mortgage held by older households was notably less than that held by people in general (€38,600 as compared with €124,900 in 2018).[109] However, it is worth noting that the cost to older people of servicing that mortgage was greater than it was for people in general (18.8% debt service to income ratio as compared with 13.1% in 2018).[110]

While compared to people in general, older people were less likely to have reported difficulties with the cost of housing, the least well-off older households were more likely than their older counterparts to have reported that housing costs imposed a heavy financial burden and to have been in arrears with day-to-day household expenses.[111]

The quality of the place where people live is described in this working paper using three dimensions of the *Well-being Framework*. First, the Housing & the Built Environment dimension is concerned with how housing and its location shapes the ability of an individual to meet their needs for shelter, safety and social belonging as well as their ability to avail of certain opportunities. The built environment aspect of the dimension refers to the infrastructure and services that provide people with the opportunity to move freely and easily within their own local area and beyond. For older people, quality of living conditions is important to maintaining good physical and mental health, the ability to live independently and life satisfaction.[112] Living conditions may be seen in terms of the quality of the building itself (whether or not there are problems with its structure, damp and mould or pests) and how comfortable the building is to live in (heating). Older housing stock is more likely to exhibit problems and to be occupied by older people.[113] When older people encounter difficulties heating their homes[114], they are more likely to have poorer self-rated health, clinically relevant depressive symptoms and chronic pain.[115] Cold living conditions are associated with increased mortality due to exacerbation of respiratory and cardiovascular conditions and increased incidence of stroke as well as increased morbidity in terms of arthritis, colds and 'flus and increased risk of accidents and injuries.[116] Living conditions may also include the

---

[107] Central Statistics Office, HFC37.
[108] Eurostat, ILC_LVHO02.
[109] Central Statistics Office, HFC18.
[110] Central Statistics Office, HFC32.
[111] Eurostat, ILC_LVHO07a. In this working paper, least well-off households is used to refer to those households composed of either one adult aged 65 years or older or two adults of which at least one is aged 65 years or older, where household incomes is below 60% of median equivalised income. The older counterparts is used to refer to such household composition where household income is above 60% of median equivalised income.
[112] McLoughlin and Scarlett, 2018; Breen, 2013.
[113] Orr, Scarlett, Donoghue and McGarrigle, 2016.
[114] The World Health Organisation recommends that indoor home temperatures are kept at a minimum of 18°C and even higher for sedentary older adults. (World Health Organization, 1984.)
[115] Pisters, Veenhof, van Dijk et al., 2012; Mezuk, Edwards, Lohman et al., 2012.
[116] Gibney, S., M. Ward and S. Shannon, 2018. Fuel poverty refers to households that have difficulties heating their homes. A household having to spending 10% or more of household income on heating is seen as a key threshold in terms of identifying fuel poverty and it has been estimated

number of people living in the household. As people age, they are more likely to live alone. While this can allow older people to maintain independence and self-esteem, it may also contribute to social isolation and loneliness and poor mental health.[117]

Second, the Safety & Security dimension of the *Well-being Framework* is concerned with the social, cultural, natural and institutional factors that shape the ability of an individual to live life and engage in activities without fear of harm from other people as well as to mitigate risks and impacts associated with infrastructural, mechanical and natural hazards. It is important that people feel safe, both in their own homes and when they are out-and-about.[118] For older people, feeling safe at home and in their neighbourhoods is a key element of a good quality of life.[119] Older adults who perceive their neighbourhoods as unsafe, particularly at night, tend to engage in less physical activity, regardless of socioeconomic status.[120]

Third, the Environment, Climate & Biodiversity dimension of the *Well-being Framework* is concerned with the place where people live and work and how it shapes their ability to meet physiological needs such as clean water and air as well as more transcendental needs such as relating to and interacting with nature. The quality of the environment is one of a number of factors associated with where people live that can impact on the quality of life experienced by older people in their local community.[121]

In terms of the quality of their homes, older people were somewhat less likely than people in general to have reported that their accommodation suffered from problems such as damp or leaking roofs (an average of 11.4% as compared with 13.7% in 2018-20) or that they were unable to keep their houses adequately warm. However, older people who live in the least well-off households were more likely (14.8%) than their older counterparts (10.6%) to have reported that they were living in poor quality accommodation. The least well-off older households were also more likely to have reported an inability to keep their house adequately warm, especially those living in one-adult older households.[122]

Beyond their own homes, there would appear to have been an improvement in the quality of the areas where older people live. In particular, there have been decreases in the shares of older people reporting crime, violence or vandalism in their area (from an average of 11.9% in 2003-05 to an average of 7.9% in 2018-20), noisy neighbours or streets (from an average of 10.9% to an average of 5.6%) and pollution, grime or other environmental problems (from an average of 7.7% to an average of 4.9%).[123]

In terms of feeling safe about themselves and their property, older people were less likely than people in general to have reported that they had been a victim of personal crime or to have reported that crime, violence or vandalism is a problem in their area.[124] However, they were more likely to worry about being a victim of crime and were somewhat less likely to feel very safe walking in their local area at night.[125]

---

that a quarter of all Irish households spent more than 10% of household income on heating. It has also been reported that half of older people in Ireland went without food or new clothing in order to pay for heating bills and are likely to forego heating and food if they have other high priority bills such as mortgages to pay. (Collins, 1986; Department of Communications, Energy and Natural Resources, 2015; Goodman, 2011.)

[117] McLoughlin and Scarlett, 2018.

[118] De Donder, de Witte, Dury et al., 2012.

[119] Gabriel and Bowling, 2004.

[120] Bennett, McNeill, Wolin et al. 2007; Tucker-Seeley, Subramanian, Li and Sorensen, 2009.

[121] Eurostat, 2020.

[122] Eurostat, ILC_MDHO01 ILC_MDES01.

[123] Eurostat, ILC_MDDW01 ILC_MDDW02.

[124] Central Statistics Office, CVS38 ; Eurostat, ILC_MDDW03.

[125] Central Statistics Office, CVS02 CVS07.

Finally, as people age they can encounter difficulties moving around the communities where they live. This can have a negative impact on their ability to access services or to continue to participate in their local communities.[126] Gibney, Moore and Shannon (2019) have investigated the relationship between the age-friendliness of local environments and self-reported loneliness amongst adults aged 55 years or older in Ireland. They have found that higher loneliness scores were associated with age-friendly place-based difficulties (i.e. with transport, accessing social services, barriers to community activities, lower social engagement, and experiences and perceptions of ageism in the community).[127] The *HaPAI Survey* (2018: 101) has found that 39% of people aged 70 years or older had difficulty walking in their local area as compared with 16% of people aged 55-69 years. Of those aged 55 years or older, 28% of females and 21% of males encountered such difficulties. In 2016, about half of females and more than a third of males aged 65 years or older reported having difficulty accessing essential services. Accessing public transport was the service that people were most likely to have difficulty with followed by banking services and grocery shops / supermarkets. People aged 65 years or older also reported encountering difficulties accessing cinema, theatre or cultural centres (32% of males and 44% of females) and recreational or green areas (8%).[128]

Box 1 – Age-Friendly Cities and Communities

In *Programme for Government – Our Shared Future*, the Government set out an age-friendly commitment to support older people to live in their own home with dignity and independence for as long as possible. This approach is part of a global response to population ageing that has been initiative by the World Health Organization[129] that is focussed on the health and well-being of older people.[130] In 2019, the World Health Organization acknowledged Ireland as the first fully affiliated country given the structures that are in place to prepare for demographic change and population ageing with a focus on prevention and early intervention.[131]

In Ireland, the programme is led by Age Friendly Ireland, a shared service function of local government that provides a national infrastructure to bring key stakeholders[132] together to plan collaboratively, to share resources and to streamline their work in meeting the interests and needs of older people. The Irish Age Friendly programme is closely aligned to national policies, in particular, the *Housing Options for Our Ageing Population* and *Housing for All – A New Housing Plan for Ireland*, *National Positive Ageing Strategy*, *SláinteCare*, the *Irish National Dementia Strategy*, the *Healthy and Positive Ageing Initiative, Healthy Ireland* and *National Planning Framework*.

One of the critical success factors of the shared service has been the multi-agency commitment and that multidimensional nature of the work which aligns with eight WHO domains for age-friendly communities. The programme is holistic in the sense that it encompasses citizen participation, statutory agencies, NGO groups, academics and private sector bodies. The programme structure operates consistently in each local authority area and comprises 31 strategic Age Friendly Alliances chaired by a local authority Chief Executive, 31 Older People's Councils, 31 Programme Managers dedicated to implementing a local Age Friendly Strategy, 31 Age Friendly Technical Advisors and interdepartmental working groups within the local authority. Age Friendly Programme managers

[126] See https://agefriendlyireland.ie/ for further information initiatives to address this challenge.
[127] They also found that loneliness scores were significantly higher for those in poorer health, who lived alone, were materially deprived and those never or formerly married.
[128] See *Positive Ageing Indicators 2018* (2018: 98, 100 and 102).
[129] World Health Organization, 2015; World Health Organization, 2007b.
[130] It focuses on eight themes that are closely associated with the dimensions set out in the Well-being Framework: outdoor spaces and buildings; transportation; housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community and health services.
[131] In 2013, under the Dublin Declaration on Age-Friendly Cities and Communities in Europe Ireland committed to develop cities and counties in which older people can live full, active, engaged and health lives.
[132] That is, local authorities, An Garda Síochána, the Health Service Executive, Education and Training Boards, NGOs, Older People's Councils, business and third level sector representatives.

deliver diverse outputs to prepare for population ageing, ranging from built environment and active travel measures to training, participation and communication activities. Initiatives with a multidimensional focus are effective in meeting the objectives of more than one policy area. A recent example is a national programme of creative regional initiatives for older people funded by the Creative Ireland Programme, which is being delivered in the context of older people's health and well-being. In a similar vein, there is a strong alignment between the age-friendly and climate action agendas with regard to sustainable communities. The age-friendly shared service is working closely with the Climate Action Regional Offices to engage older people in climate awareness and action.

There are many ways in which cities and counties can and have been developed so that they support people's enjoyment of healthier, more active and connected lives. The types of actions that can be taken include those that help provide walkable, attractive and accessible spaces as well as those that support participation and tackle inequality.[133] More specifically, the linking health and housing services under *Housing Options for Ageing Population* has supported the provision of a range of options that enable people to age-in-place. Furthermore, the *Healthy Age Friendly Homes* programme is being piloted in nine local authority areas and is a person centric approach to housing, health, digital technologies and community and social supports to work towards reducing early admission to long-term residential care, hospital avoidance (in particular, reducing average length of stays) and promoting health and well-being.

The COVID-19 pandemic meant that many organisations had to think differently about how to deliver their services to the public and support marginalised communities including older people. The response to the COVID-19 pandemic demonstrated both the resilience of older people in the face of adversity and what can be achieved when service providers and the community and voluntary sector cooperate and coordinate their activities. A variety of national level responses sought to promote coordination of community activity, service provision and volunteering in order to help older people:

- Keep active – it was important to keep active especially when access to opportunities for doing so were restricted and local radio was a useful approach to doing so in in Donegal (*Physical Activity Awareness Raising*) and Sligo (*Exercise from Home*) while Age & Opportunity provided an over the phone exercise class, *Fitline*;

- Stay connected – while recognising that technology could not replace the camaraderie of meeting people, people acknowledged the opportunities that it provided for people to stay in touch and the supports that were offered by initiatives such as *Staying Connected Initiative* (Skerries), *Digital Connections* (Tipperary) and *Digital Smartphone Project* (Clare);

- Switch off and be creative – people also reported that they read more, took online classes, undertook gardening and DIY jobs in their homes, engaged in creative writing and watched virtual concerts and online painting. Interactive, intergenerational creative projects were supported by initiatives such as *CovidNotebook* (Kildare) and *Song Ties* (Monaghan);

- Eat well – during the most restrictive periods, many older people were able to rely on family and neighbours to access food while others were supported by the emergency services and local community and voluntary groups, in particular at parish level by many GAA clubs; and

- Mind their mood – while many had a sense of just getting on with things, others felt varying degrees of anxiety or a sense of being overwhelmed and initiative to support people included *Ceol le Cheile* (Donegal), *Blue Bibs* (Cork) and *Covid Care Concerts* (Mobile Music Machine).[134]

---

[133] For further details see Age Friendly Ireland: http://agefriendlyireland.ie

[134] The HSE and Age Friendly Ireland have published a document that showcases initiatives undertaken to support the needs of older people during COVID-19 pandemic, *Ireland's Response to Older People During COVID-19. A Legacy Document of Health Service Executive, Age Friendly Ireland & Other Initiatives.* https://agefriendlyireland.ie/wp-content/uploads/2022/03/A-Legacy-Document-of-Health-Service-Executive-Age-Friendly-Ireland-Other-Initiatives-Irelands-Response-to-Older-People-During-COVID-19.pdf

5. Discussion

While life in Ireland has undergone many changes, perhaps one of the most significant is that Irish people are living longer lives. This change is often seen in terms of people's health. However, if the benefits of increased life expectancy are to be fully realised there is a need to utilise a broader perspective that focuses on how life is lived in older age.

The various approaches to conceptualising ageing encompass more than the familiar focus on physical and mental health. Public policy and ageing is about ensuring that older people have opportunities to take an active part in their communities and society, to enjoy an independent and good quality of life. These types of opportunities range across a broad spectrum, from labour market participation to social, cultural, spiritual or civic activities to positive personal and societal perceptions about growing older and how this is part of the life-course to feeling and being confident, safe and secure at home and when out-and-about, with family, neighbours and carers, and meeting day-to-day and future needs.

The *Well-being Framework for Ireland* offers a multi-dimensional approach to describing how the lives of older people in Ireland have changed and how they differ from other groups within the population. In general terms, it would appear that older people living in Ireland are experiencing healthier lives than was previously the case and have increasing opportunities to participate in all aspects of life. Furthermore, it is evident that, for the most part, older people are able to live confident and secure lives in their own homes and communities

For the most part, older Irish people feel that they are in control of their lives, have a strong sense of autonomy and self-realisation and feel that life has meaning and enjoyment. Older Irish people feel that they can both look forward to each day and look back on their life to date with a sense of happiness. More generally, there are a range of civic participation fora that provide older people with an opportunity to voice their interests and inform public policy (e.g., Older People's Councils (representative groups of older people who work together and with key State and voluntary agencies); Irish Seniors Citizens' Parliament (a representative organisation run by older volunteers elected annually to promote the views of older people in policy development and decision-making); Age Friendly Alliance (high-level cross-sector strategic partnership at local authority level that seeks to develop and oversee the realisation of Age Friendly City or County Strategies).

Health is perhaps the most salient aspect of well-being in older age. From a health perspective, the well-being of older people living in Ireland today would appear to be better than it was some two or three decades ago, but is less good than that of younger cohorts. There has been an improvement in older people's perceptions of their own health and this has coincided with sizeable improvements in more objective measures of health status. Compared to older people living in Ireland two or three decades ago, there have been increases in life expectancy (especially amongst older males) and the proportion of additional years lived in health, and decreases in mortality rates. However, as people age, there is increased prevalence of morbidity, disability, frailty and pre-frailty and dementia.[135] There is a mixed picture in terms of older people and health behaviours. On the one hand, older people are less likely than younger cohorts to smoke, engage in excessive consumption of alcohol, or consume unhealthy snack foods. On the other hand, compared to younger cohorts, older people are more likely to consume alcohol on a weekly basis, and are less likely to eat fruit or vegetables or achieve recommend levels of active exercise each week. Furthermore, notable

[135] McNicholas and Laird, 2018; McGarrigle and Ward, 2018; O'Halloran, 2020; O'Halloran and O'Shea, 2018; Feeney and Tobin, 2018; Morgan, Gibney and Shannon, 2017; Pierce and Pierce, 2017.

shares of older people are either overweight or obese (though these are somewhat less prevalent amongst people aged 75 years or older). Finally, in this context it is also worth noting the additional stresses that older people are encountering in terms of providing care for another and at end-of-life, in particular how people's preference for passing in their own homes is unlikely to be realised.[136]

Retirement from paid employment is an important life decision that can impact on various aspects of people's well-being. How people react to an increase in "free" time and a reduction in income will vary from person to person, and may in part be associated with how well they have planned for retirement. For some people, the drop in income can contribute to material deprivation and marginalisation while the absence of employment may lead to a loss of purpose and identity. It is worth noting that a sizeable share of older people have no plans or intention of retiring and, for some of this group of older people, unfortunately, ill-health would appear to be a strong driver of retirement.[137]

In Ireland, older people are a lot more likely than their younger counterparts to be satisfied-than-dissatisfied with time use. In particular, retirement provides some people with an opportunity of playing a more active part in their local communities than might otherwise have been available to them when they were employed (e.g., volunteer in their communities or participate in educational, social or sporting activities). However, this type of participation begins to lessen as people age, especially around the age of 75 years.[138] Furthermore, it would appear that some may be more constrained than others in choosing how to use this additional time. For instance, some older people are providing over 60 hours of care each week. Older people who cared for grandchildren prior to retirement not only continue to do so, but are likely to do so for a greater number of hours.[139]

The COVID-19 pandemic had a negative impact on people's well-being in terms of restricting their opportunities for engagement with others outside of their own homes and on their mental and physical health.[140] Older people had to change everyday patterns of behaviour and activities, especially in terms of getting together with family and friends. For some older people, the pandemic had a deleterious impact on mental health, especially amongst those who became carers during the pandemic. In terms of people's physical health, the restrictions associated with the pandemic are associated with unmet healthcare needs. In part this was due to cancellations or rescheduling by the healthcare provider, but was also influenced by older people being afraid to attend an appointment or deciding that a healthcare need could wait.[141]

Over the last couple of decades, it would seem that ageing in Irish society is associated with increasing confidence and security about being able to meet day-to-day needs, both now and into the future, and their own personal safety. For older people, there have been some improvements in material and living standard aspects of well-being. The likelihood of older households experiencing poverty has decreased and older households are less likely than households in general to encounter difficulties paying household costs. Older people are more

---

[136] May et al., 2017.
[137] Ward, 2019; Ward, Gibney and Mosca, 2018; Eurostat, 2020; Allen, and Daly, 2016; Allen, Daly and Institute of Health Equity, 2016; Allen, 2008; Institute of Health Equity, 2004; Roberts and Bell, 2015.
[138] Scarlett et al., 2021.
[139] McGarrigle, 2021; Ward, 2019; Eurostat, 2020.
[140] In 2020, TILDA fielded a Self-Completion Questionnaire that sought to examine how the COVID-19 pandemic changed the lives of older people in Ireland over the course of the first few months of the pandemic. The data collected focused on changes to normal every day activities due to social-distancing and other restrictions on social interactions and on how these impacted people's lives, in particular their physical and mental health.
[141] Ward, 2021; Lalor, Gibney and Ward, 2021; Scarlett et al., 2021.

likely than younger counterparts to own their own homes and are less likely to have mortgage debt. That said, amongst the small proportion of people aged 65 years or older who have a mortgage, the median value of that debt has increased and, as a proportion of income, the cost of servicing that debt is greater than it is for other cohorts.

It would also appear that older people in Ireland now have greater opportunities to continue being economically active than was previously the case. While there has been a notable increase in labour market participation by those aged 60-69 years, it is not clear to what extent this is a consequence of choice or necessity. That said, there would appear to be some benefits as the median equivalised net income of people aged 65 years or older who continue to be economically active is now greater than that of the working age population (having been three-quarters of that average at the turn of the millennium). It is also important to note that, in contrast to the working age population, this cohort of older people are more likely to be self-employed than employed, with the former more likely to be working full-time and the latter working part-time.[142]

These changes may in part be associated with shifts in the distribution of educational qualifications across the population. For instance, those who are approaching retirement age today are more likely than their counterparts in the early 1990s to have a tertiary education and less likely to have at best a lower secondary education. However, it remains the case that within the working age population, older cohorts are less likely than younger cohorts to have a third level qualification and are more likely to have lower levels of educational attainment.

It is difficult to offer a definitive conclusion about the well-being of older people living in Ireland. Clearly, there have been some significant improvements in well-being. However, it is also clear that despite these improvements, some aspects of older people's well-being are less than those of people in general, and for some older people their well-being is less than that of other older people.

The benefit of utilising the *Well-being Framework* to describe the well-being of older people is that it provides an opportunity to be clear about what is meant by policy goals that seek to "enhance well-being". First, it offers an opportunity to be more specific and to go beyond a concern with health in older age. For example, it provides an opportunity to articulate clearly what it means to enhance well-being in terms of what people do (i.e., work, volunteer, express their voice, attend events, highlight social issues) and what people want to be (i.e., being able to meet their current and future needs, being secure at home and when they are out-and-about). Second, it offers an opportunity to consider how to frame policy goals. Policy goals should not simply be presented in terms of improvements over time but should also seek to reduce differences between older people and people in general and, perhaps more importantly, reduce differences between different cohorts of older people.

Policy around ageing is associated with both complex policy challenges (concerned with multiple outcomes in a number of different policy domains) and complex policy interventions (involving a portfolio of services and interventions provided by a range of actors concerned with one or more outcomes across several policy domains in a context of no single organisation having overall control and ongoing change in the lives of those in receipt of the services or interventions).[143] Clarity around policy goals can inform and shape the design and implementation of interventions. First, it can help frame the variety of services that are delivered, from those reasonable straightforward interventions and services that are provide to a diverse group of people to the more specialised or longer-term interventions and services that are provided to a targeted group of people. Second, it creates opportunities for each

[142] Eurostat, LFSA_EFTPT.
[143] For more thorough discussion see: HM Treasury, 2020; Ling, 2012; Stirling, 2010.

stage of the policy making cycle to consider evidence, whether setting out the rationale for the intervention, selecting between potential policy interventions, reviewing an existing programme or intervention to determine how it might be improved. Finally, the linkages between the various dimensions of well-being can bring to the fore questions of co-ordination and cooperation with other policy areas that may shape the effectiveness of a service or intervention.

6. Concluding Comments

This working paper has sought to describe the lives of older people in Ireland by utilising Ireland's *Well-being Framework*. The value of doing so is to provide an opportunity to reflect on the benefits and challenges of one of the most remarkable developments in Ireland, that people are now living longer lives. That people in Ireland are now living longer lives is not simply about ensuring that these additional years are lived in health, but that people have opportunities to live in ways they find meaningful and of value to themselves, their families, their communities and society.

The various conceptualisations of ageing set out a guide as to what it might mean for older people "to lead the kind of lives they value – and have reason to value". While each of the approaches to understanding ageing recognise the importance of "being" healthy, they also include notions of "being" independent, confident and secure, and the importance of "doing" such as having opportunities to work and learn, participate in family life, take an active part in community life, participate in the activities available in their local areas.

By framing the description of the lives of older people in Ireland, the *Well-being Framework* has highlighted how the "beings" and "doings" of older people have changed over the course of the last few decades. In addition, the *Well-being Framework*'s focus on equality has contributed to identifying the ways in which the well-being of older people differ from people in general as well as within the population of older people.

Public policies that focus on particular groups of people are likely to not only seek to address complex policy challenges but are also likely to require complex policy interventions. The benefit of adopting a well-being perspective to public policy is that it will support and inform a broad understanding of people's experiences, help identify policy challenges and how they may be related to each other, and examine how public policy can enhance people's well-being. As this working paper is an initial effort at using the *Well-being Framework* to describe the lives of older people in Ireland, further work may develop a deeper more expert analysis of how relevant policies and programmes are enhancing well-being of older people.

Appendix A – National Goals and Objectives of the National Positive Ageing Strategy

Remove barriers to participation and provide more opportunities for the continued involvement of people as they age in all aspects of cultural, economic and social life in their communities according to their needs, preferences and capacities.

Objectives

- Develop a wide range of employment options (including options for gradual retirement) for people as they age and identify any barriers (legislative, attitudinal, custom and practice) to continued employment and training opportunities for people as they age.
- Promote access (in terms of affordability, transport availability, accessibility of venue) to a wide range of opportunities for continued learning and education for older people.
- Promote the concept of active citizenship and the value of volunteering, and encourage people of all ages to become more involved in and to contribute to their own communities.
- Promote the development of opportunities for engagement and participation of people of all ages in a range of arts, cultural, spiritual, leisure, learning and physical activities in their local communities.
- Enable people as they age 'to get out and about' through the provision of accessible, affordable, and flexible transport systems in both rural and urban areas.

Support people as they age to maintain, improve or manage their physical and mental health and wellbeing.

Objectives

- Prevent and reduce disability, chronic disease and premature mortality as people age by supporting the development and implementation of policies to reduce associated lifestyle factors.
- Promote the development and delivery of a continuum of high quality care services and supports that are responsive to the changing needs and preferences of people as they age and at end of life.
- Recognise and support the role of carers by implementing the National Carers' Strategy (2012).

Enable people to age with confidence, security and dignity in their own homes and communities for as long as possible.

Objectives

- Provide income and other supports to enable people as they age to enjoy an acceptable standard of living.
- Facilitate older people to live in well-maintained, affordable, safe and secure homes, which are suitable to their physical and social needs.
- Support the design and development of age friendly public spaces, transport and buildings.
- Continue to implement An Garda Síochána Older People Strategy and empower people as they age to live free from fear in their own homes, to feel safe and confident outside in their own communities, and support an environment where this sense of security is enhanced.

- Continue to address the problem of elder abuse at all levels of society through raising awareness, improving reporting rates and developing services.

Support and use research about people as they age to better inform policy responses to population ageing in Ireland.

Objectives

- Continue to employ an evidence-informed approach to decision-making at all levels of planning.
- Promote the development of a comprehensive framework for gathering data in relation to all aspects of ageing and older people to underpin evidence-informed policy making.

Source: Department of Health. 2013. *Positive Ageing – Starts Now! The National Positive Ageing Strategy*: 20-21.

Bibliography

Alkire, S. 2002. *Valuing Freedoms: Sen's Capability Approach and Poverty Reduction.* Oxford: Oxford University Press.

Allen, J. 2008. *Older People and Wellbeing*. London: Institute for Public Policy Research.

Allen, J., and S. Daly. 2016. *Older people and the social determinants of health*. Briefing Paper. London: British Medical Association.

Allen, J., S. Daly and Institute of Health Equity. 2016. *Inequalities in mental health, cognitive impairment and dementia among older people*. London: Institute of Health Equity.

Baltes, P.B., and M.M. Baltes. 1990. 'Psychological perspectives on successful aging: The model of selective optimization with compensation'. In P.B. Baltes and M.M. Baltes (eds). *Successful aging: Perspectives from the behavioral sciences*. New York: Cambridge University Press.

Bass, S.A., F.G.Caro and Y. Chen. 1993. *Achieving a Productive Society*. Westport: Auburn House.

Bennett, G.G., L.H. McNeill, K.Y. Wolin et al. 2007. 'Safe to walk? Neighborhood safety and physical activity among public housing residents'. *PLoS Medicine*. Vol.*4* (10): 1599–1607.

Berkman, L.F., T. Glass, I. Brissette and T.E. Seeman. 2000. 'From social integration to health: Durkheim in the new millennium'. *Social Science & Medicine*. Vol.51 (6): 843-857.

Bowling, A. and P. Dieppe. 2005. 'What is successful ageing and who should define it?'. *British Medical Journal*. Vol.331.

Brand, J. 2015. 'The far reaching impact of job loss and unemployment'. *Annual Review of Sociology*. Vol.41: 359-375.

Breen, C. 2013. *Focus on Housing and the Health of Older People*. Dublin: Centre for Ageing Research and Development in Ireland.

Collins, K.J. 1986. 'Low indoor temperatures and morbidity in the elderly'. *Age and Ageing*. Vol.15 (4): 212-220.

Cronin de Chavez, A., K. Backett-Milburn, O. Parry and S. Platt. 2005. "Understanding and researching wellbeing: Its usage in different disciplines and potential for health research and health promotion." *Health Education Journal*. Vol.64 (1): 70-87.

Dean, H. 2009. "Critiquing capabilities: the distractions of a beguiling concept." Critical Social Policy. Vol.29 (2): 261-273.

De Donder, L., N. de Witte, S. Dury et al. 2012. 'Individual risk factors of feelings of unsafety in later life'. *European Journal of Ageing*. Vol.9 (3): 233–242.

Department of Communications, Energy and Natural Resources. 2015. *Bottom-up analysis of fuel poverty in Ireland*. Dublin: Department of Communications, Energy and Natural Resources.

Department of Health. 2013a. *Positive Ageing – Starts Now! The National Positive Ageing Strategy*.

Department of Health. 2013b. *Healthy Ireland – A Framework for Improved Health and Wellbeing, 2013-2025*.

Department of Health. 2015a. *Healthy and Positive Ageing Initiative Literature Review*. Dublin: Department of Health.

Depp, C.A., and D.V. Jeste. 2006. 'Definitions and predictors of successful aging: a comprehensive review of larger quantitative studies'. *The American Journal of Geriatric Psychiatry*. Vol.14 (1): 6–20.

DeSalvo, K.B., N. Bloser, K. Reynolds et al. 2006. 'Mortality Prediction with a Single General Self-Rated Health Question: A Meta-Analysis'. *Journal of General Internal Medicine*. Vol. 21 (3): 267-75.

Diener, E. 2006. 'Guidelines for National Indicators of Subjective Well-Being and Ill-Being'. *Applied Research in Quality of Life*. Vol.*1* (2): 151–157.

Diener, E., R.E. Lucas and C. Napa Scollon. 2006. "Beyond the hedonic treadmill: Revising the adaptation theory of well-being." *American Psychologist*. Vol.61 (4): 305-314.

Dolan, P. 2014. *Happiness by Design: Finding Pleasure and Purpose in Everyday Life*. London: Allen Lane.

Donoghue, O., M. O'Connell and R.A. Kenny. 2016. *Walking to Wellbeing – Physical Activity, Social Participation and Psychological Health in Irish Adults aged 50 years and Older*. Dublin: TILDA.

Drewnowski, A. and S. Specter. 2004. 'Poverty and obesity: the role of energy density and energy cost'. *The American Journal of Clinical Nutrition*. Vol.79 (1): 6-16.

Eurostat. 2020. *Ageing Europe. Looking at the Lives of Older People in the EU*. 2020 Edition. Luxembourg: Publications Office of the European Union.

Feeney, J., and K. Tobin. 2018. 'Cognitive change over time.' In N. Turner, O. Donoghue and R.A. Kenny (eds.). *Wellbeing and Health in Ireland's over 50s 2009-2016*. Dublin: TILDA.

Gabriel, Z., and A. Bowling. 2004. 'Quality of life from the perspectives of older people'. *Ageing & Society*. Vol.24: 675–691.

Gallo, W., E.H. Bradley, M. Siegel and S.V Kasl. 2000. 'Health Effects of Involuntary Job Loss Among Older Workers Findings From the Health and Retirement Survey'. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*. Vol.55 (3): 131-140.

George, L.K. 2010. 'Still Happy After All These Years: Research Frontiers on Subjective Well-being in Later Life'. *Journal of Gerontology: Social Sciences* Vol.*65B* (3): 331–339.

Gibney, S., M. Ward and S. Shannon. 2018. 'Housing conditions and non-communicable diseases among older adults in Ireland'. *Quality in Ageing and Older Adults*. Vol.19 (3): 191-204.

Gibney, S., M. Ward, S. Shannon, T. Moore and N. Moran. 2018. *Positive ageing in age friendly cities and counties: local indicators report*. Dublin: Department of Health.

Gibney, S., T. Moore and S. Shannon. 2019. 'Loneliness in later life: a cross-sectional survey analysis of place-based factors in Ireland'. *Quality in Ageing and Older Adults*. Vol.20 (2): 80-96.

Goodman, P. 2011. *Fuel Poverty, Older People and Cold Weather: An All-island Analysis*. Dublin: Dublin Institute of Technology.

Hardoon, D., N. Hey and S. Brunetti. 2020. *Wellbeing Evidence at the Heart of Policy*. https://whatworkswellbeing.org/wp-content/uploads/2020/02/WEHP-full-report-Feb2020_.pdf

Hawkley, L.C. and J.T. Cacioppo. 2010. 'Loneliness matters: a theoretical and empirical review of consequences and mechanisms'. *Annals of Behavioural Medicine*. Vol.40 (2): 218-27.

Hawkley, L.C., R.A. Thisted, J.T. Cacioppo. 2009. 'Loneliness Predicts Reduced Physical Activity: Cross-Sectional and Longitudinal Analyses'. *Health Psychology*. Vol.28 (3): 354-363.

Heisler, M., H. Choi, J.D. Piette et al. 2012. 'Adults with cardiovascular disease who help others: a prospective study of health outcomes'. *Journal of Behavioral Medicine*. Vol.36 (2): 199–211.

HM Treasury. 2021. *Wellbeing Guidance for Appraisal: Supplementary Green Book Guidance*. London: HM Treasury.

Holt-Lunstad, J. 2017. 'The potential public health relevance of social isolation and loneliness: prevalence, epidemiology, and risk factors'. *Public Policy and Aging Report*. Vol.27 (4): 127-130.

Holt-Lunstad, J., T.B. Smith and J.B. Layton. 2010. 'Social relationships and mortality risk: a metaanalytic review'. *PLOS Medicine*. Vol.7.

House, J.S., C. Robbins and H.L. Metzner. 1982. 'The association of social relationships and activities with mortality: prospective evidence from the Tecumseh Community Health Study'. *American Journal of Epidemiology*. Vol.116 (1): 123-140.

Hudson, E., D. Madden and I. Mosca. 2015. *Inequalities in Health Behaviours*. Research Brief. Dublin: Centre for Ageing Research and Development in Ireland.

Idler, E.L. and Y. Benyamini. 1997. 'Self-rated health and mortality: a review of twenty-seven community studies'. *Journal of Health and Social Behaviour*. Vol.38 (1): 21-37.

Institute of Health Equity. 2004. 'Local Action on health inequalities: Improving Access to green spaces'. *Health Equity Evidence Review*. Vol.8.

Lalor, G., S. Gibney and M. Ward. 2021. "Changes to everyday activities in response to COVID-19 restrictions." In M. Ward, P. O'Mahoney and R.A. Kenny (eds.). *Altered lives in a time of crisis: The impact of the COVID-19 pandemic on the lives of older adults in Ireland*. Dublin: The Irish Longitudinal Study on Ageing.

Lee, Y. 2000. 'The predictive value of self assessed general, physical, and mental health on functional decline and mortality in older adults'. *Journal of Epidemiology and Community Health*. Vol. 54 (2): 123-129.

Levy, B.R and L.M. Myers. 2004. 'Preventive health behaviors influenced by self-perceptions of aging'. Preventive Medicine. Vol.39 (3): 625-629.

Levy, B.R., M.D. Slade and S.V.Kasl. 2002. ‘Longitudinal benefit of positive self-perceptions of aging on functional health’. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*. Vol.57 (5): 409-417.

Levy, B.R., M.D. Slade, S.R. Kunkel and S.V. Kasl. 2002. ‘Longevity increased by positive self-perceptions of aging’. *Journal of Personality and Social Psychology*. Vol.83 (2): 261-70.

Ling, T. 2012. ‘Evaluating complex and unfolding events in real time.’ *Evaluation*. Vol.18 (1): 79-91.

Lum, T.Y. and E. Lightfoot. 2005. ‘The Effects of Volunteering on the Physical and Mental Health of Older People’. *Research on Aging*. Vol. 27 (1): 31-55.

Marmot Review Team. 2010. *Fair Society Healthy Lives*. London: UCL.

Marmot Review Team. 2011. *The Health Impacts of Cold Homes and Fuel Poverty*. London: UCL.

May, P., C. McGarrigle and C. Normand. 2017. *The end of life experience of older adults in Ireland*. Dublin: TILDA.

McGarrigle, C. 2021 “Changes to caregiving roles.” In M. Ward, P. O’Mahoney and R.A. Kenny (eds.). *Altered lives in a time of crisis: The impact of the COVID-19 pandemic on the lives of older adults in Ireland*. Dublin: The Irish Longitudinal Study on Ageing.

McGarrigle, C., and M. Ward. 2018. ‘Quality Of Life and Relationships.’ In N. Turner, O. Donoghue and R.A. Kenny (eds.). *Wellbeing and Health in Ireland’s over 50s 2009-2016*. Dublin: TILDA.

McGee, H., K. Morgan, A. Hickey, H. Burke and G. Savva. 2011. ‘Quality Of Life and Beliefs About Ageing.’ In A. Barrett, G. Savva, V. Timonen and R.A. Kenny (eds.). *Fifty Plus in Ireland 2011 First results from the Irish Longitudinal Study on Ageing (TILDA)*. Dublin: TILDA.

McLoughlin, S. and S. Scarlett. 2018. “Living conditions of adults in Ireland.” In N. Turner, O. Donoghue and R.A. Kenny (eds.). *Wellbeing and Health in Ireland’s over 50s 2009-2016*. Dublin: The Irish Longitudinal Study on Ageing.

McMunn, A., J. Nazroo, M. Wahrendorf et al. 2009. ‘Participation in socially productive activities, reciprocity and wellbeing in later life: baseline results in England’. *Ageing & Society*. Vol.29: 765-782.

McNicholas, T., and E. Laird. 2018. ‘Change in chronic disease prevalence and health behaviours over the first four waves of TILDA.’ In N. Turner, O. Donoghue and R.A. Kenny (eds.). *Wellbeing and Health in Ireland’s over 50s 2009-2016*. Dublin: TILDA.

Mezuk, B., L. Edwards, M. Lohman et al. 2012. ‘Depression and frailty in later life: a synthetic review’. *International Journal of Geriatric Psychiatry*. Vol.27 (9): 879-892.

Montross, L. P., C.A. Depp, J. Daly et al. 2006. ‘Correlates of self-rated successful aging among community-dwelling older adults’. *The American Journal of Geriatric Psychiatry.* Vol.14 (1): 43–51.

Morgan, M., S. Gibney and S. Shannon. 2017. *HaPAI Research Review: Promoting Brain Health*. Dublin: HaPAI.

Nieminen, T., T. Harkanen, T. Martelin et al. 2015. ‘Social capital and all-cause mortality among Finnish men and women aged 30-79’. *European Journal of Public Health*. Vol. 25 (6): 972-978.

Nussbaum, M. 1999. *Sex and Social Justice*. Oxford: Oxford University Press.

Nussbaum, M. 2000. *Women and Human Development: The Capabilities Approach*. Cambridge: Cambridge University Press.

O’Halloran, A., and M. O’Shea. 2018. ‘Frailty.’ In N. Turner, O. Donoghue and R.A. Kenny (eds.). *Wellbeing and Health in Ireland’s over 50s 2009-2016*. Dublin: TILDA.

O’Halloran, A., C McGarrigle, S. Scarlett et al. 2020. *TILDA Report on Population Estimates of Physical Frailty in Ireland to Inform Demographics for Over 50s in Ireland during the COVID-19 Pandemic*. Dublin: The Irish Longitudinal Study on Ageing.

Organisation for Economic Co-operation and Development. 1998. *Maintaining Prosperity in an Ageing Society*. Paris: OECD Publishing.

Organisation for Economic Co-operation and Development. 2013. *OECD Guidelines on Measuring Subjective Well-being*. Paris: OECD Publishing.

Orr, J., S. Scarlett, O. Donoghue and C. McGarrigle. 2016. *Housing conditions of Ireland’s older population – implications for physical and mental health*. Dublin: TILDA.

Pierce, M. and T. Pierce. 2017. ‘Prevalence of Dementia in Ireland’. In E. O’Shea, S. Cahill and M. Pierce (eds.). *Developing and Implementing Dementia Policy in Ireland*. Galway: Centre for Economic and Social Research on Dementia.

Pisters, M.F., C. Veenhof, G.M. van Dijk et al. 2012. 'The course of limitations in activities over 5 years in patients with knee and hip osteoarthritis with moderate functional limitations: risk factors for future functional decline'. *Osteoarthritis and Cartilage*. Vol.20 (6): 503-510.

Popovici, I. and M.T. French. 2013. 'Does Unemployment Lead to Greater Alcohol Consumption?' *Industrial Relations*. Vol.52 (2): 444-466.

Roberts, G. and R. Bell. 2015. *Social Inequalities in the leading causes of early death. A life course approach*. London: Institute of Health Equity and Department of Health.

Robertson, D.A. and R.A. Kenny. 2015. 'Negative Perceptions of Aging Modify the Relationship Between Frailty and Cognitive Function'. *Personality and Individual Differences*. Vol.100: 120-125.

Robertson, D.A., B.L. King-Kallimanis and R.A. Kenny, R.A. 2015. 'Negative Perceptions of Aging Predict Longitudinal Decline in Cognitive Function'. *Psychology and Aging*. Vol.31 (1): 71-81.

Robertson, D.A., G.M. Savva, B.L. King-Kallimanis and R.A. Kenny. 2015. 'Negative Perceptions of Aging and Decline in Walking Speed: A Self-Fulfilling Prophecy'. *PLOS ONE*. Vol.10 (4).

Robeyns, I. 2003. "Sen's Capability Approach and Gender Inequality: Selecting Relevant Capabilities." *Feminist Economics*. Vol. 9 (2/3): 61–92.

Robeyns, I. and M.F. Byskov. Winter 2020. "The Capability Approach". In E.N. Zalta (ed.) *The Stanford Encyclopaedia of Philosophy.* https://plato.stanford.edu/archives/win2020/entries/capability-approach/

Ryan, R., and E. Deci. 2001. 'On happiness and human potentials: A review of research on hedonic and eudaimonic well-being'. *Annual Review of Psychology*. Vol.*52*: 141–66.

Ryff, C.D., and B.H. Singer. 2008. 'Know Thyself and Become What You Are: A Eudaimonic Approach to Psychological Well-Being'. *Journal of Happiness Studies*. Vol.*9* (1): 13–39.

Santini, Z.I., A. Koyanagi, S. Tyrovolas and J.M. Haro. 2015. 'The association of relationship quality and social networks with depression, anxiety, and suicidal ideation among older married adults: Findings from a cross-sectional analysis of the Irish Longitudinal Study on Ageing (TILDA)'. *Journal of Affective Disorders*. Vol.179: 134-141.

Scarlett, S., A.Hever, M. Ward and R.A. Kenny. 2021. *Creative activity in the ageing population*. Dublin: The Irish Longitudinal Study on Ageing.

Schulz, R., and P. Sherwood. 2008. 'Physical and Mental Health Effects of Family Caregiving'. *American Journal of Nursing*. Vol.108 (9): 23–27.

Seeman, T.E. 1996. 'Social ties and health: the benefits of social integration'. *Annals of Epidemiology*. Vol. 6 (5): 442-451.

Sen, A. 1987. *Commodities and Capabilities.* Oxford: Oxford University Press.

Sen, A. 1992. *Inequality Re-examined*. Oxford: Clarendon Press.

Sen, A. 1993. "Capability and Well-being." In M. Nussbaum and A. Sen (eds.) *The Quality of Life.* Oxford: Clarendon Press: 30–53.

Sen, A. 1999. *Development as Freedom*. Oxford: Oxford University Press.

Sen, A. 2005. "Human Rights and Capabilities." *Journal of Human Development*. Vol.6 (2): 151-166.

Stegenga, B. T., I. Nazareth, F. Torres-gonza et al. 2012. 'Depression, anxiety and physical function: exploring the strength of causality'. *Journal of Epidemiology & Community Health*. Vol.*66.*

Stiglitz, J., A. Sen and J.-P.Fitoussi. 2009. *Report of the Commission on the Measurement of Economic Performance and Social Progress*. Paris: Commission on the Measurement of Economic Performance and Social Progress.

Stirling, A. 2010. 'Keep it complex.' *Nature.* Vol.468: 1029-1031.

Taylor, D. 2011. "Wellbeing and Welfare: A Psychosocial Analysis of Being Well and Doing Well Enough". Journal of Social Policy. Vol.40 (4): 777-794.

Tucker-Seeley, R.D., S.V. Subramanian, Y. Li and G. Sorensen. 2009. 'Neighborhood Safety, Socioeconomic Status, and Physical Activity in Older Adults'. *American Journal of Preventive Medicine*. Vol.*37* (3): 207–213.

Victor, C.R., S.J. Scambler, A. Bowling and J. Bond. 2005. 'The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain'. *Ageing & Society*. Vol. 25 (6): 357-375.

Wahrendorf, M. and J. Siegrist. 2010. 'Are changes in productive activities of older people associated with changes in their well-being? Results of a longitudinal European study'. *European Journal of Ageing*. Vol.7 (2): 59-68.

Wald, N.J. and A.K. Hackshaw. 1996. 'Cigarette smoking: an epidemiological overview'. *British Medical Bulletin*. Vol.52 (1): 3-11.

Waldron, I. and D. Lye. 1989. 'Employment, unemployment, occupation, and smoking'. *American Journal of Preventive Medicine*. Vol.5 (3): 142-149.

Ward, M. 2019. *Irish adults transition to retirement – wellbeing, social participation and health-related behaviours. Findings from The Irish Longitudinal Study on Ageing (TILDA)*. Dublin: The Irish Longitudinal Study on Ageing.

Ward, M. 2021. "Loneliness during the COVID-19 pandemic." In M. Ward, P. O'Mahoney and R.A. Kenny (eds.). *Altered lives in a time of crisis: The impact of the COVID-19 pandemic on the lives of older adults in Ireland*. Dublin: The Irish Longitudinal Study on Ageing.

Ward, M., C.A. McGarrigle and R.A. Kenny. 2018. 'More than health: quality of life trajectories among older adults-findings from The Irish Longitudinal Study of Ageing (TILDA)'. *Quality of life research: an international journal of quality of life aspects of treatment, care and rehabilitation*. Vol.28 (2): 429-439.

Ward, M., S. Gibney and I. Mosca. 2018. "Volunteering and social participation." In N. Turner, O. Donoghue and R.A. Kenny (eds.). *Wellbeing and Health in Ireland's over 50s 2009-2016*. Dublin: The Irish Longitudinal Study on Ageing.

White, S. Winter 2005. "Social Minimum." In E.N. Zalta (ed.) *The Stanford Encyclopaedia of Philosophy* https://plato.stanford.edu/archives/win2015/entries/social-minimum/

Windsor, T.D. and K.J. Anstey. 2010. 'Age differences in psychosocial predictors of positive and negative affect: a longitudinal investigation of young, midlife, and older adults'. *Psychology and Aging*. Vol.25 (3): 641-652.

Winter, K.H., E.D. Bouldin and E.M. Andresen. 2010. 'Lack of choice in caregiving decision and caregiver risk of stress, North Carolina, 2005'. *Preventing Chronic Disease*. Vol.*7* (2).

World Health Organization Quality of Life Group. 1997. *Programme on Mental Health. WHOQOL Measuring Quality of Life*. Geneva: World Health Organization.

World Health Organization. 1984. *The Effects of the Indoor Housing Climate on the Health of the Elderly: Report on a WHO Working Group, Graz, Austria, 20-24 September 1982.*

World Health Organization. 2002. *Active Ageing – A Policy Framework*. Geneva: World Health Organization.

World Health Organization. 2007a. *Demystifying the myths of ageing*. Geneva: World Health Organization.

World Health Organization. 2007b. *Global Age-friendly Cities: A Guide*. Geneva: World Health Organization.

World Health Organization. 2010. *Global Recommendations on Physical Activity for Health*. Geneva: World Health Organization.

World Health Organization. 2014. *Global status report on alcohol and health*. Geneva: World Health Organization.

World Health Organization. 2015. *World report on ageing and health*. Geneva: World Health Organization.

Wren, M-A., C. Keegan, B. Walsh, A. Bergin, J. Eighan, A. Brick, S. Connolly, D. Watson and J. Banks. 2017. *Projections Of Demand For Healthcare In Ireland, 2015-2030 First Report From The Hippocrates Model*. Research Series Number 67. Report Prepared for the Department of Health by the Economic and Social Research Institute.