

Older people and health in the North West of England

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September 2002

ISBN 1-874-038-73-2

Acknowledgments

We would like to acknowledge all those who have given their help, advice and support in the production of this report. We would like to thank colleagues in the Department of Public Health, University of Liverpool and the rest of the North West Public Health Observatory. We would also like to thank the members of the North West Older Persons' Taskforce and colleagues at the North West Regional Office.

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1. Why focus on older people? The policy context.

In 1998, the Secretary General of the UN, Kofi Annan, said¹:

'A society for all ages is one that does not caricature older persons as patients and pensioners. Instead, it sees them as both agents and beneficiaries of development. It honours traditional elders in their leadership and consultative roles in communities throughout the world.'

The United Nations declared 1999 as 'The Year of the Older People' and the programme of work is ongoing. The Second World Assembly on Ageing took place in Madrid between 8th and 12th of April 2002.

Older people are an important part of British society. They have a wealth of experiences and have contributed greatly to growth in all areas of life in Britain. Changes in society have meant that how older people live and interact with each other and other age groups are now different from even twenty years ago. This group and their circumstances are of such interest to the present government that there is a separate National Service Framework for Older People². The framework has set out eight standards (see box 1).

Box 1: National Service Framework standards.

- Rooting out discrimination: NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.
- Person-centred care: NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.
- Intermediate care: Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.
- General hospital care: Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.
- Stroke: The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.
- Falls: The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their population of older people. Older people who have fallen receive effective treatment and, with their carers, receive advice on prevention through a specialised falls service.
- Mental health in older people: Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and their carers.
- The promotion of health and active life in older age: The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

Source: Department of Health. Older People, National Service Framework, 2001

2. Numbers of older people and their socio-economic circumstances

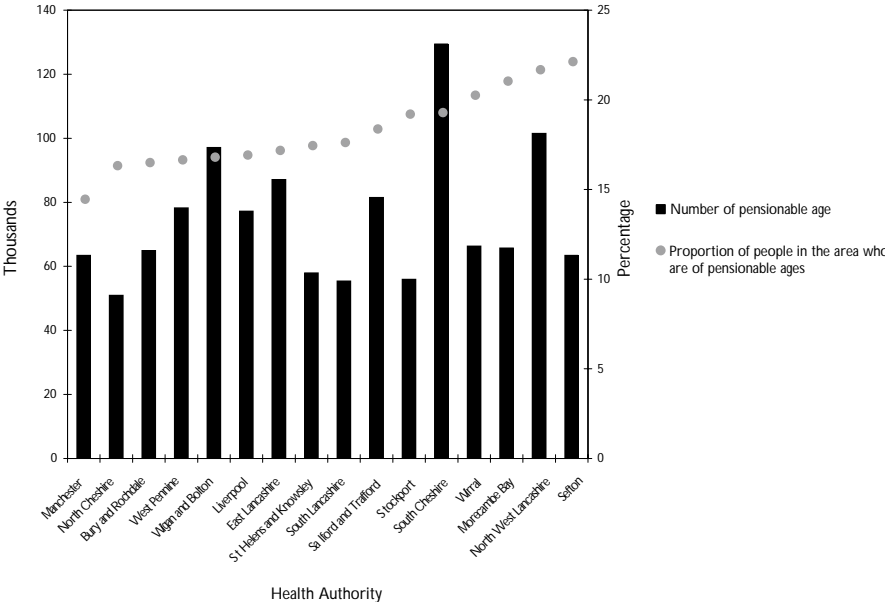
Not only the numbers of people, but the circumstances in which they live are important factors in the planning process for services to be used by older people. In particular, there are a number of factors which can impact both on the need for care and on the health of individuals. Research by the Personal Social Services Unit suggests that factors which should be taken into account when trying to look at future needs for long-term care for older people include the numbers of older people, their household type, dependency level, and present levels of both formal and informal care. These are all used in their model to help project the future costs as well as need for long-term care³.

The main sources of information about the numbers of people living in an area, and the types of household in which they live, are from the Office for National Statistics (population estimates), the Government Actuary's Department (population projections) and the Department of Transport, Local Government and the Regions (household numbers). The incomes of older people and the benefits they receive are reported by the Department of Work and Pensions. Information is available in a variety of formats, and for a variety of geographical and age ranges.

How many older people are there?

In mid-2000, men aged 65 and over and women aged 60 and over were of pensionable ages. There were more than 9 million people of pensionable ages in England, over 1 million of them living in the North West NHS Region⁴. This is 18% of the people living in this region, the same as the proportion of people in England who are of pensionable ages. However, the proportion of men aged 65 and over and women aged 60 and over living in the health authorities making up the region is not constant (see figure 1). Although South Cheshire has the highest number of pensionable ages (129 thousand people) and the highest population at all ages

Figure 1: People of pensionable ages, HAs of the North West region, 2000



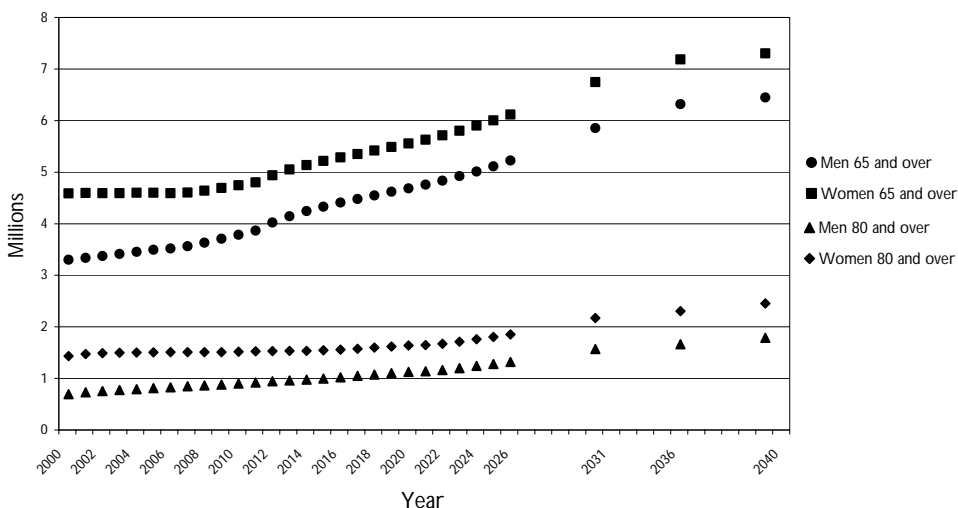
Source: Office for National Statistics

(673 thousand), it does not have the highest proportion of its residents in these age groups. Sefton has 22 per cent of its population in this category. The health authority with the smallest proportion of its population of pensionable ages is Manchester at 14 per cent. The ethnic makeup of the health authorities explains some of this difference. Ethnic minority groups tend to be younger⁵ and so areas with higher numbers of people from minority ethnic groups tend to have a younger age profile than those with few residents from these groups.

The number of older people in England has grown substantially throughout the last century and this is expected to continue for many years to come. Over the next twenty years, the number of people aged 65 and over in England is expected to grow by more than 2 million and to grow even faster in the following twenty years so that by 2040 more than 13 million people in England will be aged 65 and over⁶.

In England in the year 2000, the numbers of males and females in each age group are about the same. This is not so at older ages. At present, there are 40% more women than men aged 65 and over. At older ages, this difference is even more marked with more than twice as many women as men aged 80 and over. These differences are mainly due to the patterns of longer life expectancy in women since the rapid decline in maternal mortality early in the twentieth century. The differences are expected to continue but to decrease substantially so that by 2040 there will be about 13% more women than men aged 65 and over. By 2040 at older ages, those aged 80 and over, the difference between the numbers of women and men will be substantially smaller than in 2000 (see figure 2). Again this has implications for planning for services for these age groups. Although many of the needs of older men and women are the same, and gender is not a deciding factor in the need for long-term care³, there are differences in uses of health services as noted later in this report. At present, the large gender differences need to be taken into account when planning services, but future needs will be different.

Figure 2: Projections of numbers of men and women, England



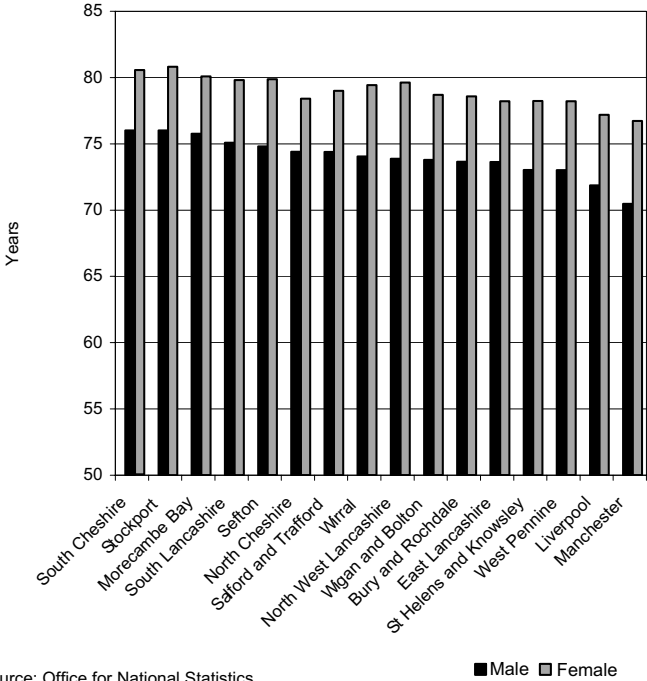
Source: Government Actuary's Department

How long can people in the North West expect to live?

Life expectancy at birth is the average number of years a baby born today could expect to live. In England in 1998-2000, the life expectancy at birth for boys was just over 75 years and for girls was 80 years⁷. The North West NHS Region had the lowest life expectancy for both boys and girls, less than 74 and 79 years respectively. However, the health authorities making up this region were not uniformly worse than the national average (see figure 3). South Cheshire, Stockport and Morecambe Bay had life expectancy at birth for boys higher than the national value, and Stockport and South Cheshire also had life expectancy for girls higher than the England average. Manchester had life expectancy for boys 5 years less than England and 3 years less for girls.

Life expectancy at age 60 shows the average number of years a person who has reached 60 can expect to live. Life expectancy has been increasing steadily and this trend is expected to continue. In 1981, a man of 60 could expect to live a further 16 years and a woman of the same age could expect to live a further 21 years⁷. By 1999, a 60-year-old man could expect to live a further 19 years and a woman of the same age could expect to live a further 23 years.

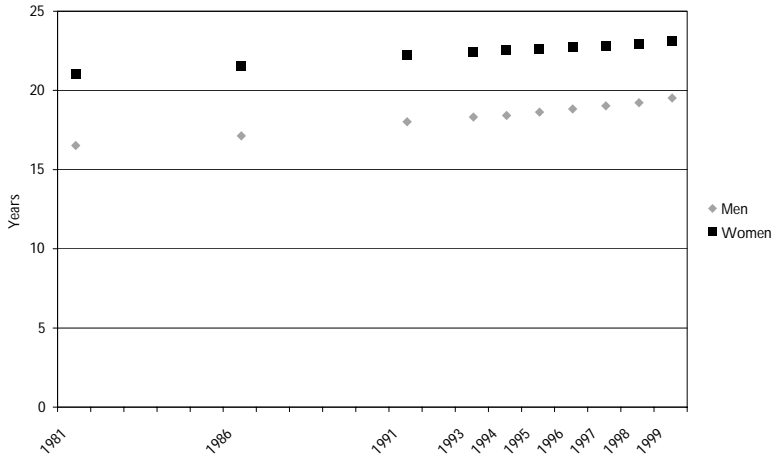
Figure 3: Life expectancy at birth, HAs of the North West region, 1998-2000



Source: Office for National Statistics

■ Male □ Female

Figure 4: Life expectancy at age 60, England

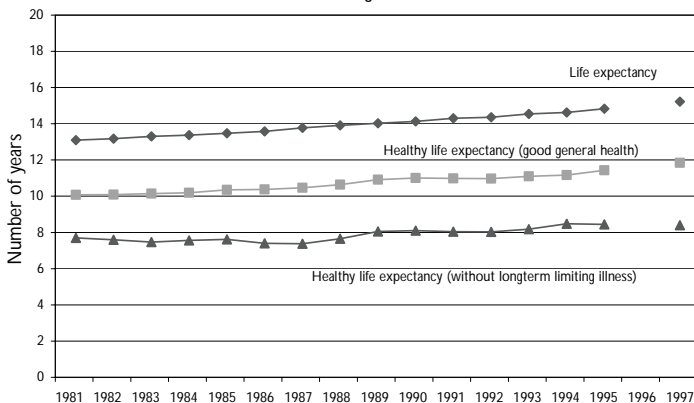


Source: Government Actuary's Department

Although life expectancy has been increasing steadily, not all the added years are lived in good health⁹. Healthy life expectancy measures not the total number of years you can expect to live, but how many of those years you can expect to be in good or fairly good health. The present government uses this indicator to measure progress in a number of different national strategies. Healthy life expectancy at birth has been chosen for both the public health⁹ and the sustainable development strategies¹⁰. Healthy life expectancy at age 65 has been chosen as one of the indicators for older people in the poverty and social exclusion strategy¹¹.

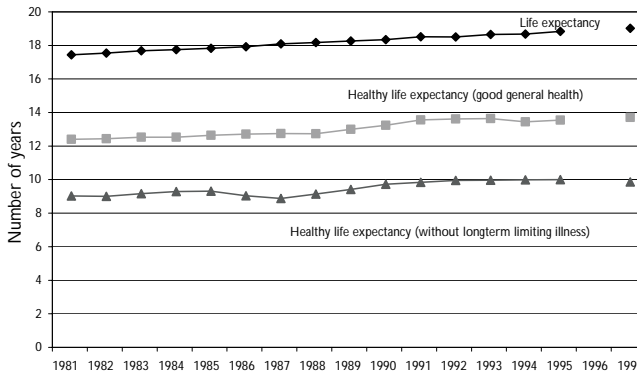
Between 1981 and 1997, life expectancy for men aged 65 rose from 13 years to over 15 years. For women, the rise over the same period was from just under 17 years to 18 years^{12,13}. The rises in *healthy* life expectancy for both men and women aged 65 were not as great as those in life expectancy. For men the rise was from just under 10 years living in good or fairly good health in 1981 to just under 12 years in 1997 (see figure 5). For women, the rise was slightly smaller over the 15 years, from just under 12 years in 1981 to 13 years in 1997.

Figure 5: Healthy life expectancy, people aged 65 and over, Great Britain
Men aged 65



Source: Office for National Statistics

Figure 5: Healthy life expectancy, people aged 65 and over, Great Britain
 Woman aged 65



Source: Office for National Statistics

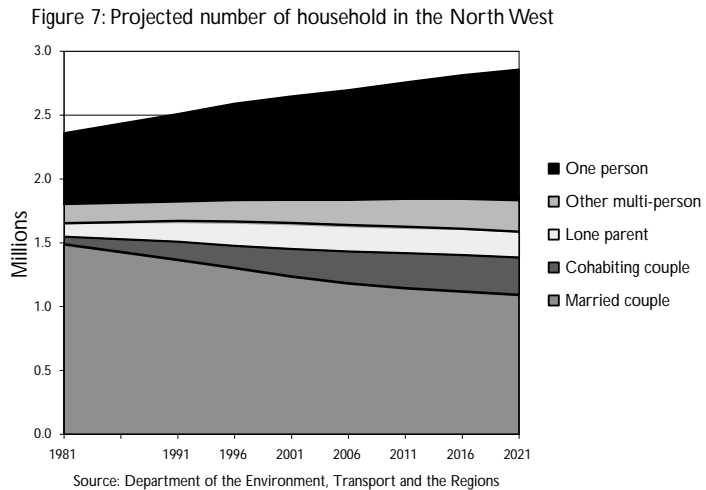
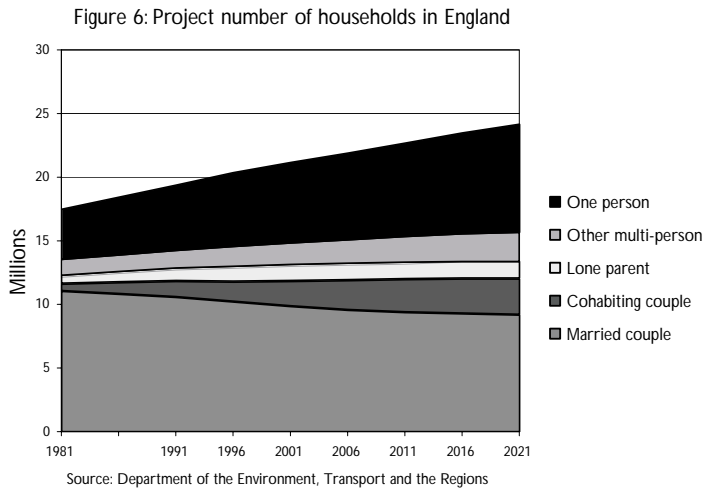
There is no internationally accepted definition of the measures of health that are used in this indicator, and its development is still on going¹². The estimates of healthy life expectancy are sensitive to the particular measure of good or ill health used. The British version uses self-perception of health, and it must be remembered that this is a subjective decision. Even so, self-reported health is an important predictor of subsequent mortality¹⁴.

In what kinds of households do older people live?

The type of households in which elderly people live is a major determinant of the need for long-term care³. For example, those aged over 65 who need help with bathing, showering, washing all over, and live alone are nearly five times as likely to get help from the NHS or personal social services than those who live with their spouse (52% and 11% respectively)¹⁵.

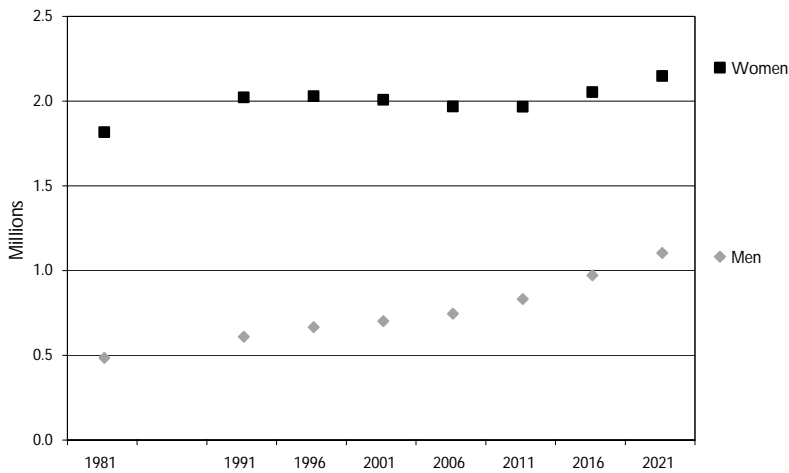
The number of households in England is projected to rise from 20 million in 1996 to 24 million in 2021¹⁶. This is a rise of nearly a fifth (19%). Over the same period, the number of households in Cheshire, Greater Manchester, Lancashire and Merseyside is expected to grow by only half this amount, 10% (see figures 6 and 7). These estimates are used for planning the numbers of houses that will be needed in the future and so are based on local government areas, not health authorities.

Not only is the total number of households calculated, but also the types of household. The overall increase in households is mainly due to the large increase in one-person households both in England and in the North West. In England, the increase in the number of cohabiting couple households is expected to more than compensate for the drop in the number of married couple households. This is not so in the North West where the growth in cohabiting couple households only accounts for about half the fall in married couple households.



An analysis of the growth in numbers of households in England¹⁷ has found that although the majority of the overall rise is concentrated on those who will be middle-aged in 2021, a substantial amount is among households who will be headed by a man aged over 65. Gender differences are difficult to disentangle as the person taken to be representative of the household is first the eldest man, and only chosen as a woman if there is no eligible man in the household. However, the growth in one person households is substantial and accounts for a major part of the increase in households headed by someone aged 65 and over. In 1996, 2 million households consisted of a woman aged 65 and over on her own and there were 650 thousand men aged 65 and over living on their own. By 2021, it is estimated that there will be a small increase in the number of older women living alone, about 150 thousand (see figure 8). The number of older men living alone will have grown by two-thirds and be over a million.

Figure 8: People aged 65 and over in one person household, England



Source: Department of Environment, Transport and the Regions

Research looking at previous cohorts to predict future patterns concludes that it is already clear what types of families will be commonplace in the years to come. The changes will have important implications for the provision of social care¹⁸. In particular, the decrease in multi-generational households will reduce the availability of family living in the same household as older relatives and so able to provide informal care. However, the rising divorce rates may mean that older people have more adult children to call on for help, because of the existence of both natural and step-children.

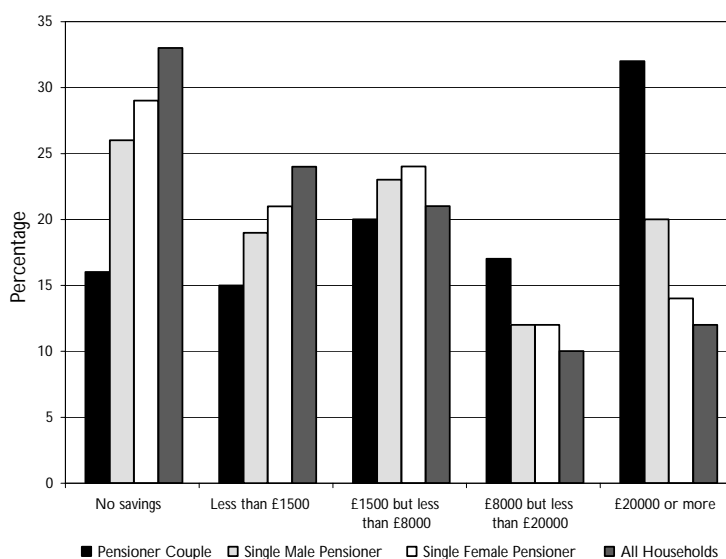
Financial circumstances

Because of the way information on incomes and earnings is collected, it can be difficult to look at individual incomes, and household incomes are not always adjusted to take into consideration the numbers of people living in the household. Even so, general points can be made. The amount of savings and income that an older person has is taken into account if they have to go into long-term residential care. However, caution is needed when predicting future patterns of both savings and incomes from what is presently the case. Today's adult women are more likely to work than previous groups and are more likely to work full-time¹⁸. This has the obvious consequence of an increase in the ability of women to build up occupational pensions. However, today's middle-aged men have had more broken work patterns than those in the past with more periods of unemployment. Men in their fifties today are less likely to be in full-time work than those of these ages in times past. Again the consequence of this is obvious. Older men in future may have less occupational pension as they will have worked for less time and may have had longer periods of unemployment than pensioners today.

Households consisting of pensioners have more savings than other types of households. About a quarter of pensioner households have no savings compared with a third of households overall (see figure 9). At the other end, pensioner households are about twice as likely to have large amounts of savings, a quarter (25%) of pensioner households have savings of £20,000 or more compared to an eighth (12%) of all types of households¹⁹. This is partly

because pensioner households have had time to build up savings while households headed by a young person have not had this opportunity. There are, however, differences across different types of pensioner households. A third (32%) of pensioner couple households have high savings (£20,000 or more) but only a fifth (20%) of single male pensioners have this amount of savings, and an even smaller proportion of single female pensioner households are in this position, about one in seven of this type of household. Single pensioner households are much more likely than couple pensioners to have no savings at all. Over a quarter (29%) of single female pensioners have no savings. Just over a quarter (26%) of single male pensioners are in this position. This compares with less than a fifth (16%) of couple pensioner households.

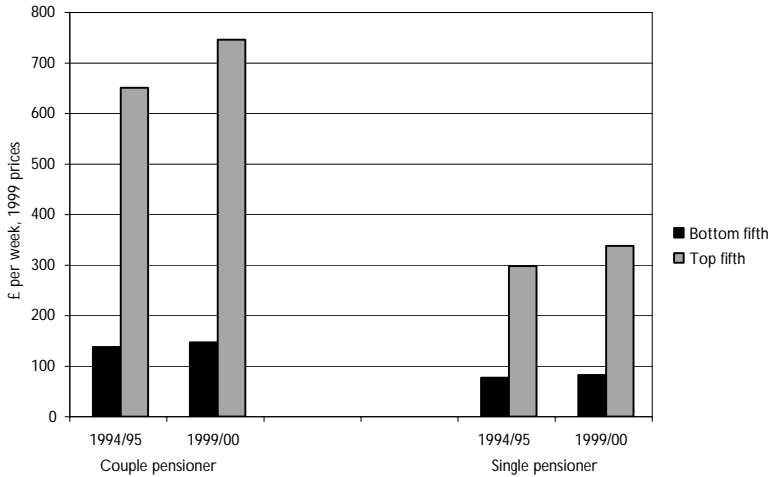
Figure 9: Amount of savings, Great Britain, 1999-2000



Source: Family Resources Survey

In 1999/2000, the average (mean) gross income before housing costs was £333 per week for a couple pensioner household and £171 for a single pensioner household²⁰. Across the income distribution, there was a substantial difference between the most affluent and the least well-off pensioners. Pensioners in the top part of the income distribution had five times the mean gross income of those in the bottom fifth (see figure 10). The difference was lessened when looking at net income, which takes into consideration taxes and other items, when the income of the top fifth was about three times that of the bottom fifth¹⁴. This was true for both couple and single pensioner households. The mean gross income of couple pensioner households before housing costs at the top of the distribution was £746 per week compared to £147 at the bottom. For single pensioner households the corresponding means were £338 and £82. The differential between the top and the bottom of the pensioners' income distribution has increased slightly over the last five years.

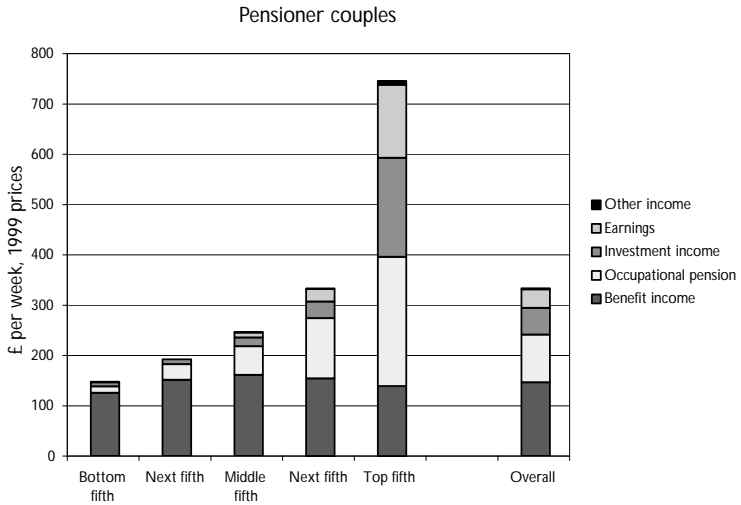
Figure 10: Mean gross income of pensioners, Great Britain



Source: Department for Work and Pensions

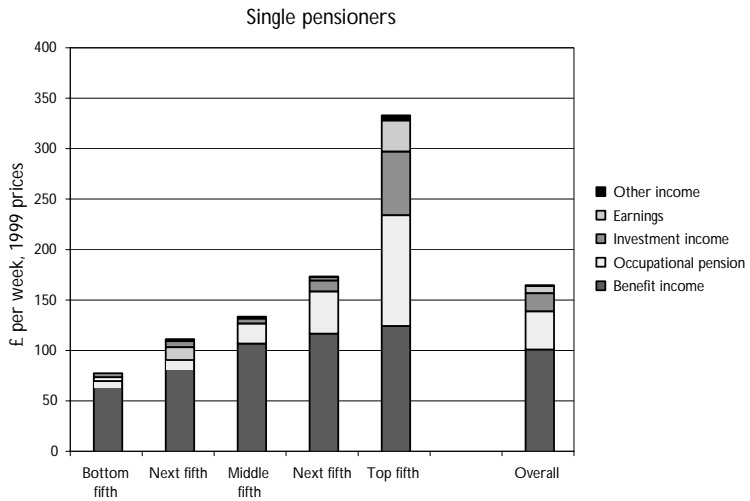
Not surprisingly, the major part of the income of older people comes from benefits, including retirement pensions, and occupational pensions²¹. The other sources are mainly investments or earnings (see figure 11). There are differences on where pensioner households receive their income depending on their position in the income distribution. Those at the top end receive a substantial amount from occupational pensions, whereas those at the bottom get the vast majority of their income from benefits, including state retirement pensions. For couples, roughly the same amount of money comes from benefits regardless of where they are on the income distribution, but this is not true for single pensioners. Many single pensioners are women, especially for the oldest age group. In May 2001, women were twice as likely as men to be receiving a top-up to their pension through the non-disabled Minimum Income Guarantee, 4% of male pensioners receive this benefit and twice this proportion (8%) of female pensioners²¹.

Figure 11: Mean gross income, Great Britain, 1999/00



Source: Department for Work and Pensions

Figure 11: Mean gross income, Great Britain, 1999/00



Source: Department for Work and Pensions

3. Health of older people

The main source of information on the general health of older people is the General Household Survey (GHS)²² from the Office for National Statistics. It covers Great Britain and asks questions of people living in private households. It is usually an annual survey, although there have been a few exceptional years when it was not carried out. The latest available data from the full survey are from 2000. The GHS had special questions for older people in 1980, 1985, 1991, 1994 and 1998 and so gives trend data for older people on issues of particular interest using the same questions for these years²³.

The Department of Health commissions the Health Survey for England (HSfE). In 2000 the HSfE was specifically on the health of older people²⁴. Unlike the GHS, the questions were asked of those in long-term care as well as in private households. Thus this source is particularly useful for looking at the differences between those in care and those living in their own homes. Unfortunately it does not have time trends.

General self-rated health

There are several ways of looking at people's health. The ones used here are self-reported general health, acute sickness (defined as restricted activity in the previous 14 days) and chronic sickness (defined as limiting longstanding illness). Difficulties with particular aspects of life are also discussed.

Over the last twenty years, the proportions of older people who reported their health as not good have remained fairly constant, about a fifth (21%) of men aged 65 and over and a quarter (25%) of women aged 65 and over²⁵. If these proportions are the same over the whole of Great Britain, then this would mean that about 85 thousand men and 150 thousand women aged 65 and over in the North West are living in poor health.

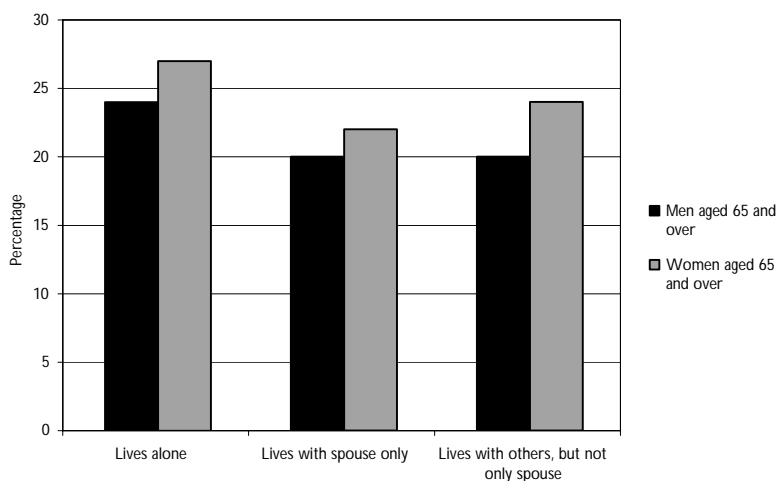
However, these are probably underestimates. Although we do not know the rate of people reporting their health as not good in different parts of Great Britain, we do know that the North West has higher rates of acute and chronic sickness than England as a whole. In 2000, 17% of people aged 16 and over living in the North West said they had acute ill health compared to 14% in England overall. For chronic illness, the equivalent figures are 36% and 32%²⁶.

When considering inequalities in the general health of older people, it is important to note that the proportions of elderly men and elderly women who live alone and say that their health is not good are higher than those who live with other people (see figure 12).

Acute Sickness

About a quarter (24%) of women and a fifth (21%) of men aged 65 and over reported they had restricted activity in the previous 14 days – acute sickness²⁷. This means that at any one time, 230 thousand older people living in the North West have an acute illness that restricts their activity.

Figure 12: Proportion reporting health as 'not good', Great Britain, 1998



Source General Household Survey

Not only do higher proportions of women than men report having acute illness, but they also report more days of restricted activity over the whole year, 67 days on average for older women and 61 days for older men²⁷. As with many aspects of health, there are differences across the occupational groupings of the household reference person (HRP). For details of how the HRP person is chosen, see box 2²⁸. For most groups, the average number of days of restricted activity per person per year is similar for older men and women (see figure 13).

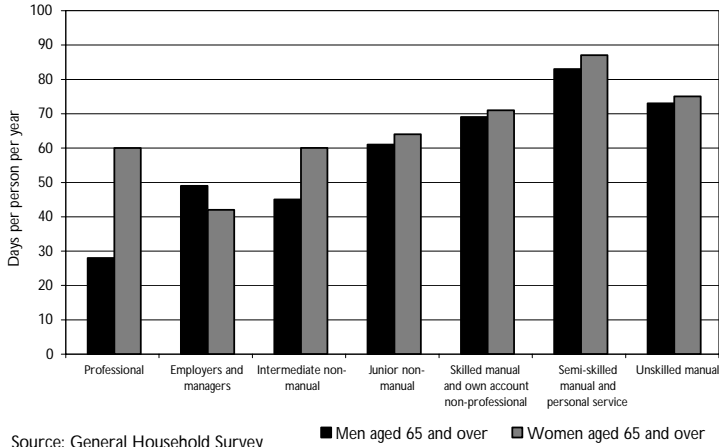
Box 2: How to decide the Household Reference Person (HRP)

In most government sponsored surveys, the household reference person (HRP) is the person in whose name the accommodation is owned or rented. If this is done jointly, the person with the highest income is the HRP. If the joint householders have exactly the same income, then the older person is taken to be the HRP.

Source: Office for National Statistics. Living in Britain Results from the 2000/2001 General Household Survey Annex A

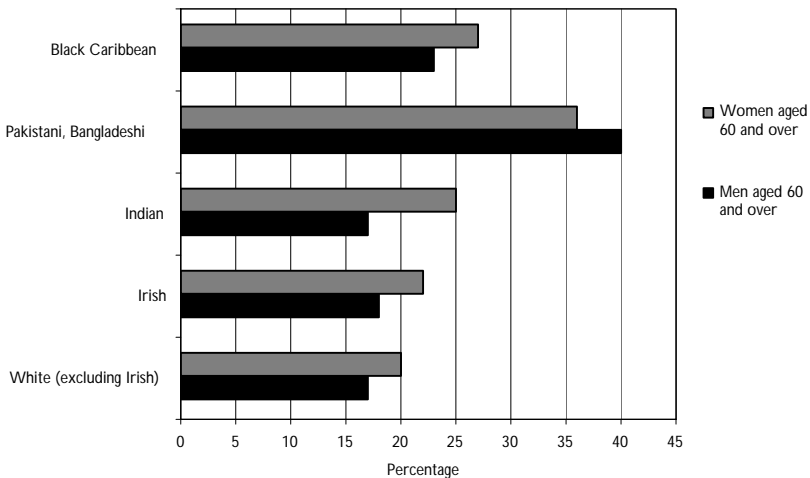
However, for households where the HRP is from the professional grouping, women have twice as many restricted activity days as men, 60 and 28 respectively²⁷. This is more to do with the low rate for men in this category than a high rate for women.

Figure 13: Average number of restricted activity days, Great Britain, 2000



By combining several years of data from the GHS, it is possible to look at some differences in those reporting an acute sickness across the minority ethnic populations of Great Britain²⁹. Compared to white older people, those from ethnic minorities are more likely to report an acute illness (see figure 14). In general, women aged 60 and over are more likely than men to report restricted activity in the previous 14 days. This is particularly so for older people from the Indian community. However, older men from the Pakistani and Bangladeshi communities are more likely to report acute illness than women from these communities.

Figure 14: Proportion reporting acute sickness, by ethnicity, Great Britain 1991-96

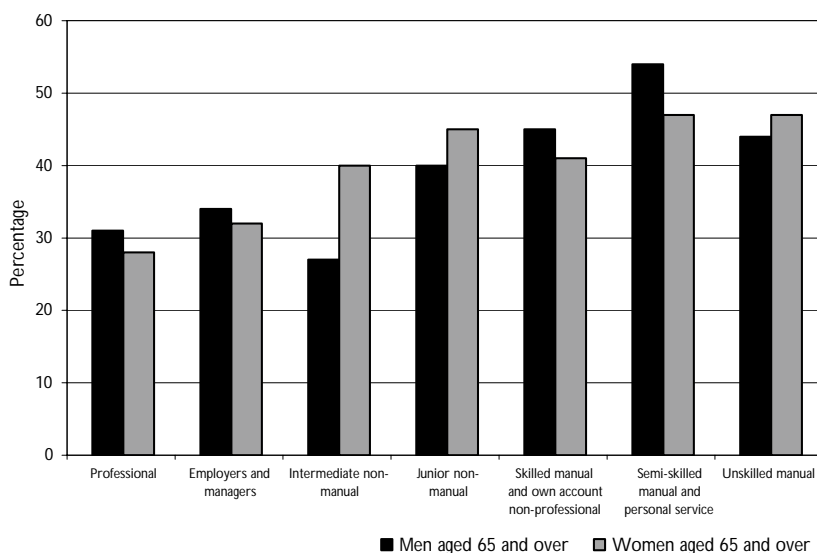


Chronic ill health

About three-fifths of both men (62%) and women (59%) aged 65 and over reported chronic sickness in 2000³⁰. This means that over 600 thousand older people are living with chronic ill health in the North West region of England.

Although there is very little overall difference between the proportion of older men and older women reporting chronic illness, there are substantial differences both by the type of households in which they live and across the occupational spectrum. The pattern for the type of household is similar to that found for general health, there are higher rates of chronic illness among both men and women who live on their own³¹. Even more remarkable are the differences across the occupational spectrum (see figure 15). Older men living in a household where the reference person is from the grouping semi-skilled manual and personal service have much higher rates of chronic illness²⁷, 54% compared to 41% in Great Britain as a whole for men in this age group. Although the patterning is fairly similar for men and women, those living in a household where the reference person is from the intermediate non-manual grouping had a substantially higher proportion of women than men reporting chronic illness, 40% and 27% respectively.

Figure 15: Chronic sickness rates, Great Britain, 2000



Source: General Household Survey

It should be remembered that people who have a longstanding condition may have more than one specific cause of chronic illness. For example, someone can say they have longstanding illness, and on more detailed questioning say that they have both a heart condition and arthritis. Thus the conditions causing chronic illness discussed below may overlap.

There are notable differences between the conditions reported by men and women with a longstanding illness³² (see figure 16). Overall musculoskeletal and heart conditions have the highest rates in both older men and older women. Nearly a third (328 per 1,000) of older men who report a longstanding illness say they have problems with their heart or

circulatory system. A slightly smaller proportion of older women reporting a longstanding condition say they have a heart condition, 284 per 1,000. Women with a chronic illness have high rates of musculoskeletal conditions, nearly half as high again as men, 334 and 226 per 1,000 respectively. Men with chronic illness report higher rates of respiratory conditions than women, 103 and 57 per 1,000 respectively.

These data refer to those living in private households. As will be seen later, there are large differences between the categories of chronic illness between those living in care and those living in private households. Problems relating to the musculoskeletal system include arthritis and back problems. Women report much higher rates of musculoskeletal problems from arthritis and rheumatism than men³³, especially at the older ages of 75 and over where the rate is nearly double in women reporting a chronic condition than in men, 250 per 1,000 and 131 per 1,000 (see figure 17). Back problems are higher among those aged 65 to 74 than those aged 75 and over. Heart and circulatory conditions include hypertension, heart attacks and strokes. Heart attack is reported more among men than women as the cause of a chronic illness to do with the heart or circulatory system. Respiratory conditions mentioned include asthma and bronchitis and emphysema. Bronchitis and emphysema are particularly high among elderly men, those aged 75 and over, where the conditions are more prevalent than back problems. All of these areas of ill health have implications for the mobility of older people, but in different ways. Lack of mobility is one of the causes of falls in the home. The difference between the number of men and women with these kinds of difficulty may affect what kinds of services they need to access and the frequency with which they need help.

Figure 16: Chronic sickness rates, Great Britain, 2000

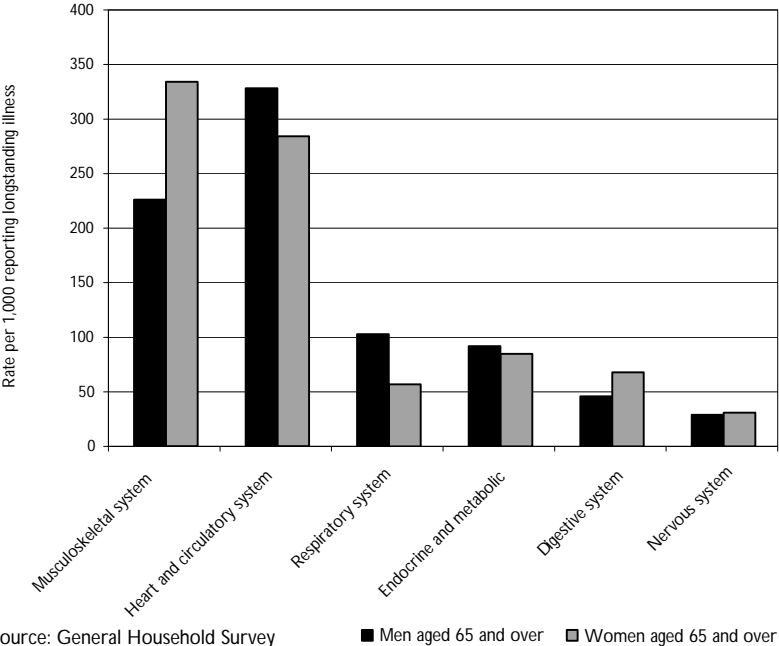
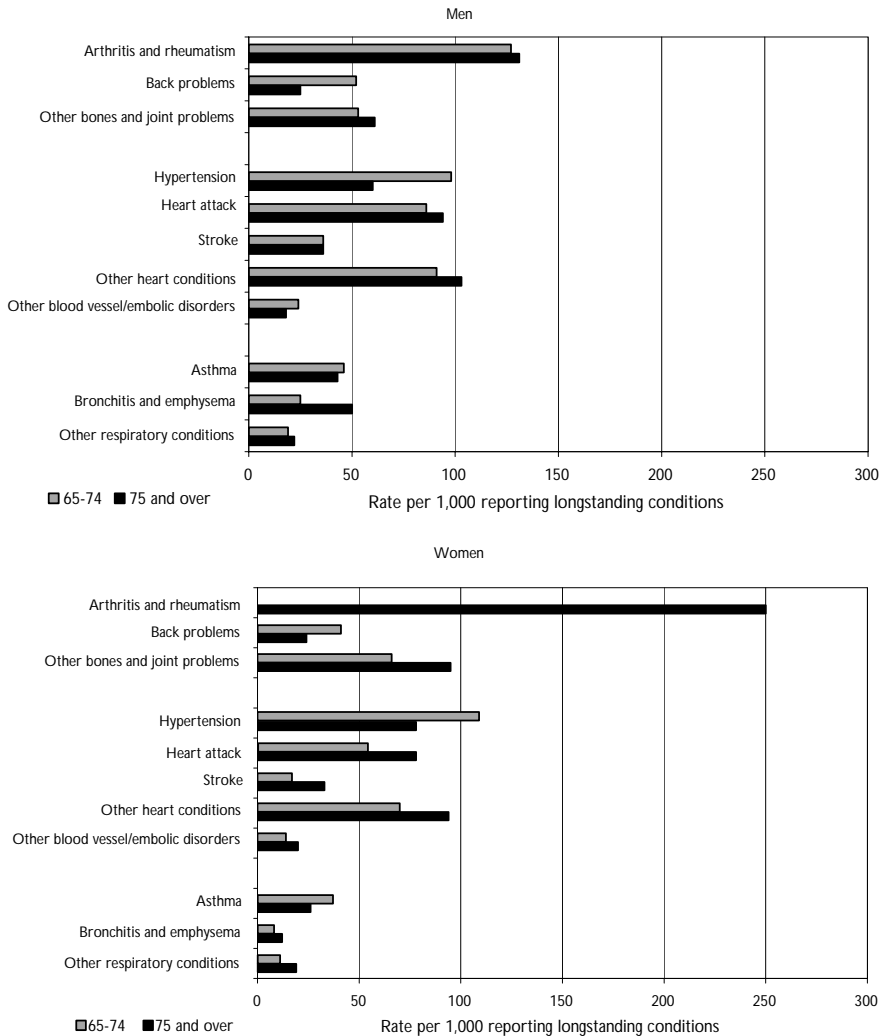


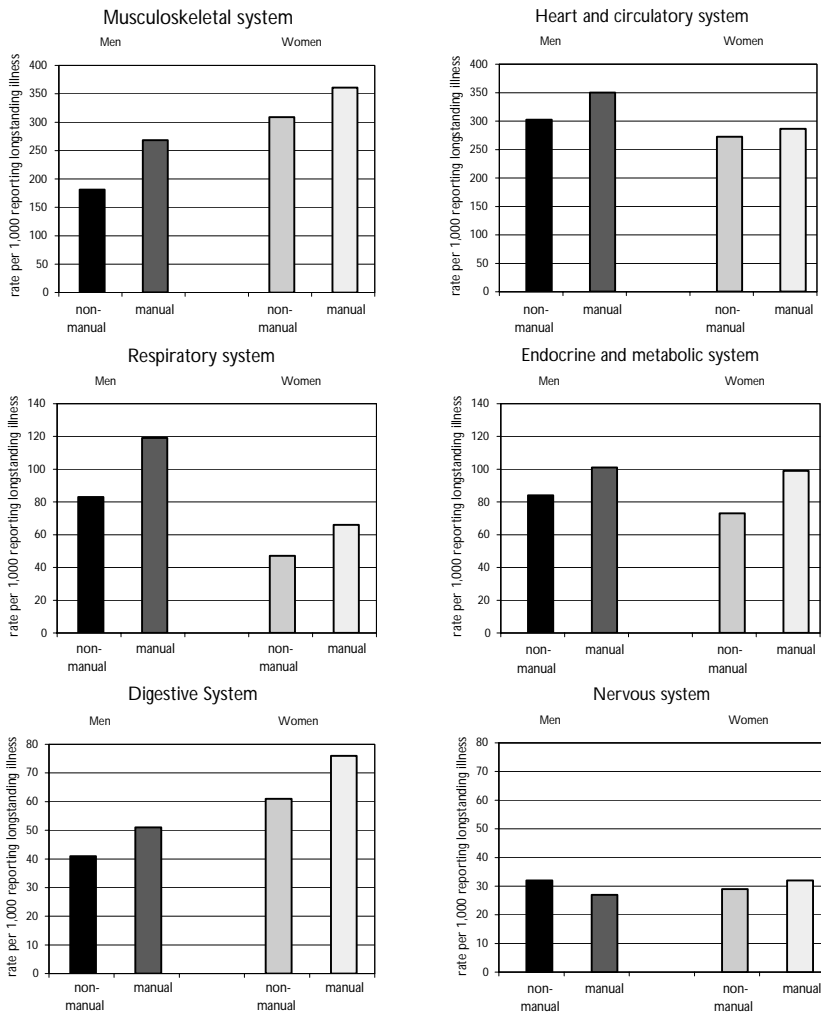
Figure 17: Chronic sickness rates for particular conditions, Great Britain, 2000



Source: General Household Survey

Rates for particular groups of chronic conditions are not constant across socio-economic groups (see figure 18). Apart from diseases of the nervous system, those older people living in households with the HRP from manual groupings have higher rates of chronic illness than those from non-manual households³⁴. This difference is particularly marked for both musculoskeletal conditions and respiratory conditions in older men. Back problems are associated with occupations involved in heavy lifting including general labouring and skilled trades in the construction industries, coal mining and nursing. There are increased risks for those men in coal mining, construction and labouring jobs to have lower respiratory disease³⁵.

Figure 18: Chronic sickness rates, ages 65 and over, Great Britain, 2000



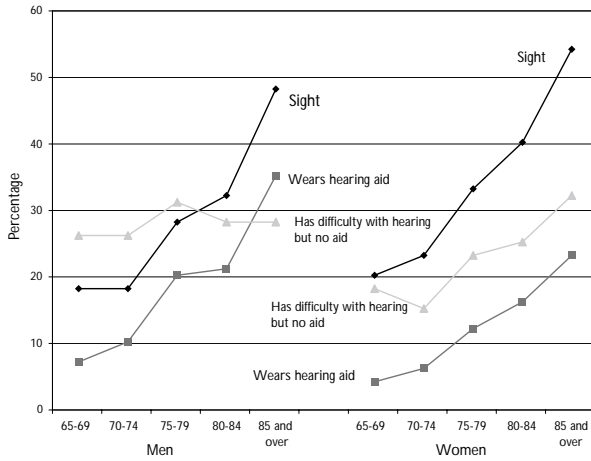
Source: General Household Survey

How good is the sight and hearing of older people?

Not surprisingly, the proportion of older people reporting difficulty with their seeing or hearing increases with age (see figure 19). Nearly a half (48%) of men and more than a half (54%) of women aged 85 and over living in private households had a problem with their sight³⁶. Poor sight can lead to trips and falls.

By the age of 75, over two-thirds (69%) of men and two-fifths (43%) of women said they had difficulty with hearing³⁷. For both men and women who say they have problems with hearing, there are considerable numbers who do not wear an aid. This is true even at the very oldest age groups (see figure 19).

Figure 19: Difficulty with seeing or hearing, Great Britain, 1998



Source: General Household Survey

Mobility

The GHS from time to time has special questions for older people on how they manage with a variety of tasks³⁸. These were last asked in 1998. Three of the sections are commented on here, mobility, self-care and domestic tasks. The tasks within each of these categories are described in box 3. The proportions of people aged 65 and over living in private households who had difficulty with these tasks have remained fairly constant over the last twenty years³⁸. The tasks causing most problems were cutting toenails (30%) and jobs involving climbing (28%).

Box 3: Tasks asked about in the General Household Survey

The questions on mobility include the following aspects:

- walk out of doors;
- get up and down stairs and steps;
- get around the house (on the level);
- get to the toilet; and
- get in and out of bed.

Self-care in the GHS includes the tasks:

- bathing, showering, washing all over;
- dressing and undressing;
- washing hands and face;
- feeding; and
- cutting toenails.

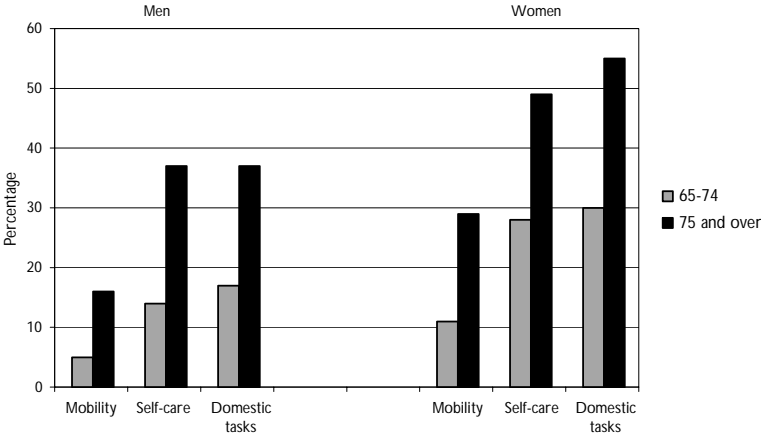
The domestic tasks asked about are:

- household shopping;
- wash and dry dishes;
- clean windows inside;
- jobs involving climbing;
- use a vacuum cleaner to clean floors;
- wash clothing by hand;
- open screw tops; and
- deal with personal affairs.

Source: Bridgwood A. People aged 65 and over, results from an independent study carried out on behalf of the Department of Health as part of the 1998 General Household Survey.

One in seven (15%) people aged 65 and over had a problem with at least one of the tasks under the heading of mobility; nearly a third (31%) had at least one difficulty with self-care; and a third (34%) had at least one problem in the domestic task list. Not surprisingly, those aged 75 and over had more difficulty than those aged between 65 and 75 (see figure 20). In general, women were more likely to have difficulty than men. This may be due to the much larger numbers of very elderly women living in private households.

Figure 20: Proportions having difficulty with at least one task, Great Britain, 1998



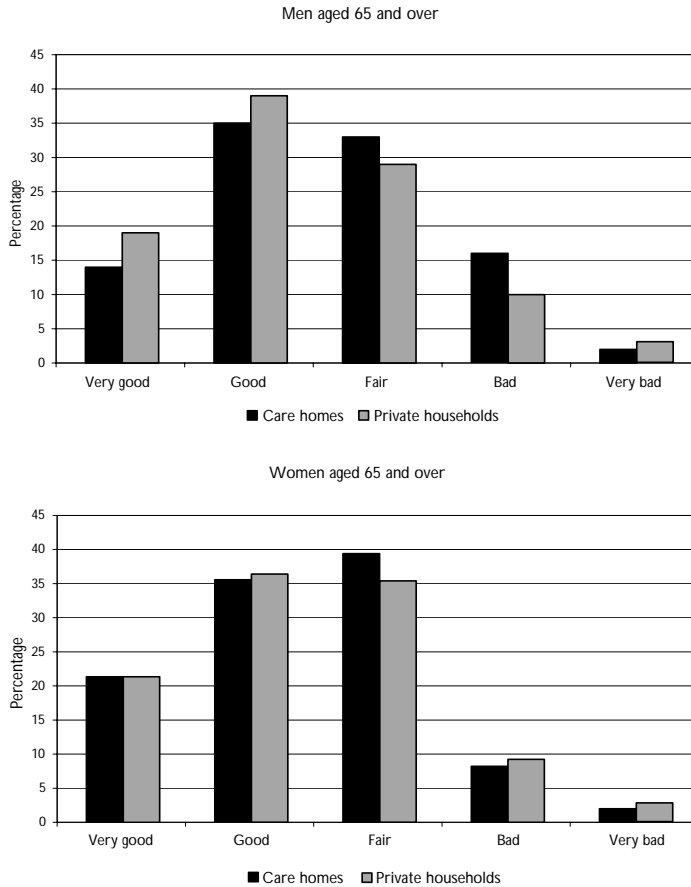
Source: General Household Survey

The health of older people living in care homes

In 2000, the Health Survey for England (HSfE)²⁴ had a special focus on older people and interviewed those living in care homes as well as in private households. As the questions were different from those used in the GHS, the results are not completely comparable with those given above. However, as the same questions were asked of those in care homes and those in private households, we can look at differences between these groups of people.

There are few differences in self-reported *general* health between those in care homes and those in private households (see figure 21). Older men living in care homes may have slightly poorer health on this scale, but the difference is not statistically significant³⁹. Very few people report their health as very bad, 3% of older men and 2% of older women. Overall, half of men in care homes (49%) and nearly three-fifths of men in private households (58%) report their health as very good or good. Slightly higher proportions of women in care homes (54%) report their health as very good or good. This compares with 56% of women aged 65 and over in private households.

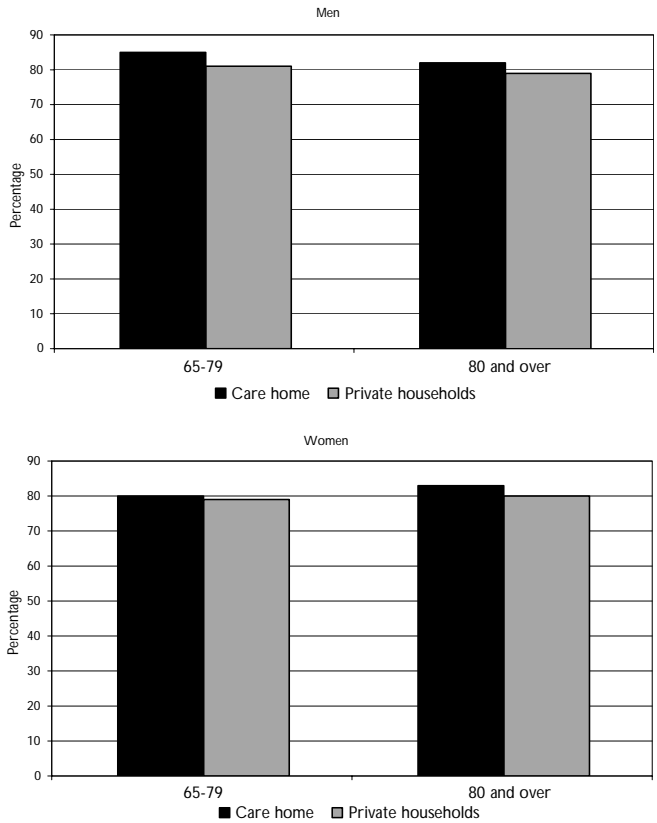
Figure 21: General Health, aged 65 and over, England 2000



Source: Health Survey for England

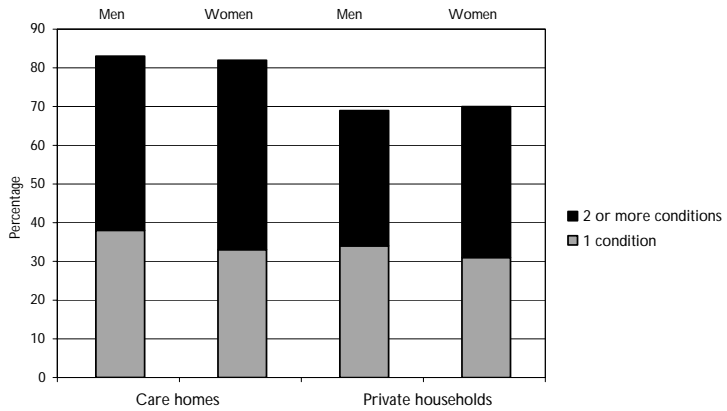
About four-fifths (80%) of older people had no acute illness in the fortnight before being interviewed by the team from the Health Survey for England in 2000⁴⁰. These rates were very similar for men and women, and whether older people lived in care homes or in private residences. Even the age of people had little effect on whether or not they reported an acute illness (see figure 22).

Figure 22: Proportion having no days of illness in the previous fortnight, England 2000



Source: Health Survey for England

Figure 23: Chronic illness, aged 65 and over, England 2000



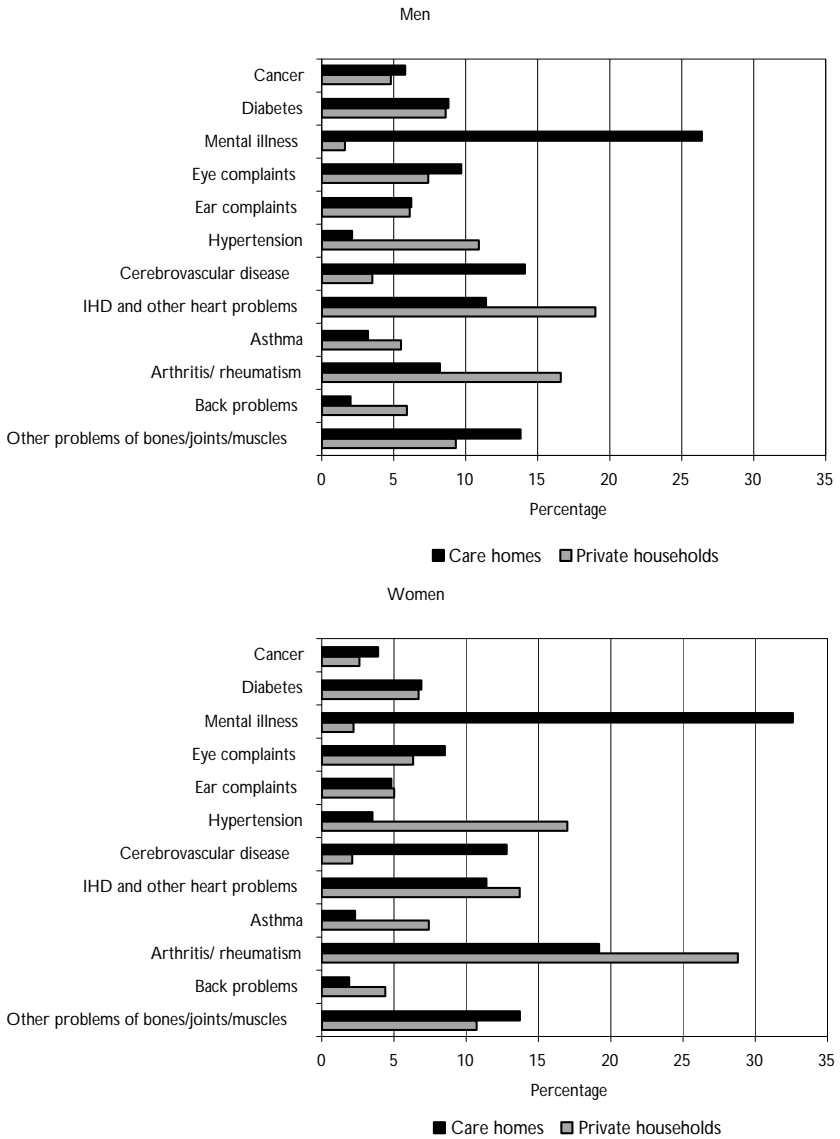
Source: Health Survey for England

Although there are no obvious differences between care home residents and those living in private households in general health or whether or not they had any days of illness in the previous fortnight, there are differences in the proportions reporting a chronic (longstanding) illness⁴¹. Between 30% and 40% of older people report they have a single chronic condition. There are no obvious differences in the proportions living in care homes or private households (see figure 23). Those living in care homes are much more likely to have two or more chronic conditions. Nearly a half of men (45%) and women (49%) living in care homes report they have two or more chronic conditions. Those living in private households are ten percentage points less likely to report more than one chronic condition, 35% of men and 39% of women.

Even more notable are the conditions from which those reporting chronic illness suffer (see figure 24). Mental illness is the chronic condition having the highest rates for both men and women living in care homes⁴². This category includes senile and pre-senile dementia, Alzheimer's disease and degenerative brain disorders. A third (33%) of women and a quarter (26%) of men living in care homes who have a chronic condition suffer from a mental illness. This is much higher than those who live in private households where about 2% reporting a chronic condition have a mental illness. The results for those in private households are consistent with those found in more detailed research on the prevalence of mental illness⁴³. Unlike the replies on general health, there are a number of proxy replies to the question on chronic illness for those living in care homes.

Cerebrovascular disease (stroke) has much higher rates among those in care homes than in private residences, 14% and 4% for men and 13% and 2% for women. For both older men and older women, higher proportions of those with arthritis live in private households. These findings could suggest that older people with chronic conditions live in private residences until they are unable to cope any longer and then move to residential accommodation. The higher proportion with arthritis living in private households has implications on the need for help with certain types of tasks discussed earlier in this report.

Figure 24: Prevalence of certain conditions among those reporting chronic illness, ages 65 and over, England, 2000



Source: Health Survey for England

4. Lifestyle factors associated with health

Many aspects of lifestyles are associated with health problems. For example, smoking is associated with chronic obstructive lung disease and lung cancer⁴⁴; alcohol consumption is associated with hypertension, cancer of the liver and is the major factor in cirrhosis of the liver^{45,46}. It is also important to eat healthily⁴⁷. Feelings about the neighbourhood and fear of crime can affect whether older people will go out of their homes. This can affect their general health if they are not getting enough exercise or their mental health if it leads to feelings of anxiety or depression.

Smoking

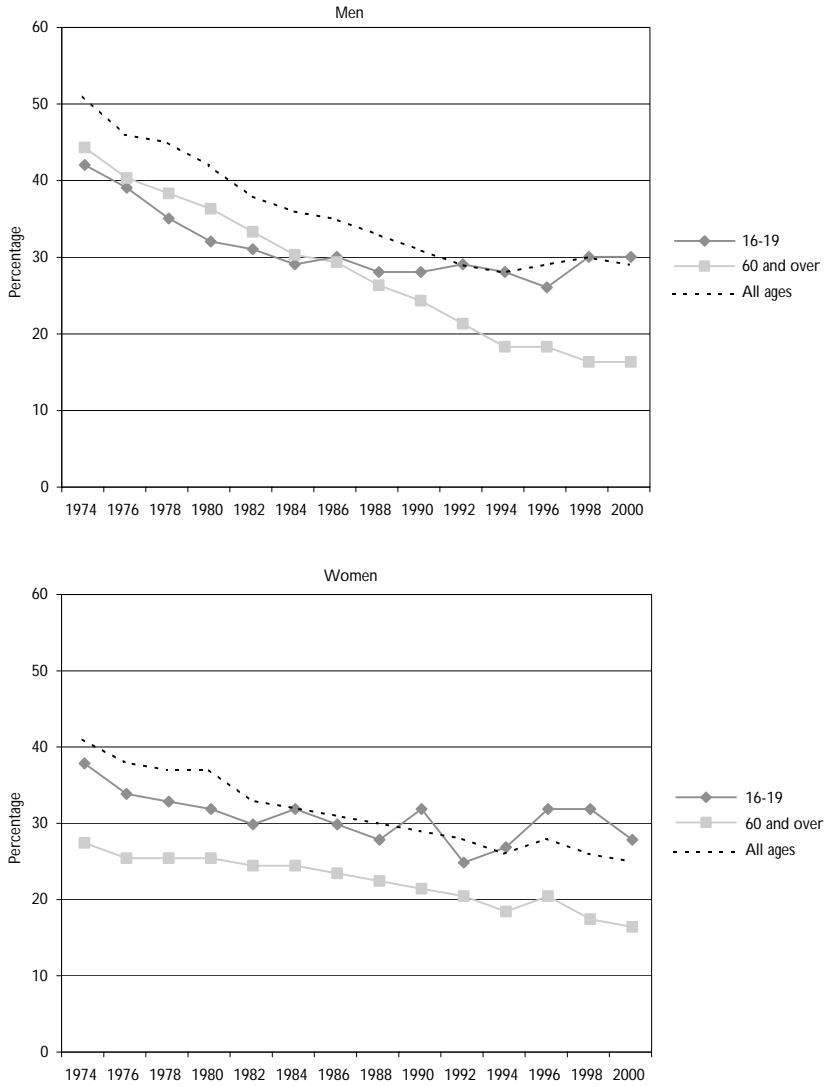
Overall about a quarter (27%) of people aged 16 and over in Great Britain in 2000 smoked cigarettes⁴⁸. There are higher rates among younger people than older people (see figure 25). About the same proportions of older men and women are smokers, 16% and 15% respectively. This compares with the big difference in the proportions of older men and women smoking 25 years ago when 44% of men aged 60 and over smoked compared to 26% of women. The differential 25 years ago in proportions of men and women smoking should be borne in mind when considering present gender differences in the causes of chronic illness and death rates from smoking related conditions, for example circulatory diseases.

The decline in cigarette smoking is particularly marked for older men. In 1974, similar proportions of young and older men smoked, 42% men aged 16 to 19 and 44% of men aged 60 and over. In 2000, 30% of young men smoked and about half that proportion of older men smoked (16%).

Over half (52%) of today's older men previously were regular smokers but currently are non-smokers⁴⁹. Nearly three-fifths (56%) of women aged 60 and over never, or only occasionally, smoked cigarettes. This compares with a third (32%) of men aged 60 and over (see figure 26).

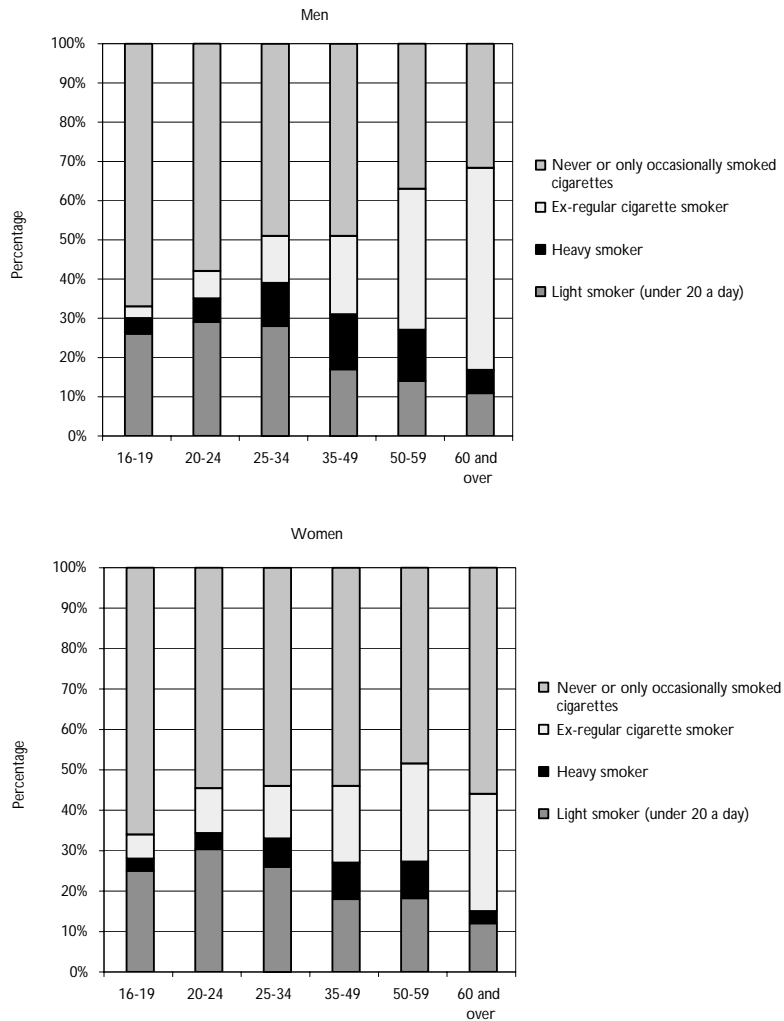
Over a half of men aged under 50 have never or only occasionally smoked cigarettes. There is less variation across the ages for women who have never smoked.

Figure 25: Proportion of cigarette smokers, Great Britain



Source: General Household Survey

Figure 26: Current smoking status, Great Britain, 2000

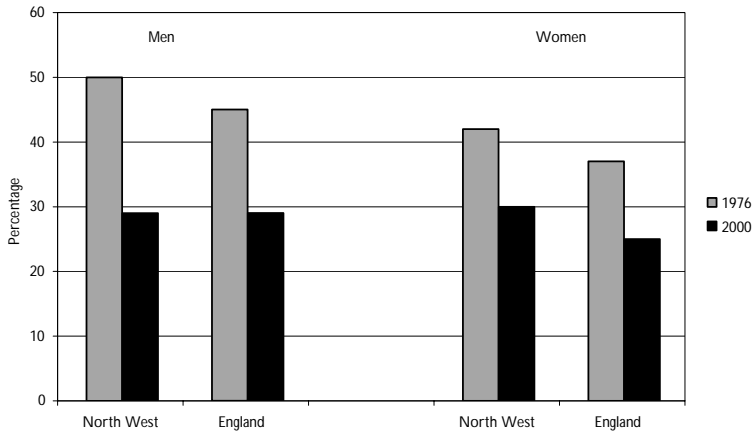


Source: General Household Survey

Is the North West different from the rest of England

The proportion of men who smoked cigarettes in 2000 in the North West was not very different from that in England as a whole (see figure 27). Twenty-five years ago, 50% of men in the North West smoked compared to 45% in England as a whole⁵⁰. Now 29% of men smoke both in the North West and in England⁵¹. For women, the difference in 1976 was 5 percentage points, and that is still the difference in 2000, 30% of women smoke in the North West and 25% smoke in England as a whole. The slightly higher rate of men smoking 25 years ago explains some, but by no means all, of the differences now in the prevalence of certain conditions in men caused by smoking.

Figure 27: Proportion smoking cigarettes, ages 16 and over, North West and England

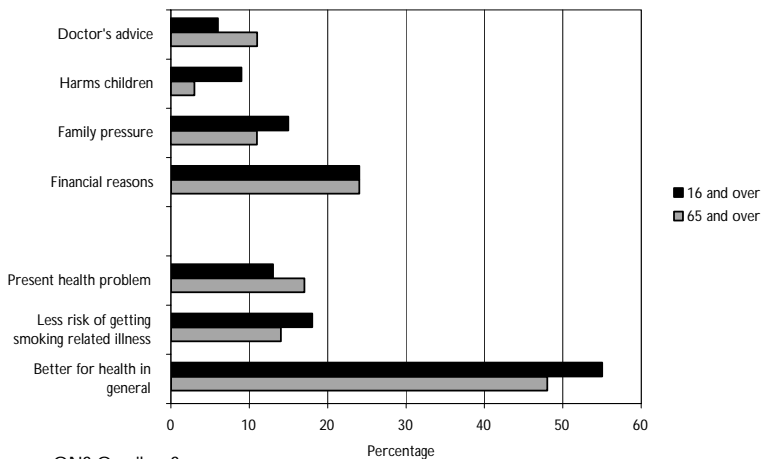


Source: General Household Survey

Why do people give up smoking?

As mentioned earlier, over half (52%) of men and nearly three-fifths (56%) of women aged over 60 are ex-smokers. A special study undertaken for the Department of Health in 2000⁵² looked at attitudes of people, both smokers and non-smokers, to smoking. Those who had been regular smokers and were now non-smokers were asked the main reason why they had given up⁵³. For those aged 65 and over, nearly two-thirds (65%) gave at least one reason related to health. Nearly a half (48%) of older people who had given up said it was because it would be better for health in general. Only a tenth (11%) said it was on doctor's advice (see figure 28). Even so, this was more than twice the proportion of younger people who said they had been advised to give up by their doctor, 4% of those between the ages of 25 and 64.

Figure 28: Main reasons for having stopped smoking, Great Britain, 2000



Source: ONS Omnibus Survey

Drinking

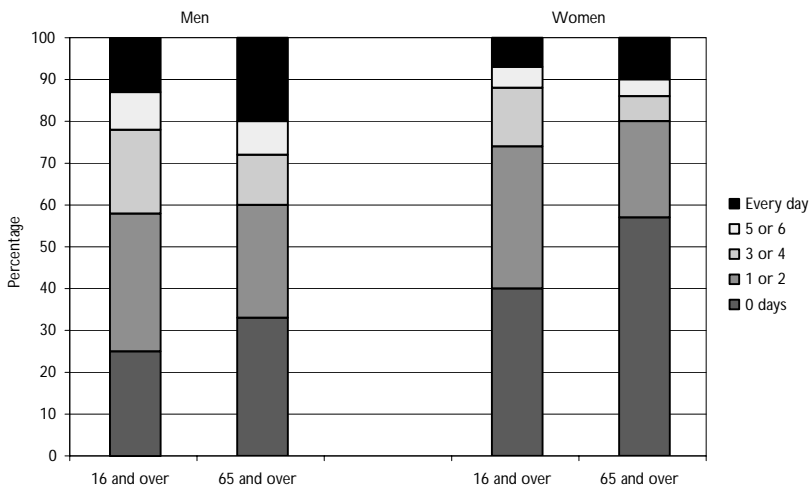
In 2000, three-quarters of men (75%) and three-fifths of women (60%) said they had drunk alcohol on at least one day in the previous week⁵⁴. Lower proportions of older men and women reported drinking in the previous week, two-thirds of men (67%) aged 65 and over and two-fifths of women (43%) aged 65 and over (see figure 29). Although it is less likely that older people will drink at all than the whole adult population, it is more likely that older people will have had a drink on each day in the past week. For men, 20% aged 65 and over say they drank on each day in the previous week compared to 13% of men of any age. For women, the difference was less marked, 10% of older women drank every day compared to 7% of adult women in Great Britain.

How much do older people drink?

The government's advice on sensible drinking is based on daily amounts⁵⁵. Different people are susceptible to different levels of alcohol. Even so, drinking more than 4 units a day (3 for women) may have some risk to health. Heavy drinking is usually considered to be drinking more than 8 units (6 for women) on any single day. This is likely to lead to drunkenness. Regularly drinking large amounts of alcohol leads to liver damage.

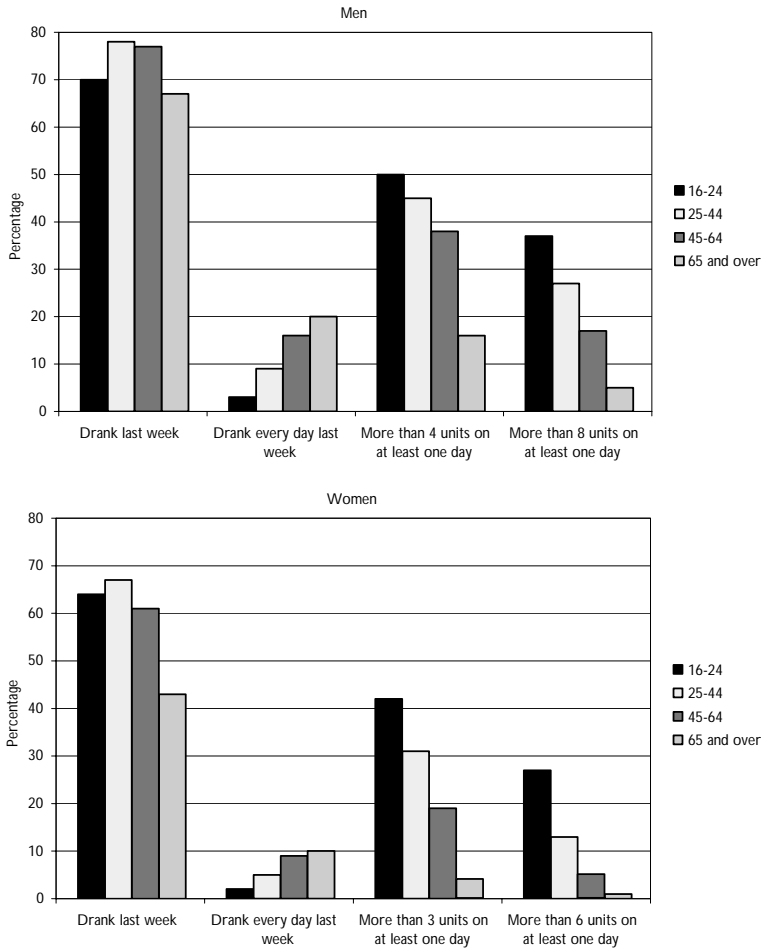
Older men are more likely to drink every day, but they are less likely to drink a large amount on any one day than young men⁵⁶. In 2000, over a third (37%) of men aged 16 to 24 and a quarter (27%) of women of these ages drank heavily on at least one day in the previous week. This compares with only a twentieth (5%) of men aged 65 and over and a hundredth (1%) of older women (see figure 30).

Figure 29: Number days drinking in previous week, Great Britain, 2000



Source: General Household Survey

Figure 30: Amount drunk last week, Great Britain, 2000

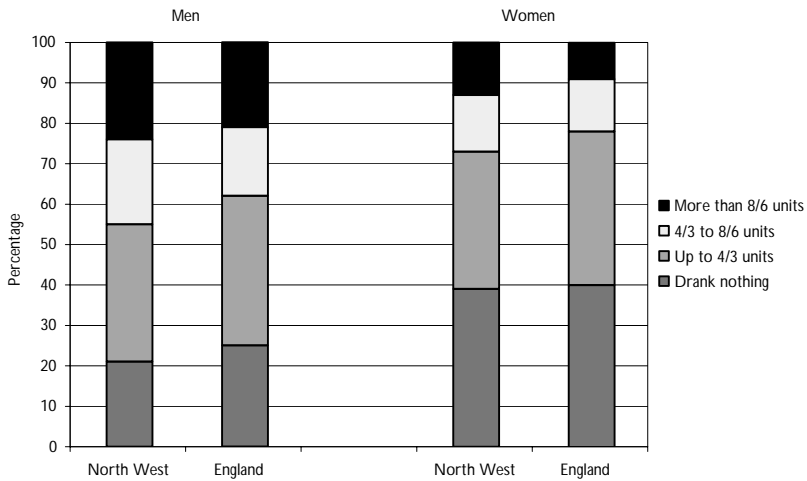


Source: General Household Survey

Is the amount drunk in the North West different from England as a whole?

People in the North West are not more likely to drink compared to those in England as a whole⁵⁷. However, this is not true for every category of drinking (see figure 31). Men in the North West are more likely to have drunk between 4 and 8 units on one day in the last week, 21% compared to 17% in England. Perhaps more worrying is that the proportion of women drinking heavily on at least one day in the previous week was higher in the North West than in England as a whole, 13% of women in the North West drank more than 6 units compared to 9% in England.

Figure 31: Maximum daily amount drunk, North West and England, 2000



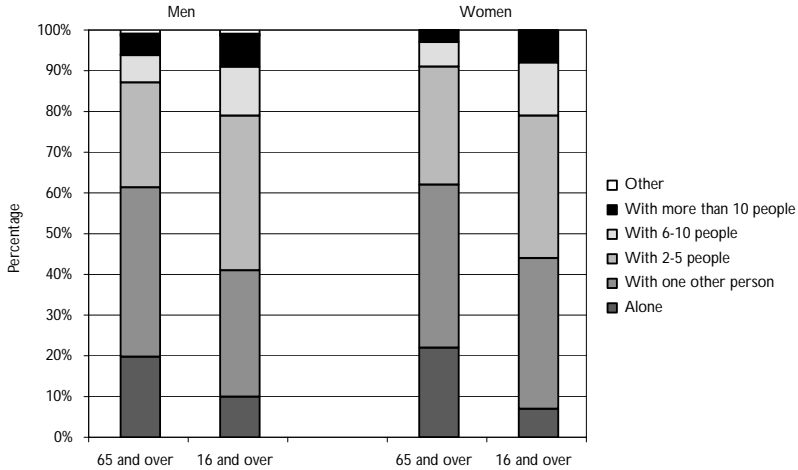
Source: General Household Survey

With whom do older people drink?

In 2000, the Department of Health commissioned a special survey on drinking attitudes and behaviour⁵⁸. People were asked questions about with whom they drank. Older men and older women were more likely to drink on their own⁵⁹ (see figure 32). A fifth (20%) of men aged 65 and over were alone on the day on which they drank heaviest. This was twice the proportion of those aged 45 to 64 (11%) and nearly three times that of younger men (7%).

Overall women were slightly less likely than men to have drunk on their own, 7% and 10% respectively. However, older women are much more likely to have drunk on their own on their heaviest drinking day (22%) compared to all adult women (7%). This is particularly worrying as older women are also much more likely to drink at home than all adult women, 70% and 51% respectively⁵⁹.

Figure 32: Drinking with other on heaviest drinking day, Great Britain, 2000



Source: ONS Omnibus Survey

Nutrition

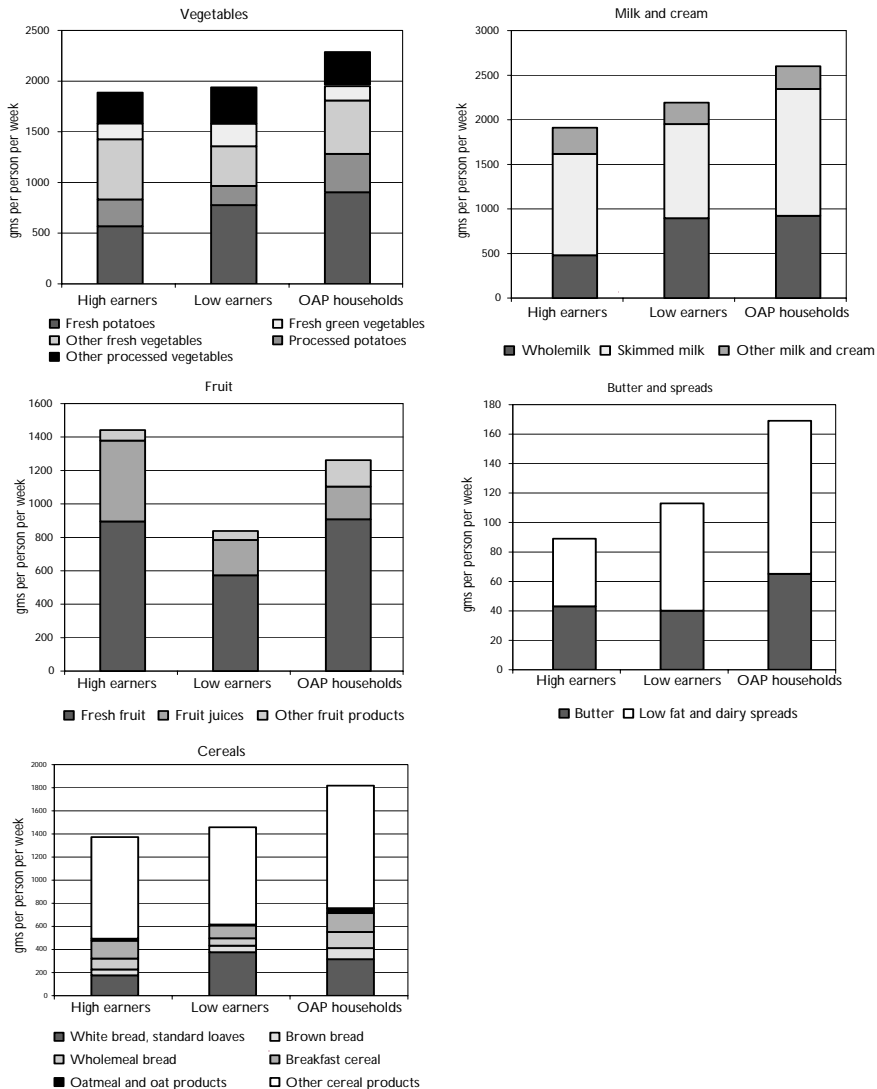
Very detailed information on the diets of older people is available from the National Diet and Nutrition Survey⁶⁰. This section will give much less detailed information to give an overview of nutrition and older people. This information has been taken mainly from the National Food Survey (NFS)⁶¹ and the Family Expenditure Survey (FES)⁶². These surveys tend to deal with household level, rather than individual level, data. This results in discussions about pensioner headed households, rather than looking at all people of specific ages living in households. In most instances the comparisons will be between high-income households (those with one or more earners and earning £725 and over per week) at the top of the income distribution, households further down which I have called low-income households (with one or more earners and under £180 per week), and households headed by a pensioner. It is important to note that information from the FES is about amounts bought, not amounts eaten.

OAP households ate more vegetables a week than the other two groups, 2274 gms per person per week compared to 1888 gms per person per week in high-income households and 1937 gms per person per week in low-income households⁶³. Not only do OAP households eat more vegetables in total, they are more likely to eat fresh vegetables than low-income households (see figure 33). OAP households ate 903 gms per person of fresh potatoes per week, 379 gms of fresh green vegetables and 526 gms of other fresh vegetables. This is four-fifths (80%) of their weekly intake of vegetables, whereas in low-income households fresh vegetables make up seven-tenths (70%) and in high-income households three-quarters (75%) of the weekly intake of vegetables.

OAP households also ate more fresh fruit per person per week, 907 gms per person per week compared to 573 gms in low-income households and 895 gms in high-income households. These households ate much more butter and spread than the other two types of households, 169 gms per person per week. This is half as much again as low-income households (113 gms) and nearly twice that of high-income households (89 gms). This may be due in part to the amount of bread

eaten in these households. In OAP households, 840 gms of bread and rolls per person per week are eaten; in low-income households 751 gms; and in high-income households 601 gms per person per week were eaten. Much more cake and biscuits are eaten in these households, 409 gms in OAP households, 244 gms in high-income households and 254 gms in low-income households.

Figure 33: Consumption of selected foods, Great Britain. 2000



Source: National Food Survey

High earners means households with one or more earners and £725 or more per week

Low earners means households with one or more earners and £180 or less per week

Do older people eat enough to have the energy to do what they want to?

The estimated average requirement (EAR) for energy depends on a large number of factors including age and gender⁶⁴. For men between 65 and 74 it is 9.71 MJ (2330 kcals) per day; for men aged 75 and over it is 8.77 MJ (2100 kcals) per day. For women the EAR is less; for those aged 65 to 74 it is 7.96 MJ (1900 kcals) per day and for those aged 75 and over it is 7.61 MJ (1810 kcals) per day. In this instance, the average is the median - that is, the amount that about half of people of these ages will need. The amount needed also depends on the mobility of the person. The National Food Survey in 2000 found that the average amount of energy per person per day in OAP households was 2200 kcals, or 99% of the EAR⁶⁵.

However, this hides differences across the types of households within this group. The National Diet and Nutrition Survey found that both older men and women receiving benefits were more likely to have low energy intakes⁶⁶. The average (median) for men receiving benefits was 7.43 MJ, about four-fifths of the EAR; and for women receiving benefits it was 5.68 MJ, about three-quarters of the EAR (see figure 34).

Older women are much more likely to have low average daily energy intakes. About half of older women should have daily energy intakes between 7.6 and 8 MJ. For both those receiving and those not receiving benefits more than nine-tenths (94% and 91%) had less than 8MJ per day. Those receiving benefits tended to have lower energy intakes than those not on benefits. Nearly three-fifths (58%) of older women on benefits had an average daily energy intake of less than 6 MJ. Just under half (48%) of older women on benefits had energy intakes this low.

The very high proportions of women having low daily energy intakes may be partly due to the large number of very elderly women living in private households. Even so, low energy intake has implications for low energy level and thus the ability to be active. This could lead to serious health conditions in elderly women. Not being able to go out can lead to anxiety and depression.

Figure 34: Average daily energy intake (MJ) per day, Great Britain, 1994

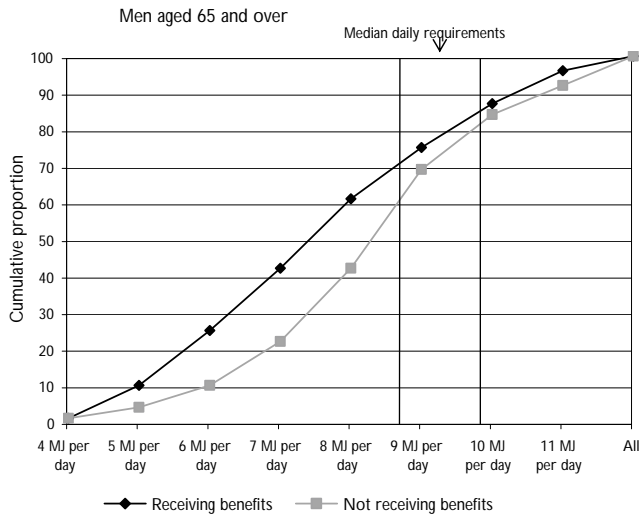
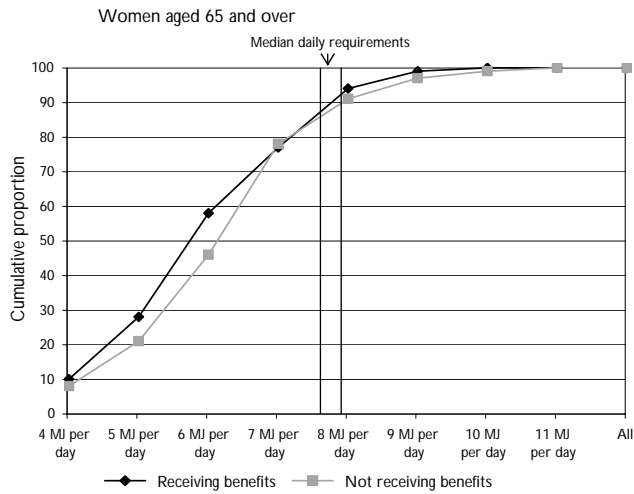


Figure 34: Average daily energy intake (MJ) per day, Great Britain, 1994



Source: National Diet and Nutrition Survey

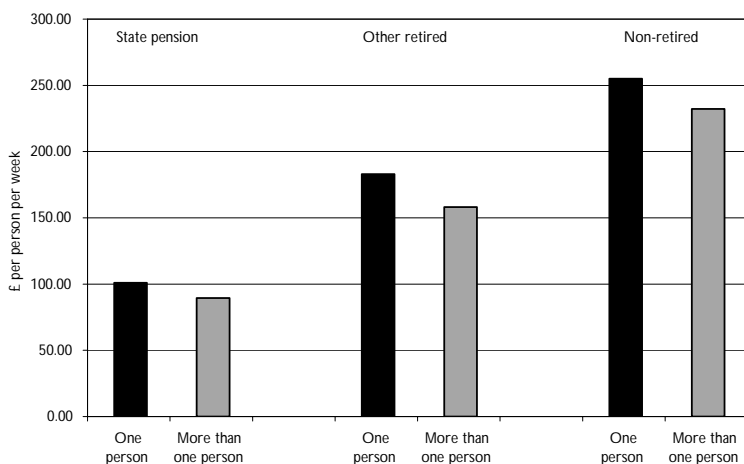
Note median daily requirement is the amount 50% should have.

Spending Patterns

How much people spend and what they buy depends not only on how much money they have, but also on personal choice. It is illuminating, however, to look at how much people spend on different items and what proportions of average weekly expenditure this constitutes.

Retired and non-retired households spend very different amounts per person per week (see figure 35). Households with more than one person spend slightly less per person than one-person households⁶⁷. Non-retired households spend more than twice as much as those retired households mainly dependent on the state pension.

Figure 35: Average weekly expenditure, United Kingdom, 2000-01

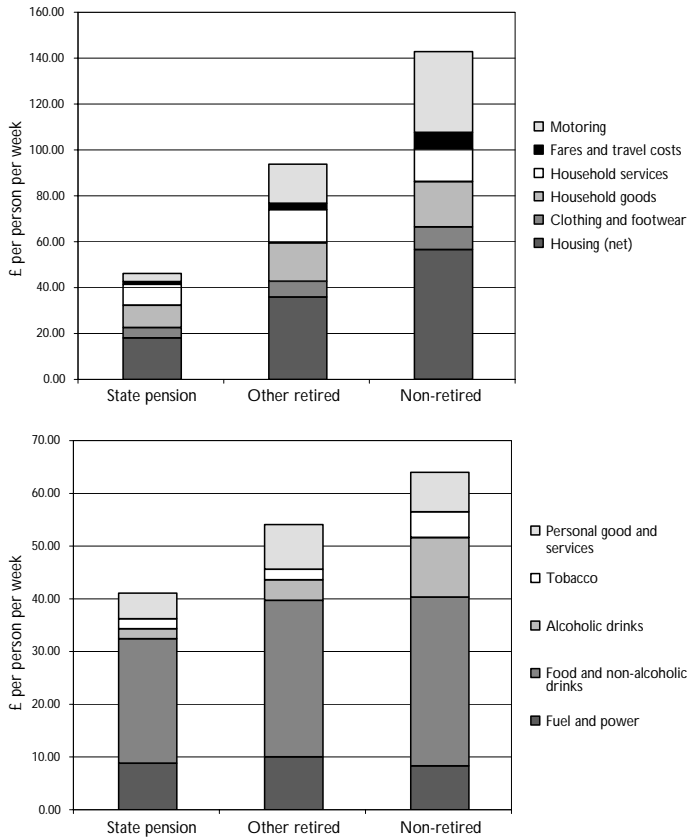


Source: Family Expenditure Survey

Much of the difference in weekly amounts spent is because of housing costs and household goods (see figure 36). This could be because of mortgage payments and non-retired households buying items that retired households already have or do not want, for example washing machines, TVs and DVDs. Motoring costs account for similar amounts of the budgets of non-retired households and retired households not mainly dependent on the state pension, 14% and 9% respectively. It accounts for a much smaller proportion of the budget of retired households mainly dependent on state pension, 3%. This may be because they do not have access to a car.

Although the actual amount of money spent on food and non-alcoholic drinks is not very different depending on the type of household, it accounts for very different proportions of the weekly expenditure. Non-retired one-person households spend £32.00 (13%) on food and non-alcoholic drinks; retired households dependent on state pensions spend £23.60 (23%); and other retired households £29.70 (16%).

Figure 36: Average weekly expenditure, one-person households, United Kingdom, 2000-01



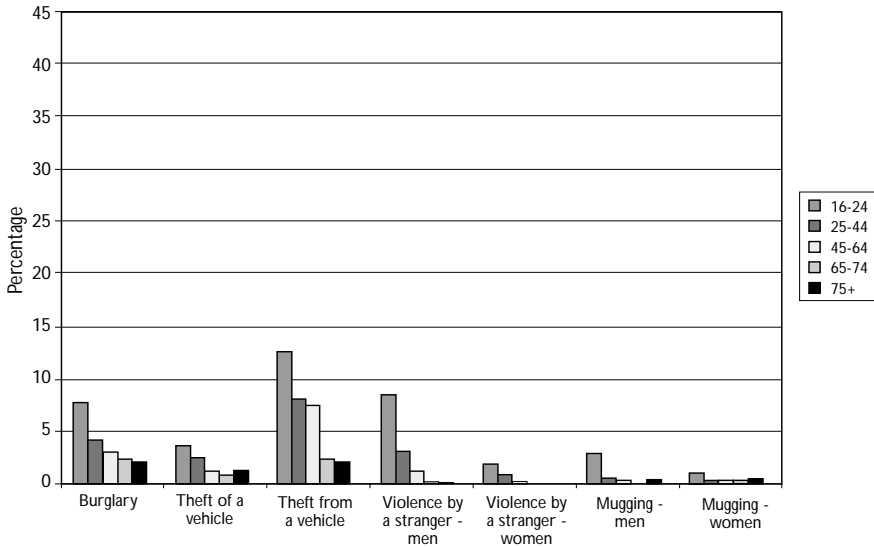
Source: Family Expenditure Survey

Going out: perceived versus actual risk of crime

About 2% of households in England and Wales in 2001 headed by someone aged 60 or over is burgled at least once in a year⁶⁸. This is very much smaller than the proportion of people aged 60 and over who say it is very/fairly likely they will be a victim in the next year⁶⁹. A quarter of men (25%) and a fifth (18%) of women aged 60 or over think they will be the victims of a burglary.

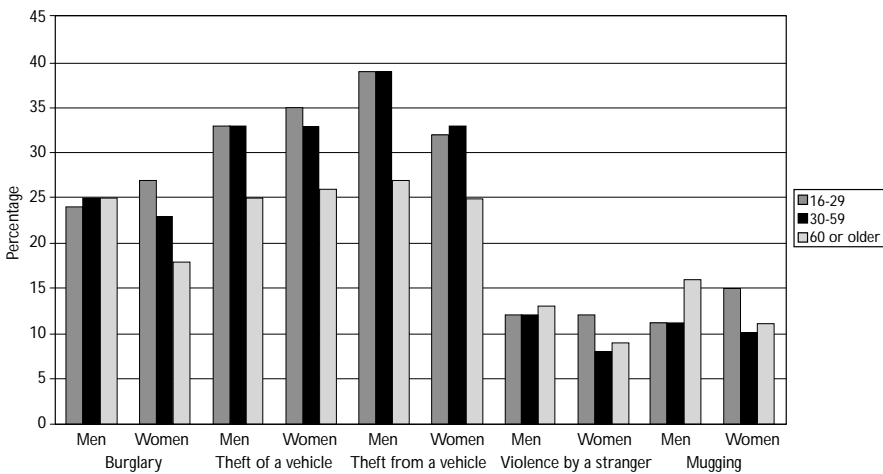
This difference between the perception of crime and the actual risk of being a victim of crime is not just for burglary (see figures 37 and 38). Over a tenth (10%) of older men and women think it very or fairly likely that they will be the victims of violence by a stranger or of a mugging in the next year. Less than a hundredth (1%) of people of these ages actually are the victims of such crimes in a year.

Figure 37: Percentage of households of crime, England and Wales, 2001



Source: British Crime Survey

Figure 38: Perception of risk of crime, England and Wales, 2001



Source: British Crime Survey

As mentioned earlier, fear of crime may prevent older people from going out of their homes. This can lead to lower levels of physical activity, which can lead to general mobility problems. Not going out can also lead to fewer social contacts which can have implications for mental health, in particular depression.

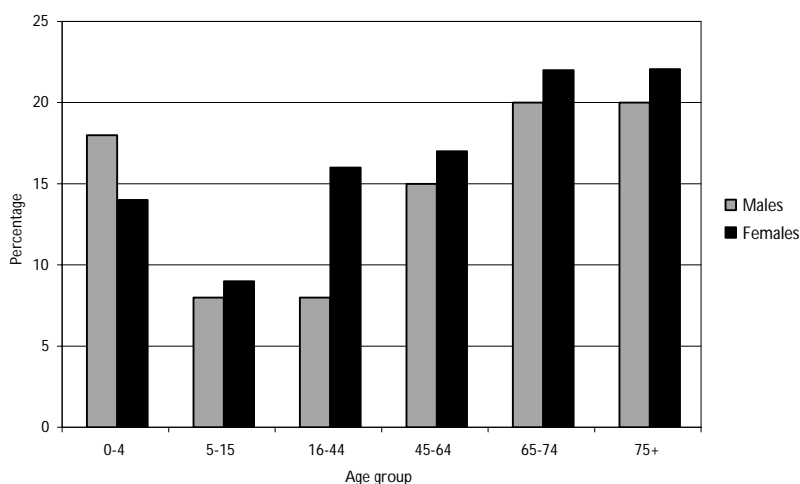
5. Older people's use of health and social care services

This section gives an overview of the types of health and social services that are used by older people. The GHS²² gives information annually on the number of GP consultations, attendances at outpatient departments, day-patient attendances and inpatient attendances. The occasional series of special reports from the GHS²³ for older people provides information on who gives help, both formal and informal, to those who cannot fully look after themselves at home. The HSE³⁹ also gives information on the use of NHS services, and includes both those living in the community and those in care homes. The Family Resources Survey⁷⁰ produces information annually on household members receiving care. The Department of Health has a number of publications giving information about contact hours for community care, but it can be difficult to translate this into information about how many individuals are cared for^{71,72}.

Primary care services

In general, the proportion of people consulting with a GP in the fortnight before being interviewed by the GHS rises with age (see figure 39). Children under 5 are the exception to this, having higher consultation rates than those of school ages⁷³. Apart from the ages 16 to 44, the rates for men and women are similar. The consultation rates at these ages may differ because of visits concerning contraceptives and pregnancy. About a fifth of older people consult a GP in any given fortnight. This means that 83 thousand men and 134 thousand women in the North West over the ages of 65 visit their GP in any given fortnight.

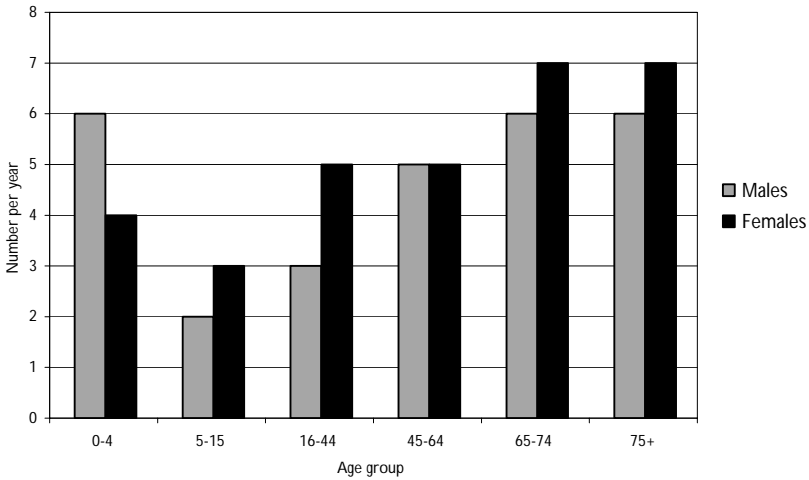
Figure 39: Proportion consulting with GP, Great Britain, 2000



Source: General Household Survey

Not only does the chance of visiting a GP rise with age, so too does the average number of visits per person per year (see figure 40). Men over 65 have about 6 consultations with a GP in a year⁷⁴ and women an average of 7. If the consultation rates are the same across Great Britain, this means that in the North West, there are about 2 million visits to GPs by older men in a year and 3 million by older women

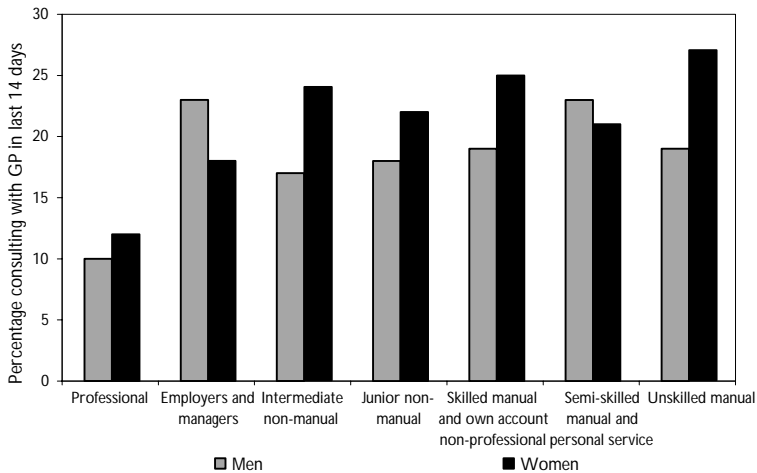
Figure 40: Average number of consultation with GP, Great Britain, 2000



Source: General Household Survey

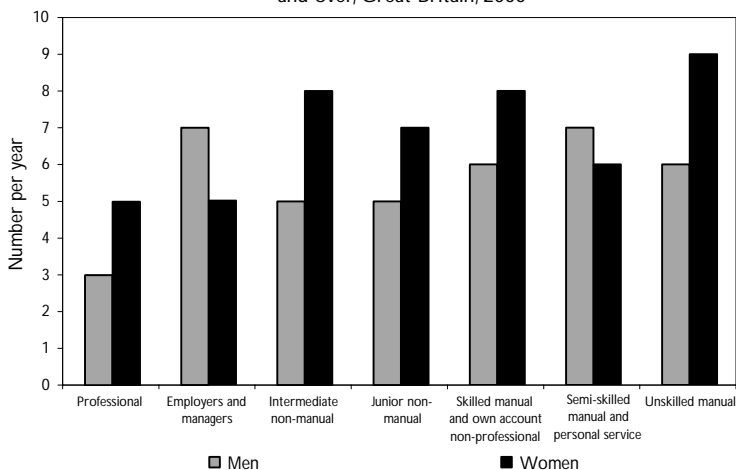
However, the chances of visiting a GP and the average number of consultations per year are not the same across the socio-economic groups within Great Britain⁷⁵(see figures 41 and 42). Those people aged 65 and over living in homes where the Household Reference Person (HRP) is from the professional group are less likely to consult with a GP and men have fewer visits than women on average over the year.

Figure 41: Consultation with GP in previous 14 days, ages 65 and over, Great Britain, 2000



Source: General Household Survey

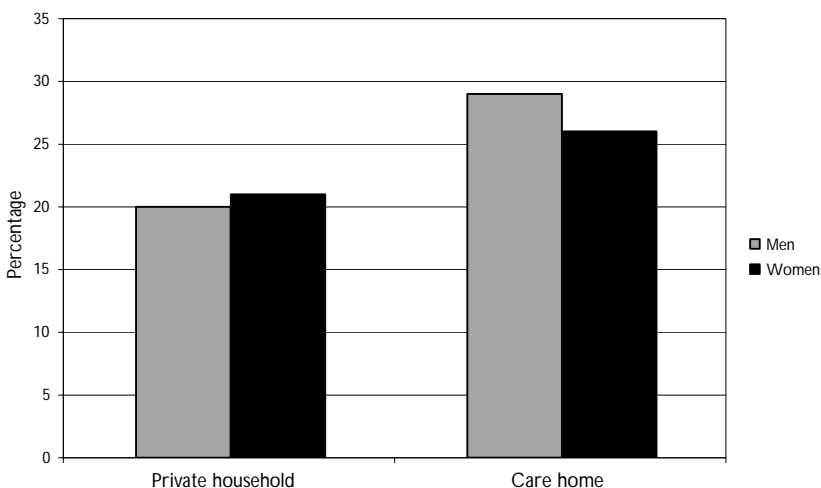
Figure 42: Average number of consultation with GP per year, ages 65 and over, Great Britain, 2000



Source: General Household Survey

As mentioned earlier, data from the Health Survey for England are not fully comparable with those from the General Household Survey. It is useful, however, to look at this source as it does give information for both those older people living in private households and those living in care homes. The same questionnaire was used for both groups. It is clear that those in care homes are more likely to have consulted with a GP than those living in private households (see figure 43). The difference is particularly marked for men⁷⁶, but it must be remembered that a higher proportion of men in care homes have a chronic illness.

Figure 43: Proportion consulting with a GP in last 14 days, ages 65 and over, England, 2000



Source: Health Survey for England

Outpatient and day patient services

As with many other indicators of NHS use, the average number of outpatient attendances increases with age⁷⁷. Overall in Great Britain in 2000, there were 121 outpatient attendances per 100 people per year. However, older people had many more than this (see figure 44). For men the average was over 2 outpatient attendances per person per year. Women had slightly fewer outpatient attendances on average, just under 2 per person per year.

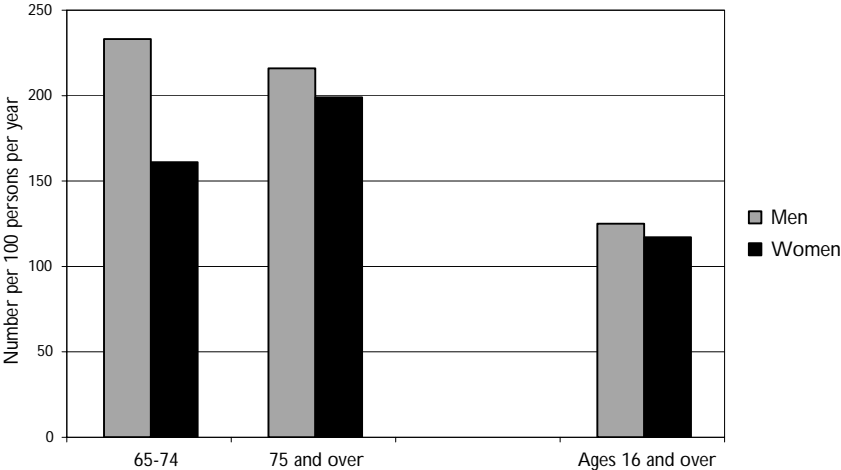
The slightly lower rate for men aged 75 and over may be due in part to the fact that this survey only asks questions of those in private households. A greater proportion of older men with severe problems are in care homes than in private households.

If these figures were constant over the whole of Great Britain, this would result in a million outpatient attendances for older men and a further million for older women in the North West region of the NHS. However, evidence from the General Practice Research Database (GPRD) suggests that outpatient referral rates in the North West are higher than in England as a whole⁷⁸, so the 2 million outpatient visits is likely to be an underestimate.

There has been a large increase in the use of day care facilities. In 1992, 4% of people had received day-patient treatment in the previous year⁷⁹. By 2000, this had risen to 7%. As with other indicators quoted here, the older age groups had even higher proportions. About a tenth of people aged 65 and over had received care as a day-patient at some point in 2000.

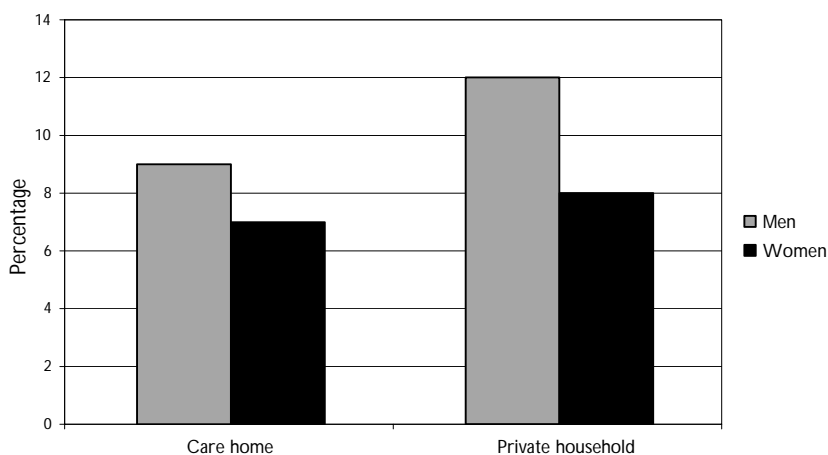
The data from the HSfE on day patient treatment gives the same general level of attendance⁸⁰. It is interesting to note that there are differences in likelihood of this attendance by whether the patient is normally resident at home or in a care home (see figure 45). Men in private households are more likely to be a day patient than those in care homes. This may be because of the higher proportion of chronic illness already mentioned among men in care homes⁴¹.

Figure 44: Average number of outpatient attendances, Great Britain, 2000



Source: General Household Survey

Figure 45: Proportion who were day patient in last year, ages 65 and over, England, 2000



Source: Health Survey for England

Hospital in-patient care

The Hospital Episode Statistics (HES) data from the Department of Health⁸¹ give a very full and comprehensive accounting of the number of consultant episodes in NHS hospitals in England. Unfortunately, it is not easy to convert these episodes to the number of cases for individuals. A person going into hospital may have more than one episode for their stay in hospital if another condition arises, or if they have more than one condition when they enter hospital. Each stay under the care of a consultant is a separate episode. The standard tables from HES show that overall there are about 10% more episodes than admissions⁸². Unfortunately this is not broken down by age. It is not unreasonable to suggest that the older the patient, or the more complex their condition, the more likely that the patient's stay includes more than one episode.

Having these limitations in mind, some conclusions can still be drawn from these data. In 2000/01, there were over 12 million episodes of care including an overnight stay in NHS hospitals in England⁸². Nearly 5 million of these episodes were for people aged 60 and over. This was about two-fifths (40%) of all the episodes. In the North West region, there were nearly 2 million episodes of inpatient care. Nearly 900 thousand involved patients aged 60 and over. This is a slightly higher proportion than in England as a whole being 45% of the total number of episodes⁸³.

The HES system records diagnosis and the standard tables give a wealth of information on these data. As ever with medical conditions, it is difficult to decide on the precise aggregation of the very detailed data to give an overall picture. It is somewhat arbitrary and idiosyncratic. However, the large-scale picture can be seen from the fact that over 600 thousand episodes for people aged 60 and over were for malignant neoplasms; over 300 thousand were for cataracts; just under 300 thousand were for ischaemic heart diseases; 200 thousand were for other heart diseases; and over 100 thousand were for cerebrovascular disease⁸².

Sickness and disability social security benefits

There are a large number of different benefits to which a person is entitled depending on the state of their health. The Department for Work and Pensions analyses the benefits received by the population over the state pension age by allocating people to one of three groups: sick and/or disabled, non-disabled Minimum Income Guarantee (MIG), and Retirement Pension (RP) only⁸⁴. Categories are described in box 4.

Box 4: Description of categories of benefit claimants who are pensioners.

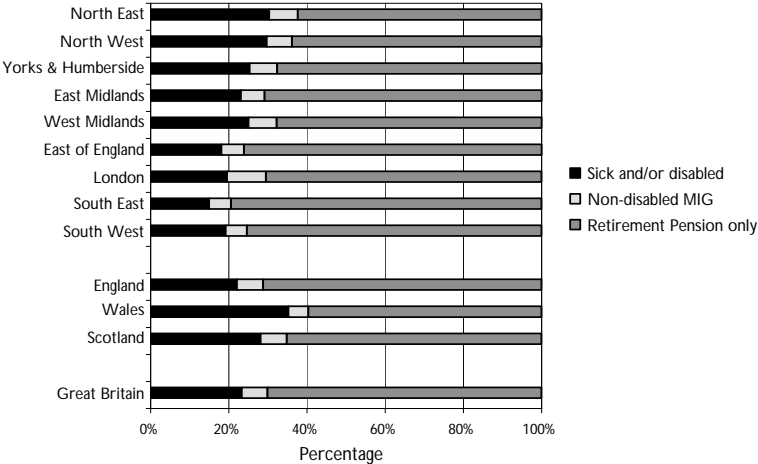
The sick and/or disabled includes those claimants who: receive one or more of Attendance Allowance (AA), Disability Living Allowance (DLA), Incapacity Benefit (IB), Severe Disablement Allowance (SDA); or on MIG and

- single and aged 60-79 in receipt of a higher Pensioner Premium (HPP) due to disability;
- in a residential care or nursing home;
- sick days being recorded;
- hospitalised cases; or an RP claimant and
- in hospital;
- receiving Invalidity Allowance (IA).

Source: Department of Work and Pensions. Client Group Analysis: pensioners.

Nearly a quarter (23%) of those above pension age in May 2001 were classified as sick and/or disabled. However, this is not constant over the whole of Great Britain⁸⁵. A higher proportion (29%) of those in the North West were in this group (see figure 46). This means that 366 thousand people in the North West who were over pension age received one or more of the benefits mentioned above. The North East and Wales were the only areas with a higher proportion of people of pension ages classified as sick and/or disabled. If the North West had the same rate as Great Britain as a whole, about 80 thousand less people would receive these benefits.

Figure 46: Pensioners, North West and Government Office Regions, 2001



Source: Department for Work and Pensions

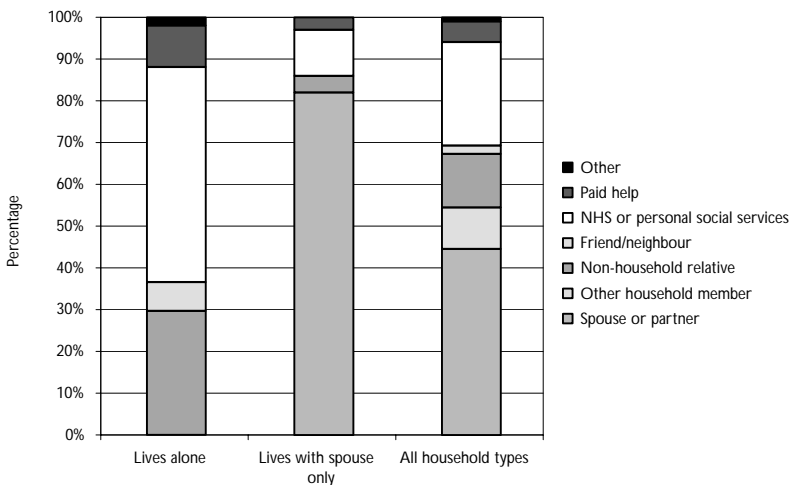
Care in the home

As mentioned earlier, the GHS on occasion asks specific questions of those aged 65 and over about their need for help²³. About 7% of older people need help with bathing, showering or washing all over⁸⁶. People who live alone and have these types of problems are much more likely to receive help from the NHS or personal social services than those living with other people (see figure 47). Over half (52%) of those who live alone receive help from the NHS or personal social services compared to a tenth (11%) of those living only with their spouse¹⁵. This is mainly because, perhaps not surprisingly, the vast majority of those needing help to wash who live with their spouse receive it from them (82%). A tenth (10%) of those living on their own who need help with bathing pay for this help.

Over half of people aged 65 and over need help with at least one domestic task¹⁵ – washing dishes, cleaning windows, using a vacuum cleaner, doing jobs involving climbing, laundry, opening screw tops, preparing a snack or making a cup of tea. Again the source of this help depends on the type of household in which the person receiving the help lives. However the people giving this type of help are not the same as those helping with bathing, showering or washing all over. Half (51%) of those who live on their own and need help with domestic tasks receive this help from a non- household relative. Nearly a quarter (23%) living by themselves pays for the help (see figure 48). Less than a tenth (about 8%) of those living with someone else pays for help with domestic tasks.

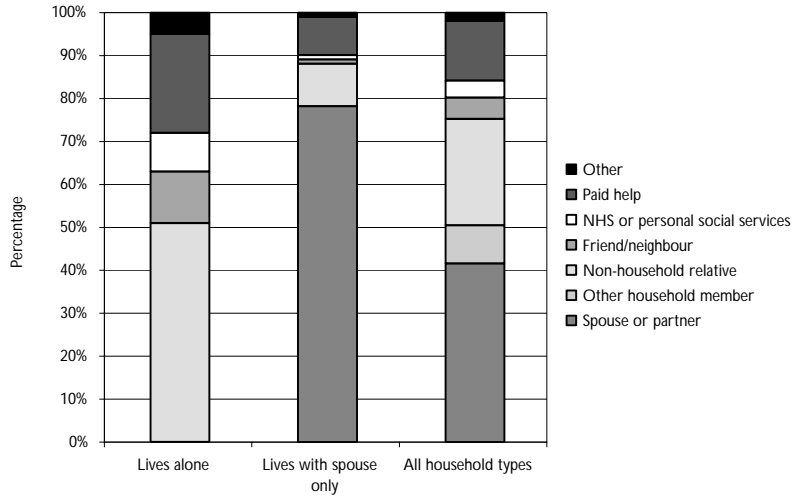
Nearly a fifth (18%) of people aged 65 and over who live on their own and a tenth (9%) of those living only with their spouse need help with household shopping⁸⁷. As with domestic tasks, relatives provide help to those older people who need it. Over a tenth (14%) of those living alone who need help with shopping receive help from the NHS or personal social services for this (see figure 49).

Figure 47: Help with bathing, ages 65 and over, Great Britain, 1998



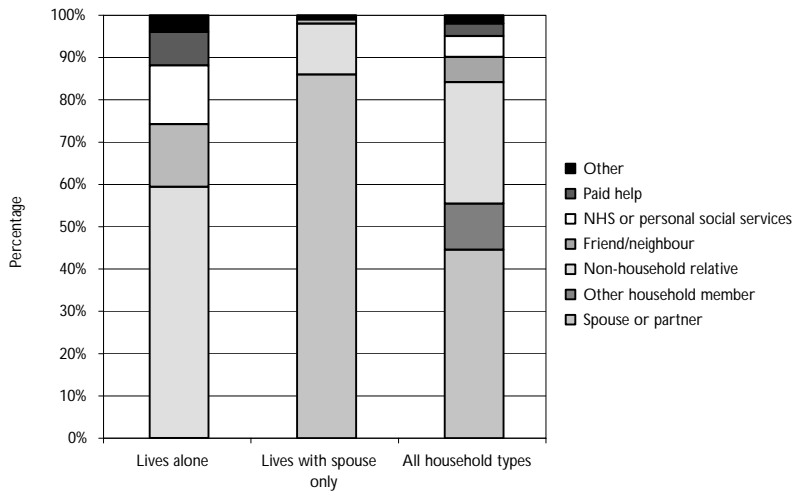
Source: General Household Survey

Figure 48: Help with domestic tasks, ages 65 and over, Great Britain, 1998



Source: General Household Survey

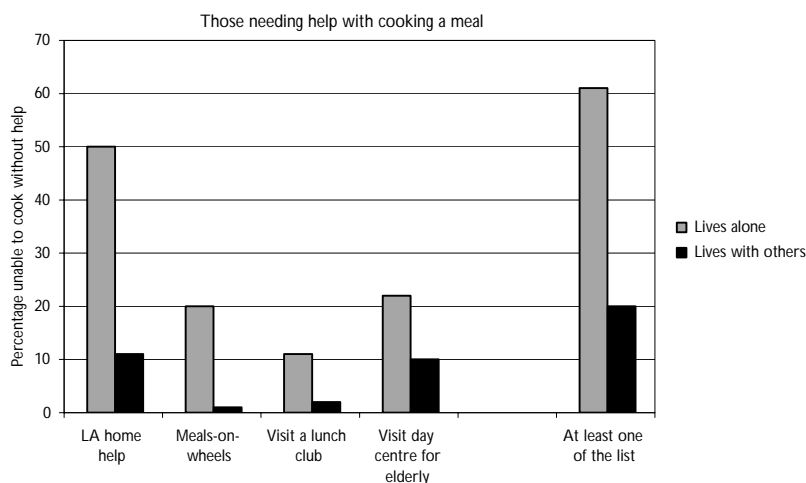
Figure 49: Help with shopping, ages 65 and over, Great Britain, 1998



Source: General Household Survey

A third (34%) of people aged 65 and over who are unable to cook a meal on their own used at least one of the following: LA home help, meals-on-wheels, lunch club, day centre for elderly⁸⁸. This varied considerably with whether the person lived on their own or with others (see figure 50). Those who lived on their own were three times as likely to use one of the services as those who lived with others. Three-fifths (61%) of those living on their own used at least one service compared to a fifth (20%) of those living with others. Those living on their own and unable to cook a meal for themselves were five times as likely to be getting the service of an LA home help. Half (50%) of those living on their own got this service compared to a tenth (11%) of those living with others. A fifth (20%) of those living on their own needing help with cooking got meals-on-wheels. A very small proportion (1%) of those living with others and needing help with cooking received meal-on-wheels.

Figure 50: Use of services, ages 65 and over, Great Britain, 1998

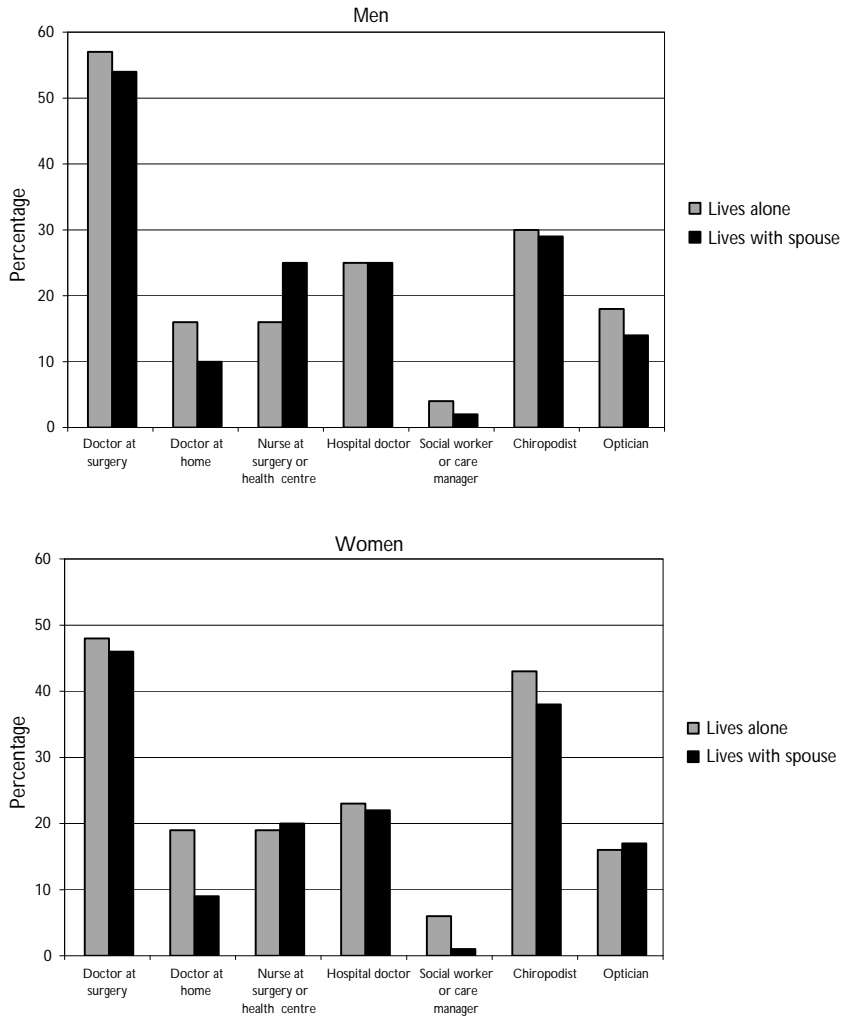


Source: General Household Survey

The increase in one-person households, especially amongst older people, taken with the information about who helps those in need of care, has implications for the future amount of service which will be needed. Even if the proportions looking for help from the NHS or personal social services do not change, the actual number of people needing help will increase because of the increase in those living on their own.

Many of the general health and social service care services are used to the same extent by those elderly people living alone or with only their spouse (see figure 51). The notable exceptions are being visited at home by a doctor and having spoken with a social worker or care manager in the last three months. These are much more common among both men and women aged 75 and over who live on their own⁸⁹.

Figure 51: Use of services in previous three months, ages 75 and over, Great Britain, 1998



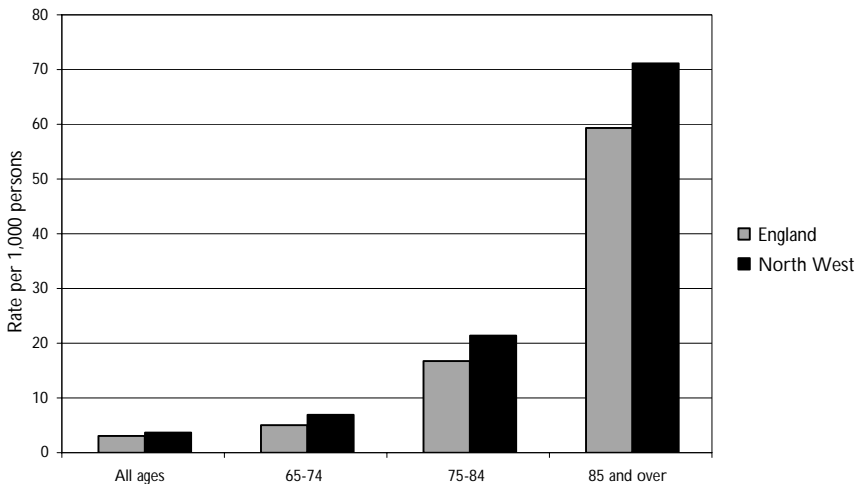
Source: General Household Survey

Nursing home care

In England in 2000-2001, there were 152 thousand people in nursing care beds. Over 24 thousand of these were in the North West⁹⁰. Over a third (36%) of these beds in the North West were occupied by people aged 85 and over, and nearly a further third (31%) were filled by people aged between 75 and 84. The occupancy rate per 1000 people of these ages was higher in the North West than in England as a whole (see figure 52). This may be due to there being more beds available in the North West rather than a greater need, but unfortunately these occupancy rates cannot tell us this.

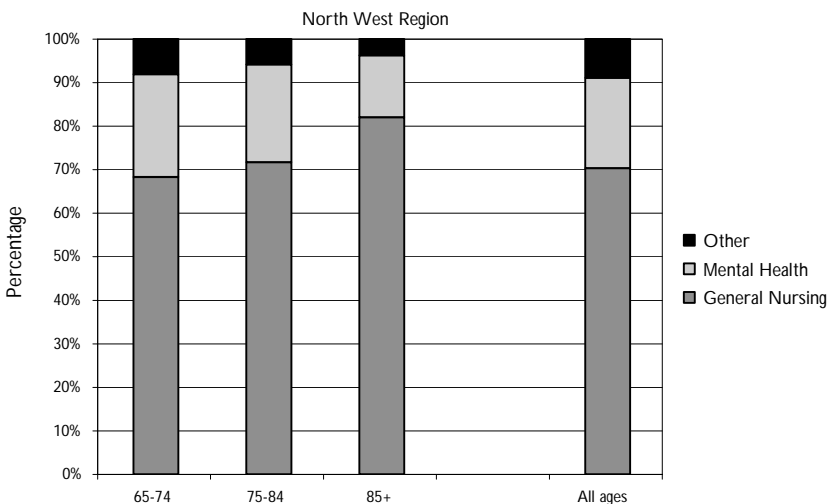
Of the 24 thousand people in the North West who were in nursing beds, the vast majority (70%) were in General Nursing beds with many of the rest (21%) being in beds designated as Mental Health. However the mix was slightly different by age (see figure 53). By the very oldest age group, over four-fifths (82%) of the beds were classified as General Nursing⁹⁰. This followed the pattern in England as a whole. Although the beds may be classified as General Nursing, this does not mean that those in the beds are not in need of or in receipt of specialised mental health care.

Figure 52: Rate of occupied nursing beds by age North West and England, 2000-2001



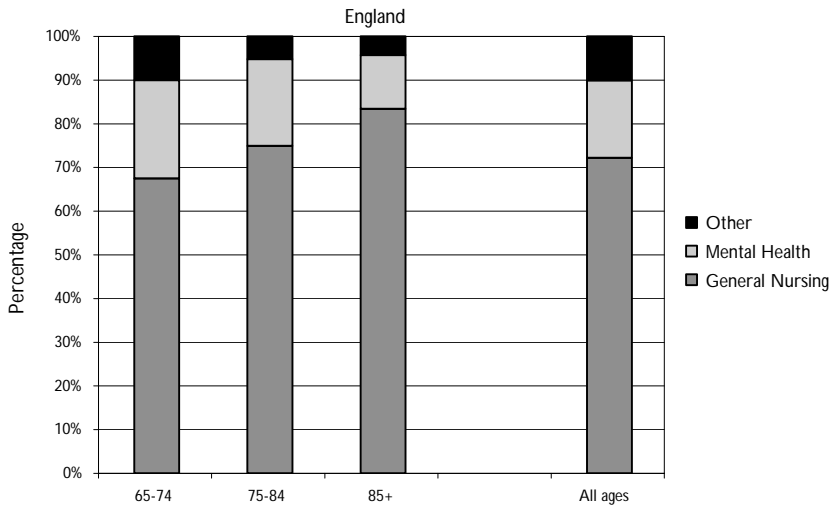
Source: Department of Health, Office for National Statistics

Figure 53: Proportion of occupied nursing beds by type and age, North West and England, 2000- 2001



Source: Department of Health

Figure 53: Occupied nursing beds, North West and England, 2000-2001



Source: Department of Health

Informal care from friends and relatives

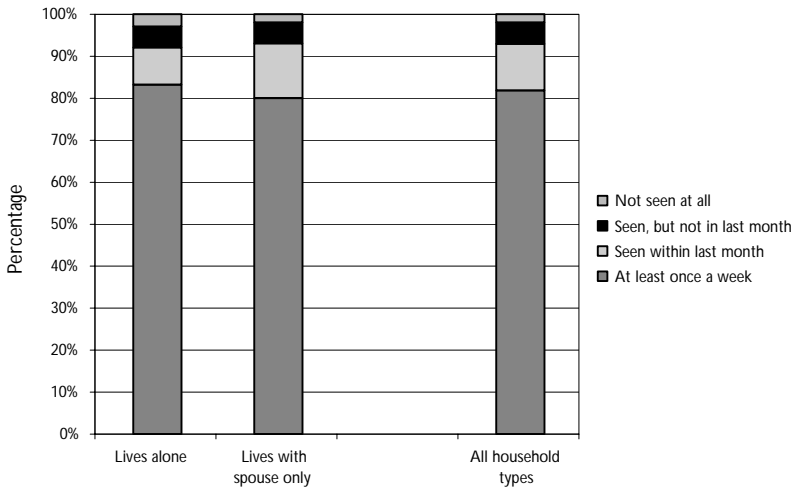
Each year, the Family Resources Survey⁷⁰ has a chapter relating to those giving and receiving care within private households. This is often considered to be informal care. Out of the 28 thousand males and 31 thousand females who were interviewed in 1999-2000, over one thousand males and nearly 2 thousand females were in receipt of care⁹¹. Over half (57%) the males and over two-thirds (69%) of the females in receipt of informal care were aged 60 and over.

It has already been noted in the sections above about particular difficulties that older people have, that much of the help they receive is from friends and relatives rather than through the formal routes of the NHS and personal social services¹⁵. This is particularly true for those living with others and for some types of help, for example shopping, for those living on their own. However, it has also been noted that with the increase in people living alone, this level of informal care may not be available in the future¹⁸.

For older people to get help from their friends and relatives, obviously they need to be in contact with them. In 1998, 2% of older people had no contact⁹² with friends or relatives (see figure 54). Even so, the vast majority saw friends and relatives at least once a week. Four-fifths (80%) of older people living on their own, and slightly more (84%) of those living with only their spouse, saw friends and relatives at least once a week.

Seeing friends and relatives is only one aspect of receiving support from them. The Perceived Social Support Scale⁹³ was designed for the Health and Lifestyles survey. It includes not only the number of contacts with friends and relatives, but further questions on the reasons for the contacts. From the questions, each of which is marked from 1 to 3, a single scale of support is created. The scale is further divided into three groups: no lack of support, some lack of support, and severe lack of support. The HSfE used this system in their survey of older people

Figure 54: Frequency of seeing friends and relatives, ages 65 and over, Great Britain, 1998

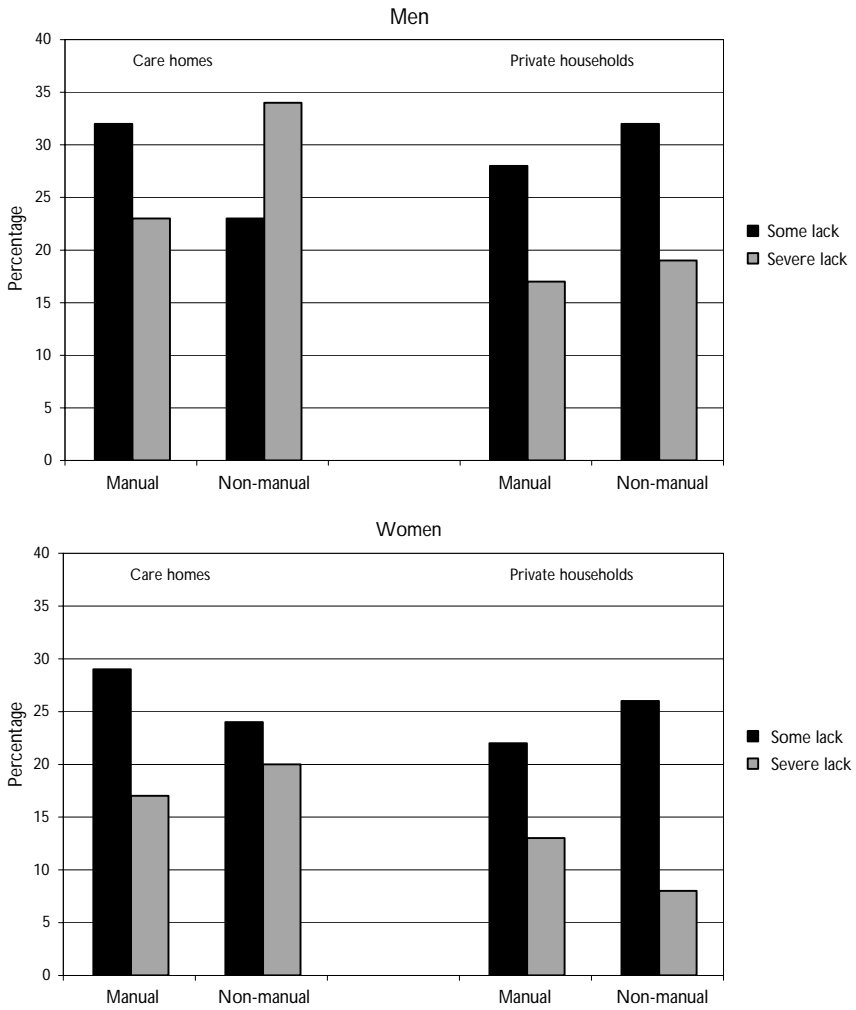


Source: General Household Survey

in 2000⁹⁴. Women are less likely than men to think they lack social support. A third (35%) of women and a half (48%) of men aged 65 and over have some lack of social support⁹⁵. Both men and women who are in care homes have lower levels of social support. This is particularly true for those men who perceive they have a severe lack of social support. A fifth (18%) of men aged 65 and over in private households have a severe lack on the Perceived Social Support Scale compared to three-tenths (29%) of those in care homes. Women aged 65 and over are much less likely to feel they have a severe lack of support, 11% compared to 18% of men, but there is still a difference between those in care homes and those in private households. A tenth (11%) of women aged 65 and over in private households have a severe lack compared to two-fifths (18%) in care homes.

For men in private households, those from the non-manual group have slightly higher levels of both categories of lack of support (see figure 55). For those in care homes, the difference is more marked. Although nearly the same proportions of both manual and non-manual men aged 65 and over living in care homes say they have the social support they need, 44% and 43% respectively, there are large differences in the proportions saying they have a severe lack of support. A third (34%) of men aged 65 and over living in care homes and from the non-manual group have a severe lack of support. This compares with a quarter (23%) of those from the manual group. Higher proportions of men in care homes perceive they have a severe lack of support than those from the equivalent groups living in private households. The patterning of social support for women is the same as for men, except for those aged 65 and over living in care homes from the non-manual group. Here there is a slightly smaller chance of a severe lack of social support. However, this group follows the general trend and it is the men living in care homes from the non-manual group who are different from the rest.

Figure 55: Perceived lack of social support, ages 65 and over, England, 2000



Source: Health Survey for England

6. Disease - specific care for older people

Older people suffer from as wide a range of diseases as any other group in society. Comments have been made earlier in this report about which conditions cause long-standing illness. Three areas have been singled out in the National Framework for Older People for special attention². These are strokes, falls and mental health. Information on these is available from a wide range of sources including special fact sheets from organisations whose particular interest is older people, for example Age Concern⁹⁶ and Help the Aged⁹⁷.

Measuring morbidity is not always easy because data are often collected on service usage rather than on the amount of a particular condition existing in society. There have been specific studies on morbidity, the latest one being the Fourth National Morbidity Survey of GPs⁹⁸. Information from GPs' prescribing and diagnosis is also available from the General Practice Research Database (GPRD)¹⁰¹. This is owned and managed by the Medicines Control Agency. It collects clinical records from over 400 practices across the United Kingdom. Information both on diagnoses and on items prescribed is collected. The number of individuals included makes this a good source for looking at the prevalence of specific conditions in the population¹⁰⁰. Some information is also available from conditions reported as causing illness in the GHS³³ and the HSfE⁴². The number of hospital episodes is available at both a national and sub-national level on an annual basis from the Hospital Episode Statistics (HES) system⁸¹. These data are published annually and are available on the web. The Compendium of Clinical and Health Indicators from the Department of Health is a good source of information about service use for specific conditions¹⁰¹. It contains rates for specific conditions at a sub-national level.

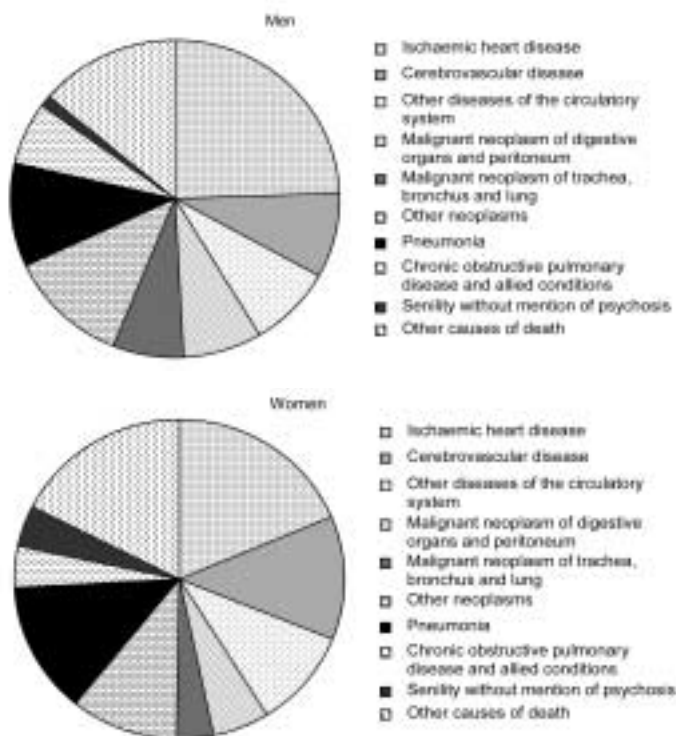
What are the major killers of older people?

Measuring mortality from specific causes is much more readily available. Annual national data are available from the Office for National Statistics¹⁰² and information is also published at a variety of sub-national levels¹⁰³. Again the Compendium is a good source of information¹⁰¹. It has information at Health Authority level wherever possible and for specific causes of deaths.

In England and Wales in 2000, 199,661 men and 244,908 women aged 65 and over died¹⁰⁴. Diseases of the circulatory system – heart disease, strokes etc – accounted for two-fifths of the deaths of men (42%) and women (41%). A quarter (24%) of the deaths of older men and a fifth (19%) of deaths of older women were from ischaemic heart disease. Cerebrovascular disease (stroke) accounted for about a tenth of deaths in these age groups (9% for men and 13% for women) and other diseases of the circulatory system accounted for a further tenth (9% for men and 10% for women). Neoplasms – cancers – caused a quarter (27%) of the deaths of older men and a fifth (20%) of the deaths of older women.

Senility made a very small contribution to the number of deaths, about 1% for men and 4% for women (see figure 56). This is partially because these data do not show all the conditions from which the deceased suffered, but only the underlying cause of death. This does not mean that only 1% of men aged 65 and over and 4% of women of these ages had some form of senility, rather these represent the numbers of people who had senility written as the cause of death on their death certificate by the certifying doctor. More information on the rules governing cause of death decisions after certification can be found in work from the Office for National Statistics¹⁰⁵. The system used for cause of death statistics changed at the beginning of 2001 and care should be taken when looking at trends¹⁰⁶.

Figure 56: Causes of death for people ages 65 and over, England and Wales, 2000



Source: Office for National Statistics.

Strokes

Strokes occur either because a clot narrows or blocks a blood vessel stopping blood getting to the brain, or because a blood vessel bursts and blood leaks into the brain and causes damage. The damage to the brain resulting from a stroke can vary from one person to another. However, stroke is a major cause of disability among older people and can result in admission to long-term residential care. It is considered so important that it has been singled out to have its own section in the National Service Framework² and the standard to be met is in box 5.

Box 5: National Service Framework standard for stroke.

The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.

People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.

Source: Department of Health. Older People, National Service Framework

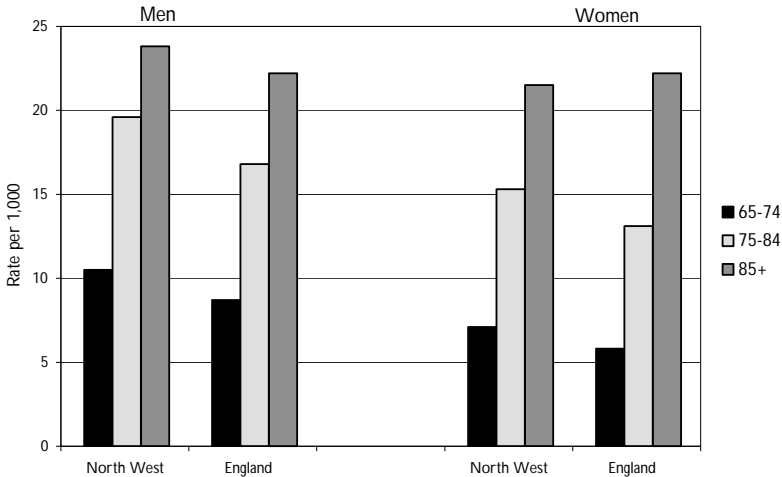
There are many sources of information about the specific treatments for stroke and preventative care to help avoid the onset of a stroke. This section looks at the statistics trying to see the size of the problem in the North West. As ever when the information comes from surveys, samples may be too small to make specific points for the North West, but information is also available from hospitalisation records which should cover all episodes of care for stroke taking place in secondary care.

Are people in the North West more at risk of a stroke?

In England in 2000, there were more than 57 thousand completed spells in hospital because of strokes to people aged 50 and over¹⁰⁷. Over 8 thousand of these were in the North West. Many people who suffer a stroke live with a chronic illness because of it. As can be seen in figure 17, a third of men and a quarter of women who live in private households and report having a chronic illness say this was due to a stroke³³. Figure 24 shows that even higher proportions of those in care homes with a chronic condition have had a stroke. Stroke is more common in the North West than in England as a whole¹⁰⁸. For the years 1994 to 1998, the age standardised prevalence rate for treated stroke in men was 2.1 per 1,000 in England and 2.5 per 1,000 in the North West. For women the rates were 2.4 per 1,000 in England and 2.8 per 1,000 in the North West.

The prevalence of treated stroke rises with age (see figure 57). Men aged 65 to 74 years in the North West have a stroke rate over 20% higher than that for England at 7.1 per 1,000 men¹⁰⁸. For those aged between 75 and 85, the North West rate was 17% higher. For the oldest age group, the rate in the North West was nearer to that of England, 23.8 and 22.2 per 1,000 respectively. This means that about 6 thousand older men are being treated for stroke in the North West. If the North West had the same rate as England for this age group, then this would fall by about 850 to just over 5 thousand men aged 65 and over. For women, the differences are less marked. Even so, if older women in the North West had the same rates as England at these ages, the number of older women needing to be treated for stroke would also fall by about 850.

Figure 57: Prevalence of stroke in the North West and England, 1994-98

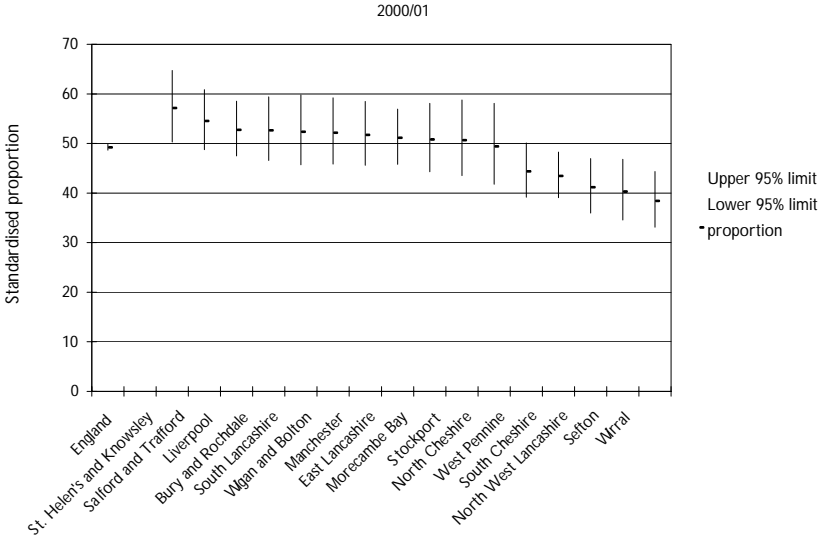


Source: General Practice Research Database

How many people in the North West go back home after having a stroke?

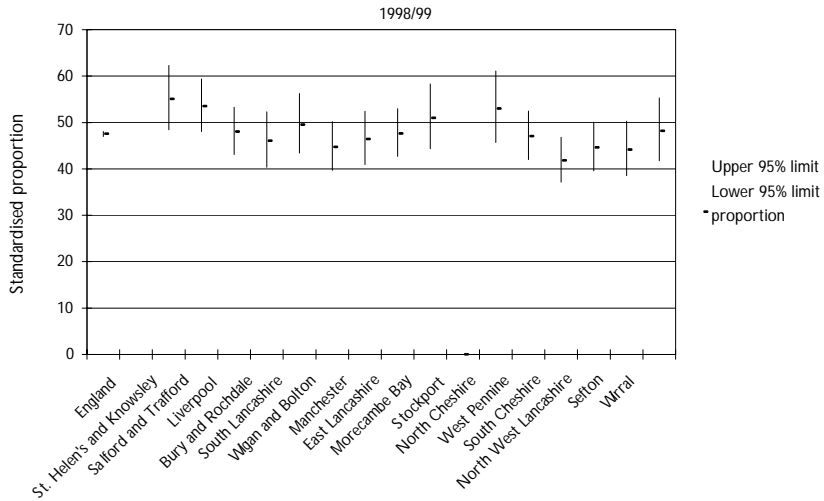
Many people who have a stroke end up in hospital. The NSF for older people states that appropriate care packages should be set in place². Although no information is easily available on the number of such packages, the NHS performance indicators do include the proportion of people who return to their usual place of residence after having been admitted to hospital as an emergency admission after a stroke¹⁰⁷. The indicator includes all those aged 50 and over. Of the 57 thousand completed inpatient spells for stroke in the North West in 2000, nearly 28 thousand resulted in people being discharged to their home. When looking at differences across the areas making up the North West, it is important to take into account that different proportions of old people live in these areas (see figure 1). Thus, the performance indicators take age and gender into account when looking at the proportion of people discharged to their home after a stroke (see figure 58). In 2000/01, four of the Health Authorities making up the North West region had significantly fewer people discharged to home after a stroke than would have been expected after taking into account the age and gender mix of these areas. However, one must be careful when drawing conclusions, as the performance in one year may be different from that in other years. For example, Wirral, whose proportion was significantly below that of England as a whole in 2000/01, was no different from the England value in 1998/99.

Figure 58: Returns to usual residence after hospital treatment for stroke, ages 50 and over, HAs in the North West region



Source: Department of Health

Figure 58: Returns to usual residence after hospital treatment for stroke, ages 50 and over, HAs in the North West region



Source: Department of Health

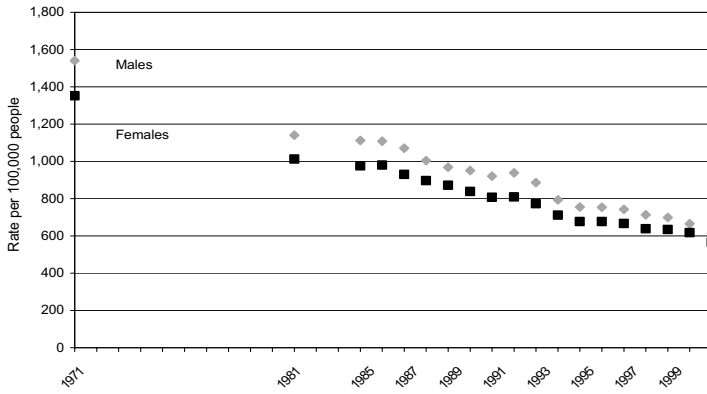
Note: no data for Stockport for 1998/99

How many people die from strokes in the North West?

In England and Wales in 2000, 19 thousand men and 33 thousand women died from cerebrovascular disease—stroke. Over 17 thousand men and 31 thousand women who died were aged 65 and over¹⁰⁴. In 1999, in the North West region, 634 men and 574 women between the ages of 65 and 74 died from strokes¹⁰⁹. Over the last thirty years, the age standardised rates for deaths from strokes in England and Wales have more than halved¹¹⁰, from 1541 per 100,000 men in 1971 to 615 per 100,000 men in 2000 and 1352 per 100,000 women in 1971 to 566 per 100,000 in 2000 (see figure 59). Even in the last ten years, there have been considerable decreases in the death rates from stroke. In 1990, the rate in England and Wales for men was 921 per 100,000 and by 2000 it had dropped by a third (33%) to 615 per 100,000 men. For women the drop was slightly less at three-tenths (30%) from 807 per 100,000 to 566 per 100,000. Death rates from stroke are decreasing across the country¹⁰⁹. In 1989, the age standardised death rate for stroke in men aged 65 to 74 in the North West region was 16% higher than that in England, 350 per 100,000 men and 301 per 100,000 men respectively (see figure 60). By 1999, the rate in the North West had fallen to 245 per 100,000 men. This was still 19% higher than the England figure of 205 per 100,000 men aged 65 to 74.

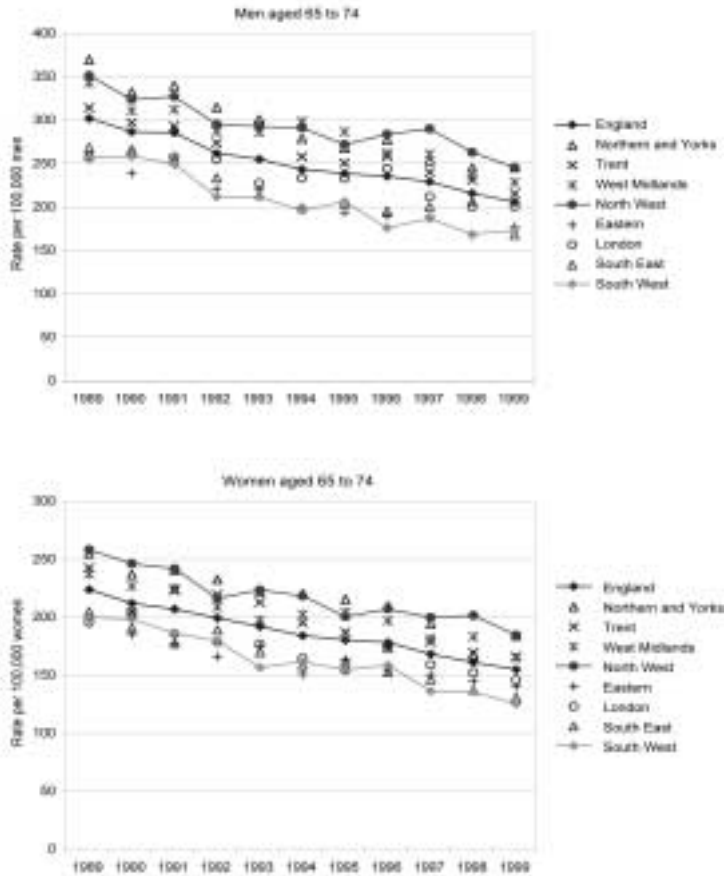
The death rates from strokes in women aged 65 to 74 are lower than those for men of the same ages. They have also been falling in the last ten years. As for men, the death rates in the North West are higher than those in England as a whole. In 1999, the rate for women aged 65 to 74 was 186 per 100,000 in the North West and 156 per 100,000 in England overall.

Figure 59: Age standardised death rates from stroke, England and Wales



Source: Office for National Statistics

Figure 60: Age standardised death rates from stroke, ages 65 to 74, North West and other regions



Source: Department of Health

Falls and accidents

Accidents can occur to anyone at any time. Prevention of accidents is a priority of the government who have set up the Government Accident Task Force¹¹¹. Falls has been chosen as one of the priority areas in the National Service Framework for Older People². Standard six is specifically about this and is in box 6.

Box 6: National Service Framework standard for falls.

The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people.

Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

Source: Department of Health. Older People, National Service Framework.

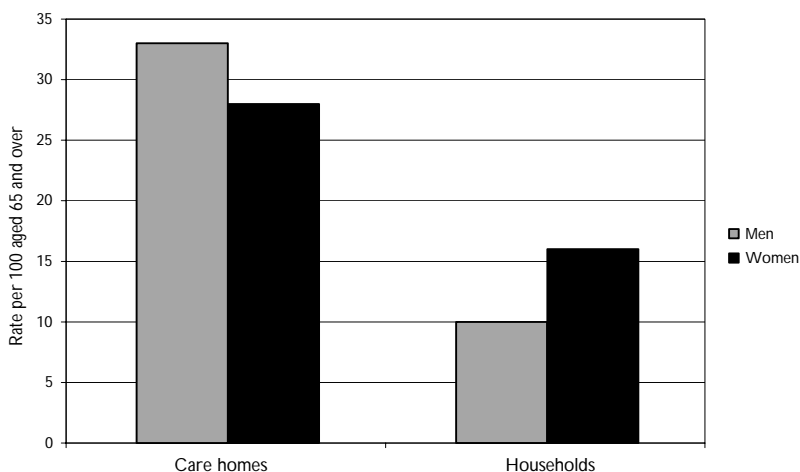
A number of organisations provide information on accidents in an easily accessible manner. These include the Royal Society for the Prevention of Accidents¹¹², Age Concern⁹⁶ and Help the Aged⁹⁷. The Department of Trade and Industry report visits to Accident and Emergency departments annually¹¹¹. A fact sheet is available for older people on accidents,¹¹³ giving information from a number of sources and contact information for organisations with specific policies for accidents. Information is also available on the internet about how to prevent falls happening at www.preventinghomefalls.gov.uk

There are several reasons why older people are more liable to have falls than younger people^{114,115}. As mentioned earlier, older people are more likely to have problems with their eyes, or with their general mobility. These types of problems can result in falls. Older people also tend to live in homes that are older and may not be fully up to standard.

The Health Survey for England (HSfE) defines a major accident as one causing the person to see a doctor or go to hospital²⁴. In 2000, the HSfE concentrated on older people and interviewed those in private households and those in care homes. As mentioned earlier, those in care homes are more likely to have a chronic illness⁴¹. This could be the reason why those in care homes are more likely than those in private households to have a major accident (see figure 61). Those in care homes are about twice as likely to have a major accident as those in private households¹¹⁶.

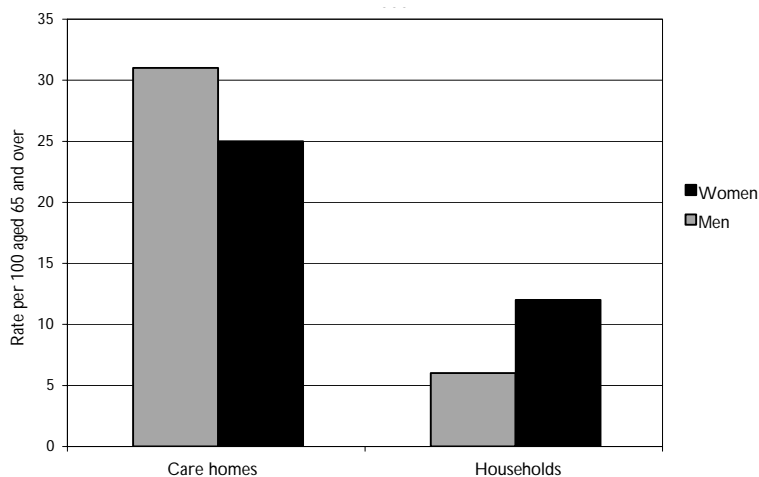
The most common cause of a major accident as defined in the HSfE in both care homes and private households is a fall¹¹⁶. As with overall accident rates, the rates for falls are higher in care homes than in private households (see figure 62). There are nearly 3 million accidents in the home resulting in people having to go to Accident and Emergency departments of hospitals each year¹¹⁷. Of these, nearly a half a million are to people aged 65 and over. If the national rate of accidents is applied to the NW region, this means that about 53 thousand visits to A&E are made by people aged 65 and over in the North West because of accidents in the home.

Figure 61: Annual major accident rates, ages 65 and over, England, 2000



Source: Health Survey for England

Figure 62: Annual major accident rates for falls, ages 65 and over, England, 2000



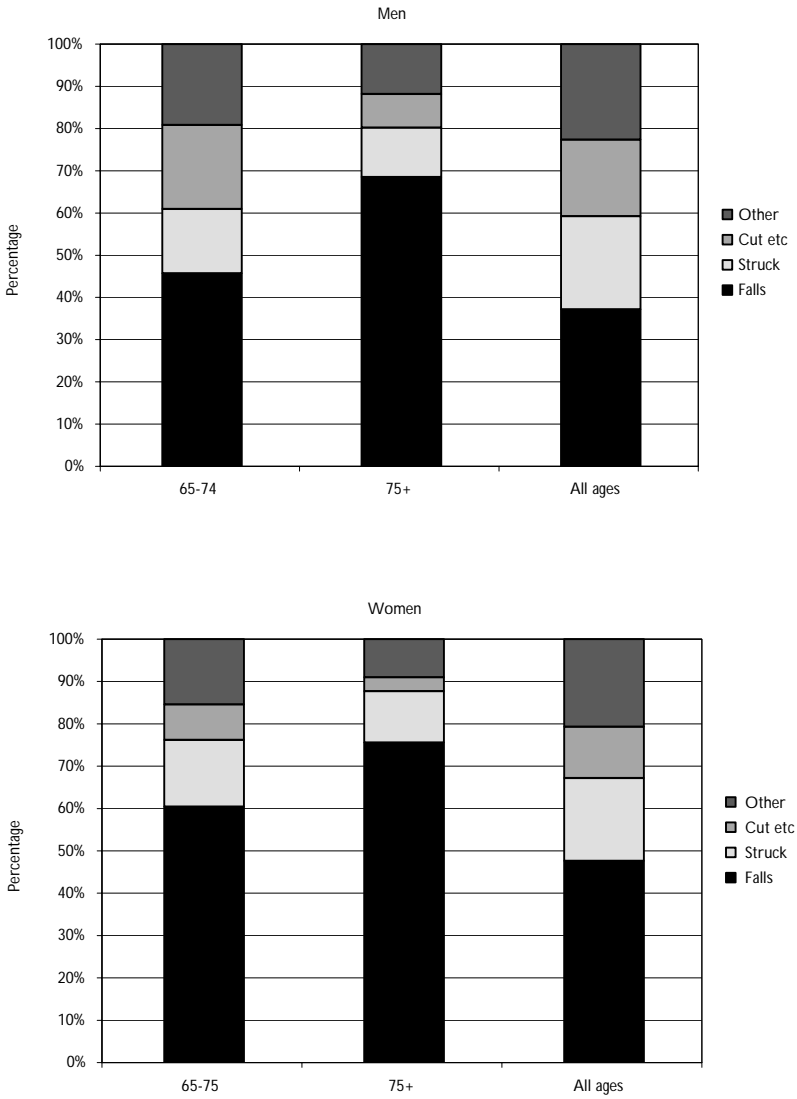
Source: Health Survey for England

What causes accidents at home?

The most common cause of home accidents is falls¹⁷. Women are more likely than men to end up in A&E because of falls (see figure 63). Nearly half (48%) of the accidents to women are because of falls in the home. Over a third (37%) of the accidents to men are because of falls, whether tripping over or falling on stairs etc. One-fifth (21%) of accidents are because a person has been struck by something; a further fifth (22%) by a variety of causes, for example over exertion, burns and scalds, suspected poisoning. The other causes are cuts, tears, punctures etc.

The causes of home accidents ending in a visit to A&E are not constant across the age ranges. Falls are even more likely as the cause for older people, both men and women aged 75 and over. More than two-thirds (69%) of A&E visits after accidents in the home for men and three-quarters (76%) of those for women aged 75 and over are because of falls. If accidents happen at the same rate to people across Great Britain, there are about 15 thousand visits to A&E in the North West region because of falls in the home to people aged 65 and over.

Figure 63: Causes of accident in the home, United Kingdom, 1999

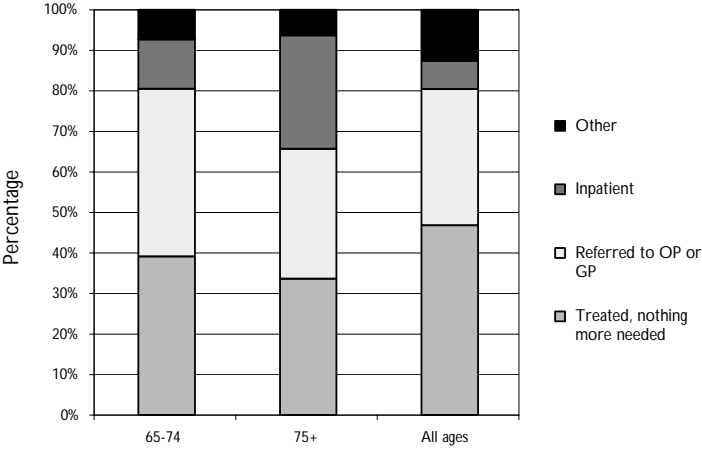


Source: Department of Trade and Industry

What happens to older people after going to A&E because of an accident?

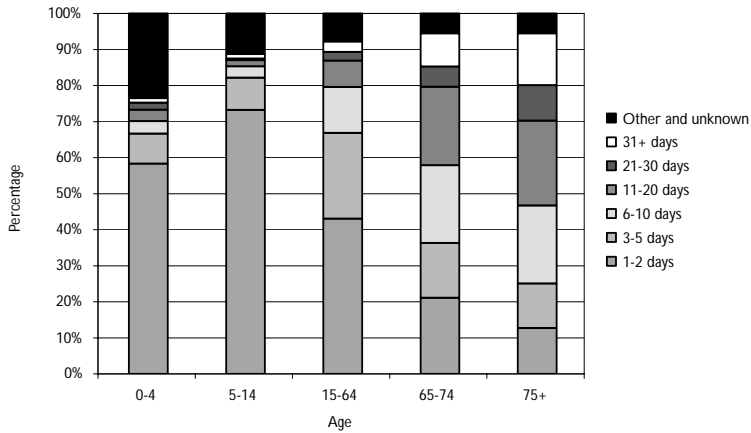
The result of the initial A&E visit after an accident in the home is most commonly treatment in the department and then no further treatment, nearly half (47%) of all visits¹¹⁸. Older people are more likely to be admitted to hospital than younger people (see figure 64), an eighth (12%) of those aged 65 to 74 and over a quarter (28%) of those aged 75 and over compared to less than a tenth (7%) of those under 65. Not only is the result of a home accident resulting in a visit to A&E most likely to be an inpatient stay for older people, the stay is also likely to be longer than those for younger people¹¹⁹. For those aged under 65 who have to have a stay in hospital as the result of an accident at home, two-thirds or more leave in 5 days or less (see fig 65). For those aged 65 to 74, about two-fifths (28%) leave in less than 6 days and for those aged 75 and over, the proportion is smaller at a quarter (25%). This could be because of the nature of the accidents to older people. As mentioned before, many of the accidents happening at home for older people are falls. These may result in broken bones which need to be operated on, or the older person may not have the necessary help at home to enable them to leave hospital after a short time.

Figure 64: Outcome of initial A&E visit, United Kingdom, 1999



Source: Department of Trade and Industry

Figure 65: Duration of inpatient stay visit to A&E, United Kingdom, 1999



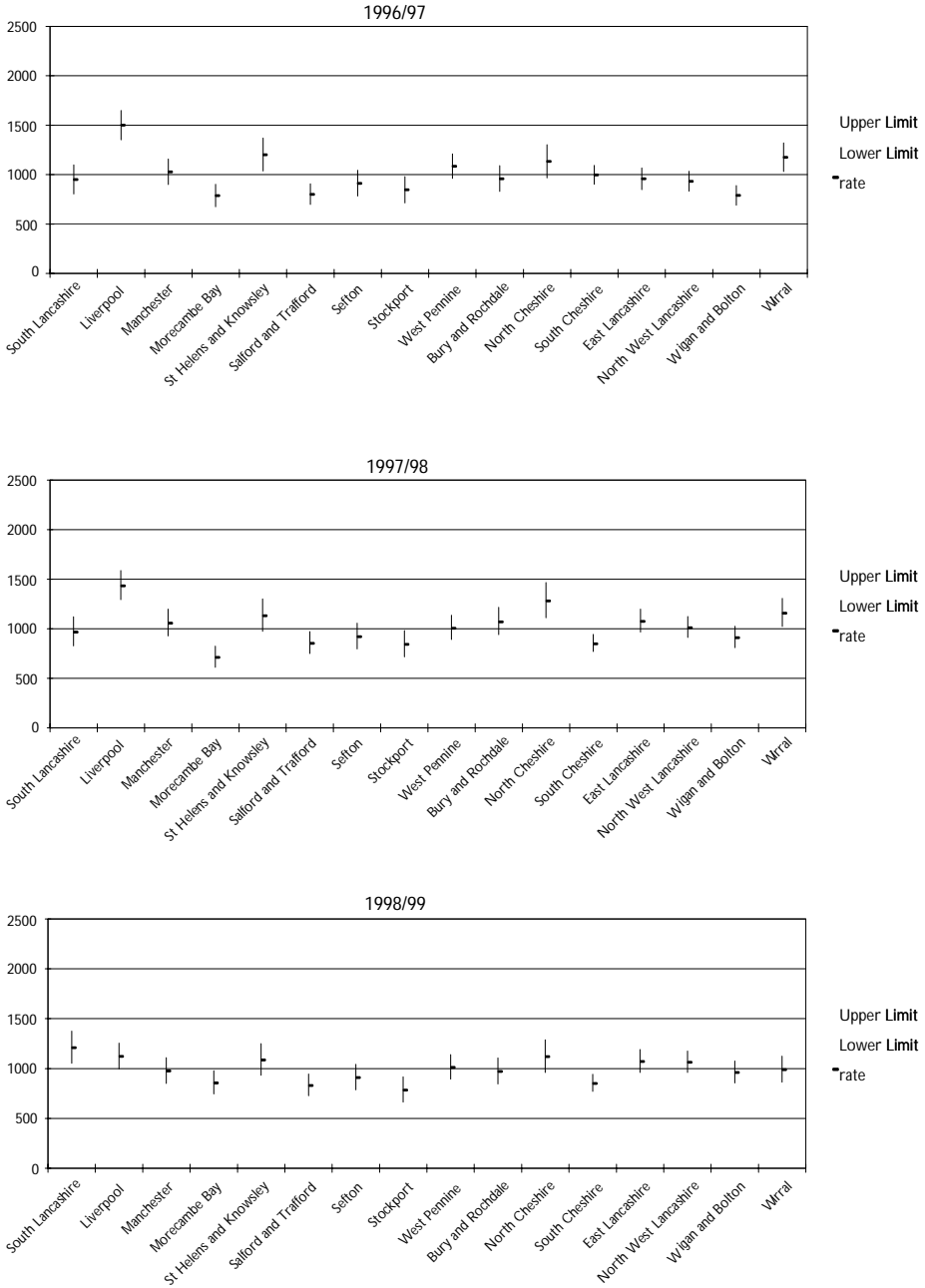
Source: Department of Trade and Industry

Are accidents predictable?

By their very nature, accidents are unpredictable. The rates of hospital admissions because of serious accidental injuries vary greatly¹²⁰, not just from area to area, but from year to year (see figures 66 and 67). In the financial year 1996/97, Liverpool HA had hospitalisation rates for older men significantly higher than the other Health Authorities in the North West region, 1500 per 100,000 men aged 65 and over. This was half as much again as the average for the region as a whole, 997 per 100,000 men. In 1998/99, the hospitalisation rates after accidents were more consistent across the whole region, at about 1000 per 100,000 men aged 65 and over.

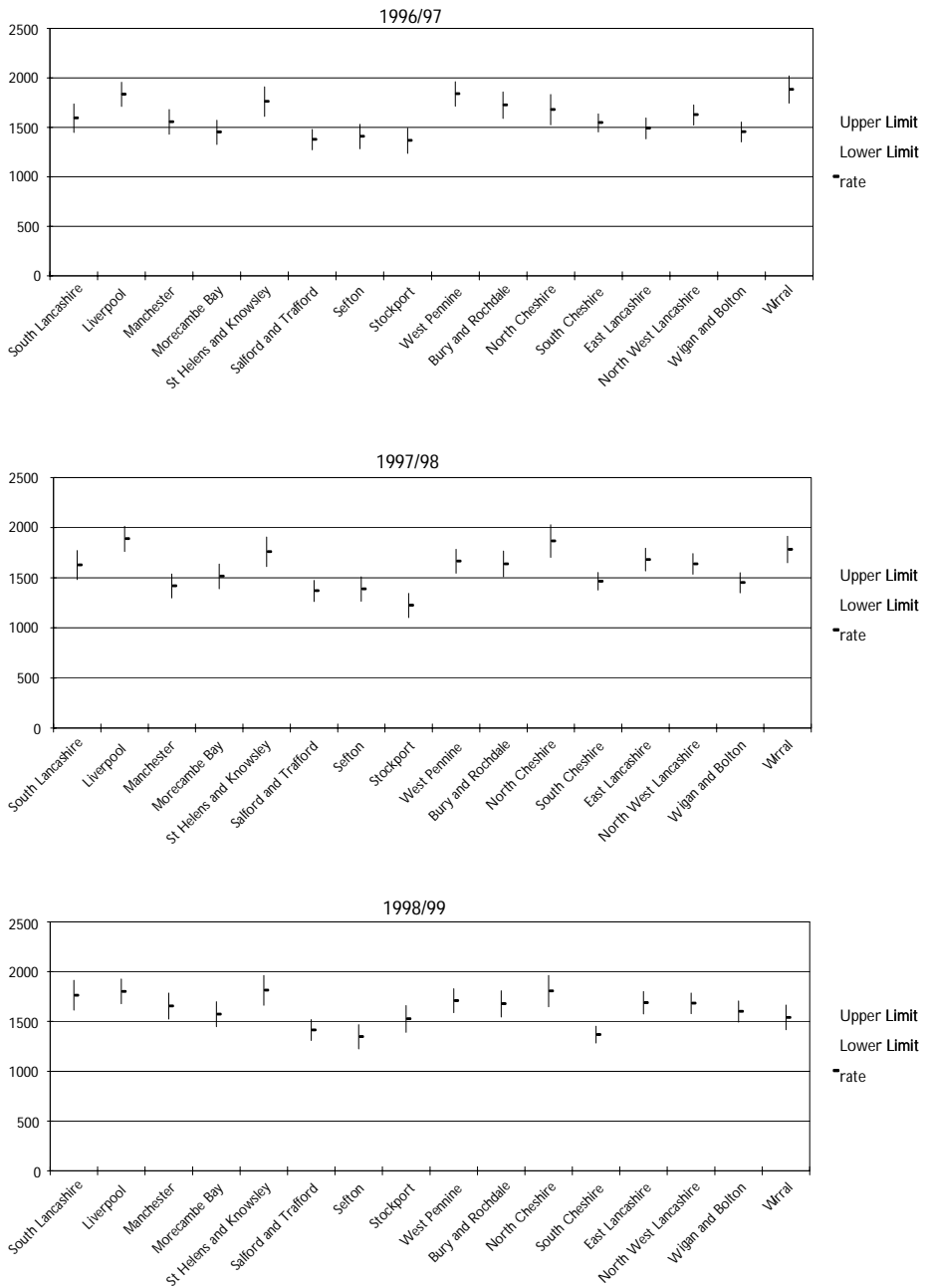
Hospital admission rates for older women are higher than those for men, about 60% higher. As for men, there are no clear patterns across the areas making up the region, nor across the years. For example in 1996/97, there was no statistical difference between the rates for North Cheshire and South Cheshire (1679 and 1546 per 100,000 women aged 65 and over respectively). However in 1998/99, the rate for North Cheshire was statistically higher than that for South Cheshire (1804 and 1368 per 100,000 women aged 65 and over respectively). This clearly illustrates that a single year can give misleading impressions and several years' information needs to be taken into account when looking at accident data.

Figure 66: Serious accident rates, men aged 65 and over, HAs in North West region, Directly standardised rates per 100,000



Source: Department of Health

Figure 67: Serious accident rates, woman aged 65 and over, HAs in North West region, Directly standardised rates per 100,000

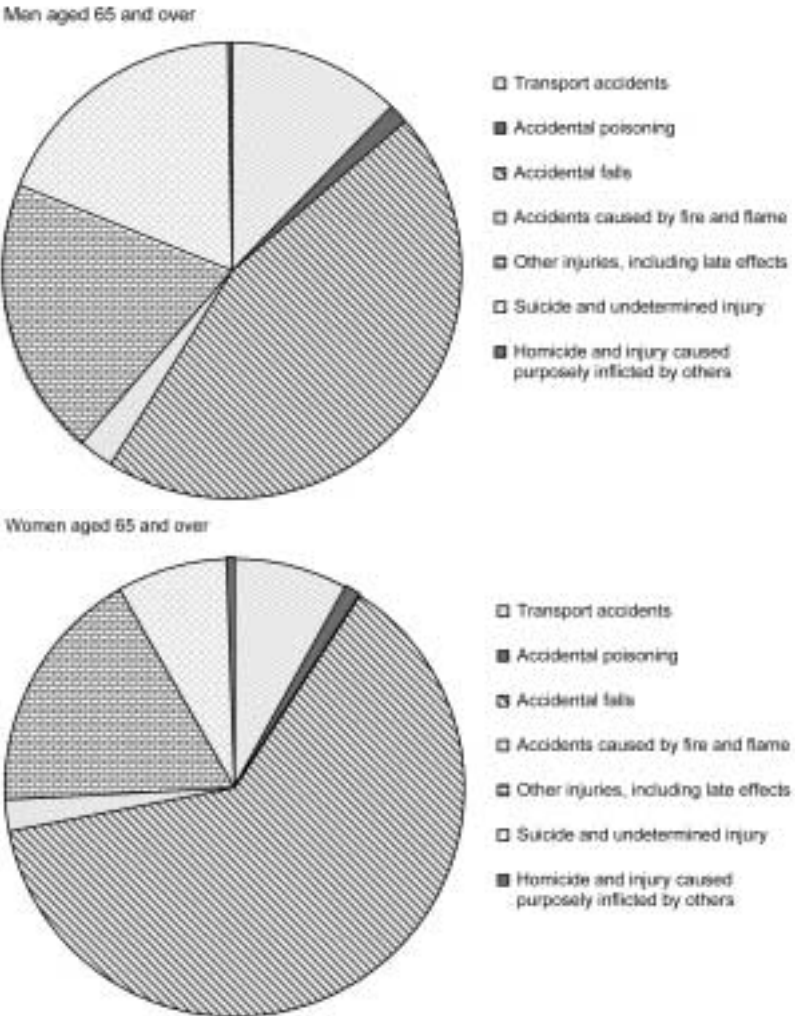


Source: Department of Health

How many deaths are there from injury and poisoning?

In England and Wales in 2000 there were over 6 thousand deaths from external causes of injury and poisoning to people aged 65 and over¹⁰⁴. This accounted for about a hundredth (1.5%) of all the deaths to people of these ages. Within this group are included a variety of forms of accidents - including road, rail and air accidents, deaths from accidents involving fires, accidental poisonings, adverse effects of drugs, misadventures during medical care, abnormal reactions and late complications, and falls. The group also includes deaths from violence, such as suicides and homicides. The largest number of deaths within the group of injury and poisoning for both older men and older women is from falls (see figure 68). Accidental falls killed 1280 men aged 65 and over in the year 2000 and 2346 women¹⁰⁴.

Figure 68: Deaths from external causes, ages 65 and over, England and Wales, 2000



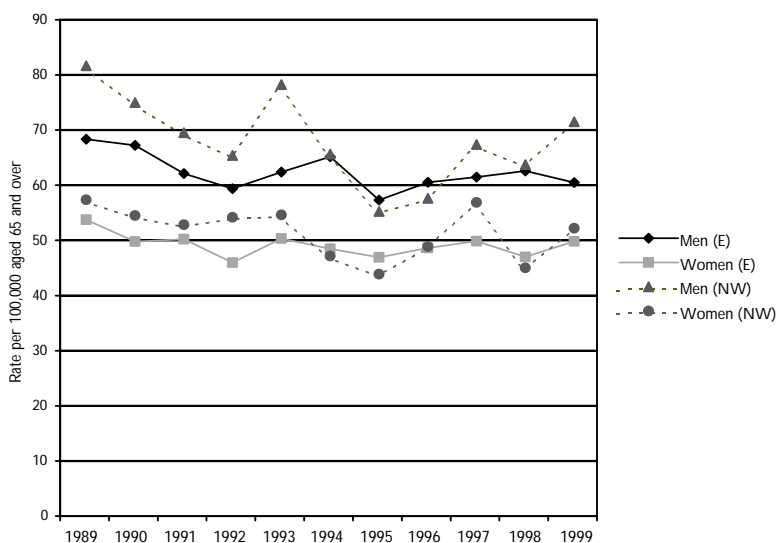
Source: Office for National Statistics

Does the North West have higher accident rates than the rest of England?

Death rates from accidents have decreased over the last 10 years both for men and for women aged 65 and over (see figure 69)¹²¹. In 1989, the death rate for men aged 65 and over was 68 per 100,000 in England as a whole and 81 per 100,000 in the North West region. By 1989 these had reduced to 60 and 71 per 100,000 respectively.

Death rates from accidents are lower for women than for men. This is true at every age¹⁰⁴. In England, the death rate from accidents for women aged 65 and over dropped from 53 per 100,000 in 1989 to 49 per 100,000 in 1999 (see figure 69). For the North West region, the drop was from 57 per 100,000 to 52 per 100,000.

Figure 69: Mortality rates from accidents, ages 65 and over, England and North West region

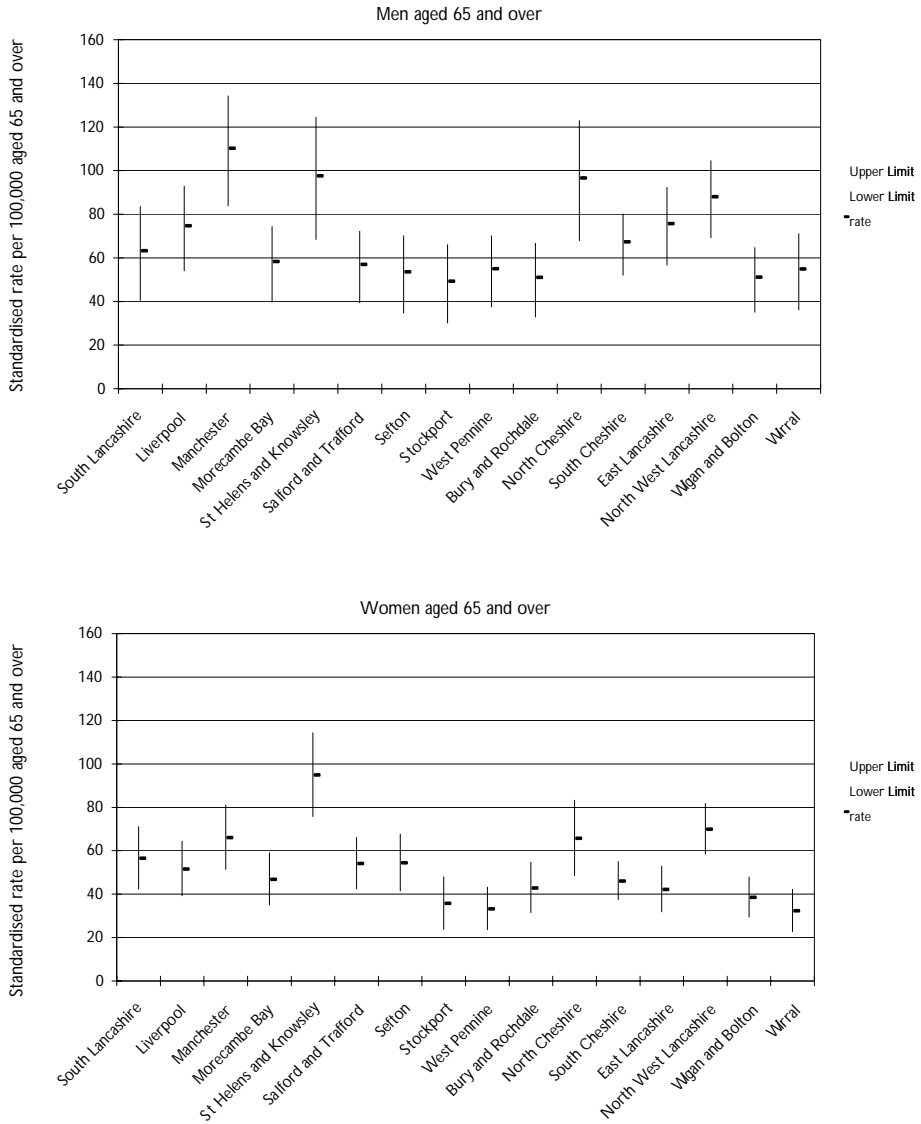


Source: Department of Health

The actual number of deaths in any one year in the North West region from accidents is small, about 200 to 300 men aged 65 and over and 350 to 400 women aged 65 and over¹²¹. This means there is considerable variability in the annual death rates for the region. Even so, the overall trend does seem to be downward.

The numbers of deaths from accidents in individual Health Authorities within the North West region is very small indeed, even when three years of data are pooled together. This makes interpretation of the variation in mortality rates difficult (see figure 70). This further emphasises the random nature of accidents.

Figure 70: Death rate from accidents, ages 65 and over, HAs within N W region, 1997-99



Source: Department of Health

7. Mental health and older people

As mentioned at the beginning of this report, people are living longer than before. However, this extra time is not all spent in good general health. There are many reasons for chronic illness in older people, and high proportions of those living in care homes have a mental illness (see figure 24). In private households, the proportion saying they have a chronic illness which is a mental illness, is quite small, about 2%. However, this increases to about 30% for those living in care homes. There is evidence that mental health problems in older people are not recognised^{122,123}. Mental health problems in older people are not confined to dementias. Significant numbers of older people suffer from depression and anxiety.

The National Service Framework for Older People² has chosen mental health as one of the special areas for comment because of the burden that it puts on the people themselves, their families, and on the NHS and social services which care for them. Standard seven is described in box 7.

Box 7: National Service Framework standard for mental health

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and their carers.

Source: Department of Health. Older People, National Service Framework

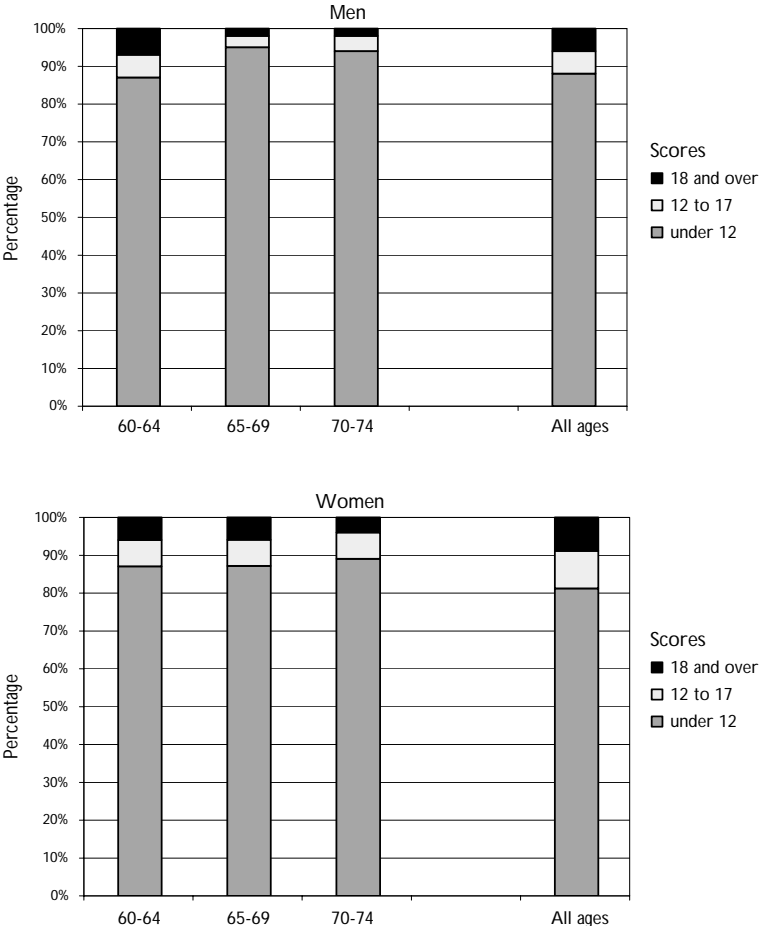
Deciding what constitutes poor mental health is a tricky area. One could stick strictly to medical diagnoses of specific mental health problems, and only consider those who were being treated for these problems. However, this would underestimate the problem. Nearly half (46%) of those identified as having two or more neurotic disorders in the Psychiatric Morbidity Survey in 2000 received no treatment¹²⁴.

The sources of quantitative information on mental health and older people are few. The Psychiatric Morbidity Survey (PMS) of adults living in private households⁴³ only included those up to the age of 74. The Health Survey for England (HSfE) concentrated on older people in 2000 and has some information on cognitive impairment⁹⁴ but not on all aspects of what may be considered mental health. The General Practice Database (GPRD) has information about the prevalence of treated depression, anxiety and schizophrenia⁹⁹ but this information only includes those diagnosed as having a problem and being treated for it. The Hospital Episode Statistics (HES) tables⁹¹ do have detailed information on hospitalisations and diagnoses, but age detail is sparse. It is hoped that the inclusion of mental health as a special area of concern in the NSF will mean that good quantitative data sources for mental health and older people will come on stream in the future.

Prevalence of poor mental health

The Psychiatric Morbidity Survey used the revised version of the Clinical Interview Schedule (CIS-R) to assess neurotic symptoms and disorders⁴³. This consists of several sections, each dealing with a separate type of symptom and given a separate score. These scores are then combined into an overall score. A score of 12 or more on this scale indicates that neurotic symptoms are significant. A score of over 18 indicates that the symptoms are severe enough to need treatment. Women are more likely to have some type of neurotic symptom¹²⁵. A fifth (18%) of women aged between 16 and 74 had a score of 12 or more (see figure 71). An eighth (12%) of men had some evidence of neurotic symptoms. These differences are also evident at older ages. The differences in the proportion of men and women having some symptoms of neurotic disorder at ages 65 and over should be treated with caution. This survey only dealt with those in private households. We have already seen that older men with severe problems are likely to be in care homes.

Figure 71: Neurotic symptom scores (CIS-R grouped) for ages 60 and over, Great Britain 2000

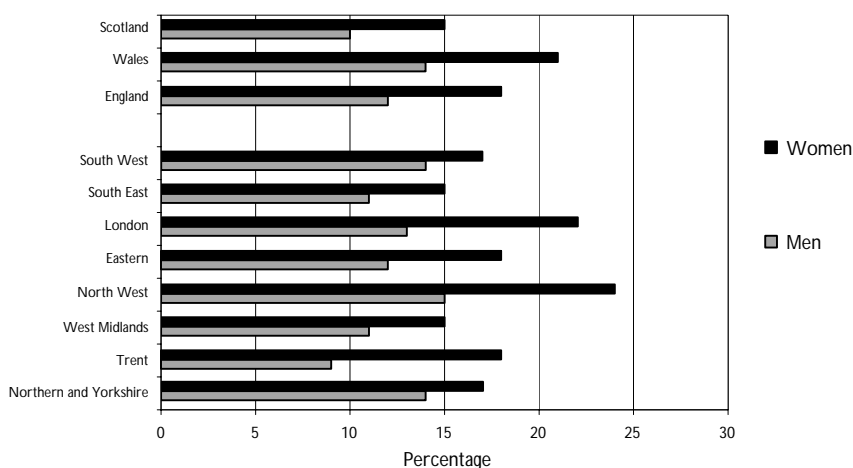


Source: Psychiatric Morbidity Survey of Adults

Is the North West different from the rest of Great Britain?

The proportion of adults living in private households in the North West¹²⁶ who have symptoms of a neurotic disorder (CIS-R score of 12 or more) is higher in the North West than in England as a whole (see figure 72). The difference is particularly large for women where a quarter (24%) in the North West has such symptoms compared to less than a fifth (18%) in England as a whole. The North West has the highest proportion of adult women with signs of neurotic disorders.

Figure 72: Proportion of men and women with symptoms of a neurotic disorder (CIS-12 score or more), ages 16-74, North West and their Regions, 2000.



Source: Psychiatric Morbidity Survey of Adults

Anxiety and depression

The prevalence of neurotic disorders differs substantially depending on the disorder considered¹²⁷. Individuals may have more than one disorder, and so the categories should not be added together to give an overall measure. Mixed anxiety and depressive disorder is more common than the others under consideration. There are some differences across the age range, and between the genders. For men, several disorders are more common at ages under 65 than over 65. This is not so obvious for women (see figure 73). Depressive episode in men aged 60 to 64 is the one case where the prevalence is higher for men than for women, 35 per thousand compared to 14 per thousand. Generalised anxiety is higher among older women than older men, 37 per thousand for women aged 65 to 69 and 30 per thousand for women aged 70 to 74. The rates for men are 14 and 16 per thousand respectively.

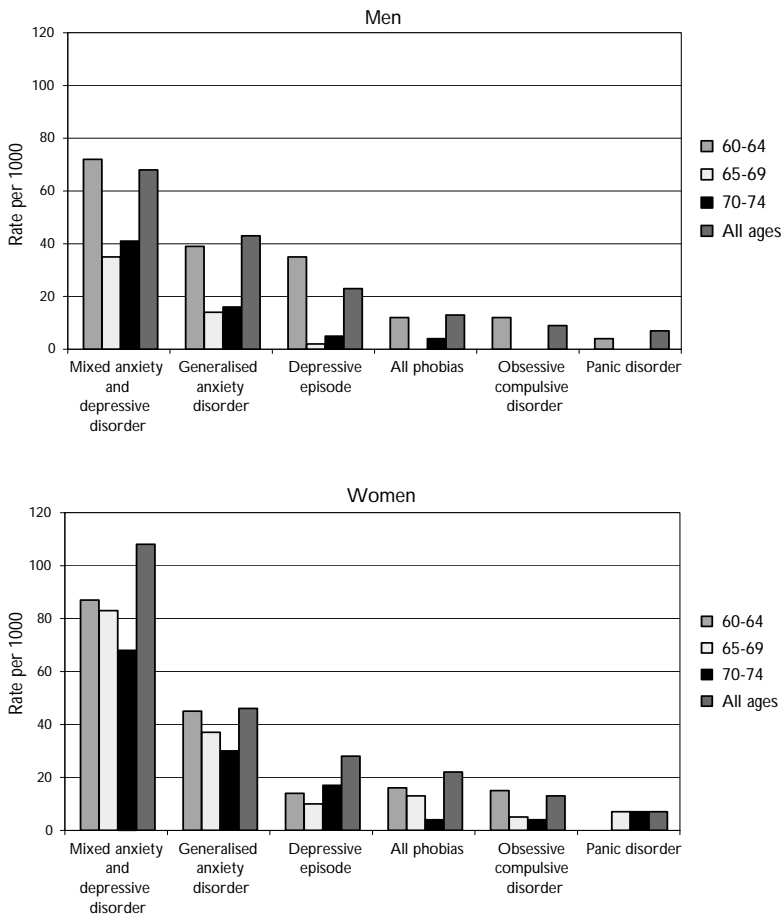
The GPRD has treatment rates for a number of neurotic disorders. One must be careful about comparing information across sources for several reasons. Firstly, GPRD information is collated from the prescriptions written by GPs and so is the number of treated patients. Secondly, there is no indication on the database as to whether the patients live in private households or in care homes. Thus these data are not comparable with those from the PMS.

Are rates the same in the North West?

The rates of treated anxiety are higher in the North West than in England as a whole (see figure 74). The age-standardised rate for men in 1994-1998 in the North West was 29 per thousand patients compared to 22 per thousand in England¹²⁸. For women, the rates were 62 per thousand patients in the North West and 48 per thousand in England. The age-specific rates show similar differences with the North West having consistently higher rates than England.

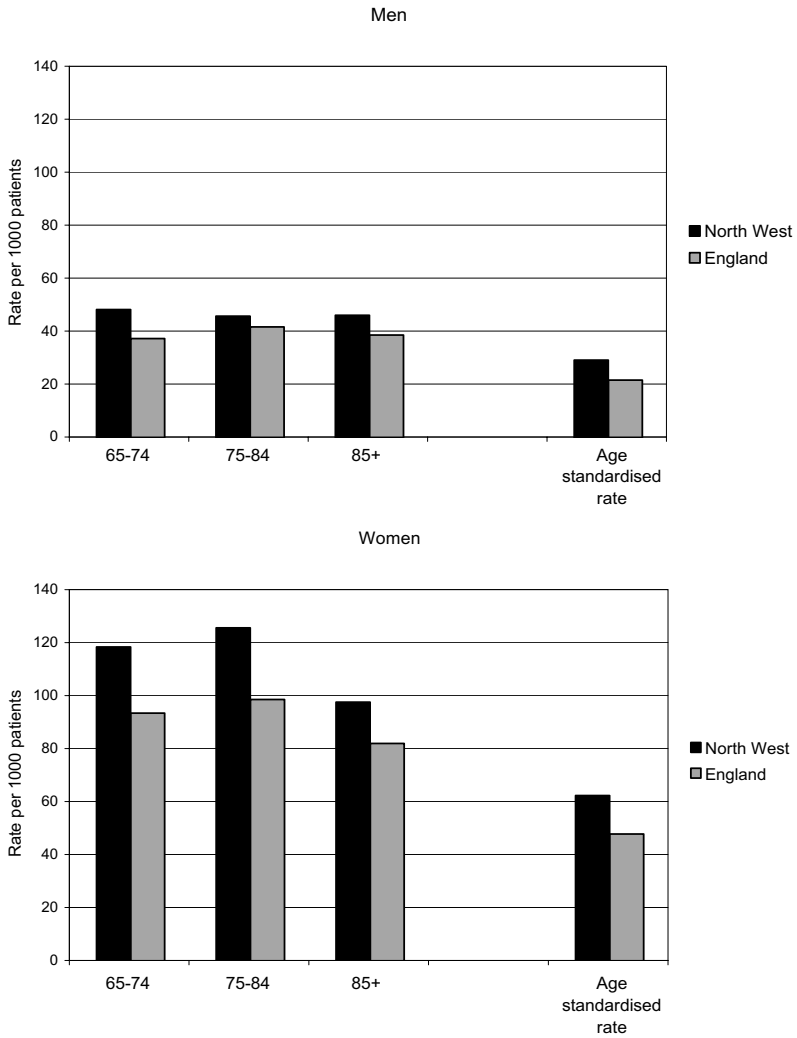
These higher rates in the North West are also evident for treated depression (see figure 75). The differences between the age-standardised rates for the North West and England are not as large as for anxiety, but they are still statistically significant¹²⁹. The rates of treated depression are much higher for women than for men, twice as high in the ages between 65 and 74. This is consistent with the finding in the PMS where the prevalence of depressive episodes in women had even higher differentials.

Figure 73: Prevalence of neurotic disorders by type and age, Great Britain, 2000



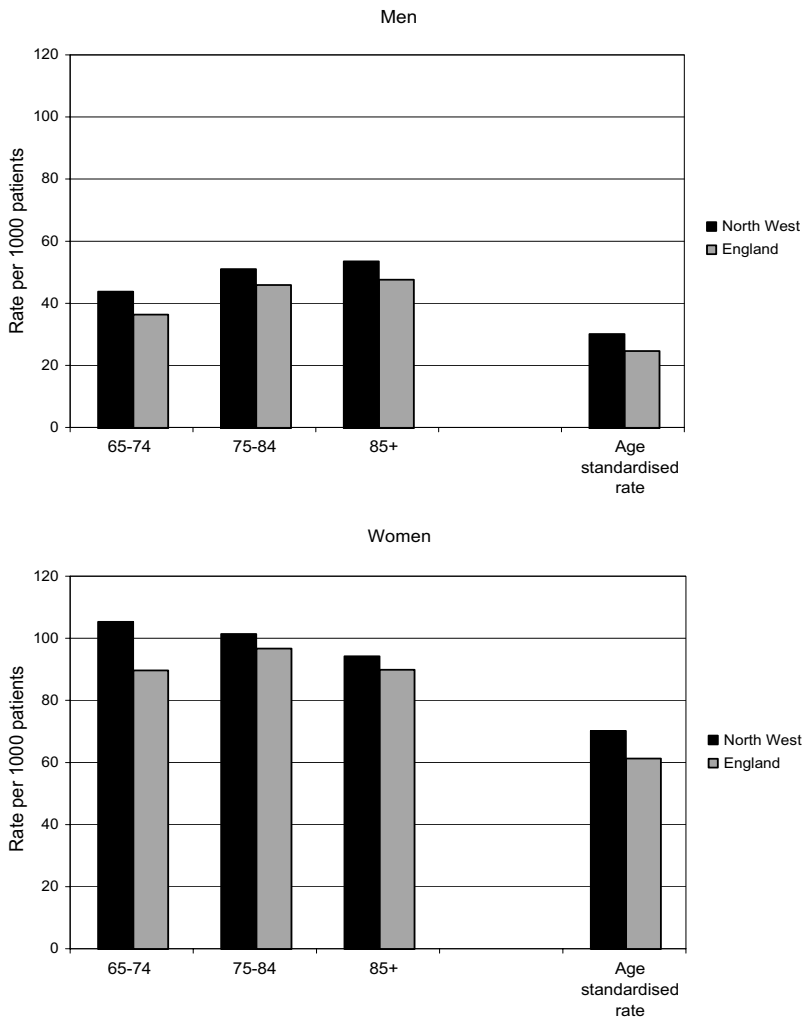
Source: Psychiatric Morbidity Survey of Adults

Figure 74: Prevalence of treated anxiety, North West and England, 1994-1998



Source: General Practice Research Database

Figure 75: Prevalence of treated depression, North West and England, 1994-1998



Source: General Practice Research Database

Severe depression can lead to hospitalisation. In 2000/01 over 30,000 episodes of care in hospitals were for people diagnosed as suffering from depressive episode or recurrent depressive disorder. Nearly two-fifths (39%) of these episodes were for people who were aged 60 or over¹³⁰.

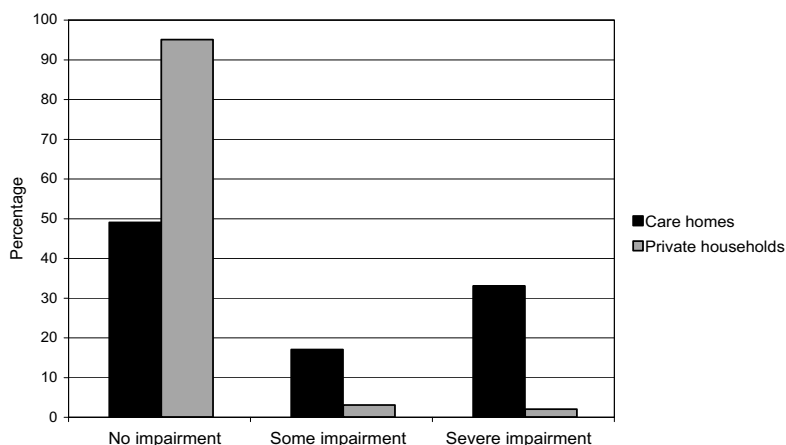
Dementia

There are no up-to-date, easily accessible data on the prevalence of dementia among the general population in Britain. The most recent is from the fourth morbidity survey relating to ten years ago when the prevalence was found to be about 4 patients per GP per year⁹⁸. The 2000 HSFE⁹⁴ did measure cognitive impairment. The test was an adapted version of the Abbreviated Mental Test Score (AMTS), which is easy to administer. The ten questions include

the respondent's age, the date of the interview, the place where the interview took place and recognition of someone the respondent knows well. This test gives a good idea of the level of cognitive impairment in respondents. Cognitive impairment is not exactly the same as dementia, but it has been recommended that GPs should carry out this kind of testing when diagnosing dementia¹³⁰.

The HSfE classified respondents into three groups, depending on the number of wrong answers to questions. Those with less than 3 incorrect answers were classified as no impairment. Those with 5 or more incorrect answers were classified as having severe impairment¹³¹. There is a very different level of impairment between those completing this test in care homes and those living in private households (see figure 76). A third (33%) of those in care homes were considered to have severe impairment while a very small proportion (2%) of those living in private households were in this category¹³². The inclusion of proxy interviews in care homes in the HSfE could lead to difficulties in the interpretation of these data. About two-fifths (38%) of people in care homes did not take this test, compared to only 1% of those living in private households. The reasons were varied, and not necessarily a reflection of impairment. If all those living in care homes are considered, not just those who took the test, then the level of severe impairment does fall, to a fifth (21%), but this is still substantially higher than in private households. Because of the very high completion rate for those in private households, the proportion considered to have severe impairment does not change.

Figure 76: Cognitive impairment in people aged 65 and over, England, 2000



Source: Health Survey for England

In 2000/01, nearly 28 thousand consultant episodes in NHS hospitals in England were because of diagnoses of dementia⁸². Three-quarters (77%) were for people aged 75 and over. Nearly all (97%) were for people aged 60 and over. Dementia in Alzheimer's diseases is included in these figures. However, Alzheimer's disease is also classified on its own, adding a further 8 thousand consultant episodes in 2000/01. In total, dementia and Alzheimer's diseases accounted for nearly 1 million bed-days in hospitals in England that year.

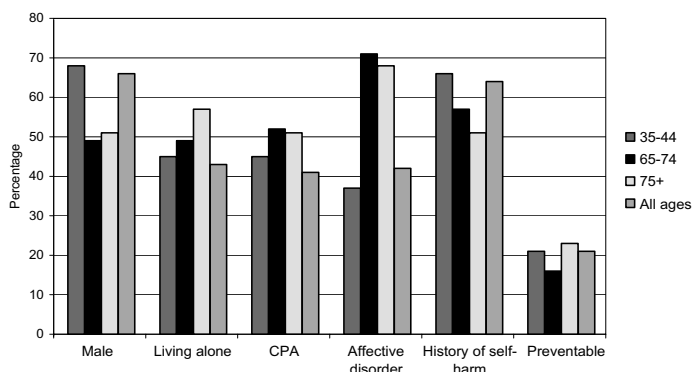
How many older people have mental disorder as their cause of death?

As with several other aspects of mental health, this is not easy to unpick. The International Classification of Diseases (revision 9)¹³³ has a section on mental disorders, which includes dementias. In England and Wales in 2000, there were nearly 11 thousand deaths classified to this grouping¹⁰⁴. More than four-fifths (87%) of these were men and women aged 65 and over. The inclusion of dementias is the reason that so many of these deaths are for older people. Nearly 4 thousand of the deaths in this group were those of older women and over 2 thousand those of older men with senile dementia.

Suicide deaths are of particular interest when talking about mental health. These deaths are not classified under the mental disorders chapter of the ICD, but under the external causes of death chapter¹³³. Deaths classified as suicide or injury undetermined as to whether accidentally or purposely inflicted are normally grouped together because most of the undetermined (open verdicts at coroners' courts) are considered to be self-inflicted but with not enough evidence for a formal verdict of suicide¹³⁴. Less than a thousand deaths a year for older men and women are from suicide¹⁰⁴. About two-thirds (64%) of these are for men aged 65 and over.

The report from the National Confidential Inquiry into Suicide¹³⁶ looked at a large number of suicides over a period of five years. Nearly 600 deaths from suicide for people aged 65 and over were examined in detail, especially as to the contacts these people had with medical services before their deaths. Unlike other age groups, about half of suicides in older people investigated were women (see figure 77). In younger age groups, suicides in contact with services in the 12 months before their death were more likely to be men than women; two-thirds (66%) of the suicides investigated were for men¹³⁶. As mentioned above, two-thirds of the suicide deaths in this age group are for men. Over half (57%) of those suicides aged over 75 lived alone, compared to two-fifths (43%) of all investigated. Older suicides were slightly less likely to have a history of self-harm. Even so, more than half did have such a history. About half of older people who committed suicide and had been in contact with mental health services in the previous 12 months were subject to a Care Programme Approach (CPA) at a level requiring multi-disciplinary review. This was slightly higher than those investigated of any age. The high incidence of affective disorder in the older age groups of suicides may be because of the incidence of such conditions in older people. The health care professionals who had been dealing with these people before their deaths thought that about a fifth of the deaths were preventable. This was fairly steady across the age ranges.

Figure 77: Suicides in contact with services in 12 months before death, 1996-2001



Source: National Confidential Inquiry into Suicide

8. Sources of information

Throughout this report, sources are mentioned at the beginning of each section and very detailed references are given to all documents used. However, this report only uses a very small part of the vast array of information available on older people. This section tries to bring together a reasonable selection of this vast information load. Much of what is available on paper is also available via the internet. As mentioned above, the sources giving socio-economic information to be able to look at inequalities are much fewer than those giving information by age, gender or area.

Paper-based sources

The Office for National Statistics (ONS) annually publishes the numbers of the population by age and gender⁴. Information is also available by geographical area, both local authority and health authority. The latest information is for mid-2000. ONS also publishes estimates of ethnic minority population by age, usually in an article in *Population Trends*. The latest estimates are for 2000 and give national estimates by gender and age⁵. Work is ongoing to produce estimates by geographical area. The 2001 Census will give counts by small areas, even smaller than local authority or health authority. This information should become available in 2003.

The Government Actuary's Department calculates population projections and life expectancy⁶. Healthy life expectancy is becoming a more important indicator. As mentioned earlier in this report, it is used in many of the government's strategies and is being developed by ONS. The latest national figures relate to 1997 and an update is due later this year¹³. At present, information is available at national level by gender and for specific ages. Sub-national estimates are being developed.

Household projections, the number of households and their makeup, are the responsibility of the Department for Transport, Local Government and the Regions. The information is primarily to help plan housing needs and so is on a local authority basis. The latest information gives projections up to 2021¹⁶.

The amount of money pensioners have is available annually from the Department for Work and Pensions from the Family Resources Survey¹⁹. This also looks at sub-national areas. The Pensioner's Income Series also uses this source. This brings together a variety of information particular for pensioners²⁰. The Department for Work also produces information on benefits in the statistical series, Client Group Analysis, pensioners²¹.

The major annual survey giving information about general living conditions in Britain is the General Household Survey from the Office for National Statistics, the latest being for the year 2000/01²². The survey has been in progress for 25 years. It enables one to see changes in household composition, ownership of consumer durables, general health status, use of health services, smoking and drinking, and a multitude of other indicators. It is usually annual, with a few exceptions and is recently been published under the title *Living in Britain*. Information is mainly in the form of tables, and there is some commentary. There are occasional special editions on the elderly²³ with extra questions asked of older people. The latest was for the year 1998/99. This includes questions on mobility and specific use of personal social services and care.

The Health Survey for England is commissioned by the Department of Health. It has a long series of information about, for example, falls and accidents as well as general health and heart disease. The latest survey had special sections for older people and for those in care homes³⁹. This source gives very valuable information about differences between those in different living arrangements. The Department of Health has a large number of statistical bulletins covering a wide range of service usage information. This is usually collated from administrative systems, and so socio-economic information is lacking. This makes looking at inequalities particularly difficult in this area.

Web-based resources

Nearly everything which is mentioned above is either already available via the internet, or is soon going to be available in this format. Box 8 gives a list of websites for government departments that have information of particular interest to those looking at older people. A good place to start when looking for government sites is www.ukonline.gov.uk, which includes links to all government departments and many government-sponsored organisations. If you need to look for specific statistics, www.statistics.gov.uk has many statistics on it grouped in themes. The ones of most relevance are probably [health and care](#) and [population and migration](#). It also contains links to statistics available from other government departments.

The internet is vast, and many sites give helpful information related to issues for older people and their health. These are very wide ranging and the list in box 9 is not, by any means, all the possibilities. A good search engine will give many more sites, depending on the actual area in which you are interested, health of elderly people, specific conditions, pensions, care and so on. These include sites set up by the government but run by non-governmental bodies. Many of the more general sites listed in box 9 give links to other organisations that may be of use as well.

Box 8: Some useful government websites

Department for Environment, Food and Rural Affairs: www.defra.gov.uk

Department for Transport, Local Government and the Regions: www.dtlr.gov.uk

Department for Work and Pensions: www.dwp.gov.uk

Department of Health: www.doh.gov.uk

Home Office: www.homeoffice.gov.uk

Government Actuary's Department: www.gad.gov.uk

Box 9: Other useful websites

General advice and information

www.ageconcern.org.uk
www.helptheaged.org.uk
www.bettergovernmentforolderpeople.gov.uk

Information about disability

www.disability.gov.uk
www.mobility-unit.detr.gov.uk/mavisgen.htm
www.acts.org.uk/diel/default.htm

Alcohol education and research

www.aerc.org.uk
www.portman-group.org.uk

Health and smoking

www.doh.gov.uk/scoth/index.htm

Accidents

www.rospace.co.uk
www.preventinghomefalls.gov.uk
www.safety.dtlr.gov.uk/fire/index.htm

General health information

www.ohn.gov.uk
www.gprd.com
www.had-online.org.uk
www.minorityhealth.gov.uk

Information for carers

www.carers.gov.uk/contents.htm

Information about pensions

www.pensionguide.gov.uk
www.pensions-ombudsman.org.uk
www.thepensionerservice.gov.uk
www.warpensions.gov.uk

Specific conditions

www.alzheimers.org.uk
www.arthritiscare.org.uk
www.arc.org.uk
www.mind.org.uk

Access to data

The data behind many of the statistics in this report are from surveys. The raw data from national surveys are usually held at the Data Archive at Essex University. This means that registered researchers can do further analysis from the raw data. The Data Archive is at www.data-archive.ac.uk. Raw data from administrative sources, for example death records and hospital systems, often have access restricted by data protection law. However, information at low levels, and in some instances the whole record, are made available to the NHS for research purposes. Access to these sources is via the regional office or the local Public Health Observatory.

Information on inequalities and older people

Information sources for the health of older people are numerous, and varied as to the level of data included. It is relatively easy to look at a wide range of indicators of health-status by age and gender. Living arrangements are also fairly widely available as an indicator on general health surveys. Unfortunately other measures of socio-economic circumstances are not so easily available for older people and so looking at inequalities and health for older people can be problematic. Most administrative systems do not include information for older people that would enable them to be classified according to occupational classifications, for example social class or socio-economic group. For older people, the most commonly available classifying

variables are gender and area of residence. As many of the data come from surveys, area classifications are not normally available for these data. In the future, the Government's commitment to tackling inequalities should mean that sources of information for older people, their health-status and socio-economic circumstances will become more easily available.

As mentioned earlier in this report, healthy life expectancy is already used as a target in several government strategies⁹⁻¹¹. The indicator is still undergoing development and the latest available information¹³⁸ gives information about healthy life expectancy at birth for health authorities in England. This shows the usual north-south divide found in many health indicators. The ongoing work should include looking at differences in this important summary measure for older people as well as for people of all ages.

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