



**UCD GEARY INSTITUTE
DISCUSSION PAPER
SERIES**

SHARE Ireland First Results

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1. Introduction

1.1 Background

The developed world in general, and Europe in particular, is facing a dramatic demographic transition. Total fertility ratios (TFR) in Europe are stable at levels well below that required to maintain current levels of population, and in 2006 the median TFR was an unprecedented 1.3 children per woman (Kohler et al., 2006). From 2015 the death rate will exceed the birth rate, and the European Union will be reliant on migration to maintain its population. Consequently, its citizens are predicted to age significantly over the coming decades, and by 2050 half of its population will be over 50. Ireland represents somewhat of an exception to the European trend, with population expected to grow to 6.7 million by 2060. Despite this, Ireland will also face the burdens of an ageing population. By 2021 the proportion of total population aged over 65 will have grown by 59 per cent, and by 2061 a further 142 per cent. The ratio of people of working age to people over the retirement age will decrease from 5.6 in 2006 to 1.8 in 2061 (Green Paper on Pensions, 2007).

The force of this demographic transition will impact on all facets of society, however it will impose an important financial burden on two areas in particular; public pension provision, and the health service. Overall, age-related spending is projected to rise from 5 per cent of GDP currently, to 13 per cent by 2050 (Green Paper on Pensions, 2007). Specifically, pension costs have been predicted to rise from 3 per cent of GDP in 2002 to 8 per cent in 2050 (Bennett et al., 2003). The urgency of this problem is such that the Irish government were prompted to set up the National Pension Reserve Fund in 2002. By 2050, it is expected that payments from the Fund will be equivalent to 3.5 per cent of GNP annually, or 25 per cent of total pension costs up to 2070 (National Pension Reserve Fund, 2007).

In addition to these financial concerns, such a change in demographic structure will likely require an increased focus on the welfare of those aged over 50. Despite recent improvements, in 2006 Ireland still ranked behind 15 other European countries in terms of life expectancy at age 65 (Eurostat). Recent research has emphasised that a wide variety of factors have the potential to impact on well being. These including economic, social, environmental and mental factors (World Health Organisation, 2002).

It is therefore vital for researchers and policy makers alike to have comprehensive data on the characteristics of the growing section of their populations, i.e. the over 50s. Funded mainly by the European Union, the Survey of Health, Ageing and Retirement in Europe (SHARE), provides such a resource. It is the first study to involve a comprehensive, pan European, multi disciplinary investigation of this particular age group (Buber et al., 2006). Established specifically to address the issues mentioned above, SHARE follows the approach successfully implemented by the English Longitudinal Study of the Ageing (ELSA) in the UK, and the Health and Retirement Survey (HRS) in the US. The first wave of SHARE was conducted in 2004/5 and featured 11 different countries across the EU (Denmark, Sweden, Austria, France, Germany, Switzerland, Belgium, the Netherlands, Spain, Italy and Greece). In 2005 Israel was added to this group. In 2006/7 the second wave extended the survey to include the Czech Republic, Poland and Ireland. Later this year, data collection for SHARELIFE (an interim wave focusing on reconstructing the life histories of the respondents involved), will be undertaken in 14 countries. The fourth wave will incorporate Slovenia and will ultimately represent a panel of over 30,000 individuals in 16 countries.

Two aspects of SHARE set it apart from other surveys. Firstly, SHARE represents the results of close international cooperation. The consultation process on the project's development has involved experts from across Europe, and the same structural and methodological guidelines have been implemented across all participating countries. The degree of harmonisation achieved in SHARE means that researchers can have confidence that they are accurately describing the differences and similarities in the ageing process across Europe (Börsch-Supan et al. 2005). Policy makers can also evaluate how the effects of similar interventions could vary across countries. In addition, SHARE is compatible with the aforementioned HRS and ELSA surveys. As well as providing national micro data on health, socio-economic status and social and family networks, the surveys can be aggregated, giving researchers access to a longitudinal database of over 30,000 individuals across Europe. A sample of this magnitude provides a powerful resource to researchers working in variety of different fields and testing a wide range of hypotheses.

Secondly, SHARE adopts a multidisciplinary approach. This enables a wider perspective and a better understanding of the crucial issues affecting this age group. As mentioned, economists are becoming increasingly interested in the psychological and biological aspects of behaviour. For example, the decision to retire has traditionally been examined in the context of various financial considerations, however Thaler and Benartzi (2004) show that the way people think about the future (independent of their resources), is also important when it comes to pension plan enrolment. Other recent research has emphasised the role of a persons' health in the decision to

retire (Smith, 1999). The scope of the SHARE questionnaire enables closer investigation of this and other issues of interest to economists, psychologists and epidemiologists and other researchers.

Survey data from the first round of the European study are freely available on the SHARE website (www.share-project.org), and the second wave of the European study (including Ireland) will be available from November 28th. Data collection on the next wave of the European study will commence at the end of this year. Subject to funding, Ireland will conduct this study throughout 2009.

1.2 Structure

SHARE is a longitudinal study, following the same group of people over time. It is intended to be biennial; however an interim module on life history, employment and health will be conducted in 2009. Participants were chosen to be a representative sample of the population over 50 years of age in each of the participating countries. Individuals in institutions were not surveyed (except for Denmark), however those involved may move to an institution at a later stage and due to the longitudinal nature of the project these individuals would then be included. All members of a household aged 50 and over are surveyed as are their partners (irrespective of age).

Data were collected using face to face computer assisted personal interviews (CAPI). The SHARE questionnaire features a number of different modules relating to various topics. The cover screen (CV), demographic (DN), and self administered questionnaire (Q), sections identify the various household members and their key characteristics such as date of birth etc. The rest of the modules relate to a range of different facets of the ageing process, and vary slightly according to the wave in which they are asked. The first wave included questions on health (physical – PH, mental – MH, cognitive function – CF, and use of health services – HC), biometric measures (grips strength – GS, walking speed – WS), various financial information (employment/pension – PS, housing – HO, assets – AS, income – HH, consumption – CO, transfers – FT), various behavioural and interpersonal questions (social support – SP, behavioural risks – BR, activities – AC, expectations – EX), and interviewer observations (IV). Respondents are also required to complete a short questionnaire themselves, which they then returned by post to the surveyors. The second wave included an additional module on deceased respondents (not applicable to Ireland as the 2007 round was the first wave conducted here). The next (interim) wave (SHARE LIFE) will take place in 14 different countries, and will use the Life History Calendar (LHC) approach, with respondents being asked to reconstruct a timeline of the major events in their lives.

2. Methodology

The SHARE study was piloted over a number of stages in Ireland. The test was conducted in November-December 2006 by the Economic and Social Research Institute (ESRI), the purpose of which was to evaluate the fieldwork procedures and reception of the questionnaire by respondents. Ten interviewers were trained in November and 26 household interviews were completed. A quota sample was used to test field procedures in both urban and rural areas.

For the main survey, 16 people were trained to conduct screening of candidates (but not the interviews themselves). This screening was done on paper, with the contact details of eligible respondents forwarded by the ESRI to fully-trained interviewers. 115 interviewers were trained to conduct the main survey, of whom 105 completed at least one interview. Each of the interviewers was required to complete 18 hours of training, over a period of three days at the ESRI in central Dublin. They were paid a fee for completed questionnaires and screening sheets, attendance at training and travelling expenses. A bonus scheme was operated to encourage a high response rate among eligible respondents.

The full survey was conducted between February 2007 and December 2007. Details of the sample size and response rate are displayed in Table 1 below. Reluctant respondents were re-contacted by the original interviewer and/or by another interviewer operating in the same area. During the screening process an average of 4 contact attempts (by telephone) were made per household. During the main process interviewers kept calling until fieldwork period ended (this entailed up to 11 calls). The average number of calls per household in gross sample was 2.5, for eligible households this number was 3.

Table 1: Sample Size and Response Rates

		Questionnaire		
		Household	Individual	Drop-off
A	Gross sample size	3823		
B	Final number non-contacts, eligible	172		
C	Final number of non-contacts, unknown eligibility	120		
D	Final number vacant addresses	459		
E	Final number of other non sample cases	1733		
F	Final number refusing, eligible	449		
G	Final number refusing, unknown eligibility	54		
H	Final number of completed cases	836	1119	814
J	Per cent eligible, where known	40%		
K	Estimated number eligible	1526	1321	1119
L	Response rate, conditional on eligibility	55%	85%	73%

Throughout the process, interviewers continued to be supervised directly by the ESRI. A project manager and research analyst were in overall charge of the project under the direction of the Head of the Survey Division, and four staff and a supervisor were directly responsible for support and monitoring. While the interviews were being conducted, the views of 58 respondents were surveyed by the ESRI (by telephone). This entailed asking about the professionalism of the interviewer, the respondent’s overall view of interview process, their date of birth, and their household size. No significant issues were detected.

3. Results

3.1 Coverscreen

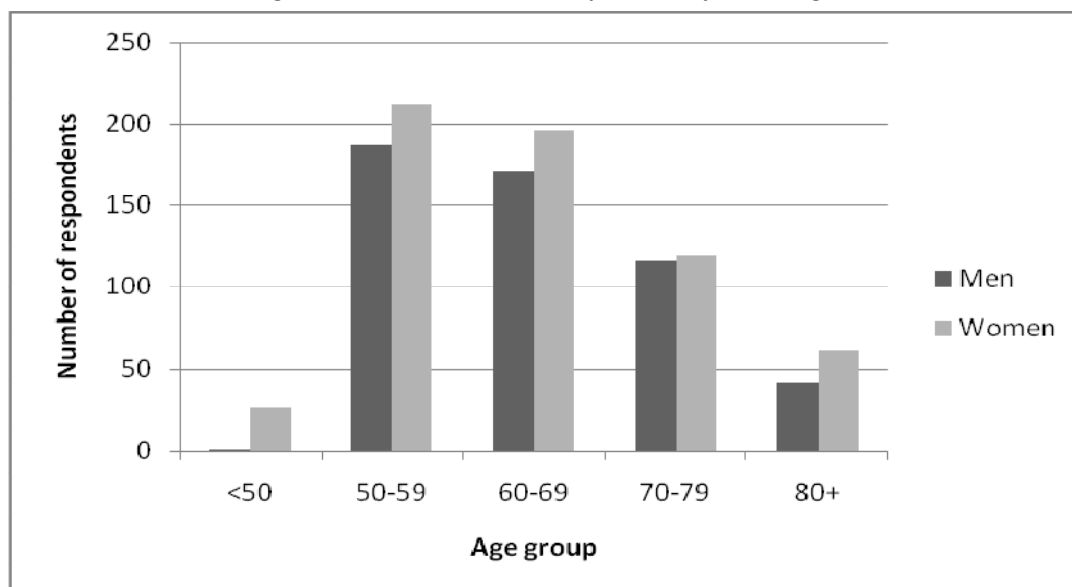
The coverscreen module includes questions on the primary characteristics of the household itself, as well as its individual constituents. Their sex, age and relationship to each of the members of the household are identified. Some questions in the following modules (such as those relating to finances and housing) only require one person to answer for the entire household, and this person is identified here. The coverscreen module is vital for tying individuals to their households, identifying families and merging the data.

3.2 Demographics

The demographic section compiles all the basic information on the individuals in the survey. This includes some of the questions asked in the coverscreen (year of birth, sex), as well as information on their nationality and educational background. In addition, respondents are asked about their families, specifically information on their spouses (if they are or were married), their siblings and their parents. Figure 3.2 shows the distribution of Irish respondents by sex and age.¹ People who are under 50 years of age and are included in the survey are partners of individuals aged 50 and above. The low number of men below 50 can be explained by the fact that these men are partners of women aged 50 and above and that male partners are, on average, older than their female partners.

¹ A small number of responses to some of the questions are missing from the data set, and these responses are omitted from the analysis of that particular question where this occurs. Refusals and responses indicating uncertainty were also omitted, unless otherwise stated.

Figure 3.2 Distribution of Irish respondents by sex and age



N = 1,132

The sample of respondents over 50 comprises 515 men and 588 women, living in 840 households. This includes 577 households with one eligible person, and 263 with two eligible individuals. Approximately 10 per cent of the population aged 50 plus in Ireland were born abroad and approximately half of that group now has Irish citizenship. Three quarters of men are married and living with partner and 60 per cent of women are married/living with partner. 22 per cent of women are widowed, compared to 8 per cent of men. The majority of men are educated to leaving certificate level only (73 per cent) and likewise for women (80 per cent).

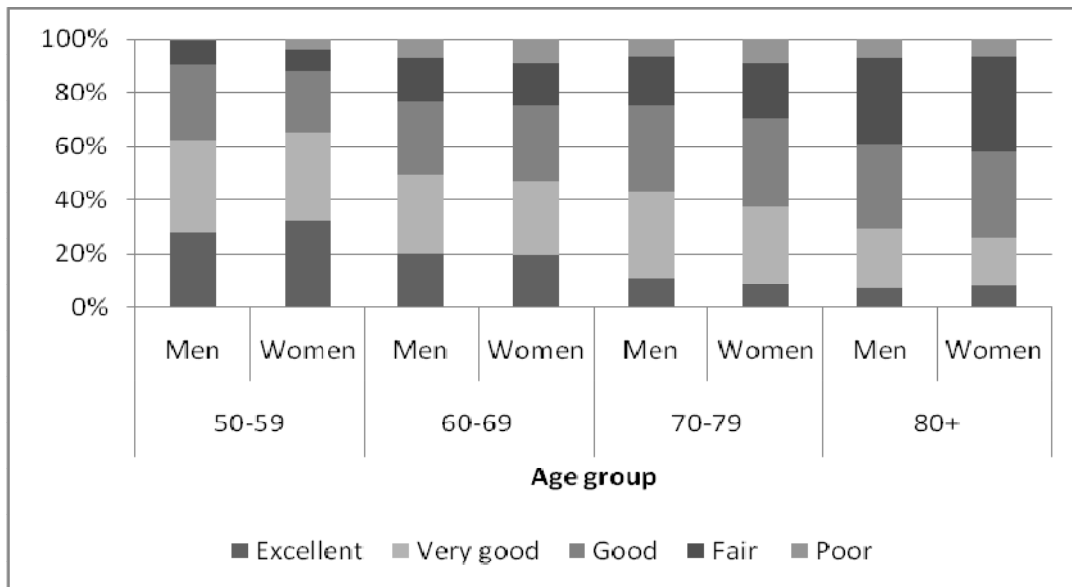
3.3 Physical Health

In the physical health module, participants were asked to rate their general health on a 5 point scale ranging from poor to excellent. This question has been shown to be a good predictor of overall health, and recent research based on other surveys of the Irish population have revealed significant gradients relating to a variety of indicators, including age.² Figure 3.3A shows that

² Delaney et al. (2007) examine data from the European Social Survey, while Kelleher et al. (2003) use SLAN, the National Survey of Lifestyle, Attitudes and Nutrition

about 60 per cent of people aged 50-59 rated their health as excellent or very good. This proportion is approximately 30 per cent for those aged over 80.

Figure 3.3A Self-assessed health among people age 50 years or older



N=1099

Respondents were also asked whether they suffered from chronic illnesses, and the symptoms involved. If participants were on medication, they were asked to provide details. Biometric measures such as height and weight were also collected. Almost one third of individuals aged 50-59 have a long term illness and this increases to over 40 per cent for the older age groups.³ In particular, women aged 70-79 have the highest rate of long-term illness at over 50 per cent. Arthritis, hypertension and high cholesterol are the most prevalent diseases for all individuals aged 50 and over. As with all self-reported measures, these results should be taken with caution, especially for those questions which relate to conditions requiring specific medical diagnosis such as hypertension. It may be, for example, that women are simply more likely to report illness. Figure 3.3B illustrates disease prevalence by gender, while table 3.3B lists the numbers reporting chronic conditions. Hypertension (high blood pressure) is the most common illness for both men and women (nearly 30 per cent of each suffer from this condition), followed by cholesterol. Arthritis is more common among women (25 per cent versus 16 per cent among men), as is osteoporosis (9 per cent among women, while it is 1 per cent among men). On the other hand, men are twice as likely to have suffered a heart attack (10 per cent versus 5 per cent among women).

³ Missing values are assumed to mean respondents suffer from none of the above

Figure 3.3B Chronic illness prevalence

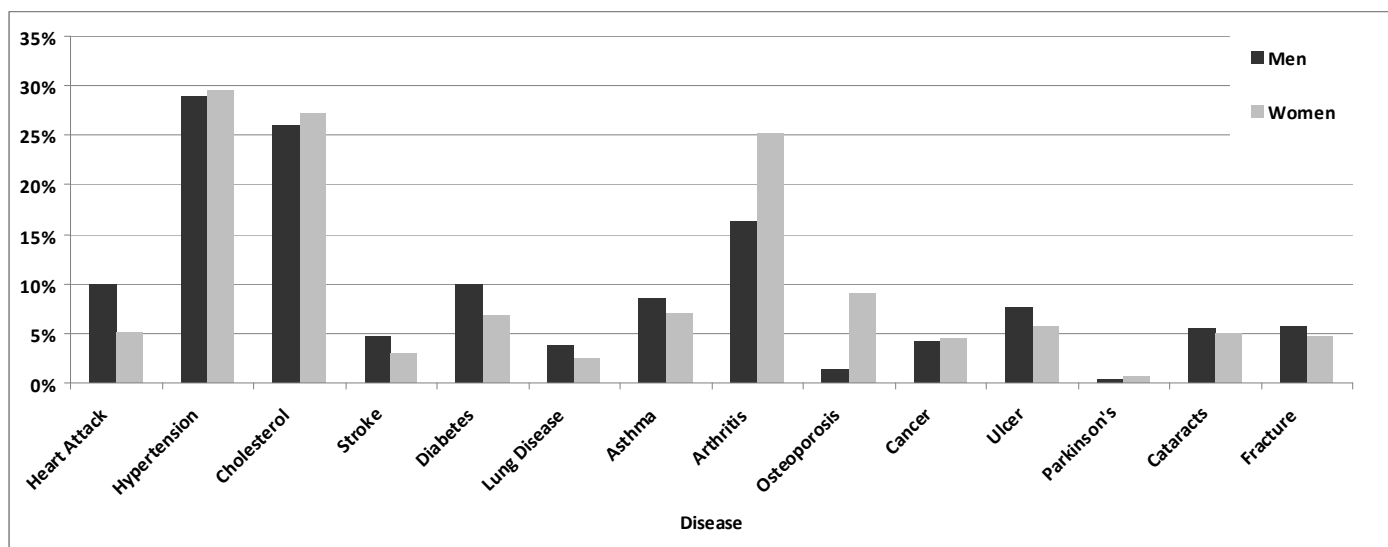
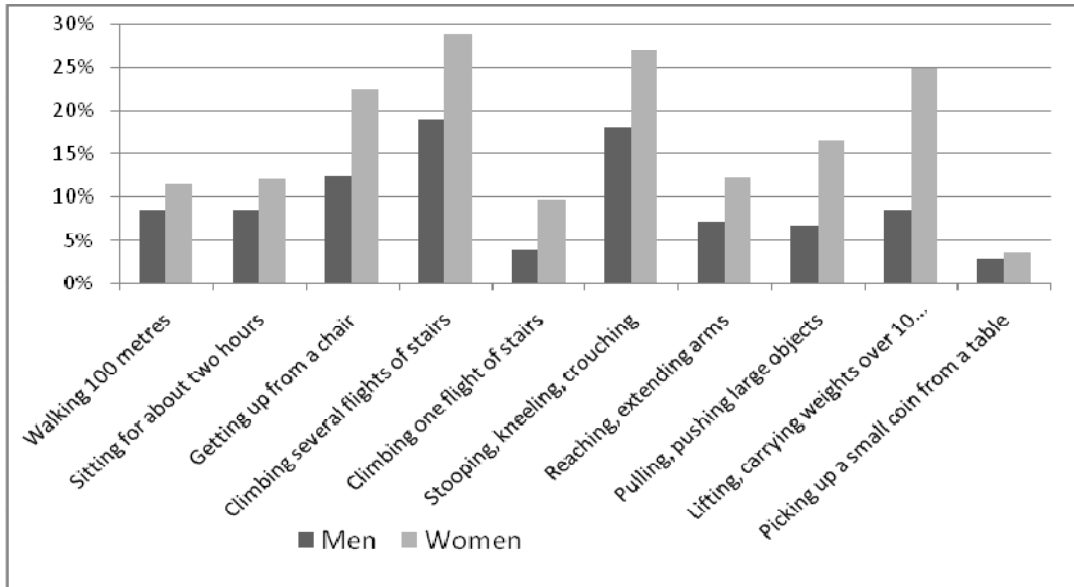


Table 3.3B Numbers reporting chronic illness

Disease	Male	Female	Total
Heart Attack	51	32	83
Hypertension	149	182	331
Cholesterol	134	168	302
Stroke	24	18	42
Diabetes	51	42	93
Lung Disease	19	15	34
Asthma	44	43	87
Arthritis	84	155	239
Osteoporosis	7	56	63
Cancer	22	28	50
Ulcer	39	35	74
Parkinson's	2	4	6
Cataracts	28	31	59
Fracture	30	29	59
Alzheimer's	5	2	7

Figure 3.3C indicates that when asked if they suffered from functional limitations lasting more than 3 months, nearly 30 per cent of respondents over 50 had difficulty climbing stairs.

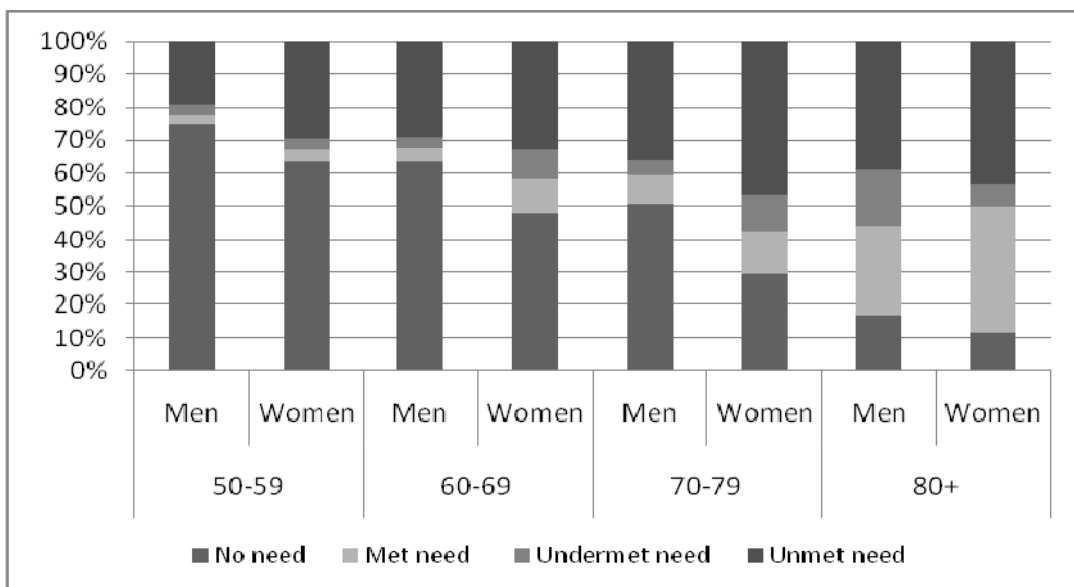
Figure 3.3C Functional limitations among people age 50 years or older



N=1100

Respondents were asked whether they received help undertaking ‘Activities of Daily Living’ (ADL), e.g. dressing, eating and ‘Instrumental Activities of Daily Living’ (IADL) e.g. preparing meals and shopping. If they received help, they were asked whether their needs were met. Figure 3.3D shows that over one third of people aged 70-79 report that the help received did not meet their need for care, and this increases to almost one half for those in the group aged 80 and over.

Figure 3.3D Need for care among respondents aged 50 years or older

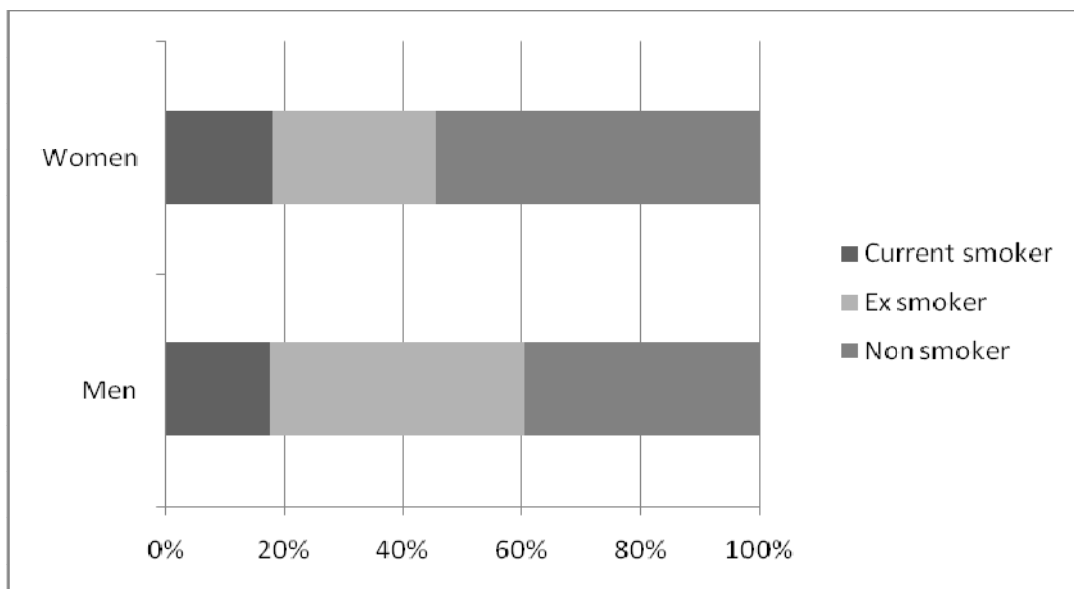


N=169

3.4 Behavioural Risks

Economists view health as a capital stock which has been built up over a lifetime. Current well being can therefore be seen as a cumulative function of behaviour and circumstance since birth (or even before). In this module respondents were asked if they currently smoked or drank alcohol on a regular basis, and whether they had ever done so. Current smokers and drinkers were asked to describe the amounts consumed, and the frequency with which they did so. Figure 3.4 demonstrates that just under 20 per cent of all people aged 50 and over are current smokers. Approximately 20 per cent of respondents drink alcohol regularly (at least 3-4 times a week). In addition, SHARE includes questions on vigorous physical activity undertaken in the past 6 months, such as sports, strenuous housework or jobs involving physical labour. Respondents were also asked about moderate activities such as gardening, cleaning the car or walking, and how often they engaged in these activities. 40 per cent of men and over 50 per cent of women never undertook vigorous activities, and approximately 10 per cent never engaged in moderate activities.

Figure 3.4 Smoking behaviour

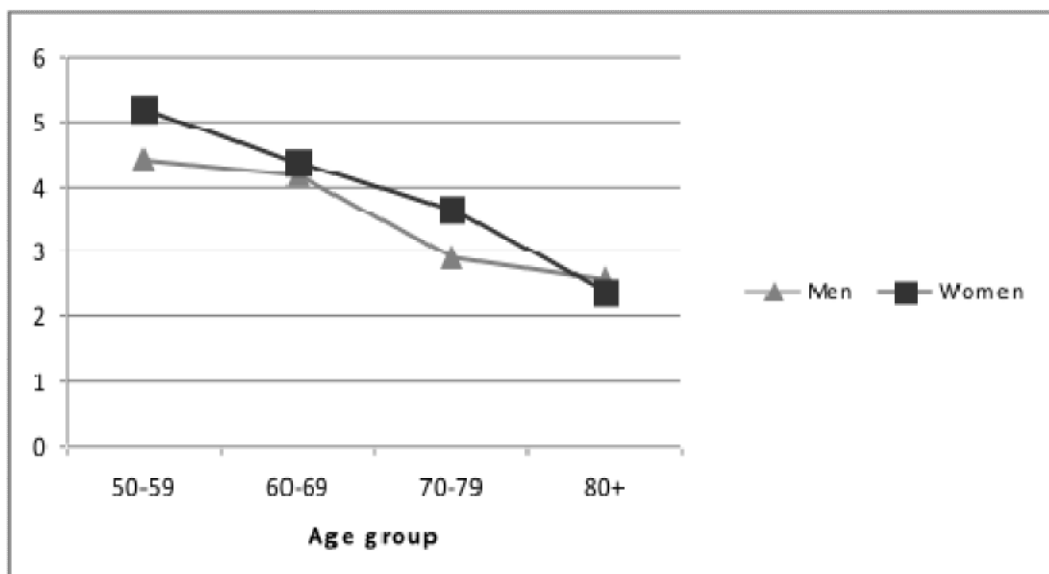


N=1124

3.5 Cognitive Function

In this module, respondents’ reading, writing and memory skills were tested. The reading and writing skills were self-reported with performance ranging from excellent to poor. For the memory test, respondents were given a list of 10 words which they were later required to recall. A low score on this word memory test has been shown to be a good predictor of cognitive impairment, particularly relating to dementia of the Alzheimer type (Knopman and Ryberg, 1989). Figure 3.5 demonstrates that the average number of words recalled decreases with age; from 5 words for women aged 50-59 to 2.5 words for women aged over 80 and from 4.4 words for men aged 50-59 to 2.6 for men aged over 80.

Figure 3.5 Word memory test (delayed recall) among people aged 50 years or older



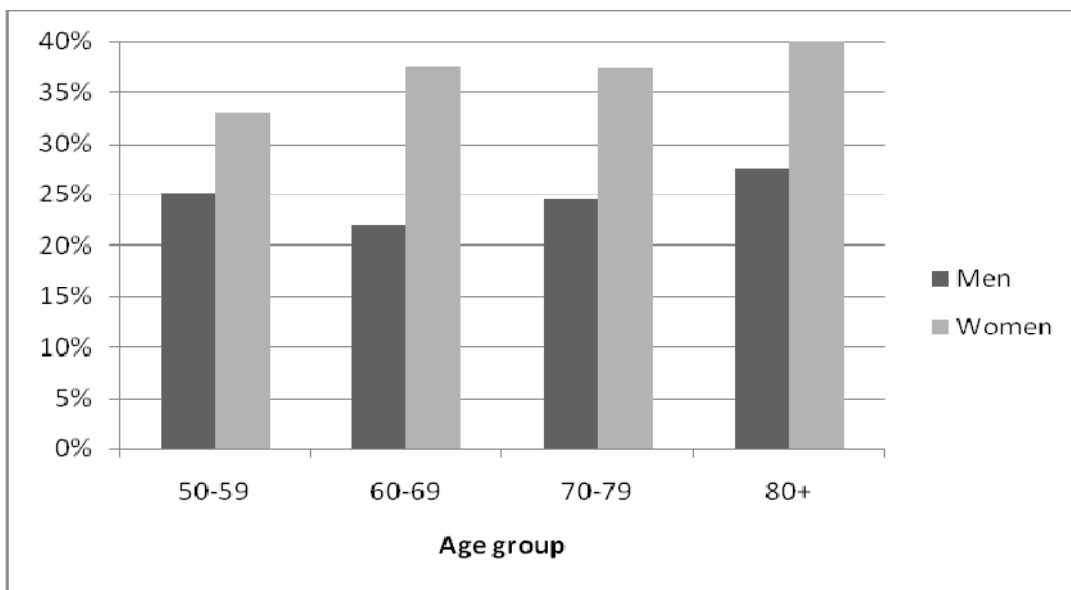
N=1077

Respondents were also asked questions about day of week, day of month, month and year. The vast majority of people knew the day of week, with 87 per cent also giving the correct day of the month. In addition, respondents’ verbal fluency was measured by asking them to name as many types of animal as possible. Their numerical aptitude was measured through a series of questions which required participants to calculate 10 percent of 1000, and to calculate the interest accruing to a hypothetical savings account (at a rate of 10 per cent for two years).

3.6 Mental Health

Mental health is another important aspect which should not be overlooked when evaluating an individual’s well being. A person’s financial circumstances may be adequate but if the person is suffering from depression, relying on the former would be an inadequate measure of the person’s welfare. For example, late-life depression is a common disorder affecting 10 per cent to 15 per cent of the population above age 65 (Beekman et al. 1999). In this module individuals were asked if they felt sad or depressed in the last month, whether they had felt guilty recently or had problems sleeping. Other questions included relate to irritability, appetite, fatigue, concentration, enjoyment and tearfulness. Figure 3.6 shows that up to 40 per cent of women over 80 reported feelings of sadness or depression in the last month. Overall, approximately 20-25 per cent of men felt sad or depressed.

Figure 3.6 People aged 50 years or older feeling sad or depressed

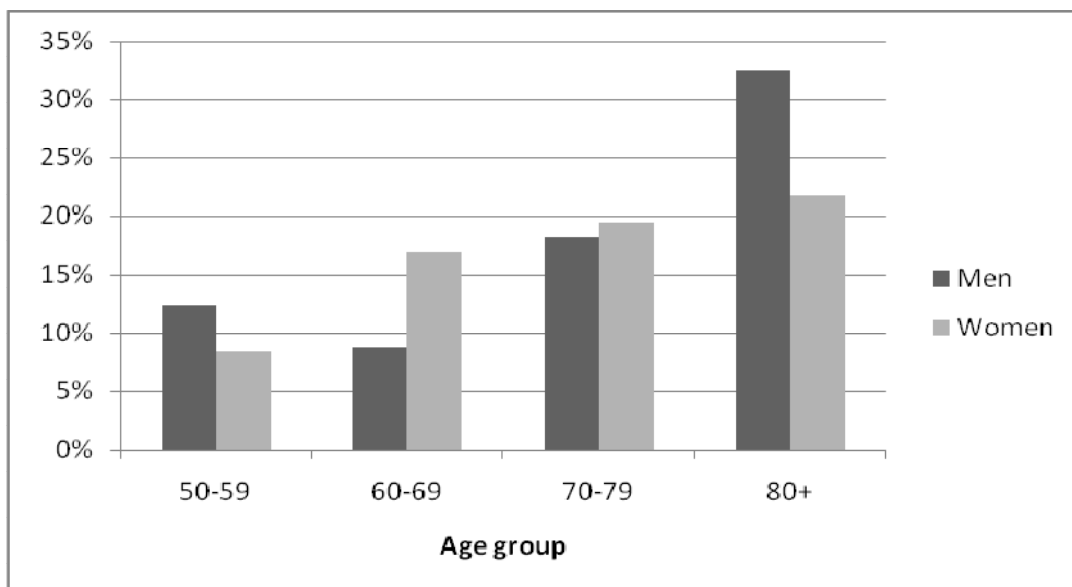


N=1088

3.7 Health Care

The magnitude of the impending demographic change requires that the health services be prepared for the strain that will be placed on them. SHARE is an important resource in this regard as it provides information on health care utilisation among respondents within the past 12 months. This data could provide the basis for projections of growth in demand for health care, especially as additional waves of the survey are built up in the future. This would enable the tracking of changes in people’s use of health services as they age. Included in this module are details of respondents’ consultations with the GPs, specialists, and dentists. Visits to inpatient and outpatient services and stays in nursing homes are also recorded. Individuals were also asked about home help and meals on wheels. Over 80 per cent of respondents had visited the GP at least once in the last 12 months, and 11 per cent had visited a specialist. Figure 3.7A shows that for those aged 70-79, just under 20 per cent recently had at least one overnight inpatient visit. The proportion of visits for the 80+ group is higher for men than women, at over 30 per cent.

Figure 3.7A People aged 50 years or older with at least one overnight stay in hospital during the past 12 months

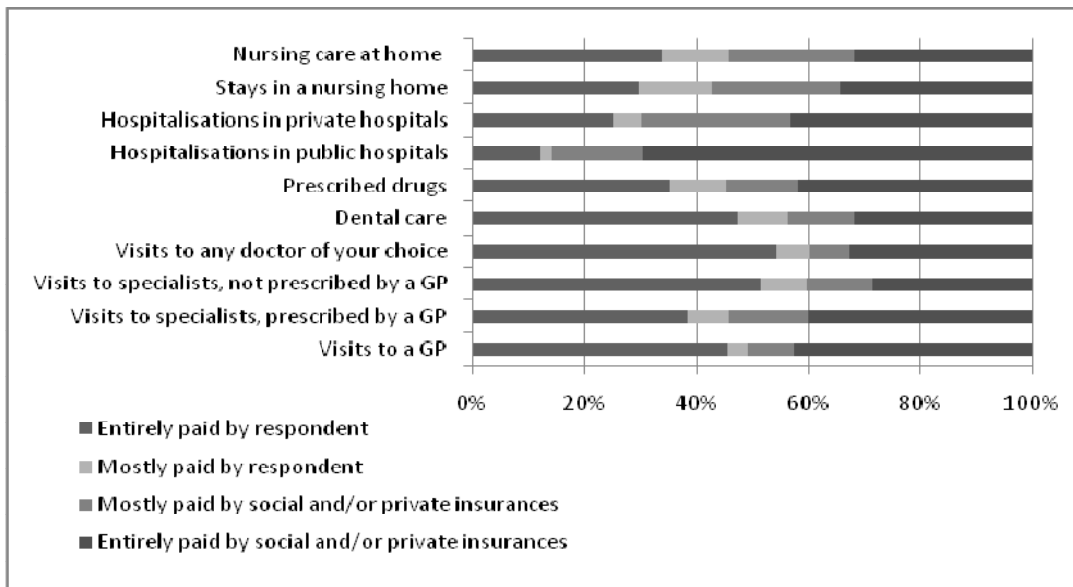


N=1096

In addition to understanding how people’s health changes as they age, it is also crucial for policy makers to estimate where the financial burden will fall. To do this they must have information on how health care is currently funded. If older people are more likely to rely on public services as opposed to insurance, this has important implications for the public finances. SHARE includes questions on how individuals fund their consumption of health care. Figure 3.7B illustrates the

proportion of each type of healthcare that was paid for by the respondent. Approximately 50 per cent of GP visits and 30 per cent of nursing home stays are paid for entirely by the respondent.

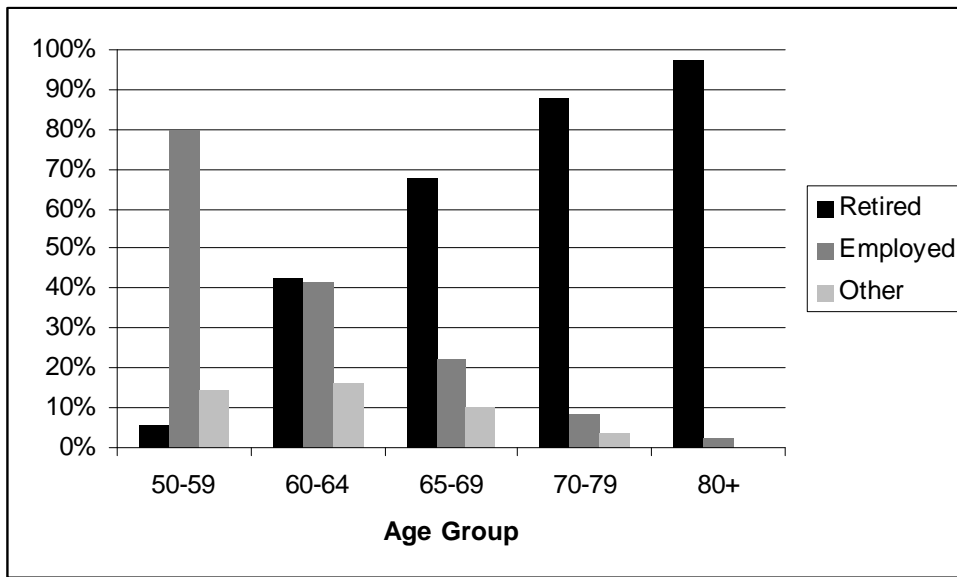
Figure 3.7B Health insurance among people aged 50 years and older



3.8 Employment

This module relates to employment and pensions. All eligible respondents were asked about their current employment status, and figure 3.8A illustrates the responses of male respondents. A large proportion of respondents were working at age 50-59, but this is reduced significantly by age 60-69.

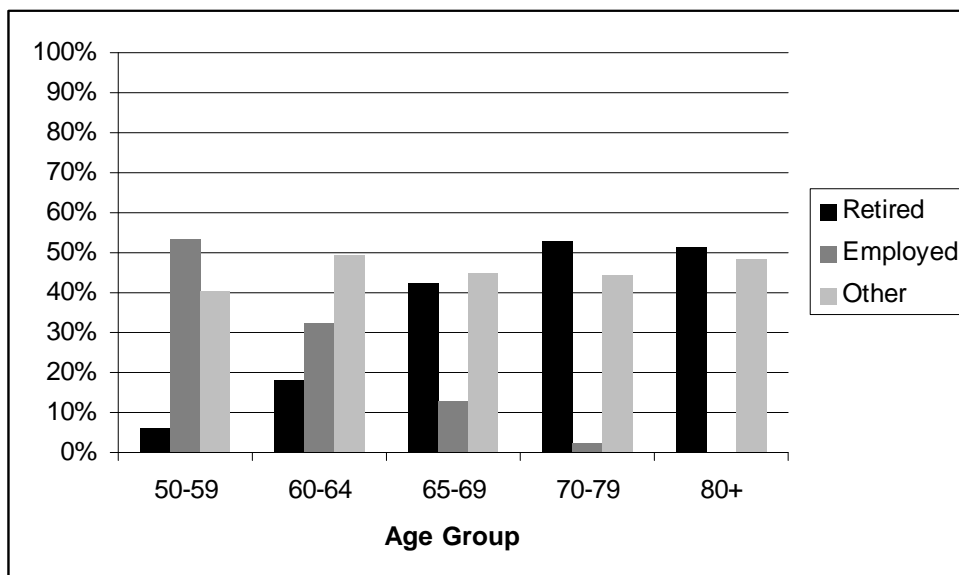
Figure 3.8A Current job situation among men aged 50 years and older



N=510

Figure 3.8B shows the corresponding participation rates for women. The proportion of women who are retired rises from less than 10 per cent for those aged 50-59 to over 50 per cent for those aged over 70. A big difference between the data for men and women is the number of women in the “other” category. This group is mainly made up of people who are home makers.

Figure 3.8B Current job situation among women aged 50 years or older

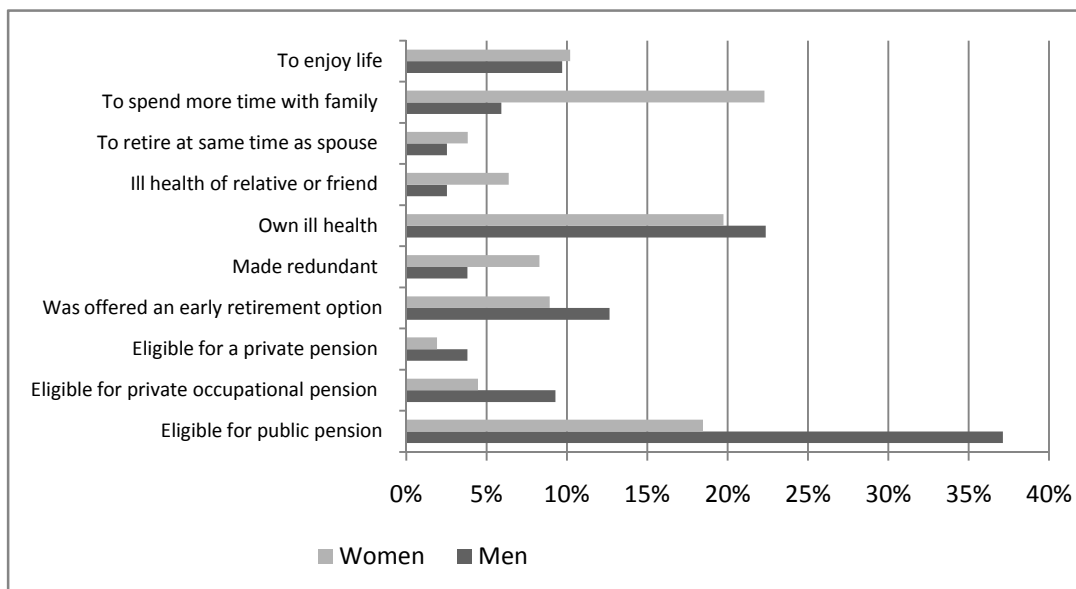


N=582

Detailed questions on employment history are also included. Overall 25 per cent are employed in professional jobs, while for women 25 per cent are employed in sales or the clerical sector. 15 per cent of men work in skilled agricultural or fisheries, and the same proportion again in trades.

As already discussed, SHARE not only also investigates the distribution of a particular attribute, it also seeks to outline the motivation behind important decisions and behaviour. In this module, respondents are asked to give reasons for their decision to retire (36 per cent overall are retired). This is important information for policy makers who wish to provide incentives for people to work longer. Figure 3.8C indicates that 20 per cent give their own ill health as a reason for early retirement and 5 per cent say they retired due to the ill health of a relative or friend. This is particularly interesting in light of the recent interest in the reverse causality between health and income. It has long been recognised that income can affect health, however recent research suggests that health can also have an effect on income, mainly through preventing the person from working in old age (Smith, 1999).

Figure 3.8C Main reasons for retirement among people aged 50 years and older



This section also includes questions on the type of work the person was engaged in, their employer, payment received, as well as job satisfaction, security, advancement and remuneration. Respondents are also asked about public and private benefits received⁴, and this is illustrated in figure 3.8D. The numbers receiving these benefits are presented in table 3.8D.

⁴ Public benefits refer to state contributory and non-contributory pensions, pre-retirement allowance, disability pensions or allowances, unemployment benefit, and widow/widower’s pension. Private benefits refer to occupational pensions, disability payments from a previous employer, and widow/widower occupational pensions

Figure 3.8D Benefit receipts among respondents aged 50 years and older

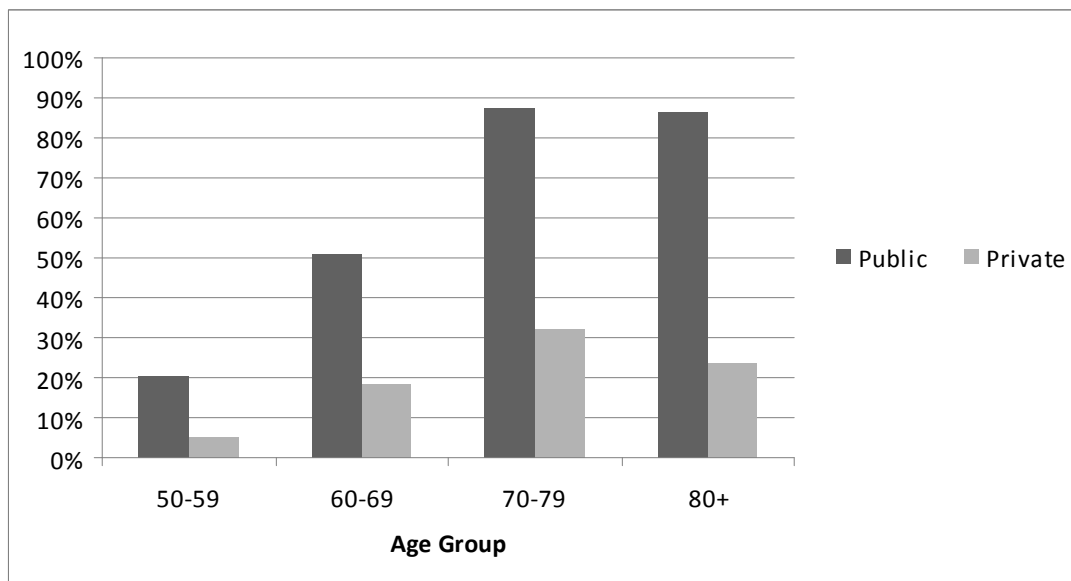


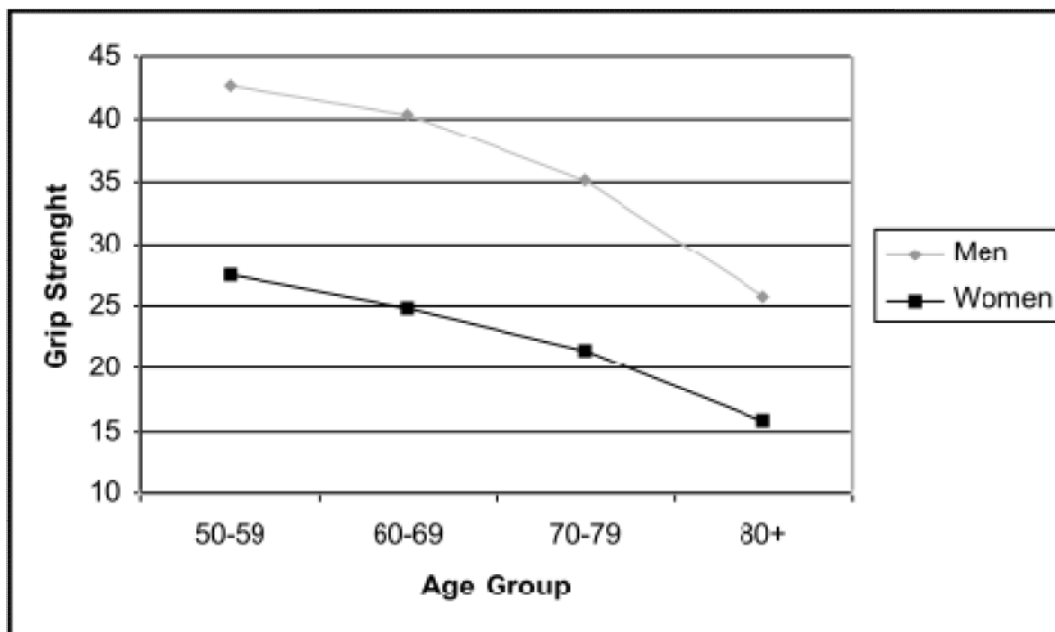
Table 3.8D Numbers Receiving Benefits

Benefit Type	Total
Private	186
Public	566

3.9 Grip Strength

Muscle strength in general declines with age among both men and women, and this also applies to upper extremity muscle strength as measured by hand-grip strength. Reduced hand-grip strength is a strong predictor of various features of aging, including disability, morbidity and mortality, and is therefore often used as an indicator of frailty. Hand-grip strength was measured using a handheld dynamometer twice in both hands; the maximum of these four hand-grip strength measurements was used in the analysis. At each stage the respondents are asked if they are comfortable to continue. Figure 3.9 graphs average grip strength and demonstrates a noticeable decline by age group, from an average of 34 for those aged 50-59, to 20 for people over 80.

Figure 3.9 Grip Strength

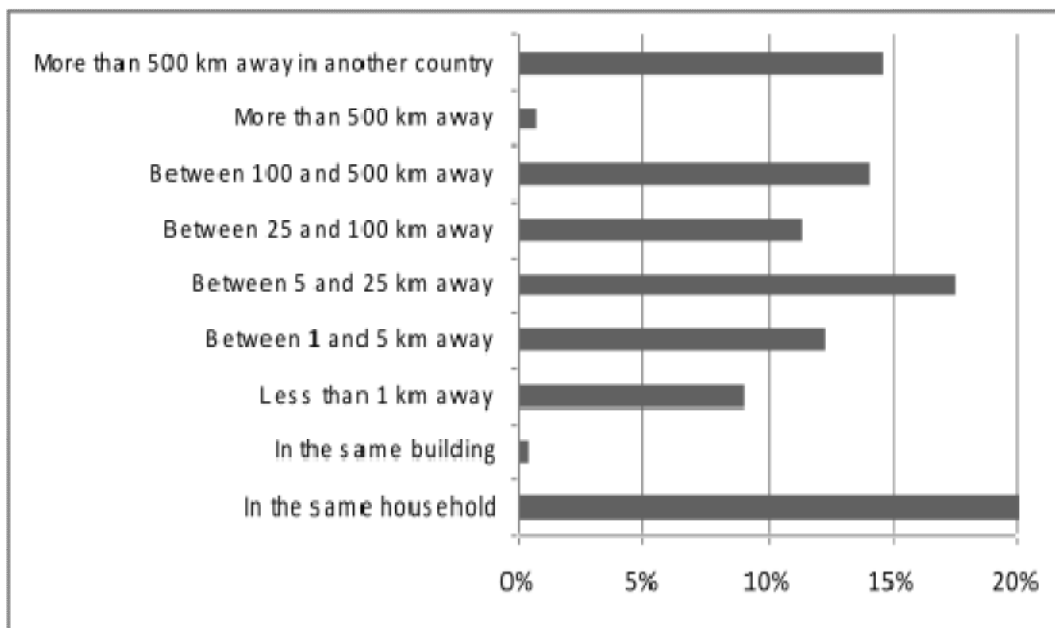


N=886

3.10 Children

This module involved questions on the children of family respondents with at least one child. The questions included information on their sex, age and proximity, to the respondent, as well as whether they were adopted or fostered. Approximately 85 per cent of respondents reported having children and 70 per cent having grandchildren. Figure 3.10 indicates that up to 20 per cent of children live in the same household as their parents, while over 10 per cent live nearby, and up to 15 per cent live in another country.

Figure 3.10 Proximity of children to their parents aged 50 years and older



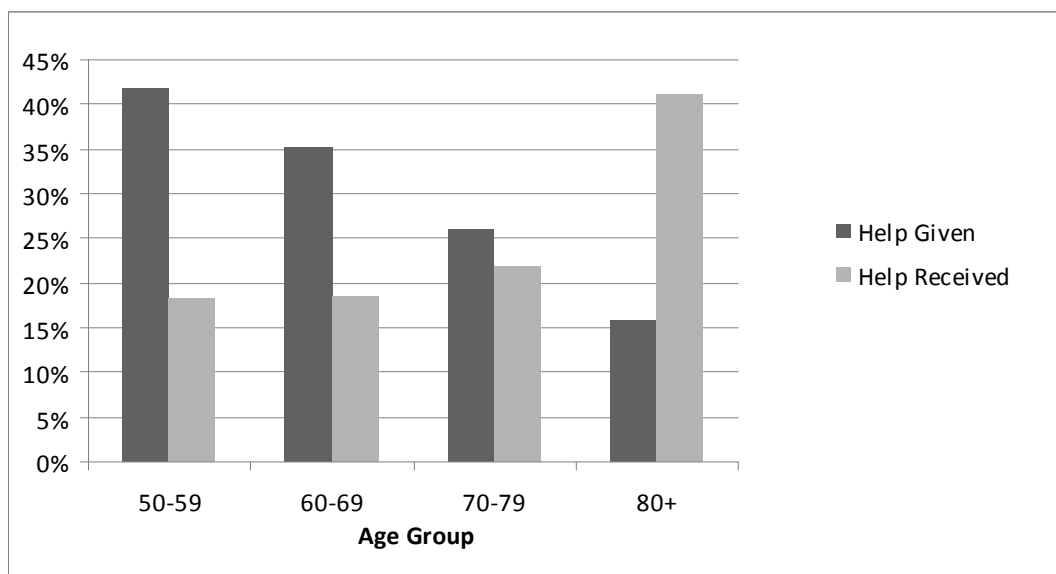
N=669

3.11 Social Support

As discussed in the introduction, SHARE is an interdisciplinary survey which investigates a variety of different facets of ageing. It has long been recognised that community support and social interaction can be an invaluable part of a person’s well being, and SHARE enables examination of this issue. In the Social Support module, respondents were asked whether they had given or received help during the past 12 months. They were then asked in detail about the type of help, the length of time involved, and about the person providing or benefiting from this assistance. Respondents are also asked about their relationship with their grandchildren.

Overall 22 per cent of respondents received help in the past 12 months, however figure 3.11 below documents that older people tend to receive more help. 20 per cent of 50-59 year olds received some help, while the corresponding figure for the 80+ age group was 40 per cent. The opposite trend characterises the proportion of people providing help. While 40 per cent of 50-59 year olds did so, for people over 80 the figure was less than half this (16 per cent). Overall 34 per cent of people provided help in the past 12 months.

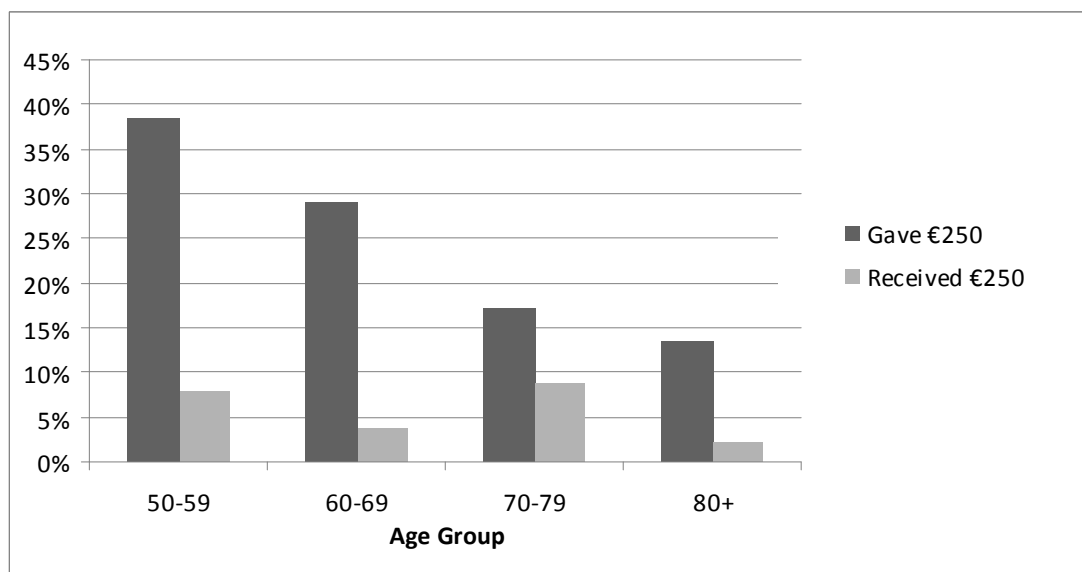
Figure 3.11 Proportion of respondents giving and receiving help



3.12 Financial Transfers

The importance of non-labour related income should not be ignored when evaluating an individual’s welfare. Only questioning individuals about their employment status or pension may misrepresent the resources at a household’s disposal. SHARE includes detailed questions on financial transfers, including the amounts involved, and importantly the source or destination of the transfer. Respondents were also asked to elaborate on the motivation behind these transfers. Figure 3.12 below shows that individuals in the higher age groups are less likely to have given gifts of €250 or more in the past 12 months. Almost 40 per cent of those in the 50-59 category had recently given a financial gift, while for those in the 80+ category the figure was 13 per cent. Overall, people over 50 are less likely to receive financial transfers than give them. Those aged 70-79 were the most likely to have received a gift of €250 or more over the past 12 months (9 per cent), while those over 80 were the least likely (2 per cent).

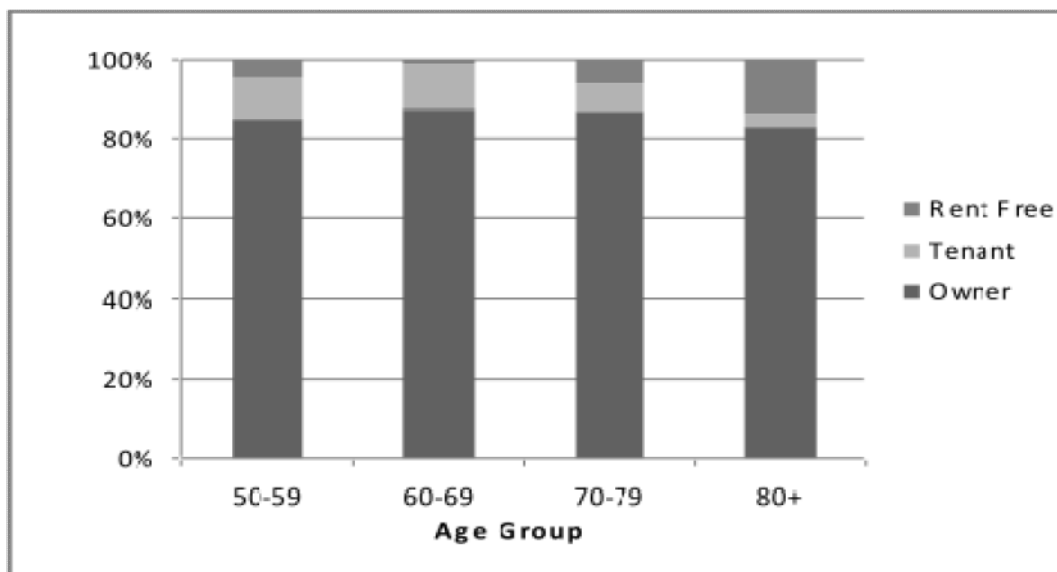
Figure 3.12 Proportion of respondents giving and receiving transfers of at least €250



3.13 Housing

Accommodation is an important component of welfare for any age group, as even with a satisfactory level of income, a person’s quality of life and health may be significantly affected by their residence. Important dimensions of housing quality include access, status of the neighbourhood, and facilities including heating and insulation. SHARE includes questions on the ownership of the respondent’s residence, and if applicable individuals are asked to document details of their mortgage, rent and charges. Respondents are also asked whether they had difficulty meeting these responsibilities in the past. Those owning their homes are asked about its value and how it was acquired. All individuals are asked to describe the features of their accommodation and neighbourhood, including type of building, the number of steps and floors respondents have to negotiate to reach their residence, and the amount of crime and violence in the vicinity. Figure 3.13 below shows that there is little variation in the proportion owning their own home by age cohort. The vast majority (86 per cent) own their accommodation. People over 70 are more likely to live rent free (1 per cent of those aged 50-59, and 3 per cent of those aged 80+), but less likely to be a tenant (4 per cent of those aged 50-59, and 14 per cent of those aged 80+ were in this category). It is important to note that the survey does not include those living in institutions.

Figure 3.13 Residence ownership among those aged 50 and older

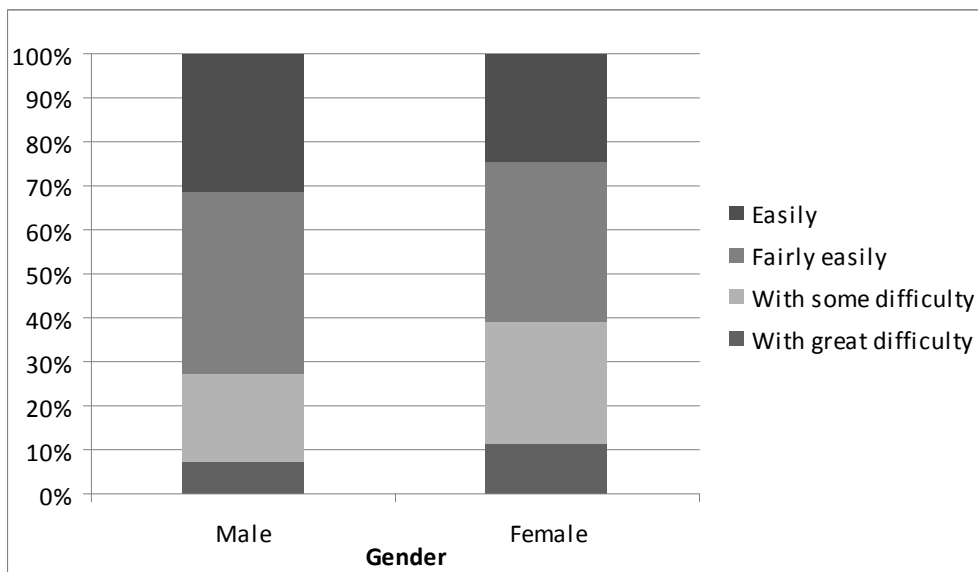


N=829

3.14 Consumption

The section on consumption attempts to evaluate the ease with which households meet their financial obligations. Consumption is regarded as one of the best measures of welfare, and respondents are asked about the amount spent on goods and services (and food and telephone charges in particular) in their household. Figure 3.14 below shows the degree to which households are able to make ends meet. Female respondents are more likely to answer that it is harder to make ends meet (11 per cent of women have great difficulty doing so, versus 7 per cent for males, and 25 per cent of women find it easy to make ends meet versus 31 per cent for men).

Figure 3.14 Frequency with which men and women find it difficult to make ends meet



N=829

3.15 Assets

This module asks in detail about the assets that households have at their disposal. This section includes questions on bank accounts, savings, bonds, and other financial assets. Respondents were asked about the value and composition of each of these, and the interest and dividends received was also recorded. Individuals were also asked to break down ownership within their household. As well as these financial instruments, respondents were asked about real assets such as properties, cars, and any debt for which they were responsible. Individuals were asked whether they had owned, or continued to own a business. Figure 3.15A demonstrates that the majority of people in every age group hold a bank account (76 per cent of people overall), although this declines slightly with age (79 per cent for those aged 50-59, but 65 per cent of people over 80). A similar trend is evident for life insurance, stock ownership and involvement in mutual funds, although the numbers holding the last 2 assets are small. Bonds are most popular with older people (8 per cent of those over 80 hold this asset). Table 3.15A lists the numbers holding these assets.

Figure 3.15A Proportion of respondents over 50 years of age holding financial assets

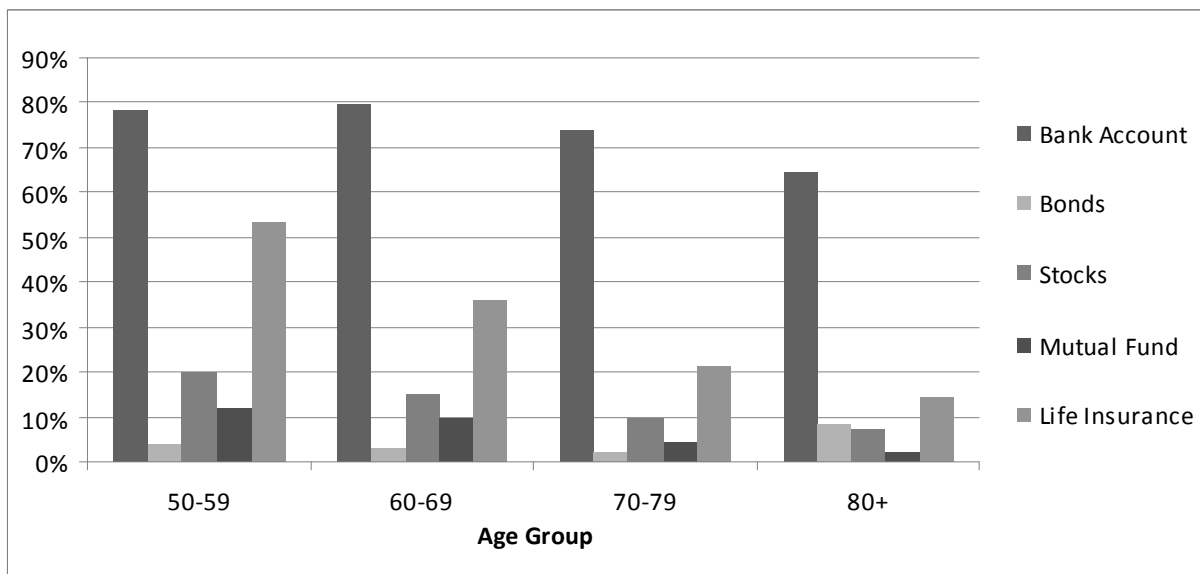
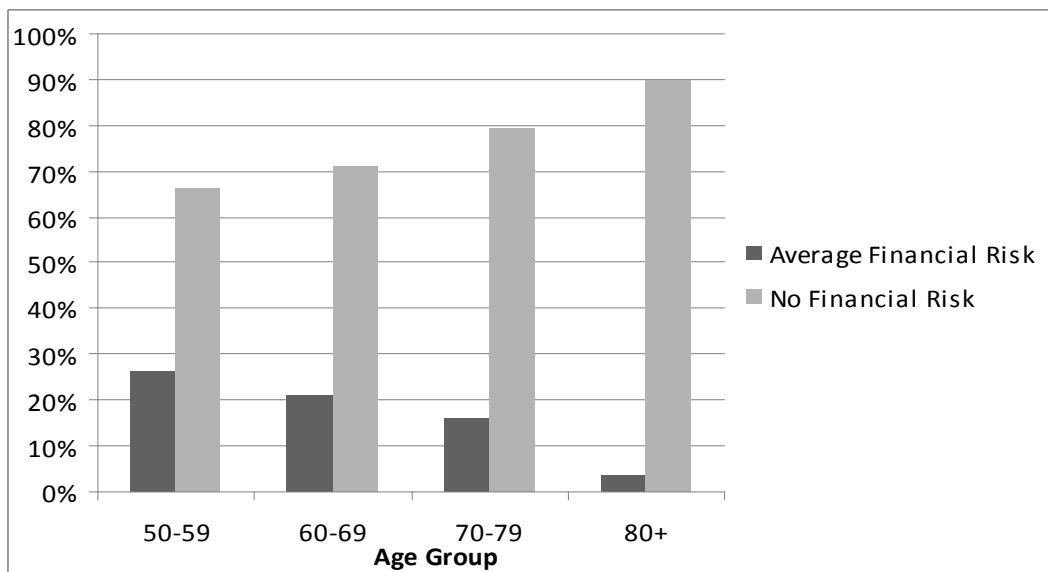


Table 3.15A Numbers holding financial assets

Financial Instrument	Total
Bank Account	609
Bonds	31
Stocks	117
Mutual Fund	68
Life Insurance	298

In keeping with the broad scope of the SHARE project, respondents are also asked about behavioural characteristics relating to their financial assets. Figure 3.15B shows that individuals in the older age categories tend to be less likely to take risks with their investments. 67 per cent of 50-59 year olds are never willing to take financial risks, while the corresponding figure for those over 80 is 90 per cent.

Figure 3.15B Proportion of respondents over 50 years of age prepared to take risks with their investments



N=824

3.16 Activities and Well Being

SHARE examines in detail the emotional welfare of respondents, as well as their time allocation across a variety of activities. This section includes questions on general life satisfaction, whether the respondent had felt depressed in the recent past, and how optimistic they were about the future. Activities engaged in were also investigated, and participants were asked about their motivations for becoming involved in these and whether they felt their contributions were appreciated. Figure 3.16A illustrates the breakdown of activities participated in across age groups. People in older age categories were less likely to be involved in social/sporting activities (33 per cent of 50-59 year olds but only 11 per cent of those aged 80+), but more likely to be involved in religious activities (29 per cent of 50-59 year olds, but 35 per cent of those over 80). Table 3.16A shows the numbers involved in these activities.

Figure 3.16A Participation in social activities

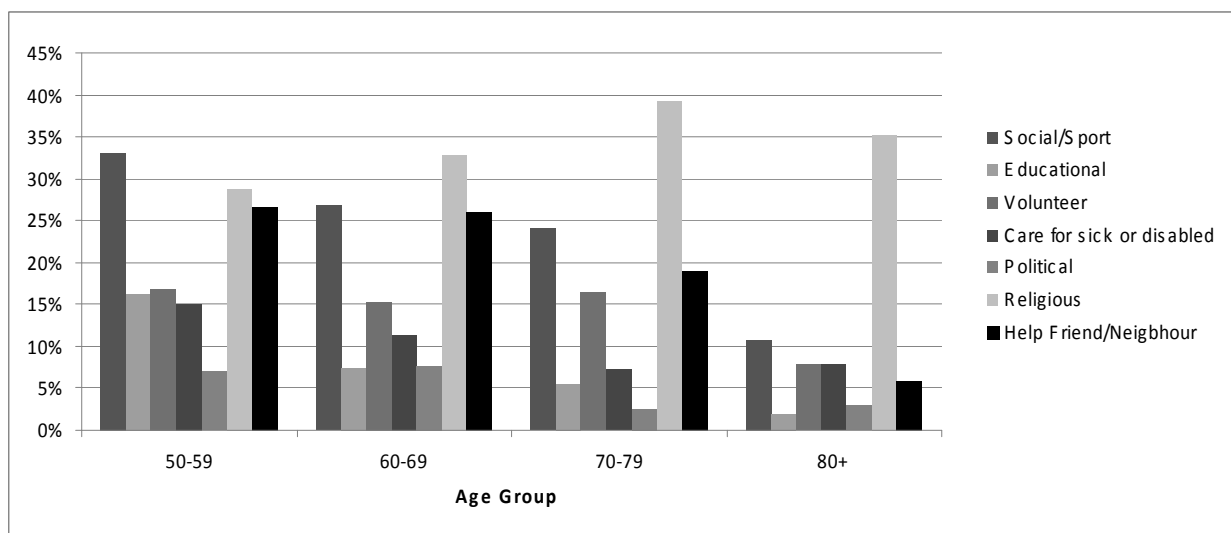
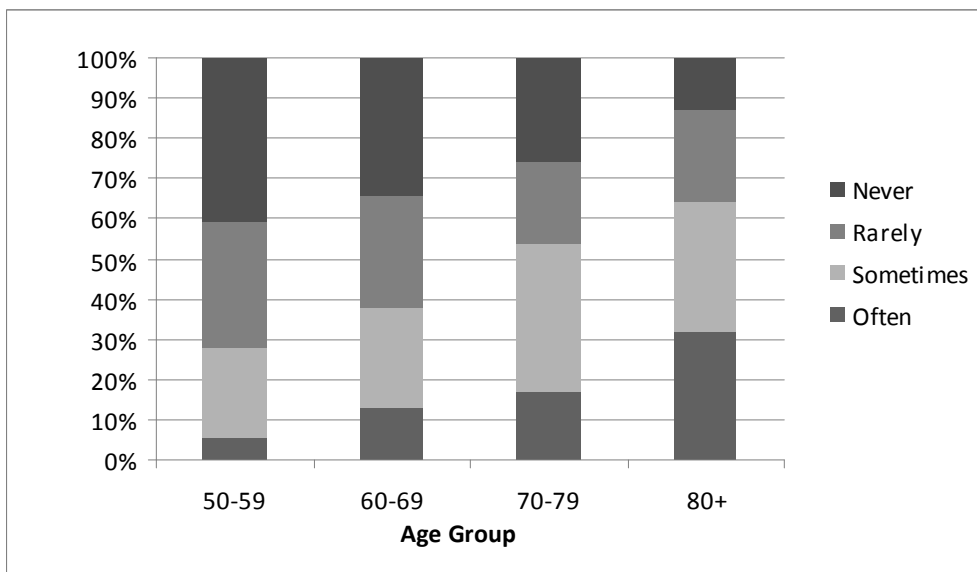


Table 3.16A Numbers participating in social activities

Activity	Total
Social/Sport	307
Education	112
Volunteer	176
Care for sick/disabled	133
Political	65
Religious	373
Help Neighbours	262

Figure 3.16B shows the proportion of each age group who feel they are hampered in their activities by their age. There is a clear trend towards being more affected as people age. 41 per cent of people in the 50-59 age group felt they were never hampered by their age, while only 13 per cent of those over 80 felt this was the case. In contrast, 32 per cent of people aged 80+ stated that they were often affected, while only 6 per cent of 50-59 year olds gave this response.

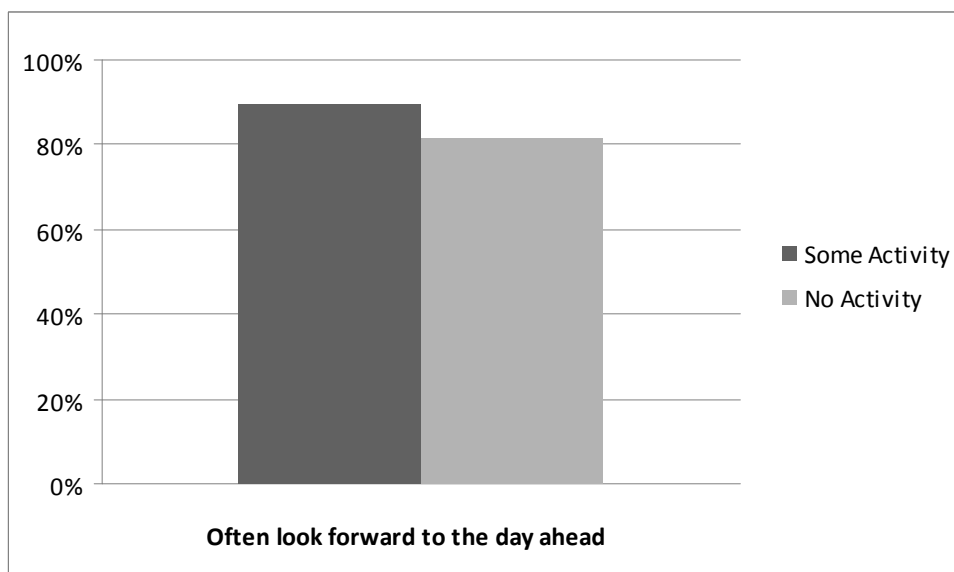
Figure 3.16B Frequency with which respondents feel hampered in their activities by their age



N=1105

SHARE’s broad scope allows extensive analysis of various facets of well being. A wide range of variables can be interacted in a manner not possible in other surveys. For example, life satisfaction can be examined in the context of whether individuals engage in the activities listed above. Figure 3.16C shows that those who engage in some activity are 8 per cent more likely to often look forward to the day ahead (89 per cent for those who take part in at least one activity versus 81 per cent for those who take part in none). This difference is statistically significant at the 1 per cent level.

Figure 3.16C Proportion of respondents stating they often look forward to the day ahead



N=1101

Table 3.16C Significance of differences in optimism by activity participation

Variable	Marginal Effect ⁵	Standard Error	z stat	P> z	95% Confidence Interval	
Participation in Some Activity	0.081	0.023	3.54	0.000	0.036	0.125

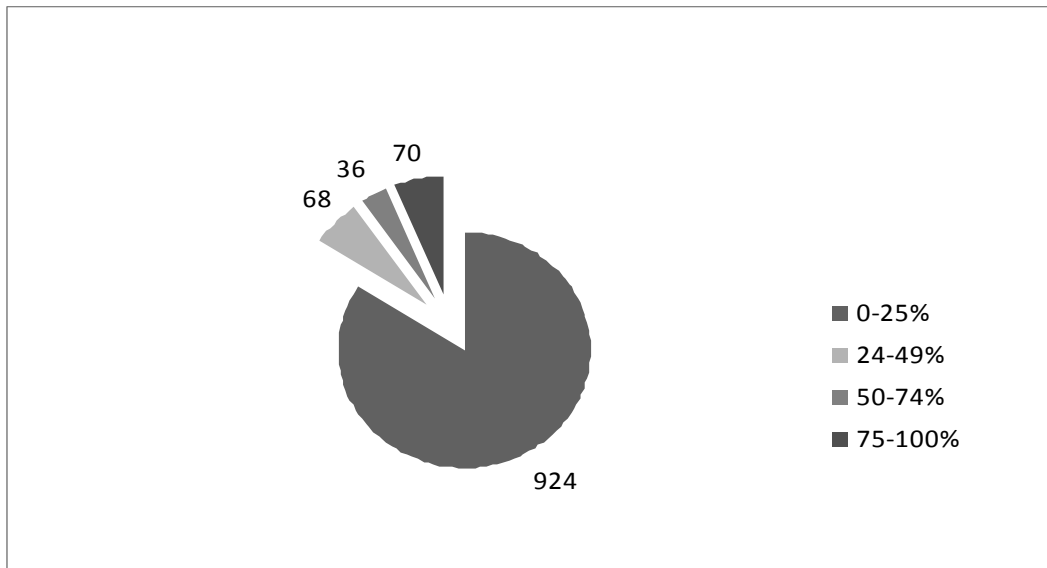
3.17 Expectations

Economists acknowledge the key role of expectations in determining present decisions, as people are assumed to factor in their expectations of future events into current behaviour, and into financial decision making in particular. For example, an individual running up large debts may be doing so in expectation of a windfall receipt. In this module respondents are asked to rate the probability that they will receive an inheritance, and also leave one. They are also asked about whether they believe the government might reduce the public pension in the future, and whether the retirement age might also be lowered. Respondents are also asked a series of questions relating to their trust in other people and their personal faith. Figure 3.17A lists the number of people rating the likelihood that they will receive an inheritance. Out of a total of 1032

⁵ Ordered logit regression, marginal effect reported for the category often looking forward to the day ahead

respondents, 924 believe there is less than a 25 per cent chance that they will receive such a windfall.

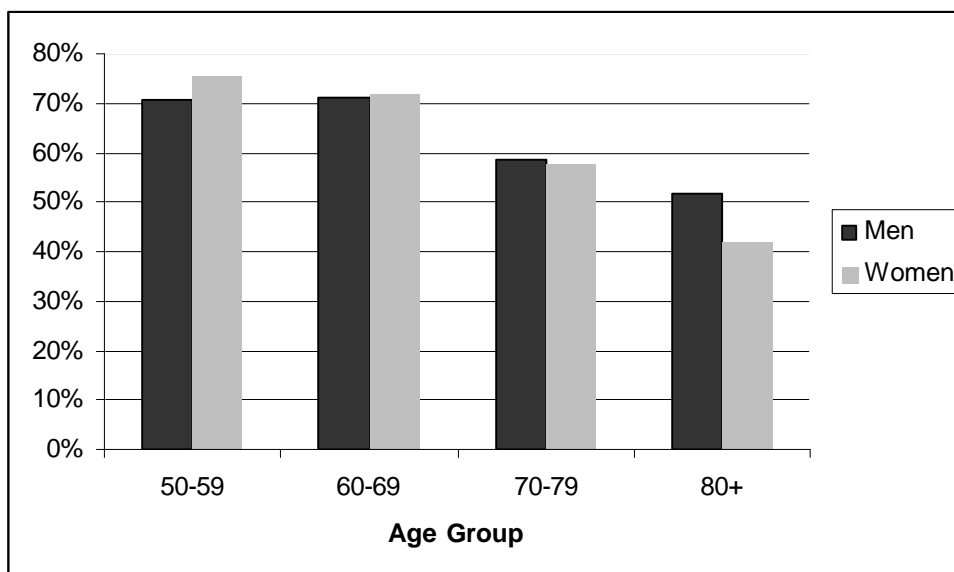
Figure 3.17A Numbers estimating the probability of receiving an inheritance



N=1117

Figure 3.17B shows the average percentage chance that people estimate that they will live for at least another 10 years.

Figure 3.17B Percentage chance of living ten more years



N=1105

4. Education and Welfare

It has been well established that a socio economic gradient exists in many aspects of well being. The relationship is most notable for health, and extends across developed and developing countries. It has recently been verified by Banks et al. (2006) for the US and the UK, and confirmed by O'Shea (1997) for the Irish case. The gradient has been further demonstrated by analysis of the European Social Survey (Delaney et al., 2007), and the national Survey on Lifestyle Attitudes and Nutrition (Kelleher et al., 2003), among other studies. SHARE provides the opportunity to evaluate the extent of these socio economic differences for a wide variety of welfare measures. This section presents a breakdown of several key variables by education level, which acts as a proxy for socio-economic status. It is important to state that this section does not argue for a causal effect of education on the outcomes examined, but rather presents the correlation between various indicators. For example, people born before the middle of the last century have, on average, generally completed fewer years of education (due to various cultural and behavioural factors specific to their cohort). These individuals are also in poorer health (on average) as they are also the eldest in the survey. Any causal relationship between education and health cannot be isolated from this age effect without further analysis. Having said this, the figures below demonstrate a significant education gradient in cognitive function, numeracy, life satisfaction and self reported health. Figure 4A shows that those with primary education (or less) score an average of 3.2 on the delayed word recall test discussed in section 3.10, while those with tertiary education score 4.9 on average. This difference is statistically significant at the 1 per cent level.

Figure 4A Cognitive function by education

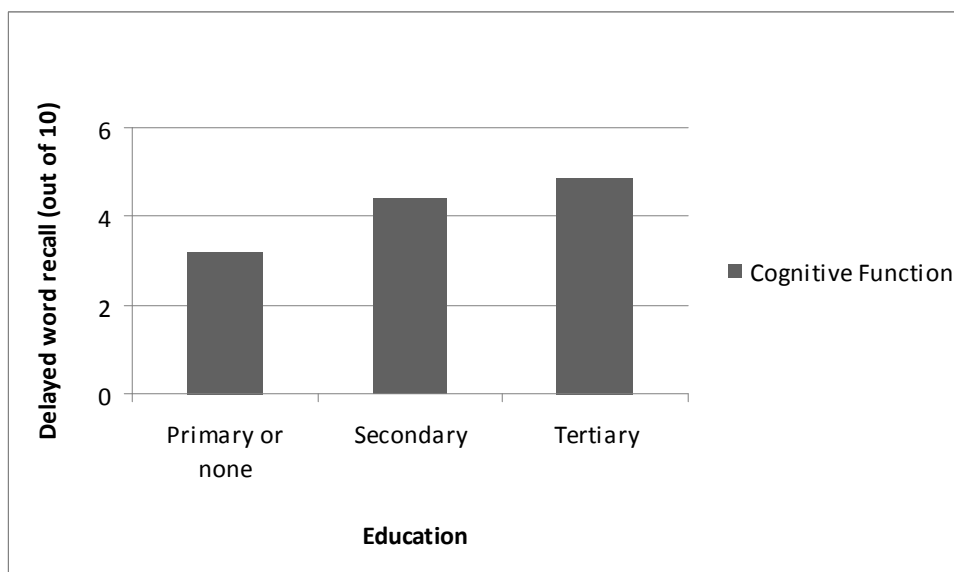


Table 4A Significance of differences in cognitive function by education

Variable	Coefficient	Standard Error ⁶	t stat	P> t	95% Confidence Interval	
Education Group	0.852	0.089	9.59	0.000	0.677	1.026

Respondents’ numeracy was also examined in the cognitive function module (each individual was asked to give 10 per cent of 1000), and figure 4B shows the proportion getting the question right for each education group. Less than 60 per cent of those with Primary or no education answered the question correctly, while over 90 per cent of those with a tertiary qualification were able to give the correct answer. This difference is statistically significant at the 1 per cent level. This is an important issue, as numeracy has been shown to be correlated with retirement savings outcomes, and some authors have argued for the targeting of low numeracy groups with pension information (Banks and Oldfield, 2007).

⁶ OLS regression

Figure 4B Numeracy by education

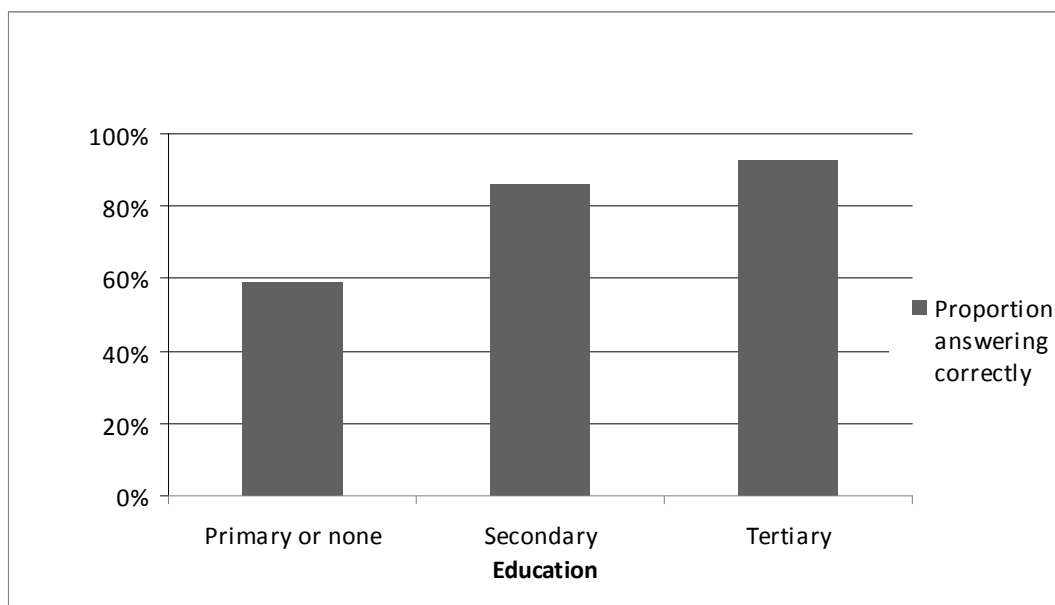


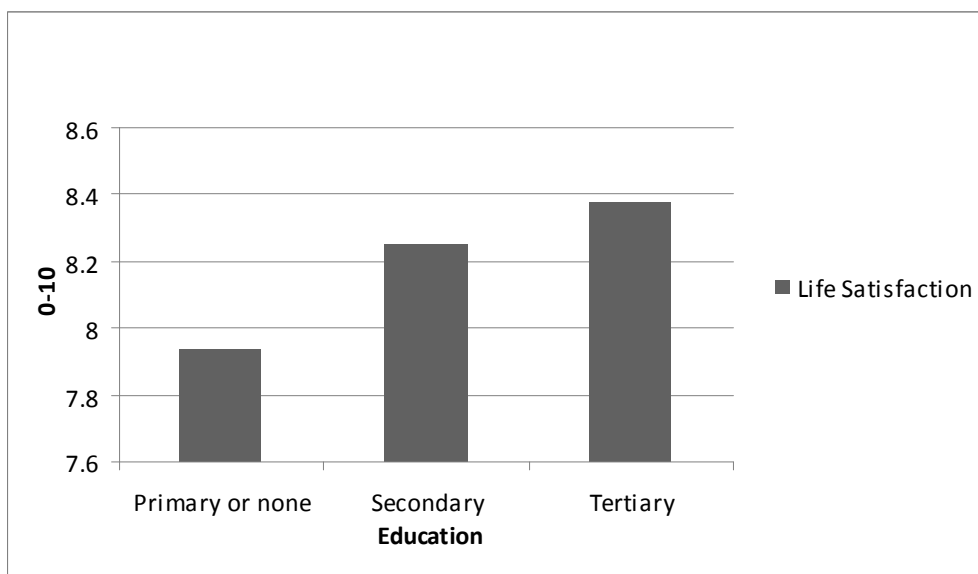
Table 4B Significance of differences in numeracy by education

Variable	Marginal Effect	Standard Error ⁷	z stat	P> z	95% Confidence Interval
Education Group	0.175	0.015	11.44	0.000	0.145 0.205

Figure 4C demonstrates that a similar gradient exists with life satisfaction. Those with primary education give a self reported life satisfaction score of 7.9, while those with tertiary education report a score of 8.4. This difference is statistically significant at the 1 per cent level.

⁷ Logit regression

Figure 4C Life Satisfaction by education



N=1105

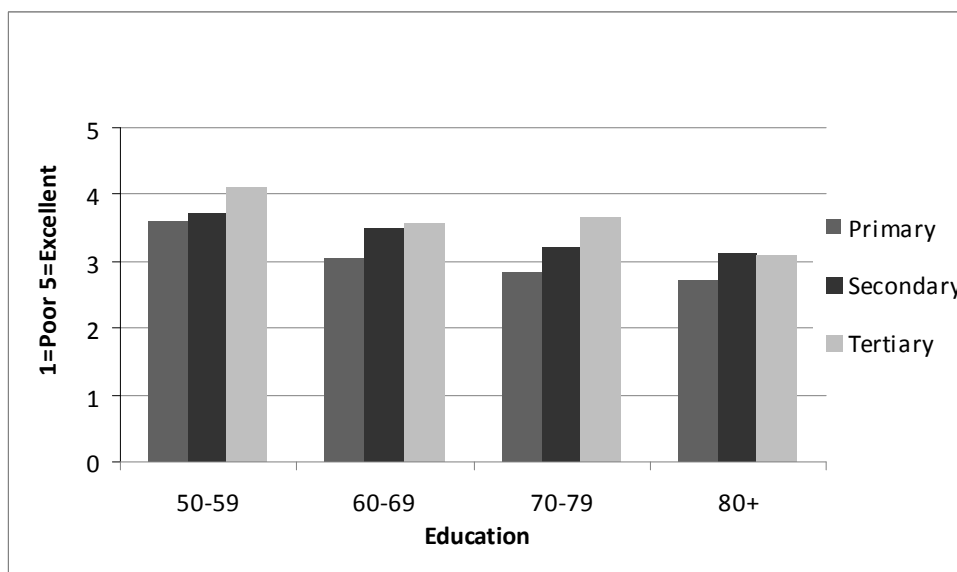
Table 4C Significance of differences in life satisfaction by education

Variable	Coefficient	Standard Error ⁸	t stat	P> t	95% Confidence Interval	
Education Group	0.231	0.066	3.5	0.000	0.101	0.36

Figure 4D illustrates the breakdown of self reported health across age groups and education levels. The fact that the health gradient within groups is less than the overall gradient can be explained by the cohort effect discussed above. Despite this, the difference in health by education is statistically significant at the 1 per cent level for those in the 50-59 and 70-79 age groups, and at the 5 per cent level for those aged 60-69. However, the difference for those aged over 80 is not significant (p=.164).

⁸ OLS regression

Figure 4D Health by education



N=1126

Table 4D Significance of differences in health by education

Age Group	Variable	Coefficient	Standard Error ⁹	z stat	P> z	95% Confidence Interval	
50-59	Education Group	0.51	0.132	3.88	0.000	0.252	0.768
60-69	Education Group	0.4	0.128	3.12	0.002	0.149	0.651
70-79	Education Group	0.707	0.166	4.26	0.000	0.381	1.032
80+	Education Group	0.363	0.261	1.39	0.164	-0.148	0.874

⁹ Ordered logit regression, coefficients reported for each age group

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