

REPORT

FOR
FUTURE LIVING

INNOVATIVE APPROACHES
TO JOINING UP
HOUSING AND HEALTH

Bill Davies

October 2014

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ABOUT IPPR NORTH

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NEW IDEAS
for CHANGE

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SUMMARY

England is undergoing a slow but seismic shift in its population. As a country it is ageing – among all households, the biggest growth is occurring in those headed by someone who is older than 65. This reflects some positive trends – medical advances mean people can expect to live longer, fuller lives – but demographic change brings with it challenges as well. The number of single-person households is growing, especially in older age, meaning that less informal support and care is provided within the home. At the same time, the costs of providing adult social care for both older and vulnerable people are increasing, putting strain on local government finances and the NHS.

For too long, the policy realms of housing and health have been disconnected, with each tending to follow its own path, often impeding or counteracting the other's objectives. This is in spite of warnings from the World Health Organization that poor-quality, inappropriate housing can drive accidents in the home, cause hospital admissions, and – at worst – lead to shorter lives (see WHO 2014).

These disconnects come at a cost. It has been estimated that poor housing costs the NHS at least £1.3 billion a year due to hazards in the home and medical problems associated with fuel poverty and energy inefficiency (Nichol 2014).

The gap between these policy realms becomes more visible, and more important, as people age. Older people spend more time in their home than other age-groups (HAA 2013), are more at risk of poor health, and consume over three-fifths of all social care spending (NAO 2014). It is therefore essential to ensure that the place they live in supports them in maintaining good health.

Steps to bringing housing and health together must account for people's preferences. Most people want to live independent lives and to stay in their own home as they age. England's housing offer, however, is not equipped to support people to stay where they are, or to move on to more appropriate housing. Contrary to consumer demands, the new stock of open-market, mainstream housing is small by international standards (Roberts-Hughes 2011). More than a fifth of houses still fail to meet the Decent Homes standard, first set in 2000 (DCLG 2014a). Of the four key measures of accessibility, which assess people's ability to move around and thus to stay in their own home, only 5 per cent of English houses have all four, and over a quarter of houses have none (ibid). Even adapting the current stock is not simple: for 43 per cent of the housing stock in England, adaptation to meet the key accessibility standards is either unfeasible or would require major works (ibid).

When people want to move on to accommodation that is potentially more appropriate for their needs, the options remain limited. The main political parties are now committing to major housebuilding targets, so it is essential that they consider the type of housing they are building, and who these houses will be for. With older age-groups seeing the biggest increases in population projections, new units suitable for these groups is a core part of the answer. Despite an array of different bespoke units designed specifically for older people, the stock that could help people to live independently in old age is in short supply. Retirement homes, with or without care and support, provide only 5 per cent of housing for older people (Clifford et al 2011), despite evidence of much higher demand.

Housing provision needs to change to reflect the serious impact that inadequate housing stock has on the health of our older population and on the state of public finances.

Helping people to adapt their homes

First, policy needs to be designed to offer more to people who want to stay living independently in their own homes for longer. People should be encouraged to take responsibility for adapting their owner-occupied property as they age. Two mechanisms offer a way forward, while potentially shielding the already overstretched system of disabled facilities grants (DFGs): an **adaptations insurance premium on buildings cover for over-50s**, and **equity release loans and low-interest loan facilities provided by local authorities**.

For low-income social renters, the way that DFGs are allocated should be reformed to ensure that the long delays of the current system are not getting in the way of adaptations that could provide a preventative benefit. To this end, **GPs should be able to 'prescribe' home adaptation grants where a patient's health would benefit**.

Ensuring housing reflects societal changes

Second, new housing provision needs to reflect social change by offering the additional space that older people seek and meeting higher building standards that support independent living in older age. Doing so will limit the future spill-over costs of poor housing to the NHS and adult social care system.

Decent space standards and Lifetime Homes standards should be phased in to national building regulations requirements. However, previous experience of public leadership in housing standards, such as that provided by Parker Morris in the last century, has shown that improved standards in the social sector can drive better behaviour in the private sector. To this end, the Homes and Communities Agency (HCA) should ensure that **building homes both to minimum space standards, and adaptable to Lifetime Homes standards is a condition of public funding**. These standards should extend to all homes supported with public money, including developments financed by local authorities and ALMOs.

In addition, **central government should allow local authorities to apply their own additional minimum space and accessibility standards for developments**. To compensate for the additional costs of building to Lifetime Homes standards and space standards, local authorities should be allowed to offer **new homes built to these specifications discounted stamp duty up to a sale value of £500,000 where the buyer is over 55**. As an additional benefit, incentivising housing transactions among older people should increase the availability of larger family homes in the property market.

Supporting people to look after one another

Third, there needs to be a much more supportive environment for people who want to continue to live independently, and take responsibility for looking after each other. One part of the answer is to deliver more specialist sheltered housing. The limits of private development in this market mean that social housing providers will need to be more active in delivering sheltered accommodation. With capital grants to fund new developments dwindling, local authorities **should deploy their borrowing capacity via housing revenue accounts and housing corporations to invest in sheltered accommodation**.

Any new developments should also enable older people to do more for themselves and for each other. Older people already provide mutual support in the home, bringing together housing and health in direct and informal ways. It is estimated that the informal care market is larger than the formal care market, with around 1.2 million people in England over the age of 65 providing some form of informal care to adult children, partners or friends (ONS 2014f). International evidence highlights 'intentional community' models – such as multigenerational housing and senior

cohousing – that support this form of care bespoke housing developments and the retrofitting of existing clusters of homes.

‘Intentional community’ models should be systematically tested in the market by social housing providers and the Department of Health. Local authorities and the Department of Health (DoH) should make available their surplus land to bids by organised and interested community groups looking to provide mutually supportive living arrangements.

The international evidence offers examples of how households across the income spectrum can participate in developing appropriate housing for independent living:

- For middle-income groups, there should be a more supportive environment for people seeking to build community housing themselves. Local authorities such as Leeds City Council and housing associations such as Hanover have shown that self-starters can successfully deliver community housing, with their support.
- For lower-income groups, local authorities and housing associations looking to develop new schemes should invite their own tenants to form community housing groups to ‘codesign’ and drive future developments. These arrangements should be closely monitored to gauge their impact on demand for social care.

The preferences of older people are not supported by the inadequate choices available in the English housing market. In most cases, it will be appropriate to better support people to live in their own homes for as long as possible. The new housing stock of the future must reflect this, and our existing stock must be adapted to it. At the same time, there needs to be a more comprehensive offer for those who seek to move on, which demands more innovative approaches to delivering housing that is capable of supporting both formal and informal approaches to maintaining good health in older age.

1. INTRODUCTION: RESEARCH QUESTIONS AND METHODOLOGY

In exploring housing and health for older people, our research examined the following questions:

- What do older people expect from their housing and housing providers?
- What choices does the UK housing market offer older and vulnerable people?¹
- What can we learn from the international literature about housing for older people, and can so-called intentional community approaches offer innovative housing and care solutions?

And:

- How can the public policy environment be adapted to ensure more choice in future housing and support arrangements and more cost-effective public service delivery?
- How might solutions for older people be applied more widely to support people with other social needs?

To understand older people's expectations in the housing market, our research looked at previous research on the preferences of people aged 65 and over, drawing on both quantitative surveys and qualitative interviews undertaken by others. In addition, we ran two focus groups of our own, involving over-55s and over-65s, to provide deeper information on people's wishes in this area.

With an understanding of what older groups need and expect from the housing market, our research used statistical methods to create a clear picture of the housing that older people inhabit now and the choices that the English housing market offers to them. This drew on a range of sources, including data from the 2011 census, the English Housing Survey, the Care Quality Commission, and a number of other sources devoted to older people's housing, such as Age UK and studies by the New Policy Institute.

Having established that the English housing market presents only a limited range of options to older people, our research explored the international literature to identify different models of housing and support, focusing on countries that face similar demographic challenges. This review considered ideas that could potentially be adopted in England and adapted to an English housing and health context. We then tested a number of these ideas with our two focus groups.

Finally, based on the information drawn from our research, and through consultation with external experts, this report outlines a range of possible policy measures designed to ensure that the current and future stock of housing for older people is more effectively focussed on supporting their health requirements.

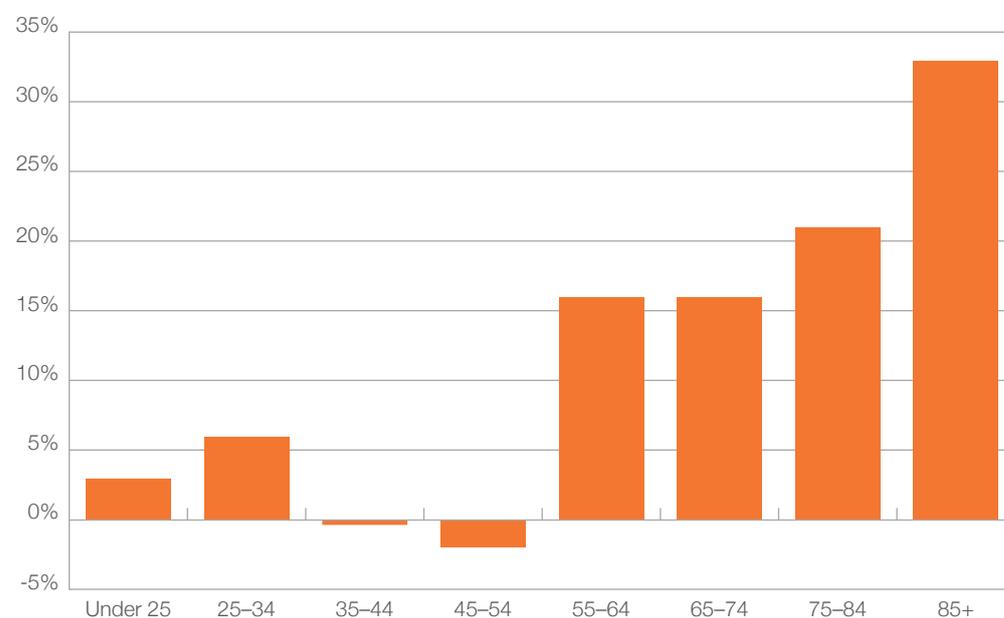
¹ See the appendix for a clarification of the terms 'older people' and 'vulnerable people', as they are used in this context.

2. BACKGROUND: AGE, HOUSING, OWNERSHIP AND OCCUPANCY

The English population is ageing, with the section of the population aged 65 or over is set to grow faster than younger age-groups in the coming decade.

Figure 2.1

Percentage change in number of individuals, by age-group (England, 2012–2021)



Source: ONS 2014c

While the proportion of individuals aged 35–54 is set to *fall* over this period, the groups seeing the most growth are over the age of 55. By far the strongest growth is in the over-85 group, which in only 10 years is set to increase in size by a third. By 2036, the share of the population over the age of 65 will have climbed from 17 per cent in 2010 to nearly a quarter (Lawton and Silim 2012). The implications of a population that is older overall, and includes a much larger group of much older people, have been discussed in length in a range of papers covering the impacts on health, care arrangements, pension entitlements and public finances (ibid).

Beneath the headline population data are other factors that warrant attention. As people get older, these other factors include how the structure of households may change and how the physical and mental health profile of older age-groups may change.

Household structure

In terms of household structure, table 2.1 outlines the marital status of England's over-65 population, by comparison with under-65s.

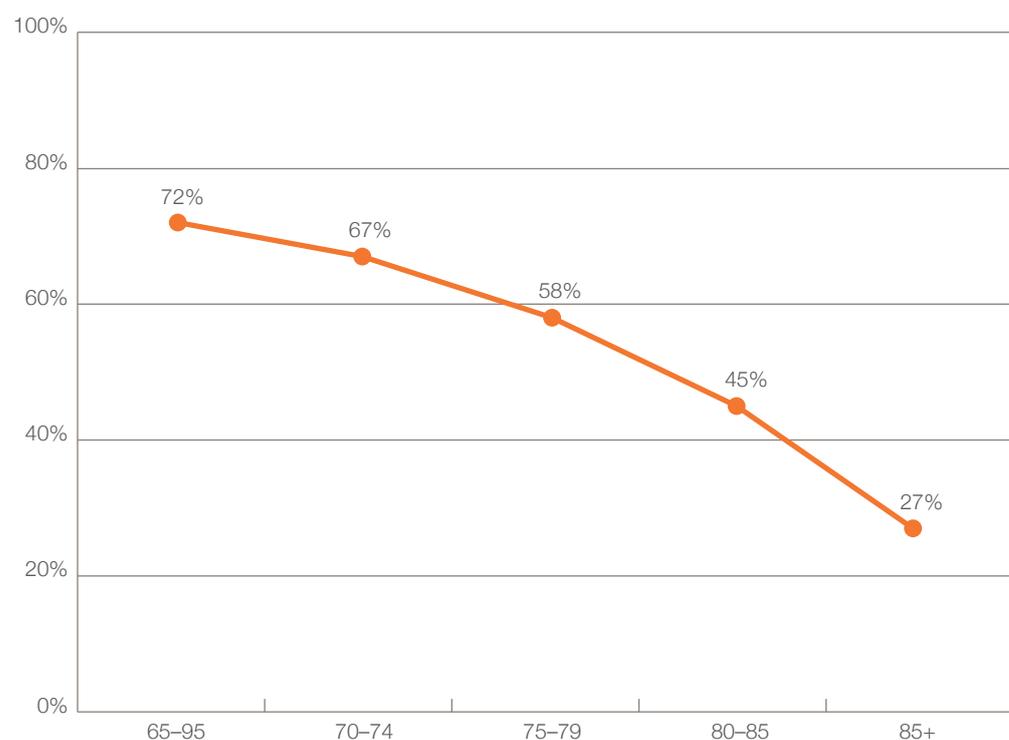
Table 2.1
Relationship status of households (England, 2011)

	16–64	Over 65
Living in a couple: Total	58%	59%
Married or in a registered same-sex civil partnership	43%	56%
Cohabiting	14%	3%
Not living in a couple: Total	42%	41%
Single (never married or never registered a same-sex civil partnership)	31%	5%
Married or in a registered same-sex civil partnership	1%	2%
Separated (but still legally married or in a same-sex civil partnership)	2%	1%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	6%	7%
Widowed or surviving partner from a same-sex civil partnership	1%	26%

Source: ONS 2014d

These data show some predictable patterns: marriage is more prevalent among the older group, but so too are widows and widowers living alone after the death of their partners. Figure 2.2 shows this change in life situation more clearly, showing the share of households living together as a couple in older age-groups.

Figure 2.2
Proportion of households living as a couple, by age-group (England, 2011)



Source: ONS 2014e

From this we can see that the size of households changes dramatically over time, particularly as households enter their 80s. While 72 per cent of households aged 65–69 live as a couple, this falls to 45 per cent for those aged 80 and older (ONS 2014e).

Households and health

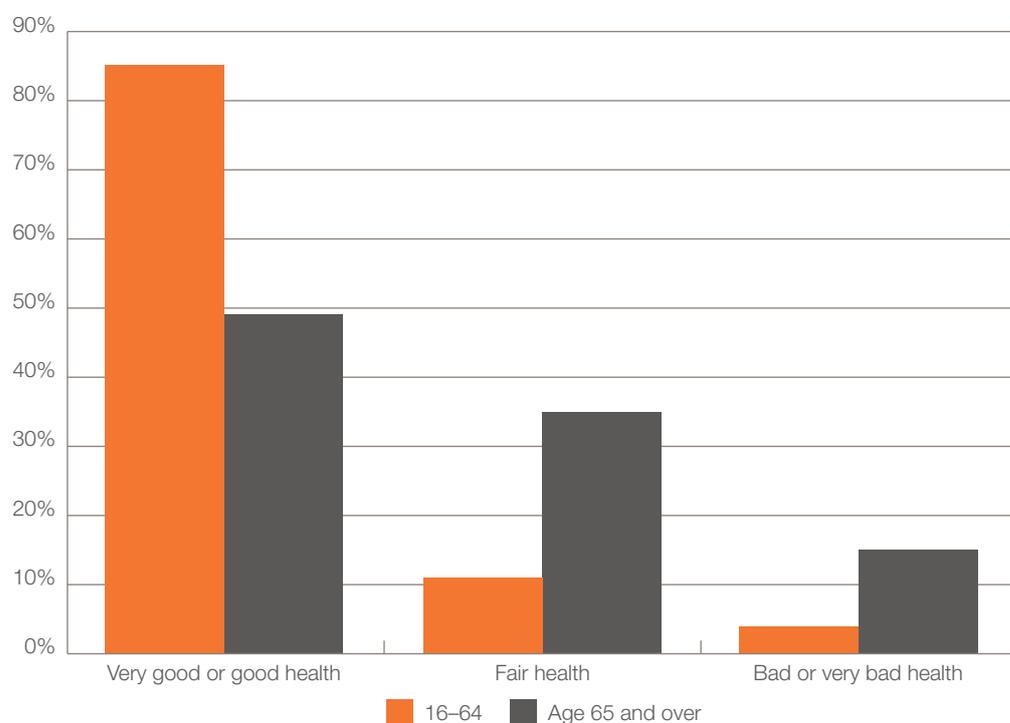
As partners pass away, the informal care, support and companionship provided by them disappears. With this loss, the risks to health from bereavement increase (see Martikainen and Valkonen 1996, Stroebe et al 2007). In addition, single-person households today find informal support and companionship more difficult to access. For example, McNeil and Hunter (2014) show that, compared to previous generations:

- Older generations now are less likely to have children to care for them.
- Children are now more likely to live further away from their parents.
- The community assets that once helped to support older people, such as libraries, post offices and pubs, are disappearing.

People on lower incomes may be at higher risk of isolation and loneliness than others. This is because the demography of low-income older people is different: according to DWP housing benefit statistics, 80 per cent of claimants over 65 in England are single (DWP 2014a).

In combination with increased isolation and loneliness, the older people become the more acute their health needs are, as shown in figure 2.3.

Figure 2.3
Health status by age-group (England, 2011)



Source: ONS 2014g

Note: In this case, 'health status' is self-identified by the respondents.

In addition, just over half (52 per cent) of older people report having a long-term health problem or disability that limits their day-to-day activities (ONS 2013).

Many older people give and receive informal support in their own home. Informal provision is a major part of the care system in England, and – if considered in monetary terms – the value of informal care far outstrips current expenditure on formal care (NAO 2014). ‘Care’ covers a range of supporting activities, on a spectrum, ranging from simple acts such as cooking, cleaning and helping with day-to-day tasks such as taking medication through to more intensive arrangements. Linda Pickard has estimated that ‘around 85 per cent of disabled older people living in their own homes in England receive informal care and, of these, over 80 per cent receive care from either a spouse, an adult child or both’ (Pickard 2008).

The scale of informal provision in England and Wales is substantial: according to 2011 census data, 14 per cent (1.3 million) of the household population aged 65 and over provided some level of unpaid care (which includes looking after a partner, older parent, or adult child); this included 6.9 per cent who provided 1–19 hours of unpaid care a week, 1.8 per cent who provided 20–49 hours, and 5.6 per cent who provided 50 hours or more each week (ONS 2013). Age UK estimates the total value of informal care at around £11 billion (Age UK 2014).

Such support is both economically and socially valuable, as it can delay or even prevent people accessing formal care services, which are more expensive, and tackle isolation and loneliness, which are known to affect other health outcomes in turn (McNeil and Hunter 2014). The extent to which informal care can enable older people to continue living in their home will vary according to their condition, their proximity to informal care provision (such as family and friends), and the ability of their living environment to support their changing health and family dynamics.

Owner-occupancy and mobility

The government reports that ‘older people occupy nearly a third of all homes’ in England, despite 2011 population estimates showing that over-65s represent only 16 per cent of the population (ONS 2012).² Overwhelmingly, the majority of older households in England (77 per cent) own their own homes, which is 12 percentage points higher than the aggregate rate of owner-occupancy (DCLG 2014a). Most own their properties outright, as shown in figure 2.4.

As outright ownership levels rise with age, ownership with mortgage debt falls away. This combination of high ownership levels and low levels of mortgage debt means that older people hold a considerable stock of property equity: households of over-65s collectively own around £500 billion of mortgage-free property equity (Clifford et al 2011). In addition, over-50s account for ‘40 per cent of consumer spending, 60 per cent of UK total savings, and 80 per cent of the nation’s wealth’ (ibid). While owner-occupancy levels are predicted to fall for younger households – by 2 per cent between 2013 and 2018 – the Office for Budget Responsibility predicts no such trend for pensioners, with the rate for this group expected to rise by more than 1 per cent over the same period (OBR 2014).

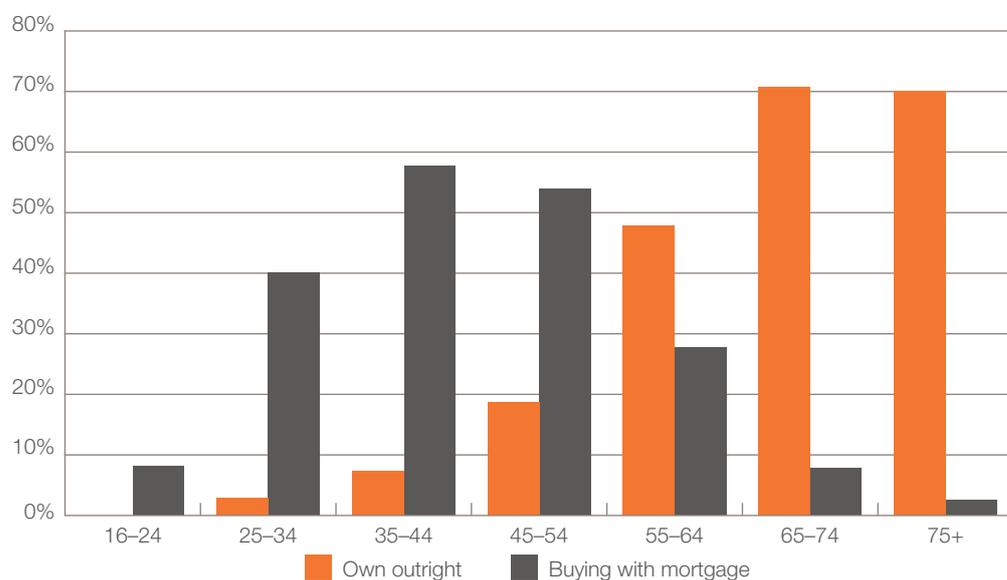
Despite being both substantial holders of property and property equity, over-65s are not, relatively speaking, an active age-group in the property market. In their study for the New Policy Institute (NPI), Pannell et al (2012) estimated that an average of around 110,000 older households move to owner-occupation property (from any tenure) each year, while overall residential property transactions for England were around 790,000 in 2012/13 (HMRC 2013). This suggests that over-65s were responsible for no more than around 14 per cent of property transactions,³ despite representing 16 per cent of the population and occupying a third of homes.

² The extent to which older people ‘overconsume’ their housing is discussed briefly below.

³ The estimate of Pannell et al was based on over-55s, not over-65s. Therefore, the 14 per cent is a maximum estimate, and the true total is likely to be significantly lower.

Figure 2.4

Owner-occupancy status, by age-group (England, 2012/13)



Source: English Housing Survey (DCLG 2014a)

Reinforcing this finding, the NPI study goes on to show that households over the age of 55 are much less likely to move home: just 28 per cent had moved home in the previous 10 years, compared to 66 per cent of other households (Pannell et al 2012). The reluctance of older people to move home even when health and family dynamics change is a challenge for policymakers and housing providers seeking a more efficient and appropriate allocation of existing housing stock.

Older renters

While the overwhelming majority of households over the age of 65 are homeowners, and the majority of those homeowners are living mortgage-free, there remains a significant minority (a quarter of households headed by someone over the age of 65) who do not own the property they inhabit.

Of the 1.3million older households who do not own their own home, the majority (78% per cent) are social tenants, with the remainder in private rented accommodation (DCLG 2014a). This contrasts markedly with the wider population, where private renting now exceeds social renting for the first time in half a century (DCLG 2014a).⁴ Of those who rent from social landlords, 46 per cent live in local authority homes, with the remaining 56 per cent living in properties owned by a registered social landlord (RSL)(DCLG 2014a).

Most of these older tenants are not on high incomes. There are around 1.06 million over-65 households in England claiming housing benefit to support the costs of (predominantly) social rent properties (DWP 2014a). This means that the overwhelming majority of older households who are renting are in receipt in housing benefit to meet the costs of their rent.

⁴ The higher share of the elderly in social housing relative to younger groups of the population is explained by several factors. First, allocation priorities for social housing waiting lists often favour older and vulnerable tenants, giving them an advantage over other groups looking to access social rented properties. Second, in the decades before the 'right to buy' was introduced, social housing construction was higher, social tenancies were less scarce, and tenants of good social rented homes – elderly inhabitants in particular – could stay put. Now, access for younger people needing social housing is increasingly constrained by diminished supply.

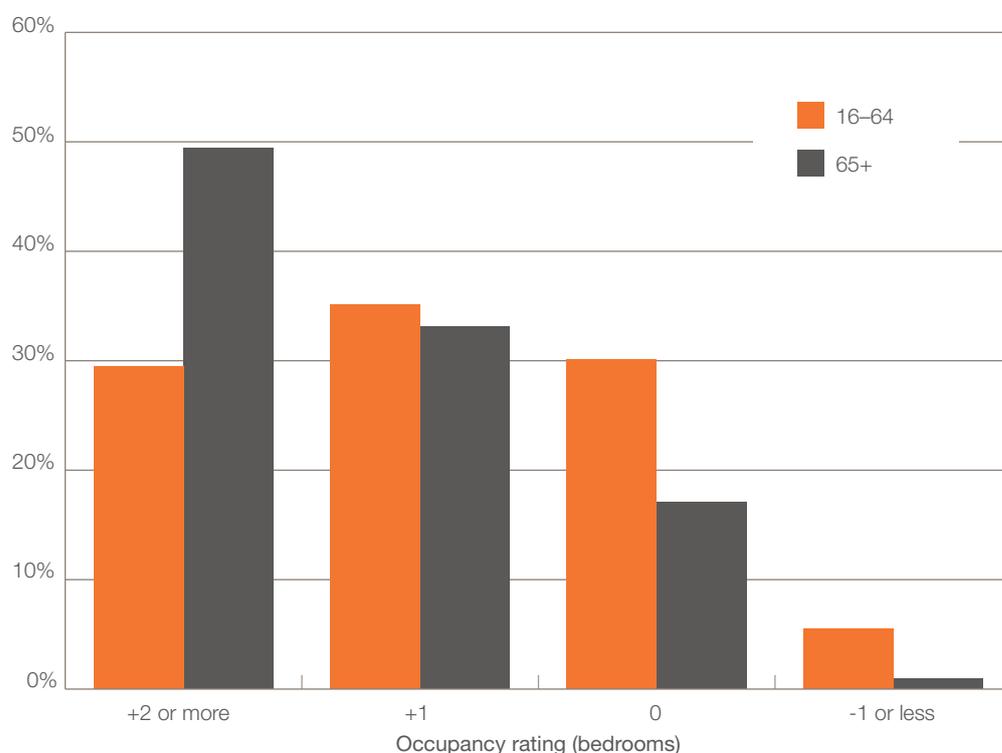
Moreover, as with owner-occupiers, social renters are reluctant to move as they get older (Pannell et al 2012).

Under-occupancy

Older people are less likely to move as their circumstances change, for example, as their dependent children leave home. This can result in older people continuing to live in houses that are perceived as ‘too big’, in a phenomenon commonly known as under-occupancy. Figure 2.5 shows the number of unoccupied bedrooms per household (the ‘occupancy rating’), as a comparison between under- and over-65 age-groups.

Figure 2.5

Occupancy rating (number of unoccupied bedrooms) per resident, by age-group (England, 2011)



Source: ONS 2014b

Note: For example, +2 indicates two unoccupied bedrooms.

While older people are technically more likely to under-occupy their property, the validity of the definition of ‘under-occupancy’ is contested. Age UK, for instance, argues that the official definition of under-occupation is at odds with what older people understand by the term. Nevertheless, using existing housing stock more efficiently would have its advantages:

‘If just half of the 58 per cent of over-60s interested in moving (downsizing or otherwise) were able to move, this would release around £365 billion worth of (mainly family-sized) property – with nearly half being three-bedroom and 20 per cent being four-bedroom homes.’

AgeUK 2014

Yet public policy has not looked to tackle under-occupation among the over-65s. Recent attempts to reallocate social housing through the under-occupation penalty on housing benefit (or ‘bedroom tax’) excluded the largest group of under-occupiers – the over 65s – and was not aimed at owner-occupiers at all.

Summary

Over-65s make up the fastest growing section of households in the UK. Longer lives are a positive development, but there is a growing proportion of people, especially on low incomes, who live alone. There are also substantial health problems among the older population, with over half managing a condition that limits their daily activities.

As most own their properties – outside of either the bespoke ‘retirement’ housing market or residential care – many will need some combination of formal and informal support to allow them to continue to manage their health conditions and live at home. They will also need a living environment that can support their condition. However, many are reluctant to move when their health or living circumstances change.

The following two chapters illustrate how this is partly a result of the mismatch between what older people want in a good home and what the market actually offers.

3.

WHAT DO PEOPLE WANT FROM HOUSING AS THEY AGE?

If policymakers want to make better use of the housing stock that is available to older people, and to encourage people to move to different, more appropriate accommodation to suit their family size and health requirements, then provision must account for the preferences of older people.

General housing preferences

There have been a range of studies looking this question. Recently, survey work conducted by the NPI for Shelter and the Joseph Rowntree Foundation provided a detailed picture of the preferences of people aged 55 and over (Pannell et al 2012). Their report found that, in terms of their housing, older people prioritise the following factors:

- close to shops, services and transport links
- somewhere safe and secure
- close to family and friends.

Other factors mentioned in the review but given lower priority were those that might make moving more attractive for older people, including ‘living somewhere with dedicated on-site facilities (ie healthcare services and social activities)’ (ibid).

Of the specific property requirements, the NPI report identified three common priorities:

- well-insulated/easy to heat
- own garden or outdoor space
- at least one spare bedroom.

We put these priorities to our focus groups, and asked participants: ‘If you needed to move house in the next 10–15 years, what features would the property need to support you?’

‘One extra room I’d like, so that my family could stay’

‘I’d like solar panels to keep the energy costs down’

‘And decent windows and doors that shut properly’

‘You’d have to have a garden that you could look after’

However, preferences are generally broader than this. Table 3.1 provides a summary of the key themes across a synthesis of the literature by the NPI, our IPPR North two focus groups, survey and focus group work by the National Housing Federation (NHF), and qualitative research for the Department of Communities and Local Government (DCLG).

Across different studies, there are various preferences that show up repeatedly. Principal among these is a desire for space, with at least two bedrooms (equivalent to the ‘+1’ occupancy rating in figure 2.5) to support sleeping separately where preferred, having relatives and friends to stay, or simply for storage. Access is also identified as essential, both in terms of the ability to conveniently reach local services and transport links, and to move easily around the house and have

assistive technology installed where that becomes necessary. Our focus groups were also particularly keen to stress the importance of gardens, both to spend time in and as a way to keep fit.

It is clear is that most of the preferences shown in the table – such as security, good looks and space – will be shared by younger age-groups too.

Table 2.1
Summary of older people’s preferences for housing

	NPI	IPPR North focus groups	NHF*	DCLG
Location	Housing that is well-located in terms of nearby green space, public transport, shops and leisure facilities	Good transport links into town / to the shops		Access to services, including transport
Accessibility		Accessibility features, such as room for a stair lift	Accessibility	Accessibility around the home
Security	A safe and secure location and with good road and pedestrian access.		Safe and secure	
Space	At least two reasonable sized bedrooms – or if not, at least an equivalent large enough flexible open-plan space	A spare bedroom for family and friends to stay, and if necessary look after you		Two bedrooms, both for singles and couples
	Not too small with enough living space to sit, to eat, for hobbies and to have friends round		Spacious and attractive	Living space for other activities of daily life
	Storage space that is accessible	Storage space for possessions and hobbies		
	A reasonable sized kitchen with room for dishwasher and washing machine	Big kitchen / kitchen-diner		
	A good sized and attractive (not ‘hospital-style’) bathroom			Downstairs bathrooms and walk-in showers
Running costs	Easy to manage and economical central heating system	Easy and inexpensive to heat/run		
Garden	Pleasant outlook and some outside green space	A manageable garden		
Community / privacy	Housing that looks nice from the outside, and if there are communal areas they should be welcoming, well cared for and not institutional	My own front door	Allows residents to socialise and feel included	
Support		If sheltered, there should be someone on site to look out for you / to give family peace of mind	Provides flexible, personalised support	Help with one-off tasks
			Within an age friendly environment	Inclusive environment
			Has help available	
			Offers freedom, choice and flexibility	

Sources: Pannell et al 2012, Clifford et al 2011, Croucher 2008
* The NHF research (Clifford et al 2011) focused on retirement housing.

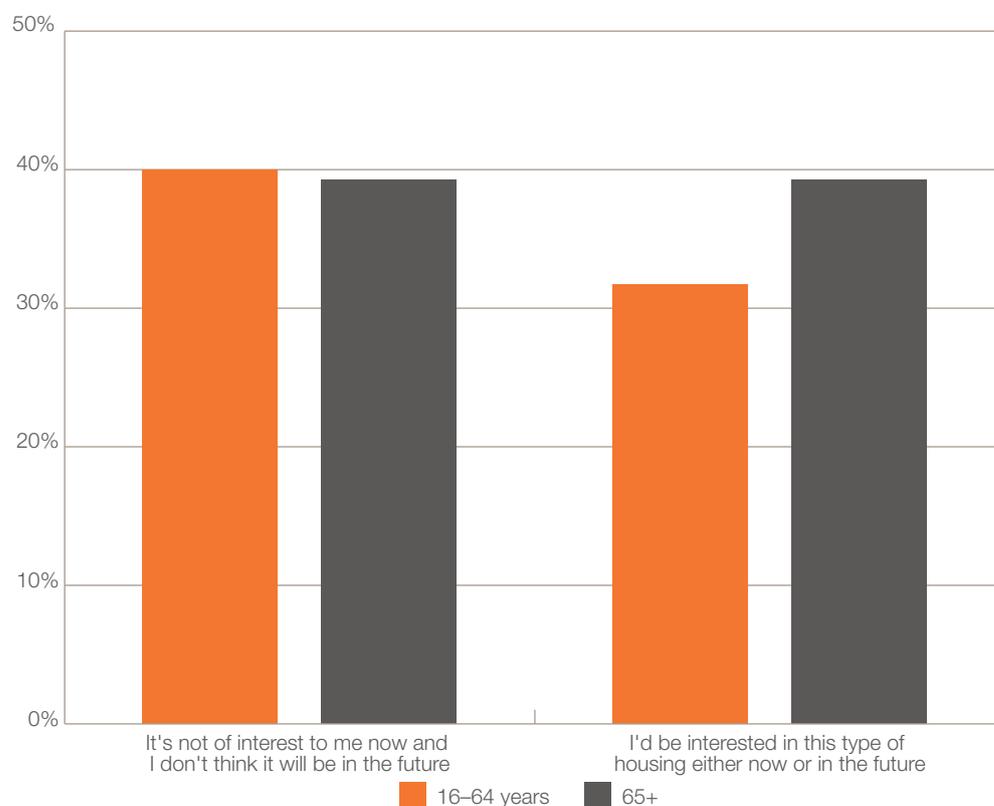
Targeted support facilities

Another feature of previous research and our own focus group discussions are facilities specifically targeted at older people, such as help with one-off tasks, on-site managers or wardens, and communal spaces and social activities.

Many of these targeted services are available within 'retirement housing' – that is, specialised housing developments for elderly and vulnerable people. However, the supply of this type of housing, as opposed to 'general-needs' housing, is very limited, with retirement housing catering for only around 5 per cent of older people (Clifford et al 2011). This does not imply that people are not interested in retirement housing, or will not become interested as they get older. Indeed, polling indicates the opposite, as figure 3.1 shows.

Figure 3.1

Attitudes to retirement housing, by age-group (Great Britain, 2012)



Source: Hughes 2012

Note: Poll conducted by YouGov, base 897.

This suggests that potential interest in retirement housing is much higher than its current availability. In addition, while older people are generally owner-occupiers, most specialist accommodation for older people is available for rent rather than purchase.

'In 2010, there were an estimated 610,000 units of retirement housing, 90 per cent of which were 'with support' and 10 per cent 'with care' ... By tenure, 20 per cent were for ownership and 80 per cent for rent.'

Pannell et al 2012

By contrast, there are around 10 times as many older households in England: ONS data shows there are around 6 million households headed by a person aged 65 or over, expected to rise to more than 7 million by 2021 (ONS 2013). If national policy objectives continue to emphasise a more efficient use of the housing stock, by enabling people to move out of their old (larger) homes and potentially downsize to bespoke retirement communities, then more action is needed to promote these types of developments for owner-occupation as well as rent, in order to bridge the gap between potential demand and actual supply.

Attitudes to care homes

If physical and mental health deteriorates, some older people need to go into accommodation providing residential care. Data from the Care Quality Commission (CQC) suggests there are around 13,000 residential care homes in England, and a further 4,500 homes offering nursing care (CQC 2014a), offering 464,000 bed spaces in total. Residential care and nursing homes attract a great deal of attention from the media, but cater for a relatively small section of the older population, accommodating only around 400,000 people over the age of 65, or 4 per cent of all over-65s.

The quality and cost of care in England varies. The CQC has found that one in 10 care homes is not providing the full care and support that residents require (CQC 2014b). Generally, care is expensive, and the costs and financial support available vary widely by local area – maximum weekly fees paid out by local authorities are recorded as ranging from £331 to £1,082 (NAO 2014).

The cost and reputation of residential care appears to influence people's attitudes to it. Survey data on this point is dated, but is outlined in detail in the flagship Wanless review of adult social care. The summary of the evidence available at the time is worth quoting at length:

'A national survey of older people living in the community (McCafferty 1994) found that after the onset of significant disability more than four-fifths of older people wished to remain in their present homes, supported by community-based services. Other surveys (Fell and Foster 1994) asked where people would like to live if they were housebound and again their current home was prioritised, although a significant number also chose sheltered housing. Only 5 per cent wanted to either move to a home or in with their family. One-third of the respondents in the Grey Matters survey (Sykes and Leather 1997) said that they would not like to move under any circumstances. A review of the literature carried out by the DWP (in 1999) supported this view (Boaz et al 1999).'

Wanless 2006

The review goes on further to explore people's attitudes to moving into residential care, showing that as many as 41 per cent of people were against going into residential care. A more recent poll by YouGov for the Alzheimer's Society found that 70 per cent of respondents would be 'scared' of moving into residential care homes (Alzheimer's Society 2013).

Attitudes are understandable in the context of recent abuse scandals and patchy quality. The latest CQC update identified that around 9 per cent of residential homes are failing to meet monitoring standards, rising to around 14 per cent for nursing homes (CQC 2014b). Research by Robards et al (2014) found more serious outcomes. Controlling for a range of variables (including health), the research identified that people who moved into residential housing had a higher mortality rate than people who stayed in individual accommodation. This was particularly true of single people.

These attitudes are reflected in government's longstanding preference for keeping people out of residential care and living independent of care services altogether where feasible. For instance, the National Health Service and Community Care Act of 1990 made local authorities responsible for organising community care, and emphasised that local government should provide support for people in their own homes where possible. This thread continues to run through current government objectives, partly on account of people's preferences, but also on account of the expense of providing care out of public funding, and especially the cost burden associated with institutional care homes.

Given the expense of receiving institutional care to both residents and the public purse, taking preventative action to ensure older and vulnerable people are able to live independently for as long as possible must be a key objective –not least because it is not clear that residential care can absorb the strain. The insurance firm Bupa, among others, has predicted that by 2020 there will be a shortage of 100,000 places in adult social care, a consequence of declining provision and increased fiscal tightening (Bupa 2011).

Summary

The key demands of older people in the housing market are much the same as those of other people in the housing market: reasonable-sized houses, in good places, with modern fittings that are cheap to run.

What is also clear is that when health needs change, people appear to prefer to remain in their own home with support either in the home or in the community, rather than be transferred into institutional care facilities. This is not to imply that as people age they are not aware that where they presently live may not be appropriate forever or may need to be adapted. While they may be reluctant to plan their housing needs far in advance (Pannell et al 2012), our focus groups showed that people in the younger group (50–55) were aware of the potential changes to family size, income and health that might affect what they need from their accommodation and what compromises might be necessary.

The challenge for the market, social housing developers and policymakers is to develop housing both that people want to live in, and that permits people to live healthy, independent lives in their home for as long as possible. As the following chapter outlines, our current stock of housing falls well short of supporting either aim.

4.

UNHEALTHY HOUSING: THE STATE OF ENGLAND'S HOUSING OPTIONS FOR OLDER PEOPLE

Whether or not it is convenient, either for planning policymakers in Whitehall or delivery agencies at the local authority level, housing and health are connected. The World Health Organization says that 'poor design or construction of homes is the cause of most home accidents. In some European countries, home accidents kill more people than do road accidents' (WHO 2014). A briefing for the Housing Learning and Improvement Network summarises the connections succinctly:

'Housing quality and suitability is a major determinant of health and well-being, and hence impacts on demand for NHS services. Older people are the main users of both hospital and primary care and their homes are a particularly important factor in maintaining physical and mental health and addressing health inequalities.'

'There is a causal link between housing and the main long term conditions (eg heart disease, stroke, respiratory, arthritis) whilst risk of falls, a major cause of injury and hospital admission amongst older people, is significantly affected by housing characteristics and the wider built environment.'

HAA 2013

Across all age-groups, housing that fails to meet the basic 'Decent Homes' standard is estimated to cost the NHS in England around £600 million per year on account of hazards in the home, and a further £700 million per year due to inadequate heating (Nichol 2014). There are, as well, specific costs associated with older people. The costs of hospital admissions for trips and falls, for example, are high: David Oliver at the King's Fund estimates that 'falls account for around 40 per cent of all ambulance call-outs to the homes of people over 65 and are a leading cause of older people's use of hospital beds'(Oliver 2013). Hip replacements, a common consequence of falls among older people, cost the NHS around £2 billion a year in surgery and care (HAA 2013), with the average cost of each operation estimated at around £28,000 (Papworth Trust 2012).

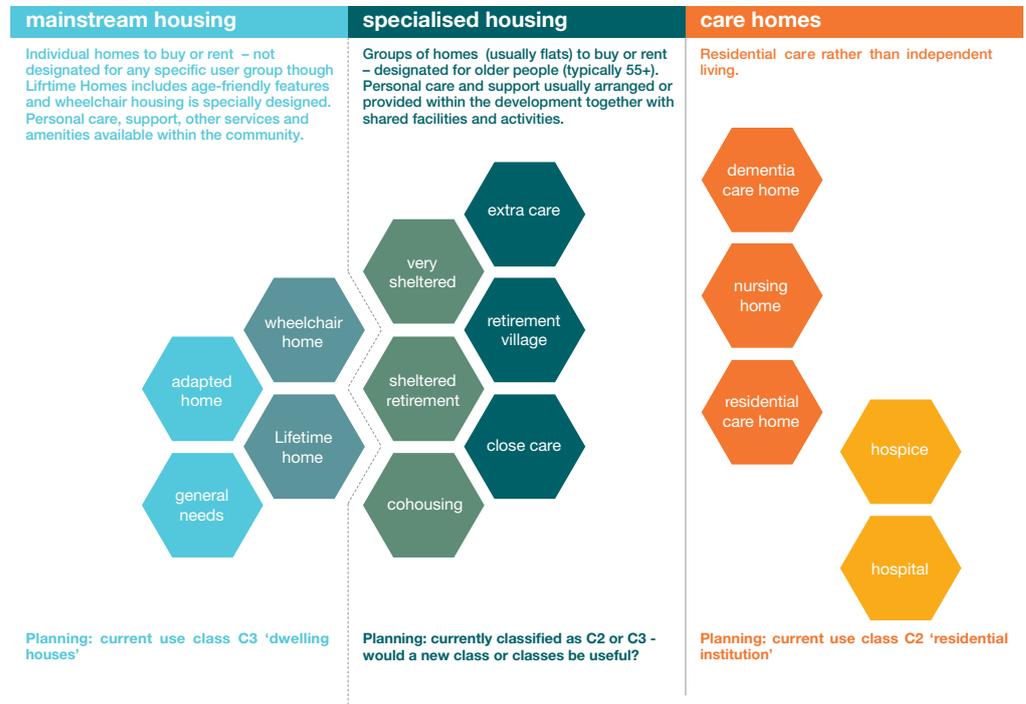
The connection between an older person's health and their environment is complicated (see for example Lord et al 2007). However, because hospital visits and residential care (and domiciliary care) are so expensive, supporting people to live independently is entirely in step not only with public health and finance objectives but also with the preferences of people as they age.

Healthy mainstream and community housing

Figure 4.1 shows the variety of housing options on offer to older people. To the left is the most common form of housing for older people, 'mainstream housing', which is not designated (or necessarily designed) for any particular group of people, whether ageing or vulnerable.

Figure 4.1

Mainstream, specialised and care-home housing: the HAPPI spectrum



Source: Best and Porteus 2012

Note: This diagram was supplied to the All Party Parliamentary Group on Housing and Care for Older People as part of the 'Housing Our Ageing Population Plan for Implementation' programme, or HAPPI 2.

As outlined in the previous chapter, living in mainstream housing is overwhelmingly the most common housing option for older people. It also appears to be the preferred option of future older generations. The Wanless review into older people and care found that for most people (62 per cent) their preference would be to remain in their own home and receive support from family and friends (Wanless 2006).

Given that the majority of older people live in mainstream housing, and polling suggests that future generations will want to do so as well, having homes that support and even benefit their health is important. Decency, space and accessibility are therefore essential to ensuring that older people can enjoy good health in their own home.

The Decent Homes standard defines a basic level of housing quality in England, covering a range of potentially hazardous effects of living in different types of accommodation. However, data from the English Housing Survey shows that around 1.7 million people aged 60 or over are living in houses that do not meet this standard (DCLG 2014a). While social housing (local authority or RSL) tends to perform well in meeting the standard, most older people live in private, owner-occupied accommodation. Moreover, because they tend to spend more time at home than people in other age-groups, older people are more susceptible to the effects of poor-quality housing. According to Age UK (2014), over-65s spend around 80 per cent of their time in their own homes, with over-80s spending 90 per cent of their time at home.

England's space problem

The previous chapter showed that older people prioritise space, for having people to stay, having visiting support (HAA 2013), and storing health and medical equipment when necessary. However, the new UK housing stock is not providing this essential space. As a 2006 report for the mayor of London summarised:

'Space standards in the UK are below the European average, indeed UK standards appear to be near the bottom of the range. There is also some evidence that the differences between space standards in public and private provision are greater in the UK than elsewhere in Europe.'

HATC 2006

More recent research on the emerging stock of housing has reinforced this concern. For instance, a report by the Royal Institute of British Architects (RIBA) found that new homes in England are typically the smallest in western Europe. It estimated the average floor area of a new English home at 76m², compared with 87.7m² in Ireland (15 per cent bigger), 115.5m² in the Netherlands (53 per cent bigger) and 137m² in Denmark (80 per cent bigger) (Roberts-Hughes 2011).

This is supported by the English Housing Survey, which suggests that the average floor area has decreased over time, with newer homes generally having lower average floor areas (DCLG 2014a). The causes of this are complex, and partly reflect shifts in tenure patterns. However, RIBA also contends that:

'One reason many countries have bigger new homes is that they have space standards that set the minimum floor areas. In England and Wales there have only been space standards for publicly funded homes, and even these have been small compared to international examples.'

Roberts-Hughes 2011

Larger homes would support both the housing and health policy objectives and the preferences of older people. Yet deterioration in the regulatory environment has allowed smaller homes to proliferate. The disappearance of strong building standards, such as Parker Morris, and new, more limited building regulations have allowed smaller houses to be built.

As well as failing to live up to older people's expectations of housing, these smaller homes are less well equipped to accommodate changes in people's health and support requirements, and thus are less well suited to England's ageing population. For instance, narrow staircases often cannot support stair-lifts, and entrance-level toilet and bathroom facilities may be excluded from new-build plans. In a recent consultation exercise for the government, 70 per cent of the 249 respondents supported space standards⁵ being applied by local authorities, and of these 80 per cent felt that these standards should be linked to accessibility (DCLG 2014b). However, the government's response to imposing space standards has been cautious, stating that it would 'develop a national space standard to be available to councils where there was a need and where this would not stop development' (HM Government 2014).

Other mainstream factors

There are other factors, beyond living space, which mean that England's existing and new housing stock may limit the ability of people to live healthy lives at home. To ensure that people can live in their homes if they have physical health problems, such as limited mobility, a set of standards called 'Lifetime Homes' was developed in the 1990s to provide guidance on how new-build housing could support people as they age and be adaptable to residents' changing needs.

⁵ Building regulations cover a range of areas, but omitted from this are regulations covering the size of rooms. National guidance on the size of rooms is also absent (see Shelter 2013).

Based on research by Habiteq HA, Age UK and the Joseph Rowntree Foundation, the Lifetime Homes approach:

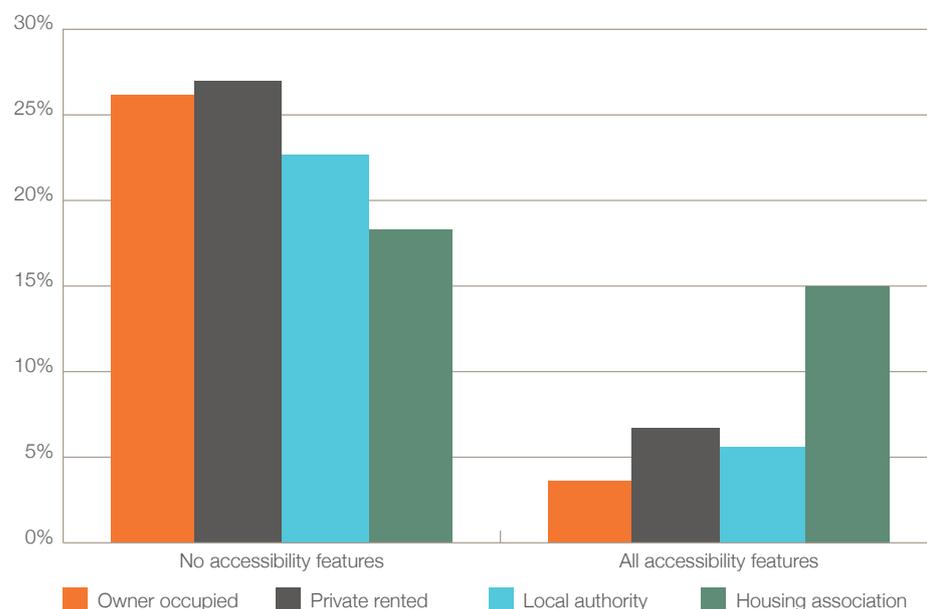
'...Seeks to enable 'general needs' housing to provide, either from the outset or through simple and cost-effective adaptation, design solutions that meet the existing and changing needs of diverse households. This offers the occupants more choice over where they live and which visitors they can accommodate for any given time scale.'

Lifetime Homes 2014

Lifetime Homes guidance includes a wide range of specifications, such as for level access, parking, the size of doorways and the width of stairwells required to allow supportive infrastructure.⁶

However, currently, older people generally do not live in new-build homes, so while setting standards for future developments may increase the choice available to older people looking to move, it would do little to support those living in their current housing. Despite the logic of better accessibility standards, existing and new housing stock largely fails basic accessibility tests. The English Housing Survey, for instance, measures four key features that promote accessibility: level access, flush thresholds, sufficiently wide doors and a downstairs bathroom. Of its sample, it found that only 5 per cent of houses had all four of these features (DCLG 2014a), and 25 per cent of properties had none at all. As figure 4.2 indicates, the prevalence of these four key features also differed by tenure type.

Figure 4.2
Key accessibility features, by tenure type (England, 2012/13)



Source: English Housing Survey, CLG 2014

Note: The four key accessibility features are level access, flush thresholds, sufficiently wide doors and a downstairs bathroom.

⁶ The key areas covered by the design guidelines include: approach to all entrances, approach to dwelling from parking (distance, gradients and widths), bathrooms, circulation space, communal stairs and lifts, entrance-level living space, entrance-level WC and shower drainage, entrances, glazing and window handles, internal doorways and hallways, location of service controls, parking (width or widening capability), potential for entrance-level bed space, potential for fitting of hoists and bedroom/bathroom, potential for stair-lifts, or through-floor lifts, and WC and bathroom walls.

While the private rented sector performed worst, providing the highest proportion of properties with none of the four accessibility features, relatively few older people (5 per cent) currently live in this sector. It is also notable that housing association properties performed much better than owner-occupied, private rented or local authority stock.⁷

The challenge for policymakers is that older people do not tend to live in new properties. Instead, the older properties they tend to live in require adaptation to make them safely inhabitable for residents and visitors alike. For this much larger group of older people, adaptations can allow them to remain in place when their health or life circumstances change.

Our focus group discussions highlighted different attitudes to adaptations:

'I know a few people who are staying in the same home, and had to get a chair-lift in.'

'Yes, I live upstairs, and I don't think there would be room for that.'

'I couldn't stand a chair-lift, have you seen them? I think if it comes to that I'd be looking to downsize.'

Another participant reflected on the cost of adapting property to stay in:

'[A neighbour] has just had to put her own shower in, because she finds it hard to get in and out of the bath – she's had to pay something like £300.'

The cost of adaptations is particularly important. Making minor adaptations can be a relatively low-cost approach to supporting people to stay in their own home where they have relatively low-level needs, including adapting existing facilities to make them easier to access and use. However, the English Housing Survey shows that for 43 per cent of existing housing stock in England, adapting it to meet the core accessibility standards would either require major work or simply be unfeasible. Predictably, older houses are more likely to be more difficult to adapt (DCLG 2014a).

For those living in properties that can accommodate adaptation, small-scale interventions are available. For instance, home improvement agencies (often called 'Care and Repair'⁸) work in conjunction with handyman programmes to provide advice and some support to vulnerable, disabled and older people seeking small adjustments to their properties or help with assembling furniture or putting up shelves. The programme received a highly positive review by academics at York University, who highlighted strong returns on often small investments in services (Croucher et al 2012). Provision remains patchy, however, and with government data showing that around one in six pensioners (or around 1.8 million) is living in poverty (DWP 2014b), many will need financial assistance for changes to their homes to support independent living.

The financial assistance currently available is largely limited to disabled facilities grants (DFGs). The means-tested DFGs have attracted some criticism: despite increased central funding by government (currently around £260 million), the administration system is sluggish, with a quarter of people waiting longer than a year for their grant to be awarded (Papworth Trust 2012). This means that there are long delays before the preventative value of adaptations is realised. The system has also latent demand, where adaptations are needed but grants have not been awarded, which has been estimated to be around 10 times current grant levels.

7 This disparities between tenure types generally reflect property age: housing associations tend to have relatively newer stock, and certain conditions of public funding have demanded stricter standards of their construction than other market housing. Similar conditions also apply to local authority stock, but having largely stopped developing homes, a smaller share of LA stock is new, and therefore covered.

8 See for example: <http://www.careandrepair-manchester.org.uk/about-us/>

In addition, some local authorities have responded to government increases in DFGs by reducing their own contribution to the funding (see Murphy et al 2013).

Fundamentally, to bridge the gap between health and housing while building properties that older and vulnerable people actually want to live in, improved space standards will have to be married up with accessibility standards. Space standards alone do not guarantee accessibility, and Lifetime Homes standards do not guarantee that a property will have adequate space for care support. Addressing this disconnection may demand a more robust regulatory environment.

In-home care

For people whose support needs have become more intensive and so exceed the capacity of minor adaptations, home visits and in-house care arrangements can enable them to continue to live in their own home. This in-home 'domiciliary care' takes a variety of forms. Care is often arranged for key periods of the day, to support people in getting out of bed, washed and fed in the morning, to provide lunch and social contact, or to provide an evening meal and help in going to bed. The costs of these services also vary widely, but domiciliary care is often expensive, with means-tested financial support available only to those with low incomes. The most expensive option is live-in care, whereby care workers stay at the person's house, often on shifts that last weeks at a time, to provide intensive care and support. In-house nursing care is also available.

Ensuring the quality of this care, given the enormous growth of this sector, is proving a logistical challenge for the industry regulator, the Care Quality Commission (CQC). While the CQC did identify that a majority of providers (of a sample of 250, responsible for 4,600 clients) were providing adequate visiting or live-in care, a significant minority (26 per cent) were not meeting the expected standard (CQC 2014b).

Specialised housing to support semi-independent living

Finally, a small proportion of older people will move into bespoke 'specialised housing' for older people, which are generally groups of homes (usually flats) to buy or to let, designated for older people. Personal support and care is usually arranged or provided within the development, together with shared facilities and activities. This way, residents are supported to live independent lives as far as possible.

For example, Age UK describes one particular specialist option, sheltered accommodation:

'Each scheme usually has between 20 and 40 self-contained flats or bungalows, but there will often be communal areas, such as the lounge, laundry room and garden. Many schemes run social events for residents.'

Age UK 2014

Clifford et al (2011) estimated that around 5 per cent of older people live in retirement homes, a category which includes retirement villages, sheltered housing, and alms houses. There is limited data available on the appropriateness of specialist housing in terms of supporting wider social objectives. However, Age UK points to problems with space in the specialist sector – as with the mainstream sector – arguing that 'most older people want a home with at least two bedrooms but most specialist provision has only one' (Age UK 2014). This perception emerged in our focus group discussions as well:

'I've been in a few [retirement homes]. It depends on how much you want to pay, but most are one bedroom.'

The limited supply of specialist housing combined with its failure to provide the space that older people expect and often require is a clear problem if policymakers wish to encourage older people to live in places where they can support themselves for longer.

In terms of support services provided in a specialist housing environment, it is estimated that around 450,000 such homes exist, either occupied or available (Pannell and Blood 2012). The diversity of the sector means that systematic evidence of its impact on residents' health and wellbeing is not available. However, there is some evidence on the importance of having a warden service present, and that – as with mainstream housing – many schemes fail to provide basic accessibility design features (ibid).

While most specialised housing (as opposed to 'care homes', the next stage of the HAPPI2 grouping) does not provide or facilitate support for people with more intensive care needs, some schemes do. Both 'extra-care' and 'very sheltered' arrangements cover 'social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home' (NHS UK 2014).

The purpose of extra-care housing is to allow for a broader spectrum of support to be offered to residents than is generally possible in retirement housing, serving to bridge the gap between retirement housing and care homes without having the distress of people having to move.⁹ An evaluation of 19 schemes for the Department of Health found that 'better outcomes and similar or lower costs indicate that extra-care housing appears to be a cost-effective alternative for people with the same characteristics who currently move into residential care' (Netten et al 2011). Other research for the Joseph Rowntree Foundation evaluated the social outcomes of these 15 schemes for residents, and found evidence that schemes were positive in promoting the social wellbeing of residents and tackling social isolation (Callaghan et al 2009).

Summary

The links between poor health and poor housing are clear, but as policy areas they are distinct. If hospital admissions are to be reduced and the strain on adult social care provision contained then it is essential that other policy areas are supporting healthier independent living at home. Yet the housing offer for older people and vulnerable people is inadequate.

Homes in England are smaller than in other comparative countries. This can prevent people from getting the in-home support that they need, and discourage others who want to move to find more appropriate housing. Small spaces also prevent adaptations that would allow people to stay at home. Furthermore, only one in 20 homes is fully accessible, according to government definitions, and there are considerable challenges to retrofitting the existing stock to allow people to live independently as they age.

Specialist stock, while better equipped for older and vulnerable people, remains in very short supply, accounting for as little as 5 per cent of the market. This is far below the potential demand for the stock. With these figures in mind, it is unsurprising that over-65s hold around one-third of the English housing stock but are responsible for as few as one in 10 property transactions (Pannell and

⁹ For instance, if people living in their homes become more unwell, or need more intensive support arrangements, they can stay in their current accommodation and the housing association or scheme manager will be able to arrange extra-care support. The distinction between this and 'standard' sheltered accommodation is that it is not necessary for people to move when their needs intensify, and services such as cooked meals and adult social care are available as 'extras'.

Blood 2012). Alternative options are insufficiently attractive or available (or both) to encourage older people to move.

Ultimately, with the pressure on social care and NHS budgets reaching unsustainable levels, reforms to other policy areas that can contribute to reductions in health costs should be promoted to meet shared objectives. In housing, this should focus on providing a housing offer that supports healthy, longer-term independent living and reduces pressures on other public services. At present, policy is not aligned, and the environment is ripe for innovation. The following chapter explores how the gaps between housing and health are bridged in other countries that, like England, are facing the challenges of an ageing population.

5.

INTERNATIONAL PERSPECTIVES: SUPPORT FOR OLDER PEOPLE'S HOUSING

Driven by good standards of living and access to high-quality healthcare, population ageing is affecting most advanced economies. Many face a similar parcel of challenges to England, particularly the financial burden associated with providing health and social care for their growing elderly populations, and their policymakers have made a plethora of responses to the challenge of supporting independent living. Through a review of international case studies, this chapter sets out some important examples.

Supporting independent living at home

The majority of people who took part in our focus group discussions (15 of 24) felt that they would want to continue to live in their current accommodation for the next 10 to 15 years. But, as we have discussed already, new and existing housing stock and care arrangements in the home are often not at an appropriate level.

Different countries have adopted differing strategies, from promoting informal care in the home, to emphasising the role of care facilities in supporting people to move back into their home after receiving care elsewhere.

Austria is among Europe's highest spenders on care and support for the elderly (HELPS 2012). It has a rich variety of housing options for older people, from mixed to designated communities, a degree of multigenerational housing, adapted homes, and flat-share arrangements akin to the Shared Lives concept (several of which are discussed in greater detail below). Despite this, the emphasis has increasingly been (as elsewhere) on supporting people to remain in their own homes. The federal government and state governments are increasingly active in providing tax incentives and subsidies to encourage developers to build accessible and appropriate housing for older people (ibid).¹⁰

Austria: Space standards, Vienna

The Viennese government took the step of introducing space standards – equivalent to the UK's Lifetime Homes guidelines – and enshrining them in municipal law. This defined standards of space and accessibility, in order to ensure that older people could remain in place for longer (Klenovec 2013). Regulations also apply to redeveloping certain types of existing properties, to ensure that they are future-proofed for changing requirements.

The UK has, comparatively, been light-touch in terms of both providing incentives for developers to focus on building homes that are appropriate for all generations and using legislation to drive up standards in new developments. As noted in the previous chapter, the government's response to the recent consultation on accessibility asserted that it would support increased regulation only where it would not prevent development going ahead.

¹⁰ Planning law and regulations are predominantly the responsibility of the *Land* (states) in Austria. Local authorities within each of the *lander* are responsible for determining local spatial plans.

In addition, the Austrian government has sought to make effective use of the informal care sector. Family members are able to purchase insurance as a family caregiver to cover lost income from caring responsibilities, via a voluntary uplift in their social insurance premiums to be drawn on in the future. This flexible approach is a significant step beyond the limited British system of carers' allowance, which provides a modest income for family carers.

In an alternative approach, Finland offers considerable support through heavy subsidies for housing adaptations, which people can access by applying to their municipal government:

'In normal cases, subsidies amount to at most 40 per cent of the total costs of the repair. In exceptional cases, up to 70 per cent of the costs may be assumed if failing to make the repairs would mean that the resident would need to relocate long-term because mobility within the living space is limited or the provision of social and care services cannot be guaranteed.'

Stula 2012

Long-term care insurance

Japan has been in the midst of a demographic crisis for much longer than comparator countries, and has the largest over-65 population share of any developed economy. As in England, levels of owner-occupancy in Japan are high, and housing is a highly prized asset.

The care system is financed by a system of mandatory 'long-term care insurance' (LTCI), introduced with reforms to the health and care systems in 2000. The objective of these reforms was to distinguish financially between the health and care systems, to add transparency to the costs and implications of long-term health and care needs, and to prevent 'social hospitalisation', where older people are effectively abandoned to the healthcare system because too little residential support was available (see Curry et al 2013). The scope of the LTCI system is wide but there are two aspects that are worthy of further attention: substantial support for home adaptations and an emphasis on institutional rehabilitative services.

On home adaptations, the majority of older people in Japan (83 per cent) live in privately owned housing (Shirakawa 2011). Of those who need care, around four-fifths receive care at home or in the community, rather than in institutional settings (ibid). This naturally therefore demands housing that can be adapted to allow them to remain in their own home. The Japanese LTCI system covers some of the costs to enable people to do so by funding adaptations through the health insurance fund. Consequently, the Japanese housing market is much better prepared for demographic change than the UK's.

'48.7 per cent of general housing is [...] equipped for older persons, while 15.7 per cent of dwellings owned by the occupants, among whom is an elderly person/s, were remodelled between 2004 and 2008 to accommodate the older occupant's needs. The Japanese Long-Term Care Insurance compensates up to US\$2,100 (\$1 = 95 yen) for remodelling of a house to suit elderly occupants.'

Shirakawa 2011

By comparison with England, the level of adaptation in the Japanese housing market is enviable, and the wide availability of financing support for all LTCI policy-holders contrasts with the means-tested DFGs available in the UK (see Murphy et al 2013).

The remaining quarter of people not living in their own home receive some form of residential care. One group of residential facilities falls under the banner of 'LTCI facility'.

Japan: LTCI facilities

There are three types of LTCI facility (Shirakawa 2014):

- **'Daily care assisted'** (6,241 facilities): facilities which provide services such as meals, and help with bathing and toileting. The facilities are aimed at people who need 24-hour care. Medical care is not usually provided.
- **'Rehabilitation'** (3,709): aimed at helping people recently discharged from a hospital who require rehabilitation to be able to return to their home.
- **'Medical care'** (1,883): providing both medical care and long-term care.

Such a strong emphasis on institutional rehabilitative services is unusual, and may help to reduce the cost burden of hospital readmissions. In general, these facilities are massively oversubscribed, yet they often exist in isolated areas, despite the fact that in Japan, as elsewhere, people would rather remain in their homes as they age.

Clearly, this is problematic from a cost-intensity perspective, as evidence shows that as contact 'between the elderly and their family decreases, this often leads to (is a key factor in) the move to institutional care' (HELPS 2012).

The emphasis on institutional rehabilitative and recovery services for hospital discharge is more prominent in Japan than in England (Curry et al 2013). There is some limited availability of 'step-down' accommodation to gradually transition people from institutional settings back to their homes, but provision is limited, and a recent audit of intermediate care estimated that current capacity is around half the level of demand (NHS Benchmarking Network 2013). This matters because older people account for around 54 per cent of hospital bed-days (Hope 2014). While a stronger emphasis of this kind would be welcome in the England, it is significant that the Japanese system is funded, like many other international examples, by a public and universal insurance system, for which the UK has no equivalent scheme.

The demand for all types of care is such that the Japanese government is experimenting with more wrap-around support for people to remain in their homes, in part to reduce costs and relieve pressure on the LTCI facilities.

Independent living in community settings

The case for recognising, supporting and ultimately harnessing the skills of the informal care market is set out at length by McNeil and Hunter (2014). A key lesson from this research is that some living arrangements lend themselves favourably to supporting informal care networks.

One creative model has the potential to cover the spectrum of societal care needs. In Germany, the country with the second oldest population in the developed world, after Japan, the federal government supported the development of a radical housing experiment that provides mutual support for and by different age-groups.

Germany: *Mehrgenerationenhäuser* (multigenerational housing)

Mehrgenerationenhäuser developments are intended to achieve a shift away from the limited, formal retirement village model (of the kind we see in England), and to replace it with cross-generational communities capable of providing a system of mutual support for everyone living there, young and old alike.

In particular, the objective is to provide low-cost childcare, tackle loneliness and enhance community cohesion by giving older people a clear and significant role in childcare while keeping them active and at the heart of the community. The model is delivered through community buildings that simultaneously act as community centres, daycare centres and the equivalent of a retirement home's communal areas – offering company for older people, and affordable childcare for local parents. There are around 500 of these *Mehrgenerationenhäuser*, supported by federal funds (McNeil and Hunter 2014).

Providing supportive community settings for the delivery of informal care in the UK while simultaneously tackling social isolation would be a valuable and worthwhile outcome, and would build on the already considerable informal care market (as outlined in chapter 2). Providing mutual support for partners and family is already a common occurrence; to do so in a more supportive setting could offer a promising way of linking up issues around housing and health.

New developments are not strictly necessary: such community living models could be retrofitted to countless community centres up and down the country, if the requisite collective enthusiasm for the system could be identified and harnessed. Several of our focus group participants recognised the value of doing so, which is crucial; for the model to work, there has to be sufficient enthusiasm among older people to provide the childcare element. Our focus groups were asked particularly to appraise whether an intentional community approach might work.

'Some older people love [looking after children] – my mam still lives in a family street.'

'That [model of living] is like being like a large family.'

'I could do the childcare aspect – I've been doing it all my life.'

Although the comparison to family life was prominent in discussions, not all participants felt they would want to live near their own family.

'I love my family, but I don't want to live on top of them.'

'I've spent much of my life supporting my family, and when we needed childcare we had to pay for it'

Another participant reflected on how the model could actively improve relations between older and younger generations.

'I was watching a programme about elderly people going to an exercise class, and having a chat and a cup of tea in the community centre, and they were getting hassle from youths outside, 12 and 13-year-olds. It must have been a youth group that got involved, and what they did was to get the kids involved, to mix with the old people. It was amazing what they did in a fortnight, getting these groups to interact with each other. The older people were showing them how to cook, and the younger people were showing them their music.'

UK: Shared Lives

One model that may offer a guide for retrofitting care to communities is the Shared Lives model that has emerged in various places in England. Shared Lives promotes elderly or vulnerable people moving in with or visiting carers, to receive care. The model works by introducing the vulnerable or elderly person to the intended carer, through a system which matches the needs of the individual and the support capacities of the carer. The would-be carer's accommodation will be checked to see whether it can be adapted to the needs of the individual, and if the arrangement suits both people involved then the individual will move into the carer's home, or visit as appropriate.

This approach is less expensive for the cared-for individual than live-in support, and has met all of the five core standards expected by the CQC inspection regime (CQC 2014b). Looking ahead, it is possible that with the permission of local authorities, housing associations could foster a Shared Lives approach through their allocations policy, encouraging recognised carers to move into newly available properties in areas with high care needs, and exchanging care support for access to social rents.

However, where multigenerational living arrangements cannot be retrofitted to existing community centres, new housing developments would have to be built. In

this case, the intentional community approach often requires groups to collectively design and develop their own properties, something that is rare in the UK. Self-build (or more precisely custom-build) represents only around 7.6 per cent of the UK development market, which is low by international standards (Wallace et al 2013). Alex Morton has reported that, given the opportunity, a majority of Britons would like to self-build (Morton 2014) but the appetite for collective self-build needs to be explored further.¹¹

Research by the University of Sheffield argues that the groups most likely to be able to launch new community developments are ‘empty-nesters’ and ‘baby-boomers’ who are both asset-rich and put off by the current offer of retirement communities (CCB 2014). Examples of private, self-starting models of mutual support have emerged in some developments in the US, which have built in their own arrangements should the health of residents decline.

United States: senior cohousing, Wolf Creek Lodge

The Wolf Creek Lodge project is a medium-sized community housing project for privately funded house-buyers over the age of 50. The project currently has 30 individual homes on the site, and a large common house at the centre of the development that supports community social activities, such as meals, physical exercise and group meetings.

The members collectively have emphasised community living and environmentally friendly building practices. Of particular interest within the model is the potential for the development to adapt to changing healthcare needs. The group says:

‘[We] have a one-bedroom suite above the Common House that can be used by a caregiver should the need arise. In the event that one or more members require professional assistance, a caregiver could live on site. This suite is currently used as an additional guest room.’

Source: <http://www.wolfcreeklodge.org/common-house/>

The test for self-starting communities providing mutual support is to get the right group of people together. When asked about how this kind of system might work, our focus groups reflected not only on an individual’s ability to opt out but also on how people were chosen for the community in the first instance, with a system of ‘try before you buy’.

‘I think the process could start with family and friends getting together. If you’re going to build a community, you should start with family, friends and neighbours, or it could be in an area where family, friends and neighbours are close by.’

‘How about a six-month trial period, where people would give it a go, and the community and they [the person] would reflect on whether it would work over the long run?’

While the American model is suitable for asset-rich, self-starting baby-boomers, a large number of older people are neither income- nor asset-rich. Equally, while the German *Mehrgenerationenhäuser* model could work well for people who want to live in a mixed-age environment, some older people want to live more closely with other people of their own age.

‘Enabling older people to live in child-free environments is a reflection of a strong preference for this among some older people and can offer a more conducive setting for articulating the older person’s voice and priorities.’

Brenton 2013

11 The UK government’s proposed ‘right to build’ is intended to raise self-build to 25 per cent of the development market, and is reflected upon in the following chapter.

Senior cohousing on the continent

On the continent, older people's cohousing or 'senior cohousing' is often actively supported and delivered by government and housing associations. Senior cohousing is the development of new housing units that are built to the specifications of their members and include mutual community governance and support arrangements, such as informal care, structures for formal care, and mutual support through cooking and social activities. As Brenton reports, in the Netherlands:

'[O]fficial promotion of the concept of the 'living group' in central government policy was based on the grounds that it sustains health and wellbeing and therefore reduces demand on health and social care services. This was combined with its practical implementation through partnerships between Dutch local authorities and housing associations.'

ibid

In this case, older residents of government housing or housing associations would be encouraged to codesign their future accommodation and living arrangements, with governance structures put in place with the support of either the municipal government or housing association. Once in place, the allocation of properties in the new communities, within reason, is left to its residents.

Denmark: Senior cohousing in practice

Denmark, one of the principal drivers of the cohousing movement, has had some success in delivering cohousing for older people (Gooding 2010).

'There are about 350 collective housing units for senior citizens with 5–6000 residents. The smallest examples of collective housing have five and the largest has 106 residences. Most of them between have 15 and 30 residences around a common house. There are about 140 intergenerational collective housing units where children, young people and elderly people live together.'

Given that such models are typically voluntary and involve new developments, it can take a number of years for op-cohousing developments to get the right people together, to plan and design the community, and to agree on a system of rules of self-governance.

DKS is one example of a co-ownership scheme, with residents contributing about one-quarter of the building costs. It has a minimum entry age of 55 (though several communities also have a maximum entry age of 65 or more); would-be residents must not intend to have any children living with them, and must be able to look after themselves. Anyone on the social housing provider's waiting list can apply to DKS and people are accepted on a 'first come, first served' basis, but residents ensure that all applicants understand the ethos of DKS (Bamford 2005).

The model of cohousing for people at the same stage of their lives was, among our focus group participants, a more popular approach to delivering intentional communities:

'It'd be much easier having age-groups together.'

'I [can't] see older people wanting to live with younger families. Some are alright, I accept it, but kids playing out[side], and the noise...'

In the UK, senior cohousing is taking small steps, some with the help of RSLs, such as Hanover Housing Association, which specialises in providing RSL properties for older people. One of the more advanced plans is the Older Women's Cohousing project, where Hanover has helped a women's group to secure land for their project and continues to provide technical support in the design process (see Pati 2011).

As well as fostering the right environment for self-build to take place, another challenge to the model is presented by the additional support needs of people as

they age. The Danish model described above, for instance, required that residents are able to care for themselves. In the Netherlands and Denmark, given that part of the purpose is preventative – that is, to keep people active and supported to prevent (or delay) the need for institutional support – when people’s care needs become greater, they will often move out if they cannot arrange to have professional care in situ.

In Sweden, there are around eight senior cohousing developments, with four in Stockholm. John Killock has reported that, while uncommon, some senior cohousing developments are able support care arrangements, including an example of where cohousing is combined with service housing to provide professional care for those who need it (Killock 2012).

Sweden: Cohousing with care

An example of embedding formal care arrangements within a collective community is found in Sweden, where in the 1980s a large new development was supported by the local government.

The development is state-owned, and the care arrangements are provided on site by public health organisations who share the facilities with the residents (Vestbro 2014):

‘In Linköping a model was developed that combined the self-work idea with care facilities run by the municipality. The cohousing project, called Stolplyckan, drew on the experiences of Hässelby family hotel.

‘In order to provide an economic base for the municipal services, the project comprised as many as 184 apartments, 35 of which were for elderly people and nine for the disabled.’

Older residents and those with disabilities are encouraged to use the communal facilities on site to receive support and ensure that to tackle isolation.

Members of one group in the UK, the London Countryside Cohousing Group (LCCG), have agreed among themselves to provide some informal care. Formed in 2006, the LCCG has recently acquired land and planning permission for a senior cohousing development for 23 homes. The group is intending to build properties to ‘passive house’ standards¹² (in order to support low running costs), and expects to provide some care services for its members as their health becomes more difficult to manage independently.¹³

This feature was raised by a member of one of our focus groups:

‘I don’t know if I could offer that support to the same level as a professional, but you’ve just got to not go into [such a community] if you don’t want to do it.’

Nevertheless, housing associations or local authorities could reasonably design housing with specifications that could accommodate more extensive care support, equivalent to the extra-care model outlined in the previous chapter, and invite social care providers to arrange on-site provision.

Forging a middle-ground between the purely private and purely public sectors is crucial to providing an inclusive housing offer. Mixing tenure options within a community housing development is potentially advantageous for two reasons. First, capital grant money from the HCA is dwindling, and RSLs and local authorities are having to depend more heavily on cross-subsidy to finance new building – cohousing developments are just one alternative setting for doing so. Second, single-tenure communities are more likely to encounter hostility, such as that

12 See: <http://www.passivhaus.org.uk/standard.jsp?id=122>

13 See: <http://www.lccohousing.co.uk/>

associated often with gated communities, communes or ‘ghettos’. Indeed, to combat common misconceptions, fostering these kind of models in the UK is partly about providing people with more information about what these kind of intentional communities are and – critically – what they are not.

Summary

These international examples illustrate a variety of ways to support people to live better and longer in their own home, such as through more accessible and generous adaptation grants. Some places, like Vienna, go so far as to stipulate that the existing stock of housing should be retrofitted to support people with old age and disabilities.

The international evidence also illustrates new ways of living that would tackle isolation and reduce the burden on the adult social care system by aligning housing developments with new collective models of living. Nonetheless, these diverse models share a common and distinctive core:

- emphasising independent living through mutual but informal support structures
- facilitating these structures either through the design of new developments or through retrofitting support spaces to existing facilities.

Given the current stresses on the adult social care system in England, pursuing these models potentially offer a better way of life for people looking to move property in older age, and a reprieve for overstretched care services. While models in England are in their infancy, tentative steps towards more collective housing options are beginning to emerge, with the backing of local government, housing associations and dedicated community housing networks that provide technical advice and support.

Right now, the UK housing market and social care market present many barriers to these new models, whether because of the fragmentation of the housing and care funding systems, reduced state investment in capital, the development disincentives facing major housing developers, or the cultural factors that differentiate the UK from its European neighbours. What is clear, however, is that continuing along the current path – characterised by limited specialist housing development and the production of small, inappropriate and inflexible housing – will not serve successive generations as they age. The policy environment is thus ripe for experimentation with new ways of devising, funding and developing housing.

6.

CONCLUSIONS AND RECOMMENDATIONS

Over-65s are the fastest growing age-group of the UK population, but our housing market is failing to keep pace with their numbers, their health, and their expectations.

The expectations of older people in the English housing market are clear. Generally older people want what younger people want: spacious housing that has room to accommodate guests and hobbies, that is located near local amenities, and is economical to run. Most also want to stay in their homes, independent of expensive institutional care, for as long as they can. In theory, government policy reflects these preferences, in as much as it seeks to contain the costs of older people's conditions on NHS and adult social care budgets.

However, the English housing market is not supporting these mutual objectives. Existing housing stock is ill-equipped to cope with population ageing. As little as 5 per cent of homes are fully accessible, by the government's definition, and a quarter of English houses have no accessibility features whatsoever. When over half of over-65s are managing a health condition, for our housing and health policies to be operating in such an unsynchronised manner is unsustainable.

Equally, the lack of decent space standards for new developments has resulted in ever-smaller new dwellings that older people do not want to live in, still largely fail to meet accessibility standards, and are difficult to adapt in response to people's changing health needs. Coupled with the fact that bespoke retirement accommodation accounts for only 5 per cent of the stock, and that most of that is only available for rent, it is no surprise that older people are reluctant to free up larger family homes.

England, however, is not alone in facing this housing-and-health problem. Other countries face similar demographic challenges, and have managed to supply a better housing offer for their elderly populations, and so to bind more closely together the different strands of housing and health policy, to achieve better outcomes for both. To make similar gains in this country, the policy environment, where health and housing domains remain largely separate, will need reform to ensure that both are pushing in the same direction.

Encouraging adaptations

As the majority of older people, and next generation of older people, are likely to need to adapt their housing to manage health conditions, they should be encouraged to take responsibility for doing so themselves. For homeowners who ultimately have a stake in the value of the asset, these costs should not, where avoidable, fall on the state. If they are not willing to invest directly in adapting their home, middle- to high-income earners over the age of 50 should be offered a choice of taking out either 'adaptations insurance' or a loan to fund such work.

For owner-occupiers who are asset-rich but income-poor, **local authorities should develop local equity-release schemes**, tying loans to meet the costs of adaptations to the sale value of the property, whenever it comes on the market. For

those reluctant to tie adaptations to the value of their properties, **local authorities could potentially offer small-scale low-interest loans to support adaptations.**

A more proactive model would deploy the insurance market as a potential alternative to encourage people as they age to absorb the costs of adapting their homes for the future. **Government should consult with the insurance industry to explore the potential for financing housing adaptations via an additional insurance premium as part of buildings insurance cover for over-50s.**¹⁴

This would serve to shelter the DFG system from owner-occupiers and to dedicate funds to those on low incomes living in rented property. The current reactive approach, and the long delays in identified by the Papworth Trust, are undermining the potential preventative value of home adaptations. To improve this, **GPs should be allowed to ‘prescribe’ home adaptation grants where a patient’s would benefit.** GPs in England are already involved in other forms of non-medical ‘social prescriptions’ (see for example Dayson and Bashir 2014) and are well-placed to identify where – and critically when – a patient would benefit from support to manage their condition in their own home. According to our proposal, GPs would be able prescribe that local authority and RSL landlords should direct occupational therapists to visit patients’ homes. Where adaptations are advised, the DFG should cover reasonable costs, as it does now. To reduce bottlenecks in the system, delays in home visits that exceed a month should permit a privately booked occupational therapist, funded by the local authority. Finally, for those who are outside the DFG system, who have opted for insurance or equity release, GPs should advise patients on when adaptations might be necessary, to help inform homeowners’ decisions.

Encouraging better standards

In the long run, new housing developments need to be more responsive to demographic change. In practice, this means that new housing should match people’s needs in later life by meeting basic space and Lifetime Homes standards.

The government should be looking to **phase in decent minimum national space standards for all new housing developments.** In addition to the current accessibility standards, new homes should be built to be easily adaptable to full **Lifetime Homes standards, and as such should also be phased in to building regulations.** Given that many developments are fully planned, the government should consult with social and market developers to determine the timetable for these changes.

However, given the leadership role that public money can play in driving behaviour, new public funding should immediately support this objective. To this end, the **Homes and Communities Agency (HCA) should commit to ensuring both space and Lifetime Homes standards are a condition of grant funding,** and to demand that both are applied to other developments supported by public money, including local authority developments and those of ALMOs.

For those local authorities who wish to go further, **central government should allow local authorities to apply their own additional space and accessibility standards for developments** without the current burdens imposed by Whitehall.

Past experience in the UK – for instance, of Parker Morris standards – has shown that where the public sector provides leadership on space standards in their housing developments, the private sector often follow. However, applying space standards and Lifetime Homes principles implies additional development costs. To ease the transition, then, **local authorities should be allowed to set stamp duty**

¹⁴ The premium should depend on the challenge of adapting a home to make it appropriate – in effect, how close it is to meeting accessibility and Lifetime Homes standards.

discounts on new dwellings valued up to £500,000 where space and Lifetime Homes criteria are met. The discount should apply to owner-occupiers over 55, and will have the added benefit of incentivising more property transactions among older owner occupiers, potentially freeing up larger family homes in the process.

Supporting new communities with informal care

Keeping people out of institutional care settings is central to the government's strategy for older people, and over the short term retrofitting services is an essential part of the solution. This means providing advice and financial support to enable households to improve the accessibility and appropriateness of their current housing. Being proactive in this area should allow for longer independent living, and fewer incidents that result in hospitalisations and longer-term support and care needs.

While remaining in their 'mainstream' home will be appropriate for many people, developing specialist accommodation that offers informal care and support and relieves social isolation should be promoted. Part of the answer is in sheltered housing schemes. The private market would receive some stimulus from the stamp duty discount proposed above, but the private market cannot be relied upon to meet demand. Social housing providers – and local authorities in particular – will need to fill this gap in the market. In the context of current dwindling grant funding, sources of finance will need to be drawn from elsewhere. Therefore, local authorities will need to deploy their own borrowing capacity to see new specialist housing delivered, both by using their housing revenue accounts (see Griffith and Jefferys 2014) and by establishing housing corporations that can borrow from the public works loan board to finance new sheltered housing developments.

New developments should also explore international systems of mutually supportive 'intentional community' approaches to fuse informal care networks with new housing developments, investing in these networks to curb demands on adult social care.

There are a range of approaches to community housing, for older people who want to live either in mixed-age communities or with other older people exclusively. Where specialist housing for older people is not readily available, people should be encouraged to take the development process into their own hands.

For equity-rich self-starters, the help needed will largely consist of technical advice. In these cases, the government's right to build initiative, to encourage local authorities to deliver 'shovel-ready' development sites, should both simplify the process for identifying land and provide more clarity over infrastructure responsibilities.

For lower-income groups, social landlords will be essential to supporting new community housing models. Demand for these living arrangements needs to be properly established and their effects understood. To this end, local authorities should open and publicise 'cohousing consultations' to test local interest, and to identify potential sites for cohousing developments. In parallel, **social landlords looking to develop new stock should ballot their tenants to establish if there is local interest, and to identify groups of tenants to steer cohousing developments**, offering both technical support and encouragement.

At the closure of the consultations, land-holding **local authorities and the Department of Health should offer land for long-term lease to groups seeking to provide collective informal care in community settings.** The make-up of groups would determine the level of support needed to get projects of self-build (or codesigned) communities off the ground. The government's 'community right to build' policy has provided the legal framework to bring this about, through encouraging local land-release where community support and governance structures are in place. The consultation process should bring much more attention to the 'right to build' programme.

Bids for leased land should be encouraged from organised community groups partnered with housing associations, health and care providers, or local authority housing developers who are supporting such schemes. Preferential status should be given to bids from older people looking to downsize from their current social rented home, and to those who are building informal and formal care structures into their plans.

The HCA should be supporting development by underwriting loans and providing technical advice to inexperienced but enthusiastic groups of people.

Finally, the **initial batch of community housing developments should be closely monitored by the Department of Health to fully evaluate potential health outcomes**, to establish whether the wider development of community housing would result in long-term savings to health and adult social care budgets. Delivering collective community arrangements will take time and patience, not least to identify and support the right groups of people. Nonetheless, the financial burden of social care will not disappear anytime soon, and so long-term options that emphasise mutual community support should be strongly encouraged.

Ultimately, the options for older people in the housing market are poor. Given the limited choice and supply of bespoke housing for older people, it is appropriate to support people to live in their own homes for as long as possible. However, anaemic housing supply levels and a concentrated development market demands that new innovative approaches are found to deliver specialist housing that supports health objectives. More radical approaches, like collective communities, must form part of the answer to providing a more health-conscious housing offer in England.

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APPENDIX: OLDER AND VULNERABLE PEOPLE

In policy terms, ‘older people’ and ‘vulnerable people’ are often used interchangeably. The HCA, the main government grant-giving agency to housing providers and regulator of social housing in England, often refers to them in the same way. For instance: ‘it is important that the needs of vulnerable and older people are integral to thinking in terms of demand and supply (for example, planning for future demographic changes); wider sustainable placemaking, including the need to meet diverse housing needs’.¹⁵

However, vulnerability covers a wider range of complex needs that may or may not affect older people. For instance, the HCA recognises a range of vulnerable groups; those relevant to this paper include:

- people with learning disabilities
- people with physical or sensory disabilities
- people with mental health problems.

Many older people will fall within these categories. For instance, older people are more prone to some mental health problems, such as Alzheimer’s, and will need specific support in their home or potentially in an institutional setting.

Indeed, public policies to support both older and vulnerable people often occur in tandem. The latest National Audit Office review¹⁶ identified that around £19.1 billion was spent in 2012/13 on adult social care by local authorities in England, with a further £2.1 billion by the NHS. While older people account for 61 per cent of the adult social care budget, the significant minority of 39 per cent is consumed by younger adults and children,¹⁷ and accounts for around 430,000 people in England aged between 16–64.¹⁸ Thus, a significant chunk of the adult social care budget is consumed by people under the age of 65, and many of the challenges those who need support face are shared with older people, such as getting around and accomplishing day-to-day tasks.

Similar facilities and support mechanisms, let alone shared facilities, are not going to be appropriate for all groups, such as offenders or people needing rehabilitative services. The types of support required will differ, as a large number of those classified groups – such as refugees or former offenders – will demand little physical support or assistance with living independently but will nevertheless require housing that is safe and secure. Other strategies exist for these groups.

Nevertheless, reforms to policy can help many older and vulnerable people alike. The majority of younger people receiving adult social care receive care either in their home, or within the community, rather than in institutional settings, and census data shows that there are around 1.8 million people under the age of 65 whose day-to-day activities are limited a lot by their health or a disability.

15 See: <http://www.homesandcommunities.co.uk/ourwork/vulnerable-and-older-people>

16 National Audit Office [NAO] (2014) *Adult social care in England: Overview*, London. <http://www.nao.org.uk/report/adult-social-care-england-overview-2/#>

17 National Housing Federation (2011) *Breaking the Mould: Re-visioning Older People’s Housing*, London. <http://www.housing.org.uk/publications/browse/breaking-the-mould-re-visioning-older-peoples-housing/>

18 130,000 of whom have a learning disability, 130,000 of whom have a mental health problem, and a further 160,000 have a physical or sensory disability.

It is clear that extending improvements to the housing offer beyond older people will mean that houses that can support people to live as independently as possible for longer, that have improved accessibility for those living in them, and the room to provide domiciliary care. These must provide the space and versatility to offer additional support (via care and nursing) whether delivered by the private sector or the state.