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Getting On:

Well-being in later life

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Contents

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1. Introduction

James McCormick

We have known for some time that the population of the United Kingdom is getting older and that the number of people aged over 75 (sometimes referred to as the 'older old') is growing particularly quickly. Encouragingly, healthy life expectancy – the number of years lived without illness or disability – is improving on average.

There is a lively policy debate about later life, dominated by how to improve pensions and social care, and who will foot the bill. But there is much less information about people's experiences of growing older: their quality of life, their expectations and their emotional wellbeing. ippr's work on 'the politics of ageing' seeks to plug this gap, and, further, to place a clearer focus on inequalities in older people's wellbeing.

This report sets out a wider agenda for policymakers and practitioners. It reviews UK policies for older people and international practice, as well as the priorities of older people in urban versus rural locations. It concludes with recommendations for action, which signal a fresh approach to later life and seek to challenge outdated assumptions.

First, in this introductory chapter, we review the existing evidence on wellbeing in later life. We consider five 'essential elements' of wellbeing as well as some of the emerging risks facing older people.

Wellbeing in later life

The evidence on older people's wellbeing is mixed. In the UK, measures of happiness appear to take a U-shape across the life course, with both younger and older people happier than those in middle age. However, this offers only a partial account since the best-known UK study (Blanchflower and Oswald 2004) does not report data for people aged over 70 (Allen 2008). The pattern after the age of 80 is not considered although other evidence (referred to below) indicates that in these years people can expect poorer mental health and lower levels of wellbeing.

Recent evidence (Academy of Medical Sciences 2009) presents a more optimistic view of ageing in the UK than in the past. The consensus among British medical researchers points to healthy life expectancy rising faster than it was previously thought it would. This has two implications for policymakers: first, there is a need to understand the protective factors that mean some are faring better in later life than ever before; and second, we must address the risk factors that continue to mean others face poor emotional well-being in later life. These issues are reviewed in subsequent chapters.

Recent studies in the United States suggest that older people tend to get happier even into their nineties, except for people with dementia-related ill health (Carstensen 2009). Findings suggest that older people increasingly make the most of the time they have left, having learned how to cope with loss and disappointment. In addition, they show older people being far less prone to persistent negative moods than young adults, more resilient to personal criticism and better at controlling and balancing emotions as they got older. The advice arising from the research is to start preparing early, for example by investing time in social networks outside the home and workplace.

Essential elements of wellbeing in later life

Nazroo *et al* (2005) developed a framework around the main factors influencing quality of life for older people. We have adapted it based on our review of evidence for the UK and identified five 'essential elements' of wellbeing in later life. These are:

- Resilience
- Independence
- Health
- Income and wealth
- Having a role and having time

Resilience

The significance of life changes for wellbeing is clear. For older people, deteriorating health, the onset of disability, bereavement and relationship breakdown pose the biggest risks to emotional wellbeing (Banks *et al* 2006). These can trigger low-level depression and worse. What follows depends greatly on resilience – the capacity to cope with difficult life events. Having good social networks and an active social life can reduce the risks, including depression, and the quality of social relationships can influence the way the brain processes information (Carstensen 2009).

Factors contributing to a person's resilience are:

- Previous experiences and the degree to which we are prepared for difficult transitions
- The breadth of social networks spanning both strong and weak ties (family and friends as well as peer/self-help support and service providers)
- Other personal resources for coping (for example, income and educational levels).

A longitudinal study in Finland has found that people aged around 50 and living alone were twice as likely as those who were married or co-habiting to develop dementia between the ages of 65 and 79 (Håkansson et al 2009). The risk for those who were widowed or divorced was three times as high. The study followed people over a 21-year period and identified a 'substantial and independent association between [couple] status in mid-life and cognitive function in later life'. In addition, further research by the Karolinska Institute in Sweden found that having an extensive social network, keeping active and staying socially connected appear to protect against dementia. Carstensen (2009) cites a study of more than 1,000 Swedes, none of whom had shown signs of dementia before the study. Those with a strong social network were 60 per cent less likely to develop symptoms of cognitive impairment than those who did not have such social ties. But we know less about how social networks can be strengthened or repaired.

Friendships and social networks

Declining health and disability harm emotional wellbeing partly through their *social impact*. For example, mobility may be reduced, leading to less contact with family and friends and less opportunity to go out. This may increase feelings of isolation, withdrawal and even cause a fear of going out and is one pathway to depression. Eighty per cent of older people who say they are 'often lonely' live alone (Actor *et al* 2002).

However, higher levels of social contact and especially positive interaction with friends reduce the risk of depression even for those with poor health or disabilities. For some, active involvement in faith communities can offer a sense of acceptance, purpose and participation in a supportive network. A key question is how support services, irrespective of who funds and delivers them, can tackle isolation more effectively.

Independence

Housing and home

Housing is particularly important for people over 75 who spend long periods at home. Single person households in England are most likely to be living in non-decent homes, including one-third (34 per cent) of single people aged 60 and over (Office for National Statistics 2008). There is greater recognition today of the role of design in creating truly accessible housing, places and public services. We are likely to see a shifting balance of care with older people staying in their own homes for longer. Indeed, despite an increasing number of older people receiving care, already fewer are now in residential and nursing homes. Enabling older people to live at home for longer will require significant growth of preventative support in the community, from support for older people to stay active and independent to simple housing adaptations and more intensive social care at home, as well as greater clarity on different forms of housing with care (for example, sheltered housing).

Recent evidence from England suggests that warden services have become patchier with the withdrawal of the ring-fenced Supporting People budget. In some cases, warden support has been reduced from on-site to weekly or less frequent visits. This may increase anxiety and stress for residents, breaching the expectation of support that encouraged some to opt for sheltered housing. Many older people who would struggle to live independently might benefit from sheltered housing but would need to move to more expensive residential care if adequate support were not available.

Environment and isolation

The impact of the physical environment on wellbeing has been established in various studies. Living in a highly urban environment can increase low-level depression among older people as a result of poorer housing quality, the amount of traffic, persistent noise, litter and graffiti, lack of green space and clean air, and few social contacts within the neighbourhood (Allen 2008). These factors are especially significant for older people living alone and lacking an active social life.

Fieldwork from North East England and London (see Chapter 5) shows that isolation undermines the wellbeing of older people in small towns and rural areas as well as those in busy urban neighbourhoods. How safe people perceive an area to be may also impact on their willingness to go out and could cause isolation. When walking alone in a neighbourhood after dark, the proportion of people aged 60–74 who felt safe was 6 per cent lower than among adults as a whole and it was 23 per cent lower among people aged 75 and over[1] (Scottish Government 2008).

Health

In Great Britain as a whole, younger old people[2] are 3 to 5 per cent more likely than the next youngest age cohort to say their health is 'not good'. People over 75 are 11 per cent more likely to report the same (Table 1.1). On this measure, the poor health gap doubles after the age of 75. In Scotland, younger old people[3] are 9 per cent more likely than the next youngest group[4] to report a long-term limiting illness, health problem or disability, but the over-70s are 17 per cent more likely to do this. The proportion of people over 75 saying their health is not good, or reporting long-term illness or disability has not risen in the last 20 years (Allen 2008). But due to the projected increase in the number of people aged 75 and over, prevalence rates would need to drop to avoid a significantly bigger number in this group having these problems in the future.

1. A larger number of the oldest respondents (20 per cent) said they did not know, suggesting they go out seldom or not at all after dark.
2. Aged 65–74 in Office for National Statistics data and 60–74 in the Scottish Household Survey
3. Aged 60–69 in the Scottish Health Survey
4. Aged 50–59 in the Scottish Health Survey

Table 1.1 Perception of own health by age group, Great Britain (2008) and Scotland (2008)

Great Britain (2008)			Scotland (2008)		
Age range	% reporting their health is:		Age range	% reporting their health is:	
	Good or fairly good	Not good		Good or fairly good	Not good
45–64	85	15	45–59	84	16
65–74	80	20	60–74	81	19
75 and over	74	26	75 and over	73	27

Source: Office for National Statistics 2008, Scottish Government 2008

Wellbeing, mental health and depression

The English Longitudinal Study of Ageing (ELSA) shines a light on the changing lives of people as they get older. An overall measure of well-being has been derived from it (Department for Work and Pensions 2009). The median wellbeing score for respondents aged 65–79 was one point lower than among those aged 50–64. However, the score among people aged 80 and over was four points lower. Although the difference is not marked, it appears that people in the middle stage of later life (65–79) are more like the next youngest age group than the next oldest in terms of well-being.

The English Health Survey includes a set of questions on mental health based on a 12-point measure (General Health Questionnaire – GHQ12). People scoring zero are considered to be free of mental ill health. Expressed as an average for 2004–06, around two-thirds (68 per cent) of women aged 65–79 and a higher proportion (71 per cent) of men in the same age group had a score of zero (Table 1.2). People in this age group fare *better* than the next youngest respondents (50–64 year olds). Among people aged over 80, the proportion scoring zero falls to just over half (56 per cent). Four in ten people in this age group express at least one type of mental health problem.

Those scoring 4 or more on this measure are regarded as having some form of mental ill health. Among people aged 65–79, 10 per cent of women and 9 per cent of men reached this threshold. Again, they fare better than the next youngest age group. But the rate increases among those aged 80 and over, to 15 per cent of women and 18 per cent of men. There are signs that mental health declines faster among men after the age of 80.

By this measure, people aged 65–79 had the *lowest* risk of mental ill health of any age group, old or young, while those aged 80 and over had the highest risk of all. There are signs that mental health declines faster among men than women after the age of 80. Nonetheless, a majority of people aged over 80 appear to stay free of mental ill health. As well as doing a better job of supporting those who are vulnerable to depression, we should focus more closely on the protective factors that enable many to reach this age in good mental health.

Isolation, loneliness and loss contribute to poor emotional wellbeing in later life. This may be expressed as reduced life satisfaction, low-level depression or worse. The pathways, far less their causes, are not recorded by the NHS. A significant degree of under-reporting of mental health problems among older people is thus widely suspected (Allen 2008, UK Inquiry into Mental Health and Well-being in Later Life 2007). The failure to detect and treat mental

Table 1.2 Average mental health (GHQ12) scores in England, by age and sex (2004–06)

	Women (%)				Men (%)			
Age range	16–49	50–64	65–79	80-plus	16–49	50–64	65–79	80-plus
Score 0	60	64	68	56	69	68	71	56
Score 1–3	25	20	21	29	21	20	20	26
Score 4+	15	16	10	15	10	12	9	18

Source: Adapted from Department for Work and Pensions (2009: 56-50, Indicator 12)

health problems properly affects all age groups, but the distinctive features for older people are the 'normalising' of depression by some health and care practitioners, as well as the much reduced chance of being offered a range of treatments including talking therapies (UK Inquiry into Mental Health and Well-being in Later Life 2007).

While recorded rates of depression provide a very cautious estimate of the true picture, they indicate the highest rates of depression occur among people over 75. Between 35 and 40 people per thousand (3.5–4.0 per cent) of people aged over 75 are registered as having depression. The projected growth in the number of older people with depression by 2025 is highest among people aged 85 and over (80 per cent), followed by people aged 65–74 (40 per cent) and then people in the age group in between, aged 75–84 (33 per cent) (UK Inquiry into Mental Health and Well-being in Later Life 2007).

Depression rates appear to double among older people suffering ill health and disability and are highest of all among older people in care homes. An estimated two in five are in this position (Allen 2008). A significant amount of preventable depression occurs in care homes, as well as inappropriate, liberal prescription of anti-depressants and anti-psychotic drugs, which may do more harm than good. Following an expert review it was reported in November 2009 that: 'Needless use of anti-psychotic drugs is widespread in dementia care and contributes to the death of many patients' (Triggle 2009). There are also cases of covert treatment (for example, administering drugs in food).

The risk of depression is higher, as well, for older people with dementia and especially so for 'intensive carers' such as older carers of people with dementia. Rates also vary by ethnicity: Pakistani and Bangladeshi women in England and Wales have the highest rates of long-term illness and disability which are likely to be a risk factor for depression in later life. Pakistani and Indian women have the highest recorded rates of depression of any ethnic group.

Income and wealth

Until recently, older age was strongly associated with poverty. Various changes to means-tested benefits helped the poverty rate to fall steadily from 1997 to 2007, although it has stalled in recent years. Poverty in older age fell in every part of the UK over the same period (Palmer 2009). The reduction was biggest in Scotland where the rate halved, followed by the North East and Yorkshire and the Humber, two of the English regions previously with the highest poverty rates. The smallest reductions were in the East Midlands and Wales. Despite significant progress, in 2007 one in three people aged 85 or over was still living on a low income compared with one in five people aged 65 to 69. The highest risk was among women in the oldest age group living alone. Moreover, persistent poverty[5] among older people in the three-year period 2002–05 was in the range 13–15 per cent. Although this was lower than five years earlier, older people were still 1.5 to 2.5 times more likely to experience persistent poverty than working-age adults.

Having a role and having time

The loss of status and identity that comes with retirement may come as a blow to people who feel they have little or no choice over whether and when to give up employment. This may be affected by employers observing the UK's Default Retirement Age, pension rules that discourage flexible working in later life and a phased approach to retirement, or the pressure of having care responsibilities that cannot easily be combined with paid work. Some older people find they have too much unfilled time on their hands due to isolation and loneliness. While 90 per cent of people aged 60 and over in the UK have grandchildren, regular contact with them tends to lessen with age and with distance (Allen 2008). Others may find they have too little time to pursue interests outside the home and family as a result of very significant care responsibilities for their partner, relative, disabled child or grandchildren. Carers providing an intensive level of care face the toughest circumstances of all.

5. Defined as being on a low income for three years out of four

Older people can enhance their wellbeing by having a role outside the home and family, and having the time to pursue other interests. These include continuing to work (on a flexible basis), pursuing social activities with friends, volunteering and learning. However, it appears that relatively few older people are involved in some of these activities and the rate of participation drops significantly among people over 75. For example, the Scottish Household Survey (Scottish Government 2008) shows volunteering rates falling 3 per cent between the pre-retirement cohort (aged 45–59) and those in the early and middle years of later life (60–74), but dropping a further 12 per cent from the age of 75. The same survey shows participation in adult learning of 3 per cent among 60–74 year olds and just 1 per cent of people aged 75 and over.

Emerging risks

Other emerging risks to wellbeing in later life have been identified recently. These may not be 'new' risks for older people, but are becoming understood more clearly as a result of better evidence. They include the trend towards increased debt, both unsecured loans and outstanding mortgages, and problematic alcohol consumption. One in eight older people increases the amount they drink after retirement, with one third of those who are drinking more reporting that depression or bereavement is the main reason (Foundation 66, 2009).

Summing up

The 'essential elements' of wellbeing in later life are increasingly well understood. They span the related factors of resilience, independence, health, income and wealth, and having a role – as well time to pursue that role. The brief review of evidence introduced in this chapter highlights the need to take a fresh approach to later life, especially with people over 75 in mind. On average, people in the UK fare relatively well up to their mid-seventies as measured by wellbeing, physical and mental health, level of poverty, risk of depression and levels of participation. In many respects, they appear more like people in the next youngest age group than the next oldest. But a turning point comes in the lives of many from the age of 75. Even though many people continue to thrive, the elements of wellbeing we describe can deteriorate, and it is clear that inequalities in later life are greater among people aged 75 and over.

In the following chapters, we consider survey evidence on attitudes to later life and approaches to ageing taken by policymakers in the last decade or so across the UK, as well as drawing comparisons from other countries. We then turn to explore the experiences and views of older people living in rural North East England as well as in London and Newcastle. We identify a number of everyday priorities drawn from focus group discussions in these locations. We then summarise the key themes which define a system to improve wellbeing in later life, adding further elements to those introduced in this chapter. We conclude with a set of recommendations for policy and practice.

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2. Understanding attitudes to later life

James McCormick

The level of wellbeing a person has in later life will in part be a reflection of how society views older people, as well as being impacted by material factors including income, health and social support. The attitudes of service providers, employers and the person on the street present a tougher challenge for policymakers than these material factors. Some of these providers continue to be discriminatory (Age Concern and Help The Aged 2009). In order to consider how people in Britain view later life and old age, ippr commissioned a survey of attitudes.[1] This chapter discusses the main findings.

Spending time with older people

Some older people do suffer from isolation, but on the whole there is considerable contact between the older and younger generations (Table 2.1). Two-thirds of respondents said they have contact with someone they know aged over 65 at least a few times a month. This includes almost half who have contact at least a few times every week. Around one in five has occasional contact (monthly or a few times each year) and one in eight has contact once a year or less. There is, however, some indication of a difference between the generations, with people in their middle years spending more time with older people than young people do. More than three-quarters of those aged 55 and over have frequent contact (that is, at least twice a month) compared with just less than half of 25–34 year olds.

Table 2.1: Frequency of contact with people you know aged over 65 (%)

Respondent age group	Frequent	Occasional	Infrequent or never
18–24	58	22	15
25–34	47	29	18
35–44	70	16	10
45–54	72	18	8
55 and over	78	12	10
All	67	18	12

Frequent: daily, a few times a week, or a few times a month
Occasional: monthly or once every few months
Infrequent or never: once a year, less often or never

There are also marked differences in levels of contact with older people depending on location. The level of frequent contact is highest in Scotland and South West England and lowest by some margin in London. This is likely to reflect the capital's distinctive role in attracting people to work from across Britain, many of whom have moved away from older relatives. There is a small difference between the sexes, with women 4 per cent more likely than men to spend time with older people every day.

The happiest years

Broadly, we tend to think people are happiest when they are youngest, while older age is least associated with the happiest times in people's lives (Table 2.2). Half of respondents think people are happiest before the age of 45 and just over a quarter think that it is before 25 that we are happiest. Only around one in ten thinks that people 65 and over are happiest.

1. An online survey was carried out by YouGov for ippr in January 2009. The sample size was 2189 adults. The figures reported in this chapter have been weighted so they are representative of all British adults aged 18 and over.

The smallest number of respondents thought that the happiest years come after age 75. These opinions are true for respondents of all ages, except those aged 55 and over. Slightly more of them think people are happiest after the age of 45 than before, and they are more likely than others to think happiness peaks at either 55–64 or 65–74.

Table 2.2: Age at which most people in the UK are thought to be happiest, by % of respondents in each age group

	Age range thought to be happiest (% of respondents)			
Respondent age group	Under 25	25–44	45–64	65+
18–24	38	28	17	7
25–34	34	23	18	9
35–44	29	20	19	14
45–54	28	26	27	6
55 and over	20	22	28	16
All	27	23	23	11

There are clear geographical differences in attitudes (Table 2.3). Almost one in five respondents in both the South West of England and in Wales think the years after 65 are the happiest, specifically for the younger old aged between 65 and 74. Much smaller proportions say this in Scotland and Yorkshire and the Humber.

Table 2.3: Age at which most people in the UK are thought to be happiest, by % of respondents in each region and nation (ranked by % from age 65+)

	Age range thought to be happiest (% of respondents)			
Respondent location	Under 25	25–44	45–64	65+
South West	22	25	23	19
Wales	18	14	26	17
East Midlands	34	14	25	15
East of England	29	27	18	12
North West	26	26	23	12
South East	24	19	30	12
London	26	32	20	11
West Midlands	27	21	20	9
Yorkshire & Humber	30	20	28	8
Scotland	30	26	23	5
All	27	23	23	11

Note: Figures for North East and Northern Ireland not shown as respondent numbers are below 100

The least happy years

It is common for people to think that the time that is the least happy is in the first 45 years of a person's life (Table 2.4). Almost half of respondents think this while just over a third believe that it is after age 45 that people are least happy. Respondents aged under 45 are more likely to think people are least happy between 25 and 44 years of age than at any other time – perhaps this reflects the stresses associated with the stage in life when many people are repaying student debts, seeking to buy a house and having children. In contrast, after the age of 45 people are more likely than others to see the years after 65 as the least happy – twice as many as among respondents aged 35–44.

Table 2.4: Age at which most people in the UK are thought to be least happy, by % of respondents in each age group

	Age range thought to be least happy (% of respondents)				
Respondent age group	Under 25	25–44	45–64	65+	Net most or least happy from 65+*
18–24	19	29	19	22	-15
25–34	20	34	12	16	-7
35–44	22	30	16	13	+1
45–54	18	18	21	26	-20
55 and over	23	18	13	27	-11
All	21	25	15	22	-11

*For discussion of this column see text under Table 2.5

There are also some marked geographical differences in the way people perceive age groups that are least happy (Table 2.5). People in the East of England, Yorkshire and the Humber, East Midlands and London consider older age to be the least happy time of life. More than a quarter of people in the East of England think this, whereas in Wales half that amount do.

More surprising, given the differing experiences of paid and unpaid work, health and life expectancy between the sexes, no significant difference of opinion appears between women and men.

Table 2.5: Age at which most people in the UK are thought to be least happy, by % of respondents in each region and nation (ranked by net % from age 65+)

	Age range thought to be least happy (% of respondents)				
Respondent location	Under 25	25–44	45–64	65+	Net most or least happy from 65+
Yorkshire & Humber	24	22	9	27	-19
East of England	16	24	17	28	-16
Scotland	21	23	15	21	-16
North West	15	29	14	26	-14
London	21	22	19	24	-13
East Midlands	21	18	23	23	-8
West Midlands	17	25	16	15	-6
South East	23	27	15	17	-5
South West	29	21	14	23	-4
Wales	20	29	14	14	+3
All	21	25	15	22	-11

Note: Figures for North East and Northern Ireland not shown as respondent numbers are below 100

Overall, our views of happiness in later life are more negative than positive. Around one in ten respondents thinks the happiest years are to be found after the age of 65, but around one in five believes this is the least happy time of our lives. This gives a negative balance for our opinion of older age (-11), shown in the last column of Tables 2.4 and 2.5. People aged over 55 take the same view of later life as respondents taken as a whole group. The view of later life is most negative among 45–54 year olds, which may reflect this group's experience of caring for older relatives. On balance, the view of life after age 65 is positive only among people aged 35–44 and those living in Wales. The view is most negative of all in Yorkshire and the Humber, followed by Scotland and the East of England.

Contributing to society

Unsurprisingly, two-thirds of respondents think people make the greatest financial contribution to society when they are in the middle of their working lives, aged either 35–44 or 45–54. Less than one in ten thinks that 55–64 year olds contribute the most financially, and just 1 per cent opts for the younger old (65–74). Respondents aged 55 and over are much more likely than others to think 55–64 year olds make the biggest financial contribution, although three-quarters still believe people younger than themselves contribute most. People aged over 65 are thought to contribute the least financially. More than one in four takes this view, but younger respondents are more likely than older respondents to agree with it.

While those in the middle years are thought to contribute the most financially, the picture is different when we look at contributing most in other (non-financial) ways (Table 2.6). These were not specified in the survey, but might be considered to include the unpaid work of carers and volunteers. People think that the peak ages for contributing most in other ways are in the second half of the life-course. People in their pre-retirement years and the younger old are perceived to make a significant contribution. More than one-third of respondents think people aged over 55 contribute most in other ways. This rises to almost half for respondents who themselves are aged over 55. Less than a quarter of the under-25s share this view. Only 1 per cent think people 75 and over contribute most.

Table 2.6: Age at which most people in the UK are thought to contribute most to our society in other (non-financial) ways, by % of respondents in each age group

	Age range thought to contribute most (% of respondents)						
Respondent age group	Under 25	25–34	35–44	45–54	55–64	65–74	75+
18–24	22	15	15	11	10	11	2
25–34	7	13	18	17	11	14	1
35–44	6	8	17	15	17	14	1
45–54	3	5	12	23	25	13	0
55 and over	2	5	12	17	26	21	1
All	6	8	14	17	19	16	1

About one quarter think that people aged over 65 contribute the least in other, non-financial ways. Here, people distinguish between stages of older age: only 2 per cent think 65–74 year olds contribute least but one in five says this about people aged 85 and over. Overall, respondents are 7 per cent more likely to say people aged 65 and over contribute least than contribute most in non-financial ways (Table 2.7, next page). This is true of people in every part of Britain, though people regard the non-financial contribution of this age group most positively in Scotland, and most negatively in the East of England.

Table 2.7: Perceptions of other, non-financial contribution to society of people aged over 65, by % of respondents in each region and nation

	% respondents with the view that:	
Respondent location	Aged 65+ contribute most	Aged 65+ contribute least
London	16	23
North West	13	23
Yorkshire & Humber	14	19
East Midlands	16	25
West Midlands	17	23
East of England	19	29
South East	19	23
South West	19	24
Wales	16	24
Scotland	22	25
All	17	24

Summing up

The ippr attitudes survey results suggest that views about later life are more complex than may be expected. Attitudes are likely to be formed partly from the contact people have with older people. They are also based on where a person is in his or her own life-course. We are likely to think people in the same age group as ourselves, or the one next to us, make a greater contribution to society than others. These findings suggest we interpret these questions through the lens of our own and our peers' experiences.

There are other intriguing clues in the data about variations in how we view older age. For example, people aged 45–54 have the least positive view of later life in terms of happiness, while people aged 35–44 make the most positive assessment. The attitudes of 45–54 year olds are likely to be influenced by the experiences of their parents and relatives in older age. Without further research, we cannot be sure if the experiences of today's older people are leading to more negative attitudes about later life than in the past or whether this is a consistent view of this stage in life.

Questions arise, as well, about the patterns that do *not* appear – notably, that there are only small differences between the views of women and men despite their being significant differences between the sexes in life expectancy, the probability of living alone and of living with poor health or a disability.

Important variations are also seen across Britain, ranging from a relatively positive view of happiness in later life in Wales to more negative views in Yorkshire and the Humber. It would be unwise to speculate too far on what might underpin such differences, although it may be the case that the older age structure of the Welsh population and the 10-year strategy for older people introduced by the Welsh Assembly Government may have had a modest influence on attitudes there.

Finally, views distinguish clearly between the stages of older age: the years between 65 and 74 are viewed much more positively than those after the age of 85. This boundary may be moving upwards. In terms of contributing to society in non-financial ways, people aged 65–74 are regarded as being more like those who are aged 55–64 than people over 75.

The core aim of the UK Government's strategy on ageing is to create a 'society for all ages' (HM Government 2009). Legislation to tackle age discrimination will help in this mission, but

the task of changing outdated assumptions about later life goes far beyond the remit of policymaking. Social marketing initiatives such as 'See the person, not the age' in Scotland (2008–09), employer-led approaches like 'Age Positive' and increased contact between the generations through schools and social care settings highlight the wider agenda involved. Taking further steps like these to improve our understanding of attitudes, and to challenge them where necessary, will be essential in an ageing society.

References

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3. Policies for peace of mind?

James McCormick and Eleanor McDowell

This chapter considers the changing policy and practice landscape for older people over the last decade. In particular, we look at how far policymakers have aimed to improve wellbeing for all older people or whether they have only targeted some, based on need, income or stage within older age. Note that there is no consistent definition of who 'older people' are. Some strategies apply to everyone aged over 50, some are aimed at the over-60s, some are based on state pension age, and others target the 'older old', aged over 75 or 80.

We do not know very much yet about the impacts of programmes to improve older people's quality of life. Evaluation of policies for older people is patchy, but various patterns can be seen, nonetheless.

As a result of devolution, various policy aims for older people have emerged across the United Kingdom. We set out the key points in relation to this below. (See McCormick *et al* 2009 for a fuller discussion.)[1] Broadly, policies involving cash payments, employment and equalities legislation apply across the UK while other services, such as concessionary travel, warm housing, health and care, apply to England, with separate devolved policies in the other nations.

Older people's policy in the UK and England

The UK Government's ageing strategy, *Building a Society for All Ages*, was published in July 2009 (HM Government 2009). It follows the *Opportunity Age* strategy, which introduced a comprehensive set of indicators to measure progress for older people and presented the raft of policy reforms made since 1997 (summarised in Box 3.1).

Box 3.1. Key policy reforms on ageing since 1997

- Pension Credit including Guarantee introduced
- Basic State Pension increased by 7 per cent over inflation, plus changes made to eligibility (to take effect from 2010), credits for carers of children up to age 12 (2011) and Turner recommendations including auto-enrolment in pension schemes and linking of Basic State Pension to earnings (from 2012)
- Free prescriptions, sight tests and off-peak bus travel instated throughout England for over-60s
- Help with central heating/insulation targeted to Pension Credit recipients and free energy efficiency measures/insulation introduced for over-70s
- Free TV licences provided for over-75s
- Winter Fuel Payments made to all households that include someone aged 60-plus (higher rate for 80-plus)
- Age discrimination and harassment at work outlawed (2006). Integrated Equality Bill to include new protection against harmful age discrimination in goods and services, and a duty on public sector agencies to 'age-proof' their policies.

Source: Government Equalities Office (2009)

1. ippr's Devolution in Practice series offers a wider assessment of how the third term of devolution is affecting key policy areas. See www.ippr.org.uk/ipprnorth/research/teams/project.asp?id=3354&pid=3354

In addition to the reforms identified as significant by the Government Equalities Office, the goal of *personalisation* in social care services has grown in importance. Legislation passed in 1996 authorised local authorities throughout the UK to make direct payments to care users in place of providing services directly. In 2003, new regulations required English councils to offer direct payments to all adults using community care services, while similar guidance came into force in Scotland and Northern Ireland around the same time and later in Wales. There has been a marked growth in the number of clients receiving direct payments in England in the last decade. Despite growing support in the devolved nations, take-up has been at about half the rate of England's (Riddell *et al* 2006).

The English framework for adult social care services, *Putting People First* (Department of Health 2007), gave fresh impetus to the debate, introducing the idea of *personal budgets*. These can be taken as a direct payment, or the local council can commission a service in agreement with the service user and carer, or a combination of both is possible (Moullin 2008). The framework also introduced *individual budgets*, covering a larger range of funding sources including Supporting People (a partnership of local government service users and support agencies). The results of piloting in 13 English councils in 2006–07 were generally positive, but older people supported by adult services were more likely to report not wanting the additional burden of planning and managing their own care (IBSEN 2008). Older people are a highly diverse group and thus further evaluation will be needed to improve our understanding of whom these approaches can work best for.

Where to next? The UK Government's ageing strategy sets out the vision of a 'society for all ages'. It seeks to challenge 'outdated stereotypes about later life as a time of dependency and decline' and create a society where 'people are no longer defined by age' (HM Government 2009). The Equality Bill, to be introduced in April 2012, will extend legal protection against negative and unreasonable discrimination in consumer services, following equalities legislation covering employment in 2006.

But the 'default' retirement age is still under discussion. The UK Government recognises concern about enforced retirement at the state pension age and has pledged a review for 2010 (earlier than originally planned). ippr endorses scrapping the default position.

The tougher cultural challenge of changing attitudes and expectations about later life also remains. While this is recognised in government, the bulk of the 2009 strategy focuses on early intervention to enable more people to stay well for longer, and is grouped into the themes of:

- Wellbeing through active ageing
- Family and care roles
- A local focus on prevention
- Advocacy, scrutiny and involvement.

We discuss these themes below.

Wellbeing through active ageing

The *Building a Society for All Ages* strategy notes that wellbeing is reduced by inactivity and loneliness, which result from 'not taking advantage of opportunities available'. Policymakers have grasped the need to reduce 'cliff-edge' effects associated with age, where people lapse from activity as they grow older when they would prefer to combine some paid and unpaid work with social activity. There is also recognition of the scale of untapped market opportunities represented by consumers aged over 50, for example in leisure and learning.

As well as expanding the range of opportunities for older people and promoting their involvement, a clearer analysis is needed of the barriers that reduce involvement for people in different stages of later life. We need a better grasp of the dynamics of ageing, to improve

our understanding of what is effective at reducing barriers over time. For example, we know that rates of involvement in volunteering, leisure and learning decline significantly with age. This reflects a mix of constraints as well as choice and leaves a sizeable minority of people who would like to continue or return to these activities but lack the support or information to do so.

What steps in this direction are included in the Government's strategy? An 'Active at 60' programme is proposed from 2010, bringing together national information on pensions, benefits and other entitlements while testing out ways of making local information available through councils. Information will be provided to all people approaching state pension age by the Pension Service. Pre-retirement courses to improve awareness of financial education, adult learning and volunteering opportunities will be expanded through Citizens Advice and voluntary sector partners. Other sources of information, advice and guidance will be expanded as well, covering money guidance, housing and care.

All of this raises the question of how to deliver information in a format and at a time when it is likely to have most impact. Older people place a high value on getting hold of good, accurate information. This can help people stay independent and in control of their lives for longer, especially if they need to deal with complicated systems to access essential services (Horton 2009). There is ongoing work in Newcastle, for example, focused on creating a stronger local system for information, advice and advocacy by improving awareness and signposting rather than creating short-life projects or new services. The key findings from that project to date are summarised in Box 3.2. ippr recommends further research to explore what is the best mix of approaches (including face-to-face, written information, telephone advice lines and websites) for older people according to their individual circumstances.

One of the most promising developments appears to be all-in-one smart cards. Concessionary bus passes in England typically use smart-card technology, which could be adapted for other purposes. This is being considered by the Welsh Assembly Government for older people in Wales. *Building a Society for All Ages* notes that this has already been extended in Derbyshire, where smart cards are used for library registration and to give access to both central and local government services as well as discounts with various businesses.

Box 3.2. Creating a stronger information, advice and advocacy system for older people – example of Newcastle

Instead of creating new projects and services, the focus in Newcastle has been on how existing systems can be made more 'older person friendly', efficient and effective. This emphasis on system change is especially pertinent in the current public spending environment.

There is a central database of information, which older people, carers and staff can access. This is key to ensuring universal access to information and advice. Outreach to older people is undertaken by frontline staff from various agencies that promote and make use of a website dedicated to older people. Briefings are conducted with frontline staff including nurses, social workers, librarians, care home activity coordinators, sheltered housing officers and Citizens Advice volunteers.

A multi-agency signposting scheme is being developed*. This is coordinated through one central point that shares information from various agencies. It builds the signposting role of frontline staff, enabling older people to access preventative services through a single point of contact.

Essential features include giving older people a variety of ways to share their experiences and views and using their feedback to improve services. Newcastle Elders Council helped gather the views of isolated groups including housebound older people and black and minority ethnic communities. A network of frontline staff and older people was developed to ensure they contribute to change. The Council meets twice a year and gathers feedback on real-life situations.

**Newcastle's approach is similar to the 'First Contact' initiative in Nottinghamshire (Horton 2009).*

Source: Horton (2009)

These approaches to supporting participation in everyday activity will be useful for many older people. But they may be of little help to those who are housebound, frail, in long-stay hospital wards or in residential/nursing care. Any strategy must benefit older people who are not able to live independently. *Building a Society for All Ages* makes a nod in this direction with its references to informal learning and digital inclusion opportunities for people in care, as well as opportunities to share life experiences and knowledge with younger people through school-age mentoring. But overall, more creative thinking and action are needed if the strategy is to get to grips with the diverse circumstances of people over 75 in particular.

Family and care roles

Many older carers take on the role of primary care-giver, commonly to a parent or spouse. Others continue as carer to a disabled child well into their adulthood. The health and wellbeing of carers has slowly achieved a higher profile, reflected in the National Carers Strategy (Department of Health 2008), which recognises carers as 'expert partners'. This agenda is developing further with the belated recognition of the need for a framework to include extended families – particularly grandparents – who take on the care of children when parents cannot.

Building a Society for All Ages proposes the development of a carers' helpline, website and training programme in England and has set up a 'Dignity in Care Champions' Network[2]. While these are welcome steps, many people in later life still find themselves in financial hardship as a result of their unpaid care role. Extending state pension protection to carers of children up to 12 will help some grandparents. If the supply of unpaid care is to be sustainable in the face of various pressures – many carers are getting older and less able to cope, while others expect to remain in employment for longer – a bolder package will be required, starting with the right for carers to receive the support they have been assessed as needing.

A local focus on prevention

The UK strategy aims to promote health, wellbeing and independence in later life. A package of 'health prevention' measures will be developed for older people. The title reveals some confusion in terminology: it would be better referred to as *health promotion* or similar. Nonetheless, the direction of change is clearly helpful in bringing together existing services (for example, preventing falls and help with foot care) and will be expanded to include other conditions that may impact on the quality of people's later lives such as arthritis, continence care and depression.

Recently published strategies for dementia and strokes will be followed by a new service guide and strategy (*New Horizons*), outlining approaches for improving the mental health of older people and their carers. The UK Government is proposing to identify in 2010 the help that needs to be available to improve care for these conditions. This is good as far as it goes, but underplays the need to improve service quality and understanding among service planners and providers about targeting and achieving better outcomes.

By default, England has become devolved in substantial areas of policy. Health, social care and education policies passed at Westminster now apply only to England in most cases. Pensions, benefits, employment and equality laws are reserved to Westminster and apply throughout the UK. Below, we narrow our focus to two significant local initiatives, LinkAge Plus and Partnership for Older People's Projects, both designed to take a preventative focus at home and in the community. These have been piloted recently in parts of England. Mindful of the gap between strategy and delivery, we look at local partnership-working to

3. The Network 'supports people to share views, resources, knowledge and best practice on issues relating to dignity in health and social care settings' (www.networks.nhs.uk/networks/page/909).

shine a light on how progress is made or frustrated. Such approaches are at the forefront of the Treasury's thinking about making savings as well as increased health and wellbeing in later life.

LinkAge Plus

LinkAge Plus (LAP) is led by the Department for Work and Pensions in England. LAP projects are described as providing 'that little bit of help' on a day-to-day basis to promote wellbeing and independence and reduce the need for more intensive support. LAP has been adapted by most local authorities in Wales but not in Scotland. LAP helps organisations work on partnerships, capacity-building and the involvement of older people in services, to:

- reduce duplication
- achieve delivery of more relevant, tailored and preventative services
- increase satisfaction
- increase cost effectiveness.

Among the desired outcomes from the pilots are: a more positive view of ageing in society, greater confidence among older people, improved quality of life, and financial benefits for individuals and society.

An evaluation has looked at the costs and benefits of the LAP pilots (Watt *et al* 2007). It estimated the benefits in terms of preventative savings from upstream activity, notably from delayed progression to more costly residential care and a reduced number of emergency admissions to hospital. The review authors noted that if LAP initiatives achieved these things in 5 per cent of cases, major savings could be achieved: for example, the unit cost of treating a hip fracture is more than £25,000 while the average costs of LAP contacts are small.

The focus of LAP activity has varied, from linking up services and signposting towards other existing – sometimes mainstream – services as well as extra provision, for example new approaches to maximise benefit take-up among older people not claiming their full entitlements, home security and installation of smoke alarms, and opportunities to socialise more. In many cases it was found that extra support in the community was available but not accessed, reflecting patchy levels of awareness among service providers as well as older people. Support was used to help voluntary sector partners attract extra funding and volunteers.

Among the benefits for older people highlighted in a further interim report (Daly 2009) were enhanced safety and peace of mind (achieved, for example, after taking up handyman services); physical and mental health benefits arising from schemes to address the inactivity and isolation that accelerate preventable ill health and dependency (for example, walking groups, befriending, peer volunteering); financial security through increased benefit uptake; and mobility, through community transport initiatives which recognise that older women are much more reliant on public transport and more likely than older men to report difficulties accessing local services. Initiatives usually concentrated on people at low or moderate risk of falling or being admitted to hospital as an emergency. Some pilots also focused on some minority ethnic groups, older men and rural communities as well as inner-city neighbourhoods.

Other positive findings from Daly (2009) include better inter-agency working which has led to single access points for services, service gaps being filled and some positive work with private care homes (for example to install exercise equipment). These findings focus more on inputs than evidence of outcomes, or a clear view of the pathways that might link them. However, a separate business-case assessment of the LAP pilots (cited in HM Government 2009) showed substantial added value using return on investment measures for specific elements including home adaptations and home security improvements. Such services more than covered their costs.

A further report (Willis and Dalziel 2009) analysed how the range of LAP initiatives contribute to a framework for capacity-building. It considered the evidence across 10 dimensions, including enhanced staff skills resulting in better ways of working within existing services; efficiency gains through reduced duplication; holistic views of older people's quality of life leading to person-centred approaches to commissioning; and multiplier effects where older people have been engaged in policy development and service design. The authors conclude:

> *There is emerging evidence that the work of LAP pilots is fostering a radical change away from traditional needs or service-centred approaches towards strategic commissioning founded on a people-centred approach. The focus of such work is on improving outcomes … and not simply ensuring improved access, integration or partnership working.* (Willis and Dalziel 2009)

This is a hopeful assessment. Although there may be a degree of over-claiming the success of the LAP programme, it appears to have added much to our knowledge of preventative work for older people living at low to moderate risk of needing acute interventions and shows that local partnership working can shift the focus of service commissioners and providers onto better outcomes.

Partnership for Older People's Projects

Led by the Department of Health in England, Partnerships for Older People's Projects (POPP) bring a focus on early intervention to health and care in the community. The underlying aim of POPP is:

> *…to create a sustainable shift in resources and culture away from the focus on institutional and hospital-based crisis care, towards earlier and better targeted interventions for older people within community settings.* (Personal Social Services Research Unit [PSSRU] 2008)

Most of the projects were due to complete pilot work by March 2009. The findings discussed below are drawn from an interim evaluation of the period 2006–08 (PSSRU 2008). It found that almost 100,000 people had received a service via 470 projects in 29 locations across England.

- Seven out of ten projects (71 per cent) were found to offer *universal services*, aimed at all older people and their carers. These included handyman schemes, gardening, shopping, leisure and signposting, suggesting overlap with LAP activity, though in different locations.
- About one in seven projects (14 per cent) offered additional support (for example, medicines management, falls prevention and telecare services) to older people *at risk of hospital admission*.
- A smaller number (8 per cent) provided specialist support, including 'hospital at home' and intensive support teams, to those *at serious risk of imminent hospital admission*.
- A further 7 per cent of projects were focused on *capacity-building* rather than service delivery, covering staff training and needs mapping.

POPP appears to have been successful in reaching people over 75: almost two-thirds of service users were aged over 75 and almost one-third over 85. Preventative and early intervention work can occur at various stages of older age since the trigger points for escalating need, ill health or frailty appear at varying times. Almost half of those involved in service delivery were themselves older volunteers, and in a quarter of cases older people were trained to undertake research, though it was more common for voluntary organisations to speak on behalf of older people rather than engaging with others who do not usually get involved.

The impact of POPP was assessed against five criteria (PSSRU 2008). Key findings were:

- *Cost-effectiveness*: Pilot sites had a clear effect on reducing hospital emergency admissions compared with 'control' locations. For every £1 spent, an average of 73p was saved on the monthly cost of emergency hospital bed-days.[3] On this measure, POPP initiatives came close to paying for themselves. The authors note that this type of cost-effectiveness needs to be compared with beneficial outcomes to older people. There would be little point in reducing the use of acute health care if cases were merely deferred and presented to hospitals in a more severe state.
- *Service use change*: Savings from there being fewer overnight stays in hospital were found to significantly outweigh the cost of greater use of primary care and home services such as meals on wheels, social work and community nurses. A net average saving of £410 per person was estimated.
- *Quality of life:* Projects appeared to have a positive effect on quality of life perceptions, including better mobility, less anxiety and less pain. Even on the least favourable assumptions, costs related to these benefits were estimated to be one-third below the recognised 'break-even' threshold.
- *Cultural change:* Projects aimed to change working cultures in health and care as well as shifting resources into the community. The evaluation noted that greater focus on preventative services to improve wellbeing has 'reinvigorated locality working with older people to identify needs and inform commissioning processes'. Projects were thought to have accelerated joint commissioning in health and social care, especially between councils and the voluntary sector. But reforms to Primary Care Trusts and the lack of full involvement of GPs remained obstacles.
- *Sustainability:* Long-term service reform will rely on savings from acute/residential care and mainstreaming successful POPP approaches. It is promising that only 4 per cent of projects said they did not intend to continue the service after Department of Health funding finished. However, the main barrier was projects being unable to capture savings from acute services. On this measure, POPP was no more successful than earlier approaches.[4]

In spite of the good practice and savings identified, it appears that the painstaking work of partnership only gets us so far before failing to move resources into prevention in the community. The Community Health & Care Partnerships (CHCP) model in Scotland incorporates two organisational cultures (from the NHS and local government) within statutory partnerships, but even this is some way removed from having a single set of objectives and resources to deploy for older people. A bolder conclusion is that integration of health and care services into a single agency is required if decision-making is to become truly responsive in an ageing society.

Looking ahead, the evaluation authors conclude that commissioning should focus on value for money and return on investment. Some interventions will produce net savings and others will improve quality of life at a net cost. While it is hard to measure the impact of low-level preventative services, better estimates can be made using more appropriate survey and interview methods with people at different stages of old age.

Advocacy, scrutiny and involvement

The establishment of a UK Advisory Forum on Ageing was announced by the Department for Work and Pensions in February 2009 (HM Government 2009). It will work with the Government to identify additional steps to improve wellbeing and independence in later life. The Forum will include ministers from the devolved nations and officials from the English

3. The assumed cost was £120 per day.
4. This finding is true at the interim stage. Findings from the final evaluation may differ.

regions as well as voluntary sector stakeholders. The UK Government will report on progress towards achieving the vision set out in its recent ageing strategy (ibid) to a Cabinet Committee on Ageing and to this new Forum. At this stage it is not clear how far the new Forum will play a scrutiny or accountability role, as distinct from an advisory role. However, it has the potential to serve as a valuable vehicle for learning lessons on policy and practice between the four countries of the UK.

In terms of advocacy, the UK Government appointed a Voice of Older People, Dame Joan Bakewell, in November 2008. The role is independent from government, serving as an informed advocate on issues that affect older people's lives across the UK. One aim is to raise the profile of age equality issues and encourage public debate, particularly as the Equality Bill progresses through Parliament, as well as giving views on other key policies. The role is described as unique within government. It may be useful in terms of raising awareness and influencing debate, but represents a different approach from the Older People's Commissioner and Advocate roles established in Wales and Northern Ireland respectively (McCormick *et al* 2009). The Welsh role, in particular, offers more scope to hold government and public service providers to account.

Summing up: policy on ageing in the UK and England

The approaches to preventative working discussed here are relatively modest in scope, but interim evaluations point to some very effective practice that should now be consolidated. Most of the initiatives attend to local quality of life issues of high importance to older people. Many have broken new ground in commissioning of services, engagement with older people and capacity-building and are demonstrated to be cost-effective. Yet it is less clear how to make positive changes stick in the longer term – notably, how to divert budget savings in the NHS to investment in community services. Just like changing outdated attitudes in society as a whole, the challenge here is one of cultural proportions. No amount of good partnership work is likely to deliver the kind of integrated planning and resource flexibility needed. It is hard to escape the conclusion that a single agency spanning health and care services is the model most likely to achieve this.

Devolved policies for older people

In the last decade sustained progress was made in reducing poverty in older age, although this has stalled since 2005 and has reversed in some parts of the UK. Policies to tackle poverty have been led by the UK Government. They span targeted measures to boost low incomes such as the Pension Credit Guarantee as well as universal payments such as the Winter Fuel Allowance to address the impact of higher fuel costs, and universal age-related measures for people over 75, such as free TV licences for the over-75s and a larger Winter Fuel Allowance for the over-80s. The devolved administrations have few powers to act directly in this area, but have taken steps to reduce the costs associated with public transport and warm housing.

Variations in these policies have been modest, with the exception of Scotland's Free Personal and Nursing Care policy.

The age of entitlement to a free bus pass is 65 in Northern Ireland but 60 in the rest of the UK. Travel on any route at any time is permitted in Scotland, but restricted to off-peak journeys elsewhere. Concessionary rail travel has been piloted in parts of Wales and concessionary travel has been proposed in Northern Ireland. Free swimming for the over-60s (England and Wales) and access to cultural facilities (Wales) have been introduced more recently.

Local authorities may also decide to reduce or remove costs for older people. In Wales, this has meant variations in home care costs between councils being reduced and the threshold at which charges become payable being raised to help older people on modest incomes.

We know quite a lot about the objectives of various policies but not enough about their impact. It is too early to assess what difference devolution has made to outcomes for older people as a whole group. Nonetheless, strengths can be identified in each country's approach:

- Wales has developed a comprehensive *Strategy for Older People* spanning 10 years, rooted in a clear statement of citizenship. Its strength lies in its future potential rather than clear outcomes already delivered, but Wales appears to be particularly well placed to make the most of its devolved powers.
- Scotland has more extensive powers to legislate than Wales and has made the boldest move of all in extending free personal and nursing care to all older people assessed as being in need. This has removed problems sometimes associated with means-testing like inefficiency, low uptake, perverse incentives and, for some, indignity, while extending benefits to those who would previously have been required to pay. Yet there is now less sense of momentum around older people's issues in Scotland than in Wales.
- Northern Ireland is, in many ways, just getting started but even here a clear focus on increasing the uptake of Pension Credit has led to impressive results. More significantly, the rapidly changing environment for public finances creates considerable uncertainty about future pledges.
- Different approaches to advocacy and scrutiny on behalf of older people have been taken. The Commissioner for Older People in Wales appears to represent the most advanced 'independent champion' model in the UK. Northern Ireland has an interim Older People's Advocate without statutory powers, but there will be a fully-fledged Commissioner role by 2011. The UK Government has appointed an independent Voice of Older People who will raise issues of concern for England as well as UK-wide issues. Scotland is alone in having no such dedicated role.

Devolution means that further divergence in policies for older people is likely, but if there is better cross-country sharing of lessons from policy and practice, we might also find examples of convergence as one country's experience influences another's.

Conclusions

Overall, the bulk of UK policies have put more money into the pockets of older people while devolved policies have reduced the cost of using services. These are likely to have some clear benefits in terms of inclusion, independence and wellbeing. But it is doubtful that we will see much more along these lines in the coming years, and quite possible that current eligibility will come under scrutiny within an ultra-tight public spending environment. Draft Budgets for 2010–11 signal the start of a process of cutting public expenditure, which is expected to last for years. Policies for older people are not targeted at this stage, but it is hard to see how governments will manage to avoid changing the basis of entitlement for future recipients (Audit Scotland 2009). If ages of entitlement are to change or some element of contribution introduced in place of free access, it is essential that this is done on the basis of rigorous impact assessment. The first priority should be to ensure that the oldest, poorest and most vulnerable older people are not disadvantaged.

A clear reform agenda for older people has been mapped out by voluntary sector organisations in recent years, most thoroughly in the *One Voice* report from Age Concern and Help The Aged (2009). The single most significant issue is reforming the costs and quality of social care, the subject of various inquiries and reviews but of little progress in England since 1997. Instead of restating the conclusions of *One Voice*, which we largely support, we identify in Chapter 6 of this report a number of cross-cutting themes that we believe should be addressed in order to achieve a breakthrough in older people's wellbeing.

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4. Lessons from abroad: ageing and wellbeing in an international context

Jonathan Clifton

Britain is not alone in facing the challenges of an ageing population. What used to be an issue for Europe has now become a challenge for nearly every continent. By 2050 one fifth of the world's population will be aged over 60. The fastest increases in ageing will be seen in Asia and Latin America, where the proportion of the population aged over 60 will double in less than 20 years from now.

While population ageing is common across many countries, the experience of growing old varies depending on the context in which it happens. In Japan for example, life satisfaction is highest among the over-65s, whereas in Hungary this age group is the least satisfied (Donovan and Halpern 2002). Across Europe, rates of depression among older people vary – in Amsterdam they are half what they are in Munich, for example (Copeland *et al* 2004). And inter-continentally, a fifth of Americans in their seventies are still working, compared with just 1 per cent in France (Harper 2009).

These international variations demonstrate that decline and disengagement from society are not inevitable consequences of older age. Variations in culture, policy, services, environment and attitudes mean the experience of ageing is different depending on where you live. It is open to change.

This chapter provides examples of policies and programmes that have been introduced in other countries to respond to the issue of older people's wellbeing. It focuses on policy areas beyond the traditional realm of healthcare and pensions – looking instead at the four themes of relationships, work, learning and the built environment[1]. The aim is that these case studies will inspire new responses to ageing in the UK.

Relationships

Tackling isolation and social exclusion should be the bedrock of any attempts to improve older people's wellbeing. Loneliness and isolation are closely linked to poor mental and physical health – a particular problem when one third of older people in the UK say they are lonely and a fifth feel isolated (Leadbeater 2009, Actor *et al* 2002). A new agenda for government in the coming years will be to help older people maintain and develop social networks (Oancea 2008).

The case studies on the next page demonstrate different approaches to older people's wellbeing that focus on building and harnessing people's relationships with those around them.

Discussion – relationships

Targeting relationships and social ties will be central to improving older people's wellbeing, even in the presence of other barriers to their quality of life. This will require a different philosophy from the state – moving away from centralised programmes that deliver a service in isolation, towards enabling and harnessing 'everyday relationships', as seen in the examples.

1. For a more detailed review of the literature on each of these four themes and how they influence older people's wellbeing, see Clifton 2009.

Case study: Hureai Kippu, Japan

Relationships and work

Japan's population structure is often talked about in crisis terms given that the country has one of the world's most rapidly ageing populations. The fact that its social care system is almost entirely publicly funded means ageing could put a particular strain on public finances (OECD 2005).

In response to this challenge Japan introduced a 'health care currency', or *hureai kippu* in 1991. This is effectively a timebank scheme which is dedicated to caring for the elderly. People who volunteer gain credits, the number of which depends on the time given and the type of task, with more onerous tasks earning more credits. The credits are stored in the same way as savings – the currency is simply in hours instead of yen (Kent 2001).

The scheme operates in the same way as a bank. This means that credits can be banked for the future as a form of social care insurance, so when a person needs support she can draw on the credits she has earned. Credits can also be transferred to others. Many people provide help to an elderly person near to them, and then transfer the credits they earn to an elderly relative living in a different part of the country. In this way they can ensure their relatives receive support without actually moving to live near them (Aldridge *et al* 2002).

The scheme has been proved to provide a high standard of care. What's more, the majority of elderly people actually prefer receiving support under the *hureai kippu* scheme than paying by yen, because they build better relationships with their carers. They also prefer it to services provided by charities, which make them feel dependent (Lietaer 2001).

This case-study demonstrates how Japan has responded to the challenge of providing social care by focusing on 'everyday relationships'. Rather than innovating services provided by the state, Japan has responded by innovating methods of exchange and payment. These have strengthened social ties and encouraged families and communities to play more of a role.

Case study: Summerhill Active Retirement Group, Ireland

Relationships

Started in a rural Irish village in 1988 by Mary Nally, a nurse despairing of the lack of social services available for older people locally, the Summerhill Active Retirement Group now has an international reach (Intel 2009).

Nally gathered retired people in the area together to form their own group to respond to the challenges of being older and living in a remote setting. Their Active Retirement Group (ARG) was granted some land and a Portakabin by the Irish Health Service, and set about organising their own activities and fundraising to enable them to grow and employ staff.

The Portakabin has meeting rooms, a laundry, a library, internet cafe and offices and aims to provide a welcoming environment for all. The group organises a number of services and activities including exercise classes, a laundry service, a choir, regular day trips and holidays, outreach to residents of a nursing home, monthly visits by a chiropodist, visiting speakers, first aid courses, IT classes and concerts. They are also politically active – both on issues relating to older people and other excluded groups. Their 'Millennium Bus' provides door-to-door transport for those who need it – ensuring people can be brought into the community (www.thirdage-ireland.com).

With the help of a social entrepreneur, the Summerhill ARG has developed two national organisations – including a telephone hotline for older people that is soon to expand internationally. The phone line is staffed by older volunteers and provides a listening ear for the isolated and lonely.

Summerhill has been successful because it grew organically in response to a local need and older people run the project themselves. The focus is on building relationships and activities, rather than distributing resources and services. It enables older people to contribute and be active, rather than passively consume services. As a social enterprise it has created additional resources by collaborating with the state, not-for-profits and communities.

Public services have tended to assume that meeting basic care needs should come first, and that strong relationships are a secondary effect of being well provided for in other areas. In fact it is often the other way around. Relationships 'provide people with access to the basic care they need' (Leadbeater 2009: 55). As the case studies above demonstrate, if people have strong relationships and social connections, access to many of the resources and services they need will follow.

In the examples of Japan and Ireland, services were redesigned to be delivered through local people and so that communities build up around the service. They do not just provide a service to meet a need, but create a space in which older people can contribute to a relationship as well. The *way* in which support is given to older people is therefore as important as the actual support being given. Services can do a lot to mask necessity as choice. For example the 'Rural Transportation Service' in Ireland is an essential service for older people, without which many of them could not live independently, but it markets itself as a regular bus service which older people can choose to use (Roberts 2009).

A focus on relationships in delivering services and improving wellbeing has not traditionally been the preserve of progressive politics. It will require a different infrastructure, skill set and scale of approach than service providers and local authorities are generally used to.

Work

While the main argument for people working later in life has been that it is a solution to a looming pensions gap and declining productivity, changing the way we work and retire can also improve health and wellbeing. For many retirement is a happy time of relaxation, but for others 'it is a challenging event that leads to long periods spent alone or inactive, feeling worthless and having no purpose' (Allen 2008: 30).

Working later in life can help mitigate many of these problems, allowing people to maintain a sense of purpose and their social relationships, and engage in productive activities (Calvo 2006). The case studies below provide examples of where both paid and unpaid work have been encouraged.

Case-study: Experience Corps, United States

Work and relationships

Working in 23 cities, Experience Corps is one of the largest social enterprises for older people in the US. It engages people typically over the age of 55 to volunteer as tutors and classroom assistants in primary schools.

Experience Corps is built on a model of intensive volunteering. Members commit to 10–15 hours of work a week for a whole school year. However, there is flexibility in timetabling. Volunteers are provided with training and support and receive a stipend of around $100–300 a month. Despite the high workload, nearly three quarters who start the programme complete it (see www.experiencecorps.org).

Independent research on the benefits of Experience Corps has found that it generates improved physical and mental health, leading some to classify it as 'a public health intervention for older adults' (Barron *et al* 2009: 649). It has all the hallmarks of a successful scheme that promotes wellbeing among older people: it is a meaningful and valued activity; it provides cognitive and physical stimulation; and it enables social interaction across age groups.

A number of features of Experience Corps contribute to its success:

- Strong infrastructure. Paid staff and professional systems oversee recruitment, coordination, training and supervision of volunteers.
- Volunteers receive a stipend. The stipend enables a greater range of people to volunteer and to do so for more hours each week; ensures people are committed to seeing the programme through; and serves as a public recognition that the work is valued (Centre for Social Development 2008c).

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Experience Corps, United States *cont.*

- Effective information campaigns. Experience Corps has worked hard to overcome information barriers, for example by contacting people directly in areas near schools and asking them to volunteer (Centre for Social Development 2008a). It carefully targets its message, talking about 'experience' rather than 'age' and referring to job title (e.g. 'tutor') rather than calling them 'volunteer' (Experience Corps 2005).
- Flexible work routine coupled with firm commitment. The mixture of asking volunteers to commit to a year's service but allowing flexible work schedules has enabled people to volunteer and ensures they take the scheme seriously.
- Team environment. Support is provided from other volunteers and staff in the schools where they are located. Working in a team provides more support and social networks.
- Works in partnership. Partners include AARP, a powerful group for older people, which spreads information about Experience Corps to its members, and Elderhostel, a university for older people, which offers free courses to those who volunteer with Experience Corps.

Case-study: Phased retirement, Norway

Work

Norway, like many European countries, struggles to retain workers in their sixties (Risku and Vidlund 2008). People face long periods in retirement and a sudden cut-off from work. In 2010 it will introduce changes to the pension system to promote longer working lives and phased retirement (Holmoy and Stensnes 2008, Risku and Vidlund 2008).

The aim is to create a system that gives people more choice over when and how they retire, but that encourages them to work later in life. It breaks away from the notion that retirement is a single-stage event at a fixed age, reshaping it as something that can be phased in over time.

The main way it will do this is by keeping the minimum retirement age as 62, but adding significant financial incentives to work later. By remaining in the workforce for longer a person's state pension will increase, and vice versa. The annual pension will increase by about 7.5 per cent for each additional year spent in the labour force without drawing a pension. There will be no upper limit on pension age.

The other key change is that people will be able to draw on their pension while still working, without the pension being reduced. This will allow them to couple elements of work and retirement.

Pensions will also adjust with life expectancy, creating an 'actuarial system'. This means if life expectancy increases by one year an individual will have to work an additional eight months in order to receive the same pension entitlement. Someone born in 1983, for example, will have to retire at age 71 if they want to receive the same level of pension as someone who retires aged 67 today.

In recognition that individuals will need to cover more caring responsibilities in coming decades, pension entitlements will also be accrued for unpaid care work.

Discussion – work

Longer working lives can help older people maintain good wellbeing. Increasing the pension age will not be enough to ensure people work later in life, and on its own could be regressive as it reduces the control people have over their lives. The challenge is to innovate new approaches to working, the transition to retirement, and what retirement itself consists of.

The case studies presented here demonstrate ways in which this is being done. In Norway, the central state has not raised the pension age, but has given people more

incentives to work later and the ability to phase out of work gradually. This means they can fit work around other commitments and it prevents a sudden cut-off from the labour force. They have more control over this key transition in life.

The case of Experience Corps in the US demonstrates how a not-for-profit organisation is reshaping retirement by encouraging older people to commit to intensive voluntary work. The evidence suggests that if people are actively asked to volunteer, if their work is properly managed and flexible, and if they receive a stipend and recognition of their contribution, then their experience can considerably improve their wellbeing.

The way the workplace is organised is also important. Relatively simple changes can enable people to work later in life. These include providing older people access to training opportunities so they keep up with developments, allowing flexible working so they can fit work around tasks such as caring for loved ones, adjusting tasks to ones that older people are better suited to, and using better designed furniture and fittings.

Rethinking work and retirement is not just a task for government. As the Organisation for Economic Cooperation and Development says, 'It will require the co-operation of government, employers, trade unions and civil society to adopt and implement a new agenda of age-friendly policies and practices' (OECD 2006: 14).

Learning

While education has traditionally been the preserve of the young, there is a growing movement towards a model of 'lifelong learning'. Learning can considerably improve older people's wellbeing (Field 2009). It builds self-esteem, a sense of agency, increases social interaction, develops skills to help one cope with life's challenges and stimulates interest.

However, stereotypes that paint ageing as a process of cognitive decline mean older people are overlooked in the learning agenda. Adult education is skewed towards training for the labour market. As a result, only a minority of older people in the UK take part in formal learning (Jamieson 2007). Those older people who are involved in learning tend to be middle class and have previous experience of further education. There is therefore a need to reduce the inequalities in access to adult learning.

The following case studies demonstrate how both governments and non-governmental organisations have encouraged lifelong learning in other countries.

Case-study: SeniorNet, United States and worldwide

Learning and relationships

In 1976, following a conference on the potential of Information Technology (IT) to influence the lives of older people, SeniorNet was born. Its aim is to provide older people with access to computer technologies and bridge the so-called 'digital divide'.

It has grown enormously, now teaching 20,000 students in learning centres each year. 100,000 participants use its website each month and it relies on the help of 4,000 volunteers (SeniorNet 2006).

SeniorNet has established learning centres in a variety of locations (such as libraries, colleges and community centres). Courses are delivered by volunteer instructors – who are themselves older people – and range from simple 'computer fundamentals' to more advanced courses such as 'buying and selling on eBay'. The emphasis is on creating a low-pressure environment and providing the opportunity to practice.

The SeniorNet website itself is a resource for those who are unable to attend learning centres. The website hosts online courses, distance learning, chat rooms to share information and meet pen pals.

An example of one of its services is the 'Books and Culture' area of the website, which hosts an international book club administered by 27 volunteers

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SeniorNet *cont.*

from around the world. This project also sparked SeniorNet's Prison Library Project, which is run by volunteers to collect new or used books to donate to prison libraries, creating a 'spill-over' of benefits as a result of empowering members with technology and linking them with like-minded individuals (SeniorNet 2006).

Strengths of the programme

The SeniorNet programme has been widely recognised with awards and positive reviews in the media (see for example *New York Times* 2007). Key strengths include:

- The focus is on empowering older people through technology, not a paternalistic focus on teaching and imparting knowledge
- The courses seek to bring people together into a community rather than individual learning
- The methodology of 'seniors teaching seniors' has proved very effective, as the tutors have a good understanding of older learners' needs and fears
- Learner participation in designing and requesting courses ensures the classes are relevant, meet learners' needs and are interactive
- The strong focus on using volunteers enables skills to be harnessed and older people to make a contribution, and keeps costs down
- Classes are dedicated to older people meaning they can be developed with specific needs in mind, for example, creating a less pressured environment and a relaxed pace
- A maximum of 16 participants on a course with three to four instructors ensures personal attention
- Locally-based centres can tap into local networks of volunteers, sponsors, students and so on while getting support from national head office.

Case Study: English Language Partners, New Zealand

Learning, work and relationships

English Language Partners is New Zealand's largest settlement agency for migrants and refugees. The organisation grew up organically within individual communities who noticed a need for home tutoring among migrants who could not attend formal English language classes. Volunteers – about half of whom are over age 55 – act as home tutors (ESOL Home Tutors 2008).

The work of English Language Partners is built on a philosophy of lifelong learning. Those receiving tuition are generally adults – some of whom are older migrants who have come to join their children in New Zealand. The benefits for the tutees include acquiring language skills, building social contacts, a sense of purpose and a sense of achievement. As a 95-year-old Russian enrolled in the programme explained: 'this is like my family, I look forward to coming here everyday' (Joshua 2009).

Learning is also central to the tutors. The volunteers receive 20 hours of teacher training and are awarded a qualification recognised by the New Zealand Qualifications Authority. Learning continues well beyond the initial training courses as volunteers go into people's homes and learn about new cultures, dealing with other people and putting their teaching techniques into practice.

English Language Partners has the hallmarks of a successful social enterprise: harnessing social capital, building relationships between people, building individuals' capabilities to live independently, effective monitoring and improvement mechanisms, being responsive to local need, and enabling the participation of the people they are serving. Underpinning the work of both the tutors and tutees is lifelong learning.

Case study: University of the Elderly and Community Education, China

Learning

Lifelong learning is not a foreign concept to the Chinese, who have a long history of education throughout the life-course (Kai-Ming *et al* 1999). Its cultural and political attitude towards adult education has permeated China's response to its ageing population.

China has introduced a system of 'universities for the elderly' and 'community education' designed specifically for retired people. It boasts 26,000 institutions of higher learning for older people, with a total enrolment of 2.3 million students. In 2006 it promised that 10,000 more senior citizens' universities and schools would be established across the country (*China Daily* 2006). The education system for older people is built on a view that sees learning opportunities for older people 'as welfare as well as education – the overall objective is to make lives after retirement meaningful' (Kai-Ming *et al* 1999: 128).

Since 2000 China has also developed a programme of 'community education'. Community education works by opening up resources such as libraries, museums and sports clubs into an integrated local network – linked to central colleges and schools for support. Branches are run by local communities, by a mixture of paid teachers and voluntary staff. Classes range from art and calligraphy to health and foreign languages.

Underlying China's developments in education is a focus on lifelong learning, equality of provision for *all* citizens and the aim to satisfy cultural – not just labour market – needs. For example, the Constitution of the People's Republic of China emphasises that all citizens have the right to receive education and the 2004 Action Programme for Vitalizing Education talked of 'building a system of lifelong education' (CNCU 2008: 9–11).

China is responding to a set of unique challenges related to rapid economic and social development, not least that of having a large number of elderly people who did not have access to education in their youth. Despite this, its response to the issue of ageing and learning is instructive to other countries for a number of reasons:

- It demonstrates how a cultural attitude supportive of learning across the life-course can influence policy and the design of the education system
- It provides an example of an institutional response to the challenge of learning in later life – building an entire education system of schools and colleges for older people
- The aims of the education system go beyond simply training young people for the labour market. There is also an emphasis on equal access for all citizens to education opportunities and on the benefits of learning to culture, society and wellbeing.

Discussion – learning

Learning can be an important driver of wellbeing in later life, though public attitudes and material barriers mean it is often seen as something for younger generations being trained for the workforce. The case studies presented above all challenge the assumption that ageing is characterised by cognitive decline and low motivation to learn.

The success of the approach of the example projects is down to:

- Older people being given support to learn in a communal environment
- The use of peer-to-peer teaching methods
- Older people being empowered to participate rather than simply being imparted knowledge.

These programmes tap into people's needs and wants – delivering opportunities for learning that are built around people's daily lives, be it learning how to use digital photos to keep in touch with family and friends or how to teach so they can help settle immigrants into their communities. In the case of China, we see how education institutions can be built and adjusted to encourage learning in older age, shifting their philosophy to assume that older people are part of their target audience.

Rather than seeing different stages of life dominated by a key activity (with younger years spent in education, middle years in work and older years in retirement and leisure), we need to adapt to a more integrated model with elements of education, work and leisure all taking place throughout the life-course.

Built environment

The design of homes and cities has not kept pace with the reality of how people live their lives. House building and planning agreements have been based on a model of nuclear families, the able bodied, working residents and people being prepared to travel to access services. Yet it is older people who will account for half of the increase in households between now and 2026, meaning there will be 2.4 million more 'older households' in the UK than there are today (Communities and Local Government 2008). The way we build homes and communities must reflect a different reality: that many older residents live on their own, are not working and are less mobile than the rest of the population.

There is a growing appreciation in the disciplines of planning and architecture of the relation between humans and their environment. While this has tended to focus on people's physical needs, much can also be done to facilitate good mental health. The case studies below demonstrate how the built environment can support older people's wellbeing.

Case study: University-Linked Retirement Communities (ULRCs), United States

Built environment, learning and relationships

On a 10-acre site near to the University of California in Davis, a not-for-profit organisation has built a 'University Retirement Community'. It contains a range of living options including independent cottages and apartments, assisted living units and a 51-bed skilled nursing centre with a 14-bed Alzheimer's wing. The units range in size and residents are able to customise and decorate them how they wish.

There are many amenities specifically for the retirement community, including meeting and dining rooms, cafes, a library, fitness centre and parking. But being so close to the university campus, residents have access to much more. They can use the university hospital, watch university sporting matches and attend cultural events. Lecturers come to give talks, and there are opportunities to participate in classes and mentor students.

The residents are assured of frequent intergenerational contact, because many younger students from the campus have part-time jobs in the retirement community – servicing the shops and cafes (Harrison and Tsao 2006).

This example is part of a growing trend for retirement communities to be built on university campuses – there are about 60 in the US (Harrison and Tsao 2006). They have been set up by private developers, not-for-profit organisations and universities themselves (Halligan 2004).

Through an innovative approach to the built environment and service delivery – which uses an established infrastructure and community – it lays many of the foundations to wellbeing in later life.

There are also considerable benefits to the university, including jobs for students servicing the retirement community, financial benefits from rent or sale of the land, older people contributing to campus life (for example, through guest lecturing and volunteering), and increasing the one area of diversity that universities struggle most to address: age.

Case study: Preventative Home Visits, Finland

Built environment and relationships

Finland has pioneered a system of preventative home visits for older people, in an attempt to shift the focus from treatment to prevention. Their purpose is to:

'…assess and support independence, to provide information about services, to identify risk factors endangering the person's health and welfare, and to check the safety of the home and surroundings. The likely future need for individual services can also be established.' (Ministry of Social Affairs and Health 2008: 23–24)

Trained professionals enter the homes of older people – both to assess the physical surroundings but also to advise on health and provide information about resources and services available. These visits are targeted at older people who do not yet need health and welfare services but are deemed 'at-risk' – such as those who live alone, are on low incomes, are susceptible to falls, have chronic diseases and those recently widowed.

The visits are seen as a way to prevent poor health, keep costs low, enable people to age in their own homes and ensure they have a more active retirement. A particular problem was seen to be that while advice and health promotion goes on in early stages of life – through school health programmes, child centres, maternity clinics and occupational health in the workplace, it tends to peter out after retirement. Finland is therefore trying to put a new infrastructure in place to continue educational work around promoting healthy living and identifying problems early (Voutillainen 2009).

The visits are a highly personalised approach to service delivery – providing information to people, giving them advice on the options available for their care and support, and navigating them through the complex system of services.

Discussion – built environment

The way we build our homes and communities will have to adjust to growing numbers of older people – who are often less mobile than the rest of us and living on their own. Changes to the built environment can dramatically improve the wellbeing of older people and offset the mounting pressure of care and support costs. While this is acknowledged in UK government policies such as *Lifetime Homes, Lifetime Neighbourhoods* (Communities and Local Government 2008) it is not yet a reality in the physical fabric of many towns and cities.

The case studies outlined above demonstrate how the built environment can be better designed. They each have a number of specific features – for example, giving personalised advice in the home in the case of Finland's home visits, or targeting an active lifestyle involving learning and intergenerational contact in the case of retirement communities linked to universities. Indeed, careful design of things as small as being able to see vegetation and feel fresh air can hugely improve people's satisfaction (Kaplan 2001, Alves and Sugiyama 2006).

Two principles lie behind both of the case studies. The first is the need to design the built environment to connect people to services, activities and other people. Both examples sought to improve these connections. The second is the importance of enabling people to 'age in place', both by helping them to stay in their homes and to move beyond them (Roberts and Prendergast 2009). This can require rethinking how services are delivered (for example via door-to-door transport or home visits) as well as how towns and cities are designed.

New approaches to building 'a society for all ages'

The UK government has outlined its ambition to 'build a society for all ages' (HM Government 2009). This chapter has provided case studies of how countries with different political systems and cultures are responding to the same challenge. While we cannot directly import good models from overseas, we can identify the underlying principles and approaches

that make for successful and innovative interventions to improve the wellbeing of our ageing population.

The case studies presented in this chapter highlight the new approaches that will be needed:

- A premium will have to be placed on building relationships between people. This will require new ways of encouraging people to give up their time to help others, and small scale activities rather than big state-run programmes.
- Local providers and social enterprises will take centre-stage, especially given the financial constraints on central government. Social enterprises can create considerable additional resources with small inputs from government.
- Services should be personalised to allow individual needs in this diverse and growing population to be taken into account. One size will not fit all.
- Responses will have to tap into people's experiences, motivations and daily routines to ensure their buy-in – we must provide older people with things they want. It is essential to change people's attitudes as well as introducing new policies and programmes.
- Older people should be enabled to contribute, not be seen as passive consumers. Services and activities must be designed to encourage their contribution.
- Older people will need information and advice from trusted sources to help them make the most of the opportunities available.
- Retirement from paid work must be more of a 'phased transition' in life than a sudden cut-off at retirement age. Elements of work, learning and leisure can be better integrated throughout the life course.
- Independent living and leading an active life in older age can sometimes require support. Services and the built environment can be designed to support people to live independently. Creating independence does not mean leaving older people to fend for themselves.

How might these principles be put into practice in the UK? Below are just a handful of pointers that could be taken from the experience of other countries when trying to improve older people's wellbeing in areas beyond the traditional realm of pensions and health care.

- Encourage volunteering. Experience Corps found that people are more likely to volunteer when they are asked to do so – so the proposed 'Active at Sixty Packages', which the Government's ageing strategy suggested should be sent to everyone in the UK on their sixtieth birthday, should include requests from local organisations for help with voluntary work.
- Introduce home visits. Finland found that going into people's homes is a good way to share information. Home visits could help make older people aware of the support and services they are entitled to.
- Support organisation of groups. Summerhill Active Retirement Group could become a model for how local government can provide small amounts of support (such as land and a minibus) to enable older people to organise their own groups up and down the country.
- Encourage learning. The Chinese model of Universities of the Elderly could inspire education providers in the UK to make it easier for older people to enroll on courses and access student loans.

Conclusions

Few countries' populations have been untouched by the effects of ageing. The way societies have responded has lagged behind the reality of people's lives. While the state pension age in the UK is currently 60 for women and 65 for men, many are able and willing to work

longer. Education is designed primarily for children and young people, but adults need and want to learn as well. Cities and homes have been designed largely for the able-bodied but many of us will become less able as we get older.

The underlying problem is that we have designed our institutions and communities according to an image of life after 65 that is out of date. Later life is frequently seen as a time of decline, dependence and disengagement from society. The challenge is to build a society that assumes older people should participate and be active for as long as possible, and to the best of their ability – not one that assumes they are dependent and disengaged. We need to adjust institutions, services and communities to support older people to realise this vision.

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5. Creating a responsive and supportive community for older people: qualitative analysis of wellbeing in older age

Alice Sachrajda with Myriam Cherti

In an age of increasing longevity, listening to, and acting on, the concerns of older people is essential in order to shape ageing policy and practice. This chapter reflects a range of views from groups of older people of different backgrounds living in different parts of the country. It sets out the findings of a qualitative analysis based on a series of ippr focus groups in Berwick-upon-Tweed, Newcastle-upon-Tyne and London in 2009.

While carrying out the research, efforts were made to engage with some people who may currently be excluded from the debates about ageing and wellbeing in later life, including those in rural areas, those in residential care homes, and marginalised groups including some minority ethnic communities. Box 5.1 explains our focus group recruitment and the diverse make-up of the groups.

Box 5.1: Recruitment and make-up of the focus groups

Participants were recruited by contacting a range of community and voluntary organisations, day care centres, adult education institutions and residential care homes. This includes day care centres and drop in centres (including Age Concern and St John's Ambulance), Age Concern BME (black and minority ethnic) Elders Group and BME day care centres, Citizens Advice Bureau, educational institutions attended by older people, residential care homes and support groups. A 'snowballing' effect took place whereby people told acquaintances about the events, who then attended too.

A total of 46 people attended the focus groups, 33 women and 13 men. The high numbers of women attending may be due to large proportions of women attending day care centres. The age of participants ranged from 51 to 102 but the majority of participants were in their seventies (22 in total) and the median age was 73. Nine of the participants were over 80 years old. Three community representatives/interpreters also took part in the discussions, whose ages ranged from 51 to 58.

Box 5.2. The use of peer researchers

Peer researchers can positively influence research design and provide valuable contributions based on their knowledge and experience. Before the focus groups a meeting was held between researchers and an older person who acted as a group facilitator. This enabled an evaluation of the focus group discussion guide. Qualified peer researchers (from Year's Ahead, The North East Regional Forum on Ageing) commented on the discussion guide for the focus groups. Their recommendations were incorporated into the focus group discussions and the final analysis.

Listening to the views of people of varying ages about older age is important. Research shows that the period after age 65 is not experienced uniformly and people over 80 suffer significantly and gradually worse outcomes than the 'younger old' (Allen 2008). Peer researchers have been involved throughout the course of this work to inform the research – see Box 5.2.

While recognising that older people's wellbeing is a broad subject, we focus in this chapter on the themes of overcoming isolation, fostering social networks and engaging in activities in later life, as these were areas of importance for the majority of participants[1]. The first part of the chapter explores the need for targeted care and support and the second part looks at the concept of 'active ageing'. It concludes with some recommendations, with a particular emphasis on practical, and often simple, changes that can be made to improve older people's wellbeing. The quotes in this chapter are taken from the focus groups.

Targeted care and support

The Ageing Strategy (HM Government 2009) sets out the Government's plans for better public services in later life. It includes positive suggestions for more preventative health strategies, as well as a UK Advisory Forum on Ageing to provide advice to ministers. These developments should go some way towards creating a more responsive and inclusive society for older people.

1. This may in part be due to the number of participants who were recruited from day care centres and community support groups.

The Ageing Strategy also recognises the need to strengthen community and family networks. For all focus group participants, strengthening social networks was considered an area of major importance, requiring a targeted approach that is tailored to individual need and reaches out to those who are most excluded or isolated.

Strengthening social networks

> *It would be wonderful to have people who may be, quite apart from carers, people who simply come in to give that person emotional support, that friendship and listening ear that people need and then that person could be a [link] between 'do you need to go to the library today?', 'do you need the doctor?', an in-between person who would go and visit and be a link.* (Staff representative from a care home in Newcastle)

Reaching the most isolated older people

Day care and drop in centres are relied on for much valued support, advice and friendship – which in turn help to foster both mental and physical stimulation. Such centres give a welcome break from the long periods of time alone that can become the norm for many older people. Funding for older people's activities was a key area of concern for the participants. Several people referred to schemes and classes that had stopped due to lack of funding, in particular a 'buddy' support scheme and IT classes.

But despite voluntary and community initiatives, and schemes such as LinkAge Plus (LAP) and Partnerships for Older People's Projects (POPP) (see Chapter 3) there are still people who are not being reached and remain isolated, in some cases for years at a time. As identified by Age Concern: 'Wellbeing and prevention are far easier to secure for people who are already in touch with services, plugged into social networks and able to articulate what they want' (Yates *et al* 2008: 7).

One participant in Berwick described how isolated she had become before receiving help:

> *Due to circumstances from which I can do nothing about I lost my place and for four or five years I never saw anybody and then my care manager got me into Age Concern and I absolutely love it.*

The problem of isolation resonated strongly with the majority of participants and a number of personal experiences were shared. For example, one woman in the Berwick focus group felt able to open up to the group as she conveyed how difficult she found it being alone: *'I get lonely and depressed as well … and it's most of the time.'*

A number of other participants referred to loneliness as a catalyst to other more worrying problems, such as depression and alcohol abuse. A London focus group participant wrote down the following observation in a breakout session: *'They start to take to drink. It's a way of coping with their loneliness.'* It has been shown that alcohol abuse is both a cause and a symptom of depression and social exclusion (Allen 2008).

Loneliness and social isolation appears to be a particular concern for the 'older old' and for people from BME communities. Research shows that people over 75 are more vulnerable to depression, social isolation and exclusion. Poor physical health and high levels of poverty have been identified among older people from BME communities, and both compound the likelihood of depression and isolation in older age (Allen 2008). A community representative, interpreting on behalf of participants from the Chinese community in Newcastle, expressed the extent of this feeling: *'sometimes they feel they want to die because life is hard.'*

In order to address these issues, focus group participants referred to the need for direct contact with older people, better advocacy services, tailored support, improved communication, referral channels and peer support initiatives. These suggestions are elaborated on below.

Direct contact and access to information

Participants in every focus group felt that a more dedicated effort was needed to make direct contact with older people living alone. The option of preventative home visits of the type taking place in Finland, discussed further in Chapter 4, was introduced to the groups and received a positive response.

The proposed Active at 60 package (HM Government 2009), to be sent to people on their sixtieth birthdays with information on entitlements and opportunities, was welcomed by the participants as a step in the right direction, but cannot be a substitute for making direct contact. As stated by a participant in Berwick:

> *You can send out all the bits of paper in the world, but people don't read it. That's why I'm saying they need to be contacted, once a month, even if it's ten minutes.*

While direct contact may not be needed by all older people, for some it is an important lifeline. Direct contact is of particular importance to members of BME communities who may confront cultural and linguistic barriers, lack of independence and in some cases discrimination:

> *Some people don't have their own independence. They depend on their children to sort out all their finance for them, especially when the pension book was discarded. People find it difficult to use a card and a PIN number; therefore they depend on other people to do that. Sometimes they can be abused by their own family for finance, so there's quite a few issues in the community.* (Interpreter for participants from Asian community in Newcastle)

Advice and advocacy

Focus groups participants stressed that they would benefit from having an advocate who could represent them. The language was determined and forthright. A Berwick participant described how, *'you've nobody to fight, there's nobody to fight your corner'*, while a London participant stated: *'Age Concern can fight for me.'* These comments demonstrate that some older people feel the need to fight for their rights, or have others fight for them, as they are not currently being respected.

On the one hand, participants acknowledged the importance of roles such as Wales's Older People's Commissioner and the Voice of Older People in England to act as advocates for older people. In addition, it was recognised that representatives do exist at the community level. One Newcastle participant referred to an Elder's Council that gives a voice to older people. However, there was concern about whether these representatives and advocates were reaching out to a sufficiently broad range of people:

> *I have attended one or two meetings and mostly it is retired people as well, and they are doing quite well. But I am not quite so sure how many people in the public know about it.* (Participant in Newcastle)

On the other hand, participants recognised the need for advocacy on a personal and one-to-one basis. In particular, direct contact is important for the most isolated older people. Participants referred to 'helpers', 'care workers', 'outreach workers', 'care managers', 'people who are appointed to go into community care' and 'Social Services' but there was no consensus on whose role it should be to provide direct contact. The acute pressures on Social Services were recognised by an interpreter and community representative for participants from the Asian community in Newcastle:

> *I have been working in Newcastle for so long now and found that Social Services are very much behind in terms of helping people, because only people with critical needs are getting personal care. There's no other service available at all.*

There may be reluctance from some older people to admit to Social Services that they need support, for fear of being labelled as incapable of staying in their own home. Others may feel reluctant to become dependent on such a service. Many of the participants referred to the need for support on an ad hoc basis, or to meet some basic social needs, rather than because of an acute care need. The LAP/POPP initiatives (see Chapter 3) are a modest and welcome step towards prevention and early intervention, but are a very long way from delivering the small amounts of help and support that many older people would obviously like. For example, one woman in Berwick felt she would benefit just from someone helping her to structure her day: *'It's just to try and work out a timetable or something so as you don't make the day so long.'*

The move away from a 'one size fits all' approach towards personalisation in the care and support sector was welcomed by the participants. Greater flexibility and discretion among care and support workers would allow for a more tailored service to different people, providing small scale assistance to some, as well as targeted and focused support to those most in need. The latter include the physically frail and/or disabled, the 'older old', those living alone, those in rural areas, carers of people with dementia, some BME groups, and those known to have depression and chronic mental health problems. A participant in Berwick stressed the importance of tailoring a service to the particular needs of the individual: *'Some of them may only need one visit to make sure they're all right, other people may need regular visits to talk to them.'* Personalised, targeted care would also ensure that those going through difficult transitions (such as bereavement and taking on caring roles) could receive tailored short-term support.

Communication and signposting

Many of the participants referred to the need for improved communication about older people's services. Some felt that better publicity was needed, both in terms of social activities, and where to go for advice and support. Berwick participants wanted to be more informed about activities in their local area. One man there said: *'Nobody communicates.'*

All of the focus groups discussed the digital/technical divide. Some people were proficient in using computers and were keen to attend classes to learn more. Others did not want to and the reasons for this included: difficultly in accessing classes, financial restrictions and lack of confidence in developing new skills. For some people there was a real sense of fear attached to the growing reliance on computers and the internet. As a source of information, the internet is evidently important and the numbers of people accessing information in this way will continue to increase. However, participants from Newcastle stressed the need for more information and advice through other means:

> *I still think the Government could put out more publicity in the news. I mean, most people listen to the news either on the radio or the television. The Government do put out a certain amount of information, but I think they could put out more.*

Participants felt that professionals should be alerted to the specific needs of the most excluded and greater efforts should be made to ensure that those who are most isolated are referred to the relevant services. A participant in Newcastle said:

> *If doctors find older people are in need of help they ought to be able to refer them or notify an authority to do something about it, rather than just treat their medical condition and leave it at that.*

A number of participants felt that they would like to receive more health information from their GP. In some communities, certain health concerns are particularly prevalent. The interpreter for the participants from the Asian community in Newcastle described how: *'Most of the people here are diabetic. Got heart problems, [blood pressure] problems, it is well known that the West End is well known for depression and poverty.'* Participants

acknowledged that research and better targeted advice on health concerns that affect older people in particular communities would be highly beneficial.

The voluntary sector provides an invaluable service to many older people. One participant in Berwick referred to a 'buddy programme' that had been set up by the St John's Ambulance day care centre to encourage older people to get to know one another and to help people who were more isolated or housebound, particularly the 'older old'. She explained that the programme had now come to an end, due to a lack of funding, but that she still keeps in touch with her 'buddy' from the programme:

> *I'm so sad because she sees nobody. It's so sad when I'm bringing her back. You know, it pulls on your heart strings.*

Schemes such as these were regarded by participants as invaluable, both to those who are isolated and to those who provide support, but they appear highly vulnerable to withdrawal due to lack of funding. Despite the innovative work of the voluntary sector, obstacles remain for some people in finding out about their services. One participant from Newcastle described how: *'There are a lot of people who need help but don't know where to get it.'*

Participants were asked to discuss a case study that referred to an Elder Helpline in Florida. The response was very positive. Newcastle participants commented how: *'We all have the same issues, so therefore I think a telephone service or something would be ideal.'*

A number of advice lines do exist in the UK (notably those provided by Counsel and Care[2] and FirstStop[3]) but as participants did not appear to be aware of their services, more signposting from other agencies and publicity would help to improve the capacity and reach of these support services.

Preparation alongside prevention

> *Being independent, that's very important to all of us.* (London participant)

Support to stay at home

The possibility of going into residential or nursing care produced an anxious response among many participants. They discussed the negative effects this potential change can have on independence and emotional wellbeing. A woman in the London focus group wrote down the following statement during a breakout group:

> *Giving more support so we had effective choice about staying and dying in our own homes – allaying fears that we would have to sell them to pay for institutional care.*

This touches on two pertinent issues: adequate support and informed choice. These should be considered hand in hand. Again, this is an issue that affects particularly the 'older old' and goes some way towards explaining the high levels of anxiety felt among this age group.

A number of participants were worried that being in a care home would reduce their sense of independence, and therefore their ability to perform simple tasks for themselves. A participant in Berwick expressed how:

> *A lot of people are put in care homes because their family don't want to be overseeing them … but you see, the less they do, the less they'll want to do.*

2. See: www.counselandcare.org.uk
3. See: www.firststopcareadvice.org.uk

Preventative efforts to allow people the chance to stay in their own home for longer must be targeted to particular needs. Participants referred to a number of different ways in which they could be better supported at home. These included:

- Registered handy-person schemes (*'Recommend safe and qualified trade people'*)
- Help with household tasks (*'Support with cleaning, housework'*)
- Social Services assessments (*'Register of people in own home – support, visits'*)
- Improved health and safety (*'Safety on the stairs – how to turn, put in rails/banisters'*)
- Entry phones installed, safety alarms distributed and sufficient lighting near homes.

Easing the transition into a cared environment

At the Newcastle focus group a staff representative from a care home expressed concern about people staying on their own to the point where they can simply no longer cope, and then getting transferred to a care home:

> *In this country we tried keeping people in their own homes for as long as possible with the result that when people do come into care they're suffering more mental and physical infirmities than they would have done [had they gone earlier].*

Many of the participants felt that a balance was important. Ensuring respect and support for preventative efforts to preserve independence was considered necessary, alongside the need to prepare and equip the 'older old' for moving into a cared environment, should the occasion arise.

Recognition of the benefits of gradual change was a recurring theme in the focus groups. This idea is not new, notably in terms of phased retirement, which the majority of focus groups participants were also favourable towards. However, more emphasis is needed on a steady transition towards increased care and support. This ties into the need for focused and targeted advocacy, as highlighted above. One participant at the London focus group described how: *'You need to build them up first, not just take them [into care homes].'*

Care homes will remain necessary for some; small rather than large care homes were strongly preferred by participants and it was felt that these would ease the transition from home life to being in an institutional setting better. One woman in Newcastle summed up her group's view:

> *I thought it was an excellent idea to have care homes organised in smaller, independent units. Rather than a big care home of many people who find it hard to get to know each other, if you have a little unit comprising maybe six or seven people it would be more like a family.*

The participants in London came to a similar conclusion. One described care in larger homes as being *'watered down'*, and another agreed that *'no one has time for you'*.

Active ageing

The Government's Ageing Strategy (HM Government 2009) draws attention to new entitlements, such as free swimming and bus travel, through the proposed Active at 60 package. Attaining the highest possible standard of mental and physical health is a right that belongs to all and becomes no less important in older age. Observing this with a range of options, tailored facilities and with due respect for the diverse needs of older people will go some way towards achieving increased self esteem and improved wellbeing.

Mental stimulation and exercise: more options, better health

> *I don't want to exist: I want to live.* (London participant)

Intergenerational initiatives, peer learning and voluntary work

Participants in all areas wrote down activities that they had benefited from and would like to see more of. Their notes included:

> *More free classes in over sixty club*
>
> *IT training to obtain a qualification would build our self-esteem*
>
> *Drama classes which helps people with memory and speech*
>
> *Being able to learn, appreciate arts and the environment*

At present the national policy and funding priority is for training and educational courses for 16- to 19-year-olds (Lee 2006). However, mental stimulation for older people undoubtedly improves wellbeing and participants felt that it should be given greater prominence than it is currently. In particular, participants stressed that renewed funding for community day care centres is essential to maintain and increase provision for older people's activities.

The Government's Ageing Strategy recognises that a shift in attitude and behaviour across society is required so that old age is no longer perceived as a time of dependency and exclusion (HM Government 2009). Innovative methods of intergenerational and peer learning promote respect and understanding across age, class and ethnic divides and were welcomed by focus group participants.

The option of older people living on campuses and learning alongside students was introduced to the groups, based on a case study from the United States (see Chapter 4). Some participants were anxious about how they might cope in a university environment. But despite having reservations about living with younger people (concern was expressed about noise and the difference in interests between younger and older people), the majority of participants were open to such an idea. Several people had already undertaken activities with Open University and the University of the Third Age. They encouraged others based on their experience, highlighting the benefits of peer support and the need for more schemes that encourage peer learning.

In the London focus group some participants questioned another who had been studying, asking, *'Nobody looks at you as if you're old and they don't want to be near to you?'* The person replied: *'Nobody looks at you like that because you're all coming together to learn.'*

Peer support and peer learning are important engagement methods, enabling people to volunteer and socialise. They are beneficial for the 'older old' group, who may be more isolated. This was identified by one of the London participants who described how:

> *For those that are homebound I think it would be very nice if we had supportive groups among our own peers where there are people who are a little bit more active.*

Some participants thought that people should be actively encouraged to volunteer. One participant in Berwick felt that it would be beneficial if volunteering was 'aimed at people that took early retirement'. However, frustration was voiced about the need for volunteers to complete numerous forms and checks. Several participants in Berwick described how the lengthy process before volunteering was enough to put them off altogether. One man from Berwick described his experience:

> *I'm very active in promoting chess especially amongst young children. I also go to the day centre at their request to run chess there, but I've just been given a very complex sheet of papers to fill in to qualify as a*

> *volunteer. I'm not a volunteer, I responded to a request and I'm a little disenchanted, because the attitude, you know, that you're a bit suspect until you can prove your innocence.*

The benefits of exercise

Exercising can become more of a challenge for people as they get older, as articulated by a participant in Newcastle: *'As you are getting older you don't think you can do it, you have to push yourself, you have to encourage yourself to do it.'* Despite government support for local authorities in England to provide some free services such as swimming, there appear to be pressures on funding for some alternative activities. One of the London participants said this was her main concern: *'I'm here for older people to have some facilities, like yoga, Tai Chi and this sort of facility is sometimes cut.'*

Participants placed a high value on some facilities specifically for older people, like day centres, but were also supportive of bridge-building activities with other age groups. One of the London participants was concerned about the lack of consultation with older people, and the assumptions that were made, when making decisions about outdoor space:

> *There is a beautiful section of the estate for the elderly. And what happens? They build a playground for toddlers right in front. And the answer was: 'Because the old people like to watch the children playing.'*

All participants felt that they should be consulted on decisions around public services and outdoor space. This will in turn result in services that cater for all ages.

When discussing a case study from Germany, where a play area was designed specifically for older people as well as children, the London participants were receptive, as long as the facilities were accessible:

> Interviewer: *So Germany and Thailand have introduced exercise facilities so they're alongside the children's play area. They have a grandparents' exercise area.*
>
> R1: *Lovely, lovely idea, I think it's a brilliant idea.'*
>
> Interviewer: *Do you think that's something you would enjoy?*
>
> R1: *I think it's a wonderful idea, yes.*
>
> R2: *It depends on your mobility.*
>
> R1: *Yes, it depends how you could go there.*

Initiatives such as these promote community involvement, particularly if older people are involved in the design stages. The Government has made small steps to promote intergenerational activities, including the 'Generations Together' programme, which will fund 12 projects across the country.

Urban and rural transport: Small changes, big difference

> *Transport is really a fundamental practical consideration, whether you are in a care home or in the community, because if you can't get to something then you stay put, don't you? And then you become lonely and isolated, so the provision of transport is very important.* (Newcastle participant)

Availability, access and safety

Concerns about availability, access and safety were raised in relation to public transport. A number of participants avoided public transport because they feared being hurt when the

bus drove away quickly, or because of problems accessing the bus in the first place. Berwick participants explained:

> *That's one of the reasons I don't travel by a bus, because I have pains in my lower back…*
>
> *It's all very well to say you've got a bus pass but some can't even get to the bus stop.*

Others relied heavily on public transport. One participant in Berwick explained:

> *I never used a bus pass till I had a mini stroke [but] I find it extremely convenient now.*

Those participants who used public transport felt that it would be beneficial for public transport workers to be trained about responding to the needs of older people. They would be more willing to use public transport if drivers waited for them to take a seat, made efforts to reduce the amount of jerking and jolting and kept to minimum speed limits. It is important to note that this would have benefits for other people too, in particular for disabled people and adults with babies or young children.

Members of the Chinese community in Newcastle identified transport as a serious obstacle to maintaining social interaction. The Chinese community representative referred to a lunch club that takes place every week. She explained that without transport being facilitated for the service users, many people would not be able to attend.

Coping with living in a rural area

> *Living here, it must be harder when you're older living in a very rural community.* (Berwick participant)

The majority of participants in the Berwick group expressed frustration at the low availability of transport in their area, particularly in the more rural locations. This related to absence of any transport at all for some people in remoter areas, and also the lack of coordination between rail and road.

Services such as 'Runaround Northumberland' were described as a key lifeline to people in rural areas. However, some local participants were unaware of this service. When one explained to the rest of the group how the service worked, the others were interested to find out more. Raising awareness about these services is perhaps the first step. As demand rises and ensures viability of the service, increased provision and funding would be more likely to follow.

Some of the Berwick participants suggested changes to redress the imbalance of provision of services for those in rural areas. Suggestions were to improve parking facilities:

> *There's a leisure sports centre, there's an arts centre. It's all in Berwick. So people now have to travel, which is difficult. And there's nowhere to park when they get here.*

Another suggestion was to subsidise those coming further distances:

> *I reckon that the people in the four mile radius north and south of the river should pay the full price. Everyone else, Scottish or north Northumbrians, should get a discounted price.*

Berwick participants did highlight the advantages, as well as the disadvantages, of living in a rural area. The positives included how living in a rural area can provide strong, established social networks and the extent that people will go to in order to stay in touch with people in their area.

Conclusions and recommendations

Below we provide recommendations that stem from the focus group discussions.

Reducing social exclusion in older age

The risk of social exclusion increases with age. Greater efforts should be focused on reaching those who are most isolated, who will often be the 'older old'. In many cases this would be someone to provide emotional support, planning and advice about everyday affairs. Targeting the support and tailoring it to the individual is the key. The following observations and recommendations were put forward by our participants:

- Information regarding telephone support and advice lines for older people should be included in the Government Active at 60 packs, referred to on the radio and on television and advertised in public places, such as libraries and GPs' surgeries. Increased awareness of existing telephone help lines would also be beneficial to family and/or carers needing advice and support in caring for older friends and relatives.
- Radio and television phone-ins and advice programmes are valued ways of receiving information and advice, particularly for those who are isolated. Those with a local community focus are of particular benefit.
- For some people who are particularly isolated, there is no substitute for direct, face-to-face contact. Existing door-to-door services (for example, library deliveries, social services assessments, health visits) could be used more effectively to signpost older people to agencies and community organisations who can provide support and advice.

Supporting older people from minority ethnic communities

The specific requirements of older people from minority ethnic communities require greater understanding.[4] Many people from BME communities have to face layered discrimination due to ethnicity and age. In particular, overcoming isolation, language barriers, particular health needs and transport problems requires more focus. Mainstream service providers have a responsibility to understand and act on 'multiple diversity' among service users, for example around ethnic, cultural and gender differences among the 'older old'. Recommendations from the participants are as follows:

- The time offered (and in some cases directly allocated) to older people when seeing health professionals should be increased, particularly when that person is from a minority ethnic community. This would enable doctors to educate older people about common health problems in older age, and health problems that are particularly prevalent among some communities.
- Links between health services and voluntary/community projects need to be improved so that someone from a minority community who is isolated can be given information about specific local activities and support groups in their area.

Preventative measures alongside preparation for increased care needs

A paradigm shift in the way that care services for older people are managed is essential in order to improve wellbeing in the longer term. The raft of preventative initiatives being introduced by the Government are to be welcomed, but these should not be at the expense of supportive and gradual preparation for moving into a cared environment, should the need arise. Improvements in the following areas were identified by participants:

- An 'Independent at 75' pack (much like the Active at 60 pack), containing targeted advice and recommendations specifically for the 'older old' (including local information

4. Some research has been carried out investigating wellbeing of older people and ethnicity. See Nazroo *et al* 2005. However, more research is needed if we are to better understand the needs of older BME community members.

accessible by phone), would help to elaborate on preventative strategies that are already available, in addition to preparation and advice on the possible need for increased care in later life.

- Preventative home visits are an important way of supporting people who choose to stay in their own home. A lot of services (such as handy-person schemes to prevent hazards, install safety alarms and entry phones) are widely available but just not known about or taken up. Increased awareness of these schemes is necessary.
- Personalisation of services and individual budgets for social care is important. But advisers and brokers are needed to help older people make the best choices[5]. In some cases this will simply be routine planning support in order to establish timetables and a structure to the day. It may also consist of planning for the future, including care options and in some cases providing support and advice when coping with a major life change, such as becoming a full-time carer or coping with bereavement.

Better communication and signposting

Improved communication will allow older people to be linked in to services and activities in their local area. Awareness of many existing activities and services is often patchy. The benefits of peer learning and intergenerational activities are increasingly understood, but more support and funding for such initiatives is needed. Participants contributed to the following recommendations:

- Peer support schemes are beneficial to both the peer supporter and those who are isolated and in need of support. Increased funding and awareness of the benefits of such schemes is needed.
- The Government's Ageing Strategy refers to 12 intergenerational projects across the country. While this is to be commended, more efforts to fund and support intergenerational activities would be beneficial, in particular involving incentives for universities, schools and colleges to take part. Classes (such as IT, art, language and drama) run by younger people for older people, and/or by older people for younger people would provide teaching practice, as well as providing valuable learning opportunities.
- Increased funding is needed for community-run projects that set up drama, art, language, day trips, dancing classes and so on, all of which help in the long term with memory, speech, building self-esteem and reaffirming social networks.
- Provision of exercise equipment and more opportunities for older people to exercise in public parks and sport centres would be welcomed.
- A centralised system for Criminal Records Bureau (CRB) checks would prevent people having to complete more than one CRB form for every voluntary job undertaken. Many older people are put off volunteering because of the obstacles that are currently in place. It is important to note that this would have a wider benefit to other people too. It would reduce bureaucracy and reduce the amount of money going into repeatedly recording the same information.

5. ippr has carried out extensive work on the role of personal advisers in the welfare to work sector (McNeil 2009). Similar commitment is now needed on how to provide citizen-centred support to people and their carers at home and in the community. This needs to happen through public service professionals, but also through volunteering and time bank schemes, and the voluntary sector providing services commissioned by councils and health authorities.

Overcoming transport obstacles

Finally, the need for greater awareness of the needs of older people is particularly acute in relation to public transport. For many older people, transport concerns are a major hindrance to wellbeing. The following recommendations were made by participants:

- Training for public transport workers focusing on the specific needs of the elderly is imperative. In particular, bus driver training on braking carefully and so on would go some way towards making older people safer when travelling on public transport.
- Greater awareness and funding of independent, community transport providers, particularly in rural locations and for BME community members who are more isolated, could help to reach a large number of people who are presently at risk of being excluded.
- Linking up road and rail services is important for those using public transport in rural areas.

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6. Wellbeing in later life: summing up the themes

James McCormick

A set of cross-cutting themes emerge from our review of evidence, earlier working papers and fieldwork findings for the Politics of Ageing project, which we present in this chapter. We see these as the basis of a system to improve wellbeing in later life. These are grouped around the essential elements identified in the opening chapter, to which we add three further elements. These themes set out the basis for proposed actions.

Resilience

- Build resilience by strengthening social networks

Independence

- Improve systems of information, advice and advocacy
- Design places and services to enhance independence
- Prepare as well as prevent

Having a role and having time

- Encourage volunteering and learning

Income and wealth

- Target support in new ways

Health

- Put wellbeing at the heart of health and care services

Citizenship

- Promote dignity, involvement and feedback

Intelligence

- Gather better data on people over 75

Mainstreaming

- Put older people's issues into the mainstream.

The need to build resilience by strengthening social networks

Investing in social activity outside the home and workplace, not just for now but for the long term, is good for our health and wellbeing. Having broad social networks appears to protect against isolation, depression and dementia in later life, especially among those who have been bereaved or divorced or live alone in middle age. The primary care sector could take the lead in encouraging people to increase their participation, through proactive sharing of information on volunteering, learning and sporting activities. Vulnerable older people – for example those who live alone with little social contact – could also be referred through a GP or nurse to peer support groups and volunteering opportunities.

One promising approach is to develop peer mentoring and befriending support specifically for older people who live alone and have few social contacts. For example, the Big Lottery Fund-supported 'Brighter Futures' initiative trains older people as peer mentors and befrienders to visit isolated older people in their neighbourhood, drawing on information from service providers and community networks. Volunteers like these can act as advocates for older people who are otherwise alone. This is likely to become all the more important in the future.

Help provided in kind such as meeting space and office support from public bodies could enable older people's groups to develop. Summerhill Active Retirement Group in Ireland (see Chapter 4) could become a model for how local government in the UK can provide assets (including land and transport) to enable older people to organise their own support groups. There is also growing interest in projects bringing older and younger people together, although feedback from older people suggests such approaches are attractive for some but not all, and need to be balanced with opportunities for older people to socialise with their peers.

Where contact with family members is limited because of distance from them, support packages could be offered by the telecoms sector for older people to learn how to use Skype and web cameras. Contact might be limited for other reasons too. For example, some grandparents find themselves excluded from their grandchildren's lives when their child's relationship breaks down. Greater clarity on their rights in the law could help here.

Building resilience in later life is a complex task. While health services need to do more to identify and treat depression among older people, a bigger task is to pick up sooner on the warning signs. A simple risk-check could be used by service providers for spotting who is likely to be at risk of depression. This would be distinct from a formal, primary-care diagnosis tool. Instead, we envisage a means of raising awareness among frontline staff and volunteers in all agencies.

The main factors putting older people at risk are given in Box 6.1. This is not a comprehensive list and others may find themselves at risk despite having few of these characteristics (for example, a widow who lives with her extended family and does much of the care of her grandchildren might still feel isolated and have little time for her own social life). The list should, however, help service providers to spot who is likely to be at higher risk and to target appropriate support.

Box 6.1. Risk-check for depression in older age

- Deteriorating health and/or physical mobility
- Bereavement and relationship breakdown (including in mid-life)
- Living alone and often feeling lonely
- Lack of social contact with friends and family
- Isolation (distant from support networks, lack of transport, lack of services)
- Ethnicity (especially black and minority ethnic older people)
- Poverty, especially persistent
- Aged 80 and over
- Dementia (including risks to main carer)
- Living in residential or nursing care
- Low resilience (e.g. multiple factors from above applying)
- Low preparation (e.g. sudden rather than gradual incidence of above factors)

The need to improve systems of information, advice and advocacy

Focus group findings point to the need to use familiar communication channels as well as new technology. Telephone and local media (radio, television and newspapers) are still effective ways to raise awareness and share information with many older people and their carers. For some, there is no substitute for direct, face-to-face contact. A great deal of

relevant information is available in health centres, libraries and other community venues. But displaying an array of posters and leaflets is not a very effective way to reach isolated older people who could benefit the most from knowing about a weekly lunch club or a volunteering project that offers peer support. A friendly word of encouragement from staff and volunteers in these places could achieve much more.

There may be a need for someone to offer emotional support and advice on planning for everyday matters. ippr has carried out extensive research on the role of personal advisers in the welfare-to-work sector (McNeil 2009). New research is needed to explore the range of support roles needed by older people and their carers and effective ways to address these needs.

The need to design places and services to enhance independence

Residents of both urban and rural areas place a high value on making public transport easier to use, through bus companies training their drivers to make journeys safer, rail operators reducing gaps between trains and platforms, and better coordination of bus and rail timetables in rural areas. Community transport services are needed between rural locations to fill the gaps left by very limited bus services. Minibus services provided by voluntary and community organisations can provide a lifeline for older people who are otherwise housebound and for minority ethnic communities to access day centres.

Awareness of these services is often patchy, their reach limited and funding vulnerable. Rather than seeking to create separate services for older people, the priority should be to ensure existing services are adapted to become accessible and promoted to increase their use. This applies to private services too. The growth of online food shopping is likely to have bypassed many older people who could benefit. Home delivery could be made easier for housebound and isolated older people if retailers made a commitment to working with voluntary agencies in the communities they serve.

Planning rules need to become much tougher in order to make places 'age-friendly'. Public duties on service providers can either be seen as a burden or a spur to innovation and to better serve the needs of older people. In Germany, some retailers have introduced signage and food packaging with bigger print, have raised shelves and widened aisles in supermarkets, provided trolleys with seats allowing shoppers to rest and produced 'single-pack' items aimed at people living alone. Other improvements would be to adapt spaces in public parks and exercise equipment in sport centres, to better equip and locate public toilets, make housing adaptations and improve street lighting. When commissioners and providers go beyond tokenistic consultation with older people, they are more likely to design services for the benefit of all.

Finally, personalisation of adult social care services is likely to become more important in future. This is a promising way to address distinctive needs within a diverse and growing population. Yet older people are least comfortable about making use of the state's 'individual budgets' and are among those with the greatest need for trusted advice to help them make the best choices. In some cases, they don't need formal care, but support with planning ahead. In other cases, support needs to be adapted or specialised for people with complex health problems and their carers, and older people from black and minority ethnic backgrounds.

The need to prepare as well as prevent

The raft of preventative initiatives proposed by the UK Government in its Ageing Strategy is to be welcomed. Enabling more people to stay healthy and active during working age is the best investment for wellbeing in later life. But this does not reduce the need for preventative approaches in older age, such as those used in LinkAge Plus and Partnerships for Older People Projects. This agenda should encompass interventions at different ages – whenever they are relevant. This matters for people who have already experienced loss, disability and

dependence. Oliver James argues that we can influence how people with dementia fare in their daily living rather than giving up on them (James 2008). The same applies to people who have a terminal illness. The proposed Active at 60 package will provide those approaching retirement with information, advice and guidance. It should be adapted – for example, with an Independent at 75 package – for people who face greater risks of difficult life events and poor emotional wellbeing, following consultation and testing of the approaches best suited to older people's diverse circumstances.

Running through these preventative approaches at any age should be support to prepare for life changes as an essential building block of resilience. The first big change for most people comes when they retire from paid work. We believe there is an overwhelming case to make this a more flexible stage of life, so we wholly endorse calls to scrap the default retirement age in the UK. The benefits of enabling people to have more control over when they retire are likely to far outweigh any problems. Employee demand will lead to this change happening eventually. But it should be part of a wider shift to better integrate work, care, learning, leisure and volunteering across the life-course.

ippr's focus group participants also stressed the value of preparation for other kinds of change, for example becoming a carer of someone with dementia, moving into sheltered housing or residential care. All of these involve upheaval. Some would cope better if they were able to count on trustworthy support. In the UK, social services undertake assessments in the home, giving advice on matters from falls prevention to handy-person schemes to placing house keys in a security box outside for emergency access. However, support is usually given on a *reactive* basis, for example after an older person has had a fall and been admitted to hospital. In contrast, preventative home visits in Finland have been an effective way to share information about support services and make adaptations to enable independent living for longer (Clifton 2009).

Later life need not be a time of dependency and decline. But we cannot bank on a future where we remain healthy and independent then die in our sleep at a ripe old age. Even as tomorrow's 80-year-olds remain healthier for longer, a responsibility remains to meet the needs of isolated, vulnerable, frail and dependent older people. A more honest approach to dependency is needed that enables people to cope better with loss of independence whether that happens in stages or more suddenly. For example, wider recognition may be needed of a right to depend on others in later life if the need arises. This might offer a more positive way to frame 'dependency' than the UK Ageing Strategy's reference to 'supporting people who are caring for dependents' or demographic projections that talk of a simple age-based dependency ratio.

The need to encourage volunteering and learning

In future, we will have to wait longer before claiming state pensions. More will choose to work longer and for many 'retirement' will refer only to leaving paid work. It might be abandoned altogether as an outdated concept. But how will we fill our time? Staying active, and having a role in something, is known to enhance health and wellbeing. This is about more than retaining a role within families, as a grandparent for example. Opportunities should be designed to encourage active contributions. The evidence on volunteering is particularly encouraging.

Volunteering enables older people to make a contribution, participate in social activity and engage in community life. At present, volunteering peaks among people in their forties and fifties, falls for people in their sixties and then falls faster still after the age of 70. So we are not achieving the potential benefits of volunteering for older people or society. The biggest issue is how to attract more people to volunteer, and how they can be enabled to carry on if they want to, even if their health or mobility deteriorates.

Part of the answer is to get better at asking people. In the United States, Experience Corps found that people were much more likely to volunteer when asked (Clifton 2009). The proposed Active at 60 Packages, which will be sent to everyone in the UK on their sixtieth birthday, should include requests from local organisations for volunteers. Obstacles for those wishing to volunteer need to be minimised to ensure that criminal record checks do not duplicate information that can be gathered elsewhere or take so long that interested applicants give up. Another part of the answer is to adapt volunteering opportunities to fit the lives of older people, including carers and those who are housebound, for example by providing volunteer positions on telephone peer support schemes.

Good experiences of adult learning also enhance wellbeing, but relatively few older people are involved in learning. The Chinese model of Universities of the Elderly should offer inspiration to education providers in the UK to make it easier for older people to enrol on courses. Entry requirements and loans should not discriminate against older learners. At the neighbourhood level, IT classes led by peer tutors (older people trained to coach other older learners) as well as inter-generational schemes would be welcomed. Activities should extend to drama, art, language, local history, dancing and beyond, all of which help with memory and speech capacity, as well as providing social support. Public bodies should be responsible for demonstrating how mainstream learning provision is becoming more accessible and adapted for older people.

The need to target support in new ways

The greatest decline in poverty in the last decade has been among older people, but the over-80s are still much more likely to be poor than other people. And older people on average are more exposed to *persistent* poverty than working age people. Having a large income is not the most important criterion for wellbeing, but not having to worry about money can improve resilience.

Looking ahead, can we find a route between universal and targeted support? The first of these has many advantages over the latter – it means there is no stigma attached to getting support and that the take-up level is good, and gives everyone a stake in what's available. But it is much more costly and does not distinguish between the different circumstances of older people in need and the better-off.

The provision of free bus travel for all over-60s in Britain is likely to come under scrutiny in the coming years. This service is particularly helpful for older people who have a low income and no access to a car, and for people over 75 who have had to give up driving. But in theory it also allows the well-off to travel from one end of the country to the other at no cost – good for wellbeing but perhaps a dubious use of resources in such a tight time for public finances.

Bus passes could be run on a membership basis. All older people would continue to receive their bus pass, with the age of entitlement raised to 65 when state pension age is equalised. A modest annual fee could be levied but waived for those on Pension Credit Guarantee, but we would still be left with the problem of many people who do not claim Pension Credit missing out. While it is possible this could serve as a catalyst for increasing levels of receipt, we consider it too risky while take-up levels remain one-third lower than they should be. A better option is for discounted fares to be payable between the ages of 65 and 69, with free travel passes for the over-70s.

Similarly, the Winter Fuel Allowance could continue to be paid to all from age 65 but be taxed. We define this as *progressive universalism*, where everyone receives a basic benefit and the tax system, rather than being means-tested, is used to ensure the benefit is worth more to those on low and modest incomes. The practical objection is that such reforms would not raise much money after taking administrative costs into account, compared with the bigger sums associated with reducing tax credits for better-off families (White 2009).

Targeting could be done in other ways. For example, benefits such as Winter Fuel Allowance and free bus passes could be deferred until later than state pension age. These could be paid from the age of 75 on the same basis as free TV licences, on the grounds that the risks of poverty, illness and poor mental health rise steadily after this age. However, significant inequalities in life expectancy remain in the UK. The chances of living beyond 80 are much higher in affluent than poor areas, so benefits targeted to people over 75 would be worth more to the better off. There are other practical objections to moving in this direction: many vulnerable older people are younger than 75, so the preventative benefits of supporting the younger old would be eroded. For these reasons, we are not persuaded of the merits of this kind of targeting.

Finally, targeting of resources should also adapt to the changing experiences of older people. Not enough is known about how people spend their time in later life, particularly the differences between the younger and older old. But we do know important inequalities exist. Isolation and depression can arise from spending too much time alone. Others, such as intensive carers of older people with dementia, have too little time for themselves. For them, the care-life balance is as out of kilter as the work-life balance is for many families. They need to become the highest priority for policies to support carers. In addition, grandparents may end up providing more care for their grandchildren than they can cope with. Where they are caring full-time *in loco parentis*, they should be entitled to the same support as parents and other guardians.[1]

The need to put wellbeing at the heart of health and care services

The state of one's health is influenced by many things in daily life, which enhance or erode wellbeing. Taking a systems approach to older people means strengthening protective factors and reducing the risk factors; the health of older people reflects all the issues discussed so far in this chapter.

Health and care services are also an important part of this wider picture. Improved wellbeing is not only a goal for people in order that they can live independently. Exploring how best to tackle the boredom of an average day in a long-stay ward or care home should become a high priority. For example, residential care and nursing homes should be opened up to volunteer befrienders (Neuberger 2008), to develop a wider range of social contacts and potentially a network of advocates for older people who live alone or lack others who can speak up for them and help them voice their views and concerns. Health and care providers should be expected to commission mainstream library, leisure and learning services for care homes. To increase inter-generational contact, every school could twin with a care home or long-stay hospital ward. In addition, frontline staff need to allocate more time to raise awareness of health problems associated with later life and to understand more about conditions affecting people from different minority ethnic groups.

The need to promote dignity, involvement and feedback

Legal protection against age discrimination should have sufficient power to increase a sense of equal citizenship among us all, thus providing a better deal for older workers and consumers generally. The specific needs of older people from minority ethnic communities – many of whom face more than one type of discrimination due to their ethnicity and their age – remain to be addressed. A dedicated mission within mainstream service strategies, to adapt provision to respond to specific circumstances, is required to help older people avoid isolation and meet particular health, housing or transport needs.

In older age a person's wellbeing relies partly on having a new emphasis on dignity. At a local level, the NHS and councils have a responsibility to ensure that frontline staff respect

1. In Scotland, a similar debate on kinship carers is gathering momentum. Any proposals to introduce a kinship care payment from within the devolved budget would result in DWP benefits being cut.

older people's dignity. However, a rights-based approach rooted in *citizenship* would provide more robust grounds for progress than relying on others to confer dignity and respect (Smith *et al* 2009).

The tools used to capture older people's experiences as service users are limited. Frail and vulnerable people, and those with visual or communication impairments, are unlikely to complete surveys seeking feedback on social care services. Many people over 75 recall a time when these services were not available or were only for the better-off and thus some have low expectations, while others are reluctant to express dissatisfaction because they fear support may be withdrawn. There are structural flaws, too, within inspection and regulation systems which tend to focus on minimum standards. The situation may be even worse when night-time care (rarely the subject of inspection) is considered.

Despite concerted efforts to improve them, systems of care regulation are too far removed from the experiences of vulnerable older people. Feedback between service users and providers is poor due to uneven power relations and the highly personal nature of the issues involved. There appears to be no consistent means of seeking out the comments, concerns and ideas for improvement, which service users and carers could contribute, despite them being a vital source of expert knowledge. The same applies to frontline staff. Volunteers and befrienders can also play a role in reducing isolation and in whistle-blowing on behalf of those who lack advocates. In short, the ways we improve health and care services need to become more open, democratic and proactive.

The need to gather better data on people over 75

Methods of collecting data by age group remain stuck in the past. This matters because it may lead to policies being based on false assumptions. For example, life satisfaction in the UK seems to follow a U-shaped curve (Allen 2008), but reporting on this measure stops at those aged 70. We do not know much about how life satisfaction changes after this age.

Age definitions in surveys are also inconsistent. It is usual for surveys to group together everyone aged 65 and over. Some health surveys in England include the over-80s as a category and the English Longitudinal Survey of Ageing (ELSA) is building up a valuable source of tracking data as the cohort of people aged over 80 grows. A turning point for many older people's health and wellbeing appears to come after 75 or 80 in the UK. Understanding when and how this threshold occurs will be of growing importance. The UK's central and devolved governments should ensure that there is adequate coverage of the over-75s in surveys and official data sources, in line with population ageing.

The need to put older people's issues into the mainstream

We have observed a tension between pursuing a distinct agenda for older people's issues and the goal of mainstreaming age as an 'ordinary' equalities matter. That goal is the right one – but when will the UK be ready to achieve it? Age discrimination and ageist attitudes remain a blunt fact of life.

We believe that the Welsh Assembly Government's 10-year strategy of moving closer to mainstreaming, using a dedicated approach to older people as the catalyst, has a lot of merit. Its actions have included establishing a Commissioner for Older People. This approach is being followed in Northern Ireland, while England has an advocacy role without powers and Scotland is pursuing age matters through an integrated approach to equalities and human rights.

The Commissioner model should be evaluated and the lessons applied in England and Scotland. Creating an office with investigative powers that can hold public agencies to account seems more effective than creating a separate department or minister specifically for ageing, which could result in other parts of government ignoring the issue. Whether such a role is still needed in future will depend on how much progress is made towards

mainstreaming issues of age, especially among people over 75. The truest indicator of progress will be seen when tomorrow's 85-year-olds are no more at risk from isolation, depression and discrimination by service providers than other adults.

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7. Recommendations

The task emerging from this project is to create a system for improving wellbeing in later life. Rather than designing new services, the main focus should be on understanding what enhances and erodes wellbeing among older people and applying the lessons consistently. Policymakers and practitioners need to look beyond the familiar issues of work, pensions and social care, to decide how best to support social networks, independence and activity.

Running through our analysis is the finding that many small things can make a big difference. Some of the changes we recommend look modest but this does not mean they will be achieved easily – some will require intricate and patient multi-agency working. Since we already know a lot about what older people need and the solutions they value , the priority is to keep wellbeing in mind when making decisions. The table below is a summary of the cross-cutting themes and recommendations developed in the previous chapter.

Essential elements for wellbeing in later life	Themes	Recommendations
Resilience	• Build resilience by strengthening social networks, before and during later life	• Develop a simple risk-check for depression • Make primary care a gateway: sign-post bereaved and separated people aged 50+ towards social networks (e.g. peer support, self-help, volunteering) • Provide peer mentoring/befriending support for isolated older people • Encourage in-kind support and asset sharing by public agencies to support older people's networks • Expand activities to improve contact between generations (e.g. through schools and care homes as well as community-based projects) • Develop technology packages to help grandparents stay in touch with distant family members
Independence	• Improve systems of information, advice and advocacy • Design places and services to enhance independence • Prepare as well as prevent	• Use familiar forms of communication (phone, local media) as well as new technology • Information to be promoted by frontline staff rather than being passively available • Make public transport more suitable for older people (e.g. controlling speed and braking on buses) • Toughen planning rules for age-friendly places • Innovation in private services such as retail (e.g. improve home delivery of shopping for isolated elderly) • Improve advice and advocacy to make personalised services work (e.g. to older people from BME backgrounds and to people over 75) • Scrap the default retirement age and increase choice over when to stop working • Offer preventative home visits to enable independent living for longer • Target people aged 75 and over, as well as from age 60, within the UK Ageing Strategy • Recognise the right to depend when need arises

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Essential elements for wellbeing in later life	Themes	Recommendations
Having a role and having time	• Encourage volunteering and learning	• Ensure more people are asked to volunteer before and during retirement • Adapt volunteering opportunities to enable more disabled and housebound older people to contribute • Expand learning opportunities for older people, including peer support with IT • Give top priority within the carers strategy to 'intensive carers' (e.g. older people caring for people with dementia) • Make financial entitlements transferable to grandparents providing full-time care *in loco parentis* for grandchildren
Income and wealth	• Target support in new ways, based on progressive universalism	• Raise age of entitlement for various benefits/services from 60 when state pension age is equalised at 65/66 • Discount bus fares from ages 65–69 • Retain free bus passes from age 70 • Tax Winter Fuel Allowance
Health	• Put wellbeing at the heart of health and care services	• Place responsibility on health and care providers to commission mainstream learning and leisure services for older people in care homes and long-stay wards • Raise awareness among frontline health staff of health conditions in older age as well as specific health circumstances of BME elderly
Citizenship	• Promote dignity, involvement and feedback	• Protect against age discrimination through law • Adapt mainstream services to diverse needs of older people (e.g. BME elderly, people over 75) • Proactively seek views and experiences of older service users and their carers, volunteers and befrienders, and frontline staff • Improve regular feedback from service users to providers and commissioners • Address 'blind spots' in regulation (e.g. night-time care)
Intelligence	• Gather better data on people over 75	• UK and devolved governments to ensure adequate coverage of the over-75s in surveys and other data sources
Mainstreaming	• Put older people's issues into the mainstream	• Work towards older people's issues being addressed better by adapting *mainstream* services and policies • But continue with *dedicated* strategies for ageing and older people, including independent scrutiny roles, as a means of getting there