One Hundred Not Out: resilience and active ageing

Yvonne Roberts

About the Young Foundation

The Young Foundation brings together insight, innovation and entrepreneurship to meet social needs. We have a 55 year track record of success with ventures such as the Open University, Which?, the School for Social Entrepreneurs and Healthline (the precursor to NHS Direct). We work across the UK and internationally – carrying out research, influencing policy, creating new organisations and supporting others to do the same, often with imaginative uses of new technology. We now have over 60 staff, working on over 40 ventures at any one time, with staff in New York and Paris as well as London and Birmingham in the UK.

www.youngfoundation.org

Our Work on Ageing

The Young Foundation works to address social isolation, resilience and enable the elderly to remain in their own homes through a range of projects; potential solutions lie in diverse fields including how we build homes and communities, develop and use technology and ventures that translate latent community skills into valuable resources.

We have worked on ageing for many years; indeed Michael Young pioneered new thinking about active ageing, helping to create many new organisations, from the University of the Third Age to Grandparents Plus. Today our work encompasses research, the design of new public or community services and the launch of new ventures that can better meet the needs of older people. These include Tyze, a network model facilitating informal and formal care and support; Full of Life, a peer-to-peer community based project to promote emotional resilience skills for older people and Care4Care, a new community focused campaign to get many more volunteers caring for older people that allows them to 'bank' their hours to draw upon when they need care themselves, like a time pension. Other ventures - Neuroresponse and Maslaha - are testing new approaches to supporting people with long-term conditions and work with many older people. We are also working with over 30 local authorities on the Ageing Well Innovation programme- an initiative, backed by the Ageing Well team at Local Government Improvement and Development, supporting local authorities to develop good places to grow older.

THE YOUNG FOUNDATION

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> **Most nations create policies from the perspective of waiting for presenting problems rather than anticipating and preventing them; from protection against negative effects of problems rather than empowerment to deal with them; from a public health model rather than a human growth and development model.**
>
> — Edith Grotberg, Resilience for Tomorrow (2005)

Foreword

Simon Tucker

The European working age population will begin to shrink this year and by 2025, more than a third of people living in the UK will be over 55. In meeting the challenges that these shifts in demographics bring, we should not lose sight of our reasons to celebrate.

Too often the tone of our discussions about the ageing population takes on an apocalyptic turn. This breeds social pessimism about human agency; as if we have created inexorably longer lives but are powerless to make the choices we need to if we are to reap the benefits. This in turn feeds ageism and deepens individual pessimism about our own future and those of our loved ones.

There are few changes as momentous and with such profound implications as those taking place in relation to ageing. This is not just about us living longer; the profile of our lives has changed and along with this our expectations. We have on average fewer children to care for and to care for us. Fewer people marry or stay together and for those who do, a lifelong partnership now increasingly means half a century or more. Many people are able to stay active for longer and the number of years between retirement and the end of our lives has increased.

Acknowledging the positive aspects of these changes is important if we are to shift perception of older people and ageing itself. Understanding some of the drivers behind these changes; the political choices that were made and the human ingenuity that got us here may make us better equipped to face the future.

The creation of a universal entitlement to health services, rapid advances in medicine and technology, new knowledge, social innovations and institutions; have all contributed to increasing life expectancy and our capacity for active older age. All will play a part in continuing these trends and will be critical in responding to their impact.

We will all feel these impacts; although a central question we need to answer is how we ensure that both the advantages and burdens are carried more equally. Meeting the needs of individuals in an ageing society is then a social challenge; one that requires us to be creative in our thinking, positive in our approach but realistic about the scale of social innovation and change required.

For, as Yvonne Roberts makes clear, the scale and nature of the challenge is huge if we are simply to meet the care needs of the long-term sick, let alone maximize people's chances of being able to be active for longer. As Yvonne argues, success will depend on strategies that see active ageing – and older people – as assets rather than burdens, that focus on people as active contributors, not passive recipients. Our shared task is to redesign existing services and develop new approaches that unlock that potential.

The Young Foundation is by nature optimistic; we start with the assumption that there are always new ways of tackling problems, even when we cannot see the way forward straight away. But we are also practical; our work ultimately seeks to enable individuals, institutions and communities to design social innovations that meet social need.

We have worked on ageing for many years; indeed Michael Young pioneered new thinking about active ageing, helping to create organisations like the University of the Third Age and Grandparents Plus. Today our work on active ageing includes Tyze, a network model facilitating informal and formal care and support and Full of Life, a peer-to-peer community based project to promote emotional resilience skills for older people. Other ventures – the Ageing Well Programme, Neuroresponse and Maslaha - are trailing new models for supporting people with long-term conditions

This year will see the launch of a major new venture, Care4Care. This will enable people to develop a 'care pension' where for each hour they volunteer for older people, they will be able to 'bank' an hour to draw down when they or family members need care. These kinds of ideas are radical. They are consistent with Yvonne's argument for the need for a major shift from crisis to prevention and a renewed focus on the skills we need to develop in enabling active ageing.

The Young Foundation's challenge is scale; how we, having prototyped and tested new approaches, grow these innovations so that they are able to make a real impact on the growing challenge of demographic change. Care4Care is intuitively a fantastic idea: it speaks to enlightened self-interest, altruism and reciprocity. Our job now is to make it into a social innovation that is game changing. One that recognises that however many arguments we have about the role of the state in providing social care – and there are plenty to be had - we are going to have to plan and act differently if we are to meet future needs.

The government's challenge is also scale. A recent report by the King's Fund suggests that there will be a social care funding gap of £1 billion by 2014 unless councils can achieve unprecedented efficiency savings. At the same time, there is speculation that the government may delay implementation of the Dilnot Commission until 2025

If we are lucky, we will live longer. To what extent these extra years are characterised by hardship, isolation and ill-health will not just be about luck: it requires organisations like the Young Foundation to be highly ambitious about the practical innovations they deliver. And it requires government to act now.

1 Introduction

Life expectancy in the UK is increasing at more than five hours a day, every day.[1] Improvements in the diagnosis and treatment of diseases as well as changes in areas such as diet, housing, sanitation and education have contributed to the doubling of lifespans in much of the world over the past 150 years. As a result, we face what has been termed an 'agequake'.

For the first time in history in the UK the number of people over 60 outnumbers those under 16.[2] In the future, centenarians will become a much more common group in society. The combination of rising life expectancy and a low birth rate means that the populations of the more affluent parts of the world are ageing. A common reaction to this is pessimistic: how will society cope as potentially ever greater numbers live longer and longer with chronic illness and frailty supported by a dwindling group of people of working age?

A recent report[3] by the Organisation for Economic Co-operation and Development (OECD) claims that Britain faces one of the biggest care bills in the industrialised world. If the OECD's predictions are correct, and the current system of care and support remains unchanged, by 2050 Britain will spend more than a fifth of its entire national output on services for the elderly. Already the demographic change is adding £1 billion a year to NHS[4] costs at a time when the health service is being asked to make efficiency savings of £15-£20 billion by 2015. One in 24 of the population is now aged 80 or over; by 2050, that figure will reach one in 10. "With costs rising fast, countries must get better value for money from their spending on long-term care," says Angel Gurría, Secretary-General of the OECD. "The piecemeal policies in place in many countries must be overhauled."

This paper discusses the possible shape of that overhaul and how the current system can be remodelled to ensure both better value for money and to improve the opportunities for the majority of older people to enjoy a better quality of life, living well for longer as active members of their communities. It discusses the barriers to such a radical shift taking place; chief among them is a system of health and social care designed at the establishment of the NHS in the 1940s. Then, only a minority of retirees were long-lived. The care they required was mainly acute and hospital-based. Now, the major challenge is no longer acute care but the number of people living longer at home with one or more long-term condition such as arthritis, diabetes and respiratory problems. Yet hospitals and acute care still dominate the ageing agenda. In addition to the experience of living longer with poor health, there are also now more older people who have experienced the fragmentation of their families caused by separation and divorce. As a result, loneliness is an issue for many; loneliness has a detrimental impact on wellbeing and resilience, vital assets at any age but perhaps particularly precious for older people as they may become more physically fragile and have to adjust to a changing world.

A major barrier to change is the lack of integration[5] in health, free at the point of delivery, and social care that provides day-to-day support frequently paid for by the recipient. Over 40 pieces of legislation and a mass of guidelines have been issued since the birth of the NHS to try and stitch together a seamless service. Instead, separate professional silos persist with different budgets and confusing eligibility criteria that are subject to a postcode lottery. Services paid for in one area, are free in another. Residential care, for instance, for dementia patients is classed as a medical necessity (as established in law) and therefore free in parts

of England, but in other areas it is classified as social care and therefore charged to the individual.

In July 2011, the independent Commission on Funding of Care and Support chaired by economist Andrew Dilnot published its final report offering proposals on how to share the cost of long-term care.

The Commission made clear that its aim is to render the welfare state affordable, ensure fair play and observe the human rights of older people. Among its recommendations is that an individuals' lifetime contributions towards his or her social care costs should be capped. After the cap is reached, individuals would be eligible for full state support. Dilnot's recommendation is that the cap should be between £25,000 and £50,000, with the Commission highlighting £35,000 as the most appropriate and fair figure. Those wanting to protect themselves against the full cost could take out insurance under a scheme Dilnot said he hoped would be in place by 2015. It was estimated that the Commission's proposals would cost the state around £1.7 billion. This amounts to one four hundredth of public spending. The decision to accept or reject Dilnot's recommendations is a political not an economic one.

By the end of 2011, however, the government indicated that it might be 2025 before radical action is taken. In addition, Andrew Lansley, the health secretary, has refused to rule out a pensioner tax to pay for older age care. People may also have to pay into insurance schemes and/or release equity in their homes to meet the full cost of care. Ros Altmann of Saga, the company that caters for the over-50s, warned in December 2011: If we don't engage in proper reform now, it will cost far more later, both in terms of money and poorer quality of life. If we wait until 2025, the NHS could be bankrupt.

Michelle Mitchell of Age UK has underlined the need for immediate action. "Care is in crisis now. We need reform now and not in ten years time." [7]

Under the current system charges are unlimited and, as a result, 20,000 people a year have to sell their houses to meet the fees for a residential home. According to the Commission, a quarter of over-65s will need no care at all, one in 10 will incur costs of up to £150,000 and 1 per cent could require £400,000 worth of medical and social care.

As Dilnot has said:

> *The balance between individual responsibility and state responsibility that we have at the moment doesn't seem to be the right one, it's widely seen as unfair … Many people think it wouldn't be unreasonable for them to make some contribution. They just don't want the system that they face at the moment [in which] if they turn out to be one of the least fortunate who ends up needing a great deal of care, they lose everything.*[8]

Even if the issue of how we meet the cost of care bills for an ageing population is settled, there is the danger that it will create a two-tier system of care, poorer for those with less resources, and contrary to the core principle of the NHS. The aim of any change has to be the promotion of active ageing and healthy life expectancy, defined as the number of years lived without illness or disability. The country cannot afford to do otherwise. If this change is to be realised rapidly it requires significant investment in prevention and early intervention, the tackling of ageism and an end to 'care' viewed as the uncoordinated management of older peoples' crisis and decline. It is this crisis-driven approach that leads to unplanned hospital admissions:[9] inappropriate use of accident and emergency (A&E) and premature admissions to residential care, at a personal cost to the individual and a high price to the public purse.

As a step towards creating a new more equitable model of care, the Law Commission, the government's advisory body on legislative reform, has proposed a radical streamlining of the current hodge podge of legislation into a single act for adult social care in England and Wales. Frances Patterson QC, the law commissioner leading the project has said:

> *We are seeking to bring clarity to the system of social care. We are not seeking to change existing entitlements. A clear modern statute will save time and money wasted on operating the current time-expired system.*

Under the new act, there would be a set of core principles to guide decision-making on social care and councils would have explicit duties to assess individuals' needs and provide services to those who are eligible. As this paper argues, promoting and supporting active ageing will require eligibility and existing entitlements to be redefined.

Of course, the encouragement of active ageing is not restricted to social care and health. It impacts on housing, transport, leisure, popular culture, planning of public spaces, employment and more. But what exactly is meant by active ageing?

The World Health Organisation (WHO) defines it as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life". WHO has called for "a new paradigm, one that views older people as active participants in an age-integrated society." Active ageing is promised as

"the norm" in Healthy Lives, Healthy People, the White Paper on public health published by the Government in 2010. This gives a commitment to enable older people to take an active role in community life and to participate in education, leisure and cultural activities.

A commitment to prevention and active ageing is not new. It has been explored in numerous policy papers and initiatives, by both Labour and Conservative governments, over the past 20 years. In spite of this, ageism and crisis management prevail. As one report pointed out in 2004, services for older people, "have been seen to be predominantly focussed on a narrow range of intensive services that support the most vulnerable in times of crisis … In fact, at any one time, only about 15 per cent of older people are in immediate touch with care services: meanwhile the vast majority receive little attention." [10]

The arguments for change may be familiar but new drivers are in play that may force greater practical action. Among them are the scale of the financial crisis and the resulting cuts to services and the sharp rise in youth unemployment. Who wins the jobs that are available and who takes priority in receiving limited state resources? The way in which the challenge to limited resources is framed frays social bonds between young and old.[11]

Urgent action is also driven by the rising numbers of people aged 60 and over admitted to hospitals, as a result of an unplanned admission. This is increasing at a faster rate than any other age range. The number of 60 to 74 year olds being admitted to hospital has risen by 48 per cent in the past 10 years. The number of patients admitted aged 75 and over has risen by 66 per cent; this compared with an increase of 38 per cent in the general population.[12] In 2010, the Department of Health instructed GPs to reduce A&E admissions by one fifth and it instructed hospitals to reduce length of stay by 25 per cent and A&E attendance by 10 per cent.

Another lever for change is the care deficit. As the welfare state is shrinking, so are the numbers of relatives available or willing to take on the support of a dependent older person. For instance, 21 per cent of women born in 1964 are predicted to have no children, compared with 14 per cent born in 1931. Over the next 20 years, grown-up children are expected to spend 13 per cent more time caring for relatives but, if current practices remain unchanged, demand for such care is estimated to soar by 55 per cent.[13] If unpaid care is in short supply, how will the state fill the void?

An OECD report [14] says that upgrading the status of the long-term care workforce by improving pay and conditions is key and is already taking place in Germany, the Netherlands, Sweden and Norway but not in the UK. To meet future demand, countries will need to attract more migrants who already make up a substantial part of the population of care workers. Encouraging part-time work and respite

care for carers and paying benefits to people looking after family members are all cost-effective policies, reducing demand for expensive institutional care.

Adding to the pressure are higher public expectations of what health and social care ought to deliver, driven by improved knowledge and access to information. The deference and paternalism that marked much of the traditional support of older people is being replaced by peer-to-peer help and technological progress, including access to information on the Internet and the self-management of conditions via mobile phones, apps and new communities of interest (for instance, PatientsLikeMe which shares knowledge on over 500 conditions).

To concentrate attention on the scale and immediacy of the challenges, the European Commission has designated 2012, European Year for Active Ageing. The call to action is clear but the compulsion to stick with the familiar and resist change is strong no matter what the consequences.

This paper gives examples of innovative approaches that have already managed to transcend this conservative pull. It argues for the development of new metrics so the value of prevention and consequent improvement in wellbeing are better measured and costed. This would provide greater justification for the commissioning of such services. This paper points out the obvious: healthy ageing is easier if income is reasonable; social exclusion is combated; ageism and elder abuse is tackled and the ecology of life – getting on a bus, living at home and shopping – is designed to meet the abilities and requirements of the whole population from babies to centenarians, utilising all that technology and social innovation has to offer.

In addition, this report proposes that a 'SWAP approach' be applied to all policies and measures aimed at encouraging active ageing. SWAP is an acronym that stands for:

- **Start with the person** not the services that are available and which may be inappropriate or even detrimental. Starting with the person is a key aspect of personalisation that "enables the individual alone or in groups to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive." [15]
- **Wellbeing matters.**[16] A growing body of international research points to the part wellbeing plays in equipping a person to develop resilience, handle adversity and build a flourishing life, for instance by maintaining positive social networks.[17] Attention to wellbeing requires a stronger focus on preparation for the major transitions in older age and a more age-aware investment in technology, housing, leisure, education, transport and public spaces so people can grow older, retaining as much of their quality of life as possible.

- **Asset-based.** An older person is considered as an active citizen with skills and experience that have a value to the community of which they are a part. An older person, even with several long-term conditions, is much more than a passive recipient who is 'done to'. An asset-based approach endorses the importance of dignity and identity, aspects than can be damaged by the ageist 'cues' in society and the language and behaviour of others, including health and social care professionals.
- **Prevention.** Interventions that reduce, for example, unplanned hospital admissions and improve the management of often complex long-term conditions. These interventions move beyond the purely medicalised model and offers 'a little bit of help', when required, involving the civic sector and peer-to-peer help. A shift from crisis management to prevention requires greater innovation, including at neighbourhood level and investment in pilots, that if successful can be quickly scaled up. Prevention is helped by the development of robust metrics to show its value and the savings it makes further down the line. These tools may require additional incentives to encourage GPs, social care and public health commissioners to make a cultural shift and commission preventative services that, at present, are severely under-financed.

SWAP is intended as a litmus test, to direct and add drive and clarity to the process of change. A number of charities, projects and services have successfully embraced aspects of SWAP (examples of which are discussed later). But what is perhaps lacking is a wholesale adoption on a large enough scale to make the major cultural shift required. Prevention, integrated care and the maintenance of an active and engaged daily life are beneficial for older people but crucially, can also significantly reduce costs to the public purse.

Inevitably, the route ahead for the promotion of active ageing has to bend with a much reduced welfare state, the ramifications of which are still unclear. A number of local authorities are already targeting help only to those with "critical" or "higher substantial" needs.[18] Recent reports by the Care Quality Commission, Ann Abraham, the health service ombudsperson,[19] and the Patients Association[20] describing the inhuman care of some older patients in hospitals and homes indicate how much still needs to be done.

Healthy life expectancy is not easy to achieve. Longevity can result in profound social, economic, psychological and biological demands. However, remarkable recent experiments in laboratory animals have shown that quite simple interventions can substantially extend lifespan, improve overall health and slow the onset of age related diseases. Furthermore, studies have demonstrated that ageing is highly malleable, so in principle it is open to intervention.[21] Wealth, life experience, genes, outlook, a sense of usefulness and belonging, and connections to family and the neighbourhood all contribute to a much more vibrant experience of senescence. The goal of a 'good' and productive long life is possible if there are appropriate interventions at the right time, if health

inequalities are robustly addressed and if the individual is treated as a person with capabilities who is rooted in a community, not a bundle of problems and symptoms living an isolated existence.

Another major obstacle in the way of radical change is the widely-held belief that falls, isolation and vulnerability are still too often viewed as a 'natural' part of the 'self-destruct' mechanism of ageing. As a result research into the process of ageing has not flourished in the UK.[22] Ageism still seeps through the system. A considerable body of research has highlighted the prevalence of age discrimination in healthcare and the need to tackle prejudicial assumptions among medical professionals that ill health in older people is an inevitable symptom of their age rather than a treatable condition.[23]

The problems associated with growing older are often compounded by the reluctance of many who are younger to prepare practically, mentally and financially for the final third of their lives. Consequently, while the 'young old', the baby boomers born in the decades immediately after the war, may demand better services than their parents, there is a risk that even this group may experience a spiral of decline in which their personal capabilities as well as their material resources are depleted. The cumulative impact, for instance, of major transitions such as retirement or divorce, a drop in income, loss of identity and the diagnosis of one or more long-term conditions are all events that may have a negative impact on the 'young old' when experienced in a system that has proved slow to modernise.

This paper argues that current systems combined with ageist attitudes hinders the development of an effective agenda to promote and maintain active ageing. It briefly looks at the potential value of a SWAP approach and provides some domestic and international examples of how it works in practice. It argues for a greater investment in innovation so new and sustainable services can be developed that better support active ageing.

It attempts to make the case for better measurements of effectiveness to give policy-makers and commissioners the clearly costed evidence that justifies the shift from crisis management to prevention. The current financial crisis and the demographic challenge, creates an imperative to recast the mould of growing older not just for the benefit of older people today but also for the centenarians of tomorrow and society as a whole.

2 What does an ageing population look like?

> **No-one would consider a 30 year old in the same age group as a 70 year old and yet people persist in considering that everyone over 60 is in the same age group!**
>
> — Nurse, 63, Mass Observation (2006)

Michelangelo was writing poetry and designing buildings until his death at 89. John Glenn Junior made his second trip into space at the age of 77. Winston Churchill retired at 81. The folk artist 'Grandma Moses', who began her career late in life, was named "Young Woman of the Year" by *Mademoiselle* magazine when she was 88 and died, still working, at 101. Ageing did not diminish their talent. Social entrepreneur Michael Young called the insistence on judging an individual's capabilities solely by his or her age "chronologism".[24] In defiance of chronologism, he co-founded the University of the Third Age (U3A), entirely run by older volunteers to educate and stimulate people in the third age of life.

In the 1900s, chronologism was a minority issue. Only 4 per cent of the population of UK was aged 60 or older. By 2020 that figure will reach 25 per cent.[25] Half the children born at the millennium can expect to become centenarians.[26] Already there are over 12 million people of state pension age, almost one in five of the population in the UK.[27]

Moreover, the experience of growing older has never been more diverse. As Christina Victor, Professor of Public Health at Brunel University London, points out, older people can no longer be "conceptualised as a single homogeneous group who all experience life in an identical undifferentiated fashion." Patterns of ageing challenge stereotypes. The New England Centenarian study, for instance, has found that a quarter of the 169 centenarians taking part in its research were free of any significant cognitive disorders and even surpassed much younger research interviewers on some mental tests.

About 15 per cent lived independently in their own homes, some held jobs and most were healthy until the end of their lives.[28] The centenarians involved in the study share a number of characteristics: resilience (defined as an ability to bounce back from adversity and experience good outcomes), self-sufficiency, intellectual activity, sense of humour, religious beliefs, strong connections with other people, low blood pressure, appreciation of simple pleasures, a zest for life, they do not smoke or drink heavily, many play musical instruments and follow a diet similar to the Mediterranean diet.

A variation in a gene called FOX03A is also found much more frequently in people living to 100 and beyond.[29] William Gibson, the science fiction writer, has written that the future is here already, just distributed unevenly. So could the New England centenarians give a glimpse of what a far more positive framework for ageing might achieve for many more?

Some of the baby boomers, now approaching retirement, with or without the influential centenarian gene, may already have enough personal resources to follow a similar route to 'old old' age. Sections of the post-war baby boomer generation, for instance, own significant amounts of wealth.[30] More older people are staying on in work and over 50s account for 40 per cent of consumer spending and 60 per cent of total savings.[31] For them ageing could become one

long experiential adventure, lived mostly in good health, liberated from the routine of paid employment. Many in this group may achieve 'compressed morbidity', delaying the onset of chronic and disabling diseases to, at best, the last few months of life.

Baby boomers

Over 65s are a net contributor to society amounting to between £30 billion and £40 billion a year because they pay tax, spend money that creates jobs, deliver billions of pounds of free care and contribute to charities and volunteering.

Broken down, over 65s pay £45 billion in taxes; they spend £64 billion on goods and services; they provide social care worth around £30 billion; they volunteer to the value of £10 billion and they donate £10 billion a year to charity.

This offsets the £136 billion cost of the older person's share of the NHS, pensions and other welfare benefits.

The baby boomers are better off than their predecessors; they are better educated and they will work longer. So the net contribution to the economy and society is likely to rise to about £75 billion by 2030.

Many baby boomers also have the wherewithal as veteran consumers to collate information, make considered choices, complain if quality of service is inadequate and buy whatever support they require when they require it. This relative affluence, however, has contributed to a rise in so-called lifestyle conditions such as obesity, diabetes and heart disease, also on the increase among the less prosperous. Thirty-six per cent of people aged 65-74 and 47 per cent of those aged 75 and older consider themselves to have a long-standing illness or disability that limits their activities.[32] Over 15.4 million people, a high proportion who are older, have one or more long-term condition and it is believed many more are undiagnosed.[33] In addition, one in 14 people over the age of 65 and one in six over the age of 80 have some form of dementia.[34]

While some older people are affluent, deprivation remains a major issue for many. Although the previous Labour Government lifted a million pensioners out of poverty in the decade up to 2009, 16 per cent of pensioners in the UK still live below the poverty line.[35] This equates to £206 disposable income a week after housing costs for a couple and £119 per week for a single person.[36] Over a million pensioners live in severe and persistent poverty (50 per cent below the median income), many from ethnic minority communities.[37] A third of older people live in "non decent" or hazardous housing. If housing does not change, some forecasts say that long-term care expenditure will rise by around 325 per cent between 2002 and 2041 due to falls, delayed discharges and premature moves into care.[38]

The Marmot Review, an independent review of health inequalities, refers to the social gradient:

> *a systematic pattern of declining health linked to declining socio-economic status in England. People in lower socio-economic groups experience the highest level of anxiety and depression and are more likely to suffer from chronic illness such as diabetes.*[39]

While many living alone may enjoy their lives and have a wide circle of friends and relatives, for others loneliness is also a profound problem. Sixty-three per cent of women and 35 per cent of men aged 75 and over live alone.[40] These figures are very likely to increase because baby boomers have lived through a steep rise in divorce and separation.

While the rate of severe loneliness in people aged over 65 has remained constant since 1945, ranging from 5 to 9 per cent, the proportion of people rating themselves as "sometimes" lonely has significantly increased from the rates of 11 to 22 per cent found in earlier studies to 31 per cent in the 1990s.[41]

The 2008/9 English Longitudinal Study of Ageing (ELSA) found that older people who lived with a partner were less likely to show signs of depression than those who were single, while those who were separated or divorced were even more likely to show signs of depression than other people living alone. Those who were widowed were the most likely to show signs of depression. Over 700,000 people aged 65 and older do not get out of their house more than once a week.[42] Lack of suitable public transport and fear of unfamiliar public spaces characterised their everyday experiences.[43]

Growing older manifests itself in different ways at different times for individuals and for different groups. The challenge for government and society is how to respond to these variations and to the inequalities contained within these patterns, to ensure that quality of life is maintained for all and costs controlled as the numbers of older people grow. The fact that the shape and structure of the welfare state has not substantially changed in 70 years makes this very challenging. It requires political will. As the next chapter argues flexible services that begin with the individual who controls a budget spent to suit his or her specific needs, can mean smarter solutions, quicker responses to problems and better value for money. This opens up the system for innovative interventions and uses of resources in ways that we have not even yet begun to imagine.

3 S: Start with the person

It is ironic that while people over 60 years of age are the main users of health and social care, services are rarely designed with their needs in mind. Appropriate low-level support, for example, to prevent or postpone a crisis is difficult to obtain. For professionals who are committed to improving services, the separate silos of health and social care can make a holistic approach difficult to apply in practice.

This is not least because a saving in one budget may result in a loss of income in another area. For example, savings made as a result of reducing unplanned hospital visits, may result in the loss of revenue to because beds have not been filled. While much attention is being paid to who is in charge of commissioning in the NHS, equally important and much neglected is the issue of what needs to be commissioned to avert a crisis in care for an ageing population.

The separation of health and social care and the chronic under-investment in prevention has led to the development of services that, from the point of view of older people, often do not fit their requirements. A study by the Joseph Rowntree Foundation (JRF) of a group of older people in Bradford, for instance, conveyed, "a strong sense that services were run for the convenience and budgets of the service providers rather than for the benefit of the recipient." [44]

What this means in practise is that a social care assessment, conducted by social services, is unlikely to take into account, for instance, the isolation of an older person. Instead, prime attention is paid to what an individual can or cannot do for themselves in practical terms.[45] The overlooking of the impact of isolation adds to the potential cost to the public purse as a result, for instance, of falls and undiagnosed illness. It also contributes to 'bed blocking'. Thousands of older patients are forced to stay in hospital after they are fit enough to leave because they have no support at home and they are waiting for an appropriate care package that is difficult to arrange in part because of professional silos.[46]

An ethos that starts with a holistic assessment of the requirements of the person requires a major shift in the allocation of resources as well as changes to the training of professionals who are the gatekeepers to these services. A number of research projects have explored examples of integrated care that link health and social care more coherently[47]. Personalisation takes the process a stage further by allowing an older person or his or her advocate to purchase customised support according to the older person's own needs and timetable. The contrast of this approach with the experience of many older recipients of support was revealed in research published by JRF in 2007. It gave the still not untypical case of Edward and May Smith, both 85, and married for 59 years.[48]

May had had a serious stroke and was in hospital for several weeks. She lost the use of her left side and became blind in one eye. The hospital staff did not offer May or Edward an assessment of their needs or a referral to social services. After May's discharge, it was taken for granted that Edward, who was suffering from early onset dementia, then undiagnosed, would cope alone. May made a good recovery but she had difficulty walking, suffered memory loss and needed Edward's help washing and dressing.

Edward and May initially organised their own home help and a gardener. As time progressed both Edward and May had a number of falls. Each fall was treated as separate medical episodes. May experienced a series of nosebleeds and on one occasion was admitted to hospital. Hospital staff seemed unaware that Edward faced difficulties at home. Eventually, after some negotiation, home care service was arranged for Edward. When Edward was admitted to hospital, May lost that service. "May and Edward were dealt with as two individuals by two different teams who produced two care packages and seemed unable to recognise the interconnectedness of the support that one person provided for another," the report pointed out.

Under the previous government, the Department of Health encouraged commissioners of health and social care to develop 'person centred' or personalised care plans for people with long-term conditions, working with patients to help them to manage their conditions better and make choices that might, for instance, enable them to engage in society more. The current government has, in addition, announced a significant expansion of personalised budgets that allow an individual or an advocate to buy services and support. Cuts to public spending already mean that, in many cases, the budgets are insufficient to meet need. Personal budgets have also proved unpopular with some older people who dislike the additional bureaucracy, responsibility and frustration of managing their own support system. These are concerns that need to be addressed.

A JRF report on personalisation, The Standards We Expect Project, pointed out that while practitioners and individuals support and highly rate personalisation, "a range of substantial barriers is seriously impeding the long-term sustainability and widespread application of person-centred support and putting it at risk."[49]

The report continued:

> *The inadequate funding of social care and negative aspects of its culture underlie these barriers. These encourage institutionalisation, poor quality provision, inequity and late intervention. As a result people's basic rights are not being met. Achieving person-centred support emerges as inseparable from fundamental cultural and funding change.*

The changes required to make personalisation happen are wide-ranging and unsettling. They confront many vested interests and challenge some traditional services. As Simon Duffy of The Centre for Welfare Reform argues, the person in need can only receive a diminished benefit from some of these traditional services because many are unlikely to be a perfect fit. At the same time, an individual is unlikely to have the extra resources to pull in other more suitable help. Duffy gives the example of a place at a poor quality day centre that costs £10,000 a year. The older person puts up with it because there is no alternative. In contrast, if a person has his or her own budget (and advocacy if required), in theory, a tailor-made service can be purchased. 'Pull economics' are then at work. The poor quality day care centre has to change or lose out.

A person with a personal budget may visit a day centre when he or she chooses (giving a challenge to those planning capacity); he or she can buy other services such as education, care help, transport and leisure. He or she can collaborate with others in the community by pooling funds, skills and possibly devising new services. As Simon Duffy says, "By putting money in the 'right' hands and in the right way (as a flexible entitlement) it can take on a new and dynamic role and can support the development and use of other resources. It is this process that explains why people can get better lives with less money; because the money that you can control works harder than the money you can't control."[50]

Duffy continues, "The power of personalisation will continue to lie primarily in its inherent effectiveness. Approaches which make better use of people's abilities, communities and natural positive motivation will always have some advantage even when political and financial circumstances prove challenging … The real choice … is whether the welfare state wishes to move from a paternalistic model of service delivery towards a model which treats people as citizens, not service users."[51]

'Starting with the person' is not just about who controls an individual's budget, it also involves better coordination between health and social care; primary and secondary care; acute hospitals and medical interventions that are best provided in the community, closer to an older person's home. The Esther Project in Jönköping, Sweden, is a much-praised example of what can be achieved. Jönköping County Council is responsible for the health and social care of 330,000 residents (roughly the population of the average Primary Care Trust) living around Höglandet. It has a worldwide reputation as the highest performing health community in the world.[52]

As part of the process of reorganisation, 'Esther' was invented: an 88 year old ailing but competent woman with a chronic condition and occasional acute needs. In the words of Dr Mats Bojestig, chief of the department of medicine at Höglandet Hospital:

> *We can each imagine our own 'Esther'. And we can ask ourselves in our work 'What's best for Esther?'* [53]

Before Jönköping's reorganisation, this was an example of Esther's experience of uncoordinated care. She lived alone. On one occasion, she had oedema that forced her to sit up all night. She called her home nurse who told her to see the GP. Esther could not manage the stairs of her flat so an ambulance was called. The GP then directed her to A&E. She waited three hours and was eventually admitted. The system required her to repeat her story over and over again; it took an inordinate length of time and it undermined her sense of being in control. Was this kind of emergency admission to hospital necessarily a move that was beneficial to Esther?

In Britain, a single day in a hospital bed can cost several hundreds of pounds. But often hospital referrals are simply a way of ensuring that patients get treatment faster. As Bojestig says, "If she (Esther) complains of a headache and her GP says she should see a neurologist, the referral would take three months. For Esther that is not acceptable. So she goes to the Emergency Room (similar to A&E). The doctor there knows that if he puts her in to hospital, the next day there will be a neurologist to visit her."

After long consultations, the Esther Project decided to fuse primary and secondary care, 'creating one queue instead of two'. A health and social care team now includes a GP, health professionals and immediate access to specialists in the community who would otherwise be based in a hospital. The result has been a 20 per cent reduction in the use of hospital beds, a reduction in waiting time and greater patient satisfaction, as well as one of the lowest budgets for health care in Sweden.[54]

At the time of writing, in England and Wales, 16 integrated care pilots are underway, testing different models of integrated health and social care but progress has been hampered by the organisational changes within the NHS. Some areas have already begun to incorporate an integrated approach. Torbay, for example, has a population of 140,000 with a much higher proportion of over 65s (23 per cent) than in many other areas. Five integrated health and social care teams are organised in zones aligned with general practices. Each team has a single manager, a single point of contact and a single assessment process.

'Mrs Smith', a fictional character aged 85, was created, strongly representative of actual experiences and in the mould of Jokoping's Esther, to drive the re-organisation forward. Under the remodelled scheme, Mrs Smith has one professional who is her key worker, health and social care have a shared electronic record, budgets are pooled, and the response can be speedy. Access to occupational therapists, physiotherapists and district nurses can be managed within hours. Delayed transfers of care from hospital have been reduced to almost zero: however dismantling professional silos continues to be a challenge.

In Hampshire integration has progressed even further. As part of its personalisation and integrated care agenda a Community Innovations Team now includes a social worker, an occupational therapist, a nurse, a community support worker and a community development worker. The aim is to provide holistic support. After an assessment of an individual's needs, a support worker helps draw up an action plan with the older person. If an activity in which a person expresses an interest is not available, the community development worker may help to establish it.

In summary, this chapter argues that while it is widely acknowledged that 'starting with the person' demands integration of health and social care and personalisation, a more efficient, effective new model of support for older people will not happen if it is left to commissioners and it is drastically underfunded and poorly supported. What is essential and urgently required is a driving political will on the part of government; appropriate legislation and incentives to accelerate change and investment in new services that make personalisation in all its manifestations, friendlier and easier to use for those who will benefit most from its adoption.

An essential part of Hampshire's approach has been to address more than an older person's medical and practical day-to-day requirements by also paying attention to the importance of maintaining a sense of wellbeing; keeping an older person active and engaged in his or her local community. The next chapter looks more closely at what we know boosts wellbeing and the circumstances and types of interventions, often well-intentioned, that may severely deplete it in older people.

4 W: Wellbeing

> **“I drive a car that is now ten years old and generally speaking I am utterly content with my lot because I have long accepted the fact that I have everything that old age can hope for. Peace, quiet, comfort to name but three essentials…the best thing about old age is that it brings wisdom – the ability to look back and learn from one’s own life.**
>
> — 75 year old, Mass Observation (2006)[55]

> **“Except that I’m a bit arthritic, this is my favourite age – confidence in oneself is beyond price and that includes financial security. Actually being able to walk, to move is a blessing.**
>
> — 71-year-old woman, Mass Observation (1992)[56]

In the 1980s an influential feminist critique of Gross Domestic Product (GDP) argued that it needed to value more than economic growth. Where was the ‘price’, for instance, put on women’s unpaid domestic work such as care giving and the cost of the detrimental impact of some economic policies on natural resources? Now, there is wider recognition that as we value what we measure, what we measure needs to include something more than financial profit and loss.

The 2009 Stiglitz-Sen-Fitoussi Commission set up by France’s President Nicholas Sarkozy, proposed, as a starting point a number of reforms to the use of GDP. These included measuring “quality of life via subjective indicators such as happiness and wellbeing”. It proposed more objective measures drawn from Sen’s capability framework. At the risk of over-simplification, Sen argues that opting for a good life requires an individual to exercise genuine choice and that in turn demands that citizens have fully realised capabilities (‘beings and doings’ that Sen calls “functionings”). The role society plays in constructing an environment that determines choices is vital. Governments should be measured against the concrete capabilities of their citizens, including their older citizens.

Other commentators and academics such as Lord Layard, Geoff Mulgan and Anthony Seldon, have made the case that the tasks of enriching capabilities and improving wellbeing need to have a stronger role in policy-making. Wellbeing is now regularly referred to in the context of health, social care and the workplace and has begun to be crudely measured by the Office of National Statistics (ONS). However, while the importance of wellbeing is increasingly discussed that discussion has yet to consciously influence on any significant scale the shaping of early intervention and constructive support for older people and particularly the ‘old old’, those who are aged 80 and over.

As yet there is no consensus on how wellbeing is defined, although there is a growing body of international research that indicates how it can be fostered and what undermines it.[58] The New Economics Foundation (nef), for instance, has identified five ways for individuals to safeguard wellbeing in everyday life: connect, be active, take notice, keep learning and give. Professor Ingrid Schoon at the Institute of Education also points out the connection between wellbeing and resilience. “The ability to make decisions, to overcome challenges, to ask for help, the story we tell ourselves when we fail are all resilient behaviours that impact on wellbeing, either positively or negatively. Additionally, positive feelings of wellbeing associated with resilience can in turn lead to higher levels of subjective wellbeing.”[59]

The Audit Commission has also identified a number of not unsurprising factors that improve the wellbeing of older people and their sense of having control over their lives.[60] These include:

- A safe comfortable home using aids, adaptations and assistive technology;
- Neighbourhood close to friends, shops and amenities in safe well-designed 'age friendly' towns and streets;
- Social activities, social networks and keeping busy;
- Getting out and about (car, bus, shared taxis and mobility scooters);
- Income, including the availability of benefits advice; and
- Information, from an independent source to help navigate the system and know about the services and opportunities that are available.

The central importance of having a sense of control or self-efficacy was also a theme in a study led by Ann Bowling of University College, London that involved 999 over 65s. It found that quality of life deteriorated as people grew old, especially for women who were more likely to have lost a partner. The study found that the other main building blocks or drivers of wellbeing and quality of life were influenced by:

- Peoples' standards of comparison and expectations in life;
- A sense of optimism (an asset rather than deficit view of life);
- Good health and physical functioning. Engaging in a number of social activities and feeling supported;
- Living in a neighbourhood with good community facilities and services including transport; and
- Feeling safe in the neighbourhood.

Of course, many older people are highly adept at caring for their own wellbeing and maintaining connections with others. According to the Survey of Health, Ageing and Retirement in Europe (SHARE), for instance, 10 per cent of the European Community's older population do voluntary work; 17 per cent give informal help and 5 per cent care for a sick or disabled person.[61] SHARE points out: "Men and women who are socially productive, exhibit significantly better self-rated health, less depressive symptoms and bodily symptoms and their quality of life is higher."[62]

In the UK, the largest group of volunteers is drawn from those past 60. Age UK receives 650,000 hours of voluntary support; most are given by older people. One American study found that rates of volunteering do not decline significantly until people are in their mid-70s; older volunteers commit more hours than their younger counterparts and "there is good evidence of a reciprocal relationship between volunteering and wellbeing".[63]

In deprived areas too, helping out and reciprocity is very strongly in evidence. "The neighbours are good", one 79 year old woman reported in Liverpool. "The chap over the road takes my bin out if I'm not there and brings it back for me. I've seen him this morning, talked to him. And the lady next door… We've all got keys."[64]

Volunteering, social networks and involvement with others are essential parts of maintaining wellbeing. Yet the opportunities for many older people to stay connected are perhaps not sufficiently explored by local authorities and health and social care professionals. The Young Foundation, for instance, has developed a diagnostic tool, the Wellbeing and Resilience Measure (WARM).[65] It measures wellbeing and resilience in small local communities such as housing estates. It helps local professionals, residents and organisations to see which services are having an impact on peoples' lives and which are not. The usefulness of WARM to wellbeing and the active ageing agenda is illustrated by a piece of work the Young Foundation conducted for the Wiltshire Think Family Board commissioned by Wiltshire County Council in 2010.[66]

A small number of families on an estate were chaotic and in crisis but the research also revealed a number of older people, retired, with time on their hands who were willing and able to do more as volunteers in their local community but whose skills were not being utilised.

Staying connected, retaining a sense of independence and feeling secure in your own community are essential to wellbeing yet shamefully they move out of reach of many people as they grow older. Modern developments in technology, the internet and social networking as well as improved understanding of the importance of the planning and design of housing and public places should all now be working together to improve the quality of older people's lives. Sadly, as the chapter briefly describes, sometimes, on the contrary, they combine to have a negative impact that could be easily avoided.

Since the 1970s, Aaron Antonovsky and others have highlighted the factors that create and support human health and wellbeing. Antonovsky says that some people stay well in situations of material hardship when others do not because they have "a sense of coherence". They are able to understand the situation they are in, have reasons to improve their health and have the power and resources – material, social or psychological – to cope with stress and challenges. Much of this view has a resonance with what the Young Foundation and others are learning about resilience and wellbeing and how both can be developed, even later in life.

We know, for instance, that social isolation undermines wellbeing. The Campaign to End Loneliness, launched in 2010, has called for the early detection of those who have little contact with others to become a more prominent goal in social care. Commissioners and policy-makers also need to have greater awareness that older men and women may require different approaches to tackle poor health and isolation. In work for the Growing Older programme, for instance, Sara Arber and others found that working-class men, especially if bereaved, divorced or single, were less involved in religious, community and sports clubs than middle class men but did attend fast-reducing social clubs. The reasons were that they saw clubs for older people as designed for women, as places where attendees were passive recipients of services, and as a last resort. Day Centres were seen as "a last resort". The study warned that policy-makers tend to measure the quantity and quality of social networks with a "feminine ruler" rather than considering the different ways of viewing "intimacy and friendship patterns in the lives of older men".[67]

Sensitivity to the specific needs of older people and the diversity within the ageing population is required in the use of technology and its relationship to the improvement (not the undermining) of wellbeing. Unfortunately, while there have been striking progress in some areas, referred to later in this chapter, the use of technology is also marked by a persistent ageism and a lack of sufficient understanding of the very varied market for which it is aiming, and the assets and talent that that market offers. As Simone de Beauvoir pointed out in *Old Age*, "Modern technocratic society thinks that knowledge does not accumulate with the years but grows out of date."[68]

Telemedicine or telehealth, for example, provides equipment in peoples' homes to monitor vital signs such as blood pressure, blood oxygen and weight. So, for example, an older person with chronic obstructive pulmonary disorder (COPD) can record her pulse, weight and blood pressure on a daily basis. These readings are related to a community nurse who can act swiftly if the results are of concern. Telecare, a separate development, uses a combination of alarm and sensors (to register, for instance, when a person falls) and other equipment to help people live independently. In theory, both should boost wellbeing but there are concerns.

One study, for instance, revealed that 55 per cent of telehealth users gave up within six months. Arguably, such a rejection does not help a sense of self-efficacy that is considered a constituent part of wellbeing. Other studies have found significant barriers to the adoption of technology by some older people. They include a lack of access to the Internet; low awareness of what technology can offer and inadequate marketing for the target group aimed, for instance, at the 'frail elderly' with whom most older people do not wish to identify. As Alan Newell of Dundee University points out, "Most technologies give the impression of being designed by and for 24 year old males. Little technology is sensitive to the needs and wants of older people."

Other issues that deter older people include anxieties around cost; security (for example, identity theft) and concerns that telemedicine, for instance, will increase a sense of isolation. However when technology works it can be transformative. The Angus Gold project, for instance, now ended, offered training to the over-50s in using technology. Participants said it helped them to maintain social ties, especially with families; they discovered common ground with younger relatives and some participants became volunteers training others.

The role of technology in older peoples' lives is being explored in an EC project called Netcarity. Established in 2009, the four-year programme is researching and testing technologies to improve the wellbeing, confidence, independence, safety, health and communication of older people. Technology is also being used to create 'smart' houses in which sensors, for instance, can tell the difference between a fall that signals a person needs help and someone having a lie down. Smart houses will turn electricity and heat on and off and 'message' to carers, living at a distance, that all is well with an older relative.

What is a challenge is maintaining a balance, respecting the rights of older people. So smart houses, for example, do not become intrusive 'Big Brother' style surveillance that are convenient for relatives but which may increase a sense of vulnerable dependency rather than ensuring, for older people, that they achieve a longer period of independence and quality of life. Part of the answer may lie in participation. Older people should be enabled to have a central role in the design, branding and marketing of technological advances that can impact positively on their lives. A project that investigated older people and access to technology argued strongly for the benefits of this. The project report pointed out that the goal is "digital participation for a purpose and the purpose links closely to the belief that the scope to contribute, participate and engage is an essential ingredient of older people's wellbeing."[69] This asset-based approach is discussed in a later chapter.

Participation in design might also make a difference in the take up of home adaptations and their contribution to wellbeing. Research has shown that home adaptations (such as grab rails) can reduce falls and considerably improve the wellbeing and independence of older and disabled people. However, funding for adaptations for those on a limited income is scandalously difficult to obtain in many areas of the UK. In addition, there appears to be an unwillingness to make changes even amongst those who do have the resources, perhaps because of a lack of involvement in the design and process.

Where older people live, and how their accommodation encourages or inhibits their sense of being as an integral and valued part of their own community also impacts on wellbeing. Architect Roger Battersby, a member of the Housing Our Ageing Population Panel for Innovation, (HAPPI) visited several inspirational housing developments in the UK and the rest of Europe for a report published in 2010. He says, "We need to start with the labels that stigmatise housing for older people: sheltered housing, supported housing, extra care … all describe places where none of us would wish to go if we had any choice."

Darwin Court in London has facilities open to the public and is one of the housing developments visited by the HAPPI. Resident Pat Kelly said, "I love it. It's got the security. It's got everything I would want, the IT room, the restaurant, the swimming pool, everything … Grandchildren come and go … There's a park opposite … I couldn't move out of here. I love it." The Panel visited a range of models on the premise that 'one size fits all' is no solution. In Groningen in the Netherlands, De Rokade is housed in a spectacular apartment tower in the centre of the city and offers several types of accommodation including 200 day care and nursing beds and a kindergarten; 74 apartments and an indoor 'town square'. Space, storage, security, light, adaptability that embraces telecare and telehealth; pleasant to the eye and connected to the rest of the world are all factors that contribute to an ethos that is more than bricks and mortar.

HAPPI panel member, Sir Richard MacCormac, said, of his visit to the Rokade scheme, "I got a wonderful sense of civilised values about elderly people, which was reflected in the architecture. I was very impressed and affected by it. I was reminded that while the kinship system that supported family ties and social coherence has fallen away in advanced European countries, we don't need to abandon the idea of there being a social fabric."

Geoff Mulgan, Chief Executive of NESTA, has written about the importance of "loveability not just livability" in the design of public spaces and buildings, an approach that encourages social interaction between all generations and that welcomes rather than intimidates those who may be physically more vulnerable. In 2007 the WHO undertook a project to identify the characteristics that make the social fabric of a city more 'age-friendly'. WHO worked in collaboration with 35 cities across the globe and published a set of guidelines. Some features that make a difference are modest in delivery but profound in impact: from helpful bank managers to priority in shops; from adequate toilets in public spaces, to places for men to gather such as the men's shed movement in Australia.[70]

Policy-makers, planners, politicians, designers, technocrats and commissioners all have a role to play in creating a society in which the wellbeing of older people is actively promoted. However, individual responsibility also needs to be exercised to prepare better for the transitions that come with older age and which can dent wellbeing. One of the aims of the Campaign to End Loneliness, for example, is to encourage more of us to future proof our lives. However, studies indicate this is not a popular idea. A 2010 YouGov poll for the Centre for Social Justice Older Age review for example, revealed that 52 per cent of people polled had not given much thought to growing older (in terms of income, accommodation and lifestyle).[71] According to the same poll, a third of older people said the advice they were given approaching retirement was "poor". Far greater investment is required to raise public awareness about the importance of preparing for ageing.

Research by the Department for Work and Pensions (DWP) describes retirement, for instance, as "a pivotal moment" for most people.[72] It reports, "Even for those with plans for later life, and the financial means to execute them, it can be daunting; for those without either plans or financial stability, it can be both scary and depressing. Crucially, it can also be the first step towards becoming socially isolated, with all the associated negative impacts for physical and mental health outcomes."

According to Canadian research people in paid work at 65 are happiest. However, employment in older age is often brutal; either it ends abruptly or it is difficult to negotiate a gradual tapering off or sufficient flexibility in part-time employment. In 2008, John Whatmore and Graham Ross Russell, both very active and in their late 70s, established Retirement Reinvented, a website that encourages older people to contribute and pool their knowledge, wit and wisdom.[73] It also offers information, advice and news. Graham Ross Russell says, "Retirement is a difficult word and it has all the wrong connotations. A couple of years before retirement and a couple of years after are the crucial period. During that time if you get off your bike, it's very difficult to get back on. And that often means a huge waste of talent and experience. For those who don't wish it to be, retirement shouldn't be an ending. It should be a new beginning."

Research by the DWP has helped it to define those who are most vulnerable at this change from a paid to workless life. They tend to be:

- from a lower socio-economic group;
- widowed or divorced;
- rent their home;
- lead unhealthy lifestyles;
- have a limiting long-standing illness; and
- dislike computers and IT.

A 2010 workshop with men and women from this target group, aged from 58–67 years established that these older people are influenced to become or remain active by the following:

- help in taking the first step
- the value they get from undertaking an activity, for example, health benefits/ self worth
- social contact, for example, companionship, time with friends and family.[74]

A number of the initiatives around the Big Society such as locally recruited community organisers to encourage those over 60 to become more socially engaged may reach those most isolated whose wellbeing is under the greatest threat but these initiatives are on a small scale compared to the size of the challenge ahead.

Leaving paid work as a major turning point that can cause a profound dip in a sense of wellbeing has received some attention. What is less well recognised but which will become a far more common experience as lives grow longer, is the move from older age to 'old old' age, reaching eighty and living for another decade or more. Chronology is not necessarily much guide but while some handle the added years with panache others do seem to experience a significant deterioration. How much this is in response to physical and mental deterioration and how much of this is in response to the expectations of others and the cues society gives, is discussed in the next chapter.

This also briefly describes how an asset based approach to the individual and the community of which he or she is a part – professionals, for instance, working with rather than doing to – may be one of the most significant routes to maintaining wellbeing for all older people, including the 'old old', at a saving to the public purse and resulting in a valuable growth in precious social capital.[75]

5 A: Assets

In the 1990s, Hazel Stutely, a health visitor, began to visit families on the Beacon Estate near Falmouth in Cornwall, in one of the most deprived wards in the country. Initially, she says, her caseload was "overwhelming".[76] The crime rate was high, unemployment levels were at 30 per cent, half the houses had no central heating and were of poor quality; vandalism was a major problem and so was substance abuse.

Many of the older people were unwell, isolated and afraid. The estate had no police station and the statutory services were 11 miles away in Truro. Hazel Stutely began to work with the local community:

> *People sometimes ask me what was the most difficult part of the Beacon project? It was to convince five people out of 6,000 that change could happen and that they could lead it.*

Over the next few years the Beacon Community Regeneration Partnership flourished. Grants and awards were won; housing improved; the statutory services returned to the estate; employment increased; educational attainment went up; fear of crime was reduced by 78 per cent and, as success followed success so social engagement for all ages increased markedly. Hazel went on to repeat the formula for triggering community engagement on an estate in Redruth. The Redruth North ward had a population of 4,000, 80 per cent living in poverty and 48 per cent of households contained one or more members with a life-limiting illness. She adopted the same asset-based approach as she had used on the Beacon Estate. Rather than focus on problems, she worked to identify people's skills and capabilities and encouraged them to come up with their own solutions, working collectively.

One of the conclusions she has reached is that older people are often the social glue in a community and an asset-based approach,[77] even towards the 'old old', those with complex long-term conditions, has a clear connection with wellbeing and active ageing as well as the resilience of the whole community, however disadvantaged.

"In Redruth, we had a number of older people who were very much the driving force," Hazel Stutely explains.

> *We still have to learn about how the change in morale spreads from a few to the many but it does have a significant impact on the health of individuals, including very much older people, and their level of social engagement.*

So what does an asset-based approach mean for health and the active ageing agenda? Anthony Morgan, former associate director of the National Institute for Health and Clinical Excellence (NICE), described a health asset as "any factor or resource that enhances the ability of individuals, communities and population to maintain and sustain health and wellbeing. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses."

An asset is any of the following:

- The practical skills, capacity and knowledge of local residents;
- The passions and interests of local residents that give them energy for change;
- The networks and connections in a community;
- The effectiveness of local community and voluntary associations;
- The resources of public, private and civic sector organisations that are available to support the community; and
- The physical and economic resources of a place that enhance wellbeing.[78]

As a report outlining the ingredients of an asset-based approach explains, an asset-based strategy counters "the more familiar 'deficit' approach [that] focuses on the problems, needs and deficiencies in a community such as deprivation, illness and health-damaging behaviours. It designs services to fill the gaps and fix the problems. As a result, a community can feel disempowered and dependent; people can become passive recipients of services rather than active agents in their own and their families' lives."[79]

In 2010 the Department of Health commissioned the Health Empowerment Leverage Project to demonstrate the business case for the wider use of community based methods of health improvement. HELP's early conclusions are that the prevailing pattern in dealing with health issues has been "short-term activities and projects aiming to influence separately one or two lifestyle behaviours." It continues, "Even innovative projects about 'engaging communities' tend to use the term far too loosely, often in practice describing activities targeted only at individuals or at people categorised by certain health conditions."

The report recommends what it calls a Combined Health Improvement (CHI) Strategy, a "long-term whole neighbourhood basis" that has long been employed in the US in areas such as Seattle's Neighbourhood Programme.[80,81] This approach also embraces new developments in "network science" that examines how change spreads through social networks, "health buddies" and "old fashioned flesh and blood relationships"[82] and fresh thinking on behaviour change.[83] Such a strategy, HELP says, "in no way detracts from the responsibility of individuals to look after their own health. On the contrary, what CHI address is the fact that peoples' lifestyle choices are strongly influenced by those around them and by local conditions. Conversely, purposeful community activities addressing local problems and generating even small but tangible improvements have a marked effect leading to better health and better lifestyle choices."[84]

The positive impact of this approach on developing a community's assets and its connection to the active ageing agenda seem self-evident. It may also help to reverse a trend begun in the late 1990s, in which an increase in home care for older people with intensive social care needs and often socially isolated, took attention away from their connections to their own wider community and the importance of valuing and encouraging positive interaction between all ages.

Volunteering and social enterprises and services that lessen that sense of alienation – that see older people as an asset in community-building rather than a liability – help to reduce anxiety and improve wellbeing. Organisations such as Demos, NESTA and the Young Foundation, now working with Local Government Improvement and Development (LGID) and older people on ways to promote active ageing, as well as charities such as Age UK and United for All Ages have underlined the importance of assisting the growth[85] of the social wealth[86] of older people and their communities.[87]

An asset-based approach has another advantage. Over time, it might help to recalibrate the ageist views that many hold about older people that in turn have a negative influence on the perception older people have of themselves, a view that can damage health and wellbeing. The power of cues and the influence that the views of others can have on an older person's own attitude to ageing, are now becoming a much stronger theme of exploration in behaviour change and neuroscience. Cordelia Fine in *Delusions of Gender* [88] shows how the current narrative of certainty around what is frequently referred to as the "hard wired" brain is misguided: we still know little. What we can assert is that the mind has remarkable plasticity; the process of ageing too is malleable. Men and women are made not born. They pick up their cues on how to behave from the culture in which they live.

Fine gives the example of Adam Galinsky's series of experiments. He and his colleagues showed participants a photograph of a professor, a cheerleader an elderly person or an African American man. Some of the volunteers were asked to be the person in the photograph and write a day in the life of that individual. Asked to rate their own traits after the exercise, those who had imagined themselves as cheerleaders rated themselves as more sexy and attractive compared with the control sample. Those who walked in the shoes of the elderly person felt weaker and more dependent.

The researchers then went on to show that these changes in self-concept had an effect on subsequent behaviour. Pretending to be a professor, for instance, improved analytic skills compared with controls while 'self-merging' with an older person diminished personal assets. Fine quotes the Australian writer Helen Garner that one can either, "think of people as discreet bubbles floating past each other and sometimes colliding or … see them overlap, seep into each other's lives, penetrate the fabric of each other."

Research in neuroscience for instance by Mary Helen Immordino-Yang at the University of Southern California[89] indicates that having admiration for another person's good work can act as a personal motivator to behave in a similar fashion. Older people, like individuals of all ages, respond to the expectations made of them and the assumptions conveyed about their capabilities and assets or the alleged lack of them. Obviously, a person with several long-term conditions may find it more of a challenge to stay active and involved but it's striking that there are many examples of those who do contribute much, against the odds, helped by innovative organisations and charities (some examples are given at the end of this paper).

Behaviour change and the appropriate cues to encourage positive choices are, in theory, high on the Government's agenda but in practice, the lessons from research are often ignored and particularly so when it comes to older people. In terms of loneliness and older people, for instance, a meta-analysis of twenty studies found that interventions targeting social cognition – a person's thoughts about themselves and others – were more effective than strategies such as increasing social support and creating opportunities for social interaction. Studies that used cognitive behavioural therapy were found to be particularly effective. As the author of one study, John Cacioppo said, "effective interventions are not so much about providing others with people with whom they can interact, providing social support … as they are about changing how people who feel lonely perceive, think about and act toward other people." [90]

Offering more imaginative support, tackling ageism, and creating a range of ways in which an older person might choose to become more involved or re-involved with his or her community at a time when traditional meeting places such as local post offices, libraries and working men's clubs are closing down is daunting but that is often, itself, a trigger to creativity. Innovative support also suggests a different range of interventions might be required, for instance, in the self-management of long-term conditions. The 2010 guide for commissioners does refer to a holistic approach but there is little mention of the importance of connections with the community or working to change an individual's mindset.

England currently has 15.4 million people with long-term conditions – 30 per cent of the population. They account for more than 50 per cent of all GP appointments; 65 per cent of all outpatient appointments and over 70 per cent of all inpatient days.

Due to an ageing population, it is estimated that by 2025 there will be 42 per cent more people in England aged 65 or over. The number of people with at least one LTC will rise to 18 million. According to the Department of Health, LTCs account for £7 out of every £10 spend on health. Social care budgets will also be stretched by the demands of an ageing population. By 2022 the number of people aged 65 and over with some disability will increase by 40 per cent to 3.3 million.

The number of disabled older people receiving informal care (in households) will rise by 39 per cent to 2.4 million. The number in residential care homes will increase by 40 per cent (to 280,000) and in nursing homes by 42 per cent (to 170,000). Total long-term care expenditure is forecast to rise by 29 per cent to £26.4 billion.

Department of Health (2010)

So, how might an asset-based approach as part of the SWAP framework influence services and the involvement of the third society in promoting active ageing?

- Work by IDeA and The Young Foundation[91] on wellbeing indicates that communities flourish when they have control and genuine opportunities to influence decisions. They have regular contact with neighbours. And they have confidence in their capacity to cope and to control their own circumstances. Control, contact and confidence add up to a premium of high value to older people.
- A service or intervention needs clear outcomes and is costed accurately. This may involve the further development of metrics that measure and put a value on, for instance, improved wellbeing. It also requires robust evaluations that verify the effectiveness of the intervention or service and determine that the SWAP themes are being applied.
- Services and projects involve older people with professionals in design and delivery.
- A culture is developed that encourages commissioners to seek out new ideas to improve the quality of older peoples' lives and the self management of long-term conditions. Ideas that, with help, can be turned rapidly from a working model into pilots and sustainable social ventures.

Personalisation, attention paid to wellbeing and an asset-based approach all also signal the importance of prevention and the early identification of those most at risk. Prevention is the subject of the next chapter.

6 P: Prevention

For an older person, prevention is both about slowing down the physical and psychological decline that may be compounded by depression, isolation and a sense of one's own vulnerability and avoiding where possible the circumstances and crises that can deplete resilience and wellbeing as well as cause damage to health. Crises such as unplanned hospital admissions; delayed discharge after a hospital stay and falls.

According to the charity Age UK, falls may be costing the NHS in England up to £4.6m a day. The lack of attention to the avoidance of falls is a striking example of how ageism plus the lack of investment in prevention adds up to a costly NHS bill and unnecessary pain, suffering and loss of confidence and dignity for older people. One in three people aged over 65 will have a fall; 45 per cent of those over the age of 80. Forty per cent of people living in long-term care experience recurrent falls.[92] Falls are a major cause of injury and death among the over seventies and account for more than 50 per cent of hospital admissions for accidental injury. Yet, falls are not synonymous with growing older. The lack of action to reduce falls signals how an older person's quality of life is undermined by ageism at a price paid by us all.

The Department of Health (2009) has given an illustration of the impact of falls in one Primary Care Trust with a population of 300,000. Among the 45,000 people aged 65 and over:

- 15,500 will fall each year;
- 6,700 will fall twice or more; and
- 2,000 will attend an A&E department of a minor injuries unit;
- A similar number will call an ambulance service, and
- 1000 will sustain a fracture, 360 to the hip.[93]

According to WHO, the rise in the number of persons over the age of 80 means falls and falls injury, will accelerate "at an alarming rate" if preventative measures are not taken, "in the immediate future".[94] WHO also points out that health and social care providers are unprepared to prevent and manage falls in older age, some believing that these are an inevitable part of growing older. The WHO report states that, "Social interaction is inversely related to the risk of falls."

Older people fall for a range of reasons. They include the environment, loose carpets, uneven pavements, insufficient lighting, the decline of physical and cognitive capacities and the co-morbidity associated with chronic illnesses. Women and those on a lower income have a greater number of falls. Falls are also iatrogenic, conditions induced by incorrect diagnosis and treatments. Examples include over-prescription of medicines that cause side effects and interactions among the drugs that are prescribed.

The attitude of some older people also plays a part. Fear of falling can lead to an overall decline in the quality of life as an older person restricts his or her social activities; activities that maintain self-esteem, confidence, strength and balance. Many older people believe that falls prevention means home modifications that they do not want not least because it signals their declining powers. As a result, in spite of some good examples of falls prevention intervention, there is a low uptake. According to research, the way in which interventions are offered with an asset-based approach: "This is what it means you can do" rather than a reminder of the older person's fragility, has a stronger chance of success.[95]

Prevention for older people, as this paper has argued earlier, means providing services that avoid or delay the need for costly intensive interventions and strategies and approaches that promote quality of life and social engagement. At present, it is unclear who decides when support is required and what kind of support that should be. As a JRF report says, is it decided by "medical diagnosis, social care assessment, older people themselves or their families?" [96] A prescient report[97] published in 2003, also proposed a change to the objectives behind prevention that resonates with the SWAP agenda. The paper said, "The old definition [of prevention] is characterised by promoting choice and independence. While still important, we need to go beyond these to a more complete sense of empowerment. Adults not only exercise choice between the options they are given or face, they possess the much greater ability to control their lives and create their own options … We should promote ways in which older people are able to exercise more control in their lives. We should support the maintenance and development of new relationships, no longer based on dependency but on an equal footing, contributing as well as receiving."

Ageism explains much of the historical neglect of falls and their link with older people's self-management of long-term conditions. It perhaps also explains the shocking lack of progress in devising effective prevention strategies in both health and social care, and the lack of a consensus on metrics to measure the savings further down the line that are the result of early appropriate intervention. The PARR tool (Patients At Risk of Hospital Readmission) utilises hospital data to predict which patients may be admitted to hospital over a 12-month period. This is now being replaced with great difficulty by more refined tools, including those that combine data from hospitals, GPs and social care, linked by an individual's NHS number. Research in the US, Canada and the UK, shows that it is crucial that intervention is provided before a serious crisis occurs resulting in an emergency admission.[98]

The effective use of predictive modelling is a crucial tool in meeting the health and social care challenges of an older population. Impactability means the readiness of patients to accept preventative interventions. Research into impactability models, now being developed by Dr Geraint Lewis at the Nuffield Institute and others, means that the sub-group of high-risk patients most amenable to hospital avoidance programmes can be identified. According to Dr Lewis, prevention may involve, "taking or stopping a medication, doing a test, reducing available medical costs, making a behavioural change, or changing the person's environment." The ethical dilemma, as Dr Lewis points out, is one of equity. Predictive risk is, so far, a mainly medicalised model. It may not, for instance, help those who are isolated and who have fallen but recovered unaided. Or who are in the early stage of undiagnosed dementia or who have never registered with a GP or chosen not to engage with health and social services.[99]

In a study published in 2007, the writers pointed out, "We need to be much clearer about understanding what 'prevention' is; it isn't just providing the same service in similar portions at an earlier stage. It should be about equipping people with the skills, coping techniques and circumstances to remain independent. It's as much about learning how to use a computer, purchasing an active lifestyle or ensuring a safe neighbourhood as it is about providing one hour of home care per week. It is a responsibility that extends well beyond social services."

The JRF Older People's Inquiry (2004) also reinforced the message that "older people valued support which enabled them to have a life worth living". The Inquiry pointed out that "that little bit of help" made a vital difference but it was very difficult to secure. It selected thirteen organisations that in different ways were part of a bigger picture that enabled an older person to have a better quality of life. They included Trafford Care and Repair that provides advice, help, risk assessments and carries out small repairs around the house, charging £10 a visit. The Cinnamon Trust, a charity that helps older or terminally-ill people care for their pets, including short or long-term fostering and Keeping in Touch for people with visual impairment. In return for a small membership fee, it helps with practical tasks such as shopping for colour coordinated clothes; filling in forms and labelling food.

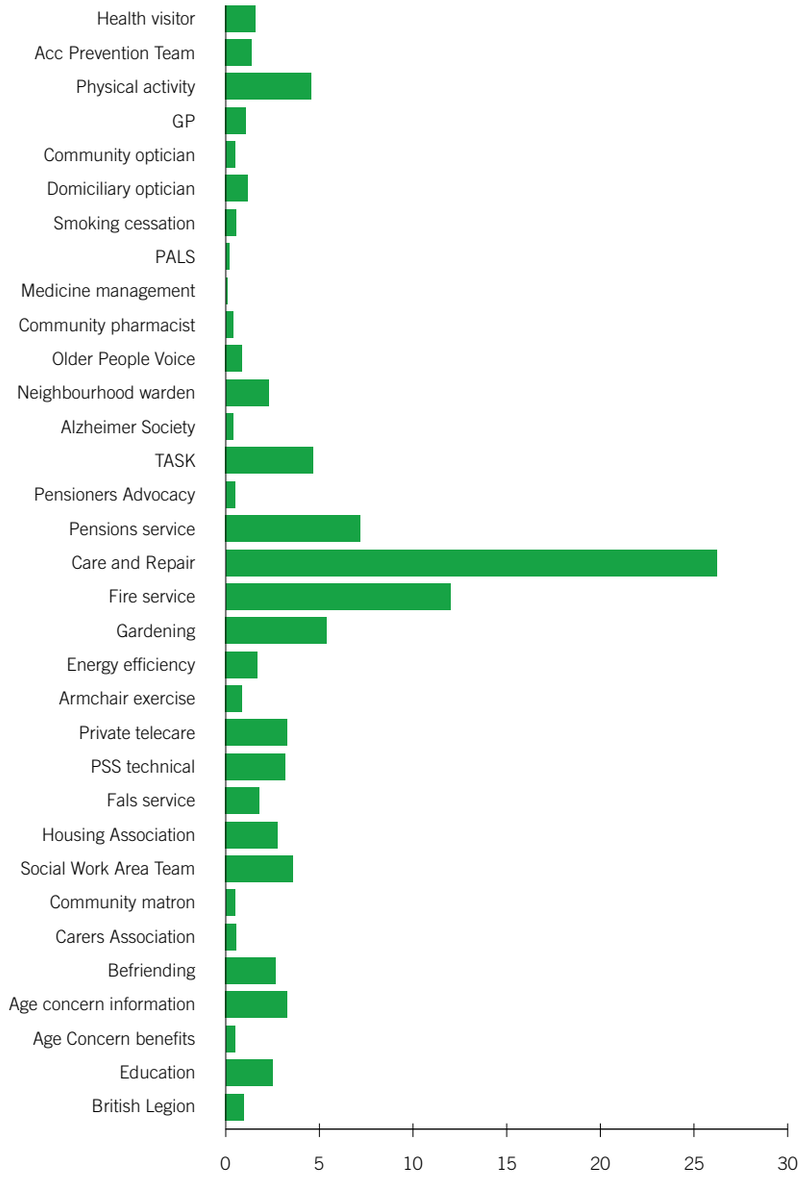
The Older Peoples' Inquiry found that a number of these organisations were highly innovative in their use of resources and the engagement of older people in the design of the projects and use of technology. However, they needed support for further development and sustainability not least in terms of funding. A problem that is even more acute now. Preventative strategies do have clear savings and benefits but at a time of severe cutbacks when even intensive support is affected, how can these strategies prove their worth in a way that commissioners will support? How and where can new money be found; outcomes agreed and effectiveness measured? These are questions to which the Young Foundation amongst others is working to find practical answers in order to help develop services and ventures that can properly sustain active ageing.[100]

One example developed by the Young Foundation is the Social Entrepreneur in Residence (SEiR) Programme. A person is recruited locally and based in a GP consortia or a charity or a local authority, and supported by the Young Foundation in London, he or she scouts for entrepreneurs with strong ideas or fledgling ventures that, for instance, can help with active ageing. The SEiR then provides a mix of coaching and business expertise and knowledge of the commissioning system to help that individual or a team to create a sustainable service.

Can prevention save money? An evaluation of the Partnership for Older Peoples' Project (POPP), funded by the Department of Health for the previous government, indicates that it can. The POPP initiative ran from 2006–2009. Its aim was to improve independence, health and wellbeing for older people via a series of projects providing local services that were integrated. The expectation was that partnerships would be forged with health and social care organisations, voluntary and community groups and older people themselves. The aim was to improve the quality of life and prevent or delay the need for higher intensity or institutional care. Twenty-nine local authorities were involved; a quarter of a million people used one or more of the services that had a budget of £60 million.

The Knowsley POPP, IKAN, ("I know someone who can!") pilot, for instance, still in action, had a team of workers who conducted holistic assessments of the low level needs of people aged 55 and over and referred individuals on to a range of services. A Handyperson scheme and an assistive technology scheme, offering for instance text telephones for the hard of hearing and electronic alarm sensors for those prone to falls, ran in conjunction with advice and information and befriending services. In addition, older people with mental health issues were placed with a carer in the carer's own home and a flexicare service provided easily accessed[101] flexible support to avoid hospital admittance and speed up discharge.

Percentage of Onward Referrals by Referred to Agency



- IKAN evaluation showing the range of services called upon. Knowsley POPPs Final Evaluation Report (2008) Liverpool John Moores University.

The final POPPs evaluation (2010) pointed out that two-thirds of users were aged 85 and over. The evaluation said, "POPP services appear to have improved users' quality of life, varying with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventative projects also had an impact."[102]

Significantly, an additional investment of £1 in POPP services would produce greater than £1 in savings in emergency bed days. In community facing projects such as help with day-to-day maintenance, the larger the project, the greater the saving. The reductions in hospital overnight stays (47 per cent); use of A&E departments (29 per cent) and reductions in physiotherapy/occupational therapy and clinic or outpatient departments by one in ten resulted in a cost reduction of £2,166 per person.

The evaluation also pointed to the barriers to success. For instance, the cost reduction in secondary, primary and social care is difficult to translate into a cost saving. It explained, "Moving monies around the health and social care system was a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation. Professional silos and separate budgets continue to be a barrier to this kind of joined-up seamless approach. A lack of coherence around what is being measured to illustrate success; what outcomes have been achieved and what kind of price tag is attached to both is also a hurdle that needs to be overcome."

Prevention may save money but how easy is it to identify older people who might benefit from 'a little bit of help', and is offering help the only route? In the asset-based model older people are also asked to reciprocate, to use the skills and experience they have acquired over a lifetime in exchange for whatever support they might need. Age UK, the Alzheimer's Society, The Young Foundation and other organisations have begun to develop services, for instance, around the idea of navigators and advocates, guiding older people, negotiating and securing the kinds of services they require early enough, working with them so they are active agents in their own lives, incorporating, where suitable, technological platforms. Social networking sites such as the Canadian based Tyze[103] are also pioneering innovative support systems using the web.

The Young Foundation is also working with Professor Heinz Wolff, on Care4Care, an idea based on Professor Wolff's conviction, after a lifetime in bio-engineering, that at a point when older people become much more vulnerable the most important technology is a pair of 'helping hands'. Care4Care builds on the experience of time-banking (people giving their time and expertise in return for the time and expertise of others) and Fureai Kippu, a Japanese scheme of caring credits, in which grown-up children care for an older person in their own area and that allows their parents to access care credits in another area. Care4Care is a membership club that depends upon a younger person providing a few hours a week caring for a neighbour. This allows him or her to bank those hours and draw on them when they themselves are older.

Care4Care pilots being run in 2012 will need to address a series of challenges. These include: the mobility of the population; what happens in areas where the number of older people dominates; possible resistance to turning a helping hand into a bankable asset.

The work of trying to construct a different kind of support system that sees older people as part of the solution, an asset not simply a problem and a liability is in its infancy. If it succeeds on a large enough scale, it will offer those who have passed their sixtieth birthday greater control over their lives and it will culturally reinforce the notion that they still have a great deal to offer.

Conclusion

Gaston Berger, the French writer and industrialist, said the purpose of looking to the future is to disturb the present. The pioneers of wellbeing, looking to the future, have been trying to draw our attention to the adaptability of ageing for years. Professor Thomas Kirkwood of the centre for ageing and health at Newcastle University, for instance, refers to mental capital as "the bank account of the mind", not used by spending, but enhanced by putting it to work. And age offers little limit as to how the mind can be employed.

In *The Secret Life of the Grown-Up Brain*, Barbara Strauch writes, "As we age, we power up not down … In some cases … people in middle age … begin to use two sides of their brain instead of one – a trick called bilateralisation. Those who recruit – or learn to recruit – the strength of their brain's powerful frontal cortex, in particular, develop what scientists call 'cognitive reserve', thought to be a buffer against ageing."

She then points out that while the brain may be adapting, the settings and prevailing attitudes in which ageing takes place are proving much more resistant to change. She writes, "The trappings and timetables of our lives are woefully out of date – set up for long-ago lifespans in which by middle age we were expected to curl up – and give up. But if, as current trends indicate, many of us manage to live well into our eighties and nineties, and if we manage to keep our brains intact … what will we be doing?" [104]

The answer is, in many cases, not a lot, if the current priorities, prejudices and uncoordinated systems prevail. According to the Academy of Medical Sciences, research in the UK into the mental and physical processes of growing older, has not flourished. It calls for greater innovation in attracting the "brightest minds" to work together; the creation of multidisciplinary centres of excellence; an audit of current research; strong funding support for what needs to be done and a correction to "the lack of robust markers to measure interventions to promote healthy ageing."

As this paper has attempted to outline, active ageing also requires political will and an ethos that incorporates the SWAP agenda to guide policy and the design of services. Across the globe, governments are attempting to address the challenge of ageing populations. AGE Platform Europe,[105] for instance, embraces 150 organisations representing over 150 million people aged 50-plus in the EU. Among the issues it has on its agenda is improving the care in long-stay homes; addressing the training, skills and status of those employed (and often poorly-paid) who provide formal care; taking action on elder abuse and improving rights for older disabled people. Action is welcome. However, this paper argues that the philosophy that drives and shapes and evaluates such initiatives is crucial if good rather than harm is to be done; opportunities maximised and inventiveness encouraged.

To recap: active ageing requires incentives to speed health and social care integration and a holistic approach and legislation to give that cultural change a strong anchor in society. These measures need to be backed by more rigorous research into what works, why and for whom and in what circumstance (given the diversity of older people). It requires the application of robust metrics and an imaginative use of data for instance in offering the right kind of support before a crisis is reached. It demands a proper value placed on outcomes once dismissed as soft such as an improvement in wellbeing and reduction in isolation. This, in turn, ought to encourage more innovative commissioning. It is imperative that older people are involved in the design and delivery of services and support not just for their own age group but also for the community of whom they are a part. It requires a greater investment, even in a difficult financial climate, in innovatory ideas that can be quickly developed and, if effective, turned into services that can be rolled out. As a society, we need to recognise that ageing has reached a new frontier that requires different tools to carve out a better future. The next decade of octogenarians and centenarians, for example, may require 'a little bit of help' of a type that has yet to be conceived. Indeed as 'elderpreneurs', they may well devise and develop an army of projects, as Michael Young once did, that benefits the whole of society and further confounds ageism.

Already, we are witnessing, out of necessity, a more meticulous use of scant resources, new collaborations and a greater recognition that older people are active engaged citizens with rights, responsibilities and capabilities that are of value to the whole community. (Grandparents, for example, provide 40 per cent of childcare for working parents, almost entirely unpaid.) But much more is required. One of the justified complaints of older people is that as the birthdays pass by, so they are gradually rendered invisible. However, in years to come, the sheer numbers of older people, ought to force those who are younger, and fearful of ageing, to heed the request of those who are senior, to "Look me in the eye".[106] Optimistically, it may impel more determined action against the darker side of ageing, the warehousing in sub-standard residential homes of the demented and fragile; the cumulative impact of disease and neglect; the unending loneliness and the lack of dignity in dying and the terrible toll taken by discrimination. If we fail to act, we lose the essence of what it means to be human beings living in a civil society and we darken our own last days.

In *Beyond Power: On Women, Men and Morals* the late Marilyn French writes, "The best intentioned efforts to solve human problems falter or fail because they are dyed in the same patterns of thinking that created the problem." Research for this paper has revealed a paradox. Over the past 20 years, any number of startlingly innovative and initially successful services have been piloted but most have failed to take root. This is not least because they have struggled to survive in a traditional paternalistic setting that believes the system comes first, not the needs of the individual.

Now, we have a clear choice. We can haphazardly veer between ancient and modern services and attitudes and head for a crisis in resources and human grief on an epic scale. Or we can begin to create a society of which we can all be proud, fit for the current generation of older people and for "our future selves".[107]

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For the first time in history in the UK the number of people over 60 outnumbers those under 16. A common reaction to this is pessimistic. This breeds social pessimism; as if we have created inexorably longer lives but are powerless to make the choices we need to if we are to reap the benefits. This in turn feeds ageism and deepens individual pessimism about our own future and those of our loved ones.

Without shying away from the enormity of the challenges ahead, Yvonne Roberts argues for a strategies that see active ageing – and older people – as assets rather than burdens, that focus on people as active contributors, not passive recipients.

Drawing on the work of the Young Foundation and international examples, she outlines and recommends new kinds of sustainable and scalable services with strong roots in voluntary action and the community.

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