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Early Action
Task Force

Looking Forward to Later Life

Taking an early action approach to our ageing society

Early Action Task Force

The Early Action Task Force

The Early Action Task Force is a group of leaders from across the sectors committed to building a society that prevents problems from occurring rather than one that, as now, struggles with the consequences. The Task Force is led by Community Links

This paper was prepared on behalf of the Early Action Task Force by Will Horwitz

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For more information about the Early Action Task Force visit **www.community-links.org/earlyaction**

Community Links

Our purpose is to champion social change. We pioneer new ideas and new ways of working locally and share the learning nationally with practitioners and policy makers. As a result, we are recognised as national leaders in regeneration and social policy.

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Summary

Unprecedented increases in life expectancy over the last century have not been matched with a clear understanding, across society, of what we expect from our newfound older age.

Government's approach is piecemeal and uncoordinated, driven by only the clearest looming liabilities (for example on pensions) or in response to crises (such as in social care). By reacting once problems have developed and badly managing crisis situations governments can incur great cost for little impact.

If, instead, public services, businesses, civil society and all of us as individuals were *ready,* both to take advantage of the opportunities and to successfully navigate the challenges of later life, we would experience a triple dividend – increased wellbeing, reduced costs, and increased contribution. This requires a new vision for later life. We propose some ideas that help illustrate what it might look like.

Its aim: wellbeing

Current policies target an incoherent mix of individual priorities - mortality, or income, or physical heath - while ignoring or detracting from others. Instead an overarching strategy should set one clear goal; increasing wellbeing:

- Feeling in control, happy, secure, at home, valued by others and that life has a purpose.
- Having sufficient income not to be excluded from society.
- Staying healthy, mentally and physically, or living as well as possible with health conditions
- Being connected to others via a range of personal relationships, interactions and meaningful participation.

Despite attitudes to the contrary it is not inevitable that the contributors to wellbeing - social connectedness, contribution, a decent income, secure housing, mobility, the absence of discrimination – will decline as we age.

"By reacting once problems have developed governments can incur great cost for little impact"

We suggest nine ideas to illustrate a new vision for later life.

1. Re-write birthday cards: Tackling society's pervasively negative attitudes to ageing – exhibited in, amongst much else, birthday cards which routinely mock the process of getting older - is a precursor to all the other changes described in this report. People with a negative attitude to their own ageing die 7.5 years younger than those who look on it more positively. And if poor health, increased loneliness, reduced mobility, or lower income continue to be seen as an inevitable consequence of getting older, by society and by ourselves as we age, then they will remain so.

2. Abolish age-related benefits: In middle or later life, chronological age is no longer a reliable guide to vulnerability or policy. Age-related criteria - for example in the allocation of benefits like the winter fuel allowance, free TV licences and bus passes - reinforce stereotypes about old age and misallocate resources. Instead we should focus on the major transitions at which some are ready to seize opportunity, deal with setbacks and thrive, while others struggle. Traditionally these transitions include retirement, bereavement, the onset of ill health and the loss of mobility, becoming a grandparent, and taking on caring responsibilities. It is our readiness in advance, not access to services provided afterwards, that have the most significant impact on how successfully we navigate transitions.

"Many health conditions are preventable, particularly through intervention in middle age"

3. Bind a rising state pension age to falling health inequality: Poor health in later life disproportionately affects poorer people, is exceedingly costly both in wellbeing and to the public purse. Many of these health conditions are preventable, particularly through intervention in middle age. But without the incentives in place, spending and effort to tackle health inequalities and delay the onset of health problems is pitifully low. One way to dramatically strengthen these incentives would be to legislate so that the state pension age can only rise if the gap in life expectancy between richest and poorest is shrinking. This would make state pension rises fairer, but also provide an extremely strong incentive for government to invest in tackling health inequality, since the sustainability of the state pension would be riding on it.

4. Abolish 'retirement': The opportunities in later life - to work, to contribute, to learn, to spend time with friends and family, to enjoy leisure time, just as throughout life - are not at all well captured by the concept of 'retirement', which is negative and reductive, signifying little more than a withdrawal from the labour market. We should think of this stage of life as our 'choice years' and aim to build a portfolio of activities including paid work, unpaid contribution, learning and leisure. A National Later Life Service could help us prepare, a restructured labour market would allow for gradually reducing hours and changing roles so most of us continue working past the state pension age, there would be new support for learning, and new institutions – such as Ready Institutes (see below) which would transform opportunities for participation.

5. End the befriending movement: The befriending movement ameliorates the worst effects of loneliness but does little to prevent it in the first place. Social relationships with friends and family are vital to wellbeing; in their absence loneliness is more detrimental to health than smoking. A concerted drive to prioritise relationships through the design of public services, support for civil society, and reform of the structural barriers to social participation – income, transport, planning, technology – should aim to abolish severe loneliness within ten years, leaving no role for befriending schemes.

6. Ban door knobs: Door knobs are significantly more difficult to use than levers, particularly for people with arthritis. It is just a minor example of the myriad of ways in which society could be better designed for older people. Others include public toilets, seats in shops, bus timetables, planning, housing and city design. Initiatives like age-friendly cities and dementia-friendly communities begin to address these systematic flaws. Unlike the disability movement's ongoing but incrementally successful fight for access, the approach of older people and their advocates so far has been one of mild persuasion rather than angry demanding of rights. Will this change?

7. Transform the care system: Care should provide the emotional and practical support needed to live an active life but in public provision it is an increasingly-stretched crisis response service, often doing little to promote wellbeing. This perpetuates the idea that older age is about dependency and decline not active participation and contribution. The system should better incorporate families and communities without taking advantage of them, be reoriented towards prevention, and take account of universal structures and services - transport, neighbourhood planning, shops, housing - which are just as important as the one-on-one or group support most associated with social care.

"There are no major public institutions dedicated to providing early support and investment in later life, only health and social care which deal in crises"

8. Teach later life skills: Older people navigating difficult transitions – bereavement or the onset of ill health for example – are particularly susceptible to mental health problems, with substantial knock-on costs. There are three components to the mental resilience necessary to successfully navigate transition and the first two – wellbeing, and social connection –are core to this report. The third – psychological coping strategies – is also vital. These skills should be made available to everyone approaching later life.

9. Introduce Ready Institutes: There are no major public institutions dedicated to providing early support and investment in later life, only health and social care which deal in crises. Drawing on the lessons of the previous government's aborted 'Sure Start for Later Life' and subsequent schemes, we propose a national network of Ready Institutes in every area. Each would act as a central coordinating resource – working directly with older people to link them with existing services, and driving the adoption of age-friendly processes throughout local employers, charities, shops, clubs, churches and societies. Coordinated locally, they would drive or support many of the other ideas proposed in the report.

To achieve this, government will have to be:

1. Longer term: Living longer, healthier, happier lives in later life requires a healthier, happier middle age and a series of successful transitions. Only with a rigorous focus on the impact of today's decisions on the next decade or the one after will we prioritise policies that ensure we are ready. It is not enough for our public institutions, led by government, to be capable of looking longer term - they do this occasionally in any case. They must be *forced* to look longer term in every decision, through the underlying mechanisms of government particularly the spending rules. The Early Action Task Force has proposed a series of ideas including ten year tests for every spending decision.

2. Better integrated: A focus on the longer term is not enough if money spent by one department will lead to savings in another, or while cost-cutting in one will just pile pressure on another. Some form of integration of health and social care spending looks likely in the medium term, to better align incentives which clearly distort delivery of sensible policy. But the issues covered above go far wider than health and care, to cover employment, social connection, discrimination, transport, and far more. The occasional integration of one department or funding stream with another does not seem sufficient to ensure a more coherent approach to prioritising vital objectives across the public sector. This leads to the third conclusion:

3. More local: All the issues covered above - mental and physical health, care, social connection, discrimination, employment - are deeply intertwined. Poor diet in middle age could lead to physical health problems which, soon after retirement and in the absence of good social care support, stop someone leaving the house. The subsequent isolation in turns causes deterioration in mental health, which results in further physical health problems and an onward, downward spiral. These issues are currently tackled piecemeal by various branches of government which tend to see each other as rivals rather than collaborators for the common good. Much of the fine detail of these stories is determinedly local though - the route of the local bus service, the planning of new housing, support for social clubs or public space.

This incongruence will only be resolved by devolving decision making downwards, so services and support operating in an area are joined not only to each other but to the wider structures of a place - its businesses and civil society, it's planning and housing, its community leaders, children, parents, semi-retirees: all its citizens including those most senior. This paper is not an argument for localism but it does seem one of the inevitable consequences of a forward looking, all-encompassing vision for later life.

4. More positive and more ambitious: While government fixates on our health and care needs and our pension liabilities the rest of us hope for something more from later life. We don't just want healthcare and acute social care delivered more efficiently and pensions paid later – we want to seize the opportunities later life offers, and successfully navigate its challenges; new aims, new institutions, new structures, new attitudes to age, and a new ambition. Government's first job is to lead the debate; to launch a new conversation.

Where else?

There is a wealth of relevant literature - a vision for later life needs to be assembled, not crafted from scratch - but two documents will be particularly important

1. The House of Lords' (2013) authoritative report into public services and population aging, with its comprehensive set of recommendations oriented around the future sustainability of public services.

2. The forthcoming NICE guidance "Disability, dementia and frailty in later life – mid-life approaches to prevention" due in 2015.

Introduction: Are you ready?

This paper asks if we're ready for later life. By 2025 almost one in every four people in the UK will be aged over 65; 13.5 million people up from 10.8 million today (derived from ONS, 2011). As individuals we wholeheartedly welcome our longer lives; yet in aggregate we worry. We describe ourselves as a 'pressure' a 'burden' or even a 'time bomb' that will bankrupt public services and force a dwindling working-age population to work longer and harder to keep their predecessors propped up in nursing homes.

"Are you ready?" is the name of the US government's disaster-preparedness website, where being ready for a hurricane promises little more than desperate survival through the storm. Surviving setbacks and emerging stronger is sometimes called resilience and towards the ends of our lives it is surely vital, as the challenges we face throughout life - how to cope with bereavement, ill-health, unemployment or lack of money - can assume greater significance and new ones emerge; reduced dexterity, the need to rely on others for the basic tasks of living by which we've previously defined our independence.

But "Are you ready?" is also the question US officials in pioneering cities like San Antonio ask of five year olds soon to start school. Not because school is disastrous but because it is full of opportunities: "are you ready to learn to read, to count, to progress and thrive and then, aged 11 will you be ready to move to secondary school and succeed there too?"

Throughout childhood public services help us get ready; at primary school, then secondary, then perhaps college or university. But by our middle and older ages they and much of society have retreated, lurking and only likely to intervene in a crisis; when the Local Authority decides we are in 'critical' need of social care, or the 999 call summons an ambulance. These services are necessary in the last resort of course but they are also expensive, traumatic, and much later than they need be.

"By 2025 almost one in every four people in the UK will be aged over 65"

To be ready to seize opportunity and to thrive is a more ambitious and more transformative aim than simply to be ready to fight-off disaster. It challenges many of our deeply-held assumptions about later life; it recognises and unleashes our potential, our time, our skills and experience.

Early action

The Early Action Task Force has argued that in every policy area acute, last-resort services persist in part because government and public services are unable to look ahead, to invest now in early action which could forestall later problems and their attendant costs. In its two reports, 'The Triple Dividend' and 'The Deciding Time', it argues that 'readiness' should be the organising principle around which we reorient public services and society, and it asks why common sense - preventing problems before they arise rather than waiting and paying the price - has not become common practice

'The Deciding Time' suggests there are five barriers to early action, including the short-term thinking deeply embedded in public spending rules which prevents investment now to forestall later problems, and fragmented public service delivery mechanisms which prevent investment in one area to save money down the line in another.

This paper follows on from these two reports, applying an early action lens to the experience of ageing. It asks what a bold, ambitious government could do to revolutionise the experience of aging in future decades. By looking ten, twenty or thirty years ahead and prioritising early action how could we turn our ageing society into an opportunity?

A vision for later life

In March 2013 The House of Lords' Committee on Public Service and Demographic Change, chaired by Lord Filkin, published a comprehensive and highly-regarded report; 'Ready for Aging?' It mined the policy areas most crucial to later life and made wide-ranging recommendations, some of which we include in this paper. At its heart was a criticism of government's lack of strategic thinking or vision for later life. It said:

"The Cabinet has not assessed the implications of an ageing society holistically, and has left it to Departments who have looked, in varying degrees, at the implications for their own policies and costs. The government have not looked at ageing from the point of view of the public nor considered how policies may need to change to equip people better to address longer lives."

Three months after the report was published Lord Filkin bemoaned government's refusal to produce both a vision for our aging society and *"some sort of outline of how...we should go about making that vision a reality."* (Lord Filkin, 2013).

Government's approach to our aging society - piecemeal, uncoordinated, driven by only the most pressing, looming liabilities (for example on pensions) or in response to crises (like social care) mirrors to some extent our own attitudes as citizens. Only half of 50 - 59 year olds said they had ambitions for later life (Age UK, 2013).

It is not just public services that must be ready for later life, but individuals, society and all its institutions. As a government but even more importantly as a society we must start to develop a positive, shared vision for later life and learn how to be ready for it. Government can set up the conversation but we must all take part. This paper is the Task Force's contribution to that vision.

The report

The next section looks at the underlying aim of this vision: a good later life. The subsequent nine chapters cover various ways in which society will have to change to bring about this vision of a good later life, before the final chapter draws out some implications for government.

It presents ideas rather than firm recommendations, intended to provoke discussion. The themes represented in each chapter are each worthy of at least a report on their own, and indeed have been covered in far more depth elsewhere.

We hope that bringing them together like this will help show how a sufficiently bold, ambitious plan for later life could transform society in a way that a narrow focus on particular policy areas will never achieve.

A good later life

There are some things no government, however visionary, will be able to completely eliminate from older age; bereavement, illness, declining dexterity. We can probably agree on what we want to avoid - loneliness, poverty, anxiety, unnecessary suffering. But a good life is not defined against the countless things that didn't happen but by the things we strive for; the opportunity to contribute, to love and be loved, to care and be cared for, to be in good health - mentally and physically - for as long as possible, to enjoy our home and have the freedom to experience the world outside it and the money to treat ourselves and others every once in a while.

The previous government's Social Exclusion Unit (2006) led a large piece of work on social exclusion amongst older people. They measured social exclusion along seven dimensions:

- social relationships (contact with family and friends);
- cultural activities (such as going to the cinema or theatre);
- civic activities (such as being a member of a local interest group, undertaking volunteering or voting);
- access to basic services (such as health services and shops);
- neighbourhood exclusion (feeling safe in your local area);
- financial products (such as a bank account, or long term savings); and
- material consumption (such as being able to afford household utilities and an annual holiday).

Many of these are explored in the following chapters. They found that 80% of people aged over 50 were not excluded on any of these dimensions; 13% were excluded on two of the dimensions and 7% were excluded on three or more.

> **"a good life is not defined against the countless things that didn't happen but by the things we strive for"**

Combating social exclusion is clearly important but we can aim higher - not just ensuring that no-one is excluded, but that we are all ready to thrive. Drawing on the work of Nesta (Khan, 2013), the WHO (2002), IPPR (2009), Katz et al (2011) and the Royal Voluntary Service (Hoban et al, 2013) we suggest the following ingredients are vital to a good later life:

- Feeling in control, happy, secure, at home, valued by others and that life has a purpose.
- Having sufficient income not to be excluded from society.
- Staying healthy, mentally and physically, or living as well as possible with health conditions
- Being connected to others via a range of personal relationships, interactions and meaningful participation.

No inevitable decline

People generally associate old age with decline (see chapter two, below) but this is only true if society believes and allows it to be so. It is worth, perhaps, separating out health from other factors that influence wellbeing.

The genetic effects of aging do take their toll eventually and so there is a certain inevitability about a decline in health in our last years. However, we are a long way from reaching the point at which no more can be done to prolong healthy life. To date, increases in life expectancy have been accompanied by increases in the proportion of our lives we spend with disability or health problems, which can have a strong negative impact on wellbeing.

The ‘compression of morbidity’ hypothesis (Fries et al, 2011) argues that by delaying the onset of infirmity in old age the lifetime burden of disease can be ‘compressed’ into a shorter time before death. There is increasing evidence that this is possible, with profound implications for the debate about our health as we age. ‘Healthy aging’ - extending the time during which we are free from disability - should therefore sit alongside reducing mortality as a key priority of health policy for later life.

On the other hand, despite what many think and in contrast to the assumptions embedded in many institutions, there is no inevitability about the decline of other contributors to wellbeing: social connectedness, contribution, a decent income, secure housing, mobility, the absence of discrimination. These should all be in place for everyone throughout later life. Any notion of a ‘managed decline’ must be replaced by a far more ambitious agenda to enhance and maintain wellbeing throughout life.

“Any notion of a ‘managed decline’ must be replaced by a far more ambitious agenda to enhance and maintain wellbeing throughout life”

1.Re-write birthday cards

Promote positive attitudes to ageing

Summary

Tackling pervasively negative attitudes to ageing – apparent in, amongst much else, birthday cards which routinely mock the process of getting older - is a precursor to all the other changes described in this report. People with a negative attitude to their own ageing die 7.5 years younger than those who look on it more positively. If poor health, increased loneliness, reduced mobility, or lower incomes are accepted as an inevitable consequence of getting older, by society and even by ourselves as we age, then they will remain so.

Ageism in practice

To see society's attitude to age clearly laid out you need travel no further than your local newsagent, where a long line of birthday cards will jokingly but unrelentingly portray ageing as negative; best to pretend it's not happening at all. Nearby will be a row of papers and magazines fixated on youth - on youthful beauty, youthful pursuits and youthful interests.

In an excellent diatribe on pervasive ageism, Brian Appleyard (2009) draws attention to the overwhelmingly negative attitudes towards old age in everything from adverts that promise to "fight the signs of ageing" to tabloid stories that venerate youthful beauty even in the old, to public policy professionals fretting over our 'ageing population': "Like the cosmetics ads and the tabloid stories, the reporters of the "demographic time bomb" seem consumed by the conviction that oldness is always and everywhere a bad thing."

In a focus group conducted by the RSA (Lindley & Broome, 2013), participants aged 21 - 32 were asked about their perceptions of 'old age'. Responses included 'old fogey, wizened, inactive, wrinkles, lonely, pills, biscuits, and bingo.'

Presented with a photograph of an elderly couple kissing in bed, the reaction of one woman in her twenties was "I'm sorry but that's just wrong. I don't want to see that. Nobody wants to see that."

Even so-called 'transitioners' aged 51 - 70 mentioned 'dodderies, fragility, neediness, crotchety, and fear', although they also cited 'continuity' and 'national treasures' on the more positive side.

"People with a negative attitude to their own ageing die 7.5 years younger than those who look on it more positively"

Attitudes are complex, and while simultaneously fetishising youth in our consumption habits and hating the concept of ageing, we tend to have a more positive view of individual older people, who are seen as more competent, more friendly and as having higher moral standards than people in their twenties (Sweiry & Willitts, 2012). Young people support spending on pensioners above spending on welfare for working-age adults.

Yet the two public policy narratives closely associated with older age are negative; the 'burden' imposed by older people as they become more dependent on public services, and the 'greed' associated with the baby boomer generation at or approaching retirement age who have lived the good life and left their grandchildren to pay for it and their care costs (Bazalgette et al, 2011).

Attitudes matter

There is clear evidence that ageism affects health and wellbeing directly. One particularly striking study found that people with a positive attitude to their own ageing lived on average 7.5 years longer than those with less positive self-perceptions of ageing (Levy et al, 2002). Another study conducted over 23 years found a difference of five years (Lakra et al, 2012).

A symptom: birthday cards

'Humorous' birthday card messages with a sinister undertone: getting older is synonymous with decline:

"Don't worry about getting older, just roll with the 'paunches.'"
"You know you are getting older when it takes twice as long to look half as good."
"Your secrets are safe with your friends because they can't remember them either."
"You know you are getting older when your back goes out more than you do."

'Overaccomodation' is the term used to describe speakers who are overly polite, overly simplified, slower and louder when addressing older people, caused by the stereotype that older people are likely to have hearing problems, declining intellect or cognitive problems. It can also manifest in the downplaying of serious thoughts or concerns of older people. There is evidence that it is a self-fulfilling prophecy; older people who are regularly spoken to in this way develop the characteristics that are assumed to be associated with old age (Lindley & Broome, 2013).

And these negative attitudes can be reflected in the provision of services and access to opportunity. Employers are often wary of employing older workers because of a perceived lack of skill. Mortality rates for people with cancer are improving fast for people aged under 75, dropping much more slowly for people aged 74 - 85 and actually getting worse for those aged over 85 (Macmillan, 2012), while for common mental health problems people over 75 are much less likely to have access to talking therapies and six times more likely to be on tranquilisers compared to people between 16 and 34 (Age UK, 2013b). The Mental Health Foundation (2009) have shown how people aged over 65 tend to receive lower cost mental health support packages than younger people, and at 65 people are often passed from adult mental health services to older people's services set up to deal with dementia but not depression (Age Cymru, 2013).

Meanwhile, conditions which predominantly affect older people, like sight loss or dementia, receive significantly less research and support funding than illnesses which can strike earlier in life. As we age we often treat problems like sight loss as inevitable rather than preventable (Rotheroe et al, 2013).

And as we discuss below, older people are systematically excluded from many aspects of society not consciously but because we unwittingly design space and services for the young and middle aged, while assuming wrongly that old age itself is the main barrier to participation in later life. If poor health, increased loneliness, reduced mobility, or lower incomes are accepted as an inevitable consequence of getting older, by society and even by ourselves as we age, then they will remain so.

Previous generations of older people have not challenged the underlying problematisation of old age in the same way as - for example - disability activists have successfully challenged the systematic exclusion of disabled people. This lack of challenge is, in itself, a sign of the power and pervasiveness of ageist attitudes but should begin to change, not least because the baby boomer generation currently entering later life have demanded new rights and freedoms throughout their lives and show no signs of stopping now.

Shifting attitudes to ageing would have a dramatic impact on everything else discussed in this report. Birthday cards are of course the symptom not the problem itself and we're not proposing an earnest campaign to rewrite them. Instead we need a concerted effort across all sectors to tackle pervasive ageism. Government can begin by carefully framing announcements concerned with later life (banning the word 'vulnerable' perhaps). Charities could be at the forefront of public campaigns. And smart businesses realise they would benefit too; if we live 7.5 years longer, that's seven more birthday cards to sell, for a start.

2. Abolish age-related benefits

Focus on transitions not ages

Summary

In childhood our relatively uniform pace of genetically-determined development provides some justification for aligning public policy with chronological age. This is not the case in middle or older age since environmental influences have long since overridden the genetic effects of aging - sixty five year olds are incredibly diverse in a whole range of domains; health, wealth, social connectedness, family structure, wellbeing. Age-related criteria - for example in the allocation of benefits like the winter fuel allowance, free TV licences and bus passes - reinforce stereotypes about old age and misallocate resources.

Instead we should focus on the major transitions at which some are ready to seize opportunity, deal with setbacks and thrive, while others struggle. Traditionally these transitions include retirement, bereavement, the onset of ill health and the loss of mobility, becoming a grandparent, and taking on caring responsibilities. It is our readiness in advance, not access to services provided afterwards, that have the most significant impact on how successfully we navigate transitions, reinforcing the importance of being ready.

Transitions not age

We rarely describe ourselves as old. We don't want to see our lives hemmed in by such an identity or be lumped in with everyone else born a decade or two before or after, however convenient the label is for policy makers and report authors.

Instead we describe ourselves according to the transitions we have made and roles we now fulfil; mother, husband, researcher, volunteer, friend. Some of these - both positive and negative - are particularly associated with the later years of life: grandparent, carer, widower, retired, cancer-survivor.

These descriptions - the positive and the negative - are for more useful than 'older'. Almost all are the consequences of transitions.

In childhood our age closely determines many of the major transitions we experience: starting school, the onset of puberty, moving to college, looking for a job. Environmental influences have a significant impact on how we grow up but there is a strong genetic component too which shapes our development.

"we should focus on the major transitions at which some are ready to seize opportunity, deal with setbacks and thrive"

Often public policy tries to adopt a similar approach as we age; 60 or 65 traditionally marks the transition from being a 'working age adult' to being in 'older age'. But of course we don't age in one neat transition, cohort-by-cohort. Environmental influences have long since outweighed the genetic effects of aging. Major transitions like a decline in health or mobility, bereavement, becoming a grandparent or a carer happen over an enormous range of ages. A healthy 65 year old will have more in common with a healthy 45 year old than with a recently bereaved 75 year old with dementia. Even retirement - traditionally associated with the state pension age - in reality occurs over a broad spread of ages both before and after the (now rising) benchmark of 60 or 65. In healthcare, this distinction between our age in years and the impact of our environment on health is recognised in the contrasting of chronological age with 'biological age' - the average age of someone in the same state of health. When asked what

"Rather than focus on chronological age we should focus on the important transitions that are likely to occur as we age"

stage of life they were currently in, 55% of 60–64 year olds said 'later life or old age', but 43% said 'middle adulthood (Hulme, 2012). Lord Best has described the years after traditional retirement age as our 'extended middle age' (Best 2013).

Indeed some have argued that the 'population time bomb' feared by many commentators is an artefact of our obsession with age. The older population who are deemed 'dependent' on middle age workers is usually calculated as the number of people aged over 65, and the ratio of the former to the later is increasing rapidly. But large numbers of people aged over 65 are healthy and contributing, not 'dependent' in any real sense. By defining the 'dependent' population instead as those with a life expectancy of less than 15 years (still a crude measure admittedly) the 'dependency' ratio is relatively stable not rocketing up, and much less threatening (Spijker and MacInnes, 2013).

Rather than focus on chronological age - a largely spurious measure in this context - we should focus on the important transitions that are likely to occur as we age; life events, positive or negative, which can precipitate significant changes in wellbeing.

It is at these transition points that we are often at greatest risk of experiencing a loss of wellbeing, setting us on a path away from a good later life. A long period of caring for an ill partner followed by their death may leave us emotionally vulnerable as well as lacking the social connections we neglected while caring took over. Or a sudden retirement may leave us without the sense of purpose and the comradeship we experienced at work. On the other hand, of course, some of these transitions can be opportunities to be seized. We describe below the benefits of abandoning retirement in favour of our 'choice years', while a move to a smaller home might relieve us of the costs and responsibilities of a mostly-empty house.

Currently, for too many people these transitions lead to crisis, if not immediately then eventually, as a trajectory is set, a downward spiral begins. As well as being terrible for the person involved this usually entails greater cost to the state and deprives society, friends and family of the contribution they could make. In contrast some people seize transitions as opportunities, or navigate them successfully, maintaining or developing all the characteristics identified above of a good later life.

Public services, meanwhile, tend to intervene - if at all - once a transition has led to a crisis and the downward spiral has already begun. They can manage the worst impacts of these crises but often little else.

A focus on transitions should replace chronological age in public policy for later life.

Nine transitions

Unlike in childhood and younger adulthood there has been little formal study into transitions in later life. The only in-depth analysis conducted to date is soon to be published (Robertson, forthcoming). The Calouste Gulbenkian Foundation (2013) has done some initial work on this, as has Age UK Oxfordshire (unpublished). Drawing on their work we have picked out eight commonly-experience transitions that are important to later life.

Three should be unambiguously positive, although are not experienced thus by all at present. The rest of this report presents ways in which they could become wholly positive changes.

1) Retirement: Still, for the majority, experienced as the sudden cessation of paid work around the state pension age. However, as we argue in chapter four, it is a restrictive and reductive concept that should be abolished in its current form – instead this stage of life is our 'choice years'.

2) Becoming a grandparent: with the joys, and sometimes the caring responsibilities, that come with it. Grandparents play a vital and under-recognised role in society, which should be better rewarded. See chapter four.

3) Moving home or not: a difficult decision for many older people at present, whether to downsize and move, benefiting from a smaller house or being closer to family but losing the family home and a social network built-up often over decades.

Three would be avoided if possible but are nonetheless experienced far more negatively than is necessary. We suggest ways in which the negative impacts could be minimised or negated entirely

4) A decline in health or mobility: the onset of physical or mental health conditions, including those which restrict movement particularly out of the house. These can and should be delayed or prevented entirely (see chapters three and eight) and even when they occur should not affect wellbeing to the same extent they do currently (see chapters six and seven).

5) Becoming a carer: most commonly for a parent, partner or family member. Despite the necessarily negative precursor to this transition (a relative becoming ill), it can be a powerful shared experience if supported correctly. See chapter seven.

6) Stopping driving: often necessitated by health conditions and a sensible decision, it nonetheless can have severe consequences for mobility and freedom, particularly in rural areas. This should not be the case. See chapter six.

Transitions in later life

Currently being trialled on a small scale, a National Retirement Service - modelled on the National Citizens Service (Hulme, 2012) – would be accessed in the years leading up to the traditional retirement age. It supports people to think through options for shifting to different kinds of work, for managing the transition into retirement and for their life post-retirement. The Beth Johnson Foundation have successfully trialled various versions of 'life coaching' or support services for people in their fifties and older, as part of their pioneering life course approach to ageing (Wealleans, 2013).

One is unambiguously negative:

7) Bereavement: The loss of a loved one, for example a spouse or partner. Nonetheless some will withstand the trauma much better than others. Social support is particularly important, as we explore in chapter five.

And one is entirely unavoidable:

8) Dying: A lot of taboo surrounds death but a good death is surely the culmination of a good later life and readiness for the end of life is as crucial as readiness earlier on. This report doesn't cover dying, but Demos' excellent 'Dying for Change' report (Leadbeater, 2010) does better than we could.

Implications for income

This analysis argues that we should stop differentiating between people based on their age. One of the clearest examples of where public policy does this already is in the provision of 'universal' age-related benefits, for example the winter fuel allowance and free bus passes and TV licenses, where people over a certain age are deemed inherently more in need of support, or in lower tax rates on income for retired people.

"older age is no longer a proxy for poverty so there should be a 'presumption of equality' across age groups"

Of course many older people are surviving on low incomes. Fourteen per cent of retired people live below the poverty line (1.6m) and 8% live in 'severe poverty.' Rates of poverty increase with age so those aged over 80 are most likely to be in poverty compared to younger retirees. Women, disabled people and people from BME groups are significantly more likely to be in poverty in retirement and there is a significant gap between the highest and lowest income deciles; the wealthiest 10% of 55–64-year-olds each have more than £1.3 million in assets, compared to the least wealthy 10% who each own less than £28,000 (Age UK, 2013b)

However older people are less likely to live in poverty than working age adults, a dramatic turnaround from the situation at the start of the millennium when older people were far more likely to be poor (JRF, 2013), and income inequality is greater among working age people than pensioners. Meanwhile the average income for older people - traditionally much lower - is rising just as average income for working age adults falls, and they are predicted to be equivalent in ten year's time (Harrop, 2013).

The Fabian Society's Andrew Harrop (2013) has used this to argue that "older age is no longer a proxy for poverty so there should be a 'presumption of equality' across age groups." He suggests incomes in retirement should be taxed at the same rates as working age income (at least at the median), and that "less protection from the austerity cuts for older people could be part of a 'grand bargain' – with revenue used to fund health and wellbeing."

Changes like these naturally risk being seen as punitive even though their justification is sound. They would, of course, be politically risky, and there are legitimate concerns about the stigma attached to means-tested benefits and its impact on take-up rates; if all means-tested benefit entitlements were taken up, pensioner poverty in 2011 would have been 9%, rather than 15% (Age UK, 2013). On the other hand, every time the winter fuel allowance is defended on the basis that 'vulnerable pensioners' need it to survive it perpetuates the stereotype that older people are vulnerable and in need of our support, rather than - as are people of any age - widely-varying in assets and vulnerability.

Where politicians have advocated abolishing age-related benefits they have done so on the basis that it will save money. This might be true, but is not enough on its own. It would be stronger to argue that it is wrong to associate age with vulnerability in adulthood. Instead the money should be shifted into funding early action during our middle age to improve wellbeing in later life, such as the ideas suggested throughout the report. It could be focused particularly on support in the lead-up to transitions, perhaps to fund the network of Ready Institutes we suggest in the final chapter, and some of it could be used to increase take-up of, and reduce the stigma associated with, means-tested benefits.

The state pension is, of course, an age-related benefit as well but we would exclude it from this analysis because unlike the others it is not justified on the basis of older people's special 'needs' but as a core entitlement paid for by a lifetime of national insurance contributions, just as healthcare is throughout life. Nonetheless we argue below that the state pension age should be come increasingly dissociated from retirement (an outdated concept in itself).

While the state pension is still important – over half the retirement income for 73% of single pensioners is from the state pension and other benefits, and they are the only source of income for 16% (Age UK, 2013) - it is of declining significance overall: in 1977 retired

"Abandoning age as a proxy for vulnerability is just one way to confront the stereotypes associated with later life"

households received, on average, 18% of their income from private pensions compared to 53% from the state pension; by 2010/11 the state pension contribution had fallen to 38% and the proportion of income from private pensions risen dramatically to 41% (ONS, 2012).

Abandoning age

Abandoning age as a proxy for vulnerability is just one way to confront the stereotypes associated with later life outlined in the previous chapter. Focusing instead on transitions – as much on the lead up to them as their aftermath – is at the core of the remaining chapters.

3. Bind a rising state pension age to falling health inequality

Extend healthy ageing for all

Summary

Poor health in later life disproportionately affects poorer people, is exceedingly costly in wellbeing and to the public purse, and is often preventable, particularly through intervention in middle age. But without the incentives in place, spending and effort to tackle health inequalities and delay the onset of health problems is pitifully low.

Meanwhile, to reduce unsustainable future state pension liabilities government plans to raise the state pension age in line with life expectancy. This is coherent policy given rapidly rising life expectancy, but means that poorer people - who are usually less healthy and die younger - will lose out far more than richer people. A fair solution would be to raise the state pension age only when health inequality reduces.

Making this a statutory link - so government can only raise the state pension age when the gap in (healthy) life expectancy between the richest and poorest has fallen - would provide a strong financial incentive to tackle health inequalities, in order to forestall looming pension liabilities. An added benefit would be the considerable savings in health and social care spending as a result of improved health in later life.

Health in later life

Ill health is clearly detrimental to wellbeing; the obvious distress of diagnosis and prognosis, the potential loss of mobility which can be an enormous barrier to social participation, the extra costs which can put a severe strain on income, and the new role for friends and relatives who might be taking on caring responsibilities. We cover, in other sections, how services and individuals could be better prepared (for example the importance of support with mobility in maintaining social connections). Instead, this section concentrates on how to prevent or delay the onset of ill health in the first place.

A decline in physical health clearly becomes more likely as we age. Much of the suffering endured by older people today is preventable or treatable but goes unprevented or untreated. Significant advances in medical technology can keep us alive longer but they have not been matched by advances in the social structures and services that influence health more widely and deliver these technologies. This means that the proportion of our lives we are likely to spend living with a disability in our final years has not diminished, and that our wealth has an enormous impact on how healthy we are likely to be into later life.

We don't age healthily

A woman aged 65 now can expect to live another 21.1 years, half of this free from disability (for men the figures are 18.5 and 10.1 years disability-free). Two fifths of people aged over 65 have a limiting long-standing illness. The post-war generation currently entering retirement do so with lower rates of heart disease (primarily thanks to reductions in smoking) but higher rates of diabetes, obesity and mental health problems (Melzer et al, 2012). Of those born in 1946 (turning 74 in 2015) 54% have hypertension, 31% are obese and 25% have diabetes (Pierce et al, 2012).

The main health conditions affecting people in later life include heart disease, strokes, dementia, arthritis, cancer, incontinence, osteoporosis, malnutrition, hearing and sight loss.

Health is unequally shared

The authoritative Marmot Review (2010) laid bare the impact of inequality on health across the life course; many of these impacts accumulate over decades and are experienced most severely in later life, not least the 17 year difference in disability-free life expectancy between people living in the richest and poorest areas.

"Significant advances in medical technology can keep us alive longer but they have not been matched by advances in the social structures and services that influence health more widely"

Middle age is vital

The Chief Medical Officer (2012) has identified seven 'health risk' factors; smoking, binge drinking, low fruit and vegetable consumption, obesity, diabetes, high blood pressure and raised cholesterol. These are most common in middle age and much less common in young people and older people: middle age is key.

These are as much if not more to do with the cultural influences and economic structures which surround us as with individual choices. Hence the most significant 'lifestyle' factors linked to poor health throughout life are themselves strongly determined by socio-economic status.

We can stay healthier for longer

The Compression of Morbidity thesis (Fries, 2011) says that it is possible to delay the onset of disease until much closer to death, increasing the proportion of our lives we spend in good health. This could have profound implications for our aging society, and should be given far more prominence in public policy.

An extensive, well-evidenced literature suggests how we could begin to reduce health inequality and extend healthy ageing, yet government pursues most of these half-heartedly at best. To take just three simple examples:

Exercise: "If exercise were a pill, it would be one of the most cost-effective drugs ever invented." Exercise can reduce the risk of heart disease, stroke, diabetes, depression, dementia, falls, and cancer (Age UK, 2013 & NHS, 2013b). The Department of Health (2004) estimated the cost of physical inactivity in England at £8.2bn annually. Yet only 20% of adults undertake the recommended level of exercise. (BBC, 2013b). In Sweden, as just one example, employers are required to offer a tax-free allowance worth the equivalent of several hundred pounds for employees to spend on exercise or health-promoting activity, in a scheme called Friskvard.

Diet: The Food Standards Agency has estimated 300,000 deaths a year can be attributed in part to poor diet (NICE, 2010). The costs of poor diets have been estimated at £6bn a year (BBC, 2005).

Smoking: Aggressive and sustained anti-smoking campaigns, and more recently the bans on smoking in public places and on advertising contributed to smoking rates redcing by half between 1980 and 2007 but 21% of adults still smoke and that has not reduced since 2007 (NHS Information Centre, 2010).

Employers leading

In Sweden, each employee is entitled to 3,000 kroner (roughly £330) each year to spend on activities related to keeping healthy. The scheme is called Friskvård, which translates as 'wellness' or 'healthcare' and covers a whole range of sports, dance, martial arts, stress management courses, office massages, and even choral singing in the workplace.

In his 2004 report Securing Good Health for the Whole Population David Wanless wrote:

"What is striking is that there has been so much written often covering similar ground and apparently sound, setting out the well-known major determinants of health, but rigorous implementation of identified solutions has often been sadly lacking... If we are going to capitalise on the growing cross-party support for early action, we must recognise and tackle the barriers, align the incentives and, first and foremost, we must win hearts and minds throughout Whitehall, local government, public services and wider civil society."

It could have been written this year.

Harnessing the state pension age for public health

Government clearly needs stronger incentives to improve public health. The strongest incentives in the public sector are usually financial and often act against early action; meeting this year's budget takes precedence over the possible long term savings of investment for the future. Clearly the looming prospect of increasingly unsustainable healthcare costs for older age is not yet enough to stimulate serious action on public health.

However the state pension - perhaps because it is easy to forecast - is a public sector liability which government is taking steps to tackle, by gradually raising the state pension age ultimately in line with life expectancy. This penalises poorer people unfairly, since the poorest are likely to be less healthy in older age and die much younger. In roughly half the local authorities in the country healthy life expectancy at birth is less than 65, below the (male) state pension age even before it begins rising (ONS, 2013).

City-wide exercise

The Ciclovia movement was born in South America several decades ago; every Sunday in over 100 major cities large sections of roads are closed to traffic and opened to cyclists, walkers, runners and skaters. In Bogota over 1m people take part each week and it accounts for an astonishing 14% of the entire city's recommended weekly exercise. (Heath, 2012).

One - clearly impractical - way to address this unfairness would be to set a bespoke state pension age for each individual according to their healthy life expectancy. The only other option is to reduce health inequality such that when we all have the right to claim a state pension we all have roughly the same number of healthy years during which to enjoy it.

"There is a moral case for increasing the state pension age only when health inequality falls"

There is therefore a moral case for increasing the state pension age only when health inequality falls. Enshrining this in law, such that the state pension age could only rise if measures of (healthy) life expectancy fell, would have the added benefit of significantly increasing the incentive on government to tackle health inequalities, since considerable, and easily predictable, future pension costs would be riding on their success, alongside the health care costs which already result from our failure to act effectively.

Government doesn't tackle health inequalities because it doesn't have an incentive to do so. But a brave, forward-thinking government could embed public health deeply into the psyche of the public sector if it announced and then embedded in legislation that the state pension age would only rise as planned once health inequalities had been reduced.

There would be targets and target dates, which would maintain the status quo until they were reached. The state pension age would become a factor not just of life expectancy but also of inequality in life expectancy.

Any government tempted to repeal the Bill would do so in the face of significant public anger and in the meantime it would be embedded in OBR spending forecasts and in Treasury spending plans. It would tie-in these large economy-level indicators to the everyday actions that determine our health in later life.

4. Abolish "retirement"

Rethink time, work, learning and contribution in later life

Summary

A new stage of life has emerged: the years or decades around and after the traditional retirement age during which some thrive but many struggle. The opportunities - to work, to contribute, to learn, to spend time with friends and family, to enjoy leisure time, just as throughout life - are not at all well captured by the concept of 'retirement', which is negative and reductive, signifying little more than a withdrawal from the labour market.

We should abolish 'retirement' and replace it with our 'choice years' – a portfolio mixing some paid work with volunteering, informal social contribution, leisure, learning and time with friends and family. It would involve:

- Developing a universal mid-life career review service, to help people plan for the transition
- Restructuring the labour market so it continues to harness the skills of workers as they age.
- Targeting the abolition of traditional retirement - so that 90% of people continue with some paid work after the state pension age.
- Increasing support for learning of all kinds into later life
- Providing opportunities for and recognition of unpaid contribution (for example through the Ready Institute movement discussed below).

These opportunities would be suitable for people right up until the end of their life - the constituent parts of the portfolio shifting perhaps, but no one denied the rights to contribute, learn, socialise and gain recognition.

By keeping us happier, healthier and earning for longer it would save public money but more importantly it would unlock vast potential for economic and social contribution.

"Retirement"

Before the introduction of the state pension 'retirement' held little meaning at all - most would work until it was no longer possible, at which point family were the only source of support. In the early 20th century, the introduction of a state pension granted those lucky enough to survive to 65 a few years at the end of their life with some independent financial support from the state.

"We should abolish 'retirement' and replace it with our 'choice years'"

Life expectancy increased and the state pension age remained constant during the latter half of the twentieth century, but a new stage of life - after traditional retirement age but before very old age - has taken on increasing significance. Lord Best (2013) has argued that we have in effect extended middle age: "And by understanding the opportunities during this extension of middle age, we can prepare for those later years, taking the steps to prevent and address in advance the issues of frailty and ill-health we may face later."

By 2030 a 65 year old woman can expect to live another 26 years (23 for a man) (House of Lords, 2013); when the contributory state pension was first introduced only a third of men and 40% of women even lived to 65 (BBC, 2011).

Figures like these are usually used to illustrate the unsustainable future of our pension system, but the potential of these years for increasing wellbeing, contribution, good health and happiness has been cruelly overlooked

Reforming the workplace

BT have introduced a set of flexible working practices that are available to all employees but specifically designed for older members of staff to improve retention and ease the transition into later life. They include part time working, and an easing of working commitments in the latter stages of work ("Wind Down" and "Ease Down" respectively), "Step Down" whereby senior employees continue to work but with less responsibility, and "Helping Hands" whereby employees can take time out to work for a charity (NHS Employers, 2013).

The luckiest develop a 'portfolio' lifestyle mixing paid work with volunteering, informal social contribution, leisure, learning and time with friends and family; not really 'retired' - withdrawn - at all but just changing roles to suit a different stage of life. Good luck - understanding employers or fortunate career choices, strong social networks, good health and sufficient income - all leave people in a position to choose.

Others of us struggle, unable to continue working or to find ways of participating, perhaps constrained by health or family circumstance, forced out of the labour market and unable to find roles that provide meaning and support wellbeing. The strong value society places on paid work can exacerbate a sense that these years without it are reserved solely for a gradual decline.

Crucially the institutions of society do not help at all with this transition: public and private services supporting the labour market virtually stop at 65 if not earlier, there is no support to plan for the transition, very little opportunity for learning, and only patchy provision of support to volunteer or engage unpaid. Perhaps most importantly of all, there is little consensus in society on what these years are for.

There is a similar vacuum in government policy, which largely ignores this period of our lives, seeing older people almost entirely through the prism of a pension liability, and then the vulnerability and cost associated with the last few years of social care and health problems.

Our 'choice years'

In place of retirement we could call this stage of life our 'choice years' – in many ways the best of all; free from the anxiety of being a teenager, the responsibilities of being a parent, the stress of full-time work. It should be a stage of life replete with choices, over how to spend our time and money. What could these choice years involve?

1) Some paid work

The first and biggest break is that paid work (of the right kind) should continue into our choice years; we will no longer experience the sudden cessation of employment that defines retirement.

This is slowly beginning to happen. In 2008 one third of employees said they would like to work beyond 65 (Bazalgette et al, 2011). Older people are working more; between 1995 and 2010 the employment rate of those aged over 65 increased from 8% to 12% for men, and 3% to 7% for women. There are now over one million people aged over 65 in work or looking for work (Caldwell, 2013). On the other hand, people aged 50 - 64 are the most likely of any age group to be unemployed for longer than one year (Bazalgette et al, 2011), suggesting a labour market that is not well adapted to older adults even before state pension age.

Working longer is usually argued for on financial grounds, and recent reforms in this vein will see the state pension age rise over the next few decades. These arguments are of course important and touched on below but there is another - more significant - reason why we should be able to choose to carry on working: the right kind of work makes us healthier and happier.

"an institution oriented towards harnessing the skills and experiences of people of all ages"

Work is strongly associated with better mental health in adults (DWP, 2012), and in the medium and long-term retirement seems to have a negative impact on both mental and physical health. For some the abrupt departure from the workplace and working routines of decades can sever social ties and remove an important sense of purpose; many of the risks associated with retirement are social, emotional and behavioural as well as financial (Hulme, 2012).

Seemingly contradicting this, in the short-term retirement leads to a health boost for the majority (although not for all) (Sahlgren, 2013). For those who seize the opportunity to develop new interests and devote more time to friends and family, it is a profoundly positive time associated with increased wellbeing and better mental health. Feeling in control of the decision is a crucial determinant of successful retirement; feeling forced to retire is as damaging to mental health as feeling forced to continue working (Grant, 2013 and Bazalgette et al 2011).

In our choice years we will square this circle; harnessing the social and emotional benefits of work - the sense of purpose and contribution, the social network, and of course the income - along with the health boost that many of us experience on retirement through having more time to develop new interests, spend time with friends and family, worry less and enjoy more, and finally the sense of control – the choice - that is vital to wellbeing.

How? Our choice years will see us working, but choosing to work less and in different roles.

To achieve this, a labour market still designed in the interests of a young or middle aged, 'full-time' male worker will need to be transformed (with benefits for all of us) into an institution oriented towards harnessing the skills and experiences of people of all ages, with opportunities to take part for anything from 1 to 60 hours each week, as flexibly as necessary.

Of course being forced to work longer, by government edict or financial imperative is not the same as choosing to do so, and feeling in control of the decision over how long and how to work is vital for wellbeing.

The New Economics Foundation has argued that older workers could reduce their working week by one hour each year. An employee on 40 hours per week when they were 55 years old would be working 30 hours by the age of 65 and, and only 20 hours if they continued until they were 75 (Coote, 2013). Age UK (2012) recommends that all jobs should be 'flexible by default' such that employers would have to justify why a job could not be done flexibly. This should be accompanied by a range of support for employers and employees to manage the transition. They have also (Age UK, 2013c) recommended that the next round of government's Work Programme includes extra payments for providers who successfully support older workers into employment, and that people over 55 are referred to the programme after six months not one year.

IPPR have suggested allowing parental leave to be transferred to grandparents, while in Sweden pension income is taxed at a higher rate than employment income, increasing the incentive to keep working. None of these come close to the scale of change needed but they point in the right direction, as does government's recent abolition of the default retirement age.

The engagement of employers will be absolutely vital to this agenda and some are leading the way. BT have introduced a set of flexible working practices that are available to all employees but specifically designed for older members of staff to improve retention and ease the transition into later life. They include part time working, and an easing of working commitments in the latter stages of work ("Wind Down" and "Ease Down" respectively), "Step Down" whereby senior employees continue to work but with less responsibility, and "Helping Hands" whereby employees can take time out to work for a charity (NHS Employers, 2013). In the US, a new organisation Encore promotes "encore careers" – "jobs that combine personal meaning, continued income and social impact in the second half of life." (www.encore.org) Best practice in the business world could quickly become standard practice in the public sector and ultimately across all employers.

2) Unpaid contribution: care, volunteering, participation

The second component of our choice years will be unpaid participation. A sense of being valued, of having purpose, participating, and contributing is vital to wellbeing throughout life, but traditionally recognition for the contribution we make has tailed off as we stop paid-work and age, until we are seen merely as the passive recipients of services and support in our final years (e.g. see Hoban et al, 2013).

This is profoundly wrong even in our final years but nonsensical in the preceding years where we often participate more, in more ways, than at any other time in our lives. Some of this is through work as above, some through formal volunteering schemes but most in other ways; caring for relatives or grandchildren, the everyday social support we provide for friends and family, our participation in leisure activities and in our communities where the benefits to others are not at all explicit but nonetheless vital. Community Links has coined the phrase 'Willing Citizens' to describe the everyday actions of millions of people which together build and sustain a good

"A sense of being valued, of having purpose, participating, and contributing is vital to wellbeing"

society (Council on Social Action, 2008). In later life our willingness does not diminish and so services and structures must not quash it.

Recognition

The first step is to properly recognise the value of unpaid contribution. In total the Royal Voluntary Service (2011) estimated older people made a positive contribution worth £40 billion to the UK economy in 2010, which will rise to £77bn by 2030. Nearly 4.9 million people aged 65 and over (60%) take part in volunteering or civic engagement (Age UK, 2013b). Grandparents provide 1.7bn hours of childcare for their grandchildren each year (Grandparents Plus, 2013) and 43% of children under five whose mother is working are looked after by grandparents (Age UK, 2013b). Almost one in five baby boomers - aged 55-64 - are providing some form of care, while the figure is only slightly less at 16% for 65-74 year olds (Carers UK, 2012). (Care is covered in more detail below).

Recognition of these activities - where it exists at all - is largely confined to a personal 'thank you', or sometimes the organisational sign of appreciation - a certificate or a volunteer social event. Some newer models like time-banking in schemes such as Spice or the Circle movement allow contributions of one form to be exchanged for services of another.

Sometimes the state goes some way to providing recompense, for example in the provision of carers' allowance, but delivers it so begrudgingly that it rarely conveys appreciation or value. Sometimes it recognises the value, particularly of volunteering, but misunderstands people's motivation; the unsuccessful 'Experience Corps' launched by the previous government showed

that people do not want to be exhorted to 'volunteer' by a centralised, heavily-marketed, target-driven effort from central government.

Mostly however unpaid contribution goes undervalued because we attach such cultural value to work which attracts a salary. The paid labour market is the centre of intense political attention, legislation and public funding, with ministers and departments devoted to it. Unpaid contribution - not just in later life - is in contrast covered haphazardly, where at all, by a disparate range of policies and poorly conceived incentives.

We suggest, then, that formal volunteering and informal everyday participation in social activities should be aggressively promoted by public policy wherever possible not just because of the cost-savings associated with having services delivered for free but because of the benefits for all of us in meaningful participation in rewarding activity. This will be integral to the Ready Institute proposal we develop in chapter nine.

3) Learning

Learning is yet another area which public policy increasingly views only through the lens of employment. Opportunities for learning are heavily weighted towards childhood and adolescence, with some job-based training for our first few decades in work, all oriented towards improving labour market performance, all justified as 'investment' in human capital which earn returns via higher wages.

This is important of course, and opportunities to learn will be crucial to the labour market shifts described above, so there is a role for work-related schemes specifically tailored to supporting moves into new roles. But it offers only a painfully narrow view of the importance of learning to wellbeing, health and happiness.

There is evidence that learning, particularly informal learning, improves wellbeing (Jenkins & Mostafa, 2012), providing purpose, new social networks and opportunities to participate. Institutions like the University for the Third Age and adult education colleges are important but currently only 13% of people over 75 are engaged in learning, compared with 30% of 50 - 74 year olds, and 64% of 18 - 24 year olds (Schuller & Watson, 2011).

Julia Neuberger (2008) elegantly explains the importance of learning in later life:

"It means learning for the sake of it, not necessarily to make yourself employable, but so that you can play a wider role in society or be a more rounded person. It might be about learning skills as much as learning things: joining a choir, learning to sculpt or starting a rock group. It might be, like Peggy McAlpine, learning to paraglide off the coast of Cyprus a few days after her hundredth birthday. It all keeps people active and healthy, builds society and asserts the idea of education as a lifelong activity."

The Inquiry into the Future of Lifelong Learning (Schuller & Watson, 2011) suggests a modest redistribution of resources towards older age, a national set of learning entitlements, and far greater focus on flexibility in learning opportunities.

A National Later Life Planning Service?

The constituent parts described above of our choice years will require profound changes in existing institutions but also, perhaps the foundation of a new one, to support individuals to put together their own portfolio.

In a report with the Gulbenkian Foundation Lord Wei has identified the lack of guidance and support for older workers about the later stages of their career and the transition into this new age. He has proposed a National Retirement Service modelled on the National Citizens Service (Hulme, 2012), accessed in the years leading up to the traditional retirement age, which supports people to think through options for shifting to different kinds of work, for managing the transition into retirement and for their life post-retirement. The Beth Johnson Foundation have successfully trialled various versions of 'life coaching' or

support services for people in their fifties and older, as part of their pioneering life course approach to ageing (Wealleans, 2013).

A new national service of this kind will certainly be an important part of the transition. How it should be structured and delivered is less clear. The Experience Corps effort cautions against new, centrally-run institutions. Indeed a 'Sure Start for older people' was also proposed by the last government but failed to get off the ground as well. We propose some ways in which this advisory and planning function could be integrated into a new institution which we've called the Ready Institute.

Ending retirement – a government target?

These changes and many more will only come about through government's clear leadership. This could be led by a grand challenge and target, to end retirement, in two senses.

Firstly to gradually increase the proportion of people who choose to stay in paid-work after the state pension age, not because of financial necessity or government edict but because they choose to.

Secondly, and connected to this, the ambition to end retirement is about changing its negative connotations – that retirement is about withdrawing from the labour market and from active contribution to society. This is as much a cultural problem as one of legislation or spending directly; 'retirement' does not do justice to the vital roles we continue to perform as we age and their value to society, and therefore should be retired itself. Instead these are our choice years – in many ways the best we have. We should be able to make the most of them, however we choose.

"'retirement' does not do justice to the vital roles we continue to perform as we age and their value to society"

5. End the befriending movement

Prioritise meaningful participation, relationships, and social connection

Summary

Befriending schemes ameliorate the worst effects of loneliness but offer only a role as passive recipient rather than an opportunity for meaningful participation

Nonetheless they are clearly important while severe loneliness persists. Social relationships with friends and family are vital to wellbeing; in their absence loneliness is more detrimental to health than smoking.

To stave off loneliness we should better recognise the ways in which it is caused and prevented:

1 Via the delivery of public services, which can directly help or hinder relationships forming, for example in social care, or health.

2 In support for, and structures associated with, social activities - charities, churches, social or sports clubs, museums, galleries

3 Through wider structural factors - income, transport, environment, planning - which create the conditions for social contact.

A perception of meaningful participation is vital in ensuring social contact has a positive impact on wellbeing; feeling like a passive recipient of a service negates its possible benefits.

Government should explicitly recognise its influence on relationships in all these spheres, and account for their value in making decisions. A concerted drive to abolish severe loneliness within ten years should leave no role for befriending schemes.

What's wrong with befriending

We could all agree that it would be better if foodbanks did not need to exist. While people cannot afford food they are surely vital, but in a good society there would be no demand for their services because everyone would have enough to eat.

In similar fashion befriending services identify a need - older people living alone who are often extremely lonely - and provide a volunteer-driven response; regular visits intended to provide some companionship and alleviate the worst consequences of loneliness.

"Social relationships with friends and family are vital to wellbeing; in their absence loneliness is more detrimental to health than smoking'"

However just as we should be working to eliminate the need for foodbanks so we should aim to abolish befriending schemes within the decade. Their existence is an indictment of a wider failing, and that is what we should try to solve.

The importance of social connection

In a major piece of research over the last three years hundreds of older people were asked, in surveys and focus groups, what contributes most to their wellbeing. The answer was clear and unsurprising: "social connectedness." The relationships and social contacts with family, friends and within communities that bestow a sense of belonging and value, of love and comradeship, of 'fun, good conversation and laughter' (Hoban et al, 2013).

"People with more social connections develop fewer colds, are healthier and happier"

Loneliness is usually understood to mean the "subjective, unwelcome feeling of loss or lack of companionship" (Campaign to End Loneliness, 2013). It is distinct from 'social isolation' which is an objective measure of the number of social contacts we have. So we can feel lonely even when we are in relationships or surrounded by friends and neighbours.

While we will all experience loneliness at times its most pernicious effects are felt when it persists and becomes a chronic condition. In a large meta-analysis Holt-Lunstad (2010) found that loneliness and social isolation can have a similar impact on the risk of death as smoking or drinking, and more of an impact than many well-understood risk-factors such as obesity or lack of exercise. It is also closely linked to depression: one study found that amongst those aged 65 - 74, just 9.5% of people with ten or more close relationships showed signs of depression; the figure for people with one or none was 29% (Bazalgette et al, 2011). And longitudinal research has proved that loneliness leads to depression, not the other way around (Bolton, 2012). People with more social connections develop fewer colds (Cohen et al, 1997), are healthier and happier.

Loneliness is not a problem specific to, or even most severe amongst, older people; younger people are more likely to feel lonely and are more likely to worry about it (Griffin, 2010). Over half of 18 - 34 year olds have felt depressed because they were alone compared to 32% of those aged over 55. In general we feel less lonely as we get older, but this trend reverses for the last years of our lives.

Men's sheds

Men's Sheds provide tools, equipment and space where older men can meet to work on hands-on projects; a collaborative version of the shed at the bottom of the garden. For older men who do not feel comfortable in traditional services for older people they provide a vital opportunity to build and maintain friendships and keep active. Started in Australia they have now spread to the UK, and have their own association here. www.menssheds.org.uk

Around 900,000 older people in the UK are estimated to be lonely; around 10% of the population aged over 65. Comparing studies across decades suggests the proportion of older people reporting chronic loneliness has remained fairly constant, although the proportion saying they are sometimes lonely has increased considerably (Bolton, 2012).

Loneliness can afflict us all at any age but some transitions common to later life put us particularly at risk; almost two thirds of widows and widowers over 52 report feeling lonely some of the time or often. And while a fifth of adults in good health report feeling lonely, the figure is three times as high for adults in poor health (Beaumont, 2013). Two fifths of people with dementia say they are lonely (Kane and Cook, 2013). Older people who see their children less than once a month are twice as likely to be lonely as people who see their children every day. There are about 3.8m older adults who live on their own; and of those living alone aged over 75 nearly three quarters say they feel lonely. (WRVS, 2012).

Crucially it is the relationships and support we have before and during transitions that are important, more than those developed afterwards in response (Bazalgette et al, 2011). And a feeling of being in control of life can be a powerful protector against feeling lonely (Newall et al, 2013). The trajectory we set in the years and decades leading up to transitions is crucial to our social relationships in older age.

"public policy regularly intervenes to promote physically healthier lifestyles but does not take account of our social networks and relationships"

Prioritising contribution and relationships

We all know that eating a healthy diet and taking regular exercise are good for our health and wellbeing and we try and invest time and resources in them. We don't necessarily feel the same way about building and maintaining friendships, even though social networks are crucial not just to our enjoyment of life now but also our health and wellbeing in the future. Similarly, public policy regularly intervenes to promote physically healthier lifestyles but does not explicitly take account of our social networks and relationships even though, just as with diet or exercise, our behaviour is strongly constrained by statutory, voluntary and business actors.

We suggest government has three spheres of influence in which it already, largely unconsciously, shapes social relationships.

1 Public services - Commission for Love

The first is in the direct delivery of public services. Community Links have coined the phrase 'deep value' to describe an effective relationship between the people delivering and people using public services, in which it is the "deeper qualities of the human bond that nourish confidence, inspire self esteem, unlock potential, erode inequality and so have the power to transform" (Bell and Smerdon, 2011). Public services can be delivered in ways that enhance or detract from these relationships; for example 60% of Local Authorities commission social care visits lasting less than 15 minutes (Leonard Cheshire Disability, 2013).

The public sector is extremely conscious of the diet it provides for children in school and patients in hospital - rightly aware of its role in promoting public health in its direct interactions with citizens. We suggest public services should be equally conscious of their impact on effective relationships, and design these into not out of the delivery process. For older people this is particularly important in hospital and social care; recent scandals have exposed the awful consequences when care is delivered without compassion; this care and concern cannot be legislated for directly but it can be designed for, by taking into account the importance of relationships as separate from the transaction itself.

Shared Lives schemes, whereby families accommodate and support people with social care needs and are paid a small amount in return, are a very strong example of the right approach - providing for basic care needs but in a way that prioritises building and sustaining social relationships, and not coincidentally saves money. Similarly effective are Village Agent schemes, where local residents are paid to act as a contact point for older people, providing a listening ear, helping arrange repairs or help around the house, proactively approaching people who might benefit from extra support, signposting to services, and connecting to social networks. Taking on a role that might have been filled in the past by a local shop-owner, postmaster or vicar.

2 Social activities - promote meaningful contribution

Government's second sphere of influence is in the funding, support and legislative environment for activities that facilitate social connections. Grant (2013) identifies four domains of social activity: civic engagement (membership of political parties, charities, churches), leisure activity (membership of sports, music, arts or social clubs), cultural engagement (going to the cinema, theatre, art gallery, concert), and social networks (friends, and family).

"Being a 'beneficiary' might bring certain practical benefits but being a recipient is a passive experience"

The environment government creates - through legislation, support and funding is crucial to the first three of these - through grants, tax breaks, gift aid, legislative frameworks, and much more. Even the fourth is more amenable to government intervention that many assume; the 'marriage tax break' being just the latest example. Demos (Bazalgette et al, 2011) argue that "ensuring that core services such as libraries and leisure centres are available and accessible to older people is therefore an essential part of supporting active ageing." These provide far more than opportunity for social relationships but that consideration should be at their core.

Critical to this is a greater appreciation of the importance of 'meaningful contribution' to wellbeing (e.g. Khan, 2013). Efforts to tackle loneliness, for example, are more successful when they involve meaningful participation in group activities as opposed to one-on-one service-based activities like befriending schemes.

This is not surprising - the reason we go to church, play football, join a reading club, or volunteer is not, explicitly at least, to stave off our own loneliness. When we are recipients of a service - however well meaning - we generally do not feel as valuable as when we are contributing to it ourselves. No one should ever see themselves as the 'beneficiary' of a volunteer programme (or of a professionally-delivered service, for that matter). Being a 'beneficiary' might bring certain practical benefits but being a recipient is a passive experience. Schemes like Men's Sheds provide a clear alternative; places where older men can meet, often in an actual shed, to share tools, to collaborate and to socialise, but most importantly to participate.

3 Wider society

Ultimately loneliness is a symptom not just of the absence of particular schemes but by the structure of wider society - the way housing is designed and allocated, transport is organised, technology is accessed, time is valued. We look at these issues separately in the next chapter.

6. Ban door knobs

Build an environment suitable for later life

Summary

"It is not being older that is a problem but being older in our current society" (Forrest, 2013).

Door knobs are significantly more difficult to use than levers, particularly for people with arthritis. It is just a minor example of the myriad ways in which society could be better designed for older people. Others include public toilets, seats in shops, bus timetables, planning, housing and city design.

Initiatives like age-friendly cities and dementia-friendly communities begin to address these systematic flaws, although unlike the disability movement's ongoing but incrementally successful fight for access, the approach of older people and their advocates so far has been one of mild persuasion rather than angry demanding of rights.

The problem with door knobs

From last year new housing developments in Vancouver are required to install levers rather than knobs on doors and sinks (Badger, 2013). At face value it might seem a bizarre intervention for city government and for those in early and middle age the choice is merely aesthetic. But for increasing numbers of us as we age and are more likely to develop arthritis, the doorknob is an unnecessary, sometimes crippling, hindrance to everyday life, when levers are so much easier to operate.

It is just one small example of the multiple ways in which being older or disabled is a barrier not because of age or disability itself but because of the way in which society around us has been designed or built. "It is not being older that is a problem but being older in our current society" (Forrest, 2013).

Stockholm is blanketed in snow for up to six months every year, so clearing the roads is a vital job for the city council, who have always followed the traditional pattern - major arteries first, followed by roads around the big workplaces in the centre, and finally the neighbourhoods, smaller roads and schools further out. Stockholm's deputy mayor became increasingly aware that this strategy implicitly prioritised full time employees over the needs of others in society; he particularly identified women taking children to school (he has called for 'gender-equal ploughing'), but older people are likely to be equally affected, many potentially trapped inside until the plough arrives (Garlock, 2014).

"the approach of older people and their advocates so far has been one of mild persuasion rather than angry demanding of rights"

In her fantastic book and manifesto for older age 'Not Dead Yet', Julia Neuberger repeatedly mentions public toilets and seating in shops, as two apparently minor conveniences that can take on increasing significance as we age until their absence can prevent us visiting town centres at all. Relatively small investments, or innovative ways of providing them, could transform some older people's experience of public space, with a whole range of knock-on consequences for our health, wellbeing, and dependence on much more expensive state services.

The social model

Access for disabled people to buildings and services has improved dramatically in the last few decades, driven by determined activists arguing with strong moral force that it is not physical condition which is disabling but the way society is designed around it. Being a wheelchair user is only difficult if there are stairs and no lift or ramp.

"the structures around us are arguably far more important than our personal decisions or lifestyle"

Several authors have noted how this 'social model' of disability has been less successfully applied to older people, including by ourselves as we age. For example, Blood and Bamford (2010) argue that older disabled people are generally still viewed through a 'medical model' with a focus on impairment, dependence, care, dignity, frailty and pity. Whereas disabled people have challenged the idea that disability should prevent equal participation in society, we are too willing to accept that being marginalised, poorly served by public and private services, and gradually excluded from society are natural consequences of getting older. We should challenge this head on.

Importance for social connection

We identify above the importance of social connection to wellbeing in later life and here, as elsewhere, the structures around us are arguably far more important than our personal decisions or lifestyle. Griffin (2010) argues that services specifically tailored to older people who are struggling with social isolation, like befriending schemes, can be valuable but are not "a radical solution to tackle social exclusion or 'root causes or seek to change situations that were untenable'" (Griffin, 2010). She quotes Professor Christina Victor:

"Rather than "artificially" trying to develop social links, we might be better advised to try to ameliorate the negative effects of structural factors such as income, transport problems and the ability of older people to maintain their existing relationships and participate fully in society." (Victor, quoted in Griffin, 2010).

Benches on demand

In New York the CityBench scheme allows any resident to suggest new locations for benches using a simple online form. The city transport authority will consider the suggestion and wherever possible install and maintain a bench. They promise 1000 new benches a year, and prioritise locations which will be of particular use to older people, including at bus stops, hospitals and near shops.

There are varied and complex ways in which society can influence social interaction but they include:

- Transport: suitable transport must be accessible and affordable enough for people to visit each other, to go to social events and groups, to participate in the social life of their neighbourhood and more widely. What is the impact on social relationships of a rural bus service, for example, or the Central Line? Ensuring that older people can access transport, through the design of universal systems and through specific help (like dial-a-ride schemes, or the mobility component of disability living allowance) is vital.

- Neighbourhood planning: the design of communities can severely affect how sociable they become - formal and informal places to meet or stop and have a chat, easy access to shared facilities, transport options, streetscapes and more.

- Income: low income is a crucial bar to social connection, denying opportunities to meet up (when the drink down the pub or the dinner out is too expensive), to join clubs and participate in social activity.

- Work and the economy: long hours hinder social relationships outside of work and, as discussed below, retirement can deprive some people of much of their social connection. Long commutes are another barrier.

- Technology: has been simultaneously accused of distracting us from social interaction - too much time in front of the computer - and eulogised as the solution - through communicating and building new networks online; it can do both, depending on how it is used.

- Democratic participation: wellbeing, an ability to influence local circumstances, and opportunities for social interaction are intimately linked (e.g. see Bacon et al, 2010).

Age-friendly cities and dementia-friendly communities

The emergence in the last few years of movements for 'age-friendly cities' and for 'dementia-friendly communities' builds on this social or 'citizenship' model of ageing. In different ways both movements ask cities and communities (not just public services but businesses, shops, and wider civil society) to better adapt to older people and people with dementia.

Dementia friendly communities

When the Mental Health Foundation asked members of the baby boomer generation what most concerned them about getting old, 'loss of mental abilities' in particular dementia was their greatest fear (Grant 2013). There are 800,000 people with dementia in the UK and yet less than half (44%) of people with dementia currently receive a diagnosis. The number of people with dementia is, estimated to rise to over one million by 2021 and reach 1.7m by 2051 (Kane and Cook, 2013). One in three people aged over 65 will die with a form of the disease (Age UK, 2013).

The most significant risk factors for dementia are age and family history, but lifestyle still plays an important role, particularly lifestyle and health 20 to 30 years prior to the onset of illness. In particular 'what's good for the heart is good for the head' and vice versa - obesity, hypertension, high cholesterol, smoking, a poor diet and heavy drinking in middle age all seem to raise the risk of developing dementia in later life (Grant, 2013), as does stress in middle age (Johansson et al, 2013).

"'age-friendly cities' and 'dementia-friendly communities' ask cities and communities to better adapt to older people and people with dementia"

The financial cost to the UK (the NHS, local authorities and families) was over £23 billion in 2012, and it is expected to grow to £27bn by 2018. Up to a quarter of hospital beds are occupied by older patients with dementia, and they remain in for longer than others with similar conditions (Age UK, 2013).

Crucially however, even where it cannot be prevented, dementia does not need to diminish self-reported quality of life, which can be maintained through participation in stimulating and creative activities, and relationships with carers and family (Grant, 2013). Hence the importance of dementia-friendly communities. According to the Alzheimer's Society, dementia friendly communities have ten characteristics including the involvement of people with dementia, accessible community activities, consistent and reliable travel options, and respectful and responsive business owners and services. The society and movement provides training and awareness sessions for employees of key institutions around the community. It is a growing movement, at the centre of the Prime Minister's Dementia Challenge launched in 2013, and adopted in communities throughout the country.

Age-friendly cities

Meanwhile the age-friendly city movement is led internationally by the World Health Organisation, with about 12 cities signed up in the UK. One of the most high profile, Manchester, have pioneered a citizenship-based approach which they usefully contrast with the prevailing medical and care approaches to addressing ageing, which see us primarily as sick or incapable of self-support (McGarry, 2013):

Medical model	Care Model	Citizenship Model
You are a Patient	You are a Customer	You are a Citizen
Focus on individual	Focus on individual, family, and informal networks	Focus on neighbourhood and city
Clinical interventions	Care interventions	Promoting social capital and participation
Commission for 'frail elderly'	Commission for vulnerable people	Age-proof universal services
Prevention of entry into hospital	Prevention to delay entry to care system	Reducing social exclusion
Health (and care) system	Whole system	Changing social structures and attitudes

Will we shout louder?

These age-friendly and dementia-friendly movements are positive, vital, and gaining momentum. Although their tone is often mild, the challenge they pose to how we design services and communities is ultimately profound. Combined with similar initiatives like the movement for child-friendly cities, they make the case for a society reoriented away from prioritising the needs solely of full-time, middle aged, primarily male workers.

However it is interesting to compare their tone - generally one of gentle persuasion - to the strident rights-based demands of disabled activists which has seen such progress on equal access (albeit with much further to go). The next generation approaching traditional retirement age are the baby boomers, who have challenged entrenched systems throughout their lives - will this be their next fight?

"'age-friendly cities' make the case for a society reoriented away from prioritising the needs solely of full-time, middle aged, primarily male workers"

7. Transform the care system

A community concern not a crisis response

Summary

Care is the practical and emotional support needed to lead an active life. Unfortunately its manifestation in public provision is as an increasingly-stretched crisis response service, often doing little to promote wellbeing. Only 4% of local authority care spending goes on prevention.

We suggest care should encompass four domains:

- 'Looking out for each other' - the 'simple reciprocities of everyday life' that prevent the need for care arising in the first place.
- 'Looking after each other' - the more formal provision of care, unpaid, by networks of families and friends.
- Professional care - funded either privately or by the state, delivered through a variety of routes.
- Healthcare - although intended to provide treatment rather than ongoing care it is often left doing the latter at enormous cost.

Alongside these sit broader structures and universal services - transport, neighbourhood planning, shops, housing - which are just as important as the one-on-one or group support most associated with social care.

The framework around social care must change to prioritise increased wellbeing by:

- Focusing on the importance of relationships as well as transactions.
- Adapting universal services and environments as well as providing support directly.
- Reconfiguring the relationships between the four domains described above, to ensure care is always provided at the earliest possible stage, and transitions happen at the right time.
- Ensuring co-production of services, so they work better and promote meaningful participation.

Looking again at care

It is unfortunate that care dominates so many debates about older people, further perpetuating the idea that old age is primarily about vulnerability and need. At its best social care is the practical and emotional support some people need to live an active life, to maintain wellbeing and dignity.

"Only 4% of local authority care spending goes on prevention"

Instead, there is growing recognition that our present system is neither financially sustainable nor effective at promoting wellbeing. It is increasingly a crisis response rather than a crisis prevention service.

Responsibility for providing care for older people is split, grudgingly and often dysfunctionally, between public services and networks of family and friends. We suggest there are five domains of care.

1. Looking out for each other

We wouldn't normally consider this 'care' at all, but instead just the 'simple habits and reciprocities of everyday life' in David Halpern's eloquent phrase. Mowing the neighbour's grass, changing a lightbulb for your mother-in-law, keeping an eye on your friend's cat, popping-in to see someone when they've got a cold or inviting them round to dinner when they've had a tough day. This is not 'care' in the formal sense but in its sum it keeps us well and healthy in a thousand almost indiscernible ways. "…that best portion of a good man's life, his little, nameless, unremembered acts of kindness and of love" as Wordsworth's "Lines composed above Tintern Abbey" records.

Sixty five percent of people aged over 65 regularly help older neighbours (House of Lords, 2013).

The Task Force often tells the true story of two older women who become ill. One, without a support network, is unable to cope at home, and is soon shuttling between hospital and institutional care and deteriorating rapidly. She never returns home. The other, a member of a local allotment club, is able to stay at home because other members organise an informal rota to check in, bring food, and help with medication. The woman recovers soon afterwards and returns to gardening duties.

A truly integrated, holistic, early action plan for care would look beyond the formal provision to these simple actions; it would be as concerned with the local gardening club at one end of the spectrum as with the local hospital at the other.

Shared Lives

Shared Lives schemes match older and disabled adults who are unable to live fully independently with families willing to become Shared Lives carers. In exchange for a small fee families welcome the person into their home, family and networks, maintaining the relationships, companionship and activity that can prevent mental and physical health deteriorating. As well leading to better outcomes for those involved, it significantly reduces health and social care costs.

2. Looking after each other

Once we have more clearly identified needs which demand more sustained care, particularly as we get older, we come to rely on close friends or family to provide the more regular, sustained, intensive support necessary. Its scale is dramatic: the value of unpaid care by family and friends is valued at £119bn per year. Six and half million people in the UK care for someone, most commonly their parents (40%) or partner (26%). Of these, 2.2m provide more than 20 hours care per week (Carers UK, 2012). To take just one example, 670,000 people in the UK act as primary carers for people with dementia, saving the state £8 billion per year (Alzheimer's Society, 2012).

"the value of unpaid care by family and friends is valued at £119bn per year"

Unfortunately it can also impose significant costs on those doing the caring, affecting health, income, their own social relationships, and work. People giving up work to care for older or disabled relatives cost the UK £5.3 billion in 2012, and 83% of carers say it has worsened their health (Carers UK, 2012).

Older people undertake much of this care; almost one in five baby boomers - aged 55-64 - are providing some form of care, while the figure is only slightly less at 16% for 65-74 year olds. The total value of unpaid family care undertaken by those aged over 60 is estimated at £50bn per year (Age UK, 2013b).

Care by friends and family means people maintain or access new social networks, and offers a flexibility and responsiveness beyond anything the state could offer. It is a tangible manifestation of the values - love, compassion, reciprocity and mutual support - on which society depends but public services struggle to embody. Unfortunately when unconnected to the right support it can be destructive and detrimental for carers and those being cared for - isolating, unhealthy, emotionally incapacitating. Eventually, for many, it gets too much; and then the state steps in.

3. Care by professionals

Professional care is either paid for privately, or provided publicly; public support for care in older age is provided through local authority provision of adult social care services; either in residential care settings or more commonly via home visits from care professionals, or via 'personal budgets' which people can spend on care services they require. In 87% of councils social care is only available for people whose needs are judged to be 'substantial' or 'critical', with needs judged 'moderate' or 'low' not entitled to any support (ADASS, 2013), although local authorities will often try and provide information or signpost people who do not meet the eligibility criteria to other services.

"a tangible manifestation of the values - love, compassion, reciprocity and mutual support - on which society depends but public services struggle to embody"

Seventy six per cent of us will need some form of care in our older age (DoH, 2012). A total of £9.07 billion was spent on social care for just over one million people in 2011/12 (Audit Commission, 2013). Surging demand and falling budgets are putting care services under unprecedented pressure, with the Association of Directors of Social Services (2013) describing the outlook as 'bleak'. Meanwhile only 4% of social care spending goes on prevention.

4. Care in hospital

When all these avenues of care have been exhausted (or more often than not, when they have not been properly provided in the first place) people go to hospital. Emergency readmissions to hospital for people aged over 75 rose 88% in the ten years to 2009/10 (Age UK, 2013); 29% of hospital bed days could be avoided if care was better managed (Age UK, 2013b).

5. Creating the conditions for care:

The extent to which we can overcome barriers to live an active and independent life is partly dependent on the services and individual support we are able to access (i.e. 1-4 above) but also on the universal services and wider structures that dictate our environment; accessible transport, suitable opportunities for recreation and leisure, age-friendly planning and design. While it is the responsibility of care services to try and facilitate access, this agenda extends far beyond the care system and illustrates further the need for a broader vision for later life.

Looking forward

There are important debates about how acute services can best be delivered - how to root out abuse and build in compassion and quality - which we do not touch on here beyond pointing out the importance of 'co-producing' services with those delivering and receiving them, to ensure they are better designed and to provide opportunity for meaningful engagement as explored above. But it is reforming the fault lines between these four domains of care, currently dysfunctional and hotly contested, that would yield the most profound, preventative changes.

We are probably furthest ahead in rethinking the boundary between social care and acute hospital care - long recognised as highly deficient, with trailblazers like Torbay showing how integrating social care and health can help smooth this transition, preventing unnecessary hospital admissions and improving wellbeing. Government have now announced some support for health and social care integration accompanied by £3.8bn of funding and the Labour opposition have argued for a faster pace of change. Schemes like the one that Age UK and Cornwall Council and NHS are piloting with Social Finance further demonstrate the potential of this approach.

We are less advanced in tackling the boundary between statutory and family-provided care. Currently entitlement to statutory care is based entirely on physical or mental health needs. Unlike other countries, in the UK this takes no account of the support available from friends or family, which means the process of accessing support is a straightforward fight to prove the severity of need, and then, perversely, maintaining that support is conditional upon needs remaining sufficiently acute (In Control et al, 2013).

Carers allowance provides some financial support to people who spend over 35 hours a week on caring duties, and local authorities provide some practical support. But beyond this the framework for how care needs are prevented and then met is piecemeal and in some crucial respects non-existent.

Government have recognised some of these issues in the Care Bill (2013), which if passed will require local authorities to consider how they can prevent social care needs arising or worsening; to provide advice and information to people on preventative support available; to offer an assessment for support to carers; and to take into

account the capacity of family and neighbours to provide some care when designing services.

For some this last point is welcome recognition of communities' valuable role in the process, for others it is loophole that providers will exploit to shift more of the burden of care onto unpaid and highly-pressured relatives. Similar suspicion was voiced in response to Care Minister Norman Lamb's suggestion that Neighbourhood Watch schemes take on some responsibility for caring for 'lonely and miserable' older people (Delmar-Morgan, 2013).

Which they are will largely be determined by how they are implemented but it is clear that the change they hope to provoke - of reconfiguring that crucial interaction between us looking after each other and the state stepping in - is vital to a sustainable preventative future for social care.

Structurally the implications of this are twofold; first that funding for social care and health must be brought together - as is starting to happen - to ensure that cost-savings associated with good preventative care provided by local authorities don't just accrue to the NHS, hugely distorting incentives. And secondly, that this funding should be coordinated locally, to ensure it is joined up with the institutions promoting social connectedness; people looking out for and looking after one another.

"reconfiguring that crucial interaction between us looking after each other and the state stepping in - is vital to a sustainable preventative future for social care"

8. Teach coping strategies

Promoting mental resilience in later life

Summary

Older people navigating difficult transitions – bereavement or the onset of ill-health for example – are particularly susceptible to mental health problems, with substantial knock-on costs. There are three components to the mental resilience necessary to successfully navigate transition and the first two – wellbeing, and social connection –are core to this report. The third – psychological coping strategies – is also vital. Their teaching should be a core part of the services offered by new institutions like Ready Institutes (see below).

Mental health in later life

Between the ages of about 60 and 70 people's mental health is better, on average, than for almost any other age group; 82% of older people said that in the last two weeks, they felt happy or contented either most days or every day (Age UK, 2013). This age commonly coincides with the transition for many from work to retirement, with becoming a grandparent, before the major health impacts of older age have been felt. In many ways it is a remarkable recovery given that in our previous two decades - our 40s and 50s - we experience the highest rates of mental health problems of any age group (McCullock, 2009).

But this remarkable upsurge in mental wellbeing reverses again from about the age of 70 onwards, with two particularly prevalent conditions - depression and dementia - taking hold. Almost half of people in long stay residential care are estimated to have depression below the threshold for major depression (Meeks et al, 2011), and one study estimated that 40% of older people visiting their GP had a mental health problem (Health and Information Centre, 2012). Overall depression affects more than 1 in 5 people aged over 65; over 2m people (Age UK, 2013).

The Mental Health Foundation's comprehensive enquiry into mental health and wellbeing in older age (Grant, 2013) identified risk and protection factors for mental illness in later life:

Risk factors:

Retirement and other transitions

- Chronic medical illnesses, pain and disability
- Care giving
- Psychosocial adversity
- Daily stressors
- Life events
- Organic brain disease
- Having low levels of physical activity
- Financial insecurity

Protection factors

- Social ties, relationships and connectedness
- Living in a supportive and enabling physical environment
- Personal characteristics
- Physical activity

Reproduced from Grant (2013)
These protection factors are all covered in various sections below.

A meta-analysis has found that a diagnosis of depression for people aged over 65 increased their mortality rate by 70 % (Age UK Oxfordshire, 2011). A US study found that older people with depression cost health services almost twice as much as a similar group without depression, and only 1% of this cost went on treating the depression (Unützer et al, 2009).

The onset of depression is usually linked to major life transitions, in older people particularly the death of a partner or loved one, and the onset of physical illness can each lead to depression, although neither inevitably do (RCP, 2013).

“a population more equipped with some of the tools revealed by positive psychology would better navigate the transitions of later life. ”

Mind (2013) identify three components of the ‘mental resilience’ which characterises those who successfully navigate experiences like bereavement, retirement, unemployment or ill-health. The first, wellbeing, forms the overarching premise for this report and includes several areas covered elsewhere, including physical activity, learning, and contributing. The second, ‘social connections,’ is also covered above. Both contribute to far more than mental resilience. The third is psychological coping strategies.

Proponents of positive psychology argue that it is possible to learn techniques that boost our ability to deal with stress and adversity. Martin Seligman, one of the most high profile advocates, has said:

“We have discovered that there are human strengths that act as buffers against mental illness: courage, future-mindedness, optimism, interpersonal skill, faith, work ethic, hope, honesty, perseverance, the capacity for flow and insight, to name several….Much of the task of prevention in this new century will be to create a science of human strength whose mission will be to understand and learn how to foster these virtues in young people” (quoted in Mind, 2013).

The practical activities stemming from the insights of positive psychology should be widely incorporated into the institutions of adulthood particularly workplaces. This would be an important role for the Ready Institutes we propose in the next chapter. This would have to be done with skill to avoid ridicule or stigmatisation, and is clearly not an alternative to addressing more fundamental inequalities in society which cause mental ill-health. But nonetheless a population more equipped with some of the tools revealed by positive psychology would better navigate the transitions of later life.

9. New institutions to help us be ready for later life

There is clearly an institutional gap around later life, identified multiple times in the preceding chapters. For children, for parents, for adults in the labour market there are large institutions dedicated to providing early support and investment but in later life the only public services left are the health and social care systems, both dealing almost exclusively with crises. We have suggested the need for institutions to help us plan for our choice years, to support social connection and meaningful contribution, to guide us through transitions and to reduce health inequalities as we age.

A precedent - Sure Start for Later Life

In 2006 government's Social Exclusion Unit put forward a bold, ambitious plan: replicating the Sure Start model pioneered for young children with older people's services. It said: *"Early intervention in later life can prevent inequalities in advanced age and makes economic sense. Sure Start's guiding principles offer a radical and transferable model for services for older people. The services are different but the principles and outcomes are shared."*

The approach was piloted in ten areas around the country but soon charities sensed it was losing momentum (Samuels, 2008) and although the pilots continued the issue soon fell off the government's agenda.

Nonetheless the final evaluation of the pilot sites was positive, finding that local areas had developed useful services, almost all of which continued after the pilot funding ended. It estimated savings of between £1.80 and £2.65 for every £1 invested in projects, scheme broke even in their first year (Davis and Ritters, 2009).

Five years after the pilot ended some of the schemes, such Gloucester's Village Agents, are still going strong and being replicated in other local authorities. Several areas have adopted a 'care coordinator' approach whereby trusted people act as a referral and liaison in the community, supporting older people to access local services from reading groups to exercise classes. (Lawton, 2013).

"institutions to help us plan for our choice years, to support social connection and meaningful contribution, to guide us through transitions and to reduce health inequalities as we age"

There is clearly mileage in this approach but it is tentative in its ambition and not being adopted nearly fast enough nor radically enough, particularly as local government grapples with severe budget cuts. It is time to revive and build on the ambition of that original proposal. We suggest the development of Ready Institutes.

The Ready Institute

A Ready Institute in every area would do three things:

1 Liaise directly with individuals, particularly at points of transition, to ensure they can access all the opportunities and services available. This would be similar to the role of a care coordinator but not confined just to those with care needs; a fifty-five year old looking to reduce their hours at work or a sixty year old couple who have just moved to the area would be just as important as an eighty five year old just out of hospital because it is too late to wait until problems develop; far better to ensure we are ready to stave them off or navigate them successfully.

2 Sit at the centre of a diverse network of public, private, third sector and civil society organisations, driving the adoption of age-friendly services, policies, designs and rules. These would be the buildings, services, clubs and societies

Village Agents

Village Agents take on a role that might have been filled in past by a local postmaster, shop owner, or vicar: they stay in touch with older people in their area, providing information and advice, signposting to other services and ensuring everyone is receiving the support they need, from statutory or other sources. Originally piloted in Gloucestershire as part of the 'Sure Start for Later Life' pilots, they have now spread across the country.

to which people are directed and where people are first contacted - workplaces, shops, sports clubs, churches, GPs, schools as well as the hospital, the care home, and the social services department. To be part of the Ready Institute organisations would be encouraged or required to sign up to a set of principles modelled on those below. Time banking could be at its core – so that contribution in one sphere can be exchanged for access to support or services via another member.

3 Incubate or develop new services to meet new demands; identifying gaps in provision, supporting groups of people particularly older people to develop and spin-off new businesses, charities or associations, sourcing new funding, and constantly evaluating and improving.

This new institution would have an overarching aim to improve wellbeing in later life. This will in turn save public money but saving is not its primary aim.

It would:

- Promote wellbeing by ensuring we are all ready for later life; both resilient to shocks but more importantly prepared and supported to seize opportunities and to thrive.
- Be particularly important in the lead-up to transitions, ensuring we seize the positive and deal as well as possible with the negative.
- Prioritise relationships, social connection, contribution and meaningful participation, because these are crucial to wellbeing.
- Challenge head-on the stereotypes and discrimination associated with later life

To do all these successfully it will have to:

Be locally rooted, tailored to its neighbourhoods and communities. It must not repeat the mistakes of the Experience Corps - directed from central government via call centres and a website, disconnected from and sometimes directly in competition with local civil society. Ready Institute members would have access to various benefits – perhaps the right to very cheap access to local authority facilities (as in Denmark, where local authorities are required to provide cheap accommodation to adult learning associations, and cover the cost of facilitators).

But nationally backed: local authorities, now more than ever, do not have the money or the capacity to develop ambitious new services like these without strong leadership and finance from central government.

Be proudly cross-sector: if it restricts itself to health and social care and the most obvious parts of the voluntary sector it will merely mirror the gaps in existing services. Instead it must recognise that employers, shops, businesses, churches, mosques, sports clubs, universities, and more are vital.

Local Area Coordination

Local Area Coordination is an approach developed in Australia in the late 80s and now sits at their of their social care system. Much like Village Agents, Local Area Coordinators provide information, advice and small amounts of funding from outside the traditional care system. They can signpost to existing services but also encourage people to set up new ones, to develop relationships and engage in activities locally. A very similar role – the care coordinator - is being trialled in Scotland's social care reforms.

"a diverse network of public, private, third sector and civil society organisations, driving the adoption of age-friendly services, policies, designs and rules"

Be open to all: an institution that becomes associated with ill health and care needs amongst the oldest old will fail to attract anyone else. Instead it must be just as relevant to a fifty year old planning their next career move as to an eighty year old just out of hospital. It should be associated with workplaces, football clubs and pubs just as much as bingo halls, hospitals, and care homes and should carry no stigma itself.

IPPR's Condition of Britain project documents the experience of Leeds' Neighbourhood Networks, of which there are 37 around the city fulfilling some of the roles described above (Lawton, 2013). There are undoubtedly other examples around the country.

To illustrate its potential consider a couple of scenarios.

Pete is approaching retirement age, enjoys his job and hasn't really made a plan for what to do next. His workplace is signed up to the Ready Institute and as a result has recently introduced a new 'step down' option whereby older employees can reduce their hours and take on a mentoring role for younger staff. The company also hosts weekly 'second career' planning sessions delivered by another Ready Institute member, a charity specialising in it. Pete attends one of these sessions where he learns about the 'step down' scheme and soon applies. The advisor also talks through with Pete ideas for what else he could do in his newly-acquired spare time, and shows him the website with all the local Ready Institute members - everything from the football club to the local university. Pete pursues a few ideas he's always wanted to try, and is soon volunteering as a coach at the football club where he meets a whole new circle of friends of all ages, and doing a part time diploma at the local college.

Leeds Neighbourhood Networks
Leeds City Council has helped to build 37 'neighbourhood networks' over the last 20 years; independent, local organisations which support older people to get involved in their community, build and maintain friendships, volunteer and access support. (Lawton, 2013).

Margaret and Doug are 75 and Doug has recently been diagnosed as terminally ill. On a visit to the GP they meet Pat, from the local Ready Institute, who introduces herself. She makes sure they know about all the services available locally for cancer patients, and the support Margaret is entitled to as a carer. Because the shops in their local town centre and the bus service to get them there are all members of Ready Institute they know they can continue to visit, go shopping, attend church, go to the library, and see friends. When Doug passes away Margaret is heavily supported by members of the church and by Pat, who pops in regularly. Soon Pat has put Margaret in touch with a couple of other recently-widowed women nearby and before long they've formed a support group for others. The group becomes a Ready Institute member soon afterwards.

Implications for government

How should government respond as we age? It would be possible to carry on muddling through, responding to imminent liabilities, gradually shifting more and more cash towards social care and acute hospital treatment, not accounting for lost contribution because we never expected it in the first place. As personal tragedy piles up, costs rise inexorably and potential is wasted.

Instead our vision calls for a different way of working.

1 Longer term: Living longer, healthier, happier lives in later life requires a healthier, happier middle age and a series of successful transitions. Only with a rigorous focus on the impact of today's decisions on the next decade or the one after will we prioritise policies that ensure we are ready. It is not enough for our public institutions, led by government, to be capable of looking longer term - they do this occasionally in any case. They must be *forced* to look longer term in every decision, through the underlying mechanisms of government particularly the spending rules. The Early Action Task Force has proposed a series of ideas including ten year tests for every spending decision.

2 Better integrated: A focus on the longer-term is not enough if money spent by one department will lead to savings in another, or while cost cutting in one will just pile pressure on another. Some form of integration of health and social care spending looks likely in the medium-term, to better align incentives which clearly distort delivery of sensible policy. But the issues covered above go far wider than health and care, to cover employment, social connection, discrimination, transport, and far more. The occasional integration of one department or funding stream with another does not seem sufficient to ensure a more coherent approach to prioritising vital objectives across the public sector. This leads to the third conclusion:

3) More local: All the issues covered above - mental and physical health, care, social connection, discrimination, employment - are deeply intertwined. Poor diet in middle age could lead to physical health problems which, soon after retirement and in the absence of good social care support, stop someone leaving the house. The subsequent isolation in turns causes deterioration in mental health, which results in further physical health problems and an onward, downward spiral. These issues are currently tackled piecemeal by various branches of government which tend to see each other as rivals rather than collaborators for the common good. Much of the fine detail of these stories is determinedly local though - the route of the local bus service, the planning of new housing, support for social clubs or public space.

> **"While government fixates on our health and care needs and our pension liabilities the rest of us hope for something more from later life"**

The only way this incongruence will be ultimately resolved will be in devolving decision making downwards, so services and support operating in an area are joined not only to each other but to the wider structures of a place - its businesses and civil society, it's planning and housing, its community leaders, children, parents, semi-retirees: all its citizens including those most senior. This paper is not an argument for localism but it does seem one of the inevitable consequences of a forward looking, all-encompassing vision for later life.

4 More positive and more ambitious: While government fixates on our health and care needs and our pension liabilities the rest of us hope for something more from later life. We don't just want healthcare and acute social care delivered more efficiently (although that would be nice) and pensions paid later – we want to seize the opportunities later life offers, and successfully navigate its challenges. New aims, new institutions, new structures, new attitudes to age, and a new ambition. Government's first job is to lead the debate; to launch a new conversation.

Summary of our ideas

1. Re-write birthday cards
Promote positive attitudes to ageing

2. Abolish age-related benefits
Focus on transitions not ages

3. Bind a rising state pension age to falling health inequality
Extend healthy ageing for all

4. Abolish retirement
Rethink time, work, learning and contribution in later life

5. End the 'befriending' movement
Prioritise meaningful participation, relationships, and social connection

6. Ban door knobs
Build an environment suitable for later life

7. Transform the care system
A community concern not a crisis response

8. Teach coping strategies
Promoting mental resilience in later life

9. Introduce Ready Institutes
A new institution for later life

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Looking Forward to Later Life

Taking an early action approach to our ageing society

Unprecedented increases in life expectancy over the last century have not been matched with a clear understanding, across society, of what we expect from our newfound older age.

Government's approach is piecemeal and uncoordinated, driven by only the clearest looming liabilities (for example on pensions) or in response to crises (such as in social care). By reacting once problems have developed and badly managing crisis situations governments can incur great cost for little impact.

If, instead, public services, businesses, civil society and all of us as individuals were ready, both to take advantage of the opportunities and to successfully navigate the challenges of later life, we would experience a triple dividend – increased wellbeing, reduced costs, and increased contribution. This requires a new vision for later life. This report proposes some ideas that help illustrate what it might look like.

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