The hanover@50 debate

Strengthening relationships to prevent isolation and loneliness in old age

DR SAMANTHA CALLAN OF THE CENTRE FOR SOCIAL JUSTICE *JUNE 2013*

THE CENTRE FOR SOCIAL JUSTICE

#8 in a series of 9 think pieces from leading UK think tanks to mark Hanover's 50th year of providing high quality housing and related services for older people

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Key findings

This paper expresses concern that 'fairness' in older age is often expressed as a spreadsheet. We should look more broadly at how loneliness and isolation can blight older people's health and wellbeing. Ultimately we need to address societal and family breakdown and ameliorate its impact, particularly on the poorest, in old age.

The paper says:

- Additional social care funding is welcome but it will be swallowed up by the vast increase in the numbers eligible for free social care
- People experiencing low incomes alongside complex needs such as homelessness and addiction also need a fair deal
- A national strategy should strengthen 'couple' relationships given that high divorce rates have led to isolation and loneliness
- Family breakdown loosens the bonds of responsibility and makes it less likely adult children will feel they should care for ageing parents
- Community-based approaches, such as 'buddying' schemes, can replicate care previously provided by family and friends and bridge the gap between professional and personal relationships.

About Hanover

Since 1963, when Hanover was founded, we have become one of the UK's leading specialist providers of retirement housing and related services.

We are a registered provider and manage almost 19,000 properties in over 600 locations. These include:

- Around 5,000 home ownership (typically leasehold) properties
- Around 14,000 properties for rent, including 3,000 Extra Care properties where residents can access 24-hour care on-site.

Hanover also manages a 24-hour, 365 day a year emergency response service, handling over 400,000 calls a year from over 20,000 residents.

By 2016, Hanover aims to develop 1,250 new-style homes for older people.

We operate in over 175 local authority areas across England and Wales with over 30,000 residents and customers.

We aim to be the leading provider for older people looking for high quality housing and related services.

About this series

The Hanover@50 Debate is part of our work around our 50th anniversary.

The debate aims to stimulate discussion around some of the key issues facing our society when it comes to our ageing population, with a particular focus on housing.

Sheltered and retirement housing is often perceived poorly, despite residents and tenants reporting high levels of satisfaction. So the concept of 'retirement housing' needs to change if it is to be a credible and positive choice for people as they grow older.

To help start the discussion, we have commissioned a series of think pieces and new research from 9 think tanks from across the political spectrum.

We've asked the think tanks to question the assumptions, challenge perceptions and consider the principles that underpin much of policy around housing and the ageing population.

We want to generate fresh ideas about future policy and provision of housing and services for older people that take account of social, economic and demographic change.

And we're hoping these pieces will help set an agenda for providing housing options and creating services that are age positive without being ageist by either prejudicing, or privileging, older people.

About The Centre for Social Justice

The Centre for Social Justice is an independent think tank established in 2004 to seek effective solutions to the poverty that blights parts of Britain.

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Introduction – unpicking 'fairness'

The issue of 'fairness' in older age increasingly tends to be expressed in terms of 'getting a decent return for a lifetime of paying tax' or the right to preserve an inheritance for one's children instead of having to sell the family home to pay for care. In addition there are still many elderly people who fought for their country and, as a nation, we retain a strong sense that it is 'fair' to defend their interests now.

However there is another side to the issue of fairness in older age which rarely gets mentioned. The Centre for Social Justice's particular concern about the way the policy agenda is currently framed is that it pays inadequate attention to the need to drive up the quality of care and generally transform the experience of our poorest pensioners.

Our reports emphasise the need to celebrate old age and to find better ways of ensuring the wisdom and experience gleaned by individuals over decades is not allowed to go to waste. They describe how many older people are enjoying life, making a valuable contribution to their communities and are deeply loved by their families. Yet our research has exposed the other side of the coin and how, for too many, older age brings harder challenges.

This is particularly the case for those battling with poverty, loneliness, isolation and housing problems in the UK's most deprived neighbourhoods, where crime and its consequences all too frequently blight daily life. The majority of crime is committed in our poorest areas and its impact is often most acutely felt by people living in those streets and estates.

This think piece will look at how policy and practice should address these aspects of fairness and ensure attention is given to broader concerns than those which currently dominate both media coverage of older age issues and the political agenda.

‘Doing Dilnot’ should not be the overriding priority

It is essential that serious consideration is given to how we as a nation will pay for care and pensions and there is no doubt that obtaining reliable financial advice and planning ahead are essential. Yet there is a tendency to treat older age and particularly the care of older people like a spreadsheet. Debates on ways forward focus on who should receive financial assistance and on what scale. They fixate on appropriate caps on personal liability for the cost of care, levels of contribution for board and lodging, and where thresholds for eligibility for state assistance should be set so that personal saving can still be considered worthwhile.

Such was the remit of the 2011 Dilnot Commission on Funding of Care and Support and the overriding concern of its final report.[1] A consensus has emerged, in what has tended to be a highly divided sector, that his conclusions provide a reasonably fair way to handle the spiralling personal costs of care. Richard Humphries, Senior Research Fellow at the King’s Fund, referred to the unusual level of assent to Dilnot as an important first step, when he gave evidence to the Health Select Committee:

The almost unanimous support given to Dilnot’s recommendations suggests we are on the cusp of not a total solution, as colleagues have alluded to, but at least a way forward, a way through it.[2]

We agree that the Dilnot Report has made an invaluable contribution to the national debate given that the cost of care presents an enormous challenge to individuals and society. There also needs to be a step change in the quality of financial advice people receive to prepare them for older age and enable them to plan ahead.

Yet the consensus around Dilnot does not address our broken care system which people would increasingly be brought into under its eligibility criteria. Although one of the Dilnot Commissioners referred to ‘driving up quality by increasing the pot of money’[3], its measures would also increase greatly the number of people drawing upon that pot by bringing into the means-tested system home owners who want to preserve their capital and keep the inheritances of their children intact. There is a strong likelihood that extra resources would be quickly swallowed up.

Moreover, desperately needed reforms to the current system would not necessarily flow from the anticipated influx of finance because they require profound cultural change. The Government acknowledges the need to address our broken care system in its recent white paper: ‘We cannot improve care and support by pouring ever more money into a system that does not work.’[4] It cites the problems of a system that only tends to react in a crisis, offers inadequate access to good information and advice and provides a variable and inconsistent quality of care – where it is available.

The most frequently heard complaint in our own research concerned the prevalence of so-called ‘flying visits’. The restrictive brevity of home care visits is due not only

to an inadequate level of accountability in domiciliary care (compared to more intense supervision in residential care settings) but also to councils' cost-driven commissioning practices. Paying for 15 minute slots (rarely long enough to provide high quality personal care) and not factoring in travel time for care workers greatly contributes to the care workforce – which has a high annual turnover – being highly demoralised and badly paid.

We are not simply dismissing the concerns of those with some financial security that has often been diligently and sacrificially built up; it is a tragedy to use all your assets to pay for care. But we do not think it is the only tragedy of later life. Our concern as an organisation is for the most impoverished and the desperately low quality of life of some of our poorest pensioners. Our two landmark reports describe the unwelcome ramifications of poverty in older age and the need to ensure that tackling its root causes rises up the political agenda.[5]

It is a tragedy to use all your assets to pay for care. But we do not think it is the only tragedy of later life.

It became clear to us, for example when we hosted a Parliamentary roundtable of MPs from across the political spectrum, many of whom were obviously deeply motivated to tackle older age disadvantage, that there are currently few votes in that particular aspect of the agenda. Despite the perceived power of the 'grey vote', one MP described the lack of engagement the neediest older people tend to have with the political process: "Not many are coming to surgeries, my impression is that this is a generation who do not complain."

This could begin to change given current debates over universal benefits for pensioners and growing awareness of the potential 'unfairness' of continuing to pay these when financial circumstances in older age differ so markedly. Social justice dimensions of older age that affect a significant minority could and should gain salience in a similar way to issues surrounding child poverty.

Moreover, even if the recommendations of the Dilnot Report were implemented to the letter, without a veritable revolution in the way we think about ensuring older people receive superb care, we run the risk of ignoring another major driver of inequality in older age – loneliness and isolation. Recently founded initiatives like The Silver Line have emerged in response to this need.[6] Inspired in part by CSJ work in this area, this organisation aims to provide a national helpline for older people. Recorded phone conversations from their pilots in Manchester and the Isle of Man provide valuable insights which we draw on below. Friends of the Elderly also run visiting and phoning befriending services. Our reports have showcased others such as Thanet's Good Neighbours Service, Healthy Ardwick and Participle's Southwark Circle. These organisations do not simply ensure older people have contact with others but also draw them into webs of reciprocity, underlining the fact that they still have a huge contribution to make to society.

It is essential to consider the underlying issues driving isolation, older people's lack of contact with each other and how these are related to a lack of resilience in old age. These impinge on other enormous social policy challenges of our day, such as how

to prevent crises in mental and physical health thereby avoiding costly and distressing hospitalisation, particularly by delivering better care in the community.

Overall, the importance of social relationships is largely neglected in policy, yet relationships themselves are a resource. The main emphasis of this think piece will thus be on the need to take a far more relational approach to ageing and to preparing for ageing. Making the most of all available resources is absolutely essential if we as a society are to 'do' older age better.

Defining pensioner poverty

Just as the older age population is incredibly diverse, the problem of pensioner poverty affects people in a very broad range of circumstances: those who are asset-rich but income-poor, those who have no assets and very little income, and those who have lived with multiple needs for much of their lives such as addictions and mental health problems; problems which are undoubtedly exacerbated by increased infirmity. Arguably it also includes those who have sufficient income and assets but are unable to access the support necessary to live a satisfying life because of ill-health, dementia or intense caring responsibilities.

One elderly lady who rang The Silver Line was in the late stages of terminal cancer and had no regular visitors. Between the first contact and the follow-up phone call made by the service a week later, her phone had been switched to incoming calls only, due to non-payment of bills. The Silver Line volunteer was able to ensure that she began to receive her winter fuel payments which cleared her telephone arrears. She had simply felt far too unwell to make arrangements that had previously been well within her capability.

Money remains an essential indicator of whether an individual lives in poverty or not. It is highly concerning therefore, that 17 per cent of pensioners are currently living below the poverty line, a million of whom are deemed to be in severe poverty.[7] Indeed money becomes particularly crucial for older people as the majority tend to spend more on essentials like food at a time when disposable income and the opportunities to earn more often decrease.[8]

Yet rigidly holding to arbitrary definitions of poverty such as income levels and assets can prove narrow and unhelpful, and we need to adopt a broader understanding of poverty (using, for example, the Family Resources Survey's material deprivation indicator[9]). Otherwise many older people will simply continue to drift above and below the poverty line without an enduring change in the quality of their lives or opportunities.

Research has found, unsurprisingly, that experiencing a poor quality of life is strongly correlated with living in poverty. In a study carried out by Professor Thomas Scharf, two thirds of those reporting a (very) low quality of life were living in poverty.[10] The English Longitudinal Study of Ageing (ESLA) study also showed that, as well as their level of physical functioning, an individual's income level is significantly correlated with well-being and quality of life.[11]

The CSJ is concerned not only with alleviating older age poverty but also with tackling what is driving the creation of conditions where people are socially excluded in broader ways. According to the University of Bristol, social exclusion:
"involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole."[12]

Relational poverty can go hand-in-hand with financial need

It becomes apparent when looking at the kinds of things pensioners in poverty have to do without, that poverty can be strongly associated with social isolation and limited access to relationships. The Scharf study cited above found that almost half of those living in poverty had gone without buying clothes in the previous year, a third had foregone buying shoes, almost a quarter had sacrificed going out, one in five had gone without heating and telephoning friends or family, and 15 per cent reported they went without food. Not having nice clothes and making do with shoes that are worn out or let the rain in can make it harder to get out and about, especially if there is no money for trips. This makes it more likely that people who live on their own will go several days without seeing people – and worries about paying the phone or food bill will prevent them making calls or having people round for meals.

And 'seeing people' is not always enough. Another caller told the Silver Line 'it's the difference between loneliness and being alone. You can have a lot of people around you and feel lonely.' This older person touched on an important distinction between experiencing loneliness and experiencing isolation or solitude. One geriatrician eloquently describes loneliness as 'a pain an individual feels when they want companionship but can't have it'.[13] Accordingly, any strategy to defeat loneliness has to be grounded in the understanding that it is not simply a matter of being alone – loneliness is a physical and psychological pain of desiring companionship, not just activity and company.

Moreover, resilience in older age, the ability to cope with life's challenges and bounce back from adversity, depends strongly on maintaining a high level of wellbeing which is, in turn, closely linked with people's ability to maintain enriching social networks. This can be hindered by living alone, as Yvonne Roberts points out:

While many living alone may enjoy their lives and have a wide circle of friends and relatives, for others loneliness is also a profound problem. Sixty-three per cent of women and 35 per cent of men aged 75 and over live alone.[14]

She goes on to flag up that these figures are on an upward trend 'because baby boomers have lived through a steep rise in divorce and separation.'[15] In 1971 only one per cent of those over 65 were divorced but this has changed markedly over the last 40 years, reaching five per cent in 2001. While comparable data is not yet available from the 2011 Census, this number is projected to reach 13 per cent by 2021.[16] This is also concerning because those who are separated or divorced in older age are more likely to show signs of depression than older people who live with a partner and those who have always been single.[17]

Although there are other reasons why people become lonely and isolated in older age, the role played by family breakdown is clearly significant. Yet it tends to be neglected, largely because it is considered by many to be an inevitable feature of modern life.

However, our research has demonstrated that family breakdown hits the poorest hardest and is not merely an effect of poverty but also a cause.

Unsurprisingly it is also a driver of poor health. The concept of health inequalities is best summed up in Professor Sir Michael Marmot's recently-coined phrase 'the social gradient in health': the poorer you are the worse your mental and physical health is likely to be. Given that close relationships, especially with family, are becoming increasingly acknowledged as a health asset, we are concerned that there might also, therefore, be a social gradient in older age loneliness and isolation. Although people from all income brackets can be lonely in older age, relational poverty is closely related to material poverty. Those who have more financial resources and security also tend to have good relationships with family and friends.[18]

In summary, ageing sustainably is closely bound up with sustaining relationships. In the next section we will look more closely at how this country's high rate of family breakdown profoundly affects the quality of life enjoyed by many older people in the UK today, one of the many reasons why its prevention should be the overriding priority of family policy. Preventing and alleviating relational poverty requires acknowledging how the culture of family breakdown affects a range of older age issues, particularly in our poorest communities where it is most concentrated.

Family breakdown and care in older age

When divorce or separation has taken place in people's own relationships or in those of their children or other close relatives, this can have a significant impact on their later life. This is not simply because they do not have a husband, wife or partner to provide (often) mutual care as they become more infirm. Neither is it necessarily that bonds have been broken, as a direct result of the split, with former children, grandchildren, daughters- and sons-in-law or friends and they no longer spend time with them and are therefore completely unable to be part of a patchwork of care and support.

Research indicates that, in a more diffuse and pervasive way, the greater fragility of adult relationships has weakened many people's sense of a duty of care to older family members, even when they are still in contact with them. As a result, care for older family members cannot be taken for granted to the same extent as it was historically. Contemporary sociologists describe how family breakdown has led to a significant cultural shift in the ethics of personal life that has affected the willingness of many family members to provide care to older relatives. Professor Anthony Giddens describes how, in a high divorce society like ours, with its implicit understanding that family relationships are impermanent, relationships are 'subject to greater negotiation than before' so that whereas in the past 'kinship relations used to be a taken for granted basis of trust; now trust has to be negotiated and bargained for and commitment [between kin] is as much of an issue as in sexual relations.'[19]

Finch and Mason have also described the way in which people now have to work out how to treat their relatives so that 'responsibilities are thus created rather than flowing automatically from specific relationships.'[20] In terms of care, what that may mean is that being willing to support an older family member increasingly depends on the quality of relationships forged throughout life, upon what Finch has termed ' cumulative commitments'.

Family breakdown has led to a significant cultural shift in the ethics of personal life that has affected the willingness of many family members to provide care to older relatives.

This affects not only extended family but also the immediate family; explaining, for example, why different siblings within one family might have very different ideas about how much care they should or should not provide for ageing relatives. Where any care is forthcoming (and even that cannot be taken for granted) this may mean only one or two family members are willing to share the load. Our research highlighted the increasing intensity of caring roles, and suggested that the cultural shift described above is proving as significant as the increasing physical dispersal of families.

Polling we conducted just before Christmas Day in 2011 found that nearly a quarter of a million people aged 75 and over in the UK would spend the day alone. Perhaps even more harrowingly, 40 per cent of those alone on the biggest day of the year had children

living in the UK. The poll also found that about 370,000 over 75s spend 'zero hours' with other people on a typical day; nearly a fifth of older people living alone. One 90 year-old woman from Yorkshire, when asked how much time she spends with other people on a typical day, replied, 'Does the TV count? I see people on the TV all day.'[21]

Getting ahead of the drivers of loneliness and isolation

It is vital to ensure isolated and lonely older people have a wide range of opportunities to sustain and develop nurturing relationships and to maintain sufficient contact with others. Moreover, given what is known about how divorce and separation can lead to a dearth of family support in older age, this heightens the urgency for developing a national strategy to strengthen families and prevent relationship breakdown. As with many social challenges, prevention 'upstream' has to be combined with attention 'downriver' to alleviate current isolation and relational poverty.

It was mentioned earlier that close relationships, especially with family, are health assets. Epidemiologists at University College London have found that older people with lower levels of support not only have significantly higher blood pressure but also higher inflammation levels (which tends to indicate underlying illness). The health gains (in terms of decreased risk of mortality) from having a high level of social support, far outstrip those associated with abstinence from alcohol, having a lean BMI, or stopping smoking.[22] Unsurprisingly, couple relationships are particularly important in sustaining or compromising health. It has been estimated that at least three-quarters of the Government's Public Health Outcomes Framework indicators are influenced (directly or indirectly) by the quality of people's couple relationships.[23]

Consequentially, enabling people to build the quality of these relationships and sustain them where possible, thereby tackling family breakdown, must become a central concern of the public health agenda. The CSJ has consistently argued that the Government should take a strong and vocal lead in tackling the 'culture of relationship breakdown' through every available means, including the law, the tax and benefits systems, and frontline services that are already working with families. Recognising marriage in the tax system highlights the importance of marriage and acknowledges that its explicit promotion is indispensable for fostering a culture that values stable relationships. (Regardless of income or education, unmarried parents are more than twice as likely to split up as married parents.)[24]

At the local level this will require those who are responsible for tackling public health problems (including clinical commissioning groups, local authorities and directors of public health) to make couple relationships a key focus of joint strategic needs assessments and commissioning plans. At its simplest, this means doing all that is possible to destigmatise the take-up of relationship support and making it as available as possible. Solutions could include launching a national 'healthy heart' campaign with local premises such as children's centres, GPs surgeries, schools and other community hubs displaying a trusted kitemark to indicate that this is a place where people can get relational support.

Resilient families

We have already touched on the importance of increasing resilience in older age if people are to avoid the premature onset of a high level of dependency requiring, for example, long-term care. Thinking more broadly about what drives resilience in old age will enable people to prepare for it better as well as help to improve the quality of life for those already in this stage of life.

However, rather than treating resilience as an individual trait, it is better to focus on the ability of whole families to cope with the challenges that older age presents. At an individual level this would enable those responsible for ensuring an older person has adequate support to assess where strengths and difficulties lie within the family, and assuming that neither the family nor public services will bear the entire load.

At a societal level this would help to drive a relational, family-based and sustainable approach to employment that would make flexible working for carers and older people, not just parents, more culturally acceptable. If grandparents were freed up to provide child-care or volunteer in the community while they are still working this would better enable them to keep contributing to society as they leave paid employment. Moreover, if today's workers make caring for people in the generation above a priority, they are investing in their own care in older age by setting an example to their children.

Caring communities

Given that families are increasingly mobile with many adult children living at significant distances from their elderly parents, in the UK or even abroad, community-based approaches which both provide support to older people and enable them to contribute, are vital. Ideally these will have a positive affect across the whole community because loneliness is by no means restricted to those in retirement.

Indeed researchers like the psychologist John Cacioppo, based at the University of Chicago, describe loneliness as 'a social phenomenon that exists within a society and can spread through it, from person to person, like a disease,'[25] rather than a condition that affects people individually, either due to their circumstances or their personality type. Treating loneliness therefore requires looking beyond individuals who seem most affected by it, such as older people in 'relational poverty', and addressing larger, society-based issues.

Cacioppo emphasizes the need for people to build good quality connections and the role that communities can play in this: 'Communities that encourage regular interaction among members, either through regular gatherings or mutually beneficial projects that require everyone's input, for example, are more likely to foster stronger, more meaningful connections than those that don't encourage social investment.'[26]

One lady who contacted The Silver Line over the Christmas period confessed that she had felt suicidal on Boxing Day – and how she longs to be useful. 'I can do a bit of shopping for someone. Or read to someone.' Many older people already make huge contributions to society, with one 2009 survey estimating that people aged 50 and over form two-thirds of the volunteer workforce and account for nearly 70 per cent of the total number of hours provided by volunteers.[27] It is vital that local government (and other) community development initiatives recognise that older people can also create and develop social action programmes. Financial and other help to implement ideas born out of their considerable experience could enable them to transform the lives of those of retirement age who are frail, isolated and financially insecure – or make a difference across the generations, helping children, young people or parents with very little support.

In the process of conducting our research into older age poverty we visited a range of mature and successful international community development projects that have made sustainable ageing a central consideration of wider planning processes. For example we saw inspiring examples in Seattle of older people being meaningfully included in the development of a vision of a community that would support them as they age. 'Ageing Your Way' neighbourhood gatherings have, since 2010, successfully drawn people at or approaching retirement age into a number of evening gatherings, hosted at local community centres. These provide an ideas space for developing a vision of the kind of city they would like to live in as they age and a roadmap for how to get there, for example by imagining what local projects might go some way towards realising that vision.

Such gatherings are part of a wider culture of community engagement that treats all of the people in a neighbourhood as part of the solution to its particular social needs and consciously aims to build stronger connections between all of its members. This approach, spearheaded by Seattle City Council's Department of Neighbourhoods (DON) over the last 20 years is based on a conviction that, as founding director Jim Diers told the CSJ: 'There's a role for government. There's a role for charities. But there's no substitute for community.'

Our reports consistently emphasise the importance of charities in helping to build that sense of community. Volunteer Emergency Service Eindhoven (VES) is a charity we visited in Holland which has developed to meet a very specific need: the prevalence of many marginalised older people who are only in contact with professionals. VES discovered that a significant number of older people in Eindhoven – particularly those suffering from long-term physical and mental health conditions – only interacted regularly with people like social workers, GPs, psychiatrists, nurses and therapists. Their social networks were non-existent, due either to the nature or duration of their illness/ disability, or to their living in extreme isolation for many years.

VES matches volunteers to older people who act as specially coached and supported 'buddies'. A 'buddy' is neither a friend nor a professional but someone in-between; their sole responsibility is to help that person develop or rediscover their social networks.

VES Director Luc van Dijck told us how 'it is very difficult to move from contact with a professional to friendship with other people.' A relationship with a professional is not genuinely reciprocal. When a person only has contact with professionals this can generate a distorted view of social interaction and an inability to have real, two-way friendships. A social worker or community nurse is paid to engage with someone so their 'tolerance level' is likely to be higher. They will less readily send off the social cues that indicate when boundaries of acceptable behaviour have been breached. VES matches volunteers to older people who act as specially coached and supported 'buddies'. A 'buddy' is neither a friend nor a professional but someone in-between; their sole responsibility is to help that person develop or rediscover their social networks.

Improving residential care

Up to this point the solutions we have explored have tended to be suitable for people who are still living in their own homes. However, much of the current social care debate is focused on those who are unable to cope at home. It is important to recognise that huge variability exists in the needs and capabilities of people in this group. However we will focus here on those not yet needing nursing care, where a real gap seems to exist in the UK market for an inspirational model we came across in Albany, New York.

Housing-based models like Extra Care (which typically have a 24/7 on-site 'pay as you go' care team and provide older people with a flexible menu of services to meet a wide range of need) have existed for some time in the UK, but they are relatively uncommon. We need to keep evolving practice and to learn from affordable and effective solutions that ensure people retain their independence to the greatest possible extent. 'Staying in control' while avoiding isolation are hallmarks of Green House's 'communal living' for elders approach.

Green Houses are places where small groups of unrelated individuals can live together in homely, self-contained facilities that have residents' rooms built off communal lounge/kitchen/eating areas. Devoid of long corridors, the design features of the facilities are important to the Green House ethos. So too is the way they are staffed. Based on a staff-resident ratio of 1:5 or, maximum, 1:6, Dr Bill Thomas, the geriatrician who pioneered the model, jettisoned the standard care worker approach in favour of multi-tasking, highly-skilled professionals who run the home from top to bottom.

They decide, in partnership with residents, how to make life as congenial as possible for the home; they cook meals and then eat with the residents and wear their own clothes. The aim is to break down professional barriers between staff and residents and, most importantly, to nurture and maintain a community. Job satisfaction, salaries and contact hours with residents are all far higher than is typical for the US (and UK) care sector – but costs can be kept within the necessary limits.

Around 1,000 older people live in approximately 100 Green Houses spread across nearly 30 states and they have proven their financial worth. Designed not with the wealthy but the poorest in mind, the majority of residents on a national basis are state-supported. As Dr Thomas explained, the Green House model 'can't be one cent more expensive than the nursing homes which Medicare reimburse.'

We describe this model in more detail in our Age of Opportunity report. Since that publication a UK equivalent, EvermoreTM, has already emerged that is similarly intentional about building community and could support a mixed tenure approach whereby units within each site could be paid for through a range of funding models. These would enable people from a range of income brackets to have access to shared accommodation, creating much fairer access to residential care which maximises autonomy, regardless of means. Many of the units would be sold in a straightforward way to people with existing real estate so they could continue to own property. Other units would be rented to individuals (including those eligible for housing benefits) or to adult social care services for placing people with needs.

Family-sized care

Finally, other older people (infirm or otherwise) may prefer living in an even smaller community that is on the same scale as a nuclear family household. We need to ensure adequate policy attention is given to finding solutions to the structural impediments (for example, planning regulations) that hinder family members, who would like to, from bringing their older relatives under their roof. But we also need to exploit other opportunities to provide family-sized care where related adults are unavailable.

Shared Lives Care initiatives in many local authority areas make ordinary family homes and relationships available to the UK care sector, and provide support to many older people and those with mental illness or other disabilities. Again, a range of funding streams which include personal budgets are currently being used to pay for this care. Although it has seen high take-up in the North West of England there is still significant room for expansion there and elsewhere. The immediately cashable savings from making Shared Lives a mainstream care alternative would be significant. In addition, Chief Executive of Shared Lives Plus, Alex Fox, explains that

'the long- term gains from people finding a home and community in which to settle and belong, rather than staying dependent on traditional services and institutions, would be huge. A shift to Shared Lives and other family-based and micro-scale approaches would build the community relationships needed to tackle problems like isolation, service-dependence and chaotic lifestyles.'

Conclusion

Delivering fairness will require going far beyond securing a funding commitment from this and future Governments to make older age affordable. Everyone aspires to a good quality of life for their loved ones now, however infirm they may be, and for themselves when the time of greater dependence comes. Ensuring this is the experience of people throughout society, whatever their income, will necessitate nothing less than a deep change in the culture of care, not just at a professional level but also in wider society.

This will require a heightened sense of the value of relationships and the need to prioritise the attitudes and actions that develop and sustain them in the teeth of a myriad of competing pressures.

Given that family breakdown drives much older age poverty as well as much older age loneliness and isolation, we can no longer treat it as inevitable if we want to make progress in these vital areas. A public health approach to building and sustaining good quality relationships needs to be seen as indispensable for engendering greater resilience in older age. A significant body of research indicates the gains in health and well-being that can be won.

The benefits of building caring communities will extend to people of every age group and income bracket, by ensuring that all, including the most vulnerable, feel a sense of belonging and purpose. This will require that residential solutions fit for the 21st century are able to give older people meaningful connections with each other and work with the grain of their preferences instead of insisting on conformity to routines and regimes.

We may be living in an age of austerity, but necessity is the mother of invention. By working creatively and collaboratively to secure a better older age for everyone we will be able to say that this was in fact an age of opportunity – and that we did not let it pass us by.

References

1 Dilnot A, Warner N and Williams J, *Fairer Care Funding: The Report of the Commission on Funding of Care and Support*, London: Department of Health, July 2011

2 Available at http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1583/11102501.htm

3 Cited in evidence from Dr James Mumford to the Health Select Committee http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1583/12011001.htm

4 Department of Health, *Caring for our Future: reforming care and support*, White Paper, London: Department of Health, 2012

5 Centre for Social Justice, *The Forgotten Age: Understanding Poverty and Social Exclusion in Later Life*, London: Centre for Social Justice, 2010 and Centre for Social Justice, *Age of Opportunity: Transforming the lives of older people in poverty*, London: Centre for Social Justice, 2011

6 http://www.thesilverline.org.uk/

7 2.0 million before housing costs (BHC), and 1.7 million after housing costs (AHC) Department for Work and Pensions, *First Release: Households Below Average Income Statistics*, London: Department for Work and Pensions, June 2012

8 Office for National Statistics, *Family Expenditure, 2009 edition*, Newport: Office for National Statistics, 2010, p115

9 http://research.dwp.gov.uk/asd/frs/

10 Scharf et al, *Growing older in socially deprived areas: social exclusion in later life*, London: Help the Aged, 2002

11 Institute of Fiscal Studies, 2006 English Longitudinal Study of Ageing, Living in the 21st Century: older people in England (Wave 3) London: Institute of Fiscal Studies, 2008

12 Ruth Levitas, Christina Pantazis, Eldin Fahmy, David Gordon, Eva Lloyd and Demi Patsios, *The Multi-Dimensional Analysis of Social Exclusion*, Bristol: University of Bristol, 2007

13 Dr Bill Thomas, cited in *The Forgotten Age: Understanding Poverty and Social Exclusion in Later Life*, 2010 p109

14 Roberts Y, One Hundred Not Out: Resilience and Active Ageing Young Foundation, London: Young Foundation, 2012 with statistics taken from ONS, *Older Peoples Day Statistical Bulletin*, Newport: Office of National Statistics, 2010

15 Roberts Y, One Hundred Not Out: Resilience and Active Ageing Young Foundation, London: Young Foundation, 2012 p19

16 Office of National Statistics, *Social Trends 34*, Newport: Office of National Statistics, 2004

17 The 2008/9 English Longitudinal Study of Ageing (ELSA) which also showed that those who were widowed were the most likely to show signs of depression.

18 Bartley M, *Life gets under your skin*, UCL Research Department of Epidemiology and Public Health on behalf of the ESRC International Centre for Lifecourse Studies in Society and Health, 2012 p15

19 Giddens A, *The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Societies*, Cambridge: Polity Press, 1992, p96

20 Finch J and Mason J, Negotiating Family Responsibilities, , London and New York: Tavistock/Routledge, 1993, p167

21 Poll conducted by telephone by Survation between 16th-21st December 2011. The population sample was 2003 single-occupancy households where the resident's age was 75 years and over.

22 Holt-Lunstad J, Smith TB, Layton JB, Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Med 7(7), 2010

23 Tavistock Centre for Couple Relations, *What do couple relationships have to do with public health?* London: Tavistock Centre for Couple Relations, 2012

24 Analysis of Millennium Cohort Study corroborated by Goodman A and Greaves E, Cohabitation, marriage and relationship stability, IFS Briefing Note BN107, London: Institute for Fiscal Studies, 2010

25 http://www.time.com/time/health/article/0,8599,1943748,00.html

26 ibid

27 Volunteering in the Third Age, *The indispensable backbone of voluntary action: measuring and valuing the contribution of older volunteers*, London: Volunteering in the Third Age, 2009