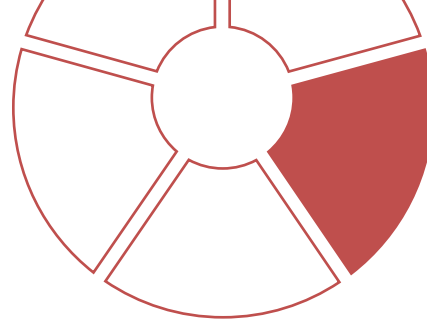




# HEALTHY AGEING IN THE 21ST CENTURY: THE BEST IS YET TO COME

Birmingham Policy Commission

The Report  
2014



# Foreword

## by the Chair of the Commission



When I was asked to chair this Birmingham University Policy Commission on Healthy Ageing, I thought 'Where better to host such an important investigation?'. Birmingham is a multicultural city. Its 'super-diverse' population provides an ideal opportunity to explore the implications of ageing for ethnically diverse people from across the world. This is a subject area in which there is a paucity of research. The Policy Commission found a need to recognise and accommodate super-diversity and also that cultural sensitivity should be a vital component in the planning of future services for the elderly.

It is, of course, a great success that the proportion of people aged over 60 years is growing faster than any other age group. But, we heard from those giving evidence to the Commission that patterns of ill-health in the older population reflect those in earlier life, with poverty being the most significant causal factor of early death and ill-health in later life. The stark fact is that now, in the 21st Century, people from poorer backgrounds die younger and spend more of their shorter lives with disabilities than those from more affluent backgrounds. Dramatic differences remain between the best off and the worst off in England – an unjust social gradient in health that needs addressing. Healthy ageing should be the life-long goal for individuals, communities and governments. Policies to reduce health inequalities should focus on reducing the social gradient in health by acting on all of the social determinants of health to ensure that people regardless of their socioeconomic status are able to live to a healthier old age.

Increasing numbers of older people flourishing in later life bring with them many opportunities and challenges that require society to adapt in order for the older people to fulfil their potential. A common theme was a desire for more control, independence and security. We heard of numerous examples of older people making huge contributions to their communities including Elders' Councils influencing policies at local level. But the involvement of older people is not universal. Much more could be achieved if older people had a louder voice at all levels of policy making. This may be made more effective by establishing a Commissioner for Older People who would be charged with the responsibility for encouraging every level of government to listen to the voices of all older people, vulnerable and healthy alike, and with ensuring that their rights and interests are protected and promoted.

I would like to thank our Commissioners for their excellent contributions, those who gave evidence and Sonia Large and Audrey Nganwa for their great help and support. My final thanks go to our academic leads Professor Heather Draper and Professor Jean McHale who have worked tirelessly on this project for over a year demonstrating the benefits of bringing together academic leaders from different disciplines to combine to produce important recommendations for society as a whole.

**Professor Steve Field CBE FRCP FRCGP FFPHM**  
**Chief Inspector of General Practice for the Care Quality Commission\***  
**and General Practitioner in inner-city Birmingham**

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# Acknowledgments

The University of Birmingham wishes to express its gratitude to the Commissioners for the time and expertise they have given to the Birmingham Policy Commission on Healthy Ageing in the 21st Century. The Commission benefitted greatly from the conscientiousness and dedication of the Commissioners and is grateful for the commitment, active participation and valuable input that played such a key role in commission proceedings and the production of this report.

Particular thanks are extended to the Commission Chair, Professor Steve Field, for his continued commitment to the Commission despite two significant professional role changes over its lifetime.

The University would also like to acknowledge all those who contributed by sending written evidence and participating in commission evidence-gathering sessions. These contributions helped to shape the Commissioners' thinking and the recommendations detailed in this report.

We are grateful to all those who participated in the AgeWell conferences (September 2012 and September 2013) and in the consultation groups held across the City of Birmingham. The Commission benefitted greatly from hearing about the experience of ageing in Birmingham. Special thanks are also extended to Chandrika Gordhan, whose skills and expertise ensured that the composition of these groups was as richly diverse as the city itself.

Sonia Large and Audrey Nganwa managed the commission process efficiently, with unfailing cheerfulness and patience. The Commission was also supported by colleagues in the University's Stakeholder Relations team, Deborah Walker in the Press Office, and Helen Hancock, whose editing input is very much appreciated. The Academic Leads are most grateful to Sarah-Jane Fenton, who conducted the literature review, organised the evidence, made drafting suggestions and wrote up much of the material to which this document is linked. Much appreciation is extended to Jenni Lynch, who used her placement with the Commission to help with our work on technology and ageing, and to Charles Irvine, who undertook a review of the relevant legal and related policy materials. Finally, we would like to thank Dr Sarabjit Singh Chandan from Guru Nanak Nishkam Sewak Jatha, Birmingham, for the many valuable contributions he made throughout the life of the Commission.

The views expressed in this report reflect the discussions of the Policy Commission and the research that informed them. They do not necessarily reflect the personal opinions of the individuals involved.

**Professor Heather Draper**  
**Professor Jean McHale**

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# Summary

## Key findings

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- The experience of ageing is a complex one that is only loosely associated with how old someone is.
- Different cultures think about ageing in different ways – yet these differences are not fully understood in our society.
- Health inequalities associated with socio-economic disadvantage are also found in the older population.
- Enabling people to experience healthy ageing is a long-term project, for which society, communities, and we as individuals, need to plan carefully.
- Older people want control and independence, but this can be in tension with their need for security, care and support.
- Technological support for older people can contribute to healthy ageing, if the support is sensitively developed and applied.
- Older people make a huge contribution to society. Some communities and faith groups draw on this contribution in responding to the needs of all their members. Sharing this good practice presents a real opportunity for communities of all kinds.

## Recommendations

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- When planning services for an ageing population in the UK, there is a need to recognise and accommodate super-diversity. Cultural sensitivity should be a vital component in all future services for older people.
- The human rights of older people should be at the heart of health and social care policy.
- A new statutory post of Commissioner for Older People should be created in England
- Reciprocal relationships that bolster healthy ageing should be central to future care and support arrangements.
- Policy makers need to design policies that harness people's instinctive behaviours to work towards, rather than against, healthy ageing.
- More effort needs to be made to give older people a louder voice in respect of their environment and local community
- Ageing in a super-diverse society is a major challenge that society does not yet fully understand. Gaining a better understanding is something that Research Councils and other research commissioning bodies should prioritise.



Introduction



# Introduction



In 2011 the University of Birmingham launched a policy commission on healthy ageing to explore different expectations for flourishing in later life and how good health in later life can be promoted. This Report first presents our key findings and then sets out the Commission's recommendations for healthy ageing in the UK's 21st Century super-diverse society.

The Commission's view is that **healthy ageing can and should be a realistic goal for the younger, the older and the oldest amongst us**. Much more must be done so that we can fully benefit from the enormous potential that exists within the UK's ageing – and often still active and healthy – population. This is a long term, but essential project. **It involves filling major gaps in understanding**, for example, about the extensive contribution that older people make, the ways in which the different and diverse communities in the UK think about and approach ageing, how older people can live safely and flourish, and how new technological possibilities can be appropriately used to support independence amongst older people. **The voice of the growing cohort of older people must be at the heart of decisions across the range of public services**. These changes will be strengthened by a stronger institutional framework. Accordingly, **we support the establishment of a Commissioner**

**for Older People in England** drawing upon the lessons from Wales and Northern Ireland, **alongside clearer legal rights and responsibilities and a major debate on the introduction of a Convention on the Rights of the Older Person**.

From the outset, the Commission was determined to focus on the positive aspects of ageing when considering what healthy ageing in the 21st Century could look like. We chose healthy ageing as our focus because feeling healthy can be an important prerequisite for flourishing in later life. But ageing well and ageing healthily are affected by other factors: financial security, good quality care and advice, appropriate housing, being socially connected and having meaningful relationships, having independence and control over one's life, and having a sense of being able to contribute to society and being valued. These are all widely recognised as factors associated with good ageing as well as healthy ageing. The absence of one or more of them can inhibit healthy ageing – or indeed health at any age. And where they are absent, there is no single, quick fix to ensure health at the level of individuals or populations.

Indeed, the idea of healthy ageing could be regarded as something of an oxymoron, since people often

associate 'being old' with signs of ill-health, diminished capacities and impairments, rather than with a particular chronological age. One is more likely to experience poor health in the period before death, whenever it occurs, than simply because one has reached a certain age. And even when it occurs in older age, the period of ill health before death is now 'compressed into fewer years' (Bowling and Dieppe 2005 p.1548) than it used to be. Accordingly, the recipe for a good older age is likely to require much the same ingredients as the recipe for a good life in general. If we want to promote good older age, we need to concentrate on removing obstacles to flourishing in general, particularly as how we flourish, or fail to flourish, in our early and mid-life will impact on the extent to which we are able to flourish in our later life.

The Commission also wanted to reflect the fact that the University of Birmingham is located in a city that has a 'super-diverse' population. Over the past 20 years, the UK has experienced a new pattern of migration that has been labelled 'super-diversity' (Vertovec, 2007). Compared to post-colonial migrants, these super-diverse migrant groups are smaller in number, more transient, less organised, and more economically stratified. They are also more likely

to move into areas that are already ethnically diverse, bringing together multiple languages, faiths and religious practices, and cultural norms and values, resulting in diversity both between and within ethnic groups. This represents a diaspora of peoples from across the world (Phillimore 2011). The Commission explicitly sought to understand healthy ageing in the context of such super-diversity. Whilst there is some understanding of ageing in Black and Minority Ethnic (BME) communities, there is as yet very limited research that explores ageing in a super-diverse 21st Century UK context. The experiences of established BME communities and super-diverse communities are likely to be different, and this has major implications for planning and delivering our goal of healthy ageing.

To take seriously the attainment of a good older age means making ageing well a life-long goal for individuals, communities and the policies initiated by the State. This was the conclusion drawn from much of the evidence presented to the Commission on ageing well and healthy ageing. Patterns of ill-health in the older population reflect those in earlier life, with poverty, and the concomitant loss of control over daily life, being the biggest indicator, and potentially the most significant causal factor, of ill-health in later life. Becoming old, and then dying, is much more likely to be experienced at a younger age if one is socially and economically deprived than if one is not (Marmot 2010).

Ill-health per se need not, however, prevent flourishing in later life, though it may make it more difficult. Many older people regard themselves as relatively healthy, and happy, even though they are living with several different chronic diseases and/or impairments. We need to be mindful of the gulf between objective, medicalised measures of well-being, and the subjective psycho-social criteria that individuals may themselves use to assess the quality of their lives: for instance, sense of achievement, sense of value, degree of control, and opportunities to express qualities such as spirituality or humour (Bowling 2007).

There is always scope for ensuring that the quality of those areas of older people's lives that remain unaffected by disease or impairment is maximised, to ensure that older people find pleasure and satisfaction in exercising the capabilities they continue to have, and also to support those who need care – be this 'social' or healthcare – in a manner that is compatible with living well. In short, there is much that can still be done to facilitate a good older age for those who are currently in the later stages of their lives, even those who are experiencing ill-health created as a result of patterns and constraints established in earlier life.

Following a scoping phase, and informed by a literature review, the Commission held five half-day workshops, four in London and one in Birmingham, to which relevant policy makers, practitioners and academics gave evidence and where pre-circulated questions were debated. Interviews were held with, and written evidence obtained from, key informants who were unable to attend the workshops. The Commission also convened a series of consultation groups comprised of older people from across Birmingham to gain the views of the city's diverse population.

We also took advantage of AgeWell meetings organised in the University in 2012 and 2013, first to ask local older people what the priorities of the Commission should be, and then to gain their reactions our recommendations. We were also able to draw on current research by the University of Birmingham into the views of local older people in other contexts, for instance in relation to telecare and robotics. Together, these Birmingham voices punctuate the report.

### Commission Chair

- Professor Steve Field CBE FRCGP FFPH FRCP, Chief Inspector of General Practice, Care Quality Commission

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- Bhai Sahib Mohinder Singh, Chairman of Guru Nanak Nishkam Sewak Jatha
- Professor Janice Thompson, Professor of Public Health Nutrition and Exercise, University of Birmingham

This report of the Commission's findings and recommendations is available electronically at <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/report.aspx>

The website also contains hyperlinks to papers that discuss each topic in greater depth, to the written evidence presented to the Commission, and to slides and summaries of discussions accumulated over the life-time of the Commission.



Key Findings



## Key findings

# The experience of ageing is a complex one that is only loosely associated with how old someone is.

Ageing is much more than the accumulation of years: as important as chronological age are people's social and physical environment, and biological and psychological factors.

The Commission's **consultation groups** explored people's views on ageing, the situations in which they felt old, and what this meant in relation to their identity and culture. We were told by our participants that ageing is a complex experience that is not steady or continuous over time. It is not experienced chronologically nor can it be represented by a straight diagonal line on a time/ageing axis. Rather, it is experienced in a variety of different ways. People can feel old one day and not the next. Our participants also told us that social connectedness is very important to the positive elements of ageing, as is respect and intergenerational respect, with loneliness, social isolation and loss of respect contributing significantly to the negative aspects.

*"Everything is about individual. It all depends on how you as a person feel about getting old. So long as you are able to do everything and can manage, that is fine. So why fight it?"*

**Arabic Women's Awareness Group**

*"I am so glad that I am old now. I get lot of help from my family. My children and my grandchildren are really good... Oh I wish I was a lot older!"*

**UK Caribbean Seniors**

*"Healthy ageing means social interaction – is just as important as exercising"*

**AgeWell 2012**

In biological terms, ageing is often associated with functional decline, suggesting a physiological definition of ageing might be 'the increasing frailty of an organism with time that reduces its ability to deal with stress, resulting in increased chances of disease and death'. Biogerontologists are making **significant progress** in understanding the processes of ageing.

This biological definition focuses on decline and the loss of functions to the exclusion of the more positive experiences and possibilities that remain. It also perpetuates an understanding of ageing that stands in constant contrast to that of youth, so that ageing well is associated with retaining youthful activities and appearance. Indeed, positive images of ageing are often taken to be those of older people remarkably continuing with activities that much younger people might struggle to achieve. We heard that some older people deplore such portrayals, which not only set the wrong 'standard' for success but also set the bar at a level that invites failure and diminishes other achievements by comparison.

Valuable insights on ageing are provided through images created by older people themselves, and **Lorna Warren** shared with us some images taken by older women. These illustrate the benefits of giving older people a meaningful say in how the positive aspects of ageing are portrayed. We also heard from **Philip Tew and Nick Hubble** that older people noticed a lack of characters in fictional literature that they could associate with, because older people were either portrayed in a way that they could not relate to, or were completely absent. One of the challenges for the Commission has been that the concept of health itself is often thought of in terms of absence



of illness or disease, whilst at the same time population health measures include 'years lived' as a measure of health and economists stress the additional costs of retaining existing services as the population as a whole becomes progressively older.

This leaves academics and others investigating ageing as a more positive phenomenon having first to address the more negative associations of being 'up the hill, but not over it' (Bartley, 2012:



14). There is merit in avoiding both the 'deficit' and the 'heroic' models of ageing (Godfrey et al., 2004) and looking for other ways to understand healthy ageing.

Ageing well, and in particular 'successful ageing', are often reported both as socially constructed and as a multi-dimensional concepts (Fernández-Ballesteros et al., 2009; Bowling, 1993, 2007). In the literature on ageing we found the richer ingredients suggested for healthy ageing included: personal

resilience, wisdom, good cognitive function, being socially engaged, independence, avoiding intergenerational conflict, having social and other capital, the achievement of spiritual peace, and appropriate and accessible public services. **Academic perspectives on ageing and what healthy ageing looks like will need to adapt to embrace these more synoptic definitions of what it means to age well. One standard set of criteria does not enable us to explore the**

inter-relationships between people and time, and the possibility of feeling 'old' at some times and not at others.

Overall we found that it is not the age that you are that dictates how old you feel; nor is it solely your health status (although that is undeniably important). Healthy ageing relates to the activities you undertake, the environment in which you live, the services you have access to, how valued and valuable you feel and, importantly, your social networks.

*"If you've got your health you can do anything... If your brain's gone it's somebody else's problem"*

**Halesowen and Dudley Elders Group**

*"Eat the right things, exercise, and keep your mind focused...keep busy and that's what I do, and I am 84"*

**UK Caribbean Seniors**

*"The only time you feel old is when you feel ill"*

**Halesowen and Dudley Elders Group**

*"I think you're more health-conscious when you're older than any other time in your life"*

**Halesowen and Dudley Elders Group**

For a fuller account of the Commission's thinking on the science of ageing, see 'The Ageing Process and Healthy Ageing', and for more on the complexity of ageing, see 'The Experience of Ageing is Complex'. These can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>



## Key findings

# Different cultures think about ageing in different ways – yet these differences are not fully understood in our society.

Ageing healthily is often understood in different ways by different groups in our diverse community.



So 'ageing is not necessarily ethnically neutral' (Bowling, 1993: 449), and lay views on healthy ageing vary according to culture (Hung et al. 2010). However, **our literature review confirmed that existing research into cultural understandings of ageing and how it is negotiated in different groups in the UK is very limited.** One example is Gardener's study of older people (referred to as elders) from the Bengali population in London (Gardener 2002); and there is a small body of literature on specific groups' experiences of ageing outside the UK. These studies are not, however, generalizable to whole or specific populations within the UK. Similarly, we know something of migrants' experiences of ageing in Sweden (Torres 2013) but there is little comparable data available on the UK.

It was clear from the evidence presented by the [Centre for Policy on Ageing](#) that ethnicity is going to impact on the profile of the ageing population in the UK and the provision of services for older people. We also heard from [Nat Lievesley](#) that patterns of behaviour associated with health improvement in BME communities are not uniform across the UK, but vary by region and social-economic status. There is, however, a paucity of data on variations in relation to healthy ageing. Improving understanding of variation in the UK is even more significant in areas that are experiencing super-diversity, such as Birmingham.

Expectations in relation to familial support for older people in the UK have been found to be culturally nuanced and linked to generational as well as ethnic identity

(Sin, 2007). The relationships individuals have with their community, with the state, and with their family, are not uniform, and policy and research need to understand these dynamics in order to utilise existing support networks or step in where care is failing. We need to know more about successful or healthy ageing, what this looks like in different communities, and how it is differently understood.

Studies from other countries illustrate the value of culturally specific research. For instance, Tseng (2013) in a study in the USA comparing the views of African American, American Indian, Chinese, Latino, Vietnamese and white older adults, found that different perceptions of ageing well were given different weight by different groups. For example, social involvement was given greater weight as an important active ingredient of successful ageing by American Indian, White, and African American participants than by other groups. Thiamwong et al. (2013) identified the notion of ‘tham ma’ in Thailand, as the most highly rated value for achieving healthy ageing. It is linked to behaviour that includes ‘enjoyment through helping family and participating in community activities, staying away from stress, and making merit and helping other people without expecting anything in return’ (p. 259). **Research such as this clearly demonstrates that greater awareness of culturally nuanced understandings could help shape healthy ageing policy for the 21st century.** We saw evidence of the success of culturally responsive services in **Chandrika Gordhan’s** presentation on the Birmingham Arthritis Resource Centre, which has successfully targeted

socially and educationally excluded groups, especially newer immigrants BME groups, with a view to improving understanding of musculoskeletal disease (including the myth that arthritis is only a problem for older people). There is much to be learned from initiatives such as this.

Our discussions with **Birmingham faith leaders** also demonstrated **that faith beliefs may have an impact on the framing of healthy ageing, even within similar ethnic groups.** Major Samuel Edgar, for instance, told us that from the point of view of those in the Salvation Army, there is a duty to keep the body healthy in order to better serve God for longer (though spiritual health is paramount). All the faith representatives present felt that their faith portrayed life as a blessing, which they felt enabled those with faith to maintain a positive outlook. We received **written evidence** from the Guru Nanak Nishkam Sewak Jatha Sikh community that explained the importance of faith as a means of keeping the spirit fresh as the body becomes frail.

From international research we know that there are differences between individuals and groups that materially affect the experience of ageing. **Our lack of knowledge about different cultural understandings of significant factors related to ageing may mean we fail to plan appropriately for healthy ageing in a super-diverse, multi-cultural society.** By focusing on the positive aspects of ageing, the Commission has highlighted fertile ground for future research on diversity and different understandings of ageing and what it means to age well.

*“Getting old for a woman is when she stops her menstrual cycle, and starts going grey”*

**Arabic Women’s Awareness Group**

*“When we become old we are like children, so you need your children to look after you. This is why children are important and you have to raise them properly so they grow up to respect you. But things are now changing with young people, and some young people do not want to live with their elders”*

**Arabic Women’s Awareness Group**

*“Healthy ageing is more than simple health and well-being, but it can be related to cultural practices”*

**AgeWell 2012**

*“Some ethnic communities value elders more than others”*

**AgeWell 2012**

For a fuller account of the Commission’s thinking on the need for a better understanding of cultural differences, see ‘Cultural Differences in Ageing in the UK – A Significant Knowledge Gap’. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>



## Key findings

# Health inequalities associated with socio-economic disadvantage are also found in the older population.

The Commissioners were determined to understand how a population can flourish and remain as healthy as possible while it aged, but we did not underestimate the challenges of achieving this.

One major issue is how to ensure that all older people are able to age well. We heard evidence from researchers knowledgeable about health inequalities, including [Diana Kuh](#) and [Peter Goldblatt](#), and examined a large number of studies. From this evidence, it is clear that **patterns of inequality established even before we are born can affect our health as we age, and the issue of health inequality remains a challenge for policy makers in relation to healthy ageing.**

*“Our men are in low paid jobs – well, the majority of them – and it only pays for the family to barely keep afloat, so how can we save money for our old age? Just impossible to save when not much money is coming in to pay for basics.”*

**Arabic Women’s Awareness Group**

*“Money is really important, because without adequate money you cannot eat good food, pay your bills, keep warm, enjoy going out... You do need money to survive instead of just existing.”*

**Halesowen Asian Elderly Association**

*“I think it is good to take responsibility over your future years, but sometimes it is so difficult. How can you think about your old age if you end up being ill with long term illness and cannot go out to work.”*

**Halesowen Asian Elderly Association**

This is because even where patterns of health inequality are seen, it is not obvious what could or should be done in response to these.

In England and Wales most deaths (80 per cent) occur in the population aged over 65, and just under half of all other deaths (eight per cent) occur in those aged 55-64. That most people die when they are old is arguably a marker of successful public health rather than an indicator of inequality for older people. In the absence of an elixir of life, everyone will die eventually, and dying later rather than sooner is regarded as a good thing in our society. Inequalities appear, however, when we start to look at who is dying within these two broad age bands. Women tend to live longer than men but men and women from more deprived areas and lower socio-economic groups are disproportionately represented amongst those who die towards the younger end of older age, and also experience more years of ill health before they die. Although women live longer, they live for longer in poorer health, as their healthy life expectancy (healthspan) gains have been smaller (Salomon et al 2012). Amongst the oldest of older people (85 plus years) more women than men live alone, in rented accommodation, and experience the highest rates of poverty (Age UK, 2013: 11).

Poverty within ageing populations is not uniformly distributed – it does not follow that if you are old you are poor. Instead, the serious concern in relation to ageing and poverty is that those who have been socio-economically disadvantaged throughout their lives carry this disadvantage through to old age. Poverty at all ages, ‘is a significant socio-economic health determinant,

with negative effects on health, life expectancy and disability’ (EuroHealthNet, 2010: 2). [Peter Goldblatt](#) reported striking differences between social classes in the proportions of people entering retirement with health problems.

For the older people we spoke to in our consultation groups, shortage of money was a concern. They pointed out that money was also tight when they were younger, making it hard for them to save for later life. The Birmingham Policy Commission on the [Distribution of Wealth](#) has already commented on wealth inequalities and pension policy, and made policy recommendations in regard to the poorest, the richest and those in the middle. Socio-economic status and financial hardship raise pertinent questions about quality of life and health inequalities specifically in relation to healthy ageing and the potential for flourishing (Marmot, 2010)

There is a complex tripartite relationship between health, ageing and health inequalities. Some individuals are able to remain positive about their self-reported health and well-being, even though they have chronic illness and/or disabilities, especially when they are socially well connected and report a good mental quality of life (Grundy et al 2007). [Tom Kirkwood](#) reported that whilst ‘those aged 85 plus experience multimorbidity (75 per cent have four or more medical conditions) ...78 per cent rate their health as “good”, “very good” or “excellent”’. People do not necessarily become, or feel, progressively more ill as they get older.

Indeed, there is evidence that the very long-lived may have fewer health detriments than those at the younger end

of older age. This may be because older people from poor socio-economic backgrounds find it more difficult to access health services, widening the health inequalities between socio-economic groups as they age (Chandola et al. 2007). Thus although an individual's longevity and healthspan are influenced by their genetic make-up, ultimately the survival of the fittest may be the survival of those who are richest and always have been.

From the evidence we reviewed, we draw two conclusions: **it is possible for the oldest of the old to achieve healthy ageing; and more needs to be done to ensure that the poor are as able to flourish in later life as the wealthy.** The latter aim may only be achieved by evening out inequalities in younger life.

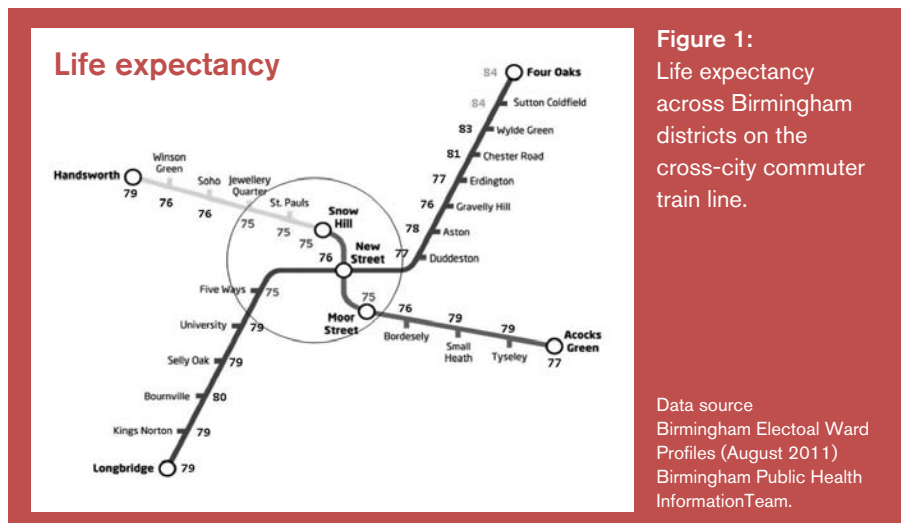
*“Older people that are connected to the internet may have a huge advantage over those that are not in terms of accessing information and feeling involved”*

AgeWell 2013

*“Worrying about those sort of things [financial worries] drags you down mentally”*

Halesowen and Dudley Elders Group

For a fuller account of our analysis of the evidence on health inequalities and ageing see 'The Ageing Process and Healthy Ageing' and 'General Patterns of Health Inequalities Are Repeated in the Older Population'. These can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>



A map of the cross-city train line in Birmingham emphasises the differences in life expectancy across the city, with just eight stops on the line showing an eight-year disparity (Figure 1). The highest life expectancy in 2011 was seen in Sutton Coldfield, at 84 years, but fell by seven years, to 77, in Duddeston and by eight years, to 76, in Soho. The latter two are areas of lower socio-economic status and high ethnic minority populations.



## Key findings

# Enabling people to experience healthy ageing is a long term project, for which society, communities, and we as individuals need to plan carefully.

In the previous section we saw how an individual's overall health is very influential in determining their health in older life.

If patterns of health outcomes are established even before we are born and then continue through our childhood and into our adult lives, healthy ageing can be promoted by ensuring that parents and then their children flourish in ways that set them up to age well. Then, as those children reach adulthood, they need to engage in financial and other forms of planning for their older life; and their circumstances will affect the health of any children they choose to have.

On an individual level such prudence can be difficult to achieve, and not just because of the impact of social inequalities. We sometimes see our immediate concerns, needs and desires as much more pressing. It is not always obvious that our future self is more

important than our present self, nor that our present selves should shoulder the burden of our future selves. Later we discuss how we can incorporate into our planning approaches that make it easier for individuals to behave in ways that will benefit their future, older selves. But it is important also to acknowledge that some balance does need to be struck between living for the present and living for a future – which may, after all, not arrive. There is a difference between accepting responsibility for our future selves and being slaves to our future interests.

Planning for adequate financial resources in later life is a central issue. People in our consultation groups varied in their views about the balance between individual responsibility to plan for a financially secure future and the State's role.

We spoke with some older people whose plans for later life were disrupted by forces they felt were beyond their control – like the recent financial crash and ill health. Others acknowledged that they had not planned for later life. It is likely that cultural and other values and beliefs will affect people's attitudes to future planning. Nonetheless, there is plenty of scope for improvement in education for healthy ageing. But to be successful, such interventions need to be sensitive to super-diversity. The Commission also heard evidence from [Phillip Tew and Nick Hubble](#),

who described how older people need on-going control over, and involvement in, building their own narratives; and that older people are feeling increasingly alienated by a policy rhetoric that presents them as a social or financial burden.

There is also evidence that there are public services that older people value particularly highly. These related primarily to health care (which is beyond the remit of this report), place and space, mobility and transport, and personal safety.

The importance of physical and social environments in healthy ageing was evident in our literature review. Owen and Bell (2004) found that 'having household objects with particular personal significance; having enough space for self-actualisation (that is, to be able to do things that help you realise your own potential); living in a place that has links to their own personal history; living in a secure accessible neighbourhood; having some contact with the community every day; and maintaining appropriate boundaries between public and private spaces' (p.9) were all important to ageing well. Macintyre et al., (2002) discuss the work of Ellaway & Cummins (2002) who through their analysis of the effects of place on health, proposed five environmental characteristics that impinge on the lives of older people, including: those that affect everybody; the characteristics of the specific location where older people spend the largest proportion of their time; services, including transport, street maintenance,

*"One of the problems is that there is little information for people about what you can and should do after retirement"*

AgeWell 2012

*"In an ideal world we should all start to prepare our retirement much earlier, but it should be a shared responsibility where you, the family and the government also play a major role in supporting elders"*

Halesowen Asian Elderly Association

## Box 1:

# Local older people's views about public transport

policing, health and social care; socio-cultural characteristics, including community cohesion and cultural integration; and perceptions of neighbourhood.

The significance of public transport was a strong theme that emerged in our consultation groups. Public transport seems to have an importance that goes beyond enabling mobility between significant places that provide social connectedness. It was itself a form of social connection, providing an opportunity for social interaction. Also, traveling on public transport was viewed as an economical, warm and safe activity in its own right.

That free public transport is highly valued does not mean that it is beyond improvement. Our consultation group participants and those attending AgeWell meetings reported that buses are not always driven with due concern for less physically robust passengers. Rapid braking and acceleration throw people off balance, which threatens actual and perceived safety. Likewise, conventions such as ensuring that those less able to stand are offered a seat are not enforced (see Box 1). These comments illustrate the relationship between physical capacities and social construction when it comes to frailty and vulnerability. So does the relationship between physical environment and personal safety. Healthy ageing policies can reduce perceived frailty by improving the physical environment.



*“Public transport needs to be improved. My balance is not good, and often worry that I may fall. People nowadays will not give up their seat for you.”*

**Arabic Women's Awareness Group**

*“I just can't help myself. When I see somebody alone on a bus looking a bit down I'll have a chat.”*

**Halesowen and Dudley Elders Group**

*“Getting around is difficult.”*

**UK Caribbean Seniors**

*“Taxis are expensive and other public transport is not appropriate in these circumstances.”*

**AgeWell 2013**

*“I can jump on a bus and not have to worry about paying, you know, because that way you can sort of go to a friend's anytime or do anything.”*

**Halesowen and Dudley Elders Group**

*“When I want to go out I just call a taxi, so having money to pay for a taxi does help me, as I would be too scared to go on the public transport.”*

**Ladies Gujarati Shia Muslim Group**

*“I was talking to a bus driver one day and he said, ‘I've got people who get on the number 8, because it's a big circle, isn't it, and just go all the way round.’ They have circle 11. All the way round. Takes about two and a half hours... because it was warm upstairs and they didn't have to have the heating on at home then and then felt they've saved some money that way, but they go all the way round and they just do nothing else, they'll have a bus ride.”*

**Halesowen and Dudley Elders Group**

*“There was a lady I met on the bus one day, she said she went on the bus because it was the only time she ever spoke to anybody. She was alone and she used to go on the bus and speak to people.”*

**Halesowen and Dudley Elders Group**



Better street lighting and pavements may enable people to feel safer choosing to walk rather than use motorised transportation. Walking sustains and improves general fitness, which is also a constituent of healthy ageing. Walking is also facilitated by the convenient local setting of goods and services, particularly food shops. Food poverty – created by the closure of, or expensive goods in, local food shops – was one of the poverties facing older people identified to the Commission by **Adrian Philips**, Director of Health for Birmingham City Council.

Whilst there was much focus on individual planning, the Commission also looked at what issues were presented in relation to more centralised planning. The evidence we heard suggests that at all levels **longer term planning over multiple lifetimes, rather than on an individual lifetime basis, is required. Modifications to services and infrastructure are essential in relation to planning for healthy ageing in the 21st century.**

A planning opportunity for healthy ageing may have been created by the reforms to health and social care implemented in the Health and Social Care Act 2012. Unitary and County Council Local Authorities now have the statutory lead responsibility for improving health locally and coordinating efforts to protect the public's health and well-being, as well as ensuring health services effectively promote the population's health. **This means that local government has an unprecedented opportunity to promote the public's health and well-being through the full range of its activities.**

*“If you are active outside of your normal place of work and you keep that activity going you get to the time when you're supposed to retire and as long as you maintain that external activity I think that keeps your health and your mental health right so you are able to carry on doing things... I remember you used to hear of people, they get to retiring age and think, 'What am I going to do?' ”*

**Halesowen and Dudley Elders Group**

*“Wishes and reality are two entirely different things. Nobody is prepared. They don't want to think about retiring or what they're going to do. They just want to carry on with living today at today's pace.”*

**Halesowen and Dudley Elders Group**

For more information about evidence to the Commission about planning, please see 'Ensuring that People Experience Healthy Ageing is a Long Term Project'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>







## Key findings

# Older people want control and independence, but this can be in tension with their need for security, care and support.

The Commission heard much evidence that the ability of individuals to have control over, and independence in, their lives is a key contributor to healthy ageing. The ability to take autonomous decisions is, however, affected by a number of different physiological, environmental, social and financial factors.

It is always difficult to isolate those things that are truly in our control from those things that are not. With the things that are not in our control, there is a further difficulty in determining whether – and to what extent – they are in the control of anyone else, and the extent to which this control could and should be handed back to us.

Studies on twins suggest that around 25% per cent of longevity is inheritable, but this means that 75 per cent is dictated by environmental influences and is open to interventions both positive and negative (Herskind et al 1996; Fraser and Shalik 2001). Many research resources have been spent on looking for the biomarkers of ageing (Johnson 2006). However, just as there is no unifying theory for the cause of ageing, there

*“Being independent is for me really the most important thing and being in charge of your life, without depending on others, is vital”*

**UK Caribbean Seniors**

*“So long as I could be with others, and can take care of myself, then being old in Birmingham is not a problem”*

**Ladies Gujarati Shia Muslim Group**



*“Change is a common element of life and we need to accept change with the right help and support”* Halesowen Asian Elderly Association

is unlikely to be a single biomarker of ageing; but rather a composite set of variables is likely to emerge. Not all environmental factors are within our control, and we know from work on obesity that even those factors that appear to be within our control – such as what and how much we eat – are subject to external forces that it may be difficult for individuals themselves to combat.

Bolstering psychological resilience has been offered as a potential solution to the excessive influence of environmental factors but, as we have already seen, an individual's capacity for resilience may be affected by their socio-economic status. This emphasis on psychological resilience is something of a mixed

blessing. Focussing on improving the psychological resilience of the less fortunate, rather than improving their environments (i.e. removing the features that might require psychological resilience), can seem wrong (Gutheil and Congress 2000). But equally the role of the State in redistributing benefits and forcing change – including encouraging individuals to improve their own social circumstances – is also controversial.

The idea that individuals need to be supported to maintain their independence is also something of a contradiction. Yet there is evidence that – insofar as independence is judged by the avoidance of institutionalised care – social connectedness, family relationships

and access to services all contribute to independence and resilience so that older people's own assessment of their well-being is also improved (Wiles et al 2012).

The Commission heard evidence from [Ayesha Janjua](#) representing the [Office for Public Management](#) (OPM) that older people wanted independence and to feel as though they were making a contribution. However, there is also a clear role for the State and often a role for the private sector, e.g. bus schemes run by local supermarkets to provide transport for grocery shopping.

Independence helps people age well and with dignity (Sin, 2007; Age UK, 2013a; Age Concern, 2010). One of the stated motivations for the personalisation agenda (Social Care Institute for Excellence) is to engender a sense of choice and control in how independence is maintained. It aims to do this by putting older people in charge of their care budget, thereby giving them a choice about how to cater for their dependency and promoting their independence. However, it is not clear whether care is being provided to all those who need it (Carr and Robins 2009). Moreover, according to an Age UK blog, personalisation is not giving older people greater choices: the majority of care is still managed by the local authority, choice is restricted to preferred suppliers, people do not even realize that they have a personal budget, and there is a perception that reducing costs rather than enhancing choice is the real motivator (Age UK 2013b).

Many older people who need help depend on informal care, and many of those older people who do not need care provide it for those who do. **Particular attention needs to be paid to those older people who are or who have formerly been carers in relation to their own support needs for successful ageing. These needs are distinctive and potentially differ from those of the general ageing population.** What is enabling one person to feel independent and in control in his or her own home may be preventing another from achieving his or her potential to age well. **We need a greater understanding of older people's views on how to reconcile their needs and desires in relation to control, independence and security.**

Technology is increasingly being used to maintain independence and support professional and informal carers in the community. This is reviewed in the next section, where the tension between choice and security is also explored.

For a fuller account of the Commission's analysis of the evidence used in this section see 'The Ageing process and Healthy Ageing'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>

*"In my case I feel as if I have lost my identity. I suffer with a lot of joint pains and unable to sleep at night so always feeling tired, general weakness in terms of physically and emotionally."*

**Arabic Women's Awareness Group**

*"It would be nice to live in a community, bring people together by living close to each other, but maintaining independence and privacy"*

**AgeWell 2012**

*"The most worrying thing is this: it's this fine line between support and control."*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG2**

## Key findings

# Investment in technological support for older people can contribute to healthy ageing, if sensitively developed and applied.

Older people often want to live in their homes for as long as possible, and this aspect of their independence is associated with ageing well.

Ageing well is linked to people being independent, as we have seen, and their feelings about living at home are linked to their sense of identity and independence, their connection with their community, and their feelings of security and familiarity (Clough et al., 2004; Peace et al., 2006; Wiles et al., 2012a; King & Farmer, 2009). Tele-technology offers ways in which such independence can be sustained for longer: for example, through systems to detect falls, aids for sensory impairment, medication management, memory prompts, and vital signs monitoring (Fisk, 2003). It is also increasingly being used as an extension of hospital out-patient monitoring

*“She used to say: ‘It’s [fall alarm] it’s rubbing me neck’. So I got ribbon, then I plaited some wool...but nothing worked.... ‘It’s irritating me neck, so it was on the table at the side of her chair.’”*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG1**

*“I suppose a robot is not like a human that you can interact with really. (UBFG1) I’d rather have a robot than interfering carers or neighbours. (UBFG2) Well I’d want a robot which would put its arm around me.”*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG3**

and care. The types of equipment used range from low-tech standalone pieces, such as vibrating pagers or motion sensor lights, to sophisticated monitoring equipment, such as GPS trackers or even ingestible sensors in pills to promote medication adherence (Bryant Howren, Van Liew, & Christensen, 2013).

Over the past ten years, the UK Government has consistently promoted technology-based provision of care in the community. It has backed this position with large-scale funds and encouragement for relevant industries. The White Paper [Our Health, Our Care, Our Say: A New Direction for Community Services](#) (DH 2006) drew attention to the ageing population and the need to keep people healthy as they aged. Eighty million pounds was allocated to local authorities between April 2006 and April 2008 for the purpose of setting up telecare innovations to support people to live independently in their own homes and reduce avoidable admissions to residential care (DH 2005). This emphasis on enabling people to live well at home has been a constant in government policy, also being dealt with in the White Paper [Building the National Care Service](#) (DH, 2010), which promotes the use of new technologies in housing and social care policy to give people the confidence to stay in their own homes.

The current Coalition Government reaffirmed support for telecare and telehealth (DH 2012), following positive headline results from the [Whole Systems Demonstrator](#) (WSD) programme – the largest randomised control trial of telecare and telehealth in the world,

set up to provide a clear evidence base for investment in technology (DH, 2011). The trial focused on diabetes, heart failure and chronic obstructive pulmonary disease (COPD). Over 70 per cent of trial participants were aged over 65. It showed that tele-technology could reduce mortality rates by 45 per cent and prevent unnecessary hospital admissions (Steventon et al., 2013).

As tele-technology develops, the distinction between telehealth (associated with medical care) and telecare (associated with supporting social care) (Fisk 2003) is becoming blurred. Telehealth has recently been defined as ‘the means by which technologies and related services concerned with people’s health and well-being are accessed by them or provided for them at a distance.’ (teleSCoPE 2014 p.14)

The broadening in scope of ideas about telehealth has complemented advances in smart home technology aimed at improving people’s quality of life through the management of their home environment, usually through non-obtrusive monitoring of the inhabitant and/or encouraging their independence (Chan, Campo, Estève, & Fourniols, 2009). There is global interest in smart home developments that use environmental sensors focused on comfort, energy efficiency, safety and security, activity monitoring, smart appliances and biometrics, as well as the more usual falls detection systems and memory prompting technologies (Chan et al., 2009; Helal et al., 2005).





Robotic technology is also being harnessed for therapeutic and care purposes. Single function devices to help with eating, companionship, rehabilitation and re-enablement, and domestic chores, amongst others, have been developed. More ambitious multi-functioning robots linked into tele-technology through smart homes are also being developed, though these are unlikely to come onto the market for several years yet, and may prove economically unviable unless they are widely adopted in the developed world.

Technology is also being developed that encourages social interaction, for example enabling video-mediated contact between friends and family and virtual participation in group activities (Demiris & Hensel, 2008). The stereotype of older people's unwillingness to engage with technology can be readily contradicted (Mitzner et al., 2010). Technology may also improve social interaction by increasing people's desire to leave home and meet others (Bradley & Poppen, 2003; Osman, Poulson, & Nicolle, 2005).

**There is little research specifically concerned with the experiences of people of black and minority ethnic origin with telecare and telehealth.** Assumptions about high levels of family support, particularly for Asian older people, may be dampening enthusiasm

for these initiatives. These assumptions may not be accurate for all older people. Also, technology that functions primarily in English may impact on user confidence (Sanders et al., 2012). **In the 21st century it is imperative that services are sensitive to language differences.**

**Devices need to be user friendly, taking into account the varying needs for, and expectations of, the technology. They must also be acceptable to potential users and not stigmatize them. Older people should have an input into their design and also the ethical norms that govern their use.** There is a risk that increased reliance of tele-technology to support independence may lead to greater social isolation, intrude into privacy and erode dignity and control (Draper & Sorell 2013). Without careful implementation, tele-technology may also conflict with legal principles such as Article 8 of the European Convention of Human Rights, which safeguards the right to personal privacy. **Access to internet services has been increased by the use of mobile devices, but access in deprived areas may still not be affordable. Greater consideration may also need to be given to the way in which security may be both enhanced and eroded by tele-technologies,** which may increase confidence in safety on the one

hand and leave users vulnerable to fraud and other kinds of internet-facilitated wrong-doing on the other.

*“Because medication is a major problem for people not remembering what they’ve taken, if they’ve taken too many, and so on.”*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG2**

*“I’ve got a slight problem that this is very Big Brother-ish.”*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG2**

*“My mother still plays on her computer and she’s ninety-three. I mean, she goes on Skype and talks to us and she does things on it.”*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG3**

For more information on the Commission's thinking on tele-technologies and the evidence reviewed see 'Ageing Well with Technology'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>



## Key findings

# Older people make a huge contribution to society. Some communities and faith groups draw on this contribution in responding to the needs of all their members.

Sharing this good practice presents a real opportunity for communities of all kinds.

Discussions about ageing often focus on the potential burden on society of the ageing population and fail to indicate the positive contribution that older people are making within their families, their local communities and society more broadly. Yet older people do make a significant contribution to society, and in a variety of often unnoticed ways. This brings benefits to others, but is also an essential

aspect of healthy ageing, enabling older people to sustain social networks, a sense of being valued, and good mental and physical health.

**Evidence** from the **Office for Public Management** (OPM) showed how an asset-based approach to healthy ageing can highlight the contributions made by older people. For instance, 65 per cent of volunteers are over 50 years of age, and 25 per cent of informal care-providers are 60 plus. Sally Greengross informed the House of Lords debate on Older People: Their Place and Contribution in Society, that 10.4 million people aged 65 plus volunteer for 10 hours a week. In 2010, it was reported that voluntary service by people over 65 was worth £40 billion to the UK economy with a prediction that this could increase to £77 billion by 2030 (WRVS 2010). The same report noted the extent to which older people provide 'social glue' within communities through a myriad of volunteering projects and personal initiatives. We were also direct examples of contributions from participants in our consultation groups, many of whom related their contributions to their cultural and religious beliefs.

These contributions were not only framed in terms of personal and family relationships; they were also linked to local communities. This message was reinforced by the OPM's local

asset-based plans and examples. Indeed, a strong link between older people and communities was found in our consultation groups, all of which were located within existing local structures, especially those in BME groups.

**A real challenge for policy makers looking at healthy ageing in the 21st century is marrying the agendas of healthy ageing, the importance of community, and resilience and contributions from older people.**

Promoting what can only be mutually beneficial initiatives has to be a proactive goal of both national and local governments. We heard from **Age Concern, Birmingham**, that one of the difficulties with sustaining local projects is that they are subject to a 'churn' of residents, especially in areas of cheap housing where people move away as soon as they are able to afford to do so.

One of the strongest messages from our findings is the agency and power that older people have in relation to positive change and innovation. Remaining actively engaged in their community benefits both sides. There are also costs to both sides when older people do not remain engaged in the community, not just in terms of lost potential, but in diminishing mental health and well-being (Age UK, 2010). **There is a need for cities and areas across the UK to ensure that core services are sufficient to encourage a flourishing ageing population to continue making a huge contribution.**

*"Yes, community or being part of the community is really important for me and I am right to say for us all. My community is supportive and it is good to meet here as a group, and we talk and have some food and drink and share our concerns and have a good laugh too"*

**Arabic Women's Awareness Group**

*"Here at the Clifton Mosque we have everything that we need. There is a nursery, community rooms, and eight apartments and there is a caretaker always available if we need help, so we are well looked after"*

**Ladies Gujarati Shia Muslim Group**

*"We no longer have NHS doing things to us. We have to take responsibility and to empower each other to set up own health clubs"*

**AgeWell 2012**

We would like to highlight in this report one example: the achievements of the Guru Nanak Nishkam Sewak Jatha Sikh community based around Handsworth (see Box 2).

*"I'm treasurer for the local park. We've got a committee and we've managed to get a big improvement to our local park"*

**Halesowen and Dudley Elders Group**

*"Community or a good community will always work together to bring change. Change does not happen on its own"*

**Halesowen Asian Elderly Association**

*"We meet every week ...and we have tea and biscuits and chat about things and we've been doing this for ages. A local school found out we were doing this and said '[You've] all lived through Second World War. We're doing a history project on Second World War. Would you like to come around and talk to us about it?' It was fantastic! These kids were absolutely enthralled"*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG1**

For more information on the Commission's work on these contributions of older people and local communities see 'What Older People and Local Communities Are Contributing'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>

## Box 2:

# Guru Nanak Nishkam Sewak Jatha, Birmingham. A Sikh Faith-Based Organisation

- 1972 – Prayer meetings are held in the homes of four or five local families.
- 1976 – The Gurudwara on Soho Road (originally the Polish Club) is purchased to house the growing congregation.
- 1993 – Following the purchase of adjoining properties, the Soho Road complex is redeveloped in Sikh style using Sewa (selfless service).
- 1995 – A thriving Gurudwara emerges. It is a space that is used for a variety of religious and social gatherings and purposes, including for education, funded wholly from donations: 'Self-help, self-reliance and community participation is encouraged and practiced'.
- 2003 – Building work for the Nishkam Civic Centre at 6 Soho Road commences using Sewa.
- 2006 – The Nishkam Civic Centre is opened. It offers health and education services, amongst others.
- 2009 – The Nishkam School Trust is established. A nursery, primary and then secondary school are all opened by 2011, again using Sewa. Older members of the community are invited to share experiences and skills within the school.
- 2012 – The Nishkam Health Trust is established. This provides:
  - 20,000-25,000 free hot meals weekly, of which 60-70 per cent are served to older members
  - counselling and guidance
  - opportunities to do a range of Nishkam Sewa (selfless service) throughout the Gurudwara complex e.g. holding prayer services, cooking, cleaning, infrastructure work
  - opportunities to attend and participate in organised pilgrimage tours in India and Africa
  - use of a library
  - participation in holistic living via the use of the NCA gym in a culturally sensitive environment
  - a pharmacy and a free collection/delivery service for medicines
  - a voluntary foot care clinic
  - soon to be established: a GP surgery



Recommendations

## Recommendation 1

# When planning services for an ageing population in the UK there is a need to recognise and accommodate super-diversity.

Cultural sensitivity should be a vital component in all future services for the elderly.

The UK has an increasingly 'super-diverse' population (Vertovec, 2007). The impact of cultural nuances on experiences of healthy ageing, however, is something which has received little attention. There is a need to ensure that policy makers engage with the challenges of ensuring positive ageing in a super-diverse society and reflect this in the planning process. Research by McCann et al. (2008) illustrates that there needs to be broader understanding of ageing in relation to sub-populations (in this instance, women). Their research challenges the way in which ageing is primarily understood by policy makers as a matter of individuals' ability to undertake particular, often physical, functions. Within society, individuals' views on healthy ageing are likely to be more diverse, and these researchers argue that late mid-life and older people's views on successful ageing must be sought. Their research supports the view of the Commission that **understanding of healthy ageing has to take into account the views of those to whom the understanding is applied.**

Service providers are often preoccupied with planning for bed shortages and the burden of disease in the short term, but should give more attention to planning for the super-diverse future in a way that optimises opportunities for healthy ageing. As health promotion is only one aspect of healthy ageing, planning across services and at all levels of governance needs to take place.

The Commission has seen that there

are cultural nuances in relation to understandings of ageing and what healthy ageing means (Clarke and Warren, 2007; Sin, 2007; Chong et al., 2006; Hung et al., 2010; Lau & Morse, 2008; Torres, 1999; Torres, 2013; Thiamwong et al., 2013). In a presentation from the Centre for Policy on Ageing on their work on **the future of ageing in the ethnic minority population of England and Wales**, Nat Lieslesley reported, in line with an Office of National Statistics report of 2003, that 'ethnicity is a "multi-faceted and changing phenomenon" that may reflect a combination of a number of features including country of birth, nationality, language spoken at home, ancestral country of birth, skin colour, national or geographical origin, racial group and religion' and, moreover, that 'ethnicity is a self-assessed concept that may change over time and is not the same as country of birth or nationality'.

*"There is an obsession within all our culture to be young, due to the fact that older generations are often pushed to the side or ignored. In a sense, looking younger may be a way to fight the ageism that is embedded in our society."*

Halesowen Asian Elderly Association

*"In many Asian families the seniors live with their family, but I tell you that they have no life because they feel it is their responsibility to look after us. But the young people are too busy trying to cope with their jobs and their young family etc. So how can they look after us properly?"*

Halesowen Asian Elderly Association





This understanding of ethnicity is important to consider in a super-diverse UK context, and especially important to individuals' lived experience of ageing. Early experiences of migration, and in particular of racism, can have a profound effect on older people and their expectations in relation to ageing (Clarke & Warren, 2007). As **Laura Warren**, highlighted, issues of gender, and representations of ageing and gender, also need to be considered proactively in relation to supporting a healthy ageing population. **Naina Patel's** evidence on healthy and positive ageing, in particular relating to the BME population in the UK, showed that there has been slow progress in research in this area, and it is not on the policy or research funding agenda. Further, she found that BME older people were treated as a homogenous group without cultural or socio-economic distinctions being made. These distinctions are important, as illustrated in the evidence submitted by **Peter Goldblatt** to the effect that socio-economic disadvantage is an important feature of health inequality and this is an inequality that persists

*“My faith is really important to me. It helps me to stay on a right path. Having a good amount of wisdom and education will help you age better, because you will know what to do during difficult times.”*

**Arabic Women's Awareness Group**

*“Being part of this community and where we live is also important and rewarding”*

**Ladies Gujarati Shia Muslim Group**

into old age, with real consequences. Naina Patel referred also to the importance of social clubs and initiatives run in communities by the third sector and how, due to changes in commissioning structures and funding cuts, these smaller organisations risk being lost, potentially damaging the bridges between policy, BME communities and BME community organisations. She stressed the need to provide further education and better access to resources and services that may support healthy ageing as a process. Community champions were mentioned as one potential solution. Better access to information about healthy ageing and support for lifestyle choices and activities would, however, be of benefit across communities, even whilst targeting specific issues identified in relation to BME communities.

Planning needs must also take into account issues of individual rights and equality. The Human Rights Act 1998 gives protection with respect to human rights in the context of faith and belief under Article 8; and the Equality Act 2010 includes age, race and religion under its protected characteristics. **Effective planning needs to recognise the reality, challenges and opportunities of super-diversity, and the particular rights and interests of members of a super-diverse population.**

To learn more about the evidence behind this recommendation, see 'Planning and Super-diversity'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>







## Recommendation 2

# The human rights of older people should be at the heart of health and social care policy.

An ageing population will provide an increasing challenge for the delivery of health and social care services in the future, as *Ready for Ageing*, the House of Lords report, also recently highlighted. These challenges are not just about resourcing and the types of services that are delivered, but also about the rights of older citizens especially when they are vulnerable.

Recent cases of abuse and poor caring demonstrate that the human rights of older people must be taken seriously in the management, planning and delivery of health and social care. This requires urgent attention in order to make a real difference to ageing well and healthily. **Initiatives should be taken locally by care commissioners and providers, but in addition this requires action at a national and international level. We urge support for the steps being taken within the United Nations and at European level to give special recognition and protection to the rights and interests of older people.**

A start was made by the first World Assembly on Ageing in 1982, convened by the United Nations General Assembly, and which produced the Vienna

*“Our views as older people are not listened to, and age discrimination towards older people is common”*

AgeWell 2012

*“One legacy of the Olympics and Paralympics is that it involved young and disabled people in sport. I want to join a sports club but would sports clubs welcome the elderly.”*

AgeWell 2012

International Plan on Ageing. This expressed member states' commitment to the application of rights contained in the Universal Declaration of Human Rights to the ageing population, and to ensuring that quality of life was not impeded by ageing. In 1991 the UN Principles for Older Persons addressed questions from access to adequate food, water and health care, to integration into society and being able to live in safe, adaptable environments and live at home as long as possible. The United Nations has now established an Open Ended Working Group on Ageing (UN 2010) and called for governments to:

*Mainstream the concerns of older persons into their policy agendas, bearing in mind the crucial importance of family intergenerational interdependence, solidarity and reciprocity for social development and the realization of all human rights for older persons, and to prevent age discrimination and provide social integration (UN 2010).*

In addition, the United Nations goes on to state that it:

*Further calls upon Member States to address the well-being and adequate health care of older persons, as well as any cases of neglect, abuse and violence against older persons, by designing more effective prevention strategies and stronger laws and policies to address these problems and their underlying factors (UN 2011).*

While some older peoples' rights may be specifically safeguarded within other conventions, such as the UN Convention on the Rights of Persons with Disabilities, reliance on this convention would not be



appropriate in the context healthy ageing. As [Ann Gallagher](#) noted in her evidence to the Commission, there is an important difference between being old and being frail or having disabilities.

In contrast to the rights of the child, **there are still no international conventions directed solely at the rights of older people.** In more recent rights declarations there are, however, provisions which make reference to the rights of the older person. The EU Charter of Fundamental Rights contains specific reference to the rights of older people



in Article 25. The rights of older people are also addressed in Article 23 of the European Social Charter, which concerns the right of older people to social protection. The Steering Group on Human Rights of the Council of Europe (CDDH) in 2012 established an Expert Working Group to examine whether a non-binding document on the human rights of older people should be adopted. In 2013 the working group produced the Draft Recommendation of the Committee of Ministers to Member States on the Promotion of the Human Rights of Older People. This aims 'to ensure the full

and equal rights and fundamental freedoms for older persons and promote respect for their dignity'. Its provisions make reference to the importance of non-discrimination, autonomy and the prevention of violence and abuse, and to the aim that 'member states should establish and guarantee that appropriate health and long term quality care is available'.

The adoption and implementation of international conventions both at UN and Council of Europe level concerning the rights of older people should

be a watershed moment in the way in which we view older people in society. **The need to afford special recognition and protection to the rights and interests of older people should be an integrally important moment in evolving policy and law in this area in the future.** This does not mean that all such rights will equate to a right to demand access to resources in all situations and regardless of the interests of others. Difficult questions will still need to be addressed in relation to resource allocation; likewise to accommodating a range of diverse needs. Nonetheless, **there is now an opportunity to consider the adoption of a new approach to rights through pro-active engagement with fundamental values,** rather than simply triggered by controversy and scandal. **Awareness of the rights of older people in relation to the development of law and of policy is where the mainstreaming of rights becomes critical.**

*"I'm sure the mentality of people who work in the various departments, they do have an attitude. 'Oh, old person'"*

**Halesowen and Dudley Elders Group**

*"People of a certain age often find it difficult to obtain opportunities that are more prevalent to younger people"*

**Halesowen and Dudley Elders Group**

To learn more about the evidence on the need to mainstream human rights, read 'Equality and Inclusion'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>

## Recommendation 3

# A new statutory post of Commissioner for Older People should be created in England.

There is a strong case for creating a statutory post of Commissioner for Older People in order to ensure older people's interests are effectively represented and their rights promoted and protected. This will help to fill the gaps in existing frameworks in England as well as providing a focus for the development of new provisions and practices.

The devolved governments are leading the way here and England could learn from their approach. Wales has had an Older People's Commissioner since 2006 ([www.olderpeoplewales.com](http://www.olderpeoplewales.com)) and Northern Ireland a Commissioner for Older People since 2011 ([www.copni.org](http://www.copni.org)). In 2012 the Welsh Commissioner issued hard-hitting reports expressing concerns regarding respect for dignity in care and service provision both within and outside hospital (Older People's Commissioner for Wales, 2012a and 2012b). In the recent report *A Thousand Little Barriers* the Commissioner highlighted the small daily challenges which can lead to multiple barriers for the older person (Older People's Commissioner, 2013). In Northern Ireland the Commissioner has highlighted the need for better involvement of older

people in all aspects of civic, community and public life:

- adequate standards of living
- real safety at home and in the community
- decent, affordable and flexible housing
- health and social care services that are high quality and person-centred
- public transport that maximises independence and choice
- equality and fair treatment
- protection from age discrimination
- protection from abuse (COPNI 2011)

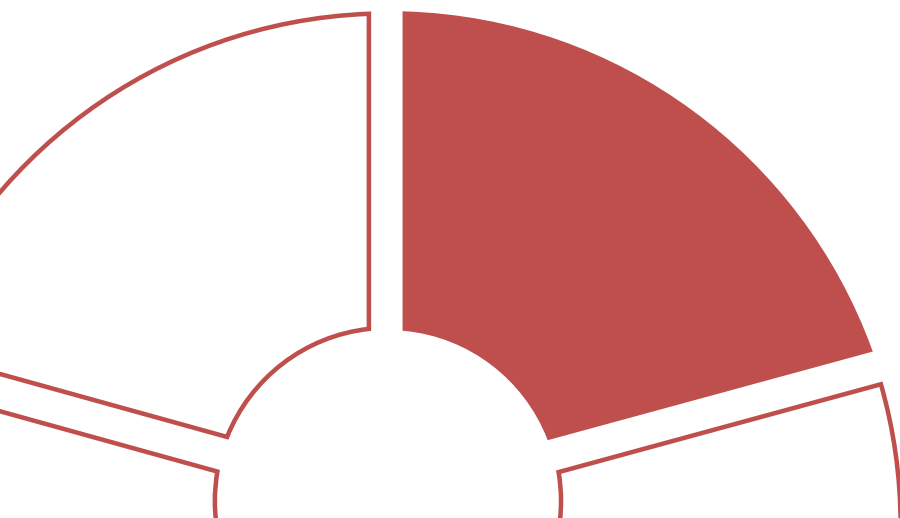
A bill to create a commissioner was introduced in Scotland in 2004. Although it was unsuccessful, the proposal remains under debate (Health and Social Care Alliance, 2013). The creation of an older people's commissioner for England was advocated in 2012 by Baroness Joan Bakewell, in an unsuccessful amendment to the Health and Social Care Bill, and in the CentreForum Report in September 2013 (Burstow 2013).

The position in England remains fragmented. Since October 2000, when the Human Rights Act 1998 came into force, English law must be interpreted consistently with the provisions of the European Convention on Human Rights. This is, however, a very general

declaration of civil and political human rights, and there is no specific reference in the Convention to discrimination on the basis of age.

NHS bodies are required to comply with the NHS Constitution and, as [Kathryn Hill](#) (Policy Advisor Equalities and Human Rights, Age UK) pointed out in her evidence, patients may in the future wish to make use of this. In many respects, however, the NHS Constitution is a combination of existing rights and aspirational rights. A further provision, which may prove more important in ascertaining the rights of older people in the future, is section 1C of the NHS Act 2006. This imposes a duty on NHS bodies to have regard to the need to reduce inequalities between the people of England in respect of the benefits that may be obtained by them from the health service. This may be utilized to challenge age- and cultural/faith-based inequalities in relation to service provision.

In practice, the Equality Act 2010 could prove more influential in safeguarding the rights of older people than the Human Rights Act 1998 over the longer term. This Equality Act 2010 concerns discrimination across a range of protected characteristics, including gender, sexuality, age, race and religion, with combined discrimination cases being brought together. The Act also places specific statutory duties upon public authorities to foster equality. As Age UK commented, 'In relation to healthcare, eliminating age discrimination would allow older people to have access to services on the basis of clinical need alone. Age-based differences would only be permitted if they could be objectively justified.' The Equality and Human Rights Commission (EHRC), established under the Equality Act 2010, provides





an important mechanism through which the rights and interests of older people in a multi-cultural society may be safeguarded. It has already produced documents addressing ageing and the rights and interests of older people (Equality and Human Rights Commission 2008 and 2009).

Despite the Human Rights Act, the Equality Act and the establishment of the EHRC, there is no single statutory body or person solely concerned with the human rights and interests of older people. In the past, governments have appointed figures such as Baroness Joan Bakewell, Professor Iain Philp and Professor David Oliver to promote or to address the interests and needs of older people. Bakewell was appointed in 2008 as a Voice for Older People (BBC 2008). Philp was appointed as National Clinical Director ('Tsar') for older people at the Department of Health in 2000 and held that post until 2008. He was succeeded by Oliver as National Clinical Director for Older People from 2009 to 2013. Both these types of role can be seen as limited in scope. One was an internal Department of Health role, the other an external role raising awareness and challenges. There is a strong case for going beyond temporary political appointments of this type and appointing a 'Commissioner' for older people. Such a person;

*Would ensure that older people's interests were given effective recognition in the media and in government policy making. Further the Commissioner would be able to develop an overview of the issues affecting older people and demonstrate how different forms of disadvantage compound each other. Finally, it would provide a way of investigations being undertaken in areas where it is feared that older people are abused but which have not been proved (Herring, 2009).*

The case for such a commissioner remains compelling. **Establishing an older people's commissioner with investigative powers would ensure that the rights of vulnerable older people**

**were protected and promoted. Such a commissioner would have a statutory role in facilitating the mainstreaming of the rights of older people and the upholding the rights contained in any subsequent United Nations or Council of Europe document concerning the rights of older people.** While the Welsh and Northern Ireland Older Persons Commissioner provide useful starting points, any introduction of such a Commissioner in England should be accompanied by a strengthening of powers and state accountability in the area. It would be critical for the Commissioner to work alongside the Equality and Human Rights Commission, Health Service Commissioner and the Care Quality Commission. Equally, it is important that such a Commissioner should not be subsumed by those bodies that already undertake critically important functions. There is a danger that increasing the workload of those bodies further without large scale commitment of new resources could lead to a notable dilution in the efficacy of review. The older people's commissioner should have a statutory duty to present annual reports to Parliament. Consideration should also be given to provision for direct enforceability of the Commissioner's reports. A related series of local 'champions' for older people working at local authority level to heighten awareness of such issues at ground level on a day-to-day basis would also be useful.

It is important to bear in mind that not all older people are vulnerable, frail and in need of protection. What is required is that they are given a much louder voice in shaping their social environment and community (see Recommendation 6). **We envisage that a Commissioner for Older People would facilitate the development of strategy for ensuring that healthy older people also have a voice at all levels of planning and service provision.** This is something that already happens in Wales. The Welsh Government's Strategy for Older People 2013-23 led not only to the establishment of the post of Commissioner, but also to the appointment of a Deputy Minister with particular responsibility for older

people and a Ministerial Advisory Group on ageing, and to the implementation of free swimming for older people and free bus passes. Wales also has the Welsh Senate of Older People, something that Scotland is considering emulating. In Wales there is further active debate regarding a Welsh declaration of rights for older people. In December 2013 the Welsh Government published a consultation on a Draft Welsh Declaration on the rights of Older People (Welsh Government 2013a).

*"Our voices are being fed in all the time but they [the agencies] are not listening to us."*

**AgeWell 2013**

*"Agencies need to be in contact with other appropriate agencies so that individuals (especially older and already vulnerable individuals) do not have to be asked the same questions over and over again."*

**AgeWell 2013**

*"The state has a major role to play in caring for the vulnerable people. Not all family members are supportive, and without the help of the state who can some people turn to?"*

**Halesowen Asian Elderly Association**

*"If you have a disability there is a nonsense – they give drivers just three minutes to get you on the bus ... I have had on occasions where they have come to collect me and I could not get on the bus on time and they left me! The reality is that this is a government-led service and you have nobody to complain to. I have personally written four complaints."*

**UK Caribbean Seniors**

To learn more about the Commission's thinking on a Commissioner for Older People, read 'Equality and Inclusion'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>

## Recommendation 4

# Reciprocal relationships that bolster healthy ageing should be central to future care and support arrangements.

Much is known about the way in which older people want to be cared for or treated more generally.



Older people want to be cared for in ways that promote security, respect for autonomy and social inclusion: principles by which all competent adults should arguably be treated, no matter what age they are. Many older people want to exercise their capacities to help others, even when they are themselves in need of help. As such, reciprocal relationships should be central to care and support for healthy ageing. This emphasises the contribution and value of older people as well as the positive aspects of ageing.

The Commission grappled with the issue of how support relates to healthy ageing, and how to balance the obligations of individuals against the resources of the welfare state. Evidence from [Jane Carrier](#), National Development Team for Inclusion, [Ayesha Janjua](#), Office for Public Management, and [Noreen Siba](#), International Longevity Centre-UK, emphasised the potentially reciprocal nature of caring relationships. Reciprocity could be seen as the antidote to dependence on the welfare state, with individuals encouraged to care for each-other. But this is not the only interpretation. **Reciprocity can also be a manifestation of mutual respect in society, in which individuals recognise that there is the potential for virtually all kinds of caring relationship to be of mutual benefit.**

There is considerable scope for mutual benefit in the case of healthy older people given the contributions they are already making. For instance, they may be giving financial support to their younger family members, providing childcare, completing domestic tasks, acting as the repository

of a family's history, helping grandchildren with homework, and so on. Retired individuals make up much of the volunteer workforce, and many are informal care givers to older spouses, parents and other family members.

There are ethical reasons to explore the potential of reciprocal care arrangements that go beyond those associated directly with economic advantage or a reflex desire to 'return the favour'. Free-riding is arguably unfair. Other things being equal, being in a position to trade, either in kind or with money, is a means of maintaining equality and mutual respect in our dealings with others as we strive to satisfy our own needs. Work – or, more specifically, productive and variously fulfilling ways of occupying our time – is dignifying; it is a means of social integration and interaction, is a demonstration of our value, and can be important to how we define ourselves. Relationships within which only one party is regarded as having something to give can erode dignity and independence and lead to feelings of an ever-growing debt that can never be repaid, even where help is willingly provided with no expectation of anything in return. On the other hand, **reciprocal relationships willingly entered into may promote autonomy, independence, dignity.**

A number of localities have initiatives in which older people form reciprocal relationships where informal care and support are exchanged for benefits in kind, for example, home-sharing, car-pooling and time-banking. These, however, are limited to particular areas and are subject to ebb and flow.

Such initiatives have the added bonus of reducing social isolation. We heard how older people not only contribute to their families, communities and society, but actively want opportunities to contribute, and rightly want their existing contribution to be recognised and to feel valuable and valued.

**Reciprocal relationships may enable older people to build or maintain their resilience, independence and sense of being in control of their lives.**

As well as providing a welfare safety net, the state should invest more in schemes that encourage and facilitate reciprocal relationships to be organised and formed from the social assets of older people. There is evidence that people want their local services to start with their social capital rather than their deficits – thereby 'turning the welfare state upside down' (HSMC 2013)

For a fuller account of the Commission's thinking on care and reciprocity, please read 'Care, Reciprocity and Being Valued'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>

*"I do not save any money, I just give it away to my children and grandchildren and that makes me feel really good about myself."*

**Ladies Gujarati Shia Muslim Group**

*"More time to do what I want to do and being a volunteer here in this centre keeps me really motivated."*

**Halesowen Asian Elderly Association**

*"I like helping my family over there as it makes me feel really good to give money to them. Well, that is how we have been raised – to help each other if and when you can."*

**Arabic Women's Awareness Group**

*"I always say to them, 'I'm glad you live [nearby] because I'm closer to my tools'."*

**Halesowen and Dudley Elders Group**

*"Older people... still have the capacity to do things for themselves and for others... We don't want things done for us all the time, we also want to be doing things to help and contribute."*

**AgeWell 2012**

*"We live in a small block of flats. There's six flats, and because I do the bins every Wednesday, I do the garden refuse and black box collections. I do it for everybody every week."*

**Halesowen and Dudley Elders Group**



## Recommendation 5

# Policy makers need to design policies that harness people's instinctive behaviours to work towards, rather than against, healthy ageing.

Healthy ageing results from a combination of biological, environmental, emotional and social factors. It is also about the choices we make in life.

These choices relate to our decisions about smoking, drinking and exercise and, perhaps less obviously, whether we volunteer, get married, or take out a pension. Individuals – for a variety of reasons – do not always make decisions that will best promote their well-being in the future.

Social contact is important in ageing well. We heard, however, from [Age Concern](#)

that older people's concerns about their safety can lead them to remain isolated either at home or within small communities, especially as they get older. Such fears can isolate people from inter-generational contact and disincline them to volunteer.

We also heard from [Adrian Philips](#), Director of Public Health, Birmingham City Council, that healthcare is often not used by those most in need of it. For example, flu vaccination rates in Birmingham are lowest in the most disadvantaged communities. People rarely make an impartial assessment of the health benefits of being vaccinated and instead seem to be overly swayed by negative connotations of needles and perceptions of what the social norm is within their community. Other behaviours work against healthy ageing, from consumption of junk food because it is 'fast' or easily available, to being deterred from taking exercise because of a perception in some BME groups that to do so is immodest. Indeed, in relation to exercise there seems to be a notion that old age is a time to slow down and be less physically active, which can impede healthy ageing. This notion

*"I'm sure you get cases of people, of this sort of age group [89 years old], don't they, they don't really know how to change direction."*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG1**

*"How far ought we, as potential users, be pushed in our interests for our own good? So how would you balance that kind of idea ... nudging in the direction of what someone else thinks is in their interests."*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG1**





appears to be unique to humans and is not seen in other species.

The reasons behind behaviours that work against healthy ageing are complex. 'Instinctive' behaviour is associated with automatic and quick choices that draw on associative memory and feature a lack of voluntary control (Kahemann 2011). **Some systematic traits of instinctive behaviour have been identified. These traits include being swayed by social norms, reacting to strong emotional associations with certain options, and a general tendency to stick with the default option** (whatever it may be) (Dolan et al 2010).

Traditional approaches to policy can treat people as detached individuals who always rationally weigh the costs and benefits of different options. In contrast, behavioural approaches to public policy use systematic features of human behaviour to ensure that people's instinctive choices better match their long-term goals. Although there is scepticism and debate about the appropriateness of behavioural approaches, they have the potential to improve healthy ageing in the UK.

In terms of the challenges relating to social isolation and the low uptake of healthcare services, **policies based on incentives or information may fail to achieve behaviour change. Instead policies need to engage with individuals' emotional associations.** This may mean, for example, directly addressing the fear of needles, or ensuring that socialising and volunteering opportunities are available in safe environments that bring to mind positive associations. Moreover, as **Chandrika Gordhan** informed the Commission, differences in beliefs about diseases such as arthritis in different ethnic communities can introduce delays in accessing health services. Where genuine social norms differ from public perceptions, this should be emphasised to people. For example, to encourage uptake of healthcare services, providers might make more effort to point out that most people in a particular group have used the service, if this is the case.

The current generations of older people have often had healthy lifestyles in the past. Rather than intervening to teach people the importance of healthy lifestyles as they age, we heard from **Adrian Philips** that effort might be better focused on 'reactivating' healthy behaviours and lifestyles from their past. **An important consideration is who communicates this message (and not just what they communicate).** People are more likely to trust and act on advice from people who are like themselves.

Clearly there is still an important role for traditional policy initiatives to encourage behaviours associated with ageing well, whether this is tackling crime, subsidising transport or providing better information to tackle the 'information poverty' of old age. Nonetheless, **policy-makers need to design policies that harness people's instinctive behaviours to work towards, rather than against, healthy ageing.**

For a fuller account of the Commission's thinking on behaviour, please read 'Behavioural Policy for Healthy Ageing'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>

*"I like to learn new things. At 67 I too call a taxi to go out. I believe in being independent and I like to learn as much as possible even at this age."*

**Ladies Gujarati Shia Muslim Group**

*"So that we all know we should be active and we should be doing things and that would make us feel better and it does make us feel better."*

**Halesowen and Dudley Elders Group**

*"Unless you're a forceful person you won't force yourself to go out and find the things that are on offer."*

**Halesowen and Dudley Elders Group**

*"It would be nice to be encouraged to join a club."*

**AgeWell 2012**



## Recommendation 6

# More effort needs to be made to give older people a louder voice in respect of their environment and local community.

The views of older people are crucial when designing strategies to support people to live independently and well in later life. This may appear obvious, but the views of professionals and 'experts' still dominate policy debate. To ensure that services are designed so that they are fit for the purpose of serving an ageing society, older people must be involved at all stages in developing plans. **In giving older people a louder voice, it is important to engage, and then listen to, all older people, including those from disadvantaged backgrounds and from BME groups, and also to ensure that there is proper representation in super-diverse cities and areas like Birmingham.**

The Commission found some good examples of the involvement of older people in planning services and in research designed to increase our knowledge about how to age healthily. However, this is not universally the case.

The work of [Age UK](#) is exemplary. Age UK

is a relatively new organisation formed in 2009 on the merger of Age Concern England and Help the Aged, which joined together to create a new charity dedicated to 'improving later life for everyone'. They are involved locally and nationally across the UK working with and for older people. Their work includes campaigning, funding research and working with businesses to provide products.

In their paper [Agenda for Later Life 2013](#) Age UK calls for better involvement of older people when planning public services, including health and social care, housing, transport and income. **We strongly support their call.**

Age UK supports groups of older people, their families, friends and carers to run local campaigns to improve their neighbourhood: in short, it supports involvement. Their campaign, [Improve Your Local Neighbourhood – Change One Thing](#), targets issues that can make the difference between being isolated at home and being able to get out and about in the local area. These include local transport, safe streets, pavements being in good repair to prevent falls, places to rest, and access to shops, a post office and banks.

We also found evidence of good practice at the University of Birmingham, where older people have been engaged in research and planning since the early 1980s when Professor Bernard Isaacs, Professor of Geriatric Medicine, created the [Birmingham 1000 Elders](#). This was the result of his determination to involve older people in research that used questionnaires to find out about all aspects of life as an older adult in the UK, looking

at issues such as health, housing, social activity, and pensions. More recently, under the leadership of Professor Janet Lord, the activities of the 1000 Elders have expanded to include involvement in medical research, including research into heart disease, infections in old age and falls. Recruitment is an on-going process through adverts in the local media and talks to local community groups. Healthy adults over the age of 65 are recruited to be members of the group, which at one point had over 3000 members.

As a Commission, we were able to make use of the access that the Birmingham 1000 Elders provided to older people in the region, and Professor Field attended two AgeWell meetings. These are annual meetings of the Birmingham 1000 elders that include accessible briefings about the latest research in ageing, give feedback to participants, and provide practical information for promoting good health in later life. At the first meeting attended by Professor Field, during our scoping phase, was able to get feedback on the Commission's plans and, at the most recent, in 2013, he was able to get reaction to our proposed recommendations. The group was also invited to participate in the Birmingham Voices consultation groups.

In the North East of England, there are excellent examples of engagement with older people. The [Institute for Ageing and Health](#) at Newcastle University was founded in 1994 with a vision of understanding the ageing process and disease mechanisms, and translating their internationally recognised scientific research excellence and knowledge into healthcare benefits for people

*"It comes back to talking to the individual about what she would find helpful to do."*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG1**

*"So we could decide before we get to the some of these scenarios as to how much intervention we actually want from a robot"*

**Acceptable Robotics Companions for Ageing Years – ACCOMPANY – project UBFG2**

in the global community.

The Institute is also involved in **'VOICENorth'** where a large representative group of older people across the North East share their views and life experiences to shape future research and policy-making. In collaboration with the region's local authorities, they have also developed ***The North East Charter for Changing Age*** to help shape the wider North East's response to its ageing population. The Charter sets out guiding principles to direct policy-making and strategy development in each authority, not just on health and social care but on all aspects of development – be it future transport or housing, culture or work.

Our Birmingham Voices evidence gathering was also facilitated by another Birmingham innovation, the **Birmingham Arthritis Resource Centre (BARC)**, which is based in the central library. We were heartened to learn just how many people contacted by the network of champions wanted to come along to our **consultation groups**.





In this report we have reviewed evidence on how:

- healthy ageing is experienced differently by different groups, and by individuals within those groups.
- ageing is a complex, life-long interaction between social and physical environments, and between biology, psychology and years lived, which is subject to health inequalities, ageism and resilience of the older person
- healthy ageing can be achieved by the promotion of independence, identity, control, personal resilience, wisdom, good cognitive function, being socially engaged, independence, avoiding intergenerational conflict, respect and value, and accessible public services.

**The evidence points to ageing well being a deeply individual experience. Moreover it became apparent that ways need to be found to support and strengthen the many different voices of older people if they are to be clearly heard.** In this respect the Commission sees two distinct ways in which older people can have a stronger voice.

*“I don’t feel that I [have a voice] but not because I’m older but because I’m a foreigner... Well I think as a foreigner I have to be a lot more careful about having a voice. That’s my feeling. And maybe that’s the rest of all my friends and acquaintances don’t think so but that’s how I feel.”*

**Halesowen and Dudley  
Elders Group**

*“With this group we come together from diverse backgrounds, but together we are so much stronger and we provide mutual support and friendships, it does not matter what faith you are we are all one family and we share in each other good and sad times together... That to me is what makes a good community.”*

**Halesowen Asian  
Elderly Association**

*“They should use us because we are valuable.”*

**AgeWell 2012**

The first is by having a strong advocate for the interests of older people, and here we support calls for a commissioner for older people, as discussed in our third recommendation. But this concept of a louder voice for older people is somewhat predicated on an understanding of ageing that this Commission has tried to avoid, namely the deficit model of ageing that highlights frailty and vulnerability. As a Commission, we were tasked to look at healthy ageing, and to do this we have very consciously avoided straying into the territory of caring for those whose health is poor. We have argued that healthy ageing should be a realistic possibility for even the oldest of older people.

Accordingly, **a second way of promoting a stronger voice for older people is to ensure that healthy older people themselves are heard** alongside a commissioner or other advocates for those who are less fortunate and more vulnerable. This can be achieved in a variety of ways. First, there should be involvement of older people in decision-making and planning at all levels; and engagement with older people should be an explicit policy objective for national and regional governance structures. Second, local authorities should be encouraged to be proactive in supporting and facilitating community hubs (both virtual and physical) where these exist. Third, research must be undertaken into different cultural understandings of ageing, including understandings of choice, agency and voice, and what these mean for different groups.

For a fuller account of the Commission’s thinking on giving older people a louder voice see ‘More Effort Needs to be Made to Give Older People a Louder Voice’. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>







## Recommendation 7

# Ageing in a super-diverse society is a major challenge that society does not yet fully understand.

Gaining a better understanding of this is something that Research Councils and other research commissioning bodies need to prioritise.

**The predominant multicultural model of service provision is unlikely to be adequate to meet the needs of super-diverse communities.**

The more fragmented nature of a super-diverse society means that some sections will lack established community groups that can engage in consultation. In addition, it is more difficult to locate the multitude of super-diverse groups to examine their needs and determine how to deliver effective provision.

There is evidence that the complex interplay between families, cultural norms and social influences impact on the ability of some ethnic minority older adults to make healthy behavioural changes. Faith and religion are important factors that can act as either promoters or inhibitors of adopting and sustaining healthy lifestyle behaviours subsequently affecting a person's potential for ageing healthfully.

Research at the University of Birmingham has demonstrated that ethnically diverse groups are under-represented in clinical and health research despite many ethnic minorities suffering increased rates of morbidity and premature mortality.

It is unclear whether this under-representation is due to 'planned exclusion', 'inadvertent exclusion', 'non-participation', or a combination of these (Redwood & Gill 2013).

**Lack of inclusion of diverse ethnic groups in clinical and health research affects resource allocation for services, and compromises the validity and**



**generalisability of research findings.** It is therefore unacceptable.

Ethnic minorities are willing to participate in research if it is directly relevant to them as individuals and to their community, and if they are approached with sensitivity and a clear explanation of what the research will involve. Chandrika Gordhan told us about how the [Birmingham Arthritis Resource Centre](#) (BARC)

had engaged a series of community champions to help to mentor and educate older people with arthritis in local ethnic minority communities. She went on to help the Commission to find our 'Birmingham Voices' via this network of champions. At the same time, we found that some older ethnic minority UK adults feel over-researched, and that the research they participate in has not been of benefit in improving their health.



They want services and research that directly involve their input and meet their needs, both cultural and linguistic. Researchers were viewed as being out of touch with what is needed to promote healthy ageing in their communities.

In addition, we heard **evidence** from the **Centre for Policy on Ageing** pointing to the need to train those working within health research, practice and service

provision in cultural competency. There must be awareness of the unique and defining characteristics of diverse populations involved in health care and research settings. This includes understanding the importance of social and cultural influences on individuals' beliefs and behaviours. In the context of research, bringing cultural competence to bear on study design and implementation, the analysis and interpretation of results, and the drawing of conclusions and presentation of findings can help to ensure that research is applicable to ethnically diverse populations. **Most researchers do not understand the perspectives of ethnic minority communities and have not received training in cultural competence. They are, therefore, unable to incorporate these perspectives into their work.**

To promote healthy ageing in a super-diverse society, methodological approaches and tools employed within research, practice and policy settings need to be developed and validated for use within super-diverse populations across the lifespan.

For a fuller account of the Commission's thinking on the challenge of ageing in a multicultural and super-diverse society, please read Ageing in a Multicultural/Super-diverse Society: New Challenges, New Dimensions'. This can be found on our website <http://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/fullreport.aspx>

*"I know when my sister was in hospital the nurses were totally naïve and ignorant about her needs, so the medical and care staff should be trained about other cultural needs."*

**Arabic Women's Awareness Group**

*"I know it is our children's duty and responsibility to care for us, but things are now changing and if I have to go in the care home then the state should provide a home that meets our Islamic way of living. This really frightens me. We cannot be together with men in the same care home. We need a place where we could pray and the care workers need to be culturally aware of our needs."*

**Arabic Women's Awareness Group**

*"I am 67 now, and I am really happy with my life and attending the mosque regularly is very important for me to feel good about myself."*

**Ladies Gujarati Shia Muslim Group**

*"Church is my community too."*

**UK Caribbean Seniors**



# Appendix A

## The Commission's Work Programme

The Policy Commission heard and deliberated on evidence from a range of sources, agreed conclusions and recommendations, and explored these through a variety of tools, including consultation group discussions.

### Scoping Phase of the Commission

Activities included:

- Developing the idea for the Policy Commission with University of Birmingham academics and Commissioners
- Launching the Policy Commission at the Labour Party Conference (September 2011) with a debate chaired by Professor Adam Tickell, Provost and Vice Principal, University of Birmingham. Panel members included Professor Jean McHale (Co-Academic Lead of the Commission), Mervyn Kohler (Age UK) and Finbarr Martin (British Geriatrics Society)
- Commissioner meetings to agree the content and process of the Policy Commission

### Evidence Gathering and Deliberation Phase of the Commission

Activities included:

- Five half-day workshops to hear and deliberate on evidence from policy makers, practitioners and academics:
- Workshop 1: Ageing and well-being: flourishing in later life (12 February 2013 – am)
- Workshop 2: Ageing and well-being: health in later life (12 February 2013 – pm)
- Workshops 3 and 4: Equality and inclusion: a question of rights and responsibilities (12 April 2013)
- Workshop 5: The role of the physical, social and emotional environment in ensuring healthy ageing in multicultural UK cities (21 May 2013)

- Reviewing written evidence submitted to the commission
- Consultations with:
  - Birmingham Faith Leaders' Group
  - Equality and Human Rights Commission
  - Birmingham 1000 Elders – a group of adults over the age of 65, drawn from across society to inform University of Birmingham research (AgeWell Conferences 2012 and 2013)
- Focus group discussions with representatives of a range of ethnic minority communities as well as those of the white British majority. There were five groups drawn from i) Clifton Road Mosque Ladies Group, ii) a mixed male and female group from Halesowen Asian Elderly Association, iii) the Arabic Women's Awareness Group, iv) UK Caribbean Seniors, and v) the Halesowen and Dudley Elders Group. Meetings with the groups were held between February and April 2013.
- Commissioners' meetings to reflect on the issues raised in the workshops and consultations, and to deliberate on policy options
- Commissioners' meetings to finalise the commission findings and recommendations



# Appendix B

## Contributors to the Policy Commission

To inform its deliberations, the Commission consulted a wide range of experts who contributed to the Commission's work. These included:

### **Birmingham Faith Leaders' Group**

### **Birmingham 1000 Elders Group**

#### **Claire Ball**

Development Manager – Equalities and Human Rights, Age UK

#### **Simon Bennett**

Development Officer, Age Concern Birmingham

#### **Angela Bradford**

Extra Care Commissioning and Healthy Lifestyle Director, ExtraCare

#### **Jane Carrier**

Head of Policy and Research, National Development Team for Inclusion (NDTi)

### **Equality and Human Rights Commission**

#### **Ann Gallagher**

Reader in Nursing Ethics, University of Surrey and Director, International Centre for Nursing Ethics

#### **Professor Peter Goldblatt**

Deputy Director, Institute of Health Equity, University College London

#### **Dr Lisa Goodson**

Lecturer in Applied Social Studies, University of Birmingham

#### **Chandrika Gordhan**

Centre Manager, Birmingham Arthritis Resource Centre (BARC)

#### **Melanie Grey**

Performance Management Officer, Birmingham City Council

#### **Katherine Hill**

Policy Adviser – Equalities and Human Rights, Age UK

#### **Dr Nick Hubble**

New Dynamics of Ageing Programme, Brunel University

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Fellow, Health and Social Care Team, Office of Public Management (OPM)

#### **Professor Tom Kirkwood**

Associate Dean for Ageing, Institute for Ageing and Health, Newcastle University

#### **Professor Paul Knight**

President, British Geriatrics Society

#### **Mervyn Kohler**

Special Adviser, Age UK

#### **Professor Diana Kuh**

Director, Medical Research Council (MRC) Unit for Lifelong Health and Ageing, University College London

#### **Nat Lievesley**

Researcher, Centre for Policy on Ageing (CPA)

#### **Jennifer Lynch**

Doctoral Candidate, University of Birmingham

#### **Angus Malcolm**

Associate, The Good Governance Institute (GGI)

#### **Professor Finbarr Martin**

Non-Executive Director, National Institute for Health and Care Excellence (NICE) and past President, British Geriatrics Society

#### **Professor Jonathan Montgomery**

Professor of Healthcare Law, Southampton University, and Chair, Nuffield Council on Bioethics

#### **Professor James Nazroo**

Joint lead investigator on the

English Longitudinal Study of Ageing, a multi-disciplinary panel study of those aged 50 and over, University of Manchester and Director of the Cathy Marsh Centre for Census and Survey Research

#### **Professor Chris Newdick**

Professor of Health Law, University of Reading

#### **Pannel Croft Village**

Newtown, Birmingham

#### **Professor Naina Patel**

Director, Policy Research Institute on Ageing and Ethnicity

#### **Dr Linda Patterson**

Clinical Vice President – Royal College of Physicians

#### **John Payne**

Partnership Director, ExtraCare

#### **Adrian Phillips**

Director of Public Health, Birmingham City Council

#### **Lord Sutherland of Houndwood**

Royal Commission on Long Term Care of the Elderly 1997-99

#### **Professor Philip Tew**

New Dynamics of Ageing Programme, Brunel University

#### **Dr Lorna Warren**

Senior Lecturer in Social Policy, University of Sheffield

#### **Professor Christina Victor**

Professor of Public Health, Brunel University

#### **Bob Williams**

Founder, Uniitee

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ISBN 9780704428409

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