

**Help the Aged**

# **Older People: Our neglected assets**

April 2004

The Help the Aged vision is of a future where older people are highly valued, have lives that are richer and voices that are heard. The Charity is working to combat poverty, reduce isolation, defeat ageism and promote quality in care



# Executive Summary

Policies and resource allocation need to take greater account of two changes, occurring as a result of increasing longevity, the consequences of which are little understood:

- The changing profile of our lives.
- The increasing polarisation of wealth, income and opportunity in the UK.

The focus of this paper is on early intervention and investment in appropriate services. It presents an assessment of existing experience of early intervention in older people's lives and the drivers towards an expansion of this approach.

The paper is rooted in our firm belief that our older population is an economic and social asset. It offers a response to the picture of social exclusion and wasted resources, painted by our diverse contacts with older people and a growing body of research.

As a charity that puts older people at the heart of our agenda, we believe that our increasing longevity is cause for celebration. However, we find it cause for concern that life expectancy shows a continuing gulf between socio-economic groups. Furthermore, we recognise that within overall demographic movements, there are trends which directly and formidably challenge public services and existing policies, for example, the increasing numbers of older people suffering from dementia.

Help the Aged shares the Government's goal to maximise healthy life expectancy and to achieve increasing 'compression of morbidity', and believes that a change in approach is needed if this is to be

achieved. We entirely agree with Derek Wanless in his report 'Securing Good Health for the Whole Population', that greater leadership and organisation in public health is needed and that the Government needs to create more effective delivery frameworks for the required step change. We present such a framework below.

If society pushes people in their 50s, 60s and 70s aside from work and other forms of participation, those people are far more likely to decline into dependency. However, if policy builds on positive assumptions about how healthy and active older people can potentially be, there is no need for a gloomy picture to transpire in practice.

While government policy to date has produced some welcome and noticeable effects in reducing some of the most corrosive disadvantages among our older population, considerable challenges still remain. The substantial inequalities within our society are likely to widen under the pressures of the ageing of the population unless far-sighted action is taken over the next few years.

## Government action

The Government must work to tackle the gross waste of older workers in the labour market; the unacceptably high numbers of pensioners living in persistent income poverty; the gaps in health outcomes within different social, ethnic, and age-related groups; and the routine exclusion of older people from opportunities to contribute to society. The four fundamental areas of later life – equal opportunity, work, money and

active citizenship – must be comprehensively addressed in order to promote healthy independent ageing and to facilitate the inclusion of older people as contributing citizens. We believe that early intervention is the only effective way to achieve this.

Work to prevent decline and dependency is not without precedent. The best of this work has not just promoted policy, practice and spending – which averts the premature withdrawal, decline and dependency of older people – but has also adopted an approach that views older people as active, energetic citizens. However, this work must be built upon.

In our report, we highlight a number of areas of existing government work which we believe point the way forward in tackling the challenges ahead:

- Population ageing has prompted a substantial increase in health spending, but the rate of investment in social care lags markedly behind. There are many points along the care system, particularly in Social Services, that are creaking under the demand, and preventative stages of public service delivery have been the most squeezed.
- There has been some piecemeal work on early intervention, but positive results from a number of small-scale pilots have not been translated into mainstream practice.
- There is a welcome commitment to tackling health inequalities and this has rightly emphasised the importance of influencing the mid-life stages.
- There have been a number of initiatives aimed at better co-ordination in delivery, and experience of these projects has shown some value in joining up. The Care Direct pilots put into practice the notion of a seamless service, guiding enquirers efficiently to the appropriate authority. This work now needs to be

developed as part of the Third Age Service.

- The work within the Department of Health to create a Single Assessment Process for older people has clear potential to identify the levels of current unmet need and limit the number of different approaches an older person has to make in order to receive essential services.
- There have been central funds for innovative work to invest early and save later, through the Invest to Save budget, but curiously there do not appear to have been any major projects bringing health and social services together, despite the obvious potential savings to be made through effective alliance.
- The work to provide integrated services for children and young people, through Sure Start and Connexions, has demonstrated very positive outcomes from integrated service provision and one-to-one support. This begs the question of their applicability, in key principles, to the needs of other age groups facing disadvantage.

In looking to the future, Help the Aged believes the Government must address the current imbalance in public policy, at the expense of older people, and present solutions similar, in resource and political commitment, to Sure Start and Connexions.

At root, any solution to the challenges created by an ageing population must be a partnership between central government, local agencies and older people themselves. However, we believe there is a clear need for strong leadership.

## A “Sure Start for Older People”?: Gateways

We consider there is a strong argument for a new initiative to embody the vision we believe ministers have for the new ‘Third Age Service’ by offering a holistic, well-targeted, cost-effective service to older people. The service would complement the work being done as part of the Third Age Programme, with progress being made within the Department of Health in the development of the Single Assessment Process. Such a service could achieve direct benefits on the scale of Sure Start/Connexions and would serve as a powerful signal and example to all local agencies with responsibilities. It would also respond to the Wanless report’s recommendation for better delivery frameworks. Our proposal would go significantly further than any previous initiatives, in linking health risks to poverty and lack of opportunity.

The service we propose – *Gateways* – would:

- focus on geographical areas, client groups and other factors which put older people most at risk of premature withdrawal from work, ill-health, decline and dependency, drawing on the lessons of the Health Development Agency (HDA) pilots. Areas would be selected using indexes, including the Index of Multiple Deprivation, and the Help the Aged income index “Older People Count”<sup>1</sup>;
- provide users with an in-the-round reappraisal of their health, housing situation, financial well-being and skill base, building on and extending the principles that underpin the delivery of the Single Assessment Process for older people;
- link such users to services that will enable them to remain engaged and maximise their potential and their wellbeing;

- place older people themselves at the centre of the planning, development and monitoring of the service; and
- set such services within the context of local preventative strategies, drawing on the commentary by researchers about success factors in strategies for promoting independence.

We propose that, in first instance, this approach should be piloted, using a fund drawn from within the existing budgets of the Third Age Service, and the Single Assessment Process, under the principles of ‘Invest to Save’. We believe that this project could expand and develop the current vision of a Third Age Programme, but must be developed as a genuinely cross-departmental project – on the model of Sure Start. As Derek Wanless observed, there is a lack of solid evidence to support public health intervention, and the pilots should be rigorously evaluated for their cost-effectiveness.

In addition to our specific *Gateways* proposal, we recommend that the Government:

- reviews and redresses the imbalance between social and health care funding, building on the welcome increases announced in 2003;
- retains or reinstates those special grants which stimulate and develop preventative services; and
- adjusts the targeting and monitoring regime to reverse the collapse in low-level social care provision.

## The pay-off

We believe that a programme of preventative action will see a dramatic pay-off. For example:

- increasing labour market participation in later life would lead to improved savings for retirement and decreased dependency on the State;

- a reduction of 30 per cent in falls among older people would reduce health and care costs by almost £400 million;
- intervention to reduce fuel poverty and improve the efficiency of homes would cut the costs of treating cold-related illnesses, including heart attacks, stroke and pneumonia;
- increasing provision of low-level care could contribute to a reduction in morbidity, saving up to 30 per cent of the costs of care;
- delaying the onset of dementia by just five years could halve the cost burden of caring for victims.

We recommend that resources are targeted on preventative actions, which will achieve these pay backs as well as increasing personal well-being in the fourth stage of life. Our objective should be that the largest possible percentage of people gain choice and opportunity from the elongation of the lifespan rather than end up dependent and without choice.

Help the Aged commends the preventative approach, embodied in its *Gateways* proposal, to Government, and offers, in its report, an assessment of a number of areas in which such an approach could achieve results.

# I: Introduction

## Scope

1. This paper has been compiled by Help the Aged, in consultation with a range of partners including the Oxford Institute of Ageing and the Third Age Employment Network (TAEN). The focus of this paper is on early intervention and investment in appropriate services, on what is known about their impact and cost-effectiveness, and what possibilities for future extension of this work there may be.

## Introduction

2. Help the Aged bases its work on a profound commitment to the rights of older people and to them as fully-active members of society. The Charity's emphasis on tackling disadvantage permeates its work. It also recognises that many of the unfair challenges, or unnecessary obstacles faced by older people, are shared by many other people who exhibit 'differences' from the majority – such as those with disabilities or those from minority ethnic communities. It seeks, wherever possible, to link its work and key concerns with other agencies on a broader platform.

3. At the heart of the Help the Aged approach is a commitment to listen to older people and to respond to their views and wishes. Help the Aged places

special emphasis on the nurturing of a flourishing movement of independent senior citizens' forums. Most important of all, the message of the Charity's work is that older people represent a very large potential, social and economic asset to society.

4. Unfortunately, ours is a society which neglects these assets, with damaging and expensive consequences for us all.

**Through our diverse contacts with older people, ranging from service delivery to structured research, we have formed a picture of social exclusion and wasted resources.** This is both unnecessary and unsustainable. In this paper we put forward some ideas for remedying this.

## II: The challenge

### Background

**5. Public policy must confront the scale of the challenge of population ageing in the United Kingdom.** The UK national population structure, in line with most western countries, has aged continuously over the past century: one measure of ageing is the increase in the percentage of those over 60 years and a decrease in those under 15 years – the 2001 Census recorded that the former outnumber the latter<sup>2</sup>. Government policies in all areas need to grapple with these shifts in the composition of society.

**6.** The most dramatic increases have been in the ‘oldest old’ age groups. By 2025, more than 25 per cent of the UK’s population will be aged over 60 years, with more than a third over 75. **The numbers of those over 85 are projected to rise by 88 per cent** from 0.9 million in 1996 to 1.7 million in 2031.<sup>3</sup>

**7.** The gains in longevity must be seen as the most remarkable advance for humanity and there is no evident ceiling to such advances. Repeatedly, official calculations of maximum life expectancy have been confounded by actual progress.

**8.** These benefits are more available to people in industrialised countries than for those in developing countries, the latter affected often by a parlous combination of high child mortality and hazards in adult life. And *within* industrialised countries, there continue to be large variations by reason of gender and class: A boy born today in Manchester has a life expectancy of 71; a girl born in Kensington and Chelsea can expect to live until she is 84<sup>4</sup>. **Life**

### **expectancy shows a continuing gulf between socio-economic groups**

which is at its most extreme between people in Classes I and V respectively: an ‘unskilled’ man may expect 7.4 fewer years of life than his ‘professional’ counterpart.<sup>5</sup>

### **9. Within these overall movements there are trends which directly and formidably challenge public services and existing policies.**

To take one serious condition as an example, the incidence of dementia rises from very low levels in young-middle age to as high a rate as one in five in the over-80 age group. It is estimated that the numbers of people affected by dementia will rise from their current levels of 700,000 to 1.5 million by the middle of the century. The costs of supporting people with dementia are set to rise from £4.6 billion per annum five years ago to £10.9 billion in 2031<sup>6</sup>. This assumes that there are no medical advances which fundamentally change the picture of need.

**10.** Taking the special needs of older people together, including not just dementia but all conditions, the number of dependent older people is set to rise from 2.5 million to 4 million<sup>7</sup>.

### **11. Help the Aged shares the Government’s goal to maximise healthy life expectancy and to achieve increasing ‘compression of morbidity’:**

a smaller proportion of overall lifespan spent living with a limiting long-term illness or disability. There is much debate about the rate of progress here. It would appear that there have been fractional increases in the proportion of healthy years over the last few years – from 76 per cent to 77 per

cent (men) and 70 per cent to 71 per cent (women).<sup>8</sup> However, older women, in particular, continue to face a very significant part of their life in poor health. This further limits the contribution they can make to society and impairs their quality of life.

**12.** There is an associated controversy about the scale of the growing challenge. This centres on worsening 'dependency ratios'. One extreme of the debate paints an Armageddon picture of burden upon a dwindling population of working age, weighed down by the demands of an ever-growing mass of dependent, enfeebled older people. Another, more positive view, and one to which Help the Aged broadly subscribes, declares that bald ratios equating specific age groups with 'dependency' run the risk of becoming a self-fulfilling prophecy. **If society pushes people in their 50s, 60s and 70s aside from work and other forms of citizenship and participation, these people are far more likely to decline into dependency. We believe that if policy builds on positive assumptions about how healthy and active older people can potentially be, there is no need for the gloomy picture to transpire in practice.**

Substantial policy improvement

**13.** In response to these trends, the Government has adopted several constructive policies, and made very significant investments of expenditure across a range of programmes. In the field of pensions, for example, the Government is currently investing an extra estimated £9 billion a year in tackling pensioner poverty and providing a basic platform of income, by identifying and targeting extra support for the poorest older people, through the new Pension Service and in due course via a holistic approach currently

termed the Third Age Programme.

**14.** Other major initiatives relating to older people include, for example:

- large scale investment in improved services to older people via the NHS Plan 2000<sup>9</sup>;
- the review of public health approaches undertaken by Derek Wanless<sup>10</sup> on behalf of the Government to support the delivery and successful attainment of the 'fully engaged' scenario outlined in his original report<sup>11</sup> and the very welcome enthusiasm for a more holistic approach to health and wellbeing;
- the National Service Framework for Older People<sup>12</sup> and, in particular, its recognition of the importance of tackling the 'wider determinants of health', which placed a responsibility on the NHS and local councils to work in partnership to identify actions to improve the health and well-being of older people;
- specific policy programmes to tackle poverty and inequality, with a strong emphasis on the links between them and adverse health, such as
  - the target of ending child poverty by 2020, with intermediary targets;
  - the Health Inequalities Action Programme 2003;
  - modernising Government (particularly relevant via social services);
  - Better Government for Older People;
  - the UK Fuel Poverty strategy;
  - the New Deal 50-plus, Jobcentre Plus, Pathways to Work etc; and
- policies to combat age discrimination, through the adoption by 2006 of the

European Union Employment Directive to promote age diversity in employment, supported by a new Commission for Equality and Human Rights, alongside a national drive through the Age Positive campaign.

**These and other policy initiatives have had a welcome and noticeable effect in reducing some of the most corrosive disadvantages, such as:**

- reductions in poverty on certain recognised measures (though importantly *not* persistent poverty, which has remained at the same level over the past decade or so), which have been recognised as substantial and commendable by independent commentators<sup>13</sup>;
- improvements in health outcomes and a new framework for policy which has been widely welcomed by older people and their representative groups; and
- some recent improvements in the participation of older workers, with a million more over 50 year olds taking part in work than in 1997 (though demography accounts for a lot of this, and the increases are mainly confined to the more economically advantaged areas of the country).<sup>14</sup>

The case for further work and change

**15. Despite these improvements, considerable challenges still remain. The substantial inequalities within our society are likely to widen under the pressures of the ageing of the population unless far-sighted action is taken over the next few years. The Government must work to tackle the gross waste of older workers in the labour market, the unacceptably high numbers of pensioners living in persistent income poverty, the gaps in health outcomes within different social,**

**ethnic, and age-related groups, and the routine exclusion of older people from opportunities to contribute to society.**

**16.** Help the Aged considers that a strategy that combines robust age equality measures with greater investment in 'preventative' public services for older people is the only way to tackle this problem in a cost-effective manner.

**17.** While some government initiatives have flirted with this approach, a strategic lead from the centre is needed to consolidate and magnify the promising progress made in the smaller scale projects funded to date.

Preventing decline and dependency

**18. It is clear that work to prevent decline and dependency is not without precedent, and has been variously labelled 'prevention', 'promoting independence', 'upstream investment' and 'social inclusion'.**

**19. The best of this has not just promoted policy, practice and spending which averts the premature withdrawal, decline and dependency of older people, but has also adopted an approach that views older people as active, energetic citizens, mirroring the philosophy evident in the National Service Framework for Older People, and at the heart of Better Government for Older People.**

**20.** The potential area of intervention is very wide-ranging, starting at birth and extending to activities to help older people stay living in their own home. But what is clear is that most of the determinants of healthy, independent ageing lie outside the formal health and care systems.

The determinants of healthy, independent living

**21. Help the Aged considers that there are four fundamental areas of later life which must first be comprehensively addressed in order to promote healthy, independent ageing and to facilitate the inclusion of older people as contributing citizens:**

- **Equal opportunity:** Public policy and common practice across all sectors of life must place older people on equal terms. Only with full access to services and opportunities can the potential contribution of older people be realised. The Government's current proposal to confine age discrimination legislation to employment will severely limit its efficacy in reaching this goal. But if all public bodies had a positive duty to promote equality for age, as they have for race and will soon have for disability, this would encourage a much more proactive approach and could have a significant impact on a range of public policies and practices, as is happening in Northern Ireland.
- **Work:** A versatile and substantial programme is needed to ensure the retention, motivation, re-skilling,

guidance to and flexible treatment of older workers, to sustain this vital ingredient of independence, self-esteem, dignity and economic well-being. There are encouraging developments, such as 'Pathways to Work', but these must be built upon.

- **Money:** The Government must encourage a realistic approach to adequate lifetime savings across the whole working population but, at the same time, secure in the long-term, a transparent, trustworthy and decent state-provided foundation for later income. This subject has been well-rehearsed by Help the Aged and others elsewhere.
- **Active citizenship:** Integrated policies are needed to promote the full inclusion and participation of people in communities and neighbourhoods as they grow older, ranging from good transport, safe streets, available technology, access to exercise and sport, to neighbourhood renewal and a versatile range of housing opportunities, education and lifelong learning.

Government programmes have made progress in each of the above areas. Help the Aged believes it is now time to build upon this work.

## III: Current directions in public policy

**22.** As discussed, the Government has demonstrated, in various ways, its commitment to promoting healthy and independent living and its acceptance of the principle of early investment. Below, we outline the measures which we believe must be built upon in order to meet the challenge of demographic ageing.

Welcome increases in health spending, social care less favoured

**23.** Investment in public spending on health has been unprecedented. In the years from 2002/3, spending on the NHS is expected to rise from £72.1 billion to £105.6 billion in 2007/2008, an increase of over 46 per cent. In real terms, the proportion of GDP spent on the NHS will rise from 7.7 per cent in 2002/2003 to 9.4 per cent in 2007/2008, bringing the UK easily up to European levels of health spending.<sup>15</sup> These very substantial increases are underpinned by strategic policy initiatives, especially those set out in the NHS Plan and the National Service Frameworks (NSFs), including specifically the NSF for Older People. There is no denying the strength of commitment to health care as expressed in funding priorities. It is now a question of delivery.

**24.** Social care has also benefited from funding increases in real terms and, at a level of 6 per cent over three years, these result in a £1bn increase per annum by 2004–05.<sup>16</sup> This funding has been channelled into six different aspects of social care, with an emphasis on the promotion of independent living. This is underpinned by a Public Service

Agreement target to increase by March 2006 the number of those supported intensively to live at home to 30 per cent of the total being supported by Social Services at home or in residential care.<sup>17</sup> **However, the rate of investment in social care lags markedly behind that in health care, and there are many points along the care system, particularly in Social Services, that are creaking under the demand.** Furthermore, social care for older people tends to be more limited in quality and more task-based than it is for younger people.

**25.** Help the Aged believes that this imbalance must be addressed. Care needs exist across a continuum, from minor and incipient to major and long-term, with many variations and fluctuations in between. This ought to imply at least an evenness of approach to public investment across that range, if not, arguably, a disproportionately heavy investment at the social care end of the spectrum, by way of early intervention that will prevent needs from escalating and becoming more entrenched. Yet this is not happening. As illustrated below, in the section on low-level services, **these preventative stages of public service delivery have in fact been the most squeezed.**

Piecemeal work on early intervention

**26.** The promotion of active, healthier ageing has been on the public agenda for some time and it experienced a revival of interest in the 1990s. For example, following the 'Modernising Social Services' White Paper of 1998<sup>18</sup>, a series

of ring-fenced grants totalling £887m over three years were created under the banner of 'Promoting Independence', including a grant stream of £100m over that period specifically under the 'prevention' heading.

**27.** The 'Prevention Grant' was intended to stimulate the development of preventive strategies, and local authorities were required to target low level support at people most at risk of losing their independence. A third of the grants were targeted specifically at services for older people. Some 1,100 services were developed overall. Typically, these included improvements or enhancements in the field of domiciliary care, such as:

- support workers for independent living schemes
- additional occupational therapists
- gardening, decorating or voluntary transport

Unfortunately, such 'low-level' help does not appear to be as valued by local authorities and professionals as it is by older people themselves, but very often it makes the difference between an active life and one of decline.

**28.** Early evidence suggested that local authorities were starting to apply the principle of early intervention. However, they did this mainly by maintaining existing services that would otherwise have stopped rather than through the innovation of wholly new schemes with radical new designs. Relatively few authorities had moved ahead to embed such schemes within their existing strategies for community care and support, and often the services funded were piecemeal add-ons.<sup>19</sup> The impression is of a highly worthwhile initiative, but one in the early stages of development which arguably needed further evaluation, reinforcement and enhancement. The grants were however

only available for a three-year period up to 2001–02

**29.** The Health Development Agency has just published the evaluation of its *eight pre-retirement pilot projects*<sup>20</sup>. In a variety of settings, local agencies, such as PCTs and voluntary sector bodies, developed specific approaches for specific, potentially disadvantaged groups – such as farmers, unemployed men in the inner-cities and Asian women – to enable them to confront their own health and well-being related issues and take positive action.

**30.** The pilots reported positive results, and they helpfully point the way to the factors that make the difference between success and failure in such interventions. The link between health advice with access, at the same time to financial counselling, was particularly valuable. Overall, the recurrent theme is of benefit to individuals and hence public services, from well-timed, carefully targeted help as people move through life transitions. However, now that the pilot phase is over, the Government must ensure it rises to the challenge of 'mainstreaming' this valuable approach. There is similar material available from innovations, such as the Pennell Initiative for Women's Health and elsewhere, on which to build.

## Attacking health inequalities

**31.** From the outset, with the specific impetus of the 'Acheson Inquiry'<sup>21</sup>, this Government has recognised and acted upon the direct association between poverty and adverse health outcomes, and in 'Tackling Health Inequalities'<sup>22</sup> has now put forward an action plan towards reducing inequalities in infant mortality and life expectancy. Achieving a 10 per cent reduction in the gap between worst and average life expectancy within the next seven years will be hugely challenging. Rightly, the paper emphasises

the importance of influencing the mid-life stages:

'the key interventions are...targeting the over-50s – among whom the greatest short-term impact on life expectancy will be made'.<sup>23</sup>

### Better co-ordinated delivery

**32.** *The Health Act 1999*<sup>24</sup> flexibilities together with the *Health and Social Care Act 2001*<sup>25</sup> brought the potential to ensure a better service for older people from the closer co-ordination of services through pooled budgets, lead commissioning and greater integration. However, the progress in securing these advances has been somewhat tentative. There are very few *Care Trusts* focusing on older people, and the early evidence of these trusts does not point to powerful improvements. **However, the experience of older people through, for example, the Better Government for Older People pilots 1998–2000**<sup>26</sup> points to a concrete value in more joining up of services. Some pioneering practice in delivering an integrated, needs-based, strategic service exists, such as the work of the EPICS project in Buckinghamshire. This offers an integrated approach to healthcare based on comprehensive information and early intervention, and elsewhere too, but such work is often isolated and hidden from view.

### Care Direct and the Third Age Service

**33.** *Care Direct* has offered an important experiment in providing older people with better co-ordinated information about their case needs, through a series of pilot projects in the south-west of England.<sup>27</sup> **These have put into practice the notion of a seamless service, guiding enquirers efficiently**

**to the appropriate authority.** The feedback from users of *Care Direct* shows exceptionally high levels of customer satisfaction. The learning from this needs to be used to be fully exploited and some continuity of policy maintained as this work is transferred to the Department for Work and Pensions, and built into the development of the new *Third Age Service* – which the Labour party said would

'build on *Care Direct* to provide a better integration of health, housing, benefits and social care for older people'<sup>29</sup>

### Single Assessment Process

**34.** Local authorities are now being required to combine their procedures for assessing client need, in order to ensure a more efficient service to older clients and ensure a better match between service provision and need. **This has clear potential to identify the levels of current unmet need and limit the number of different approaches an older person has to make in order to receive essential services.**

### Integrated services for children and young people

**35.** The political spotlight, resource allocation, and the drive for new policy initiatives have prioritised the interests of children and younger people. With a momentous commitment to end child poverty by 2020, and intermediary targets to support that goal, the Government has initiated many ways of addressing disadvantage in the early years. It may be instructive to review the relevance and effects of two specific interventions: *Sure Start* and *Connexions*.

**36.** The success of *Sure Start* depends on accurate targeting of interventions at disadvantaged areas, offering very

practical, joined-up help and advice to young families, which takes account of joined-up nature of real lives. The underlying economic model demonstrated benefits multiplying costs several times.<sup>29</sup>

**37.** The effectiveness of *Connexions* depends on personal advisers to work across boundaries of public authorities in order to deliver an integrated service for advice, guidance and personal development opportunities.<sup>30</sup>

**38. Both programmes have combined strong political commitment with significant resource investment. Both have achieved conspicuous success, which begs the question of their applicability, in key principles, to the needs of other age groups facing disadvantage.**

### Invest to Save

**39.** The Treasury-Cabinet Office led programme of 'Invest to Save' budgets has provided funding for work that takes up

the principle of early investment for later benefit. At July 2002, the programme had allocated £310m to 334 projects involving a wide range of government departments, but **curiously there do not appear to have been any major projects bringing health and social services together, despite the obvious potential savings to be made through effective alliance.**

Important gains have been achieved, as observed independently by the National Audit Office<sup>31</sup>. There would appear to be great potential here for promoting active, healthier ageing through investment in early intervention.

**40.** Most recently, Derek Wanless' report 'Securing Good Health for the Whole Population' highlights the need for more effective implementation of public health work, and government-led action to achieve a more effective delivery framework. **We agree, and this paper offers a proposal for greater coherence in delivery.**

## IV: Some ways forward

**41. Help the Aged believes there is an imbalance in public policy, at the expense of older people.** We applaud the Government's progress in reducing child poverty and value the wide range of initiatives that are successfully reducing disadvantage in younger age groups. The foundations of successful participation in work and in communities are clearly laid in early years and youth, and clearly child poverty, if not dealt with, becomes pensioner poverty. But given current demographic trends, it is now an economic imperative that the Government turn more attention to older people.

**42.** Help the Aged believes that the initiatives noted above, from both within and outside Government, point one way – towards the need for a strategic lead on better co-ordinated action earlier on in later life to promote independent living.

### Local and national partnership

**43. The opportunities and challenges created by an ageing population must be dealt with in partnership: a partnership between central government, local agencies and older people themselves.** In a situation where Primary Care Trusts will control 75 per cent of the NHS budget, it is clear that local action to assess and respond to needs will make a great deal of difference. However, the Government cannot simply stand back and allow local accountability to decide whether the needs of older people are being anticipated effectively. We think that a new 'seniors' initiative that will complement and spur on such action is entirely consistent with existing

programmes and proposals, and will build on and synthesize the wealth of what is already being done with what is already known.

### A new flagship service: Gateways

**44.** Building on the principles described above, we consider there is a strong argument for a new initiative to embody the vision we believe ministers have for the new 'Third Age Service' by offering a holistic, well-targeted, cost-effective service to older people. The service would complement the work being done on the Third Age Programme, with the progress being made within the Department of Health in the development of the Single Assessment Process. It would be targeted at areas of social exclusion and poor health outcomes. We believe such a service could achieve direct benefits on the scale of Sure Start/Connexions and would serve as a powerful signal and example to all local agencies with responsibilities.

**45.** The essence of the new service – which we term *Gateways* – would be to:

- focus on geographical areas, client groups and other factors where older people are most at risk of premature withdrawal from work, health, decline and dependency, drawing on the lessons of the HDA pilots. Areas would be selected using indexes including the Index of Multiple Deprivation, and the Help the Aged income index “Older People Count”<sup>32</sup>;
- provide users with an in-the-round reappraisal of their health, housing situation, financial well-being and skill base, building on and extending the principles that underpin the delivery of the Single Assessment Process for older people;
- link such users to services that will enable them to remain engaged and maximise their potential and their well-being;
- place older people themselves at the centre of the planning, development and monitoring of the service; and
- set such services within the context of local preventative strategies, drawing on the commentary by researchers about success factors in strategies for promoting independence.

**46.** In the first instance, this approach should be piloted, using a fund drawn from within the existing budgets of the Third Age Service, and the Single Assessment Process, under the principles of ‘Invest to Save’. We believe that this project could expand and develop the current vision of a Third Age Programme, but must be developed as a genuinely cross-departmental project – on the model of Sure Start. Most domestic departments would have a stake in the creation of such a service, but clearly DWP, DH, and ODPM would be central to the success of this approach.

**47.** *Gateways* could be the central, branded initiative around which all policies and programmes could cohere, as part of a full-blooded drive by Government to secure a more fully engaged older population. There are many arenas, though, in which specific interventions would be cost-effective. In the final section of this report, we outline six particular areas in which we believe early intervention would be appropriate.

In addition to our specific *Gateways* proposal, we recommend that the Government:

- reviews and redresses the imbalance between social and health care funding, building on the welcome initial increases announced in 2003;
- retains or reinstates those special grants which stimulate and develop preventative services; and
- adjusts the targeting and monitoring regime to reverse the collapse in low-level social care provision.

## V: Early intervention: priority areas for cost effective impact

**48.** Help the Aged has direct and specialist knowledge and understanding of a number of important areas of daily life and issues affecting older people. This series of expert contributions sets out the evidence that demonstrates how serious these particular issues are, but also how much can possibly be done through prompt intervention to deal with the economic and social problems presented.

### i) Engaging Older Workers in the Labour Market

#### Context

**49.** The potential pensions crisis, with too many people saving too little to finance a longer period of retirement, will only be averted by a combination of greater pension saving and more years of paid employment. The objective of extending working life is shared by many countries, particularly within the EU. The UK Government has developed some useful experience with a range of initiatives, but the overall picture remains rather small scale and lacking coherent drive. While the numbers of people over 50 in employment have risen during the last six years (after decades of decline), the increase in the most part is a result of demographic change and the movement of the baby-boomer generation through that age cohort.

**50.** It is not just pension formation which could gain from lengthening the opportunity to work. From the individual perspective, there would be health benefits: though the argument is not

universally applicable, there is evidence to suggest that active workers enjoy healthier lives and greater self-esteem and confidence. From a societal perspective, there are obvious potential savings in social security payments, particularly Incapacity Benefit and benefits to low income pensioners and early retirees. From an economic standpoint, the positive contribution of older workers (in terms of experience, reliability, absence etc.) is increasingly appreciated by a growing number of employers.

The keys to working longer are six fold:

- Older adults need access to career guidance. Currently, only £300million of the £8billion budget for adult learning is spent on career guidance. Adult career guidance must be expanded into a mainstream, high profile service.
- Enhanced skills training and learning opportunities for adults are vital. Older workers are offered training and skills upgrades less often than younger workers. In a flexible and fast-moving labour market, this must be addressed.
- There must be robust action to tackle age discrimination, through effective primary legislation which has real teeth and covers goods and services as well as employment and training.
- Work/life balance is not just an issue for families with children. It is a technique of thinking which needs to be applied to older people seeking to scale back or scale down their commitment to the workplace, and to those with caring responsibilities.
- Incentives and employee benefits are still constructed primarily with younger people in mind. It is important

to look afresh at the rules on combining earned income and pension income, after an individual has reached their organisation's pension scheme age. Other employee benefits, more specifically targeted, need investigation.

- If older workers face redundancy, it is important to provide them quickly with support and opportunities: depression, loss of self-esteem and unemployment can become established rapidly and permanently.

## Current framework

**51.** The UK Government, as noted above, has made intermittent and tentative steps to address these issues. These efforts are not wrong, but they have been partial and consequently have had little impact. The idea of an ever earlier retirement than previous generations has been a strong and growing expectation over the last three decades or so, and reversing that trend in a positive and dynamic way, and with the urgency imposed by the potential pensions crisis, demands a more purposeful and rigorous policy.

**52.** A ban on age discrimination in the workplace is due to be implemented by the end of 2006. But the lesson learned in over 30 years of experience in the fields of race and gender discrimination is that a legal pronouncement is not enough. There must be monitoring and enforcement by a Commission, which gives advice and leadership to employment tribunals and to employees, employers and their representatives. There also needs to be capacity to support individuals with advice and guidance, and bring test cases before the courts. The structure of the proposed Commission for Equality and Human Rights is still being discussed, but there is a clear question mark over the Government's purpose and resolve as regards age discrimination. Discussion still

thrives on the utility of a 'normal' or 'mandatory' retirement age – a concept which has had little practical application in the recent decades of early retirement settlements. There must be a clearer, less ambiguous, message from the Government.

**53.** The treatment of pension schemes and pension income needs attention. Sensible, uncontroversial ideas have been in play for years, most recently rehearsed in the Green Paper on pensions in December 2002<sup>33</sup>, but progress is painfully slow. If people are to be persuaded to work longer, they need to see their pension grow – not decline, as has resulted from the perfidy of the annuities market in recent years. Final salary schemes are facing many challenges, but as currently defined they are also an impediment to downsizing one's employment career (but so would be career average pensions, so a note of caution here). Inland Revenue rules about combining pension income with income from employment need recasting. Only the will to act seems to be missing.

**54.** New Deal 50 Plus delivers a service which is too little, too late and reaches too few. Again a sensible and uncontroversial concept, it fails spectacularly on detail. Only available after six months unemployment, and then only to people on qualifying benefits if training is required, it has little relevance to most of the target group which should be using it. Lifelong Learning, as a programme for older people, is cursory: the idea is beyond contradiction but the implementation is beyond perception. To re-equip people with older skills, we should be lifting the current (age 55) cap on student loans, revising the Career Development Loan scheme, encouraging a learning culture with tax and other incentives, lifting the age barriers on modern apprenticeships and ensuring that they are designed to suit older adults. We must also provide a statutory right for

time off for training. All these ideas have been the subject of pilots – usually with good results – but none have been applied as a rigorous, concerted whole to the older population.

### Earlier intervention

**54.** Earlier intervention to offer older workers options for training and retraining, downshifting careers and working more flexibly would help prevent labour market withdrawal.

**55.** This would, in turn, have a positive effect on the well-being of those involved, and produce economic benefits in terms of the improved financial position of older people in work and the expected reduction in early decline.

### How would ‘Gateways’ help?

**56.** A well-targeted and integrated service for communities with high levels of worklessness among older people, provided under a nationally-recognisable banner, would be well-placed to help older workers and potential workers identify the best balance of work, retraining and retirement for them. By linking users with other services, it could also help tackle some of the health, housing and financial issues which can contribute to withdrawal from the labour market.

## ii) Preventing falls among older people

### Context

**57.** Falls represent the most frequent and serious type of accident in the over-65s age group. Falls destroy confidence, increase isolation and reduce

independence. The after-effects of even the most minor fall can be catastrophic for an older person’s physical and mental health.

**58.** Around 30 per cent of over 65s living in the community will fall in a year. This rises to approximately half of those aged 85 and over. An estimated 1,500 older people die each year as a result of a fall in the home.<sup>34</sup> **However, there is a strong consensus that up to a 30 per cent reduction in falls can be achieved if local health and social care communities work together.**

**59.** Doing this would also produce substantial economic benefits:

- Falls cost the NHS an estimated £981 million a year<sup>35</sup>. **Reducing falls by 30 per cent would reduce the bill by £174.3 million.**
- Hip fractures owing to falls cost the NHS £910 million per year.<sup>36</sup> There are an estimated 70,000 osteoporosis-related hip fractures each year at a cost of £13,000 each to the NHS<sup>37</sup>. Reducing falls by 30 per cent would mean 21,000 fewer hip fractures and would reduce the bill by £273 million.
- Personal social services for long-term care, resulting from a fall, costs an estimated £400 million. Falls are a major factor leading to premature admission to permanent residential care. Reducing falls by 30 per cent would reduce the bill by £120 million.
- The Department of Health estimates that in 2002–03, 119,400 older people were permanently admitted to residential care and supported by local authorities. Falls are the major reason for 40 per cent of nursing home admissions;<sup>38</sup> therefore we postulate that nearly 50,000 admissions to local authority-funded residential care places are because of falls. **Reducing falls by 30 per cent would keep some 14,000 older people in their own homes.**

## Current Framework

**60.** Standard Six of the National Service Framework for Older People sets out strategies to reduce the number of falls that result in serious injury and aims to ensure access to effective treatment and rehabilitation for those who have fallen. Standard Eight aims to extend the healthy life expectancy of older people. Prevention of falls is key to both Standards.

**61.** However, constraints on local budgets, a lack of understanding and commitment among local commissioners, age discrimination against older people (the false assumption that falls are an inevitable part of getting older) and lack of partnership-working all militate against investment in falls prevention services.

**62.** Much research on falls prevention is focused on high risk groups, ie older people who have already fallen, and has tended to focus on medical interventions. For example, the University of Newcastle syncope (black out) and falls study found that a rapid access to a falls and syncope facility reduces emergency admissions 15-fold, the equivalent to an annual saving of 18 beds, 6,616 bed days or 2,400 consultant episodes.<sup>39</sup> The evidence is only relevant to the small number of older people who fall because of syncope, but the principle of cost-effectiveness is much more widely applicable.

## Earlier intervention

**63.** Concentrating on high-risk individuals ignores the majority of older people who are at risk of falling, but have not yet fallen. Help the Aged believes that low-cost interventions, which involve large numbers of older people, promote the participation of older people in maintaining their own health and prevent first falls happening.

**64.** This is confirmed by recent evidence from the National Primary Care Development Team (NPDT). The Falls Collaboratives identified up to a 60 per cent reduction in falls based on activities that develop 'healthy communities'. This project measured 'an increase in social capital', using community performance indicators developed by NPDT and the New Economics Foundation<sup>40</sup>.

**65.** Investing in local falls prevention programmes that reduce the incidence of falls in this way, in Help the Aged's view, offers benefits for older people, and for the demands on the local health economy.

**66.** Evidence suggests that balance training, home visits and modifications carried out by trained personnel and high dose Vitamin D supplementation should be included in such a preventive approach to falls. The National Institute for Clinical Excellence is currently preparing guidelines on falls prevention and treatment, based on a review of the evidence to date, which is due to be published in April 2004.

## How would 'Gateways' help?

**67.** A more holistic service for later life would be the ideal delivery vehicle for the messages on exercise, medicines checks and diet, which are an important part of falls prevention. Messages delivered by a nationally recognised service for later life would be less stigmatised than more traditional delivery vehicles. Importantly, it could ensure that older people have access to a wider range of exercise options which would improve motivation to participate.

### iii) Fuel poverty

#### Context

**68.** An awareness of fuel poverty has been an important driver of two Government strategies since 1997: the development of the Winter Fuel Payments and the refashioning of the Home Energy Efficiency Scheme (HEES), now under different names in the devolved authorities. Alongside these, the Energy Efficiency Commitment (EEC) has been developed with a partial focus on fuel poverty.

**69.** The numbers of people in fuel poverty have fallen, but they still remain large (in England, between 1.9m and 2.7m vulnerable households, depending on the definitions used).<sup>41</sup> Most expert commentators (and indeed ministers) see falling domestic fuel prices as the principal contributor to the reduction in fuel poverty, though increased benefits available to the least well-off have played their part. Worryingly, fuel prices have now begun to rise and this trend is likely to continue, so many of the gains could be wiped out in the near future.

**70.** With more than half the households in fuel poverty being older people, this is clearly a major concern to Help the Aged. Of single person households, over 60 years old, 22 per cent are in fuel poverty, and these alone account for 40 per cent of the fuel poor.<sup>42</sup> Furthermore, older people are more likely to experience persistent poverty (three of the last four years below the poverty line)<sup>43</sup>, so it follows that these 17 per cent of older households will be acutely vulnerable to persistent fuel poverty. Projections by the Joseph Rowntree Foundation on older people's incomes<sup>44</sup> show that the impact of Pension Credit – when it is claimed – will raise a significant number of older people above the poverty line but not by

much, so these people will continue to be vulnerable to fuel poverty as domestic fuel prices rise.

**71.** Warm Front has been appraised by the National Audit Office, which noted areas of success, but also commented that it was poorly targeted on the fuel poor<sup>45</sup>. This may not be a stinging criticism. It is easier to identify fuel poverty in older households because of their fixed incomes, but other households tend to move in and out of fuel poverty. Add to that, fluctuations in fuel prices, benefit rates and people's propensity to move house, and the task of identifying fuel poor households using current definitions (and there seem few sensible alternatives) becomes an inexact science. It may also be a wasteful diversion of programme resources, because the other overarching objective (of the Energy White Paper) is the improvement of energy efficiency in the housing stock in order to reduce absolutely the consumption of fossil fuel. To tie Warm Front too tightly to fuel poor households, as its only measure of success, could be counter-productive – and certainly wasteful – in the context of the energy strategy. Likewise, tying it too closely to specific energy efficiency measures, and to ceilings on expenditure per household, poses the risk that the work done may not lift households in occupation out of fuel poverty. The more flexible strategy adopted in Scotland, where the achievement of effective central heating is the goal, has much to commend it.<sup>46</sup>

#### Current Framework

**72.** The Government is currently spending £1.9bn on Winter Fuel Payments<sup>47</sup>, which, along with other benefit increases, has contributed to a reduction in fuel poverty, and which is hugely popular with the older population. But the expenditure of less

than 20 per cent of this is allocated to the HEES-related work, which aims to lift households out of fuel poverty by energy efficiency improvements. This balance feels wrong. The latter approach would improve the housing stock and prolong its life, reduce the domestic consumption of fossil fuels and their associated emissions, and would improve the lives and health of that home's occupants both today and in the future. It is a programme which should commend a much higher priority. Furthermore, the Fuel Poverty Advisory Group is warning that the fuel poverty targets will not be met without a step change in the resources dedicated to this work.

**73.** The Warm Front and its sister (devolved) programmes apply primarily to private sector housing. The local authority and Registered Social Landlord sectors need to generate their own funds, and have different instruments to use and targets to achieve. Warm Zones were started as pilots to explore different ways in different settings for these schemes not only to work together but to secure the involvement of EEC and the fuel suppliers too. This integration has got to make sense, yet there is no sign of a drive to learn from the pilots and roll-out a mainstream programme.

**74.** Further initiatives could also be co-ordinated with energy efficiency work. Some local authorities have used their capital spending programmes (for example, Neighbourhood Renewal) to link to Warm Front, but there is no directive nor incentive for them to do so. Some Health and Social Service authorities have spotted the health gains achievable through linkage, not least to facilitate intermediate care or hospital discharge, but again there is no specific guidance. The current framework to meet the needs of vulnerable people in a range of different circumstances is patchy and inefficient, and therefore less effective

than it could be. This is despite a plethora of pilots and experimentation from which a huge amount of largely un-disseminated experience has been gained.

## Earlier intervention

**75.** The Met Office, in collaboration with the Department of Health, is pioneering a forecasting system which provides information to NHS Trusts on the effects of winter cold on their workload pressures. Winter cold precipitates a seasonal increase in respiratory illness, pneumonia, heart attacks and stroke. Cold conditions can also reduce dexterity and muscle strength, and increase the incidence of accidents and falls. The primary aim of the forecasting system is to predict hospital admissions and relate these data to workload pressures using length of stay. The second aim is to predict which patients are more vulnerable to being admitted. The programme, 'Forecasting the Nation's Health' is in its third and successful year. Not only should it provide efficiency savings to the NHS but it should also mitigate some of the appalling excess winter death statistics of recent years.

**76.** In collaboration with the Met Office, Help the Aged is developing a major scientific trial to provide health forecasts to older people living in the community. This initiative builds upon the successful 'Forecasting the Nation's Health' programme. Such forecasting systems have been successful for hot weather<sup>48</sup> but there have been few examples for winter forecasting. The trial aims to provide successful forecasting which will reduce the incidence of winter illness in the older population. Such preventative action will not only improve the quality of life and health of older people but will also offer a potential reduction in the costs of health and social care

at a critical time of year for the NHS and Social Services.

**77.** Both Warm Front (and its related schemes) and EEC are to be renegotiated for 2005–08. If the targets for fuel poverty reduction are to be met, both will need vigorous expansion.

**78.** Other social and material gains should be linked to the development of these programmes. Benefit take-up, health improvements, social care (in terms of aids and adaptations) and housing standards would all show gains, leading to the faster attainment of Public Service Agreements in these areas.

**79.** Apart from the gains to individual households, there must be efficiency gains from integrating these disparate initiatives.

**80.** An efficiently powered gas central heating system is clearly the most effective way to reduce fuel poverty. This leads to a problem for households not on the gas network. For many, imaginative solutions will need devising, but immediately there are half a million households within 2km of a gas main, for whom this modest investment would bring quick benefits.

### How would Gateways help?

**81.** A more integrated gateway for older people's services would be better placed to identify older people in fuel poverty and advise on the full range of potential solutions – from providing a benefits check to identify any unclaimed entitlements, to flagging up schemes such as Warm Front and Home Improvement Agencies, to providing tips on cutting fuel bills.

## iv) Dementia

### Context

**82.** Alzheimer's disease is the most common cause of dementia, followed by vascular dementia, dementia with Lewy bodies and Parkinson's disease. While usually developing slowly and steadily in people over the age of 65, some people develop dementia earlier on in mid-life, usually following a rapid course.

**83.** Recent estimates of the number of people with dementia in the UK for 1998 are 461,000<sup>49</sup>; the National Institute for Clinical Excellence (NICE) in 2001 estimated 700,000<sup>50</sup>. Establishing reliable estimates of the number of affected people however is complex because of differences in diagnosis and classification. However, what is not in disagreement is that the number of people in the UK with dementia is increasing, and will increase substantially in the coming decades (estimated in a recent study to increase by 66 per cent between 1998 and 2031). Half of those with dementia will experience significant problems with daily living, requiring a corresponding increase in help through home and institutional care, pharmacological and behavioural interventions.

**84.** Apart from this general demographic change which predisposes to dementia (increasing age is the major risk factor for dementia), additional factors come into play when assessing future cost implications, such as the severity of the condition, availability of informal care, future policies concerning social and health services, and unit costs of those services.

**85.** The impact of dementia upon the health and social care system is already high, generating substantial direct costs. Expenditure on long-term care services

for older people with dementia is set to increase from around £4.6 billion in 1998 to around £10.9 billion in 2031. These figures do not reflect the true wider costs of dementia to society, as it does not include the costs of the wider range of services and public agencies and costs of informal care, including loss of carer's earnings.

**86.** Dementia also devastates the lives of sufferers' families and carers. Loss of short-term memory and reasoning, leading to an inability to cope with personal affairs and independent living, finally degenerates to a loss of recognition of names, faces and common objects as well as an inability to communicate. Most long-term care for older people living in their own homes is currently provided by informal carers. Research evidence shows the deleterious effect upon the general health and mental health of the carer in such circumstances<sup>51</sup>. Additionally, increasing severity of cognitive impairment requires increasing input by those who care for them<sup>52</sup>. Costs on carers are predominantly opportunity costs, including reduced hours of employment, withdrawal from social interaction and decline in well-being.

### Current Framework

**87.** Many drugs are available to treat the secondary symptoms of dementia, such as anti-depressants, tranquillisers and anti-anxiety agents. Interventions to improve mental skills or enhance the ability to cope with daily living have been developed in the past two decades. Recent drugs introduced for Alzheimer's (donepezil, rivastigmine and galantamine) may also slow the progression of the symptoms in people with mild to moderate Alzheimer's disease. New effective psychosocial interventions have also been developed. However, access to these treatments is, at best, patchy in the

UK, resulting in inequalities of access: 'post-code' prescription.

**88.** The National Service Framework for Older People proposes a model for older people with dementia that stresses the importance of early diagnosis. Both pharmacological treatments for Alzheimer's for those meeting criteria laid out by the NICE, and non-pharmacological management, may reduce the impact or slow the symptom progression. However, these interventions are aimed at lessening the symptoms and impact of the disease; they do not address the underlying causes of the dementia and do not affect the ultimate course of the condition.

### Earlier intervention

**89.** Prevention strategies are at present restricted to the research arena – including anti-inflammatory strategies to dampen neurological damage and vaccination to actively remove the build-up of abnormal proteins in the brains of those with Alzheimer's – and have either been restricted to early human trials or are being tested in animal models. If the predicted increases in personal, social, and economic toll are to be addressed in the long term, then research funds and efforts need to be directed at unravelling the causes and the pathological mechanisms of dementia in order to develop rational prevention strategies.

**90.** While some rare forms of dementia have a strong genetic cause, the vast majority arise sporadically, with multiple genes and environmental factors contributing to their susceptibility. Despite some susceptibility genes being known, genetic screening is not an option for predicting who will get dementia either through population screening or more selective testing.

**91.** Unless more effective treatments are developed to control dementia, there will be a substantial increase in the demand for long-term care services. **If treatments were developed to reduce the percentage of older people with dementia by only 1 per cent per year, this would broadly offset the increasing long-term care costs due to rising numbers of older people. If the onset of Alzheimer's could be delayed by five years, the number of people developing it, and the costs would be halved.** It is therefore vital that research into controlling the disease process is given high priority; treating symptoms is not enough.

### How would 'Gateways' help?

**92.** A service that is able to target and promote prompt signposting to activities and interventions that contribute to the delaying and slowing of the progression of the disease, would help minimise the devastating personal, social and economic impact of dementia.

### v) 'Low level' social care:

#### Context

**93.** Research has demonstrated the importance of low-level social care services for older people<sup>53</sup>. Even such apparently minor details as the appearance of an older person's home can impact upon their comfort, sense of well-being and social participation.

**94.** Low-level social care services help older people to manage what have been termed the 'daily hassles' – 'the myriad of little things that [older people] could either not do, or found difficulty in doing,

because of increasing disability'<sup>54</sup>.

**95.** Lack of low-level support has been shown to impact on older people's mental health<sup>55</sup> and crucially 'daily hassles' – described above – have been shown to have more impact upon psychological distress than major life events, such as bereavement.

**96.** The incidence of avoidable depression in older age increases the need for more intensive service provision, such as primary care, specialist mental health services or pharmacological treatments. In essence, depressed older people are at high risk of physical disabilities and/or increasing dependency. And the evidence suggests that one episode of depression increases the likelihood of further recurrent episodes. Older people with depression are more likely to go into long-term residential care settings and have poorer outcomes from rehabilitation services and intermediate care services as a consequence of poor motivation. Consequently, maintaining an older person's independence and reducing the incidence of depression has a direct impact on the person's future level of dependency and use of formal care services.

**97.** Low-level social care services also bring with them improvements in social contact and general support. Evidence indicates that this can result in reduced demand on other more costly services, such as primary care<sup>56</sup>. A proactive approach that reduced dependency and morbidity by just 1 per cent could reduce publicly-funded care costs by as much as 30 per cent<sup>57</sup>.

**98.** More widely, low-level social care services offer benefits to informal carers, by relieving the pressures which can cause 'carer stress' which currently affects some 52 per cent of carers<sup>58</sup>.

## Current framework

**99.** Unfortunately in recent years, the number of households receiving low-level social care has fallen dramatically. While the total number of hours of home care delivered has increased by 76 per cent since 1992, these are being delivered to fewer households. The proportion of households receiving just one weekly visit of two hours or less has dramatically decreased from 42 per cent in 1992 to 17 per cent in 2002<sup>59</sup>. The Government's focus on providing more intensive packages of care has meant that those with moderate or lower level social care needs find it increasingly difficult to obtain services that will maintain and promote their independence.

## Earlier intervention

**100.** **There is an urgent need to restructure the way in which services are provided for older people, balancing the vital intensive services with the equally important preventative aspect of low-level care.**

Levelling the playing field in relation to eligibility criteria for community care (for example, through the implementation of the Fair Access to Care Guidance) is a welcome development by the Government, but runs the risk of exacerbating the priority being placed on services to manage crises and high level needs. While the Prevention Grants/Promoting Independence Grants have been seen as an opportunity to target this area of unmet need, they are insufficient to transform service delivery on a grand scale.

**101.** Maintaining older people's independence not only helps to improve quality of life, but research has also indicated that it increases an individual's life expectancy and reduces the number of days spent in an acute setting or a care

home<sup>60</sup>. Failure to promote, maintain and maximise older people's independence in this way therefore brings with it the risk of increasing costs to other parts of the local health economy.

**102.** Help the Aged believes that the low priority placed on such essential services undermines the Government's stated commitment to promoting independent living in older age.

## How would 'Gateways' help?

**103.** It is clear that the substantial under-investment in social care must be addressed to enable local authorities to meet currently unmet needs.

**104.** However, we believe that ultimately cost savings would result from a more integrated approach to older people's services, which could not only help in identifying need but could simultaneously identify opportunities and potential among older people and therefore help reduce the burden of avoidable decline and dependency in older age.

## vi) Stroke

### Context

**105.** Stroke is a debilitating disease which affects some 110,000 new sufferers each year in the UK, most of whom are older people (approximately 75 per cent over 65 years of age)<sup>61</sup>. The WHO defines stroke as 'rapidly developing clinical signs of focal (at times global) disturbance of cerebral function, lasting more than 24 hours or leading to death with no apparent cause other than that of vascular origin'<sup>62</sup>.

**106.** It is the third commonest cause of death (representing approximately 12 per cent of deaths in England and Wales) and

the single most important cause of disability in those at home. On average, every 53 seconds, someone in the UK experiences a stroke. Every 3.1 minutes, someone dies of one.<sup>63</sup>

**107.** For those who survive the initial stroke, 53 per cent are physically dependent on others at six months post-stroke (24 per cent severely disabled), 12 per cent need institutional care at 12 months, and up to a quarter of nursing home beds are occupied by stroke patients.<sup>64</sup>

**108.** For all industrialised economies, stroke raises an enormous challenge. It imposes a huge cost on the economy, not only in lost production but also in terms of the human and financial costs of acute, chronic and long-term health and social care.

**109.** Stroke is the most important cause of morbidity and long-term disability in Europe, the USA and other industrialised countries, imposing a huge economic burden. The overall annual incidence of stroke is estimated as 127,000 in Germany, 110,000 in the UK, 78,000 in France and 500,000 in the USA<sup>65</sup>. There are an estimated 30,000 recurrent strokes each year in the UK.

**110.** In spite of their seriousness, these figures may well be an underestimate and are likely to worsen. Further, it is estimated that if recent trends in ischemic stroke mortality continue, increases in stroke deaths will outpace overall population growth, with a doubling in deaths over the next 30 years.<sup>66</sup> The risk of having a stroke increases with age. Therefore, the incidence and prevalence of stroke are also both likely to rise as the population ages.

**111.** The high case-fatality rate and morbidity associated with stroke make substantial demands on health care resources. In the UK, stroke accounts for

nearly 5 per cent of National Health Service expenditure. **It has been estimated that stroke imposes a £1.36bn cost to the NHS (4.4 per cent of total expenditure) with some 7.7 million working days lost each year, amounting to some £445 million in lost productivity.**<sup>67</sup>

**112.** In 1990, the average cost of hospital treatment for a stroke survivor was £7,500 in the UK, but in many European countries it is much higher. Increasingly sophisticated medical technology and the ever-increasing pressure on healthcare budgets have led to the development of a more accurate model of the costs of stroke care – the ‘stroke treatment economic model (STEM)’. Using STEM, the short-term management cost of stroke has been revised to be £8,326 (\$13,649) per patient. Hospital stay was the major cost driver. Using a long-term model, it is estimated that the subsequent costs amount to £75,985 (\$124,564) for a major and £27,995 (\$45,893) for a minor stroke.<sup>68</sup>

**113.** The short-term (acute) and long-term (chronic) costs of stroke are substantial and place a major burden on health and social care services. In view of the increasingly older population and the often unsatisfactory treatments that are available, there is a pressing case to improve the prevention of stroke.

## Current Framework

**114.** The National Service Framework for Older People<sup>69</sup>, published by the Department of Health in March 2001, prioritised action to improve the prevention of stroke, and the care of stroke victims. Standard Five of the NSF anticipated that every hospital would have specialist stroke units in place by April 2004, and every person suspected of suffering a stroke would have access

to improved diagnostic and specialist services as appropriate. Since then, the Government claims that approximately 83 per cent of hospital trusts in England had plans in place to develop specialist stroke services by April 2004<sup>70</sup>.

**115.** The most recent national survey of stroke services published in 2002 concluded that only 36 per cent of admitted patients spent any time in a stroke unit, and only 27 per cent spent the majority of their time in such a specialist unit<sup>71</sup>. The audit also concluded that, although around 91 per cent of appropriate patients were on anti-thrombotic medication at discharge and six-month follow up, more needs to be done to improve secondary prevention by managing hypertension and persuading patients to modify behavioural risk factors<sup>72</sup>.

### Earlier intervention

**116.** The risks for stroke are well documented. Many of the causes of stroke are preventable and therefore may be referred to as modifiable risk factors, which are:

- smoking
- physical activity
- diet
- contraceptive pill
- high blood cholesterol and lipids
- obesity
- drinking alcohol
- drug abuse
- social deprivation
- dementia (in older people)
- high blood pressure
- heart disease
- high erythrocyte (red blood cell – rbc) count

- exposure to extremes of temperature (seasonal heat or cold)

**117.** However, some risk factors, which have been identified by research, are non-modifiable and their value lies in indicating priority groups. These include:

- history of TIAs (transient ischaemic attack)
- age (older people at 55–plus are more at risk)
- gender (men have a higher risk of stroke but stroke mortality is higher in women)
- race or ethnicity (those of black or African origin are more susceptible to stroke)
- diabetes
- history of prior stroke
- heredity/genetics
- geographical location (those living in the north have a higher risk than those in the south of the UK)

**118.** **There is an array of medical interventions of relatively low cost which are known to reduce the risk of stroke<sup>73</sup>. It is clear that in any strategy to minimise the incidence of stroke, these interventions should be exploited optimally.**

**119.** A clear opportunity exists to reduce the enormous human, social and economic cost of stroke, disproportionately borne by the older and more vulnerable population, by a strategy based on preventative measures building on the important contribution of the National Service Framework for Older People. These measures involve addressing the known modifiable risk factors for stroke via proven medical interventions and by targeting the high risk groups, especially the older population. It is important to note that evidence exists<sup>74</sup> to show that social deprivation is an important risk factor for stroke, as well as social inclusion and

health factors. Therefore, by addressing the inequalities of health and income, a valuable opportunity to redress the enormous costs of stroke presents itself to Government.

### How would 'Gateways' help?

**120.** The holistic approach to older people's services that we propose could better deliver the health promotion messages so vital to dealing with the modifiable risk factors. It would also be better placed to address the economic deprivation which substantially increases risk.



# References

1. *Older People Count: The Help the Aged Income Index for Older People in England and Wales*. Help the Aged, 2003.
2. *Census 2001*. Office for National Statistics, 2002.
3. *United Kingdom Population Projections 2002–2031*. Office for National Statistics, 2003.
4. *Life Expectancy at Birth: Local and Health Authorities in England and Wales 2000–2002*. Office for National Statistics, 2003.
5. 'Life expectancy at age 65 by gender and social class 1972–1999'. *Health Statistics Quarterly* 15, Autumn 2002.
6. Comas-Herrera, Wittenberg, Raphael, Pickard, Linda and Knapp, Martin. *Cognitive Impairment in Older People: Its Implications for Future Demand for Services and Costs*. Personal Social Services Research Unit, University of Kent, 2003.
7. Comas-Herrera, Adelina, Pickard, Linda, Wittenberg, Raphael, Davies, Bleddyn and Darton, Robin. *Future Demand for Long-Term Care, 2001 to 2031: Projections of Demand for Long-Term Care for Older People in England*. Personal Social Services Research Unit, London School of Economics and Political Science, 2003.
8. O'Connell, Alison. *Raising State Pension Age: An Update*. Pensions Policy Institute, 2003.
9. *The NHS Plan*. Department of Health, 2000.
10. Wanless, Derek. *Securing Good Health for the Whole Population: Population Health Trends*. HM Treasury, 2003.
11. Wanless, Derek. *Securing Our Future Health: Taking a Long-Term View*. Final Report. HM Treasury, 2002.
12. The National Service Framework for Older People. Department of Health, 2001.
13. New Policy Institute. *Monitoring Poverty and Social Exclusion 2003*. Joseph Rowntree Foundation, 2003.
14. *Labour Market Statistics, December 2003*. Office for National Statistics, 2003.
15. *Delivering the NHS Plan*. Department of Health, 2002.
16. Ibid.
17. *Department of Health Expenditure Plans: 2002–03 to 2003–04*. Department of Health, 2002.
18. *Modernising Social Services*. Department of Health, 1998.
19. Wistow, Gerald and Randall, Tracy. 'Spend Now Save Later'. *Community Care* 1 March 2001.
20. Bowers, Helen, Secker, Janny, Llanes, Marlen and Webb, Dale. *The Gap Years: Rediscovering Mid-Life as the Route to Healthy Active Ageing*. Health Development Agency, 2003.
21. Acheson, Sir Donald. *Inquiry into Inequalities in Health*. Department of Health, 1998.

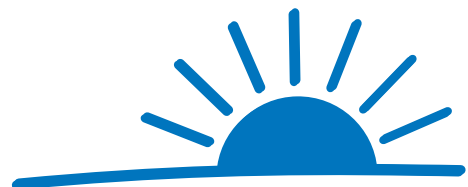
22. *Tackling Health Inequalities: A Programme for Action*. Department of Health, 2003
23. Ibid.
24. *Health Act 2000*. The Stationery Office, 1999.
25. *Health and Social Care Act 2001*. The Stationery Office, 2001.
26. Hayden, Carol and Boaz, Annette. *Making a Difference: the Better Government for Older People Programme Evaluation Report*. Better Government for Older People, 2000.
27. [www.caredirect.gov.uk](http://www.caredirect.gov.uk)
28. *Ambitions for Britain: The Labour Party Manifesto*. Labour Party, 2001.
29. [www.surestart.gov.uk](http://www.surestart.gov.uk)
30. [www.connexions.gov.uk](http://www.connexions.gov.uk)
31. National Audit Office. *The Invest To Save Budget*. Stationery Office, 2002.
32. *Older People Count: The Help the Aged Income Index for Older People in England and Wales*. Help the Aged, 2003.
33. *Simplicity, Security and Choice: Working and Saving for Retirement*. Department for Work and Pensions, 2002.
34. *Home Safety Network. Falls: Introduction*. Department for Trade and Industry, 2003. [www.dti.gov.uk/homesafetynetwork/fl\\_intro.htm](http://www.dti.gov.uk/homesafetynetwork/fl_intro.htm)
35. Scuffham P,(2003). 'Incidence and cost of unintentional falls in older people in the UK' *Journal of Epidemiology and Community Health*; 57:740-4.
36. Based on figures from *Strategy to Reduce Falls and Fractures Amongst Older People in Blackpool, Fylde and Wyre*. Fylde Coast Strategy Group, 2002.
37. National Osteoporosis Society [www.nos.org.uk](http://www.nos.org.uk)
38. *How can we help older people not fall again? Implementing the Older People's NSF Falls Standard: Support for commissioning good services*. Department of Health, 2003.
39. Kenny, R.A. *Impact of a Dedicated Syncope and Falls Facility for Older Adults on Emergency Care*. University of Newcastle, 2001. [www.nyx.org.uk/modernprogrammes/olderpeople/goodpractice/july2001/syncop](http://www.nyx.org.uk/modernprogrammes/olderpeople/goodpractice/july2001/syncop)
40. 'Reducing Health Inequalities' *HSJ Awards Supplement, Health Service Journal* 16 October 2003 p15.
41. *Fuel Poverty Advisory Group (For England): First Annual Report 2002/3*. Department for Trade and Industry, 2003.
42. Ibid.
43. *Households Below Average Income 1994/95 to 2001/02*. Department for Work and Pensions, 2003.
44. Sutherland, Holly, Sefton, Tom and Piachaud, David. *Poverty in Britain: the Impact of Government Policy Since 1997*. Joseph Rowntree Foundation, 2003.
45. *Warm Front: Helping to Combat Fuel Poverty*. National Audit Office, 2003.
46. *Cold Homes: The UK's Winter Death Scandal*. Help the Aged, 2003.

47. Department for Work and Pensions *Departmental Report*. Department for Work and Pensions, 2003.
48. Kalkstein LS (1995). Lessons from a very hot summer. *Lancet*, 346, 857-859.
49. Comas-Herrera A, Wittenberg R, Pickard L, Knapp M and MRC-CFAS. (January 2003) *Cognitive impairment in older people: its implications for future demand for services and costs*. PSSRU Discussion Paper 1728.
50. *Guidance on the use of Donepezil, Rivastigmine and Galantamine for the treatment of Alzheimer's disease*. National Institute for Clinical Excellence, Technology Appraisal Guidance no. 19, January 2001.
51. Bauld L, Chesterman J, Davies B, Judge K and Mangalore R. *Caring for older people: an assessment of community care in the 1990s*. Ashgate, 2000.
52. Langa K, Chernew M, Kabeto M, Herzog A et al (2001). 'National estimates of the quantity and cost of informal caregiving for the elderly with dementia.' *Journal of General Internal Medicine* 16: 770-8.
53. See for example, Heather Clark, Sue Dyer & Jo Horwood: *That Little Bit Of Help: The high value of low level preventative services for older people*. Joseph Rowntree Foundation, 1998.
54. Ibid.
55. Godfrey, Mary and Randell, Tracy: *Older People With Depression* (unpublished).
56. Tanner, Denise. 'Sustaining The Self In Later Life: Supporting Older People In The Community.' *Ageing and Society* Vol.21 Part 3 May 2001.
57. Continuing Care Conference / Research into Ageing (1998) *Fit for the Future: The prevention of dependency in later life*.
58. *A National Strategy For Carers: Caring about Carers*. The Stationery Office, 1999
59. *Community Care Statistics 2002: Home care services for adults*, England. Department of Health, 2003
60. E.Williams, G.Fisher, U.Junius, H.Sandholzer, D.Jones & M.Vass: *An Evidence-Based Approach To Assessing Older People In Primary Care (Appendix 10)*, Royal College of General Practitioners, 2002.
61. Liebetrau, M; Steen B, Skoog I (2003). 'Stroke in 85 year olds.' *Stroke*, 34, 2617.
62. 'European Stroke Prevention Study'. *The Lancet*, 12 December 1987, 1371-4.
63. [www.stroke.org.uk](http://www.stroke.org.uk)
64. [www.strokeassociation.org](http://www.strokeassociation.org)
65. Bogousslavsky J, Kaste M, Olsen TS, Hacke W, Orgogozo JM (2000). 'Risk factors and stroke prevention.' *Cerebrovascular Disorders*. 2000;10 Supplement 3:12-21
66. Hacke W, Kaste M, Skyhoj Olsen T, Orgogozo JM, Bogousslavsky J. (2000) 'European Stroke Initiative. Recommendations for stroke management' The European Stroke Initiative Writing Committee, *European Journal of Neurology*, 7, (6):607-23.
67. Forbes, J, (1993) 'Cost of Stroke'. *Scottish Medical Journal*, 38 (Supplement) 1-4.

68. Caro J, Huybrechts KF. (1999) 'Stroke treatment economic model (STEM): predicting long-term costs from functional status'. *Stroke*, 30(12): 2574-9.
69. *National Service Framework for Older People*. Department of Health, 2001.
70. Dr Stephen Ladyman, Parliamentary Under-Secretary of State for Health. House of Commons Written Answer, 14 October 2003.
71. *Summary Report on the National Sentinel Stroke Audit 2001–2002*. Royal College of Physicians of London, 2002.
72. Ibid.
73. Hacke, W. Op. Cit.
74. Aslanyan S, Weir CJ, Lees KR, Reid JL, McInnes GT (2003). 'Effect of area-based deprivation on the severity, subtype, and outcome of ischemic stroke.' *Stroke*, 34, 11, 2628-9.



ISBN No: 1-904528-41-4  
May 2004



## Help the Aged

Working for a future where older people  
are highly valued, have lives that are richer  
and voices that are heard.