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1 Critical themes and issues in ageing

In this chapter we set the scene for the context of social work with older people by outlining the key themes and issues in ageing. We deliberately take a critical gerontological approach from the outset. This is in preference to presenting basic facts and figures and outlining the problems older people face. Although social workers will need to know details and consequences of population ageing, they also need to reframe some perspectives through which older people have been stereotyped, for example, as burdens on society by virtue of their numbers and being dependent on family members. Social workers will by the nature of their role and tasks deal with the most socially excluded older people with the most complex needs in society, but they need to take a wider perspective to look at the diversity of ageing and view experiences in later life in a positive light, rather than treating ageing necessarily as a negative experience. Even when people face crises, the strengths they have developed and demonstrated throughout their lifecourse need to be acknowledged. It is imperative that social workers understand and take a critical gerontological approach in their practice if they are to work effectively with older people in an anti-discriminatory way.

It is important, first, to look at the people we are talking about and the situations faced by an ageing population. After defining and critically evaluating the concepts of ‘ageing’ and ‘old age’, we look at the diversity of the older population in terms of structural factors such as gender, ethnicity and class. We then move on to look at the differences in how people experience ageing and later life based on differences in location, housing and living arrangements and health. All these factors, along with more individual factors, such as social relationships and social support (particularly from carers) will have an impact on their quality of life. The challenge for social work is to operate within this diverse context in a positive way and to challenge the myth that ageing is inevitably a period of decline.

Defining ageing: what is 'old'?

There have been shifting definitions of 'old' throughout history. Whereas two hundred years ago someone aged 40 seemed 'old', today they would be considered 'young'. Legal institutions and bureaucracies have notions of 'old', for example, retirement ages at 60 and 65 in the UK, free bus passes available at 60 or the requirement to renew a driving licence at 70. Definitions and expressions of age also differ across cultures, for example, in Bosnia, old age is not linked to chronological age or external appearance but a 'loss of power' (Vincent, 2003, p. 15) referring to both physical and social strength.

Longevity has been the success story of modern society with more of the population living longer into old age. The number of centagenarians in Britain continues to rise (Dalley and Smith, 1997). The definition of 'old' has stretched beyond imagination. At the turn of the century, a boy born in 1901 could expect to live to 45 and a girl to 49; today those figures are 75 and 80 years respectively (Office of National Statistics, 2003). General improvements in public health, housing, better food supplies and better working conditions have greatly improved our standard of living. This has meant more people have survived beyond infancy and lived into adulthood. The 2001 census data show that the ageing of the UK population is particularly evident when the number of people aged over 85 is considered. On census day 1951, there were 0.2 million people aged 85 and over (0.4 per cent of the total population). By census day 2001, this had grown to just over 1.1 million (1.9 per cent of the total population) (ONS, 2003). Predictions for 2031 suggest a rapid rise in the population over the age of 85 and over, which will then comprise 3.8 per cent of the UK population (www.statistics.gov.uk 2004). It is the rapid increase in the proportion of the 85-plus age group in comparison to older people in general that is significant for the planning of social and health care services, as disability tends to increase with later life. Whether as a society we will be able to sustain such increases in longevity is a moot point as obesity in childhood, inadequate diet and lack of exercise with increases in alcohol consumption threaten this trend.

Our subjective assessment of age is, however, governed by other definitions of age – imposed through the age of retirement (60 for women and 65 for men in the UK) or through health rationing (for example, until recently, breast cancer screening was offered on the NHS to women aged between 50 and 65 only, suggesting that older people over this age did not suffer from breast cancer. It has now been extended to age 70 (Kings Fund, 2002). Similarly, health and lifestyle advice is not always offered to older people although many older people are unaware that their lifestyles are unhealthy (Age Concern, 2000). The definition of 'old' is therefore flexible and a construction of society. For example, as a response to a pensions crisis in 2003, the UK government equalised retirement ages between women and men and proposed later life working beyond the 2003 formal retirement age. A further construction of age is the difference between the 'young' old, generally considered between 60 and 75 and the 'old' old over 75. This distinction continues to be arbitrary but is a powerful one in the discussion of the demographics of age. However, as differing lifestyles become a choice for any age, the distinction is increasingly blurred and an erroneous one to make. A more flexible approach is to consider the process of ageing rather than a fixed period of old age; in this sense we all share in the process (Thompson, 1995). This blurring of stages of the lifecourse has become a popular view of postmodernists (Featherstone and Hepworth, 1989) as discussed in Chapter 2. The 'mask of ageing' describes the experience where one's subjective age and external appearance are at odds with each other (Biggs, 1997). This has relevance for social work, particularly in assessing presenting needs.

What defines old age and its associated experiences will be dependent on factors other than chronological age. Bond, Coleman and Peace (1993), argue that age is less significant than class. Older people with high incomes and resources have more in common with younger people with similar incomes and resources than other older people without such resources; being a similar age does not mean a similar experience of ageing.

Lifestyle choice, rather than fixed stereotypes of age, has been increasingly a feature of 'active ageing' or 'positive ageing'. At one extreme, older people are seen as youthful and living 'designer lives' (Featherstone and Hepworth, 1989). This optimistic view of old age has been pursued by business as older people provide new marketing opportunities as consumers with money to spend.

Ageing for the two sets of 'baby boomers', for example, those born between 1946 and 1950 and 1961 and 1965 will be a different experience from those people born earlier in the twentieth century. The first cohort of 'baby boomers', although born in a period of post-war austerity, lived through the 'swinging sixties', rock and roll, Vietnam and 'flower power'. This is clearly a far cry from their parents' generation and earlier cohorts who lived through the Second World War, rationing, Glen Miller and big band music, and Lyon's corner houses. For the second cohort born into prosperity between 1961 and 1965, access to occupational pensions, home ownership and the potential to accrue capital through investments allowed greater potential consumer power; yet they also experienced the recession of the 1970s with many never experiencing a permanent full-time occupation and growing inequality (Evandrou, 1997). Differences in terms of life expectancy, savings, relationships, pension payments and rewards will be evident between these two cohorts (Evandrou, 1998). The second 'baby boomer' group are set to be the wealthiest cohorts of older people. The contrast may be even greater between generations growing up using modern technology, the Internet, email and international travel. The ageing experience, however, may be very different again for those ageing without access to such resources.

Similarly, as we discuss later in this chapter, social resources through family and friends are an important factor in later life and family life has changed with rising divorce rates, reconstituted families, later marriages and age-gapped families, along with geographical distance between generations. This also means that different generations and cohorts will experience family life very differently. Unlike any previous generation, a larger percentage of older people over the age of 60 will be entering old age as divorced; having experience of second or multiple marriages and partnerships and may have a large network of step-children and grandchildren. With remarriage and divorce, older people may experience a transition to other intimate partnerships discovering, perhaps for the first time, their sexual orientation. More liberal attitudes toward gay and lesbian relationships will be available to them in later life than at any other stage in their lifecourse.

Increasingly, healthy older people enjoy activities traditionally associated with 'youth' such as hiking, mountain climbing, biking and flying. These experiences are no longer exceptional. Older people contribute significantly in all areas of social life, for example, through ongoing provision of support (practical, emotional, financial) to adult offspring and significantly, to grandchildren and to family members needing care. They also participate in a range of citizenship roles (for example, the magistracy, parish councils, prison monitoring boards, all of which, however, have age cut-off points) and through the provision of human resources, skill and expertise in the voluntary sector.

At the other extreme, there are older people who have experienced poverty for much or all of their lives. Being socially excluded, for example, from owning good quality housing, from regular paid work, from access to health care, and from living in vibrant communities, are often the associated consequences of living in poverty. In older age, people may be experiencing a continuity of poverty, which could be worsened by ageing (for example, as a result of widowhood or the experience of illness). Older people may have managed during their lives but, because they have no pension or financial resources, may experience poverty in retirement. The National Audit Office (2002) states that 2 million pensioners are classified as living in low-income households. This problem is exacerbated by the consistently low take-up of benefit entitlements (for example, pension credit, council tax relief and housing benefit). Scharf et al. (2002) reported that 45 per cent of older people living in three deprived areas in England could be defined as poor. That is, older people living in economically and socially deprived areas of England appear to be at least twice as likely to experience poverty as those in Britain as a whole.

It is essential that age and ageing are thought about as a heterogeneous experience and process, rather than assuming that 'the elderly' are a group of people who are very similar to, or the same, as each other. Underpinning heterogeneity are the critical issues of diversity of ageing and the lifecourse. The older population is as diverse as the population anywhere else in the lifecourse. Consideration of the gendered nature of ageing and the experience of people from minority ethnic groups illustrate this point.

Older women: the 'feminisation of ageing'

The world of 'old age' is a world of women. The only exception is among some black and minority ethnic groups where men over

60 clearly outnumber women (www.statistics.gov 2004). Women continue to live longer than men; boys and girls born in 2000 can expect to live to 75 and 80 years respectively (ONS, 2003). The difference in longevity is attributed to men being more likely to experience acute and life-threatening illness which may result in mortality whereas women are more likely to experience long-term, chronic and disabling conditions (Ginn and Arber, 1995). Increased longevity for women, together with features common to women's lives, results in particular consequences for older women. For example, traditionally, women have tended to marry men older than themselves and this means they may be more likely to care for their husbands, and are more likely to be widows. In 1995, 32 per cent of women aged between 65 and 74 were widows compared to 10 per cent of men of the same age range (OPCS, 1995) Chambers has commented that 'widowhood is the likely circumstance of older women and it becomes the norm as they move into old, old age' (2000, p. 127). It also follows that women experience widowhood for longer durations than their male counterparts. Without support from a male spouse, women who are widows, and become disabled and ill are more likely than men to enter residential care (Arber and Ginn, 1991). The same is true for women who have never married.

Women, particularly those in their eighties in 2004, are also more likely to have had sparse or interrupted work records. This is because married women in the 1930s, 1940s and 1950s were discouraged from working (apart from during the war) or if they did work, they were likely to have experienced significant disruptions for child care and family caregiving. Moreover, part-time and low paid work meant that women were paid less than their male counterparts and equal pay did not exist for much of the past century. Given the potential for interruptions to work, or a lack of paid work, women are much less likely to have contributed to their own pensions, or their pension contributions are inadequate (Arber and Ginn, 1995). This means that older women, especially those living alone, are more likely to be reliant on state pension provision and older women, living alone are likely to be the most deprived. Help the Aged (2003) state that only 49 per cent of women receive the full basic state pension, compared with 92 per cent of men. Acquiring a pension through a husband's earnings is becoming increasingly risky because of the propensity of divorce and collapse of the male breadwinner model (Crompton, 1999) with no guarantee of the husband accruing pension contributions. A gender-oriented pension policy which takes into account the caring commitments of women through their lifecourse is essential, if poverty is to be avoided in older age (Ginn, et al., 2001).

Although the social networks of older women are more extensive than men, the majority of older women whom social workers meet will be living alone. Some 50 per cent of women aged 75 and over live alone compared to 32 per cent of men of similar age (ONS, 2001a). Increasingly living alone is becoming a choice for older people, but for the majority of older people it is a situation they find themselves in after the loss of a partner, divorce and wider socio-economic circumstances. However, living alone may become a common experience for future cohorts of older people. Since the 1990s it has been an increasing trend for people under retirement age (Hall et al., 1999) and may remain so as this cohort ages. With living alone increasing for women in higher socio-economic groups with the benefits of independence being stressed, this will have consequences for future ageing populations in terms of community planning, housing and support.

In reviewing care services, social care is often viewed in gender-neutral terms. Until the 1980s women were invisible in social policy. However, this situation has changed and care services are increasingly gender-sensitive. In residential care, for example, women over the age of 85 are over-represented, along with those older people who have previously lived alone. Increasingly issues over the funding of long-term care, the closure of care homes and the movement of older people between care homes, when they can no longer afford to pay or where homes have closed, have had a disproportionately negative impact on women in residential care.

There is circularity in the feminisation of this caring relationship. Many of the people living in care homes are women, cared for by women who may be engaged in informal care (for relatives) as well as in a formal (paid) capacity (Cameron and Phillips, 2003). Work routines in care homes may facilitate part-time employment to enable women to manage other caring responsibilities, and the pay and conditions are often at the national minimum. The scene is set for future generations of women engaged in this type of work to experience the poverty of their older sisters.

Cuts in community services, particularly in relation to transport, are also likely to affect women significantly. Women are more likely to rely on public transport than men and generally have less opportunity to drive cars than men, thus, in later life, accessibility becomes a heightened issue, particularly for women living at some distance from services and family.

Older men have traditionally been discussed in the literature on ageing in their role as retirees from work (Phillipson, 1982), their dependence on services following bereavement (Arber and Ginn, 1991), and more recently, male identity (Courtenay, 2000) and their role in the spousal care relationship (Rose and Bruce, 1995; Davidson et al., 2000; Calasanti, 2003). In gerontology, however, the study of masculinity has traditionally been ignored (Calasanti, 2003) and the 'female script' has been taken as the predominant experience, partly because men were not seen as 'problems' and consequently have not been researched to the same extent as women. However, we are now realising that men do not fit the stereotypes portrayed through the female lens, for example, increasing proportions of men will live alone over the age of 65 (Davies et al., 1998) and fewer with a spouse which is the image portrayed of the 'old man'. Male caring is also becoming a common experience, particularly among spouses.

Ethnicity

The numbers and experiences of people from minority ethnic groups mirror differing patterns of migration to and within the UK. There are more than twice the numbers of people from minority ethnic groups in Britain now than in 1991, constituting 4 per cent of the older population (www.statistics.gov 2004; White, 2002). Too often the literature has grouped all ethnic minority groups together when talking about responding to an ageing Britain. Yet there are differences in ageing structures of various groups, resulting from the pattern of migration from countries of origin. Two-thirds of the black and ethnic population aged 60 and over are represented by black Caribbean and Indian communities and the remaining third are represented by black Africans, Chinese, Bangladeshis, Pakistanis and other groups (Qureshi, 1998; www.statistics.gov.uk 2004). Patterns of migration also point to different experiences for groups of black and minority ethnic people. The experience of ageing for people from black and minority ethnic groups must be underpinned by an awareness of diversity rather than assumptions about homogeneity. There is an increasing literature and research base on the experiences of older migrants in the UK, which overturns the previously held stereotypes of ‘family looking after their own’ (Atkin and Rollings, 1996; Butt et al., 2003), but there is increasing evidence that traditional services are geared up to a white population and institutional racism excludes people from black and minority ethnic groups from accessing services. Indeed, research evidence confirms that minority ethnic groups face the same issues as the majority white population, particularly in terms of the stresses of caregiving (Blakemore and Boneham, 1994; Atkin and Rollings, 1996; Phillipson et al., 2003). Many of these needs are met by black voluntary organisations that often face the uncertainties of short-term funding.

Other structural disadvantages and the effects of racism may compound these issues. Norman (1985a), in her hypothesis on triple jeopardy, highlighted the ways in which multiple experiences of exclusion and disadvantage, promoted by oppression and discrimination, deny people from minority ethnic groups full rights to citizenship. Phillipson et al. illustrate the experience of multiple disadvantages in their study of Bangladeshi women living in Tower Hamlets and comment: ‘The depth of social exclusion illustrated by inadequate housing, poor health and low incomes underlines the case for an urgent, targeted response within social policy’ (2003, p. 67). The implication for social work here is to recognise the social conditions and factors that constrain and exclude minority ethnic groups and to work with them in empowering ways to overcome disadvantage. Phillipson et al. also examined problematic caring relationships among Bangladeshi participants and argued that extended families, rather than reducing need, actually increased it. In this study, people reported suffering from language barriers, poor knowledge of resources and their difficulties were compounded by the running down of resources and services in deprived inner city areas. In this study, one woman, Mukta (with seven children) sums up her experience:

> The lifts don’t work and there are always boys having drugs on the stairs. It is very frightening. The main door is supposed to be locked but they break it. They always break the lifts. Me

> and my husband are both not well and it is difficult for him to climb all these stairs.
>
> (2003, p. 32)

A study of older Chinese people by Chau and Yu (2000) concludes that social inclusion for participants was compromised by a number of barriers, such as language and lack of family support to help sustain intergenerational relationships. As well as identifying some practical developments to remove those barriers, the authors highlight the importance of starting where older Chinese people would wish to start and this inevitably means adopting clear and robust strategies for their meaningful participation and involvement.

Health

A further area of difference between older people is in relation to their health; such diversity will increasingly be significant for social workers to appreciate as health becomes a major area in assessment, and health professionals are key actors in multi-disciplinary work.

The majority of older people are healthy and live independent lives; consequently, old age should not be associated with disease. Even when people self-report their health, more than a third over the age of 75 say their health is good. Even living with a long-term health condition does not necessarily mean that older people would rate their subjective well-being negatively or indeed, their overall quality of life (Siddell, 1995).

However, health problems can affect larger numbers of people in later life. For example, the Living in Britain survey (ONS, 2001b) notes that 38 per cent of men and 28 per cent of women aged over 65 reported hearing impairments. Older women more than men report difficulties with their eyes – 31 per cent and 25 per cent, respectively. Older women are more likely than men to suffer chronic illness or functional disability (Arber and Ginn, 1991) and are more likely to rate their health as poorer. The impact of conditions such as arthritis on mobility is well known, and 23 per cent of the population aged 65 and over reported permanent mobility difficulties (ONS, 2001b). Overall, elderly women were more likely to report permanent mobility difficulties than men (27 per cent and 19 per cent respectively). The ONS Survey in 2001 also showed that the numbers of older people with permanent health difficulties increased with age with 11 per cent of people aged 65–69 reporting permanent difficulties compared with 60 per cent of people aged 85 and over. Living with such disabling conditions requires some adjustment to daily routine and activity.

Mental ill-health may also be an experience in older age; this may be because a person has had long-standing mental health needs and has aged with them, or because a person has developed mental ill-health in later life. While dementia can affect people through the whole lifecourse, its prevalence is higher with increased age. The Alzheimer's Society (2003) estimates that dementia currently affects over 750 000 older people in the UK. Over 18 000 people diagnosed with dementia are under 65. Data on diagnosis suggest that dementia affects 1 person in 20 aged 65 and over and 1 person in 5 aged 80 and over.

Based on prevalence and incidence statistics, the Alzheimer's Society estimates that by 2050, the number of people with dementia will have risen to over 1.5 million people. Clearly, it is essential that planning takes account of these changes and there will be a vital role for social workers in this context. The experience of dementia and the potential social work role in dementia care are discussed in Chapters 4 and 5 of this book.

Depression can affect anyone but it is more common in older people than any other age group. The Mental Health Foundation (2003) estimate that 10–15 per cent of older people living in the community show symptoms of depression but this figure rises to approximately 40 per cent when considering older people living in care homes. Depression may be caused by the experience or difficulties in managing or coping with bereavement, loss and change. People may also become depressed as a result of untreated illness; it is easy to imagine, for example, how unmanaged or untreated pain experienced over periods of time can result in a person feeling low and depressed. Many people have depression and dementia, with depression often going undiagnosed in these circumstances. Medication (for example, antibiotics, anti-parkinsonian, anti-psychotic drugs) and its side effects can also be a cause of depression. This is an important consideration as 70 per cent of older people take prescribed medication on a regular or long-term basis (DoH, 2001a). At a practical level, this may be a major contributory factor in the high incidence of depression among older people living in care home environments as the population of older people living in care homes are more likely to be receiving medication for a range of illnesses and conditions. Moreover, the evidence is that older people are often over-medicated (Jackson, 1996: www.SocietyGuardian.co.uk); this may be particularly an issue for older people with dementia who are perceived as having 'challenging behaviour' and may be given medication to manage their behaviour (Jackson, 1996). The potential for age-based discrimination in the context of mental health is an issue which is of concern to older people affected, their families and practitioners (Age Concern, 2002).

Older adults, as with any group in the population, can also experience problems with alcohol (The Mental Health Foundation, 2003), and men are at significantly greater risk than older women, although this is changing. Alcohol abuse can be unrecognised among older people; this may be, to a significant extent, caused by ageist assumptions (for example, that older people do not drink alcohol in excess). This is likely to be a particular issue for people who develop problems with alcohol in later life, rather than people who have had a long-standing problem. Warnes and Crane (2000) highlight a strong relationship between homelessness and heavy drinking.

Class and income

In old age the effect of class and income is amplified through retirement. Class influences lifestyles in older age. Additionally, the lower the socio-economic status of an older person, the more likely it is that they will experience ill-health. Contributing to an occupational pension, owning property, accruing savings and retiring on a high income (Thompson, 1995) will also influence financial health in later life. In the past 30 years the increasing importance of a non-state pension has resulted in a growing inequality between those who have and those who do not have occupational pensions. Redundancy, unemployment, care for dependent children or adults all have a significant impact on the ability of people to accrue such pension (Falkingham, 1998; Gunnarsson, 2002; Evandrou and Glaser, 2003). Low public pensions are increasingly meaning a reliance on means-tested top-up benefits, with a quarter of all older people in Britain dependent on Pensioner Credit or entitled to it but not claiming it (Vincent, 2003). Inequality between generations is a current issue and the UK government attempted to address this issue with limits on welfare being concentrated on those most in need and an encouragement to private provision and saving for the majority of society. With the erosion of the state pension and increases in public expenditure and the council tax, older people are finding a political voice.

Location

The socio-economic and demographic factors discussed above divide the older population in a number of ways. These are also linked to where people live, as the experience of ageing will also be affected by diversity in where older people live, for example, between rural and urban environments; in cities, and in and between different countries. Although it is beyond the scope of this book to highlight global differences in ageing, placing Britain relative to other countries does throw some light on the relative position of older people in Britain today.

The majority of the world's population of older people (61 per cent) live in poorer countries, many where life expectancy remains below 50 (www.who.int/imp 2003). In 2004 globally about 1.2 billion people were living on an income of less than $1 per day and about 100 million of these are older than 60 (Petersen, 2004).

Trends in Britain reflect more general trends at a European level. Low fertility levels and extended longevity mean that the EU population is ageing, particularly those over age 80. At the same time the population of working age is dwindling; in 2001 the old age dependency ratio (the population aged 65 and over as a percentage of the working age population 15–64) had risen to 24.6 per cent; an increase of 4 per cent in 10 years (Eurostat, 2002). This continuing trend will have implications for social policy in all EU member states and, even with the more balanced demographics of the new accession states, this will remain a significant issue on the migration agenda.

Moving from a European level to a country level, significant differences in the experiences of ageing are found in urban and rural areas. For some older people there is a choice of migrating to warmer climates of other countries or to the seaside. This next section discusses such differences in location and the movement between areas. Social workers also need to understand the importance of 'place' to older people and the difficulties that distance can pose to older people, particularly if they are in need of care.

Older people living in rural areas may face a lack of services and difficulties accessing any limited provision. The experience of older people living in rural areas is influenced by factors such as poor transport, centralisation of services and resources, and poor service provision (Pugh, 2000). Older people living in rural communities may express need in terms of loneliness and isolation, accentuated by depopulation, the purchase of local houses as second homes and holiday houses, and the loss of personal networks through geographical mobility and bereavement. Pugh has argued that the increasing trend towards managerialist social work has meant that the wider social, emotional and psychological needs of older people are ignored in favour of the provision of practical services. This, of course, is not just an issue for older people living in rural environments. Clearly, there is a need for welfare and social care services to develop in the context of familiarity with the area and the population that it serves. While it may seem sensible to provide extra resources for a day centre in the main town to accommodate older people living in scattered villages 10 miles away, to the older people in question, travelling 10 miles to town for a few hours may feel unfamiliar, stressful and unnecessary.

Ageing in the inner city, however, does not necessarily mean that older people will have easy access to a range of support services. Many older people live in deprived inner city areas with poor resources. Scharf et al. (2002), in their study of ageing in three deprived inner city areas, highlighted that 34 per cent of respondents identified the lack of social clubs or community centres for older people in the neighbourhood. Other locations that superficially appear to be satisfactory may also not meet the needs of older people; urban regeneration, for example, can create environments suitable for professionally mobile couples but facilities that are important to other citizens have exited the area. Suburban areas too may suffer from poor transport links or out-of town shopping centres may cause the demise or deterioration of more traditional town centre shopping areas accessible to older people without public transport.

Location may also be an important factor encouraging movement in later life. For several decades, retirement migration has been a feature of British society. King et al. (2000, p. 5) identify five changes in twentieth-century society that have had a strong influence on aspirations of later life. They are:

1 The growth of retirement.
2 Increased survival rates (and therefore, longer retirement).
3 Greater affluence.
4 Improved education.
5 Better quality housing.

These factors have contributed to large numbers of people leaving urban and suburban settings for coastal and rural towns and villages. In some areas, for example, Worthing, the impact of retirement migration has significantly altered the demography of the population and impacted on service provision, particularly where social networks have not been established in the new area (Karn, 1977). Increasingly, wealthier older people are moving abroad to places such as Southern Spain and Italy to savour the benefits of the climate. However, this also poses a number of potential problems in respect of future welfare provision, which King et al. (2000) highlight as an issue that is yet to be faced in the context of European migration.

Location takes on increasing significance as generations live further apart from each other. This not only has implications for regular social contact and support but also for the quality of relationships and provision of care. With increasing globalisation and migration, issues of support to older people come into focus. Geographic proximity is the major element in solidarity between family members. Children who live long distances away from their parents experience considerable conflict and cope with anxiety and stress through telephone and email contact (Baldock, 2000). Connidis (2001) found that ambivalence in relationships could also be created through distance. Thus, proximity, distance and movement become particularly significant when care needs arise. Joseph and Hallman (1998) found that stress and interference with work resulted from the spatial arrangements of home, work and older relative. Having to travel in different directions to work and to the home of an older relative around work time can be stressful.

Long distances come into sharp focus for ethnic communities engaged in transnational caring (Phillipson et al., 2001). Schiller et al. (1992, p. 5) describe such people as 'transmigrants' who link their country of origin and their new country of settlement, sustaining familial, social and economic relationships and taking actions such as decision-making across boundaries. Sending money home for the care of older relatives linked several generations in Phillipson et al.'s (2001) study.

Housing and communities

In considering crucial issues in ageing, which have particular relevance for social work, housing is a key factor. Community care policies are underpinned by the principle of 'keeping people at home for as long as possible' and promoting independence rather than requiring a move to specialist provision when care needs arise. Housing has a crucial role to play in this equation as people 'age in place'. Housing conditions and housing tenure also play significant roles in the quality of life (Hughes, 1995). The Joseph Rowntree Foundation (2000) highlights the importance of good quality housing to health and well-being; however, it found in an analysis of community care plans that housing was often not discussed in the plan, even when they came from areas where housing was more likely to be sub-standard. There is great diversity in housing wealth, with 15 per cent of older homeowners being income and equity poor; 5 per cent being both income rich and equity rich. Further diversity in housing can be seen in relation to ethnicity, housing status and rural/urban location (Heywood et al., 2002). Older people are more likely to be living in sub-standard inappropriate housing stock, which lack basic amenities. The English Housing Conditions Survey (Office of the Deputy Prime Minister, 2003) indicates that 35 per cent of older people were living in an unsatisfactory home but were 'much more likely to do so where they are low income private sector households, the oldest person is 85 years old, or they have lived in their home for 30 years or more' (2001, p. 11). Older people are also twice as likely as younger people to live in rented accommodation. The Living in Britain survey (ONS, 2001b) indicated that 27 per cent of older people were tenants or joint tenants. Older people, particularly older women, may reside in private rented accommodation and be vulnerable to the commitment of landlords to maintain homes to a decent standard.

In the past, sheltered housing has been seen as a viable alternative. The initial intentions of sheltered provision to provide companionship and community life as well as enable independence, however, backfired with an increasing tendency to be dependent on the warden. Some schemes which were designed with one small bedroom in particular were also ‘hard to let’ (Tinker et al., 1995) and there was no evidence to suggest that sheltered housing led to a reduction in residential or nursing home care admissions. Such special needs housing for older people was seen as ‘ageist’ (Stewart et al., 1999) and rooted in focusing on the deficits of older people rather than the inadequacy of planners and architects. Similarly, ‘Staying Put’ and ‘Care and Repair’ schemes come under fire for the same criticism. However, this has led to an under-investment in both specialist and ordinary housing.

The debate has mainly been about whether housing should be a specialist provision for older people (segregation) or whether ordinary generalist housing is a better option (integration), yet in recent years age-segregated housing has taken on a new and different dynamic. Rather than be seen as a welfare provision, older people are buying into an identity of active lifestyle and participation through retirement communities. Although well established as a provision in the USA, it is only recently that this form of living arrangement has taken off in the UK with different models appearing (e.g. from the leisure village idea to the continuing care model). Research shows that there are a number of benefits to this way of living, such as an improved sense of health and well-being (Bernard et al., 2003). There has also been a widespread critique describing retirement communities in the USA in particular as geriatric ghettos, segregated from intergenerational community life where residents don’t always agree on how the environment should be structured and where the retirement communities do not always embrace residents with disabilities. They have also been criticised for their leisure rather than their care orientation – they are more about helping people come to terms with retirement status than providing care to older people in later life (Metsch, 1996).

Separate from housing but of increasing significance is the work on ‘the meaning of home’. The definition of ‘home’, however, has been regarded as a domestic setting with all its associated memories but less attention has been applied to this principle once older people have entered residential care. Although the principle is to make the residential facility as ‘homely’ as possible, when tested, a home for life is sometimes what it is not (e.g. Cowl and ORS v Plymouth

City Council, 2001). On the microlevel there are other issues that concern social workers, for example, there are issues regarding the extent to which older people with 'antisocial behaviour' (such as noisy or violent neighbours; or those living alone and at risk because of dementia) should remain in their own homes.

The significance of home is, however, taking precedence in housing policy to encourage initiatives for people to remain in their own homes. The use of technology will have a profound effect on our housing provision in this respect. There have been a number of initiatives in this arena which assist older people. Three are briefly outlined below:

1 Lifetime homes to meet the needs of all the family are of increasing significance, initially termed 'multi-generational housing' to promote the theme of 'home for life' (Kelly, 2001, p. 57). It is claimed that such housing enables greater mobility through larger space, better standards, planning and fixtures; while locating such housing in accessible areas will also improve a feeling of neighbourhood community. One of the criteria, for example, inside the home is space for a wheelchair to turn in all ground floor rooms, the sitting room to be at entrance level and sufficient space downstairs for a bed or the conversion of a room into a bedroom. Contrary to the universal myth that all older people could downsize in later life, many older people will need as much space as earlier in their lives to maintain their lifestyles (Appleton, 2002).
2 For existing old homes, 'Care and Repair' or 'Staying Put' schemes have been initiated, although there has been criticism about the delay in work to get the home in a good state and quality suitable for the older person rather than meeting regulations (Allen et al., 1997). Re-sale is an issue with many owners in terms of whether they will be able to market a property with a stair lift and other adaptations.
3 Smart homes where technology has been installed to facilitate automation and user-initiated communication emerged in the 1980s to be used by people with mobility problems or sensory impairments as well as communication problems. Such examples include social alarms, automatic lighting, temperature-monitoring devices and medicine monitoring. Movement activated technology using Passive Intra Red devices (switching lights on and off automatically in response to movement) has proved to have considerable potential for people with dementia. Although older people are able to use and adapt to a wide range of technologies

(Appleton, 1999), there are issues of intrusiveness and lifestyle monitoring (Fisk, 1996), for example, through closed-circuit television. There is, however, little evidence to support fears that such monitoring may completely reduce the need for personal contact.

The circumstances of older people who are vulnerable to homelessness or who are homeless are generally under-recognised. The UK Coalition on Older Homelessness 2004 (www.olderhomelessness.org.uk/) defines older homeless people as 'those who are 50 plus and are sleeping rough or living in appropriate temporary accommodation, or are at risk of homelessness'. Warnes and Crane (2000) differentiate between 'official' homeless older people and the 'unofficial' or single homeless population. Official figures suggest that between 4000 and 5000 older people in England lose their homes each year. However, there is a lack of comprehensive statistical evidence showing the true extent of the situation. Help the Aged (2003) estimates that approximately 21 000 people are living in inappropriate hostel accommodation. Help the Aged have combined these figures with the numbers of older people who had referred themselves to bed and breakfast in the country (approximately 27000) and suggest that an estimate of homelessness among older people in Great Britain resides in the region of 48 000. Warnes and Crane highlight a need for a dedicated service provision for older homeless people. They argue: 'Even when there is a full spectrum of all-age homeless services, providing a pathway from the streets to independent housing, they are unlikely to meet all the needs of older and long-term homeless people' (2000, p. 172). Dedicated services should focus attention on, for example, outreach, rehabilitation and resettlement.

How older people use and perceive spaces in their communities is crucial, however, for their quality of life. A study by Scharf et al. (2002) illustrates the significance of environment, indicating that older people who live in deprived neighbourhoods are more vulnerable to crime than those living in other neighbourhoods. Of the people participating in their survey, 40 per cent had been victims of one or more types of crime in the two years prior to the interview. While crime surveys repeatedly show that older people are relatively unlikely to be victims of crime, their study showed otherwise, particularly for ethnic minorities. Vulnerability to crime is linked to poverty and social inequality as many studies over the years have suggested (Hough, 1995; Silverman and Della-Giustina, 2001; Scharf et al., 2002).

Older people's perceptions of place were also affected by their experience of crime. Lower levels of satisfaction were reported with their neighbourhood among those reported as victims of crime. Neighbourhood satisfaction is also linked to older people's sense of identity. Dissatisfaction with place can translate into a loss of identity and reduced quality of life for older people.

Transportation in terms of walking, driving and use of the public transport system are crucial issues for many older people. Older people can be excluded from transport systems: financially, temporally (unable to get to activities at night); personally and spatially (unable to get to destinations). The goal of transport policy should be to offer all members of society safe, satisfactory and environmentally friendly transportation resources at the lowest possible socio-economic cost, while at the same time integrating people with functional impairments into all parts of society. To make public transport attractive, it must be adapted to the needs of travellers. The design of public transport must proceed from a holistic perspective and presuppose that people have very different needs and preferences when they travel. This implies a demand for high trip frequency, efficiency and good information about travel options, combined with high level service and an accessible outdoor environment with short distances to bus stops and train stations.

Older people, however, use private transport and this is likely to increase, as women in the next generation are more likely to be driving than the current generation of 80-year-olds. Many drivers over 70 experience problems with driving because of physical changes – in vision, ability to detect messages among the clutter on the road – and do not have a quick response time. Yet older people over 75 have fewer crashes per number of licensed drivers (OECD, 2001). Improved sign maintenance, illumination, better 'cat's eyes' and better warnings of crossroads as well as better vehicle design can assist in this respect. Relinquishing driving can be difficult for all sorts of reasons as mentioned earlier if older people are located in remote areas.

Living arrangements

The theme of housing and community raises the issue of living arrangements in general. The determinants of living arrangements are demographic factors (level of childlessness, number of children, trends in marriage and divorce and mortality levels); characteristics of older people (health, education and income); cultural contexts (values); policy (availability of social care); characteristics of family networks (size, age, marital status, income and education) (Tomassini et al., 2003).

Considerable changes have taken place in the living arrangements of older people in the past century. There has been a marked decline in 'complex households' with a corresponding move to single or solo living or living with one other, generally a spouse. Higher proportions of never-married, divorced and childless people than before will require support and living arrangements in old age. Co-residence may have declined as 'intimacy at a distance' has grown with better communication (Grundy, 1999). This may be true for even close relationships such as children.

Care homes

The history of residential care has been well documented (Means and Smith, 1985, 1998; Phillips, 1992; Means et al., 2003). In 2001 there were 341 000 places in residential care homes in the independent and public sectors, mainly for older people. Profiles of such older people show a greater degree of disability and dependency in 2004 than in 1990. Flexibility and choice have been increasing themes in the discussion of residential care, along with attempts to create a 'homely' environment. The most sensitive debates, however, have been over how such care can be financed, with the setting up of the Royal Commission on Long Term Care in 1997 (Sutherland Report, 1999) and the quality and standards that can be expected in such provision. A discussion of the process of admission to care can be found in Chapter 2.

Social relationships

Members of the same cohort have much in common as they have continuity with the past, particularly in terms of global historical events, for example, the Second World War will be a reference point for many current 90-year-olds. In terms of intimate relations, then, the marital relationship is one of peers. Married women are more likely to have a confidant outside the family than men. For men they are more likely to say it is their wife; for women it is likely to be a same-sex friend.

Intergenerational relationships can consist of a number of relationships – daughter, son and grandchildren. Active grandparenting can be a role of choice as it is a relationship not based on rights and obligations but on voluntary and personal involvement. The role has been made more of an ambiguous one as divorce and remarriage increase. However, in such situations grandparents can provide stability and continuity with the past. One of the key areas for social workers is to assess the quality of such relationships as informal care plays a crucial role in supporting older people (see Chapter 2).

Social support

In studies of the family and the community life of older people, the role of the family in supporting older people is central (Wenger, 1984; Phillipson et al., 2001). Similarly, older people themselves play significant reciprocal roles within their families, spanning among other things, caregiving, financial and emotional support. Alongside family, friends are also important, particularly for those without family (Phillipson et al., 2001). In communities they also play important roles as citizens or volunteers. When older people are asked about who is important in their lives, family and friends are rated highly; less so are community members such as vicars; in contrast, formal support services such as health and social workers are inconsequential in the lives of the majority of older people (Phillipson et al., 2001).

Carers

Many older people play supportive roles to grandchildren and children but they are most likely to encounter a social worker when they are in need of support themselves. Such support can come from informal (family, friends), and formal sources (care workers and other professionals). Carers, both in a paid and unpaid capacity, play a pivotal role in the care of older people. Without the support of key social care workers and family carers, the role of the social worker would be impossible.

One of the difficulties in establishing the number of carers in the population is the inconsistency in the definition of a ‘carer’, both in research studies and in the census. Census figures have varied between 6.8 million (1991) to 5.2 million (in 2001). The current census definition (2001) asks if 'you provide unpaid personal help for a friend or family member with a long-term illness, health problem or disability'. You are asked to include problems which are due to old age. Personal help is defined as including help with basic tasks such as feeding or dressing. Unpaid carers, generally spouses, other family members, friends and others in the community are generally designated under the term 'informal carer' although this is misleading as there is little that is 'informal' about this role. On the other hand, those grouped under 'formal' carers are paid and seen as part of the low-waged, low-skilled social care workforce. This group will be discussed later in Chapter 2.

Since the early 1980s there has been a growing literature on carers of older people. The plight of carers was first highlighted in the feminist literature of the time with an emphasis on the burdens and stresses placed on 'informal' carers, predominantly female and married (Finch and Groves, 1983; Lewis and Meredith, 1988). The profile of carers is, however, far from the stereotype of the 1980s as research has disaggregated the type of carer, nature of care, gender and the situations faced by carers.

The majority of carers under 65 are women. The difference is most marked in the 45–64 age group where 27 per cent of women compared with 19 per cent of men are carers (ONS, 2003). Although the overall impression is that it is predominantly women reciprocating in the care role, men are increasingly playing a role in the care relationship (Fisher, 1994; Arber et al., 2003). Overall, 58 per cent of carers in Britain are women; 42 per cent are men. One in four carers is between 45 and 64 and can face the difficulties of juggling home life, care and work. Carers UK claim there are 4 million people combining work with informal care for another adult (Howard, 2002).

Caregiving can stretch across all age groups. Loss of education can be another factor faced by 'young carers' looking after disabled parents (Becker, et al., 1998). Increasingly, the issues faced by older carers looking after their spouse raise particular issues of interdependency. Similarly, an older parent caring for an adult with a learning disability is an issue as more people with a learning disability are surviving into old age (Walker and Walker, 1998).

Further differentiation can be made in terms of the nature of the task. Women are more likely to help with personal care tasks than men who are more likely to be involved in taking the older person out or managing their finances. Some 60 per cent of carers are looking after someone with a physical disability; 7 per cent are looking after someone with a mental health problem. This differentiation will lead to potentially different kinds of stress for carers and different experiences of care. In one study of carers of adults with learning disabilities, 80 per cent of carers reported levels of stress indicative of psychiatric problems. This was associated with material disadvantage, lack of informal support, and low take-up of services due in part to lack of information, staff with inappropriate language skills and general neglect of religious and cultural needs in assessment (Haton et al., 1998).

Providing care is also time-consuming with 1.7 million carers devoting at least 20 hours a week to caring and 855 000 of these spending over 50 hours in this role. Consequently, the impact on carers' employment can be severe. In the Carers UK survey (Howard, 2002) around six out of ten carers had given up work to provide care. The consequences of the loss of income and pension accruement for women to provide security in their own old age can therefore be significant (Evandrou and Glaser, 2003).

The location of care also impacts on the type and frequency of care provision. The majority of carers (over two-thirds) provide care to someone who lives in a separate household. A number of studies illustrate the difficulties where distance between home, work and the care recipient – with 30 minutes travelling time being the cut-off point for providing daily personal care (Phillips et al., 2003).

One of the major limitations of earlier definitions of 'care' was the emphasis on 'instrumental care' – 'doing for' or 'doing with' tasks often to the exclusion of emotional caring. Nolan et al. (1998) highlight the stress of this kind of care long before caring is 'seen' and describes this as anticipatory care, based on anticipated future need. Eligibility for services, however, has long been associated with the demonstration of 'hands on' care; it ignores the stresses carers may face emotionally, as they 'monitor from a distance'.

There are a number of further factors in caregiving impacting on the experiences for both carer and care recipient, such as the history of the past relationship and the quality of that relationship (the relationship may be based on years of abuse between father and child, with the roles of abuser and abused now reversed); prognosis and trajectory of the illness or condition requiring care and the carer's attitude (Nolan et al., 1998).

Increasingly, we have an extensive body of knowledge from both carers' accounts and quantitative information about what it is to be engaged in informal care. Financial costs can stem from a loss of income in addition to the increased costs from care such as incontinence aids; physical costs arise through risks of personal injury in lifting, fatigue and stress; mental and emotional costs and social costs through isolation and potential household conflict. Such problems may be appraised as stress factors by carers. As Nolan et al. (1996) illustrate, however, the rewards and satisfactions of caregiving are rarely addressed. They can exist, however, in terms of interpersonal factors (such as satisfaction derived from meeting the need for nurturing and care; feeling that they are able to repay and reciprocate for the caring done by the person needing care in the past) and intrapersonal factors (such as a sense of fulfilment in helping another or religious beliefs in caring). Satisfaction in a number of studies referenced above is associated with a good past history in the relationship and the attitude of the carer to their caring role.

Care is found in a variety of situations and relationships. Carers are the linchpin of sustaining older people in the community. Older people themselves value and prefer a mixture of care from both family and friends and from care workers (Daatland and Herlofson, 2003). The dynamics of care are, however, changing with different relationships emerging, e.g. lesbian and gay care relationships and friends talking on more care tasks, together with different expectations of who should provide care in the future.

All the above factors will play a role in the quality of life of older people. In the past five years there have been a number of research studies addressing this issue (www.shef.ac.uk/uni/projects/gop 2003). Assessing the quality of life and understanding the factors involved in this is an essential skill for social workers.

Quality of life

The lifecourse is central to any understanding of ageing, as this chapter has outlined. The individual experience of ageing will be determined by the cultural, economic, clinical, and social factors over a lifetime. Diversity in quality of life is a dominant theme therefore in old age. It is the subjective evaluation of objective living conditions that has an impact on people's behaviour.

Research shows that, in particular, health, income and education have a strong impact on most dimensions of subjective quality of life (Tesch-Roemer et al., 2003). This is not to say that objective conditions do not play a significant part. Health, income and wealth, age and gender all correlate to satisfaction in old age (Mannell and Dupuis, 1996). The influence of social networks and social support characteristics is also vital in subjective well-being. Marital status is important in this respect with older married men having higher levels of satisfaction compared to non-married men and married women; similarly, having children also has an impact.

Conclusion: implications for social work

The diverse situations and heterogeneity of older people provide a backdrop to social work. It is crucial to acknowledge the diversity in social, cultural, economic, financial, political, gender, generational and ethnic circumstances among others. This collage of circumstances and experience also has a temporal dimension as present circumstances are shaped by a lifetime of events, relationships, economic and social circumstances as well as class, gender, ethnicity, race and location.

Social workers, however, will meet older people from all lifestyles through their personal and professional relationships yet they are more likely to work with those who experience poverty, ill health, depression, dementia, and traumas in earlier years, along with those in greatest need. It is imperative that social workers place their work in context and do not view older people from a negative and ageist perspective.

As we learn more about the situation of older people, this becomes an exciting time for those engaged in practice with older people. Future cohorts may bring very different agendas as living arrangements, expectations and aspirations, economic and societal circumstances change.

Given that most older people do not need a social worker or come into contact with them, why is social work with older people important? What are the reasons for social work and what is the remit of the social worker in the lives of older people? Chapter 2 turns to why social work has a role to play in the lives of older people.

putting it into practice

Activity 1

Think about an older person you know. How does their experience differ from yours? How have gender, class, income, culture and location influenced their experiences in later life? You may find it helpful to interview them about significant life events and their experience of later life.

Activity 2

Investigate a cross-section of newspapers covering the main news items of the week. To what extent are older people evident in the news? What images and situations are portrayed in the media? How can these images be challenged or promoted?

Activity 3

What differences are there in the experiences of men and women in old age? To what extent do such differences exist for older people in other countries? You may like to consider ageing in Africa, China or Iceland!

Further reading

Ageing and Society http://titles.cambridge.org/journals/journal

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