

Managing resources in later life

Older people's experience of change and continuity

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This report explores the changing lives of older people and shows how resources are used to manage change and maintain stability.

An ageing population continues to be of policy concern, in relation to meeting the needs of older people now, and for future welfare provision. This research explores how older people plan, use and value the different resources available to them. Resources are broadly defined, to explore the relative value of different structural, social and individual resources and how they interlink. This holistic overview highlights the complexity of older people's lives, the variety of resources that people draw on to help manage change and the work involved in maintaining continuity and preventing change.

In-depth interviews with people (aged 65–84 at the first interview) were conducted two years apart to explore their changing needs and resources as they move through later life.

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Research background

An ageing population continues to be of policy concern – in relation to meeting the needs of the current generation of older people, and in terms of future welfare provision.

This research aims to provide an understanding of how older people plan, use and value the different resources available to them. This report draws together findings from two waves of in-depth interviews to explore the changing needs and resources of older people as they move through later life. The first interview took place in 2005 with 91 households. Participants were spread across age (65–84), gender, household type (single and couples), income and urban/rural areas. A second interview took place in 2007 with 78 of the original 91 households. This interview focused on people's experiences over the two years. The longitudinal approach provides an insight into how older people manage change, the impact of change on their quality of life and also how resources are drawn on to maintain stability.

Health and well-being

An important aspect of this research is how changes in older people's health impact on their everyday lives and how these changes are managed. Most of the research participants had experienced a spell of ill health or a general decline in their health that had affected their quality of life. This often meant that they needed more help to live independently. Resources drawn on included extra help from family, friends, social services, health services and mobility aids, as well as money to pay for additional help in the home, to get around or for aids and adaptations. Older people also used personal strategies such as their past experiences and individual attitudes to help cope

with declining health and mobility. This included resilience, 'battling on with it' and determination not to 'give in'. However, accepting what they could no longer do and 'pacing oneself' was another way that people dealt with frustration and helped to protect themselves from further health deterioration. The research findings also highlight the difficulties that many lone older people face in finding and negotiating their own support to continue to live independently.

Changes in home and property

For older people with worsening health, the home can become more significant, as they become less mobile and go out less often. For the few participants who had moved, being in a more suitable and manageable property had made a positive difference to their lives. However, moving was often seen as a stressful and daunting experience, and people talked about practical and emotional obstacles to moving. For some participants, adaptations to help with mobility had made life easier and grants to upgrade a property had improved their home environment. However, people's determination to manage without help and lack of information could prevent their needs being met. Cutbacks in warden cover were felt most strongly by people with limited mobility who lived alone. People's uncertainty about their future health, what help was available and how it was funded, could inhibit them thinking about future home support or residential care needs. These findings reveal a need for trustworthy, reliable information about housing choices, equity release and practical support to help older people move to a more manageable property. Furthermore, better information is needed about what help is available to adapt and improve a property, which can help people to remain living independently.

Transitions in the wider world: changes in relationships, community and travel

Changes in older people's social networks, their own life transitions, their neighbourhood and travel illustrate the dynamic nature of older people's lives, and that their quality of life can rest on the circumstances of others and society more widely. Family moving closer had led to improved social lives and more contact with grandchildren. People who had experienced family and friends moving away, becoming ill or dying missed the emotional and social support as well as practical help. The impact was most noticeable for those who lived alone and had more limited mobility or money. A few participants had experienced significant relationship changes themselves including a bereavement, separation and forming new companionships.

Increased help from neighbours was valuable to those whose health had declined. However, problems with neighbours or in the general area could have an overwhelming impact on people's quality of life. Local services were valued, particularly where this involved personal contact. The impact of changes within communities, with neighbours, local services and the built environment highlights how older people's lives can be affected by factors seen to be beyond their control and that sometimes they felt that their needs were ignored.

The introduction of free, off-peak, local bus travel between interview waves had enabled people to travel more widely at no cost and, for some, had shifted their use of buses from functional to more leisurely purposes – benefits not shared by those less mobile and unable to access public transport. Some car drivers had increased their use of buses because of the free pass and others had changed their driving habits because of changes in health or confidence. For those who are unable to use the bus and who do not drive, the alternative is to pay for taxis or rely on others for lifts. This can compromise people's independence and those without family and friends to help with transport have more limited alternatives.

Financial well-being

Some participants' perceptions of their financial circumstances had changed between interview waves. The impact of changes depended on: the extent of change in income or expenditure and how this balanced out; the relativity of any change to people's overall financial circumstances; and the availability of resources that could be drawn on to cushion the effects of change. Households who were more financially secure at Wave One were generally in a similar position at Wave Two, but, for those in more constrained circumstances, smaller differences in income or outgoings were more noticeable. Additional benefits made a huge difference to older people with low incomes, although lack of knowledge about entitlement and stigma about claiming benefits could deter people from claiming. For people whose finances were finely poised, extra outgoings or large and unanticipated outlays could tip the balance, as they had nothing to fall back on.

Older people also used informal strategies that helped them to manage their financial situations and maintain financial stability. This included direct and indirect financial support from family, and drawing on individual budgeting skills and attitudes to cope in constrained circumstances. This revealed that how older people spend does not always reflect what they need, as many were influenced by past experiences and lifetime values. A keenness for value for money can also inhibit older people acquiring what they need. The findings show a need for more wide-ranging information on current and future financial issues, particularly for those living alone, without family and who lack financial knowledge.

Ageing, identity and society

How older people felt about ageing and old age, and their contributions to family and wider society were issues that emerged from their experiences of life between the interviews. Participants, across ages, often did not see themselves as old and differentiated themselves from stereotypical perceptions of 'old people'. The findings show the extent of stigma and the sense of loss associated with being old, the fear of dependence and the

hard work put into continuing to avoid it. Keeping a young appearance was important to some women, whereas men were more concerned with their physical ability, and both talked about visible mobility aids as symbols of dependence.

People feared becoming dependent on others and feeling that their role in society or family was diminishing. Different ways of participating in society included paid employment, voluntary activities and helping others practically, financially or through imparting advice. A key issue is that having a role – however small, whether in public or private – can add value, meaning and sense of purpose to older people's lives.

Conclusions and policy implications

This study illustrates how changes experienced by older people, particularly in their health, can have wide-reaching consequences, and that the often uncontrollable and unanticipated nature of change can make it difficult to plan for. The findings highlight the efforts older people make to retain independence and adapt to their changing situation by drawing on a range of personal, social, structural and economic resources. These can act as a 'managing mechanism' to help people adjust to and cope with change, and as a 'protective force', which can prevent change and/or lessen the impact of it. A key issue is the difficulty that older people face when they do not have access to the resources they need. Living alone, not having family nearby, declining health and mobility, limited finances and lack of knowledge about how to get help can make it more difficult to maintain

independence – with people most vulnerable when these factors combine.

There is a need for clear and reliable information about a range of issues affecting older people, from benefits, services and support in the home, through to future needs, including care. A key issue for policy-makers is finding the best way to deliver information and support to those in most need, and to some who may resist admitting that need. Older people in constrained circumstances are most affected by increased outgoings and their financial well-being may well depend on whether government policies can serve to balance increased living costs. The findings demonstrate how old age can be stigmatised and older people may be reluctant to admit to needing help. This highlights the importance of extending the policy of mainstreaming older people's needs, so that they are seen as part of the norm rather than as problematic, and to help older people feel more valued and included.

This report highlights that, for older people, the relationship between independence and dependence is socially determined by the resources that they have available to them. For many participants, change brought about a degree of movement from independence to dependence. However, dependence in later life is not inevitable, as the impact of getting older can be mediated by the resources that people have available to them. It is crucial, therefore, that people reach later life with enough social, economic and psychological resources to counter the negative impact of change.

1 Introduction

The UK's ageing population is a continuing area of policy concern in relation to meeting the needs of the current generation of older people and also because of the fear that future provision will be inadequate to deal with the growing numbers of older people. More people are reaching older age and living longer when they get there. In 2007, for the first time in this country, the number of people of state pension age exceeded the number of children (Help the Aged, 2008). This has future implications in terms of the ratio of people able to support those who are retired from the labour market. Projections indicate that the trend is growing faster than at first thought, as the number of people aged over 65 is expected to increase by nearly a quarter in the next ten years and nearly a half in 20 years. Interestingly, it is the rise in the number of the oldest old that is growing most dramatically, with those over 80 expected to increase by three-quarters in 20 years' time (Age Concern, 2008a). This, coupled with the fact that the post-war generation of 'baby boomers' are reaching their 60s, highlights the growing diversity among the older-age population as people are likely to have increasingly different needs and expectations.

As well as direct financial support through pensions and financial benefits, an ageing population has implications for the demands placed on services, health provision and care support. This is highlighted in current debates about the issue of funding care (see further below), which raises questions about the interaction between the State and individual responsibility.

The research on which this report is based was commissioned by the Joseph Rowntree Foundation under its Resources in Later Life (RILL) programme. The programme aims to inform policy about 'how the resources available to people compare to what they need in order to escape poverty, hardship and disadvantage in later life'.

This involves understanding how various resources interact to help meet the changing needs and aspirations of older people throughout later life, and barriers to accessing resources.

This particular project is designed to provide a detailed understanding, through a series of in-depth interviews, of how older people (aged 65+) plan, use and value the resources available to them to achieve an acceptable quality of life. A longitudinal approach allows an exploration of how older people's needs and resources change over time, the impact of changes in their lives and how these are managed. An important feature of this work is that resources are broadly defined to include, in addition to finances, health, social networks, neighbourhood and community resources, housing and transport – this allows an insight into the relative value of these different resources and how they might interlink. A qualitative methodology complements quantitative projects in the RILL programme (Burholt and Windle, 2006; Middleton *et al.*, 2007), as it can help to explain the processes behind people's behaviour, attitudes and priorities, and to gain an insight into how they experience and adapt to change, an understanding of which is valuable to policy-makers.

The first report of this longitudinal piece of work (Hill *et al.*, 2007) drew on 91 interviews with older people and focused on their experiences up to the time of the interview (which took place in 2005) and their expectations about the future. This report is based on follow-up interviews with 78 of these participants, which were conducted two years later, and explores their experiences of change over this period and how resources are affected and drawn on in this process. It also highlights how resources can be used in order to maintain stability and, in doing so, reveals the work that can be involved in preventing change.

Policy context

The findings from the first wave of research highlighted several issues that had implications for government policy around health and financial planning. These topics are still extremely relevant and these, as well as other debates and developments that have taken place between interview waves, will briefly be outlined in order to provide context to the research findings in this report. Devolution means that there are differences in policies in different countries of the UK, and health, community care and transport are the responsibility of the Scottish and Welsh Parliaments. It is not possible to provide a comprehensive review here, so the focus is on the English policy context, as this is where this research was conducted.

Planning ahead in later life – funding care

An issue highlighted in the Wave One report was the use of assets as a form of funding for later life, with participants expressing particular resistance to the idea of selling homes in order to fund residential care – planning for potential health decline was also seen as difficult given uncertainty about what to plan for. The issue of funding care has been of increasing policy interest, with concerns about the inadequacy of current provision to deal with increasing need, as well as ongoing debates about the extent of individual and the State's responsibility in meeting the cost.

The Government recognises that the current care system is not sustainable and that a 'radical rethink' rather than incremental investment is required (HM Treasury, 2007a). In May 2008 the Government launched a public consultation on what could be done to improve, pay for and provide financial help for care and support in the future. Key questions were: how to put its vision into practice; balancing responsibilities between the family, the individual and the State; and how to divide and target resources among people (HM Government, 2008). There have been numerous contributions that suggest that difficult choices will have to be made to meet demand for a more universal funding system, with more clarity about personal contribution (Caring Choices, 2008) and the idea of a new social insurance model of funding long-term care (Lloyd, 2008).

Pensioner incomes

The financial well-being of older people continues to be debated. The Wave One interviews highlighted how people's past circumstances, life events and attitudes affected any planning for retirement and, therefore, outcomes in later life. Since the first wave of interviews, the Pensions Act 2007 has been progressing pension reforms (DWP, 2006) that are intended to provide a sustainable pension system and encourage individual provision for future pensioners.

However, although steady progress had been made in reducing pensioner poverty since 1998, most recent figures reveal that the number of pensioners in poverty actually rose in the last year.¹ Pension Credit has been a key strategy to combat pensioner poverty. However, despite government targets to increase take-up, there remain around one-third of pensioner households entitled to the benefit who are not claiming it (DWP, 2008b). Moreover, this figure and the 40 per cent of pensioners not claiming their Council Tax Benefit show that take-up has not improved in the last year (DWP, 2008b). The importance of benefits to older people's financial well-being was highlighted at Wave One. The difference made to participants receiving benefits between interview waves is covered in this report, as are issues that helped or hindered them in making a claim.

A further recent concern has been the substantial rise in living costs, in particular the effect of rising fuel bills on pensioners' well-being. This was beginning to take hold at the time of the Wave Two interviews and had already made a difference to some participants. Campaign groups have called on the Government for stronger measures than the one-off increase to the Winter Fuel Payment announced in the April 2008 Budget (Age Concern/Help the Aged, 2008).

Meeting the needs of older people

Other aspects of policy have also brought the needs of older people into focus. In February 2008, a cross-government strategy on housing to meet the needs of an ageing society was published (DCLG, 2008). While much of the focus was on the longer term in designing homes to meet lifetime needs, it also contained a commitment to expand rapid repairs and adaptations services for current generations of

older people – a need that was identified at Wave One of our research. This aspect was welcomed particularly by groups who had campaigned for some time on the difference that receiving that ‘bit of help’ can make to older people being able to stay in their own homes.

In terms of delivering services, the Government has set out a vision of health and social care services that will provide more choice and local care, and give people more control and support to remain independent – for example, through the piloting of individual budgets (HM Treasury, 2007a, 2007b). Calls have also been made for more individualised care, early intervention and preventative and community-based services (DoH, 2007a).

Access to information and services in the local community is a crucial part of this shift to more personalisation and choice, as older people need to be aware of the options available to them in order to make informed decisions. Recognising this need, LinkAge Plus projects were set up by the Department for Work and Pensions (DWP) in 2006 to pilot ways of integrating and joining up a broad range of services to make them more accessible to older people. However, concerns continue to be raised about how well the needs of older people are being met (Audit Commission, 2008) and the social exclusion of older people (Age Concern, 2008b). Access to information was raised at Wave One and is very relevant in the second interviews as people’s needs change.²

Equality legislation and championing the needs of older people

A further policy development was the Equality Bill announced in June 2008, which included measures to streamline and strengthen discrimination legislation, including banning age discrimination. The proposals to make age discrimination illegal have been warmly welcomed by campaign groups, and cover the provision of goods, facilities and services and extending the public sector equality duty to include age, so that older people’s needs are taken into account in public services.

Other policy developments have taken place in the devolved areas of the UK. In April 2008, the first Commissioner for Older People in Wales was appointed as an advocate for older people’s

causes in Wales and to ensure that their interests are safeguarded and promoted. In Northern Ireland, the intention is to create a similar position and a consultation is taking place to discuss the role and its powers. The Scottish Government published its action plan for an ageing population in Scotland and intends to set up a National Forum on Ageing (Scottish Executive, 2007). An overview of figures and indicators on the position of older people in Scotland, Wales and Northern Ireland is included in Help the Aged’s (2008) *Spotlight Report*.

Research aims and objectives

This research was commissioned in order to provide a longitudinal qualitative approach to investigate the following.

- How older people have planned³ and are planning their resources in later life.
 - How people deploy their resources and if and how people plan for the future.
 - What supports or undermines the planning and use of resources and how this impacts on quality of life.
- What resources (material, social, health, financial) are available to older people, as well as the interaction between these different resources.
 - How people value different resources.
 - What are the barriers to accessing resources?
 - What strategies are used in the deployment of resources?
- The attitudes and aspirations of older people, and the extent to which aspirations are fulfilled or are fulfillable in the context of finite resources.

The central aim of the second wave of research is to explore: how needs, resources and aspirations

change over time; how people adapt to change and how changes impact on older people's plans and ability to plan; and the use of resources and the relative value people place on different resources. Linked to this is how resources are drawn on to maintain stability and to protect against change.

Research design and methodology

The first set of 91 in-depth interviews took place in summer/autumn 2005. The participants, from a region of central England, were spread across age (65–84), gender, household type (single and couples), income and urban/rural areas – see the Wave One report (Hill *et al.*, 2007), for detail of this stage of the research. The sample size reflects the longitudinal nature of the research, designed for follow-up over four years, and as such allows for potential attrition. Participants were contacted by telephone approximately one year after the first interview in order to capture any information about changes and also to maintain contact and momentum with them. The second interview took place in summer/autumn 2007 with 78 of the original 91 households (see Appendix for more details of the sample composition). The lengths of interviews varied but were usually around one-and-a-half hours. A topic guide was used, but the order of the subjects covered was deliberately left open and was led by the participant so that issues of most salience to them were covered first. Interviews were recorded, transcribed and analysed using Atlas.ti computer software.

The focus of the analysis was on participants' experiences over the two years to explore how any changes had come about and the issues faced by them in dealing with change, as well experiences of 'episodes' that they might have recovered from but that could leave a lasting impact. A more detailed account of the methodology and sample is included in the Appendix.

One of the challenges presented by this research was that, by necessity, the design required an exploration of a wide range of issues with participants, as so many aspects of their life were of interest. This was a key dimension to the research in order to gain an insight into how different resources interlinked – for example, how a change in one dimension of a participant's life affected other aspects. Furthermore, this allowed an exploration of the variety of resources that people drew on to help manage and deal with change, as well as maintain continuity. A balance had to be struck between presenting the rich qualitative findings covering the breadth of the research and the need to retain a holistic overview of people's lives. This report aims to portray the complexity of people's lives in relation to, not only the range of different circumstances among participants, but also the multitude of aspects within just one life. Case studies have been used within the chapters to illustrate the 'ripple effect' of changes between the interview waves and their impact on, and with, other resources and aspects of people's lives. Where this is the case, names have been changed to preserve anonymity.

2 Health and well-being in later life

This chapter explores the changes that participants have experienced to their health since Wave One of the research. The focus is on how changes in people's health impact on their everyday lives and how these changes are managed. The chapter highlights the resources needed and drawn on, and the strategies used by older people to maintain their independence.

Health was identified as the most important aspect of participants' lives both at Wave One of the research and at Wave Two. Often, before discussing anything else, participants raised as a cause for concern ill health, which many felt had become more problematic for them over the course of the research.

It is important to note at the outset that a few participants had experienced some improvement in their health since Wave One. These now had better mobility, which had enabled them to get out and about, and resume hobbies that they had been unable to do previously. As such, their quality of life was significantly better. There were also some participants who had experienced no change in their health condition. However, this did not mean that they had no health problems at all, rather that they were not any worse than at Wave One. It is important to note the active work they put in to maintain their health and prevent an existing condition deteriorating. Some of the strategies they used were taking more exercise, multivitamins and supplements, and watching their diets. It was those living on higher incomes who were most likely to discuss action taken to prevent ill health.

However, the research found that the majority of participants had experienced some form of ill health since Wave One. These included falls, bouts of ill health and an overall decline in health and mobility.

Experiences of ill health

Falls

Falls were a common occurrence among the older participants. Some had experienced a fall as a 'one-off' event (usually through dizziness); others (usually the oldest participants) had experienced a fall because of their poor mobility, which had deteriorated since Wave One. Falling had profound consequences for participants. It resulted in shaken confidence, often leaving them reluctant to carry on with 'normal' aspects of everyday living, such as cooking, vacuuming the stairs, doing the gardening, and even being able to take a bath on their own, in case of accidents. Moreover, experiences of falling meant that participants were terrified of lying alone for long periods without being found:

Man: *... it's confidence, your confidence goes for a Burton you know.*

Interviewer: *In what way?*

Man: *Well you're frightened, well should I do it, or shouldn't I, because if I go flat out now nobody's going to know I'm here, you know.*

(Single man, aged 79)

This fear also applied to those who were experiencing increased health problems since Wave One. Those living on their own felt particularly vulnerable.

The longer-term impact for participants was to be more careful about what they did and how they did it. One participant, whose deteriorating health had affected his balance causing several falls, explained:

... you work out which is best for you, what you can do and what you can't do, you don't

put yourself in the position where you can overbalance. You've got to be in control in other words.

(Single man, aged 79)

Having falls could also trigger thoughts about getting adaptations in the house, even if these thoughts were not always acted on. For a few, having a fall produced feelings of frustration at no longer being able to do what they previously did with little difficulty and having to wait for others (mainly family) to help them out.

Episodes of ill health

Other serious episodes of ill health included a severe angina attack, which left the participant bed-bound for three days, a mild heart attack and strokes. The impact of these included a reduction in energy levels, which often resulted in prioritising some tasks over others, leaving non-essential tasks, such as gardening, for others to do. Episodes such as these also affected temporarily what participants were able to do for friends or family. For example, some had to stop providing childcare for grandchildren or help for ill adult children. While a few younger participants had made a recovery, older participants struggled to recuperate. Having a serious episode of ill health, for older participants, added to existing conditions that combined to produce a greater long-term impact, in that there was an increased need for help with 'everyday' activities. People drew on their partners, family, friends and neighbours to take on some of their household tasks and chores while they were recovering. For those with numerous health conditions, these episodes could tip them over into needing more formal support than at Wave One (see the section on 'The need for formal/professional support' later in this chapter). Those older participants who lived alone found it was too much effort to cook or garden after being so ill.

Health decline between waves

Health deterioration among older people was usually the result of a combination of different conditions coming together and, even when one aspect had improved, there could still be an overall decline. Participants spoke about numerous health

problems affecting internal organs – heart, kidneys, lungs, bowels – which resulted in difficulties in breathing and poor mobility. Combinations of conditions such as heart disease, diabetes and lung problems were more common among those living on low incomes and these conditions, in some cases, created further circulatory and mobility difficulties, reflecting existing knowledge of health inequalities (Craig and Mindell, 2007). In addition, there were numerous joint and mobility problems – arthritis, spondylitis, spine, knee and hip problems – which were experienced by some in each age and income group. However, when compared to those living on high incomes, those in low-income households were more likely to have experienced a decline in health overall. Most participants also expressed concerns about deteriorating eyesight, hearing and memory loss. The combination of these symptoms often meant that participants felt that they were faring much worse than at the first wave – that they were slowing down, lacking in energy and 'generally just getting older'. A further discussion about the perception of ageing will be continued in Chapter 6.

The impact of health decline

The consequences of deteriorating health on participants' lives were numerous and wide-ranging. Declining health significantly affected their well-being, with many talking about feeling 'down' or 'low'. This was particularly the case when they could not get out and about to see other people, as this helped them to take their mind off their own problems. A few mentioned feeling suicidal, especially if in constant pain and feeling lonely. Loneliness seemed to be a particularly important issue to older women living on their own.

I mean I've sat here days and days and not seen anyone ... You don't talk to anybody. I'm going upstairs at night and I'm saying goodnight to myself, I get halfway up the stairs and I say, 'goodnight', and then I think, oh god what would I do if anybody answered!

(Single woman, aged 81)

Declining health also impacted on single older women's confidence to go out alone. In many

cases they recognised that this stress did not help their mental well-being either. Suffering a decline in physical health, then, can have a 'knock-on' detrimental effect on the mental well-being of older people, particularly single older people, as they move through later life.

Declining health affected participants' mobility and their ability to get around their own homes easily and manage basic household tasks. It also affected their ability to do the more 'heavy' or hard-to-reach tasks such as cutting down trees or hedges, decorating and window cleaning. Window cleaners were particularly valued, as many participants could not reach to clean their windows and this generation of women took great pride in the state of their houses:

And I struggle to do windows ... I've got a window cleaner and it's like as if I've won the pools! And [name] said 'oh you'll never get a window cleaner', but I've got one, and he wipes me frames, and it's a godsend.

(Single woman, aged 79)

Where people were less able to get out, the home itself became more central to their lives. Different emotions were in evidence here – on the one hand, spending effort (and money) on making the home environment as nice as possible was a way of coping with being more restricted to it:

It makes it more pleasurable for me to live in the house and have things I want, because I can't go on a holiday can I. So I have the things in my home, which I use that money for that, and keeping my home in order.

(Single woman, aged 75)

However, the home could also be a source of anxiety, particularly for participants living on their own. Women were concerned that they could not keep it as tidy and clean as they would like: 'I know me front room's a tip, although I don't use it as such, but it's still on your mind isn't it' (single woman, aged 79). Men were concerned about being unable to keep up with their garden. Being at home more and seeing things deteriorate around them not only was a source of frustration that they could do nothing about but also could

serve as a constant reminder to participants of their lessening ability to do the everyday things they once did: 'it gets on me, I cry sometimes' (single woman, aged 69).

Poorer health also affected participants' mobility around their neighbourhoods. This, in turn, prevented socialising with family and friends, and reduced their ability to participate in social and community activities. A few participants who had previously enjoyed holidays at home and abroad found the additional effort required to sort, pack and board the coach or plane too much. Holidays became harder to organise and, once there, harder to enjoy:

So [husband] can't walk because of his breathing, and I can't walk with me spine, so we're just, we go and come back, you know, it's a change of scenery. But it's not the same now to what it used to be.

(Woman, aged 71, couple household)

Poorer health also affected how easily participants were able to get to and from shops, banks, hairdressers, doctors and hospitals – ironic considering that the latter become increasingly important because of deteriorating health.

Betty's story, presented below, illustrates how ill health affects the ability to do the everyday household tasks that are often taken for granted. The story also shows how, for older people living on their own, remaining independent means drawing heavily on both formal and informal support. Most importantly, it highlights the need that many ill older people have for someone simply to talk to regularly.

Betty's story

Betty was 72 years old when we first met her. She lived in a warden-controlled bungalow on the edge of a small village, which she had moved to two years previously. She had been widowed 15 years ago and had no children, but a sister lived nearby. She received Attendance Allowance, Pension Credit and Council Tax Benefit. Betty had spent much of her life providing care, first for her father and then for her husband.

Betty had a number of serious health conditions at Wave One. She had undergone drastic surgery in her 30s and suffered from osteoporosis. Her mobility was limited and she could only walk with a walking frame. She also had angina and diabetes. At Wave One she attended a community day centre in a nearby town twice a week using community transport. She also attended the local community centre. Betty paid a gardener and a niece who came once a fortnight to clean for her. She saw her sister once a week and had a (private) chiropodist appointment at her sister's house. Occasionally Betty's brother-in-law took her to her sister's for dinner. She saw her warden in the mornings and they telephoned in the afternoon. She received eight meals on wheels every two weeks through social services.

Betty used her car regularly, which was paid for through her 'mobility allowance'. The car was a 'godsend' as she lived quite a distance from amenities, such as shops, doctors' surgeries and hospitals.

When we visited Betty two years later her health was much worse and she had been hospitalised twice during this time – first, because of a slight stroke but an infection had extended her stay. Betty was then readmitted after a heart attack. She had alerted help during the night by using the emergency alarm system for which she was exceedingly grateful. Betty's diabetes had also become worse and she now injected herself with insulin. These bouts of ill health had left her feeling much weaker and more breathless and tired. She was now receiving specialist care from a cardiac nurse who visited her once a fortnight. She now also used two sticks to help her keep her balance around the house, as she experienced dizziness more frequently and had fallen on several occasions, including a fall two days before we visited her. Betty tried to carry on with her usual household tasks but found it difficult when she could not do what she had previously been able to do. She felt frustrated, and talked about how, sometimes, she sat and cried when unable to do something such as folding sheets or opening a jar.

Betty had stopped going to the community centres after being in hospital; however, she had made herself go again two weeks later. She felt it was important to try and get out and about as soon as possible.

Betty now gets more help from her gardener, who does a range of different jobs for her besides her garden, including shopping and helping with her laundry. She still pays her niece for fortnightly cleaning. Betty would like more help in the house but feels that an hourly rate of £12.20 is unaffordable. She would have valued someone being around to make her a cup of tea and have a chat.

Betty tended to drive now only when she had someone to accompany her. She felt that the location of her bungalow was no longer suitable, as it was too far from amenities and she felt shut off from other people. She had now decided to put herself on a waiting list for a flat in a complex in a nearby town.

The need for formal/professional support

Those whose health had deteriorated had an increased need for many different forms of support, from mobility aids to help them get around and adaptations to help them in their home, through to support from friends, family and more formal services within and beyond their homes. In some cases, these forms of support were regarded as necessary but were not always welcome. In others, they were discounted as the first step on the ladder to complete dependence. In these cases, people talked about carrying on while they still could. However, for those with the most limited mobility, aids, adaptations and informal and formal support were crucial for enabling some quality of life and a level of independence.

Mobility aids

Those participants who had obtained mobility scooters during the research really valued them, particularly when it came to getting to local shops and seeing friends and relatives. Moreover, they viewed scooters as a 'lifeline' and as a way of enabling them to do what they wanted to do, when they wanted to do it.

... that little chariot has been the best thing that's ever happened to me. Now, instead of walking up to my daughter's, I can jump in there and go for a cup of tea, no problem, and I've been using it, enjoying it and loving it.

(Single man, aged 81)

do anything or nothing and, when they came, two men came, it took until Thursday to get them to come, they couldn't come till before Thursday, and there I am from Saturday, no milk, no bread.

(Single man, aged 79)

However, participants also recognised that there were some limitations to their use. For example, one issue was being able to use a scooter in wet weather without having to buy a separate rain cover at considerable extra cost. Another issue for those with scooters was where to store them. One woman had to keep her scooter dismantled in her front porch. This posed a problem when she wanted to use it, as neither she nor her husband was physically able to put it together easily.

Another major issue for participants was how suitable their local environment was for using a scooter. Some participants complained that the paths in their local vicinity were not suitable, as the kerbs had not been lowered enough in places and surfaces were uneven. Many participants also lived in very hilly locations and their scooters could not cope easily with steep hills. Where this was the case, people had to find alternative means of getting to and from shops, facilities and services. Furthermore, holiday coach companies did not take mobility scooters, which made it difficult for people who used them to maintain their independence once they had arrived at their destination.

One further issue was the way that mobility scooters were sold to participants and the level of aftercare service provided. For example, one man recounted his experience of being sold a mobility scooter. His tale was one of aggressive sales techniques, having been contacted daily by one company or another, high call-out charges and poor-quality information and workmanship (as his first scooter lasted only two years). He had been made to feel particularly vulnerable by what he saw as lack of care from the scooter providers:

... it happened [the fuse in the scooter blew] on a Saturday at 12 o'clock and I couldn't get anybody on the phone, so I rang up, the only place I could get any answer at all was [company name in nearest city centre] ... and the call-out fee was £50, whether they

Older single people with limited mobility are already vulnerable through their health condition and its impact on their daily lives. They would benefit greatly from scooter companies being more considerate of their needs.

The barriers to getting a mobility scooter, particularly among older women who had limited mobility, were a fear of crashing, of falling off, of being unable to steer and of running into pedestrians. In many cases, though not all, this was related to not being able to drive and a lack of confidence and experience in using the roads. However, this may change as younger generations of women who presently drive get older.

People with limited mobility continued to manage as best they could by using walking sticks, 'walkers' and shopping trolleys in order to get around. In one instance, an older woman used a pram to get around her local area. She considered it a much more stable walking aid than her more recently acquired 'walker'.

[The walker] goes too fast. And they go, 'don't talk so ridiculous mother, you're pushing it!' I said 'I know that'. But it does, the pram is solid, I can lean on it, you know, it feels solid, the walker doesn't, it moves very quickly, you've only just got to and it's gone that way.

(Single woman, aged 81)

The pram made her feel more secure and enabled her to get to local shops and amenities with confidence.

Other purchases to help deal with increased health needs included a trolley/walker aid, a riser chair, bath rails, a lightweight sweeper, special shoes, a nebuliser and a magnifier. Participants buying these aids had experienced deteriorating health between interviews but were in receipt of health-related benefits and felt income was sufficient to cover such costs. This is not to say that some of these items could not have been obtained via social services. Indeed, one

