

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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Executive summary

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

participant (who had received increased health and means-tested benefits) was aware that this was a possibility but had decided to purchase a mobility aid herself:

I bought one of these trolley things meself, I suppose I could have, they do say you can get them from social services, but I wanted one now, I don't want to be assessed to say I'm bad enough to have one and leave it for three months, do you know what I mean. You want it when you can't walk. And I thought, 'oh I'm not waiting for them, I'll buy my own'.

(Single woman, aged 75)

This case illustrates that having enough money enabled her to take control of her own situation, as she felt she could afford it.

As their health declined, some participants had also made a variety of adaptations to their home, which had helped them to continue to live with some independence. This will be discussed in more detail in Chapter 3.

Formal support within the home¹

Deteriorating health often brought about an increased need for support. This involved additional expenditure, particularly among participants living on their own. People who had employed cleaners since Wave One were enthusiastic and appreciated the additional support, as it restored cleanliness and order and allowed them, in some cases, to spend more time doing other things. Participants were grateful, even when they were initially reluctant to get a cleaner and some had been dubious about doing so. This was primarily to do with the extent to which they felt they could trust having a stranger in their home. However, some participants had also recognised that they could no longer manage to do what they had previously done and had employed a cleaner when their, more reluctant, partner was no longer able to help out with the household chores:

Oh yes, I'd wanted help, but he [husband] were very stubborn, and we could manage, we've always, he's always tried to do what we can ourselves, you know, but it just got, I just

couldn't do it in the end, it was just too much for me. And then he's got gradually worse, so he couldn't do it, so in the end you know I'd got to get some help.

(Woman, aged 71, couple household)

People held divided opinions about receiving help outside their families and friends. Many felt that they would rather pay someone to do chores and, therefore, be less of a 'burden' on family, while others wanted to have a familiar face who they felt they could talk to in their house.

Although deteriorating health produces increased need for support, it was not always received. In one instance, a younger lone participant had been reassessed by social services and had her paid help withdrawn since the first wave of the research. This was especially problematic for her, as she had no children and no family to draw on for support. The loss had a dramatic impact on her life as she had previously had someone to shop and help with daily chores:

Well it's made a big difference really because ... I can't do it, I can't do anything, because I can't bend, and my ironing, it has to stay upstairs until such a time, I mean I can't even bend to put the clothes away in drawers, I can't bend, with the pain in my back.

(Single woman, aged 72)

It seems particularly harsh when less help, and not more, is the result. She now has to rely on a friend to help with shopping. However, her friend had been ill and was unable to help out for a while. Relying on friends meant that participants had less control over their own lives if anything went wrong in their friends' lives. Formal support, then, is crucial to enable older people to live with some semblance of dignity and independence in their own home.

While paying for help was sometimes on a formal basis in the home or garden, a few participants had started giving money to friends or associates to take or accompany them in going out. Although this was not necessarily a formal arrangement, monetary recognition of help (even by way of gifts, paying for car tax, etc.) was felt to be necessary to show their gratitude, but also,

in one case, as a way of maintaining such help given their reliance on it and likely longer-term need: 'you've got to pay for it haven't you, you can't let people do anything for nothing. Well after a while they'd get a bit tired wouldn't they' (single woman, aged 75). Again, paying for help allowed participants an element of control over their own situation.

There was great uncertainty among many participants about what the State would provide for people with poor health and mobility, or how to engage privately paid help. Many of those who had experienced a decline in their health since the first wave would have appreciated more information about what formal help was available to them and where to find it. Word-of-mouth advice about what was available in their area was often found through neighbours, friends and family. However, participants would have benefited from access to trustworthy and reliable information, such as where to find household help – and, particularly, local general home and garden maintenance services – from an official source. Those gardeners who advertised locally tended to provide landscape rather than 'odd-job' services. There is a real need among older participants to have what has been termed that 'bit of help' within the home (Raynes *et al.*, 2006). This is especially important for those without the resource of family and friends to draw on for something as deceptively simple as changing a light bulb.

Health services

Some participants who had experienced a decline in their health since the first wave had an increasing need for health-care services. This was particularly the case among those who had experienced the onset of more serious conditions such as heart disease and cancer, and these participants now received more help within their own home from specialist nurses (cardiac nurses, Macmillan nurses, diabetes nurses and stoma nurses) to take blood, inject, discuss worries and check how they were managing their condition. They all seemed very positive about their specialist care. Participants viewed these nurses as 'go betweens' or advocates acting on their behalf, finding out more information, setting up appointments with consultants and doctors,

and also providing them with further information and reassurance about medication. This can be important to those suffering from serious health conditions, whatever their stage in the life course, but can become critical when people become older and confused about what happens next.

Other health-care services, such as chiropody, were considered particularly convenient when they were based in clinics nearby or accessed within the home. Having a service provided at home removed the stress and anxiety entailed in having to get there, which was particularly hard for those without transport (see Chapter 4). However, a few participants appeared to be missing out on service provision. For example, an older, visually impaired man had previously (before Wave One) experienced a good relationship with a social worker who had accessed information and advice for him, and even taken him out and about. However, this service had stopped when the social worker had moved to another district and he had not been offered a replacement. Moreover, he was uncertain about having to build a new relationship with an unfamiliar person.

Local GPs received some praise, particularly if they were 'family doctors' who had known participants for a long time. This made it easier to discuss sensitive issues and, in some instances, obtain prescriptions for partners if they, too, were unwell, saving an additional visit. However, there was criticism about GPs for several reasons, which included being able to get an appointment in the first place and a lack of continuity of care, as participants often felt that they had to repeat themselves whenever they saw a different doctor. Having to go over old ground at each visit was considered tiresome, particularly for participants with multiple health conditions.

In a few other instances, dissatisfaction was expressed about the treatment participants received at hospitals, including feelings of frustration after their questions were ignored. In one case, a visually impaired participant had undergone gall bladder surgery since Wave One. He discussed how his needs were overlooked on the hospital ward, as, when it came to mealtimes, staff would put food down or call out without addressing him by name. Very often he did not realise food was there or that staff were, indeed,

addressing him. Those older people with existing conditions need extra time and attention to help them back on the road to recovery.

Informal support

Partners as a resource

People with long-term health conditions who had a partner appreciated their partner's role in preventing further health problems. Partners organised their diet, medication and exercise regimes, and alerted emergency services if participants' health became worse. Older people with a partner could draw on them to provide help with cooking, cleaning and shopping.

One effect of living alone was that participants felt they could no longer afford to be ill. They had no choice but to be independent. One participant who had been widowed for around ten years noted:

... you've got nobody to say, 'Would you like a cup of tea? I'll fetch you a cup of tea.' You've got to do it yourself, whether you want to or not, you see.

(Single man, aged 78)

Although partners provided help with a wide range of activities of daily living, participants' whose health had declined were extremely conscious of the additional stress they felt they were putting on their partner and tried to protect them from the worst instances of pain or difficulty wherever possible (see also George and Mary's story later in this chapter). The implications for those who live alone, however, are that they have to pay comparatively more for help, rely on others or manage without.

Partners also acted as an emotional resource, often providing comfort and sharing humour as a way of dealing with the bleakness of poor health. It was particularly evident as a 'chivvyng' device when one person was feeling 'lower' than the other. Humour made difficult situations more bearable, as one couple who both had serious health conditions explained:

Well I sort of laugh at her and she laughs at me when I drop things, or trip, or anything like that. I laugh at her when she's on floor and she

can't get up. I say, 'shall I get you a cushion?', you know, that sort of thing. 'If you stop there it'll soon be bedtime and there'll be somebody about in the morning, I'm not stopping here all night.'

(Man, aged 78, couple household)

Having someone with whom to share laughter made health problems easier to cope with.

When a participant's partner also experienced ill health, the couple had to draw on even more help from others, and those with no children had to rely on friends and neighbours.

Family as a resource

Older people whose health had declined between waves increasingly relied on help given by family, friends and neighbours. Being less able to do things and, in turn, needing others to help them was difficult, as participants felt that they were imposing on their friends and families' lives, and they frequently spoke about not wanting to trouble them:

Man: *But, as we say, we try and struggle along on our own, instead of ringing up and asking them for help.*

Woman: *We do, yes.*

Man: *I know it's our own silly fault, but we don't want to become a pain to anybody.*

(Couple, aged 79 and 80)

If help was offered, though, it was generally warmly welcomed by those requiring extra support. It was the act of having to ask that caused concern. Experiencing a spell of ill health, or an overall decline in health, meant having to wait for support. For example, those needing help to eat had to wait to have their food delivered, prepared and, in some cases, cut up for them. Others with mobility problems had to wait to be picked up or to have someone lift and fetch items for them. Participants, therefore, had to fit in with others' plans and activities, rather than spontaneously act at their own pace in their own time. As such, they felt that they were no longer in control.

George and Mary's story, presented below, illustrates the extent to which older people draw on family to help them, particularly when their health is deteriorating. It also shows that the impact of ill health can begin quite early in life. However, most importantly, it highlights how older people try to shield their families from the full extent of their illness. They are not only trying to cope with their own ill health, but also protecting the well-being of their loved ones. At first glance, George and Mary's circumstances seem quite bleak. However, the close and loving relationship with their family mitigated much of the impact of their worsening health.

George and Mary's story

George and Mary have been married for over 50 years. They have lived in their council house on the outskirts of a city for 45 years. They have a very large family and most of their children, grandchildren and great-grandchildren live nearby.

When we first met the couple, George was recovering from a heart attack. He was also suffering from diabetes and had poor mobility because of problems with his feet. He had also recently had swollen legs because of lung problems and was on a lot of different medication. Mary had a long-term serious heart condition and swollen knees, and was a wheelchair user. George had given up work to be her full-time carer when he was in his early 50s. They had a 20-year-old stairlift but it was unreliable and falling apart, and the couple were waiting for a replacement. They had regular help with shopping from one daughter, paid a granddaughter to clean weekly and their sons provided help with 'heavier' household and maintenance tasks. The couple's social life revolved around their family and all of their children dropped in at least weekly. George and Mary felt better off financially now than ever before, as they had had to juggle their finances in the past to bring up their large family.

At Wave Two of the research, George had seen a slight improvement in his diabetes. Although it had initially worsened, he had been

put on insulin, which was easing the symptoms. However, his heart condition had deteriorated and he was now regularly visiting a cardiologist and having blood taken by a community nurse. He was increasingly reliant on his children taking him to and from hospital appointments. However, he had recently refused his daughter's offer of a lift to the hospital because he was aware that it upset her to see him suffer from the after-effects of tests and he wanted to spare her that. Instead, he had organised a taxi to get to the hospital and a porter to take him to the relevant department. Mary had also experienced worsening health. She had recently been very ill with an ear and chest infection, which had led to her sleeping more and doing less than at Wave One. The couple had received a new stairlift from the council and also handrails and a perching stool that helped them to manage around the house. They relied increasingly on help from their family. One daughter now came to help four times a week. If the couple went out, their children or grandchildren provided lifts. One son who was due to take them on holiday had been seriously ill, so George and Mary had arranged to stay with their daughter instead.

Having friends or family who would take participants out, whether to the shops or for outings, on picnics and to garden centres, for example, was very warmly welcomed by those who lived alone and whose mobility had deteriorated. Even the 'normal' everyday activity of looking in shops was considered a treat for those who could no longer get out and about as much. Being able to spend time doing what most people take for granted was a common theme among participants. For example, one older man whose eyesight had deteriorated to the extent that he had almost no sight would have appreciated being escorted and accompanied to the pub (neither he nor his wife drove):

I wish I had a personal friend to say 'are you coming out for an hour?' ... or something like that, going out for a drink or anything like that. But I haven't got one ... I mean, I could pay a taxi if I wanted to go over to [nearby town] and

have a drink in the afternoon, I could phone for a taxi, but he would have to take me into the pub and sit me down, and then come and fetch me out when it's time to come home.
(Man, aged 80, couple household)

Most of those who could not drive, who had limited mobility and who were attending more frequent hospital and doctors' appointments had to rely on partners, family, friends and neighbours to provide lifts there and back. Even some who could still drive relied on others to accompany them. The result of declining health, which affects the ability to get out and about, is an increased reliance on others, especially having to 'fit in' with others at their convenience rather than the participants.

Given the extent of the impact of ill health on older people's lives, it seems important to explore some of the personal attitudes that were used as a way of helping to lessen that impact. The next section explores the role of participants' inner resources in coping with their declining health.

Inner resources

Resistance and resilience

The research found that many participants held a 'carry on regardless' attitude to their own health condition. Even in the face of some very serious health conditions, their resilience was impressive. Determination and a sense of not giving in were apparent among many of the older and most vulnerable participants. There was considerable pride expressed in the ability to still do the everyday, taken-for-granted tasks and activities that other people were perceived to be able to do. There was also dignity in getting up the stairs, while one was still able to, without any help. Admitting to needing help is, for these participants, tantamount to admitting weakness. They were determined to 'battle on'. As this woman said, having experienced a complication after an operation:

Woman: *I thought, that's all I need. Come in with one thing and out with another [laughing]. But it'll not alter me.*

Interviewer: *I was going to say what difference has that made to you?*

Woman: *It, not, no it not alter me. I shall keep going.*

Interviewer: *And has it made any difference to what you can do?*

Woman: *No, no, no. I shall do what I can. Nowt will keep me in!*
(Single woman, aged 71)

Some participants put this 'getting on with it' attitude down to the influence of the Second World War on their upbringing:

Woman: *I mean that if you've got a problem you don't sit down and cry about it, get on with it, you find a way round it. I mean my mother always used to say, I suppose we were brought up hard, if anything went wrong then, through the war, we'll cry tomorrow, not today, and by tomorrow you didn't cry.*

Man: *You never knew when you were going to be bombed.*

Woman: *You gritted your teeth and got on with it you know, when the telegrams came.*

Interviewer: *And what difference do you feel that will make to you as you get older, having that sort of attitude?*

Woman: *Well it never goes, because, even though you get older, I think you still have those same feelings, you still feel the same. If you've got a problem, there's got to be an answer and we'll find it. And you do, you don't just sit around and moan about it, you just get on with it.*
(Couple, aged 79 and 81)

Accepting limitations

In contrast, some participants believed that they should accept what they could not do, as well as what they could, as this was perceived as less frustrating than continuing to try to do things that required strength and stamina beyond their abilities. In this way, participants felt that they had some control over, or way of coping with, that condition, and in preventing further ill health:

Oh I've slowed down a lot, a lot. I don't do half, nowhere near half, of what I used to do two years ago. It seems to have just come to a stop. It isn't because I want it to, it's just that I know that I can't, I know how far I can go, I know what I can do, and I'm not going to push myself any more, which I have been doing, I'm just going to take things as they come ... You don't get frustrated; you think well I know I can't do it, so too bad.

(Single woman, aged 81)

Those whose health had worsened since Wave One, talked repeatedly about the need to 'pace oneself' in order to manage their condition – to sit down, rest and take 'breathers' from whatever task they were engaged in. By doing this, participants were able to get through the task in hand, without further injury or accident, and felt some satisfaction at completing it in the end. Having breaks from activities and resting was also considered a good way to get tasks done:

... now when I Hoover, because of my knees, you know, I find if I've hoovered through here then I need a rest, so I sit down, get another glass of water and have a rest, you know, pick up the paper and have a look at the paper, or do the crossword or something for ten minutes and then get up and do the dusting, that sort of thing. No, I suppose it's pacing yourself isn't it, really, you know ... I know what I can do and how much I can do, and then have a rest and that's fair enough, you know, it all gets done in the end.

(Single woman, aged 84)

Another strategy used to manage declining health was to try and avoid stress and worry. This was

particularly the case among those with serious long-term health conditions such as heart disease:

Man: *You just carry on, walk, don't try and run, just walk and take your time. We've got all day haven't we, no matter what we do, we've got all day.*

Interviewer: *And how much do you think your attitude helps you deal with it?*

Man: *Well I just take things as they come, I don't worry about anything, worry never helps anybody, so I just, well, if it happens it happens.*
(Man, aged 73, couple household)

Thoughts about the future

As the Wave One report noted (Hill *et al.*, 2007), participants found the uncertainty of ill health hard to plan for and, consequently, most did not make plans to accommodate it. For some, this was still difficult, while, for others, not wanting to think ahead was a way of coping:

But I don't like the idea of sitting down with [partner] and saying 'if I suddenly break my legs what will you do?' Or, if I have a serious illness, or if you have a serious illness, 'how will I cope?' I just don't want to talk that way at the moment. I don't want to, because I think if it comes we shall cope, won't we. We will won't we?

(Man, aged 82, couple household)

Discussions about the future at this wave focused on 'what if' scenarios to encourage participants to talk about what they would do if their health worsened. Generally, participants whose health had declined discussed staying in their own homes with additional help, moving in with family, moving into smaller or sheltered accommodation and the prospect of residential care.

Residential care

The first wave of research (Hill *et al.*, 2007) noted that many people, particularly those in the older age group, had concerns about having to

go into residential care. This was a theme that continued to be of importance, especially among those whose health had declined. Remaining independent was the priority and, although participants talked about not wanting to burden their families and friends, they acknowledged the role that they played in enabling them to continue living at home. However, participants seemed to be more amenable to the idea of residential care homes when they had visited friends and relatives in perceived 'good' homes, where people were seen as engaged and reasonably alert. Some lone participants noted they would have little choice if they had nobody else and if they could no longer cope at home alone – especially during the night. As one lone participant whose only child lived several hundred miles away recognised:

I mean got to ask for home help to come, and you're on your own, you don't know at night-time you may need help, things like that. And you can't get help 24 hours if you're in your own flat or own home.

(Single woman, aged 74)

It was those who had provided care for their parents in the past or had cared for partners who tended to see residential care as more of an option for the future than others. This was because they

had experience of the hard work that providing care could actually entail, especially if their partners or parents needed 24-hour care. Caring had a significant impact on participants' own well-being. It contributed to their assertions that they did not want this for their children or relatives.

Conclusion

This chapter has shown that the overwhelming majority of participants had experienced a spell of ill health, or a decline in their health that had profound implications for their overall quality of life and had resulted in them needing extra help to live independently. Those living alone and in ill health are the most vulnerable to isolation and loneliness. Lone participants without partners and family nearby have the most need for formal support to continue to live as independently as possible in their own home. Older people are not passive but continuously strive to cope with, and adapt to, the demands that their ill health places on them. However, this research highlights the difficulties that many lone older people face in finding and negotiating their own support – from knowing what the State will provide through to accessing the help and services they need to enable them to continue to live in their own home in later life.

3 Changes in home and property

This chapter focuses on the home environment, which, as discussed in the previous chapter, can become more significant, especially where people experience declining mobility. Changes in participants' home circumstances include the experience and impact of moving, adaptations, alterations, refurbishments and changes in warden service. Issues faced by older people deciding whether to stay in a property or move are explored, as well as potential decision-making in the future. Sometimes issues relate to changes in participants' needs and the factors that help or hinder these needs being met. This includes the presence or absence of external resources, access to information or personal resistance to change.

Moving

Moving can be a way of making adjustments to suit changing health or financial needs, to a more manageable property, to a more convenient location or to release capital (Croucher, 2008). How participants' plans, experiences and views about moving developed over the two-year period are used to explore the impact of, and barriers to, moving.

The experience of moving

A few participants had moved, all of whom had been planning or considering moving at the time of the first interview. Most had moved from owner-occupier to rented, warden-controlled properties and had already started the process at Wave One, having already been allocated a property or been on a waiting list. Another had sold their house and bought a bungalow – although finding one within their price range had meant that it had required a lot of modernising. Factors said to be helpful with the moving process included help from a friend or family, being able to leave furniture behind and having a period of overlap in order to move gradually. All were moving to smaller properties and participants felt that one of the hardest parts

was getting rid of possessions, 'memories'. Looking on it as a 'fresh start' by purchasing new items and decorating could help to cope with the upset and sense of loss. Most of those who had moved were couples and, even where they had received help, the experience of moving was sometimes 'traumatic'. Unsurprisingly, for a newly single participant, clearing the house alone had been hard both emotionally and physically. Although all of these participants had health conditions, they were still mobile, albeit with some restrictions, and had not experienced a drastic decline in health between interview waves.

The impact of moving

The decision to move was based generally on a combination of factors. Apart from a marital split, reasons included wanting a more convenient, nicer location, more manageable property or garden and to release capital. As well as fulfilling these needs, other positive aspects of moving were: the security of being in a warden-controlled property; social activities where there was a community centre; not being responsible for maintenance where renting; less reliance on a car or bus now they were closer to amenities; and being in a friendlier environment, which could contribute to feeling more relaxed and content with life. All of those who had moved were happy with their current situation, reflecting other research, which suggests that quality and suitability of accommodation can be of more concern than tenure (Croucher *et al.*, 2008). Money raised from selling a property had enhanced the lives of some participants (see Chapter 5), although overlaps between renting and selling a property and waiting for the money to come through had sometimes been a drain on existing savings.

Harry and Anne's story presented below illustrates the range of issues that contributed to their decision to move and the multiple impacts this had made on their lives.

Harry and Anne's story

Harry was aged 71 and Anne 69 when we first visited them. They had been living together for four years; both had been widowed in the past. They lived in a village in a house with a large garden that Harry had owned for over 40 years. They received higher than the basic state pension and partial Council Tax Benefit. They felt their income was just sufficient but had to budget carefully as their few thousand pounds of savings was dwindling.

Neither Harry nor Anne drove. The closure of the local post office and shop meant that they relied on buses to get to the nearest town even for a paper or pint of milk. However, the fares were costing £12 per week and, with no evening or Sunday service, they felt restricted.

Anne had a little arthritis but was in reasonable health. Harry's heart attacks and angina meant that he could not exert himself, so keeping up with the garden and walking uphill (to the bus stop) was becoming more difficult. Both liked to be active. They went to town most days on the bus and sometimes further afield for days out. They enjoyed holidays on the coach or train and would have gone more often if they could have afforded it.

At the time of the first interview, the couple had just been offered a housing association bungalow in the nearby town after a two-year wait and were selling the house to Harry's daughter for a reduced price. They were looking forward to moving closer to amenities and to a more manageable property. They felt that a warden-controlled property would provide security in their older age and would free up some money.

Harry and Anne moved soon after the first interview and, two years later, were very content. Living in a bungalow with no stairs to climb or garden to maintain was better for Harry. While conscious that they were the youngest people in the complex, the couple felt that they had 'slotted in' well. They had taken on organising social activities and enjoyed helping the 'older' residents.

Being in the town had made a huge difference to Harry and Anne, as they could

now walk (on the level) to the shops and services in five minutes and were no longer reliant on the bus. Being so close to town was also helpful as they were both a bit slower than two years before and Anne was now using a stick as her arthritis had worsened.

Selling his house to his daughter gave Harry pleasure through being able to see his family benefit from it, which meant a lot to him. Harry had reserved some money to leave to his grandchildren and was content that the remainder would last his lifetime. Financially, the couple felt better off, as the rent was manageable from their income and they had more savings to draw on, which they used to treat themselves – for example, having meals out and more holidays.

Steps towards moving

Moving tended to be a developmental process, a series of steps or a combination of factors that contributed to participants' decision-making and the practicalities of moving. A few property-owners who were considering moving at Wave One now felt further on and saw a move as more imminent. One couple had been offered a council bungalow after a four-year wait and another, who were increasingly dissatisfied with their large house and garden, were considering a choice of flats. After experiencing a bout of ill health, a few participants were making tentative plans to move. Among these, one couple had looked into getting a warden-controlled flat, which they felt would be easier to manage and would provide security in case one of them became housebound in the future. Another older woman was closer to moving in with her daughter, as she was relying on her family much more than at Wave One for support. By doing this, she felt she would be less of a 'burden' to them than staying in her own home. In one case, an impending move was unanticipated as it involved rehousing a couple because of damp in their social rented property. Despite their initial hesitancy, they saw moving from a house to a ground-floor, warden-controlled flat as more suitable in the longer term because of their declining mobility.

Changes in need and desire had also occurred

between interviews where participants, who were content at Wave One, now wanted to move to a different area. These participants had experienced problems with neighbours and youths, or a decline in health including a period of not being able to drive, which had resulted in a wish to move to a less isolated location. Those already in warden-controlled properties had requested transfers, although when or whether a suitable property would become available was uncertain (see below).

Barriers to moving

For those wanting to move (some since before Wave One) a key issue was the availability of a suitable property. Waiting lists for warden-controlled properties were seen as problematic. The perception of being overlooked and ‘fobbed off’ led to frustration at the lack of progress and ability to do anything about it. For those with low income or no savings who were in rented accommodation, the feeling of helplessness was particularly acute, especially where neighbourhood disturbance was affecting their quality of life (see Chapter 4). Obstacles for home-owners included the affordability of bungalows, limited supply of owned properties for older people and not being comfortable with the idea of renting (see also Croucher, 2008; Maxwell and Sodha, 2006).

A few participants whose health had deteriorated had thought since Wave One about moving, particularly to be closer to family. Others had considered moving because they had friends who had downsized, but the participants had eventually decided against it. While many older people recognised the sense in moving to smaller, more manageable properties, they had concerns – for example, the daunting process, the emotional ties to their home, they would miss their garden, the new property’s rooms would be too small, uncertainty about sleeping on the ground floor and not knowing where to go. It could therefore be seen as something to consider only ‘if it came to it’ and as a last resort. Participants also mentioned psychological barriers to moving to a property that was designed specifically for older people. One participant recalled a discussion with her fiercely independent husband:

It makes you feel old going into those. That’s why he won’t go. He said, ‘no, it would make

me feel too old’. When you go into these places, you see, you’re with all the old people, groaning and moaning and everything.

(Woman, aged 83, couple household)

As with reasons for moving, barriers to moving were often multifaceted, with a range of practical and emotional factors in play. Occasionally, there were differences of opinion within couples and the compromise was to stay put.

Implications

Several key issues have emerged in relation to the moving process. First, moving was perceived as, and could be, a stressful and daunting experience. Having help was valued and facing the ‘rigmarole’ alone could be an obstacle: Participants often felt that ‘It’s easier to do nothing’. They were particularly uncertain where one of a couple was in too poor health to help pack, where they had no one to call on or were reluctant to ask their family to help. A few felt that they could face moving if they had some assistance, which indicates that there is a need for some type of service to provide information and advice, as well as practical support – dealing with estate agents, providing transport to view properties, help with packing, etc. One couple who both had serious health conditions had thought about moving but explained:

Well I’ll tell you the honest truth, if I could organise somebody to, say, clear this place out and if we could sell it and it didn’t hang on until winter when you had to worry about frozen pipes and things, I would move. But I just can’t bring myself to start it off and do it myself.

(Man, aged 79, couple household)

However, it is also apparent that clearing out possessions can be a highly personal process, which, in many cases, people prefer to do themselves – hence a balance needs to be struck between offering practical help without interfering.

Second, is the issue of time. All of those who had moved had started the process or had been thinking about it two years previously and the wait for a rented, warden-controlled property had sometimes been years. While there was a need to match needs and desires to property

type and location,¹ the perception was that there were very few bungalows available. There is a need, then, to consider the financial and logistic implications if selling a property to move into rented accommodation. Furthermore, if people find it difficult to think ahead because of uncertainty around health needs (see Chapter 2), there is a danger that a decision to move will be made in response to an immediate need, which, if this then entails a wait, might cause difficulty. As Croucher (2008) found, older people are often reluctant to prepare for changes in housing need, despite the importance of making decisions while well enough to cope with the upheaval.

Staying in current property

Often participants were content that their home was suitable for current and future needs, and felt no need to think about moving, for example, from a warden-controlled property or from a home where adaptations had been made in the past. However, for some participants, changes within either a property or their own circumstances could have implications for how suitable it might be to stay put. Key issues were experience of, and resistance to, adaptations for mobility needs and property refurbishments. Changes in warden cover also had implications for some participants.

Adaptations in relation to health and mobility needs

Declining health can make getting around a property more difficult, particularly climbing stairs and getting in and out of the bath. Over the two-year period, several participants whose mobility had become more limited had made adaptations to their property. This not only made life easier but also meant that they could manage without thinking about moving. One participant had bought a stairlift because the stairs were becoming more difficult and she had expected this to get worse. Although she tried not to use the stairlift all of the time, knowing it was there when needed provided a sense of security. The provision of a replacement stairlift had also sealed the decision to stay put for another couple. A bath lift and walk-in showers had made a big difference (practically and with confidence) for participants who had become more unsteady and nervous about bathing.

However, for others, despite increased need, such adaptations had not been made. Barriers to making such adaptations included: the design of a property, which could not accommodate a stairlift; difficulties getting a shower and a stairlift from social services; and affordability. People were managing by crawling up stairs and strip washing or showering at their daughter's house. Others had also experienced more limited mobility but were resistant to the idea of adaptations. Some had a fear of getting stuck on a stairlift and another was concerned that the noise from using it would disturb neighbours. However, many were simply determined to manage without (see also Chapter 2):

It's like giving in isn't it, yes, it's like giving in. I can come down the stairs one step at a time, and I go up on my hands and knees, but if you've got a stairlift then you give up altogether don't you. You just sit on at the bottom and I think climb to the top, but I don't know, I've never had one, never been on one.

(Single woman, aged 79)

Adaptations for those in social rented accommodation had been made through the council, housing association or social services. Occasionally, property-owners had accessed adaptations via social services, although participants' families had initiated applications for more costly items such as a shower or bath lift. Other participants had funded adaptations themselves, in one case using up savings to buy a stairlift. In all but one instance, those who mentioned obstacles or were resistant to adaptations were property-owners, indicating that more barriers, whether perceived or otherwise, were faced by this group. Access to information about what is available and how to apply for grants to have adaptations appears to be needed, in particular by home-owners.

Upgrades and refurbishment to property

Two further areas of change that emerged from the research were updates to private homes through grants and the refurbishment of social rented properties.

Several home-owners on means-tested benefits had accessed grants for work to upgrade their property. Free cavity wall, loft insulation and

grants to provide central heating/boilers had made a difference to the warmth and efficiency of properties. Other home-owners had, or were in the process of having, more extensive work such as roofing, rewiring and new windows, which had been arranged via a housing improvement agency. Improvements to the security of participants' property included door and window locks, and an alarm, which were provided by the Handyvan service² and the police, which made people feel safer: 'more confident when you go to bed'.

A key issue is a lack of information about such schemes. Advertising for these schemes was rarely mentioned. One couple in long-term contact with social services had previously received grants and knew how to apply, but most often people had found out about schemes through family, friends and neighbours. Here, people felt that they would otherwise have been oblivious to such schemes and would not have had the work done or would have found it difficult to fund. Several had mentioned the need at Wave One but had deemed it unaffordable – for example, one participant whose savings would have been used up on only part of the work that had been carried out through the grant:

I've not asked for these here other things to be done. I mean all that you could do is do the essentials like if you get a hole in the roof and it was teeming in where you couldn't live. But no, I wouldn't have anything done. I know I'd got to have my boiler done, but I should have gone for this here option about having the Gas Board, but, as I say, thanks to my friend said, why don't you ring them here, and I should never have known, and I should never have got it done.

(Single man, aged 78)

Upgrades to council or housing association rented properties had also taken place over the two-year period, including new kitchens, doors, windows and rewiring. Generally, participants were happy with the outcome; however, several issues were raised. First was the difficulty of being in the property while extensive work was carried out – the 'upheaval' and mess could be 'upsetting', particularly where participants were in poor health and likely to be around the home

and/or found it difficult to clean up. Several wondered whether it would have been easier to cope if they had moved out temporarily. Second was the lack of consultation and the extent to which people's needs were taken into account. In a few cases, participants did feel that their wishes and feelings had been accommodated and this was appreciated. Others felt their views had been ignored in relation to the positioning of cupboards and switches. A few also wondered whether the work had been appropriate or necessary and occasionally work had been left unfinished. Here, people felt that they had little choice or voice in what was being done to their home.

Changes in warden cover

Cuts in the warden service since Wave One generally related to resident wardens being replaced by 'travelling wardens' and visits being reduced from daily to weekly. The loss of regular face-to-face contact was most strongly felt by a few single participants who had limited mobility and had experienced a decline in health since Wave One. Here, participants were concerned about their vulnerability, in particular not being found if they collapsed and could not reach the pull cord. They also missed the regular human contact:

They are very good. I'm not running them down, but it's not the same as having a warden that used to come and say, 'hello, are you alright?', you know.

(Single woman, aged 74)

Others were reassured by having the back-up of the emergency pull cord and the knowledge that warden cover could be increased if they became ill. Fewer warden visits could mean more reliance on pull cords. While some participants had used them for practical and medical crises, there could be hesitancy about pulling them and some confusion about what was deemed an 'emergency' (see also Croucher *et al.*, 2008). One participant had not used the pull cord to summon help when he had fallen: 'I'd not gone into a coma or anything of that nature'. Another had not been able to reach it when stuck in a bath and several had theirs tied up out of the way. It seems that older people might not necessarily use the pull

cord when it might be considered necessary – it is not clear whether this is because people were unable to anticipate the need for help or just did not want to ‘cause a fuss’.

There was often an air of resentment about the cut-backs in warden cover: ‘they’re cutting corners’, which was perceived as a money-saving exercise rather than meeting the needs of residents (see Croucher *et al.*, 2008). This was strongly felt by a few participants who did not receive Housing Benefit and paid full rent. Wardens were often also seen as victims of the cuts: ‘it isn’t her fault, it’s the system’, which some people felt was a sign of lack of empathy by the powers that be:

You’ve got to like it or lump it, because, no matter how much you complain, don’t forget that the actual people that count they’re not old people, they don’t understand old people, as far as we’re concerned we’re just persons in an old people’s complex. They don’t bother about whether you’ve got this, that or the other, they’ve got a job to do ... I don’t think they care as much as they should, because they’re not our age.

(Single man, aged 81)

Thoughts about the future – potential options

As noted at Wave One, participants tended not to think ahead in terms of funding additional future support needs to help them stay in their own home or residential care. This related, not only to uncertainty about their future health, but also to reluctance and resentment about having to sell property to fund later old age.

Accessing and funding care to help stay in the home

There was some uncertainty about what home support (care or help at home) might be available and whether this would be paid for by the State or by individuals. For example, some participants assumed that ‘the Government’ would provide free home support, while others expected to pay either some or all of the cost. There was less concern about funding home services among participants

with high income or substantial savings. However, affording support for present and future needs was an issue for some of those in more constrained circumstances (see Chapter 5). As highlighted in Chapter 2, knowing where and how to access help is also an issue. This is a problem whether help is accessed through the State, as concerns were raised about whom to contact and eligibility for help, or privately, particularly in finding someone to trust. This indicates a real need for information about availability and entitlement – especially if people are to be encouraged to think about planning ahead to fund their future care.

Property as a potential source of funding

The possibility of releasing money from property in the future was discussed with some home-owners. Concerns were raised about how long any money would need to last, a lack of knowledge and mistrust of equity-release schemes, what role the State would play in funding care and resistance to the idea of selling property.

Several home-owners made the point that, because of the relative expense of bungalows, downsizing from a house would not necessarily generate capital. The option of selling and moving to rented accommodation could also be a dilemma because of uncertainty about how long any house capital would have to fund paying rent. One participant who currently receives means-tested benefits and realised her outgoings would considerably increase if she sold up and rented discussed her concerns:

I don’t know how long I’m going to live do I, you see ... with what I would get for this, how long is it going to last? It goes pretty quickly if you’re paying out say £400, £450 a month, it’s not going to last you long is it. I mean if you knew how many years you’d got then you could work it out, couldn’t you. But I wouldn’t take that risk.

(Single woman, aged 84)

None of the participants had used equity-release schemes since Wave One, although they were sometimes viewed as a potential last resort for the future. However, as reported at Wave One (Hill *et al.*, 2007), resistance related, not only to wanting to preserve assets, but also to uncertainty about

how the schemes worked, scepticism about the benefits and mistrust of financial companies: 'I'm not that daft, you don't get anything for nothing and they're not going to give you the full price of the thing' (single woman, aged 81). Again, reflecting existing literature (for example, Terry and Gibson, 2007), there is a need for a trustworthy and independent source of clear information on such schemes.

Participants were fearful of having to sell property, in particular to pay for residential care, and concerned about depriving relatives of their inheritance. Some were angry about the perceived injustice of having to sell their home after working hard for what they had and having 'paid into the system' over a lifetime. For example, one widowed participant with only limited savings explained why her property was so important:

I don't think it's fair, we weren't born into privileged families, either of us, I mean we've worked hard to get what we've got, and that's the only thing I've got to leave to the children you see, I've got three children, and you do like to think that you're going to leave them a little bit ... and if I went in a home they'd take this and they'd take the money, they would, and that would be it, you know, just for the care, it's £300–400 a week you know in those places.

(Single woman, aged 78)

This also reflects concerns that any capital or savings would be insufficient to cover potentially substantial residential care charges. However, there was a general understanding among home-owners and those with reasonable savings that residential care would entail self-funding or at least some contribution towards fees. A few had taken action to protect their assets by putting property in children's names or giving money away either before or since Wave One (see Chapter 5).

Others, however, were reluctantly resigned that, if it came to it, they would have to use savings or money from a house sale to fund residential care, particularly where they had no family.

Conclusion

This chapter demonstrates that changes in older people's living environment through moving or having adaptations to help with mobility or grants to improve their homes had overall made a positive difference to their lives. However, several cross-cutting issues have emerged that can hamper the benefit from such changes in meeting current or potential future needs. When older people want, or need, to install a stairlift, access a grant or move, barriers can go beyond the 'usual' constraints such as a lack of money or availability. Barriers can also include individual resistance, hesitancy or concern, as well as lack of knowledge or support – factors that can be interrelated.

Older people need trustworthy information about housing choices and equity release, as well as practical support to enable them to make a move. There is also a need for better information about the availability of property and support in their area, what older people are entitled to and how best to access that support. In addition, older people need clear information about the process of adapting and improving their property, which can help them to remain independent in their own homes. This seems particularly relevant for home-owners, those who might not have had previous contact with social services or experience of accessing financial or practical support and people who do not have family around to act as advocates or as sources of information and encouragement.

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

This chapter focuses on transitions in participants' relationships and the wider world around them. Participants' experience of change in their social networks as well as their own life transitions, the local neighbourhood and travel, and the impact of these changes is explored. This chapter illustrates the dynamic nature of older people's lives and demonstrates that quality of life can be dependent on the circumstances of others and society more widely, changes to which are, therefore, often perceived to be beyond their control.

Changes in social networks and their impact

As reported at Wave One and elsewhere (for example, Bowling, 2005; Bowling and Gabriel, 2007), social networks are vitally important to older people's quality of life and can act as a social, emotional and practical resource. Changes had taken place in participants' social networks since the first wave of the research, which impacted on their lives. They included changes in participants' own relationships, as well as the effect of transitions in the lives of those around them. This illustrates how the dynamics of older people's social networks can affect their everyday lives.

The transitions of others

The life transitions of participants' family and friends, such as moving away or nearer, their ill health or death, changing jobs, relationship breakdowns and the addition and growing up of grandchildren could have varying impacts on participants' social relationships. The impact of such changes depended on the extent and type of contact lost or gained and the availability of other resources. However, a key issue is that, generally, these were circumstances external to, and beyond the control of, participants.

Family and friends moving nearer or further away

A few participants whose children had moved closer to them since the first wave felt that their social lives had improved as they were going out more with their children and gained a lot of pleasure from more frequent contact with them and their grandchildren (especially if they had previously lived some distance away).

Some participants' children and friends had moved away since the first wave of the research. This was especially hard on widows and widowers whose children had previously lived close by. Not only did they miss the companionship and practical help, but the loss of having someone 'on tap' meant that their relationships were less spontaneous and required more organising than previously. Ways of coping included 'getting on with it' and relying on help and company from other family members.

The impact of family moving away depended on how far they had moved and on participants' physical and financial circumstances – those in poor health and with limited money being more restricted in their ability to visit. Here, family moving abroad was particularly upsetting, as the concern was that they would not see each other again. Those in higher-income households, or with family who had the 'know-how', were also more likely to have, and to be able to use, new technology, such as 'webcams', than those in lower-income households. This gave them an added ability to keep in touch with each other. A few participants who were less able physically to get out to see others or whose friends/family were living further away mentioned the increased importance of the telephone to maintain their relationships.

The case study presented below illustrates the impact that a son emigrating had on one couple, and shows how their own worsening health

and their financial situation relates to this loss. Importantly, Mark and Fiona's story demonstrates how their son's knowledge enabled them to make full use of computer technology and how this, in turn, softened the blow of his emigration.

Mark and Fiona's story

Mark and Fiona are a loving, family-oriented couple who have a council house on the edge of a city, where they have lived for ten years. Mark was 66 and Fiona, at 59, had not yet begun to receive her state pension when the research began. They had one son living several hundred miles away and one daughter living close by. Another daughter had died and this loss still impacted heavily on both of them.

Mark had had several heart attacks and operations on his knees. Further knee operations were no longer possible because of his heart condition. The latter had also forced him to retire, although he had since taken on some part-time work. Fiona was asthmatic and had blood pressure problems. After long-term nursing of their daughter, Fiona had trained in the hope of getting office work, but was unable to do so and took part-time factory work until she, too, was forced to retire with back and neck problems. Neither of them was particularly mobile, but they still managed to get out and about, including to visit their son up to three times a year, as he sent them travel tickets. Their major activity was looking after their only grandchild – whom they both adored – while their daughter was working. In return, their daughter shopped for them and, occasionally, took them out for a meal.

Two years later, there had been significant change for Mark and Fiona. After a few 'twinges' in his chest, Mark had given up work altogether and the family were now totally reliant on benefit. Fiona had become deaf in one ear and had been diagnosed with diabetes, and, more significantly, their granddaughter had also been diagnosed with a serious health condition. The whole family had had to learn how to deal with her care and administer her medication. Despite the downward turn in health, they stayed upbeat

about it: 'you've got to deteriorate a little bit else everybody would be living forever'.

The most significant change is that their son has now emigrated to the other side of the world. They feel the distance keenly and speak of him as being '29 hours away'. They will not be able to afford the air fare until an annuity matures in three years' time; nor will they get tickets as a gift again. However, before their son left, he bought them a laptop and webcam, and arranged lessons for them so they would be able to communicate with him, which they have started doing. The couple's aim is to be able to visit him before they become unable to do so, as already the cost of insurance to fly is extortionate and they would have to take an extended journey, as neither can fly long haul because of their health. It was the only thing they were looking forward to doing and they were happy to spend every penny they had in order to make the trip. They just hoped that, by the time they had the money, their health would allow the journey, otherwise, they might never see their son again: 'The only thing I'm looking forward to is going to see [son]. Because whatever happens I would like to see him before anything happens to us.'

Death or illness of family and friends

Illness and death of siblings and other relatives between waves of the research again involved the loss of both companionship and practical support, which was felt particularly by those without children. The emotional or psychological impact was also an issue. Siblings and friends dying was a particular cause of anguish when few remained in a participant's immediate social or family circle, which could act as a stark and unwelcome reminder of their own mortality:

Woman: *A lot of friends in our age group have died in the last two years.*

Interviewer: *And what difference has that made to you then?*

Woman: *Well it makes you sad because [pause].*

Man: *It makes you sad and it makes you think.*

Woman: *Yeah, it makes you think three score year and ten you know, don't dwell on it really, don't, try not to think about it too much, but when somebody does die it does bring it home to you.*
(Couple, both aged 71)

The illness of children could lead to increased stress and anxiety for participants, both for those providing additional assistance and for those unable to help because of distance, or being unwell or immobile themselves. Furthermore, a child's worsening health was a source of worry about how their children would fare in the future, as participants were aware that they would not be around to help their children out: 'what's going to happen when I'm not here?' (single woman, aged 86).

Where a child's health had improved, participants were called on less often to help out and, for those unable to travel, their children were now able to travel to them. This meant that they were less anxious about them at Wave Two than at Wave One.

The birth and growing up of grandchildren

Participants also reported additional grandchildren and great-grandchildren between waves. This sometimes produced more face-to-face contact in order to 'show off' the new baby and sometimes less because of further work and time devoted to the newcomers by their parents.

Participants talked of the changing nature of relationships with grandchildren as they grew up. Seeing grandchildren less frequently was often viewed as an inevitable part of the child's development. The frequent refrain was that 'they've got their own lives to lead'. Participants justified the lack of contact because of their grandchildren's busy lives, which were perceived to be full of school, university, exams, work and boy/girlfriends. Those who had grandchildren living closer to home had to work harder to justify why they saw them infrequently. Where participants had grandchildren at some distance they especially and appreciated their efforts to visit, sometimes

hardly believing that the grandchildren would actually want to spend time with them.

In a few cases, participants believed that their grandchildren were unruly, noisy and badly behaved, which had contributed to the refusal of a family holiday and caused hesitancy about moving in with a daughter and family.

Other external changes in families lives

Family changing their jobs could also impact on participants' lives. The difference was felt both practically, for example, doing house maintenance once undertaken by a nephew who was now working longer hours, and socially, where a daughter no longer took a participant out and about as part of her driving job. Again, this disruption to 'usual' contact hit hardest those with no other siblings or children in the area.

Adult children's relationships were a particular issue for participants where the children were under strain or had separated between waves. This involved worrying about the potential consequences of the relationship breakdown, particularly if there were grandchildren and concerns about losing contact and, in one case, where a child had mental health difficulties. This family tension could have a severe impact on participants' well-being and, in the extreme, the anxiety was thought to have contributed to a stroke.

Participants' transitions

Transitions that had taken place in participants' own lives between interview waves included new relationships with members of the opposite sex, marital separation and the death of a spouse.

New relationships with the opposite sex

Two widowed male participants had formed relationships with women since the first wave of the research. The emphasis was very much on friendship and they stressed the importance of companionship for them:

... we went out quite a few times together, we enjoyed it together, there was no, no hanky panky, nothing like that I mean I said, I don't hold with that, I don't want no hanky panky or anything, just friends. She said well I feel just the same. Because we both feel a little bit

lonely, she lost her husband, I lost my wife and we didn't want any, but just friends.

(Single man, aged 80)

Both men met the women while out doing different things. Being able to get out and about is a vital resource (see also the section on 'Travelling further afield' later in this chapter) to meet different people and could, ultimately, enable new relationships to begin and flourish. Having a friend of the opposite sex was important to the men and seen as qualitatively different to having male companionship. Women were considered to have added value – they were able to talk and engage the men's interest. Being able to entertain women friends for both of these participants was also a source of pride. Going out with a 'lady friend' made them feel special.

Occasionally tension had arisen between widowed participants and their children between the two waves of research where (male) participants were involved in new relationships developed before Wave One. In these cases, offspring were concerned about the financial motivations of the 'lady friends' and for their parents' welfare. The result was that the participants themselves could feel under scrutiny. In one case, it had led to the 'lady friend' avoiding contact for a while.

Separation

One couple had separated since the first wave of the research, after 30 years of marriage. At Wave One, the female participant had spoken about how difficult it was to continue living with her husband. The separation had meant a new lease of life for her in that she had freedom to do what she wanted, when she wanted to do it. Moving to a warden-controlled home with a community centre had enabled her to meet new people through participating in different activities. Another participant who had divorced shortly before Wave One (at the age of 80) was continuing to enjoy her independence and full social life, and reflected that she wished she had left her unhappy marriage earlier. The implications for people in later life are, therefore, that they do not have to remain in a

couple for convention's sake and that, although it might be hard, they do have choices that can lead to a more fulfilled and peaceful life.

The death of a spouse

One participant's husband had died between the first and second wave of the research. They were a West Indian couple who had been married for over 40 years. His death had an impact on many areas of her life – she missed him terribly and felt his loss even in small ways such as unpacking the shopping. There was an increased awareness that she was now solely responsible for getting what she needed, when she needed it, which could be exhausting, particularly as she was unused to it and when she was feeling unwell. In particular, the bereavement had affected her feelings of vulnerability, safety and security, both within and outside her own home. Having a 'man' in the home for women of this generation could be seen as a deterrent to burglars or threats from 'outsiders'.

... but now it's me alone and I'm not going out on my own, for what's going off now, I'm not going out on my own.

(Single woman, aged 85)

Aspects of her life that made it easier to cope with the loss of her husband were belonging to a cultural centre for West Indians where she had a network of friends. She also had neighbours who offered to help with anything she needed. This support was particularly important, as none of her children lived locally and one lived abroad. Extended family could be particularly important to the recently bereaved and many of the small number of people from minority ethnic groups in the sample had relatives of the same generation living abroad. It can be a problem for people from minority ethnic groups to keep in touch with relatives living abroad as they age – especially in the event of a death. Health conditions might preclude long air journeys, or impact on the cost or availability of travel insurance, making contact with same-generation family members difficult or impossible.

Changes in neighbourhood

The importance of people's local environment and services can increase as mobility declines – a few participants living in city suburbs now seldom went to the city centre as they found travelling there and walking around too much effort. The experience and impact of changes in participants' living environment, such as relations with neighbours and others in the community, the built environment and surrounding area and local services, again reveal the extent of control that older people feel they might have over their lives.

Community relations

How people get on with others around them can hugely affect satisfaction with their environment and participants spoke of changes that had made positive and negative differences to their lives.

Neighbours

Participants missed neighbours who had moved away, both socially and in terms of practical help. Having good neighbours and being part of a community was particularly appreciated by those who had moved because of disagreements with neighbours at Wave One and this was seen as contributing to an improved quality of life. Additional help from younger neighbours to do shopping, gardening or odd jobs was welcomed as a valuable new resource by a few lone participants whose health had declined since Wave One. There was a sense that it was appreciated more because, perhaps unlike families, a neighbour had no real responsibility or obligation to help: 'it's nice that they care'.

A change in neighbours was viewed less positively where those moving in had loud cars and loud parties. Although they were of a younger generation, it was the inconsiderate nature, rather than age, that was the problem. Here, participants felt they had little in common, sometimes despite attempts to communicate, which resulted in them having little to do with each other:

He's one of them that walks about with a vest on, you know what I mean. And he's got a car, he's got two, and he's had one of them big exhausts and he only drives it in first gear, it's bang, bang, bang, I think you stupid idiot.

So I let them get on with it, I don't have no association with them.

(Single man, aged 78)

Particular problems with neighbours had sometimes developed or escalated since Wave One. The neglect of neighbouring empty or rented properties affected participants' homes and lives. Dumped rubbish, blocked alleyways or water leaks were a cause of 'worry' and frustration when response from the landlord/council was not forthcoming. More serious disputes had arisen or become worse to include verbal abuse, and council and legal involvement. The impact could have an overwhelming effect on participants' lives, detrimentally affecting their ability to relax at home and to sleep, and could have health implications (depression, increased blood pressure, weight loss). A few of these participants' problems were compounded by increased general disturbance in the area. These situations could be more salient for those who were less mobile, unable to get out as much and likely to spend more time in the home – at the extreme almost trapped. For couples, having each other was an important source of support. Where such problems had arisen, participants generally now wanted to move. However, options were felt to be limited by lack of alternative social rented accommodation (see Chapter 3) and the inability to sell a property because of subsidence. Conversely, despite the stress, one couple (in the private rented sector) were determined to stay rather than be 'driven out' – hoping to 'win the battle' was, perhaps, a way of coping.

The wider community/safety

Where people had experienced problems with anti-social behaviour in the area at Wave One, there had been both positive and negative changes over the two years. Disturbance from youths causing trouble, prostitutes and drug users had been eased though higher police presence, liaison with local people and the closure of a youth centre. Here, participants welcomed the relative peace and felt more comfortable in their homes and immediate area.

Conversely, problems had escalated (both in a city and a deprived rural area) with youths causing disturbance, vandalism and an influx of alcohol/

drug users and 'badduns' into the area. Trespass, attacks on property or verbal abuse were a particular cause of stress, put people 'on edge all the time' and affected feelings of personal safety:

I don't like them standing on the balcony because, as I say, front door's there, when I come round with the dog and they're there and start shouting and I just ignore them and just keep, you know I don't make eye contact, I just keep walking, but they know where I live, so they see me go out and they see me come in, but when I go out you just don't know what's going to happen do you. So you know I feel a bit unsafe really.

(Single woman, aged 67)

The erection of barbed wire around a property made one participant feel more secure. However, strategies to deal with the behaviour of people in the area were more difficult. Occasionally, youths had been warded away by direct action (threats or soaking with a hosepipe), but, generally, participants felt it unwise or were too frightened to get involved in confrontation. While a couple of participants were sympathetic to the needs of children for more facilities, 'they're just bored stiff', most saw the situation as hopeless because of lack of discipline by parents. Concerns were also raised about the council/housing associations using the area as a 'dumping ground' for problem tenants. Again, participants felt helpless and saw moving as the only solution, which, as noted in Chapter 3, was not necessarily a straightforward option.

The feeling that their community was changing was an issue particularly for participants who had experienced difficulties with neighbours or, more generally, with people in the area. This was often in more deprived areas and the (anti-social) behaviour of others had affected participants' quality of life, both directly and through anxiety and feelings of powerlessness (Waters *et al.*, 2008). Often these participants had lived in the area for many years and had witnessed people they knew moving out. Comparisons with the past were made with a sense of loss: 'you've lost the friendliness', perhaps because of a widening gap between themselves and the community around them, which could contribute to a loss of connection or

attachment to the immediate environment (Kellaher *et al.*, 2004; Livingston *et al.*, 2008).

The case study presented below highlights how problems with neighbours and the area impacted on one couple's life, but limited resources restricted the option to move. However, John and Sheila's story also demonstrates how other changes could compensate for the disturbance by providing them with an escape route.

John and Sheila's story

John and Sheila were both aged 69 when we first met them. They had been married for a year after both being widowed and lived in a warden-controlled flat. John had experienced a 'heart scare' but considered himself fairly fit. Sheila had angina and arthritis, and was recovering from a broken hip. She had not been able to walk properly for two years but hoped that this would improve with a forthcoming foot operation.

Money was a key issue at Wave One. Sheila had been receiving Council Tax Benefit and Housing Benefit but these had stopped when John had moved in, and the full rent and council tax combined with paying off loans left them little room for manoeuvre. They did not have savings and had to budget very carefully. One expense was a car, but this was seen as necessary given their rural location. It enabled them to get out of the village, shop more economically and was important to Sheila as she could not walk at the time.

John and Sheila were happy with the flat's size and the neighbours, although they did have problems with damp and heating. They liked the surrounding countryside, but felt that the (ex-industrial) village itself was run down and had a 'bad name'. Although nearby derelict buildings had become a gathering place for teenagers, neither John nor Sheila felt threatened and deliberately talked to the youngsters, which the couple felt 'kept them in good stead'. They did not foresee themselves moving and wanted to stay in the area near family and friends.

Two years later John and Sheila felt a little happier with the property itself after buying a

dehumidifier and a halogen heater. However, they immediately raised difficulties with a new upstairs neighbour who left the shared entrance unlocked and let in 'undesirables', which made John and Sheila feel insecure. Moreover the neighbour was 'loud' with continual banging from the front door (which was next to John and Sheila's bedroom) and shouting. To make matters worse, problems with youngsters in the area had become 'completely out of hand' (jumping on cars, vandalism, shouting abuse). The difference was that these were now younger children who John and Sheila felt unable to deal with and feared that approaching the parents would be useless or, even, risky. Both of these situations were very stressful for John and Sheila. They felt 'on edge' all the time and unable to relax in their home, which they knew was a problem given their heart conditions. However, it had contributed to Sheila losing her temper and John had experienced raised blood pressure and a mild heart attack. They now desperately want to move and have applied for a bungalow in the next village. However, they have been told they are 59th on the waiting list. They think that to rent privately would be unaffordable, so the best option is to put up with the situation and try not to let it get to them, as there is nothing they can do about it.

The couple's financial situation has improved, as Sheila had been awarded the higher rate Attendance Allowance. They have saved and bought a caravanette, which has enabled them to go on holiday at little expense and on day trips as and when they like. Given the stresses of their home environment, this means of 'escape' was extremely important.

The local built environment

Streets and public spaces are also an important aspect of the local environment, and participants mentioned various positive and negative changes. On the positive side, efforts made to clean up deprived areas through painting buildings and more cleaners (in a city), and the removal of derelict buildings (in a village) were welcomed as a 'big improvement'. Where a wheelchair had to be used for the first time after a stroke, dropped

kerbs had alleviated a husband's concern about managing to push his wife around.

However, some changes made life more difficult for older people. Road and redevelopment work had, for example, closed a walkway or footbridge, which meant taking diversions to get to shops. The additional distance was difficult where participants had breathing and mobility problems, and the disruption involved making adjustments to a usual route (across a busy road) for someone who was visually impaired. This meant loss of familiarity, which had been an important component of coping with sight loss over previous years. Difficulties caused by the closure of a city centre bus station during redevelopment work included a lack of seating at replacement bus stops and their distance from shops and hospitals. In one case, changes not only posed practical problems but also left a participant feeling somewhat excluded from the new development, as if it wasn't really for her:

They're not for old people, it's all young people, all the new centre is for young people, it's got all the shops in, and it's got pizza bars and it's a young person's place now. There's cinemas and I think they're going to build a casino somewhere. It's not an old people's town any more, no, they've not thought about old people at all.

(Single woman, aged 78)

These experiences highlight the importance of taking into account older people's needs in relation, not only to the effects of temporary changes while work is carried out, but also to the end result.

Services and facilities

Changes in local services included the opening and improvement of local facilities, such as shops or a health clinic, as well as the closure of, or diminishing services at, post offices, the accident and emergency department at a local hospital and a housing association office. The practical impact was either lessening or increasing the need to travel and was seen as more problematic where there was no car in the household. Safety concerns were also raised where this potentially entailed travelling further afield with sums of

cash. Changes also related to how services were delivered and used. Prescription and newsagent home delivery services had become a valuable aid to coping for several participants whose mobility was more limited since Wave One and could no longer walk to collect these in person.

Where a service or facility had closed, participants spoke of missing the personal relationship built with members of staff, sometimes over many years. Face-to-face contact is an important component of service provision, as illustrated by one couple's preference to take a bus to a more distant housing association office than telephone with queries when the local office closed. The relationship with service providers was valued particularly by participants living alone, especially if they were less able to go out very easily:

You have to have a bit of a joke, a bit of a laugh with some of them or life would be too miserable wouldn't it. [Regarding prescription delivery person.]

(Single woman, aged 72)

Sometimes this had extended beyond the service itself and, occasionally, corresponded with changes in other aspects of participants' lives. For example, where a home help had been withdrawn and a participant's mobility was limited, a newspaper girl would post letters. A developing friendship with a local shopkeeper had become increasingly important for another participant, perhaps also because he missed the daily contact with a warden:

There's times when I've left something, I left me glasses last time and a big car drew up there, 'you've left your glasses'. Whereas, normally, shopkeepers would say, 'oh he'll fetch them when he wants them'. Oh they're great people.

(Single man, aged 81)

This 'going the extra mile' was greatly appreciated – particularly where face-to-face contact was part of a service. Taking the time for a chat is down to individual staff and the benefits of doing so can make a tremendous difference to those older people who have limited contact with others.

Travelling further afield

Research suggests the importance of transport in securing older people's social inclusion and independence within communities (Smith *et al.*, 2006; Social Exclusion Unit, 2006). This research highlights how transport becomes more than getting from A to B. It becomes linked with enabling people to do new and different things, and to meet up with other people in doing so. In addition, going further afield includes holidaying and the research highlights how changes in the types of holidays impact on participants' lives.

Changes in transport use

The interaction between the introduction of the bus pass and the difference this made to participants' use of buses and their cars is explored, as well as other factors affecting changes in car driving.

Introduction of the bus pass

The introduction of free, local, off-peak bus travel¹ for people aged 60 and above was warmly welcomed by participants on accessible bus routes and those able to get out and about easily. It made a real difference to their quality of life in that they were able to travel to, and meet up with, friends and family at no cost. Not only was the financial benefit felt (especially by lower-income participants who were already regular bus users), but, since the first wave of research, many participants were more frequently travelling further from their homes, visiting different places and accessing shops, markets and restaurants, and having days out to places further afield that they would not otherwise have visited:

I met three friends on Saturday and we caught [two buses] and just had ever such a little steady poddle ... you know and then caught the bus back and we took sandwiches and a pack up and it was a beautiful day.

(Single woman, aged 70)

In other words, the impact of the bus pass was to extend the participants' horizons by shifting the purpose of travel from the functional, or everyday, to more leisure or social use. Several participants were looking forward to the introduction of free bus

travel on a national basis, so they could journey further from home or use when they were away on holiday.

Some car drivers had also increased their bus use since the first wave, although mainly for financial gain. It was also seen as less hassle in finding a place to park in town or city centres, it suited the sentiments of those who had environmental concerns and it enabled those who had worries about driving to continue to get out and about without a car. This was particularly important where a stroke had 'knocked' a participant's driving confidence:

Woman: *The actual physical thing of driving it and then my mind having to concentrate on watching traffic lights and traffic coming, and traffic coming at the side of me and back of me, I honestly don't think that I've got the confidence, and to be honest all these different buses that we've caught, and we've sent off for loads of bus timetables.*

Man: *We didn't realise what a good bus service there was around here.*

Woman: *How easy it is to travel by bus. No hassle, no having to watch the traffic coming near you, and I can actually look out of the bus window and see scenery.*

(Couple, both aged 69)

A review on mobility (Smith *et al.*, 2006)² found that people with cars tended not to use buses and experienced problems with public transport when they gave up driving. This indicates that people might fear the unknown and need time to become familiar with using public transport. The evidence here of car drivers moving towards combining car and bus use suggests that the introduction of free bus passes might be a way of easing the transition to using public transport before there is a need to stop driving altogether. This may be of interest in future research.

Changing driving habits

Changes in driving were linked to participants' decreasing confidence, either in their own abilities (after illness, difficulties with their eyesight, driving in the dark and being shaken up after getting lost) or concern about the risks posed by the inconsiderate nature of other drivers. Driving was perceived as more frightening now than in the past. In some cases, this was linked to a general loss of enjoyment in driving (see Smith *et al.*, 2006). One participant had given up his car completely since the first wave because of perceived risks on the road as well as expense. Although the bus pass softened the blow, in that he could get into town and back, stopping driving meant that he was unable to visit relatives as often, as they were not on a direct bus route. A few participants had experienced improvement in their health since the first wave (after a stroke, eye operation), which had enabled them to resume driving. The impact of being able to drive again enabled wider social contact with friends and family, and resumption of leisure activities.

Car convenience

Most participants who had access to a car tended to continue to use it to access shops and facilities, especially where these were not on a bus route. The car was considered more convenient in terms of door-to-door transport and carrying shopping. Those with limited mobility were not using buses more frequently than at Wave One. Indeed, some had stopped using them because of: difficulties getting to and from the bus stop; being less mobile once reaching their destination; getting on and off the bus (especially when carrying items); and no longer being able to go out on their own – related to changes in health. In these cases, the tendency was to rely on taxis and lifts from others, or to use their own car. It was mainly older women participants who could not drive. This has financial implications as, while taxis were seen as expensive, for some, particularly women living alone, they saw little alternative.³

One participant had acquired a car since the first wave of research. This had made a big difference as he had been suffering from a leg condition, which meant he was unable to get

around easily. Having a car was convenient, he did not have to plan his journeys and he could now visit his relatives in a neighbouring city more easily and on impulse:

It's very good when you know something needs doing quickly, just get in the car and go and do it. If you've got a long way to go then it's easy, just get out the house, get in the car and go and come back.

(Man, aged 69, couple household)

Travelling, therefore, was an issue of great importance to participants and they discussed their travelling needs in the widest sense, including the changes some had made in their holiday arrangements.

Changes in holidays

It is important to note the impact of holidays on older people's quality of life and the beneficial effects of a change of scene. As highlighted elsewhere, a number of participants had changed the frequency of holidays, going less often than at Wave One because of changes in their health and mobility (Chapter 2) or having more limited finances (Chapter 5) or, indeed, going more often where they were financially better off or were more inclined to use savings (Chapter 5). However, of interest here is where a change in having a holiday at all or the type of holidaying had made a real difference to people's lives. Two participants had experienced holidays funded by the British Legion, which had enabled them to have, for the first time, a fortnight's holiday that they would not otherwise have been able to afford. This had given them a new 'lease of life' and enabled them to return rested and refreshed:

Interviewer: *You've said about this holiday, which is something new, and you're smiling when you talk about it. What difference has that made to you?*

Man: *Oh I felt a lot better when I come back ... Picked me up quite a lot ... I don't know why, a change you know, change of scene and everything.*

Interviewer: *So it's not something you'd really thought about doing on your own?*

Man: *Oh no I wasn't bothered duck. But it's made a spark, made me want to go again.*

(Single man, aged 81)

There was also evidence of changes in how participants took their holidays. Two households had purchased a caravan – one fixed at a coastal site and one a mobile camper van. These new purchases had massively improved the participants' quality of life since the first wave. They had provided a form of escape and allowed participants to go and do what they pleased, when they wanted, in what was termed 'a home from home'. One widowed participant recalled her thinking behind the decision:

I mean it's the same as this caravan, I mean me daughters you know, especially me oldest daughter, she said, 'I don't know what you need one for'. She said, 'buying a caravan at your age'. I said, 'look I've told him I'm not going yet and your father's not having me yet either!' I said 'I'm happy enough as I am, I can go, I can do what I want'. I said, 'I'm going and I'm going on holiday and I'm going more than once an' all'.

(Single woman, aged 71)

Having new or different types of holidays opened up the lives of some participants, allowing them to experience different places, the benefits of having a break and change of scene and, in some cases, freedom: 'it's been what you call an uplift for me'.

Conclusion

This chapter has covered a range of issues that are important to the social inclusion of older people and several cross-cutting themes have emerged. Older people's lives are not static and this research highlights the continually changing nature of participants' lives and the influence of the world around them. People's quality of life can be affected positively or negatively by transitions in their own social relationships as well as the

circumstances of those around them as they move through the life course. The impact of changes within communities, relationships with neighbours and the local environment also highlights how people's lives could be affected by factors seen to be beyond their control and how sometimes they felt their needs were ignored.

A further overarching issue relates to the presence or absence of independence and how this links to other resources such as health, finances and social networks. Both public and private transport provides the means to an independent life for older people. The introduction of free off-peak bus travel has enabled those who can access it to travel further afield and broaden their horizons. However, those less agile have the most difficulty travelling on buses and are likely to be missing out on some of the pleasures of travelling more widely.⁴ Alternative travel methods involve costs, such as running a car or paying for a taxi, or can compromise independence because of a reliance on lifts. This, as shown, involves having to wait.

5 Financial well-being

This chapter focuses on participants' perceptions of their financial circumstances and how this had changed between interview waves. It explores the multitude of factors that affect financial well-being over time, including how formal and informal resources can be drawn on to help manage change or maintain stability. Influences such as past values and current constraints on spending and perceptions of need are also explored, as well as thoughts about the sufficiency of financial resources for the future and any plans made.

Perceptions of financial circumstances

It is useful to explore how participants saw their financial situation and whether they felt any better off or worse off than at Wave One, why this might be and the impact on their lives. This is not an objective assessment of whether people actually had more or less income/capital, but it attempts to provide an insight into the array of interacting factors that contribute to their perceptions of their financial well-being. The impact of changes in income or expenditure depended on several factors: first, the extent of change in either direction and how this balanced out; second, the relativity of any change to people's overall financial circumstances, i.e. their 'starting position'; third, the resources they had available to draw on, which could cushion the effects of change. Overall, households who were more financially secure and had substantial savings at Wave One were generally in a similar position at Wave Two. While those with higher incomes did experience change, they were more likely to be protected from the smaller differences in income or outlay, which could result in those with lower incomes and limited financial reserves feeling better or worse off.

Feeling better off

Participants who felt that their financial situation had improved since Wave One had generally

experienced increases in income or capital and/or decreases in outgoings. Those feeling better off included a range of income groups, but the type and scale of changes experienced were different for those in an already comfortable financial position from those in less secure circumstances.

In an already comfortable financial position at Wave One

These participants had reasonable savings/pension levels at Wave One and tended to be in the younger age group. They felt better off through receiving sums of money from house sales, inheritances or investments and, in one case, increased earnings from publishing. The key point here is that these participants did not need this extra money for day-to-day living and drawing on it was, therefore, seen as more of a choice. They used it to buy additional items such as a new car, holidays or household goods, but it also brought greater longer-term security for themselves and their family: 'I reckon I can carry on as I am until I'm 90 and there might be still a bit left then for my grandsons'.

With more limited funds at Wave One

For participants with lower incomes and savings, smaller changes, which may not necessarily be noticed by higher-income groups, made a difference. Indeed, a few who had turned 80 since Wave One commented on the financial benefit of receiving an extra £100 Winter Fuel Payment: 'it's been a boon, it really has'. Less spending on outgoings contributed to feeling better off for a few older single men, in one case after giving up a car. However, as one participant found, saving even fairly small amounts across different areas of life could combine to make a difference, without even deliberately trying to economise (see Derek's story later in this chapter).

The receipt of additional or increased means-tested benefits (Pension Credit, Council Tax

Benefit, Housing Benefit) or health-related benefits (Attendance Allowance) also made a positive difference. Participants' lives were enhanced through being able to buy everyday items such as clothes or shoes that they would not have been able to buy before, or spend money on holidays or meals out. Furthermore, being able to save even only small amounts enabled the purchase of larger items, in some cases taking over a year to fund, which highlights that changes in financial circumstances can take time to make a difference. As might be expected, the receipt of (increased) health-related benefits often coincided with additional spending on health care (see Chapter 2). However, participants in this group felt able to cover the costs with the help of their additional income.

The key to feeling better off for those on lower incomes/receiving means-tested benefits was having surplus income that now covered more than just bills. While these participants were not thinking in the longer term or accruing savings for later old age (except in one case for funeral costs), the fact that they were now able to build reserves, albeit in some cases very small amounts, could make a huge difference. Practically this could be a means to improving life – for example, through saving for a holiday or washing machine – but it also contributed to participants' psychological well-being by providing freedom from financial worry. One couple described the difference that receiving benefits had made to their quality of life:

Well it's like a tonic, it's a big help, tremendous help ... We know that, if the kettle broke or me washer broke down, we've got money to get one, and that's the difference of knowing and the peace of mind and contentment knowing whatever breaks down, if the telly packs up, I can go and get another one, and that's where we get the happiness from, you know.

(Woman, aged 71, couple household)

Derek's story, presented below, illustrates how a range of changes can interrelate to have an impact. It was not immediately obvious why Derek felt better off but small changes in his outgoings, combined with having an incentive and the means to save, had resulted in him having extra money for the first time, which had given him a sense of security.

Derek's story

Derek was aged 79 when we first visited him. He had never married and lived alone in a council flat on the edge of a town. His sister and brother lived locally. Healthwise, Derek felt he was doing well for his age. However, fluid on his lungs had reduced his energy so he could not walk too far. He also had back pain and no sight in one eye.

Derek's income consisted of the state pension and Pension Credit. He had never been good with money, had always had poorly paid work and had never been able to save. He lived from week to week and only ever had a few pounds left by pension day, so could buy large items only once a year when he received his Winter Fuel Payment. He planned to spend the next payment on a new stove. Derek did not have a bank account but managed his bills by having his gas and electric on a meter and he gave cash to his sister every week to pay the water rates. One gripe was the new system for collecting his pension. He had trouble putting in the pin number and felt a bit put out that it had been 'forced' on him without enough explanation.

Derek was a man of routine. He got the bus into town every morning, did a bit of shopping and went to a local social club for a few pints with his mates before coming home. The bus was important to Derek as it was too much for him to walk into town now, but the half-price pass helped with the cost. Overall, Derek was fairly content with his life; he didn't foresee any changes and hoped just to 'plod along as normal'.

A lot had happened in Derek's life during the two years between interviews. He had had a severe angina attack, which had left him housebound for eight weeks. His brother had been an enormous help, bringing microwave meals and providing lifts to the hospital. By the time of the interview Derek was recovering well, and, apart from being slower and drinking less, was back to his usual routine.

Derek felt financially better off than at Wave One and had started to save money for the

first time. Lots of things had helped – he was spending less on alcohol and could buy six ready meals for £5. He had also saved money on bus fares since the free pass had been introduced. His Winter Fuel Payment had increased when he had reached 80 and he hadn't spent it on a cooker, as the council had replaced his old one when his flat had been refurbished. His view of the pension payment system had also changed. He now used it to save money as, each week, he let some of his money accumulate to add to his unspent Winter Fuel Payment. Having money to fall back on was a relief for Derek and gave him a new confidence: 'you're not worried you're on your bloody uppers'.

Another change was that Derek had been on a two-week holiday, which had been paid for by the British Legion. This was a totally new experience for him as he hadn't been outside the county for years, let alone on holiday. He had had a great time and was keen to go again, so much so that he was going to try to pay for himself next time. Having this to look forward to gave him a real incentive to save.

Feeling worse off

Reasons for feeling worse off than at Wave One related generally to increases in participants' outgoings that were not matched by a corresponding change in income. Again, the impact of such changes depended on their scale and existing levels of income and savings/reserves.

With more limited funds at Wave One

Participants who perceived themselves as worse off had often been in constrained financial circumstances two years earlier, with limited surplus income, and so increased outgoings were more noticeable. Additional demands on finances included:

- rises in everyday living costs such as higher household bills, increased price of shopping, and higher petrol and general costs of running a car;
- one-off outlays such as car repairs or house maintenance for owner-occupiers, sometimes

routine but also unexpected – for example, a burst pipe;

- costs of additional health needs – for example, a stairlift, paid help or clothes/special food where there had been a dramatic weight loss.

Some of these participants felt that they could just cope with 'usual' increases,¹ but, when this coincided with unanticipated larger outlay, the impact was less manageable because of the absence of savings to draw on. One participant had required a loan for double glazing. People spoke of the need to prioritise certain outlays over others and weighed up the necessity of items before spending. Restricting spending for some meant 'going without' things such as new clothes, making repairs or decorating the house. A few participants had used all, or a substantial portion, of their savings and several, who were saving at Wave One, said that this was no longer possible, even when it had been only small amounts. People were concerned about their future financial security where they feared that they would have insufficient funds to cover even medium-term needs. One participant described the emotional pressure of managing in ever-constrained circumstances as becoming 'more of a strain and worry now'.

Among this group there were less households claiming means-tested benefits than those who were not, although several had enquired or tried to claim recently. A few had received additional benefits but these had not outweighed the compounded effects of multiple demands on their income. The fact that most of these participants had worked in the past, and several had previously experienced living on relatively high incomes, could affect their perceptions of their financial circumstances, particularly if they felt there was little they could do to improve their situation.

In an already comfortable financial position at Wave One

A few couples in the younger age range also perceived themselves to be worse off. However, this was only in relation to their immediate income/outgoings and, in contrast to those discussed above, they felt secure in their overall financial position because they had more leeway and

savings to fall back on. These participants had experienced a reduction in part-time earnings or had noticed increased general costs and had responded by cutting back on 'ancillary things' such as a second foreign holiday or installing a water meter, while still protecting their savings. The difference here is that, although these participants felt somewhat worse off over the last two years, they could make adjustments that did not inhibit their lifestyle or affect their longer-term 'solid' financial circumstances.

Managing financial well-being and the resources drawn on

Although many participants did not feel that they were any better or worse off than at Wave One, this does not necessarily indicate a static state, as often changes had been absorbed, balanced out or managed. Good pensions and savings can protect against changes that could otherwise be detrimental to financial well-being. However, where these were not available, other resources were relied on to maintain a steady state. For participants in more constrained circumstances, preventing a decline in financial well-being can require considerable effort and organisation. In discussions of financial issues at both Wave One and Wave Two, participants commonly used the term 'I can manage'. Managing included the use of formal and structural resources, and informal ways of organising finances, as well as drawing on personal attitudes and strategies of coping to respond to changes or to maintain stability.

Use of formal financial systems

Structural financial systems are a key element to managing finances. Participants discussed access to the benefit system, their use of financial services and the pension system.

Benefit receipt

Receiving new or increased means-tested and/or health-related benefits since Wave One could contribute to participants' improved financial well-being, balance out increases in other expenditure such as health care, or make up loss of income where paid employment had decreased or stopped. Council Tax Benefit and Housing Benefit

also acted as protection against increased rents and council tax rates.

Participants were sometimes unaware of the benefits available, did not realise that they might be eligible or were uncertain about the application process (see also Age Concern, 2006; Blunt *et al.*, 2006). Several had been surprised to receive (additional) means-tested benefits since Wave One – telephone calls 'out of the blue',² home visits or a link from another benefit had initiated applications. Family or friends had encouraged applications for Attendance Allowance where participants were hesitant about applying or uncertain whether their mobility was impaired enough. The application procedure itself was often not as daunting as people had perceived, in part because of the approach and helpfulness of staff on the telephone and through face-to-face visits. As at Wave One (Hill *et al.*, 2007), it was the older age group who held most negative attitudes towards benefit receipt (see also Moffatt and Higgs, 2007) with participants feeling 'on the cadge'. They also stressed how 'truthful' they had been in making their application for means-tested or health-related benefits. Knowing others who received benefits and justifying it against years of taxpaying helped to ease these feelings.

Banking services and financial advice

Occasionally participants had adapted their use of financial services since Wave One. For example, a pension was now paid into a bank account following the closure of a local post office or bills were now paid by direct debit because a pension was paid directly into the bank. While some participants saw direct debits as useful, others were wary of automated systems because they preferred to have personal control over transactions. Several participants who had received house sale money saw advice from a bank/building society adviser as useful – a service that was also valued by someone who had been widowed a few years before Wave One but was still getting used to dealing with financial matters. For one participant with debts, advice and arrangements to reduce payments enabled the repayment of several loans and prevented a financial situation deteriorating.

The pension system

Prior to Wave One a new system of state pension payment was implemented (the Post Office Card Account).³ Reservations expressed at Wave One, particularly about remembering the pin number, were no longer raised and, in contrast, a few participants spoke of the advantages of the new system. Here, a couple of older single men were using the system to save by deliberately withdrawing less than their state pension amount and letting the balance accrue. Both had limited incomes including means-tested benefits and had not been able to save at Wave One:

I've got about 100 quid in me post office as I can go and draw on as well as me pension, that's reassuring. I mean, with the old type of pension book, you sign for it and you got the lot, and you'd spend it unless you was diligent and could save it, so I thought well last time when it went up I'll carry on and see how I go, and I've just drawn the same amount out and it keeps mounting up each week.

(Single man, aged 78)

While the post office account is not the best means of saving, given that it does not attract interest, for these participants the fact that they were now managing to save at all was seen as an achievement.

Informal managing strategies

Another crucial aspect of how people manage financially is at a more individual level. To help them adapt to financial situations, participants used various informal strategies, which enabled them to maintain financial stability or protected them against reduced financial well-being.

Family as a resource

Having family around can be a source of financial support in a number of ways. Some participants' families provided direct financial support by paying for participants' household items or holidays – things that those in more constrained circumstances were unlikely to have afforded otherwise. Where participants' needs had changed, family support with practical help at home, with transport or with house maintenance could negate paying for external services (see

also Dominy and Kempson, 2006). Although participants often recognised them with payment or some form of reciprocation (see Chapter 6), this was likely to incur less cost than formal arrangements. Furthermore, family (generally children but also siblings and nieces) had also been a source of indirect financial support. They provided advice and help with banking/saving, accessing grants or social services for adaptations, initiating benefit applications and sourcing goods and services cheaper via the internet. Just having someone to talk financial matters through with could be valuable, the absence of which was felt by a single participant with no children who had found it hard to make financial decisions alone:

I had no choice, I didn't know what to do. I'd got no money, no one who can help me, so I had to be a bit brave and make a decision. You either make the right one or the wrong one. I think I made the right one.

(Single woman, aged 72)

Knowledge/financial wherewithal

Financial knowledge was also a resource drawn on to manage and maintain a secure financial position. Participants who had substantial savings or investments tended to be financially astute and aware of how to get the most from their money – for example, the best use of financial institutions and close monitoring of investments. The few participants who had switched energy companies were financially comfortable and were in the younger age group. However, participants expressed hesitancy about doing this, even for a regular internet user: 'I'm very conservative, I stick to what I know'. As many older people do not use the internet and find company-automated telephone systems obstructive, the likelihood of 'shopping around' for cheaper fuel is low.

Conversely, lack of financial shrewdness can leave people open to dubious practices. Several participants in constrained financial circumstances had experienced attempts to charge them unnecessarily for things. For example, there were instances of attempts to charge participants to upgrade an alarm system, the doubling of an agreed price for a kitchen (this participant was still awaiting return of the deposit at the time

of interview) and a scheme where a company would have a claim on the property after putting in windows. These incidents had involved home visits and participants spoke of feeling under pressure and a 'nasty' salesperson, and they had sometimes not understood what they were signing. Although they had realised before it was too late, in one case only after a child had intervened, the experience had left them feeling vulnerable.

Budgeting skills

Participants with more limited financial leeway felt that the tight control of household budgets was vital to maintaining a steady financial state and, where necessary, dealing with increased demands such as rising costs or unexpected expenditure. Careful budgeting involved discipline and the range of strategies employed included:

- stocking up on offers and keeping in frozen food and essentials that could be used to fall back on if necessary;
- using a car to enable easier shopping at supermarkets, especially in rural areas where local shops were few and were considered to be expensive;
- using charity shops and knowing where to get cheap meals out;
- conserving energy use through controlled use of heating, (free) cavity wall insulation, a new boiler, minimal water in kettles, low-watt bulbs;
- saving small amounts each week to fund household goods or maintenance, or to put towards bills;
- 'living within your means', which could involve 'doing without' rather than going into debt – something that was generally frowned on.

Attitude as a coping resource

For some participants with limited savings and tight financial budgets it seemed that a stoical outlook was a valuable resource. Although they

had little alternative, accepting financial limitations, and in cases adapting aspirations, helped people to cope with the frustration of not being able to afford things or hankering after what was not possible – meaning a closer psychological alignment with their actual circumstances (Lelkes, 2008). Several participants said that they had accepted that they could not have what they were used to – for example, when they were working – and that they had learnt to cut back. 'Getting on with it' and 'not dwelling' on things were seen by some as ways to avoid pointless worry, especially because it was unlikely that they would be able to change the situation. As one woman who was finding it more difficult to manage and had limited savings to draw on explained:

I would like to be able to have the room decorated and not have to worry, you know just go ahead and have a new carpet. But I don't let it get me down because, if I start worrying about what I haven't got, I should get very depressed.

(Single woman, aged 70)

Resilience also helped them to deal with constraints: 'I've managed on a lot less'. One participant with debts seemed to justify his position by talking down the (unlikely) alternative of having a lot of money:

I know you can't live without money but it doesn't always make everything better. Because I think a bit of a struggle makes you tougher ... If you've got loads of money in your pocket, you wouldn't enjoy it so much.

(Man, aged 69, couple household)

Eric and Joan's story, presented below, illustrates how a couple have learnt to adapt to changes in their financial circumstances, which they did not envisage when they planned for their retirement. Importantly, it illustrates how they are 'getting on with it'. The case study shows that Eric and Joan are managing on a very tight budget and are using a range of strategies to cope with everyday rises in living costs, as well as more unexpected outlays. However, they are also aware that being on such a constrained budget has longer-term implications.

Eric and Joan's story

At the time of the first interview, Eric was aged 76 and Joan 79. They lived in an upstairs, privately rented flat on the edge of a city. Although the area had problems, the couple liked having shops and services on their doorstep and the community feel of the area. They paid a low rent and felt that the flat suited their needs as long as Eric could manage to get up the steps with his knee problems.

Eric had retired in his 50s when his demanding job had become too much. He had known that this would reduce his pension, but had received a good pay-out, which he had anticipated would last until he was pensionable age. However, the couple were hit by the 1980s' stock market crash and had to sell their property. Eric started working part-time when he was 70, partly for money and partly to keep himself occupied, and intended to continue working for the foreseeable future.

They had been refused Pension Credit because Eric's earnings and pension were too high, but had not applied for Council Tax or Housing Benefit as they paid a low rent and didn't want to 'rock the boat'. Eric was determined to 'work his way back up' and the couple were managing to save a little. Although their lifestyle was not what they had envisaged for their retirement, they had adjusted their outlook on life and felt that, as long as they had each other, they were happy.

Two years later Eric's knee problem was worse. He was still working, although driving was more difficult, as was getting up the steps to the flat. While he could manage for the time being, if his mobility became worse they would have to move, which would probably mean a higher rent. Eric felt this would be the trigger to give up work and hoped that they would then be eligible for benefits to help with rent and council tax.

Eric had kept track of changes in their income and outgoings. While their pensions had gone up a little, the rises in living costs, in particular utility bills and running the car,

had outweighed this, so overall they had slightly less money than at Wave One. In order to manage this and save a little, they tightly controlled their budget. Eric kept a close eye on supermarket prices and shopped around. He had also 'juggled' by cancelling items from the home insurance. Joan had always been good with money and used her well-honed strategies to 'squirrel away' money:

Every night he comes in, he'll go through his pockets. I have every five, every 20, every ten off him, the tens go in the yellow pig upstairs, the 20s go in the big whisky bottle, the fives go in my dimple bottle and then, when I've got £5 in the fives, and that takes a little bit of doing, then we reckon it all up.

As well as keeping a little 'worry money' back for emergencies, Joan kept the freezer well stocked. This had helped when they had been faced with a sudden car repair bill, as they could eat from the freezer for a week. However, setbacks like this ate into their savings and it was difficult to top them up again. Their aim was to save £20 a month because they were conscious that they did not yet have sufficient savings to cover their funerals.

Influences on spending and perceptions of need

The complex issue of declining spending in older age (Middleton *et al.*, 2007), possible reasons for this and its interaction with (perceived) need (Dominy and Kempson, 2006; Finch and Kemp, 2006) is an area worthy of further investigation. This section explores whether older people go without something because it is not affordable, they just do not want it or it is not value for money. Past experience and deeply held values influenced participants' attitudes towards spending and perceived needs, while other factors such as health changes could constrain both the ability and inclination to spend.

Past influences on current spending patterns/attitudes

Participants' experiences earlier in life established deep-rooted attitudes towards spending. These included: being brought up to be 'careful' with money (mainly in the older age group); their own experience of hard times (across ages); and in one case the 'business mind' from years of self-employment. These influences that had helped them manage over the years had become a way of life, including for those who now had high incomes or substantial savings. In some cases, participants who found it difficult to spend money, even though they could afford to do so, recognised the irrationality of the situation but found it hard to change lifetime habits. One couple explained how they were still adjusting to having more income after receiving benefits:

We're so used to scraping and scrapping, that it's very hard to go out and spend money although we've got it ... I couldn't just go and, for the sake of spending, I couldn't do it, it's just not in you after all these years. All my life I've been poor, it's only this last few years we've had, I've had any money.

(Woman, aged 71, couple household)

Often participants were proud of their thriftiness and saw spending money unnecessarily as 'giving in to weakness'. Principles of not wasting money and making things last sometimes led to a need to justify spending – for example, by replacing something only when it was broken or buying a Nintendo for 'learning' rather than leisure. Participants' desire for value for money (across income groups) was evident in everyday purchases where they described buying special offers and the satisfaction of getting a bargain. There was also a wish not to feel that they were paying more than necessary for something. This demonstrates that spending patterns can sometimes be linked to the willingness to pay, rather than the ability to do so:

I won't pay over the odds for things that I think are expensive ... I would buy it if I could afford it, but if I thought it was expensive I wouldn't buy it. I'm like that, I'm very cute on prices you know.

(Single man, aged 81)

Value for money as a potential barrier to meeting need?

Being cautious about spending money can be crucial to managing in constrained circumstances. However, the desire for value for money could act as a potential barrier to spending on things that might be helpful in people's lives.

Participants sometimes resisted paying for formal help or services despite having ample funds – the issue here was not affordability, but justification of cost. Even where it was recognised that paid help could be useful – for example, where health had declined – a few participants were put off by the cost not being seen to represent value for money for the (perceived) service performed:

It's no good getting social security because it costs a blooming fortune ... I mean it's about £8 an hour and they're not allowed to go up a pair of steps and they're not allowed to wash the floor either, is that it? That was it I think. But it's hardly worthwhile and I thought well I never got £8 an hour all my life and I'm not paying.

(Man, aged 79, couple household)

Views about council/social services provision were also influenced by the thought that the organisation was making what a few participants saw as excessive money from them. One participant had been 'really upset' to realise that social services received more of the hourly rate than the home help received herself. Another, whose private arrangement had temporarily stopped, felt that formal provision at £9 or more an hour was a 'rip-off', so was managing without. Cutbacks had also been made where services were no longer seen as justifying the cost. Here, one participant had stopped using a laundry service, as he felt the quality was below par and another had reduced the number of days she went to a day centre because the increase in price was viewed as excessive. One advantage to paying people privately for help was that participants could ensure that their money went directly to the person performing the service, which provided reassurance and an element of control.

Having low needs/wants

Participants across income groups sometimes emphasised their low wants and needs. A key

issue is the link between this and affordability – for example, the extent to which people genuinely do not want something or whether it is a way of coping with not being able to afford something.

As noted in previous research (Dominy and Kempson, 2006), this is a tricky issue to separate out. Some people in low/medium-income groups (mostly on means-tested benefits, mostly older), with limited or no savings, discussed how their lifestyles entailed low needs, but at the same time this enabled them to manage on their incomes and, in some cases, save. However, the fact that these participants saw this as their choice, rather than because of financial constraint, meant that they did not feel that they were ‘doing without’ or restricting themselves (like others discussed earlier in this chapter). Not drinking or smoking was mentioned repeatedly as an example of not needing to spend more, as well as not wanting new furniture and having non-extravagant tastes:

If I want a little treat you see I have it, but you see I haven't got expensive tastes, the things that I like are sort of basic things ... Well to me being extravagant would be like always buying Baxters' soups when you know I could have Co-op soups, which to me are just as good, I wouldn't have them if they weren't as good.

(Single woman, aged 84)

Participants who did have savings/surplus income also felt that, although they could easily afford it, they had no desire to spend more – for example, on holidays: ‘I don't like the heat’, or on things they did not see as needing: ‘neither of us could work a computer anyway, or a car, so there you go’. A key factor here is these participants’ non-materialistic values and contentment with what they had. As one gentleman noted: ‘I've never been a person that's envious of others’. At Wave One, participants across ages and income groups distinguished themselves from younger generations who they felt expected to ‘have everything now’, an issue reflected in other research that highlights public concern about increased consumerism and greed in British society (Watts, 2008).

Health/mobility constraints on spending

While health decline could put more demand on outgoings because of additional needs (see

earlier in this chapter), it also limited activities that could impact on spending (see Chapter 2). Where participants’ health, and in particular mobility, had declined they spent less on socialising, leisure interests and holidays. While some said that they did not want to go on holiday, their perceptions of need could be related to the fact that, to do so, would be enormously difficult to manage and lower energy levels meant less motivation towards activities: ‘as you get older you lose the lust for dashing around’. The issue here is that these participants had less choice about how money could be spent, as health restricted their options and influenced their desire for physical activity. Several participants were aware of the irony that they had more money now than in the past, but their health curtailed spending it:

When you was fit, all the years and years back, I couldn't really afford to throw £100 down the drain but now it don't matter, I can throw £100 down the drain, we can't go you see.

(Man, aged 79, couple household)

Thoughts about the future

Having sufficient financial provision for later old age is of concern, given the potential for increased need for support as people live longer. This section looks at people's thoughts about future finances, including their perceptions of how sufficient their finances might be, the potential resources that could be drawn on if necessary and plans that had been made since Wave One.

Sufficiency of finances for the future

How people looked ahead tended to depend on their current financial situation. As at Wave One, participants with higher incomes and substantial savings were generally content that these would see them through, and usually expected to leave reasonable inheritances for their family. A few of the older participants with reasonable savings were more inclined to spend money since Wave One, either on themselves – for example, on more holidays, a TV, keyboard, or private operation – or as gifts to family members. This was because they felt that they might as well enjoy the benefit of their wealth while they still could and that their savings

were going to be more than sufficient. An added factor for a couple of participants in their 80s with no children was an awareness of their age and that, although they had extended family, they had no responsibilities to leave inheritances to children:

Well I'm not going to live that much longer am I, by any law of averages. Now, if I was 63, that would be very different wouldn't it. I thought well I've got money sitting in the bank what's the good in it sitting there when I'm not using it.
(Single woman, aged 83)

However, a few participants were monitoring their spending in order to protect their savings. In some cases, this was despite having more than ample savings for their own needs. Sometimes this was influenced by experiences of past hardship and people spoke of an inbuilt dread of not having enough money, as well as the desire to ensure that they could provide for their families if children needed financial help in the future, or through inheritances.

Occasionally, younger participants (up to their early 70s) were limiting their spending and making an effort to preserve their savings because of an awareness that they might be required in later life:

I've got to really sort of think, well you don't know how long you're going to be here for, so you've got to sort of have that little bit of a bank you know.
(Single woman, aged 67)

However, for those with limited income and savings, looking ahead financially could be more about hoping that they would continue to manage in the present and longer-term planning was perhaps even meaningless:

Well I don't look too far ahead in the future, as long as I can keep going and paying my way ... Well you can't really have financial plans for the future when you, you're virtually rock-bottom with what you've got you see so, who knows, perhaps my premium bonds have come up this month, what few I've got, you can live in hope.
(Single woman, aged 70)

Experiences of poor health could influence thoughts about mortality. In one case, recent health problems had focused a participant's attention on the present, with any energy put into getting by day to day rather than thinking ahead:

I really haven't got any interest in saving. I mean I could be dead tomorrow couldn't I and could have spent whatever I'd saved ... I've other things to think about now.
(Single woman, aged 68)

For participants in rented accommodation with limited savings, having enough to cover funerals was sometimes seen as the key future financial plan and of importance given that they had no property to leave to family. An increase in benefit since Wave One had enabled one couple to save enough to cover funeral costs. However, where savings were not enough to do this, it was a real worry:

We need to work on it because we're not in a position where we can die tomorrow because we've got to stay alive for a bit longer! Yes, we've a plan not to die yet, because the other one can't afford it! So we've got to keep each other going.
(Man, aged 78, couple household)

Potential resources that could be drawn on

Apart from uncertainty about how long savings would need to last, there is also the issue of the resources available for older people to draw on. A few participants who were not claiming means-tested benefits expected the benefit system to kick in should savings go below a certain level, although others feared that their pension income excluded them from such help. The potential for family financial support was occasionally mentioned should anything 'really serious' happen – children were often said to be financially secure, indeed better off than lower/middle-income group participants. However, independence and pride would most likely make this a last resort (see Chapter 6).

In terms of funding future home or residential care needs, there was some uncertainty among

home-owners around entitlement to provision and reservations around selling property or using equity release (see Chapter 3). However, they were generally aware that they had potential options. Participants without property or substantial savings were aware that they had no means of funding residential care themselves and it was generally assumed that the Government would have to step in should the need arise. For some, having no property was seen as a relief in that they had nothing to lose. However, there was still uncertainty about the financial implications of going into residential care: 'In residential care they take your pension off you, I don't know whether they give you any pocket money' (single man, aged 81).

Plans made for others since Wave One

Occasionally, between interview waves, participants had taken action that could be seen as planning for the future. However, this was not necessarily for their own future, as, although it involved participants' own financial affairs, the action was often for the benefit of their family. This included direct transfers of lump sums of money, assets or continued or increased gifts to family members. These were often seen as a form of early inheritance, the advantage being that this ensured that money went where it was intended and avoided inheritance tax: 'I don't want the Chancellor of the Exchequer to have it, I want them to have it' (single woman, aged 86). It also gave them pleasure to be able to see their family benefit from such gifts.

Plans of longer-term benefit to family included altering house deeds (which it was thought would protect future inheritance), arrangements for future powers of attorney and updating wills. A couple of older participants were giving additional thought to setting their financial affairs in order by putting money into more accessible accounts: 'it's easier for anybody who takes over to deal with it'. Interestingly these were both participants without children. Those with family often mentioned detailed discussions that they had had with their children about their deaths. As noted at Wave One, planning for death was often an area of importance for participants, as it was something over which they could exercise control and ease any 'burden' on family.

Conclusion

Changes in participants' circumstances were easier to manage if they had money. Having a 'healthy' financial situation to begin with cushioned people from the worst impact of increasing outgoings and need in later life. Those without this struggled more to manage and any additional outgoings and expenditure were enough to push them over the edge. For participants on low incomes, additional benefits made a huge difference to their quality of life on a day-to-day basis but also provided financial security and peace of mind (see also Moffatt and Scambler, 2008). While practical support and encouragement to initiate contact and help with applications was a key component in accessing benefits, the fact that some older people still saw means-tested benefits as a hand-out rather than entitlement indicates that stigma is an ongoing issue – something not associated with the Winter Fuel Payment or free bus pass. However, it is the issue of larger sums of money, often sudden or unanticipated outlay, that can have most consequence for those who have limited leeway and are not necessarily receiving means-tested benefits. Given that older people are more constrained than younger age groups in their ability to earn money, their incomes are generally fairly static. Options are therefore limited to releasing money from property assets where these are held. However, this is not necessarily seen as a desirable or straightforward option (see earlier in this chapter and Chapter 3). How older people spend may not necessarily reflect what they need and, even where incomes had increased, participants' lifetime values had influenced how and what they spent. Moreover, keenness for value for money can inhibit older people, who may be out of touch with current hourly rates, in acquiring the services they need. More generally, there appears to be a need for wide-ranging information on current and future financial issues, particularly for those older people who live alone, who do not have family or other support services around them to draw on for advice and who maybe lack financial knowledge.

6 Ageing, identity and society

This chapter sets the participants' experiences in the context of getting older and what it means to them to age in England today. It demonstrates how their understanding and experience since Wave One impact on their identity and sense of belonging in society. It explores participants' feelings about ageing, old age and their contributions to family and wider society.

Perceptions of old age and ageing

Tulle-Winton (2000) notes the contradictory nature of ageing, recognising that the experience of old age is something that is sometimes felt keenly and sometimes forgotten. Old age is experienced both bodily and socially, and being old, therefore, is a fluid and unfixed identity, which is subject to interior and exterior challenges. This explains the often contradictory way that participants discussed ageing – on the one hand it was others that were old, on the other hand it was themselves.

This section addresses two distinct but related concepts: how older people perceive old age in general and how they perceive their own ageing. These views have implications for the way that ageing is perceived by all generations and how we, as a society, respond.

The 'othering' of old age

Participants viewed being old as something they most definitely were not. They believed that other people were old and this applied whether participants were in their 60s, 70s or 80s. 'Old people', they believed, were different from them in that they were seen to moan about their health, were inactive, 'vegetated', were unable and unwilling to participate in their wider communities and were content to be dependent on others:

I don't want to get like that. They just sit there, 'oh I can't do this, and I can't do that'.

(Single woman, aged 68)

Participants believed that older people sounded, looked, acted and even thought differently from them. As one woman, whose attitude, despite her restricted physical mobility, was very much to live life for the moment, pointed out:

Well to be quite honest I find that older people don't think the way that I think. You see some as I was telling you about my friend, 'oh let him have a car', I mean we're talking about 70 years old now, not 20- and 30-year-old people, 70-odd ... have what you can while you can and, if you want anything, don't hesitate to have it.

(Single woman, aged 75)

The paradox was that many participants had displayed such behaviours themselves, depending on their own circumstances at any given time.

Those helping to organise activities for others also marked themselves out very deliberately as different. In some cases this was because they were ten or more years younger, although an 80-year-old man who organised Christmas parties for 'the pensioners' highlighted that the role of provider, rather than receiver, was significant in distinguishing between who was perceived as old.

How older people feel they are perceived

The markers of old age

Looking young was a particular concern of many of the women participants and they often asked whether researchers thought they looked their age. Many believed having certain attributes contributed to looking old even if they didn't necessarily feel it. Featherstone and Hepworth (1991) refer to this strategy of believing that the real self lies beneath the old exterior as the 'mask of ageing'. Women, in particular, expressed a fear about being viewed as an 'old' woman. Some deliberately opted for more contemporary fashions, which they believed contributed to feeling younger:

Let's put it this way, I'm probably daft because I don't want to grow old, I don't want to dress like an old person ... I like my jeans, I like my cropped trouser, I like tops, I like anything so I will not grow old or look old.

(Woman, aged 72, couple household)

Several older women were conscious about how their legs looked. One 79-year-old woman noted her surprise one day at discovering that she had 'old woman's legs'. Another was proud to have been complimented for having attractive legs even though she had difficulties in walking.

In contrast, some of the male participants believed that getting older manifested itself in their physical ability and inability, so much so that several insisted on giving researchers a demonstration of their physical fitness:

Oh it's, well I'm not quite the chap I was, I used to be as strong as a horse at one time, but them days has gone. I mean there's some jobs in garden I have to have done now, if I want a tree lifting or anything like that, I can't get it out, it used to be a piece of cake to me. It's just, as you're getting older, you get that little bit older and weaker.

(Single man, aged 86)

Walking sticks, mobility scooters and emergency alarms worn around the neck were also regarded, by both men and women, as contributing to an image of being old and were seen as symbols of dependence.

Well I see these people, men and women with walking sticks and I think you look a damn sight older than me, with a walking stick.

(Single man, aged 81)

Being old and visible

Many older women who had mobility problems and difficulties in getting around cared desperately about how other people perceived them. They expressed a dread of being seen as being in the way, of holding people up and, above all else, of being a nuisance:

Just getting on the bus, off the bus, because I have to pull meself up, I take me walking stick and I took, not that one, that one's my best, and it's getting up off the bus, you know, when I've sat for a while, I have to pull myself up, but I don't like people to see me, and I feel I'm holding them up, I don't like to be in the way.

(Single woman, aged 79)

In one case, a fear of being perceived as fraudulent impacted on how a participant with mobility difficulties managed when walking outside:

I know if I set out to walk up to the post office, it's a slope up there, I would have to stop four or five times on the way, pretend to be looking at something ... so that folks don't know that I'm in pain ... Because I don't take a walking stick when I go out you know, I feel, I mean I've heard folks say, 'oh she's after some benefits with her walking stick', but I never have walked out with a walking stick. I've took it on the bus with me, I've got a fold-up one, and if I'm in a strange place I'll use it, but as for walking up the road, no, because I've heard them talk about folks.

(Single woman, aged 79)

Covering up pain and presenting a capable and coping image was important to these participants and a fundamental way of maintaining their pride. The stigma of being old, then, is so great that it affects how older people themselves perceive old age.

Perceptions of own ageing

When participants were asked how they felt about their own ageing, they tended to discuss it in terms of 'slowing down' and of having less energy than they had in the past, rather than getting old. As mentioned in Chapter 2, many participants highlighted the need to pace themselves, as they noticed that it took them longer to do things than it once would have. Resistance to ill health has been discussed in Chapter 2 but participants, too, acknowledged its role as a way of coping with getting older.

So you are getting older but you still don't want to admit it, you know, I say we'll have to get out walking more. I'm getting stiff and out of, you know unfit like, but it's not really, you're getting old.

(Man, aged 69, couple household)

Not keeping up with grandchildren was also a worry for those providing care or just spending time with them. Despite thoroughly enjoying their grandchildren's company and the role they played in making them feel younger, many participants acknowledged that the physical effort required was occasionally a little too much. Furthermore, there could be differences in expectations between the generations when spending time together on holiday, for example:

I mean I have been once on holiday with my son and his family since I've been in this flat, but I didn't enjoy it very much. I mean I've slowed down obviously and four young children and I felt that I wasn't keeping up, do you know what I mean and, whereas they wanted to be in the water half the time, my body has rather changed and I don't feel like displaying it in public, you know.

(Single woman, aged 78)

Again, particularly for women, growing older meant looking different and needing to hide it.

It seemed that, for some participants, reaching 80 was a key factor in feeling older. This was sometimes in relation to having to attend medical appointments or being unable to have an operation. However, for some, there was also personal significance attached to reaching 80. One participant described her way of dealing with it:

I didn't think about age until I got to 80 and I thought to myself, Christ, you're 80. I thought I daren't go out, I might have a heart attack, so I sat myself down and I said, now why should you have a heart attack, you've never had any heart problems before, why should you suddenly have one now. It was just a number. So get on with it. So I got my coat on and went out!

(Woman, aged 81, couple household)

Ageing, then, brought about challenges that could be met in various ways, depending on participants' perceptions, experiences and understanding. Having a sense of purpose while ageing was one way of dealing with those challenges and vitally important in contributing to participants' own identities as they moved through later life, as described in the next section.

Having a role and sense of purpose

Making a contribution and having a role was important to participants, although the extent of their involvement depended on people's circumstances, which were subject to change. Of interest here is how different types of participation and involvement in society, and within family life, can provide a sense of purpose. From paid employment, through to voluntary activities, helping others, giving money and simply being able to impart advice or knowledge – all were ways of maintaining some sort of role. A great fear was of becoming dependent on others, which could mean feeling as though one's role in society or family was diminishing.

The role of work

Most of those in employment at Wave One had intended to carry on working and at Wave Two only one had stopped, although a couple had reduced their hours. As reported at Wave One, money was often not the motivating factor and the need for activity, 'keeping the mind active' and getting out and seeing people was important. One participant, who was finding it harder to do physical jobs in the home, was concerned that if he did not work he would 'just vegetate'. Being treated with respect and being valued by employers for doing a good job continued to give these participants a sense of achievement. Conversely, feeling pressurised and not liking the 'attitude' of an employer led to giving up a job where a participant had started work between waves of the research.

Most of those still working hoped to continue as long as they could, although this was less strongly felt by those who worked mainly for the money and who had more physically demanding jobs that were becoming more difficult. One

participant, whose mobility had declined between interviews, expected to give up work in a few years (when he was 80) but intended to expand his voluntary activities to fill the gap. However, for others, the thought of stopping work was 'lousy' in that it would leave a gap in their lives and could lead to isolation, particularly for widow(er)s. One view was that working warded off ageing and ill health:

I think it would deteriorate because there isn't anything in life to go for, to try and achieve is there. I should be sitting here looking through a window thinking, you see ... I should have to get myself one of them little wheelie cars.

(Single man, aged 78)

Participation and activity in society

Many older people could be seen as having time as a resource. Participation in voluntary and community activities is likely to be beneficial to the wider society, but also making a contribution can provide a sense of purpose for participants. Activities ranged from formal involvement in health authority consultation processes, responsibilities at community centres, social clubs or local organisations and church warden duties, to helping out in charity shops, organising raffles, collecting newspapers or knitting for charity, and in one case taking in homeless people. As with paid employment, the value of such roles included not only mental stimulation and contact with others, but also satisfaction at being able to help other people: 'I feel as if I'm doing something good and I feel better for it'. One participant had strived to maintain his charity work by making alternative arrangements after he had giving up driving. Others had reduced their roles, sometimes deliberately, in order to step back from the responsibility and/or for health reasons. However, where this was not a choice, one participant felt as though he now served no 'useful function'. Although most people got a lot out of their involvement, it had occasionally become a source of anxiety. This tended to be where organising others was becoming difficult, the responsibility was becoming too much or there was pressure because it was felt that there was no one else to take over the role. The difference here was that

participation was not necessarily on participants' own terms.

Helping others/having a role in others' lives

As noted in earlier chapters, help from others was a valuable resource. However, the practical, financial or emotional help provided by participants could also be an essential form of support, in particular for family members.

Providing practical help

Practical help included childcare, cooking, washing, gardening and lifts. Care and support for family had sometimes increased where the circumstances of others had changed – for example, to help an ill sibling or to look after grandchildren when a daughter had returned to work. Changes in participants' own lives were more likely to signify a decrease in their support provision where a health decline or episode made physical help for others too much, or when time was wanted to do other things.

Financial support

Giving money to family from house sales or regular sums of money (particularly where high/medium income), sometimes with a proviso not to be spent on 'silly things', were seen as ways of contributing to the well-being and success of their family. This could be of particular importance where it was difficult to provide practical help because of health or distance. As well as acknowledging the satisfaction of having an ongoing influence or role in their families' lives, participants sometimes stressed their responsibility as a parent in regard to practical and financial support: 'anything I can do to make their life easier I've got a duty to do it'. For participants with poor health and mobility, money given by way of reciprocation for help could be a way of easing feelings of 'guilt' and redressing the balance of increasing dependency. 'Paying a son well' for lifts to the hospital or giving health benefits to a daughter made it easier to accept and justify levels of support. Where a participant was now unable to walk unaided, she gained great pleasure in giving money and gifts to friends and family, as it was one area of her life over which she had control – being still financially, if not physically, independent:

I just have to look on the bright side and make people happy and family around me, friends and, if they're smiling, you know.

(Single woman, aged 75)

Imparting advice

Being able to influence younger generations gave some participants a sense of pride, particularly where it was felt that their advice or values had been taken on board. Sometimes this stemmed from financial giving through encouraging grandchildren to save, reward for studying hard or helping family to achieve aspirations. However, simply being consulted, listened to and heeded was extremely rewarding to participants, as it signified that they still had worth, despite age gaps and physical or geographical limitations.

The fear of a diminishing role

As seen from previous chapters, managing change often related to ways of maintaining independence and a big fear was becoming dependent on others. Sometimes this was linked to notions of relinquishing established roles – of parent, authority figure, provider of support. As one widowed participant explained in relation to future care:

Why should my kids look after me? It's me that's supposed to look after them and help them. Not them do it for me.

(Single woman, aged 68)

A few participants noted changes or occurrences, which, albeit due to the good intentions of their family, to them signified the potential erosion of independence. A daughter's plan to move her mother closer was resisted: 'I've always been in command and I don't intend losing it' and, while appreciated, a family's concern could be construed as stifling:

The funny thing about what we don't realise, and not many people do I suppose, is how caring the family are. Although I criticise about

[son], he's worried all the time about us. 'Don't do that dad. Why do you do that? Don't stand on that stool you'll fall. If you break your leg, well.' I can't breathe.

(Man, aged 82, couple household)

Not being able to do things they once did had an impact on participants' pride and depending on others for everyday tasks was upsetting and involved having to wait for, and rely on, family help – for example, for meals, to be with them when bathing and using DIY tools. Repeated references were made to being a 'burden' on family, indicating a loss in status and worth for participants who, in the extreme, felt as if the parent and child roles had reversed. This was explained by one participant whose worsening health had made her increasingly reliant on her daughter:

Woman: *I think, this is what I've thought myself, I've thought well when you're a kiddy and you're growing up, you're learning. But when you get older, when you start getting older, you start going backwards.*

Interviewer: *In what way?*

Woman: *Well I feel as if I'm a kid again. You know, when I'm round at [daughter's] I feel as if I'm a child and she's talking to me as if I'm a child.*

Interviewer: *How does that make you feel then?*

Woman: *Not very good, not very good. And I think, well I suppose I am really. It's when I'm on my own and I think what I used to do and no longer can I do it, that's the hard part. I don't accept it very well.*

(Single woman, aged 79)

Conclusion

This chapter has highlighted that ageing is a social and bodily process that affects how people feel about, and experience, old age. As a society we need to think about how we, too, respond to ageing and old age. This chapter notes the sense of loss that ageing brings to the person, the fear of dependence and the constant work required to continue to avoid it. However, it also highlights that having a role plays a positive part in older people's lives, and that a sense of purpose and value can be gained in numerous ways. While older people's active participation in their communities is recognised and encouraged, the roles provided in private can also be very important. The opportunity to have a voice and be listened to is extremely valuable, in particular for those experiencing a different form of ageing, namely ill health and isolation.

7 Conclusion

The key aim of this research was to discover how older people plan, use and value their resources as they move through later life. The longitudinal component of the research is therefore crucial to enable a thorough understanding of the transitions that take place in older people's lives and the resources that they draw on in order to manage these transitions or, indeed, to prevent aspects of their lives from deteriorating.

This study brings added value to existing research as it illustrates how any changes experienced by older people, in particular in their health, can have wide-reaching consequences. The findings demonstrate the impact of such changes and how this permeates into many other aspects of older people's lives. The research also highlights the uncontrollable and unanticipated nature of change in later life. It was, therefore, often perceived as difficult to plan for.

Exploring older people's lives longitudinally has revealed the complexity of the many lives involved in this study and, importantly, the effort made to retain independence in the face of difficult circumstances. The findings counter the notion of passivity in later life, with many older people making concerted efforts to adapt to their changing situation – even when these changes were beyond their control. They managed to do so by drawing on a wide range of differently available resources. Longitudinal research also shows how some changes take time to make an impact on older people's lives.

Resources in later life

The findings highlight the complex interaction between a range of resources and change. Where available, resources can act in two interlinked ways. First, they can act as a 'managing mechanism' to be drawn on and used to help people adjust to, and cope with, change. Second, they can act as a 'protective force', which can prevent change and/or lessen the impact of it.

The findings highlight the diversity of resources that people had available to draw on. They include personal, social, structural, economic and psychological resources.

Using resources to manage and protect against change

Health is a crucial resource and it was the loss, in particular of mobility, which had the most effect on participants' lives. How participants were able to manage depended often on the presence of other resources.

Social resources included partners, families, friends and neighbours who could be drawn on for practical, as well as emotional, support. Families, and partners in particular, were a key component in participants' ability to manage health decline, as they often stepped in to provide support in the home and with transport. Family support could also mean less need to pay for help, which could protect participants from drawing on their own finances. Families often also played an important advocacy role – for example, in accessing adaptations or benefits and services.

Having financial resources to draw on can, again, be a crucial resource to manage ill health and to maintain independence more generally. Being able to pay for help or aids in the home, or taxis, for example, can lessen the impact of change. Moreover, those with reasonable incomes and savings were less vulnerable to rising living costs and could also cover any unexpected outlay.

Formal services and state provision could make a huge difference to people's lives. For example, accessing specialist health services and adaptations helped people to cope with declining health or mobility. Grants to improve properties, and, in particular, new benefit claims, could make a tremendous difference to participants' quality of life. The findings also demonstrate the impact of free local bus travel and how this had expanded the lives of some participants.

However, the use of, and access to, services, grants and benefits often depended on having the right knowledge. Being aware of what is available, what you are entitled to and how to access or apply for this is crucial to meeting older people's changing needs (see further below). Furthermore, participants with financial wherewithal were able to get the most from financial institutions, while others were more vulnerable to being exploited.

The findings also highlight how psychological as well as practical resources were drawn on to help people manage and cope with change. For example, older people were both determined to help manage a health decline and coped with their frustration by accepting what they could no longer do. They also drew on their life experiences to help them deal with change.

Lack of resources

While all of these resources can be used to protect and enhance older people's well-being, a key finding of this research is the difficulty that certain older people face when they do not have access to the resources that they need to help manage changes in later life. This means that they are in a weaker 'starting position' and are more vulnerable than others. As a result, maintaining their independence can become harder – for example, if they have to negotiate access to their own care and support.

Participants living alone and without family nearby were in most need of practical support when their health declined, and at risk of isolation and loneliness. Furthermore, the research demonstrates that some people without sources of support who are not known to social services, and also some home-owners, might not be aware of the formal resources that could be available to them.

Lack of mobility, in particular, could have a far-reaching impact on people's ability to do everyday tasks and to socialise. Moreover, participants with limited mobility missed out on the benefits of free bus travel and therefore incurred additional cost or reliance on others. Declining health could also involve additional costs. Again, the ability to manage this depended on the extent of available financial resources. Furthermore, health decline often involved a combination of multiple conditions, which impacted on people's ability

to cope. It was hard enough to cope with just one illness. The onset of another made things especially difficult.

Those who were already in constrained financial circumstances at Wave One found it more difficult to cope with rising living costs, as they had very little to fall back on. Sometimes, managing their situation was a balancing act, so, if an unexpected demand on their finances occurred, it could tip the balance. Again, lack of knowledge about how to get the most from their money or what help could be available meant that those in an already weak position found it most difficult to get out of it.

The findings demonstrate that psychological factors can also be a hindrance in meeting needs. Resistance to admitting need – for example, for a stairlift, mobility aid or help in the home – or reluctance to spend money even if something can be afforded, can also be a barrier to people accessing resources that might make life easier.

Helping older people to meet their needs

As highlighted above, the research findings demonstrate that, with access to appropriate resources, older people are able and willing to adapt to change. However, it is where people are lacking, either in resources or support, that they can experience difficulty meeting their needs. Several issues are of interest to policy-makers, such as how best to provide information and services that can help improve the lives of older people.

Information and support

There is a real need for clear and reliable information about a whole host of issues, 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 the most need, and to some who may resist admitting that need (see also Sykes and Hedges, 2008).

Financial information services need to be seen to be trustworthy and independent and, from this research, personal contact appears to be the best way of delivering such information to older people.

The range of financial information required covers benefit entitlement, use of banking, making a will and funding future care. The findings support the need for the recently announced national Money Guidance Service (HM Treasury, 2008b).¹ A further policy response that could help overcome the stigma of claiming benefits and lack of awareness of entitlement is automatic payment based on potential eligibility, which has been suggested as a possible way forward (Help the Aged, 2007).

People feel daunted about, and need to be emotionally comfortable with, the idea of moving in order to take that step. Policy-makers need to find ways of encouraging people to think ahead in later life, particularly in relation to staying in, or moving from, their home. Where people had moved they were positive about the benefits. Including the personal experiences of people who had moved in information about housing choices and support might be helpful in allaying fears about the transition.

The research findings highlight how one change in an older person's circumstances can affect their need for a range of resources. Therefore, providing joined-up support and information such as through LinkAge Plus should help contribute to maintaining independence in later life (Ritters and Davis, 2008).

Chapter 4 demonstrates the importance of transport, and being able to get out and about, to social inclusion. While the introduction of free local bus travel was positively welcomed, some older people were excluded from its benefits, particularly those with limited mobility or who lived in rural areas. Some form of concession to be used against other modes of transport could be a possibility. Age Concern notes that the Department of Health (DoH) is exploring a pilot transport component within Individual Budgets that would entitle people to concessionary travel for social care reasons (Age Concern, 2007, p. 112). However, this research suggests that the benefits of free transport are much wider than this and supports calls for an alternative to the bus pass such as taxi tokens, community transport or free dial-a-ride schemes (Help the Aged, 2008).

The research findings raise potential implications for the introduction of personalised budgets. The intention is for people to choose where to access services. However, there is a

possibility that those with a keenness for value for money, and who may be out of touch with current hourly rates, could face dilemmas over making decisions about procuring services. Therefore, information, advice and advocacy support are likely to be essential aspects of the introduction of personalised budgets for older people (DoH, 2007b; Glendinning *et al.*, 2008).

Without targeted information, delivered in the most appropriate way, some older people are likely to face difficulties with accessing and negotiating their own support.

Meeting financial needs

Older people in constrained circumstances seem most affected by general increased outgoings. However, they are also most likely to feel the benefit of policy interventions such as the recently announced (one-off) rise in the Winter Fuel Payment (HM Treasury, 2008a) or potential realignment of pensions with earnings (DWP, 2006).² The key to these older people's financial well-being will be whether such government policies can indeed serve to balance increased costs of living – an issue of particular relevance given substantial price rises in the months after these interviews took place.

Mainstreaming older people's needs

The research highlights the importance of mainstreaming older people's needs, so that policy-makers see them as part of the norm, rather than as unusual or problematic. The findings show that old age can be stigmatised and that older people may be reluctant to admit a need for adaptations, for example. The Government has made a start in addressing this through the National Strategy for Housing in an Ageing Society (DCLG, 2008). This introduces the idea that adapting homes to make them more manageable in later life could become the norm and is welcomed as a step forward in seeing those in later life as a fully included group within society.

This research shows the importance of a safe and inclusive wider neighbourhood to older people's well-being and this is also widely recognised by Government (DCLG, 2008; HM Treasury, 2007b). This study adds to existing research (see also Help the Aged, 2008; Waters *et al.*, 2008), which suggests the need to directly

inform older people that their needs are being taken into account in the face of what they perceive as an uncertain world. This particularly relates to changing community dynamics, the attitudes or behaviour of those around them and the environments from which they sometimes feel excluded.

Another possible solution to mainstreaming older people's needs is to introduce an Every Older Person Matters policy framework, which could draw on the Every Child Matters framework as a way of prioritising and addressing older people's needs. As the Audit Commission (2008) has noted, Every Child Matters provides clear guidance, processes and a legislative framework, which would considerably help to improve the services and outcomes for older people.

Transitions and ageing

This study shows that, for many older people with poor health and mobility, being old means more time spent waiting for some form of help, from whatever source. Change, then, for many of the participants brought about a degree of movement from independence to dependence, which impacted on their identities as older people and contributed to feelings of 'being a burden' or 'a nuisance'. The research highlights how older people can sometimes feel powerless or ignored. However, it also shows how having a

role in life can ease this perception. Ensuring that older people participate fully in society is a key aim of government policy and the Active Ageing Agenda (DWP, 2005). While this promotes the active involvement of older people within their communities, the research findings demonstrate the importance of having a role in private. The value of having a voice and being heard should not, therefore, be underestimated. Care must be taken to ensure that those experiencing a less overtly active form of ageing are not removed from the policy limelight.

This research demonstrates the extent to which ageing is a social as well as a bodily process, and that the relationship between independence and dependence is socially determined by the resources that people have to manage the physiological challenges that ageing can bring about. This, in turn, means that dependence in later life is not inevitable, as independence can be supported by a wide range of social and economic resources.

However, the findings also demonstrate that older people are not born old; they are a product of their past experiences. How the ageing process is navigated depends on the resources that older people have at their disposal when they enter later life. It is essential that people begin later life with enough social, economic and psychological resources to act as a 'buffer' to the negative impact of change.

Notes

Chapter 1

1. The numbers of pensioners in relative poverty rose by 300,000 to 2.5 million (before housing costs [BHC]) and by 200,000 (after housing costs [AHC]) to 2.1 million between 2005–06 and 2006–07. However, overall, between 1998–99 and 2006–07, the number of pensioners in relative poverty has fallen by 200,000 (BHC) and 900,000 (AHC). Relative poverty is defined as 60 per cent below contemporary median income (DWP, 2008a). The risk of poverty is higher among pensioners who live alone, are aged over 85, live in privately rented accommodation, or are from minority ethnic groups.
2. The research for this project did not take place in a Link-Age Plus pilot area.
3. Wave One explored how people had planned for retirement and their reflections on those plans.

Chapter 2

1. Formal support refers to paid support, which can include family and friends but refers mostly to 'outside' external help.

Chapter 3

1. The importance of place (being in a reasonable area, near to family and existing social networks), wanting more than one bedroom, so that visitors could stay, and suitability for pets were key housing criteria for some older people in this study, as reflected in other research (Croucher, 2008). While such factors perhaps limit housing choices, they are likely to contribute to quality of life in older age.
2. Handyvan was a service operated by the local council and Help the Aged to help older people feel safer in their home through the provision of security equipment, locks and smoke alarms.

Chapter 4

1. Free, off-peak, local bus travel within the area was introduced in April 2006 (between interview waves). In 2008 (since the second wave of interviews), this was extended to local buses anywhere in England.
2. This review was completed before the introduction of concessionary travel for people aged 60 and over in 2006.
3. Attendance Allowance does not contain a mobility element.
4. Help the Aged (2008) notes that 45 per cent of older people do not use buses because of mobility problems.

Chapter 5

1. It should be noted that these interviews took place in summer/autumn 2007 and, although the impact of gas, electric, petrol and food price increases had been felt, the cost of such commodities has subsequently increased further.
2. One participant said that they were contacted by the council but others were not always clear about who had telephoned them or, in one case, what benefit it was in relation to.
3. The Post Office Card Account replaced the book with a card and pin number and also the whole amount does not have to be withdrawn at once.

Chapter 7

1. As recommended by the *Thoresen Review of Generic Financial Advice* commissioned by the Government (HM Treasury, 2008b).
2. Announced in May 2006 (DWP, 2006), but not due to come into effect until 2012.

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Appendix:

Design, methodology and sample

This appendix provides further detail about the research design, method and sample. This project was designed to provide a detailed understanding of how older people plan, use and value the resources available to them to achieve an acceptable quality of life. A qualitative longitudinal approach was adopted to meet these aims. Longitudinal qualitative studies highlight the complexity of people's lives, the interaction of different resources on which they draw and the structural context within which they operate (Corden and Nice, 2007; Millar, 2007; Smith, 2003). Biographical approaches, which 'walk alongside' participants (Thompson *et al.*, 2004), capture events and happenings, as well as people's subjective views and attitudes, which can influence their decisions and actions. This research consisted of two interviews, two years apart, to explore how older people's needs and resources changed over time, the impact of changes in their lives and how these were managed.

The appendix of the Wave One report (Hill *et al.*, 2007) provides further detail about the recruitment of participants and the first wave of interviews.

Project Consultative Group

Other studies have highlighted the value of older people's 'meaningful involvement' in research, as they are 'best experts' to inform understanding about issues they face (Dewar, 2005; Joseph Rowntree Foundation, 2004). While participation can take many different forms and levels of involvement, it is important for it to be built into the research from the start (Clough *et al.*, 2006; Joseph Rowntree Foundation, 2004). Consultation with older people was included in the design of this project through setting up a group of local

older people. The purpose of this group was to provide guidance and advice to the research team throughout the project and to ensure that the issues and concerns of older people were represented in the research. A group of twelve older people met with the research team at various stages of the project – this had reduced to ten by the last meeting, as one had moved and another had died. The group provided valuable advice about recruitment and research materials, and about planning the interim contact and second interview, and commented on each wave of research findings.

Attrition

A first set of 91 interviews took place in 2005. While the sample size allowed for potential attrition over four years, the research team built in additional processes to keep in touch with participants to minimise this as far as possible. This included contacting participants by telephone one year after the first interview and sending them Christmas cards every year, accompanied by an update about the research and a reply slip to amend contact details.

A second face-to-face interview took place in 2007 with 78 of the original 91 households. Of the 13 who did not take part, five participants (and/or their partners) were experiencing severe health problems, including stays in hospital, and could not cope with being interviewed at that time. Two participants in couple households who had been interviewed together with their partners at Wave One had recently been bereaved and also felt unable to take part. However, several of these participants wished to be kept in touch with the research, and hoped to be involved if further waves took place. Two single participants had died and the research team were unable to contact two others. Only two participants dropped out, purely because they were no longer interested in the research. The attrition rates were spread fairly evenly across single and couple households, age groups, and low- and medium-income groups (see further below).

The sample

Table A1 provides a breakdown of the main sample characteristics at Wave One and Wave Two.

Table A1: Sample characteristics at Wave One and Wave Two

Sub-groups	Wave One	Wave Two
Age 65–74* at Wave 1	44	38
Age 75–84 at Wave 1	47	40
Single man	20	17
Single woman**	30	27
Couples	41	34
Low income***	32	21
Medium income	49	47
High income	10	10
People from minority ethnic groups	6	6
Total interviews	91	78

*Age of main respondent – a few had partners who were younger or older than this range.

**One single woman was part of a couple at Wave One but was bereaved between interviews.

***Households were divided into income groups for the Wave One analysis (see Hill et al., 2007). Where there was partial data, a ‘best estimate’ was used. A standard categorisation of below the 60 per cent median income after housing costs was used to derive the low and middle sub-groups, and a third ‘high’ category was introduced, derived from interview data. Rather than undertake a detailed collection of financial data at Wave Two, the three categories remained in use. However, where people had experienced changes in financial circumstances between Wave One and Wave Two, or further information was revealed during the second interview, households were reallocated to a different group (this was generally from the low to medium category).

Participants were from a range of localities, including a city and suburbs, towns and villages, and rural areas. The majority (51) were owner-occupiers and, of the 27 renting, 17 were in warden-controlled accommodation. Thirty-eight households were in receipt of means-tested

benefits and 28 received health-related benefits. Twelve participants had been in paid work since Wave One.

In terms of experiences between interviews, one female participant who took part in Wave Two had been bereaved since Wave One. Only three participants felt that their health had improved overall, 40 reported health declines, 15 had experienced an episode of ill health and 20 felt about the same. Financially, 18 felt better off, 11 worse off and 48 around the same. Four households had moved since Wave One. These groupings based on change were drawn on in the analysis (see below).

Analysis

A matrix summarising participant information across different aspects of their lives at Wave One, at the interim contact and at Wave Two provided an overview of participants’ circumstances at each stage of the research, highlighting where change had occurred. Interviews were transcribed verbatim and imported into Atlas.ti (a qualitative data analysis computer software programme). The data was explored for themes and emerging issues. Cross-sectional analysis included the use of sub-groups based on sample characteristics and by types of change experienced between the interview waves. Rather than purely comparing circumstances at Wave One and Wave Two, the focus of analysis was on participants’ experiences over the two years. This allowed an exploration of how any changes had come about, the issues faced by participants in dealing with change, the resources drawn on to help them manage and adapt to change, as well as the impact of change. We were also able to capture events that might not necessarily be seen as an obvious change but could still affect people’s lives – for example, experiences of ‘episodes’ that could leave a lasting impact. Furthermore, this approach also provided a valuable insight into how older people managed to maintain stability and prevent or resist change.

The Joseph Rowntree Foundation has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy-makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the authors and not necessarily those of the Foundation.

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