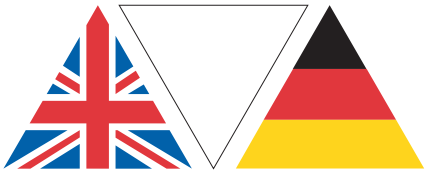

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Ageing and Social Policy: Britain and Germany Compared

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Ageing and Social Policy: Towards an Agenda for Policy Learning Between Britain and Germany

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Preface

This report is one of six commissioned by the Anglo-German Foundation in an effort to give added focus to its work in supporting comparative research and discussion of key issues facing policy-makers in both the public and the private sector in Britain and Germany.

Topics were selected for their relevance in both countries, and for their potential to yield policy-learning dividends. Authors were selected for their expertise in the 'state of the art' in Britain and Germany. They were asked to review current knowledge, and to identify gaps in that knowledge, which might form an agenda for future bilateral research and discussion.

The Foundation's Board of Trustees will use the reports, and the reaction and comments they generate, to assess the potential of each topic as an area of focus for future investment by the Foundation.

Introductory remarks

The aim of this short study is to present our main findings concerning the situation of seniors and the corresponding policy approaches and research perspectives in the United Kingdom and Germany within a comparative framework. In addition, specific fields in need of action in each country are outlined. In this context the current debate about the future of social policy with regard to demographic change is also taken into account. Research suggestions are proposed for the field of ageing and social policy for older people, and these may serve as guidelines for the Anglo-German-Foundation in its decisions about which projects to sponsor.

The study begins with the two country reports with corresponding structures. These reports are followed by a direct comparison and an outline of recommendations for comparative research projects derived from our analysis.

1 Ageing and social policy for seniors in Germany

1.1 Demographic data

At the end of 2000 about 82.2 million people lived in Germany. Of these 7.3 million (8.9 per cent) were foreigners. The share of those aged 60 and over amounted to roughly 23 per cent (about 19.0 million), that of persons aged below 20 to roughly 21 per cent (about 17.3 million), while those aged 80 and over accounted for almost 4 per cent (about 3.1 million).

On the whole, the (current and future) demographic situation in Germany is characterised by the following megatrends which, to varying degrees, affect all EU member states: the process of population ageing, which has already been observable for a long time, is progressing further. This is due to a decrease in the birth rate to a level a third below the rate required to maintain zero population growth, and to an increase in average life expectancy. In its ninth co-ordinated population prognosis of 2000, which encompasses the period up to 2050, Germany's Federal Bureau of Statistics expects the birth rate to remain constant at its current low level. At the same time, average life expectancy at birth will rise from 74.0 years (males) and 78.1 years (females) today to 80.3 years and 84.5 years respectively in 2050. The remaining life expectancy of a person aged 60 will rise from 18.9 years (men) and 23.3 years (women) today to 21.6 years and 26.7 years respectively in 2050 (see Table 1.1).

The consequences are a decline of the total population, a decrease in the absolute number and proportion of young people, as well as an increasing number and proportion of older people, especially very old people. According to the Federal Bureau of Statistics, by 2050 those aged 60 years and over will account for about 36 per cent of the population, those aged below 20 years will decrease to about 19 per cent and the total population will shrink to around 70 million people. By the same time, the proportion of

Table 1.1
Population of Germany by age group, 2000–2050 (millions)

Age group	2000	2010	2020	2030	2040	2050
0–20	17.5	15.4	14.1	13.4	12.4	11.5
20–30	9.6	9.7	9.0	7.9	7.6	7.2
30–50	26.0	24.2	20.6	20.1	18.3	16.9
50–65	15.5	15.7	19.3	16.4	14.7	14.6
65 and older	13.3	16.4	17.2	20.0	21.5	20.2
Total	**81.9**	**81.4**	**80.2**	**77.8**	**74.5**	**70.4**

Source: Statistisches Bundesamt (2000: 26)

those aged 80 and over will increase to more than 11 per cent of the total population. These trends are often characterised in Germany as 'threefold ageing': the absolute number of older people is increasing; their relative share of the total population is rising; and they are living longer lives. If it had not been for immigration, the (total) population figures would already have shrunk. Even if it is assumed that immigration continues to increase, these developments cannot be stopped; at best they may be lessened.

As a result of the demographic changes discussed, the need for action in social policies for the elderly is obvious. In particular, the topics of working life (see Section 1.2), securing income in old age (Section 1.3), health and caregiving requirements (Sections 1.4 and 1.5), catering for other infrastructural needs (Section 1.6), housing policy (Section 1.7) as well as the organisation of leisure time (Sections 1.8 and 1.9) must be addressed. Recently the German Parliament has passed the final report of the Parliamentary Inquiry Commission created especially to examine these questions. Important conclusions reached by the Commission will be taken into account in this study.

1.2 Work and employment

For more than two decades the number of older employees in Germany has been declining. There are, however, important regional and gender differences. The falling rate of gainful employment in old age applies especially to men; for women (albeit only in the former West Germany) an increase in the rate can be observed up to the age of 60. The falling employment rates in old age are particularly drastic in the former East Germany, where changes in the labour market have led to a higher average rate of 'release' from the labour market for older men and women alike. The falling rate of employment of older people is caused *inter alia* by the practice of early retirement which has been widespread since the 1970s and mirrors the health problems and the higher risks older employees face in the labour market (see Table 1.2).

Table 1.2
Employment rate by age and gender for 1970–1997 in western Germany and also for 1995 and 1997 in eastern Germany (%)

	55–60 years old		60–65 years old	
Year	**Men**	**Women**	**Men**	**Women**
1970	89.1	37.2	74.7	22.5
1975	85.7	38.4	58.3	16.4
1978	83.8	38.9	43.1	12.1
1995	79.0	48.8	33.0	13.0
1995 (New Länder)	62.4	53.7	15.7	3.6
1997	78.5	50.9	32.5	13.6
1997 (New Länder)	77.7	71.8	17.5	5.1

Sources: Statistisches Bundesamt (1977, 1978, 1979, 1997); Greiner (1996)

The situation of older employees is characterised by a high level of discrimination. The unemployment rate of the 55–59 age group has risen markedly and, in comparison to the average of all age groups, more than proportionally within the past decade. Unemployment of older employees tends to be of long duration, with the risk of becoming permanent. Once unemployed, their main problem is to find a new, stable job –more than half fail to do so, according to research data. In 2000 those aged 55 and over accounted for almost 24 per cent of the unemployed and for more than a third of the long-term unemployed.

The higher risk of unemployment is, however, only the tip of the iceberg of the actual problems older people face in their working lives. In addition, they are confronted with numerous forms of direct and indirect discrimination in the workplace, including:

- selective employment and recruitment policies based on age;
- allocation of tasks according to age criteria;
- exclusion from further vocational training and education within the company;
- reduced opportunities for promotion within the company;
- low regard for the value of experience and the need for intergenerational knowledge transfer within the workforce; as well as
- short-term planning in personnel policies.

Due to demographic changes, however, in the medium and long term Germany can expect to see a labour shortage, on the one hand, and the ageing of the workforce on the other hand (see Table 1.3). In the future the needs of the labour market will have to be met with fewer and, on average, older employees. As a consequence, most experts are

Table 1.3
Age composition of the German workforce 1996–2040

Age group	1996	2000	2010	2020	2030	2040
	No. of persons					
15–24	4.7	4.8	5.2	4.5	4.0	4.0
25–34	11.5	10.4	8.4	8.7	7.7	7.0
35–44	10.9	11.8	11.2	9.1	9.4	8.3
45–54	8.3	8.7	11.3	10.6	8.7	9.0
55–64	5.0	4.8	4.8	6.5	6.0	5.5
Total	40.5	40.5	40.8	39.4	35.8	33.8
	Proportion of workforce (%)					
15–24	12	12	13	11	11	12
25–34	28	26	20	22	21	21
35–44	27	29	27	23	26	25
45–54	21	21	28	27	24	27
55–64	12	12	12	16	17	16
Total	100	100	100	100	100	100
Average age (years)	39.9	39.6	40.5	41.5	41.5	41.5

Source: Rössel *et al.* (1999: 38)

of the opinion that the widespread policy of early retirement will have to be abandoned, the working life prolonged and the employment chances of future cohorts of older employees enhanced. The need for action over pensions and labour market policies must especially focus on the following points:

- the review of social welfare legislation encouraging early retirement;
- raising the legal age limit for retirement (which has been law since 1992);
- the introduction of regulations fostering part-time work for older employees (law since 1996);
- special attempts to integrate older unemployed;
- promoting the employability of older employees;
- special training measures and programmes for older workers;
- putting the concept of 'lifelong learning' into practice;
- readjusting employment policies to accommodate to an ageing workforce;
- the reorganisation of working time throughout the course of life.

1.3 Income, poverty and wealth in old age

The system of retirement insurance in Germany has as its goal to secure the income of the gainfully employed once they are retired in such a way that on the whole their accustomed standard of living can be maintained in old age. The system consists of several components, which differ with regard to financing, benefits and the degree to which they are voluntary. As a consequence, the individual's financial situation in old age depends largely on which part of the system he or she belongs to and perhaps on combining benefits from the different parts.

The great majority of those in work are covered by the statutory pension insurance scheme for all employees. Civil servants are covered by their own scheme, and the self-employed can choose between several special schemes. For some employees in the private sector as well as for workers and staff in the civil service additional forms of provision for old age exist in the form of private company (occupational) pension schemes. In 2002 a new (additional) private retirement insurance scheme with statutory regulations and state subsidies was created – however, membership is on a voluntary basis. For the seniors of today it is true in principle that former civil servants have enjoyed the best insurance coverage. Of those formerly employed in the private sector those who receive benefits from a private company pension scheme in addition to the statutory pension insurance scheme for all employees are best off. These patterns of distribution also basically apply to surviving dependants.

Furthermore, the financial situation of seniors in Germany to a large degree mirrors their income achieved during employment. This is due to the fact that the allocation of benefit payments by the state-controlled insurance schemes is largely founded on the principle of an equivalence between contributions and benefits. This also applies to benefits for surviving dependants. To put it simply, high income and long and/or continuous periods of employment lead to a satisfactory income in old age. A low income and/or short, discontinuous working life will raise the risk of becoming impoverished in old age.

While poverty in old age was widespread in Germany until the 1970s, only a minority of the elderly are poor today. This can, for example, be gleaned from the increased income from assets enjoyed by seniors but also from the financial transfers from seniors to their children and grandchildren. Despite a high level of financial satisfaction on the whole, there are significant differences in the amount of benefits received. As mentioned earlier, people with a low average income during their working life and short or discontinuous periods of employment tend to be inadequately provided for financially in old age. This applies, for instance, to many women who have raised children or have cared for relatives but also to many male blue-collar workers without qualifications. Many older migrants who had low-paid jobs and/or were covered for only short periods of time by the statutory pension insurance scheme for all employees are also affected. Another disadvantaged group are older people in the former East Germany who have a considerably lower income from private assets and from private company (occupational) pension schemes and/or who were often compulsorily sent into early retirement and thus had a shorter working life (see Section 1.2).

In the future those employees who do not have long and continuous working lives will be especially at risk. This group includes many unemployed people, women who have taken a break to have children or look after elderly relatives, and those (many of them again women) with discontinuities in their working lives and/or with flexible working time arrangements (e.g. part-time work, temporary jobs). The latter is, *inter alia*, an expression of the growing trend of 'destandardisation' of work (e.g. outsourcing) in companies. That said, it is also partly due to the consequences of social change (e.g. the increasing divorce rate). Financial and income risks are probably also in store for those who cannot (or do not want to) pay into the private insurance schemes introduced on a voluntary basis in 2002 (see above).

In sum, the state-controlled pension policy in Germany today has to face two central challenges:

- Against the background of demographic change it is important to secure the long-term stability of pension schemes. This is equally true for systems based on the pay-as-you-go principle and for private pension schemes based on the capital stock system. Apart from the decreasing number of contributors, the growing number of benefit receivers, on the one hand, and the higher life expectancy, on the other hand, affect the financial stability of pension schemes.
- In Germany there is a trend towards a rise in the number of discontinuous and/or unstable working arrangements (part-time work, temporary work contracts, decisions in favour of financially less secure self-employment, jobs not subject to compulsory insurance, etc.). They have become the only form of gainful employment open to many (e.g. single parents). The consequences of unemployment, which may sometimes be long-term, and compulsory early retirement must be added to these risk factors. Thus, many experts fear that an increase in poverty in old age cannot be avoided.

At the level of social policy, there is a need for action to secure the financial stability of state-controlled retirement insurance in the long term. The pension reform of 2001/2002 can be seen as a step in this direction. On the other hand, it is necessary to protect those individuals with interruptions in their working lives or with low income throughout their working lives from poverty in old age. Finally, steps must be taken to create the necessary

preconditions so that the whole structure of retirement insurance can fulfil its obligation to secure people's future standard of living.

1.4 Health and health care

Although there are no signs of a simple correlation between illness and age, the number of illnesses, especially chronic illnesses, does increase with advanced age. Symptoms of age-specific multimorbidity are characteristic of older people living in Germany. This process begins in the 40–55 age group; among those in the 70–80 age group the average number of illnesses is as high as 3.4. Due to the strong rise in the number of very old people, the age-specific morbidity constitutes a specific challenge for the health care system of the future.

In addition, the risk of morbidity is correlated with social status (higher risk goes with lower social status and vice versa). This is also true for life expectancy. On the whole the state of health in old age must be seen as the result of several factors determining the life course: the material, psychological and social living conditions. For example, older migrants have a generally higher risk of morbidity and a lower life expectancy. This must be interpreted as the result of the living and working conditions of migrants.

The longitudinal data needed to measure changes in the state of health of older people are not available in Germany. It is believed that rates of morbidity have been falling – due, *inter alia*, to progress in medicine, better living conditions and a better awareness of health issues. At the same time, however, due to rising life expectancy and increases in the number of very old people, the number of the chronically ill will grow. This is because new and in many cases irreversible illnesses such as dementia which occur more often in very old age. In other words: people's health is generally improving but at the same time the proportion of chronically health-impaired elderly will also increase. As a result the need for nursing care will increase (see Section 1.5).

As a result of demographic changes, the health care system will have to be prepared for a new group of patients who are, on average, older and more often show signs of multimorbidity. It will face higher levels of demand for both out-patient and in-patient treatment. In Germany per-capita health expenditure has been rising for years in all three mentioned areas of health care, albeit at different rates. Thus the financing of medical treatment in the future has become a crucial point of discussion in Germany. The ageing of society is seen by many as the driving force for growing expenditure in the health sector as a whole and is a constant worry to those keen to reduce costs. The ideal from a senior-friendly point of view would be a system of high-quality medical treatment which takes into account demographic change while maintaining costs at an acceptable level. The rationing of medical treatment by age (already in effect in the United Kingdom) has, so far, found no advocates in Germany.

Given this demographic background, there is an urgent need for socio-political action especially in the following areas.

- encouraging health awareness and preventive medicine (preventing health-damaging behaviour and conditions);

- early diagnosis and holistic treatment;
- adjusting the health care system to new needs arising from demographic changes;
- geriatric and geronto-psychiatric training for doctors and other health sector staff;
- development of medical treatment (sensitive to demographic trends) on the basis of evidence-based medicine;
- a stronger orientation towards the needs of the chronically ill;
- encouraging the out-patient sector;
- co-ordinating in- and out-patient treatment;
- consolidating geriatric rehabilitation;
- interlinking preventive, curative, rehabilitative and nursing treatment;
- interdisciplinary co-operation of all people working within the health sector;
- improving the data and information base for health policy decision making;
- strengthening geriatric research and teaching.

The need for special efforts for the socially disadvantaged and for people in life situations which are risky is particularly obvious.

1.5 The need for nursing and the organisation of caregiving

As with the risk of becoming ill, the need for nursing care also has no simple connection with ageing. Nonetheless, the need for nursing care rises with age. While less than 5 per cent of all people over 65 are seen to be in need of care, this figure rises to about 45 per cent for men over 90 and to roughly 60 per cent for women over 90. The need for care depends not so much on actual age as it does on remaining life expectancy.

On the whole, between 2 and 2.5 million people in Germany are in need of nursing care, corresponding to between 2.5 and 3 per cent of the total population. Of these about 80 per cent receive benefits from long-term care insurance. Between 1.5 and 2 million mostly older people who still live in their own homes and are not in need of care but who do need help with everyday tasks (see Section 1.6) must be added to these figures.

In Germany, about 70 per cent of persons in need of nursing care are cared for at home; the rest are cared for in nursing homes and other institutions. The rate of institutionalisation rises rapidly with age (see below). Relatives are the main caregivers at home, accounting for about three-quarters of cases. Mostly the caregiver is a close relative who in the majority of cases lives in the same household as the person in need of care. The main burden of nursing is borne by women, usually wives, often daughters or daughters-in-law. Furthermore, caregivers are themselves often older people.

The need for nursing is increasingly connected to dementia. Almost 1 million people, more than 7 per cent of those aged 65 and over, are affected by this illness. The risk of suffering from dementia rises strongly with age.

Against the background of rising life expectancy, expected rises in the risk of morbidity (see Section 1.4) and the increasing number of very old people, it seems likely that the number of people in need of care and the number of cases dementia will continue to rise if the status quo is maintained. Preventive measures to curb the need for nursing and/or to prevent the onset of dementia must therefore be one of the high-priority tasks of future politics and research. This fact was also stressed by the recently published Report on Seniors by the German government (Bunderministerium für Familie 2002).

The provision of nursing care at home faces the following challenges which also indicate the need for political action:

- Changing family structures (see Section 1.8) will lead to a reduction in the number of potential caregivers in the medium and long term and make it necessary to build up professional and voluntary/informal support structures.
- Against a background of rising gainful employment, women are experiencing difficulties in reconciling the demands of caregiving and employment, and the resulting need, *inter alia*, for flexible working hours and care leave has repercussions for workforce relations as well as political implications.
- In the process of developing improved nursing structures at home, the increasing differentiation into groups with different care needs has to be taken into account. This applies especially to dementia patients, older migrants, and older singles as well as disabled older people.
- The caregiving service industry for patients living outside institutions has not yet adjusted to the new structural demands. This is true as far as quantity (e.g. there are not enough day and night care services available) and quality (e.g. nursing staff with insufficient general qualifications and too few qualified to deal with, for instance, dementia) are concerned.
- Households in which caregiving takes place very often are overburdened with the situation psychologically and physically. A variety of support structures (e.g. counselling and case management) need to be strengthened.
- The shortcomings in the co-operation of all services and occupational groups involved in caregiving must be overcome by means of integrated nursing services. This also applies to the co-operation of professional caregivers with private support networks.
- The lack of quality standards for caregiving makes the work of professional and informal caregivers more difficult. Therefore, in the future more attention must be paid to developing such standards.
- Despite high demand, in- and outpatient hospice services are very rare in Germany.

There are roughly 600,000 people living in nursing homes and similar institutions. As a group they are chronically ill and becoming older, and they need increasingly high levels of intensive care. Far more than half of them suffer from dementia, and for newcomers this figure exceeds two-thirds. Their average age is currently over 81, and disproportionate numbers of them are women and singles.

At present, nursing homes in Germany are in the process of restructuring; this is taking place at the same time as the introduction of the long-term care insurance. The need for action exists especially on the following levels:

- Co-ordination with the medical sector due to a high degree of overlapping of medical and nursing demands.
- A new orientation towards the nursing needs of old people suffering from dementia.
- A differentiation of the services offered by nursing homes according to changing demands. This includes not only medical and nursing care but also palliative care, psychological and social support, help with everyday tasks, supporting and helping relatives and, in particular regions, a sensitivity to cultural differences when nursing.
- Securing and checking the quality of care as well as the involvement and participation of nursing home inhabitants themselves, or of their relatives or intermediary agents if appropriate. (Recently the legal framework has been improved to foster this process.)
- More and better-qualified staff at all and levels, including innovative approaches to recruitment and training.

1.6 Maintaining independence

Despite the large proportion of sick people and those in need of care, the majority of older people in Germany live at home without the help and support of third parties. This is especially true for so-called young and 'normal' seniors, up to about the age of 75–80 years. The policy goals concerning their well-being can be summarised as follows:

- fostering their social and societal integration;
- promoting their ability to live independently and autonomously for as long as possible.

Social services active in this area are traditionally the responsibility of local authority districts which, according to the subsidiarity principle, work closely with private sector charitable institutions and other privately organised welfare associations. Offering these services for older people is one of the essential communal tasks in the promotion of welfare, guaranteed by constitutional law. Such services can essentially be subdivided into two groups with the following tasks:

- Measures to promote and secure integration. These include cultural and educational activities (including universities of the third age), tourism, clubs and leisure centres, Internet cafés, the promotion of intra- and intergenerational communication, political representation at the local level (e.g. local senior citizens' councils), advisory services, physical fitness activities, self-help groups, and voluntary work.
- Measures to promote the ability to live independently. These include help with domestic tasks, accompanying and visiting services, helping in supplying with services, housing counselling, adjusting living spaces in line with need (see Section 1.7), mobile meal services, crisis counselling, and special services for the disabled.

These services are by no means available to the same extent everywhere in Germany. Availability is poor particularly in rural areas, areas lacking in infrastructure and/or

economically weak areas. In addition, co-ordination between individual services tends to be the exception even in the face of obvious qualitative advantages. Apart from insecure financing, other problems arise because these services often only reach certain subgroups of older people. For instance, older people belonging to weaker social and economic groups (e.g. migrants, single-person households) benefit less from such services. There is thus a need for action to improve the financing and co-ordination of these services, to target them more evenly across the community and to improve user involvement and user participation. Problems of acceptance will, however, remain because these services are sponsored by different organisations. Problems of co-operation are the rule if, as is typical in this area, professionals volunteers work together.

For older migrants these services are hardly available at the moment. It is not yet clear which organisations might initiate them.

1.7 Housing

The main goal of the promotion of older people's welfare in Germany is to foster their ability to live independently as long as possible. The fashioning of living spaces and the built environment to accommodate the needs of the elderly is therefore of the highest importance. This is especially urgent in the case of beginning need for help and care. Typically, seniors in Germany live independently in normal apartments outside institutions. Only about 5 per cent live in homes. Ownership of living space in old age is widespread. For a minority of seniors, however, living independently in their own normal apartment will not be possible in future. Apart from nursing homes and other institutions, a number of special housing arrangements have been established, especially for older people in need of help. These new forms of housing arrangements need to be developed further in a qualified manner, and quality standards, hitherto practically unheard of, will therefore have to be put in place. Special housing arrangements include apartments specifically designed for older people as well as the various forms of sheltered housing. New forms of housing arrangements are also being tested for handicapped seniors. For seniors who by and large are healthy (and even for those suffering from dementia but otherwise not in great need of physical care), there are so-called 'alternative' living arrangements such sharing a house or flat, with other seniors or with other generations, but these are very rare and usually still at an early stage of development. All special housing arrangements, however, reflect the attempt to react to the heterogeneity within the group of seniors.

In Germany there is general agreement that the promotion of living in normal apartments should have priority. Nonetheless, given that there is likely to be increasing demand for them among future cohorts of older people, then these special forms of housing should also be developed and promoted. This is a central message of the second Report on Seniors of 1998 of the German government, which deals explicitly with the question of housing in old age (Bundesministerium für Familie 1998).

Normal apartments, however, remain the main focus of attention. Here it is particularly important to adjust these apartments to the changes in physical constitution typical of old age. Housing counselling, the adjustment of living space, modernisation measures meeting the new demands, especially as far as barrier-free living space and access to

buildings and apartments are concerned, as well as the refashioning of bathrooms/sanitary areas to meet the needs of older people are possible measures. It is also important to put technological innovations to good use in facilitating independent living. Finally, the use of the new media is part of the current attempt to promote autonomous forms of living for seniors.

Older people in Germany wish to remain in their familiar surroundings as long as possible. This entails not only a feeling of familiarity and the possibility of maintaining social contacts but also often security, protection and support. Therefore experts regard the refashioning of residential surroundings in a more senior-friendly way as one of the priorities of future policy programmes for seniors.

1.8 Social networks and social support

Over the past two decades there has been increasing interest in the role social support plays in helping people cope with life stress. Numerous studies have found that individuals who get practical help and/or emotional support from others are healthier than those without such relationships. Indeed, the support supplied through social attachments to others has been shown not only to directly affect psychological adjustment but also to provide a buffer that helps moderate the detrimental effects of life stress on health and well-being.

Nevertheless, German research assessing the role of social support in moderating the negative effects of life stress indicates that the effectiveness of such support depends on many factors. These include type and amount of support provided, as well as the context surrounding the support transaction and the recipient's satisfaction with the support. It has become increasingly evident that the quality of support is as important as its quantity, if not more so.

The support network of German seniors consists predominantly of close family members such as spouse, children, grandchildren or sisters and brothers, followed by other relatives, friends, neighbours and acquaintances. However, this is affected by age, marital status, feelings of family closeness, whether or not the individual has children, and state of health – to name only a few important variables. For example, for old persons who are in need of care and/or live in an institution, professionals can also become an important network members, providing not only practical help but also emotional support.

It is argued that reciprocity – the perception of an equal exchange of support – is a basic aspect of normal well-functioning support networks. In general, German research data show that there is a history of support exchange among family members over the life course, so that intergenerational reciprocity within families is one dimension of solidarity. With regard to non-kin support, however, short-term reciprocity seems to be a significant precondition for the provision of social support. In addition, family links have a strong component of obligation, whereas friendship is optional.

In old age, social networks are very seldom created completely new. Rather, they are more or less the expression of a lifelong development. In this vein, the concept of a convoy of social relations seems especially useful. It assumes an intra- and interindividual

perspective on social relationships, one which takes into account the continuities and discontinuities, the stability and change, the growth and development of both the individual and those with whom he or she interacts.

The social network of an older person is threatened and weakened in many ways. The first way is the loss of important network members and support providers through death (e.g., spouse). Second, older persons themselves may no longer be able to 'invest' into their network in terms of reciprocity because they are too ill and fragile. The loss of significant support providers can result. Therefore, older persons who do not have children or other close family members who could give them practical help and emotional support if they need them are in danger of not having a reliable social network. The same holds for older people living in nursing homes.

But due to socio-demographic changes, more reasons can be mentioned which influence the size and composition of social networks and the provision of social support:

- It is doubtful whether the family can meet the need for help and care of their older members in the longer term. As a result of women's growing participation in education and employment since the 1960s in particular, and the increasing tendency for pluralisation of lifestyles and the trend towards individualisation, women, the traditional providers of care, have acquired more scope for action and more options for organising their lives. Consequently, there has also been an increase in lifestyles not involving marriage and family. This trend finds its expression in rising divorce rates, a growing number of single-person households, and an ever-increasing proportion of women who remain childless throughout their lives.
- At the same time, family structures are becoming ever more complex and diversified. In the long term, this may mean that family ties do not imply the same strong element of obligation that they do now. In this context, it is argued that family ties are no longer so much a matter of course, that they are becoming weaker and more fragile, more dependent on personal involvement and external circumstances.
- Lastly, labour market policy constraints and the associated need for job mobility and flexibility are increasingly forcing families to become widely scattered. This imposes a not inconsiderable restriction on the opportunities to support relatives in need of assistance and care.

Against the backdrop of these tendencies, four political challenges are of significance:

- How can more social support, especially practical help, be provided in the future?
- How can existing social networks be maintained and strengthened? And how can informal support providers be supported?
- What can be done to supplement existing social networks? How can new ones be created in old age (e.g., new friendships, new self-help groups)?
- What kind of supportive measures does society have to provide in each case?

Also, in a wider perspective, the question remains whether demographic changes will have an influence on intergenerational relationships in society as a whole, bearing in mind that the cohesion of a society is determined by the solidarity of its members. With regard to so-called 'generational conflict' one has to realise that older persons are not

only the recipients of social support. They also provide support – at least in a family context – to a large extent. Political measures can help to improve (non-kin) intergenerational relationships systematically in all areas of life (e.g., housing and the workplace). This means that older persons have to be encouraged to be more 'productive' – both older and younger persons need to be aware that old age is not incompatible with having a lot of competencies. It also means that society has to give older persons different opportunities to practise 'active ageing' in everyday life. For example, a society can facilitate the voluntary work the elderly do for young people by, for example, improving the financial incentives.

1.9 Societal and political participation

To guarantee the societal and political participation of older persons is another central task for a future ageing society. In this context, one important question is how older people themselves can actively engage in creating and influencing their living conditions and their environment, whether it be at the micro level (e.g., private and institutional housing) or at the macro level (e.g., political parties and parliament). Additionally, older people have to be involved in the process of 'quality assurance' regarding the care services and institutions which are designed mainly for them.

German research points to the fact that the majority of older persons withdraw from social and political activities. Although 'disengagement theory' is still quoted in this context, it is not yet known whether this development is a real 'age' or rather a 'cohort' effect. Thus, the question of an appropriate form of representation arises.

Special attention has to be given to the political participation of older persons at the local, regional and national level. In this connection, the following questions are of importance:

- What role do the representative bodies (e.g., senior citizens' councils) play at the local level?
- How can the political participation of all groups of older persons (e.g., socially disadvantaged elderly and/or politically distant groups) be achieved?

At a higher political level it seems to be necessary to redefine the role and function of older members of political parties, unions or other organisations. Also it has to be discussed whether initiatives of older persons themselves, on the one hand, or age-integrated concepts, on the other hand, are more useful for a successful political participation. In general, it will be necessary to maintain various forms of representation at different levels. These should be oriented strongly towards people's cultural, national and other features.

The user involvement of older persons with regard 'their' social services can be also seen as underdeveloped. The wishes and needs of the elderly themselves are hardly taken into consideration when services are offered, and hitherto they have not been involved in matters of quality assurance and quality control. Very often it is assumed that especially older persons who need support and care cannot take on the role of the 'critical'

consumer. However, in the wake of the growing privatisation of social services which are then subject to the laws of the market and competition, effective consumer protection measures are needed. The greatest priority has to be given to the protection from abuse of those older persons who are especially vulnerable.

Nevertheless, two successful German examples can be mentioned. With regard to internal quality control, the role of older people as consumers can be empowered by user surveys. With regard to external quality control, the interests and wishes of older persons – once acknowledged – can be used for the development of consumer protection strategies.

A further important question which should be discussed is how the 'unused potential' of (younger) seniors might be better employed by society. This issue is embedded in the overarching discussion of how to arrange the intergenerational contract in a more balanced way. Active ageing is thus currently regarded less as an individual challenge, and more as a societal task which has to be taken on by those older people who have no other obligations (e.g. care of other seniors, support of single-parent families).

As a result, the meaning of 'active ageing' may in future undergo a shift away from the hitherto prevailing interpretation which primarily refers to individual preferences and attitudes. One significant question might be whether the 'new' seniors are entitled to be socially inactive (apart from individual activities, such as travelling), or where there is a 'duty' in terms of being socially obliged to the world around them (e.g. as experts in different former job-related areas, as voluntary workers, political participation).

In principle, this concept of 'active ageing' might harmonise with a widespread positive attitude amongst early retirees towards (meaningful) activities in retirement which might also serve as starting points for suitable propositions for social commitments. Recently published German research confirms willingness among more than 80 per cent of German (younger) seniors, provided that activities do not relate to their previous employment and, crucially, provided that they can decide when they are done.

In recent years several public initiatives have been launched to try to raise the level of societal commitment of older people, including:

- seniors working as unpaid experts (e.g., as craftsmen, advisers, teachers);
- a 'senior expert service' (e.g. advising young entrepreneurs, working in developing countries);
- seniors working in senior citizens' advice bureaux;
- senior co-operative societies;
- political participation in different organisations (e.g. political parties, trade unions, local caring conferences, senior citizens' councils at the local level);
- seniors working as volunteers in the social sector (e.g. educating the young unemployed);
- seniors working as volunteers to care for the environment;
- seniors editing local newspapers;
- seniors as mediators of historical experience (e.g. in schools, so-called 'talking cafés').

However, it is believed that only small proportion of seniors are actively involved in such measures. This leads to the general question whether the early loss of paid work can be substituted by unpaid voluntary work at all, and in turn to the question of how to encourage seniors to get involved. But there is general agreement that get involved they must!

1.10 Research on ageing

Experts are unanimous in their opinion that research in the field of gerontology is underdeveloped in Germany in comparison with other countries (e.g., the USA), due *inter alia* to a lack of adequate funding. This is especially true for applied research on socio-political questions. There are no national programmes sponsoring research into gerontology, especially gerontological research from a socio-political angle. The latter is *de facto* carried out systematically only in one location (Dortmund). The available funds are distributed amongst research organisations of very different character, and the responsibility for the allocation of public funds for gerontological research is also strongly fragmented. Moreover, the overall sum spent on research into gerontology is far from adequate in view of the political and social challenges arising from demographic changes. Furthermore, the existing research centres (Berlin, Dortmund, Heidelberg and Nuremberg) which have developed positively from both a quantitative and qualitative point of view in recent years are insufficiently linked, mostly conducting their research in isolation from each other. Interdisciplinary research does not take place on a large scale, although it is considered essential by all experts. This is, *inter alia*, due to the fact that gerontology is underrepresented at German universities.

One of the main priorities of socio-political research in future must be to examine the socio-political implications of demographic changes and consequently to offer recommendations for the development of adequate policies. These recommendations should especially encompass the world of work, strategies for putting to use the existing potential and competencies of older people, social and health care as well as nursing of the very old and, in addition, the strengthening of independence in old age. To achieve this, it is necessary to differentiate the varied groups of elderly (e.g. according to cohorts, social status, cultural backgrounds, gender). The questions and recommendations for a common research programme listed in more detail in Chapter 3 can be used for a more precise description of the desired research agenda.

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2 Ageing and social policy for seniors in the United Kingdom

Ageing has been a major focus for social policy in the UK for at least three decades and, as the implications of population ageing have become clearer, this issue has moved up the policy agenda. There is a rich tradition of social gerontological research in the UK and this brief overview will not be able to do full justice to it. I will focus on the main policy issues and, at the end, report on a new initiative to co-ordinate research on ageing. First of all, some basic demographic information will provide the backcloth to the subsequent review.

2.1 Demographic data

Table 2.1 shows the proportion of the total population made up by different age groups, and the predicted expansion in the proportion of older people over the next seven decades. As can be seen, population ageing is expected to continue as the population of young people shrinks and that of older people rises. The two socio-demographic factors underlying this development are falling fertility rates and increased longevity. The trend is a long-term one: at the turn of the twentieth century those aged 65 and over comprised just 4.7 per cent of the population and those aged 80 and over only 0.3 per cent. Presently there are some 10.8 million people over state pension age (60 for women, 65 for men), and this figure is projected to rise by 11 per cent to 11.9 million by 2011, to 12.3 million by 2021 and to 16 million by 2040 when the median age of the population will be 44.5 years. Without the recent increase in the women's state pension age to 65 this total figure would have been 18 million in 2040.

Table 2.1
Population of the UK by age group, 2000–2070 (%)

Ages	2000	2010	2020	2031	2041	2051	2061	2070
0–14	18.9	16.8	16.2	16.0	15.3	15.3	15.5	15.4
15–29	19.1	19.6	18.1	16.8	17.2	16.9	16.7	16.9
30–44	23.0	20.9	19.3	19.5	18.1	18.4	18.7	18.3
45–59	18.5	20.3	21.3	18.3	19.4	18.6	18.2	18.8
60–74	13.1	14.9	16.4	18.7	17.1	17.2	17.7	16.8
75 and over	7.4	7.6	8.6	10.7	13.0	13.6	13.2	13.8
All ages	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Government Actuary's Department and Office for National Statistics (2000)

Hidden within the figures in Table 2.1 is one of the most important features of the older population – its gender distribution. At successively older ages the population of women increasingly exceeds that of men. Currently, 49 per cent of those aged 0–24 are women, 50 per cent of those aged 25–64, 53 per cent of the 65–74 age group, 61 per cent of the 75–84 age group, and 72 per cent of those aged 85 and over. The main reason for this is that the life expectancy of women (at birth) exceeds that of men by 4.9 years. Although men's life expectancy is projected to improve over the next 45 years, so will women's. Therefore, by 2040, the differential is still expected to be around 5 years (78.6 years for men and 83.6 years for women, compared with 75.1 years and 80.0 respectively today). Largely because of different life expectancies, the majority of men aged 75 and over are married (62 per cent), whereas the majority of women of that age are widowed (64 per cent).

Among minority ethnic groups the population of older people is currently much smaller than it is for the white population – only 6 per cent of the black population, 7 per cent of the Indian, 6 per cent of the Chinese and 3 per cent of the Pakistani/Bangladeshi are over the age of 65, compared with 16 per cent of the white group. Progressive ageing of minority ethnic groups is expected in the future (but depends on fertility levels, mortality rates and net immigration).

2.2 Work and employment

Older people, particularly older men, have been regarded by employers and policy makers as a sort of reserve army of labour – encouraged to stay in employment at times of labour shortage (as in the late 1940s and early 1950s) and quickly jettisoned when demand contracts (as in the mid-1970s). Mindful of the decline in the numbers of young people entering employment and the cost of pensions, the government is currently running campaigns to try to persuade employers to recruit or retrain older workers and has introduced policies such as the New Deal 50+ with the same intention. As in most of the rest of the EU, this is a difficult task for policy because, as Table 2.2 shows, there is a well-entrenched trend towards early exit. Only a minority of men now 'retire' in the

Table 2.2
Labour force participation of older men and women in Britain 1951–1998 (%)

Age group	1951	1961	1971	1975	1981	1985	1991	1995	1998
Men									
55–59	95.0	97.0	95.3	93.0	89.4	82.0	80.6	73.7	74.5
60–64	87.7	91.0	86.6	82.3	69.3	54.4	54.1	50.1	49.5
65+	31.1	25.0	23.5	19.2	10.3	8.2	8.6	8.2	7.6
Women									
55–59	29.1	39.2	50.9	52.4	53.4	52.1	54.3	55.7	54.6
60–64	14.1	19.7	28.8	28.6	23.3	18.9	23.9	25.0	23.7
65+	4.6	6.3	4.9	3.7	3.0	3.3	3.1	3.2	3.4

Sources: 1951–71 Census of Population for England and Wales and for Scotland; 1975–92 Department of Employment, *Gazette* (various); Department or Work and Pensions (2002)

conventional sense of leaving employment on or close to their 65th birthday. The majority leave employment at earlier ages and reach the state pension age in a variety of non-employed statuses, such as unemployment, long-term sickness or disability, and early retirement.

UK research shows that the main factors explaining the growth of early exit among British men are demand-related, particularly the recession of the mid-1970s and early 1980s. In view of the changing nature of employment it is unlikely, however, that older workers will be automatically drawn back into employment. Considerable research effort has been devoted to the issue of employment among older workers in recent years and, among other things, this shows that people aged 50–60 face widespread age discrimination from employers. For example, age restrictions in job advertisements are a common barrier to employment. Employers often restrict access to training programmes to workers under the age of 50. Yet when employers are asked to rank the most important factors discouraging the recruitment older workers 'lack of appropriate skills' comes top of the list. There is, in other words, a self-fulfilling prophecy at work here. Many employers have been shown to hold stereotypical attitudes towards older workers: for example, that they are hard to train, are too cautious, cannot adapt to new technology and are inflexible. Such prejudices are not supported by research evidence which, for example, shows that older workers require appropriate training and skills development and that this can lead to enhanced productivity and improved job performance. It is also clear that a key to training mature workers is learning confidence and that this can be increased (and anxiety about learning reduced) through the provision of basic literacy and numerical skills training.

One obvious result of labour market discrimination against older workers is the high rates of long-term unemployment and non-employment among this age group. Older workers are more likely than younger ones to be unemployed for long or very long periods. Nearly a quarter of unemployed men aged 50–64 have been out of work for 3 years or more, compared with a fifth of unemployed men in their thirties and forties. They are also much more likely than younger workers to occupy other non-employed statuses such as sick, disabled and early retired. UK research shows that there are two main groups of early retired older workers: on the one hand, those who have freely chosen to leave employment and, on the other, those who are coerced by redundancy or forced by ill health to withdraw. The psychological impact of long-term unemployment on older workers is considerable and lessens the closer the individual gets to state pension age.

In view of the ageing of the UK workforce it is widely accepted that early exit and age discrimination must be combated, and there has been a great deal of policy activity in this field in recent years, including a series of campaigns to persuade employers to recruit, train and retain older workers, a special version of the New Deal programme aimed at older unemployed workers and a major report, published under the title *Winning the Generation Game* (Cabinet Office 2000), which highlighted five main barriers to employment among older workers:

- prejudices among society and employers (and sometimes older people themselves);
- perverse incentives in occupational pension systems that encourage early retirement;
- assumptions by government agencies that 'write off' older workers;
- obsolete skills; and
- barriers to volunteering and other community contributions.

The report proposed a detailed strategy to increase employment and other activity in later life, and the implementation of this is being overseen by a Cabinet Committee.

2.3 Income, poverty and wealth in old age

In a comparative EU perspective British pensioners tend to be worse off than those in other northern countries. The explanation for this lies in the basic structure of pension provision erected in the late 1940s and the policies of subsequent governments which sought to first enhance (in the 1970s) and then dismantle (in the 1980s) the public pension system. The introduction of public pensions started in 1908 and was made universal 40 years later, following the recommendations of the Beveridge Report. Unlike Bismarck, Beveridge believed that the best approach to pensions was to create a basic universal floor upon which people could build their own voluntary contributions. This floor has always been set at a low level in the UK (unlike the universal public pensions in Scandinavia), fluctuating between one-fifth and one-third of male manual earnings. Also, contrary to Beveridge's intention that there should have been a substantial national insurance (NI) fund built up before pensioners were paid, the post-war Labour government decided to introduce the basic NI pension at once and, as a result, it is financed on a pay-as-you-go (PAYG) basis. In other words, the NI contributions of those in employment are used to pay the pensions of those in retirement.

Unfortunately, the PAYG system is vulnerable to political interference, and when the social contract was instigated those involved did not envisage that a future government would drastically rewrite the rules. This is what happened, in effect, in the 1980s. The Thatcher government was intent on cutting public expenditure and, because of the scale of pension spending, this was a prime target. Thus, in 1980, the government altered the uprating link for the NI pension from earnings to prices. The cumulative effect of this seemingly innocuous cut has been to reduce the value of the basic pension. The reductions represent more than one-third of the value of the existing pension levels. Then, in 1986, the government cut in half the value of the State Earnings Related Pension (SERP), which was introduced with all-party support in 1978 and was due to reach full maturity in 1988. The reduction in the SERP scheme affected women in particular because the relatively generous credits (called Home Responsibility Protection) for periods spent out of employment (for example, in child rearing) have been curtailed. These cuts had a deterrent effect on younger generations, undermining their confidence in the state pension system and encouraging them to invest in private pensions. It is a salutary fact that, if these trends had continued, the NI pension would have been worth less than 10 per cent of average earnings in 2020. As well as deterrence, positive inducements were offered for people to opt out of the state sector and into the private one. These have taken the form of generous NI contribution rebates and tax relief, costing more than £16 billion. The result is that some 6 million contributors were enticed from the SERP scheme into private personal pension plans, leaving less than 17 per cent of the workforce in the SERP scheme. However, it is estimated that because of the mis-selling of personal pensions, as many as 2 million people would have been better off staying in the state scheme.

The Blair government, first elected in 1997 on a reformist agenda, has implemented a further change to the pensions system by enhancing the 'partnership' between the state

and private sector, so that public expenditure by the state on pensions will shift towards the private sector, from 60 per cent at present to 40 per cent by 2050. Improvements in the position of the poorest pensioners were seen as a priority and will be achieved through provision of the (means-tested) Minimum Income Guarantee (MIG) – in reality, Income Support for older people. Indeed, the policy towards improving the position of current pensioners is focused upon a means-tested route. In outline, the new pensions structure is as follows. The basic pension will remain but shrink in real terms, with the SERP being replaced from April 2002 by a new State Second Pension (SSP or S2P) in order to boost the pensions of the lowest paid – those earning less than £9,000 per annum. Those earning above £9,000 per year and who are not members of an occupational pension scheme, have been encouraged to take out a funded Stakeholder Pension available from April 2001. This is a low-cost, flexible savings device provided by the private sector, which upon retirement is used to buy an annuity.

At the time of writing, the government is introducing the Pension Credit. This is made up of two components, a guarantee and a savings credit. The former will replace MIG from 2003 but will work to raise the income of those pensioner couples whose pension and savings amount to less than £154 per week (in the case of single pensioners less that £100 per week) to these levels. Higher rates will apply to those with disabilities, and all those aged 60 and over can claim. It will allow pensioners who are currently excluded or receive a lower amount of MIG because of savings to receive an income, as there will be no capital cut-off. The other element, the savings credit, will be awarded for five years with no need to report minor changes and provide all those who have savings and receive the guarantee a payment of 60p for every pound of second pension or other savings income they have up to a maximum of £18.60 per week for couples and £13.80 per week for single people. Should the pensioner have no savings, the situation for many older pensioners, then this rises to £31 and £23 per week, respectively.

Despite the fact that social security is by far the largest expenditure programme and older people receive over half of it, there is still a close association between low income and poverty and old age. There is no 'official' poverty line in the UK. Instead, a widely used definition of poverty is based on 50 per cent of median income after housing costs. On this basis, the latest figures show that 25 per cent of pensioner couples and 37 per cent of single pensioners were in poverty in 1998/99, some 3 million people. At the same time there is no doubt that the income of some pensioners has increased substantially, largely due to the impact of occupational pensions. There is, in fact, a polarisation of older people between poverty and affluence. The income of the top 20 per cent of pensioners has increased by 70 per cent since 1979, whereas that of the lowest 20 per cent has risen by only 38 per cent. This is largely attributable to the increasing numbers of (mainly male) pensioners retiring with good occupational pensions. This is reflected in the median net income (after housing costs) figures. For couples aged below 75 the median income was £270 per week, for single people £125. Corresponding figures for those over 75 are £218 for couples and £109 for single people.

The poorest pensioners tend to be very elderly women, while the most affluent tend to be younger couples. Older people from minority ethnic groups are more likely to be poor in old age than their white counterparts. These differences signal the failure of the British pension system to provide for those in low-paid part-time or discontinuous employment, especially women, and this represents a huge policy challenge. At the same time UK pensioners are reluctant to subject themselves to means tests and, consequently, there are at least 500,000 living below the MIG level. Public pension spending is lower than the EU

average (11.5 per cent of GDP, compared with 13 per cent in Germany and 12.7 per cent in the EU) and, therefore, there has not been an economic imperative to reduce it (the imperative in the 1980s was ideological). However, there are currently fears among experts in the UK that the existing structure of pension provision is simply not adequate to guarantee the income of future pensioners. These fears are based on three factors: the low level of the basic NI pension; stock market volatility and the risk this creates for those with private defined contribution pensions; and the very recent collapse of the occupational pension system that has guaranteed many older people a decent standard of living. Public pension provision was undermined in the 1980s, and it is questionable whether the private market is able to prevent the risk of poverty in old age in the face of uncertainty in world stock markets and the changing nature of employment and careers (destandardisation of working life). Thus the main pension policy challenge in the UK is not concerned with long-term financial stability, as in some other EU countries, but with how to ensure an adequate standard of living for tomorrow's pensioners and, most urgently, how to eradicate poverty among today's.

2.4 Health and health care

Good health figures prominently in all subjective assessments of quality of life in old age and it is related to age: higher proportions of successively older age groups report poor health and low levels of functional capacity.

A long-standing observation of UK research is the paradox of gender differences in health in old age: men are more likely to die at earlier ages than women, but women suffer higher levels of morbidity (although recent research suggests that differences in ill health between men and women are not as great as previously suggested). Some studies suggest that there is no gender difference in self-assessed health, but higher levels of functional incapacity among older women. As noted previously, older women are prone to poverty, and this socio-economic disadvantage is associated with ill health. Older women are much more likely than men to experience restrictions in mobility, ability to perform household tasks and self-care. For example, nearly half of women over the age of 85 are unable to walk on the street unaided, compared with under one-fifth of men in the same age group. There are also strong associations between a person's last main occupation and health in later life. For example, among those over 80 professional men report 20 per cent more 'good' health than other class groups. Older people with the highest income report the best health: those in the lowest quintile of income are 60 per cent more likely to have poor health compared to those in the top quintile, after taking social class and housing tenure into account.

The incidence of cognitive impairment has increased with longevity and rises among each age group of older people: the prevalence of moderate or severe cognitive impairment is 2.3 per cent in those aged 65–74, 7.2 per cent in those aged 75–84 and 21.9 per cent in those aged 85 and over. Cognitive impairment is one of the main reasons why older people enter long-term institutional care. Older people are two to three times more likely to be depressed than to have dementia. Depression is not part of normal ageing or age-related, but it is more common among older people who are physically ill. Older people with Parkinson's disease, stroke, neurological disorders or dementia have higher rates of depression. Depression without treatment easily becomes a chronic disorder producing

high levels of mortality and morbidity. In later life depression is a largely untreated and undetected condition. Older depressed people will make two to three times as many visits to their GP as older people with no depression (which could help in identifying and treating depression). Many studies agree that depression is contributed to by deteriorating health in later years and that support from family members and the availability of a confidant is protection against depression. People with low coping resources, such as economic difficulties, are more likely to report depression. Not much research has been done on older people in migrant groups, who might have fewer resources to cope with mental health problems. One study, among the Somali community in London, found that the main elements causing depression for this group of older people were: decreased mobility and pain; life-threatening illnesses and inadequate access to services; breakdown in social support; loss of family members in civil war in Somalia and separation from family; economic losses in Somalia and the need to support relatives who were left behind; destruction of property by civil war; migration issues and confusion about life expectations and feelings of deprivation; loss of work roles; ageism; and citizenship issues.

Older people receive a large proportion of health expenditure (as well as social security spending). In 1999/2000 around £28 million was spent on hospital and community health services, and nearly two-fifths of this was spent on those aged 65 and over. Expenditure on that age group (£1,371 per head) was four times the level of spending on people aged between 16 and 44. (Spending per head on children aged 0–4 was £1,085.).

Five major challenges confront health services for older people in the UK. First, there has been a long-standing undercapacity in key areas, such as dementia care and stroke rehabilitation although the investment required is not necessarily in health services alone but, usually, at the interface between health and social care. This is the reason why the issue of the future cost of health care for an ageing population has not been significant in the UK compared to some other EU countries. Therefore, secondly, there is a need to break down the traditional barrier between health and social care, which has been a particular impediment to the development of holistic and seamless care for older people. The government has introduced guidance and new 'joined-up' structures to try to demolish this division between health and social care (what a previous Secretary of State for Health referred to as a 'Berlin wall'). This implies not just the need for new structures but also new multi-skilled health and social care workers. Thirdly, age discrimination in the distribution of health services and procedures (e.g. screening, kidney replacement) is well documented. As a result the UK government introduced a National Service Framework for Older People in 2000, the first aim of which is to 'root out' discrimination on grounds of age. Time will tell how successful this strategy has been. There is also evidence that gender and ethnicity are used to discriminate negatively in the distribution of treatment to older people. Fourthly, there are substantial variations in both the levels and standards of care provided to older people in hospitals in different parts of the UK. Thus another important facet of the National Service Framework is to try to improve the quality and consistency of health care. Fifthly, there is the need to promote 'healthy ageing' across the life course in the context of a health service that is dominated by acute provision and in which prevention has never been a significant feature.

2.5 The Need for Nursing and the Organisation of Caregiving

If older people need care it is most often provided by themselves or by close relatives. If the need is substantial and/or there are no available relatives then they may be cared for in hospitals, nursing homes or residential homes, depending on the level of need. The NHS provides care free at the point of use but the expectation is that in-patient care will be for short, acute episodes. NHS beds have declined in number from about 400,000 in the early 1970s to 190,000 in 2000. This decrease has been matched by a dramatic growth in the nursing home industry in England from 28,000 places in 1983 to 196,000 in 1999. Over half of all health care beds are in nursing homes in England, which means that large parts of the UK health care sector have been privatised.

Only 1 per cent of people aged 65–74 live in care homes or hospitals, but this rises to 25 per cent for those over the age of 85. Thus, for a significant proportion of older people such institutions provide end-of-life care. Among those over 80 living in long-stay institutions there are 2.3 times as many women as men.

Following the rapid growth of nursing homes there has been a great deal of expert and professional concern about the quality of care provided and, particularly, the lack of national standards. The current government has taken action, and the Care Standards Act 2000 created a new regulatory regime in which the new National Care Standards Commission has jurisdiction over care services, including care homes. However, the national care standards are for guidance and are not legally enforceable. Moreover, staffing levels in care homes are a key factor in ensuring good-quality care, but minimum staffing ratios have only recently been specified: since May 2002, care homes have had to observe uniform staffing levels following the introduction of new guidelines. The guidelines apply to newly registered homes, with existing homes having a few more months in which to comply.

The vast majority of older people needing care and support, even in advanced old age, receive it in their own homes or those of relatives. The main family carers of older people are usually adult children (mostly daughters) and/or spouses. Thus a great amount of care of older people is provided by other older people (in the 50–60 and 80-plus age ranges). Older people living in the community may be entitled to receive home care or community nursing support. Home care is organised by, though increasingly rarely provided by, local authorities, while community nurses are part of the NHS. The former entails a charge, while the latter is free. In recent years home care support has been targeted more and more towards the most severely disabled, which has excluded the once important preventive role of this service.

Local authorities provide approximately 398,000 households with home help and home care (2000). However, while there has been an increase of two-thirds in the number of home help contact hours since 1992 (2.8 million, up from 1.7 million), the number of households that received this help fell by 6 per cent. Thus a smaller number of households received a more intensive service. The decline in the role of local authorities as direct providers of home care can be seen in the fact that, while in 1992 only 2 per cent of home help services were provided by 'independent' sector parties (private sector plus voluntary sector) being commissioned to carry out the care by local authorities, by 2000 this figure

had reached 50 per cent. The dramatic rise in provision of house care by independent sector has been matched by a cut of one-quarter in local authority direct services.

Because social care services are the responsibility of local authorities (as providers or commissioners) their levels and quality vary between areas, as do the fees charged. In most urban localities older people would expect to find home care/home help services, day care and meals-on-wheels provision supplied mainly by private and voluntary providers. Services are more patchy in rural areas.

Another key policy issue with regard to health and social care is its financing. The rules on paying for long-term care in UK are complicated. There are three sources of state funding for institutional care: Income Support, NHS and local authority funding. Income Support and local authority funding are means-tested, which means that people with income or capital above certain levels have to pay for their care in full, unless the NHS provides it. In April 1993 new arrangements came into force for people going into care homes: a local authority assessment must be performed if they wish to apply for state funding. People who have capital of less than £16,000 and an income level less than Income Support level for a person living in the community will be entitled to Income Support and a residential allowance is also payable. Local authorities have agreed a baseline of care home fees for which they will take responsibility, and each authority has set its own baseline for different levels of care for which it will accept financial responsibility. Variations between different local authority baseline fees are substantial.

It was hoped that the controversial issue of funding long-term care would be settled by the report of the Royal Commission set up to investigate this issue in 1998. Its landmark report proposed that all nursing and personal care should be provided free and funded from taxation. However, the government took a different view and, from April 2002, agreed to publicly fund nursing care only (such care is defined as being provided by, or under the supervision of, a registered nurse). This restricted response to the Royal Commission has left many thousands of older people with the responsibility for funding the bulk of their own care and, for many of them, having to sell their houses to meet the cost.

Looking to the future, it is predicted that, despite a long-term trend towards reductions in morbidity, the need for care will rise. This is due to the combination of increasing life expectancy and chronic conditions such as dementia. On the other hand, there are changes in family structure, such as falling fertility and rising marriage breakdown, which will reduce the pool of potential family carers. In addition, the growth in labour market participation among women places particular strains on the main carers of older people. The key policy foci in this field are likely to be:

- finding ways to share care more effectively between the family and formal sector to prevent the breakdown of caring relationships and sustain independent living;
- encouraging employment-based policies aimed at reconciling paid work and caregiving;
- increasing the provision of home care and support services to enable care to be provided on a 24-hour basis, to renew the preventive role of social care and to stop the rationing of services according to the availability of relatives;
- paying particular attention to the care needs of minority ethnic groups;
- raising the quality and consistency of home care and nursing/residential services;

- increasing the availability of palliative care services;
- enabling care recipients and their carers to have a real voice in the provision of all kinds of services;
- tackling the funding issue to ensure that the risk of long-term care, like that of acute care, is borne by the whole community – the decision by the Scottish Parliament to implement the Royal Commission's proposals on the funding of long-term care has put pressure on central government to follow suit for the rest of the UK.

2.6 Maintaining independence

The goal of maintaining independence has been on the policy agenda of successive governments for more than 50 years. Unfortunately, this general aspiration of 'community care' – meaning care in the community – has not been realised and has frequently been referred to as 'community neglect'. Thus, as noted previously, the majority of older people in need of care in the UK live at home and either care for themselves or receive support from relatives and/or friends, with little (or usually no) input from services. There are two main reasons for this relatively poor state of affairs.

First there is a historical underinvestment in community-based services to support independent living. Local authorities are responsible for providing these services, such as home help, meals-on-wheels and aids and adaptations, with equipment for disabled older people often being supplied by the health service. But insufficient resources have been devoted to create a good-quality service and, because the central funds have never been ring-fenced, local autonomy means that there are large regional disparities in what older people may expect by way of support.

On top of this long-term underfunding came severe budget cuts in the 1980s and 1990s and, faced also with increased demand, social services departments have targeted services on people in the greatest need. As a result there has been a sharp reduction in prevention and rehabilitation (which was always a low priority). Older people value low-intensity support services which enable them to stay at home. For its part the Department of Health now recognises the need for services to move towards more preventive objectives rather than only emphasising the 'high-risk' groups. Such services, however, are largely underdeveloped and uncoordinated – and, in some local authorities, non-existent. There is an urgent need for more services which delay or prevent the need for more costly care and also for the promotion of quality of life and community engagement. There is a dearth of such services designed to overcome exclusion and to promote integration, compared with Germany. Older people want to avoid dependency and reliance on other people, and they want to receive help without burdening others. UK research points to the need for community-based support to be directed at supporting older people's efforts to maintain their autonomy, independence and reciprocity.

Second, there has until recently only been a genralised exortation with regard to community care, with local authorities being left to implement the policy. The resulting inadequacy and unevenness of provision was one of the motivations behind the National Service Framework (NSF) published in March 2001. The NSF sets standards for the care of older people across health and social services regardless of whether an older person is

being cared for at home, in a residential setting, or in hospital. As noted previously, the first NSF standard concerns age discrimination, and others focus on providing person-centred care, promoting older people's health and independence and fitting services around people's needs. Each standard has an implementation strategy for local services and a series of milestones to be achieved. Thus there is some expectation that this clear policy guidance will, at last, lead to the development of integrative services.

One of the NSF standards covers 'intermediate care' – integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living – and the government has embarked upon a substantial expansion of these services. The NSF standard directs service providers to enable older people to have access to such services designed to 'promote their independence'. In a very recent announcement (July 2002) the government has said that it will mandate local authorities to provide cash so that older people can purchase their own supportive services.

2.7 Housing

Only 7 per cent of older people live in residential and nursing homes and, therefore, the majority live in private dwellings. Choosing where to live is dependent on many factors in an older person's life situation. Often the decision about a change in living situation is made under the stress of the present arrangement breaking down, and complicating the decision process is the added pressure of an unpredictable future in terms of functional ability and state of health. Housing decisions also have a fundamental effect of the financial situation of the older person, their family and the state. Most older people do not want to move to a residential or nursing home, because of their love of their own home and the negative views they have of residential life. The sense of self and activity is altered by a move to a residential home, and it is seen as 'living in someone else's home'. The key element in influencing people's feeling of well-being is the extent to which they control their decisions and manage their activities of daily living. For frail older people the decision to move to a nursing or residential home is often made by others.

There are increasing numbers of older homeowners living in a range of financial and social circumstances. Data about ageing of the population and household structures of older people are available but they do not explore issues of tenure and its influence on wealth and income of older people, their responsibilities for house maintenance and social care needs. The house-owning ageing population includes a large proportion of households that are equity-rich and income-poor. Young female-headed households are experiencing some of the worst housing conditions, especially lone women with children, and it is likely that female-headed households will form a disproportionate number of future old age home owners.

Home ownership can be experienced by older people as a benefit or a burden, or both. On the positive side, it means freedom to do as they please, and it gives them security and control over their future. Set against that are the responsibility of organising and supervising repairs and maintenance and the burden of paying for them. Many older people worry that they don't know which repairs need to be done and about finding reliable people to do them.

Architectural disability refers to the ways the physical design and construction of buildings form barriers for people, making the built environment uncomfortable and unsafe for people to use it. Architectural disability is mainly caused by small spaces and difficult changes of level. Design faults in the built environment can cause exclusion by denying access to buildings, lowering people's self-esteem by discrimination. This is a problem for people from all walks of life: mothers with young children in pushchairs, tall, short or disabled people, as well as older people.

In the UK most of the housing stock is not ideal for growing older in, because it is unsuitable for adaptation: houses might be too big, expensive to run, in the wrong place or inconvenient. Some older people feel constrained by their housing environment and see the situation as completely negative and disabling. What older people want is suitable mainstream housing, designed with changing needs in mind. In the future, when older people will become the majority, the emphasis in design might shift towards older people's needs as the mainstream and not as special needs provision. This might give older people the right to choose their living environment and lifestyle rather than being forced into a narrow band of options depending on state of health or on temperament. Older people with sufficient means can enjoy a specially designed environment, but others will stay trapped in architecturally disabling housing while the special needs approach to housing in old age predominates.

Sheltered housing has been developed as an alternative resource to meet the housing and support needs of those older people who do not require expensive residential care but are unable to stay in their own homes because they are too expensive to run and repair or are situated in areas of high crime or far away from supporting relatives. Sheltered housing offers a sense of security and contact with other people. In these communal environments older people find it easy to share role models and gain reference groups where personal self-evaluation or resolve is strengthened by the age-segregated environment.

2.8 Social networks and social support

Social networks are widely regarded as critical to the quality of life of older people but there is very little research evidence to show just how important they are and what contributions they make. What evidence there is tends to focus on the role of families. There are increasing proportions of families spanning three or more generations and increasing numbers of older people who either live in nursing or care homes, alone or with their relatives. Close to three-quarters of the population, with the exception of those in their fifties, are part of three-generational families. Many mothers with children younger than 18 receive help from their own mothers, and half of mothers aged 50 and over receive help from their eldest child. Because they live longer women are more likely than men to be involved with family members across several generations.

Grandparents can play important social support roles, for example in assisting working mothers with child care. Such support is most common when the grandchildren are very young and dependent. There is evidence too of increased support given by grandchildren to older people following widowhood.

Older people without children tend to have close relationships with their siblings throughout their lives. Well-being in later life is enhanced by good sibling relationships. These are influenced by social network structure, geographical proximity, health and gender. In general functional support is at a low level between older siblings, but there are high levels of affectional solidarity.

It is clear in the UK that family solidarity and reciprocity remain vibrant, and the clearest demonstration of this is in the provision of unpaid care to older people. At the same time research points to a critical element of obligation in caring relationships between kin. There is not only reciprocal support and exchanges over the life course but also, concurrently, between older people and their adult children and grandchildren.

The main policy focus in this field has been on the caring roles of kin in maintaining older people in the community. Decades of campaigning for the rights of carers resulted in the passing of the Carers (Recognition and Assessment) Act in 1996, which gave carers the right to an independent assessment of their needs. This has been followed by a series of measures aimed at ensuring that the health and social care providers pay proper attention to carers. There is a vocal lobby on behalf of carers which points out, among other things, that the unpaid contribution of the carers of mostly frail older people saves the government some £57 billion.

Despite the major contribution of family carers to the support of older people and the growing recognition of carers within the health and social services there is a need for further, more concerted policy action in this field:

- the changes in family structure and demography, referred to previously, which will leave many older people without available family support;
- the growth of chronic conditions, such as dementia, that strain caring relationships;
- the survival of people with intellectual disabilities beyond their lifelong parent carers;
- general ageing of the caring relationship;
- the neglect of the care and support needs of seniors from minority ethnic groups often due to erroneous practitioner and policy maker assumptions about the existence of special caring relationships within such minorities.

As proposed in Section 2.5, there is a need for policies that share the care of older people more effectively between the family and the state. For the reasons already mentioned, it is unlikely that the family can go on, as currently, providing the main and often only source of support for older people. There is also a need for policies that tackle loneliness and isolation among a small proportion of older people (around 8 per cent). Although recent UK research shows that the common perception that loneliness has increased among older people over the past 50 years is erroneous, it is still a significant problem and is neglected by policy. Policy should also address the greater fear of crime among older than younger people. Strategies might include community capacity building and intergenerational activities (although there are no signs in the UK of generational conflicts).

2.9 Social and political participation

Social and political participation have been increasing among older people as a result of the improvements in health and living standards in this age group. It is only very recently that this has become of interest to policy makers as a result of policy commitments to active and healthy ageing and greater participation in the policy process.

Voluntary activity is common in the UK, and some two out of five volunteers are over the age of 60. The most likely people to volunteer are those from a middle-class occupational background. Older people share many leisure pursuits in common with younger people, but societal ageing has also brought with it increasing availability of specialist provision for older people, for example reminiscence, open learning, intergenerational activities and information technology training. These facilities are usually provided by voluntary sector organisations such as Age Concern. Local authority adult education departments usually provide reduced-rate services for pensioners. There are many local authority special programmes in leisure centres and sporting facilities.

The Cabinet Office inquiry referred to in Section 2.2 placed the issue of volunteering and community contributions on the agenda of central government in a concerted way for the first time. Reflecting a general orientation towards 'active ageing', government policy is being diverted towards encouraging voluntary action among older people. Drawing on US experience, a new senior volunteer programme has been launched: the experience corps. There are some organisations dedicated to organising older volunteers, particularly aimed at utilising the expertise of the recently retired, but so far these are not widespread.

The UK has also seen the rise of political participation among older people in the last decade. This has been a grass-roots movement that has responded to policy rather than being encouraged by it, the main impetus being cuts in pensions in the 1980s and 1990s. Numerous local pensioner action groups and pensioner forums have sprung up independently of the established voluntary groups working on behalf of older people (although some of these groups have supported the pensioner forums). The local and regional forums and action groups combine as the constituency of the National Pensioners Convention (which claims 1.5 million members). Following the 1997 election of the Labour government, encouragement has been given to the participation of older people in local government by the Better Government for Older People initiative. In practice, however, the real involvement of older people in decision making is very limited.

Another key aspect of participation concerns the health and social services and, specifically, the issue of who should decide on the treatment or care to be provided. In the past this was not an issue: it was the task of professionals to decide on the appropriate care or treatment. Over the last decade, however, pressure has built up among various groups of service users for more involvement in such decisions. This 'user involvement' movement was initiated by disabled people, but recently older people and their carers have played key roles too. The policy process has responded gradually, first recognising the rights of carers, then the rights of users to consultation; most recently, patients' and users' forums are being built into the health and social services.

Key future policy issues concerning participation include:

- Maintaining activity beyond pension age in the interests of both health and social inclusion. In particular, policy makers need to find ways of utilising the skills and expertise of the early retired and younger old. There are skill and labour shortages in various sectors, including health and social care, and this pool of political volunteers needs to be targeted.
- Finding effective ways to genuinely engage older people in the policy making process, not to give then special rights but to overcome exclusion.
- Enabling service users to exercise greater power over the nature and delivery of services.

2.10 Research on ageing

In recent years, ageing research has raised its profile in the UK, and a key driver of change is the policy making process. In 1995 a government scientific initiative on Extending Quality of Life (EQUAL), led to specific research council programmes. One of those sponsored by the Economic and Social Research Council (ESRC), called Growing Older, has an explicit focus on policy and practice (http://www.shef.ac.uk/uni/projects/gop). This programme covers six key topics in the quality of life of older people: its definition and measurement; inequalities in quality of life; technology and the built environment; health and productive ageing; family and support networks; and participation and activity. It consists of 24 separate projects and is due to complete its work in 2003. In addition, there are parallel programmes sponsored by the Engineering and Physical Sciences Research Council and the Biotechnology and Biological Sciences Research Council. Another initiative by four of the UK's scientific research councils, the National Collaboration on Ageing Research (NCAR), aims to encourage multidisciplinary research (http://www.shef.ac.uk/ukncar).

Apart from the UK research councils there are a wide range of funders of ageing research, and one aim of NCAR is to bring together all of the main ones for a regular discussion of priorities. In the social sciences and policy-related field there are three that should be highlighted. The Department of Health is a major funder of research on ageing, and most of its resources are linked to policy priorities (at present the NSF for Older People). The Rowntree Foundation has a long record of research in this field and currently focuses on the empowerment of older people with regard to services and later-life pathways. The Nuffield Foundation has a large research programme on ageing which, like the ESRC Growing Older Programme, focuses on quality of life.

The key issues for the future, assuming a continuing flow of resources into research and ageing, are how to bridge the gap between scientific research and policy and practice, and how to encourage collaboration across disciplinary boundaries. With regard to specific future research priorities the relatively neglected issues include technology, housing and transport; pensions and income security; the oldest old; diversity in ageing; and citizenship with regard to locality and place. Also there is a need to develop methodologies for researching numerically small populations of older people, whose numbers are growing faster than average (e.g. minority ethnic groups), and which enable

older people to participate directly in research. Across all topics of ageing research there is an absence of comparative studies.

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3 Comparative summary and recommendations for research

3.1 Comparative summary

Both Germany and the UK are experiencing threefold population ageing: the absolute number of older people is increasing; their relative share of the total population is rising; and they are living longer. In both countries the two core underlying factors are declining fertility and increased longevity. These trends are both long-term ones and are predicted to stabilise in the future. One of the most important features of the older population in both countries is the gender distribution: at successively older ages in Germany as well as in the UK the population of women increasingly exceeds that of men. For both countries it is also true that progressive ageing of minority ethnic groups is expected; however, the population of older migrants in both countries is currently much smaller than that of the native population.

In both countries, older workers, particularly men, have in the past been regarded by employers and policy makers as a sort of reserve army of labour. Early exit has been a well-entrenched trend which began in the 1970s. However, early exit of older workers can be seen as the 'tip of the iceberg' of the actual problems older workers face in their working lives. In both countries older workers have been confronted with numerous forms of direct and indirect discrimination in the workplace. Long-term unemployment and non-employment among older workers has been the most evidence of this. Both countries are now beginning to rethink their policies towards older workers. The ageing of the workforce in the UK and in Germany is thus the starting point for endeavours to stop early exit and to postpone the *de facto* retirement age. In Germany, the financial consequences of early exit for the stability of the public old age income security systems are an additional starting point. In both countries special programmes have recently been implemented. Time will tell whether a reduction in the hitherto prevailing age discrimination in employment in both countries will be realised.

In terms of the distribution of income, poverty and wealth in old age there are clear differences between the two countries. These primarily mirror differences in the basic structure of public and private old age income provision, which in both countries has been facing fundamental changes, previously in Germany and currently in the UK. In Germany an additional private retirement scheme with statutory regulations and state subsidies on a voluntary basis was created, complementing the three existing pillars – statutory pension insurance scheme for all employees, the old age civil servant scheme and private company pension schemes. In the UK a Pension Credit system will be introduced which will lead to a slightly higher level of basic income. In all, in Germany poverty in old age only affects a minority today, whereas economic wealth is widespread. In the UK there is both a continuing association between low income and poverty in old age as well as a polarisation of older people between poverty and affluence. However, in Germany, as a result of both social change and an increase in the number of people with discontinuous and/or unstable working arrangements, future cohorts of older people may

also face low incomes. In both countries there is a need for social policy action both to secure the financial instability of old age income security systems against a backdrop of demographic changes and to combat (UK) or prevent (Germany) poverty in old age.

Although there are no signs of a simple correlation between illness and old age in both countries, the number of persons with poor health, chronic illnesses and multimorbidity increases with age. Also in both countries the risk of morbidity increases with lower social status and is extraordinarily high within minority ethnic groups. As a whole, in both countries the state of health in old age must be seen as the result of several factors determining the life course: the material, psychological and social living conditions. For example, in the UK there is a strong association between a person's last main occupation and health in later life. In both countries older people with the highest income report the best health. Furthermore, in both countries the incidence of cognitive impairment has increased with longevity and at the same time is one of the main reasons why older people enter long-term institutional care. Consequently, fighting and preventing dementia is an important goal of health policy in both countries. Similarities can also be found in the shared goal of breaking down the traditional barriers between health and social care. Unlike in Germany, age, gender and racial discrimination in the distribution of health services and procedures is widespread in the UK, and is said to be one of the major challenges confronting health services for older people. Finally, in both countries the need to promote prevention has not hitherto been a significant feature; however, at least in Germany it is currently seen as a major starting point for action in health policy. It remains to be seen whether enough financial resources will be made available.

In both countries, if older people need care it is most often provided by themselves or by close relatives. The main family carers are usually ether adult children (mainly daughters) and/or spouses. Thus, in both countries people in need of care have to move into nursing homes or hospitals. The figures for Germany and the UK are roughly comparable. However, in the UK there are profound regional differences in the distribution of care services. This used to be true for Germany as well, but these differences have been evened out in the wake of the introduction in 1994/6 of Long-Term Care Insurance, at least in the case of community services and nursing homes. However, there are still important gaps in day care and night care services. Financing long-term care is still a major social policy issue in both countries; albeit, with different perspectives. Whereas in the UK for many in need of care it is of crucial importance whether they have to pay the bulk of their home care themselves, in Germany the crucial question is how Long-Term Care Insurance can be protected from the financial constraints which are expected in the wake of demographic change.

In both countries a rising number of older people in need of care is expected. This has to be seen against the background of rising further life-expectancy, the development of morbidity risks and in the increasing number of very old people. A further rise in the number of dementia cases is expected as well. Together with changing family patterns and a further rising gainful employment of women a further enlargement of professional care services is seen as inevitable in both countries.

This is also true for home care, which is increasingly affected by similar factors. Here, too, reconciling work and care of the elderly is seen as an important issue for women in both countries. As a whole, preventive measures to curb the need for nursing and/or the onset of dementia should become a high priority for future policy and research.

In both countries only a very small percentage of older people live in institutions; far more than 90 per cent live in private dwellings. In both countries housing policy is currently seen as an important tool in pursuit of the overarching goal of fostering the ability of seniors to live independently as long as possible. For both countries it is true that larger proportions of older people live in their own homes; however, home ownership in old age can be experienced as a benefit or a burden. What older people want is suitable mainstream housing which is designed with changing needs in mind. In Germany special services have been created in order to support independent living, such as housing counselling, the adjustment of living space and special modernisation measures to promote better access to buildings and apartments. However, in the UK most of the housing stock is not ideal for growing older in, because it is unsuitable for adaptation. In both countries the concept of sheltered housing has been developed as a suitable alternative, but it is not widespread in Germany.

The most important social network of older persons in both countries is the family. However, changing family patterns constitute a threat to this in both countries. However, family solidarity is still strong in both countries, and reciprocity is a major element in intergenerational relations. In both countries children play an important role in caring, whereas grandparents play important social and financial support roles, especially when the grandchildren are very young and dependent. Against the background of changing family patterns and a rising number of older single households, it is crucial to ask how existing social networks can be stabilised and/or how new informal networks can be created that might supplement or compensate family networks (e.g. community work).

The issue of societal and political participation among older people has become a significant one, in policy terms, in both countries. Both countries have witnessed the growth of grass-roots organisations of older persons. The decentralised structure of government in Germany appears to offer more opportunities for participation in decision making compared to the UK. Moreover, there are more public policy initiatives designed to increase social participation than in the UK. Nonetheless both countries are on a similar path towards raising participation, reflecting a common acceptance of the policy of active ageing. The two countries differ, however, in the extent of the development of the practice of user involvement in health and social care, with Germany lagging somewhat behind the UK.

When it comes to the sponsorship of ageing research it is not surprising to find that the UK is centralised and Germany decentralised. The centralisation of research in the UK has led recently to several major national initiatives to encourage research in this field and, especially, interdisciplinary research.

3.2 Proposals for a joint research programme

As this brief summary shows, there is common potential for comparative research between Germany and the UK. Here, for illustration purposes, we suggest some possible lines of inquiry, all of which would be of great relevance to other EU countries as well.

The importance of population ageing

Research might focus on how both countries are adapting to the challenges of their ageing societies. What are the main policies and principals underlying them? What lessons might be exchanged?

- Recent political discussion/policy proposals to tackle future demographic challenges
- The generational contract in both countries – pressures and contributions
- Pros and cons of a gender-specific policy for old age
- Assessment of the current/future migration policy with special emphasis on older migrants
- Comparison of training and further training of professionals working with older persons (in all sectors: social workers, professional carers, general practitioners etc.)
- Gerontological research activities and priorities in both countries

Work and employment

This is clearly a critical area for future policy research and there is a substantial foundation of comparative work on which to build.

- Comparison of corporate practices with regard to in-company older workers (German–UK follow-up study of the European Foundation's Age-Barrier Project)
- Comparison of national labour market strategies and policies towards older workers/older unemployed
- Self-employment of older workers
- Pathways from employment to retirement

Income, poverty and wealth in old age

The World Assembly on Ageing has placed this issue at the top of the international policy agenda.

- Poverty in old age in both countries and how to combat/prevent it
- Pros and cons of private old age income security schemes
- Social change, changes in life courses and the so-called normal biography and implications for old age income security
- The economic power of old age – economic implications of demographic change for national economic development/growth

Health and health care

Health systems are in flux in both countries and population ageing is commonly recognised as a significant source of pressure.

- Development of health expenditures and demographic change
- Social status, gender, ethnicity and illness/health in old age
- How to prevent chronic diseases in old age (including self-help activities)
- Opportunities and barriers to the combination of health and social care
- How to adapt the health care systems in both countries according to demographic changes, age-specific morbidity etc.

Long-term care

- Similarity to health this topic is of great importance to both countries.
- Evaluation of services that prevent the need for home care
- Ambulatory services including sheltered housing for older people suffering from dementia
- User involvement and user empowerment in professional care services
- Promotion of informal help and support for older persons in need, of care including the integration of professional and informal carers
- Quality standards and quality assurance in care services
- Reconciling work and eldercare
- Hospices and other services for dying persons
- Violence and care for the elderly – myths or reality?
- The interweaving of care with other social and health services

Housing

This is recognised in both countries as critical for the independence and well-being of older people.

- Technical support for independent living in old age
- Sheltered housing
- Services promoting independent living in old age (cleaning etc.)
- Smart housing, housing designs and technology as aids to independent living

Social networks and social support

This is a neglected area of research but a critical element of quality of life in old age.

- The role of informal networks in quality of life in old age and how to maintain, strengthen and supplement them (e.g. community work)
- Policies to tackle loneliness and isolation among older persons, particularly among persons living alone
- Divorce, marriage and friendship in old age in both countries
- Older persons as grandparents

Societal and political participation

Another neglected issue for research in both countries but one that is of growing importance.

- Political power and political participation in old age
- The role of older members within political parties, unions and other organisations
- Empowerment of older service users
- Measures promoting inter- and intragenerational solidarity
- How to use the productivity and the potential of older persons in a better way?
- Seniors as volunteers.