

London Research Centre

**Health Strategy for London:
Rapid review on Older people in London**

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Summary and conclusion of findings

The health of older people in London is affected by a wide range of factors and services. The built environment, income, housing, access to transport and services, crime, pollution as well as the availability of both informal and formal care. Many policies and services are not developed with the health needs of older people in mind but their impact is none the less important. This review looks at the demographic profile of older people in London and future trends, and at the impact of a range of factors on their health and well

Age structure of the older population

Older people as a group are immensely diverse, more so in London than elsewhere in the country.

London's population aged 65 and over was estimated to be just under 920,000 in 1997. This overall number is projected to decrease by about four per cent by 2001 and then by a further four per cent by 2006, and one per cent up to 2011 after which it will increase. This general decline will affect all age groups except those aged 85 and over, whose numbers were projected to increase by three per cent by 2001 before falling by two per cent up to 2006. Older men in the 85 and over age group will see a marked increase.

Older people are under represented in London's population compared to the rest of the country, especially in the 65-74 age group. About 13 per cent of London's population was aged 65 and over compared to 16 per cent for England as a whole and 15 per cent for the other Metropolitan authorities.

For Inner London less than 12 per cent of the population was in the 65 and over age group while for Outer London it was slightly higher at just over 13 per cent.

Ethnicity

London has the highest concentration of people from minority ethnic groups in late middle age and old age of any part of the country. London will also experience the fastest growth of older people from minority ethnic groups over the next decade of any part of the country.

The 1991 Census showed that nearly half of all ethnic minority residents over pensionable age in Great Britain were living in London. Because of the generally younger age structure of black and minority ethnic groups, they only made up seven per cent of London's total population aged 65 and over in 1991 while they formed just over three per cent of the England total. The proportion aged 65 and over from ethnic minority groups was projected to increase to nearly 15 per cent in London by 2006.

The living arrangements of older people

London has a higher proportion of older people living alone than most other parts of the country. Data from the 1991 Census showed that just over 35 per cent of all London's pensioners lived alone, more than three quarters of whom were women. This compares with a figure of just over 30 per cent of pensioners living alone in other parts of the country.

Disability and illness

The health of older Londoners is generally better than that of older people in the rest of England and they experience a lower incidence of disease and death at all ages. However, as the ethnic composition of London's older population changes health needs and health status will increasingly reflect the specific needs of minority groups. At the same time the general prosperity of London conceals districts of some of the most intense deprivation in the country.

Older peoples incomes

Retired people living on state pensions are among the most disadvantaged in Britain especially single older people.

An study by the Association of London Authorities found that nearly 1 in 10 pensioner households in London do not heat their bedrooms or living rooms because of concern about heating bills; nearly 1 in 5 older Londoners find it difficult to raise money to pay their heating bills; and 1 in 4 pensioners homes in London lack central heating.

The chances of dying before the age 75 in areas of east and South London are almost twice as high as in the least deprived parts of the capital. Such variations also exist within boroughs and this divide has been widening in London and the UK as whole. Five of the ten most deprived areas in the country and 13 of the most 20 deprived are in London.

Over the last 10-15 years the fall in mortality in London has not kept pace with the national decline and the difference in mortality between affluent and deprived wards has increased.

Rates of limiting long-term illness also correlate with measures of deprivation and show a concentration in wards in certain Inner London boroughs. Though the rate for all of London is slightly lower than the national average, for some boroughs the averages are up to 35 per cent higher than the national rate.

Health and social care

Age is an important source of inequality in health, especially in relation to access to services. Older people are more than other age groups to experience problems in gaining access to NHS treatment and services which could substantially benefit them.

The Turnberg Report into health services in London identified services under pressure across the whole range of services, from community and primary care to hospital based services. The impact of these pressures was mostly keenly felt in the care of elderly people and those with mental illness.

The situation in London is more complicated than in other parts of the country due to the impact of factors such as ethnicity, low income and issues such as transport and housing. Joint working in London is also made more complicated by the large number of geographical and administrative boundaries that exist in London.

Housing and health in London

The quality of much of the housing stock in London is not high. Currently there are around 243,000 properties in London which are classified as 'unfit' for human habitation more than three quarters of which are in the private sector. There are also estimated to be another 400,000 local authority and 20,000 housing association dwellings are in need of renovation.

Many 'unfit' properties are lived in by owner occupiers who simply cannot afford the upkeep of their property and London's private housing is made up of housing that is older than the national average. Private sector housing tends to have more poor quality housing than the social housing sector.

Housing in London is the most expensive in the UK to both rent and buy. Because of this and due to older people's generally low incomes and a shortage of affordable alternative housing, for many in London there remain few options in terms of moving to more 'habitable' premises.

London has a higher proportion of flats than elsewhere in the country. One in four council properties in Inner London is in a high rise block (over 5 storeys) and there is strong evidence to suggest that living in this kind of property can have detrimental effects on health.

For many older people, the design and adaptation of their housing, the housing and development policies pursued by the relevant authorities, and the way in which health and social care services are delivered can greatly affect their ability to cope with existing

Residential care for older people in London

For many older people residential and nursing care will be sometimes a necessary and perhaps the only choice. But London has fewer residential and nursing homes for older people than elsewhere in Britain. This is due reasons such as the low profit margins to be gained through this kind of business (around £10 per bed per week) the high cost of building new homes in the capital and also older people choosing to go into care outside London.

Currently in London there are waiting lists for admission into care or nursing homes for elderly mentally ill clients (EMI) a problem that can be further compounded by the need to place some clients in places which can cater for special diets or offer specific languages.

Homelessness

For many older people the issue is not one of poor housing but of homelessness.

Age Concern London have suggested that in 1991 around 30 per cent of those living on the streets or in hostels in London were over 50 and in 1995/96 Bridge Housing Association calculated that 38 per cent of the homeless people they housed were over 50.

Homeless people are at greater risk of mortality and morbidity. It has been estimated that rates of long-term illness among the homeless is 2.5 times greater than that for the rest of the population.

Accessing public transport for older people

For many older people good public transport is an essential part of getting access to a wide range of goods and services that are not always available locally.

Older people are more likely than other groups to find access to public transport difficult and are less likely to have access to alternatives such as cars. As well as having lower disposable incomes than many other groups in society, they are also more likely to feel unsafe in public and are among the most vulnerable groups in the community in terms of accidents and the harmful effects of air pollution.

All of these factors can deter older people from making or being able to make journeys. It leaves many older people dependent on often inadequate and more expensive local services such as shops that fail to meet their needs and can increase their own sense of isolation from wider society. The result is often worsening physical and mental health.

Crime

For many older people the level of crime or more importantly the fear of it is a major concern. Many older people feel afraid to travel or leave their homes after dark. With amenities often located some distance away from where older people live it means for many the journey is just too long or difficult for them to feel that they can safely undertake it.

The effects of crimes and the fear of crime can cause increased isolation, lack of activity and depression, leading to the need for service intervention, including in some cases admission to hospital or residential care. A study for the Department of Health on the reasons why older people choose to enter residential care found that fear, including the fear of crime, was a major factor in the decision.

Isolation and older people

Isolation can have a far reaching impact on the health and well-being of older people ranging from depression and an inability to fight ill-health, through to mental illness and suicide. Isolation among older people is often a gradual process which takes over their lives, and it has multiple causes. These include health problems, disability, death of a partner or friends, loss of a role in society, poverty, fear of crime, cultural isolation and lack of understanding or ageist attitudes.

Changes in the culture or in the local environment can also leave older people feeling isolated, as can migration or language difficulties. Older people also often find it hard to share their thoughts and feelings or feel that their experiences will be of little concern to those younger than them.

Conclusions

The agenda for improving the health and well being of older people in London is a complex and diverse one. Although many authorities can, on their own, take practical steps to improve the health and well-being of older people within their own areas, the real gains for older people and for the services that they rely on are likely to come through the development of long-term partnerships between the community and a wide range of service providers. This will be based on the recognition of the complex nature of health and health improvement and the role that each has to play.

The King's Fund London Commission recommended, 'The health and social care of older people should be recast within a wider, more inclusive approach to the well-being of older people within national and city-wide policies. This will require greatly improved policy co-ordination for social security and environmental policies as well as health and social care. Within London, community and borough development and regeneration programmes need consciously to include measures to support the well being of older Londoners, including their safety.'

The Better Government for Older People initiative, launched by the Cabinet Office in 1998, 'aims to improve public services for older people by better meeting their needs, listening to their views, and encouraging and recognising their contribution'.

The key to better services and better health is strategic partnership between different services and the people they aim to serve.

Many authorities already understand their own role as a service but not necessarily in terms of how they can work with other services toward common aims. Equally the history of the involvement of members of the community is less developed in some services than in others.

The challenge for all services in London is therefore a complex one involving the use of traditional skills and areas of expertise and the development of new ones.

The role of the Mayor will be pivotal in helping to improve the health of older people in London because of the important role that they will play in the economic, social and environmental affairs of the capital.

Demography

Age structure of the older population

Older people as a group are immensely diverse, more so in London than elsewhere in the country.

London's population aged 65 and over was estimated to be just under 920,000 in 1997¹. This overall number is projected to decrease by about four per cent by 2001 and then by a further four per cent by 2006, and one per cent up to 2011 after which it will increase. This general decline will affect all age groups except those aged 85 and over, whose numbers were projected to increase by three per cent by 2001 before falling by two per cent up to 2006. Older men in the 85 and over age group will see a marked increase (table 1).

However, older people are under represented in London's population compared to the rest of the country, especially in the 65-74 age group. ONS figures for 1998 (table 2) show that about 13 per cent of London's population were aged 65 and over compared to 16 per cent for England as a whole and 15 per cent for the other Metropolitan authorities.

There are also differences between Inner and Outer London. For Inner London less than 12 per cent of the population was in the 65 and over age group while for Outer London it was slightly higher at just over 13 per cent. It is however, also worth noting that there are divergences around these patterns across London. For example, at the 1991 Census the boroughs of Bromley, Richmond upon Thames and Barking and Dagenham all had an above national average proportion of older people.

The reason for this difference between London and the rest of the country is that London experiences a high rate of migration of young people from other parts of the country but also has a much higher outward migration rate among those aged 60-74, especially from those in above average income groups. London also loses substantial numbers of those aged 75 and over, who either move to be nearer relatives or to take up a place in a residential or nursing home outside the capital. There is also evidence of migration from the Inner to the Outer London boroughs.

London also has a higher proportion of young people in its population than the rest of the country partly because of the large number of people from minority ethnic groups that live in London. The history of migration of these groups means that they have a much younger age profile than the rest of the population. As these communities mature there are likely to be more older people among these groups with a consequent increase in the proportion of older people in London.

The short fall in the 65-74 age group means that the mean age of London's older population is higher than the rest of the country. Data for 1995 showed that the mean age of a man in London in the 65 and over age group was 73.8 compared to 73.6 for England. For women the mean was 75.9 for London and 75.5 nationally.²

Ethnicity

London has the highest concentration of people from minority ethnic groups in late middle age and old age of any part of the country. London will also experience the fastest growth of older people from minority ethnic groups over the next decade of any part of the country.

The 1991 Census showed that nearly half of all ethnic minority residents over pensionable age in Great Britain were living in London. Because of the generally younger age structure of black and minority ethnic groups, they only made up seven per cent of London's total population aged 65 and over in 1991 while they formed just over three per cent of the England total. The proportion aged 65 and over from ethnic minority groups was projected to increase to nearly 15 per cent in London by 2006 (Table 3). This does not include Irish people, who were not classified separately in the last Census, but information on country of birth shows that one in twenty people of pensionable age in London in 1991, were born in Ireland.

Table 3 shows that Black Caribbean elders in London constitute 35 per cent of the total number of older people from minority ethnic groups with Indian elders accounting for a further 31 per cent of the total, reflecting the pattern of immigration into the UK. The fastest growing groups (in terms of increases in ethnic elders) between 1997 and 2011 will be from older people from the Black African, Other Asian and Bangladeshi communities.

Men are also in the majority among the Black Caribbean and Bangladeshi populations in their 50's and 60's, again reflecting migration patterns.

The living arrangements of older people

A number of factors have an important bearing on the living arrangements of older people and will be important in determining the future care needs of older people. Of particular importance are changes in marriage and fertility patterns, the increase in longevity, the rise in divorce, cohabitation and lone parenthood and availability of informal care. The uncertain impact of these changes makes it difficult to predict the future care needs of older people in London

General Household Survey³ (GHS) data for 1996-97 shows that nationally of those aged 65 and over living in private households, 26 per cent of men and 49 per cent of women lived alone, a figure which increased for those aged 85 and over to 52 per cent of men and 71 per cent of women.

London has a higher proportion of older people living alone than most other parts of the country. Data from the 1991 Census showed that just over 35 per cent of all London's pensioners lived alone, more than three quarters of whom were women. This compares with a figure of just over 30 per cent of pensioners living alone in other parts of the country. Only in Greater London, Manchester and Tyne and Wear did the proportion exceed 35 per cent.⁴

The likelihood of living in an institution is also linked to age and marital status. Data from the 1991 Census showed that nationally 16 per cent of men and 27 per cent of women aged 85 and over were living in a non-private household of some description. The data also shows that 32 per cent of single men and 21 per cent of widowed men aged 85 and over lived in an institutional setting as did 36 per cent of single women and 28 per cent of widowed women. In 1991 only 6.3 per cent of Inner London's 85 and over population and 9.3 per cent of the Outer London population lived in a nursing home compared to a national figure of 15.3 per cent in 1991.⁵

A higher proportion of women live alone than men for all age groups while more men live with a spouse. The majority of older men aged 65 and over, 62 per cent, live with their spouse compared to just 38 per cent of women. The proportion of older people who are

married declines with age. Because men die at a younger age than women, older men are more likely to be married than older women especially among very old people. In 1997 over half of men aged 80 and over were married compared to only one in six women of the same age. Men also tend to marry younger women and widowers are more likely to re-marry than widows are while divorced men have higher remarriage rates than divorced women.⁶ At the time of the 1991 Census 8 per cent of men had remarried while 4 per cent were divorced. This compares with 4.1 per cent and 5.1 per cent of women.

However, as life expectancy has increased faster for men than for women the expectancy of widowhood has fallen for all age groups except for women in their 80's. Against this the incidence of divorce has increased rapidly with younger older people more likely to be divorced than older people.

Cohabitation has also increased. Office of National Statistics (ONS)⁷ data suggests that in 1996 around 2 per cent of men and women aged 55 to 64 and 1 per cent of those aged 65 and over in England and Wales were cohabiting. It is anticipated that the proportion cohabiting will increase in the future.

Informal caring

Although informal care is very important in maintaining people in the community, ONS data shows that only a tenth of elderly people would chose to live with relatives or friends if they became unable to care for themselves, although much informal care is provided by people outside of the home. However, the high level of mobility in London's population means that family networks are more dispersed and it has been argued that there is a lower prevalence of care by relatives in London than elsewhere.⁷

Patterns of family life based on ethnicity show both similarities and distinct differences between ethnic groups. ONS⁷ cite an Age Concern analysis of GHS 1984-1994 data which shows that 31 per cent of white households containing people aged 60 and over contained just one person compared to 25 per cent of 'Black' older households and just 8 per cent of Indian older people households. For London 1991 Census data showed that over 36 per cent of all white pensioners lived alone as did 30 per cent of Black Caribbean and 34 per cent of Black Other. Against this only 10 per cent of both Indian and Bangladeshi older people lived alone.

The Age Concern data also showed that for all ethnic groups just 1 per cent of households containing people aged 60 and over were three-generation households. But this figure rose to 32 per cent for Indian households and 54 per cent for Pakistani/Bangladeshi households containing people aged over 60. The reasons for different households structures are complex and may be as much because of economic necessity as choice. It also can't be assumed that these patterns will continue into the future or that these household patterns imply any less need for services.

Life expectancy

Life expectancy is currently rising by about two years every decade for men and one and a half years for women.² Currently a man aged 65-69 can expect to live for another 14.8 years while a woman of the same age can expect to live for a further 18.6 years. A man can expect 13.5 of those years to be disability free and a woman 15.6. In 1997 life expectancy in the UK was over 74 years for men and over 79 for women with life expectancy at all ages increasing.²

Women have lower death rates than men at all ages. For older men the death rate nationally in 1997 was 3,262 per 100,000 and for women 3,075.⁸ Men currently outnumber women until round the age of 50 above which there are increasingly more women than men. By the age of 85 there are three women to every man in London but data suggests that this imbalance is being steadily eroded over time such that by 2021 there will be about two women aged 85 and over for every man of the same age in London, in line with national trends (Table 1).

Mortality rates can be affected by the age structure of the population and rates in London are generally below national rates. Age-specific death rates in 1996 were 27.2 per 1,000 people aged 65-75 compared to 27.0 for England but were 65.8 for those aged 75-84 and 152.2 for those aged 85 and over against England rates of 67.1 and 162.3 respectively⁹

Allowing for London's older age structure Hamblin, quoted in Warnes,⁶ calculated that in the period 1989-1994 males in London aged 65 and over experienced 4 per cent fewer deaths per year than the rest of England and Wales while women experienced 7 per cent fewer.

However in Inner London Hamblin also found that men had a slightly higher mortality rate than would be expected while women were still below what would be expected. Part of the explanation for this is that groups such as Black Caribbean and Bangladeshi communities have more older men than women and both have higher death rates than the general UK population. Over representation of males in these sub-populations helps to account for these differences.

The reason for the differences between London and the rest of the country lies partly in social class composition. London has a higher representation of higher occupational classes than the rest of the country and a comparative lack of heavy industry. Life expectancy is linked to social class and also to ethnicity. In 1992-1996 an unskilled man aged 60 could expect to live nearly 13 more years, about 4 years less than men in the professional class. There is also evidence that London exports some of its deaths in terms of people moving away from the capital to residential and nursing homes, or to be nearer relatives.

Disability and illness

The health of older Londoners is generally better than that of older people in the rest of England and they experience a lower incidence of disease and death at all ages. However, as the ethnic composition of London's older population changes health needs and health status will increasingly reflect the specific needs of minority groups. At the same time the general prosperity of London conceals districts of some of the most intense deprivation in the country.

While the prevalence of disability and illness increase with age (table 4) successive cohorts have different exposures to risk factors such as smoking and diet, and age specific prevalence rates of physical and mental disorders are not necessarily constant. Information on the prevalence of disability and ill-health is difficult to map accurately and the evidence is mixed. However, the broad morbidity patterns of London's older people does not differ greatly from national patterns⁶ although there are consistent differences between the inner and outer areas.

The Health Survey for England has a self reported measure of health and found that the proportion of people reporting good health declines with age while men generally report better health than women. At ages below 80 men and women who lived with a partner reported better health than those who didn't.

The most comprehensive study of disability, the OPCS Surveys of Disability,⁹ carried out in the mid 1980's, found that 24 per cent of those aged 60-69 had a disability, rising to 67 per cent of those aged 80 and over (table 4). Data for the 1990-91 and 1996-97 General Household Surveys based on all adult respondents showed that London had a lower rate of prevalence than the nation as a whole.

The 1991 Census asked whether each person had a limiting long-term illness, health problem or handicap which limited the daily activities or work they could do, with specific instructions to include problems due to old age. The Census showed that in London 26.8 per cent of older people aged 60-64 had a limiting long-term illness rising to 60.3 per cent for those aged 85 and over. Overall 38.1 per cent of people of pensionable age reported a limiting long-term illness in London compared to 39.2 per cent nationally. However, the figure for Inner London was 40.1 per cent, higher than the national figure, while for Outer London it was 36.7 per cent. These rates varied considerably from 33.1 per cent in Kensington and Chelsea to 45.5 per cent in Hackney.⁴

Warnes also cites a study by Benzeval et al 1992 which found that the average number of physical illness symptoms was 2.8 per cent lower in London than in England but 3.5 per cent higher than the other metropolitan areas. The proportion of people assessed as unfit was 5.6 per cent lower than for England. But he also found higher levels of limiting disability in London but not non-limiting disability.

However, one further summary measure is the percentage assessed as having poor overall health which showed an excess of 12.5 per cent for London. It was estimated that 26 per cent of men aged 60-69 and 35 per cent of women had poor health, and among those aged 70 and over this figure rose to 32 per cent of men and 50 per cent of women (Benzeval et al cited in Warnes).

Data from the General Household Survey suggest that rates of limiting long-standing illness have not changed significantly since 1975 but this may be due to a greater self awareness of health and methods of diagnosis. However, healthy life expectancy, as based on the GHS and the self-reported limiting long-standing illness question is open to wide interpretation. Bone et al 1995, cited by Warnes, found health expectancy to have increased in proportion to life expectancy 'with the result that the proportion of remaining years of life free of these disabilities has almost stabilised'. Against this Bebbington et al 1991, also cited in Warnes, argues the opposite and that 'the trend in ratio of health expectancy to life expectancy ... indicates no compression of morbidity'.

Studies on mental illness suggest that one per cent of those aged 65-74, five per cent at aged 75-84, 20 per cent at age 85 and 33 per cent of those in their nineties will have dementia of which up to one third will be severe.¹⁰ Many people with dementia live alone and have care needs that include some kind of supervision.

Estimates of the prevalence of depressions among people aged 65 and over range between 5 and 13 per cent for men and between 8 and 25 per cent for woman.¹¹ Depression is largely unrecognised and untreated among older people. One London survey found that more than a third of people over the age of 65 showed some evidence

of depression, and for 12 per cent this was “pervasive”.¹² A study in 1991 screened patients aged 75 years and over for depression and dementia. Up to 30 per cent of those studied needed further assessment for depression.¹³

Some groups are more at risk than others. Between 26 and 44 per cent of those receiving domiciliary care suffer from clinically significant levels of depression, while for those in residential care, the rates vary from 30 to 50 per cent.¹⁴

A recent study has shown that the factor most likely to influence people’s use of community health and social services is living alone, which is one of the risk factors in depression. Depression is also difficult to distinguish from early dementia, as older patients often deny their mood disorder and focus on their memory problems.¹⁵

Depression is known to affect physical health and mortality, including suicide. In Cattell and Jolley’s¹⁶ study in 1995, almost two thirds of the suicides were of people who had a diagnosis of depression. The risk of suicide among elderly people with depression may be four times as high as that in a similar group of younger people. Those most at risk are male, living alone, not married, socially isolated, recently bereaved or recent home-movers. There are also clinical risk-factors, such as hypochondria, insomnia, weight loss and chronic physical ill-health. Suicide rates for elderly people in London are among the highest in the UK. However, elderly black people are much less likely to commit suicide than elderly white people..

Depression in older people is associated with other kinds of mortality, besides suicide with long-standing depression seen as a predictor of mortality. Older physically ill patients with depression are more likely to die from their physical illness than non-depressed patients with the same condition. One reason for this may be that depression appears to be a major cause of non-compliance with medication. In addition, depression is a recognised side-effect of some medications that are frequently prescribed to older adults.

Although percentages vary widely, there is agreement that depression is a widespread and underrated phenomenon among the elderly. One of the problems in assessing its extent is that it is often not diagnosed. The condition may arise from internal causes (personality or brain function) or from external causes like bereavement. It is often hard to distinguish between understandable reactive depression, caused by events like bereavement, and a clinically significant depression.¹⁷ There is also a widespread assumption that depression or at least sadness is a normal accompaniment of growing old.

Symptoms of anxiety are also very common amongst older people, but the reported prevalence of those classified as needing specialist psychiatric treatment is only two to four per cent.

Table 1: Projections of older people of London, 1997-2016

	65-74		75-84		85 and over		All 65 and over	
	No	Change	No	Change	No	Change	No	Change
Males								
1997	224	-	121	-	30	-	375	-
2001	216	-3.6%	121	0%	33	+10.0%	369	-1.6%
2006	209	-3.3%	120	-1.0%	34	+3.0%	362	-1.9%
2011	211	+1.0%	116	-3.4%	36	+5.9%	362	0
2016	230	+9.0%	114	-1.7%	37	+2.8%	381	+5.2%
Females								
1997	262	-	197	-	86	-	545	-
2001	244	-6.7%	186	-5.6%	88	+2.3%	517	+5.2%
2006	236	-3.3%	174	-6.5%	84	-4.5%	494	-4.5%
2011	244	+3.4%	161	-7.5%	83	+1.2%	487	-1.4%
2016	269	+10.2%	157	-2.5%	80	-3.7%	505	+3.7%
All								
1997	486	-	318	-	117	-	920	-
2001	460	-5.4%	306	-3.8	120	+2.6%	887	-3.6%
2006	444	-3.5%	294	-4.0%	118	-1.7%	856	-3.5%
2011	455	+2.5%	276	-6.2%	118	0	849	-1.0%
2016	499	+9.7%	270	-2.2%	116	-1.7%	886	+4.4%

Source: LRC/ONS projections

Table 2: Older people as a percentage of total population by age group 1998

	65-69	70-74	75-79	80-84	85+	65 and over	75 and over	85 and over
Inner London	3.3	2.9	2.4	1.6	1.5	11.7	5.6	1.5
Outer London	3.7	3.2	2.8	1.8	1.8	13.4	6.5	1.8
Greater London	3.6	3.1	2.7	1.7	1.7	12.8	6.2	1.7
Metropolitan counties	4.4	3.9	3.3	2.0	1.8	15.4	7.0	1.8
Shire Counties	4.7	4.2	3.6	2.2	2.1	16.9	8.0	2.1
England	4.4	3.9	3.4	2.1	1.9	15.7	7.4	1.9

ONS Population estimates

Table 3: London's population aged 65 and over 1997-2011 by ethnic group

	1997	2001	2006	2011	1997-2011 % change
White	843,100	782,900	723,000	700,000	-17
Black Caribbean	27,300	35,800	43,500	44,600	63
Black African	3,800	5,100	7,700	10,000	163
Black Other	1,600	2,000	2,400	2,800	75
Indian	24,500	30,200	35,600	40,400	65
Pakistani	3,400	5,000	7,200	8,600	53
Bangladeshi	3,200	4,500	6,200	6,800	113
Chinese	2,900	3,400	4,200	5,000	72
Other Asian	4,800	6,200	8,300	10,800	125
Other	6,000	6,900	8,200	9,500	58
All ethnic minority	77,700	99,100	124,300	138,500	78
All persons	920,800	882,100	847,400	838,500	-9

London Research Centre and ONS

Table 4: Number with a disability in London by level of disability
(1 = lowest level of disability)

	Disability level by age group - percentage at each level						With any disability		Total pop by age group
	None	1-2	3-4	5-6	7-8	9-10	'000s	%	'000s
65-69	72.8	10.9	6.6	4.6	3.2	1.9	69.6	27.2	255.7
70-74	66.7	13.2	8.2	6.0	4.0	1.9	74.8	33.3	224.5
75-79	52.8	14.3	11.1	10.1	7.2	4.4	91.4	47.2	193.7
80-84	37.4	16.6	13.3	12.9	11.5	8.3	77.8	62.6	124.2
85+	21.7	9.1	11.5	18.0	19.3	20.2	97.3	78.3	124.3
65+	55.7	12.8	9.5	9.0	7.4	5.7	410.9	44.3	922.4

Source: OPCS Disability Survey

Income, deprivation and older people

Introduction

Income is a key determinant of health. Poor people have a greater likelihood of poor health^{18, 19} and the highest mortality rates are among those with persistently low incomes.

Levels of income tend to fall with age, which is partly a reflection of the fact that older people tend to live alone and not to be in paid work. But many poor older people have been poor all of their lives and find their position worsening as they age. Lifetime social circumstances are strongly related to morbidity and mortality in adulthood including childhood and adult circumstances and studies suggest that there is better health amongst the more affluent social classes.

The problem of health, income and deprivation has many facets at both an individual and geographical level. Such variation becomes apparent when comparing geographic areas with different levels of wealth measured using a composite indicator of material deprivation and comparing these with measures of health. The most deprived areas are also the ones with the highest mortality rates. There is also evidence of an association between the degree of variation in income and increased variation in mortality with London having a more unequal distribution of wealth than most other parts of the country.

Older peoples incomes

Retired people living on state pensions are among the most disadvantaged in Britain especially single older people. Average net equivalised²⁰ income for the period 1995-97 for a person in a pensioner couple household over retirement age was £243 per week compared to £232 for a single pensioner. However, pensioner couples in the bottom quintile in the UK received on average £134 gross income while those in the top received £606 per week.⁷

Older people are more likely to be located toward the bottom of the income distribution. Table 5 shows the distribution of pensioners' income against the national distribution. If pensioners were equally distributed through the income distribution, then 20 per cent of pensioners would be in each quintile group. As can be seen 52 per cent of pensioner couples are in the lowest two-fifths of income as are 58 per cent of single pensioners.⁷ Data from the Department of Social Security for 1994/95 shows that before housing costs 22 per cent of pensioner couples and 24 per cent of single pensioners have a household income 50 per cent below the national average compared to 19 per cent of the total population. After housing costs this figures rises to 25 per cent of pensioner couples and 33 per cent of single pensioners against a national figure of 24 per cent.²¹

A recent study for Help the Aged found that half of those age 80 and over live on £80 or less a week; one in four worries about being able to afford food; while two-thirds are concerned about paying for clothing or heating bills. Six out of ten respondents lived on less than £160 per week and 22 per cent of all respondents lived on less than £80 per week while one third spent less than £30 a week on food.²²

An earlier study by the Association of London Authorities found that nearly 1 in 10 pensioner households in London do not heat their bedrooms or living rooms because of concern about heating bills; nearly 1 in 5 older Londoners find it difficult to raise money to pay their heating bills; and 1 in 4 pensioners homes in London lack central heating.²³

Inequality among pensioners has also increased. In 1977 those in the top 20 per cent of income received 34 per cent of the income and those in the bottom 20 per cent received 13 per cent of total equivalised disposable income of retired households. In 1997-98 those at the top got 38 per cent and those at the bottom 10 per cent.

Gender has an impact both on average income and sources of income. A DSS analysis of the Family Resources Survey found that at all ages, older women have a lower average gross income than men. In 1996-97 average gross income of women in their fifties was £149 per week compared to £353 for men. For women in their 80's the average was £102 per week and for men £139.²⁴

In the past women have also tended to have shorter working lives than men and to have a reduced entitlement to occupational pensions on retirement. For many older female pensioners entitlement to the state pension will be based on the contributions of their spouse. Female pensioners receive a lower proportion of their incomes from occupational pensions than men and a higher proportion from benefits.

There are also substantial differences in the income distribution of pensioners from different ethnic groups. An analysis by Evandrou of pooled GHS data from 1984 to 1994 shows that while 30 per cent of White elderly adults (those over 60) were in the bottom quintile of the income distribution, 55 per cent of Indian elderly adults and 71 per cent of Pakistani or Bangladeshi elderly adults were in the bottom quintile.²⁵

Sources of income

Sources from which pensioners draw their income varies according to their overall level of income. The poorest pensioners rely heavily on state pension and benefits which made up more than four-fifths of the income of the bottom quintile in 1996-97.⁷

Older pensioners rely more on benefits as a source of income than younger ones and get a smaller proportion of their income from occupational pensions and investments .

In addition to couples having a higher income than single people in the same age group they also receive a lower proportion of their total income from benefits, including the state retirement pension and a higher proportion from occupational pensions, investments and earnings.

In 1996-97, 20 per cent of the average gross income of women in their seventies but 37 per cent of men's came from occupational pensions.⁷

Another factor that has an impact on people's income is the death of their partner. Average total household income falls on widowhood and the proportion of income from various sources changes. In particular widows become more reliant on state pensions and benefits.

Although some older people continue to work after reaching retirement age many obtain most of their income from pensions, either state or occupational or both. The Government Actuary Department estimated that in 1991, 6.5 millions pensioners received payments from occupational schemes.⁷

Few pensioners live on state pensions alone and the number of people with occupational schemes is increasing. However, older pensioners receive, on average, less income from occupational schemes than younger ones.⁷

Receipt of occupational pensions also varies between ethnic groups. The Family Resources Survey²⁶ shows that around three-fifths of households in Great Britain with a White head over pensionable age were in receipt of one or more occupational pension in 1997-98, compared with around a quarter of those with a head from the Indian, Pakistani or Bangladeshi group.

Membership of occupational pensions among non-pensioners still working has been falling in recent years mainly among full-time male employees while women's membership has been fairly stable. Against this the number in receipt of personal pensions is rising, with one quarter of men and two-fifths of women with a personal pension in 1996-97 in the work-force.⁷ Membership of pension schemes increases with earnings.

Research shows that most people think the basic state pension is too low to live on. In practice very few people live on just the basic state pension as they top it up with other benefits such as income support, housing benefit and council tax benefit unless they have other income or capital. But many of these benefits are aimed at the less well off.

The proportion of older people receiving council tax benefits and housing benefit increases with age and the proportion of older people aged 80 and over receiving income support is double that for those in their seventies (table 6).

In 1997-98 around a quarter of people aged 80 and over in Great Britain were in receipt of income support, partly reflecting different rules for the over 80's and the fact that older generations are likely to have less income from other sources. Receipt of income related benefit is also higher among women than men, reflecting the lower incomes of women. Receipt of disability benefits also rises with age as an older person is more likely to suffer from some form of illness or disability. Data shows for those benefit receiving family units where the household head was aged 80 and over, 29 per cent of were in receipt of disability benefits compared to 10 per cent of those where the household head was in their fifties.

While it would appear that in the future many older people will have an income that will allow them to live without recourse to income related benefits, there will still be a substantial number of older people who will depend on these benefits.

Assets

Older people also have a variety of assets they have built up over their lives. Those in the higher social classes are the most likely to have made investments for retirement. In 1994, 66 per cent of professional people and 9 per cent of semi-skilled and unskilled people had made such investments and couples were more likely than single people to have some form of financial assets.

One of the major assets that many people have is their house, which is often owned outright, effectively reducing household expenditure through not paying rent or a mortgage but many older people may have difficulty in repairing and maintaining their homes. Many older people do not of course own their own property.

However, retired people are less likely to be able to replace any assets spent and many are asset rich but income poor. They are also more susceptible to negative event such

as the onset of disability or ill-health which are likely to diminish savings as a result of the extra costs incurred.

In 1997-98 almost a third of single pensioners and one-sixth of pensioner couples had no savings at all. Couples were generally more likely to have higher savings than single people while single women were less likely than single men to have savings. Three quarters of single male pensioners had some savings compared with less than two-thirds of single female pensioners.⁷

Expenditure

Household expenditure also declines as people get older although older people are also more likely to have additional expenses associated with disability. In 1997-98 in households where the head was in their fifties, total expenditure per head was £165 per week compared with less than £100 per week where the head was aged 80 or more.⁷ Expenditure on leisure in particular declines.²⁷

Retired households have very different patterns of expenditure depending upon whether their income is derived from state pensions and benefits or from other sources.⁷ Less income and more income from benefits also means a higher proportion of household income is spent on essentials such as food, light and fuel than other households. These patterns also vary depending on whether there is a single person or couple in the household. There is also less 'spare' income in lower income households to pay for emergencies or even essentials such as extra heating during cold weather.

Poverty and health.

The relationship between low income, deprivation and health is a complex one. It ranges from practical issues such as being unable to heat and maintain the home or to feed yourself properly, to a greater likelihood of disability and loss of independence and susceptibility to a range of illness including coronary heart disease, respiratory disease and mental illness. Within the wider community it involves the effects of pollution, crime, accidents, poor housing and greater social exclusion and social pressures.

Differences in individual behaviour and lifestyle, for example smoking and diet, also have an effect on health. But this does not explain how these behaviours arise in the first place or the extent to which they are related to wider social and economic factors.

Differences in health between age groups can also arise because of cohort effects whereby the general population may become healthier as a consequence of wider changes in society such as increased affluence or public health initiatives.

However, the relationship between deprivation indicators and health status is strong and enduring. There are several definitions of deprivation available but Bardsley and Flatley²⁸ using Jarman UPA scores, (a composite measure of deprivation based on a number of indicators), demonstrate that the areas in London with highest levels of deprivation also have the highest levels of premature mortality.

The chances of dying before the age 75 in areas of east and South London are almost twice as high as in the least deprived parts of the capital. Such variations also exist within boroughs and this divide has been widening in London and the UK as whole. Five of the ten most deprived areas in the country and 13 of the most 20 deprived are in London. While Inner London is generally more deprived than Outer London even relatively affluent boroughs can have highly deprived areas within their boundaries.

Over the last 10-15 years the fall in mortality in London has not kept pace with the national decline and the difference in mortality between affluent and deprived wards has increased. The relative mortality of the most affluent wards improved by 0.7 per cent but for the most deprived worsened by 8.4 per cent which is evidence of a widening of the health divide within London.²⁹

Limiting long-term illness

Although the Standard Mortality Ratio is often used as a used to assess health status, mortality statistics are the end measure of ill-health and can disguise the need for services over a period of time leading up to death. For some key health problems, mortality statistics do not really show the burdens that are experienced. Chronic diseases can have a big impact on peoples lives and well-being, yet they are minor aspects of mortality statistics. However, data on morbidity for many conditions are not available and we can only estimate the prevalence across London.

As a measure of ill-health, limiting long -term illness, derived form the 1991 census is quite useful. It is a self-reported measure that covers the whole population. When standardised for age and sex (based on whole population but it is mainly older people in this category) Flatley and Bardsley³⁰ show that the overall rate of limiting long term illness for London is 96.9 compared to 100 for England and Wales. This figure rises to 110 for Inner London and 89 for Outer London. The highest rates were recorded in Hackney, Tower Hamlets, Newham and Islington which were 20-30 per cent higher than the national average. The boroughs of Richmond, Kingston, Kensington and Chelsea and Barnet were below the national average by a similar amount but these differences become even more acute at ward level.

Rates of limiting long-term illness also correlate with measures of deprivation and show a concentration in wards in certain Inner London boroughs. Though the rate for all of London is slightly lower than the national average, for some boroughs the averages are up to 35 per cent higher than the national rate.

The incidence of illness and infectious diseases such as TB is also higher in some boroughs than others. This variation is felt to be associated with changing patterns of immigration, poverty, and poor housing. Hospital admission rates for emergency admissions and acute mental health problems also show particularly wide variations with much higher rates in the most deprived areas within London.

Approaches to dealing with the issues raised

Many of the problems associated with low income and deprivation are entrenched across generations and require structural and national initiatives beyond the remit of health services. But while not having a remit to deal with low income and deprivation, health services have an important role in dealing with its effects and in acting in partnership with other authorities to promote health in London.

Many local authorities already pursue active anti-poverty strategies and many other initiatives such as crime reduction strategies, environmental policies all impact on health. Increasingly local authorities will also be expected to play an increasingly active role as community leaders, building partnerships with other agencies to promote the economic, social and environmental well-being of local people. Health services will be a key part of this new agenda of partnership. The needs of older Londoners, while not always at the centre of these initiatives ,will still need to be considered.

At the same time local authorities will have an opportunity to play a greater role in the development of local health services through initiatives such as Health Improvement Plans.

Within the context of a Pan-London approach, the election of a Mayor will be an important step for London. Although the Mayor will not have any responsibility for the provision of health services, they will be expected to promote the 'economic, social and environmental well being' of Londoners as well as having a responsibility to consider the impact on health of policies being pursued. The agenda and structures for this are still to be determined and await the election of the Mayor.

Table 5: Distribution of equivalised disposable income 1996-97

	Bottom Quintile	2nd Quintile	3rd Quintile	4th Quintile	Top Quintile
Pensioner couple	23	29	21	15	12
Single pensioner	25	33	21	13	7

Source: ONS Social Focus on Older People

Table 6: Percentage of pensioner households with incomes below half mean 1993/94

	Before housing costs	After housing costs
Pensioner couple	22	25
Single pensioner	24	33
All family types	19	24

Source: Department of Social Security

Table 7: Proportion of family units in receipt of selected benefits; by age of head 1997-98

	50-59	60-64	65-69	70-79	80 and over
Retirement pension	2	38	93	99	98
Council tax benefit	15	22	26	35	43
Housing benefit	10	12	19	24	29
Disability benefits	10	15	17	18	29
Income support	7	13	12	12	24
Incapacity benefit	13	19	6	0	0
Widows benefits	4	2	0	0	0
Jobseekers allowance	3	1	0	0	0

Source: ONS Social Focus on Older People

Health and Social Services

Introduction:

This section will look specifically at the issues of health and social care provision that affect the health and well being of older people.

Age is an important source of inequality in health, especially in relation to access to services. Older people are not only more likely to experience health problems but are the age group most likely to experience problems in gaining access to NHS treatment and services which could substantially benefit them. However, the pattern of use of services in London is a complex one.

The Turnberg Report³¹ into health services in London identified services under pressure across the whole range of services, from community and primary care to hospital based services. The impact of these pressures was mostly keenly felt in the care of elderly people and those with mental illness.

The situation in London is more complicated than in other parts of the country due to the impact of factors such as ethnicity, gender, low income and issues such as transport and housing. Joint working in London is also made more complicated by the large number of geographical and administrative boundaries that exist in London.

Social care continues to play an important role in the lives of older people with care needs. Between 1993 and 1997, London boroughs more than doubled the number of older people they supported in residential and nursing homes and almost doubled the number of hours of home care supplied.

However, services are fragmented and many older people do not receive the care that they should.

General practitioners

Analysis of the 1994-95 General Household Survey by Evandrou³² found that among the population in London aged 60 and over living in private households, one fifth, around a quarter of a million people, reported having visited their GP in the last two weeks, some more than once. This is a slightly higher rate than for the rest of Great Britain.

Within London around 14 per cent reported seeing a doctor in their own home, a figure that ranged from 4.4 per cent of those aged 65-74 to 13.8 per cent of those aged 75 and over. However, these estimates are substantially below those for the rest of Great Britain and suggest that London's GPs make around one third fewer home visits to older people than those elsewhere in the country.

Apart from the 0-4 age group older people use GP services more than any other age group with the 75 and over age groups using services more than those aged 65-74. The rate of use by gender is about equal but most older people are women.

The 1997 Turnberg³² Report typified primary care services in London as lagging behind those in the rest of the country. The problems identified included difficulties with recruitment of GPs; a fall in the total number of GPs in London against a rise across England as a whole; a high proportion of single handed practices in London; a large number of practices below recommended standards, and too many premises that are generally poor.

Initiatives such as London Initiative Zone funds have helped to bring about an increase in the number of GPs practising in London and many GPs now also have extra support staff. However, the availability of GPs in London has failed to match that of the rest of the country.

Turnberg found that the number of GPs in London fell by 1% between 1990 and 1996 while it increased by 6% for the rest of England. From 1977/78 to 1996/96 the proportion of single handed GPs in London decreased from 30.6 per cent to 20 per cent but in England outside London the decrease was from 13.3 per cent to 8.7 per cent. During that period the proportion of GPs in London aged 65 and over and the proportion with patient lists of 2,500 or more was persistently greater in London than in England. Data shows that at October 1998 the average list size for the then North Thames Region was 2,000 and for South Thames was 1,952. The average for the UK as a whole was 1,808.³³

In some parts of London patterns of general practice are closer to the rest of England but in some areas it is much worse with high workloads and consultation rates, pressure on services, poor health and social conditions of patients' and longer consultations per patients.

Data from the National Survey of NHS Patients 1998³⁴ shows that the wait to see a GP in London is longer than elsewhere in the country. For England as a whole 6 per cent waited 4-7 days to see a GP of their choice and 2 per cent waited 8 or more days. This compared to 11 per cent in Inner London who waited for 4-7 days and 3 per cent who waited for 8 or more days. Consultations also take longer in London. Nationally 76 per cent of consultations take less than 10 minutes compared with 71 per cent in London.

Data from the National Survey of NHS Patients also shows that although 27 per cent of people in London stated that it was important to be able to see a GP from their own ethnic group, of these only 30 per cent were able to do so every time, compared to 42 per cent in England as a whole. Data suggests that minority ethnic groups have high consultation rates with GPs but are less likely to be referred on to other services. The reasons for this are not fully understood.³⁵ With a large increase in the number of older people from minority ethnic groups expected in London in the next twenty years the discrimination and poor service that they face is likely to increase rather than diminish as their needs grow.³⁶

Turnberg also argued that the large number of single-handed practitioners in London and the low number of practice premises which provide accommodation above minimum standards is a measure of the lack of progress in developing primary care. The problem is especially acute in East London. The definition of acceptable premises varies but using health authorities own local definitions, in 1997 fewer than 50 per cent of premises in London met acceptable minimum standards compared with nearly all practice premises being above minimum standards in the rest of England.

Turnberg saw this lack of progress as a serious impediment to the improvement of primary care in London particularly in offering a wider range of services to patients and in supporting the development of effective team work.

Data from the National Survey of NHS Patients also shows that access to GP premises in London is generally poor compared to the rest of the country. In London 15 per cent of

disabled people felt that access to their GP surgery was difficult or very difficult compared to 10 per cent for England.

Turnberg also noted persistent and high levels of shortages in recruiting and retaining nursing and therapy staff to the extent that this may jeopardise progress in improving primary and community health care standards in London. Since Turnberg this problem has become even more acute, caused in part by the rise in house prices in London

Hospital based services

In 1994-95 around 14 per cent of London's older people aged 60 and over, 161,000 people, were admitted to hospital although not necessarily within the capital. Many more, around 22 per cent, or 278,000 people were hospital and community health services outpatients during the year.

Data from the GHS, analysed by Evandrou,³³ showed that just over one-fifth of the London sample of older people had seen a hospital doctor during the previous three months, a contact rate that was 8 per cent greater than the rest of the country.

However, older Londoners living in inner-deprived areas appear to make less use of acute hospital services than their counterparts in similar areas of England. They also use specialised hospital services for older people less than people do in comparable areas elsewhere. Low usage of general acute services has been observed among Londoners of all age groups in the inner city. However, the rest of London has higher per capita rates than other areas, producing London-wide hospitalisation rates that are above national levels.

Warnes³⁷ also argues that the pattern of lower utilisation by older inner-deprived Londoners is accentuated when the number of hospital bed-days occupied by older people is considered. Data for inner London for 1994-95 shows considerably lower usage rates compared to other areas. Difference in use of beds in comparison with other similarly deprived areas reflects lower hospital length of stay and more day cases for London residents.

Data from the GHS³³ shows that 18 per cent of those aged 75 and over in London had been hospital inpatients, similar to national rates. For those aged 60-74 in London, 10 per cent had been inpatients against 13 per cent nationally.

Overall London had approximately 17,400 acute beds in 1995³². The Tomlinson Report³⁸ argued that London had too many hi-tech beds and insufficient primary care services. However, a significant proportion of these beds are used by non-Londoners and Turnberg concluded that, allowing for use by non-Londoners, there was no evidence that there are more acute beds in London than the England average. In fact the evidence suggested that London probably had fewer beds available to its population than the average and recommended against further bed losses.

London has in fact lost beds at a significantly faster rate than the rest of the country.³² Between 1990/91 and 1995/96 the number of inpatient acute beds fell in inner London by 1130, largely as a result of greater efficiency. During this period acute beds in London as a whole fell by 2761 and the total number of beds fell by 9271.

London's acute bed provision is lower than for any comparable urban population in the UK. Data for 1997/98 shows that for the then North Thames region average daily

available beds per 1000 population was 4.2 and for South Thames was 3.6. For Great Britain it was 4.3.³⁴

Specialist geriatric services form only a small part of the total provision and use of services by older people. However, they are an important service as they provide treatment for older people for multiple chronic conditions and are a recognition of their specific health needs. In 1994-95, 5 per cent of total London hospital activity was in the geriatric speciality³⁸ but Jarman^{39, 40} found that London has a smaller proportion of hospital beds available for older people compared with other urban areas. Care of elderly services are also unevenly spread across London with localised variations with an unusually small proportion of capacity in the inner London hospitals.

Overall London also has slightly longer waiting times than the rest of the country for both ordinary admissions and day case waiting times.⁴¹ Up to June 1999, 8.4 per cent of people waiting for an ordinary admission in London had been waiting for 12 months or longer compared to 6.6 per cent for England as whole. Similarly 3.6 per cent of people in London waiting for a day case admission had been waiting 12 months or more compared to 2.8 per cent for England as a whole.

Community health services, especially district nursing and health visiting, are also an important source of health services for older people but comparisons between areas are difficult to make because of issues of data validity and reliability. Services throughout the United Kingdom show variation in usage both between and within regions.

Age Concern England⁴² point to the low priority given to community health services as evidence of the low priority given to older peoples' health needs. Over two-thirds of chiropody patients are over 65 with more than 10 per cent over 85. But some authorities have withdrawn or rationed access to chiropody. As a result many older people suffer unnecessarily and even become housebound.

A further example that Age Concern gives is the apparent low priority given to stroke patients. The care and support of people who have had strokes accounted for an estimated 5.8 per cent of NHS and social services expenditure in 1995/96. These costs are, according to Age Concern, set to increase by 30 per cent in real terms by 2023 yet there is insufficient investment in rehabilitation programmes.

Philpott and Bannerjee⁴³ also found considerable variation in mental health provision for older people across London. In 1992 there were 51 consultants in London working full-time or part time in old age psychiatry. In 1982, a small survey found that at least 7 London District Health Authorities had no consultant psycho-geriatrician and only six had specific services for the elderly mentally ill. They also found that across London those aged 75 years and over have a substantially lower consultation rate than in other parts of the country. Older people suffer from high rates of depression and other mental illness but there is again evidence of problems in getting the help they need.

Age discrimination:

Organisations such as Age Concern England argue that a combination of under-funding of health care services and ageist attitudes have resulted in rationing criteria replacing services based on clinical need which discriminate against older people at all levels of health service provision simply because they are old.

This discrimination is often explicit, such as when patients are told that a treatment is unavailable to them because of their age, or it is implicit such as when the NHS gives older peoples' needs a low priority or when they experience poor levels of care.

Both the Royal College of Physicians and the Medical Research Council state that age discrimination in the NHS is a significant problem. The General Medical Council's code of Good Medical Practice specifically states that the age of the patient should not affect provision of any treatment which should be based on the ability of the patient to benefit.⁴⁴

The NHS Executive, announcing the National Service Framework for Standards of NHS Hospital Care for Older People said that 'older people in the NHS should have the same quality of care as younger people, based on clinical need, not their age or where they happen to live', (HSC 1998/220). The government has also asserted the principle that age should not be a determining factor in the health care of NHS patients.

In a study published by Hospital Doctor and Doctor⁴⁵ in 1999, 53 per cent of those GPs questioned said that a patient's age was an influencing factor in determining treatment. In a recent study by Age Concern/Gallup,⁴⁶ it was found that 1 in 20 people aged 65 and over had been refused NHS treatment. This study also found that up to 2 million people have noticed different treatment from the NHS since their 50th birthday, the most common problems being with doctors.

Age Concern offer a number of examples of apparent discrimination against older people.⁴⁷ These include:

- An apparent policy to refuse heart transplants to anyone over 60
- Evidence that kidney dialysis is rationed on the basis of age
- Older people are offered different treatments for illnesses such as cancer even though they can respond just as well to treatment and are often excluded from many clinical trials;
- Women over 65 are not routinely invited for breast cancer screening despite evidence that they are at greater risk of developing the disease;
- Older people are also more than twice as likely as those under 65 to die of heart disease and more than 5 times as likely to have a heart attack, yet older patients are less likely to receive specialist cardiac treatment.

Age Concern also argue that some GP's are reluctant to take older people on to their lists, citing cost and their own lack of knowledge about old age pathologies. There is also evidence of older people being struck off of GP lists.

Age Concern argue that even when discrimination is not explicit, a lack of understanding and knowledge among both older people and health professionals can result in older people receiving poorer health care than they need or are entitled to. For example, many complaints that older people suffer from are dismissed as being a normal part of old age.

Many older people also report negative attitudes from NHS staff. They feel fobbed off and treated as complaining, do not feel listened to and that their needs are low priority or are not taken seriously. The result is that they feel that they are denied access to services and the quality of care expected by younger people This discrimination is often reinforced by older people themselves who may be reluctant to complain or believe that illness is a normal part of.

Similarly, Age Concern also argues that there is evidence of inappropriate use of drugs to manage patients' behaviour. They quote research which shows that up to 24 per cent of care home residents may be on anti-psychotics, often as a means of controlling behaviour.⁴⁸

Furthermore many of the services that older people need to maintain their health and well being are often seen as low priority within the NHS. A Patients Association report⁴⁹ argues that due to a preoccupation with acute services health authorities are unable to give priority to issues such as incontinence services that are more important to many older people. In terms of quality of life and associated treatment, the cost of not providing such services is often high. At the same time, while thousands of NHS continuing care beds have been lost there is a shortage of district nurses needed to meet people's health needs in the community.

Age Concern England also argue that the low priority of older people within the NHS is reflected in waiting list times. Age Concern quote a 1999 article in Hospital Doctor which published the views of a GP who stated that 'hundreds of elderly people deteriorated so much while waiting for hip replacement surgery that they became unfit to operate on'.⁵⁰

Joint working between health and social services

Joint working between health and social services is a particularly important area for older people in terms of rehabilitation following illness or a period in hospital and in terms of helping older people to remain independent.

The barriers to joint working have been well documented and include:^{51, 52, 53}

- a lack of sufficient joint strategic and operational activity between social services departments and primary health services,
- duplication and delay for services users and carers;
- poor communication between social services and primary health practitioners and professionals about service users and patients;
- insufficient multi-disciplinary assessment of older people
- a need for more joint training
- different funding regimes that encourage cost shunting

As the Turnberg Report noted, the complexity of boundaries in London has made joint working between health and social services in London more difficult to achieve than elsewhere. London has 32 boroughs plus the City of London and 16 health authorities. These are separately funded organisations with different lines of accountability and policy perspectives.

The Audit Commission report 'The Coming of Age'⁵⁴ argued that the NHS and social services appeared to be locked in a vicious circle. Pressures on beds and shortage of funds has meant that people have often been discharged from hospital before they were ready to be and before services could be put into place. The Audit Commission also found evidence that because of a lack of alternatives people were often discharged into inappropriate care with heavy emphasis on the use of acute beds and care in residential settings.

Hospital discharge arrangements, based upon legislation and guidance, place a responsibility on local authorities and health providers to work together to assess, plan and meet the needs of people leaving hospital. According to the Patients Charter before

hospital discharge can happen a decision should be made about the continuing health of social care needs of the individual concerned with agencies such as community nursing services and local authorities social services departments being fully involved.

However, a qualitative survey⁵⁵ into hospital discharge arrangements in London among Community Health Councils and community organisations made the following criticisms:

- Hospital discharges are often based only on medical need. It was felt that the NHS no longer accepted responsibility for people once they could be declared “medically fit” and the social needs of individuals do not appear to play a full role in determining need.
- Concern was also expressed at the harsh dividing line between health and social services and that it was not uncommon for health and social services to hold differing perspectives about where the responsibility for provision lies
- People are being discharged earlier due to improved medical care but also because of increased pressure on beds, some before they are fully recovered or before services are in place. Many people do not complain from fear of prejudicing their treatment in the future.
- There is often not enough time to plan for a discharge. Services are often not in place at time of discharge or insufficient notice is given of discharge that can happen very suddenly. But it was also sometimes delayed because of poor planning.
- User and carer involvement is often seen as tokenistic and with little participation at the level where important decisions were taken. Their views were given little consideration and relatives felt that patients were being pushed out of hospital. There was also a lack of involvement of GP’s in discharge arrangements who were frequently not informed that their patient had been discharged and sometimes that they had been admitted.
- There was evidence of elderly people being discharged against their will and of carers being pressurised into receiving people at home before they were ready to and without adequate support. They were often pressured into making quick decisions about the future care of relatives and friends.
- There were insufficient services providing either health or social care in the community to support the numbers of people being discharged from hospital. People feel isolated following discharge.

The government has identified two key indicators for the interface between health and social care. One of these is emergency admissions of older people which it sees as a measure of the effectiveness of hospital discharge and community care arrangements for older people and as an indicator of how well these agencies are working together. The second indicator is on delayed hospital discharge of people aged over 75 which it sees as being partly caused by poor communication between relevant care organisations.

Table 8 shows data for both of these indicators for 1997/8 and 1998/9 for London’s health authorities compared to the rest of the country.

Table 8: Emergency hospital admissions and delayed discharges for people aged 75 and over per 1000 population aged 75 and over 1997/98 and 1998/99

	Emergency hospital admission	Delayed discharge from hospital		Emergency Hospital Admission	Delayed discharge from hospital
	1997/98	1997/98		1998/99	1998/99

London	245	1.9		251	2.3
Met Districts	295	1.9		298	1.6
Shires/UA's	253	1.6		260	1.6
England	263	1.8		268	1.7

Source: DoH⁵⁶

The data shows that London has a lower emergency admission rate of those aged 75 and over than the rest of the country but has more of a problem with delayed discharges. The gap between London and the rest of the country for this indicator widened between 1997/98 and 1998.99

At individual health authority level a more varied picture emerges. The rate of emergency admissions varies from a rate of 159 per 1000 population aged 75 and over for 1998/99 for Kensington, Chelsea and Westminster to 368. for Brent. Delayed discharges for this period varied from 1.1 per 1,000 population aged 75 and over for Barnet to 4.7 for Hillingdon.

Table 9 shows this data for health authorities in London expressed as a percentage of all discharges from hospital of people aged 75 and over and as a percentage of all admissions of people aged 75 and over.

This table shows that nationally 0.2 per cent of discharges from hospital of people aged 75 and over were delayed. Within London these rates varied from 0.1 per cent for Lambeth, Southwark and Lewisham, Camden and Islington, Barnet, Bexley and Greenwich and Bromley to 0.5 for Hillingdon.

The data also shows that nationally 8.4 per cent of admissions of people aged 75 and over were emergencies. Within London these rates varied from 5.8 per cent for Kensington, Chelsea and Westminster to 11.8 per cent for Redbridge and Waltham Forest.

Table 9 Emergency hospital admissions and delayed discharge for people aged over 75 expressed as a percentage

Health Authority	% delayed discharges	% Emergency hospital admission
	1997/98	1997/98
Barking and Havering	0.4	7.6
Barnet	0.1	6.7
Bexley and Greenwich	0.1	8.3
Brent and Harrow	0.2	5.9
Bromley	0.1	9.9
Camden and Islington	0.1	8.1
Croydon	0.2	9.5
Ealing, H'smith and Hounslow	0.3	7.0
Enfield and Haringey	0.2	7.1
Hillingdon	0.5	8.0
Kensington, Chelsea and Westminster	0.3	5.8
Kingston and Richmond	0.4	7.6

Lambeth, Southwark and Lewisham	0.1	8.0
Merton, Sutton and Wandsworth	0.3	8.6
Redbridge and Waltham Forest	0.2	11.8
England	0.2	8.4

Source: DoH ⁵⁷

The New Agenda

The health White Paper 'The New NHS'⁵⁷ and the social services White Paper 'Modernising Social Services',⁵⁸ both emphasise the development of services that are more responsive to local need and which aim to promote independence. This is also identified as a priority in the National Priority Guidance for Health and Social Services for 1999-2001.⁵⁹

As part of this Primary Care Groups have been established which aim to improve the health of their local populations, develop primary care and community health services and commission hospital services. These groups will work closely with social services on both planning and delivery of services; and will have social services representation on their governing bodies.

Health Improvement Programmes are also being developed for each health authority area to provide the local strategy for improving health and health care with involvement from partner agencies such as local government and voluntary bodies. A key element of the Health Improvement Programme in each area will be Joint Investment Plans, drawn up between health and social services to deal particularly with groups where co-ordinated services are most important

The government has also made money available for the development of preventative services to provide some low level support to people most at risk of losing their independence.

Involvement in Primary Care Groups is beginning to focus social services departments' strategic attention on primary health and starting to raise primary health services up the social services agenda

The government has also proposed new arrangements to allow health and social services to work together through proposals for pooled budgets, lead commissioning where one authority transfers funds to the other who will then take responsibility for purchasing both health and social care; and integrated provision where one organisation provides both health and social care.⁶⁰

In response to the Health Committee Report on joint working between health and social services and as part of its own existing agenda the government is also reviewing the roles and responsibilities of both services in relation to joint working and further guidance is expected soon.

Social care

The provision of social care plays a very important role in the lives of older people with care needs, mostly concentrated in the oldest age groups. The interaction of social services and health services provision has been a continuing source of tension in London as elsewhere. The main issues in this section relate to the increased concentration of social care services on those in greatest need and the consequent loss of services at the preventative level; the quality of care in residential and nursing homes, and their relative

scarcity in London; and the perceived inequalities in charging between social and health care and different systems for charging for Domiciliary care.

Issues

The community care changes implemented in 1993 have led to local authorities taking over the support of many more people in residential and nursing homes and at the same time they have provided an increasing amount of care at home. Between 1993 and 1997, London boroughs more than doubled the number of older people they supported in residential and nursing homes and almost doubled the number of hours of home care supplied.⁶¹ Concern nationally has centred on the increasing focus of services on those in greatest need. The Continuing Care Conference reported, "One effect of the community care changes has been an increasing focus on people in greatest need, with a parallel withdrawal from lower levels of support."⁶² Within the constraint of local authority budgets, demand has been contained through tightened eligibility criteria that have squeezed out those with lower levels of need for help.

Generally, provision of support services is higher in London, especially Inner London boroughs than the average nationally, although there is variation between boroughs. In London in 1997, just under ten per cent of the population aged 65 and over were receiving home care arranged by the local authority, considerably higher than the eight per cent rate in England as a whole. The rate increases markedly by age, so that over 40 per cent of those aged 85 and over in London were receiving home care.

Table 9: Percentage of older age groups in London receiving personal social services arranged by local authorities, 1997.

Service	Age group			Total
	65-74	75-84	85 & over	65 & over
	%	%	%	%
Home care	3.3	10.7	40.3	9.7
Day Centre places				4.2
Meals at home	0.7	3.1	9.4	2.7
Supported in residential & nursing homes	0.6	2.4	9.7	2.4

Source: London Research Centre estimates based on Department of Health figures.

The increasing concentration of home care services is reflected in the proportion of households receiving more than five hours of home care per week and two hours or fewer per week. Between 1994 and 1997, the proportion of households receiving home care in London who received two hours or less help per week decreased from 47 per cent to 36 per cent, while the proportion receiving more than five hours increased from 22 per cent to 33 per cent. These are similar to national trends. With meals at homes, the increasing concentration is reflected in the percentage of meals served at the weekend, which increased from 13 per cent in London in 1994 to 18 per cent in 1997. While the trend was in the same direction in England, the percentage of meals served at the weekend was much lower nationally, at nine per cent in 1997.

London has only two-thirds of the amount of residential and nursing home provision as England as a whole, although London boroughs support almost as many people in such homes. The result is that often people are placed in homes outside the original borough's boundaries and outside London, although this may be by choice in many cases, for instance, in order to be nearer to relatives. Recent trends have shown an increase in the

number of nursing home places, but a decrease in residential homes, despite the shortage in London.

There are concerns about the quality of care that can be provided within the fee limits which local authorities are prepared to pay for residential and nursing home places. Laing and Buisson⁶³ have estimated that profits in independent homes for elderly or disabled people average only £10 per bed per week. They predicted more home closures as a result of the National Required Standards which will come into force in 2001.

The UK Central Council for Nursing, Midwifery and Health Visiting reported that in 1995-96, nursing homes accounted for 43 per cent of the serious complaints they received, compared with eight per cent in 1990-91⁶⁴.

Tony Warnes in his report on older people to the King's Fund London Commission⁶ quotes from the Health Advisory Service⁶⁵, 'Older people with complex needs are falling through the cracks between agencies. Services are fragmented, there are problems with funding, a lack of proper assessment and re-assessment, inequity and inadequate communication. The absence of any means to monitor the quality and effectiveness of multi-provider care is a serious impediment to the diagnosis of weaknesses in health and social services for older people and their correction. The present blindness to system performance is a major weakness that is rarely recognised let alone tackled.'

A seminar on home support services organised by the Joint Initiative for Community Care, the Nuffield Institute for Health and the King's Fund⁶⁶ identified major weaknesses in the nature of home support services, and in their commissioning, organisation and delivery. They called for action on a number of fronts, including market management; ensuring adequate regulation and accreditation procedures operate; dealing with resource inadequacies and ensuring that preventative support is not squeezed out by inappropriate targeting.

Charging for social care

There has been continuing debate about the issue of charging for social care, both in terms of paying for residential and nursing home care in contrast with free NHS hospital care and in paying for Domiciliary services. The Royal Commission on Long Term Care⁶⁷ recommended that all personal care should be paid out of general taxation, while the living and housing costs elements should be subject to co-payment, according to means. It is reported to be unlikely that the Government will accede to this recommendation, although there may be a three month breathing space before there is any question of residents having to sell their homes to pay residential and nursing fees⁶⁸.

In London, as elsewhere, there is a wide range of systems of charging for domiciliary services and variation in the maximum and minimum charges⁶⁹. By 1998, just two boroughs had a free service.

Approaches to dealing with the issues raised

The health and social care agenda in London is a complex one. The delivery of, need for and access to services in London is determined by a large number of factors, many of which are beyond the control or influence of either health or social care authorities.

However, the quality and nature of services in London have a direct impact on the health and well being of older people. Plans to develop and upgrade facilities are always restrained by resources but Turnberg identified lack of progress in upgrading GP

premises and reducing the number of single-handed practitioners as being serious impediments to the improvement of primary care in London. The development of GP services in London is recognised as a priority in the NHS modernisation plan for London.⁷⁰

Similarly the needs of minority ethnic groups within current NHS care arrangements are not likely to be met without positive action to address their needs in relation to issues such as access, languages and discrimination.

Joint working between health and social services remains an area where much could be done to both rehabilitate older people after stays in hospital and to remain in their own homes. The King's Fund London Commission⁷¹ recommended, the development of joint commissioning approaches between health and local authorities, with costed and time tabled local plans for the development of older people's services.

The government has set a challenging agenda for both health and social services to improve how they meet and respond to need. At the local level the opportunity for health and social services to work more closely together is being brought about by changes in how services are planned and delivered. However, the challenges in London are greater than elsewhere because of the number of authorities involved in health and social care in London and because of the diversity of need in London. These authorities will often have to address both local and London wide priorities and some issues will need a London wide approach.

Furthermore, responding to the needs of older people in London means recognising the diversity of those needs and engaging in a dialogue with older people. A strong policy against ageism within the NHS in London is also important if older people's needs are not going to be marginalised.

The Better Government for Older People initiative, launched by the Cabinet Office in 1998, 'aims to improve public services for older people by better meeting their needs, listening to their views, and encouraging and recognising their contribution'. Twenty-eight local pilot projects have been established, including the London boroughs of Kensington & Chelsea, Hackney, Hammersmith & Fulham, Harrow and Lambeth. The programme will run for two years initially and a best practice guide will be published in April 2000, reflecting the experience of the pilots and other relevant work, to encourage further local initiatives and to draw out policy lessons nationally.

The development of regional inspection and registration arrangements for residential, nursing and domiciliary care will also help to raise standards across the region. Local authorities in London have worked together to develop a co-ordinated approach to the inspection and accreditation of Domiciliary services, in advance of the development of the national guidelines⁷².

Further research

Research around current joint working arrangements in London and the problems encountered would seem to be a particular issue that would need to be addressed.

Similarly ongoing research into the needs of older people in London and ways of bringing them further into the policy making process should be a priority.

Housing and older people

Introduction

Good quality and affordable housing is an important factor in promoting the health and well being of older people. The beneficial effects go beyond any immediate health needs. Well designed housing with access to local goods and services can do much to help older people remain in their own homes and live as independently as possible, a key aim of community care. External factors such as the environment, crime or fear of crime, the provision of local amenities and an accessible public transport system also all contribute to the health and well being of older people.

However, older people in London are disproportionately affected by housing that is of a low quality and does not meet their wider social and health care needs. For some it is not just a question of poor housing which is the problem they face, but homelessness with all its attendant difficulties.

Housing and health in London

Poor quality housing is a direct cause of ill-health, but it is also an additional risk factor for many older people already at risk of ill-health and can exacerbate the effects of pre-existing conditions. Cold and damp housing have been linked with a range of health conditions especially respiratory problems, infections and allergic disease; over-crowded households are prone to infectious diseases as are households that share facilities; while high rise living and households that are isolated from the wider communities have been linked to mental ill-health and stress as well as facing greater difficulties in maintaining themselves.⁷³

The quality of much of the housing stock in London is not high. Currently there are around 243,000 properties in London which are classified as 'unfit' for human habitation more than three quarters of which are in the private sector.⁷⁴ There are also estimated to be another 400,000 local authority and 20,000 housing association dwellings are in need of renovation.²⁹

Many 'unfit' properties are lived in by owner occupiers who simply cannot afford the upkeep of their property and London's private housing is made up of housing that is older than the national average. Private sector housing tends to have more poor quality housing than the social housing sector. Although a low proportion of older people live in the private rented sector, older people are more likely to live in the worst housing in this sector. However, as local authority housing provision has declined, so the private sector has expanded.

Housing in London is the most expensive in the UK to both rent and buy. Because of this and due to older people's generally low incomes and a shortage of affordable alternative housing, for many in London there remain few options in terms of moving to more 'habitable' premises.

A national study by Shelter found:⁷⁵

- Older people occupied 32 per cent of the worst dwellings.
- between 40 and 60 per cent of older people live in pre-1919 terrace dwellings which are most likely to be unfit or in a poor state of repair
- Lone elderly people are especially affected by lack of amenities
- Home owners with a low income tend to be concentrated in the worst housing.

- Around 75 per cent of people on the lowest incomes, living in the poorest housing conditions, are pensioners.

For people on low incomes, the effects of cold and damp can be made worse by the high costs of trying to heat homes that are of poor quality, have little or no insulation, and have old, expensive and inefficient heating systems. Older people also spend more time at home than other groups. The result can be what is known as fuel poverty, defined as the inability to afford to adequately heat the home.

The costs of poor housing are not just borne by older people in terms of their health. Carr-Hill, quoted in Bardsley et al,²⁹ estimated that people in damp housing incurred health service costs 50 per cent higher than comparable groups matched for income. It was further estimated that damp housing costs the NHS in London 5 per cent of its budget. Furthermore poor quality housing has also been shown to affect the need for services such as social services⁷⁶ as people in these properties are more likely to have health and social care needs.

The majority of older people in the UK own their own homes (around 64 per cent)⁷⁷ in line with the rest of the population. However, in London the type of housing that older people live in is different to the rest of the country. At the time of the 1991 Census 55 per cent of older Londoners lived in owner occupied property. However, in Inner London 68 per cent of older people lived in rented accommodation compared to a national average of 34 per cent. Even within the capital there are variations with 84 per cent of all older people in Tower Hamlets in rented accommodation and 27.2 per cent had no central heating.⁷⁸

London has a higher proportion of flats than elsewhere in the country. One in four council properties in Inner London is in a high rise block (over 5 storeys) and there is strong evidence to suggest that living in this kind of property can have detrimental effects on health.²⁹

Older people can also find themselves in accommodation with shared facilities such as kitchen and bathroom or in over-crowded accommodation. At the time of the 1991 Census 1.7 per cent of pensioner households in London lived in non-self contained accommodation while 2.7 per cent of households lacked or shared the use of bath/shower and/or an inside toilet. Over-crowding is a particular problem for some minority ethnic communities due in part to low incomes or the shortage of larger properties. It has been estimated that 54 per cent of Bangladeshi households and 23 per cent of Pakistani households are overcrowded.²⁹

Promoting independence for older people

For many older people, the design and adaptation of their housing, the housing and development policies pursued by the relevant authorities, and the way in which health and social care services are delivered can greatly affect their ability to cope with existing and potential health problems and their potential to live independently.

Responding to these special needs can include a variety of measures ranging from building adaptations to special packages of care in amenity and sheltered housing projects. Design and maintenance can help reduce accidents, which are an important cause of ill health among older people. Older people can be given more independence through adapting or offering services in their homes to enable them to remain there rather than move into a residential care or nursing home. Such initiatives can range from fitting a stair-lift to providing a bath chair.

The government now requires new homes to be built that are wheelchair accessible. But budgets for aids and adaptations are limited and many older people only come to the notice of the relevant authorities when they have already deteriorated in their health. Many older people don't have the resources to adapt their homes or to maintain or repair them. A number of capital release schemes are available as are grants for home improvements but the scale of the problem is beyond the reach of these programmes.

For some people re-housing may be the best course to follow. Local authorities will respond to housing needs that are a medical priority but will designate the priority themselves. However, the ability of public housing to meet such needs has become limited as demand has increased and available stock has decreased. A relatively large proportion of those who claim medical priority fail to get re-housed and face long-waiting lists. These mixed results are seen by some as indicating the importance of appropriate services at home which can be more effective and less costly.^{79, 80}

Increasingly, medical priority in housing has given way to policies targeted at groups categorised as having a special need of which frail elderly people are one group. Although there has been criticism of the creation of special provision⁸¹ the distinction is recognised by the main housing associations and by the Housing Corporation. Sheltered housing provides a safe housing environment for older people, usually combining several units of self-contained independent accommodation with communal space and on-site or visiting wardens. However, this is not what everyone wants. Some sheltered housing does not meet the expectations of some older people and many don't want to live in bedsits or shared facilities.

Whereas housing is seen as a key element of successful illness prevention strategies, for many older people there is a feeling of not having much choice as to what type of housing they are able to live in. Research commissioned by the Joseph Rowntree Foundation and Anchor Trust⁸² found that older people regard access to a range of good quality and appropriate housing, together with the delivery of practical support services into the home, as vital to their well-being. In the case of London, the range is simply not there. Additionally, London has fewer residential and nursing homes for older people than anywhere in the UK.⁸³

It is also important to look at the way that housing promotes independence in conjunction with a range of other factors, for example transport and the environment. A fully adapted home, although welcomed by many older people, would be of limited purpose if there are few local amenities and a public transport system that did not take their needs into account.

Help the Aged has highlighted these issues and the ways in which older people can be given more independence and control over their own lives.⁸⁴ They argue that accessible services such as primary and specialist care and local goods and services are very important in supporting older people and are linked with issues such as transport policy and the environment.

Residential care for older people in London

For many older people residential and nursing care will be sometimes a necessary and perhaps the only choice. But London has fewer residential and nursing homes for older people than elsewhere in Britain.³² This is due reasons such as the low profit margins to be gained through this kind of business (around £10 per bed per week),⁸⁵ the high cost of

building new homes in the capital and also older people choosing to go into care outside London.

Currently in London there are waiting lists for admission into care or nursing homes for elderly mentally ill clients (EMI) a problem that can be further compounded by the need to place some clients in places which can cater for special diets or offer specific languages.

Government policy places an emphasis away from residential and nursing care homes toward care in the community but this is undermined if appropriate housing and development policies are not pursued.

Homelessness

For many older people the issue is not one of poor housing but of homelessness. Official statistics on homelessness are limited and offer a number of definitions of homelessness ranging from street homeless to people living in temporary accommodation.

Homelessness in London has always been and continues to be a major social. However, the actual number of older homeless people has is in dispute largely due to different ways of assessing the problem. Age Concern London have suggested that in 1991 around 30 per cent of those living on the streets or in hostels in London were over 50 and in 1995/96 Bridge Housing Association calculated that 38 per cent of the homeless people they housed were over 50.⁸⁶

Homeless people are at greater risk of mortality and morbidity. It has been estimated that rates of long-term illness among the homeless is 2.5 times greater than that for the rest of the population.²⁹

People become homeless in later years for a variety of reasons including break up of relationships, financial problems and rent arrears, bereavement, poor health, unemployment, loss of tied accommodation, and admission to hospital. Many of the problems that older homeless people face, such as mental illness are often contributory factors in becoming homeless in the first place. While local authorities include age as an indicator of vulnerability for rehousing many will not rehouse people until they reach retirement age.

Older homeless people sleeping rough are more likely than younger people to have health and social problems which are not treated and face problems in getting access to health service especially primary and community care.⁸⁷ This is due not just to the nature of their lifestyle but also to the fact that many older homeless people do not use hostels and day centres because of the fear of violence or intimidation from younger homeless people.⁸⁸ This makes them difficult to contact except through initiatives such as street out-reach.

In many instances, the health of an individual homeless person can have very real consequences for public health generally such as tuberculosis which has been shown to be increasing particularly among older homeless people.⁸⁹ Other conditions include chronic respiratory disease and trauma and problems associated with alcohol, drug misuse and mental health.

Approaches to dealing with the issues raised

Poor housing is linked to the wider problems that people face such as low income. Associations between health, housing and a whole range of other social indicators

means health improvements are most likely to come from a wide range of inter-sector developments such as regeneration.

The extent to which health-related criteria have been used in developing and assessing regeneration programmes and development is limited but there may be greater scope with the elections of London's new Mayor who must include an assessment of the impact of all policies on the health of Londoners.

At a more local level many groups have argued that the most effective way of ensuring that older people maintain their independence is to involve them in the planning and design of housing as well as developing health and social care services that take greater account of their wider needs in trying to maintain their independence. Within this the new NHS offers greater scope for closer working with local authorities to develop inter agency working that more fully responds to older peoples needs and build upon the already considerable experience of joint working within London.

Transport, mobility and pollution

Introduction

This section will look at the impact that transport, mobility and pollution has on the health and well being of older Londoners.

From the perspective of health the Acheson Report defined the primary function of transport as being to enable access to people, goods and services. Access to appropriate transport is also seen as an important factor in the development and maintenance of social and community life which are seen as key determinants of health.

The general growth in traffic levels and a lack of accessible transport have helped to reduce mobility and access to goods and services as well as restricting social and community life, particularly for those already experiencing disadvantage. While certain methods of transport, such as walking and cycling are seen as being beneficial to health in themselves, others are seen as being potentially harmful because of the risks of accidents and air pollution.⁹⁰

Older people are more likely than other groups to find access to public transport difficult and are less likely to have access to alternatives such as cars. As well as having lower disposable incomes than many other groups in society, they are also more likely to feel unsafe in public and are among the most vulnerable groups in the community in terms of accidents and the harmful effects of air pollution. All of these factors can deter older people from making or being able to make journeys. It leaves many older people dependent on often inadequate and more expensive local services such as shops that fail to meet their needs and can increase their own sense of isolation from wider society. The result is often worsening physical and mental health.

Accessing public transport for older people

Car ownership in London is substantially less than in other parts of the country. Whereas nationally over two thirds of households own a car, less than 50 per cent own a car in Inner London.⁹¹ This figure is even lower for older people who are more reliant on public transport services.

For many older people good public transport is an essential part of getting access to a wide range of goods and services that are not always available locally. In London public transport centres around buses and underground and older people in London have free use of London Transport after the morning rush hour.

Many health facilities such as GP's and chemists are available locally but older people are more likely to need specialist hospital based services where access to public transport is an issue. The difficulties that older people face in using public transport can result in long journeys or the need to pay for taxis. Even in those cases where it is possible for older people to access public transport, the journey time necessary to reach many destinations in London may be long and tiring.

But access to health care services is only part of the services that older people need to live healthy and fulfilling lives. Shopping and social amenities are also important and play a vital role in the health and well being of older people. Patterns of development have seen a move away from locally based shopping and leisure facilities to more centralised developments built around access by car with often only limited access by public transport. As locally based leisure services and shops have closed or re-located to other

areas, public transport within these area has often declined and with it the opportunity for older people to engage in social activities and social interaction. Although many older people make use of local community centres and associations, others prefer to go into more public social spaces for which access to suitable public transport is essential. This often means both longer journey times and more difficult journeys.

Even if journey length and time present no difficulties access to public transport presents older people with a number of other problems that can deter use. Older people are often faced with inaccessible stations not designed for their use, or with trains and buses that they have trouble boarding. They may also have to contend with overcrowded buses and trains during peak times.

Research published by the Centre for Transport Studies⁹² identifies what the authors refer to as a 'journey chain' which starts at the person's home or starting base and finishes when they reach their final destination. They point out that each mode of transport used represents a 'link' in the journey chain and if even one form of transport is not accessible then the whole journey is likely to be aborted. Although the problems of physical access to many transport services has already been highlighted, others also exist.

For many older people the level of crime or more importantly the fear of it is also a major concern. Many older people feel afraid to travel or leave their homes after dark.⁹³ With amenities often located some distance away from where older people live it means for many the journey is just too long or difficult for them to feel that they can safely undertake it.

The sheer volume of traffic in area can also have an impact. Research by Appleyard and Lintell (1972)⁹⁴ has shown that as the amount of traffic in an area increases, so the sense of community and neighbourliness for local residents declines. Areas with less traffic tended to have high levels of social interaction whereas the opposite was the case for those areas where traffic was heavy. For older people, this decline in community can have very negative effects in terms of their social and health well-being. Many begin to feel isolated from family and friends and also from the wider community. The result is that many older people simply don't go out.

Road accidents

For many older people it should still be possible to get to the places they want to visit through walking. However, this also presents health issues for older people in London due to accidents and fear of accidents and high levels of vehicle-related emissions.

London currently suffers from the highest number of pedestrian road casualties in the UK with 116 per 100,000 (48 per cent higher than the UK average)⁹⁵ and 47 per cent of all pedestrian fatalities are among those aged over 60. In addition, research has consistently shown that around 20 per cent of serious injuries and 35 per cent of slight injuries go unreported to the police⁹⁶ so the actual number of road accidents in London is probably higher still. Even this does not take into consideration near misses which, although not resulting in immediate physical injury can lead to severe mental anguish.

This level of pedestrian road accidents is perhaps surprising considering that the speed of traffic in the Capital is lower than that of other UK cities (an average of 17.1 miles per hour).⁹⁷ It has also been pointed out that road accident rates in London are only part of the equation in terms of road accidents influencing the health of older people.⁹⁸ The main

issue appears to be the fear of accidents that is influencing the health and well being of the older people. Although the actual number of pedestrians killed in road accidents has fallen in recent years, Cahill argues that this reduction has been achieved through encouraging a climate of fear in which fewer vulnerable pedestrians are killed each year because fewer are willing to take the risk of being a pedestrian.⁹⁹

Vehicle emissions

Historically, London has always suffered from air pollution problems but more recently the focus on the causes of this has switched to traffic related pollution. While pollutants such as Sulphur Dioxide have reduced substantially others such as Nitrogen Dioxide, Ozone and small particles (known as PM10), all of which are largely traffic related, have increased dramatically. In 1994 the Royal Commission on the Environment warned that pollution caused through traffic represented a serious threat to public health and estimated that the particulates from fuel were responsible for an excess mortality rate of 10, 000 a year nationally.¹⁰⁰ This pollution has been shown to affect the health of older people, particularly through exacerbating existing respiratory problems, and has also been linked with heart disease. The DETR recommends that older people spend as much time in-doors during cold or very hot weather.¹⁰¹

Pollution from traffic is worse around main roads and research conducted by the London Research Centre has shown that pollution levels along most roads in the Capital are particularly high.¹⁰² A study conducted in Birmingham in 1993 showed a direct link between hospital admissions of older people with respiratory problems and peak traffic on the city's main roads.¹⁰³ Similarly, research conducted by Whitelegg et al suggested that up to 15 million people could be suffering from minor health problems as a result of heavy traffic near their homes.¹⁰⁴ It showed a clear relationship between the amount of traffic on the roads and the amount of illness such as headaches, ear infections, runny noses that local people suffered from.

Table 9: Potential health impact of pollutants on older people

Pollutant	Potential Health Impact on Older People
Nitrogen Dioxide Sulphur Dioxide and Ozone	These gasses irritate the airways of the lungs, and increasing the symptoms of those suffering from breathing problems or lung diseases.
Particles	These are carried deep into the lungs where they can cause inflammation and a worsening of the condition of people with breathing difficulties or heart and lung diseases. These are particularly bad during the winter when breathing is often more difficult.
Carbon Monoxide	This gas prevents the normal transport of oxygen by the blood. This can lead to a significant reduction in the supply of oxygen to the heart which is particularly dangerous for older people.

Source: DETR, 1999

Noise pollution

Noise pollution is a growing environmental health issue. In 1997/98 there were nearly 110,000 complaints made to Environmental Health Officers regarding unacceptable levels of noise in London.¹⁰⁵ Although less than five per cent of these resulted in any

action being taken, it is evident that noise continues to be a major issue for Londoners and particularly older people.

For many people who live on or near main traffic thoroughfares there is the added problem of noise pollution caused through traffic. Whereas high levels of noise pollution can cause permanent loss of hearing, traffic is unlikely to reach this level. However, persistent exposure to even lower levels such as that created by traffic can lead to severe psychological stress which in itself weakens the body's immune system against other ailments.¹⁰⁶

Table 10
Vehicle Noise: Prosecutions and conviction, London 1996

	Numbers	
	Metropolitan Police District	City of London Police
Prosecutions	789	20
Convictions	536	15
Written Warnings	13	0
Fixed Penalty Charges	69	1

Source: Home Office

The noise pollution caused through traffic, although detrimental to long term health,¹⁰⁷ tends not to be the subject of complaint compared to other causes. Complaints about noise originating from domestic premises continue to rise being 50 per cent higher in 1997 than in the previous two years. The effect of such disturbances tends to be the interruption of sleep which in itself can lead on to other health problems.

Table 11
Noise Complaints Received by Environmental Health Officers (London), 1996-97

	Complaints per 10,000 residents	Boroughs Responding (No.)
Domestic premises	134.1	17
Industrial and commercial properties	29.9	18
Vehicles, machinery and equipment in street	6.3	17
Noise in street	3.1	18
Construction, demolition, etc.	8.4	17

Source: Chartered Institute of Environmental Health

Approaches to dealing with the issues raised

The health and well being of older people is affected by a wide variety of factors. However, the impact which public transport and the environment has on these is particularly high. In many ways an effective public transport system can vastly improve the quality of life for thousands of older people in London, if such transport is accessible to them.

However, as has been seen accessible public transport is not just a question of appropriately designed buildings and vehicles but is as much about confidence in use, fear of crime and a general feeling of safety within the community London's relatively high number of road accidents involving pedestrians and the higher than average fatality

rate for older people involved in them may discourage many from making any journeys that involve crossing main roads. Additionally, the air and noise pollution caused through excessive traffic in London make such journeys even more difficult.

At the same time the environmental issues associated with pollution and the availability of local services and facilities are keys aspects of planning policy. Planning the environment would involve development policies that allow people access to services locally rather than being dependent on private or public transport as well as allowing access through good public transport for everyone as part of a package of reducing traffic pollution and accidents. This requires concentrated action across a number of bodies

Further research needs

In particular, research into the accessibility of much of London's transport system to those with mobility aids would be useful together with recommendations as to how best to adapt the Capital's transport network to make it more inclusive. Research is also needed into alternative ways of ensuring access to services for older people that are more locally based.

Crime and safety

Introduction

Recommendation 13 of the report 'Reducing health inequalities' says, "We recommend the development of policies to reduce the fear of crime and violence and to create a safe environment in which to live".

The impact of crime on older people's health can be directly through the actual occurrence of crimes or more generally through the fear of crime. Those in the oldest age groups are also more likely to suffer health problems, or die, because of accidents.

Older people as victims of crime

The British Crime Survey found that 5.7 per cent of households in London in 1997 were victims of burglary, close to the England average¹⁰⁸. In the country as a whole, households headed by someone over 60 are less likely than average to have experienced a burglary (4.0 per cent). There are factors which increase the risk of burglary which may adversely affect older Londoners in some areas. Burglary rates are higher in Inner City areas, on council estates and among Asian households.

Crimes of violence affect a higher proportion of people in London than in any other region except the North West, with 5.6 per cent of adults experiencing them in 1997. Nationally, 4.7 per cent of adults experienced a violent crime in 1997, but rates decreased sharply with age. 1.2 per cent of those living in households headed by someone aged 60 or over experienced violent crime in 1997.

Overall crime rates are highest in central and inner London boroughs and lowest in outer London¹⁰⁹. In 1997-98, the central boroughs of Westminster and Camden had rates of 384 and 221 offences per 1,000 population respectively. After these boroughs, the rates ranged from 181 per 1,000 in both Southwark and Kensington and Chelsea to 78 per 1,000 in Havering and 75 in Barnet.

Elder abuse

The extent of abuse of older people is difficult to quantify, since much of it may go unreported. Abuse can be either physical, emotional or financial and may include sexual and racial harassment. It may be perpetrated by family members, paid carers or other people with access to older people's homes. The charity Action on Elder Abuse has estimated that about one in 50 pensioners are subject to physical abuse and one in 20 to other forms of abuse¹¹⁰. The Alzheimer's Disease Society found in a survey that one in ten of friends and relatives of residents with Alzheimer's had been mistreated or neglected in care homes¹¹¹.

Fear of crime

A study of the fear of crime from the British Crime Survey¹¹² found that there was little difference between age groups in the percentage who were very worried about mugging, although women were more worried than men. People aged over 60 were less likely to worry about burglary or theft from cars. However, older people were more likely to feel unsafe out alone after dark – 64 per cent of older women felt a bit or very unsafe and 28 per cent of older men, compared with 47 per cent of women and 12 per cent of men aged 30 to 59. To place this in perspective, older people worry much more about illness affecting their family than about any sort of crime.

Amongst those aged 60 and over, the percentages reporting they never went out for fear of crime was five per cent of women and two per cent of men, but this rose to 11 per cent for women and three per cent for men in inner city areas. For all age groups, Asian people were more likely to feel worried about all types of crimes than white people.

The effects of crimes and the fear of crime can cause increased isolation, lack of activity and depression, leading to the need for service intervention, including in some cases admission to hospital or residential care. A study for the Department of Health on the reasons why older people choose to enter residential care found that fear, including the fear of crime, was a major factor in the decision¹¹³. An earlier study by Davies et al asked elderly users of Domiciliary services about their fears and worries¹¹⁴. This found 39 per cent of the sample had fears of being attacked or burgled.

Accidents in the home (road accidents are covered in the transport section)
Overall, major accident rates are lower amongst older people than younger age groups, but this is because these rates cover all types of accidents, including traffic accidents and sporting injuries. The Health Survey for England¹¹⁵ asked respondents how many accidents they had had in the last 12 months for which a hospital was visited or a doctor consulted. The rate for men aged 65 to 74 was nine per cent and for women, 14 per cent. These rates went up to 12 per cent for men and 20 per cent for women in the 75 and over age group.

Fire fatalities and casualties

Although deaths from fires are relatively rare – there were an estimated 643 deaths in 1998 – in terms of the rate per million population, older people are more likely to be involved¹¹⁶. In 1998, the rate of fatalities from fires in the UK was 14 per million amongst those age 60 to 64, 17 per million for those aged 65 to 79 and 36 per million for those aged 80 and over. This compares with a rate of 12 per million for all ages. For non-fatal casualties, there was a similarly high rate for those aged 80 and over, at 496 per million, compared with an average of 296 for the whole population. Those aged 60 to 64 and 65 to 79 however, had a lower than average rate of casualties, at 236 and 496 per million respectively.

Approaches to dealing with the issues raised

The Home Office has provided funding for anti-burglar cover for the homes facing the highest risk of burglary. The money was to be used to lend alarms to those who could not afford to fit them and for local authorities to set up rapid reaction repair services using glaziers and blacksmiths to help burglary victims. Mobile closed circuit television was also to be provided.

Examples of specific initiatives listed by the Metropolitan Police Service¹¹⁷ to assist older people include:

- A contact scheme at Wembley to monitor the well-being of elderly people living alone. This relies upon residents keeping an eye on their neighbours and reporting any concerns to the police.
- 'Warden watch' aims to reduce attacks on older people in sheltered accommodation. This involves a ring-round scheme where wardens warn each other of possible threats to their premises.
- A 'Home Care' scheme in Lambeth was set up in 1997 by Lambeth Crime Prevention Panel, the police, Lambeth Council, the Safer Brixton Project and the Inner London Probation Service, because of concern about older people being subject to bogus

callers and 'con artists'. The scheme provides improved security, including door chains and viewers.

- In Tottenham, older people were given personal attack alarms, to help them feel more confident when out and about.
- A national telephone helpline has been established by the charity Action on Elder Abuse.

While older people can be helped to improve the security of their own homes, measures also need to be taken to improve the outside environment, to encourage more social interaction and reduce isolation. Many of the issues relating to crime and safety need to be addressed through general measures to reduce crime and to improve safety, for instance on public transport and roads and through better lighting. Under the Crime and Disorder Act 1998, local authorities and police have been given the responsibility of drawing up a crime and disorder reduction strategy for their borough. While the reduction of the fear of crime generally will be an aim of these strategies, there is not necessarily an explicit strategy for older people.

Further research needs

Evidence is lacking on the effectiveness of crime reduction and safety improvement measures on the well-being of older people and on their independence.

Isolation and older people

Introduction

Within this review reference has been made to isolation as a consequence of housing and development policies in general. But comment needs to be made on specific aspects of isolation for older people that have not been fully addressed elsewhere.

For the purpose of this review, social isolation may be considered in terms of informal and formal relationships. Whereas the informal relationships with family and friends can provide emotional satisfaction, formal social roles at work and in the community can provide meaning or structure to people's lives. Conversely, the loss of these formal roles can adversely affect people's state of mind and health.

Isolation can have a far reaching impact on the health and well-being of older people ranging from depression and an inability to fight ill-health, through to mental illness and suicide. Isolation among older people is often a gradual process which takes over their lives, and it has multiple causes.¹¹⁸ These include health problems, disability, death of a partner or friends, loss of a role in society, poverty, fear of crime, cultural isolation and lack of understanding or ageist attitudes.

Changes in the culture or in the local environment can also leave older people feeling isolated, as can migration or language difficulties. Older people also often find it hard to share their thoughts and feelings or feel that their experiences will be of little concern to those younger than them.

Effects of isolation - loneliness and lack of participation

It is important to distinguish between isolation and loneliness.¹¹⁹ Isolation is seen to be an objective state, whereby people have a general lack of social relations. Loneliness however is the subjective feeling of missing the company of some person, or of people in general. Whereas some people may choose a solitary life, very few people choose loneliness. Both however can have a profound impact on the lives of older people.

A report by British Gas in 1991 found that 90 per cent of the population believed loneliness to be a problem associated with old age. However, only 32 per cent of the older people interviewed said that it was a problem for them personally. Other European and American studies report that about two thirds of older people are never or rarely lonely; one fifth are lonely sometimes and about a tenth say that they are lonely very often. This suggests that loneliness in older people may be overestimated and that a perception of them as lonely is partly because of negative stereotypes of old age. It is, however, a frequent problem for about 1 in 10 older people, almost one million people in total in Britain.⁸⁸

Loneliness appears particularly to affect the very old, the bereaved, and elderly living people isolated by disability. However, it can also be a problem for older people who are not on their own, such as married women, those living with married children, or those living in sheltered accommodation or residential care.

Whereas loneliness tends to be associated with lack of friends or family, the lack of formal participation in society can also lead to a loss of morale and self-respect. Harding, in a report for Help the Aged¹²⁰ argues that in our society there are few opportunities for older people to participate meaningfully and that opportunities that there were have been eroded. The report criticises cutbacks in adult education and in grants to voluntary

organisations, which have had to restrict their activities and concentrate on “services.” At the same time reductions in the level of social care staffing have led to a “problem-focused” approach in care services which has compounded the image of older people as a burden. The result has been that services have concentrated on physical health to the neglect of social health.

Harding maintains that despite the valuable contributions made by many older people to society, ageist attitudes prevail. They are evident, for example, in care services, where clients are not given enough chance to make their own decisions, in care packages that don't fully address individual needs and in age discrimination in the labour market.

However, most older people do remain in charge of their lives and retirement can open up a whole new phase of life. According to a study carried out in Hackney and Braintree between 1987 and 1991, also quoted in Harding, older people were generally well supported by their families and friends. The study also found that greater social contact and involvement with others appeared to be associated with greater satisfaction with their lives, and, literally, with survival.

Isolation can be more acute among elderly people with disabilities. This has been shown, for example, in two recent studies of the visually impaired. Baker and Winyard¹²¹ reported on a survey of 514 older blind and partially sighted people in 1997. Six in ten never went out on their own while more than four in ten said that their most frequently used form of transport was a car belonging to someone else. Over two thirds of those who did use public transport found it either difficult or virtually impossible to use. More than half the sample lived alone and 4 in 10 found loneliness particularly worrying. Only 1 in 4 visited a cafe during the average week and 1 in 10 went to a pub. Those who did go out found that being ignored was a common problem. Conversation was often addressed to a carer or companion rather than to the visually impaired person. Almost half the sample agreed that the older blind and partially sighted are left out of society.

Although the RNIB study did not focus on health, it is apparent that several risk factors are greater among the visually impaired: They are more isolated, feel more left out, live in greater poverty and have other chronic health problems. These are also risk factors for depression.

There are other disabilities which affect the social lives of elderly people. An important example, which needs more attention, is deafness. Harbert¹²² argued that visiting staff need more training in this area.

Approaches to dealing with issues raised

Many recommendations have been made to combat isolation and loneliness among elderly people.

Age Concern points out that isolation has complex causes. Therefore, a broad, multi-agency approach is required. Less than 3 per cent of older people in London live in residential care. The external environment, planning, housing, crime prevention, transport and leisure policies all have a much greater impact on people's quality of life. Their recommendations include among other things, supporting independence and choice, despite the risks that this may pose.

A report for Help the Aged⁸⁹ on the quality of life of older people, emphasised the importance of meaningful participation. The recommendations included:

- Legislation to combat age discrimination
- Pursue action to extend working life for those that want it
- Include older workers in the New Deal
- Include involvement and activities in the inspection requirements of social care facilities
- Support and extend opportunities for older people to be involved

Forbes⁸⁸ in an article on loneliness among older people, recommended several types of solution:

- Community involvement for all ages, for instance, participation in locally organised outings
- Activities with other older people, for example, local history groups, or the University of the Third Age
- Specialist Groups, like Cruse, which offers counselling and support after bereavement.
- Befriending schemes
- Getting a telephone
- Suitable housing with, for example, central alarm systems

Within the context of health services, greater consideration needs to be given to the impact of isolation and loneliness on older people. Health and social services staff may be the only people coming into contact with many older people and they can have an important role to play in helping people develop and maintain contact with the outside world not just through the services that they offer but through being a contact point and being able to put older people in contact with other organisations that can offer help including voluntary organisations

Similarly they can design information strategies that recognise the particular needs of people with disabilities such as visual and hearing impairment and the increasing needs of older people whose first language may not be English.

In combating isolation much can be done through sympathetic housing, transport and general development policies that recognise the impact that isolation and loneliness can have on the mental and physical well-being of older people.

Further research needs

Less is known about the mechanisms of cause and effect. For example, how does isolation affect people's emotional states and what are the mediating factors?

There is also evidence that some groups, such as the visually impaired, are at much greater risk than others. Identification of the risk factors will provide a focus for research and for practical remedies.

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- 1 LRC Mid-Year Estimates 1998
 - 2 Kings Fund, Transforming Health In London, 1997
 - 3 Office For National Statistics, General Household Survey
 - 4 London Research Centre, London's Older People, 1996
 - 5 Warnes, T., The Health And Care Of Older People In London, King's Fund, 1997
 - 6 Office For National Statistics, Social Focus On Older People, HMSO, 1997
 - 7 Eversley, D.E.C., 1992, Cited In Warnes, T., The Health And Care Of Older People In London, King's Fund, 1997
 - 8 Office For National Statistics, Regional Trends, Stationery Office, 1998
 - 9 Martin, J., Meltzer, H., Elliot, D., The Prevalence Of Disability Among Adults, Office Of Population Censuses And Surveys, HMSO, 1988
 - 10 Alzheimer's Disease Society, Home Alone: Living Alone With Dementia,
 - 11 Victor, C., Broken down by age and sex; an examination of old age in the inner city 1996 and Iliffe et al Assessment of older people in general practice 1991
 - 12 Gurland, 1983 Cited In Counsel And Care. Being Cared For: A Discussion Document About Older People Living At Home. Counsel And Care, London 1994.
 - 13 Mottram P, Hamer C, Williams J. Sad Screening. Nursing Times, 92(49), Pp 38-39, 4 December 1996.
 - 14 George, M. Section On Elderly In Russell O, Sone K, George M. Hidden Meanings. Community Care, Pp 18-21, 6-12 February 1997.
 - 15 Crosby, G. Elderly People. Research Matters, Pp 28-30, April-October 1997
 - 16 Cited in Crosby, C., Elderly People, Research Matters, pp 28-30, April-October 1997
 - 17 Macey Quoted in Russell O, Sone K, George M. Hidden Meanings. Community Care, Pp 18-21, 6-12 February 1997.
 - 18 Black D., Morrise, J., Smith, C., Townesend, P., Inequalities In Health; Report Of A Working Group, London, Department Of Health And Social Security, 1980
 - 19 Acheson, D., Independent Inquiry Into Inequalities In Health, London, The Stationery Office, 1998
 - 20 Equalisation Is An Adjustment To Take Account Of Variations In The Size And Composition Of The Households In Which Individuals Live. This Reflects The Understanding That A Larger Household Needs A Higher Income To Have A Comparable Standard Of Living To A Smaller One.
 - 21 Department Of Social Security, Social Security Statistics '97, The Stationery Office, 1997
 - 22 Hall, S., The Guardian 5th October 1999, p10
 - 23 Association Of London Authorities, Poor Prospects; An Audit Of Poverty In London, 1995
 - 24 Quoted in Office For National Statistics, Social Focus On Older People, HMSO, 1997
 - 25 Evandrou. M., Social Exclusion And Ethnic Elders, London Age, Issue 25 January 1999
 - 26 Family Resources Survey 1997-98, Department Of Social Security, 1999
 - 27 Family Expenditure Survey 1997/98, Office for National Statistics, 1998
 - 28 Bardsley, M., Health Of Londoners, 1997
 - 29 Bardsley Et Al, Deprivation And Health In London, Health Of Londoners Project, 1995
 - 30 Bardsley Et Al, Deprivation And Health In London, Health Of Londoners Project, 1995
 - 31 Turnberg, L., Health Services in London – A Strategic Review 1997
 - 32 In Warnes, T., The Health and Care of Older People in London, King's Fund 1997
 - 33 Regional Trends 1999, Office for National Statistics, 1999
 - 34 NHS Executive, National surveys of NHS patients; General practice 1998, October 1999
 - 35 Pharoah, 1995 cited in Warnes, T., The Health and Care of Older People in London, King's Fund 1997
 - 36 Age Concern, Age and Race: Double Discrimination, 1998
 - 37 Warnes, T., The Health and Care of Older People in London, King's Fund 1997
 - 38 Tomlinson Report
 - 39 Jarman, B., Is London overbedded? British Medical Journal, 1993: 306: 979-82
 - 40 Edwards, N., Raferty, J., Bedtime stories, Health Service Journal, 2nd March 1995
 - 41 Department of Health Statistical Data at www.doh.gov.uk
 - 42 Age Concern England, Turning your back on us: Older people and the NHS, 1999
 - 43 cited in Warnes, T., The Health and Care of Older People in London, King's Fund 1997
 - 44 cited in Age Concern England, Turning your back on us: Older people and the NHS, 1999
 - 45 cited in Age Concern England, Turning your back on us: Older people and the NHS, 1999
 - 46 cited in Age Concern England, Turning your back on us: Older people and the NHS, 1999
 - 47 Age Concern England, Turning your back on us: Older people and the NHS, 1999
 - 48 cited in Age Concern England, Turning your back on us: Older people and the NHS, 1999
 - 49 Patients Association, The priority given to commissioning health services for elderly people and those with incontinence problems by health authorities, June 1998
 - 50 cited in Age Concern England, Turning your back on us: Older people and the NHS, 1999
 - 51 House of Commons, Health Committee Report on the relationship between health and social services, Volume I and II, 1998

-
- 52 Social Services Inspectorate, Moving on, Report of the national inspection of social services department arrangements for the discharge of older people from hospital to residential or nursing home care, Department of Health, 1995
- 53 Social Services Inspectorate, Of primary importance; Inspection of social services departments' links with primary health services – older people, Department of Health, 1999
- 54 Audit Commission. The Coming of Age: Improving Care Services for Older People, Audit Commission Publications, 1997
- 55 Joule, N., London hospitals – Discharging their responsibility? A report of a survey of discharge policies and practices in London March 1994, The Greater London Association of Community Health Councils
- 56 Department of Health, Performance Assessment Framework indicator data, 1999
- 57 Department of Health, The New NHS; modern, dependable, 1997
- 58 Department of Health, Modernising Social Services, 1998
- 59 Department of Health, Modernising health and social services, National Priorities Guidance 1999/00 – 2001/02, September 1998
- 60 Department of Health, Partnership in Action: (New Opportunities for Joint Working between Health and Social Services) September 1998
- 61 Social Care In London: Trends In Social Services Activity 1993-97, London Research Centre, 1999
- 62 Fit For The Future: The Prevention Of Dependency In Later Life, Report Of The Continuing Care Conference, 1998.
- 63 Laing & Buisson, Care Of Elderly People, Market Survey 1999, Laing & Buisson Publications Ltd
- 64 Reported In The Observer, 3 November 1996.
- 65 Addressing The Balance, Health Advisory Service, London, HMSO, 1997.
- 66 Henwood, M., Ed. Our Turn Next: A Fresh Look At Home Support Services For Older People, Nuffield Institute For Health, 1998
- 67 With Respect To Old Age: Long Term Care – Rights And Responsibilities, A Report By The Royal Commission On Long Term Care, 1999
- 68 Reported In The Guardian, Financial Times And Telegraph, 20 August 1999.
- 69 London Research Centre, Social Care In London, Trends In Social Services Activity 1993 To 1997, London Research Centre, 1999
- 70 NHS Executive, The modernisation plan for the NHS in London 1999-2002, 1999
- 71 King's Fund , Transforming Health In London, King's Fund Publishing, 1997
- 72 Domiciliary Care – Quality Standards For Inspection And Accreditation Of Services, Produced By The London Domiciliary Care Forum And Published By The London Research Centre, 1998.
- 73 The Health Of Londoners Project (1998), Housing And Health In London: A Review By The Health Of Londoners Project, East London And The City Health Authority, London
- 74 London Research Centre, Government Office For London And The Office For National Statistics (1999), Focus On London '99, The Stationery Office, London
- 75 Shelter, Older People And Housing, 1997
- 76 Ambrose, cited in The Health Of Londoners Project (1998), Housing And Health In London: A Review By The Health Of Londoners Project, East London And The City Health Authority, London
- 77 Age Concern (1997) Housing And Older People, Now And In The Future: Some Figures, Age Concern England, London.
- 78 London Research Centre, 1991 Census Data
- 79 Smith, S.J., Health Status and the Housing System, Social Science and Medicine, 31 (7) 753-62
- 80 Smith, S.J., Alexander, A., and Hill, S., Housing provision for people with health and mobility needs; A good practice Guide, Joseph Rowntree Foundation, 1999
- 81 Arnold, P., et al. Community Care; The Housing Dimension. York , Joseph Rowntree Foundation, 1993
- 82 Joseph Rowntree Foundation And Anchor Trust (1999) Promoting Well-Being: Developing A Preventive Approach For Older People' Cited In 'Harnessing Grey Power' In Housing, July/August 1999.
- 83 Social Care In London, London Research Centre, 1998
- 84 Help The Aged (1997) A Life Worth Living - The Independence And Inclusion Of Older People, Help The Aged, London.
- 85 Daily Telegraph 20.08.99 P.9
- 86 The Housing Associations Charitable Trust In Association With Age Concern, 1997, A Forgotten Generation? Homeless Older People, A Case For Action, HACT, London.
- 87 Moore, H., North, C., And Owens, C., 1996, Go Home And Rest; The Use Of Accident And Emergency Departments By Homeless People, London: Shelter
- 88 Crane, M (1997) Homeless Truths - Challenging The Myths About Older Homeless People, Help The Aged And Crisis, London.
- 89 Citron, K., Southern, A., and Dixon, S., (1990) Out Of The Shadow: Detecting And Treating Tuberculosis Amongst Single Homeless People, Crisis, London.
- 90 Gary McGrogan (1999), 'Transport' In Perspectives In Public Health, Edited By Sian Griffiths And David S Hunter, Radcliffe Medical Press, Oxon.
- 91 Source: Department Of The Environment, Transport And The Regions Cited In Focus On London '99 , London Research Centre, Government Office For London And The Office For National Statistics, Published By The Stationers Office, 1999.
- 92 Tyler, N., Brown, N., And Lynas, J., "Improving Accessibility To Bus Systems For Elderly People", Centre For Transport Studies, University College London, 1997.
- 93 'Pensioners' Transport Survey' Help The Aged, June 1998.

-
- 94 Appleyard, D., And Lintell, M., (1972) 'The Environmental Quality Of City Streets: The Resident's Viewpoint', In American Institute Of Planners Journal, 38, Pp. 84-101.
- 95 Road Accidents Great Britain 1998 - The Casualty Report , Published By The Department Of Environment, Transport And The Regions, September 1999.
- 96 Tunbridge, R. J., (1987), The Use Of Linked Transport - Health Road Casualty Data, Crowthorne, Dept. Of Transport Road Research Laboratory Report RR96 And Hobbs, L. A., Gratton, E., And Hobbs, J. A., (1979) Classification Of Injury Severity By Length Of Stay In Hospital, London, Transport Research Laboratory Report, No. 871.
- 97 Source: Department Of The Environment, Transport And The Regions And Cited In Focus On London '99, Ibid.
- 98 See For Example, Adams, J., (1995) Risk, UCL Press, London.
- 99 Cited In M. Cahill, 'Consumerism And The Future Of Social Policy' In N. Ellison And C Pierson (Eds.) Developments In British Social Policy, (1998) Macmillan, London.
- 100 M. Cahill (1998), Ibid.
- 101 Air Pollution; What It Means For Your Health, Advice Leaflet Issued By The Department Of The Environment, Transport And The Regions, 1999.
- 102 'The London Atmospheric Emissions Inventory' Published By The London Research Centre. 1995 And Cited In Focus On London '99, Ibid.
- 103 Cited In Linda Jones (1994), Ibid.
- 104 Whitelegg, J., Gatrell, A. And Naumann, P. (1993) Traffic And Health, University Of Lancaster, Environmental Epidemiological Research Unit.
- 105 Source: Environmental Health Agency Statistics, 1998.
- 106 Whitelegg Et Al (1993), Ibid.
- 107 Office For Economic Co-Operation And Development (OECD) (1991), Fighting Noise In The 1990's, OECD, Paris.
- 108 Home Office Statistical Bulletin 4/99 Burglary Of Domestic Dwellings
- 109 Metropolitan Police Statistics
- 110 Everybody's Business: Taking Action On Elder Abuse, Action On Elder Abuse, 1995.
- 111 Alzheimer's Disease Society Reported In The Guardian, Independent, Times And Telegraph On 28 May 1997.
- 112 Anxiety About Crime: Findings From The British Crime Survey, Home Office Research Study 147, 1995
- 113 The F Factor. Reasons Why Some Older People Choose Residential Care. Department Of Health, November 94.
- 114 Davies B P, Bebbington A And Charnley H Resources, Needs And Outcomes In Community-Based Care, Personal Social Services Research Unit, Kent University, 1990.
- 115 Reported In Social Trends 29, Office For National Statistics, 1999
- 116 Home Office Statistical Bulletin 15/99, Fire Statistics, United Kingdom, 1998
- 117 Listed On The Website For The Metropolitan Police Service At [Http://Met.Police.Uk/](http://Met.Police.Uk/)
- 118 Age Concern London. Isolation And Older People. Age Concern London, 1998.
- 119 Forbes, A. Loneliness. British Medical Journal, 313, Pp 352-4, 10 August 1996.
- 120 Harding, T. A Life Worth Living. Help The Aged, London 1997.
- 121 Baker, M., and Winward, S., Lost Vision, RNIB, London 1998
- 122 Harbert, W., Isolated elderly people; reflections on policy, Policy Studies 16(2) pp 4-21, Summer 1995