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Identifying the health gain from retirement housing

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Identifying the health gain from retirement housing[1]

1 Introduction

In ‘the good old days’ it used to be that older people were regarded with a mildly patronising tolerance. White haired old ladies stood in rose-covered cottage doorways whilst genial gents rummaged in their sheds for potting compost. They were everybody’s vision of grandparents. Now older people, alongside terrorism and global warming, are increasingly being portrayed as a threat to society.

“Britain faces a bleak future of higher taxes and a rising deficit if ministers continue to increase spending on state pensions and the NHS, a hard-hitting report warns today” says the Daily Mail[2]. *“The country is facing a demographic time bomb with the number of over-65s set to increase by 1.4 million over the next five years…. this ageing population threatens to overwhelm the Coalition's attempts to bring down the UK's biggest ever peace-time deficit”.*

Not to be outdone, the Telegraph thunders a similarly ‘explosive’ headline[3] *“Healthcare time bomb as pensioner numbers rocket”* and continues with *“According to the ONS’s flagship report into population trends, the number of pensioners is expected to surge in the coming decades as post-war baby-boomers reach retirement age.”*

If it’s any comfort, Britain is not alone, as the Taipei Times illustrates with yet another ballistic reference[4].

“Life expectancy has soared in China, while fertility has plummeted due to strict birth control policies. In 2009, there were 167 million over-60s, about an eighth of the population. By 2050, there will be 480 million, while the number of young people will have fallen. “It’s a time bomb,” said Wang Fen of the Brookings-Tsinghua Centre for Public Policy in Beijing.

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[1] This is an independent review of the evidence compiled by the Institute of Public Care at Oxford Brookes University. It has been funded by McCarthy & Stone to whom we are grateful for their support.
[2] *Walker K (29 June 2012).* Britain’s age timebomb: Cost of 1.4m extra pensioners ‘means NHS cannot stay free’. Available at http://www.dailymail.co.uk/news/article-2009269/Cost-1-4m-extra-pensioners-means-NHS-stay-free.html [Accessed 01 May 2012]
[3] *Hall J (17 February 2012).* Healthcare timebomb as pensioner numbers rocket. Available at http://www.telegraph.co.uk/news/uknews/9087228/Healthcare-timebomb-as-pensioner-numbers-rocket.html [Accessed 01 May 2012]
[4] *Branigan T (24 March 2012).* China’s aging population timebomb. Available at http://www.taipeitimes.com/News/editorials/archives/2012/03/24/2003528556 [Accessed 01 May 2012]

This paper attempts to 'explode' some of the myths about the impact of our ageing society, look at where concern should really be expressed, and how we can manage, without wrecking the economy, to support an ageing population through a more effective focus on housing based solutions.

2 The extent of demographic change

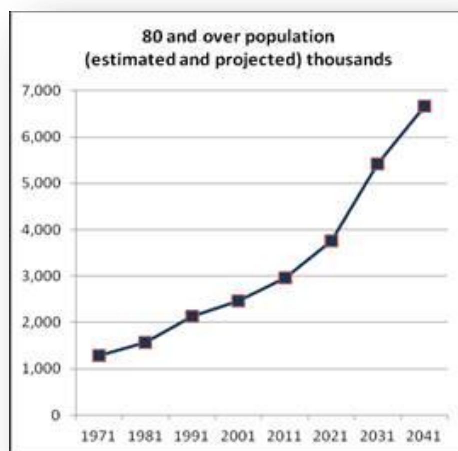
It is of course true that the population of older people is rising. For the UK as a whole, the 65 and over population has increased by 40% over the last forty years. This is expected to accelerate to an increase of 51% over the next twenty years. As the table below shows, this trend is even more marked amongst the oldest old population with those aged eighty and over having increased by 130% between 1971 and 2011 and predicted to rise by a further 82%, over the next twenty years.

Table 1: Population growth of 65+ and 80+ in the UK.

UK *(England, Wales Scotland and Northern Ireland)*	1971	2011	2031
Total population aged 65 and over	7,408,000	10,508,000	15,837,000
Total population aged 80 and over	1,287,000	2,970,000	5,415,000

2010-based National Population Projections. (2011) ONS

Chart 1: Growth of 80+ population



This accelerated growth in the oldest old population is illustrated by Graph 1 which also shows that the increase begins to accelerate from the current time onwards[5].

However, the older people's population is not uniform in its distribution. For example in Tower Hamlets the population aged 80 and over is estimated to increase by as little as 4% whereas in Herefordshire the increase will be more than 100% (see Table 2.). This pattern is equally true for the

[5] *Office for National Statistics (2012).* 2010-based National Population Projections.

other countries of the UK. For example, in Scotland the estimated population aged 65 and over ranges from 19% in Glasgow to 33.5% in Dumfries and Galloway[6].

Generally the older population in the shires is set to increase by more than that in the boroughs and unitary authorities, although some of the southern unitaries such as Torbay and North Somerset will experience an increase more in line with the Shires.

Table 2: Anticipated population growth in Tower Hamlets compared to Herefordshire

	2011	2030	Projected percentage increase
Tower Hamlets total population aged 80 and over	4,500	4,700	4.4%
Herefordshire total population aged 80 and over	11,600	23,400	101.7%

Projecting Older People Population Information (POPPI) System – Population aged 65 and over projected to 2030

Finally, life expectancy is also rapidly increasing. In 198, men aged 65 could expect on average to live a further 14 years and women aged 65 a further 18 years. By 2010 this had risen to 18 years for men and 20 for women. By 2051, additional life expectancy for men aged 65 is projected to be 25 years; for women aged 65 it is projected to be nearly 28 years.[7] Again there are differences across the UK with the current average life expectancy for men at 65 in Glasgow being fourteen more years, whilst in Kensington and Chelsea it is 24 more years[8]. The increase is perhaps most marked by the number of centenarians (people aged 100 years or more) living in the UK. This has increased from 2,500 in 1980 to 12,640 by 2010[9].

Summary

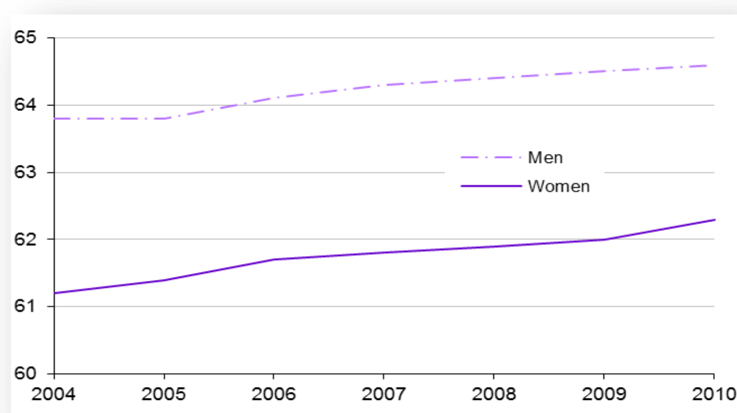
In some respects the media have got it right. The older people's population will numerically increase and increase as a proportion of the total population although it is neither a uniform increase nor an explosion as the 'time bomb' analogy suggests. However, the numerical growth only tells part of the story. The next section explores some of the other crucial differentials in the population such as those concerning wealth and health.

[6] *Scottish Government*, Demographic change in Scotland http://www.scotland.gov.uk/publications/2010/
[7] *Office for National Statistics (2010*). Pension Trends, Chapter 2: Population change.
[8] *Office for National Statistics (2010).* Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2004-06 to 2008-10
[9] *Office for National Statistics (2010).* Population Estimates of the Very Elderly,

3 The impact of demographic change

As illustrated by the Introduction the media tends to portray an increasingly ageing society only as a problem, particularly in terms of the costs of ill health and pensions and the diminution of an economically active labour force as compared to the population living in retirement. However, just as the demographic profile of the UK is changing so is the nature and complexity of older age. For example, notwithstanding the coming changes to the state pension age, as can be seen from the chart below[10], people have already begun to retire later.

Chart 2. Average age of withdrawal from the labour market using the duration of working life indicator, by sex, 2004 to 2010



Perhaps the most significant change is in the comparative wealth that older people enjoy. This can be shown through two factors – income and housing.

- Average gross pensioner incomes have increased by 44% in real terms between 1994/95 and 2008/09, well ahead of the growth in average earnings[11]. Currently, 59% of older people receive an occupational pension as compared to just 13% prior to 1945[12].
- Over three quarters of people aged 65-74 are living in property that they own[13]. Again this is in contrast to the post war period, when in 1945 fewer than 40% of all people were owner occupiers and many rented

[10] *Office for National Statistics.* Analysis based on Annual Population Survey and single calendar year versions of Interim Life Tables.
[11] *Office for National Statistics (2010).* Pension Trends, Chapter 11 Pensioner Income and Expenditure.
[12] Data from the *Pensions Policy Institute.*
[13] *Projecting Older People Population Information (POPPI) System.* Living Status; Tenure; Proportion of population aged 65 and over by age and tenure, year 2001. http://www.poppi.org.uk

from the private sector[14]. The value of housing equity held by older people in the UK has been estimated as ranging from £751 billion[15] to £1 trillion[16] which, even at its lowest estimate, means around £83,000 for every person aged 65 and over. Half of all housing equity is held by people aged 65 and over[17].

Far from being a financial liability the WRVS estimated in 2010 that older people made a net contribution to economic wealth of around £40 billion across the UK. They see this as rising to £77 billion by 2030[18].

However, it is equally obvious that there are downsides to ageing. A number of health conditions are far more common in old age, such as strokes, falls, chronic obstructive pulmonary disease, etc. As Howse[19] notes, we might be living longer but they are not all years of good health:

"It certainly looks as though total life expectancy in the UK is increasing faster than either the expectation of life in good health or the expectation of life without limiting longstanding illness".

This suggestion is borne out by the Office for National Statistics (ONS) data[20]. Whilst life expectancy is increasing, the period of life lived disability-free is hardly changing. Therefore, the period of healthy life expectancy for men at 65 is only ten of the seventeen likely years to be lived, whilst for women it is eleven years out of twenty.

Increasingly, the picture on offer as longevity increases is, for many people, a two-tier old age. On the one hand an early, immediate post-retirement, period of comparative health and prosperity, followed by an older old age where there is a greater risk of increased physical and mental infirmity, of owning a property that becomes increasingly hard to manage and sadly for many, either the death of a lifelong partner or one family member caring for another.

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[14] *Roger Burrows (2003).* Poverty and home ownership in contemporary Britain, Joseph Rowntree Foundation.

[15] Data from Key Retirement Solutions Equity Release index which tracks the amount of equity held in property by people over 65 years of age in Great Britain. Figures are based on analysis of data from; the Office for National Statistics Family Spending Report (2009); the Land Registry House Price Index; Registers of Scotland House Price Statistics; and ICM (2010).

[16] *Michael Ball (2011)* Housing markets and independence in old age: expanding the opportunities, Henley Business School

[17] *Care & Repair England (2006).* Small things matter: the key role of handyperson services.

[18] *WRVS (2011).* Gold age pensioners: Valuing the Economic Contribution of Older People in the UK.

[19] *Howse K (2006).* Increasing Life Expectancy and the Compression of Morbidity: A Critical Review of the Debate. Oxford Institute of Ageing, July 2006. Working Paper Number 206.

[20] *ONS (2011)* Health Expectancies at birth and age 65 in the United Kingdom

In addition, the final years of life for many people may also be spent living alone, due to men dying earlier than women as well as the impact of divorce. The number of people in the UK aged 65 and over estimated to be living alone in 2011 was just over 3.5 million. These figures are projected to increase to just over 4.2 million in 2020 and to almost 5.3 million in 2030.

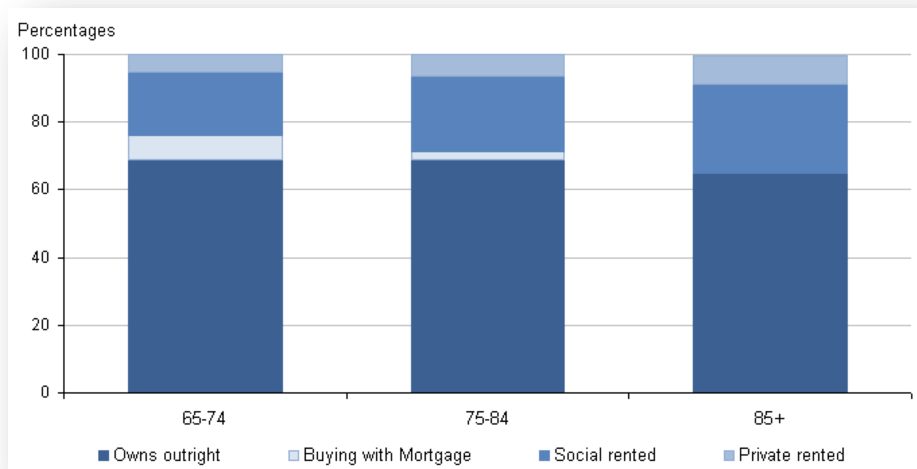
Summary

The numerical data shows an increasingly ageing population. However, within those figures is the distinction between years of healthy life as compared to life with some form of incapacity. If old age policy is to be seen as successful it not only needs to extend people's lifespan but also the number of years of healthy lifestyle. There is little indication that this is yet occurring. On the other hand many more older people have access to personal financial resources and housing equity than they did at the founding of the welfare state.

4 Housing tenure and preference

As has already been stated in the preceding section, the majority of older people live in homes which they have purchased. Chart 3 shows the distribution of different housing tenures for older people.

Chart 3. Housing tenure by age of Household Reference Person (HRP), Great Britain, 2009[21]



However, just as for the distribution of the older peoples population there is not a uniform picture across the UK. For example, in the South-East of

[21] *Office for National Statistics(2010)* - General Lifestyle Survey

England, 81% of 65-74 year olds, are owner occupiers, whereas in the North-East of England, 67% of 65-74 year olds own their house. These differentials are then further exacerbated by house prices given that in the South East the current average house price is £268,000 whilst for the North it is £138,000[22]

In terms of housing choice, The Wanless Review[23] offered an analysis of people's preferences for housing and care. It illustrated that whilst there is a clear preference by older people to remain in their family home, many older people do contemplate a move to alternative accommodation, with over twice as many people preferring a move to some form of sheltered housing as compared to residential care. Although such preferences are sometimes treated as absolute, ie, all older people want to remain in their traditional family home, in reality they are influenced by people's ability to manage in their current property, their capacity to move and their perception of the choices available.

This demand for housing suitable for older people has been more recently re-enforced by a YouGov poll for Shelter. This suggested that

"over a third of older people are interested in the idea of retirement housing, or would be in the future. This equates to over six million older people and suggests that there is latent demand for retirement housing; an opportunity which the market is yet to fully exploit. It is possible that with better awareness and more targeted marketing, demand could grow further."[24]

For some people their home not only becomes a burden but a reminder of what they used to do but now can no longer manage, as Hills research reveals.

"Being at home more and seeing things deteriorate around them not only was a source of frustration that they could do nothing about but also could serve as a constant reminder to participants of their lessening ability to do the everyday things they once did."[25]

When people do decide to move the decision can often come about through a variety of factors. Some of these are positive such as *"wanting a more convenient, nicer location, more manageable property or garden and to release capital"* or through negative factors such as divorce, death of a

[22] *BBC* (2012). UK House prices: October – December 2011. (Based on figures provided by the Land Registry of England and Wales). Available at http://news.bbc.co.uk/1/shared/spl/hi/in_depth/uk_house_prices/regions/html/region1.stm [Accessed 1 May 2012]
[23] *Wanless D (2006).* Securing Good Care for Older People: Taking a long-term view. King's Fund.
[24] *Shelter (2012)* A better fit? Creating housing choices for an ageing population
[25] *Hill K, Sutton L and Cox L (2009)* Managing resources in later life: Older people's experience of change and continuity, Joseph Rowntree Foundation

partner or deteriorating health[26]. Interestingly the Shelter report highlights that the motivation to move is more likely to come from cost and lifestyle factors such as saving on heating (59%) having space (50%)and privacy (35%) than from a fear of incapacity, (11%) being able to manage the property (11%) or accessibility (24%). Desire to move is one thing, as Hill's study shows, capacity to do so is another.

"Moving was seen as a stressful and daunting experience and emotional ties to a home, anxiety about the upheaval and uncertainty about the practicalities (especially for those living alone or in poor health) could mean that it was a decision people put off until 'it came to it'. Even if a decision was made, moving was not necessarily straightforward due to the availability of bungalows, waiting lists for warden accommodation and selling their own property[27]".

Despite the value of the housing assets held by older people, the current market is dominated either by sheltered housing, mainly in the public sector, or care homes. Despite 76% of older people being home owners 77% of specialist housing is for rent and only 23%for sale[28]. Less than 40,000 specialist housing units are extra care housing[29]. In comparison there are over 18,000 care homes with some 470,000 places[30].

Summary

The simplistic view of older people's housing preferences is that all older people wish to remain in their traditional family home. However, the research suggests this is as much a reflection about what is available and the difficulty of moving, as about a genuine desire to stay put. All research of course, only reflects past and current perceptions. The coming generation of older home owners may well be much more used to seeing 'home' not as a permanent dwelling but a changing place purchased on the basis of family and personal circumstances.

5 The health of older people

Whilst old age is not automatically synonymous with poor health and many people live throughout their lives without disabling conditions, the risk of a

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[26] *Hill K, Sutton L and Cox L (2009)* Managing resources in later life: Older people's experience of change and continuity, Joseph Rowntree Foundation
[27] *Katherine Hill, Liz Sutton and Lynne Cox (2009)* Managing resources in later life: Older people's experience of change and continuity, Joseph Rowntree Foundation
[28] *Joseph Rowntree Foundation (2012)* Older Peoples Housing Choice, Quality of Life and Under Occupation
[29] *Homes and Communities Agency (2009).* Housing our Ageing Population: Panel for Innovation (HAPPI) Report.
[30] *Care Quality Commission (2011)* The state of health care and adult social care in England: An overview of key themes in care in 2010/11.

physical and mental impairment dramatically increases with age. For example, nearly half of all disabled people are aged 65 and over.

Dementia

With regard to dementia, the number of people with diagnosed and undiagnosed dementia in the UK is estimated as 821,884[31] representing 1.3% of the total UK population. However, its incidence amongst the population aged eighty and over is one in six. In total, it is estimated that a third of people aged over 65 will develop a dementia at some point in their older age[32]. Currently the likelihood of a care home admission for this population is high as compared to frail older people. For example, over a third of people with dementia who go into hospital from their own homes are discharged to a care home setting, a much higher proportion than for all older people having a hospital admission[33].

Cold weather

Older people are more likely to be vulnerable to cold weather. This is partly because they are more likely to have existing medical conditions[34]. Britain has an increased number of deaths in winter, greater than in many other European countries. As Table 4 shows, the effects of cold weather can be directly measured.[35]

Table 4: The impact of low temperature on health and well-being

Indoor temperature	Effect
21° Celsius	Recommended living room temperature
18° Celsius	Minimum temperature with no health risk, though may feel cold
Under 16° Celsius	Resistance to respiratory diseases may be diminished
9 – 12° Celsius	Increases blood pressure and risk of cardiovascular disease
5° Celsius	High risk of hypothermia

[31] *Luengo-Fernandez R, Leal J and Gray G* (2010). Dementia 2010, Alzheimer's Research Trust.
[32] *Alzheimer's Society (2012).* Dementia 2012 A National Challenge. Available at http://www.alzheimers.org.uk/infographic [accessed 01 May 2012]
[33] *Alzheimer's Society (2009).* Counting the Cost; Caring for people with dementia on hospital wards.
[34] *Burholt V and Windle G (2006).* Keeping warm? Self-reported housing and home energy efficiency factors impacting on older people heating homes in North Wales. *Energy Policy, 34(10), pp 1198–1208.*
[35] *Department of Health (2009).* Keep Warm Keep Well. Supporting Vulnerable People During Cold Weather.

Interestingly, there does not need to be protracted cold weather to have an impact on the deaths of older people. A sudden cold snap can be equally as dangerous. Cold weather deaths from heart disease increase almost immediately[36], reaching their highest just two days after the coldest weather. The steepest rise for stroke takes place five days into a cold spell. It takes another week for deaths from respiratory illnesses to peak. After a cold spell, it takes more than a month for death levels to return to normal.

In winter a 1° C decrease in temperature is associated with a 1.35% increase in the daily number of total natural deaths (1.72% increase in cardiovascular deaths, 3.30% increase in respiratory deaths and 1.25% increase in cerebro-vascular deaths). This increase is greater for older age groups[37].

Falls

Proportionally, older people; are most at risk of a fall, their falls result in worse injuries and they take longer to recover. Injurious falls, including over 70,000 hip fractures annually, are the leading cause of accident-related mortality in older people. Around two thirds of deaths and very serious injuries from falls on stairs or steps in the home are to people aged 65 years and over[38]. As the Royal College of Physicians states[39]:

"Falls often lead to reduced functional ability and thus increased dependency on families, carers and services. An ageing population means that the rate of falls and fractures are increasing and will continue to do so unless action is taken to address serious inadequacies in services".

In the NHS Hospital Episode Statistics for 2010-11[40], there were more than 108,000 consultant episodes for fracture of the femur. Of these, more than 84,000 (78%) were for patients aged 75 years or over

The combined cost of hospitalisation and social care for hip fractures (most of which are due to falls) is estimated at £2 billion a year[41]. A study of the

[36] *Donaldson G C and Keatinge W R (1997).* Early increases in ischaemic heart disease mortality dissociated from and later changes associated with respiratory mortality after cold weather in south east England. *Journal of Epidemiology and Community Health 1997; 51 pp 643-648.*
[37] *Analitis et al (2008).* Effects of Cold Weather on Mortality: Results from 15 European Cities within the PHEWE Project. American Journal of Epidemiology 168: 12; pp 1397–140.
[38] *Office of the Deputy Prime Minister (2003).* Statistical Evidence to Support the Housing Health and Safety Rating System Volume II – Summary of Results.
[39] *Royal College of Physicians (2011).* Falling Standards, Broken Promises, Report of the National Audit of falls and bone health in older people 2010.
[40] *The NHS Information Centre, Hospital Episode Statistics for England*. Inpatient statistics, 2010-11. Primary diagnosis: 3 character tables 2010-11. http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=192
[41] *British Orthopaedic Association (2011).* The National Hip Fracture Database National Report 2011.

cost of hip fracture in the UK in 2000 looked at hospital costs, as well as ambulance costs, social care-costs, GP costs and outpatient costs[42]. The total estimated cost calculated was £726 million, of which £236 million was health-care related and £490 million social care. The average cost of a single hip-fracture was almost £25,500 a year at 2000 prices. Using Retail Price Index figures, this would equate to approximately £28,600 in 2005 and £35,000 in 2011. The study concludes:

"The treatment of hip fractures places a heavy burden on the NHS and social care services. As the UK population ages, the cost of falls is expected to escalate. Therefore measures to reduce the incidence of falls will generate significant savings to the NHS and society as a whole."

Despite this, some eleven years later, the Royal College is acerbic in its condemnation of NHS falls performance:[43]

"The audit shows that there is unacceptable variation in the quality of NHS services for care and prevention of falls and fractures. In many areas, there is a major gap between what NHS organisations state they provide, in terms of commissioning, protocols or structure; and what clinical audit reveals in terms of actual care provided. The audit shows that older patients with fractures do not routinely receive key aspects of care for falls prevention or bone health, needlessly exposing them to a greater risk of further falls and fractures".

Stroke

Whilst stroke is not solely confined to older people, its incidence is much greater in older age. Three quarters of all strokes occur in people aged 65 and over and those aged 75 and over are nine times more likely to have a first ever stroke and a 14-fold higher risk of suffering a recurrent stroke than people aged 45 to 64 years.[44] Given its greater incidence amongst older people this is then compounded by the poor quality of health service response to stroke.

For example, the National Sentinel Stroke Audit identified twelve basic interventions that should be common to all stroke treatment[45]. It noted that only 16% of patients received all twelve interventions and commented.

"What these figures show is that although great progress has been made in improving the delivery of individual standards the chances of a patient

[42] *S Parrott (June 2000).* The Economic Cost of Hip Fracture in the UK. *University of York*
[43] *Royal College of Physicians* (2011). Falling Standards, Broken Promises, Report of the National Audit of falls and bone health in older people 2010.
[44] *Carroll K et al* (2001). Stroke Incidence and Risk Factors in a Population-based Cohort Study. Office for National Statistics. Health Statistics Quarterly; *12. Winter 2001*.
[45] *Royal College of Physicians (2010).* National Sentinel Stroke Audit; Organisational Audit 2010.

receiving high quality care across the whole pathway is low. None of these key indicators should be regarded as optional."

An example of poor interventions surrounds the use of anti-coagulants (basically blood thinners). The audit states:

"Patients are dying and having disabling strokes because of our failure to anticoagulate people appropriately. Predictably the prevalence of risk factors is much higher in the older patients (75+ years)".

Vision

Visual impairment leads to 90,000 falls per year in England and Wales at a cost of £130 million[46]. The chances of hip-fracture for those with "poor depth perception" are six times the norm [47].

"Sensory impairments become increasingly common as people age: around 80% of people over 60 have a visual impairment, 75% of people over 60 have a hearing impairment, and 22% have both a visual and hearing impairment."[48]

Mental Health

It is not just physical health and dementia that causes concern in older age but also mental health as the National Mental Health Development Unit reports[49]. One in four older people have symptoms of depression that require treatment although fewer than one in six older people with depression discuss their symptoms with their GP and only half of these receive adequate treatment. However, interventions to increase social participation, physical activity, continued learning and volunteering, and reduction of fuel poverty can prevent depression, particularly in older people.

Summary

The above material has been presented as a series of separate conditions or issues. In reality many older people have a range of conditions which interact with each other. For example dementia and delirium are strong risk

[46] *Heyword F and Turner L (2007).* Better outcomes, lower costs. School for Policy Studies, University of Bristol on behalf of the Office for Disability Issues, Department for Work and Pensions.
[47] *Ivers R et al (2000).* Visual Impairment and Risk of Hip Fracture. American Journal of Epidemiology 2000; 152, No 7.
[48] *Department of Health (2001).* National Service Framework for Older People.
[49] *Carolyn Chew Graham et al (2011).* Management of depression in older people: why this is important in primary care. National Mental Health Development Unit.

factors for falls and fractures.[50] Urinary incontinence is a common feature of older people who have had strokes although as the Royal College audit notes[51]:

"Management of urinary continence remains an area where major improvements are needed. This is one of the most common and distressing symptoms caused by stroke and yet less than two thirds of incontinent patients have any plan documented to show how the issue is being managed".

The overarching message here is that even if the NHS considerably improves its performance with regard to old age conditions the health service will be under considerable pressure over the next thirty years. Therefore, any interventions that can help to lessen either the impact of those conditions or the likelihood of them occurring, are clearly well worth exploring.

6 What impact can housing have on health and well-being?

If older people are far more prone to certain health conditions, then their housing circumstances may be both a contributory factor as well as a solution to these problems. Poor housing circumstances may of course not just be a feature of limited economic wealth. Many older home owners may be asset rich but still have a property that is a danger to them through its poor state of repair, through inadequate heating and insulation or through the presence of a number of home hazards such as dangerous flooring or steps. Some older people may simply not recognise that their property has become a hazard or that its physical state has deteriorated.

Warmth and fuel

As stated above much of the winter increase in mortality is attributable to the effects of cold, and there are strong reasons to think that inadequate home heating may be an important risk factor.

In 2007, 2.8 million households in England experienced fuel poverty[52] (defined as having to spend 10% or more of household income on heating the home). Half of all fuel poor households include at least one person aged over 60 years and a quarter of fuel poor households include an occupant over 75 years old. Older people are more likely to be fuel poor, as

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[50] *Royal College of Physicians (2011).* Falling Standards, Broken Promises, Report of the National Audit of falls and bone health in older people 2010
[51] *Royal College of Physicians* (2010). National Sentinel Stroke Audit; Organisational Audit 2010.
[52] *Department of Health* (2009). Annual Report of the Chief Medical Officer.

they are likely to spend longer periods of time in their homes than other people and therefore require their houses to be heated for longer periods[53].

Healy carried out an analysis of excess winter deaths,[54] describing variations in excess mortality in different European countries, and found that rates of death do not necessarily match different climatic conditions. Often higher rates of excess winter mortality are found in countries with less severe, milder winter climates (such as Greece, the UK, Spain, Ireland and Portugal), than countries with more severe winters (Finland, Germany and the Netherlands), who appear to suffer far less from excess winter mortality. These findings highlight that colder countries, which have had higher building standards than the UK, have much lower rates of excess winter deaths.

Wilkinson[55] provides strong evidence that winter mortality is linked to poorly heated homes. He analysed more than 80,000 deaths from cardiovascular disease in England and data from the 1991 English House Condition Survey. Deaths from cardiovascular disease were almost 23% higher in winter than the average for the rest of the year. There was more winter mortality the older the property and there was a strong link between excess winter mortality and lower indoor temperatures. Residents of the 25% coldest homes had around 20% greater risk of death than the warmest homes.

The Marmot Review team[56] affirmed that the main health conditions associated with cold housing are circulatory diseases, respiratory problems and mental ill-health. The Review team summarises its study on excess winter deaths, as follows[57]:

- Countries which have more energy efficient housing have lower excess winter deaths.
- There is a relationship between excess winter deaths and low SAP[58] rating/low indoor temperature.

[53] *Burholt V and Windle G (2006).* Keeping warm? Self-reported housing and home energy efficiency factors impacting on older people heating homes in North Wales. *Energy Policy 34; 10, July 2006, pp 1198–1208.*
[54] *Healy J D (2003).* Excess winter mortality in Europe: a cross country analysis identifying key risk factors. Journal of Epidemiology and Community Health 2003;57: pp 784–789
[55] *Paul Wilkinson et al (2001).* Cold comfort; the social and environmental determinants of excess winter deaths in England 1986-96.
[56] *Marmot Review Team (2011).* The Health Impacts of Cold Homes and Fuel Poverty. Friends of the Earth.
[57] *Marmot Review Team (2011).* The Health Impacts of Cold Homes and Fuel Poverty. Friends of the Earth.
[58] The Standard Assessment Procedure (SAP) is the Government's approved mechanism for measuring home energy efficiency: it calculates a home's typical annual energy costs for space and water heating as well as lighting. The SAP scale runs from 1 (low) to 100 (high).

- Excess winter deaths are almost three times higher in the coldest quarter of housing than in the warmest.
- 21.5% of all excess winter deaths are attributable to the coldest quarter of housing, because of it being colder than other housing.
- Around 40% of excess winter deaths are attributable to cardio-vascular diseases.
- Around 33% of excess winter deaths are attributable to respiratory diseases.

Vision

There is a clear link between older age poorer vision and falls. Good housing design can do much to help lessen the danger of falls for people with poor vision as the RNIB and The Thomas Pocklington Trust report[59]. Improvements to design and lighting can have a considerable impact. For example providing:

- *"Good tonal contrast between surfaces contrast between floor and cupboards can help orientation*
- *Contrast between the worktop and the wall behind it helps when placing objects on the top*
- *Contrast between the wall and the electrical switches and sockets can make them easier to locate*
- *Contrasting handles on cupboards and drawers are also helpful".*

Falls

It is generally acknowledged that removing or lessening home hazards on its own will not automatically produce a reduction in falls. People fall for a variety of reasons; poor vision, wrong medication, poor balance and gate, the consequences of dementia and stroke. However, it is equally recognised that housing and housing adaptations can still help in reducing falls.

"There is not conclusive evidence that addressing home hazards alone…will reduce falls and fractures. But these hazards should be addressed, using professionally prescribed environmental assessment and modification, because problems with vision, balance, chronic conditions and side effects of medication that increase with age will hinder people's ability to negotiate these home hazards and increase the risk of falls and fractures."[60]

[59] *Thomas Pocklington Trust and RNIB (2010)* Making the most of your sight.
[60] *Department of Health (2009)* Falls and fractures: effective interventions in health and social care.

Obviously, where people remain in their traditional family home, in some, although not all instances, it may be possible to introduce modifications to property to lessen the likelihood of falls. Equally these features can also be designed into retirement housing schemes. As a Demos think-tank report stated:

"To reduce the numbers of older people with physical limitations who are living in inappropriate accommodation, putting them at risk of falls and social isolation, we need to take a more proactive approach to meeting older people's housing needs."[61]

Mental health

The Warm Front evaluation team[62] assessed the mental health impact of cold homes on adults and found that the temperature of the home has an effect on mental health, in particular anxiety and depression. The study showed that as average bedroom temperatures rose, the chances of occupants avoiding depression increased. Residents with bedroom temperatures at 21°C are 50% less likely to suffer depression and anxiety than those with temperatures of 15°C.

Social isolation among older people is exacerbated by living in a cold home. Costly fuel bills prevent older people from going out, they fear returning, already feeling cold, to a cold home, or they are reluctant to invite friends into a cold house.

One research report[63] found the most consistent health outcome of housing interventions in small studies and in systematic reviews is improved mental health. Depression is a significant risk factor for fracture in older women[64]; there is a 30% increased risk of hip fracture in older women if they are suffering from depression.

There has been little research conducted into the role of supported housing and dementia care, although an increasing number of housing schemes for people with dementia have been developed. Nevertheless, those studies which have been conducted demonstrate that, on the whole, people with dementia can benefit from the support offered in sheltered and extra care

[61] *Bazalgette L et al (2011).* Coming of Age. *Demos*
[62] *Green G and Gilbertson J (2008).* Warm Front Better Health: Health impact evaluation of the Warm Front Scheme. Centre for Regional, Economic and Social Research, Sheffield Hallam University.
[63] *Heyword F and Turner L (2007).* Better outcomes, lower costs. School for Policy Studies, University of Bristol on behalf of the Office for Disability Issues, Department for Work and Pensions.
[64] *Whooley M A et al (1999).* Depression, Falls, and Risk of Fracture in Older Women. *Archives of Internal Medicine 1999; 159: pp 484-490.*

housing. For example, Kitwood et al[65], found that sheltered housing can offer a positive environment to people with dementia, provided that appropriate opportunities for social interaction are available. The role of housing staff was identified as critical in the integration of tenants with dementia.

Arthritis

As part of the Warm Front health impact evaluation[66], interviews were conducted with 49 households which received home energy improvements in five urban areas. They found that almost a quarter of respondents reported easing of chronic conditions such as arthritis.

Cold, damp homes increase the risk of arthritic symptoms which impacts on strength and dexterity, both of which decrease as temperatures drop, increasing the risk of injuries. This can result in periods of prolonged immobility, making it even more difficult to keep warm[67]. A cold house increases the risk of falls in the elderly. Domestic accidents, including fatalities, are more common in cold homes.

Neighbourhood

The wider neighbourhood can also affect the health of older people[68]. Physical housing conditions may be a determining factor of health, but the wider neighbourhood – unemployment, educational attainment, the level of antisocial behaviour, fear of crime – are also important. Housing and health professionals interviewed in this DTI study recognised more indirect links to health through feelings of safety both within the home and the neighbourhood. It is likely that improvements to housing will also be accompanied by improvements to the mental health of the inhabitants.

Loneliness and exclusion is a reality for millions of older people according to a report from Age UK[69] which states that 11 per cent of people aged 65 or over are often or always lonely and that neighbourhoods that exclude older people can exacerbate isolation and feelings of loneliness.

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[65] *Kitwood T, Buckland S and Petre T (1995*). Brighter Futures: a report on research into provision for persons with dementia in residential homes, nursing homes and sheltered housing. Anchor Housing Association.
[66] *Gilbertson J et al (2006).* Home is where the hearth is: grant recipients' views of England's home energy efficiency scheme (Warm Front). *Social science and medicine, 63; 4, pp 946-956.*
[67] *Department of Trade and Industry (2001).* The UK Fuel Poverty Strategy.
[68] *Housing Corporation (2006).* Good Housing and Good Health? A review and recommendations for housing and health practitioners.
[69] *Harrop A and Jopling K (2009).* One Voice - Shaping our ageing society. *Age UK.*

Summary

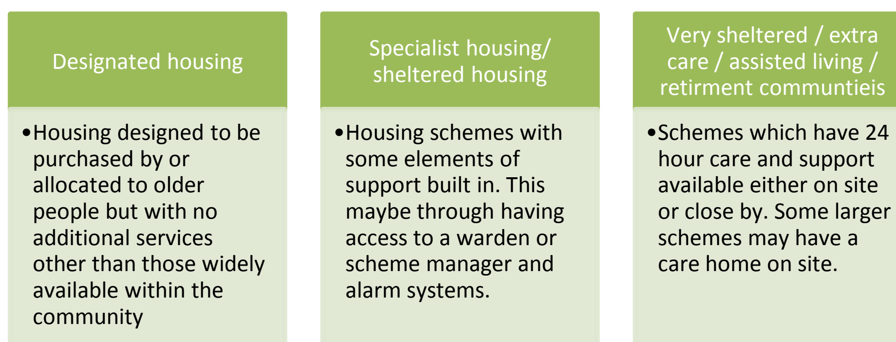
From this and the preceding section it can clearly be seen that poor health and NHS performance has, and will have, a significant impact on the potentiality to depress the period of ill health or morbidity that older people suffer and hence on costs to the public purse. It is equally clear that warm, well designed housing can play a significant part in changing that outcome and reducing costs. Some of this can be achieved by people making modifications to their own home, but for many a move into a wider range of age-suitable housing would appear beneficial to them and financially advantageous to the public purse through reducing heath care expenditure.

7 The retirement housing choice

The provision of specialised housing for older people is not a new concept. From medieval times almshouses for the poor, elderly and sick as well as for travellers became commonplace with the first recorded almshouse being founded by King Athelstan in York in the 10th Century[70]. Enshrined in legislation in The Act for the Relief of the Poor 1601 they were eventually superseded by the 19th century poor law and its development of the workhouse.

It was then not until the post war period and the founding of the modern welfare state that the development of the concept of sheltered housing for older people began to take off[71]. Sheltered housing was seen as part of a continuum between general needs housing and the higher care provided in residential care homes.

Such housing has always taken many different forms although as the population ages, increasingly many people within sheltered housing schemes seek some form of care and support. The diagram below offers a simple typology of such housing.



[70] *The Almshouse Association (2012).* What are Almshouses? Available at http://www.almshouses.org/index.php?option=com_content&view=article&id=87&Itemid=55 [Accessed 01 May 2012]
[71] *Housing LIN and ADASS (2011).* Strategic Housing for Older People (SHOP) A Resource Pack.

Although there are a number of differences between different types of schemes, the motivation for people entering some form of age segregated property, whether for rent, lease or purchase, often centres around a set of common themes such as downsizing and having manageable property, security, and access to support, whether from neighbours, voluntary or professional care.

Sheltered housing / general retirement housing

Sheltered housing generally consists of a group of independent accommodation units, some with a scheme manager (or warden) who may live onsite. Schemes generally provide 24-hour emergency help through an alarm system. Accommodation is usually self-contained, but there are often communal areas, such as a lounge, laundry room and garden. Some schemes also run social events for residents and have guest rooms that can be rented out if friends and family wish to stay. Historically, such housing was initially supplied for rent by local authorities and more recently housing associations. However, over the last thirty years there has been an increase in the number of private schemes.

Very sheltered / extra care / assisted living

New forms of sheltered housing and retirement housing have developed in recent years, designed for, although not exclusively occupied by, older people who are less able to complete tasks of-day-to-day living for themselves, and have, or anticipate that they might have, higher care needs. Known by a variety of names (although extra care has been used here), it has received impetus in recent years from the Department of Health, both in term of policy and in a grant funding programme for local authorities.

Primarily this is housing which has been designed, built or adapted to facilitate the care and support needs that its owners/tenants may have now or in the future, with access to care and support twenty four hours a day either on site or by call [72]. Most extra care schemes have as their objective that they should be capable of providing a home for life for their tenants / owners, if they so desire[73] .

In addition to the communal facilities often found in sheltered housing (residents' lounge, guest suite, laundry), extra care housing may include a restaurant or dining room, health and fitness facilities, hobby rooms and computer facilities. Domestic support and personal care are available, usually provided by on-site staff. Properties can be rented, owned or part-owned and part-rented. There is a limited amount of extra care housing in

[72] *Housing LIN and ADASS (2011).* Strategic Housing for Older People (SHOP) A Resource Pack.
[73] *Department of Health.* Extra Care Housing Bidding Guidance 2008 – 2010.

most areas and most providers set eligibility criteria which prospective residents have to meet.

Retirement villages / retirement communities

Further variations on the extra care theme are retirement villages. Frequently these will be, although by no means exclusively, provided by the private sector or specialist developers. The tendency is to be considerably larger than extra care schemes, eg, Denham Garden Village owned by the Anchor Trust has 327 housing units.

Villages will usually contain all the facilities and services provided by sheltered and extra care schemes. In addition, they may provide, a wider range of dining facilities, hairdressers, shops, on-site health services, some have swimming pools and others have leisure or recreational facilities. The emphasis is often on lifestyle choice. Some schemes also have residential care services available on site if tenants / owners become unable to manage in their own property.

Summary

Regardless of the type of scheme there is a considerable uniformity about the key features of most specialist housing, eg, designated land and accommodation, warm accessible accommodation, companionship and security, access to care and support and an emphasis on offering a quality of life. The variables are normally in the degree to which the above are offered, the form of tenure and in owner occupation or lease, the price to be paid.

8 What is the impact of retirement housing on the health of older people?

In terms of this paper the critical question is whether there is sufficient evidence to suggest that retirement housing offers significant gains to people's health. To do this relies on reviewing what is a fairly limited research literature. Some conclusions are fairly obvious and scarcely require academic research, eg, housing schemes that have good heating systems are better for older people than housing that does not, although that does not obviate the outcome.

However, there are some recent studies, notably Bäumker's review of extra care housing in Bradford [74], research by the International Longevity Centre[75]

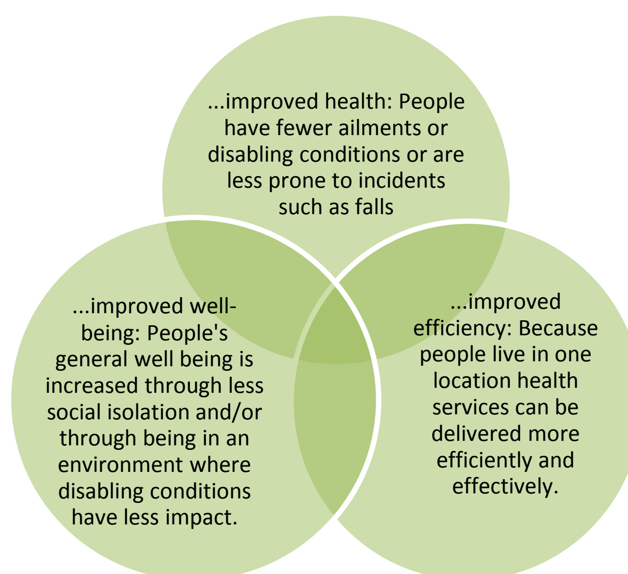
[74] *Bäumker T et al (2008).* Costs and outcomes of an extra care housing scheme in Bradford. Joseph Rowntree Foundation

[75] *Kneale D (2011).* Establishing the extra in Extra Care: Perspectives from three Extra Care Housing Providers. International Longevity Centre.

and the Personal Social Services Research Unit (PSSRU) review[76] of the government's extra care housing initiative, which all throw light on the impact on health of retirement housing.

Overall, any potential gain from all the different types of retirement housing can probably be measured in one of three ways as the diagram below illustrates.

Does retirement housing offer…



Health gain

The PSSRU study covered over 800 people in 19 schemes and had a thirty month follow up period. It identified that although not as frail as care home populations, the average resident in extra care schemes was considerably frailer than a matched sample of all older people (over 50% were unable to go out of doors, use stairs or able to wash all over without assistance. This is as compared to 11% within the whole community).The study came to some clear conclusions:

- For residents with care needs, the most important factors for moving were related to health and managing their long-term condition.
- Extra care produced considerably lower rates of mortality than a matched sample in care homes. For example the expectation was that 50% per cent of the residents aged 65 or over would have died by 32 months. In fact, among the residents aged 65 or over who were followed up over the full period of 30 months, only 34% had died.
- Using the Bartel Index (which measures people's capacity to take part in normal activities of daily living) over 40% of people followed up were

[76] *Netton et al* (2011). Improving housing with care choices for older people: an evaluation of extra care housing*. PSSRU / Housing LIN.*

at a better level of physical functioning at six months and at 18 months after moving in.

- People expect and receive higher levels of social interaction than in the community.

The International Longevity Centre (ILC) study reviewed extensive records from three private sector providers of extra care housing. Their conclusions can be summarised as follows:

- Extra care housing is associated with a reduced level of expected nights spent in hospital.
- Those in extra care housing are more likely to stay longer in hospital but this looks to be due to the fact that those in extra care housing as compared to those in the community are not admitted for minor conditions.
- A significant proportion of those who enter extra care housing with care needs, or those who enter with no care needs but subsequently experience a decline in health, will go on to experience an improvement in their health corresponding to a reduction in the care package received.
- About 8% of residents in extra care housing in this study enter institutional accommodation from extra care housing after five years of residence. Compared to those living in the community in receipt of domiciliary care, those in extra care housing are less likely to enter institutional accommodation.

Such findings are broadly matched by a number of other studies.

Kingston et al's study of a retirement community[77] found that, although many people had moved because of poor health, they assessed their own health as better than a matched sample of older people living in the locality where many of the retirement community's residents used to live. The self-reported health status of the locality sample declined over time, whereas there were few changes in the health status of the residents. The conclusion reached was that security, peer support, a general sense of optimism and the knowledge that care and support needs would be met by scheme staff rather than by relatives, all contributed to the residents' physical and mental well-being.

In a large survey, which reported in 2004, 345 residents at forty four McCarthy and Stone developments were[78], interviewed. Over 50% of residents believed that private sheltered housing helped to promote good

[77] *Kingston P et al (2001).* Assessing the health impact of age-specific housing. Health and Social Care in the Community, 9; 4, pp 228–34.
[78] *ORB (2004).* A Better Life: Private Sheltered Housing and Independent Living for Older People.

health. More than half of all residents (55%) considered their health to be good or very good. Bearing in mind the average age of residents (79.5yrs), this compares favourably to the general population of whom only 41% of 65-74 year-olds feel their health is good falling to 32% for those aged 75+. The study, like the later ILC work also looked at hospital admission. It found that whilst a higher percentage might receive an inpatient episode, they remained in hospital for only half the time of those not living in retirement housing. This was estimated as producing an annual cost saving to the NHS of £2,598 per resident per annum.

It could of course be argued that those who moved into such schemes were in better health beforehand or were from generally healthier backgrounds although the hospital admission figures would tend not to bear this out. They may of course indicate better and earlier detection of certain conditions. Nonetheless, the results still seem to be borne out by other studies which have differing samples.

A paper by Biggs et al[79] suggested that on average there was an improvement by residents of more than 35% in mobility and 20% in functions of daily living in the retirement living scheme they studied. They also found a 25% reduction in the use of medication by residents after admission. These findings were echoed in research undertaken by the Extra Care Charitable Trust[80]. They reported for residents moving into ECH:

"The superficial physical assessment score jumped more than 50 per cent on average; there was a mobility improvement of more than 35 per cent; a 20 per cent improvement in daily living functions; a 10 per cent increase in sensory ability; and a 25 per cent reduction in medication use. The majority of residents had transferred from hospital or nursing homes, and the greatest improvements were seen in the first 10 weeks in extra care".

Croucher et al, claim from their research that purpose built accommodation removes many of the difficulties and dangers of living in inappropriate accommodation[81], in particular the risk of falls. It also enables the effective targeting of occupant groups for health promotion initiatives such as immunisation, exercise programmes and health checks. Furthermore, it may be that by the targeting particular medical conditions associated with hospital and care home admission (eg, continence, dehydration and falls) it is possible to reduce this trend.

[79] *Biggs S et al (2000).* Lifestyles of belief: narrative and culture in a retirement community. *Ageing and Society 20; 6, pp 649–72*.
[80] *Extra Care Charitable Trust (2006)* cited in Securing Good Care for Older people (The Wanless Review), Kings Fund
[81] *Croucher, Pleace and Bevan (2003).* Residents' views of a Continuing Care Retirement Community. Joseph Rowntree Foundation.

Croucher's view is again re-enforced by the ILC research[82]. Although they recognise that there are some flaws in their methodology (although these may well under-value the benefits of extra care housing) the gains from retirement housing over people living within the community in terms of falls was clear. The fall rate in the extra care housing population stood at 31%, as compared to a similar advantaged population in receipt of care in the community at 49%. This distinction may not only be down to better care and more level access but also to exercise classes which are more prevalent and accessible for older people in retirement housing.

Better use of health resources

The ORB study suggested that the good health of residents was underlined by their use of the NHS. Only 21% of residents had received inpatient care over the last year. Health benefits for residents included fewer overnight stays in hospital and residents felt it easier to return home since moving to extra care housing (this finding is important because of the high costs of in-patient care). Over half (54%) of residents had received no outpatient treatment (of those that did, the mean number of visits was 1.7 times per year); and 13% had not needed to visit their GP in the last year.

The Bradford study of an extra care housing scheme, Rowanberries,[83] sought to understand both the costs and the outcomes delivered by the scheme. It found that the better health enjoyed by those living in the scheme meant that health care costs were lower (more than a 50% reduction), mainly through a reduction in the intensity of nurse consultations and hospital visits. More people accessed community services but less often than before moving into the scheme. In addition, the proportion of residents using acute services such as accident and emergency, outpatient appointments and inpatient stays, was slightly lower in all instances after the move into the scheme.

Quality of life and well-being

In the study conducted with McCarthy and Stone residents 'satisfaction level' was seen to be high amongst the older people interviewed:

"92% reported themselves as very happy or mainly contented with their new accommodation. Most look forward to living there for some time to come and, when asked if they would recommend where they lived to others in similar circumstances, 57% gave a 10 out of 10 positive score and only 5% gave a score of less than five."

[82] *Kneale D (2011).* Establishing the extra in Extra Care: Perspectives from three Extra Care Housing Providers. International Longevity Centre.
[83] *Bäumker et al (2008).* Costs and outcomes of an extra care housing scheme in Bradford. Joseph Rowntree Foundation.

In the Bradford study residents were interviewed at admission and asked to reflect on their quality of life *prior to* moving in. Most people selected ‘alright’, although three residents stated their previous quality of life was so bad that it could not be worse. Six months later there was a noticeable shift in how people described their current quality of life in Rowanberries, with the largest proportion reporting a ‘good’ and no one reporting very poor quality of life. As Croucher states:

“A purpose built environment, along with increased opportunities for social interaction with a peer group as well as the care and support on offer, will generate a greater sense of well-being and improved health status or maintenance of health status”[84]

Biggs’ study also found that with regard to quality of life:

“Residents not only lived longer than expected but achieved a quality of life far exceeding that experienced by residents in traditional homes, becoming ill at a lower rate than is usual.”

In a study undertaken by Greenwood and Smith[85] the positive contribution that extra care housing made to the health and well-being of occupants was attributed to:

- Being in a safer, warmer, more accessible environment in comparison to where people had lived before,
- A reduction in social isolation due to increased social contact and companionship,
- The recognition by staff of previously unrecognised health and care needs.

An evaluation of Reeve Court Retirement Village [86]concluded that it appeared to maximise health and emotional wellbeing for many of the people who lived there, providing a wide range of opportunities to achieve and enjoy life, while supporting vulnerable residents to do so. Improved health and wellbeing are likely to have the effect of prolonging independent living. Similarly, a study of housing for people in later life in Australia[87] showed that many residents of retirement communities reported improved quality of life, particularly linked to the social environment, the support provided for house and garden maintenance, the health support received and the quality of the physical environment.

The generally beneficial effects of extra care housing on their residents were also identified as being significant by managers of schemes. In a

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[84] *Croucher K et al (2006).* Housing with care in later life. Joseph Rowntree Foundation
[85] *Greenwood C and Smith J (1999).* Sharing in Extra Care. Hanover Housing Group.
[86] *Housing LIN* (2008). Case Study No 43: Reeve Court Retirement Village.
[87] *Jones et al (January 2010).* Service integrated housing for Australians in later life. Australian Housing and Urban Research Institute, Queensland Research Centre.

series of interviews conducted by the Institute of Public Care (IPC) for the Housing Corporation[88] managers were asked to assess the impact on health and well-being of a move to extra care housing. The responses were as follows:

Table 5: Managers views of the gains from Extra Care Housing

Area of Improvement	Number of schemes		
	In all cases	**In some cases**	**In no cases**
Greater interaction & involvement	15	14	
Improved self-care	6	26	
Sense of improved health & wellbeing by the individual	14	21	
Improved mobility function	3	27	1
Increase in sensory ability	3	23	6
Improvement in being able to undertake daily living function	9	26	
Improved sense of independence	20	15	
Improved mental health	4	25	5
Increased feelings of happiness & enjoyment	16	19	

Finally, although incorporating data that goes beyond just health benefits, Frontier Economics for the Homes and Community Agency identified the overall net impact of capital funding for specialist housing on the cost of wider public services.[89] They showed that the overall benefit per older person per annum is £444 per year. However, their estimates were mainly directed at housing for rent with funding from the Homes and Communities Agency. The gain would be greater where owner occupiers purchased housing using their own assets.

If that information is put together with the proposition from Professor Michael Ball at the Henley Research Institute[90] about the need to increase the supply of owner occupied retirement housing, together with the economic benefit of freeing up family housing then a crude figure could be estimated of minimum net gain from an increase in the supply of retirement

[88] *Housing Corporation (2007).* Raising the stakes: Promoting extra care housing.
[89] *Frontier Economics (2010)* Financial benefits of investment in specialist housing for vulnerable and older people
[90] *Ball M (2011).* Housing markets and independence in old age: expanding the opportunities, Henley Business School.

housing. Based on the above propositions the annual saving by 2033 could be at least £307 million per annum[91].

Although the above figures are conservative and would not all be based on health gain, this is an area that could benefit from further economic modelling.

Summary

Although the number of research studies with a control group, ie, comparing a range of sample populations in the community with those in retirement housing is limited, the weight of evidence through case studies, audits and research, shows that there is an unequivocal health gain to be made through the provision of all forms of retirement housing.

None of the studies showed there was either a health deterioration or even a standstill in people's health and well-being when they moved to this form of provision. Instead the evidence is that for many people there was a substantial improvement in health, a diminution in the volume of care and support required and a greater sense of security and well-being.

Moving forward

The general evidence of health gain from new build retirement housing is clearly strong. When combined with the demographic growth of the older people's population, the prevalence of home ownership amongst that population, the potential health profile of the oldest old group and poor health sector performance, the case for a significant stimulus of this sector is considerable.

It would be hoped that the forthcoming Social Care White Paper might provide such a stimulus. There are a variety of relatively low cost measures that could help in this respect:

- To ensure that in any role local authorities play in offering older people better information, that buying and selling housing and moving into retirement housing, heavily features.
- To encourage the delivery of new retirement housing across all tenures through the planning system.
- To establish with the sector a national kite mark for housing that identifies it as offering accessibility and the capacity to have a range of health and care services delivered into it. This does not have to be just

[91] Calculated on the basis of; an annual saving of £629 per person per annum in owner occupied housing suitable for older people, 320,000 housing units developed over the 20 years, plus the 105,000 units that already exist and a saving of £40 million per annum through 'trickle down' in freeing up family housing.

for designated retirement housing but could be for any housing that applies and meets the standard.

- Older people are clear that the prospect of moving in older age is not easy, either in terms of selling their property or in terms of physically packing up and moving. There are already a number of schemes around the country to help with this but these need a considerable extension and much greater publicity. This could include financial assistance with pack and move schemes for older people aged over 75 where they are moving into purpose built retirement housing.
- A stamp duty holiday / reduction for older people moving into new accommodation and for those buying their property.
- A reduction in council tax for older people living in retirement housing, to encourage take-up.
- Financial support for legal and conveyance fees for older people moving into retirement housing.
- Support to developers in sharing financial risk either through the development of interest free loan schemes to be repaid as properties are sold.
- Incentives to local authorities to release land for the development of older people's housing schemes.
- Many of the current public and indeed private schemes still convey a sense of 'less eligibility', of ageism and institutionalisation. An annual design competition which focuses on properties and schemes that can evidence; good design, reduced maintenance costs for owners and show reduced health care expenditure may help to challenge the sector to stop producing older people's housing and to produce housing suitable for older people. The aim should be to develop properties that people want to live in and want to buy rather than properties which they feel obliged to occupy.
- Commission a longitudinal study comparing heath performance of different forms of retirement housing.

From housing providers it would be good to see a wider range of concepts and prices alongside slightly more adventurous design. Participation in further research in terms of looking at the average savings per scheme and at the differentials between different types of scheme could also be of benefit. However it needs to be remembered that this is housing first not the reconstruction of care homes in flats and apartments.

In the end this is fundamentally about creating a diversity of choice of property for purchase that is suitable for all of us as we advance towards old age. Older people using their equity to deliver a health and care gain to society, at little to no cost to the public purse, whilst at the same time freeing up family housing, can only be of considerable benefit and worth pursuing and encouraging on a wider scale than currently occurs.