
THE SIXTH
F. OSWALD BARNETT
ORATION

AGEING IN
PLACE:
WHAT CAN WE
LEARN FROM
EACH OTHER?

by Professor Anthea Tinker
Professor of Social Gerontology,
Kings College London, England
1999

Oration held at St Johns Southgate,
Thursday, 9 September 1999



Ecumenical Housing Inc



Copelen

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Published by
Ecumenical Housing Inc
Victorian Council of Churches
6th Floor, 20 Queen Street,
Melbourne, Vic 3000
and
Copelen
Suite 5, 115 Hawthorn Road,
North Caulfield, Vic 3161

First Published September 1999

National Library of Australia
Cataloguing-in-Publication:

Tinker, Anthea
Ageing in place: what can we learn from each other?

ISBN 0 85821 143 2

- I. Barnett, F. Oswald (Frederick Oswald), 1883-1972.
2. Aged – Care – Great Britain.
3. Aged – Housing – Great Britain.
4. Aged – Care – Australia.
5. Aged – Housing – Australia.
- I. Copelen Child and Family Services.
- II. Ecumenical Housing (Inc).
- III. Title. (Series: F.Oswald Barnett Oration; no.6).

363.5946

F. OSWALD BARNETT



After a visit to a slum mission, F. Oswald Barnett, a public accountant and a member of the Methodist Church, became involved in the establishment of the Methodist Babies' Home in 1929. In 1934 Barnett formed a study group focused on housing reform, including slum demolition and the establishment of a state financed housing authority. The Barnett Study Group, which included in its membership, G.K. Tucker, founder of the Brotherhood of St Laurence, became the driving force behind a campaign which led to the establishment of the Housing Commission of Victoria in 1938, on which Barnett served as a Commissioner until 1948.

Then, as now, there is need to campaign against housing poverty and for the renewal of the partnership between the state and the community that is necessary to ensure housing justice.

The F. Oswald Barnett Oration seeks to acknowledge the contribution Barnett made to eliminating poor housing conditions. It also seeks to remind contemporary society that the task is not yet complete - housing poverty remains a social problem of the highest significance. The oration provides an opportunity for the churches and others of goodwill to recognise the significance of the work of F. Oswald Barnett and to renew their commitment to housing justice which ensures appropriate, secure and affordable housing for all Australians.

This oration is jointly sponsored by Ecumenical Housing, (a commission of the Victorian Council of Churches) and Copelen (formerly Methodist Babies' Home).

PROFESSOR ANTHEA TINKER

Professor of Social Gerontology, Kings College London and Research Consultant to the UK Royal Commission on Long Term Care.

The focus of Prof. Tinker's research in Gerontology has been on older people in their own homes. Her work started with a study of how older people could be enabled to live next door to their relatives without actually being part of the household. This national study of Granny Flats was followed by a wider study of policies to enable older people and their families to move closer. This national study of Elderly People Near Relatives was funded by the Department of the Environment when Prof. Tinker was at City University, London.

Prof. Tinker then spent 10 years in the Department of the Environment as Principal Research Officer, where she was responsible for all the research on older people and policy advice. While there, she did two more national studies. The first of these was Staying at Home, which examined innovative ways in which older people could remain in homes of their own, and involved both housing and social services authorities. The second was An Evaluation of Very Sheltered Housing which showed that while this was a more expensive option than staying at home, it was very satisfactory. All these studies led to policy advice by the DOE in circulars to local authorities and providers and general policy advice to government.

Prof. Tinker then went to Kings College, where she was Director of the Age Concern Institute of Gerontology for 10 years to 1998. Since her retirement from that position, she remains at the College undertaking research and supervising research students. She is the first Social Scientist to be elected President of the Royal College of Medicine's Section of Geriatrics and Gerontology and was made a Fellow of Kings College London in 1998.

Among the wide range of studies carried out at the Age Concern Institute, was a national survey of "Difficult to Let" Sheltered Housing. This led to policy advice to the DOE and the Housing

Corporation. She is now completing a study of very old people (85+) living in their own homes, with a focus on housing and home, using national quantitative and qualitative data.

During the last 10 years, Prof. Tinker has advised the OECD about housing and urban issues. Her other main interest is in Ageing and Technology (Gerontechnology). She has been a Consultant to the European Union for about 8 years. One of her interests in the EU is the evaluation of research in technology and ageing, and she has worked with the COST group (Co-operation in the field of Scientific and Technical research). Her other interest in the EU work has been in ethical issues.

Over the last 18 months, Prof. Tinker has been a research consultant to the Royal Commission on Long Term Care. The Royal Commission was set up to 'examine the short and long term options for elderly people, both in their own homes and in other settings, and to recommend how, and in what circumstances, the cost of such care should be apportioned between public funds and individuals'. The research consultancy was 'to review research and practice into alternative models of care for elderly people, specifically those that may allow more dependent elderly people to remain living in community settings rather than in an institutional setting'. The consultancy was won by the team led by Prof. Tinker at the Age Concern Institute of Gerontology at Kings College through competitive tender. The research explored four alternative models to institutional care: co-resident caring, home care, very sheltered housing and assistive technology. The report of the Royal Commission was released in early March.

ACKNOWLEDGEMENTS

Ecumenical Housing and Copelen acknowledge the sponsorship provided by the International Year of Older Persons Secretariat in the Victorian Department of Human Services.



AGEING IN PLACE: WHAT CAN WE LEARN FROM EACH OTHER?

INTRODUCTION

I am greatly honoured to have been invited to give this Oration and have read the previous ones with much interest. What strikes me from these is both some common themes with the UK and the differences. I will take this up in the course of my talk. But it is also significant that you have chosen Ageing as your topic. This is especially appropriate as 1999 is the United Nations International Year of Older Persons and I have used the Principles they have chosen as a structure for this talk.

In asking the question posed in the title of this talk 'Ageing in Place: what can we learn from each other?' I will not dwell on the many things that I think we can learn from Australia but concentrate on some current experiences in the UK so that you can see what some of our problems are and how they have been tackled. In some cases this does not make happy reading for us. We have learnt the hard way, for example about housing which no-one wants, but there are success stories too.

One common theme is a demographic one. Like you we have an ageing population.

Table 1: Numbers and projected numbers of older people in the UK and Australia as a % of the total population

	65+		80+	
	Australia	UK	Australia	UK
1986	10.5	15	1.9	3
1996	12.1	16	2.6	4
2016 Aus/2011 UK	15.8	16	3.9	4

Source Australia: World Congress of Gerontology, Adelaide *Older Australia at a Glance*, 1997, UK: Tinker (1996)

The average percentage of people over the age of 65 in the European Union is 16%. The Australian proportion is currently lower.

Although the ageing of our population has taken place in the UK, that is not the case in many other countries. In the developing countries for example the large increase in the proportion of older people is only just being seen and is in part a reflection of a drop in the birth rates. But we also share some other demographic features which are having an effect on all social policies including housing. Increases in divorce, in co-habitation rather than marriage, women having children either later in life or not at all and the uncertain futures for many young adults (which can have all kinds of effects including them leaving home later in life than previous generations) will all have an effect on the demand for housing.

What we also have is a greater divide between those older people who are financially well off and those who are poor. So, like Australia, there should be a concern about those who are socially excluded from the market. I say should but this is not always what is happening in practice.

THE UNITED NATIONS PRINCIPLES FOR OLDER PEOPLE IN 1999

The United Nations principles are:

- Independence
- Participation
- Care
- Self-fulfillment
- Dignity

Nearly everything that I want to say about Ageing in Place can be included under these headings. However some have more relevance than others so I will not give equal treatment to them. But there is one other principle which I would like to add because it has special relevance for our topic and that is 'choice'. So I would like to examine this first.

AGEING IN PLACE: CHOICE

There are particular issues to do with choice which are relevant for ageing in place. These are:

- tenure
- mainstream or specialised housing
- type of area to live in or move to
- type of building

TENURE

Owner occupation is the main form of tenure both in the UK (about two thirds) and Australia (about four fifths). This is the case for people of all ages including older people, which is interesting. Australia has one of the highest rates of home ownership in the world. Why is it such a sought after option in our countries when this is not the case in others (for example, Germany with a rate of 38% and the Netherlands with 46%). In some countries such as New Zealand it has been held that 'becoming a home owner is a rite of passage; anybody who reaches 40 without buying a house is decidedly suspect, not fully adult' (McLeod quoted in Dupuis and Thorns, 1996). In the UK this policy has been encouraged by successive governments through tax incentives but also through the 'right to buy' scheme whereby tenants of social housing have the right to buy their home at a discount. There is plenty of evidence that this is the preferred tenure and that there are many advantages for owners. For example they have the right to repair or renovate their property (subject to any legal restrictions of course) and also the possibility of raising an income from the home. Home equity schemes have been tried in both our countries and research taken place on them. Recent research which we have carried out shows that while many older people can draw on the home for an income the amount is not usually very large. Many homes in the UK are worth very little. Having something to leave to their families is another advantage and the shock by some people at having to sell their home to pay for long term care when they thought that this would be paid for by the National Health Service was an important factor which the recent Royal Commission on Long Term Care noted (Royal Commission, 1999).

But there are also problems for older people. One is upkeep of the

home. Here problems include affordability, not recognising problems, not having the energy or expertise to do anything about them, a lack of knowledge about reputable builders and an inability to organise and supervise the work and check that it has been done properly. Some very successful schemes are running in the UK under the title of Home Improvement Agencies (HIA). Most are under the umbrella of the organisation Care and Repair.

What they do is:

- help people decide on work to be done
- advise on, and arrange, finance
- organise all the building work
- sort out personal and practical problems
- withdraw sensitively and appropriately
- refer on if necessary

They have been very positively evaluated - for example:

- 90% of clients would recommend the service to others
- 55% would not have, or were unlikely to have, undertaken the work without HIA assistance
- 7% would have had to move without HIA support

They are funded in part by the Government who give grants to the agency. Simpler and even lower cost schemes which have proved popular are handyperson's schemes where small repairs, minor adaptations and

home security have been provided (Appleton, 1996). The clients are mainly elderly women, living alone and on low incomes.

Social housing has undergone a vast change in the UK. In the local authority sector not only have many homes been sold off but virtually no building has taken place as a result of Government policies. Much of the existing stock has been transferred either to housing associations or to groups of tenants. There has been little evaluation of the results of this. Housing associations have been the preferred form of social housing by both the last Conservative Government and by the current Labor one. But again grants and loans have been cut and there has been little investment in housing including that for older people. The residualisation of housing in the social sector means that it is increasingly seen as a last resort for people with problems. This is ironic in some ways because much of the housing for older people is of a high standard. The achievements of social housing were clearly put in the second (Walker, 1995) and third (Yates, 1996) Orations and these we must remember when we also think about the advantages of owner occupation.

A major issue for us now is housing in which no-one wants to live. Low demand is typified by high vacancy levels, rapid turnover, short or absent waiting lists and falling house prices. It occurs in all tenures and especially in the North of England. Low demand is often associated with negative stereotyping of an area and this has a cumulative effect. . In some cases low demand is understandable because the area has unpopular housing such as high rise blocks but in other cases it is new build. In a few cases it is new sheltered housing. At the same time we have great demand for housing and homes for an extra 4.1 million people are needed in England (Niner, 1999). There are many Government assisted schemes especially of urban regeneration to try to help overcome the problem,

MAINSTREAM OR SPECIALISED HOUSING

In the UK 95% of people aged 65 and over live in homes of their own. Of these 90% are in mainstream housing and 5% in specialised (mainly sheltered) housing. Sheltered housing is accommodation which is grouped with some communal facilities (a common room and usually also a laundry and guest room), a warden (resident or non resident) and an alarm system which links the people there with a warden. Only 5% are in some form of institutional care (hospitals, nursing homes or residential care homes). The proportion in institutional care is slightly higher than some other countries of Europe (e.g. Greece) but lower than others (e.g. Scandinavia).

It is unfortunate that the debate, and sometimes, sadly, research, about mainstream and specialised housing has too often been polarised with the advocates of one or the other claiming that theirs is the preferred option. The truth is that both have a role. What older people need is choice. What we do know from research is the inappropriateness of housing for many older people. There is evidence from all kinds of housing (and from institutions) that there are people there who neither want nor need to be there. In the case of sheltered housing there is a problem of 'difficult to let' housing where there are schemes for both sheltered and very sheltered housing with little or no demand (Tinker et al 1995). Often a combination of factors contributed to sheltered (and very sheltered) housing schemes being difficult to let. Bedsits and shared bathrooms were unpopular. Letting difficulties arose when schemes were located in 'problem' areas or where local shops or public transport were lacking. The growing number of ways in which older people could remain in their own homes was also cited as a reason together with over-provision. In other words older people are voting with their feet not to move into this form of accommodation.

There are two messages here. The first is to make sure that there is demand for a certain type of housing before building it. The second is what to do with schemes which have become unpopular. Good solutions to the latter are to enhance the facilities such as turning two bedsitters into one flat or by turning a sheltered into a very sheltered scheme. A disastrous solution is to introduce other groups into the scheme to fill it up. For example younger men with alcohol problems or large numbers of older people with dementia.

TYPE OF AREA TO LIVE IN OR MOVE TO

Older people are not a very mobile group. There is a peak of movement at retirement when the move is often to a more pleasant environment such as a seaside area and then again in very old age when the move is more likely to be to nearer relatives in order to get support. Policy analysts are suggesting increasingly that people ought to move before their home becomes unsuitable. So ageing in place may not always be the answer if it means ageing in an area and home which is not appropriate for that person.

Research on people who move to retirement areas shows the kinds of problems for people who technically age in place but not in the same place as they lived for many years. They may lose their social networks, present the local authorities with problems of demand for services and one partner may die soon leaving the other one (usually the woman) isolated, unable to drive and with a big garden which she cannot manage.

Those who own their own homes have much more of a chance to move than those who are in the social rented sector. They have choice. So again those who are excluded from the market are often left with

what others do not want.

We do not have the experience that you do of retirement communities. Research from the United States shows a mixed picture with them proving very successful for some people. But some older people are moved out when they become physically or mentally dependent. Some schemes have become bankrupt. Obviously all these situations pose problems. One scheme has recently been opened in the UK in York. After careful actuarial calculations it was found that only people with considerable assets would be accepted.

There is an ethical dilemma which we face over moving in the social rented sector which is where older people are technically 'underoccupying' property. If they occupy a three bedroom house which could be used for a family it could be argued that the case for the older person moving is a strong one. But against that is all the evidence that for an older person who has to move against their will the occasion will be akin to bereavement. In the UK people in social housing have, with certain exceptions, a right to remain there. They cannot just be moved. However they can be persuaded to move and this is sometimes done with the offer of grants which include the cost of removal.

TYPE OF BUILDING

Most older people, in common with people of all ages, live in houses in the UK. This would not necessarily pose a problem for them as they age if the toilet was on the ground floor. But in most cases it is on the first floor on a level with the bedroom. Although grants are available for people with disabilities many older people are either forced to move because of problems like this or they lead sordid lives on the ground floor with

commodes. Almost as bad is the problems of older people who are trapped in flats without a lift. We have not yet solved all these problems. What would help for the future would be more building of 'Lifetime' homes. These incorporate 16 design standards which ensure that the home is flexible, adaptable and accessible for people of all ages and their changing needs (Joseph Rowntree Foundation, 1997). Most of these features have little additional costs.

AGEING IN PLACE: INDEPENDENCE

The UN principle is 'Independence, including being able to reside at home as long as possible.'

I think that we ought to pay particular attention to the word 'independence'. Those of us who have undertaken surveys of older people know how often they use this word 'independent' to express their desire to remain at home. To me it seems particularly unfortunate that we should see it as a virtue to be independent at all times. For none of us are truly independent. We all depend on each other. I will come back to this in my conclusions.

Returning to the UN wording then there is overwhelming evidence that older people do want to be able to 'reside at home for as long as possible'. This is evident in research across the world. Indeed in the UK the evidence is that the older the person the more likely is that to be the case with the exception of some people in very old age who have great physical or mental problems. However these are the views of the current generation of older people and current forms of institutions. Much depends on the choice which is being offered. For example if residential care became more attractive say like a good hotel more people might choose it. More may have to choose it too if they do not have families to turn to.



But what has also to be taken into account is the views of other people especially those of the family. Here again we have an ethical dilemma. Is it the right of the older person to age in place no matter what the cost to the carer? In the UK we are increasingly acknowledging the rights of carers and indeed they now have the right to have their own needs assessed. But it is not just a legal matter. Whose rights and desires are to prevail when it is the older person who wants to remain at home but the family are worried about the dangers? Or the family feel that they cannot provide an adequate level of care? What is interesting is that I have posed the question in those terms i.e. the older person who wants to stay at home and the family would prefer them to move. In the research we undertook for the Royal Commission on long term care the opposite was the case in the Focus Groups (Tinker et al 1999). It was the older people who said they would be prepared to move into institutional care rather than put a burden on their families and the families who said that they would be prepared to have the older person live with them rather than go into an institution.

We also need to acknowledge in this discussion that there are many new ways in which older people can be helped to maintain their independence. For example we examined the role of Assistive Technology in the research we did for the Royal Commission (Tinker et al, 1999). This included communications equipment such as telephones and alarms, equipment to aid problems of mobility, personal and domestic care, smart homes and telemedicine/telecare. They can answer problems of communications, mobility, manipulation, orientation and cognition. Although technology is unlikely to replace people there are many ways in which the independence of older people can be enhanced. For example the use of mobile phones and alarms can enable people to contact others both for emergencies and for many other purposes such as for social reasons. Most of us use kettles

which turn themselves off and micro ovens. These can make a great deal of difference to people's independence and may enable them to remain at home. But even more sophisticated are 'smart homes' where many more such devices can be provided to help with cooking, personal care and for communications. There are even such bizarre examples as older people having robots as pets (in Japan).

AGEING IN PLACE: PARTICIPATION

The UN principle is 'Participation, including opportunities for older persons to share their knowledge and skills with the younger generation'.

A great deal could be said about the participation of older people in society but this is not the place. However, in the context of 'ageing in place' one issue is whether housing can provide a focus for a sharing of lives with other generations. The only case where research has been done to any extent is over 'granny flats' where the older person occupies a home adjacent (either above, below or by the side of) the family home. The theory is that the two households can give mutual support. The family can keep an eye on the older person and give support where needed and the same can be done by the older person. For example the older person can baby-sit or keep an eye on the property. In the UK research showed that some local authorities were providing this form of accommodation and that it was popular with families (Tinker, 1980). However it was inflexible in that the family might move or the older person die. What was the position then? The only answer seemed to be to move an unrelated family or older person in. Local authorities were not planning to expand their provision. In the private sector the granny flat can be used for another member of the family such as an adult child or for staff such as an au pair or housekeeper. Some research

suggest that 2% of the market in the UK could be this kind of accommodation (Morton, 1993). One problem which we have that Australia does not have to the same extent is lack of land. I know that granny flats have been provided in a number of places in Australia.

The question of participation also raises the issue of balanced communities. For some people of all ages the ideal may be a community where there is a balance of ages but others the research shows that they would prefer to live with people of their own age. Again this is a matter of choice, but it also raises issues about exclusion which is currently a matter of great concern in the UK.

AGEING IN PLACE: CARE

The UN principle is 'Care, including benefiting from family and community care and protection in accordance with each society's system of cultural values'.

I don't intend going into details about community care in the UK except to make a few points. The main one is that no one element of care is likely to allow someone to age in place. If they need care then it is likely that 'a package of care' which incorporates many different elements will be needed. For example an alarm by itself is unlikely to solve problems. There is also need for someone to organise the care package. We all have experiences we can share about care management.

We also need to acknowledge that the majority of care in both our countries continues to be given by families. Family care far outstrips that from other sources except in specialist cases.

Turning specifically to housing the example I would like to give of care

is that of very sheltered or extra care housing. This kind of provision is sheltered with the addition of 24 hour cover by a warden, meals (sometimes two a day but sometimes only one) and some extra communal provision such as special baths. Of the half a million units of sheltered housing only 3.5% is very sheltered. It enables older people to age in place although this is obviously not their original home. While some of it is difficult to let (for the same reasons as for sheltered housing which were given earlier) research shows that this is a popular and cost effective form of care. It is also cheaper in most circumstances than residential care. Research for the Royal Commission found that a growing proportion of tenants have a high level of dependency but at the same time a growing proportion have none. It may be that providers are seeking a mixture of frail and fit tenants. The research also shows that the evidence is mixed about the ability of current schemes to provide an alternative to institutions with some evidence about a lack of care services. It is also for most of the situations described in the report more expensive in terms of resource costs to the economy than staying in non specialised housing.

The research concludes:

‘Ways of meeting potential demand for very sheltered housing and of making better use of sheltered include turning the latter into very sheltered, making greater use of communal facilities and enhancing the role of the warden. However, there needs to be clear agreement about allocation procedures in the public sector with a likely emphasis on more dependent older people. The different models of providing care i.e. in house or from the outside need more research and evaluation and some interesting new ways are being developed’ (Tinker et al, 1999, p. 6)

AGEING IN PLACE: SELF-FULFILMENT

The UN principle is 'Self-fulfillment, including access to the educational, cultural, spiritual and recreational resources of society'

To age in place there also has to be an acknowledgment that there is access to these resources. It is here that the churches can give a lead both in provision and in trying to change policies of the providers.

AGEING IN PLACE: DIGNITY

The UN principle is 'Dignity, including being treated fairly regardless of age, gender, racial or ethnic background, disabilities or other status'

One of the lessons for those of us who study Gerontology is not to generalise about older people. I hope that none of us will talk about 'the elderly' as a homogeneous group. I will just give a few examples of these categories as they relate to ageing in place

AGE

Just as no-one in their right mind would talk about a group of people with a 30 year age span, for example those aged 20-50, as one group so it is equally dangerous to group all older people together. A group which spans 60 to over 90 is likely to be very different. But breaking groups down into chronological ages is dangerous anyway. Although it is true that increasing age brings on average a greater level of physical and mental disabilities it is not the case for everyone. Research shows that some people aged 90 and over have very little in the way of disabilities or problems.

The current tendency is to talk about the 'very old' but even here there is no agreement about what this is. A current research project I am undertaking has arbitrarily taken 85 and over but there is a great deal of interest in the over 90s. The real research interest in the world is in centenarians. Providers talk about housing for the 'frail elderly' but often without defining what is meant.

GENDER

Gender differences in old age are pronounced. Women are more likely to live alone, to have both physical and mental problems, to live in worse housing and to have lower incomes than men in most countries. The reasons for some of these problems stems from their previous lives when, for example, they were more likely to be in occupations which were less well paid than men and to have been in part time employment because of child care. This almost inevitably leads to poverty in old age. To take one of these factors - living alone - this has profound implications for providers of housing. It means in effect that what we are talking about is not older people but older women. Their perspectives, for example their need for security, may be different from men. But, on the other hand, women have on average richer social lives than men. This means that their social support networks are likely to be stronger.

RACIAL OR ETHNIC BACKGROUND

The moving account of the problems and needs of people from an aboriginal background presented in last year's oration are another indication that we must not generalise about older people (O'Donoghue, 1998). In the UK there is a distinction between older people who have been born in the UK and those who have been born elsewhere. For those who were born elsewhere the issue is whether they will want to return to their country of birth in old age.

Research shows that, while many may express this wish, when it comes to it few choose to do so. This is understandable given that their families are likely to be in the UK. The main issue for debate is whether services should be separate or integrated. For example should there be sheltered housing schemes specifically for say people of Pakistani origin or should they be offered accommodation in what will probably be a predominantly a white scheme. Research suggest that while both may be acceptable and wanted the need is for more general schemes which are culturally sensitive to the needs of all the people.

DISABILITIES

A distinction is made here between people who have been disabled from birth and those who have become disabled with age. The problems and solutions may be different. For example those who have been blind from birth may find that they have adapted to different circumstances whereas those who have only just lost, or are losing, their eyesight present different problems.

One problem is that of people with dementia. This term covers a number of different conditions but the prevalence increases dramatically with age. Whereas 5% of people age 65 and over suffer from dementia, 20% of those aged 85 and over do. One of the main problems faced by housing providers is that of people with dementia remaining in their own homes. Where it is possible to find out from them, and we are increasingly finding that this is possible (see for example Malcolm Goldmith's book (1996) *Hearing the Voice of People with Dementia*), and from their families they do wish to remain and age in place. The majority in the UK are in their own homes. The problem is how they can do so safely. Smart houses and passive alarms can aid this but pose ethical problems. The real issue is when they pose safety problems for others e.g. when they wander. For those who have to move, but where it is still possible to keep a home, very sheltered housing

is a good solution. Research shows that this can be very successful especially where there is some degree of separation from other old people. People in a scheme are likely to tolerate their own members becoming demented but may not take kindly to new residents coming into their schemes.

OTHERS eg. HOMELESS PEOPLE

The majority of homeless people in the UK are families. Although forming only a minor proportion older people are a vulnerable group. Recent research shows that they have been largely ignored by service providers and policy makers (Crane, 1999). Many had been homeless since they were teenagers or since early adulthood but some had come to it late after relationship breakdown or problems with housing.

Where the UK differs from Australia in considering special groups is the attention you give to Veterans. They form a high proportion of the reports that I was given to read before coming to Australia. The attention given to this group is not surprising but we have no equivalent in the UK. Ex service men and women have some special organisations but there is little special provision for them.

The examples given above are not just to do with dignity and the respect which ought to be given to older people but are also about age discrimination.

SOME CONCLUSIONS

Ageing in place is a world wide concept. It is now widely accepted by organisations like the UN, the OECD and the European Union. But practical ways in which the rhetoric can be translated into policies are sometimes lacking. A few innovations to back up what families are doing is not enough. In the first

oration it was stated that housing poverty remains a social problem of the highest significance (Howe, 1994). Fortunately housing is moving up the agenda in the UK and is being acknowledged as the key to successful ageing. The Royal Commission on Long-term care stated as one of their main conclusions: 'The Commission recommends that more care is given to people in their own homes. Therefore the role of housing will be increasingly important in the provision of long-term care' (Royal Commission, 1999, p. xix).

Another very important issue is costs. Our research for the Royal Commission found that there is no general rule about whether care in ordinary housing, adapted if necessary, costs more or less than care in very sheltered housing. Nor is there a general rule about either being less costly than full-time residential care. It depends on how many hours of care is provided. For most of the situations we looked at care at home was cheaper than either very sheltered housing or residential care but that was not the case for all the situations.

We cannot look at ageing in place without considering some other related issues. One relevant issue is who is to provide services. The fundamental question which was touched on in the response to the second oration and in the third is that of public and private responsibilities. In Western Europe the tendency has been more and more towards private provision with a stress on the individual. This is where I come back to the point I made earlier about a sense of mutual dependence. Individualism has, of course, its role but so has a sense of sharing. This is why the main recommendation of the Royal Commission has been so surprising. It has bucked the trend of individualism. The recommendation was that:

'The costs of long term care should be split between living costs, housing costs and personal care. Personal care should be available according

to need and paid for from general taxation: the rest should be subject to a co-payment according to means' (Royal Commission, 1999, p. xix).

Another conclusion is that there is need for more information about the options for ageing in place as well as the alternatives. The need for collaboration between agencies is another necessity. Just as the need for good housing must be recognised so must the need for good health care. There are many ways in which strategies can be developed to link housing with community care but I would not say that we have got the answers right. The most extreme is to have one agency only for housing and community care but this risks being a mammoth organisation. Another is to have an organisation/department for older people but this has been criticised as having the potential to marginalise older people into a special group. More fruitful are schemes which encourage people and organisations to work together. The greatest incentive is always money and there are various devices for this in the UK. But at the heart of all this must be personalities for if people do not get on and trust one another all the formal links will come to nothing.

As a researcher you would probably not expect me to leave research off the agenda. We need more research into schemes which enable people to remain at home and more specifically on outcomes for older people in different situations.

My conclusion then is that ageing in place is possible but we need the will and the knowledge to enable this to take place for more people if this is what they want.

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