

Older people in rural areas: Vulnerability due to poor health paper



Rural England research projects

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Rural England Community Interest Company, established in 2014, brings together organisations with a strong rural focus. One of its core aims is to support research that improves access to information about issues affecting rural England.

This paper forms part of wider suite of research exploring different aspects of vulnerability as affecting older rural residents. We hope the findings will be of interest to you.

Main findings

Although generally experiencing better health than residents of similar age in urban areas older rural people are particularly vulnerable to the following factors affecting their health:

- The oldest old are overrepresented in rural areas especially the South, South West and East Anglia placing disproportionate demands on Health and Social services in those areas:
- Demographic trends show an increasing number of older people, particularly in rural areas, but no increase in the number of potential next generation family carers.
- Health and Social Care funding does not adequately reflect the percentage of older people in a particular area or the additional costs associated with sparsity.
- There are lower levels of health service provision in rural areas
- Many residents of smaller rural settlements in particular experience considerable difficulties in accessing health services
- Declining public transport is worsening difficulties experienced by older rural residents in accessing health services
- There is significant hidden demand for health services
- The rural elderly are more likely to live in housing which is older, in poor condition and/or poorly designed in relation to their needs. This difficulty is compounded by the lack of options to move to more suitable accommodation within their home community
- Poor broadband speeds and reliability severely limit options for telecare provision in many rural areas

1. Introduction

This paper is an interim output from a project being undertaken by Rural England on rural vulnerability as affecting older people.

Health is a crucial factor affecting the quality of life, happiness and wellbeing of older people living in rural areas but the provision of accessible health care faces many challenges. These include; demographic change; structural change affecting the NHS and Social Care provision; financial constraints on service providers; reducing rural public transport options; expectations around care provision by family, friends and the 'Big Society'; and, quite possibly, changing expectations and behaviours of older people themselves.

This paper references evidence from a variety of existing reports and refers to relevant available data sets. This project defines 'older people' as those aged 65 and over, although evidence sources sometimes use different definitions. Where possible consideration is given to different age subgroups of older people such as those aged 85 plus but unfortunately many data sources do not permit this.

The definitions of 'rural' most commonly used in this report are:

1. The ONS-Defra rural-urban classification which identifies settlements with fewer than 10,000 residents as rural (and further sub-divides these into rural towns, villages, and hamlets/isolated dwellings).
2. The ONS Defra rural urban classification of Local Authority Areas with three categories of Rural 80, Rural 50 and Significant Rural.

2. Demographics and the demand for health services and social care

The English population is ageing. Between the census in 2001 and that in 2011 the number of older people (65+ years) in England increased from 15.8% to 16.3% of the population (7.83 to 8.66 million) and is projected to increase further to 23% by 2035 (ONS 2012).

Older people already form a disproportionate share of the overall rural population and this gap is expected to widen in the future.

Usual resident population of urban and rural areas by age, 2001 and 2011 England and Wales

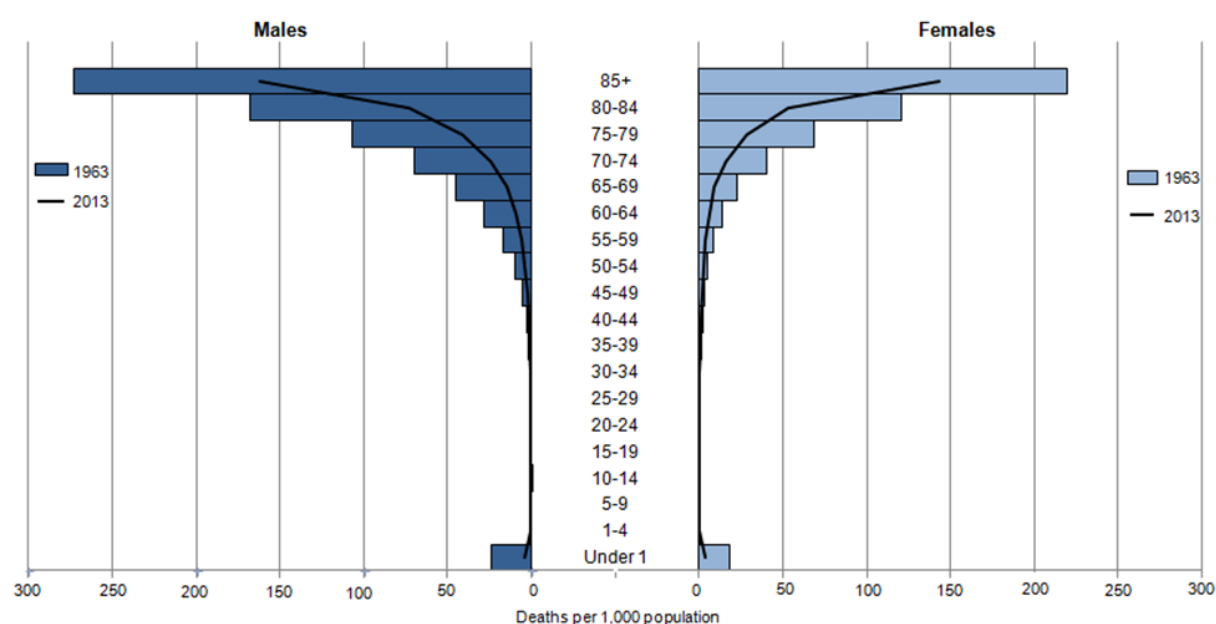
Age	2001 Percentage		2011 Percentage	
	Urban	Rural	Urban	Rural
0-14	19.1	17.9	18.0	16.2
15-29	19.8	14.7	21.1	14.8
30-44	22.9	21.3	21.2	17.7
45-59	18.1	22.4	18.8	22.3
60-74	12.7	15.4	13.6	19.6
75+	7.4	8.3	7.4	9.4

Source: 2001 and 2011 Census - Office for National Statistics

As demonstrated in more detail in the introductory section to this research there are significant geographical variations in the current distribution of older people in England. Areas with the highest proportions of older people include Cumbria, Devon, Dorset, Lincolnshire and Somerset, where more than 20% of the population is 65 years and older.

Population ageing in the UK is caused by a combination of rising longevity and medium fertility. Both these factors have implications for health and social care with increasing longevity increasing demand and medium fertility limiting the supply of family care. As the solid line on the graph below illustrates the number of deaths per 1000 people within each of the over 60 age groups has dropped markedly in the 50 years between 1963 and 2013.

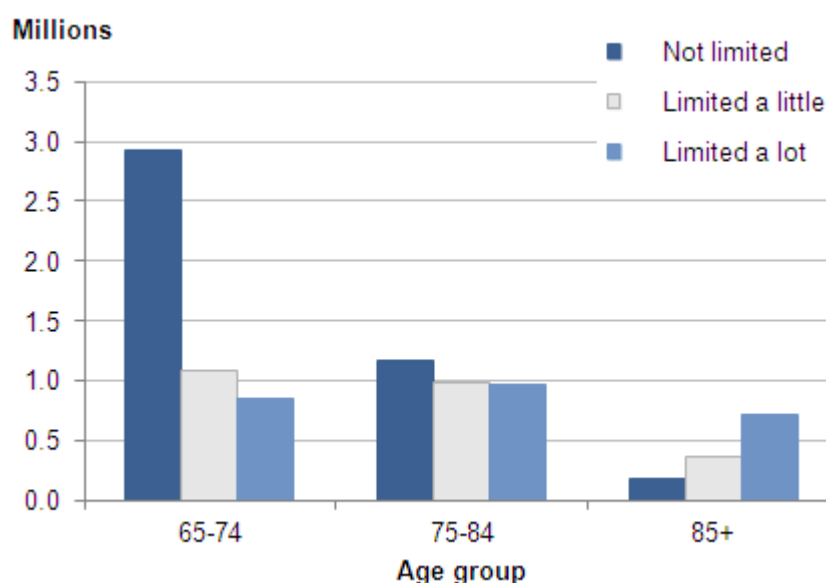
Age-Specific Mortality Rates, 1963 and 2013. England and Wales



Source: Hoff, A (using ONS data)

Rising longevity will have significant implications for future health service and social care provision as the prevalence of long-term health problems and disability increase with age. This is illustrated in table 3 below which for most people in the 65-7 age group their ability to carry out activities of daily living is not limited by long term health problems or disability. For those age 75-84 there are still slightly more people in the not limited category than either the 'limited a little' or 'Limited a lot'. However for those aged 85+ 'Limited a lot' is the most common category.

Table 1 Impact of long-term health problems or disability on the ability to carry out daily activities, by older age groups, 2011, England & Wales. Source: Census - Office for National Statistics



The 'oldest old', over 85 years, are of particular significance as health problems and the likelihood of disability increase with age and this age group is notably over-represented in South West England, Southern England and East Anglia. This is also the fastest growing age group in England numbering 1.22m (2.28% of the total population) in 2012 and projected to rise to 1.88m (3.22%) in 2025 and 2.9m (4.78%) in 2035. (ONS 2012). Much of this increase is a result of a projected rise in male life expectancy

It cannot be assumed that health and social care needs amongst older rural people are or will be evident. Rural Ageing research carried out by TNS BMRB in conjunction with the International Longevity Centre (ILC) for Defra in 2013 identified evidence of significant unmet needs from health services but found that these were often hidden. Service users themselves tend not to identify unmet need, and are also reluctant to discuss challenges around getting the health care that they require. Also, many older rural residents do not seek out preventative health care or even acute treatment, and in some cases avoid seeking care even in moments of emergency and health crisis. Amongst the reasons given for this were a 'make do' attitude, reluctance to make a fuss and the explicit and implicit fear of emerging age-related health issues.

The same research identified a tendency for older people to present to health services in moments of crisis resulting in significant challenges to health service providers and often necessitating "more intensive, immediate, invasive and complex responses". This may be a result of the lack of access to social care and prevention services that reduce acute hospital admissions and highlights the need for service providers for older rural people to prompt/ facilitate older people to voice their unmet need, and/or to screen for need.

Looking to the future it is evident that the needs of an ageing population will place increasing demands on health and social care providers and that these pressures are likely to be felt most acutely in those rural areas with the highest proportions of older people.

Whilst it is beyond the scope of this research to look in detail at future health and social care needs the following projections for the period 2005-2041 (PSSRU 2008) and by Gov.uk (2010) provide some indication of the potential scale of increasing demand:

- The numbers of disabled older people, unable to perform at least one instrumental activity of daily living (IADL) or having problems with at least one activity of daily living (ADL), would grow by 108% , from around 2.4 million to around 4.95 million.
- The number of older people with moderate or severe disability, needing help with one or more ADL tasks, would increase by 122% from around 950,000 to around 2.1 million.
- The numbers of disabled older people in households receiving informal care would increase by 102%, from approximately 1.75 million to over 3.5 million.
- Care by children will still need to increase by approximately 90% if the proportion of disabled older people receiving care from their children is to remain the same as today.
- The numbers of users of non-residential formal services would need to rise by 102%, from 1.5 million to 3.1 million, to keep pace with demographic pressures

- The numbers of older people in care homes (and long-stay hospital care) would need to rise by 139%, from 345,000 to 825,000.

“Growing numbers of elderly people also have an impact on the NHS, where average spending for retired households is nearly double that for non-retired households: in 2007/08 the average value of NHS services for retired households was £5,200 compared with £2,800 for non-retired. These averages conceal variation across older age groups, with the cost of service provision for the most elderly likely to be much greater than for younger retired people. The Department of Health estimates that the average cost of providing hospital and community health services for a person aged 85 years or more is around three times greater than for a person aged 65 to 74 years.” (Gov.uk 2010)

3. Accessibility of health services

A number of factors may lead older people living in rural areas being comparatively vulnerable to inequalities in health care provision. These factors include:

- Funding criteria and how the budget is allocated between sectors and geographically
- Ageism in the provision of services.
- Difficulties in getting to services due to distance and poor transport provision.
- Constraints on development and use of telecare services

Allocation of health budget

Research by Professor Sheena Asthana concludes that the current approach to NHS funding fails to promote the goal of ‘equal opportunity of access to health care for equal needs’. She argues that while need for health care is shaped by the interaction of age and factors such as deprivation, those areas grappling with the highest burdens of chronic illness, disability and death are those with the oldest populations. However, the highest NHS allocations tend to be given to areas with the highest levels of deprivation rather than those with the oldest populations. This puts rural areas with high numbers of elderly people at comparative disadvantage.

Funding allocations to Clinical Commissioning Groups for 2015/16 vary widely with a distinct north-south variation. By region the North is receiving £1259 per head of population compared to £1099 in the South. Groups of CCGs in Merseyside receive £1451 per head; Cumbria, Northumberland and Tyne and Wear £1353; and Durham, Darlington and Tees £1314. Whilst the very lowest allocations are to Thames Valley and Hertfordshire and South Midlands, East Anglia (£1085); Leicestershire and Lincolnshire (£1089); Arden, Herefordshire and Worcestershire (£1090) and Bristol, North Somerset, Somerset and South Gloucester (£1090) receive the next lowest levels of funding.

NHS funding provision in rural areas allocations takes no account of sparsity (low population numbers per unit area). However, rural areas often lack economies of scale in service provision (such as the higher unit costs of running smaller hospitals in rural areas) and necessitate higher

levels of unproductive staff travel time (e.g. per home/ care home visit). This further disadvantages rural areas with older populations.

There is also a rural dimension to the proposed phasing out of the Minimum Practice Income Guarantee (MPIG), which distributed £110 million to small GP surgeries. According to the Department of Health around 100 GP practices are thought to rely heavily upon the MPIG. Many, though not all, are in rural locations.

Many small rural GP practices are also facing recruitment difficulties. Commenting on a RCGP survey indicating that 10.2% of full-time GP positions are vacant, Dr Chaand Nagpaul, BMA GP committee chair, has been quoted as saying (Good Health Suite 2015): “Feedback from our members suggest that rural areas are being hit hard by this crisis as these practices often have to deliver care in challenging circumstances, sometimes with isolated, older populations away from hospitals that are broken up by large distances....” “We are concerned that some GP practices in rural communities are in these circumstances struggling to remain financially viable or recruit new GPs as their budgets don’t reflect the unique strain they are under.”

Public health budgets, transferred to local authorities in 2013/14, also, in general, provide substantially more funding for urban than for rural areas. For example, the 2014/15 grants per head of population to Surrey £22; East Riding of Yorkshire £27; Somerset £29; Cumbria £31; Devon £31 are markedly below the England average of £51 and dramatically below the £133 allocated to Kensington and Chelsea! It should be noted that the Government intends a £200m in-year reduction to the 2015/16 public health budget but the distribution of these cuts between Local Authorities is not yet known.

Ageism in the provision of services

Despite the NHS being required by the Equality Act 2010 to promote age equality and eliminate age discrimination in the provision of services a number of researches have expressed concerns about ageism in the NHS. However, there is not known to be a specifically rural dimension. The following examples are illustrative.

Research carried out for RCS and Age UK (2014) analyzing surgery rates for six common procedures showed widespread variation in the rates of surgery for people aged over 65 and 75, depending on where they live. That study found that a number of CCGs have very few people in the over 75 age group who had received surgery for breast excision, gall stones, hernia repair, colorectal incision and/or knee replacements. People living with breast cancer who were aged over 65 faced the biggest variation in access to surgery depending on where they live - with a 37-fold difference in the rate of breast excision (removal of breast tissue). It further warned that almost a fifth of CCGs recorded a decline of more than 25 per cent in at least three procedures between patients aged over 65 and over 75.

The King’s Fund (2013) has found that “some services and system rules are skewed in favour of the young, with far worse access and quality for older people in services like mental health and psychological therapies. And some conditions largely affecting older people (eg, dementia,

osteoarthritis, osteoporosis or incontinence) receive systematically worse attention and treatment than those equally common in mid-life. “

Difficulties in getting to services

Proportionately, there are lower levels of medical facilities for older people in rural areas compared with urban areas, including GP surgeries, pharmacies, and hospitals. In 2010 there were 1,987 GP surgeries located in rural areas of England (almost 20% of the total). However, only 1,247 of these were principal sites for those surgeries. They were numerically split quite evenly between rural town locations and village/hamlet locations. Also in 2010 there were 213 hospitals located in rural areas (which was 11% of the total). As might be expected, these were mainly in rural town locations. (CRC 2011).

Differences between rural and urban residents’ distances from specific health services are illustrated in the table below.

Percentage of population within specified distance of service

Service	Year	Distance	Total		
			Rural	Urban	England
GP surgeries (All sites) (4km)	2000	<= 4K	68%	100%	94%
		>4K	32%	0%	6%
	2006	<= 4K	75%	100%	95%
		<= 4K	25%	0%	5%
	2010	<= 4K	80%	100%	96%
		>4K	20%	0%	4%
	2011	<= 4K	80%	100%	96%
		>4K	20%	0%	4%

Hospitals (8km)	2010	<= 8K	55%	97%	89%
		>8K	45%	3%	11%
	2011	<= 8K	55%	97%	89%
		>8K	45%	3%	11%
NHS Dentists (4km)	2006	<= 4K	61%	100%	60%
		>4K	39%	0%	40%
	2010	<= 4K	57%	100%	56%
		>4K	43%	0%	44%
	2011	<= 4K	57%	100%	56%
		>4K	43%	0%	44%
	2012	<= 4K	51%	99%	50%
		>4K	49%	1%	50%

Pharmacies (4km)	2010	<= 4K	67%	100%	93%
		>4K	33%	0%	7%
	2011	<= 4K	66%	100%	93%
		>4K	34%	0%	7%
	2012	<= 4K	63%	100%	92%
		>4K	37%	0%	8%

Source: Rural Services Series 2013, Defra

As is to be expected the proportion of rural residents living within the closer specified distances of the four services is considerably less than that of urban residents. Whilst the proportion of rural residents living near GP surgeries appears to be increasing this seems suspect perhaps suggesting some inconsistency in the datasets used.

There has been a slight reduction in accessibility to pharmacies and the reduction in the proportion of rural residents within 4Km of an NHS dentist is particularly notable.

It should also not be assumed that the services provided in urban and rural locations are equivalent, e.g. not all hospitals will run 24 hour A&E, so these simple proximity figures are likely to hide even more pronounced rural-urban differences in accessibility to specific/specialist services. Whilst it is recognised that achieving economies of scale will inevitably mean that access and the achievement of certain NHS targets will tend to be poorer in rural areas it is important that services are rural proofed and those difference between urban and rural monitored and rationally justified.

Distance is only one factor affecting accessibility. Transport availability, convenience and cost are key barriers to accessing health services for older people in rural areas. The reduction in rural bus services will have caused difficulties to many patients trying to access health care perhaps particularly to those having to travel when ill or seeking urgent medical/dental attention. It also affects visitors and indeed service providers “we end up doing an awful lot of home visits just because patients can’t get here on public transport, people who are physically capable of getting here but can’t” (Herefordshire Unitary Authority, Health quoted in Defra 2013)

The extent to which the lack of public transport, and/ or cost of alternatives, prevents older rural residents from making desirable health appointments is unknown. However, of 214 Parish Councillors who responded to a sounding board survey, (RSN 2015) only 32% thought that a GP surgery was conveniently accessible by bus from the largest settlement in their Parish suggesting that transport to health is a widespread problem.

Problems of accessibility are also compounded for older rural residents with multiple long-term conditions and frailty when the location health care is fragmented by clinical specialism and only available in the regional specialist centres.

Constraints on development and use of telecare services

Telecare could potentially have considerable benefits for older rural residents but those benefits are dependent on the technology and infrastructure being both accessible and affordable.

Broadband speeds are frequently poor in rural areas. Using 2013 data, Farrington et al (2015) found that only 6% of the urban sample lived in a unit postcode area where the average broadband sync speed was 6.3Mbit/s or less, compared to over 40% of rural respondents. Commenting on that study's findings (Jackson 2015) observes "that more than 1 million people in Britain are *excluded or face challenges in engaging in normal online activities because they live in remote rural areas* where slow or non-existent Internet connectivity is still a serious problem.

ONS data (2015) also shows that whilst only 14% of all households have no internet access this rises to 50% in those households comprising a single adult aged over 65. A number of factors may hinder older people's use of the internet including cost/ accessibility, fear and uncertainty, low broadband speeds and poor reliability. Rural pensioners are also likely to find it more difficult to access alternative free or low cost internet provision such as the short sessions often available in Council Offices and libraries.

4. Accessibility of social care

"Despite rising demand for social care services, the funding, and subsequent number of people in receipt of this care, is declining. Without substantial growth in the overall funding envelope the Government's aspirations to 'transform the social care system to focus on prevention and the needs and goals of people requiring care' cannot be achieved. Indeed the use of funding is going in the opposite direction." Age UK (2014)

Research by Age UK (2014) found that, in England, the number of people aged 85 and over (the group most likely to need care) increased by 30% between 2005 and 2014. This age group is projected to rise by over 220%, from almost 1 million in 2005 to around 3.2 million in 2041. Much of this increase is a result of a projected rise in male life expectancy. (PSSRU 2008).

Data (hscic 2014) shows that in 2013-14 gross expenditure by Councils with Adult Social Services Responsibilities (CASSRs) on all adult social care was £17.2bn. Of that 51% (£8.8bn) was on older people aged 65 and over. Far from rising to meet increased demand the same source reports gross current expenditure in real terms on older people reducing from £10,080m in 2008/9 to £8,850m in 2013/14 or from 56% of the whole social services budget to 51%.

From 2010/11 to 2013/14 government funding to councils reduced by 19.6% and, despite increasing the proportion of budget spent on average by councils on adult social care to over 40 per cent in 2013/14, the actual amount spent decreased on average by 20 per cent (£2.8 billion) between 2011/12 and 2013/14 (Age UK 2014).

Age UK (2014) have found that this reduced funding has resulted in an increased focus on substantial and critical needs risks leaving no public funding available for most of those with moderate needs.

Only 13 per cent of councils considered people with ‘moderate’ needs eligible for funding in 2013/14, compared with nearly half of councils in 2005/6. Overall the proportion of older people aged 65 and over in receipt of local authority supported social care services decreased sharply from 15.3% in 2005/6 to 9.9% in 2012/13.

The level of unmet need is difficult to gauge, both because some is hidden and also due to the different methodologies that may be utilised. However by way of illustration ONS (2011) using ELSA 2008 data provided the following statistics:

Those experiencing a care need for both dressing and bathing aspects of daily living

% within total population aged 65+	9
Of those:	
Receiving informal support	50.5%
Formal state support	19.8%
Formal paid support	3.3%
TOTAL RECEIVING ANY SUPPORT	68.4%
NOT RECEIVING ANY SUPPORT	31.6%

Those ‘not receiving any support’ have an unmet need. Thus in the illustration above 31.6% of those aged over 65 and experiencing a care need for both dressing and bathing aspects of daily living had an unmet need.

A recently published interim report from ResPublica (Crawford and Read 2015) highlights a crisis in the residential care sector which accommodates 425,000 people and one in six people aged over 85. In summary it argues that demand is rising (by an estimated 15% in the next 5 years) but that local authority fees are failing to meet care providers operational costs with an average shortfall per publicly resident of £31-50 per week. It asserts that “within five years, care homes will be underfunded by 1.1 billion per year for the level of need that is being demanded by a growing aged population” and that if nothing is done to address that funding gap “there will be a projected loss of 37,000 care beds”. The research estimates that if all those 37,000 lost care home beds flow through to hospital wards the cost to the NHS would be some £3billion per year. Since staff costs equate to an average of some 62% of revenue in England’s care homes (Knight Frank 2015), the introduction of the living wage in April 2016 (increasing the minimum wage for those over 25 by 7.5%) is likely to further worsen the funding gap.

5. Social care provided by family

There are some 5.8 million informal carers in England and Wales (Office for National Statistics, 2013) “Most care for older people is not provided by the state or private agencies but by family members, at an estimated value of £55 billion annually” (McNeil and Hunter 2014). The importance of informal

carers is illustrated by The Alzheimer's Society (2014) which puts the annual care costs of dementia in the UK amount at £26.3 billion – of which £17.4bn is met by those with dementia and their families and just £8.8bn by the state.

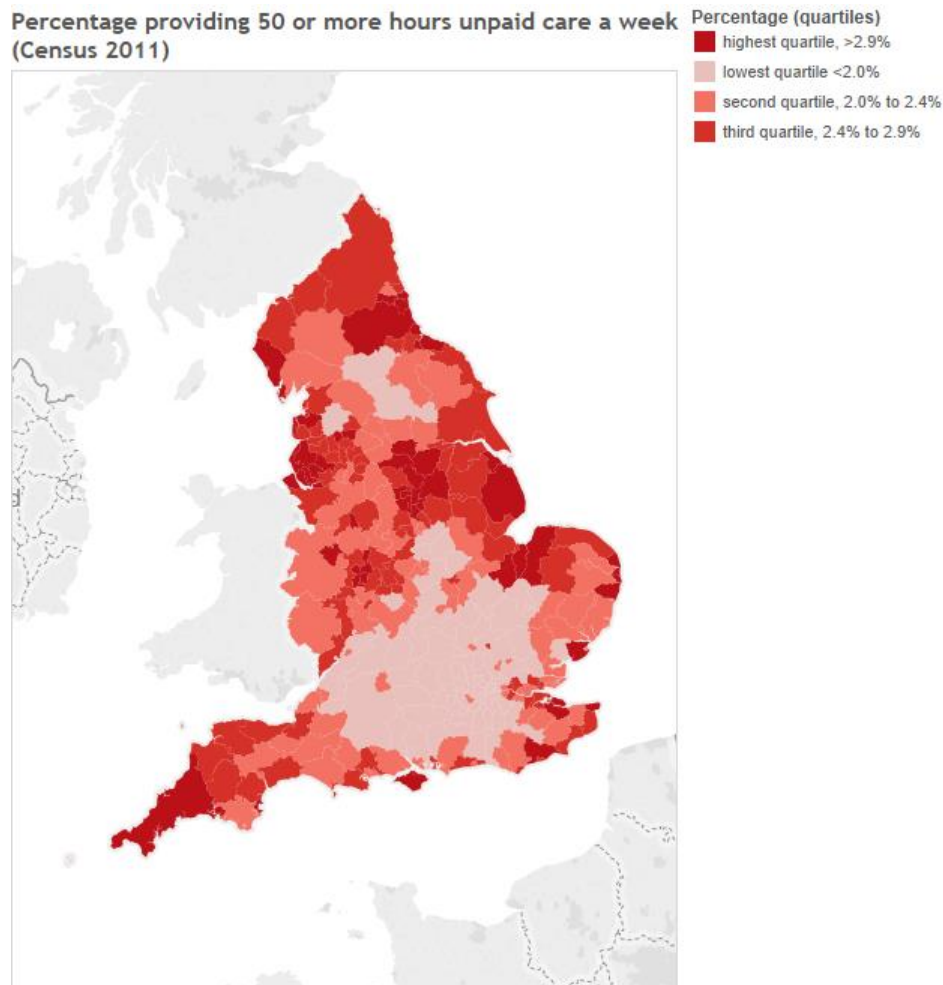
The proportion of usual residents providing unpaid care of all kinds increased between 2001 and 2011 and there was little difference between urban and rural areas in the percentages providing more than 20 hours of care a week (ONS). Residents in sparse areas were however identified as being more likely than residents of non-sparse areas to be providing 20 or more hours care. By contrast, there was a difference between urban and rural areas in the proportion of residents providing 1 to 19 hours of care. In urban areas this figure decreased from 6.6 per cent to 6.2 per cent. This compares with a figure of 7.9 per cent in rural areas in 2011.

Percentage of usual residents providing unpaid care (of all kinds) in urban and rural areas England and Wales, 2001 and 2011

Classification Census		Provides no unpaid care	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
Urban	2001	90.2	6.6	1.1	2.1
	2011	90.0	6.2	1.4	2.4
Rural	2001	89.2	7.8	1.0	2.0
	2011	88.3	7.9	1.3	2.4

Source ONS 2001 and 2011 Census

“Older rural residents are much more likely than their urban counterparts to provide some form of care to one another, 24% in rural areas compared to 18% in urban locations” (Source: Life Opportunities Survey quoted in Defra 2013)



The geographical distribution shown above shows a marked similarity to the distribution of people aged 85+.

Growing need will arise due to the increasing numbers of older people, particularly those aged 85 and over, and increasing constraints on Council social care budgets. However, whilst researchers may assert that “caregiving by adult children will have to rise in order to cope with the increasing demand for informal care” (Hoff, A p18) it is far from clear that this is a realistic expectation

The family care gap is growing as the number of older people in need of care is predicted to outstrip the number of family members able to provide it. “In England alone, although the number of children providing care to their parents for more than 20 hours a week is projected to increase by 20 per cent to 485,000 by 2032, there is likely to be a shortfall of 160,000 caregivers, because demand will increase by 60 per cent over the same period.” (McNeil and Hunter 2014). That unmet demand is likely to be disproportionately located in rural areas with the highest proportion of older people.

When care is provided to older people by adult children it is predominantly supplied by daughters (Hoff). However, in only a single generation there have been huge shifts in female employment, marriage/divorce and family formation. In April-June 2013 67% of UK women aged 16-64 were in the labour market compared to 53% in 1971 (ONS 2013c). Many factors such as the rise in tertiary education, equal pay legislation and the costs of house purchase suggest that there is unlikely to be a reversal in this trend.

The average family size for women born in 1965 was 1.91. In their mothers generation born in 1936 the average was 2.39 (Whiting). The proportion of childless people in the UK has also increased from 11% for those born in 1941 to 18% for those born in 1968 (Office for National Statistics, 2014). These demographic factors mean that there is both a reduction in the potential number of adult children-to-parent carers and also an increased proportion of older people who have no adult children who might be asked for help.

Increased geographical mobility and separation between family generations is likely to further reduce the availability of care provision. These impacts may be particularly acute in rural areas where limited housing and employment opportunities often encourage re-location of young adults and also in those rural and coastal areas experiencing significant in-migration of older people. Cultural factors also affect the provision of care within the family for example less than 15% of older people aged 55 years and over live with adult children in the UK whereas nearly half (48%) do in Ireland, parts of Spain, Italy, Hungary or Poland (Dykstra and Komter, 2012 quoted in Hoff).

There are also issues around unreasonable burdens potentially being placed on unpaid carers. Hoff comments that informal carers are 2.5 times more likely to experience psychological distress than non-carers, and working carers are two to three times more likely to suffer poor health than those without caregiving responsibilities. The Alzheimer's Society (2014) states that 43% of dementia carers receive insufficient support. Even giving 10 hours care a week is said to affect people's ability to stay in work (McNeil and Hunter 2014). These concerns raise uncomfortable questions about whether a reasonable balance is achievable between individual and state responsibilities.

Spouses are the most important support source for married older people in need of care and are also the fastest growing group of informal care providers (Hoff). For at least partly demographic reasons, especially more men living longer, it is expected that spousal care will become increasingly more important. The proportion of women aged 75 and over who are widowed is projected to fall from 60 per cent in 2008 to 39 per cent in 2033 and during the same period the proportion of men aged 75 and over who are widowed is expected to fall from 25 per cent to 18 per cent (ONS 2010). Over the next 30 years, the number of cohabiting older people with support needs is projected to rise faster than the equivalent number of single people (Pickard 2012).

It is important to consider the support needs of carers, as required in the Care Act. Older carers may well have their own care needs and disabilities and these factors may limit their caring role. There is concern too that caring may negatively affect their own wellbeing (Pickard et al 2012). The Princess Royal Trust for Carers (2011) found that two-thirds of carers over the age of 60 have long-term health problems or a disability themselves, and surveys of older carers suggest that they often feel 'invisible and undervalued' (Age UK 2010).

6. Housing factors

By far the largest majority (93%) of older people live in mainstream housing. Of those some three-quarters of these are owner-occupiers, the majority owning their homes outright, and about a quarter live in rented accommodation. Across the regions older people occupy around 35% of all houses, with little variation between different areas of the country. The exception to this is London and the South West, which have 22% and 40% of houses occupied by older people, respectively. (Torrington 2014)

Nationally few older households live in specialist accommodation designed for their needs and only 5.6% are in supported housing (2008–10 data) but it has been estimated that there 300,000 people will be seeking housing with support by 2019 (Torrington 2014). Older people also occupy most of the 465,000 places in residential care homes. The proportion of the population aged 65 and over who were living in communal establishments declined from 4.5 per cent (374,000) in 2001 to 3.7 per cent (337,000) in 2011.

There are significant variations in housing patterns associated with age and marital status. In 2011, about one in ten men and one in five women aged 85 and over lived in a communal establishment, with the remainder living in a private household. Tenure is strongly associated with marital status - only 13.0% of those who are married or cohabiting rent their home but 43.4% of those who are separated and 29.5% of those who are widowed do so (ONS).

Research also suggests that the housing stock is mismatched with the needs of older households. Many live in properties that are too large for their needs or wishes or in properties that are not well designed for their current or future needs (for example, only 5% of homes have key features required for access (Torrington)). This has implications for a number of health related issues as living in a safely designed environment with access to peers is likely to result in, for example, fewer falls and reduced isolation

Proportion of housing built pre 1919 and post 1990 and failing decent home criteria

	Pre 1919	Post 1990	Failing decent Home criteria 2006
Hamlets and Isolated dwellings	52%	6.7%	14.6%
Village	29.7%	8.9%	9.8%
Town and fringe	16.9%	9.0%	7.0%
Urban > 10,000	17.9%	6.9%	7.5%

Source CRC 2011

In rural areas the housing stock is generally older and a higher proportion in poor condition which can adversely affect older residents health and well-being. Older people living in smaller rural settlements are therefore particularly vulnerable to living in housing that is in poor condition or, by reason of design, ill-suited to supporting them if /when care needs develop. This problem is compounded by the lack of options to relocate into more suitable accommodation within the same community where support may be available from family and friends and to which they may well feel a strong emotional attachment.

Demand for housing adaptations are expected to rise significantly. Care and Repair (Adams) report that the number of older disabled people is expected to rise from 2.3m in 2002 to 4.6m in 2041, over 70% of whom will be owner occupiers, many on low incomes. They estimate that by 2036 around 810,000 people aged 75 and over will be living in unsuitable homes. They make the case that adaptations are cost-effective in terms of reducing falls (1 in 3 aged over 65 and 1 in 2 aged over 80 fall

at home each year; falls account for half of hospital admissions for accidental injury and 10-25% of all ambulance call-outs for older people). However Care and Repair highlight uncertainties concerning future funding through the Better Care Fund (Department of Health) rather than direct to Local Housing Authorities (DCLG).

References

Adams, S (undated) Home adaptations- time for innovation in delivery. Care and Repair England http://www.naidex.co.uk/files/home_adaptations_time_for_innovation_in_delivery_sue_adams.pdf

Age UK (2010) Invisible but Invaluable, London. <http://www.ageuk.org.uk/Documents/ENGB/Campaigns/ID9494%20Invisible%20But%20Invaluable%20Report.pdf?dtrk=true>

Age UK (2014) Care in Crisis. http://www.ageuk.org.uk/Documents/EN-GB/Campaigns/CIC/Care_in_Crisis_report_2014.pdf?epslanguage=en-GB?dtrk%3Dtrue

Age UK (2014b) Later life in Rural England. http://www.ageuk.org.uk/brandpartnerglobal/bedfordshirevpp/late_r_life_in_rural_england_report_lr.pdf

Alzheimer's Society (2014) Dementia 2014 Infographic http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=2761

Asthana S (2013) NHS Resource Allocation: are we betraying the principle of universality? Paper submitted to NHS England.

Asthana, S and Gibson,A (2013b), Francis and funding: an explanation for 'failing' hospitals, Health Service Journal (2013 (2)). <http://www.hsj.co.uk/comment/francis-and-funding-an-explanation-for-failing-hospitals/5055730.article>

Commission for Rural Communities (2011) State of the Countryside 2010. <http://webarchive.nationalarchives.gov.uk/20110303145243/http://ruralcommunities.gov.uk/state-of-the-countryside>

Crawford,E and Read,C (2015) The Care Collapse: The imminent crisis in residential care and its impact on the NHS. Interim Report –ResPublica. <http://www.respublica.org.uk/our-work/publications/the-care-collapse-the-imminent-crisis-in-residential-care-and-its-impact-on-the-nhs/>

Department of Health (online) (2013, updated 2014). Public Health Grants to Local Authorities from 2013-2016. Table of ring-fenced Public Health grants to Local Authorities.

<https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15>

Defra Rural Ageing Research Summary Report of Findings 2013.

https://www.google.co.uk/?gws_rd=ssl#q=Defra+Rural+Ageing+Research+Summary+Report+of+Findings+2013

Dykstra, P. A. and Komter, A. E. (2012) *Generational interdependencies in families*. Demographic Research 27, 487–506.

ELSA (2008) Health and social Engagement amongst the oldest old. www.elsa-project.ac.uk/uploads/elsa/report10/ch6.pdf

Farrington, J.; Philip, L.; Cottrill, C.; Abbott, P.; Blank, G.; Dutton, W (2015) Two-speed Britain: Rural Internet Use

http://www.dotrural.ac.uk/wp-content/uploads/2015/08/TwoSpeedBritain_18Aug2015Final.pdf

Good health suite (online) 7 September 2015 GP Vacancy levels mean seven-day working plans are unrealistic, says RCGP <http://www.thegoodhealthsuite.co.uk/GP/management-staffing/556-gpvacancy-levels-mean-seven-day-working-plans-are-unrealistic-says-rcgp>

Gov.uk online The ageing population: key issues for the 2010 Parliament
Wittenberg, R.; Pickard, L.; Malley, J.; King, D.; Comas-Herrera, A.; Darton, R.
Future Demand for Social Care, 2005 to 2041: Projections of Demand for Social Care for Older People in England . Personal Social Service Discussion Paper 2514, 2008.
<http://www.parliament.uk/business/publications/research/key-issues-for-the-new-parliament/value-for-money-in-public-services/the-ageing-population/>

Health and Social care information Centre (2014) Personal Social Services: Expenditure and Unit Costs, England - 2013-14, Final release . <http://www.hscic.gov.uk/catalogue/PUB16111/pss-exp-eng-13-14-fin-rpt.pdf>

Hoff, A (2015) Government Office for Science. Current and future challenges of family care in the UK. <http://dera.ioe.ac.uk/24148/1/gs-15-18-future-ageing-family-care-er09.pdf>

Jackson, M. (2015) Academic Study Reveals Urban and Rural Broadband Speed Gaps IPS News
<http://www.ispreview.co.uk/index.php/2015/09/academic-study-reveals-urban-and-ruralbroadband-speed-gaps.html>

Kings Fund (2013) We must end ageism and age discrimination in health and social care.
<http://www.kingsfund.org.uk/blog/2013/05/we-must-end-ageism-and-age-discrimination-health-and-social-care>

Knight Frank Research (2015) Care Homes Trading Performance Review
<http://content.knightfrank.com/research/548/documents/en/2015-3267.pdf>

McNeil,C. and Hunter,J (2014) The generation strain: Collective solutions to care in an ageing society. IPPR
<http://www.ippr.org/publications/the-generation-strain-collective-solutions-to-care-in-an-ageingsociety>

Nazroo, J.(2015) Government Office for Science.Future of ageing: volunteering, informal care and paid work in later life. <https://www.gov.uk/government/publications/future-of-ageing-volunteering-informal-care-and-paid-work-in-later-life>

NHS England (Dec 2013) CCG allocations 2014/15 and 2015/16.
<https://www.england.nhs.uk/2013/12/ccg-allocations/>

ONS (2001), Health Statistics Quarterly number 11. <http://web.ons.gov.uk/ons/rel/hsq/health-statistics-quarterly/no--11--autumn-2001/index.html?translation-component=&calling-id=77-6175-4&currLang=English&format=print>

ONS (2011) Measuring unmet need for social care amongst older people. Population Trends 145 Autumn 2011. www.ons.gov.uk/ons/rel/.../ard-pt145-unmet-social-care-need.pdf

ONS (2012) Population Ageing in the UK its Constituent Countries and the EU.
http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171776_258607.pdf

ONS (2013) 2011 census Analysis- Comparing Rural and Urban Areas of England and Wales.
<http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/rural-urban-analysis/comparing-rural-and-urban-areas-of-england-and-wales.html>

ONS (2013b) What does the 2011 Census tell us about the "oldest old" living in England & Wales?
<http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/rel/mortality-ageing/characteristics-of-older-people/what-does-the-2011-census-tell-us-about-the-oldest-old-living-in-england-and-wales-/characteristics-of-the--oldest-old--from-the-2011-census.html>

ONS (2013c) Women in the labour market.
<http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/womeninthelabourmarket/2013-09-25>

ONS (2014) *Childbearing for Women Born in Different Years, England and Wales, 2013*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_387280.pdf

ONS (2015) Internet Access – Households and Individuals 2015.

<http://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2015-08-06>

Pickard L, King D, Knapp M, and Perkins M (2012) Overcoming barriers: Unpaid care and employment in England, London: NIHR School for Social Care Research.

http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/Findings_10_carers-employment_web.pdf

Princess Royal Trust for Carers (2011) Always on Call Always Concerned. A Survey of the Experiences of Older Carers. https://www.carers.org/sites/default/files/always_on_call_always_concerned.pdf

PSSRU (2008) Future demand for social care, 2005 TO 2041: Projections of demand for social care for older people in England. Report to the Strategy Unit (Cabinet Office) and Department of Health <http://www.pssru.ac.uk/pdf/dp2514.pdf>

RCS and Age UK (2014) research by Mph health. Access all Ages 2. Exploring variations in access to surgery among older people. <https://www.rcseng.ac.uk/news/docs/access-all-ages-2>

Torrington, J. (2014) What developments in the built environment will support the adaptation and 'future proofing' of homes and local neighbourhoods so that people can age well in place over the

life course, stay safe and maintain independent lives? Foresight, Government Office for Science.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445583/g-s-15-11-future-ageing-homes-neighbourhoods-er21.pdf

Rural England Stakeholders:



Rural England Supporters:

