



Office of the
Deputy Prime Minister

Creating sustainable communities

The impact of government policy on social exclusion among older people

A review of the literature
for the Social Exclusion Unit
in the Breaking the Cycle series



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August 2004

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CONTENTS

Executive Summary		5
Chapter 1:	Introduction and conceptual framework	9
	Introduction	9
	Conceptual Framework	9
	Methodology of the Review	13
Chapter 2:	Review of policies	14
	2:1 Policies relating to income	15
	Introduction	15
	Minimum Income Guarantee	17
	Housing Benefit	22
	Council Tax Benefit	26
	Attendance Allowance and Disability Living Allowance	29
	Social Fund	35
	Addressing financial exclusion of older people: Direct Payment and Universal Banking Services	39
	Addressing fuel poverty among older people: Warm Front	45
	2:2 Policies relating to health and social care	53
	Introduction	53
	Community care policies and social exclusion	53
	Health Action Zones	65
	NHS Direct and Care Direct and Social Exclusion and Older People	71
	2:3 Older people and neighbourhood renewal	75
	Neighbourhood Renewal and New Deal for Communities	75
	Introduction	75
	Home Improvement Agencies	79
	2:4 Crime, social exclusion and older people	81
	Introduction	81
	Policies to reduce crime and fear of crime	82
	Trends in crime affecting older people	83
	Evaluating the success of policy initiatives	84
Chapter 3:	Conclusion	88
References		91

TABLES

Table 1:	Expenditure in long-term care for older people by source: 1996 figures and projections from the PSSRU long-term care financing model (billions of pounds)	55
Table 2:	Average number of contact hours per household per week, 1992 to 2002	57
Table 3:	Households receiving intensive home care	58

EXECUTIVE SUMMARY

Introduction

This report presents the findings of research that reviews the impact of Government policy on the social exclusion of older people. The research was commissioned by the Social Exclusion Unit in July 2003, and is mainly based on research and analytical evidence published until February 2004. This is one of four reviews commissioned to inform the Social Exclusion Unit's assessment of progress made in tackling social exclusion.

Developing policies to combat social exclusion has been an important element of Government policy since the election of the first Labour administration in 1997. Initiatives have been undertaken targeting poverty and exclusion affecting older people. These initiatives – set out in documents such as the Department for Work and Pensions' annual **Opportunity for All** reports – have been part of a wider debate about the meaning of social exclusion as a concept, and in particular the relevance of its application to groups such as elderly people. This review examines available research evidence on the effectiveness of policies aimed at limiting the impact of social exclusion in old age.

The project team set itself three main aims:

- first, to examine the success of policies designed to tackle social exclusion in old age;
- second, to consider whether the evidence suggests some policies have been more successful than others;
- third, to identify factors that may either assist the development or create obstacles to the implementation of effective policies.

To achieve these aims this report:

- examines the background to issues relating to social exclusion in old age;
- identifies the range of policies used to tackle exclusion;
- considers evidence about the impact of policies designed to integrate older people into social and community life.

Conceptualising social exclusion

The review takes a broad look at social exclusion and identifies four groups of conditions that might cause exclusion:

- **Age-related characteristics** refer to the way in which older people are disproportionately affected by certain kinds of losses or restrictions relating to income, health or reduced social ties. Such changes might take place across all points of the life course but they are likely to feature more prominently in later life given income changes associated with retirement, the impact of chronic disabling conditions, and increased needs among people adjusting to living alone.

- **Cumulative disadvantage** refers to the way that the same birth cohorts may become more unequal over time. For example, limited educational and work opportunities at early points in the life course may have long-term consequences in terms of reduced income in old age or limited awareness about how to access the full range of social and health services.
- **Community characteristics** highlight the way older people, who may have strong attachments to their locality, may also be vulnerable. Typically this concerns changes associated with population turnover, economic decline, and rising levels of crime and insecurity within neighbourhoods.
- **Age-based discrimination** refers to the impact of ageism within economic and social policies that contributes to various forms of social exclusion in old age. The debate around ageism has challenged the link with age as a form of dependency, emphasising instead various different forms of positive engagement that can be maintained throughout the latter half of the life course.

Review of policies

A wide range of policies could reasonably be viewed as trying to tackle social exclusion in one form or another. The selection of policies to be studied for the review was guided by two principles. These are adequacy of research data, and relevance to the social exclusion debate. As a result, the review addresses 19 policy areas grouped under four broad headings. These can in turn be linked to the drivers of social exclusion in later life outlined above.

These are:

Policies relating to income (age/cumulative disadvantage)

- Minimum Income Guarantee.
- Housing Benefit;
- Council Tax Benefit;
- Attendance Allowance and Disability Living Allowance (including Carer's Allowance);
- Social Fund (including Winter Fuel Payments and Cold Weather Payments);
- Direct Payment and Universal Banking Services;
- Warm Front.

Policies relating to health and social care (age/cumulative disadvantage/age-based discrimination)

- Community Care policies;
- Health Action Zones;
- NHS Direct;
- Care Direct.

Policies relating to urban and neighbourhood renewal (community characteristics)

- Neighbourhood Renewal Fund;
- New Deal for Communities;
- Community Empowerment Fund;
- Home Improvement Agencies.

Policies relating to crime (community characteristics)

- Reducing Burglary Initiative.
- Neighbourhood Wardens;
- Locks for Pensioners;
- Distraction Burglary Task Force.

Key findings

On the drivers of social exclusion in later life, the evidence suggests that in general, Government policy has been more successful in addressing exclusion based on **age-related characteristics** and **age-based discrimination**. By comparison, exclusion driven by **cumulative disadvantage** and **community characteristics** has proved more difficult to tackle.

- **Taking the age-related area, government policy can claim some successes.** Particularly noteworthy, for example, have been the reduction in the proportion of older people on absolute low incomes; the stabilisation/reduction in the proportion of pensioners experiencing relative poverty; the enhanced support for people with high levels of dependency; and the securing of innovations in the community care field. All these gains might be said to modify or reduce some of the pressures affecting people as they move into their 70s and beyond: for example, pressures that arise through the loss of income associated with retirement; problems stemming from chronic health conditions; and problems linked to the impact of changes associated with life course transitions.
- **In contrast, social exclusion arising from cumulative disadvantage appears more resistant to change.** The proportion of those on persistently low incomes has remained almost constant since the early 1990s. This suggests a hard core of older people who have probably encountered poverty at points throughout their life, and who go on to experience high levels of deprivation in old age. As an illustration, those who have traditionally been poor in old age appear to remain so: single older women, those from ethnic minorities, and those with disabilities. These are also the groups who fail in large numbers to claim means-tested benefits. Low expectations and a lack of awareness of services (a product of cohort rather than age-related differences) have partly been addressed in the community care reforms and through innovations such as NHS Direct and Care Direct. But even here it is noticeable that key groups continue to exclude themselves, and that the 'service-rich' probably do much better than the 'service poor' in utilising service innovations.
- **Problems arising from community change remain a significant driver leading to social exclusion in old age.** Some successes have been recorded with initiatives such as Neighbourhood Wardens, the Reducing Burglary Initiative, and individual projects under New Deal for Communities. However, there is no clear evidence that the needs of older people are being given systematic attention in urban regeneration schemes. Areas of high population

turnover and economic deprivation remain an important driver leading to exclusion in old age. This is reinforced where feelings of insecurity produce restrictions on daily living. While worries or fears about particular crimes may have receded, concern about the 'unsafe' nature of urban communities remains high and may limit older people's involvement in a range of activities.

- **Measures designed to tackle age-based discrimination have been extensive and are beginning to produce a cultural shift in perceptions of older people.** In some respects this is not an easy target to measure, and systematic evidence on the impact of policies has yet to be collected. Also, some of the most significant policies designed to challenge ageism – such as the National Service Framework – are still at an early assessment stage. But the range of activity is impressive, notably through the activities promoted by Better Government for Older People, a number of community-based activities in Health Action Zones, community care work, and the development of a range of policies around older people and pensions in the Department for Work and Pensions.

In summary, therefore, the review suggests that the impact of policies on social exclusion has been uneven. Policy has been stronger in tackling certain types of problems which cluster in old age, and in challenging myths and stereotypes about older people. It has been less successful in challenging inequalities which are carried through into old age and which reflect the experiences of particular birth cohorts and groups within these cohorts. In addition, policy has been less successful – at least based on current evidence – in limiting problems that arise from communities affected by economic decline and high rates of population turnover.

Suggestions for future policy development

Arising from these key findings, the review concludes by suggesting three types of policy development that might be important to consider:

- Monitoring the impact of new types of poverty and social exclusion which emerge in old age, against which existing policies may prove inadequate. Some groups, notably divorced and single women with inadequate pension provision, are likely to need policy intervention in order to prevent new forms of social exclusion emerging over the next few years.
- Community care policies need to be broadened to embrace more effectively the social exclusion agenda. While the extent of change in this policy area has been extensive over the past decade, there is a case for widening the scope of this work and extending the ambitions of care in the community.
- In all areas certain groups remain excluded still from key services and benefits. However, the differences between and within groups – such as minority ethnic groups, those with mental health problems, or people with disabilities – can be large. The next phase of the social exclusion debate needs therefore to acknowledge the complex differences between groups and the implications of this for new forms of social exclusion.

CHAPTER 1: Introduction and conceptual framework

Introduction

This report presents the findings of research that reviews the impact of Government policy on the social exclusion of older people. The research was commissioned by the Social Exclusion Unit in July 2003, and is mainly based on research and analytical evidence published until February 2004. This is one of four reviews commissioned to inform the Social Exclusion Unit's assessment of progress made in tackling social exclusion.

Developing policies to combat social exclusion has been an important element of Government policy since the election of the first Labour administration in 1997. A number of policy initiatives have been undertaken, targeting poverty and exclusion affecting older people. These initiatives – set out in documents such as the Department for Work and Pensions' annual **Opportunity for All** reports – have themselves been part of a wider debate about the meaning of social exclusion as a concept, and in particular the relevance of its application to groups such as elderly people. This review examines the available research evidence concerning the effectiveness of policies aimed at limiting the impact of social exclusion in old age.

The project team set itself three main aims:

- first, to examine the success of policies designed to tackle social exclusion in old age;
- second, to consider whether the evidence suggests some policies have been more successful than others;
- third, to identify factors which may either assist the development or create obstacles to the implementation of effective policies.

To achieve these aims this report:

- examines the background to issues relating to social exclusion in old age;
- identifies the range of policies used to tackle exclusion;
- considers evidence about the impact of policies designed to integrate older people into social and community life.

Conceptual Framework

What is social exclusion in old age?

In the 1950s and 1960s, researchers such as Townsend and Wedderburn (1965) showed older people to be one of the largest groups living in poverty, with widowed and single older people being identified as especially vulnerable. Townsend (1981) widened the debate with the idea of older people being affected by forms of 'structured dependency'. This was produced by

compulsory retirement, poverty and restricted social roles. It was developed through the 1990s with awareness of widening inequalities between pensioners dependent on welfare benefits and those with access to occupational pensions and savings.

Definitions of social exclusion typically draw together distributional dimensions of poverty (that is lack of material resources) and relational aspects (lack of social ties). This is reflected in the Government's definition of social exclusion representing 'a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, discrimination, poor housing, high crime, bad health and family breakdown'.

Measures of social exclusion thus attempt to identify groups lacking in resources, as well as people whose lives are affected by, for example, discrimination, chronic sickness, geographical location, or cultural identification. The approach taken in the study undertaken here tends to follow this definition: **lack of material resources is viewed as an important cause of non-participation, but the role of non-material factors will also be highlighted.**

Following the above, Burchardt et al. (1999) have sought to develop an operational definition of social exclusion, encompassing five distinct elements relating to an individual's participation in 'normal' activities. These are:

- consumption activity – the ability to consume up to a minimum level, the goods and services considered normal for society;
- savings activity – the accumulation of savings, pension entitlements or property ownership;
- production activity – engagement in an economically or socially valued activity;
- political activity – engagement in some collective effort to improve or protect the immediate or wider social and physical environment; and
- social activity – engagement in significant social interaction with family or friends and identifying with a cultural group or community.

Scharf et al. (2002) have emphasised the spatial dimension to social exclusion, drawing on Perri 6's (1997) view that: '[Social exclusion] is a useful term in societies in which there is a growing polarisation of access and opportunity, so that often small areas – a housing estate, an inner or outer urban area – are effectively cut off from life around them'. This idea is further developed by Madanipour et al. (1998) who refer to the multi-dimensionality of social exclusion and its impact on particular types of location. They suggest that:

'Social exclusion is defined as a multi-dimensional process, in which various forms of exclusion are combined: participation in decision making and political processes, access to employment and material resources, and integration into common cultural processes. When combined, they create acute forms of exclusion that find a spatial manifestation in particular neighbourhoods.' (p. 22)

Applying the concept of social exclusion to older people

There are at least three difficulties associated with debates linking social exclusion to the range of situations faced by older people. These are also reflected in attempts to operationalise the concept in research.

The first difficulty concerns the centrality of labour market participation as an indicator of social inclusion (Levitas, 1998). The focus of exclusion debates on work and employment leaves unclear the position of older people who have permanently withdrawn from their occupational roles. For example, in their production domain of exclusion, Burchardt et al. (1999) judge as 'included' and 'engaged in a socially valued activity' those who have reached state retirement age and are retired. This runs counter to research in social gerontology that highlights the exclusionary impact of retirement on many older people (Phillipson, 1998).

A second difficulty arises from an emphasis in exclusion debates on the dynamic nature of social exclusion (Byrne, 1999). Household panel studies show how people move in and out of poverty/exclusion as their circumstances change (Burchardt, 2000; Leisering and Walker, 1998). The evidence from such studies leads to the conclusion that, as Perri 6 (1997) asserts, '... most people get out of poverty'. This gives rise to the impression that exclusion boundaries are essentially fluid rather than rigid. But older people's situation is likely to be different. For those prone to exclusion, the experience may be more permanent than would be the case for other groups. Thus, while exclusion from political activity or social interaction might represent an episodic characteristic of younger people's lives, older people may face additional difficulties in seeking to escape the enduring impact of such situations. Equally, older people who lack adequate material resources are unlikely to be able to 'get out of poverty' without a lot of financial state support.

A third problem concerns the neighbourhood dimension of exclusion, and its impact on older people's sense of identity (Scharf et al, 2002). For many reasons, the local residential environment may represent a much more important aspect of exclusion for older people than for other age groups. On the one hand, older people tend to spend more time than younger people in their immediate neighbourhood. On the other, many older people have spent much of their lives in a particular neighbourhood, deriving a strong sense of emotional investment both in their home and surrounding community (Phillipson et al., 2000).

Against this background, and building on a review of different approaches to measuring social exclusion, Scharf and Smith (2004) suggest that older people may experience, in one or more of the following forms exclusion from:

- material resources;
- social relations;
- civic activities;
- basic services;
- neighbourhood exclusion.

From this examination of issues concerning the application of the concept, we move to a consideration of experiences of exclusion and the range of policies designed to tackle the problem.

Are some individuals/groups of older people more at risk of exclusion than others?

A common theme from research is that groups of older people will be affected by social exclusion in different ways. The following examples are illustrative but are examined in more detail in the literature review:

- Those affected by cumulative (life course) disadvantage and persistent poverty, for example, women without occupational pensions; some older people from ethnic minority groups; homeless older people.
- Those affected by contracting social networks, for example older people experiencing loneliness and intense social isolation; older people without informal carers; single person households.
- Those affected by area disadvantage, for example, older people residing in inner city communities subject to economic and social decline; older people living in remote rural communities characterised by a loss of services and amenities.
- Those marginalised through physical and mental ill-health, for example, the frail elderly with multiple chronic conditions.
- Those affected by the operation of ageist beliefs and practices, for example, older people seeking employment or access to particular services.
- Those cut off from new technologies, for example, older people without access to the internet.
- Those who experience difficulty in exercising their civic rights, for example, older people not registered to vote; older people who find contact with legal and advice services problematic.

What are the causes of social exclusion?

The next issue then becomes: what are the mechanisms/drivers that might result in older people not achieving one or more of the 'wants' or 'life chances' outlined in the previous section? In the case of older people we are suggesting that the conditions that might cause exclusion can be grouped under four headings: age-related characteristics; cumulative disadvantage; community characteristics, and age-based discrimination:

- **Age-related characteristics** refer to the way in which older people are disproportionately affected by certain kind of losses or restrictions relating to income, health or reduced social ties. Such changes might take place across all points of the life course but they are likely to feature more prominently in later life given retirement associated income changes, the impact of chronic disabling conditions, and increased needs among people adjusting to living alone.
- **Cumulative disadvantage** refers to the fact that birth cohorts may become more unequal over time. For example, limited educational and work opportunities at early points in the life course may in the long-term lead to reduced income in old age or limited awareness about how to access the full range of social and health services.
- **Community characteristics** highlight how older people, who may have strong attachments to their locality, may also be vulnerable to changes associated with population turnover, economic decline, and rising levels of crime and insecurity within neighbourhoods.
- **Age-based discrimination** refers to the impact of ageism within economic and social policies that contributes to various forms of social exclusion in old age. The debate around ageism has challenged the link with age as a form of dependency. It emphasises instead various different forms of positive engagement that can be maintained throughout the latter half of the life course.

Methodology of the Review

Given the broad conceptualisation of social exclusion that this review looks at, the research group was interested in generating a comprehensive list of policies and initiatives relating to each exclusion driver. To an initial list of policies and initiatives supplied by the Social Exclusion Unit, the group added further policies that reflected different dimensions of exclusion affecting older people. A final list of policies to review was subsequently agreed with the Social Exclusion Unit. This included both targeted schemes (for example, the Minimum Income Guarantee) and mainstream policies (Housing Benefit).

Various techniques were used to find evidence to include in the review. In particular, electronic search techniques were used to identify relevant materials. Concerning academic analyses, this entailed systematic use of a range of electronic databases, including EBSCO, ISI Web of Knowledge, BIDS [Ingenta], ScienceDirect, Cambridge Scientific Abstract Internet Database, PsycINFO, First Search and Swetswise. A key source on ageing is the Centre for Policy on Ageing's AgeInfo database. Electronic search engines, in particular Google, were used to find other sources of evidence, including that generated by central and local government departments and a range of voluntary organisations. The research team also compiled a list of relevant research centres and think tanks, and used this information to explore the organisations' websites. A separate search of relevant government department websites was also done.

The search strategy was limited to evidence relating to the period 1997 to 2003. It sought to identify a general literature on the theme of social exclusion among older people, in addition to a narrower literature addressing specific policies. Such a search strategy yielded many documents. The list included many sources that were later judged irrelevant to the review's needs. Ultimately, the research group generated an interim list of some 215 sources to be included. Each of these sources was then explicitly linked to a particular policy area or initiative relating to the review's theme. While preparing the review, more material was generated to inform the review. This encompassed a range of government documents and official statistics, as well as examples of local schemes that related to the policy area being examined. Such an approach was necessitated by the lack of data relating to some policies and initiatives.

The review is based largely on academic analyses of relevant policy areas. Where appropriate, priority has been given to highlighting findings reported by independent, academic commentators in peer-reviewed publications. A lot of evidence arises from official publications, commissioned by government departments but undertaken by independent researchers. Material based on the analysis of voluntary bodies and/or special interest groups, is included where there is an absence of more robust alternative sources or where the argument adds significantly to the academic and policy debate.

CHAPTER 2: Review of policies

A wide range of policies could reasonably be viewed as attempting to tackle social exclusion in one form or another. These range from income support measures, such as the Social Fund, Attendance Allowance and Housing Benefit, to support for Carers, free TV licences, and crime prevention work. Two principles guided the selection of policies to be studied for the review: first, adequacy of research data; and, second, relevance to the social exclusion debate.

On the first of these, the final selection of policies reflected a prior sifting of the available research data, with a focus on those policies that had received some form of evaluation. In some cases, important policies are the subject of ongoing evaluation, for example the National Service Framework for Older People, Intermediate Care. In others, full evaluation has yet to be commissioned, for example Better Government for Older People. In some cases there was insufficient data to draw safe conclusions about the impact of a policy on older people, at least in the social exclusion arena, for example Healthy Living Centres.

Second, our priority was to find a range of policies which could reasonably be linked to the social exclusion debate, and which had been tested with sufficient rigour to allow some conclusions to be drawn.

Having sifted through the research, using the methodology identified earlier, 19 policy areas were identified as fitting the above criteria:

Policies relating to income (age/cumulative disadvantage):

- Minimum Income Guarantee;
- Housing Benefit;
- Council Tax Benefit;
- Attendance Allowance and Disability Living Allowance (including Carer's Allowance);
- Social Fund (including Winter Fuel Payments and Cold Weather Payments);
- Direct Payment and Universal Banking Services;
- Warm Front.

Health and social care policies (age/cumulative disadvantage/age-based discrimination):

- Community Care policies;
- Health Action Zones;
- NHS Direct;
- Care Direct.

Urban and neighbourhood renewal policies (community characteristics)

- Neighbourhood Renewal Fund;
- New Deal for Communities;

- Community Empowerment Fund;
- Home Improvement Agencies.

Policies on crime (community characteristics):

- Reducing Burglary Initiative;
- Neighbourhood Wardens.
- Locks for Pensioners;
- Distraction Burglary Task Force.

Findings for each of these policies will now be reviewed with a provisional conclusion dealing with issues relating to the overall impact and inter-relationship between policies.

2:1 Policies relating to income

Introduction

This section reviews evidence on policies that seek to maintain older people's incomes. The focus is on identifying the impact on older people of the following policies (selected on the basis of their importance to those who are potentially vulnerable to poverty and social exclusion):

- Minimum Income Guarantee (Pension Credit);
- Housing Benefit;
- Council Tax Benefit;
- Attendance Allowance and Disability Living Allowance (including Carer's Allowance); and
- Social Fund (including Winter Fuel Payments and Cold Weather Payments).

The analysis undertaken in this section also includes two further policy areas that are directly related to income:

- Direct Payment and Universal Banking Services (addressed here in relation to debates about 'financial exclusion'); and
- Warm Front (which addresses the income-related theme of 'fuel poverty').

At the heart of attempts to address social exclusion through age-related changes is a concern with pensioner poverty. The British welfare state has long recognised the particular income maintenance needs of older people. The state provides a wide range of benefits that seek to cushion the loss of income associated with no longer having a job and the consumption of savings in retirement. According to the most recent data, some 10.5 million people over state pension age claimed at least one of the major state benefits in May 2003. This represented 100% of the pensioner population (Department for Work and Pensions, 2003a: 7). The state seeks to encourage people to save for their retirement throughout their working lives. It does so by requiring individuals to contribute to different types of pension scheme, and by supporting other types of savings activity.

Income maintenance programmes for older people recognise a key difference between the relative situations of older and younger people on low incomes. While many people of working age may experience poverty at some stage, the chances of escaping it are improved by having a job. For most older people, the opportunity to escape poverty is limited by lack of access to employment. As a result, a key means of avoiding poverty in old age is by preventive strategies, for example, by making saving compulsory for those of working age. Another way is by policies that seek to supplement pensioners' incomes (for those currently retired and on low incomes).

The 1980s were associated with a significant widening of income inequality in the UK (Hills, 1998). During the 1990s inequalities in income tended to fluctuate, and this pattern has continued through to the first years of the new century (Department for Work and Pensions, 2003n Lakin, 2003: 11). This general picture also applied to older people, where during the 1980s, income varied greatly between different groups of pensioners (Hancock and Weir, 1994; Falkingham, 1998).

Key differences have emerged between older people who have an occupational pension and those reliant solely on state benefits. While the average real incomes from occupational pensions rose by an estimated 152% between 1979 and 1996-97, benefit incomes increased by just 39% during this period (House of Commons, 2003a: 19). A significant factor in the growing divide between these groups was the diminishing value of the State Retirement Pension in relation to rising earnings. This gap followed the 1980 change in rules for the up-rating of the retirement pension.

A major impact of these growing income inequalities was the rising proportion of pensioners experiencing relative poverty through the 1980s and early 1990s. The scale of the increase is reflected in the analysis of pensioner incomes undertaken by the Institute for Fiscal Studies: 'Over the second half of the 1980s ... relative pensioner poverty – measured by the proportion of pensioners on incomes below 60% median AHC income – more than tripled, from around 13% in 1984 to about 41% in 1989. The rate then fell back sharply again over the early 1990s to about 26% in 1993-94' (Goodman et al. 2003: 22).

Tackling social exclusion experienced by older people arising from low incomes is the focus of a range of policies. In this review, attention examines those income maintenance policies that are likely to be of greatest significance to older people with low incomes. This reflects the emphasis of government policy on targeting financial support on those pensioners in greatest need. The key policy innovation for the period under review is the Minimum Income Guarantee (subsumed by the Pension Credit scheme in October 2003). In addition, the review assesses the impact of the key means-tested benefits (Housing Benefit, Council Tax Benefit and the Social Fund) along with the universal benefits (Attendance Allowance and Disability Living Allowance) in addressing social exclusion of older people. The broader, income-related issues of financial exclusion and fuel poverty are addressed through an examination of, respectively, the Direct Payment/Universal Banking Services scheme and Warm Front.

A consistent theme of this section of the review relates to take-up of benefits by older people. Some of the more general issues involved in debates about take-up of means-tested benefits are addressed in the discussion on the Minimum Income Guarantee. Where more specific evidence relating to take-up of particular benefits exists, this is addressed in the review's appropriate sub-section.

Minimum Income Guarantee

Description of policy

'In 1997, we recognised that there was much to reform in the field of pensions. But by their very nature, this is a long-term process. Our first priority was to address the low incomes among current pensioners. That is why we put in place Minimum Income Guarantee.' (Department for Work and Pensions, 2002a: 68)

Together with the State Retirement Pension, for the period under review, the Minimum Income Guarantee (MIG) represented a major plank of Government policy. That policy aimed to tackle the poverty faced by current cohorts of older people. Introduced in April 1999, as a re-branding of Income Support for pensioners, the scheme was subsumed within the new Pension Credit system in October 2003. [It is beyond the scope of this review to assess the impact of this relatively new measure].

Scope of Minimum Income Guarantee

Minimum Income Guarantee was a means-tested benefit. Paid through Income Support, it was designed to provide extra financial assistance to help meet the living costs of people aged 60 and over who are living on low incomes. Entitlement could also be linked to receipt of a range of other state benefits, with Housing Benefit and Council Tax Benefit being of most relevance to pensioners (see below). The budget allocated to the Minimum Income Guarantee increased by more than the rate of inflation since its introduction, with upgrading subsequently linked to rises in average earnings. Since its launch in April 1999, real-terms spending on the Minimum Income Guarantee (at 2004-2005 prices) grew from £4,206 million in 1999-2000 to £4,798 million in 2002-2003 (Department for Work and Pensions data).¹

When the Minimum Income Guarantee was first introduced, its value was set at a rate somewhat higher than the earlier levels of Income Support. After 1999, the Minimum Income Guarantee's value was increased each year by more than the related rise in State Retirement Pension and by more than the inflation rate. The biggest boost occurred in 2001, with significant up-rating and the equalisation of rates across age-bands. For pensioners under 75, this meant an increase from £78.45 to £92.15 each week for a single person, and from £121.95 to £140.55 for a couple. The steady increase in the level of the Minimum Income Guarantee since 1999, especially from 2001 onwards, had the effect of significantly increasing the number of pensioners who were entitled to claim the benefit. In 1999-2000, 1.62 million pensioner households received the Minimum Income Guarantee. This number increased to 1.73 million in 2001-2002. The most recent data show that 1.76 million pensioner households received the Minimum Income Guarantee in 2002-2003.²

From 2003-2004, the benefit sought to raise the weekly income of recipients to £102.10 for a single pensioner and £155.80 for a pensioner couple. People facing particular needs, for example carers or disabled people, were potentially eligible to receive additional payments. There were also supplements to the Minimum Income Guarantee for older pensioners, with a maximum rate payable to those aged 80 and over. Average weekly sums of Minimum Income Guarantee claimed by all pensioners increased from £36.80 to £39.70 between 1999-2000 and 2000-2001 (Department for Work and Pensions, 2003b: 18; Table 1.8). The principal restriction applying to those who might qualify for the Minimum Income Guarantee on low income grounds concerned applicants' savings. Pensioners with savings above £12,000 did not qualify for the benefit, while those with savings of between £6,000 and £12,000 were entitled to a reduced level of the Minimum Income Guarantee. The Pension Credit system, introduced from October 2003, seeks to provide greater financial rewards to savers.

1 Details available from: http://www.dwp.gov.uk/asd/asd4/medium_term.asp

2 Details available from: http://www.dwp.gov.uk/asd/asd1/is/is_quarterly_nov03.asp

Research on Minimum Income Guarantee

The Minimum Income Guarantee has not had an independent evaluation. An evaluation of its telephone claim line (Bunt et al., 2001) is of some relevance, as is an earlier evaluation of Income Support Pilots designed to identify pensioners entitled to Income Support but not claiming the benefit (Croden et al., 1999). Despite the lack of a full evaluation of the Minimum Income Guarantee, there is much statistical and research evidence relating to aspects of the policy that can be used to judge the Minimum Income Guarantee's effectiveness in addressing pensioner poverty. A particular focus has been on benefit take-up and reasons for non-take-up by so-called 'entitled non-recipients'. The evidence ranges from official government reports to independent academic analyses and includes useful contributions from voluntary sector organisations.

Evaluating the success of the Minimum Income Guarantee

In the absence of a formal evaluation of the policy, to some extent the success of the Minimum Income Guarantee can be judged from the benefit's take-up rates, and the extent to which it has contributed to a reduction in poverty among older people. Pensioner poverty trends are addressed at the end of this section. In reviewing the evidence on the Minimum Income Guarantee, it is also worth emphasising that many of the issues raised about the take-up of this particular benefit are of general relevance across the range of income-related policies.

Caseload take-up data show that 1.52 million pensioner 'families' claimed the Minimum Income Guarantee in 2001-2002. The overwhelming majority of claimants (960,000) were single female pensioners. Pensioner couples and single male pensioners accounted for 280,000 and 270,000 claims respectively. Benefit take-up ranged from 63% to 72% of all entitled pensioners. Between 67% and 75% of single female pensioners claimed the Minimum Income Guarantee, compared with a range of 52% to 62% for pensioner couples (Department for Work and Pensions, 2004a: 18; Table 1.7). Take-up rates tend to be higher for younger pensioners, and decline steadily with age (Pudney et al., 2002: 9). The evidence points to a fall in take-up between 2000-2001 and 2001-2002, with pensioner couples even less likely to claim their benefit entitlement (Department for Work and Pensions, 2003b: 18; Table 1.7). However, across all pensioner age groups, those eligible for the highest amounts of benefit are more likely to take-up benefits.

In 2001-2002, the latest financial year for which comparable data are available, it was estimated that 32% of all pensioners and 41% of single pensioners received at least one type of means-tested benefit. Just 18% of pensioner couples received such benefits (Department for Work and Pensions, 2002b: 49, Table 9). Examination of take-up rates of the most important income-related benefits, highlights different levels of acceptance of various means-tested benefits. In this respect, Minimum Income Guarantee take-up is significantly lower than that for Housing Benefit, but somewhat higher than Council Tax Benefit take-up. While between 63% and 72% of pensioners entitled to the Minimum Income Guarantee claimed the benefit in 2000-2001, the corresponding range for Housing Benefit was between 83% and 90%. Council Tax Benefit was claimed by between 57% and 63% of eligible pensioners (Department for Work and Pensions, 2004a).

These figures can be turned around to indicate the degree of non Minimum Income Guarantee take-up. In this respect, between 22% and 36% of pensioners failed to claim their Minimum Income Guarantee entitlement in 1999-2000. In 2000-2001, this proportion narrowed to between 24% and 32%, but increased in 2001-2002 to between 28% and 37% (Department for Work and Pensions, 2004a: 18; Table 1.7). Pensioners appear to be less likely than non-pensioners to claim means-tested benefits (National Audit Office, 2002a: 16).

There is a lot of literature on reasons for the non-take-up of means-tested benefits (Citizens Advice, 2003; Costigan et al., 1999; Cowell, 1986; Fry and Stark, 1987, 1993; National Audit Office, 2002a; Pudney et al., 2002). In its report on pensioner take-up of benefit entitlements, the National Audit Office (2002a) identifies barriers at two levels. These concern, first, the structure

and administration of the benefits system and, second, individuals' behaviour on benefits and the claiming process. On the benefits system, the National Audit Office (2002a) cites the following barriers to take-up for pensioners:

- **The complexity of the benefits system** as a whole is further related to confusion over the naming of particular benefits. An example is the shift from Income Support to the Minimum Income Guarantee. Other confusing issues concern the different rules on capital limits for different benefits, the need for pensioners to supply similar information to different bodies when seeking to increase their incomes, the lack of public understanding of how receipt of one benefit (such as the Minimum Income Guarantee) can lead to entitlement to other benefits, and a reluctance to claim unless people were sure that the claim would lead to receipt of benefits.
- **Means-testing.** Means-tested benefits have traditionally had lower take-up than universal or contributory benefits.
- **Leaving the initiative to the pensioner.** The benefits system is administered in such a way that requires pensioners to take the initiative to claim their entitlement. Many older people only become aware of their entitlement following a 'life-changing event', such as illness or disability, or after a bereavement.
- **Unresponsive or inaccessible channels of communication.** Many older people appear reluctant to use the telephone to pursue a benefit claim. Reasons for this reluctance include the dislike of disclosing personal information over the phone, and hearing-difficulties. There is also evidence that some older people dislike visiting Benefits Agency offices to make a claim. They give transport/mobility problems as a cause, or express concern about the physical environment of the local Benefit Agency office (Bunt et al., 2001).³
- **Access to information and advice.** Older people may find it difficult to access relevant information for a potential benefit claim. In this respect, the National Audit Office (2002a) notes that 'it is among the most dependent older people, with the lowest income and little or no savings, that obtaining benefit information is perceived as most difficult' (p. 24).

At the level of the individual, the National Audit Office (2002a) study reports five common barriers to benefit take-up:

- **Ignorance of, and misconceptions about, the benefits available.** Many older people lack knowledge about the benefits system, or even about the benefits that they currently receive. This leads to a series of potential misunderstandings in relation to individuals' perceptions of their entitlement to benefits, and the consequences of claiming benefits.
- **Difficulty completing forms.**
- **Fear of stigma and humiliation.** This is judged to be particularly prevalent among the oldest age-cohorts, and applies especially to means-tested benefits such as the Minimum Income Guarantee rather than to universal benefits, such as free television licences for the over-75s or the Winter Fuel Payment. A survey of Citizens Advice Bureaux (Citizens Advice, 2003) suggests 'old-fashioned stigma is a huge barrier for a generation brought up to cope and take responsibility for themselves and their families' (p. 4).

3 The Pension Service, established in April 2002, has since assumed the role previously fulfilled by the Benefits Agency in delivering pensioner related benefits and services. It is too soon to evaluate older people's views about these new delivery arrangements.

- **Fear of losing independence.** For some older people, receipt of means-tested benefits may be perceived as a loss of independence, and inability to cope. This too, was found to apply more to older than younger pensioners.
- **Perception that making a claim is not worth the effort.** Pensioners who judge that a claim might only lead to a slight improvement in their income are less likely to pursue their entitlement than those who would benefit most. This finding is supported by an analysis of Family Resources Survey data for 1997 to 2000. Hancock et al. (2003: 10f.) show that non-take-up is higher for pensioners whose benefit entitlements are lowest.

These findings mirror those of an earlier analysis of barriers to the take-up of Income Support by older people (Costigan et al., 1999). They are further supported by recent research evidence. An example is the evaluation of the Minimum Income Guarantee claim line undertaken by Bunt et al. (2001). It indicates that the most common reason cited by those pensioners who had contacted the claim line yet subsequently failed to return a claim form was that they felt they would not be eligible for Minimum Income Guarantee. This applied to 44% of non-completed claims. A further 28% of non-completions were attributed to aspects of the Minimum Income Guarantee application process. Reasons were the complexity of the claim form, concern about the personal nature of some questions or the inability to locate documents required to support the application (Bunt et al, 2001: 39f.). A similar picture emerges from analysis of the 1999-2000 Northern Ireland Life and Times Survey. Nearly half of those identified as being potentially entitled to claim the Minimum Income Guarantee (47%) did not wish to pursue a claim. The most important reasons given were linked to the bother of filling out forms and the disclosure of personal information. Issues linked to pride or stigma were of only secondary importance (Evason et al., 2002: 43).

Who are the entitled non-recipients of the Minimum Income Guarantee? There is relatively limited evidence on the characteristics of non-recipients. However, the research that is available suggests that non-receipt is linked to characteristics such as household composition, age and gender. As for other means-tested benefits, the composition of the entitled non-recipient group broadly follows the composition of recipients. In relation to age, a significant proportion of those who fail to claim their benefit entitlements are aged at least 75. In 2001-2002, 56% of all pensioner entitled non-recipients were 75 years of age or over compared with 47% of entitled recipients of Minimum Income Guarantee. While 67% of single female pensioner entitled non-recipients were aged 75 or over, the corresponding proportions for single males or pensioner couples were 49% and 40% respectively. The same overall pattern exists among those pensioners who were entitled to and in receipt of Minimum Income Guarantee (59%, 34% and 22% respectively) (Department for Work and Pensions, 2004a: 21). Pensioners living in rural areas and those with sensory impairments have also been identified as being less likely to receive state benefits (National Audit Office, 2002a: 26). It is likely that those living in deprived urban areas, where poverty rates are above the national average, are also disproportionately affected by low take-up rates (Scharf et al., 2002).

The fourth **Opportunity for All** report pays particular attention to the lack of take-up by older people from ethnic minority groups, suggesting the need for further research (Department for Work and Pensions, 2002a: 19).⁴ The many barriers faced by minority group potential benefit claimants are also highlighted by the National Audit Office (2002a: 28). In addition to the barriers to take-up that apply to older people in general, those belonging to ethnic minority groups may experience problems. These include language and literacy problems, limitations in interpretation services, difficulty in providing necessary documentary evidence to support a claim, and lack of contact with the formal benefit system and a reliance on informal or community-based services. The same issues were highlighted in a recent analysis of barriers to benefit take-up by older people belonging to a range of black and ethnic minority groups, along with a concern about the potential impact of take-up on residency (Barnard and Pettigrew, 2003: 32).

4 A fifth Opportunity for All report was published in September 2003. However, the latest report does not address the issue of benefit take-up.

Despite long-recognised problems with take-up of means-tested benefits, current policy persists in pursuing a strategy which targets those in greatest need. Some researchers suggest that a shift in emphasis from means-tested to universal benefits would be a more effective way of securing pensioners' living standards. In this respect, Evason et al. (2002) note: 'It might be argued that, after so much effort to maximise take-up rates generally, it would be more sensible to abandon what has turned into social policy's equivalent of the search for the Holy Grail. Government cannot do this, however, because take-up has been pinpointed (..) as the Achilles heel of current pensions policy. In consequence, unprecedented efforts have been made since 1999 to get pensioners to claim the Minimum Income Guarantee' (p. 38).

A number of steps have been taken to simplify the process of claiming the Minimum Income Guarantee, and thereby increase benefit take-up.

This has included:

- A reduction in the length of the claim form from 40 to ten pages, and a simplification of the questions.
- The introduction in May 2000 of a telephone claim line for the Minimum Income Guarantee. This occurred in response to research done on behalf of the then Department for Social Security which indicated a dislike of visiting Benefits Agency offices among pensioners (Costigan et al., 1999: 56f.). The evaluation of the Minimum Income Guarantee claim line has proved inconclusive, but around two-thirds of callers agreed that use of the telephone was less embarrassing than a personal visit to a Benefits Agency office (Bunt et al., 2001).
- A national television advertising campaign in 2000 helped significantly to raise awareness of the Minimum Income Guarantee among pensioners from 42% to 76% (National Audit Office, 2002a: 37).
- A series of measures to identify potential claimants. Those claiming State Retirement Pension by phone are now asked questions about their potential entitlement to the Minimum Income Guarantee. People who claim their State Retirement Pension by post are sent a leaflet explaining the Minimum Income Guarantee.
- Other life events now trigger the sending to potential recipients of a leaflet explaining the Minimum Income Guarantee. Such triggers include reaching age 75 or 80, or receiving other benefits such as Attendance Allowance or Invalid Care Allowance (Department for Work and Pensions, 2002a: 69).

The National Audit Office (2002a) highlights a number of national and local initiatives that have sought to increase rates of benefit take-up by pensioners. However, these initiatives have not been subject to systematic cost and benefit evaluation. While national take-up campaigns are likely to generate many new claims, many of these are likely to be unsuccessful. By contrast: 'Local outreach work is much more resource-intensive and focused, but may be more likely to make successful contact with people from hard-to-reach groups' (National Audit Office, 2002a: 45). This point is echoed by Citizens Advice (2003: 5) who identify face-to-face contact and successful targeting as the two most important factors in benefit take-up work with older people. Although based on relatively limited data, Citizens Advice suggest that some of their take-up campaigns have identified an average benefit gain of £85 per client for every £1 invested in the campaign (Citizens Advice, 2002: 5).⁵

5 The report fails to indicate the time period to which the benefit gain applies (Citizens Advice, 2002).

Conclusions: impacts of the Minimum Income Guarantee on the social exclusion of older people

The stabilisation or modest reduction in relative poverty among pensioners since 1999-2000 – depending on which poverty measure is used – has coincided with the introduction of the Minimum Income Guarantee. When viewed alongside existing means-tested benefits, it is possible to argue that the Minimum Income Guarantee has made a significant contribution to the reduction (or at least stabilisation) of pensioner poverty (discussed in more detail in the summary to this section). As such, it represents an important device for promoting the social inclusion of older people.

In their review of social exclusion indicators, Palmer et al. (2002) point to the potential of further reductions in the numbers of pensioners affected by poverty, commenting that: 'although the Government's Minimum Income Guarantee (MIG) for pensioners was introduced in April 1999, the big rises in the amounts actually came into effect in April 2001 and are thus not included in the 2000-01 figures. While the 2001 increases are unlikely to lift pensioners above the low-income threshold, it will move them much closer to it' (p. 76).

Take-up of the new Pension Credit system is likely to continue to be an issue. This point is forcefully made by Arber and Ginn (2004) who comment: 'It remains to be seen what the impact of the recently introduced Pension Credit scheme (which subsumes the MIG scheme) will be on pensioner incomes, although the official target of 73% take-up suggests that many older people will not receive the help they are entitled to' (Arber and Ginn, 2004:9). In this respect, in December 2003, 2.53 million pensioners – or just over half of the 4.9 million people estimated to be eligible – were already receiving Pension Credit (Department for Work and Pensions data).

One reason why pensioner poverty continues to pose a problem is that not all those who are eligible to claim benefits pursue their claim. However, this is only part of the problem. In their analysis of Family Resources Survey data, Goodman et al. (2003) point to potential limitations associated with the improvement of benefit take-up rates. Taking a poverty measure based on 60% of median income after housing costs, full take-up of benefit entitlements would 'only' reduce the overall number of pensioners classified as poor by between 100,000 and 200,000 people (or 1 to 2 percentage points). The advantages of increasing take-up to 100% are more pronounced in relation to a poverty measure at the 50% of median income level. It also helps to reduce poverty 'gaps'. Full Minimum Income Guarantee take-up by all entitled pensioners would reduce the 'depth' of poverty by just over two percentage points (Goodman et al., 2003: 35).

Housing Benefit

Description of policy

Housing Benefit (HB) is designed to contribute towards meeting the housing costs of people with low incomes who live in private or social rented accommodation. The major aim of Housing Benefit is 'to support those who would not otherwise be able to afford an acceptable standard of housing' (Hills, 2001: 1888). The benefit may represent the full amount or a part of a claimant's rental costs, and is available to people of all ages. Along with other means-tested benefits, such as Income Support (MIG) and Council Tax Benefit, Housing Benefit represents an important source of income for many older people. The Housing Benefit scheme is administered by local authorities on behalf of the Department for Work and Pensions.

Scope of Housing Benefit

Housing Benefit is calculated in a similar way to Council Tax Benefit. Eligibility is based on a calculation that links individuals' financial and household circumstances to their rental costs. Applicants who have more than £16,000 in savings are not entitled to receive Housing Benefit, while those with savings of between £6,000 and £16,000 may receive a reduced benefit payment.

In 2001-2002, expenditure on Housing Benefit was £11.5 billion (Department for Work and Pensions, 2003e). Since 1996, there has been a steady decrease in the overall numbers of people receiving Housing Benefit. In 1996, there were around 4.8 million Housing Benefit recipients. By May 2003, the latest date for which comparable data are available, the number of recipients had decreased to 3.8 million (Department for Work and Pensions, 2003e, 2003f).

As with other means-tested benefits, Housing Benefit has been subject to reform in recent years. After the 1997 general election, the Housing Benefit scheme was identified as a source of potential savings on benefits. A key reason was that the programme was perceived to be vulnerable to fraud (Kemp, 2000: 268). A series of deficiencies in the existing Housing Benefit system were subsequently highlighted in the welfare reform Green Paper of 1998 (Department of Social Security, 1998), leading to a range of changes in benefit rules and regulations. However, the government's original aim of radically reorganising Housing Benefit has tended to give way to a more modest programme of benefit reform (Department for Work and Pensions, 2003g: 36; Kemp, 2000: 271).

Research on Housing Benefit

There is limited research evidence on Housing Benefit and older people. Statistical analyses of Housing Benefit recipient data are undertaken by the Department for Work and Pensions, and these have become more sophisticated in recent years allowing analysis by client group. The National Audit Office's (2002a) study of pensioner poverty provides a useful analysis of benefit take-up issues, some of which are relevant to Housing Benefit. Hancock et al. (2003) address the multiple take-up of benefit entitlements by pensioner households. While most academic analyses of Housing Benefit tend not to focus on the situation of older people, they provide some helpful information on the operation and weaknesses of the scheme that can sometimes be applied to their situation (for example Cowan and Marsh, 2001; Hills, 2001; Kemp, 2000).

Evaluating the success of Housing Benefit

A potential indicator of Housing Benefit's relative success is the extent to which older people take up their benefit entitlement. In May 2002, 1.63 million of the UK's 3.81 million Housing Benefit recipients – or just over two-fifths – were aged 60 and over (Department for Work and Pensions, 2003e: Table 3.3). In 2000-2001, 1.66 million pensioner 'families' received Housing Benefit in the UK. This represented a fall from the corresponding figure for 1999-2000, when 1.74 million pensioner 'families' received the benefit (Department for Work and Pensions, 2003b). However, analysis by the Department for Work and Pensions suggests that 'there was no evidence of a change in take-up among those pensioners who were entitled in both years, and little difference in the rate of take-up between this group and those newly entitled to Housing Benefit' (Department for Work and Pensions, 2003b: 27).

Analysis of Family Resources Survey data shows that some groups of older people are more likely to receive Housing Benefit than others. This is likely to reflect the position of such groups in the overall income distribution. While 12% of all 'benefit units' were in receipt of Housing Benefit in 2001-2002, this proportion increased to 25% for single male pensioners and 27% for single female pensioners. By contrast, only 10% of pensioner couples received Housing Benefit payments (Department for Work and Pensions, 2003h: Table 3.15).

For a means-tested benefit, Housing Benefit take-up is perceived to be relatively high. Between 86% and 94% of eligible pensioner recipients received payments under the Housing Benefit scheme in 2000-2001. However, for the same period, it was still estimated that between 110,000 and 270,000 pensioner 'families' were entitled to receive Housing Benefit, but were not doing so (Department for Work and Pensions, 2003b: 27, Table 2.1). Overall, in recent years around one in ten pensioners have consistently failed to claim their Housing Benefit entitlement (National Audit Office, 2002a: 16; Hancock et al., 2003: 5).

In May 2002, the average weekly Housing Benefit paid to claimants aged 60 and over was £48.50 (Department for Work and Pensions, 2003e, Table 3.7). On average, pensioner 'families' claimed Housing Benefit worth £42.80 a week in 2000-2001. The average weekly amount that went unclaimed by entitled non-recipients was £25.80 (Department for Work and Pensions, 2003b: 27, Table 2.2). While older people who have most to gain from claiming Housing Benefit are most likely to take-up their benefit entitlement, non-take-up continues to deprive many older people of a potentially significant proportion of their income entitlement.

Closer analysis of pensioner entitled non-recipients has been undertaken by the Department for Work and Pensions. This suggests that non-recipients are disproportionately located in the bottom two deciles of the income distribution. Before housing costs are considered, some six out of ten pensioner entitled non-recipients had incomes in this range. After housing costs, the proportion increases to around seven in ten (Department for Work and Pensions, 2003b: 30; Table 2.5). Non-receipt of Housing Benefit has also been shown to be closely related to low household income. Before housing costs, 54% of entitled non-recipient pensioners lived in households with below 60% of median income, compared with 14% of Housing Benefit recipients. These proportions increase greatly once housing costs are taken into account (Department for Work and Pensions, 2003b: 31, Table 2.7). This suggests that pensioners who receive Housing Benefit are significantly less likely to be living in poor households than those who are entitled to Housing Benefit but are not receiving the benefit.

Analysis of claimants' experiences of delivery of Housing Benefit (and Council Tax Benefit) by local authorities, provides useful indicators of the difficulties associated with claiming such benefits. Though not specifically focusing on older claimants, the study done by Pettigrew et al. (1999), based on 30 group discussions in ten local authorities, suggested that:

- Older people were more likely than younger applicants to require and seek help with Housing Benefit applications.
- Claimants did not consider the telephone the most useful means of contacting the local authority. Problems concerned identifying the appropriate person to deal with the case, being passed from person to person, the absence of contact 'names' from the office, and calls being cut off without explanation.
- When dealing with local authority staff, older claimants appeared to dislike discussing complex personal issues with people they felt were a lot younger than them.
- Practical steps could be taken to improve service and efficiency. These include a reduction in the time taken to process claims, the combination of Housing Benefit and Council Tax Benefit forms, and changes to local authority offices such as the introduction of appointment systems, the provision of greater privacy, and more knowledgeable staff (Pettigrew et al., 1999).

Some of these points were echoed by Age Concern England (2000) in its submission to the House of Commons Social Security Committee's inquiry into Housing Benefit (House of Commons, 2000). Based on the – albeit anecdotal – experience of their benefits advisers, Age Concern England

expressed misgivings about the operation of the Housing Benefit system, noting the 'considerable variation in service' between different parts of England. The organisation highlighted difficulties experienced by older people over the administration of Housing Benefit. These included:

- Delays in the processing of claims. Age Concern England's benefits advisers reported that many people had to wait far longer than the anticipated 14 days for a claim to be processed. In some cases, claim forms were lost necessitating completion of a new application.
- Difficulty in contacting local authority benefits sections by telephone. In particular, the absence of a named member of staff to deal with individual claims or requests for information, was regarded as a weakness of existing systems.
- The need to provide original documents to support a Housing Benefit claim can raise difficulties for some older people. Many people are unwilling to post such documents, for fear of losing them, and are consequently obliged to attend the benefits office in person. This can prove problematic for older people with mobility problems, but also raises problems for those dealing with the claims of people with mental health problems.
- Some local authority staff appear to deal insensitively with the needs of older people. This relates to the checks and anti-fraud measures applied to control Housing Benefit misuse. Some older people feared that their benefits might be stopped after routine visits by local authority staff. In this context, Cowan and Marsh (2001: 266) point to the potentially damaging effects that extensive anti-fraud measures can have on people's lives. Linking receipt of welfare benefits to fraud can potentially lead to further stigmatisation of Housing Benefit recipients (Cowan and Marsh, 2001: 266).
- The Housing Benefit system formerly required a renewal of claims every 60 weeks. Age Concern England noted that some older people may assume that the initial claim is sufficient, and not proceed with the renewal.⁶

For another group of older people, the system of Housing Benefit administration might pose particular difficulties. In a study of Housing Benefit paid to people living in a range of supported accommodation, including many older people living in sheltered housing, Cebulla et al. (1999) found a lot of confusion over Housing Benefit payment calculation. This confusion arose from the different methods used by housing providers to determine their charges, and from the application of a range of methods to assess benefit entitlements by Housing Benefit administrators. The authors of this study concluded that: 'Only a small minority of claims was soundly based' (p. 5).

The weaknesses of the existing Housing Benefit system are acknowledged in the Government's latest National Action Plan on Social Inclusion (Department for Work and Pensions, 2003g). Drawing on the experiences of claimants, Housing Benefit is identified as 'a problem area in the benefit system. It does not cover full rents in many places, it is not really available to owner-occupiers and it is frequently late and wrongly estimated, leading to fines, debt and stress' (p.88).

Conclusions: impacts of Housing Benefit on the social exclusion of older people

By meeting some or all of recipients' housing costs,, Housing Benefit provides many older people with the security of an affordable home. This in itself represents an important element of social inclusion in contemporary society. Housing Benefit represents a major source of income for low income older people. When viewed in the context of other means-tested benefits received, the

⁶ From April 2004 this particular requirement was removed to align Housing Benefit with the new Pension Credit system (Department for Work and Pensions, 2003g).

scheme can contribute well to alleviating pensioner poverty. Households Below Average Income data suggest that older people who receive Housing Benefit, experienced a reduced risk of low income when compared to older people as a whole. 22% of all pensioners lived in households with an income below 60% of median household income in 2001-2002. For those in receipt of Housing Benefit, the corresponding proportion was 10% on the before housing costs measure and 34% on the after housing costs measure (Department for Work and Pensions, 2003d: 113, Table 6.6). There is limited evidence to allow conclusions to be drawn about the impact of Housing Benefit in reducing social exclusion experienced by particular groups of older people.

Government reforms have sought to simplify the Housing Benefit application process, with the link to the Pension Credit system likely to increase take-up. People who contact the freephone Pension Credit application line are now asked if they are claiming Housing Benefit (and/or Council Tax Benefit). If they are not, a Housing Benefit/Council Tax Benefit claim form is posted to them along with their Pension Credit details. The applicant is then required to complete the claim form and return it to their local authority for processing.⁷

Older people who are not receiving their Housing Benefit entitlements are most likely to belong to the poorest group of pensioners. However, there is evidence that some take-up strategies might be more effective in reaching this group than others. In this respect, the submission by Newcastle Upon Tyne City Council's Welfare Rights Service to the Institute of Revenues, Rating and Valuation's inquiry into Council Tax Benefit and Housing Benefit explicitly focuses on benefit take-up among older people (Newcastle Upon Tyne, 2001). This highlights the success of active take-up strategies in promoting benefit take-up. In particular, identification of older people who appear to be entitled but not claiming Housing Benefit, results in a home visit to all potential claimants, unless he or she has actively refused the service (p. 83). These findings, generated through the work of a single organisation and not subject to systematic scientific evaluation, at least raise the question of whether such schemes might succeed in other localities.

A final point relates to the scope of the Housing Benefit system. While the benefit can be seen as successfully meeting the needs of low income tenants, there is a wider issue over the situation of low income owner-occupiers. Those who qualify are entitled to have necessary repair costs met through the Housing Benefit scheme. However, no equivalent help is available to people who own their homes (Hills, 2001: 1894). This is likely to increase the financial insecurity of some groups of older home-owners, including those who have bought homes formerly owned by local authorities, some ethnic minority groups, and older people living in areas characterised by a substantial drop in house prices.

Council Tax Benefit

Description of policy

Council Tax Benefit is a means-tested benefit designed to help those on low incomes meet some or all of the amount of their Council Tax liability. Introduced in 1993, the Council Tax itself represents a key source of local government income, with the scale of Council Tax charges levied against individual households being largely determined by local authorities. Individuals' liability to Council Tax – and consequently their potential entitlement to Council Tax Benefit – varies according to the value of applicants' homes.

7 Information supplied by Department for Work and Pensions.

Scope of Council Tax Benefit

There are two ways of receiving Council Tax Benefit. The first is determined through eligibility to other state benefits, including Income Support (MIG). A second route is offered through the Second Adult Rebate system. This provides for a reduced Council Tax bill for those living with a person, other than a partner, who is on a low income. Most of the research evidence relates to the first of these benefit routes.

Eligibility to receive Council Tax Benefit is determined by the applicant's income and capital. In April 2000, the amount of income and capital that pensioners were able to receive before losing part of their benefit entitlement was increased by more than the increase in State Retirement Pension. As a result, pensioners with more than £16,000 in capital are ineligible to claim Council Tax Benefit, while capital of between £6,000 and £16,000 results in a reduced entitlement.

Applications for Council Tax Benefit are processed by local authorities. In some areas, it is possible to claim Council Tax Benefit on the same form as Housing Benefit, since much of the same information is required to process both types of benefit. A key feature of the new Pension Credit scheme (introduced in October 2003), has been the facility for older people to claim Council Tax Benefit (and Housing Benefit) at the same time as the credit. In these cases, the Department for Work and Pensions forwards the relevant claim form(s) to applicants. On completion, applicants are required to pass the form(s) on to their local authority for processing. People who are entitled to receive Pension Guarantee Credit have their Council Tax liability met in full by the local authority.

A significant outcome of the change in rules concerning Council Tax Benefit applicable amounts (described above), and an increase in Council Tax bills by more than the rate of inflation in recent years, has been an increasing number of pensioners who are eligible to receive Council Tax Benefit. Overall, some 4.6 million households received Council Tax Benefit in May 2003 – the latest year for which data is available. Of the 4.7 million households receiving Council Tax Benefit in 2000-2001, around half (2.36 million) were pensioner households (Department for Work and Pensions, 2003b). The overall expenditure on Council Tax Benefit represented £2.7 billion in 2001-2002 (Department for Work and Pensions, 2003e).

Research on Council Tax Benefit

Besides research undertaken on behalf of the Department for Work and Pensions, there is a small number of studies that investigate issues relating to Council Tax Benefit and the situation of older people. The work of Clark et al. (1999) for the Joseph Rowntree Foundation has recently been supplemented by the New Policy Institute's (2003) analysis of the impact of Council Tax on older people's income, undertaken on behalf of Help the Aged.

Evaluating the success of Council Tax Benefit

The most recent data relating to the take-up of Council Tax Benefit by older people covers the period 2000-2001 (Department for Work and Pensions, 2003b). In that year, 2.36 million pensioner 'families' received the benefit. Many older people on low incomes are therefore relieved of all or part of their Council Tax obligation.

However, pensioner Council Tax Benefit take-up is significantly lower than for other means-tested benefits. It is estimated that between 32% and 38% of entitled pensioners are not receiving their Council Tax Benefit entitlement. This corresponds to between 1.1 million and 1.43 million pensioner 'families' (Department for Work and Pensions, 2003b: 35, Table 3.1). The evidence also points to a lower take-up by pensioner than non-pensioner households. While 84% of entitled non-pensioners claimed Council Tax Benefit in 2000-2001, the corresponding rate for pensioners was just 65% (New Policy Institute, 2003: 12).

Analysis of Family Resources Survey data highlights variations between different groups of older people in relation to receipt of Council Tax Benefit. Overall, 16% of all 'benefit units' received Council Tax Benefit in 2001-2002. While 17% of pensioner couples received the benefit, the proportions for single pensioners were much higher. Thirty-one per cent of single male pensioners and 38% of single female pensioners received Council Tax Benefit in 2001-2002 (Department for Work and Pensions, 2003h: Table 3.15).

On average, pensioner 'families' claimed Council Tax Benefit worth £9.20 a week in 2000-2001. This represented an increase from £8.40 in 1999-2000. The average weekly amount that went unclaimed by entitled non-recipients in 2000-2001 was £7.60 (Department for Work and Pensions, 2003b: 35, Table 3.2). In comparison with Housing Benefit take-up data, there is less difference between the average weekly amounts of Council Tax Benefit that are claimed and the average amounts that remain unclaimed. The Department for Work and Pensions analysis suggests that around three-fifths of pensioner entitled non-recipients lived in households with incomes below 60% of median household income (before housing costs). After housing costs are taken into account, this proportion falls to just over half (52%) (Department for Work and Pensions, 2003b: 40, Table 3.9).

It is difficult to separate an analysis of Council Tax Benefit take-up data from a broader investigation into the Council Tax itself. In this respect, the study of the impact of Council Tax on older people's income undertaken by the New Policy Institute (2003: 1) is important in summarising four key problems with the tax:

- The tax represents a greater burden for lower income households than for higher income households. While this affects pensioner and non-pensioner households in the same way, pensioner households are more likely to be affected by low incomes than non-pensioners.
- Council Tax has been increasing by more than the rate of inflation for the ten years since its introduction. Since increases in the State Retirement Pension are linked to the rate of inflation, this results in a reduction in the disposable income of many pensioner households.⁸
- The Council Tax represents more of a burden for pensioner than for non-pensioner households. This is true for both single pensioners and pensioner couples. Citing data from the Households Below Average Income study for 2000-2001, the New Policy Institute (2003) analysis suggests that 'among households paying the tax either in full or in part, council tax represented 3% of net income of all households, compared with some 5.5% for single pensioners and 5% for pensioner couples' (p.4). There is also some evidence to suggest that the Council Tax burden is greater for older pensioners than for those who have recently retired.
- Many pensioners are not claiming their Council Tax Benefit entitlement. This is especially so for many older people who own their homes outright. According to the New Policy Institute (2003: 6) about one in four pensioners with net weekly incomes below £100 and about half of those with incomes between £100 and £150, pay the full Council Tax. While almost all those with net weekly incomes below £150 who live in socially rented accommodation received Council Tax Benefit, the proportion of Council Tax Benefit recipients who were home-owners and had the same net income, was just one third (New Policy Institute, 2003: 6).

8 Council Tax is taken into account in the calculation of the Retail Price Index. However, for those who spend a higher than average proportion of their income on Council Tax and who are not in receipt of Council Tax Benefit, this will not fully compensate them for the Council Tax increase.

These points are echoed in an earlier analysis of Council Tax Benefit undertaken by researchers based at the Institute for Fiscal Studies (IFS). In their study, Clark et al. (1999) showed that while most claimants of Council Tax Benefit were found in the lowest income deciles, the benefit 'has comparatively little effect on the burden of the poorest income decile, and that relatively few recipients are found there' (Clark et al., 1999: 3). This includes many older people, with pensioners identified as a group that is left with a higher Council Tax burden even after taking account of benefit payments.

Conclusions: the impacts of Council Tax Benefit on the social exclusion of older people

There is limited evidence on which to judge the impact of Council Tax Benefit in reducing social exclusion among older people. Those on low incomes who claim the benefit receive an important boost to their weekly incomes. However, relatively high rates of non-take-up of this benefit suggests that many older people on low incomes are losing out on a potentially significant addition to that income. In particular this applies to older owner-occupiers who may not be entitled to receive other forms of means-tested benefit.

Attendance Allowance and Disability Living Allowance

Description of policy

Attendance Allowance (AA), introduced in 1971, is a non-contributory, tax-free benefit aimed at people over the age of 65 who are severely disabled, physically or mentally, and require help with personal care. Since April 1992, people who were disabled before the age of 65 have been eligible to receive Disability Living Allowance (DLA) instead of Attendance Allowance. Disability Living Allowance is a non-contributory benefit available to those under the age of 65 who have care or supervision needs or who have mobility problems. People who have been awarded Disability Living Allowance before reaching the age of 65 continue to receive this benefit after that age. A medical assessment may be needed before eligibility for either Attendance Allowance or Disability Living Allowance can be established. Receipt of either benefit also qualifies older people for higher rates of some other state benefits including MIG (now Pension Credit).

Scope of Attendance Allowance/Disability Living Allowance

Attendance Allowance claimants over the age of 65 who need help both during the day and at night are eligible to receive a higher rate of benefit. A lower rate is available to people needing help either during the day or at night. The current rates of Attendance Allowance are £57.20 a week (higher rate) and £38.30 a week (lower rate). Government expenditure on Attendance Allowance was estimated as £3.25 billion for the period 2002-2003 (National Audit Office, 2003a: 10).

Disability Living Allowance comprises two components (Counsel and Care 2003b). The first is a care component, the receipt of which is based on similar criteria to those concerning Attendance Allowance. This component can be paid at three rates. People who need care or supervision during the day and night are entitled to a higher rate of £57.20. A middle rate of £38.30 is paid to those needing such help during either the day or the night. The lower rate of £15.15 is paid to people who are unable to cook a hot main meal or who need help for at least an hour a day.

The second component of Disability Living Allowance relates to an individual's mobility needs. This element is paid at two rates. The higher rate of £39.95 is paid to people whose mobility is severely restricted, for example by a physical disability, or who are both deaf and blind. The lower rate mobility component is paid at a rate of £15.15 to people who are able to walk, but are unable to

walk outside in an unfamiliar area without guidance or supervision. Government expenditure on Disability Living Allowance – for claimants of all ages – was estimated to be £7.05 billion in 2002-2003 (National Audit Office, 2003a: 10).

Disability Living Allowance and Attendance Allowance can be awarded for either a fixed period of time or for an indefinite period. Those qualifying for both the care and mobility components of Disability Living Allowance will receive these for the same time period. People over the age of 65 are ineligible to apply for the mobility component of Disability Living Allowance. However, those who have already received such payments before reaching that age can continue to receive this form of the benefit until the end of the fixed period, or indefinitely.

People who qualify to receive the higher rate mobility component of Disability Living Allowance are entitled to additional forms of support. This can include help to purchase a car or an electric wheelchair under the Motability Scheme. Also, people who provide care for 35 hours or more each week to someone receiving Attendance Allowance or one of the two higher rates of Disability Living Allowance care component, may be entitled to receive Carer's Allowance (previously called Invalid Care Allowance). Although a restriction limiting receipt of Carer's Allowance (CA) to people under the age of 65 was lifted in October 2002, the numbers of older people claiming this benefit at any one time are relatively small. In August 2003, there were estimated to be 38,000 people aged 60 and over receiving Carer's Allowance, with an average benefit of £26.52 a week paid to people aged 65 and over (Department for Work and Pensions, 2003l: Table CA2). The relatively low number of Carer's Allowance claimants is partly due to overlapping benefit rules. They mean that someone who already receives £43.15 a week or more from other social security benefits (including the state retirement pension) is ineligible to receive Carer's Allowance (Counsel and Care 2003c). However, Carer's Allowance recipients who also receive means-tested benefits, such as Pension Credit, Housing Benefit or Council Tax Benefit, are entitled to an additional Carer Premium of £25.10. The key beneficiaries of the 2002 rule change on Carer's Allowance, appear to be older carers. These are mainly women, who fail to qualify for a basic state pension or whose pension entitlement falls below the £43.15 sum.

Research on Attendance Allowance/Disability Living Allowance

Given the potential importance of disability benefits such as Attendance Allowance and Disability Living Allowance in alleviating poverty (and social exclusion) among older people, it is perhaps surprising that there is relatively little independent academic research relating to these particular benefits (Evason et al., 2002: 41). However, there are several robust studies that have been done by or on behalf of official bodies such as the National Audit Office and the Department for Work and Pensions. While the analysis undertaken here relies primarily on such studies, where appropriate, use is also made of a range of statistical data collected through nationally representative surveys. Several studies have addressed the role of primary care professionals in relation to encouraging higher take-up of disability benefits. These are reviewed by Greasley and Small (2002).

Evaluating the success of Attendance Allowance/Disability Living Allowance

Analysis of Family Resources Survey data show that about a fifth of pensioner households received at least one type of disability benefit in 2001-2002 (Department for Work and Pensions, 2002b).⁹ This proportion has increased greatly in recent decades. In 1979, the proportion of pensioner households receiving such benefits was around 4% (Department of Social Security, 2000: 48).

9 While DLA and AA account for the greatest proportion of disability benefits claimed by older people, this figure also includes other benefits such as War Disablement Pension, Invalid Care Allowance, Industrial Disablement Pension, Severe Disablement Allowance, Disabled Person's Tax Credit and Statutory Sick Pay.

Pensioner couples are more likely to receive disability benefits than single pensioners, and receipt is slightly more common among pensioners who had been retired longer (Department for Work and Pensions, 2002b: 51; Table 10). The average amount of disability benefits awarded to pensioners was £53 a week in 2001-2. While such benefits increased by on average 30% between 1979 and 1996-7, 'estimates for more recent years do not suggest any major changes in the second half of the 1990s' (Department for Work and Pensions, 2002b: 50).

In August 2003, when the most recent data were published, there were an estimated 1.36 million recipients of Attendance Allowance in the UK. Of this number 680,000 people were receiving the higher rate and 679,000 the lower rate of benefit. Given the nature of the benefit, the likelihood that a person will receive Attendance Allowance, increases significantly with age. While just under 46,000 people aged 65 to 69 years received Attendance Allowance in August 2003, the corresponding number of those aged 80 to 84 years was 382,000 (Department for Work and Pensions, 2003j; Tables AA1 and AA2). According to the most recent Family Resources Survey, 5% of people receiving benefit aged 65 to 74 years, 18% of those aged 75 to 84 years and 28% of those aged 85 and over received Attendance Allowance in 2001-2002 (Department for Work and Pensions, 2003h: Table 3.18). The overwhelming majority of older people receive Attendance Allowance and at least one other state benefit. In most cases this is the basic state pension, or the basic state pension with MIG (Department for Work and Pensions, 2003a: 22; Table 3.3).

In August 2003, there were some 2.53 million recipients of Disability Living Allowance of all ages in the UK. Of this total, 570,000 received the mobility component alone, 336,000 received only the care component, and the remaining 1.6 million claimants received both mobility and care components. About 930,000 recipients of Disability Living Allowance (37% of all recipients) were aged 60 or over (Department for Work and Pensions, 2003k: Tables DLA1 and DLA2). Given the eligibility criteria for receipt of the benefit, it is not surprising that data from the Family Resources Survey show the proportion of older people receiving Disability Living Allowance to be declining with age. While the care component of the benefit is received by 10% of benefit recipients aged 60 to 64 years in 2001-2002, the respective proportion was 7% of those aged 65 to 69 years, and just 2% of those aged 70 and over. A similar pattern exists for the mobility component of Disability Living Allowance. It is received by 12% of benefit recipients headed by a person aged 60 to 64 years, and just 1% of those aged 85 and over (Department for Work and Pensions, 2003h: Table 3.18). As for Attendance Allowance, most recipients of Disability Living Allowance also receive other state benefits, in particular the basic state pension and the Minimum Income Guarantee (Department for Work and Pensions, 2003a: 22; Table 3.3).

There is only limited recent evidence addressing take-up rates among those potentially entitled to receive disability benefits. A study using data from 1996-1997 estimated that take-up of Attendance Allowance was between 40% and 60% of those potentially eligible (Craig and Greenslade, 1998). This figure is substantially lower than the take-up rates reported for other key benefits, such as the Minimum Income Guarantee (now Pension Credit), Housing Benefit and Council Tax Benefit. However, these estimates were produced when DLA was a relatively new benefit. The number of people aged 65 and over claiming Attendance Allowance or Disability Living Allowance has risen by 21% since 1996 – though many claims ultimately prove unsuccessful (National Audit Office, 2002a: 16).

In discussing barriers to benefit take-up by older people, Mayhew (2002) suggests that the evidence relating to disability benefits is unclear: 'While pensioners regard disability benefits less negatively than Income Support – like Housing Benefit and Council Tax Benefit they are seen as paying for essential items or services – evidence among people of all ages suggests that the attitudinal and process-related barriers to claiming disability benefits are similar to those against claiming Income Support' (Mayhew 2002: 63). Barnard and Pettigrew's (2003) analysis of barriers experienced by older black and ethnic minority group people, emphasises this point, while also highlighting difficulties associated with lack of knowledge of benefit rules: 'Older people also worried that their health problems were not severe enough to merit the benefit and that they

might have to return the money later. This concern was exacerbated if they saw 'severely disabled' written on their documents, indicating a higher level of benefit. In contrast, other older people did not realise that there was an upper limit to the benefit and thought that it would continue to increase as their condition worsened, even if they were already receiving the highest level' (Barnard and Pettigrew, 2003: 120).

The Department for Work and Pensions (DWP) has acknowledged that relatively low take-up of disability benefits is problematic. The DWP has recently been taking steps 'to improve the take-up of Disability Living Allowance and Attendance Allowance. It has been doing this in a carefully directed way by working closely with partners, such as local authorities and welfare rights organisations, which can identify potential claimants to disability benefits' (Department for Work and Pensions, 2003c: 106).

There is some evidence that welfare advice delivered at a suitable time and location can lead to improved take-up of disability benefits by older people. In their review of welfare advice provided in GP surgeries, Greasley and Small (2002) report on a number of local case studies that delivered additional benefits to primary care patients. Attendance Allowance figured prominently as the benefit least likely to be claimed by potentially eligible older people in many of the case studies. For example, a campaign in Camden – conducted in conjunction with the local Citizens Advice Bureau – involved writing to all patients over the age of 80 registered with a GP practice. Of the 206 people contacted, 45% (93 people) subsequently received additional benefits equivalent to £137,820 in extra annual income. Attendance Allowance was cited as the most common benefit taken up after such a campaign (Greasley and Small, 2002: 8).

Drawing on their detailed review of the literature relating to the provision of welfare advice services in primary care, Greasley and Small (2002: 16f) identify eight advantages associated with providing advice services within general practices:

- the service is local and accessible, offering the potential of home visits by advice workers. This provides access to welfare advice for people who might otherwise be 'excluded due to age, poor health, poverty, lack of transport, or psychological barriers in visiting mainstream advice services';
- providing a service within a GP practice serves to legitimise the claims process, reducing the stigma often associated by older people with claiming state benefits';
- the service raises local awareness of welfare advice services';
- the service enhances health workers' knowledge of welfare advice services and benefits. As a result, health workers are able to offer better advice and meet patients' needs in a more holistic way';
- advice workers in GP surgeries can act as a useful resource for health professionals when dealing with health-related benefits claims such as Disability Living Allowance. For example, the experience and knowledge of welfare advice workers can save time for GPs completing forms, and ensure the correct submission of claims';
- in highly deprived areas, the service can provide a useful resource to practices in which many consultations have 'an underlying psycho-socio-economic basis'. This is likely to relieve some of the pressures placed on health professionals working in such settings';
- 'the service may lead to an improvement in the health and quality of life of patients';

- any improvement in the health and quality of life of patients might contribute to a reduction in patients' use of NHS resources, for example consultations and prescriptions.

Recent changes to claiming Attendance Allowance/Disability Living Allowance

Alongside innovative approaches to encouraging higher rates of take-up of disability benefits, the Department for Work and Pensions has been addressing problematic aspects of the administration of such benefits. Mayhew (2002) summarises a key element of the resistance of some older people to claim benefits in the following way: 'There is an expectation that claim forms will be long and complex, or that there will be a lot of forms to fill in. The perceived complexity of the claim forms is such that some older people feel that success in obtaining help is more a question of energy and mental agility than need' (Mayhew, 2002:59). Key issues concerning both Attendance Allowance and Disability Living Allowance are the complexity of the claims process, and the ensuing relatively high rates of appeals against decisions made. Recent changes have sought to make progress in simplifying the claims process for both Attendance Allowance and Disability Living Allowance.

In October 2003, a shorter and simpler form for people claiming Attendance Allowance was introduced across the UK. The new form has been reduced in size from 37 to 19 pages. This followed successful pilots in Bristol and Glasgow. Piloting found the shortened form to be simpler to complete and less intrusive than the original form, and resulted in significantly fewer appeals and fewer medical evidence checks. The Bristol pilot also suggested a reduction in processing times by up to six days without affecting decision accuracy (National Audit Office, 2003a: 15). Analysis of customers' views about the new claim form showed that 75% of claimants found the revised form easy to complete (Hansard, 8 July 2003: Column 757W).

While the Department for Work and Pensions considered the pilot of the new Attendance Allowance forms a success, there have been criticisms of the pilot from welfare advice workers. These have been expressed most coherently on the Benefits and Work organisation's website (www.benefitsandwork.co.uk). In particular, the reduction in the number of appeals following the introduction of the reduced claim form, is interpreted as reflecting a greater difficulty in mounting an appeal. Further concerns have been expressed over the large number of claims determined solely on the basis of the information presented in the shortened form, and not subject to further evidence gathering: 'Reliance on just the information in the short forms is worrying enough in relation to Attendance Allowance, where 80% of new claims result in an award. If the same procedures are followed in relation to Disability Living Allowance however, where only about half new claims are successful, it will be a very major concern indeed for disabled people' (Donnison, 2003: 3).

A shortened Disability Living Allowance claim form was trialled in Glasgow between January and April 2003. The Disability Living Allowance pilot involved a 15 minute telephone interview as an 'interactive claim process', to generate a shorter, individualised Disability Living Allowance claim form. While the evaluation of the Disability Living Allowance pilot is still awaited, a decision to extend the revised form to the country as a whole should take account of the comments of disability rights advisers expressed above.

In recent years there have been improvements in the speed of processing Attendance Allowance and Disability Living Allowance claim forms. In 2000-2001 it took on average 30.5 days to process the Attendance Allowance relevant forms. By 2002-2003 this had been reduced to 24.2 days. That meant that recipients received their benefit entitlement some six days earlier than was previously the case. Initial evidence on the revised Attendance Allowance claim form suggests a further improvement in processing time, with claims taking on average 22.6 days (Hansard, 8 July 2003: Column 757W). The improvement in processing times of Disability Living Allowance claims has been slightly less pronounced; between 2000-2001 and 2002-2003 the number of days taken to process initial claims fell from 46.8 days to 42 days (National Audit Office, 2003a: 14).

While there has been some success in delivering Attendance Allowance and Disability Living Allowance decisions more quickly, there continues to be cause for concern about the relatively high degree of inaccuracy and number of appeals against such decisions. Just 55% of initial and reconsidered decisions relating to Attendance Allowance and Disability Living Allowance were judged to be correct in 2001-2002. This represented a fall from the previous year's figure of 61%, and is significantly worse than corresponding accuracy figures for other state benefits (National Audit Office, 2003b: 16).

In 2002-2003, nearly 270,000 requests were made to review initial decisions on Disability Living Allowance (Department for Work and Pensions, 2003k: Table DLA9). The corresponding number of requests for Attendance Allowance was 85,000 (Department for Work and Pensions, 2003j: Table AA9). A high proportion of appeals prove to be successful. In September 2002, 54% of Disability Living Allowance appeals and 47% of Attendance Allowance appeals led to a reconsideration of the applicant's eligibility for the benefit or the award of a higher rate of benefit (National Audit Office 2003a: 5). The most common reason given for a successful appeal for these benefits was new evidence being available to the appeals tribunals. This applied to 72% of appeals. However, more worrying perhaps, was the finding that in 42% of appeals over Attendance Allowance and Disability Living Allowance, the appeals tribunal came to a different decision on the basis of the same initial evidence (National Audit Office, 2003b: 23). This mirrors the findings of an earlier study of Disability Living Allowance and Attendance Allowance awards in 1998 by the Disability Living Allowance Advisory Board (DLAAB) and the National Adjudication, Support, Checking and Advisory Team (NASCT) which highlighted the uncertainty over the accuracy and consistency of decision-making (Swales, 1998). This suggests the existence of a persisting weakness within the Department for Work and Pension's Disability and Carers Service over the administration of such disability benefits.

The relatively high number of appeals against decisions on eligibility for Attendance Allowance and Disability Living Allowance, and the proportion of successful appeals, raises several issues for older people who are vulnerable to forms of social exclusion. In particular, those with limited language and literacy skills are likely to find the process of pursuing a claim against an initial decision difficult. Older minority ethnic group people are potentially most likely to experience difficulties in this regard. For example, Barnard and Pettigrew's (2003: 120) review of barriers to the take-up of benefits by older people belonging to such groups, highlights the complexity of forms as being a key issue. Where new forms of claiming such benefits rely on telephone interviews, this may act to the disadvantage of those older people who lack access to a telephone or who dislike using one to discuss personal matters.

Conclusions: impacts of Attendance Allowance/Disability Living Allowance on the social exclusion of older people

Analysis of Households Below Average Income data show that pensioners who receive disability benefits, experience a reduced risk of low income when compared with those receiving other key state benefits (MIG, HB). After housing costs, 11% of Disability Living Allowance recipient pensioners and 6% of those receiving Attendance Allowance lived in households with below 60% of median household income in 2001-2002. The corresponding proportion of all pensioners living in such low income households was 22% (Department for Work and Pensions, 2003d: 113; Table 6.6). While the risk of low income appears to be lower for Attendance Allowance or Disability Living Allowance recipients, the Department for Work and Pensions has long acknowledged that such data may understate the extent of this particular risk. That is because there are often higher living costs associated with the disabilities that these benefits are intended to support (Department for Work and Pensions, 2003d: 99; also Lakin, 2003: 17). This point is further emphasised by Goodman et al. (2003) who note that: 'In the HBAI statistics, those who receive [extra] social security benefits due to disability, will appear better off than those who do not have such disabilities. If this extra income is given purely to cover the expenses for the extra needs that the disability generates – for extra care, transport and heating costs, for example – then the extra

money would not truly [improve their] living standards' (Goodman et al., 2003: 44). Further research would help in improving understanding of the impact of disability benefits on the living standards of different groups of older people.

While the evidence suggests that universal disability benefits are likely to contribute greatly to reducing the risk of income poverty in old age, older people vulnerable to forms of social exclusion may find aspects of the operation of such benefits more problematic. Studies have highlighted the complex nature of the claims process and the high degree of inaccurate decisions relating to claims. These factors are likely to impact most greatly on those older people who lack language and literacy skills, or who lack contact with the informal and formal sources of help that are often required to complete an application for disability benefits.

A longstanding issue over Attendance Allowance and Disability Living Allowance is the apparent discriminatory manner in which entitlement to these benefits operates in relation to age. Central to the critique of organisations such as Help the Aged and the Disability Alliance is the fact that the mobility part of Disability Living Allowance is not available to disabled people over 65 (Help the Aged, 2002a). There appears to be no logical reason why older people should be denied access to this form of support simply on the basis of age rather than the nature of their disability. Consideration might be given to removing this upper age limit, and bringing disability benefits closer in line with the earlier decision on Carer's Allowance. Such a move would inevitably have significant public spending implications. However, for older people vulnerable to social exclusion, help with mobility needs, could prove an important source of reintegration – for example by enabling access to transport.

Social Fund

Description of policy

The Social Fund was introduced in 1988 with the aim of providing a variety of forms of financial support to people on low incomes. The scheme is available to people of all ages. For older people, the Social Fund can be regarded as a potential supplement to other state benefits, such as Income Support (MIG), replaced by Pension Credit, Housing Benefit and Council Tax Benefit. Apart from crisis loans, payments from the discretionary social fund are only available to older people who receive Minimum Income Guarantee (since October 2003, Pension Credit).¹⁰

Scope of the Social Fund

There are two elements of the Social Fund that address older people's needs. One is a regulated component. This is designed to meet largely predictable events and encompasses **Winter Fuel Payments, Cold Weather Payments, Sure Start Maternity Grant** and **Funeral Payments**. Such payments are provided to individuals on the basis of a set of regulations. The second component is a discretionary element aimed at providing flexible support for individuals facing often unexpected needs. In turn, it comprises three types of support. **Community Care Grants** aim to promote independent living in non-institutional settings for vulnerable people. **Community Care Grants** provide financial support to ease exceptional pressures faced by families and help with some travelling costs. **Budgeting Loans** are available to meet the cost of one-off expenses that low-income households might otherwise find it difficult to budget for. **Crisis Loans** exist to meet expenses that arise in an emergency, and aim to prevent serious damage or risk to applicants' health and safety. Access to each of these three types of financial assistance is determined at the discretion of Department for Work and Pensions staff (see Rowe, 2002).

¹⁰ Introduction of Pension Credit has expanded access to the Social Fund, because loans are now available to people who receive savings credit only, as well as to those who receive the income guarantee element.

The regulated component of the Social Fund had a gross expenditure of £166 million in 2002-2003, plus £1.76 billion on Winter Fuel Payments. The discretionary component had a gross budget in 2002-2003 of £627 million. Excluding Winter Fuel Payments, in this period the fund's regulated and discretionary components provided payments worth over £820 million, with over four million awards made (Department for Work and Pensions, 2003i).

Research on the Social Fund

There is relatively limited evidence available on Social Fund use by older people. However, some useful insights appear in a recent study done for the Department for Work and Pensions (Kempson et al., 2002). This report draws on in-depth interviews with 37 older people in four different locations to examine reasons for take-up and non-take-up of discretionary Social Fund payments. There are some general studies of Social Fund use (Rowe, 2002) and several official documents (Department for Work and Pensions, 2001, 2003i; Social Security Select Committee, 2001), but despite its relatively limited scope, the report by Kempson et al. (2002) represents the main source used in the subsequent analysis.

Evaluating the success of the Social Fund

Together with Income Support (MIG), the discretionary Social Fund can potentially provide financial support at key moments of need to older people who are vulnerable to social exclusion on the grounds of low incomes. For example, a Budgeting Loan might help meet the one-off cost of a new refrigerator or cooker, while a Community Care grant could be used to pay for a move into sheltered accommodation. Concerning the introduction of the Universal Banking Services, older people who have difficulty in managing a bank account, may increasingly have to turn to the Crisis Loan system for short-term financial support (see page 44). An important indicator of the extent to which the fund is meeting older people's needs is therefore the number of applications and successful applications that there are.

Kempson et al. (2002: 8) cite analysis of take-up data to show that pensioners are significantly less likely to make use of the Social Fund than people from other eligible groups: 'In May 2001, 37% of all people eligible to apply to the fund were pensioners ... yet figures on Social Fund take-up show that pensioners accounted for only:

- 10% of expenditure on Community Care grants.
- 4% of expenditure on Budgeting Loans.
- 1% of expenditure on Crisis Loans.'

Older people's use of the loan schemes appeared to be especially low (Kempson et al.: 8). The most recent data on Social Fund take-up relate to the period 2002-2003. These suggest a continuation of the pattern identified by Kempson et al. (2002). In 2002-2003, 9.3% of Community Care grants expenditure, 4.7% of Budgeting Loans expenditure and 1.4% of Crisis Loans expenditure was paid to pensioners (Department for Work and Pensions, 2003i: 20; Annex 3).

There are several plausible explanations for the relatively limited use of the Social Fund by older people. These occur alongside issues identified more generally in relation to the lack of take-up of benefits by some groups of older people (see the Minimum Income Guarantee analysis on page 18).

A first difficulty, highlighted in research on the scheme as a whole, yet likely to act to the disadvantage of older applicants, concerns an apparent lack of openness about the distribution of Social Fund resources. As Rowe (2002: 21) suggests, despite the existence of directions concerning the way in which discretionary payments are made 'the way in which these operate is, in practice,

unknown, inequitable and not easily accounted for'. Drawing on interviews with Social Fund officers, Rowe (2002: 23) identifies the game played out by benefit claimants and gatekeepers: 'Those who know the rules and understand how to play within them will access funds'. The implication is that potential claimants who are unfamiliar with the rules of the game may have limited access to discretionary payments under the Social Fund scheme: 'For a scheme meant to be flexible, the Social Fund appears hostile and unresponsive to applicants' (Rowe, 2002: 23). Responding to such a critique, changes were made in August 2002 to the directions and guidance to local budget managers. These changes have ensured that budget loan applicants with similar personal circumstances should receive the same outcome regardless of where they live (Department for Work and Pensions, 2003i: 7).

Second, many older people are unaware of the existence of the Social Fund. This was one of the key weaknesses highlighted in the study undertaken by Kempson et al. (2002). Older people – even those receiving discretionary payments under the Social Fund – appeared to be unaware of the fund's existence. Those who were aware, were likely to have found out about the scheme by chance. There was also a lot of confusion about the scheme's operation. Some older people had applied for Budgeting Loans when a Community Care Grant might have been available (Kempson et al., 2002: 58). In this respect, the Select Committee on Social Security (2001) recommended the introduction of a rule that would have allowed a Community Care Grant instead of a Budgeting Loan if eligibility for the latter was proved after receipt of a loan. This recommendation was subsequently rejected by Government (Department for Work and Pensions, 2001: 7).

Third, take-up of the Social Fund may be limited by older people's reluctance to take on debt. This was a point highlighted by Help the Aged (2001) in their submission to the Select Committee on Social Security's review of the Social Fund, where they comment that: 'Older people are much less likely to have a credit card or overdraft, and may have less experience of loans and borrowing. For many there is still a great stigma attached to debt, and there is much anecdotal evidence that some older people would rather go without than get into debt'. Repayments under the loan schemes can account for much of an applicant's weekly income. According to Kempson et al. (2002), around half of Budgeting Loan applicants were making repayments that represented 15% of their Minimum Income Guarantee amount.

In contrast with applications made under the discretionary scheme, older people appear rather more likely to take-up payments made under the regulated Social Fund. In this respect, the Office of Fair Trading (OFT) inquiry into the funeral industry provides useful data on the Social Fund's Funeral Payment scheme. In 1999-2000, some 7% of total deaths (44,000 cases) were subject to awards under this scheme, with the average award being £866. The Office of Fair Trading reported that some funeral directors considered the £600 maximum payment (in 2001) to be too low and inadequate to meet the costs of the services they provided (Office of Fair Trading, 2001: 24). In response to this suggestion, and a recommendation of the Select Committee on Social Security (2001), this payment has – since April 2003 – been raised to £700 (Department for Work and Pensions, 2003i). Besides this sum, claimants are entitled to receive a contribution towards the costs of a grave and burial or cremation, the cost of doctor's certificates and reasonable transport costs. The impact of such additional costs raises the average Funeral Payment above the £700 figure. According to the most recent data, in 2002-2003 45,000 Funeral Payments were made through the Social Fund, with an average award of £929 (Department for Work and Pensions, 2003i: 18). Just over two-fifths of awards were made to pensioners (40.8%) (Department for Work and Pensions, 2003i: 19).

Winter Fuel Payments – delivered through the Pension Service – are also marked by high take-up levels. Introduced as a universal benefit in 1997, the Winter Fuel Payment forms a key component of the Government's commitment to end fuel poverty for older people by 2010 (see also review of Warm Front scheme on page 45). It is currently fixed at an annual £200 payment for households aged 60 to 79. Since the 2003 Budget, households including one or more people aged 80 or over, qualify for a higher payment of £300. In 2002-2003 Winter Fuel Payments were made to 11.3

million pensioners living in some eight million households (Department for Work and Pensions, 2003a). An estimated two million households were expected to receive the 80-plus payment in 2003-2004. While such payments are highly valued by many older people as an important addition to their incomes, there is cause to doubt the long-term effectiveness of the scheme in addressing the fuel poverty issue (Hewett, 2002) (see review of Warm Front scheme on page 45). As a universal benefit, the Winter Fuel Payment goes to all pensioners irrespective of their income or vulnerability to fuel poverty. As such, it is perhaps more useful to consider such a payment to be part of the state pension than a means of addressing the needs of older people who are fuel poor.

Cold Weather Payments aim to provide extra help with heating costs to people on low incomes who receive a range of means-tested benefits, including the Minimum Income Guarantee (Pension Credit). A Cold Weather Payment of £8.50 is made automatically to those who qualify when the average temperature is recorded as, or forecast to be, 0 degrees centigrade or below over seven consecutive days. The number and value of payments necessarily varies from year to year depending on weather conditions. While over 3.5 million payments were made to people of all ages in 2000-2001, the corresponding number was 1.68 million in 2002-2003 (amounting to £14.24 million) (Hansard, 16 December 2003: Column 871W). Such payments can provide an important boost to the incomes of pensioners during periods of prolonged cold weather. The fact that payment is made automatically without the need to apply, makes the system straightforward for recipients. However, the fact that receipt of Minimum Income Guarantee (Pension Credit) acts as a condition for accessing Cold Weather Payments means that those older people who fail to claim this benefit will lose out on the additional income. Also, Shenton (2002) makes the obvious point about Cold Weather Payments that they may not necessarily help to alleviate fuel poverty: 'The problem here is that payments are only made when there are severe weather conditions and are paid after expense may or may not have already been incurred. Fuel poor households however, may choose to spend this money on other essential items' (Shenton, 2002).

Conclusions: impacts of the Social Fund on the social exclusion of older people

There is limited evidence that the impact of the Social Fund reduces social exclusion among older people. In principle, the fund's discretionary component can provide the flexible type of support needed by older people faced with the difficulty of replacing expensive household items. Kempson et al. (2002: 38) report that Social Fund applicants most commonly used the fund to pay for white goods, beds and bedding, and floor coverings. The lack of affordability of such basic items indicates poverty, as shown in a series of scientific studies (for example, Gordon et al., 2000; Mack and Lansley, 1985; Scharf et al., 2002). However, given Kempson et al.'s (2002) finding that the level of need for Social Fund applicants and non-applicants was broadly similar, it is likely that many people vulnerable to exclusion are not receiving the support they are entitled to.

Drawing on the work done by Kempson et al. (2002), it is evident that many older people on low incomes are unfamiliar with the range of support potentially available through the Social Fund scheme. This is particularly evident in relation to the discretionary component of the fund. Kempson et al. highlight four strategies that could overcome the disproportionately low take-up of Social Fund awards by older people, including:

- increasing awareness and knowledge;
- overcoming the stigma of applying;
- overcoming communication difficulties; and
- reducing repayment levels for loans.

The Department for Work and Pensions Annual Report for 2002-2003 on the Social Fund suggests that consideration is being given to providing pensioners with 'easy and effective access to the Social Fund scheme through the Pension Service' (Department for Work and Pensions, 2003i: 11). While simplification of the application process is likely to prove beneficial for some older people, pensioners who are particularly vulnerable to social exclusion on low income grounds, are likely to benefit most from a strategy that moves away from loans towards a more transparent grants system.

In relation to particular groups of older people who have been highlighted as being vulnerable to social exclusion, the review of research on the Social Fund is inevitably limited. There is an absence of research that acknowledges the potentially different experiences of this particular scheme according to such characteristics as age, gender, ethnic background, health and disability, and place of residence.

There is also a wider agenda pertaining to the Social Fund and its potential role in promoting financial inclusion. In a recent study, the Institute for Public Policy Research and Citizens Advice argue for the need to transform the Social Fund into a social lender, maintaining the mix of grants and loans but expanding access and eligibility to loans and ending the cash limited nature of grants (Regan and Paxton, 2003). It would be useful to consider the impact of such a shift on the situation of older people.

Addressing financial exclusion of older people: Direct Payment and Universal Banking Services

Background

Exclusion from financial services and products represents a key component of social exclusion. At one level, such exclusion relates to a lack of access to basic financial products such as bank or building society accounts and savings or insurance products. Such exclusion affects both individuals and the communities in which they live. At another level, there is growing recognition of the exclusionary impact associated with individuals' lack of adequate information or knowledge about financial matters. These include financial products, the outcome of risk assessment done by financial organisations, the conditions attached by such organisations to their financial products, and the marketing strategies adopted by them (Carlton et al, 2003: 6).

In the mid-1990s, it was estimated that one and a half million households in Britain (7%) did not use any form of financial service. One in five households made use of only one or two financial products. People aged 70 and over were identified as one of the groups most likely to experience such financial exclusion (Kempson and Whyley, 1999). The fact that the proportion of people without a current account, insurance products or savings accounts is relatively small represents a key part of the financial exclusion agenda. McCormick et al. (2004: 94) argue that 'those who are outside the system are smaller in number than in the past, but the consequences are harsher and the prospects for inclusion without coordinated government action are slim'. Such exclusion has a disproportionate impact on low income households. In 2001-2002, one in six of the poorest households did not have any type of bank or building society account, which was four times the rate for households on average incomes (Palmer et al., 2003: 101).

Addressing financial exclusion is identified by Kempson and Whyley (1999: 2) as a key policy concern 'because the options for operating a household budget without mainstream financial services are more expensive and often unregulated. For communities with limited access to financial products, this process becomes self-reinforcing and is an important factor in social exclusion'. The impact of such exclusion on marginalised geographic areas was further highlighted in the Policy Action Team 14 (1999: 1) report on access to financial services: 'People in poor

neighbourhoods may make little use [of] financial services for reasons that are related to the area itself. Where crime rates are high, property insurance, both household and business, may be unaffordable. Remoteness from major commercial centres, and the withdrawal of financial service outlets from poor communities, may be factors in low income households' non-use of mainstream institutions'.

Financial exclusion and older people

Research suggests that some groups of older people may be especially prone to the experience of financial exclusion. For example, those aged 80 and over are disproportionately likely to lack a bank or building society current account (Financial Services Authority, 2000: 28). In their study of older people in deprived areas, Scharf et al. (2002: 100) report that 39% of those aged 60 and over had not used a bank or building society in the year preceding interview. Those belonging to some minority groups may also be disproportionately affected. In this respect, African-Caribbean, Pakistani and Bangladeshi households have been identified as being vulnerable to exclusion from financial services (Financial Services Authority, 2000: 21).

The National Institute of Adult Continuing Education (NIACE) has conducted a number of studies that examine the relationship of older people to financial issues. In its **It doesn't add up** report, Soulsby and Lee (2002) highlight several factors that suggest a need for developing educational programmes to improve older people's basic knowledge of financial matters. Key findings included:

- Financial issues are potentially complex for people of all ages, but older people may be unlikely to take full advantage of 'the financial benefits, services and concessions available to them. Lack of knowledge, advice and understanding of financial matters generally are important factors, but so are lack of confidence and trust, and the inhibitions of pride'.
- 'Older people need someone – whether a person or agency – that they can trust and older people prefer face-to-face meetings'. Given the existence of a highly fragmented financial services system, there is a need to provide older people with impartial and objective advice, guidance and information.
- 'The relationship between older people and those who provide financial services and utilities is not helpful. There is a perception that services have been created for younger people and the needs of older people ignored.'
- 'The increasing use of ICT for financial services may exclude older people but conversely it can be part of the solution in educational environments' (Carlton et al., 2002: 2f).

Description of policy initiatives to address financial exclusion

Recent government policy has sought to combine the dual aims of providing greater access to financial products for those on low incomes, while also increasing efficiency in the delivery of pensions and state benefits (Department for Work and Pensions, 2003c: 35). This latter aim is reflected in the Department for Work and Pensions' PSA target to 'make significant progress towards modernising welfare delivery so that by 2005, 85% of customers have their benefit paid into their bank accounts'. The key policy initiatives on financial inclusion are the Direct Payment and Universal Banking Services schemes.

The Direct Payment initiative aims to increase the proportion of people who receive pension and benefit payments by electronic means directly into a bank or building society account. Besides greatly reducing transaction costs, the Direct Payment scheme aims to cut down on benefit fraud, and help increase the number of people with bank accounts.

A broader aim of Direct Payment is to sustain the Post Office network, as identified in the Performance and Innovation Unit's (2000) **Counter Revolution** report. The PIU report identifies the central role played by post offices in both urban and rural communities. It also identifies ways in which the viability of the network can be secured. In this regard, income related to benefit payments represents a central component of the Post Office's resources, with the payment of social security benefits accounting for over a third (35%) of network income in 2000 (Performance and Innovation Unit, 2000: 4). The loss of such income is a major challenge for the Post Office network. Older and poorer people are the network's most frequent users, and are therefore crucial to sustaining a dense network of post offices (Postcomm, 2002). These groups are also the most acutely affected by the closure of Post Office branches (Postcomm, 2003: 67).

Since April 2003, direct payments into bank and building society accounts have become the normal method for paying benefits, pensions and tax credits. The aim is to phase out order books and girocheques over a two-year period, with the overwhelming majority of benefits paid into an account by 2005. A small number of people who are unable to manage a bank account will be able to make use of an emerging 'Exceptions Service'.¹¹

Most people who already have a bank account opt for their pensions and benefits to be paid directly into that account. A recent study suggests that only some 5% of those interviewed as part of a representative national study were unable to receive direct payments (Coleman et al., 2002: 72). In this context, nine out of ten pensioners already have a bank or building society account suitable for receipt of direct payments (House of Commons, 2003b: 7).

For people who don't have access to a suitable bank or building society account, the Universal Banking Services scheme has been introduced. Broadly, the scheme has adopted the central recommendations of a report published by the New Policy Institute (Donovan and Palmer, 1999). Universal Banking Services consists of two strands:

- The first strand has seen 17 major banks and building societies make their basic bank accounts available, free of charge, at Post Office counters from April 2003. Such accounts allow most transactions, including direct debits, but do not allow account holders to go overdrawn or to issue cheques (Financial Services Authority, 2003).
- The second strand is the introduction of the Post Office card account. This is designed to be a straightforward account specifically for the receipt of benefits, pensions and tax credit payments. Such accounts can be accessed at any Post Office. Account holders are issued with a card and Personal Identification Number (PIN), which are then used together to make withdrawals. This system means that benefit claimants are still able to collect cash at a Post Office branch if they wish. An extra feature of the Post Office card account is that people who are unable to collect their benefit payments themselves can access the account through a carer or other trusted person. In such cases, the carer can be issued with their own card and PIN to access the account.

The Direct Payment scheme is being phased in over a number of months. People are being invited to supply their account details as part of a rolling programme over a two-year period. A Customer Conversion Centre has been created which offers support and assistance to customers, helping them to decide on the account most suitable for their circumstances. The first invitations were issued in April 2003. People uncertain about how best to receive their pension and benefit payments, can continue receiving such payments through the traditional order book system until early 2005.

11 Chris Pond, Parliamentary Under-Secretary, in a Written Ministerial Statement announced on 11/5/04 that the very small number of our customers who cannot genuinely open or manage an account would receive a Cheque Payment. In his statement are the groups of customers likely to have to use it.

Research on Direct Payment and Universal Banking Services

The Direct Payment scheme and Universal Banking Services represent recent policies aimed at promoting financial inclusion of previously marginalised social groups. Consequently there is relatively limited research evidence relating to either scheme. Besides some useful academic analyses of issues associated with Direct Payment and Universal Banking Services (Coleman et al., 2002; Kempson and Whyley, 2001), the review draws on evidence from public sources (government departments, Hansard, Postcomm) and a range of voluntary sector organisations.

Evaluating the success of Direct Payment and Universal Banking Services

A key indicator of success for these schemes is the extent to which they have been taken up by potential customers. Payment of pensions and benefits directly into bank accounts was introduced in the early 1980s. The proportion of Department for Work and Pensions customers making use of such payments has increased steadily over time. In 1996, 26% of all customers used this payment method (House of Commons, 2003b: 7). By June 2002, this proportion had increased to 43%. In August 2003, an estimated 12.3 million customers (47%) received their pension and benefit payments by automated credit transfer (Department for Work and Pensions, 2003m: 223; Table 1). By April 04 the proportion of customers who received some or all of their benefits paid by Direct Payment is 69.9%. The proportion of customers who received all of their benefits by Direct Payment is 63.6%.¹²

Older people are as likely to use the Direct Payment scheme as younger age-groups are. Forty-seven per cent of pensioners (5.8 million people) received their benefits by such means (Department for Work and Pensions, 2003m: 223; Table 1). This proportion is higher among new pensioners; 60% of this group had opted for Direct Payment in 2002 (House of Commons, 2003b: 7).

It is too soon to judge the take-up of the Post Office card account. However, the number of older people opening such accounts has been increasing in recent months. The most recent Postcomm report suggests that of claimants responding to an initial letter sent by the Department for Work and Pensions to over 3.2 million customers, by end of June 2003 '14% (nearly 290,000) of child benefit recipients had requested a card account. Also making such a request were 50% (74,000) of pensioners, and about 40% (nearly 47,000) of Jobcentre Plus customers. The remaining respondents gave bank account details, including accounts which can be used at a Post Office' (Postcomm, 2003: 6).

Customers receiving payment into an account are now the majority. There is a lot of work to be done to achieve the target of paying 85% of customers by direct payment in 2005, but the programme is on schedule to deliver the PSA target and is likely to exceed it.

Some older people seem likely to prove resistant to the change to direct payments. In their survey, Coleman et al. (2002: 74) showed that around two thirds of those of pensionable age would be willing to have their state pension paid directly into an account. This leaves about a third who might be unwilling to accept direct payments.

Kempson and Whyley (2001) have studied the characteristics of benefit recipients who were not paid by Direct Payment. Their study, based on a large-scale survey, sought to examine potential customer concerns about a move to Direct Payment. While the overwhelming majority of customers were likely to prove amenable to the shift to Direct Payment, the research identified two relatively small groups who were likely to prove highly resistant to change:

12 Latest DWP data, personal communication.

- A group who already hold a suitable account but are unlikely to be persuaded to have their pensions or benefits paid into it. This group, representing around 6% of customers, were described in the research as being 'very elderly' and as having 'tenuous links with banking'. The group 'found it difficult to access bank and building society branches, had a strong preference for operating a cash budget and a deep-seated objection to being paid by [Automated Credit Transfer]'.
- A group who do not have a bank or building society account and are unlikely to open one to receive their benefit or pension. Four per cent of customers fell into this category. According to the research: 'These people had a low level of mobility and a reliance on benefits as their sole source of income' (Kempson and Whyley, 2001).

In relation to the concerns of older people, Kempson and Whyley (2001) showed that pensioners were generally keen to maintain Post Office access to their pensions and benefits, and wished to retain the ability to collect their money weekly. The Direct Payment scheme introduced in April 2003 has sought to meet each of these points.

Some – largely technical – difficulties have been identified in the early stages of introducing Universal Banking Services. Many of these relate to the operation of the Post Office card account scheme. Some organisations have drawn attention to the potentially off-putting bureaucratic procedure associated with opening such an account (National Pensioners Convention, 2003: 2), with some suggesting that this reflects a Government preference for people to open basic bank accounts. While consumer groups and Postwatch identify eight steps that claimants need to take before it is possible to operate a Post Office card account, the Department for Work and Pensions suggests that only three steps are involved (Postcomm, 2003: 15). Government data suggest that two million people have 'managed to get through that very difficult maze to open a Post Office Card Account, well in advance of the 2005 deadline' and that 'these figures disprove the suggestion that we are trying to discourage people.' (Hansard, 7 January 2004: Col. 109WH). However, it is evident that those with potentially limited knowledge of financial services are likely to find parts of the Post Office card account scheme confusing.

Other criticisms arise from the speed with which the Direct Payment initiative has been implemented. The House of Commons Trade and Industry Committee commented that 'there remains a significant number of people for whom the traditional system of payment by means of the order book is the best option. This includes many elderly or disabled people, for whom the prospect of opening an account of any sort presents difficulties and anxieties. It also includes those customers who rely on weekly cash payments as an integral part of their budgeting. We do not feel that the Government took the needs of these people and the impact of a change in policy properly into account before Direct Payment was introduced' (House of Commons, 2003b: 3).

An outcome of the shift to Direct Payment has been that procedures for a variety of individual circumstances and needs have yet to be fully developed. This creates difficulties for a significant minority of older people. For example, present arrangements for the non-regular withdrawal of funds from Post Office accounts have been judged by a range of organisations as unsatisfactory. People who are unwell for a short period, or – as is increasingly common – those who are housebound and have a number of different carers, are likely to experience difficulty accessing their pensions and benefits since the current system only takes account of the needs of individuals with a main carer (Postcomm, 2003: 17). This issue is being taken forward by organisations such as Age Concern (2003), and in discussions between DWP and customer representative groups.

The arrangements for those older people who forget their PIN numbers is likely to represent a particular concern. Currently, users of the Post Office card account system can have three attempts to key in their PIN before their card is withheld (for obvious security reasons). Since it can take several days¹³ before the card and a new PIN are reissued, some older people may face severe, short-term financial hardship. While the option of applying for a Crisis Loan from the Social Fund is available to people facing such a situation, it remains unclear whether those who have difficulty managing a Post Office card account will be able to negotiate their way through the process of applying for a Crisis Loan.

A further difficulty concerns the development of the Exceptions Service for those people who are unable to manage a bank account. The introduction of the Direct Payment scheme has proceeded before precise details of the Exceptions Service have been publicised. This has led to 'uncertainty and confusion over the means by which some groups of disadvantaged people will receive their benefits in future' (House of Commons, 2003b: 31). While the Government is maintaining its commitment to phase out order books in 2005 (Hansard, 7 January 2004: Col. 110WH), it remains unclear what will happen to the 15% of Department for Work and Pensions who will need to be treated as 'exceptions' should the department meet its PSA target. This is a key issue in relation to the financial exclusion agenda, since the exceptions service is likely to be used by some of society's most vulnerable groups. According to Postcomm, such a service 'needs to cater for people who may not be familiar with banking and for vulnerable people for whom [the shift to Direct Payment] may be a major and challenging change, for example, very elderly people or those suffering from mental illnesses making employment difficult' (Postcomm, 2003: 17). Organisations such as Help the Aged have identified the lack of detail about the Exceptions Service as being a central weakness of the Direct Payment scheme, which it otherwise supports (Help the Aged, 2004).

Conclusions: impacts of policy initiatives relating to financial exclusion on the social exclusion of older people

In summary, recent government policy on promoting financial inclusion has focused mainly on providing previously marginalised individuals and groups with access to basic financial products. While acknowledging the benefits linked to securing access to financial services concerning promoting social inclusion, it is evident that the overriding aim of policy has been to reduce the transaction costs associated with the payment of state pensions and benefits.

The speed with which Direct Payment and Universal Banking Services have been introduced has created difficulties for potential customers of these services. Particular concerns affecting older people involve the lack of clarity concerning the emerging Exceptions Service and issues linked to the collection of funds from accounts by third parties. Many of these issues have now been resolved, or are under discussion.

While the Payment Modernisation Programme is likely to achieve its aim of greatly increasing the proportion of people with access to a basic account, the mechanisms for promoting financial literacy among this group are relatively limited. People with relatively limited knowledge of managing a bank or building society account are likely to benefit from a range of schemes designed to improve on their financial skills. This is a message that is made powerfully in recent studies from the National Institute of Adult Continuing Education (Carlton et al., 2002; Soulsby and Lee, 2002) and the Institute for Public Policy Research and Citizens Advice (Regan and Paxton, 2003).

13 The Service Level Agreement states that the replacement of cards and PINS is to be made within four days.

Addressing fuel poverty among older people: Warm Front

Background

Using an official definition, fuel poverty is said to occur when a household needs to spend 10% or more of its income on fuel in order to maintain satisfactory heating and other energy services. There are estimated to be over four million households in the UK currently experiencing such fuel poverty. Help the Aged (2003: 2) suggest that half such households contain an older person. The Government's Fuel Poverty Strategy seeks to end fuel poverty among vulnerable households by 2010 and to end fuel poverty completely by 2016. A key component of this strategy is the Warm Front scheme. It is included in the analysis here to reflect the close link between fuel poverty and income poverty for vulnerable households. This is also reflected in the take-up mechanisms of the Warm Front scheme, which seek to target low-income households that receive means-tested benefits.

Description of policy

The Warm Front scheme was established in June 2000, to replace the previous Home Energy Efficiency Scheme (HEES). Originally called 'new HEES', it was rebranded 'Warm Front' for marketing purposes in February 2001.

The aim of Warm Front is to improve energy efficiency for vulnerable households in fuel poverty, in the private rented and owner occupied sectors. The scheme provides grants of up to £1,500 for insulation, energy efficiency measures and heating improvements. Warm Front plus is an extension of the scheme available to the over 60s which also covers the installation of central heating and has a grant maximum of £2,500.

Scope of Warm Front

Warm Front grants are available to private rented and owner-occupied households in receipt of specific benefits. The over 60s are eligible if they receive either means tested benefits (Minimum Income Guarantee, Housing Benefit, Council Tax Benefit), or disability benefits (Attendance Allowance, Disability Living Allowance, Industrial Injuries Disablement Benefit or War Disablement Pension).

Fuel Poverty among those living in social housing is being addressed through programmes to improve the quality of social housing and by programmes provided as part of the Energy Efficiency Commitment negotiated with energy companies. These schemes are not considered in the following discussion.

Warm Front is overseen and funded by the Department for Environment Food and Rural Affairs (DEFRA) and has an annual expenditure of around £150 million a year. The scheme is administered on behalf of the Department by two scheme managers – the EAGA partnership and Powergen Warm Front Ltd (formerly TXU Warm Front Ltd).

DEFRA has a Public Service Agreement to improve the energy efficiency of 600,000 homes between 2001 and 2004. The Fuel Poverty Strategy aims to assist 800,000 households through the Warm Front scheme by 2004. The Department requires that around 60% of Warm Front grants go to the over 60s.

Warm Front grants are distributed on a first-come-first-served basis on application by the householder. Warm Front Scheme Managers are encouraged to carry out marketing work and make efforts to target potential recipients.

Research on Warm Front

The National Audit Office (2003d) has recently carried out an investigation into the work of Warm Front. It has been assessing how well Warm Front is meeting the Government's objectives on tackling fuel poverty. However there seems to be no evidence available as yet on Warm Front's wider impact on older people's lives. Government commissioned research on the health effects of the Warm Front programme was due in late 2003.

Also due in 2003 were the interim results of an evaluation of the pilot Warm Zones schemes. The schemes are bringing together different local projects to tackle fuel poverty with a target to reduce fuel poverty by 50% overall and end severe fuel poverty (where 20% of total income is spent on fuel) completely.

Evaluating the success of Warm Front

As noted above, the Government's target is to end fuel poverty among vulnerable households by 2010 and to end fuel poverty completely by 2016. A household is defined as in fuel poverty if, in order to maintain a satisfactory heating regime, it is required to spend more than 10% of income on all household fuel use. There are two sub-definitions. The first considers income to include all benefits. The second, which is sometimes necessary for comparison, considers income excluding housing benefit and income support for mortgage interest.

According to figures from the National Audit Office (2003d), 40% of fuel poor households are households with one person over 60, another 13% comprise couples over 60.

There has been a reduction in fuel poverty in recent years, but the Government has acknowledged that this is largely due to increases in income and reduction in fuel prices, rather than the effect of the Warm Front programme. Older people's incomes have been increased by a range of measures, in particular the Minimum Income Guarantee and the Winter Fuel Payment. In this respect, Hewett (2002) argues that recent government energy policy has focused too heavily on raising older people's incomes as a means of addressing fuel poverty rather than on tackling inadequacies in the housing stock: 'a much greater effort is being devoted to the income side of fuel poverty than the investment in insulation. The annual bill for the Winter Fuel Allowance to pensioners is £1.7 billion, whereas the already increased budget for the Home Energy Efficiency Scheme is currently £200 million. Without denying the social benefit of the Winter Fuel Allowance of £200 for every pensioner, there does appear to be an imbalance of Government spending towards short term income support above investment in the building infrastructure' (Hewett, 2002: 12).

According to the Government's First Progress Report on the Fuel Poverty Strategy, the Warm Front Scheme is on course to meet targets for the number of households benefiting. Between April 2001 and December 2002, 470,000 households received Warm Front grants. In 2002 alone, 303,000 households were helped by Warm Front, and the average grant was £445 and the average potential fuel saving per household was £150 a year. In 2001-02 Warm Front grants improved the energy efficiency of recipients' homes by 13 points on average (Department for Environment, Food and Rural Affairs, 2003).

Beneficiaries of the Warm Front scheme report good levels of satisfaction. Ninety per cent report being satisfied and 95% say they would recommend the scheme to a friend. However, the literature suggests that, while the Warm Front scheme has the potential to reduce fuel poverty, it is not currently making as much of an impact on the fuel poverty problem as it might. The National Audit Office (2003d) considers the main problems with the scheme to be that:

- there are problems with the match between eligibility for the scheme and fuel poverty. Around a third of the fuel poor may be ineligible and up to two thirds of eligible households may not be fuel poor;

- the heating and insulation measures available under the Scheme may be insufficient to move households out of fuel poverty in at least 20% of cases;
- only 14% of grants reached the least energy efficient homes and there is limited targeting of grants towards those households in greatest need.

Problems arise because Warm Front grants are distributed on the basis of receipt of certain 'passport' benefits, rather than on assessment of whether the household is in fuel poverty. This means that some households that are in fuel poverty may not be eligible, while other households not in fuel poverty will be.

Research carried out in the Warm Zones pilot areas showed that some 30% of those in fuel poverty were not eligible for the Warm Front scheme, while research carried out by Warm Front scheme manager TXU concluded, more pessimistically, that some 60% of those in fuel poverty were ineligible.

The group of ineligible but fuel poor households can be split into three main categories:

- Those who **ought** to be eligible for Warm Front grants, but are not claiming benefits for which they are eligible, which would passport them to Warm Front. Scheme Managers found that some 20% to 40% of non-recipients fell into this category. This finding has led the Fuel Poverty Advisory Group to call for the Warm Front programme to include benefit health checks.
- Those who are not considered 'vulnerable' – for example those near the benefits level, but not within it – including pensioners with small private pensions. Age Concern England (2001) report that 60% of single pensioner households are fuel poor, but only 47% are on means tested benefits, leaving a significant number without help from Warm Front. The National Audit Office (2003d) point out that the introduction of the Pension Credit could assist this group by bringing more into means-tested benefit. The National Audit Office and the Department for Environment, Food and Rural Affairs estimate Pension Credit may make a further 300,000 older people eligible for the Warm Front scheme.
- Those who have very high heating costs – especially those living in homes which are hard to heat. The Fuel Poverty Advisory Group conclude, 'fuel poverty is as much or more property than income related' and recommend that measures should be retargeted on property rather than income.

Conversely some households that are not fuel poor may be eligible for, and receiving benefits from, the Warm Front scheme. The Fuel Poverty Advisory Group estimate that about half of those benefiting from the Warm Front programme are not fuel poor. The National Audit Office (2003d) takes the more pessimistic view that only 30% of Warm Front grants reach those in fuel poverty. There are two main reasons for this:

- some of the benefits that passport to Warm Front are not means tested and therefore those in receipt of them may not be fuel poor;
- because the scheme makes no assessment of the energy efficiency of the households it benefits, some of those receiving grants may already have efficient homes and low heating costs.

In order to meet the Government's targets for reducing fuel poverty, the National Audit Office (2003d) report that 90% of Warm Front grants would need to reach those in fuel poverty.

The National Audit Office (2003d) found that, in at least a fifth of cases, the improvements made by Warm Front were not sufficient to lift recipients out of fuel poverty. More pessimistically, the Fuel Poverty Advisory Group estimates that, of the 200,000 people helped by Warm Front every year, only 40,000 are taken out of fuel poverty.

The problems associated with the scheme can be divided as follows:

- **Warm Front does not provide the right kind of measures to tackle fuel poverty:** Both the National Audit Office (2003d) and Age Concern England point out that the Warm Front scheme is of limited value to those in 'hard to treat' properties – for example those without a gas supply or with solid walls. That is because Warm Front does not cover external wall insulation, covers only basic connection to a nearby gas supply and cannot provide alternative forms of central heating – for example oil fired. However, 25% of those in fuel poverty are not on mains gas and 44% of fuel poor homes have solid walls. The scheme is also limited by the fact that it provides only 'like for like' replacements, even when these are not the most efficient. However, in some cases this problem is overcome by bringing in funds from the Energy Efficiency Commitment. Both Age Concern and the National Audit Office (2003d) also point out that the scheme cannot help those whose heating systems are inefficient due to malfunction or which fail intermittently. That is because the system has to be completely broken to be eligible for replacement.
- **Warm Front does not provide enough to tackle fuel poverty:** The National Audit Office (2003d) point out that in 3% of cases the costs of measures provided under the Warm Front scheme exceed the grant ceiling. They also point out that this may represent an underestimate of the problem as many more may choose not to take the full package offered so as to avoid paying the top-up costs. This inflexibility can limit the effectiveness of the scheme. For example, a household may be assessed as needing central heating and insulation, but if the grant will not pay for both they are likely to take only the central heating. However without insulation this may be expensive to run and therefore not reduce the household's fuel poverty. Costs may be particularly high where properties are in the 'hard to treat' category, and yet as discussed, fuel poverty levels are high in these properties. However, whenever possible, the scheme managers try to minimise the percentage of customer contributions by covering the cost of works through other funds.

Both the National Audit Office (2003d) and ACE suggest that, no matter what the success of Warm Front is, other factors may also affect fuel poverty – for example, incomes changes and changes in fuel costs. ACE contend that the fuel poverty problem cannot be solved by energy efficiency measures alone. They argue that an area based approach to fuel poverty – such as that taken by Warm Zones – is likely to be more effective in tackling fuel poverty.

The only target for how Warm Front grants should be distributed, beyond the eligibility criteria, is the requirement that 60% of grants should go to the over 60s. However in 2002 only 49% of grants reached this group and the National Audit Office (2003d) recommend that DEFRA take action with Scheme Managers to ensure that this target is met.

The National Audit Office (2003d) also note that the lack of other mechanisms to target the most needy in fuel poverty or home energy efficiency terms, means that the funding allocated to Warm Front may not be being spent most effectively.

There is no assessment of the existing efficiency of the home. The scheme works on the basis of providing eligible households with whatever measures are not already in place, regardless of likely impact on energy efficiency. However, before offering measures, the property's insulation and heating need is assessed and appropriate measures are recommended. Because of this, many Warm Front grants go to homes that are already efficient and many grants provide only small-scale measures, which have little or no impact on home energy efficiency.

The National Audit Office (2003d) report that in 2001-02:

- Twenty per cent of Warm Front grants led to an improvement of between 0 and 1 point on the SAP (Standard Assessment Procedure) rating. Fifty per cent led to an improvement of between 0 and 10 SAP points.
- Twenty per cent of cases received only draught proofing and light bulbs – neither of which improve the household's SAP rating. Expenditure on these measures accounted for 9% of total expenditure.
- Thirteen per cent of homes helped by the scheme had a SAP rating of over 60 points. £8 million was spent on these households. Eighty-six per cent of grants went to those with a SAP rating of over 20 points.

The National Audit Office (2003d) report a disproportionate focus on the distribution of urban household grants. They describe this as being due to the greater ease with which eligible households in urban areas can be identified. While there is limited data on exact distribution, figures from Eaga suggest only 5% of their grants went to rural households. Their findings come despite the fact that 28% of the fuel poor live in rural areas and 12% of households in rural areas are fuel poor compared with 8% in urban areas. However, Scheme Managers are now taking some initiatives to promote Warm Front in rural areas – for example accompanying health workers and taking buses out to villages to promote the scheme.

Problems also result from the fact that the scheme is run on a first-come-first-served basis, and there is no official mechanism for prioritising the most needy or urgent cases. The National Audit Office (2003d) report instances of Scheme Managers using their discretion to do this, but recommend that this system should be formalised.

The Government's First Annual Report on the Fuel Poverty Strategy acknowledged that Warm Front had got off to a slow start after its launch in June 2000. However, it is now on course to meet targets.

The success of Warm Front has been hindered by a skills shortage in the trades required to carry out work. This has led the Government to encourage Warm Front Scheme Managers to stimulate training of new tradesmen through the scheme.

The normal target for carrying out heating work is 120 working days and for insulation work it is 40 days from the time of the survey. Around half the jobs completed by the Warm Front scheme currently fall behind completion targets. These long waiting times exacerbate the problems caused by the lack of prioritisation.

Conclusions: impacts of Warm Front on the social exclusion of older people

Whilst it is widely accepted that fuel poverty damages people's quality of life and health, the fuel poor suffer more illnesses such as influenza, heart disease and strokes. There is also an increased risk of winter death among those in fuel poverty. However, there is no research currently available to assess the impact of the Warm Front scheme specifically on these issues.

However older people who are living in fuel poverty, are receiving the relevant passport benefits and those whose homes are suitable for the kind of measure offered under the Warm Front scheme (in other words are on mains gas, or have cavity walls etc), theoretically should have more efficient homes as a result of the scheme. They should therefore be benefiting from increased disposable income, or a more comfortable and healthy living environment or both.

However, those who are not eligible, because they are not claiming benefits or because their incomes just exceed benefit levels, and those whose homes are not suited to the measures offered by the scheme, may still face the problems associated with fuel poverty.

In summary, the review of research on the Warm Front programme gives rise to a number of areas for policy development:

- there are evidently some problems with the targeting of the scheme, and further refinement would help to ensure funds are targeted on those most in need and that higher risk cases can be prioritised;
- consideration should be given to making the scheme more flexible in order for it to meet the needs of older people living in 'hard to treat' housing;
- benefits health checks are being conducted on a trial basis. They should usefully complement the scheme both by increasing the number of people eligible for the scheme and, via improved incomes, by contributing to the fight against fuel poverty. The introduction of the Pension Credit should improve the position of those pensioners who have small private pensions previously above benefits levels;
- further research would help assess the health and other effects of reducing fuel poverty and improving energy efficiency.

Detailed discussion on the future of Warm Front will be set out in the Fuel Poverty Implementation Plan. This will consider options for targeting, eligibility and the effectiveness of measures in response to the Public Accounts Committee and the National Audit Office reports. The final version of this plan will now be issued after the Spending Review in Summer 2004.

Summary: the impact of policies relating to income in reducing social exclusion of older people

The review of policies on income is to be summarised in this section by examining the impact of such policies on older people who are potentially vulnerable to social exclusion. Some themes, arising from the literature review, that cut across a range of policies are also explored.

A concern with tackling poverty lies at the heart of a range of policy measures on income. In this respect, the proportion of pensioners experiencing relative poverty, defined as receiving less than 60% of median household income (before and after housing costs), represents a key indicator of the relative success of such policies in recent years. Current trends in older people's experience of poverty should be viewed in the context of a steady rise in pensioner poverty through the 1980s. Since the beginning of the 1990s the proportion of older people experiencing low incomes has tended to fluctuate.

The impact of income maintenance policies can be judged by examining evidence on the three low-income indicators highlighted in the annual **Opportunity for All** reports (Department for Work and Pensions, 2002, 2003c):

- the proportion of pensioners living in households with relative low incomes;
- the proportion of pensioners living in households with low incomes in an absolute sense;
- the proportion of pensioners living in households with persistent low incomes.

Taking the relative low-income indicator, the evidence on trends in pensioner poverty since 1996-97 is mixed. Much depends on whether household incomes are measured on a before or after housing costs basis. On the after-housing costs measure, the percentage of pensioners living in low-income households has fallen from 27% in 1996-97 to 21% in 2002-2003. The before-housing costs measure shows little variation over this period. In 2002-2003, 21% of pensioners were defined as poor using this measure – the same proportion as in 1996-97 (Department for Work and Pensions, 2004b: 114). These differing trends in the household incomes of pensioners reflect the impact on older people's incomes of means-tested benefits. Since before-housing cost income includes both Housing Benefit and Council Tax Benefit, any increases in rental or council tax costs perversely result in a higher household income, even though the recipient will be no better off financially. By contrast, a growing proportion of older people who own their homes outright – representing 61% of people aged 65 and over in 2001 – will have very low housing costs. Therefore they will be higher up the income distribution after taking account of housing costs rather than before-housing costs.

Government estimates show that in 2002-03, the latest year for which data are available, around 2.2 million pensioners were living in households with below 60% of median household income on before and after housing costs bases (Department for Work and Pensions, 2004b: 115).

On the absolute low income measure – defined in relation to pensioners' median income fixed at 1996-97 levels in real terms – the evidence is clearer. On both before and after housing costs bases, the proportion of pensioners with absolute low incomes has declined greatly. After-housing costs, the respective proportion declined from 27% in 1996-97 to 11% in 2001-02 and to 9% in 2002-03 (Department for Work and Pensions, 2004b: 114). This measure shows the impact on pensioner incomes of such policy measures as the Minimum Income Guarantee and above-inflation increases in the value of the State Retirement Pension.

The third income measure against which the relative success or otherwise of income maintenance policies can be judged, concerns pensioners with persistent low incomes. They are defined as having lived in a household with a low income in at least three years out of a four-year period. Here too, the evidence is mixed. The proportion of pensioners with persistent low incomes has fluctuated between 16 and 18% since the early 1990s. For the period 1998 to 2001, the relevant proportion was 18% (Department for Work and Pensions, 2003c: 200). It should be borne in mind that the latest data for measuring persistent low income covers the period 1998 to 2001. That was before the largest increases in the value of the Minimum Income Guarantee came into force.

Taking the three poverty measures together points to a persisting problem of poverty affecting a significant proportion of older people in England. The absolute low income measure is useful in providing evidence of real terms increases in pensioner incomes since 1996-97. But the relative poverty indicators point to a continuing gap between pensioner incomes and those of the population as a whole. Between a fifth and a quarter of pensioners are currently living in low income households, depending on whether a before or after housing costs measure is used. Around 18% have persistently low incomes. Also, the proportions experiencing relative low income have altered relatively little in recent years. This can in part be attributed to the strength of the national economy in recent years. During times of economic growth, median incomes can rise rapidly, making it difficult for those who have left the labour market, to keep pace financially. In estimating that median income has grown by 2.6% a year since 1997, the Brewer et al. (2004: 2) make the point that: 'Pensioners are also continuing to become richer relative to the rest of the population. For the first time in almost 20 years, a pensioner drawn at random from the population is less likely to be in poverty than a non-pensioner, measuring incomes [after housing costs].' Even so, in terms of achieving social inclusion, one can argue for the need to maintain the living standards of older people compared with those of the population as a whole. In this respect, policies such as the Minimum Income Guarantee and above-inflation increases in the State Retirement Pension have been important in contributing towards a stabilisation of the proportions

of older people experiencing relative poverty. The Pension Credit system, introduced in October 2003, is slightly more generous than the Minimum Income Guarantee and is likely to maintain the trend towards a stabilisation/reduction of pensioner poverty.

Research shows that some groups of older people continue to be disproportionately affected by low incomes. Indeed, the groups who have historically been most acutely affected by poverty are still those most likely to live in low income households. This includes single female pensioners, people aged 75 and over, those belonging to black and ethnic minority groups, and older people living in deprived urban and rural communities. The reasons for such poverty tend to be structural and are consequently less amenable to change in the short-term. The big investment made by government in alleviating pensioner poverty in recent years has succeeded in lifting a considerable proportion of those on the margins of poverty out of this state. However, there is a large, 'hard to reach' group of older people whose daily lives are still blighted by the experience of poverty.

Take-up of the Minimum Income Guarantee (now Pension Credit) and other means-tested benefits is a further important indicator relating to the success of government policy. While the Department for Work and Pensions has taken a number of important steps in recent years to improve take-up of the Minimum Income Guarantee, Housing Benefit, Council Tax Benefit, Attendance Allowance, Disability Living Allowance and the Social Fund, research suggests that low take-up continues to be an issue. This equally applies to schemes such as Warm Front. It is also evident that take-up rates vary, often a lot, between the various benefits. Therefore, while Housing Benefit is claimed by around nine out of ten entitled pensioners, the corresponding proportion for Council Tax Benefit is under seven out of ten. Given the positive impact of the receipt of such benefits on household income, more clearly needs to be done to ensure that vulnerable households receive their full benefit entitlements.

There are particular concerns about key groups within the older population who are less likely to claim benefit entitlements than others. According to the National Audit Office (2002a: 26), this includes those in the oldest age groups – who are disproportionately women – people belonging to black and ethnic minority groups, and those with disabilities. There are also geographic differences in benefit take-up, with older people in rural areas and those in deprived urban areas less likely to pursue a benefit claim (National Audit Office, 2002a: 26). Encouraging take-up within these groups is essential, since they are also the groups most likely to be prone to other forms of social exclusion. An important step towards addressing some of these issues has already been taken by the Department for Work and Pensions in its recently published qualitative study exploring the delivery of benefits and services for black and ethnic minority older people (Barnard and Pettigrew, 2003). This study should be viewed alongside the earlier National Audit Office (2002a) analysis which highlights practical steps that could be taken to increase take-up rates.

There is now sufficient evidence available to show what works in terms of increasing benefit take-up among older people. Policy should now consider how best to translate this evidence into a series of practical steps that target those whose lives would be improved most by an increase in their benefit income. The emerging Third Age Service might play a useful role with this. Given many older people's preference for face-to-face contact with welfare professionals, there is also scope to develop a system of personal advisers who could address some of the complex issues faced by older people in negotiating their way through the benefits system. This occurs already for younger people through the Connexions service).

The review shows that significant progress has been made in recent years on the administration of policies related to income. The procedures governing the operation of most state benefits have been streamlined and claim forms simplified. Direct Payment of pensions and benefits holds the potential of improving the ability of older people to manage their finances independently and in a dignified way. However, there are also shortcomings in such bureaucratic procedures that are likely to have a disproportionate impact on those prone to social exclusion. For example, the introduction of Direct Payments and the Universal Banking Service has occurred without sufficient

consideration being given to the specific needs of those who are unable to manage a bank or building society account. The Social Fund has retained much of its complexity, and is as a result not as well used by vulnerable older people as it should be.

2:2 Policies relating to health and social care

Introduction

This section brings together a range of policies falling under the broad heading of health and social care. These may have direct and indirect implications for tackling social exclusion in relation to the three drivers of age-related, cumulative disadvantage and age-based discrimination. Community care policies are especially important in relation to the first of these, tackling a range of problems affecting older people that may cause social exclusion of some kind or another. Cumulative disadvantage is also acknowledged in that some services, for example Care Direct, may address concerns about the under-use of services due to lack of awareness and/or low expectations. Confronting ageism is now an important feature of health and social care and is given particular prominence in the National Service Framework for Older People.

Community care policies and social exclusion

Background

Community care may be seen as an important component of policies designed to combat social exclusion. It has a direct role in assisting the participation of older people in mainstream social activities, notably through promoting access to a wide range of supportive services-informal as well as formal. Community care policies are also charged with an explicit commitment to tackle age-discrimination and to maximise the involvement of users in the design and management of care packages. The starting point for considering this strand of policy is the White Paper **Caring for People**, published in November 1989. This document laid down principles – subsequently codified in the 1990 National Health Service and Community Care Act – which may be seen as central to the task of assisting social integration in late life (Hughes, 1995). These principles were built around the themes of **home, choice** and **independence**.

On the concept of home, the main aim of community care policy was described as ‘enabl[ing] people to live as normal a life as possible in their own homes or in a homely environment in the community’ (Department of Health, 1989, 1.8). Choice was also seen as fundamental to the new approach to community care, with a commitment to providing both users and carers with more say in how they lived their lives and the services they needed, through the explicit aim of providing services ‘that allow a range of choice for consumers’ (Ibid. 1.10). The final element was the promotion of independence, expressed in the White Paper as ‘...provid[ing] the right amount of care and support to help people achieve maximum possible independence, and by acquiring or requiring basic living skills, to help them to achieve their full potential’ (ibid, 1.8).

Description of community care policies

The major objective of Government of policy in the field of community care remains that of ‘promoting community-based alternatives to residential care and enhancing the independence of service users’ (Henwood, 2000: 15). This approach has been extended and refined through a range of legislation and policy documents through the 1990s and beyond. Some of the most significant of these may be listed as follows:

- 1995 Carers (Recognition and Services) Act (provided the right for carers to have their own assessment of need).
- 1996 Community Care (Direct Payments) Act (cash instead of social services for disabled people of working age, first introduced in April 1997 and extended to older disabled people in 2000).
- 1997 Better Government of Older People (formed to stimulate improvements in services for older people).
- 1998 White Paper *Modernising Social Services* (emphasised need to 'promote people's independence while treating them with dignity and respect at all times, and protecting their safety'). Introduction of Partnership Grant (£647 million) 'to foster partnership between health and social services in promoting independence as an objective of adult services'.
- 1999 Health Act (introduction of range of new 'flexibilities' to promoting joint working between health and social care agencies with use of pooled budgets, lead commissioning and integrated providers).
- 2000 NHS Plan (upgrading of partnership flexibilities from optional to mandatory status).
- 2001 National Service Framework for Older People (sets out national standards and service models).
- 2001 Promoting Independence Grant (replacement of Partnership and Prevention Special Grants). Objectives of the grant (£296 million in 2001-02) include 'developing services to enable people to live independently and promote their social inclusion' (Department of Health).

These policy developments reflect important shifts of emphasis in community care in the 1990s including:

- attempts to encourage 'low-level' support to people at risk of losing their independence (as reflected in the Partnership and Prevention Grants);
- initiatives aimed at encouraging users to have more control over the services they receive (Direct Payments being one such example);
- various initiatives to strengthen support for informal carers, notably the 1995 Carers Act and the 2000 Carers and Disabled Children Act (which included Direct Payments being made available to carers).

Scope of community care policies

Financially, support in the community to older people is a major area of expenditure for central and local government. Spending on Personal Social Services for Older People in England was £6.2 billion in 2001-2002, with charges to clients recouping just over a quarter of the total. The main expenditure was for residential provision (£3,730m), day and domiciliary provision (£1,890m) and assessment and care management (£560m).

Modelling of expenditure in long-term care in all categories (NHS, PSS, user fees etc) by the Personal Social Services Research Unit (PSSRU) (Table One) confirms the significance of this area, with a projected increase of £9.8 billion in overall expenditure in 1996 to £24.3 billion in 2031 (cited in Henwood, 2001).

Table 1: Expenditure in long-term care for older people by source: 1996 figures and projections from the PSSRU long-term care financing model (billions of pounds)

Expenditure Source	1996	2000	2010	2020	2031
NHS	2.2	2.3	2.9	4.0	6.0
PSS net	4.3	4.4	5.1	6.5	9.3
Total public finance	6.4	6.8	8.1	10.5	15.3
User fees	1.5	1.5	1.8	2.3	3.4
Private sector	1.9	2.2	3.0	3.8	5.6
Total private sector	3.4	3.7	4.8	6.1	9.0
Overall expenditure	9.8	10.5	12.8	16.6	24.3

Source: Wittenberg, R., Pickard, L. Comas-Herrera, A., Davies, B., Darton, R, cited in Henwood, M. (2001), p.185. (PSS = Personal Social Services).

Research on community care and social exclusion

The development of community care has been tracked by a lot of research, including longitudinal studies (notably those conducted by the PSSRU, see, for example, Bauld et al., 2000), cross-sectional studies, and commentaries and reviews (for example Parker, 2000; Royal Commission on Long-term Care, 1999; Tanner, 2003). Evaluating the data from a social exclusion perspective requires consideration of three types of questions:

- Have the community care reforms promoted access to services and aided the maintenance of independence?
- Have the reforms aided participation by older people in mainstream social activities?
- Have the reforms assisted groups typically marginalised from mainstream services (e.g. those from ethnic minorities, carers, the cognitively impaired).

Evaluating the success of community care policies

Gains and limitations of the reforms in promoting independence

The first question invites a general assessment of the strengths as well as weaknesses of community care policies. Bauld et al. (2000: 14) argue that there is a 'significant level of consensus in the post-reform literature that innovative and effective domiciliary services have been developed since 1993'. They go on to suggest that:

'There is now greater recognition among social services departments of the wish of older people to remain in their own homes which has resulted in concerted efforts to make that possible. The requirement that users and carers should be involved in assessment and planning has provided older people who wish to remain at home with greater opportunities to state their views and play a role in choosing appropriate forms of support...Forms of care previously provided in institutional settings – most notably personal care services – can now increasingly be provided at home, and developments in new forms of housing and in aids and adaptations have made remaining in the community a more viable option for a growing number of older people.' (Bauld et al., 2000: 14-15)

Warburton and McCracken (1999) in a Department of Health review of the 1993 reforms for the Royal Commission on Long-Term Care, suggested that evidence from inspections, research and other sources indicated that 'innovative and effective services' had begun to develop. They concluded that: 'There is greater recognition by SSDs of the wish of many older people to remain living in their own homes as long as is feasible, and increasingly determined efforts by SSDs make this possible'.

Recent reports from the PSSRU research suggest that community services are achieving important goals such as preventing institutionalisation, reducing caregiver burden and contributing to user satisfaction. Davies and Fernandez (2003:27) note that: 'Service contributions are particularly large for the most dependent users, many of whom received more intensive service packages than pre-reform'.

Another important dimension concerns user involvement in the process of assessment. Data reported by Bauld et al. (2000: 372) found a high level of involvement reported by care managers and users: 'Among care managers, 70% reported that users had been involved to a large extent in assessment, with an additional 17% reporting some involvement. A similar proportion (71%) of users themselves reported that they had a say in assessment, although the proportions were slightly lower (60%) among more dependent users...'

High levels of satisfaction among users of home care services (with important exceptions noted on page 57) have also been reported. Statistics on the experiences of older people of home care, have been gathered by the Department of Health, with 87,000 people responding to a survey conducted through social service departments in England in 2003 (Department of Health, Bulletin 2003/26). Overall, 57% of respondents said they were 'extremely' or 'very' satisfied with the help they receive from social services. Of those clients with physical disabilities, 58% answered 'extremely' or 'very' satisfied. This was not significantly different to those clients in the learning disability, mental health or other vulnerable group where 57% said they were 'extremely' or 'very' satisfied. Overall, 89% of all respondents answered they were 'extremely', 'very' or 'quite' satisfied with the services they receive. High levels of satisfaction with services has also been reported in work carried out by the Social Services Inspectorate (see, for example, Little, 2002: 11) and by PSSRU (Bauld et al., 2000).

Progress can also be reported on joint working between health and social care, with examples such as Local Implementation Teams (formed to implement the NSF for older people), work around intermediate care, and integrated community equipment services (Social Services Inspectorate, 2003). The Social Services Inspectorate's most recent review of older people's services found that: 'About half the councils inspected were making significant joint management arrangements with health to support the increased integration of operations and commissioning. These appointments addressed joint accountabilities and promoted seamless delivery' (Bainbridge and Ricketts, 2003:61). Inspections by the Social Services Inspectorate in 2002-2003 concluded that: 'All councils were planning older people's services [together] with health services' (Social Services Inspectorate, 2003: 30).

Finally, the Social Services Inspectorate, reviewing their latest round of inspections, report evidence for the '...beginnings of a fundamental cultural shift in social care to one which is focused on promoting independence. The shared values and beliefs of the staff are evolving from an era when users are offered what was available and were 'looked after' by services that cared for the individual and minimised risks'. The authors of the report conclude that: 'The principle of person-centred, needs-led planning is starting to offer choice and empowerment (Bainbridge and Ricketts, 2003: 1).

Limitations of the community care reforms

Along with the apparent gains from the community care reforms, some limitations and problems have also been reported. From a social exclusion perspective some significant areas of difficulty relate to:

- first, meeting 'high' as opposed to 'low' intensity needs;
- second, lack of choice and involvement in services;
- third, problems with implementing reforms such as Direct Payments.

A consistent finding from research concerns the extent to which 'the price of achieving more intensive personal care has been paid for... by the removal of 'low level' support (Audit Commission, 1997; Royal Commission on Long Term Care Research Seminar, 1999). Parker (2000: 1) argues that 'within a resource-constrained system...better and more comprehensive packages of help have gone to those with high levels of need'. Trends in home care support, reinforce these observations. An estimated 381,900 clients received home care during 2002. This represents a 3% decrease from the 2001 figure of 395,500 and an 8% decrease since 2000 (when the figure was 414,700). On the other hand, both contact hours (Tables 2 and 3) and average number of visits have increased greatly. In 2002, the average number of contact hours per household was 8.1 hours. This was almost 1.5 times the average number of contact hours provided in 1997 (5.4 hours). More than half of households received six or more visits during the week in 2002, compared with 38% in 1997. In 2002, 41% of all households had six or more visits and over five contact hours of home care, an increase from 28% in 1997 (Department of Health, 2003a).

Table 2: Average number of contact hours per household per week, 1992 to 2002

Year	All Sectors	CSSR	Independent
1992	3.2	3.2	3.7
1993	3.5	3.4	4.6
1994	4.1	3.7	7.2
1995	4.7	4.0	7.5
1996	5.1	4.3	7.4
1997	5.4	4.5	7.6
1998	5.8	5.0	7.8
1999	6.3	5.2	8.1
2000	7.0	5.5	8.2
2001	7.5	6.0	8.4
2002	8.1	6.4	8.8

Source: HH1 FORM, Tables 1, 2A, 2B and 3A (for 2000 onwards)

Table 3: Households receiving intensive home care

	England, survey week during September	
	More than 5 contact hours and 6 or more visits ⁽¹⁾	Rounded numbers More than 10 contact hours and 6 or more visits
1992	58,100	—
1993	61,800	—
1994	86,800	—
1995	107,900	—
1996	107,100	—
1997	117,600	—
1998	133,800	60,700
1999	143,500	68,700
2000	151,700	72,300
2001	156,800	77,400
2002	160,800	81,500 ⁽²⁾

Source: Department of Health annual returns HH1 and KS1

1. Prior to 2000 the figures include double counting of households receiving care from more than one sector

2. Provisional data from HH1

Despite the above, the value of 'low level' preventive services has also been highlighted as important in maintaining independence and promoting social inclusion (Tanner, 2001). Clark et al. (1998) argued from their study that help with housework, gardening, laundry and home maintenance, both enhanced quality of life and encouraged independence. The research from these authors demonstrated that:

'...the appearance of their home can impact [on] older people's comfort, sense of well-being and social participation. Having a clean and tidy home meant that older people felt more confident in inviting people in. At the same time, it was important to present an image to the outside world of the home 'sailing along' as it always had done. The public identities of older people, and in particular women, were very tied up with the presentation of their homes to the outside world. Their home became a demonstration of their competence as adult members of the community. Therefore its appearance was an important factor in feeling included in society.'

Harding (1999:42) reinforced these points in her conclusion to her paper prepared for the Royal Commission on Long-Term Care:

'...while there has undoubtedly been an increase in personal care to some older people, there are grave doubts about the quality of life that has resulted from this. Meanwhile, many older people have ended up in residential or nursing home care due to low cost ceilings on the provision of domiciliary care and the lack of rehabilitation facilities and intensive short-term support to enable them to return home from hospital. In parallel, less intensive forms of home-based care, which may well have been sustaining the independence of many thousands of older people, have been lost, with unknown and unexplored consequences for increased dependency.'

Clearly, the expectation is that developments such as the Partnership and Prevention Special Grant and its successor the Promoting Independence Grant (DoH, 2001b), will help restore prevention as an important area of work with older people. Wistow and Randall's (2001) early evaluation of Prevention Grants showed nearly one-third of year one spending was directed at services for older

people. The authors suggested that a large number of authorities were at least beginning to fund services associated with the development of community resources, healthy ageing, capacity building and empowerment. On the other hand, the most recent survey of councils by the Social Services Inspectorate (Bainbridge and Ricketts, 2003: 19) concluded that: '...most councils inspected had made little investment in, and had no strategy for developing, low-level prevention and support services. Usually, the voluntary sector was providing an uncoordinated patchwork of services'. Also, the amount of money available for preventive work suggests that councils are likely to struggle to expand such work. This may be reinforced by the difficulty of clearly demonstrating the value of 'low-level' support. Lewis et al. (1999) observe in a study of local authorities that: 'In order to obtain mainstream funding for "low level" services, managers often found that they were under pressure to demonstrate effectiveness and financial benefit'. The following comment from a manager illustrated this problem: 'When you are battling for resources, it doesn't matter how much you might believe in prevention if you can't really prove the value of the outcome'.

The second general area of concern relates to choice and user involvement in services. These are important themes in the exclusion/inclusion agenda and are highlighted both in various elements of community care legislation and in developments such as Better Government for Older People (BGOP). Research in the mid- to late-1990s suggested that significant degrees of tension remained in respect of these areas. Parker (2000) cites the work of Myers and MacDonald who found that while care managers sought to give service users and carers greater control over the care management process, various factors, including resource availability and professional assessment of risk, could run counter to real empowerment. Parker's (2000: 3) conclusion (reflecting findings from research carried out by Hardy, Young and Wistow, 1999; Tanner, 1998; and Rummery and Glendinning, 1999) was that:

'Assessment, which was seen as the cornerstone of good quality community care and responsive service commissioning, has, become a rationing device. Some people do not even manage to gain access to an assessment, never mind the services that might follow from it.'

Later research has refined aspects of this criticism, expressing concern about what is viewed as an overly-bureaucratised care management process (Challis et al., 2001). In particular, the argument is made that while the original intention may have been to provide an integrated and holistic service, in practice users often experience their care as 'discontinuous and episodic' (Ware et al., 2003: 421). Challis et al. (2001) suggest that the reality of care management is a lot different from the original projects which were typified by small caseloads and frequent contact with clients. In contrast, Ware et al. (2003:421) summarise their research findings on this issue as follows:

'In our sample of authorities, by contrast, we find a prime focus on financial controls and the routinisation of tasks. There were examples of good practice where care managers recognised the importance of continuing personal relationships and a holistic approach to user and carer needs. However, where care management essentially comprises the disparate short-term tasks, it is questionable how far the continuity of relationships can be sustained and encouraged.'

These points were also brought out in the Social Services Inspectorate report (Little, 2002) *Improving Older People's Services*, in the following comment relating to inspections carried out over 2001-02:

'Overall, assessments were of good standard, but with some important shortfalls such as the lack of personal information. Care plans were too often service-led. This was linked to the volume of work, the need to complete it within reasonable timescales and to shortages of local resources. There was also a lack of creative thinking about how best to devise a personalised plan for older people, drawing on their strengths as well as their needs.'

Some of the problems associated with extending choice and control over services have been reflected in difficulties associated with the implementation of the Direct Payments scheme. This measure was first introduced for disabled adults of working age in 1997 and extended to older disabled people in 2000. However, by 2002-2003 there are still only 1,000 older people in England receiving direct payments – just five people per council. The Social Services Inspectorate make the observation that their inspections:

'...found that many direct payments schemes had been designed for people of working age and did not take the particular needs of older people into account. This limited the accessibility and usefulness of direct payments. Failure to offer direct payments systematically and poor public information were further barriers. Some councils had no arrangements for advocacy or support by voluntary organisations. In others that did fund support by voluntary-sector organisations, limited funding restricted access.' (Bainbridge and Ricketts, 2003: 29)

Evaluation of a simulated Direct Payments scheme in Portsmouth confirmed a high level of satisfaction among participants (Patmore, 2002). But the qualifications expressed in the research findings are also noteworthy. They suggest that this kind of approach may create difficulties for those especially vulnerable and/or socially isolated. Research by Patmore found that:

'Some older people can feel daunted by new arrangements which, whatever gains they promise, sound as though they may burden one with having to make more decisions and organise one's services oneself. Also, while some older people resented care managers' control of their services, there were others who actually feared loss of care managers' presence as intermediaries who could address any problems with the provider on their behalf. Reservations about managing services for oneself resulted in people declining to participate and in the relatively small number who would try the simulated Direct Payments option, the option required most from the service user. In the Direct Payments option some older people encountered difficulties in finding a worker. They feared recruiting a stranger via advertising but, if one had few remaining social connections, it was hard to find a suitable person in any other way.' (Patmore, 2002: 32)

A more positive experience of direct payments has been reported in a study by Clark et al. (2004) who concluded that they were a positive option for older people, resulting in greater choice and control in respect of daily living. However, they noted some age discrimination in the operation of the scheme, with their sample having only limited access to the full range of social and leisure services available to adults.

The balance of evidence about the community care reforms suggest some gains for those with complex needs but fewer improvements for those with lower levels of dependency. Bauld et al. (2000: 388) summarise the key trends as follows:

'The greater emphasis on care management and planning has resulted in scarce resources being targeted more effectively than hitherto towards those older people with the greatest needs...[There] is clear evidence that this resulted in tangible benefits for users...[However]...the findings also make the point that in a system where resources in relation to needs have been constrained for many years, any gains will have their associated costs. In so far as targeting has achieved many gains for particular groups of users, it may have been at the expense of appropriate investments in prevention and rehabilitation that have imposed costs on other parts of the health and social care system and added to the burdens placed on some carers.'

Community care and social participation

Increased support within the home is clearly relevant to challenging social exclusion in late old age. However, another important question is whether the gains achieved assist participation in mainstream activities or whether they simply contribute to sustaining a tolerable standard of living. Some studies have advanced the view that community care is currently failing the test of promoting social inclusion, focusing instead on issues to do with what Harding (1999:42) refers to

as 'maintenance and safety' and what Tanner (2003: 501) defines as 'survival needs'. Harding (1999: 42) suggests that while the nature and objectives of services for younger people have undergone radical change, reflecting awareness from professionals about the need to promote 'autonomy and inclusion in mainstream life and activities', the same appears much less true about services for older people. She illustrates this point with the example of day services which Harding argues have become narrowly-focused on 'care' rather than inclusiveness. Against this: 'Day care should be one of the ways of enabling older people to retain their personal interests and their involvement in life and create new opportunities for involvement in the wider community'.

A possible source for widening the focus of work with older people is the **Single Assessment Process** (SAP) (Department of Health, 2002c). It raises the possibility of a more 'person-centred' approach to defining the needs of the individual. However, researchers such as Hunter (2001) and Tanner (2003) have raised doubts about whether the SAP will demonstrate significant improvements in the range of services that people receive. Tanner (2003: 508) for example suggests that:

'...if "needs" are only what councils will provide for in relation to their eligibility criteria, and the service user's definition of need falls outside this, we are not further forward in terms of the wider access to services (as opposed to assessment). Despite statements about the need to involve older people in assessment...the emphasis is more on the roles and relationships of professional experts who are driving the process. Even the new 'case-finding' proposal implies professionals may know better than older people when they need help. It has been suggested, too, that the **Single Assessment Process** will lead to greater confusion amongst older people about the responsibilities of different agencies and about their legal entitlements and this is another potential source of disempowerment.'

Tanner (2001, 2003), Wistow (2003), Harding (1999), in response to the above concerns, argue the case for shifting the focus of community care to that of 'enhancing quality of life rather than the narrower one of reducing individually-defined risk' (Tanner, 2003: 511). Wistow et al. (2003) link this with the framework developed by the World Health Organisation (2002) of 'active ageing', this defined as: the 'process of optimising opportunities for health, participation and security in order to enhance quality of life as people age'. Wistow et al. (2003) suggest that this approach implies both a broader approach to community care, one focusing on strategies which can maximise control, interdependence and social integration, as opposed to the virtues of choice and independence which have been the traditional aims of public policy towards older people. The authors argue that:

'There is evidence that mortality and morbidity are more strongly related to the experience of control over one's life than the exposure to health risks *per se*. In addition, there is some evidence that community-based social capital is associated with better health status...From a number of perspectives, therefore, it appears that the ability to live successfully in local communities is based on interdependence to a greater extent than independence. Older people need to be able to give as well as receive if they are to maintain their self-esteem and sense of purpose in life. In practice, therefore, it is the interdependence and social integration of individuals in local communities that make possible the independent lifestyles on which public policy has more traditionally focused.' (Wistow et al., 2003: 4-5; see, also, Scharf et al., 2002; Phillipson et al., 2004)

Tanner (2003:511) concludes that in respect of prevention, perspectives such as the above, would translate to a concern with the: 'development of community resources, capacity-building, health ageing and empowerment... This is not about older people's access to 'care' but about changing the nature of the communities they live in and their involvement in them, as participants in helping networks... Indeed it is argued that the very success of "community care" policy must be measured by the extent to which care givers and receivers are enabled to achieve full-citizenship within the community and control over the lives and services they use'.

This broader approach to community care confirms the importance of establishing linkages with area-based strategies in the field of prevention – for example Health Action Zones – as well as work around urban and rural regeneration. It also suggests the need to embed developments such as the National Service Framework and the Single Assessment Process within a wider focus on social integration and empowerment at community and neighbourhood-based levels.

Community care and marginalised groups

A further question to ask of the community care reforms concerns the extent to which they have been successful in reaching groups who have traditionally missed out on support. Notably they are those such as ethnic minorities, carers and those with complex mental health needs. The research evidence for each of these groups will now be reviewed, beginning with findings relating to minority ethnic groups.

Support for Black and minority ethnic older people

Successive studies through the 1990s pointed to major problems in service provision for older people from ethnic minority groups (Askham et al., 1995; Carlin, 1994; Boneham et al., 1997; Patel, 1999). The Commission for Racial Equality concluded from their study that:

'Ethnic minorities are both under- and over-represented as users of health and social care services. Typically, where care is more akin to control and brings restrictions on users' autonomy, ethnic minorities are over-represented. Where the services are 'caring', ethnic minorities tend to be under-represented. This is particularly apparent in mental health services.' (cited in Henwood, 2000: 59)

Patel (1999), in work for the Royal Commission on Long Term Care, highlighted the inadequacy of mainstream providers '...and the compensatory effect of minority ethnic organisations who continue to act as "primary providers"'. Qualitative research in the 1990s also indicated ethnic minorities as having limited knowledge about the full range of community health services and social services provision (see Boaz et al., 1999; Blakemore and Boneham, 1993). On the other hand research also pointed to significant variations within the population of ethnic elders, a point often missed in commentaries on this topic. Blakemore (2002), for example, argued that:

'The position of minority ethnic communities has often been portrayed as one of common disadvantage compared with the position facing the white majority. In this way existing research has tended to racialise the debate about minority needs, focusing on problems in community care as if they affect all black people equally. In fact some minority communities are in a much better position than others to lessen the impact of 'race' discrimination, inadequate care services and social disadvantage. All the signs point to increasing inequalities in community care among Britain's minority black and South Asian communities, while the black/white divide becomes less distinctive than it was.'

Even so, research and inspections over the past three years suggest continuing problems facing black and minority ethnic elders. From their inspections for 2001-2002 the Social Services Inspectorate reported some good examples of low-level community support services targeted at this group. Yet there appeared 'few councils which could offer people an intensive service which provided for their cultural and religious needs, such as long-residential care, a short-term break or high-level domiciliary care' (Little, 2002: 21). Fruin's (2000) review of provision for short-term breaks for people with physical disabilities and older people, found users and carers from ethnic minority communities to be significantly under-represented as beneficiaries of short-term breaks. The most recent Social Services Inspectorate review came to the conclusion that:

'Almost all the councils inspected had gaps in their provision for meeting needs arising from minority cultures. These were particularly noteworthy for more intensive services including respite and residential care. Where the services provided were not culturally sensitive, there was much potential for isolation and poor outcomes, exacerbated by language difficulties and potential staff

misunderstandings. Services sensitive to cultural needs were often those providing less intensive community support, meals, and day and domiciliary care.’ (Bainbridge and Ricketts, 2003: 27; see, also, Ware et al., 2003: 417)

Surveys of users of home care services suggest lower levels of satisfaction among ethnic elders. Results from a survey carried out for the Department of Health in 2002-2003 found 58% of white respondents ‘extremely’ or ‘very’ satisfied compared to 44% of black and minority ethnic respondents. Just over one in ten of the latter expressed dissatisfaction with the nature of the help they received in their own home (Department of Health, 2003a).

Some evidence for improvement in the range of services for older people from ethnic minority groups has been found through Performance Assessment Framework (PAF) data on services for adults and older people, and carers: ‘The indicator for ethnicity [in relation to the former group] receiving services after an assessment, showed an improvement on 2001-2002, and is set to remain acceptably stable in 2002-2003’ (Social Services Inspectorate, 2003: 28). Findings on black and ethnic minority carers were, however, much less satisfactory, with difficulties in recruiting respite carers from black and ethnic minority groups, and delays in establishing department-wide minority ethnic strategies (see further page 64).

Henwood (2000) suggests that examples of innovative and responsive services have invariably originated from black and minority ethnic-led voluntary organisations in a ‘bottom-up’ approach. She notes that even though there are examples of good providers, for example, from statutory bodies, these tend not to be incorporated into the mainstream. Henwood (2000:61) concludes that:

‘There are probably many relevant factors, including pressures from existing and potential service users, action from front-line staff and their managers, and effective advocacy by black and minority ethnic voluntary organisations. Encouraging the spread of innovative developments on the ground is critical, particularly if they are to become mainstream rather than ‘specialist’ and often marginal...[thus] the challenge is not just about developing a range of different services to meet the needs of black and minority ethnic groups, but also, more demandingly, that appropriate skills, knowledge and attitudes are developed in **all** workers.’

Although the general findings on the problems facing black and minority ethnic elders are clear, the experiences of particular groups needs further study. Phillipson et al. (2003) suggest that poverty and language difficulties may create particular difficulties for carers from the Bangladeshi community. Lindsay et al. (1997) report on the poor uptake of services among Asian Gujaratis. Scharf et al. (2002) have highlighted difficulties facing older Pakistani and Somali people living in areas characterised by high social deprivation. More detailed studies on the experiences of different cohorts of ethnic minorities is, however, urgently required if a more accurate assessment of their needs is to be made.

Support for carers

Academic research in the 1980s highlighted the pressure on informal carers, women in particular. The importance of their role had been highlighted in the White Paper *Caring for People* but with no specific recommendations for assistance. This changed with the passage of the 1995 Carers (Recognition and Services) Act which confirmed both new rights and a clear legal status. In particular, people providing a **regular** and **substantial** amount of care can ask for an assessment of their ability to care when the person they are looking after is being assessed for community care services. This right is also extended to people **intending** to care in the future.

Bauld et al. (2000) note that evidence from the Social Services Inspectorate and Kings Fund Carers Impact programme indicates that the number of carer assessments are increasing and special initiatives, such as support groups and designated workers for carers, are developing. Parker

(1999), in her review for the Royal Commission, found that carers had been incorporated into SSDs' thinking and practice in a way that was not evident ten years ago'. She also pointed to the range of special initiatives directed at carers which had begun to appear.

However, the Bauld et al. (2000) and Parker (1999) reviews covering the 1990s were critical about the limitations of the support for carers. Bauld et al. (2000: 17) concluded that: 'Despite greater awareness of carers and their needs...there is limited research evidence of improved outcomes in the post-reform period, or even of adequate support from services'. Parker (1999: 63) took the view that: 'In all areas...there is a serious question mark over whether or not the changes have delivered significant, rather than marginal, improvement in access to the core services which support carers best'. Awareness of legislative changes remains a significant problem. Research by Arksey et al. (2000) in a study of carers with 'heavy caring responsibilities' found most of those surveyed having only limited knowledge of the Carers Act and their entitlements. Bainbridge and Ricketts (2003: 45) for the Social Services Inspectorate find that nationally performance remained poor in the provision of carers' assessments with most councils not achieving their targets.

Some improvements are likely to have occurred since the research of the mid to late-1990s, though more recent reports from the Social Services Inspectorate suggest continuing difficulties for carers over access to 'practical help and general support' (Little, 2002: 23). But we still know relatively little about the problems facing particular groups of carers such as those on low incomes, or from particular ethnic minorities, or those living in areas of high social deprivation. Exploring the impact of social exclusion on caring responsibilities, or vice versa, would seem a useful step towards developing further work in this area.

Support for people with mental health needs

Service responses to mental health needs is another area with major gaps both generally and for particular groups (Audit Commission, 2002; Department of Health, 2000). Bainbridge and Ricketts (2003: 25) in SSI inspections over 2002-2003 noted that many councils reported a shortfall in services designed to meet the needs of older people with mental health difficulties. Also, they commented that: 'All too often, where good services did exist, they were isolated and disconnected'. Common problems cited in the report included:

- the mental health needs of black and minority ethnic elders were often unmet, particularly for intensive services;
- lack of strategic grasp and practical planning;
- shortfalls in the availability of services sometimes resulting in placements/provision that met needs poorly;
- institutional options were often seen as the mainstay of provision;
- older people's mental health services were usually unable to access intermediate care;
- some locations with community mental health teams lacked provider services;
- little focus on the needs of older people with functional mental health needs.

People with dementia as well as their carers may experience various forms of exclusion and service discrimination. Little (2002: 22) from the Social Services Inspectorate found that for the period 2001-2002 '...few councils had yet developed specific domiciliary care services to assist people with dementia to live in their own homes'. Bauld et al. (2000) highlighted the pressures on carers

of cognitively impaired older people, particularly in respect of lower levels of satisfaction with the services provided to them. The 12th Annual Report for the Social Services Inspectorate (2003) concluded that:

‘While good progress has been made towards the NSF milestone for reviewing eligibility criteria for services to eliminate age-related discrimination, in some areas patchy or poor mental health services for older people remain. Isolated, uncoordinated, and inaccessible, these services could be described as an indirect way of discriminating against older service users, and should be a priority for improvement.’

Ethnic elders may be particularly vulnerable in respect of access to services. Social Services Inspectorate inspections in 2002-03 found that: ‘Representation of black and ethnic minority perspectives in strategic planning for mental health services was very poor’. Part of the problem may be lack of knowledge among providers of the types and range of problems facing ethnic elders in their local area. This was commented on in the research by Patel et al. (1998). It found that while much information exists about dementia experienced by the majority ethnic groups in statistical, economic cost and research terms, this is much less the case for older people from Black and Asian ethnic groups.

Conclusions: impacts of community care policies on the social exclusion of older people

Despite the important gains made by the reforms in community care, notably in helping to maintain very dependent older people in their own homes for longer periods, the limitations from a social exclusion perspective are also apparent. In summary these may be listed as follows:

- limitations of low-level preventive work with older people;
- continuing problems in maximising user-involvement and empowerment;
- problem of continuing focus on survival needs to the detriment of inclusion of older people into mainstream activities;
- limited integration of community care with community development;
- continuing difficulties faced by marginalised groups such as those with mental health needs, black and minority ethnic elders, and carers.

More generally, this review highlights the possibility of refocusing the community care debate around social inclusion issues. This should be carried forward into specific areas such as assessment and service delivery, as well as broader concerns that address the capacity of the communities in which people live to sustain independent/interdependent living.

Health Action Zones

Description of programme

Attempts to tackle social exclusion through community change have taken a variety of forms. They include area health initiatives, anti-poverty programmes, activities around crime reduction, and community development. Typically, programmes target geographically-defined areas with multiple problems such as high levels of poverty and ill-health, poor services and infrastructure, high levels of crime and unemployment (Howse, 2003). The development of Health Action Zones (HAZ) was

announced in 1997. These were viewed as a new way of tackling health inequalities in areas of high levels of deprivation (Department of Health, 2001). In October 1997, health authorities together with local authorities and other agencies were invited to submit bids to become Health Action Zones. In the call for bids, the three strategic objectives of Health Action Zones were outlined as follows (Department of Health, 1997):

- to identify and address the public health needs of the local area;
- to increase the effectiveness, efficiency and responsiveness of services;
- to develop partnerships for improving people's health and relevant services, adding value through synergy between the work of different agencies.

In some instances the Health Action Zone initiative coincides or overlaps with other government programmes focused on inequalities and exclusion. Examples are Single Regeneration Budgets, the Neighbourhood Renewal Strategy, and Education Action Zones. Howse (2003:14) describes the underlying theme behind the development of the Health Action Zone initiative as follows:

'The engagement of local communities is one of the principles...of the structure and aims of the HAZs. They are to increase public involvement in the planning of services, and empower service users and patients to take responsibility for their own health and decisions about care. That is why they have been set up as partnerships between the NHS, local authorities, the voluntary and private sectors, and community groups. It is not surprising, therefore, that programmes for enhancing community involvement are cited by most of the HAZs as a central part of their work; nor that some of the local HAZ strategies should make an explicit commitment to a community development approach to health.'

Scope of the Health Action Zones initiative

A total of 26 Health Action Zones were set up in two waves over 1998 and 1999. They range in population from 180,000 to 1.4 million people and cover over 13 million people in total. Altogether more than £274 million was allocated to assist Health Action Zones in the three years from April 1999. This funding has also been used to leverage change in the more substantial budgets of health and local authorities. Funding for Health Action Zones has been extended to 2005-6 with further funding of £140 million but with Health Action Zone activities now mainstreamed within the relevant Primary Care Trust (PCT). Another element is the Fellowships Scheme. The funding from that enables front line staff in the NHS, Social Services and the Voluntary Sector to take time out from their work to assess better ways of 'tackling health inequalities and modernising services' (Department of Health, 2001).

The Health Action Zones initiative fits firmly within policies designed to tackle social exclusion. Health Action Zones are located in areas of high deprivation levels with some of the poorest health levels. Health Action Zone health authorities accounted for 15 out of the 25 most deprived areas in the late 1990s. The majority also had illness and mortality rates greater than the national average based on Health Survey of England and ONS data (National Evaluation, 1999). On the other hand, the areas themselves are diverse ranging from inner cities, rural areas and ex-coalfield communities (Bauld and Judge, 2002).

Research on Health Action Zones

An edited volume from Linda Bauld and Ken Judge has been produced which summarises Health Action Zones work on collaboration, evaluation and innovation, although there is little material in this collection specifically relating to older people (Bauld and Judge, 2002). Reports are however available providing information on the scope of activities involving older people, including some from the national evaluation of Health Action Zones (Bauld and Judge, 1999; Judge and Bauld,

2002; Lawson et al., 2002) and evaluation reports from the local projects (Merseyside Health Action Zone, 1999, 2001; Tyne and Wear Health Action Zone Partnership, 1999; Adams, 2001; Booth, 2001; Health Action Zones, 2001; McNally, 2001; Tyrer, 2001; Christie, 2002; Leicester City Health Action Zone, 2002; Tilford et al., 2002). This material has been accessed in the discussion that follows.

Evaluating the success of the Health Action Zones initiative in incorporating issues affecting older people

Coverage by Health Action Zones of issues affecting older people, needs to be considered in at least three different ways:

- First, to what extent are the health concerns of older people directly covered in Health Action Zones (**the age-related question**)?
- Second, to what extent are general health issues affecting other groups (young people or the unemployed) also related to later life issues (**the cumulative disadvantage issue**)?
- Third, to what extent are links made between health concerns in old age and problems about urban deprivation and regeneration policies aimed at tackling these (**an age discrimination issue**)?

Evidence from the first wave of Health Action Zones (Judge and Bauld, 1999) found the largest proportion of programmes (21%) tackling the determinants of poor health, such as unemployment, housing and education; 16% were concerned with improving the health of specific population groups. Almost half of these programmes focused on younger people, a smaller number on older people and the remainder on ethnic minority groups or parents. The national evaluation of Health Action Zones provides further evidence on the focus of the programmes. Lawson et al. (2002: 4) in their presentation of preliminary findings from the integrated case studies comment that:

‘The report describes the approaches that have been taken to addressing the health issues associated with children and young people, coronary heart disease (CHD) and employment. The rationale behind the selection of these topics was that the purpose-based analysis of the June 2000 high level statement documentation showed that these were the most prevalent types of HAZ activities within the population focus, health problem and structural focus categories’.

On the other hand, a small number of Health Action Zones did identify work with older people as a priority group – for example, Hull and East Riding, Leicester, Cornwall, South Yorkshire and Tyne and Wear – and a larger number have included work with older people in their spectrum of activities. Our review of the 26 Health Action Zones websites indicates that this work falls into two main categories: first, promoting health and independence; second, encouraging participation and partnership. An example of the former is provided by Wolverhampton’s Older People’s workstream which ‘aims to develop new ways of promoting the health, well-being and independence of older people’. The objectives here are:

- to prevent ill health and disability through physical exercise, social activity and knowledge of health issues;
- to help people to recover their independence after a spell of illness, through the provision of therapy services and rehabilitation (Crockett, 2002: 16).

Howse (2003: 16) summarises some of the activity in Wolverhampton as follows:

'A team of 12 Peer Health Mentors use their skills, knowledge and life experience to give advice to people of their own age, and have so far spoken to over 1,000 people. The mentors provide information, give talks on numerous subjects and are involved in developing activities that promote healthy living among older people such as walking, alternative therapies and reminiscence groups. The project takes a holistic approach to health promotion. Besides addressing issues relating to the physical well-being of the over-50s, it also aims to generate new activities for older people in order to promote their mental well-being. The Mount Shiloh project received money...to provide a wide range of activities for African Caribbean elders in a venue that would cater for their cultural preferences. Visiting speakers carry out informal health education work and give advice on health, advocacy and welfare benefits'. The HAZ is also setting up several local Older People's Resource Centres, which will act as a basis for befriending projects, exercise classes, a café, support for carers...'

In terms of promoting independence in old age, the evaluation of the Merseyside Health Action Zone (Mackinnon, 2003: 26) highlighted what it described as an 'innovative intervention known as The Dawn Patrol':

'This scheme involved children checking the homes of older people on their way to school. If the older person was up they would put a sign in the window and if there was no sign, the child would get somebody to go round and check that person was well. This scheme has 'proved to have lots of benefits and has been rolled out to other places' .

Hull and East Riding Health Action Zone report 'shifting the balance of support and service for older people towards health improvement and retaining independence'. This Health Action Zone reports giving particular emphasis in achieving this goal to developing intermediate care services and work on falls prevention. Cornwall and Isles of Scilly Health Action Zone also highlight promoting independence and preventing accidents as major activities, including community rehabilitation, proactive risk assessments and medicines' management.

The second major theme in Health Action Zone work around older people concerns issues about partnership and participation. The Department of Health describes the Age Well programme in Sandwell Health Action Zone as 'typical of work partnership with older people within Health Action Zones to ensure that they have an equal voice in policy and practice at strategic and local levels within partner organisations. The commitment to older people extends to those at particular risk of "missing out", for example those who are disabled. The involvement of black and other ethnic minority older people is also a significant project. At the same time a programme of practical work has been undertaken, including:

- publishing an A-Z of services for older people;
- developing an approved list of local builders and tradesmen;
- extending the availability of chiropody and similar services at a local level;
- enabling people to remain in their own homes by making increased investment to support their needs; and
- piloting work to prevent accidents through Primary Care Teams....'

Anticipated outcomes of this work (Allen, 2002: 37) are described as follows:

- increased sense of involvement and control among older people in Sandwell;
- evidence of active participation in organisational decision-making by older people;
- reduction in isolation of older people;
- increased quality of life, as reported by older people;
- improved health status of older people, including 20% reduction in accidents by 2010'.

The work of other Health Action Zones has included stakeholder conferences involving older people, designed to shape future health policies and planning. Merseyside Health Action Zone (2001) provides a detailed example of one such event. Also, the description of the planning behind one particular conference reflects the theme of social inclusion running through the Health Action Zone:

'In order to facilitate participation by older people there was attention to detail in the planning of the event. A sound system was used and translators and carers provided for those who required them. Pre-conference materials were in large print and translated into appropriate languages and Braille according to the needs of the individual. Accessible transport was provided and the individual's cultural, religious and dietary requirements were met. A decision was made by the design team to invite groups of older people from two of the boroughs only, in order that those attending would be with friends and not isolated. Eighteen older people attended out of a total of 86 participants. Age Concern Liverpool and Sefton Pensioners Advocacy helped prepare for the event and provided support during the conference. A range of older people from fit to infirm and from diverse ethnic groups attended. The timing of the programme was adjusted to meet their needs. This attention to detail illustrates how HAZ principles of equity and community involvement can be put into practice.' (Merseyside Health Action Zone, 2001: 7-8)

Evaluating the success of Health Action Zones in reducing social exclusion of older people

The evidence to date suggests that many Health Action Zones have incorporated issues affecting older people and that these report success in involving people in campaigns and conferences on the one side, and in promoting health awareness and access to services on the other. The following examples are cited for illustration:

'The Health Action Zone joined forces with Eastern [Home Energy Efficiency Scheme] to organise a seminar to raise awareness and promote a government grant scheme aimed at subsidising the costs of home heating. The purpose of the seminar was to ensure that disadvantaged households in Hull and East Riding had the opportunity to benefit from government grants of up to £2,000, which can be used for insulating lofts and walls, draught-proofing and installing a central heating system...Referrals to the scheme from this area increased sharply following this seminar...500 people benefited from the scheme as a direct result of this intervention'. (Hull and East Riding HAZ)

'A forum to enable Wolverhampton's over-50s to have their say, and influence the development of services for older people, has attracted over 60 members since it was set up in November 1999 ... An event to engage older people from African Caribbean and Asian Communities attracted nearly 100 participants and has resulted in the formation of the Black Elders partnership.' (Frankel, 2003)

'[Cornwall and Isles of Scilly Health Action Zone] Eldercare workstream ... Intermediate outcomes as at March 2003 include:

- evidence of agencies switching funding to support co-ordination of signposting services;
- safer and more supportive home environments for older people;
- increased range of care options available;
- improved professional knowledge of range of alternative services available;
- 1,000 elderly people benefiting from falls prevention work, including early interventions and promoting exercise;
- development of care pathway.'

'[Merseyside Health Action Zone's (2001)] progress report on the follow-up to their Older People's conference, find the positive changes identified as follows:

- involvement of older people, for example in selection and recruitment of professional staff;
- awareness of older people and their needs;
- enthusiasm for change;
- joined up working and creative services;
- positive attitudes to mental health issues for older people;
- transport reaching more areas and more routes;
- befriending and assessment of needs.'

The long-term impact of this work is rather more difficult to assess, notably in terms of the likelihood of it being adopted by mainstream services. Also, much of the Health Action Zones activity for older people is not itself innovatory nor designed to address inequalities in any basic sense. The strength of the Health Action Zone work has been to focus on a relatively narrow range of issues to do with improving the responsiveness of providers to the needs of older people. Alternatively, it has been targeted at improving outcomes in specific areas such as accidents, falls and rehabilitation.

Conclusions: impacts of Health Action Zones on the social exclusion of older people

Health Action Zones have developed themes relevant to promoting social inclusion. The most significant of these have been:

- encouraging participation in health care services among elderly people;
- developing health promotion schemes targeted at older people;
- stimulating work among black and minority ethnic elders;
- developing a community dimension to health promotion work in old age.

From a social exclusion perspective, however, two main gaps in work to date might be identified:

- **First, activity around tackling disadvantage which runs throughout the life course and which may be cumulative in its effect.** The problem here is that work around children and families, unemployment, coronary heart disease, and old age, are invariably treated as separate topics, rather than a linked set of issues. Tyne and Wear Health Action Zone acknowledge this point with their action theme on 'Healthy Citizenship –adding years of life and improving life capacity'. But even here, it is unclear how this particular theme is related to challenging deprivation in old age given the focus on items such as improving assessment tools for the over- 80s, improving specialist housing provision, and providing focused and accessible leisure. **The implication of this is that much of the work of HAZs, where it has been relevant to older people, has focused on age-related issues along with the impact of age-based discrimination. Problems arising from the impact of cumulative disadvantage through the life course have been given far less attention.**
- **Second, although the Health Action Zones are usually linked to neighbourhood renewal strategies and regeneration policies of various kinds, links to policies affecting older people are relatively rare.** Thus the regeneration theme hardly figures in Health Action Zone work with older people, despite the commitment to a community development approach. This reinforces the more general finding from researchers such as Riseborough and Sribjlanin (2000: 22) about the extent to which older people have been left out of the debate around urban regeneration – a point discussed in more detail in the discussion on urban renewal. The danger here is that health policies will fail to address either how regeneration and renewal can be used to benefit the health of groups such as older people, or, conversely, how urban renewal schemes can themselves exacerbate health inequalities (Cave et al., 2002).

NHS Direct and Care Direct and Social Exclusion and Older People

Description of programme

NHS Direct and Care Direct may both be seen as relevant to the social exclusion agenda. The framework for these policies was summarised by the White Paper *Modernising Government*, which identified the need to bring government services and information about them, closer to users and carers. Emphasis was further placed on the need to achieve 'seamless integration' in provision across a range of social and health care needs. NHS Direct and Care Direct also reflect aspirations to using information technology in the drive to make 'government and its services more accessible' (McNeil, 2001: 2; see, also, Cabinet Office, 2000).

NHS Direct was launched in 1998 as a 24 hour-a-day/seven days-a-week service; national telephone coverage was achieved in November 2000. The service came with the remit of providing: '... easier and faster health advice and information to the public' (National Audit Office, 2002b). NHS Direct is now the world's largest provider of telephone healthcare advice. It received 3.5 million calls in 2000-01, with call volumes set to double the following year. NHS Direct employs (2002 figures) around 0.5% of all full-time equivalent qualified nurses in the NHS, with 20% of its nursing workforce coming from outside the NHS. By 2002 the annual cost of the service was £90 million per annum (National Audit Office, 2002b).

Care Direct was launched as a pilot by the Department of Health in the autumn of 2001 as a single gateway or 'one stop shop', offering information and support to people over 60 and their carers. The case for the service was identified in a Treasury and Cabinet Office-sponsored review of ways to improve information targeted at older people. The review identified the case for a single phone number that would route callers to a network of advisers based either in NHS Direct call centres or specialist centres. Call centres and help desks were to provide the same core information

about care and support services and social security benefits and be open out of hours. Also, people who did not wish to, or could not, use the telephone should be able to see Care Direct advisers in person at places that were easy to reach, for example, at the main help desk or potentially in the person's own home (McNeil, 2001). £30 million was allocated over the period 2001-02 to 2003-4 to run pilot schemes in 20 local authority areas (six in phase one and 14 in phase two). The Care Direct pilots have now ended, with 12 months' transitional funding put in place in preparation for the Department of Work and Pensions' Third Age Service. Formal evaluation of Care Direct has been undertaken by the PSSRU at the University of Kent (Bebbington and Unell, 2003a, 2003b). The assessment below is based on the interim reports from this evaluation.

Scope of NHS Direct and Care Direct

NHS Direct was launched in three first wave areas in 1998 covering 1.3 million people. Following this the service has been extended in successive waves and by November 2000 was available to the whole of England and Wales. Munro et al. (2001: 1) list the objectives of the service as:

- Offering the public a confidential, reliable and consistent source of professional advice on healthcare, 24 hours a day, so that people can manage their problems at home or know where to turn for appropriate care.
- Providing simple and speedy access to a full and up-to-date range of health and related information.
- Helping to improve quality, increase cost-effectiveness and reduce unnecessary demands on other NHS services by providing a more appropriate response to the public's needs.
- Allowing professionals to develop their role in enabling patients to be partners in self-care, and helping them to focus on those patients for whom their skills are most needed.

Munro et al. (2001: 71) note from their evaluation of the service that NHS Direct has evolved into a: '...well-used, functioning service whose pace of development shows no sign of slowing'. They further comment that: '...our evidence shows that the population's use of NHS Direct is increasing. [That suggests] that it responds to unmet need, although the service is still a comparatively small player in relation to the total volume of unscheduled health care, being used in about 5% of all episodes of ill-health where unscheduled care is sought'.

Care Direct was itself partially modelled on NHS Direct with the development of a free-phone telephone number with supplementary internet link. Unlike the latter however it has been piloted around specific localities, driven by partnerships within the local authority areas. According to the Care Direct Evaluation Newsletter (No.3: 5): '...there have been some differences in approach, and [in] the first year, differences in performance. Bournemouth subcontracted the service's running to a local voluntary organisation serving older people and their carers. In Bristol and Gloucestershire, Care Direct has been integrated in different ways into a front end service for adults. The other three sites adopted a more freestanding approach under social services management, but all arrangements have been subject to development'.

Some of the Care Direct pilots gave a specific reference to the importance of their work for social inclusion/exclusion strategies. Among the key values and principles of the Bournemouth CAREdirect partnership were:

- To improve the independence, inclusion and quality of life of older people in the Borough.
- To reach all the communities of older people in Bournemouth, recognising ethnic cultural diversity and including isolated vulnerable older people traditionally marginalised.

CAREdirect Bristol (2001) included the following in its set of aims:

- To provide a service which will actively reach out to 'excluded' communities.

In terms of the service's scope in the initial pilot areas, Bebbington and Unell (2003a) report that by the end of 2002 the service was well ahead of the first-year target of ten calls per 100 people aged 65 plus. Most calls are made in office hours. During the first year the out-of-hours service was dropped apart from an answering service provided by NHS Direct.

Evaluating the success of NHS Direct and Care Direct in responding to older people's needs

Measures of success with these services include:

- Are older people aware of the existence of the services?
- Are there variations in service use among different groups of older people?
- Do the services bring into mainstream services people who would under use or be excluded from existing services?

The National Audit Office (2002b) has reported data on awareness of NHS Direct, showing variation by age, ethnic group and social class. Levels of awareness peak among those 55-64 (at 70%) but are lowest for those 65-plus (at 51%). There are two kinds of explanation advanced for this finding. First, the lower acceptability of the service may reflect the desire of elderly people to have face-to-face contact with their GP (National Audit Office, 2002b). This itself reflects the fact that NHS Direct is a service for responding to acute conditions, in contrast with the long-term illnesses about which older people are consulting their GP. This is also suggested by the importance of NHS Direct in responding to parents calling on behalf of children, where a telephone service may be especially effective in dealing with worries about accidents or acute episodes of illness. Second, there is the argument that the technologies involved may create difficulties for some groups of older people. Munro et al. (2001: 71) argue here that:

'Although the [underuse of the service by older people] may reflect the greater experience and knowledge of older people in dealing with health and health care, it is also possible that it represents an increasing marginalisation of older people from accessing services through 'new technologies' such as the telephone, the web, email or digital TV. If health care policymakers are to continue to develop the role of such technologies in accessing the health service, and if this approach becomes more widespread...then an understanding of how this will impact on older users of services is urgent.'

Roland (2002:4) reinforces the last point in his brief survey of nurse-led telephone advice. He makes the point that: 'As in other countries, [for example Australia and the US], most callers [tend to be] young adults or parents calling on behalf of children. There is concern that the increasing use of telephone advice may disadvantage elderly and ethnic people, who find it less easy to use the telephone.' The evidence here is though contradictory. Bebbington and Unell (2003b: 4) in the evaluation of CARE direct comment that: '[The service] has confounded those who believe that older people will not use a telephone helpline service. About six enquiries out of seven are from people aged 60 or over, with a median age of 80.' On the other hand, age may interact with other dimensions such as class and ethnicity to limit use of telephone services. In the case of NHS Direct, awareness of the service is lower among ethnic minority groups (at 45%) and social groups D and E (49%, as against 61% for the population as a whole). It is likely that older people within these groups may have even lower levels of awareness about the kind of service NHS Direct can provide.

In the case of Care Direct, Bebbington and Unell (2003a) report data on types of users, satisfaction with the service and general effectiveness. Their survey of 600 callers confirmed that callers, or those ringing on someone's behalf, tended to have a level of dependency higher than older people in general. A third of those calling on their own were aged between 80 and 89 years. Main reasons for contacting the service included money and benefits (around 33%), social care (around 19%), and aids and adaptation (around 16%). Just over half of all enquiries were dealt with fully in the course of a single call. The remainder involved a ring-back to the caller following a simple investigation or, in some cases, a referral to another agency, with about one third resulting in new services or support, or at least moves in that direction by the time of the survey. In the survey of 600 callers, 83% thought that Care Direct had provided the help they needed. This led to action in one-half of all cases, either via a referral for new services or support (32%), or by the caller taking further action on their behalf or, in some cases, both (Bebbington and Unell, 2003a: 20).

As an example of the last finding, CARE Direct Devon (2003) report that their service is now close to its capacity receiving between 100 and 200 calls a day, with 97% of callers either very or quite satisfied with the service received. They note that over a nine month period the service helped callers claim more than £2 million in additional benefit:

'[Devon] CARE Direct aims to resolve every call at the point of contact or if necessary will research and telephone the caller back making referrals to other agencies on the caller's behalf if appropriate. Advisers are able to offer advice about care and support at home, home security and safety at home, as well as keeping well, and maintaining healthy lifestyles. Many people have commented on how convenient it is to have one contact telephone number to deal with and resolve such a wide range of issues.' (CARE Direct Devon, Report of the Director of Social Services, July 2003)

Despite problems over particular topics such as advice on housing, Bebbington and Unell (2003a: 20) conclude that Care Direct has performed well against the evaluation criteria of (a) meeting targets for call volumes; (b) providing an accessible and appropriate service for users; and (c) providing core information about a defined range of services. They conclude that: 'As it has bedded down in the six sites, it has demonstrated its capacity to respond to a broader repertoire of issues, work together with local agencies in partnership initiatives (such as fast track schemes for aids and adaptations) and develop new ways for its target users to connect with the service'.

Evaluating the success of NHS Direct and Care Direct in reducing social exclusion

The extent to which a telephone-led facility promotes access to services – especially among users who experience exclusion – has yet to be fully answered in the existing research. Customer satisfaction appears high – both for NHS Direct (Munro et al., 2001; Commission for Health Improvement, 2003) and Care Direct (Bebbington and Unell, 2003a). But there are significant groups of non-users. They are almost certainly drawn from those already disadvantaged within the health and social care system. George (2002) makes the point that: 'Rather than reach people who are currently failed by the health system, NHS Direct may have discovered previously unexpressed demand among the worried and well middle-classes'. Efforts are being made to improve use among older people, ethnic minorities and younger people (Commission for Health Improvement, 2003), but detailed research on the success of these efforts has to be reported.

There is some evidence that callers may already be familiar to, or integrated with, the statutory and voluntary sector. Bebbington and Unell (2003a: 19) report that in their survey of 600 callers, one-third were already in contact with social services, and a similar proportion already received a disability benefit'.

On a more positive note, the evaluation of Care Direct does suggest this type of service can play a role in promoting independence among older people. This reflects the role of the service in improving the range of information and advice available to older people; facilitating multidisciplinary working between health and social care; and providing additional support to informal carers of older people.

Conclusions: impacts of NHS Direct and Care Direct on the social exclusion of older people

Both NHS Direct and Care Direct are still relatively new services and hence further research will be important in assessing the value of telephone-based services for widening options for advice and assistance to older people. The evidence thus far suggests that they may play a valuable supportive role to mainstream services in maintaining independence. Whether this applies to all groups of older people remains unclear. NHS Direct is probably under-used by very elderly people, but this may reflect the service's limitations for those with chronic – as opposed to acute – conditions. Certainly, the technology itself is unlikely to be the problem, given experiences with Care Direct. On the other hand, there is a concern that investments at this level - an annual cost of £90 million in the case of NHS Direct and an initial allocation of £30 million to Care Direct – may simply widen the choices for already well-informed consumers rather than assist those excluded or marginalised from health and social services.

2:3 Older people and neighbourhood renewal

Neighbourhood Renewal and New Deal for Communities

Introduction

Urban renewal and neighbourhood regeneration represent major strands within policies to combat social exclusion. A national strategy for neighbourhood renewal was established in 2001, the aim of which was to tackle 'the unacceptably bad conditions in this country's poor neighbourhoods' (Social Exclusion Unit, 2001a). This policy built on reports from the Social Exclusion Unit highlighting the large gap between England's most deprived neighbourhoods and the rest of the country. This particularly concerned joblessness, sub-standard housing, poor health and low incomes. The trends highlighted indicated a growing separation between rich and poor areas, especially over the 1980s and into the 1990s:

'Over this period, communities became less mixed and more vulnerable, with poor people more likely to be concentrated in the same places. Places that started with the highest unemployment often also saw the greatest rise in unemployment. Health inequalities widened. The proportion of people living in relatively low income households more than doubled between the end of the 1970s and the beginning of the 1990s.' (Social Exclusion Unit, 2001a)

The problems facing people in poor communities were summarised as follows in the **National Strategy Action Plan** (Social Exclusion Unit, 2001a: 17):

'Poor services in deprived neighbourhoods compound the misery of living on a low income, with people who already have trouble making ends meet also facing higher prices in shops, worse schools, fewer doctors and higher rates of crime. This can be particularly problematic for especially vulnerable groups including older people, lone parents, disabled people, and black and minority ethnic residents.'

Strategies on neighbourhood renewal may be highly significant for older people given the way they may be affected by population turnover, accelerating rates of crime, and a decline in the standard of housing (Hannan Foundation, 2001; Hardill, 2003; Scharf et al., 2002; Phillipson et al., 2000; Newman, 2003). A high proportion of elderly people will be long-term residents with strong attachments to their area. The study by Phillipson et al. (2000) of older people in three urban areas found respondents had lived at their current address for nearly 25 years. In the Bethnal Green district of London, white respondents had lived in their house or flat for an average of 22.3 years. That figure was virtually identical to that which had been reported by Townsend researching in the same district some 50 years previously.

In some areas length of residence will be considerably longer. In a study of Wolverhampton, nearly one in four elderly respondents had lived at the same address for 40 or more years, eight % had been at the same address for 50 or more years (Phillipson et al., 2000). Even in areas of high deprivation (such as those in the study by Scharf et al, 2002), older people are likely to report a strong degree of identification with their community. In the Scharf et al. (2002) study of districts in Liverpool, Manchester and Newham, three out of four respondents identified positive features about their neighbourhood, with most of these commenting on the presence of good neighbours, friends and family. More than three-quarters of respondents (78%) indicated that they had at least one friend in their community or neighbourhood. Of those people with local friends, almost half (47%) had a chat or did something with a friend every day.

Against the above finding, it is also clear that older people are highly sensitive to changes within their neighbourhood. Compared with younger age groups they are more likely to report that the area has deteriorated within the past two years (Neighbourhood Renewal Unit, 2003a); and to express feelings of insecurity and fear about crime (Help the Aged, 2002b). Also, with increased dependence on the immediate locality for shops and services of various kinds, changes in the quality and level of local provision may create additional problems for older people compared with other age groups.

Policy development

Policy initiatives on regeneration involve both expenditure to improve services in deprived areas. This includes efforts to 'bend' public spending in favour of areas experiencing high deprivation, and specific initiatives to support and stimulate change to assist in 'kick starting the renewal process' (Neighbourhood Renewal Unit, 2003b). The most important of these include the Neighbourhood Renewal Fund, the Community Empowerment Fund, New Deal for Communities, and the Neighbourhood Wardens Programme (discussed in the section on Crime and Social Exclusion). Much of the work of the neighbourhood renewal programme – predominantly urban though with some rural areas – has focused on England's 88 most deprived local authority areas. The aim of activity in these areas is to deliver 'long-term sustainable improvements to people's quality of life – including economic prosperity, safer communities, high quality schools, decent housing and better health' (Neighbourhood Renewal Unit, 2003c). The means of achieving this draws together:

'...not only most of the public services, but also business, voluntary and community organisations. Residents and communities are at the heart of this process, and the strategy put their needs at the top of the agenda, taking a 'bottom up' approach rather than imposing solutions from above. Its important that everyone has a chance to get involved – men and women, older people, and people with disabilities, children and young people.'

The 88 areas of high deprivation are eligible for a share of a Neighbourhood Renewal Fund that provides £900 million over the period 2001-02 to 2003-4. This money is distributed through local strategic partnerships (LSPs) which set priorities for their areas and develop renewal strategies to fit local needs. An additional £96 million funding stream, the Community Empowerment Fund and Community Chest, has also been set up to help neighbourhood groups to develop activities through local strategic partnerships. The intention of this fund is to strengthen the activities of voluntary groups operating in areas with a high level of deprivation.

Among targeted renewal initiatives, New Deal for Communities (NDC) is the biggest. It represents some £2 billion investment over ten years in 39 severely deprived areas. Launched in 1998, New Deal for Communities is seen to be a means both of directly benefiting the 39 communities but also as a test bed to develop policies that may be relevant for urban renewal policies more generally. The New Deal for Communities operates through neighbourhood partnerships, particularly with community organisations but also with the public, business and voluntary sectors. The work of the New Deal for Communities is being evaluated around five outcome areas: crime reduction, health, education, problems of worklessness, and environmental issues (including housing). A national evaluation team to monitor progress of the New Deal for Communities was established in 2001 and is producing annual reports (see, for example, Neighbourhood Renewal Unit, 2003d).

Evaluating the impact of regeneration policies

It is too early to assess the impact of regeneration policies on specific groups. Even for the initial group of 17 New Deal for Communities launched in 1998, 2001-02 was the first year of programme implementation, and evaluation reports are still focusing on the collection of general statistics about the different areas (although the National Audit Office have produced an early progress report). Even so, some specific points might be made about the place of older people in regeneration policies and the extent to which their needs are likely to figure in the implementation of particular policies. A cautionary note has been expressed by Riseborough and Sribjlanin (2000) who reviewed the impact of programmes such as City Challenge and the Single Regeneration Budget, as well as from initial evidence about the links established by the Better Government for Older People Programme with regeneration issues. The research presented findings from a desk study of secondary material and conclusions from original research interviews with key organisations on older people's involvement in regeneration.

The study by Riseborough and Sribjlanin (2000) took the view that older people were often 'invisible' in regeneration policies, as illustrated by their absence in the work of regional development agencies. Very few of the Better Government for Older People pilots had established links with themes connected with urban renewal. In some cases the problem was less the absence of older people, more an underlying 'ageism' in the construction of policies:

'Looking more closely at the benefits from regeneration for older people there is a tendency in current and previous regeneration bids to stereotype older citizens. For example, older people are mentioned only as service recipients, victims or are referred to largely as people who needed to be "cared for", particularly in early SRB bids...It would be extreme to say that older people are cast only as recipients and victims but the tendency to depict them in this way is noticeable in regeneration plans and bids. It is also likely that these roles are accepted and even suggested by older people themselves in some localities. However, the evidence suggests that experience of ageism and the effects on older people that lead them to internalise ageist stereotypes is not understood or recognised by most partnerships. Also, although an increasing proportion of partnerships work with and directly employ community workers, the work that there is with all sections of the community and all age groups, is relatively rare.'

The research's conclusion was that older people had been at best marginalised in regeneration policy and practice and at worst excluded. This assessment was largely on the basis of policies through the 1990s. The crucial test will be whether the community-focused approach adopted in New Deal for Communities and neighbourhood renewal more generally is able to be inclusive of all age and social groups.

There is limited information at present to assess whether older people have achieved greater visibility in regeneration and renewal policies. What evidence there is suggests that partnerships – such as those associated with New Deal for Communities – will need to work hard to ensure that older people are fully involved. A surprising finding from the 2002-03 report of the national evaluation of New Deal for Communities was that levels of trust in NDCs were lowest among the over-65s and highest among 16-24 year olds (Neighbourhood Renewal Unit, 2003a). The Annual Review of the New Deal for Communities for 2001-2002 (Neighbourhood Renewal Unit, 2003d) highlights a range of initiatives under development of relevance to older people.

However, the evaluation reports published thus far give relatively limited attention to age in contrast with other social and cultural factors influencing neighbourhoods. Also, there is still limited evidence that to quote the study from Riseborough and Sribjlanin (2000: 22): '...the potential to use the community development expertise of older people's organisations, and older people's experience from [neighbourhood projects] has...percolated through into regeneration practice as a whole'.

A further concern is that older people are still – despite the lessons from research – being treated as one group within regeneration policies. That is despite the vast needs of the over-80s in contrast with those in their 60s; differences between women and men; and contrasting needs of elderly people in different ethnic groups.

Older people are also likely to have different perspectives and concerns when contrasted with other age groups. In comparison with younger age groups they are likely to have lived in the same community for much of their lives. In the 39 New Deal for Communities areas, 43% of residents – taking all age groups – had lived in the locality for **less than five years**; only 22% had lived in the area for more than 20 years, with most of these being elderly people. The Scharf et al (2002) study of localities with similar characteristics to those of the New Deal for Communities found 79% of older people had lived in their neighbourhood for 20 years or more, and 47% had been in the area for 40 or more years.

On the above evidence it is not surprising that older people are more likely when compared with younger groups to view the community as having deteriorated over the years. They are more likely to have a historical basis for making an assessment. But they are also likely, as the research review at the beginning demonstrated, to have a significant attachment to their neighbourhood. This aspect could be turned into a positive force for change in the field of urban regeneration.

Conclusions: impacts of neighbourhood renewal policies on the social exclusion of older people

These are still relatively early days in respect of judging the effectiveness of neighbourhood renewal policies. It is certainly not too late to ensure that older people become more directly involved in shaping renewal strategies at a local level, and that the impact of this is measured more directly in project evaluations. It will be essential, however, that New Deal for Communities and similar projects give fuller acknowledgement of the differences between older people and other age groups, as well as differences within the older population.

Also, it will be important to develop a clearer view of how elderly people are affected by urbanisation as an economic and social process. It will also be essential to clarify how regeneration policies can contribute directly to improving the quality of life in old age, with urban living being seen as a positive rather than negative force in the lives of older people.

Home Improvement Agencies

Description of policy

Home Improvement Agencies (HIAs) are mostly small, not for profit organisations that assist vulnerable homeowners or private sector residents who are elderly, disabled or on low incomes, to repair, improve, maintain or adapt their homes. Home Improvement Agencies are also referred to as 'Care and Repair' agencies or 'Staying Put' schemes.

Scope of Home Improvement Agencies

Home Improvement Agencies started to receive central government funding from April 1987, and this has gradually expanded. By 1999, a total of £5.2 million was helping 192 Home Improvement Agencies. From April 2001, a new funding scheme began for three years, with a total of £8.5 million helping 235 Home Improvement Agencies. From April 2003, all Office of the Deputy Prime Minister funding will be paid to Home Improvement Agencies via the Supporting People programme.

An important element of Home Improvement Agencies funding is that central funding is only provided if it is matched by other funding sources, such as housing and health authorities, or charities.

Home Improvement Agencies help eligible people carry out a range of improvements, from small repairs to major renovation or adaptation. Tasks range from fitting new locks to installing a new downstairs bathroom. The actual tasks are funded from local authority grants, charities, the Social Fund, client's savings and loans and equity release.

Many Home Improvement Agencies have developed services in addition to their 'core' service. Some of these include: handyperson schemes; 'home to hospital' schemes; gardening schemes; improving home security; energy efficiency improvements and approved builders' lists.

Home Improvement Agencies exist in a changing policy environment. On one level, they are increasingly part of a strategy to encourage private sector renewal, through local authority-led housing strategies. On another level, they are also a part of the Supporting People initiative. At both these levels, there is a lot of change in both policy and operating contexts. Also, there is an increasing emphasis on equity release as a key mechanism for financing private sector renewal, and a changing system of available grants.

Research on Home Improvement Agencies

There is relatively limited evidence available in relation to the overall impact of Home Improvement Agencies. The most wide-ranging evaluation of their work was done at Bristol University in the late 1980s to evaluate the pilot programme. There have been studies about particular initiatives, for example, handyperson services and hospital discharge support. Often these are advocacy documents rather than genuine critical evaluations.

Evaluating the success of Home Improvement Agencies

Home Improvement Agencies have been seen as successful in helping older people access a range of funding sources, for home improvements, and supporting them through the process. They continue to receive central government funding, and a recent review by the Office of the Deputy Prime Minister (2003) emphasised their importance to both Supporting People agenda and private sector renewal.

However, Home Improvement Agencies are relatively small scale operations, and are reliant on existing grants available from the local authority and others. Two-fifths (40%) of Home Improvement Agencies completed less than 90 jobs in 2001-2002, while 60% completed more than 90 jobs. There are some key constraints on Home Improvement Initiatives, such as a lack of: branding; visibility to the public; capacity and funding; set service standards; and co-operation between managing agents.

Poor housing is an important risk factor for social exclusion. Most of current housing disrepair and unfitness exists in the private sector stock with older people more likely to be occupants of this poor housing (Foundations, 2002).

There is evidence that Home Improvement Agencies can reach vulnerable clients (Foundations factsheet 2). The national co-ordinating body proposes that:

- three quarters of Home Improvement Agency clients are on £75 a week or on a means-tested benefit;
- many agencies help clients take-up benefits. One agency added an average increase to their weekly income of £44.60. Another claimed an additional £44,000 for their clients over a year period.

Many older people in poor housing face other barriers to improving their housing situation:

- Cost. Most owners have no long-term maintenance plan or specific financial provision for future repair costs. Do-it-yourself work is not an option for many older people. People are reluctant to borrow money for building work, especially repairs. For low-income households without savings, emergency repairs pose special problems, and the job is often botched or neglected.
- People sometimes delay tackling work because they cannot find a builder they can trust or because of the disruption involved.
- There is some lack of awareness of problems of the technical issues involved, especially for those on low-incomes and older people.

Home Improvement Agencies play an active role in helping older people overcome these barriers.

The agencies also have an important part to play in the health and social care agenda. Housing improvements can help improve health – for example through helping to prevent falls and cold related illnesses. They have also helped with discharge from hospital, and provide welfare benefits advice.

Theoretically, it appears that Home Improvement Agencies can help reduce social exclusion. They deal with vulnerable older people to improve their housing situation, which can have important impacts on their well-being and health. In addition, they can help to access grants and builders, in a way that many vulnerable older people would find difficult to do.

Conclusions: impacts of Home Improvement Agencies on the social exclusion of older people

Health Improvement Agencies appear to have an important role in reducing social exclusion in a number of ways. That is especially so in terms of their helping to ensure the success of the private sector renewal strategy. However, their effectiveness could be limited by partial coverage and modest capacity.

2:4 Crime, social exclusion and older people

Introduction

Issues about the experience and fear of crime form an important part of policies to combat social exclusion. Worries about crime and fear of victimisation may have an important impact on the quality of daily life in old age, and this may be especially the case in areas of high social deprivation. The Home Office has set targets for reducing fear of crime (see Department for Work and Pensions, 2003c). Surveys of the extent of crime experienced by older people, drawing on the British Crime Survey, are now available (Chivite-Matthews and Maggs, 2002). At the same time pressure groups and charities have identified fear of crime as a major concern for different groups of older people (Help the Aged, 2002b, 2002c).

Discussion about crime in relation to older people should be placed within the context of important variables against which the impact of policies must be measured. Research evidence suggests that age itself is less important than other variables in producing worries and fears about crime. These include gender, past experiences of abuse and violence, and geographical location. Help the Aged (2002c), in their report *Older People and Fear of Crime*, note forthcoming research from Chadee and Ditton which found that when respondents' ages were banded into ten-year intervals, neither fear of property crime nor fear of personal crime increased progressively through the different age groups. If anything, the very old were the least afraid, at least in relation to property crime. On the other hand, gender does appear as an important variable. For example, in the 2000 British Crime Survey 26% of women aged 60 and over, reported being very worried about being mugged, compared with 12% of men in this age group. In relation to being physically attacked, the comparable figures were 23% for women and 8% for men (see, also, Scharf et al., 2002).

The community/place dimension may also play an important role in experiences and fears about crime. Successive reports from the British Crime Survey have shown that those living in inner city neighbourhoods tend to report low levels of safety when compared with groups from other types of areas (see also Silverman and Della-Gisutina, 2001). Scharf et al. (2002) confirmed this finding in their study of older people living in areas of high deprivation. The 2001 British Crime Survey emphasised that older people were much less likely to experience physical assaults than people in other age groups. Just 1% of adults living in households headed by a person aged 60 and over had been a victim of violence in 1999 and 2000, compared with a figure of 3.9% of all households. The study by Scharf et al. (2002) reported a significantly higher risk level in deprived urban areas with 15% of older people having either experienced an assault or had something they were carrying stolen from them.

Feelings about crime may additionally reflect negative experiences encountered at different points across the lifecourse. One survey (cited in Help the Aged, 2002c) found that middle-aged and older women reported a slightly higher rate of violent attacks over a lifetime when compared with younger women in the survey: 'The research concluded that experiences of violence and harassment have an important and cumulative bearing on contemporary fear of crime, regardless of when these experiences occurred within an individual's lifespan. They can have the effect of

heightening older women's perceptions of their personal risk, especially outside the home... This is particularly true of older women who are in poor health and live alone on low incomes in deprived areas' (Help the Aged, 2002c:22).

Finally, health factors will also be a significant factor in relation to expressions of insecurity and fear of crime. Poor health may result in some older people feeling less able to defend themselves or being more vulnerable to physical attack. The British Crime Survey confirms that for all age groups those that perceive their health to be poor or very poor also tend to report higher levels of fear. In the case of older people, 32% of those 60 and over in bad/very bad health report being worried about being mugged, compared with 17% of those saying they were in fair/good/very good health. Equivalent figures for worries about physical attack were 24% and 15% (Chivite-Matthews and Maggs, 2002).

From this brief summary of the research literature it is clear that a range of factors associated with social exclusion may contribute to fears about crime. Hough (1995), from his analysis of the 1994 British Crime Survey, summarises these as: '...being female, aged over 60, an inner city resident, in poor health, aware of local disorder and having a neighbour who has been mugged...[all these factors] were all strongly associated with feeling unsafe'. Scharf et al. (2002:61) conclude that: 'While the majority of older people are not recent victims of crime, there are substantial numbers who have experienced serious types of crime. Our research points to the fact that not only are older people fearful of crime in deprived areas but that they are justified in many of their anxieties'.

There is some evidence, albeit based on small samples, that where older people are subject to burglaries then the impact can be especially severe. Research by Donaldson (2003) under the Reducing Burglary Initiative found that elderly victims of burglary decline in health faster than non-victims of similar age. In this particular study, covering sheltered housing tenants, two years after the crime had occurred, they were 2.4 times more likely to have died or to be in residential care than their non-burgled neighbours.

Policies to reduce crime and fear of crime

Tackling older people's fear of crime is complex given the range of underlying factors such as poor health, low income and area deprivation. Crime reduction has occupied an important part of government social policy with the Crime Reduction Programme (CRP) focusing on burglary, targeted policing, CCTV, national initiatives, early interventions in the lives of those at risk of offending and domestic violence (Curtin et al., 2001). Policies that have been targeted at vulnerable groups such as older people include:

- **The Reducing Burglary Initiative**, £32 million has been targeted at neighbourhoods that experience high burglary rates with the aim of developing 'innovative burglary reduction strategies' (Kodz and Pease, 2003).
- **Neighbourhood Wardens**: A Neighbourhood Warden Unit based in the ODPM (formerly DETR) has been established with £18.5 million (2000-04) to support existing Neighbourhood Warden schemes and help get new ones going (Social Exclusion Unit, 2001b).
- **Locks for Pensioners**: Complementing the DETR's Home Energy Efficiency Scheme, the Crime Reduction Programme included £8 million to be spent on improving security for low-income pensioners in local authority areas that had burglary rates above the national average.

- **The Distraction Burglary Task Force.** This was created by the Home Office in 2000, this has had a particular focus on examining ways of reducing the vulnerability of older people to distraction burglary. These are those where the offenders trick the victims into letting them into their home.

Before examining the impact of some of these policies, general trends regarding crime in relation to older people will first be reviewed.

Trends in crime affecting older people

The Government has set a target of reducing the 'proportion of older people whose lives are affected by fear of crime' (Department for Work and Pensions, 2003c) using 1998 as the baseline year. In 1998, drawing on data from the British Crime Survey, 10% of those 60 and over said that their life was greatly affected by crime. By 2002-3 this figure had dropped to 8%. For men the trend was relatively stable throughout this period, with a high of 7% and a low of 6% in successive years from 2000-1. The trend for women showed a decline from 14% in 1998, to 9% in 2002-3.

The analysis of British Crime Survey (BCS) data by Chivite-Matthews and Maggs (2002) covers a ten-year period from 1991 to 2001. Their analysis suggests that at least in the 1990s the experience of crime among people 60 and over remained more or less constant – 12% to 14% from 1991 to 1999. In comparison with other age groups, older people's risk of suffering from a household or personal crime is generally much lower. Also, taking 1995 as a baseline there has been a downward trend for key areas such as risk of vandalism, risk of burglary, and risk of vehicle-related thefts.

Generalised worries about different aspects of crime demonstrate a pattern of decline over the period 1992 to 2001. In 1992, 22% of women 60 or older were 'very worried' about burglary. This figure rose to 25% in 1996 but has since declined to 18% in the 2001 BCS. The figures for men show a drop from 18% very worried in 1996, to 13% in 2001. These trends are not confined to older people but are consistent across all age groups. On the other hand, the extent to which older people are 'very worried' about being mugged has remained unchanged at 18% across the period 1992 to 2001. Women are more likely to express fears about being mugged in comparison with men, although the per cent reporting being 'very worried' has declined at least since 1996 from 26% to 22% in 2001.

If there is some evidence for a moderation in fears about crime, this appears less true of older people's feelings of safety in their immediate environment. Among women aged 60 and over around one in three report feeling 'very unsafe' out at night. British Crime Survey data found 33% reporting this in 1994 with an identical figure being found in 2002-03 and little fluctuation in the intervening years. The figures for older men are much lower – at around one in ten saying they feel 'very unsafe'. Income plays a mediating role influencing feelings of safety: 36% of women in households with an income less than £10,000 report feeling very unsafe; the comparable figure for households with more than £10,000 a year is 22%. These figures are well in excess of other age groups and confirm that for many older people their immediate locality is virtually a 'no go area' by late afternoon.

Such findings from a general population of older people should be seen in the context of the results from the study by Scharf et al. (2002) of older people in areas of severe deprivation. Here, the proportion expressing that they felt unsafe in moving around their community was much higher than in the British Crime Survey. The study found that most older people would feel unsafe if they had to go out alone in their neighbourhood after dark. Two-thirds of respondents would feel either a bit unsafe or very unsafe under these circumstances. Very few people, 7% would feel

very safe when out alone after dark. Another important finding from this study was that both gender and age were strongly associated with feelings of neighbourhood safety: 56% of women reported that they would feel very unsafe if out in their neighbourhood after dark, compared with 28% of men. In respect of age, 57% of those 75 years and over felt unsafe compared with 38% of those aged 60 to 74 years.

In contrast with the world outside, the home environment – at least on the basis of the BCS and studies such as those by Scharf et al. (2002) – appears much more secure. In the 2000 BCS, 90% of respondents 60 and over reported feeling very or fairly safe when alone in their homes at night. In areas of high deprivation the figure is virtually identical at 87%. Nonetheless, even in the Scharf et al (2002) research 16% of women felt either a bit (11%) or very (5%) unsafe in their homes at night. These figures are worrying given the projected growth in the population of older people living alone and in particular that of very elderly women.

Evaluating the success of policy initiatives

In overall terms the research evidence seems to be pointing to a general moderation in worries about crime among older people. This change can be clearly identified as taking place from the mid-1990s onwards. But it is difficult to isolate the precise factors that may have influenced changes among older people, and whether they are different to those which appeared to have affected all age groups. Also, more general economic and social changes may also impact on crime trends – both positively and negatively. On the other hand, the difficulties confronting those in deprived areas and elderly women living alone appear to have persisted for much of this period. Some of the issues raised by these groups have been covered in specific initiatives such as the Reducing Burglary Initiative (RBI), funding for Neighbourhood Wardens and work in the area of Distraction Burglary.

The first round of the RBI, funded 63 **Strategic Development Projects** (SDPs). The projects were located in neighbourhoods that had experienced at least twice the national recorded domestic burglary rate for each of the previous three years. A key aim of the RBI was to find out what burglary reduction strategies work best and in what type of area (Kodz and Pease, 2003). The projects themselves were encouraged to develop a range of innovative burglary reduction strategies. Early reports on this initiative suggest some success in reducing burglary levels. Kodz and Pease (2003) report that 21 months after the launch of the RBI, burglaries declined in 55 SDPs by 20% compared with the pre-project period. The net reduction in burglaries was 7% in the SDP areas, when taking into account burglary reduction in the comparison areas.

From the reports covering individual projects in Birmingham (Stirchley), Sandwell, Solihull and Rochdale, it is clear that much of the work has been highly relevant in tackling crime experienced by older people. Some examples here include: free personal attack alarms for certain groups deemed vulnerable to burglary – such as the elderly or women living alone (Rochdale); target hardening vulnerable properties including OAP bungalows (Solihull); and environmental changes to protect neighbourhoods from burglary (Birmingham).

Work from the RBI has also been useful in clarifying the circumstances by which older people may become vulnerable to burglary even though on national statistics they are at less risk than other age groups. Curtin et al (2002:3) in a report on examples from local crime reduction partnerships draw on Tilley et al's (1999) notion of: '... "virtual" communities of individuals sharing common socio-demographic characteristics but who do not necessarily live within a tight geographical location'. An interesting finding from their work in identifying populations at risk, concerned problems facing elderly people living in small sheltered accommodation developments: 'They were found to be at high risk, notwithstanding the nationally lower than average burglary risk faced by older people. The suggestion from this area was that the crucial factor was the grouping [together]

of vulnerable victims' (see, also, Donaldson, 2003). The resulting project aimed to reduce domestic burglary in the virtual communities identified by 25% within 12 months of commencement. Target hardening of the homes of older people was a key approach adopted by the project.

Neighbourhood Warden Schemes have been the subject of research reported by Jacobson and Saville (1999) and the Neighbourhood Renewal Unit (2004). The argument for such schemes was put forward in the Social Exclusion Unit (1998) report *Bringing Britain Together* (1998) where it was suggested that: '... some problems associated with crime and fear of crime can be tackled through the presence of a full-time, recognisable "warden" with the capacity to take preventive action against crime and disorder and provide general assistance to residents' (see, also, Social Exclusion Unit, 2001b). Jacobson and Saville (1999) studied 49 schemes, the majority of which had the following core objectives to their work:

- Crime prevention – reducing levels of crime, anti-social behaviour and fear of crime.
- Environmental improvements – including the removal of litter and graffiti, improving the appearance and general state of repair of properties and public areas.
- Community development – involving, for example, the promotion of community solidarity and confidence in local agencies, and intolerance of crime and disorder.

From their review Jacobson and Saville (1999: vii) conclude that: 'The emerging evidence...does suggest that warden schemes can help to address many of the problems faced by deprived neighbourhoods. It appears that schemes often in conjunction with other local crime prevention initiatives, can contribute to bringing down levels of crime and fear of crime. Research undertaken on behalf of the Neighbourhood Renewal Unit (2004) found that wardens were especially successful at reducing fear of crime among older people. Warden schemes that encompass environmental and community-based aims, together with crime prevention elements, appear to have the potential to reverse the social and physical decline of poor areas. In drawing in the skills, expertise and goodwill of a variety of local individuals and agencies, many schemes engage in constructive and wide-ranging partnership activities which have tangible impacts on lives'.

At the same time, it remains unclear whether the positive impact on localities is long-lasting, and whether it benefits some groups more than others.

Another important area of work has emerged from the **Distraction Burglary Task Force** formed in April 2000. The aim of the Taskforce was 'to tackle distraction burglary and thereby improve the quality of life of vulnerable communities through a co-ordinated national partnership initiative within England and Wales' (Thornton et al, 2003: i).¹⁴ A wide range of partners have been involved in the taskforce including the police, local authorities and agencies, utility companies and organisations with responsibilities to deliver services to older vulnerable people.

White older adults are assumed to be the prime targets of distraction burglary. Police statistics show some 19,400 recorded distraction burglary offences in 2001-2 (Thornton et al., 2003). Thornton et al. (2003) identified risk factors for those vulnerable to distraction burglary including: problems with mobility and activities of daily living; receiving more visits from professional carers than from friends; receiving fewer regular visitors. Environmental risk factors included: neglected gardens and outside maintenance; surrounding houses being in poor condition; front door not being visible to the street or neighbours. This report made recommendations aimed at professionals working with victims of distraction burglary, both in relation to raising awareness and reducing vulnerability (Thornton et al., 2003: 52-55; see, also, Home Office Development and Practice Report No.11).

14 The Distraction Burglary Task Force includes members from voluntary sector organisations such as Age Concern and Help the Aged.

Help the Aged conducted an NOP Survey in 2003 to explore the extent to which older people are at risk from distraction burglary or 'bogus caller crime'. Among the findings of this study were:

- over a twelve month period some 300,000 older people had been potentially approached by suspicious callers;
- an estimated 180,000 of these incidents resulted in entry;
- approximately 122,000 people had money/possessions stolen;
- 51% of older people fail to report bogus caller incidents to the police;
- 42% of people aged 60 and over are unaware of campaigns aimed at raising public awareness of doorstep etiquette to prevent distraction burglary;
- 25% of older people open the door without employing any precautions;
- 23% of women aged 60 and over worry every time they answer the door to unknown callers.

Some of the recommendations from this work include:

- the need for police forces to encourage older people to report bogus caller incidents;
- the potential role of neighbourhood wardens in publicising this type of crime;
- the importance of awareness campaigns directed at the problem of distraction burglary.

Conclusions: impacts of policies to reduce crime and fear of crime on the social exclusion of older people

It is difficult from this review to trace particular factors that might have influenced trends relating to crime experienced by older people. Clearly, general worries appear to be on a downward trend, as are experiences of problems such as physical violence, mugging and burglary. On the other hand, there is still a significant problem relating to the fears that older people have about moving around their neighbourhood after dark. This particular fear has proved fairly resistant to change and is at a level that appears well in excess of other age groups, especially in high deprivation neighbourhoods.

A cautionary point is that existing crime surveys may overestimate the fear of crime, particularly concerning the frequency with which citizens feel fearful. Farrell and Gadd (2003) have tested new survey questions in this area which attempt to measure changes in the fear of crime over time. In contrast with existing research suggesting that about a third of UK citizens were 'very' or 'fairly' worried about the fear of crime, their study found that only some 15% had felt 'very' or 'fairly' fearful in the last year, and of these only 8% felt so frequently. It remains unresolved, however, whether particular age/cohorts are more vulnerable to crime – especially those in their 70s and 80s and over, and women in particular.

A further difficulty in interpreting trends on crime and older people is that detailed studies examining particular groups within the older population have yet to be carried out. The study by Chivite-Matthews and Maggs (2002) while a valuable review of the BCS on older people, has a limited range of comparisons within the population aged 60 and over. It would be helpful in this regard to have more studies focusing on:

- the experience of crime suffered by those 85 and older (mainly women);
- older people living in areas subject to significant population turnover (which may be a crucial variable in respect of vulnerability to crime);
- those in poor health or who experience particular types of disability.

CHAPTER 3: Conclusion

This review has drawn on a wide range of evidence in order to assess the degree to which government policy has impacted on older people who are potentially vulnerable to forms of social exclusion. Given the diverse nature of Britain's older population, the review has adopted a broad conceptualisation of social exclusion in order to accommodate the range of ways in which older people may experience marginalisation from social and economic life. However, a lack of appropriate scientific evidence has meant that it is not always possible to assess the impact of government policy on particular groups. In this respect, there is a clear and urgent need for the policy and research communities to generate additional evidence relating to the circumstances of older people judged vulnerable to various forms of exclusion.

Taking the evidence reviewed in this report, what have been the strengths and limitations of government policy in the field of social exclusion and older people? To answer this, we need to go back to the drivers of exclusion discussed in Section One, namely, **age-related characteristics, cumulative disadvantage, community characteristics, and age-based discrimination**. A key finding from our work is that the evidence suggests greater success in the first and last of these in comparison with the second and third.

- **Taking the age-related area, government policy can claim a number of successes.** Particularly noteworthy, for example, have been the reduction in the proportion of older people on absolute low incomes; the stabilisation/reduction in the proportion of pensioners experiencing relative poverty; the enhanced support for people with high levels of dependency; and the securing of innovations in the field of community care. All of these gains might be said to modify or reduce some of the pressures affecting people as they move into their 70s and beyond: for example, pressures that arise through the loss of income associated with retirement; problems stemming from chronic health conditions; and problems linked to the impact of changes associated with life course transitions.
- **In contrast, social exclusion arising from cumulative disadvantage through the life course appears more resistant to change.** The proportion of those on persistently low incomes has remained almost constant since the early 1990s. This suggests a hard core of older people who have probably encountered poverty at points throughout their life, and who go on to experience high levels of deprivation in old age (Scharf et al., 2002). These are also the groups who fail in large numbers to claim means-tested benefits. Low expectations and a lack of awareness of services (a product of cohort-rather than age-related differences) have partly been addressed in the community care reforms and through innovations such as NHS Direct and Care Direct. But even here it is noticeable that key groups continue to exclude themselves, and that the 'service-rich' probably do considerably better than the 'service poor' in utilising service innovations.
- **Problems arising from community change remain a significant driver leading to social exclusion in old age.** Some successes have been recorded with initiatives such as Neighbourhood Wardens, the Reducing Burglary Initiative, and individual projects under New Deal for Communities. However, there is no clear evidence that the needs of older people are being given systematic attention in urban regeneration schemes. Areas characterised by high population turnover and economic deprivation remain an important driver leading to exclusion in old age. This is reinforced where feelings of insecurity produce restrictions on daily living. While worries or fears about particular crimes may have receded, concern about the 'unsafe' nature of urban communities remains high and may limit older people's involvement in a range of activities.

- **Measures designed to tackle age-based discrimination have been extensive and are beginning to produce a cultural shift in perceptions of older people.** In some respects this is not an easy target to measure and systematic evidence on the impact of policies has yet to be collected. Moreover, some of the most significant policies designed to challenge ageism (such as the National Service Framework) are still at an early stage of assessment. But the range of activity is impressive, notably through the activities promoted by Better Government for Older People, a number of community-based activities in Health Action Zones, work in the area of community care, and the development of a range of policies around older people and pensions in the Department for Work and Pensions.

Further research on all of the above areas is undoubtedly required. In particular, more research is needed exploring the relationship between particular policies and their impact or otherwise on social exclusion in old age. While acknowledging the limitations of available research, however, the conclusion of this report is that the impact of policies on social exclusion has been uneven. Government policy has been stronger in tackling certain types of problems which cluster in old age, and in challenging myths and stereotypes about older people. It has been less able to mitigate the effects of inequalities which are carried through into old age and which reflect the impact of cumulative disadvantage experienced over the life course. In addition, policy has been less successful – at least on the basis of current evidence – in limiting problems that arise from communities affected by economic decline and high rates of population turnover.

Arising from these conclusions, we would suggest three types of policy development that might be important to consider:

- **Policies that monitor the impact of new types of poverty and social exclusion which emerge in old age against which existing policies may prove inadequate.** To take two examples: first, at the current time there is the challenge of a substantial cohort of people entering late old age who were part of the large groups swelling the ranks of the early retired in the 1970s and 1980s (Phillipson, 2002). Laczko (1990), for example, raised the possibility that this group would represent the ‘new poor’ in the pensioner population and the extent to which this has emerged requires further investigation. Second, there is the gendered nature of poverty in old age, highlighted in recent work by Arber and Ginn (2004). They give particular emphasis to the difficulties facing divorced women, who have no prospect of inheriting a widow’s pension and who are much less likely than men to receive a private pension. **Each of the above groups will require attention in order to prevent new forms of social exclusion emerging over the next few years.**
- **Policies in the field of community care need to be broadened to embrace more effectively the social exclusion agenda.** The extent of change in community care has been extensive over the past ten years, with many forms of service innovation. Our review suggests however a case for widening the scope of this work and extending the ambitions of care in the community. Tessa Harding’s point (1999) is important here: **much community care remains built around ‘survival needs’ rather than moving older people into mainstream activities.** This is further reflected in the continuing difficulties in ensuring effective user-involvement and empowerment. Reports from the Social Services Inspectorate do suggest that a cultural change is beginning to take place in Social Services Departments and elsewhere, but this work still needs to be more firmly tied to a view that **promoting social inclusion is an integral part of community care practice.**
- **A third issue is that, in all areas, certain groups remain excluded still from key services and benefits.** This applies, for example, to some minority ethnic groups, some groups with mental health problems, people living in rural areas, and some groups with certain forms of disability. The qualifications here are significant. The debate needs to move on from blanket descriptions of all individuals covered by these labels being affected by social exclusion in some form or another. Rather, the variations are considerable, though as yet only

superficially grasped by policy or research. Too many reports tend to assume, to take one example, that all minority groups are equally deprived in respect of income or services. But the differences are immense, reflecting variations in migration histories, cultural factors, community-based issues, and economic factors. **The next phase of the social exclusion debate needs therefore to acknowledge the complex differences between groups and the implications of this for new forms of exclusion in old age.**

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