Policy challenges briefing

Ageing
We are fortunate to be enjoying increasing life expectancy in the UK. As the population ages, we are faced with great opportunities for our society, but also major challenges which need to be urgently addressed. More than 10 million people in the UK are currently over 65 years old, and the latest projections suggest they will be joined by a further 5.5 million in 20 years’ time. The numbers of the “oldest old” are growing even faster, with the fastest growth expected among those aged 85 and over. Healthy life expectancy is not increasing as quickly, resulting in greater demands on the NHS and other public services. Social shifts, such as the increasing numbers of people ageing without having children as future carers, also place significant strains on non-medical social care needs. Together, these changes raise major policy concerns about the future provision of health and social care for older people.

Edited by Moira V. Faul and Shona Jane Lee
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Healthy life expectancy is not increasing as quickly, resulting in greater demands on the NHS and other public services. Social shifts, such as the increasing numbers of people ageing without having children as future carers, also place significant strains on non-medical social care needs. Together, these changes raise major policy concerns about the future provision of health and social care for older people.

This policy challenges briefing brings together a range of perspectives on the opportunities and challenges of ageing. Our first three authors introduce the urgency for innovative policy solutions for an ageing population from local (Jane Kennedy), national (Andrea Lee), and global (Brian S. Collins) perspectives. Kay-Tee Khaw outlines the micro and macro aspects of policies for healthier ageing, while the increase in solitary older people is addressed by Richard M. Smith. Heather Draper discusses the cultural and socio-economic diversity of older people, and Louise Lafontue describes how this diversity affects health behaviours in mid- and later-life. Alex Gimson, Carol Brayne and Ann Netten argue for the centrality of the older person in health and social care provision. John Clarkson states that similarly user-centred processes are also required in product design. Finally, Juliet Foster argues that diverse views of ageing are socially constructed ideas, not objective facts.
The UK's ageing population has considerable consequences for public services. As a percentage of the UK population, the over 65s are expected to increase until at least 2035. The number of older people with care needs is expected to rise by more than 60% in the same period. This will have a significant impact on the costs of health and social care.

England has an inappropriate model of health and social care to cope with a changing pattern of ill-health and care needs from an ageing population. Radical changes are needed to the delivery of health and social care in order to address future demand from – and provide appropriate care for – older people.

The Office of National Statistics (ONS) has projected that in England in 2030 there will be 51% more people aged 65 and over, and 101% more people aged 85 and over, than in 2010. Looking further into the future, ONS suggests that over a 50-year period we can expect a doubling of the population in the UK aged over 65, and a fourfold increase in those aged over 85.

Local authorities already find it difficult to meet the needs of all those people who require social services, and the situation is only getting worse as the population ages. Councils are facing the dual challenge of an ageing population and significant budgetary pressures. Adult social care is one of the largest spend areas for local authorities. However, adult social care budgets have not kept pace with the growing demand for services. The funding gap in adult social care in London by 2018 is estimated to be at least £907 million.

Social care absorbs a rising proportion of the resources available to councils. To accommodate the rising costs of adult care, spending on other council services will drop by 66% in cash terms by the end of the decade, from £24.5 billion in 2010-11 to £8.4 billion in 2019-20. This is the equivalent of an 80% cut in real terms. Local government needs to understand how to make savings through preventive and collaborative action, and how to delay care costs. Yet they struggle to do so.

This raises a number of challenging questions for policy:

- How can local government reduce current users’ need for formal care and reduce demand for formal care by older people who are not currently using the system?
- Recommended approaches may promise to cut costs in the long term, but what short-term investment implications do they carry, or what short-term savings might they deliver?
- In implementing the innovative policy solutions we are looking for, what are the possible risks of any solution, both to the population and to local authorities?
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References
One of the key themes coming out of the ageing policy challenge is maintaining independence without suffering from being isolated.

This tension between independence and isolation is interesting: for me it is a meaningful expression of the challenges of an ageing population. Older people want to retain some sense of independence, but we know that loneliness and isolation have become a concern in the older population, and this has ramifications for health, for demands on services, and for how our society views itself.

We have statistics, case studies and personal experience of knowing older people today and the kind of lives they lead. Curiously, measures of subjective wellbeing can be very high in later life and certainly higher than middle age. But underlying this, old age can be a period of acute anxiety: one poll revealed that 62% of over 65-year olds are worried about being seen as a problem to society, and 20% worry about being a burden on friends and family. Furthermore, the over-65s are substantially more concerned about their future needs being met than their current needs (see figure opposite).

Looking ahead to tomorrow’s old, what about the current 50 and 60-year olds, who will be the next generation of 70 and 80-year olds? Higher divorce rates amongst the old, and single household occupation, are factors that potentially increase the risk of tomorrow’s old experiencing isolation. At the same time, the abolition of a mandatory retirement age and the post-war generation’s proficiency with social media could enable them to stay independent for longer and mitigate some effects of isolation.

The future will bring new challenges, changing circumstances and opportunities for the generation born after the Second World War. We all need to become better prepared for the future. Policies will need to adapt in order to reflect the changing needs and expectations of older people. What could and should be done to help tomorrow’s old people plan for their older age? These are tough questions we have to face.
Over-65s are substantially more concerned about future needs

- **Overall health**: 38% increase
- **Financial situation**: 29% increase
- **Suitability of accommodation**: 56% increase
- **Social contact with others**: 33% increase
- **Personal safety and security**: 35% increase

Increase in concern that future needs will not be met (compared to current needs)

Source: YouGov (2014)
70% of the world’s population live in urban environments, and the impact of infrastructure and service governance on the way people live in these is significant. There are many definitions of the term “liveability”, but an important aspect of this is that ageing people need to coexist with everyone else in their environment.

While we need policies to ensure that ageing people are looked after in both a physical and service context, we also have to ensure that everyone else is content at the same time. Given economic limitations, it is clear that ideal solutions cannot be provided for every community, and there are compromises everywhere. Ageing is a multicultural, multi-sectoral issue. For example, how can we make mobility and transport accessible to older people, yet compatible with everyone else at the same time?

The global economy is largely what drives our well-being and capability to provide services. The US is still the largest economic powerhouse in the world, so the fraction of the working population in the US and how much it changes is a very important issue. If those people who are 65 years and over don’t maintain economic activity, their capability to drive one of the largest economies in the world to support everyone else will diminish.

These demographics vary across different parts of the world: in a lot of countries, the projected median age between 2010 and 2050 ranges from quite young to quite old in those 40 years. However, in the USA there is much less variation, and other major global economic players like Germany and Japan see a much greater shift toward older populations. As a result, large countries like China, Brazil and Mexico whose populations are also shifting into “ageing situations” will face increasingly large problems, as the economy depends on where the working population of these countries are positioned on this scale.

There is strong evidence for the impact of education on population growth and demography in the future, as enrolment into tertiary education, particularly among women, means birth rates would tail off very quickly. Based on such projections, by 2100 we could have a population that is smaller than it is now.

There is a sufficient body of evidence and policy interventions in other countries targeting education that make a significant difference on the scale of the population globally. By altering people’s life trajectories, the amount of people’s lives spent on education, caring, having children, or working, can be redistributed more evenly across the age range and between men and women. Exploring such models could put policy and governance frameworks in a better position to manage ageing, both at an individual and community level.

Observations relating to policy include:
- Demographics are uncertain and therefore planning for different trajectories is essential. All age groups should be interested in ageing, and this should be more heavily promoted.
- Could we systematically take more advantage of citizen science research methods?
- International collaboration needs improvement, learning from the experience of where others have succeeded/failed.

References
Estimated median age in selected countries: 2010 and 2015

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<tr>
<th>Country</th>
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<td>United States</td>
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Source: UN (2013)
As maximum life expectancy changes, people are surviving later and the proportion of older people will increase. This has huge implications for social structures that were designed for a younger population.

If we are going to change structures then we must have some ability to project into the future what healthcare needs are going to be. Modelling allows us to make these projections, allowing us to understand these changes in order to consider how we might redesign society for an ageing population.

Healthy ageing is critical to how society may look in the future. A healthy society must maintain healthy living throughout the life course, and policy must address what needs to be done to prepare for an ageing population. As we get older we are more likely to suffer disabilities, and this has significant consequences in cost terms.

We need to explore how policy changes can help

to:
- Encourage environments for healthy ageing lifestyles, which in turn encourage better health in the population.
- Improve objective measures such as being able to clean or feed oneself, as opposed to “being able to live independently”.
- Provoke macro-level changes in society, not just policies aimed at individuals.

Successful ageing trajectories are modifiable, and it is important to understand and put in place policies for both micro- and macro-interventions that positively affect the key drivers of positive change.

There have been numerous behavioural interventions implemented at an individual level, but the impacts of these are potentially trivial compared with scaled up interventions. For example, smoking micro-interventions such as counselling, nicotine replacement, and electronic cigarettes may have had some impact at an individual level, but the most substantial impacts on behaviour at population level have been achieved through national policies on taxation, pricing, advertising and laws against passive smoking. There is, however, less formal impact assessment of these national policies than of smaller studies focused on individual behaviours.

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References
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Healthy ageing is critical to how society may look in the future. A healthy society must maintain healthy living throughout the life course, and policy must address what needs to be done to prepare for an ageing population. As we get older we are more likely to suffer disabilities, and this has significant consequences in cost terms. We need to reduce disease and disability at the same time as improving functional health, quality of life, and the use of health services and social care.

Modifying lifestyle behaviours can have a surprisingly big impact on disability as well as mortality. There is also good evidence that very small postponements in disability can have huge impacts on population projection, and on healthcare and social care costs. For example, for each year we postpone dementia on average across the population, we reduce the prevalence of dementia by 10%.

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We need to explore how policy changes can help to:

1. Support successful ageing trajectories which are modifiable, and it is important to understand and put in place policies for both micro- and macro-interventions that positively affect the key drivers of positive change.
2. Encourage environments for healthy ageing lifestyles, which in turn encourage better health in the population.
3. Improve objective measures such as being able to clean or feed oneself, as opposed to “being able to live independently”.
4. Provoke macro-level changes in society, not just policies aimed at individuals.

Projected numbers of people aged 60 years and over in the UK

Source: ONS (1999)
The 2011 census showed that a third of all households in England and Wales contain just one person. That represents an enormous change in residential arrangements compared to 1900, when only 5% of all households contained solitary persons. If these trends continue, almost a half of all households will be solitaries by 2025.

This growth is marked among the elderly, and especially so among the very elderly. The number of persons aged 65 and over in single-person households will have grown from approximately 3 million in 2008 to just under 5 million in 2024, and the number of solitaries over 85 will have grown from 573,000 in 1961 to 1.5 million by 2024 – a rate of growth far faster than for any other group within the population as a whole.

This shift has implications for health and caring arrangements for those in the oldest age groups. Key issues are the extent of care available to the solitary elderly person, and the level of social interaction of those living alone – a risk factor for both depression and cognitive decline. Most long-term care for older people is still provided by family and friends for free, and we are at an historic high point regarding the availability of kin for that purpose.

Despite the fact that more friends and family than ever before are available to take care of the elderly, more policy initiatives are essential to enable the solitary elderly to remain in their own homes, since this is their overwhelming preference. This requires better coordination across health, long-term care and social services.

It is not possible to avoid the political context. Public attitudes prove consistently to be positive towards the NHS and expenditure on it, but less so with regard to spending on social care. We seem currently to be observing what is an unfortunate effect of a disjunction between, on the one hand, policy relating to waiting time to treatment in hospital A&E departments (alongside ‘bed-blocking’ in hospitals more generally), and on the other, local authority reductions in funding social care packages, the majority of which are directed to the solitary elderly.

Policy should serve to maintain the social interaction of the elderly and enhancement of their self esteem, at the same time as improving the autonomy and health status of people with physical impairments.

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References
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Source: ONS (2011)
Healthy ageing can and should be a realistic goal for everyone in society. It relates to the environment in which you live, the services you have access to, how valuable you feel, and your social network.

Different cultures think about ageing in different ways, and ethnicity impacts on the profile and needs of the ageing population. The UK’s super-diverse society contains smaller groups of migrants who are more transient, less organised as definable communities, and more economically stratified. This has major implications for planning and delivering our goal of healthy ageing, and any interventions need to be sensitive to such super-diversity. Research and policy need to understand these dynamics in order to utilise existing support networks.

Health inequalities associated with socio-economic disadvantage are also found in the older population, and remain a challenge for policy makers in relation to healthy ageing. More needs to be done to ensure that the poor, as well as the wealthy, are able to flourish in later life. This may only be achieved by addressing inequalities in younger life; ensuring parents and their children flourish in ways that set them up to age well.

Advances in technology can improve people’s quality of life and encourage independence, but devices need to take into account varying needs and expectations. Design must therefore involve the input of older people, and greater consideration must be given to the security of tele-technologies to ensure the safeguarding of vulnerable users against fraud.

Much more must be done so that we can fully benefit from the enormous potential that exists within the UK’s ageing population.

Real challenges for policy makers are:
- Marrying the agendas of healthy ageing, the importance of community, and resilience of and contributions from older people.
- Promoting what can only be mutually beneficial initiatives has to be a proactive goal of both national and local governments.
- Putting the voice of the growing cohort of older people at the heart of policy decisions across the range of public services.

Drawing on lessons learned from Wales and Northern Ireland, a Commissioner for Older People in England should be established. Recognition of the human rights of older people is critically important. This is a matter for health and social care providers, and also requires action at national and international levels.
Life expectancy across Birmingham commuter train lines

Source: Birmingham Policy Commission (2014)
In order to prevent negative health outcomes in later life we have to act now. Modifying behaviours in mid-life and later life affects different types of outcomes relevant to the older population, which could potentially impact positively on health services and healthcare as a whole.

At the Cambridge Institute of Public Health, we have been looking at the current evidence to inform the development of NICE’s public health guidance for mid-life approaches to prevent or delay the onset of disability, dementia and frailty in later life.

There is consistent evidence that mid-life physical activity, a healthy diet (including fruit and vegetables), and participation in a diverse range of intellectual and leisure activities all have beneficial effects on later-life outcomes. Across all populations studied there is consistent evidence that mid-life smoking has a detrimental effect on multiple outcomes in later life. Evidence specific to mid-life alcohol consumption was mixed (due to wide differences in how studies are conducted).

In terms of interventions, we identified good quality evidence suggesting that modification of behavioural risks can occur in mid-life, and can be cost-effective if these changes are sustained in the long term. These include the promotion of physical activity and good diet behaviours; reduction or cessation of smoking and alcohol consumption; weight management; and interventions addressing multiple unhealthy behaviours.

Importantly, due consideration must be paid to how personal, environmental, and social factors act as facilitators or barriers in the uptake of these healthy behaviours in mid-life. Personal factors such as gender, socio-economic status, ethnicity, employment, individual expectations and previous experiences of healthy behaviours all play a role in the extent to which people may change their behaviours. The type of work and home environments can facilitate – or get in the way of – people taking on healthier behaviours, and affect people’s access to health-promoting resources and interventions. Moreover, being in a social environment where norms and networks support people who wish to change their behaviours is critical.

Finally, the organisation, design and delivery of health promoting interventions can make it easier or harder for certain segments of society to take on healthier behaviours.

Emphasis should now be placed on designing, implementing and evaluating tailored interventions that will foster sustained adoption of healthy behaviours across different communities, settings and geographies.

References
Healthy behaviours in mid-life: facilitators and barriers

Facilitators and barriers

- Personal
- Social
- Environmental

Health outcomes

- Ageing well
- Healthy behaviours
- Chronic conditions
- Health inequalities

Source: Lafortune et al. (2014)
In recent years, the delivery of health and social care has become fragmented, with multiple providers delivering component parts of a single patient’s clinical pathway. To achieve integrated care, those involved with planning and providing services must impose the user’s perspective as the organising principle of service delivery.

In a number of different geographical areas within the UK, attempts have been made to integrate some of these services so that problems which may occur at the interfaces between providers can be avoided. These attempts are predicated on trying to deliver care centred around the individual patient rather than around the particular service.

No single “best practice” model of integrated care exists. What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations. Organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care.

What is most vital is to focus on the goal of benefiting service users. It also appears that integrated care requires a single point of coordination of care accessible by professionals and patients/carers. Named, contactable care coordinators or case managers are beneficial, as is partnership-working between health and social care with aligned outcomes.

In all of the successful integrated care projects, certain factors were identified as critical:
- Additional and sustained services outside hospital.
- Increased capacity in primary and community care (which may result in downsizing of activity undertaken in acute hospitals).
- The involvement of the voluntary sector.
- Shared access to IT and all information relevant to a patient’s clinical condition, progress, and his or her journey through different components of health and social care.
- The consideration of the whole disease pathway or total health needs of a defined population, rather than just a small sub-section of the whole.

Whilst these principles of delivery may be clear, it remains difficult to identify robust evidence of either improved patient outcomes or efficiencies derived from integrated care. In part this is because attempts to integrate small sections of a care pathway are unlikely to demonstrate benefit without integration along the whole length of the pathway. Patient satisfaction with integrated care pilot studies has been high, but it is likely that any potential benefit will only be delivered by a whole-system approach.
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Patient-centred, integrated health and social care
We are all likely to go through periods of ill health before death, and these will vary in severity as we progress towards the end of life. Healthy ageing and end-of-life trajectories require holistic, patient-centred approaches, rather than the single-disorder approach that is the norm.

Despite decades of evidence that patterns of health within ageing populations usually comprise a spectrum of co-morbidities, there is a widespread fixation within the biomedical community and pharmaceutical industry on treating single conditions. For example, Alzheimer’s disease is a complicated concept encompassing neuropathological factors and the presence of dementia syndrome (which itself lies on a continuum), which do not usually have a one-to-one relationship. There is too much orientation towards identifying and treating single disorders. In contrast, a more holistic view of prevention, detection and care recognises the reality that healthy ageing and end-of-life trajectories are more about being supported in your environment to function and live (and die) as well as possible.

The preferred model is that of a successful ageing trajectory with a rapid terminal decline and high quality of life. Unfortunately, evidence suggests that terminal decline tends to be longer and more drawn out in reality. Some variables that modify these paths have been identified, however. Higher education, for example, is associated with sharper terminal decline in health and an individual dying more quickly after manifesting dementia syndrome. This demonstrates potentially protective effects of education against dementia, and much preferable end-of-life trajectories, where independence can be retained leading up to death.

Research in this area suggests four key messages for policy makers:

- Move away from single-disorder approaches that are expensive and poorly-evidenced with regard to the older old. Instead, older people need approaches that prioritise all of their needs, ailments, and potential and actual contributions.
- Improving community and societal cohesion is critical to improving quality of life leading up to death.
- Establishing a common language relating to ill health and expectations is important. However this is complicated given the variation in social, economic, environmental, medical, local and global contexts.
- In medicine, the priorities of research agendas are mostly decided by researchers and pharmaceutical companies. We need to give more consideration to what older people really want; and how this might change across generations.

References
Ageing and end-of-life trajectories

Successful ageing trajectory

Unsuccessful ageing trajectory

Source: Cosco, et al. (2013)
The UK is seeing an increasing demand for social care, driven by a growing older population and changes in household composition. Older age is associated with increased levels of impairment, but improved health outcomes can lead to reduced demand for social care.

Both social care and healthcare are concerned with maintaining and improving quality of life, but their roles differ. In health you are looking at quality of life through the treatment and mitigation of impairment. Social care and social services are focused on compensation for impairment: for example, can you participate in activities and see people you want to; are you clean and comfortable; are you getting enough to eat?

The figure opposite shows the contribution of home care services to quality of life. The blue area represents the impact of home care user service packages on social care related quality of life. The grey area shows what people feel they would experience without these home care services. This figure shows that the contribution of services received by this group was greatest for personal cleanliness and comfort, followed by control over daily life. The lowest scoring aspects were occupation and social participation, which indicates that home care services have a limited impact on these more interactive aspects of quality of life for older people.

Policy makers and practitioners need to:
- Put quality of life objectives in the context of older people’s priorities.
- Work with older people, their carers and their communities to generate a variety of ways to meet their priorities.
- Get a good working relationship between agencies.

Collaboration between different agencies can generate a variety of ways to achieve these outcomes and has the potential to mitigate some of these problems. However, such collaboration is difficult in the context of dividing lines between institutions with separate responsibilities and budgets, and across organisations with diverse cultures. Furthermore, we have limited data in social care and where we do have the data, sharing across organisations is a challenge. Funding is another challenge: the increasing demand for and decreasing supply of social care is set against a background of already limited and continually decreasing resources.

Ultimately, the main drivers of improved quality of life are the individual older person, and his or her carers, community and environment. Each older person has his or her own priorities and we have to respect these. No one solution is going to fit all, and our core challenges lie in understanding the perspectives and priorities of individual older people and their carers.

References
Contribution of home care services to quality of life

The diagram illustrates the impact of home care services on various aspects of older people's quality of life. The key areas include:

- **Accommodation cleanliness and comfort**
- **Dignity**
- **Control over daily life**
- **Occupation**
- **Social participation**
- **Food and drink**
- **Safety**

The blue area represents the impact of home care on reported quality of life, while the gray area indicates older people’s experience without home care services. The data is sourced from Netten et al., (2012).
“I have always wished for my computer to be as easy to use as my telephone; my wish has come true because I can no longer figure out how to use my telephone.”

This comment – made sometime around 1990 by Bjarne Stoustrup, an eminent computer scientist, after a frustrating attempt to use a “feature-rich” telephone – exemplifies the challenge felt by many people interacting with the modern world. If the demand put on us by a product – be it a jam jar, mobile phone or asthma inhaler – exceeds our capability to respond, we may be excluded from using it; resulting in toast without jam, a missed call, or poor respiratory health.

As world populations age, the variation of capability across the population increases, particularly in older age where the mean capability also decreases. As we grow older we will generally see less, hear less, have decreasing cognitive powers and be less mobile. This provides particular challenges for designers and service providers, who need to accommodate such changes if people are to be able to continue to use their products and services through life.

Whilst there are many success stories in designing for this “wider” population, such as cordless kettles and accessible phones, many new products and services challenge – and will continue to challenge – older or less-able users. In any generation, new ways of interacting with products and new service paradigms have the potential to alienate and exclude people.

With an ageing population comes the additional challenge of finding sufficient carers to support those in need of care. In this context, independent living goes from being an aspiration to an imperative. There is a need to find novel approaches to the design of products and services to enable such independence, delivering value to both users and business.

Inclusive Design acknowledges that it is normal to be different, and advocates the design of mainstream products and services that are accessible to – and usable by – as many people as reasonably possible without the need for special adaptation or specialised design. It is based on the principle of enabling designers to understand the diverse capabilities of potential users and to match their products to these needs. In this way Inclusive Design is simply better design.

Roger Coleman, an early advocate of Inclusive Design, once said “[the world] can ultimately be made a better, more inclusive place by a more responsible approach to design in business, government and education, and collective efforts by all three.” There is a future need to support independent living through designers with the skills to innovate, businesses with the will to change and think differently about the markets they address, and people-focused policies to encourage businesses and designers to move towards this future together.

Professor John Clarkson
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When thinking about ageing and older people, we draw on socially constructed understandings that circulate within society. There is a risk that many of these beliefs can be taken as matters of fact, and go unchallenged.

Representations and ideas are never held in the abstract, but instead influence the way we approach an issue in our daily lives (how we act), and how we approach other people in relation to that issue (how we interact). In some literature this has been referred to as a “project” (Bauer and Gaskell, 1999). It is crucial to understand these shared representations, projects and their implications when considering interventions of any kind.

Research into understandings of ageing shows that ideas are centred on both losses and gains, which can be seen as biological and/or psychological. Yet different aspects of these representations will be emphasised amongst different groups, and vary according to differences in age, gender or ethnicity (Foster, 2003).

Wachelke (2010), for example, found in one study that older people were more positive about ageing than younger people; in another, Italian participants were more positive than Brazilian participants, focusing on ideas of family life for older adults rather than social exclusion. It is essential to recognise the diversity of views of ageing and older people that are held across different groups – and the implications of those diverse views – both in order to be able to challenge problematic assumptions (amongst public and professionals) and to design effective programmes and interventions.

Holding understandings about a particular topic also involves understanding that other people can have different ideas from your own. Sometimes these differences co-exist in parallel, but in some cases they are in conflict with each other, and we need to be able to respond to these situations. There are also differentials in power to be considered, and we need to be conscious of the impact these have on different groups. Definitions and notions of “independence” and “recovery”, for example, are often established by professionals when the individuals who are affected more directly by an issue may hold different ideas which will affect their actions and interactions.

There is substantial evidence from social and health psychology of the disastrous effects of public education campaigns that lack understanding and awareness of what is going on at the ground level. Examples include early HIV-Aids information campaigns in the 1980s, and the many other health campaigns that have failed to engage with target populations, imposing messages in a top-down manner that can have no effect or even negative consequences. A more bottom-up approach is needed, drawing on pooled knowledge across sectors and disciplines to establish clarity on shared understandings about ageing populations, and their manifold influences.

References
In 2014-15, the Centre for Science and Policy (CSaP) and PublicHealth@Cambridge worked in partnership on a Policy Challenge addressing the impacts and opportunities of an ageing population.

The PublicHealth@Cambridge Network is a multidisciplinary community of researchers supporting development of new research and co-ordinated activities in areas of importance to public health and facilitating translation of research to benefit current and future populations.

The Centre for Science and Policy promotes engagement between academic research and government in order to improve the use of evidence in public policy and support academics in the public policy dimensions of their research.

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CSaP Policy Challenges Programme
Funded by the ESRC, this initiative addresses high-priority public policy issues identified by the Centre for Science and Policy’s (CSaP) Policy Fellows. The Programme enables government policy makers and industry leaders to better engage with each other and with multi-disciplinary groups of academics who have insights to offer on a key policy challenge they face.

To follow and contribute to this policy challenge, go to www.csap.cam.ac.uk/policy-challenges