

Ageing Across Europe



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Executive summary

Many European countries, including the UK, are now facing the dual challenge of responding to the demographic changes brought by population ageing, while also implementing tough austerity measures following the 2008 financial and economic crisis. With increasing pressure on public budgets, this is an important moment to consider what it is that makes a country a good place to grow old, and where possible to learn lessons from our European neighbours on the policies and services that are most effective in giving older people a good quality of life. This new evidence will contribute to a national debate in the UK about our aspirations for our older citizens and how we might best achieve them in an increasingly challenging fiscal environment.

The research

We have chosen three comparator countries from the EU for this study: Germany, the Netherlands and Sweden. Each of these countries has a unique set of social and cultural characteristics, policies and institutional traditions, which can offer the UK valuable insights into the many factors that support or challenge positive experiences of ageing.

The methodology for this research had two main elements:

- a literature review to explore each country's unique demographic context and identify the institutional frameworks, policies and services that are in place to support older people
- quantitative analysis of European Social Survey data to compare experiences of ageing across the four EU countries in the five policy domains of income and poverty, health and health provision, well-being, social inclusion and participation, and age discrimination.

In this second strand of the research we developed an 'Experiences of Ageing Matrix' composed of a basket of 30 indicators from the European Social Survey. The matrix ranks the four countries in order of success in each of the five policy domains and also provides an overall ranking across five domains:

- income and poverty
- health and health provision
- well-being
- social inclusion and participation
- age discrimination.

We also conducted longitudinal analysis to identify any trends over time between three rounds of the survey (conducted in 2006, 2008 and 2010), and performed statistical analyses to identify correlations within each country between older people's outcomes across the five themes.



Findings

Overall findings

Overall the Experiences of Ageing Matrix demonstrated that Sweden had the highest score, indicating it had the most positive overall experiences of ageing, with a mean score of 51.72. The Netherlands came a very close second, with a mean score of 51.69, the UK came third with a mean score of 49.94, and Germany had the lowest mean score with 49.50 points out of 100 (table 1).

Table 1 Overall findings of the experiences of ageing matrix

	Theme 1: income and poverty (ranking)	Theme 2: health and health provision (ranking)	Theme 3: well-being (ranking)	Theme 4: social inclusion and par- ticipation (ranking)	Theme 5: age dis- crimination (ranking)	Overall score (ranking)
Germany	50.42 (3)	48.97 (4)	49.19 (4)	48.97 (4)	49.96 (2)	49.50 (4)
UK	48.01 (4)	50.45 (3)	50.68 (3)	50.84 (3)	49.73 (4)	49.94 (3)
Netherlands	53.81 (1)	52.20 (2)	51.13 (2)	51.48 (1)	49.82 (3)	51.69 (2)
Sweden	51.84 (2)	52.63 (1)	51.32 (1)	51.20 (2)	51.59 (1)	51.72 (1)

The analysis of correlations between the five themes identified positive correlations between the indicators for income, health and social participation in each of the four countries studied. There was also a positive correlation in each of the four countries between well-being and health and well-being and social participation. In each case the strength of the correlations differed between countries. This indicates that in each of the four countries, if an older person had a high income, they were more likely to have good health, while better levels of health were also associated with higher rates of social participation.

These findings highlight how important it is that policymakers should consider the complex interaction between the themes explored in this research when designing policies aimed at tackling poverty, poor health or social exclusion among older people.

Income and poverty

In the Experiences of Ageing Matrix the UK performed most poorly of the four countries against the set of indicators related to income and poverty. On average we found UK pensioners to have the lowest net income and were the most likely to have had to manage on a lower income, draw on savings or economise on their expenditure in the last three years. Pensioners in the UK also had the lowest perception of the overall living standards of pensioners of all four countries.



This reflects the fact that with 21.4 per cent of UK pensioners considered to be at risk of poverty in 2010, the UK has a substantially higher proportion of pensioners at risk of poverty than the other three countries. The UK also demonstrates greater income inequality among pensioners. These findings may indicate that not enough pensioners in the UK are currently eligible for a full basic state pension, or that the level at which the basic state pension is currently set is inadequate to give pensioners in the UK a sufficient standard of living. This research identified a significant correlation between income and health and income and social participation in the UK. Therefore, the greater level of income inequality in the UK has worrying implications for health inequalities, while the high proportion of pensioners at risk of poverty is likely to threaten social inclusion in old age.

Germany ranked third in the income and poverty domain, while Sweden ranked second and the Netherlands ranked first. This high ranking reflects the fact that the Netherlands has the lowest risk of pensioner poverty of the four countries, which at 5.9 per cent in 2010 is substantially below the EU-27 average of 15.8 per cent of pensioners at risk of poverty. This is likely to be related to the relatively generous level at which the basic state pension in the Netherlands is set in comparison with the other three countries, and the low eligibility requirements for a basic state pension in the Netherlands.

Health and health provision

Germany ranked the lowest overall of the four countries against the set of indicators in the matrix that related to health and health provision. This was mainly because the German respondents were more dissatisfied with healthcare in their country than the respondents from the other three countries. A larger proportion of German older people gave their current healthcare system a low rating and thought that funding for their healthcare system was unsustainable. The UK had the highest rating for the state of health services in the country nowadays, although more older people thought that they might not have access to health care if they needed it.

However, it was the UK that performed lowest on two of the three indicators that related to personal health. The German respondents ranked lowest on the question about self-rated general health (followed by the UK), but the UK respondents registered the lowest mean score for life-limiting illness and the lowest score for 'feeling active and vigorous'. This reflects the fact that both the UK and Germany clearly face considerable public health challenges in relation to population ageing. A range of data indicate that the UK has the highest rates of alcohol use of the four countries, and also the highest rate of obesity, closely followed by Germany, while Germany has the highest rate of diabetes. Both obesity and diabetes are associated with a number of long-term health conditions that are likely to impact negatively on older people's independence and quality of life, and limit the extent to which they can engage in work. These are very significant issues for national governments that aim to address population ageing by encouraging older people to remain in work for longer.

In comparison, Sweden and the Netherlands both performed well on the health indicators included in the matrix, with Sweden ranking slightly higher overall.



Social participation and well-being in old age

Our analysis in the Experiences of Ageing Matrix presented in chapter 7 demonstrated that Sweden ranked highest among the four countries for well-being among older people and the Netherlands ranked highest for older people's social participation. However, these two countries' total mean scores were close together within both of these themes.

The UK ranked third of all four countries against the set of matrix indicators corresponding to well-being and social inclusion and participation. Germany ranked fourth against each of these themes. Within the well-being theme, older people in the UK ranked second for the extent to which they felt they were free to live their lives and the extent to which they felt their life was valuable and worthwhile. This might indicate they have a greater sense of autonomy than older people in Germany and Sweden, who both ranked lower than the UK. However, the UK ranked third on the general life satisfaction and general happiness indicators and fourth on the indicator measuring the extent to which older people felt they had time to do things they enjoyed.

Within the theme of social participation, the UK ranked second highest on the indicator reflecting the frequency of social contact but also demonstrated the lowest score among the four countries for loneliness, indicating that older people in the UK feel lonely more frequently than in the other three countries. Older people in the UK also ranked third for having someone to confide in. In contrast, Germany pensioners were on average the least lonely, but the matrix demonstrated that levels of well-being were consistently lowest in Germany across most of the indicators used in the matrix. The sample of older people in Germany also registered the lowest levels of social trust and belief in other people's helpfulness.

One factor responsible for the UK's relatively poor performance against the loneliness indicator in the Experiences of Ageing Matrix may be long-term underinvestment by local authorities in services that reduce social isolation and loneliness. This under-provision is currently being exacerbated by the cuts that local authorities are making to community services for older people to accommodate the reduction in their budgets caused by national austerity measures.

It is also notable that countries with higher rates of volunteering at all ages (eg the Netherlands and Sweden), and traditions of volunteering in leisure activities such as sports and cultural activities, appear to offer older people more opportunities for social participation while also supporting more frequent contact between the generations. Further investigation is needed to identify whether these factors of higher rates of voluntary activity and intergenerational contact are linked.

Age discrimination

The UK ranked lowest overall on the set of matrix indicators relating to age discrimination. Examination of the individual indicators demonstrates that older people in the UK are more concerned about age discrimination than older people in the Netherlands, Germany and Sweden and more likely to feel negative towards young people. Our matrix findings also demonstrated that older women in the UK are more likely to feel they are subject to discriminatory attitudes



than older men. This may indicate a particular interaction between ageist and sexist attitudes in the UK that is not as prevalent in the other three countries studied.

There was also a significant association in the UK survey samples between the health indicators and the age discrimination indicators. This suggests that older people who had poorer health were more likely to be concerned about age discrimination, and there might be an interaction between age-related discrimination and discrimination towards people who have poor health or are disabled, with important implications for policy. Further research is needed to understand why the UK rates particularly highly against age discrimination indicators, and how these other types of discrimination might be mutually reinforcing.

Policy directions for the UK

We can see from the review of evidence presented in this report that the UK faces multiple challenges in providing older people with positive experiences of ageing, scoring poorly (although not always the worst) across every theme in the matrix. We can also see that these themes are highly interrelated, therefore policy approaches that attempt to address individual issues in silos (eg pensions or social care), while ignoring the related issues of age discrimination, health, social participation and employment, are likely to be ineffective. The correlation we have identified in each country between the various factors of income, health and social participation indicates that there is the potential to create a virtuous circle, whereby general improvements in health and income could also improve older people's social participation. However, if action is not taken there is likewise the potential for a downward spiral whereby older people who suffer from poverty or poor health may be at greater risk of experiencing isolation and loneliness.

None of these challenges can be addressed in isolation. Therefore with this in mind our findings suggest that a multilevel approach should be taken to improving experiences of ageing in the UK, including:

- developing cross-government strategies on preparing for an ageing society in England, Scotland, Wales and Northern Ireland (in Wales and Northern Ireland the Commissioner for Older People is likely to have a key role in this)
- tackling pensioner poverty by taking action to increase take-up of occupational and personal pensions and introducing a single tier 'citizens' pension' for UK residents, which is paid at an adequate rate and has sufficiently low eligibility requirements to ensure broad access
- taking action to tackle age discrimination throughout health and social care services, including basic training in meeting the requirements of the Equality Act 2010 for all new health and social care professionals, with training also available as part of continuous professional development
- making healthy ageing a central part of the UK's public health strategy and tasking the agencies responsible for public health at a local level (health and well-being boards in England, local health boards in Wales, community health partnerships in Scotland and health trusts in Northern Ireland) with promoting healthy ageing and coordinating local services for older people that support social participation and reduce loneliness



- developing cross-sector national responsibility deals in each of the UK's devolved administrations to promote healthy ageing
- including in the Adult Social Care Outcomes Framework for England (and the equivalent frameworks for Scotland, Wales and Northern Ireland) a robust standalone indicator for measuring the extent of loneliness among older people who use social care
- developing an action plan with cross-sector collaboration for increasing older people's participation in voluntary activities with the aim of increasing social participation in retirement and supporting intergenerational relationships
- conducting research to investigate the causes of complex forms of age-related discrimination
- working in partnership with employers to recognise the value of older workers, make more effective use of their skills and experience, build relationships between different generations of workers and smooth the transition between working and retirement.

In conclusion, there is no denying that the UK faces significant challenges in adapting to population ageing, while simultaneously tackling the national budget deficit. However, we consider that the positive examples provided in this study by Sweden and the Netherlands show that with sustained social and political commitment, the UK could tackle pensioner poverty and improve levels of health and social inclusion for older people just as successfully as these two high-performing EU countries.



Introduction

The European Union has designated 2012 as the 'European Year for Active Ageing and Solidarity between Generations'. One of the primary aims of this initiative is to 'reverse the idea that older persons are a burden on society'; another is to enable older people to stay in work for longer, remain healthy for longer and at the same time to improve 'the physical, mental, and social well-being of older members of society'.¹ However, this initiative comes in the context of tough economic times following the 2008 financial and economic crisis, with years and perhaps decades of austerity measures looming in many EU countries. At the same time, Europe faces unprecedented population ageing, with the ratio between workers and pensioners across Europe projected to change from approximately 4:1 to 2:1 between now and 2060.²

In the context of these challenges, when social solidarity between the generations might seem to be under increasing strain, and people approaching retirement are at risk of having the benefits and services they rely on reduced as a result of austerity measures, this is an important moment to reconsider the question of what makes a country a good place to grow old. The increasing focus on active ageing at a European level also presents exciting opportunities for policymakers in the UK to learn from their European neighbours on the policies and services that are most effective in achieving the outcomes that older people value, such as good health and strong social relationships.

Therefore, the purpose of this study is to contribute new evidence to the national debate in this country about how the UK compares to other EU countries in areas such as the living standards of pensioners, health outcomes, and social participation and well-being; and to identify how we can learn from the experiences of other EU countries and thereby improve the lives of older people in the UK.

We have chosen three comparator countries for this study – Germany, the Netherlands and Sweden – for the particular insights they can provide. We identified Germany as a valuable comparator country as we thought that its particularly large older population, which has a relatively poor health profile in comparison with other northern European countries, could hold valuable lessons for the UK. We chose the Netherlands on the basis of its exemplary low rates of pensioner poverty and high health rankings to provide a high performing benchmark on pension provision and health outcomes with which to compare the UK and other countries in the study. And we selected Sweden for its exemplary performance against indicators of social inclusion among older people, which is combined with a high performance on objective measures of health.

The approach that we have taken is to conduct a detailed review of the policies in place in each of these countries and available comparative data reflecting older people's outcomes in five domains: income, health, well-being, social participation and age discrimination. Our findings from this review are presented in section 1.

In section 2 we present our findings from new analysis of the European Social Survey, which compares experiences of ageing in these five domains across the four countries studied. This



includes a matrix, which ranks the four countries in order of success in each of the five policy domains and provides an overall ranking across all five domains. We conducted longitudinal analyses of the European Social Survey to identify how the various indicators have changed over time in the four countries, and statistical analyses to identify correlations within each country between older people's outcomes across the five themes.

In section 3 we interpret these findings in the context of the policies outlined in section 1 to draw out the policy implications of our findings and make new policy proposals for how we can improve people's experiences of ageing across the EU and specifically in the UK.



Section 1

Country profiles



1 Demographics

The trend of population ageing taking place across the EU is driven by three key demographic factors. First, there has been a long-term trend of declining fertility rates in EU countries since the mid-1960s, with fewer children being born to each woman. In 2002 the fertility rate across the 27 EU member states (EU-27) reached an all-time low at 1.45 births per woman.³ By 2009 this figure had recovered slightly to an average of 1.59, but it remains substantially below the replacement rate required to keep a population stable, which is estimated at 2.1 births per woman.⁴

Second, reductions in infant mortality and increasing longevity have contributed to gains in life expectancy both at birth and at age 65. In the EU-27 countries, life expectancy at birth has increased by about a decade since the 1960s.⁵ Between 2002 and 2008, life expectancy at birth across the 27 countries increased by an average of 1.5 years for women and 1.9 years for men.⁶ Life expectancy at age 65 also improved at a rapid rate during this time period, increasing from 17.9 years to 19.1 years across the 27 EU countries between 2002 and 2008.⁷

Third, as a result of the 'baby boom', whereby national fertility rates rapidly increased and then declined in many countries around the world after the Second World War, a particularly large birth cohort is now reaching retirement age in some European countries.⁸ This generational effect of large baby boomer generations entering retirement is a major factor currently driving rapid yearly increases in public spending on age-related benefits and services such as pensions and healthcare, as we will explore in subsequent chapters.

According to an analysis by Eurostat, the ten European countries most affected by demographic ageing according to a series of four indicators (median age, the proportion of people aged 65+, the proportion of people aged 80+ and the old age support ratio) are the following, in descending order: Italy, Germany, Sweden, Greece, Austria, Belgium, France, Portugal, Finland and Switzerland. The UK is ranked twelfth out of the 31 countries listed.⁹

Taken together, these three trends have contributed to significant changes in the age structure of European populations. Sweden was very much a trailblazer in this area: between 1950 and the turn of the twenty-first century, the proportion of older people in Sweden had doubled.¹⁰ As a recent demographic study observes, 'During recent years other countries have caught up and the process of population ageing continues, with the world's share of elderly being likely to more than double by 2050.'¹¹ However, projections by Eurostat suggest that the rapid rate of population ageing we are currently experiencing will have slowed in most European countries by 2060, 'the year by which most of the baby boomers will have died out'.¹² By this point it is predicted that Sweden 'may turn out to be one of the youngest European populations'.¹³

We will now look at the specific demographic dynamics of the four countries that feature in this study.



Table 2 Demographic indicators in four EU comparator countries, 2010¹⁴

	Median age (years)	Population aged 65+ (N) ¹⁵	Share of population aged 65+ (%)	Young age support ratio (%)	Old age support ratio (%)	Share of population aged 80+ (%)
Germany	44.2	16,901,742	20.7	20.5	31.4	5.1
UK	39.6	10,205,108	16.5	26.4	24.9	4.6
Netherlands	40.6	2,538,328	15.3	26.2	22.8	3.9
Sweden	40.7	1,690,777	18.1	25.4	27.7	5.3
EU-27	40.9	87,094,001	17.4	23.3	25.9	4.7

Germany

Germany has a particularly large older population in comparison with other EU countries (see table 2), numbering 16,901,742 people in 2010. In the same year 20.7 per cent of the German population was aged 65 or over, compared with an EU average of 17.4 per cent of populations at this age. This means that Germany has a relatively high old age support ratio (the proportion of older people aged 65+ in comparison with those of working age) at 31.4 per cent, compared with an EU average of 25.9 per cent.

Germany also has a particularly low birth rate; according to Eurostat figures, in 2009 Germany had a fertility rate of 1.36 live births per woman (the average rate among the EU-27 countries was 1.59).¹⁶ This has contributed to a low young age support ratio (the proportion of young people aged 0 to 14 in comparison with those of working age) at 20.5 per cent compared with an average of 23.3 across the EU-27 countries.

These two factors of there being a relatively small younger population and a large older population contribute to a particularly high median age in Germany of 44.2 years. This is the highest median age out of all the EU-27 countries.¹⁷ Germany was the first European country to reach a median age of 42 in 2005 and Eurostat estimates that Germany will be the first country to reach a median age of 46 in 2014 and of 50 in 2037. It is also projected that Germany could have an old age support ratio of 0.5 by 2013 – there would be only two people of working age for each older person.¹⁸

UK

The UK ranks lower than the EU-27 average on all of the population ageing indicators set out in table 2. Out of the four countries studied, only the Netherlands demonstrates a lesser degree of population ageing according to some of them: the proportion of the population aged 65+, the old age support ratio and the share of the population aged 80+. However, the Netherlands has a slightly older median age than the UK at 40.6, compared with the UK's 39.6.



Some of these indicators, such as median age and proportion of the population aged 65+, will be influenced by the mini-baby boom that the UK has experienced in recent years, with fertility rates in England and Wales in 2010 having increased by 22 per cent since 2001.¹⁹ In 2009, the total fertility rate in the UK was 1.94 compared with an EU-27 average of 1.59.²⁰ Therefore, in 2010 the UK's young age support ratio was the highest of the four countries at 26.4, compared with an EU-27 average of 23.3.

However, while the UK does not demonstrate as great a degree of population ageing as Germany and Sweden, in absolute terms, the UK has the second largest older population of the four countries studied, with 10,205,108 people aged 65+ in 2010.

The Netherlands

The Netherlands has a relatively small older population with only 15.3 per cent of Dutch people aged 65 or over, compared with an EU-27 average of 17.4. However, in absolute terms its older population is considerably larger than that of Sweden, at 2,538,328 people.²¹

As mentioned above, of the four countries considered in this study the Netherlands exhibits the least degree of population ageing according to three of the four indicators included in table 2. These are: share of the population aged 65+, old age support ratio and share of the population aged 80+. On each of these indicators the Netherlands is below the EU-27 average.

However, the Netherlands has a slightly higher median age than the UK, perhaps because of its lower total fertility rate during the last decade. As of 2009 this stood at 1.79 live births per woman compared with the UK's total fertility rate of 1.94.²²

Sweden

In absolute terms Sweden's older population is small, numbering only 1,690,777. This is a tenth of the size of Germany's older population (16,901,742).²³ Despite this, of the four countries in this study, Sweden has the second largest older population as a proportion of the whole country population, with 18.1 per cent of people aged 65+. This compares with 20.7 per cent of people being aged 65+ in Germany and 16.5 per cent in the UK.²⁴

In previous years, Sweden had an older demographic than Germany: 'For a large part of the 20th century, Sweden was the country with the highest median age.'²⁵ The 2011 Eurostat report discussed above found that both Italy and Germany have now overtaken Sweden on a combined set of indicators of population ageing.²⁶

However, according to one indicator of population ageing – the share of the population aged 80 or over – Sweden still outstrips Germany. In 2010 5.3 per cent of the Swedish population was aged 80+, compared with 5.1 per cent in Germany, 4.6 per cent in the UK and an EU average of 4.7 per cent.²⁷ This reflects Sweden's earlier position in the trend of population



ageing and the relatively high life expectancy in Sweden. In 2009 at age 65 the average Swedish person can expect to live for another 19.8 years, compared with 19.6 years in the UK, 19.4 years in the Netherlands, 19.3 years in Germany and an EU-27 average of 19.1 years.²⁸



2 Income and pensions provision

This chapter will begin by comparing various indicators of income, risk of poverty and material deprivation for people aged 65+ in Germany, the UK, the Netherlands and Sweden, before outlining the pension provisions and other pensioner benefits that are in place in each of the four countries.

Income and material deprivation indicators

A number of agreed EU indicators are publicly available to allow cross-country comparisons of income and poverty among people in the 65+ age group. Some of these are relative measures of income or poverty, which compare income levels of people aged 65+ (a proxy for pensioners) with those of younger (non-retired) age groups. These relative indicators include 'risk of poverty', relative median income ratio and aggregate replacement ratio. Other indicators consider measures of material deprivation: 'a household's ability to afford certain items'.²⁹ These are measures of absolute, as opposed to relative, poverty. We will first consider how the four EU comparator countries fare against the relative measures of income and deprivation, before observing how they fare on absolute measures of material deprivation.

Relative income and poverty indicators

The three income-based measures, with values for each of the four comparator countries, are set out in table 3.

Table 3 Income measures for people aged 65+ in four EU comparator countries, 2006, 2008 and 2010

	Risk of poverty (%) ³⁰			Relative median income ratio ³¹			Aggregate replacement ratio ³²		
	2006	2008	2010	2006	2008	2010	2006	2008	2010
Germany	12.6	14.9	14.1	0.93	0.87	0.89	0.46	0.44	0.49
UK	26.1	27.3	21.4	0.73	0.74	0.81	0.45	0.43	0.48
Netherlands	5.8	9.4	5.9	0.87	0.84	0.87	0.43	0.43	0.47
Sweden	11.3	15.0	15.5	0.85	0.78	0.79	0.62	0.62	0.60
EU-27 ³³	19.0	18.9	15.8	0.85	0.85	0.88	0.51	0.50	0.53

Risk of poverty

The 'risk of poverty' indicator is calculated according to 'the share of persons with an equivalised disposable income that is below the threshold of 60% of national equivalised median income'.³⁴



'Disposable' income means 'the total income of a household (after tax and other deductions) available for spending or saving'.³⁵ The incomes are 'equivalised' by giving different weightings to each member of the household (eg the first adult has a weighting of 1.0, other adult members have a weighting of 0.5 and children aged under 14 have a weighting of 0.3).³⁶

For the purpose of this study, we are looking only at the data for people at risk of poverty who are aged 65+. On this indicator, the UK performs significantly worse than the other three countries and has the lowest ranking at each of the three time points. In 2010, 21.4 per cent of UK pensioners were considered at risk of poverty, compared with 15.5 per cent of pensioners in Sweden, 14.9 per cent of pensioners in Germany and only 5.9 per cent of Dutch pensioners.

However, if we look at the risk of poverty indicator across each of the three time points this suggests that the UK is heading in the right direction, starting from a high of 26.1 per cent of people aged 65+ at risk of poverty. In comparison, Germany and the Netherlands demonstrate an increased risk of pensioner poverty during this time period, while the risk of pensioner poverty in the Netherlands has remained roughly constant.

Relative median income ratio

The relative median income ratio indicator is calculated as 'the ratio between the median equivalised disposable income of persons aged 65 or over and the median equivalised disposable income of persons aged between 0 and 64'.³⁷ This indicator compares the incomes of pensioner households after tax and other deductions with the incomes of non-pensioner households.

According to this measure, on average pensioner households in the UK fared worse in comparison with working-age households than those in the other three countries in 2006 and 2008. However, in 2010 Sweden dipped slightly below the UK on this measure with a ratio of 0.79. Germany consistently performed best out of the four countries on this measure, although the relative median income ratio has decreased over time in Germany from 0.93 in 2006 to 0.89 in 2010.

Aggregate replacement ratio

The aggregate replacement ratio indicator measures the reduction in income that people experience when they reach retirement. This indicator 'is calculated as the average income from pensions among those persons aged 65 to 74 compared with the average income from work among those persons aged 50 to 59'.³⁸

According to this indicator, the Netherlands has consistently ranked worst across the three time points, indicating that while pensioners in the Netherlands are at low risk of poverty, on average they experience a larger drop in income at retirement. However, the UK demonstrates a similar aggregate replacement ratio at each of the three time points and in 2010 had only a very slightly higher ratio: 0.48 compared to 0.47. Germany's aggregate replacement ratio in 2010 was also very close at 0.49, while Sweden achieved a much higher aggregate replacement ratio across all three time points, with 0.62 in 2006 and 0.60 in 2010.



Indicators of material deprivation

The rate of material deprivation is calculated according to the proportion of people in a country who cannot afford to buy or pay for at least three out of the following nine items or expenses:

- mortgage or rent payments, utility bills, hire purchase installments or other loan payments
- one week's annual holiday away from home
- a meal with meat, chicken, fish (or vegetarian equivalent) every second day
- unexpected financial expenses (set amount corresponding to the monthly national at-risk-of poverty threshold of the previous year)
- a telephone (including mobile phone)
- a colour TV
- a washing machine
- a car
- adequate heating of the home.³⁹

The term 'severe material deprivation' is used to describe those who cannot afford at least four of these items.

Table 4 shows the proportion of people aged 65+ in each of the comparator countries who might be considered to be living in either material deprivation or severe material deprivation in 2009.

Table 4 Extent of material deprivation and severe material deprivation among people aged 65+ in four EU comparator countries, 2009⁴⁰

	People aged 65+ suffering from material deprivation (%)	People aged 65+ suffering from severe material deprivation (%)
Germany	6.8 (4)	2.1 (4)
UK	4.9 (3)	1.3 (3)
Netherlands	2.6 (1)	0.3 (1)
Sweden	2.8 (2)	0.7 (2)
EU-27	14.3	6.7

As table 4 clearly shows, Germany ranks lowest for indicators of both material deprivation and severe material deprivation, followed by the UK; the Netherlands and Sweden have much lower proportions of pensioners at risk of this type of material poverty.



A 2012 study by Eurostat observed that there were 12 EU member states in which fewer than 3 per cent of the population aged 65+ was living in severe material deprivation (each of our four comparator countries falls within this category). Among these 12 states, the lowest proportions of severe material deprivation were in Luxembourg, the Netherlands, Sweden and Denmark.⁴¹ One dimension that the above data do not show is the greater risk of material deprivation experienced by single pensioner households. Table 5 demonstrates some of the inequalities between single person pensioner households and two person pensioner households against these indicators of material deprivation. In almost every case, single person households are shown to be at greater risk of poverty.

Table 5 Specific financial limitations affecting people aged 65+ in four EU comparator countries, 2009⁴²

	Inability to keep home adequately warm (%)		Inability to pay for one week's annual holiday away from home (%)		Inability to afford a meal with meat or vegetarian equivalent every second day (%)		Inability to face unexpected financial expenses (%)		Arrears with mortgage, rent, utility bills or hire purchase (%)	
	Single adult	Two adults	Single adult	Two adults	Single adult	Two adults	Single adult	Two adults	Single adult	Two adults
Germany	5.8	1.6	27.1	12.0	13.8	5.4	36.6	17.1	2.3	1.9
UK	5.0	5.0	22.7	13.3	4.0	1.7	25.5	15.7	–	–
Netherlands	1.7	0.6	20.7	12.7	2.8	0.8	19.0	11.2	0.5	0.9
Sweden	2.1	0.8	19.3	7.2	3.8	1.3	22.3	6.6	2.0	1.5
EU-27	11.7	7.4	43.6	31.2	13.1	7.4	40.0	25.0	4.7	3.9

Approach to pension provision in the four comparator countries

Earnings, as opposed to wealth, are the primary source of income across European countries and following retirement public pensions tend to take the primary role in replacing earnings. Therefore, EU countries' pension policies take a central role in maintaining older people's standard of living following retirement and in preventing poverty in old age.

A 2012 report by Eurostat observes, 'In general, one of the main policy concerns in relation to pensions relates to the ability of systems to provide adequate and sustainable retirement.'⁴³ The words 'adequate' and 'sustainable' encapsulate the primary tension in European public pension systems: the need to provide a pension safety-net that can guarantee people an adequate standard of living in retirement, while also being sustainable in the context of a long-term trend of population ageing that is projected to last for at least the next 50 years. Between 2010 and 2060 it is estimated that the old-age support ratio across the 27 EU member states will double, with two people of working age for each person aged over 65 in 2060, compared with four people at present.⁴⁴



In recent years, most European member states have sought to prepare for these joint challenges of adequacy and sustainability through pension reforms.⁴⁵ These reforms have mainly included increases in the state pension age and other financial incentives to encourage people to stay in work for longer, structural changes from an emphasis on pay-as-you-go pensions to funded private pensions and transferring risk from the state or employer to the individual, particularly through a shift from defined benefit to defined contribution schemes.⁴⁶ At the same time, many EU states have taken measures to 'address adequacy gaps... through efforts to broaden coverage, support building up rights, ease access to pensions for vulnerable groups and increase in financial support for poorer pensioners'.⁴⁷

In light of these reforms, the European Commission's 2010 pensions green paper has highlighted the systemic risks posed by a greater reliance on private pensions: the recent financial crisis in 2008 caused private pension funds to lose more than 20 per cent of their value.⁴⁸ Therefore, the green paper observes the need to improve regulation of funded pension schemes to ensure they are both efficient and safe in the context of future financial crises.⁴⁹

Each of the four EU countries compared in this study has historically developed its own very different approach to pension provision; therefore it is challenging to identify data that can allow for straightforward cross-country comparison. In tables 6 and 7, some data are provided to illustrate total government expenditure on pensions in the four countries and contributions by employees and employers in three of the four countries (excluding the UK). Table 8 compares the current statutory ages at which state pensions are given in each of the four countries. In the remainder of this chapter we will look in more detail at current pension policy and recent reforms in each of the four countries, drawing substantially on the comprehensive OECD report *Pensions at a Glance 2011*.

Table 6 Total government expenditure on pensions and proportion of the population aged 65+ in four EU comparator countries, 2008⁵⁰

	Total government expenditure on pensions (% of GDP)	Proportion of the population aged 65+ (%)
Germany	12.3	20.1
UK	11.4*	16.1
Netherlands	12.0	14.7
Sweden	11.8	17.5
EU-27	12.1*	17.1*

* These values were still provisional at the time of writing.



Table 7 Contribution by employees and employers to public pension schemes in four EU comparator countries, 2009⁵¹

	Contributions by employee (% of gross earnings)	Contributions by employer (% of gross earnings)	Total contributions to public pension schemes (% of gross earnings)
Germany	10.0	10.0	19.9
UK	No separate pension contribution		
Netherlands	17.9	0.0	17.9
Sweden	7.0	11.9	18.9
EU-27	7.9	14.0	22.5

Table 8 State pension age in four EU comparator countries, 2011

	Men	Women
Germany ⁵²	65 years (increasing to 67 between 2012 and 2029)	
UK ⁵³	65 years	60–65 years (calculated according to date of birth)*
Netherlands ⁵⁴	65 years	
Sweden ⁵⁵	61–65 years**	

*Women's state pension age will reach 65 in 2020.

**Income and premium pension can be received from age 61; it is possible to receive a guaranteed state pension from age 65.

Pensions in Germany

To qualify for an old age pension in Germany men and women must be aged 65 and have made five or more years of pension contributions. Those who have made fewer than five years' contributions do not have any pension entitlements.⁵⁶ In 2007 German MPs approved pension reforms causing the retirement age in Germany to increase gradually to 67 between 2012 and 2029.⁵⁷

The state pension system in Germany has only one tier and is a pay-as-you-go (PAYG) system. Each year of contributions at the level of national average earnings (€30,625 in 2008) earns one point towards the individual's pension.⁵⁸ Those who earn more or less than the national average make larger or smaller contributions and earn proportionately more or fewer pension points. However, contributions are capped at 208 per cent of national average earnings.⁵⁹ People who provide childcare are also credited with pension points up to the value of one pension point per



year. Unemployed people have pension contributions made on their behalf for up to 24 months. After this period, lower contributions are made on behalf of the unemployed person and they are means-tested.⁶⁰

At retirement, the pension points the individual has earned across their lifetime are added up. The total number of pension points is then multiplied by a 'pension-point value'. The pension point value is adjusted annually according to three factors:

It is updated in line with gross wages.

- Changes in the contribution rates to the state pension scheme and to subsidised voluntary schemes are factored in so that increased contribution rates reduce the adjustment of the pension point value.
- Since July 2005 the pension point value has been linked to changes in the old age support ratio (the ratio of retirement-age people to working people).⁶¹

As the OECD's 2011 report observes, this element of linkage between the adjustment of the pension point value and the old age support ratio is aimed at ensuring the scheme is financially sustainable in the face of population ageing.⁶²

In addition to statutory pension provision, personal and occupational 'Riester' pensions are available from a number of institutions such as banks and insurance companies. The German state provides subsidies for people to build up personal and occupational pensions, which have been comparatively successful; as of 2006 around 64 per cent of German employees were covered by an occupational pension plan, compared with 47 per cent of UK employees in the same time period.⁶³

Since 2003 German retirees who are not entitled to a state pension because they have an insufficient record of pension contributions have been eligible for a 'basic income' or *Grundsicherung*, which is a means-tested benefit for people aged 65+. In 2008 the basic income amounted to €8,424 per year in the western Länder (about £7,050).⁶⁴ This includes housing benefits and fuel costs at average rates; the OECD estimates that 'this is equivalent to 26.7 per cent of relevant average gross earnings'.⁶⁵

A 2008 study by the Oxford Institute of Ageing observed that the main weakness of German pension provision is that it is:

good at maintaining previous earning differentials, but not at reducing poverty. In other words, pensioners who earned much previously will get a decent pension. In contrast, those who did not will remain poor compared to other pensioners.⁶⁶

This analysis corroborates the evidence shown in tables 4 and 5 that German pensioners have a greater risk of material deprivation than pensioners in the other three comparison countries.



Pensions in the UK

The state pension age in the UK is currently 65 for men, while women's state pension age is in the process of increasing from 60 to 65 between 2010 and November 2018.⁶⁷ According to the Pensions Act 2007, the state pension age for both men and women was to increase to 66 between 2024 and 2028 and then increase to 68 between 2034 and 2046.⁶⁸ However, the UK Coalition Government plans to bring this transition forward, so that the state pension age for men and women will begin to increase from December 2018, reaching 66 in October 2020.⁶⁹ The UK Government will then increase the state pension age to 67 between April 2026 and April 2028.⁷⁰ Therefore according to these plans the state pension age will reach 67 for men and women in the UK one year before it reaches 67 in Germany, with this transition from a state pension age of 65 compressed into a slightly shorter period of time.

Following changes brought in by the Pensions Act 2007, which came into force in 2010, to be eligible for the basic state pension, people need to fall into one of the following categories:

- have made contributions for 30 qualifying years (previously eligibility required contributions for nine-tenths of a person's working life, eg 44 years for a person who has a state pension age of 65)
- have been treated as if they have made contributions for this period of time
- have received pension credits covering this period of time (eg for years spent providing childcare or receiving unemployment or disability benefits).⁷¹

The basic state pension is paid to everyone who meets these eligibility criteria at a flat rate. In 2011/12 this is a rate of £102.15 per week.⁷² In April 2011 the UK Coalition Government added to the 2007 legislation a 'triple guarantee' that pensions would be uprated by earnings, prices or 2.5 per cent each year, whichever is higher.⁷³ This will protect the value of the basic state pension in line with average earnings, making it less likely that people will find themselves in relative poverty in retirement.

There is also an earnings-related element of the state pension in the UK called the second state pension. This is calculated on the basis of an individual's average salary across their working life, with previous years' pay increased in proportion to average earnings, and it is price-indexed following retirement. As of 2008 approximately 35 per cent of employees in the UK were contracted-out of the second state pension, instead paying into an occupational or other personal pension scheme.⁷⁴ However, in total only around half of UK employees are estimated to be members of an employer-sponsored pension scheme (5 per cent less than in 1997)⁷⁵ and around 750,000 employers in the private sector did not provide a workplace pension in 2007.⁷⁶ As noted above, Germany has achieved higher coverage of occupational pensions, with 64 per cent of German employees covered by an occupational pension plan.

The Pensions Act 2008 made new provisions to help incentivise and support low earners to save for their retirement, which come into force in 2012. From 2012 employers will have the duty automatically to enrol into a pension scheme any employees who are aged between 22 and state pension age who are earning at least £7,475 a year.⁷⁷ To support employers to



offer workplace pensions, the Pensions Act 2008 also legislated for the National Employment Savings Trust (NEST) to be set up. This is a defined contribution pension scheme that will be available to employers from October 2012. It will also be available to self-employed people and will offer flexibility to temporary workers who have the option of carrying their NEST membership between jobs or having more than one employer paying into their pension scheme simultaneously.⁷⁸

In 2003 the UK Government also put in place a minimum income guarantee for pensioners who are on a very low income. This takes the form of a means-tested Pension Credit that provides a safety net for those who are not eligible for a full basic state pension. There are two elements to this: a guarantee credit, which provides a minimum income, and a savings credit, which attempts to prevent people who accumulate modest savings from being penalised. In 2008/09 the Pension Credit was worth £124.05 for individuals and £189.35 for older people living as a couple.⁷⁹ Therefore, in 2008 the UK's guaranteed minimum income for pensioners was less generous than its equivalent in Germany (at about £6,500 for an individual over one year, compared with approximately £7,050 in Germany).

In line with the critique of the German pension system presented above, the UK's pension system can also be criticised for inadequately compensating for earnings inequalities experienced during people's working lives, putting pensioners who are not eligible for the full basic state pension at risk of poverty in retirement. As we have seen above, with 21.4 per cent of pensioners at risk of poverty, the UK is well above the EU-27 average of 15.8 per cent and performing considerably worse on this rating in comparison with the other three countries featuring in this study.

The means-tested nature of the Pension Credit presents two disadvantages: first, this could act as a disincentive for people on a low income to save for retirement, because the accumulation of savings over a certain level could make them ineligible for pension credit, leaving them with a lower income.⁸⁰ Second, the charity Age UK has estimated that approximately a third of people who are eligible to receive pension credit do not claim it, either because they are not aware of it or because they do not like the idea of taking government benefits.⁸¹ We will make recommendations for how these issues might be addressed in section 3 of this report.

Pensions in the Netherlands

In the Netherlands the current age of eligibility for the statutory old-age pension is 65 and all residents are eligible from this age.⁸² However, in June 2011 the Dutch government and its social partners (trade unions and employers' representatives) signed a new pension contract to approve an increase in the state pension age to 66 by 2020 and to 67 by 2025.⁸³ It is proposed that the retirement age will be reviewed every five years and will increase to reflect gains in life expectancy.⁸⁴ These reforms would mean that the state pension age in the Netherlands reached 67 three years before the UK and five years before Germany. Older workers in the Netherlands would therefore be required to make this transition within a shorter time period, despite the fact that population ageing is happening at a slower rate in the Netherlands than in Germany and the UK.



In 2008 the gross pension benefit for a single person in the Netherlands, including an additional holiday allowance, was worth 29 per cent of average earnings or an annual total of €12,718. The value of the gross pension benefit is linked to the minimum wage and is uprated every six months.⁸⁵ The amount of benefit that people receive also varies depending on their circumstances and the members of their household. For example, people receive larger or smaller monthly payments depending on whether they are single, a single parent or have a cohabiting partner who is or is not eligible for a state pension.⁸⁶ The basic pension is increased by 2 per cent for each year that the individual has lived or worked in the country. As eligibility is not based on a minimum number of contributions, years when people are not in paid employment do not reduce entitlements.⁸⁷ There is also a social assistance scheme under the Work and Social Assistance Act to enable older people who have not been resident in the Netherlands for the requisite number of years to receive a guaranteed minimum income at the same level as the basic pension.⁸⁸ It is up to the municipal authorities to determine whether a person is eligible for this additional allowance.⁸⁹ Therefore at €12,718 or approximately £10,600, the annual minimum income entitlement offered by the Dutch state pension system is substantially more generous than that on offer in either the UK (£6,500) or Germany (£7,050).

The law does not require employers to provide an occupational pension scheme, although approximately 91 per cent of Dutch employees are enrolled in such a scheme, suggesting that occupational pensions 'are therefore best thought of as quasi-mandatory'.⁹⁰ In 2008 there were 656 separate pension funds operating in the Netherlands and around 90 per cent of employees enrolled in these funds had a defined benefit scheme, with the remaining proportion participating in a defined contribution scheme.⁹¹ The entitlement of about 97 per cent of people enrolled in defined benefit schemes would be calculated on the basis of average earnings across their lifetime. Only about 1.3 per cent were eligible for final salary pensions.⁹²

Those enrolled in occupational pension schemes cannot gain credits for periods when they are not working (for example because of childcare commitments), but in many cases people can opt to make additional payments to make up for missed contributions.⁹³

When people change jobs, their pensions entitlements may be transferred to their new employer. Occupational pensions schemes are coordinated with the statutory pension system, restricting the total pension entitlements a person can receive to 100 per cent of final salary at age 25 from both statutory and private pensions. Most pension funds aim to replace 70 per cent of their stakeholders' final salary in retirement.⁹⁴

However, it now looks like the very generous pension benefits provided through these occupational schemes might soon be a thing of the past. Under the proposals outlined in the new pension contract mentioned above, Dutch occupational pension providers will have greater scope to shift risk onto employees by offering defined contribution rather than defined benefit pensions schemes. This will increase uncertainty for participants in occupational pension schemes regarding the level of income they can expect to receive in retirement. At the time of writing (spring 2012), these proposals are still under consideration by the Dutch Government, with significant levels of opposition from prominent trade unions.⁹⁵



Pensions in Sweden

The state pension age in Sweden is flexible, with an option to draw the income-based and premium pensions (either wholly or partially) from the age of 61. However, the guarantee pension, which provides a minimum pension income, cannot be drawn until age 65.⁹⁶

There is currently a debate in Sweden about whether the retirement age should be indexed against life expectancy, so that the state pension age would rise automatically in line with increasing longevity (as is the case in Denmark⁹⁷). This proposal is supported by many business leaders, including a former finance minister who is now the chairman of the Sweden's largest pension fund.⁹⁸ To consider this issue, the Swedish Government's Working Group on Pensions has appointed an independent inquiry 'to analyse pension-related age limits and obstacles to a longer working life'. This inquiry is scheduled to make its final report by April 2013, with an interim report in April 2012.⁹⁹

Each year, Swedish workers make pensions contributions worth 7 per cent of their gross salary. In addition to this their employer makes a contribution worth 11.9 per cent of their gross salary (as of 2009), making up the total contribution to 18.9 per cent.¹⁰⁰ Most of the employee contribution is paid towards the notional-accounts system, with a small proportion (2.33 per cent of gross earnings) paid into the defined-contribution-funded 'premium' pensions.¹⁰¹ People who spend periods out of the workforce to care for children aged four or under have their pension accounts credited on their behalf (if two parents provide care, the lower of the two earners receives the credits). Parental benefits are also considered as pensionable income, therefore they must contribute 7 per cent gross income to their pension account, while the Government makes up the employer's contributions. The same principle applies to unemployment benefits.¹⁰²

The notional accounts system is an earnings-related pension scheme, which is topped up each year with the pension income held for people who have died early. This is referred to as 'inheritance gains' and it is redistributed to the generation that is of the same age as those who have died.¹⁰³ When the individual retires, the savings they have accumulated in their notional account (including 'inheritance gains') are converted into an annuity, using a calculation that takes into account the individual's retirement age and their life expectancy (which is based on national mortality tables). After retirement, pensions are uprated in line with average earnings.¹⁰⁴ There is also a 'balance mechanism' to ensure that the national pension system is sustainable; if the ratio of assets (balance held plus contributions from workers) falls below a certain level, the size of pensions payments and credits to notional accounts are reduced (with the costs therefore falling on both current pensioners and future pensioners). However, when the ratio recovers, the size of payments will increase.¹⁰⁵ As the Swedish Government website explains, 'Strong income growth means pensions will be higher, while poor income growth will correspondingly result in poor pension growth.'¹⁰⁶

As mentioned above, in addition to the notional accounts, Swedish employees also pay a small proportion of their earnings into a defined contribution personal pension known as a premium pension. They can choose how they invest their premium pension and how they withdraw their benefits when they retire – either converting the pension into an annuity early on to avoid risk or continuing to invest their pension to increase returns.¹⁰⁷



Both of these types of statutory pension (notional accounts and premium pensions) can be deferred as long as the individual wishes, thereby increasing the size of payments when the pension is claimed. People can also choose to continue working while receiving their pension, or draw down their pension gradually to supplement their pay (drawing down a quarter, half or three-quarters of the full pension).¹⁰⁸

In addition to the statutory pensions, private occupational pensions schemes (of which there are only four main schemes in Sweden) were estimated to cover approximately 90 per cent of employees in 2008; a similar rate of coverage to the Dutch occupational pension schemes. Therefore, these schemes can be considered 'quasi-mandatory'.¹⁰⁹

According to the Swedish Government, the state pension system is 'financially autonomous and completely separate from the central government budget'.¹¹⁰ However, the Swedish state does fund from its central budget a guarantee pension, which provides a minimum income for pensioners with low pension entitlements.¹¹¹ There are eligibility requirements based on residency for the guarantee pension. Minimum eligibility requires three years' residency in Sweden, while the maximum guarantee pension cannot be obtained unless the individual has been resident in Sweden for 40 years. A shorter duration of residency reduces the size of the guarantee pension.¹¹² The standard rate of the guarantee pension is index-linked so that it increases in line with inflation.¹¹³ The guarantee pension supplements the statutory pensions that people are eligible for (including pensions they might be drawing from another country) but they are not means-tested according to income or occupational pensions. Therefore, it is possible for people to work while receiving the guarantee pension and they are not penalised if they are able to accumulate savings.¹¹⁴ In 2008 the full guaranteed benefit was worth SEK 87,330 for a single pensioner (approximately £8,210.15), which amounted to 25 per cent of gross average earnings in Sweden. Therefore the Swedish basic income is slightly less generous than the Dutch basic income (which provided approximately 29 per cent of average earnings in 2008) but provides a more generous net basic income than in the UK and Germany.

In addition to the guarantee pension, Swedish pensioners who are on a low income are eligible for means-tested housing benefit, which covers 93 per cent of housing costs. This is considered to be an important element of social protection for Swedish pensioners living on a low income.¹¹⁵

The measures of retirement income and poverty that we considered above show that on average Sweden's pension system provides a relatively good replacement income; in 2010 the aggregate replacement ratio was 0.60, performing best out of the four comparator countries and above the EU-27 average of 0.53.¹¹⁶ There is also a relatively low risk of material deprivation in comparison with the other countries with 2.8 per cent of pensioners at risk of material deprivation compared with the EU-27 average of 14.3 per cent.¹¹⁷ However, while the risk of pensioner poverty in Sweden in 2010 was at about the EU-27 average, with 15.5 per cent of pensioners at risk, this proportion has increased since 2006 when it stood at 11.3 per cent,¹¹⁸ suggesting that there is no room for complacency.



3 Health and social care

This section of the report will start by comparing health outcomes for people aged 65+ in each of the four comparator countries. We will then consider each individual country's approach to the provision of health and social care. The statistics used to make cross-country comparisons for this chapter are mainly drawn from Eurostat, Organisation for Economic Co-operation and Development (OECD) and World Health Organization (WHO) figures.

Health outcomes in the four comparator countries

In this section we present a range of health indicators to demonstrate how health outcomes vary between the four comparator countries. Where possible we have identified health outcomes data that is specific to the 65+ age group. Where this was not possible, the data presented cover the whole adult population.

Life expectancy at age 65

Table 9 sets out life expectancies at age 65 according to gender in each of the four countries. As this shows, Germany has the lowest total life expectancy of the four countries, and shares the lowest male life expectancy with the Netherlands. In 2009 the UK shared the lowest female life expectancy at age 65 with Germany, with female life expectancy in the Netherlands only slightly higher. Sweden consistently has the highest life expectancy at age 65, performing best in both gender categories and overall.

Table 9 Life expectancy at age 65 in four EU comparator countries, 2009¹¹⁹

	Male (yrs)	Female (yrs)	Total (yrs)
Germany	17.6 (=3)	20.8 (=3)	19.3 (4)
UK	18.1 (2)	20.8 (=3)	19.6 (2)
Netherlands	17.6 (=3)	21.0 (2)	19.4 (3)
Sweden	18.2 (1)	21.2 (1)	19.8 (1)
EU-27	17.2	20.7	19.1

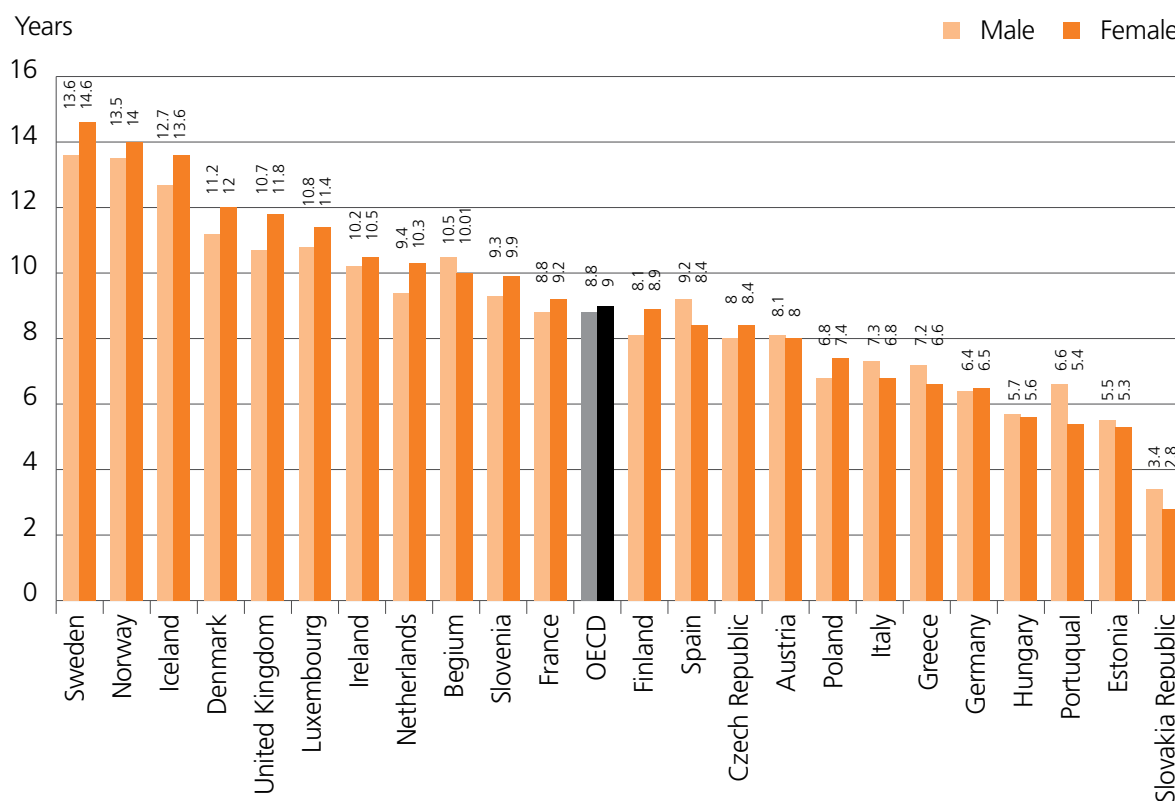
Healthy life expectancy

As figure 1 demonstrates, healthy life expectancy at age 65 follows a similar pattern to life expectancy, with Swedish people aged 65+ having the highest number of healthy life years to look forward to and German people having the fewest. Healthy life expectancy at age 65 is slightly higher for older people in the UK for both genders than for Dutch people. If we compare



these life expectancy figures with those for healthy life expectancy, we find that on average a woman in Sweden could expect to spend 6.6 years in poor health after the age of 65, compared with an average of 14.3 years spent in poor health by a woman in Germany. In comparison in Sweden on average a man will spend 4.6 years in poor health after the age of 65, while a man in Germany will spend 11.2 years in poor health. This relatively low healthy life expectancy in Germany for both genders has clear implications for German older people's quality of life in old age, and poses a risk of there being very high costs to health and social care services in Germany.

Figure 1 Healthy life years at age 65, European countries, 2009



Source: OECD, *Health at a Glance 2011*¹²⁰

The data set out in table 10 corroborate this finding that German older people have a greater risk of experiencing poor health than those in other countries; Germany has the highest prevalence of long-term illness in each of the age categories. This reaches almost three-quarters of people in the 85+ age group (83.6 per cent of men and 70.0 per cent of women). In table 10 we can also see that the UK has the second highest prevalence of long-term illness in each of the age categories. However, whereas table 9 showed that healthy life expectancy for men and women is higher in Sweden than in the other countries, table 10 shows the Netherlands and Sweden to have a very similar proportion of older people with a long-standing illness in the age categories 65–74 and 75–84. In the age category 85+, the Netherlands clearly has the lowest total proportion of people with a long-standing illness at 52.6 per cent, while Sweden's total for this age group stands at 55.6 per cent. However, these total sums obscure the interesting gender differences at play: in Sweden women aged 85+ are more likely than men to have long-term health problems, whereas in the Netherlands, Germany and the UK it is men in this age group who are more likely to have long-term health problems.



Table 10 Proportion of older people with a long-standing illness or health problem, by gender and age group, in four EU comparator countries, 2009¹²¹

	Aged 65–74 (%)			Aged 75–84 (%)			Aged 85+ (%)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Germany	61.2	58.6	59.8	71.1	71.2	71.2	83.6	70.0	74.4
UK	60.0	56.9	58.4	63.0	68.8	66.4	71.6	68.9	70.0
Netherlands	44.4	50.1	47.3	53.2	58.9	56.7	60.3	49.2	52.6
Sweden	45.5	50.0	47.8	55.2	57.2	56.3	45.5	60.6	55.6
EU-27	53.2	56.1	54.8	63.2	67.0	65.5	67.8	68.3	68.1

Health indicators including estimated prevalence of diabetes, obesity and alcohol and tobacco consumption

Table 11 presents a variety of health indicators for each of the comparator countries. These data are not segregated according to age group; therefore they reflect health outcomes for the whole adult population rather than being limited to people aged 65+. Although these data are not specific to older people they can provide the broader context of health behaviours and characteristics of adults in each country, which are also likely to apply to the older generation.

Table 11 Health outcomes data for the whole adult population in four EU comparator countries

	Gender	Prevalence estimates of diabetes, adults aged 20–79 years in 2010 (%) ¹²²	Estimated prevalence of obesity in adults aged 20+ years in 2008 (%) ¹²³	Alcohol consumption (litres per population aged 15+ years) ¹²⁴ in 2009 ¹²⁵	Tobacco consumption (% of population smokes daily) ¹²⁶
Germany	Male	–	25.9	–	26.4
	Female	–	24.4	–	17.6
	Total	8.9	25.1	9.7	21.9
UK	Male	–	26.0	–	22.3
	Female	–	27.7	–	20.7
	Total	3.6	26.9	10.2	21.5
Netherlands	Male	–	18.1	–	25.5
	Female	–	19.5	–	19.8
	Total	5.3	18.8	9.4	22.6
Sweden	Male	–	19.9	–	13.5
	Female	–	17.3	–	15
	Total	5.2	18.6	7.4	14.3



While there is some variation in the ranking of countries between the four indicators presented in table 11, there is a fairly consistent trend of Germany and the UK having relatively poor health outcomes. At 8.9 per cent of the adult population, Germany has a substantially higher estimated prevalence of diabetes than the other three countries. The UK has the highest prevalence of obesity among both men and women (an average of 26.9 per cent of the population were estimated to be obese in 2008), closely followed by Germany. The UK is also estimated to consume the highest number of litres of alcohol per head each year, with Germany's consumption of alcohol second highest. It is only in the category of smoking that neither Germany nor the UK has the poorest outcomes. These data indicate that the Netherlands has the highest proportion of frequent smokers, followed by Germany.

While Germany performs poorly on most of these health indicators, Sweden almost uniformly has the best health outcomes, with the lowest prevalence of obesity and the lowest consumption of alcohol and tobacco.

Self-perceived health

The final health outcome we will consider in this chapter is self-perceived health in people aged 65+ (see table 12). As with the previous indicators, out of the four countries it is German older people who report the poorest health outcomes in each of the three age categories (64–75, 75–84 and 85+), most frequently describing their health as 'very bad' and least frequently describing their health as 'very good'.

Table 12 Self-perceived health in older age groups in four EU comparator countries, 2009¹²⁷

	Aged 65–74		Aged 75–84		Aged 85+	
	Very good (%)	Very bad (%)	Very good (%)	Very bad (%)	Very good (%)	Very bad (%)
Germany	3.6 (4)	2.2 (4)	1.2 (4)	4.0 (4)	2.5(4)	9.7 (4)
UK	21.6 (2)	2.1 (3)	16.4 (1)	2.8 (3)	12.8 (1)	3.7 (3)
Netherlands	11.6 (3)	0.6 (1)	10.6 (3)	2.7 (2)	7.3 (3)	0.9 (1)
Sweden	24.8 (1)	1.8 (2)	12.9 (2)	2.4 (1)	8.8 (2)	2.7 (2)
EU-27	6.5	3.6	4.3	6.9	4	10

Sweden has a particularly strong performance in the 65–74 age category, with almost a quarter of people in this age group rating their health as 'very good'. In the 75–84 and 85+ age groups older people in the UK are most likely to rate their health as 'very good' (16.4 per cent for those aged 75–84; 12.8 per cent for those aged 85+), with Swedish older people coming second and Dutch older people third.



Health care and social care services in the four comparator countries

Each of the four countries considered in this study has developed its own approach to providing its citizens with healthcare coverage. A recent OECD study by Joumard et al, published in 2010, developed a typology of the various healthcare systems in operation in OECD countries, which is useful for comparing the healthcare policies of our four comparator countries.¹²⁸ The six broad categories of healthcare system developed by this study, and the countries identified as falling into each category, are set out in Table 13.

Table 13 Typology of OECD healthcare systems¹²⁹

Healthcare system definition	OECD countries
<p>Group 1 These countries rely extensively on market mechanisms in regulating the basic insurance coverage. Private providers play an important role and are mostly paid through fee-for-service schemes. Users are offered ample choice among providers but gate-keeping arrangements are in place. There is no strict spending rule and little reliance on regulation of prices paid by third-party payers to control public spending growth. These countries still differ significantly in the degree of decentralisation: sub-national governments have extensive autonomy in managing health care services in Switzerland, while the Netherlands is at the opposite side of the spectrum.</p>	<p>Germany Netherlands Slovak Republic Switzerland</p>
<p>Group 2 In these countries public basic insurance coverage is combined with private insurance beyond the basic coverage. There is a heavy reliance on market mechanisms at the provider level, with wide patient choice among providers and fairly large incentives to produce high volumes of services contained by gate-keeping arrangements.</p>	<p>Australia Belgium Canada France</p>
<p>Group 3 This group is characterised by public basic insurance coverage, with little private insurance beyond the basic coverage. There is extensive private provision of care, with wide patient choice among providers and fairly large incentives to produce high volumes of services. There is no gate-keeping and soft budget constraint, and limited information on quality and prices to stimulate competition.</p>	<p>Austria Czech Republic Greece Japan Korea Luxembourg</p>
<p>Group 4 The healthcare systems in these countries offer free choice of provider to patients in all three areas of care – primary, specialist and hospital care – with no gate-keeping. However, private provision is very limited, suppliers have few incentives to increase volumes and their prices tend to be tightly regulated. The budget constraint is weak, except in Sweden, where it is very strict.</p>	<p>Iceland Sweden Turkey</p>
<p>Group 5 Mostly public insurance. Health care is provided by a heavily regulated public system and the role of gate-keeping is important. Patient choice among providers is limited and the budget constraint imposed via the budget process is rather soft.</p>	<p>Denmark Finland Mexico Portugal Spain</p>
<p>Group 6 This group also consists of heavily regulated public systems. The budget constraint is more stringent than in most other OECD countries. Compared with the previous group, the possibility for patients of choosing between providers tends to be large and sub-national government autonomy tends to be lower. Over-the-basic coverage is very limited, except in Ireland and New Zealand, where duplicative coverage is significant and provides faster private-sector access to medical services.</p>	<p>Hungary Ireland Italy New Zealand Norway Poland UK</p>



As shown in table 13, Germany and the Netherlands both fall into Group 1 of the typology, which describes countries that provide access to healthcare mainly through basic health insurance coverage. Under this scenario there is a strong reliance on market mechanisms, and private healthcare providers play a strong role in the health system.

Healthcare in Germany and the Netherlands

In Germany most people purchase public health insurance through their employer: 'coverage is universal, co-payments and deductibles are moderate, and premia are based on income'.¹³⁰ An unusual feature of this system is that if the employee's income exceeds a 'compulsory insurance threshold' they can choose to purchase their health insurance privately. In this case the size of premiums is calculated according to the person's age and health.¹³¹ Doctors are paid compensation for treating insured patients and the compensation they receive for treating privately insured patients is usually more than twice as high as for publicly insured patients, giving doctors a greater motivation to treat privately insured clients. It is estimated that 90 per cent of the German public has public health insurance, while the remainder purchases private insurance.¹³² Research by Eurostat, which sought to measure the extent of unmet need for medical examination or treatment in 2009, found that the level of unmet health needs was very low in each of the four countries featuring in this study (see table 15). However, in Germany there was a slightly larger proportion of people who felt that cost had acted a barrier to them accessing medical treatment, particularly those in the lowest income decile.¹³³

When the WHO ranked 191 countries on the basis of the overall performance of their health system in 2000, Germany was ranked 25th.¹³⁴

In the Netherlands people are required to take out private health care insurance, which covers standard healthcare such as GP appointments, hospital tests and purchasing medication.¹³⁵ The market is regulated so that private health insurance providers 'are obliged to offer a core universal insurance package for health care at a fixed price for all, whether young or old, healthy or sick'.¹³⁶ The premiums that people pay for their basic coverage vary between insurance providers. However, the state covers medical care for children aged under 18. In addition to this private health insurance, employees also pay an income-related contribution to the costs of health insurance, which their employer then reimburses.¹³⁷

The Netherlands was ranked 17 when the WHO rated international health systems in 2000.¹³⁸ The Euro Health Consumer Index (compiled by the privately funded Swedish company Health Consumer Powerhouse), which focuses on consumer empowerment and patients' rights, ranked the Netherlands' health system first out of 33 European countries in 2009.¹³⁹

The 2010 OECD study by Joumard et al identified the fact that while the German and Dutch healthcare systems operate in a similar way, the Netherlands operates a rather more centralised healthcare system than Germany.¹⁴⁰ They observed that group 1 countries such as Germany and the Netherlands that provide basic health insurance through the market have higher administrative costs than other types of health system. They also found that spending on healthcare per capita tends to be higher in these group 1 countries that rely heavily on the



market to provide basic health insurance. Table 14 presents a range of data on healthcare costs in each of the four comparator countries, demonstrating that Germany and the Netherlands do indeed have the highest healthcare costs as a proportion of GDP of the four countries (10.5 per cent of GDP in Germany and 9.9 per cent of GDP in the Netherlands).

The OECD study by Joumard et al concluded that countries such as Germany and the Netherlands that have a system based on private health insurance tend to have lower inequalities in health status. However, they cautioned that not too much emphasis should be placed on this as 'health inequalities are largely driven by socio-economic factors and thus determined outside the health care sector'.¹⁴¹

Healthcare in the UK

The OECD study placed the UK's health care system in group 6, which includes countries that have a 'heavily regulated' public healthcare system in which budget controls are very stringent, and where patients have a large choice of providers.

The UK's National Health Service is centrally funded through general taxation. With the exception of charges for some prescriptions and optical and dental services, the NHS remains free at the point of use for anyone who is resident in the UK. The Department of Health is responsible for the NHS in England, controlling England's ten strategic health authorities (SHAs), which oversee all NHS activities in England; each SHA supervises all the NHS trusts in its area. The devolved administrations of Scotland, Wales and Northern Ireland run their own NHS services separately.¹⁴²

In England primary care trusts (PCTs) are in charge of primary care and have a major role around commissioning secondary care; they control 80 per cent of England's NHS budget.¹⁴³ Territorial health boards in Scotland, local health boards in Wales and health and social care trusts in Northern Ireland perform the same role. The NHS in England had a budget of £105.9 billion in 2011/12, rising to £114.4 billion in 2014/15,¹⁴⁴ with proportionate sums awarded to the devolved administrations in Scotland, Wales and Northern Ireland as determined by the Barnett Formula.¹⁴⁵

The UK was ranked 18 when the WHO rated international health systems in 2000 (one place after the Netherlands).¹⁴⁶ The Euro Health Consumer Index (compiled by the privately funded Swedish company Health Consumer Powerhouse ranked the UK's health system 14th out of 33 European countries in 2009.¹⁴⁷

Healthcare in Sweden

The OECD study by Joumard et al typifies Sweden as a 'group 4' country characterised by a healthcare system that provides patients with a large degree of choice of provider in primary, secondary and tertiary care, with relatively low use of private health care providers. In Sweden



healthcare is considered to be 'a central part of the country's comprehensive welfare state', although there is a strong element of decentralisation in how healthcare is provided.¹⁴⁸ Health care is funded mainly through local taxes, with some grant funding from central government. According to WHO figures, set out in table 14, 16.8 per cent of Swedish health care is funded privately through patient fees.

Reforms to increase competition in health provision have occurred relatively recently in Sweden. New laws in 2007 allowed hospitals to be privatised and enabled other private health care providers to be set up.¹⁴⁹ As of 2008, 29 per cent of outpatient visits were to private providers, funded by the Swedish state, and in 2009 further legislation allowed the privatisation of pharmacies. It remains a small proportion of Swedish people who have private health insurance but between 2004 and 2008 this increased from 2.3 per cent to 4.6 per cent.¹⁵⁰

Sweden was ranked 23 of 191 countries in the 2000 WHO rating of international health systems¹⁵¹ was ranked 8 out of 33 countries in the Euro Health Consumer Index in 2009.¹⁵²

Table 14 Health expenditure statistics in four EU comparator countries, 2008 and 2009

	Germany	UK	Netherlands	Sweden
Expenditure on health as % of GDP (2008) ¹⁵³	10.5	8.7	9.9	9.4
General government expenditure on health as % of total expenditure on health (2008) ¹⁵⁴	74.6	82.6	75.3	78.1
Private expenditure on health as % of total expenditure on health (2008) ¹⁵⁵	22.0	17.4	16.5	16.8
Social security expenditure on health as % of general government expenditure on health (2008) ¹⁵⁶	90.8	0	93.3	0
Out-of-pocket expenditure as % of private expenditure on health (2008) ¹⁵⁷	53.9	63.7	34.9	92.8
Private prepaid plans as % of private expenditure on health (2008) ¹⁵⁸	42.7	6.7	33.7	1.2
Per capita government expenditure on health at average exchange rate, US\$ (2008) ¹⁵⁹	3,523	3,116	3,948	3,794
Out-of-pocket expenditure on health as % of final household consumption (2009) ¹⁶⁰	2.4	1.6	1.5	3.5



Table 15 People with unmet needs for medical examination in four EU comparator countries, 2009¹⁶¹

Reason given	Waiting time			Could not afford to			Too far to travel		
	Q1: lowest income %	Q5: highest income %	Total %	Q1: lowest income %	Q5: highest income %	Total %	Q1: lowest income %	Q5: highest income %	Total %
Germany	1.0	0.4	0.6	4.1	0.2	1.3	0.3	0.0	0.1
UK	1.2	0.7	1.1	0.1	0.1	0.1	0.3	-	0.1
Netherlands	0.2	0.1	0.2	0.1	-	0.1	-	-	0.0
Sweden	2.0	1.1	1.5	1.2	0.1	0.4	0.1	0.1	0.1
EU-27	1.7	0.5	1.0	4.8	0.3	1.9	0.6	0.0	0.2

Social care in the four comparator countries

Social care in Germany

Germany introduced a new system for providing universal insurance coverage for social care with the Long-Term Care Act, which was passed in 1994. This reduced individual people's liability for paying expensive care costs and increased benefit provisions.¹⁶² Another important aim of introducing this insurance was to prevent people from being dependent on social assistance, which was perceived to be 'highly stigmatising and incompatible with basic German citizenship rights'.¹⁶³

People in Germany who hold statutory health insurance are also automatically enrolled into the long-term care insurance programme, and people who purchase private health insurance must have long-term care insurance; therefore, coverage is universal.¹⁶⁴

The social insurance scheme for long-term care now covers approximately 90 per cent of the German population, with the remainder covered by private insurance schemes.¹⁶⁵

People pay for their long-term care insurance on a pay-as-you-go basis and the costs are split between the employee and the employer, with each paying 50 per cent. The size of contributions is graduated according to income (since 2008 people who earn less than €44,550 pay 1.95 per cent of their income).¹⁶⁶ From January 2005 it was also required that insurance holders who had no children had to pay an extra 0.25 per cent. Pensioners must continue to fund these costs from their retirement incomes but people who are unemployed have their payments made on their behalf through unemployment insurance.¹⁶⁷ Altogether public spending accounts for at least 50 per cent of spending on long-term care, while despite the insurance system, 31 per cent of spending on care is made up of direct charges to service users.¹⁶⁸

Before 2008 German people were not eligible for public long-term care benefits unless they



had made at least five years' worth of contributions before applying. In 2008 the Nursing Care Time Act reduced the period of contributions required for eligibility to two years. A person who requires long-term care must also be assessed by the medical review board to identify the nature of the person's care needs and their severity.¹⁶⁹

People with care needs are assessed as falling into one of three 'dependency levels' and the quantity of benefits they receive depends on which level applies to them, and on where they receive the care (eg at home or in an institutional setting). Since 2008 a person with eligible care needs has a choice between receiving cash, services or a combination of the two, every six months.¹⁷⁰ However, long-term care benefits only provide a fairly basic level of care and if a person's care needs are above this threshold, they might need to pay for additional care, or apply for social assistance, which is means-tested. People can also pay for supplementary long-term care insurance.¹⁷¹

In addition to covering care costs for the recipient, long-term care insurance also covers benefits for informal carers: they can take up to four weeks' holiday per year and have their expenses covered. Carers can also have free training courses and if they provide care for more than 14 hours each week the insurance programme covers their pension payments.

Social care in the UK

Responsibility for administering social care in the UK is devolved to the constituent countries of England, Wales, Scotland and Northern Ireland, which each have their own policies. Funding for social care in the UK 'comes from a combination of central taxation (formula and specific grant to local authorities-block grants), local taxation (council tax) and user charges for social care services'.¹⁷²

In England, Scotland and Wales local authorities take responsibility for social care in coordination with the regional health boards, while in Northern Ireland the health and social care trusts are responsible for social care.¹⁷³ Local authorities also have the role of assessing people's care needs and identifying whether they meet the locally set eligibility thresholds for access to state-funded care. In England local authorities set their eligibility criteria according to the nationally agreed Fair Access to Care Services assessment framework, which identifies four levels of need: 'critical', 'substantial', 'moderate' or 'low'.¹⁷⁴ Equivalent frameworks are in place in Scotland, Wales and Northern Ireland. In addition to the domiciliary care and care home services that are provided in Great Britain, Northern Ireland provides a widespread home help service for older people with lower-end support needs.¹⁷⁵

Whereas health services in the UK are 'free at the point of use', eligibility for publicly funded social care services is restricted and in addition to conducting a needs assessment, which identifies whether the older person meets the eligibility threshold for state-funded care, local authorities also apply means-testing to determine whether the recipient will need to contribute to the cost of their care. Charges tend to be based on the older person's ability to pay, rather than the cost of the service. In Scotland personal care and nursing care for people aged 65 and over are now free for people who are assessed as having a care need, but in Scotland care



home fees continue to be means-tested, in line with the rest of the UK. Therefore only the personal care or nursing care element of care home fees is automatically funded by the state.¹⁷⁶ The assets threshold above which older people in Scotland need to pay for their own care home accommodation is £22,750. Those with assets of lower than £14,000 are eligible for the maximum level of financial support from the local authority.¹⁷⁷

In England older people who have assets of more than £23,250 are not eligible for financial support from the state towards the costs of their care.¹⁷⁸ Below this level of assets, the financial support people may receive to meet their care costs depends on their income and care needs, with separate rules for domiciliary care and residential care. If an older person requires residential care, their housing assets are included in the means test, as long as no dependants are occupying the home. This means that older people entering residential care often find they have to sell their home to pay for their care.¹⁷⁹ However, housing assets are not included in the means test for domiciliary care and local authorities must ensure that their charges for home care do not reduce the service user's net income to below the 'basic' level of income support (at the level of Pension Credit Guarantee Credit), plus a 'buffer' of at least 25 per cent.¹⁸⁰

The funding system in Wales is very similar to the system in England, although the cap above which people are liable to pay the full costs of their care is set slightly lower in Wales at £22,000.¹⁸¹ Since 2006 Welsh local authorities have been slightly more restricted than English local authorities in the charges they can make for home care; in Wales there is a buffer of 35 per cent above income support levels before local authorities can make any charges for care.¹⁸² In Northern Ireland the assets threshold above which people must meet their full residential care costs is set at £23,250 (including the value of their home).¹⁸³ More than two-thirds (70 per cent) of older people who live in care homes in Northern Ireland have their care entirely funded by the state (because the incomes of older people in Northern Ireland are relatively low).¹⁸⁴ However, no charges are made for domiciliary care in Northern Ireland, including personal care and other types of home help.¹⁸⁵

Current estimations suggest that in England about a quarter of people aged 65 have very low care costs, or no costs at all during their lives; half of the population pay care costs up to £20,000; and 10 per cent of people pay care costs of more than £100,000.¹⁸⁶ Overall it is estimated that in England in 2009/10 approximately £8,300 million was spent privately on social care for people aged 65+, in comparison with £7,500 million of public funding.¹⁸⁷ According to these figures currently around 52.5 per cent of social care for older people is privately funded, while 47.5 per cent of care is publicly funded. Therefore, more than half of the costs of older people's social care in England are currently falling on older people and their families. Comparable figures are not available for Scotland, Wales and Northern Ireland.

While the funding rules for social care services vary between the constituent countries of the UK, Attendance Allowance is available at an equal rate throughout the UK to people aged over 65 who have needed help with their personal care for at least six months. This is a tax-free and non-means-tested benefit.¹⁸⁸ In Scotland older people in care homes who receive free personal care lose their entitlement to Attendance Allowance.¹⁸⁹

The Dilnot Commission, which was set up by the UK Coalition Government to review the social



care funding system for England, proposed in July 2011 that means-tested support should continue to be available to people, but the threshold for assets above which people are not eligible for financial support with residential care should be increased from the current level of £23,250 to £100,000.¹⁹⁰ The Commission also recommended that individual people's contributions to their own care costs throughout their lifetime should be capped (at somewhere between £25,000 and £50,000), above which amount the state would fund their care; £35,000 was proposed to be 'an appropriate and fair figure'.¹⁹¹

The Commission suggested that people who enter adulthood needing care and support should have their care costs funded and a means-test should not be applied. The UK Government's response to the Dilnot Commission will have implications for all of the devolved administrations in the UK as the Independent Commission on Social Services in Wales recently noted: 'Any major reform of how care is paid for will need to be led by the UK Government as key areas such as taxation, National Insurance and welfare benefits are non-devolved.'¹⁹² The UK Government is expected to publish a white paper on social care and an update on social care funding reform in spring 2012.¹⁹³

Social care in the Netherlands

The Netherlands was the first OECD country to put in place compulsory social health insurance to cover social care in 1968. The Exceptional Medical Expenses Act (AWBZ) is a compulsory national insurance package that covers long-term care for disabled or older people.¹⁹⁴

Employees pay a percentage of their wages towards their AWBZ insurance premiums, depending on their level of income. The AWBZ insurance covers two-thirds of the national costs for social care, with the remaining third paid for by the Dutch Government out of taxes. However, about 8 per cent of the cost of care is also covered by 'co-payments' by the service user or their family. These are divided into 'low' and 'high' co-payments (a maximum of €759 'low' or €2,081 'high' per month). The size of the co-payment is decided by the individual's level of need and their income.¹⁹⁵

People who require social care are assessed for their care needs according to a national standardised assessment procedure, which is coordinated centrally by the Centre for Indications Care. People can receive their benefits in a personal cash budget or in the form of care services. Personal budgets are worth a smaller amount than the care services. People can use their personal care budgets to hire their family members as paid caregivers.¹⁹⁶

Social care in Sweden

According to a 2011 OECD report, Sweden spends the most on long-term care out of OECD countries, alongside the Netherlands and Nordic countries like Norway.¹⁹⁷ Spending on social care is shared between central government, regional governments and local governments, although since 1992 primary responsibility has resided with local governments to encourage integration.¹⁹⁸ Most funding for social programmes in Sweden comes from local taxes;



therefore there are concerns that demographic pressures from population ageing will make this arrangement increasingly unsustainable.¹⁹⁹

There are no eligibility criteria for accessing care services in Sweden although the person must be assessed as having some form of impairment. Local offices organise the process of assessing people's care needs and no means-testing is applied. In 2010 85 per cent of long-term care was funded through local taxation, 12 per cent through grants from national government and only 3–4 per cent came from charges to service users.²⁰⁰ The level of charge made depends on an assessment of the individual's income, taking into account their housing and other living costs.²⁰¹

Services are delivered through a combination of public and private care providers; municipal authorities can make grants to voluntary organisations that provide services that complement government services. Since the Law on the System of Choice in the Public Sector was passed in 2009, Sweden has tried to improve cost-effectiveness and standards by stimulating more private providers to enter the market. The purpose of this change of policy is to increase the choice of service providers available to service users.²⁰²



4 Social participation and quality of life

There is now a strong body of evidence that links the quality of older people's social relationships and the frequency with which they socialise and participate in their community with health, well-being and quality of life.²⁰³ Therefore, alongside income and health, social participation and well-being are also extremely important dimensions for governments to consider in developing strategies to support successful ageing societies. As one recent study put it, 'The opposite of loneliness is feeling embedded.'²⁰⁴

In this chapter we will provide an overview of evidence of the extent and type of older people's social participation in each of the four comparator countries, compare evidence of national well-being in each of the four countries and consider various measures of intergenerational cohesion and age discrimination. This will provide a broad context for the more detailed analysis that we will present in section 2, detailing the levels of social participation, well-being and age discrimination in each of the four countries as evidenced by the Experiences of Ageing Matrix.

Social participation

The level of social participation in a country could be assessed according to a wide variety of different measures. One example might be the rates of volunteering that take place in that country. A Eurobarometer survey conducted in 2011 asked respondents of all age groups whether they participate or do voluntary work in a range of types of organisations, and found that across the 27 EU member states, an average of 26 per cent of people were involved in these activities. Within the four countries we are focusing on in this study, rates of participation or volunteering ranged from 55 per cent in Sweden to 26 per cent in the UK, while in Germany 45 per cent of people were involved in voluntary activities and in the Netherlands 50 per cent.²⁰⁵

Another Eurobarometer survey that was conducted earlier in 2011 focused specifically on voluntary work, as opposed to general social participation, asking participants aged 15+ the question 'do you currently have a voluntary activity on a regular or occasional basis?' This survey found that 57 per cent of adults in the Netherlands volunteer, 34 per cent of people in Germany, 23 per cent of people in the UK and 21 per cent of people in Sweden.²⁰⁶ As we will discuss in more detail below, the discrepancy in the findings between the two surveys reflects the fact that people in Sweden are more likely to participate in voluntary associations for leisure purposes (eg sports or cultural activities), therefore they will not necessarily class this as voluntary 'work'.²⁰⁷ This indicates that the later Eurobarometer survey provides a good measure of social participation in community-based activities, but not necessarily of voluntary 'work' as it might be conceived of in the UK. The earlier Eurobarometer survey, which focused more narrowly on voluntary work, found that levels of volunteering in Sweden were roughly similar to those in the UK.

Other more subjective measures of social participation and inclusion have also been employed to enable cross-country comparison: one European survey conducted in 2007 asked survey respondents about the extent to which they agreed with the statement 'I feel left out of society'. They found that overall throughout the 27 member states, 9 per cent of people agreed with this



statement. In our four countries the proportion of people who felt left out fell either side of this average, with a high of 12 per cent of respondents from the UK saying they felt left out and a low of only 4 per cent of Dutch respondents feeling left out; 6 per cent of Swedish people and 7 per cent of German people said they felt left out.²⁰⁸ This suggests that adults in the UK might be at higher risk of social exclusion than their continental counterparts, which has implications for the well-being of older people, among whom rates of loneliness and depression are often higher than in the general population.²⁰⁹

Table 16 presents six indicators of social inclusion and participation, this time specifically for people aged 65+, which have featured in Europe-wide surveys in recent years. The indicators relate to questions posed to people of all age groups on whether their country or local area is an 'age friendly' environment, and to older people about the types of social or learning activities they are involved in.

In 2011 the majority of Swedish (71 per cent) and Dutch people (73 per cent) thought their country was an 'age friendly' environment, a much higher proportion than the average view of people in the EU as a whole. In comparison, only slightly more than half of German people thought their country was an 'age friendly' environment. The proportion of people in Germany and the UK who agreed with the second indicator – that their local area was an 'age friendly' environment – was higher than those who agreed with the first (and for Germany close to the EU average). In the UK, 75 per cent said they thought their local area was age-friendly, a figure much closer to that for people with a similar view in the Netherlands and Sweden. This poses interesting questions about why the local area might be considered more age-friendly than the country as a whole.

The next four indicators in the table cover rates of participation in various types of activities. This provides interesting comparison as the varying scores between countries might indicate different cultural preferences for certain activities. They show that German older people are the least likely to get together with friends or family at least once a month for a drink or a meal (54.5 per cent compared with 79.5 per cent in Sweden), but are the most likely to take part in a leisure activity such as watching sport, or going to the cinema or a concert regularly (57 per cent compared with 45.1 per cent in the UK). German older people are also the second most likely (after Swedish older people) to be enrolled in educational courses. This substantial variation between the indicators highlights the importance of using a mixture of indicators to explore levels of social participation.



Table 16 Indicators of social inclusion and participation for people aged 65+ in four EU comparator countries

Indicator	Germany (%)	UK (%)	Netherlands (%)	Sweden (%)	EU-27 (%)
Proportion of respondents aged 15+ who think the country is an 'age friendly' environment (eg adapted to the needs of older people) (2011) ²¹⁰	53	64	73	71	57
Proportion of respondents aged 15+ who think the local area is an 'age friendly' environment (eg adapted to the needs of older people) (2011) ²¹¹	66	75	76	77	65
Proportion of people aged 65+ who get together with friends or family for a drink or meal at least once a month (2009) ²¹²	54.5	63.9	77.2	79.5	59.6
Proportion of people aged 65+ who regularly participate in a leisure activity such as sport, cinema, concert (2009) ²¹³	57	45.1	51.9	51.3	35.3
Proportion of retired people who are currently participating in community work or volunteering (2008) ²¹⁴	45	42	52	37	34
Proportion of retired people who are enrolled in or leading educational courses (2008) ²¹⁵	24	20	18	28	16

The underlying importance of social relationships, which can be facilitated by regular social activities, is evidenced by a longitudinal study conducted in England in 2008/09, which found that the number of close relationships that older people had and the frequency of their social contact was associated with their level of well-being. Analysis of the survey results for people aged 65–74 found that only 9.5 per cent of people who had at least ten close relationships showed signs of depression, compared with 29 per cent of people who had one or fewer close relationships. Older people who had more frequent contact with their friends and family rated higher on life satisfaction and quality of life measures than those who had less frequent social contact.²¹⁶

Well-being

The concept of well-being has crept up the policy agenda in the UK and many EU countries, with policy narratives at a European level increasingly taking the issue of well-being in old age seriously. The European Commission's 2012 report *Active Ageing and Solidarity Between Generations* highlights the importance of well-being as a dimension of mental and physical health, as well as a key indicator of quality of life.²¹⁷

Previous research has found that well-being does not tend to follow a linear trajectory



throughout life and it is incorrect to assume that older people are necessarily less happy than younger people:

In an influential study of the age distribution of life satisfaction, Blanchflower and Oswald (2004) showed that people's levels of happiness followed a U-shaped curve, with least happiness in middle age – a pattern that was consistent in 72 out of 80 countries they studied. For both men and women in the UK, dissatisfaction peaked at around the age of 44, after which life satisfaction improves to its highest level during the life course.²¹⁸

This finding is partly borne out in research conducted in 2007 by the European Foundation for the Improvement of Living and Working Conditions (Eurofound), which found that across the EU-27 countries, life satisfaction was at the same level in the 18–34-year-old respondents and the 65+ age group, who on average rated their happiness at 7.1 out of 10. In the 35–49 age group the rating was very slightly lower at 7.0, and in the 50–64 age group slightly lower again at 6.9. However, ratings for happiness did not conform to this 'U-shaped curve', with people's self-rated happiness declining in a linear trajectory from 7.7 out of 10 in the 18–34 age group to 7.3 in the 65+ age group.²¹⁹

The same Eurofound survey found that when all age groups were combined, there were clear national differences in levels of life satisfaction and happiness between the countries surveyed. The average rating for life satisfaction across the 27 member states was 7 out of 10, but this varied between an average rating of 5 for people in Bulgaria and 8.5 in Denmark. Sweden came second of the 31 countries surveyed with an average life satisfaction rating of 8.3, while the Netherlands had an average rating of 7.9, the UK averaged 7.3 and Germany averaged 7.2. In answer to a second question, 'how happy would you say you are?', the average rating out of 10 across the EU-27 was 7.5. Swedish people had an average score of 8.2, Dutch people scored 8, people in the UK scored 7.8 and German people 7.5. This presents interesting questions regarding how local socio-economic circumstances or national characteristics might shape these collective scores.

We will look in detail at indicators that specifically consider the quality of life of older people aged 65+ in each of the four countries in section 2.

Age discrimination

Another dimension that could clearly affect older people's quality of life is the level of implicit or explicit age discrimination tolerated in their country. Narratives about older people's value and place in society inevitably exert an influence on identity and self-esteem. Table 17 presents a number of indicators that could be used to infer the level of age discrimination that is present in each of the four countries. However, age discrimination is a complex concept with many dimensions; therefore this is not a straightforward issue to interpret. For example, in Germany a smaller proportion of the population considers that age discrimination is widespread than in the UK, but in Germany a higher proportion of people agrees with the manifestly 'ageist' statement that 'older people are a burden for society' than in the UK. Therefore there may be varying cultural understanding of what 'age discrimination' means, and whether it is an issue of concern.



In Sweden people collectively gave a relatively high mean age for when 'a person is considered old' at 66.6 (compared with 60.1 in Germany), suggesting they have a more inclusive attitude. However, in Sweden 14 per cent of the population agreed that older people are a burden for society, the highest proportion of the four countries, which might indicate an intolerant attitude towards older people. This suggests that discriminatory attitudes are manifest in different ways in different countries.

The authors of a 2012 Eurobarometer study of 'active ageing', which contributed some of these survey findings, observed that one of the most significant findings of this study was that 'there is no generational divide in opinions on most issues covered. Older people and their contribution to society are, on the whole, rather seen in a positive light.' However, they observed that 'there are striking differences in attitudes across countries'. Therefore they suggested that in light of this, 'policy makers who want to promote active ageing will have to take into account not only different social and economic realities, but also very different mindsets in their populations'.²²⁰

Table 17 Indicators of age discrimination in four EU comparator countries

Indicator	Germany (%)	UK (%)	Netherlands (%)	Sweden (%)	EU-27 (%)
Mean age at which a person is considered old (2012) ²²¹	60.1	61.9	70.4	66.6	63.9
Proportion who believe there should be a compulsory retirement age (2012) ²²²	17	29	19	33	41
Proportion of the population aged 15+ that agreed or agreed strongly that older people are a burden for society (2009) ²²³	12	9	5	14	14
Proportion of the population aged 15+ that thought age discrimination was widespread (2008) ²²⁴	34	48	44	41	42

Intergenerational cohesion

A 2012 statistical study by the European Commission observed that one important factor that could contribute to intergenerational conflict and age discrimination is a lack of positive interaction between generations.²²⁵ Table 18 looks at a range of indicators of people's views on the quality of intergenerational contact in their country and the value they place on intergenerational relationships.

The 2009 Eurobarometer survey findings presented in this table demonstrate that intergenerational relationships are valued highly in each of these four countries: between 88 per cent and 92 per cent of those surveyed agreed that local authorities should take a role in fostering intergenerational contact. However, it appears that there is a varying level of success in each country's current approach to providing these opportunities for different generations to meet. The respondents from the UK indicated the highest level of discontent, with 76 per cent of people agreeing that there were not enough opportunities for intergenerational contact



currently. This compares with only 46 per cent of people in the Netherlands. Similarly, only 24 per cent of respondents from the UK thought that the government was currently doing a good job in this area, whereas 49 per cent of Dutch people were satisfied with their government's efforts. A 2004 study of factors influencing intergenerational contact in the Netherlands found that Dutch older people who worked or took part in some kind of voluntary work were more likely to have young people who were unrelated to them in their social networks.²²⁶ Therefore, it is probably no coincidence that in the Netherlands there are higher volunteering rates among retired people, and less evidence of public dissatisfaction with opportunities for intergenerational contact.

Table 18 Views on intergenerational cohesion in four EU comparator countries

Indicator	Germany (%)	UK (%)	Netherlands (%)	Sweden (%)	EU-27 (%)
Proportion of population aged 15+ that agreed or agreed strongly agreed that there are not enough opportunities for older and younger people to meet and work together (2009) ²²⁷	50	76	46	55	64
Proportion of population aged 15+ that agreed or agreed strongly that local authorities should support initiatives that foster stronger relations between young people and older people (2009) ²²⁸	92	92	88	89	92
Proportion of population aged 15+ that agrees or agrees strongly that the government is doing a good job in promoting a better understanding between the young and the old (2009) ²²⁹	22	24	49	29	27

In the final part of this chapter we will consider briefly the relationship between the voluntary sector and the state in each of the four countries and how this might affect older people's opportunities for social participation.

The role of the voluntary sector

We have observed above the varying rates of social participation and voluntary work among adults in each of the four countries this study focuses on. In this part of the chapter we will consider how the relationship between the welfare state and the voluntary sector in each of these countries might influence the types of voluntary activities that are available to older people.

An influential comparative study of the non-profit sector across 24 countries conducted by Salamon and Sokolowski at Johns Hopkins University in the early 2000s found that 'volunteering is augmented rather than inhibited by a formal organizational base, which in turn grows as a result of state support'. This would suggest that volunteering levels are likely to be higher in countries that have strong statutory services and a well-developed voluntary sector. They further commented:



volunteering, and more generally civic participation and self-organization of individuals to pursue common interests, are... instruments and outcomes of social policies that are highly dependent on each country's institutional path of development.²³⁰

Salamon and Sokolowski categorised the 24 countries included in their 2003 study into four types of institutional tradition: 'social democratic', 'liberal', 'corporatist' or 'statist'. They labelled Sweden as 'social democratic', the UK as 'liberal' and Germany and the Netherlands as 'corporatist'. They describe the 'social democratic' institutional tradition as one in which mobilised workers have insisted on universal provision of strong state services, leading to the development of an extensive welfare system. This goes on to shape the character of the voluntary sector as health, education and social care services are predominantly provided by the state, therefore volunteering 'is likely to be largely expressive in form, with limited reliance on volunteers for service functions'.²³¹

In contrast, in Salamon and Sokolowski's 'liberal' model (typified by the UK), there is under-provision of state services in some areas and more limited provision of welfare, leading to 'heavy reliance on voluntary action instead' in delivering some core services such as social care.²³² In the 'corporatist' model, which lies between the liberal and social democratic models, government services are often provided 'through voluntary organisations, many of them religiously affiliated'.²³³ This leads to relatively high spending on welfare, while voluntary sector organisations are strongly involved in providing services. However, Salamon and Sokolowski recognised that Germany and the Netherlands did not comfortably fit this model as voluntary activities in these countries were more 'expressive' in character than they would have predicted.²³⁴ Other analysis has identified the Dutch welfare state as a combination of the 'corporatist' and 'social democratic' models.²³⁵

Subsequent studies have shared Salamon and Sokolowski's analysis that the welfare state in Sweden dominated core services such as health, education and social care between the 1930s and 1970s.²³⁶ However, recent studies have also observed new trends emerging following the budget cutbacks that were made in Sweden in the early 1990s. During this period, some functions of the Swedish welfare state were privatised, while at the same time there were cuts to service provision, leading to 'decreased universalism' in social care.²³⁷ This process has corresponded with higher levels of informal care and voluntary activities related to service provision in Sweden. One 2008 study observed that the increasing role of volunteers in providing welfare services is 'problematic' as 'the practice is largely invisible due to the cultural myth that the state provides all welfare'.²³⁸ However, the recognised role of the voluntary sector in Sweden is to promote 'expressive' activities and social participation rather than taking on 'core welfare' tasks. A 2011 study of 'productive ageing' concluded that broadly speaking older people's voluntary activities in Sweden remain more likely to involve sports or cultural associations than welfare-related roles.²³⁹ As observed above in relation to the Netherlands, this could help to explain the greater degree of intergenerational mixing found in Sweden in comparison with Germany and the UK.

In contrast, in the UK, where the approach to welfare tends to be typified as 'liberal', social services have traditionally been less extensive and 'self-reliance' in old age has been particularly



encouraged.²⁴⁰ These limitations in the availability of publicly funded care have meant that volunteers, including formal volunteers and informal carers, have traditionally played an important role in service delivery. In recent decades, the role of the voluntary sector has also changed considerably, with public sector reforms introduced in the 1990s leading to charities playing a stronger role in delivering publicly funded services.²⁴¹ The public sector cuts announced in the 2010 spending review (discussed in more detail in chapter 5) will therefore impact on both statutory and commissioned voluntary sector services, potentially leading to a greater reliance on volunteers in service provision as observed in Sweden following the 1990s. This could affect the nature of older people's social participation in the UK in future years, directing more of older people's time towards informal caring as opposed to participating in leisure-orientated activities. This might also reduce the potential for intergenerational mixing, which is more likely to be facilitated by community-based leisure activities than by informal caring roles.

In Germany the voluntary sector has had a long-standing partnership with the public sector in delivering public services; social services are frequently 'delivered by large welfare organisations that are highly professionalized and with low volunteer levels'.²⁴² More recently the private sector has also played an increasing role in service delivery, particularly in the health and social care sectors, competing with the traditional third sector service providers.²⁴³ Germany is a middle-ranking EU country with respect to volunteering levels,²⁴⁴ although the proportion of older people volunteering is growing faster than other age groups. Between 1999 and 2004, the proportion of older people aged between 66 and 75 increased from 26 per cent to 31 per cent.²⁴⁵ This may reflect the fact that historically there has not been a strong emphasis on promoting volunteering among older people in Germany, which may be related to the strong link between volunteering and employment. In Germany 23 per cent of volunteering activity is related to the individual's current or (if retired) former job.²⁴⁶

However, as a recent study observed, 'In Germany, a change in perspective regarding old age is currently taking place' and volunteering and other types of social participation in old age are increasingly viewed as an important part of the Germany government's strategy for managing the challenges of population ageing.²⁴⁷ Like Sweden and the Netherlands, the types of volunteering that German older people prefer to participate in are of an 'expressive character', including mainly 'sports/exercise, church/religion, the social domain, recreation/social interaction as well as culture/music'. Service-type volunteering roles in the areas of 'fire and rescue services, youth work/education, school/kindergarten, health and justice/delinquency problems' make up a smaller proportion of activities.²⁴⁸ However, institutional support for these activities may be under threat. A recent study observed that the decreasing funding streams available from local government in Germany, which has previously played a strong role in providing grants to non-profit service providers such as volunteer centres, could limit the capacity of the sector to sustain community-based projects and promote older people's social participation.²⁴⁹

Like Germany, the Dutch not-for-profit sector has historically been heavily involved in providing welfare services such as health, social care and social housing services.²⁵⁰ Consequently the third sector is a large employer in the Netherlands and the 2004 John Hopkins Global Civil Society Index identified the Netherlands as having the largest voluntary sector of the 34 countries included in the study.²⁵¹ Following the Second World War, the Dutch states increasing reliance on the third sector for delivering services gradually blurred the distinction between public and non-profit – private – agencies'.²⁵² However, reforms brought in during the 1990s increased



the independence of the third sector by reducing state control.²⁵³ A 2005 study observed that contemporary Dutch legislation creates a supportive environment for third sector organisations, including tax relief and little state regulation unless the organisation is receiving statutory funding, which has facilitated the growth of the third sector.²⁵⁴

The particular dominance of the third sector in the Netherlands may help to explain the particularly high rates of volunteering evidenced above. Unlike Germany, older people in the Netherlands play a particularly strong role in volunteering; the 2008 Eurobarometer survey showed that 52 per cent of Dutch retired people were involved in some kind of community work at the time of the survey.²⁵⁵ A 2011 study comparing rates of volunteering in the Netherlands in 2005 with those in 1975 found that during this period volunteering has become increasingly dominated by pensioners and homemakers, which they suggest may reflect increasing time pressures limiting the activities of working-age people.²⁵⁶ Surveys suggest that Dutch older people's preferred volunteering activities include 'work in sports clubs, religious or ideological organisations, neighbourhood support and the support of older people who are disabled or in need of care'.²⁵⁷ However, while the Netherlands might seem to have particularly high rates of social participation in old age, here as in other countries older people remain at higher risk of social isolation than other age groups and there is an increasing policy focus in the Netherlands on the problem of social isolation and loneliness in old age. In 2010 this led to the formation of a National Coalition against loneliness involving 14 (mainly third sector) organisations and companies.²⁵⁸



5 The impact of austerity measures on older people

Following the 2008 financial and economic crisis and the subsequent recession across Europe, many European governments have recognised the need to employ austerity measures to tackle inflated public debt and put their country's finances on a more sustainable footing. While this might be necessary in the medium to long term, in the short term the spending cuts and tax rises planned in each country could have worrying implications for more vulnerable social groups, such as pensioners living on a low income or older people with poor health who are reliant on health and social care services. This chapter will review the austerity measures that are planned in Germany, the UK, the Netherlands and Sweden and the extent to which they are likely to impact on older people.

Austerity measures in Germany

In 2009 the German Government ran a public deficit of 3 per cent of GDP; this increased to 3.3 per cent in 2010, thereby breaching the fiscal rules of the European Stability and Growth Pact, which demands that public deficits must not exceed 3 per cent of GDP.²⁵⁹ During this time Germany's debt level increased from 73.5 per cent to 83.2 per cent of GDP. Therefore, in December 2009, ECOFIN called on the German Government to reduce its deficit before 2013.²⁶⁰

In June 2010, the German Government announced its plans to reduce the budget deficit by €80 billion. This included a proposal to make job cuts in the public sector (leading to about 15,000 job losses by 2014²⁶¹), reform the military and reduce the welfare budget by €30 billion.²⁶² The planned welfare spending cuts included reducing some parental benefits and scrapping others, abolishing some benefits for the long-term unemployed and changing the way that unemployment programmes are delivered. Welfare reforms that could potentially have an impact on future or current pensioners include the decision to reduce the rate of pension insurance for people on long-term unemployment benefits and a reduction in the heating allowance paid to people on housing benefit.²⁶³ No cuts in pensions spending were included in this package but it was subsequently announced that health insurance premiums would be raised and cuts made to healthcare budgets.²⁶⁴ This squeeze on funding for healthcare could potentially have a negative impact on older people, who tend to be the highest users of healthcare.

The German narrative concerning the need for an austerity drive is closely bound up with the longer-term narrative about the need to improve the sustainability of public finances in the face of population ageing. In its 2011 German Stability Programme update, the German Federal Ministry of Finance observed,

The post-war baby boom generations are now gradually reaching retirement age. As a consequence, the old-age dependency ratio, which describes the ratio between those of retirement age and those of working age in the population, will climb more quickly than it has done in the past.²⁶⁵



Therefore, the reform that will most affect people approaching retirement age is the previously mentioned increase in the general retirement age to 67, which is planned to take place between 2012 and 2029.²⁶⁶

Austerity measures in the UK

Austerity measures that the UK Government has taken following the 2008 financial crisis and the ensuing recession have included a combination of welfare reforms, other spending cuts and tax increases (including a higher rate of VAT and increases in national insurance contributions).

The welfare reforms that were announced in the UK Government's 2010 comprehensive spending review have so far had relatively little impact on older people, falling instead particularly on other groups such as working-age disabled people and the unemployed. Like Germany, pension spending was protected and the 2010 spending review confirmed that the state pension would be uprated by earnings, prices or 2.5 per cent, whichever is the highest (the so-called 'triple lock').²⁶⁷ The UK Government also pledged to protect other key universal benefits for older people such as winter fuel payments, concessionary bus travel and free eye tests, prescriptions and TV licences. The NHS in England also came out relatively unscathed with its budget of £105.9 billion in 2011/12 projected to rise to £114.4 billion in 2014/15, with proportionate increases allocated to the devolved authorities.²⁶⁸ More recently, it was announced in the 2012 budget that from April 2013 new pensioners will not receive the higher personal income tax allowance that people aged 65+ have previously received, and current pensioners will have their personal allowance frozen at current rates.²⁶⁹ Chancellor George Osborne has emphasised that current pensioners will not lose out in real terms as those affected by the change will be compensated by this year's increase in the state pension of 5.3 per cent.²⁷⁰ It will be new pensioners who will be most affected by this change, standing to lose up to £285 per year. However, the personal allowance of the poorest pensioners – whose annual income will not reach the new universal threshold for untaxed income of £9,205 – will not be frozen.

The main austerity measures affecting older people in the UK are the sooner than expected rise in the state pension age to 66 (as discussed in chapter 2) and cuts to the spending settlements for the devolved administrations and English local authorities. In the 2010 comprehensive spending review Scotland's overall budget was reduced by £4.1 billion between 2010/11 and 2014/15,²⁷¹ while the Welsh Assembly's budget was cut by £1.8 billion between 2010/11 and 2014/15.²⁷² There are fears that these cuts will have a substantial impact on the provision of services for older people such as low-level care and support services and community and public transport during this period.²⁷³

For English councils the budget cuts amounted to 28 per cent in real terms over the four years from 2010/11 to 2014/15, with serious implications for the funding available for social care and other services for older people.²⁷⁴ It was also announced in the spending review that there would be £2 billion per year of additional funding for social care in England to compensate for these cuts, but concerns have been raised that this additional funding is not ring-fenced, therefore local authorities may allocate the money to other priorities rather than social care.²⁷⁵ Even if this £2 billion is spent on social care, when the cuts to councils' budgets are taken into account



this sum amounts to a net reduction in the funding available for social care. Written evidence from the Local Government Association to the House of Commons Health Select Committee in October 2011 estimated that in the financial year 2011/12 funding for social care as a whole was cut by almost £1 billion, while Age UK estimated that this amounted to a net reduction in spending on social care for older people by 4.5 per cent or £341 million between 2011/12 and the previous year.

The main implications for older people of these cuts are:

- *Tightening eligibility criteria:* In 2011 15 councils changed their eligibility threshold for social care from 'moderate' to 'substantial' need, so that 82 per cent of local authorities restricted eligibility for state-funded social care to older people with 'substantial' or 'critical' needs.²⁷⁶
- *Increased service charges:* Demos research examining the effect of spending cuts in England and Wales found that the majority of local authorities were responding to the squeezes on their budgets by increasing service charges for older and disabled people, or in some cases introducing a new charge for a service that was previously free.²⁷⁷ For example, Islington Council changed its charging policy from June 2011 so that the discretionary 15 per cent discount on care charges they had previously offered to for people paying for their own care was no longer available.²⁷⁸ Shropshire Council increased the cost of their community meals services by 9 per cent between 2011/12 and 2012/13.²⁷⁹
- *Closing community support services:* Demos's 2011 research also found that approximately half of councils in England and Wales planned to close some services for older people and disabled people. The types of service that were hardest hit were residential services, day centres and respite services.²⁸⁰

Therefore, while universal welfare benefits for older people have been protected so far in the public spending cuts, older people who use social care are at risk of substantial increases in costs, or of finding they are ineligible for state-funded care altogether. As Demos's research has shown, many older people are also seeing much-valued local services disappear as a result of local spending cuts.

In addition to these changes to local services, the increase in VAT mentioned above will also affect older people's spending power by increasing the cost of goods and services. Research by the Office for National Statistics in October 2011 found that increases in VAT disproportionately affect the poorest households in the UK (such as the 21 per cent of pensioners considered to be at risk of poverty). In 2009/10 the poorest fifth of households spent 10 per cent of their disposable income on VAT, whereas the richest fifth spent only 5 per cent of their disposable income on VAT in that year.²⁸¹ As a result of the increase in VAT from 17.5 per cent to 20 per cent in January 2011, older people have less disposable income available to pay for services, transport and social activities, potentially increasing the risk of social isolation.

Austerity measures in the Netherlands

In the Netherlands the centre-right coalition government formed in October 2010 (led by new Prime Minister Mark Rutte) announced plans to cut the budget deficit by €18 billion by 2015.²⁸²



This figure included €3.2 billion that had already been identified by the previous ('Balkenende IV') Government in the summer, while the new government also outlined a further €14.8 billion of additional savings.²⁸³ These austerity measures included tightened spending in healthcare:

In curative care, measures are being taken to recoup excess spending from medical specialists. Hospitals are also imposed a fee reduction and further measures have been taken. In Dutch Mental Healthcare (GGZ), a patient contribution has been introduced and under the Exceptional Medical Expenses Act (AWBZ) the minimum personal contribution has been raised.²⁸⁴

Despite these plans to cut spending on health, the coalition agreement of October 2010 clearly prioritises care of the elderly, stating:

We want far more carers, more initial and further training, more patients' rights, more and better quality standards, a stronger Healthcare Inspectorate (IGZ), lower overheads, less regulation, more community care, smaller care institutions and more measures to prevent abuse of the elderly.²⁸⁵

As discussed in chapter 2, the reforms that are likely to impact most significantly on older people – particularly those now approaching retirement age and future generations of older people – are the planned increases in the state pension age, which will be increased to 66 by 2020, and the wider proposed transition from defined benefit pension schemes to defined contribution pensions.²⁸⁶

In December 2011, the finance minister Jan Kees de Jager admitted that further measures might be required to shore up the public finances given a forecast that the budget deficit would hit 4.1 per cent of GDP in 2012. One potential reform would be the faster introduction of a higher state pension age.²⁸⁷ Further reforms are likely to be announced in spring 2012.

Austerity measures in Sweden

Unlike many other European countries, Sweden has not had to push through austerity measures to keep its public finances in order in the wake of the 2008 crisis. Instead, the Swedish centre-right alliance government announced in September 2011 that in response to a slackening economy, its 2012 budget would include infrastructure projects, a labour market package and a higher housing supplement for old-age pensioners.²⁸⁸

In December 2011, an article in the *Economist* praised Sweden for its 'tight fiscal policy, a budget surplus of some 0.1 per cent of GDP and a shrinking public debt', a legacy of the previous financial crisis that Sweden successfully tackled in the early 1990s. However, the same article also warned that Sweden could still suffer fall-out from the euro zone's financial challenges: 'Exports make up half of GDP and many companies report slowing foreign demand. Growth could drop below 1 per cent next year.'²⁸⁹

Although no immediate austerity measures are needed, as we saw in chapter 1, Sweden is



subject to the same demographic pressures posed by population ageing that other European countries are currently grappling with. Therefore, the Swedish prime minister recently raised the question of future changes to the pension system, suggesting that in the future Swedish people might have to work until they are 75.²⁹⁰

Section 2 will look in more detail at how these various issues of pensions policies, healthcare spending and intergenerational cohesion interact in older people's lives in each of the four countries.



Section 2

Comparing experiences of ageing
in Germany, The UK, The Netherlands
and Sweden



6 Methodology

In section 2 of this report we present the results from three separate pieces of analysis we have performed using rounds 3, 4 and 5 of the European Social Survey, which were conducted in 25 different European countries including the countries we are focusing on in this study: Germany, the UK, the Netherlands and Sweden. These three elements include:

- creating a matrix to compare the experiences of older people in four EU countries across five themes (income and poverty, health and health provision, well-being, social inclusion and participation, and age discrimination)
- longitudinal analysis exploring how older people's experiences have changed between the three time points of the European Social Survey rounds (2006, 2008 and 2010)
- analysing the correlations between the five themes employed in the matrix.

This chapter will outline briefly the methodology for each of these elements.

Methodology for creating the Experiences of Ageing Matrix²⁹¹

Selection of indicators

The indicators for the Experiences of Ageing Matrix were selected from rounds 3,²⁹² 4²⁹³ and 5²⁹⁴ of the European Social Survey. The analysis includes only respondents who were aged 65 and over in the UK, Germany, Sweden and the Netherlands (with one exception, discussed below). The sample sizes for each round are shown in table 19.

Table 19 Sample sizes for the European Social Survey, 2006, 2008 and 2010

	European Social Survey Round 5 (2010)	European Social Survey Round 4 (2008)	European Social Survey Round 3 (2006)
UK	606	540	580
Netherlands	433	387	388
Germany	631	612	609
Sweden	374	412	361

The matrix is made up of five themes, each containing six variables. The full list of variables is shown in appendix 1. Each country was assigned a score per variable. We calculated the variable score by first recoding the variable so that positive answers were given higher values. We then standardised the variable by converting all values into z-scores based on the mean and standard deviation calculated from all 65+ respondents in the dataset, across all four countries. We then



calculated the mean z-score per country. This process was carried out for each variable. Data were weighted using a design weight at all times. We used a population weight for calculating the cross-country z-scores, since the Norwegian Social Science Data Service recommends using a population weight when comparing multiple countries with reference to the average of the countries.²⁹⁵

We treated two variables slightly differently: the variable 'Age people start being described as old' and the variable 'People over 70 are a burden on health service these days'. For these variables we included people of all ages in the analysis (as opposed to limiting this to those people surveyed who were aged 65+) to allow for a broader understanding of attitudes towards ageing in the four countries being studied. For the first variable we made the assumption that a higher age given by the respondent signalled a lesser degree of age discrimination in that country.

We then calculated each country's theme score by computing the mean of the country's six scores corresponding to the variables falling under that theme. Each of these scores we transformed into t-scores with a range of 0 to 100 and a mean of 50. We found the average total score per country by computing the mean of the country's five theme scores.

For the age and gender splits, we undertook a similar process, calculating mean z-scores per age and gender group per country. We then followed the same method to calculate the general scores.

Finally, we conducted ANOVA analyses for each of the 30 indicators to determine the statistical significance of the difference between the countries' mean scores, which decides the country rankings. The ANOVA, otherwise known as an 'analysis of variance', is used to determine the size and statistical significance of means between two or more groups for a given variable. A statically significant result for a given ANOVA indicates that there is 95 per cent certainty that the differences in means are accurate. A level of significance at 0.05 (a 95 per cent confidence interval) indicates that the differences in means found in our sample would occur in the actual population as well.

Limitations and assumptions

The sample sizes may be small in comparison with each country's population aged 65+ but are large enough to provide indicative and statistically significant representations of the opinions and experiences of people aged 65+ in the four countries studied.

Data from three separate rounds of the European Social Survey has been used (rounds 3, 4 and 5), covering a period of five years (2006–2011). We have taken this approach because the questionnaires that were used in each of the three rounds had strengths in different areas; the 2006 round included detailed questions about well-being, while the 2008 round included detailed questions about age discrimination. We chose a basket of 30 indicators from a combination of the three surveys and each individual indicator is given equal weighting in the calculations. Where possible we have used data from the 2010 round of the survey as they are the most up to date.



It is important to bear in mind that within the matrix the data corresponding to the four countries are derived from sample groups from three separate survey rounds (collected in 2006, 2008 and 2010), each involving different participants. The longitudinal analysis that we conducted for this report (reported in chapter 8) found that the mean scores of individual countries showed some small variations between the three time points of the survey, although in most cases we did not find these changes to be statistically significant. There were also some variations in the countries' relative rankings against individual indicators between the three time points, which we will outline in detail in chapter 8. However, while these complexities must be borne in mind, the ANOVA analysis has confirmed that the country rankings presented in the matrix in chapter 7 were statistically significant in 27 of the 30 indicators, suggesting that the results overall have a high level of reliability.

Methodology for conducting the longitudinal analysis across the survey's three time points

The purpose of the longitudinal element to this research was to identify how experiences of ageing had changed over time in each of the four comparator countries. The time period that we wished to look at was the same time period covered by the three rounds of the European Social Survey conducted between 2006 and 2010.

To undertake this longitudinal analysis it was necessary to identify survey questions that were present in rounds 3, 4 and 5 of the European Social Survey. This meant that it was not possible to look at the theme of age discrimination longitudinally as questions specifically on age discrimination were only included in round 3 of the European Social Survey, which took place in 2008. The list of indicators that we included in our longitudinal analysis is presented in appendix 2.

To conduct the longitudinal analysis and thereby examine the temporal changes relating to key issues of ageing in Europe, it was necessary to merge the three data sets. However, as the items were all on the same scale, with the slight exception of one item, no standardisation was required in this case. Means were derived for each item in the scales for each country, for each of the years 2006, 2008, and 2010. The differences in means were visually inspected, and a correlations matrix was generated to determine the statistical significance and relationship among the variables over time. It should be noted that this is not a substitute for longitudinal analysis using a longitudinal data set (as opposed to three separate surveys with unique participants in each), nor can causal aspects be inferred. However, it does shed sufficient light on the relationships among these variables, which is a useful first step in assessing the relative change in these scale items over time.

Methodology for analysing the correlations between the themes of the experiences of ageing matrix

For the longitudinal portion of the analyses (outlined above), it was necessary to merge the datasets to examine the temporal changes relating to key issues of aging in Europe. To assess the



strength and direction of the relationship between specific items within a country over time, we also ran a correlation analysis for each item in the first four scales where repeated measurement in the European Social Survey was available.

To do this, specific items were entered into bivariate correlations for the years 2006, 2008 and 2010. The correlation analyses utilise the slope between two or more items to determine the strength and direction of the relationship between them. This produces a Pearson product coefficient, along with the statistical significance of the relationship. For each relationship, for instance between general satisfaction in life in 2006 and 2008, the correlation coefficient and statistical significance p-values were generated. The means and standard deviations of the items per year, per country, were also calculated. These are reported for each relationship between the themes in the tables in appendix 3.

As each item was the same, and measured in the same way, from one year to the next by the European Social Survey, no standardisation transformation was required. Therefore the correlations, as well as the means and standard deviations, are determined using varying scales that reflect the items' original coding scheme. For instance, some item responses were on a scale of 1 to 10, while others were on a scale of 1 to 4. Although this does not make inter-item comparisons possible, it is very easy to compare scores accurately within a country across years, and across countries for the same item to generate country rankings.



7 The experiences of ageing matrix

Overall findings

The matrix that we present in this chapter has been designed so that experiences of ageing among people aged 65+ can be compared in five thematic areas (income and poverty, health and health provision, well-being, social inclusion and participation, and age discrimination) between Germany, the UK, the Netherlands and Sweden. This allows total mean scores to be produced for each country and an overall country ranking to be determined. The full set of 30 indicators we used to calculate the total mean scores are presented in appendix 1.

As we explained in the previous chapter, the indicators used in the matrix have been standardised so that in each case a lower score always signifies a worse performance against the indicator. Therefore if, for example, a country has a low score for life-limiting illness, this means that a larger proportion of respondents in that country had a life-limiting illness. Equally, if a country has a low score for happiness, it means that fewer people responding to the survey rated their own happiness highly.

The overall results from this analysis are presented in table 20 and figure 2. Table 20 demonstrates that in the overall country ranking, Sweden had the highest mean score at 51.72, with the Netherlands coming very close to this with 51.69. The UK came third with a mean score of 49.94 and Germany had the lowest mean score with 49.50.

As demonstrated below, our ANOVA analysis confirms that the vast majority of the differences between countries, in each of the 30 indicators making up the overall country ranking, are statistically significant at the level of 0.05, indicating a 95 per cent confidence interval that the differences in means found in our sample occur in the actual population as well.

On this basis we assume that the overall country ranking presented in the matrix, which is based on an average of these indicators and weighted by population, is also significant and indicative of how the experiences of older people in each of these four countries compare in the five thematic areas.

Table 20 Overall findings of the experiences of ageing matrix

	Theme 1: income and poverty (ranking)	Theme 2: health and health provision (ranking)	Theme 3: well-being (ranking)	Theme 4: social inclusion and par- ticipation (ranking)	Theme 5: age dis- crimination (ranking)	Overall score (ranking)
Germany	50.42 (3)	48.97 (4)	49.19 (4)	48.97 (4)	49.96 (2)	49.50 (4)
UK	48.01 (4)	50.45 (3)	50.68 (3)	50.84 (3)	49.73 (4)	49.94 (3)
Netherlands	53.81 (1)	52.20 (2)	51.13 (2)	51.48 (1)	49.82 (3)	51.69 (2)
Sweden	51.84 (2)	52.63 (1)	51.32 (1)	51.20 (2)	51.59 (1)	51.72 (1)



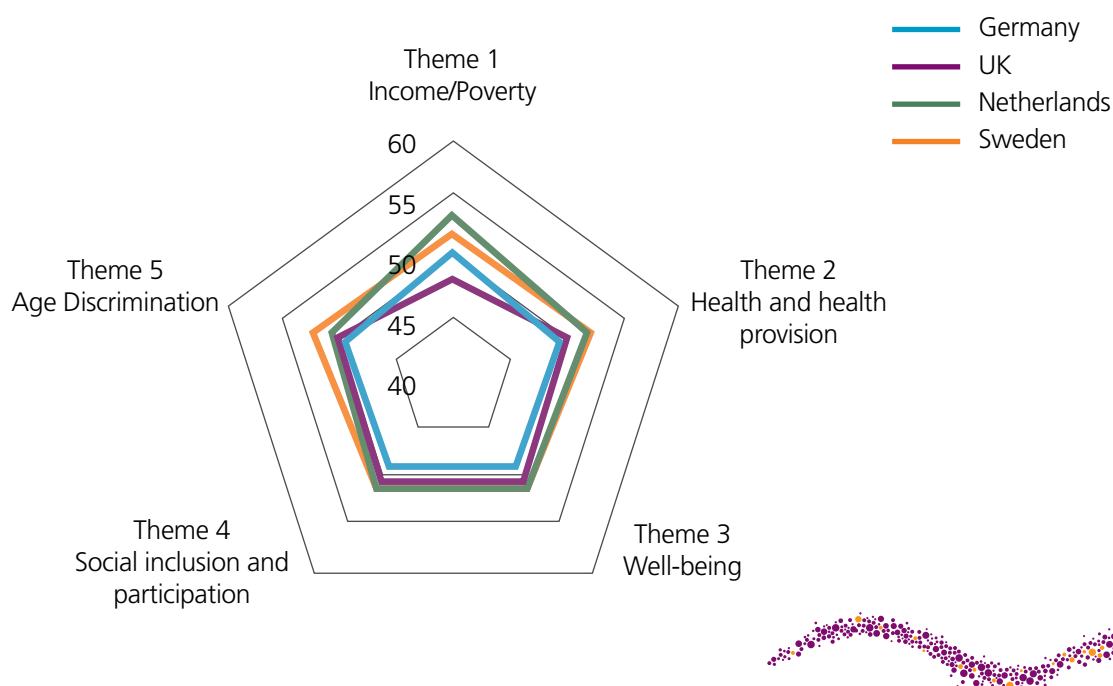
Within the individual themes, the UK ranked lowest on income and poverty with a mean score of 48.01, while the Netherlands, which ranked first, outstripped the other countries with a mean score of 53.81. This theme demonstrated the greatest disparity in scores between the four countries of all five themes (a gap of 5.8 between the Netherlands' mean score and the UK's mean score).

In the 'health and health provision' category Germany ranked lowest with a mean score of 48.97, followed by the UK with 50.45, while Sweden came highest with a mean score of 52.63. In the more detailed discussion of the individual health indicators below we will see that this overall score hides the more complex picture beneath, which is brought out by the mean scores obtained for individual indicators. Germany actually had a higher score than the UK in two of three indicators reflecting personal health, but German older people had a generally lower perception of the quality and sustainability of health services.

In the well-being category Sweden had the highest mean score at 51.32, followed by the Netherlands (51.13) and then the UK (50.68), with Germany ranking lowest with a mean score of 49.19. In the social inclusion and participation theme, this time it was the Netherlands that ranked highest with a mean score of 51.48. Sweden came close behind with a mean score of 51.20, while the UK came third with a mean score of 50.84 and Germany ranked lowest with a mean score of 48.97.

Finally, in the age discrimination category, the UK ranked lowest, thereby demonstrating the greatest degree of societal ageism, with a mean score of 49.73. The Netherlands followed close behind with a mean score of 49.82 and Germany came second with 49.96. These three countries' mean scores were closer together than in the other themes (with a gap of only 0.09 between the UK's and the Netherlands' mean scores, and only 0.14 points between the Netherlands' and Germany's mean scores). However, Sweden had a substantially higher mean score at 51.59 (with a gap of 1.63 points between Sweden's and the next highest score), demonstrating a lower prevalence of societal ageism. We will discuss the scores against individual indicators in more detail below.

Figure 2 Overall mean scores for each country from the experiences of ageing matrix



Overall findings segmented by gender

In table 21 we present the same matrix, this time segmented according to gender. This demonstrates how men and women ranked higher or lower in each country according to the five categories.

Looking at the overall scores segmented by gender, we can see that of the four countries the Netherlands demonstrates the highest mean scores overall for women (with a total mean score of 51.32, compared to 51.26 in Sweden), whereas Sweden demonstrates the highest mean scores for men, with a total mean score of 52.19 compared to 52.01 in the Netherlands.

Table 21 Experiences of Ageing Matrix segmented by gender

	Theme 1: income and poverty (ranking)	Theme 2: health and health provision (ranking)	Theme 3: well-being (ranking)	Theme 4: social inclusion and par- ticipation (ranking)	Theme 5: age dis- crimination (ranking)	Overall score (ranking)
Germany						
Men	51.40 (3)	49.51 (4)	49.73 (4)	49.01 (4)	49.99 (3)	49.93 (4)
Women	49.25 (3)	48.34 (4)	48.72 (4)	48.93 (4)	49.92 (2)	49.03 (4)
UK						
Men	48.46 (4)	51.25 (3)	50.66 (3)	50.60 (3)	50.43 (2)	50.28 (3)
Women	47.60 (4)	49.69 (3)	50.70 (3)	51.04 (3)	48.96 (4)	49.60 (3)
Netherlands						
Men	54.57 (1)	52.82 (2)	51.46 (2)	51.33 (1)	49.86 (4)	52.01 (2)
Women	52.84 (1)	51.52 (2)	50.82 (2)	51.64 (1)	49.78 (3)	51.32 (1)
Sweden						
Men	53.45 (2)	53.30 (1)	51.72 (1)	50.99 (2)	51.51 (1)	52.19 (1)
Women	50.25 (2)	51.98 (1)	51.00 (1)	51.42 (2)	51.66 (1)	51.26 (2)

In the income category, older women had lower mean scores than older men in each of the four countries. In the UK the gender gap on income measures was the smallest with a difference of 0.86 points, followed by the Netherlands with a gap of 1.73 points (within the overall scale which ranges between 0 and 100). Germany had the third largest gender gap on income measures of 2.15, while in Sweden the male and female overall mean scores for income were furthest apart with a gap of 3.2.

In the health and health provision category, the mean scores for women also ranked lower than men in each of the four countries, indicating they either have poorer health or poorer perceptions of health services in their country. The largest gender gap was in the UK with men's mean score 1.56 higher than women's, while the smallest gender gap (of 1.17) was in Germany.



In the well-being category, men had higher well-being than women in Germany, the Netherlands and Sweden. The largest gap was in Germany with men's mean score 1.01 points higher than women's. In the UK, women's scores reflected only very slightly higher well-being than men, suggesting that older men and women's well-being is more or less on a par.

In the social inclusion and participation theme, older German men had a very slightly higher mean score than older German women (a gap of just 0.08). In the Netherlands women's mean scores were slightly higher (0.31). In the UK and Sweden women's scores for social participation were also higher than men's (0.43 higher in Sweden and 0.44 higher in the UK).

Under the age discrimination theme, men and women's perceptions of age discrimination were roughly equal in Germany, the Netherlands and Sweden. In Germany and the Netherlands, women had a slightly lower mean score and in Sweden women had a slightly higher mean score (indicating greater levels of age discrimination towards or among women). However, in the UK there was a more substantial difference between older men and older women's mean scores for the age discrimination theme with women's mean score for the theme 1.47 points lower. This suggests that older women in the UK thought age discrimination was more of a problem than older men did. We can confirm this by looking at the individual indicators: under the indicator 'How often in the past year have you been treated with prejudice because of age?' women in the UK had a mean score of 48.75 and men had a mean score of 52.12. Therefore under this indicator older women's mean score was 3.37 points lower than men's, showing that women were more likely than men to feel that people had treated them in a prejudicial way on the basis of their age.

Overall findings segmented by age group (65–79 and 80+)

In table 22 we present the same matrix a third time, this time segmented into the two age groups 65–79 and 80+. This demonstrates whether the 'older old' (aged 80+) ranked higher or lower than the 'younger old' (aged 65–79) in each country according to the five categories.



Table 22 Experiences of Ageing Matrix segmented by age group

	Theme 1: income and poverty (ranking)	Theme 2: health and health provision (ranking)	Theme 3: well-being (ranking)	Theme 4: social inclusion and par- ticipation (ranking)	Theme 5: age dis- crimination (ranking)	Overall score (ranking)
Germany						
65–79 years	50.46 (3)	49.14 (4)	49.20 (4)	48.94 (4)	50.02 (2)	49.55 (4)
80+ years	50.20 (3)	47.98 (4)	49.12 (4)	49.17 (4)	49.56 (4)	49.20 (4)
UK						
65–79 years	47.74 (4)	50.72 (3)	50.70 (3)	51.07 (3)	49.53 (4)	49.95 (3)
80+ years	48.97 (4)	49.58 (3)	50.63 (2)	50.08 (2)	50.48 (2)	49.95 (3)
Netherlands						
65–79 years	53.83 (1)	52.36 (2)	51.46 (1)	51.64 (1)	49.84 (3)	51.83 (1)
80+ years	53.55 (1)	51.49 (2)	49.73 (3)	50.76 (1)	49.72 (3)	51.05 (2)
Sweden						
65–79 years	51.84 (2)	52.80 (1)	51.37 (2)	51.49 (2)	51.42 (1)	51.78 (2)
80+ years	51.70 (2)	51.89 (1)	51.16 (1)	50.02 (3)	52.20 (1)	51.39 (1)

From the evidence base derived from academic gerontology and social policy, we would expect the ‘older old’ to fare worse in almost all of these categories. For example, people tend to have a lower income when they are older, as they are less likely to be working and their pensions tend to be of lower value than more recently retired generations’ pensions.²⁹⁶ People are more likely to experience a life-limiting illness when they are older; as we have seen in chapter 3, in the UK, healthy life expectancy at age 65 was 75.7 for men and 76.8 for women in 2009.

Therefore, it is surprising that while the 80+ age group has a lower overall score than the ‘younger old’ age group in Germany, the Netherlands and Sweden, in the UK their scores are exactly equal. This is mainly because in the UK the 80+ age group had a higher score than the 65–79 age group under the age discrimination theme and under the income theme.

Given the evidence referenced above, it might seem strange that older pensioners in the UK have a higher score under the income theme than younger pensioners. However, if we look at the individual indicators that make up the income theme we can see the reason for this: older people in the UK in the 80+ age group did indeed score lower than those aged 65–79 on household net income (a mean score of 44.56 in comparison with 48.08 for the ‘younger old’). The ‘younger old’ in the UK were more likely to feel that they had had to manage on a lower income in the last three years, and had lower perceptions of the overall standard of living of pensioners than the ‘older old’ did (with a mean score of 46.13 compared with 49.07 for those aged 80+).

In the ‘health and health provision’ theme we can see that, as we would expect, the ‘older old’ age group has a lower mean score in each of the four countries. The Netherlands had the smallest gap in the two groups’ mean scores, at 0.87. Sweden had a gap of 0.91 and the UK and Germany had gaps of 0.14 and 0.16 points, respectively.



If we turn to well-being, we can see that despite the fact that the 'older old' group has poorer health on average than the 'younger old', their well-being is not substantially lower in three of the four countries. In Germany there is only a difference between the two age groups of 0.08, in the UK a difference of 0.07 and in Sweden a difference of 0.21. This is in keeping with previous research which has found 'that people's levels of happiness followed a U shaped curve, with least happiness in middle age', suggesting that on average people's happiness tends to increase as they move through early old age.²⁹⁷ However, there is also evidence that people aged over 80 are at greater risk of becoming depressed, particularly if they develop poor health.²⁹⁸

In the Netherlands the 'older old' had a notably lower score for well-being than the 'younger old', with a gap of 1.73 in the total mean scores. If we look at the individual well-being indicators, this shows that the most notable differences in well-being between the Dutch 'older old' and 'younger old' were in the following indicators: 'having time to do things that I enjoy' (a difference between the mean scores of 1.56); 'frequency of feeling depressed' (a difference of 2.76); 'feeling free to decide how I live my life' (a difference of 2.18); and 'feeling that the things I do in life are valuable and worthwhile' (a difference of 3.02). Smaller differences of 0.39 and 0.5 were registered in life satisfaction and self-rated happiness, respectively.

Under the social inclusion and participation theme we can see in table 22 that, as you might expect, the 'older old' had a lower mean score for social participation in the UK, the Netherlands and Sweden. Interestingly the 'younger old' had a slightly lower mean score in Germany (although the difference here was only 0.23).

In the 'age discrimination' category, people aged 80+ had higher mean scores for age discrimination in Germany and the Netherlands and Sweden than people aged 65–79, suggesting there is less concern or evidence of age discrimination among the older age group. In contrast, in the UK the 'younger old' were more concerned about age discrimination than the 'older old' (a difference in their mean scores of 0.95). If we look in detail at the individual indicators that sit within this theme, we can see that the largest difference in scores relates to the question 'how serious a problem is age discrimination in the UK?' People in the UK aged 80+ had a mean score that was higher by 3.43 points, indicating that they thought age discrimination was less of a problem. However, people in the UK from the 65–79 age group also reported less negative feelings towards people in their 20s than people aged 80+ (a difference of 1.05), while people aged 80+ were slightly less likely to feel they were treated with prejudice than the 'younger old'. They were also quite a lot less likely to feel they were treated with a lack of respect than the 'younger old' (a difference of 3.17). We will consider the individual age discrimination indicators in more detail below.

Mean scores for individual indicators

We will now look in detail at the mean scores of each country against the six individual indicators that make up each theme, beginning with income and poverty. In the data tables presented in the remainder of this chapter, the indicators that demonstrated statistically significant differences between the countries' mean scores are marked with two asterisks (p-value = 0.05).



Theme 1: Income and poverty

We observed at the beginning of this chapter that the Netherlands had a considerably higher total mean score than the other three countries in the income theme, while the UK had the lowest total score. Each country's mean score against each of the individual indicators is set out in table 23.

Table 23 Cross-country comparison of six income indicators in four EU comparator countries, 2008 and 2010

Income						
	Indicator 1: household total net in- come (2010) (ranking)**	Indicator 2: level of comfort with household income nowadays (2010) (ranking)**	Indicator 3: extent to which had to manage on lower household income in last 3 years (2010) (ranking)**	Indicator 4: extent to which had to draw on savings in last three years (2010) (ranking)**	Indicator 5: extent to which had to cut back on holidays or expenditure in last 3 years (2010) (ranking)**	Indicator 6: perception of overall standard of living of pensioners (2008) (ranking)**
Germany	51.04 (2)	48.82 (4)	50.68 (3)	50.98 (3)	50.00 (3)	50.99 (2)
UK	47.25 (4)	50.30 (3)	47.77 (4)	47.59 (4)	48.40 (4)	46.75 (4)
Netherlands	53.44 (1)	52.79 (2)	53.21 (1)	52.52 (1)	53.73 (1)	57.15 (1)
Sweden	50.95 (3)	53.48 (1)	52.22 (2)	51.90 (2)	53.42 (2)	49.06 (3)

Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p -value = 0.05)

The first income indicator, which looks at net household income, shows that the Dutch respondents aged 65+ had the highest score for net household income, followed by older people in Germany, then Sweden and then the UK (a slightly different order than in the *total* scores for the income theme, in which Swedish older people ranked higher than German older people). However, if we look at the second indicator we see that while the Dutch had the highest net income score, the Swedish pensioners scored highest for their level of comfort with their income, followed by the Dutch. The German pensioners scored lowest in this category.

Overall, pensioners in the UK most frequently had the lowest ranking against the income-related indicators (ranking fourth in five of six categories), while Germany most frequently occupied third place (in three of six categories). The Netherlands demonstrated the highest mean scores in five of six categories. As the asterisks in table 23 demonstrate, our ANOVA analyses identified that the differences in country means for each of these six indicators were statistically significant.

Theme 2: Health and health provision

At the beginning of this chapter we saw that Swedish older people had the highest total mean



score for health and health provision with, followed by the Netherlands, then the UK and with Germany scoring the lowest. Table 24 sets out the individual mean scores for each country against each indicator.

Table 24 Cross-country comparison of the six health indicators, 2008 and 2010

Health						
	Indicator 1: subjective health: 'How is your health in general?' (2010) (ranking)**	Indicator 2: do you have a life limiting illness or disability? (2010) (ranking)**	Indicator 3: have you felt active and vigorous in the last 2 weeks? (2010) (ranking)**	Indicator 4: the state of health services in country nowadays (2010) (ranking)**	Indicator 5: will the country be able to afford the present level of public health care 10 years from now? (2008) (ranking)**	Indicator 6: how likely is it that you will not receive the health care you really need if you become ill? (2008) (ranking)
Germany	48.20 (4)	49.99 (3)	50.67 (3)	45.81 (4)	49.09 (4)	50.02 (3)
UK	51.51 (2)	49.38 (4)	48.01 (4)	54.32 (1)	49.82 (3)	49.62 (4)
Netherlands	51.06 (3)	51.48 (1)	52.76 (1)	53.45 (3)	53.92 (1)	50.51 (2)
Sweden	53.83 (1)	51.40 (2)	51.88 (2)	53.62 (2)	53.88 (2)	51.14 (1)

Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p-value = 0.05)

The first three indicators within the health theme are concerned with the individual health of the survey respondent. Here the UK demonstrates the lowest mean score in two of the three indicators, with Germany ranking fourth once and third twice. The Dutch respondents demonstrated the highest mean scores according to two personal health indicators, while Sweden demonstrated the highest mean score once (and second highest twice). This suggests that overall the UK's sample of older people had the poorest health and the sample of older people in the Netherlands had the best health.

The next three indicators focus on older people's views on the standard of health provision in their country and their perceptions of its sustainability and accessibility. These indicators present a more mixed picture. Again, the UK's and Germany's rankings reflect relatively lower mean scores: Germany ranked fourth in two categories and third in one category, demonstrating the most pessimistic attitudes toward the standard, sustainability and accessibility of health services. The UK ranked fourth for accessibility of health services, third for sustainability and first for the standard of current health provision. Sweden had the highest rankings overall, ranking first in one health provision category and second in two categories, while the Netherlands' rankings were fairly mixed, including rankings of first, second and third.

Our ANOVA analyses found that the differences in country means were statistically significant for the first five indicators, but the sixth indicator did not demonstrate statistically significant differences.



Theme 3: Well-being

Earlier in this chapter we observed that sample of Swedish older people had the highest overall mean score under the well-being theme, followed by the Netherlands' sample and then the UK's sample, with the sample of German older people demonstrating the lowest overall mean score for well-being. Table 25 sets out the individual mean scores for each country against each well-being indicator.

Table 25 Cross-country comparison of six well-being indicators, 2006 and 2010

Well-being						
	Indicator 1: satisfaction with life as a whole (2010) (ranking)**	Indicator 2: general happiness (2010) (ranking)**	Indicator 3: extent to which you feel free to decide how you live your life (2006) (ranking)**	Indicator 4: extent to which you have time to do things you enjoy (2006) (ranking)	Indicator 5: extent to which you feel your life is valuable and worthwhile (2006) (ranking)**	Indicator 6: how frequently did you feel depressed in the last week? (2006) (ranking)**
Germany	49.31 (4)	48.85 (4)	48.93 (4)	50.01 (3)	49.41 (4)	48.60 (4)
UK	50.11 (3)	50.96 (3)	51.30 (2)	49.74 (4)	50.54 (2)	51.47 (2)
Netherlands	51.42 (2)	51.31 (2)	51.34 (1)	50.31 (2)	51.38 (1)	51.03 (3)
Sweden	52.63 (1)	51.66 (1)	49.80 (3)	51.28 (1)	50.08 (3)	52.48 (1)

Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p -value = 0.05)

As table 25 shows, the country rankings for well-being against each indicator are relatively consistent, with the German respondents reporting the lowest well-being in five of six categories, including the lowest life satisfaction and general happiness and the greatest frequency of depression. The Swedish respondents reported the highest well-being in four out of six categories, while the Dutch respondents had the highest mean score for two indicators – 'the extent to which you are free to live your life as you choose' (with almost exactly the same mean score as people in the UK) and 'the extent to which you feel that the things you do in your life are valuable and worthwhile'. The UK respondents ranked third in two of the indicators, second in three of the indicators ('feeling free to choose how to live your life'; 'feeling that your life is valuable and worthwhile'; and 'feeling less frequently depressed') and fourth in one indicator ('the extent to which you have time to do things you enjoy').

Our ANOVA analyses found that the differences in country means were statistically significant for five of the six well-being indicators. There were no statistically significant differences for the indicator 'extent to which you have time to do things you enjoy'.



Theme 4: Social inclusion and participation

The total mean scores for each theme presented in the matrix above demonstrated that Dutch older people had the highest total mean score for social inclusion and participation, followed by Swedish people, with older people in the UK ranking third and German older people last. Table 26 sets out the individual mean scores for each country against each social inclusion indicator.

Table 26 Cross-country comparison of six social inclusion and participation indicators, 2010

Participation						
	Indicator 1: generally speaking, would you say that most people can be trusted? (ranking)**	Indicator 2: Would you say that most of the time, people try to be helpful? (ranking)**	Indicator 3: How often do you meet socially with friends, relatives and work colleagues? (ranking)**	Indicator 4: Do you have anyone with whom you can discuss intimate and personal matters? (ranking)**	Indicator 5: Compared to other people of your age, how often would you say you take part in social activities? (ranking)	Indicator 6: How much of the time during the last week did you feel lonely? (ranking)**
Germany	47.28 (4)	47.12 (4)	48.10 (4)	51.28 (1)	49.89 (3)	50.17 (2)
UK	52.36 (3)	53.05 (2)	51.64 (2)	48.83 (3)	49.78 (4)	49.40 (4)
Netherlands	52.45 (2)	51.34 (3)	53.02 (1)	49.52 (2)	50.91 (1)	51.62 (1)
Sweden	54.35 (1)	53.62 (1)	51.35 (3)	47.38 (4)	50.80 (2)	49.72 (3)

Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p-value = 0.05)

There is less consistency in the countries' rankings in the social inclusion indicators than in the well-being indicators. The Netherlands, which ranked highest overall for this theme, demonstrated the highest mean score in three of the six categories (those that related to frequency of socialising and frequency of experiencing loneliness). Sweden's sample demonstrated the highest mean score in two of the six social inclusion indicators (those that related to social bonds: the extent to which most people can be trusted or 'try to be helpful'). Yet Sweden also had the lowest mean score for the indicator 'do you have anyone with whom you can discuss intimate and person matters?' and ranked third for frequency of socialising and frequency of experiencing loneliness.

Germany's sample demonstrated the lowest mean score for the two social bond indicators (relating to trust and helpfulness) and the indicator relating to frequency of social contact. However, Germany also ranked highest for having someone with whom you can discuss intimate and personal matters, which reinforces the fact that while the sample of German older people was comparatively less sociable, they were not the loneliest.

The UK came second in two indicators (belief in helpfulness and frequency of social contact),



third in social trust and having a person to confide in, and fourth in the indicator 'how frequently do you take part in social activities in comparison to other people of your age'. Perhaps most worryingly, the UK's sample also had the lowest score for loneliness, indicating that older people in the UK feel lonely more frequently than older people in the other three countries. This may be related to feelings of 'emotional loneliness' (signified by the relatively low mean score for having a person to confide in), as opposed to 'social loneliness', as older people in the UK had the second highest mean score for frequency of social contact.²⁹⁹

Our ANOVA analyses found that the differences in country means were statistically significant for five of the six social inclusion and participation indicators. The indicator 'compared to other people of your age, how often would you say you take part in social activities?' did not demonstrate statistically significant differences.

Theme 5: Age discrimination

The UK had the lowest total mean score for age discrimination, suggesting that age discrimination was thought to be a problem by a larger proportion of people in the UK than in the other countries covered. The Netherlands had the next lowest score, followed by Germany, then Sweden with the highest total mean score. Table 27 sets out the individual mean scores for each country against each age discrimination indicator.

Table 27 Cross-country comparison of six age discrimination indicators, 2008

Age discrimination						
	Indicator 1: at what age do you think people generally start being described as old? (ranking)**	Indicator 2: do you think people over 70 are a burden on the [country]'s health service nowadays? (ranking)**	Indicator 3: how negative or positive you feel towards people in their 20s? (ranking)**	Indicator 4: how often, in the past year, anyone has shown prejudice against you or treated you unfairly because of your age? (ranking)**	Indicator 5: how often in the past year have you felt that someone showed you a lack of respect because of your age?	Indicator 6: how severe would you say discrimination is in [country] against people because of their age – whether they are old or young? (ranking)**
Germany	50.83 (3)	46.99 (4)	51.60 (2)	49.59 (3)	49.93 (3)	50.79 (1)
UK	48.20 (4)	54.02 (1)	46.63 (4)	50.81 (2)	49.06 (4)	49.65 (3)
Netherlands	51.78 (1)	50.57 (2)	49.09 (3)	48.55 (4)	52.47 (1)	46.45 (4)
Sweden	51.11 (2)	50.40 (3)	54.58 (1)	51.31 (1)	52.41 (2)	49.72 (2)

Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p-value = 0.05)



As we set out in the methodology chapter, in this theme the survey sample was not exactly the same as in the previous four themes. In the first two indicators ('age people start being described as old' and 'people over 70 are a burden on health service these days') we analysed responses from the entire survey sample rather than filtering for people aged 65+. This is because we are interested in the wider social context of the country and the extent to which people of all age groups might demonstrate more or less stereotypical or discriminatory attitudes towards older people. In the subsequent four age discrimination indicators we did filter for age and limited our analysis to those aged 65+.

Again, as with the social inclusion and participation indicators, the age discrimination indicators present a fairly mixed picture. The UK ranked fourth in three age discrimination indicators: the age at which a person might be described as old (reflecting the views of the whole survey sample), negativity towards people in their 20s (reflecting the views of people aged 65+), and feeling that you have been shown a lack of respect on the basis of your age (reflecting the views of people aged 65+). There was nearly an eight-point difference between the extent to which older people in the UK feel negative towards people in their 20s, and the extent to which older people in Sweden feel this way. The Netherlands ranked fourth in two indicators: people aged 65+ feeling they had been treated unfairly on the basis of their age and people aged 65+ believing that age discrimination was a serious problem in their country.

Another important finding was that Germany ranked fourth against the second indicator, suggesting that a higher proportion of German respondents of all age groups believe people aged over 70 are a burden on health services. Germany's mean score for this indicator was just over seven points lower than the UK's mean score. However, counter-intuitively, German older people were the least likely to think that age discrimination was a serious problem in their country. One interpretation of these findings might be that in German society age discrimination is less widely acknowledged as a problem, therefore people might be less self-conscious about stating opinions that could be considered ageist.

As the asterisks in table 27 demonstrate, our ANOVA analyses identified that the differences in country means for each of these six age discrimination indicators were statistically significant.

Summary of findings in chapter 7

Overall findings

Sweden had the highest mean score of all four countries in the Experiences of Ageing Matrix, followed by the Netherlands, the UK and then Germany. Within the individual five themes:

- The Netherlands ranked highest on income and poverty and the UK ranked lowest.
- Sweden ranked highest on health and health provision, while Germany ranked lowest.
- Sweden ranked highest on well-being, while Germany ranked lowest.
- The Netherlands ranked highest on social inclusion and participation, while Germany ranked lowest.
- Sweden ranked highest on age discrimination (indicating the lowest level of age discrimination) while the UK ranked lowest.



Findings on gender segmentation

When the country samples were segmented by gender, Sweden had the highest mean score in the matrix for men, while the Netherlands had the highest mean score for women. The UK ranked third for both men and women and Germany ranked fourth for both genders.

These are other key findings:

- In each country women had lower mean scores in the income theme than men. The gender gap between mean scores on income was largest in Sweden, second largest in Germany and smallest in the UK.
- Women's mean scores for health also ranked lower than those for men in each of the four countries, suggesting they either have poorer health or poorer perceptions of health services in their country.
- In the well-being category, men had higher well-being than women in Germany, the Netherlands and Sweden. In the UK men's and women's well-being was on a par.
- In the social inclusion and participation theme, older German men had a very slightly higher mean score than older German women. In the Netherlands, UK and Sweden, women's scores for social participation were slightly higher than men's.
- Under the age discrimination theme, men and women's perceptions of age discrimination were roughly equal in Germany, the Netherlands and Sweden. In the UK there was a more substantial difference between older men and older women's mean scores for the age discrimination theme with women's mean score for the theme 1.47 points lower. This was more pronounced for individual indicators.

Findings on age segmentation

The 80+ age group had a lower overall score than the 65–79 age group in Germany, the Netherlands and Sweden. In the UK their overall scores of the two age groups were exactly equal. This is mainly because in the UK the 80+ age group had a higher score than the 65–79 age group under the age discrimination theme and under the income theme.

These are other key findings:

- In the income theme the 'older old' age group had a lower score than the 'younger old' in Germany, the Netherlands and Sweden.
- In the 'health and health provision' theme the 'older old' age group had a lower mean score in each of the four countries.
- Well-being in the 'older old' age group was not substantially lower in three of the four countries (Germany, the UK, Sweden) but was notably lower in the Netherlands with a gap of 1.73 in the total mean scores.
- The 'older old' had a lower mean score for social participation in the UK, the Netherlands and Sweden, but the 'younger old' had a slightly lower mean score in Germany.



- In the 'age discrimination' category, people aged 80+ had higher mean scores for age discrimination in Germany, the Netherlands and Sweden than people aged 65–79, indicating there is less concern or evidence of age discrimination among the older age group in these countries. However, in the UK the 'younger old' demonstrated greater concern than the 'older old' about being treated with prejudice or a lack of respect. People aged 80+ in the UK had more negative feelings towards people in their 20s than people aged 65–79.

Findings against individual indicators

Theme 1: Income

Pensioners in the UK most frequently had the lowest ranking against the income-related indicators (ranking fourth in five of six categories), while Germany most frequently occupied third place (in three of six categories). The Netherlands demonstrated the highest mean scores in five of six categories.

Theme 2: Health and health provision

The UK demonstrates the lowest mean score in two of the three indicators that related to personal health, with Germany scoring lowest once and second-lowest twice. The Dutch respondents demonstrated the highest mean scores according to two personal health indicators, while Sweden demonstrated the highest mean score once. This suggests that overall the UK's sample of older people had the poorest health and the sample of older people in the Netherlands had the best health.

In the three indicators that related to older people's views on the standard of health provision in their country and their perceptions of its sustainability and accessibility, Germany ranked lowest twice and the UK ranked lowest once. Sweden had the highest rankings overall, coming first in one health provision category and second in two categories.

Theme 3: Well-being

The country rankings for well-being against each indicator were relatively consistent, with the German respondents reporting the lowest well-being in five of six categories, including the lowest life satisfaction and general happiness and the greatest frequency of depression. The Swedish respondents reported the highest well-being in four out of six categories, while the Dutch respondents had the highest mean score for two indicators.

Theme 4: Social inclusion and participation

The Netherlands, which ranked highest overall for this theme, demonstrated the highest mean score in three of the six categories. Sweden's sample demonstrated the highest mean score in two of the six social inclusion indicators. However, Sweden also had the lowest mean score for having someone to confide in and for loneliness. The sample of older people in Germany ranked lowest against three indicators, including the frequency of social contact, but highest for having somebody to confide in, which reinforces the fact that while the sample of German older people was comparatively less sociable, they were not the most lonely.



Theme 5: Age discrimination

The UK ranked fourth in three of six age discrimination indicators. There was nearly an eight-point difference between the extent to which older people in the UK feel negative towards people in their 20s, and the extent to which older people in Sweden feel this way. The Netherlands ranked fourth in two indicators: people aged 65+ feeling they had been treated unfairly on the basis of their age, and people aged 65+ believing that age discrimination was a serious problem in their country.



8 Longitudinal analysis of each country's performance against the experiences of ageing themes

This section presents the findings from the longitudinal portion of our research, which compares findings between three consecutive rounds of the European Social Survey: Rounds 3 (2006), 4 (2008) and 5 (2010).

There are some small variations in the country rankings between chapters 7 and 8. This is because in the matrix we have applied unique population weights to ensure that the survey samples were representative of each country's whole population, but the methodology employed for this longitudinal analysis meant that no population weights could be applied. The purpose of the analysis in this chapter is to establish changes over time, as opposed to final rankings. Therefore where variations exist, the country rankings presented in the matrix should be considered definitive.

Theme 1: Income and poverty

In this theme two income-related indicators were available in the European Social Survey across the three time points. These measured older people's net household income and their level of comfort with their income:

- Older people's income was measured in deciles (decile 1 with the lowest income and decile 10 with the highest income).
- Older people also rated their level of comfort with their current income between 1 and 4 (1 = living comfortably on present income; 2 = coping on present income; 3 = finding it difficult on present income; 4 = finding it very difficult on present income).

The mean scores for each country against each of these indicators are set out in table 28.

Table 28 Comparison of country means for indicators of older people's income, 2006, 2008 and 2010

	Total household income			Level of comfort with income		
	2006 (ranking)	2008 (ranking)	2010 (ranking)	2006 (ranking)	2008 (ranking)	2010 (ranking)
Germany	5.97 (3)	3.80 (3)	4.33 (3)	1.93 (4)	1.80 (4)	1.86 (4)
UK	5.53 (4)	3.56 (4)	3.20 (4)	1.66 (2)	1.70 (3)	1.72 (3)
Netherlands	6.12 (2)	4.96 (2)	4.82 (1)	1.67 (3)	1.59 (2)	1.58 (2)
Sweden	6.14 (1)	5.30 (1)	4.49 (2)	1.50 (1)	1.51 (1)	1.50 (1)

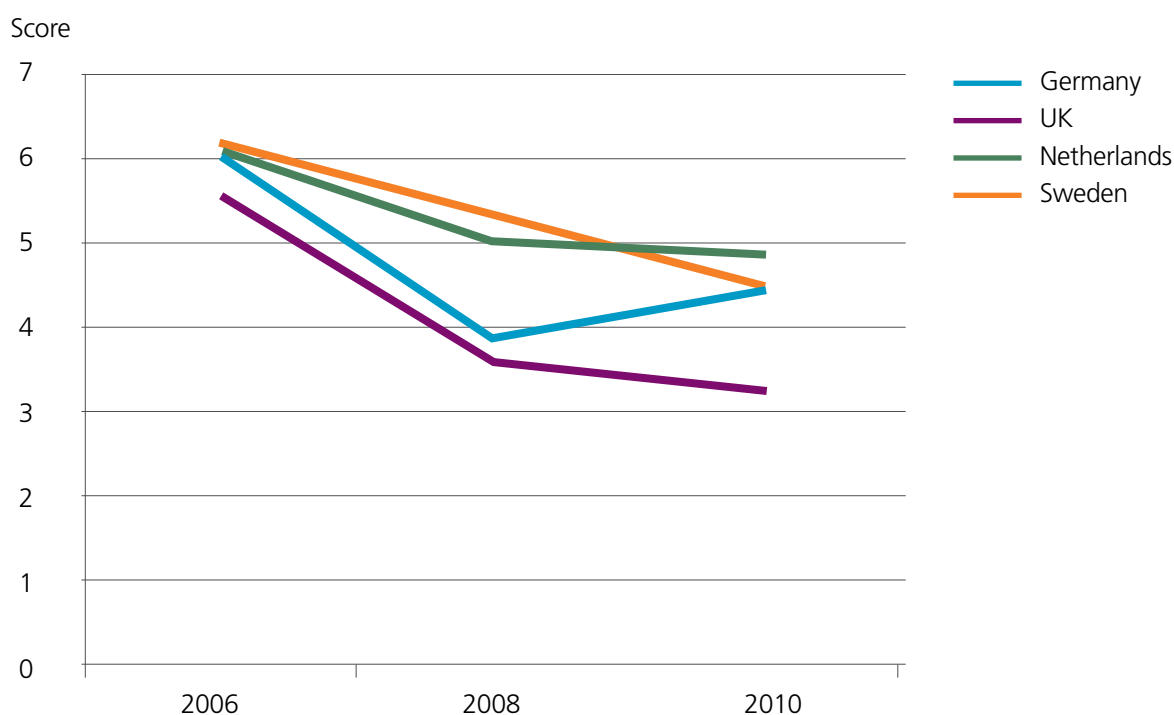


Total household income

At all three time points (2006, 2008 and 2010), the samples of older people in the UK ranked fourth on income, suggesting they have the lowest mean net income of the four countries, while the samples of older people in Germany ranked third (figure 3). In 2006 and 2008 the samples of older people in Sweden had the highest mean net income, while in 2010 the ranking changed so that the sample of older people in the Netherlands had the highest mean net income of the four countries.

Each of the country samples showed decreases in average household income between 2006 and 2010. In the UK a statistically significant correlation was found in the decrease in household income between the two years' samples in 2006 and 2008. Between 2008 and 2010 the change in means show there had been a further drop in average income but no significant correlation was identified. In the Netherlands, Germany and Sweden we did not find the changes between the three time points to be statistically significant.

Figure 3 Older people's total household income in the four countries, 2006, 2008 and 2010



Level of comfort with income

According to this indicator, (whereby older people who are most comfortable on their income score 1, while older people who are the least comfortable score 4), lower scores indicate that the older people surveyed had a greater level of comfort with their income. The country rankings were reasonably consistent across the three time points, with most consistency shown between 2008 and 2010. Across all three years older people in Germany reported the highest scores,



demonstrating they are the least comfortable with their income. Sweden's samples were also consistently the most comfortable across all four years with a mean of approximately 1.50. However, between the 2006 and 2008 surveys, the UK and the Netherlands changed rankings (the UK ranked second in 2006 and the Netherlands ranked second in 2008 and 2010).

The comfort level provided by older people's current income was shown to have increased between 2006 and 2010 for Germany and the Netherlands, increased slightly in the UK and remained consistent in Sweden across the three time points. These changes in older people's comfort levels were not identified as being statistically significant.

Theme 2: Health and health provision

Three indicators were available for comparing health and health provision across the three survey samples:

- the older person's overall rating of their country's health services (rated from 0 to 10 with 10 indicating that the health services were extremely good)
- the older person's self-rated general health (a score of 1 represents 'very good' while a score of 5 represents 'very bad')
- the older person's experience of life-limiting illness or disability (a rating of 1 indicated that their activities were limited 'a lot', a rating of 2 indicated they were limited 'to some extent' and a rating of 3 indicated that they were *not* limited by any illness).

The mean scores for each country against each of these indicators are set out in table 29 and figure 4.

Table 29 Comparison of country means for indicators of older people's health and their perceptions of health provision, 2006, 2008 and 2010

	Health services			General health			Life-limiting illness		
	2006	2008	2010	2006	2008	2010	2006	2008	2010
Germany	4.39 (4)	4.49 (4)	4.78 (4)	2.86 (4)	2.76 (4)	2.73 (4)	2.33 (=3)	2.40 (4)	2.39 (4)
UK	5.94 (3)	6.88 (1)	6.99 (1)	2.37 (2)	2.34 (2)	2.43 (2)	2.33 (=3)	2.38 (3)	2.35 (3)
Netherlands	6.36 (2)	6.53 (3)	6.71 (3)	2.53 (3)	2.43 (3)	2.45 (3)	2.41 (1)	2.45 (1)	2.50 (2)
Sweden	6.49 (1)	6.56 (2)	6.80 (2)	2.33 (1)	2.30 (1)	2.18 (1)	2.36 (2)	2.42 (2)	2.52 (1)

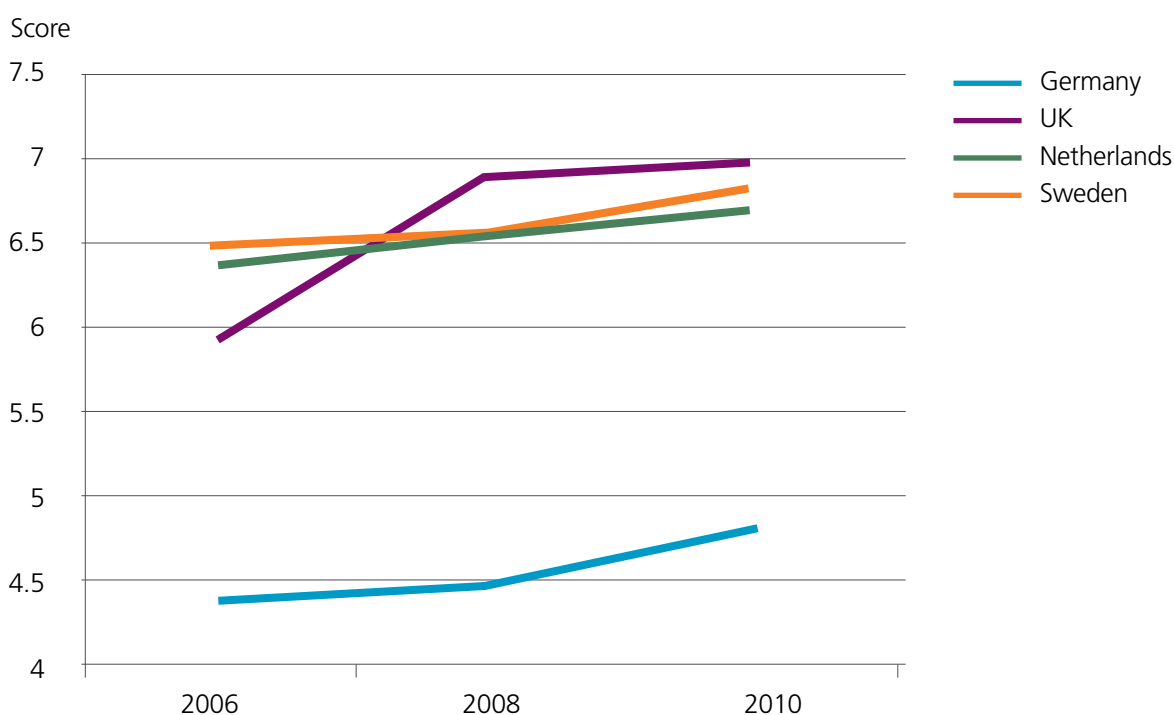


Standard of health services

In 2006, the sample of older people from Sweden had the highest rating for health services, with a mean of 6.49, while the sample taken from Germany gave the lowest mean at 4.39. However, in 2008 and 2010, the UK rose to have the highest ratings for health services, with a mean value of 6.99. Therefore, the country rankings for this indicator changed between 2006 and 2008 but remained the same between 2008 and 2010. Germany had the lowest mean score of the four countries across all three time points.

The overall trend demonstrated improving perceptions among older people of the standard of health services, as each country's samples provided higher ratings for the health services between 2006 and 2008 and between 2008 and 2010. Older people in the UK and Sweden demonstrated a statistically significant increase in their health service ratings between 2006 and 2008, but we did not identify any significant correlation between the subsequent years, nor in Germany and the Netherlands between any years.

Figure 4 Older people's rating of health services in the four countries, 2006, 2008 and 2010



Self-reported general health

The country rankings for self-reported general health were consistent across all three time periods with Sweden's samples of older people reporting the best self-rated health in 2006, 2008 and 2010. At each time point the UK's sample ranked second, the Netherlands ranked third and Germany ranked fourth, showing that the older people in Germany gave the worst health ratings of the four countries.



Differences in the countries' mean scores between the survey rounds showed that the self-reported general health of people aged over 65 had slightly improved between 2006 and 2010 in Germany, the Netherlands and Sweden, but not in the UK, where health ratings slightly declined. We did not identify these changes in health ratings between the years to be statistically significant in any of the four countries.

Self-reported life-limiting illness

Some variations in the countries' rankings on self-reported life-limiting illness is demonstrated between the years. In 2006 and 2008, the Netherlands ranked first (indicating lower levels of life-limiting illness) and Sweden ranked second, but their rankings reversed in 2010. In 2006 and 2008 the UK and Germany had equal scores for life-limiting illness (therefore sharing third and fourth rankings), but in 2008 and 2010, the UK had a very slightly lower mean score, therefore ranking fourth place in these years (indicating the highest rates of life limiting illness of the four countries).

Ratings for self-reported life-limiting illness suggested there had been an improvement in health in all four countries between 2006 and 2010. However, we did not find the improvements in health ratings within each country between 2006 and 2010 to be statistically significant.

Theme 3: Well-being

Two indicators were available to compare well-being between the 2006, 2008 and 2010 survey rounds:

- Older people rated their life satisfaction between 0 and 10 (a person who scored 0 was extremely dissatisfied with their life and a person who scored 10 was extremely satisfied).
- Older people rated their general happiness between 0 and 10 (a person who rated themselves at 0 was 'extremely unhappy', while a person who rated themselves at 10 was 'extremely happy').

The mean scores for each country against each of these indicators are set out in table 30 and figure 5.

Table 30 Comparison of country means for indicators of older people's well-being, 2006, 2008 and 2010

	General life satisfaction			General happiness		
	2006	2008	2010	2006	2008	2010
Germany	6.93 (4)	7.19 (4)	7.28 (4)	6.87 (4)	7.27 (4)	7.36 (4)
UK	7.34 (3)	7.40 (3)	7.49 (3)	7.66 (2/3)	7.79 (2)	7.69 (3)
Netherlands	7.41 (2)	7.64 (2)	7.79 (2)	7.66 (2/3)	7.68 (3)	7.78 (2)
Sweden	7.95 (1)	8.06 (1)	8.06 (1)	7.93 (1)	7.98 (1)	7.93 (1)

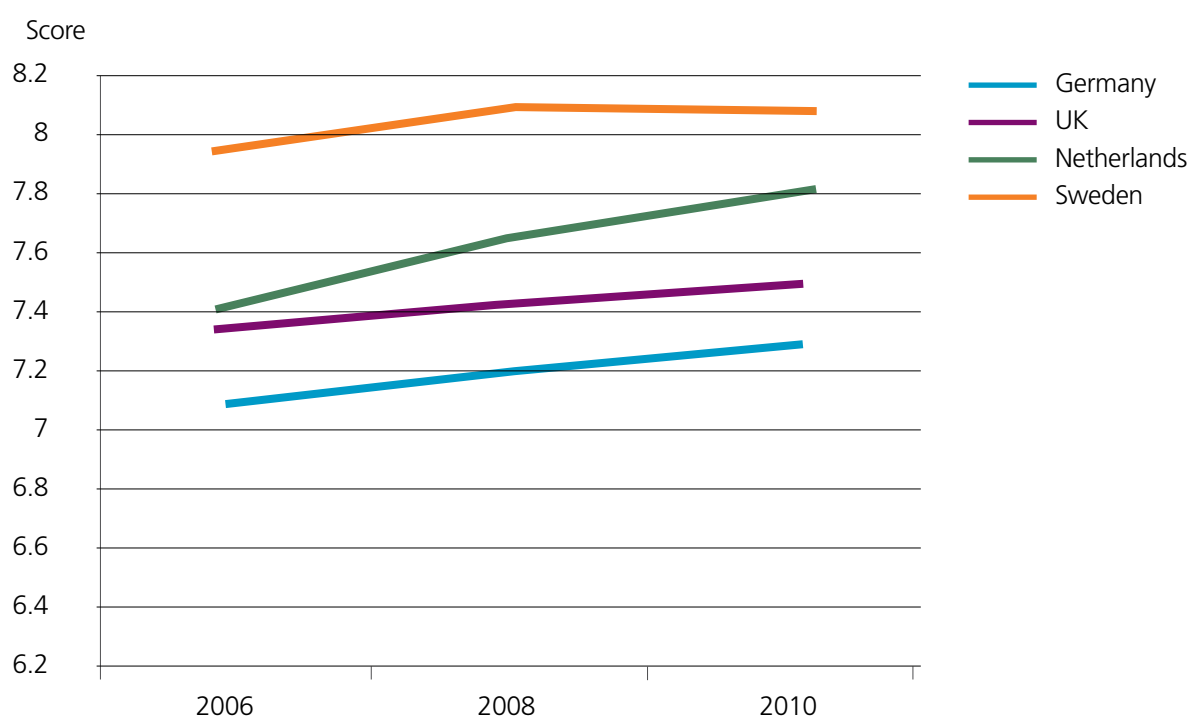


General life satisfaction

We found that the country rankings for life satisfaction among older people were consistent across all three time points, with life satisfaction highest in Sweden, second in the Netherlands, third in the UK and lowest in Germany. In 2008 and 2010 the mean scores for the samples of older people in Sweden was above 8 out of 10.

Across all four countries the mean in 2010 was higher than the mean in 2006, suggesting there had been an increase in self-rated life satisfaction during this period although these changes were not identified as statistically significant.

Figure 5 Older people's self-rated life satisfaction in the four countries, 2006, 2008 and 2010



General happiness

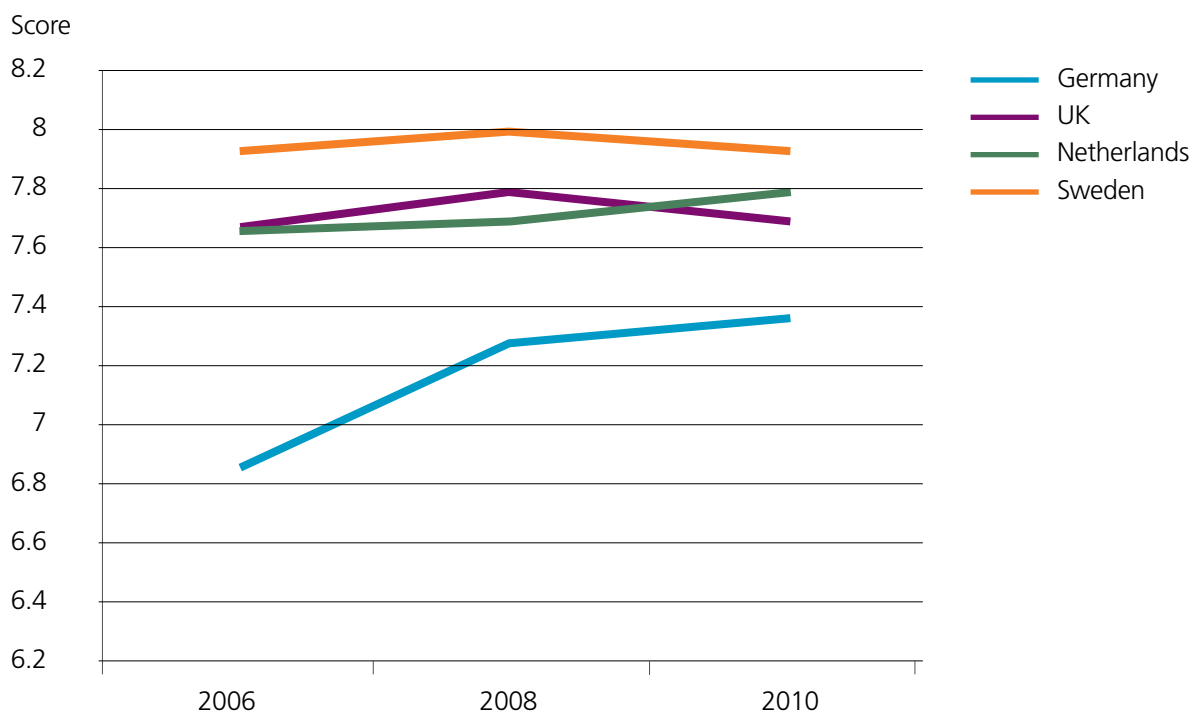
Sweden also consistently ranked first for older people's general happiness at all three time points (figure 6). At the same time, the sample of older people in Germany consistently ranked fourth for general happiness, but there was some fluctuation over time in the rankings of the samples from the UK and the Netherlands. The two countries demonstrated equal mean scores in 2006, but in 2008 the UK ranked second and the Netherlands third, while these rankings reversed in 2010.

Comparing the countries' mean scores over time, older people's rating of general happiness slightly improved in Germany between 2006 and 2010 and also in the Netherlands. Happiness ratings in Sweden and the UK remained roughly stable (with slightly more fluctuation in the UK).



We did not identify any statistically significant correlations between the three years.

Figure 6 Older people's self-rated general happiness in the four countries, 2006, 2008 and 2010



Theme 4: Social inclusion and participation

Six indicators were available for comparing social inclusion and participation in the four countries across the time points:

- The first indicator invited the participant to say whether generally speaking most people can be trusted, ranging from 0 to 10 (a rating of 0 means 'you can't be too careful'; a rating of 10 means that 'most people can be trusted').
- The second indicator assessed people's helpfulness (a rating of 0 means that people mostly look out for themselves; a rating of 10 means that people mostly try to be helpful).
- The third indicator looked at how often the respondent meets socially with friends, relatives or colleagues (a rating of 1 indicated 'never'; 2 less than once a month; 3 once a month; 4 several times a month; 5 once a week; 6 several times a week and a rating of 7 indicated 'every day').
- The question for the fourth indicator was 'do you have anyone with whom you can discuss intimate and personal matters?' This was a simple binary indicator with 'yes' scoring 1 and 'no' scoring 2).
- For the fifth indicator people were asked whether they take part in social activities more or less than other people their age. Answers ranged from 1 to 5 with 1 corresponding to 'much less than most' and 5 corresponding to 'much more than most'.



- The sixth indicator, which assessed loneliness, was only available in the 2006 and 2010 survey samples. People were asked to say how much of the time during the last week they had felt lonely on a scale of 1 to 4, 1 signifying 'none or almost none of the time' and 4 signifying 'all or almost all of the time'.

The mean scores for each country against each of these indicators are set out in table 31.

Table 31 Comparison of country means for indicators measuring older people's social inclusion and participation, 2006, 2008 and 2010

	Trusting others			Helpfulness of others			Frequency of socialising with others		
	2006	2008	2010	2006	2008	2010	2006	2008	2010
Germany	4.30 (4)	4.63 (4)	4.42 (4)	5.06 (4)	5.25 (4)	5.18 (4)	4.31 (4)	4.29 (4)	4.39 (4)
UK	5.66 (2)	5.58 (3)	5.80 (2)	6.11 (2)	6.33 (2)	6.36 (2)	5.17 (1)	5.05 (2)	5.07 (2)
Netherlands	5.54 (3)	5.89 (2)	5.79 (3)	5.51 (3)	5.87 (3)	6.00 (3)	5.08 (2)	5.15 (1)	5.22 (1)
Sweden	6.23 (1)	6.28 (1)	6.25 (1)	6.54 (1)	6.48 (1)	6.49 (1)	4.94 (3)	4.95 (3)	4.94 (3)

	Closeness with others			Social activity compared with others of same age			Frequency of experiencing loneliness		
	2006	2008	2010	2006	2008	2010	2006	2008	2010
Germany	1.08 (1)	1.07 (1)	1.06 (1)	2.63 (4)	2.65 (4)	2.73 (4)	1.47 (2)	–	1.31 (2)
UK	1.14 (3)	1.12 (2)	1.14 (3)	2.73 (3)	2.80 (3)	2.75 (3)	1.50 (=3)	–	1.46 (4)
Netherlands	1.12 (2)	1.16 (3)	1.12 (2)	2.77 (2)	2.84 (1)	2.85 (1/2)	1.50 (=3)	–	1.29 (1)
Sweden	1.17 (4)	1.18 (4)	1.16 (4)	2.86 (1)	2.83 (2)	2.85 (1/2)	1.40 (1)	–	1.34 (3)

Trust in others

The sample of older people in Germany aged 65+ had the lowest trust ratings at all three time points, with mean scores of approximately 4.5 out of a possible 10. The sample of older people



in Sweden had the highest mean scores for trust in others at all three time points. There was some fluctuation in the ranking positions of the UK and the Netherlands, with the UK ranking second in 2006 and 2010 and the Netherlands ranking second in 2008.

Each of the four countries experienced some increase in their ratings of trust in others between 2006 and 2010. However, we did not find these changes to be statistically significant.

Helpfulness of others

The country rankings for ratings of the helpfulness of others were consistent across all three time points. The mean scores for Swedish older people's ratings of the helpfulness of others were highest at all time points (with mean scores near to 6.5 out of 10), while older people in the UK's ratings of helpfulness ranked second highest, the Netherlands ranked third highest and the sample of older people in Germany came fourth, suggesting that on average they found people less helpful (with an average mean score of 5.16 out of 10).

Germany, the UK and the Netherlands demonstrated an increase in average ratings of the helpfulness of others, although this change was not significant. However, in Sweden the average rating of helpfulness decreased during between 2006 and 2010 and the small drop in ratings of helpfulness between 2006 and 2008 was found to be statistically significant.

Meeting socially with others

There was some consistency in the countries' rankings across the three time points for the frequency with which people aged 65+ socialised with others. Germany ranked fourth at all three time points with a mean score of approximately 4.3 out of a total score of 7, showing that respondents socialise several times a month. Sweden consistently ranked third, with mean scores of approximately 4.95 at all three time points, showing that respondents socialise close to 'once a week', which had a score of 5. The UK and the Netherlands variously ranked second and first at different time points, with the UK ranking first in 2006, with a mean score of 5.17, while the Netherlands ranked first in 2008 and 2010, with mean scores of 5.15 and 5.22.

Between 2006 and 2010 Sweden's ratings for frequency of socialising remained stable; the mean scores for Germany and the Netherlands rose and the UK's slightly dropped. The only change that registered as statistically significant was the increase in older people's social activity in the Netherlands between 2008 and 2010.

Someone to confide in

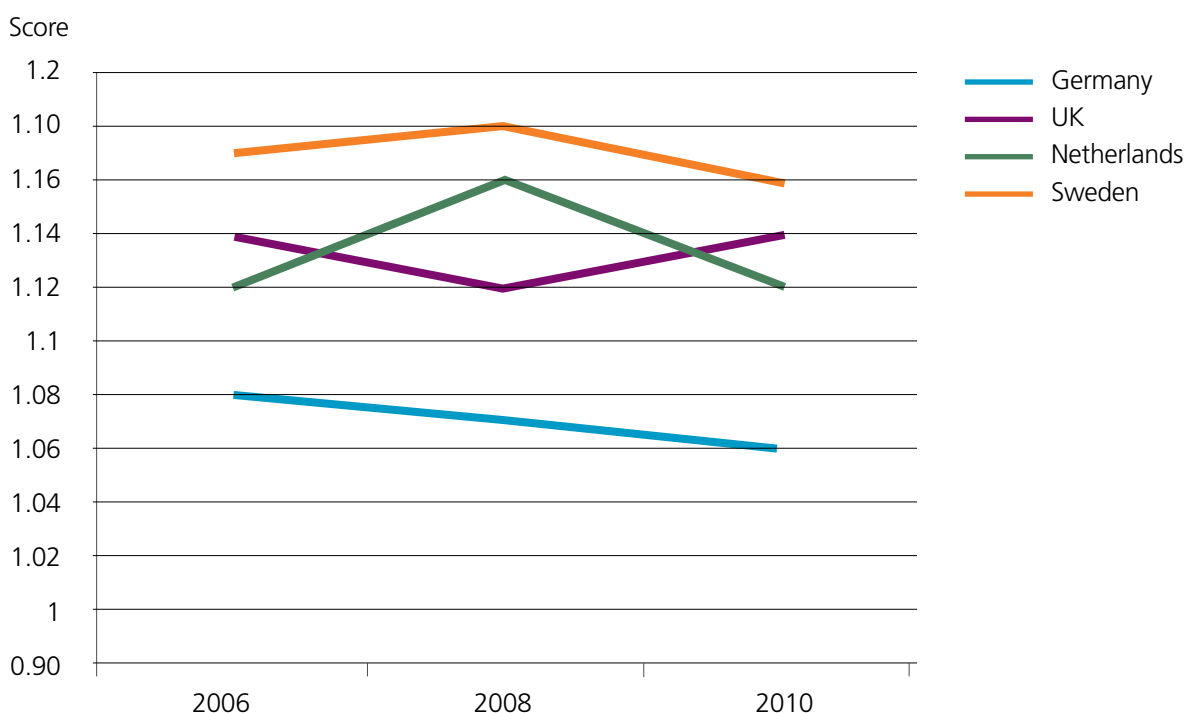
The 'closeness with others' indicator was dichotomously coded, so that people were asked to give a 'yes' or 'no' answer to the question 'do you have anyone with whom you can discuss intimate and personal matters?' with 'yes' scoring 1 and 'no' scoring 2.



The sample of older people in Germany consistently ranked highest across the three years, with a lower mean score indicating that more of them had someone they could confide in. The sample of older people in Sweden consistently ranked lowest against this indicator with a higher mean score. The UK and the Netherlands variously ranked second and third, with the Netherlands ranking second in 2006 and 2010 and the UK ranking second in 2008 (figure 7).

Between 2006 and 2010 the samples of older people in Germany demonstrated a slight decrease in the mean score, suggesting a slight increase in the odds of having someone to confide in. The mean score of the sample of older people in Sweden in 2010 was also very slightly lower than the sample's mean score in 2006, indicating a slight increase in the odds of having someone to confide in. Mean scores in the UK and the Netherlands ended in 2010 as they started in 2008. All of the four countries had a mean score closer to 1 than 2, implying that the majority *did* have someone to confide in. We did not identify changes between the years to be statistically significant in any of the four countries.

Figure 7 Older people's perceived closeness with others in each of the four countries, 2006, 2008 and 2010



Social activity compared with others

As mentioned above, the score for social activity compared with others was coded from 1 to 5, where 1 indicated that the respondent engaged in much less social activity than other people of their age group, and 5 indicated they engaged in much more social activity than others of their age.



The lower ranking countries (the UK and Germany) had consistent rankings across the three time points, with the UK ranking third and Germany ranking fourth. There was a little fluctuation in the rankings of the samples of older people in Sweden and the Netherlands between 2006 and 2010, with Sweden ranking first in 2006, the Netherlands ranking first in 2008, and the two countries demonstrating an equal mean score for relative social activity in 2010.

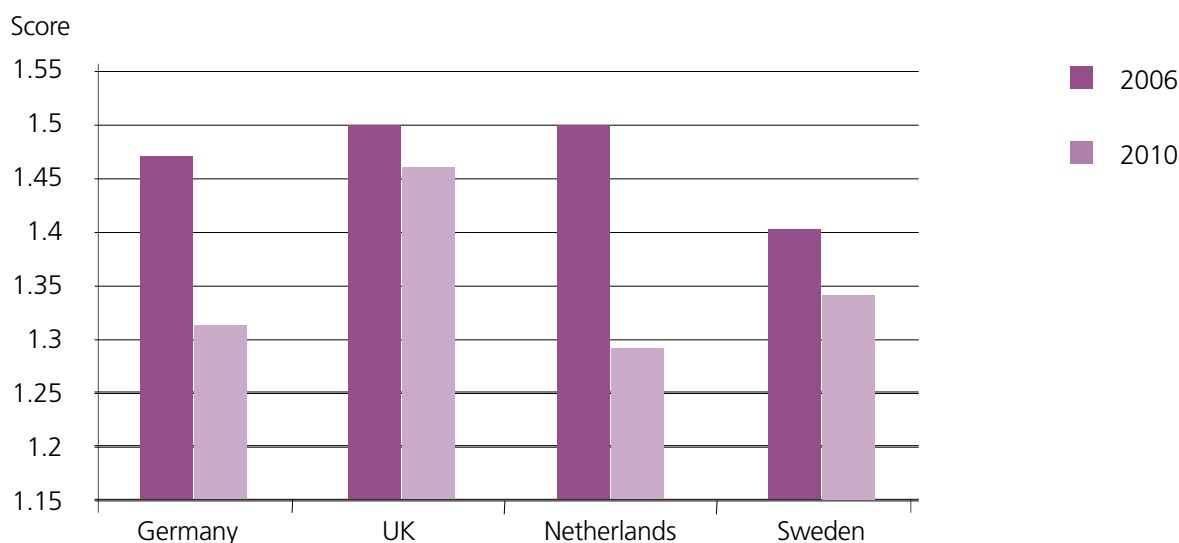
The samples of older people in Sweden demonstrated a very small and non-significant drop in relative social activity between 2006 and 2008. Relative social activity remained fairly stable for the sampled older people in the UK, with an increase between 2006 and 2008, and a significant, though small, drop by 2010. Ratings of social activity compared with others in Germany increased between 2006 and 2008, with significance found for the rises in 2008 and 2010. In the Netherlands social activity increased between 2006 and 2010 but this change was not found to be significant.

Frequency of experiencing loneliness

We have compared the country samples' ratings for loneliness between the 2006 and 2010 survey rounds as data on loneliness were not available in 2008. The country rankings between 2006 and 2010 are not very consistent, although Germany ranked second least lonely in both years. The sample of older people in Sweden had the lowest average rating in 2006, indicating that older people in Sweden were the least lonely of all older people in the four countries at that time. However, in 2010 the sample of older people in the Netherlands had a slightly lower rating, suggesting that Dutch older people were the least lonely group in 2010. Older people in the UK had the highest ratings for loneliness in 2010, and tied for highest with the Netherlands in 2006 with a mean score of 1.50 out of a possible 4 (this falls halfway between being lonely 'none or almost none of the time' and 'some of the time' during the past week).

Mean scores for loneliness among people aged 65+ decreased across all four countries between 2006 and 2010 (figure 8). We did not find these apparent decreases in loneliness to be statistically significant.

Figure 8 Older people's self-rated loneliness in each of the four countries, 2006 and 2010



Summary of findings in chapter 8

Theme 1: Income

Our analysis of the income indicators across the three time points found that older people's average net incomes in each of the countries decreased between 2006 and 2010, but the only change in income found to be statistically significant was the drop in mean net income demonstrated in the UK between 2006 and 2008.

The indicator that related to the level of comfort provided by older people's current income found that comfort increased in Germany and the Netherlands between 2006 and 2010, increased slightly in the UK and remained constant in Sweden. We found no significant correlations here.

Theme 2: Health and health provision

The indicator that provided a rating of older people's perceptions of health services found that ratings of health services improved in each country between 2006 and 2010. This increase was statistically significant in the UK and Sweden but not in the Netherlands and Germany.

Self-reported health improved in Germany, the Netherlands and Sweden between 2006 and 2010 but slightly declined in the UK. We did not identify any of these changes to be statistically significant.

Ratings for life-limiting illness or disability showed a slight improvement in all four countries between 2006 and 2010, but we did not find these changes to be statistically significant.

Theme 3: Well-being

Between 2006 and 2010, all four countries demonstrated increased self-rated life satisfaction although these changes were not identified as statistically significant.

Mean scores for self-rated general happiness slightly improved in the Netherlands and Germany between 2006 and 2010, but stayed more or less stable in Sweden and the UK. We did not identify any statistically significant correlations in any of the countries.

Theme 4: Social inclusion and participation

The surveyed samples of older people in all four countries demonstrated increases in trust between 2006 and 2010, but we did not find these changes to be statistically significant.

Germany, the UK and the Netherlands demonstrated an increase in average ratings of the helpfulness of others, although this change was not significant. However, in Sweden the average



rating of helpfulness decreased between 2006 and 2010 and the drop in ratings of helpfulness between 2006 and 2008 was found to be statistically significant.

Sweden's ratings for frequency of socialising remained stable between 2006 and 2010. Germany and the Netherlands scores rose, while the UK's slightly dropped. The only change that registered as statistically significant was the increase in older people's social activity in the Netherlands between 2008 and 2010.

In all four of the countries ratings for whether older people have someone they can confide in remained very similar or the same between 2006 and 2010. We did not identify the very small changes between the years as statistically significant in any of the four countries.

Trends in older people's rating of their levels of social activity in relation to others of their age group varied between the four countries. In Sweden and the UK the ratings remained fairly stable between 2006 and 2010, although in the UK there was a small but significant drop between 2008 and 2010. Ratings of social activity compared with others in Germany increased between 2006 and 2010, with significance found for the rise in 2008, and in 2010. In the Netherlands social activity increased between 2006 and 2010, but we did not find this change to be significant.

Loneliness among people aged 65+ decreased across all four countries between 2006 and 2010 by varying degrees, but we did not find these changes to be statistically significant.

Overall findings

Overall this analysis indicates that changes in mean scores between the time periods within each country tended not to be significant. It is the difference between the individual countries' mean scores (as discussed in detail in chapter 7) that is of most interest to this study. This chapter also found that in most cases there was some consistency in the individual countries' rankings against each indicator across the three time points 2006, 2008 and 2010.



9 Correlations between the experiences of ageing themes

In the next stage of our research we analysed the European Social Survey data to identify the relationships within each country between sets of indicators within the five themes that make up the Experiences of Ageing Matrix. In this chapter we present our findings on the correlations between these themes (income and poverty, health and health provision, well-being, social inclusion and participation, and age discrimination). Detailed data tables depicting the correlations between the themes for each country are set out in appendix 3.

In each case we identified whether the correlation reached statistical significance at the threshold of 0.05. We have also categorised the strength of the correlation as 'weak' if there is a correlation between 0.05 and 0.2 and 'moderate' if there is a correlation between 0.2 and 0.4. We did not identify any strong correlations that were higher than 0.4.

The relationship between income and health

Our analysis identified a statistically significant relationship between the set of income indicators and the health indicators in each of the four countries studied, although this relationship varied in strength. This statistically significant relationship was weakest in the UK, which had a small but significant correlation of 0.127, compared with 0.195 in Sweden. The moderate correlation between income and health in the Netherlands (0.311) was the strongest of those identified between any two themes in the Netherlands. Germany demonstrated the strongest correlation between income and health in any of the four countries, with a moderate correlation of 0.326. This shows that in all four countries as the level of income for people aged 65+ rose, ratings for health and health provision also rose and this relationship was most evident in Germany.

The relationship between income and well-being

Our analysis also identified a moderate and statistically significant relationship between the income indicators and the well-being indicators in Germany with a correlation of 0.286. However, we did not identify any statistically significant correlation between the income and well-being indicators in any of the other three countries.

The relationship between income and social participation

When we analysed the relationship between the income and social participation indicators we found that there was a significant and positive correlation between these two themes in all four countries: as levels of income for those aged over 65 increased, levels of social inclusion also rose. Again, this relationship was strongest in Germany, where we identified a moderate correlation of 0.277. The next strongest correlation was in the Netherlands, where we



found a correlation of 0.221. We found the weakest correlations between income and social participation in the UK and Sweden, which each demonstrated a weak but significant correlation of 0.140.

The relationship between health and well-being

Our analysis identified a significant and positive correlation between the health indicators and the well-being indicators in each of the four countries. This shows that when people rated their own health and health provision more highly, they also had higher mean scores for well-being (and vice versa). Once again, this relationship was strongest in Germany, where there was a moderate correlation of 0.238. The next strongest relationship was found in Sweden, which had a moderate positive correlation of 0.218. The Netherlands and the UK had weaker, although statistically significant, correlations of 0.174 and 0.139 respectively.

The relationship between health and social participation

Our analysis also found a statistically significant and positive relationship between the ratings for health and health provision and those for social participation in each of the four countries. In Germany this relationship was the strongest out of all the relationships between the five themes with a positive correlation of 0.338. The next strongest correlation was found in Sweden at 0.243. In the UK there was a moderate positive correlation of 0.220, which was also the strongest relationship within the UK between any of the five themes. This indicates that as health ratings rose, ratings of social participation also rose moderately in these three countries. In the Netherlands we identified a weaker correlation of 0.144, suggesting that as health ratings increased, ratings of social participation were also slightly higher.

The relationship between health and age discrimination

The only country that demonstrated any statistically significant correlation with age discrimination was the UK, where we identified a positive, although weak, correlation between health and age discrimination (0.136). This relationship was not as strong as the relationship between health and social participation, but was stronger than the relationship between income and health. The existence of this correlation indicates that as the health ratings for people aged over 65 in the UK increase, those people are less likely to demonstrate or be concerned by age discrimination. However, we did not identify a correlation between age discrimination and another theme in any of the other countries.

The relationship between well-being and social participation

Finally, we identified positive and statistically significant correlations between ratings for well-being and for social participation in each of the four countries. This indicates that the higher people aged over 65 rated their well-being, the more social activities they participated in (and



vice versa). The strongest relationships between these sets of indicators were in Germany (a moderate correlation of 0.250) and Sweden (a correlation of 0.247). These variables were weakly but significantly related in the UK (0.162) and the Netherlands (0.138).

Summary of findings in chapter 9

In this chapter we identified the following statistically significant correlations between the five themes:

- **Income and health:** we identified correlations between income and health in all four countries (eg those with higher incomes had better health and more trust in the health system). The correlations were weak correlation in the UK and Sweden, and moderate in the Netherlands and Germany.
- **Income and well-being:** there was a moderate correlation between income measures and well-being in Germany (but not in any other country). Therefore in Germany it was clear that those who had higher incomes had higher well-being.
- **Income and social participation:** we found significant correlations between income and social participation in all four countries, suggesting that those who had higher incomes also scored higher for social participation. The correlations were moderate in Germany and the Netherlands, and weak in the UK and Sweden.
- **Health and well-being:** we identified positive correlations between health and well-being in all four countries (those who had better health had higher well-being). The correlations were moderate in Germany and Sweden, and weak in the Netherlands and the UK.
- **Health and social participation:** we identified positive correlations between health and social participation in all four countries (better health related to higher social participation). There were moderate correlations in Germany, Sweden and the UK, and a weak correlation in the Netherlands.
- **Health and age discrimination:** the only correlation between health and age discrimination we identified in this area was in the UK, where there was a weak correlation between health and age discrimination. This shows that in the UK people who had poorer health and the worst perceptions of health services were more concerned about age discrimination.
- **Well-being and social participation:** there were correlations between well-being ratings and social participation ratings in all four countries (people with higher well-being were more socially active and included). In Germany and Sweden this was a moderate correlation; in the UK and the Netherlands it was a weaker correlation.



Section 3

Analysis and policy implications

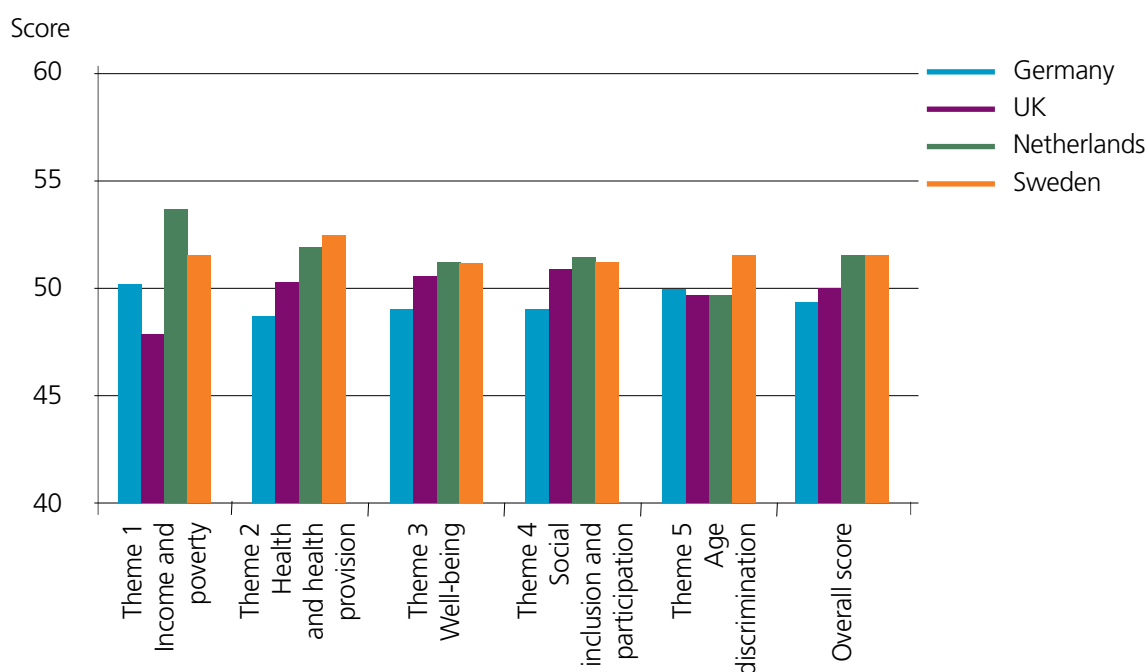


10 Analysis and implications for ageing policy in Europe

Overall findings

The results presented in chapter 7 found that in the Experiences of Ageing Matrix, which was made up of a basket of 30 indicators from the European Social Survey arranged into five separate themes, Sweden demonstrated the most positive overall experiences of ageing, with a mean score of 51.72, the Netherlands came a very close second with a mean score of 51.69, the UK came third with a mean score of 49.94, and Germany had the lowest mean score with 49.50 points out of 100. Figure 9 presents these overall country rankings.

Figure 9 Total mean scores against each theme in the Experiences of Ageing Matrix



The analysis of correlations between the five themes (income and poverty, health and health provision, well-being, social inclusion and participation, and age discrimination), which is presented in detail in chapter 9, identified a complex interaction between the indicators for income, health and social participation in each of the four countries studied. In all four countries statistically significant correlations were identified between income and health, income and social participation, and health and social participation. The well-being indicators also significantly correlated with the health and the social participation indicators in each case.

However, the strength of these relationships varied between the four countries. Germany tended to demonstrate stronger correlations between the indicators than the other three



countries – often at a moderate, rather than weak, level – and Germany was the only country to demonstrate a significant correlation between the income and well-being indicators, which was found to be moderately strong.

Unfortunately the analysis in this study cannot unpick the causal relationship between the indicators to explain, for example, whether it is low social participation that is causing poor well-being among older people, or poor well-being that is affecting older people's ability to participate socially. Therefore, policymakers will need to consider the complex interaction between the themes explored in this research when designing policies aimed at tackling poverty, poor health or social exclusion among older people. Given Germany's comparatively poor performance against the health, well-being and social participation indicators, this evidence of a mutually reinforcing relationship between these indicators and the income indicators, and of the greater strength of these relationships than in the other countries, is cause for concern, which should prompt further research and policy debate. There are also important implications for the UK, which performed the most poorly of the four countries against the income-related indicators (and is shown by Eurostat data to have the highest risk of pensioner poverty) and demonstrated significant correlations between income and health and income and social participation. Therefore, not only do older people in the UK have a greater risk of poverty, but those living in poverty also have a higher risk of poor health and social exclusion, which is then related to poor well-being.

Recently the European Union has championed policy initiatives, such as the 2012 European Year for Active Ageing and Solidarity between Generations, which highlight the need for EU member states to take a constructive approach to population ageing, and recognise the complexity of the various factors that affect older people's opportunities to 'lead active, healthy and participative lives well beyond their retirement'.³⁰⁰ This EU initiative recognises that in the context of an ageing Europe, failure to address the barriers to older people participating in work and broader society will not only have a negative impact on older people but could also compromise the sustainability of public finances, and 'solidarity' between the working-age population and those in retirement.³⁰¹ However, it is for national governments to take action on these issues, and the purpose of this study is to identify how the UK is performing in five areas that affect older people's quality of life in comparison with three other EU countries, and how we can learn from their successes or the challenges they face.

We will now explore the implications of the key findings from our research within each of the five themes.

Key findings within each of the five themes

Income and poverty in old age

In the Experiences of Ageing Matrix, Germany had the second lowest ranking against the income theme, and within this theme demonstrated the lowest ranking against the indicator measuring older people's level of comfort with their income. This greater level of discomfort with living standards in Germany might be caused by comparatively high consumer prices or



other living costs in Germany, which could also account for the higher proportion of German pensioners who we identified as suffering from material deprivation (6.8 per cent of people aged 65+ in 2009, compared with 4.9 per cent of older people in the UK and 2.6 per cent in the Netherlands).³⁰²

However, the Eurostat data reviewed in chapter 2 also showed that on average German pensioners have a fairly high relative median income ratio (which compares pensioners' incomes with those of the working-age population). In 2010 Germany had the highest relative median income ratio of the four countries, above the EU-27 average. This would suggest that on average German pensioners are relatively well provided for (in comparison with the working-age population), but that there is a small proportion of pensioners who are relatively very disadvantaged. Previous research has shown that the majority of pensioners in Germany rely on their state pension to make up most of their income.³⁰³ Therefore, those at greatest risk of poverty and material deprivation may be those who do not qualify for a full state pension and have particularly high living costs (eg on housing). Trends of an increasing risk of poverty in Germany combined with an ageing population suggest that this problem will increase in future years if steps are not taken to address low pensions entitlements and material deprivation caused by high living costs. The correlations we have identified imply that increasing rates of pensioner poverty in Germany are likely to be associated with poorer health and well-being and a greater risk of social exclusion in old age.

Although Germany performs poorly on some indicators of pensioners' living standards it is the UK that currently performs most poorly of the four countries on income overall. The UK had the lowest mean score in five out of the six indicators used in the matrix, demonstrating that on average UK pensioners have the lowest net income and in the last three years are most likely to have had to manage on a lower income, draw on savings or economise on their expenditure. Pensioners in the UK also had the lowest perception of the living standards of pensioners of all four countries. Eurostat data also demonstrate that the UK has the second lowest relative median income ratio in 2010 (after Sweden) and the highest risk of poverty out of the four countries, with a startling one-fifth of pensioners at risk of poverty in 2010 according to Eurostat data.³⁰⁴

This suggests that while incomes for pensioners in the UK have on average improved since 2006 in relation to the working-age population (eg the relative median income ratio and aggregate replacement ratio have increased), there remains quite a large contingent who are disadvantaged in comparison with people of their own age cohort. This reflects the fact that the UK has greater income inequality among pensioners than Germany, the Netherlands and Sweden (see table 32) and may indicate that not enough pensioners in the UK are currently eligible for a full basic state pension, or that the basic state pension is inadequate to give pensioners in the UK a sufficient standard of living. Given the significant correlation that we have established between income and health and income and social participation in the UK, this greater level of income inequality clearly has worrying implications for health inequalities and social inclusion in old age.



Table 32 Inequality of income distribution (income quintile share ratio) among people aged 65+ in four EU comparator countries, 2010

Income quintile share ratio ³⁰⁵	
Germany	3.8
UK	4.3
Netherlands	3.1
Sweden	3.1
EU-27	4.0

Although Germany and the UK demonstrated lower rankings for income and health in the matrix, indicating there was a more negative reinforcing relationship between these influences in these countries, the Netherlands and Sweden demonstrated more positive relationships. Notably, the Netherlands ranked first overall in the income theme and ranked first in five out of six income-related indicators. Eurostat data also demonstrate that the Netherlands has the lowest risk of pensioner poverty of the four countries, which at 5.9 per cent in 2010 is substantially below the EU-27 average of 15.8 per cent of pensioners being at risk of poverty, while Dutch pensioners also currently have a comparatively good relative median income ratio, just below the EU-27 average.

However, it will be a challenge to sustain this strikingly good record on older people's incomes in the Netherlands in future decades in the context of population ageing; as we observed in chapter 2, political debate in the Netherlands is currently very much focused on the need to make radical reforms in the pension system to ensure its long-term sustainability. Therefore it will be important that the Dutch Government makes these reforms in a way that does not compromise the living standards – and by association health and social participation – of current and future generations of Dutch pensioners.

Our analysis in the matrix, and the Eurostat data reviewed in chapter 2, indicated that Sweden performs well on some indicators of pensioner income and less well on others. The Eurostat data demonstrated that the risk of poverty has increased for Swedish pensioners between 2006 and 2010 (from 11.3 per cent of pensioners to 15.5 per cent of pensioners). In 2010 the risk of poverty in Sweden was therefore slightly higher than in Germany (although below the EU-27 average).³⁰⁶ In 2010 Sweden also had the lowest relative median income ratio of the four countries, suggesting that Swedish pensioners are less well off in relation to working-age people. However, according to other measures, Swedish pensioners are in a relatively good position: in 2010 Swedish pensioners had by far the best aggregate replacement ratio of the four countries, which has been consistently high since 2006 and remains above the EU-27 average. The sample of older people in Sweden responding to the matrix indicator measuring their level of comfort with their income also ranked highest of the four countries, indicating that living costs in Sweden may be comparatively lower than in the other three countries.

These findings inevitably conceal inequalities within these aggregate figures: our analysis of the matrix segmented by gender found that of the four countries Sweden registered the largest



gap in income between men and women. Our analysis also found that there was a correlation between income and health in Sweden and that this was stronger than in the UK (almost at a moderate level), but weaker than the relationship between these two variables in the Netherlands and Germany. Income was also weakly related to social participation in Sweden. Therefore, groups of older people at greater risk of poverty in Sweden, including women, may be also at greater risk of poor health and low social participation. However, it is important to note that, as observed above, overall income distribution among pensioners in Sweden is less unequal than in the UK.

We will consider in the next chapter how the UK might learn from the pension policies in place in the Netherlands and Sweden to reduce rates of pensioner poverty.

Health in old age and health provision

In the matrix presented in chapter 7 we considered two aspects of health under the ‘health and health provision theme’: the personal health of the older people from each country participating in the survey and their perceptions of the standard, sustainability and accessibility of health services in their country. The overall findings from this theme ranked Germany lowest of the four countries. This was mainly because the German respondents were more dissatisfied with healthcare in their country than the respondents from the other three countries. A larger proportion of German older people gave their current healthcare system a low rating and thought that funding for their healthcare system was unsustainable. The UK had the highest rating for the state of health services in the country nowadays, although more older people thought they might not have access to health care if they needed it.

Despite their high rating for the state of health services in the country, UK respondents performed lowest on two of the three indicators that related to personal health. The German respondents ranked lowest on the question about self-rated general health (followed by the UK), but the UK respondents registered the lowest mean score for life-limiting illness and the lowest score for ‘feeling active and vigorous’. Both the UK and Germany clearly face considerable public health challenges in relation to the ageing of the population. The various health data we reviewed in chapter 2 demonstrated that the UK had the highest rate of alcohol use and the highest estimated prevalence of obesity. The data reviewed earlier also showed that Germany has the highest rate of diabetes of the four countries, and the second highest rate of frequent smoking. Both obesity and diabetes are associated with a variety of long-term health conditions that are likely to impact negatively on older people’s independence and quality of life, and limit the extent to which they can engage in work. These are very significant issues for national governments, which aim to address population ageing by encouraging older people to remain in work for longer.

In comparison, Sweden and the Netherlands both performed well on the health indicators included in the matrix, with Sweden ranking slightly higher overall. Sweden and the Netherlands received very similar mean scores on three of the six indicators, with the Netherlands obtaining a slightly higher mean score for ‘feeling active and vigorous’ and Sweden returning a higher mean score for people feeling that they would have access to healthcare if they needed it. Similarly,



the Eurostat data reviewed in chapter 3 demonstrated that the Netherlands and Sweden have relatively low rates of obesity and diabetes (each time slightly lower in Sweden), which has good implications for people's health in old age. The Eurostat data showed that Sweden has a particularly high life expectancy and both men and women have relatively few years spent in poor health in old age.

These findings have important policy implications for the countries studied. It is encouraging that older people in the UK have a relatively high opinion of the standard of health services, and correspondingly it should be a concern in Germany that older people have a comparatively low opinion of health services. Other Eurostat data indicate that a slightly larger proportion of people in Germany felt that cost had acted as a barrier to them accessing medical treatment, particularly for those in the lowest income decile, with serious implications for health inequalities.

Potentially even more significant than these issues of access to health care are the public health challenges associated with population ageing. Each of the four countries studied is already in the process of increasing the state pension age or is discussing the potential to do so in the future to cope with the structural challenges posed by population ageing, whereby in future years an increasingly small number of workers will be tasked with paying pensions and other benefits for a growing cohort of pensioners. However, simply raising the state pension age will be ineffectual if older people are not in sufficiently good health to work. The independent review of health inequalities in England, conducted by Michael Marmot on behalf of the UK Government in 2010, observed, 'If society wishes to have a healthy population, working until 68 years, it is essential to take action to both raise the general level of health and flatten the social gradient.'³⁰⁷

Poor health in old age also has considerable implications for health and welfare budgets, the cost of which will ultimately fall on the working population. These issues are particularly pressing for Germany, which like the UK demonstrates a poor profile against public health measures but unlike the UK has the oldest demographic in Europe, with 20.7 per cent of the German population aged 65+ in 2010, compared with 16.5 per cent in the UK. Germany also demonstrated the strongest correlations between health and well-being and health and social participation of the four countries, demonstrating that health affects not only older people's ability to participate in employment but also their ability to participate in volunteering and other social activities that contribute to social inclusion. The correlation between health and income is also relevant, as older people who are able to work for longer are likely to have better pension entitlements and therefore a better standard of living in retirement.

With these factors in mind, there is a strong argument that national governments should view healthy ageing as a public health issue as important as drinking, smoking, obesity and diabetes. To promote healthy ageing, national governments will need to tackle these public health issues at a general population level as well as in the older population, as unhealthy behaviours and health inequalities that begin earlier in life are likely to persist in old age, with negative consequences for the whole of society.³⁰⁸ We will discuss opportunities for the UK to develop healthy ageing policies in more detail in the next chapter.



Social participation and well-being in old age

Our analysis in the Experiences of Ageing Matrix presented in chapter 7 demonstrated that Sweden ranked highest among the four countries for well-being among older people and the Netherlands ranked highest for older people's social participation, although these two countries' total mean scores were close together within both of these themes. The Netherlands' high ranking on social participation corresponds with the particularly high rate of volunteering in Dutch society that we observed in chapter 4. However, in the light of the fact that Sweden had a high ranking for general well-being, it was notable that Sweden had the second lowest ranking for loneliness (with a mean score just a little higher than that in the UK) and that older people in Sweden were the least likely of those in the four countries to say they had someone with whom they could discuss intimate and personal matters.

This demonstrates that although social participation and well-being are correlated, they measure different things, and people do not necessarily need to have high rates of social participation to be happy or satisfied with their lives. Social participation is also not always protective against loneliness; as noted previously, social loneliness and emotional loneliness are two distinct types of social isolation. The UK ranked second highest on the indicator of social participation but also demonstrated the poorest score among the four countries for the frequency with which older people felt lonely. Older people in the UK also ranked third on having someone to confide in. In contrast, in Germany older people registered lower rankings for social participation, but were most likely out of the four countries to feel they had someone they could confide in. Although German pensioners were on average less lonely, the matrix also found that levels of well-being were consistently lowest in Germany across most of the indicators used in the matrix. The sample of older people in Germany also registered the lowest levels of social trust and belief in other people's helpfulness.

This presents interesting questions about the different cultural characteristics of the survey respondents from each country, their different social expectations and the extent to which they value various types of social interaction. These differences suggest that policy initiatives to combat social isolation that might be successful in one country would not necessarily transfer easily to another society. Therefore while we can learn from other countries' approaches to promoting social inclusion in old age, it is essential that policy responses are appropriate to the particular needs and characteristics of the specific populations they are serving. As previously observed, policies aiming to combat social isolation in old age also need to take into account the complex relationship between income, health and social participation that we have identified (with these relationships identified as strongest in Germany). Coordinated policy responses are needed that recognise the role that low income or poor health might play in reducing older people's opportunities to socialise.

As we have observed in chapters 3 and 4, each country also has its own unique social traditions, institutional framework and approach to delivering services, which each shape the opportunities for social participation that are likely to be available to older people. As previous studies have observed, it is likely that strong and well-resourced institutions are needed to recruit and support volunteers to undertake voluntary activities.³⁰⁹ Countries that wish to promote volunteering among older people might wish to investigate the social and structural factors



that have contributed to the exceptionally high rates of volunteering among older people in the Netherlands. For example, it may be relevant that the Netherlands has promoted a culture of volunteering from an early age by including volunteering within the school curriculum.³¹⁰ It may also be significant that the Netherlands has a particularly large voluntary sector. Interestingly, since the 2008 economic crisis increasing numbers of people have taken part in volunteering in the Netherlands, with staff in volunteering centres witnessing ‘a clear increase of the demand’.³¹¹ Further research is needed to identify why volunteering rates tend to drop off sharply after the age of 75 in most European countries, including in the Netherlands.³¹²

It is also important to note that different countries exhibit different trends in the types of volunteering activity and social participation that older people undertake. As we observed in chapter 4, in the UK volunteering roles have traditionally included a greater emphasis on providing social services, whereas in Sweden, where the state has been more dominant in providing welfare services, volunteering is traditionally more associated with ‘expressive’ activities such as sports, cultural activities and advocacy groups and associations. The level of investment in social care services in a country might affect the proportion of older people who are able to participate in volunteering, and the range of volunteering opportunities that are available to older people. While both types of volunteering role (‘service’ roles and ‘expressive’ roles) are evidently very socially valuable, they may have different social dynamics. For example, older people who participate in leisure activities such as sports clubs might be more likely to come into contact with younger generations than older people who volunteer in health or social care, although this would need to be confirmed by further research.

With these issues in mind, it is notable that the Netherlands and Sweden do not only exhibit particularly high rates of volunteering among all age ranges, but also tend to perform better than the UK and Germany on the various measures of intergenerational cohesion considered in chapter 4; further investigation is needed to identify whether these factors are linked. We will consider the potential relationship between intergenerational contact and age discrimination below.

Perceptions of age discrimination

Our analysis in the Experiences of Ageing Matrix found that the UK ranked lowest of the four countries on the age discrimination theme, suggesting that age discrimination is a greater problem in the UK. The Netherlands and Germany had slightly higher mean scores than the UK (indicating they have less age discrimination), while Sweden stood apart from the other countries with a mean score that was higher by several points. A Eurobarometer survey conducted in 2011 is illustrative of the broad variations in how older people are perceived between countries. Whereas in the Netherlands people on average thought that a person might be considered old at age 70.4 and in Sweden at 66.6, in the UK people think that old age starts at 61.9 and in Germany at 60.1.³¹³

Closer analysis of the matrix results according to gender also found that while people in the UK were most concerned about age discrimination, women in the UK were notably more likely to feel they had been affected by age discrimination than men. In response to the question ‘how



often in the past year have you been treated with prejudice because of age?', the mean score of women in the UK was 3.67 points lower than men's, suggesting they were considerably more likely to feel that people had treated them in a prejudicial way on the basis of their age. This may indicate that there is a particular interaction between ageist and sexist attitudes in the UK that is not as prevalent in the other three countries studied. It is also notable that the UK was the only country in which we found that the age discrimination indicators significantly correlated with those from another variable: health and health provision. This might suggest there is an interaction between age-related discrimination and discrimination towards people who have poor health or are disabled, with important implications for policy. Further research is needed to understand why the UK rates particularly highly against age discrimination indicators, and how these other types of discrimination might be mutually reinforcing.

The UK also had the lowest mean score against the indicator relating to the question 'how negative or positive do you feel towards people in their 20s?', showing that older people in the UK have more negative attitudes towards young people than is exhibited by older people in the other countries. This may well be related to the Eurostat data that we reviewed in chapter 4, which demonstrated that people in the UK are more concerned than those in the other three countries that there is too much age segregation in our society and not enough opportunities for older and younger people to work together on common projects.

Other social dynamics, including employment policies, may well also exert an influence on societal perceptions of older people. Each of the four countries included in this study now has legislation in place that is designed to combat age discrimination. However, the UK is the only country that has taken the step of abandoning its default retirement age, so that employers must be able to 'objectively justify' their decision to terminate a person's employment on the basis of their age.³¹⁴ In Germany the legal retirement age is currently 65 and will soon increase to 67 in line with the increasing state pension age.³¹⁵ In the Netherlands, the retirement age is currently 65³¹⁶ and in Sweden an employer can terminate a person's employment 'without just cause' at 67.³¹⁷ These countries may wish to consider whether this institutionalised discriminatory treatment of older workers is compatible with their intentions of increasing the participation of older people in the workforce to combat the fiscal pressures associated with population ageing. As this example shows, there is more that can be done to share good practice between European governments in improving working conditions and increasing labour market participation for older workers.

It is encouraging that the European Union is currently responding to population ageing in Europe by championing 'active ageing and intergenerational solidarity', with a particular emphasis on challenging discriminatory attitudes. However, this research has demonstrated that at the level of individual European societies, the challenges of population ageing are perceived in different ways, depending on the individual social and institutional context. For example, the results in the matrix demonstrated that German respondents (of all ages) were the most likely of the four countries to say they thought people aged over 70 were a burden on the country's health services, but German older people were also the least likely to think that age discrimination was a serious problem in their country. This counterintuitive finding demonstrates the complexity of these issues and difficulties involved in interpreting the findings.



While each country needs to develop its own policy responses to tackle its specific challenges associated with population ageing, this research shows that the way these measures are developed and communicated is important. Policymakers in all countries must remain aware of the impact that rhetoric depicting older people as a 'burden' could have on social attitudes towards older people and the potential to increase discriminatory behaviour. In contrast, policy approaches that engage with older people as partners in identifying solutions to the challenges of an ageing society, as opposed to seeing them as *the problem*, are far more likely to encourage inclusive and non-discriminatory attitudes towards older people.



11 Policy directions for the UK

In this final chapter we will explore the particular implications for the UK that are raised by this report's findings in the areas of income and pensions, health and health provision, social participation and well-being, and age discrimination, and propose directions that could be taken in each of these areas to improve policies on ageing.

Overall, our analysis in the Experiences of Ageing Matrix found that the UK did not rank first or second out of the four countries in any of the five categories explored and the UK performed particularly poorly (ranking fourth) in two of the matrix's themes: income and 'poverty and age discrimination'. As we have mentioned in the previous chapter, our analysis of the European Social Survey data also demonstrated that in the UK there were statistically significant correlations between respondents' mean scores on income, health and social participation, and also between social participation and well-being. These tended to be relatively weak correlations (whereas in Germany we found most of the correlations to be moderately strong) but they nonetheless demonstrate that older people in the UK who have a low income are likely to be at greater risk of poor health and lower social participation. This should be of particular concern given the UK's particularly high rate of older people who are at risk of poverty in comparison with other EU countries.

If policies developed in the UK to improve people's experiences of ageing are to be successful, policymakers will need to consider how these various factors of income, health and social participation are likely to interact at the level of individual older people's lives, their wider communities and nationally. More successful policy approaches are likely to be those that tackle these issues simultaneously.

It is also notable that while the European Union is currently highlighting the benefits of taking a joined-up approach to tackling the issues associated with population ageing, the national governments and assemblies in the UK have tended to tackle these issues within individual silos such as social care policy or employment policy. Wales and Northern Ireland may be closer to developing a coordinated approach on population ageing as they have both recently legislated to create the post of commissioner for older people, while the English and Scottish parliaments have declined to do so. However, even without the post of commissioner there is much that could be done at a national level in England and Scotland to develop a more integrated response to population ageing. An effective cross-government ageing strategy might include the identification of a number of key indicators (such as those included in our matrix) to monitor progress in reducing the rate of poverty among older people, improving older people's health and well-being, increasing social participation and reducing loneliness. In England these policy goals are currently pursued in a fairly piecemeal fashion, showing a failure to prioritise the needs of older people at a national level.

There are also opportunities to increase accountability at a local level for improving older people's health and well-being. Following reforms introduced by the Coalition Government, local authorities in England are to be made responsible for meeting the public health needs of their populations through the establishment of local health and well-being boards. As we will discuss



below, these boards could play an important role in promoting healthy ageing and coordinating local services for older people in England, while the local health boards in Wales, community health partnerships in Scotland and health trusts in Northern Ireland could also take on this role.

In the remainder of this chapter we will consider the specific implications of the findings in this report for the UK, and propose policy directions that could be taken to improve life for older people in the UK.

Income and pensions

As we have demonstrated previously in this report, in recent years the incomes of UK pensioners have increased faster than average earnings, increasing the prosperity of pensioners in relation to the working age population.³¹⁸ However, while the UK may have reduced income inequality between pensioners and working-age people, inequalities among the cohort of people already retired have increased in recent years.³¹⁹ At the bottom end of the scale, there is a sizable minority of pensioners in the UK – around a fifth – who are considered at risk of poverty. While this is an inexcusably large proportion, there has been progress in recent years – the UK was the only one of the four countries included in this study where there has been a clear reduction in the rate of its older people at risk of poverty since 2006 – but despite this improvement the UK still has a rate of pensioner poverty substantially higher than that of the other three countries we have examined, and the average for the EU as a whole.

Therefore it is important that the UK should learn from the policies in place in other EU countries that contribute to lower rates of poverty among older people. In particular, as we have seen from the matrix results presented in chapter 7, the Netherlands performed particularly well against the indicator based on older people's net household income, while Swedish older people reported the highest level of comfort with their current income. According to Eurostat data, in the Netherlands only 6 per cent of older people are considered to be at risk of poverty.

The differences in pensions take up between these two countries and the UK may well explain this difference. As discussed in chapter 2, occupational pensions in Sweden and the Netherlands are considered to be 'quasi-mandatory' and around 90 per cent of employees in each country were enrolled in occupational pensions schemes in 2008. This compares with around 47 per cent of employees in the UK and 64 per cent of employees in Germany. Following the Pensions Act 2008, from 2012 employers will have a new duty automatically to enrol their employees into a pension scheme if they are earning at least £7,475 each year. Increasing the provision and take-up of occupational pensions to ensure that fewer people rely solely on their state pension for their income in retirement should remain a priority for UK policymakers if we hope to see older people's poverty improve to be on par with the likes of those in the Netherlands and Sweden.

Learning further from the Netherlands' example, another important policy to reduce pensioner poverty in old age could be the introduction of a flat-rate citizens' pension. In the Netherlands all residents aged over 65 are eligible for a pension (regardless of how many years they have worked) and the amount an individual receives is larger or smaller depending on their circumstances (eg if they are single, a single parent or cohabiting with a person who is or is not



eligible for a state pension). Currently in the UK people must have made 30 years of pension contributions to qualify for a full basic state pension. As observed in chapter 2, those who do not qualify for a full basic state pension are dependent on the means-tested Pension Credit for a minimum income, which can have the effect of penalising people if they try to accumulate savings. Another problem is that many older people are unaware that they are eligible for Pension Credit; therefore it often goes unclaimed.

A flat-rate pension with very low eligibility requirements, paid at a sufficient level to guarantee adequate living standards, could address this problem by making means-tested pension credit unnecessary. It is therefore very promising that the UK Government has been considering proposals to introduce a single-tier citizens pension at the rate of £140 per week. The 2012 budget confirmed the UK Government's intention to 'reform the State Pension into a single tier pension for future pensioners.'³²⁰ However, the proposed requirement in the DWP's 2011 white paper that people must have made seven years' worth of pension contributions would mean that eligibility for the new flat-rate pension would remain more restricted than its equivalent in the Netherlands, potentially reducing its capacity to combat poverty – particularly among women and carers, or those in poor health.³²¹ It also should not be assumed that a pension of £140 per week will be adequate to alleviate poverty in all cases; this figure will need to be considered very carefully.

Health and health provision

Our analysis of European Social Survey data presented in the matrix in chapter 7 demonstrated that older people in the UK feel relatively positive about the standard of health care they receive through the NHS, but have some concerns about its financial sustainability. Surprisingly, given the universal free healthcare available through the NHS, respondents from the UK were the least confident of the four countries that they would receive the healthcare they really needed if they became ill. This could reflect concerns about age discrimination in health services, which the Government is now moving to address following the Equality Act 2010, which bans age discrimination in all public services, including health and social care, with an implementation date of April 2012. However, a series of high profile investigations by the Parliamentary and Health Ombudsman and the Care Quality Commission, which have provided damning evidence of substandard care for older people in hospital, demonstrate that dismissive treatment of vulnerable older people is currently a fairly entrenched social problem.³²² A recent report by the Commission on Improving Dignity in Care, led by the NHS Confederation, has made a series of recommendations for improving care of older people in hospitals and care homes.³²³ In addition to these recommendations, the Government should also consider measures to tackle age discrimination in primary health services, to bring about the wider culture change that is needed. This might include embedding age awareness and anti-discrimination training in the initial professional training of all health and social care professionals, while also making age awareness training available as part of continuous professional development to improve compliance with the Equality Act.

The UK's performance against the matrix indicators reflecting personal health presented an even more mixed picture than the indicators concerning health services. While the UK ranked second



out of the four countries based on older people's assessment of their own general health, the UK ranked fourth on life-limiting illness or disability and whether or not the respondents had 'felt active and vigorous in the last two weeks'. An average of the three mean scores for the personal-health related indicators gives the UK and Germany almost exactly equal scores. As mentioned in the previous chapter, this reflects the serious public health challenges that the UK and Germany face as a result of their populations' unhealthy lifestyles, which feature high rates of obesity and alcohol consumption.

Our correlations analysis – outlined in chapter 9 – has demonstrated the significant relationship between health, social participation and well-being in the UK; therefore it is clear that poor health in old age has serious implications for all aspects of older people's lives. In the UK our increasing life expectancy is not yet matched by increasing healthy life expectancy, so older people are spending a greater proportion of their lives in poor health, with implications for health budgets as well as older people's well-being and social participation. If this situation is not addressed, older people's scepticism about the future financial sustainability of the NHS might be justified.

It is clear that to make radical improvements in older people's health in the UK, policymakers will need to achieve general improvements in public health throughout the life-course at a population level. This is how Swedish older people remain the healthiest among the countries we reviewed. There is also a specific need to ensure that older people, who are most at risk of developing long-term health conditions, remain healthy later in life. Therefore, to give full recognition to the scale of the public health challenge that we currently face, we propose that healthy ageing should be reframed as a public health issue that is given as much emphasis as alcohol abuse, smoking and obesity. This could also help to present older people's health as a central issue as opposed to a marginal concern, which could help to bring about the culture change that is needed to end age discrimination in health care.

The new health and well-being boards currently being established in England and their equivalents in Scotland, Wales and Northern Ireland should be given key responsibilities for coordinating healthy ageing services at a local level. Partnerships with local older people's groups to help design and deliver these services would be important to ensure that they were desirable and appropriate. Local authorities could then be assessed on their success in achieving healthy ageing outcomes, as they currently are against targets relating to teenage pregnancy or smoking.

The Department of Health also currently has public health 'responsibility deals' with partners from all sectors to tackle issues such as alcohol abuse and obesity.³²⁴ The devolved governments for England, Scotland, Wales and Northern Ireland should also broker national responsibility deals on healthy ageing, which would bring together all sectors (public, private and non-profit) to agree their individual responsibilities for promoting and supporting good health in old age. This national approach might then be replicated at a local level, giving local businesses and voluntary and community organisations a role in promoting healthy ageing locally.



Social inclusion and well-being

In the Experiences of Ageing Matrix we found that overall the UK ranked third out of the four countries within the well-being and the social participation themes. However, if we break down the well-being theme into its component indicators, we found older people in the UK had higher rankings (ranking second) for the extent to which they felt they were free to live their lives and the extent to which they felt their life was valuable and worthwhile. This suggests there might be a greater sense of autonomy among older people in the UK than among those in Germany and Sweden, who both ranked lower than the UK, but the UK ranked third on the general life satisfaction and general happiness indicators and fourth on the indicator measuring the extent to which older people felt they had time to do things they enjoyed.

Within the social inclusion and participation theme, the UK ranked the lowest of all four countries on the frequency with which they felt lonely, and their perception of how frequently they socialised in comparison with other people of their age. They also ranked third on the extent to which they felt most people could be trusted and whether they had anyone to confide in. However, the UK ranked second on the frequency with which older people met socially with family or friends.

As we have suggested previously, this disparity between UK older people's relatively frequent social contact and low ranking on loneliness highlights the difference between social and emotional loneliness: a person who socialises frequently might still feel emotionally lonely if they are not satisfied with the intimacy of their social relationships, and frequency of social contact is a fairly poor proxy for feelings of isolation and exclusion. This is something to bear in mind in designing policy approaches to combating loneliness in older people; increasing older people's opportunities for social interaction might help to reduce some feelings of loneliness but will not necessarily be effective in reducing feelings of emotional loneliness.³²⁵

One of the factors responsible for the UK's relatively poor performance against the loneliness indicator in the Experiences of Ageing Matrix may be long-term underinvestment by local authorities in services that reduce social isolation and loneliness. In 2008 the Audit Commission's report *Don't Stop Me Now* found that most local authorities were poorly prepared for an ageing population. Only 28 per cent of councils had developed cross-cutting strategies for meeting the needs of older people, while 45 per cent of councils were in the early stages of developing a strategy and 27 per cent of councils 'focused solely on social care and made no other provision for older people'.³²⁶ This report observed that targeted services to support older people's independence have an important role in reducing the risk of social isolation, but 'opportunities to provide low level interventions are often missed'.³²⁷

More recently, as we have seen in chapter 5, there is evidence that this previous under-provision of low level social support is now being exacerbated by the austerity measures that local authorities in England and Wales are having to make to accommodate the reduced spending settlement announced in the 2010 comprehensive spending review. This is impacting on services older people in England and Wales in three main areas, by:



- tightening eligibility criteria for social care
- increasing service charges
- closing community support centres.

Each of these cost-cutting measures risks increasing social isolation and loneliness for older people who find they can no longer access services they have previously relied on. Therefore, in the context of this extremely tight spending settlement and evidence of contracting service provision for older people, now more than ever it is essential that mechanisms are in place to ensure that local authorities prioritise reducing loneliness in old age as an important outcome, and are able to monitor their progress in working towards this goal.

Health and well-being boards could provide an important mechanism for promoting this agenda locally if they were given a holistic responsibility for supporting healthy ageing, as we have suggested above. Older people's well-being and social participation could be included within local public health frameworks as important indicators of good health. There is an established body of research which demonstrates that loneliness in itself poses a health risk, with people who are socially isolated experiencing a substantially increased risk of mortality.³²⁸ Our analysis of the European Social Survey data also identified significant correlations between UK older people's health and their levels of social participation and also between their income and their level of social participation. It is not possible to identify causality; therefore one of these factors could be causing the other, or there could be a two-way causal relationship or 'virtuous circle' at work. It is clear that policymakers considering future strategies aimed at combating social isolation among older people in the UK will need to consider how barriers caused by poverty or poor health might be reducing older people's opportunities to participate socially. A valuable role for health and well-being boards could be to provide seed funding for local initiatives that support healthy ageing and reduce loneliness for older people at risk of social isolation.

Social care commissioners should also be given specific responsibilities for reducing the risk of loneliness and social isolation among older people who use social care. Older people who use social care are likely to have poorer health than older people who do not require social care, and as this study has demonstrated, poor health is associated with a lower rate of social participation. However, the current Adult Social Care Outcomes Framework does not include an indicator to measure the rate of loneliness among older social care users. The framework briefly considers older people's social participation only as one of eight domains within a composite measure of 'quality of life',³²⁹ which could allow the issue of social isolation and loneliness among older people to be overlooked entirely.

If the UK Government wishes to demonstrate that it takes the issue of loneliness in old age seriously, it should include in the Adult Social Care Outcomes Framework for England a robust standalone indicator measuring the extent of loneliness among older people who use social care. The devolved governments for Scotland, Wales and Northern Ireland should also ensure that an equivalent indicator is included in their own outcome frameworks. This loneliness indicator could be based on the De Jong Gierveld loneliness scale³³⁰ or another robust assessment tool that distinguishes between emotional and social loneliness, while also providing a composite measure for loneliness as a whole.



We have noted in this study that the countries with higher rates of volunteering at all ages (eg the Netherlands and Sweden), and traditions of volunteering in leisure activities such as sports and cultural activities, appear to offer older people more opportunities for social participation while also supporting more frequent contact between the generations. In our matrix the sample of older people from the Netherlands ranked first on infrequency of experiencing loneliness and frequency of social contact, while the sample from Sweden ranked highest on levels of social trust and the extent to which they believed people try to be helpful. The evidence reviewed in chapter 4 is also informative. According to the 2011 Eurobarometer survey cited in chapter 4, 57 per cent of adults in the Netherlands participate in voluntary work compared with only 23 per cent of adults in the UK. There is also evidence that voluntary activities can play a valuable role in bringing older and young people together: a Dutch study from 2004 confirmed that older people who worked or took part in some kind of voluntary work were more likely to have young people who were unrelated to them in their social networks.³³¹ A 2009 survey found that 76 per cent of adults (aged 15+) in the UK agree that there are not enough opportunities for older and younger people to come together, compared with 46 per cent of adults in the Netherlands. The same survey found that 92 per cent of people in the UK thought that local authorities should take a role in supporting initiatives to build stronger relationships between older and younger people.

Therefore, we propose that the devolved governments in the UK should each consider developing an action plan for increasing older people's participation in volunteering opportunities as part of a coordinated cross-government ageing strategy, with the aim of increasing older people's opportunities for social participation and opportunities for intergenerational contact. Public sector organisations such as schools, universities and health and well-being boards, voluntary and community organisations and employers could all have important roles to play in this. In particular, the potential role of employers in brokering relationships between older people who are approaching retirement and organisations that could offer older people volunteering opportunities post-retirement is currently largely untapped. However, it is likely that the success of a drive to increase rates of volunteering among older people would depend on the roles on offer being sufficiently flexible and varied to fit in with older people's commitments, interests and capabilities.

Tackling age discrimination

The experiences of ageing matrix found that older people in the UK are more concerned overall about age discrimination than older people in the Netherlands, Germany and Sweden and – according to one indicator – are more likely to manifest negative attitudes towards young people. As we have observed previously, there are also three further dimensions to this that create an even more complex picture. Older women were more likely to feel they had been treated with prejudice because of their age than older men; older people aged between 65–79 were more likely to feel they were treated with prejudice than older people aged 80+; and in our correlations analysis we found that there was a significant association in the UK survey samples between the health indicators and the age discrimination indicators, showing that older people who had poorer health were more likely to be concerned about age discrimination. As we have mentioned above, tackling age discrimination in healthcare could be an important first step



in addressing these concerns. Further research is also needed to investigate these dynamics in greater detail, to understand whether older women and disabled older people are particularly vulnerable to complex forms of discrimination and how this problem might be addressed.

The proposals outlined in the previous point for increasing opportunities for older people to undertake voluntary work, including shared activities with young people, could potentially help to increase understanding between older and young people and reduce discriminatory attitudes. The workplace could be another important site for tackling age discrimination in UK society. As we have mentioned previously, the Coalition Government's decision to abolish the default retirement age represents substantial progress in the direction of strengthening older people's employment rights, but there is more that could be done in the workplace to recognise older worker's skills and capabilities and bring older and younger generations together. For example, greater use of workplace mentoring schemes between older and younger employees could benefit employers by facilitating the transfer of skills and knowledge between different generational cohorts of workers, and could also help to highlight the valuable attributes that both older and younger workers bring to the workplace. Such schemes could also help to bridge employment and retirement by helping older workers to develop transferrable skills that could subsequently be used in a voluntary capacity.

Summary and conclusion

We can see from the review of evidence presented in this chapter that the UK faces multiple challenges in providing older people with positive experiences of ageing, as it scored poorly (although not always the worst) across every theme in the matrix. We can also see that these themes are highly interrelated. Therefore policy approaches that attempt to address individual issues in silos (eg pensions or social care) while ignoring the related issues of age discrimination, health, social participation and employment are likely to be ineffective. None of these challenges can be addressed in isolation. Therefore with this in mind our findings suggest that multilevel approach should be taken to improving experiences of ageing in the UK, including:

- developing cross-government strategies on preparing for an ageing society in England, Scotland, Wales and Northern Ireland (in Wales and Northern Ireland the Commissioner for Older People is likely to have a key role in this)
- tackling pensioner poverty by taking action to increase take-up of occupational and personal pensions and introducing a single tier 'citizens' pension' for UK residents, which is paid at an adequate rate and has sufficiently low eligibility requirements to ensure broad access
- taking action to tackle age discrimination throughout health and social care services, including basic training in meeting the requirements of the Equality Act 2010 for all new health and social care professionals, with training also available as part of continuous professional development
- making healthy ageing a central part of the UK's public health strategy and tasking the agencies responsible for public health at a local level (health and well-being boards in England, local health boards in Wales, community health partnerships in Scotland and health trusts in Northern Ireland) with promoting healthy ageing and coordinating local services for older people that support social participation and reduce loneliness



- developing cross-sector responsibility deals in each part of the UK to promote healthy ageing
- including in the Adult Social Care Outcomes Framework for England a robust stand-alone indicator for measuring the extent of loneliness among older people who use social care
- developing an action plan with cross-sector collaboration for increasing older people's participation in voluntary activities with the aim of increasing social participation in retirement and supporting intergenerational relationships
- conducting research to investigate the causes of complex forms of age-related discrimination
- working in partnership with employers to recognise the value of older workers, make more effective use of their skills and experience, build relationships between different generations of workers and smooth the transition between working and retirement.

It will be challenging for the UK governments and regional assemblies to coordinate an integrated strategy on preparing for an ageing society that works on all of these fronts simultaneously, when they are more accustomed to addressing these issues in silos. The introduction of a commissioner for older people in Wales and Northern Ireland represents an exciting opportunity to give such a cross-sector agenda political momentum. In England and Scotland a different approach may be needed. Reframing ageing as a public health issue could provide a much-needed focal point for coordination at national and local levels, bringing the issue of ageing out of the auspices of pensions and care into the mainstream well-being agenda which will be promoted locally in England through health and well-being boards.

It is only by transforming how we view ageing – not as a problem to be solved but as an important transition that we will all experience – that we can bring about the change of mindset that is needed to ensure that all older people in the UK receive the support they need to participate fully in our society.

While it is undeniable that our ageing society poses many fiscal and structural challenges, the examples provided by Sweden and the Netherlands demonstrate that with sustained social and political commitment, the UK could tackle pensioner poverty and improve levels of health and social inclusion for older people just as successfully as these two high-performing EU countries.



Appendix 1 Variables selected to perform comparative analysis for the Experiences of Ageing Matrix

Theme 1: Income and poverty indicators

Table 33 Survey questions on income and poverty, 2008 and 2010

No	Year	Survey	Question	Survey question asked
1	2010	European Social Survey – main questionnaire		Please tell me which letter on this card describes your household's income, after tax and compulsory deductions, from all sources? Please give an estimate.
2	2010	European Social Survey – main questionnaire		Which of the descriptions on this card comes closest to describing how you feel about your household income nowadays?
3	2010	European Social Survey – main questionnaire	G8	What has applied to you in the last three years? I have had to manage on a lower household income.
4	2010	European Social Survey – main questionnaire	G9	What has applied to you in the last three years? I have had to draw on my savings or get into debt to cover ordinary living expenses.
5	2010	European Social Survey – main questionnaire	G10	What has applied to you in the last three years? I have had to cut back on holidays or new household equipment.
6	2008	European Social Survey – main questionnaire	D11	Using this card [scale of 0 to 10], what do you think overall about the standard of living of pensioners? Please tell me on a score of 0 to 10, where 0 means extremely bad and 10 means extremely good.



Theme 2: Health and health provision indicators

Table 34 Survey questions on health and health provision, 2008 and 2010

No	Year	Survey	Question	Survey question asked
1	2010	European Social Survey – main questionnaire	B29	Please say what you think overall about the state of health services in this country nowadays?
2	2010	European Social Survey – main questionnaire	C15	How is your health in general? Would you say it is: very good; good; fair; bad; or very bad?
3	2010	European Social Survey – main questionnaire	C16	Are you hampered in your daily activities in any way by any longstanding illness, or disability, infirmity or mental health problem? If yes, is that a lot or to some extent?.
4	2010	European Social Survey – main questionnaire	G3	Say how often you have felt like this over the last two weeks: 'I have felt active and vigorous'.
5	2008	European Social Survey – main questionnaire	D45	There is some debate nowadays about the cost of providing public health care in [this country]. Thinking about 10 years from now, which of the statements on this card comes closest to your own opinion? [The country will not be able to afford the present level of public health care; the country will be able to afford the present level of public health care but not to increase it; the country will be able to afford to increase the level of public health care.]
6	2008	European Social Survey – main questionnaire	D49	During the next 12 months how likely is it that you will not receive the health care you really need if you become ill?



Theme 3: Well-being indicators

Table 35 Survey questions on well-being, 2006 and 2010

No	Year	Survey	Question	Survey question asked
1	2010	European Social Survey – main questionnaire	B24	All things considered, how satisfied are you with your life as a whole nowadays?
2	2010	European Social Survey – main questionnaire	C1	Taking all things together, how happy would you say you are?
3	2006	European Social Survey – main questionnaire	E23	Agree or disagree with the following statement: I feel I am free to decide for myself how to live my life.
4	2006	European Social Survey – main questionnaire	E24	Agree or disagree with the following statement: In my daily life, I seldom have time to do the things I really enjoy.
5	2006	European Social Survey – main questionnaire	E40	Agree or disagree with the following statement: I generally feel that what I do in my life is valuable and worthwhile.
6	2006	European Social Survey – main questionnaire	E8	Using this card, please tell me how much of the time during the past week... you felt depressed?

Theme 4: Social inclusion and participation indicators

Table 36 Survey questions on social inclusion and participation, 2010

No	Year	Survey	Question	Survey question asked
1	2010	European Social Survey – main questionnaire	A8	Using this card, generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?
2	2010	European Social Survey – main questionnaire	A10	Would you say that most of the time, people try to be helpful or that they are mostly looking out for themselves?
3	2010	European Social Survey – main questionnaire	C2	How often do you meet socially with friends, relatives and work colleagues?
4	2010	European Social Survey – main questionnaire	C3	Do you have anyone with whom you can discuss intimate and personal matters?
5	2010	European Social Survey – main questionnaire	C4	Compared to other people of your age, how often would you say you take part in social activities?
6	2010	European Social Survey – main questionnaire	G7	Using this card, please tell me how much of the time during the last week you felt lonely?



Theme 5: Age discrimination indicators

Table 37 Survey questions on age discrimination, 2008

No	Year	Survey	Question	Survey question asked
1	2008	European Social Survey – main questionnaire	E2	At what age do you think people generally start being described as old?
2	2008	European Social Survey – main questionnaire	E12	Using this card, please tell me whether or not you think people over 70 are a burden on [country]'s health service these days?
3	2008	European Social Survey – main questionnaire	E33	Using this card, tell me overall how negative or positive you feel towards people in their 20s?
4	2008	European Social Survey – main questionnaire	E35	Using this card please tell me how often, in the past year, anyone has shown prejudice against you or treated you unfairly because of your age?
5	2008	European Social Survey – main questionnaire	E38	And how often, if at all, in the past year have you felt that someone showed you a lack of respect because of your age, for instance by ignoring or patronising you?
6	2008	European Social Survey – main questionnaire	E55	How serious, if at all, would you say discrimination is in [country] against people because of their age – whether they are old or young.



Appendix 2 Indicators included in the longitudinal analysis

We have included the following indicators in our longitudinal analysis because they are present in European Social Survey Rounds 3 (2006), 4 (2008) and 5 (2010):

Theme 1: Income and poverty indicators

Table 38 Survey questions on income and poverty, 2006, 2008 and 2010

No	Year question	Year question	Year question	Survey	Survey question asked
1	2006 F32	2008 F32	2010 F41	European Social Survey – main questionnaire	Please tell me which letter on this card describes your household's income, after tax and compulsory deductions, from all sources? Please give an estimate.
2	2006 F33	2008 F33	2010 F42	European Social Survey – main questionnaire	Which of the descriptions on this card comes closest to how you feel about your household income nowadays?

Theme 2: Health and health provision indicators

Table 39 Survey questions on health and health provision, 2006, 2008 and 2010

No	Year question	Year question	Year question	Survey	Survey question asked
1	2006 B29	2008 B29	2010 B29	European Social Survey – main questionnaire	Please say what you think overall about the state of health services in this country nowadays?
2	2006 C15	2008 C15	2010 C15	European Social Survey – main questionnaire	How is your health in general? Would you say it is: very good; good; fair; bad; or very bad?
3	2006 C16	2008 C16	2010 C16	European Social Survey – main questionnaire	Are you hampered in your daily activities in any way by any longstanding illness, or disability, infirmity or mental health problem? If yes, is that a lot or to some extent?



Theme 3: Well-being indicators

Table 40 Survey questions on well-being, 2006, 2008 and 2010

No	Year question	Year question	Year question	Survey	Survey question asked
1	2006 B24	2008 B24	2010 B24	European Social Survey – main questionnaire	All things considered, how satisfied are you with your life as a whole nowadays?
2	2006 C1	2008 C1	2010 C1	European Social Survey – main questionnaire	Taking all things together, how happy would you say you are?

Theme 4: Social inclusion and participation indicators

Table 41 Survey questions on social inclusion and participation, 2006, 2008 and 2010

No	Year question	Year question	Year question	Survey	Survey question asked
1	2006 A8	2008 A8	2010 A8	European Social Survey – main questionnaire	Using this card, generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?
2	2006 A10	2008 A10	2010 A10	European Social Survey – main questionnaire	Would you say that most of the time, people try to be helpful or that they are mostly looking out for themselves?
3	2006 C2	2008 C2	2010 C2	European Social Survey – main questionnaire	How often do you meet socially with friends, relatives and work colleagues?
4	2006 C3	2008 C3	2010 C3	European Social Survey – main questionnaire	Do you have anyone with whom you can discuss intimate and personal matters?
5	2006 C4	2008 C4	2010 C4	European Social Survey – main questionnaire	Compared to other people of your age, how often would you say you take part in social activities?
6	2006 E12	N/A	2010 G7	European Social Survey – main questionnaire	Using this card, please tell me how much of the time during the last week you felt lonely?

NB There are no data on age discrimination (theme 5) in years 2006 and 2010 of the survey so we could not look at this theme longitudinally.



Appendix 3 Data tables for the correlations between the experiences of ageing themes

Table 42 Comparison of scale means by country

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
UK	48.01	50.68	50.68	50.89	49.72
Germany	50.41	48.96	49.18	48.97	49.95
Netherlands	53.80	52.19	51.13	51.47	49.81
Sweden	51.84	52.62	51.32	51.20	51.58

The UK had the lowest scores for scale 1, while the Netherlands had the highest. Germany had the lowest scores for scale 2, while Sweden had the highest. Germany again had the lowest for scale 3, while Sweden just surpassed the Netherlands with the highest average score. Germany was lowest for scale 4, with the Netherlands this time taking the top spot. For the final scale, the UK was the lowest ranked, while Sweden was the highest.

The UK

Table 43 Comparison of theme means in the UK

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Mean (t)	48.01	50.68	50.68	50.89	49.72
Z mean	-.1990	.0445	.0683	.0842	-.0272
Min	-2.407	-2.123	-3.570	-2.706	-3.438
Max	1.322	1.454	1.250	1.412	1.869

Table 44 Correlations among themes in the UK

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Theme 1	–	.127*	.087	.140**	.027
Theme 2		–	.139**	.220**	.136**
Theme 3			–	.162**	-.022
Theme 4				–	.055
Theme 5					–



Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p-value = 0.05)

The UK had the highest ratings for scale 4, social inclusion and participation, while the lowest was for income and poverty in scale 1. There was a small but statistically significant relationship between scales 1 and 2, indicating that as income rises, health and health provision ratings also rise.

Scale 1 also related significantly with scale 4, social inclusion and participation. The higher income and comfort level with income, the more social activity among those over 65 in the UK.

Scale 2 was positively and significantly related with scales 3, 4, and 5, though scale 4 was the strongest. This indicates that as the health of those over 65 in the UK increases, so does their social participation. The same relationship, but to a less degree, applies to health with well-being, and health and views on age discrimination.

Finally, scale 3 and 4 were positively and statistically correlated, indicating that as the well-being of older people in the UK increases, so does their social participation.

Germany

Table 45 Comparison of theme means in Germany

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Mean (t)	50.41	48.96	49.18	48.97	49.95
Z mean	.0417	-.1034	-.0814	-.1026	-.0045
Min	-2.407	-2.123	-3.570	-2.706	-3.438
Max	1.322	1.454	1.250	1.412	1.869

Table 46 Correlations among themes in Germany

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Theme 1	–	.326*	.286**	.277**	.078
Theme 2		–	.238**	.338**	.075
Theme 3			–	.250**	.000
Theme 4				–	.012
Theme 5					–

Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p-value = 0.05)



Germans over 65 provided the best ratings on scale 5, levels of age discrimination, though the worst ratings for scale 4, social inclusion and participation.

We uncovered a moderate and statistically significant relationship among scale 1, income and poverty, and scales 2, 3, and 4. In each case, as the level of income for those over 65 increased, the health, well-being and level of social inclusion also rose.

Scale 2 also significantly and positively related to well-being, so as health and health provisions increase, so does well-being.

Health and social participation were significantly and positively correlated, and this positive significant relationship was the strongest among all the relationships.

Finally, there was a significant and positive association between well-being and social participation for the German elders, in that the higher scores of well-being, the more social activities they participate in. Scale 5 was not significantly related to any other scale for this country's samples.

The Netherlands

Table 47 Comparison of theme means in the Netherlands

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Mean (t)	53.80	52.19	51.13	51.47	49.81
Z mean	.3805	.2199	.1133	.1476	-.0181
Min	-2.407	-2.123	-3.570	-2.706	-3.438
Max	1.322	1.454	1.250	1.412	1.869

Table 48 Correlations among themes in the Netherlands

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Theme 1	–	.311**	.044	.221**	-.070
Theme 2		–	.174*	.144*	.055
Theme 3			–	.138**	-.117
Theme 4				–	-.069
Theme 5					–

Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p-value = 0.05)



The sample of elders from the Netherlands provided exceptionally high ratings overall, though the highest was for scale 1: income and poverty. The lowest rating was for scale 5, age discrimination, though this value was still above the mean.

A significant and positive correlation was found between scale 1 and scales 2 and 4. This indicates that as income rises, so do health and health provision ratings, as well as levels of social participation.

Scale 2, health and health provision, was slightly, but significantly, related to scales 3 and 4. This indicates that as health ratings rise, so do ratings of well-being, and social participation.

Finally, well-being and social participation were positively and statistically correlated, indicating that as well-being increases, so does social participation. Once again, scale 5, age discrimination, did not significantly relate to any of the other scales for the country's samples.

Sweden

Table 49 Comparison of theme means in Sweden

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Mean (t)	51.84	52.62	51.32	51.20	51.58
Z mean	.1840	.2626	.1321	.1202	.1587
Min	-2.407	-2.123	-3.570	-2.706	-3.438
Max	1.322	1.454	1.250	1.412	1.869

Table 50 Correlations among themes in Sweden

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Theme 1	–	.195**	.131	.140*	-.074
Theme 2		–	.218**	.243**	.057
Theme 3			–	.247**	.000
Theme 4				–	-.069
Theme 5					–

Note: **Indicators that demonstrated statistically significant differences between the countries' mean scores (p-value = 0.05)

The samples of older people in Sweden also gave high scores on all five scales, with scale 2, health and health provision, as their top rated. Interestingly, scale 3, well-being, was the lowest



of the five scales, though still above the statistical average.

A significant and positive correlation was found between scale 1 and scales 2 and 4. This indicates that as income rises, so do health and health provision ratings, as well as levels of social participation.

Scale 2, health and health provision, was significantly related to scales 3 and 4. This indicates that as health ratings rise, ratings of well-being and social participation rise moderately as well.

Finally, well-being and social participation were positively and statistically correlated, indicating that as well-being increases, so does social participation. As before, age discrimination in scale 5 was not related significantly to any of the other scales for the country's samples.



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