The Oxford Institute of Population Ageing

The Development of the Healthy Ageing Economy

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Introduction

In recent years, there has been a growth in the number of organisations with an interest in older adults working with and for older adults in the United Kingdom, both nationally, regionally and locally. In addition, there has been a growth in the number of corporate bodies who see the commercial opportunities in ageing populations. The United Kingdom also has strong expertise in both the NGO and private sector as far as the provision of services and goods for older people and their families is concerned.

This report – the first of a series of five reports – will explore the development over the latter half of the 20th century and up to the present day of the healthy ageing economy.

The second report will present an overview of key national organisations working with and for older people (directly or indirectly) in the United Kingdom. It will also include selected local organisations working in the field. This will be complemented by selected international case studies.

The third report will present a similar overview of key corporate organisations working with and for older people (directly or indirectly) in the United Kingdom.

The fourth report of the series presents a scoping and mapping of policy initiatives for older adults. This will comprise a review of relevant national government policies, enabling a synthesis of challenges, and possible solutions from the design world.

The fifth report will present the UN/WHO Age-friendly city initiative, with selected case studies from different continents.

The main methodology employed throughout has been desk research drawing on government documents, organisation publications and web resources. In a number of cases, key individuals have been invited to submit materials which have been utilised. Each report has extensively referenced all materials which have been sourced and used in the reports.

Contents

Prologue

As in much of the high income world, the population of the UK has aged dramatically in the latter part of the 20th century, and continues to do so in the 21st century. Not only are more and more of us living longer and longer, but we are also remaining relatively healthy, independent and active for most of these increasingly long lives. And as these countries have aged, there has been an increasing focus on the provision of support for the ever-increasing number of older people in the population – financial, social and health care support – and this focus has brought with it quite rightly an increasing awareness of the changing nature of these ageing populations and the older people in them. An awareness that older people today are very different from older people of our parents' and grandparents' generations – that they are healthier, more active and engaged, and willing and wanting to contribute to society, both at home in their families, in their communities and in the workplace. In the meantime, governments have struggled even to begin to comprehend these fundamental changes, and therefore we have seen 21st century challenges addressed with 20th and even 19th century structures, if they are addressed at all (Leeson & Harper 2006, 2007, 2007a and 2007b)[1].

With this increasing awareness – particularly after the 2nd World War – we have seen the emergence of non-governmental initiatives to complement national and local government initiatives to support older people, both for and not-for-profit, and more recently the ageing of our populations has become a magnet for businesses providing

[1] Leeson, G.W. & Harper S. (2007) The Global Ageing Survey (GLAS) - Ageing and later life, Hong Kong and Asia, Research report 307, Oxford Institute of Ageing, University of Oxford.
Leeson, G.W. & Harper S. (2007) The Global Ageing Survey (GLAS) - Ageing and later life, the Americas, Research report 207, Oxford Institute of Ageing, University of Oxford.
Leeson, G.W. & Harper S. (2007) The Global Ageing Survey (GLAS) - Ageing and later life, United Kingdom and Europe, Research report 107, Oxford Institute of Ageing, University of Oxford.
Leeson, G.W. & Harper S. (2006) The Global Ageing Survey (GLAS) – Attitudes to ageing and later life, Research report 106, Oxford Institute of Ageing, University of Oxford.

everything the modern older person could ever need, from intercontinental travel to mobility scooters, from luxury living to grab rails. The potential is seemingly endless.

And it is all driven by something as simple as numbers, or shall we say demography?

1. The demography

The 20th century saw a dramatic transformation of the population structure of the UK as changes in the levels of fertility, mortality and migration manifested themselves. By the early 1920s the traditional population pyramid (representing the age and sex distribution of the UK population) at the beginning of the 20th century had already changed quite dramatically, with the base of the pyramid, which represents predominantly births, contracting while the middle section of the pyramid, affected predominantly by declining mortality and immigration, was expanding.

So by the mid-1920s, for example, those aged under 15 years comprised 28 per cent of the total male population and 25 per cent of the total female population. By 2015, these proportions had decreased to 18 and 17 per cent respectively. This shrinking of the young population is one dimension of an ageing population. The second dimension is the increasing proportion of older people in the population, and in the UK in this same period, the proportions aged over 65 years had increased from 6 per cent for males and 7 per cent for females to 16 and 19 per cent respectively.

As already suggested, these changes are formed and driven by changing levels of fertility and mortality.

Let us consider fertility levels first of all, and also the drivers of the changes in levels of fertility[2]. The situation is complex.

The early work of Easterlin[3] suggested that economic uncertainty and rising unemployment reduces the tendency to marry and have children. This work outlined the classic economic theories of fertility, which acknowledge the role of the costs of children and even further distinguish between direct costs such as food, clothing and

[2] Leeson, G.W. (2018) Global demographic change and grandparenthood, *Contemporary Social Science*, pp. 1-14.

[3] Easterlin, R. (1968) *Population*, *Labor Force and Long Swings in Economic Growth*, National Bureau of Economic Research, New York.
Easterlin, R. A. (1976) The conflict between aspirations and resources, *Population and Development Review*, Vol. 2(3), pp. 417–425.

education and indirect (opportunity) costs such as loss of income. It has been argued that the patterns of economic development across the 20th century led to a century of more or less uninterrupted fertility decline, in as much as this economic development had increased both the socially constructed costs of children and the opportunity costs of responsible parenthood[4]. It appears that levels of educational attainment of females appear to influence fertility behaviour even in situations where there is no increasing labour force participation[5], but the costs of having and rearing children also influence the decision-making processes associated with reproductive behaviour[6]. As the cost per child increases then the number of children decreases[7] so that as disposable income increases with economic growth this increases the opportunity costs of having children, and there does seem to have been a significant body of evidence underpinning this negative correlation between economic growth and fertility (op cit 6), but this has been challenged by more recent findings[8] which suggest a convex impact of economic growth on levels of fertility. Other factors could also influence the development of fertility, for example, housing although the available evidence is suggestive but not conclusive, highlighting rather the complex of associated factors which may also impact on fertility[9]. Social and cultural factors may well play a role,

[4] Preston, S. (1986) Changing values and falling birth rates, *Population and Development Review*, Supplement Vol. 12, pp. 176-195.
[5] Jain, A.K. (1981) The effect of female education on fertility: a simple explanation, *Demography*, Vol. 18 (4), pp. 577-595.
[6] Grant, J. et al (2004) *Low fertility and population ageing: causes, consequences and policy options*, MG205, RAND, Santa Monica, California.
[7] Becker, G. (1960) *An economic analysis of fertility*, Universities-National Bureau of Economic Research Conference, Series 11, pp. 209-231.
[8] Luci, A. & Thevenon, O. (2010) *Does economic development drive the fertility rebound in OECD countries?* Working paper 167, L'Institut National D'Etudes Demographiques (INED), Paris.
Myrskyla, M., Kohler, H. et al (2009) Advances in development reverse fertility declines, *Nature*, Vol. 460 (7256), pp. 741-743.
Orsal, D.D. & Goldstein, J.D. (2010) *The increasing importance of economic conditions on fertility*, Working Paper 2010-014, Max Planck Institute for Demographic Research, Rostock.
[9] Kulu, H. & Vikat, A. (2008) Fertility differences by housing type: an effect of housing conditions or of selective moves? *Demographic Research*, Vol. 17 (II-26), pp. 775-820; Mulder, C.H. & Billari, F.C. (2010) Homeownership regimes and low fertility, *Housing Studies*, Vol. 25 (4), pp. 527-541.

but evidencing is more problematic, and the relationships between public policy and fertility are similarly complex and difficult to determine[10].

Fertility in the UK declined steadily after the turn of the 20th century towards replacement level in what was regarded as the continued fertility decline of the demographic transition[11] and then to below replacement level in what became known as the second demographic transition[12]. In the 1970s to 1990s, these baby-bust levels of fertility in many high income countries were unprecedented and not expected to remain at these levels, but as a result, the UK has been in an extended period of below replacement level fertility for almost 40 years. Recent evidence would suggest, however, that levels of fertility are increasing towards replacement level, but it should be noted that a previous increase in fertility from 1977 until 1980 was followed by a 20-year long decline. In line with declining fertility, age at first birth increased from around 20 to around 30 years, something which in itself limited the potential level of completed fertility.

History has clearly shown that predicting future levels of fertility is fraught with difficulty. The evidence available is that the UK has now been in this low fertility "trap" for almost 40 years, and there would appear to be reliable evidence that this is likely to change significantly in the coming decades. Small families at the population level have become the norm, and modern lifestyles – in line with Easterlin's theories – are not conducive to large families. There are concerns in some countries about these low levels of childbearing, and governments there are looking to find ways to encourage higher levels of childbearing. The arguments for this course of action being the ageing of the population and the dependency on immigration to maintain the

[10] Gaier, A.H. (2007) The impact of family policies on fertility in industrialized countries: a review of the literature, *Population Research and Policy Review*, Vol. 26, pp. 323-346.
[11] Kirk, D. (1996) Demographic transition theory, *Population Studies*, Vol. 50 (3), pp. 361– 387.
[12] Van de Kaa, D.J. (1987) Europe's second demographic transition, *Population Bulletin*, Vol. 42 (1), pp. 3–57.

workforce (in the face of the ageing of the population and the low levels of childbearing).

An equally fundamental shift in demography has been the continuing extension of our life expectancies.

Globally, life expectancies have been increasing steadily since the turn of the 20th century[13], but what has been particularly striking is the improvement in survival at older ages[14] and there is an increasing body of evidence that lives will continue to be extended for some time to come[15]. Indeed, there is strong historical evidence to support this future[16] in as much as female life expectancy at birth in the longest lived country at any time has increased year on year since 1840 at a rate of approximately 2.5 years per decade, and the same is true, but at a slower rate, for males[17].

The first half of the 20th century saw life expectancies at birth for both males and females in the more developed world increase by around 20 years. This was driven primarily by declines in mortality among younger age groups, but the future development in mortality will be dominated by declines among older age groups, reflecting the demographic reversal of the earlier conviction that mortality at older ages was intractable[18]. However, while life expectancy at birth has increased steadily,

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[13] Leeson, G.W. (1982) Demographic Ageing in Denmark in the 20th Century, *The Eugenics Society Bulletin*, Vol. 14, pp. 46-52.

[14] Leeson, G.W. (1981) Ældres dødelighed 1960-1980 (The mortality of older people in Denmark, 1960-80), *Ugeskr. Læger*, 143, pp. 2324-7.

Vaupel, J. (1998) Demographic analysis of aging and longevity, *The American Economic Review*, Vol. 88 (2), pp. 242-247.

[15] Leeson, G.W. (2014) Future prospects for longevity, *Post Reproductive Health*, Vol. 20 (1), pp. 17-21.

Leeson, G.W. (2016) The impact of mortality development on the number of centenarians in England and Wales, *Journal of Population Research*, Springer, 23 September 2016, pp. 1-15.

[16] Oeppen, J. & Vaupel, J. (2002), Broken limits to life expectancy, *Science, Policy Forum: demography*, Vol. 296, pp. 1029-1031.

[17] Westendorp, R.G.J. (2004) Are we becoming less disposable? *EMBO Reports 5*, pp.2-6.

[18] Wilmoth, J.R. (1997) In search of limits: what do demographic trends suggest about the future of human longevity, in *Between Zeus and the Salmon* (eds. Wachter, K.W. & Finch, C.E.), National Academy Press, Washington DC, pp. 38-64.

Vaupel, J. (1998) Demographic analysis of aging and longevity, *The American Economic Review*, Vol. 88 (2), pp. 242-247.

life expectancy at age 65 was slow in beginning to increase. Indeed, from the mid-19th century to the early 20th century, it remained more or less the same, and the difference between male and female life expectancy at age 65 was small. The turn of the 20th century saw life expectancy at age 65 begin to increase steadily – particularly for females, and with this came a divergence of male and female life expectancies, mirroring the development to some extent for life expectancies at birth. Around the world, new generations can expect to live longer than previous generations, and the rate of increase is surprisingly strong and constant (op cit 15).

This development is replicated in the UK, although in recent years there is evidence cross-sectionally at least that the pace of improvement in life expectancy is slowing down and that mortality rates in some age groups are increasing or stagnating[19]. As people have been living longer we have seen steady increases in life expectancy for many decades, however, since 2011 these increases have been slowing down. More specifically, mortality rates have continued to improve for those aged 55 to 89 years in the UK, but as mentioned, the rate of improvement has slowed, and mortality rates for those aged 90 years and over in the UK have shown no improvement since 2011. At the same time, mortality rates among those aged 15 to 54 years have been increasing since 2012 in the UK.

Prior to this slowing down (now possibly exacerbated by the Corona pandemic), there had been significant declines in mortality among the extreme aged with the age-specific mortality rate for females in their early 80s, for example, declining from about 120 per 1000 population in the 1950s to 75 by the 1990s. Improvements were also observed for males in their early 80s, their mortality rate falling from around 160 to 120 per 1000 population in this same period. This has of course impacted on life expectancies in later life.

[19] *Changing trends in mortality: a cross-UK comparison*, *1981 to 2016*, ONS, 2018.

Period life expectancy at birth[20] in the UK had as mentioned been steadily increasing, with males gaining 2.38 months per year over the previous 60 years, and females slightly less at 2.14 months per year. The gender difference in life expectancy at birth had been largest during the late 1960s, when it was over 6 years, but the difference has since decreased, and is currently less than 4 years. By 2020, life expectancy at birth had reached 79.8 years for males and 83.3 years for females.

Over this same 60-year period, life expectancy at ages 65 and 80 in the UK have increased as mid and late life mortality have declined. At both ages, female life expectancy has increased slightly faster over the whole period. At age 65 years, the gain for females has been 6.32 years compared with 6.08 for males. At age 80 years, the gain for females has been 3.5 years compared with 3.05 years for males. The gender differential has, however, been decreasing from the late 1970s (for 65-year-olds) and the early 1990s (for 80-year-olds), following the same pattern as that outlined above for overall life expectancy.

Another way of expressing these improvements in mortality is by way of survivorship. In the first half of the 20th century, improving survivorship was almost all limited to younger ages, but after 1950, survivorship from birth to age 15 years in the UK has stagnated, simply because death before age 15 has been more or less eliminated. On the other hand, survivorship from age 60 to age 75 years has improved so that 81 per cent of 60-year-olds now survive to age 75 years and 92 per cent of a birth cohort survives to age 60 years.

Old age as we currently define it is something that awaits us all.

Despite the slowing down in the increasing life expectancy mentioned above, it is predicted that life expectancies will continue to increase in the coming decades[21] reaching 83.4 years for males and 86.2 7ears for females by 2050. The increasing trends

[20] Period life expectancy is calculated assuming age-specific mortality rates observed in the given year remain constant in the future.
[21] *Expectation of life, principal projection, UK*, ONS, December 2019.

in life expectancy are projected to continue to beyond the middle of the 21st century (and beyond), with life expectancies at birth reaching 85.4 years for males and 88 years for females in 2068, reducing the gender difference to around 3 years.

These same ONS data reveal that in 2020, life expectancy at age 65 is 19 years for males and 21.2 years for females, increasing to 21.4 years for males and 23.4 years for females by 2050. At age 80, current life expectancies of 8.6 years for males and 9.8 years for females are predicted to reach 10.1 and 11.2 years respectively by 2050. This means that by 2050, life expectancies at age 80 will be at levels observed at around age 70 years at the beginning of the 1980s, while life expectancies at age 65 in 2050 will correspond to those observed at age 50-55 years at the beginning of the 1980s.

Cohort life expectancies[22] in the UK are significantly higher than the period life expectancies discussed above. Therefore, for a boy born in 2020, the cohort life expectancy is 87.9 years (compared with the period value of 79.8 years) and for a girl it is 90.5 years (compared with 83.3 years). By 2050, these cohort life expectancies at birth are expected to reach 91.1 years for a boy born in 2050 and 93.2 years for a girl – again showing a converging gender gap in life expectancy at birth.

In other words, the demography of the future remains one of an ageing population, with life expectancies at birth creeping ever closer to 100 years by the end of the 21st century. Indeed, this will also be a century of centenarians[23]. This development brings challenges and opportunities as these future cohorts of older people in the UK bring with them into old age different aspirations and expectations.

How do we shape this future?

[22] Cohort life expectancy is calculated assuming that age-specific mortality rates change over time.
[23] Op.cit. 15, Leeson (2016).

2. The emergence of organisations working for and with older people

Interestingly, as the welfare state developed and expanded, providing more and more support to more and more citizens, there has also been a paradoxical growth in non-governmental organisations established to meet the needs of those falling outside the safety net of this welfare state. This is also true in respect of organisations working for and with older people, and not just in the UK.

Before looking at the emergence of organisations working for and with older people, it is perhaps useful to consider three institutional structures which historically defined older people as a separate group from everyone else, and which have fuelled the need for these organisations.

The three institutional structures are:

Alms houses

Pension systems

Geriatrics as a medical speciality.

Alms houses developed from institutions for poor disadvantaged of all ages (with older people a small minority among them) to institutions populated by older people, a result of the development of welfare for specific groups (poor, sick, disabled). This meant that the group of (all) older people became homogenised into this group needing help and support (away from the community).

The introduction of **pension systems** created a marginalised social space for older people – these systems define an exact age beyond which citizens become dependent, separated from the productive section of the population. This then provides a well-defined phase of life called old age, anchored in society's judicial and administrative structure.

The statistical preconditions needed to regard older people as a well-defined group within legislation are to a great extent linked to the work of Belgian statistician, Quetelet (1796-1874):

"*Man is born, grows up, and dies, according to certain laws which have never been properly investigated……..*"

This approach facilitates a statistical definition of old age based on probabilities, and along with this comes the opportunity to treat and understand older people collectively as a group in a **chronologically defined phase of life**.

This is closely related to the final institutional structure – the medicalisation of the ageing body/person. Geriatrics is born as a discipline around 1840 and has Quetelet as its actual and most important basis. Medicine dominated ageing – geriatric medicine was in the *business* of defying ageing – even defying death. The medicalisation of ageing – helped by the marginalisation of old age and older people – led to the dominant image of ageing (and old people) as one characterised by the tired, failing, ageing body. Medicine had a monopoly on even the social construction of old age. It was here the research was focused – on ill health and combatting this ill health in later life.

However, it was around the time of the introduction of pension systems in Europe that civil society organisations working for older (poor and disadvantaged) people began to appear.

So for example, in 1905, The Church Army League of Friends of the Poor was founded by The Church Army's founder, Wilson Carlisle. Its main aim at the time was to recruit an army of volunteers to befriend poor families. However, in 1911, the organisation became independent and 60 years later changed its name to Friends of the Elderly. Elsewhere in Europe, In Denmark, for example, the Copenhagen clergyman Hermann Koch established EGV in 1910. He was one of the first in Denmark to draw attention to the needs of poor, older people. It happened at a time when it was difficult to be

old if you did not have close family with resources. One of Koch's first initiatives was Christmas parties for poor older people, where Copenhagen university students joined in to help – a true intergenerational activity! As it grew, EGV collected money to establish activities - for example, a rural retreat where poor old people from Copenhagen could take a summer break outside the city. Within EGV, later, the Danish Folk High School Tradition was adopted specifically for older people, and more recently the organisation established DaneAge, one of the largest (relatively) organisations working for and with older people in the world.

The emergence of such organisations in the UK gathered momentum as a result of the 2nd World War, at which time there was a growing realisation of the effects of the war on older people. Conscription had led to the dislocation and breakdown of family life and there was a recognition that the existing poor laws could not provide the needed support for older people whose family support networks had been shattered.

Not surprisingly, this history is closely linked to the history of what is now known as Age UK, so in the following we shall outline this history to provide the broader context of work with and for older people in the UK by non-governmental organisations.

In 1940, the Old People's Welfare Committee was formed as a forum for discussion between government and voluntary organisations. The committee changed its name in 1944 to the National Old People's Welfare Committee and became responsible for the co-ordination of the activities of local older people's welfare committees across the country. The national committee was able to access government and local funds as the government pursued the development of the welfare state from the 1950s onwards and these funds enabled the committee to provide services to local committees, and also to train wardens of old people's homes. This reliance on government funding was unsustainable if the committee was to represent older people and campaign for their needs to be met by that self-same government, but it was decided to break this link – a risky decision, but one that has proven to have been the right decision. The charity moved to new premises and managed to negotiate that it would retain its government

grant, but more importantly a salaried and accountable CEO was appointed. Shortly after this development, in 1971, the organisation changed its name yet again. It became Age Concern and at the same time separated from government completely and from the National Council for Social Service. All of this while launching its *manifesto for old age*. The organisation was now a national lobby on behalf of older people but also an organisation that engaged in service provision to local governments.

So a great deal was happening in terms of non-governmental response to the needs of older people, not just in the UK but further afield. In 1961, the Help the Aged Refugees Appeal was set up and raised £105,302 in its first year to address the needs of older refugees impacted by natural disasters and the conflict in the former Yugoslavia, former East Pakistan (now Bangladesh) and Rwanda. The organisation was renamed Help the Aged and in addition to continuing its international aid work, it began working with and for older people in the UK particularly in respect of establishing day centres and pioneering better housing for older people.

As the population aged and the new generations of older people expected different lifestyles from those of their parents and grandparents, the *business potential* materialised, and in 1977 Help the Aged (Trading) Ltd was launched. Its aim was to raise funds through commercial activities. And it was not just the UK population which was ageing. This was becoming a global phenomenon. In response, HelpAge International was founded in 1983, a network of organisations including Help the Aged which would work globally to improve the quality of life of older people. At home, the work of both Age Concern and Help the Aged – along with many more local and regional organisation – expanded to address the social, political and financial changes which were impacting older people's lives. In terms of lobbying and campaigning on behalf of older people both nationally, regionally and locally, the many organisations across the UK sharing the name Age Concern came together in a federation to strengthen this work, but also to reflect the independence and autonomy but also the interdependence of the many organisations. Meanwhile, Help the Aged

was extremely successful with its many campaigns, for example against elder abuse and age discrimination.

And the business side of the activities had not been forgotten. In the early years of the 21st century, Help the Aged launched a series of business initiatives, ranging from ethical gifts to support its work overseas to financial products for the over-50s.

In retrospect, it was a natural development that saw Age Concern England and Help the Aged merge into what is now known as Age UK to continue the work for and with older people in the UK.

3. The emergence of the old age industry

In the previous section, we have alluded to the fact that the business potential arising from an ageing population was acknowledged at a relatively early date. In the last 20-30 years, this area has expanded significantly. Today, it is in its own right *big business*.

The silver economy! As the baby boomers have aged and societies have become increasingly aware that these new generations of older people will be healthier, more active, more independent, better educated and – most importantly in this context – wealthier than previous generations, then the market has seen its opportunity.

A blog post for the Oxford Institute of Population Ageing describes this as the burgeoning silver economy[24]. The size of this economy is formidable, and not just in the UK, and it is attracting not just business and research but also governments[25]. Europe's silver economy was estimated to have a value of €3.7 trillion in 2015, and is expected to increase to €5.7 trillion by 2025[26]. In the UK, spending by older consumers

[24] Lloyd, D. (2020) The Burgeoning Silver Economy, Blog-post, Oxford Institute of Population Ageing, January 2020.
[25] As part of its Industrial Strategy, the UK Government has pledged £98 million to support innovation to promote healthy ageing.
[26] *The Silver Economy*, European Commission, Bruxelles, 2018.

is expected to rise from £319 billion, corresponding to 54 per cent of total consumer spending, in 2018 to £550 billion and 63 per cent by 2040[27].

So, this is a massive market to tap into, and one could be excused from thinking that those descending on this burgeoning economy are reminiscent of the proverbial bees round a honey pot, but it is not a new phenomenon. Instead, it is a phenomenon which business has been slow to address, even though its potential was being highlighted in the 1960s[28], and again in the 1980s[29] and again in the 1990s[30]. Indeed, in the mid-1980s, the older population as a market segment was even named *The Methuselah Market*[31] and defined (in the UK) as those within 5 years of before/after retirement. It is interesting to note that one of the results of this research echoes that found 20 years later in Oxford's Global Ageing Survey (GLAS), namely that those in early retirement had a far more positive attitude to retirement than those approaching retirement[32]. However, even though there was repeated (academic) interest in this market segment of the population, it was largely viewed as a segment that had been and continued to be ignored[33]. There would appear to have been three reasons for this state of affairs vis a vis older consumers, namely their (perceived) lack buying power, their unattractiveness compared with young consumers (with whom the market was obsessed), and a lack of knowledge about their consumption patterns.

So, it was generally assumed that older consumers had low incomes and little spending power whereas in actual fact in the years leading up to retirement they had in all likelihood their highest income, and even after retirement their disposable

[27] *Maximising the Longevity Dividend*, International Longevity Centre UK, London, 2019.
[28] Morse, L. (1964) *Old Folks: An Overlooked Market?* Duns Review and Modern History, Vol. 83, April, 45, 46, pp. 86-88.
[29] Schewe, C. D. (1988) Marketing to our Aging Population: Responding to Physiological Changes, *Journal of Consumer Marketing*, Vol. 5, No. 3, pp. 61-73.
[30] Moschis, G.P. (1992) *Marketing to Older Consumers – A Handbook of Information for Strategy Development*, Westpoint, Connecticut, Quorum Books.
[31] Tynan, A.C. & Drayton, J.L. (1985) The Methuselah Market, *Journal of Marketing Management*, Vol. 1, pp. 75-85.
[32] Op.cit 1, Leeson & Harper.
[33] For example, Phillips, L. W. & Sternthal, B. (1977) Age differences in information processing: A perspective on the aged consumer, *Journal of Marketing Research*, Vol. 14(4), pp. 444-45.

income remained high. And yet, there was a prevalent *cult of the young*. Advertising targeted and was populated by young people actively out there spending, amounting almost to an obsession with young consumers[34]. Interestingly, it was even argued in the UK that part of the problem here was that perceptions of older people were strengthened by the *cult of need of older people*, understandably portrayed by organisations such as Age Concern and Help the Aged, all of which links into the institutional structures defining old age and older people, as discussed above. This gave us the negative stereotypical image of older people as a homogenous group all in need of care and support waiting out their final years doing nothing – at least as far as the market was concerned.

And there was good reason for believing this. Commercial media depended on income from advertising and because older people were perceived as non-consumers they were invisible in advertising. Everyone was aware of the absence of both product and media activity targeting older consumers and this reinforced the negative stereotype of older people which in turn meant that new products and services for older consumers were not forthcoming. In other words, there was a circular self-reinforcement of this myth.

This UK perspective is repeated in the US context too[35].

Fast forward to today and the silver economy is burgeoning! The European Union commissions work on the silver economy and the UK government's healthy ageing programme as part of its Industrial Strategy targets the group of older people as consumers. And the days when marketing and advertising campaigns focused solely on the cult of youth have gone as it is recognised that the older segment of the population (still) represents a significant untapped market[36].

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[34] Bartos, R. (1980) Over 49: The invisible consumer market, *Harvard Business Review*, Vol. 58(1), pp. 140-148.
[35] *H. Lee Meadow, H., Stephen C. Cosmas, S.C. & Plotkin, A. (1981) The Elderly Consumer: Past, Present, and Future, Advances in Consumer Research, Vol. 8, pp. 742-747.*
[36] Klebl, K. (2007) *Development of the Generation 50-plus – Effects on retail marketing*, Saarbrücken, VDM Verlag, Dr. Müller.

So what is the silver economy and why is so important?

Broadly speaking, the silver economy is that part of the general economy which is related to the needs and demands of older adults (those over the age of 50 years) and is therefore includes the products and services purchased directly by those in this segment of the population as well as the economic activity generated by this spending. With this definition, the silver economy comprises all economic activities – both public and private and both direct and indirect - related to the production, consumption and trade of goods and services which address the needs and desires of older people.

For several decades now, policy-makers have addressed the societal challenge of an ageing population, focusing initially on the sustainability of health and social care and the provision of pensions. However, in more recent years, the opportunities as well as the challenges of an ageing population have been recognised and this means that focus has been extended to include a whole range of innovative activities designed to improve the quality of life of older people. As such of course, while addressing the needs and desires of older people, the silver economy also offers opportunities for younger generations.

Older people do of course spend, but as we age, our spending on "non-essential" items declines while our spending on essential items remains more or less unchanged[37]. A number of factors may drive this development of spending with age, for example deteriorating health and the inappropriateness of retail environments as well as goods available, along with and an increasing tendency to save *just in case*. The UK government has supported inclusive design and, as mentioned, has pledged £98 million to support innovation in goods and services as part of its Industrial Strategy Grand Challenge on healthy ageing. In addition, the Government has established a

[37] Brancati, C. Beach, B. Franklin, B and Jones, M. (2015) *Understanding retirement journeys: Expectations vs reality*, ILC-UK, London.

Longevity Council to advise how the quality of life of older people can be improved by innovations in products, services and technology.

The silver economy would benefit from innovations to enable and encourage people to remain in work longer (and beyond the state pension age) as this clearly would benefit those individuals wishing to extend their working lives as well as the wider economy, and the UK government has introduced various measures to encourage this development, for example *Business in the Community* in 2016 was designed to increase the number of 50-69 year olds in work by 1 million by 2022.

Increasing older consumer spending would benefit the silver economy too. According to a 2019 report from the ILC-UK[38], older households have had the greatest share of consumer spending since 2013, and this share is expected to rise from 54 per cent in 2018 to 63 per cent in 2040. The over-50s segment of the population is becoming increasingly important to the UK economy in as much as older households are predicted to spend £550 billion a year by 2040[39], which will amount to 63 per cent of total household spending. Not only is this absolute spend significantly more than today, when it stands at about £231 billion, but it is also significantly more than the predicted spend of younger households by that same year.

But of course the *over-50s* and *older households* are broad categorisations within the population, and breaking these groups down provides some interesting data for other sub-segments of these population groups. For example, retired households are the prime drivers of the increased spending of older consumers. Their total spending increased by 75 per cent in the period from 2001 to 2018, which compares to the 16 per cent contraction of spending of households aged under 50 in this same period. Much of this is driven itself by the increase in the number of retired households and the decline in the number of younger households, a result of the demographic development outlined above, and therefore the contribution to GDP has

[38] Op cit 27.
[39] This excludes spending on housing.

increased/declined accordingly for the older/younger groups respectively. So, the average spending of the older consumer has increased, but since 2001 the average spending of younger households has been greater than the average spending of over-50s households aged 50 and over, even though the difference in average spending has decreased, and it is expected that by the early 2030s, older households will be spending more than younger household[40]. It is interesting to note that the decline in spending which has traditionally been observed after retirement now occurs at increasingly older ages with a significant decline after age 75 years[41].

So what are these older consumers spending their money on?

Not surprisingly, spending is over a wide range of forms of consumption. Approximately 25 per cent of the older consumer spending in the private sector is on housing and utilities. This spending was worth €815b across the EU Member States in 2015[42], and if food, beverages and transport are added then spending on these categories comprises about 50 per cent of all older consumer spending. It is interesting to note that EU-wide in 2015, spending on social service support for older and disabled (and other) people is extremely modest, accounting for only just over 1 per cent of private consumption, and the figure is below 1 per cent for older consumers.

More specifically, in the UK, certain sectors are expected to experience significant growth in older consumer over the next 20 years. This applies to recreation and culture, transport and household goods and services, while spending by older consumers on health is expected to decline by more than 20 per cent[43]. It would appear that older consumers are choosing increasingly to spend on so-called non-essential goods (recreation and culture and restaurants and hotels, alcohol, miscellaneous,

[40] This holds true for so-called equivalised expenditure too, so this development is not attributable to changing household composition. Equivalisation means that members of a household receive different weightings and the total household income is then divided by the sum of the weightings to yield a representative income. These equivalised measures take into account household size and composition thereby allowing a robust comparison.
[41] Brancati, C. & Sinclair, D. (2016) *The Missing £Billions. The economic cost of failing to adapt our high street to respond to demographic change*, ILC-UK, London.
[42] Op.cit. 26.
[43] Op.cit 27.

communication and household goods and services), but the question remains whether or not businesses understand the wants or the needs of this segment of the population.

Of course, the silver economy is not simply a question of spending. Older people continue to work, some significantly beyond the state pension age, and the research shows clearly that older people do indeed wish to continue to contribute to society, by working among other things[44]. The link between enabling and encouraging older people to continue to work beyond the state pension age and the silver economy in terms of the increasing and diversifying levels of consumption of this group is clear. Remaining in work will *ceteris paribus* increase an individual's potential spending power.

The silver economy has now become the longevity economy[45]. This 2016 report from AARP and Oxford Economics, although focusing on the US context has wider applicability, and the conclusions echo much of what has been said in the previous work, discussed above. So the so-called *longevity economy* is seen as a major driver of the economy in the United States, thanks to the employment, investment, consumption and charitable activities of the older segment of the population (those aged 50 years and over). Again, it is highlighted that meeting the needs of this group demands both an understanding of the needs of the group (as a heterogeneous and not a homogenous group) and an attractive delivery of these needs. Acknowledging the consumption and spending levels of the group, their influence of the market is also a key factor moving forward.

The report does not neglect the workplace and the older workforce, underlining the need for longer working lives in multiple careers and a strategy to maximise productivity of the group in a society with declining numbers of younger workers.

[44] Op.cit 1.
[45] Oxford Economics (2016) *The Longevity Economy*, AARP/Oxford Economics.

New technologies to enable ageing in place are seen as an important area for research and development in the longevity economy.

The key questions in all of these different approaches are: how will older consumers spend in the future; how will the market engage with these changes; and how will policy support these changes? We conclude this introductory contextualisation by addressing briefly the market and policy reactions.

4. Developing the old age industry

Work commissioned for the European Commission[46] identified 10 sectors and innovations within those sectors, which could drive the silver economy. These are based on the developments outlined above in terms of older consumer spending and older consumer wants and needs. What has to be borne in mind, however, is that – as we have attempted to point out above – the older consumer group can be rather crudely divided into at least two distinct types in terms of the silver economy.

The first type is the new generation of more active, healthier and wealthier older people who wish to maintain as much of their younger lifestyles as possible and at the same time wish to engage in new activities as they reduce working hours, perhaps, or work more flexibly, perhaps, or withdraw from active employment completely.

The second type is the more dependent older person in need of support to remain active for as long as possible.

One could arguably add a third type, namely those at the end of their lives in need of long-term care, but in care settings removed from the institutionalised nursing environment that has pertained thus far in western societies.

The private and public sector has traditionally addressed the needs of types 2 and 3, but the arguments in the research and the literature since the 1960s (as discussed above) suggest there is still a need to address the needs and wants of type 1.

[46] Op.cit 26.

Authors have identified a number of sectors which could benefit from investment in the silver economy[47], for example banks and insurance companies, the automotive sector (including driverless cars and improved forms of public transport), mobile health (often called mHealth)[48], robotics to provide care support and companionship, tourism[49], home-based ICT technologies to monitor healthcare, life style industries to promote active, healthy ageing attractively (including wearable technologies, personalised nutrition and preventative medicines), education and training (similar perhaps to the Danish Folk High Schools[50]), and age-friendly environments in both the public and the private domains.

Clearly, the success of silver economy is dependent on the success of policies to promote and support healthy ageing among all citizens across the life course.

There is currently a lack of scale in solutions. Implementations only take place on a small scale and are scattered across different regions and municipalities. The lack of scale intertwines with a lack of capacity and knowledge on how to develop these solutions at a larger scale and results in few evidenced benefits, no ecosystem of well-aligned stakeholders and the limited availability of solutions. This hinders the possibilities of economic growth and the creation of new jobs that could come with the larger scale implementation of these technologies. While technological solutions exist to assist older people in maintaining an active and healthy lifestyle, there may be a perceived lack of service and business models to support the uptake of such solutions. Even with such models in place, users will only be ready to pay for a service if it provides them with an adequate value.

[47] Op.cit 26 and Meiners, N.H. & Seeberger, B. (2010) Marketing to Senior Citizens: Challenges and Opportunities, *The Journal of Social, Political and Economic Studies*, Vol. 35 (3), pp. 293-328.
[48] mHealth refers to medicine and public health supported by mobile devices, for example mobile phones, tablet computers, and smart watches.
[49] Balderas-Cejudo, M.A. & Leeson, G.W. (2020) Senior Tourism and Customer Experience: Links and Opportunities. In: Saurabh Kumar Dixit (ed) *The Routledge Handbook of Tourism Experience Management and Marketing*, Routledge, pp. 570-579.
[50] Leeson, G.W. (2009) Educacao e aprendizagem ao longo da vida, *Forum Gulbenkian de Saude sobre o Envelhecimento*, Lisbon, Portugal.

5. The development of policy to promote and support the silver economy

It would be natural to suggest that policies from national and regional governments need to encourage the growth of the silver economy but at the same time address the societal challenges of an ageing population. In the UK, this is reflected in the focus on the so-called healthy ageing economy. So generally speaking, any policy or policies being considered should aim to raise awareness among all population groups of the benefits of an active and healthy life-style, which would in addition promote prevention rather than cure by developing and driving forward policies to promote integrated people-centred health services.

It is probably fair to say that while active and healthy ageing as a concept is nothing new, it is only more recently that governments and public health campaigns have begun to invest in the concept. Indeed, in the UK, a strategy for active ageing was proposed almost 20 years ago[51], which argued that a holistic approach to the five key policy domains of employment, pensions, retirement, health and citizenship would enable high-income countries to address the challenges and opportunities arising from the ageing of their populations. In the United States, however, a form of this concept surfaces in the early 1960s as *successful ageing* which referred to the maintenance in older age of behaviours and attitudes hitherto regarded as identifying with middle age behaviours and attitudes[52].

From the idea of successful ageing in the 1960s, the discourse changed – if not in detail then in semantics – to one of so-called *productive ageing* in the 1980s. This was a significant change of focus in as much as it included the concept of development over an individual's life course in acknowledgement of the growing body of research that indicated that chronological age was not necessarily the only predictor of

[51] Walker, A. (2002) A strategy for active ageing, *International Social Security Review*, Vol. 55 (1), pp. 121-139.
[52] Havighurst, R. (1963) Successful ageing, in Williams, R., Tibbitts, C. & Donahue, W. (eds.), *Process of Ageing*, Vol. 1, New York, Atherton.

functionality[53]. In addition, the concept provided a more positive and contributory dimension to human ageing in a societal context and moved the discourse away from a simple (albeit important) one focused solely on policy initiatives to address the challenges of meeting the costs of providing public pensions and health and social care to the increasing numbers of older people. However, as policy makers took on this new concept, they saw only in relation to the workplace, so productive ageing was all about enabling older workers to remain in the workplace and at the same time enabling their employment to be more flexible. In fact, the true meaning of productive ageing centres on the idea that older people continue to contribute to society in all manner of ways, none of which necessarily falls within the strict definition of economic productivity[54]. The long-held societal view of older people as a burden was being seriously challenged[55]. Towards the end of the 20th and the beginning of the 21st century, it was time for a successor to productive ageing. This time the focus would be on preserving mental and physical health as people age rather than simply keeping them in the workplace beyond normal retirement age. The World Health Organisation's (WHO) concept of healthy ageing encompasses the health, the independence and the (broadly defined) productivity of older people in society[56]. Moving forward to 2014, the World Health Assembly asked for a comprehensive global strategy and action plan on ageing and health, and subsequently in early 2016 the *Multi-sectoral action for a life course approach to healthy ageing: global strategy and plan of action on ageing and health* was adopted. This strategy for the 5 years to 2020 had two goals, namely evidence-based action to maximize functional ability that reaches every person, and by 2020 to have established the evidence and partnerships to support a *Decade of Healthy Ageing* from 2020 to 2030. This WHO initiative is an opportunity *to*

[53] Neugarten, B.L. & Datan, N. (1973) Sociological Perspectives on the Life Cycle, in *Life Span Developmental Psycholody* (eds. Baltes, P.B. & Schaie, K.W.), pp. 53-59, Elsevier.
[54] O'Reilly, P. & Caro, F.G. (1995) Productive Aging: An Overview of the Literature, *Journal of Aging and Social Policy*, Vol. 6 (3), pp. 39-71.
[55] Leeson, G.W. (2017) Realizing the Potentials of Ageing, *Journal of Population Ageing*, Vol. 10 (4), pp 1-7.

[56] World Health Organisation (1994) *Health for All: Updated Targets*, Copenhagen: World Health Organisation.

bring together governments, civil society, international agencies, professionals, academia, the media, and the private sector for ten years of concerted, catalytic and collaborative action to improve the lives of older people, their families, and the communities in which they live and outlines ten priorities towards a decade of healthy ageing[57].

The ten priorities put forward by WHO are:

Establishing a platform for innovation and change by connecting people and ideas;

Supporting country planning and action to create policies that enable people to live long and healthy lives;

Collecting accurate up-to-date and meaningful data on healthy ageing;

Promoting research that addresses the current and future needs of older people;

Aligning health systems to the needs of older people;

Laying the foundations for a long-term care system in every country;

Ensuring the human resources necessary for integrated care;

Undertaking a global campaign to combat ageism;

Defining the economic case for investment;

Enhancing the global network for age-friendly cities and communities.

It is interesting to hold these WHO priorities, which are clearly for a global strategy, up against the seven key principles of active ageing which according to Walker (2002) are necessary to bring together the policy domains to address successfully the challenges of population ageing. In summary, the following principles (adjusted from Walker 2002)) lay out a framework for *active ageing* at a national level:

[57] World Health Organisation (2017) *10 priorities towards a decade of healthy ageing*, Department of Ageing and Life Course, Geneva, World Health Organisation.

• *active ageing* comprises all (and not just paid employment) activities which contribute to individual well-being and/or to the individual's family, to the local community or to society at large;
• *active ageing* is valid for all older people, including those with some degree of frailty and dependency;
• *active ageing* is applicable across the life course, and not just in later life;
• *active ageing* is supported by intergenerational solidarity, fairness between generations and intergenerational activities;
• *active ageing* implies rights and obligations - rights to social protection, to lifelong education and to training and obligations to take advantage of education and training to promote active ageing (and the ensuing health benefits);
• *active ageing* needs to be participative and empowering;
• *active ageing* has to respect regional and cultural diversity.

Clearly the two are different but complement one another.

More recently, Public Health England (PHE) has published a consensus statement on healthy ageing. It sets out PHE's vision *for making England the best place in the world to grow old, giving all citizens the opportunities and support they need to have a healthy and good quality later life and making the best use of the strengths, skills and experience of older people*[58].

Again it is interesting – given the different contexts in which they have been proposed – to compare the points of the consensus statement with those of WHO and (adjusted) Walker, outlined above. The PHE consensus statement brings together a number of signatories from a range of organisations across national and local government,

[58] Public Health England (2019) *A consensus on healthy ageing*, London, PHE.

charity and voluntary organisations, public health bodies, academics and the NHS, and the consensus lays out five commitments:

1.To prioritise prevention and ensure access to services and support when needed. Prevention would be promoted by evidence-based interventions at an individual level accompanied by population-level policies across government departments, as well as education, awareness-raising and empowerment programmes. Ensuring access to services and support would man that an individual's changing needs would not be a barrier to maintaining or improving health.

2.To remove barriers and create more opportunities for older adults to contribute to society, providing workplaces that support health at work, create flexibility in roles, and recruit, develop, promote and retain staff of every age. This would also encompass policies and practices to support unpaid carers, as well as initiatives to support older adults who want to volunteer. Removing barriers to participation would necessitate the provision of more flexible opportunities for engagement and access to affordable transport, along with acknowledgement of people's contributions and support to develop new skills.

3.To ensure good homes and communities which will enable people to remain healthy, active and independent in later life. This includes accessible transport, good quality green spaces, accessible services and facilities and community-centred approaches to support and encourage community participation across the generations.

4.To reduce inequalities in healthy life expectancy across different socio-, economic, geographical and demographic groups of the population. This includes ensuring opportunities for good education, work, financial security and housing, as well as ensuring timely, appropriate and accessible health and social care services for all.

5.To challenge ageist and negative language, culture and practices in both policy and practice and to shift the conversation to one which celebrates and recognises the successes and benefits of an ageing population.

So much of the discourse, regardless of the institutional origin focuses on public health initiatives, adding healthy life years to our lives, but also on challenging and reversing the pertaining attitude to older people – to change a narrative of dependency to a narrative of contribution, inactiveness to activity. The European Policy Centre has stated this transition rather more dramatically: *EU member states must commit themselves to address this shared challenge. By bringing about an attitude change and by transforming society, EU countries can prevent the welfare, health and financial systems from collapsing, and ensure that population pyramids are no longer seen as a threat but instead become a narrative for growth, success and social cohesion*[59].

The Centre's policy brief looks at healthy and active ageing holistically as a key component of government response to demographic change moving forward, and it states that *the EU and its member states must tackle the issue at the heart of the challenge: offering older people adequate social protection while ensuring that the tax and social contributions burden does not become unsustainable for the working population,* and their view is that this can be achieved by promoting health (across the life course), by utilising innovative products, services and processes (designed for an ageing population), as well as enabling people to remain in work (if they wish to do so and are able to do so). There is an acknowledgement that the development of the growing silver economy will not just benefit older people but wider society as older people demand new services and products, ranging from for example personalised care to age-friendly technologies which will enable them to maintain healthy, independent

[59] Ahtonen, A. (2012) *Healthy and active ageing: turning the "silver" economy into gold*, Policy Brief, European Policy Centre, Brussels.

lives. Furthermore, increased life expectancy together with healthy ageing would mean that older people would not only benefit in a personal sense but they would also be in a better position to contribute to the labour market and society, all of which would reduce pressure on health and social services, and therefore on public budgets. Equally important, enabling and including older people in the labour market and society would enhance social cohesion and strengthen intergenerational solidarity and justice.

As well as highlighting the need for action to develop the silver economy to the benefit of older people and society as a whole, the Centre suggested five broad policy actions at EU level, reflecting again the same sort of ideas outlined in the above.

1. Healthy life expectancy

In line with a number of governments, NGOs and international organisations, the primary action suggested is to address healthy life expectancy and inequalities in these expectancies. This demands actions to promote health and tackle the causes of ill health at all levels of society.

2. Creating age-friendly environments

This would need to address issues such as transport, infrastructure, pollution, housing, public spaces and services. Workplaces need to be adapted to the abilities of older people to encourage them to remain in work for longer.

3. Increasing the retirement age and the labour market participation rate

Across the EU, the number of people of *traditional* working age is declining. This trend is unsustainable if current levels of welfare are to be maintained. To respond to this development and challenge, labour markets need to be more mobile and flexible. This would require that the EU develops an integrated labour market, but any changes to

the retirement age in order to increase labour participation rates would need to be made by national governments. Consideration should be given to making early retirement less flexible and later retirement more accessible thereby enabling workers to manage actively their transition from work to retirement. Volunteering should be valued and opportunities for second career developed.

4. Creating a European market for health-related products and services

Active, healthy ageing needs to be supported by the development of new and the promotion of existing products and services, which currently face a number of barriers to their widespread use. A single EU market for health would address these barriers.

5. Involving EU citizens in the transition

The Centre concludes by emphasising that these policy actions need the engagement and involvement of citizens across Europe, which requires that new, innovative solutions be developed with and for consumers, and this in turn requires that businesses understand the needs of older people. Mass-market products and services must be accessible to them. People of all ages are now more than ever before involved in their own health care – they are knowledgeable patients[60]. Policies must educate and support, making us all knowledgeable patients, and policy communication must be clear and strong.

In conclusion, the Centre calls for a change in attitudes towards active and healthy ageing and a drive to it an objective across all sectors and policy areas. This demands better governance, greater social innovation, and more investment in measures that promote active and healthy ageing. Furthermore, the Centre highlights the

[60] Karlsson, M. (2008) The Knowledgeable Patient: Investigating the role of lay knowledge in the production of health, Working Paper, Oxford Institute of Ageing, University of Oxford.

importance of being able to document the cost-effectiveness of policies and actions so that public investments in health care and health promotion can be seen to be working in the best interests of society as a whole – individuals, families and communities.

Much of the same has been voiced in a more recent Green Paper from the EU Commisssion[61].

A number of UN initiatives also come together to address the overall issue of the active, healthy ageing economy – age-friendly cities and the healthy ageing decade, to name but two – embedded in the UN Agenda 2030 for Sustainable Development.

The Global Age-Friendly Cities Network, which we consider with case studies later in this report, consists of more than 830 cities and communities in 41 countries[62]. Each of these cities/communities is, in accordance with WHO objectives, working to improve the physical and social environment to make them better places in which to age, and so age-friendly cities and communities promote healthy and active ageing. The aim is to enable older people to age safely and free from poverty and with autonomy and dignity in a suitable place, while being able to continue to develop personally and to contribute to their families and communities. This is done together with older people, and so many of these cities/communities have charters, or something similar, for older people, and there is an emphasis too on sustainable and inclusive urban development.

The Decade of Healthy Ageing 2020-2030 was endorsed in August 2020 by the 73rd World Health Assembly. This plan has older people at its centre and brings together, among others, governments, civil society and international agencies to improve the lives of older people, their families, and the communities in which they live. In addition, the United Nations Agenda 2030 for Sustainable Development outlines a plan of action in order to achieve sustainable development in a balanced way for all.

[61] European Commission (2021) Green Paper on Ageing: Fostering Solidarity and Responsibility Between Generations, COM(2021) 50 final, Brussels.
[62] https://www.who.int/ageing/age-friendly-environments/en/

The Agenda comprises 17 Sustainable Development Goals (SDGs), which together take an integrated and cross-cutting approach designed to ***leave no one behind*** and points to the specific needs and vulnerabilities of older people.

Population ageing is therefore an integral part of the SDGs, both individually and collectively, and importantly the Agenda 2030 highlights the importance of spatial development – particularly with regard to cities. Every dimension of the structure and functioning of cities has an immediate and direct impact on people's lives and especially for older people in respect of health, access to services, equity, social integration, security, provision of opportunities and resilience. The planning and configuration of cities determines the opportunities for inclusiveness.

The New Urban Agenda (NUA), approved at the United Nations Conference on Housing and Sustainable Urban Development (Habitat III) in Quito in 2016, once again stresses the importance of *good urbanization* as governments attempt to address the global challenges of facing them and their communities and citizens in the 21st century. The Agenda has a vision of *cities for all* and commits to "addressing the social, economic and spatial implications of ageing populations……while improving the quality of life of the urban population". This involves the effective participation and inclusion of older people in decision-making processes on urban development as well as a commitment to the promotion of equitable and affordable access to the basics of the urban physical and social infrastructure, ensuring the rights and needs of older people with integrated age- and gender-sensitive housing policies and approaches.

The new UN-Habitat Strategic Plan 2020 includes older people in the issue of social inclusion, which cross-cuts four areas of change, namely reduced spatial inequality and poverty in communities; enhanced shared prosperity of cities and regions; strengthened climate action and improved urban environment; effective urban crisis prevention and response.

Of course, older people form a rich and diverse group and each one experiences cities in different ways, dependent obviously on the built space, but also on a variety of economic, social and even political and cultural aspects. Some of the notable elements of these needs in cities are**:**

Issues related to the physical environment, such as adequate, healthy and accessible-to-all public spaces; adequate, affordable and accessible-to-all public transport; adequate and accessible-to-all private spaces (and not only housing) which facilitate mobility and independence;

Issues related to socio-economic circumstances such as adequate and affordable housing;

Issues related to social activities such as the inclusion of older people (intergenerationally) in available activities in urban areas, including recreational, cultural and training activities as well as their inclusion in decision-making processes at the planning and managementlevel;

Issues related to support and assistance such the availability and accessibility of efficient health systems (including new information technologies for remote care); and finally

Issues related to disadvantages based on the intersection of old age, identity, gender, disability, sexual orientation and race.

Taking inspiration from and echoing much of the sentiment of this strategic plan, a recent congress[63] focused on areas of particular interest for this current overview report, namely:

Public spaces which should have a dual function in respect of older people in as much as they provide the domains for activity and socialisation. The appropriate urban

[63] Cities for all: ageing and inclusiveness, 19th Euskal Hiria Congress, expert meeting, Vitoria-Gasteiz, Spain, November 2020.

design encourages and enables older people to utilise public space as part of social, gender and age mix.

Housing as a living space is where people generally and older people specifically spend most of their time and an individual's quality of life depends largely on the quality of these living space. Collaborative housing schemes as part of and with support from the broader community promote active ageing with older people actively engaged (along with all age groups) in their development. Such schemes also promote intergenerational urban planning and strengthen social networks, enabling those who wish to do so to age in place.

Mobility enables social inclusion for those at risk of isolation for a variety of reasons, be they health or financial or other. Affordable and accessible public transport is key in this respect.

Health and care is of course an important dimension for consideration in urban settings. In 1986, the WHO's so-called Ottawa Charter for Health Promotion recognised the impact of the urban environment on health, and a growing body of scientific evidence supports this, revealing at the same time both an urban health advantage and an urban health penalty[64].

6. Concluding remarks

With this report providing a context and platform for the following three reports, we shall move to the more specific areas of practice (charity and corporate) and policy in the United Kingdom and beyond.

As mentioned earlier, in the United Kingdom in recent decades, there has been a growth in the number of organisations working both with and for older adults, nationally, regionally and locally. This will be reviewed in the second report.

[64] Vlahov, D. et al. (2005) The Urban Health "Advantage", *Journal of Urban Health*, 82, pp. 1-4; Rydin, Y. et al. (2012) Shaping cities for health: complexity and the planning of urban environments in the 21st century, *The Lancet*, Vol. 379 (9831), pp. 2079-2108.

In addition, there has been a growth in the number of corporate bodies in the United Kingdom who see the commercial opportunities in ageing populations. The third report will review this area.

Finally, the fourth report will review policy developments to address the challenges and opportunities of an ageing population, in the United Kingdom and beyond. The final report will also review the UN/WHO Age-friendly city initiative, with illustrative case-studies.

Much of the history and practice and policy narrative outlined above will be seen reflected in the current status in the United Kingdom and elsewhere, as we shall see in the subsequent reports.