

# A social policy on ageing: to reduce the costs of old age, we must improve the entire life course



*Far from being predetermined, the course ageing takes is subject to a variety of influences throughout one's life. This is something that policymakers have so far failed to appreciate, argues [Alan Walker](#). He makes the case for a new strategy which focuses on the whole life course, with the intention of preventing many of the chronic conditions associated with later life.*

Policymakers and social policy analysts are guilty of neglecting ageing, despite the fact that it is now recognised officially as a 'grand challenge'. However, it is not ageing that is in the focus of official social policy orthodoxy, but old age. Moreover, as the periodic hand-wringing about the 'burden' of growing numbers of older people demonstrates, this unique historical phenomenon is regarded widely as a negative development: later life is a 'natural' period of decline and this means ever increasing health and social care costs. The 2017 General Election witnessed a particularly poisonous version of this depressing conclusion. The recent [IFS/Health Foundation report](#) on future health and social care funding draws the same conclusion, albeit in highly measured terms devoid of political rhetoric.

By focusing on old age rather than ageing, social policy analysts have forsaken what should have been a leading role in responding to one of the biggest challenges facing the world. This space has been claimed instead by orthodox economists, whose assumptions and instruments, such as dependency ratios, are inherently negative about population ageing.

From this starting point it is common for projections to be made of future health and social care costs based on present day demand and expenditures. In other words, instead of asking if rising demand is inevitable and, if not, what social policy approaches might mitigate it, it is assumed that more older people means more health and social care spending. For example, in its central projections of future health spending the Office for Budget Responsibility assumes that the health of an individual of a given age and sex does not change over time. Put differently, more years of life at older ages means an expansion in the number of years spent in ill health.

It is time for a fresh start and a new perspective. Rather than focussing only on old age and older people, we need to foreground the ageing process itself. This radical shift in emphasis should lead to conversations about how the chronic conditions associated with later life, which are the principal drivers of demand for health and social care, can be prevented or, at least, postponed. In place of the demographic despair behind many cost containment strategies is the potential for savings for reinvestment and, more importantly, substantial improvements in well-being and quality of life for eventually millions of people. The question why this deceptively simple point has been ignored for decades highlights the barriers to prevention, which I will return to later.

First, what is the evidence behind this call for a new policy approach? Recognising the highly complex nature of the ageing process scientists from a wide range of disciplines have been working together to both improve understanding and to fashion appropriate responses. Leading examples of such multi-disciplinarity are the [UK New Dynamics of Ageing Research Programme](#) and the European project [Mobilising the Potential of Active Ageing](#).

The core conclusion from this massive body of recent research is that, while ageing is inevitable, it is also malleable: the precise course that ageing takes is not predetermined but rather subject to a variety of influences. Not only is there no 'ageing gene' but, in practice, genetics play only a minor role, around one-fifth of the association with disability and cause of death, while a host of other external and 'environmental' factors are the major influences. Thus loss of functional ability is often wrongly seen as an inevitable consequence of ageing whereas, in fact, it results from a variety of non-genetic causes, including inactivity.

How we age is shaped by the social, political, and economic environments into which we are born and within which we develop and live our lives. Poor housing, lack of access to clean air and green spaces, precarious and stressful employment, limited availability of fresh food, and the over-supply of health-damaging substances including alcohol, tobacco, and high calorific foods are well-known risk factors for the main chronic conditions that are associated overwhelmingly with older age – coronary heart disease (CHD), stroke, diabetes, cancer – which require medical treatment and long-term care. These poor living conditions can result in exposure to pathogens and stressful events, deprivation of positive social connections and health-damaging practices, all of which increase the risk of chronic conditions in later life and the resulting functional limitations. Air pollution is a huge environmental threat to health, resulting in 40-50,000 premature deaths annually in the UK and an unknown number of chronic disabilities. Poor housing contributes to a range of health conditions including cardiovascular disease, asthma and mental ill health.

Tobacco use, poor diets, lack of physical exercise and excess alcoholic consumption are also all associated with the main causes of functional limitations in later life – adult obesity and smoking are the two biggest global drivers of chronic conditions and premature death. Inactivity results in a loss of fitness (strength, stamina, suppleness and skill). Variable exposure to these potentially avoidable risk factors helps to explain the UK's large inequalities in life expectancy and healthy life expectancy, and the vastly different outcomes in old age, where two people of the same age may have sharply contrasting capabilities. For example, research on frailty in later life found that older people (65+) who were wealthy and lived in affluent neighbourhoods had half the amount of frailty compared with those who were poor and living in deprived neighbourhoods. At the other end of the life course, Public Health England figures show that 11.7% of children aged 11 were obese in 2017 among the richest 5% but, among the poorest 5%, 26% were obese.

Once the causes of ageing are understood, and the evidence is now overwhelming, the next step should be relatively simple. Since ageing is malleable, as well as individual actions to own and attempt to modify the generally assumed path towards old age, social policies also have a big role to play in trying to reduce the prevalence and severity of chronic conditions.

As well as urgent action on unhealthy production and consumption, the prioritisation of ageing requires a longer term strategic approach. My favoured term for this strategy is 'active ageing' but the title is far less important than the substance. The two essential ingredients are: a life course focus, and an explicit intention to *prevent* both chronic conditions and their grossly unequal distribution. In practice this strategy would entail specific actions at different stages of the life to promote knowledge about ageing and the actions that can ensure increases in healthy life expectancy. For example, as well as combating child poverty and reducing inequalities in access to education, all children need to be introduced to the reality of the 100+ year life-span and taught about the ways in which they can reach it healthily.

A life course orientation to the promotion of healthy life expectancy would entail specific measures geared to its different stages, including childhood, working, and later life. Also, because of the very wide inequalities in health expectancies we will need to disproportionately invest in approaches that effectively address the needs of deprived areas and groups, including culturally sensitive interventions for people of black and minority ethnic origin.

One measure that transcends all age groups is the promotion of physical exercise: the evidence on its beneficial effects in preventing chronic physical and mental conditions is now so robust that a large-scale national programme is warranted. Exercise improves fitness and, with it, functional ability and resilience. Even small amounts of regular physical activity have a positive health effect and this effect seems to hold regardless of gender, race, ethnicity or age. Moreover improved fitness has a beneficial impact on cognitive ability, not only in midlife but into old age as well. Indeed, exercise may reverse a decline in functional capacity and fitness that has already occurred and be of benefit to those who already have chronic conditions.

The striking characteristic of these active ageing measures is the combination of big potential impact and low cost. So why have they not been pursued with vigour officially at scale? The difficulty of switching resources from treatment to prevention is well known and has been rendered even more challenging by service cuts in the name of austerity (eg. smoking cessation services). In addition, there are powerful vested interests in later life disability and behind unhealthy production and consumption. Short-term political horizons militate against longer term strategies, and some politicians are ideologically opposed to the collective action required to deliver a comprehensive long term approach like active ageing.

Finally, even if the massively upscaled preventative approach to the life course advocated here was introduced tomorrow, there would still be a need for remedial interventions to reduce the personal impact of chronic conditions, such as hip and knee replacements, to enable people to remain active for as long as possible. There is evidence too that minor muscle strengthening exercises by very frail older people can improve both physical and mental health. In the longer term an active ageing strategy for all ages would help to postpone the need for remedial interventions and also the need for long-term care.

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Note: the above draws on the author's [published work](#) in the Journal of Social Policy.

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