The relationship between independence, inclusion and wellbeing: the perspective of older citizens living in Coventry, UK

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Abstract

Independence, inclusion and wellbeing are commonly seen in a complementary relationship in policy and research literature. This paper examines the meaning of these terms for older citizens living in Coventry and the implications for policy implementation. The data presented, obtained from a large community survey of citizens of 55 years and over living in Coventry, found that although most survey participants were able to function independently, participate in ordinary community life and enjoyed reasonable physical and mental health, many others experienced a series of significant barriers to inclusion and wellbeing.

The paper concludes that there is no automatic convergence between independence, inclusion and wellbeing at the level of the individual citizen and that to address this issue, more socially inclusive rather than individualistic forms of independence may be more appropriate goals for local public agencies.

Keywords: older people, citizenship, inclusion, independence, wellbeing

Introduction

Three important policy objectives, amongst others, shape the creation and delivery of services and support for older citizens in England at the present time. The first is the objective of supporting the *independence* of older people. Although this has been ubiquitous in UK social policies relating to older people for many years, the idea that this is best achieved through the creation of services and support that enhance choice and control – for example, through personal budgets – is arguably more recent. The second is *inclusion*, or enabling of older citizens to participate fully in economic, educational, social and community activities. The third, which is the pursuit of *wellbeing*, is an even more recent addition to social policy lexicon, and draws attention to the importance of good physical and mental health in old age.

This paper will report on the perspectives of older people about these policy objectives, using data collected from a large community survey of people aged 55 and older who lived in Coventry in 2010, and on behalf of the Coventry Older People's Partnership which comprised the City Council, local Primary Care Trust (NHS) and a range of third sector organisations including Age UK. It was designed to find out about the lifestyles, aspirations, and concerns of people aged 55 and over to inform the City Council's 'Promoting Independence' Framework – a local strategic plan for older people in the city over the next decade.

Much research and information collected on or with older people in the UK focuses upon their health and social care needs to support the planning of NHS and social care services. A distinctive feature of this survey is that the brief given to the research team was much wider: our objective was to obtain a more general idea of what older citizens wanted from their local services and community and on issues and areas of concern for them. The full report can be accessed at http://wwwm.coventry.ac.uk/researchnet/SISC/Documents/55+%20Survey%20Full%20Report.pdf.

A specific aim of this paper is to describe the perceptions of older citizens of their own levels of independence, inclusion and wellbeing and assess what implications these perceptions may have for these policies and the relationship between them. Our contention is that there is no automatic convergence of independence, inclusion and wellbeing at the level of the individual citizen.

The rest of the paper is organised into five sections. In the section immediately below, the policy context will be summarised, which will be followed by a description of the methods used to collect the data. A third section presents the findings of the survey. These are then discussed within the context of English policies relating to older people. Finally, the paper offers some conclusions.

Independence, inclusion and wellbeing: the policy context for key issues

Independence, choice and control

The maintenance, or restoration of independence, and the prevention of 'dependency' are long standing policy objectives, seen as essential to prevent unnecessary admission into hospital, or residential care, at a time when the proportion of older people in the general population is rising and because of the need to reduce spending because of the austerity programme of the present Government. The provision of choice to enhance control over services has more recently been seen as the means by which independence can best be achieved.

Given the degree of importance attached to the promotion of choice in public sector services, the equivocal support for enhanced choice in social care, especially in relation to older citizens, is noteworthy. Some commentators have suggested that personal budgets – the main instrument by which choice and therefore greater control is achieved – may not always be the best way of providing services for older people (Daly, 2009; Orellana, 2010; Barnes, 2011;

Woolham & Benton, 2012). Barnes, for example, commenting on *Putting People First* (DH, 2007) (a policy document that arguably has been particularly influential in promoting independence and inclusion in social care), notes that although there is some recognition of the importance of *inter-dependence* in people's lives, the focus in policy discourse is more commonly on individuals whose needs and interests may be opposed to each other in a competitive market situation rather than on the relationships within which care and support is provided. A related observation is made elsewhere by Plath (2007) who argues that independence confers both benefits and disadvantages and draws attention to the fact that older people in her study identified two distinct variants of 'independence': one rooted in individual values and emphasising the need to do things alone, the other relating to feeling valued and feelings of connectedness to others.

Participation and inclusion

The participation of older citizens – economically, educationally and in social and community life – thereby promoting their inclusion in the fabric of society, is the second policy objective on which this paper focuses. For convenience, in this paper, we have structured our summary of this issue into two sections, dealing with economic and educational participation, and social and community participation, respectively.

a. Economic and educational participation

Whilst 6.7 million people over 50 were in paid work in the UK in 2004, there were additionally approximately half to one million older people who could be considered as potential additional workers, since not all older people who want to work, or who are able to work, are currently employed (O'Neil & Welsh, 2006). In addition, older people seeking work remain unemployed for longer than younger workers (Age Concern, 2008).

A significant policy objective of the previous Labour Government, therefore, was to increase the opportunities for older people to

re-enter employment or to remain in work as they grow older (HMG, 2005; ODPM, 2006), a direction of policy continued by the current Coalition Government (HMG, 2010). There are a number of reasons for pursuing this direction. Not least are demographic changes (see Demakakos, 2008). These mean that there will be an increasing number of older people relatively and absolutely. Therefore, in order to sustain economic progress, a greater proportion and number of people over 50 years will need to be in employment, including a greater number and proportion working past the statutory pension age.

The therapeutic benefit of participation in learning for older people – both in formal educational settings and less formal opportunities to acquire new knowledge or skills – has been comparatively overlooked until recently. A recent report offers clear evidence that such participation is associated with higher wellbeing (Department for Business, Innovation and Skills, Nov. 2012).

b. Social and community participation

The Government and others (notably Curry, 2006; Wistow *et al*., 2003) have also recognised and sought to address issues of social exclusion experienced by older people (ODPM, 2005; 2006; Daly, [DWP], 2009). Other agencies have indicated the scale of the problems faced by older people in the UK today. Help the Aged (2008, p.6) reported that 'one third of older people report feeling out of touch with modern life and a further one in eight say they are often or always lonely'. According to the Joseph Rowntree Foundation, we are witnessing a perceived decline of community: 'communities are weak and people are increasingly isolated from their neighbours, as people tend to see themselves as individuals and not as part of a wider society, leading to selfishness and insularity' (JRF, 2008, p.1). Age Concern (2008) has attempted to quantify the scale of the phenomenon in stating that 1.2 million people over 50 years of age face multiple exclusions with the likelihood of social exclusion intensifying in later life.

Health and wellbeing

A third, more recent policy strand, refers to the health and wellbeing of older people, and has been a major theme of frequently cited analyses of demographic pressures facing the NHS (Wanless, 2003) and local authority Social Services Departments (Wanless, 2006) as well as in legislation and guidance, as exemplified in a number of policy documents (Hayden & Boaz, 2000; ODPM, 2000; 2005; 2006; DH, 2001; 2004; 2005; 2006a; 2006b; 2008; Audit Commission, 2002; DWP, 2002; ADSS/LGA, 2003; HMG, 2005; 2007).

The direction of policy has included an emphasis on prevention and on 'upstream' activities that promote older people's health and wellbeing (see: Curry, 2006; Daly, 2009; JRF, 2005). The broad thrust of much of this is for action to encourage citizens to remain independent by taking more responsibility for their own health, to reduce demand for NHS and social care services arising from obesity, alcohol misuse and smoking which cause illnesses such as diabetes, heart disease, stroke, or COPD, and result in life-limiting and often avoidable impairments.

Relationships between independence, inclusion and wellbeing

The Oxford Shorter Dictionary offers four meanings for the noun independence, which are, briefly: 'freedom from outside control', 'not depending on another for livelihood or subsistence', 'capable of acting and thinking for oneself' and, finally, 'not connected with another or with each other'. This fourth meaning is perhaps one with which some policy makers may be less familiar and is at odds with definitions of the noun 'inclusion' which is defined in the same dictionary as 'the action or state of including or of being included within a group or structure'. Finally, wellbeing is described as 'the state of being comfortable, healthy, or happy'. In policy terms, although independence and social inclusion are seen as desirable objectives in their own right, they are rarely defined as contradictory objectives in the UK literature,

though the paper has already drawn attention to the work of commentators who have expressed concerns about the values that underpin the delivery of choice and control to achieve independence. Independence and inclusion are also associated with enhanced wellbeing in both national policy guidance (DH, 2005) and locally in health and wellbeing strategies in England.

Method

Data was collected through a self-completion questionnaire which was developed by the authors in consultation with the partnership group. The final questionnaire's content and design was a compromise between the needs and requirements of local stakeholder organisations and the desire of the university team for rigour through the use of, for example, validated scales. To keep the survey manageable whilst addressing the expectations of stakeholders, questions were 'home grown', though informed by other community surveys. Care was taken over layout and design to make it easy to read and complete. This included printing the questionnaire on pale yellow paper, the use of a non-serif font and a relatively large font size (14 point). A final draft version of the questionnaire was cognitively tested by a member of the research team who led a discussion with older people who attended a local Day Care Centre. In addition, a meeting was held with members of the Older People's Forum in Coventry who received copies of the questionnaire and gave feedback about content and design. Minor amendments were made based on the feedback received.

The final questionnaire contained 57 predominantly closed questions, and was 23 pages long. Questions focused on a wide range of issues, including home and neighbourhood, use of technology, participation in leisure, learning, employment and life, general health and wellbeing, use of health, social care and voluntary organisations, mobility and transport, social life and activities, and economic participation. Eligibility criteria were that participants had to be aged 55 or over, resident in Coventry or registered with a Coventry based GP Practice.

Data collection

Three methods of data collection were used. The first was a postal survey. Contact details of local residents came from three sources: first, a database of people living in sheltered and very sheltered housing dwellings in Coventry made available by the City Council, second, two databases of older residents who had used advice or information services provided by Coventry Age UK over the previous 12 months and, third, older people who had used Coventry Social Services over the previous 12 months. This data was combined and cleaned by removing incomplete addresses, people who did not meet the survey's eligibility criteria, and people whose details appeared on more than one of the lists. Checks were also made with the organisations that had provided the contact details to delete people recently deceased from the mailing list. From a combined survey population of 7,653, a random sample of 1,626 was selected. The size of the sample was based on an assumed response rate of 40% which would generate an overall confidence interval of +/- 4%. A single reminder letter was sent out a fortnight after the first mail-shot to non-respondents. On both occasions, members of the sample were sent a covering letter, questionnaire and pre-paid self-addressed envelope.

The second method of data collection was an online version of the questionnaire prepared using 'survey monkey' software. This was advertised widely through the city via local stakeholder agencies.

Finally, questionnaires, pre-paid envelopes and posters were used with 'ballot boxes' left in a wide range of public buildings likely to be used by older citizens, including libraries and day centres.

Ethical approval for the study was obtained from both Coventry City Council and Coventry University before it commenced.

Table 1. Responses by source

Postal Survey	638 (41%)
Questionnaires left in public buildings in Coventry	749 (48%)
Online questionnaire	169 (11%)
TOTAL	1558 (100%)

As can be seen in **Table 1**, over 1500 people took part in the survey - 2% of the population of people aged 55+ living in Coventry. The average age of those who took part was 70.6 years. Two thirds were female and 94% described their ethnic origin as White. As might be expected, most were retired. Just under a fifth said they were caring for someone (the majority were caring for another adult) and in many cases, a significant amount of time was spent caring: the average amount was over 50 hours per week. Males and people from BME groups were slightly under-represented amongst respondents. People from lower socio-economic groups may also have been under-represented but comparative population wide data could not be found to confirm this.

Collected data was entered into an SPSS database for analysis.

Findings

Key findings from the survey are presented under three thematic headings: choice, control and levels of independence, economic, educational, social and community participation, and health and wellbeing.

1. Choice, control and levels of independence

Direct payments for future care needs

The present and previous governments have been keen to promote the use of personal budgets, preferably in the form of direct payments, to enable people who use social care services to purchase the care they need (Department of Health, 2010). Advocates of this approach to care delivery (see, for example, Leadbeater, 2004; Leadbeater *et al.*, 2008; Poll *et al.*, 2006) claim that it promotes choice and enhanced control over services, and therefore empowers and promotes inclusion (through purchasing power); independence (as people are able to act autonomously in choosing their care and support); and wellbeing (as care is more personalised and more likely to enable people to achieve their goals and outcomes).

Figure 1. Question: as we get older, some of us will need help to enable us to live as independently as possible. You may receive care or support, or know someone who does. We are interested in knowing your views on how we should best provide this help. Given the choice, which of the following would be your preferred way of getting care and support should you need it? (X^2 31.609 p=0.000)
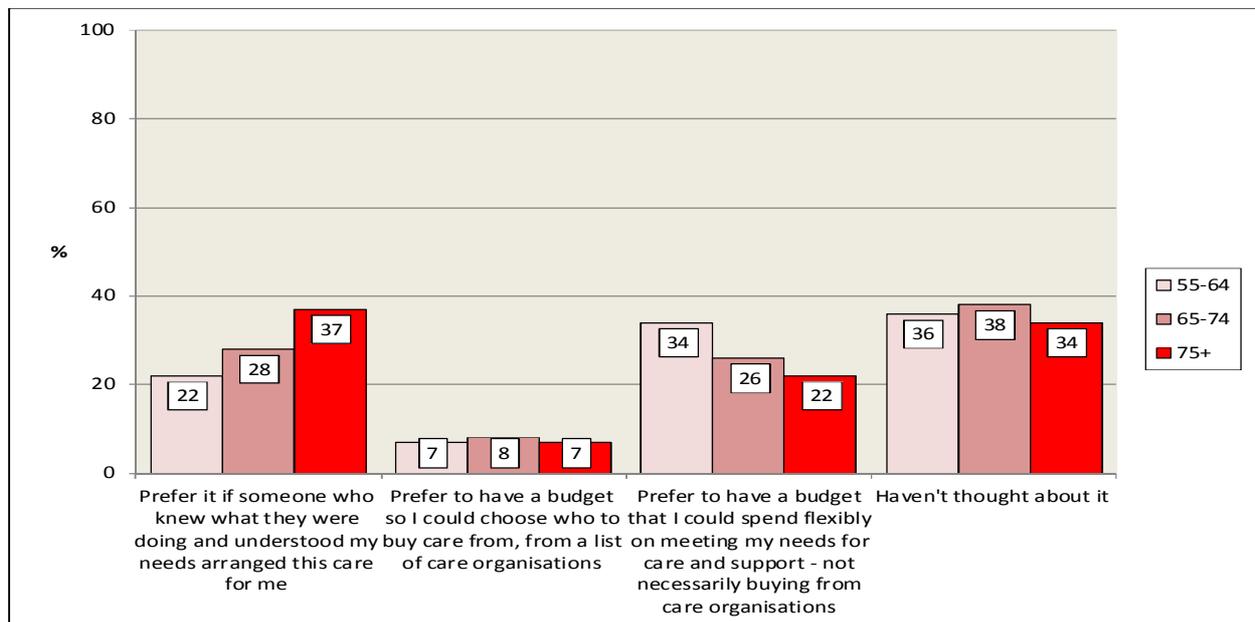
Figure 1 shows that not all survey participants were keen on the idea of having their own budget, and that the proportion of those willing to consider a personal budget declined – and the proportion who said they would prefer their care to be organised by someone else – increased with age.

Staying put or moving to better adapted housing

There is increasing recognition of the importance of 'ageing in place' (Sixsmith & Sixsmith, 2008) and the need to prevent unnecessary admission into institutional care. The survey asked where people would like care and support to be provided if or when it became needed.

Overall, over two thirds of respondents indicated that their preference would be to remain living in their current accommodation. Only 2% stated a preference to move into residential or nursing care, and the proportions of people who would countenance a move into housing with support schemes – low support schemes such as ordinary sheltered housing or high support – such as 'Extra Care' or very sheltered housing – were also very low. Reasons for these findings have been explored in other studies and include familiarity with local area, and preservation of local social and friendship networks (O'Bryant, 2008). Respondents clearly saw living in their own home as the best way to maintain their independence and avoid exclusion (through perceived institutionalisation). The older people were, the more likely they were to say they wished to remain living at their current address.

2. Economic, educational, social and community participation

*a. Economic and educational participation*

Economic participation

As might be expected, the survey confirmed that the majority of respondents (67%) were retired, whilst 18% were 'economically active'. People aged 75 and over were much less likely to be working than those aged between 55 and 64.

Money worries

Just over a third of respondents said they had no money worries, and a similar proportion said they could only manage if they budgeted carefully. By contrast, a large minority of respondents were not financially secure.

Figure 2. Question: as we get older, some of us will need help to enable us to live our lives and be as independent as possible. If you needed care and support, which of the following statements best describes what you might prefer? (n=1485, (X^2 52.044 p=0.000)
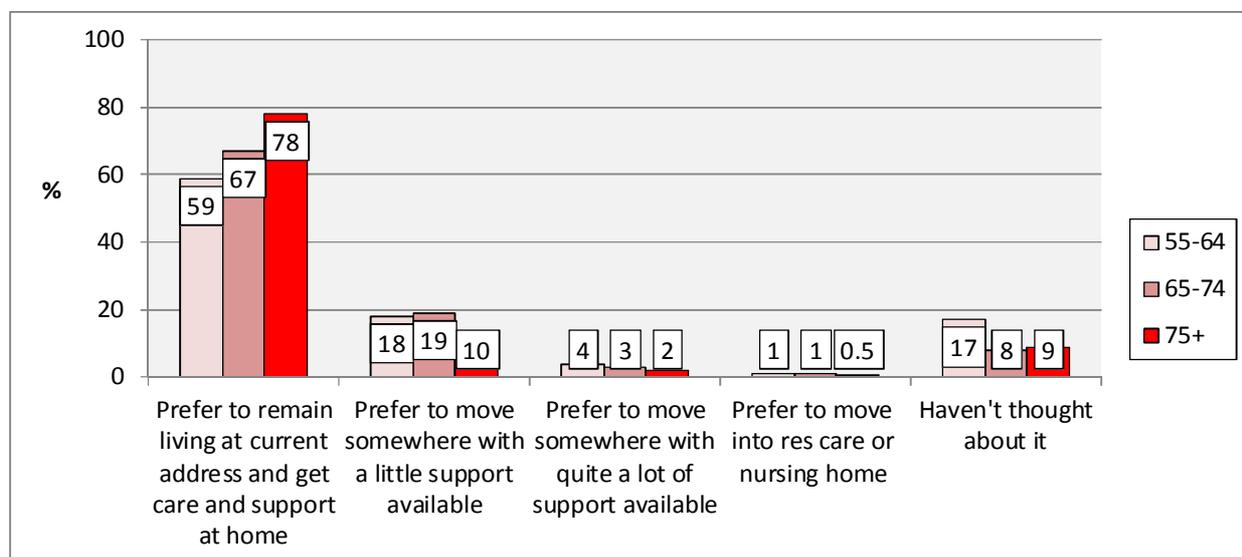
Figure 3. Question: do you have enough money to live on at the present time? (n=1480)
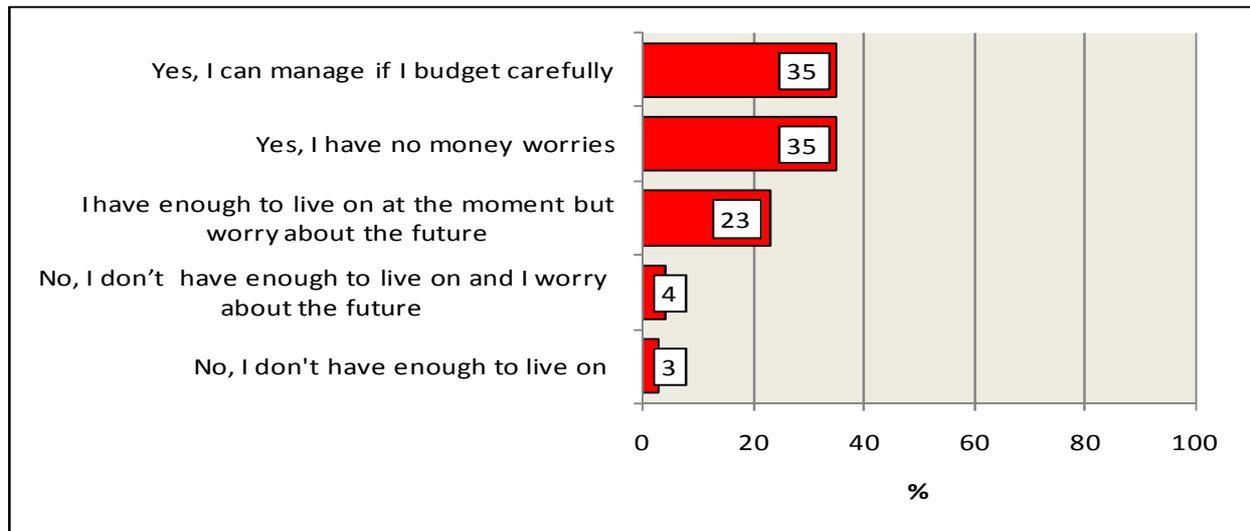
7% of respondents admitted to not having enough to live on (and worrying about this), but almost a quarter were managing but worried. These are concerning figures given the age of the group and the fact that the majority were retired or coming to the end of their working lives. People who were still working full-time were more likely to say that they had enough to live on (67/47%) compared to people who had retired (361/36%).

Barriers to getting help with money worries

Commenting on reasons why people might find it difficult to seek advice about their finances, people said that they did not know who to trust, or that, based on previous experiences, they did not trust advice offered by 'independent advisors' or had (perhaps more recently acquired) a general lack of confidence in the banking system.

Given the shortcomings of different sources of advice, even though people may have lacked detailed knowledge or understanding of financial issues, responses suggested that because financial advisors could not be trusted, respondents 'self-excluded', preferring to rely purely on their own judgements.

Interests in, and impediments to, participating in educational and leisure activities

Over half - 908 (59%) of respondents did not answer a question intended to find out more about the extent of participation in a range of leisure time activities, including educational participation – suggesting either that many people who responded had few hobbies or interests, or that those included in the survey were insufficiently broad to capture the diversity of pursuits and activities in which people were engaged.

Amongst those who replied, as can be seen in **Figure 4**, the most popular form of recreational activity was 'exercise or sport', followed by 'gardening & horticulture'. Almost a quarter of those who replied said they had taken part in some form of educational activity over the previous year, including art and craft classes, a vocational class of some kind, talks and lectures, learning a foreign language, distance learning or studying for an academic qualification.

Respondents were also asked to describe any barriers or obstacles that prevented them from taking part in learning and leisure activities, or made it difficult. Over 600 people did respond to this question. Following analysis a small number of issues seemed to predominate from responses.

Figure 4. Question: have you been involved in any of the following kinds of learning or leisure activities in the past year?
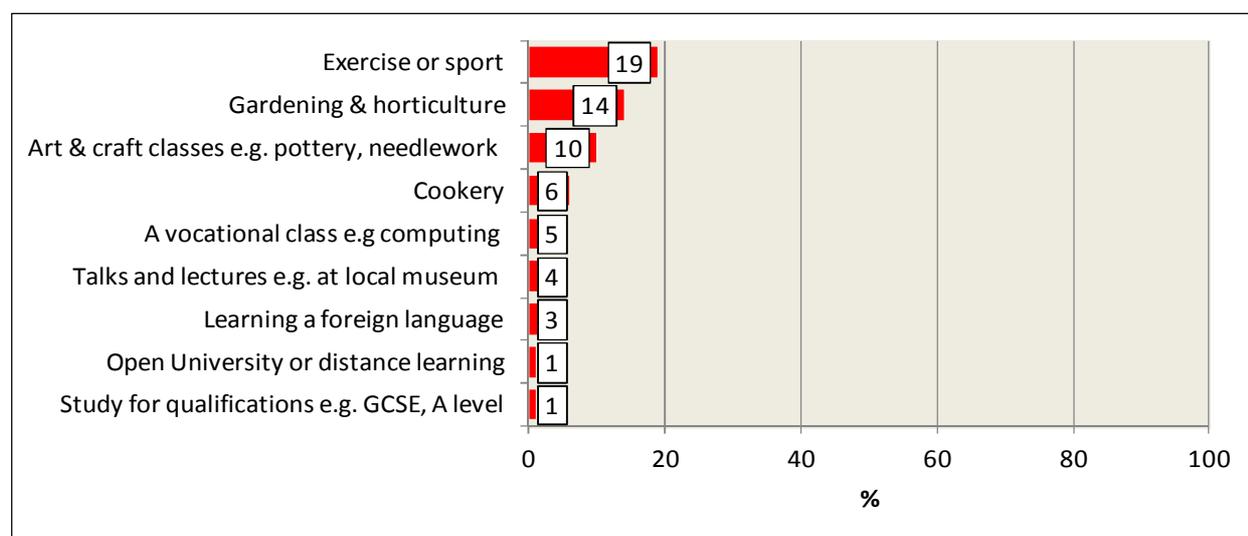
The first was disability or illness, which made it hard or impossible for people to take part because of physical impairments, reduced mobility which made it hard for the person to get in and out of buildings, or forgetfulness. These were by far the most frequently mentioned barriers to participation amongst those who answered the question.

The second was mobility – in the form of access to appropriate transport and the route taken by public transport – also very frequently mentioned as an obstacle:

> *Nothing is easily accessible by public transport during the day.*

Cost was another barrier:

> *I'm not eligible for support but as I work only part-time and my husband is unemployed and with a small works pension money is tight.*

Concerns for personal safety, specifically in getting to and from an activity, were also mentioned frequently:

> *Not safe to go out alone, especially after dark.*

Other obstacles mentioned included the timing of the activity (a number of respondents noted that they preferred events to be available during the day rather than the evenings) and an inability to go out easily because of their role as a carer – for a disabled husband or wife but also grandchildren.

b. Social and community participation

Loneliness and isolation

Just under half (46%) of respondents said they lived alone. Older people (aged 75+), women, and White respondents were most likely to live alone. 18% also said they were not able to see friends or relatives, or keep in touch with them as often as they would like to, and 16% admitted to feelings of loneliness either 'most' or 'some' days. Possible causes and consequences of loneliness are explored by the authors elsewhere (Woolham, Daly & Hughes, forthcoming 2013).

Use of community resources

Questions about use of mainstream services were also included in the survey to gauge how much they used them and what they most valued.

Figure 5. Locally valued services compared with use of these services
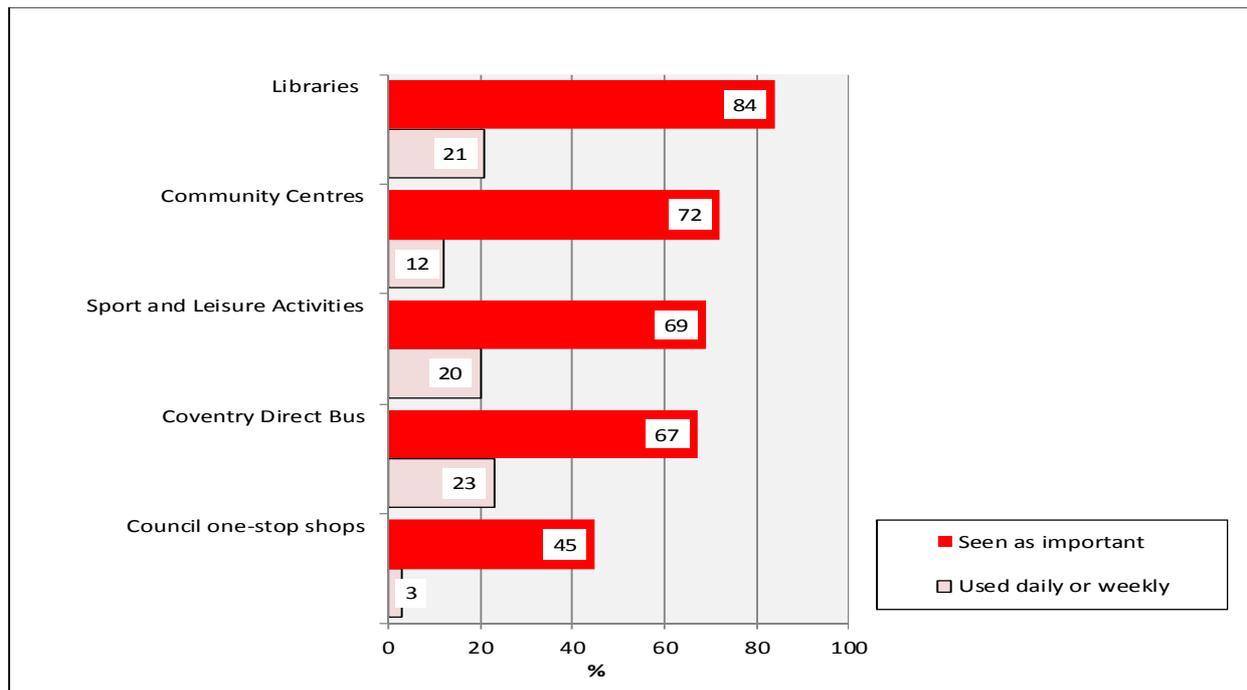
The survey found that although local community services and resources were all regarded as very important and valued by respondents, only a minority of respondents used them regularly. There appeared to be a number of reasons for this. Access to transport, general levels of mobility and fitness, and concerns about the safety of the external environment all affected the extent to which people were included or excluded from using these services.

Barriers to participation

Problems with walking and personal mobility were most frequently cited as barriers to being able to take part in everyday social activities, followed by the costs of participating.

Lack of information about what was 'going on' in Coventry was cited as an issue by just under a quarter of respondents. The absence of a companion to do things with was also mentioned by 15% of respondents.

Transport

Access to transport, the accessibility of this transport, and personal mobility were important factors in supporting community participation and social inclusion. Given the relatively high proportion of respondents who said they had poor personal mobility, it was perhaps unsurprising that 6% of respondents said that they never left their home and only 12% said that they would walk short distances within Coventry. In fact, 38% of respondents said that their usual form of transport over short distances within Coventry was the 'bus service, followed by 37% who said they usually travelled by car. Younger respondents (55-64) were more likely to walk or travel by car: older respondents (75+) were more reliant on the local 'bus service.

Feedback on what would improve the ability of respondents to get out and about was also obtained.

Rapid repairs to pavements was the most frequently mentioned issue followed by a desire for better facilities for people with impaired mobility.

Figure 6. Top 5 barriers to participation in everyday activities
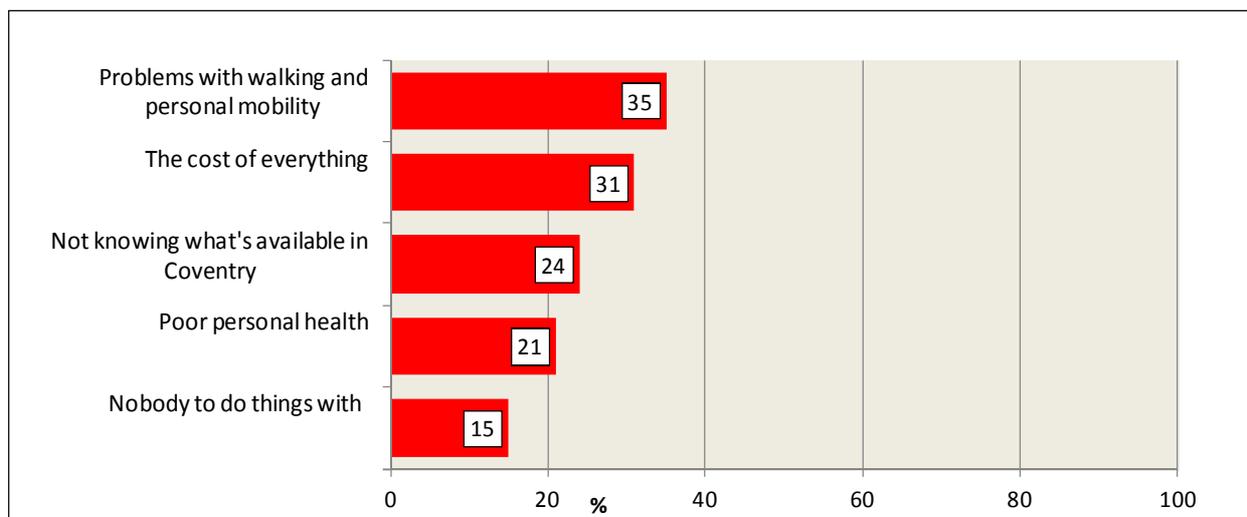
Figure 7. Top 5 things respondents said would improve their ability to get out and about in and around Coventry
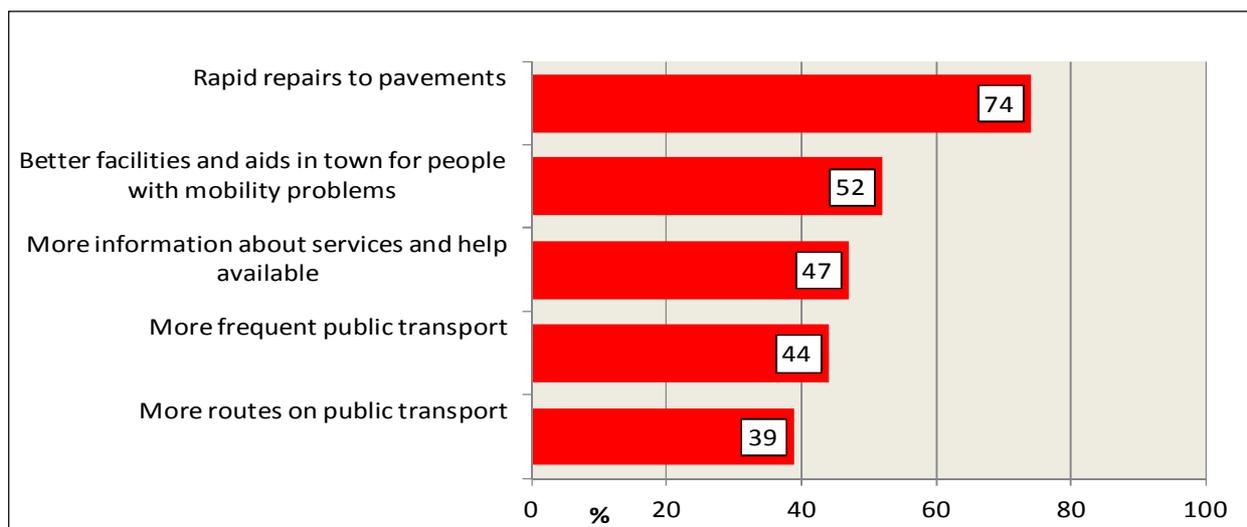
Access to modern technologies of communication

Large proportions of those who took part in our survey seemed to be in danger of being left behind by the rate of technological change. Over a quarter (28%) said they rarely or never used a mobile telephone, and 46% said that they 'rarely' or 'never' used a personal computer, or the internet. A quarter of respondents also indicated that they 'rarely' or 'never' had access to a TV which had 'free-view' channels**.**

The proportion of people who did *not* use mobile phones, personal computers or the internet increased sharply with age. 10% of people aged 55-64 said they never used a mobile phone compared to 32% of the 75+ group. Personal computers were not used by 21% of the 55-64 age group but 69% of the those aged 75 and over, and whilst 23% of the 55-64 age group did not use the internet, the corresponding figure for the 75+ group was 71%. (X^2 206.409 p= 0.000). The proportion of people who never used a TV set with 'free-view' was 18% for the 55-64 group and 32% for those aged 75+. (X^2 53.548 p=0.000)

3. Health and wellbeing

Reported health status and enjoyment of life

Exactly half of respondents in the Coventry survey described their health as 'excellent' or 'good'. Just over a fifth said their health was poor or very poor.

People aged over 75, and people from BME groups were more likely to report poorer health. Impaired sight, hearing and mobility reportedly 'very much' affected between 11 and 29% of respondents.

The questionnaire also asked people if they were enjoying their lives. Well over half said they found life enjoyable. Just over one fifth either did not feel their life was as good as they would have liked it to be, or were not enjoying it. The age of respondents did not make a significant difference to how much, or little, people seemed to enjoy their lives.

*Keeping fit and lifestyle changes*

A series of questions asked respondents about exercise and lifestyle related to the maintenance of health, independence and wellbeing.

Large numbers of respondents remained physically active through walking, housework and gardening. The older respondents were, the less likely they were to take any form of exercise.

Table 2. Do you use any of the following kinds of technology?

	Often	**Sometimes**	**Rarely**	**Never**
A mobile phone	562 (39%)	406 (29%)	201 (14%)	256 (18%)
A personal computer	501 (42%)	151 (13%)	59 (5%)	492 (41%)
The internet	477 (40%)	167 (14%)	52 (4%)	507 (42%)
A TV with 'freeview'	850 (62%)	178 (13%)	45 (3%)	301 (22%)

Figure 8. All in all, how much are you enjoying your current life? (n=1504)
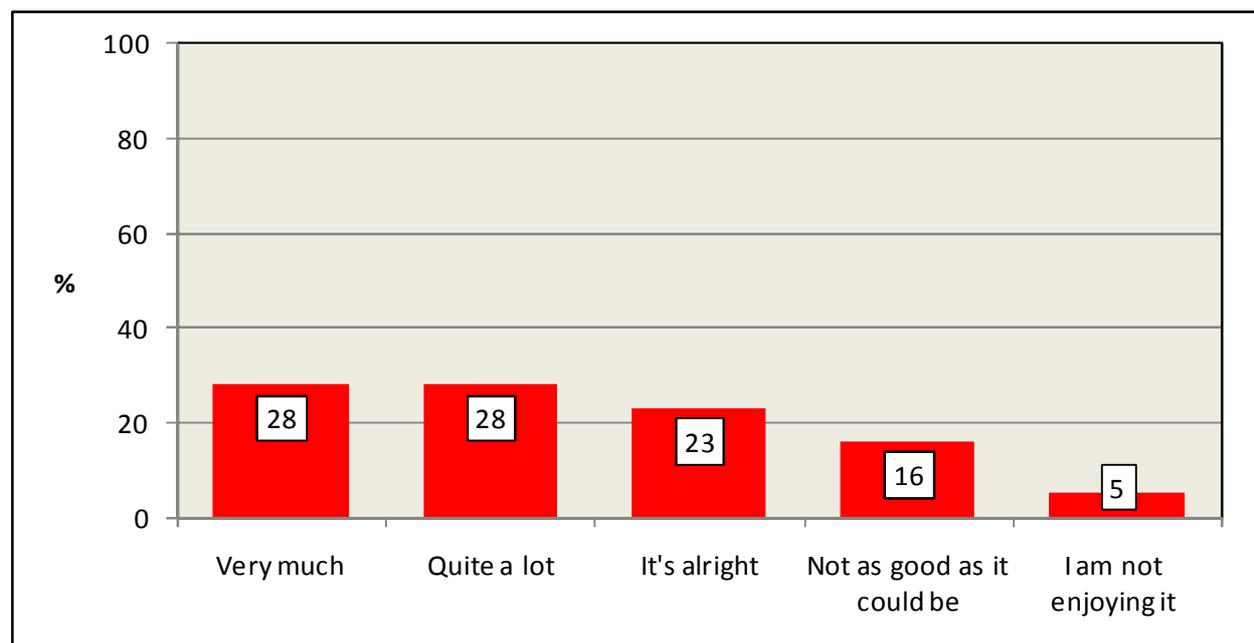
Figure 9. Question: as we get older, it may be less easy to keep fit by exercising regularly. How often do you do any of the following kinds of exercise vigorously enough to be slightly out of breath?
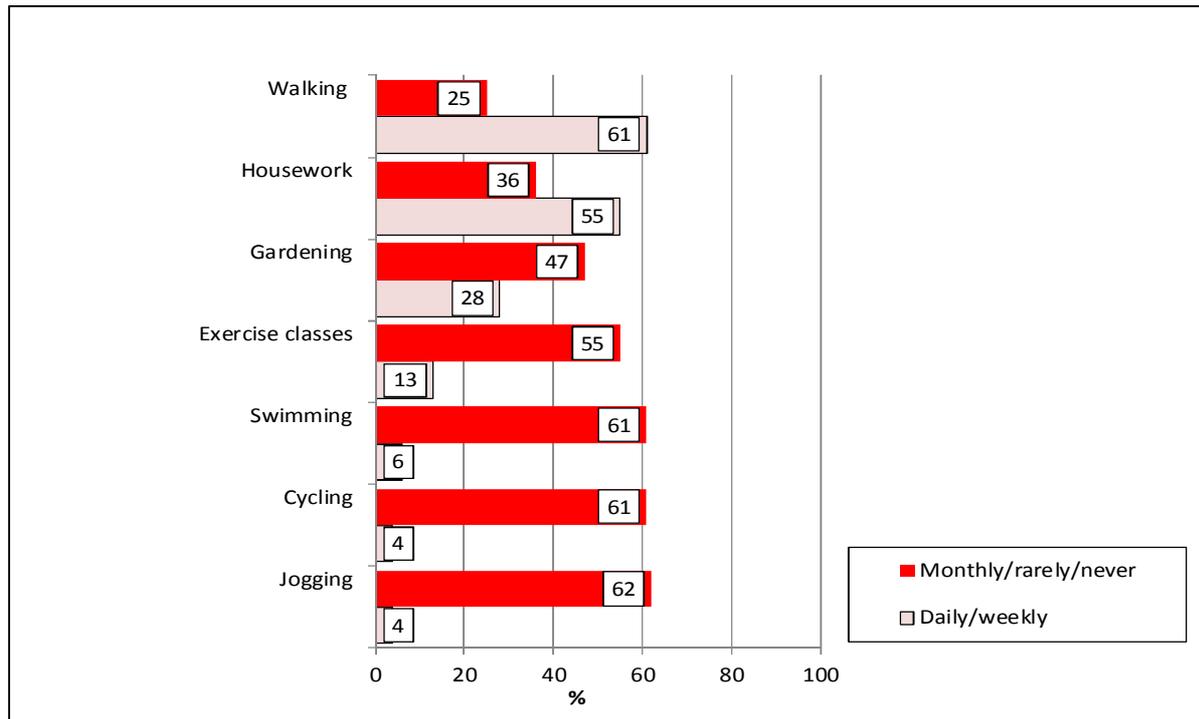
Respondents who rarely or never exercised were asked about reasons for this.

Table 3. Top five reasons respondents gave for not taking regular exercise

An illness or disability prevents me	544 (35%)
I have not got the energy	238 (15%)
Other ways of spending my time are more important to me	205 (13%)
I'm worried about hurting myself	142 (9%)
I have no-one to exercise with	139 (9%)

From a range of possible reasons, illness or disability and lack of energy were the most frequently cited reasons.

This is not to say, however, that people were uninterested in improving their health.

Table 4. Top five lifestyle changes respondents said they would like to make

Lose, or gain weight	608 (39%)
Take more exercise	448 (29%)
Get out of the house more	357 (23%)
Have more social contact with people	329 (21%)
Improve my diet	304 (20%)

As can be seen in **Table 4**, well over a third of respondents said they wanted to lose or gain weight, over a quarter wanted to take more exercise and a fifth wanted to improve their diet.

Information

One precondition for those wanting to maintain or improve their health and wellbeing might be access to appropriate information about how to do so. The questionnaire asked people if they knew where to advise a third party to go for help for a range of health issues.

Table 5. Respondents who said they did *not* know where to advise people to go for help in relation to a range of health issues: the top 5 issues

	Did not know where to access information
Protecting people from abuse	692 (62%)
Making more social contacts	646 (57%)
Sexual health issues	634 (57%)
Help with drug misuse	633 (55%)
Mental/emotional issues	570 (50%)

Although respondents felt they knew where to advise people to go for help with issues such as smoking cessation or alcohol misuse, as can be seen in **Table 5**, fewer than half said they knew where to advise people to go (and, by extension, would not be able to seek advice for themselves) for help with a range of other issues.

Discussion

Limitations

The data on which this paper has been based has a number of limitations. Postal surveys suffer from the inherent weakness of poor response rates, and potential response bias as respondents whose first language is not English, or who have poor literacy skills, are sometimes disadvantaged. Though the response rate to our postal survey was comparatively high for community surveys of this kind (a similar kind of community survey carried out in Oldham in 2006 achieved a response rate of 25% (Oldham Council, 2006)), males, and people from non-white ethnic groups were a little under-represented, and it seemed likely that there was some under-representation of people from lower socio-economic groups – though this could not be confirmed. There is also a very small possibility of multiple responses from the same person due to the variety of different methods of data collection. Finally, the questionnaire was large, validated scales were not used and thorough validation of questions that were included was not possible. However, the response rate suggests that size did not seem to be an obstacle – and that the issues on which the survey focused were ones about which older residents wanted to engage.

The number of responses and the time and care many respondents took to provide us with additional information suggests that our questions were appropriate for those we invited to take part, and participation was seen as worthwhile by many of Coventry's older residents. It would have been useful to have undertaken some qualitative interviews

with a purposive and representative sample, but this was also beyond the resources and remit of the study.

Choice, control and independence

Independence amongst people who use social services is commonly defined by opportunities to exercise choice, and to exert control. Two questions from the survey focused on this. The first was about the attractiveness of personal budgets. The older the participants in our survey were, the less likely they were to feel enthused by the idea of managing a Personal Budget, and the more likely they were to express a preference for someone else to arrange care and support for them. This is consistent with studies of uptake of personal budgets - particularly as Direct Payments - elsewhere (ADASS, 2011; Hatton *et al.*, 2011). A problem for policy makers has been to determine the causes of low uptake: differences in uptake amongst local authorities has led some to suggest that the problem lies with social workers not informing people about personal budgets and Direct Payments. However, the size of the budget available (Beresford, 2009a; 2009b), the amount, and quality of support available to budget holders (and the degree of permanence of this support) may make budget ownership less attractive to many older people, who may not wish to take on responsibility for managing a budget and, whilst valuing their independence, would prefer someone else to take on the main burden of responsibility. Our survey found that many older respondents seemed happier to relinquish some control providing a competent person, who understood their needs, arranged their care. These preconditions are important and suggest a willingness, or desire, to share control over care with another person providing this person could be entrusted with this responsibility.

Perhaps less surprising than responses to personal budgets is that the overwhelming majority of respondents did not wish to move into different accommodation to obtain care

or support. This is consistent with earlier research (Townsend, 1962; Sinclair, 1986; Sinclair *et al*., 1988). Reasons for these findings have been explored elsewhere and include familiarity with local area, and preservation of local social and friendship networks. Respondents clearly saw living in their own home as the best way to maintain their independence and avoid exclusion (through perceived institutionalisation).

In relation both to preferred ways of arranging personal care, and in relation to preparedness to move to a form of housing that might be better adapted to their needs, the importance of social relationships are salient: either in respect of having a relationship of trust with another person, or prioritising the maintenance of social and friendship networks. This suggests, perhaps, that older respondents attached more importance to *inter-dependence* than independence.

Economic, educational, social and community participation

Inclusion is usually defined by the ability of people to take part, or participate, in their local community or wider society. Inclusion in economic, educational, social and community activities are affected by a range of factors.

Economic participation

Only a minority of respondents said they had no money worries. For the majority, careful managing of household finances was essential and at the other end of the spectrum a significant minority were experiencing economic hardship, or were concerned about the prospect of hardship. There was a widespread distrust of financial institutions that might offer advice. Financial hardship is one very significant form of social exclusion (ODPM, 2005; 2006): without financial resources, participation in many other educational social and community activities becomes impossible unless these are free at the point of use. Although the policy

direction may be toward encouraging older people to become economically active, this became increasingly less likely with age amongst the survey's respondents. Lack of money and lack of trustworthy advice placed limits on economic participation amongst respondents, and precluded choice.

Educational participation

Large numbers of respondents did not provide any information about involvement in formal or informal learning, suggesting that participation was not high amongst older people in the city. In part, this seemed to be to do with a small number of barriers that excluded many respondents, including lack of access due to an absence of affordable or accessible transport, the financial cost of learning and lack of information about available educational activities. Arguably, many respondents found themselves unable to take part due to an absence of support from within their local community to enable this. For example, a lack of affordable transport, unaddressed safety concerns, or the absence of subsidies, and discounts on educational activities for older citizens may have prevented participation in otherwise valued activities.

Social and community participation

Almost half of participants in this survey lived alone and a substantial minority admitted to feelings of loneliness at least 'occasionally'. The survey also revealed significant barriers to social and community participation, including poor mobility, lack of confidence to participate, the absence of a companion to do things with and low income. As with barriers to educational participation, these excluding factors could often not be resolved through the exercise of independent activity: impeding factors were beyond the immediate control of individual respondents: support from institutions and other individuals would be needed to overcome them. Support, or some degree of companionship or connectedness to others, and being 'valued' by the wider community, arguably might also offer more effective ways

of supporting inclusion and independence than pursuing these activities in a solitary fashion.

The paper has already drawn attention to the 'digital divide': the oldest survey participants were also much less likely to regularly use the internet, and some seemed effectively cut off from community life by a lack of information about opportunities to participate. Many respondents were undoubtedly excluded from knowledge by a lack of access to newer social media.

In relation to educational, social and community participation, inclusion seemed to be dependent to some extent on the presence of a wider societal infrastructure (for example, the availability of regular and conveniently located bus services, adequate disabled access, the availability of the local service and its cost) and not just the respondent's physical capacity, ability to drive or income. The withdrawal, either of services, or subsidy to service operators, because of the present government's austerity programme may make it harder for some older people to participate and this may lead to more exclusion.

Health and wellbeing

Although the majority of respondents in the survey felt their general level of health was good, and they were enjoying life, the number of people who said they were in poor or indifferent health increased with age. However, lack of enjoyment of life, and therefore poor wellbeing, was more closely associated with illness, disability, loneliness and isolation than age – all factors likely to lead to social exclusion.

Maintaining or improving health - an important way of remaining more independent - also seemed to be problematic for many respondents. The numbers who took exercise declined with age: something often associated with illness or disability. Many respondents were keen to make changes to their lifestyle to improve their overall level of

health and fitness, but were effectively excluded by being unable to overcome barriers, both real and sometimes perceived, to doing so.

Knowledge of where to get advice for health-related issues was variable. Although some respondents knew where to seek advice for a range of health and wellbeing related issues, they were unclear about others: for example, how to protect others (and by extension, themselves) from abuse. Clear, accurate, accessible and timely information is likely to be a precondition to enable older citizens to fully participate in their community and wider society: the absence of information (or more properly the knowledge this confers), may lead to greater levels of exclusion. The widespread lack of access to new technologies such as mobile telephones, computers and the internet added to these risks.

Conclusions

This paper has explored the views of older citizens living in Coventry, UK, about their independence, inclusion and wellbeing and the relationship between these themes. Findings presented in the paper have suggested that whilst most older citizens were independent, able to participate in everyday community activities and were reasonably healthy, happy and comfortable, there were a number of issues that created significant barriers to inclusion and which threatened wellbeing. These included impaired mobility, lack of access to affordable or accessible transport, a lack of financial resources, impaired social networks, ill-health and lack of access to information. The prevalence and salience of these issues often increased with age, but age did not itself seem to be their primary cause. Our findings also suggest that the twin aims of independence and inclusion do not automatically converge. Independence for many older people did not seem to be highly valued if it meant the solitary pursuit of activities or tasks such as, for example, taking on responsibility for spending a personal budget. Inclusion, on the

other hand, was highly valued but difficult for many older people to achieve. To address this policy problem, more socially inclusive, rather than individualistic forms of independence (Plath, 2007), or 'inter-dependence', may be a more appropriate goal for public agencies to pursue.

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