THE AGEING POPULATION IN THE 21ST CENTURY:

NEW REALITIES

la Caixa” Foundation
PUBLISHER
"la Caixa" Banking Foundation, 2017

AUTHORS
Mayte Sancho, Matia Institute
Javier Yanguas, Matia Institute
Elena del Barrio, Matia Institute

"la Caixa" Foundation
THE AGEING POPULATION IN THE 21ST CENTURY:

NEW REALITIES

People First

CARING FOR OTHERS THE WAY WE WOULD LIKE TO BE CARED FOR
New realities
1 New realities linked to population ageing

1.1. Socio-demographic data .................................................. 6
1.2. Conditions of life for people over the age of 65 .................................................. 7
1.3. Social and economic changes in the last ten years ........................................... 12
1.4. Cohort studies and the compression of morbidity ........................................... 16
1.5. Vital stages in the ageing process ............................................. 23
1.6. Elderly people’s new roles: worries and needs ............................................. 29

2 Towards a new framework for understanding people throughout the ageing process ................................ 32

2.1. Trends in planning for an ageing population ........................................... 33
   2.1.1. From the socio-economic impact of ageing to the construction of a caring society ........................................... 33
   2.1.2. Identifying priorities for action with ageing people through social, not-for-profit organisations ........................................... 36

2.2. The “la Caixa” Foundation Elderly Programme:
    from tributes to old age to a new look at the elderly in the 21st century .............. 46
    Principles and values of the “la Caixa” Foundation Elderly Programme ........................................... 47

3 Bibliography and sources .................................................. 48
1

New realities

linked to population ageing
1.1. Socio-demographic data

Statistics show that there are almost 8.5 million elderly people in Spain today (INE, 2014). This figure represents 18.1% of the total population. There are 2,650,992 million people aged over 80, amounting to 5.7% of the total population and 31.4% of the elderly population. Consequently, 2 out of every 10 people in Spain are elderly and 3 out of every 10 people are octogenarians. Of these people aged over 80, 63.7% are women and 36.3% are men. There are 13,165 people aged a hundred or over, of whom 79.2% are women.

In 1996, the percentage of the elderly population rose to 15.6% and the octogenarian population to 3.5%. In the last 18 years, the elderly population figure has increased by 26.3%, while the population aged 80 and over has risen by 48.1%, almost doubling. The population aged a hundred and over has grown by 58.7%. This uneven growth between the groups has come about due to what has been termed the “democratisation of old age” or the democratisation of survival, meaning the general increased life expectancy for most of the population (Pérez Díaz, 2005). In addition, it should be borne in mind that the 70-79 age bracket includes cohorts with reduced numbers due to losses during the Spanish Civil War and the post-war years.

These figures changed as the cohorts born during the baby boom reached the 65-years-old age group. The baby boom phenomenon was widespread among many European countries after the Second World War and was the result of a significant rise in the birth rate between 1957 and 1977. These generations currently represent a third of the entire population and will reach retirement age in the 2020s (Barrio et al., 2015).

Life expectancy is the average number of years that a person of a certain age would expect to live if the standard mortality pattern by age (mortality rates for each age) currently observed continues. Life expectancy is the most widely used indicator to make comparisons about the mortality rate in different populations and, based on that, about the state of health and the level of development of a population. In Western countries, life expectancy improved considerably during the last century and we have succeeded in reducing the probability of death thanks to medical and technological
TABLES 1, 2, 3 AND 4. POPULATION BY AGE AND GENDER

2014

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Population</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 65 years</td>
<td>8,442,427</td>
<td>18.1%</td>
</tr>
<tr>
<td>&gt; 80 years</td>
<td>2,650,992</td>
<td>5.7%</td>
</tr>
<tr>
<td>&gt; 100 years</td>
<td>13,165</td>
<td></td>
</tr>
</tbody>
</table>

MEN | WOMEN
---|---
> 65 years: 3,613,455 (15.7%)
> 80 years: 1,689,925 (7.1%)
> 100 years: 10,428

Source: INE, INEbase, Estadística del Padrón Continuo, 1 January 2014.

1996

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Population</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 65 years</td>
<td>6,196,497</td>
<td>15.6%</td>
</tr>
<tr>
<td>&gt; 80 years</td>
<td>1,376,207</td>
<td>3.5%</td>
</tr>
<tr>
<td>&gt; 100 years</td>
<td>5,442</td>
<td></td>
</tr>
</tbody>
</table>

MEN | WOMEN
---|---
> 65 years: 2,581,667 (13.3%)
> 80 years: 913,946 (4.5%)
> 100 years: 3,573

Source: Drawn up in-house using data from the INE, INEbase, Estadística del Padrón Continuo, 1 January 1996.

2050

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Population</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 65 years</td>
<td>16,448,452</td>
<td>37.6%</td>
</tr>
<tr>
<td>&gt; 80 years</td>
<td>6,976,423</td>
<td>16.0%</td>
</tr>
<tr>
<td>&gt; 100 years</td>
<td>172,459</td>
<td></td>
</tr>
</tbody>
</table>

MEN | WOMEN
---|---
> 65 years: 7,431,518 (35.2%)
> 80 years: 4,060,036 (18.0%)
> 100 years: 1,870

Source: Drawn up in-house using data from the INE, INEbase: Proyecciones de población 2014-2064.

2064

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Population</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 65 years</td>
<td>15,829,223</td>
<td>38.7%</td>
</tr>
<tr>
<td>&gt; 80 years</td>
<td>8,848,483</td>
<td>21.6%</td>
</tr>
<tr>
<td>&gt; 100 years</td>
<td>372,775</td>
<td></td>
</tr>
</tbody>
</table>

MEN | WOMEN
---|---
> 65 years: 7,105,585 (36.1%)
> 80 years: 5,076,913 (24.0%)
> 100 years: 264,962

advances, reductions in infant mortality rates, dietary and lifestyle changes, and improvements to living conditions, education and access to health services (INE, 2015). The latest data for 2014 (INE, provisional data) indicate that life expectancy at birth is 80.2 years for men and 85.7 years for women, with the overall average standing at 83 years. Life expectancy in the opening decade of the 20th century was around 40 years; a century later, this figure has doubled. Population projections for 2064 suggest that life expectancy will rise to 92.65 years, 94.3 for women and 91 for men.

According to The Ageing Report, issued by the European Commission (2015), Spanish women’s life expectancy was the highest in the European Union (EU-28). In contrast, the fertility rate is one of the lowest (1.3 children per woman). The projections regarding this ratio indicate that Spain will remain one of the countries with the lowest scores. Even though the figure will rise slightly above today’s level, it will go up to 1.9 children per woman in 2060, making Spain the third country in Europe with the lowest fertility rate.

---

**GRAPH 1. LIFE EXPECTANCY IN 1908-2014 AND PROJECTIONS FOR 2019-2063**

<table>
<thead>
<tr>
<th>Year</th>
<th>Women</th>
<th>Men</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1908</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1911</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1914</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1917</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1920</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1923</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1926</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1929</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1932</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1935</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1938</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1941</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1944</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1947</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1950</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1953</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1956</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1959</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1962</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1965</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1968</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1971</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1974</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1977</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1983</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1986</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1989</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2029</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2034</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The population figures forecast that by 2050, the number of elderly people will rise to 16,448,452, almost double the current number (INE, 2014), and will account for 37.6% of the total population. There will be around 7 million octogenarians, representing 16% of the total population and 42.4% of the elderly population. The forecast is that there will be 172,459 people aged a hundred and over, an increase of 92.4%. In other words, the number of people aged a hundred and over will rise thirteen-fold in the coming 36 years.

The population projections for 2064, the last year in the INE’s analysis, forecast a future in which almost 4 out of every 10 people in our country will be over 65 years old, and 2 out of every 10 will be octogenarians.

According to projections produced by Eurostat (European Commission, 2015), in 2060 Spain will be the third country in the EU-28 with the highest proportion of octogenarians, behind Portugal and Greece.

It has been calculated that there will be an inversion in the future demographic trend. Over a period of 20 years up to 2035, it is expected that the number of octogenarians will be higher than the number of young people in their childhood years and that it will be twice as high in 2060.
In the early 21st century, the first inversion of the demographic trend occurred, with the number of elderly people exceeding the number of children. Before the midway point of this century is reached, there will be another historic demographic inversion, with a dramatic increase in the population in the later stages of old age, which will take place at a rapid pace and will have implications in various areas of life. The current size of the elderly population, its recent growth and its foreseeable future evolution are a challenge facing political leaders, the health, economic and social system and the individuals themselves and their families (Abellán and Sancho, 2011).
One of the main tendencies over the course of the 20th century was the significant change in the patterns of disease and death. Chronic and degenerative diseases replaced infectious and parasitic diseases: this was a global epidemiological change that was particularly marked among the elderly, among whom degenerative diseases are now the main diagnosed causes of disease and death. Improvements in the pharmaceutical industry, rehabilitation and the health system are contributing to a delay in the onset of disability and death (Abellán and Sancho, 2011).

In the realm of care and the need for help, the changes that have taken place in recent years seem to reveal an upward trend in the percentage of the population who are dependent. According to the latest data from the National Health Survey in Spain (Ministry of Health, Social Services and Equality, 2011), 34.30% of elderly people require help for their personal care, whereas this figure stood at 28.53% in 1993. In the case of people aged 85 and over, these figures rose from 70.63% in 1993 to 72.36% in 2011. The increase in life expectancy, greater survival of the cohorts and greater longevity are among the reasons for the increase in the number of people who find themselves in this situation, which concurs with point 1.4 in this study, in which it is possible to see a certain rise in morbidity (Puga et al., 2014). This corresponds with the

**GRAPH 5. DEPENDENCY FOR PERSONAL CARE, 1993-2011**


---

1.2. Conditions of life for people over the age of 65

---

12 New realities
fact that there is a higher percentage of women than men in these situations: 76.38% of women over 85 years old and 64.86% of men, since women make up the majority of the older cohorts. Functional dependency in relation to personal care among the population aged 65 and over is calculated in the ENSE on the basis of the ability to carry out eight activities: taking medicine (remembering the amount and the time when medication has to be taken); eating (cutting up food and putting it in their mouth); dressing and undressing and choosing what clothes to wear; combing their hair (women); shaving (men); cutting their toenails; washing their face and body from the waist up; taking a shower and bathing; and remaining alone at night. The interviewee is considered functionally dependent with regard to personal care if they answer they “can do it with help” or “cannot do it at all” in response to at least one of the activities. In total, almost 3 million elderly people in Spain are regarded as functionally dependent. Almost 800,000 are aged over 85 (population data for 2011).

In the case of needing help with domestic chores, the percentages rise to almost 8 of every 10 people aged 85 and over and almost 4 in 10 people aged over 65. In other words, an overwhelming majority of people aged 85 require help to carry out domestic tasks in their home. Functional dependence in relation to domestic chores is evaluated on the basis of people’s ability to perform 13 activities: using the phone (finding the number and dialling it); buying food or clothing; preparing their own breakfast; preparing their own lunch; cutting a slice of bread; doing the dishes; making their bed; changing the sheets; washing small items of clothing by hand; washing clothing in a machine; cleaning the house or flat (cleaning or sweeping the floor); cleaning a stain on the floor; and sewing on a button.

The figures for people who are functionally dependent with regard to mobility are similar to those above: 78.11% of people aged 85 and over and 37.74% of elderly people are in this situation. These are the figures that have risen most in comparison with those of 1993: by 7.81% in the case of elderly people and by 9.62% in the case of people aged 85 and over. Consequently, in the last 18 years the number of people aged 85 and over who require help with mobility has risen by almost 10%.

In the realm of care and the need for help, the changes that have taken place in recent years seem to reveal an upward trend in the percentage of the population who are dependent.
Dependency with regard to mobility is evaluated on the basis of the ability to carry out six activities: taking a bus, the underground, taxi, etc.; handling their own money (paying bills, dealing with the bank, signing cheques); walking (with or without a stick); getting out of bed and going to bed; climbing ten steps; and walking for one hour. The interviewee is considered functionally dependent with regard to mobility if they answer they “can do it with help” or “cannot do it at all” in response to at least one of the activities.

This rise in the older population, the increase in life expectancy and the consequent growth in the dependent population is expected to result in a fall in the ratio of family support. The family support ratio is calculated on the basis of the number of people aged 45-64 in comparison with those aged 80 and over, the assumption being that the people in the younger age bracket (45-64) are the potential caregivers of the octogenarians, the people who are potentially dependent. The ratio of family support will drop from 4.67 in 2014 to 1.14 in 2064 (INE). In other words, for every octogenarian there will be 1.14 people between the ages of 45 and 64 as potential caregivers within the family. It seems that this ratio will need to be revised given that a very large number of people aged between 65 and 80 are also performing significant support and care tasks today.

Source: Drawn up in-house using data from the Encuesta Nacional de Salud de España, 1993-2011, Ministry of Health, Social Services and Equality
According to figures in *The Ageing Report* (European Commission, 2015), Spain is the third country in Europe with the highest dependency ratio, calculated in this case as the number of octogenarians in comparison with the number of people of working age (15-64). In other words, in Spain in the period 2013-2060, the number of elderly people in comparison with those potentially in the labour market will exceed that of most countries in Europe, with only Portugal and Greece recording higher figures.

This rise in the older population, the increase in life expectancy and the consequent growth in the dependent population is expected to result in a fall in the ratio of family support.
One striking figure regarding the changes that have taken place among the elderly population in recent decades is the rise in the number of single-person households. According to the latest figures from the INE (2014, provisional figures), 22.6% of elderly people are living on their own today. This figure has risen from 14.2% in 1998. A total of 1,853,700 people aged 65 and over are now living alone in Spain.

This tendency can be seen not only among the elderly population but in the entire population. In recent years, single-person households have been on the rise in every age bracket. According to the INE, there are 4,535,100 single-person households in Spain. Of this total figure, 1,853,700 (40.9%) are people aged 65 and over, and of them, 72.2% are women (1,337,700 households). A comparison with the average figures for 2013 shows that the number of single-person households has increased by 2.8%. In absolute terms, there are 123,100 more single-person households. This is the type of household that has seen the highest increase. The propensity for living in solitude varies according to gender and age. Thus, it is higher among men until the age of 55 and higher among women from the age of 65.

---

**1.3. Social and economic changes in the last ten years**

One striking figure regarding the changes that have taken place among the elderly population in recent decades is the rise in the number of single-person households. According to the latest figures from the INE (2014, provisional figures), 22.6% of elderly people are living on their own today. This figure has risen from 14.2% in 1998. A total of 1,853,700 people aged 65 and over are now living alone in Spain.

This tendency can be seen not only among the elderly population but in the entire population. In recent years, single-person households have been on the rise in every age bracket. According to the INE, there are 4,535,100 single-person households in Spain. Of this total figure, 1,853,700 (40.9%) are people aged 65 and over, and of them, 72.2% are women (1,337,700 households). A comparison with the average figures for 2013 shows that the number of single-person households has increased by 2.8%. In absolute terms, there are 123,100 more single-person households. This is the type of household that has seen the highest increase. The propensity for living in solitude varies according to gender and age. Thus, it is higher among men until the age of 55 and higher among women from the age of 65.

---

**Graph 9. Households with people aged 65 and over by household structure, 1998-2014**

Source: Drawn up in-house using data from the INE, Encuesta Continua de Hogares 2014, press release (17/4/2015)

We use the term ‘propensity’ to mean the quotient between the number of people in each age group living alone and the total number of people in this age group.
Even so, in comparison with European data, Spain is one of the countries with the lowest percentages of people living alone in the EU-27 (2013).

Another major social change in the elderly population is the improvement to these people’s level of education. In the population pyramid by level of education for 1991, we can see how the oldest cohorts included a considerable number of people who were illiterate and a large majority whose only education was primary schooling.

The population profile for 2011 presents a different picture: the population with primary education or who are illiterate has shrunk, whereas the number of those with secondary schooling or advanced studies has increased. For example, the percentage of the population aged 70 to 74 with advanced educational qualifications went up from 3.2% in 1991 to 8.1% in 2011.

It is expected that the level of education will continue to rise in the future, since the number of people aged 50 to 54 with advanced studies rose from 5.6% to 19.5%. These generations are those that will reach the age of 65 in 2020.
One consequence of this rise in the level of education is also evident in the increased usage of computers and the **new information and communications technologies (ICTs)**. A scant 7.5% of the elderly population (65-74) used computers in 2006, but in 2014 25.8% of people used them frequently. Today’s figure for the population aged 55 to 64 rises to 54.2%. Consequently, most members of the future generations of elderly people will use computers as a tool in their everyday lives, since, in addition to the fact that twice as many of this generation use computers in comparison with the previous generation, there is evidence of a narrowing of the digital divide. The usage of these tools is increasing as the cohorts advance.

A similar situation can be seen in Internet usage. Most people in all age groups (76.2%) use the Internet. In the case of the elderly population, more than 1 person in every 4 states that they use it regularly (in the last three months). This figure has risen from a bare 5 in a hundred in 8 years. More than half of the population aged between 55 and 64 uses the Internet nowadays.

In both Internet and computer usage, the most significant rise in the various age groups is in this generation. People aged between 55 and 64 have very quickly begun to incorporate the ITCs to a considerable extent into their everyday lives, with an increase of more than 30 percentage points in the use of computers and almost 40 in the use of the Internet. This population will be the next generation of elderly people, and they will have higher
technological skills and education levels than the generations that have gone before them.

The analysis of the economic changes that have occurred in recent years shows how, in contrast with the total population, the average income per person has tended to rise over the last five years, apart from in 2011. During the financial crisis, the elderly in Spain managed to maintain and even slightly improve their economic status, whereas this fell considerably among the general population.

Most members of the future generations of elderly people will use computers as a tool in their everyday lives, since, in addition to the fact that twice as many of this generation use computers in comparison with the previous generation, there is evidence of a narrowing of the digital divide.
The value of retirement and widower/widow’s pensions has not fallen, even during the financial crisis. The average value of pensions has risen considerably in the last 30 years, with retirement pensions going up from 117.39 euros in 1981 to 1,007.69 euros in 2014, and widower/widow’s pensions going up from 75.73 euros to 626.12 euros. There is an evident difference between the average retirement pension and the average widower/widow’s pension. The average amount paid in retirement pensions ranges from 835.77 euros in Galicia to 1,245.67 euros in the Basque Country. In the case of widower/widow’s pensions, this varies between 528.89 euros in Galicia and 742.49 euros in the Basque Country.

According to the latest study published by the Social Observatory for the Elderly (Workers’ Commissions [CCOO], 2014), 19.9% of households in Spain in 2013 were supported by a person receiving a retirement pension. The number of households whose main source of income is a retirement pension has risen during the financial crisis, amounting to 20% of all households in 2013. The highest proportions of homes supported by people receiving a retirement pension are to be found in the autonomous communities of Castile and León (24.7%) and Asturias (24%), where almost one in four households is supported by a retired person. The lowest proportions of homes supported by a person receiving a retirement pension are in the autonomous communities of the Canary Islands (13%) and the Balearic Islands (16%).
Parents help their children financially on a regular basis in our country and the impact of the current economic crisis has led to an increase in this support. The high unemployment rate in recent years, which has particularly affected young people, has meant that families of origin have become increasingly important in maintaining others living in separate households. Consequently, elderly people, who have greater financial stability guaranteed by their pension and the fact that they own their own home, have had to solve their relatives’ money problems.

The home, from an economic perspective, is an asset that can be enjoyed as property or wealth. It may be a heavy burden or, on the contrary, it may free up a considerable part of the budget that can be spent on other needs (Pérez Ortiz, 2006).
Home ownership is regarded as a very important indicator when analysing elderly people's resources and financial position. It alleviates family budgets and, as a result, provides a considerable sense of security at this stage of life (Barrio et al., 2015). A large majority of elderly people own their homes (89.8%). The tendency seems, moreover, to be increasing, though a small decline was observed between 2012 and 2013. Conversely, home ownership has dropped slightly among the rest of the population.

The high unemployment rate in recent years, which has particularly affected young people, has meant that families of origin have become increasingly important in maintaining others living in separate households.
1.4. Cohort studies and the compression of morbidity

After the striking snapshot above related to the demographic changes and transformations that have taken place in living conditions, we need to answer a number of questions before we go on to describe and define the new ‘types’ of old age seen today. Two of these questions are particularly pertinent to this study.

The first question is whether or not, in light of the irrefutable increase in life expectancy in Western societies, we have extended the period of life that people spend with a disability. And the second question, which complements the first, is whether, regardless of the fact that we live longer (disabled or otherwise), there are or are not improvements in individuals’ functioning in various ambits (physical, cognitive, emotional, independence as regards activities of daily living [ADLs], etc.) as they age.

In other words, whether people born in different cohorts function better or worse in various areas at the same age. These two questions will not only make it easier for us to define the types of ageing that exist but will also provide grounds for the initiatives and actions that the “la Caixa” Banking Foundation proposes to undertake.

The answer to the first question is complex. It is easy to define what mortality is, but it is considerably more difficult to define what we mean by morbidity and disability, which are clearly multidimensional concepts (Martin et al., 2010) and which vary from one study to another, making it difficult to compare them given the different definitions of the same concept that exist.

A number of theories analyse whether the increase in life expectancy means a gain in the number of years without disability or whether, in contrast, we live longer at the expense of spending more years being disabled. There are three classic theories that address this issue:

1. The compression of morbidity theory
2. The expansion of morbidity theory
3. The dynamic equilibrium hypothesis
CLASSIC THEORIES THAT ANALYSE WHETHER THE INCREASE IN LIFE EXPECTANCY MEANS A GAIN IN THE NUMBER OF YEARS WITHOUT DISABILITY OR WHETHER WE LIVE LONGER AT THE EXPENSE OF SPENDING MORE YEARS BEING DISABLED

1. The compression of morbidity theory (Fries, 1980), according to which human life has a limit that life expectancy approaches and that chronic diseases and the disability associated with them can be compressed towards the end of life, with their onset delayed thanks to healthier lifestyles and improved healthcare and treatments, thereby reducing the number of years that we spend disabled.

2. The expansion of morbidity theory (Gruenberg, 1977; Olshansky et al., 1991), according to which increased life expectancy means that we live for more years with chronic diseases and disability, since problems are assumed to start at the same age but we live longer with them due to improvements in healthcare that can prolong life (in this case, health improvements can delay the onset of disability but these people live longer, resulting in an increase in the timespan spent living with problems).

3. The dynamic equilibrium hypothesis (Manton, 1982), according to which increased longevity also means a longer period spent with disability, but the time spent living with severe disability is reduced due to medical care or changes in lifestyle that limit the impact of chronic diseases on disability.

While these tendencies towards compression, expansion or equilibrium may appear sequentially over time or co-exist in other places, the data in Spain (Puga et al., 2014) point to an increase in the number of years before the onset of disability in recent five-year periods, though there has been a decline in recent years, with more years spent with disability, due in the main to the economic recession. Inter-regional differences and a north-south divide have also been identified, with longer life expectancy without disability concentrated in the north. Andalusia is an exception in the south, as life expectancy there is broadly in line with that in northern Spain. Thus, in the light of the data available today, it is not possible to arrive at a clear answer on whether morbidity is compressed or not and we will have to await new data that will perhaps shed light on this issue.
With regard to the second question of whether or not there are improvements in individuals’ functioning throughout the ageing process, that is to say, whether people born in different cohorts function, at the same age, better or worse in different ambits, there is increasing evidence to indicate this improvement has occurred. Even though there are discrepancies between the various research projects that seek to quantify this improvement, a number of authors and studies suggest that there have been gains in various evaluation areas that are all of benefit to cohorts born later in comparison with those born earlier.

In answer to both the first and the second questions raised in this section, it seems evident that there have been improvements in individuals’ various areas of functioning during the early stages of ageing. However, there are doubts (Gerstorf et al., 2011; Hülür et al., 2013) regarding the possibility of these improvements extending into very advanced ages, which continue, as detailed in point 1.2 of this report, to present significant needs for which people require help.

**IN SHORT, WE CAN SAY THAT WE HAVE SCIENTIFIC EVIDENCE ON ASPECTS SUCH AS:**

1. Delayed onset of physical, cognitive and functional decline (Lindenberger, 2012; Small, et al., 2011; Vaupel, 2010; Falk et al., 2014), which occurs at increasingly older ages, though it is to be expected that this decline will take place before the individual dies (Christensen et al., 2008).

2. Improved wellbeing (Gerstorf et al., 2015).

3. Fewer difficulties (among women) in coping in stressful events (Perrig-Chiello et al., 2015).

4. Greater involvement in added-value (free time) activities (Falk et al., 2014), which has a knock-on effect of improved preventive behaviour.

5. Continuation of an identity unrelated to age for longer (Falk et al., 2014).

6. Greater satisfaction in social contacts (Falk et al., 2014).
1.5. Vital stages in the ageing process

The increase in life expectancy has led to a change in the significance of ages. Understanding and describing how people experience the various circumstances and conditions of ageing is fundamental if we are to formulate initiatives that support the various situations in which need and help arise.

This would seem to be a key issue: living longer leads to an increase in the diversification and fragmentation of the various stages of life and old age (Broussy, 2013; International Longevity Centre Brazil, 2015). The traditional trio of infancy, adulthood and old age have, in the last century, been joined by a number of other stages: childhood, preadolescence, adolescence, youth, adulthood, old age, the last of which can itself now be divided into at least three further sub-stages, maturity, frailty and care, that make the lifecycle more complex and individualised.

In terms of ageing, and to define it in a single phrase: we have gone from a homogenising concept of a single ‘third age’ to three distinct and very personal stages of what we have come to call ageing. In the first stage, the subjects see themselves as “older but not old”; during the second stage, they start to become frail; and in the third, they suffer from a loss of autonomy, described in various terms depending on the literature (Yanguas et al., 2008; Prieto et al., 2009; Broussy, 2013; Prieto et al., 2015). These three stages do not necessarily evolve, nor do they affect every individual, and they develop under the umbrella of the tremendous differences between individuals that are always an aspect of old age.

In brief:

**Early stage:**
The early stage is characterised by a generalised perception among people that they feel older but are not yet old-aged or very old-aged. Not that many years ago, retirement was seen as a prelude to the end of life, but for people retiring today (between the ages of 55 and 65), this stage is the beginning of a new life. Some are still ‘older parents’ with ‘young children’, and, for those who have the ability, this is a new and unexplored, unknown, dynamic and active phase that is full of fresh possibilities, offering the opportunity to change the direction of one’s life, to give free rein to desires and aspirations that had been put on hold. People who define themselves as adults continue to carry out the same activities and perform the same roles that they done throughout their lives, and what they leave behind is not their adult life – their life project – in order to move on to another phase; what they abandon is their employed past, not their life's trajectory. They do not perceive a shift in phase, as their elders before them...
would have done years ago; their awareness is instead rooted in the idea that their process of maturing has not come to an end: they do not talk of disengaging and withdrawing but of growth and development. The difficulty lies in imagining the future as a space of personal projection; the complication at times lies in connecting with one’s own desires and understanding that activities give meaning to and channel the life project that each individual wishes to pursue.

**Second stage:**
The second stage hypothetically begins when the first signs of questionable health appear and the person loses the dynamism of the previous phase. This stage is a process of constant adaptation to more restrictive limits in which there is an increasing distance between desires and reality, in which the individual undergoes a process of worsening frailty, in which fears begin to appear. Many people in this phase vouch for the fact that at this time they are engaged in an “all-out struggle” against the loss of identity and importance, in which feelings of isolation and loneliness grow as this process advances. There is no specific age at which this occurs, but there are two main phenomena to it:

* a. The inversion of the solidarity within the family, which shifts from “parents to children” to “children to parents”. The “centre of gravity of reciprocity” changes: the older members go from being the carers of the later generations (children and grandchildren) to being those cared for by the younger generations, who begin to take responsibility for their parents (not so much in the sense of care as in a transposition of roles).

* b. Due to displacement syndrome, in which the subject gradually loses their place in the world and in the family, the usual roles of the earlier phase (of adulthood) are gradually left behind as a result of the loss of vitality and dynamism that derives from the ageing process itself.

**Third stage:**
The third phase, in which a potential loss of autonomy and the consequent need for care may appear. This phase may not necessarily occur; when it does, it is generally among increasingly older people (the risk rises as people age). During this phase, which is a process, not a state (it is not necessarily an ongoing and unstoppable decline, as autonomy may be lost and then recovered), the main challenge following the onset of the need for care is to combat the loss of contact with the world and others. Leaving aside illnesses that cause the individual to disintegrate (for example, Alzheimer’s), the deficiencies that generate dependency limit and impoverish interpersonal relationships, which are subject to a “logic of care in dependency”, which runs the risk of ignoring the individual’s life story, their personal identity and their life project. This is the stage of care, of interdependence, of putting in place mechanisms and models of support that ensure a decent quality of life, the highest possible standard of wellbeing, founded on the premise of full respect for the individual’s dignity and rights, their interests and preferences, while ensuring they participate effectively.
“Active Ageing: A Policy Framework in Response to the Longevity Revolution” (International Longevity Centre Brazil, 2015) – the most recent document on which there is consensus that reviews the paradigm of active ageing – places the emphasis on questions similar to those formulated in this section, though in a more general manner. It stems from a central idea, which is the need to abandon our current notions on retirement and ageing, proposing in their place a more flexible, less rigid and structured view. The document outlines the emergence of a new phase of ageing – though broadly equivalent to the first phase described above – which it terms ‘gerontolescence’, characterised by years lived to the full from the sixth decade onward. The report also emphasises older people’s resilience and adaptation. Moreover, with regard to the report issued by the WHO in 2002, this document includes lifelong learning as the fourth pillar of active ageing, the other three being health, participation and security.

To sum up, there is broad agreement that increased life expectancy has resulted in the emergence of various phases in what we understand old age to be: an initial phase full of vitality, in which the individual seeks the maximum expression of their development as a mature adult; a second phase marked by the onset of frailty; and a third phase – which may not affect everyone – defined by a possible need for care. This increasing complexity of old age calls for:

1. **New conceptual approaches**, since we are talking about almost three decades of life that extend from the culmination of the process of maturing (period of growth) to the end of the individual’s life. This is the same period of life as occurs between the ages of 30 and 60 or 20 and 50.

2. **New and multiple interventions**, from the idea of lifelong learning, enabling the individual to pursue and expand their life project, to addressing frailty, role reversal, etc.

3. **An understanding that we have no ‘handbook’**: we have no in-depth knowledge as yet of all the challenges implicit in each stage and we have to generate this knowledge and devise resources to deal with these challenges and the relationship between each phase and the preceding generations.

4. **An acceptance that these realities are here to stay**, with the prospect that investment in research into health will add still further to this complexity.
1.6. Elderly people’s new roles: worries and needs

The increase in life expectancy and the change in the significance of the stages analysed above intersect with a number of social changes and other situations deriving from investment in health and healthy living. These changes test the ability of elderly people to adapt, transforming the roles they must play and the situations in which they find themselves. In other words, the three phases described above are interconnected with new changes with which they interact and from which new realities emerge. We are at the present time barely able to envisage what these new realities might be, but they will be characteristic aspects of ageing in the future.

Perhaps the most important developments will be the social changes that accompany this revolution in longevity. In a striking and succinct manner, Zygmunt Bauman (Bauman, 2007; Bauman, 2009) uses the metaphor of a liquid society to define that in which – economics apart – human bonds are increasingly fragile and there is greater individualism. This liquid character defines societies marked by the transitory and volatile nature of relationships, societies that also live in a time without the certainties of previous eras. Today’s generations of older people, regardless of the stage of old age that they are at, have to cope with new and unexpected scenarios in a society affected by parameters that give rise to unforeseen uncertainties that it is increasingly difficult to formulate a response to. These situations have an impact on many different levels of a society in the throes of change, in which individuals or their families may face financial instability, changes in their relationships with their children or between generations, changes in the welfare state and the benefits and services it provides, changes in employment, globalisation, urban development, new waves of migration,

Today’s generations of older people, regardless of the stage of old age that they are at, have to cope with new and unexpected scenarios in a society affected by parameters that give rise to unforeseen uncertainties that it is increasingly difficult to formulate a response to.
In addition and juxtaposed to ageing itself and the change that takes place in this process, there are other variables of a ‘contextual’ nature that are characteristic of the daily lives they themselves and their close family lead.

Social inequalities and a whole host of other such transformations.

In other words, in addition and juxtaposed to ageing itself and the change that takes place in this process, there are other variables of a ‘contextual’ nature. Though they are nothing to do with the individual, these variables are, nevertheless, characteristic of the daily lives they themselves and their close family lead. Moreover, it is almost obligatory to respond to these variables and people do not feel they are equipped to do so. A description of all these possible situations would be lengthy, but a few examples will be enough to get to the bottom of the underlying new roles and situations:

1. Just a few decades ago, when people were reaching the legal retirement age, the generation before them had died and the generation that followed them was operating autonomously and was well settled in their adult phase. Nowadays, however, many people over the age of 60 are living in different circumstances, as in many cases their parents are still alive and they are also looking after dependent children.

2. It is increasingly common to come across women in their seventies and eighties whose children have returned, with their own children, to live with them due to separations, divorce or the recession. Consequently, these elderly women once again become ‘housewives’ in the traditional sense after decades of not performing this role, when their own capacities are shrinking and they must suddenly abandon their own life project in order to adapt to the new circumstances.

3. Men and women in their late fifties and early sixties are looking to add to their retirement pension, which
remains in the short and possibly the long term their family’s main source of income, at a time when their own life project and capacities were pointing them in other directions, and they are forced instead to acquire new skills and knowledge.

**Are the people now growing old aware of this process of change and their acquisition of new roles?**

There is little evidence regarding people's perception of performing new roles. The only available data comes from a survey of 1,209 people in Terrassa, Tortosa and Girona, carried out by the Institute of Governance and Public Policies (IGOP) of the Autonomous University of Barcelona for the “la Caixa” Banking Foundation as part of the “With You Always” project. When old and young alike were asked if they felt they were performing new roles, the questionnaire revealed that: a) 79% of the sample of elderly people believe that they are carrying out new roles and that they do so on a regular basis, and only 8% of them denied that they were engaged in activities other than those of their predecessors; and b) regardless of age, 79% of those surveyed are of the view that elderly people are performing new roles. The opinion of the majority, then, seems to be that people will eventually find themselves adapting their roles to suit the new circumstances.

These social changes analysed from the perspective of the individual in the paragraphs above have had an impact at a general level, as elderly people at various stages of old age are having to take on roles that are not in keeping with and bear no relation to what they were expecting at this time of their life, new roles they sometimes perceive as being beyond their capabilities. Earlier stable dynamics, such as training followed by employment followed by retirement are being shattered; traditional gender roles are disappearing; retirement is becoming blurred, since it will be combined with temporary part-time jobs; different generations of fewer members will live together and occupy the same space, resulting in greater intergenerational friction; and the old will compete for jobs with the young. These and a whole host of other new situations will transform our society and old age as we currently understand it. The last stages of people's lifecycle are becoming more flexible and more complex. There will be a greater need to be adaptable and for lifelong learning, an essential tool for a future that is ever more uncertain and unsettled, the less predictable future that Bauman described in his metaphor as being ‘liquid’.
Towards a new framework for understanding people throughout the ageing process
2.1. Trends in planning for an ageing population

2.1.1. From the socio-economic impact of ageing to the construction of a caring society

The description given thus far paints a picture of the striking demographic transition and its social and economic consequences that most developed countries are currently caught up in. It also depicts the effects that these changes have had on the ageing process and the experience of it. Every developed county is to some extent attempting to react to a new structure of modern societies that demands different responses suited to the characteristics of its citizens.

What is required, then, is a reformulation of the current model of governance that will mainstream ageing in every area of policy: the construction of public spaces, neighbourhoods, towns and cities; health and social services; transport; the education system; and the system of production. All these aspects of public policy must be adapted to an ageing society whose members are living to unprecedented ages and who demand to be included and to participate to the full in social and community life. In short, every affected public and private sector needs to make an enormous social effort to achieve change across the board whereby the ageing sector of the population can take its rightful place, not just due to the strength of its numbers, but also because of the role they are already playing now in the construction of a modern, developed society that generates wealth through ageing and lays down values that are essential for its members.

Viewed in this light, it becomes clear that increased life expectancy in developed countries, among them Spain, should not be associated solely with a problematic increase in public spending, but also with significant economic growth generated by serving the needs and preferences of its more elderly members. In short, it offers the strong prospect of employment in personal and local services, as well as considerable potential for the industrial and technological sector. From the point of view of consumption, people currently in the process of ageing represent a significant opportunity for many areas: design and fashion, cosmetics, tourism and leisure, education, healthy environments for exercising, etc., thereby affecting most manufacturing sectors. Nor should we ignore the socio-economic impact deriving from the growing need for care provision from a broad, multidimensional perspective.
It is necessary and also right to spread this message, which is as yet little heard, as it may contribute to bringing about the required change in society’s perception of old age, which is all too often associated with dependency, disease and expense (2004 CIS Barometer). Reflection on a new model of governance for our society will help to disseminate a much more positive image that is more in keeping with the reality regarding elderly people, potential consumers in this ‘silver’ market now emerging in every developed country, underpinned by the perception that ageing represents a potential strong boost to economic growth and employment. This, combined with the growing role of older people in the transfer of unpaid attention and care, makes the continuation of a welfare society possible.

In Europe, the USA and Australia, innovative initiatives are multiplying, led by elderly people themselves, thereby demonstrating their ability to make decisions about their own lives, as well as the crucial contribution they continue to make to the society they have been building over many decades. Organisations for the elderly, such as the American Association of Retired Persons (AARP), which has 40 million members over the age of 50, united by the motto “To serve, not be served”, are a veritable lobbying group capable of influencing many of the political decisions made in their country. This model of associations is popular today in many European countries.

In addition, the planning by various countries and regions for an ageing population attempts to address what is now the paradigm of the ‘old age revolution’ from at least two perspectives:

1. The initiatives of some countries that incorporate ageing as a mainstream element in the life of society and decision-making. France is the obvious example of this stance, having approved its Act on Adapting Society to an Ageing Population on 17 July 2014. This act represents a sea-change in the notion of ‘old age’, which was formerly viewed by social policies as a population group that needed to be ‘integrated’ into society. By taking this innovative approach, French society as a whole is proposing to make changes to its structures in order to adapt itself to the demographic shift. The positive perspective of an aged society stems from the role of the ‘silver economy’, whereby the ageing population will provide the main source of onshore employment in the coming years. But that is not all. This act traces the itinerary of ageing to the end of life, addressing all the issues that are today of concern, both conceptually and in terms of their practical application, to political leaders, planners and academics: frailty, dependency, remaining in one’s own home, caregivers and end of life. All of these are governed by a conceptual framework that promotes the culture of independence and the caring society.

2. The more traditional sectorial or specialist approach in order to meet the needs of this large and diverse
population group, commonly adopted in the UK, the States and Canada. By and large, this approach is structured into three major areas:

a. Plans on active ageing, which grew out of the Second World Assembly on Ageing (Madrid, 2002) and the dissemination of *Active Ageing: A Political Framework*, a document that quickly became a veritable paradigm on the subject and which has very recently been revised and circulated (International Longevity Centre Brazil, 2015). On occasions, this type of plan has been used to systematise and integrate the activities offered by various public and private bodies to people who are in the process of ageing and are independent, active and keen to pursue initiatives focused on:
   - Remaining independent and preventing disease: physical exercise and cognitive training.
   - The satisfactory use of free time, centred above all on travel and the activities that derive from it.
   - Learning new skills and areas of knowledge previously unexplored. Classes and universities of all kinds for older people are playing a very important role in this respect.
   - Special mention must be made of the world of the information and communications technologies: the use of computers, the Internet, mobile devices, etc., which has helped to significantly shrink the digital divide, as shown in graphs 13 and 14, opening up a world of opportunities for the elderly. The “la Caixa” Foundation has played a very important part in this process.
   - Participation in social and community life through associations and bodies for the elderly or through their involvement in volunteer, residents and faith-based organisations, political parties, etc. The evidence seems to suggest that the results are as yet limited, though this is not the place for in-depth analysis.

b. Socio-health plans intended to meet the needs that arise due to dependency and which are very closely focused on the organisation and management of health and social systems to do with long-term care. In most instances, these plans revolve around complying with the wish of people who need help to remain in their home, an aspiration which has thus far not received satisfactory responses through the co-ordination, integration and diversification of care and services.

c. Plans aimed at people with dementia, in particular Alzheimer’s, the impact of which is highly significant, since plans and strategies to address it are being devised in every developed country. This type of initiative is governed by the multidimensional, integrated, social and health-related approach and the development of proposals based on the principle of complementarity in care. Associations led by relatives of people with dementia are playing a very important role in raising awareness of these diseases and in demanding responses from the authorities and other initiatives of a public nature.

Lastly, from a broader and more integral perspective, there is now a significant increase in another type of plan focused above all on the concept of housing due...
New realities

...to its central importance in keeping people who require help in their usual home. This issue has now acquired a mainstreamed and preventive aspect by promoting decision-making with regard to the home and the local surroundings prior to the onset of dependency. There are a number of initiatives in this area, notable among them those implemented in the UK and other English-speaking countries, in particular:


2. **Providing Housing Support for Older and Vulnerable People,** United Kingdom.

### 2.1.2. Identifying priorities for action with ageing people through social, not-for-profit organisations

Following on from this cursory review of the main trends in planning for an ageing population, we will now examine the central issue of this report.

Our starting point is the evolution observed in recent years in the concept of social protection systems and in general in the distribution of responsibilities in meeting the needs of the elderly. In broad brush terms, the charitable and care models that prevailed until the late 1980s in Spain gave way to a public system of social services and, much later, to the configuration of a full right, set forth in Law 39/2006 on the Promotion of Personal Autonomy and Care for Dependent Persons, enacted on 14 December 2006. Following on from the almost full coverage by public systems of the basic needs of people who require help, in the private sector there has been a dramatic rise in the programmes and services that complement the basic services guaranteed by law, without which an integrated model of care like the one we have now, however insufficient, would not exist. The for-profit and not-for-profit third sector and social enterprises, through foundations set up by savings banks, social-responsibility actions, initiatives of a voluntary nature, associations and an ever larger range of for-profit programmes and services make up a map of initiatives that go beyond mere care for dependent people.

---

by offering numerous possibilities throughout the entire ageing process, complementing our public system and, more particularly, the meeting of needs through family support, paradoxically termed ‘informal’.

In short, the impressive increase in life expectancy that is building very long-lived societies with high welfare expectations is leading – apparently irreversibly – to the need to develop a model of collaboration and shared responsibility if we want to uphold and improve the wellbeing of modern societies. The role of the not-for-profit third sector is essential in this scenario, in particular following the severe socio-economic crisis that we are caught up in and which has reduced many people’s spending power, as a result of which, certain support given years ago – with an effort made by the family – that was acquired in the private marketplace or provided by public services is currently only accessible for thousands of citizens via the third sector, which is now meeting pressing needs that stem from dependency.

In the light of this set of circumstances, what are the priority issues that the “la Caixa” Foundation must take up in order to offer responses to unmet social needs in the area of ageing?

Eighteen years ago, the “la Caixa” Foundation set in motion its CiberCaixa initiative, in which the active role of elderly people is promoted and their participation in society encouraged. Its efforts to give older people access to the ITCs in its own centres and many public centres for the elderly around Spain have played an undisputed role in reducing the vast digital divide that even today separates the elderly from the rest of society. More than 75,000 people benefit from this kind of initiative every year. In addition, during this same period significant impetus has been given to a series of actions to promote active ageing, the effects of which are revealed in an analysis of the major changes that this population group has undergone, with these initiatives being viewed – logically – as a contribution that complements those of the public sector in particular but also

The impressive increase in life expectancy that is building very long-lived societies with high welfare expectations is leading to the need to develop a model of collaboration and shared responsibility if we want to uphold and improve the wellbeing of modern societies.
those of the not-for-profit and for-profit third sector and social enterprises. This inclusive function extends far beyond the integration of these technologies into the daily lives of people who are ageing, since it promotes the ‘normalisation’ of this population group and its participation in social and community life on an equal footing.

The simple observation of the level of education of ageing people (graphs 11 and 12) and their access to the Internet (graph 14) forces us to assess the degree of priority accorded to this type of intervention nowadays, when the generations currently moving into old age have a very different socio-educational profile. With regard to frail people and those who need care, while it is necessary to maintain the programmed initiatives, which continue to fulfil an extremely important social function in some amits, it seems essential to engage in reflection in the light of the observed needs of this population group at a different moment in their lives.

In consequence, detailed below is a series of initiatives and actions that need to be addressed in collaboration with the public sector to complement its efforts:

1. Helping people as they age and the quest for a more supportive society

Contributing to the personal development of people who are retiring and facing a long stretch of time ahead of them that they have to fill with meaningful activities represents a fresh way to help a new social group of people that will grow constantly in the coming years (those born during the baby boom). These are mature people who have the opportunity – and the challenge – to embark on a new life without their employment-related obligations of the past. This offers the possibility of promoting an old age with improved quality of life and wellbeing, a different approach to this entire stage of life that fosters a fairer and more supportive society by involving older people in added-value activities for themselves and for society as a whole. The change in values derives from involving these citizens in the future of society: hundreds of thousands of healthy people full of vitality demanding new challenges and opportunities constitute an essential resource as we work towards a fairer and more supportive society, a socially innovative society.

To this end, there is a need to foster a new understanding and action regarding this initial stage of ageing, which must be addressed on the basis of paradigms of development and not the prevention of losses or decline, as is generally the case in elderly planning. It is essential to take as our starting point the psychological needs that trigger forms of behaviour, such as autonomy, competence and personal growth and development,
that respond to the natural need to pursue interests, to put skills into practice, to overcome challenges, that respond to people’s need to control and be masters of their own destiny, to be free to initiate behaviours, to be capable of making choices that can in turn determine actions, to be agents responsible for causing the things that happen to them. Hinging on all of that, there is a need to set in motion actions that will result in social transformation and innovation.

2. Prevention of frailty and dependency through multidisciplinary initiatives beforehand

Anticipating the loss of autonomy and the onset of frailty is becoming the top priority in policies on aging intended to lead to a lifelong “culture of autonomy” and to make citizens responsible for ensuring that prevention is “a matter for everyone” (Broussy, 2013).

There is extensive evidence regarding the influence of lifestyles, social and psychological health-related factors (WHO, 2002) opportunities to access information and a wide range of other aspects that will, to a large extent, predict people’s quality of life during old age and their ability to retain their independence. Foreseeing problems that can occur in advanced old age, associated with dependency and chronic illness, is an undisputed priority, all the more so when the generation of knowledge on these issues is now accessible to the general population. In addition, however, access to information, mentoring and guidance to encourage appropriate habits and behaviour and to promote decision-making regarding the future of people who are ageing are a question of equal opportunities and equity.

The areas of action that underpin this trend in future action are extremely diverse and range from those related to guidance and advice on making decisions that will affect old age today or in the future to the extensive world of health promotion and disease prevention and which include very important aspects such as those to do with housing, social relationships, filling free time, social participation and lifelong learning, which is now seen as one of the four pillars of active ageing (International Longevity Centre Brazil, 2015). Learning to age, managing decline, anticipating and preventing risks and preserving emotional stability are essential skills to learn in the process of ageing, and present opportunities for retaining personal autonomy, which is regarded as highly desirable as time passes. With this approach, lifelong learning, seen until very recently as educational initiatives around the early phase of ageing, shows how important it is to design educational interventions and materials of another nature that will help people to grasp the consequences that arise when decisions about our habits, behaviour, possessions and home are not made at the right time. Remaining in our own home in very advanced old age will depend in large measure on the opportunity to plan our lives in advance.
3. Tackling loneliness

Even though there are far fewer single-person households in Mediterranean countries than elsewhere in central and northern Europe (Graph 10), living alone as a way of life is increasing among older people. As has been said, the initial results from the Rolling Household Survey indicate that 1,853,700 people are living alone, 70% of whom (1,074,800) are women. While this figure can be interpreted in a positive light as an indicator of competence and independence among old people, and this is undoubtedly the case, a more detailed analysis of this situation shows that this is an increasing social reality that requires special attention, as 365,480 people over the age of 85 are living alone. It is this stage of life at a very advanced age that the impact of risk indicators multiplies. Though we do not as yet have more precise data, we know that a large number of these very elderly people, most of them women, need help with mobility and in carrying out domestic chores (78.12%) and their personal care (72.3%) (Graphs 5-7).

If we add to these circumstances others to do with poor disabled access in the home and the environment, or low income levels, which affect most widows, we can clearly see one of the most pressing problems caused when solitude and poverty combine in old age: physical and emotional isolation and the consequent high social and health risks for these people.

It is, therefore, important to distinguish between these two concepts, which are often used interchangeably (Cattan, M. et al., 2005):

**Loneliness**: A concept to do solely with emotional isolation. An unpleasant feeling associated with the absence or loss of relationships with others.

Even though there are far fewer single-person households in Mediterranean countries than elsewhere in central and northern Europe, living alone as a way of life is increasing among older people.
Social isolation. An objective situation to do with no or only limited contact between the elderly person and their close network.

Some countries have tackled loneliness among the elderly as a state issue. An example of this is the MONALISA (Mobilisation nationale contre l'isolement social des âgés) project organised by the French government in 2012, involving civil society, volunteer organisations, associations of the elderly and carers, trade unions, etc. in a considerable mobilisation of the entire country in a bid to generate social networks that will provide companionship and support for the elderly, in particular those aged over 75, who are isolated from the rest of society.

This growing concern in response to the irreversible increase in loneliness among the very elderly has led to numerous research studies regarding its impact on mental health above all, but also the effectiveness of various types of intervention (Losada et al.; 2012, Cattan et al.; 2005; Cohen-Mansfield and Rotem, 2013).

Despite the existence of initiatives in Spain to provide companionship and support for people who are lonely (organised by the Federation of Friends of the Elderly, the Red Cross and others), the increasing magnitude and importance of this issue demands an effort that will to a large extent fall to the third sector and social enterprises given that the public authorities must by law deal with cases of dependency and the many needs for resources and services that these give rise to.

An analysis of the evolution of loneliness among citizens, which now affects more than 4.5 million people in Spain, leads us to propose two types of intervention:

Companionship for elderly people who feel lonely. This support is to be affective and personalised in an attempt to fulfil the preferences and desires of these people. The current trend is increasingly for companionship that fosters networking with other people living nearby, if possible within the same neighbourhood, thereby facilitating more stable relationships and these people's independence, while not forgetting that there are many situations in which companionship in the home remains preferable for various reasons, particularly in the case of dependent people. In this section on companionship, we should not ignore the needs of people living in institutions, most of whom are dependent and many of whom are very elderly, or those reaching the end of their lives.

Acquisition of skills and competences to improve solitude. The increase in the number of single-person households has made this way of life ‘normal’. It is, therefore, to be expected that when members of the younger generations reach old age, they will not perceive to the same extent that they have been abandoned, with all the tragedy and negative consequences
this entails, a phenomenon that occurs with particular intensity in Mediterranean countries.

Notwithstanding this, it seems necessary to take a proactive approach that offers educational and relational initiatives so that people can enjoy their solitude and embrace it with more skills than those of the very elderly today. Once again, this is a population group that has had no chance to ready themselves for this situation, since individuals and society’s expectation has always been that care and companionship would be provided within the family. This represents an extensive field of individual and collective intervention to be explored.

4. Care and carers
Most of the needs that elderly people require help with are met within the home environment, largely by daughters and wives, but also by other members of the family and close friends and family. Consequently, ‘informal care’ is of a surprising magnitude when considered from any analytical viewpoint.

In 2011, the Institute of Fiscal Studies issued a Survey on Disabilities, Personal Independence and Dependency (INE, 2008), which determined that 4,600 million hours of family care had been provided in 2008. In monetary terms, this enormous number of hours equates to between 3.24% and 5.37% of the GDP that same year depending on the scenarios of costs and hours used, with considerable differences between the autonomous communities (Oliva et al., 2011).

Women’s increasing incorporation into the workplace has not led to a clear reduction in their caring activities in the domestic environment (IMSERSO, 1994; Ioé and Rodríguez, 1995). In any event, we have detailed information regarding the impact of the burden of caring for others on carers’ health and quality of life (Rogero, 2011; Fast et al., 1999), as well as its repercussions in terms of the costs of chronic diseases (Wimo, 2002; Oliva and Osuna, 2009).

The Invisible Costs of Illness (2002), a study by Professor Durán, was a reference for many subsequent analyses.
Perhaps the most significant advance observed in recent years related to caring is the unanimous recognition of the need for a complementary approach to address this situation. The care required by dependent people today is of such a magnitude and intensity that it cannot be provided without the support of professional health and social services, the not-for-profit third sector that undertakes companionship tasks, and families. In addition, attention should also be drawn to the important part played by the “invisible social protection army”, consisting until recently of daughters, now helped by hundreds of thousands of domestic employees, most of them immigrants, who make it possible to keep these people in their own homes and enable women to combine employment and home life.

Intensity and a considerable increase in the number of hours and years of care, as well as the complexity of this care, sum up a situation that cannot easily be sustained without the collaboration and shared responsibility of society as a whole in addressing it (Tobia et al., 2010). Every developed country devotes effort to identifying interventions capable of minimising the consequences of care, both personal and social. For this reason, this ambit is regarded as a priority, in our case in terms of the companionship and support for carers by:

- Equipping them with the skills needed to carry out the required tasks.
- Offering them emotional support and strategies to address and handle complex situations.
- Improving their communication skills, based on a two-fold understanding: that dependency and care are a relationship involving at least two parties, the caregiver and the person receiving care; and that communication, consensus and understanding need to be a feature of the entire process.
- Facilitating the co-ordination and management of care, including rest and respite breaks, which are essential for the caregiver.

5. The care model: personalisation and good treatment

The need to define an agreed conceptual framework and to make progress regarding the introduction of substantial and significant changes in the model of care for elderly people who need support is patently a challenge, one that has been repeatedly raised in professional ambits and among the elderly, academic and scientific circles, citizens, etc. It is a relatively recent path generated by a sizeable movement that questions the more traditional model of care that is quite professionalised and very focused on the tasks that have to be done and on guaranteeing the safety of people and professionals (Díaz-Veiga and Sancho, 2012). This route needed to be pursued and greater professionalisation was required, above all to make it now possible to press forward with a model of care underpinned by ethics and centred
entirely on people, their rights, their preferences and their wellbeing. The fundamental principles of such an approach are dignity and the promotion of independence.

The experience of other countries that have been advancing along these lines for decades shows that people-centred care represents a profound cultural change that requires ongoing training and mentoring, that demands that we unlearn certain behaviours and adopt others that shift the attention away from the task and onto the person. It necessitates a change in professional roles and requires us to learn to work as a team to make robust and shared decisions, and to accept controlled risks. In short, it calls for us to review each of our everyday behaviours and to refocus them on the wellbeing and independence of those people who, very often, lost their ability to decide long ago (Martínez, 2010). Ongoing effort is required, therefore, to eradicate ingrained behaviours which, though they might not constitute abuse, are frankly open to improvement and which accord little if any importance to the people who, due to their frailty, are incapable of expressing their desires or of complaining.

One of the core aspects of this change consists of identifying the best ways to inculcate a culture of good treatment and thereby do away with a veritable social disease, elder abuse, which is all too often hidden from view but the incidence of which is intolerable (Tabueña, 2009).

Even though the set of problems associated with elder abuse is becoming increasingly visible, research into violence was until very recently focused exclusively on child abuse and, later, on gender violence against women. The ill-treatment of elderly people was ignored and it is, therefore, the last type of abuse that researchers have concerned themselves with. There are undoubtedly many reasons for this process, but there is one, related to the social value of old age and the stereotypes attached to this stage of life, which is without question the chief cause of this lack of interest in situations that are clearly tragic. For this reason, it remains a priority to

People-centred care represents a profound cultural change that requires ongoing training and mentoring, that demands that we unlearn certain behaviours and adopt others that shift the attention away from the task and onto the person.
incorporate into plans and training for professionals the issue of the **stereotypes** that we reproduce every day in our behaviour (Fernández-Ballesteros et al., 2014).

We still face a distorted perception of the reality of this segment of the population due to the fact that they are mistakenly associated with illness and disease, dependence, frailty and deficiencies, making them, in this misperception, a social burden. The outcome of these social depictions is that old age is clearly undervalued as a stage of life that makes cohabitation with others possible in our society with a degree of tolerance that would be inadmissible in similar situations that might occur in any other population group. Combating this type of situation involves an approach that is already familiar but not implemented sufficiently widely: understanding in order to act, raise awareness, train and intervene in the most effective way (WHO, 2002).

Once again, the third sector and social enterprises have an essential role to play in each of the phases of the path marked out, particularly in relation to awareness-raising, training and spreading best practices (Pérez Rojo et al., 2011), complementing the powers and duties of the public authorities.
2.2. The “la Caixa” Foundation Elderly Programme: from tributes to old age to a new look at the elderly in the 21st century

Principles and values of the “la Caixa” Foundation Elderly Programme

The issue of ageing is now surrounded by this climate of change; new priorities for care are being identified and the central aspects of the elderly programmes run by the “la Caixa” Foundation are being reformulated based on a series of conceptual principles that underpin this entire process and offer an ethical framework that provides appropriate responses to the new needs. These principles have emerged from the identification of criteria that it is now agreed will guide the Foundation’s strategic work. They include:

1. Recognition that heterogeneity is an incontrovertible characteristic of people aged 55 and over, leading us to work in an individualised manner. The deeply entrenched tendency in elderly care to provide standardised services to hundreds of thousands...

IT IS IN THIS CONCEPTUAL FRAMEWORK THAT WE WILL NOW GO ON TO SINGLE OUT SOME OF THE PRINCIPLES THAT WILL GOVERN THE WORK OF THE “LA CAIXA” FOUNDATION.

1. Dignity

Regarded as a fundamental ethical category. Of the various ways in which this term is used, we note its close connection with respect and equality in the consideration that every person deserves and the consequent duty to recognise their civic rights. It constitutes the basis of ‘good treatment’ and of the efforts to combat the stereotypes associated with ageing that are deeply rooted in our society. Dignity is related to respect, the assumption each person is a singular being whose needs are multidimensional, who has a viewpoint of their own that needs to be respected, and who is a subject – regardless of their condition – with capabilities and rights.

2. Independence

This concept, which is gradually being incorporated into elderly care and has now become a paradigm, occupies an essential place in the formulation of the theoretical and ethical framework covering responses to people’s needs. Independence is related to the ability to choose, to freedom and, above all, the right to retain control over one’s own life and one’s daily surroundings. It has become an increasingly important social value and as such needs to be included in every plan. Applying it calls for respect for people’s self-determination and their right to receive the support needed to enable them to make decisions without coercion and of their own volition. Implicit within it is a recognition of the heterogeneity of people and their preferences and, in consequence, the need to diversify to the maximum the options presented to people who are ageing.
of people who have reached old age with different experiences and along different paths seems to be in the throes of terminal decline, though considerable effort will still be required from all the bodies involved.

A mainstreamed approach to the process of ageing. Even though research into gerontology constantly provides evidence of the close connection between the various areas that constitute an individual’s life, the way in which issues related to ageing are tackled is detrimental to this joined-up and systemic vision. In the light of the complexity of the question of ageing, in which physical, cognitive and emotional aspects have an impact on a wide range of areas, including urban development, housing and mobility policies, economic and local growth and myriad others, we need, as indicated earlier, a model of governance capable of offering this all-encompassing vision that ageing demands.

These criteria call for an evolving approach to ageing founded at all times on the criterion of the normalisation of this large group of people, who have increasingly embarked on life paths in which age is not as significant a factor as other aspects, such as level of education, professional activity, purchasing power, interests, preferences, etc.

3. Participation
The World Health Organization has established this principle as one of the crucial mainstays of active ageing, alongside good health, lifelong learning and security. It represents a sea change in the traditional concept of ageing, which is associated with the stereotypes of passiveness and the lack of an identified social role. Participation is a right, one that is also connected with the recognition of people as citizens with a part to play in building the society in which they live.

It implies the need for their voice to be taken into account in any process to make decisions that might involve them, as well as the duty to integrate and include people who are ageing in the initiatives that they wish to take part in based on solidarity and civic responsibility. Effective participation is also connected with other principles discussed here, such as dignity and independence.

4. Shared responsibility
Only through collective, individual and shared responsibility, through humanitarian collaboration that encompasses the efforts made by the various departments of the public authorities, the not-for-profit third sector and for-profit social enterprises, community participation movements and associations, will we be able to offer a satisfactory response that meets people’s desires and preferences. The diversity of needs, support and care that they have demand this.

There is a need to forge a civic movement in which every generation and social sector plays its part in building a welfare society for every age group. Shared responsibility is the only way to build an active and healthy life project for all citizens.
3

Bibliography and sources


/ Christensen et al. (2013). Physical and cognitive function of people older than 90 years: a comparison of two Danish cohorts born 10 years apart. The Lancet.


/ Instituto Nacional de Estadística (INE). Statistical sources:
- Encuesta de Condiciones de Vida (ECV), 2014.
- Encuesta sobre Equipamiento y Uso de Tecnologías de la Información y la Comunicación en los Hogares, 2014.
- Estadística del Padrón Continuo a 1 de enero de 1996.
- Estadística del Padrón Continuo a 1 de enero de 2014.
- Proyecciones de población 2014-2064.

/ INSS. Pensiones Contributivas del Sistema de la Seguridad Social. Ministerio de Empleo y Seguridad Social.


/ Law 39/2006, of 14 December 2006, on the Promotion of Personal Autonomy and Care for Dependent Persons.


/ Pioneer Network. Retrieved from: http://www.pioneernetwork.net/


/ Proyecto MONALISA. Retrieved from: http://www.monalisa-assso.fr/


