Aspects of co-production

The implications for work, health and volunteering

The concept of ‘co-production’ is emerging as a radical challenge to existing approaches to local economic development and the delivery of welfare and public services. As part of the Hidden Work research programme with the Joseph Rowntree Foundation, **nef** (the new economics foundation) organised three expert seminars on co-production. Each one was framed by an essay that set some of the challenges thrown up by a new idea. This publication makes those essays more widely available.

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Essay I: The downside of full employment

Sandra is 28, has two children, and lives in a small block of council flats in a semi-rural part of the Welsh Valleys. She is unemployed, but she is not inactive.

Although the flats where she lives used to be run-down and still have something of a reputation, they're undergoing a very real transformation, due in no small part to people like Sandra. She is one of a group of local mums who has volunteered to staff the local community flat so that it can be open on weekends, when many residents would like to use it but can't because paid staff aren't around. She also helps run the local youth club, helped launch a community garden, and is now involved in running the local adopt-a-station scheme.

This is valuable work. Local police, interviewed as part of nef's (the new economics foundation's) co-production research project, say that the investment Sandra and other community residents have made has reduced vandalism and saves them time and money. Yet current government employment policy would prefer Sandra to be in paid work.

Here is the question we pose: If employment policy succeeds and mums like Sandra have no alternative but to take up paid work, will this be an indicator of success for society? Will full employment – not in its purest economic sense, but in the sense of getting everybody of working age into paid jobs – really contribute that much to the economy that it would compensate for the loss of people like Sandra from their local neighbourhoods?

Over the next five years, the Department for Work and Pensions (DWP) has three main aims: to get 300,000 additional lone parents into paid work, to get one million people on Incapacity Benefit into jobs, and to encourage another million people to stay on in paid work past the age of 65.

This essay focuses primarily on lone parents, the majority of whom are single mothers. They are of particular interest to the government for two reasons: firstly, because it sees getting lone parents into paid work as the best way of reducing child poverty and secondly because it sees paid work as the best way to fund future investment in public services.

Despite what we know both intuitively and from formal research – that young children are better off at home in their first two years – Gordon Brown's 2004 budget concentrated on the provision of nursery places for

babies in children's centres as part of a major push to get their mothers into work. Education Secretary Ruth Kelly has also made it clear that schools should stay open 12 hours a day to cater for working parents.

Ministers would no doubt explain that this is simply designed to provide more choice to working women, but by implication it would appear that paid employment takes precedence over the needs of children. Just opening schools longer will cost an extra £680 million. This and the other resources engaged might arguably be better spent supporting people like Sandra to continue to invest their energy in their own families and local communities.

So important to ministers is the objective of full employment that successful and popular initiatives like Sure Start are subtly shifting so that their primary purpose is to support working parents rather than develop healthy children and cohesive communities. "The early Sure Start documents make very little reference to 'childcare' in the sense of somewhere where children can be looked after to enable their parents to work," said Professor Norman Glass, the architect of Sure Start. "It was all about child development."[1]

The implications of full employment

There are, of course, significant social and economic implications of all this. Our primary concern is that the type of unpaid, unacknowledged work being done all over the country by people like Sandra – whether it is investing in children's future well-being, helping refugees to settle in, understanding the impact of a local planning application, organising a local fair trade fair, or keeping a station free of graffiti – takes time and energy, both of which are often in short supply at the end of a long day at work. Further, it seems that the government assumes this work is either so unimportant that it need not be replaced, or that it can somehow be substituted by the market economy, presumably paid for through newly acquired taxes and wages.

Informal childcare and other caring

The evidence is that parents looking after babies full-time in their first year of life are critically important, and to allow that to happen, the government's ten-year childcare strategy, *Choice for Parents* has flexibility in employment at its heart.[2]

We also know that, given the option, most parents will choose informal childcare over professional services. Yet Ofsted, which holds regulatory responsibility for childcare, has prioritised the latter. So much so that Working Families is now actively campaigning to have support, information and training provided to informal carers. They hope this will counteract the growing perception that informal care provided by friends or family is less valuable than that provided by professional providers.

If a mother does decide to go to work, the cost of a nursery place for an under-3 is £134 per week – presumably taking a fair chunk out of her wages – and much of it is already subsidised by the government anyway.

It is hard to put a figure on the value of the informal childcare that currently takes place in the UK. One estimate, using the wages of live-in nannies as a guide, placed the value of informal care at £75 billion a year for under-5's (1999 figures) and £225 billion a year for all children.[3] We also know that about five per cent of school-age children look after themselves during school holidays and about nine per cent come home after school to empty houses.[4]

As well as childcare, about 890,000 people over 16 are informally caring for sick and ageing relatives for 50 or more hours a week, at an equivalent cost of £57.4 billion per year – nearly as much as the cost of running the NHS.[5] As the population ages, this figure is likely to increase. Carers UK expects that demand to have increased by up to 60 per cent – another 3.4 million people – in 35 to 40 years' time.[6] Some will get Carers' Allowance, but many may find themselves forced into paid work instead.

Some of the work they do informally – shopping, cleaning, providing financial support, bathing, administering medicine, even giving occupational therapy – could certainly be provided by paid staff – but what about the love, patience and shared history? It is hard to see how we will be able to write a job description for that.

Neighbourhood support

Full employment would also considerably reduce the amount of time and energy that people have for community activity. The 2001 Home Office Citizenship survey estimated that formal and informal volunteering – excluding employer-supported volunteering – combined to contribute the equivalent of about £36 billion to the UK economy.[7]

The National Centre for Volunteering estimated volunteer contributions at £41 billion, making volunteering the third largest contributor to GDP in the UK.[8] Formal volunteering alone was valued at £25 billion, which would rank it fourth by industry sector.[9]

It would be wrong to suggest that these figures rely so heavily on the contributions made by people outside paid work that they would drop dramatically if most people were in paid work. But we know that the profile of voluntary involvement is changing – working people have less time and often prefer to give financially.

A major study of Chicago by the Harvard School of Public Health showed that it was the willingness of neighbours to intervene in small ways that was by far the most important factor in reducing crime.[10] If people spend their days at work, they don't get many opportunities to know their neighbours. Full employment, in other words, is likely to be corrosive of social capital.

What we found through our research was that many of those people considered of no benefit to the formal economy because of illness, age or ethnicity are extraordinarily active in keeping people and places alive and well. And according to the 2001 Home Office Citizenship Survey, as many as 58 per cent of them had been involved in social participation in the past year and 64 per cent in informal volunteering – we can only guess at how much of this would cease if people were in full-time work.

The Treasury dilemma

The total cost of Carers Allowance (£1.1 billion) and Incapacity Benefit (£6.8 billion) is dwarfed by the value of the unpaid work undertaken every day across the UK. But the single-issue, quick-win focus of government employment targets means that many of the true costs of full employment will probably never be acknowledged. These include obvious costs like the need to provide basic care to older people, as well as less directly attributable costs like higher rates of youth crime, stress-related illness, and depression.

In its latest proposals for restructuring Incapacity Benefit, the DWP also admits that for about 20 per cent of the 2.7 million people currently receiving IB, conventional full-time work will never be appropriate or possible.

Another less obvious challenge relates again to single parents. The evidence from **nef**'s co-production research suggests that aside from caring responsibilities, single parents often have very little confidence in their ability to participate in the formal workplace and lack the self-esteem to consider formal training or further education. Many live in communities with an historical culture of low achievement. We should not underestimate the impact this might have on future employment policy.

But our research shows that initiatives like the PATCH (Parents and Their Children's' Hopes) project in Glasgow, where flexible learning and capacity-building activities take place in a familiar environment, significant gains are being made in levels of confidence and emotional well-being. Parents are taking responsibility for co-producing both their own and their children's well-being by participating in parenting classes, healthy eating, stress management, and complementary therapies.

In the Welsh Valleys, another of the research sites, mothers are earning time credits through the local time bank by running after-school activities for children in the community flat and spending them on driving lessons so they can take their children out. Sandra is one of these time bank members.

These activities are probably a great deal more beneficial to families and communities – and to individual self-esteem – than most paid work options currently available. The knowledge that they are capable of making a meaningful contribution can change people's lives, especially if they look for paid work at some point in the future.

The question for ministers is just how significant they consider a parent's potential to contribute to individual, family and community well-being, and whether forcing lone parents into paid jobs is always the best solution. And given rates of teenage pregnancy, self-harm, truancy, bullying, drug and alcohol abuse, and childhood obesity, whether there might be better ways of engaging them.

The problem is that the available work options are often limited to two unpalatable extremes: low-status, no-prospect, insecure and part-time, or full-time, better-paid, long hours and high stress. Both limit the ability of parents to exercise the kind of confident parenting that society needs.

Alternatives

The findings from **nef**'s co-production research shows that many people outside paid employment are involved in worthwhile, even vital, activity in their communities. This is not really unexpected: one study in Canada found that one in five single parents on welfare was engaged in two or more activities involving working, studying or volunteering.[11]

Our research has revealed a vast range of informal, unacknowledged work that is undertaken in those neighbourhoods considered to be most 'disadvantaged', by people frequently considered a 'drain on society' – single mothers, refugees and asylum-seekers, people with mental health problems, and those too young or too old for conventional jobs. People like Karen (two children) and Molly (three children) also from the same flats in

the Welsh Valleys, who help run the local playgroup and the community flat. And the single dad (two children) in Glasgow who can't work but helps with the fruit barrows at the SEAL project 'to keep from going mad', and the parents who volunteered and set up the breakfast club at a local primary school.

This is work that keeps local neighbourhoods safe, clean and inviting, keeps people healthy and happy. and enhances people's abilities as parents, friends, neighbours, and potential employees – but never appears in government employment statistics.

One organisation that recognises the vital contribution of people outside paid work is Macmillan Cancer Care. Not only does Macmillan recognise the contribution that service users can make because of their direct experience of the disease, it also believes giving something back is a crucial part of the cancer recovery process.

This may take the form of delivering training, fundraising, volunteering in shops, providing user expertise and much else besides – returning to paid work is often simply not an option.

But official emphasis on full employment is undermining Macmillan's attempts to recognise and value this unpaid contribution. "We're being forced away from more innovative forms of user involvement back towards more traditional volunteering – and consequently disempowering people – because the basis of working with users is valuing their expertise and we can't find a way of effectively doing this," said Macmillan's head of user involvement Jane Bradburn.[12]

For many cancer patients, paid work is neither possible nor desirable. Yet Macmillan is no longer able to pay honorariums to service users for their contributions, because of tax and benefit rules.

If Macmillan recognises their service-users as vital assets capable of doing irreplaceable – though non-salaried work – then other organisations and public services would probably do so as well. The question is whether this kind of work, for which those involved are often uniquely qualified, might not be more significant and sustainable than forcing these same people into conventional paid jobs.

This is not to claim that paid employment, if it is available, should not be an option for anyone currently on Incapacity Benefit. It is just to propose that the government should be exploring ways of valuing the work that many people are doing outside paid employment – looking after children, looking after each other, reducing crime, being expert patients, and much else. This work is necessary.

It is also not affordable or replaceable at market prices.

Re-defining work

How far can we go towards redefining what we consider to be 'work'? This new category of work – between paid employment and enforced idleness – requires that we find new ways of valuing those intangible necessities of life that make us uniquely human: even something as simple as providing a shoulder to cry on.

We also need to acknowledge that increasing income alone will not alleviate poverty. These activities play a crucial role in keeping us physically

and emotionally healthy. This may not mean paying for them directly – in fact, financial remuneration frequently undermines their value and power – but it must mean new forms of reward and recognition.

Some alternative proposals:

- Invest in approaches that strengthen social capital and use people's inherent assets – like community time banks– to generate new support systems for struggling families and communities.
- Make sure that any such investment is made with the understanding that a focus on valuing people as assets will take time – both in changing working practice and in changing community perspectives. Plan more realistic development and evaluation timeframes, beyond current three-year cycles.
- Short-term funding priorities and pre-determined floor targets allow little scope for involving people outside paid work in the delivery of public services. Commissioning guidance should include explicit advice and information on practical ways to incorporate co-production into service delivery.
- Since the government is already experimenting with incentivising behaviour – the DfES 'Learning Options' pilots add £10 to the basic benefit entitlement for participation in formal learning – there may be other ways to reform the benefits system to actively reward vital community involvement. Specifically, that means reviewing restrictions on contributors receiving goods or services in return for their efforts.
- Recognise the use of evaluation methodologies ('distance travelled', for example) which document 'soft' outcomes like improved confidence and subjective well-being.
- Refocus childcare regulations to promote and improve informal care and encourage the development of more community-based solutions.

Essay 2: The best medicine: can the NHS go beyond illness?

Gina is a former accountant, living in south east London, who has had three nervous breakdowns. She has serious weight and circulation problems and her doctor told her she had to start walking a mile a day.

Like many of the other 2.7 million people on Incapacity Benefit, Gina's primary social contact was with health professionals. Her low self-esteem, social isolation and multiple health problems made the prospect of walking a mile on her own every day in London – or the obvious solution, joining a gym – almost inconceivable. The chances were that, as with so many other chronic health problems, Gina would not keep up the effort.

But she did, and she did so by joining a time bank attached to her surgery, which linked her up with people who could support her – and who she could support too. The result was new friendships, more confidence, and better health. Now she is *jogging* a mile every day, looking for a job and volunteering at the local credit union. And health professionals aren't the only people she sees any more.

It is worth looking more closely at how we classify this success story, which clearly demonstrates not only a strategy which has actually improved, rather than simply managed, several inter-related chronic health problems – and hopefully means one less person on Incapacity Benefit in the near future.

Is this a common approach by NHS professionals? Well, yes and no. It certainly started with a GP – albeit an enlightened one – who acknowledged that the standard route of prescribing medication and treating the obvious physical symptoms might not be the best medicine for what were clearly primarily psycho-social problems. And who also realised that simply urging 'more exercise' was not going to work. But Gina's success story also depended on contributions from neighbours and neighbourhood organisations. For most of us, the world of NHS professionals, and that of the informal support we need to help stay well, are light years apart.

Soon she would have been eligible for a personal health trainer, but it was not another health professional she needed. She was able to partner up with a gym buddy, who supports her in her efforts to get fit. This is 'co-production' – but not just between doctor and patient, but between both of

them and with neighbours, and with voluntary organisations as the interface between them.

Community health services

Gina's story is rare. **nef**'s co-production research project shows that individuals and neighbourhoods can make significant contributions to people's physical and mental health – sometimes in partnerships with, but more frequently in parallel with local health services rather than integrated with them. As long as health commissioning remains tightly wedded to hard outcomes and floor targets primarily based on clinical and pharmacological interventions, the emphasis remains on a rather narrow kind of cure.

In mental health services, in particular, statistical evidence still shows you are likely to lose both your job and relationship if you spend more than a few weeks as an in-patient.

South London & Maudsley (SLAM) NHS Trust director Zoe Reed quotes one service user demanding: "Give us our lives back!"[13] The problem is that users are drawn into the institution and its systems, rather than making small interventions when these would help and then retreating again.

"How do you put Humpty Dumpty together again?" asks Professor Tom Craig at the Institute of Psychiatry, explaining that he knows how to get a patient to talk about a mental problem and how to prescribe the right drugs, but is powerless to provide what he knows is the best medicine: friends, social networks and work.[14]

These are vital to recovery from a range of problems, especially chronic conditions. But actually, the regulations attached to Incapacity Benefit encourage people to stay inactive, exile people from anything that might be remotely construed as 'work', and rule out any activity that can give them a meaningful role in society.

Scale

Incapacity Benefit has shot to the top of the political agenda because of the dramatic tripling of numbers in ten years: one third of those on IB claim benefit on the grounds of mental ill health. But this isn't the whole story. As many as 60 percent of all adults in the UK have some form of chronic illness and 8.8 million are ill enough to severely limit their day-to-day ability to cope.

And it is getting worse. By 2030, chronic disease in over-65s is expected to double. This was a major influencing factor in Derek Wanless' estimate that investment in public health and public engagement might save the NHS £30 billion a year by 2022 – half the current budget of the NHS.[15]

Prevention

Prevention is difficult for an NHS which has no levers on many of the causes of ill-health. While mental health services have recently started to take big strides towards recognising the need for more holistic and preventative approaches to mental health, mental health promotion only became a key policy aim in 2001 when it appeared in the National Service

Framework. Services are still pre-occupied with the treatment and care of those with severe and enduring mental illness and the disconnection between public health and mental health services looks set to continue.

Towards a Wellness Service

The trouble with an NHS pre-occupied with professional care is that it has tended to overlook the vital contribution that patients – and their families and neighbours – make to keeping and making each other well. The Expert Patient Programme is a good example that illustrates how this contribution can be realised, and how things may be gradually changing.[16]

Evaluation of the programme implies that where patients and health professionals act together to co-produce a positive outcome, there are long-term reciprocal benefits for all: volunteers are recognised as assets as a result of their experience, participants are more able to live successfully with their conditions, and professionals are less likely to have to deal with problems that are essentially self-managing.

The term 'co-production', the subject of **nef**'s research project, originated as a term to describe the critical role that service 'consumers' have for the success of professionals. It was originally coined in the 1970s in Chicago, when research there found that neighbourhood crime rates went up when police stopped walking the beat and lost their vital connections with local community members.[17] It is being used increasingly in health to describe the reciprocal relationship necessary between professionals and individuals to make positive change a reality, but has also been deepened and put into a broader context by the work of the civil rights lawyer Edgar Cahn.[18]

Individuals

The World Health Organisation estimates that healthy life expectancy in Britain could be raised by around 5.4 per cent by successfully tackling the problems resulting from irregular blood pressure, high cholesterol, obesity, tobacco and alcohol.[19] But this begs two questions. First, if the health service has the know-how, how will we be able to pay for it? And secondly, in a society that places freedom and choice above all else, how will individuals be encouraged to take more responsibility for making positive decisions about their own health?

Our existing welfare system requires people to demonstrate serious, long-term problems in order to be eligible for support. It also identifies people according to their *dis*abilities, implicitly assuming any abilities are not only irrelevant, but can actually be counter-productive to a successful outcome. This narrow identification process reduces people to the sum of their illness in order to treat the largest number as quickly and cheaply as possible.

The doctor-patient 'relationship' has often collapsed into a simple delivery system, rather than a relationship capable of changing people's lives. When public health minister Hazel Blears talked about reintroducing 'an element of reciprocity', she was talking about tackling the corrosive situation where all elements of relationship have been ironed out in the name of professional status.[20]

Neighbourhoods

But co-production has to be more than a one-to-one relationship between doctor and patient. We know the impact of social isolation has on people's health.[21] Co-production incorporates strengthened roles for families, neighbours and community organisations – to provide the caring, encouragement, transportation, and activities that people need to get and stay well.

This is not news. It was the principle that underpinned the development of Peckham's Pioneer Health Centre in the 1930s, health buses and well-woman clinics in the 1980s, and healthy living centres and time banks in the 1990s. There was a deliberate attempt at the start of the NHS to break up the informal networks of support and advice that played such a role in maintaining health, and these are the successors to those lost systems.[22]

There is increasing recognition that informal community activities help change people's attitudes towards their own health, their own efficacy, sense of control and responsibility – and that informal peer pressure is far more effective than being told what is good for you.[23] But innovations capable of rebuilding neighbourhood support have tended to exist outside formal NHS structures.

nef's co-production research has revealed how people can sometimes develop the kind of co-operative local support they need to tackle ill-health. In London, SLAM's Traumatic Stress Service is working with Groundwork and a local time bank to enable disenfranchised Kosovan men to use their native farming skills to support local gardening schemes. In Glasgow, volunteers at the SEAL project run a fruit barrow scheme and support the neighbourhood oral health team by teaching nursery children about healthy eating. In Wales, a group of sixth formers, who first got together when they refurbished their common-room for time credits, have just teamed up with specialists from DrugAid to script, film and edit a video about drink spiking.

What drives them to improve their own health is maionly the influence of their relationships with other people. What drives them to support each other is the positive impact they see their contributions make to other lives. Life on Incapacity Benefit rarely allows this to happen, let alone encourages it.

Again, these are not new ideas: they are a few of the myriad of small initiatives that achieve this in different ways, mainly at the margins or barely tolerated inside the mainstream. The challenge is to find a way of making them central. A major American foundation describes it like this. "While social networks are not an alternative for what the services families need, they play a critical role in addressing the issues that services cannot address, or in some instances the issues that the service delivery system even creates – isolation, powerlessness, the loss of self-image and self-worth".[24]

Asset-based services

Gina is one of those helping to create this new kind of community web of support. So is one of her gym buddies who gets additional exercise and earns time credits by taking a 77-year-old friend who is wheel-chair bound out for walks. That man in the wheelchair returns the favour by putting on his shirt and tie on 'work days', and stuffing envelopes at home for a local

community organisation. Like other patients with chronic health problems, none come to the situation without something to offer. They have their time, and their knowledge of what works for them – and probably skills and experience of vital importance to their local communities.

This may be the basic insight behind the development of a Wellness Service: patients are assets that need not be wasted, as they tend to be under a target-driven NHS. A Wellness Service will recognise these as assets, value and reward them, and develop institutions capable of using them.[25]

Those institutions capable of doing that are either in the voluntary sector (Green Gyms) or on the fringes of the NHS (patient support groups). Only a very few manage to bring these systematically into the mainstream, as SLAM's Cares of Life Project collaborates with Peckham churches to promote mental health in the Afro-Caribbean community.

Where this is happening, it is clearly having an impact. "Co-production helps the trust and social services achieve community participation for service users and carers", says Nick Hervey, SLAM's head of social care. "It is tailor-made to allow the social inclusion of mental health service users as it validates their contributions without affecting their income, but can also be a pathway to other things such as paid work."

Why not?

So why is this Wellness Service, so vital to the future funding of the NHS and to reducing the number of those on IB, not happening in more than a patchwork way, occasionally, mainly in the voluntary sector? Why are these isolated gems of excellent practice struggling in the margins, as bolt-on initiatives with short-term funding and no mechanisms to replicate what they have learned?

One reason is the limited definition of health we work with, which is one of the by-products of institutionalising healthcare. The Alma Alta Declaration of 1978 agreed that the best definition of health was not the absence of illness, but the achievement of each individual's full potential.

Another is the difficulty government departments have planning and co-ordinating broader services. Jamie Oliver's school meals, for example – so crucial to long-term health – are defined as 'education'. Work-place smoking is the responsibility of the Department of Trade and Industry. Another is that co-producing health with patients, with families and neighbours, does not fit easily into the existing systems and targets.

This may be why interventions seem to work best when they do not challenge existing NHS systems. A more sophisticated approach may be to recognise this and find other ways of bringing the parallel approaches closer without actually trying to force them together.

Either way, a key problem is how best to engage the army of potential co-producers sitting idle on Incapacity Benefit – a third of whom actually want to work.[26] And to do so without undermining an already disempowered and over-burdened cadre of health professionals.

Work and government policy

The size of the Incapacity Benefit roster is partly a result of deliberate government policy in the 1990s to hide mass unemployment figures.[27] But it is also a testament to the failure of the NHS to tackle chronic health problems effectively, and the increasing dependence and isolation faced by people on IB.

And for all the official determination to lower the figures – there is a target of one million back to work within five years – the benefits system is vigilant in its determination to clamp down on any informal efforts at recovery, community involvement, informal learning or other activities that will strengthen individual skills and emotional resilience.

We have learned a little about this first-hand. One of our own researchers – a SLAM service user trained through **nef**'s co-production project as part of our action research team – recently made the mistake of telling his benefits advisor what he was doing. As a result of his pride in his first-ever foray into research 'work', his IB status may well be re-assessed. Yet the DfES is piloting a 'Learning Option' – a £10 benefits top-up for registering for *formal* learning. It was taking this initiative outside an official government scheme that caused the problems.

So the most important shift required is for government to change the rules around Incapacity Benefit – not just to encourage people into formal work, which is now happening – but to encourage them into activities that will improve their own quality of life, and protect and improve the quality of life of those around them.

This new space – between paid employment and inactivity – is, in some ways, healthier than either because while the social connections created may mimic those developed in the workplace, the actions take place in a flexible and personalised way that most paid employment is unwilling to support. It is particularly important for those with mental health problems, which count for the largest proportion of those on Incapacity Benefit.[28] But it is also absolutely vital for providing the new frontline of the Wellness Service, which consists largely of patients, their families and their neighbours, working informally.

Some proposals:

- Recognise that almost everybody has some time or activity to offer – not just semi-professional volunteering – and that they badly need to engage them.
- Re-evaluate the long-term implications of a 'consumer' model of the NHS. Commissioning guidance needs to recommend good practice in building reciprocal human relationships between professionals, patients and neighbours.
- Experiment with partnerships between public and voluntary sectors to engage clients and their neighbours as co-producers of services.

Essay 3: Natural resources: Older people at home alone

Mary is 79 and lives in Catford in south east London. She has mobility problems and survives on a small state pension. She has no immediate family and she lives alone.

From one perspective, she typifies the people that so worry policy-makers when they contemplate the future and its cohorts of aging baby-boomers. She is a drain on the public purse and a complex collection of problems for NHS health and social care services.

But look a little closer, and the picture changes. As a member of the time bank at her local health centre, Mary has been exchanging her time with John, a 40-year-old recovering alcoholic, who lives in a hostel nearby. He tends her garden – and learns about plants and planting, guided by her years of experience – and she shares her wisdom and local knowledge with him on walks through the area. *"I've learned things about Catford – astonishing things,"* he says. *"Historical curiosities, local history, stuff about the war. I'm benefiting from Mary's sharing of history and seeing things differently."*

Mary sees the difference in him, but he also knows he is changing too. *"I didn't realise I had it in me, to take an interest in people, to be generous with my time with people. I know this now because Mary showed me."* It may be the gardening; it may be the local history. More likely it is seeing life through someone else's eyes, sharing time with someone who is prepared to make an effort, and giving something back to the person who's helping you out because they need you as much as you need them. The value of feeling useful, when your main experience had been as a recipient of welfare service, can be transformative.[29]

The magic in this match is not hard to identify: they share a common experience as former civil servants, and a local time bank had the sense to match them up. But the real question is why we continue to need to define people in ways that can obscure the potential resources they represent for society around them.

As lone individuals, Mary and John are likely to become an increasing cost to tax-payers. Bring them together creatively, and they are less so. And the benefits don't stop there. John describes it best: *"I don't just think that it's just me and Mary that are affected – it kind of spreads out. If we are making each other feel a bit happier we are making other people feel happier."*

This is the essence of co-production. It requires that professional agencies acknowledge the contributions people make as people, and find ways of encouraging and valuing them. It is also important to notice the kind of activities that are creating the benefits Mary and John are experiencing: simple, informal activities like picking up a prescription or going for a walk – the kind of things that don't require elaborate planning, high levels of investment, specialist skills or qualifications.

It is also hard to make them the subject of performance targets. Yet **nef**'s co-production research indicates that this kind of 'work' may have disproportionate value in terms of heath promotion and illness prevention.[30]

Co-production provides a critique of the way that the health and social care services focus primarily on the treatment of illness and function within a system that responds only to worsening health. For many older people, this can create a vicious circle of identification with illness, and supports the prevailing social messages that they have nothing worthwhile to offer. For Mary, and many others like her, it only takes a slight shift in perception to see her as an asset – with very real cost savings for the health service attached. Just how much would it cost to pay someone to do what she's doing for free in keeping John on track?

The Indiana University team that developed the concept of co-production, under Professor Elinor Ostrom, believed the original confusion arose because of a myth that services were neatly demarcated between agencies and sectors, when the truth was that a variety of interlocking services were responsible for different aspects of the same problems – and there was no real divide between public sector agencies and clients.[31]

Since then, the concept has been refined and developed by the work of the law professor and co-founder of the US National Legal Services Programme, Edgar Cahn. For Cahn, 'co-production' means that – if professionals are going to succeed in the long-term – welfare programmes, policing or health, need to be partnerships between professionals and clients that respect what both sides need to provide.[32]

This is particularly relevant to older people. In particular, it requires systems that can broaden our definition of work, and which allow the people who are normally the object of volunteering or health services to be actively engaged in providing mutual support. This can both broaden the way work is understood and be transformative for the people taking part.

The threat

The difficulty is that this idea, while it is obvious to people on the ground that older people are a hidden resource, can elude policy-makers or those who place too much reliance on indicators and metrics.

The result is that, in many policy areas, the potential contribution that can be made by older people – and younger people as well, of course – is under threat from the side-effects of technocratic policies, whether they are the modernisation of volunteering, the increased professionalisation of healthcare or the full employment agenda.

The full employment agenda

Greater longevity and a rapidly ageing population is the most prominent driver behind many of these policies, with its likely impact on pensions. The government objective is to extend the working life, beyond the traditional retirement age, of one million people, according to the Department of Work and Pensions five-year plan.[33]

There is no doubt that people could carry on paid work for longer, and there will be economic benefits for the nation if they do so. But what is missing from the debate is the recognition of the importance of what they are often doing now after retirement instead of paid work. The debate about pensions seems to exclude the insight that they may already be making a vital contribution which is critical to the economic and social sustainability of the nation.

Like Mary, Jessie and Coral are both retired and in their 70s. One is West Indian and one Nigerian, and they offer health advice and information to local residents through a health bus run by the Cares of Life (CoLP) in Peckham. CoLP is one of a number of community initiative supported by the South London and Maudsley NHS Trust, designed to encourage the uptake of mental health services by the local Afro-Caribbean population. They are not in paid work, but they are nonetheless carrying out vital activity.

In fact, the UK employment rate for 55-64 year-olds is already 55.5 per cent, compared to an EU average of 44 per cent. As many as two thirds of the growth in the Labour market since 1997 has been in over-50s – though these figures include people who may be working as little as one hour a week.

One of the problems is that paid work after 60 or 65 tends to be in low skill, low pay, low prospects work. In fact, despite the increase in paid work among older people, the main increase in their income has been through income support and benefits take-up.[34] The biggest rise in the employment rate among older workers is among women, who are often more willing to take on lower paid jobs.

Important as it undoubtedly is to encourage people into paid work beyond the age of 65, the emphasis on paid work – rather than all the other critical work that people are already doing in retirement – has allowed some of the other threats to this kind of co-production to become more intense.

Modernisation of volunteering

Those who are now retired were brought up with a culture of volunteering, often derived from the efforts of their parents and those around them during the Second World War. There is no evidence that younger generations lack that basic understanding of reciprocity and neighbourhood involvement, the underlying culture of neighbourliness, but there is no doubt that the prevailing culture of isolation, instant gratification and dependence has changed the way people regard their personal responsibilities.[35]

On the other hand, as they get older – at least if present trends continue – the next generation of retired volunteers will face a battery of hurdles including insurance restrictions on their volunteer involvement, bizarre regulations which exclude them from most activities after a certain age, and dwindling public transport.[36]

There is also a shift going on in the *kind* of voluntary activity that people are involved with. There is a trend towards more formalised volunteering, delivered via a voluntary sector agency – often paid to administer the programme by central government or lottery money.

The overwhelming bias of employment regulations is also to encourage people into formal voluntary activities that might enhance their employability while clamping down on anyone doing the same informally. Certainly, the fear of losing benefits is a major disincentive for people to volunteer.[37]

The official public backing for informal community activity is matched by official suspicion of anyone carrying out informal work when they are on benefits, and by structures that increasingly threaten the informal organisations that promote it: often quite old-established, not usually formally constituted. Often they are linked to some local institution like a club or a church.

These are unlikely to have lottery money and certainly are not in the running for bidding for government contracts. Yet the work they do is probably widespread and certainly important. Sometimes it is threatened by the disappearance of low-rent community spaces as councils seek to realise market value from community halls and venues. Sometimes their host institutions, the community centres and social clubs, are also either threatened or are now manned by paid staff.[38]

Over-professionalisation

Sometimes, of course, the generation that were the backbone of this informal sector are not being replaced by a new generation that have been brought up with a more passive approach to life. Younger generations are more prone to depression. They are more isolated in adult life, which will undoubtedly lead to even greater isolation in old age.

The consumer society, and its concomitant approach to healthcare has encouraged them to assume a passivity in the face of illness or disability – waiting for NHS professionals to provide a service. It has obscured from them just how important it is for them to play an equally active role in getting well and staying well.

These lessons are increasingly important as you get older. For professional services to be effective, informal effort is required. Without the informal effort, other things unravel.[39] Yet the blinkered approach to over-65s, that somehow the only dignified solution is more paid work, can obscure the fact that the unpaid work they are doing – either on their own account or on account of their neighbours – may be equally important.

It is true that paid work may keep people healthier for longer as they get older, but it provides no solution once they are ill. A job will not help them pick up a prescription or walk the dog or fetch some milk, let alone provide a shoulder to cry on. Yet all of these are just as vital to getting well and staying well in old age.

A co-production approach

The co-production research that lies behind this project has demonstrated again the value of involvement in unpaid work for people who are getting older participation.

Informal work means people can use their skills, like Jessie and Coral, working as volunteers for the 'health bus' in Peckham. It reduces loneliness and isolation, increases self-worth, and offsets stereotypes about older people as needing help. It demonstrates in graphic terms that, although you may have retired, you are still of great value to community. It means you can acquire informal skills and pass them on, and build what is increasingly known as social capital. Health problems may prevent paid work, but they do not prevent people being assets to their neighbourhoods.

This is not, strictly speaking, ordinary volunteering. These are people who are taking on unpaid (though not necessarily unrewarded) activity through public services that they are involved with as patients or in other capacities. They may be taking them on as part of their treatment.

Co-production, in public or voluntary services, create opportunities for people to gain confidence in their ability to contribute. It means that they leave the house occasionally, mix with people and maybe start them on a ladder of involvement – which might lead to upgrading skills and even maybe to paid employment if it was appropriate.

Evidence from **nef**'s co-production research suggests this is playing a role of breaking the cycle of low aspiration in communities of disadvantage. As one frontline staff member in Glasgow noted:

"There are wee pockets of success – of parents having the confidence to go on and go to college or do a course, or participate in the PPP [Positive Parenting Programme]. They say: 'Oh, that's not for me', and the next thing you know, they are doing it."

Re-defining work

There is no doubt that the population is aging. The 65-74 year-old age group and the over-85s will both be ten per cent bigger even by the next general election. That has implications for healthcare, and the current model of health for older patients – a simple consumer idea that doctors dole out health to passive patients – is not likely to be either effective or affordable.

The Wanless Report concluded that the NHS could survive and thrive only if people took responsibility for their own health: the government has yet to understand the implications of this.[40]

One of the major impacts on the cost of treating an ageing population is the increasing burden of managing chronic conditions, and which current practices – which emphasise pharmacological solutions – do not tackle effectively. But just as society needs people with time and the ability to care, to provide the kind of informal support that older people need to deal

with these and other problems, officials try to siphon off as many of them as possible back into paid employment.

What we seem to lack is the infrastructure that can involve patients, or other users of public services, as partners with professionals. There are big examples as well as little ones. Lehigh Hospital in Pennsylvania, for example, tells patients who are discharged from hospital they will be visited by people who will shop for them and see how they are, and in return they will be asked to do the same for someone else. This kind of reciprocal system can have an impact on problems like emergency re-admissions.[41]

But in the UK, the evidence is that the way public services are evaluated, the emphasis on paid work, and other official bias, tends to undermine this kind of approach.

Some alternative proposals:

- Co-production tends to be small-scale, though it may be quite widespread, and above all it needs more experimentation – focused specifically on problems like bed-blocking, emergency re-admissions, loneliness, and using the assets that other patients represent as potential solutions.
- Chronic conditions require a whole new approach to treatment: it is clear that simple pharmaceutical dependency is not effective, and requires some kind of extension of the Expert Patient Scheme.
- The evaluation systems in most public services pay no attention whatever to using patients or other beneficiaries as assets – and many targets actively inhibit this. How can we reform the target system so that it does not waste these people?
- The key to successful co-production is embedding those taking part in some kind of reciprocal system. If so, what privileges can older people be given in return for the efforts they make – especially if it is over and above what is required for their own recovery?

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