

Older People and Wellbeing

by Jessica Allen

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Contents

About ippr	3
About the author	3
Acknowledgements	3
Introduction	4
1. Age, health and happiness	6
Demographic and health trends.....	6
<i>Life expectancy and population growth</i>	6
<i>Ageing population</i>	8
<i>Healthy life expectancy</i>	9
<i>Inequalities in health and life expectancy</i>	11
Trends in wellbeing	12
<i>Defining and measuring wellbeing</i>	12
<i>Trends in wellbeing in the UK</i>	13
<i>Wellbeing in older people</i>	15
<i>Future trends in older people's mental wellbeing</i>	17
Summary	18
2. Factors that shape wellbeing in older people	20
Social exclusion, inequalities and health	20
<i>Poverty and deprivation</i>	21
<i>Physical health</i>	24
<i>Ethnicity</i>	25
<i>Gender</i>	27
<i>Lack of diagnosis of mental health conditions</i>	27
Relationships and social life	27
<i>Contact with friends and family</i>	27
<i>Marital status</i>	28
<i>Living alone</i>	29
<i>Age discrimination</i>	30
Events and transitions in life that can trigger poor mental wellbeing	30
<i>Retirement</i>	30
<i>Bereavement</i>	31
<i>Care: giving and receiving</i>	31
Community participation	32
<i>Crime and fear of crime</i>	32
<i>Local environment</i>	33
<i>Housing quality</i>	34
Protecting wellbeing	34
<i>Taking an active grandparenting role</i>	34
<i>Exercise</i>	35
<i>Education and learning</i>	35
<i>Volunteering</i>	35
<i>Personal resilience</i>	36
<i>Religion</i>	36
<i>Respect</i>	36
3. Conclusions	37
References.....	38

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Introduction

The wellbeing of young people in the UK has recently been the subject of unprecedented attention and scrutiny. For example, a UNICEF report published in 2007 caused shock and consternation by suggesting that despite a decade of investment and policy focus on young people, the UK was the worst place in Europe to be a child. But what of older people? While their plight has not been the subject of such extensive analysis or government focus, the UK is not always a great place to be old either.

Although the UK population is living longer and is in better health than ever, and older people are wealthier than they were, like the rest of the population, older people are not getting any happier. There is some evidence that older people may be becoming decreasingly satisfied, lonelier and more depressed and, due to demographic changes, there are increasing numbers of older people, many of whom are living with low levels of life satisfaction and wellbeing. This is particularly so if you are poor, isolated, in ill health, living alone, in unfit housing or rundown neighbourhoods and worse still if you are a carer or living in a care home: and all of these risk factors apply to a large proportion of the UK's older population.

This report, the first in a series on older people and wellbeing from ippr, describes some of the key social trends in the UK and assesses how these may be impacting on older people and their wellbeing.

Not an inevitability

The over-65s, and particularly the increasing numbers of people over the age of 80, have been relatively neglected demographic groups. Too many older people live with preventable depression, loneliness and isolation. Unhappiness in old age is not inevitable, even for those with poor physical health and limited mobility. This report highlights the significance of support in fostering wellbeing and social and community participation for older people, particularly for those most at risk of isolation and exclusion. This analysis will be developed in the second phase of this work in 2008 and 2009.

It is worth noting at the outset that there are significant national differences in wellbeing among older populations, further enhancing the case for there being no inevitability to the situation in the UK. For example, in Japan, where old people are accorded great respect, life satisfaction is highest among the over-65s. In Hungary, by contrast, the young are the most satisfied and satisfaction is low among older generations (Donovan and Halpern 2002).

The current policy context

A number of recent, well-intentioned policy documents from central government have set out ways of improving levels of wellbeing among older people (see, for example, Department for Work and Pensions 2005, ODPM 2006b, Department of Health 2004). But the overall focus of national policy continues to be children and young people. Furthermore, some of these documents have languished after launch and the proposals have not been acted upon. The political appetite to drive through proposals sometimes appears to be lacking.

The Social Exclusion Unit's report on ending social exclusion for older people emphasised the need for strong leadership to prioritise wellbeing of older people (ODPM 2006a). A number of departments have a considerable impact on the lives of older people: the Department for Work and Pensions has formal responsibility for older people but has tended to focus most on issues around benefits and pensions; the Department of Health focuses on health and social care; and the Department for Communities and Local Government on housing, local government and urban regeneration. However, the work of these departments is not always sufficiently joined up and there is no department or office with sole responsibility for older people in the same way that the Department for Children, Schools and Families has responsibility for young people.

The Social Exclusion Unit report proposed a review of plans for an Office for Ageing and Older People which could provide the kind of leadership and cross-government working that is currently lacking. However, a move of this kind has not yet taken place. It also promised effective action to tackle

inequalities and exclusion for older people, and recommended a similar approach to the Sure Start programme that exists for younger people. While the analysis remains sound, implementation has been patchy and there is still no Sure Start for Later Life.

The first cross-government strategy to focus on older people, *Opportunity Age* (DWP 2005), contains many excellent proposals around ending discrimination, tackling inequalities, and offering more support and interventions for older people. Some of the specific proposals have been introduced, and pilots such as LinkAge Plus are running.¹ However, as with the proposals in the Social Exclusion Unit's report, there has not yet been sufficient impact. As this report describes, too many older people are still struggling with preventable levels of unhappiness and depression, with many remaining excluded, suffering from poverty, poor housing, ill health and discrimination.

One important strand of recent national Government policy activity relating to older people has been social care and unpaid care. Care needs in people aged 65 and over are estimated to rise by 87 per cent by 2051 from 2002 levels and by 2041 the number of disabled people is expected to double compared with 2002 (Moullin 2008). In 2008 the Government launched a national debate, leading to a Green Paper in 2009, about the future care system. These debates and strategies show recognition that the current care system is in need of a major redrawing in terms of funding, types of care support offered and where and how care should be delivered. The need for a thorough rethink of wellbeing in later life is made all the more pressing given the projected increases in numbers of people over 65 in the UK and other developed countries.

Structure of the report

In the first chapter we describe the dominant demographic and health trends in the UK, with a focus on people of 65 and older. Health and wealth are often seen as strong predictors of levels of wellbeing. However, as we show in the second part of the chapter, levels of life satisfaction and wellbeing have stagnated over the last 40 to 50 years, despite better health and increasing wealth. Some studies show increased prevalence of mental health problems and deteriorating levels of life satisfaction, particularly for people over 75. Our analysis of population structure, health, inequality and levels of wellbeing provides the context for the rest of the report, which focuses on current and likely changes in the drivers of wellbeing for older people.

In the second chapter, in order to assess existing and future trends in older people's wellbeing, we discuss in more detail the main drivers of wellbeing for this group. Physical health and relative income levels are significant, but the most important factors relate to social interaction and community participation. We assess trends in older people's income, highlighting levels of inequality, despite wealth increases for almost all of the last 20 years.

We go on to assess other important drivers of poor emotional wellbeing and those that can support and protect good wellbeing. This analysis is based around four principal areas: levels of social exclusion and inequality, relationships and social life, life events such as retirement and bereavement and levels of participation in community life. There are opportunities for positive activities which older people value to be better supported by government and services, which could in turn reduce the prevalence of depression, isolation and loneliness.

In the concluding chapter we recommend that more needs to be done to support older people's wellbeing and set out our intentions for phase two of ippr's work on the politics of ageing.

1. There are eight LinkAge Plus pilots, which aim to give older people access to more integrated services, including housing, transport, health and social care, work, and volunteering opportunities.

1. Age, health and happiness

This chapter sets the context for our analysis of ageing and future levels of wellbeing for older people. We explore demographic trends that show that a growing section of the population will be over 65 in years to come. There have been striking gains in life expectancy and some gains in healthy life expectancy, which mean that we are all expected to live longer and in better health, although this not universal across all social groups.

In the second half of the chapter we go on to examine how, despite increases in wealth and advances in health, there have not been commensurate improvements in national wellbeing – in fact, on some indications wellbeing is deteriorating. This stagnation or decline in wellbeing has been noticed within government and by other analysts and there are suggestions that instead of using gross domestic product as a measure of progress, levels of life satisfaction or happiness should be used. We describe possible future trends in older people’s levels of wellbeing and suggest that the numbers of older people with low wellbeing may be rising. This may be the result of an increasing prevalence of mental health problems, as well as demographic changes.

Demographic and health trends

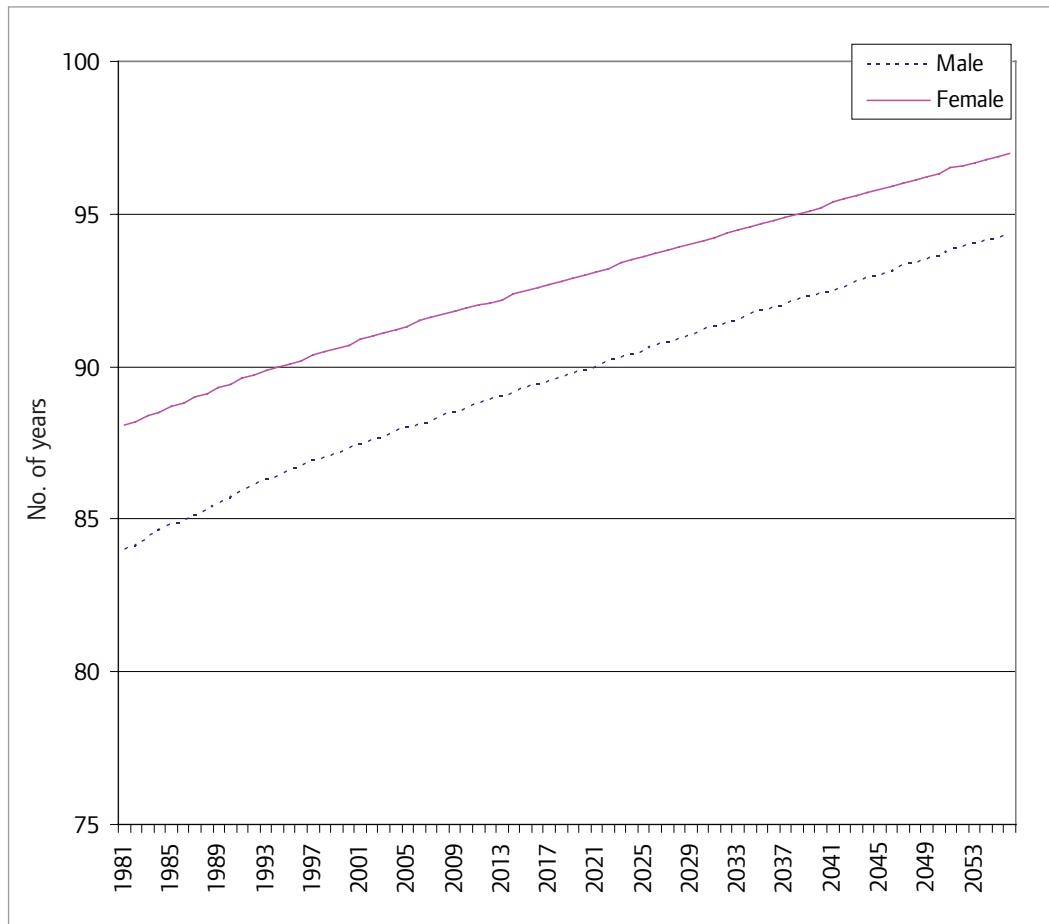
Life expectancy and population growth

The 20th century brought dramatic gains in life expectancy in the UK. In 1901, baby boys born in the UK could expect to live for around 45 years and girls for 49 years. By 2006 baby boys could expect to live for 77 years and girls for 81 years. Further increases are expected as medical innovation continues.

Figure 1.1 illustrates real and projected gains in life expectancy for men and women. The cohort life expectancy projections try to take account of future health and medical improvements.

Figure 1.1. Male and female life expectancy at birth, UK, 1981-2056

Source: Government Actuary’s Department (www.gad.gov.uk/Demography_data/Life_Tables/docs/2006/2006UKeolb.asp)



However, despite striking overall gains in life expectancy for everybody, there remain significant differences in life expectancy between social classes. Professional classes have longer life expectancy than all other social groups. Despite government targets and interventions the gap continues to widen with latest figures showing a 2 per cent increase in inequality for men and 11 per cent for women between 1995-7 and 2006-7 (Department of Health 2008).

Figure 1.2. Male life expectancy at birth – manual and non-manual occupations, England and Wales, 1972-2005

Source: Office for National Statistics 2007a

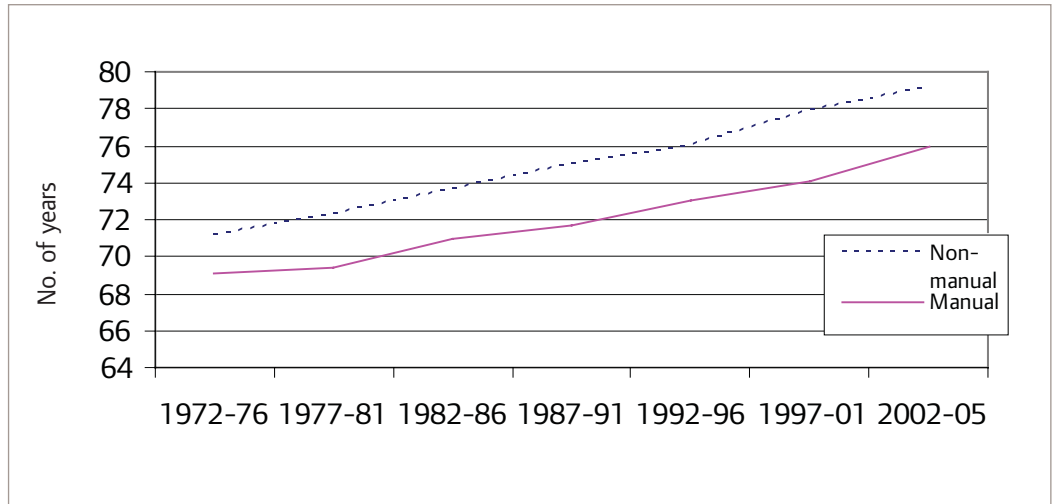
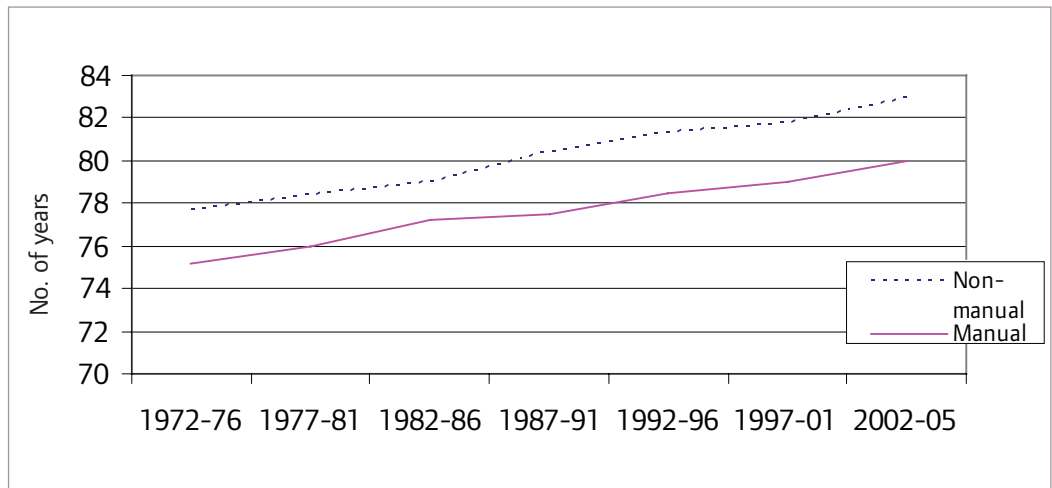


Figure 1.3. Female life expectancy at birth – manual and non-manual occupations, England and Wales, 1972-2005

Source: Office for National Statistics 2007a

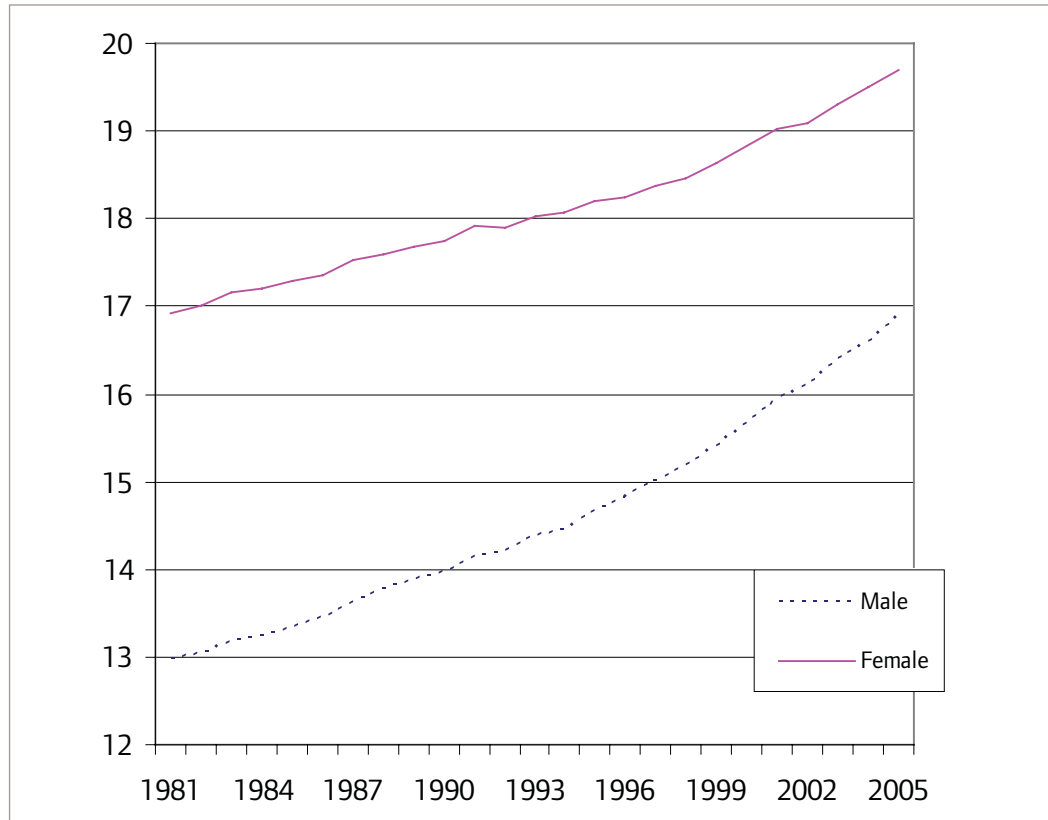


The increase in life expectancy among older adults has been particularly dramatic, and as Figure 1.4 shows, at 65 people can expect to go on living for an increasingly long time. Between 1980-82 and 2004-06 life expectancy at age 65 in the UK increased by four years for men and 2.8 years for females. The gap between male and female life expectancy is narrowing (Figure 1.4, next page).

By 2031 the UK population is projected to increase from its 2006 level of 60.6 million to 71.1 million, according to estimates from the Office for National Statistics (ONS 2008b), a growth of just under 11 million people in 25 years, or a rough average of 0.4 million people per year.

Figure 1.4. Life expectancy at age 65

Source: Office for National Statistics 2008a



Ageing population

As the UK's population is growing it is also ageing and by 2020, one in five people in the UK will be aged 65 and over, more than the numbers under 16. As the population is living longer the absolute and relative numbers of older people in the population are increasing. The ageing of the UK population poses challenges in terms of caring for older people and financing support for people over 65 (Moullin 2007, 2008). In 2006 there were 3.3 people of working age for every person of state pension age; this figure is set to fall to 2.9 people by 2031 (ONS 2008c).

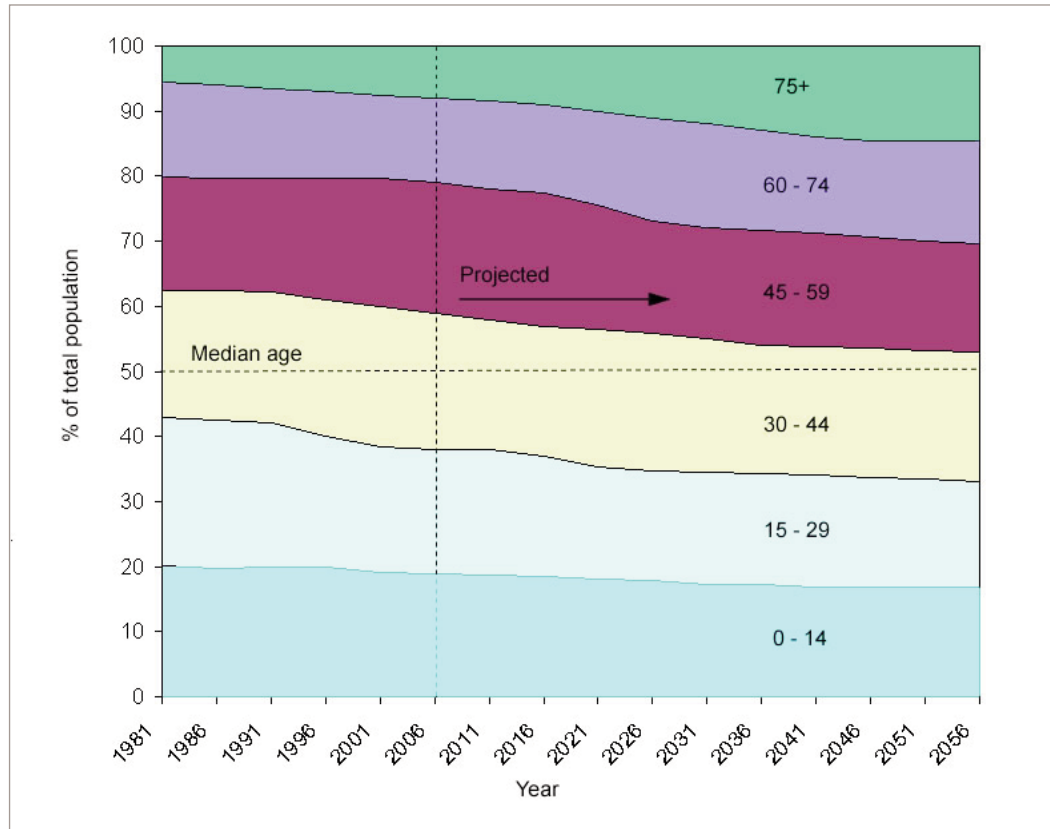
An ageing population is an issue for many of the member states of the European Union. In the UK, 16 per cent of the population were aged 65 or over in 2007, lower than the EU average of 17 per cent. Some European countries, such as Italy and Germany, have higher dependency ratios of 19.9 and 19.8 per cent respectively (Eurostat 2008).

Figure 1.5 depicts the age distribution of the UK population. It shows that by 2020 a much larger share of the population will be over 75.

The proportion of people over 75 is projected to increase faster than any other age group, which is unsurprising given the particularly rapid recent increases in life expectancy for people over 65. The highest age group, the over-85s, is also projected to rise substantially from 1.9 per cent in 2004 to 2.7 per cent by 2020. And by 2031 estimates indicate that there will be nearly 3 million over-85s compared with 1.2 million in 2006 and around 0.6 million in 1981 (ONS 2008b).

Figure 1.5. Actual and projected age distribution, UK, 1981-2056

Source: ONS 2008b



Healthy life expectancy

While the UK has a growing and ageing population, with marked increases in life expectancy, not all the years gained are lived in good health. For older people, as for all age groups, good physical health is important for mental health and wellbeing. There is plenty of evidence showing that chronic health problems and disability often result in depression and other mental health problems for older age groups. This is discussed in more detail in Chapter 2.

Examining trends in health gives us some strong indications of older people’s wellbeing. Healthy life expectancy, that is expected years of life in ‘good’ or ‘fairly good’ health, is lower than overall life expectancy. In the UK in 2004, baby boys could expect at birth to live in good health for 67.9 years and to be free of disability for 62.3 years (while total life expectancy in 2004 was 76.6). Therefore boys could expect 14.3 years with a disability and 8.7 years in poor health. Girls born in 2004 could expect to live 81 years, with 70.3 years in good or fairly good health, 10.7 years in poor health and just over 17 years with a disability. (See Table 1.1.)

	Males		Females	
	At birth	At age 65	At birth	At age 65
Life expectancy	76.6	16.6	81	19.4
Healthy life expectancy	67.9	12.5	70.3	14.5
Years spent in poor health	8.7	4.1	10.7	4.9
Disability-free life expectancy	62.3	9.9	63.9	10.7
Years spent with disability	14.3	6.7	17.1	8.7

Source: ONS 2008c

Table 1.2 shows how in Great Britain in 2004, just under a quarter of men and 28 per cent of women over 75 considered their health to be poor. For women in particular the period over 75 is marked by a significant decline in health, but for both men and women over 75 a third of people are still in good health and nearly three quarters are in good or fairly good health.

There are clear implications for wellbeing. For those over 75 poor health affected over a quarter of all people, making that group particularly vulnerable to depression, social isolation and exclusion.

Table 1.2. Self-reported general health in Great Britain, by sex and age, 2006 (%)

	Good	Fairly good	Not good
Males			
0–15	85	12	2
16–24	83	14	3
25–44	74	20	6
45–64	58	28	14
65–74	44	36	19
75 and over	33	43	24
All ages	68	23	9
Females			
0–15	87	11	2
16–24	78	18	3
25–44	70	21	8
45–64	59	26	15
65–74	43	38	19
75 and over	33	39	28
All ages	66	23	11

Source: ONS 2008c

Overall, the proportion of people in Great Britain reporting an illness or disability has not changed since 1995. This is perhaps surprising given the increases in the proportion of older people in the population and suggests that an ageing population does not necessarily bring proportionate health challenges.

Table 1.3. Proportion of people who reported a limiting longstanding illness, disability or infirmity, Great Britain (%)

Year	1975	1985	1995	2005	2006
Percentage	15	17	19	19	19

Source: ONS 2006a

However, there is still insufficient evidence in the UK to determine whether years gained through longer life expectancy will be matched by years of good health. There is an ongoing debate as to whether future generations will live longer but more disabled lives, or, alternatively, lives that are increasingly healthy (ippr Trading 2007). In the United States there is some evidence to show that the period of time during which a person experiences disability is becoming shorter and that there is an increase in healthy life expectancy (Jagger *et al* 2006). However, the results of statistical projections depend greatly on the definitions of illness and disability that are used.

Box 1.1 sets out projections on levels of disability under three different scenarios of health expectancy: a compression of morbidity, that is, less illness, an expansion of morbidity, meaning more illness, and a combination of both.

Box 1.1. Levels of disability – three scenarios

With a compression of morbidity, there is a pronounced reduction in prevalence rates of the more severe levels of disability. For example, in females aged 60 to 79, the prevalence rate for serious disability falls from 2.0 per cent to 1.6 per cent between the years 2004 and 2020.

With an expansion of morbidity, the prevalence rates for more serious disability increase, with the situation deteriorating up to the year 2020. For example, the proportion of females aged over 80 who are in the highest two disability categories is projected to increase from 14.7 per cent to 16.0 per cent.

With a combination of compression and expansion of morbidity, the proportion of lives projected to be without disability increases between the years 2004 and 2020 (with a corresponding decrease in the proportion of lives expected to be disabled).

Source: Rickaysen 2005, cited in ippr Trading 2007

In 2002, people in the UK enjoyed more time without a disability than people in many other European countries. For men, only Sweden, Finland, Portugal, Hungary and France have a higher percentage of years lived without a disability, and for women, only Sweden, Finland, the Netherlands and Hungary (Eurostat 2002).

However, simply because the numbers of older people are increasing, the numbers of people with a disability or poor health will increase dramatically. The King's Fund estimates that with no change in the prevalence of diseases or the age of becoming disabled (an unrealistic assumption because health needs and treatments change rapidly), there will be a 67 per cent increase in the numbers of people with a disability over the next 20 years. The number of people over 85 with a disability will double and the numbers experiencing one of the key diseases considered in the study will have increased by over 40 per cent by 2025 (Jagger *et al* 2006). The numbers potentially facing low-level mental health problems and poor emotional wellbeing as a result of poor health and disability will also rise significantly.

Box 1.2. Definition of disability

'Disability' refers to the disadvantage experienced by an individual as a result of barriers, including physical and attitudinal barriers, that impact on people with mental or physical impairments and/or long-term ill health.

A 'disabled person' is anyone who is disadvantaged by the way in which the wider environment interacts with their impairment or long-term health problem. This may vary over time.

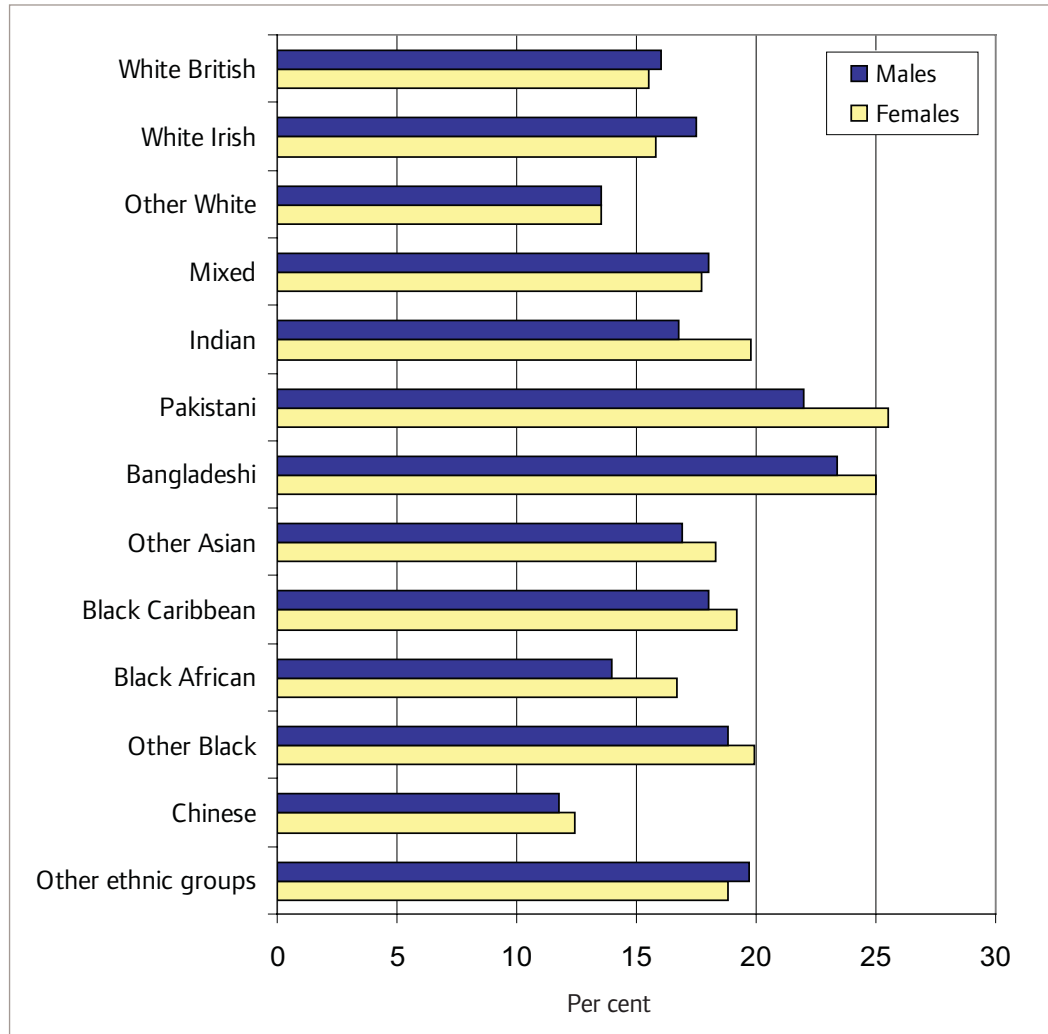
Inequalities in health and life expectancy

Good health is not spread evenly across the population and health is significantly related to socio-economic status, ethnicity, gender and geographic location.

Figure 1.6 (next page) shows differences in the incidence of long-term illness and disability, measured by ethnic group and gender, in England and Wales. Pakistani and Bangladeshi men and women have worse health than other ethnic groups. Chinese men and women have the best health and white groups also fare relatively well.

Figure 1.6. Age-standardised rates of long-term illness or disability that restricts daily activities, by ethnic group and sex, England and Wales, 2001

Source: Dunnell 2008



While there have been increases in life expectancy for everyone, inequalities in life expectancy and child mortality, measured according to socio-economic status, have actually widened in the last ten years (Department of Health 2008). As there is an association between poor physical health and poor emotional wellbeing, there is a strong likelihood that health inequalities are likely to translate into widening wellbeing and mental health inequalities too.

Trends in wellbeing

Having begun by exploring trends in population structure and health, in this section we discuss the growing drive to measure wellbeing, and describe some of the main measures used. We go on to describe levels of mental-health problems and wellbeing in the UK among older people. While levels of health and also wealth give some indication of wellbeing there is evidence that above a certain level, increasing wealth and health do not lead to matched improvements in feelings of wellbeing.

Defining and measuring wellbeing

The notion that a nation's level of wellbeing or happiness is more important than its wealth has begun to gain credence within policy and academic circles (although this may be challenged in economically tougher times). This interest reflects the finding that while income and wealth may continue to escalate, levels of wellbeing stagnate when one obtains an annual income level of £20,000. This is the so-called Easterlin paradox, named after a theory postulated by Richard Easterlin in 1974.

In the UK Lord Layard has been a leading proponent of the drive to consider happiness rather than GDP as an indicator of progress, stating:

‘...GDP is a hopeless measure of welfare. For since the War that measure has shot up by leaps and bounds, while the happiness of the population has stagnated. To understand how the economy actually affects our wellbeing, we have to use psychology as well as economics.’ (Layard 2003)

The Government has accepted that wellbeing and life satisfaction are important measures of progress (Donovan and Halpern 2002), and notes that the public also supports this notion of progress.

Despite the increasing importance attached to society’s wellbeing or life satisfaction there is no single, definitive measure used. International bodies such as the Organisation for Economic Cooperation and Development (OECD) are promoting debate about what progress means and how a shared view of societal wellbeing can be produced, based on high-quality statistics. In the UK the Office for National Statistics and other Government offices are exploring the measurement of societal wellbeing drawing on a range of indicators (Allin 2007, Donovan and Halpern 2002).

However imprecisely defined, Government studies have used measures of happiness and satisfaction, as reported by research respondents themselves, to compare levels of wellbeing between various groups of people. There does seem to be consistency between the findings and a general confidence in the measures of wellbeing. The General Health Questionnaire surveys are an important and frequently used measure of wellbeing. The questions try to establish low-level mental health problems, particularly those relating to stress, feelings of hopelessness and low self-esteem.

Box 1.3. How do we define wellbeing?

In this report, we take a broad definition of emotional wellbeing. We do not include serious mental health problems such as dementia or psychotic mental illnesses such as schizophrenia. This is because the causes and treatment of serious mental health problems are significantly different from the causes, prevention and possible treatment of lower-level mental health problems. Most people and organisations working in mental health distinguish between ‘neurotic’ or common ‘low-level’ mental health problems, and psychotic or serious mental health problems, such as dementia, schizophrenia and hallucinations.

We therefore include as an indicator of emotional wellbeing the incidence of low-level mental health problems such as depression, anxiety, stress, panic attacks, phobias and obsessive-compulsive disorders. But emotional wellbeing is broader than just the presence (or absence) of common mental health problems and so we also include life satisfaction and levels of happiness.

In the second phase of ippr’s work on older people, we will refine and develop a definition of wellbeing in older people, based on original research with older people. (Meanwhile, in this report we draw on existing research to indicate levels of measured wellbeing in older people.)

Trends in wellbeing in the UK

Levels of wellbeing and life satisfaction in Britain have stayed fairly flat since the 1950s (before which they had been rising); see Figure 1.7, next page.

These findings are reproduced in the US, Japan and many other developed countries (Layard 2003). Although international comparisons are difficult because interpretations of life satisfaction vary, surveys show that in the UK, life satisfaction in 2001 was just above the EU average; see Figure 1.8, next page.

The variations in life satisfaction are partly related to how unequal societies are. Portugal and Greece, for example, have high levels of inequality and their citizens are less satisfied than those in other EU countries. The World Values Survey in 2007 attempted to correlate levels of inequality and life satisfaction across selected countries worldwide and found that the most unequal countries were the least satisfied. The survey found that Britain ranks in the bottom-half of OECD countries for both the average level of satisfaction and inequalities in the distribution of life satisfaction, ranking 17th for the level of life satisfaction and 18th for equality of GDP per capita. The Government has acknowledged that these international comparisons suggest there is scope to improve life satisfaction in Britain, and for it to be more evenly distributed across the British population.

Figure 1.7. British life satisfaction and prosperity

Source: based on PMSU 2007

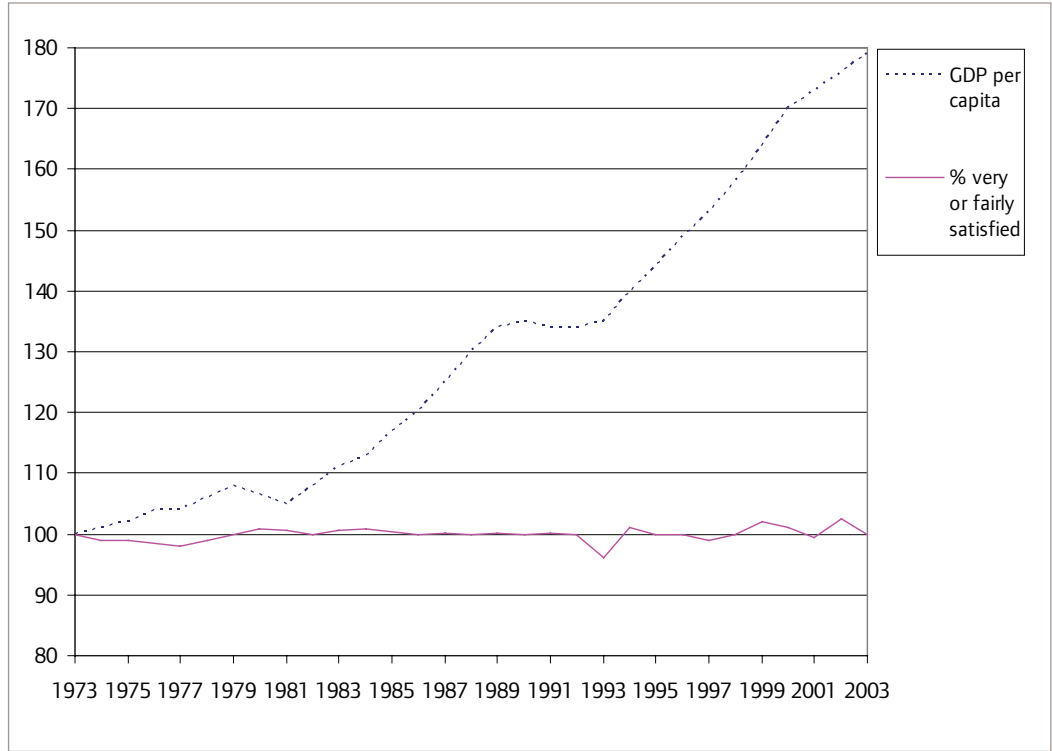
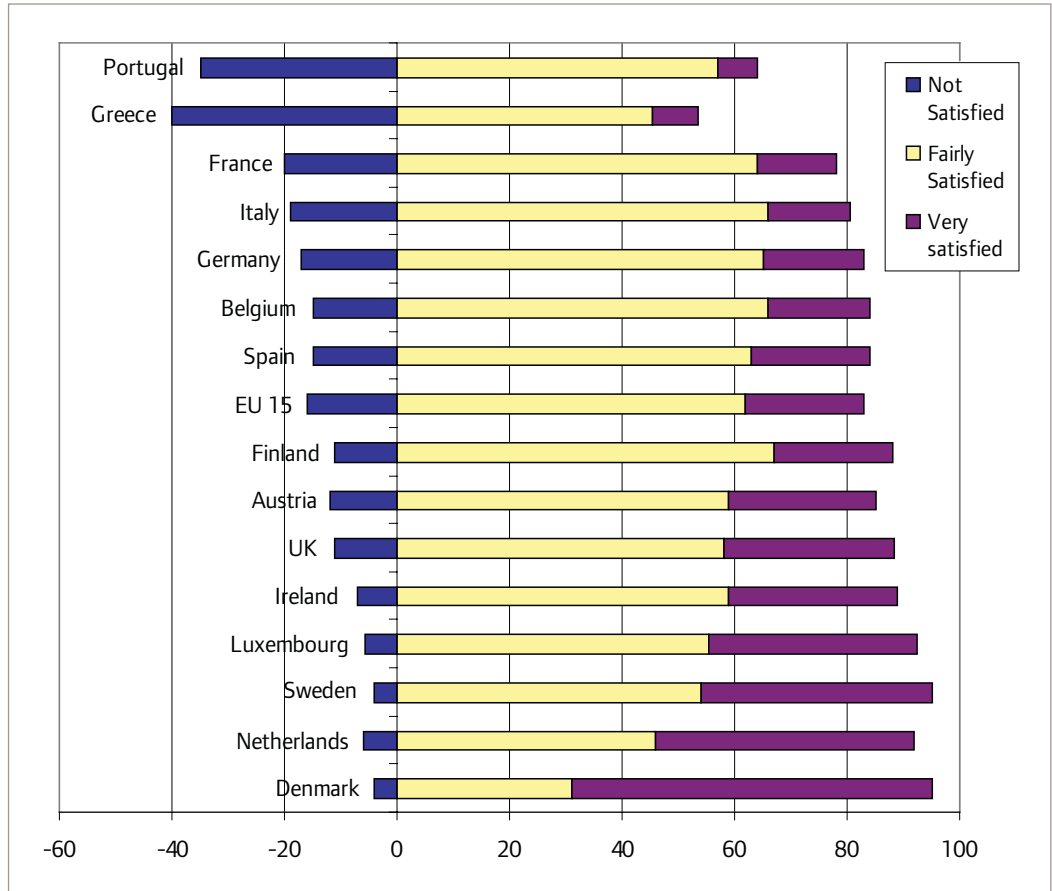


Figure 1.8. Life satisfaction in EU member states, 2001

Source: Eurobarometer



There is some controversy over trends in mental health in the UK, with studies identifying that measured increases in prevalence are sometimes due to there simply being more diagnosis. However, there are some indications that mental health in the UK is worsening. Using measures of mental health problems in 2001, the Office for National Statistics' *Psychiatric Morbidity Report* found that one in four British adults experiences at least one diagnosable mental health problem in any one year, and one in six experiences this at any given time (ONS 2001).

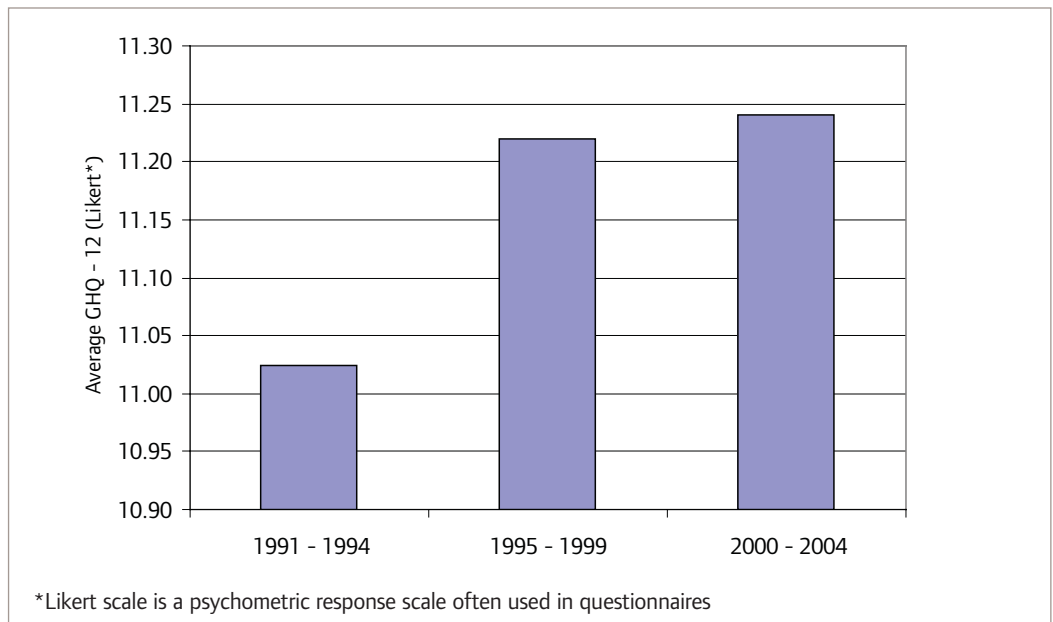
There was also an increase in the proportion of people reporting mental illnesses and behavioural disorders as the medical reason underlying claims for incapacity benefit and severe disablement allowance, growing from 33 per cent in 2001 to 41 per cent in 2007 (Dunnell 2008), as shown in Table 1.3. Furthermore, a Strategy Unit report on life satisfaction showed a rise in the incidence of mental health problems for both men and women between 1993 and 2000 (Prime Minister's Strategy Unit 2007).

Table 1.3. Combined incapacity benefit and severe disablement claimants, measured by type of medical reason, Great Britain, 2001 and 2007

	2001	2007
Mental and behavioural disorders	33%	41%
Physical disorders	67%	59%
Total claimants (millions) = 100 per cent	2.8%	2.7%

Source: Dunnell 2008

Figure 1.9.
Average psychological distress levels over time in Britain: 1991–2004, based on General Health Questionnaire
Source: Oswald and Powdthavee 2007a



Oswald and Powdthavee (2007a) report that mental wellbeing is worsening in Britain. Figure 1.9 shows for representative samples of Britons that General Health Questionnaire psychological distress scores rose from 1991 onwards. And Lord Layard has argued that all the evidence suggests that incidence of clinical depression has increased since the Second World War (Layard 2003).

Wellbeing in older people

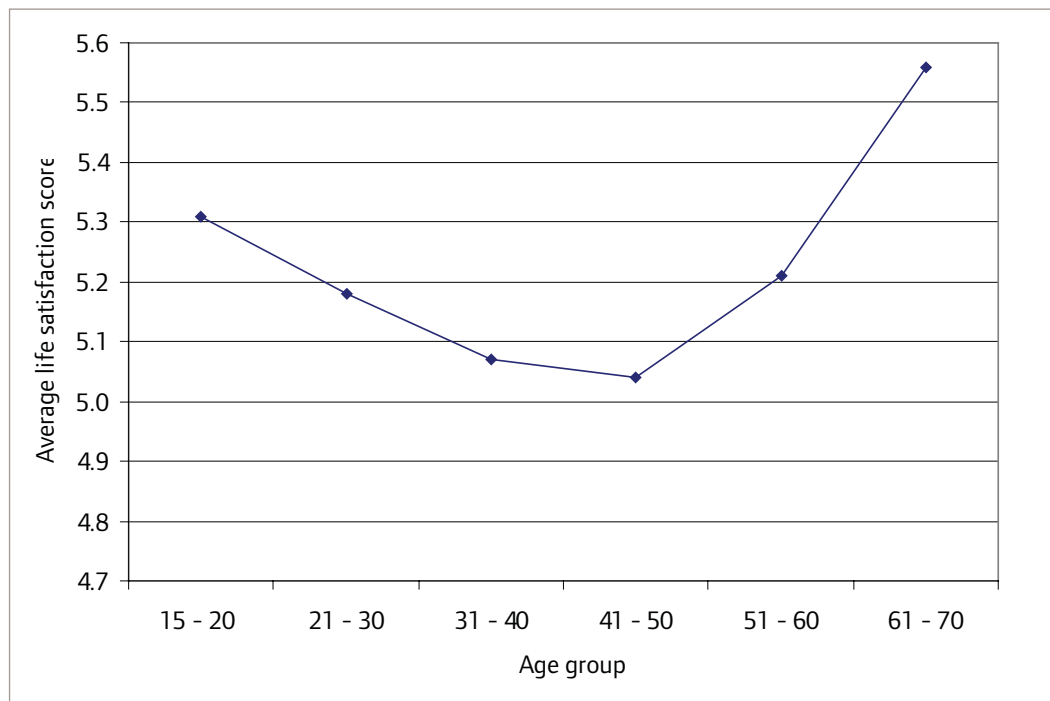
Most older people in the UK are healthy and happy and make valuable contributions to society and to the economy. In fact, old age, defined as over 65 years, is often seen as a time of relative contentment, although there is some debate about levels of wellbeing in older people, just as there is for the population as a whole. In this section we discuss some of the often contradictory evidence about levels of mental health problems and wellbeing in older age groups.

Many of the contradictions arise because so many mental health problems, particularly for older people, remain undiagnosed and untreated. There has been a tendency, including in Government, to view older people as a homogenous group. However, the period after 65 is not experienced uniformly and people over 80 suffer significantly and gradually worse outcomes than 'younger old' people. A single grouping based on the over-65s has thus led to rather over-optimistic assessments of the state of wellbeing for many older people. There are also wider inequalities in older people's wellbeing that relate to levels of poverty, health, education, family contact and social and community participation, which are discussed in Chapter 2.

In an influential study of the age distribution of life satisfaction, Blanchflower and Oswald (2004) showed that people's levels of happiness followed a U-shaped curve, with least happiness in middle age – a pattern that was consistent in 72 out of 80 countries they studied. For both men and women in the UK, dissatisfaction peaked at around the age of 44, after which life satisfaction improves to its highest level during the life course.

Figure 1.10.
Average life satisfaction score by age group

Source: Oswald 2007



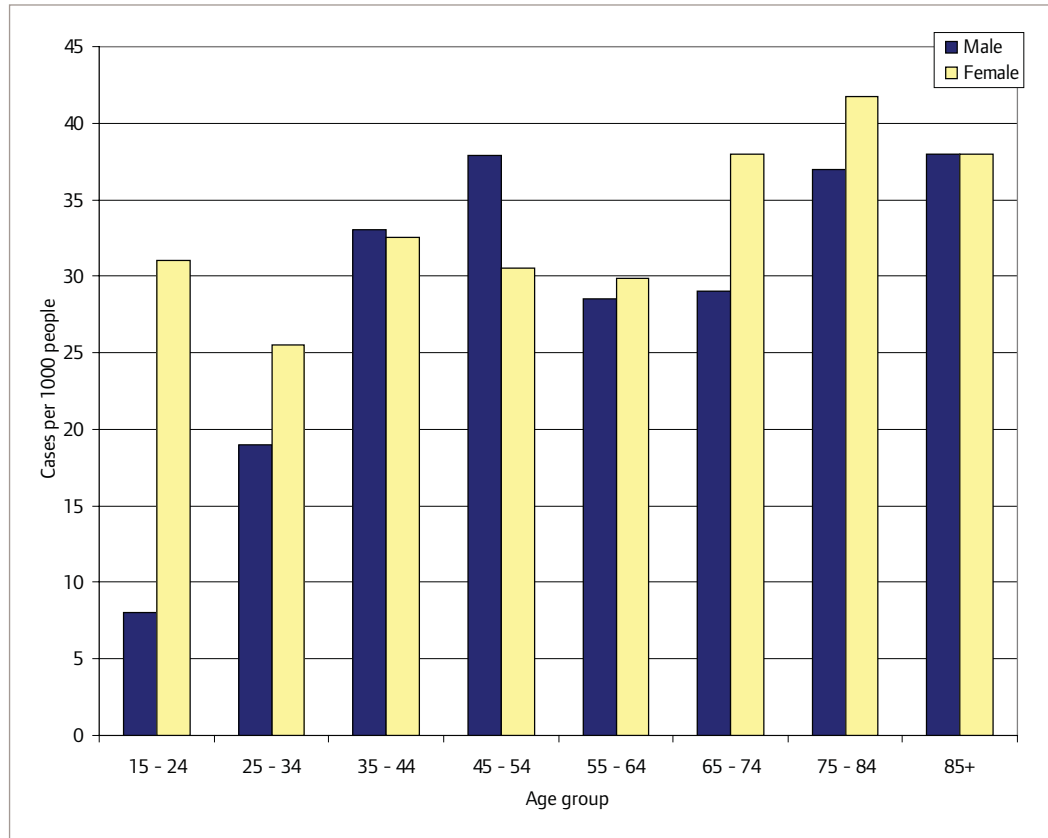
However, the assumptions made by the U-shaped curve findings are not applicable to older age groups. There does seem to be clear evidence that the post-80 period is marked by increasing depression. Zarit *et al* (1999), who focused on people over 80, found that depressive symptoms increased over time, and that this was associated with poor health (referred to in Surr *et al* 2005). A Berlin Ageing Study drew similar conclusions (Wernicke *et al* 2000) and found that the 'younger old' (70-84) reported consistently higher positive wellbeing than the 'older old' (85+) (referred to in Surr *et al* 2005).

A 2008 King's Fund report (McCrone *et al* 2008) suggests that reported relatively low rates of mental health problems for older people may be due to insensitive diagnostic tools used in the most often referred-to survey of mental health, the Psychiatric Morbidity Survey (ONS 2001b). A recent report from Age Concern and the Mental Health Foundation also shows that rates of depression actually increase with age (Lee 2006).

The King's Fund analysis found that there is no reduction in depression in older age; in fact for both men and women depression is at highest levels at this point in life. The study shows significant numbers of older people with depression, and for men there are rapid increases in prevalence over 75.

Figure 1.11.
Prevalence of depression, by gender and age group

Source: McCrone *et al* 2008



Depression is the most common mental health problem in later life. Estimates vary because much depression is unrecorded, but it is likely that 20 to 25 per cent of older people experience depression that impacts significantly on their quality of life (Lee 2006). In addition, there are many more people who experience psychological or emotional distress associated with isolation, loneliness or loss. These problems are not recorded by the health or medical care system but contribute to poor emotional wellbeing and low life satisfaction. The numbers of older people with poor emotional wellbeing, as we have defined it – including other common mental health problems and poor life satisfaction – are likely to be much higher than the estimates of 20 to 25 per cent of older people with depression.

Some serious mental health problems, particularly dementia, have a highly significant impact on older people. Dementia is particularly significant because it affects so many older people, as many as 25 per cent over 85, and because it affects family and friends. People caring for people with dementia have a much higher likelihood of being depressed themselves and so rising numbers of people with dementia are likely to have a double impact on wellbeing.

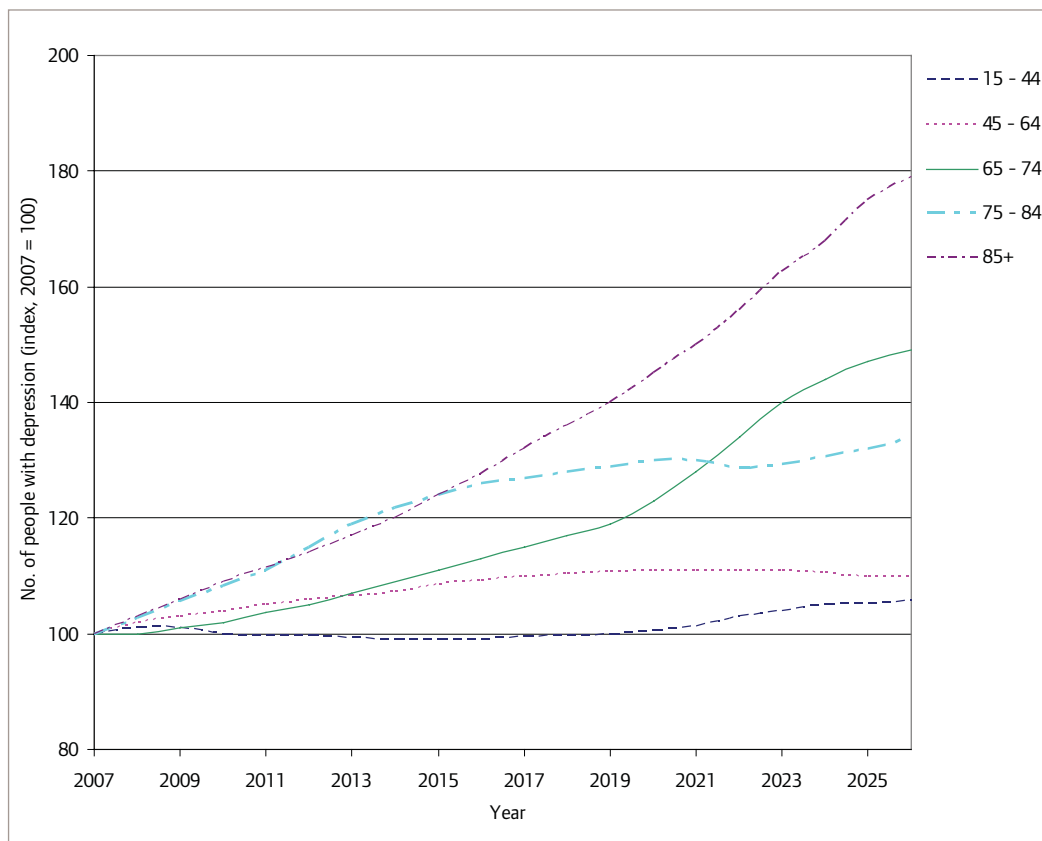
Future trends in older people's mental wellbeing

Depression and anxiety disorders are set to become more prevalent in the next 20 years due to increasing numbers of older people, according to McCrone *et al* (2008), with the suggestion that increases in prevalence will be driven by demographics alone (see Figure 1.12, next page).

However, the somewhat optimistic assumption that the prevalence of mental health problems is not increasing for older people contradicts other evidence we outlined earlier that suggests that mental health problems are becoming more prevalent across the UK population. Additionally, as we have discussed the number of older people will rise, on its own leading to a substantial increase in the number of older people with mental health problems and general poor emotional wellbeing. Currently about three million older people in the UK suffer from a mental health problem and this is expected to rise by one third over the next 15 years (Anderson *et al* 2008), and there are estimated to be currently 2.4 million older people with depression severe enough to impair quality of life. These figures are likely to be underestimates as only one third of older people with depression discuss their symptoms with their GP (Chew-Graham *et al* 2004).

Figure 1.12.
Projected change
in number of
people with
depression, 2007
to 2026

Source: McCrone *et al* 2008



Additionally, for people aged over 80 there are further downward trends in wellbeing. And although serious cases of mental health are not the focus of this report, it is worth noting that the numbers with serious mental health problems and dementia are set to rise substantially as numbers of older people, and those aged over 85 in particular, grow. This will have a wide impact as increasing numbers of carers, family and friends find their quality of life may worsen as a result.

For four reasons, then, we can expect to see a significant increase in the numbers of older people with poor emotional wellbeing:

1. Mental health problems may be becoming more prevalent across the life course.
2. The number of old people is set to rise markedly.
3. The number and proportion of *older* old people are also increasing.
4. There will be a rise in the number of carers, who are at higher risk of depression than the rest of the population. Many of these carers will be older people, caring for spouses or even parents.

Summary

The UK's population is ageing because the birth rate has been falling for the past 30 years and life expectancy and health improving. The numbers of older people, both in absolute numbers and proportionately, will increase significantly and more people will survive past their 85th birthday and many past their 100th. There is some evidence that people are also living longer in better health – although both health and length of life correspond closely to socio-economic status and also to ethnicity.

While there have been striking gains in health and wealth in the UK, these have not translated into improvements in life satisfaction and happiness, in common with other countries. Indeed, there is some evidence of worsening trends in mental health problems. Wellbeing is becoming an increasingly important measure of progress and on the available evidence progress seems to have stalled in the UK.

There is some debate over the prevalence of mental health problems among older people. However, it does appear that prevalence of mental health problems increases with age, particularly for those over 75, and that the prevalence of poor wellbeing also rises.

Future trends in wellbeing are also disputed, but as the number of *older* old people increases there is likely to be a corresponding growth in the incidence of mental health problems and levels of poor wellbeing.

2. Factors that shape wellbeing in older people

Many older people enjoy life, but a significant proportion struggle with loneliness, isolation, low-level mental health problems like depression or even more serious problems that lead to suicide. Certain groups of older people are at more risk of poor emotional wellbeing than others: these are typically the poorest, the very elderly, some minority ethnic groups, the most isolated, those with worse physical health, and, the most significant though often neglected, those without an active social or community life.

This chapter assesses trends in the key drivers of older people's wellbeing – both those that affect it negatively and those that can improve wellbeing and protect older people against depression, loneliness and isolation. We contend that there is far more that policymakers can do to protect and foster a better sense of wellbeing for the UK's growing number of older people.

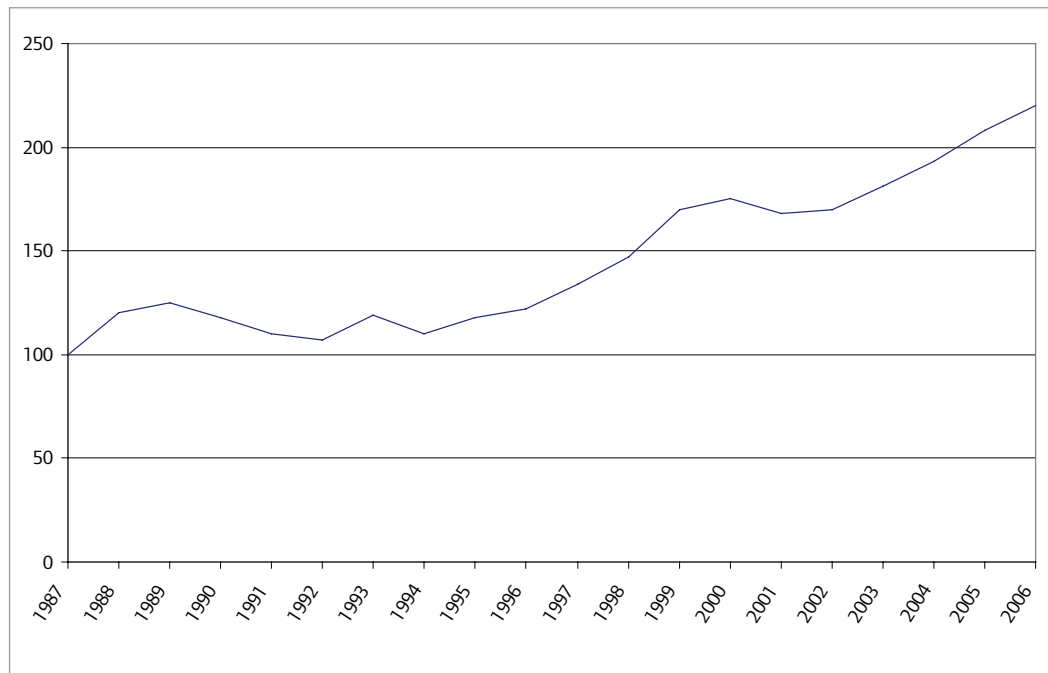
Social exclusion, inequalities and health

Levels of wealth have increased for almost everyone, but not equally and there is evidence of widening income inequalities between the top and bottom groups. For older people income and wealth have increased more than the average, although 2006–7 figures show 300,000 more pensioners in poverty than the previous year, perhaps indicating a reversal of this trend. Over-75s are faring relatively badly with lower incomes than the 65–74 age group.

Household wealth more than doubled in the UK between 1987 and 2006 and people are spending two and a half times more on goods and services than in 1971 (Dunnell 2008); see Figure 2.1. Over the period 1987 to 2006 real household disposable income per head rose by around 60 per cent.

Figure 2.1. Net wealth per head (from 1987 baseline=100)

Source: Dunnell 2008



The rises are, however, unequally distributed and the share of wealth of the wealthiest 1 per cent of the population was 21 per cent in 2003, having risen from 17 per cent in 1991. Income inequality was at its highest ever level in 2006–7 (Brewer *et al* 2008). Income inequality in the UK is higher than the European average. In the UK, the top 20 per cent of the income distribution receives 5.4 times greater a share of total income than that received by the bottom 20 per cent of the population, comparing to an EU average ratio of 4.8 (Eurostat 2007).

This is significant because levels of inequality in income and wealth are very important in shaping levels of satisfaction and wellbeing among the general population. Wide inequalities have been found to be detrimental to wellbeing, causing stress and unhappiness (Pickett and Wilkinson 2007).

Poverty and deprivation

For pensioners (men over 65 and women over 60), real income and share of national income have risen significantly since 1979; and the gross income of pensioner families averaged over all ages and family types rose by 37 per cent in real terms between 1994/95 and 2005/06, compared with an increase of about 17 per cent in real average earnings (ONS 2008c).

Figure 2.2. Real income of pensioners, 1979-1996/7 and 1994/5-2004/5 (from 1979 baseline=100)

Source: ONS 2006b

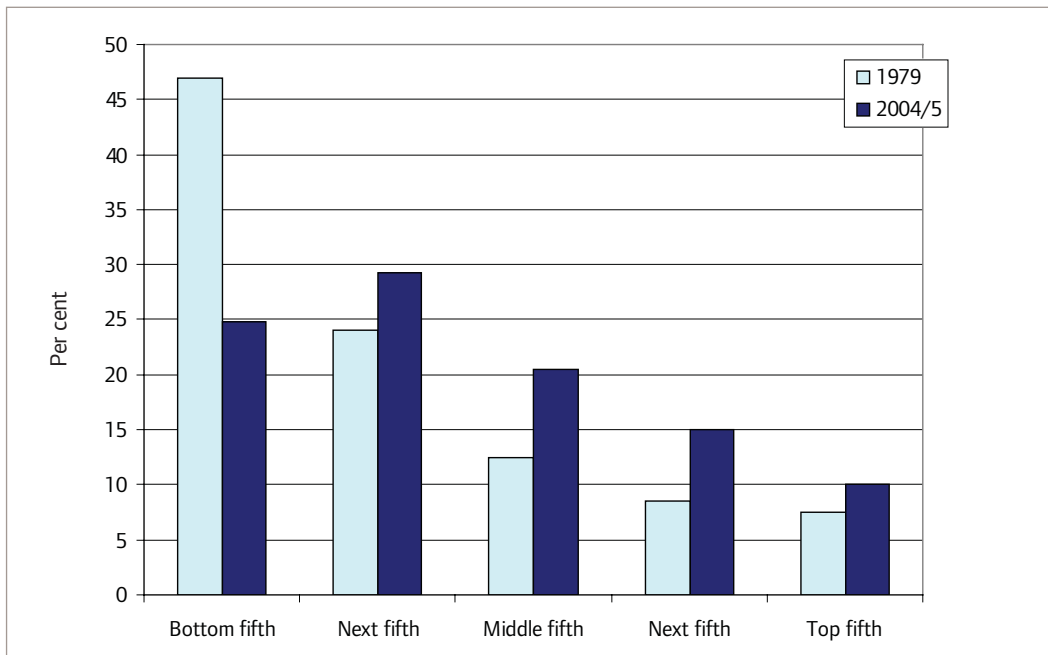


Pensioners’ average income rose faster than younger people’s earnings between 1996/7 and 2004/5 (25 per cent compared with 15 per cent). These rises came from increases in occupational pensions, investments and benefits.

The effect of these rises in pensioner incomes has been a movement of pensioners up the overall income distribution ladder. The proportion of pensioners in each fifth of the income distribution in 1979 and 2004/5 is shown in Figure 2.3. In 1979 47 per cent of all pensioners were in the bottom

Figure 2.3. Pensioners’ position in the overall net income distribution, 1979 and 2004/5

Source: ONS 2006b



fifth, as measured before housing costs, and by 2004/5 this proportion had almost halved to 25 per cent. However, this still means that a quarter of pensioners are in the bottom fifth for income and nearly a third more are in the second fifth.

Although the figures for pensioner poverty show significant improvement since 1990, in 2005/6 just over a fifth of all pensioners were still receiving less than 60 per cent of the median income. This increased to 23 per cent (after housing costs) in 2006/7. There is also an age gradient to pensioner poverty with 18 per cent of 65- to 69-year-olds receiving less than 60 per cent of median income, compared to 32 per cent of the over-85s (Department for Work and Pensions 2008).

Table 2.1. Individuals living in households below 60 per cent of median household disposable income in the UK (%)

Years	Children	Pensioners	People of working age
1990-91	27	37	15
1991-92	28	32	16
1992-93	29	28	16
1993/94-94/95	27	24	15
1994/95	25	24	15
1995/96	24	24	14
1996/97	27	25	15
1997/98	27	25	15
1998/99	26	27	15
1999/2000	26	25	15
2000/01	23	25	15
2001/02	23	25	15
2002/03	23	24	15
2003/04	22	23	15
2004/05	21	21	14
2005/06	22	21	15

Source: ONS 2008c

The most recent figures, for 2006-7, show a worsening trend for relative pensioner poverty and between 2005-6 and 2006-7 there was an increase of 300,000 in the number of pensioners in relative poverty after housing costs, bringing the total to 2.1 million. In 2006 rates of poverty among older people were much higher in the UK than in many other European countries. The UK poverty rate for over-65s compares unfavourably with the 2006 EU average (Eurostat 2007).

Looking at a wider age group, in 2006 the Social Exclusion Unit found 3.4 million people over 50 lived in relative poverty and 1.2 million people over 50 in England faced severe, exclusion (ODPM 2006a). Around half of people over 50 suffered disadvantage with respect to one aspect of their life.

Poverty has a clear relationship with poor emotional wellbeing across the life cycle and worsening income inequalities compound that. And the evidence that poverty at an early age, even prenatally, is a strong predictor of outcomes, is clear and unequivocal (Bamfield 2007). As the first report from the *UK Inquiry into Mental Health and Wellbeing in Later Life* states:

‘Disadvantage in childhood or early adulthood often leads to impaired physical and mental health in later life. Early vulnerability to mental health problems is predictive not just of mental health problems in later life but also of poor socialisation, criminality, lack of participation and relationship difficulties. On the other hand, advantage in childhood or early adult life may result in better physical and mental health in later life.’ (Lee 2006: 14)

The Government has acted on this evidence and invested significantly in trying to reduce the number of children living in poverty and in 2006/7 there were 600,000 fewer children in relative poverty than 10 years previously. The investments made in early years and childhood have achieved a great deal and if the improvements are sustained through adulthood there are likely to be fewer older people with emotional and mental health problems as a result.

The imperative to invest early to achieve lifelong benefits has dominated the policy agenda for the last ten years, and has partly been a response to the demands for clear cost-efficacy by the Treasury. The Treasury has accepted that early (in age terms) intervention has long-term gains. However, to some extent this approach has worked against older people, who have not received anything like the resource, attention and focus as the young. This should be rectified: as old age becomes increasingly long as people live for longer, there is evidence that investment in early old age will pay off in older old age. Moreover, there are compelling ethical, moral and social justice reasons for further support and investment in older age.

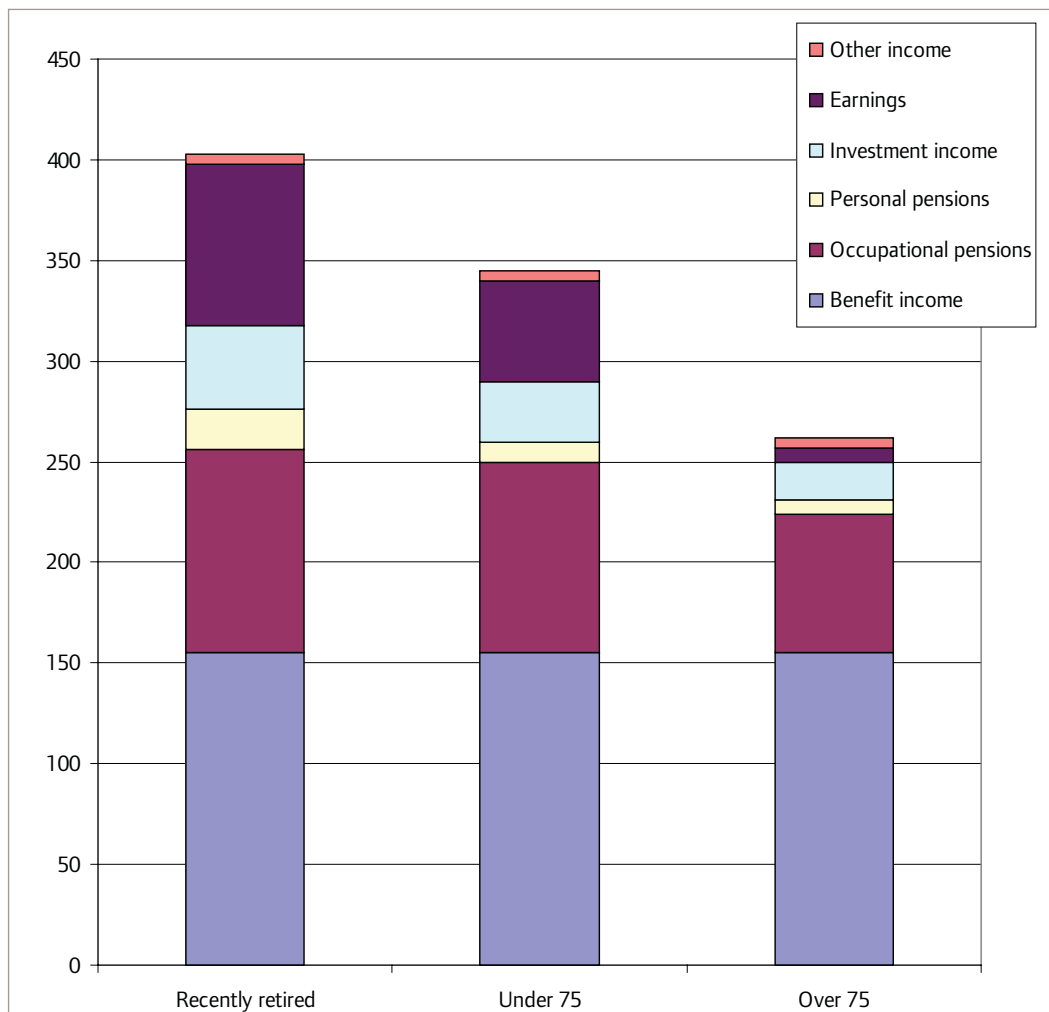
Inequalities within the over-65 group

High levels of inequality are increasingly being recognised as detrimental to emotional wellbeing and mental health – resulting in envy which causes stress, and the feeling of relative failure. Within the over-65 age group itself, the gains in income and wealth have not been spread equally:

- Single pensioners have less than half the earnings of married pensioners.
- Older pensioners have significantly lower incomes than younger pensioners (see Figure 2.4).
- Female pensioners have, on average, lower incomes than men. For example, single retired men had an average net income of £220 per week in 2004/5 compared with £186 for single female pensioners (ONS (2006)).

Figure 2.4.
Sources of pensioners' income, by age group

Source: ONS 2006



- There are **geographical inequalities**: pensioners in the South East of England and London have on average higher incomes than pensioners in other parts of the UK. Average income from state benefits varies much less between regions than other types of income (ONS 2006).
- **Minority ethnic groups** account for 3.5 per cent of all pensioners in Great Britain and that proportion is growing. Some ethnic minority pensioners have lower overall income than their white counterparts. A large part of this difference is due to ethnic minority pensioners being less likely to receive occupational or private pensions. They are also less likely to receive state retirement pension (ONS 2006).

Income inequalities among older people compound existing deprivation and physical and mental health inequalities to produce significantly higher likelihood of poor emotional wellbeing for those groups.

The Office for National Statistics states that: 'Common mental disorders are more prevalent in manual socio-economic groups than in non-manual socio-economic groups. The prevalence was highest in Social Class V (18 per cent) and lowest in Social Classes I or II combined (6 per cent)' (ONS 2003: xii). Suicide rates in the most deprived areas in England and Wales from 1999 to 2003 were more than double those in the least deprived areas (Dunnell 2008).

The strong association between levels of deprivation and poor emotional wellbeing is partly explained by stresses associated with poverty – struggling to make ends meet, poor housing conditions and wider physical environment, fear of crime, and relatively poor physical health are all experienced more the more deprived you are. The stress associated with living in an unequal society is increasingly seen as vital in understanding the rise of poor mental health and wellbeing in 'rich' societies (Pickett and Wilkinson 2007).

Figure 2.5.
General Health Questionnaire 12 score (observed and age-standardised), by equivalised household income and sex (men and women aged 16 or over)

Source: Donovan and Halpern 2002

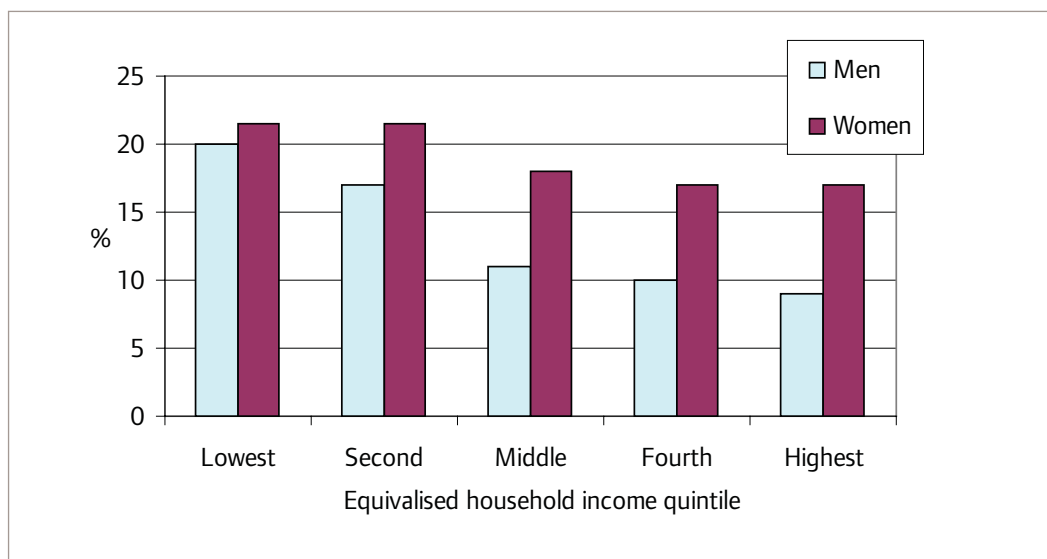


Figure 2.5 shows how stress, as measured by the General Health Questionnaire 12 score, relates to income level and gender.

Physical health

There is a wealth of evidence showing that physical health is closely associated with emotional wellbeing. This is particularly relevant for older people, who suffer much higher levels of chronic ill health than the rest of the population. Health is overwhelmingly felt to be the most important determinant of happiness among the over-55s. It has been estimated that up to 70 per cent of all new cases of depression arising in older people may be caused by disability associated with ill health (Surr *et al* 2005, ONS 2003). Most studies have found that prevalence rates of depression are approximately double for older people suffering ill health and disability compared with those who are healthy. In the EU almost one in three people aged 85 or over say they are severely limited by physical or mental health conditions in the activities they normally do (Eurobarometer 2007).

Prince *et al* (1998) suggested that immobility associated with physical illness brings about isolation and limited contact with friends and neighbours in the local area, leading to loss of intimacy and reduced sense of community, further exacerbating isolation, loneliness and depression. Verhaak *et al* (2005) (cited in Surr *et al* 2005) provide further evidence of this: from a national panel of GPs' patients followed over more than 15 years, the most important effect from mental distress among chronically ill people was the social impact of ill health, rather than the illness itself. However, the relationship we currently see in the UK between age, poor physical health and poor emotional wellbeing is not inevitable: services and community interventions aimed at reducing social isolation and improving community support can reduce these impacts.

Moreover, while physical disability is a risk factor for the onset of depression, depressive symptoms can in turn lead to increased disability. A Finnish longitudinal study examining the relationship between depression and physical disability reported that depressed older people were at high risk for physical disabilities (Kivela and Pakkala 2001, referred to in Surr *et al* 2005).

The need to encourage and support healthy living for over-65s is important, both to improve physical health and to sustain emotional wellbeing for older people. However, health improvement campaigns and public health measures are mostly geared towards younger age groups with older people's health often neglected until people become ill and require treatment. Physical activity, eating healthily and drinking sensibly are all closely linked to both good physical and mental health for older people as well as younger people. Across all age groups levels of physical activity, good nutrition and sensible drinking are declining. Levels of obesity continue to rise in both children and adults and the proportion of alcohol-related deaths in the UK more than doubled between 1991 and 2006 (ONS 2008c).

In the next 10 years and beyond there will be even more significant impacts as today's middle aged and younger people age and the rising burden of obesity, poor nutrition, smoking and excessive drinking impact on older people's physical and mental health.

Alcohol abuse is both a cause and a symptom of serious and low-level mental health problems, social exclusion and isolation. Approximately 10 to 30 per cent of older people who abuse alcohol become depressed and they are also at greater risk of suicide (Beeston 2006). Figures also show that older men are currently between two and six times more likely than older women to abuse alcohol. Although alcohol abuse is a problem for people of all ages, it is more likely to go unrecognised among older people.

The proportion of over-65s who smoked in the UK was higher than the EU average in 1999, particularly for women – almost one in five women aged over 65 smoked in the UK in 1999 compared with just one in ten on average in the EU (Swedish National Institute of Public Health 2006). Smoking rates have fallen, however, in the UK since 1999. Smoking is closely associated with deprivation, with more deprived groups more likely to smoke, and is at least partly responsible for widening inequalities in health between socio-economic groups.

There is a clear need to invest in health promotion campaigns aimed at older people and to continue to drive initiatives and interventions to improve older people's health. As well as receiving fewer diagnoses and less treatment for mental health problems there is also some evidence that older people receive less preventative treatments from health services (Leatherman *et al* 2007). For instance, a 2005 analysis of the prescription of preventative medicine following heart attack showed clear age-based differences (Ramsay *et al* 2005, cited in Leatherman *et al* 2007).

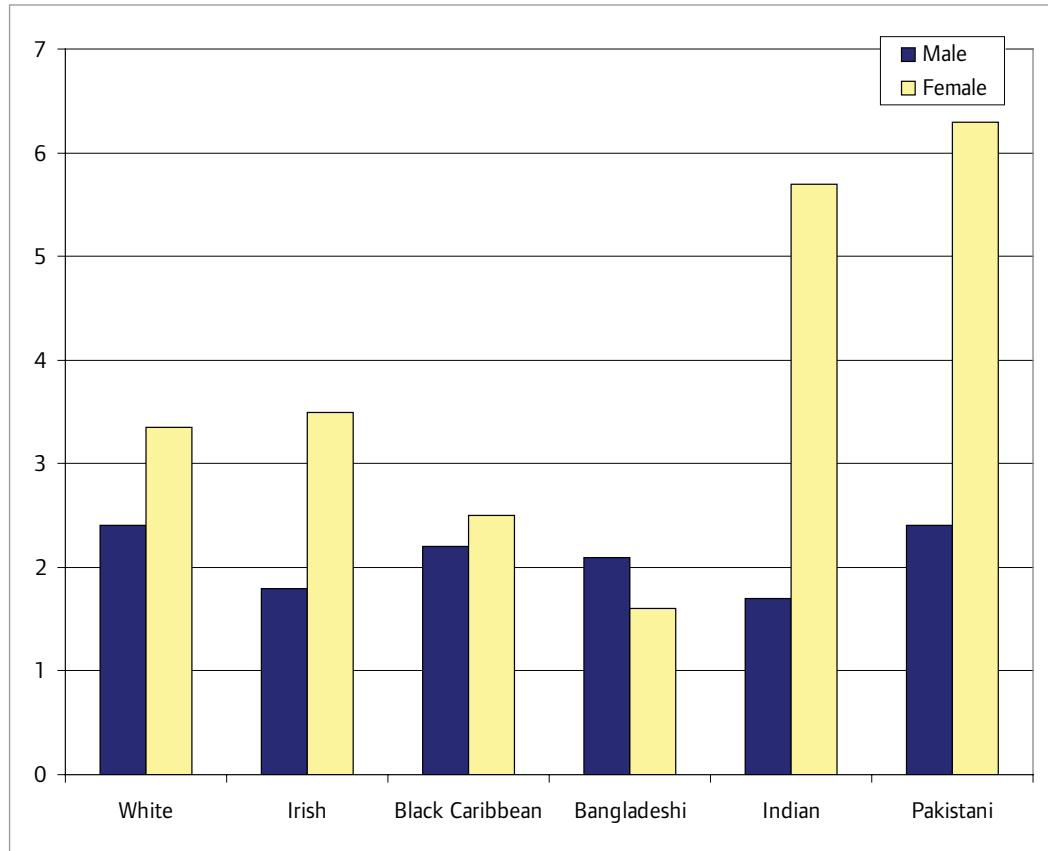
Ethnicity

There is evidence indicating that some black and minority ethnic (BME) groups are particularly susceptible to certain mental health problems, for instance depression, and in general, rates of mental health problems are thought to be higher in minority ethnic groups than in the white population. However, those groups are less likely to have their mental health problems detected by a GP (NIMHE 2003).

Compared with the white population, there are higher rates of depression among Indian and Pakistani women, but lower rates among Black Caribbean and Bangladeshi women. Male rates of depression are

Figure 2.6.
Percentage of
people with
depression, by
ethnic group and
gender

Source: McCrone *et al* 2008



more uniform although white and Pakistani men fare worse than men from other ethnic groups. There is likely to be considerable under-diagnosis and underreporting of depression, particularly for men.

In Britain, research into the physical and mental health of older people from BME groups is in its infancy (Smaje 1995). But poorer physical health and higher levels of poverty have been reported among some minority ethnic groups, as discussed earlier, and both are risk factors for depression in older age.

A 2005 study by Nazroo *et al*, based on interviews, found that there were six main factors that influenced the quality of life of older people: having a role, support networks, income and wealth, health, having time, and independence. While this was the case for all older people, the ways the factors were experienced were influenced by a person's ethnicity. For example, the extent of family networks, the level of pension resources, or health can all be shaped by ethnicity. The interviews identified social, practical and emotional support as key to a good quality of life. Partner, family, friends and religion emerged as the main sources of support.

In terms of family and friendship support, older people in the Indian and Pakistani groups fared well compared with the white group. The research also showed religion to be significant in terms of emotional and practical support. The role of religion in helping protect older people against depression and poor emotional wellbeing is discussed later in this chapter. It is worth noting here that for some BME groups, relatively high levels of religious belief and participation helped protect against poor emotional wellbeing.

For many older people loss of respect or status is one of the contributory factors that leads to poor emotional wellbeing. The role of older people within communities and families varies according to ethnicity. For instance older Pakistani and Indian people in multi-generational homes retain their status as head of household, even if they have declining physical health or need a carer at home; this is often not the case in other ethnic cultures (Nazroo *et al* 2005).

There are lessons to be learnt from different communities within the UK as well as from abroad, both for the applicability and transferability of approaches to the wider community and to help government

and others to develop and tailor appropriate services for particular communities. It is important that more research evidence is undertaken and used to shape future policymaking.

Gender

Women are more prone to some mental health problems than men are, particularly depression, self-harm and eating disorders, with 14 per cent of women compared with 9 per cent of men having disorders of this kind (ONS 2003). Numerous research reports and a large body of evidence indicates that women report more depressive symptoms than men, both at younger ages and later in life (Surr *et al* 2005). The situation deteriorates for men, too, as they age, and they become increasingly susceptible to depression.

Lack of diagnosis of mental health conditions

Across the age spectrum many mental health conditions are not diagnosed or treated. For example, the King's Fund found in 2008 that 51 per cent of people with anxiety disorders are not in contact with services and of those who are, 46 per cent do not receive medication or psychological therapy (McCrone *et al* 2008).

Lack of diagnosis is particularly acute in older people and there are almost certainly higher levels of depression and poor emotional wellbeing for this group than is captured in statistics. Of those older people who do discuss their depression with their GP, only half receive therapy or treatment. Fewer than one in 10 are referred to specialist mental health services, and in general they are not offered the range of treatments, such as talking therapies, that are available to younger clients (Godfrey *et al* 2004).

The National Services Framework for older people suggests that under-detection of mental illness in older people is widespread, due to the nature of the symptoms and the fact that many older people live alone (Department of Health 2004). The lack of diagnosis and reporting of mental health problems in older people is compounded, and partly caused by, a widespread lack of focus on older people within mental health policy. Mental health initiatives have tended to target adults of working age and children and young people (Lee 2006).

Relationships and social life

Contact with friends and family

The most important factors underlying older people's mental health and wellbeing are social and community participation. There is a sizeable body of research evidence linking the strength and quality of social relationships and community engagement to health, wellbeing and quality of life for older people (Berkman and Syme 1979, Beekman 2000, Gottlieb 1987, Smith *et al* 2002, reviewed by Surr *et al* 2005). Higher levels of social support, specifically frequency of contact with friends, reduce the risks for depression even for those with poor physical health (Prince *et al* 1998). Conversely, lack of social support is associated with increased mortality and poor health.

Having a close, confiding relationship lessens the impact of depression. It also helps in dealing with major life events and stress including chronic illness (Surr *et al* 2005). This is recognised and voiced by older people themselves. As the *UK Inquiry into Mental Health and Wellbeing in Later Life* states: '[o]lder people say that visits to or from friends and family motivate them to get out of bed in the morning. Having someone to talk things over with helps them to cope with worries. Many say that the most important thing is to feel wanted and needed by others' (Lee 2006: 42). However, there are large numbers of older people who experience isolation and loneliness. Estimates suggest that 1 million older people in the UK are socially isolated and this number is projected to rise to 2.2 million over the next 15 years if the issue is not addressed (*ibid*).

A survey in 1992 showed that compared with other countries in what was then the EC, people in the UK had less daily contact with other people than those in other countries except for Denmark and an above average number of people – 40 per cent – who never had contact with family or friends (Eurobarometer 1993).

Increases in the number of people with no children or with one child are likely to impact on wellbeing in later age as contact with family is considered by many older people to be very important and having few, or no, children clearly means less contact.

Figure 2.7.
Proximity to grandchildren

Source: Presentation at ippr seminar on grandparenting, 2008

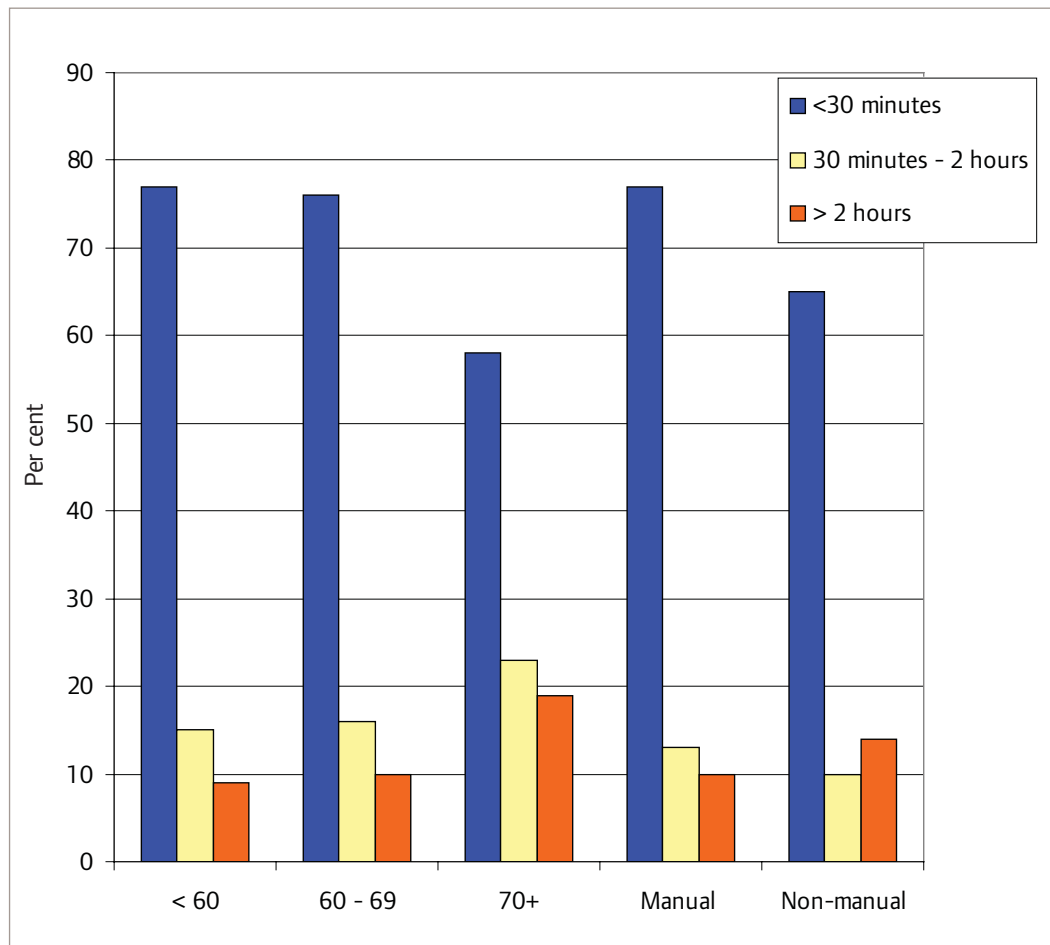


Figure 2.7 shows differences in physical proximity to grandchildren, by age and social class. It shows that proximity tends to reduce with increasing age, just when support in the form of contact is most needed by older people. It also shows that non-manual groups tend to live further away from grandchildren than manual groups.

In 2005 the British Social Attitudes Survey asked respondents how much time they spent with friends and family. Women tended to spend more time with both family and friends than men: 65 per cent stated that they saw members of their family or other relatives weekly or nearly every week and 63 per cent saw friends weekly, compared with 57 per cent and 58 per cent respectively for men (ONS 2008c). For many older people contact declines for reasons such as being in poor physical health, moving house or into a care home, or becoming a carer. A study exploring trends in loneliness among older people found that nearly a fifth felt lonely and isolated (Actor *et al* 2002).

Research into what older people value about close relationships shows that feeling useful and giving support and help to others is particularly important to them. There is a growing literature on the benefits and value to older people of volunteering, which is explored more at the end of this chapter.

Marital status

Never marrying is associated with a low prevalence of mental health problems, with just 8 per cent of men and 4 per cent women who do not marry experiencing such problems. Divorce and separation result in a high prevalence of low-level mental health problems (experienced by 19 per cent of divorced or separated women and 17 per cent of men). Marriage is associated with a low prevalence

of mental health problems in men (7 per cent) but, significantly, married women had a higher prevalence (12 per cent). This appears also to be the case across Europe with evidence from 13 out of 14 European countries showing that marriage was a protective factor for men but a risk factor among women when it came to low-level mental health problems (ONS 2003). Therefore trends in marriage and divorce are important in understanding trends and patterns of mental health problems and emotional wellbeing.

Living alone

Unsurprisingly, reported levels of loneliness are higher among those who live alone compared with those who live with others. Among those living alone, 17 per cent rated themselves as ‘often/always lonely’ compared with 2 per cent living with others, and 80 per cent of the ‘often lonely’ lived alone (Actor *et al* 2002).

Table 2.2. Proportion of men and women living alone, by age, Great Britain, 1986 and 2006 (%)

	1986	2006
Women aged 25-44	4	8
Women aged 75+	61	61
Men aged 25-44	7	14
Men aged 75+	24	32

Source: Dunnell 2008

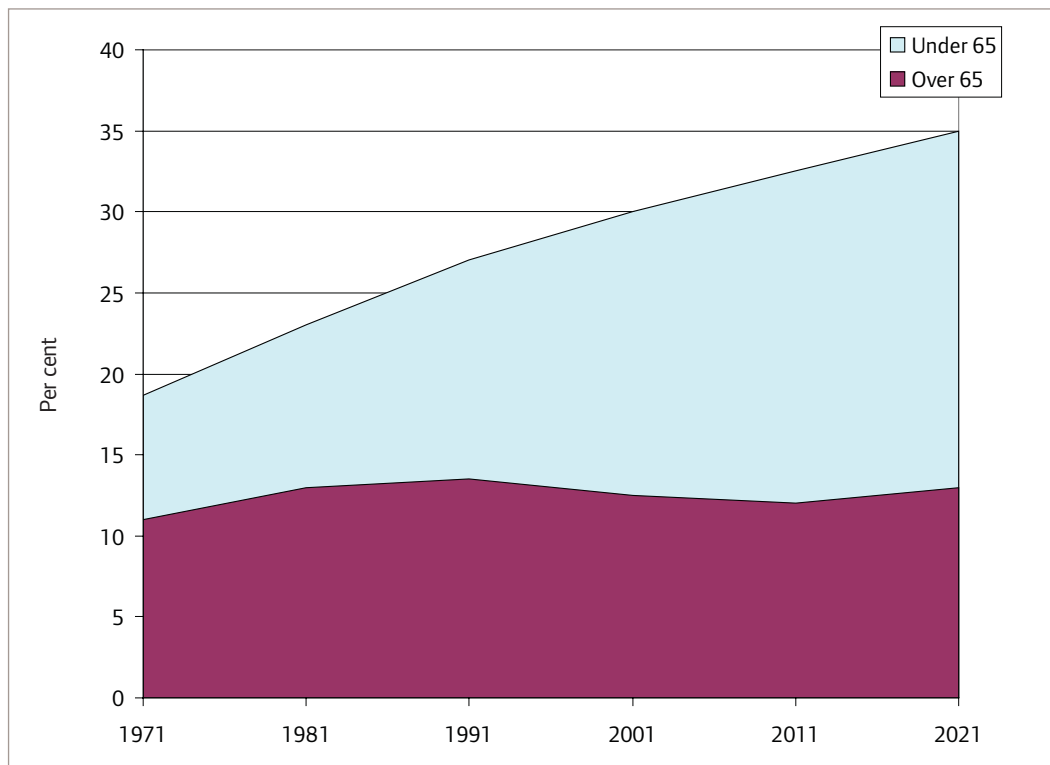
There have been significant changes in living arrangements over the past 40 years, with more people living alone, increasing the likelihood of loneliness and isolation for older people.

While the proportion of older women living alone in Great Britain has remained stable over the last 20 years, the proportion of older men living alone has increased, reflecting increasing life expectancy for men over 65 and changing living arrangements. Even so, women aged 75 or over were almost twice as likely to be living alone as men aged 75 or over in 2006.

There is likely to be a sustained and significant increase in numbers of people living alone. Figures for England suggest that 70 per cent of projected growth in the number of households up until 2026 will

Figure 2.8.
Proportion of single-person households, 1971-2021

Source: PMSU 2008



be because of an increase in single-person households. Many of these are home to people aged 65 and over. The proportion of men and women between 25 and 44 living alone has doubled and as those people get older this will likely increase the proportion of older people living alone, making policy intervention and support for social engagement for older people living alone even more important.

Age discrimination

Discrimination against people based on their age is widespread and compared with other forms of discrimination is often seen as 'acceptable'. This kind of discrimination unnecessarily excludes older people from many services, public places, community life, leisure activities, employment, mainstream culture, media and public debate. Such neglect fosters a culture that tends to overlook or ignore the views of older people and make them feel 'cast aside'. A survey of the EU countries in 2007 indicated that in the UK a higher than average proportion of people think that age discrimination is widespread (51 per cent compared with the EU average of 46 per cent), ranking 18th out of 25 countries (Eurobarometer 2007).

In 2005 the Department for Work and Pensions, which has responsibility for older people, set out a promising and ambitious strategy for improving older people's wellbeing. While many of the proposals have yet to be acted on, the document acknowledges the pernicious effects of ageism and discrimination (DWP 2005). Following this, the Government's report *A Sure Start to Later Life* set out that everyone, including older people, has the right to participate and continue throughout their lives in having meaningful relationships and roles (ODPM 2006b). However, there has not been sufficiently sustained or ambitious action to counter widespread discrimination, although it is too early to judge the success of recent discrimination legislation.

Discrimination also happens within families, with older people's needs marginalised or ignored. The extent to which this happens can reflect differences in ethnic groups. For instance in Bengali and some other Asian cultures, age is revered and people gain family and community respect as they age.

Older people with mental health problems face additional discrimination. Prejudice against people with mental health problems is widespread and contributes to under-diagnosis of these problems across the age spectrum and a reluctance for people to admit to themselves, their family or health services that they have a problem of this nature. For older people this kind of discrimination exacerbates some of the most challenging problems associated with ageing, including loss of social life, respect and feeling isolated and excluded.

Events and transitions in life that can trigger poor mental wellbeing

There is evidence that particular life events are powerful risk factors in the onset of depression among older people (Surr *et al* 2005). These include onset of poor physical health, bereavement, retirement, divorce, illness of a close partner and taking on caring roles. These factors are particularly prevalent for older people because the likelihood of a destabilising and negative life event is higher in older age.

In a community-based study, Brilman and Ormel (2001) found that events that caused severe stress (particularly death, physical disabilities and hospitalisation of someone close) were associated with onset of the first episode of depression among older people (cited in Surr *et al* 2005). The incidence and duration of depression, stress and anxiety following a negative life event are partly dependent on previous life events and personal resources and capacity to cope, and partly on support available both from family and friends and from services and community-based interventions.

Retirement

For some older people retirement offers the opportunity to participate more fully in other activities and spend more time with family and friends. However, for others it is a challenging event that leads to long periods spent alone or inactive, feeling 'worthless' and having no purpose. Only half of all retired people say they wanted to stop working and over a third say they felt forced to stop (Lee 2006) and 'cast aside', which clearly undermines wellbeing. Retirement is often accompanied by a significant drop in income, having to adjust expenditure, move homes or dispose of other assets, also adversely affecting wellbeing.

One-third of adult lives are lived in retirement and as life expectancy increases and work patterns change, this proportion will increase. The average number of years we live in retirement has already nearly doubled over the past half-century, from 11 to almost 20 years (Lee 2006).

Bereavement

Most people face bereavement and grief as they age. Women are at greater risk because they are more likely to live longer than men. Cross-sectional surveys (for example, the General Household Survey) show that around 50 per cent of older women are widowed compared with 20 per cent of older men, and the proportions increase with age. Whereas just under a third of women (28 per cent) and 9 per cent of men up to age 74 are widowed, the corresponding rate for those aged 75 and over is 62 per cent and 28 per cent respectively.

While bereavement is traumatic and stressful for everyone, most older people eventually manage the distress and adjust. For some, levels of wellbeing recover to the same levels or higher as before the bereavement (Oswald 2007). However, some research describes how between 10 and 20 per cent of older people suffer severe grief which can, if unsupported, lead to serious depression, chronic ill health, and disability (see Surr *et al* 2005). Bereaved men are at greater risk of death than women, particularly during the first 12 months following bereavement. Suicide rates and depression are also significantly higher in bereaved men.

There is some evidence that socio-economic factors impact on the way bereavement is experienced. For example, higher educational status and income levels may play a protective role, again highlighting the likelihood of further inequalities in wellbeing and the need for carefully targeted interventions. Bereavement may involve significant changes and further losses, for example loss of income, relocation and loss of contact with family and friends. Targeted and effective support to bereaved older people could help them through the immediate short-term period and help improve their long-term wellbeing.

Care: receiving and giving

A survey suggested that depression affected one in five older people living in the community, rising to two in five for those in care homes (Godfrey *et al* 2004), with much going undiagnosed and untreated. Mental health problems, including depression, are also a major reason for admission to nursing and residential care.

There is a lack of research into why so many care home residents are depressed and whether they were already depressed when they entered or they become depressed as a result of doing so. Care homes vary in the way that depressed older people are treated and how attempts are made to prevent depression. Again, there is a lack of research in this area in the UK.

ippr has found that people receiving and giving care are not receiving the support they need. And while most analyses concentrate on the costs of care and the need for increasing supply of carers and care homes, it is important to focus also on the quality of care given in care homes and by carers. More research would at least allow identification of best practice and promotion of wellbeing as a goal in itself (Moullin 2007).

A study by the Department of Health and Ageing in Australia, which involved 1,758 older people in 168 care homes, found that they were affected by being unable to take part in activities, poor relationships with staff and other residents, and not being visited enough (referred to in O'Hanlon *et al* 2007). There are also likely to be significant variations in the detection and treatment of depression, just as there are in the wider community. In some cases, depression among older people in care homes has become normalised and staff fail to see that depression does not have to be a normal part of ageing or a necessary consequence of living in a care home.

Many older people care for another family member. In fact the English social care system is reliant on having enough unpaid carers to look after people who need it. Currently three million older people provide care that is worth £15.2 billion a year (Moullin 2007). People aged 50 and over, particularly those aged 50-59, are more likely to be providing informal care than any other age group. In the UK,

14 per cent of people care for or look after a dependent person of 65 years or older, just above the EU average of 12 per cent (Eurobarometer 2004).

For many people, giving care is rewarding and done out of choice (Moullin 2007, 2008). However, for too many people giving care is not just a choice but a necessity and the amount of care they have to give, unsupported by services, has a damaging impact on their physical and mental health, can harm their life chances, and undermine their sense of wellbeing. In one study, those who were beginning to give care at an intensive rate (over 20 hours per week) had increasing symptoms of depression the more intense caregiving they gave, poorer self-reported health and health behaviours and outcomes that became progressively worse over time than those of their peer group (Surr *et al* 2005).

Evidence linking mental health problems with care-giving to people with dementia is seen as robust. From their review of studies published during the period 1989 to 1995, Schulz *et al* (1995) found that virtually all studies reported high levels of depressive symptoms among care-givers (28 to 55 per cent) (cited in Surr *et al* 2005). Given that the numbers of older people with dementia are set to rise, the impact on carers' wellbeing needs to be considered urgently.

There is clearly far more to be done to support carers and prevent them from experiencing depression and worsening physical health. ippr in its argument for more, better targeted support to be offered to carers has said: 'a just society can be judged on how it supports people who need care to live independent lives. But care for adults has rarely received the attention it deserves' (Moullin 2008: 4).

Looking at attitudes towards caring for older family members who need regular help, in the UK a substantially lower percentage of people than the EU average say they should live with their children (20 per cent compared with 30 per cent). A higher than average proportion of people in the UK say public or private service providers should visit their home and provide them with appropriate help and care instead. Two-thirds of British people think dependent people have to rely too much on their relatives – lower than in many countries but significantly higher than Finland and Denmark, for example (Eurobarometer 2007).

Public opinion of whether people would be provided with appropriate help and long-term care in the future should they need it also varies greatly among the countries of the EU, with Greece having the highest proportion of people believing this, at 89 per cent, followed by Belgium at 88 per cent. The UK is lowest among EU members with only 61 per cent believing they will receive appropriate care when they need it (Eurobarometer 2007).

England's social care system for older people needs to be reappraised, both for those in care homes and for those giving and receiving care at home, with a greater emphasis on emotional health. Currently most of the policy debates and research are based on funding and supply concerns. While these are important, there is a need to ensure that the debates do not lose sight of the overall ambition of the social care system: to protect and support people who need care to live happy and independent lives.

Community participation

In our analysis we have highlighted the importance for older people of having an active social life. However, many factors mitigate against older people's active participation in their local community. Physical access can be a significant barrier to participation, for example busy roads can be very difficult to negotiate for people with limited mobility. And fear of crime or fear of young people in public spaces may also prevent older people from accessing and using public spaces. In this section we describe some of the main barriers to community participation and access for older people.

Crime and fear of crime

One of the most frequently suggested explanations for older people's sense of isolation and social exclusion within their community is crime. Becoming a victim of crime has a significant and long-lasting impact on older people's wellbeing, leading in some cases to serious depression and withdrawal from social engagement. There is evidence to suggest that the increased risk of depression as a result of crime can persist over a long period of time for older people (ONS 2008c).

According to the British Crime Survey over-60s are the age group the least likely to be a victim of crime. Overall levels of crime are falling, which should further reduce the impact of crime on older people. However, the increase in numbers of older people will in all likelihood result in increases in numbers of older victims.

Fear of crime is also often reported to contribute to older people's isolation and exclusion from participation in community life. There has been a fall in fear of crime in England and Wales in all age groups.

In 2003 in the UK, the over-65s had slightly higher levels of trust in people than younger age groups. This was not the case in other European countries except for Portugal and Finland (Swedish National Institute of Public Health 2006).

Local environment

There are age-related differences about what people find most problematic in their local area. People over 65 are somewhat less likely than some other age groups to view litter, teenagers hanging around, vandalism, crime, drugs, graffiti, and drunk and disruptive people as serious problems (ONS 2008c).

Table 2.3. Aspects of their neighbourhood householders viewed as a serious problem, England: by age, 2006/07 (%)

	16–24	25–34	35–44	45–64	65 and over	All aged 16 or over
Traffic	12	17	19	21	19	19
Litter and rubbish in the streets	14	13	13	15	11	13
Teenagers hanging around on the street	15	18	16	13	8	13
Vandalism and hooliganism	11	11	10	10	8	10
Crime	14	13	12	11	7	10
People using or dealing drugs	9	10	10	10	5	9
Noise (excluding noisy neighbours)	8	7	6	7	6	7
Dogs	8	8	8	6	5	7
Graffiti	5	5	5	5	4	5
People being drunk or disruptive	8	8	6	5	2	5
Neighbours (including noisy neighbours)	7	6	5	5	2	4

People over 65 find traffic the most problematic of all the potential issues in a neighbourhood and from this ONS survey appear surprisingly unworried about teenagers, crime and drugs. For older people traffic presents a significant obstacle to leaving the house, socialising and participating in community life. In a different study of 600 older people by Scharf *et al* (2002) carried out in the most deprived wards of three local authorities in England, particular features of the physical environment were sources of stress and anxiety: deterioration in the physical fabric – lack of maintenance of buildings and public spaces – and environmental problems such as traffic noise and pollution.

Using data from a longitudinal study of ageing in Amsterdam, Knipscheer *et al* (2000) explored the relationship between the physical environment and depression in older people (cited in Surr *et al* 2005). They found that living in a highly urban environment increased poor emotional wellbeing and low-level depression among older people. Highly urban environments were associated with worse housing, a higher risk of being a victim of crime, worse traffic and having fewer social contacts within the neighbourhood. All of these, as we have described above, are risks for poor emotional wellbeing in older people. On the other hand, feeling able to influence the environment and having a community role, decreased depressive symptoms in older people.

Housing quality

Housing quality is highly significant for older people's emotional wellbeing. Poor housing contributes to depression, anxiety and stress and older people are most susceptible as they are more likely than other age groups to spend long periods of time at home.

There have been some improvements in housing quality in the last ten years and in 2005 there were six million houses categorised as 'non-decent', down from 9.1 million in 1996, the proportion of non-decent homes falling from 45 per cent to 27 per cent (Lee 2006). However, six million is still a large number. The proportion of older people living in non-decent homes is 34 per cent, just over a third.

Table 2.3. Poor living conditions in England, by type of household, 2005 (%)

	Non-decent homes	Poor-quality environments	Energy-inefficient homes	Homes in serious disrepair
One-person households				
Aged under 60	35	20	10	11
Aged 60 and over	34	14	11	13
One-family households				
Couple, no dependent children				
Aged under 60	25	16	11	9
Aged 60 and over	23	11	13	9
Couple with dependent children	22	16	8	8
Lone parent with dependent children	26	23	7	14
Other multi-person households	28	21	9	12
All households	27	16	10	10

Source: ONS 2008c

The Social Exclusion Unit estimated that 2.2 million households with a person over 60 live in unfit housing (ODPM 2006a). 13 per cent of older people live in homes that are in serious disrepair, slightly more than for people under 60. Cold, damp homes that are poorly heated have been linked to ill health and early deaths among older people.

Protecting older people's wellbeing

In some respects, what fosters good emotional wellbeing in older people is the converse of some of the factors that undermine it. Certainly in all the areas we describe above there is more that carefully targeted and designed policies and services could do to offer support. Below we outline some other factors which, for many older people, help protect their emotional wellbeing.

Taking on an active grandparenting role

Older people often refer to being an active grandparent to their grandchildren as both a source of pleasure, and as giving them a purpose (Lee 2006). In 2007 there were 13 million grandparents over the age of 50 in the UK (PMSU 2008) and in 2001 almost 90 per cent of people aged 60 and over were grandparents (ONS 2001c). In the future there will be an increase in the numbers of older people not having grandchildren, as fewer people have children, but also in the numbers of grandparents, as the population ages.

Grandparents provide 26 per cent of childcare, more than any other source, either formal or informal: 10 per cent is provided by friends or neighbours and 17 per cent in formal day care (PMSU 2008). This saves families in the UK £3.9 billion in childcare costs annually (Lee 2006), and makes a highly significant contribution to the national economy and to the lives of children.

There is some evidence that the role of grandparents is becoming even more significant. In June 2003 30 per cent of grandparents described themselves as a friend or confidant to their grandchildren, but

this had risen by August 2006 to 58 per cent (PMSU 2008). 61 per cent of grandparents see their grandchildren at least once a week and a further 17 per cent see their grandchildren monthly (information from participants in a private ippr seminar).

After having a mother staying at home full time, grandparents are the most popular choice of childcare-givers for mothers (Leach *et al* 2008), as they are considered to provide the most intimate and loving care. However, there is some evidence that childcare is considered a burden or an obligation by some grandparents and one study found that 39 per cent of grandparents would like to have a life free from too many family duties (information from private ippr seminar).

There is still a lack of information about the impact on the quality of life and wellbeing of families of grandparents providing care for their grandchildren. The quality of care provided by grandparents is highly variable and there is little support for them, and no regulation. Research by campaigning organisations has found that the majority of British grandparents bringing up their grandchildren have experienced financial difficulties as a result, and receive very little external financial support.

Exercise

For all age groups exercise protects against mental health problems including depression, as well as preventing physical health problems: a small number of epidemiological studies have examined the relationship between physical activity and depressive symptoms over time, finding exercise to give a positive effect on mental wellbeing.

Despite this evidence, there is currently little provision or encouragement for older people to exercise and what there is mostly focuses on the physical health benefits. But some positive steps include measures in the National Service Framework for Older People, developed in 2001, to test out ways of encouraging older people to take exercise, and from 2008 swimming will be free for people over 60.

Education and learning

While the level of education achieved as a young adult is a significant indicator of emotional wellbeing in later life, continuing education and learning is also important both for developing an active social life and as a source of mental stimulation and focus. More than a third of people in their sixties in England and Wales are involved in adult learning. Organisations such as the Open University encourage older people's participation in learning. However, funding for community-based adult learning is very limited and many courses valued by older people are being cut: the funding and national policy priority is for courses for 16- to 19-year-olds (Lee 2006).

Volunteering

Volunteering is considered very important for older people and for all the charities and services that depend on volunteers. Volunteering is associated with increased life satisfaction, with some evidence that older people derive greater mental health benefits from volunteering than younger age groups. It enables older people to make a contribution and is a means by which to participate socially and engage in community life, which reduces the likelihood of their experiencing depression and increases life satisfaction, improves morale and self esteem, creates larger social networks and increases altruistic behaviour (Surr *et al* 2005). Interest in volunteering peaks in the years immediately following retirement and helps the transition from working life into retirement. Nearly a quarter of people aged 50 and over are engaged in formal voluntary activity (Lee 2006).

However, there are barriers to older people's participation in volunteering. Nearly one-fifth of organisations place upper age limits on volunteering opportunities, or on specific tasks such as driving (Lee 2006). Other barriers include poor physical health, lack of skills, fear of crime and lack of transport on the part of the would-be volunteer and while the Government's current efforts to boost volunteering numbers focus on young people.

The Department of Health is currently developing a strategy on volunteering in health and care which aims to raise the esteem and profile of volunteering, develop support for volunteers, evaluate the benefits of volunteering and allow coherent investment in volunteering. It is important that the future strategy focuses on how to most effectively support volunteering

for older people, particularly the older old and how to encourage and enable older people who do not currently volunteer to participate. The strategy presently focuses on volunteering in care and health services, but it would be valuable to broaden this focus beyond those services and recognise the value to health and wellbeing for volunteers, whatever the sector they volunteer for.

Personal resilience

Most older people are not depressed, even if they experience significant difficult events. But for others, similar events do lead to depression, for a wide range of reasons. Support is very important, but internal personal factors in the form of self-esteem and self-efficacy in managing stress and difficult life events also play a significant role. Low self-esteem is a powerful predictor of low-level depression (Surr *et al* 2005). There are complex explanations for how self-esteem and efficacy develop, much of which relate to experiences in childhood and are beyond the scope of this paper. It is significant that having good social support and an active social life can lessen the effect of low self-esteem and self-efficacy (ibid).

Religion

Research has shown that religion helps some people to cope with difficult life transitions, such as losing a job or divorce, and can foster good emotional wellbeing for older people (Donovan and Halpern 2002). The benefits stem from giving people a sense of purpose and continued participation in a social and supportive social network. More benefits are experienced through active participation in religious events. According to the British Social Attitudes Survey 54 per cent of the population in Great Britain claimed to belong to a religion in 2006, a fall of 3 per cent since 1996.

Respect

Feeling valued, respected and understood contributes to good mental health and wellbeing (Lee 2006). As described earlier, age discrimination and feeling excluded from mainstream society can contribute to poor emotional wellbeing and loneliness among older people. There is a clear need to foster and encourage older people's active participation and contribution to community groups, schools and other neighbourhood activities. Encouraging other age groups to respect older people and encourage more social interaction with them requires some quite fundamental cultural shifts, yet there are traditions among some ethnic groups in the UK and abroad that could offer the UK some excellent examples.

3. Conclusions

While Government has argued that many excluded older people require additional support and help, the required coordinated action, prioritisation, resources and political and public appetite have been lacking. The focus in this report on wellbeing has highlighted the complexity of issues and factors that drive wellbeing for everyone, not just older people and there are inequalities in the way they are experienced which are related to wider social and economic inequalities.

Drivers of wellbeing – summary

Emotional wellbeing is shaped by many factors, including gender, ethnicity, socio-economic status and inequalities, and physical health. Lack of diagnosis and treatment of mental health problems is widespread. Continued participation in neighbourhood, family life and social life are seen as particularly important in protecting emotional wellbeing in later life. In fact, the impact of poor physical health is often mainly felt through the resulting impact on social and community participation.

We have highlighted continued and often worsening inequalities in income and physical health which compound and deepen existing inequalities in older people's mental health and wellbeing. There is also a clear socio-economic divide in later life, just as in childhood and earlier adulthood – being relatively poor is a significant risk factor for poor emotional wellbeing in later life.

There is a clear need to tackle pensioner poverty and health inequalities, and a need for more targeted interventions to support those most at risk of poor emotional wellbeing. There are specific trigger points in older people's lives, times when additional support is needed, particularly around retirement, bereavement, moving into a caring role and moving into a care home.

Being able to maintain a role within the family and local area and participate in social and community life is seen as important for good emotional wellbeing, but there are many obstacles for older people. Changes in family formations and a growing number of people living alone are likely to lead to increased numbers of older people feeling isolated and depressed. Poor-quality housing contributes to poor physical and mental health for older people and just over a third of older people live in poor-quality housing.

Similarly, poorly maintained physical environments and being a victim of crime undermine wellbeing and contribute to depression, isolation and loneliness. Traffic problems are a further obstacle to community participation and feelings of control, both of which are highly valued by older people.

In the second phase of our work, ippr will advocate more effective strategies to support older people, particularly those most at risk, to participate in community and social life.

Future work: international comparisons

While old age is sometimes assumed to be a time of loneliness and isolation this does not have to be the case: other countries and cultures whose attitudes to ageing are different from those in the UK do not have the same levels of exclusion and unhappiness. In the second phase of this work ippr will be exploring ageing in other countries and cultures in more detail and assessing whether the most successful policies, services and approaches can be applied in the UK. We will also be asking older people themselves what they would find most helpful, particularly for those most at risk and during times of difficulty. We will be advocating a new approach to ageing in which promoting wellbeing and sound mental health of all older people is a political and public priority. We will also examine efficacy in care systems, again using international comparative evidence.

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