

1. Introduction

Michael Marmot *University College London*

James Banks *Institute for Fiscal Studies and University College London*

Richard Blundell *Institute for Fiscal Studies and University College London*

Carli Lessof *National Centre for Social Research*

James Nazroo *University College London*

1.1 Why an English Longitudinal Study of Ageing?

Ask people about ageing in our society, and everyone has a view. Most would think it widely known that older age is a time of declining mental and physical function, worse health, and economic and social dependency. The elderly are a ‘problem’. Indeed, a small number of people over the age of 65 fit this stereotype. Most do not. What is striking about the health and social circumstances of older people in society is how variable the picture is, ranging from this rather depressing stereotype to that of vigorous octogenarians, economically and socially independent, with little disability, wide social and cultural interests and much to contribute to society.

It is precisely to understand this variability that the English Longitudinal Study of Ageing (ELSA) was established. It has three principal purposes. Firstly, to complete the picture of what it means to grow older in the new century. Surprisingly, the range of pictures painted in this report has hitherto been available only in partial form. There has been much concern with pensions, but little information on who has what financial arrangements for retirement; much concern with increasing disability, but sparse data on the range of positive functions with increasing age; worry over increasing social isolation of older people, but little evidence on who is doing what at older ages. Completing the picture means going into detail. It is not sufficient to know that mental functions decline with age; it is important to know which functions. It is not enough to know that people’s physical functions decline with age; it is important to know how that decline varies depending on gender, occupational career and circumstances in later life.

This leads to a second principal purpose of ELSA, which is to examine the interrelationship between different areas of life. What is the relationship, for example, between health and adequacy of financial arrangements for older age? How does social status relate to the quality of the social environment? Why do people in lower social positions appear to be suffering from age-related declines at an earlier age than people in higher social positions? How does the nature of pension arrangements affect people’s continued

participation in the workplace? How does cognitive function influence people's ability to plan for their financial future? By bringing together scientists from different disciplines and gathering high-quality information on these different 'domains' of life, ELSA provides a resource that is unique in Britain.

The third purpose of ELSA is understanding. What accounts for the variety of patterns that we see? The aim here is, very clearly, to provide the scientific basis for policy. What determines whether old age will be a time of misery and dependency, or one of vigour, social engagement and good health? Which of these pictures, and the whole range in between, will dominate has profound import for social and medical services, for the economy and for the design of neighbourhoods, as well as for the well-being of the population.

1.2 Background to ELSA

The ageing of the population that is now unfolding is qualitatively different from what has gone before. Life expectancy for those reaching age 65, for example, is now over 15 years for men and nearly 20 years for women. This has increased by more than four years for each group between 1960 and 2000. This rate of change is unprecedented for men – male life expectancy at age 65 rose by only one year between 1840 and 1960 – while female life expectancy at age 65 has been rising steadily since 1900. By 2020, the over-50s will constitute 40% of the British population (and 47% of the population aged 15 and over), and by 2040, 30% will be aged 60 or over.

The increase in life expectancy differs markedly for people in different social strata. Life expectancy at 65 for men in the top social class is 17.5, compared with 13.4 for men in the bottom one. Healthy life expectancy shows even bigger social differences. A comparison of areas of England classified according to degree of social and material deprivation showed that healthy life expectancy at birth was 66 for men and 68 for women in the most affluent areas, compared with 49 (men) and 52 (women) in the most deprived. The challenge, then, is to understand not only differences in length of life, but differences in quality of life among social groups.

In policy terms, the economic, social and political consequences of this dramatic shift in the age distribution are bound to be far-reaching. Older people are currently relatively large consumers of NHS resources and of benefit expenditures (38% of NHS expenditure is spent on the 16% of the population currently over 65, and those over state pension age account for 57% of benefit expenditures). So, with increases in longevity and therefore in the proportion of the oldest old within the population, the consequences both for the NHS and for social services will be considerable. Social isolation is exacerbated with old age as family members and friends in the same cohort tend to die, as physical mobility tends to decrease and as a sense of vulnerability tends to increase. These correlates of old age are likely to place increasing pressure on state and local authority provision, including that of social workers, home helps and sheltered housing schemes. Such pressures will be impossible to ignore, not just because of burgeoning need but since, in straightforward electoral terms, the preferences of older voters will be

important to all political parties, particularly if turn-out among young voters continues at its present low level.

However, trends in the age profile of the population will provide an increasingly crude yardstick by which to measure pension, health care or social service needs. In the first instance, to the extent that extended healthy lives lead to longer working lives, the relative numbers of pension or benefit dependants to taxpayers will rise by less than expected, easing the pressure on the financing of state provision. But even if working lives did not lengthen, other socially productive activities engaged in by healthier older individuals (such as caring) may reduce the demands that would otherwise have been placed on the State, and may result in a further lowering of needs to the extent that these activities lead to more favourable outcomes for the individuals themselves. ELSA will enable us to study the determinants of retirement and how employment patterns in later life might be expected to change with changes in health and in the economic and social environment.

In this context, it is important to acknowledge that the ways in which people retire have changed and that the ways in which people live in their retirement are also undergoing a radical transformation. Indeed, the experience and image of old age as a whole is changing. As a result of the increase in healthy life expectancy and improvements in the economic position of older people, a new phase of the life course – the ‘Third Age’ – has opened for some between exit from the labour market and the onset of physical dependency. However, this experience is by no means uniform for this particular cohort, with great inequalities in both health and economic position. And it may be a phenomenon that becomes less common with future cohorts of older people, as expectations and policies around retirement and pension provision change. This reflects a growing diversity of experiences of older ages that is likely to be structured by socio-economic position, gender and ethnicity, as well as by generational and time-period-specific effects. Nevertheless, the growth of the demographic group for whom earning through employment is no longer a primary activity may also be giving rise to a reinvigoration of non-material objectives and values. Research based on the data gathered in ELSA will be able to document this process, and diversity and inequalities in it, and to investigate its implications both for individuals’ mental and physical health and quality of life and for the wider community and economy.

1.3 Wider significance of ELSA

ELSA is supported by major grants from the US National Institute on Aging (NIA) and from several departments of the British Government. The British Government supports ELSA because of its unique ability to lay out the picture of the diversity of ageing trajectories and to inform both short- and long-term policy options for our ageing population. The NIA supports ELSA because of its scientific and international value. In particular, there is a companion study to ELSA in the USA – the Health and Retirement Study (HRS). HRS, as is ELSA, is a longitudinal study that follows people’s health and economic and social circumstances through retirement into older age. ELSA has been planned to be directly comparable to HRS. Scientists and policy-makers in

both the USA and Britain will benefit from the comparative analysis of data obtained from people living under very different arrangements of health and social services and economic policies.

ELSA and HRS have also become models for other studies of ageing. The Study of Health and Retirement in Europe is being planned in several European countries and will yield data comparable to ELSA, and a study similar to HRS has been established in Mexico. Similarly, a programme of work setting up new longitudinal studies in the Czech Republic, Poland and Russia is being coordinated from the International Centre for Health and Society at University College London. New cohort studies, along ELSA lines, are now under active consideration in Ireland, Canada and Australia.

1.4 Key challenges emerging from the present report

ELSA is a longitudinal study, which means that the same individuals are followed and re-interviewed every two years. The real scientific yield from ELSA will come, therefore, from analysing how changes over time in one domain feed into functioning in another. For example, the finding that sick people have lower incomes than those who are healthy could arise because low income leads to ill health. The causal direction could also be the other way: ill health could lead to loss of earning power and hence to lower income. Longitudinal data hold out better prospect of determining the relative importance of these two pathways than the simple 'cross-sectional' description of low income and poor health being linked.

Nevertheless, this first report of findings from the first wave of ELSA has highlighted a number of areas that demand attention. These are presented in the Summary in this chapter and, in detail, in the chapters that follow. The theme of this review of broad issues emerging from the findings is diversity.

Middle age is no paradise; old age is not hell

Difficulty with mobility increases with age. This does not mean that middle-age people are immune to declines in function. Surprisingly, 43% of respondents in their 50s reported some difficulty with mobility.

Similarly, difficulties with independent living increase with age. This does not mean that all older people have difficulty: 58% of respondents in their 80s and beyond have no difficulties with basic activities of daily life. The challenge for the future is to understand what leads some 80-year-olds to high levels of functioning and some 50-year-olds already to show signs of decline.

Diversity means inequality

The economic situation for individuals over 50 vary from rich, through comfortable to parlous. There are, of course, big differences in incomes. More extreme are the differences in wealth. Average financial wealth plus wealth from physical assets (excluding housing) in the over-50 population is £82,500.

Half the population have £17,500 or less; and a quarter of the population have £2,200 or less. Holdings of the three main forms of wealth – housing, pensions and financial assets – are correlated: those without housing or pension wealth also have the lowest levels of financial wealth.

Adequacy of pension arrangements varies greatly, and people's likelihood of staying in the workforce appears to be related not only to age or ability to function, but also to whether pension arrangements for retirement provide an incentive to retire.

Health and wealth are linked

The issue of social inequality runs right through this report. People with more education, higher-status jobs, higher income or more wealth have better health and better cognitive and physical function. It is not simply that poor people have worse health than those who are not poor; there is a social gradient. The lower the social position, the more ill health and loss of function.

The link between social status and health is seen, too, when people are asked to rank their social standing. Even allowing for their level of wealth, those who rank themselves lower in the hierarchy have worse health than those whose self-ranking is more favourable.

Being lower in the social hierarchy is equivalent to more rapid ageing

Ill health comes to all of us eventually, but it comes, on average, at an earlier age to people lower in the social hierarchy. A similar pattern is present for loss of function. The disability gap between social classes is equivalent to the gap between age groups 10 or more years apart. When assessing memory, education and occupational class have a more powerful effect than age.

The extent to which this insight can be translated into policy is, as yet, unknown. If it were possible to delay the decline in function of those with little education to the age when those with more education show decline, the impact on the population would be profound.

Wide diversity in social and physical environment

Participation in most social activities varies according to level in society. In terms of the social activities covered, with few exceptions, people of higher status have a wider array of social activities and participation in clubs and organisations than people of lower status.

The social environment is important. The lower the social position, the more likely are people to live in neighbourhoods characterised by low social capital – here measured by descriptions of the area according to degrees of vandalism and graffiti, loneliness, trustworthiness and friendliness.

Next steps

Such findings raise a number of more complex questions. The long-term agenda of ELSA is to provide the data that can address such questions. The

longitudinal nature of the study is central to this, and that involves two elements. Firstly, the ELSA sample was drawn from the Health Survey for England (HSE), and so there already exist two observations of the ELSA participants. As part of the general release of ELSA data for use by other analysts, we will provide mechanisms to link the data from the HSE with those from ELSA.

More importantly, and on an ongoing basis, ELSA participants will be contacted every two years to participate in a new wave of data collection. This will allow us to understand how and why people's lives change as they grow older. The next wave of ELSA data collection will take place in 2004 and will involve both an interview along the lines of that conducted for the first wave of ELSA and a physical assessment conducted by a nurse.

1.5 Methods

Our focus in this report is on the findings from the first wave of ELSA, not its design or its implementation. It goes without saying that a rigorous methodological approach must be a key feature of any longitudinal study that will stay the course and provide the quality of data needed for analysis. More detail is provided in Chapter 9 of this report and in a separate technical volume.¹

The ELSA sample is drawn from households previously responding to the HSE, and the HSE survey years 1998, 1999 and 2001 were used as a basis for this. Individuals were eligible for interview if they were born on or before 29 February 1952, had been living in a responding HSE household and were, at the time of the ELSA interview, still living in a private residential address in England. In addition, partners under the age of 50, and new partners who had moved into the household since HSE, were also given a full interview. Great efforts were made to ensure that the fieldwork was successful, including a thorough strategy for tracing and contacting eligible individuals who had moved since their last interview. Ultimately, the survey achieved a household response rate of 70%, with 96% of individuals responding within households. This equates to an overall individual response rate of 67%. This provides a sample of 11,392, which includes 204 partial and 158 proxy responses. In addition, 636 partners under 50 and 72 new partners were interviewed, equating to a total sample of 12,100. This provides a sound basis for future waves of the study. It should be noted that the main analysis of this report excludes proxy interviews and interviews with new and younger partners.

The topic areas covered by the ELSA questionnaire at wave 1 included: individual and household characteristics; physical, cognitive, mental and psychological health; social participation and social support; housing, work, pensions, income and assets; and expectations for the future. In translating such a wide variety of concepts into operationalised measures that could fit together in a household setting, the study benefited from the close

¹R. Taylor, L. Conway, L. Calderwood and C. Lessof, *Health, Wealth and Lifestyles of the Older Population in England: The 2002 English Longitudinal Study of Ageing, Technical Report*, National Centre for Social Research, London, forthcoming.

collaboration between survey specialists and substantive experts from the different fields. ELSA uses tried-and-tested measures where they exist, and has developed or incorporated survey approaches new to the UK where they do not. Examples of these include: unfolding bracket methods to mitigate non-response problems on financial variables; concurrent interviewing in the cases where households have more than one eligible respondent (coupled with a period of the interview spent privately with each respondent for the collection of sensitive data); and the use of ‘percentage chance’ questions to understand people’s expectations of the future.

The early development of the survey instruments was characterised by lively debates, ‘expert panels’ convened to aid the design of new or difficult elements of the survey, cognitive testing of new modules of questions and two extensive pilots that tested the survey instruments and fieldwork approach. ELSA benefited from its relatively long development period. As we will interview respondents at two-yearly waves, we are now preparing to start fieldwork again in 2004. Wave 2, which will include a nurse visit, is being developed using the same approach.

1.6 Reporting conventions

Throughout this report, all tables give weighted calculations. For further details on the weighting methods, see Chapter 9. Statistics in cells with between 30 and 49 observations are indicated by the use of square brackets. Statistics that would be based on fewer than 30 observations are omitted from tables.

1.7 Acknowledgements

ELSA is a large multi-centre and multi-disciplinary study that would not have been possible without the efforts and dedication of a great number of people. The study is managed by a small committee chaired by Professor Sir Michael Marmot and made up of James Banks, Richard Blundell, Bob Erens, Carli Lessof and James Nazroo. Roger Jowell played a crucial role in establishing the study and was formerly a member of this committee. We would like to express our gratitude for the support we have received from a number of sources.

Foremost of those who deserve recognition are the participants in the study. They have given generously of their time in both the ELSA interview and the earlier Health Survey for England interview. We hope that participating in the interview has been of interest to them and that the value of this work is apparent – and, of course, that they will continue to participate in the study!

The institutions involved in the study are the International Centre for Health and Society at University College London, the Institute for Fiscal Studies, the National Centre for Social Research, the University of Cambridge, the University of Nottingham and the University of Oxford. A great many individuals in each of these institutions have been involved in the study, some of whom are reflected in the authorship of chapters in this report. Others,

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