

## **Summary**

### **Chapter 2**

#### **The socio-demographic characteristics of the ELSA population**

- The cohorts covered in ELSA are ones in which marriage is the norm and cohabitation applies to a small minority. Unsurprisingly, widowhood is highly prevalent at old ages especially for women.
- Overall, only a small proportion of people in the sample have one or more children living in the household (21% of men and 17% of women), but nearly half of the men and women in their early 50s had one or more of their children living with them.
- Among men, the percentages living with at least one of their children drop substantially in successively older groups up to age 65–69 years; in this age group, 14% are living with children. The transition appears to occur earlier for women, so that by age 60–64 years only 14% are living with children.
- Household size decreases with age more sharply for women than for men: two thirds of women and one third of men aged 80 years and over are living alone, but about one in ten of both men and women live alone in their early 50s.
- Around 1 in 6 of those aged under 65 years in 2002–03 was living in smaller household in 2004–05. Few of those aged 75 years or over in 2002–03 were living in a household of different size when interviewed again in 2004–05. Fewer than 5% of participants were living in larger households in 2004–05 than in 2002–03.
- Analyses by wealth show that people who are married or cohabiting are more likely to be wealthy, while people who are divorced, single or widowed are more likely to be poor. Wealthier people are also less likely to live alone than poorer people. This is in part an artefact of the way in which wealth was defined to include combined assets of couples, but could nevertheless indicate greater hardship for those who are alone.
- A strong gradient in mortality rates by age was observed, as expected. Overall, more men than women died between wave 1 and wave 2. Further, the mortality rates were higher amongst those in the lowest wealth quintile compared to those in the highest wealth quintile.

### **Chapter 3**

#### **Labour market transitions**

- Nearly 15% of those in paid work aged between 50 and the state pension age in 2002–03 had left work by 2004–05. Movements out of paid work were more common among men aged 60 or over and women aged 55 or over than they were among younger individuals. Both women and (particularly) men in part-time work in 2002–03 were more likely to have left work than those in full-time work.

## *Introduction*

- Most of those who were not in paid work in 2002–03 were still not in work in 2004–05. However, 8% of those aged 50 to the state pension age who were out of work had returned to paid work by 2004–05. This was more common among those at least five years younger than the state pension age in 2002–03.
- Among 50- to 54-year-olds, those in paid work in 2002–03 in the poorest and the richest wealth quintiles were the most likely to leave work. Similarly, amongst this same age group, those not in paid work in 2002–03 in the poorest two wealth quintiles and the richest wealth quintile were the least likely to return to work.
- Men who were in paid work and contributing to a defined benefit pension in 2002–03 were much more likely to leave work than those who had been in paid work and contributing to a defined contribution pension in 2002–03. Among women, the likelihood of remaining in work did not vary by whether they had contributed to a defined benefit or a defined contribution private pension in 2002–03.
- Among those in paid work in 2002–03, those who reported that their health was only fair or poor were about twice as likely to leave work as those who had reported being in excellent or very good health. In addition, among those who were not in paid work in 2002–03, those who had reported worse health were less likely to return to work than those who had reported being in excellent or very good health in 2002–03. This difference was particularly large for men aged 50 to 54.
- A vast majority (81%) of employees whose employers have a compulsory retirement age say they would not want to work beyond this age, even if their employer allowed it. However, a greater proportion of employees feel constrained by the compulsory retirement age the lower it is.
- Almost two-thirds of men, and half of women, aged 52 to 54 who were not in paid work in 2004–05 report that they had a disability that affected the amount of work that they could do, compared with only one-in-fifteen men and women in the same group who were working full-time.

## **Chapter 4**

### **Self-reported physical health**

- Seventeen chronic conditions were considered, all of which have potential to increase difficulties in daily function among sufferers. A quarter of participants recorded at least one additional diagnosis between the interviews in 2002–03 and 2004–05 (median time lapse: 27 months).
- By the end of the second wave of fieldwork, half those in their early 50s in 2002–03 were without diagnosis of any of these conditions but only one-in-ten of those aged 80 years or over.
- Women had an advantage in prevalence and a small advantage in incidence of diagnosis of at least one of seven cardiovascular disease (CVD)-related conditions, but this did not apply when all 17 conditions were considered together.

- Of four CVD-related conditions and six other physical diseases analysed separately, percentage incidence of diagnosis was particularly high for cataracts among those aged 75 and over in 2002–03 (15% of men and 22% of women without previous cataracts) and for arthritis among women aged 60 and over (one-in-eight of those without the condition previously).
- Experience of chest pain symptoms was not strongly age-related.
- Experience of troubling pain, and, more specifically, of severe pain in the back, hip, knees or feet, was not age-related.
- Balance problems and dizziness were considerably more common the older the person (for example, three-out-of-five women aged 80 and over experienced one or both of these at least sometimes, compared with only one-out-of-five women in their 50s).
- Older age was also associated with greater likelihood of multiple falls.
- Falls may affect life more if one lives alone. More people aged 60 to 74 living alone experienced them than their counterparts living with others. This was not true of older people still living in the community.
- Among people aged under 75, greater wealth was accompanied by greater health, as measured in this chapter. This applied to incidence of at least one disease, being free of diagnosis of the 17 conditions, and experience of chest pain, of balance problems or dizziness, of severe pain and of specific severe pain at two or more specific parts of the body (back, hip, knee, foot).
- Once aged at least 75, associations between health indicators and wealth largely disappeared. They remained for women for incidence of CVD-related conditions, experience of angina symptoms, experience of severe pain generally and experience of severe pain in multiple specific parts of the body.

## **Chapter 5**

### **Measures of physical health**

- The age patterns differ for Body Mass Index (BMI) and Waist-Hip Ratio (WHR). In men, BMI peaks earlier than in women (55–59 years compared with 60–64 years), while WHR peaks at 70–74 in men, but continues to increase with age in women.
- There is clear pattern of differences in anthropometric measures with wealth. BMI in women and WHR in both men and women, show linear negative trends across the quintiles of wealth. This pattern is not seen in BMI in men.
- Among ELSA participants, systolic and diastolic blood pressure show different patterns with age. Systolic blood pressure does not rise inexorably with age but peaks in people in groups in their 70s and thereafter falls. Diastolic pressure falls with age in all women and in men older than 60 years.

## *Introduction*

- Different cardiovascular risk factors pattern differently by age. The percentage of people with hypertension (except for the very oldest group), diagnosed diabetes and mean levels of C-reactive protein (CRP) increases with age. By contrast, the percentage of people with high total and LDL cholesterol decreases with age after 60 years.
- Different cardiovascular risk factors also show different patterns with wealth. As wealth increases, there is a decrease in mean systolic blood pressure, the percentage of people with hypertension, high risk levels of HDL cholesterol and triglycerides, diagnosed and undiagnosed diabetes and mean CRP levels. By contrast, there is no association with diastolic blood pressure and the prevalence of high total and LDL cholesterol increases with increasing wealth.
- Different lipids measures show different patterns by sex. The overall prevalence of high total and LDL cholesterol is very high and higher for women than for men. Detrimental levels of triglycerides are more prevalent in men than women.
- All measures of lung function deteriorate with advancing age and there is a shallow gradient with wealth, richer people being somewhat advantaged. There is a clear effect of smoking; lung function is always better in those who have never smoked than in those who currently smoke.
- Mean haemoglobin decreases with age in both men and women. The prevalence of anaemia is greatest in the oldest groups.
- Ferritin levels show an inverted U shape with age in both sexes. Low ferritin levels in women show the same pattern with age, but no age related pattern is seen in men. Mean haemoglobin is not associated with wealth and ferritin only shows some signs of an advantage for the richest group.

## **Chapter 6** **Measured physical performance**

- Performance measures offer an objective marker of functioning, free from differences in attitudes to reporting difficulties. ELSA wave 2 (2004–05) included tests of lower limb functioning plus grip strength.
- Overall tested performance declines with age, but some of the oldest people maintain high functioning. For example, the weakest 25% of women aged 52–59 have measured grip strengths of 24 kg or less, but the top 5% women aged 80 and over have grip strengths of 25 kg and above.
- Those living in the poorest households have significantly higher rates of impairment on all tests. For instance, compared with those in the wealthiest fifth of households, men and women in the poorest fifth of households are approximately two and a half times as likely to perform poorly on the Short Physical Performance Battery of tests.
- Incidence rates of poor function on the gait speed test are also associated with low wealth. Both men and women in the poorest group are significantly more likely to have developed gait speed limitations between the first and second ELSA waves than those in the wealthiest group.

- Performance test results are useful in detecting differences among high- as well as low-functioning individuals, and provide reliable measures for identifying factors that might delay the onset of functional limitations.

## **Chapter 7**

### **Quality of healthcare**

- The quality of healthcare received by ELSA respondents was assessed against pre-defined evidence-based quality indicators for those who reported having been diagnosed with diabetes mellitus, hypertension, ischaemic heart disease, cerebrovascular disease, osteoarthritis, depression, osteoporosis or raised cholesterol; or having problems with balance, falls, vision, hearing, anticoagulation, pain, urinary incontinence or smoking. Indicated care is healthcare that meets the standard described in the quality indicator.
- The proportion of ELSA respondents reporting that they received indicated care varied substantially by condition, from eight-out-of-ten respondents with newly diagnosed heart attack or angina, to only one-in-seven of those with balance problems.
- The health problems presented in this chapter can be divided into three groups according to the quality of care reported by respondents. Over two-thirds of respondents reported receiving indicated care for hypertension, ischaemic heart disease, diabetes, hearing problems and pain. Less than two-thirds but more than one-third received indicated care for diabetes (with an additional risk factor), osteoporosis, vision, incontinence and falls. Less than one-third of respondents received indicated care for problems with balance.
- A high proportion of those receiving healthcare advice from a health professional reported following that advice.
- Few differences in the quality of healthcare were reported by wealthier respondents compared with poorer respondents, which suggests that healthcare for the interventions studied in ELSA is provided equitably to those in need, regardless of socio-economic status. Exceptions were incontinence management and diabetes education.

## **Chapter 8**

### **Cognitive function**

- One-third of the sample reported that their memory had worsened over the past two years. Compared with wave 1, 38% fewer regarded their memory as excellent and 20% more regarded their memory as poor.
- Participants' own ratings of their memory, however, are an unreliable guide to their actual memory performance, and their ratings of the change in their memory are an equally unreliable guide to the observed change in their memory performance.
- Older groups have a double disadvantage in relation to their memory performance; on tests of word recall, not only do they remember fewer words when tested immediately, but after a brief delay they forget more of

## *Introduction*

what they could recall initially. To counteract this age-related loss, it is recommended that important information be provided to older people in written form.

- Older groups have a striking impairment in prospective memory – that is, remembering to carry out an action without being reminded. Around two-thirds of participants aged 75 and older forgot to perform an action that they had earlier been instructed to carry out. If the findings are indicative of forgetfulness in daily life, then they raise concerns about the health and safety of older people, in relation to such activities as remembering to take medication, pay bills and lock doors.
- Speed of information processing was the most sensitive measure of cognitive decline over the two-year period. The older the group, the greater the degree of decline.
- Literacy was assessed for the first time in a UK population sample of people aged 65 years or more. The literacy measure assessed how well respondents understood written instructions about taking an Aspirin tablet. Some degree of literacy impairment was surprisingly widespread, being found in one-third of the sample. Literacy was strongly age-related: one-half of the oldest group (80+) made at least one error on the task, compared with one-quarter of the under 60s. Only some of the age differences in literacy can be explained by differences in education, since the trend for literacy impairment to increase with age is evident even when controlling for level of education.
- The higher the level of wealth, the better the cognitive performance on all measures except speed of processing. Compared to those in the highest wealth quintile, almost eight times as many respondents in the lowest quintile were impaired in both literacy and numeracy.

## **Chapter 9** **Expenditure and consumption**

- On average, those aged 52 and over spend £45 per adult per week on food; this pattern is relatively constant across age groups.
- Food spending rises with wealth, particularly for food consumed out of the home. Spending on food out of the home is almost five times higher for those at the top of the wealth distribution than for those at the bottom.
- The level of spending on basics – food, fuel and clothing – increases with wealth, but the budget share falls, as would be expected for goods that are considered economic necessities.
- Nevertheless, even among the very poorest groups of the ELSA sample – low-wealth households aged 75 and over – spending on ‘basics’ accounts for less than 35% of disposable income.
- Transfers to people outside the household account for 4% of disposable income on average, and for as much as 7% amongst the wealthiest oldest households. For almost all groups, average transfers are greater than average spending on either clothing or leisure services.

- The percentage of the elderly spending more than 10% of their income on domestic fuel is 8.3% but this rate varies systematically by age, wealth, health and quality of life. Amongst the oldest old and the poorest groups, rates are higher (11½% for those aged 75 and over and 14% for the lowest wealth quintile).
- Consumption of services from durable goods owned by households is an important aspect of consumption for older households. Durable ownership rates are high and non-negligible even for the high-technology goods such as DVDs and personal computers.
- On average, 40% of the population aged 52 and over have adopted digital television in their household. Amongst those 75 and over, these rates are less than 30%; for women aged 80 and over, the rates are as low as 15%.
- The frequency with which durables are replaced varies across the wealth distribution, and the spending on each replacement rises sharply with wealth.
- Measures of durable ownership and durable replacement and expenditure-based poverty measures correlate with self-perceived measures of both social status and quality of life, which suggests an important role for consumption measures when thinking about broader social outcomes for the older population.

## **Chapter 10**

### **Loneliness, relative deprivation and life satisfaction**

- People aged 80 and older are the most vulnerable to loneliness.
- More women than men report feeling lonely, but this difference lessens with age and for those over 80 years old it remains notable only on the 'feel lack of companionship' dimension of loneliness.
- There is a socio-economic gradient in loneliness.
- Living with a partner and feeling her or him very close lowers rates of loneliness.
- Having children but not feeling close to any of them is associated with higher rates of loneliness than being childless.
- Contact with children is an important correlate of loneliness.
- People without friends report the highest rates of loneliness.
- The older people become, the less they feel that the money they have is insufficient to meet their needs.
- The older people become, the more they feel deprived compared with people around them.
- Being of pre-retirement age (less than 60) or over 80 negatively affects levels of satisfaction with life.
- Relationships with friends and family exert a powerful influence on people's life satisfaction.

## *Introduction*

- Wealth is an important determinant of people's life satisfaction but its effect declines over the age of 75.

## **Chapter 11** **Perceptions of ageing**

- On the whole, ageing is a positive experience for the majority of the respondents.
- Wealth does not affect in a consistent way respondents' experiences and perceptions of growing older.
- The majority of the respondents do not think of themselves as old.
- Future health status seems to be the most important concern for the majority of the respondents.
- Wealthier respondents are more likely to say that old age starts later and middle age ends later, independent of their age and sex.
- Healthier respondents are more likely to say that old age starts later and middle age ends later, independent of their age and sex.
- The majority of the respondents feel younger than their actual age.
- Respondents who feel younger than their actual age have better self-perceived health than the rest of the respondents.
- The majority of the respondents would prefer to be younger than their actual age.
- Respondents who would prefer to be younger have worse self-perceived health than those who prefer to be their actual age.