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STUDIES OF AGEING AND WELLBEING: SUMMARY DESCRIPTIONS OF KEY INTERNATIONAL STUDIES AND THEIR IMPLICATIONS FOR THE DEVELOPMENT OF THE EWAS RESEARCH

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ENHANCING WELLBEING IN AN AGEING SOCIETY (EWAS)

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ABSTRACT

This report sets out the results of a review of a selection of research studies of ageing which provide insights into enhancing the wellbeing of older people. The review provides summary descriptions and edited excerpts of selected international studies, with a significant emphasis on how these studies relate to the EWAS perspectives on wellbeing. It emphasises the domains the other studies cover; differences and similarities in the way common domains are covered in the EWAS research and the other studies; differences and similarities in question lines; ways to build on the foundations of the other studies; and the sorts of directions the EWAS researchers could consider for future research work. In addition the review provides some limited comment on the use of research findings to influence policy, and the involvement of and distribution of research findings to service providers, older people, the private sector and other stakeholders.

Although the domains addressed in the EWAS study overlap with various domains in all these research programmes, the EWAS research programme will be based largely, though with some minor variations, on the ten wellbeing components described and measured in the Ministry of Social Development's Social Report. In the EWAS research, these are Health, Education, Work and Retirement, Income Assets Living Standards and Housing, Rights and Entitlements, Leisure and Recreation, Living Arrangements, Safety, Social Connectedness and Culture and Religion

CONTENTS

Acronyms: studies and institutions

BASE	Berlin Ageing Study
ELSA	English Longitudinal Study of Ageing
ESRC	Economic and Social Research Council
ESAW	European Study of Adult Wellbeing
EWAS	Enhancing Wellbeing in an Ageing Society
FCSPRU	Family Centre Social Policy Research Unit
HRS	Health and Retirement Study
JRF	Joseph Rowntree Foundation
LASA	Longitudinal Ageing Study Amsterdam
LSN	Living arrangements and social networks of older adults
OASIS	Old Age and Autonomy: the Role of Service Systems and Intergenerational Solidarity
OIA	Oxford Institute of Ageing
SHARE	Survey of Health, Ageing and Retirement in Europe
WALS	Widowhood Adaptation Longitudinal Study

1. INTRODUCTION

This report sets out the results of a review of a selection of research studies of ageing which provide insights into enhancing the wellbeing of older people.

This review provides summary descriptions and edited excerpts of selected international studies, with a significant emphasis on how these studies relate to the EWAS perspectives on wellbeing. It emphasises:

- the domains the other studies cover
- differences and similarities in the way common domains are covered in the EWAS research and the other studies
- differences and similarities in question lines
- ways to build on the foundations of the other studies and
- the sorts of directions the EWAS researchers could consider for future research work.

In addition the review provides some limited comment on:

- the use of research findings to influence policy
- the involvement of and distribution of research findings to service providers, older people, the private sector and other stakeholders.

Many of the studies have a strong emphasis on the determinants and consequences of the health status of older people. EWAS is collecting sufficient health data to allow international comparisons to be made, but its emphasis lies elsewhere.

EWAS is in the vanguard of the new wave of studies of ageing, in exploring the multiple determinants of wellbeing in older people in addition to health: social connectedness (intra- and extra-familial), income and wealth, participation in paid and unpaid work, access to market and government goods and services, satisfaction with one's life and circumstances – all the physical and psychic goods which determine wellbeing.

In an earlier paper, (Working paper No. 8: *The Concept of Wellbeing and its Application in a Study of Ageing in Aotearoa New Zealand*[1]) Dr Peter King has articulated the foundation for this approach, with a comprehensive analysis of different perspectives on wellbeing. This paper, while not proposing an hypothesis of the way in which the different components of wellbeing may interact (for example, that subjective assessments of wellbeing act as filters for objective measures, to promote a more "steady state" assessment of an individual's wellbeing than the objective data would suggest), enunciates a view that the critical endpoint of elements of wellbeing is *agency* - the ability of the individual to act and interact with their environment, to experience independence and interdependence, and to possess capability in all the dimensions of their lives.

[1] King, P. (2007). *The Concept Of Wellbeing And Its Application In A Study Of Ageing In Aotearoa New Zealand* The Family Centre Social Policy Research Unit EWAS Working Paper 8.

For this reason the review does not dwell on health findings from other studies nor, except in some limited circumstances, suggest further health areas that EWAS researchers might pursue.

The review takes as its starting point the ten domains of the Ministry of Social Development's Social Report[2] as reflected in the draft EWAS questionnaire of May 2007.

The longitudinal studies traversed in this report are:

BASE (Berlin Ageing Study)

ELSA (English Longitudinal Study on Ageing)

ESAW (European Study of Adult Wellbeing)

HRS (Health and Retirement Study)

LASA (The Longitudinal Ageing Study Amsterdam)

LSN (Living arrangements and social networks of older adults) and WALS (Widowhood Adaptation Longitudinal Study)

OASIS (Old Age and Autonomy: the Role of Service Systems and Intergenerational Solidarity)

SHARE (Survey of Health, Ageing and Retirement in Europe)

A major, non-longitudinal study is also traversed: the ESRC (Economic and Social Research Council) *Growing Older* programme. Keele University's significant programme of ageing research is also surveyed; a considerable volume of material from the Joseph Rowntree Foundation is included; and material from the Oxford Institute on Ageing is also considered.

[2] www.ewas.net.nz/Publications/filesEWAS/Conceptualising%20wellbeing.pdf

2. NEW ZEALAND PERSPECTIVES ON WELLBEING

The EWAS programme of research will be the first major study of ageing in New Zealand. EWAS has based its domains on the ten wellbeing components described and measured in the Ministry of Social Development's Social Report. Before considering the EWAS domains and their measurement there is value in briefly considering the structure of the Social Report itself.

2.1 The Social Report

The Social Report was first produced by the Ministry in 2001, and has been published annually since then. The report defines wellbeing straightforwardly as

"… those aspects of life that society collectively agrees are important for a person's happiness, quality of life and welfare" (Social Report, 2006 p 4).

The point that this is a collective view is emphasised again:

"the social report focuses on those aspects of wellbeing most people hold in common" (Social Report, 2006 p 4).

The domains are:

- Health
- Knowledge and skills
- Paid work
- Economic standard of living
- Civil and political rights
- Cultural identity
- Leisure and recreation
- Physical environment
- Safety
- Social connectedness

The desired outcome statements and indicators for the domains are attached at the end of this section. Indicators to measure these domains ("desired social outcomes" in the report) are selected against these criteria:

- *relevant to the social outcome of interest* – the indicator should be the most accurate statistic for measuring both the level and extent of change in the social outcome of interest, and it should adequately reflect what it is intended to measure
- *based on broad support* – ideally there should be wide support for the indicators chosen so they will not be changed regularly
- *grounded in research* – there should be sound evidence on key influences and factors affecting outcomes
- *able to be disaggregated* – it should be possible to break the data down by age, sex, socio-economic status, ethnicity, region and, where possible, to the individual (or smallest group possible), so we can compare outcomes for different groups

- *consistent over time* – the usefulness of indicators is related directly to the ability to track trends over time, so indicators should be consistent over time
- *statistically sound* – the measurement of indicators needs to be methodologically rigorous
- *timely* – data needs to be collected and reported regularly and frequently to ensure that indicators are providing up-to-date information
- *allow international comparisons* – as well as reflecting the social goals of New Zealanders, indicators need to be consistent with those used in international programmes so we can make comparisons (Social Report, 2006 p 5).

The discussions amongst EWAS partners demonstrate that their selection of indicators has been driven by similar concerns.

The report has three major report areas. The first provides background and contextual information on the size and composition of the New Zealand population. The second section, the core of the report, is organised around the 10 outcome domains. The outcome domains contain a two-page summary of each indicator. The final section, the Conclusion, summarises how social wellbeing has changed over time and how different population subgroups are faring.

2.2 The Social Report and EWAS: differences and similarities

The Social Report uses ten domains of wellbeing that have widespread support across the New Zealand adult population, and strongly emphasises objective measures of wellbeing (see page 7). This matches the Report's stated purpose:

- to provide and monitor over time measures of wellbeing and quality of life that complement existing economic and environmental indicators
- to compare New Zealand with other countries on measures of wellbeing
- to provide greater transparency in government and to contribute to better informed public debate
- to help identify key issues and areas where we need to take action, which can in turn help with planning and decision making.

Of 42 indicators in the 2006 report, only six are subjective. They are:

- feeling safe (as a subset of safety)
- feeling lonely and trust in others (as subsets of social connectedness)
- satisfaction with work life balance (as a subset of paid work),
- satisfaction with leisure time (as a subset of leisure and recreation) and
- living standards, also a subset of economic standard of living, where the measure for those with low living standards takes into account people's subjective perceptions of how well off they are.

The stated purpose of the EWAS research is "to provide the understanding that is essential for policy formulation and the delivery of services for enhancing well being in an ageing New Zealand society", and the involvement of stakeholders in the design of the research, and its end use, is a distinguishing feature of the programme. The research programme takes the underlying theoretical position that "Wellbeing in an ageing society (in this case New Zealand) is socially constructed, and can therefore be

"enhanced", or in other words that the wellbeing of ageing and older persons in particular is socially constructed, and can therefore be "enhanced"[3]. An early working definition of wellbeing applied by EWAS researchers was: ""the satisfaction of an individual's goals and needs through the actualisation of their abilities and lifestyle" (Hird, 2003:5, adaptation of definition by Emerson 1985:282 in Koopman-Boyden, 2007, p 16)[4]

The EWAS research has been well-informed by considerable stakeholder consultation[5], which has gathered input from national, regional, cultural, policy, government, non-government, advocacy, self help and service organisations, as well as individual older people and carers. Stakeholders were asked three specific questions:

- Given the scope of this programme of research, what critical areas of focus would provide useful information for your organisation?
- What specific questions in either the survey or the focus group interviews would extract the sort of information your organisation would find helpful?
- Please offer any suggestions or advice that you think will enhance this research programme and make it more beneficial to your organisation, other organisations and the wellbeing of older people in New Zealand?[6]

As a result the EWAS questionnaire begins with the same ten domains as the Social Report:

- Health (Health - mental and physical)
- Knowledge and Skills (Education)
- Work (Paid, unpaid and voluntary work)
- Economic Standard of Living
- Rights (Being aware of their entitlements and rights)
- Leisure and recreation (Participation in leisure and recreation activities)
- Physical environment (The physical environment inside and outside the house)
- Safety (Feelings of safety)
- Social Connectedness (Contact with Family and Other People)
- Cultural Identity (no separate section on this; questions appear within other sections).

but (in some cases) scopes them differently, and measures them through a greater range of subjective as well as objective lenses. The primary difference is the EWAS questionnaire's focus on wellbeing (satisfaction): an introductory question is asked about respondent's overall satisfaction with their life at present: they are asked this again about each domain, and the question of overall satisfaction is returned to at the

[3] Koopman-Boyden, P (2007 unpublished) The theoretical underpinning and conceptualisation of Wellbeing in the overall research programme, and its methodological applications in Objectives 2 & 3 (the national surveys): p 2

[4] Emerson, E.B. (1985). Evaluating the impact of deinstitutionalization on the lives of mentally retarded people. American Journal of Mental Deficiency, 90(3), 277-288. Hird, S. (2003). What is wellbeing: a brief review of current literature and concepts, NHS Health Scotland. Retrieved 30 April, 2007, from http://www.phis.org.uk/doc.pl?file=pdf/wellbeing in Koopman-Boyden (2007) op.cit.

[5] Waldegrave, C. (2006) *Stakeholder Consultations In Ageing Research,* The Family Centre Social Policy Research Unit, EWAS Working Paper.

[6] Ibid, 13

conclusion of the interview. This approach is well supported in the literature (see particularly the Berlin Ageing Study).

A further notable difference is in the EWAS questionnaire's careful unpicking of the history of respondents' participation in paid and unpaid work, their reasons for participation and withdrawal from paid work, and their anticipated future participation. Sources of income, assets and expenditure, access to shops and transport, and factors that would enable people to continue living in their own homes, are also features of the EWAS questionnaire that are not included in the Social Report. Again, all of these areas of enquiry are well supported by the literature on ageing and wellbeing.

The range and quality of respondents' social interactions is explored in detail in the EWAS questionnaire, and it also collects information on other aspects of people's life experiences, such as family structures over time and at present, contributions to society, and leadership, migration between and within countries, and religious practice.

Finally, the domain of civil and political rights is measured in very different ways in the Social Report and the EWAS research. The Social Report describes these rights as:

"fall(ing) into two broad categories. The first requires that people are protected from interference or abuse of power by others. The second requires that society is organised in a way that enables all people to develop to their full potential.. . . Wellbeing depends on people having a sense of choice or control over their lives, and on being reasonably able to do the things they value" [7]

However, the Social Report's only indicators for measuring these concepts is through measuring voter turnout; the proportion of women in government; the level of perceived discrimination; and perceived corruption in public affairs. There is no measurement of social and economic rights.

In contrast, the EWAS study defines this domain as "being aware of their entitlements and rights". The questionnaire examines respondents' perception of their ability to access social and economic goods, primarily services from government, that are crucial to their ability to exercise choice or control over their lives. The areas are:

- finance
- access to adequate health care when needed
- access to residential care if needed
- support from family
- support from the government.

Interestingly, the EWAS questionnaire does not ask directly about perceived age discrimination.

In summary the EWAS questionnaire adapts the domains and objectively oriented measures of the Social Report to fit its research purposes: it gives more weight to the subjective measures of the wellbeing domains, and investigates in much more detail

[7] SR p 70

areas such as access to transport, contact with others, and paid work participation, that have been shown in the literature to be correlated with wellbeing in ageing.

2.3 Other New Zealand Government work

The Ministry of Social Development has recently developed a Positive Ageing Indicators Report, whose purpose is to monitor older New Zealanders' overall wellbeing and quality of life and identify key issues for action to improve positive ageing. The population of interest is, except where otherwise specified, those aged 65+. The domains are based on New Zealand's *Positive Ageing Strategy*.

The domain and indicators are:

- Income (disposable, private, living standards, low incomes)
- Health (life expectancy at 65, general health (self-report), cigarette smoking, unmet needs in primary health care, flu vaccination)
- Housing (quality (self-report), ownership, affordability)
- Transport (Licenses' drivers, public transport use)
- Living in the community (living at home 85+, disability allowance, criminal victimisation 60+, fear of crime 60+, trust in others)
- Māori cultural identity (Te ao Māori 65 to 69, te reo speakers)
- Access to facilities and services (non-big city access to services, internet access)
- Attitudes (life satisfaction, physical activity, perceived age discrimination 18+)
- Employment (paid employment, average hourly earnings)
- Opportunities (voluntary work, loneliness, participation in education, community inclusion (self-report), participation in cultural and arts activities)

This Report lies closer to the EWAS research in intention and areas of enquiry than the Social Report, with a similar focus on transport (with the inclusion of a question about holding a driver's licence), and on unmet primary health care needs. Perceived age discrimination is included, as it is in the Social Report.

***The Social Report 2006* outcome domains and indicators** *(updated indicators in bold)*

Health

DESIRED OUTCOME STATEMENT	INDICATORS
Everybody has the opportunity to enjoy a long and healthy life. Avoidable deaths, disease, and injuries are prevented. Everybody has the ability to function, participate and live independently or appropriately supported in society.	1. Health expectancy **2. Life expectancy** **3. Suicide** **4. Cigarette smoking** 5. Obesity

Knowledge and Skills

DESIRED OUTCOME STATEMENT	INDICATORS
Everybody has the knowledge and skills needed to participate fully in society. Lifelong learning and education are valued and supported.	**6. Participation in early childhood education** **7. School leavers with higher qualifications** **8. Participation in tertiary education** **9. Educational attainment of the adult population** 10. Adult literacy skills in English

Paid Work

DESIRED OUTCOME STATEMENT	INDICATORS
Everybody has access to meaningful, rewarding and safe employment. An appropriate balance is maintained between paid work and other aspects of life.o	**11. Unemployment** **12. Employment** **13. Median hourly earnings** **14. Workplace injury claims** 15. Satisfaction with work-life balance

Economic Standard of Living

DESIRED OUTCOME STATEMENT	INDICATORS
New Zealand is a prosperous society, reflecting the value of both paid and unpaid work. Everybody has access to an adequate income and decent, affordable housing that meets their needs. With an adequate standard of living, people are well-placed to participate fully in society and to exercise choice about how to live their lives.	**16. Market income per person** 17. Income inequality 18. Population with low incomes **19. Population with low living standards** 20. Housing affordability 21. Household crowding

Civil and Political Rights

DESIRED OUTCOME STATEMENT	INDICATORS
Everybody enjoys civil and political rights. Mechanisms to regulate and arbitrate people's rights in respect of each other are trustworthy.	**22. Voter turnout** **23. Representation of women in government** **24. Perceived discrimination** **25. Perceived corruption**

Cultural Identity

DESIRED OUTCOME STATEMENT	INDICATORS
New Zealanders share a strong national identity, have a sense of belonging and value cultural diversity. Everybody is able to pass their cultural traditions on to future generations. Māori culture is valued and protected.	**26. Local content programming on New Zealand television** 27. Māori language speakers 28. Language retention

Leisure and Recreation

DESIRED OUTCOME STATEMENT	INDICATORS
Everybody is satisfied with their participation in leisure and recreation activities. They have sufficient time to do what they want to do and can access an adequate range of opportunities for leisure and recreation.	29. Satisfaction with leisure time **30. Participation in sport and active leisure** 31. Participation in cultural and arts activities

Physical Environment

DESIRED OUTCOME STATEMENT	INDICATORS
The natural and built environment in which people live is clean, healthy and beautiful. Everybody is able to access natural areas and public spaces.	**32. Air quality** **33. Drinking water quality**

Safety

DESIRED OUTCOME STATEMENT	INDICATORS
Everybody enjoys physical safety and feels secure. People are free from victimisation, abuse, violence and avoidable injury.	**34. Intentional injury child mortality** 35. Criminal victimisation 36. Perceptions of safety **37. Road casualties**

Social Connectedness

DESIRED OUTCOME STATEMENT	INDICATORS
People enjoy constructive relationships with others in their families, whānau, communities, iwi and workplaces. Families support and nurture those in need of care. New Zealand is an inclusive society where people are able to access information and support.	**38. Telephone and internet access in the home** **39. Regular contact with family/friends** 40. Trust in others 41. Loneliness 42. Contact between young people and their parents

3. OASIS RESEARCH PROJECT

3.1 Introduction: purpose and scope

The project *OASIS: Old Age and Autonomy: The Role of service Systems and Intergenerational Solidarity* was an EU funded project under the "Quality of Life and Management of Living Resources" Programme. The project analysed "the intersecting role of the family and the welfare state on autonomy and quality of life in old age. More specifically the aim has been (1) to explore the variation in intergenerational solidarity and ambivalence across countries; (2) to study the interacting roles of family care and social systems, and (3) to analyse the impact of families and services on quality of life in old age".[8] Data was collected in Norway, England, Germany, Spain and Israel. The project began in February 2000 and concluded in January 2003.

The major goal of the study is "to provide a knowledge base of how to support autonomy in old age to enhance wellbeing of elders and their family caregivers and improve the basis for policy and planning."[9]. This goal makes clear the study's orientation: that autonomy is a major source of wellbeing in ageing, and that the wellbeing of family caregivers is also an important, though subsidiary, wellbeing goal.

The OASIS research project situated its work in the context of ageing populations, with changes in family structures, norms and behaviour like the decrease in fertility rates, increased rates of divorce and the growing rate of women's participation in the labour force adding to the challenges faced by societies, families and individuals. Similar demographic and social shifts are happening in New Zealand.

3.2 Domains covered by OASIS, and their differences and similarities with EWAS

The OASIS survey questionnaire contained the following fifteen topic areas: socio-demographic data; house and environment; occupational activity and socio-economic status; health and functional ability; help and services; parents; other family members; social relationships; norms and values (regarding familial interchanges); preferences and coping; quality of life; income; miscellaneous.

- Socio-demographic data covered:
- Marital status (married, unmarried partner, widowed, divorced)
- Household situation (living alone, with others)
- Generational household structure (one, two, three, four generations)
- Number of family generations (1,2,3,4,5)
- Number of children (1,2,3+)

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[8] OASIS Research Project: *Findings,* November 2003, http://oasis.haifa.ac.il/downloads/findings.pdf, p 1

[9] Lowenstein, A. and Ogg, J. (2003) *OASIS Research Project: Old Age and Autonomy: the Role of Service Systems and Intergenerational Solidarity: Final Report*. Haifa, p i.

While these two documents are readily available, little else can be accessed without payment.

- Parents (none, one, both)
- Siblings (none, 1, 2, 3+)
- Grandparents (none, 1, 2, 3 and 4)
- Grandchildren (none, 1, 2, 3 and 4)
- Adult grandchildren (none, 1, 2, 3 and more)

The EWAS questionnaire also explores in considerable depth the family structures and family living arrangements of those taking part. It goes further than the OASIS study in gathering data on parental age when the respondent was born, length of time living in New Zealand, country of birth and rural or urban upbringing and current residence.

Methodology

Baseline data was collected through surveys from representative urban samples of people 25 years and over, living at home. For the quantitative survey, the sample consisted of approximately 6,000 people aged between 25-74 years (N=4,042) and 75+ (N=6,1 06). About 1,200 were interviewed in each of the five countries.

Older people "at risk of dependency" (aged 75 and above with health problems) were identified in the survey, and samples of ten dyads in each country (50 in all) of older people "at risk" and the child they would mostly rely on in case of need were selected for in-depth interviews focussing on coping and quality of life.

Quantitative phase

The questionnaire used for the survey had two sections: the standardised international survey instrument and specific country context questions.

The main instruments used in the OASIS questionnaire are the scale on physical functioning taken from the SF 36 Health Survey Instrument, the Family Solidarity and Conflict Scales, Intergenerational Ambivalence, Flexible Goal Adjustment Scale, Filial Responsibility Scales, the WHOQOL Quality of Life Scale, the PANAS – Positive and Negative Affect Scale, as well as scales developed specifically for the project, such as the Help and Use of Services Scales.[10]

Qualitative phase

The key elements of the qualitative research were:

- multiple methods, focussing on an interpretive and naturalistic approach to the subject matter
- research undertaken in natural settings, with an attempt to interpret phenomena in terms of the meaning that people bring to them
- the structure and use of a collection of a variety of empirical materials
- the production of richly detailed materials which allow conceptual and experiential meanings to be given to social events, experiences and process in individual, group and community life
- an open-ended, flexible means of creating hypotheses for structural analysis.

[10] OASIS final report, p 64

A comprehensive description of OASIS's methodology, and the challenges faced by the researchers, is contained in Chapters 3 and 4 of the Final Report.

3.3 Differences and similarities in question lines

The OASIS study has considerable commonality of purpose with the EWAS study in that it aims "to provide a knowledge base of how to support autonomy in old age and enhance wellbeing of elders and their family caregivers and improve the basis for policy and planning" (OASIS final report, p i).

The OASIS study posed eight basic research questions:

1. What is the actual and preferred balance between familial and formal service systems?
2. Do families and services substitute for each other in care systems?
3. How do family norms and practices (family culture) influence service systems, and vice versa how are they influenced by welfare systems?
4. How do behavioural and normative patterns vary between countries and generations?
5. What are the normative ideal of intergenerational care and living arrangements in the different countries?
6. To what extent are these norms shared across cohorts/generations, and what changes are to be expected in the future?
7. How do families handle intergenerational ambivalence, and how is ambivalence related to quality of life?
8. Can intergenerational solidarity and ambivalence exist together? Is there a balance? How do they reflect on quality of life?

The main issues covered in the project included themes on three levels: the macro-societal level, comparing welfare states and their management of risks and opportunities, and examining family cultures (and the use of substitution or complementarity in the support provided by families and services); the meso level, considering intergenerational family solidarity, conflict and ambivalence, norms and ideals regarding elder care and patterns of service use by the elderly and their families: and on the micro or individual level, considering the quality of life of elders and their family caregivers.

Each of the three levels of enquiry in the OASIS project is rich in potential areas for exploration in future research.

Macro level – welfare regimes and family cultures

At the macro level all states have moved into providing more of the care and support that was once the domain of family members. But differences of perception remain about the reasonable balance between state and private care. Although the EWAS study will not be directly undertaking cross-country comparisons, the data it will collect on ethnicity and country of origin of respondents will allow it to explore whether the experience of differing countries' welfare regimes has an influence on family norms about providing care and willingness to use State care, or whether ethnicity exerts a stronger influence. Further, OASIS's insights that State provision of care, and geographical separation, have not diminished the provision of family

support, or feelings of family obligations (Chapter 1, pp 4 and 5) will be a useful area of investigation, as they run counter to generally expressed public opinion in New Zealand

Meso level – intergenerational solidarity, conflict and ambivalence

The OASIS authors contend that associations between quality of life and intergenerational family exchanges and support ((solidarity, conflict, and ambivalence) provide indicators of the likely success of different help and support systems (Chapter 1, page 10) – one of the basic goals of the OASIS research.

Solidarity may be thought of as having three dimensions – opportunities for interaction (structural and associational solidarity); closeness and warmth (affectual solidarity) and helping behaviours (functional solidarity). The presence or absence of intergenerational solidarity has an impact on self esteem and psychological wellbeing, and higher family solidarity helps people cope better in situations of stress, such as widowhood or immigration (Silverstein and Bengston 1998[11]; Katz and Lowenstein 1999[12]). It should be noted that these concepts do not hold a single value – studies have shown that high levels of solidarity can create heavy demands on time and family resources in families with few resources (Belle, 1986[13]) – a finding that has been replicated in several studies of Māori and Pacific People in New Zealand. There has, however, been little research on family solidarity and its impact, positive or negative, across the New Zealand population as a whole.

A new concept, that of ambivalence, has been put forward as an alternative to the solidarity paradigm in studying parent-child relations, especially in later life (Luescher and Pillemer 1998[14]). It is based on post-modern and feminist theories of the family, and contends that "families today are characterised by plurality and a multiplicity of forms, such as divorce, remarriage and blended families, all of which give rise to contradictions in roles, norms, emotions and motivations". Bengston et al[15] contend that, in close families, solidarity comes first, conflict follows, and ambivalence springs from the intersection of the two. This more nuanced understanding of family relationships is likely also to emerge in EWAS's research.

Micro level: quality of life/wellbeing

OASIS and EWAS share an interest in measuring both subjective and objective dimensions of wellbeing or quality of life (note that the OASIS study uses the terms "subjective wellbeing" and "subjective quality of life (QOL)" interchangeably).

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[11] Silverstein, M., Bengston, V.L. and Litwak, E. (forthcoming) Theoretical approaches to problems of families, aging and social support in the context of modernization. In V.L. Bengston and A. Litwak (eds), *Global aging and challenges to families*. New York, Aldine de Gruyther.

[12] Katz, R. and Lowenstein, A. (1999). Adjustment of older Soviet immigrant parents and adult children residing in shared households: An intergenerational comparison. *Family Relations,* 43 (1), 43-60

[13] Belle, D.E. (1986) The impact of poverty on social networks. In L. Lein and M.B. Sussman (eds) *The ties that bind: Mens' and womens' social networks*. New York: Howarth Press

[14] Luescher, K. and Pillemer, K. (1998). Intergenerational ambivalence: A new approach to the study of parent-child relations in later life. *Journal of Marriage and the Family*, 60, 413-425

[15] Bengston, V.L., Giarrusso, R., Marby, J.D. and Silverstein, M. (2002) Solidarity, conflict, and ambivalence: Complementary or competing perspectives on intergenerational relations? *Journal and the Family*, 64, 568 -576

The study emphasises the importance of examining subjective as well as objective quality of life.

Subjective quality of life is defined as cognitive evaluations in respect to various life domains (physical health, psychological wellbeing, social relations and environmental conditions, measured using WHOQOL-BREF[16]), and as emotional states (positive and negative affects), measured using PANAS[17].

Four broad research questions are posed:

- Descriptive comparisons – are there differences in the subjective quality of life across the four countries? – here macro-level influences are considered
- Correlates – what aspects of living conditions influence subjective quality of life?
- Family structures and quality of life – do family relations and structures, such as the existence of children) influence subjective quality of life?
- Do functional supports (whether from families or services) influence subjective quality of life?

While country comparisons are not available to the EWAS study, analyses of sub populations, such as immigrant/New Zealand born populations, urban/rural, single/multiple ethnicities, religious/no religious affiliation, may reveal unexpected variations to both levels of subjective QOL, its correlates, and the impact of family structures. Unexpected results, and those that appear ambiguous, could be explored further in the qualitative work to come.

3.4 Intergenerational interactions: OASIS dyads and the EWAS study

There are clear differences between the OASIS project and EWAS, not least in the project design, where the dyads of older people "at risk" and the child who is most likely to be called on to help has given OASIS the opportunity for great depth of exploration of family solidarity, conflict and ambivalence. It would be possible for the EWAS project similarly to identify from the survey responses older people who are at risk of dependency, and to build questions into future research that allowed researchers to identify those respondents who were the primary family caregiver for an elderly person at risk of dependency.

Although these groups would not be dyads, and therefore interviews would be unable to reveal the texture of particular family relationships, qualitative interviews of both groups, and comparisons of their answers, would allow EWAS to sharpen the intergenerational comparison of experiences of quality of life of the elderly person and the family caregiver, and ways of coping when the older person is at risk of dependency. The question of whether State care substitutes for family care, or whether family care complements that provided by the State is of particular interest.

[16] The WHOQOL-BREF instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment. The WHOQOL-BREF is a shorter version of the original instrument.

[17] The PANAS (Positive and Negative Affect Schedule) consists of 10 positive affects (interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive, and active) and 10 negative affects (distressed, upset, guilty, scared, hostile, irritable, ashamed, nervous, jittery, and afraid).

This is an important policy question for New Zealand, as the government needs to balance its responsibility to ensure older people receive the care they need against the possibility that families may withdraw from providing care if they believe the State will take up the responsibility.

Autonomy and dependence: a caveat

The OASIS study is clearly a fruitful source of approaches EWAS may consider in its future work. The closeness of the two approaches is exemplified in this statement in the OASIS final report:

> ". . . the research is concerned with how autonomy and competence are promoted in old age by both families and services."(Oasis final report p 230).
>
> which is consistent with the EWAS researchers' interest in improving wellbeing, through both policy and practice. The text immediately following this quote makes clear, however, the divergences between EWAS and OASIS:
>
> "Consequently dependency is not of interest per se, but in how it relates dynamically with autonomy. The focus is on then on the onset of dependency, and on the risk of "becoming dependent" which is defined in functional terms. Thus the dimensional range of dependency is restricted, and *other dimensions such as psychological, social and economic are omitted* (my emphasis).. . .The objective is to concentrate on how families and services respond to the risk of becoming functionally dependent and the interconnection of these macro-structural factors such as service organisation of a country, and the micro factors, such as family cultures and expectations of care. The aim is to answer the research question: how do family norms and practices (family culture) influence the service systems and vice-versa, how are they influenced by different welfare regimes?"

This is not to say that the OASIS researchers are uninterested in psychological, social and economic *wellbeing*: in fact these are important dimensions of their analysis of Quality of life (see discussion above). Rather, it is clear that the researchers do not examine *dependence* in these dimensions.

3.5 The use of research findings to influence policy

The Final Report includes policy relevant recommendations for each of the eight research questions, and derives, from the overall study, recommendations relating to each of the three levels of analysis: the macro-social, the meso-familial, and the micro-individual. While OASIS findings have been widely disseminated in EU literature and through academic publications, there is little evidence of active stakeholder engagement in the study, either through the establishment of the areas for investigation, or in the distribution of research findings to service providers, older people, the private sector and other stakeholders.

3.6 The results[18]

The Oasis study found that complementarity between families and services was more prevalent than substitution, but both young and old preferred more welfare state responsibility. Personal resources had a great bearing on the wellbeing of older people.

Norms, values and preferences

Filial norms are still strong in each of the five countries. Young people were as supportive as older people. But supporting older parents was neither absolute nor unconditional – a substantial minority (between 16 and 34 per cent) did not subscribe to such norms. Support for norms was generally higher in the South.

Filial solidarity did not mean people did not expect the state to play a substantial role. Public opinion in all five countries was in favour of some form of partnership between the family and the welfare state.

Older generations seemed more reluctant to receive help from the family when there were alternatives than young people were to give it – in fact younger people seemed more inclined to family care provision. Spain is the exception, with older people preferring family care, and younger people preferring the state to provide such help.

Family solidarity and conflict

Solidarity was measured on six dimensions: associational, affectual, (emotional closeness), consensual (similarity of opinions), functional (assistance provided and received), normative (attitudes to filial responsibilities) and structural (geographic proximity).

Similarities and differences among countries were apparent. Norway had high proximity, affectual and consensual solidarity, but relatively low functional solidarity in terms of help from children. England had high levels of solidarity except normative solidarity; in Germany functional solidarity was high, but affectual and associational solidarity was low. Spain had one of the highest levels of proximity, but the lowest for consensus. Israeli families lived close to each other, had frequent daily face to face and telephone contact, shared similar views, and expressed the highest levels of affectual solidarity. Normative solidarity was moderate, but functional solidarity (except for children's emotional support of the parents) was low. The survey revealed little conflict, though this emerged in the interviews.

Intergeneration ambivalence

Ambivalent feelings emerged more in the face to face interviews than in the survey, with older people experiencing ambivalence at an individual level during periods of chronic illness or disability when roles were renegotiated.

Four different types of parent-child relationships emerged:

- Harmonious relationships (24%) with parents feeling extremely close to their child.

[18] This material is largely taken from the November 2003 Findings Report: more detail, especially of the rationale for the research and the methodology, is given in the OASIS final report (http://oasis.haifa.ac.il/)

- Steady relationships (32%) which were more emotionally distant than the first, but still close.
- Ambivalent family relationships (27%) with parents tending to feel neither close nor distant from their children. Occasionally the relationships in this group could have unpleasant moments but there were attempts to keep the family harmonious.
- Distant relationships (17%) where the relationship showed signs of emotional distancing, and there was more likely to be conflict, mixed feelings, and a difference of view.

Important differences were apparent among the countries. Harmonious relationships tended to be characteristic of Israeli parents and their children; Spanish and English parents reported the highest rates of "steady" relationships; ambivalent relationships were most evident in Germany, Spain and Norway; and distant relationships were most often reported in England.

Quality of life

There were clear age, country and gender differences in quality of life. Health, education and income were universally important to the subjective quality of life of people, regardless of their age. Intergenerational relationships were positively related to two dimensions of quality of life "physical health" and "psychological wellbeing". This seems especially true when elderly parents have one or two children compared with none. Family networks had limited relevance for quality of life. Help from family and services were negatively related to quality of life, probably because they were not sufficient to compensate for needs and deficiencies, which limited autonomy.

Strengthening the individual resources of older people is seen by the researchers as a crucial support for older people's autonomy and quality of life.

The Balance between Family and Service Support

The large majority of older people aged 75 and over who lived in the community did not have a major need for care and support. When they did, the family continued to play an important supportive role, whether financially or emotionally. Comprehensive services, where available, did reduce the demand on families to be involved in daily practical care. Women continue to be the main providers of care, even when they are in paid employment.

Older people had a greater sense of satisfaction and autonomy, however, where there was a greater choice of care. Services are mediating factors that had an influence on the wellbeing of older people and their families: wellbeing depended on the accessibility and perception of services. The more services offered, the more positively they were valued and the more satisfied older people felt.

Services as complements to or substitutes for families

Family help tended to be higher in countries with low service levels (Spain and Germany) and lower where service levels were higher (Norway and Israel). There were still substantial levels of family help in countries with high levels of services. A division of labour emerged between families and services, with less demand on the family to provide physical or constant instrumental support. It appears that families are specialising in care provision: when some needs were met (and substituted by care

providers), families directed their efforts to other needs and concerns. An example of this is emotional support, where services are traditionally poor at replacing the family's role. There is little evidence therefore of the state eroding.

There was considerable uncertainty about formal care, particularly in the data from the qualitative interviews. When it was provided it was greatly appreciated and appeared to make the difference between managing independently and being unable to do so.

Policy recommendations

- The OASIS researchers have made the following primary policy recommendations of the basis of their research findings:
- There was consensus among the older respondents that the welfare state should shoulder much more responsibility for future need and care.
- Receiving help from the formal sector helps older people maintain their autonomy and independence. Services should therefore be more accessible to older people.
- A wider use of more creative services in community care, housing, transportation, and education is necessary if autonomy, independence and family solidarity are to be the foundation of a good quality of life for older people in Europe.
- More choice in care arrangements is preferred.
- Policy needs to recognise the centrality of the family in welfare provision and needs to support family caregivers.
- Women are still the main caregivers for family members in need. Social policies that improve the lives of women in the context of the family and the workplace are critical.
- Policy should also recognise the key role of older people themselves in caring for their partners. They are active as care givers, not solely as receivers of care.
- Family care giving should be strengthened through services such as the training of caregivers, supportive and respite services.
- Long-term care needs to be an attractive alternative to family care
- Policy must concentrate on building, protecting and maintaining individual resources to ensure quality of life of older people. The accumulation of individual resources, such as education, income and health earlier in life are therefore important areas of policy consideration.

4. BERLIN AGEING STUDY (BASE)

4.1 Introduction: purpose and scope

The Berlin Ageing Study is a multidisciplinary investigation of old people aged 70 to over 100 years who live in the former West Berlin. It is an extensive study of old age and ageing, ranging from 70 to 100 years, that was carried out by psychologists, sociologists, physicians, and scientists from a variety of other disciplines. A random sample of more than 500 senior residents of the former West Berlin was examined in depth. Topics investigated include intellectual abilities, self and personality, social relationships, physical health, medical treatment and care, mental disorders such as depression and dementia, socioeconomic conditions, everyday competence, subjective wellbeing, and gender differences.

EWAS and BASE both examine older people's social resources and social participation. EWAS areas such as education, work, culture, the physical environment and safety are not included in BASE. Both examine health, with BASE extendng this into intelligence and intellectual functioning.

Three features represent the special characteristics of BASE: (1) Sample heterogeneity through local representativeness (for West Berlin), (2) a focus on very old people (70-105 years), and (3) broadly based interdisciplinary investigations (internal medicine, geriatrics, psychiatry, psychology, sociology, and social policy).

Apart from discipline-specific topics, four common and intersecting theoretical orientations guided the study: (1) differential ageing, (2) continuity versus discontinuity of ageing, (3) range and limits of plasticity and reserve capacity, and (4) old age and ageing as interdisciplinary and systemic phenomena.

In the Main Study (1990-1993), a core sample of 516 individuals was closely examined in 14 sessions covering their mental and physical health, their psychological functioning, and their social and economic situation. Since then, the study has been continued as a longitudinal study, and surviving participants have been re-examined six times.

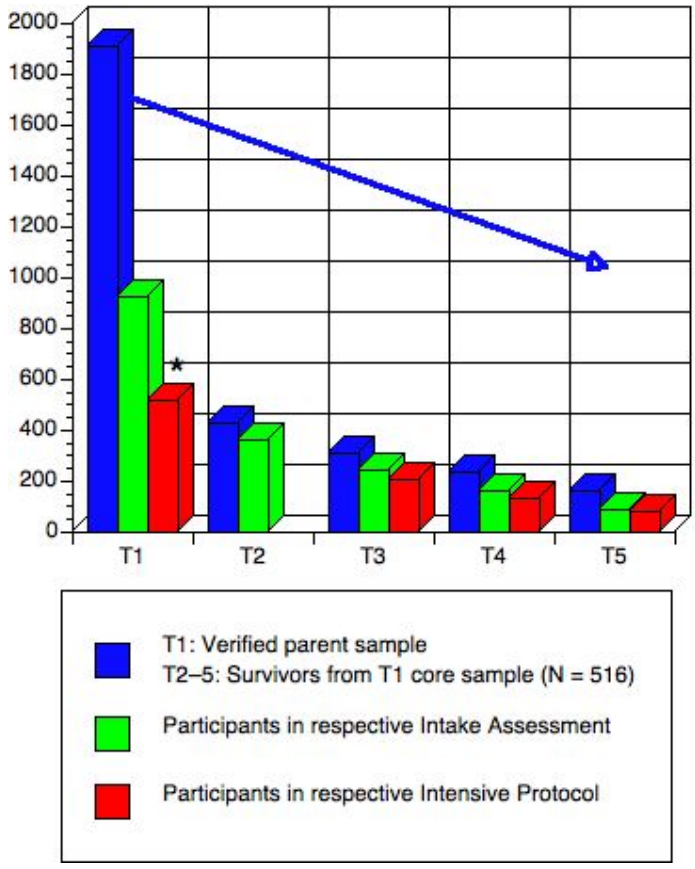
Of the original parent sample of 1908, 928 took part in the Intake Assessment, and 516 continued and completed the entire 14-session Intensive Protocol.

The core sample of people taking part in the Intensive Protocol was stratified by age and gender with 43 men and 43 women in each of the six age groups (70-74, 75-79, 80-84, 85-89, 90-94, and 95+ years; total N = 516). This allowed comparison of subgroups (e.g., among the very old or those affected by dementia) with sufficient statistical power.

4.2 Longitudinal Follow-ups

Only the 516 Intensive Protocol participants were followed in examinations over the subsequent years. However, mortality data on the parent sample were regularly provided by the city registry.

Schema of Longitudinal BASE Samples up to T5[19]



Multidisciplinary Intake Assessment at T1, repeated on all following occasions

The first session of the study was designed to gain as much basic information as possible at an early stage. On average, it took 90 minutes to answer the 100 questions on a wide range of topics. Measures important to each of the research units involved were assessed.

Intensive Assessment Protocol

The Intensive Protocol of 14 sessions was designed to assess the many facets of old age and ageing using a variety of standardised instruments and measures selected by the four research units on the basis of their previous work.

Reduced Intensive Protocol at T3 and T4

For the longitudinal re-examination, the original Intensive Protocol was cut back to six sessions: the Intake Assessment, a session organised by each of the research units, and a session including the Yesterday Interview.

Assessment Protocol at T5 and T6

[19]http// www.base-berlin.mpg.de/Samples.html

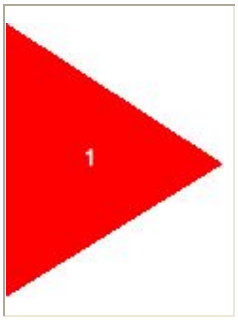
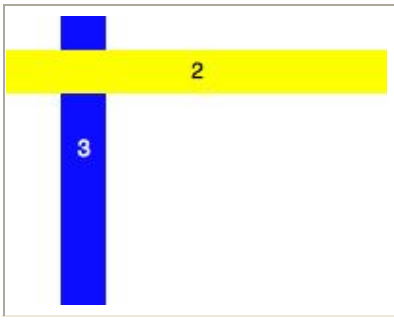
Three sessions were conducted entailing a repeat of the Intake Assessment that was enriched by psychiatry measures, a dental examination and repeats of measures of the Psychology Unit.

Assessment Protocol at T7

After a repeat of the Intake Assessment enriched by psychiatry measures, a burst of six identical psychology sessions was carried out within two weeks.

Organising Questions

The overall organisation of the BASE research is shown schematically below:

Scientific field	Life history (retrospective)	Age/Cohort groups 70-74 75-79 80-84 85-89 90-94 95+
Internal Medicine/ Geriatrics Psychiatry Psychology Sociology/ Social Policy		

1.	Are individual age differences predictable on the basis of life history data?
2.	How large are age differences within domains, and which direction do they take?
3.	What are the trans-disciplinary relationships across different domains?

4.3 Domains covered by BASE, and their differences and similarities with EWAS

Topics investigated include intellectual abilities, self and personality, social relationships, physical health, medical treatment and care, mental disorders such as depression and dementia, socioeconomic conditions, everyday competence, subjective wellbeing, and gender differences. Although these span the same broad sweep as EWAS, BASE researchers reflect traditional interests in ageing research by emphasising the collection of health data. This they extend beyond the usual bounds with significant examinations of intelligence and intellectual functioning, self and personality. EWAS and BASE share an interest in understanding closely older people's social resources and social participation, but important EWAS areas such as education, work, culture, the physical environment and safety do not form part of the BASE study.

Four research units were involved in the BASE study (internal medicine/geriatric, psychiatry, psychology, and sociology and social policy). Their respective domains of interest, and the sub-domains, are set out in the chart below. It is clear that the areas selected for studies were not drawn directly from consultations with end-users (whether policy makers or service deliverers), or consultations with older people

themselves or their advocates. The scale, scope and frequency of the data collection, and the wide range of research publications, however, mean that there is a rich source of material for stakeholders to use.

<table>
<tr><td colspan="3">Internal Medicine/Geriatrics Unit</td></tr>
<tr><td>Objective Health
Cardiovascular system
Musculoskeletal system
Immune system
Dental status
Multi-morbidity</td><td>Functional Capacity
Activities of Daily Living (ADL)
Physical performance</td><td>Treatment Needs
Medication
Dental treatment
Integration of treatment needs</td></tr>
<tr><td>Subjective Health
Subjective physical health
Subjective vision and hearing</td><td>Risk Profile
Cardiovascular risk factors</td><td>Reference Values
Physical performance
Organ functioning
Metabolism</td></tr>
<tr><td colspan="3">Psychiatry Unit</td></tr>
<tr><td colspan="3">Psychiatric Morbidity in Old Age</td></tr>
<tr><td>Spectrum
Mental illness
Depression syndrome
Dementia syndrome
Psychopathology (sub diagnostic)</td><td>Predictors
Previous illnesses
Multi-/co-morbidity
Other risk factors</td><td>Consequences
Health/illness behaviour
Everyday competence
Self-efficacy</td></tr>
<tr><td colspan="3">Psychology Unit</td></tr>
<tr><td>Intelligence and Intellectual Functioning
Mechanics of intelligence
Pragmatics of intelligence</td><td>Self and Personality
Self concept
Personality dimensions
Emotional state/affect
Self-regulatory processes</td><td>Social Relationships
Network structure
Social support
Changes of the network
Negative aspects
Satisfaction with relationships
Relationships in retrospect</td></tr>
<tr><td colspan="3">Sociology and Social Policy Unit</td></tr>
<tr><td colspan="2">Life History and Generational Dynamics
Social background
Migration history
Educational history
Employment history
Partnership history
Family life history</td><td>Economic Situation and Social Security
Assets
Sources of income
Transfers
Income expenditure
Consumer sovereignty</td></tr>
<tr><td colspan="2">Later Phases of the Family Life Cycle</td><td>Social Resources and Social Participation</td></tr>
</table>

Current social structure of the family Social structure of the generations Changes of familial social structure	Social status Housing standards/environment Social care Social and cultural participation	

4.4 Measures

Methods applied by the Sociology/Social Policy Unit included a life history instrument developed in earlier research, items from the German Socioeconomic Panel (GSOEP) questionnaire, and others. Measures used by the Psychology Unit ranged from a computerised battery of standard intelligence tests, standard measures of personality and self-related beliefs, open-ended self-descriptions, and a questionnaire about coping styles, to a structured interview about social life and support networks. The Psychiatry Unit applied standard psychiatric measures such as the Brief Psychiatric Rating Scale, the "Geriatric Mental State, Version A" (GMSA) interview, the Center for Epidemiologic Studies-Depression Scale (CES-D), and questionnaires dealing with, for example, medication use, the utilisation of medical care, and subjective illness beliefs. In addition to a standardised medical history a full-body, non-invasive medical and dental examination was conducted by the Internal Medicine/Geriatrics Unit. Methods ranging from biochemical analysis to computer scanning were applied.

Although details of the various instruments are not available through internet search, the BASE study welcomes inquiries from researchers.

4.5 The BASE interpretation of wellbeing, and its usefulness for EWAS

The authors advance a view of subjective wellbeing for old people which proposes that the influence of *socio-demographic variables* (age, gender, marital status and place of residence) and *objective life conditions* (number of moderate to severe illnesses, vision/ hearing/ balance/ gait, financial situation, number of relatives close by, and social activity) are filtered through the person's *subjective domain evaluations* (health/vision/hearing/mobility, satisfaction with finances and activities, and satisfaction with social and familial relationships) to create an *overall subjective wellbeing.* This may prove a fruitful way for EWAS to integrate the objective and subjective measures of wellbeing that are included in its survey.

Researchers for the BASE study argue that, although their research suggests that the self-regulation processes that contribute to adaptation to changing life conditions (e.g., changes in aspiration levels and objects of comparison) operate effectively in old age, the cumulative challenges and losses of very old age could tap the limits of these adaptive processes. For this reason, they argue that it is essential to implement measures supportive of wellbeing in late adulthood. There is much room, for example, for improving living conditions through technological development, political measures, and social change. As New Zealand's population ages, and the number of very old (85+) increases substantially, the challenge of maintaining wellbeing for the elderly will become more acute.

4.6 Building on the BASE approach

The BASE study collected a much greater depth of information that EWAS will be able to do, and has had the benefit of five successive waves of data collection. Nevertheless there is value in considering some of the more fruitful areas of BASE's analyses in the light of current policy interests in New Zealand and stakeholder interests.

EWAS's stakeholders' interests are summarised in the EWAS paper (*Stakeholder Consultations in Ageing Research*, Working Paper 7, Waldegrave 2006):

"The areas referred to most consistently are: access to services, activities and support; health; culture; and family. The emphases in these and other areas were on living better and living well. Information was sought on services, activities and support in order to enhance the quality and value of neighbourhoods so older people could feel valued, safe and seen as contributors. The issues raised around health were not focused on frailty and sickness but rather on mobility, sight and hearing that would enable ongoing independence and participation in families and communities. Participation in one's culture and family was also addressed primarily around issues of wellbeing, fulfillment and inclusion." (Waldegrave, p 21)

Presented below are summaries of a selection of BASE's published research results in areas of policy interest in New Zealand, and which align with EWAS's stakeholders' interests. These are taken from *The Berlin Ageing Study: Ageing from 70 to 100*[20] and the most relevant findings in each section are italicised. It is notable that there is considerable overlap with the EWAS areas of interest, except in the case of access issues, including access to transport and shops, which do not feature strongly in the BASE research. This may well be because the study is situated in Berlin, a city with a dense population, served by efficient public transport and well-distributed shops.

Ten studies are presented. They are ordered from those focused on the general area of wellbeing, to ones exploring more specific dimensions of functioning in old age.

1. Sources and processes of wellbeing

BASE researchers examined ideas about the sources and processes of wellbeing in the context of a model which allows an integration of medical, sociological, and psychological perspectives. The researchers describe the levels of wellbeing reported by the participants in the first cross-sectional measurement phase of the Study, and examine the extent to which objective and subjective indicators of specific life domains predict overall individual wellbeing.

Results from this investigation were multifaceted. The majority of participants reported satisfaction with their present life conditions. However, older women, individuals aged 85 and over, and persons living in institutions reported less frequent experience of positive emotions, an important component of wellbeing. Path analysis indicated that *subjective domain evaluations (especially subjective health) were stronger predictors of subjective wellbeing than were the objective measures of domain status.* This finding suggests that the self-regulation processes that contribute to adaptation to changing life conditions (e.g., changes in aspiration levels and objects

[20] P. B. Baltes & K. U. Mayer (Eds.) New York, 1999, 2001, Cambridge University Press

for comparison) operate effectively in old age. The cumulative challenges and losses of very old age could tap the limits of these adaptive processes.

2. Number, nature, and functions of social relationships in old age

The consequences of widowhood, childlessness, and institutionalisation on the social relationships and loneliness of elderly people were also examined. The findings reveal that it is *incorrect to assume that the social integration of older adults is marked by a lack of role in society*, or that social relationships remain unchanged in quality and quantity into very old age.

There is a high degree of childlessness among those aged 85 years and older, but this can primarily be interpreted as a cohort effect. Although the loss of relatives from one's own generation is a common occurrence in very old age, the experience of being a great-grandparent also gains in importance. *No uniform age differences can be found where non-relatives are concerned;* whereas the number of friends decreases with age, the proportion of old people who include other non-relatives in their social network remains relatively constant. The social network of widows and widowers has a structure similar to that of married people. *However, the childless have smaller networks than parents, and the institutionalised have smaller networks than those living in private households. The size of the social network was not related to mental health and subjective wellbeing.* In fact, emotionally lonely people with large social networks - those who were lonely in a crowd - were slightly more depressed and less satisfied with their lives than similarly lonely people with small social networks. Married people feel lonely less frequently, whereas the institutionalised and the childless do so more often. Those aged 85 and older receive substantially more help than they give, but, remarkably, some very old people still support others.

3. Social and economic life circumstances of old and very old people in West Berlin: how socio-economic resources influence social participation and health

Information on education, occupational position, household income, housing conditions, forms of household, social activities, and media consumption are analysed. Three hypotheses about socio-economic differentiation and its consequences are examined: (a) *age-relatedness*, where socio-economic factors lose importance in comparison to age-related conditions such as health; (b) *socio-economic continuity*, which suggests that socio-economic differences continue to influence life-styles and activities in old age; and (c) *cumulation,* where the impact of socio-economic differentiation increases in old age.

The study mainly found age-associated differences in social activities and social participation, both of which are *highly related to health status*. In these cases, socio-economic resources can only partially compensate for health impairments. Until the move into a senior citizens home, stability in income and housing conditions is found, reflecting the social position attained before retirement. Thus, in terms of the economic situation, age does not discriminate between individuals. The cumulation hypothesis is substantiated *only with regard to utilisation of care, where socio-economic inequality in old age becomes more pronounced.* Members (mostly male) of higher social classes are rarely institutionalised and are more likely to be cared for at home.

4. Age trends in three domains: intelligence, self and personality, and social relationships.

In the domain of intelligence, negative age differences between 70 and 103 years were substantial and were closely associated with indicators of biological deterioration. In contrast, age-related differences in personality, self-related beliefs, and social relationships were fewer and considerably smaller (approximately 0.5 SD).

At a general level, these domains seemed to be less affected by age-related decline than is true for intellectual functioning. Closer examination, however, revealed that age differences on aspects of self, personality, and social relationships were all in a less-than-desirable direction. *In advanced old age, individuals may be pushed to the limits of their adaptive psychological capacity*.

A further question concerns the overall systemic nature of psychological functioning in old age. The relative risk of membership in the less desirable profile subgroups was 2.5 times larger for the very old (85-103 years) than for people between the ages of 70 and 84 years, and *1.3 times larger for women than men*. *The very old appear to be a distinct group psychologically.* This finding is consistent with recent predictions about a "fourth age" based on a theoretical analysis of the biological-genetic and socio-cultural architecture of life-span development.

5. The feminisation of old age

The BASE researchers examined in which bio-psychosocial variables - physical, functional, and mental health, personality, and social integration - men and women differ. Gender differences found in the domains examined were small and there were few age differences (from ages 70 to over 100) within the noted gender differences. Of the 26 bio-psychosocial variables, when considered separately, 14 show significant gender differences and 4 a significant age-by-gender interaction effect. Most of these differences are in the health domain. In this context the most significant variables are marital and educational status, physical health, and hearing. *Not being married and having less education, as well as suffering from a musculoskeletal disease, and having good hearing significantly increase the likelihood of being an old woman*. The researchers raise the question of whether the fact of feminisation of old age is rendering a discussion about gender differences in old age obsolete.

6. Limits and potentials of intellectual functioning in old age

A psychometric battery of 14 cognitive tests was used to assess individual differences in five intellectual abilities: reasoning, memory, perceptual speed, knowledge and fluency. In addition, the Enhanced Cued Recall test (ECR) was administered to identify dementia-specific cognitive impairments in cue utilization and learning potential. The results points to *sizable and highly inter-correlated age-based losses* in various aspects of brain-related functioning, including sensory functions such as vision and hearing. Intellectual abilities declined with age, and ability inter-correlations were high. Gender differences were small in size, and did not interact with age. Results obtained with the ECR demonstrate that *the ability to learn from experience is preserved in normal cognitive ageing across the entire age range studied,* but severely impaired in individuals with dementia.

7. Self and personality in old age

The BASE researchers examined various aspects of self and personality in old age (personality characteristics, self-definitions, experience of time, personal life investment, coping styles, affect) and relates them to individuals' satisfaction with their own ageing. They then, based on a model of psychological resilience in old age, examined whether these aspects of self and personality are protective of ageing satisfaction (on a correlational level) in the face of somatic or socio-economic risks. The results indicate that the self and personality involve processes and characteristics that help to maintain, or minimise the loss of, ageing satisfaction in the presence of somatic and socio-economic risk factors.

8. Types and frequencies of psychiatric illnesses in old age, their somatic and social predictors, and their consequences

Nearly half of the West Berliners aged 70 and above had no psychiatric disorders, whereas less than a quarter was clearly psychiatrically ill. The remaining third consisted of carriers of psychopathological symptoms without illness value (16%) and of psychiatric syndromes with illness value (17%).

The most frequent psychiatric illness in old age is dementia, affecting 14% of those aged 70 years and above. *The number of dementia cases increases strongly with age*. Whereas no cases were found in BASE at the age of 70, more than 40% of 90-year-olds were affected. Depressive illnesses are the second most frequent psychiatric diagnosis, affecting 9% of the elderly population. *There is no clear relationship with age for depression*. On the level of diagnoses, there is no association between dementia and depression, though this is not the case at the symptomatic level.

Persons with depressive illnesses or dementia have a higher rate of physical illnesses than the mentally healthy. It remains to be seen whether physical illnesses are the causes or consequences of mental illnesses. In terms of possible social risk factors, an important finding is that *a lower level of education increases the likelihood of a dementia diagnosis*. This is in agreement with other studies.

9. Physical morbidity and disability, and psychological and social functioning

Evidence from gerontological research suggests that physical morbidity and disability in old age are among the most important causes for decline in other functional domains such as social and psychological functioning. However, comprehensive cross-disciplinary analyses on the significance of morbidity and disability in old age and during transition into very old age are scarce.

BASE researchers examined the strength of associations between (a) somatic and mental health, (b) health and psychosocial status, and (c) objective and subjective health using multi-dimensional indicators of physical, mental, psychological, and social functioning. The analyses focus on two central questions, namely: (1) to what extent is health an explanatory variable for age differences in other functional domains? (2) do the associations between health and other domains themselves vary with age?

The results reveal clear age-independent correlations between somatic and psychiatric morbidity as well as between psychosocial factors and health. Moreover, health indicators fully explain the negative effects of age on psychosocial resources and on mental health. However, the significance of objective health for subjective evaluations decreases significantly with age. In this domain, the findings are consistent with recent hypotheses that emphasise multiple intra-individual mechanisms working to maintain positive self-appraisal despite objective decline. The recording of

subjectively perceived physical complaints should, therefore, be part of the evaluation of older peoples' subjective wellbeing.

BASE research has also been used to establish what is known about currently controversial policy areas not directly related to ageing: a very interesting example is found in *Gerodontology* (17, 39-44[21]) where a study was reported which examined amalgam fillings and cognitive abilities in a representative sample of the elderly population. The research "negated a correlation between the dental state and the pathogenesis of dementia and the physiological age-related decline in cognitive abilities. Thus the presence of amalgam fillings did neither correlate to a demented mental condition nor an impaired cognitive performance."

A significant challenge to current health policy is found in other work drawn from the BASE Study in *New Frontiers in the Future of Ageing: From Successful Ageing of the Young Old to the Dilemmas of the Fourth Age*[22]**.** This work concludes that "new theoretical and practical endeavours are required to deal with the challenges of increased numbers of the oldest old and the associated prevalence of frailty and forms of psychological mortality (e.g., loss of identity, psychological autonomy and a sense of control). . . . Future study and discussion should focus on the critical question of whether the continuing major investments into extending the life span into the fourth age actually reduce the opportunities of an increasing number of people to live and die in dignity."

4.7 The use of research findings to influence policy and practice

The BASE researchers have drawn explicit and comprehensive policy implications from their work, and there is no doubt that the comprehensiveness and detail of the BASE research will have had an impact on ageing policies in Germany, the wider European community, and further afield. But there is no documented trajectory from findings through policy recommendations to policy and practice change. Once again, it appears the EWAS approach of direct end-user involvement in the research work is unique.

[21] Nitschke, I., Müller, F., Smith, J., and Hopfenmüller, W. (2000) *Gerodontology,* 17, 39-44
[22] Baltes, P., and Smith, J (2003) *Gerontology.* Vol.49:p123-135

5. THE UNIVERSITY OF MICHIGAN HEALTH AND RETIREMENT STUDY

5.1 Introduction: Purpose and scope

The University of Michigan Health and Retirement Study (HRS) surveys more than 22,000 Americans over the age of 50 every two years. Supported by the National Institute on Aging the study paints an emerging portrait of an ageing America's physical and mental health, insurance coverage, financial status, family support systems, labour market status, and retirement planning. As with other studies, health is put at the centre of the examination of ageing, while the roles of social connectedness, the physical environment, and cultural identity in creating wellbeing remain less examined.

The Health and Retirement Study was created in a deliberate effort to establish a longitudinal observatory for multi- and interdisciplinary studies of aging populations [23] but its design and coverage, have evolved across time. The HRS design began with a decision to represent the US population in 1992 at ages 51 to 61 (and their spouses of whatever age). Because only 16.6 percent of households contained people in this age range, a large screening survey was undertaken by the Survey Research Center at the University of Michigan.

As opportunities arose, coverage was first increased at older ages by incorporation of participants in a companion study, Assets and Health Dynamics of the Oldest Old (AHEAD), which covered cohorts born in 1890 to 1923, who were 70 and older in 1993[24]. A decision was made to integrate the HRS and AHEAD questionnaires in 1995 and to combine the field periods in 1998. At that time, the HRS committed to a steady state design by adding two new cohorts, the "Children of the Depression" (born in 1924 to 1930) and the "War Babies" (born in 1942 to 1947). By 1998 the HRS became cross-sectionally representative of the US population older than 50, and a decision was made to maintain the steady state by adding a new six-year cohort every six years[25],[26].

Objectives and Design of the HRS

- The HRS collects data to help:
- Explain the antecedents and consequences of retirement
- Examine the relationships among health, income, and wealth over time

[23] Juster, F. T. and Richard Suzman. (1995). "The Health and Retirement Study: Data quality and early results," *Journal of Human Resources* 30(Supplement): S7–S56.
[24] Soldo, B., Hurd, M., Rodgers, W., and Wallace, R. (1997). "Asset and health dynamics among the oldest old: An overview of the AHEAD study," *Journals of Gerontology, Series B, Psychological Sciences and Social Sciences* 52 Spec No: 1–20.
[25] Willis, R. J. (1999). Theory confronts data: How the HRS is shaped by the economics of aging and how the economics of aging will be shaped by the HRS. *Labour Economics,* vol.6(2,): p119–145.
[26] This material on the history of the HRS is taken from Robert M. Hauser and Robert J. Willis *Survey Design and Methodology in the Health and Retirement Study and the Wisconsin Longitudinal Study*

- Examine life cycle patterns of wealth accumulation and consumption
- Monitor work disability
- Examine how the mix and distribution of economic, family, and program resources affect key outcomes, including retirement, "dissaving," health declines, and institutionalisation.

There is a wealth of information on the study readily available on the web: the material reproduced below is a summarised extract from the Study's home page and related links (http://hrsonline.isr.umich.edu/).

A note on sample design
The HRS core sample design is a multi-stage area probability sample of households. To allow independent analysis of key subgroups, the core sample is augmented by three supplements. These supplements are: a 1.86:1 over-sample of African Americans: a 1.72:1 over sample of Hispanics and a 2:1 over-sample of Floridians. In addition, in order to improve coverage of the oldest old households with extremely frail respondents, a second sampling frame, the Health Care Financing Administrations (HCFA) Enrolment Data Base, was employed.

Data collection
A visual display of HRS data collection efforts, past, present and future, is reproduced at the end of this short chapter. The modules for each wave of data collection, and a summary of their analysis, are also included in Appendix 5A.

Documentation and background information
The HRS data collection instruments are perhaps the most intricate and wide-ranging in the field. Questionnaires[27] are available for download, as are matching data descriptions and Codebooks. Detailed information on survey design[28], sample design, and survey content[29] are available, and data releases are ongoing.

User guides
User Guides[30] are designed to provide analysts with documentation about the concepts, measures and questions in the HRS surveys. These reports expand upon the information found in codebooks, questionnaires and data descriptions. They also provide comprehensive descriptions of created measures (including their origin), changes made across waves, variable distributions, and results from data quality analysis.

Bibliography[31]
This contains all types of publications based on HRS data; lists of not-yet-published *Working Papers* and a *Documentation Report Series*. Further information may be found in the publications of the University of Michigan's Population Studies Centre[32].

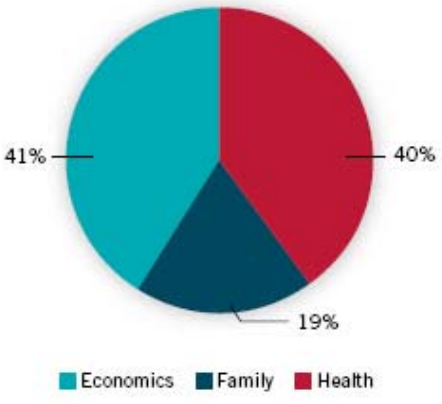
[27] http://hrsonline.isr.umich.edu/meta/sho_meta.php?hfyle=qnaires
[28] http://hrsonline.isr.umich.edu/docs/sho_refs.php?hfyle=design&xtyp=2
[29] http://hrsonline.isr.umich.edu/intro/sho_uinfo.php?hfyle=content&xtyp=2
[30] http://hrsonline.isr.umich.edu/docs/sho_refs.php?hfyle=index&xtyp=3#g1
[31] http://hrsonline.isr.umich.edu/papers/sho_papers.php?hfyle=bib_all
[32] http://hrsonline.isr.umich.edu/intro/sho_intro.php?hfyle=howsite

Some examples of recent research are provided in the Fall 2005 newsletter (the latest available on the web)[33], and are attached at the end of this chapter. Selected Citations for Journal Articles using HRS Data from 2005 (taken from the Dynamic Bibliography on the HRS Web site) are also provided.

5.2 Domains covered by the HRS, and differences and similarities with EWAS

The figure below indicates the share of time during the hour-plus HRS interview that is devoted to three broad areas of inquiry - economics, health, and family:[34]

Figure 2



Within these categories, the HRS specifically focuses on:

Economic Circumstances

The HRS collects detailed information about older Americans' economic circumstances - sources and amounts of income; the composition and amounts of assets; and entitlements to current and future benefits such as those provided through Social Security, Medicare, Medicaid, employer pension plans, and employer-sponsored health insurance. Data describing the movement of assets, including gifts and bequests, time (e.g. to provide daily living assistance), and housing within families, are also collected, as are data about earnings, savings, and spending of individuals and families as they approach retirement and over the course of their retirement until death.

Occupations and Employment

Occupation and employment information collected by the HRS covers job characteristics, job mobility, work hours, attitudes toward retirement, employer-provided benefits (including health insurance, pensions, 401(k) plans, and other employer-sponsored saving programs), retirement benefits, and early retirement incentive offers.

[33] http://hrsonline.isr.umich.edu/news/newsletter/Fall2005UsrNws.pdf

[34] *Growing Older in America: The Health & Retirement Study,* (2007) National Institute on Aging National Institutes of Health U.S. Department of Health and Human Services.

Health and Health Care
The HRS collects information about chronic illness, functional ability, depression, and self assessed health status, and examines health related behaviour such as smoking, alcohol use, and exercise. Health care utilisation data gathered through the study describe physician visits, hospitalisations, nursing home stays, surgeries, dental care, prescription drug use, use of assistive devices (e.g. eyeglasses and walkers), and receipt of care giving services, as well as health and long-term care insurance coverage, out-of-pocket medical costs, and receipt of assistance with medical expenses.

In the 2006 data collection, the HRS expanded to include biological information about the participants in an updated effort to match biological factors with health and social data.

Cognition
The HRS is unique among large surveys in its use of direct measures of cognition, drawn from established clinical instruments. These measures provide data on cognitive change with ageing and the impact of dementia on families. They have also found new application in studies of economic behaviour and survey response patterns.

Living and Housing Arrangements
The survey explores the relationships between people's living arrangements and the availability or use of long-term care services such as nursing home residence, services offered to residents living in other housing arrangements, and special housing features for people who are physically impaired. It also gathers data about the type of housing structure in which HRS participants live, housing ownership or financial arrangements, entry fees or association payments, and the sharing of housing with children or others.

Demographics and Family Relationships
The HRS gathers standard demographic facts such as age, racial/ethnic background, education, marital status and history, and family composition. Among married participants, detailed health and economic information is collected from both spouses. General demographic information about HRS participants' parents, children, and siblings is also gathered. In addition, survey interviews document the relationships among family members and the nature of intergenerational family supports, including financial transfers, care giving, joint housing arrangements, and time spent with family members.

New developments in 2006-2011
The most significant innovation in design for the next six years is the development of the "enhanced face-to-face" (EFTF) interview. In addition to the standard longitudinal HRS content, these personal interviews will collect (from consenting respondents) physical performance measures, anthropometric measures, blood pressure, dried blood spots for the measurement of cholesterol, haemoglobin A1c, and C-reactive protein, DNA samples to be placed in a repository, and a self-administered questionnaire of psychosocial measures. This enhanced health content will greatly enrich the research potential of the HRS into the health and wellbeing of the older US population.

Experimental modules
The HRS uses "experimental modules"—short sequences of questions administered to randomly selected subgroups of participants at the end of the survey. To date, more than 70 experimental modules have asked about physiological capacity, early childhood experiences, personality, quality of life, employment opportunities, use of complementary and alternative medicines, parental wealth, activities and time use, nutrition, medical directives, living wills, retirement expectations and planning, sleep, and functional ability. The HRS is now calling for suggestions for experimental modules for the 2008 survey.

International studies
A growing number of countries have developed their own longitudinal studies of ageing combining country-specific elements with a deliberate effort to enhance comparability with HRS and each other. Data have been released for Mexico (MHAS 2001, 2003), England (ELSA 2002), nine countries of Europe (SHARE 2004), and are being collected in Korea (KLoSA).

The Aging, Demographics, and Memory Study (Adams)
ADAMS began as a supplement to the HRS with the specific aim of conducting a population-based study of dementia. ADAMS fieldwork began in August, 2001 and continued through to March, 2005.

At the beginning, HRS formed a partnership with a research team at Duke University to conduct in-person clinical assessments for dementia on selected HRS respondents. The purpose was to gather information on respondents' cognitive status and assign a diagnosis related to dementia. Prior community-based studies of dementia have focused on a particular geographical area or have been based on nationally distributed samples that are not representative of the population. This study was the first of its kind to conduct in-home assessments of dementia in a national sample that is representative of the elderly population in the United States.

Comparison with EWAS Domains
As HRS has incorporated other American studies over the years and helped develop comparable measures across a wide range of countries, it has become recognised in many quarters as the gold standard of longitudinal ageing research. The resources available to it and the sample size mean that it is able to study its key domains at a depth not possible by EWAS with its smaller population and resources. A detailed examination of the economic and health domains would be valuable for EWAS researchers to consider so that from the range of measures applied, they can choose those which would be most applicable and practical. HRS also seeks much more detailed information on areas like disability, physical health and wider family relationships, all of which are valuable and worthy of further consideration by EWAS. EWAS, on the other hand, places emphasis on other domains that receive less focus in HRS. These include rights and entitlements, safety, cultural identity and leisure. Its scope is wider than HRS, but it is restricted in the depth it can address in the three broad HRS areas of inquiry - economics, health, and family relationships.

5.3 Building on the HRS approach

There is no overt articulation of the concept of "wellbeing" in the overall design and analysis of the Study, as is evident with the Berlin Ageing Study and EWAS, but data on all of the multifarious domains which may impact on quality of life are collected, and their correlations and causal links are studied in detail. The most important aspect of the HRS study for EWAS is the international comparability that will come from using collection instruments that are the same as, or compatible with, those used by the HRS.

5.4 Some examples of research results from the HRS

1. Net Worth Predicts Symptom Burden at the End of Life[35]

Patient care at the end of life is directly related to wealth and patient access to health care. Older adults, Silveira, et al. found, are particularly vulnerable to symptoms that could be treated with palliative care at the end of life. They studied 2,604 deceased adults using Health and Retirement Study data from waves 1993-1998 representing 7.9 million older adults in the United States. Subjects ranged in age from age 70-108 (median 84). Data were collected from proxies (primarily a daughter/stepdaughter or spouse) following the death of the respondent.

The researchers' unique findings included a significant inverse relationship between net worth and the incidence of six symptoms (symptom burden) at the end of life. Three of the symptoms that the researchers expected to find at the end of life, were: anorexia, confusion and fatigue, while the other three symptoms would have been treatable: depression, dyspnoea and pain.

Respondents with a net worth in the top two quartiles, more than $182,000 and $70,000-182,000, had the least symptom burden, with a likelihood of 9% and 10% of the six symptoms respectively. Net worth was significantly associated with one treatable symptom – pain, in an inverse dose-response fashion. The relationship of net worth to the other two treatable symptoms, depression and dyspnoea, was not found to be statistically significant, however they also tended toward an inverse relationship with net worth.

In addition, there was a statistically significant correlation between symptom burden (one-six symptoms) with age, net worth, and chronic conditions (cancer, lung disease, cardiovascular disease, stroke, and cognitive impairment). Age was inversely related to symptom burden in a dose-response manner. Cognitive impairment had the strongest association with symptom burden. Those respondents had 43% more symptoms than those without cognitive impairment.

2. The Impact of Childhood and Adult SES on Physical, Mental, and Cognitive Well-Being in Later Life[36]

[35] Silveira, M.J., Kabeto, M.U. , and Langa, K.M. (2005) *Net Worth Predicts Symptom Burden at the End of Life,* Journal of Palliative Medicine, Vol. 8, No.4.

[36] Luo, Y. and Waite, L. J., (2005) The Impact of Childhood and Adult SES on Physical, Mental, and Cognitive Well-Being in Later Life. *Journals of Gerontology, Series B: Social Sciences*, vol. 60B, pp. S93-S101.

Multiple variables used by Luo and Waite, from HRS 1998, indicated that the socioeconomic status (SES) one has in childhood affects later physical, mental and cognitive health. The SES variables included: the educational attainment of the mother and father, if the father was a white-collar worker, whether the respondent identified the family as poor, average, or well-off. Health variables used to indicate wellbeing were: self-reported health, functional limitations, chronic conditions, depressive symptoms, self-rated memory and cognitive functioning.

Childhood SES variables had a significant effect on all six health outcomes. Those who were wealthy had better self-rated health and memory, but there was no advantage to wealth over average on the other four health variables. Those who reported being poor had significantly less wellbeing in later life than those with average or wealthy families in childhood.

The researchers also analysed adult SES and interactions of SES variables with gender and race. Adult educational attainment and higher household income were strong predictors of all variables of wellbeing in a positive direction. The effects of adult SES on health were stronger for respondents with low childhood SES than those with higher childhood SES. Women reported more functional limitations and depressive symptoms than men, but their health indicators improved with adult education. Adult income had a larger positive effect for men's health.

Adult education and adult income affected Whites' and non-Whites' wellbeing differently. There was a stronger relationship between income and cognitive functioning for Blacks than for Whites. All health variables improved in Hispanics with increasing education attainment in adulthood, but the effect was weaker than in Whites.

3. Health and Living Arrangements of Older Americans: Does Marriage Matter?[37]

Policy makers are increasingly concerned with the living arrangements of the elderly and the part that plays in their health. Researchers now have the longitudinal data from AHEAD/HRS to study the effects of health on living arrangements, specifically, in this case, the difference marriage makes.

Liang, et al., used data from the Asset and Health Dynamics among the Oldest Old Study (AHEAD) from three waves 1993, 1995, and 1998. This sample of individuals, 70 years or older in 1993 and spouses of any age were split into two groups for the purpose of this analysis: those who were married (those co-habiting included) and those who were not. Self-reported health, physical functioning and cognition variables were then correlated to these two living arrangements.

The research is unique in that it had longitudinal data from a national sample over a five-year span that defined a time-sequence and the researchers could account for competing risks such as institutionalisation or death. A full set of self-reported health measures was available to accurately assess the impact of marriage and non-marriage.

[37] Liang, J., Brown, J. W., Krause, N. M., Ofstedal, M. B., and Bennett, J. (2005) Health and Living Arrangements of Older Americans: Does Marriage Matter? *Journal of Aging and Health*, vol. 17, no. 3: pp. 305.

The previous confusion of marriage status affects on health were avoided by analysing the two groups separately. Liang et al., also controlled for prior living arrangements.

These researchers found that higher cognitive abilities in unmarried adults led to a lower probability of living with children or others. In contrast, self-reported health and cognitive abilities were significantly less important for the living arrangements of married individuals. Being married led to a significantly less likelihood of nursing home admission, for example. Those living with children, also, were less likely to be admitted to a nursing home. These research findings support the importance of marriage in maintaining a stable living arrangement over time in those individuals 70 years old and older.

Selected Citations for Journal Articles Using HRS Data from 2005 (Taken from the Dynamic Bibliography on the HRS Web site)

Economics

Herd, P., Ensuring a Minimum: Social Security Reform and Women, The Gerontologist, vol. 45, 2005.

Johnson, R. W., Uccello, C. E., and Goldwyn, J. H., *Who foregoes survivor protection in employer-sponsored pension annuities*? The Gerontologist, vol. 45, pp. 26-35, 2005.

Kim, H. and Lee, J., Unequal Effects of Elders' Health Problems on Wealth Depletion across Race and Ethnicity Journal of Consumer Affairs, pp. 148-72, 2005.

Labour

Emptage, N. P., Sturm, R., and Robinson, R. L., *Depression and co morbid pain as predictors of disability, employment, insurance status, and health care costs.* Psychiatric services (Washington, D.C.), vol. 56, pp. 468-74, 2005.

Szinovacz, M. and Davey, A., *Predictors of Perceptions of Involuntary Retirement* The Gerontologist, vol. 45, pp. 36-47, 2005.

Family

Brown, S. L., Bulanda, J. R., and Lee, G. R., *The Significance of Cohabitation: Marital Status and Mental Health Benefits among Middle-Aged and Older Adults* The Journals of Gerontology: Social Sciences, vol. 60B, pp. S521-529, 2005.

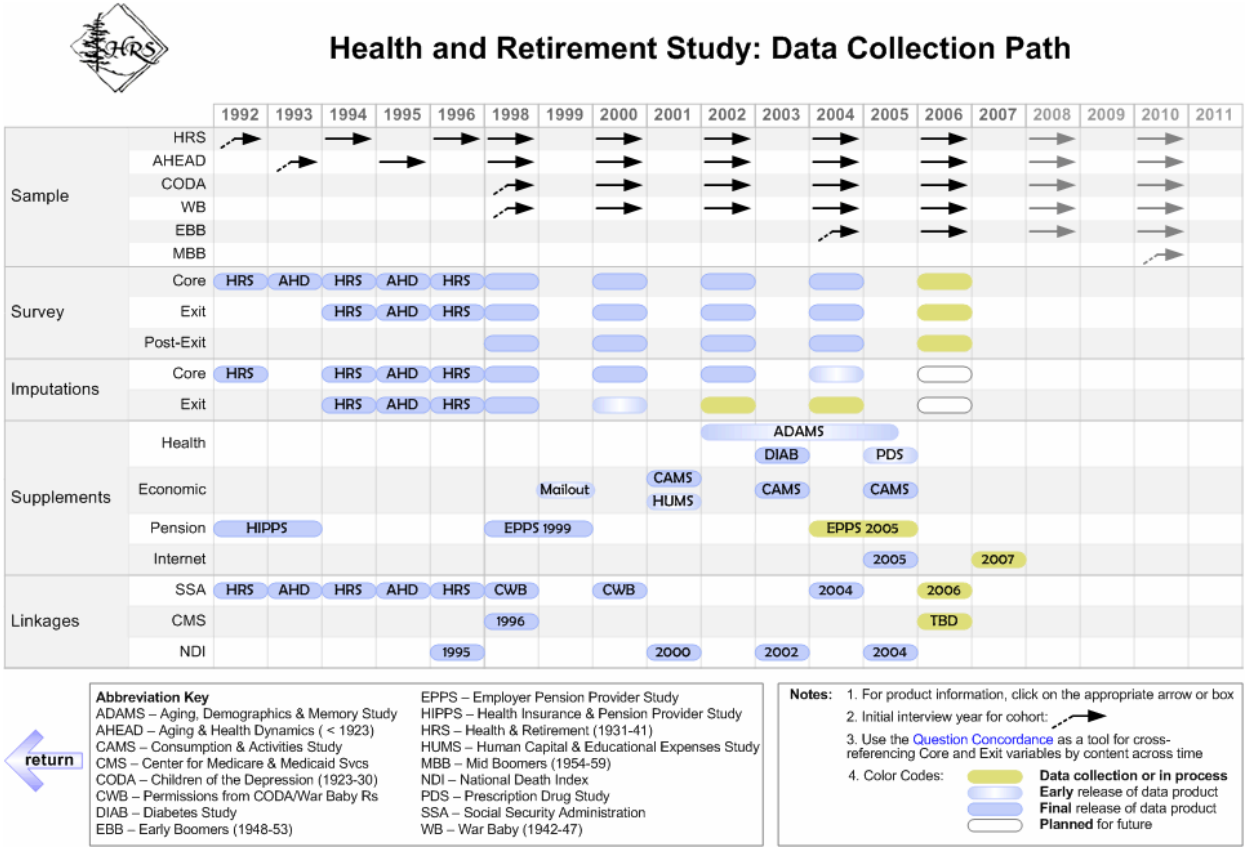
Health

He, X. Z. and Baker, D. W., Differences in leisure-time, household, and work-related physical activity by race, ethnicity, and education. Journal of general internal medicine, vol. 20, pp. 259-66, 2005.

Killian, T. S., Turner, J., and Cain, R., *Depressive symptoms of caregiving women in midlife: the role of physical health.* J Women Aging, vol. 17, pp. 115-27, 2005

.Lum, T. Y. and Lightfoot, E., *The Effects of Volunteering on the Physical and Mental Health of Older People* Research on Aging, vol. 27, pp. 31-55, 2005.

5.5 Appendix 5A



6. THE SURVEY OF HEALTH, AGEING AND RETIREMENT IN EUROPE

6.1 Introduction – purpose and scope

The Survey of Health, Ageing and Retirement in Europe (SHARE) is a multidisciplinary and cross-national database of micro data on health, socio-economic status and social and family networks of some 27,000 persons aged 50 or over. Eleven countries contributed data to the 2004 SHARE baseline study. They are a balanced representation of the various regions in Europe, ranging from Scandinavia (Denmark and Sweden) through Central Europe (Austria, France, Germany, Switzerland, Belgium, and the Netherlands) to the Mediterranean (Spain, Italy and Greece). Further data have been collected in 2005-06 in Israel. Two 'new' EU member states - the Czech Republic and Poland - as well as Ireland joined SHARE in 2006. SHARE is a longitudinal project and the same respondents were interviewed again at the end of 2006. When the data from the second wave of SHARE become available, a more complete study will be possible.

SHARE is co-ordinated at the Mannheim Research Institute for the Economics of Ageing. It has been designed after the role models of the U.S. Health and Retirement Study (HRS) and the English Longitudinal Study of Ageing (ELSA). Compared with the HRS and ELSA, SHARE has the advantage of encompassing cross-national variations of public policies, cultures and histories in a variety of European countries.

Based on probability samples in all participating countries, SHARE represents the non-institutionalised population aged 50 and older. Spouses are also interviewed if they are younger than 50. Data collection in Belgium and Israel as well as the collection of data from supplementary samples in some countries was not completed in April 2005. These data will be included in Release 2 of the SHARE data, which is scheduled for the winter 2006/2007.

The SHARE main questionnaire consists of 20 modules (supplemented by a self-completion questionnaire). The main part of the SHARE 2004 questionnaire is asked of all eligible individuals in a household, who have been identified in the introductory module – hence data are collected on partners' (and former partners') socio-economic history, including education and paid work history. Some modules concerning the household rather than the individual are answered only by the designated financial, family, or housing respondent.

Who answers to which modules of the SHARE questionnaire?						
Module	Name	All Respondents	Financial Respondent	Housing Respondent	Family Respondent	Non Proxy Section
CV	Coverscreen					
DN	Demographics	x				
PH	Physical Health	x				
BR	Behavioral Risks	x				
CF	Cognitive Function	x				x
MH	Mental Health	x				x (parts)
HC	Health Care	x				
EP	Employment and Pensions	x				
GS	Grip Strength	x				x
WS	Walking Speed	x				x
CH	Children				x	
SP	Social Support				x	
FT	Financial Transfers		x			
HO	Housing			x		
HH	Household Income			x		
CO	Consumption			x		
AS	Assets		x			
AC	Activities	x				x
EX	Expectations	x				x
IV	Interviewer Observations					

6.2 Domains covered by SHARE, and their differences and similarities with EWAS

Data collected include health variables (self-reported health, physical functioning, cognitive functioning, health behaviour (including smoking and alcohol consumption), use of health care facilities), psychological variables (psychological health, wellbeing, life satisfaction), socio-economic variables (current work activity, job characteristics (including supervision of others, job satisfaction), opportunities to work past retirement age, sources and composition of current income, wealth and consumption, housing, education), and social support variables (e.g. assistance within families, transfers of income and assets, social networks, volunteer activities). It also includes information about family structures, settings and relationships, household size and composition; norms and values about the roles and responsibilities of partners, and of families and the

State; social inclusion; religious affiliation, participation and education by parents; political affiliation and pets.

While the SHARE domains are very similar to EWAS, the scope and detail of the information collection is in excess of the material EWAS is able to complete in its more limited survey and interview processes.

6.3 Differences and similarities in question lines

The SHARE data contain a large amount of information concerning various forms of transfers between individuals and households. Respondents were asked about the financial transfers of at least 250€ received and given during the last 12 months. They are asked to report the amount and the relationship with the donor or recipient. Concerning assistance in time, individuals report whether they received or gave any of three forms of practical help during the last 12 months: personal care (help with dressing, bathing or showering, eating, getting in and out of bed and using the toilet), practical tasks (home repairs, gardening, help with transport, shopping and household chores), and help with paperwork (filling out forms, or setting financial or legal matters). Information about the relationship with the donor or recipient, the frequency and the number of hours devoted to the help is also collected.

There is also significant data collection on the characteristics of the parents of the respondent. Parents' characteristics include age, paid work history, health status, living arrangement (couple, father only, or mother only), distance from adult children and whether the parent gave at least 250€ to the child in the last 12 months. The scope of this information collection allows SHARE data to be examined to understand significant policy issues, such as intergenerational (from adult child to parent) transfers of time and money, and the impact of adult children's income and paid work participation on these, and the impact of money and time transfers from mother to daughter, and their impact on the daughter's labour market participation. Both of these are described further below.

There is much less emphasis in the SHARE data on the *range and frequency of interactions* with others (particularly those outside the family) – a central part of the EWAS initial questionnaire. SHARE's focus on *transfers* (of time, particular forms of assistance and money) between respondents and those they help, or who help them, will give insight into areas where intergenerational, and interpersonal, exchanges operate in ways to support or confound policy settings. An example of this is recorded below, in the analysis of the impact of care and money given by older mothers on their daughters' labour market participation.

While the SHARE questionnaire covers both objective and subjective measures of wellbeing, it has much less emphasis than the EWAS questionnaire on the respondent's satisfaction with the individual dimensions of wellbeing: the question is asked only about job satisfaction, and about satisfaction with what the respondent has achieved in the voluntary/leisure/educational area. Instead, the questionnaire enquires into psychological wellbeing through measuring the optimism of the respondent by asking them to estimate

the likelihood of various positive events, ranging from a sunny day tomorrow, to inheriting money.

The sex, age, and educational level of the interviewers are also recorded, as are the interviewers' observations.

6.4 Building on the SHARE approach

There is little in the published SHARE literature that deals directly with wellbeing or quality of life: those that I have found are recorded below. Instead, SHARE's strength lies in the great wealth of data collected about its subjects, and about those who live with them who are also 50+. SHARE is unique in its ability to explore in detail exchanges of time, money and care across the generations, and to illuminate the meanings participants ascribe to the exchange. This suggests question lines that would be useful for qualitative interviews, as a more detailed understanding of these informal exchanges will allow public policy to be designed so as to complement, and not crowd out, private transfers.

Some of the SHARE results are in line with our expectations (these are recorded in more detail below):

Education, income, net worth, and car ownership consistently related to quality of life, but the association of home ownership was less consistent.

Contented employees work for longer.

Others may be different from our expectations:

Good health does not equate with longevity

Others, again, point to areas worth investigating:

If differences in reporting styles are taken into account, cross-country variations in general health are reduced.

The SHARE study has collected a greater range of information than EWAS will have time in the field to do, and repetition through the successive waves of data collection will enrich the information further. As with studies such as BASE and OASIS, there is value in considering early articles analysing SHARE data in the light of current policy interests in New Zealand and stakeholder interests.

Current policy issues in New Zealand that are likely to persist for some years, which the SHARE study illuminates, include:

- increasing the labour market participation of the elderly and of women
- ways to mitigate the effects of illness on labour market participation
- improving productivity while expanding participation

- the most effective spend of the health dollar in improving the health of an ageing population
- designing State support for older people that does not crowd out support from family members.

EWAS's stakeholders' interests are summarised in the EWAS paper (*Stakeholder Consultations in Ageing Research*, Working Paper 7, Waldegrave 2006), and may be distilled as: "access to services, activities and support; health; culture; and family. The emphases in these and other areas were on living better and living well." (p 21)

Presented below are summaries of a selection of SHARE's published research results in areas of policy interest in New Zealand, and which align with EWAS's stakeholders' interests. They are broadly ordered from a general summary of results through socio-economic status, to family interactions and labour market issues to health, including cognitive functioning.

One further comment is warranted: a number of the variations among countries recorded in the SHARE survey have been included, although they are not directly replicable for New Zealand. This is both because of the inherent interest of the information, and because similar differences may exist among New Zealand's differing ethnic populations or even amongst rural and urban dwellers, or those of differing socio-economic status.

"50+ in Europe" – Summary of initial results[38]

The family plays an important role in the lives of older people throughout Europe. However significant differences exist between southern and northern Europe. In Denmark, for example, only 13 per cent of respondents live with their offspring. The corresponding figure for Spain is 52 per cent, and more than 80 per cent of people live in the direct vicinity of their children. Similarly, while 42 per cent of Danes see their parents every day, the corresponding figure for respondents in the Mediterranean countries nudges 86 per cent.

Mutual support within families is an important resource for families throughout Europe, and in Southern Europe in particular. Grandparents provide a great deal of help caring for children, for example. A third of respondents aged 65 and over reported providing daily help or child care – on average 4.6 hours a day. An important role is also played by mutual financial support. The data show that in northern Europe financial help is provided by parents and in southern Europe, in contrast, by the younger generation.

The age of retirement varies widely throughout Europe. Health appears to be less important than is generally assumed. More important are the differences in national pension and social security systems. Employers and employees take particular advantage of early retirement in countries, such as Austria or France, where economic incentives to exit the labour force are present. The results also demonstrate how important job

[38] *50+ in Europe* – Summary of initial results, Mannheim Research Institute for the Economics of Ageing (MEA), Mannheim 2006

satisfaction is. *Contented employees work for longer.* Individual responsibility and professional recognition also predispose people to postpone their retirement for longer. Poor working conditions, on the other hand, are frequently associated with health problems and early retirement.

Almost all senior citizens in Europe draw a public pension. More than half supplement this pension from additional sources of income in old age. In countries such as Sweden or the Netherlands, almost two thirds of retirees have an additional occupational pension. However, in most countries occupational pensions account for a much smaller share of income than do public pensions. Even less provision is made privately via, for example, life insurance policies. Sweden ranks highest with almost 20 per cent of all the country's pensioners in receipt of such benefits. The European average, in contrast, is 10 per cent. Pension benefits are lowest among the low-skilled – particularly if people in this group take early retirement.

Senior citizens participate in a great deal of voluntary work: in total around ten per cent of European over-50s undertake unpaid voluntary work. A significantly larger proportion of older people are involved in voluntary work in northern Europe than in southern Europe: more than 20 per cent in the Netherlands and less than four per cent in Spain and Greece. Two thirds of respondents said that the reason for undertaking voluntary work was to do something useful in retirement. However, people's health is an important factor in this context, and senior citizens who are in poor health are less likely to engage in voluntary work than people of the same age who feel fit and healthy.

Poverty in old age continues to be a serious problem in some European countries. Senior citizens in southern Europe generally have to get by with lower incomes than older people in northern Europe. However, the picture is rosier if home ownership is also taken into account. In many cases *financial hardship is mitigated by family proximity*. Living with children – not only in the same household, but also in separate flats in the same house – also provides important *protection against poverty*. This proximity is frequent not only in Southern Europe, but also in Germany and Austria.

Good health does not equate with longevity. Northern Europeans are healthier and richer, but people in southern Europe live longer. The Danes, followed by the Swedes and Swiss, are the most satisfied with their health. Health problems are closely related to age throughout Europe. Disorders such as cataracts are experienced five times more often by the over-80s than by people in the 50-59 age group. Women suffer from most complaints significantly more frequently than men, but men face greater health threats. Experts believe that one of the reasons is men's tendency to adopt riskier lifestyles such as smoking more and drinking more alcohol.

Education and income affect health. Men's and women's health and lifestyles are strongly influenced by income and education in all European countries. Respondents with lower levels of formal education engage in much less physical exercise and suffer more often from obesity than do people of the same age with higher levels of formal education. In all countries men are significantly more often overweight than women.

Childhood experience and professional training impact on mental fitness. Mental fitness is not simply inherited. Striking differences are apparent between countries. Respondents in Mediterranean countries, for example, appear to experience a more dramatic mental decline with increasing age. This may be due to the fact that the professional training situation in these countries is not as good as in northern countries.

SHARE: summaries of particular studies

1. Socio-economic position and quality of life among older people in 10 European countries: results of the SHARE study [39]

This study examines associations between quality of life and multiple indicators of socio-economic position among people aged 50 or more years in 10 European countries, and analyses whether the relative importance of the socio-economic measures vary by age. 15,080 cases were analysed. Quality of life was measured by a short version of the CASP-19 questionnaire, which represents quality of life as comprising four conceptual domains of individual needs that are particularly relevant in later life: control (C), autonomy (A), self-realisation (S) and pleasure (P). Five indicators of socio-economic position were used: income, education, home ownership, net worth, and car ownership. Quality of life was associated with socio-economic position, but the associations varied by country. Relatively small socio-economic differences in quality of life were observed for Switzerland, but comparatively large differences in Germany. *Education, income, net worth, and car ownership consistently related to quality of life*, but the *association of home ownership was less consistent*. There was no indication that the socio-economic differences in quality of life diminished after retirement (i.e. from 65+ years).

2. Cross-national differences in income poverty among Europe's 50+ [40]

This study considers income poverty among the 50+ population in 10 EU countries using data from the SHARE (Survey of Health, Ageing and Retirement in Europe) project. It finds that unemployment, being a homemaker, being self-employed, living alone, and having a child living close, are associated with an increased likelihood of poverty. The findings suggest that the poverty rate ranges from 10 percent (in Sweden) to 22 percent (in Switzerland and Spain). The poverty rate is in general lower among the northern countries and higher in the southern countries. Less risk of poverty can be found among those that have supervision over the workplace, have obtained more education, are home owners, and, in some countries, among those that are relatively old. Less poverty risk can be found among those that had or have supervision over the workplace, have obtained more education, or are home owners. It is likely that a nearby living adult child has more possibilities to help out. There is significantly higher poverty associated with 65+ age groups in Denmark and Sweden, while in Austria, Switzerland, and Spain this age group has a lower poverty risk. There is on the other hand, no consensus in the data that retired

[39] Von Dem Knesebeck, O., Wahrendorf, M., Hyde, M., and Siegrist, J. (2007) *Ageing and Society*. Cambridge: Vol.27 Part 2:pg. 269

[40] Hallberg, D. (2006) Department of Economics, Uppsala University. 24 pp.

are more likely to be poor once other factors are controlled for, rather, for Austria, the reverse is true.

3. Proximity and Contacts between Older Parents and Their Children: A European Comparison [41]

In addition to a brief description of the geography of families in 10 continental European countries, determinants of intergenerational proximity and contacts are examined in this study. Even when micro level factors are controlled for, Mediterranean people continue to exhibit closer family relations than their northern counterparts. When looking at the contemporary European picture as a whole, there is *no indication of a decline of intergenerational relations.*

4. How do middle-aged children allocate time and money transfers to their older parents in Europe? [42]

As noted above, the SHARE data contain a large amount of information concerning various forms of transfers between individuals and households. The analysis in this study focuses on the adult children's point of view. It consists in individuals who are between 50 and 69 years old, have at least one parent alive and do not live with them. The survey includes 5,244 observations fulfilling these conditions. (The study excludes adult children living with their parents because the data do not allow evaluation of the existence, direction and the importance of the intra-household transfers taking place between the adult children and their parents. The drawback of this exclusion is that it might underestimate in-kind transfers if they are positively correlated with cohabitation, as is very likely.)

Only 2.6% of adult children provide financial assistance to their parents in European countries. Some significant differences appear across countries with Switzerland and Greece having the highest proportion of upstream financial transfer (6.1% and 5.5% respectively) and Denmark, the Netherlands and Italy having the lowest (0.8%, 1.2% and 1.3% respectively).

In the *provision of care*, the following pattern obtains:

Northern countries - Sweden, Denmark and the Netherlands - that rely more on the State to support the elderly, provide a modest amount of informal help and offer a wider range of formal assistance such as home help and institutions.

Western countries - Germany, France, Austria and Switzerland – that rely on the State to provide long-term care to elderly but do not neglect the role of the family in the provision of care.

[41] Karsten Hank. (2007) *Journal of Marriage and Family*. Minneapolis: Vol.69, Issue 1; pg. 157, 17 pgs

[42] Bonsang, E. (2006) *CREPP Working Papers 2006/02*. CREPP, HEC-Management School University of Liège

Mediterranean countries - Italy, Spain and Greece – where the role of the family in the provision of assistance to the elderly is very important while the State only accounts for a little part of the help.

Paradoxically, Northern countries (Sweden, Denmark, and the Netherlands) have the highest proportion of adult children providing time assistance to their parents while Mediterranean countries, (Spain, Italy and Greece) have the lowest. It appears that adult children in Northern countries share the burden of assistance to parents among siblings while in Southern countries, the burden is essentially carried by one of the children, especially by the cohabiting one. Once the intensity of the help is taken into account, Mediterranean countries exhibit the highest number of hours of assistance to parents. Adult children living in Northern countries provide "occasional assistance" to their parent that mainly consists of practical household help, while adult children from Mediterranean countries are more involved in personal care. This difference in the pattern of time assistance may be due to *differences in the development of formal care* across these two regions.

The decision about providing time assistance is not influenced by employment status, but the intensity of care giving is reduced when adult children work more. The decision to provide financial assistance to parents increases as adult children work more, suggesting that adult children substitute financial transfers for time transfers as they become more active in the labour market. This suggests that those working more are unable to assist their parents as much as necessary and complete their assistance by providing money to buy formal care. The other source of substitution between time and money transfers is distance from parents. Adult children living far from their parents tend to substitute money for time.

The results of this cross-national study are particularly pertinent for New Zealand, as the government seeks to balance the guarantee of adequate care for older people who wish to "age in place" against the importance of encouraging family members to provide care, with important results obtained about the role proximity (especially in the same household) plays in the provision of informal care, as well as the clear impact of State systems of care on the care provided by family members.

5. The support of parents in old age by those born during 1945-1954: a European perspective[43]

A study was conducted to investigate the help that the European birth cohort of 1945-54 who were included in the SHARE survey, now aged in their 50s, gave to their elderly parents during the 12 months prior to being surveyed in 2004. Findings revealed that the proportions that had provided practical help to their parents during the previous 12 months had a north-south gradient, from about one in three in the northern countries to 15 percent or less in the southern countries. It was also discovered, in contrast, that the proportions of helpers providing regular and almost daily assistance had an inverse pattern, being low in Sweden and Denmark and much higher in the south.

[43] Ogg, J., and Renaut, S. (2006) *Ageing and Society*, vol. 26 no. 5:pp. 723-43

6. Social productivity and well-being of older people: Baseline results from the SHARE study[44]

Social and productive activities have been associated with more favourable wellbeing and health outcomes in older populations. There is limited consensus on what aspects account for the observed effect and what pathways may underlie their associations. This study explores types and quality of productive activities (voluntary work, care for a person, informal help) and their association with two indicators of wellbeing (depressive symptoms and quality of life). Quality of social productivity is analysed in terms of exchange reciprocity. Results confirm an association of productive activity with wellbeing. However, this association varies according to experienced quality of exchange: reciprocity between efforts spent and rewards received is associated with positive wellbeing (with the exception of caring), while non-reciprocal exchange (high effort and low reward) is associated with negative wellbeing in all activities. The findings underline the need to improve the quality of exchange in socially productive activities as a means of motivating older people to participate in social activities.

7. The participation of older Europeans in volunteer work[45]

Using micro-data from the 2004 Survey of Health, Ageing and Retirement in Europe (SHARE), this paper examines the relationships between selected socio-demographic characteristics and the rates of participation in voluntary work in 10 European countries among those aged 50 or more years. The analysis reveals relatively high participation rates in Northern Europe and relatively low participation rates in Mediterranean countries, and shows that *age, education, health and involvement in other social activities strongly influence an individual's propensity to engage in volunteer work*. There is no evidence that country differences can be explained by variations in population composition or attributes, such as the age structure or differences in health status. The findings suggest that policies and programmes to encourage older citizens to make greater use of their productive capacities are feasible. Further research needs to account for the influences of institutions and culture on participation in volunteering.

8. Do Downward Private Transfers Enhance Maternal Labour Supply? Evidence from around Europe[46]

Drawing on a theoretical model based on 2317 mother-daughter pairs from the 2003 SHARE data on 10 European countries, the authors investigated the impact of private transfers on the career choices of transfer-receiving young mothers. In addition to detailed information on the primary respondent, the data base also contains some information on up to four randomly selected respondent's children. This latter information includes not only human capital characteristics, but also number of children, age of the youngest and eldest child, and labour force participation. Although information on the actual number of hours of work supplied by the child is missing, the researchers were able to distinguish between different levels of labour force involvement, such as full

[44] Wahrendorf, M., von dem Knesebeck, O., and Siegrist, J. (2006). *European Journal of Ageing.* Vol 3(2): pp. 67-73

[45] Erlinghagen, M., and Hank, K. (2006). *Ageing and Society.* Cambridge: Vol.26 Part 4. pg. 567

[46] Ralitza D., and François-Charles W. (2006) *IZA Discussion Paper No. 2469*

time work, part time work and no work, which provides sufficient grounds for analysing the impact of transfers on the degree of labour market involvement of the recipient. The researchers are clear about the relevance of their enquiry, and their reasons hold true for New Zealand:

"The large body of research addressing the choice of childcare and work among mothers typically concentrates on the labour market implications of government induced monetary incentives, treating the availability of informal care as exogenously given . . . . At the same time, the literature studying the impact of downward intergenerational transfers on the labour supply of young individuals has focused predominantly on consequences of downward monetary gifts such as human capital investment or work disincentives. . . . . To the best of our knowledge, the only microeconomic studies that address the impact of intergenerational solidarity find a positive impact of intergenerational co-residence on the labour supply of young female participants in the intergenerational exchange and interpret this result as indicative of a high correlation of co-residence and downward transfers and hence positive effect of the latter on the work effort of the recipient. This leaves out of focus not only the potentially important implications of intergenerational solidarity in both co-residing and non-co-residing households, but also the qualitatively different implications of the receipts of monetary and time transfers. On the one hand, there is strong evidence to suggest that while intergenerational co-residence . . . is decreasingly frequent, time services, specially in the form of grandchild care are non-decreasing and indeed on the rise. . . . . Even more importantly, failure to consider the possibility of substituting monetary for time transfers to children may have important implications from the point of view of economic performance. For instance, macrotheoretical evidence suggests that while time transfers increase the labour force participation of young people, monetary transfers decrease their work effort. . . . " (pages 2 & 3)

For Europe as a whole, they found a strong positive impact of grandchild care on the labour force *participation* decision of the mother, but no clear impact of either grandchild care or monetary transfers on the mother's *degree* of labour market involvement. While both recipients and donors with better human capital endowments are more likely to participate in a monetary transaction, time transfers are such that mothers with lower levels of human capital tend to assist the professional development of their better endowed daughters.

Overall, the empirical results are consistent with the theoretical predictions and reflect an efficient intergenerational and labour market participation environment. Specifically, a higher level of human capital is the driving force behind the receipt of assistance. Parents support their better off as opposed to weaker children and it is the stronger children that benefit from higher level of labour market involvement. Indeed, not only are human capital endowments the driving force behind monetary transfers, but also mothers with lower endowments enter an intergenerational solidarity pattern by providing time assistance to their better off daughters.

Finally family related institutions have an impact on both intergenerational transfers and labour supply: there is a higher level of grandchild care supply in the least generous in terms of institutionalised assistance régimes. However, they are far from being a major determinant of choices such as the degree of labour market involvement of young mothers.

9. The Institutional Determinants of Early Retirement in Europe[47]

This paper investigates early retirement determinants across several European countries using the rich 2005 SHARE (Survey of Health, Ageing and Retirement in Europe) microdataset, which produces more precise estimates of the effects of institutional and economic factors like pension systems, unemployment, and employment protection legislation. The analysis shows that pension systems offering generous early retirement options encourage early departure from the labor market. In addition, *pension wealth accrual rate exerts a greater influence on early retirement decisions than does the average replacement rate*, while stricter employment protection legislation has no significant impact. As Kiwisaver individual pension funds build over the coming year this effect may become apparent in New Zealand.

10. Labour force participation of the elderly in Europe: the importance of being healthy[48]

This study considered study labour force participation behaviour of individuals aged 50-64 in 11 European countries. The empirical analysis shows that health is multi-dimensional, in the sense that different health indicators have their own significant impact on individuals' participation decisions. Health effects differ markedly between countries. A counterfactual exercise shows that improved health conditions may yield over 10 percentage points higher participation rates for men in countries like Austria, Germany and Spain, and for females in the Netherlands and Sweden. Moreover, declining health conditions with age account for the majority of the decline in participation rates as people age.

11. Depression And Social Involvement Among Elders[49]

This study has two aims: first, to explore how social involvement changes by age among European elders, and second, to disclose the relationship by age between social involvement and depression among study participants. The study used data from the Ageing and Retirement in Europe database (SHARE; 2004), subjecting a sample of 10207 elders aged 65 or older (Mean age = 73.84, SD = 6.84) to analysis in terms of the study questions. About 45% of the participants (n = 4601) were males and the remainder females (n = 5606). Study results determined that, without notable gender differences, European elders participate less in social activities with increasing age to statistically significant degrees; younger elders tend to be more socially involved and older elders less

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[47] Justina A.V. Fischer & Alfonso Sousa-Poza, 2006. "**The Institutional Determinants of Early Retirement in Europe**," University of St. Gallen Department of Economics working paper series 2006 2006-08, Department of Economics, University of St. Gallen.

[48] Kalwij, A., and Vermeulen, F. (2005). *Discussion Paper: 130*. Tilburg University, Centre for Economic Research.

[49] Hisham Motkal Abu-Rayya (2006) Depression And Social Involvement Among Elders. *The Internet Journal of Health,* Volume 5, Number 1.

so. Symptoms of depression also emerged as negatively correlated with social involvement to statistically significant degrees, when age was controlled for, for both males and females. The study's findings imply that by increasing their social participation, European elders might be able to stave off feelings of depression.

12. Occupational Activities and Cognitive Reserve: a Frontier Approach Applied to the Survey on Health, Ageing, and Retirement in Europe (SHARE)[50]

This study considered the impact of occupational activities, defined in a broad sense, on cognitive functions among the European population aged 50 and over. It used individual data collected during the first wave of SHARE, performed in 2004. Compared to the majority of studies in the cognitive reserve[51] literature, the advantage of this survey is that it includes a large population distributed geographically throughout Europe. Moreover, the multidisciplinary nature of SHARE allowed the researchers to simultaneously analyse several dimensions of participants' lives: physical and mental health, mobility, occupational activities, and socioeconomic status, in addition to cognitive performances, whereas most of the studies focus on only a few of these parameters.

As expected, the results show that *cognitive performance is mainly driven by age (negatively),* which refers to cognitive ageing, and *by years of education (positively).* This second result is clearly in accordance with studies suggesting that education is one of the major factors contributing to the development of the "cognitive reserve". Taking into account the effects of age and education, the researchers tested simultaneously the effect of different factors (associated directly or indirectly with the notion of "general activity") that potentially drive cognitive performance and therefore contribute to the formation of individuals' cognitive reserve. The results show that, after controlling for the side effects of some factors not associated with the notion of "activity" (such as sex, being born inside or outside the country, and suffering from a chronic disease), *all types of occupational activities (*professional or not) *clearly have a positive effect* on cognitive reserve constitution. More specifically, individuals who continue to work or who engage in a non-professional activity have better cognitive performance.

The analyses show that this positive effect is not restricted to professional activities but is also observed for non-professional activities, depending on their number and frequency. The contribution of non-professional activities is equivalent to (or even slightly greater than) the impact of professional activities. This can be explained by the fact that non-professional occupational activities are mostly voluntary, while professional activity are imposed for some people, and this may generate depression and anxiety, factors that have negative effects on cognitive functioning. Some studies show that retirement can lead to a reduction in depressive symptomatology.

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[50] Stéphane Adam et al. *CREPP Working Paper 2006/05.* University of Liège

[51] *cognitive reserve* relates to the fact that innate intelligence or aspects of life experience such as educational or occupational attainments provide a reserve, represented by a set of skills or repertoires, that allow some people to prevent the cognitive decline associated with normal ageing or Alzheimer's disease.

In addition to the effect of professional or non-professional activities, the significant protective effect of the practice of physical activities is highlighted in the study, and this applies to both strenuous and moderate *physical activity. This effect is slighter, and weaker, than the effects of professional and non-professional activities*.

Finally, the results show that belonging to the less wealthy quartile of the population, and *living alone* (variables indirectly associated with the notion of activity) *have a negative impact on the preservation of cognitive reserve*; the latter result is consistent with studies showing that social isolation or social disengagement is a risk factor for cognitive impairment among elderly persons

The important problem of the "causal relation", which is not always addressed in studies, is not examined in this study. Indeed, the question is whether the decrease in cognitive functioning is the consequence of the reduction in activity or vice versa. The authors look forward to being able to disentangle the causal chain once the data from the second wave of the SHARE study are available.

13. True Health vs Response Styles: Exploring Cross-Country Differences in Self-Reported Health[52]

The aim of this paper is to decompose cross-national differences in self-reported general health into parts explained by differences in true health, measured by diagnosed conditions and measurements, and parts explained by cross-cultural differences in response styles. (This serves as a useful counterpoint to the "50+ in Europe" paper cited above, which showed northern countries reporting better health, but a shorter life span). Self-rated general health shows large cross-country variations. According to their self-reports, the healthiest respondents live in the Scandinavian countries and the least healthy live in Southern Europe. Counterfactual self-reported health distributions that assume an identical response style in each country show much less variation in self-reports than factual self-reports. Danish and Swedish respondents tend to largely over-rate their health (relative to the average) whereas Germans tend to under-rate their health. If differences in reporting styles are taken into account, cross-country variations in general health are reduced but not eliminated. Failing to account for differences in reporting styles may yield misleading results.

14. Cognitive Abilities and Portfolio Choice[53]

This study is included to demonstrate the range of correlational investigations that are possible with a database as comprehensive as SHARE's. It examined the relation between cognitive ability and the decision to invest in stocks using the Survey of Health, Ageing and Retirement in Europe (SHARE). The survey has detailed data on wealth and portfolio composition of individuals and three indicators of cognitive abilities: mathematical, verbal fluency, and recall skills. The propensity to invest in stocks is strongly associated with cognitive abilities, for both direct stock market participation and indirect participation through mutual funds and investment accounts. Stockholding

[52] Jurges, H. (2007) *Health Economics*, vol. 16, no. 2, pp. 163-78
[53] Christelis, D., Jappelli, T., and Padula, M. (2006). *CEPR Discussion Papers*: 5735

increases with social interactions and intention to leave a bequest, and is negatively associated with health status.

6.5 The use of research findings to influence policy and practice

Results from the SHARE study have been published only in the last eighteen months: it is not yet possible to say how they may influence policy and practice. As with other studies, it appears the EWAS approach of direct end-user involvement in the research work is unique.

7. ENGLISH LONGITUDINAL STUDY OF AGEING (ELSA)

7.1 Introduction: purpose and scope[54]

The English Longitudinal Study of Ageing is an interdisciplinary data resource on health, economic position and quality of life as people age. ELSA is the first study in the UK to connect a full range of topics necessary to understand the economic, social, psychological and health elements of the ageing process. ELSA is a large multi-centre and multi-disciplinary study. The institutions primarily involved in the study are the University College London, the Institute for Fiscal Studies, the National Centre for Social Research and the University of Cambridge.

The aim of ELSA is to explore the unfolding dynamic relationships between health, functioning, social networks and economic position. A third of people in Britain are now aged 50 or over. This group accounts for half the nation's spending and three quarters of its wealth. Many people now retire earlier and enjoy an active and healthy retirement, but some struggle financially and/or suffer poor health. ELSA is in effect a study of people's quality of life, repeated every two years as they age beyond 50 and of the factors associated with it.

The survey covers a broad set of topics relevant to a full understanding of the ageing process. These include:

- health, disability, healthy life expectancy;
- the relationship between economic position and both physical and cognitive health;
- the determinants of economic position in older age;
- the timing and circumstances of retirement and post-retirement labour market activity;
- the nature of social networks, support and participation;
- household and family structure and the transfer of resources.

One of the study's key aims is to help the government plan for an ageing population and longer periods of retirement, and to ensure that the UK's healthcare and pension systems will be able to meet everyone's needs. This lies close to EWAS's aim to "provide the understanding that is essential for policy formulation and the delivery of services for enhancing wellbeing in an ageing New Zealand society"

[54] This introductory material is largely taken from the ELSA website, http://www.esds.ac.uk/longitudinal/access/elsa/

7.2 Methodology[55]

The ELSA sample is drawn from households previously responding to the Health Survey for England (HSE) in the years 1998, 1999 and 2001. The major advantage of the HSE sampling source is that baseline data on respondents' health (details of morbidity, lifestyle, diets and blood samples) had already been collected before the first wave of data collection began. Individuals were eligible for interview if they were born before 1 March 1952, had been living in a responding HSE household and were, at the time of the ELSA 2002–03 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 full interviews.

Those eligible from HSE who took part in ELSA Wave 1 are designated as core members. In the second wave, which took place between June 2004 and July 2005, the core members and their partners were eligible for further interview, provided they were still alive and had not refused any further contact after the first interview. The number achieved for each of these can be represented graphically[56]:

[55] This introductory sketch of ELSA's methodology is drawn from James Banks, Elizabeth Breeze, Carli Lessof and James Nazroo (eds) (2006) *Retirement, health and relationships of the older population in England: The 2004 English Longitudinal Study Of Ageing (Wave 2).*.The Institute for Fiscal Studies, London. Chapter 12 of the book contains a much fuller description.

[56] From Carli Lessof, London National Centre for Social Research: *English Longitudinal Study of Ageing: Methods and Forward Look* British Academy, 7 July 2006 (Presentation at the launch of the report covering the second wave of the ELSA survey) www.ifs.org.uk/elsa/report06/methods_july06.pdf

Of those who completed a Wave 1 interview and were eligible for a Wave 2 interview as an ELSA 'core member', 81.5% took part. Of these, 88.2% also took part in the nurse interview (representing 71.2% of those eligible for a Wave 2 interview).

In 2002–03, there was a face-to-face interview and a self-completion form. In 2004–05, there was also a nurse visit. The health and the functioning measures in the interview are primarily self-report – with the exception of a timed walk for gait speed and some objective memory and cognitive function tests. The nurse visit added objective measures of risk factors for cardiovascular diseases in the form of blood analytes and blood pressure, and also included anthropometric measures (from height, weight, waist and hip). Finally, some objective physical function measures were included, namely lung function, muscle strength (grip strength) and lower limb mobility (balance tests, chair rises).

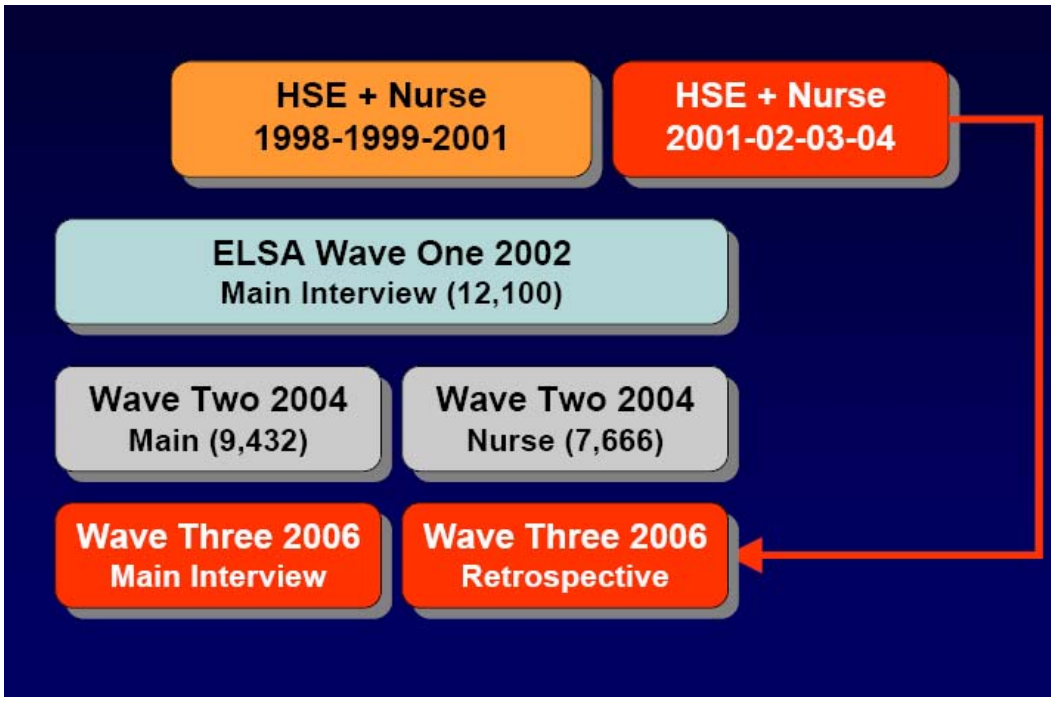
The Wave 2 interviews reflected back on information collected in the first wave so that participants could update their information rather than start again from the beginning. This method applied in particular to diagnosed diseases, employment and membership of pension schemes.

The response rate at Wave 2 was *considerably higher than the response rate at Wave 1.* This higher rate of response is expected for future waves.

Changes were also made to Wave 3:

- a new sample of 50 to 53 year olds has been recruited
- new or rotating questions have been asked in the following areas:
  - services and transport
  - dental health, fruit and vegetables
  - expectations for the future
- anchoring vignettes have been added in the additional self-completion questionnaire
- a retrospective interview.

The full set of investigations to this point is:



7.3 Domains covered by ELSA, and their differences and similarities with EWAS

The topic areas covered in the ELSA interview and self-completion questionnaire at Wave 1 included:

- individual and household characteristics (including paid work undertaken by all household members);
- physical, cognitive, mental and psychological health;
- social participation and social support;
- housing, work, pensions, income and assets; and expectations for the future.

The same broad areas were covered in Wave 2 but there were changes in some of the details. The more significant changes are noted here. Questions were added about:

- different forms of expenditure (for example, on fuel, leisure, clothing and transfers) ;
- questions about *quality* of healthcare were added;
- numeracy was added to the cognitive function section but one memory test was removed;
- there were new questions on relative deprivation and also on life satisfaction and on the way people perceive ageing and their own age;
- there was some enhancement of a section about the relationship between effort and reward in people's lives and the motivation and satisfaction (or lack of them) they feel when caring for others or undertaking voluntary work.

Fuller information about the information collected about all of the domains above is included at the end of this chapter in Appendix 7A.

The most striking differences between the ELSA questionnaire and nurse interview, and the EWAS first questionnaire, are: the detail of the health data collected in ELSA (and in the prior study); the enquiry into respondents' assessment of the quality of their relationships with family and friends, and of perceived social status; and the wealth of administrative data available to ELSA researchers if permission to access this information is given. The information that is then available (as data, rather than personal recollection) to researchers is considerable:

- NHS Central Register
- New employers for private pension plans
- Hospital episodes
- National Insurance Contributions
- Benefits, including state pensions and tax credits
- Tax records, savings, private pensions

EWAS, in contrast, records extensive demographic and family structure data, and much more about respondents' *perceptions* about their personal capabilities, ability to access transport and services, sense of personal and neighbourhood safety and social connectedness, and occupational histories – information much more aligned with EWAS's stakeholders' interests, recorded by Waldegrave as:

". . . access to services, activities and support; health; culture; and family. The emphases in these and other areas were on living better and living well. Information was sought on services, activities and support in order to enhance the quality and value of neighbourhoods so older people could feel valued, safe and seen as contributors. The issues raised around health were not focused on frailty and sickness but rather on mobility, sight and hearing that would enable ongoing independence and participation in families and communities. Participation in one's culture and family was also addressed primarily around issues of wellbeing, fulfillment and inclusion." (Waldegrave, p 21)

As with the parent HRS study ELSA contains no articulated theory of the construction of wellbeing, focussing rather on paying attention to "the great diversity in health, physical, social and psychological functioning and economic fortunes in the population"[57] in its report on the first wave of field work. The report on the second wave of research reveals a different organising principle: how each of the areas covered by ELSA varies according to people's level of wealth.

7.4 Building on the ELSA approach

Set out below is a summary of what the second wave of ELSA is able to reveal about the characteristics of people over 50 in Britain; what they do (and are able to do) and what is now known about why some people have good trajectories in older age and some less good. Material has been selected to illustrate avenues of enquiry in areas of policy interest in New Zealand, and those which align with EWAS's stakeholders' interests. The

[57] James Banks, Elizabeth Breeze, Carli Lessof and James Nazroo (eds) (2006) *Retirement, health and relationships of the older population in England: The 2004 English Longitudinal Study Of Ageing (Wave 2).* The Institute for Fiscal Studies, London. P 13

material is taken from the official report on ELSA's second wave[58], and from published research that draws on the ELSA data. Five result areas and six published papers are summarised.

The ELSA results starkly demonstrate the interrelationship between wealth and all other dimensions of wellbeing, particularly health. EWAS's current research plan will enable most of these relationships to be examined, but any reliance on self-reported health data may limit its analytical utility, particularly given the inconsistency between self-reported and objectively measured health revealed in the ELSA study. This is particularly pertinent for mobility, sight and hearing, which are areas of significant interest to EWAS's stakeholders.

7.5 ELSA results

1. Expenditure and consumption

Although expenditure goes down with age, there is evidence that this reduction, on average, is seen as a diminishing problem. Researchers asked not only about consumption but whether people lacked enough money to meet their own needs. At age 52–59, only 10% of people in the bottom quintile of wealth said they never lacked money to spend on their own needs. This proportion had increased to above 30% at 70 years or over. For the richest 20% – people in the top wealth quintile – the proportion rose from 50% never lacking money to meet their needs at age 52–59 to over 60% at age 70 or over.

This 'improvement' for older relative to younger people could reflect a changing definition of what constitutes a 'need' as people age, but objective measures point to a continuing problem.

ELSA defined "fuel poverty" as a household spending more than 10% of its income on domestic fuel. Although the overall prevalence of fuel poverty in ELSA is 8.3%, it is much higher, at just under 20%, among participants aged under 60 in the bottom wealth quintile. Fuel poverty is more marked for older women than older men. The quality-of-life measure, CASP-19, is strongly linked to fuel poverty.

2. Experiences of ageing

In all the important policy-related discussions of work, economic fortunes, health and functioning, it is possible to forget that older age can be a time of loneliness and isolation. There is a socio-economic gradient in loneliness. Approximately twice as many people in the poorest wealth quintile as in the richest feel isolated often or some of the time. Not surprisingly, feeling left out is more common for people living without a spouse or with a spouse with whom they do not have a close relationship. Living alone, in turn, is more common in the poorer wealth groups.

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

[58] Op cit

loneliness, and people without friends report the highest rates of loneliness. People aged 80 and older are the most vulnerable to loneliness. More women than men report feeling lonely, but this difference lessens with age.

Perceptions seem to matter. Respondents who feel younger than their actual age have better self-perceived health than the rest of the respondents. Respondents who would prefer to be younger have worse self-perceived health than those who prefer to be their actual age. The majority of the respondents would prefer to be younger than their actual age. Which comes first, the attitude to age or the better health, will only be settled as longitudinal data on this question is gathered.

Future health status seems to be the most important concern for the majority of the respondents. Healthier respondents are more likely to say that old age starts later and middle age ends later, independent of their age and sex. Wealthier respondents are more likely to say that old age starts later and middle age ends later, independent of their age and sex.

3. Relative deprivation and life satisfaction

The older people become, the less they feel that the money they have is insufficient to meet their needs, but the older people become, the more they feel deprived compared with people around them. As noted above, wealth is an important determinant of people's life satisfaction but its effect declines over the age of 75.

Age affects life satisfaction: 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.

Interestingly, about half the population of people 52 years and above describe ageing as a positive experience. Ageing is described as negative by a minority, but *negative experiences of ageing are far more common amongst the poorest than the richest.* Even at age 75+, a majority of people do not think of themselves as old.

4. Labour market transitions

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 in 2004-2005 than those in full-time work.

Eight per cent of those aged 50 up to the state pension age who were out of work in 2002-2003 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.

Men who were in paid work and contributing to a *defined benefit pension*[59] 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* [60] 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.

Almost two-thirds of men, and half of women, aged 52 to 54 who were not in paid work in 2004–05 reported 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.

5. Health at older ages

In the ELSA Wave 1 report, three-fifths of people at age 80 or over described their health as good, very good or excellent. This contradicted the assertion that older age means inevitable ill health.

This is not to deny the real need for medical care at older ages. One way the researchers looked at this was the proportion of people who remain free of disease, including four eye diseases, seven cardiovascular diseases and six other physical diseases. The proportion who still had none of these diseases in 2004–05 falls from around half those who were aged 50–54 in 2002–03 to around one in-ten of those aged 75–79 in 2002–03. For those aged under 75, the wealthiest were less likely than the poorest to report a new condition in 2004–05.

Given the high prevalence of one or more diseases in people surviving to older ages, the quality of healthcare is important. At Wave 2, ELSA introduced measures of healthcare *quality.* These will become increasingly important in longitudinal analyses as ELSA assesses the impact of new diseases on health and functioning.

A particular strength of ELSA is the presence of biological markers of illness. This strength can be illustrated by a recently published comparison of socio-economic differences in a number of diseases between studies in England and those in the US, including ELSA and the US-based Health and Retirement Study (Banks et al., 2006). The comparison was confined to white men and women aged 55–64.

A striking finding was that for *each of six conditions, American men and women had more illness than the English*, although national expenditure on healthcare per head is two-and-a-half times higher in the US than in the UK. It is possible that Americans report

[59] The scheme guarantees a fixed income, generally a proportion of salary over the 5 years prior to retirement

[60] The personal contribution to the scheme is set, but the income a person receives depends on the fund's performance

more illness more frequently than the English, not because they have more illness but because they are more likely to have it detected – greater medicalisation of the population. ELSA therefore compared biological markers of disease. For these, too, Americans were worse off. The presence of biomarkers made the conclusion much more secure than had ELSA relied only on self-reports of doctor-diagnosed illness. Thus, the introduction of biomarkers in Wave 2 of ELSA greatly enhances the opportunity for learning the nature of health differences between countries.

Similarly, when comparisons are made within ELSA by region, by age and by wealth quintile, the presence of biomarkers lends much to interpretation of observed differences in health. The results show that increased risk is linked clearly to wealth – the less the wealth the higher the risk.

C-reactive protein (CRP) is a marker of inflammation and is strongly linked to risk of heart disease. The close link between lower wealth and increased CRP levels suggests that CRP can be used as another biological marker *of the biological effects of low socio-economic position. Alternatively, it could be a marker that poor health leads to wealth reductions.* Further longitudinal data will distinguish the relative contribution of these two mechanisms.

6. Physical and cognitive functioning

A major concern as people age is not only with specific diseases but with ability to function, physically and mentally. Wave 1 of ELSA showed *striking differences in physical functioning by socio-economic position: the more education people had the longer was their physical functioning preserved*. In Wave 2 the data suggest that the wealthiest were less likely than the poorest to deteriorate in function between the two fieldwork waves.

Cognitive performance is an important part of continued ability to function independently. 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.*

At Wave 1, ELSA found that, although cognitive function declined in all socio-economic groups, it started from a much lower level among those with less education. Therefore those of lower education were at much greater disadvantage at each age. Prospective memory is remembering to do something in the future without being reminded. *In Wave 2, around 60% of participants aged 75 and older forgot to perform an action that they had previously been requested to carry out. If this is indicative of performance in everyday life, it means that action is necessary to help older people cope with this forgetfulness,* as it raises concerns about the health and safety of older people, in relation to such activities as remembering to take medication, pay bills and lock doors.

On simple measures of numeracy and literacy, there were striking socio-economic differences, such that substantial proportions of the poorest people scored low on literacy and/or numeracy. Although only 4% overall were impaired on both literacy and

numeracy, *almost eight times the proportion of participants in the lowest quintile were impaired as in the highest*. These measures, too, have important implications for continued ability to function in everyday life.

Important analyses for future waves of ELSA will be the determinants of what puts people on better or worse trajectories of change in functioning with age.

7.6 ELSA research

1. Quality of life at older ages: evidence from the English Longitudinal Study of Ageing (wave 1)[61]

Objectives
The objectives of the study were to investigate whether longstanding illnesses, social context, and current socioeconomic circumstances predict quality of life. Secondary analysis of Wave 1 of the English longitudinal study of ageing was carried out. Missing data were imputed and multiple regression analyses conducted. A nationally representative sample of non-institutionalised adults living in England (n = 11 234, 54.5% women, age 65.1 (SD 10.2) years) was examined. Quality of life was measured by CASP-19, a 19 item Likert scaled index.

Results
The quality of life was reduced by depression, poor perceived financial situation limitations in mobility difficulties with everyday activities and limiting longstanding illness.

The quality of life was improved by trusting relationships with family and friends, frequent contacts with friends, living in good neighbourhoods and having two cars. The regression models explained 48% variation in CASP-19 scores. There were slight differences between age groups and between men and women.

Conclusions
Efforts to improve quality of life in early old age need to address financial hardships, functionally limiting disease, lack of at least one trusting relationship, and inability to move out of a disfavoured neighbourhood. There is the potential for improved quality of life in early old age (the third age) if these factors are controlled.

[61] Netuveli, G., Richard, D., Wiggins, R. et al, (2006). *Journal of Epidemiology and Community Health*, Vol. 60, pp. 357-363.

2. Neighborhood Effects on Health And Well-Being in Later Life: A Conceptual Analysis[62].

Objectives
Lawton and Nahemow argued that with increasing age people's behavioural competence becomes more sensitive to environment demands. Their 'environmental docility hypothesis' has been extended to consideration of area effects on health and wellbeing in later life. The study considers two possible mechanisms for this. One suggests that there is a decline in material resourcefulness with increasing age, which leads to greater dependency upon others and hence greater vulnerability to neighbourhood resourcefulness. The second sees the problem arising from the consequences of 'ageing in place' whereby neighbourhoods in decline leave older people deprived of alternative routes out of the neighbourhood.

While the former predicts a significant interaction between individual and communal indices of poverty, irrespective of the historical links between the individual and their area of residence, the latter suggests that longer exposure to a deprived neighbourhood, rather than age, impacts most upon health.

Results
Using data from the English Longitudinal Study of Ageing, the researchers demonstrate that *length of residence* in deprived neighbourhoods correlates more strongly with age than in advantaged neighbourhoods. When length of residence is held constant, age group differences in the impact of neighbourhood on respondents remains. They conclude that the "environmental docility" hypothesis (which suggests that with increasing age people's behavioural competence becomes more sensitive to environment demands) is supported.

3. The SES health gradient on both sides of the Atlantic[63]
This paper investigates the size of health differences that exist among men in England and the United States and how those differences vary by Socio-Economic Status (SES) in both countries. Three SES measures are emphasised - education, household income, and household wealth - and the health outcomes investigated span multiple dimensions as well.

International comparisons have played a central part of the recent debate involving the 'SES health gradient' with some authors citing cross-country differences in levels of income equality and mortality as among the most compelling evidence that unequal societies have negative impacts on individual health outcomes. In spite of the analytical advantages of making such international comparisons, until recently good micro data measuring both SES and health in comparable ways have not been available for both countries. In order to facilitate the type of research represented in this paper, both the

[62] Gilleard, C., Higgs, P., and Hyde, M. (2004). *The Gerontologist*. Vol.44, Washington.
[63] Banks, J., Marmot, M., Oldfield, Z., and Smith, J. (2007). *Institute of Fiscal Studies Working Papers, W07/04*, January 2007, www.ifs.org.uk/publications.php?publication_id=3834

health and SES measures in ELSA and HRS were purposefully constructed to be as directly comparable as possible.

The analysis presents data on some of the most salient issues regarding the social health gradient in health and the manner in which this health gradient differs for men across the two countries in question.

There are a several key findings:

- across a wide variety of diagnosed diseases, average health status among mature men is much worse in America compared to England, confirming non-gender specific findings reported in earlier research
- there exists a steep negative health gradient for men in both countries where men at the bottom of the economic hierarchy are in much worse health than those at the top. This social health gradient exists whether education, income, or financial wealth is used as the marker of SES
- while the negative social gradient in male health characterises men in both countries, it appears to be steeper in the United States
- these central conclusions are maintained even after controlling for a standard set of behavioural risk factors such as smoking, drinking, and obesity and are equally true using either biological measures of disease or individual self-reports.

In contrast to these disease based measures of health, the health of American men appears to be superior to the health of English men when *self-reported subjective general health status* is used as the measure of health status. This apparent contradiction does not result from differences in co-morbidity, emotional health, or ability to function, all of which still point to mature American men being less healthy than their English counterparts.

The contradiction most likely stems instead from different thresholds used by Americans and English when evaluating their health status on subjective scales. For the same 'objective' health status, Americans are much more likely to say that their health is good than are the English.

Finally, preliminary data indicates that feedbacks from new health events to household income are also one of the reasons that underlie the strength of the income gradient with health in England. Previous research has demonstrated its importance as one of the underlying causes in the United States and these results suggest that that conclusion should most likely be extended to England.

4. Obesity More Than Doubles Mobility Disability in Peri-Retirement Age British Men and Women[64]

Background
The sharp rise of obesity in the U.S., peaking in peri-retirement age groups, is being mirrored in other countries, particularly the UK. Evidence suggests an association between obesity and future mobility disability, but is limited by methodological problems, such as a lack of longitudinal data, use of body mass index (BMI) rather than measures of fat distribution, or by use of self-reported disability status as an outcome without objective performance measures.

Objective
The study sought to identify which measures of body composition best predict subsequent mobility disability and to determine the risk of disability attributable to these measures. 1030 women and 888 men aged 55-75 at baseline from the 1998 Health Survey for England were followed-up in the English Longitudinal Study of Aging in 2002. Baseline weight, height, BMI, waist and hip circumference, and waist-hip ratio were evaluated as markers of risk.

Results
The main outcomes were slow gait speed (measured), difficulty walking a quarter of a mile (self-reported), and difficulty with 2 or more mobility related daily activities (self-reported). Waist circumference was most strongly associated with risk of measured mobility disability: in women and in men. Waist circumference was also strongly associated with self-reported disability, although weight became a comparable independent predictor for self-reported (but not measured) disability.

Conclusions
Fat distribution and weight are major determinants of mobility disability across the peri-retirement ages. This adds to the importance of effective anti-obesity measures across the life-course, particularly for those in low socio-economic groups.

5. The Relationship between Health and Social Participation[65]

Objective
It has been long established that poor health has a negative impact on social participation and quality of life. However the focus of much gerontological research is on the predictors of healthy ageing. The question the study sought to answer is whether engagement in social participation can have a positive effect on the health of the older population. The researchers analysed the relationship between health and social participation using data from over 12,000 respondents aged 50+ years from ELSA collected in 2002/3.

[64] Angleman, S., Harris, T., and Melzer, D. (2004) *The Gerontologist*, Washington:Vol.44, Iss. 1: pg. 352
[65] Higgs, P., Nazroo, J., and Hyde, M. (2004) *The Gerontologist*. Washington: Vol.44, Iss. 1: pg. 288

Results
Bivariate analyses showed a strong relationship between all forms of social participation and physical and mental health, including different dimensions of social participation such as cinema going, organisational membership and voting. After controlling for education, income, age, gender and martial status, those who were actively engaged in forms of social participation such as theatre going, using the Internet, voting at the last election and holidaying abroad were less likely to report poor general health. Similar results were found for the risk of reporting depression and cinema going, using the Internet and holidaying in Britain. The researchers concur from these findings that participation in social engagement has a positive effect on the health of the over 50s in England.

6. Economic capabilities, choices and outcomes at older ages[66]
Intense policy and academic interest in the 'economics of ageing' has come about as a result of the demographic trends that have been experienced over the last 50 years and that are projected for the next 50 years. Key economic policy issues relate to the design of public pensions, welfare systems, healthcare and invalidity benefits, and the regulation of private pensions and other retirement saving.

This paper presents an overview of the beginnings of a research agenda targeted towards increasing the empirical evidence on these issues in England and providing extensive data for subsequent research. The paper focuses on summarising some recent data on how individuals' economic circumstances, and in particular the ability and willingness to work, change from age 50 onwards (reported above). This will be a key factor in determining the ability of economic institutions to adjust to new socio-demographic realities in which individuals are living for longer. Further issues for more extensive empirical research are also identified.

[66] Banks, J. (2006) *Fiscal Studies*, Vol. 27, No. 3: pp. 281-311

7.7 Appendix 7A: ELSA data collection

Household Demographics
The purpose of the Household Demographics module is to keep up-to-date the information on demographics, family structure and relations.

Topics covered are:

- For all current household members: sex, date of birth/age, and relationships between them; also whether in paid employment;
- Household exits: identify people who had left the household, why they had done so (including death) and when;
- At each wave any new entrants are added to the household information (including date joined);
- Children Grid: collect details of children (including step, foster and adopted) that live outside the household (include names, sex, date of birth/age and relationship of child to other household members);

Individual Demographics
The Individual Demographics Module updates more detailed demographic information about each ELSA member. Information collected at previous waves (including HSE) is checked to see if still accurate and any changes recorded.

The details are:

- age last birthday
- sex
- legal marital status
- number of living grandchildren or great grandchildren (children covered in Household Demographics module)
- number of living siblings
- natural parents: if alive, current age; if dead, year of death, age at death and cause thereof; for all, the age left education
- identifies who was the respondent's main carer during childhood and that person's main occupation when the respondent was aged 14 years. This historic information is only collected once from an ELSA member.

Health
The Health module concerns the respondent's state of health, functional limitations, and certain behavioural aspects of their daily life that are likely to influence health. In Wave 2 the nurse visit covers the biomedical aspects of. ELSA has a particularly strong contribution in cardiovascular disease and physical function performance.
The main subsections are:

- Subjective measures including self-reported general health, longstanding illness and limiting longstanding illness.

- Perceptions of presence of problems with eyesight, hearing or walking and, if appropriate, awareness of any eye disease and reasons for difficulty in walking.
- Chronic diseases and psychiatric problems ever diagnosed by a doctor (as recalled by respondent). Continuing participants are then asked to report new diagnoses since the previous interview and to specify when they were told.
- For most of the diseases, there is a single question in each wave about receiving medication or other treatment. Ten forms of cardiovascular disease or its precursors are recorded. For some of these cardiovascular disease (CVD) further details are collected of symptoms experienced recently. The other chronic physical illnesses covered are: chronic lung diseases; asthma, arthritis and osteoporosis, cancers, Parkinson's disease. The psychiatric conditions include depression, dementia and cognitive impairment.
- The respondent's change in memory and cognitive performance over the previous two years - only applies for those with a proxy informant.
- Falls, fractures sustained as a result of falls, and joint replacements.
- Symptoms of pain, dizziness, respiratory symptoms, and urinary incontinence
- Disability and functioning, including avoidance of activities, ability to do activities of daily living (ADL) and instrumental activities of daily living (IADLs), use of mobility aids. Receipt of formal and informal care in connection with these ADLs and IADLs.
- Health behaviours encompass current tobacco and alcohol consumption, and self-report of level of physical activity.

The self-reported mobility questions are complemented by a timed walking speed test for people aged 60 years and over at the time of the interview.

In Wave 2 the health section included questions about quality of care, based on indicators developed in the USA for assessing the care of vulnerable elders (ACOVE).

Nurse Visit

In Wave 2, the core members of ELSA were offered a nurse visit to obtain objective biological information and measures of physical functioning.

Social Participation

The Social Participation modules assess levels of social integration and exclusion. A number of related items are covered in other parts of the questionnaire (particularly the self-completion), including participation in education and voluntary activities (found in Work and Pensions).

In Wave 1 the Social participation module covered caring responsibilities, various social and cultural activities, and membership of organizations. Respondents are asked whether they would like to participate in activities more often. It also covers transport options available as this may be a barrier to participation. Questions on access to key facilities were in the self-completion questionnaire.

In Wave 2 the questions on caring and voluntary work were enhanced by asking about motivations for caring and voluntary work.

The Effort and Reward module was introduced in Wave 2 to bring together psychosocial measures deriving from the hypothesis that an imbalance in these leads to stress and hence to ill health. Questions refer to several aspects of people's lives.

Work and Pensions
The Work and Pensions module collects from each member of the ELSA sample employment details, job characteristics, earnings, occupational pension contributions or receipts, and retirement decisions. It includes information about job search, training and voluntary activities if relevant. One use of the job details is to assign National Statistics Socioeconomic Classification to individuals.

In addition to those areas covered in Wave 1, the Work and Pensions module in Wave 2 also covers:

- why sample members left/started work or changed job and the ways in which their jobs have/could be changed to make it easier for them to continue working;
- expectations of future income from state pensions and from private pensions.

Income and Assets
In the Income and Assets module, those identified as providers of financial information, are asked about their individual and joint income, assets and debts. Summary information on the income and assets of other household members is collected where appropriate. This section of the interview is modelled fairly closely on the Health and Retirement Survey.

Topics covered are:

- Sources of income: state pension, private pension, annuity income, health and disability benefits, non means-tested benefits, intra-family transfers, income from savings or assets whether in the form of interest or dividends, or rent. Salary and some aspects of occupational pension are covered in the Work and Pensions section.
- Assets including value of money accounts, stocks and shares, TESSAs, ISAs, Premium Bonds, life insurance, value of real assets such as property, inheritance, or works of art.
- Information on debts from credit cards, purchase order agreements, formal and informal loans. These are offset against assets.
- Organisation of family finances.

Housing
In the Housing module the financial respondent is asked to provide details of current tenure of main home, housing type and quality, house value and mortgage liabilities.

Topics covered are:

- Financial commitments: identifying the person that rents/buys accommodation, details of rent payments, mortgage arrangements and any loans or other financial measures taken to pay for the accommodation.
- Housing type and quality such as whether facilities and services included in rent, number of rooms, adjustments done to the accommodation/ special features.
- Ownership of durables such as telephone, deep freeze or computer and on access to private vehicles. In Wave 2 respondents were also asked about purchase of durables.
- Expenditure on food. In Wave 2 the consumption questions were extended to clothes, leisure activities, fuel expenditure and transfers to charity.
- Subjective perceptions of housing such as difficulties with paying the rent or mortgage, and problems with the housing such as noise, dirt or decay.

Cognitive Function
The cognitive functioning module covers memory, language and executive function. Dimensions of cognitive function included in both Waves 1 and 2 were: meta-memory; orientation in time; prospective memory; word list learning; verbal fluency; visual search. In Wave 1 basic arithmetic ability was assessed and in Wave 2 literacy was assessed. These last two will not be repeated in Wave 3.

Psychosocial Health
The Psychosocial Health module covers psychological health and perceptions of old age. There are other items of psychosocial risk factors in the self-completion part of the questionnaire. A core part of this module measures depression using the CES-D scale. In Wave 2 this was supplemented by some quality of care questions. In Waves 1 and 3 there were also questions on the respondents' perceptions of the ages at which old age starts and middle age finishes.

Expectations
An Expectations module is included to see whether perceptions of what the future holds foreshadow the reality - and to compare sub-groups to see if such attitudes might be on the pathway to health and income differences between them.

Questions cover expectations of living beyond a specified age, working beyond a specified age, being limited in work by health, and of financial situation. The respondent's financial planning horizon was also measured in Waves 1 and 2.

Self Completion Questionnaire
Core items are the CASP quality of life questionnaire, views of relationships with family and friends, and perceived social status. Details of the previous week's alcohol consumption are also requested.

Items that will appear in some waves but not others are the GHQ12, accessibility of key facilities, and questions about the neighbourhood that provide a measure of social capital. Items added in Wave 2 and expected to be collected biennially are the Diener life

satisfaction scale and questions about perceptions of positive and negative aspects of ageing.

Final Questions

Miscellaneous information that does not easily fit elsewhere is collected in the Final Questions Module. Classificatory information on ethnic group, country of birth, and education is collected. Importantly this section seeks consent from respondents to collect a range of further information from them and about them.

8. ESAW (AGEING WELL: A EUROPEAN STUDY OF ADULT WELL-BEING)

8.1 Introduction: purpose and scope

The European Study of Adult Well-being (ESAW) was designed as part of the Global Ageing Research Network (GARNET), initiated by the Indiana University Center on Aging and Aged. The aim of the parent project is "to develop a globally applicable model of Ageing Well, estimating the direct causal contribution of five key components, along with personal characteristics and culture, to the outcome variable Ageing Well. The five components included in the study are: (1) physical health and functional status; (2) cognitive efficacy (in ESAW renamed self resources); (3) material security; (4) social support resources; and (5) life activity." [67]

ESAW, funded by the European Union, represents a European sub-group of the larger global study, which aims to develop a European model of Adult Well-being, using the five key components and parallel methodology.

The project was carried out in 2002-2003 in six European countries (Austria, Italy, Luxemburg, the Netherlands, Sweden and the United Kingdom). It is based on individual interviews administered by means of a structured questionnaire to national samples of 1,800-2,500 non-institutionalised subjects (e.g. not hospitalised nor in long term care facilities), aged 50-90, in each of the six countries.

A representative population of adults aged 50-90 was selected by each of the country teams. Samples included both rural and urban areas. In the United Kingdom, three distinct sub-samples were drawn representing England, Scotland and Wales. Because of the differences in the settlement patterns and population density, the definition of rurality used was left up to each participating country to decide, according to the relevant definition applied at a national level.

8.2 ESAW and EWAS: differences and similarities

Dimensions of wellbeing

The ESAW study, in fact, situates the five domains under review (physical health and functional status; cognitive efficacy (in ESAW renamed self resources); material security; social support resources; and life activity) as the five key causes of wellbeing, although the wellbeing *outcomes* are "life satisfaction" and "life appraisal". Perceived life satisfaction has been measured through the "life satisfaction index" used by Wood and

[67] Ferring, D., and Wenger, C. (2003) *Comparative Report on The European Model of Ageing Well.* Luxembour: www.bangor.ac.uk/esaw/model%20final%20report.pdf, p 4,

colleagues (Wood et al 1969). Life appraisal has been assessed through Cantril's "Self Anchoring Scale"[68].

In each of the five domains objective information has been collected, as well as the subjective judgments of the respondents of their status (for example, health) or satisfaction with the domain. ESAW investigates the impact of intervening variables (country, age, gender, urban/rural, ethnicity, living arrangements, work status, income and education) on objective and subjective measures of the wellbeing domains under review. The domains and indicators are attached at Appendix 8A.

While such a structured study allows for illuminating differences among countries to be brought into sharp relief, EWAS' approach may prove to be richer in allowing additional variables (such as cultural affiliation) to emerge as important determinants of wellbeing as the analysis proceeds.

Comparative studies have been completed and published on each of the five factors under review, with a two further studies: one on a "European model" of successful ageing and one on socio-cultural differences across participating countries (a very brief summary only of this final report is included below). As well as a summary document encapsulating the research findings, a full paper is published which provides a thorough analysis of current theoretical approaches to the domain, pertinent country policy settings, the methodology chosen for the ESAW research, and the reasons for the choice. The papers on physical health and functional status; cognitive efficacy (renamed self resources), and material security are particularly rich, and would repay close reading, although the physical health study itself is disappointingly narrow.

The reports of results are outlined below, with a brief comment (where relevant) on the domains covered by ESAW, and their differences and similarities with EWAS, and fruitful ways to build on the ESAW approach in the qualitative work to be done over the next eighteen months.

Once again, there is little evidence in the available papers of the involvement of and distribution of research findings to service providers, older people, the private sector and other stakeholders. Each of the papers provide a brief assessment of the policy implications of the findings, but there is no explicit link between ESAW and the policy making processes in the contributing countries.

8.3 Comparative reports

1. Comparative Report on Social Support Resources[69]

[68] Cantril, H. (1965). *The pattern of human concerns*. New Jersey: Rutgers University Press.
[69] Burholt, V., Wenger, CG., Lamura, G., Paulsson, C., van der Meer, M., Ferring, D., & Glueck, J. (2003) Bangor: www.bangor.ac.uk/esaw/social%20resources%20final%20report.pdf

This report presents findings from the ESAW on informal sources of social support available to older Europeans. It provides a cross-country comparison of the characteristics of the sample with regard to selected variables: satisfaction with relationships, OARS social resources scale [70] (contact with others, family and relationships, satisfaction with contact and help) and the Wenger support network typology (five types of support networks based on the availability of local kin, frequency of face-to-face interaction with family, friends and neighbours and community integration). Three Support Network Resource Scales were developed (availability of family, contact with non-kin and community participation) which are also compared among countries.

The report considers the effect of the following variables: country, age, gender, rural or urban residence (location), ethnicity, household composition, work status, education and income on satisfaction with and the availability and types of social support and social participation for older people. ESAW countries are classified according to the comparative levels of participation and engagement in three social spheres, family, friends and community.

The results show that there are both differences and similarities in social support between the six European countries in the study:

- *Age* impacts on satisfaction with relationships, social resources, availability of family, contact with non-kin and community participation. However, it was only for social resources and availability of family that the impact of age was similar for all participating countries. The analyses indicate that in all participating countries the oldest respondents have fewer social resources than younger respondents and fewer available family members.

- *Gender* was a strong indicator of social resources in all countries. *Contrary to previous evidence men had greater social resources than women.* Gender did not intervene strongly across all countries in the other social relationships (availability of family, non-kin relationships and community participation), or satisfaction with relationships.

- Overall, *living arrangements* are found to be very strong indicators of social resources and availability of family in all countries. Older people living alone had the lowest levels of social resources and those living with members of the younger generation had the highest levels of available family.

[70] Older Americans' Resources and Services Multidimensional Functional Assessment, an interview schedule which covers several domains of physical and psychological health that has been proven with respect to its reliability and validity (see, for example, Center for Study of Aging and Human Development. Mangen, DJ & Peterson, WA (1982). Research instruments in social gerontology. (3 vols). Minneapolis, MN: University of Minnesota Pr. V. 3, health, program evaluation and demography. Pg. 24-26, 44-75, 159-160, 315-316

- *Working status* is a good predictor of social resources and availability of family across the countries participating in the study. Work was associated with increased availability of family, but decreased levels of interactions with friends and neighbours.

- ESAW identified greater levels of social resources and family availability in the *rural* areas of the Netherlands and Austria than in *urban* areas.

- There are some *ethnic* differences in social support in Sweden. These differences are likely to be due to ethnic segregation, preferred family forms, filial obligation and settlement patterns. Differences between groups in other countries were not observed, although they may exist, as several distinctly different ethnic groups have been categorised under the terms 'non-European' and 'other-European'.

- The associations between education and social resources differed between countries. For the total sample, education to only primary school level is associated with lower levels of social resources but higher levels of family availability. In Italy, Austria and Sweden the lowest level of education is associated with high levels of non-kin relationships. Education in later life may not be significant if older people lack the resources to socially participate.

- *Income* is a good indicator of social resources in all of the participating countries. However the findings are not so clear-cut for the other areas of social relationships. The inherent difficulties associated with measuring relative income perhaps strengthen the one finding that was applicable to all countries: that *high income is associated with high levels of social resources.*

The report highlights some important cross-cutting themes. Of particular concern to policy makers are:

- The gendered dimension of social resources, which demonstrate *higher levels of informal social resources available to men.*

- The social policy implications of the projected increase in the proportion of older *people living alone, who currently appear to have fewer social resources* than others.

- The differences found between the social resources of *those working and not working,* implying that major changes may occur in people's access to family, friends and community social resources during the transition to retirement.

Income inequities that impact on social resources both nationally and across Europe.

Building on the ESAW approach: social support resources

There are three issues in the ESAW report on social support resources that EWAS could consider in its next phases: family structures, the relative strengths of the social supports of men and women, and education in later life.

The ESAW study has placed emphasis changes in the structure of families:

"Many commentators have noted that the demographic transition within societies has affected the shape of the family, from horizontal to vertical... The size of generations has become smaller but the number of living generations has increased… In the Netherlands, research has shown that 55% of older people belong to three generation families and nearly 20% belong to families of four or more generations…In Sweden, at the age of 50, half of the population has at least one living parent."(page 10)

This pattern is likely to be more accurate for New Zealand Pakeha/European families than others. It would be useful to explore in some depth both family structures and the proximity of family members (including identifying those who live in the same household or very close by) as it is clear that ESAW, and other studies such as SHARE, point to the importance of proximity in increasing the frequency and depth of familial support. As with the SHARE study, close questioning about the kind, degree and direction of family support, and careful investigation of the proximity of kin will allow the researchers to understand how important proximity is in the New Zealand context. The findings may have important implications for housing policy as well as policy on, for example, payment for informal carers.

It goes without saying that ESAW's provocative finding that men have greater informal social supports than women warrants investigation in New Zealand: some amplification of the question lines about who provides social supports may be useful, as would the addition, in qualitative interviews, of a question about whether the respondent has a confidant and, if so, the relationship of the confidant to the respondent.

Finally, the ESAW results are a timely reminder that we ought not to accept education in later life as necessarily conferring a benefit: without social resources older people may not be able to participate. This link is also worth investigating in the future EWAS studies.

2. Comparative Report on Ageing Well and Life Activities[71]

This report presents results from ESAW on participation in life activities and satisfaction (the method used for collecting this information is attached at Appendix 8B) with activity involvement of older adults in Europe. It provides a cross-cultural comparison of participation in both productive and leisure life activities and satisfaction with activity involvement, and relates participation and satisfaction to country, age, gender, urban/rural, ethnicity, living arrangement, work status, income and educational differences. This is represented diagrammatically below:

[71] Droogleever Fortuijn, J., van der Meer, M., Sassenrath, S., Quattrini, S., Ferring, D., Burholt, V., Windle, G., Borg, C., (2003). Amsterdam: www.bangor.ac.uk/esaw/life%20activities%20final%20report.pdf

Conceptual scheme for the study of life activities in Europe

Positions →	**Life activity →**	**Perceptions of ageing-well**
Social	engagement in productive and leisure	perceived life satisfaction
Age	activities	life appraisal
Gender	• participation	
Living	• frequency	
arrangement	• variety	
Ethnicity	• change (disengagement)	
Employment		
status	satisfaction	
Income		
Education		
Health		
Geographical		
Country		
Rural/urban		

Key results

In general, the activity patterns of older adults can be characterised by *variety* in the activity *pattern* and in the specific *type of activity*. In all ESAW countries major differences in variety can be found between groups with different ages, living arrangements, income and education. In the younger age groups two main activity types can be found in all ESAW countries. The first is dominated by individualistic out-of-door activities far from home, and is characteristic of people with high income, high educational level, good health condition and urban dwellers. The second type is dominated by local community centered activities, and is characteristic of people with slightly lower income and educational levels, and is more typical of rural areas. In the older age groups home-based activities are dominant.

In all ESAW countries, participation in life activities and satisfaction with activity involvement are important for wellbeing.

- *Age* is an important indicator of participation in life activities and is weakly related to satisfaction with involvement. In all ESAW countries the oldest age groups participate less and are less satisfied with involvement than younger respondents.

- *Gender* differences are important only with respect to participation in productive activities. In all countries men do more paid work, while women are more active in home-based activities. Gender differences are particularly pronounced in Italy.

- There are minor differences in participation between *urban and rural* areas in the Netherlands, Italy and Austria. There are no urban/rural differences in satisfaction with activity involvement.

- There are some *ethnic* differences in participation and satisfaction: in the UK respondents belonging to the national majority are more active and more satisfied than respondents from minority groups.

- *Living arrangements* are an *important indicator* of participation in life activities and satisfaction with activity involvement. In all ESAW countries people living alone participate less in paid work, out-of-door activities and community centered activities and are less satisfied with activity involvement than people living with a spouse and/or others.

- In all ESAW countries respondents who are *employed* participate more in out-of-door activities and are more satisfied with involvement in productive activities than respondents who are not employed.

- Both *education* and *income* are strong predictors of participation in life activities and satisfaction with involvement in all countries. In particular, respondents with only primary education and respondents with a low income level have relatively low participation and satisfaction levels. Education is especially important in the Netherlands, while income is an important factor in the United Kingdom and Sweden.

The ESAW countries can be classified according to participation in activities and satisfaction with involvement in the following way:

The Netherlands: high variety; high levels of participation overall, but low participation in full-time work; high satisfaction. Education is related to levels of participation and satisfaction.

Luxembourg: low variety; low participation in all activities; high satisfaction. Age is related to differences in participation and satisfaction.

Italy: low variety; low participation with the exception of community-centered activities; low satisfaction. Age, gender and working status are related to participation and satisfaction.

Austria: high variety; moderately high participation levels, in particular in out-of-door activities; low satisfaction. Age is an important factor for participation.

United Kingdom: low variety; high participation in home-based and community-centered activities; high satisfaction. Living arrangements, ethnicity, employment status, income and education all have a strong impact on participation and satisfaction.

Sweden: low variety; low participation with the exception of paid work; low satisfaction. Age, living arrangements, and income are important for participation.

Building on the ESAW approach: participation in life activities and satisfaction
These results raise some interesting questions which may be worth pursuing in the question lines that are being developed at present. First, the results once again underscore the importance of living arrangements, with those living alone participating less, and rating themselves as less satisfied than those who live with others. Second, the variety of activities available has no consistent impact on satisfaction; nor does the level of participation across the population. This suggests that what is at work here is not being captured by the selected intervening variables. Third, the UK results suggest that home-based activities may be worth exploring as a relatively unexamined source of satisfaction.

From a policy perspective three issues stand out:

1. The increasing numbers of older people living alone, who currently have lower levels of participation and satisfaction than people living with others.
2. The impact of income and education on participation and satisfaction.
3. The cumulative effect of social differences on participation and satisfaction, for example for older people living alone in urban areas, with low income.

3. Comparative report on physical health and functional status[72]

While the majority of the ESAW reports consider the effect of the variables of country, age, gender, rural or urban residence, ethnicity, household composition and socio-economic status on the wellbeing domains under review, the health report focuses almost exclusively on the variables of country and age. This significantly weakens its policy interest and utility to EWAS, and no recommendations are made for building on the EWAS approach, beyond a reading of the full report, in particular for its discussion of the interconnection of objective and subjective health status.

The report also covers physical health only – the left hand column in the table below. (The two other columns are covered in the social resources and life resources reports respectively). Nevertheless, the major findings are included here.

[72] Ferring, F., Rahm Hallberg, I., et al, University of Luxembourg, www.bangor.ac.uk/esaw/health%20final%20report.pdf

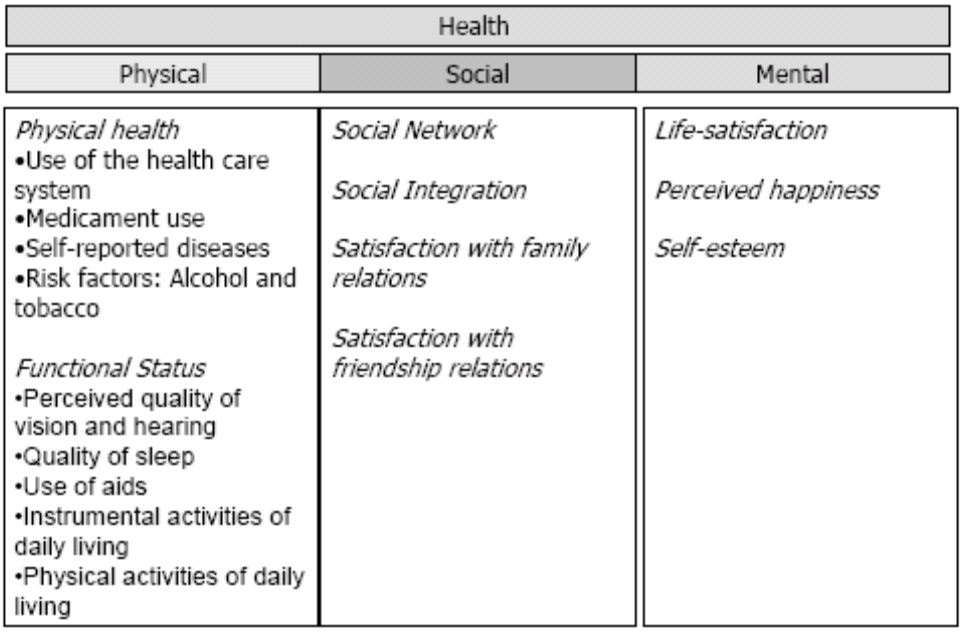


Figure 1: Indicators of physical and functional status in ESAW.

Areas of focus

Aspects of individual health and functional status were considered using self-reports from people aged 50-90 years. The results highlight disease prevalence, medication use, functional status, the use of prosthetics, and health risk behaviours.

Functional status was measured by the self-reported competence to perform seven instrumental and physical activities of daily living. Instrumental activities encompassed those which would guarantee autonomous living (e.g. shopping and preparing meals), whereas physical activities described functioning and dependency (e.g. whether respondents needed help getting in or out of bed). The use of eleven aids and appliances (apart from glasses and hearing aids) was investigated. Alcohol consumption and cigarette smoking were used as indicators of health risk behaviours. Use of medication was investigated by asking respondents about their frequency of use of a list of 20 common medications.

Use of the health care system was measured by counting how many times in the last six months respondents had seen a doctor (or health professional) other than as an inpatient in a hospital; days they were so ill that they were unable to carry on usual activities; days in a hospital for physical or emotional health problems; days in a nursing home or rehabilitation centre for physical health problems; and need medical care or treatment beyond what they are receiving.

- *Disease prevalence* under 75 years was low in each national sample, but there was a pronounced increase in the number of self-reported diseases in the oldest age groups. Women in the older age groups reported more illnesses than men of a comparable age. High blood pressure, arthritis and rheumatism were the most frequently reported diseases in all six countries.

- *Medication use* increased with age. Women took more medicaments than men. High blood pressure medication and prescribed painkillers were the most often used medications in all six countries, followed by arthritis medication and blood thinner medicine. Digitalis pills for the heart and hormones were most frequently reported only in the Netherlands and Sweden.

- *Functional status:* In each country a majority of older people reported no problems with instrumental activities or physical activities. However the capability to perform instrumental and physical activities decreased with age and was more pronounced for female respondents aged 80 to 90.

- *Aids and appliances:* the use of partial or complete false teeth was most frequently reported (42%); followed by a cane or walking stick (8%).

- *Health risk behaviours:* Sweden had the highest proportion of respondents consuming alcohol (80%) followed by comparable proportions (70%) in the Netherlands, Luxembourg, Austria, and the UK. The smallest proportion of alcohol consumption was observed in Italy (56%). Austria reported the highest total quantities consumed, followed by Sweden. Lower levels were reported by the Netherlands and Luxembourg, with the lowest levels reported for Italy and the UK. For all countries alcohol consumption decreased with age (from 70 onwards) and women drank less than men. Around one-fifth (21%) of older people in the total sample smoked. For all participating countries smoking decreased with age. In all countries men smoked more than women.

- *Overall health status:* the Netherlands, and to some extent, the Swedish sample, showed the best ratings of health status compared to all other national samples. The UK sample was characterised by the lowest ratings of general health. Luxembourg and Italy showed more pronounced ratings of moderate and deteriorating health. The Austrian sample showed values in between.

- *Use of the health care system:* results did not show a frequent use of the health care system, which also indicates a comparatively high health status with respect to these criteria. The largest differences between the participating countries were in the number of visits to doctors and in satisfaction with the health care system.

- *Gender, living arrangements and income:* The data clearly showed that older women with low incomes and living alone are over-represented within the group with deteriorating health. The probability of elderly women being bereaved and having reduced financial means is quite high. Taking the results so far together, being a woman, living alone and having a low income represents a pronounced risk category for deteriorating health in old age.

4. Comparative Report on Self Resources in Advanced and Old Age[73]

The ESAW project focuses on the role of the "self" as a resource for a subjectively good old age. While modern theories of life-span psychology no longer view ageing as a necessarily negative process consisting exclusively of losses, it is the time of life that involves most losses, and a time in which losses outweigh gains. ESAW's approach is to emphasise the fact that the various facets of the self and the individual's belief system constitute an important resource that older people draw upon when facing challenges in other domains.

ESAW assessed self-esteem, locus-of-control, resilience and mental health of respondents. These areas were evaluated by established self-report instruments often used in international research agendas. Self-esteem was assessed by the widely used measure of global self-esteem designed by Rosenberg[74]. Control was assessed by the Spheres of Control Scale developed by Paulhus[75]. Resilience was assessed by the Resilience Scale developed by Wagnild and Young[76]. ESAW also used the mental health scale from the Older Americans' Resources and Services Multidimensional Functional Assessment.

Key results are summarised below:

- Significant differences between *age groups*, with resource levels decreasing with increasing age, were found somewhat more often than would have been expected, given the general stability of self-resources in old age reported in the literature. However, the differences found in the ESAW study were generally small. Inconsistent findings between studies might be due to sample size, with the ESAW sample characterized by a solid statistical power.

- *Gender* differences were significant for self esteem, personal control, interpersonal control, socio-political control, and mental health, with men showing higher levels than women in each of these scales. As with age, differences for gender are generally small. These findings, while being in agreement with the literature, are interesting in light of the fact that the ESAW findings *do not reveal any gender difference for resilience.*

- Significant differences between individuals living in *rural and urban* areas were found for sociopolitical control (with people from urban environments showing higher levels of sociopolitical control than people living in rural areas), and resilience and mental health (with people from rural areas having higher levels of resilience and enjoying better mental health than people from urban areas).

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[73] Weber, G., Glück, J., Sassenrath, S., and Heiss, C. (2003) University of Vienna: www.bangor.ac.uk/esaw/self%20resources%20final%20report.pdf

[74] Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

[75] Originally designed to assess personal control, interpersonal control, and socio-political control. Paulhus, D.L., & Christie, R. (1981). *Spheres of control: An interactionist approach to assessment of perceived control*. In H.L Lefcourt (Ed.), *Research with the locus of control construct* (pp. 161-188). New York: Academic Press.

[76] www.resiliencescale.com/

- Differences between *ethnic groups* were significant only for mental health. In all cases, individuals from the national majority reported better levels of mental health than, individuals from non-European countries. Individuals from other European countries were in between. These findings may be related to long-lasting cultural adaptation and assimilation issues. A significant interaction was found between ethnicity and country on mental health.

- *Household composition* was a general predictor of self-resources, with significant differences in self esteem, personal control, interpersonal control, and mental health. In all of these scales, individuals living alone reported lower levels than individuals living with others. This effect may be related to the more general gender effect, as more women than men are living alone in old age.

- There were significant differences in *working status* in all scales, with working individuals showing higher levels of self resources than non-working individuals. Changes in life situation usually associated with old age are highly associated with retirement. Before retiring, individuals may not be "feeling old" at all.

Building on the ESAW approach: Self Resources
Most of the results noted above are ones which the EWAS research already has in view. However, when one looks across all the factors which ESAW assessed (self-esteem, locus-of-control, resilience and mental health using established self-report instruments often used in international research agendas) the gender differences found in self-esteem and locus of control (and the lack of gender difference in resilience) suggest a closer investigation of these areas in EWAS's qualitative interviews could be worth considering.

5. Comparative Report on Ageing Well and Material Security in Europe[77]
The following areas of material security were taken into consideration:

- *occupational status* (employed full-time, employed part-time, retired, not employed & seeking work, not employed & not seeking work);

- *income and availability of assets* (earnings from income, rental, interest, insurance payments, social security payments, veteran administration benefits, disability payments, unemployment compensation, retirement pension from job, alimony or child support, scholarships and stipends, regular financial assistance from family, welfare payments and aid to dependent children, social assistance – assets are not defined in the report);

- *housing status and adequacy* (house owners, whether outright or paying mortgage, renters, responsible for all, part, or none of the rent; those living in public housing

[77] Lamura, G., et al (2003) Bangor: www.bangor.ac.uk/esaw/material%20security%20final%20report.pdf

or receiving a rent subsidy; subjective assessment of whether housing is decent, and safe);

- *availability and adequacy of food resources* (pay for own food, needing help to pay for or obtain own food, help with paying for food or meals (family or friends, food stamps or government aid, prepared food from agency or organisational programme));

- *health insurance availability and utilisation (*covered by public or private health care; able to pay for medications, glasses, dentures, dentist, optician etc)

- *perceived adequacy of material resources* (assets and financial resources sufficient to meet emergencies, expenses too heavy to meet payments, need more financial assistance, financial situation better, the same or worse than those of the same age, financial resources meet needs very well, fairly well or poorly, usually have enough money to buy some luxuries, think that in future will have enough money to meet needs).

The report considers the effect of country, age, gender, rural or urban residence, ethnicity, household composition and education on material security variables listed above, and the relationship between these variables and wellbeing.

Key results:
Income was calculated for terciles (thirds) per country.

- *Age related inequalities* are quite low overall, with almost none in Luxembourg. In Sweden and Austria differences are greater with fewer respondents in the younger age group in the lowest income tercile. In Luxembourg, Austria and Italy the younger age groups are most satisfied with their income; in the Netherlands, UK and Sweden, the most satisfied are the older age groups.

- *Gender* related income inequalities are evident in Austria (where women are poorer than men), and almost absent in Italy.

- Low income is associated with *rural* locations in Italy, Austria and the Netherlands.

- Belonging to an *ethnic minority* increases the probability of belonging to the lower income tercile, especially in the UK and Sweden.

- In the UK, the Netherlands and Sweden, living arrangements make a significant difference to income, with those living alone more likely to have lower incomes and people living with a partner more frequently belong to the higher income tercile.

- *Educational level* is positively associated with income *in all samples*

- Cross-national differences were identified for *housing tenure*. About half of the respondents in Austria and the Netherlands are house owners, compared to about 80% in Italy and Luxembourg. British and Dutch citizens obtain more public housing support than others, in the form of rent subsidies and/or public housing.

- *Data on health care insurance* reveal that in most ESAW countries – where universal coverage is in practice delivered by national health care systems – a growing quota of the population is resorting to supplementary private health insurance. The highest level of supplementary insurance for hospitalisation or doctor bills is in Luxembourg and the lowest in Italy.

- "*Material adequacy*": a greater proportion of respondents in Italy, the UK and Sweden than in other countries state that they are not able to cover health care expenses. The same countries show a higher proportion who need help in paying for their food. Austrian respondents are more likely than others to say they do not have enough financial resources to meet emergencies.

- Regular payments of expenses are a problem for over one-fifth of the whole ESAW sample. This is especially the case for Swedish respondents and to a lesser extent for Italians, British and Austrians. Despite these difficulties only the British and Italians admit a need for more financial assistance.

- Respondents from the Netherlands and Luxembourg most seldom think of themselves as being in a worse financial situation than other people of the same age. On the other hand, British, Swedish and Austrian respondents are more likely to report being in a worse financial situation than others.

- *Material security indicators and wellbeing*: the strongest correlations are found between wellbeing and *economic satisfaction* (**"**sufficient resources to meet emergencies", the "ability to make payments", "enough money to meet needs in the future"), general material security, self-assessed income adequacy and the availability of enough financial resources to meet needs or to buy small luxuries.

- *Material security and life satisfaction*: more satisfied subjects are generally employed full time, own their own home, do not live in public housing nor receive a rent subsidy, feel they live in a decent and safe place, and have enough resources to meet payments. Among those who say they do not have enough resources, those who need help paying for their food are in the worse position, showing the lowest levels of satisfaction.

- *Perceived life satisfaction*: the strongest correlations are found with aspects such as economic satisfaction, as well as the general feeling of individuals about the "ability of their financial resources to meet their needs" and their "own financial position compared with other people"), the general material security score, self perception of income adequacy, and the availability of enough financial resources to meet needs or to buy luxuries. *Variables such as the availability and kind of*

health care insurance, working status or the source of income appear much less important.

- *Economic adequacy:* older people in Luxembourg and Austria have the highest levels of economic adequacy and those in Italy the lowest. Economic adequacy:
  - decreases in *older age* groups in Italy and Austria, but increases in the Netherlands, the UK and Sweden;
  - is higher in Dutch and British *rural areas*, but in the urban areas of the other countries;
  - is higher for national majorities, and lower for non-Europeans;
  - is lower for those who live alone or with children, compared to those with other living arrangements; and
  - is universally higher among older people with a higher level of education level.

Building on the ESAW approach: material security and wellbeing

There is little in ESAW's examination of material security and wellbeing that would add to EWAS's current approach. The one additional element that may be worth teasing out in the interviews is to enquire, in addition to the total household economic resources and their availability to meet the needs of the respondent, some investigation of whether the respondent perceives themselves as *needing help* in meeting material needs.

6. *Comparative Report on the European Model of Ageing Well*[78]

Age-related changes are primarily described by an increasing rate of losses compared with a decreasing number of gains, and the adaptation to those changes poses one of the core questions of gerontological research. Within the European Model of Ageing Well this question was addressed by relating two indicators of psychological wellbeing to the individual estimation of four life domains. In particular, life satisfaction and feelings of self-worth were chosen as indicators of psychological wellbeing, and these were best predicted by estimates of (1) material security, (2) physical health and functional status, (3) social support re-sources, and (4) life activities.

Structural equation modelling was used to estimate the predictive power of the four life domains under consideration for life satisfaction and feelings of self-worth. Each life domain as well as the criteria was measured by using two indicator variables. The authors look to integrate their findings in a single explanatory model:

[78] Ferring, D., Wenger, C., Hoffmann, M., Petit, C., Weber, G., Luck, J., Burholt, V., Woods, B. Balducci, C. Spazzafumo, L. & Thissen, F. (2003). The European Model of Aging Well. European Study of Adult Well-Being (ESAW): Comparative report. Bangor, University of Bangor, Wales, UK (website in:%% 20final http://www.bangor.ac.uk/esaw/model 20report.pdf)

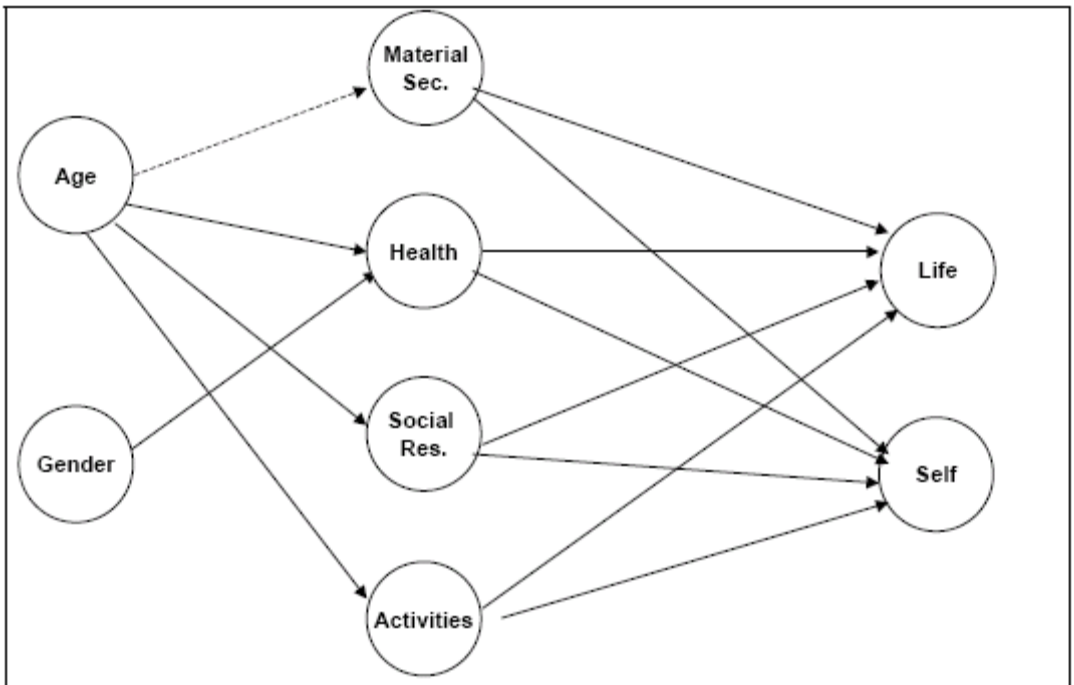

Figure 9: Model integrating indirect effects of age and gender on life satisfaction and self-worth on the basis of latent correlations.

Ageing well final report p 32

Results:
In the total sample:

- Perceived material security represented by far the most important predictor of life satisfaction (γ=.44), followed by perceived health status (γ=.24).
- High frequency of life activities (γ=.14) as well as perceived social support resources (γ=.13) predicted life satisfaction in a less pronounced way.
- Material security (γ=.23), perceived health status (γ=.20), and social support resources (γ=.20) had comparable predictive weights for feelings of self-worth;
- Life activities had the lowest predictive power (γ=.12).

Policy implications.
The authors stress the following policy implications:
"Material security proved to be one of the most important predictors, and the results emphasise the need for legislation, which protects (or enhances) pensions, since people need to feel that their income is secure for the future. Social policy would be well advised to promote measures which guarantee material security.

In the long term the results also have clear implications for the *educational system*, since those, who have better education and skills are able to get better jobs, which secure material security in old age

The results stress the importance of health to older people. Consideration should be given to *preventive health care information and education* commencing *early in the ageing process*. Impaired mobility can result in reduced access to social resources as well as life

activities, and this fosters the need for appropriate transport facilities providing easy entry to buses and trains. Domiciliary services which maintain people near to family and friends and allow for a comparatively active life should also be encouraged.

All in all, the perception of the life domains under consideration explained differences in life satisfaction and self-worth, and this points to the importance of the *psychological make-up* of people, which seems to be critical in the adaptation to ageing. Results reported here therefore have implications for *child-raising and education in general*, as well as social programmes aimed at compensation for the aggregate effects of disadvantage resulting from low educational expectations, race, gender, and poverty.

Special programmes developed for older people should aim at *reinforcement of self-worth and competencies*, and should value the experience and uniqueness of older people." (summarised from pp 33-34 *Ageing well* final report)

Building on the ESAW approach: material security
The importance of material security for successful ageing is already well integrated into the EWAS approach. As noted above, the ESAW examination of self worth, disaggregated into self-worth and resilience, could be fruitful avenues for EWAS to explore in the upcoming qualitative interviews, as they are powerful protective factors against the impact of deterioration in objective measures of wellbeing.

7. Contextualising Adult Well-Being in Europe: Report on Socio-Cultural Differences in ESAW Nations[79]
The report considers the ESAW countries across the dimensions of demography of ageing, the geographic/national context of ageing, and national political and social systems.

1. Demography of Ageing
Analysis of demographic trends in the EU/ESAW countries reveals elements both of uniformity and diversity.
Unity highlights

- A growing importance of older people in society both in absolute numbers and in proportion.
- Life expectancy is increasing for both men and women throughout the EU; women still significantly out-number men in the oldest age groups.
- The older population is itself ageing.
- The heterogeneity of the older population is increasing.

Diversity highlights

- Italy is now the EU's most aged country.

[79] Scharf, T., van der Meer, M., Thissen, F., & Melchiorre, MG. (2003). www.bangor.ac.uk/esaw/model%20final%20report.pdf

- Italy has a high focus on familism, where multi-generational households are still quite common.
- Sweden is associated with a strong degree of de-familisation. Sweden also has a low proportion of households in which older people live with persons other than their partner.
- The remaining ESAW countries can be regarded as a heterogeneous 'Western Europe' cluster, characterised by familism and defamilisation, and a relatively inter-mediate aged population.

2. The Geographical Context of Ageing

Cultural diversity remains strong despite the influence of socio-economic processes that tend to promote homogeneity.

Analyses of national approaches to public policy, socio-economic and cultural dimensions, value orientations and family structures point to the *persisting relevance of the nation as* a context for ageing well.

While all ESAW countries can be classed as post-industrial societies, industrial production in the economies of Austria, Italy and Luxembourg, and the persisting role played by agriculture in the national economies of Italy and Austria remain important distinctions.

3. Overview of Political and Social Policy Systems

National political and social policy systems exert a direct impact on adult wellbeing, whilst also influencing the development of national age structures.

Political systems

Democratic systems evolved slowly over time in four nations (UK, Luxembourg, the Netherlands and Sweden) but were imposed by external factors in Italy and Austria.
A moderate multi-party system predominates in Austria, Luxembourg, the Netherlands and Sweden. Italy is in a state of transition in relation to its party system. The UK has an established two-party system. Austria has a fully developed federal structure.

There is a striking degree of similarity between Luxembourg, the Netherlands and Sweden in terms of their political systems. Austria and Italy also share some common features. The UK stands out as having a political system that differs in key ways from that of other ESAW nations.

Social policy systems

The UK represents an isolated example of an Anglo-Saxon welfare state that displays residual characteristics. The result is a high degree of inequality in old age, and relatively limited resources devoted to health and social care.

The Swedish welfare state has been subject to change in recent years; however, there is still evidence of its universalistic characteristics in the way in which it provides for the material and social wellbeing of its citizens. While the Netherlands displays elements of

the Nordic model in relation to universalistic provision of key benefits and services, its social security system is based on the aim of maintaining individuals' existing positions in the social hierarchy.

Austria and Luxembourg correspond most closely to the traditional corporatist model of a welfare state. Italy represents something of a paradox. Alongside its 'Bismarckian' social security system and a universal system of health care, it maintains a social care system founded on a traditional familistic model.

8.4 Appendix 8A

Constructs and indicators within the European Model of Ageing Well

Domain/construct	**Indicators**	***Aggregate* indices, measures, and items being used**
Health	Self reported diseases Self reported medications	Number of diseases out of a list of 26 diseases (OARS Multidimensional Functional Assessment Questionnaire) Number of medications out of a list of 20 medications (OARS Multidimensional Functional Assessment Questionnaire)
Material security	Sufficiency of present financial resources	"How well do you feel your needs are met by the financial resources you have?" (3-point rating scale (poorly to very well)); (OARS Multidimensional Functional Assessment Questionnaire) "At the present time, do you feel that you will have enough money for your needs in future?" (Dichotomous rating; Yes, no). (OARS Multidimensional Functional Assessment Questionnaire)
Social support resources	Social integration	Aggregate index comprising the following items: • "How many people do you know well enough to visit in their homes?" (4-point rating scale: none, 1-2, 3-4, 5 or more); • "About how many times did you talk to someone - friends, relatives, or others, in the past week (either in person, on the telephone, or e-mail)". (4-point rating scale: not at all, once, 2-6 times, once a day or more). • "How many times during the past week did you spend some time with someone who does not live with you, that is you went to see them or they came to visit you, or you went out to do things together?" (4-point rating scale: not at all, once, 2-6 times, once a day or more). (OARS Multidimensional Functional Assessment Questionnaire)
Social support resources	Communication and contact	Aggregate index comprising the following items: • "If you have friends in this community/

		neighbourhood, how often do you have a chat or do something with one of your friends?" (5 point-rating scale: never, daily, 2-3 times a week, at least weekly); • "How often do you see any of your neighbours to have a chat with or do something with?" (5 point-rating scale: never, daily, 2-3 times a week, at least weekly). (Practitioner Assessment of Network Type (PANT), Wenger, 1989[80]).
Life activities	In-house activities	Frequency of four in-home activities: • "participation in home maintenance and housekeeping", "participation in hobbies and indoor activities", "participation in social activities at home (i.e. visiting, phoning)", and "occupation with the media (i.e. newspaper, internet)" (Lifestyle Factors and Health Outcomes for Older Adults, Hawkins et al. 1996[81])
Life activities	Out of house activities	Frequency of five activities: outdoor activities, sports, cultural activities (i.e. movies, concerts), going-out (i.e. restaurant, pub), and miscellaneous activities (Lifestyle Factors and Health Outcomes for Older Adults, Hawkins et al. 1996)
Self-worth	Self esteem	Aggregate index of the "Self-Esteem-Scale" (Rosenberg, 1965), an often used and soundly tested instrument to measure global self-esteem. The 10 Items of the scale are rated on a 5-point scale ranging from "strongly agree" to "strongly disagree".
	Resilience	Aggregate index of the Resilience scale, a component of the OARS Multidimensional Functional Assessment Questionnaire (Fillenbaum, 1988). The scale used here comprised of 20 items to be answered on a 7-point rating scale, ranging from "strongly disagree" to "strongly agree".

[80] Wenger, C. (1994). *Support Networks of Older People*. Bangor: Centre for Social Policy Research & Development. (PQUAL1)

[81] Hawkins, B. A., Eklund, S. J., Yang, J., Binkley, A. L., Weixing, S., Hseih, C. and Li, X. (1996). *Lifestyle Factors and Health Outcomes of Older Adults in China, Australia and the United States ; Final Project Report in English and Chinese*. School of Health, Physical Education and Recreation, Indiana University, Bloomington, Indiana.

Life satisfaction		Two test halves constructed from the "Life satisfaction scale" by Neugarten, Havighurst and Tobin (1961[82]), a soundly proven measure of life satisfaction comprising 13 statements to be answered on a 3-point rating scale, ranging from "strongly disagree" to "not sure".

[82] Havighurst, R.J., Neugarten, B.L., Tobin, S.S., Kane, R.A. & Kane, R.L. (1981). *Assessing the elderly: A practical guide to measurement.* Lexington, Mass.: Lexington Books. Pg. 174-189

8.5 Appendix 8B

Participation in life activities: measuring satisfaction
A five-point scale ranging from 'highly dissatisfied' to 'highly satisfied' was used to indicate satisfaction with the involvement in productive or leisure activities. With respect to leisure, the respondents were also asked how they felt about their leisure involvement compared with five years ago. In this case a three-point scale was used (better, about the same, or worse).

Attention is paid to the overall life satisfaction of the respondents by using Life Satisfaction Index Z (Wood et al. 1969), and an instrument based on Cantril's Self Anchoring Scale (1965). In the Index scale, respondents are asked to indicate whether they agree or disagree or are not sure in relation to 13 statements pertaining to satisfaction with life. Scores range from 0 (the lowest rate of satisfaction) to 26 (the highest possible satisfaction rate).

The Anchoring Scale was developed to incorporate the respondent's cultural and personal perceptions into a rating of life satisfaction. Respondents are asked to rate their present life situation in relation to what they consider to be the worst possible and best possible life. A blank 10-rung ladder is presented visually and respondents indicate responses by placing X on a rung that represents their current life situation. The top of the ladder represents the best life situation imaginable and the bottom the worst life situation. In some countries a ranking on the basis of commonly accepted report marks was made, with the numbers 1 (worst) to 10 (best) scores. (page 16, Life Activities report).

9. THE ESRC GROWING OLDER PROGRAMME

9.1 Introduction: purpose and scope

The Economic and Social Research Council (ESCR) Growing Older Programme consisted of 24 research projects focussed on how to extend the quality of life in old age. They were commissioned together as part of a £3.5 million investment by the UK Economic and Social Research Council (ESRC). In its introductory web page the Council says:

"It is expected that, by operating as a concerted programme, this research effort will produce added value and make a substantial impact on policy and practice."[83]

The Programme ran from 1999 to April 2004**.**

The Programme had two main objectives:

- To pursue a broad-based multi-disciplinary programme designed to generate new knowledge on extending quality life.
- To contribute to the development of policies and practices in the field and, thereby, to make a direct contribution to extending quality of life. (There is no readily available information on the extent to which the Programme achieved this goal).

The Programme covered six research topics:

Defining and Measuring Quality of Life

- Housebound older people
- Quality of life of healthy older people
- Adding quality to quantity
- Spiritual beliefs and existential meaning in later life
- An anthropological investigation of lay and professionals' meanings of quality of life
- Environment and identity in later life

Inequalities in Quality of Life

- Influences on quality of life in early old age
- Inequalities in quality of life among people aged 75 years and over
- Ethnic inequalities in quality of life at older ages
- Older people in deprived neighbourhoods
- Exploring perceptions of quality of life of frail older people during and after their transition to institutional care

The Role of Technology and the Built Environment

- Transport and ageing

Healthy and Productive Ageing

- Quality of life and real life cognitive functioning

[83] http://www.growingolder.group.shef.ac.uk/AboutTheProgramme.htm

- Older people's experience of paid employment
- Evaluating the impact of reminiscence on the quality of life of older people

Family and Support Networks

- Older men, their social worlds and healthy lifestyles
- Older widow(er)s
- Quality of life and social support among people from different ethnic groups
- Family work and quality of life
- Loneliness, social isolation and living alone in later life
- Grandparenthood

Participation and Activity in Later Life

- Empowerment and disempowerment
- Older women's lives and voices
- Older people and lifelong learning

A brief, selective, summary of each project is included in section 9.3. The summaries seek to highlight those findings or policy implications that are relevant to EWAS researchers' interests or methodological approaches.

9.2 Ways to build on the Growing Older approach

The *Growing Older* programme is of interest to New Zealand researchers, because it is a series of investigations which actively sought to build a knowledge base and shape policy thinking about older people in a country whose social policy settings and institutional structures are similar to New Zealand's. For those reasons alone it would be worthwhile for EWAS researchers to be in touch with the Council to understand the impact of the research on policy.

New Zealand and the United Kingdom differ, however, in their social structures – although New Zealand's older population remains predominantly Pakeha (European), with family structures largely inherited from the United Kingdom, Māori as tangata whenua, and the large numbers of Pacific people in New Zealand, have very different family structures, and they are, over time, shifting the family structures and values of the rest of the population.

The primary value of the *Growing Older* programme to EWAS is the very broad range of dimensions of growing older that are covered in the 24 studies, most of which have different respondent sets and different mixes of methodologies. The programmes that are potentially very fruitful for EWAS to review, because they fall outside EWAS's current core interests, are:

- The systematic investigation of the impact of serious and sustained religious engagement (rather than simply attendance at services) on the ability of older people to maintain wellbeing in the face or serious loss (Project 4)
- The bringing to light of the way older people conceived of their lives, and of quality of life, in contrast to professionals' categorisations. This is more than "subjective wellbeing", which is well examined in the Berlin Ageing Study and others: it points to the need to understand the primary narratives old people use to make sense of their lives across all of the wellbeing domains (Project 1).
- Examining the attitudes of transport professionals to older people, and older people's preferences for transport (Project 12), to understand more clearly the

points of resistance or leverage in changing transport policy to meed the needs and interests of older people.

- The central importance of agency (or control, or efficacy) in many studies for the wellbeing of older people
- The involvement of older people themselves in the design, delivery and evaluation of research (Projects 23 and 24).
- In addition, innovative approaches to the dissemination of research findings, such as an interactive CD Rom incorporating video, audio, text and film stills to represent findings visually as well as in written format (Projects 11 and 24) are valuable.

9.3 ESRC growing older programme: research summaries[84]

Defining and Measuring Quality of Life (6 projects)

1. Housebound older people: the links between identity, self-esteem and the use of care services[85] (John Baldock and Jan Hadlow)

The study

The study sought to understand why some disabled older people living in the community do not seek or do not accept health and social care services to which they are entitled. The methodological innovation was to link two generally separate approaches to understanding the lives of older people: the social policy focus on needs and services; and an approach drawn from social gerontology that involves the biographical study of 'ageing from within' and how people manage their identities as they grow older. Thirty-five people, aged 75 and over and living alone, who had recently become housebound because of a limiting physical condition were interviewed twice over six months using established qualitative schedules.

The findings

Firstly, the research showed that:

- Older people who have recently become housebound suffer an initial drop in self-esteem but for most this soon recovers as they redistribute the bases on which self-confidence is built away from health and social contacts and towards family and aspects of mental and spiritual life.
- Self-esteem is more likely to be sustained where there are changes in routine or increased contacts with family or other people.
- Self-esteem is more likely to stay low or fall where health worsens or there is little change in routine or contacts.

Policy conclusions:

- Service providers should intervene early in almost any way that increases an older person's contact with others but they should expect resistance from the older person.

Secondly, the research showed that:

[84] Growing Older Programme Project Summaries. Economic and Social Research Council http://www.esrc.ac.uk ISBN 0-86226-296-8

[85] www.growingolder.group.shef.ac.uk/JohnBaldock_F4.pdf

- Old age is indeed a time of 'identity work' in which people search for ways to sustain their self-images and to link their present existences to their previous lives. There is a need to be seen, and to see themselves, not as needy service users but as whole persons with lives of value and achievement. As a result they focus less on practical needs than service providers might wish to do.
- Few older people mentioned services when asked about sources of quality in their lives even though 15 had been assessed and ten were receiving home care services.
- When describing their lives they used categories and ideas unlike those used by professionals: 'Self-talk' (a focus on feelings, relationships, selves) compared with 'Needs-talk' (a focus on resources, abilities, disabilities)
- There are limits to the degree to which older peoples' conceptions of their circumstances and needs can be reconciled with those of potential service providers.

2. Quality of life of healthy older people: residential setting and social comparison processes[86] (J Graham Beaumont and Pamela Kenealy)

The study

The study investigated the perceived quality of life of healthy older people within the researchers' locality, and in particular how their living arrangements (living alone, with a partner, in sheltered housing or residential accommodation) contributed to how they evaluated their quality of life. It also investigated how making social comparisons with others influenced the judgments which participants made.

Key findings

- The most important factors in determining a perceived good quality of life were the individual's perception of their health, freedom from depression, personal optimism, well-retained cognitive abilities and aspects of the social environment.
- The common themes concerning quality of life were issues related to family, health, and to the conditions associated with the home.
- Those who were living with their partner tended to report the highest quality of life; those in residential homes, irrespective of their health or disability, reported the poorest quality of life.
- Depression leads to a lower perception of quality of life, rather than a poor quality of life leading to depression.
- The dominant social comparison strategy was a downward contrast (to consider yourself unlike those who are 'worse off ') as an adaptive approach which enhances perceived quality of life
- Those who engaged in voluntary work tended to have a decline in their perceived quality of life.
- Deficits in autobiographical memory are associated with a better perceived quality of life and a lower level of depression.
- Reports of perceptions of quality of life are heavily influenced by the nature of the question which is asked.

3. Adding quality to quantity: older people's views on their quality of life and its enhancement[87] (Ann Bowling, Zahava Gabriel, David Banister and Stephen Sutton)

[86] /www.growingolder.group.shef.ac.uk/Go-Findings_20.pdf

The study
The study set out to explore older people's definitions of, and priorities for, a good quality of life. Nine hundred and ninety nine randomly sampled people aged 65 and over, living at home in Britain, were interviewed for the study. The interview schedule was semi-structured. The respondents were broadly similar in their socio-demographic characteristics to those of people aged 65+ in Britain from mid-term population estimates from the 1991 Census, and compared with respondents aged 65+, living at home, to the comparable General Household Survey.

Key findings

- Most men and women rated their quality of life as good in varying degrees, as opposed to just all right or bad.
- Quality of life deteriorated with older age, with almost three-quarters of the group aged 65-69 rating their lives overall as 'So good it could not be better' or 'Very good' in comparison with about half to a third of those in older age groups
- The main drivers of quality of life in older age were:
    - People's standards of social comparison and expectations in life.
    - A sense of optimism and belief that 'all will be well in the end' rather than a tendency to think the worst
    - Having good health and physical functioning.
    - Engaging in a large number of social activities and feeling supported.
    - Living in a neighbourhood with good community facilities and services, including transport.
    - Feeling safe in one's neighbourhood.
    - Self-efficacy, and having a sense of control over one's life was possibly a mediating variable.
- These factors contributed far more to perceived quality of life than indicators of material circumstances, such as actual level of income, education, home ownership, or social class.
- The results of the modelling were supported by the open-ended survey responses and by the qualitative interviews, with the addition of some other key factors – particularly, the importance of the perception of having an adequate income, and of retaining independence and control over one's life.

4. Spiritual beliefs and existential meaning in later life: the experience of older bereaved spouses[88] (Peter Coleman, Fionnuala McKiernan, Marie Mills and Peter Speck)

The study
The current generation of British older people was brought up within a much more religious society than today's. Yet little is known about the belief systems they currently

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[87] www.growingolder.group.shef.ac.uk/Bowling_F7.pdf
[88] www.growingolder.group.shef.ac.uk/Coleman_Findings_3.pdf

hold. This research explores the significance of spiritual belief for the wellbeing of a sample of older bereaved spouses drawn from a Christian background.

The study set out to investigate older people's religious, spiritual and other beliefs and understandings about existential meaning in the context of bereavement of spouse. The study was an exploratory one, aiming to provide rich descriptions of the issues that arise relating to belief and support for it following bereavement. With the help of GPs and funeral directors in the three cities/towns in the South of England, the researchers recruited 28 bereaved spouses to the study, 22 women and six men. They interviewed three times, over the one-year study period, all but two of these people.

Key findings

- Most of the sample held to a Christian belief system but only a minority attended church worship or spoke to church ministers or members about matters of belief.
- Strength of belief, i.e. sureness with which participants held to belief in the efficacy of a spiritual power outside themselves, was related to their adjustment to bereavement.
- None of those with strong belief systems indicated depression or lack of perceived meaning in life.
- Depressive symptoms and poor adjustment were concentrated among the 11 members of the sample of moderate belief, all of whom prayed but only a minority of whom attended church or believed in life after death.
- Despite their lack of contact with local churches, most of the sample, including non-believers, would have appreciated contact from church following bereavement

The findings indicate the relevance of belief to wellbeing in later life, and the need for secular welfare organisations to be more prepared to work with religious and other organisations in promoting spiritual wellbeing with the current generations of older people. They also illustrate the importance of support from religious organisations to their older members.

This is an emerging area of interest in the general field of wellbeing research, and it may be useful for EWAS to consider examining the role of belief, and of religious organisations, in the lives and wellbeing of older New Zealanders.

5. An anthropological investigation of lay and professionals' meanings of quality of life[89] *(Christopher McKevitt, Vincent La Placa and Charles Wolfe)*

The study

The study investigated the concept of quality of life in health care, using stroke as a case study. Interviews were conducted with stroke patients and health care professionals; a national survey of physicians, physiotherapists, occupational therapists; and ethnographic work on a stroke unit.

Key findings

Professionals defined quality of life in two senses: as a measurable outcome and, more commonly, as 'happiness', evaluated by each individual for him/herself. Few professionals had used quality of life measures (25 per cent of survey responders) but in this sense

[89] www.growingolder.group.shef.ac.uk/ChrisMcKevitt_F2.pdf

quality of life was considered difficult to define and operationalise. The objectification of the subjective through questionnaires which quality of life measurement entails was regarded as paradoxical and there were concerns about the interpretation and application of results from standardised instruments.

However, therapists felt that quality of life measurement offered an opportunity to generate evidence for their interventions with patients. The widely used notion of quality of life as happiness was linked to an assumption that clinical interventions aim to improve patient quality of life. It was also reported that professionals evaluate patient quality of life informally through observation and conversation, using such assessments to assist in the delivery of care.

In clinical work 'quality of life' was rarely invoked explicitly. Rather, clinical decision-making used evidence of disease and recovery, measured objectively but also subjectively, through professionals' narratives of their patients' progress, participation and expectations. Patient and family views were canvassed but judged in terms of how realistic they were.

'Quality of life' did not appear to inform older stroke patients' evaluations of the impact of their stroke; rather impact and recovery were discussed in terms of 'return to normal'. This suggests that the illness is evaluated temporally, with reference to the patient's own prior normality.

Quality of life assessment is a contested domain. The idea that patient quality of life can be assessed through observation may be problematic. The researchers suggest that the concept of quality of life is a core symbolic domain of biomedical practice which can evoke assertions and questions about the relationship between suffering, disability, dignity, independence and a life worth living.

6. Environment and identity in later life: a cross-setting study[90] (Sheila Peace, Caroline Holland and Leonie Kellaher)

The study

Although an increasing proportion of older people live in age segregated settings, for most older people domestic homes in mixed communities continue to be the location of everyday life. The person/environment relationship is a complex one that involves the formation, maintenance and expression of self-identity. As people age and experience losses in other domains of life, their relationships with the places where they live can change and become more critical. The study looked at homes, neighbourhoods, and the spaces in between. It included a range of housing from residential care homes and sheltered housing to different types and tenures of flats and houses in different sizes of settlements.

The research had three principal phases:

- Focus groups with older people in Bedford, Haringey and Northamptonshire, to establish areas for further investigation – an approach similar to EWAS's developmental phase.

[90] /www.growingolder.group.shef.ac.uk/Go_Findings_18.pdf

- Comprehensive interviews with 54 older men and women in the same three areas. The interview schedules included a purpose-designed interview tool, the 'wheel of life' to allow interactivity.
- Five of the respondents also described their relationships with the places they lived in a video, *At Home: Place Identity and Later Life*.

Key findings
The study suggests a 'theory of re-engagement', with a 'life of quality' being achieved when older people can adopt specific strategies that allow attachment on their own terms to the social and material fabric of everyday life. People in the study used material, social and cognitive mediators to optimise the mix of 'self' and 'other' in their environments, and they looked for ways to reinforce or recreate points of attachment to place.

The significance of favourite spaces was enhanced by people's ability to be able to move away from them as part of their daily routine in order to return 'energised' by change. This 'journey' could be into or beyond the neighbourhood or just to other rooms in the home; and it had physical and psychological benefits related to the sense of self and mastery of environment, which could be compromised in more institutional settings.

Inequalities in Quality of Life (5 projects)

7. Influences on quality of life in early old age[91] (David Blane, Paul Higgs and Richard Wiggins)

The study
The study investigated short and long-term influences on quality of life in early old age (the stage of life between labour market exit and the onset of physical dependency; say ages 60/65-75 years, with a periphery 55-85 years). For a growing proportion of the population, early old age is characterised by reasonable health and comparative affluence, making possible a more positive quality of life. Other studies have shown that 'health' in early old age is influenced independently by events which happened many decades earlier.

The study was designed to identify any similar long-term influences on 'quality of life'. The study conceptualised this more positive quality of life in terms of control, autonomy, self-realisation and pleasure (akin to Sen's capabilities, and in line with EWAS's approach); and constructed a 19-item scale to measure these aspects of a person's life. The resulting measure (CASP-19) was included in a postal survey of a stratified random sample of the Boyd Orr cohort, who had been surveyed as children in 1937-39 and was re-surveyed in 1997/98, during early old age, when retrospective information about their adult years was collected. The study design allowed quality of life in early old age, as measured by CASP-19, to be examined in relation to short-term (postal survey and 1997/98 survey) and long-term (1937-39 survey and 1997/98 retrospective data) influences. Subsequently the measurement of quality of life used in this survey, CASP-19 has been included in three large British surveys and in surveys of Western Europe and Eastern Europe.

Key findings

[91] /www.growingolder.group.shef.ac.uk/Go_Findings_18.pdf

- Quality of life in early old age is influenced by a number of factors, including health, financial circumstances, quality of social relationships, characteristics of residential locality and control over the process of labour market exit.
- No single factor is predominant. Health (first) and financial circumstances (second) are important, but quality of life in early old age is the net outcome of the influence of many factors.
- The amount of social disadvantage accumulated during childhood and adulthood predicts quality of life in early old age, but these long-term factors are influential only through their effect on more immediate circumstances, such as pension adequacy, residential locality and health. In this sense, good quality of life is possible for all in early old age, irrespective of earlier disadvantage

8. Inequalities in quality of life among people aged 75 years and over[92] (Elizabeth Breeze)

The study

The study involved secondary analysis of data from the large-scale national Medical Research Council Trial of the Assessment and Management of Older People in the Community. Its aim was to study associations between socio-economic factors and quality of life of older people and to explore whether these are explained by factors that are related both to socio-economic status and to quality of life. The outcomes were derived from the Philadelphia Geriatric Morale Scale and four dimensions of the Sickness Impact Profile (SIP). Out of 9,547 people eligible, 6,298 (66 per cent) provided full information on quality of life and explanatory factors.

The findings

- There were clear differentials in chances of poor quality of life by housing tenure. Self-reported health problems plus smoking and alcohol consumption jointly accounted for half or more of the tenure differentials, depending on the outcome.
- Help received did not act as a buffer for socio-economic differences in morale. Low socio-economic position in both middle age and old age nearly doubled the risk of poor SIP outcomes and increased the chance of poor morale by 75 per cent.
- Area deprivation had an additional effect to social class for the SIP outcomes.
- The results for morale were different from those for the three SIP dimensions involving physical functioning. For example,
    - poor morale is less age-related and more gender-related;
    - the tenure differential for morale and social interaction is less among people living alone or with spouse than among people living with others;
    - population density only has a clear association with poor morale with the rural areas carrying least risk.

Policy implications

Older people retain the legacy of past socio-economic position and are subject to current socio-economic influences, so policies to reduce health inequalities should encompass older generations as well as younger ones. The area findings are consistent with current policies that aim to alter community environments as well as to empower individuals to

[92] www.growingolder.group.shef.ac.uk/ElizBreeze_F1.pdf

retain independence. Actions to affect morale differentials may have to be different to those aimed at reducing inequalities in functioning.

9. Ethnic inequalities in quality of life at older ages: subjective and objective components[93] *(James Nazroo, Madhavi Bajekal, David Blane and Ini Grewal)*

The study
The study set out to investigate ethnic inequalities in the circumstances of older people, using a broad conceptualisation of quality of life. The study focussed on four ethnic groups, Caribbean, Indian, Pakistani and white, and was conducted in two phases: secondary analysis of quantitative data to describe levels of inequality across ethnic groups; and a qualitative study that focussed on explaining ethnic differences in influences on and levels of quality of life.

Key findings
The quantitative part of the study revealed increasing ethnic inequality with age for factors that are typically included in research: material conditions, health, crime and physical environment. For these, the white group tended to be in the most advantaged position, followed by the Indian and Caribbean groups and then the Pakistani group, which had the poorest outcome for each of these dimensions. However, for those influences concerned with less formal elements of the community – social networks and perceptions of the local infrastructure – differences were reversed, with older Pakistani people better off than others and white people the worst off.

In the qualitative interviews respondents from all ethnic groups identified six factors that influenced their quality of life: having a role, support networks, income and wealth, health, having time, and independence. While these factors were present in accounts from all ethnic groups, the ways in which they were experienced varied by ethnicity. The qualitative interviews also offered explanations for how the ethnic inequalities experienced in older age emerged. Migration and consequent employment and health histories, formation of migrant communities and maintenance and disruption of family networks, all appeared important. The qualitative findings suggested that the investment that migrant people had made in developing local communities, in terms of both local infrastructure and community networks, buffered them from inequality and provided great reward.

10. Older people in deprived neighbourhoods: social exclusion and quality of life in old age (Thomas Scharf, Chris Phillipson, Paul Kingston and Allison Smith) (also noted in the Keele chapter)

The study
The study sought to generate new insights into the experience of inequality in later life. It examined aspects of the quality of life of older people living in areas of intense social deprivation, developing understanding of factors that contribute to social inclusion and exclusion in later life. A particular focus was on exploring ways in which older people handle the multiple risks associated with living in deprived urban environments, along with the survival strategies and support networks that develop. The research involved a survey

[93] www.growingolder.group.shef.ac.uk/Nazroo_Findings_11.pdf

of 600 people aged 60 and over living in deprived areas of three English cities, and in-depth interviews with 130 older people from the same areas.

Key findings
Analysis has highlighted a series of risks faced by older people in socially deprived neighbourhoods. These include a heightened risk of poverty and vulnerability to intense forms of social deprivation, a disproportionately high incidence of crime, and relatively high rates of social isolation and loneliness. The research has confirmed that older people belonging to some minority ethnic groups are especially prone to the multiple risks associated with social exclusion.

The research has been characterised by a high level of engagement with user groups.

11. Exploring perceptions of quality of life of frail older people during and after their transition to institutional care[94] *(Susan Tester, Gill Hubbard, Murna Downs, Charlotte MacDonald and Joan Murphy)*

The study
The aim of the study was to contribute to understanding of the meaning of quality of life for frail older people, from the perspectives of older people themselves, during a period that is usually perceived negatively. The five objectives were to develop a new conceptualisation of quality of life in frail older age; to develop innovative methods of eliciting frail older people's views; to examine ways in which transition to institutional care affects quality of life; to identify inequalities in experiences of quality of life; and, to examine links between quality of life and quality of care.

This was an ethnographic study prioritising the views of older people with all types of physical and/or mental frailty. The methods used were: six focus groups; 24 hour observation in four care home settings; individual interviews and observations with 52 frail residents recently moved in to care homes. The researchers successfully elicited subjective views and experiences of frail older residents. Talking Mats™ was one innovative method of interviewing those with communication difficulties. An innovative method of disseminating findings produced an interactive CD Rom incorporating video, audio, text and film stills to represent findings visually as well as in written format.

Key findings
Despite the negative aspects of frail older age and life in care homes, the researchers observed and elicited perceptions of good quality of life in the aspects of their lives that people perceived as key components of quality of life: sense of self; environment and care; relationships; and activities.

Quality of life was influenced in positive or negative ways by responses to frailty; sense of self; communication; control; continuities and discontinuities. Participants' gender, social class and ethnicity also affected their perceptions and experiences.

Policy implications

[94] www.growingolder.group.shef.ac.uk/GOFindings24.pdf

Policymakers, providers and practitioners must disregard their own assumptions and focus on the different priorities held by frail older people. Care providers have an important role in enabling residents to maintain their sense of self, to communicate verbally and non-verbally, to exercise control and rights, to maintain and develop relationships, and to have meaningful activity and interaction within the contexts of institutional care settings.

The Role of Technology and the Built Environment (1 project)

12. Transport and ageing: extending quality of life for older people via public and private transport[95] *(Mary Gilhooly, Kerry Hamilton, Maureen O'Neill, Jane Gow, Nina Webster and Frank Pike)*

The study
Accessible public transport and the independence that comes with car driving are generally thought to be linked to quality of life in old age. However, there has been almost no research on this topic in the UK. The study used a multi-method approach to explore the relationship between quality of life and access to public and private transport. The study also examined the extent to which the transport needs of elderly people are taken into account by transport professionals.

Key findings
Car ownership and access to transport were found to be associated with higher perceived quality of life, and to be 'independent' predictors of quality of life. In other words, the fact that car drivers/owners reported higher quality of life than non-car owners/drivers could not simply be explained by the fact that they were wealthier.

The study is one of the first to demonstrate that good access to transport itself is associated with higher perceived quality of life. A number of barriers to the use of public transport were noted, the most frequent being concern about personal security in the evening or at night. Fewer than 50 per cent of respondents thought that the needs of older people were considered by the operators of underground, bus or rail services.

In interviews with professionals, car manufacturers were found to be thinking about how to make car driving easier and safer for older people. Train and bus operators, on the other hand, perceived older people as a 'nuisance', partly because of demands for free access. Disability (conceived of largely in terms of wheelchair accessibility) was a concern, rather than ageing. The sensory impairments common in old age were rarely mentioned by public transport operators.

The findings that car ownership and access were associated with quality of life for older people do not fit with current transport policy, which aims to reduce car travel and increase the use of public transport. To decrease car use, the Government should give greater consideration to those aspects of car travel that are associated with improved quality of life. Barriers to the use of public transport by older people must also be addressed.

Healthy and Productive Ageing (3 projects)

[95] www.growingolder.group.shef.ac.uk/MaryGilTransp_F16.pdf

13. Quality of life and real life cognitive functioning[96] *(Mary Gilhooly, Louise Phillips, Ken Gilhooly and Phil Hanlon)*

The study

The study examined the predictive value of mid-life risk factors for cognitive functioning in old age. Participants were drawn from a study of middle-aged people living in Paisley and Renfrew which had been conducted 30 years previously. Current cognitive functioning, both abstract and real world, was assessed along with beliefs and attitudes regarding maintenance of cognitive functioning in old age. Cognitive functioning was examined in relation to perceived quality of life. The aims of the study were:

- To determine the predictive value of risk factors measured in mid-life to 'real world' and 'abstract' cognitive functioning in old age.
- To determine the impact of morbidity history on current cognitive functioning.
- To examine lay concepts of factors influencing cognitive functioning in later life.
- To examine the degree to which older people engage in specific behaviours to maintain and enhance cognitive functioning in old age.
- To examine the relationship between cognitive functioning and perceived quality of life.

Key findings

- Mid-life risk factors such as blood pressure, cholesterol, and blood glucose were not significant predictors of cognitive functioning (thinking, memory, and reasoning) in old age. Mid-life lung function, a measure of 'biological ageing' was, however, associated with some aspects of 'abstract' cognitive functioning.
- Morbidity history was not correlated with late-life cognitive functioning. However, those who rated their current physical health as good or excellent performed better on tests assessing a 'speed' component of abstract cognitive functioning.
- Most of the elderly people in the study expressed the view that keeping active and interested, reading, doing puzzles, socialising and keeping healthy could help to prevent cognitive decline in old age. Sixty per cent deliberately engaged in specific activities to maintain good cognitive functioning.
- Engagement in mental activities was found to be associated with better performance on the 'speed' tests of abstract cognitive functioning. Engagement in physical and social activities was not associated with better performance on any of the tests of cognitive functioning.
- Better performance on the 'real world' problem solving tasks was associated with higher ratings of quality of life. Performance on 'abstract' tasks was not associated with perceived quality of life.

14. Older people's experience of paid employment[97] *(Ivan Robertson, Peter Warr, Militza Callinan and Philip Bardzil)*

The study

[96] www.growingolder.group.shef.ac.uk/MaryGilQOL_F15.pdf
[97] www.growingolder.group.shef.ac.uk/IvanRobertson_F14.pdf

The study examined patterns of subjective wellbeing associated with employment status between the ages of 50 and 75. Information was gathered by questionnaire from 1,167 unemployed, employed and retired men and women, covering affective wellbeing and life satisfaction as well as reports of motivation, health and environmental perceptions.

Key findings
Respondents who were unemployed and seeking a job exhibited significantly poorer subjective wellbeing than those who were employed or retired. However, no overall difference was found between the wellbeing of employed and retired persons. Separate analyses below and above state retirement age revealed that a significant difference was in fact present between those groups: early retired and late employed people reported the highest wellbeing. That difference was shown to reflect respondents' personal choice: people in those groups had mainly chosen to be either early retired or employed beyond the conventional age of retirement.

Wellbeing differences between unemployment, employment and retirement were also a function of perceived environments in those roles. In particular, differences in opportunity for personal control, variety, environmental clarity and physical security were associated with level of wellbeing irrespective of a person's employment status.

Older people's wellbeing is thus not a simple function of their employment status. It is associated with personal preference (was a person's status more chosen or enforced?) and the nature of environmental characteristics experienced in that status. Comparisons based merely on employment status can be misleading, because findings in any particular investigation depend on the preferences and environmental conditions of the people who happen to have been studied.

Parallel analyses examined the frequency of some daily activities (music and drama involvement, home and garden work, etc.) in each employment status. Activities in the family, social, the church and charity domains were found to be important for subjective wellbeing in this age-range, but variations in other kinds of activity were not associated with wellbeing. Although some differences were observed in the frequency of certain activities between older people in unemployment, employment and retirement, activities' links with wellbeing were generally similar irrespective of employment status.

15. Evaluating the impact of reminiscence on the quality of life of older people[98] (Kevin McKee, Fiona Wilson, Helen Elford, Fiona Goudie, Man Chung, Gillie Bolton and Sharron Hinchliff)

The study
Reminiscence is 'the vocal or silent recall of events in a person's life, either alone, or with another person or group of people'. The researchers set out to determine whether reminiscence, when provided as an activity for frail older people in long-term care settings, improved their quality of life. They assessed the quality of life of 142 older people living in care settings. Over a period of one month, one group of these residents participated in reminiscence activities while a second group participated in other forms of activities (the 'intervention' groups). A third group (our 'control' group) simply went about their everyday lives during this period. At the end of the month, the researchers assessed the residents' quality of life, and again after a further month. They also carried out interviews

[98] www.growingolder.group.shef.ac.uk/McKee_Findings8.pdf

and focus groups with care staff, residents, and family carers of older people, to establish their views on reminiscence.

Key findings
Residents who participated in the activities were found at the end of the period of intervention to have better quality of life than residents who had not participated in the activities. The level of psychological benefits obtained through involvement in reminiscence activities did not differ significantly from that obtained through involvement in other activities. This suggests that it is the process of engagement in meaningful activity that primarily produces benefits rather than specific aspects of that activity. Older people with relatively high levels of cognitive impairment benefited just as much from engagement in activities as older people free of cognitive impairment.

Reminiscing was most helpful, first, as a way for older people to convey meaningful identities and events in their lives to care staff; and, second, as a means to enhance intergenerational family relationships through conversations about family history.

Care staff expressed concern that social care (talking, listening, sharing) of older people is not recognised or encouraged as 'real work' within care settings.

Residents expressed feelings of 'discontinuity' from their true self and from the present world. As these feelings might be exacerbated through a focus on the past, engagement with older people's feelings of discontinuity should be integrated with reminiscence work.

Family and Support Networks (6 projects)

16. Older men, their social worlds and healthy lifestyles[99] (Sara Arber, Kate Davidson, Kim Perren and Tom Daly)

The study
The aim of the study was to provide a better understanding of the meaning of masculinity and its influence on health behaviours and the social worlds of older men, particularly contrasted by marital status. The study objectives were:

- To examine masculinity among older men by focussing on the nature of: family support provided to older men; their involvement in social relationships with both older men and women; and participation in formal, leisure and social organisations. The interaction between these three types of support was examined, within the context of older men's differential level of health, living arrangements and other resources.
- To examine how these three types of social support relationships are linked to older men's lifestyles (physical activity, smoking and drinking) and their self-assessed health and psycho-social health, focussing on how these differ for older men according to their marital status, health status, class, biography and material resources.

[99] www.growingolder.group.shef.ac.uk/Arber_F12.pdf

The study used a multi-method approach comprising: observational research into 25 social organisations with older people in their membership; qualitative interviews with 83 older men (31 married, 30 widowed, 10 divorced and 12 never married); and secondary analysis of three national datasets.

Key findings

- Men, particularly lone older men, shun clubs which cater specifically for older people (e.g. Day Centres). Such clubs need to be more congenial for older men so that they do not feel they are 'yielding up' their individuality, or admitting some sort of 'defeat' by attending.
- Researchers and service providers tend to measure the quantity and quality of social inclusion in later life with a 'feminine ruler'. It is important to seek different ways of viewing intimacy and friendship patterns in the lives of older men.
- Partnership status influences both primary and secondary health promoting behaviour. Partnered men take fewer health damaging risks (smoking, drinking, poor diet and minimal exercise), than lone older men. However, divorced older men are more likely to indulge in risk taking health behaviour than any other group.

17. Older widow(er)s: bereavement and gender effects on lifestyle and participation (Kate Bennett, Philip Smith and Georgina Hughes)

The study

The study examined the lifestyles of women and men widowed in late life, highlighting gender, social participation, wellbeing and emotional response, with a view to promoting more effective adjustment to bereavement and widowhood. It had four main objectives: to identify and investigate the variations amongst widowed people with respect to gender, lifestyles, social participation and transitions from married to widowed status; to examine emotional adjustment following bereavement: to identify patterns of response and circumstances that led to successful or unsuccessful adjustment to bereavement and widowhood; and to propose strategies both for prevention of and intervention in unsuccessful adaptation to bereavement and widowhood.

Key findings

There were gender differences in widowhood in beliefs and experience. Both genders believed that men fared worse, but their experiences were more complex. 'Keeping busy' was an important aspect of widowed life, providing structure, meaning and an active means of coping. Women's transition from married to widowed status provided opportunities for new activities and personal growth, as well as restrictions and sadness. Men more often reported experiencing depression.

Several responses were associated with adjustment, e.g. for successful coping, 'talking to one's dead spouse', for unsuccessful coping, emotionally 'keeping themselves to themselves'. Some were gender specific: e.g. for successful coping: for men 'being selfish', for women 'being comfortable alone'. Only one circumstance distinguished copers from non-copers: the spouses of the non-copers were more likely to have been ill for some time but their death was nevertheless unexpected.

There was a relationship between bereavement experiences and cognitive functioning, in an unexpected direction. Copers appeared to be doing so at the expense of their verbal cognitive functioning. Strategies are proposed to promote successful adaptation, for

example, widows may be encouraged not to keep their feelings to themselves, and widowed people themselves were keen to emphasise the value of keeping busy as a means of coping with bereavement and widowhood.

18. Quality of life and social support among people from different ethnic groups [100] *(Jabeer Butt and Jo Moriarty)*

The study
The aim of the study was to document similarities and differences in social support and quality of life in a sample consisting of people from different ethnic groups. The main innovation of the study was its attempt to obtain a nationally representative sampling frame by recruiting a sample from people who had taken part in the Family Resources Survey (FRS), although this did not proceed as intended.

Key findings
Much has been written about the 'myth of return' in which people who have emigrated talk of moving back to their country of birth. A small number of people did alternate between Britain and their country of birth, but the overwhelming majority saw themselves as firmly established in their local communities where they had lived for many years. It was in this context that the study found all older people played an active role in shaping their social relationships, suggesting that while structural reasons such as access to a car or public transport may contribute to social support, the role of individual agency must not be underestimated.

The study paints a complex picture of older people's expectation of support from their families. White older people tended to have lower expectations of the frequency and type of support that they received from their children. Asian older people often described a system of reciprocal support, with daughters and daughter-in-laws providing practical help. In return Asian older people looked after their grandchildren. For some Black Caribbean women, support from services rather than their family was often seen as not only acceptable, but also their right.

About half the people from minority ethnic groups said they had experienced racism, a figure which is likely to be an under estimate given a widespread reluctance to speak about the topic. By contrast, only those white people who were from a 'hidden' minority, such as Welsh or Irish people or who had a Black partner reported they had experienced racism. The results also suggest that those who experienced racism were more likely to report dissatisfaction with their neighbourhood. The experience of racism needs to be considered in any discussion of quality of life of older people.

[100] www.growingolder.group.shef.ac.uk/GOFindings23.pdf

19. Family work and quality of life: changing economic and social roles[101] *(Maria Evandrou and Karen Glaser)*

The study
Recent socio-economic and demographic changes, such as increasing female labour force participation, rises in the age children leave home and improvements in longevity, are all likely to have increased the number of people 'caught in the middle' – that is, juggling paid work and caring responsibilities, while still supporting their own children. The study explored changes in economic and social roles across four British birth cohorts passing through mid-life (45-59/64 years). It investigated the relationship between multiple role responsibilities and a range of indicators of quality of life including health, material resources and engagement in social activities.

The study involved secondary analysis of four different surveys: the 2000 British Household Panel Study (BHPS), the 1994-95 Family and Working Lives Survey (FWLS), the 1985, 1990, and 1995 General Household Survey (GHS) and the longitudinal 1988/89 and 1994 Retirement Survey (RS).

Key findings
The results showed that the proportion of people with multiple role commitments in mid-life is relatively low at any one point in time. Only one in 15 women, and one in 20 men, aged 45-49 occupies all three roles[102] concurrently. However, when viewed over the life course, it is much more common. The likelihood of having multiple role commitments appears to be increasing across successive birth cohorts.

Multiple role responsibilities made little difference to entitlements to basic state pensions. There were, however, significant differences with respect to entitlements to second tier pensions, with women (especially mothers) being particularly disadvantaged. Furthermore, combining paid employment with care giving was not an option for a significant minority of women. Thus, women who have fulfilled the important social roles of carers and parents look likely to continue to run the risk of being socially excluded in terms of financial resources in later life.

20. Loneliness, social isolation and living alone in later life[103] *(Christina Victor, Sasha Scambler, Ann Bowling and John Bond)*

The study
An important component of the quality of life of older people is social participation and engagement. The study investigated three key elements of social participation in contemporary society: loneliness, isolation and living alone in later life, and was undertaken to address the gaps in knowledge concerning these three aspects of later life. In particular the researchers investigated four key questions:

- What is the prevalence of loneliness, isolation and living alone in later life?
- What are the inter-relationships between these variables?
- What are the vulnerability and protector factors associated with them?

[101] www.growingolder.group.shef.ac.uk/MariaEvandrou_F5.pdf
[102] As noted above, the three roles are juggling work and caring responsibilities, and still supporting children
[103] /www.growingolder.group.shef.ac.uk/ChristinaVic_F17.pdf

- How do contemporary patterns of loneliness, isolation and living alone compare with those described for previous generations of elders?

A key issue that the project sought to address concerned terminology as 'loneliness', 'social isolation' and 'living alone 'are often used interchangeably, although they are three distinct (but linked) concepts. 'Living alone' is the most straightforward to define and measure in objective terms. 'Social isolation' relates to the integration of individuals (and groups) into the wider social environment and is measured by the number, type and duration of contacts between individuals and the wider social environment. 'Loneliness' refers to how individuals evaluate their level and quality of social contact and engagement. The study used a combination of quantitative and qualitative approaches, interviewing 999 and 48 people aged 65 years and over respectively.

Key findings
Overall, only a minority report that they are often/always lonely (seven per cent) or isolated with 17 per cent reporting less than weekly contact with family/friends and neighbours and 11 per cent with less than monthly contact. These levels are comparable to those reported 50 years ago. However the forms of social contact have changed with current generations of older people reporting both direct social contacts and more indirect, but no less valuable, forms of contact such as the telephone.

While the concepts (contact and loneliness) are inter-related they are not coterminous. Among those living alone, 17 per cent rate themselves as 'often/always' lonely compared with two per cent living with others and 80 per cent of the 'often lonely' live alone. A four fold typology can be used to describe the inter-relationships between loneliness and isolation: the lonely and isolated, the lonely, the isolated and those who are neither.

Isolation was, for the purpose of this exploratory analysis, defined in two ways: (a) those without weekly direct contact with family, friends or neighbours (17 per cent) and (b) those with less than monthly direct contact with family or friends (11 per cent).

The distribution and relationship between loneliness and isolation is similar regardless of the definition used. In both the contemporary and historical cohorts of elders there are a small minority who are both lonely and isolated (one to two per cent) and two independent groups of lonely (five per cent) and isolated (ten to 15 per cent) elders, and a fourth group who experience neither state (approximately 78 per cent).

The data demonstrate the dynamic nature of loneliness and isolation across the life course and the varying pathways into loneliness and isolation in later life. There are two distinct groups: those for whom loneliness/isolation is a continuation of previous experiences and those for whom it is a new experience.

21. Grandparenthood: its meaning and its contribution to older people's lives[104] *(Lynda Clarke and Ceridwen Roberts Cairns)*

The study
The main aim of the study was to explore the role of grandparenthood in the lives of older people. It employed both quantitative and qualitative techniques. In the first stage, a telephone interview of a national sample of grandparents was conducted by ONS in 1999/2000, which was repeated and extended in 2001. In Stage 2, a sample of 45 grandparents from the national survey was interviewed in depth on the meaning and operation of grandparent roles.

Key findings

- Nearly one in four (38 per cent) of grandparents had grandchildren who were not living with both parents and one-fifth of grandparents had at least one step-grandchild.
- Grandparents saw grandchildren more frequently than expected, the majority saw them at least once a week (62 per cent).The same proportion of grandparents (60 per cent) reported other contact; via telephone, letter or email.
- Demographic factors were more important than socio-economic factors in predicting contact with grandchildren. Weekly contact was related most strongly to proximity (how close they lived) but lineage (whether the grandchildren were related through sons or daughters) was more important than family type.
- Grandparents were less likely to see the grandchildren of sons on a weekly basis, especially if they had experienced family break-up, than the grandchildren of daughters. They were less likely to see older grandchildren (aged ten and over) and non-married grandfathers were less likely to see grandchildren weekly.

The qualitative study confirmed the importance of grandchildren to grandparents: 'That was the only thing I wanted in this life …a grandchild' and 'It makes life more worth living …it's something to look forward to'. The main feeling was of strong emotional closeness and stories generally told of the contribution grandchildren made to the quality of their lives.

Participation and Activity in Later Life (3 projects)

22. Empowerment and disempowerment: a comparative study of African-Caribbean, Asian and White British women in their third age[105] *(Haleh Afshar, Myfanwy Franks, Mary Maynard and Sharon Wray)*

The study
The study was concerned with how older people from a range of ethnic groups understand and evaluate their quality of life and how this quality might successfully be extended. It was based on in-depth qualitative interviews and focus groups with 150 able-bodied women of 60-75 years from a range of African Caribbean, Asian and White British backgrounds. The research aimed to:

[104] www.growingolder.group.shef.ac.uk/GOFindings22.pdf
[105] www.growingolder.group.shef.ac.uk/Maynard_Findings_10.pdf

- Explore what is rewarding, what is debilitating and why, in relation to quality of life.
- Analyse coping strategies, how these might be enhanced and the role of enablers.
- Provide policy recommendations.
- Contribute to the development of theorising about ageing.
- Develop methodological awareness of the role of ethnicity and age as part of the research process.

Key findings
Broadly speaking, the women's discussions of quality of life may be divided into two categories: physical and material factors, and emotional issues, psychological wellbeing and social support.

The first category includes leisure/work activities; access to resources, such as housing and transport; environmental issues, for example rubbish, fear of crime and lack of safety; and matters of embodiment relating to health, mobility and fitness. Health was the most important issue for the participants, while income, although significant, did not emerge as the most important concern.

In the second category, participants focused on shared identities, especially in relation to different languages, cultures and traditions; social networks of family, friends and community; faith and spirituality; and changing meanings and dimensions of time and space. Many of the views about quality of life were linked to notions of 'purpose' and ideas about 'being'. 'Purpose' refers to having a clear set of roles and functions to perform, especially to a 'moral economy of kin', where there are accepted tasks, obligations and reciprocities which bind families together. 'Being' is highly correlated with notions of spirituality and faith, especially for minority ethnic women.

The research indicates that older women are not necessarily disempowered by later life, although they also require adequate support and services. Empowerment and disempowerment are not set in binary opposition and a more differentiated model is required more fully to understand needs and experiences across cultural differences.

23. Older women's lives and voices: participation and policy in Sheffield[106] (Lorna Warren,Tony Maltby and Joe Cook)

The study
The primary aims for this 'change-oriented research' were to:
Increase knowledge and awareness of factors shaping the quality of life of older women across different ethnic groups and their desire and ability to 'have a say' in the services available to them.
Achieve this by adopting a participatory approach, involving older women in designing and carrying out the research and in promoting and evaluating change.

Key findings
In the interviews and discussions, quality of life was expressed as:

[106] www.growingolder.group.shef.ac.uk/Go_Findings_21.pdf

- Increased self-acceptance and confidence.
- The easing of domestic and childcare commitments.
- Increased leisure and work opportunities.
- The importance of family. Some had new roles providing childcare for grandchildren.

To date, the most significant outcomes of the research have included:

- Participation of older women in Sheffield including women from Black Caribbean, Chinese, Irish, Somali and White British, in a series of successful discussion groups (n 100) and in life story interviews (n 44).
- Identification of key aspects affecting quality of life of participants which unite as well as distinguish individual groups and individual group members.
- Recruitment and training of ten older women volunteers to work with the research team in selecting topics for and carrying out life story interviews with their co-participants in the discussion groups. They helped identify the main points of the findings and continue to play a key part in publicising these findings and associated recommendations for policy and practice.
- Production of a video featuring participants in the project and documenting the aims of and background to the project; how the research was carried out; how older women have been involved; what the women the researchers have worked with have had to say about their lives, the services they use – or would like to use – and about the idea of having a say.
- Identification by policymakers, organisers and providers of services, through use of semi-structured interviews, of barriers to and schemes for increasing participation, and the success of initiatives in including older women and widening the choices available to them.
- Rigorous dissemination, UK-wide as well as internationally, of findings and lessons from the study at conferences and seminars, and within undergraduate and postgraduate teaching.

24. Older people and lifelong learning: choices and experiences[107] (Alexandra Withnall)

The study

The promotion of a culture of lifelong learning is a cornerstone of educational policy throughout the European Union and beyond. Yet little is known about older people's experiences of learning and education over the life course, the factors that affect whether they choose to learn in retirement and what role learning plays in their lives as they grow older. The study set out to explore these issues in depth using a range of different investigative methods including the use of a small group of older people themselves as interviewers of their peers.

Key findings

- A whole range of different influences, both collective and individual, interact within a changing social and cultural framework to impact on people's propensity to learn and their learning activities at different times during their lives including the post-work period.

[107] www.growingolder.group.shef.ac.uk/AlexWithnall_F13.pdf

- Between three and ten years after retirement is the time when older people are most likely to attend a course or class with word-of-mouth recommendation or being taken along by a friend, important motivational factors in the final decision to join.
- Participation is perceived to have a range of positive outcomes including self-satisfaction, keeping the brain active, intellectual stimulation and pleasure and enjoyment. However, many consider learning to be a mainly informal activity that is an integral and important part of their daily lives.
- Overall, the study shows that older people are interested in a very wide variety of topics and subjects and continue to learn in a diverse range of ways with radio and TV programmes, reading, discussing the news with family and friends and voluntary and social activities being particularly important sources of stimulation for those who felt too old or infirm to attend a course or class.

The study has implications for educationalists, for broadcasters and for other organisations specifically concerned with older people. In particular, older people's varied circumstances and learning preferences need to be acknowledged in order to widen choice and to stimulate interest.

In sum, the set of studies canvassed above show the power of a multi-faceted, interlinked series of research studies which bring different analytical frameworks, methodologies, and academic disciplines, to the task of understanding the lives of older people. Many of these studies are also enriched by the care they have taken to put older people and their perspectives, at the centre of their investigations – an approach already built into EWAS's modus operandi.

10. LASA AND LSN

10.1 LASA: Introduction: purpose and scope[108]

At the start of LASA (the Longitudinal Ageing Study Amsterdam) in 1991, almost all research in the Netherlands among older people had been cross-sectional and single-discipline. LASA was designed to be an interdisciplinary, longitudinal study to provide a basis for developing and evaluating central and local government policy in the field of ageing, whose overall objective is to enhance the autonomy and quality of life of older persons. It is expected that by using longitudinal data, policy relevant aspects of ageing can be identified and new policy aims can be developed. Assumptions from which policy measures are developed can be tested, and effects of policy changes can be assessed prospectively.

The initial sample was weighted according to expected mortality at mid-term within each sex and age group, so that after five years equal numbers of men and women were expected to be alive in the ages 55-59, 60-64, 65-69, 70-74, 75-79, and 80-85 years. The sample was constructed to reflect the national distribution of urbanisation and population density. The sample was based in three culturally distinct geographical areas. To be able to distinguish age, cohort and period effects, in 2002 a new cohort (birth years 1938-1947) has been sampled from the same sampling frame as the original cohort.

LASA and LSN
LASA uses the "Living arrangements and social networks of older adults" (LSN) sample (a fuller description of this research programme is provided later in this chapter – see 10.5). While LASA is designed as an interdisciplinary project with potentially policy relevant outcomes, the main purpose of LSN is the development of theory and methods for the study of living arrangements and social networks in old age.

The baseline study for LSN took place during 1992, and part of the LSN data are baseline material for LASA. The LASA baseline was carried out separately 11 months later. In 1995-1996, 1998-1999, and 2001-2002 almost identical follow-up data collections were conducted. The data collection among a new cohort has been completed in 2003. A data collection among all 1908-1947 birth cohorts was conducted in 2005-2006. In a limited number of side studies of specific sub-samples, topics are studied for which additional data collection is needed with more frequent intervals.

10.2 Domains covered by LASA, and their differences and similarities with EWAS

LASA's main topics of concern are autonomy and quality of life of older persons:
Autonomy is operationally defined as functioning, i.e. observable behaviour (objective wellbeing in EWAS terms).
Quality of life is defined as the evaluation by older persons of their functioning (in EWAS terms subjective wellbeing).

[108] Much of this material is sourced from the LASA homepage (http://www.lasa-vu.nl/index.html)

Four components of functioning are examined: physical, cognitive, emotional and social. The study focuses primarily on *predictors* of change in these components of functioning, on *trajectories* of functioning, and on *consequences* of change in functioning.

LASA's central questions are:

- Among older persons, what changes over time take place in the physical, cognitive, emotional and social components of functioning?
- What are the predictors of change for each of the four components of functioning?
- How are changes in the four components of functioning interrelated?
- What are the consequences of changes in functioning in terms of older persons' contributions to society, their adjustment and their need for care?

The most important of the side studies are on the course of depression, and on predictors of falls and fractures.

Measurement instruments largely correspond to those used in potentially comparable research elsewhere in the Netherlands, and a number are selected for international comparability.

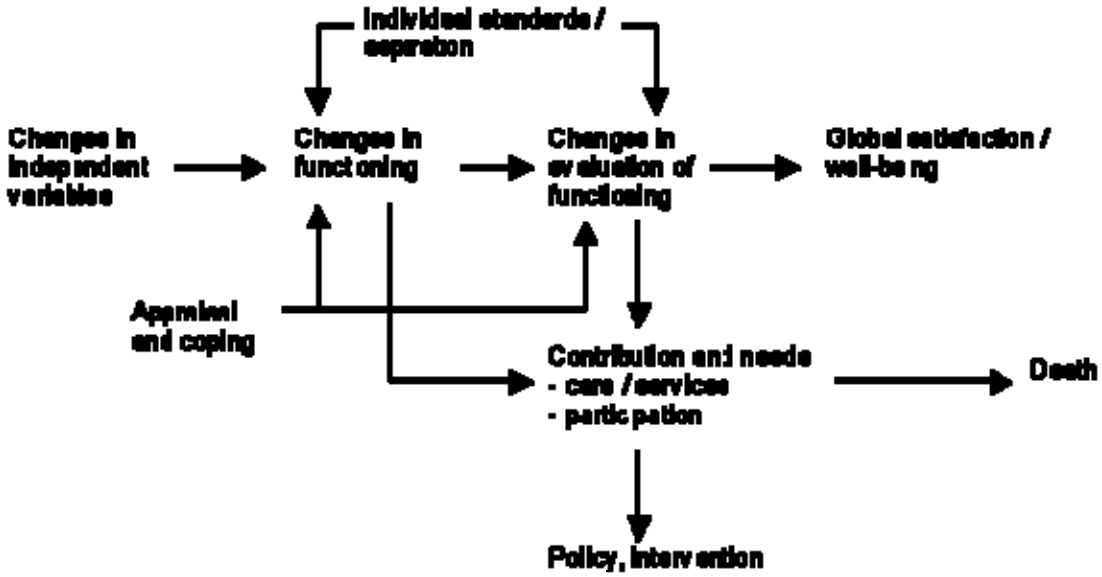
Physical functioning is measured by self-reports on functional limitations, and by objective measures of endurance, strength, mobility, coordination, balance, and vision. *Cognitive functioning* is measured by a brief screening test of dementia, and by tests of intelligence, learning capacity, memory, and information processing speed. *Emotional functioning* is measured by widely used depression and anxiety scales. *Social functioning* is measured by composition of the social network, frequency of contacts, exchange of support, and by social participation. In addition to the behavioural aspect of functioning, the *respondent's evaluation* of their functioning is recorded, including self-perceptions of health, memory complaints, and loneliness.

Characteristics that are expected to predict changes in one of more of the components of functioning (*independent variables*) focus on both the environment and to the individual: chronic conditions, use of medications, objective clinical assessments, use of services, life style, personality, personal biography, housing and living arrangements, socio-economic status, and "life events" prior to and during the study period.

Personal standards or aspiration levels and coping can be expected to influence trajectories as *mediating variables*, and are defined for the purposes of this study as norms about ageing, priorities in life, perceived self-efficacy, mastery, humour as a coping strategy, meta-memory, and standards of affiliation.

The consequences of improvements and declines in functioning and resulting (in)dependence are measured in terms of the need for health and social services. All of the variables are described in greater detail in section 10.5.

The conceptual model described is summarised in the figure below.



10.3 Building on the LASA approach

As with a number of the other studies, particularly those based on the HRS, there is much greater data collected in LASA on health conditions, both subjective and objective, than is possible for EWAS. LASA also includes a very detailed examination of marital status and relationship history – something that may be of greater importance in New Zealand as the more diverse family structures that have emerged in the last two decades move into the older age group.

The most interesting aspect of LASA's domain definitions and data collection for EWAS is the emphasis on the *expectations for the future* of the respondents, and on their norms for ageing and relationships: these prospective dimensions of ageing are worth considering for inclusion in the next round of questionnaires for the younger cohort. The use of vignettes as an exploratory tool is also interesting: it would be worth considering the role of different narrative techniques for engaging older people and eliciting complex attitudinal information. Other studies use extended interviews to probe questions of cross-generational emotional engagements.

10.4 LASA studies

LASA has produced a stream of reports derived from studies of LASA data. These investigate a wide spectrum of issues to do with ageing. Fifteen of those that are likely to be of interest to EWAS researchers are summarised below.

1. Changes in contact and support within intergenerational relationships in the Netherlands: A cohort and time-sequential perspective. van der Pas, S., van Tilburg, T.G., & Knipscheer, C.P.M. In T. Owens & J.J. Suitor (Eds.), *Advances in life course research: Interpersonal relations across the life course* (Vol. 12; pp. 243-274). London: Elsevier Science, 2007.

The study

This study investigates whether the frequency of contact and support exchanged in relationships between parents and adult children declines over successive cohorts and over

individual time in the Netherlands. Respondents included a birth cohort from 1928 - 1937 with data collected in 1992 (N = 941) and in 2002 (N = 574) and a birth cohort from 1938 - 1947 with data collected in 2002 (N = 884). The researchers assessed cohort and time-sequential changes.

Results
Parents of the later cohort had more contact and support exchanges with their children than the earlier cohort, revealing that families have not declined in importance. Nevertheless, contact and supportive exchanges with adult children decreased over time in both cohorts, suggesting that parents and children devote less time to intergenerational relationships during this later phase.

2. Prayer and depressive symptoms in a period of secularisation: patterns among older adults in The Netherlands. Braam, A.W., Deeg, D.J.H., Poppelaars, J.L., Beekman, A.T.F., & van Tilburg, W.. *American Journal of Geriatric Psychiatry,* Vol 15, 2007, 273-281.

The study
Prayer is generally recognised as an important aspect of religiousness. Relatively few empirical studies examined the relation between prayer and depressive symptoms in later life, and findings so far are mixed.

Method
Respondents aged 60-91 years, participated in the third (N = 1,702) and fourth (N = 1,346) assessment cycles, with three-year intervals, of the Longitudinal Ageing Study Amsterdam. Data were collected on frequency of prayer, perceived meaningfulness of prayer, religious affiliation, church attendance, salience of religion, demographics, and health variables. Depressive symptoms were assessed with the Center for Epidemiologic Studies-Depression Scale.

Results
In the total sample, there was no significant association between frequency of prayer and depressive symptoms. Among those who were not religiously affiliated, prayer was associated with higher levels of depressive symptoms. The results were particularly pronounced among widowed respondents who were not religiously affiliated. At three-year follow up, prayer did not predict change of depressive symptoms.

3. What does quality of life mean to older frail and non-frail community-dwelling adults in the Netherlands? Puts, M.T.E., Shekary, N., Widdershoven, G., Heldens, J., Lips, P., Deeg, D.J.H. *Quality of Life Research,* 16, 263-277, 2007.

The study
Quality of life is a commonly used but seldom defined concept and there is no consensus on how to define it. The aim of this study was to explore the meaning of quality of life to older frail and non-frail persons living in the community.

Method

Qualitative interviews were conducted with 25 older men and women. The audio-taped interviews were transcribed and coded for content and analysed using the grounded-theory approach.

Results
Five themes emerged: (physical) health, psychological wellbeing, social contacts, activities, and home and neighborhood. Factors that influenced quality of life were having good medical care, finances and a car. Respondents compared themselves mostly to others whose situation was worse than their own, which resulted in a satisfactory perceived quality of life. However, the health of the frail limited the amount and scope of activities that they performed. This led to a lower quality of life perceived by the frail compared to the non-frail.

4. Target groups for the prevention of late-life anxiety. Smit, F., Comijs, H., Schoevers, R., Cuijpers, P., Deeg, D., & Beekman, A. *British Jounal of Psychiatry,* 190, 428-434, 2007.

The study
Anxiety disorders in older people are highly prevalent, yet there is little evidence to guide targeted prevention strategies. This study aimed to identify subgroups at increased risk of developing anxiety in later life.

Method
Anxiety was measured with the Hospital Anxiety and Depression anxiety sub-scale in1931people aged 55-85 years followed over 3 years. Risk factors were identified that had a high combined attributable fraction, indicative of substantial health gains when the adverse effect of the risk factors can be contained.

Results
Factors significantly associated with increased risk of developing anxiety included sub-threshold anxiety, depression, two or more chronic illnesses, poor sense of mastery, poor self-rated health and low educational level. The identified risk groups are small, thus providing prevention with a narrow focus, and health gains are likely to be more substantial than in groups not exposed to these risk factors. Nevertheless, more research is needed to produce evidence on target groups where prevention has optimal impacts.

5. The effect of age-related height loss on the BMI classification of older men and women. Visser, M., & Deeg, D.J.H. *International Journal of Body Composition Research,* 5, 35-40, 2007.

The study
Age-related height loss may affect the calculation of body mass index (BMI) and subsequently the classification of under- and overweight in older men and women. This study aimed to quantify the effect of using body height measured 9 years earlier instead of using current body height on the prevalence rates of under- and overweight in a population-based sample of older men and women.

Method
Complete data on current, measured body height and weight (2001-02) and measured body height and weight 9 years earlier were available for 1163 men and women aged 63 to 93 years who participated in the Longitudinal Ageing Study Amsterdam.

Results
When BMI was calculated using current height, 5.6% of the older men and women were classified one BMI category higher (eg overweight instead of normal weight) than when using height measured 9 years earlier. Estimates of longitudinal change in BMI during follow-up were biased when age-related height loss was not taken into account.

The results of this study suggest a substantial overestimation of the point prevalence rates of overweight and obesity and of the longitudinal increase in BMI with ageing in older men and women when ignoring the age-related height loss.

6. Cosmic transcendence and framework of meaning in life: Patterns among older adults in the Netherlands. Braam, A.W., Bramsen, I., van Tilburg, T.G., van der Ploeg, H.M., & Deeg, D.J.H. *Journal of Gerontology, 61B,* S121-S128, 2006.

The study
Gerotranscendence has been conceptualised as a potential development accompanying normal ageing. Gerotranscendence is defined as a shift in metaperspective from a materialistic and pragmatic world view to a more cosmic and transcendent one. The aim of the present study was to examine (a) how cosmic transcendence relates to having a framework of meaning in life and (b) whether religiousness and demographic characteristics influence possible relationships.

Method
Participants were 928 older Dutch adults who responded to a questionnaire that included the Cosmic Transcendence scale, aspects of religiousness, and the Framework of Meaning in Life subscale of the Life Regard Index.

Results.
A substantial, positive association between cosmic transcendence and framework of meaning in life was observed. This association was much more pronounced among participants who were less involved in religion, who were women, who were age 75 or older, or who were widowed. The study indicates that the personal relevance of cosmic transcendence depends on cultural factors such as secularisation. Furthermore, cosmic transcendence seems to unfold as an important domain in the life view of women, the older old, and the widowed.

7. A 6-item scale for overall, emotional, and social loneliness: Confirmatory tests on survey data. de Jong Gierveld, J., & van Tilburg, T.G *Research on Ageing, 28,* 582-598, 2006.

The study
Loneliness is an indicator of social wellbeing and pertains to the feeling of missing an intimate relationship (emotional loneliness) or missing a wider social network (social loneliness). The 11-item De Jong Gierveld Loneliness Scale has proved to be a valid and reliable measurement instrument for overall, emotional, and social loneliness, although its length has sometimes rendered it difficult to use in large surveys. In this study, the authors empirically tested a shortened version of the scale on data from two surveys (N = 9,448).

Results
Confirmatory factor analyses confirmed the specification of two latent factors. Congruent validity and the relationship with determinants (partner status, health) proved to be optimal. The 6-item De Jong Gierveld Loneliness Scale is a reliable and valid measurement instrument for overall, emotional, and social loneliness that is suitable for large surveys.

8. Explanations of socioeconomic differences in changes in physical function in older adults: Results from the Longitudinal Ageing Study Amsterdam. Koster, A., Bosma, H., Broese van Groenou, M.I., Kempen, G.I.J.M., Penninx, B.W.J.H., van Eijk, J.Th.M., & Deeg, D.J.H. *BMC Public Health,* 6: 244, 1-12, 2006

The study
This study examines the association between socioeconomic status and changes in physical function in younger- (aged 55–70 years) and older-old (aged 70–85 years) adults and seeks to determine the relative contribution of diseases, behavioral, and psychosocial factors in explaining this association.

Methods
Data were from 2,366 men and women, aged 55–85 years, participating in the Longitudinal Ageing Study Amsterdam (LASA). Two indicators of socioeconomic status were used: education and income. Physical function was measured by self-reported physical ability over nine years of follow-up.

Results
In older adults, low socioeconomic status was related to a poorer level of physical function during nine years of follow-up. In subjects who were between 55 and 70 years old, there was an additional significant socioeconomic-differential decline in physical function, while socioeconomic differentials did not further widen in subjects 70 years and older. Behavioral factors, mainly BMI and physical activity, largely explained the socioeconomic differences in physical function in the youngest age group, while psychosocial factors reduced socioeconomic status differences most in the oldest age group.

The findings indicate age-specificity of both the pattern of socioeconomic status differences in function in older persons and the mechanisms underlying these associations.

9. Socioeconomic differences in incident depression in older adults: The role of psychosocial factors, physical health status, and behavioral factors. Koster, A., Bosma, H., Kempen, G.I.J.M., Penninx, B.W.J.H., Beekman, A.T.F, Deeg, D.J.H., & van Eijk, J.Th. *Journal of Psychosomatic Research,* 61, 619-627, 2006.

The study
The objective of this study was to examine the association between socioeconomic status (SES) and the onset of depression in older adults and to determine the relative contribution of psychosocial factors, physical health status, and behavioral factors in explaining this link.

Method
Data were collected from 2593 men and women, aged 55–85 years, participating in the Longitudinal Ageing Study Amsterdam. Two indicators of SES were used: education and income. The onset of depression was measured over 9 years of follow-up.

Results
Adjusted hazard ratios of incident depression were significantly higher in those with low education and low income. Psychosocial factors explained on average 16% of the SES differences in incident depression, physical health status on average 7%, and behavioral factors less than 5%.

In older adults, low SES predicted the incidence of depression. Part of this association was explained by psychosocial factors and physical health status.

10. Personality and the onset of depression in late life. Steunenberg, B., Beekman, A.T.F., Deeg, D.J.H., & Kerkhof, A.J.F.M. *Journal of Affective Disorders,* 92, 243-251, 2006

The study
This study addresses the question whether personality is a predictor for becoming depressed in late life. The researchers expect that personality traits are significantly associated with the onset of depression, but that the effect of personality is overwhelmed by the effect of health related variables. The second research question concerns whether the strength of this association is affected by the influence of age or age-related deteriorations in the other prognostic factors. They hypothesise that a high neuroticism level or low levels of mastery, self-efficacy or self-esteem strengthen the impact of the health-related variables and social situational factors on the onset of depression in late life.

Method
Out of a population-based baseline sample (Longitudinal Ageing Study Amsterdam) of 1511 non-depressed elderly respondents (55–85 years at baseline), 255 (17%) developed a clinically relevant level of depressive symptoms during the 6-year follow-up period. Data on the effect of personality on onset were analysed using logistic regression analyses.

Result
Both at univariate and multivariate level, the personality traits studied predicted the onset of depression. The effect of neuroticism was more strongly related to onset than health-related and social factors. Results revealed no significant interaction effects between the personality characteristics and age or the other prognostic factors on the association with onset of depression.

Personality, neuroticism in particular, was found to be a consistent and important predictor of the onset of depressive symptoms in late life, even more important than health-related and situational factors, and ageing did not affect the strength of this association.

11. Disaster and associated changes in physical and mental health in older residents. Deeg, D.J.H., Huizink, A.C., Comijs, H.C., & Smid, T *European Journal of Public Health, 15 (2),* 170-174, 2005.

The study
Long-term health consequences of disasters have not been studied extensively, one reason amongst others is that no pre-disaster observation is available. This study focuses on an aeroplane crash on an Amsterdam suburb. The ongoing Longitudinal Ageing Study

Amsterdam has one pre-disaster and several post-disaster observations, making it possible to study changes in health, taking pre-disaster health characteristics into account.

Method
Three exposure groups are distinguished: those living within a radius of 1 km from the disaster (initial *n*=39), those living between a radius of 1 and 2 km from the disaster (initial *n*=56), and those living in the rest of the city of Amsterdam (initial *n*=508). Health measures include general health, health in comparison with age peers, functional limitations, disability and cognitive functioning. These measures are based on self-ratings, interviewer observations, or both.

Results:
Older persons living closest to the disaster area are likely to experience health decline in the wake of a disaster, over and above the health decline that would occur normally with ageing. The disaster-associated health decline is small, and most obvious in the ability to perform actions (such as mobility), but is not observed in either disability in daily functioning, nor in self-perceptions of health. Cognitive functioning even shows a short-term improvement.

These findings suggest substantial resilience in older adults, despite their common health problems.

12. Discrepancies between personal income and neighbourhood status: Effects on physical and mental health. Deeg, D.J.H., & Thomése, G.C.F. *European Journal of Ageing,* 2, 98-108, 2005.

The study
During their life course, older persons' income level may become discrepant with the socio-economic status of their neighbourhood. This study examines whether and how such discrepancies affect older persons' physical and mental health.

Method
Using baseline data from the Longitudinal Ageing Study Amsterdam, 2,540 non-institutionalised persons aged 55–85 years were classified based on self-reported income and neighbourhood status. Two categories defined discrepancies: discrepant-low (DL, low income in high-status neighbourhood), and discrepant-high (DH, high income in low-status neighbourhood). Both categories were compared with the same reference category: matched-high (MH, high personal and high neighbourhood income status). A range of health indicators were examined, as well as mediating effects of neighbourhood and individual characteristics. Among the 504 persons who reported a high income, 16% lived in a low-status neighbourhood (DH). Conversely, among the 757 persons living in a high-status neighbourhood, 24% had a low income (DL). The DL category mainly lived in rural areas, and the DH category predominantly in large cities.

Results
The data show discrepant income effects (DL vs. MH) on physical and cognitive ability, self-rated health, and loneliness, and discrepant neighbourhood effects (DH vs. MH) on physical and cognitive ability, depressive symptoms, and loneliness. Personal income effects were partly mediated by other personal characteristics, and neighbourhood effects were fully mediated by socio-economic neighbourhood characteristics as well as by older persons' perceptions of their neighbourhood and their income. It is concluded that

discrepancies between personal income and neighbourhood status, accrued throughout the life course, are associated with poor health.

13. Changes in older adult loneliness: Results from a seven-year longitudinal study. Dykstra, P.A., Van Tilburg, T.G., & de Jong Gierveld, J. *Research on Ageing, 26*, 725-747, 2005.

The study
This study examines loneliness and its correlates – health, residential care, partner status, and network size – over a seven-year period among adults born between 1908 and 1937. The four waves of data are from the Dutch 'Living Arrangements and Social Networks of Older Adults' and the 'Longitudinal Ageing Study of Amsterdam' programs. Data from at least two waves are available for 2925 respondents.

Results show that older adults generally become lonelier as time passes. The increase is greater for the oldest, the partnered, and those with a better functional capacity at baseline. Older adults who lose their partner by death show the greatest increase in loneliness. Not all older adults become lonelier: improvement in functional capacity and network expansion lead to less loneliness. Entry into residential care does not affect loneliness. The longitudinal design provides new insights into factors that protect against loneliness compared to cross-sectional studies.

14. Measuring older adults' filial responsibility expectations: Exploring the application of a vignette technique and an item scale. van der Pas, S., van Tilburg, T.G., & Knipscheer, C.P.M. *Educational and Psychological Measurement, 65,* 1026-1045, 2005.

The study
This study focused on two conceptually distinct measures of the filial responsibility expectations of older adults: a vignette technique and an attitude item scale. Data were based on 1,553 respondents aged 61 to 92 years who participated in the Longitudinal Ageing Study Amsterdam in 1998 to1999.

Results
The item scale had multiple dimensions of filial expectations. Older adults distinguished between emotional-, instrumental-, contact-, and information-oriented expectations. The vignette technique resulted in a one-dimensional measurement of expectations. The intercorrelation between the scores of the item scale and vignette technique was modest, indicating a certain amount of overlap. Child characteristics incorporated into the vignettes added to the specificity of measurements of filial expectations.

The authors observed that older adults were more likely to have expectations for care from an adult child who is not employed and does not have children. Minor differences between sons and daughters were observed.

15. Past experiences and older adults' attitudes: A lifecourse perspective. Poortman, A., & van Tilburg, T.G. *Ageing and Society, 25*, 19-39, 2005.

The study
In this study the researchers apply a life course perspective to an examination of older adults' attitudes about gender roles and moral issues. The study goes beyond previous research in that it examines the relationships between older adults 'attitudes and: (a) experiences in the parental home, (b) people's own marital and work experiences through the entire life course, and (c) the marital and work experiences of their children. The sample consists of respondents aged 55 or more years from the 'Living Arrangements and Social Networks of Older Adults in the Netherlands' survey of 1992 and the 'Longitudinal Ageing Study Amsterdam '.

Results
A large majority of older adults subscribe to the view that people have the freedom to make their own choices about the issues of voluntary childlessness, abortion and euthanasia. Similarly, older adults favour equality between men and women. Multivariate analyses show that people's attitudes are generally consistent with their life course experiences. It is found that unconventional life course experiences, particularly with respect to childbearing, associate with more progressive attitudes in late life. The behaviour and life course experiences of their children are also related to older adults 'attitudes. Particularly, if their children co-habited, older adults tend to be more progressive. These findings suggest that an important mechanism by which societal change may have affected older adults is through their children's experiences.

10.5 Framework of measurement instruments[109]

LASA Data collection B (1992-1993); as reported in Deeg, Knipscheer & Van Tilburg (1993), Chapter 11

Dependent variables

Physical functioning

1. Performance tests for the measurement of dexterity, strength and endurance.
2. Habitual level of activity (time and energy expenditure) using a list of the following physical activities: walking, biking, sporting, gardening, light housekeeping and heavy housekeeping work.

Cognitive functioning

1. Cognitive impairment (MMSE).
2. Everyday memory.
3. Fluid intelligence.
4. Speed.
5. Memory and learning ability.

Emotional functioning

1. Depressive symptoms.
2. Global well-being (2 items). Source: Statistics Netherlands (1990)
3. Meta-emotion (evaluation of emotional functioning).

Social functioning

1. Social network characteristics, exchange of support, and confidants, categorised as:
    - household members, including the partner
    - children and their partners
    - other family members
    - neighbours
    - contacts through work and school
    - members of organisations
    - others.

2. Loneliness, where 11 dimensions are explored:
    - There is always someone I can talk to about my day-to-day problems
    - I miss having a really close friend
    - I experience a general sense of emptiness
    - There are plenty of people I can lean on when I have problems
    - I miss the pleasure of the company of others
    - I find my circle of friends and acquaintances too limited
    - There are many people I can trust completely
    - There are enough people I feel close to
    - I miss having people around

[109] http://www.lasa-vu.nl/lasa_framework_of_measurement_instruments.html for details of instruments used and references

- I often feel rejected
- I can call on my friends whenever I need them

3. Social participation (clubs, organisations, recreation, hobbies, classes) and motivation.

Outcomes

1. Informal and formal support obtained (self care and instrumental), and a selection of 3 most valid independent activity variables
2. Care need, respondent's estimation of future care use and preferences formal/informal
3. Preferences for assistance and housing)
4. Knowledge and use of health and social services, including hospital and rehabilitation.
5. Mortality, causes of death.

Intermediary variables

1. Norms about ageing
2. Ranking of nine aspects of life (income, housing, marriage, religion, time spending, physical and mental health, family, and friends).
3. Humour as a coping strategy
4. Perceived self-efficacy
5. Mastery (Locus of control)
6. Physical perceived self-efficacy
7. Meta-memory (evaluation of memory)
8. Norms about age limit to social participation
9. Standards on relationship affiliation
10. Norms about formal and informal care

Independent variables

1. Demography (marital and partner status, changes in partner relationship); housing; living arrangements; work; pets; fear of criminality; income; income satisfaction; expected future income.
2. Present and future health perception:
   - Chronic conditions
   - Self-perceived health
   - Pain
   - Menopause
   - Sleep
   - Diet
   - Prescription drug use
   - Alcohol and tobacco use
3. Senses: hearing, vision, speech.
4. Biomedical data
5. Challenge from environment
6. Self-esteem
7. Evaluation of sexuality
8. Anxiety
9. Neuroticism, social inadequacy
10. Values and norms (Family traditionalism, Sex role conception, Religious orthodoxy, Left-right)

Added to data collection C (1995-1996)

1. Scale for Religion
2. Life events
3. Groningen Intelligence Test [110]

Added to data collection D (1998-1999)

1. Age of parents at death
2. Cognitive problems of parents
3. Decisions about end of life
4. Screening for PTSD
5. Vignettes for filial responsibility expectations
6. Happiness
7. Subjective age

[110] www.intestcom.org/Downloads/ITC2006Brussels/Session2.3.1Tellegen.pdf

10.6 LSN: Introduction: purpose and scope[111]

The following material summarises the domains covered by three studies: the LSN Main Study, the network study, and the Widowhood Adaptation Longitudinal Study (WALS).

These three studies differ from LASA study: as such they make no enquiries into important domains such as living standards, paid workforce participation, income and wealth etc. Instead, they seek to probe deeply into living arrangements and personal networks, and to understand the adaptation mechanisms for older people who experience one of the most common, and most traumatic, life shocks: the death of the partner.

The aim of collecting data for the Living Arrangements and Social Networks of older adults (LSN) Main Study was twofold. First of all, the aim was to provide descriptive information about the living arrangements and social networks of older adults (LSN Main Study). Secondly, the LSN Main Study provided the information necessary to carry out two subsidiary longitudinal studies. Respondents who experienced the transition to widowhood are followed longitudinally (Widowhood Adaptation Longitudinal Study; WALS). A second study is the Network Study, which collects more data about the features of the networks of older adults, and enables research into changes in the characteristics and the functions of the network.

The objectives of the LSN program were:

1. to provide insight into the determinants of living arrangements of older adults, their kin and non-kin networks.
2. to provide insight into the outcomes of living arrangements of older adults, and their kin and non-kin networks in terms of the availability of the social support essential for daily functioning, for coping with problems associated with life events, and for maintaining wellbeing.
3. to use these insights to separate the assumptions essential to the constructing of models predicting future trends in living arrangements and networks from the assumptions which are not.

The LSN Main Study consisted of face-to-face interviews conducted in 1992 with 4,494 respondents. The response was 62%, computed as the proportion of the number of face-to-face interviews conducted from the number of eligible sample members. This program used a stratified random sample of men and women born between 1903 and 1937, so that the respondents vary in age from 54 to 89. The mean age of the respondents is 72.8 (*SD*= 10.0). By including these cohorts in the sample, data are available about people who grew up and reached maturity before and during the Depression and during or after the Second World War.

These differences are likely to be reflected in the history of the composition of their households (e.g. membership of three-generation households, co-residence with parents as newly-weds due to housing shortage) or in the timing and the likelihood of marriage and the birth of children. In addition, data are available on older adults who, at the time of the interview, find themselves in different age-related circumstances. A large proportion of the youngest respondents face the transition from employment to retirement, and from having a family with children to having an "empty nest".

[111] This material is summarised from the home pge and linked pages for LSN: http://www.lasa-vu.nl/lsn.html

A considerable number of the oldest respondents may be facing the transition from health and independent functioning to physical ailments and restricted independent functioning. They may be facing possible admission into a home for older persons. Furthermore, there is, with increasing age, an increasing chance of widowhood (with its associated changes in the composition of the household, and changes in the social network) and the increasing chance of death of social network members. The oldest individuals, and in particular the oldest men, were over-represented in the sample.

10.7 Domains covered by LSN, and their differences and similarities with EWAS

The information below provides some examples of the complexity and multiplicity of the issues that interact in the lives of older people, rather than as material which contains particular insights that are beneficial for EWAS. As noted earlier, they do not address EWAS domains like living standards and paid workforce participation.

1. The LSN Main Study

The research program emphasises the autonomy of older adults - their ability to manage on their own. Contrary to many studies into the conditions underlying their ability to manage alone, which tend to emphasise *individual characteristics,* such as the level of cognitive performance or health status, this program centres on *characteristics of the social matrix* in which older adults are embedded. In other words, the focus is on the importance of the personal relationships for daily functioning, for coping with life events and for maintaining wellbeing. More specifically the focus is on living arrangements of older adults and their social networks.

The economic, demographic and cultural changes of recent decades have led to changes in relationships available to people and/or in the conditions providing opportunities for social interaction. The relationships of older adults are also subject to changes associated with the ageing process itself. It is unclear what the implications are for the individual older adult. How do older persons deal with the changing conditions of personal relationships and how will they deal with these changes in the future? These issues are explored through a series of linked research questions.

The first question is: what are the *determinants of living arrangements* of older adults, their kin and non-kin networks? Living arrangements refer to housing, household composition and residential environment.

Housing relates to the situation of an older adult living in a private household or in an institution of some kind. Household composition concerns the matter of the older adult living alone, or sharing the household. If the latter is the case, data are gathered about the household members, whether they are a marital partner, a non-marital partner of the same or of the opposite sex, family members (e.g. adult children, elderly parents, siblings etc.) and/or non-family related individuals. The question of residential environment refers to the location such as close to adult children and/or other family members, or whether the person lives in an area with a relatively high or relatively low sub-population of older adults, and whether the person is a relative newcomer or a long term resident.

It is likely that housing, household composition and residential environment lay down the restrictions and opportunities which an older person has for establishing and maintaining the relationships which decide their social networks. The research program aims to provide insight into the manner in which this occurs.

The second question is: what are the *outcomes* of having a specific living arrangement, kin and non-kin network in terms of the support received, and consequently in terms of daily functioning, coping with life events and maintaining wellbeing? People who are surrounded by other people, who have others available to assist them now and then with practical services, to give positive feedback or to show their affective concern, generally experience a higher level of wellbeing than those who lack such ties with others.

Support provided by social network members helps to protect older persons from experiencing negative outcomes, helps them in their efforts to improve their situation, and helps them respond to adverse events. The support is considered adequate if it meets older persons' needs for wellbeing and makes it possible for them to arrange their own lives.

Several theoretical models can be used to examine the adequacy of support, including ones which meet observed needs for support, and those which stress whether or not the support matches the expectation of the individual.

The third question is: *how can insights* into the determinants and outcomes of living arrangements and networks of older adults *be applied* in the construction of more realistic models of future trends in living arrangements and networks? In particular, research into the conditions determining the relations between wellbeing on the one hand and living arrangements or network characteristics on the other can provide insight into the question as to whether differences in living arrangements or networks among older adults should be taken into account in policy development.

2. The Network Study

The aim of the Network Study is to collect more data about the features of the networks of older adults, and to conduct research into changes in the characteristics and the functions of the network.

Three differences between the Network Study and the LSN Main Study are striking. First, the questionnaire of the Network Study is more detailed about the supportive exchanges between older adults and their network members and about other characteristics of their relationships. Second, the Network Study focuses on changes in a fixed selected part of the network, while the LSN Main Study and the successive LASA survey focus on a changing personal network. Third, (a selection of the) network members participated in the Network Study as respondents. Although the network is still ego-centric, adding information obtained from network members makes it possible to analyse the structural features of a "full" personal network, in addition to structural characteristics like the network size that can be assessed from "star" networks.

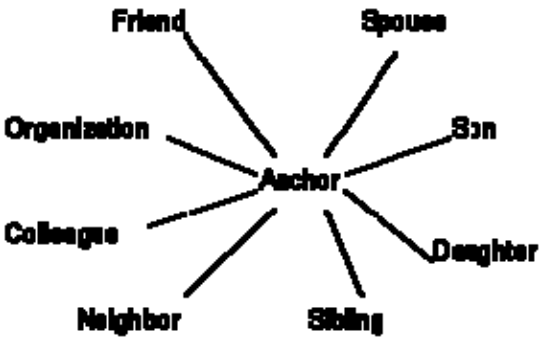


Figure 1

Figure 1 gives an example of a "star" network. The network consists of the "anchor" of the network, eight persons and their relationships with anchor. The anchor is the respondent of the LSN main survey and graphically represented as the middle of a star. In the interview for the LSN Main Study the anchor of this example mentioned at least eight persons with whom s/he is in touch regularly and who are important to him/her: partner, son, who is a member of the household, daughter, one sibling, a neighbour, a colleague, someone who is known from an organisation and a friend.

Figure 2 gives an example of a "full" network. The network consists of the "anchor" of the network, eight persons and their relationships with anchor, and their mutual relationships. The study obtains information about the content of each of the relationships from two sources: for each relationship pair the researchers have the answers of both participants in the relationship about the characteristics of the relationship.

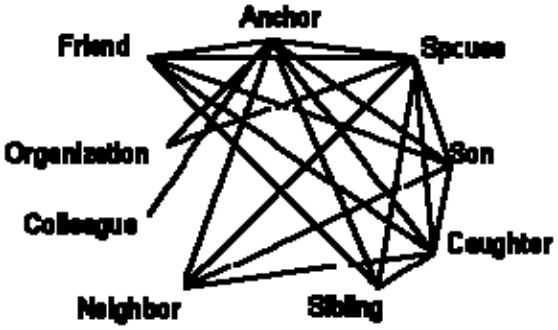


Figure 2

The personal network

The main objective was to identify the networks that reflected the socially active relationships of the elderly respondents in the core and the outer layers of the larger network.

In choosing a method to identify the personal networks, several criteria were set regarding who was to be included in the network. First, the network composition had to be as varied as possible, implying that every type of relationship deserved the same chance to be included in the network. This criterion led to a domain-specific approach in the network identification, using seven formal types of relationships (see below). A second objective

was to include all the network members the elderly respondents had regular contact with, thus identifying their socially active relationships.

However, the aim was not to include everybody they had contact with. To avoid including people they had regular contact with by definition (such as all their colleagues and all the other members of their bridge club), the criterion of the importance of the relationship was added. The respondents could only nominate the network members who they had regular contact with and who were important to them. This enabled them, for example, to nominate the two colleagues they had relatively close contact with and leave the others out of the network.

Seven domains of network members are identified. In addition, respondents could identify 'forgotten' contacts. The maximum number to be identified was 80. Per domain there is also a maximum, specified as follows:

- household members, including the partner: 12;
- children and their partners: 25 minus the number of network members identified earlier;
- other family members: 40 minus the number of network members identified earlier;
- neighbours: 50 minus the number of network members identified earlier;
- contacts through work and school: 60 minus the number of network members identified earlier;
- members of organisations: 70 minus the number of network members identified earlier;
- others: 80 minus the number of network members identified earlier ;
- "forgotten" contacts: 80 minus the number of network members identified earlier.

Thus, when fewer people in a particular domain are nominated than the maximum allows, this difference is added to the maximum for the following domain. Only very small number of respondents reached the maximum set in a specific domain. However, none nominated the maximum number (80). Therefore, respondents who reached the maximum in a specific domain had the opportunity to nominate more persons in the domain of "forgotten" contacts.

For each identified network member and its relationship with the respondent a number of questions were asked.[112] Type of relationship, living in the respondents' household, sex, frequency of contact, marital and partner status, age, travelling time, duration of the relationship, employment status, instrumental support received and given, emotional support received and given, quarrelling, most supportive relationship, confidant.

3. Widowhood Adaptation Longitudinal Study (WALS)

143 of the respondents of the LSN Main Study participated in the Widowhood Adaptation Longitudinal Study (WALS). The central aim of WALS is to examine the mental and behavioural responses of older adults in the first two-and-a-half years after the partners' death and the consequences of these responses for their personal relationships and wellbeing.

Widowhood has a strong negative impact on wellbeing, and feelings of loneliness are very common among widows and widowers. In addition, widowhood induces both losses and

[112] http://www.lasa-vu.nl/lasa_variables_network_list_of_variables.html

gains in the personal network. Usually, studies focused on either the social or the psychological consequences of widowhood. A thorough understanding of the process of adjustment to widowhood requires a focus on loneliness, network changes and individual coping responses over time.

Three issues are focused on in this study. First, the study describes short-term developments in loneliness, coping responses and personal relationships (support and contact) of conjugally bereaved older adults. Second, the study explains differences in response patterns of older widows and widowers by interpreting these within the framework of the Theory of Mental Incongruity (TMI)[113]. Third, conjoint developments in coping responses and personal relationships are examined to gain more insight in the phases of conjugal bereavement in old age.

Experiencing the loss of a partner is assumed to create 'mental incongruence' in bereaved persons due to an experienced lack of intimacy, contacts or support in social relationships. The process of adjustment is aimed at reducing this mental incongruence. This can be accomplished by behavioural coping responses (e.g. seeking for social contacts) or by mental coping responses (e.g. lowering relationship standards) are expected to result more from active support mobilisation by the older adult than from mental adjustment.

WALS is a prospective study in which participants were interviewed before their partner died (T0), and five times, with 6 - 7 months intervals, following bereavement (T1 - T5). Before partner loss, data were collected as part of the survey on "Living arrangements and social networks of older adults". LSN-respondents with a partner (n = 2606; 60% of LSN-respondents) formed the baseline group for the present. 111 respondents took part in the entire study (T0-T5).

The questionnaire administered to the respondents covered demographics, the death of the partner, coping with the death of the partner, characteristics of the partner relationship, health, ADL and IADL capacity, relationship standards, the personal network, supportive exchanges with network members, relationship discrepancies and mobilisation of relationships, loneliness, income, characteristics neighbourhood, wellbeing and personality. The questionnaire is available on the web in Dutch only.

10.8 LSN studies

Many of the published LSN studies provide significant insight into the existence and impact of older people's networks on aspects of their quality of life. Others investigate topics that are rarely explored, such as the impact of prayer on adaptation after loss. Nineteen LSN studies, which are likely to be of interest to EWAS researchers, are summarised below.

1. Gender and marital-history differences in emotional and social loneliness among Dutch older adults. Dykstra, P.A., & de Jong Gierveld, *Canadian Journal on Aging, 23*, 141-155. 2004.

[113] Experiencing the loss of a partner is assumed to create 'mental incongruity' in bereaved persons due to an experienced lack of intimacy, contacts or support in social relationships. The process of adjustment is aimed at reducing this mental incongruency. (www.lasa-vu.nl/lsn_wals.html)

The study
In this study, Weiss's (1973) theorising about the sources of emotional and social loneliness is elaborated - with notions about the asymmetric gratifications derived from marriage, about the conflicting loyalties that result from remarriage, and about selection into marriage - in order to reach an understanding of gender differences in loneliness, both in and outside of marriage. First and subsequent marriages are considered, as well as marital disruptions and never marrying. The data (N = 3737) are from the 1992 Dutch survey on older adults' living arrangements and social networks (NESTOR-LSN).

The results
Marital-history differences emerge, not only for emotional loneliness, but also (and contrary to Weiss's theoretical conceptualisations) for social loneliness. The marital-history differences in emotional and social loneliness are greater among men than women. For men, the marriage bond appears not only to be more central to emotional wellbeing than is the case for women but also to play a pivotal role in their involvement with others. Marital history offers the best explanation for differences in emotional loneliness among men, but social embeddedness characteristics also account for differences in emotional loneliness among women. Apparently, whereas men are more likely to find an intimate attachment in marriage, women also find protection from emotional loneliness in other close ties. The marital-history differences in social loneliness are largely mediated by social embeddedness characteristics, partly in different ways for men and women. Involvement in activities outside the home serves as the context for sociability for men, whereas parenthood plays a more important role in women's social engagements.

2. Employment and divorce among Dutch women born between 1903 and 1937. Fokkema, T., & Liefbroer, A.C. *History of the Family, 9*, 425–442, 2004

The study
Women's increased economic independence is often regarded as a major contributor to the rise in the divorce rate since the 1960s. The rise in female labour-force participation and educational attainment has eroded the benefits of the traditional gender division within marriage and reduced the negative financial consequences of divorce. Women's employment may also undermine traditional marital role expectations and increase stress and marital conflict. In contrast to other countries, the Netherlands has seen virtually no empirical support for this economic independence hypothesis to date. This study tests this hypothesis by examining women born between 1903 and 1937.

The results
The results of multivariate analyses confirm the economic independence hypothesis: both a high level of education and labour-force participation significantly increase women's likelihood of divorce.

3. Remarriage, unmarried cohabitation, living apart together: partner relationships following bereavement or divorce. de Jong Gierveld, J. *Journal of Marriage and the Family, 66*, 236-243, 2004

The study

Substantial proportions of people enter into new partner relationships after bereavement or divorce. Nowadays in Europe, unmarried cohabitation and living-apart-together

relationships are frequently opted for at repartnering. Drawing on the Netherlands' Living Arrangements and Social Networks survey of men and women aged 55 to 89 years (N = 4,494), this study explicates the determinants that lead widowed or divorced people to enter into old and new types of partner relationships.

Results
Cox proportional hazard regression analyses revealed that age at most recent union dissolution, the number of partner dissolutions, working during and after the most recent union dissolution, and other demographic variables are important in weighing the pros and cons of different types of living arrangements.

4 Age-segregation in later life: An examination of personal networks. Uhlenberg, P., & de Jong Gierveld, J. *Ageing & Society, 24*, 5-28, 2004.

The study
In a rapidly changing society, young adults may play an important role in teaching older adults about social, cultural and technological changes. Thus older people who lack regular contact with younger people are at risk of being excluded from contemporary social developments. But how age-segregated are older people? The level of age-segregation of older people can be studied by examining the age-composition of personal social networks.

Method
Using NESTOR-LSN survey data from the Netherlands, the researchers determined the number of younger adults that people aged 55 - 89 years identify as members of their social networks, and to examine the factors that are associated with segregation or integration.

Results
The findings show that there is a large deficit of young adults in the networks of older people, and that few older people have regular contact with younger non-kin. If age were not a factor in the selection of network members, one would expect the age distribution of adult network members to be the same as the age distribution of the entire adult population, but the ratio of actual to expected non-kin network members aged under 35 years for those aged 65 - 74 years is only 0.10. In addition, only 15 per cent of the population aged 80 or more years has weekly contact with any non-kin aged less than 65 years.

The number of children is strongly related to the total number of younger network members, because younger network members are adult children. Further, participating in organisations (work and volunteer settings) that include people of diverse ages increases the likelihood of an older person having significant cross-age interactions with non-kin.

5. Loneliness among older adults in the Netherlands, Italy and Canada: A multifaceted comparison, van Tilburg, T.G., Havens, B., & de Jong Gierveld, J. *Canadian Journal on Aging, 23*, 169-180, 2004.

The study
Loneliness is experienced in many cultures. To properly assess cross-cultural differences, attention should be paid to the level, determinants and measurement of loneliness. However, cross-cultural studies have rarely taken into account more than one of these.

Differences in the level of loneliness were hypothesised on the basis of national differences in partnership, kinship and friendship, which were assumed to be related to cultural standards within a society. Differences were examined among married and widowed older adults aged 70 to 89 years living independently in the Netherlands (N = 1847), Tuscany, Italy (N = 562) and Manitoba, Canada (N = 1134). Loneliness was measured with an 11-item scale.

Results
The Manitobans were high on emotional loneliness and the Tuscans were high on social loneliness. Partner status excepted, the determinants were nearly the same across the three locations. Differential item functioning (DIF) related to the three locations was observed for most items. Interactions with gender and the availability of a partner relationship were observed.

6. Income differentials in functional disability in old age: Relative risks of onset, recovery, decline, attrition and mortality. Broese van Groenou, M.I., Deeg, D.J.H., & Penninx, B.W.J.H. *Aging, Clinical and Experimental Research, 15*, 174-183. (2003).

The study
Socioeconomic status (SES) differences in health decline in late life may be underestimated, because the relatively higher risks of attrition of lower-SES persons are seldom taken into account. This longitudinal study aimed at comparing income differences in the course of disability, non-mortality attrition and mortality in older adults.

Methods
A sample population of 3,107 older adults who participated in the 1992/1993 baseline of the Longitudinal Aging Study Amsterdam was examined regarding changes in functional disability in 1998/1999. SES was indicated by household income.

Results
Multinomial regression analyses revealed that, for men without disability at baseline, the relative rate for attrition was four times higher and the mortality rate was twice as high for low-income compared with high-income persons. For non-disabled women, the relative risk for the onset of disability was nearly twice as high for low-income compared with high-income persons. For both men and women, these risks decreased only slightly when behavioural and psychosocial risk factors were taken into account.

Among persons with disability at baseline, the relative risks for attrition (for women) and mortality (for men) were twice as high for low-income persons, but adjustment for risk factors decreased the relative risks for attrition and mortality to a non-significant level. No income differences were found with respect to recovery and decline.

Income inequality in health in late life is to a large degree explained by the higher incidence of disability among lower-status women and by the higher attrition and mortality risks among lower status men.

7. Network size and support in old age: Differentials according to childhood and adulthood socioeconomic status. Broese van Groenou, M.I., & van Tilburg, T.G. *Ageing & Society, 23*, 625-635, 2003.

The study

This study examines the impact of childhood and adulthood socio-economic status (SES) on personal network characteristics in later life. Data are derived from 2,285 married older adults (born between 1903 and 1937) who participated in face-to-face interviews for the survey of 'Living arrangements and social networks of older adults' conducted in 1992. Childhood and adulthood SES were indicated by the father's and own level of education and occupation.

Results
Multivariate analyses showed that SES in adulthood has more impact on network features in old age than father's SES. People with lifetime low SES or with downward SES mobility had small networks, low instrumental and emotional support from non-kin, but high instrumental support from kin when compared with the upwardly mobile or those with high lifetime SES. Level of education was a better indicator of network differences than occupational prestige.

The researchers concluded that obtaining a high SES during life pays off in terms of having more supportive non-kin relationships in old age. The small networks and less supportive non-kin relationships of low status older adults make them more vulnerable to situations in which kin are unavailable or less willing to provide support.

This study underscores the distinction between types of support and types of relationships in the SES – network association. Further research on the social pathways of socio-economic inequality of health and wellbeing should take these distinctions into account.

8. The interweaving of repartnered older adults' lives with their children and siblings. de Jong Gierveld, J., & Peeters, A. *Ageing and Society, 23*, 187-205, 2003

The study
This study examines the consequences of repartnering upon the social embeddedness of older adults' lives. The starting hypotheses, that repartnering is a stressful life event and is incompletely institutionalised, are examined using the NESTOR longitudinal survey data on 4,449 respondents aged 55-89 years, together with in-depth interviews of 46 adults-aged 50 or more years who had repartnered in later life.

Results
The results indicate that more repartnered older adults choose unmarried cohabitation and to 'live apart together' than remarriage. It was also found that when two partners come together, while not surprisingly their social networks become larger than those of separated older adults who do not enter a new relationship, the quality of the subjects' relationships with their children was negatively affected. Older adults who opted for unmarried cohabitation and 'living apart together' relationships tended to have the weakest bonds with their children, principally for reasons associated with stress and (financial) insecurity.

9. Continuation of exchange with neighbours in later life: The importance of the neighbourhood context. Thomése, G.C.F., van Tilburg, T.G., & Knipscheer, C.P.M., *Personal Relationships, 10*, *535-550,* 2003.

The study

Relationships with neighbours are considered exchange relationships, in which the continuation of exchanges depends on balance in previous exchanges. This study tested whether this is the case. An exchange relationship implies that neighbour relationships are isolated units. The researchers expected, however, that neighbourhood integration also affects the continuation of exchange among neighbours. Data were from a longitudinal study among 1,692 independently living Dutch adults of ages 55 to 85 years at baseline and their 7,415 relationships with proximate network members.

Results
At a four-year follow-up, both perceived balance and neighbourhood integration at baseline increased the chance of instrumental support exchange occurring. The researchers concluded that it is too limited to view relationships between neighbours as exchange relationships, as these relationships are embedded in larger communities, where such communities exist.

10. Consequences of men's retirement for the continuation of work-related personal relationships. van Tilburg, T.G. *Ageing International, 28*, 345-358, 2003.

The study
Retirement is an important life cycle marker and has a major impact on an individual's functioning. Based upon the social convoy model, it is hypothesised that retirement decreases the likelihood of continuation of co-worker relationships. Socio-emotional selectivity theory predicts a decline in the number of peripheral relationships with ageing and thereby in network size and number of co-worker relationships among working and retired people. Data comes from the Longitudinal Aging Study Amsterdam with five observations between 1992 and 2002. At baseline 226 men aged 54-81 years were employed; 166 men retired in the course of the study.

Results
The results of multilevel regression analyses showed a stable network size both for working and retired men. Among all men the number of work-related network members declined, but more strongly among retirees. It is concluded that the convoy model fits better with the data than socio-emotional selectivity theory.

11. The long-term rewards of parenting: older adults' marital history and the likelihood of receiving support from adult children. de Jong Gierveld, J., & Dykstra, P.A. *Ageing International, 27 (3)*, 49-69, 2002.

The study
This study investigates support provided to older parents by non-resident children and compares older adults in various living arrangements, based on a typology of current partner status, marital history and gender. Data come from the Dutch 1992 survey on older adults living arrangements and social networks (NESTOR-LSN). The 4494 respondents constituted a random sample of men and women born in the years 1903 to 1937.

Results
The findings point out that ever-divorced men, regardless of whether they have repartnered, receive only marginal help from their children. Among those with new partners, 8% of the ever-divorced men and 22% of the ever-divorced women cite children as sources of help, while this is so for 45% of the ever-widowed men and 53% of the ever-widowed women.

Multivariate analyses revealed that health, educational level, number of children and travel distance are significant predictors of support from children, in addition to the significant and important contribution of marital history, partner status and gender.

12. Partner pathways after the age of fifty, de Jong Gierveld, J., & Peeters, A. *Mens & Maatschappij, 77*, 116-136, 2002.

The study
A considerable percentage of men and women aged fifty or over become involved in new partner relationships after divorce or widowhood. Partner relationships investigated in this article include remarriage, consensual unions and Living-Apart-Together (LAT). Drawing on NESTOR-LSN survey data (n = 4494) as well as in-depth interviewing of repartnered older adults (n = 46) this study explicates the motivational, socioeconomic and demographic determinants of starting a new partner relationship.

Results
Results from multinomial logistic regression analysis and the motives provided in the in-depth interviews reveal that a traditional versus a more individualistic value orientation, socioeconomic status, and financial motives in particular, contribute to the understanding of older adults' decisions to either remarry, start a consensual union or a LAT-relationship.

13. Theories on coping with loss: The impact of social support and self-esteem on adjustment to emotional and social loneliness following a partner's death in later life. van Baarsen, B. *Journal of Gerontology, B57*, S33-S42, 2002.

The study
This longitudinal study focused on the role of self-esteem and social support in adjustment to loneliness experienced by bereaved elderly persons. This study also examined the contributions of a general and a specific coping theory toward explaining loneliness. A distinction has been made between emotional loneliness and social loneliness / perceived support. The theory of mental incongruity predicts that the presence of more favourable conditions, such as higher self-esteem or more social support, results in less loneliness (i.e., less incongruity). According to the theory of relational loneliness, the partner's death leads to a loss of identity, thus increasing emotional loneliness, and social support does not mitigate emotional loneliness following a loss. In total, 101 participants, aged 55-89 years, were interviewed before and after their partners' deaths.

Results
Findings were ambiguous with regard to both theories. As hypothesised, partner loss lowered self-esteem, resulting in higher emotional loneliness and social loneliness, that is, perception of less support. Supportive personal relations reduced emotional loneliness. The presence of close friends, however, seemed to increase emotional and social loneliness (i.e., decrease perceived support) in the long term, particularly among bereaved participants with lower self-esteem.

The findings highlight the need to integrate theoretical concepts. In explaining adjustment to a partner's death, attention should be paid to underlying mechanisms relevant to the restoration process (e.g., identity change) and the ways in which the adjustment process

can be improved (e.g., intimate relationships) or impeded (e.g., dependency-sustaining relationships).

14. Patterns of adjustment to partner loss in old age: the Widowhood Adaptation Longitudinal Study. van Baarsen, B., van Duijn, M.A.J., Smit, J.H., Snijders, T.A.B., & Knipscheer, C.P.M. *Omega, Journal of Death and Dying, 44*, 5-36, 2002.

The study
This longitudinal study aims to explain emotional and social loneliness experienced by older adults (N = 99) during two-and-a-half years of widowhood. Utilisation of multilevel analysis and a "visual" cluster analysis with prescribed classification criteria enabled the researchers to search for average adaptational developments as well as individual variability in the adjustment process.

Results
Results were interpreted within the theory of mental incongruity. Adjustment to loneliness appears to develop along different individual-specific curves. About 30% of the bereaved had not adapted in two-and-a-half years to their loss in terms of emotional loneliness. The presence of favourable opportunities such as good health and high self-esteem as well as coping efforts like social behaviour resulted in lower levels of emotional and social loneliness.

The researchers concluded that a generalised adjustment process among older bereaved does not exist. Moreover, including measures of cognitions and attitudes that are related to the relational needs and desires of widow(er)s may enlarge our knowledge of how older adults adapt to partner death.

15. Partner loss in later life: Gender differences in coping shortly after bereavement. van Baarsen, B., & Broese van Groenou, M.I. *Journal of Loss and Trauma, 6*, 243-262, 2001

The study
This longitudinal study aimed to explain coping responses of older women (n = 60) and men (n = 43) at about 1 year following partner loss using a general theory of coping. The theory of mental incongruity predicts that behavioural and mental coping are responses to experienced loneliness and that they are facilitated by actual and perceived opportunities or resources.

Results
The availability of social relationships and better general health encourage coping responses among the bereaved, as well as, unexpectedly, higher social anxiety and financial stress.

Results reveal opposite effects for women and men. As time elapses since the death of the partner, men more often share their emotions with others than women. Also, the results suggest that resources play different roles in coping responses of recently bereaved women and men. Among widowers financial stress may impede emotional coping responses, while among widows higher education and having a best female friend seem to function as risk factors in coping with loss. Relative health, or the feeling one is better off than comparable

others, may protect against the negative effects of partner death, particularly among recently bereaved women.

The researchers conclude that the proposed theory offers useful concepts in understanding how recently bereaved individuals cope with partner death; however, it is not helpful in explaining the gender differences found in the present study. Further, the findings question the supposed less favourable health position of older widows and the more favourable social position of older widows and socioeconomic position of older widowers.

16. Partner and children: burden or asset for occupational attainment? Occupational mobility of men and women with different marriage and parenthood careers. Dykstra, P.A., & Fokkema, T. *Mens en Maatschappij, 75*, 110-128, 2000.

The study
With its focus on the interrelationships of occupational mobility with the life domains of marriage and parenthood, this study brings a 'family perspective' to research on social inequality, and a 'socio-economic perspective' to research on the functions of marriage. Life history data (1903-1937 birth cohorts) from the 1992 NESTOR-survey 'Living arrangements and social networks of older adults' are used to examine the ways in which men and women's marriage history (never marrying, stable first marriage, early divorce or widowhood, early remarriage) and parenthood history (remaining childless within marriage) affect their occupational attainment (prestige of last job).

Results
The findings show clear gender differences. Among men, the level of entry into the labour market is the key to occupational success. Among women, this is only part of the story. Women's occupational success is not only strongly determined by their starting position on the labour market, but also by their marital and parenthood histories. The latter are inconsequential for men's occupational success. Never married women, single divorcees, and women in second marriages achieve relatively high positions in the labour force. Among married and formerly married women, those who remain childless achieve greater success than mothers. The findings suggest that the absence rather than the presence of family ties (partner and/or children) fosters women's occupational success.

17. Neighbouring networks and environmental dependency: differential effects of neighbourhood characteristics on the relative size and composition of neighbouring networks of older adults in the Netherlands. Thomése, G.C.F., & van Tilburg, T.G. *Ageing & Society, 20*, 55-78, 2000.

The study
The effects of four social-structural neighbourhood characteristics on the relative size and the composition of neighbouring networks are tested in a sample of 3,504 older adults born between 1908 and 1937 and living in three regions in the Netherlands. Interactions with individual income and ADL capacity are included in multilevel regression analyses, to test the effects of older adults' environmental dependency.

Results

Population density and residential mobility both have a negative effect on the relative size of neighbouring networks, and the effect of urbanisation is strongest among poorer respondents.

These findings suggest that the structural effects of urbanisation work at the level of concentration rather than dispersion of personal networks, and that there is no general mechanism of environmental dependency.

18. Loneliness among older adults: Geographical and neighborhood characteristics. Broese van Groenou, M.I., van Tilburg, T.G., & de Jong Gierveld, J *Mens & Maatschappij, 74*, 235-249,1999

The study
This study examined whether differences between regions, rural and urban communities and neighbourhoods contribute to older adult loneliness, when their health and social circumstances are also taken into account. The data are from nine research projects involving older persons in several regions in the Netherlands. Six were carried out by Community Health Departments (GGDs) Three other data sets are from the NESTOR-program Living arrangements and social networks of older adults (LSN), in which older adults in Amsterdam and surroundings, Zwolle and surroundings and Oss and surroundings, participated.

Results
Multivariate multilevel regression analysis show that, controlling for the health and social circumstances of the older adults, regional differences in loneliness are small. Living in an urbanised area and in a neighbourhood with relatively few older people, contributes to more intense feelings of loneliness.

19. Living arrangements of older adults in the Netherlands and Italy: co-residence values and behaviour and their consequences for loneliness. de Jong Gierveld, J., & van Tilburg, T.G. *Journal of Cross-Cultural Gerontology, 14*, 1-24, 1999.

The study
Value studies indicate that the process of individualisation in Europe started in Sweden and Norway, and continued via France and the Netherlands; the southern European countries lag behind, and are still characterised by more traditional family orientations. Starting from this point of view, this study investigates the effects of differences between the Netherlands and Italy in the field of living arrangements of older adults with and without partners. The consequences of living alone and of co-residence with adult children have been further investigated, using loneliness as the dependent variable. The size and support functions of the network of social relationships, socio-economic resources, health, sex and age are also taken into account. Data come from face-to-face surveys among a random sample of older adults (55 to 89 year old women and men) in the Netherlands (N= 4,494) and in Italy (N= 1,570), using the same research design and questionnaire.

Results
The data show country-specific differences in household types of older adults: The proportion living alone is much higher among older people without partners in the Netherlands; the proportion co-residing with their adult children is higher in Italy than in the Netherlands.

Controlling for age, health, sex, size and support of the network, and for differences in socio-economic resources, household composition is still the most important determinant of loneliness. Living without a partner in the same household as one's adult children yields country-specific correlations that correspond with differences in value orientations: less loneliness in Italy, more loneliness in the Netherlands.

11. JOSEPH ROWNTREE FOUNDATION

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11.1 Introduction

The Joseph Rowntree Foundation (JRT)[114] is one of the largest social policy research and development charities in the UK, spending about £10 million a year on a research and development programme that seeks to better understand the causes of social difficulties and explore ways of overcoming them. The Foundation funds programmes of research and disseminates the findings (one thousand research summaries are available on line) to influence change in policy and practice. It does not carry out the research in-house, but works in partnership with a large variety of academic and other institutions to achieve its aims.

11.2 Similarities with EWAS

The Foundation shares with EWAS a strong concern that research should flow into policy, and that end users should be involved in the design, delivery and analysis of research. This latter concern has led to an ongoing stream of work, particularly in the area of ageing research, which seeks to identify and put into practice the most effective methods of engaging older people. There are other similarities with EWAS – JRT has conducted investigations into quality of life for older people; and the nature of transitions from work to retirement (though the age span that has been researched is from 50 onwards). The Foundation is also one of the limited numbers of research bodies which has published the results of research into elder abuse. Each of these areas is summarised below.

The research results published by the Foundation are derived from a multiplicity of studies, which use a diversity of research methods. This makes the Foundation's work both very different from EWAS, which is a unified programme of research, and a very rich source of ideas for areas of further investigation. For that reason, the methodologies of the various studies are noted briefly, but greater attention is paid to the fields for investigation, and the results of the research.

Because of the range and depth of the Foundation's ageing research, the extraordinary richness of the researchers' engagement with older people, the translation of many of the research's findings into policy and into practical application through the Foundation's own housing and residential schemes, and the explicit investigations into ageing for ethnic minorities in Britain, this chapter is longer than most in the report.

In order to put research into older people into the context of the Foundation's overall work programme, this section:
begins with a brief overview of the Foundation's current research themes and policy and practice development,
lists the current work programme on older people, and
presents an overview of the Foundation's work to date on older people.

Extended summaries of the studies of most direct relevance to EWAS are then included, as are short summaries of the rest of the more than 50 JRT studies that relate to older people. Further research studies relating to managing care and paying for care (28 in total) are

[114] This material is derived from the Trust's home page and linked pages (www.jrf.org.uk/)

listed but not summarised, as they discuss issues that directly arise from the UK policy settings, which differ significantly from New Zealand's.

11.3 Overview: the Foundation's current research themes, policy and practice

Current Foundation research themes and policy and practice development cover the following areas:

Research:

- Housing and neighbourhoods
- Poverty and disadvantage
- Practice and research
- Drugs and alcohol
- Governance
- Immigration and inclusion
- Independent living
- Parenting

Policy and practice development:

- Policy and practice development activities take forward the messages from the research evidence. Current programmes are:
- Back-bench councilors
- Long-term care of older people (LTC)
- Neighbourhood renewal
- Bradford Research and Development (BRAD)

The Foundation also engages in practical housing and care work through the Joseph Rowntree Housing Trust.

The Foundation's current work concerning older people
Work concerning older people currently focuses on:

- Independent living
    - The aim of this programme is to identify and understand the key barriers to achieving person-centred support for older people, disabled people and service users. It hopes to identify approaches to address these barriers which will have credibility with users and viability in policy and practice.
- Long-term care of older people
    - This programme aims to identify, encourage and build consensus around the implementation of a sustainable model for meeting the costs of long-term care throughout the UK.
- Caring Choices: who will pay for long-term care?
    - 'Caring Choices: Who will pay for long-term care?' is a nationwide initiative to help shape future policy on long-term care for older people. It seeks to raise awareness of the challenges facing the future of long-term care funding.
- Lessons from the Trust's operational work

- This programme is directly related to the operational activities of the Joseph Rowntree Housing Trust rather than being geared to more general research questions. Topic areas are wide-ranging but all have this focus, and almost all work is commissioned to a specific brief. Recent themes under which work has been undertaken include:
  - Nuisance and tolerance
  - Housing and care models
  - Housing finance and low-cost home ownership
  - Risk and regulation in the residential care sector
  - Mixed income sustainable communities
  - The care and social wellbeing of frail older people

- Current Joseph Rowntree Housing Trust (JRHT) provision
  - The Trust provides a range of housing and care options and schemes including retirement living and care, sheltered housing, renting, shared ownership, and HomeBuy (Government assisted home purchase for low income earners). It also offers transfers and swap schemes.
- Resources in later life (RILL)
  - RILL aims to identify policy and practice responses to help create stable foundations for financial security. The focus is poverty among older people now and the barriers that need to be overcome to alleviate it.
  - Understanding how to do this involves exploring how social, personal and financial resources help meet the aspirations of older people and how economic needs change throughout later life.
    Four research reports are available:
    - *The needs and resources of older people*
      This study explores the needs of people in later life, including expenditure, health, social networks, services, housing and neighbourhood, as well as income. (April 2007 - further information is given below in the section on research of particular interest to EWAS)
    - *Monitoring poverty and social exclusion in Scotland 2006.*
      The 2006 analysis of trends in poverty and social exclusion indicators in Scotland. (December 2006)
    - *The material resources and well-being of older people*
      Using a range of data from England, Scotland and Wales from the ESAW study, this research examines the material resources and financial satisfaction of older people. (March 2006 - further information is given below in the section on research of particular interest to EWAS)
    - *Progress on poverty, 1997 to 2003/4*
      This study gives the most detailed analysis to date of the government's progress on its targets for reducing poverty.
- Elders and carers in Bradford
  The aims are:
  - To identify the needs, views and perceptions of older people, their families and carers in Bradford regarding current care provision and future aspirations.
  - To identify the extent to which older people, their families and carers consider that their care and support needs are, or might be, met and by whom.

An overview of the Foundation's recent and ongoing work concerning older people
The Foundation has recently published an overview of its work to date concerning older people[115].The Foundation has a unique perspective on issues facing older people through the interaction of its research, its operations as a provider of housing and social care and its commitment to conducting a dialogue with older people so that they can articulate their own needs and perspectives.

On the one hand, this work has found that many needs are not being met and that too often older people remain vulnerable to poverty and neglect. On the other hand, the Foundation's research shows that older people's aspirations are neither excessive nor impossible to meet. Often what is wanted is security that resources and services will be forthcoming: reliability, together with a 'human' face to services, is critical. On its operational side, the Foundation has shown that it is possible to provide the things that older people consider important and which will improve their quality of life.

The paper rounds up the main areas where JRF is doing research related to older people, followed by a sample of some developments in JRF's operations and lessons being drawn.

Main areas of research and key findings:

- Older people's services, needs and perspectives:
    - The Foundation's Older People's Programme has been about the stage in life when older people might need "that bit of help" (further information is given below in the section on research of particular interest to EWAS). However, because life cannot be neatly packaged into discrete stages, the programme has looked at a broad range of issues. Crucially, it has been defined, directed and critiqued by older people themselves; they report that a lot of unmet need is not being measured or addressed.
    - Managerial ideas of quality in services need to engage more with older people's own ideas of quality.
    - The overview programme report shows how, far from being a 'burden', older people are themselves major providers of support to other older people, as well as active supporters of families and communities[116].

- Long-term care:
    - The Foundation has been looking at the difficulties with current funding of long-term care and seeking consensus on solutions. Drawing on experience of different parts of the UK and of other countries, this programme concluded that present funding arrangements are incoherent, unfair and inadequate.
    - In the long term, a thorough overhaul is needed to secure proper funding, with clear-cut systems for sharing the cost between the public purse and private individuals.

- Housing with care

[115]http://www.jrf.org.uk/older-people/documents/overview.pdf
[116] Older people shaping policy and practice, *JRF Foundations Ref: 044*, October 2004.

- The Foundation brings its own experience as well as wider research knowledge to the issue of what retirement communities can contribute to older people's wellbeing.
- A review of existing material on this topic concluded that despite strong evidence that residents value the combination of independence and security/support that such settings offer, robust evidence across a number of other dimensions is missing[117].
- The Foundation is now pursuing a comparative study of housing and care models (due to publish in Autumn 2007), and research looking specifically at social wellbeing in such settings.

- Resources in later life (RILL – noted above, and expanded on below)
  - This programme aims to identify policy and practice responses to help create stable foundations for financial security. The focus is poverty among older people now and the barriers that need to be overcome to alleviate it.

- Unlocking assets and attitudes to inheritance
  - Over some years, JRF has taken an interest in the scope for older people to tap into their housing assets to help meet needs such as home repair, care services and general living costs. This has linked into studies by the Foundation on housing renewal.
  - The work has found that most people prioritise meeting their own needs over passing on assets, and that many would be willing to consider equity release if the right terms were available.
  - The Foundation has published a study considering how the design of equity release products might be improved and, in particular, whether there is scope for public-private partnerships that would make such products more accessible and attractive to people in lower income groups[118] .

- Transitions after 50
  - A JRF research programme completed in 2004 looked at the factors affecting transitions from work to retirement, especially for those leaving work before the state pension age. This programme found that many people, especially those from disadvantaged groups, lack control over this transition process and would benefit from greater opportunities to work flexibly. (Further information is given below in the section on research of particular interest to EWAS.)
  - The Foundation followed this up by developing policy and practice ideas, focussing on how to make working lives more sustainable for those who wish to work longer[119]. This work emphasised that aspects such as workers' health and skills need to be addressed throughout working life, rather than waiting until people are on the verge of retirement when it can be harder to help them.

A sample of some developments in JRF's operations and lessons being drawn

[117] Housing with care for later life: a literature review, *JRF Findings, Ref: 0076*, February 2006
[118] Terry, R., and Gibson, R., (2007) *Local government support for equity release.* Joseph Rowntree Foundation.
[119] Hirsch, D., et al, (2005) *Sustaining working lives: a framework for policy and practice.* Joseph Rowntree Foundation.

The Foundation's initiatives include the following.

- Housing with care – changing the emphasis from residential/nursing provision to housing with care schemes, collaborating with local authorities and Primary Care Trusts to meet the health, social, and psychological well being needs of older people.
- Flexible care homes – building partnerships with care providers and commissioning feasibility study round best practice. There is a real need for housing and support services to be integrated, to provide a seamless service without the need to move home.
- Dementia and older people with learning difficulties - work on staff awareness and training, pain management for older people with learning difficulties and dementia, and long-term service provision for people who develop dementia.
- Single assessment process - thorough assessment which actively listens to and records the voice and concerns of older people is vital in planning to meet the care and support needs of older people.

11.4 Joseph Rowntree studies of most direct relevance to EWAS

Five areas are extensively summarised below, because of their similarities with EWAS's research interests:

1. Quality of life: the experience of ageing in time and place
2. Needs and resources of older people
3. Older people shaping policy and practice
4. The experience of elder abuse
5. Work and retirement: transitions after 50

1. Quality of life: the experience of ageing in time and place

Building a good life for older people in local communities: The experience of ageing in time and place[120] *Mary Godfrey, Jean Townsend and Tracy Denby* October 2004

In this study, older people describe what makes for a 'good life' in old age. The report provides a picture of growing old in two urban localities: an ethnically diverse, inner city neighbourhood and a town that has seen major de-industrialisation and unemployment over the working lives of those who are now retired. Through the experiences and voices of older people, the report explores issues such as:

- How important was their local area to older people?
- What events and experiences have shaped their views of a 'good' old age?
- What was the everyday experience of people's lives, and how did this change with loss of health and abilities, and through bereavement?

A significant and novel part of the study was the participation of older people as research partners, involved in all stages of the work: interviewing, analysis and shaping the writing.

[120] www.jrf.org.uk/knowledge/findings/socialcare/014.asp

Their experiences and views offer insight into the kinds of services and support that are likely to sustain wellbeing as people get older.

The research approach

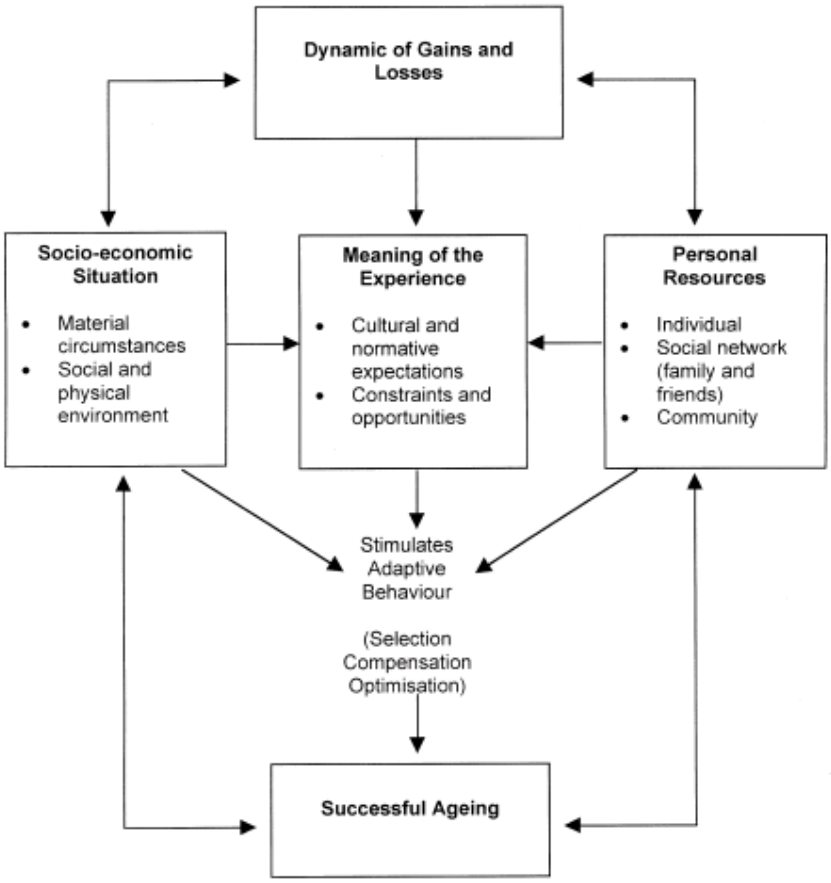
In exploring wellbeing in old age, the underpinning rationale is the duality of ageing – the tension between old age as being both about loss and adjustment, and opportunities for personal development and growth. Moreover, older people are seeking to make sense of, and are actively engaged in, a process of adaptation to physical, social, interpersonal and psychological changes, embracing both learning and adjustment. The balance of losses over gains may become more pronounced with advancing age.

This model focuses attention on the lived experience of ageing and frames the questions of interest in terms that do not deny its reality. For example:

- How do people make sense of ageing and what are the things that matter to them to maintain wellbeing?
- How do they make the most of opportunities and manage or adjust to the changes that accompany ageing?
- Are there particular kinds of transitions or changes that occur in older age which offer opportunities for growth and 'flowering'?
- Are there, conversely, transitions or changes that threaten or disrupt wellbeing and erode a positive image of self?
- How can an understanding of the process of adaptation enable us to construct service responses that compensate for loss and optimise opportunities?

In developing the framework for the study, then, the starting point was a model of ageing which locates individual experience within a broader socio-economic and cultural context (and is set out in Figure 1 below).

Figure 1 Social–cultural model of successful ageing



Key questions posed were:

- How important to older people were the localities in which they lived? In what ways did they shape the experience of ageing?
- What were the features of localities that sustained people in old age or alternatively were seen as a threat to wellbeing?
- In what ways did people's location within a specific historical and cultural context shape their current beliefs and values about 'healthy ageing'?
- What were the salient events and experiences in their lives that were viewed as significant for their self-identity and wellbeing in old age?
- What kinds of resources were available to older people within particular localities that they could draw upon in optimising opportunities and developing adaptive responses to ageing?

Methodology

The research was carried out within two urban areas: an inner-city locality and a northern town. The locality focus, the researchers considered, would allow them to examine ageing in context. In particular, they were interested in looking at how the wider structures within which older people lived their lives affected both their adaptive responses to ageing and the resources available to them to manage the process.

An important facet of the research was the adoption of a participatory approach to the study. The researchers sought to involve older people in every aspect of the research – developing the ideas, collecting the information, contributing to the writing and drawing out the conclusions. The objectives here were twofold: to enrich the research through mutual learning between researchers and older people; and to help build capacity within the groups, as a resource for the future.

Exploring quality of life

In exploring wellbeing, the researchers used a range of information collection methods:
in-depth, one-to-one interviews with older people, using a biographical or life story approach;

- focus group interviews examining key transitions over the ageing process (e.g. retirement);
- strategies for keeping well and managing loss (e.g. maintaining health and wellbeing, coping with bereavement and ill health) and service priorities to sustain life quality in old age;
- participant observation in the older people's groups (attending group meetings and activities, informal discussions with participants about life in the area and what was important for them);
- building up a picture of local networks within which older people were embedded through interviewing key informants active in the community (from tenants associations, churches and community groups, day centres and sheltered housing schemes, and older people's organisations (e.g. Age Concern, Older People's Forum).

Sampling strategy

People were purposively selected to ensure inclusion of older people across the age spectrum, in different circumstances (living alone/with a partner; men/women), with different experiences of loss (e.g. widowed, varied levels of disability) and from different minority ethnic groups (Leeds only: African-Caribbean and Asian).

A total of 84 individuals were interviewed using the life story method. The average length of interview was 90 minutes.

As an adjunct to the biographical interviews, the researchers organised focus groups with older people in a range of settings, to deepen understanding of key points of transition and the strategies people engaged in to adapt to the changes in their lives. Most were either established groups or involved people who were known to each other.

Key findings

A 'good' old age

For people in the study, ageing was simultaneously about opportunity and loss, change and adjustment. The meaning of these changes for older people and the strategies they employed to deal with them were influenced by a set of values that had been shaped by their life experiences and circumstances and the resources – psychological, social, cultural and economic – that they could draw upon.

For most of the older people interviewed, their descriptions of growing up, working and bringing up families echoed the accounts of working-class life found in the community

studies carried out in the aftermath of the Second World War. Their narratives were full of references to the close-knit, homogeneous communities in which they were brought up, and the strong ties of mutuality and friendship that linked extended family and neighbours. Themes of 'caring for' and 'caring about' dominated their descriptions of family and community life through their youth and into middle age. This was reflected in their accounts of 'neighbourliness' – both the mutual support that was offered in adversity and the routine reciprocal exchanges that were part of daily life.

It was also revealed in their stories of the two-way flow of care and support across the generations between family members. For most women in the study, this culminated in 'care giving': namely, the provision of practical support and care, often in their own homes, to frail parents and other relatives.

Now their own ageing was experienced in a very different social and material context: the enveloping framework of a welfare system that aims to provide a minimum level of security and safety for all; urban environments where poverty and deprivation sit in close proximity to wealth; the fragmentation and regeneration of neighbourhoods and communities and their cultural and ethnic heterogeneity; and the social and geographical mobility of children.

The central and underpinning value they carried through into old age and which informed their conception of a 'good' old age was interdependence. The notion of interdependence held within it a number of key values that at first sight might appear to be in conflict. These were: the importance attached to being part of a community where people cared about, and looked out for, each other; a determination 'not to be a burden' on close family and, in this sense, to be "independent'; and an emphasis on helping each other and maintaining reciprocity in relationships.

Success in managing the changes that accompanied ageing, then, was in large part determined by the extent to which people were able to maintain interdependent lives: being able to view themselves as both givers and receivers of emotional, social and practical support.

A key marker or point of transition to a different stage of life for most people in the study was retirement from paid work. This applied equally to men and women. Whilst the meaning of retirement depended on the context in which it occurred and the extent to which it took place at a time of one's choosing, leaving paid work for many was viewed as ushering in a new period in their lives, freed from the demands of paid work, domestic routines and family responsibilities. As with any major life change, however, there were interwoven themes of loss and opportunity, especially at the point of transition

There was not a single lifestyle that defined a 'good' postretirement phase. It could just as easily mean a slowing down to a gentle rhythm of daily life, 'rest and peace' from arduous physical labour, the pursuit of diverse social, leisure and learning activities, enjoying spending time with one's partner or the forging of new friendships.

Whilst the loss of intimacy that ensued with the death of a partner, soul mate or close friend could not easily be compensated for, there were other opportunities that opened up,

described particularly vividly by women. For example, developing new friendships, or participating in leisure and community activities that the freedom of being alone allowed, was described by women especially as a period of the 'flowering of old age'. For most men, on the other hand, it was the loss of intimacy and companionship that resulted from the death of a spouse that was uppermost.

Keeping well, maintaining health

Although generally people talked of health and functioning as major sources of wellbeing, a more nuanced picture was revealed through more in-depth exploration. For active older people, emphasis was on maintaining 'healthy' minds and bodies. But physical ill health and disability were also a focus of anticipatory fear, primarily because of the separate and combined impact on people's ability to maintain valued social relationships and social activities.

Maintaining mental health assumed equal if not more significance as people aged. Across the spectrum of old age, a central theme in people's stories was the need for stimulation and involvement – keeping their minds active – not only retaining an interest in the world and in people around them but being part of, and contributing to, a lively and interesting social life.

As people moved through old age, restrictions on functional abilities as a result of chronic illness and the depletion of vigour and energy through the 'weight of years' were responded to, typically with considerable resilience. Even so, there were some circumstances that challenged people's capacity for adaptation to the limit. When the change was sudden and/or catastrophic like a serious acute illness or onset of major disability following a stroke, it could result in a profound sense of discontinuity between past and present lives. Wellbeing here was not only conceived of in terms of the 'here and now', but in the context of an appraisal of one's life as being 'well lived'.

Social relationships

Central to wellbeing in old age were people's links to others: not just family but friends, neighbours and the wider community. Helping others and doing things with them enhanced people's capacity and confidence to cope with their own difficulties. They also tried to achieve some continuity between the things that gave them pleasure in the past and now. Thus, whilst the form of social relationships and social activities might change over the ageing process, their essence remained critical to wellbeing.

Participation and engagement

Both groups illustrate the fact that older people represent an enormous resource in building 'healthy' communities. Engaging older people in action to secure a 'better life' requires a range of opportunities for participation, myriad levels of engagement and support and assistance to draw out from the deep well of experience and abilities. Moreover, threats such as frailty, disability and bereavement will temporarily or permanently deplete people's capacity and momentum for involvement.

Neighbourhood and community

A central theme in the study was the significance of place in the lives of older people. In part, this reflected the length of time they had lived in particular neighbourhoods, their familiarity with its physical and social landscape and their sense of community. For many older people too, this sense of community translated into action – whether at the individual or collective level – towards making life better for others in their neighbourhood.

More than three-quarters of older people in the study had lived in the same locality for 20 years or more (including those who had come as immigrants), and a third of them had been born there. But if their lives were characterised by stability of residence, the world around them had changed dramatically. Continuity of friends and acquaintances over time provided a link between the past and the present, reinforcing people's sense of belonging. Older people here expressed strongly held values of mutuality, 'looking out for each other' and neighbourliness that extended to those who were newcomers to the area.

For older people in one location, the strength of their attachment was maintained despite the changes that had occurred in the physical and social environment: Although to the outsider it seemed to epitomize inner-city decline, it was nevertheless rich in social capital. Within its clearly defined boundaries, there existed deep and interlocking community links that embraced churches, social clubs, tenants associations and community-based groups. Older people were central pillars, sustaining and reinforcing these linkages and providing the continuity between the past and the present.

Locality assumed even more importance in the lives of older people whose spatial worlds contracted as a result of ill health, disability and reduced energy and vigour. Locality was also the prism through which the interaction between ageing, physical and social environment and socioeconomic circumstances was reflected. The physical terrain – hills, narrow and uneven footpaths – created obstacles in negotiating the environment; reliance on public transport meant that existing bus routes, for instance, circumscribed where people could go; fear and insecurity on the street shaped the structure of one's day .These varied features of locality interacted with each other in myriad, complex ways.

Formal service provision

For older people in the study, securing a 'good' old age was primarily about maintaining an 'ordinary life': 'enough' money to live on and provide treats for themselves and those close to them; the wherewithal to continue doing things from which they derived pleasure and stimulation; opportunities for social relationships and social engagement; an accessible point of contact for advice, support, help and advocacy, both in crisis and ongoing; a comfortable, clean and safe environment in which to live; an accessible, secure and negotiable external environment; and help with the kinds of tasks which posed increasing difficulties.

For most of the older people in the study, change and adjustment as a result of ageing were managed through their own efforts and with the support of family, friends and neighbours.

Whilst many of them also routinely came into contact with health services, this was peripheral to their own ongoing strategies towards maintaining their own wellbeing. The overall impression from the study was that many older people struggled to find the assistance they required.

A rethinking of the meaning of person-centred planning

Even the frailest older people invested significant time and energy in taking responsibility for and looking after themselves. They experienced considerable frustration, then, when

formal services appeared neither to understand their contribution nor even to value their expertise about their own needs.

Services appeared to adopt a minimalist conception of what was appropriate, focussing primarily on responding to the physical demands of ageing, as opposed to the psychological, emotional, social and cultural impacts of the ageing process.

Conceptions of ageing – society and self
It was evident from the research that adjustment and adaptation to the challenges of ageing do not occur in a neutral environment. First, older people were continually confronted with, and reproached by, attitudes and behaviour that devalued ageing and which they had also internalised. Second, they carried into old age the baggage they had brought with them from previous life stages. Some people in the study, for example, had small social networks or difficult and troubled relationships over many years that meant they had little in the way of social and emotional support to draw upon in old age. Conversely, people who had experienced chronic illness and physical disability throughout their lives talked about being better able to come to terms with restrictions in old age. Third, features of social structure – income and material assets that had been built up over a lifetime and the nature of the physical and social environments in which people lived – also impacted on adaptation and wellbeing.

2. Needs and resources of older people
Two selected reports, with contrasting methodologies are summarised below: one which uses administrative data to understand the resource position of older people, and one which use in-depth interviews with older people to gather information. It may be useful for EWAS to consider exploring with government agencies their willingness to undertake an examination of administrative data to complement EWAS's research.

Report 1: Measuring resources in later life: a review of the data[121] *Sue Middleton, Ruth Hancock, Karen Kellard, Jacqueline Beckhelling, Viet-Hai Phung and Kim Perren,* 1997

This quantitative report uses existing data to examine the needs of people over 65, including:

- expenditure,
- health,
- social networks,
- services ,
- housing and neighbourhoods, and
- income.

It investigates how patterns of resource use change over time, both for individual older people as they move through later life and for different generations of older people.

The datasets
Analysis was undertaken on data from five different cross-sectional and longitudinal datasets. The datasets are the British Household Panel Survey, the Expenditure and Food Survey (combining the Family Expenditure Survey and the National Food Survey), the Poverty and Social Exclusion Survey of Britain, the General Household Survey and the Health Survey for England. These were selected because they are nationally representative,

[121] www.jrf.org.uk/bookshop/details.asp?pubID=875

include sufficiently large numbers of people in later life for analysis, and contain indicators of resources and needs in addition to income, and a similar set of core variables on characteristics of older people.

In addition, the British Household Panel Survey and the Expenditure and Food Survey allow analysis of how the circumstances of individuals change with age, and of how needs and resources have changed for successive cohorts of older people.

Results

In addition to the conclusions outlined below, the research has also produced a number of findings about the limitations and possibilities of the datasets analysed, which provide scope for future research.

Ageing within later life and money

The findings seem to suggest that, contrary to current assumptions, age in itself is not a strong predictor of hardship. This may be because those who live longest into old age tend to be more affluent to start with – poorer older people (and those who were poorer before retirement) die younger on average. Therefore, paying people more simply because they are older may not be cost-effective.

Older people's lives are characterised by stability – at least in financial terms: those who were less well off earlier in later life remain less well off and those who were affluent remain affluent. Hence, poverty remains the issue for policymakers rather than increasing age.

People spend smaller proportions of their incomes as they get older, although it is unclear from this analysis what happens to this 'surplus' income. If older people are saving this money to meet the possible future costs of their care, this would be encouraging for policymakers when considering how to meet the costs of caring for increasing numbers of older, frail people.

Ageing within later life and ill-health and disability

Using age as a means of targeting resources on older people with ill-health or disability is not necessarily effective. Although the older we become, the more likely we are to experience ill-health or disability, the majority of older people do not experience severe problems. However, alternative means of targeting also have potential disadvantages. Targeting by age would be easier to justify if the aim was to help those with more moderate disabilities, but the analysis has shown that even this would not be particularly effective.

Successive generations of older people

The researchers found some evidence, particularly from data on the spending and consumer durable ownership patterns of successive generations of older people, that older people in the future will have higher aspirations than the current generation who experienced relatively low levels of affluence during their working lives. To give just one example, although older women living alone are currently less likely to have access to a car than other groups, the proportion that does have such access has been increasing over time. As more and more women who have held driving licenses throughout their lives reach

retirement; this proportion is likely to increase further, with implications for their income requirements.

There is also evidence that the prevalence of ill-health among older people is increasing from generation to generation. If this continues, then policy will need to take account, not just of the implications of declining health within later life, as described above, but also of the consequences of generations of older people that are less healthy in general.

Poverty remains the issue
It is clear that, whichever measures of needs and resources are used, financial poverty remains the issue on which policymakers need to focus – for both the current and future generations of older people. In1999, for example, small but significant proportions of older people reported that they were unable to afford to insure the contents of their home, to replace or repair broken or worn-out electrical goods or furniture and/or to keep their homes in a relatively decent state of repair.

Report 2: Understanding resources in later life: views and experiences of older people[122]
Katherine Hill, Karen Kellard, Sue Middleton, Lynne Cox and Elspeth Pound, April 2007

Increasing life expectancy means that resources in later life have to be planned and managed over longer periods. This study explores access to these resources, their importance in older people's lives, and how they interact. Resources include:

- health,
- social contacts,
- community and neighbourhood resources,
- housing,
- transport, and
- money.

Different types of planning for retirement and the factors that influence plans and outcomes are explored. A qualitative longitudinal approach was used to interview a panel of 91 respondents aged 65 to 84 to investigate the consequences of changes in circumstances in later life.

Research aims and design
The aims of the project were to investigate:

- how older people have planned and are planning their resources for later life.
- what resources are available to older people and how people value these different material, social, financial and health resources.
- how older people define (and redefine) their needs as resources change, and what strategies are used in the acquisition and deployment of resources.

In-depth interviews of around one and a half hours were undertaken during the summer of 2005 with 91 people in central England (couples where appropriate), spread across age (65–84), gender, household type (single and couples), income and urban/rural areas.

[122] www.jrf.org.uk/knowledge/findings/socialpolicy/2061.asp

Results

Health, housing, finance and family

Housing was the asset that respondents wished to pass on to their children, and few were considering cashing in remaining property assets, or equity release schemes. Most respondents recognised that their health might decline (further) in the future but, unlike retirement and death, there was less thought given to planning for future ill health. It seems that retirement is regarded as inevitable and predictable, and death is inevitable if not predictable, whereas ill health is unpredictable and, hence, cannot be planned for.

Health decline had brought additional need for help around the home and with transport and maintenance, which was often provided by family members at no cost. A combination of reducing numbers of children being born to families and increased geographic mobility may mean that such care may not be so readily available to future generations of older people, putting even greater pressure on services.

Concerns about the cost of maintenance and adaptations, particularly among homeowners, suggests a need for assistance, perhaps through a national repairs and adaptations service.

Loss of mobility was seen as the biggest problem arising from ill health since it meant a loss of independence.

Financial planning for and in later life

Respondents would advise younger people to make provision for their retirement, although with some reservations. Some supported compulsion because of concern that younger people would not save unless they were forced to do so. Others felt that people cannot be forced to save; rather, planning for retirement should be encouraged.

There were mixed messages about the likely success of automatic enrolment into personal accounts:

- On the positive side, some respondents said they would have paid into an occupational pension scheme if one had been available, and there were very few who simply had not planned and had 'frittered' money away prior to retirement.
- On the negative side, most people who had not planned financially for their retirement did not believe that this had been a realistic possibility for them. Many of those who had not planned for their retirement or whose plans had been knocked off course had been in part-time, low-waged and/or unstable employment – the pressures of which could lead to opting out of a scheme given the choice. Others had experienced unexpected life 'shocks', such as redundancy, divorce or the onset of ill health.

Lack of saving is not necessarily an indicator of financial hardship in later life. It tended to be largely those in the lower-income groups who continued to actively save, if only small amounts, as a form of budgeting for holidays, emergencies or replacement of expensive household items. This highlights that saving is not necessarily a case of building up resources for later old age, but is also (or in some cases instead) used to manage current circumstances.

Respondents in this study confirmed the continued reluctance among many in retirement, particularly those in the older age group, to apply for means-tested benefits. The fact that younger people displayed less reluctance to claim could also suggest that attitudes might change among future generations of older people.

In line with the findings of other research, most respondents were satisfied with their financial situations Most respondents also showed the aversion to debt that has been found in many other studies of older people. However, the younger respondents were less debt averse than their older counterparts. It may be, therefore, that future generations of older people, who have lived at a time when credit and, hence, debt have been more widespread and socially acceptable than in earlier times, may not be as debt averse, in which case there will be a greater need for assistance for older people in financial difficulties.

Extending working lives
Many respondents in this study ended their working lives before reaching the State Pension age, often because of ill health or redundancy. For those who continued their working lives beyond State Pension age, changes in working hours and type of work were often more influential than financial reasons. This suggests that the health of future generations and a good economic climate, as well as adapting working practices and environments to the needs of older people, could be key to the success of proposals to extend working lives.

Individual psychology
Perhaps one of the most interesting findings to emerge from this research is the role which psychological factors play in planning for retirement and satisfaction with life during retirement. While not worrying about the future can act as a coping strategy, a 'live for the moment' attitude could work against planning for the future. Whether 'financial capability' and planning for later life can be encouraged by government remains to be seen.

One of the possible reasons identified for unhappiness in the face of increasing financial affluence is the UK's unequal income distribution that encourages people to compare themselves unfavourably with those who are better off. Today's older people tended to compare themselves with those who were worse off than themselves in relation to health, finance and family support – the things that mattered most to them – rather than to those who were better off.

3. Older people shaping policy and practice[123]
Older People's Steering Group 11 October 2004

This report draws together the programme findings of 18 research projects about issues that older people have raised as central to their lives. The 18 projects covered: information, advice and advocacy; older people's own definitions of quality; the needs of black and minority ethnic older people; unmet need; issues relating to involving older people; older people's views on intermediate care; the importance of money; and older people's definitions of comfortable healthy ageing and a 'life worth living'.

Crucially, the programme was defined by older people (rather than by researchers or practitioners). Making older people's experiences the starting point highlighted both the diversity of their lives and a range of ageist assumptions and practices. The report finds

[123] www.jrf.org.uk/knowledge/findings/foundations/044.asp

that the practice of involving older people (individually and collectively) in issues relating to their lives is still at an early stage, and there need to be clearer and better standards on involvement.

The reality of old age is a constant (and at times quite rapid and radical) negotiation between losses and gains. At present, few service models seem to have fully taken on board the nature of these negotiations. The central point emerging from all the projects is that current policies, societal images of older people, services and strategies all struggle to break out of a pathologising or strongly deficit view of old age. Even where new developments are beginning to move towards a more holistic view of older people's lives, there is still a long tradition of seeing older people as 'vulnerable' and needing protection, as problematic and burdensome.

Yet the projects also show that older people are not asking for much. They themselves are often the key actors who can make a difference to their own lives and to the lives of other older people. In order to do this they may only need more appropriate – not more – support than is on offer at present.

There are many reasons why most older people do not come within the umbrella of health services and, particularly, social care services. These include poor access to low-level support, the high eligibility criteria, a degree of stigma about accepting support, and the inflexibility or inappropriateness of practice in many respects. Essentially, it is important to recognise that even if conventional health or social care services were totally approachable, that sort of service support would only ever form a small part of what it takes for most people to live well in later life.

While it is important that these services reflect what people want, it is also important that social services are not seen as the only actors who have a part to play. But changes will only have impact if older people are meaningfully involved in designing and implementing the changes, and in defining the desired 'quality of life' outcomes. Meaningful involvement requires standards on:

- the numbers of older people involved,
- the stage of development when they are included,
- their ability to influence the outcomes,
- the resources to support them in becoming involved,
- their involvement throughout the whole process.

The Steering Group, over its four-year period, also set out to learn lessons about involving older people developing programmes. The report highlights some of the tensions as well as opportunities. The programme itself has demonstrated many examples of involvement of older people. In addition to older people acting as commissioners of research, they have contributed as researchers, co researchers, interviewers, reference group members (to inform project development), peer reviewers (to comment on and scrutinise findings and conclusions), users of research findings and members of project advisory groups.

4. The experience of elder abuse

Two reports are scoped, both by the same researcher, dealing with female and male victims of elder abuse respectively. They both demonstrate the need for appropriate services and, just as importantly, the need for victims to be heard respectfully as they tell their story and identify their current needs.

Report 1: The needs of older women: Services for victims of elder abuse and other abuse[124]
Jacky Pritchard The Policy Press May 2000

This report uses qualitative research to explore the experiences of older women who have been victims of elder abuse, analyses their past and present needs and looks at appropriate service provision. It also provides some quantitative evidence on the nature and extent of such abuse. It looks at the views of older women, social workers and social care staff. They highlight the complex and long-term needs of abused older women and also reveal the difficulties workers face. Using their evidence, the author puts forward recommendations for good practice.

Research about the abuse of older people has focused on definition, prevalence and incidence. There has been little research into how to work with older victims. This project aimed to identify older women who had been victims of abuse, review their life experiences and give expression to their past and present needs.

Methodology
This qualitative research project was undertaken in three social services departments in the North of England. Monitoring systems were set up in each department to collate information about vulnerable adults. In-depth interviews were carried out with 27 older women who had been victims of elder abuse. Focus groups were run for over 300 older people. Social workers and other social care staff were interviewed and participated in focus groups. The findings of the project were validated by running a focus group for some of the interviewees; for other interviewees, a summary of the findings was sent out for comment.

Identifying abuse
Professionals seemed to struggle to define abuse, but victims (both in individual interviews and in focus groups) were able to define abuse clearly and disclosed the extensive types of abuse they had experienced during their lifetimes. Victims were very sure about what abuse meant to them and there was a high level of agreement amongst them. In contrast, a common complaint from workers was that it is difficult to work with abuse cases because some victims do not see certain actions as abusive. The research suggests that some workers (especially those uncertain of their purposes and skills) tend to project their own uncertainties on to their perceptions of what victims say to them.

Financial and emotional abuse by family members were the most common forms of abuse identified by victims. Many commented that their attitudes to being abused had changed from when they were younger: "*Then you had to put up with it*". Abuse by strangers and the fear of crime within the local community were also mentioned.

[124] www.jrf.org.uk/bookshop/details.asp?pubID=269

Needs identified by victims
Victims emphasised the need for:

- supportive discussion of earlier or current experiences,
- practical advice and information,
- appropriate housing,
- ongoing support during periods of decision-making and of adjustments in personal circumstances.

Victims were eager to talk about their experiences because they had the researcher's permission to do so. Conversely, there was evidence that some workers inhibit disclosures, either because these do not fit workers' pre-set plans, or because they dread the consequences of further demands.

Victims explained that in the past they would keep problems to themselves. They now recognised the need to talk, especially about earlier life events or abuse which had never been disclosed to anyone. Many felt they needed to sort these problems out before they died; preferably with someone who was not intimately known to them. Most victims needed to tell their story only once. They wanted to talk particularly about personal losses and bereavement: many of the women had experienced the death of a child or had had children taken away from them.

A need both in the past and present was for very informed practical help, i.e. advice and specific information related to what would happen if and when the woman left the abusive situation. They needed to know about places of safety, the choice and availability of housing, entitlements to benefits, access to joint bank accounts, obtaining a divorce etc.

Fundamental concerns were for food and warmth and for social contact and support. Victims talked at length about the poverty and hardship they had experienced in earlier life; having enough food and living in a warm environment was of paramount importance to them now.

Many victims were socially very isolated and cited the need for company. They emphasised the importance of maintaining hobbies and interests and also religious links and practices.

The needs identified by workers
Workers' attitudes to the subject of elder abuse were predominantly negative, mainly because many had insufficient knowledge, confidence or understanding in identifying abuse and its long-term effects and the skills needed to address such problems. There was a pessimistic belief that little can be done to help victims.

There was a tendency to want to 'rescue' victims from abusive situations rather than to assist victims to disclose their concerns in their own way and to make their own choices. In group discussions, workers found it hard to focus on the needs of victims, but immediately started addressing their own unmet needs, especially related to training and access to professional assistance.

Sources of help and support
Most professionals felt it was essential to build up a good relationship with a service user based on trust, but many victims found it easier to disclose abuse to a kindly stranger. Disclosure often took place during a personal and intimate activity, such as bathing. This raises issues of collaboration between services and professionals.

Victims wanted continued support during abuse investigations and in situations where they were waiting to go to court, but resented having to repeat their experiences to numerous individuals from different agencies. After leaving the abusive situation, victims often encountered problems with the length of time taken to sort out their financial entitlements. Help was needed to advise on the practical problems which worried victims (e.g. retrieving possessions/clothes from previous home; obtaining new furniture).

Victims talked about 'ongoing support', which professionals would see as long-term work. They expressed the need to talk about their lifetime experiences of abuse. The interviews indicated that the timing of these disclosures differs between individuals, and that individuals respond to different approaches.

Human and practical resources were needed for long-term work to adequately address the emotional needs of victims. This could include social workers, care workers, nurses, counsellors within day-care, day hospitals, community centres, women's centres, trauma centres.

Report 2: Male victims of elder abuse: their experiences and needs[125] *Jacki Pritchard* The Policy Press May 2000

When men regularly started to disclose about their abusive experiences to the researcher of the above study, it was decided to broaden the focus of enquiry to include men. Both quantitative and qualitative studies were undertaken for the research project

Financial abuse and neglect.
Financial abuse was the most common form of abuse experienced by male victims. In the qualitative study, 9 out of the 12 men had been subjected to gross neglect. When interviewed, the men said they did not like to live in such conditions, but no one had asked them about their life or what was happening to them.

Relationships
This study found that male victims were abused by a range of people and sometimes by more than one person. In the quantitative study, 17 out of 39 men were abused by people outside of the family. Another common pattern was that victims were often abused by more than one abuser, who were not connected to each other or related in any way.

Lack of communication
Some victims felt that they were not informed about what was happening and rarely were options put to them so they could make informed choices.

[125] www.jrf.org.uk/knowledge/findings/socialcare/362.asp

Being given permission to talk
The study found that many men had not been taken seriously when they had made allegations of abuse. Some professionals had not acknowledged that men can be victims. The men were very clear that they did have a need to talk about the abuse and other unresolved issues from their past.

Needs identified by victims

- The main needs of older abused men were:
- Advice and practical help, especially in managing finances and deciding on appropriate accommodation.
- A place of safety and the achievement of personal safety.
- The opportunity and encouragement to talk about present/past abuse and other difficulties.
- Consistent and ongoing support.

The men could verbalise very easily and explicitly the needs they had both recently and in the past they acknowledged that they needed to talk about the abuse and their life experiences. In addition, they needed practical advice and information about housing, finances and legal matters. They were clear about the type of advice and who might give it to them

The majority of men felt a sense of loyalty towards their abuser, especially if it was a family member. A key issue for the majority of men was the need to deal with the losses and bereavement they had experienced through life, including deaths, the loss of contact with particular family members, and personal control

Practice issues
Many of the men had not been assessed holistically. The tendency was for workers to respond quickly to the crisis situation without undertaking a proper adult abuse investigation and risk assessment. The fundamental principles of adult abuse work - namely self-determination, choice and equal opportunities - were frequently ignored when dealing with male victims

Long-term work
Workers focused mainly on short-term rescue work rather than on longer-term planning for dealing with the effects of abuse experienced both earlier and later in life. Seldom were protection plans developed; few men were offered long-term support or therapy.

5. Work and retirement: transitions after 50[126]

A JRF research programme completed in 2004 looked at the factors affecting transitions from work to retirement, especially for those leaving work before the state pension age. In further developing policies for older workers and seeking to provide appropriate opportunities, it is important to understand more about their experiences and preferences.

[126] www.jrf.org.uk/bookshop/details.asp?pubID=572

A report by the Prime Minister's Performance and Innovation Unit suggested that most of the reduction in older people's employment rates has not been voluntary. However, that report and subsequent policy development had to rely on an inadequate base of evidence, in terms of the factors influencing labour market behaviour after 50. To help fill this gap, the Joseph Rowntree Foundation commissioned research studies under its Transitions After 50 programme to explore the experiences and preferences of individuals at this stage of life. The key results from the research are presented below. They are followed by short summaries of each of the published papers.

The research sheds new light on people's experiences in the workforce, the manner in which they leave it and what is happening to over-fifties outside paid work. Findings reveal in particular the complexity of modern pathways out of work and factors that influence them: simple financial sticks and carrots are unlikely on their own to change retirement behaviour greatly.

Key results

- Employers are only just beginning to adopt policies to avoid squandering the talents of older workers. Training and worker development remain skewed towards younger workers.
- A high proportion of men and women over 50 care for other adults. This does not typically lead them to give up work. However, if current pressures on their lives continue to build, there is a risk that the supply of this unpaid work will reduce, at a time when demand for it is growing. This could put caring services under renewed strain.
- Workers in professional and managerial jobs tend to enjoy greater choice and control over how they leave the workforce than those in less privileged occupations.
- Financial factors tend not to be the primary force driving decisions about leaving work. Health and family considerations, together with attitudes to work, combine to create aspirations about when to retire. Financial factors, however, can be a key constraint determining when it is possible to do so.
- People who leave permanent full-time jobs before state pension age are about as likely to move initially into part-time, temporary or self-employed work as to leave the workforce directly. However, opportunities to get good 'bridge jobs' tend to be much greater for certain groups than for others.
- Leaving work early increases the long-term risk of poverty for some occupational groups, but is less important than one's overall work history. Those with modest means, but not the poorest workers, have a particular risk of a painful drop in income between early job exit and state pension age.
- People with negative experiences on leaving work, and those with financial difficulties, are less likely to engage in fulfilling activities in retirement, such as involvement in their communities.

12. KEELE UNIVERSITY

12.1 Introduction: areas of research interest

The Centre for Social Gerontology at Keele University's research focuses on the social analysis of ageing, reflecting the continued importance of gender, class and ethnicity through all phases of the life course. Drawing on a variety of disciplinary and multi-disciplinary perspectives to examine individual and social ageing, research addresses such themes as:

- family and kinship,
- inter-generational relationships,
- retirement,
- women and ageing,
- social exclusion and inclusion,
- globalisation,
- self and identity in old age,
- the social policy of later life,
- ageing in different types of environment.

The Centre specialises in conducting research that is relevant to public policy concerns. In recent years, substantive projects have explored ways in which older people may experience forms of social exclusion, the situation of older people living in disadvantaged urban communities, employment transitions for people aged 50 and over, the multiple roles of working carers, health promotion in later life, the ageing of Baby Boomers, and new housing and care choices for older people.

Developing Inter-Disciplinary Perspectives[127]

Activity at Keele in the field of gerontology has followed three main paths: first, work relating to older adults in the field of adult and continuing education; second, research and teaching in social gerontology; third, research in health care and health policy applied to later life. From a research perspective, activities have been organised through the Centre for Social Gerontology (www.keele.ac.uk/depts/so/csg/index.htm).

The Centre has developed a research agenda around the social analysis of ageing, reflecting the continued importance of gender, class and ethnicity through all phases of the life course. The enduring concern of the social gerontology group at Keele has been with the application of sociological and socio-psychological perspectives to ageing studies.

The Centre for Social Gerontology is currently engaged in research relating to the following key themes:

- the development of social theory as applied to gerontology,
- comparative social policy ,
- social exclusion in later life,
- occupational gerontology,

[127] Adapted from Phillipson, C., and Scharf, T. (2004) *Research Into Ageing At Keele: Developing Inter-Disciplinary Perspectives* , www.keele.ac.uk/depts/so/csg/index.htm

- leisure and lifestyles in retirement,
- health and social care in later life,
- quality of life and wellbeing of older people.

Current research projects include:

'Older People in Deprived Neighbourhoods: Social Exclusion and Quality of Life in Old Age': a study undertaken as part of the ESRC's Growing Older Programme (led by Tom Scharf).
The project has examined aspects of the quality of life of older people living in areas of intense social deprivation, providing an understanding of the social indicators relevant to elderly people living in poor neighbourhoods.

'*New Lifestyles in Old Age: Health, Identity and Well-being in Retirement Communities'* (directed by Miriam Bernard)
This project has aimed to explore the effects of living in retirement communities on residents, their families, staff, helping agencies and other stakeholders in the surrounding community. In doing so, it has sought to examine the contribution of this housing model to improving the wellbeing of older people. The study has taken place in collaboration with the men and women of a West Midlands retirement village, together with Touchstone Housing Association and the ExtraCare Charitable Trust.

'Old Age and Autonomy: the Role of Service Systems and Intergenerational Family Solidarity (OASIS)':[128] (The UK component of OASIS is based at Keele and is directed by Judith Phillips.)
Supported by the European Community's Fifth Framework Programme, the five-nation OASIS study seeks to learn how family cultures and service systems support autonomy and delay dependency in old age, to promote quality of life and improve the basis for policy and planning. Co-ordinated by Ariela Lowenstein, University of Haifa (Israel), the research has generated comparative data from Spain, Israel, the UK, Norway and Germany across the generations to enable the study of norms, expectations and behaviours regarding elder care. Inter-disciplinary interests have been combined within the newly-established (2003) Institute of Ageing. With colleagues from Keele's Research Institute for Life Course Studies and partners in Manchester City Council, the Centre has been successful in securing a major grant under the research councils' *New Dynamics of Ageing* programme. The 3-year project is entitled 'Promoting independence and social engagement among older people in disadvantaged communities'. This may be a study of considerable interest to EWAS, and it would be useful for EWAS researchers to maintain close contact with those involved.

12.2 Published research and working papers

Themes such as family and kinship, social exclusion and inclusion, women and ageing, self and identity in old age, and inter-generational relationships have been major topics of interest for the centre. These lie close to EWAS's areas of public policy interest, and the results of critical elements of the Centre's work are summarised below: the first (Researching Quality Of Life Of Older People: Concepts, Measures And Findings) is covered in some detail, because of its relevance to EWAS.

[128] For a fuller discussion see the OASIS chapter of this report

This chapter on the work of the centre concludes with extracts from the inaugural lecture of the Director of the Centre for Social Gerontology, Dr Thomas Scharf, which emphasise the need to ensure the voices of older people are present in the design and analysis of research. They are also a call for sustained activism on the part of all those working in the field of research on ageing.

1. Researching Quality Of Life Of Older People: Concepts, Measures And Findings[129]

This paper seeks to provide an analysis of quality of life in general terms and quality of life in relation to old age. It presents first a background on the evolution of quality of life in current discourse. Secondly, it reviews how quality of life has been conceptualised and measured within the health and social sciences; and thirdly, it presents research findings on the relationship between the quality of life of older people and family/friends support, income, crime and health. This includes a look at both the literature and preliminary findings from a series of discussion groups connected to a current research project. (The second and third parts are summarised here.) The aim of the paper is to be informative and to provide a practical guide to the conceptualisation and measurement of quality of life.

The paper stems from initial research undertaken within the context of the ESRC's Growing Older Programme. A team of researchers is examining the situation of older people living in socially deprived neighbourhoods of England, focussing in particular upon areas of Liverpool, Manchester and London. While the research also addresses such issues as poverty, social exclusion and social capital, this paper concentrates upon ways of exploring the quality of life of older people living in such environments.

A Conceptualising Quality of Life

The author states that "over the last fifty years a plethora of definitions of quality of life have emerged within health and social science disciplines. However, as yet, there exists no generic definition satisfying all proponents of quality of life research. . . Definitions vary widely in their conceptualisation of quality of life; some are very broad accounting for many indicators, others focus on more specific indicators". In Canada, the Ontario Social Development Council defines quality of life as the "product of the interplay among the social, health, economic and environmental conditions which affect human and social development" (http://www.qli-ont.org/indexe.html). Others focus on:

- health and physical function,
- life satisfaction and self-esteem,
- socio-economic factors,
- social support,
- environmental dimensions, and
- market force economics.

Flanagan (1978)[130] constructed a measure that encompasses 15 quality of life elements within 5 domains:

[129] Smith, A. (2000) *Centre for Social Gerontology, Working Paper No* 7. Centre for Social Gerontology

[130] Flanagan J.C. (1978) A research approach to improving our quality of life. *American Psychologist,* vol. 33:138-147.

Physical and Material well-being

- Material well-being and financial security
- Health and personal safety

Relations with other people

- Relations with spouse
- Having and raising children
- Relations with parents, siblings or other relatives
- Relations with friends

Social, Community and Civic Activities

- Activities related to helping or encouraging other people
- Activities relating to local and national governments

Personal Development and Fulfilment

- Intellectual development
- Personal understanding and planning
- Occupational role
- Creativity and personal expression

Recreation

- Socialising
- Passive and observational recreational activities
- Active and participatory recreational activities

Flanagan's definition touches upon two other key dimensions that are relevant to the ESRC project from which the paper derives. Aspects of social capital[131] are addressed under two domains: *social, community and civic activities*, and *recreation*. Elements of social exclusion[132] are evident in the domains of *physical and material wellbeing* and *recreation*.

A broader approach

The Quality of Life Research Centre[133], in Denmark, views objective and subjective elements of quality of life concepts as 'life surfaces'. Researchers at the Centre "believe that between these two superficial poles of existence, an existential core of experienced life meaning can be found, where the subjective and objective meet and the source of quality of life is found". Quality of Life is constructed around eight theories, organised on a continuum from subjective to objective, called the *Integrative Quality of Life Metatheory:*

From Subjective

1. Immediate self-experienced well-being

[131] Social Capital is described in the paper as "the propensity of individuals to associate together on a regular basis, to trust one another, and to engage in community affairs", and "…the extent to which individuals have regular contact with others, beyond the sphere of the family or the market, and notably the kind of face-to-face relations of relative equality associated with participation in common endeavours" (Hall 1999: 417-18).(p 8)

[132] Social Exclusion is defined "as the exclusion of individuals and groups from the main stream activities of that society. Social exclusion is about more than income poverty, but area studies in Britain have yet to demonstrate how social exclusion develops, how far it is an individual or locational problem, and how important area factors in this process." (p 8)

[133] Quality-of-Life Research Centre. Copenhagen, Denmark. http://home2.inet. tele.dk/fclk/index.htm

2. Satisfaction
3. Happiness
4. Fulfillment of needs
5. Experience of objective temporal domains
6. Experience of objective spatial domains
7. Expression of Life's potential
8. Objective factors

To Objective

(Quality of Life Research Centre (http://home2.inet.tele.dk/fclk/mql2htm))

The premise is that a definition of quality of life must come from some philosophy of human life which can be operationalised into a theoretical frame 'amenable to practical scientific investigation'.

Many definitions of quality of life fail to explore theoretical or philosophical issues. Ruta and Garratt[134] (1994) state that in "trying to arrive at a useful definition of quality of life very few researchers have appreciated the need to distinguish the factors necessary to sustain life, that enhance or impair the enjoyment of living, from whatever it is that we stay alive for". A clear 'philosophy of human life' and a theoretical framework may aid researchers in their understanding and conceptualisation of quality of life.

Building on the Keele approach to theorizing quality of life
The EWAS researchers may find it a useful exercise to create an initial philosophy and framework, based on the stakeholder consultations and preparatory work that has already been done, and to test these against the results as they flow from the field work now underway.

B. Measuring Quality of Life
The lack of a universal definition of quality of life is mirrored by the absence of agreement on its measurement. To a large extent this occurs because of the diversity of measures found between and within disciplines. The paper traverses a number of well-known measures of quality of life, including the University of Toronto's Health Promotion Centre's *Quality of Life Profile for Seniors*[135], The Quality of Life Research Centre in Copenhagen's seven criteria for measurement[136], O'Boyle and colleagues' (1992) *Schedule for the Evaluation of Individual Quality of Life (SEIQoL)*[137], and The World Health Organisation's 100 question quality of life instrument, referred to as the WHOQOL. WHO is in the process of designing one which is more relevant for an older population. However, WHOQOL was developed within a health-oriented ethos, and specifically aims to 'improve doctor-patient relationships through better understanding the illness, to assess the

[134] Ruta, D.A., & Garratt, A.M. (1994) 'Health status to quality of life measurement', In: Jenkinson C (ed) *Measuring Health and Medical Outcomes*. London, University College
[135] www.iisd.org/measure/compendium/DisplayInitiative.aspx?id=1916
[136] Quality of Life Research Centre (http://home2.inet.tele.dk/fclk/mql2htm)
[137] O'Boyle, CA., McGee, H., Hickey, A., O'Malley K., and Joyce, CR. (1992). Individual quality of life in patients undergoing hip replacement. *Lancet.* May 2;339(8801):1088-91.

effectiveness and relative merit of different treatments, and to evaluate the quality of health services' (http://www.who.int/msa/mnh/mhp/ql4.htm).

C. Conceptualising and measuring wellbeing

Wellbeing was constructed out of a psychological need to counter research strictly focussed on psychological dysfunction. Specifically, researchers such as Ryff [138] started to pose questions about 'the essential features of positive psychological functioning'. Wellbeing research, coupled with a focus on quality of life, have often resulted in the interchangability of the terms.

Similar to quality of life research, wellbeing has been measured across many different disciplines and with a variety of variables. Psychology has measured wellbeing in relation to self acceptance, purpose in life, environmental mastery, positive relationships, autonomy, personal growth, personality traits, happiness and life satisfaction and loneliness. Economists have studied it in relation to income and unemployment, and medical researchers have used it to analyse the causal relationship of illness/disease and mental wellbeing.

Few studies have gone beyond just measuring wellbeing in relation to one or two variables to develop a theoretical and/or conceptual understanding of what it is to be 'well'. The paper suggests the integrated approach adopted in the Berlin Study of Aging (BASE)[139] is likely to become increasingly influential in research on older people.

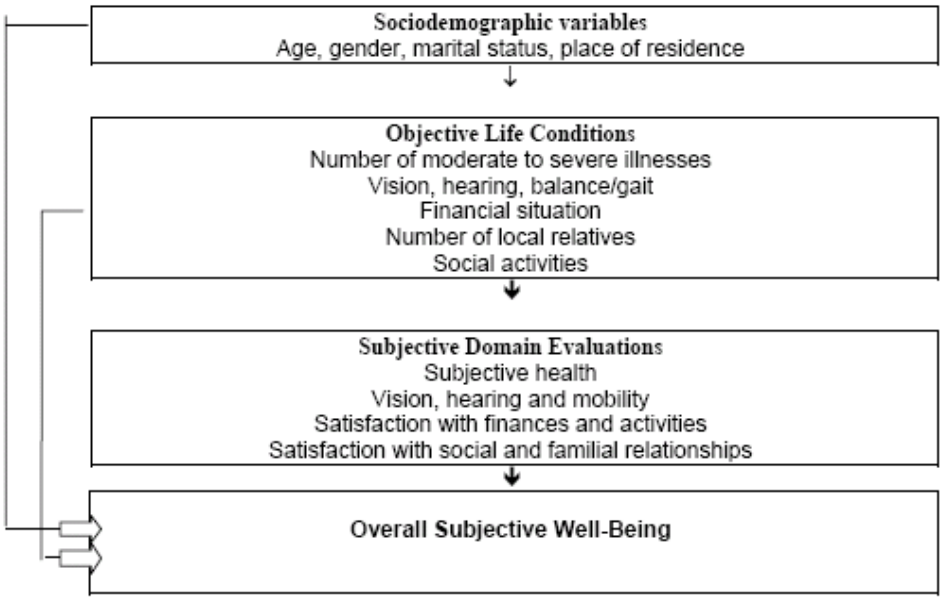
Based on the work and theory of Campbell et al[140]. (1976), Smith et al[141] (1999) developed a heuristic model, which proposes overall subjective wellbeing is a function of the direct and indirect effects of social-structural and demographic variables (e.g. age, gender, marital status), objective life conditions (e.g. housing, income, social network and activities, physical and mental health), and subjective experiences of these domain-specific life conditions. Objective life conditions have an impact on subjective wellbeing because they are processed through subjective domain evaluations:

[138] Ryff, C. (1995) 'Psychological Well-being in Adult Life', *Psychological Science* 4, 4:99-104; Ryff, C. (1996) 'Psychological Well-being: Meaning, Measurement, and implications for Psychotherapy Research', *Psychotherapy and Psychosomatic* 64:14-23

[139] See separate BASE chapter for more detail

[140] Campbell, A., Converse P.E., & Rodgers W.L. (1976*) The quality of American Life: Perceptions, evaluations and satisfactions*. New York. Russell Sage Foundation.

[141] Smith, J., Fleeson, W., Geiselmann, B., Settersten, R.A.Jr., & Kunzmann, U. (1999) 'Sources of Well-Being in Very Old Age', In: Baltes PB., Mayer KU. *The Berlin Aging Study, Aging from 70 to 100*. Cambridge. Cambridge University Press.



(p 15)

The author is of the view that the attraction of the BASE heuristic model may well be its adaptability to other studies: socio-demographic variables, subjective domain evaluations and objective life conditions can be changed so that these reflect the interests of different investigations. For example, ethnicity and social class may be important socio-economic determinants, and housing conditions, access to health and social services might help explain overall subjective wellbeing.

D. Quality of life findings

This section documents some recent social science findings relating to the quality of life amongst older people. Three are selected as being of interest to EWAS, and findings from the centre's ESRC research are also summarised.

In a study of Lawrence Heights, a large, low socio-economic Toronto neighbourhood, which looked to identify community and neighbourhood factors that influence wellbeing, results show that how neighbours got along with each other contributed to their quality of life. Also important were access to amenities, such as shops, public transport and community centres and services. For seniors, having activities to participate in, as well as groups to belong to, significantly contributed to their quality of life. Deteriorating housing, fear of crime and lack of personal safety, racial tensions and shortage of services and support was said to detract from residents' quality of life.

Michalos et al[142] (2000) surveyed 875 Canadians between the ages of 55-95 years on a number of domains relating to happiness, satisfaction with life, and satisfaction with their quality of life. Participants were asked about their *health*, *fear of crime*, *society's treatment of old people* and *preferences and problems.* Regression analysis for satisfaction with

[142] Michalos, A.C., & Zumbo, B.D. (1999) 'Public Services and the Quality of Life', *Social Indicators Reseacrh,* vol. 48:pp 125-156.; Michalos, A.C., & Zumbo, B.D. (2000) 'Criminal Victimization and the Quality of Life', *Social Indicators Research,* vol.50: pp 245-295.

quality of life revealed that 8 variables out of 22 accounted for 58% of the total variance. These were mental health, satisfaction with present age, financial security, recreational opportunities, neighbourhood, accomplishment in life, and access to retail stores.

Wilkening and McGranaham[143] (1978) examined economically deprived regions of the American Midwest and the relationship to levels of life satisfaction (which is taken to reflect quality of life). They found no difference between deprived areas and other more affluent regions.

Findings from Discussion Groups

In order to develop and improve an understanding of quality of life, researchers engaged on the ESRC research project undertook a series of group discussions with older people. Group discussions were undertaken in socially deprived neighbourhoods within three English cities. Areas of Liverpool, Manchester and London (Newham) were chosen based on their ranking on the Department of Transport and the Regions (1998) Index of Deprivation. Researchers held discussions with seven groups of older people; three in Newham, one in Manchester, two in Liverpool and one in a more affluent part of central England (selected as a source of comparison). Two groups were made up of people from minority ethnic groups, while the remaining groups were predominantly white, reflecting the ethnic composition of the selected neighbourhoods. Group discussions were tape-recorded and subsequently transcribed verbatim.

On balance, findings from the group discussions tended to confirm those of other studies. Health, social contact, family, activities (i.e. centres for older people), safe neighbourhoods (i.e. fear of personal attack, poor lighting, uneven pavements) and having sufficient finances were all mentioned as important for sustaining and experiencing quality of life. In most groups, *health and having sufficient finances* were the most frequently mentioned factors for sustaining quality of life: Social contact and activities were also valued in most groups: Most participants, specifically women, mentioned the significance of family. Many people had regular contact (i.e. telephone chat or visits) with daughters, sons and grandchildren. Crime, was also an important concern, participants feared both attack on their property and person.

Finally, the author notes that

"the assumption thus far is that quality of life, through its increasing salience within late twentieth century discourse, is a well understood concept. However, an important caveat needs to be mentioned. Hall [144](1976) found that "a large number of respondents were unable to specify and referred to being happy, contented or 'being satisfied inside yourself". Farquhar[145] (1995) also found this among her participants. Similarly, researchers engaged on the current project found that in some discussion groups the term 'quality of life' was not clearly understood. ….Researchers engaged in the study of quality of life need to give thought as to how they might wish to conceptualise this idea of life without explicitly using the term 'quality of life'. (p23)

[143] Wilkening, E.A., McGranaham, D. (1978) 'Correlates of subjective well-being in Northern Wisconsin', *Social Indicators Research* vol.5:pp 211-34

[144] Hall, J. (1976) 'Subjective measures of quality of life in Britain 1971 to 1975, Some developments and trends', *Social Trends* vol.7:pp 47-60.

[145] Farquhar, M. (1995) 'Elderly People's Definitions of Quality of Life', *Social Science and Medicine* vol.41(10):pp 1439-1446

2. Social Capital: Concepts, Measures and the Implications for Urban Communities[146]
This paper arises from a research study that addresses the experiences of older people living in socially deprived neighbourhoods of three English cities. Supported by the Economic and Social Research Council (ESRC) under its Growing Older Programme, the research examines the impact upon older people's everyday lives of the multiple risks associated with living in such environments. Such risks potentially include susceptibility to intense poverty and deprivation, vulnerability to serious crime, and restricted social relationships.

The paper covers three areas: a review some of the ideas associated with social capital, and in particular the different ways in which it has been approached in the scientific literature; a scan of the work of some of the main theorists of social capital, focussing in particular on the work of James Coleman and Robert Putnam; and a consideration of how social capital is being measured and a review some of the initial empirical work that explores linkages between social capital, health and different types of community.

The paper notes that relatively little research on the theme of social capital adopts a gerontological perspective. The authors intend to explore the connections between such diverse concepts as 'social capital', 'social exclusion' and 'quality of life' of older people, especially where they live in disadvantaged localities as the ESRD study progresses. An additional issue to consider will be the extent to which changes in social capital are linked to alterations/declines in the level of trust within the communities under investigation.

The question of how the erosion of trust within neighbourhoods (where it occurs) can affect the quality of life in old age is an important aspect for researchers to consider. Trust may be especially important for older people, for example in contexts where they have limited resources and where restrictions (through disability and lack of transport) are placed on their movement around localities. Both these aspects increase their reliance upon relationships in the immediate locality, and affect the possibility of support being given where needed.

3. Social Exclusion And Older People: Towards A Conceptual Framework[147]
The concept of social exclusion represents a key theme in current social policy debates. While poverty and income inequality continue to be important elements of the social exclusion debate, a central concern of this debate refers to loss of access to important life chances, especially those that connect individuals to the mainstream of society. However, policy initiatives on social exclusion have tended, for a combination of economic and political reasons, to focus on groups such as children, young families and the unemployed. Ways in which social exclusion may affect older people have largely been neglected.

This paper, arising from a study funded under the ESRC's Growing Older Programme, seeks to generate a better understanding of the dimensions of social exclusion that are

[146] Smith, A., Phillipson, C., and Scharf, T.(2002). *Centre for Social Gerontology, Working Paper No 9.*
[147] Scharf, T., Phillips, C., Kingston, P., and Smith, A. (2000) *Centre for Social Gerontology Working Paper No 6.*

relevant to older people. The paper draws upon initial empirical evidence generated through group discussions with older people living in socially deprived neighbourhoods in three English cities. These discussions addressed issues such as older people's income and living standards, their family and social networks, community participation, and living environment. The paper discusses the relevance of such factors in relation to social exclusion.

The paper emphasises the multi-dimensionality of social exclusion in relation to older age. In seeking to distinguish between different types of exclusion, attention has focused upon the three areas of participation and integration, spatial segregation, and institutional disengagement. Findings from group discussions with older people living in socially deprived communities tended to support these distinctions. Nevertheless, there is also a clear interconnection between these forms of exclusion.

Participation and integration refer to older people's embeddedness in social networks, and the extent to which older people contribute to or draw upon the social capital that exists in their neighbourhoods. Group discussions emphasised the importance of participation in a range of social relationships beyond the labour market as a source of social integration. Thus strong networks of families, friends and neighbours are regarded as very important by older people living in areas characterised by social deprivation. Some evidence was found that 'loose' ties within the community are important for older people, especially in terms of facilitating participation in normal daily activities.

Spatial segregation is a key component of social exclusion in old age. This was explored in terms of segregation of mental space, narratives of space and economic space:

- *mental space* which may be influenced by fears and perceptions about particular places;
- *narratives of space* which are about the degree to which people in a particular area articulate shared understandings and histories;
- *economic space* which is about the way in which social exclusion operates in spatial terms.

Limitations in mental space arose for many group members out of a concern about crime. The result for some older people was an avoidance of particular places or situations. In some areas, older people feel invisible in public spaces. Narratives of space addressed the extent to which older people expressed shared understandings and histories of their neighbourhoods. Here variations existed between the experiences of long-term residents and shorter term residents. For the former, the relentless decline of what had once been perceived to be reasonable places to live was tempered only by the shared nature of this experience. For the latter, experience of decline was not shared and a more positive view of the neighbourhood could be expressed. Where decline was identified, this often translated into tensions between different age groups or ethnic groups. With regard to use of economic space, group discussions tended to show that older people occupy different spaces to younger people.

Institutional disengagement, and its impact upon older people living in deprived urban neighbourhoods, represented a major concern of participants in group discussions. Considerable evidence of a systematic withdrawal of public and private sector institutions from marginal urban areas was presented. Thus questions arose about older people's degree of access to basic health and social care services, to financial services, and to basic facilities such as shops.

4. Rural disadvantage: Quality of life and disadvantage amongst older people – a pilot study[148]

This study highlights different forms of disadvantage experienced by older people living in diverse rural settings. It addresses the experience of disadvantage across the life course, and the impacts of such disadvantage on rural older people's quality of life. Of interest to EWAS researchers, who also investigate rural older people as a distinct group.

Method

The report is based on research undertaken using qualitative techniques, and completed within a three-month time period. The primary aim is to provide evidence of the lived experience of older people in rural communities, thereby enabling the voices of disadvantaged citizens to be heard. Designed as a pilot study, a secondary research aim is to provide useful lessons for future studies of rural ageing. Case studies, screening questionnaire, and the interview schedule are included in the study.

The research draws on screening interviews with 91 people aged 60 and over living in different types of rural community in the Midlands and North West of England. Participants were recruited with the help of a diverse range of stakeholder groups. In-depth interviews were undertaken with a sub-sample of 21 people who took part in the screening process, and who were identified as being disadvantaged in at least one aspect of their lives. Eight case studies were subsequently developed to highlight particular features of the disadvantage faced by rural older people, with analysis of interview transcripts concentrating on four types of disadvantage that potentially limit individuals' quality of life:

- lack of access to material resources,
- inadequate or poor quality social relations,
- lack of access to services and amenities, and
- disadvantage linked to rural community change.

Results

Limited material resources

While several research participants claimed not to be unduly affected by limited material resources, most revealed at least some difficulty in getting by financially. For some, there was evidence of real financial hardship, with money worries having a profoundly negative impact on health. Many participants had clearly adapted to living in relative hardship during the course of their lives. As a result, they continued to manage their finances with great care, seeking to avoid seemingly unnecessary expenses or incurring debt.

Even where finances were stretched, participants sought to manage without seeking additional support from the state, relying instead on the help of informal sources. This reflected a widespread resistance to becoming dependent on the financial support of the state. Some participants had overcome an initial reluctance to claim state support – often

[148] Scharf, T., and Bartlam, B. (2006) Centre for Social Gerontology, Keele University, for the Commission for Rural Communities (an operating division of the Countryside Agency)

the result of a financial crisis or of a sudden deterioration in health and reported a significant improvement in their quality of life.

Coping with area change

Disadvantage associated with area change contrasted expanding rural settlements with those that were stagnating. Most research participants had lived in their current settlement for a considerable length of time. The traditional argument that ageing in rural areas is synonymous with being part of a vibrant community characterised by close bonds between local family, friends and neighbours did not appear to hold true for all research participants. For those who are disadvantaged by lack of income or chronic ill health, and whose participation in community life may be limited, ageing in place might therefore represent an issue for concern.

Social relationships

Some participants suggested that the ability to cope with being alone and with isolation was a key feature of rural life, even though some people might struggle under such conditions. Alongside the experience of loneliness and isolation, there was also evidence in some interviews of a strong sense of community and of supportive relationships with family, friends and neighbours. A number of participants saw compensating factors in living in the countryside such as independence, privacy and freedom.

Access to services

Most participants reported a loss of services in their rural areas and they tended to voice concerns about being able to reach services located further away. At a yet more fundamental level, lack of street lighting and footpaths left a number of older people feeling unable to walk around their neighbourhoods, especially in the evenings or when the weather was poor.

Most participants identified transport as being a key concern in their community when it came to accessing more distant services. All respondents regarded physical access to resources and amenities as being dependent on health and mobility.

Disadvantage and quality of life

Despite the experience of disadvantage, most of the older people taking part in this study reported having a good or very good quality of life. This tended to reflect a complex set of attitudes and expectations of life. In relation to individual attitudes, the research participants displayed a dominant culture of independence and self-sufficiency. Many also appeared to have very low expectations of their current and future lives, having coped with different types of hardship throughout their lives.

Reflecting a widespread attitude of self-reliance, older people experiencing financial problems tended to play down the extent of material disadvantage in their narratives, whilst simultaneously emphasising their ability to cope with hardship. Such views also meant that several participants opted to manage without seeking to claim additional state benefit entitlements. However, older people who had successfully claimed state benefits – usually through the support of other people, rather than on their own initiative – tended to comment that this had improved their quality of life.

5. Necessities of Life: Older people's experiences of poverty[149]

This report presents findings from a study which seeks to inform the development of alternative approaches to the measurement of older people's poverty. The research, developed using qualitative techniques, explicitly focuses on the experiences of people who tend to be overlooked in much mainstream research on older people's incomes and material conditions.

Method

The study was carried out in four discrete but closely linked phases: identification of stakeholders/gatekeepers and establishing access; development of research tools; empirical data collection; and data analysis.

Building on existing research relationships, stakeholders and gatekeepers already working with the populations at the focus of the work were identified. Such stakeholders were seen as key gatekeepers and their co-operation was fundamental in terms of identifying and gaining access to potential respondents, and in minimising any sense of threat that might be posed by the researchers as 'outsiders'.

In attempting to access the views of older people who might otherwise be overlooked in standard methodologies, the research adopted a multi-method qualitative approach. This involved the development of three research tools, all of which are included in the paper. The first was an interview guide to provide the format for semi-structured group discussions. A second interview guide was drawn up for use within the individual interviews. This addressed the issues in the group discussion guide, but also included more personal questions. The interview schedules and prompts for group discussions were developed in a way that enabled the researchers to identify a broad range of items and activities that older people feel are important in their lives. These include a selection of Poverty and Social Exclusion Survey questions.

The research involved group discussions and individual interviews with older people belonging to a range of potentially disadvantaged groups:

- people aged 85 and over;
- people with a disability;
- older people who are also informal carers;
- people of Bangladeshi origin;
- people of Irish origin;
- gypsies and travellers;
- people living in rural communities; and
- people living in institutional settings.

The report argues that attempts to measure older people's poverty should take account of – and ultimately reflect much more strongly – the diversity that exists within Britain's ageing

[149] Scharf, T., Bartlam, B., Hislop, J., Bernard, M., Dunning, A., and Sim, J. (2006). *Centre for Social Gerontology, Institute for Life Course Studies,* Keele University, for Help the Aged.

population. This is likely to require new approaches to the measurement of older people's poverty, and will represent a key challenge for researchers and policy-makers.

Results

Low expectations

The research reveals the often very low expectations of older people in relation to their living standards. While all groups and individuals commented on the importance of maintaining their independence in terms of the quality of their lives, not all regarded being able to afford to participate in common social activities – such as having friends or family around for meals or attending weddings – as necessities of life. This points to the degree to which the experience of poverty has been internalised by many disadvantaged older people over the course of their lives. Very few of the research participants had ever been well off during their early years or their working lives, and most had consequently become accustomed to getting by on a modest income.

Prioritising the basics

As a consequence of generally low expectations, there was a tendency within some groups for older people to prioritise only the most basic of necessities, such as access to food, heating and clothing. Indeed, participants described a variety of coping strategies that they used in order to attain these: for instance, buying food which was past its sell-by-date, or making items such as canned soup last several days. So while some individuals identified themselves as having basic items, this did not always mean that they could afford them in the conventional sense.

Items and activities that the general population regards as being necessary in terms of material wellbeing were identified by some groups and individuals as being luxuries or non-essentials.

- Only the disabled group saw attending weddings as a necessity of life.
- Only the gypsy and traveller group viewed having friends and family round for a meal as a necessity of life
- Only carers and the over-85s viewed an annual holiday as essential
- In contrast to all other groups, those living in rural areas did not regard carpets or the ability to visit friends and family as necessities of life.

In addition, over half of the groups did not regard the following as necessities: having regular savings, having home contents insurance, or replacing worn-out furniture. Just under half the groups did not regard the following as necessities: presents for friends/ family, keeping one's home in a decent state of decoration, and having money to spend on oneself. The groups which classified the fewest items as essential were those living in rural areas (only 10 out of 20 items identified as essential), and informal carers (only 12 out of 20 items identified as essential)

Additional indicators of deprivation

It sometimes proved difficult to identify other goods and activities – beyond those for which the researchers prompted – as being essential. However, there is evidence that different groups of older people regard certain items as being necessities of life:

- *good-quality food,* identified as an issue in some groups: for example, older Irish people commented on the high cost of fresh meat and fish; Bangladeshi men referred to their inability to afford fruit and vegetables that would be a diet staple in their country of origin;

- *a good pair of slippers,* mentioned by people with mobility problems, especially where carpets were worn and they were prone to falling;
- *a mobile phone*, felt by informal carers to be an essential means of keeping in touch with family members, and as a way of being accessible at all times of the day and night;
- *the ability to pay people* who do small jobs around the home (including window cleaning, decorating, gardening, and helping with shopping): regarded as a necessity by some participants, including people aged 85 and over; other people felt that being able to buy in professional care support was a necessity;
- *mobility:* an issue raised by many older people, who regarded a range of forms of transport (including buses, taxis and mobility scooters) as necessities
- *suitable places for older people to meet:* felt to be important especially by older Bangladeshi and Irish people;
- *home security:* mentioned by several groups in relation to their own homes; also adequate Street lighting and pavements so that they could move about safely within their neighbourhoods.

Implications for policy and research

Diversity

In focussing on poverty in later life, it is important that sufficient account is taken of the diversity of experiences that increasingly characterise old age. Researchers have been aware for a long time of the growing heterogeneity of Britain's ageing population, and have been conducting studies which explore the diverse circumstances of different groups within the older population. The study presents a challenge for policymakers. Too often, policy is formulated on the basis of assumptions about a standard experience of the life course and of later life. The research shows that this type of approach is likely to overlook the needs of some of Britain's most vulnerable older people.

Informal social support

The research highlights the importance of community, social capital and strong support networks in the lives of disadvantaged older people. These structures appear to make poverty and disadvantage 'bearable'. Family members and neighbours provide informal care, everyday support and social contact which enable people to maintain a sense of independence despite often difficult circumstances relating to ill-health, disability, geographical location, ethnicity and the like. At the same time, however, in picking up the pieces this group effectively helps hide from view the stark reality of poverty and disadvantage among many older people.

Access to information

Many research participants had limited knowledge of the welfare system and were unaware of the range of benefits and support services available. Whether or not people find out about their entitlements often appears to be a matter of luck. As a result, some older people are living in a greater state of poverty than needs to be the case. The report argues the need for mechanisms which mediate between disadvantaged individuals and the benefit system to ensure that people in poverty have equal access to resources.

Measuring older people's poverty

The deprivation indicator approach described in this report is a useful tool when exploring older people's poverty. However, many older people living on fixed, low incomes do not recognize the degree to which they are disadvantaged in terms of their material resources. The consequence is that older people in poverty tend to view a rather narrow list of items as being essentials of life. The report suggests that future studies should continue to use a suitably broad list of deprivation indicators. These might also take into account some of the items and activities identified by disadvantaged older people as being necessities of life.

The importance of qualitative approaches
The research points to the importance of using qualitative approaches in order to capture the lived experiences of older people experiencing poverty and forms of disadvantage. The stories presented in the report convey the true impact of low incomes on older people's ability to participate in taken-for-granted activities, and the ways in which poverty diminishes the quality of many older people's daily lives.

Building on the Keele approach
In addition to the current questions about deprivation, EWAS researchers may consider probing to understand what older people in diverse communities themselves identify as necessities of life – the list in the current study, which ranged from mobile phones for informal carers, to suitable places to meet, demonstrates the diversity of views even among the most deprived and excluded.

6. The Extremes of Age: Challenging Poverty, Promoting Inclusion[150]
Finally, extracts from the inaugural lecture of the Director of the centre for Social Gerontology, Dr Thomas Scharf, are presented. They make a powerful argument for purposeful research – which is the approach that underpins FRST's social research investment. Dr Sharf's comments are confirmation that the EWAS research is being constructed in a way that maximises the likelihood that the results will be taken up by policy makers and be useful for older people themselves. They are also a call for sustained activism.

> "Critical gerontology: perspectives on inequalities
> In mapping out some of these extremes, I would like to draw on the critical gerontology perspective – a set of ideas closely linked to the Centre for Social Gerontology. In an illuminating book chapter by Chris Phillipson and Alan Walker[151] (1987) called 'The case for a critical gerontology'. . the argument is made that critical gerontology represents "a more value-committed approach to social gerontology – a commitment *not just to understand the social construction of ageing but to change it*" (Phillipson and Walker, 1987, p 12). In relation to the extremes of age, it demands that researchers not only engage in research that explores the characteristics and impacts of inequality, but that they also pick up the challenge to translate their findings into some form of social action.
>
> Equally importantly, the critical perspective also focuses attention on the *ways in which social gerontologists conduct their research.* Older people are no longer perceived simply as being passive subjects in some supposedly value-free research

[150] Thomas Scharf, Professor of Social Gerontology, Director, Centre for Social Gerontology, Keele University, UK, Inaugural Lecture, Westminster Theatre, Chancellor's Building, Keele University, 15th May 2007
[151] Phillipson, C. and Walker, A. (1987) 'The case for a critical gerontology', in S. DeGregorio (ed) *Social gerontology: new directions*, London: Croom Helm, pp. 1-15.

process. Instead, they are now often actively involved as participants who can contribute to the development of our research questions and to the interpretation of the research evidence.

In the words of Holstein and Minkler[152], the critical approach calls for a 'passionate' form of scholarship, one which "does not aim for control or domination, nor even for certainty, but for the freedom to pursue questions, to challenge assumptions, to hear and respect a multitude of voices, and to take engaged critique as a long-term commitment" (Holstein and Minkler, 2007: 26).

Our study, conducted in neighbourhoods of Manchester, Liverpool and London identified around half of older people as living in poverty. . .but a structured survey can only tell you so much about a person's life, generating an often uni-dimensional view of the research participant. The in-depth interview allows the researcher to put together a much fuller picture, and bring the participant to life.

The critical perspective lends itself to a multitude of questions. In relation to social inequalities, it draws attention to the diverse experiences of ageing in contrasting settings. It focuses, for example, on differences between older people living in the global North and South, between those living in different types of welfare system and none, or between people ageing in urban and rural communities. It also highlights major issues of difference within older populations – those marked by such factors as age, gender, ethnicity, social class, and health status. The critical perspective contrasts with one that – whether intentionally or not – homogenises the older population."

Health extremes

"In Knightsbridge and Belgravia average male life expectancy is 85 years. . . By contrast, average male life expectancy in parts of East Manchester is only around 67 years). In parts of Scotland the picture is bleaker still. In the Calton ward of Glasgow, male life expectancy is reported to be just 53.9 years– thirty years less than in Knightsbridge and Belgravia. . .

These data are fundamental and very familiar to social gerontologists. But at the same time they are challenging. Given that ageing research primarily focuses on people who survive to a particular age, when people die prematurely we lose sight of them in our studies. This means that *we lose sight of some of the poorest men and women within the population,* especially those living in some of our most disadvantaged urban communities. These are people who may not get a chance to receive their basic state pension, let alone meet a social gerontologist.

In the gerontological literature, there is a growing focus on the notion of cumulative disadvantage – the way in which disadvantages are accumulated during one's life and transported into old age (Crystal and Shea[153], 1990; Dannefer[154], 2003). Equally, the transition into old age itself can generate disadvantage.

[152] Holstein, M. and Minkler, M. (2007) 'Critical gerontology: reflections for the 21st century', in M.Bernard and T. Scharf (eds) *Critical Perspectives on Ageing Societies*, Bristol: Policy Press, pp. 13-26.

[153] Crystal, S. and Shea, D. (1990) 'Cumulative advantage, cumulative disadvantage, and inequality among

A key issue for critical gerontology is, therefore, to make sure that we understand as much as possible about how those people who experience the greatest disadvantage use their time. This does not always make for comfortable reading or listening.

The value orientated, critical gerontology perspective diverges from more traditional approaches. In calling for a 'passionate scholarship', Holstein and Minkler (2007) express the following sentiment: "We hold out this hope for those of us committed to critical gerontology … that we do whatever we do with passion and a belief that our scholarship can make a difference: that is move people to action" (p 26).

Against this background, the key question is one of social justice. How as a society can we tolerate a situation in which so many older people's lives are blighted by the daily grind of trying to make ends meet? Where poverty is associated with other forms of social exclusion. It may not currently be politically fashionable, but the obvious solution is a renewed focus on the redistribution of society's resources. The aim of the ageing lobby – and also of researchers committed to the critical gerontology approach – has to be to secure a national commitment to ending older people's poverty, to tackling the *structural sources of inequality.*

Our joint challenge is to win the political argument rather than the economic one."

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elderly people', *The Gerontologist* 30, 4, pp. 437-43.

[154] Dannefer, D. (2003) 'Cumulative advantage/disadvantage and the life course: cross-fertilizing age and social science theory', *Journals of Gerontology B* 58, 6, pp. S327 - 37.

13. OXFORD INSTITUTE OF AGEING

13.1 Introduction: areas of research interest

The Oxford Institute of Ageing is unique in establishing a research group to address the challenges of demographic ageing in both the more developed and the developing worlds. Population ageing is one of the major global challenges for the 21st century. By 2030 half the population of Western Europe will be aged over 50; by 2050 there will be 2 billion older people globally, 500 million of them aged over 80. The positioning of the Globalisation of Ageing Research Programme within the 21st Century School provides the opportunity to build on existing research and expertise to establish three interlinked interdisciplinary research components:

- global ageing (to address the global macroeconomic and demographic imbalances which could arise),
- redefining institutions for ageing societies (extending our research into the requirements for new economic, social and political institutions),
- longevity and radical life extension (addressing the impact on individuals as they realise the potential of life spans which may take them beyond the 9th or even 10th decade).

Global Ageing

The James Martin Global Ageing Programme provides the core of the Institute's work, and research is currently undertaken in Europe, Africa and Asia. Themes include:

- ageing workforces, extending working life and age discrimination,
- migration in response to population ageing,
- social security and intergenerational fairness,
- changing families as societies age,
- ethical issues arising from life extension,
- disease and mortality.

Demography

Demography underpins the global ageing programme. Global ageing is a result of the interaction of the dynamics of fertility and mortality and is linked closely to migration. The demography programme within the Oxford Institute of Ageing (OIA) addresses a wide range of global ageing issues particularly focussing on:

- the dynamics of global ageing,
- intergenerational support networks,
- health,
- migration,
- mortality.

13.2 Overview: research themes, and relevance to EWAS

The Institute's work is organised around four key themes – family, education, work, and health. All research areas are "underpinned" by the Institute's Global Longitudinal Ageing Study (see below), funded by HSBC (Hong Kong, Shanghai Banking Corporation). This

does not mean that each of the studies undertaken by the Institute have based their analysis exclusively, or even primarily, on the Global Ageing Study: rather, it provides a backdrop for the rest of the Institute's work. This may change in the future, as the Institute has redesigned the 2006/2007 study to ensure the data will provide robust international comparisons.

A brief synopsis of each of the themes is provided below. Two sub-themes within the families work stream are likely to be of significant interest to the EWAS research team – *multi-generational families*, with its examination of the meaning and nature of grandparenthood, and c*hanging families as societies age,* which includes the Danish Longitudinal Future Study and the Family Care projects. Another two in the Work theme - *economic security* and *work and retirement* are also relevant to the EWAS study. There is a lot of interesting focus on global issues of ageing and the experience of ageing for immigrant families which may become more relevant to the New Zealand research as demographic ageing increases in more diverse communities

There is however, little within the online material from the Institute which considers the concept of wellbeing in the multidimensional way that is being undertaken by EWAS, nor such a strong focus on involving stakeholders in the design, delivery and use of research. Nevertheless the strong policy focus in a number of publications and the emphasis on social inclusion and exclusion has parallels with the EWAS work.

13.3 Research themes and their published studies

1. Families (Families, Communities and Intergenerational Relationships)
The Institute's research interests in this area focus on four broad programmes:

- Multi-generational Families – Grandparenthood.
- Impact of Migration on Families.
- Changing Families as Societies Age (This programme also includes the Danish Longitudinal Future Study and the Family Care projects).
- Homelessness in Later Life.

*1 Multi-generational Families – Grandparenthood (*Programme Director: Harper
Researchers: Harper, Leeson, Aboderin and Ruicheva.

1. Grandmother Care in Lone Parent Families (Researchers: Harper, Smith (Social Policy); Ruicheva).
   This study combined quantitative and qualitative methodologies to explore the relationships between grandmothers and their lone parent daughters in 800 single parent families. The use of grandmothers to provide child care and the experience of grandmothering were two main foci of this study.

2. Grandparenthood (Researchers: Harper, Aboderin and Ruicheva)
   This is part of the EU funded Grandparenthood project which involves teams from 6 EU countries. The OIA team has been undertaking collaborative work with Tobias (Spain) on lone mothers and grandmothers and Hagestad (Norway) on qualitative experience of grandmothering. The study has also addressed replacement roles within multigenerational families.
   Publications: Harper, S. and Ruicheva, I. (2006) *Reconsidering the norm of non-interference*, OIA Working Paper. (Others in press)

3. Grandfathers (Researcher: Leeson)
   This new project commenced in October 2006. Using both quantitative and qualitative data it will examine the changing position of grandfathers in the UK

*2 Impact of Migration on Families (*Programme Director: Harper) Researchers: Harper, Aboderin and Ruicheva

This programme examines the impact of migrant female care labour on family structures and networks. Drawing on a network of collaborators, it examines predominantly female led health and social care migration into the EU from former Eastern European, Asian, African and Latin American countries. It focuses particularly on the impact of this migration of these women's lives and on the families left behind in the sending countries. This migration impacts not only on national welfare regimes, but also on the informal and family based care structures in these sending countries.

Publications: Harper, S., Aboderin, I. and Ruicheva, I. (2006) T*he impact of female led migration in the health and social care sectors on intergenerational relationships*, OIA Working Paper.

Aboderin, I. (2006) *Changing Nursing Contexts and Identity in Nigeria: the Making of Expectations and Experiences of Nursing in the UK*, Journal of Clinical Nursing (Others in press)

1. Nigerian Eldercare Nurses in the UK (Aboderin and Harper)
   This is a study of Nigerian nurses migrating to the UK and the impact this is having on their social responsibilities in Nigeria.

2. Bulgarian Health and Social Care Workers in Greece (Ruicheva and Harper
   This is a study of Bulgarian women who have migrated to Greece to work in the informal health and social care sector, predominantly in home settings, and the impact this is having on their social responsibilities in Bulgaria. This is a joint project with Sextant, Athens.

3. Changing Families as Societies Age (This programme also includes the Danish Longitudinal Future Study and the Family Care projects) (Programme Directors: Harper and Hoff) Researchers: Harper, Kreager, Aboderin, Leeson and Hoff

1. Family Care Projects
   This is a collection of individual projects which address issues of family relationships and care in Europe, Asia and Africa. They are:
   - *Denmark (*Leeson)
     Publications: Leeson, G. (2005) *Changing Patterns of Contact with and Attitudes to the Family in Denmark*, Journal of Intergenerational Relationships, Vol. 3 (3), pp. 25-45
   - Germany (Hoff)
     Publications: Hoff, A. (2006): Lone Mothers' Use of Informal and Formal Support: Comparative Findings from Germany and the UK. Lampeter: The Edwin Mellen Press
   - Indonesia (Kreager)

Publications: Kreager, P. (2006) Migration, Social Structure and Old-Age Support Networks: A Comparison of Three Indonesian Communities, Ageing & Society 26

- Nigeria (from July 2006) (Aboderin)

2. Danish Longitudinal Future Study
   This longitudinal future study has examined changing expectations, attitudes and behaviours of Danish people aged over 45 since 1987.

   Since 1987, the Danish Longitudinal Future Study (DLFS) has followed in three waves four generations originally aged 40-64 years, analysing and elucidating among other things their attitudes and expectations to and provisions for financial security in later life, and their perceptions of the financial situation of people in later life as well as their own intergenerational solidarity.

   In Denmark, with its universal tax-financed old age pension based on residence rather than labour market affiliation, the realisation that financial security in old age may increasingly be one's own responsibility rather than a natural pillar of the intergenerational social contract is taking root. Thus, the DLFS reveals that almost 30% of the 75-79 year old generation also receives an occupational pension while 15% have a private pension. In addition, over 80% of those aged 45-49 years are members of an occupational pension scheme.

   The large majority of future generations of older people in Denmark expect their standard of living after retirement from work to remain unchanged or worsen only slightly.

   In Denmark, where attractive, supported housing for older people has been a key element in housing policy development, both younger and older generations display a significant lack of propensity to move to housing, which would be more suitable in old age.

   Publications: Leeson, G 2004-6 Danish Longitudinal Future Study: Housing, Late Life Work and Retirement, Financial Security in Old Age, Social and Familial Networks, Leisure and Volunteering, Life Course Perspectives, Vol. I-VI, DaneAge, Copenhagen, 2004-6 (in Danish).

3. Ageing In Indonesia (Kreager)
   This is a comparative, longitudinal study of the elderly (1996-2006), their family networks, and community structures of three communities (East and West Java, West Sumatra). In collaboration with the Centre for Health Research, University of Indonesia, and Andalas University, Padang, and the Institute for South East Asian Studies, Singapore

   Publications: Kreager, P and Schroder-Butterfill, E. eds (2004) *Ageing Without Children: European and Asian Perspectives*, Oxford: Berghahn

4 Homelessness in Later Life (Programme Director: Leeson)
This is a qualitative study of elderly homeless men in Denmark. Details will be forthcoming over the next few months.

2. Education (Technology, Education and Life Long Learning)
This is a new theme for the Institute. Research interests in this area focus on developing three broad areas:

- Life Long Learning.
- Education and Life Course Transitions.
- Research Quality and Research Assessment in Education and Gerontology.

(These last two themes are being developed jointly with the Department of Education.)

1. Life Long Learning (Leeson)
This area builds on collaborative work within the EU-Network PEFETE on late life learning.
Publications: Leeson, G W (2004) *Education for Older People in Denmark*. PEFETE National Background Report.

2. Education and Life course Transitions (Oancea)
This aims to address substantive issues such as learning throughout the life course, changing patterns in life course transitions, the links between initial and continuing/ recurrent education and patterns of income and support at later ages, the budgetary impacts of demographic ageing on initial education, and education policy.
Publications: Wright, S. and Oancea, A. (2004) *Policies for 14-19 Education and Training in England, 1976 to the Present Day: A chronology*. Briefing Paper for the Nuffield Review of 14-19 Education and Training. Updated 2005.

3. Research Quality and Research Assessment in Education and Gerontology (Oancea)
This project reflects critically on the quality and nature of research and of research knowledge in education and gerontology, and on the research assessment arrangements currently in place in the two applied fields. This builds on earlier work in philosophy of social research (epistemology) and on research policy.
Publications:
Oancea, A. and Furlong, J. (2007) *Quality in applied and practice-based research. In: Research Papers in Education* (forthcoming).
Oancea, A. (2005) C*riticisms of educational research: Key topics and levels of analysis*. In: British Educational Research Journal, 31 (2).
Oancea, A. (2005) Authorship patterns of research articles in three UK-based academic journals. In: Research Intelligence, 91.
Oancea, A. (2004) *The distribution of educational research expertise – findings from the analysis of RAE 2001 submissions (I, II)*. In: Research Intelligence, 87; 88.

3 Work (Economic Security, Work and Retirement)
The Institute supports a wide range of research looking at the implications of demographic ageing for national and international labour markets, retirement practices and pension provision.
The Institute's research interests in this area focus on four broad programmes:

1. Ageing workforces (this programme also includes the Extending Working Life and Age Discrimination projects).
2. Migration in response to population ageing (this programme includes the Migrant Health and Social Care Workers collaboration).
3. Social security and intergenerational fairness.

4. Future of retirement.

All of these areas are underpinned by the Institute's global ageing study, which it is developing with HSBC through its involvement in the Future of Retirement Survey (see below)

1. Ageing Workforces (Programme Directors: Harper and Leeson) Researchers: Harper, Leeson, Ross, Saxena, Khan, Marcus, Ruicheva

I. Ageing workers: Evidence based validated capacity evaluation guidelines for physical and mental health to assist risk assessment. (Harper, Leeson, Ross, Saxena, Khan, Marcus, Ruicheva)
The purpose of the research is to develop principles of risk based approach to objective decision making on workability and employability of ageing workers. This will enable employers to comply with new age discrimination legislation, ensure that health and safety criteria are met, and that they make the best possible use of an experience older work force in a tightening labour market.
These will be validated on two contrasting occupational groups: safety critical workers in the oil industry and female health and social care workers

II. Implications of Population Ageing for the Railway Industry (Harper)
This is a small scoping study to explore the full implications of demographic ageing for the UK Railways, covering both employers and customers

III. Extending Working Life (Harper and Vlachantoni)
This research explored the transitions to self-employment of men and women in their 50s within the IT industry.

IV. ,Age Discrimination (Leeson)
A variety of European projects in Age Discrimination have been carried out by Leeson. Most recently an analysis of International Age Discrimination Cases in employment for the UK government Department of Work and Pensions (with Harper) and an examination of age discrimination in social care within the EU as part of the Health Alliance collaboration
Publications: Leeson, G, and Harper, S (2005) *Examples of International Case Law on Age Discrimination in Employment*, Department of Work and Pensions, London UK
Leeson, G (2005) *Age Discrimination and Social Care*, Pfizer Health Alliance, ILC London

2. Migration in Response to Population Ageing (Programme Directors: Leeson and Hoff) Researchers: Leeson and Hoff

1. Migrant Health and Social Care Workers (MILES) (Leeson and Hoff)
This research combines several projects designed to examine the potential for migrant labour to assist older people in the EU to continue to live independently. The programme intends to review models of eldercare provision in European welfare regimes in order to illustrate the actual and potential role of home-based migrant labour in regime-specific constructs of eldercare provision; to elucidate EU wide trends in the employment of migrant labour in the formal/informal social care workforce and the constructs of the role of the migrant eldercare worker, in order to

understand the potential for migrant eldercare labour in home-based settings; to analyse the future development of the provision of care and support for older people; and to explore the potential contribution of migrant elder care workers in both the formal and informal settings in the light of current social and health care debates and proposed reforms. The programme has established a wide network of international collaborators from the EU, Japan and USA.

2. Replacement Migration in Scandinavia (Leeson)
   This project assess whether replacement migration can address the imbalances of population ageing in the Scandinavian context.
   Publications: Leeson, G (2005) *Migration and Migrants in the European Union*, Age Concern England
   Leeson, G. (2005) *The Changing Face of the Population of Europe – An Overview*, Scottish Executive/European Economic and Social Committee, Dunblane, Scotland

3. Social Security and Intergenerational Fairness (Programme Director: Howse) Researchers: Howse, Omtzigt, Long.

1. Generational Fairness in Pension Reform (Howse and Omtzigt)
   Population ageing has caused some social commentators and policy analysts to reconsider the nature and scope of government responsibilities for the provision of income to retired people. The proposal that government scale down its responsibilities for the provision of retirement income has been justified and also criticised by appeals to intergenerational justice. This research aims to examine the relationship of fairness and justice in relation to proposed pension reform.
   Publications: Howse, K. (2004) *What has fairness got to do with it? Social justice and pension reform*, Ageing Horizons, 1, 3 – 16

2. Measuring Intergenerational Redistribution in the Vietnamese Pension System
   Researchers: (Long)

No further detail is available online.

4. Future of Retirement (Programme Director: Leeson) Researchers: Leeson, Khan, Harper, Saxena, Marcus, Kivett

In 2005 HSBC published the results of its first global survey, The Future of Retirement in a World of Rising Life Expectancies. That survey covered 11,000 adults (aged 18 and over) in ten countries and territories across four continents. This showed that people want more flexibility and freedom in the way they retire than employers and laws often allow. In 2005, HSBC published the Future of Retirement report, a global study into the changing attitudes and behaviours to ageing and longevity. The study revealed that people the world over reject the notion of a mandatory retirement age and that the traditional model of retirement is now being replaced by the desire to live a blended lifestyle – incorporating periods of work, leisure and study. Further detail is set out below, under the heading Global Ageing Study and the Future of Retirement Reports.

The OIA was invited in 2005 to collaborate on the 2nd Survey, which was already in the field. Members of the OIA led by Leeson analysed the data and authored the subsequent

report. HSBC interviewed more than 21,000 adults in 20 countries and territories across five continents, which comprise 62% of the world's population. 6,000 private-sector employers across the same 20 countries and territories were surveyed to address their attitudes to older workers and the issues presented by global ageing and changing models of retirement. The 2006/2007 wave of the survey will be redesigned by the OIA in order to allow comparative analysis with other international and national survey on ageing and later life.
Publications: The Future of Retirement: What the world wants; The Future of Retirement: What people want; The Future of Retirement: What businesses Want. HSBC, 2006 - futureofretirement@hsbc.com

4. Health (Longevity, Health and Biodemography)
The Institute's research interests in this area are focussing on developing three broad areas:

1. Ethical issues arising from life extension.
2. Disease and Mortality.
3. Health and Social Care.

1 Ethical issues arising from life extension (Howse)
No details of this area is available online
Publications: Howse, K. (2005) *Biodemography and Longevity*, Ageing Horizons, 3, 1-5.

2 Disease and Mortality

I. Mortality Rates and Influenza (Davenport)
   This involves a study of age and cohort effects in pandemic influenza (with Jim Oeppen), as well as digitisation of cause of death data for England & Wales 1855-1900. These data will be used to study effects of early disease exposure on adult life expectancy, and to follow long-run interactions between tuberculosis and other disease mortality.
II. Phytoestrogens and Alzheimer's Disease in Indonesia (Kreager, Joint with Hogervorst, Loughborough)

3 Health and Social Care
This is a collection of individual projects which address issues of health and social care in the UK, Scandinavia, Japan and Nigeria

I. Issues of Social Care in the UK (Davies)
   Publications:Davies, Bleddyn (2006)*Le livre vert de l'Angleterre sur les services sociaux pour les adultes: Indépendence, bien-être et choix'*, Retraite et Société, 47, 194-199.
   Davies, Bleddyn, Fernandez, José-Luis, and Nomer, Bulent (2000) *Equity and Efficiency Policy in Community Care: Service Needs, Productivities and Efficiencies and their Implications.* Ashgate: Aldershot.
II. Dimensions and Social Determinants of Older People's Health in Nigeria and Implications for Policy (Aboderin, from July 2006)
III. Integrated Health Care Responses to Rapid Population Ageing (INTRA): Nigeria (Aboderin)
IV. Long Term Care in Sweden (Karlsson, from September 2006)
V. Promoting Independent Living (Leeson and Harper)
VI. Publications: Harper, S. Leeson, G. and Levin, S. (2004) *Promoting Independent Living*, DWP

Global Ageing Study, and the Future of Retirement Reports
The Institute has recently entered a partnership with HSBC to undertake global surveys on ageing. A brief history of this work, and a summary of the results to date, is set out below.

In 2005 HSBC published the results of its first global survey, *The Future of Retirement in a World of Rising Life Expectancies*. That survey covered 11,000 adults (aged 18 and over) in ten countries and territories across four continents. This showed that people want more flexibility and freedom in the way they retire than employers and laws often allow.

The OIA was invited in 2005 to collaborate on the 2nd Survey, which was already in the field. Members of the OIA led by Leeson analysed the data and authored the subsequent report. The study involved interviewing some 21,000 people in 20 countries and territories (comprising 62 per cent of the world's population) about their attitudes to and behaviour about ageing and longevity. 6,000 private-sector employers across the same 20 countries and territories were surveyed to address their attitudes to older workers and the issues presented by global ageing and changing models of retirement.

In 2005 HSBC announced funding for the world's first and largest global ageing study, which is being undertaken by the Oxford Institute of Ageing. The 2006/2007 wave of the survey, covering more than 24,000 people, has been redesigned by the OIA in order to allow comparative analysis with other international and national survey on ageing and later life. In the longer term the aim of the HSBC–OIA alliance is to build a cutting edge research base on global ageing to provide information for both policy and corporate decision makers.

The study will build on the HSBC's 2005 *Future of Retirement* report. This report revealed that many of the trends in retirement behaviour, health and well being, which were once thought to occur only in affluent Western societies, are also emerging in parts of Asia, Latin America and Africa. People the world over reject the notion of a mandatory retirement age and that the traditional model of retirement is now being replaced by the desire to live a blended lifestyle – incorporating periods of work, leisure and study.

Research for the report involved interviewing 21,000 people aged between 40 and 79, in 21 countries and territories around the world. Participants were divided into four age groups, each spanning ten years, to enable the researchers to study the effect of age on attitudes and behaviour. This made it possible to compare those who are aged 40-59 with those who are aged 60-79. This second group roughly corresponds, in most of the places surveyed, to those participants who have reached retirement age.

Other key findings from the study are:

People over 60:

- *Contribute to society* – older people are contributing billions of dollars to the global economy in voluntary work. Of all those surveyed, around a third are current volunteers or have volunteered in the past. Of those who do volunteer, over 50% give half a day each week.

- *Contribute to the workforce* – older people are contributing to their communities and the economy through their labour and their taxes. In the mature economies[155], between a fifth and a half of men and women are still in work in their 60s, while in the USA a fifth of those in their 70s are still employed. In the transitional economies[156], there are large numbers active in their 60s and even 70s in the informal economy, though less in the modern service and manufacturing sectors.

- *Contribute to their families* – more older people are giving money, support and care to families and friends than there are receiving it. The contribution of older people is fundamental to the care and support that contemporary families provide. They can do this because they are more fit and active than ever before, they feel they are in control of their lives, that they are independent rather than dependent, and are generally looking forward to the next 20 to 30 years of life.

Family

The family is still chosen by the overwhelming majority of survey respondents as defining "who they are". In addition most people believe that families should be responsible for their members. People all over the world have considerable contact with family members, and that they feel responsible for the welfare of other members of their family. Globally, practical and personal support to older people in need is seen to be the responsibility of the family, while financial support is deemed to be the responsibility of the state as well.

Health

People living in mature societies and the trendsetters in the transitional economies, seem to experience only modest – if indeed any – decline in their quality of life as they age into retirement. The fact that those in urban, modern living environments in Asia, Latin America and Africa, appear to be taking on similar health and quality of life patterns to those in the mature economies is an important indication of the trend towards the new old age across the globe. Immediately after retirement, particularly in mature economies, individuals appear to experience a boost in health status, quality of life and feelings of control and independence.

In general

The data from the Future of Retirement survey shows that, far from being a time of misery, penury and frailty, life for most people in their 60s and 70s is characterised by good health, independence, control and a good quality of life. In terms of how people feel and what they are capable of at 70, that age can be said to be the new 50.

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[155] Those that industrialised early, have large service sectors, affluent populations, long-established pensions infrastructure and legislation and provide a comprehensive welfare "safety net" for their citizens. Included are Denmark, the United Kingdom, France, Germany, the United States, Canada and Japan.

[156] One that does not yet meet the definition of a mature economy. Included are Brazil and Mexico in Latin America; Russia and Turkey in Europe; India, the Philippines, Malaysia, Singapore, China, Taiwan, South Korea and Hong Kong in Asia; and South Africa and Saudi Arabia in Africa and the Middle East. In transitional economies those surveyed are considered 'trendsetters' – people who live mainly in towns and cities, and who work in the manufacturing, service sector and other modern areas of the economy, such as the information technology industry. They contrast with the greater numbers of people still in traditional, rural, family-based employment, or those working in primary industries such as mining, fishing or forestry.

13.4 Further publications

The Oxford Institute of Ageing publishes a series of Working Papers, which is designed to meet a need for informal publication for members and visitor fellows of the Institute, within social, economic and demographic aspects of ageing. In addition the Institute publishes occasional Oxford Briefings, which present developments in policy and research, mainly but not exclusively in the field of the economics of ageing. And thirdly, the Institute publishes Research Reports, which present the research findings of Institute members. The two substantial series, *Working Papers Series*, and *Ageing Horizons*, are described in more detail below.

Ageing Horizons

Ageing Horizons[157] is a review of current analysis and research on policy futures in an ageing society. It also serves as a thematic resource for abstracts, news, commentary, and debate on the policy issues that are likely to arise in the medium term as a result of population ageing.

Each issue deals with various aspects of a single theme that is of central importance to policy making in this area. Review articles, written as surveys of developments in the field, are invited from leading experts in the field. Each issue also adds new content to a library of key resources in population ageing, by providing updates on new literature relevant to the selected theme, as well as briefing notes on ongoing research programmes and projects in the field.

The review, which is produced by the Oxford Institute of Ageing and funded by HSBC, is published in hardcopy and electronically. It brings together the results of work from different countries with a view to:

- informing policy makers and policy researchers of developments in the field;
- making a critical assessment of the contribution of current research to policy analysis;
- identifying unanswered questions and unresolved problems.

Two questions are asked:

- how demographic change is likely to shape the policy agenda over the next twenty or thirty years?;
- in what ways can research help to resolve the major policy issues?.

The content of the review covers three overlapping topic areas:

- consensus and disagreement on the major policy issues raised by population ageing;
- the development of the research agenda on the policy implications of population ageing;
- the application of the techniques of 'futures thinking' (e.g. economic forecasting, microsimulation modelling, scenario planning) to the analysis of the policy implications of population ageing.

Two thematic issues are being published every year, in Spring and Autumn. The resources on the thematic pages, as well as the news digests, are updated regularly to reflect major events and publications as they occur. Thematic issues covered thus far since the journal was launched in 2004 are: pension reform, social justice and population ageing; health

[157] http://www.ageing.ox.ac.uk/ageinghorizonsnew/policy.html

policy; bio-demography and longevity; globalisation and global ageing; ageing workforces; and long-term care and ageing populations.

Working Papers Series
A series of papers has been published by the OIA since 2002: these are listed below, with brief summaries of those papers that are likely to be of interest to the EWAS researchers.

Working Papers 2007
307: Functional Solidarity between Grandparents and Grandchildren in Germany, Andreas Hoff - May 2007
This paper, which includes an extended discussion of the emergence of research into grand-parenting in Germany, presents evidence from the German Ageing Survey on patterns of intergenerational support between grandparents and their grandchildren in Germany, and how they have changed since the mid 1990s. The findings are compared with data on support patterns between the target population and their adult children. The analysis also considers the impact of age and changes over time.

The main conclusion of the paper is that the likelihood of financial transfers to grandchildren was higher in 2002 than six years earlier. There is, furthermore, a greater imbalance in the grandparent-grandchild relationship than in the parent-adult child relationship. It is suggested that financial and instrumental support patterns between grandparents and grandchildren are best explained using the intergenerational stake hypothesis, whereas the intergenerational solidarity hypothesis is better suited to explain support patterns in the parent-child relationship.

207: The Ageing Scottish Population: Trends, Consequences, Responses, Robert Raeside, Hafiz T. A. Khan - March 2007

107: Updating the debate on intergenerational fairness in pension reform, Kenneth Howse - March 2007
The paper examines the arguments involved in claims about the fairness or unfairness of government policies that would require the current working generation to bear the full impact of its lower fertility on the costs of retirement pensions. The analysis is set in the context of a wider review of debate on the role of the idea of generational fairness in assessing options for reform under conditions of population ageing.

The paper considers the reasons for accepting that generational fairness poses a serious problem for pay as you go defined benefit schemes. Comments are made on the supposed requirements of intergenerational fairness; and policy options outlined for dealing with expected changes in system dependency ratios. Finally, the policy relevance of the difference between increasing life expectancy and declining fertility as sources of changing system dependency ratios is examined.

Working Papers 2006
306 : Demography and Civil Society: A Historical Perspective on Contemporary Transitions and their implications for Population Ageing, Kreager - Oct 2006

206 : Increasing Life Expectancy and the Compression of Morbidity: A critical review of the Debate, Howse - Jul 2006

106 : Pension Liabilities and Generational Relations: The Case of Vietnam, Long - Aug 06

Working Papers 2005
305 : Gaps in the Family Networks of Older People in Three Indonesian Communities, Kreager - Aug 05

205 : 'Conditionality' and 'Limits' of Filial Obligation: Conceptual levers for developing a better understanding of the motivational basis and societal shifts or patterns in old age family support, Aboderin - Mar 05
Academic and policy debates in developing and developed world countries thus still face unresolved queries of whether filial obligation norms are 'eroding' or persisting in rapidly changing societies and whether they are 'weaker' or 'stronger' in different populations.
This paper offers a conceptual focus and theoretical ideas that may contribute to the development of a better understanding of these questions. The paper proposes that finding answers to the macro-level questions hinges on developing a better appreciation at the micro level of how filial obligation norms operate in practice - i.e. how such norms interact with personal and structural circumstances in shaping individuals' support motivations. The paper then develops specific conceptual ideas on the 'terms and conditions' that may govern this interaction, in particular on the apparent normative 'limits' and 'conditionality' of filial obligation. These two concepts are proposed as potentially useful levers for illuminating (a) how normative filial obligations interact with considerations of the personal child-parent relationship and families' socio-economic context in shaping the extent of support given and, thus, (b) how support shifts or patterns across societies have related to underlying filial obligation norms.

105 : Socio-Economic Implications of Ageing in Sri Lanka: An overview, Siddhisena - Feb 05

Working Papers 2004
404 : Securing Care and Welfare of Dependants Transnationally: Peruvians and Spaniards in Spain, Escriva - Aug 04

304 : The Demographics and Economics of UK Health and Social Care for Older Adults, Leeson - June 04

204 : Cost effectiveness and Interventions, Leeson - June 04
In an earlier review paper (Leeson 2003), the effects of an ageing population on health care costs were examined. This was against a backdrop of policy makers in much of Europe and North America expressing deep concerns with regard to the increasing pressure on health and social care costs arising from the demographic ageing of their populations.

A number of studies consider the determinants of health care costs, but in the work considered only one found that the *age structure* of the population is an explanatory factor alongside the effects of *income, lifestyle characteristics, and environmental factors.* This paper addresses specifically the cost effectiveness of care interventions –with more specific reference to work relating to falls, dementia, smoking and heart disease.

The key areas of outcome of social care are food and nutrition; personal care; safety; social participation and involvement; and control over daily life, some of which appear in the

literature as decisive for maintaining the independence of older people (Harper and Leeson 2003). Recent analyses revealed that personal care was the most important area followed by social participation and involvement, with safety identified as the least important (even when relating to falls). Age rather than gender determined preferences: those aged 85 years and over being more concerned about food and nutrition and less about social participation and involvement. Interestingly, those living alone rated social participation and involvement lower than those living with others.

104 : Coping Without Children: Comparative Historical and Cross-Cultural Perspectives, Kreager - May 04

Older generations are composed of a number of distinctive sub-populations which need much closer attention if the differential impacts of population ageing are to be accurately assessed. One such population is older people without children, a group commonly assumed to consist chiefly of small minorities of infertile couples. This paper draws on historical and contemporary population studies to show that there are many societies that have experienced levels of childlessness of 10 to 20 percent and higher, over long periods. These levels derive only in small part from infecundity; consideration is necessary of a range of demographic factors, including migration, marriage patterns, contraception and pathological sterility.

The implications of *de facto* childlessness suggest that limited or nil access to children is likely to be considerably higher than levels of infertility indicate. Rather than a marginal social phenomenon, significant numbers of elderly without children appear to be a consequence of enduring social arrangements, adaptations characteristic of long-term population stability, and adjustments to major social and economic change. Despite the aggregate advantages which levels of childlessness may give to a society in the long term, it nonetheless tends to compound the social and economic disadvantages of older people, and carries important implications for their social exclusion and powerlessness. The range of adaptive strategies that people may employ in response to childlessness and its consequences is reviewed, together with the empirical and methodological needs for further study.

Working Papers 2003

503 : Changing Families as Societies Age: care, independence and ethnicity, Harper and Levin - Sept 03

The UK's national population structure in line with most Western societies is ageing rapidly. The combination of falling fertility and increasing longevity is having an impact on family structures and resultant relationships, with the emergence of long vertical multi-generational families replacing the former laterally extended family forms. This is occurring at a time when UK government policy is placing increasing reliance on families to provide health and social care and support for the growing number of frail older people.

While there has been extensive research on family care within the majority white population, there is less understanding of the elder family care provision for the UK's growing older ethnic population. This paper discusses the changing demographics, new government policy on promoting independent living and its implications for family care provision, and reviews our current understanding of family care and support for older people within the UK's varied ethnic minority families.

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