Getting on... with life

Baby boomers, mental health and ageing well
A Review
Contents

Acknowledgements 5
Foreword 6
Executive summary 7
The ‘baby boomers’ 13
Demographic changes and population challenges 25
Ageing 31
Lives lived: Health, mental health and social care 39
Lives lived: self and relationships 75
Lives lived: work, wealth and education 99
Conclusions, key findings and implications 127
References 135
Age-related data from YouGov survey 146
The Mental Health Foundation is deeply grateful to Baroness Lola Young for chairing the inquiry panel and to all the panel members who gave generously of their time and expertise.

We are also grateful to the staff who contributed especially to Janis Grant who provided the bulk of the support to the panel and was the lead author of this review. She was supported in the primary research by Dr Sandra Grant, OBE. We would also like to acknowledge the other staff who made a key contribution to the inquiry: Toby Williamson, Paul Bristow, Dr Eva Cyhlarova, Kathryn Hill, Katrina Jenkins, Simon Lawton-Smith, Dr Andrew McCulloch, Dr Dan Robotham and our communications and support staff.

Finally we would like to acknowledge the financial support of the Esmee Fairbairn Charitable Foundation which funded the bulk of the inquiry and also provided helpful advice and support, and to the Trustees of the Mental Health Foundation for releasing additional funds.

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More people will reach their 65th birthday in the UK this year than at any other point in history. In fact 169,000 more people will be 65 this year than last year - a 30% increase in just one year - throwing up enormous challenges for how society, and health and social care in particular, will respond and cope. This is because the so called “baby boomer” generation are starting to reach retirement age. Can it be that the generation that gave us free love, drugs and rock and roll are getting on?

What makes this change so interesting and potentially pivotal, is not just its scale, but the characteristics of this generation itself. The term ‘baby boomer’ carries some negative connotations – the popular press tends to associate people born in those years with libertarian, anti-authoritarian and hedonistic values; and has blamed them for some of the current social and economic ills (real or perceived) in society. But this population cohort could well be part of the solution not just part of the problem; if we can think more radically to how they can be used. They are associated with radical social and cultural change: might they not be a source of equally radical and inventive solutions to the problems their ageing will present?

Although care must be taken when drawing conclusions about a group as diverse as a generation, clearly many in the baby boomer generation have broken the mould at every stage of life, so why should old age be any different? This is a generation that has thrived on creating social change, accepting challenges and discovering different ways of doing things. They are deciding there is more to life than simply fading away from age 60 onwards.

The Age Well project was set up by the Mental Health Foundation to explore how the baby boomers are likely to weather the transition into old age, with a particular focus on their mental health and wellbeing. We recruited a distinguished panel of politicians, business people, academics and third sector leaders to help us think this through. And we collected a wide range of views using surveys and interviews as well as the existing literature.

This is the first time that all of this information on the issue of baby boomer’s mental health has been pulled together in one place. Our intention is to support policy makers, key decision makers, strategists and researchers, as well as service designers and providers, to better plan for these major social changes and consider harnessing the talents of baby boomers themselves in finding solutions.

We would like to thank our distinguished panel, the staff of the Foundation, everyone who gave freely of their time to speak to us, and the Esmee Fairbairn Charitable Foundation for funding the inquiry. We commend our report to you.

Baroness Lola Young, Chair of the Age Well Inquiry Panel
Dr Andrew McCulloch, Chief Executive, Mental Health Foundation

For full copy of report, please visit www.mentalhealth.org.uk/agewell
This review is about baby boomers: the people born between 1946 and 1955. They are a birth cohort who grew up in the post war years of austerity, and were young people and became adults in a period when the fundamental social, cultural and economic changes that produced modern consumer society were happening: they were its vanguard.

The baby boomers are now in, or reaching, their sixties. They are moving into later life, a time often accompanied by a new range of challenges. The review sets out to explore whether the lives they have lived and their generational attitudes and behaviours have any implications for their mental health and any experience they may have of mental illness, as they grow older.

An Inquiry Panel was set up by the Mental Health Foundation in 2011, to take forward the review, to identify potential future challenges for the baby boomers and propose actions aimed at promoting mental wellbeing and protecting mental health in the future. The work was funded by the Esmee Fairbairn Charitable Foundation, with additional funding and support from the Mental Health Foundation. This review is the full and detailed version of the findings of this project. A shorter summary report is also available at [DN insert weblink].

The baby boomers
The first chapter of the review sets out the background to the baby boomers and social change, and explores the extent to which they identify as members of a generation. It also notes their diversity: to say that they are the generation of change does not mean that they have shared experiences, values and attitudes. They are a diverse group of people who, in effect, provide a bridge between the past and succeeding age groups. Nevertheless, as the chapter also notes, they have changed every station of life they have passed through; so how will this continue into old age; are baby boomers going to do things differently, and what does this mean for their future mental health? The purpose of the review is to identify what will help protect the mental health and promote mental wellbeing of this new older generation.

Mental ill health in later life
The factors that put individuals at risk of experiencing mental illness in later life, and the factors that help protect them, provide a framework for exploring the risks baby boomers face in later life, and for considering the extent to which their lives have made them more or less vulnerable to negative later life experiences. The framework is discussed in chapter 3.

The lives of the 1946-1955 baby boomers
The main aspects of the lives of the baby boomers are covered in chapters 4, 5 and 6. Each chapter contains some background history of social change, particularly as it has affected the major institutions covered by the chapter, and then brings the story up to date with recent research, statistics and analysis. Each chapter is also supported by primary evidence from three sources, in-depth interviews, a national YouGov survey and a project web survey. These are described in detail in chapter 1. The English Longitudinal Study of Ageing (ELSA) has been a major source of reported evidence and analysis.

Generational identity and attitudes to age
A good proportion of people who participated in project surveys identified in some way with the post war generation. Key themes were ‘the lucky generation’, the music of the sixties, the political activist generation and the last remnants of austerity (Chapter1).
‘Sixty is the new 40’ is an expression with which many baby boomers agree. Seventy is regarded as the beginning of old age by many, with their views linked to living longer, being active and healthy and working for longer. Physical problems are more associated with 70 than 60. At the same time being young ends in the early to mid-forties, as people look and behave ‘younger for longer’.

**Health and mental health**

People are living longer. Women in the baby boomer cohort will, on average, expect to live for over 20 years at age 65 and men for nearly 18 years. They have benefited from massive improvements in medical treatment and health technology, as well as better nutrition, education and housing. Vaccines and better drugs against infectious diseases in early life have left fewer with long term chronic conditions and many have survived conditions that would previously have led to childhood mortality. Death rates in middle years from cardiovascular disease and cancer have fallen dramatically since the 1980s so that fewer of the cohort has died in their middle years. Changing employment patterns have meant they have been less exposed to occupational hazards, and improved medical technology continues to reduce the life-threatening impact of potentially disabling conditions. The National Health Service, present throughout their lives, has provided universal free health care, enabling all to benefit from medical progress.

People interviewed for the review generally hold the NHS in high esteem and have strong aspirations about its continuing to support their wellbeing in the future. However, many have fears that its services are being eroded and that it might no longer be there for them. Research for the review also found a general agreement that people are responsible for maintaining their own physical and mental health, and a strong commitment to doing so. Baby boomers are willing to visit their GPs (women more so than men), including for mental ill health, and the evidence is that this age group is now taking more exercise and eating more fruit and vegetables than previous generations.

But despite their positive health advantages and attitudes, baby boomers have poorer health levels than might be expected or indeed possible, with implications for the future. Sedentary lifestyles, inadequate exercise, poor diets, obesity and alcohol consumption are linked to problem levels of diabetes, high blood pressure and hypertension, with implications for cardiovascular disease, cancers and musculo-skeletal conditions. Baby boomers may be unlikely to experience significant improvements in healthy and disability free living; their longer lives may include added periods of ill health. This has implications for their mental health and wellbeing, as well as their physical health. Chronic illness, pain and disability are powerful risk factors for depression and depressive symptoms. The effects of physical and mental ill health are interactive and cumulative, resulting in increasing disability. The threat to the physical health of baby boomers is also a threat to their mental health (and vice-versa).

Evidence collected by the review shows that baby boomers have little awareness about protecting their mental wellbeing, despite real concerns of future mental illness, loss of mental abilities and dementia.

The review explores the relationship between physical and mental health through a social disability model. Social and psychological contexts shape how people respond to chronic illness; evidence from the English Longitudinal Study of Ageing has shown how even small differences in life enjoyment can have profound consequences for older people’s disability. Measures of people’s satisfaction with life, feelings of sadness or happiness, and their judgments about their purpose and control of their lives, can predict their future health and also mortality. The promotion of mental wellbeing can make a contribution to making lives healthier for longer. It may also reduce health care costs.

Continuing medical research is likely to bring forward further treatments for conditions associated with ageing. Baby boomers are likely to be proactive health care consumers, with high expectations that the health service will meet their needs and not discriminate against them on the basis of age.

**Social care**

Many baby boomers have taken on caring roles, particularly in recent years as their own parents have needed care. This, together with the high profile of social care issues in public debate, has given them a critical perspective of care, plus an acknowledgment that they are unlikely to be able to count on public services for their own future care needs. The review found strong wishes among many baby boomers to remain in control of their lives and be independent as they grow older. This was linked to a wish not to be a burden to families and a frequent recognition that families may not be available to provide care, particularly where connections have been broken by divorce. The review finds that much provision of care in the future will fall on baby boomer spouses and partners: baby boomers
are likely to become carers in large numbers. There is considerable evidence that caregiving is a risk factor for mental illness despite the fact that it is usually a valued activity. The key factors are the loss of a carer’s own social networks, loss of leisure activity and duration of responsibilities.

The review has noted the personalisation of public social care budgets and the creation of markets for social care. The consumer attitudes of baby boomers and their low levels of deference to authority mean that they are more able to engage with purchasing social care than current older care users. However, the review found concerns about care relationships and the quality of care that may be available. The future costs of meeting care needs are a major issue of concern. As a result many are not considering their own possible future needs. The review has noted that decisions are yet to be taken on the proposals made by the Dilnot Commission on funding of care and support in 2011 (Dilnot Commission on Funding of Care and Support, 2011) and that the 2013 spending review is the likely earliest date for their consideration. In order to feel confident and make plans for the future people need clear policies. Fear, including fear of compromised physical and mental health and of lack of appropriate support services, is also a significant threat to mental health. Wherever possible, government and other public agencies need to provide as much certainty as possible so that individuals and families can plan ahead.

Attitudes to older people and ageism

The review found that, on the whole, ageing is seen as a fairly positive experience. Among people interviewed there was a mostly positive view about change through their lives, although mixed with concerns about future opportunities for younger people. However, looking to the future, six out of ten people surveyed said they were concerned about attitudes to older people and only around one in ten thought older people are valued in our society. The review identified how a youth-orientated society has a range of negative stereotypes about older people and ageing, and uses age as a way of imputing levels of ability, competency, skill or health. Government policy fixates on age-related decline, despite a lack of evidence of linear links. Older people may then internalise the negative stereotypes. Ageism is the systematic stereotyping and discrimination against people because of their age. It can contribute to feelings of worthlessness and despair and reduces mental health by undermining personal self esteem, putting people at risk of mental illness in the same way as other prejudices affect people. Age discrimination exacerbates older people’s sense of powerlessness and ability to live a fully engaged life; it has a significant negative impact on older people’s mental health.

Baby boomers’ attitudes to others have been shaped in a culture where discrimination has become less acceptable. Their attitudes to age suggest that baby boomers are already rejecting some earlier stereotypes. The review highlights the need for promoting good intergenerational relations and positive attitudes about age.

Family, friendship and community

There is strong evidence about the relationship between mental health and relationships. Isolation, loss or lack of family and friendship networks, bereavement and loss of emotional support, and living in unsupportive neighbourhoods are all risk factors for mental illness. Social ties, relationships and connectedness are sources of protection. Religious belief may also protect mental health.

The 1946-1955 cohort became adults at a time of social and legislative change that liberalised divorce, abortion, contraception and sexual relations and which have had profound impacts on their lives. The review found that this baby boomer cohort had generally married at a young age and those born between 1946 and 1950 had the highest marriage rates in the twentieth century. Divorce has also had its impact; for example, by the age of 40 more than a quarter of people born between 1946 and 1950 had divorced and one in four children born in 1979 experienced their parents’ divorce by age 15. By 2005, the ELSA found that around six in ten were married in their first and only marriage and around one in six were remarried. Others were divorced, widowed or single, with almost a quarter of women and one in six men being on their own. They contribute to a national trend of more people living alone; an increase of a million additional people living alone is accounted for by people aged 45-64. And the numbers are projected to increase further.

Their families, and the relationships they had built, are a source of satisfaction for many people. However, evidence collected for the project also highlights how reconstituted families may mean that connections with children are broken, and wider family relationships disrupted. For the future, four out of ten baby boomers surveyed were looking forward to spending more time with their family or partner, and three out of four expected to have friends and family who will give them support.
In terms of friendship, the review identified issues about the effects of work pressures and geographical mobility on friendships, which potentially become fewer and more transient. However, it also found a multiplicity of relationship patterns. ELSA evidence suggests that baby boomers are less involved in civic and leisure activities, and may have less developed networks than older cohorts of people. Finally, there has been a decline in religious belief and in church attendance.

The risks posed by family breakdown and community disengagement are significant. The main protective factors for the baby boomers lie in the nature of the relationships they have. The study has found evidence that relationships are now more based on ‘emotional communication’ both between couples and between parents and children. Wider family relationships, including close support from siblings, may also contribute. Friendship too, forms a part of people’s network of relationships. There has been a shift in attitudes to relationships that may provide protection to baby boomers in the future. The challenge for the future is the maintenance of these social networks as people grow older.

**Work, retirement and finances**

Baby boomers have lived through major economic and labour market changes; the notion of a job for life has been transformed into flexible working and portfolio careers. They have been defined as a group of people who see work as important – the project interviews and surveys affirm this. They now face the challenge of retirement, at a time of economic recession, which can lead to loss of a valued role and status as well as anxieties about managing on a reduced income (as well as actual experience of poverty, particularly for women). Evidence indicates that abrupt or enforced retirement is most likely to lead to mental illness.

Women have been almost as strongly engaged in paid work as men, although more of them have worked part time. Improved education opportunities have helped them fill a wider range of roles. The effects of the retirement transition on mental health and the risk for mental illness have traditionally been seen as mostly affecting men; however, baby boomer women are increasingly vulnerable to the same loss of role and identity associated with retirement. Evidence collected for the review indicates that working patterns around traditional retirement age are changing, and that fewer people are leaving, or being forced to leave, their jobs in their fifties and more are continuing to work after age 65. This is in part linked to the changing nature of employment and the higher educational qualification levels of baby boomers. The review also found that unemployment is still a greater problem for people over age 50 than younger people, and that many may give up seeking work. Employers need to do more both to recruit and train older workers and to enable people to have a controlled transition from work.

Financial resources affect the choices people can make; being poor can impair people’s capacity to make choices, undermine independence and reduce participation in social life. Living in poverty particularly over a long term, provokes stress, worry, fear of getting into debt and loss of control over life. It is a risk for loneliness. Inequality is linked to increased mental illness.

Around a third of baby boomers surveyed expressed concern about future financial insecurity. The review has found that the proportion of older people living in poverty has decreased, but nevertheless some two million current pensioners (17%) are in poverty and UK pensioner poverty is above the European average. The study has collected evidence about the growth of economic inequality since the 1970s, an increase in people unemployed, and ‘work poor’ families. Lack of work and low incomes will be risks for continuing poverty in later life. Baby boomers at greatest financial risk are single people, including the divorced, with women most at risk.

In respect of protective factors, the review has noted that if baby boomers use all their resources, including housing wealth and savings, to provide income, most will have adequate retirement resources. The real question is the attitude of baby boomers to the use of this wealth for their own support. Many are committed to helping their families. The abolition of a default retirement age has enabled people to phase retirement and to continue earning to supplement pension incomes, which is an important reason for staying in work. In terms of education as a protective factor, the baby boomers are the best educated generation yet to reach their sixties, although they have lower qualifications than succeeding generations.
Key findings and recommendations
The review has taken an overview of the lives of baby boomers from the perspective of risk and protective factors for mental ill health. The final chapter draws out a number of implications for policy and action. These are:

FIRST KEY FINDING – Health and mental health services
Our first over-arching finding is that health and adult mental health care services should work in a way that integrates services across ages, recognises the relationship between physical and mental health, and reflects the changing needs and preferences of different generations, and more specifically, the baby boomers as they grow older. This includes:

• A quick move to integration of adult mental health services across age groups and for treatment for common mental disorders to be available on the basis of need. There need to be monitoring arrangements to track progress and mechanisms to identify and share good practice.

• Drug and alcohol services need to be developed to more effectively meet the needs of older substance misusers; more research needs to be undertaken into the current use patterns and treatments that work best for older people. Additionally, there needs to be a greater public health focus on what works in the delivery of health protection measures for baby boomers to promote messages of sensible drinking that make sense to them.

• A greater public health focus on promoting good mental health among the baby boomers as well as older people, supported by better research on factors linked to mental wellbeing in later life. In particular baby boomers’ views of healthy ageing and mental wellbeing should be a focus of research to find out more about their priorities. Policy makers, and agencies such as health and well being boards, need to engage and mobilise ‘baby boomers’ individually and collectively in activities to maintain good mental health in later life.

SECOND KEY FINDING – Ageism
Ageism harms people’s mental health. We need to change attitudes to age and to older people with action across all policy areas, and with the promotion of older people as active citizens. Baby boomers need to be supported to play significant roles in promoting positive ageing and recognised for the social capital they provide to society more widely.

THIRD KEY FINDING – Protecting mental capital
Mental health in later life needs to be supported and protected as a valuable social asset. Public policy needs to recognise the enormous psychological, social and vocational resources within the baby boomer population, across all ethnic groups. Baby boomers should be encouraged and enabled to share this with each other as well as with other generations.

FOURTH KEY FINDING – Better information about dementia
There needs to be more and better public information about dementia that broadcasts messages in accessible formats to reach all ethnic groups that healthy lifestyles can protect against some forms of dementia and cognitive decline (as well as many other long-term conditions) and also that it is possible to live well with dementia. This includes:

• Health promotion messages to include information about risk factors for cognitive health and ways in which people can protect their mental health, with a particular focus on people in midlife.

• A public health focus on ‘demythologising’ dementia, to promote messages about adjusting and living well with the condition, and not seeing sufferers as ‘different people’. At the same time, the importance of early identification needs to continue to be promoted. Workplaces are identified as potential locations for such public health messages.

FIFTH KEY FINDING – Addressing inequality
Health and social inequalities in older generations, including baby boomers, have a negative effect on the health and wellbeing of the whole community, and on specific outcomes for older people, such as life expectancy and mental ill health. Policies and programmes that impact on older people need rigorous assessment at the development stage to determine their likely impact on inequalities in old age and their potential contribution to reducing them. This needs to apply both at UK, national and local levels.
SIXTH KEY FINDING – Improving employment practices
The importance of employment and workplace practices in protecting the mental health of baby boomers needs to be recognised. Governments, employers, employers’ organisations, trade unions and professional bodies need to focus on developing positive policies, which will protect and support older people in employment, improve their mental health in work and protect their mental wellbeing as they make decisions about the future.

SEVENTH KEY FINDING – Financial policies
Adequate finance to cover the whole of people’s expected remaining life spans needs to be protected now. Governments need to recognise the importance of adequate income in protecting health and wellbeing in later life when developing their fiscal and financial policies affecting older people. These policies must clearly state how they will contribute to ensuring adequate incomes for older people and equality across gender.

EIGHTH KEY FINDING – Social care
Care quality needs to be improved, as do monitoring and safeguarding mechanisms in an increasingly commercialised social care market. Innovative ways of providing care should be supported, or at least not inhibited by governments. The skills, expertise, resources and experience of baby boomers – ‘care capital’ – should be mobilised by engaging them as active participants in this process to help shape and deliver forward-looking health and social care policies and services.

NINTH KEY FINDING – Tackling loneliness
Tackling social isolation and loneliness in old age should be a priority for national and local government action. Investment in maintaining and developing public services and facilities that are known to promote social engagement and reduce risk of social exclusion will reduce spending on health and social care services further down the line. This investment needs to engage the resources of baby boomers, as they move into retirement, to support innovative initiatives and to help build protective networks at a local level that will become embedded for the present and the future.

TENTH KEY FINDING – Involving baby boomers in shaping their future
Policy makers need to recognise that baby boomers will want to go on being involved in shaping their lives and shaping the contexts in which their lives are lived. This means involving and engaging them at all levels.
Chapter 1: The ‘baby boomers’

Introduction
Baby boomers, born after the Second World War, are reaching State Pension age. They have lived through changing times and have demonstrated an ability and willingness to be part of the vanguard of those changes. Recent investigations by The Mental Health Foundation (Lee, 2006) have highlighted how later years can often be years of poor mental health for many people. This project was set up to answer the question, ‘can baby boomers also change later life? Will they do things differently and protect their mental health, or will the changes they have lived through, and the social effects of those changes, make them more vulnerable to mental ill health?’

The review has adopted a perspective that views later life simply as a later stage of people’s lived experience, not a segregated part of life. This life course perspective sees people’s later life, in particular their health and mental health, as having been shaped by their lifetime experiences. Individuals each have their own lived experience and a set of personal characteristics, but lives are also structured by shared experiences of the social world. Later life adds a number of new challenges that individuals will respond to in ways that have been formed by the lives they have lived. For baby boomers, this shared world has been one of dramatic change in culture, attitudes and behaviour.

As a society we are living longer and healthier lives, and more of us are surviving into our eighties and nineties. People’s sixties are a time of life associated with reasonably good health, mental wellbeing and involvement in family and society. The key question for the review is: how can the mental health of baby boomers be protected to help them live later lives free from mental illness?

Baby boomers growing older
As baby boomers reach their sixties their latter decades seem, like their earlier years, to be the focus of keen popular debate and speculation. How will a generation that invented youth culture deal with the challenges of growing older? This is a generation that has changed each stage of life it has reached, from youth to midlife. It seems reasonable to predict that they will also bring change to the way people in Britain grow older and live their later years. Evidence indicates that their sixties are experienced as a positive time by most people. They are able to look back on what they have achieved in their lives so far and forward to new opportunities. It is nevertheless true that growing older also generally brings new physical, social and emotional challenges to be dealt with, although there is no universal pattern to ageing. Some of these challenges will affect people’s mental health and wellbeing, and may lead to a first experience of mental illness or trigger the return of a prior disorder. The Mental Health Foundation is committed to helping all people live mentally healthier lives. This report on the 1946-1955, first wave, baby boomer population is about the contribution of good mental health and wellbeing to ageing well and to coping with challenges later life may bring. It also raises the need for better recognition and treatment of mental ill health, such as depression, for older people.
The current experience of growing older in Britain can be one of poor mental health for many people; however mental illness is not a natural part of growing older despite the frequent inclusion of depression in lists of later life conditions. This report explores the lives of the baby boomers to consider their attitudes to growing older, and also to assess whether they will be more open to acknowledging and dealing with mental ill health and more prepared to actively protect their mental wellbeing than earlier older generations. The report examines our current approaches to tackling mental illness and promoting mental wellbeing in older people and suggests the need for a greater awareness of the relationship between physical and mental health in promoting healthy ageing. It also highlights the need to raise awareness of cognitive impairment and dementia, which has become increasingly prevalent as more people survive to their eighties and nineties and which can also be assisted by early identification, improved mental health promotion, and a clearer policy focus on improving mental wellbeing.

The Age Well project
The project, of which this review is a key product, was concerned with identifying the ways in which the mental health of people born in the decade after the end of World War II can be protected and their mental wellbeing promoted. Its background is:

- People born in the 1946-1955 cohort are now approaching a period of transition; growing older brings challenges that are different to those faced in earlier life
- Evidence shows that mental illness in later life is often under-recognised, under-rated and inadequately treated
- The characteristics and experiences of these baby boomers are substantially different from those of earlier generations.

The project aimed to:

- Identify the potential mental health risks the generation is facing and the factors that may protect them and help them deal with challenges of ageing
- Assess the importance of mental wellbeing in ageing well and consider how it may be supported – through policies and actions across many sectors and fields
- Promote improvements in the provision of mental health services that reflect the needs of each generation
- Highlight issues around attitudes to ageing and older people that may affect wellbeing.

The ‘challenge’ of population ageing
The first wave baby boomers are approaching transition to retirement at a time of economic turmoil and in the context of worldwide population ageing. An increasing proportion of the population is now aged over 60 with continuing increases in life expectancy. Current economic and political language often refers to the challenges this presents, in particular in relation to the costs of supporting large numbers of older people. This report joins many calls to treat increased human longevity as a success, recognising and promoting the social and economic contribution older people make. Indeed, it will be essential to fully harness this resource.

To open up discussion about the often marginalised areas of mental health and mental wellbeing and their positive contribution to active ageing, this review sets out why they are important and considers how baby boomers can be supported to get on with their lives and age well.

Why focus on post-war baby boomers?
The term ‘baby boomers’ is used in relation to people born in the two decades after World War II, broadly in the years 1946-1964. In this period there were unusually high UK birth rates in 1946/47 and 1964 and several years of higher than average births between these peaks, creating a baby boom. The UK was not alone in experiencing these birth booms; the US in particular experienced two decades of continually raised birth levels which created an extremely large age cohort. The size of the US population phenomenon has been responsible for a continued interest in the progress of the baby boomers as a social group, an interest which has been less evident in the UK. In the US, policy makers, marketers, and media have all been keen to reflect and comment on the changing interests of this large population segment. This is becoming especially true as the oldest baby boomers reach retirement age, bringing perceived new challenges in their wake. But the baby boomers are significant for more than their numbers,
which in the UK, are proportionately lower than in the US. In a paper prepared for the King’s Fund Wanless Social Care Review in 2005 (Wanless, 2006) the review team noted that people’s expectations are changing and, in particular that the ‘so-called baby boomer generation’ were already demonstrating differences in their approach to later life compared to earlier cohorts. The key features of this difference were described as including demands for greater choice, for rooting out discrimination and for embracing the human rights agenda. These observations are based on research into the social characteristics of the baby boomers.

A force for social change
Baby boomers have been viewed by sociologists as having a distinctive set of experiences that set them apart from preceding generations. It has been suggested that they are a vanguard generation that has both experienced but also initiated social change (Huber and Skidmore, 2003). Baby boomers have also been viewed as a mid-century generation that ‘broke the mould of the modern life course’ (Gilleard and Higgs, 2002). The 1946-1955 ‘cohort’ were born in a period of post-war austerity (Evandrou, 1997). They grew up, however, in a society characterised by increasing affluence, high employment and rising wages, the growth of home ownership and increasing access to consumer goods such as televisions, refrigerators and cars. The introduction of the welfare state ensured free access to healthcare and education. Higher education expansion in the 1960s opened up further opportunities for this generation, including access for more people from working class backgrounds, although their relative numbers remained low, and more so for women. A policy emphasis on re-building the family after the war, based on highly segregated roles for men and women and a focus on domesticity and consumption in the household, has been identified (Phillipson et al, 2008). A summary of mainstream post war western culture by the historian Arthur Marwick is shown in Exhibit 1.1.

Exhibit 1.1 Pre-sixties culture

Western culture, pre-sixties
- Rigid social hierarchy
- Subordination of women to men and children to parents
- Stuffy and repressed attitudes to sex, fostered by churches
- Respect for authority
- The prevalence of racism
- Universal, if often uncomprehending, obeisance to canonised art; respect for giants of science – Einstein, Darwin etc.
- Complacency over technological advance and the growth of affluence and consumerism
- Strict formalism with regard to social relations, etiquette, dress codes etc.


The 1960s
The 1960s have been identified as a major period of social transformation with the emergence of an international youth culture at its heart. With growing affluence, consumption became associated with developing new lifestyles rather than utilitarian needs. Young people born in the 1940s and early 1950s were at the forefront of these changes, seeking products, especially music and fashion that would differentiate them from the adult world. They became the targets of the advertising industry to a greater extent than their parents (Judt, 2005). Alongside these material and lifestyle changes, there were changes in social attitudes which, like the changes in consumption patterns, have helped shape modern culture. Conservative post-war moral standards broke down in a society that had become more confident and less deferential (Thane, 2010).

Thane also highlights the formation of actively campaigning minority rights groups in the 1960s, and their success, that resulted in legal reforms including the partial legalisation of homosexuality (1967) and abortion (1967), the Race Relations Act (1965), and the Equal Pay Act (1970), followed by the Sex Discrimination Act (1975) and Race Relations Act (1976). Other liberal reforms in the period included the abolition of capital punishment (1965), the lowering of the voting age to 18, and changes
to censorship legislation. The availability of the contraceptive pill from 1961 (initially for married women only) played a significant role in changes to sexual attitudes and practices among young people, from the second half of the sixties, especially those involved in higher education.

Student activism and radicalism are also associated with the 1960s although, as historians point out, such activism was limited to a minority of young people. Judt (2005) summarises the ‘revolutions’ of the period as a revolt against the restrictions and standards and styles of life of those who managed and maintained existing society, with groups of younger people challenging established social roles and institutions.

Drug use assumed a prominent and often integral (but also overstated) role in emerging youth culture. The 1960s is also identified as a key transitional period in the history and culture of modern drug use, and in the policies adopted to respond to it (Release, 2012). Implications for later life include the continuing use of drugs by a minority of early drug takers and a possible greater willingness to find illicit drug solutions to problems associated with ageing. ‘Turning on, tuning in and dropping out’, the Sixties culture quake, while failing to initiate the global revolution some protagonists aimed for, did bring about deep and enduring changes in the social and cultural fabric of the western world (Release, 2012). Marwick’s summary of counterculture ideas is shown in Exhibit 1.2.

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Exhibit 1.2: Sixties ‘counterculture’

<table>
<thead>
<tr>
<th>Counterculture’ – the sixties</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Youth culture and trendsetting by young people</td>
</tr>
<tr>
<td>• Black civil rights</td>
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<tr>
<td>• Mass protests and student activism</td>
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<tr>
<td>• Beginnings of contemporary environmentalism</td>
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<tr>
<td>• Criticisms of technocratic society</td>
</tr>
<tr>
<td>• Triumph of popular music based on Afro-American models</td>
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<tr>
<td>• Challenges to Enlightenment rationality</td>
</tr>
<tr>
<td>• Serious appreciation of mass culture and blending of elite and popular culture</td>
</tr>
<tr>
<td>• Feminism and gay liberation</td>
</tr>
<tr>
<td>• Drug culture and ‘dropping out’.</td>
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</tbody>
</table>


The youth culture that emerged in the sixties was intended to marginalise previous generations (Gilleard and Higgs, 2007). Lifestyle driven, youth counter culture became today’s mass consumer culture, which continues to be heavily youth focused. There has been a ‘teen-aging of modern culture’ (Jones et al, 2008a). Baby boomers grew up in this period of consumption transformation and were part of the change. They are entering later life with different formative experiences to previous generations. Another approach to conceptualising processes of change sees the post war baby boomers as a ‘cohort’, comprising people born in the same timeframe and experiencing the same life course experiences. Young adults can act as catalysts for social change if new ideas are emerging. They are old enough to participate in new movements but not old enough to have made social commitments. They do not necessarily cause change but permit it to occur. If change occurs, it differentiates the cohort from others and the consequences persist in the subsequent behaviour of the cohort members (Ryder, 1965).
Legacies of change
There is a perception that the lives and experiences of the baby boomers as ‘the vanguard’ of modern consumer society have created the shared characteristics of individualism and liberalism (Huber & Skidmore, 2003). Individualism expresses itself as the likelihood of being less deferential, more non-conformist and less trusting of those in authority. This individualism is linked to ‘smart’ consumerism, with a rational and practical approach to making choices which carries over into attitudes to public services. Baby boomers’ liberalism is demonstrated in their attitudes to sexual and moral issues including cohabitation, sex before marriage, homosexuality and lone parenthood, as well as to wider issues such as men’s and women’s roles, climate change and drug legalisation (Huber and Skidmore, 2003). Such attitudes are also likely to be influential in shaping their ageing, together with their mental health and wellbeing as they grow older.

Generational identity
Their own views of a collective, separate, identity were explored through research with people born between 1946 and 1955 carried out for the project (see below for further details). A project web survey and in-depth interviews explored generational identity.

Web survey
The project ‘sign-up’ web survey asked ‘do you feel that you belong to a particular generation of people that has shared experiences?’ There was an approximately 80:20 split between those who saw themselves as part of a generation and those who did not, although because involvement in this survey was self-selected, it is possible that more people with this perspective chose to take part. The follow up questions for those answering ‘yes’ were about the generation they feel part of and what influence this has on their lives.

Which generation?: Most people who responded positively to this question referred to being post-war children, growing up in the 50s and being teenagers in the 1960s/ baby boomers. There were also references to values that people grew up with and the opportunities they had.

Generational identity – web survey comments
‘The one that was young in the ‘60’s and 70’s with all that meant in terms of music and freedom’.
‘A very optimistic generation, living at a time when everything was possible - getting jobs, housing etc.’
‘I hate the expression Baby Boomers, but that generation that probably had more freedoms than any before or since’.
‘The first one where women could easily have a career and not be dependent on men’.
‘Baby boom kids, born after the war, so tasted a bit of poverty, but was able to take advantage of education’.
‘The generation that had to be careful with money as parents didn’t have access to credit’.
‘Post war baby boom and a generation that has moved forward technology’.

Interviewees taking part in the in-depth survey programme reflected similar views:

Generational identity
‘Well aye, we rode into the sixties and made lots of social changes… pulled down barriers. There’s a bit of you always remembers that period very fondly’. Female, born 1952
‘The music, it was mood-lifting, a comfort. I could go anywhere and have access to it, like the generation before couldn’t.’ Male, born 1949
‘I grew up in an era when we genuinely believed we could change things for the better, we hadn’t got this dreadful scepticism… we still believed in the perfectibility of people and society’ Female, born 1951
‘As a young man I was influenced by an older generation, born during the war…I got most of my directives from them. My contribution to life generally is more considered according to my age than as a general consensus involving all different age groups. … I’ve met many people my age, because of working in music… and they tend to have the same .. erm.. outlook, or opinions. Male, born 1951
‘The big watershed was the pill’. Female, born 1950
‘The women’s movement; really important.’ Female, born 1951
‘I don’t see myself as a baby boomer… but I do recognise how fortunate we were’. Female, born 1950
People who said they did not feel part of a generation said that this did not represent their way of thinking, that they mixed with a wider age group of people, and that a generation description does not match their experiences.

**Not feeling part of a generation – web survey comments**

‘I do not think of myself as being part of a particular generation or cohort.’

‘I feel I belong to groups who are of mixed ages but predominantly younger than myself’.

‘Experience is a consequence of living, not necessarily shared and one’s opinion of it is influenced mainly by one’s belief system’.

‘I feel that other groups (my parents) had that feeling, but I do not’.

‘I am from an ethnic background and therefore I cannot relate my early upbringing with those born in England’.

For those who did identify with a generation, its influences on their life are seen in terms of culture, optimism and the opportunities that were available.

**Impacts of generation membership – web survey comments**

‘It makes me appreciate my good fortune to have been born into a time of greater opportunities for working class kids like myself’.

‘Increasing freedom when young. Feeling much closer to my children than I think my parents did to me’.

‘It was the start of the biggest changes ever known, young people view the 60s with awe, they feel they can relate to you because of this’.

‘I am still resourceful and can adapt to current financial circumstances. I think we were taught to solve problems.’

‘I think we have a high expectation of our entitlements from society, but also a high commitment to contribute to society’.

‘I think I am more accepting than my mother’s generation but I don’t think my life has been influenced by it’.

‘I am grateful for the opportunities given me. I appreciate my material wealth and the peace in Europe’.

The ‘baby boomers’
Overall, some key themes around definition of generation include ‘the lucky generation’, the ‘music of the sixties’, the ‘political, activist’ generation and the ‘last remnants of austerity’ generation.

A diverse generation
If baby boomers are different from their parents this does not mean that they are a homogeneous group. A further effect of the times they have lived through is the emergence of a population that is more diverse than their predecessors. Consideration of their future mental health and wellbeing needs to take into account differences in income and wealth, ethnicity, education, family relationships, health and life expectancy, and attitudes across a number of important areas. These patterns of difference are considered in the chapters of the review. Some key points are:

Health and life expectancy: People born between 1946 and 1955 had healthier childhoods with fewer infectious diseases; more have survived middle age as the midlife effects of heart disease, strokes and cancer have been successfully challenged. But they are not necessarily growing older in better health: obesity, type 2 diabetes and high blood pressure are all increasing and the gap in life expectancy and disability-free life expectancy between the richest and poorest has grown wider. And while reports of increased mental illness levels have been exaggerated, for men in particular the 1970s marked the start of an upward trend in the prevalence of mental disorder (see Chapter 4).

Ethnicity: Some 5% of the current 1946-1955 population have formed part of the inward migration to the UK that began after the war. Many will have followed parents, coming largely from the Caribbean and South Asia in the 1950s and 1960s, as expelled East African Asians in the early 1970s, as young workers in the 1960s and 1970s, or as adults in later life. Their experiences, which often included growing up in what appeared to be a hostile host community, have been different to other members of the baby boomer cohort, and sometimes difficult.

Family and relationships: Divorce has been a feature of the lives of many baby boomers. Being separated or divorced is a risk factor for poor mental health, as is being single. Poverty is also linked to marital status. Almost half of divorced and separated people are in the poorest income group (bottom quintile). Evidence suggests that people with accumulated wealth may be able to sustain marriage and that people of higher socio-economic status are ‘selected’ into marriage and remarriage. Women who are divorced are less likely than men to remarry. (Chapter 5)

Social engagement: Highest levels of organisational membership are found among baby boomers in managerial and professional roles. Levels are lowest among women in routine jobs and men in intermediate jobs. Poor health also limits people’s involvement. There is growing evidence of segregation and social fragmentation since the 1970s. (Chapter 5)

Income and wealth: Between 1977 and 2006-07, the share of income going to the top income group (quintile) increased from 36 to 42 per cent. The share of the bottom group fell from 10 to 7 per cent. In terms of wealth, by age 55-64, a tenth of households have total wealth of under £28,000, but a tenth have more than £1.3 million. (Chapter 6)

The evidence collected in this review supports the case that the first wave baby boomers are a bridging group between past and succeeding age groups (Phillipson et al, 2008). This is reflected in their values, attitudes and behaviour. This provides some continuity between generations alongside the likely transformation of ageing being put forward by commentators.
New models of later life

Both popular and academic discussions have raised the question of baby boomers’ approaches to later life and have speculated on the extent to which they may change the character of ageing. At the same time, possible contradictions between their youthful identity and growing older have also been highlighted both by popular writers and academics. Baby boomers’ ambivalent attitudes to adult ageing and the loss of youth have been flagged (Biggs et al, 2007a) as has the possible resolution of loss of ‘young’ identity by denying or actively resisting ageing (Gilleard & Higgs, 2007). It has been suggested that, with the attitudes and behaviours they take into later life, the baby boomer group may reinvent ageing and give a whole new set of meanings and styles to later life, with a focus on enjoyment and self-fulfilment, for example, through learning, travel and developing new relationships. It has also been suggested that there will be a segment who bring their critical values and activism into later life. Phillipson notes that these original affluent teenagers will enter later life with the cultural wherewithal to challenge traditional notions of ageing. Are they likely to do things differently, will they try to buy their way out of the effects of ageing? Or will the strong work focus of a large number lead them to follow national policy aspirations and extend their working lives? Will they develop new forms and approaches to social organisation? Will they challenge ageism? These are all important questions, for the baby boomers as an older population group and for an ‘ageing society’ that needs to meet new challenges. They are also important questions regarding the contribution they may make to the future mental health of baby boomers, individually and collectively.

The Demos report on the baby boomers concludes by saying that assumptions about the future are rooted in a particular conception of older generations (Huber & Skidmore, 2003). But the baby boomers ‘have transformed every station they have passed through and show no sign of stopping in old age.’ They argue the need to reconsider how ageing is conceptualised. For this review the question is, ‘will baby boomers do things differently and what will this mean for their mental health and wellbeing as they move into their next decade?’

Mental health and wellbeing in later life

The wellbeing concept

In the past ten years there has been an increasing focus on wellbeing. The contributions of the Organisation for Economic Co-operation and Development (OECD) through its 2007 declaration calling for the production of information that ‘can be used to form a shared view of national well-being and its evolution over time’ (OECD, 2007), and of a report from former French President Sarkozy’s Commission on the Measurement of Economic Development and Social Progress (Stiglitz et al, 2009), are frequently cited. Before this, a ‘wellbeing power’ to promote economic, social and environmental wellbeing was introduced into English local government in 2000, and in Scotland the 2003 Local Government in Scotland Act gives Scottish local authorities the authority to advance wellbeing. In 2012, the UK government produced first annual estimates of subjective wellbeing based on four subjective wellbeing questions included in a national survey.

There is no standard definition of wellbeing. There is however, general agreement that physical, social, environmental and psychological factors influence wellbeing (MHF, 2011). Most discussions of wellbeing consider it to have two parts, subjective wellbeing and objective wellbeing. Subjective wellbeing includes self-reported feelings of happiness and general wellbeing, and objective wellbeing comprises objective social determinants including health, environment, employment and personality. Wellbeing is the product of the social conditions which enable a positive experience of self (Taylor, 2011). Mental wellbeing contributes to this positive experience of self.
Mental Wellbeing

The Scottish Government’s mental health improvement plan (Scottish Government, 2009) defines mental wellbeing to include how people feel – their emotions and life satisfaction – and how people function – their self-acceptance, positive relations with others, personal control over their environment, purpose in life and autonomy.

The UK Government’s Foresight: Mental Capital and Wellbeing in the 21st Century project defines mental wellbeing as ‘a dynamic state, in which the individual is able to develop their potential, work productively, build strong and positive relationships with others and contribute to their community.’ Mental wellbeing is enhanced when an individual is able to fulfill their personal goals and achieve a sense of purpose in society (Jenkins et al, 2008).

Mental health is more than just the absence of symptoms of distress; it includes a positive experience of self, individual resources including self-esteem, optimism, a sense of mastery and coherence, the ability to initiate, develop and sustain mutually satisfying personal relationships, and resilience - the ability to cope with adversity (Jenkins et al, 2008). These aspects of mental health enable people to contribute to family and society. Mental health is summarised by the World Health Organisation as ‘a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life and work productively and fruitfully, and make a contribution to their communities’ (WHO, 2003).

Mental health in later life brings many benefits (McCulloch, 2009). It enables people to enjoy life and to cope with later life experiences such as bereavement and loss of physical ability. It also enables people to continue to be economically and socially engaged. Mental health, like physical health, contributes to general quality of life. How people view their mental or physical health, how they feel they are coping with daily life, can be as important as an objective assessment of illness or ability in determining their general well-being.

Mental ill-health is not the same as lack of mental health. From time to time everyone experiences psychological distress, associated with difficult life situations and events, that tests their mental health and resilience without resulting in mental illness. Such normal reactions become recognisable mental illness when they last a long time, are severe and have a damaging effect on the individual and others (Jenkins et al, 2008).

The World Health Organisation (WHO, 1946) highlights the way in which, for all individuals, mental, physical and social health are closely interwoven, vital strands of life. It is this relationship that contributes to the experience of mental ill health in later life, in particular depression. However, many other mental illnesses, including schizophrenia and manic depressive illness, are less common. The risk of dementia increases with age, in particular at older ages, with around 25% of people aged over 85 affected.

Improving mental health and wellbeing in later life will enhance people’s functionality and add life to their years as well as years to their lives. However, this remains an under-developed area for research, policy-making and action. Little has been done to address issues earlier in life that may have an impact on mental health in later years, or to promote mental health among older people. Identifying and treating older people’s mental illness, rather than assuming it is part of the natural process of ageing, also remains to be addressed. This review focuses on both these aspects, in the context of the ‘baby boomers’ growing older.

UK Inquiry into Mental Health and Wellbeing in Later Life

In 2006, the Mental Health Foundation with Age Concern (now AgeUK) published a report from a UK Inquiry into Mental Health and Wellbeing in Later Life (Lee, 2006). This identified mental health in later life as a neglected and under-resourced area across the spectrum of promotion, prevention and treatment services. It noted, in particular, how the mental health of older people falls into policy and service gaps between mental health and old age. The inquiry commissioned an evidence review and collected a wide range of data to demonstrate the prevalence of mental illness among older people and the high levels of unmet need. Evidence from older people confirmed the types of services they would like to receive, including a range of options to meet individual needs. The report concluded that the neglect of older people’s mental health represents a waste of human potential that the nation can ill afford. It suggested five thematic areas for improvements to mental health services: tackling discrimination, supporting participation in meaningful activity, supporting positive relationships, improving physical health and tackling poverty. It called for the promotion of mental wellbeing through direct and indirect approaches and the development
of greater understanding of mental health issues in later life through research and campaigning. It also proposed a government Minister to have overall responsibility for the mental health of adults of all ages.

The report made a significant impact on the awareness of mental health needs in later life and the need for services to improve. Since 2010, a new government has further addressed the recommendations in framing policies and proposals for services. Responsibility for health is of course devolved to the separate nations of the UK. The current mental health policy framework across the nations includes a number of policy strands:

*No Health without Mental Health* (Department of Health, 2011): This is the UK Government's mental health strategy for England which was published January 2011. Its opening statement reflects a key perspective, that mental health is everyone's business, and that individuals, families, employers, educators and communities all need to play their part. The title reflects a stated aim to mainstream mental health in England and, importantly, to deliver parity of esteem between mental and physical health services. Six outcome objectives have been developed with partner organisations which include the Mental Health Foundation:

- More people will have good mental health: people of all ages and backgrounds will develop well, work well, live well and age well
- More people with mental health problems will recover: people who develop mental health problems will have a good quality of life
- More people with mental health problems will have good physical health; more people with physical ill health will have better mental health
- More people will have a positive experience of care and support: access to timely, evidence-based interventions and approaches
- Fewer people will suffer avoidable harm: services will be safe and of high quality
- Fewer people will experience stigma and discrimination: negative attitudes and behaviours will decrease.

Government has described *No Health without Mental Health* as a strategy for people of all ages.

*Together for Mental Health*, published in October 2012 is the Welsh Government's 10-year strategy for improving the lives of people using mental health services, their carers and their families (Welsh Government, 2012). It is described as the first mental health strategy for Wales that is inclusive of people of all ages. At its heart is the 2010 *Mental Health Measure* (Wales), which places legal duties on health boards and local authorities to improve support for people with mental ill-health. This measure is unique to Wales. The 2012 strategy and delivery plan is aimed at:

- Promoting mental wellbeing and, where possible, preventing mental health problems developing.
- Improving information on mental health
- Increasing service user and carer involvement in decisions around their care
- Changing attitudes to mental health by tackling stigma and discrimination.
- Delivering a well designed, fully integrated network of care.
- Addressing the range of factors in people's lives which can affect mental health and wellbeing.

*Mental Health Strategy for Scotland* 2012-15: Consultation was carried out in 2011 which identified seven themes for increased emphasis:

1. Working more effectively with families and carers
2. Embedding more peer to peer work and support
3. Increasing the support for self-management and self-help approaches
4. Extending the anti-stigma agenda forward to include further work on discrimination
5. Focusing on the rights of those with mental illness
6. Developing the outcomes approach to include, personal, social and clinical outcomes
7. Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence based services

Thirty-six commitments are made including a commitment to track access of older people to psychological therapies and one to identify challenges and opportunities linked to the mental health of older people.
The project approach
The project has been supported by an Inquiry Panel chaired by Baroness Lola Young of Hornsey. Membership of the panel is listed at Appendix I. The panel met five times during the course of the project and formed three sub groups to focus on the main thematic areas. A background literature review was carried out and separately published (Robotham, 2011).

The Panel developed a model of risk and protective factors for mental illness in later life which was used to shape and assess evidence collected. This model is summarised below and developed more fully in chapter 3 of this report.

Because social change has played such a strong role in the lives of the baby boomers, evidence was collected about change in a number of social domains that will have impacted on individual life-courses. A wide range of further evidence has been analysed to describe their current lives. The study has relied heavily on the review and analysis of existing documents and major national surveys and statistical databases. It has also analysed a wide range of other publications to build an understanding of the issues, particularly in relation to mental illness and mental wellbeing, which baby boomers are likely to face.

Research was commissioned to support the project, which included:

- Thirty in-depth interviews of people born 1946-55. Analysis of the interviews has produced insights into the population’s experiences, behaviour, attitudes and values in a number of key areas, including perceptions of generation, age and ageing, families and relationships, working lives, health and mental health experiences and behaviours, religious belief, planning for the future, attitudes to future care needs and

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### Risk and protection factors for mental illness in later life

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<tr>
<th>Risk factors</th>
<th>Protective factors</th>
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<tr>
<td>• Retirement and other transitions</td>
<td>• Social ties, relationships and connectedness</td>
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<tr>
<td>• Chronic medical illnesses, pain and disability</td>
<td>• Living in a supportive and enabling physical environment</td>
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<td>• Caregiving</td>
<td>• Personal characteristics</td>
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<td>• Psychosocial adversity</td>
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<td>• Daily stressors</td>
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<tr>
<td>• Organic brain disease</td>
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<tr>
<td>• Having low levels of physical activity</td>
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<td>• Financial insecurity</td>
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wider views about experiences of social change. The interviews have helped to focus and shape the development of the review.

- A YouGov omnibus survey of a nationally representative sample of over 5,000 people of all ages over 16 about their attitudes to mental health and mental illness in later life and other views about being older (see Appendix 1 for the data from the survey presented by age).

- A survey conducted among people who signed up to the project website: ‘talkingaboutourgeneration.org.uk’. 127 respondents took part. Because they were self-selected and did not reflect the baby boomer population as a whole, the information collected has been regarded as indicative. Respondents replied to a range of attitude/information questions and asked to explain or say more about their answers. This provided semi in-depth information about topics such as the meaning of age, belonging to a generation, approaches to the future, concerns about ageing, and attitudes to work and retirement.

Together these surveys have been used to support and add insight to the wider evidence collected by the study, and in particular to help develop a greater understanding of attitudes and values and how these might shape future behaviour. It needs to be noted that the focus of the research has a future orientation – it aims to build a picture of possible trends based on past and current experience to indicate potential policy approaches for the future. However, the future depends on the actions and choices of individuals and groups; analysis of surveys and trends can only suggest possibilities.
The UK population, which currently numbers 62.3m people, is ageing (Office of National Statistics (ONS), 2011a). The median age increased between 1985 and 2011 from 35.4 years to 39 years and is projected to rise to 42.2 years by 2035. There are two factors contributing to the change in the median: an increase in numbers of people in older age groups and a decrease of those in younger age groups (absolutely and relatively). In comparison, the median age in 1911 was 25.

People aged over 65: Between 1985 and 2001 numbers increased by 1.7m bringing their population proportion to 17%. They make up 16.4%, according to the 2011 Census (ONS, 2012a), with 1946-55 baby boomers largely excluded from this figure. The percentage is projected to rise to around 23% by 2035, reflecting the numbers of baby boomers reaching age 65 and beyond in the coming decades.

• People aged 85 and over: increased from 0.7m to 1.4m between 1985 and 2010, an increase from one to just over two per cent. 23% were men in 1985 and 33% in 2010. By 2035 the number is projected at 3.5m, around 5% of the total UK population. This figure includes people born in the peak years of the post war boom.

• The number of children born in the UK has fallen consistently since its peak in 1964, and by the turn of the 21st century fertility rates were 1.63, well short of replacement levels of 2.1. The fertility rate has begun to rise again and is just under 2 at present. Long term projections are that it will level off at 1.84 children. (ONS 2008a). Between 1999 and 2007 net migration was the main driver of population change in the UK (ONS,2009).

• The ratio of women to men is projected to fall. In 1982 there were more than 330 women aged 85 or over for every 100 men and 155 women over 65 for every 100 men; by 2032 the ratios are projected to be 140:100 aged 85 and over and 120:100 aged 65 and over as male life expectancy increases at a greater rate than women’s.
Exhibit 2.1 illustrates changing population age ratios and future projections based on 2010 estimates.

**Exhibit 2.1: Population of the United Kingdom by age-group, 1971-2031**

![Percentage](image)

### Dependency ratios

The dependency ratio measures the relationship between the populations of working and non-working age. There are three parts to this: the old age ratio, the children and young people ratio and the total dependency ratio. Ratios comprise the number of people in ‘dependent’ groups for every hundred people in the working age group, 16-64. In 2000 the rate was 24.4 and in 2025 and 2050 it is projected to be 32.8 and 39.2 respectively (House of Lords Select Committee on Economic Affairs, 2003).

### The post war baby boom

The post war birth peak years represented a turnaround from more than a decade of low birth levels in the late 1920 to 1930s. At this time birth rates had been falling for fifty years and there were concerns by the 1930s that future population might fall to unsustainably low levels; the population of England and Wales was projected to be below 30m in 2000. From around 1942 birth rates began to rise, and there were substantial increases in 1946, when more than 955,000 babies were born and in 1947 when the number of UK births exceeded one million. Birth levels fell between 1948 and 1955 to a level only slightly higher than in the 1930s, before rising again in 1958 to a second peak in 1964. Exhibit 2.1 shows crude birth and death rates from 1910 to 2010. Between 1946 and 1955 8.54 million children were born, the first or early baby boom cohort; and 9.27 million were born between 1956 and 1965 giving a total ‘baby boom’ of 17.8m. Average births were thus 854,000 between 1946 and 1955 and 927,000 between 1956 and 1965, compared to an average of 727,000 in the 1930s. The second boom was followed by a dramatic decline in births in the 1970s. The increase in births after the war are generally attributed to feelings of optimism and prosperity as the economy improved; the development of the welfare state; earlier marriages; the end of war with its turmoil and the exclusion of women from paid work.
Increases in birth rates have occurred in other countries but in different ways. The United States had a continuous increase over the period 1946 to 1965. During this time some 77.3m babies were born, with annual births topping 4m between the mid-1950s and 1965, when four out of ten Americans were aged under twenty. Canada and Australia also experienced booms with Canada averaging between 400 thousand and 500 thousand children born each year between 1952 and 1965, almost twice the previous rate. In France the number of births rose by 200 thousand between 1945 and 1946 and then remained above 800 thousand for nearly thirty years. Other parts of Europe also experienced population booms, although they tended to be for much shorter periods of time (e.g. as in Finland).

Many more of the post war babies survived compared to pre-war. In 1921, 84.0 children per 1,000 live births in the UK died before the age of one. The infant mortality rate fell slowly from this level in the years up until the end of the Second World War. After the Second World War it fell from 57 per 1,000 in 1941 to less than half that at 24.4 per 1,000 in 1956 (RC Population 1949 and Social Trends 37: 2007). Improvements in diet and sanitation, better antenatal, postnatal and mother and child medical care, and the development of vaccines and immunisation programmes account for much of this improvement. Similar declines were experienced in other Western countries.

A population growing older

Longer lives

At their birth children born in the period 1946 – 1955 had a life expectancy of 67 for males and 72 for females. The life expectancy for children born in 2010 is 78 and 82 years respectively. At age 60, current life expectancy is 21.8 years for men and 24.7 years for women, an increase from 16.3 and 21.3 years in 1981. (ONS, 2011b). Mortality rates have improved at all ages. The biggest impact is reduction in infant and child mortality, followed by later increases in adult life expectancy. So while life expectancy at birth for females increased by 25 years over the twentieth century to 2002, life expectancy at 70 increased by 5.5 years. Significant increases in midlife (age 40-50) and older age life expectancy have occurred since the 1980s. The life expectancy of women aged 80 has increased from 7.5 years in 1981 to 9.4 years in 2010; that for men from 5.8 to 8.1 years. There are greater numbers of older people in the population now because more have survived to later life and are then living longer (ONS, 2009).
For demographers the current relationship between reduced mortality and fertility, which has resulted in an ageing population, has been described as an age-structural transition. This transition has been happening throughout Europe and is, over time, projected to be a worldwide phenomenon. Within Europe the UK has aged less rapidly than the EU-27 average over the last ten years and lies around the midpoint of the age distribution. Thanks to recent fertility increases, by 2035 the UK is projected to have one of the lowest proportions of people over 65; Germany has and will continue to have the highest and Ireland the smallest.

Post war immigration

Immigration has also made a contribution to the post war and current population structure. Some 157,000 Poles were amongst the first groups to be allowed to settle in the UK post war, partly because of ties made during the war years. They were joined by Italians and other Europeans. The British Nationality Act (1981) was passed in 1948 to allow 800 million people in the British Empire to live and work in the United Kingdom without needing a visa. Overall the number of British people born in the West Indies increased from 15,000 in 1951 to 172,000 in 1961 to 304,000 in 1981. Thousands of semi-skilled and unskilled South Asians also came to Britain to take up employment in the textile and steel industries. The UK population originating in South Asia was some 103,600 in 1961, 413,000 in 1971 and 1,215,000 in 1981. The early immigrants were mostly men. Once they had established themselves in Britain, they were joined by their wives and children and as families reunified and grew, a ‘second generation’ were born in England or arrived as small children with their mothers. Subsequent adult migration has added to the numbers of child settlers. However the 1946-55 born population is less ethnically diverse than the overall population. According to the 2001 Census (ONS, 2003), around 96% is white, 0.7% Black African, Black Caribbean or Black British, 2% Asian or Asian British and 1% mixed heritage or other group. The 2011 Census (ONS, 2012a) will provide more accurate data once the results are fully analysed and published.

Policy responses to the age transition

UK policy responses

The International Monetary Fund (2008) summarised the implications of ageing in Europe with the observation that, in the UK the government has “already responded” with changes to State Pension and retirement age and public sector pension provisions. The Treasury is projecting that age related spending will increase from 20.4% of GDP in 2008 to 24.1% in 2020 and 26.1% by 2030 (HM Treasury, 2008). This age-related spending includes a future need to increase spending on education and other services for children in response to recent increased birth rates. So while projections are that total public spending may rise to account for almost 50% of GDP by 2028, the UK is a relatively low tax country where receipts will not meet this expenditure need. Ben Page of Imposes Mori summarises the situation thus: ‘The British public want Scandinavian level public services for US level taxes’ (Ernst and Young, 2010). The 2020 Public Services Trust report (Ernst and Young, 2010) has a number of proposals for ‘squaring the circle’ which probably reflect the future direction of the policy debate. They include shifting health and social care spending from ‘reactionary’ to preventative, to increasing participation of citizens and service users alongside public service providers, and also ‘longevity indexing’ pensionable age.

It is clear that baby boomers will be growing older in a climate of fiscal pressure and likely service reduction. However, as already noted, projections around ageing and behaviour are based on a particular conception of older generations (Huber & Skidmore, 2003). The World Health Organisation has taken a lead in recognising what is necessary to maintain healthy, active older citizens. This review acknowledges the future challenge of larger numbers of older people and the need for better use of resources. However, this has to be part of an active ageing agenda that includes better treatment of mental ill health and a stronger focus on promoting mental wellbeing as part of an approach to addressing health and care needs and costs.
Active Ageing – the policy framework

There has been a more positive co-ordinated policy response to the ageing of western populations and the future ageing of populations worldwide, broadly led by the World Health Organisation (WHO) and the European Union (EU). The WHO 1999 International Year of Older Persons produced a statement on the requirements of living in an ageing society (European Symposium, 2001) Exhibit 2.5.

Exhibit 2.5: World Health Organisation: living in an ageing world

Living in an ageing world requires:

- acknowledging older people as a valuable resource and combating ‘ageism’
- enabling older people to be active participants in the development process
- providing adequate health care and health promotion for older people
- promoting intergenerational solidarity

A campaign was also launched by the WHO in 1999 to promote the benefits of Active Ageing. In the subsequent policy framework (WHO, 2002, the WHO sets out a rights-based life course approach that recognises diversity in ageing. A goal is the prevention or postponement of the non-communicable diseases of later life which, they argue, result in enormous human and social costs that absorb a disproportionate amount of resources which could be used to address the health problems of other age groups. It is not old age itself that is associated with increased medical spending; rather it is disability and poor health that are costly. Risks for many non-communicable diseases begin in childhood and are modified across the life span. Tobacco use, lack of physical activity, inadequate diet and other established adult risks put individuals at greater risk. Active Ageing aims to address these risks. Individuals and families need to plan and prepare for older age and adopt positive personal health practices. Supportive environments are necessary to make healthy choices the easy choices. Culture is important; if disease is accepted by a society as part of the ageing process they are less likely to provide prevention, early detection and appropriate treatment services. Culture shapes the way we age.

The WHO Active Ageing policy framework is built on three pillars summarised in Exhibit 2.6.

The EU has designated 2012 as the European Year of Active Ageing. Three areas have been prioritised for promotion: employment, participation in society and independent living. Foci are on giving older workers better chances in the labour market, recognising older people’s contribution as carers and volunteers, supporting older people to cope with health impairments and disabilities associated with ageing, and empowering people to remain in charge of their lives for as long as possible.

Exhibit 2.6: WHO healthy Ageing Policy framework

Health

- Prevent and reduce the burden of excess disabilities, chronic disease and premature mortality. The aspects of this strand include socioeconomic influences, safe environments, accessibility, hearing and vision, social support, HIV and Aids, mental health (promoting positive mental health throughout the life-course and challenging stereotypical beliefs about mental health problems and mental illness) and clean environments
- Reduce risk factors associated with major diseases and increase factors that protect health throughout the life-course. This includes, tobacco, physical activity, nutrition, healthy eating, oral health, psychological factors (building self-efficacy, cognitive skills and effective coping skills; helping older people improve their psychological wellbeing), alcohol and drugs and access to safe medications
- Develop a continuum of affordable, accessible, high quality and age friendly social services
- Provide training and education to caregivers.

Security

- Ensure the protection, safety and dignity of older people by addressing the social, financial and physical security rights and needs of people as they age
- Reduce inequities in the security rights and needs of older women.

Participation

- Provide education and learning opportunities throughout the life-course
- Recognise and enable the active participation of people in economic development activities, formal and informal work and voluntary activities as they age
- Encourage people to participate fully in family and community life as they grow older.
Mental health and active ageing

The World Health Report (WHO, 2001) highlights the burden of mental illness: major depression is the leading cause of disability globally and ranks fourth in the ten leading causes of the global burden of disease. The WHO projects that by about 2020 depression will have the dubious distinction of becoming the second greatest cause of the global disease burden. It notes how the prevalence of depressive disorder rises with age, occurs most frequently in people with a physical disability, and further increases disability levels among this population. The report highlights the inseparability of mental and physical health, that have complex and profound influences on each other. These are themes that will be developed here.

This review recognises the significance of the active ageing policy framework leading to national and international actions for promoting the health and wellbeing of people as they grow older. The focus on a wide range of factors that promote wellbeing as well addressing health and disability issues is positive. However, we believe that there needs to be a stronger and more explicit inclusion of mental health, mental wellbeing and actions to tackle mental illness in active ageing programmes, to reflect the emphasis placed on the burden of mental illness by the World Health Report (WHO, 2001), if we are to meet the ambition of healthy and active ageing.

The Equality Act 2010

Legislation preventing age discrimination was promoted in the 2006 Age Concern/ Mental Health Foundation Report, Promoting mental health and wellbeing in later life (Lee, 2006). Age discrimination was seen to be a particular problem within mental health services. The Equality Act 2010 became an Act of Parliament in April 2010 and covers all four jurisdictions in the UK. It consolidates existing equalities legislation and contains, for the first time, provisions banning age discrimination in the provision of services, and the exercise of public functions, and by private clubs and other associations. This includes provision of public services including health and social care. Implementing the age discrimination ban required secondary legislation to be made, setting out the circumstances in which it would remain lawful to use age as a reason for treating people differently. The Equality Act contains provisions to allow certain forms of age-based differential treatment to continue. For example, it is possible to justify treatment that would otherwise be direct age discrimination where it is a proportionate means of achieving a legitimate aim – this is the ‘objective justification’ test. Indirect age discrimination is also permitted where the objective justification test can be met. Service providers can also take positive action to alleviate disadvantage experienced by people of particular ages, reduce their under-representation in relation to particular activities, or meet their particular needs. The Equality Act also contains a ‘statutory authority’ exception, which allows differential treatment that would otherwise be considered age discrimination, where it is required by law. For example, exceptions to prescription charges and eyesight tests (based on age) are provided for in legislation.

In March 2011 the UK government confirmed that their intention was to bring these provisions into effect in April 2012, subject to further consultation on specific exceptions to allow certain age-differentiated treatment to continue. The Department of Health concluded that there should be no specific exceptions to the ban on age discrimination for health and social care. Implementation in April was delayed but the ban on discrimination in provision of services came into effect in October 2012. It represents a significant improvement for older people, and gives a higher profile to the importance of addressing ageism and age discrimination. The legislation was enacted by a ‘baby boomer’ Minister and, it could be argued reflects the continuing reforming attitude of the generation.

Guidance produced by the Department of Health (DH, 2012) details the provisions of the law and how they need to be implemented. A key concept is the objective testing of age based provision where the guidance says:

“Chronological age should not be used as a substitute for an individual assessment of need nor should assumptions be made based on a person’s chronological age or age stereotypes. However, where chronological age is a genuinely relevant factor in decision making, it should be capable of being objectively tested.”

Objective justification is a legal test: the age-based approach must be a ‘proportionate means of achieving a legitimate aim’. It is best to approach the test in two stages, looking first at whether there is a legitimate aim and second at whether the approach is proportionate.

In their impact assessment for the legislation the government has said that current reforms of the health and care system are driving equality in NHS services for older people. They will be reinforced by the new legislation. Implementation is not being addressed by levelling up existing service provision, rather, the whole system is being reformed, with age based treatment criteria being removed, and access to care being determined purely on the basis of need. This will automatically lead to benefits - as a blunt criterion of ability to benefit based on age is displaced by a more refined set of criteria.
Chapter 3

Ageing

Ageing as a human condition
Ageing comprises a number of dimensions that can be summarised as:

• Biological age – the ageing of the body, body systems and organs, including the brain
• Chronological age – determines birth cohort and generation membership and can act as a means of defining or limiting access to different societal arrangements
• Social age – reflects how different age groups, in particular older people, are treated, and how they organise themselves
• Psychological age – the extent to which individuals respond and adapt to their changing environment.

All ageing dimensions will impact on the experiences of the baby boomer group as they grow older. All involve elements of transition that individuals will have to deal with and can benefit from. People’s personal experiences and social and cultural contexts will have an impact on their mental health and the possibility of developing mental illness at some time. Later life involves both challenges and positive opportunities. However, it is not a separate part of life, segregated from the rest of people’s lived experience. The nature of the society in which people live, its attitudes and support for its older members, are key determinants of ageing well.

Biological ageing
Age is the single biggest risk factor for many life-threatening diseases, including heart failure, cancer and dementia, and the major burden of ill health falls on the older section of society (Academy of Medical Sciences, 2009). Physiological changes occur in the skeletonmuscular system; muscle cells are replaced by fat, and bones become less dense. The skin, eyes and hearing are also all prone to deterioration. It is these adverse changes, and the perceived approach of death, that influence mental health and wellbeing as people grow older. The Academy of Medical Sciences (AMS) define ageing, in biological terms, as a ‘progressive, generalised impairment of function that results in a loss of adaptive response to stress and an increasing probability of death.’ Ageing is driven by the accumulation of damage that contributes to many age-associated diseases. While around a quarter of the variation in life expectancy and healthy life is attributable to heritable variation between people, the AMS notes that many of the events that cause ageing and age-related diseases take place over the whole life course. Differing levels of exposure to sources of damage over a lifetime are likely to underlie variations in biological ageing and age-related disease. For example, low birth weight is associated with a range of age-related diseases including coronary heart disease, type 2 diabetes and osteoporosis. The 1946 birth cohort has been particularly valuable in demonstrating links between in utero and early childhood experiences, and adult physical and mental health and health-related behaviour (Wadsworth & Kuh, 1997). The mechanisms involved are the subject of much current research. Social and economic factors also play a significant role in the three quarters of non-heritable ageing. Poorer people in the UK die earlier, they effectively age more quickly. These differences are complex phenomena with many interacting causes, not merely early life experiences, unhealthy behaviours and poor healthcare, but also some deeper, possibly stress-related biological responses. Nevertheless healthy behaviours have a strong influence on life expectancy and health.

Chronological age
Western society has used the age 65 as a benchmark for the boundary between middle age and old age. There has been an underlying assumption that all adults show declines in mental capacity, physical health and psychological ability at this age. However calendar age is an inadequate predictor of general functioning, it is merely a convenient benchmark for the administration and organisation of functions and services.
While ageing is a biological fact, attitudes and behaviours towards people based on their chronological age are socially determined. Age is used to categorise people and serves as a proxy for expected abilities, competence, skills, experience and even health status (Wilkinson and Ferraro, 2002). The term ‘ageism’ was introduced in 1969 by Robert Butler who defined it as involving prejudicial attitudes towards older persons, old age and the ageing process, along with discriminatory practices and institutional policies that perpetuate stereotypes about older people (Dozois, 2006). This definition can be extended to any prejudice against people on the basis of their age. Prejudice can take many forms, including some that are ostensibly benevolent or tolerant. The Age Concern/ Mental Health Foundation review of mental health and wellbeing in later life identified discrimination as a risk factor for poor mental health. Experiencing discrimination can lower self-esteem and expectations of life and may lead to mental ill-health which, in turn may increase discrimination. By contrast, feeling valued, respected and understood can contribute to good mental health and wellbeing (Lee, 2006). In his work on ageism, Bytheway (2005) criticises the widespread use of open-ended upper age categories that ‘homogenise all and appear to deny older people any kind of future.’ A distorted view of the ageing process comes to dominate thinking, including the attitudes of those responsible for working with and providing services for older people. For the 1946-1955 baby boomers, whose adult lives have been formed in a youth-focused culture, age prejudice and discrimination as they grow older may have particularly serious mental health consequences. Current research into attitudes is highlighting how perceptions of age are changing, particularly amongst the baby boomers who are approaching their sixties and later age as part of their continuing lives, not a separate realm of ‘being older’.

**Sexual ageing**

Sexual desire remains active throughout life. Many studies have shown that both older men and women experience negligible loss of sexual interest and that sexual capacity continues for the majority until extreme old age. Adequate physical well-being and a healthy mental orientation to the ageing process provide a supportive climate for continuing sexual activity. Sexual experience can also be viewed as more than just sexual behaviour, but can be broadened to include the opportunity to explore personal value systems in relation to loyalty, passion, self-affirmation and relationship with the physical self (Butler and Lewis, 1982). However, the issue of sexuality, sexual health and older people appears to be another domain which has been deeply infiltrated by ageism among health professionals (Bouman, Arecelus and Benbow, 2006). The outcome of this is that older people’s sexual health needs have been ignored in both policy relating to sexual health and relationships, and policy around ageing. Sexuality is part of individual identity and contributes to mental wellbeing. Failure to recognise and support older people’s sexuality in service provision undermines this identity and harms mental health.

**Mental illness in older people**

Rates of mental illness peak between ages 45 and 54 for women and 25-54 for men. So most of the 1946-55 baby boomers will have now lived through these most difficult years. Indeed there is good evidence that mental health improves after 60. Many people experience greater life satisfaction and those who have had past psychiatric symptoms, such as schizophrenia or bipolar illness, may experience improvement as they grow older (McCulloch, 2009). However, there is also evidence that declining mental health can be a problem as people grow older and, in particular that the risk for depression increases after age 70 (Green and Benzeval, 2011). Experiencing depression and other forms of mental illness in later life is not a trivial matter. Later life depression and anxiety currently often go undiagnosed and untreated, leading to poor future prognosis. One problem is the effectiveness of the highly structured interview approach used to diagnose major depression in defining all clinically relevant forms of depression in older people. The usefulness of this diagnosis, based on Diagnostic Statistical Manual (DSM-IV) criteria, has been questioned, because a large number of older people are diagnosed below the threshold level using its scales, which have strict criteria and high specificity. This results in poor detection rate of clinically significant depression both in surveys and in primary care. The relationship between depression, physical illness and dementia also presents
problems for diagnosis. A range of broader criteria have been used in studies aiming to more accurately determine prevalence (Wilson, 2008). A recent review of almost 200 studies of older people found a median presence of depression and depressive illness below the threshold for major depression of 10% rising to 30% of hospital inpatients and 45%-50% of people in long-stay residential care (Meeks et al, 2011). The Health Survey for England (HSE) (Health and Information Centre, 2012) has found that 40% of older people who visited their GP had a mental health problem. Depression and depressive illness have been consistently demonstrated to be a significant problem for a substantial minority of older people.

Depression and depressive illness
People with depression feel themselves to be worthless, the world to be meaningless and the future hopeless (Godfrey, 2009). While depression in later life has similar features to that which occurs in earlier life, as people get older the negative thoughts that are part of depression may focus on getting older, on physical limitations, losses and what they may have failed to achieve in their lives (McCulloch, 2009). In later life depression can severely reduce people’s enjoyment of things that previously gave them pleasure. It has an impact on memory and concentration, appetite, sleep, involvement in life and relationships, and causes suffering, family disruption, disability, worsens the outcomes of many medical illnesses and increases mortality (Alexopoulos, 2005).

Suicide
Suicide is a significant risk of non-treatment of depressive illness and is estimated to be present in a majority of suicides among older people. Physical illness and social isolation are also associated and triggering events can include bereavement, retirement and recent illness (Dennis, 2009). The suicide rate of men age 85 and over is around 50% higher than that of men under 25 in the UK (ONS, 2013). Among men, the highest levels of suicide in the UK were in those aged 55+ until the late twentieth century, when they declined steeply (Thomas and Gunnell, 2010) although the suicide rate for men aged between 45—59 has risen sharply in recent years (ONS, 2013). In women, the 55-64 age group had the highest suicide rates from 1861-1966. As rates for older groups fell, those for groups aged from 25-54 increased from the 1970s.

Self-harm involves deliberate, self-inflicted, non-fatal harm. It can be seen as an expression of distress and often as a means of coping with it (Bird and Faulkner, 2000). Self-harm is relatively uncommon in older people, but research indicates that it frequently involves a high degree of suicide intent. Like suicide, it is strongly linked to experience of clinical depression as well as to feelings of hopelessness. Overdose of prescribed medicines accounts for a high proportion of such self-harm episodes (Dennis, 2009).

Risk and protection factors for depression and anxiety
A model of risk and protective factors for mental illness in later life forms an important part of the analysis carried out for this project. It has been used to structure an overview of the characteristics of the baby boomers to identify trends in risk and protective factors that might affect future mental health.

Many risk factors for poor mental health operate across the life course. They include a family history of psychiatric disorder, violence, childhood neglect, family breakdown, and unemployment. Mental health in later life may be shaped by the cumulative effects of lifetime risks, experience of a financial crisis, serious illness or injury or assault, and separation or divorce (Seymour & Gale, 2004). Age is not itself a causal factor for depression and anxiety. It is the increasing incidence of other age-related factors, which can result in depression, that are responsible (Milne, 2009). Key risk factors associated with later life, are:

Retirement and other transitions: retirement brings opportunities but also can represent the loss of a valued role and status, as well as anxieties about managing on a reduced income (as well as actual experience of poverty, particularly for women). Evidence indicates that abrupt or enforced retirement is most likely to lead to mental illness. Conversely flexible retirement has a strong evidence base.

Chronic medical illnesses, pain and disability: People suffering from chronic illnesses such as diabetes, heart disease, stroke and chronic obstructive pulmonary disease are at risk of both sub-threshold and major depression. One study found that while around 3 out of 10 older people with no depressive symptoms had a chronic condition, the same was true for 6 out of 10 with major depression or depressive symptoms (Geiselmann et al, 2001). It may be the loss of functional ability and restriction of activity associated with the disease that are the causes, rather than the disease itself, although there may also be common determinants that cause both illnesses to co-occur (e.g. stress, diet, substance use). The effects of depression and chronic illness are interactive and cumulative and lead to increased disability and poor outcomes (Godfrey, 2009). Sudden onset
illnesses such as heart attack and stroke may lead to anxiety disorder. Higher prevalence of depressive symptoms in residential institutions is linked to higher prevalence of physical illness, amongst other determinants.

**Organic brain disease:** Dementia, stroke, Parkinson's disease and cerebrovascular disease are all linked to higher prevalence of depressive symptoms both as a consequence and possibly as a co-variant or precursor.

**Bereavement:** As they grow older, people are increasingly likely to experience loss of partners and other close relatives and friends. Most people experience distress and grief with bereavement but adjust to their loss after a period of time. However, for some grief is more complicated and results in more serious depressive symptoms. Some factors associated with experiencing complicated grief include the degree of dependence on the person who has died, and if the death forms part of series of losses, including, for example, loss of social contacts or networks (Godfrey, 2009).

**Caregiving:** Almost half the people (40%) providing care to someone else in the UK is aged over 65. There is considerable evidence that caregiving is a risk factor for the development of depressive illness and other mental health problems among older carers. For example, 35-40% of carers of people with dementia may develop a depressive disorder. The key factors seem to be the loss of the carer's own social networks, loss of leisure activity, and duration of responsibilities (Godfrey, 2009).

**Loneliness and social isolation:** Loneliness has been identified as a risk factor for depression. People’s interactions with others affect their physical, behavioural and psychological functioning and wellbeing. Those with chronic mental health problems are particularly at risk of social isolation in later life.

**Change to a person’s role and status,** for example, when children leave home or move away. Damage to confidence and motivation are associated with such loss, as is loss of pleasure and reward, and hopes and expectations for the future.

**Living in poverty** particularly over a long term, provokes stress, worry, fear of getting into debt and loss of control over life. Being poor can impair people’s capacity to make choices, undermine independence and reduce participation in social life. However, debt is an independent determinant of mental health from poverty, the combination being particularly potent.

**Psychosocial adversity** such as poverty, isolation, disability, caregiving and bereavement may contribute to physiological changes that increase susceptibility to depression or trigger depression in already vulnerable older people (Alexopoulos, 2005). Women have a higher risk of depressive symptoms than men, which may be in part accounted for by their higher risk of poverty and also greater risk of disabling conditions. Discrimination and prejudice, including on grounds of race, ethnicity and sexuality, pose mental health risks across the life course. There is not a great deal of evidence about ethnicity and experience of depressive symptoms in later life, but it seems likely that experience of discrimination and other negative experiences associated with migration are likely to increase psychosocial adversity effects in later life. Australian evidence indicates that increased risk of depression among migrants is greatest in people over 65. Men have been found to be more affected by homophobia than women in later life, with mental illness linked to harmful internalisation of prejudice (D’Augelli et al 2001, cited in Seymour & Gale, 2004). Ageism, as a form of prejudice experienced in later life, also has harmful effects on mental health.

**Daily stressors:** Daily ‘hassles’ such as tasks that become more difficult because of disability or were previously done by a deceased spouse, can affect mental health. There is evidence that such cumulative and ongoing stressors may be more significant than major life events and that people in lower socio-economic groups may be more vulnerable.

**Life events:** The experience of a number of negative events such as loss of social relationships, severe illness of oneself or a close other person, and being the victim of crime or other unexpected events can accumulate and increase the risk of mental illness.
Having a low level of physical activity is linked to experiencing depression or depressive symptoms. Both aerobic and resistance type activity have been shown to enhance mood, decrease symptoms of depression, and improve wellbeing, self-efficacy and quality of life as well as reducing the risks of cognitive impairment. These improvements seem to occur independently of any increase in levels of fitness.

**Protective factors**

A range of factors are likely to help people deal with the stresses caused by the difficult challenges of later life and protect them against mental illness.

**Social ties, relationships and connectedness** are the fundamental sources of protection. This includes intimate relationships and having someone to confide in, friendship and interaction with friends, engagement in social activities and having the support of family. Maintaining good social relationships helps lower social isolation and reduces loneliness. Reciprocal help and interdependence between friends gives a sense of purpose and meaning to people’s lives. What is most important is how supported a person considers themselves to be rather than the actual level of support available.

**Community and neighbourhoods** that offer opportunities to join groups and clubs, take up voluntary work, have access to educational facilities and use social and leisure activities, promote inclusion, reciprocity and trust and protect mental health.

**Personal factors are also important:** low self-esteem is a predictor for stress; good self-esteem, self-efficacy and mastery in managing stress are personal resources that can buffer an individual against difficulties. The effects of illness and disability are mediated by how people master them. Maintaining a positive sense of self is linked to having good relationships, activities and interests, and continuing involvement that enables people to have purpose and control. As people get older the most resilient form of self-esteem is that based on a broad interest in other people.

**Living in a supportive and enabling physical environment** that provides accessibility to necessary services, including easy access to transport, and that does not create additional handicaps to daily life reduces people’s feelings of loss of functionality. Being part of a neighbourhood, and linking to others, helps build intergenerational relationships give value to everyone.

**Cognitive health**

The government’s *Foresight* study of mental capital and wellbeing in the 21st century identified two challenges of demographic change that are relevant to the baby boomer group (Deary and Gow, 2008). The first is ensuring that people maintain the best possible mental capital, defined as ‘the totality of an individual’s cognitive and emotional resources, including their cognitive capability, flexibility and efficiency of learning, emotional intelligence and resilience in the face of stress’, and so preserve their independence and wellbeing as they grow older. Dementia is identified as a major later life problem with numbers affected potentially doubling over 30 years to 1.4 million resulting in economic costs trebling to over £50bn. The second challenge is how to address the massive under-utilisation of the mental capital of older adults and to reverse the continued negative stereotyping of older age. Failure could result in a spiral of poor wellbeing, mental ill-health and exclusion and disenchantment of this large section of the population.

**Normal cognitive ageing**

Psychological changes occur throughout life. Brains decrease in weight and volume by two per cent per decade. In the same way that people experience age-related changes in physical functioning they may also experience changes in cognitive functioning, in particular in some cognitive abilities. Verbal, numerical and general knowledge abilities are generally well retained as people grow older and well-practised skills show little decline. Aspects of memory, reasoning, speed of information processing and executive function may decline. Such declines are not in the same order as dementia or mild cognitive impairment and are better considered as characteristics of ageing. Some recent evidence from the *Whitehall Longitudinal Study* of civil servants indicates the relevance of this decline for the baby boomers (Cabinet Office, 2004). Tests of memory, reasoning and vocabulary were carried out on a sample of some 7,300 civil servants who were aged 45-70 in 1997. The sample was divided into five-year age groups at the commencement of the research. After ten years all cognitive scores except vocabulary showed a decline, with evidence of faster decline in older people.
(Singh-Manoux et al, 2012). The researchers concluded that cognitive decline is already evident in early middle age (45-49 years). Deary and Gow (2008) highlight the large variation in cognitive changes among people. Such variation and the factors affecting cognitive ageing are the focus of current research, with the aim of promoting successful cognitive ageing. Any analysis of changes in cognitive ability with age has to take account of the fact that people start out with different cognitive abilities, which are reasonably consistent over life from about age 11.

Cognitive skills and mental health are intertwined (Richards and Hatch, 2011). Cognitive decline and depression often coexist and cognitive capability and mental wellbeing can be mutually self-supportive. Some people develop ‘mastery’ over the life course, which is a belief in the ability to manage important life circumstances and a sense of personal control. This binds cognition and emotion into a tool for developing goals and experiencing self-esteem when they are achieved. The consequences of this going wrong may result, for example in low attainment and impaired health in adulthood following poor development in childhood. Mastery can be undermined by circumstances such as serious illness and it declines in old age, perhaps, suggest Richards and Hatch, as a result of having to accept the most inevitable health event of all, our own death. In later life people channel cognitive resources away from goals such as making a living or supporting a family, towards maintaining emotional stability in the face of negative events. However, psychosocial development is held to continue until we die; even negative experiences can be a source of growth (Garner, 2009).

Mild cognitive impairment
Mild cognitive impairment and cognitive impairment without dementia are considered intermediate states between normal cognitive ageing and dementia where individuals experience cognitive deficits greater than expected for their age. There is a risk of progression to dementia with both these conditions; it is estimated that one in six people with MCI go on to develop dementia.

Dementia
Dementia is a syndrome due to disease of the brain, usually chronic, characterised by a progressive, global deterioration in intellect including memory, learning, orientation, language, comprehension and judgement. Dementia syndrome is linked to a large number of underlying brain pathologies.

Alzheimer’s disease, vascular dementia, dementia with Lewy bodies and frontotemporal dementia are the most common (Alzheimer’s Disease International, 2009). The boundaries between these subtypes are indistinct, and mixed forms may be the norm. The pathology (the changes that happen in the brain) with Alzheimer’s disease develops over a long period of time, and the relationship between the severity of the pathology and the presence (or absence) of dementia syndrome is not clear. Other conditions that the person has, particularly cerebrovascular disease (disease of the blood vessels supplying the brain) may be important. Alzheimer’s Disease is the most common subtype of dementia (62%) followed by vascular dementia (17%) and mixed dementia with both degenerative and vascular pathology (10%) and others (11%).

Genes can play a part in the development of some dementia. In particular, the absence or presence of one or more of three specific genes may lead to early onset Alzheimer’s (in people aged 30-40). These genes are very rare. Only one gene linked to late onset Alzheimer’s has been identified. The form of this gene that a person possesses can influence the risk of developing Alzheimer’s rather than having a direct causal effect. There are some very rare forms of vascular dementia caused by genetic mutations, but no established genetic causes for vascular dementia.

Deary notes that dementias are qualitatively as well as quantitatively different to normal cognitive decline in the pattern of loss across the spectrum of cognitive abilities (Deary et al, 2009). People with dementia often exhibit changes in behaviour and other aspects of their mental state, as well declines in carrying out daily living activities and loss of episodic memory. There are, nevertheless, difficulties in distinguishing between normative and non-normative ageing in advanced old age. Despite much research on early diagnosis no biomarkers or cognitive profiles for dementia have yet been identified.

Dementia can affect people of any age but is most common in older people (Exhibit 3.1). The way each person experiences dementia, and their rate of decline, will depend on many factors, including their physical make-up, their emotional resilience and the support that is available to them. In the UK it is estimated that only around a third of people with some form of dementia are clinically diagnosed.
Risk factors for cognitive impairment and dementia

Dementia is thought to be the outcome of long term processes happening over at least 20-30 years (Singh-Manoux et al, 2012). It is also thought that risks for dementia may evolve throughout life through factors such as childhood poverty with inadequate nutrition, overcrowding and poor housing, poor schooling, risky lifestyles and chronic stress. The life course is also associated with exposure to physical diseases that may create further risks. In particular evidence is growing that cerebrovascular disease plays a causal role. Thus the accumulation of cardiovascular risk factors, such as obesity, hypertension and hypercholesterolemia builds a risk for Alzheimer’s. It is mid-life levels that are more important than those measured in later life.

Low physical activity, smoking, poor diet and heavy drinking are lifestyle related risk factors. There is an emerging agreement that what is good for the heart is good for the head. There is little evidence that depression is a risk factor for dementia. The focus for baby boomers must be on healthy lifestyles; the challenge for health and public health services is the delivery of an effective public health message. Exhibit 3.2 shows the projected rise in the number of people with dementia to 2051. While research is focusing on the determinants of cognitive decline, the effects of age on cognition and the extent to which individual trajectories are modifiable, the baby boomers are challenged to protect their own health, to understand the implications of cognitive changes, and to facilitate early diagnosis.
Dementia and wellbeing
In recent years there has been a growing focus on the quality of life of people with dementia. Studies of people’s reported quality of life have noted a lack of association between scores on cognitive tests and quality of life scores on dementia-specific self-report measure; there is no indication that quality of life worsens as the severity of dementia increases (Woods, 2012). Some factors identified as being associated with wellbeing include participation in activities, enhancing relationships with carers through a better understanding of interactions, creative activities and continuing involvement with family. Cognitive training, involving repeated practice of cognitive tasks, has not been associated with better quality of life, however, cognitive stimulation through activity and cognitive rehabilitation have been linked.

Research has also begun to explore the experiences of people with dementia. There is a large body of work that offers a pessimistic view of life with dementia (Hulko, 2008). Hulko’s own research, asking people with dementia about their experiences, has led her to conclude that the extent to which dementia is conceptualised as a problem varies and that the more privileged a person is, the more they are likely to view dementia in a negative light. She found that less privileged individuals were more likely to dismiss the significance of dementia and resist being viewed as the sum of their symptoms. Dementia may not necessarily be problematic for people who have it. Hulko argues for an approach which counteracts the Western trend of problematising dementia to develop a more expansive measure of normality.

New ways of thinking about dementia
If the baby boomers are effectively to address the rising problem of dementia there needs to be new ways of thinking, that ‘normalise’ the condition, remove the stigma, and enable people to think differently, which will involve recognising that people are not just rational, isolated beings but also social beings whose identities are formed in social interaction with others in processes of change over the life-course (Coleman, 2012). This is a challenge for the individualism of baby boomers but also perhaps a call to their capacity to transform and reinvent the life-stages they live through.
This chapter looks at baby boomers’ health, mental health and social care experiences, expectations and attitudes. It considers the contribution that good mental health and mental wellbeing can make to the achievement of the active ageing goals of increasing healthy life expectancy, and how the attitudes and expectations of the baby boomers might affect their future health and wellbeing and use of services. It asks whether baby boomers are likely to find new ways of meeting the health challenges of ageing and find new ways of retaining their independence and dealing with potential disability. Will they have a different approach to health, mental health and ageing?

Baby boomers’ attitudes
Project research has explored baby boomers’ attitudes and views through three research exercises as well as desk research. Research included a national representative survey of people’s attitudes to mental health in later life (YouGov survey), in-depth interviews with a sample of people born 1946-55, and a self-selected qualitative survey carried out through a dedicated project website (talkingaboutourgeneration.com).

Health and mental health attitudes
The survey commissioned from YouGov asked people to identify the three things they were least looking forward to for the future, in their later years, aged 70 and over. Options included: having poor health; financial insecurity; physical disability/loss of mobility; loss of mental abilities; having to cope with death of loved ones; loss of independence/need for care for daily needs; isolation and loneliness; poor public/NHS services. In response only seven per cent of the 1946-55 cohort said that there was nothing that worried them about being older. For about half of people born 1946-1955 having poor health is their greatest concern, particularly for men, who are also more worried than women about loss of mobility. A similar number were concerned about loss of mental abilities in later life. Detailed results for health-related concerns are shown in exhibit 4.1 by gender and social category.
Exhibit 4.1 Concerns of people born 1946-55 for when older: physical and mental health

<table>
<thead>
<tr>
<th>Concerned about:</th>
<th>All %</th>
<th>Men %</th>
<th>Women %</th>
<th>ABC1 %</th>
<th>C2DE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having poor health</td>
<td>49.8</td>
<td>54.1</td>
<td>45.9</td>
<td>50.6</td>
<td>48.5</td>
</tr>
<tr>
<td>Physical disability/loss of mobility</td>
<td>44.0</td>
<td>48.4</td>
<td>40.0</td>
<td>44.3</td>
<td>43.5</td>
</tr>
<tr>
<td>Loss of mental abilities</td>
<td>52.7</td>
<td>54.4</td>
<td>51.1</td>
<td>49.1</td>
<td>44.4</td>
</tr>
<tr>
<td>Poor public services/lack of NHS support</td>
<td>22.8</td>
<td>24.1</td>
<td>21.7</td>
<td>23.1</td>
<td>22.5</td>
</tr>
</tbody>
</table>


The survey also asked people about their mental health as they got older and followed this up with questions about depression and dementia. As Exhibit 4.2 shows, more than six out of ten women in the 1946-55 cohort agree that they are concerned about their mental health when they are older, as are nearly six out of ten men. Seventy per cent of women and 67% of men say that their concern is that they will develop dementia while over a quarter also express concerns about having depression. Only around 13% actively disagree that they are concerned about getting dementia and four out of ten disagree that they are concerned about getting depressed. Around half agree with the statement that older people are not more likely to get depressed than younger people.

Exhibit 4.2 Concerns of people born 1946-55 about mental health when older

<table>
<thead>
<tr>
<th>Concerned about:</th>
<th>All %</th>
<th>Men %</th>
<th>Women %</th>
<th>ABC1 %</th>
<th>C2DE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>What mental health will be like when older</td>
<td>60.0</td>
<td>56.7</td>
<td>63.0</td>
<td>59.5</td>
<td>60.8</td>
</tr>
<tr>
<td>Getting depressed when older</td>
<td>27.4</td>
<td>24.8</td>
<td>29.7</td>
<td>26.4</td>
<td>28.8</td>
</tr>
<tr>
<td>Developing dementia when older</td>
<td>66.5</td>
<td>62.1</td>
<td>70.6</td>
<td>66.6</td>
<td>66.4</td>
</tr>
<tr>
<td>Agree that older people are not more likely to be depressed than younger people</td>
<td>49.5</td>
<td>50.3</td>
<td>48.7</td>
<td>53.8</td>
<td>42.6</td>
</tr>
</tbody>
</table>


Respondents were asked whether they had ever visited their GP for advice because they were feeling stressed, anxious or low over a period of time. Some 43% of the 1946-55 cohort said they had. Significantly more women than men said they had made such a visit (52%; 32%). For comparison, some 31% of people born 1936-45 and 19% of those born between 1925 and 1935 had made such a visit. While this may reflect an increase in prevalence of mental distress among the baby boomer group, it is more likely to reflect a willingness to identify psychological problems and do something about them, particularly among women.

When asked who they would be likely to talk to if they were feeling stressed, anxious or low over a period of time, the greatest number of the 1946-55 cohort said their spouse or partner (70% men; 50% women). Half said they would talk to their GP, a third of men and half of women said a friend, and about a third of men and four out of ten women said another family member. Around 13% of men and women said they would see a therapist or counsellor. While not a high proportion, this is almost twice the level of those born 1936-45 (7%), while only around 5% of the 1926-35 group also ticked this option. Likelihood of consulting a therapist or counsellor was highest among the 1956-65 cohort at 16.4%. Around one in ten said they would not be likely to talk with anyone about their problems, with men more likely to give this response than women.
People were asked to rank the importance of both their physical and mental health. Eight out of ten considered both mental and physical health to be very important, although there was a ten point difference on both these measures between men and women, with women giving them higher importance. Taken together with the twenty point difference between men and women in visiting a GP about psychological concerns, this differential response suggests there are issues that need further exploration in terms of gender differences.

When asked how much they know about getting older and the effects on people’s physical and mental health, a knowledge divide emerged (Exhibit 4.3). While only 15% said they did not know very much about the effects of age on physical health, 26% said the same about mental health and getting older. Once again there were considerable disparities between men and women in their stated level of knowledge. So far as the ability to influence their mental health is concerned, around a quarter of the baby boom group believed they had not very much influence and only 17% thought they had a lot of influence.

Exhibit 4.3 Attitudes to physical and mental health and getting older

<table>
<thead>
<tr>
<th>Item</th>
<th>All %</th>
<th>Men %</th>
<th>Women %</th>
<th>ABC1 %</th>
<th>C2DE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important is it for people of your age to protect their physical health - very important</td>
<td>81.2</td>
<td>75.5</td>
<td>86.4</td>
<td>82.5</td>
<td>79.1</td>
</tr>
<tr>
<td>How important is it for people of your age to protect their mental health - very important</td>
<td>80.0</td>
<td>74.5</td>
<td>84.9</td>
<td>80.6</td>
<td>78.9</td>
</tr>
<tr>
<td>How much do you feel you know about how getting older affects your physical health - a lot</td>
<td>15.9</td>
<td>13.4</td>
<td>18.2</td>
<td>17.8</td>
<td>12.9</td>
</tr>
<tr>
<td>How much do you feel you know about how getting older affects your physical health - not very much</td>
<td>14.6</td>
<td>18.6</td>
<td>10.9</td>
<td>13.5</td>
<td>16.2</td>
</tr>
<tr>
<td>How much do you feel you know about how getting older affects your mental health - a lot</td>
<td>11.0</td>
<td>8.5</td>
<td>13.3</td>
<td>12.2</td>
<td>9.2</td>
</tr>
<tr>
<td>How much do you feel you know about how getting older affects your mental health - not very much</td>
<td>26.2</td>
<td>31.5</td>
<td>21.3</td>
<td>24.2</td>
<td>29.2</td>
</tr>
<tr>
<td>How much influence do you feel you have over your mental health - a lot</td>
<td>16.5</td>
<td>14.3</td>
<td>15.2</td>
<td>16.4</td>
<td>14.7</td>
</tr>
<tr>
<td>How much influence do you feel you have over your mental health - not very much/no influence</td>
<td>27.2</td>
<td>29.8</td>
<td>24.0</td>
<td>24.1</td>
<td>33.3</td>
</tr>
</tbody>
</table>

The programme of interviews has added further insight to people’s health experiences and their attitudes to health matters. In terms of their own health many acknowledged physical changes and other new health problems.

**Health problems**

‘Bit of arthritic knee, but I had that flushed out about four or five years ago. But on the whole, just a general ache and pain now and again, and bit of a backache problem sometimes.’ Female born 1947.

‘My health is pretty good except I’ve just been diagnosed with type 2 diabetes, but apart from that my general physical health is good.’ Male, born 1949.

But although there is a general appreciation that people are living longer, and that they are also likely to have a good life expectancy, many people have had experience of their own or their partner’s parents dying in their 60s, or younger. Many also have friends and acquaintances who died relatively young. This awareness of potential early mortality somehow tempers their thinking about the future in terms of making plans and using their resources as well as making retirement decisions.

**Parents’ early death**

‘Well, my mum died at 67, his mum died at 56, very young, from a brain haemorrhage thing. His dad died at 63. So in a way, we kind of don’t expect that we’re going to live very long, hence we’re going travelling, we’re going out and about.’ Female, retired social worker, born 1950.

‘My father got a part-time job. And he died in his work, collapsed, took a heart attack in his work and died. He was sixty-eight.’ Male, retired factory worker, born 1949.

While some of the people interviewed have experienced issues of mental illness over a number of years, others have been through difficult times where they have either felt low or experienced a short period of depressive illness linked to life events. Some of the experiences of people interviewed provide some insights into the difficult challenges their lives have presented. For a number of people it has been the experience of the death of a parent, or in some cases a child that has brought a period of feeling low. For a number of other people a difficult work experience had brought stress and depression, and children’s illnesses or disability, relationship breakdowns, childbirth and caring responsibilities have contributed to periods of feeling low and depressive symptoms. In terms of more enduring conditions, a South Asian interviewee described how her arranged marriage at a young age brought on recurring depression; another woman talked of difficult childhood experiences that affected her in later life and a male interviewee talked of the effect of his parents’ repeated separations and his mother’s depression on his own health. For many however, their experience of feeling low was limited to brief periods. When asked about the future and their plans as they grew older, many could see problems of physical health limitations but few had thought of their mental wellbeing, beyond recognition of the possibilities of dementia. Public health messages about healthy lifestyles appear to have been effective in terms of people’s awareness, but not necessarily their behaviour, but when asked about protecting their mental health for the future, for example, if they were feeling low for a period, fewer had given this much consideration.

**Protecting their mental health**

‘Haven’t thought about that’. Female, born 1950

‘If I had a very low mood then I’d try to figure out why and change my life accordingly, try to find something that would cheer me up and make me want to do things. I mean if you become depressed it’s normally because you have got a reason to be depressed. There’s no way I’d go to anyone.’ Female, born 1949.

‘I would research organisations that could help; find distracting things I enjoy for example music; I’d write a journal for myself.’ Female, born 1954.

Those who had experienced mental illness at some stage in their lives had further insights to share:

‘Let it be now, stop searching, use what you’ve go for tomorrow instead of looking backwards thinking, why was I depressive?’ Male, born 1953

‘Have some pleasure. Just go and sit in the park, or,. or buy yourself a bunch of flowers, or do a bit of zumba dancing… have a bit of pleasure in your life.’ Female, born 1955
Experience of friends’ or family members’ mental health problems had given some people insight:

‘Well I’d go out anyway and meet people, talk to people I think, I think that’s a good thing because the more people you talk to about different things there’s always people seem to be worse than you or have the same things as you. I think if you meet people and talk about things that must help you a lot, well it helps me anyway.’ Male, born 1947.

For those who had done so, the experience of a period of depression is one that is not forgotten:

‘I was walking through water, couldn’t wake up, wanted to sleep all the time. All that kinda thing. But it just went away. And d’you know it was like a dread, what’s the worst thing that could happen. But yes, so … so I would say that for six months I took antidepressants and really needed them. It was something you dealt with yourself’. Female, Born 1949.

The National Health Service
The post war cohort grew up in an environment where health care was seen as a right, not something bestowed erratically by charity as it had been pre-war. These are the people that first benefited, from birth onwards from the creation of the NHS, which replaced fragmented and unequal pre-war services with a single service that:

- Was financed almost one hundred per cent from central taxation.
- Provided care for all, even people temporarily resident or visiting the country. People could be referred to any hospital, local or more distant.
- Was entirely free at the point of use (although prescription charges and dental charges were subsequently introduced).

The Wanless report (2002), which assessed the resources required to provide high quality health services in the long-term, noted that future older people were likely to be more demanding of the health service thanks to a greater awareness of health and available interventions. It identified current inequalities in access to care among people over age 65 and modelled options to reflect equal access to care and tackling age discrimination.

Concerns about a possible future lack of NHS support were expressed in the YouGov and web surveys. More than one in five people (23%) agreed that one of their concerns about growing older was related to health care services. As one respondent to the web survey summarised her concerns:

‘The sheer number of us reaching old age. Is the health service really going to be able to cope?’. 

Among the baby boomers interviewed there is a strong acknowledgement of the importance of the Welfare State in their lives, especially the National Health Service. And in terms of the future of healthcare, expectations and value are still there, but there are worries and concerns about what might be available.

Views about the NHS
‘Well health, healthcare I think England is brilliant for what funding they’ve got. When I worked abroad I went to hospitals in the Middle East. I think we’re getting looked after, really. Male, 1947.

‘I think it’s been pretty important in the sense that everyone is entitled.’ Male, born 1948.

‘My view is that the NHS is superb at dealing with emergencies. If you have a cardiac arrest the NHS will look after you, it’s maybe less good at other things.’ Female, born 1954.

Expectations for the future
‘I’m not one for private health insurance. I am expecting the National Health Service to look after me. If I need an operation for a broken hip, or I need an operation for cancer or I need some chemotherapy, or whatever, I do expect the State to provide that I’m afraid. And I do because I’ve contributed towards that, and I have quite a simplistic view that, you know, that I’ve funded it and therefore I expect my sort of return’. Male, born 1953

‘Well … I’ve been very grateful that I can just walk into my GP’s surgery and not worry about, Can I afford the doctor? I’m very grateful for that. You know ‘cos you’re aware of what people don’t have, in other countries, so it’s not something I’d want to take for granted. It would be very helpful, for one’s quality of life in the future, but I’m … I’m not … let’s say I’m not counting on it – meaning that I’m aware that it might not be there.’ Female, born 1955.

‘Oh extremely important. My feeling with the current changes to the NHS is that, well I hope it’s there when I need it because I just have this feeling that it’s being eroded’. Female, born 1954.
Overview of attitudes
Baby boomers are aware of the effects of ageing on their physical health and are concerned about what might happen in the future. They are also aware that people are generally living longer, but among many there is a cautious view about what this might mean for themselves. Most have experienced the death of a parent, in some cases at a relatively young age, and the death of friends, colleagues and acquaintances of their own age. In-depth interviews revealed a general view that people are responsible for their own health and public health messages, for example, around healthy eating and exercise were well understood, if not always acted on. But health awareness is not so great in relation to their mental health, although many had had some experience of mental ill health or distress linked to an event or events, and were generally willing to discuss their feelings and experiences. There was concern about future mental health, in particular loss of mental abilities and developing dementia, but overall little awareness of how mental health could be protected. However, while some people believed they would ‘just get on’ with any negative mental health problem, most expressed a willingness to tackle anything that arose, with talking to their GP featuring as the most common response.

Life expectancy and healthy life expectancy
Longer average life expectancy has already been noted as an important contributing factor to the ageing of the population. Increased life expectancy is a measure of the health of a population and of advances made in tackling disease and ill-health. But as greater numbers of people live to older ages a major question for policy makers is whether the population’s additional years of life will be years of healthy life or years of disability. Living longer with increased good health is of economic and social benefit, through lower future costs of care and the continuing social contribution of older people, and through benefit to individuals who ‘add life to their years, not just years to their lives’. Healthy life expectancy (HLE), defined as expected years of remaining life in ‘good’ or ‘very good’ general health, is calculated using General Lifestyle Survey (GLF: a multi-purpose continuous survey carried out by the Office for National Statistics) questions on self-assessment of health and experience of long-term illness that limits activities of daily living. Disability-free life expectancy (DFLE), defined as expected years of remaining life free from a limiting long-standing illness or disability, uses GLS questions on limitations in day-to-day activities. Both measures are therefore based on self-reported perceptions, and suffer some weaknesses as a result.

There has been considerable debate around the extent to which increased life expectancy has been matched by increases in healthy life expectancy and disability free life expectancy. There are three possible scenarios:

Compression of morbidity: Under this scenario the period of ill health and disability before death is shortened, through decreases in the prevalence of chronic diseases. With longer life expectancy the outcome is an older, healthier population. This will mitigate possible increases in long term care costs linked to population ageing.

Expansion of morbidity: The ‘failure of success’ model assumes that the incidence of disability remains the same or increases as life expectancy increases so that there is a longer period of disability and dependency before death. Greater numbers experience chronic illness and disability, putting pressure on health and social care services and on carers.

Dynamic equilibrium scenario: This acknowledges the complexity of underlying relationships and suggests that the increased prevalence of chronic diseases in ageing populations is balanced by a decrease in disease severity and slowing down of disability progression. In terms of long term costs this model suggests probable pressure on primary and local health care costs but not on social care costs.

In the UK there are mixed messages about which scenario is closest to current trends and projections. Exhibit 4.4 shows period life expectancy (i.e. life expectancy based on current mortality rates) at age 65 in 2008-10 as 17.8 years for men of which they could expect to spend 10.1 years in good health and 10.4 years free from limiting long-standing illness or disability. For women the expectancies were 20.4 years life expectancy, 11.6 years in good or very good health and 11.2 free from limiting illness or disability. Retiring at age 65 they would on average expect to spend 56 per cent and 57 per cent respectively of their retirement in good health and 58 per cent and 55 per cent respectively of their retirement free from long term illness or disability.
Recent ONS healthy life expectancy figures (Exhibit 4.5) suggest that while periods spent in good health have increased overall for both men and women over the past three decades, life expectancy has increased at a greater rate. This has lowered the proportion of life spent in favourable health states over this period. If healthy life expectancy continues to increase more slowly than life expectancy in coming decades, the baby boomers will, on average, spend a greater part of their retirement years in poor health (ONS, 2012c). This also has implications for their mental health in later years.

The English Longitudinal Study of Ageing (ELSA), which studies a longitudinal sample of people aged 50+, has explored a number of aspects of disability and ageing and has also found no apparent compression in morbidity. The survey uses self-reported disability measures including self-rated general health, presence of a longstanding illness and assessment of activity limitation as well as objective measurements in the form of a walking speed test. Information was collected across four two-year time phases. The findings reported in 2008 (Zaninotto et al, 2010) strongly indicate that levels of disability have
been stable over time and across different birth cohorts. Of the changes found, some indicated increases in levels of disability while others indicated decreases and all changes were small. One important finding was of a mismatch between trends for subjective and objective measures of disability. This raises questions about the factors behind the lack of change in overall levels of disability.

Inequalities in life expectancies

Using whole population life and healthy life expectancies obscures inequalities in future and current life chances and historical improvements. Social class and local area of residence both have an effect on life expectancy. At age 65 men in higher managerial and professional occupations have a life expectancy of 18.8 years and those in routine occupations 15.3 years, a gap of 3.5 years. The gap for women is similar. Between the four nations of the UK life expectancy at age 65 is highest in England and lowest in Scotland, a gap that has persisted as life expectancies have increased across the board. (ONS, 2011b).

There are similar gaps at local area level: in England male life expectancy at 65 is 24.4 years in Kensington & Chelsea and 15.8 years in Hartlepool. Women aged 65 in Kensington & Chelsea had an average life expectancy of 27.5 years, those in Liverpool, 18.4. Across the UK the widest disparities are between Kensington & Chelsea and Glasgow City. While overall UK life expectancy ranks 11th in the European Union (Eurostat, 2011), Scottish life expectancy for women is amongst the lowest, with only Bulgaria, Estonia, Hungary, Latvia, Lithuania, Romania and Slovakia having lower life expectancies. Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia had lower life expectancies for men (General Register Office for Scotland, 2010).

Inequalities in disability-free life expectancy (DFLE) are just as striking. For women DFLE ranged from 12.6 years in the most advantaged 20% of areas to 8.2 years in the most disadvantaged (Exhibit 4.6). The gap for men is 12.6 to 7.2 disability-free years (ONS, 2011b). As Exhibit 4.7 shows, gaps in Scotland are even greater.

Exhibit 4.6: Inequality in Life expectancy and Disability-free life expectancy for women at age 65 by area deprivation quintile, 2002-05 and 2006-09

Exhibit 4.7 Differences between highest and lowest life expectancies in Scotland

<table>
<thead>
<tr>
<th></th>
<th>Highest Female</th>
<th>Lowest Female</th>
<th>Highest male</th>
<th>Lowest male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Expectancy</td>
<td>84.2</td>
<td>76.8</td>
<td>81.0</td>
<td>70.1</td>
</tr>
<tr>
<td>Healthy life expectancy</td>
<td>70.5</td>
<td>52.5</td>
<td>68.5</td>
<td>50.0</td>
</tr>
</tbody>
</table>

Source: Scottish Public Health Observatory 2011.

Inequalities in life expectancy reflect a deeper set of underlying health and social inequalities. The Marmot Review of health inequalities in England (Marmot, 2010) identified a social gradient in health linked to social inequalities. It concluded that reducing the gradient is both a matter of fairness and social justice and will have economic benefits. As an illustration, exhibit 4.8 shows a line at 68 years, which is the proposed future UK pensionable age. A majority of the population have low disability-free life expectancy at the age of 68. The review found that the diseases that contribute to shorter lives and worse health for those at social disadvantage in England are heart disease, cancers, diseases related to drugs, alcohol, smoking, poor nutrition and obesity, accidental and violent deaths and mental illness. Wilkinson and Pickett, in their bestselling book, The Spirit Level (Wilkinson and Pickett, 2010), argue that most of the important health and social problems of the rich world are more common in unequal than...
equal societies. For both rich and poor people, inequality leads to chronic stress, which has harmful biological effects and increases illness. Marmot calls for action both to raise the general level of health and flatten the socio-economic gradient to achieve goals of greater disability-free life expectancy. Chapter 6 of this report shows that economic inequalities have been increasing over the working age lives of the baby boomer group, suggesting that healthy and disability-free life expectancy gaps may also be expected to widen in the future. Chapter 7 highlights the importance of addressing these deep inequalities to protect mental health.

Exhibit 4.8: Average life expectancy and disability-free life expectancy (DFLE) at birth, by neighbourhood income level, England, 1999–2003

Source: Fair Society, Healthy Lives, 2010
(Marmot Review, 2010)

Inequalities in mental illness

There is well researched evidence to show that people who are the most socially disadvantaged are at a greater risk of common mental disorder (Candy et al. 2007). The Adult Psychiatric Morbidity Survey 2007 (McManus et al, 2009) found a two-fold variation in common mental disorders between the highest and lowest income quintile groups, and prevalence of psychotic disorders nine times higher amongst the lowest quintile of household income than in the highest. Lack of educational qualifications, being part of a workless household, lower occupational status, living in a reconstituted family and having poor quality social support and social relations, such as living alone or break-up of social ties, are all linked to a greater risk of experiencing common mental disorders.

The relationship between inequality and the prevalence of mental ill health is highlighted on an international scale by Wilkinson and Pickett (2010). They use World Health Organisation surveys of people with mental illness for nine countries plus similar surveys in Australia, Canada and the UK, to show an association between income inequality and the proportion of people who have experienced mental illness in the past twelve months. Citing the work of Oliver James, Alain de Botton and others, Wilkinson and Pickett suggest that unequal societies place a high value on acquiring money and possessions, looking good in the eyes of others, and wanting to be famous. These kinds of values are linked to the risk of depression, anxiety and other mental illness. Exhibit 4.9 shows Wilkinson and Pickett’s plot of income inequality against prevalence of mental illness.
The health of the baby boomers

Baby boomers have lived through a period of formerly unanticipated increases in life expectancy. They have benefited from increased post-war prosperity, better nutrition, education and housing, as well as massive improvements in medical treatment and health technology. The National Health Service has provided access to universal health care, free at the point of use throughout their lives. Economic and industrial change has reduced the incidence of industrial disease, injury and death and reduced levels of physical work stress. This post-war group have also been unaffected by large scale war and resultant injury and loss of life, although they grew up in a period of international tension. Their childhood saw reduced levels of infant and childhood mortality, the near eradication of poliomyelitis and tuberculosis, and the control of other childhood infections through vaccines and new families of drugs. Many more children have survived chronic conditions who would previously have died either at birth or in early life. Similarly, more people with learning disabilities and severe physical disabilities who have survived childhood and early adulthood are now living into later life.

In their middle years baby boomers have continued to benefit from health improvements. There has, most dramatically, been a massive decline in the cardiovascular disease (CVD) death toll. In 1961 over half of all deaths were from CVD, which was the biggest killer in all age groups from 35 upwards. Death rates declined slowly between 1961 and 1985 but then experienced a major fall so that by 2009 they had decreased by 75% from 1961 levels. Despite these reductions, CVD remains the largest cause of death in the UK, and coronary heart disease mortality rates have been 30-40% higher in Scotland than in England since the 1960s. As survival rates increase, the number of people who have suffered a heart attack has also increased and around 266 million prescriptions were issued for CVD in 2008, nearly five times the number in 1986 (British Heart Foundation, 2011).

Improved diet, with reduced saturated fat and sugar intake, and the decline in smoking are important factors in CVD improvement.

Survival rates from cancer have also doubled since the 1970s. Cancer Research UK (CRUK) has produced statistics for 1979-2009 showing an increase in cancer diagnoses of 18% among people aged 40-59 (Cancer Research UK, 2012). Breast, lung, bowel and prostate cancer, account for over half of all new cases. One factor in these increased diagnoses is better detection. However, increases in bodyweight, alcohol consumption and dietary changes are also considered by CRUK to be contributory factors to increased incidence of breast, bowel and prostate cancer.

With all these lifetime health advantages baby boomers should be the healthiest group of people moving into later life. However, benefits have been accompanied by new problems, such as sedentary lifestyles and inadequate exercise, poor diet and obesity, and drug and alcohol misuse. HIV AIDS was first diagnosed in the 1980s, moves to urban living have brought increased air pollution, heavier traffic has increased total numbers of traffic deaths.
accidents; and while men reduced their levels of smoking, women have begun to catch up with them, increasing their risk of lung cancer (Health Survey for England [2009], 2010). On the positive side, people in the baby boomer age group are taking more exercise. These health and lifestyle factors will influence their health and wellbeing as they grow older, and affect future levels of healthy life expectancy.

The most recent study of the health of the 1946 birth cohort (National Survey of Health and Development (NHSD): http://www.nshd.mrc.ac.uk/) assessed 2,661 participants for fifteen conditions: cardio and cerebrovascular disease, hypertension, raised cholesterol, renal impairment, diabetes, obesity, hypothyroidism, hyperthyroidism, anaemia, respiratory disease, liver disease, psychiatric problems, cancers, atrial fibrillation on ECG and osteoporosis (Pierce et al, 2012). Participants had, on average, two disorders: just fifteen per cent were disorder free. Hypertension (54.3%) and obesity (31.1%), raised cholesterol (25.6%) and diabetes (25.0%) were the commonest conditions. Nine per cent of the sample had undiagnosed, untreated osteoporosis (79% of those with osteoporosis), 6% undiagnosed hypertension (15% of those with hypertension), 3% undiagnosed diabetes (39% of those with diabetes). Undiagnosed hypertension and diabetes were commoner in men. Undiagnosed osteoporosis was commoner in women in the full sample; however, within the group with osteoporosis, men were more likely to be undiagnosed (90%) than women (74%). The NSHD researchers conclude that ageing with clinical conditions may become the norm and suggest that new formulations of the meaning of health are emerging, which focus on the individual’s ability to adapt and self-manage physically, psychologically and socially to their changing internal and external environment. The authors also flag up implications for health services, especially general practice which, with a move from a disease-based to a risk-based medical model, delivers more preventive health care. They note that GP consultations per patient rose by 40% between 1995 and 2008.

A stock take of some of the main aspects of the health of baby boomers can be taken from the Health Survey for England 2009 and 2010 (NatCen for Social Research, 2010; NatCen for Social Research, 2011) The Scottish Health Survey 2010 (Scottish Centre for Social Research, 2011), the Welsh Health Survey 2009 (Welsh Government, 2010) and the Northern Ireland Health and Social Wellbeing survey 2005/06 (Northern Ireland Statistics and Research Agency, 2007). Exhibit 4.10. This confirms a number of worrying trends across the cohort, including increases in diabetes and obesity and continuing high levels of raised blood pressure, although this remains untreated in fewer people. Reports of self-assessed health have remained stable, although there is evidence that successive cohorts appear to report slightly higher levels of limiting long-standing illness (Evandrou and Falkingham, 2000).

Comparisons of the health characteristics of baby boomers with people born in the previous decade have been made by Rice and colleagues (2010), using data from the Health Survey for England (HSE) covering each 10 year group between the ages of 50 and 90+. This confirms higher reporting of longstanding illness accompanied by increased presence of two or more chronic conditions, among baby boomers. Baby boomers also have higher body mass indices than older cohorts, with associated higher prevalence of diabetes. These changes reflect changes over time, rather than features of baby boomers, according to these writers. The study traces trends in disease prevalence, access to health care, recognition and treatment of diseases by practitioners, and improved diagnostic criteria, as playing a big part in higher disease reporting. The earlier detection of treatable disease may, the authors add, help to reduce the prospective disability burden in later life. The writers suggest that the adverse trends they have found may be driven by widening health inequalities and flag this question for further research.
Exhibit 4.10: Unhealthy trends?
Baby boomer health status in England

**Longstanding illness** In 2009 55% of 55-64 year olds in England said they had a longstanding illness. 29% of men and 32% of women said their illnesses limited their activity in some way. Longstanding illness was lowest in the highest income group. The most common illnesses were musculoskeletal (21% men; 26% women), heart and circulatory (21% men; 13% women), respiratory system (9% men; 10% women) and endocrine/metabolic system (12% men; 14% women). 5% of men and 7% of women in the age group reported a mental disorder. In Wales 36% reported a limiting long term illness.

**Self-reported general health** Self assessed general health is a measure used for predicting future health outcomes. 66% of men and 72% of women age 55-64 reported their health as good or very good and 11% of men and 19% of women reported it as bad or very bad. Reported general health levels show a gradient by household income quintiles with 2% in the highest quintile reporting bad or very bad health compared to 15% in the lowest quintile. In Scotland the results were similar. 66% of men and 67% of women said their health was good or very good, 12% of men and 11% of women said it was bad/very bad.

**Diabetes** 11% of men and 8% of women aged 55-64 had a diabetes diagnosis. Prevalence was lowest in the highest income groups and higher in those with middle and low income. Reported diabetes has shown a substantial rise since 1994 for both men and women. Physical tests showed that in more than half of people with a diagnosis the condition was poorly controlled. Since 1993 diabetes has doubled for men and more than doubled for women in the adult population as a whole, including the 55-64 age group.

**Blood pressure and hypertension** The HSE measured blood pressure. 51% of men and 41% of women were identified as hypertensive. 20% of men and 17% of women had untreated hypertension, 1% and 8% had uncontrolled hypertension. Figures for treatment show recent improvement.

**Obesity and being overweight** In the 55-64 age group 37% of men and 32% of women were defined as obese and 44% of men and 39% of women as overweight (i.e. 81% of men and 71% of women obese or overweight). For men this age group had the highest obesity levels; for women the second highest (highest was women aged 65-74). Applying NICE health risk categories, 35% of men were considered to be at very high increased health risk, 14% high risk and 27% increased risk. For women the proportions were 23%, 27% and 13%. Measures used by the survey were Body Mass Index (kg/m2) and mean waist circumference. Overall obesity levels in the population have increased from 13% to 26% of men and from 16% to 26% of women since 1993.

**Health-related lifestyles** Men and women in the 55-64 age group were more likely than all others to eat any fruit or vegetables (96% compared to an average 93%) and the second highest to eat 5 portions or more (28% men; 38% women). On average the men consumed 3.7 portions and the women 4.0. 18% of men and 16% of women in the age group were current smokers. 43% of men used to smoke and 39% never smoked; for women the proportions were 28% and 56%. For women this age group contains the lowest percentage who had never smoked. For those men and women who smoked, the number of cigarettes smoked was higher than other age groups.

**Alcohol consumption** This age group has the highest proportions of men and women who drink almost every day (26% and 13%) and the lowest proportions of non-drinkers (8% men; 13% women). 1 in 5 men consumed more than 8 units on their heaviest weekly day drinking and 9% of women drank more than 6 units. Those in the highest income groups were more likely to have an alcoholic drink on 5 days in a week than those in the lowest income groups.

**Physical activity** 32% of 55-64 year old men and 28% of women undertake recommended levels of physical activity; 37% of both men and women have low activity levels. Their levels are however, significantly better than those of the 65-74 age group and, for women especially, fairly close to those of younger people. Activity levels have improved considerably for this age group since 1997 and for this group of baby boomer women have improved in real terms against their 1997 levels.

Source: Health Survey for England
Assessing people’s wellbeing has been seen as an increasingly important part of understanding how well a society is doing. Warwick and Edinburgh Universities were commissioned by NHS Scotland in 2006 to develop a scale for measuring positive mental wellbeing. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) comprises 14 positively worded items, with five response categories, for assessing a population’s mental wellbeing. It covers positive affect (optimism, cheerfulness, relaxation) and satisfying interpersonal relationships and positive functioning (energy, clear thinking, self-acceptance, personal development, mastery and autonomy). It has been included in the Scottish Health Survey since 2008 and is now also part of the Health Survey England.

The maximum WEMWBS score is 70. In 2010 the average score in Scotland was 49.9, very similar to the previous two years. Scores were associated with age (Exhibit 4.11). In each survey year, the mean WEMWBS score was highest among people aged 16-24 and 65-74.

In England the mean survey score in 2010 was 51.0 with people aged 55-64 having a score of 51.5 (51.2 men; 51.8 women). The age pattern of scores is similar to that in Scotland. There are score dips for people aged 75+ in both Scotland and England. In Scotland women age 75+ have consistently had the lowest score for any age group and in England women in this age group had the second lowest overall score in 2010. These scores raise some important questions about the underlying factors associated with scores and, in particular why these rise at age 65 then fall off in later life, in those aged over 75. Maintaining the mental wellbeing of older people, after age 65, needs to be a distinctive part of overall national mental wellbeing improvement targets.

Further information about WEMWBS scores and their relationship to other factors is shown in Exhibit 4.12

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**Exhibit 4.11: Warwick-Edinburgh Mental Wellbeing scores, by age group, Scotland, 2010**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>49.5</td>
<td>51.7</td>
</tr>
<tr>
<td>25-34</td>
<td>50.0</td>
<td>50.8</td>
</tr>
<tr>
<td>35-44</td>
<td>49.4</td>
<td>49.1</td>
</tr>
<tr>
<td>45-54</td>
<td>48.6</td>
<td>49.5</td>
</tr>
<tr>
<td>55-64</td>
<td>49.9</td>
<td>49.5</td>
</tr>
<tr>
<td>65-74</td>
<td>51.3</td>
<td>51.6</td>
</tr>
<tr>
<td>75+</td>
<td>49.0</td>
<td>50.1</td>
</tr>
</tbody>
</table>

Source: Scottish Health Survey, 2010 (2011)

---

**Exhibit 4.12: Warwick-Edinburgh Mental Wellbeing Scores - trends**

- **Gender** In Scotland women had a slightly lower mean score than men in 2010; in England women had a higher score.
- **Socio-economic status** In Scotland wellbeing, as measured by WEMWBS, is associated with socio-economic class. The mean score was highest among people in professional or managerial households (51.6 for men, 51.4 for women) and lowest among people in semi-routine and routine households (48.1 for men, 47.7 for women).
- **Household income** Both mean Scottish and English WEMWBS scores had a clear linear association with household income equalised for household size. Mental wellbeing was highest among people living in the highest income quintile households (52.1/52.7 for men, 52.2/52.9 for women) and lowest in the lowest income quintile households (46.6/47.6 for men, 46.1/47.3 for women).
- **Relationship to health measures** In England people who said their health was very good had high WEMWBS mean scores (men 54.1, women 54.2) and those reporting health as bad had low scores (men 41.1, women 39.7). Obese women and men and women with high blood pressure all had reduced average scores.
- **Employment** In England retired men had the highest mean score of 52.4; men and women in work scored 51.6, retired women 51.4 and unemployed men had the lowest score at 47.9.

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**English Longitudinal Study of Ageing: assessment of wellbeing**

The ELSA programme has developed a multi-dimensional measure of wellbeing which includes satisfaction with life (the reflective component), sense of autonomy and control (the effective element) and absence of negative feelings of loneliness and depression (the affective part of wellbeing). The researchers found that between phases of the study in 2004 and 2008 depression among the people in their sample showed little change, while life satisfaction deteriorated and loneliness increased (Demakakos et al. 2010). The study found that wealth is positively associated with all aspects of wellbeing. More affluent people have fewer depressive symptoms and better quality of life. Depressive
symptoms and loneliness rise with age but life satisfaction is greater over age 65. A person’s number of close relations has a positive effect on both depressive symptoms and quality of life. Some important relationships between wellbeing and other health factors were explored.

People aged 50-64 with two or more Limitations in Activities in Daily Living (ADL) reported the lowest well-being levels of all groups, with high levels of depressive symptoms.

Cardio-vascular diseases and the related risk factors, hypertension and diabetes, were linked to almost double the rate of depressive symptoms. The effects on wider life satisfaction are not large, however, their effect is greatest among people in the 50-64 age group.

Models developed by the ELSA project indicate that it is negative life events that are linked to the decreases in wellbeing found in national surveys around age 75. Once negative events associated with age, including widowhood, deterioration in health and poorer economic circumstances, are taken into account there is a strong suggestion that increases in wellbeing around age 65 continue.

The multidimensional nature of the wellbeing concept developed by the ELSA project, and the analysis of a variety of possible determinants, highlights the need to move beyond physical concepts of ageing well to approaches that integrate physical, mental and social wellbeing.

Annual Subjective Wellbeing Survey
Four questions on subjective wellbeing formed part of a UK survey in 2011-12 (Office for National Statistics, 2012e). They covered life satisfaction, feeling things are worthwhile, feeling happy and feeling anxious. The U-shaped curves previously found in such surveys were reflected in the national results. Higher ratings were reported by younger people, falling to lowest levels in those aged 40-54 and then rising between ages 55-79. As with other surveys there was a dip again at around age 80. The pattern was reversed for responses to the question, ‘how anxious did you feel yesterday’, with higher scores in the 50-54 age groups falling off at 65. Exhibit 4.13 shows the results for the happiness and anxiety questions.

Exhibit 4.13: Average happy yesterday and anxious yesterday ratings, by age

Source: Annual Population Survey (APS) - Office for National Statistics, 2012e

Baby boomers’ mental health
There has been concern since the 1970s that the prevalence of mental ill health in the UK has been increasing (Spiers & Brugha, 2012). In England the National Adult Psychiatric Morbidity Survey (APMS), carried out in 1993, 2000 and 2007, is the primary source of information on the prevalence of treated and untreated psychiatric disorder. It showed an increase in the prevalence of common mental diseases (different types of depression, and anxiety) from 15.5% to 17.6% between 1993 and 2000, but little overall change between 2000 and 2007. The population group evidencing the greatest increase from 1993 to 2007 was women aged 45-64; for men in this age group there was an increase in prevalence in 2000 but a reduction in 2007. This group includes the 1946-55 baby boomers.

The APMS is based on a sample of households and baby boomers that have been sampled for all three surveys. The survey has used standardised and basically unchanged methods of evaluation. It is therefore possible to track population groups through different surveys over the period covered. Some recent statistical analysis of the three sets of data together has looked at the prevalence of mental illness by different cohorts over the programme time span (Spiers et al, 2011; Spiers & Brugha, 2012). Using a range of techniques researchers created seven year cohorts, reflecting the seven year phases of the survey programme, and tested differences between cohort groups as well as age and time period effects. The findings are that, overall, there is little evidence that mental
illness prevalence has been increasing over recent decades. It peaks at about age 50. However, this stability follows a ‘step change’ in prevalence between male cohorts born between 1943 and 1948 and those born 1950 -56. For women differences between the cohorts were less pronounced than in men and in fact the succeeding female cohort, born 1957-63, had particularly high rates of mental illness and symptoms when surveyed aged 44-57. The step change in male symptoms includes common mental disorder and neurotic symptoms as well as ‘highly significant’ increases in fatigue and sleep problems. In females there were increases in common mental disorder and of sleep problems and worry, but they were less pronounced. These findings support the observations from HSE data made by Rice (Rice et al, 2010). Rice and colleagues’ study of the health of the baby boomer group, analysing Health Survey for England data from 1994 to 2007, suggested a cohort specific higher prevalence of mental illness based upon reported mental disorders. Spiers and colleagues (2011) link the increased prevalence among the 1950-56 cohort to their experiences of transition into adulthood during the period of 1960s social and cultural changes.

The findings of stability in mental illness prevalence are good news overall for current and future mental service provision. However, since the main cohort affected by the transition between lower and higher prevalence of mental health disorders has been the 1950-56 group, some issues are raised about how the mental health in later life of this group will compare with previous older populations, and the implications of this for prevention and treatment services.

The 2007 APMS results (McManus et al, 2009) provide a range of insights into the prevalence of all mental disorder, and main points are summarised in Exhibit 4.14. Because data are not broken down by age categories that fit the 1946-1955 baby boomers, some summary data are cited.

Exhibit 4.14: Adult Psychiatric Morbidity Survey Common Mental Disorder and Psychoses

<table>
<thead>
<tr>
<th>Common mental disorders</th>
<th>• For men, being divorced more than doubled the likelihood of having a CMD (27.7%), while for women being married slightly reduced prevalence (16.3%). Being single slightly increased the likelihood of having CMD (14.8% men, 24.6% women).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ethnicity affected prevalence of CMD most significantly for South Asian women whose prevalence was three times that of South Asian men (10.3% men; 34.3% women).</td>
</tr>
<tr>
<td></td>
<td>• One of the strongest gradients in prevalence was in relation to household income, particularly for men. Men in the lowest quintile were almost three times more likely than men in the highest to have a CMD (23.5% to 8.8%).</td>
</tr>
<tr>
<td></td>
<td>• Across all adults the prevalence of ICD-10 CMD diagnosis increased to its highest level (19.9%) in the 45-54 age group and then reduced to 55-64 (14.1%), 65-74 (10.6%) and 75+(9.9%). However, this age categorisation masks the underlying post-1950 ‘step change’ described by Spiers and colleagues.</td>
</tr>
<tr>
<td>Psychoses</td>
<td>Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder. Survey respondents were diagnosed using the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) at a second phase interview to identify probable psychosis. The survey identified 0.4% with a probable psychotic disorder in the past year; 0.3% of men and 0.5% of women. Prevalence at older ages was negligible.</td>
</tr>
</tbody>
</table>

Source: Adult Psychiatric Morbidity Survey McManus et al, 2009
Suicide rates in young men in England and Wales more than doubled between the early 1970s and the 1990s (Biddle et al, 2008). Rates for older men and women declined. Exhibit 4.15 shows trend rates for 25-34 year old males peaking in 1998. Rates among 15-24 year old males also increased between the 1970s and 90s leading to concerns about deteriorating mental wellbeing in younger people. The initial steep rise in the 1970s coincides with the 1946-1955 baby boomer cohort moving into the 25-34 age group. The factors associated with this increase are unclear but the cohort impact echoes the cohort mental ill health effects identified by Spiers and Brugha (2012). Trend analyses from the 1970s to the late 1990s show an association with increases in divorce, declines in marriage and increases in income inequality (Biddle et al, 2008).

Recent suicide statistics (ONS, 2013) show that while overall national (UK) suicide trends have been falling since 2000, rates rose in 2008 and in 2011. 2011 rates for men aged 45-59 were 22.2 per hundred thousand population, their highest rate for 25 years. Increased suicide rates were most marked among men aged 40-44 and 45-49 and men in these age groups had the highest levels in 2011. Rates for women aged 45-59 were 6.6 and have not shown the same increase. Data from Scotland also indicate that high rates are concentrated in men aged 35-54, born in the sixties and seventies. Economic recession has been linked to these increases. Rates were lowest for men and women aged 65-79, rising in those over 80. Across the UK suicide rates for men aged over 75 have fallen by more than half over thirty years, from being the highest rate for all ages, at 28.6 per thousand to the second lowest, at 13.8.

Rates for men aged 55-59 fell from 2001 to 2005, and have since risen slightly, and for men aged 60-64 have been consistent since the beginning of the century, indicating stable patterns for men in the baby boomer cohort. There is a similar stable trend for baby boomer women, although 2011 saw a small spike in rates among women aged 55-59.

The APMS asks questions about suicide attempts, suicidal thoughts and self-harm using a self-completed questionnaire. In terms of reporting of suicide attempts there was an overall average of 5.6% making such reports for all ages, but a distinct break in trend between those aged 55-64 and those aged 65-74 (5.6%: 2.7%). 16.7% of adults said they had had suicidal thoughts at some point in their life. Women were more likely than men to report such thoughts and, counter-intuitively younger people reported it more than older people. 5.6% reported that they had attempted suicide and 4.9% self-harmed. Men aged 55-64 reported the lowest level of suicidal thoughts in the past week (0.3% to an average 0.6%) and women the second lowest (0.7% to 1% average). Some issues are raised about gender differences in suicidal thoughts and completed suicide and separate data show that men are more likely to die in their first suicide attempt than women. Women who have suicidal thoughts are more likely to seek help than men. Some other findings relate to seeking help after a suicide attempt. While around 60% reported seeking help younger people, are much more likely to do so than older people. The APMS researchers found that the attributes with the strongest association with suicidal thoughts and suicide attempts were being white, divorced or separated and being in the lowest income quintile.

Alcohol use and dependence

NICE guidance on alcohol dependence and harmful drinking notes that alcoholic beverages were consumed by 87% of the population in England, and that drinking alcohol is widely socially accepted and associated with relaxation and pleasure. The guidelines add that most of the alcohol consumed by the population is drunk by a minority of heavy drinkers. According to WHO, alcohol is implicated as a risk factor in over 60 disorders including high blood pressure, stroke, coronary heart disease, liver cirrhosis and various cancers. Alcohol is also strongly associated with a wide range of mental
health problems. Depression, anxiety, drug misuse, nicotine dependence and self-harm are commonly associated with excessive alcohol consumption. Up to 41% of suicides are attributable to alcohol and 23% of people who engage in deliberate self-harm are alcohol dependent (NICE, 2011). However, there is also evidence that light to moderate alcohol consumption is associated with a reduced risk of multiple cardiovascular outcomes (Ronksley et al, 2010). The Department of Health recommends that adult men should not regularly drink more than four units of alcohol per day and women no more than three units and the Royal College of Psychiatrists’ advice is to drink less than 21 units of alcohol per week for men and 14 units for women (www.patient.co.uk).

The APMS surveys alcohol use and is a major source of information about levels of consumption in the population. It measures hazardous and harmful drinking using the World Health Organisation Alcohol Use Disorders Identification Test (AUDIT). A score of 8 or more on the questionnaire indicates hazardous drinking and a score of 16 or more, harmful drinking. A further scale is used to assess severity of alcohol dependence. In 2007 33.2% of men and 15.7% of women (overall 24.2%) were found to be hazardous drinkers, of whom 5.8% of men and 1.9% of women were harmful drinkers. Alcohol dependence was identified overall in 8.7% of men and 3.3% of women. Overall prevalence of hazardous and harmful drinking showed a decline with age with the highest levels of harmful drinking demonstrated by those aged 16-24. However:

- 26.8% of men aged 45-54 in 2007 and 23.8% aged 55-64 were deemed hazardous drinkers and 3.2% and 2.9% harmful drinkers.
- Figures for dependence show a stable pattern at around 6% of 45-54 year old men with mild dependence in 2000 and 2007 and around 5% of 55-64 year olds. However, for women there was an increase in mild dependence from 1.4% to 3.3% of 45-54 year olds between 2000 and 2007 and from 0.6 % to 0.9% among 55-64 year olds.
- Cohabiting, single and divorced men were much more likely than married men to have any alcohol dependence; being single was the greatest risk among women.

Amongst long-term heavy and alcohol dependent drinkers there is estimated to be a reduction of life expectancy by around ten to fifteen years, and therefore lower survival into later years. The highest rate of death is in the 55-74 age group, where death rates among men have doubled since the 1990s (ONS, 2010). Analysis by Alcohol Concern (Alcohol Concern, 2012) has indicated the contribution to National Health Service costs by inpatients aged 55-74 with wider alcohol-related conditions, to be about £825.6m in 2010-2011. Their report flags up a problem of unwitting middle age drinkers who are taking serious risks with their health.

Research by the Mental Health Foundation (MHF, 2006) has shown that excess alcohol use is linked to mental illness. Although in the short-term alcohol may provide people with a relatively easy coping strategy for underlying mental health issues such as stress, depression or anxiety, the research suggests that long-term alcohol misuse is damaging. Not only may it worsen the very symptoms it is being used to dampen, but it is associated with a range of other mental health consequences. These include depression, anxiety, suicide, risk-taking behaviours, personality disorders and schizophrenia. In addition, alcohol misuse is associated with increased levels of stress, relational conflict and physical injury, which in themselves can contribute to poor mental health.

Excessive alcohol drinking can also pose a number of problems as people get older because of potential aggravation of age-related health problems and interactions with medications. Metabolic changes may also result in more harmful effects at lower levels of consumption. Generally people tend to drink less as they get older. However, around a third of older people with alcohol use problems develop them in later life – often as a result of life changes such as retirement or bereavement, or feelings of boredom, loneliness and depression. Longitudinal studies suggest that there is little or no difference in patterns of alcohol drinking between retirees and non-retirees; however, recent longitudinal analysis using repeated measures of alcohol consumption showed an increase in the proportion of heavy drinkers around retirement among both men and women in a large French cohort study (Zins et al, 2011). Among men and women in non-managerial occupations, this increase was temporary and was followed by a return to the levels observed five years before retirement. Among women managers, the elevated levels of heavy drinking remained unchanged during the entire 5-year post-retirement period of the
study. These data suggest that retirement is a life transition which may increase the risk of excessive alcohol consumption, temporarily in most people, and permanently in the small group of women managers. The authors highlighted difficulties in assessing the extent to which the results observed in this cohort would hold for other working populations, other conditions of employment, or in other cultural settings.

The evidence is not yet clear on how great a problem such drinking will be as baby boomers grow older and experience the stresses of later life. It has been suggested that alcohol had a high level of availability and social acceptability during their formative young adult years which might influence behaviour, as could levels of disposable income in retirement (Institute of Alcohol Studies, 2010).

Drug misuse and dependence
While the baby boomers may do no more than continue the drinking patterns of previous generations, their use of illicit drugs and other drug misuse as they grow older is likely to present a further step change in behaviour. They were teenagers and young adults in the 1960s and 1970s when recreational use of drugs became an important phenomenon. The use of ‘purple hearts’ (a combination of amphetamine and barbiturate) by thousands of young people led to the first post war drug craze and unauthorised possession of amphetamine was banned in 1964. Recreational cannabis use only became significant in Britain in the 1960s, although its psychoactive properties had been known for a long time and it had been illegal for decades. Heroin use by younger people also began in the 1960s; in 1959 there were just 47 known heroin addicts but by 1964 this had risen to 328. Most were young people, whereas young addicts had previously been a minority, and while many older addicts had become addicted through therapeutic use, these new addicts were recreational users. Drug use became part of the social and cultural changes of the times, and for some groups symbolised the new youth culture. In particular LSD, originally developed as a psychotherapeutic agent in the 1940s, was linked to the ‘psychedelic’ movement of music and visual art. The continuing impact of this cultural shift on current attitudes is still apparent. The 2010 British Crime Survey (Flatley et al, 2010) looked at attitudes to the use of cannabis and cocaine. It is limited to people aged under 60, but found that 25% of people aged 50-59 consider that it is OK to take cannabis occasionally and 2% say that frequent use is acceptable. This is lower than for other age groups but still represents a significant measure of acceptance of cannabis. Only 4% accepted occasional use of cocaine.

Prevalence statistics for drug use in the 1960s and 1970s are not available but the official view is that use was probably much lower than today (European Monitoring Centre for Drugs and Drug Addiction, 2008). The APMS 2007 confirms that people in older age groups report lower lifetime experience than younger groups. There is a gradient in use however: while less than 4% of those aged 65+ reported lifetime use of drugs, 11% of 55-64 year olds and 20% of 45-54 year olds said they had used drugs at some time. For comparison 39% of 16-24 year olds reported lifetime use. Drug use for the past year recorded by the survey is shown in Exhibit 4.16.

Exhibit 4.16: Illicit drug use in the past year

<table>
<thead>
<tr>
<th>Drugs used</th>
<th>Men age 45-54</th>
<th>Men age 55-64</th>
<th>Women age 45-54</th>
<th>Women age 55-64</th>
<th>All adults, men &amp; women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>4.1</td>
<td>1.9</td>
<td>1.9</td>
<td>1.0</td>
<td>7.5</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>0.2</td>
<td>-</td>
<td>0.1</td>
<td>0.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Amyl nitrite</td>
<td>0.6</td>
<td>0.2</td>
<td>-</td>
<td>-</td>
<td>0.7</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.9</td>
<td>-</td>
<td>0.3</td>
<td>0.1</td>
<td>2.5</td>
</tr>
<tr>
<td>Magic mushrooms</td>
<td>0.1</td>
<td>0.5</td>
<td>-</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Tranquilisers</td>
<td>-</td>
<td>0.3</td>
<td>0.3</td>
<td>0.8</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Most use is historical. However some 4% of men and 2% of women aged 45-54 and 2% and 1% of women aged 55-64 said they had used cannabis in the last year. Slightly lower figures were found in the British Crime Survey 2010. Trends from previous surveys show no cannabis use by people aged 55-64 until 2007, as the oldest of the 1946-55 baby boomers reached this age. Drug dependence among 55-64 year olds found by the survey (1.7% men, 1.3% women) was chiefly to cannabis (men) and tranquillisers (women).

Figures for treatment show increasing numbers of older people, although still a small percentage of all those in treatment (2.7% aged 50-59 and 0.5% aged 60+ in 2008). However, the numbers age 60+ in treatment more than doubled in the four years to 2008. Most people using drugs after age 50 began their drug use as teenagers. There are three patterns to later use: continuous use, intermittent use and re-use after a period of non-use. Return to drug use is often linked to stressful experiences, such as relationship breakdown, bereavement and loneliness and isolation. As people get older and experience more pain and disability lifetime drug users will continue to use and others may turn to illicit drugs or alcohol to help mitigate the effects of pain. This raises the spectre of late onset addiction.

Drug use and ageing present a number of unknown issues. Common health problems associated with ageing may start at an earlier age amongst older drug users and drug use can accelerate the speed at which other health problems worsen (Beynon, 2009). Older people also metabolise drugs more slowly and the brain may be more sensitive to drug effects with age. Combined drug and alcohol use leads to problems, such as excessive sedation, overdosing and falls. Drug use also has implications for mental health. The APMS reported that 36% of people who were drug dependent (on drugs other than cannabis) were receiving treatment for a mental or emotional problem and that 14% who were dependent on cannabis only were receiving treatment for a mental or emotional problem.

Because drug use by older people (over 40) is largely unacknowledged, the medical effects of their drug use are often not diagnosed. The need for improved assessment in older people as well as suitable treatment and intervention services have been identified (European Monitoring Centre for Drugs and Drug Addiction, 2008). The evidence is that older people achieve equal or better results than younger people from treatment.

### Mental health inequalities

Widely used survey measures show how social inequalities affect mental health. The General Health Questionnaire (GHQ12) is a measure of psychosocial health with questions that cover broad components of psychological morbidity. It measures general levels of happiness, depression and anxiety, sleep disturbance and ability to cope over the last few weeks. A GHQ12 score of 4 or more is defined as high, indicating psychological disturbance or mental ill health. Recent survey data are available for England and Scotland. Exhibit 4.17 shows percentages with scores above 4. In both countries women have higher scores than men, and people aged 45-54 have the highest prevalence of a high score, except for Scottish men where those aged 55-64 have the highest levels. As with the Warwick Edinburgh Mental Wellbeing Score cited previously, the GHQ12 scores show improvement in the 65-74 age group and a decline after age 75. 2005 data for Northern Ireland indicate overall higher scores, with 21% of women and 16% of men overall scoring above 4.

**Exhibit 4.17: Percentages with GHQ scores above 4 by age group**

<table>
<thead>
<tr>
<th></th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
<th>Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England – women %</strong></td>
<td></td>
<td></td>
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<td></td>
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<td>16</td>
<td>15</td>
<td>16</td>
<td>20</td>
<td>15</td>
<td>10</td>
<td>14</td>
<td>16</td>
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<tr>
<td><strong>England – men %</strong></td>
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<td></td>
<td></td>
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<td></td>
<td>14</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>12</td>
<td>9</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td><strong>Scotland – women %</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>17</td>
<td>19</td>
<td>21</td>
<td>16</td>
<td>13</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td><strong>Scotland – men %</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>12</td>
<td>15</td>
<td>14</td>
<td>17</td>
<td>8</td>
<td>9</td>
<td>13</td>
</tr>
</tbody>
</table>

Sources: The Scottish Health Survey 2010 (Scottish Centre for Social Research, 2011); Health Survey England, 2010 (National Centre for Social Research, 2011)

Further analysis shows that more than twice as many men and women in lowest quintile income households had high scores compared to the highest quintile. Exhibit 4.18 illustrates quintile variation for women in England, with each quintile standardised to adjust for age variations. High GHQ scores are also linked to having a limiting longstanding illness, low consumption of fruit and vegetables, low alcohol consumption and being divorced, or separated and widowed for women only. In Wales a slightly different measure, the SF-36 has been used, with questions about people’s own perception of their physical and mental health and its impact on their daily lives. With higher scores indicating better health, the Welsh Health survey found a reducing gradient of mental component scores from people working in professional and managerial roles, through intermediate, routine and manual with the lowest level for long-term unemployed people.
Baby boomer health inequalities

Some important evidence about self-reported health in early old age has come from the longitudinal study of over 10,000 London civil servants, initially aged 35-55, carried out since 1985 (Chandola et al, 2007). Its younger members are thus part of the early, 1946-55, baby boomer group. A questionnaire covering issues related to physical, psychological and social functioning was administered over five separate phases. When the data were modelled to examine whether health inequalities increase with age it was found that physical health deteriorated for all occupational groups at older ages, while mental health tended to improve with age. However, the study found that social inequalities in self-reported health increase in early old age: people working in lower occupational grades age faster in terms of health deterioration. The improvement in mental health with age was slower for lower occupational grades, also resulting in widening health inequalities in early old age. Retirement was associated with improvement in mental health for higher grades that was not matched by lower grades. For the study authors the findings raise issues about health inequalities as the population ages. The Whitehall study researchers have suggested that low social status stifles social participation and autonomy, which harms health by producing a chronic biological stress response (Ferrie, 2004).

The English Longitudinal Study of Ageing has also begun to throw light on health and life chances in people aged over 50. Between 2004 and 2006 it found that while only 0.2% of the richest fifth of people in the sample aged 50-59 had died, 2.5% of the poorest had died. This mortality gradient was strongest in these younger sample groups, but was evident across all older ages (Banks et al, 2006).

The long term nature of some of the factors affecting health in later life is shown by the National Survey of Health and Development, a study of a cohort of people born in the first week in March 1946. Initially set up to look at maternity and infant and maternal health issues, the study is now focused on describing the processes and pathways of ageing and disease risk as well as good health and wellbeing.

Viewed from the perspective of late middle age, the study’s researchers have concluded that health in adulthood builds on childhood health and on lifestyles that are themselves a product of childhood behaviour styles, temperament and educational attainment as well as peer group and family influences in adolescence and childhood. Outcomes in adult life are the product of long term life course processes that may begin before birth and reflect a continuous interaction between individual biology and the environment, both physical and social (Wadsworth et al., 2006).
**Putting life into years**
This chapter has highlighted the continuing challenges to their health and mental health baby boomers will face in later life. In response, this review is arguing that the healthy ageing agenda needs to move beyond a focus on physical aspects of disease to more fully encompass psychological issues, including mental illness and mental health and wellbeing, i.e. the whole person. Members of the 1946-1955 baby boomer population can play an important role in taking on this wider agenda because of their attitudes and potential readiness to engage with change.

There needs to be, firstly, a stronger focus on the prevention, identification and treatment of mental illness among older people as well as consideration of the mental health needs of people who develop chronic, long-term and potentially disabling conditions. Secondly, there needs to be a clearer understanding of the contribution mental health and wellbeing can make to both limiting morbidity and the prevention or mitigation of its disabling effects. Finally mental wellbeing in later life must become an inherent part of healthy ageing. There are clear and positive signs that the healthy ageing focus is beginning to encompass wider psychosocial factors. The development of future policy on ageing needs to be led by people’s own views of healthy ageing and their priorities, and these need to influence health ageing programmes. These proposed dimensions for action are developed below.

**Better treatment of mental illness in later life**
Late-life depression has been described as a devastating disease. It complicates other medical illnesses and their management. For current older people and for baby boomers as they move towards later life, the priority need is to focus on prevention, identifying and modifying risk factors (Karp et al, 2006). Karp and colleagues define three areas for prevention: enabling effective access to treatment; preventing the development of depression in high-risk individuals, and treating mood disorders to complete remission to prevent recurrence, Exhibit 4.19.

**Access to treatment**
There is a decade or more of studies and reports reflecting concern about the low profile and expectations, and poor quality and outcomes associated with older people’s mental health and mental health services (Centre for Policy on Ageing: http://www.cpa.org.uk/index.html). Later life depression, the most prevalent condition, is under-diagnosed and under-treated. There is also evidence of poor prognosis for sufferers, particularly in the absence of treatment. The Mental Health Foundation (MHF, 2009) has made recommendations aimed at ensuring older people receive the best possible health and social care and support on a fair and equitable basis. It cited Department of Health evidence on age discrimination in mental health which found that generally it is people aged over 65 who are receiving lower cost support packages compared to younger adults. The report adds that it is in relation to common mental health problems such as depression and anxiety where the discrepancy is most notable. It also cited a Royal College of Psychiatrists report that at a time when services were facing large increases in numbers, some older people’s mental health services had seen cuts.

The Age Equality Act 2010 bans age discrimination, requiring all public services to end discrimination in the services they provide. This applies to the provision of health and social care services among others. However, although due to come into force in April 2012, implementation was delayed to October 2012.

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**Exhibit 4.19: The three dimensions for preventing later life depression**

![Diagram of three dimensions for preventing later life depression](image)

Karp et al 2006
A review of strategies for achieving age equality in mental health services (National Development Team for Inclusion, 2011) reported:

- A tendency for national mental health strategies to either avoid, ignore or downplay the prevalence of mental ill health among the older population;
- As a result a lack of whole systems, lifespan approach to mental health needs and services. This is reflected in how services are commissioned and delivered;
- A wealth of evidence that older people experience restricted access to services and support for their mental health and wellbeing compared to people under age 65;
- The involvement and influence of older people in designing and delivering responsible mental health services and support is mostly inadequate;
- There is an ongoing focus on dementia at the expense of issues associated with the far more common mental disorders that older people experience such as depression and depressive illness, anxiety, psychosis and drug and alcohol problems.

Older people with depression are currently mostly treated in primary care settings (Alexopoulos, 2005). However, primary care doctors rarely diagnose depression and, when they do, may provide inappropriate treatment. Barriers are doctors’ reluctance to discuss emotional problems, time constraints, and comorbidity with other conditions. From the patients’ perspective there is perceived stigma of mental illness and a reluctance to initiate treatment. A study of GPs found that many described depression as part of a spectrum that included loneliness, lack of social network and reduction in function (Burroughs et al, 2006). They viewed depression as ‘understandable’ and ‘justifiable’ – a view shared by the patients, and about which ‘nothing could be done’. For patients, depression was not a legitimate illness but ‘a problem of living’.

Negative outcomes of failure to diagnose were reviewed in a longitudinal study of patients in primary care with major depression (Licht-Strunk, 2009). Median duration of an episode was eighteen months with two thirds of patients taking three years to recover. This study concluded that the prognosis for depression in later life seemed poor as most people did not receive treatment for their condition. In a Dublin study of people diagnosed with depression, after three years just 10% had recovered completely, 35% had persistent depression, 25% had other case or sub-case mental illness and 30% had died (Denihan et al, 2000). This study concluded that late life depression is a chronic condition but identified positive responses to anti-depressant medication.

There is evidence of effective treatment. In particular cognitive-behavioural therapy has been shown to be equally effective with older people as younger (Cuijpers et al, 2007); myths about ageing may be challenged as part of the therapy (Evans, 2007). However there is recent evidence that less than two per cent of people with significant symptoms of depression who see their GP and get offered treatment will be referred for psychological therapy (Watts et al, 2012). Furthermore 90% of depressed older people do not see a specialist. Good results for managing later life depression come from multi-faceted interventions and collaborative care (Chew-Graham et al, 2004). Such interventions may involve a depression care manager under the supervision of a primary care doctor and a psychiatrist.

**High risk individuals**

High risk individuals include people with chronic medical illness, persistent pain, recurrent depression, social isolation and cognitive impairment. Depression worsens the course of chronic illness. Integrated care for chronic physical diseases and depression in reducing disability and improving quality of life has been positively evaluated. Simon (2001) recognises the efficacy of both pharmacological and psychosocial treatments for depression across a range of chronic medical conditions. Dennis notes the need for appropriate management of older people with depression and for further research into delivering community-orientated prevention programmes to vulnerable groups (Dennis, 2009).

**Preventing recurrence**

There need to be clear recovery models for late life mental illness, particularly depression, that define recovery in the context of quality of life and best possible social functioning. Better approaches need to be developed to treat people who do not fully recover after first-line treatment.
Connecting mental and physical health

Projections of healthy life expectancy together with survey measures of the current health, mental health and wellbeing of the 1946-55 baby boomer cohort outlined above, suggest that achieving compression of morbidity presents a challenge. Progress in increasing life expectancy and reducing morbidity has largely, to date been the result of what might be defined as ‘biomedical’ improvements. Exhibit 4.20 summarises the causes of improving health and longevity at older ages (Costa, 2005).

Exhibit 4.20: Explanations for increasing longevity

**Improved medical technology:** this includes improved clinical procedures, and the development of therapies to control chronic conditions, for example, mortality from heart attacks and long term disability from rheumatoid arthritis are substantially the results of improved medical treatments. Cataract surgery has tackled a major cause of blindness in later life, and the disabling and life threatening impacts of many other disabling conditions have been reduced by improved treatments.

**Reduced infectious disease rates:** Reduction in early life infectious diseases has had a long term impact on chronic illness in later life, including heart and lung diseases and some cognitive disorder.

**Reduced occupational stress:** the shift from manual to white collar work and the reduction in occupational hazards within manual and factory work. Effects include musculoskeletal improvements, reduced exposure to harmful materials, fewer direct physical accidents and deaths.

**Improved nutritional intake:** includes maternal nutrition and early life nutrition which may increase risk for coronary heart disease and stroke as well as possible links between early childhood growth and type 2 diabetes. Many other later life conditions have also been explored in relation to early life and in utero nutrition experiences, including stroke risk, and susceptibility to chronic disease. Nutritional deficiencies at older ages have also been linked to late life conditions.

**Life style changes:** including the cessation of smoking and the change to a low-fat diet may account for some of the recent morbidity improvements. In addition, evidence suggests that healthy lifestyles not only extend life but also help limit years with disability. People with chronic diseases may be making better choices compared to earlier cohorts of people.

**Rising incomes:** have enabled people to consume better food, housing, sanitation, and medical care. Poor living conditions and crowding were associated with high levels of respiratory and cardiovascular disease.

**Rising education:** is associated with many other health improvement factors including avoidance of risk, better knowledge of disease and links to maternal care.

Sources: Costa, 2005
Research is continuing to focus on improving health to compress morbidity. For example, there is a number of programmes aimed at increasing understanding of the biological characteristics of human ageing, improving preventive medication for chronic conditions, early life impacts on ageing and underlying biological mechanisms, the health impacts of physical activity, physical predictors of later disability, and optimal medical interventions, amongst others. Mental health in later life also features as a priority in research, and there is a growing recognition of the need for greater focus on the contribution of psychosocial factors. For example, the European Union’s Futurage project’s ‘healthy ageing’ strand has a sub-theme on psychosocial factors which, as part of its programme, aims to explore what exactly constitutes healthy ageing, and the respective importance of physical health and psychological well-being (Jagger et al, 2010). It identifies the need to develop research around the importance of social interactions that conceptualises healthy ageing as the outcome of a system rather than something intrinsic to individuals and their behaviour.

**Morbidity and disability**

While so much progress in improving life expectancy and morbidity has been made through a better understanding of biological mechanisms and improvements that have biological effects, there is a growing view that a better understanding of the relationship between disease, impairment and disability will help achieve further compression of morbidity. The importance of mental, social and behavioural factors in influencing the onset of disability has been flagged up, for example, by the Futurage healthy ageing work programme.

The World Health Organisation (WHO) defines health as a state of complete physical, mental and social wellbeing. For this concept of health, a simple model that describes a process of disablement as the manifestation of a disease, the classic biomedical model, fails to capture the cultural and social factors that are also involved. The WHO model identifies three dimensions: a disease, accident or abnormality, and their resulting impairments; disability which is a reduction or loss of functional capacity resulting from impairment; and handicap which is the social disadvantage resulting from impairment and/or disability. The model has been developed (Verbrugge and Jette, 1994) to produce a socio-medical model of disability that describes the effects of chronic and acute conditions and the personal and environmental factors that speed slow disablement. Exhibit 4.21 illustrates the model.

**Exhibit 4.21 Disablement Model**

Source: Verbrugge & Jette (1994)

**Mental health and chronic physical conditions**

The contribution of complete medical health to protection against chronic physical conditions in later life has been explored by Keyes (Keyes, 2005) whose theories of positive mental health and mental illness have helped to shape thinking about mental wellbeing. Mental health is conceptualised as a complete state that consists not merely of the absence of mental illness such as major depression, but also the presence or absence of specific dimensions of subjective wellbeing comprising positive feelings towards life (hedonia) and positive functioning in life (eudemonia). He defines five states of mental health. Complete mental health exists where people are flourishing with high levels of emotional, psychological and social wellbeing and are free of a major depressive episode. Languishing is a state of being mentally unhealthy where individuals have low levels of emotional, psychological and social wellbeing but do not meet criteria for major or minor depression. Moderately mentally healthy adults are not depressed or languishing but do not meet the criteria for flourishing. Some individuals may fit the criteria for depression and also those for languishing and finally others may be moderately mentally healthy but who report a major depressive episode. Keyes’ research suggests that about a quarter of people who have not had major depressive illness in the past year are also flourishing and that most non-depressed adults are only moderately mentally healthy and about a quarter are languishing. Completely mentally health people report the highest levels of direction in life (they know what they want out of life), intimacy (they feel really cared for), resilience (they can change bad situations for the better and learn from them) and they report the lowest levels of helplessness (feeling able to change things that are important in life).
Keyes argues that high levels of mental health act as protective factors against the accumulation of chronic physical disease and disability with age, and also that mental illness and the absence of mental health act as risk factors. He cites a range of evidence that suggests causal links between major depression and cardiovascular disease and heart attack outcomes, and the implication of depression at the onset and during the course of stroke, arthritis, asthma, diabetes, cancer and obesity. His own research assesses the relationship between mental health and the prevalence of chronic disease. He carried out complete mental health diagnoses with his subjects and collected evidence about 27 chronic physical conditions from them. His analysis of findings shows a relationship between mental health and the prevalence of chronic disease. He acknowledged there are limitations in drawing causal conclusions from his research, but says that it supports the importance of including mental health and mental illness into studies of population ageing.

Psychological wellbeing, health and functioning

The ELSA programme has collected information about the psychological wellbeing and aspects of health and physical functioning of their sample of people aged over 50, from 2002 to 2010. As part of the most recent survey analysis, the researchers have looked at changes over time in people’s health and functioning and at their psychological wellbeing measures in 2004-05 (Steptoe et al, 2012). Three aspects of psychological wellbeing have been assessed over time by the project:

- Evaluative wellbeing: people’s satisfaction with life
- Hedonic or affective wellbeing: measures of feeling, such as happiness, sadness and enjoyment.
- Eudemonic wellbeing: judgements about the meaning or purpose of one’s life including fulfilment, autonomy and control.

For each aspect of psychological wellbeing people were included in a high, medium or low wellbeing group, based on the measures used. Activities of daily living (ADL): Levels of enjoyment of life (hedonic wellbeing) were found to be inversely associated with the development of two or more ADL limitations, in people who previously had none, between 2004-05 and 2010-11. People in the group with lowest levels of enjoyment of life had four times higher risk of experiencing new ADL limitations than those in the group with highest levels; the intermediate group had three times higher risk. The researchers note that even small differences in enjoyment may have profound consequences for older people’s disability. They add that, although separably age, sex and wealth are all associated with affective wellbeing, its relationship with future disability was not accounted for by these factors. Eudemonic wellbeing had a similar graded association with subsequent ADL disability, although the association with life satisfaction was weak.

Physical function: The ELSA project has measured gait speed as a measure of physical function. The researchers found that enjoyment of life and measures of eudemonic wellbeing both predicted gait speed in 2010-11; the group of people with higher levels of wellbeing walked faster.

Self-rated health: The odds of people rating their health in the future as fair or poor were found to be greater for ELSA participants with poorer psychological wellbeing in 2004-05. People in the lowest wellbeing groups had more than two times the risk of reporting fair or poor health compared to those in the highest group. The conclusions made by the researchers are particularly significant for the appreciation of the relationship between wellbeing and poor health; they conclude that affective, eudemonic and evaluative wellbeing predict future subjective appraisals of health and that impaired wellbeing is not simply a product of poor health, but is systematically associated with the development of poor health.

Coronary heart disease (CHD): Evidence from other studies already exists of the association between wellbeing and the onset of CHD. The ELSA analysis found that being in the group with lowest levels of life enjoyment and eudemonic wellbeing were associated with 70% higher odds of becoming a cardiac patient six years later.

Cognitive function: Results of the models applied by the researchers show very little association between psychological wellbeing in 2004-05 and changes in memory between then and 2010-11. Other analyses of the data suggest that impaired psychological wellbeing may in fact develop as a result of poor cognitive function.
Further evidence that psychological well-being can predict future health was identified by following up mortality. Researchers found that survival over an average of more than nine years was associated with greater enjoyment of life in 2002–03. Effects were large, with the risk of dying being around three times greater among individuals in the lowest compared with the highest third of enjoyment of life, and were independent of age, sex, ethnicity, wealth, education, baseline health and other factors.

The mechanisms for these effects are not known. The authors suggest a number of possible underlying mechanisms, including some effects on behaviour, as well as underlying biological mechanisms. They indicate that measuring psychological wellbeing may help identify individuals at risk of future health problems and functional impairment. Their findings add further support to a proposal that public health and educational programmes might be targeted at increasing resilience to life stress and promoting positive wellbeing (Chida and Steptoe, 2008). The enhancement of positive wellbeing states, together with tackling negative states such as depression and distress, may improve adaptation to physical illness.

Resilience in older age – some research findings

Recent studies have begun to explore the idea of resilience in older people. Resilience is best understood as a dynamic process: the result of individuals interacting with their environments and the processes that either promote wellbeing or protect them against the overwhelming influences of risk factors, rather than a trait of individuals. Researchers used ELSA data to explore people’s ability to flourish under adversity (Demakakos et al, 2008). The study examined how people avoid long term or permanent decline in quality of life and wellbeing in the context of adversities such as material deprivation, widowhood and deterioration of mobility. It found evidence of resilience to adversity amongst older people in that people were able to avoid depressive symptoms, enjoy their lives and remain optimistic for the future. However, it also found that a complete recovery from intense adversities such as widowhood or loss of mobility is not easily attainable. Further analysis, putting together the findings with those from other major surveys, provides some insight into factors associated with resilience (Blane et al, 2011). The authors found that the likelihood of resilience reduced as the number of adversities increased. They concluded that resilience should not be a normative expectation of people at older ages.

Social relationships that pre-date adversity enhance resilience most, perhaps by creating continuity in lives. This suggests that policy makers should focus on the conditions of life of older people pre-adversity, which means all older people and not targeting those experiencing adversity, when it is likely to be too late. The authors note the contribution made by continuing part time employment and also free travel which enables people to maintain contacts.

Healthcare cost benefits of narrowing the life expectancy gap

Extending the period for which people live disability-free is a desirable goal for individual and collective quality of life. It also has cost implications. It has been pointed out that local estimations of costs, for example by PCTs in England, is based on models assuming that the costs of health care in certain age groups will be the same in the future as currently (allowing for inflation). However, it has been noted that such models ignore morbidity compression/ expansion and increased healthcare costs at the end of life (Caley & Sidhu, 2011). Caley and Sidhu took West Midlands regional healthcare cost projections to 2031 and remodelled them using three models. The first calculates average costs for adjusted future age bands based on current average costs. It thereby costs in an expansion of morbidity at the same rate as the increase in life expectancy and ignores costs increasing in proximity to death. For model 2 the authors assume that as life expectancy increases the age at which costs are incurred increases at the same rate, taking into account costs at proximity to death. This reduces age-related costs to bring them into line with their proximity to death. This implies also that morbidity is postponed to a point equivalent to the increase in life expectancy. Model 3 uses LE/ DFLE figures to model the actual relationship between increased life expectancy and increased disability-free life expectancy, where DFLE is less than LE. The results of this modelling illustrate both the need adequately to understand how increasing life expectancy drives costs so that they are not over-stated, and the potential healthcare cost dividend from compressing morbidity/ reducing disability. Applying the three models to their West Midlands data Caley and Sidhu projected increased costs due to an ageing population between 2006 and 2031 to be +27.98% with model 1, +12.07% with model 2 and +16.07% with model 3. The authors conclude that in order to compress morbidity heavy investment in preventative services is required to defer illness and disability to later in life. This Mental Health Foundation review proposes that mental health improvement and
promotion of mental wellbeing must be part of any prevention programme.

**Promoting mental health and wellbeing**

Promoting and improving people's quality of life and mental wellbeing is an important goal in itself; most people value a sense of emotional and social wellbeing (Friedli, 2009). The main dimensions of quality of life have been summarised as:

- Having an optimistic outlook and psychological wellbeing, especially in relation to making downward rather than unrealistic upward social comparisons;
- Having good physical health and functioning; having good social relationships, preventing loneliness and feeling helped and supported;
- Maintaining social roles, especially a large number of social activities, including voluntary work and having individual interests;
- Living in a neighbourhood with good community facilities and services, including access to affordable transport;
- Feeling safe in one's neighbourhood; having an adequate income and maintaining a sense of independence and control over one's life' (Bowling 2005, cited in Milne, 2009).

Good mental health makes an important contribution to overall quality of life. The components of positive mental health have been defined by the Foresight Mental Capital and Mental Wellbeing Project (Jenkins et al., 2008) as

- A positive sense of wellbeing;
- Individual resources including self-esteem, optimism and a sense of mastery and coherence;
- The ability to initiate, develop and sustain mutually satisfying personal relationships;
- Resilience, the ability to cope with adversity.

Mental health and physical health are closely interlinked and are both essential components of physical health. This inter-relatedness helps sustain healthier lifestyles, better physical health, improved recovery from illness, fewer limitations in daily living, and better social engagement and relationships. In order to improve mental health, both to make life better for people and to contribute to their physical health and reduced disability, as people grow older, the factors that contribute to good mental health and vulnerability for mental ill health need to be explored.

**Life events** have a significant effect on mental and physical health in later life. A life course approach maps the links between childhood circumstances and adult outcome (Friedli, 2009). Inequalities in childhood are shown to contribute to poor health in adulthood. Transition points such as redundancy, retirement and bereavement influence and are influenced by emotional, cognitive and social development. The mental resilience that people build up during their lives mediates the impact of adversity as they grow older.

**Financial resources** affect the choices people can make. Having a reasonable level of income and wealth has been shown to have a positive effect on mental health. Having low or uncertain income and living in poverty negatively impact mental health. Being poor is a risk for loneliness and harms people's ability to make choices, have freedom and control over life and be independent.

**Good living environments** including housing, transport, education, employment and accessible services contribute to good mental health. Retirement can be a risk to mental health.

**Bereavement and loss** have a negative effect on mental health. Around 10-20% of people experience ‘complicated grief’ especially with the death of a spouse which puts them at risk of experiencing depression.

**Loss of physical health** can reduce mental health particularly where this affects mobility and the ability to maintain previous activities and involvement.

**Social and family relationships** have been regularly shown to enhance mental health and wellbeing. Having close friends helps maintain morale, self-esteem and mastery and helps people feel secure and loved. Lack of social integration can reduce resources for dealing with stress and psychological problems. Evidence from the British Household Panel Study shows that people with low social support were far more likely to experience common mental illness and also less likely to recover.

**Living in a supportive community** also provides a sense of social support and belonging ad well as providing opportunities for citizenship and involvement in society.
Personal attributes such as self-esteem, the ability to deal with thoughts, feelings, and to manage life events, emotional resilience and the ability to take charge of one’s life and cope with stressful or adverse circumstances, and an optimistic outlook are all aspects of good mental health.

Fear is a significant threat to mental health – fear of financial insecurity, of war and crime, of compromised physical and mental health, and of a lack of appropriate support services.

Age discrimination is the most common form of prejudice experienced by older people.

Age stereotypes are based on mostly negative images of older people. Ageism has been defined as the ‘systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin colour and gender’ (Butler, 1969, cited by Calasanti, 2005). For Victor it is ‘an ideology which condones and sanctions the subordination and marginalisation of older people within society’ (Victor 2005, cited in Milne, 2009). Ageism contributes to feelings of worthlessness, despair and being non-deserving; it lowers self-esteem and expectations, limits access to services and underpins lack of respect shown to older people (Age Concern & University of Kent, 2005). Ageism thus reduces mental health in a number of ways; it undermines people’s personal self-esteem, reduces their access to services, and lowers their sense of engagement and participation. It puts people at risk of mental illness in the same way as other prejudices affect individuals. It is a question whether a generation of people whose lives have been shaped by the development and implementation of anti-discrimination legislation and the emergence of a national culture, built around ideas of cultural equality, will readily accept the imposition of this remaining prejudice. However, it is also reasonable to suggest that, because of the general change in attitudes during their lives, they might be more, rather than less, damaged by age discrimination and ageism.

Social care
People’s experiences of providing care, and their attitudes to their own possible future care needs, were discussed in the in-depth interviews. The web survey and the national YouGov survey also included questions about feelings around care and the future.

In the project’s sign-up web survey people were asked about their concerns for the future. Almost six out of ten said they were concerned about being able to have their future care needs met. Only about a quarter had no concerns. A number mentioned their responsibilities for others, for example, children with disabilities or health problems and their worries about them in the future. People were asked to describe their concerns and suggest what could help address them. Issues raised included the numbers of people who would be looking for help, the availability of care and what would be provided.

Concerns linked to care needs: web survey participants

‘The current state of the care of older people both at home and in hospital and what will be the case in 20/30 years’ time. People’s attitude to older people, particularly in the ‘care’ service. I have so many examples of relatives/friends who have been (and are) cared for with no consideration regarding dignity and respect.’

‘Not being recognised as a person of value, talked about rather than to; having poor health; having to go into a home; family bereavement; being alone and lonely.’

What would help:

‘Free residential care available’.

‘Being confident that I will be able to afford a good standard of care for our parents and then my husband and myself, if that becomes necessary’

‘Knowing that standards of care were good.’

‘Knowing my husband and I could get help to keep us in our own home.’

The national YouGov survey asked people to highlight their greatest concerns about getting older. For 40% loss of independence and needing care for daily needs was a main concern, with women more concerned than men (42%: 36%) and people in ABC1 social groups compared with those in C2DE (41%: 37%). Similar levels of concern about the potential need for care were expressed by all age groups with the greatest concern expressed by the oldest group, 1926-35 cohort, and the youngest, 1986-93.

The project’s in-depth interviews explored people’s views about their own possible future needs for help and the sort of help they would look for. Remaining independent featured strongly in their responses, together with the wish to remain responsible for their own decision making. People were also asked about their willingness to use their own finances for their care. While many hoped that members of their family would be there to help them, there was a general view that this was not something to be expected and, for
many, not something they wished to ‘burden’ others with. While their attitudes to healthcare are generally supportive of the NHS providing healthcare when needed, people’s attitudes to paying for social care were more flexible, with a majority recognising the need for personal contribution at some level. There was a strong awareness of pressures and limited availability of social care support.

Many people interviewed were, or had been, involved in providing care to a parent or parents (sometimes sequentially), supporting a parent providing care to another parent, or sharing care of parents with siblings or in-laws. In addition to caring for parents a number of interviewees also played an important role in caring for grandchildren. Patterns of care provided were varied. While some had experienced their parents entering public residential care, others had accessed private residential care. For many there had been a mixture of support, with significant amounts of self-funded care involved. In some cases their parents’ experiences had been difficult and had caused people to have concerns about the possibility of needing future care themselves.

Feelings about future care needs

‘Me personally, I wouldn’t like my family, if I was incontinent or had dementia, to have the bother of looking after me; I wouldn’t want them to have to run after me, I’d rather go into a nursing home’. Female, born 1955

‘My view is... I like my house very much. But I sort of set myself... by seventy-five if I’m still well, I must move from my house into ... some sort of supported living, rather than waiting for a crisis, I move.’ Female, born 1954

‘If I had to go into a care home, I hope it’s improved for the elderly by then y’know.’ Female, born 1955

‘Well my wife’s obviously a lot younger than me, so I presume she’d help me, or I hope she would help me.’ Male, born 1947

‘Just family, or families, I should say.’ Male, born 1953

On paying for care

‘I think I’ll have to pay for care because I don’t think you can necessarily rely on your family networks... I’d be paying for care to come in, or whatever.’ Female, born 1954

‘I think the situation we’ve got in Scotland is reasonably good. When you’ve worked all your life you expect something back, but I think it’s probably a balance’. Female, born 1949

‘There’s several of us that meet, I guess we might set up a semi-formal, semi-private day-care of our own... bringing our own models of collectivism of the sixties, when we did self-organise.’ Female, born 1950

‘We need to think how much taxation goes on things like defence ... we need to think what our priorities as a society are... I do pay for care, I think that if one’s realistic one has to do that’. Male, born 1955

‘I’m not eligible for public funding. There are two nations of older people, aren’t there?’ Female, born 1950.

Making future choices and decisions

‘I’d want to maintain as much independence for me as possible living in my own home with as much support as I would need .. without being taken into a home’. Male, born 1955

Feelings about future care needs (cont)

‘I’m quite independent but I suppose there’d probably get to a point where I’d be prepared to move to somewhere that was easier from the point of view of maintenance, getting about, that sort of thing. Female, born 1954.

‘It’s not at the top of my mind.’ Male, born 1951.

How they would want to be treated

‘We’d agree what they would do for whatever it would cost, not become emotionally dependent on them, as some are on their carers.’ Male, born 1948

‘With respect, like I’d give to anybody, treated as a person.’ Male, born 1947.
Social care and the baby boomers

Most social care that people need is carried out by family members. Increased longevity means increased pressure on family care as well as on social care services. In terms of care provision baby boomers have been described as a ‘sandwich generation’, responsible for the ongoing support of their own children and for their parents, as they live longer and public provision fails to keep up with growing care and support needs (Evandrou, 1997). The 2010 national survey of carers in households (NHS 2010) shows that:

Experiences of caring for older relatives

‘My gran, my father and I were looking after her. I couldn’t have done it without him; I was still working and so was he. We paid a neighbour’s daughter to come and sit with her during the day.’ Female, born 1955.

‘My father-in-law, we had a carer come in, then a live-in carer. We kept the carer after he died ‘cos my mother-in-law was showing signs of dementia. We decided she’d be better in a specialist home. My wife’s an only child... it was all a bit of a challenge’. Male, born 1953.

‘The emotional costs to my friends, who are in their sixties, who have ninety year old parents, have been enormous. Not happy experiences for the sixty year old or ninety year old; neither want to be in that position.’ Female, born 1951.

‘I think my mother is quite stressed from the strain of my father, who is in a state of pretty poor chronic health... I have three siblings and we all live close to my parents so, in effect the family all swarms around and sometimes you almost have a superabundance of help.’ Male, born 1950.

Experiences of caring for older relatives (cont)

‘Mum was in a bed and they were talking about discharge (from hospital) and the sister said, ‘your dad wouldn’t want to look after that’. I thought, good grief, that is a human being I love, it made me feel quite upset.’ Female, born 1954

‘They sent a social worker who was totally useless; they sent in another that was a religious nutter and a home help. The home help did her best, but they were using the home help to give her her tablets etcetera and the woman just couldn’t cope with it, she was just the cleaner.’ Female, born 1947

Effects on planning for own future

(Caring for my mother) .. if I’m brutally honest with myself, it’s turned me into an ostrich, the opposite of a planner. My sister and I did the absolute best we could, and part of us never thought it was good enough.’ Female, born 1951

‘What’s probably coloured my life is seeing the way my sister was treated.’ Female, born 1947

‘My in-laws were classic ‘don’t talk about it’ people. My wife couldn’t talk to them about the care issue at all, she had to make decisions. We have these discussions now .. what do you want to do if...?’ Male, born 1953

- Overall, 12% of people aged 16 or over in England were carers for a sick, disabled or elderly person, representing about 5 million adults and around 3 million households in England.
- The highest levels of caring were provided by baby boomers, aged 55–64; 18% were responsible for care, compared to around 7% of 16–34 year olds and 16% of 45–54 and 65–74 year olds.
- Overall, 21% of the people responsible for providing care were aged 55–64 (suggesting there are 1 million carers aged 55–64); 25% are aged 65+ and 21% 45–54.
- 55–64 year olds make up the highest proportion of people who provide care for someone in another household (27%), but are the least likely to be looking after someone in the same household (15%, compared to 32% of those aged 65+). They make up 23% of those who spend 20 hours or more caring per week, and 18% of those who spend 20 hours or more caring per week. Overall 57% of carers aged 55–64 care for less than 20 hours per week, 17% for 20 hours or more, and 25% care for 35 hours or more per week. This pattern indicates more baby boomers caring for parents not living with them and more people over 65 caring for a spouse or partner in the same home.
- Of carers aged 55–64 most cared for one person (80%), but 20% looked after 2 or more people. People aged between 45–64 were more likely to be caring for two or more people, (20%), compared to 17% of 16–44 year olds and 12% of those aged 65+.
- 33% of carers aged 55–64 are a sole carer (slightly lower than the average of 37%) and 66% are joint carers. They are most likely to be looking after a parent (41%), with a further 23% looking after a spouse or partner, 10% a friend or neighbour, 12% a parent in law, 6% a child and 7% another relative.

Lives lived: Health, mental health and social care
• Baby boomer carers were the most likely to anticipate an increase in caring over the next five years, with 71% believing this to be the case.

• 18% of carers aged 55-64 who looked after someone in the same household received Carers’ Allowance and 56% cared for someone who received Disability Living Allowance or Attendance Allowance. 91% of carers in this age group said they had not been offered a carers’ assessment.

The development of social care
The main policy developments in the provision of social care over recent decades have been aimed at increasing the choice and control that people exercise over the services they receive. Described as the ‘individualisation’ or ‘personalisation’ of services, these policies are seen to have a particular resonance with the consumerist attitudes of baby boomers. The wish to retain their independence and to be supported to maintain their ability to make decisions about their lives featured prominently in interviews.

Social care, provided by local authorities, is one of the products of the welfare state. Before the Second World War the only publicly funded social care for older and physically disabled people was through the Poor Law (Thane, 2009). However, much early post war provision continued to be delivered through the poor law institutions, with domiciliary services, aimed at supporting people in their homes, only being slowly developed. One of the failings of these institutional settings was the deprivation of individual identity experienced by their ‘inmates’ (Fine, 2012). Erving Goffman’s seminal study, Asylums, published in 1962 (Goffman, 1962), drew attention to the need of people entering such institutions to forgo their autonomy and sense of self. As a key text on most social studies courses of the period, Goffman’s work is likely to have shaped the perspectives of many baby boomers entering professional welfare services. Community care slowly replaced institutional or residential care, through the 1970s and 1980s, as a means of enabling people receiving care to sustain self-identity by remaining in their own homes, with their own possessions and daily routines (Fine, 2012). It also provided a means of cutting public spending and moving from public to private provision, in the 1980s (Thane, 2009). The provision of informal care, the unpaid work of family carers, has been behind the success of community care and there is substantial evidence about the impact that caring can have on a carer’s own wellbeing (Fine, 2012). Many baby boomers have been, and are, significant providers of community care.

Individualisation, the policy of creating tailored care to meet individual needs, has been a progression from community care. It has developed from a package of care tailored for a person towards a package tailored by a person. Personal budgets, cash-for-care, is the current method adopted to support a move to greater choice and control. The disability movement has been a main driver in the move to individual budgets. Established in the 1970s by disabled people, to campaign for inclusion in mainstream society, the movement sees its role as proactively redefining disability as a socially constructed phenomenon and acting against the barriers to inclusion. An analogy was drawn by its early activists to contemporary social movements, engaged in ‘participatory democratic struggles’ (Shakespeare, 1993). Control over their care resources, to enable them to define their own priorities and needs, has been a long term ambition of the movement. Choice is essential to the achievement of self-determination and citizenship (Morris, 2006). Independence refers to being able to take control and choose how life is to be led; it does not necessarily mean performing tasks for oneself. The Independent Living Fund, a social security fund, first made individual funding available to disabled people to employ helpers, in 1988 and in 1996, following further campaigning, social services departments across the UK, were enabled to make direct cash payments to working age adults, instead of providing services. The option was extended to older people and others in 2000, and offering a direct payment has been a requirement for social services departments since 2003. Individual Budgets (IBs), including funding from a number of different funding streams, were introduced in England in 2005 and in Scotland Self -Directed Support, including IBs, was promoted in 2006. IBs can be used to buy local authority, private sector and voluntary organisation services as well as support from family and friends, to meet people’s needs and preferred outcomes.

The introduction of ‘cash for care’ has been viewed from two perspectives: the creation of social care quasi-markets, and consumerism and choice (Glendinning, 2008). The increasing domination of service provision by provider interests, seen as unresponsive to user needs, and a view that competition between providers improves efficiency, quality and service responsiveness was an initial driver. The devolution of purchasing power from care managers to older people themselves was expected to give them power to help shape the social care market. A view that individual choice is a good thing in itself and that public services should more closely reflect individual circumstances, preferences and priorities, has been the second driver of change. The perspectives of the baby boomers, their
consumerism, liberalism and individualism, are seen to have shaped this. A number of arguments have been put forward to support choice (Glendinning, 2012). First, choice is argued to be fundamental to achieving citizenship, social inclusion and human rights: full citizenship involves the exercise of autonomy. Control is an important part of choice. Secondly, having choice and control are central to independence. For older people loss of decisional autonomy, the capacity to make decisions, has been linked to depression (Boyle, 2005, cited Glendinning) and enhancing control is identified as a protective factor for mental wellbeing (NHMDU, 2010). A third argument for choice and control is the redress it can provide to the vulnerability created by power inequalities between givers and receivers of care. Finally, choice and control over daily life are also seen as an outcome of social care, which contributes to independence and wellbeing.

Critiques of consumer models of social care have questioned whether theories and practices of the private consumption of goods and services (Clarke, et al., 2005, cited Glendinning). They have also pointed to the transfer of responsibility for prioritising and managing need, and the risks this may entail, from care managers to individual service users, where entitlement is measured in finite cash terms (Williamson, 2010). Findings from the IB pilot projects carried out in England between 2006 and 2008 (Moran et al., 2012) show that, overall, the older people who participated in the evaluation did not appear to benefit. Potential advantages, including greater choice and control, flexibility, respite and improved wellbeing and social participation were found. However issues around the practical and financial management of the budget, including the need to recruit staff, pay wages, tax and insurance and arrange holiday cover for a carer caused concerns. Access to information to support informed decision-making, is an essential precondition for the exercise of choice, including both insight into condition and needs and knowledge about what is available. Moran and colleagues note that an element of cultural change may be needed for the effective introduction of cash-for-care schemes; consumer choice may not come easily to people accustomed to deference to ‘expert’ welfare professionals. It seems reasonable to suggest that these same attitudes of deference will not be norm for the baby boomers.

Going beyond issues of practicality Glendinning (2012) makes a number of observations about the limits of consumerism in social care. She argues that the chronic illness and frailty associated with advanced age may create the need for ongoing change in services to meet changing and fluctuating needs; choice may only be appropriate if need is relatively permanent or predictable. In such situations choice can involve efforts that may be increasingly burdensome. Choice may also result in increasing inequalities if providers offer services that are differentiated by price and quality according to the resources, financial and personal, of the purchaser. Providers may also find ways to discourage ‘difficult’ clients and focus on those whose needs are more easily met. Choice is only possible if appropriate services are accessible. It is the use of market-style mechanisms for exercising choice that are seen to be problematic.

The marketization of social care services, in particular, the restructuring and contracting out of local authority services, has changed the working conditions of care staff. Competition has created more part-time and casual, insecure work; affordable care relies on using low skilled staff and paying low wages (Fine, 2012). This raises issues about how well the needs of people requiring care are being met, and also about the future availability of a skilled and reliable workforce. The concerns about meeting their future care, expressed by people interviewed for the project, reflect this very real issue. A 2010 inquiry into the home care of older people by the Equality and Human Rights Commission (Equality and Human Rights Commission, 2011) found that while around half of the older people, friends and family members who gave evidence to the inquiry expressed satisfaction with their home care some concerns were raised. Issues included, amongst other things, neglect because of time constraints, disregard of privacy and dignity, little attention to choice, patronising approaches, some physical abuse and rough handling and security issues caused by frequent changing of staff without warning. The EHRC notes that the majority of social care services are delivered by private sector agencies, either via contract with local authorities or directly with individuals through a mix of public and private funding. New online care marketing and brokerage services aimed at people purchasing social care with either individual budgets or private funds are also emerging and are outside the regulatory system. They expressed concern that human rights protection could fall between the gaps.
The concerns expressed by the EHRC and others highlight the importance of the care relationship. Fine (2012) writes that care requires a social relationship; the giving and receiving of care needs to be understood not as an impersonal product that is consumed by the recipient, but as a relational process in which the care-giver must also be recognised as an individual. He argues that the concept of individualisation is wrongly reduced to market-based consumer choice and an exploitative approach to care workers and to providers on unpaid care; meaningful individualisation has more to offer than the one-directional model of care provided to a passive recipient as cheaply as possible.

People who pay for care

One project interviewee referred to two nations of older people in terms of eligibility for state support for care needs. Eligibility for publicly funded social care is subject to an assessment of care needs and a means test of savings and incomes. A Royal Commission recommended in 1999 that nursing and personal care should be free. While free nursing care was introduced throughout the United Kingdom, free personal care was introduced only in Scotland.

Current estimates are that around 169,000 people in England pay for home care, projected to increase to some 250,000 by 2030, when members of the baby boomer population will be users of care. If a wider definition of support is applied, the numbers are around 272,000 in 2010 increasing to 400,000 by 2030 (The Institute of Public Care (IPC), 2011). Some 45% of people in care or nursing homes also currently pay for themselves. The home care market was worth an approximate £625 million in 2010 and the care home market some £5bn (IPC, 2011). Looking forward to the future, the IPC has produced an analysis of likely developments in the social care market that include more people paying for themselves or having personal budgets, more diverse roles performed by the care market, including more complex interventions, care homes being larger with fewer providers and the role of local authorities in delivering care being further reduced (IPC, 2010). A concern for the future is the likelihood of further public funding cuts leading to a reduction in personal budgets and requiring more people to support themselves. An ideal social care market for the future is held to be one where people using care, and their families, will contribute to local service commissioning and market development. This is the future in which baby boomers will be looking to meet their own support needs.

Social care – baby boomers and the future

Future social care pressures are a major government concern. The availability and quality of care to support them if they need care and support in later life, are of concern to many baby boomers who have seen the reduction in care options for their parents and followed public discussions about future affordability.

Projections are that the total number of older people using social care services, including residential and non-residential care, will increase, if they keep pace with demographic changes, from 2.0 million in 2010 to 3.2 million in 2030, an increase of around 60% over 20 years (Wittenberg et al., 2011). Numbers of people receiving non-residential formal services are projected to increase from 1.6 to 2.6 million, including an increase in numbers receiving local authority home care from 280,000 in 2010 to 480,000 in 2030. The numbers of older people in care homes (and long-stay hospital care) are projected to rise by 67%, from 345,000 in 2010 to 575,000 in 2030. Within this total the numbers of local authority supported residents are likely to rise by 40% in comparison with a rise of 106% in the numbers of privately funded residents, reflecting the increase in home ownership and non-eligibility for local authority services, if current policies continue. The number of people receiving informal care is projected to increase from 1.9 million in 2010 to over 3 million in 2030, with care from spouses or partners increasing more than from children. However, the amount of care provided by children will still need to increase by 50% to maintain current levels. The availability of this level of care by children is uncertain (Pickard et al., 2007). Many Project interviewees have expressed unwillingness to be future burdens on their children.

The Coalition government established a Commission on Funding of Care and Support (the Dilnot Commission), which reported in July 2011. The Commission made a number of recommendations which included the capping of individuals’ lifetime contributions towards their social care costs, which are currently potentially unlimited, with a cap between £25,000 and £50,000 (with £35,000 considered most appropriate). It also proposed increasing the asset threshold for residential care from £23,500 to £100,000 and the introduction of national eligibility criteria and portable assessments. The Care and Support Bill 2012 has reflected recommendations on assessment and eligibility criteria but includes no provision on Dilnot’s funding proposals. In January 2013 the Government confirmed that the Dilnot Commission proposals for a contributions cap for individuals would be implemented, but indicated that it was likely
to be set well above the proposed levels, at up to £75,000. Giving evidence to a House of Lords Select Committee (HoL Public Service and Demographic Change Committee, 9 January 2013), Ministers added that people should be able to take out insurance policies to pay for care. They said that proposals being developed with the financial services industry are likely to include options for people to be able to use part of their pension lump sums to buy insurance cover against long-term care costs. Ministers also said that ‘a lot more could be done on ‘trading down’ to release housing capital.

This chapter has concluded that baby boomers are no less likely than previous generations to experience a number of disabling and healthy life-limiting conditions. They are faced with reducing state options for social care and cost pressures on what is made available to people who do qualify for support. Many people will have difficult decisions to make in the future. One option to protect against future care home costs is to buy insurance cover. However, decisions to insure usually need to be made before age 70, and, at present, options are not well developed and uncertainty hangs over the purchase of cover. Planning ahead makes an important contribution to protecting mental health.

New approaches to care?
The question this review has asked throughout is ‘will baby boomers do things differently’ and how could this protect their mental health? The BBC screened a television programme, When I get older, in July 2012, in which actor Tony Robinson, born in 1946, stayed in a residential care home. At the end of his stay Robinson praised the quality of the home but added, “there must be something better than our present approach to care. They did it better in the Middle Ages, people were more incorporated in society”. He said, “the answers will arise as we begin to change our attitudes”: a new outlook could inspire new ideas. This is a challenge for baby boomers. The disability movement has shown the effectiveness of ‘citizen-led’ action for change; can baby boomers find new ways of sustaining independent living and meeting care needs if necessary? The International Longevity Centre has suggested that the care home could become a real ‘community hub’, by bringing it into the mainstream of community life and creating a more integrated society (Mason, 2012). Project interviews have found that some baby boomers are already beginning to think about different approaches, for example through co-operative and shared arrangements. Baby boomers have demonstrated a keenness to be in control. Can this lead to new patterns of choice? Can change be inclusive?

The 2012 Care and Support Bill makes clear government’s commitment to further marketisation of services. Baby boomers are likely to be more comfortable with, and able to use purchased support more effectively, than the current older population. Amid concerns about the quality of care, the challenge for baby boomers may be to define the care relationship; is it more than a purchased service, or is it just that?

Retaining independence and control over their lives is likely to be important to the mental wellbeing of the individualistic baby boomers. How and whether they develop new models may help protect their mental health.

Health and mental health – lives lived: the mental health risk / protection balance

This section examines the evidence collected in the chapter on the risk factors for mental illness and protective factors for mental health and wellbeing set out in chapter 3. The aim is to highlight areas where policy could be developed to promote mental health and mitigate the risk of mental illness.

Risk and protection factors

Health-related risk factors for experiencing mental illness in later life include:

- Chronic medical illnesses, pain and disability. People suffering from chronic illnesses such as diabetes, heart disease, stroke and chronic obstructive pulmonary disease are at risk of both sub-threshold and major depression. It is likely to be the loss of functional ability and restriction of activity associated with the disease that are the causes, rather than the disease itself. The effects of depression and chronic illness are interactive and cumulative and lead to increased disability and poor outcomes. Sudden onset illnesses such as heart attack and stroke may lead to anxiety disorders.

- Having low levels of physical activity is a risk factor for depressive symptoms.
• Organic brain disease: Dementia, stroke, Parkinson’s disease and cerebrovascular disease are all linked to higher prevalence of depressive symptoms.

• There is considerable evidence that caregiving is a risk factor for mental illness. The key factors are the loss of a carer’s own social networks, loss of leisure activity and duration of responsibilities.

• Fear, including fear of compromised physical and mental health and of lack of appropriate support services, is also a significant threat to mental health.

The evidence about the health of baby boomers is that despite the benefits of free health care throughout their lives, and of reduced mortality from the major killers of cardiovascular disease and cancer, baby boomers will be unlikely to experience significant improvements in healthy and disability-free life expectancy, relative to their overall life expectancy, in the future. Sedentary lives, poor diets and obesity, alcohol consumption and drug misuse leave them at risk of diabetes, high blood pressure and heart disease, and a number of cancers. These health risks are experienced unequally by the population, according to socio-economic group. Around a half of baby boomers in the project’s national survey were concerned about their future health.

In terms of mental health, there is some evidence of a ‘step change’ in the prevalence of mental illness among men born between 1950 and 1956, although women in this cohort did not experience the same increase. The increase is linked to experience of transition into adulthood at a time of rapid social change. This cohort will be entering a further potentially difficult life period in the future and may carry with them an increased vulnerability to mental ill health. Men in the cohort have also demonstrated recent increases in suicide rates, possibly linked to economic recession.

Alcohol and drug use have both been more socially accepted by baby boomers than by earlier cohorts. There are two aspects to their use in later life, continuation of existing habits, and the development of new patterns of misuse, perhaps in response to stresses of later life. Excessive use of both alcohol and drugs is linked to poor mental health as well as physical health issues. Social relationships can also be damaged. Both alcohol and drug use present possible mental health risks for baby boomers.

Evidence collected by the project shows baby boomers’ concerns about future loss of mental abilities but little awareness about protecting their mental wellbeing. Protection of cognitive abilities and early identification of dementia and other symptoms are important for effective treatment and to protection against depression and other mental ill health.

Projections on the future care needs and the role of spouses and partners in providing care indicate considerable future caring responsibilities for baby boomers. The availability of sufficient help from children is uncertain and public funding pressures look set to limit care available from local services. This presents a significant risk factor, both for people who will be providing care and those who will need it. There are also issues around quality of care.

Protection factors
Against the risks that have been identified there are a number of characteristics of baby boomers that may be protective, or which offer the opportunity for policy and practice development to promote mental health.

First, the project national survey showed that baby boomers rank the protection of both their health and mental health very highly (women significantly more so than men, perhaps leaving men at greater risk). They are more willing to visit their GP, including when feeling low or mentally distressed (women more so than men) and the evidence is that this age group is now taking more exercise and eating more fruit and vegetables. Interviews suggest that current public health messages about exercise and healthy eating have been heard and understood, if not always acted on.

They have a strong commitment to the role of the NHS in meeting their health needs, are likely to seek help when they need it and are also likely to be proactive in ensuring that services are available to meet their needs. The implementation of the Equality Act 2010 age discrimination provisions will help make services available according to need, which will mostly be beneficial. Continuing research is likely to improve available treatments, particularly for conditions which have been detected early. However, the project has also found that many baby boomers fear that the NHS, which has been around throughout their lives, might not always be there for them in the future and that enhanced treatment may be unattainable.

There is growing awareness that mental health and wellbeing are important in dealing with physical ill health and its potentially disabling
consequences. There is evidence that good mental health may help protect people from the onset of chronic, disabling health conditions and also reduce the disabling effects. This understanding of the relationship between mental and physical health offers opportunities for limiting the current and future effects of chronic conditions by protecting baby boomers’ mental wellbeing now. Mental wellbeing is enhanced by being physically active, spending time developing relationships, learning new skills, giving to others and being aware of oneself and the world around (NHS choices, Health A-Z, NHS website).

Much care takes place in the context of reciprocal relationships involving family, friends and neighbours. Such relationships give a sense of purpose and meaning to people’s lives and they get personal satisfaction from providing care and helping others. It is heavy caregiving, without the support of others, which can lead to stress for the caregiver. Baby boomers may be able to benefit from the growth of a market for social care and improved care consumption opportunities to provide the adaptive and flexible care they need, when they need it. There are also some first indications that baby boomers might do things differently in terms of how they control and organise their care, so that new models and approaches may emerge that are beneficial to mental wellbeing. Such models may include community hubs, co-operatives and inter-generational mutual arrangements.
In chapter four, the factors contributing to good mental health were defined as: a positive sense of wellbeing; individual resources including self-esteem, optimism and a sense of mastery and coherence; the ability to initiate, develop and sustain mutually satisfying personal relationships and resilience, the ability to cope with adversity. Self-esteem, good relationships with friends and family, supportive communities and networks, spiritual beliefs and personal coping attitudes all make a contribution. This chapter looks at the lives and relationships of the baby boomer group as they reach their sixties. To what extent do their lives and relationships put the baby boomers at risk of experiencing poor mental health, and how are they likely to meet the challenges of ageing in ways that could protect their mental wellbeing?

Survey findings
An often used quote in relation to this (and later) groups is that sixty is the new forty, that people’s views of what constitutes life phases has changed. The research for this study explored the definitions people use and the explanations they give in describing age and their own feelings about their age. The idea of belonging to a generation: what, if anything, it means to have been born in a certain period, was also investigated.

The findings demonstrate overall positive approaches to growing older that reflect wider research around age boundaries and self-perceived age. In-depth interviews explored intergenerational relationships and identities and current feelings about the world.

Questions of ageing identity are particularly important for the 1946-55 cohort which is often identified by its youthful identity as ‘the sixties generation’.

Old age and young age boundaries
The web survey was carried out with 127 people born 1946-1955 who signed up to the project website. It asked people about age boundaries, feelings about age, and age identities. Some comparisons are made with a Eurobarometer survey (Eurobarometer (EBS), 2012) on ‘active ageing’ carried out in the same time period with people over age 15:

Old age: The web survey asked at what age people generally start being old. The most common (modal) response was 70 years; the average was 64 years. The average age given in the EBS was 64 years and the UK response was 62 years. The web survey also asked people to say why they had made their age choice. Responses showed an interesting pattern of difference by age selected.

70 or above: The reasons mainly given were that people are living longer, are active and healthy longer but they begin to experience more physical problems at 70 (or 75, or 80). At 70 most people are also seen to be no longer working.

60/65: Two reasons dominated for choosing either 60 or 65; ‘official’ definitions and perception of appearance.
Why old age begins at 60/65 (selected age in brackets)

‘One becomes an OAP at 60 with a bus pass and eligible for concessions.’ (60)

‘Because traditionally that is the age when people retired and were seen as being ‘old’ and I think it’s stuck’. (65)

‘Because I am 60 and although I don’t feel or look it I am referred to as an ‘older person’ on official forms and the web etc.’ (60)

‘The face and body betray one as an older person.’ (60)

The only other reason given was general perceptions although one person also noted a transition to ‘old age’ mental health services at 65.

Why being young ends at 60/65 (selected age in brackets)

‘Then they become middle aged and society expects different things of them’. (60)

‘The average age that people become parents and house-owners has risen so many are enjoying the “freedom of youth” for longer’. (60)

‘Intuition rather than reason but probably because if you are thirty-anything you will consider yourself young. At forty you might question it’. (60)

50/55: Reasons for choosing 50 substantially related to perceptions and attitudes of others, the availability of age-related services and general feelings and experiences.

Why old age begins at 50/55 (selected age in brackets)

‘Because of descriptions in the media - news stories etc.’ (50)

‘Turning 50, there are more comments on the lines of ‘getting on a bit’. (50)

‘I work in the community and complete application forms and older people are described as 50+. I therefore believe it is the establishment making people old before their time’.

Why being young ends at 40/45 (selected age in brackets)

‘Media points to it all the time’. (40)

‘Peoples’ attitudes change towards you. The generation gap alters and suddenly you’re classed as being too old for lots of things’.

40: The smaller number choosing age 40 give a variety of reasons, mostly around ‘observation’ and perception.

40/45: The largest number of people chose this age range. References were made to being mature and having responsibilities and to no longer being able to be doing things that young people do. Some refer to middle age starting at 40.

Why old age begins at 40

‘Media points to it all the time’.

‘Peoples’ attitudes change towards you. The generation gap alters and suddenly you’re classed as being too old for lots of things’.

When young age ends: The most common (modal) response to this question was 40, the average 39. Reasons given on the whole had less specificity than those given for being old.

There was recognition by some that their own age and perspective from that age affected their views. The Eurobarometer Survey found that, on average, people said they were no longer young after 42 (UK average was 37).

40/45: The largest number of people chose this age range. References were made to being mature and having responsibilities and to no longer being able to be doing things that young people do. Some refer to middle age starting at 40.

Why being young ends at 40/45 (selected age in brackets)

‘Then they become middle aged and society expects different things of them’. (40)

‘The average age that people become parents and house-owners has risen so many are enjoying the “freedom of youth” for longer’. (40)

‘People appear to look young for longer, appear to be more active/adventurous and start families at a later age all of which seems to contribute’. (45)

‘Intuition rather than reason but probably because if you are thirty-anything you will consider yourself young. At forty you might question it’. (40)

50+: Just under a quarter of people selected age 50 or above as the age when people stop being described as young. In many explanations there is a reference to starting middle age, but in others there seems to be a transition from young to old.

Why being young ends after 50 (selected age in brackets)

‘Because 50 is now the new 40. People do not act old like they used to’. (50)

‘Because it’s kind of ‘the middle’ of one’s life’. (50)

‘People aren’t young but also not old’. (55)

‘To me it feels as if people no longer think of themselves as young once they reach 50’. (50)

50+: Just under a quarter of people selected age 50 or above as the age when people stop being described as young. In many explanations there is a reference to starting middle age, but in others there seems to be a transition from young to old.
30/35: People identifying the end of youth in the 30s linked their choice to the age of having greater responsibility and maturity and also to general perceptions and views, including those held by people this age.

Why being young ends at 30/35 (selected age in brackets)

‘People start settling down and having children once they get to their 30s’, (30)

‘Just my impression - how people talk about others, how people are portrayed in media and film’. (30)

‘Because this seems to be an age where they start to behave with greater responsibility’. (35)

20s: Few people thought young age ended below 30. Those who did often compared the 20s to the teen years: ‘Before that age they are gaining initial experiences of growing up and coping with the world’. (21)

Feelings about age

Feelings about age were explored in the web survey through four questions: preferred versus actual age; thinking about life in terms of time lived or time still to live, the advantages/disadvantages of their current age and whether participants felt they were part of a generation.

Preferred Age: The survey asked people for their actual age and preferred age. Almost half said they were comfortable with their current age: most described themselves as ‘happy’, others referred to work or family satisfaction and some saw no point in wishing to be a different age.

‘I’m happy at this age, having experience of life and relatively good health’.

‘There will always be things you wish you could go back & change, but I don’t waste time wishing for what I can’t have. No-one can turn clock back’.

For those wishing to go back to a younger age, their 30s were the preferred choice, followed by their 40s. Reasons reflect largely a wish for experience but more time still to do things. Some regarded this age as their best time or the age that reflected most how they feel about themselves. Others referred to their family life, especially having children.

‘Some achievements in career and a parent role but also a lot of time ahead’. (30)

‘I had so much future ahead of me and I often feel that age in my head’. (35)

‘Old enough to have experienced a bit of life but young enough to be enjoying life to the full’. (37)

‘I was healthier and more active, and I feel 45 on the inside - in terms of my attitudes and interests’. (45)

‘Established, but still lots of career time left’. (40)

Others looked back further to their teens and 20s, with a greater focus on living life again - mostly with the value of hindsight.

‘I would be starting out again, and if I knew what I know now, would no doubt make many different decisions that would see me take a somewhat different course with my life’. (18)

‘Because I enjoyed the year when I was 25 and in my head I am still that person’. (25)

‘Everything was possible’. (27)

Time lived or time still to live: A choice was offered between ‘think about life mostly in terms of the amount of time you have lived’ or ‘think about life in terms of the time you think you have left’. The split between the two was approximately 40:60. There does not appear to be a link between people’s orientation on this question and their preferred age.

The disadvantages/ advantages of being your age: The disadvantages of their age most frequently identified by survey participants were having less time ahead, physical and health effects and less energy. Other themes include work and career related issues, attitudes of others and keeping up with technology.
‘My knees are going! Invisible. Can’t run for the bus’

‘Health problems, other people thinking I’m too old to do things’

‘How perceptions of other people change because of my age’

‘Energy levels are going, I cannot do physical things I could do 10 years ago’

‘It would be almost impossible to get another job if I wanted to. Keeping up with information technology’

‘Time is limited’

In the in-depth interviews people were also asked about their views of being older when they were younger, any changes in their self-identity and the attitudes of others to them, and how they feel about themselves as they grow older. In terms of ideas about their younger selves’ perceptions of being old, many said they had no views. Some see older people as a source of knowledge and experience; for others, particularly where grandparents had played an important role, old age was seen as a source of values.

For a number, however, it represented a cutting off stage from younger life.

The advantages of being their age that were most identified included experience and wisdom, confidence in themselves, freedom and time to make choices, and fewer responsibilities.

‘Experience of life and how to cope with its problems and successes’

‘I am more confident and have adequate income, no mortgage and a loving family’

‘The freedom to pursue my interests and to avoid the stresses of working life’

‘Time to enjoy my life without financial worries of bringing up a young family’

‘Gained more confidence with age’

Previous generations’ influence on views of being older

‘I’ve never thought that old people were fuddy-duddies and I wasn’t going to have anything to do with them and they got in the way, I never felt that. So I think I’ve always been glad that there were older people with experience. We had a maths teacher at school who was 60 odd when he left school and he was just wonderful.’ Male, born 1949

‘I think it’s the fact that (my parents) were brought up to think that they were old once they were past 40 and their attitude to life was you reached a certain age and you only did certain things.’ Female, born 1947

‘You can remember what your mum and dad were like, you can look at them and think, I didn’t like that part, but sometimes you get dragged into being similar.’ Male, born 1953

‘I think it’s a lot easier for me than it was for my dad at my age.’ Male, born 1946

‘I always had the sense that being older gave you greater freedom. I was quite close to my grandmother... she never pulled her punches; she would say what she felt.’ Female, born 1951

‘I’ve never been someone to look too far into the future... I’ve never been particularly exposed to old age’. Male, born 1953

Ageing identities

None of the people interviewed identified themselves as old in terms of their inner identity, although there was general recognition of changes in appearance and limitations in activity. In terms of how other people treat them as older people, a number said that they noticed negative differences, others felt more positive and some had not noticed any change. On the whole women were more likely than men to experience changes in behaviour.
Attitudes of others linked to age

‘I just feel the way I felt when I was girl; you feel the same inside. But I suppose it’s when you begin to look old.’ Female, born 1952

‘Well I refuse to get upset about wrinkles; I think wrinkles have been earned. I find it difficult to tell how old people are… it’s about all age groups not wanting to age at all.’ Female, born 1949

‘Society treats you differently don’t they? They just see an old face, you’re stigmatised.’ Female, born 1951

‘I still feel I’m in my forties. Because my hair is grey I get regarded as older. I was walking round to my car and there were some kids kicking a ball around. One said to the other, hey don’t hit that old man. I looked for the old man and realised it was me.’ Male, born 1950

‘There is a thing about old being negative and young being positive; I suppose that will always be there.’ Female, born 1955

‘I’m definitely slowing down; I could do twenty press-ups like that. I could do two or three now’. But people don’t treat me differently because I’m always trying to keep up with everybody else.’ Male, born 1947

The YouGov national survey asked people if they felt they considered themselves to be part of an ‘older generation’. Around 58% of the 1946-1955 cohort said they did. There was 7 percentage points difference between the views of men and women (Men 62%, women 55%). This age group does appear from this survey question to be a watershed age for views about belonging to an older generation: only a third (33% of people) aged 45-54 agreed that they were part of an older generation and around 80% of those aged 65-74. Perhaps surprisingly, ten per cent of 18-24 year olds also identified themselves this way.

Similarity to parents – values

‘My mum and dad have been a really good role model, I think, around resilience, hard work. You’re lucky so you have to give something back. My kids are a bit more cynical.’ Female, born 1951

I think I’ve had the educational and work opportunities to broaden my mind more than my parents.’ Female, born 1954

‘I was brought up to do the best for myself and that your solidarity with others was important… You can do more together. My children have grown up in a more consumerist society; I think some of my attitudes and values are mirrored by my children but they apply them differently; my son’s more sceptical than I am.

Female, born 1949

‘I think I’m different to both. Certainly not like my parents… and I think my daughter’s generation are more fatalistic than our generation was.’  
Female, born 1951

People were asked how in touch they felt with the modern world and modern ideas. The majority immediately related the question to technology, and in particular social media to which many had less than positive feelings. In terms of the wider world people did not seem to have distanced themselves from current events and culture, including using IT for everyday, practical purposes.

Attitudes – looking back and looking forwards

As people get older they may look back nostalgically to their youth or childhood, negatively compare the present day with previous times, and be pessimistic about the future. These life attitudes may extend into negative views of younger generations. The in-depth interviews explored some aspects of life attitudes by asking people about their values and approaches to life and the extent to which they felt they share their parent’s perspectives and/or their children’s/ younger people’s. The pattern that came across most strongly was of differences between people of successive generations but at the same time a great deal of continuity and overlap was reported reflecting bridges across generations.
In touch with the modern world

‘Oh no, no, no… I mean I’m very keen on new technology, just bought an iPad... lots of the things you do you use technology. I do feel out of touch with some music... but I feel pretty switched on to most things that are happening.’ Female, born 1950

‘I suppose it is more like things like Facebook... I can’t be bothered with that or Twitter. I can’t see the point of that at all, (my children) their life revolves around Facebook and Twitter, they think it’s vital.’ Female, born 1950

‘I think I keep up to date. I like to think I keep my finger on the pulse and have an opinion as well about the world.’ Female, born 1954

Looking back over their lives and forward to the future, people were asked whether things had got better, worse or stayed about the same and what they thought about the future direction of change. Most were fairly positive about progress from the past, but for many different reasons, including better social lives, improved economic wellbeing, post war peace, science, technology and medicine, working lives and social attitudes. Looking forward to the future attitudes were split, with those whose focus was on the economic and social and the opportunities of younger generations being more negative than those who focused on scientific and technical change. Current economic and political change, including the recession and Middle East political movements, strongly affected many views about the future.

Their overall optimism about the future was shared by the respondents to the web survey. Family and friends, positive attitudes, religious belief and the ability to be active and engaged, made people positive for the future. The state of the economy, prospects of future generations, financial concerns and possible loneliness were cited as reasons for feeling less optimistic. As part of a question about concerns for the future almost six out of ten (57%) said that they were concerned about the negative attitudes to older people that might affect them in the future and only 12% agreed that older people are valued in our society. These fears about how they might be treated are likely to have a negative effect on people’s feelings about getting older.

Finally, interviewees were asked to draw on their own life experiences to offer advice to younger people, in their twenties or thirties. This was a question that most people had not thought about before but to which all gave serious consideration and clear, concise and optimistic answers. Themes included valuing friends, family and other people in general, respecting others, taking opportunities and making well thought through decisions, valuing what you have and giving something back.

Advice to younger people

‘It’s not all about money. Happiness is about being with people you like, doing things you like.’ Female, born 1949

‘Listen and look. Think a lot about the decision you’re going to make.’ Male, born 1953

‘If you don’t look after others, have an ethic of inclusivity, equality or whatever it’ll come back and bite you.’ Female, born 1950

‘Getting yourself a good education.’ Female, born 1954

‘Work hard; respect people and keep your family close to you.’ Male, born 1946

‘Do what you want to do.’ Female, born 1954

Overall, the interviews showed the baby boomers to have a positive attitude to life that placed them firmly in the present day. On intergenerational attitudes many acknowledged what they had inherited from their parents and reflected on the extent to which it had been passed on to their children or a younger generation. The current economic situation clearly affected people’s views. Many expressed concern about opportunities for younger generations and compared their chances to their own. Their concerns were also reflected in their views about the world looking forward. Whilst the positive backward looking attitude of most was reflected in their view of the future by some others were much more pessimistic or uncertain about progress in the future. However, these concerns about the world did not seem to influence attitudes about their own futures: most were ‘happy to be getting on with life’. Finally whilst the word respect was used in the context of advice to younger generations it carried a notion of equality rather than hierarchy, much of the advice passed on was about how to treat others and how to optimise opportunities.
Other writers have seen the baby boomers as a bridging generation, showing the imprint of their parents’ attitudes but also being part of a modern world that is different to their parents’ (Biggs et al., 2007b). This perspective is reflected in the interviews. This earlier research identified a ‘youthful’ self and a ‘mature’ self, with maturity being reflected in an orientation towards time left and feeling comfortable with current age, as against youth in terms of feeling younger than their physical age. The research for this review also found evidence of the mature identity and a generally positive relationship with younger groups, rather than seeing them as ‘different’. Here too there was little identification with older people, who were generally seen as a group to be cared for and helped rather than as a wider peer group. While this study has been qualitative and has limitations in generalisability, it suggests that baby boomers have self-identity that has assimilated the changes of getting older without become ‘old’. This may have positive implications in terms of the internalisation of negative stereotypes, but may also possibly have an effect on people’s willingness to make plans for the future experiences or information, such as older age, physical changes or negative discriminatory experiences.

There is a range of evidence supporting the link between age and mental wellbeing. The English Longitudinal Study of Ageing (ELSA) looked at the health effects of perceptions of old age and growing older (Demakakos et al., 2006). It took three measures: experiences and perceptions of ageing, self-perceived and desired ages and perceptions of chronological boundaries of middle and old age. The researchers concluded that ageing is on the whole a positive experience (although the younger, baby boom group were less likely to rate it positively). Across all groups in the study most people did not think of themselves as old and the majority felt younger than their actual age. Healthier participants were more likely to say that old age starts later and those who felt younger than their age had better self-perceived health than others. However, a majority would prefer to be younger than their actual age and this group had worse self-perceived health than those who preferred their actual age.

Some other research has shown a relationship between feeling younger than actual age and increased levels of life satisfaction, in the US (Westerhoff & Barrett, 2005) and that feeling older is associated with lower psychological wellbeing among people with less favourable attitudes towards ageing (Mock & Eibach, 2011). It is also suggested that older peoples’ internalised age stereotypes contribute to their self-perceptions of ageing, which in turn can have a physiological outcome (Levy et al., 2002). These researchers found that older people with more positive self-perceptions of ageing lived longer than those with less positive self-perceptions. Finally research by Schafer and Shippee (2010) has found that people’s age identity plays an important role in cognitive ageing. They showed how people with younger age identities were more optimistic about their ability to maintain memory and other aspects of cognitive ability, regardless of their objective age, although the results were more significant for women.

Research has confirmed how important attitude to ageing is for the course of development in later life. This highlights the significance of tackling age discrimination and ageism, with their negative stereotypes, and promoting positive attitudes about age among younger people. While the attitude of baby boomers may support this development of better intergenerational relations and shared perspectives, current negative popular attitudes will work in the opposite direction and harm the future wellbeing of young, middle-aged and old.

Age and generational identity
The issue of identity is important as baby boomers grow older. We live in a youth-orientated society that holds a range of negative stereotypes about older people and the ageing process (Sneed & Whittington, 2005). People use age as a way of inferring other people’s abilities, competence, skills, experience and even health status. Ageism permeates the way people react to people’s appearance, the use of language and imagery as well as employment and access to healthcare (Abrams et al., 2009). As Abrams and colleagues point out, Government policy tends to fixate on physical age-related decline despite the absence of evidence about ‘linear links between ageing and declining health and capability’. Older people themselves internalise the negative stereotypes created, which, evidence shows, can themselves have an effect on capability. Yet despite the stereotypes and discrimination most people retain a positive sense of themselves as they grow older. Psychologists suggest a number of mechanisms for coping which largely fall into two groups: those which emphasise a person’s control over their environment and those which focus on how people negotiate challenges to their ‘self’ (Sneed & Whitbourne, 2005). The concept of identity assimilation is proposed as a mechanism that older adults employ as a route to positive mental health. This involves the interpretation of factors that are relevant to self-identity in terms of existing self-identity to maintain a sense of consistency, even in the face of discrepant
**Identity and appearance**

Much has been written about the extent to which the commitment to a youthful appearance by baby boomers will lead to greater use of cosmetic surgery and other cosmetic aids. However, in their advice to the industry Mintel noted “older adults are more accepting of the faults in their appearance and are less likely to have had surgery or to consider having surgery” (Mintel, 2010). In fact just 2% of women and 1% of men in the UK have ever had cosmetic surgery; people are more likely to try exercising, beauty treatments and figure-enhancing clothes before ‘going under the knife’. Mintel observe that surgery is more appealing to younger adults: almost six in ten 16-24 year olds would like surgery compared to three in ten over 55 year olds. However, ‘mature beauty’ and the market for hair care, skincare and colour cosmetics is identified as a growing market, with opportunities for brands to launch targeted products. The impact of the ageing population with increasing income levels has already, says Mintel, contributed to an increased market for vitamins, minerals and supplements. The assessments are that the baby boomers focus is on health and that youthfulness is associated with health.

**Families and relationships**

Their families and the relationships they had built were the greatest source of life satisfaction for large numbers of project interviewees. This was true even where people had divorced but had succeeded in maintaining family relationships under pressure. However, a number also reflected on difficulties maintaining long term relationships, or their feelings after the loss of a partner.

**Feelings about relationships**

‘I think my relationships with my partners and marriage. Obviously we grew apart; for whatever reason people don’t want to be with you... but the relationships continue.’ Male, born 1953

‘I’ve got... six grandbairns who I absolutely idolise. Spending time with them .. we’re all very close-knit.’ Male, born 1946

‘I think it’s being an extended happy family.’ Female, born 1951

‘I’m not married, I have a disability... I was told that if people with (my condition) were responsible, we wouldn’t have children. Things are different now, with genetic counselling.’ Male, born 1955

There is a substantial body of evidence showing that that married people fare better than people who have never married on a variety of dimensions, including happiness and psychological wellbeing, life satisfaction, physical health and life expectancy. Research has also shown that married people are less likely to experience depression. Widowed and divorced people have been found to show higher rates than single and married people for a range of mental disorders (Bebbington, 2007).

The 1960s and 1970s saw the introduction of a range of social reforms affecting relationships, including legislation on abortion, divorce, homosexuality and the introduction of the contraceptive pill. These have all had a major effect on the lives of baby boomers, particularly in comparison with older groups, and also made an enormous contribution to social change in family relationships.

**Marriage**

The ELSA sample provides information about the marital status of the 1946-1955 cohort although the age range breakdown is not an exact match (Gjonca et al., 2006). Figures used relate to people who were aged 52-59 in 2004-05. Of this sample around 60% were married and in their first and only marriage, some 15% of men and 12% of women were remarried and around 13% of men and 18% of women were separated or divorced. Just under 8% of men and 4.5% of women had never married. Widowhood is low amongst men but increases to almost 7% in women aged 55-59. Comparisons with older age groups are difficult because of increasing widowhood with age. However the ratio of remarriage to first and only marriage was around 1:4 for men aged 52-54 and shows a gradient to 1: 8 in men aged 75-79. In women the figures are similar: 1:5 for women aged 52-54 and 1:10 for women aged 70-74.

The ELSA study looked at marital status and wealth (Gjonca et al., 2006). Being single and separated/divorced are risk factors for poor mental health and risk of mental illness. The ELSA analysis demonstrates that poverty, a further risk factor for poor mental health, is linked to marital status. People aged 52-59 in the poorest quintile are almost twice as likely as average (they comprise around 39% of those never married compared to the predicted 20%) to be never married, and those in the wealthiest quintile half as likely (9%). In terms of divorce and separation, 45.8% of divorced and separated people were in the poorest quintile and 4.6% in the richest quintile. 43.3% of widowed people in this group are also in the poorest quintile. While much of this difference is an effect of household wealth measurement, where
wealth is likely to drop after separation and widowhood, and there is combined wealth of couples, the ELSA authors suggest that people with accumulated wealth may be able to sustain health and marriage better, and that people of higher socio-economic status are selected into marriage and remarriage. ELSA data show that, for men but not for women, high educational qualifications and working in a managerial or professional occupation are linked to being married or cohabiting. Women in intermediate employment roles had the highest marriage rates.

The 1946-1950 cohort married young and had the highest marriage rates in the twentieth century Kiernan et al. 1985, cited Evandrou, 1997). Marriage rates reached a post war peak in 1972 and began to fall in the mid-1970s (Haskey, 2000). Divorce rates almost trebled in the 1960s and doubled again between 1970 and 1972 when divorce reform came into effect. The age of divorce fell, reflecting the lower marriage age and marriages ended in divorce after much shorter durations. Almost one in three marriages made in the second half of the 1970s ended in divorce and around one in four children born in 1979 had experienced divorce of parents before reaching 16. Rates of remarriage were high – replacing one family with another. By age 40 more than a quarter of people born between 1946 and 1950 had divorced. Divorce and remarriage has thus been a fact of life for baby boomers. There has been a trend for increasing rates between cohorts. In 2008 45% of marriages were projected to end in divorce, half before the tenth anniversary; people with a previous divorce are more likely to divorce again. Proportions remarrying have been falling and those cohabiting increasing, although the proportion of the 1946-55 cohort is low (Gjonca, 2006). Over the past decade there has been a rise in the numbers of people aged 50-59 and aged 60 or over divorcing, with a peak in 2004. One divorce lawyer commented that most of the so-called silver splitters that his firm has dealt with - more than 80 in the last year - were prompted by husbands taking up with other, often younger, women (Guardian, March 2009). Other factors considered to be contributing to the increase include empty nest syndrome when children have left home, and the greater demands people are now placing on relationships.

The 1946 birth cohort (National Survey of Health and Development) has been used to explore the effects of divorce among participants, at the age of 43 (Richards et al., 1997). Researchers concluded that divorce and separation were associated with increased anxiety and depression, and increased risk of alcohol abuse (where there was low frequency of contact with family and friends). Associations between divorce and mental illness were found even where the divorced person was remarried or reunited with their spouses. Effects were concluded to be long term. Further research, involving baby boomers and older subjects (age 55-74), in Australia (Gray et al., 2010), found that both men and women who remained single after their divorce had significantly lower levels of perceived social support, while there was little difference overall between those that had divorced and remarried and those that had remained married.

Analysis of levels of satisfaction regarding certain aspects of life (such as health, financial situation, home, neighbourhood, feeling safe, feeling part of their community, and the amount of free time they enjoyed) uncovered lower satisfaction with life overall for both women and men who had divorced and remained single. Women who had divorced but remarried scored less on life satisfaction ratings than women who had remained married and men who had divorced and remarried.

On a scale measuring three aspects of health - general health, vitality and mental health - a history of divorce appeared to have no effect on men's health. Divorced single women on the other hand, reported lower levels of vitality and physical and mental health than those who had remarried or who had never divorced. Divorced single men were significantly more likely to report getting together with friends and relatives at least once a week than men who were divorced and remarried, or married and never divorced. However, for women, those who had been divorced and had remarried were significantly less likely to be an active member of a sporting, hobby or community-based club, or to spend time in voluntary or charity work, than those who remained single and those who remained married.

The researchers identified, as an outcome, a need for policy-makers to develop policy relevant to a growing population of older Australians, and more commonly older women, with particular vulnerability to social isolation, physical and mental ill health and financial insecurity. These recommendations are also relevant to the UK.

There is a range of wider evidence, mostly from the US to show that married people have an advantage in terms of both health and longevity (Harper, 2004). Not having a spouse has been identified as a critical factor linked to death.
Cohabitation
Cohabitation has been an issue of interest to policymakers, with a suggestion that changing attitudes from the 1960s are responsible for its increase. People cohabitation either as part of a long term commitment, often before marrying, or as a series of relationships. In the 1960s fewer than one in a hundred people cohabited, by 1986 11% of men and 13% of women aged 16-59 were cohabiting and by 2007 it was 27% and 28% respectively. The numbers of unmarried people in the 1946-1955 baby boom cohort cohabiting in 2004-05 (Gjonca et al, 2006) was around 7% of men and 6% of women, mostly divorced or separated. The authors identify cohort differences in the frequency of cohabitation, with older cohorts less likely to cohabit.

This leaves some 16% of men and 22% of women living without a partner, mostly divorced or separated. Some 13% of both men and women live on their own; however men with high level educational qualifications are only half as likely as those with no qualifications to be living alone (9.5%;18.7%) (Gjonca and Calderwood, 2004). This growing number of lone people is important for the future older population. The number of households comprising just one person is expected to rise from 21.7m to 27.5m by 2033 (Department of Communities and Local Government, 2010). Two thirds of the increase will be people over 65.

Children
Around 75% of men in the 52-59 age band have natural children and around 11.5% have stepchildren, while around 82% of women have natural children and some 8% step children (Gjonca et al, 2006). For both men and women these trends are reflected in the 60-69 age groups, it is only among people aged over 70 that the proportion with stepchildren falls. The higher level of stepchildren among men reflects their remarriage into families with children more than women. Overall six per cent of baby boomers’ children are step children of married couples and seven per cent step children of cohabiting couples. The change between generations is shown by comparison with the baby boomer group’s own childhood experience: 89% lived for most of their lives with both parents, six per cent lived with one parent and barely three per cent were stepchildren (Gjonca and Calderwood, 2004). Among those having children, the most common number of children was two.

Baby boomers, particularly the older members of the cohort, had children at young ages. More than 60% had had a first child by age 25, eight out of ten by 30 and almost 90% by age 35. In 1977, ten per cent of births were outside marriage, double the level at the end of the war (and rising to 38% in 2000) and five per cent of the 1946-1955 cohort were lone parents at age 30. This increased to 12% for women born 1961-65. This marks a further trend, lone parenthood, held to be linked to 1960s changes in attitudes that reduced the stigma of illegitimacy. However, lone parenthood has not been a significant characteristic of this baby boomer group.

Living alone
National statistics (ONS, 2012f) for the UK on household numbers add information about people’s living arrangements, and projections suggest what is likely to happen in the future. There is a national trend towards people living in smaller households; 29% of people now live on their own, increasing from 27.8% (an increase of one million people) in 1996 and 17.7% in 1971. People aged 45-64 living alone were responsible for much of this increase in numbers; in 1996 1.59 million people of this age lived alone, in 2012 it is 2.42 million. The population numbers of the baby boom (aged 45-64) account for some of this increase. However, underlying factors identified by ONS are a reduction in the proportion in this age group who are married, from 79% in 1996 to 69% in 2012 and an increase in those never married, or divorced from 16% to 28%. Men made up more than half of those living alone (59%) and their numbers have increased at a greater rate.

Looking to the future, the numbers of baby boomers living alone is set to increase further. Over the next twenty-five years, it is estimated that two-thirds of the increase in numbers of households in England will be people living alone and one third of all of these will be over 65 (Department of Communities and Local Government, 2010). In Scotland, one person households are set to increase from 37% of the total to 45%, with numbers of women over 65 living alone set to grow by 50% and men by 90% (National Records of Scotland, 2012).

The increase in 45-64 year olds living alone has been seen by the popular press as an increase in lonely baby boomers for whom, ‘sexual freedom and serial relationships have ended in a life of no relationships’ (Daily Mail, 2012). Such reports reflect the potential risks that changing relationships may pose for the future mental health and wellbeing of baby boomers.

New relationships
A decline of the family, as evidenced by increasing divorce and more recently, cohabitation trends, has been cited as evidence of destabilisation and moral decline. If marriage and family life provide a range of
supports to people, including protection of mental health, then current trends hold a range of threats to wellbeing.

A different perspective focuses on new types of family relationships built around emotional communication or intimacy (Giddens, 1999). Family life has been transformed by the rise of couples and ‘coupledom’; marriage and the family are still called the same but their basic character has changed, with the couple, married or unmarried, at the core of what defines a family. This contrasts with the traditional family, which was an economic unit with intrinsic inequality of men and women. Key changes have included the increasing role of women in paid work, the growth of romantic love as the basis for marriage, and effective contraception which has allowed the separation of sexuality from reproduction. Emotional communication is, for Giddens, replacing the ties that used to bind people’s personal lives, in couple relations, parent-child relations and in friendship. Having children is a distinct and specific decision guided by psychological and emotional needs. Good relationships are about equals and respect and the acceptance of obligations, particularly towards children. This change in relationships between couples has also been described as a relationship of individuals and equals, which allows both men and women room for self-development and commitment. Intimate relationships may be more difficult and open to negotiation (Lewis, 2001).

Changes in the fundamental relationship of marriage may mean that couples are more able to provide intimate and emotional support to each other, particularly as they experience stresses. However, it may also result in greater expectations that cannot be met and further pressure on relationships later in life. It has been suggested that people with similar levels of psychological health marry and that, after the marriage, the quality of the relationship contributes to changes in the psychological health of both and, in turn, the relationship (Kotler, 1988).

**Support and care**

Changing family structures and relationships have raised a number of issues about future support and care relationships. Divorce raises the question of support by children in later life. The contingent nature of step parenting has been contrasted to the ‘diffuse, enduring solidarity’ of blood relationships (Allan et al 1999), raising issues about step children as carers for step parents. However, some research in the UK among the 1924-33 and 1937-46 cohorts found that relationship breakdown did not have the detrimental effects that might have been expected (Glaser, 2007), although numbers and impact are greater for baby boomers than for these previous cohorts.

Many people interviewed for the project talked of positive relationships with some or all of their children, including those now living with a previous partner. Relationships were, for many, different to those they had with their own parents. Only a minority felt that they should expect their children to provide care for them, if they needed it in the future.

Looking forward to the future around three-quarters of web survey participants consider they will have friends and family who will give them support in the future. Around four in ten people in the YouGov survey said that spending more time with their partner and family was one of the top three things they looked forward to when they were older.

Wider family relationships also contribute to support and belonging, particularly as marriages become less enduring. Siblings, in particular may provide close support or provide links to access wider extended families. Around 9 in 10 people aged 50 -59 had a living sibling. (Gjonca & Calderwood, 2004)

The baby boomers have lived their adult lives in family relationships that are different in many ways to those of their childhood. Families have continued to evolve and change and their children are entering into relationships that are different to their own, including later marriages, fewer children and later childbirth, the increase in cohabitation and family reconstitution creating more extended ‘step’ families, as well as the growth of lone parenthood. The ‘beanpole’ family of two or three generations is commonplace and many of the baby boom group are still balancing caring for parents and supporting grown-up children. Regularity of contact by children with parents over 65 fell between the 1960s and 1990s, reflecting the contact of the baby boom group amongst others, with their own parents. However, it seems probable that this level of face-to-face contact has now stabilised and that contact has a broader definition, including use of email and social media.

**Friends**

Friendship complements family in providing support for people. A growing body of evidence recognises the role that informal personal relationships can play in preventing and reducing health problems and the importance of lack of ties as explanatory variables for depression (Spencer and Pahl, 2006).
Different friendship patterns were important for people interviewed for the project and reflect the multiplicity of relationships identified by Spencer and Pahl. One male interviewed for example, discussed the deaths of his wife and son and the different nature of support provided by different members of his (male) network of friends. This interviewee also reflected on the different nature of friendship relationships between his and his parents’ generation.

Friendships

‘You make friends at work, I have some where I live but not many at the moment. My circle of friends still tends to be university friends, friends I’ve met over the years at work, and people I shared a flat with in the 1970s... and a few sort of neighbours and things. So my friends aren’t necessarily close to me. Female, born 1954

‘My friendship network is risky because people are going to start to die. My mum was saying to me that she’s only got one friend left and I thought ‘God I’d hate to be in that position. If I was I don’t know what I’d do.’ Male, born 1949

‘I don’t have close friends I share things with. I internalise it all basically. That’s the way I tend to deal with things.’ Male, born 1953

‘Y’know I have a saying that I’ve got the best friends in the world, and I have. You do need them, definitely, at times like that.’ Male, born 1946

‘Not a huge network of friends... but yes I do have quite close friends. But I tend to withdraw from my friends when things are at their worst for me. It’s the friends who come after me, discover what’s going on rather than me calling on them.’ Female, born 1951

I have a lot of friends... as you get older it’s the friendships you carry with you rather than simply the day-to-day work relationship, which are important.’ Male, born 1950

‘Our son wanted us to move to Australia. We couldn’t leave. If we had to choose between our friends and moving we’d have to keep the friends because it takes a long time... to build friends.’ Male, born 1949

Friendship has been defined as a ‘special relationship between two equal individuals involved in a uniquely constituted dyad’ (Bell and Coleman, 1998). Graham Allan suggests that friendship may be recognised increasingly as one of the main sites of activity giving life meaning. Three components have been identified: ‘friends must enjoy each other’s company, they must be useful to each other and they must share a commitment to the good’ and it has two forms, one based on mutual usefulness, the other based on pleasure where, ‘each loves the other for what he is, and not for any incidental quality’, (Doyle and Smith, 2002). But in the same way that changes to family relationships and arrangements have resulted in negative discussion about families, the view has been expressed that friendship relationships today have become fleeting and transient, that there is lack of commitment and trust and people have retreated into self-absorbed individualism. This view has been examined in a study of contemporary friendship carried out by Spencer and Pahl (2006). They take as a starting reference the American sociologist Gans, who observes that people continue to structure their lives around the family and a variety of informal groups in a pattern that he labels ‘micro-social’ and which has changed very little over time. Spencer and Pahl asked people to ‘tell them who is important to them’. They argue that the evidence they gathered about people’s ‘personal communities’ demonstrates the complexity of modern life, rather than the demise of commitment. Personal communities are ‘intimate and active ties with friends, neighbours and work mates as well as kin’, the sets of important personal relations that make up people’s social worlds. What became evident for them was the great diversity of people’s micro-social worlds; while some people look to family or partner for intimacy and support, with friends being sociable companions, others see friends as their closest confidantes and supporters. Others have diffuse ‘personal communities’ where friends and family play overlapping roles. A key finding is the diverse nature of friendship nowadays; not only are there different kinds of friendships but people vary in their range and type. Some are close, others are casual and short-lived. Some may be more vulnerable in the long term than others, for example, where they are based on a partner or professional relationships. However, some people are isolated and unhappy with unsupportive micro-social worlds. Factors associated with having fragile networks including disrupted childhood relationships. Moving to a different area may also create difficulties in establishing new relationships. Divorce, death of a partner, loss of job, drug addiction and experiencing a major illness are all factors which can disrupt people’s personal communities. However people experiencing
the same circumstances may well have different outcomes.

Graham Allan notes that relationships that are often presented as voluntary, informal and personal still operate within the constraints of class, gender, age, ethnicity and geography – which places a question about friendship being entirely a matter of choice (Allan, 1996).

Community and social engagement

Good mental health is supported when people live in functional and attractive places. Living in a poor environment is a risk factor for mental illness. Good communities enable people easily to access community facilities and services, to get involved and to not feel threatened by crime and anti-social behaviour. As people get older they provide opportunities for social engagement and the services people need to remain independent.

A study of social detachment has reviewed evidence about the effects of social attachment to demonstrate its links to better physical health, lower mortality, fewer depressive symptoms and improved subjective wellbeing (Jivraj et al., 2012). The causal processes through which these effects might operate are also explored. The researchers suggest both social and physiological explanations are relevant. Social attachments can provide a sense of purpose and increase motivation and social pressure to take care of one’s own health and wellbeing. They may act as a safeguard against stressful life events, as well as influencing health through physiological pathways.

Over recent years governments have developed a focus on how people live in local neighbourhoods. In England there have been local surveys to assess the empowerment of local communities, community cohesion and discrimination at a local level (Citizenship surveys), surveys to explore what people think about their local area, services and civil protection (Place surveys) and the development of a range of deprivation measures to collect information about small local areas in order to help target local improvement action. Recently a Big Society index has been created to include regular participation in volunteering, a belonging scale and a civic participation scale.

The ELSA 2002 survey collected information about the social activity of participants, asking them about organisational membership and cultural participation (Hyde et al., 2004). In the 50-59 age group, almost four out of ten women did not belong to any organisation, with the same true for around a third of men. Non-membership increased with age. Across the whole ELSA sample patterns of membership varied by age with people aged under 65 more likely to belong to a political party, trade union or environmental group, and those over 65 more likely to belong to a tenants or residents group or to a church. Occupation level had a strong link to organisational membership for both men and women. Highest levels of membership were found in managerial and professional men and women, with almost eight out of ten women and three-quarters of men in these roles, having organisation membership. Levels were lowest among women with routine and manual jobs, around half, and men in intermediate jobs, just under six in ten. There were also variations in the type of organisation people belonged to. People in managerial groups and women in intermediate groups were most likely to belong to a sport or exercise club, and people working in routine roles and men in intermediate roles were most likely to belong to a social club. Having fair or poor self-rated health was generally associated with lower organisational membership, particularly for women, of whom 55% were members of no organisation.

Almost all people in the 50-59 age group (94%) eat out sometimes. Seven out of ten women and just over six out of ten men went to the theatre or opera and six out of ten to the cinema and art gallery in a year. There is a falling off of all these activities between age 50-54 and 55-59, a gradient which continues with increasing age. As with membership, there are occupational group differences in participation, with men in routine and manual roles having the lowest participation and women in managerial and professional the highest (for example, 45% of routine occupation men went to the cinema compared to 80% of managerial women). Having poor health also affected participation; overall 64% of men went to the cinema but only 39% of men in fair or poor health.

Seven out of ten people aged 55-59 and eight of ten men and three quarters of women aged 50-54, owned a mobile phone. Six out of ten men and around half of women age 50-54 used the internet with proportions falling to 15% of men and ten per cent of women aged 75-79. 77% of women and 79% of men aged 50-52 said they voted in the most recent general election. These figures are lower than for other ages, 87% of women and 89% of men aged 75-79 saying they voted. There are similar gradients for newspaper readership. While numbers taking a UK holiday was similar across all age groups up to 70-74 at around 60%, people age 50-54 were most likely to have taken a holiday abroad (just under 60%) and there was a significant fall-off after age 64. The ELSA authors note how their data show that older people are engaged in a range
of activities, including activities that create value and help build a sense of community. However, the ability to participate is not equally distributed, with poor health and low occupational status creating limitations. The authors also note that across the whole sample they identified people’s frustration at not being able to participate in activities they would like to.

**Social detachment**

After the completion of the fifth wave of ELSA surveys in 2010-11, researchers used data collected between 2002/03 and 2010/11 to examine disengagement from participation in societal activities in more depth. They created four domains of social activity: civic participation, leisure activities, cultural engagement and social networks, and examined the extent to which the survey participants were detached from involvement in them. Considered across the eight years of the project, the prevalence of social detachment was found to be broadly stable, with just below one in five people detached from three or more domains of social activity. The proportion detached from social networks was very small, although higher for men (7%) than women (3%). The researchers also explored patterns of change in social detachment by tracking individuals across the eight year period. They reported on the percentages of people who, over the eight year period, never reported being detached from a domain. Their findings in relation to the 50-59 year old, baby boomer group show an interesting pattern.

**Civic participation domain** (membership of political parties, trade unions, environmental groups, tenants, neighbourhood and neighbourhood watch groups, charitable associations, voluntary work, religious organisations and churches): Around 35% were ‘never detached’ from civic participation across the period, compared to 44% of people aged over 60, and 45% of those aged over 70. For the older groups, women were more likely to be ‘never detached’ than men but for the 50-59 year olds the prevalence was similar for both.

**Leisure activities domain** (membership of education, arts or music group or evening class; a social club, sports club, gym or exercise group, or other organisation, club or society): 35% of 50-59 year olds were ‘never detached’ from leisure activities, compared to 44% of people over 60.

**Cultural engagement** (going to the cinema, an art gallery or museum or theatre, concert or opera performance at least once a year): The 50-59 year olds were more likely than those over 60 (53%; 50%) to be ‘never detached’ from this domain and were much more likely to be so than those over 70 (38%).

**Social networks** (having friends, children and other immediate family and being in contact with them): Detachment from social networks was low across all age groups. However, men aged 50-59 were the least likely to be ‘never detached’ (83.6% compared to 85.1% of all men and 89.9% of all people.

These results indicate that baby boomers may be somewhat less involved in civic and leisure activities than previous cohorts, and may have slightly less developed social networks. The authors of the study conclude overall, that ageing is not only about an increase in social detachment but also encompasses an increase in social activity. Getting older appears, they suggest, to be tied to an increased chance of detachment from leisure activities and cultural engagement but not civic engagement and social networks. Being retired is associated with a greater likelihood of being detached from civic participation (for example, through no longer being a trade union member) but is also associated with being less likely to become detached from leisure activities. Further collection of ELSA data in future waves may throw more light on the apparent higher levels of social detachment of the 50-59 year old first wave participants.

**Participation in Volunteering**

Volunteering is part of the civic participation domain studied by the ELSA. Participation in voluntary activity is good for social wellbeing, or social capital, as well as for individual mental wellbeing. There has been a great deal of debate over the last decade about whether civic engagement and social ties are decreasing and people becoming increasingly disconnected from each other. Robert Putnam, writing about the US, has identified a transition from a civically engaged society, where people are socially and politically involved, give to charity and behave in trustworthy ways to each other, to a society of ‘personal communities’ (Putnam, 1995). Single purpose organisations are replacing large groups and are more transient, and place-based organisations are being replaced by interest groups with narrower interests. Putnam focuses on the baby boomers and their children as leading the decline in community engagement. He
writes that boomers are less disposed to civic
genagement than their parents and even to some extent, less than their own children. The major contributing factors that he cites are pressure on time and money, including special pressures on two career families, suburbanisation and commuting, the effect of electronic entertainment, above all television, and changing attitudes between generations. Putnam cites the baby boomers’ libertarian attitudes and reduced respect for authority as significant factors in their non-engagement. How far this description of breakdown of community and growth of individualism relates to the UK is an area of ongoing discussion and is particularly pertinent to considering UK baby boomers.

The National Council for Voluntary Organisations (NCVO) has recently published a study of participation trends (NCVO, 2011). This says that the proposition that people are increasingly disengaged and apathetic is misleading, and that participation rates in volunteering and giving have remained largely stable over thirty years. However, some aspects of engagement have declined, including membership of political parties and trade unions. The report provides some valuable insights into participation in volunteering.

**New patterns of membership**

Membership of political parties has declined dramatically since the 1980s as people are drawn increasingly towards single issue campaigns and organisations that cross party affiliations. Trade union membership also declined throughout the 1980s and early 1990s from a peak in 1979 when unions had a total of 13.2 million members or 55% of the workforce. Exhibit 5.1 also shows changes in membership across a number of charities, with a number of long-established charities showing decline, and environmental charities, most dramatically the National Trust, showing significant increases. The NCVO notes that since the 1960s around 2,500 new charities have been registered each year.

The report further reveals that participation rates in volunteering and charitable giving were lower in 2008 than in 1981. Between 1997 and 2007 people’s membership of organisations fell from 58% to 53%. Social clubs and tenants’/residents associations both experienced significant falls. The government’s Citizenship Survey in England shows a slight fall in formal volunteering from 2001 to 2009-10 of -1%; however informal volunteering saw a drop of -13% for volunteering at least once a year and -5% for volunteering at least one a month. There is a gender difference in membership of organisations: 48% of women and 57% of men are members. Membership is highest in the 45-64 age group. The NCVO analysis concludes that, although numerous initiatives have aimed, over the last decade, to encourage greater participation at a local level there have been no step-changes.

In terms of the involvement of baby boomers, the most recent available trend data were collected in 2007 as part of the Charity Awareness Monitor (Brennan, nfp Consultancy, 2008). Levels of volunteering were tracked between 2001 and 2007. Over this period the proportion of people who had volunteered increased from 17% to 19%. In 2001 levels were highest for 55-64 year olds (23%) and lowest for 25-34 year olds (11%). By 2007 more people in age groups 16-44 were volunteering and among people aged 45-54 and over 65 levels had remained stable. However, there had been a fairly significant fall in involvement of the 55-64 age group, from 23% to 16%, and while 14% of people over 65 volunteered to a charity or voluntary organisation only 9% of 55-64 year olds volunteered in this way. The authors note that this decrease occurred despite Government targeting of volunteering initiatives to people over 50.
A long time contributor to the development of volunteering by older people has flagged up some challenges that he sees for the involvement of baby boomers in volunteering (Harbert, 2012). Harbert identifies two traditions in volunteering, philanthropy driven by women like Elizabeth Fry and the diverse practices of ‘mutual aid’ and self-help. These two strands continue today, with the philanthropists having become the voluntary sector, and self-help organisations the community sector. Harbert argues that philanthropic charities have become bureaucracies, pursuing contracts and transferring power and responsibility away from local volunteers to centrally-based paid staff. He notes that baby boomers are less inclined to accept instructions from others than previous generations and to him it seems unlikely that, as they retire, they will happily allow themselves to be controlled by men and women in suits who are at the helm of large charities. He stresses the importance of volunteers setting their own objectives and the need for organisations to provide leadership rather than management. To become fit for the twenty-first century charities will need to employ community workers and facilitators rather than volunteer managers. However, for one commentator, this analysis, whilst reflecting some valid points also raises questions about whether it is just voluntary sector bureaucracy that is discouraging baby boomer volunteers to support community volunteering or whether there is a wider lack of willingness (Miles, 2012).

**Religion and spirituality**

While many people interviewed in the project research did not formally attend church, a religious or spiritual belief remained important for some.

*Religion and belief*

‘It’s (my belief) on-going but very low key… it constitutes a rock in the background… a resting point. It’s very helpful.’ Female, born 1951

‘I have personal faith, being Christian, prayer is one of my first resorts, and having people to pray for me and with me … and then you don’t feel so much alone.’ Female, born 1955

‘I wouldn’t say I’m an atheist .. I kind of cross myself in church .. and I’m on the Board of a religious charity. You know I, I’m neutral I think about religion.’ Male, born 1950

‘I do go to church. There was a time I stopped because I didn’t like the kind of services they were having. There was a new Minister. I first met him when he came to do my husband’s funeral. And then just listening to him… So I started going again after that.’ Female, born 1947

‘I used to go to chapel, but I stopped going. I do go, but not very often. I still believe, if anyone asks me I say ‘I’m a Catholic’. I’m still a Catholic no matter what.’ Female, born 1952

‘My son believed in God so much.. He’d really get the.. Oh mum you’ve got to come.. so I want to believe in that, but I don’t.’ Female, born 1952

‘I always felt I had a Guardian Angel. Most spiritualists if you talk to them, say everybody has a guardian angel.’ Male, born 1949

‘I would say I’m an atheist, yeah, I’m more agnostic, certainly.’ Female, born 1954

‘I’m not spiritual. I used to go to these big services and I think religion is the opiate of the masses. But I have got a belief in goodness I suppose.’ Female, born 1950
When discussing the question of the significance of spirituality for baby boomers, it is important to make a distinction between the notion of spirituality and that of religious belief. Spirituality can be defined as a broader search for that which gives meaning and purpose in life. Swinton (2001) refers to spirituality as that aspect of human existence which gives it its ‘humanness’. It concerns the structures of significance that give meaning and purpose to a person’s life and helps them deal with the vicissitudes of existence. As such, it includes such vital dimensions as the quest for meaning, purpose, self-transcending knowledge, meaningful relationships, love and commitment, as well as (for some) a sense of the holy among us (Swinton, 2001). Religious belief involves belief in a higher power or deity whereas a spiritual belief framework is broader and can relate to a variety of experiences, for example relationships, community, the power of the natural world, and other experiences which provide inner purpose and meaning.

It is clear from the literature that such religious and non-religious cognitive framing has significant implications for coping and well-being. The question which needs to be addressed is the extent to which religion and/or spirituality provides a protective force for baby boomers.

A question in the 2008 British Social Attitudes survey asked about belief in God, Exhibit 5.2. Responses indicate that belief in God is highest among older age groups - for example 55% of respondents aged 55 to 64 expressed a belief in God compared to 66% of those aged over 75 and 44% of respondents aged 45 to 54. This is in the context of an overall decline in religious belief – the British Social Attitudes survey for 2009 suggests that those across all population groups in the UK who professed no religious belief rose from 31% in 1983 to 54% in 2012.

### Exhibit 5.2 Belief in God, by age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t believe in God now and I never have</td>
<td>46.2%</td>
<td>35.6%</td>
<td>29.6%</td>
<td>26.3%</td>
<td>14.0%</td>
<td>15.3%</td>
<td>11.7%</td>
</tr>
<tr>
<td>I don’t believe in God now, but I used to</td>
<td>18.9%</td>
<td>5.9%</td>
<td>8.0%</td>
<td>5.3%</td>
<td>6.1%</td>
<td>4.5%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Believe, didn’t before</td>
<td>13.0%</td>
<td>5.9%</td>
<td>8.0%</td>
<td>5.3%</td>
<td>6.1%</td>
<td>4.5%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Believe and always have</td>
<td>21.9%</td>
<td>42.7%</td>
<td>49.5%</td>
<td>43.5%</td>
<td>55.0%</td>
<td>56.5%</td>
<td>66.2%</td>
</tr>
</tbody>
</table>


The findings of this survey need to be put in the overall context of religiosity in the UK. Voas and Ling (2010), comparing religion in the United States and the UK, remark that, ‘God seems more at home in the United States’. But while religious belief may be a protective force against deteriorating mental health in older age, religion can equally bring to mind ‘fanaticism and reactionary morality’. The British Social Attitudes survey also found that 73% of respondents thought that religion could easily lead to intolerance.

Voas and Ling (2010) suggest other trends that need to be analysed – for example for those describing themselves as ‘Christian’, there has been a drift away from the established Churches and an increasing trend to identify with a broader Christian label. Those in England who described themselves as members of the Church of England declined from 40% in 1983 to 20% in 2009. As there is no specific evidence to the contrary, it is likely that the baby boomer generation will also have followed this trend. However, whilst there is clearly a decline in interest in established religion, as the research of Hay and Hunt illustrates, a continuing interest in spirituality, broadly defined, persists. The general movement away from religion is a post-war phenomenon which began in Britain in the late 1950s and which correlated with the beginning of the rise of consumer culture. As such the baby-boomers are very much a part of this movement. However, it may be that spirituality is in the process of migrating away from religion into more diffuse forms rather than disappearing altogether.
The extent to which baby boomers are more ‘spiritual’ than other people is difficult to assess. Roof (1999), in discussing the North American experience as a ‘baby boomers’ spiritual marketplace, describes a quest culture which emerged in the 1980’s as religion appeared to be in disfavour and spirituality rose in importance. Roof describes this as a ‘fascination with finding a key to unlocking one’s own life, discovering the force or energy that can invigorate and give direction to life.’ (p82).

Such a culture incorporates a ‘self-authored search, or looking inward, of wanting to grow’. The term ‘journey’ could describe mental trips and ‘imaginary movement across time and space in search of spiritual resources available to the self’. ‘This type of culture is marked by a focus on the need to be master of one’s own spiritual fate. Roof describes the post 60’s culture for baby boomers as a period of resistance to the prescriptions and theology of a particular religion and openness to ‘raw inner yearnings’. Nonetheless a ‘journey’ can take several forms and a focus on an ‘individualist’ spiritual orientation does not preclude differing perspectives on moral issues and values. As Roof points out, baby-boomers are likely to take opposing positions on issues which polarise society in the United States such as abortion and euthanasia.

It is difficult to comment with any degree of confidence to the extent to which these views can be replicated in the UK baby boomer population, particularly as there is little equivalent UK research on this issue. In particular the evidence of the ‘counter-culture’ in the 1960’s leading to the ‘spiritual marketplace’ described above is harder to detect. However, when the British Social Attitudes Survey asked people about their spirituality the results reflected a similar age gradient to that demonstrated by belief in God (British Social Attitudes, 2008), suggesting that religious belief has not generally been replaced by a wider spirituality. Overall, it is difficult to assert with confidence that the search for the ‘inner self’ and a deeper meaning of life as a guiding compass of moral values has been a priority for the baby boomers.

Religion and social change
The decline in religious belief and practice, particularly Christianity, over recent decades has been generally discussed as a process of ‘secularisation’. A recent collection of essays (Woodhead and Catto, eds, 2012) provides a richer framework for considering religion in post-war Britain, in the context of wider social changes. The essays address the significance of 1960s social and cultural changes that have been identified as key to the formation of baby boomer identities. A Christian revival is identified in the immediate post-war years, highlighted by the queen’s coronation in 1953. It was a period when ‘the national church was able to symbolise the hopes of the nation, and state and religion could act in harmony (Woodhead, 2012). The church was inherently linked to the growth of the welfare state, which represented both a Christian and a secular vision. Churches, religious charities and voluntary groups had contributed to the reforms that led to its creation and some of the resources and infrastructure of the new welfare state, such as schools and hospitals, were transferred to the state from religious bodies. One outcome of this is that religious organisations became increasingly invisible in the welfare era; they became part of the social fabric (Woodhead, 2012). For the baby boomer generation, the welfare state took on some of the communal vision of religion. As the welfare state developed professionally in the sixties and seventies it was increasingly baby boomers, who had benefited from the expansion of educational opportunities, who staffed its functions, replacing the roles of church workers and volunteers.

Brown and Lynch (Brown & Lynch, in Woodhead, 2012) explore the cultural changes associated with post war religion in Britain. They suggest that there has been a weakening of normative Christian culture in Britain in the decades since 1945. A reassertion of pre-war values accompanied post-war material improvement, where a conservative and repressive culture was allied with religious conformity and individuality and self-expression were outside the cultural mainstream and regarded as deviant. Between 1945 and 1960 church attendance and involvement in religion was high, including among young people. Brown and Lynch report that in 1950-51 42 per cent of under-18s regularly attended church or Sunday school and more than half of parents said they taught their children to say prayers.
The massive cultural changes of the 1960s, driven by individualism and autonomy from authority, and expressed as new liberal social and sexual attitudes, brought this widespread commitment to Christian social mores to an end. The outcome of this decline of the dominant post-war Christian culture three key changes are identified by Brown and Lynch, which are: the emergence of a new cultural context of ‘non-religion’; a consolidation of new religious sub-cultures; and the development of new methods of public religious engagement. A decline in church attendance, and observance of religious ceremony, including marriage and baptism, and more recently, funerals, has taken place from the 1960s. This has been accompanied by a decline of belief in God and personal religious activity along with falling identification with church or religion, with growing numbers of people (mostly younger) actively describing themselves as being of ‘no religion’. Brown and Lynch note that significant sources of value in life tend now to be mediated through personal relationships with partners, family and friends and may extend to a sense of significant attachment to those who are deceased. Against the growing dominance of a liberal, secular culture the authors also see the rise of more conservative religious groups, including Christian groups and members of other religions, which challenge not only secular culture but also traditional religious institutions that are seen as accommodating unacceptable liberalisation. Allied to these wider changes the authors also identify the increasing role of the media as the context through which people engage with religion: the mediatisation of religion. They suggest that religion and its symbols continue to circulate, but in ways that are more banal and less reverently perceived, forming an ‘unthoughtabout backdrop of cultural meanings’ (Brown and Lynch, 344).

One key moral aspect where the authors flag up growing public attitudes that are at variance with orthodox church teachings is that of suicide and assisted dying. They note growing public support, from polls of 69 per cent in favour in 1976 to 82 per cent in 2009, including 71 per cent of ‘religious’ respondents. They argue that these views reflect growing public desire for autonomy over the human body. The individualism, choice and control that are dominant values among the baby boomers, are likely to mean a growing focus on this agenda, with social and legal implications for the future. There is little evidence about relationships between mental health and the ability to make end of life decisions.

Social change has dramatically altered the nature of religious institutions in Britain. Baby boomers grew up with the strong religious normative culture of the fifties but formed their adult identities in the 1960s and seventies, as the central role of church values declined. As in other areas of social life, their attitudes and values show evidence of their role as a change generation, expressed as continuing religious beliefs held by many along with decreased religious practice and involvement.

Social media and internet
The 50-65 age group have recently been reported to be the fastest growing age group using Facebook, with numbers registered growing by some 80% between 2010 and 2011. They are using social media to connect with old friends and family and to build their own communities, perhaps contacting old workmates and school friends from decades ago. Other internet analytics suggest that around three quarters of baby boomers use the internet, that two thirds will have recently researched the internet for online shopping, that around half are signed up for online banking and that they are one of the best represented age groups for online bill payment. Over 50s are also said to represent a significant proportion on online games players.

For many, internet use has played a vital role in employment over the past two decades and social media continue to play an important role in keeping them networked for work and business opportunities. The internet therefore offers opportunities to keep engaged that have not been previously available. But, as one commentator has said, comfort with and proficiency using technology is not natural to boomers. Try as they might to act young, digital communication is not their native language, they are digital immigrants, not digital natives (Prensky, 2001).

This description of a divide between younger users, digital natives and older users, digital immigrants is helpful in understanding the challenges presented by technology. Evidence shows a further digital divide, between baby boomer internet users and those not currently using the internet. Of these latter, around half say that it is not relevant to them. There are questions too about continuing engagement of baby boomers in developments in technology; while email, internet and mobile phone use are high, smartphone and tablet use among older baby boomers is significantly less than that of younger users, with a gap that represents how and when the internet is used.
The implications for the future are that non-users may find themselves left out of important opportunities for networking and therefore potentially isolated from the mainstream and their own peers. The International Longevity Centre has recently considered how best non-users can be encouraged into use (International Longevity Centre, 2012). Some analysis of English Longitudinal Study of Ageing data for their report shows that:

- People who reported using the internet tended to report feeling more in control of various aspects of their lives.

- People who didn’t own a computer were more likely to feel that they were unable to learn a new skill, while conversely people who did own a computer were more likely to agree that they could.

- People who reported not using the internet were more likely to say that they ‘often’ felt isolated from others. Conversely, people who said they did use the internet were more likely to respond that they ‘hardly ever or never’ felt isolated. The same pattern was found for loneliness.

The ILC makes a series of policy recommendations using ‘nudge’ tactics, to achieve greater digital inclusion for older people. This includes identifying reasons for non-engagement, with internet technologies, in particular behavioural choice, and developing mechanisms for addressing these inhibiting factors.

Current users too need to be continually re-engaged in new technologies if they are to get ongoing benefit. Applying Prensky’s (2001) categorisations, ‘native’ developers of new tools need to remember the needs of these ‘immigrant users’. The willingness of many baby boomers to remain involved in a changing world, and their already relatively high degrees of IT literacy, create opportunities for future IT inclusivity and its benefits. But with the availability of publicly funded informal learning for adults declining, the IT industry needs to find ways to keep its users and potential users educated and informed.

**Loneliness**

Loneliness has been highlighted as the ‘great, unspoken public health issue’ by the Minister of State for Social Care Services, 2010-2012 (Campaign to End Loneliness, 2012). It has a detrimental effect on both mental and physical health. While loneliness affects people of all ages it has a particular impact on older people who are increasingly likely to live alone and experience social isolation. The project’s YouGov national survey asked people about their greatest concerns for being older. 10.6% of baby boomer respondents flagged up isolation and the possibility of loneliness as a concern, with more women than men expressing this (12.3%: 8.7%). Across all respondents there was an age gradient: older people were less likely to be worried about loneliness (8% of people born 1926-1945), but around a quarter of younger people expressed this concern in relation to becoming older.

Evidence from a 2011 survey (Opinium, 2011) also suggests that baby boomers (falling into the 50-59 and 60-69 survey age groups) are less likely than younger age groups to say they are lonely and more likely to say they are not lonely at all (76% of 60-69 year olds said they were ‘not lonely at all’ compared to 40% of 18-29 year olds). However, across all age groups a consistent 3% said they were ‘very lonely’.

Whilst being alone is a risk for loneliness, it is not the same thing. English Longitudinal Study of Ageing (ELSA) researchers, who surveyed social detachment, differentiate objective measures of social networks, contact and engagement from subjective measures related to feelings about relationships (Shankar, 2012). They found that, in ELSA wave 5, over a quarter of participants who reported the highest possible scores on loneliness were among the least isolated. The Mental Health Foundation report, Our Lonely Society, (Mental Health Foundation, 2010) quotes Jenny de Jong-Gierveld’s definition of loneliness, ‘a situation experienced by the individual as one where there is an unpleasant or inadmissible lack of (or quality of) certain relationships.’ For an individual, this includes having fewer relationships than desirable or having less intimacy in relationships than wished for.

Loneliness is the subjective experience of isolation, but it is not the same as being alone. Many people live happily alone and get pleasure and satisfaction from solitude. Loneliness is also something everyone may experience from time to time, for example following bereavement, after moving to a new location, retiring from work or becoming
unemployed, life changes which may more common as people grow older. It is the time factor, whether loneliness becomes long-term, that is important in determining whether it is harmful. Long term loneliness can create a persistent, self-reinforcing loop of negative thoughts and behaviours (Mental Health Foundation, 2010). At a physiological level loneliness generates stress hormones, affects the body’s immune and cardiovascular functions, raising blood pressure, as if the loneliness is preparing the body for an imminent threat (Cacioppo & Hawkley, 2007). The physiological changes and anxiety that accompany loneliness are a warning that an individual’s social ties have become too weak. Evidence from the British Household Panel surveys confirms the link to mental illness and shows that people with low social support were far more likely to experience common mental illness, and also less likely to recover.

In The Lonely Society, the Mental Health Foundation has highlighted the social nature of human beings and the need for social connectedness (Mental Health Foundation, 2010). This need varies between individuals; the subjective nature of loneliness means that circumstances that make one person feel lonely may not do so for another person. But modern society is creating greater isolation. More people live alone in small apartments, work at home and shop and socialise online. Others commute long distances back and forth to work, work long hours and barely find time for families and friends. Education and careers have led people to live at greater distances from families and childhood communities, divorce rates have increased and lone parenthood increased. Relationships that are vital to health and wellbeing are being undermined. These changes are not just demographic changes and lifestyle choices; shifts in attitude also play a part where socialising and investing time in social ties are seen as less important than productive activities like work. Modern notions of community are changing too. A report from the University of Sheffield (Dorling et al, 2008) collects evidence from censuses and other sources, to demonstrate how British society has been slowly and steadily segregating geographically since the late 1960s. The dimensions of this change include: population and house prices increasing at greater rates in some areas; population by age becoming more segregated from the 1970s to the present time, with acceleration from 2000; economic polarisation between rich and poor Britain; and social fragmentation, the degree to which people appear to be more socially isolated. Television and home entertainment have edged out traditional meeting places such as pubs and clubs, which used to bridge different generations. Cacioppo (Cacioppo et al, 2007) refers to a society that has drifted into disconnectedness through self-interest.

The growing segregation and disconnectedness described by Dorling and Cacioppo are outcomes of the wider pattern of social changes that have produced modern consumer society. The baby boomer cohort’s contribution to defining this post 1960s society is likely to mean that they have also been more exposed to negative consequences than previous generations entering their sixties, with possible future implications.

**Loneliness in later life**

Research has shown that only a minority (7%) of older people can be considered lonely or isolated and that the extent of severe loneliness has been stable for the past 50 years, although the forms of social contact changed from direct to indirect contact, such as by telephone (Victor et al, 2002). However, this research found indications of an increase in people saying they are ‘sometimes lonely’ and a decrease in those saying they are ‘never lonely’. People experiencing loneliness in later life fall into two groups: those for whom loneliness is a continuation of previous experiences, and others for whom it is a new experience, resulting from a change of circumstances such as bereavement. Approximately two thirds are estimated to experience continuing loneliness. Ten per cent of people report improvements in feelings of loneliness as they grow older. The research considered the relationship between living alone and experiencing loneliness. Among the people living alone 17 per cent rated themselves as often or always lonely compared to 2 per cent of people living with others, and 80 per cent of people who described themselves as ‘often lonely’ lived alone. Exploring risk factors for loneliness in later life, Victor and colleagues identified loneliness as being most likely to be reported by the very old, women, the non-married, those who live alone, those lacking material resources, those without educational qualifications, people who are physically and mentally frail, and people who spend long periods of time alone. These factors are often inter-related.

For baby boomers these risk factors for loneliness raise a number of issues. This chapter has already explored the growing numbers living alone, together with increased divorce rates, leaving fewer married, and the continuing lack of resources experienced, in particular, by women. To these demographic
factors there can be added their experiences of economic and social polarisation and increased social detachment, as identified by ELSA research. The evidence suggests that baby boomers could well be at greater risk of loneliness. Combined with their numbers this could indicate a substantial future problem.

In England a campaigning group, The Campaign to End Loneliness was launched in March 2012 (Campaign to End Loneliness, 2012). Its goal is to ensure that steps are being taken to tackle the factors that cause loneliness, by communities, organisations and individuals. Its specific aims are to increase people’s resilience to changes in life that can cause loneliness in older age and to reducing chronic loneliness for people who are over 65. One of its first actions is to raise the profile of loneliness with the new Health and Wellbeing Boards that are being set up in local areas, and ensuring that tackling loneliness features in local decisions about health and care expenditure. The needs of baby boomers need to be factored into the shaping of developing programmes.

Self and relationships - lives lived: the mental health risk/protection balance

Risk and protective factors for mental health

Continuing social support from networks of friends, family and wider communities are fundamental to good mental health at all ages. Absence or loss of good relationships can be risk factors for developing common mental disorders and can be linked to experiences of later life, including the effects of bereavement and disabling conditions.

Bereavement has been identified as an important risk factor. People are increasingly likely to experience loss of partners and other close relatives and friends as they grow older. Most people experience distress and grief with bereavement but adjust to their loss after a period of time. However, for some grief is more complicated and results in more serious depressive symptoms. Some factors associated with experiencing complicated grief include the degree of dependence on the person who has died and if the death forms part of series of losses, including for example loss of social contacts or networks.

• Hassles of daily life can be risk factors for depression, where these are tasks that someone is unable to do that serve as reminders of the death of a spouse or other close person, or where there are no friends, family or neighbours to help.

• Loneliness and social exclusion are risk factors for depression. Interaction with others improves physical and psychological functioning.

• Age discrimination exacerbates older people’s sense of powerlessness and ability to live a fully engaged life; it has a significant negative impact on older people’s mental health.

• Experience of discrimination and prejudice, for example on the basis of race, ethnicity or sexuality can have a cumulative effect over the life course.

Good social relationships and networks and engagement in meaningful activity are strong protective factors for mental health. Having close friends is important for self-esteem and mastery, for maintenance of morale and to prevent loneliness. Intimate relationships, with someone to confide in, help people deal with difficult and stressful life events. Meaningful activity and living in a community that offers opportunities to be involved have also been identified as making a contribution to mental wellbeing.

Evidence points to a positive influence of spirituality and religious belief on mental health in later life. Religious involvement can provide individual and social support and a sense of purpose and being able to let go of ones worries and responsibilities. There is also a sense that coming to terms with mortality is aided by a spiritual context.

There is evidence that IT, internet and social media, can make a contribution to sustaining social networks, maintaining contact with friends and family across geographical distances, and keeping people in touch with a wider world.
Risk / protection balance - risks

The evidence collected in this chapter is mixed. One of the main characteristics of the baby boomers has been high levels of early marriage and increasing rates of divorce, including increasing rates of divorce after the age of 50. Six out of ten remain in their first and only marriage, one in six men and one in nine women are remarried, and almost one in five women divorced (18% compared to 13% of men). Cohabitation rates are low at around 6.5% for men and 5.5% for women. The numbers divorced, together with single people, mean that more than one in five baby boomer women and one in six men are likely to be on their own, without a partner. Divorce has been shown to be linked to increased levels of anxiety and depression that last over a long time, lower levels of social support, reduced feelings of satisfaction with neighbourhood and community and lower feelings of safety. There is also evidence that divorce may disrupt social networks. Increased numbers divorcing and remaining single, particularly women, means that more people are likely to lack the close, supportive relationships that help people through difficult periods. There are also likely to be greater numbers experiencing isolation and loneliness, particularly women whose financial security is also often affected by divorce. Men are likely to suffer through loss of contact with children following divorce, leaving them with reduced family networks. This also has implications for care needs in later life; divorced men may find it harder to get family help than divorced women or men who have remained in a first marriage.

Increasing numbers of divorced and single people are reflected in a trend for more people to live alone. An increase of more than one million people living alone over the past fifteen years is accounted for largely by people aged 45-64, and the trend is for further increases.

Bereavement involving loss of a spouse is likely to be experienced by more men as the gap between men’s and women’s life expectancy narrows. This may have implications for support and counselling services, where new approaches may need to be developed.

Evidence collected for the chapter has also indicated that baby boomers may have been less involved in community organisations and in volunteering, than other older groups over recent years. This includes involvement in ‘civic participation’ such as belonging to political parties, trade unions, religious organisations, resident and neighbourhood groups than previous cohorts and also less involved in leisure activities such as social and sports clubs, education, arts or music groups.

There is also some evidence of greater detachment from social networks. It may be that this apparent disengagement by comparison with older groups is a result of ongoing involvement in work and that activity will increase when people are no longer fully engaged in employment. It may however, signal a change in levels of social involvement which may have future implications for mental wellbeing.

Some six out of ten baby boomers profess a belief in God although their church attendance has been part of the general decline noted since the 1970s and they are less likely to be church attenders than older groups. They are on the cusp between the age group when the majority of the population had connections with the church, and the younger group where the majority have not. It seems that they are less likely to experience the positive effects of religious belief and involvement than previous generations.

Risk/ protection balance - protection

Against the breakdown in marriage and the growth of more complex relationships and reconstituted families, the project has identified changes in the nature of relationships and the development of greater ‘emotional communication’ between partners and between parents and children. Wider relationships, such as those with siblings, have also become more valued and meaningful. It is this greater emotional commitment, which reflects the more general openness of the baby boomers that may help them deal with future life challenges. This emotional communication is extended to friendship. Despite concerns about the effect of work pressures and geographical mobility on friendship the evidence is that friends are an important part of baby boomer networks.

Attitudes to age and to ageing identity may also protect the mental wellbeing of baby boomers, as they remain active members of the world they live in and do not withdraw as they get older. The willingness of baby boomers to adopt internet use and social media as part of their engagement with the world are evidence of their strong desire to keep in touch. The challenges are to reach out to those not involved and ensure that technology does not move on and leave baby boomers behind.

Action against ageism has contributed to the 2010 Equality Act, which in turn is now creating a basis for highlighting the negative effects of age prejudice and discrimination. However, while there is evidence of a growing movement against ageism they have not reflected the anti-discrimination movements of the baby boomers’ younger years.
In terms of the question, ‘what might baby boomers do differently that will protect their mental health’, this chapter has not found any significant evidence that baby boomers are engaged in specific activities or organisation that will be protective. It is their attitudes to engaging with the world, to keeping in touch and defying age, as well as their openness and emotional engagement in relationships that are likely to contribute most. Both have their roots in the changed social attitudes that have helped shape their lives.
Chapter 6
Lives lived: work, wealth and education

Having a reasonable level of income has a positive effect on mental health while being poor limits people’s ability to make choices and is associated with loneliness. The social ties and relationships provided by employment as well as the contribution work can make to people’s self-esteem are also important contributors to mental wellbeing. Retirement from work, on the other hand, with its loss of networks and functions, can be an important risk factor. Finally, people’s level of education and their continuing engagement in learning can help protect their mental wellbeing as well as their wider mental and physical health. This chapter explores the lives of the 1946-55 baby boomers as they reach the age of 65, until recently, the default age of retirement. It looks at the decisions those in work are making about retirement: are they reflecting national policy objectives and working longer, or are they making different choices? Will the income, wealth and other resources they have acquired in their lives be sufficient to support and protect their wellbeing as they grow older or does potential reduction in their standards of living have implications for their mental health? How will they view and use the resources available to them? Will they do things differently?

Financial wellbeing
Being older used to be synonymous with being poorer. There is a general view now that the financial circumstances of people above State Pension age have improved since 1979. However, a significant proportion of those living on pensions continue to experience poverty, and rates of pensioner poverty in the UK remain above the EU average (European Commission, 2007). There is an age gradient: rates and levels of poverty in retirement increase with age. Increases in average incomes in retirement have been the result of better occupational pensions for some, greater savings and investment and, very recently, improved indexation of state pension. For baby boomers the question is whether these improvements in standards of living will continue to hold true for them. The current economic crisis is likely to have affected baby boomers disproportionately by affecting their savings and housing wealth and the returns they can achieve from pension funds, at a stage in their lives where they are unlikely to be able to make good any shortfalls. The surveys carried out for the project have asked about baby boomers’ feelings around their future finances.
Views about financial circumstances

The project’s YouGov national survey asked people which aspects of reaching age 70 most concerned them. One option offered, in a menu of options, was ‘financial insecurity’. Just under a third (31%) of the 1946-1955 cohort rated this as one of their major concerns, ranking fifth out of nine options behind ‘loss of mental abilities’, ‘having poor health’, ‘loss of independence’ and ‘physical disability’ (see Chapter 4). Women were more likely to express concern about future financial insecurity than men (33%: 28%) as were people in lower social groups (35% C2DE: 28% ABC1). Overall, amongst all the population surveyed, the proportion of people concerned about future financial security showed an age gradient from people born 1926-35 (23%) to those born 1976-85 (34%), with women at all ages more concerned than men.

The Talkingaboutourgeneration self-selected web survey of people born between 1946 and 1955, asked people whether they agreed or disagreed with the two statements: ‘I feel financially secure for the future’ and ‘I’m worried about my future financial situation’. Results are given in the table below (Exhibit 6.1).

<table>
<thead>
<tr>
<th>Concern</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>No view</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel financially secure for the future</td>
<td>8.7%</td>
<td>41.3%</td>
<td>10.3%</td>
<td>27.8%</td>
<td>11.9%</td>
</tr>
<tr>
<td>I’m worried about my future financial situation</td>
<td>13.9%</td>
<td>28.7%</td>
<td>13.1%</td>
<td>37.7%</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

Source: Talkingaboutourgeneration survey of 127 web respondents born 1946-55

While this group marginally feel more financially secure than concerned (50%: 43%), nevertheless almost one in six strongly agrees to being worried about their financial future. When asked to describe their greatest overall personal concerns for the future, health concerns were greatest, followed by worries about money.

Greatest concerns – financial issues

‘Having enough to live on, and enough time to enjoy my freedom’.

‘Being confident that I will be able to afford a good standard of care for our parents and then my husband and myself’.

What would help deal with concerns?

‘A guaranteed amount of money coming in would help’.

‘Free residential care available’.

These survey findings indicate some significant levels of financial concern for their future among baby boomers, both for daily living and in relation to future care needs. Both surveys were carried out during economic recession, which may have affected people’s views. The greater concern expressed by women is likely to be a reflection of their greater vulnerability to financial insecurity.

The family circumstances and childhood financial situations of people taking part in in-depth interviews were varied. However, many of those who are now fairly comfortably off reported considerably poorer childhoods. For others, the financial hardship of childhood has continued but without the extremes of deprivation that earlier poverty brought.

Baby boomers and the post-war economy

Baby boomers born between 1946 and 1955 have lived through a period of massive economic change, both in relation to the size and structure of the economy. They have lived their lives against a background of new products, technologies, and ways of working, new skills and roles and wide social change driven by economic development. They were born as Britain and its economy were struggling to recover from total war. They are reaching traditional retirement age in a world of wider economic inequality, globalisation and international financial crisis and recession.
Childhood Austerity
The post war world into which the earliest members of the ten year cohort were born has been described as 'austerity Britain' (Kynaston, 2007). Kynaston records continuing rationing and economic controls in post-war Britain as the country struggled to rebuild export markets and to help pay off massive war debts, at the cost of domestic consumption. The largest post war cohorts of children were born and spent their early years in a country where food, clothing and other commodities were in short supply; food rationing only finally ended in 1954. The public response to such deprivation was 'remarkably tolerant' with a sense that there was no choice and the government knew best, making the first post-war generation 'cautious, unassertive, grateful for small mercies and modest in ambition' – in marked contrast to the generation that would succeed them (Judt, 2005: 163). Britain was still, at the end of the war, the most industrialised country in the world. In 1950, the country was responsible for a quarter of the world’s trade in manufactured goods, was the world’s leading producer of ships and Europe’s lead producer of coal, steel, cars and textiles. The service sector provided half of GDP and employed roughly the same number of people as manufacturing (Kynaston, 2007).

Never had it so good – the age of affluence
In the decades after WWII, the British economy grew at an average annual rate of 2.5 per cent, fluctuating between 4 and 2 per cent annually (Anagboso 2007). Reconstruction in the 1950s led to a rapid growth in output and near full employment, with unemployment fluctuating around 1.5 – 2 per cent of the labour force until 1967, when it rose to 2.3 per cent then to 3.7 per cent in 1972. For some thirty post-war years the UK and other Western economies experienced a period of unprecedented prosperity, with the sixties described by commentators as the most prosperous decade in human history (Judt, 2005). Exhibit 6.2 illustrates the rise in post-war GDP after 1945, and how this compares to pre-war growth rates.

As the first members of the 1946-1955 cohort entered the labour market there were jobs available for all and the opportunity for young people to move easily into and out of work. The project interviewees have reflected the experiences of the time.

There were many factors driving this prosperity, including the opening of markets and increased world trade as well as investment and modernisation, with resulting increases in productivity. Growth was reflected in new patterns of consumption. Post war society became mass consumer society as people began to have the income to enable them to buy more than the necessities of life, and increased productivity meant that falling prices of what were previously luxury goods enabled many more people to afford them. The motor car was the consumer good at the heart of this expanding consumption, along with white goods and children’s toys. Science and technology played an increasing role in transforming both the range of goods and services available and the processes for creating them. Electronics and new materials, many produced as spin-offs from military research and development, led innovation, supported by the development and application of chemical and biological process engineering. Many of the discoveries and innovations that are now shaping global business, had their origins in research and development in these post war decades.

Services also grew to support these new industries and to meet wider consumer demands, including advertising, transport, communications, music and entertainment and stores and supermarkets to sell the burgeoning range of consumer goods. Public services expanded. This began the transition of the UK from a manufacturing to a service economy, in which services now account for some 75% of GDP. Baby boomers grew up in families that were mostly benefiting from
this growing prosperity, although poorer families were only slowly able to enjoy the wider opportunities of the more affluent. As we have previously noted, they also became a valuable market for youth-orientated products, especially music and fashion.

**End of the boom**

The post war boom was brought to an end in the UK by a recession that lasted from 1973-75. Two key factors were the ending of fixed exchange rates in 1971, triggered by the United States, and the increase in the price of petroleum by 70% following the Arab-Israeli ‘Yom Kippur’ war. A miners’ strike in 1974 resulted in the introduction of a three day week to conserve power. The outcomes were inflation, which peaked at 20%, a growing national trade deficit and unemployment, which reached over a million in 1977 (5.8%) and 1.5 million in 1978 (9%). By 1982 unemployment had risen above three million (12.5%). In what Judt (2005) describes as a third industrial revolution, and not just an economic downturn, the traditional manufacturing economy of Western Europe was disappearing; the recession of the seventies saw an acceleration of decline as more non-European countries entered markets, reducing prices and making large sectors of industry unviable. The result was massive job losses by miners, steelworkers, car workers and factory workers in many industries. Comparisons by the Organisation for Economic Co-operation and Development (OECD) suggest that the UK’s relative decline was greater than other OECD members and that its experience of inflation in the 1970s was worse than all except Italy (OECD, 2001). Judt sums up the 1970s as ‘the most dispiriting decade of the twentieth century’, where the prevailing spirit was that Europe’s good times had gone, and most young people were now less concerned with changing the world than finding a job. He writes that ‘the fascination with collective ambitions gave way to an obsession with personal needs’ (Judt, 2005, 477); while the culture of the 1960s had been rationalistic, the culture of the seventies turned on the individual.

The nineteen eighties saw a continued focus by government on making the economy ‘more market orientated’ (Stephenson, 2004). A series of government policies set in train in this decade saw the UK transformed to become one of the least regulated and most privatised economies among the advanced countries (Stephenson, 2004). The early 1980s was marked by recession with falling output and high unemployment that reached up to 20% in some areas of traditional industry and remained high into the latter half of the decade. One of the main outcomes of the 1980s policy changes was a large rise in income inequality, the result of rapidly growing incomes for people at the top of the income distribution, restrictions on trade union rights and the decline of unionisation which reduced general levels of earnings (Stephenson, 2004). The proportion of households with no members working has also grown since the 1980s. Exhibit 6.3 shows the upward trend in income inequality since 1979 as a Gini coefficient curve. The Gini coefficient measures the inequality among values of a frequency distribution. A measure of 0 represents perfect equality and a measure of 1 complete inequality. The increase in inequality since 1979 represents the first reversal of a trend to greater equality that began at the end of the nineteenth century.

**Exhibit 6.3: The growth of income inequality in the UK, the Gini coefficient, 1979 – 2006/07**

The recessions of the 1970s and 1980s happened as the 1946-1955 baby boomers entered their prime years of career establishment, earning and family building. They particularly affected younger baby boomers trying to enter work, but their impact was felt across the economy, particularly in parts of the country dominated by traditional industries. Many communities have struggled to recover, and the loss of their jobs has had a lasting effect on individuals and families affected. As Exhibit 6.2 shows, the economy grew again after the 1980s recession and a 1991 recession and growth continued up to 2008-09.

Increasing productivity and reduced unemployment will have benefited many, but growing divergence of opportunity has had continuing effect. The baby boomers now live in a society that has wider social divisions than the society in which they grew up, and where
the prospect of a job for life has been replaced by a flexible labour market and short term contracts. The changing economy has shaped their own experiences of employment, their prosperity and their access to resources as they grow older.

**Current financial circumstances**

**Adequacy of future retirement resources**

The recessions of the 1970s and 1980s happened as the 1946-1955 baby boomers entered their prime years of career establishment, earning and family building. They particularly affected younger baby boomers trying to enter work, but their impact was felt across the economy, particularly in parts of the country dominated by traditional industries. Many communities have struggled to recover, and the loss of their jobs has had a lasting effect on individuals and families affected. As Exhibit 6.2 shows, the economy grew again after the 1980s recession and a 1991 recession and growth continued up to 2008-09.

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- Twelve per cent of the age group would have an individual income of less than the Pension Credit Guarantee level if they only drew an income from their state and private pensions. These individuals would be dependent on non-pension wealth or means-tested benefits to avoid poverty in retirement.

- Forty-one per cent of individuals have been estimated to be in families that, in retirement, would either replace less that 67 per cent of current net family income, or fall below the Pension Credit Guarantee level, using pension income alone. They will see their income fall by a third.

- Fifty-three per cent are estimated to be in families that would replace less than 80 per cent and would see their income fall by a fifth.

However, the IFS researchers suggest that many people can fund their retirement from sources other than their pensions and the proportion of people at risk of inadequate resources is reduced using measures of income that includes pensions, annuitized non-housing wealth, expected inheritance, and imputed rental income from housing and means-tested benefits.

People at most risk of having inadequate retirement resources include single people (divorced, widowed or never married), with women more at risk than men; having low education is associated with having an income of less than the Pension Credit Guarantee level; people in lower income groups are more at risk of having a pension income below the Pension Credit Guarantee level; people in the higher income deciles are more at risk of having a pension income that replaces less than 67% of their current income.

The researchers say that further work needs to be done to find out to what extent having poor replacement income in retirement is the result of people having volatile employment through their working life and being unable to make provision, or the result of people choosing not to save.

The implications of this research and its assumptions will be of ongoing importance to the 1946-55 cohort of baby boomers. Four out of ten will have less than two-thirds of their income before retirement unless they draw down the capital values of their homes and savings to fund their retirement. The IFS researchers suggest that the available options are making use of equity-release products, downsizing, or selling and moving into rented accommodation. The report's authors themselves cite survey evidence showing people's emotional attachment to their homes, which they see as more than just an asset that can be liquidated if necessary, even to meet social care needs.

**Income**

The English Longitudinal Study of Ageing provides further evidence about the material living standards of baby boomers (Crawford et al, 2010). It collected information about income from a range of sources in all survey waves from 2002 onwards. Comparing income levels of people aged between 50 and SPA in 2002-03 with 2008-09 (see Exhibit 6.4), average income has increased in real terms, and the gap between people below and people above pension age has narrowed. Employment income is the main source of income for this group, although state benefits/pension are an important source for those in the bottom two income deciles. Between 2002 and 2008 employment income became a greater source of income for people in lower deciles and private pensions became a more important source of income for almost all groups, but
especially those in the top decile. The increase in the Gini coefficient indicates growing inequality in income distribution among both people aged 50 to SPA and people aged over SPA.

**Exhibit 6.4: Income distributions among individuals, 2002-03 and 2008-09**

<table>
<thead>
<tr>
<th></th>
<th>People aged 50-SPA</th>
<th>People aged above SPA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2002-03</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean income</td>
<td>£362</td>
<td>£244</td>
</tr>
<tr>
<td>Median Income</td>
<td>£301</td>
<td>£188</td>
</tr>
<tr>
<td>Gini coefficient</td>
<td>0.378</td>
<td>0.355</td>
</tr>
<tr>
<td><strong>2008-09</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean income</td>
<td>£414</td>
<td>£305</td>
</tr>
<tr>
<td>Median Income</td>
<td>£330</td>
<td>£228</td>
</tr>
<tr>
<td>Gini coefficient</td>
<td>0.412</td>
<td>0.381</td>
</tr>
</tbody>
</table>

£ per week at 2008-09 prices  
Source: Banks et al, 2010

The mean national weekly household disposable income for 2008-09 was £507 and the median £407 (Carrera & Beaumont, 2010).

Looking at income changes for the whole ELSA population across the period, the researchers note that the pensioner population has become better off, as younger members have reached retirement age. State benefits now form less of a share of their income and private sources, from pensions and employment, a greater source. This change in levels and source of income is likely to be reflected in baby boomers’ incomes as they retire.

**Financially inequality 1997-2007**

Baby boomers’ diverse financial circumstances in their sixties reflect patterns of change in income distribution that have taken place over their working lives. The Office for National Statistics published a review of trends in income distribution (ONS 2008b) that subdivided the thirty year period, 1977-2007 into two halves. This includes a period of substantial change, 1977 to 1991 and another of relative stability. The report also said that changes occurring in the second phase should be considered in the context of earlier changes. In the first period the share of income received by the top income quintile increased from 36 to 42 per cent. The shares received by each of the lower three quintile groups fell, in the case of the bottom quintile group from 10 to 7 per cent. Changes in quintile share were much smaller in the second phase. The Review also observed that households in higher quintile groups contained a much higher proportion of economically active adults. The bottom two quintiles contained substantially more households whose primary source of income is state benefits. Exhibit 6.5 Shows current whole population income distribution.

**Exhibit 6.5: Income distribution for the total population, 2009/10 (Before housing costs)**

Source: Department for Work and Pensions (2011)

Over the past fifty years, average household net incomes have grown by about 1.7% a year after adjustment for inflation, although the median has grown by about 1.5%, reflecting the changing distribution (Cribb et al, 2012). However, there has been a fall in average income in 2010-11, bringing living standards back to 2004-2005 levels. Inequality also fell, showing the largest one year fall since 1962, although levels still remains much higher than before the 1980s increases. Baby boomers in employment will be affected by falls in standard of living which are likely also to affect their ability to save in the key years before they retire.

**Economic inactivity**

One feature of the economic downturn in the 1970s and 1980s has been an increase in those not employed. The baby boomers are perhaps the first cohort to demonstrate this trend, which is a factor in growing inequality, but also linked to structural changes in the economy. Berthoud (2007) examined economic activity data from 1971 to 2003 and noted the increasing numbers of families (a couple or single adult, plus dependent children) who had no member in employment, which he linked to a quadrupling in numbers of people receiving social security benefits since the early 1970s. He calculated that there were two million adults who would have been likely to have a job thirty years ago, but were out of work. Those whose chances deteriorated most are disabled men with poor educational qualifications and no working
partner. There has been a steep increase, too, in the number of non-working adults without a partner, or whose partner does not have a job. The proportion has doubled from 7 per cent to 14 per cent over 30 years. Most of these ‘work-poor’ families live on social security benefits, and have very low incomes. On the other hand, around two million adults in work would probably not have had a job in the mid-1970s. Those whose job prospects have improved most are mothers, especially those with adequate qualifications, good health and a working partner. This means that the number of couples who both have a job has increased; they are ‘work-rich’.

Berthoud develops a number of economic and sociological explanations for these observations. Economic theories include the changing structure of the economy, the fall in demand for occupations requiring (male) strength and the technology-led reduction of the amount of time needed to care for a home and children. The decision to work, or not to work, is strongly affected by an individual’s sense of identity in the context of standard values. The redistribution between men on the one hand and mothers on the other has coincided with a massive change in social conventions: it is no longer considered appropriate for men to exercise all of the economic power in couples and women to undertake all the domestic duties. It may also be that ‘disability’ is more commonly accepted as an explanation for not working. Berthoud notes that while the ‘male breadwinner’ is increasingly rare, he has not yet been replaced by the ‘female breadwinner’. The polarisation between two-earner and no-earner couples may simply reflect the fact that it is now acceptable for a woman to contribute earnings alongside those of her partner, but not for her to replace them.

These emerging patterns of work-rich and work-poor families have contributed to the emergence of income inequality, among baby boomers and for later cohorts, although they are not the only factor.

Pensioner poverty
The standard measure of poverty in the UK is the proportion of individuals falling below 60% of median income. Pensioner poverty has fallen consistently since 1990 when, for 37% of pensioners, their individual income fell below the threshold of 60% of median population income, before housing costs. A focus on pensioner wellbeing through reforms to tax and benefit systems aimed at reducing the number of pensioners on very low incomes has played a leading role. Nevertheless 17% of current pensioners fell into this poverty category in 2010-11, some two million people.

Comparative figures for Europe using an EU-defined poverty indicator, which forms part of the EU Statistics on Income and Living Conditions (SILC), show that for people aged over 65 the UK ‘at-risk-of-poverty’ rate for individuals was significantly higher than the EU average, a difference of 5.5 percentage points (21.4:15.9%) (Office for National Statistics, 2012g). People aged 50–64 are also at greater risk of poverty than the European average although 18-24 and 25-49 age groups are at lower risk.

Pension incomes
Evidence on the performance of UK private pensions gives concern for the future income of people receiving pensions. The Organisation for Economic Co-operation and Development (OECD) has calculated the average annual real net returns on investment by pension funds between 2001 and 2010. Of the 22 countries included, the UK is third from bottom, showing a negative return over the decade (although it has a slightly lower than average negative return 2007-11) (OECD, 2012).

Research by the Institute of Fiscal Studies (Crawford and Tetlow, 2012) has identified that a third of people approaching retirement find it impossible even to hazard a guess about how much income they will receive from their private pension. Many who had annuity-based pensions, and did estimate their likely income, over-estimated it. People with final salary pensions were better able to produce accurate assessments. Around six in ten had not thought about how many years of retirement they needed to finance and among those who did, on average there was under-estimation. This research raises a number of issues around gaps between expectations and actual future income for baby boomers, which may have implications for their mental wellbeing.

Changes in pensions: The implications for wellbeing of baby boomers
Do pensions matter for subjective health and a sense of wellbeing? When people aged over 65 were asked what gave their lives quality, health and independence were a common priority but financial resources were seen as necessary to maintain these. In particular, a car gave independence and the ability to visit children and grandchildren, especially to those unable to walk far, while an adequate income allowed enjoyment of leisure activities and the sense of full participation in society (Bowling et al, 2001). Being able to look forward to a secure and adequate pension is therefore likely to promote wellbeing.

The baby boomers have lived through many reforms to state pensions. They have seen the decline of occupational final salary pensions, defined benefit schemes, and a spate of
Reforms to state pensions

State pension age rises. Many women in the cohort were already subject to the reforms legislated in 1995 to increase their State Pension age (SPA) gradually from 60 to 65 between 2010 and 2020. This gave a long lead-in time for them to adjust expectations and plans. But the most recent Pensions Bill, not yet ratified by Parliament (DirectGov, 2012 www.direct.gov.uk ) would raise SPA for men and women to 66 by 2020, 67 by 2028 and 68 by 2046. This allows little time to adjust, so that many of those approaching SPA feel the insecurity and lack of control of their financial future. In this section, we outline the recent and planned changes to state and private pensions, assessing how these may influence diverse cohort members’ ability to plan their retirement timing in an informed and satisfactory way and to receive an adequate wage replacement in retirement.

New Single Tier Pension. Some baby boomers, especially women with interrupted employment and low earnings, will benefit from the plan to introduce a new single tier pension (STP) from 2015-16. The full amount (£140/week in 2010 terms) will be payable to all individuals with at least 30 years of National Insurance contributions or credits at SPA, pro rata for less than 30 years. Those with less than seven years will not be eligible. The STP will include the self-employed. Credits for childcare and adult care in lieu of contributions to National Insurance (NI) are less complex, although credits for caring for an adult still require evidence of the amount of care needed and provided. This reform package represents a welcome simplification of the state pension scheme and should soon achieve near-equality in state pensions between men and women and across the earnings distribution. Spousal benefits will become redundant for most married women although it has not been stated whether these and survivor pensions will be accrued in STP, nor whether a divorcee may derive rights from her ex-husband’s STP record, as in the basic state pension. However, the government has promised to honour individuals’ state pension entitlements (or contracted-out equivalent) accrued before the reform, with no one losing the value of contributions made before 2015 (Ginn and Maclntyre, 2013). Those benefiting will therefore receive a mix of state pensions acquired across their working life, which will be earnings-related only up to 2015-6. A drawback of the STP is that it will be too low to ensure a decent standard of living without additional sources of income such as private pensions, where women, on average, remain at a disadvantage. Their median private pension wealth at age 56 has been reported as £9,100, compared with men’s £52,800 (West and Vass, 2011). The reform package is being paid for by steep rises in SPA and the rise in

scandals, including fraud and miss-selling, in private pensions. It is no surprise, then, that those now aged from 50 to state pension age feel uncertain and anxious about their pensions and were cynical about the roles of financial institutions and policymakers (Vickerstaff et al, 2008). Recent changes in the rules of state and private pensions may be experienced as complex, confusing and unfair. The reforms to defined benefit occupational pension schemes have already generated anxiety and anger among public sector employees, while the private sector’s shift to defined contribution schemes, in which employees bear the investment and annuity risks, inevitably creates uncertainty as to the adequacy of future pension income. However, the reforms will have diverse effects on members of this cohort, depending on their work history and current circumstances as well as their age. Individuals will find it difficult to understand how the reforms will affect their own situation and what they should do. This may reinforce any sense of insecurity and lack of control of their financial future. 

Further increases may be auto-linked to increasing average life expectancy and all rises in SPA will affect eligibility for the winter fuel allowance, concessionary travel and other age-related benefits. The average age of retirement has increased and is now 64.6 for men and 62.3 for women, but longer average working may not keep pace with rises in SPA for all in the cohort, given the many – and unequally-distributed - constraints on older workers in retaining their employment (see earlier section on longer working). Some will have a gap of several years between earning and pensioned retirement in which they depend on poverty-level Employment Support Allowance, means tested support or disability-related benefits. Those who lack a job and need to rely on such sources of income, with a sharp fall in living standards, are likely to experience anxiety and distress. An increasing proportion of women in their 50s and 60s are single, so must rely on their own income. Baby boomers who must stay in a job longer than planned, despite failing health or the pressure of informal caring commitments, are likely to suffer stress that could affect their own health.

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National Insurance (NI) contributions from 11 to 12% of qualifying earnings, from 2011.

**Changed indexation of pensions.**

The value of the basic state pension (BSP) fell from 26 per cent of average earnings in 1979 to an estimated 14 per cent in 2012 (DWP, 2010) bringing a drastic reduction in the living standards of those reliant on the BSP. Fortunately for the baby boomers, the STP will benefit from ‘triple lock’ indexation (annual uprating by the highest of national average earnings, RPI or 2.5%), introduced to curb the decline in purchasing power of state pensions. But RPI has been replaced by the Consumer Price Index (CPI) which excludes housing costs and is on average about 1.5 per cent lower than RPI. Even RPI failed to reflect rising costs for pensioners (Banks et al., 2010: 95) and many private (occupational and personal) pensions have also switched to CPI. Thus the cohort approaching retirement still faces inadequate indexation, except in years where national average earnings exceed CPI, with implications for declining living standards as they age. Although apparently gender-neutral, inadequate indexation affects women more than men because of their lower pensions, greater average longevity and higher risk of living alone.

**Contraction of defined benefit occupational pensions**

Given the internationally low level of UK state pensions since 1980, policymakers and the pension industry alike have been concerned to promote private pensions. However, two thirds of private sector employers provide no occupational pension scheme and only 16% of private sector employees (3 million) are contributing members of such a scheme (Association of Consulting Actuaries (ACA, 2012). Private sector employers have retreated from final salary pension provision, fearing unmanageable liabilities. Some companies became insolvent and could not deliver on their pension promise, leaving scheme members with greatly reduced pensions or none, while most defined benefit (DB) schemes have large deficits. As many as 91% of such schemes are closed to new members and 37% have also closed to future accruals for existing members. Typically, contributions have increased and pensions been reduced, while many employers have switched their scheme to a defined contribution (DC) basis, to limit their risk. Where private sector employers provide DC schemes, these usually have lower employer contributions (3-9%) than DB schemes (12-25%) (ibid.), as well as the disadvantages of uncertain and low returns on investment, combined with falling annuity rates. Only public sector employees have widespread access to a good final salary pension scheme. But their schemes are under review, with employees facing higher contributions, reduced benefits, a switch from RPI to CPI indexation and longer working, with pension age linked to the rising SPA (Hutton, 2011).

For some baby boomers, retrenchment of DB schemes and shrinking DC pensions (including personal pensions) could throw retirement plans into disarray. It has been estimated that about 85% of those aged between 50 and SPA will have sufficient pension income to meet a Minimum Income Standard at SPA; the MIS is £11,000 pa single and £15,700 pa for a couple (at 2011 prices) (Silcock et al., 2012). However, according to an industry survey, the proportion of people judged to be ‘on track for a comfortable retirement’ is rather lower. About half of employees aged over 50 were deemed to be saving enough - typically married men with stable employment in a large organisation. About a fifth (at all ages) were saving rather little - mainly younger workers with children and a mortgage. Just over a third were saving very little or nothing - typically single or cohabiting, with children, working for a small employer, low earners in part time or insecure employment (Scottish Widows, 2012). As noted above, there is a large gender difference in accumulated pension savings at age 56; some in the baby boomer cohort, especially women, will only have entitlement to the state pension (not always the full amount) and may therefore face reliance on means-tested benefits or family members. Confidence in their own private pension’s delivery on promises has declined among employees (Scottish Widows, 2012) an indicator of the anxiety the cohort is likely to share about future pension sufficiency.

**Auto-enrolled personal pensions**

Policymakers’ response to the decline of occupational pension provision has been to legislate in 2008 for auto-enrolment into workplace pensions - including the state-sponsored National Employee Savings Trust (NEST). From October 2012, employers with over 50,000 employees have been required to auto-enrol, with right to opt out, all those aged over 22 and earning at least £7,475pa in a workplace pension scheme, with employer contributions. Employees may opt in if earning between £5,035 and £7,475pa (2012 figures) but those with earnings below this level will be excluded from membership. (They can request to join but there is no obligation on their employer to make a contribution.) These will be mainly women part-timers, but also younger people and those who ‘dip’ in and out of employment, who will have no choice but to lose the employer contribution for some years. Minimum contributions from employer and employee (in addition to NI)
will start at 1 per cent of qualifying earnings from each (total 2 per cent plus tax relief) and will rise over several years to 4 per cent from employee, 3 per cent from employer and 1 per cent tax relief (total 8 per cent). For smaller organisations the start date will be delayed for several years depending on size (DWP, 2013). This protracted introduction means the youngest in the cohort will be aged 61 by the time all employers provide access and the full employer contribution. Estimates of how many will opt out after auto-enrolment vary. A recent survey indicates that, in private sector employers’ opinion, about 25% of their employees will opt out and up to 40% among small employers (Scottish Widows, 2012). Affordability is a barrier for many low paid workers. Where employees choose not to join an existing workplace pension scheme, 92% of employers believe this is due to the cost of contributions (ACA, 2012) and a survey by B&CE Benefits Schemes found 28% of workers expected they would be unable to afford the 4% contribution required under auto-enrolment, in addition to NI (The Independent, 2008). While auto-enrolment of employees will benefit some cohort members, it is likely that the most vulnerable workers – the groups identified above whose pension saving is small or zero - are also those most likely either to be excluded or to opt out of auto-enrolment because of the cost and more immediately pressing priorities for spending.

Baby boomers who are employed and not already saving in a pension scheme and therefore eligible for auto-enrolment will have a difficult choice to make: to stay enrolled in a pension chosen by their employer and pay the extra contribution, or to opt out and, for example, spend down debts or save in other ways than through a pension. On the one hand, opting out forfeits the employer contribution and tax relief, but on the other, personal pensions are inherently risky because of stock market volatility and falling annuity rates, whereas saving cash in a building society is safer and more accessible. As the cohort is aged from 57-66 (in 2012) there is limited time for their fund to grow, even if current investment returns were good and likely to remain stable, neither of which is likely in the near future. Charges for fund management will be initially under 0.5% of the fund annually, but there is no legal limit so they could increase, absorbing much of the fund. Moreover, the minimum total contributions, at 8%, will not produce a large pension, even for younger workers. The low level of the STP means that anyone likely to be eligible for means tested benefits, such as housing benefit, could find the extra saving brought no financial gain. For women, this risk is magnified by the unpredictability of their caring commitments and future relationship status, which make it difficult to calculate whether it is worthwhile to spend money on voluntary pension saving. Clearly personal pensions are not suitable for everyone and no one can be certain of their future circumstances when making a savings decision; but calculations have indicated that single people in their 40s or 50s (in 2012) with a full working history, but low earnings, are at medium risk of a personal pension being unsuitable for them (Steventon, 2006). The only free advice available will be generic; individual advice will be costly and the factors to take into account are many and complex. A further financial blow to the cohort is that the Age-Related Tax Allowance will not apply to those reaching SPA after 2013.

In terms of mental health and wellbeing of the cohort, making pension decisions in their late 40s and early 50s will be easier for those who are well-paid and in secure employment: the changes in state pensions will make little impact, despite the cessation of accruals in the state second pension, although the uncertain value of defined contribution pensions or reductions in defined benefit pension formula are likely to give concern about future living standards. For the low paid or those with insecure employment, especially women with little or no private pension saving, the new single tier state pension will provide income security at a very basic level, but not a decent standard of living. The cohort will face a bewildering range of interacting changes in state and private pensions as they approach their expected retirement. The need to make the best decision about extra pension saving or longer working (if there is a choice) could result in frustration and a sense of helplessness when faced with the complexity of the pension system, especially since the outcome could be 20 or 30 years of squeezed living standards or poverty and dependency in retirement.

**Wealth**

Wealth has been considered to include three major elements: housing wealth, pension wealth and other wealth. Across all wealth in the UK the breakdown is 39% pension wealth, 39% property wealth and 22% other wealth. The Institute for Fiscal Studies (Crossley and O’Dea, 2010) has mapped wealth by age group and expressed some concerns about the level and source of wealth owned by baby boomers, see Exhibit 6.6, which shows median financial wealth of £7,500 for heads of household aged 55-59 and £17,500 for those aged 60-64. Their analysis also showed that those who paid into a pension fund tended to have more (non-pension) financial wealth than those who did not.
The National Equality Panel’s 2010 report on economic inequality in the UK estimated that by age 55-64, a tenth of households have total wealth of under £28,000, but a tenth have more than £1.3 million (National Equality Panel, 2010).

The ELSA surveys have collected information about wealth across the four waves of the study. Family wealth holdings of people aged 50 to State Pension age, were analysed in 2008. In terms of financial wealth, savings, there was an average holding of £135,900 but a median of £14,400 reflecting a very unequal distribution. Housing wealth is less unequally distributed, with an average of £170,100, a 90th percentile of £350,000 and a 10th percentile of zero. Tracking changes in wealth over the period, researchers found that housing wealth increased between 2002-03 and 2004-05 but then fell back in real terms between 2006-07 and 2008-09, reflecting declines in house prices.

Pension wealth is the main source of wealth providing income for people in retirement. ELSA evidence on private pension wealth shows an unequal distribution, with an average of £179,500, a 90th percentile of £438,000 and a 10th percentile of zero. Exhibit 6.7 sets out wealth levels.

### Exhibit 6.6: Financial wealth in 2005, by age group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Mean</th>
<th>10th Percentile</th>
<th>25th Percentile</th>
<th>50th Percentile</th>
<th>75th Percentile</th>
<th>90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td></td>
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<tr>
<td>25-34</td>
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<tr>
<td>35-44</td>
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<td></td>
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<td>45-54</td>
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</tr>
<tr>
<td>65-74</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75+</td>
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<td></td>
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</tbody>
</table>

The height of the column represents the mean in a particular group. The black circle represents the median; the two crosses represent the 25th and 75th percentiles and the extremities of the bars the 90th and 10th percentiles.

Source: Crossley & O’Dea (2010)

### Exhibit 6.7: Distribution of family wealth (£)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>10th percentile</th>
<th>25th percentile</th>
<th>50th percentile</th>
<th>75th percentile</th>
<th>90th percentile</th>
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<tr>
<td>Private pension wealth</td>
<td>179,500</td>
<td>0</td>
<td>12,000</td>
<td>90,700</td>
<td>237,800</td>
<td>438,000</td>
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<td>Primary housing wealth</td>
<td>170,100</td>
<td>0</td>
<td>30,000</td>
<td>150,000</td>
<td>240,000</td>
<td>350,000</td>
</tr>
<tr>
<td>Non-housing wealth</td>
<td>135,900</td>
<td>3,100</td>
<td>100</td>
<td>14,400</td>
<td>81,400</td>
<td>266,900</td>
</tr>
</tbody>
</table>

Source: Crawford and O’Dea, 2012

Data ELSA 2008-09, figures at 2008-09 prices.
Housing

For many of the project interviewees early marriage, or the start of a career, was associated with getting a home. For some this involved acquiring sufficient ‘points’ to get local authority accommodation, for others it involved buying a flat or house. For some, this represented a change in housing occupancy from that of their parents and the homes they had grown up in. The ‘right to buy’ policy of the 1980s enabled some to get onto the property ownership ladder. For some interviewees divorce resulted in one partner remaining in the property and the other moving on, with implications for their current access to housing wealth in this group.

Buying a house

‘I had an accident, fractured my skull when I was sixteen and got some compensation because it wasn’t my fault. When I was 21 I got married. We used some of the compensation to buy our first flat. I decided that council house life was not for me.’ Male, born 1948

‘I got divorced, my wife kept the house, I didn’t take anything so I’m living in this flat. I’m earning good money at the moment so we’re trying to be as frugal as we can. This flat is costing me £1,000 a month; so I’m paying someone else’s mortgage. We’ll probably move to East Anglia where renting is half the price.’ Male, born 1949

“We bought a flat when we got married, it was quite affordable. We sold that, there wasn’t a huge housing boom or anything, bought this house for £17,500 in 1978. I bought my husband out when we got divorced. Female, born 1950

‘My father bought a brand new house when I was about eleven. I think it was £750 for a three-bedroom house. I got married in 1973 and bought a house. It was £8,000 then, it was quite cheap.’ Male, born 1947

‘We lived with his parents, I fell pregnant and that helped us get points from the council. We were given a flat. At the time Margaret Thatcher were offering the council houses to buy. Flats weren’t included so we did a swap with the lady opposite. Her marriage had broken up so she was quite happy.’ Female, born 1947

Housing wealth

Housing wealth has been identified as the biggest, and perhaps most fortuitous asset of the 1946-55 baby boomer group. They inherited from their parents the post war urge to own property which they have followed. The growth of home ownership has been described as ‘one of the most significant changes of the twentieth century’ (Stephens et al, 2005) Exhibit 6.8. Stephens notes that the neo-liberalisation and deregulation of the UK’s financial system in the 1980s, combined with housing privatisation mainly through the government’s Right to Buy policy, were key to promoting the growth of owner-occupation (Stephens et al, 2005). Home ownership is highest of all among the baby boomer group (Exhibit 6.8). Rising equity values, linked to deregulation of the financial system, have been said to be responsible for the growth of consumer spending, particularly among this group. However, nearly a quarter are not owner-occupiers and will not share in any benefits of home ownership and any increase in capital values that may support them in the future.

Exhibit 6.8: The growth of home ownership

Source: Williams 2007

Home-ownership became perceived by many as ‘the essential step to obtain membership of an expanding middle class for whom housing equity was pivotal in a broader lifestyle of credit based and housing equity fuelled consumption’ (Forrest et al, 1999). This has brought problems for some where a too generous mortgage has been granted against insecure earnings.
Exhibit 6.9: Home ownership by age groups

Views about education

‘I realised that with this kind of stratification in society, if you wanted to get on in life you had to have a degree, better education. So I applied to the Open University.’ Male. Born 1948

‘I went to university, I don’t think anyone else in the family went. I don’t think I could have gone without it being free and I got a maintenance grant. Dreadful, poor people nowadays, it’s absolutely appalling. Education made a huge difference, from my point of view.’ Female, born 1950

‘I went to university at the time when we got grants and didn’t have loans. But my parents because they were both working had to pay half my costs, and I know that that actually had a huge effect on their ability to live full lives. But I think we thought we had a right to everything because we’d grown up with the health service and free education.’ Male, born 1949

‘My advice to young people is ‘make sure you’re well-educated.’ Male, born 1955

‘I never, ever learnt anything at school, I never, ever committed I wish I’d have put more into my life when I was younger because I’d have been a lawyer, a doctor or something.’ Female, born 1951

‘Went to a village school. Had good teachers, but looking back, education failed me or I failed education. It took years to realise and then I saw the benefit,’ Male, born 1949

The sociologist John Goldthorpe has said that rapid change in the economic structure between the 1940s and the 1970s, with fewer blue collar jobs and more managerial and professional jobs, often in the expanding welfare state, created more ‘room at the top’ and enabled greater social mobility (Goldthorpe, 1987). In the 1930s, less than 10 per cent of the population belonged to the professional and managerial class, but it is now more than 40 per cent. The baby boomers were major beneficiaries of this very significant change. The education system also changed to reflect new requirements with the expansion of higher education and the raising of the school leaving age from 15 to 16 in 1972, a change which affected the younger members of the cohort. While only a minority of eighteen year olds went to university in the 1950s there was a general increase in the 1960s which benefited the cohort of baby boomers. Many took advantage later of the development of the Open University and other opportunities to acquire academic and professional skills. This
group is arguably the most highly educated to move into retirement years. This is an important factor in considering aspects of their mental health, including mental capacity, where there is clear evidence of the positive effects of education for wellbeing in later years. Exhibit 6.10 shows the growth in higher education in the 1960s to a mid-1970s peak.

The impact of post war education reforms is reflected in the numbers finishing their education with no qualifications. The 2002 National Basic Skills Survey (Williams et al, 2003) found that 41% of people aged over 55 had no qualifications, compared with 27% of 45-54 year olds (including most of the 1946-55 cohort). The effect of raising the school leaving age to 16 in 1972 is seen in the 35-44 age cohort, where 16% had no qualifications. Socio-demographic information collected for the ELSA further illustrates the educational attainment differences between baby boomers and older cohorts (Gjonca & Calderwood, 2004). While 21% of men aged 50-54 and 18% aged 55-59 in 2002-03 had a degree level qualification, the proportion of 65-69 year old men similarly qualified was 11.0%. Only 5.5% of women aged 65-69 had a degree or equivalent.

**Working lives**

Among the people interviewed for the project there are a number of patterns of employment. Some interviewees, employed in public sector services, professional jobs and education, had been the first, or only, member of their family to go to university. For others, a university or professional training experience came after an initial move from school into a relatively unskilled job. For yet others, school led quickly into either a long term trade or employment, perhaps after trying out a few jobs. Finally there are those whose working life has been more mixed, with changing patterns of employment. Respondents, both men and women, often reflected the relative ease of getting a job for young people in the 1960s and early 1970s, as well as the changes in the labour market in the latter seventies and eighties.

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**Exhibit 6.10: Higher Education age participation index: number of university entrants under 21 compared to average 18-19 population**

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**Getting work**

‘Left school just before my fifteenth birthday. I had a series of jobs, well then you could, I could change my job almost at will .. ‘cos there were that many jobs. It was never an issue.’ Male, born 1949

‘When I went for my first job they were offering me whatever I wanted .. if you were a graduate you could walk into a job, then if you didn’t like it you could chuck it in and go for something else. Even when I was a teenager and I was doing part time jobs working in the shops in the West End and things like that, if I didn’t like it I could chuck it in and get another within ten seconds’. Female, born 1950

‘My first summer holiday job was in the Co-op Drapery. I was thirteen. I hated it, but my mum knew the manageress. The following year I got a little waitressing job, I loved that. Female, born 1947
Working lives

‘I left school to become a nursery nurse. I trained for that. Then I decided I wanted to work in an office so I got a job in the Council. I got pregnant and we got married, after that we got divorced. I was a single parent and I went back to work at the Council because I didn’t know about benefits. I got married again and had a daughter; when she was born I went back and did my O levels and Highers and then got my professional qualification’. Female, born 1952

‘Left school at fifteen. Me final year I played for BFC ‘A’ team, but I got yellow jaundice, so it was terminated. I worked at M Tyres then Concrete Services for a while. Then I took up (house) painting with a friend. We were self-taught. I’ve been doing that roughly .. forty-four years.’ Male, born 1946

‘I’ve been a self-employed gardener for fifteen years. Before that I worked for a building firm; I got stood off in the nineties, I got three minutes’ notice’. Male, born 1949

‘In them days it was all about apprenticeships and y’know, get yourself a trade and.. so that’s a big percentage of the lads.’ Male, born 1953

‘I did an HND in IT. I was in my first job at nineteen, where I worked for twenty years. Worked my way up. Then got made redundant from there in a cutback. Then got a job for another company, was there for ten years, and got made redundant after cutbacks. This time I decided to work on a contract basis and this suited quite well.’ Male, born 1953

‘I was teaching, decided to do an Open University degree, then I did an MA, and became a senior teacher. And then I decided to have some time out, I’d been in an era where you didn’t have gap years. So I resigned. Got offered some part-time work in my parish church and did this for six years before going into the ordained ministry.’ Female, born 1955

‘I didn’t get the grades I needed so I worked in the pharmaceutical industry. I re-sat and decided to go to University to do microbiology. We had the milk round, which was very useful for getting a job, so I got a job with a confectionery company after I left university.’ Female, born 1954

‘I thoroughly enjoyed my work. Started at the bottom and worked my way up. I’ve always been the type of boss that would never ask someone to do something I wouldn’t do myself.’ Female, born 1955

While many expressed positive satisfaction about the role of work in their lives, for others it has been a means to an end of having resources on which to live. The in-depth interviews and the web survey throw some further insights on attitudes to work and views about future working. Work has clearly played an important role in forming the self-identities of the 1946-55 group and their feelings as they look back over achievements in their lives. Work has played an important role in many aspects of their lives, often through the relationships it has fostered.

What has made you most satisfied?

‘What made me most satisfied I imagine was my job. I always said I wouldn’t become a person just sitting in an office doing nothing .. and I managed to find jobs that I really enjoyed.’ Female, born 1947

‘I suppose a lot of the work I’ve done .. Lots of difficulties I came up against in getting things through the system, but we did actually achieve quite a bit.’ Female, born 1954

‘I think professionally work has always been interesting, I’ve never had to do dull, dreary, repetitive, monotonous type jobs.’ Male, born 1955

Interviewees were asked how important work had been in their lives. For many, their own work achievements and the contribution of employment to their sense of themselves was an important part of their life, although tempered by some with a broader perspective about the reasons for working.
Importance of work in life

‘Work has been very, very important. I’ve never been afraid of innovation or change in my work. I’ve flipped about a bit but in my current job all of a sudden I had to become a responsible person. It’s not just the work, it’s the people, and I’m not very good at separating the two things.’ Male, born 1949

‘I think doing work is extremely important. I loved being at home with my daughter when she was little, but it actually impacted on how I felt about myself, I think it was a status thing, a ‘stay-at-home mum’, it’s not appreciated in the same way as doing a job of work. Bringing up a whole and healthy child is one of the most important things you can do. Yes, working at something is extremely important to me.’ Female, born 1951

‘I think it’s about achieving some balance in one’s life. I worked in order to make an income in order to keep body and soul together, my attitude was no matter what I do or do not do, the world is still going to turn.’ Male, born 1955

‘I worked in a pharmacy and I loved it. I had to go off sick. I feel as if sometimes I vegetate, that’s why I look after the wee one.’ Female, born 1952

Although work was a source of satisfaction for many people, a number also identified work experiences as the cause of mental distress during their lives.

Work and stress

‘I was in the Bought Ledger Department, having to tell people they were going to get paid, knowing full well that they weren’t. That was awful, just talking about it upsets me.’ Female, born 1947

‘I did have a situation where I did not get on with my line manager; I took comfort from the fact that most people didn’t get on with her. On my way to work I would have practice conversations, it wouldn’t be a good way of starting a day. You do start questioning, thinking, is it that I can’t hack it any more? It did knock my confidence. This went on for nine months before I asked to be moved.’ Female, born 1954


Men aged 16 to 64, women aged 16 to 59.
Source: Labour Force Survey, Office for National Statistics (2008c)

The recent economic recession and reductions in public sector spending have impacted on some members of the baby boomer group, who have retired from work when they might not otherwise have done so, or are concerned about their future prospects.

Redundancy threats

‘It’s never nice to be referred to as surplus. I’m not really wanted, although I can see things that need doing in the place I work. They keep trying to match me for jobs I can’t do, I’ve got to go to an interview and the system has matched me to a post I couldn’t do. I’ll probably be made redundant next month.’ Male, born 1949

‘My organisation is having to reduce its budget by a third. At the moment I’m not getting any messages, but you never quite know what will happen. I want to go on to sixty, but I’m in a good position that if I have to go now, then it’s OK.’ Female, born 1954
Employment and the baby boomers

In 1971 around 95% of men of working age were employed. The current rate is 83%. Male employment began to fall in around 1973 and fell further through the 1980s and 1990s. Women's employment rates increased over the same period from about 59% to 71% in 2012, making women some 45% of the working population. A number of factors are linked to this increase in women working, both social and economic. Changing attitudes and culture, the impact of the women's movement, and improvements in women's educational qualifications are clearly relevant as are the Sex Discrimination and Equal Pay Acts implemented in the 1970s. New employment opportunities, including increased automation and changing work processes in manufacturing made more jobs accessible to women, the growth of service industries played a major role in bringing more women into the workforce, and the increase in part time working made more flexible employment available to suit women's childcare and other needs. In fact 93% of the total increase in women's employment between 1971 and 1993 was part-time work (Labour Market Statistics, 2008). However, part time work is generally less well paid than full time work with implications for women's earnings, savings and other wealth and pensions. Labour force participation has played an important role in the lives of women in the baby boomer group, particularly married women, 75% of whom were working in 2000.

The decrease in the proportion of men of working age who are economically active is the result of more men staying longer in fulltime education, a trend for early retirement of men in their fifties mainly due to sickness and disability, but also to long term unemployment. Age discrimination plays a role in the exclusion of both men and women over the age of 50 from employment.

Exhibit 6.12: Employment rates by age group 16- State Pension Age - trends

Source: Labour Force Survey

Attitudes to work

Research in the United States has highlighted significant differences between generations in attitudes to work (Twenge et al, 2010). Comparing the results of surveys carried out with three cohorts: baby boomers, people born 1965-1981, and those born 1982-1999 as they started their working lives, researchers conclude that younger generations are more likely to value leisure over working time and to place a premium on rewards such as higher salaries. Just 23 per cent of baby boomers agreed that "work is just making a living," compared with 34 per cent of later groups of respondents. Three-fourths of boomers said they expected work to be a central part of their lives, compared with 63 per cent of the 1982-99 cohort. Half of the baby boomers said it was very important to have a job that provides an opportunity to help others, compared to 44% of the youngest cohort. Social values such as making friends, and intrinsic values, such as an interesting, results-oriented job, were rated lower by the younger groups than by boomers. The authors summarise changes as representing a steady increase in leisure values over the generations, and a decline in work centrality.

Working status

The trend for people to either take early retirement or be excluded from the workforce for other reasons has been declining in recent years, as shown in Exhibit 6.12. The proportion of people aged between 50 and State Pension Age in work has increased from some 63% to 71%, and the activity gap between workers over 50 and 25-49 year olds has reduced from 14.6% to just over nine per cent (Barrett, 2010). Labour Force statistics from 2011 break the figures down by smaller age bands showing: around eight in ten 50-54 year olds, seven in ten 55-59 year olds, 44% of 60-64 year olds and 20% of those aged 65-69 are working. Two-thirds of those over 65 who are employed
are working part time, as well as three out of ten 55-59 year olds and four out of ten people aged 60-64. These figures show that a majority of baby boomers were still working and that, if trends of current 65-69 year olds are followed one in five is likely to continue to work, mostly part-time, and four in five will leave work at state pension age. The Labour Force Survey asks people who are working whether they would prefer to work fewer or more hours. People aged 50 to state pension age were least likely to say they were underemployed and most likely to say they were over-employed, indicating some preference for part-time work amongst this group. There is also some evidence that people in this age group are more likely to work for small and medium sized firms.

One feature of the current recession is that, compared to previous recessions, people over 50 are not losing their jobs at a disproportionate rate. The employment rate for people aged over 50 fell by 0.7% from 2008 compared to 1.7% for people age 25-49 and that of people aged over 65 increased by 1.5%.

The English Longitudinal Study of Ageing (ELSA) has tracked the employment and financial experiences of its participants. The most recent wave in 2008 collected information from people who had joined the study, aged 50, at its inception in 2002, and from a later top up sample, aged 50-53 in 2006. It therefore has good coverage of the 1946-55 cohort, who were aged 53 to 63 at the time, including some tracking of those born before 1952. The study thus collected information about the cohort but the economic recession may of course have had an effect on employment behaviour.

2008 ELSA findings are that employment rates increased between 2002-03 and 2008-09 (Crawford and Tetlow, 2010). In particular, the survey found that while employment rates of 50-54 year olds and those aged over 70 fell slightly, there was a statistically significant increase in employment of people aged 55-69. This was slightly larger in those aged 55-59 for women and for men aged 60+. Rates of both part-time and full-time work increased, but part time increases were larger. See Exhibit 6.13.

Exhibit 6.13: Percentages in work 2002-03 and 2008-09, men and women aged 50-64 by age group

<table>
<thead>
<tr>
<th></th>
<th>% in paid work 2002-03</th>
<th>% in paid work 2008-09</th>
<th>% Fulltime 2002-03</th>
<th>% Fulltime 2008-09</th>
<th>% Part time 2002-03</th>
<th>% Part time 2008-09</th>
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<tr>
<td>Men aged 50-54</td>
<td>83.2</td>
<td>83.0</td>
<td>76.5</td>
<td>73.7</td>
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<td>Men aged 55-59</td>
<td>72.6</td>
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<td>63.6</td>
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<td>47.1</td>
<td>55.4</td>
<td>35.8</td>
<td>40.0</td>
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<td>Women aged 50-54</td>
<td>75.4</td>
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<td>35.6</td>
<td>38.7</td>
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<td>26.5</td>
</tr>
</tbody>
</table>

Source: Crawford and Tetlow (2010)

Those with higher levels of education were more likely to work across all the 66 age groups, as shown in exhibit 6.14, taken from the ELSA report. Wealth and region also affected employment rates. While employment increased in all wealth quintiles, the rates of employment were highest for those in the middle quintile for people age 50-64 and in the highest quintile for people aged over 65. In terms of region, employment rates were much lower in the North East and North West than in the East of England and the South East. However, employment rates in Yorkshire and Humber and the North West showed a greater rise between 2003-03 and 2008-09 than those in London and the East of England.
Despite improvements in employment rates, unemployment of people aged over 50 is problematic. When they become unemployed, people aged 50-59 are likely to remain unemployed for 2.1 months longer than someone aged 35-49 and 3.4 months longer than someone aged 18-24. Recent research has shown that the financial impact of being unemployed is worst for people over 50, meaning that a spell of unemployment can have an impact on income lasting a lifetime (Tinsley, 2012). 2012 labour market statistics show that 48% of unemployed people over 50 have been out of work for more than a year, 50% for men. The main issues are barriers to work that face jobseekers over age 50, in particular employer discrimination. The Resolution Foundation (Cory, 2012) has flagged up the comparative poor performance of the UK in tackling unemployment and ‘joblessness’ among people aged 50+ who want to work. They detail a number of underlying weaknesses, which could be improved by policy intervention.

Women in the workforce
The increasing numbers and growing role of baby boomer women in the workforce has been an important aspect both of economic change and of wider changing relationships between men and women in many aspects of life. The women’s movement of the 60s and 70s set the goal of achieving equality for women. Although much has improved, and a strong legacy has been created for younger women, both the income gap and work status differences between men and women remain. The gender pay gap will be particularly important for women who have children and are divorced or who never marry since these groups tend to lose out in private pension building. A 2007 analysis of the differences between male and female full time earnings highlights this point, see Exhibit 6.15. If earnings of all women were compared with those of all men, including those not employed, self-employed and working part-time, the gender gap within age groups would be greater, with consequences for the amount of private pension accumulated.

Exhibit 6.14: Employment rates by education level and hours of work, by age, 2008-09

Exhibit 6.15: Median gender pay gap of full-time working age employees by age band

Source: ONS (2008c)
Retirement
While some project interviewees have happily taken retirement, particularly where a pension has been available, others either prefer to continue working or are financially unable to consider retiring.

Retiring from work and plans for the future

‘The joke in the family is that I’ll be answering emails on my way to the graveyard.’ Male born 1950

‘You know, beginning of the year there weren’t a lot going on, with the recession. I’m moody I think when I’m not doing owt; I like to be active.’ Male born 1946

‘My husband worked until he was 69. I don’t want to work to that age. My parents have lived in Florida for fifteen years. It has real grey power, run by older people, for older people. So I want to go there and feel less stigmatised by growing old. And people look and behave younger, they’re really assertive.’ Female, born 1951

‘Well I can’t afford to retire at present.. and actually I wouldn’t want to retire. I get a little tired at times, but the thought of retiring doesn’t appeal to me. The thought of doing something different appeals to me. I’m quite happy about not being in a position to retire.’ Female, born 1951

‘Originally I thought I wouldn’t get my pension until I was sixty-two. I loved working, but my husband’s five years older than me and retired early because of his health. I got to thinking, I should retire so we can do things together.’ Female, born 1949

‘Getting off the treadmill was absolutely brilliant. I listen to Radio 4, all that kind of thing. I’ve been able to do more things that I wanted to. I didn’t even know what I wanted to do because you just don’t have time to think about what it is you want. My husband’s still working but we make sure we do decent holidays together, get the long-haul flights in before we’re too decrepit.’ Female, born 1950

‘My husband’s a lorry driver. It will be sometime before he retires. He’s just started a new job which he prefers to the one he had before. But I’m not used to him being here. We fight over the TV control. If he retires and he’s here fulltime – we’ll definitely divorce!’ Female, born 1952

The web survey – attitudes to retirement

The self-selected web survey of 127 people born 1946-1955 asked about people’s employment status. Around a third of those responding were fully retired and a further 1 in 6 semi-retired. Around half were in employment, full time, part time or self-employed and one in ten were either caring for someone, looking after a home/family or long term disabled (multiple statuses were recorded).

People still working were asked to estimate the age at which they planned to fully retire. Only a minority of respondents suggested an age below 65 (about 1 in 6). The most frequent answers were, in order: plan to work indefinitely/never retire, age 70, age 65 and don’t know.

Retirement intentions – web survey respondents

‘Probably 63 when I will get my state pension, but maybe not if I’m still enjoying working’.

‘Probably later sixties - will gradually reduce amount of work I take on, until maybe 67/68’.

‘I am not sure I will ever formally retire until I am not physically or mentally fit to continue’.

‘Will probably have to work until the government says I can retire in order to get a state pension! Therefore at 66yrs I think. I would love to retire earlier in order to explore more of the world’.

Those who were employed were also asked whether they had made any plans for retirement. Many responded that they had made no plans or mentioned only the pensions they had been building. Others said they had begun to think about planning. Some had specific activities they were developing, while others were looking to reduce their working hours or were planning changes to work for the future. A number planned to move house, including those wishing to property down-size.
Plans for future retirement – web survey

‘Not plans; rather thinking of various options’. (Male, 58)

‘Yes, paying into pensions and saving as much as possible.’ (Female, 57)

‘I have bought a camper van and intend to travel when I retire’. (Female, 64)

‘Pension plan. Thinking about moving home. Thinking about building up interests to carry forward into retirement’. (Female, 56)

‘No’. (Female, 61)

‘Attempting new work area’. (Female, 62), (Male, 63) …and others.

‘Financial plans made from age 30 expecting to retire at 60 - fortunately on track. Have been developing other interests including voluntary work as part of phasing into full retirement - although I don’t regard it as ‘retiring’ as I plan to be active albeit unpaid’. (Male, 59)

‘When I do finally give up working I intend to down-size, be mortgage free and spend more time on leisure activities and holidays’. (Female, 64)

Reasons people gave for taking retirement included ill health, caring responsibilities and to have free time for other interests. Some took advantage of retirement/early retirement packages. Several mentioned stress and work pressures and others had been unable to find work as they got older.

Life after retirement – web survey

‘I have more time for myself, take my time instead of rushing around, more time for my family and grandchildren. I have been Vice Chair of a local charity since retirement and that has been a revelation’.

‘More time to do the things I want to do, but less money to do them’.

‘Freedom to choose what I would like to do. But less time!’

‘Much less pressure and more time to myself.

‘Even though I have kept myself busy working part-time, a feeling of unfulfilment or void’.

‘Loss of friends. Less confidence. Ill health.’

The main differences in their lives since retirement included having more time and not being under the same pressures as when working, and living healthier lives, although many mentioned having less money. Some mentioned that they are busier now than they have ever been and many are involved in voluntary work. However, those who took retirement on health grounds have had to come to terms with a long term condition. For some retirement has meant of loss of identity, interest and social life.

Reasons for retiring – web survey

‘Care for family members, and spend more time with partner, and indulge in hobbies’.

‘Semi-retirement - was made offered early retirement/redundancy - saw it as an opportunity to do something different with my working life’.

‘Made redundant, unable to obtain work (IT employment closes at 60)’.

‘The job (teaching) was becoming increasingly stressful and demanded all my time’.

‘I have 50 yrs. Can afford to’.

‘To go sailing’.

Reasons for the YouGov survey asked people what three opportunities they were most looking forward to for the future, with the following results, which include some interesting patterns by class and by socio-economic group):

- 40% were looking forward to being able to travel or take holidays (43% men; 36% women; 41% ABC1; 36% C2DE);
- 39% spending more time with partner/family (41% men; 37% women; 38% ABC1; 40% C2DE);
- 37% to having more time to relax (41% men; 33% women; 34% ABC1; 42% C2DE);
- 33% being able to pursue current hobbies, (36% men; 30% women; 35% ABC1; 30% C2DE);
- 27% to developing new interests (29% men; 26% women; 28% ABC1; 25% C2DE);
- 17% spending more time with friends (15% men; 19% women; 18% ABC1; 16% C2DE)
• 9% being able to volunteer (8% men; 9% women; 9% ABC1; 7% C2DE);
• 5% to being able to pursue educational opportunities (5% men and women; 7% ABC1; 2% C2DE);
• 5% moving to a new area (5% men and women; 4% ABC1; 6% C2DE).

The findings on travel were reflected by a number of people who took part in interviews, including some references to the ‘gap years’ taken by young people nowadays, which were not common when they were young but gave them ideas for the future. For younger cohorts, having more time to relax featured as their greatest anticipated opportunity with older age, although travel still rates high.

Factors associated with retirement decisions
The English Longitudinal Study of Ageing, ELSA, looks at the factors associated with not being employed (Crawford and Tetlow, 2010). For many people non-employment does not equate to retirement. For men the most reported reason, in 2008-09, was sickness or disability, while for women it was looking after home or family. 3.8% of men and 1.9% aged 55-59 stated they were unemployed, while 9.8% and 10.2% respectively said they were permanently sick or disabled. 11.5% of women and 1% of men were looking after a home or family. As Exhibit 6.9 shows, the proportions of people aged 55-64 defined as ‘inactive’ fell overall between 2002-03 and 2008-09. Being sick or disabled as a reason fell most significantly among men and looking after a family fell for women aged 55-64. Unemployment increased very slightly as a reason.

‘Retirement’ before State Pension Age (SPA): In 2008-09 28.9% of men aged 60-64 said they had retired and 8.4% of women aged 55-59. The ELSA researchers analysed some of the reasons why people withdrew from paid work before the SPA. Associated factors included:

• Being in the highest wealth quintile
• Having a private defined benefit pension
• Having a limiting longstanding illness
• Being a woman with a partner over SPA
• Having a mid education level
• Owning a home outright Living in certain regions of the country, particularly the North East and Yorkshire and the Humber.

Being able to afford to retire is thus a key aspect of retirement decisions.

Work-limiting health conditions In ELSA work, disability is defined as any health problem that limits the kind or amount of paid work a person could do. Around 26% of people aged 50-69 in 2008-09 reported a work disability, with the proportion increasing with age. Work disability was substantially more common among people with low wealth than those with high wealth. More than half of men aged 50-64 in the lowest quintile report a work disability. It was also more common among people with low education levels. This suggests that the type of work people have done affects their ability to continue in it when they develop health problems. Some factors associated with having a work disability and working included: Being under age 60

• Being part of a couple
• Having a private defined contribution pension
• Having a private defined benefit pension (women)
• Being in a higher wealth quintile (women)

Because it is a longitudinal study ELSA can be used to look at patterns over time. Tracking individuals across the phases ELSA showed that around 10% of people moved from full to part time work rather than non-employment. Factors associated with staying in the labour market included having high level education, having good health, being single and having a partner working.

Looking ahead, people were asked about their expectation of still being in work at a specific age in the future. In 2008-09 48% of women aged 55-59 expected to be in work when they were 60 compared to 36% in 2002, and 62% of men aged 55-59 expected to be working at 60 compared to 56% in 2002-03. 32% of men expected to be working at age 65 in 2008-09 compared to 26% in 2002-03. These changes in expectations broadly reflect changes in behaviour and indicate that the 1946-1955 cohort is leaving work at later ages.

Finally, ELSA 2008 looks at the characteristics of people who work after state pension age. This does not include any baby boomers but is of some interest for their future. Between 2002-03 and 2008-09 there were increases in the proportions of both men and women...
working beyond SPA, in age groups 65-69 and 60-64 respectively. Relevant factors include higher level of education, having an outstanding mortgage, not having a long-standing illness, and being in a couple where a partner is also working.

**ELSA 2008 brings out some important factors in relation to the employment of baby boomers. This includes further confirmation of trends towards working longer, particularly beyond age 55, with the greatest increase having come from part time work, the probability of increased working beyond state pension age, a decline in men having work disability, and a greater likelihood of those with such health condition being in work. Finally they have greater expectations of continuing working into the future.**

**Working longer – mental health and wellbeing implications**

Longer life expectancy, increases in state pension age, and a decline in expected value of some pensions mean many baby boomers in 2012 face the need to stay in employment longer. At the same time, others may lose their jobs due to the recession and austerity policies. What effect will these changes in the labour market have on this cohort’s health and wellbeing? Research has linked unemployment with poor physical and mental health, but the effect of being retired or employed (and earlier or later exit from the labour market) around state pension age is more complex. It depends on a number of factors, including the individual’s circumstances, orientation to work and role preferences, the conditions of their current or past job, and availability of suitable employment. In this section, we draw on research designed to disentangle how all these factors influence how employment or retirement affect psychosocial wellbeing and subjective health status.

Retirement is not a distinct labour force status, since many individuals retiring from their main full time job continue to work in some form, reducing their hours with the same employer, moving to a different job, or starting self-employment. Moreover, leaving employment does not equate to inactivity; individuals may pursue leisure interests, travel, do voluntary work or spend time on family caring. An important dimension of retirement diversity is the conditions under which individuals are employed and leave their job, including the timing and manner of transitions.

**What promotes mental health in the transition to retirement?**

Defining mental health in terms of well-established indices (low score for depression, high score for life satisfaction, cognitive capacity, verbal aptitude,) and physical health in terms of self-reported health status and functional abilities, Herzog et al (1991) found that neither work patterns per se nor occupational level had any clear effect on the health of a representative sample of US individuals aged 55-64 and 65+. However, for both age groups, higher life satisfaction and less cognitive impairment was associated with having left work by choice. Similarly, health and wellbeing were better for those whose hours of work (including no work) matched their preference. Among the employed, mental health (including unhappiness and depressive symptoms) was impaired by stressful work, but was better where individuals had control and decision latitude, echoing the relationship established by Marmot et al. (1991) for health of civil service employees in the UK. Thus what impairs wellbeing is either having little choice but to retire, or little choice but to continue in a job perceived as stressful, unrewarding or requiring too long hours.

British research is consistent with these results from the US. Warr et al. (2004), using a sample of men and women aged from 50-74, found that those individuals who were in their preferred role – whether employed, unemployed or retired – had better life satisfaction (long-term self-appraisal) and affective wellbeing (short-term feelings) than those who had been unable to choose, irrespective of age. But individuals’ role preferences were a function of the perceived quality of the ‘environment’ in terms of control, self-determination, application of acquired skills to achieve manageable goals and validate personal effectiveness, clarity as to role behaviours, variety, favourable physical working and living conditions, adequate quantity and quality of interpersonal contacts, a valued social role and sufficient money. Such environmental characteristics were independently associated with better mental health, and the authors conclude that wellbeing depends on being in a personally-preferred role, while that preference is itself influenced by the perceived environmental factors attached to the role.

This research from the US and UK indicates that having some choice as to work pattern during the transition to retirement is key to mental wellbeing, as is the quality of the work or non-work environment. A more recent study of 11 European countries (Waginger, 2009) found that early exit from the labour market was associated with poorer wellbeing, especially when forced, and that the effect lasted into later life. However, for those who
chose early retirement, voluntary activities were associated with higher wellbeing. Another study analysed preferred time use among men and women aged 50–69, using 1997 data from 20 OECD countries (Ginn and Fast, 2004). There was a common preference for more time to spend with the family or in leisure, 66% among those employed full time. In the ‘liberal’ welfare regimes (UK, US, Canada, Switzerland) 30% of men and 40% of women wanted a job (mainly part time for women) but were not employed. Most of this group who were actively seeking a job were pessimistic about finding an acceptable one, indicating a considerable unmet demand for the kind of work that individuals would like to have. Just under half of men and women were in their preferred role (ibid). Some 15 years later, in a recession and for a cohort with different expectations, role preference is less likely to be met.

The issue of encouraging older workers to stay longer in work has been considered in a report by the Chartered Institute of Personnel and Development (CIPD) (2012), drawing mainly on studies by Steve McNair and Matt Flynn. The report notes the benefits to employers of retaining older workers and identifies the management attitudes and practices that will promote older workers’ wellbeing and hence retention. These include: valuing experience and skills as much as qualifications and discussing with individuals as to their preferences and goals through regular appraisal or similar means. To enable management to respond appropriately, depending on each individual’s aims and wants, it is crucial to acknowledge that older workers are diverse: those welcoming challenge and change (‘aspirers’), those content with their job (‘stayers’), those struggling to balance work and other needs, perhaps because of informal care roles or ill-health (‘downsizers’), those with out-dated skills (‘at risk’) and those wanting to retire soon (‘leavers’), when it is useful to check whether a change in working conditions would make longer working attractive. Responses may include offering new mentoring roles, greater flexibility of hours, less responsibility, less arduous work or re-training. Echoing the findings of the research above, the report notes that older workers, like younger ones, prefer a job that is interesting, important, gives them pride, status, adequate wages, social contacts and a satisfactory balance between work and leisure. Good management – consulting workers, supporting them, providing helpful appraisal, developing, valuing and using workers’ skills, avoiding ageist assumptions but being prepared to adjust the job in the case of disability or family needs – all help to promote older workers’ job satisfaction and likelihood of being willing to remain longer in employment.

Recent research on the attitudes of those aged 60–64 identifies barriers to longer working and what might encourage individuals to work beyond age 65 (Vickerstaff et al, 2008). On the whole, older workers had a limited desire for extending their working lives but incentives included the availability of flexible working, such as part time or casual work. Choice as to the manner and timing of retirement was of great importance, but such choice was limited and unevenly distributed. Although the specific obstacles to longer working varied with individuals’ circumstances, common ones were the worker’s own poor health or the need to provide care for their partner, parents, own children or grandchildren, with sometimes a combination of these. Another barrier for those without a job was negative experience of Job Centres. For the employed, there was a gulf between the good management practices advocated by McNair and Flynn (2005) and the reality of some employers’ ageist attitudes and a requirement that workers be healthy and willing to do certain jobs thought suitable for older workers. Gender differences in attitudes and behaviour were clear, older women’s expectations of employment opportunities being depressed by previous chequered employment histories; moreover, flexible jobs that women had were often perceived as boring and less attractive in terms of choice and control than those open to men. Interestingly, there was no discernible difference in women’s attitudes between the cohort aged 60–64 and those aged 50–69, even for women affected by the rise in state pension age (although many were unaware). The study found that longer working would be more attractive if a job provided flexibility for caring roles, in terms of reducing responsibilities or hours; knowledge about their employment and state pension deferral rights after age 65; a satisfying job; advice, guidance, help and information about career development and gradual retirement; and a climate in which workers’ choices were paramount, not the agenda of government or employers.

To summarise, there is some divergence between what older workers want in the transition to retirement and the reality of employer attitudes and practice. This mismatch is not encouraging for the future mental health and wellbeing of baby boomers, who are being exhorted to work longer yet face limited opportunities for a job that is both compatible with their circumstances as well as being life-enhancing and satisfying.
The control and choice that are important for the cohort’s wellbeing depend to some extent on their current financial circumstances and future pension prospects.

**Mental health and economic wellbeing**

As noted in chapter 4, financial resources are important because they affect the choices people can make. There is a developing body of evidence to show that having a reasonable level of income and wealth has a positive effect on mental health. Higher income and socioeconomic status have been found to be associated with higher levels of wellbeing and lower rates of mental disorder in a distinct social gradient (Dolan et al 2008, cited by Royal College of Psychiatrists, 2012). A survey of 18,500 people commissioned by NHS North West in 2009 identified four factors that were closely associated with mental wellbeing as measured using the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS). Wellbeing was positively associated with having someone to provide help if in financial difficulty and overall current life satisfaction. It was negatively associated with being worried about money and with sedentary time, calculated as the number of hours a day people are sitting or reclining. The survey report concluded that people’s perception of their financial situation is very important in influencing mental wellbeing, with the economic status of households being more important than that of individuals.

In terms of mental illness, there have been consistent findings that the lower the socioeconomic status of an individual, the higher is his or her risk of mental illness (Hudson, 2005). Hudson tested several hypotheses for the causal relationships involved and found that an economic stress model provided the best explanation for the link between low socioeconomic status and mental illness. The English Longitudinal Study of Ageing found that wealth is associated with all aspects of wellbeing with more affluent individuals having fewer depressive symptoms, greater life satisfaction and better quality of life (Demakakos et al 2010). Similarly the Newcastle cohort study of people born in 1947 demonstrated links between mental illness and socio-economic status, at birth and over the life course (Tiffin et al, 2005). The findings of this study indicate that women are more sensitive to disadvantage in childhood and men are more affected by their own lack of socioeconomic success.

Mental health has, itself, been identified as the key to understanding the impact of socioeconomic inequalities on physical health and other life outcomes (Friedli, 2009). For Friedli, it is the unequal distribution of economic and social resources that affects mental health and explains resulting wider life outcome inequalities. The experience of social and economic disadvantage creates profound emotional and cognitive responses; inequality heightens people’s feelings of status insecurity and competition. Material deprivation thus erodes the emotional, spiritual and intellectual resources that are necessary for psychological wellbeing. It is people’s emotional and cognitive responses to material deprivation that create its social and psychological dimensions. Levels of mental distress need to be understood more as a response to relative deprivation than as levels of individual pathology. Friedli identifies a number of physiological and behavioural explanations that can account for the effects of poor mental health on overall health and other outcomes. These include the effects of chronic low level stress, affecting for example blood pressure and cholesterol levels, and a wide range of behavioural responses to multiple problems, impacting, for example, on care of self and children and relationships. Friedli concludes that positive mental health does confer advantages. So, for example, poor children with higher levels of psychological wellbeing have better educational outcomes than other poor children; but richer children tend to do better still.

A recent summary of the impact of the recession and austerity policies on older people and on the baby boomers has introduced the concept of the disappointment paradox (McKee & Stuckler, 2012). This affects people who have been protected from adversity earlier in life and who suffer more when it confronts them in old age. Particular risks associated with this phenomenon are cardiovascular disease and depression (McKee & Stuckler, 2012).
Work and finances – lives lived: mental health risk / protection balance

This section summarises the evidence collected in the chapter against the risk and protection factors set out in chapter 3, to identify implications for policy.

Risk factors

- Living in poverty particularly over a long term, provokes stress, worry, fear of getting into debt and loss of control over life. Being poor can impair people’s capacity to make choices, undermine independence and reduce participation in social life. It is a risk for loneliness.

- Retirement can lead to loss of a valued role and status as well as anxieties about managing on a reduced income (as well as actual experience of poverty, particularly for women). Evidence indicates that abrupt or enforced retirement is most likely to lead to mental illness.

Protective factors

- Financial resources affect the choices people can make. Having a reasonable level of income and wealth has a positive effect on mental health.

- Good housing, transport, education and employment all contribute to mental wellbeing.

Risk / protection balance - risks

Finances: For many of the project’s survey respondents, financial concerns for the future are high: around a third are worried. This chapter has shown that their concerns are valid. While current pensioner poverty has fallen it still stands at some 17% and is amongst the highest in Europe. Baby boomers will receive a State pension that has fallen in relative terms through the breaking of a link to earnings and which will continue to be inadequately indexed (although improved). The best private pensions, defined benefit schemes, have been severely limited and benefits cut; annuity-based defined contribution schemes, which have replaced them, are affected by poor returns on investment, which have lowered the sums accrued, and falling annuity rates are linked to effects of the economic crisis.

Data for 2008-09 suggest that average baby boomer income was below the national average, reflecting the greater proportion of the age group having pensions and benefits as their main income. A widening gap between the top and bottom deciles shows increasing income inequality. The chapter has identified growing inequality from the 1980s that has increased the share of income of those in the top income group and reduced the share received by the lowest groups. Inequality will persist into baby boomers’ retirement, with the risks to mental health already identified. Those most at risk are single people, divorced, widowed or never married, with women more at risk than men.

Researchers have said that almost one in six baby boomers will have income below the pension guarantee threshold on retirement; Pension Credit will top this up. Four out of ten baby boomers are predicted to have less than two thirds of their current income on retirement; it is suggested that they can fund their retirement using savings, inheritances and the value of their homes. These figures indicate that a half of baby boomers will be under financial pressure in their retirement; in many cases despite having made what they thought were satisfactory provisions.

Among the factors contributing to low incomes in retirement are low pay and lack of work. In addition to evidence collected about income inequalities the chapter has also identified continuing issues of unemployment and discrimination in recruitment among people over 50 and the financial impact this has.

For some baby boomers, low pay, poor pension provision and unemployment have put them at risk of poverty in retirement. For others the 2008 recession and economic downturn have left them less financially secure than they had thought. Both groups find themselves with potential money worries in later life. Baby boomers have lived their adult lives with growing economic prosperity. If this prosperity is now threatened, what effect will this have on their mental wellbeing?

Employment: baby boomers are moving into retirement at a time of recession. A number of participants in the project surveys flagged up the threats people are facing as budgets are cut and businesses close. People who had not expected to retire before State Pension age are now facing early, involuntary, retirement. Further evidence shows that, despite age discrimination in employment being illegal, many who lose their jobs face employer discrimination and some never work again.
While the ending of the default retirement age of 65 has promised more flexibility on retirement, which people are taking advantage of, the evidence is that employers are only slowly responding to the need to change their practices to meet the needs of retaining and recruiting older workers.

The impact of unemployment, forced retirement and also more planned retirement are being experienced more equally by women and men; women too will experience the loss of status and networks associated with work, with associated mental health risks.

Risk / protection balance - protection

Finances: While many respondents to the project’s surveys raised concerns about their finances, others said that they felt financially secure for the future. This reflects evidence collected for the study which has shown the impact of better private pensions, continued employment ownership of housing, wealth and savings for a proportion of baby boomers.

Employment: Respondents to the project surveys have indicated the important role work has played in their lives. Although some are finding themselves forced into early retirement many are talking about how they are planning their exit from work, sometimes involving stepping down to fewer hours. Others talk of moving on to something else. Wider evidence gathered for the project has found that trends for early retirement or exclusion from the workforce have been declining in recent years and the ‘activity gap’ between people over 50 and younger workers has reduced significantly. Trends to part-time working have increased for both men and women, particularly closer to state pension age. While for some, longer working may not be positive, for many it provides an opportunity to maintain networks and make controlled decisions about moving on. Baby boomers are showing willingness and a readiness to be in control of their own retirement.

Can baby boomers change attitudes about work and age? Will employers respond to the challenges of employing older workers and meet their needs for flexibility and being valued? This is a key economic challenge for a society with an ageing population.

Education: Post war education policies have meant that baby boomers are better educated than any previous cohort of older people; their education levels partly explain increased employment rates. Education is linked to better health outcomes, including mental health, which can be exploited by effective policy development.
Chapter 7
Conclusions, key findings and implications

Baby boomers’ lives
This review has adopted a perspective that views later life simply as a later stage of people’s lived experience, not a segregated part of life. This life course perspective understands people’s later life, in particular their health and mental health, as having been shaped by their lifetime experiences. Individuals each have their own lived experience and a set of personal characteristics, but lives are also structured by shared experiences of the social world people live in. As the review has shown, risk factors for mental illness have often been developing and interacting over many years. Later life adds a number of new challenges that individuals will respond to in ways that have been formed by the lives they have lived. Childhood and early adulthood are especially important developmental periods. The project has looked at how their post war childhoods, and the period of social change which young baby boomers lived through, have contributed to their life course experiences and their wider views and attitudes. A starting point has been the observation that baby boomers have been a vanguard for social change; they have done things differently and have acted as a cohort through which change has been effected. The review has explored aspects of the lives they have lived and attempted to identify some key issues that may contribute to baby boomers’ future mental health and which are likely to benefit from policy intervention.

Chapters 4, 5 and 6 have summarised risk and protective factors for mental illness relevant to the domains they have covered. They have asked what and how baby boomers have done, or are likely to do, differently, and whether this will protect their mental health. These summaries are reviewed in this chapter to draw out implications for policy and action.

Changing experiences of ageing
Baby boomers have ‘got on with their lives’ and in doing so have re-written the meaning of the various stages of the life course they have passed through – for example ‘middle age’ no longer has either its former age specificity or attitudinal implications. Life patterns are diverse and many social institutions and cultures have been transformed. Research for the project has found that baby boomers are not focused on becoming ‘old’ and planning for their ‘old age’ but are seeing their future lives as continuations of their present lives in most respects. These findings reflect wider observations about baby boomers ‘reinventing’ old age.

Later life has already changed from that experienced by many baby boomers’ parents. In particular, the financial circumstances of older people have improved over the last decade or so, with fewer experiencing extreme poverty, although the gap between those at the highest wealth and income levels and those at the lowest has widened, not narrowed. Reflecting wider changes the later life policy focus has shifted towards ‘active ageing’.

127
Nevertheless, later life does bring a number of challenges, summarised in chapter 3 of this review. These are the facts of growing older that baby boomers will need to manage if they are to successfully treat later life as a further and connected stage in their lives. Many of the challenges they will have to address may put them at risk of developing poor mental health and experiencing mental illness, either for the first time or as recurrence of earlier conditions.

**Lives lived - health and mental health**

**Risk factors for future mental health**

The overview of baby boomers’ health including mental health has identified both risks and protective factors for their future mental health.

The evidence on the health of baby boomers indicates that despite the benefits of free health care throughout their lives, and of reduced mortality from the major killers of cardiovascular disease and cancer, baby boomers will be unlikely to experience significant improvements in healthy and disability-free life expectancy, relative to their overall life expectancy, in the future. Sedentary lives, poor diets and obesity, alcohol consumption and drug misuse leave them at risk of diabetes, high blood pressure and heart disease and a number of cancers. Healthy and disability-free life projections indicate that men who are currently age 65 can expect to live for more than 17 years but spend only ten of those years disability-free; for women life expectancy is just over twenty years, around eleven disability-free. Increasing life expectancy could mean more years with poor health and leave people at greater risk of poor mental health. Health risks are experienced unequally by the population, according to socio-economic group. Around a half of baby boomers in the project’s national survey were concerned about their future health.

In terms of their experience of mental health, there is some evidence of a ‘step change’ in prevalence of mental illness among men born between 1950 and 1956 at ages 25-34, although women in this cohort did not experience the same increase. The rise is possibly linked to experience of transition into adulthood at a time of rapid social change. This cohort will be entering a further potentially difficult life period in the future and may carry with them an increased vulnerability to mental ill health. Men in the cohort have also demonstrated recent increases in suicide rates, possibly linked to economic recession.

Chronic illness, pain and disability are risk factors for depression and depressive symptoms. The effects of physical and mental ill health are interactive and cumulative resulting in increased disability.

Having low levels of physical activity is a risk factor for depressive symptoms.

**Protective factors**

Against the risks that have been identified there are a number of characteristics of baby boomers that may be protective, or which offer the opportunity for policy development on mental health promotion.

The project’s national survey shows that baby boomers rank the protection of both their health and mental health very highly (women significantly more so than men, perhaps leaving men at greater risk). They are more open about issues of mental ill health and generally willing to visit their GP, including when feeling low or mentally distressed (women more so than men). Evidence further indicates that this age group is now taking more exercise and eating fruit and vegetables. Interviews suggest that current public health messages about exercise and healthy eating have been heard and understood, if not always acted on.

Baby boomers have a strong commitment to the role of the NHS in meeting their health needs, are likely to seek help when they need it, rather than leaving conditions unattended, and are also likely to be proactive in ensuring that services are available to meet their needs. The implementation of the Equality Act 2010 age discrimination provisions will help make services available according to need, which will mostly be beneficial. Continuing research is likely to improve available treatments, particularly for conditions detected early. However, the project has also found that many baby boomers fear that the NHS, which has supported them throughout their lives, might not always be there for them in the future and that enhanced treatments may be unattainable.

**Policy implications**

The project has highlighted the need for improvements in the treatment of mental illness in later life. This includes a stronger focus on the prevention, identification and treatment of mental illness among older people. The project has noted how the separation of adult mental and older people’s mental health services at age 65 has had consequences for receipt of treatment for common mental diseases by older adults. This review has noted that some aspects of mental illness in later life may have different
characteristics to conditions experienced by younger adults. However, there is no justification for separating services at 65.

This Inquiry calls for a quick move to integration of adult mental health services across age groups and for the treatment for common mental disorders to be available on the basis of need. There need to be monitoring arrangements to track progress and for mechanisms to be created to identify and share good practice.

Substance misuse

Alcohol and drug use have both been more socially accepted by baby boomers than by earlier cohorts, with drug use first becoming a phenomenon associated with young people with the baby boomer generation. There are two aspects to the use of both alcohol and drugs in later life: continuation of existing habits and the development of new patterns of misuse, perhaps in response to stresses of later life. Excessive use of both alcohol and drugs is linked to poor mental health as well as physical health issues. In later life effects can include aggravation of age-related health problems and interactions with medications. Social relationships can also be damaged. Drug services do not seem to be geared up to support drug users over age 40, although the evidence is that older users can be treated effectively.

Drug and alcohol services need to be developed to more effectively meet the needs of older substance misusers; more research needs to be undertaken into the current use patterns and treatments that work best for older people. Additionally, there needs to be a greater public health focus on what works in the delivery of health protection measures for baby boomers to promote messages of sensible drinking that make sense to them.

Promoting mental wellbeing

There is growing awareness that mental health and wellbeing play an important role in physical illness and its potentially disabling consequences. There is evidence that good mental health may help protect people from the onset of chronic, disabling health conditions and also reduce their disabling effects. This understanding of the relationship between mental and physical health offers opportunities for limiting the current and future effects of chronic conditions by protecting baby boomers’ mental wellbeing now. It also indicates the need to promote a more holistic approach to healthcare, which recognises the interactions of mental and physical health and addresses both.

The review has further noted improved levels of mental wellbeing and life satisfaction among people in their sixties, but that this falls off in people over 70, who have some of the worst levels of mental health. There is little evidence of mental health promotion targeted at people in these age groups to enable people to protect the good mental health of their sixties. The need has been identified for more research on the factors linked to mental health and wellbeing in later life – and the reasons for its improvement and subsequent decline. The review notes recent observations that concepts of healthy ageing, and therefore of what works in health promotion, are not based on the views and priorities of people themselves, but on those of academics and professionals.

Research for the review has suggested that because of their attitudes to their own ageing, linked to individualism and self-identity, baby boomers are likely to be more responsive to such whole-person approaches and to finding personal solutions to problems.

There needs to be a greater public health focus on promoting good mental health among the baby boomers as well as older people, supported by better research on factors linked to mental wellbeing in later life. In particular baby boomers’ views of healthy ageing and mental wellbeing should be a focus of research to find out more about their priorities. Effective strategies need identifying for policy makers and health and well-being boards to engage and mobilise ‘baby boomers’ individually and collectively in activities to maintain good mental health in later life.

FIRST KEY FINDING

Adult health and mental health services should work in a way that integrates services across ages, recognises the relationship between physical and mental health, promotes good mental health throughout the life course and reflects the changing needs and preferences of different generations, and more specifically, the baby boomers as they grow older.
Ageism and mental health

One of the most significant underlying factors associated with mental illness among older people is loss of self-esteem. Self-esteem, together with optimism and a sense of mastery and coherence, are aspects of good mental health that enable people to be socially engaged and cope with stress and to be protected against mental ill health. Ageism has been identified as one of the greatest threats to older people’s mental health. Like other stereotypes, ageism can be internalised by its victims and lead to negative self-perceptions. As one contributor to the project research commented: ‘You can’t make sexist or racist comments any more in this country… but it’s still OK to make fun of older people’ (Male born 1946).

Age discrimination exacerbates older people’s sense of powerlessness and ability to live a fully engaged life; it has a significant negative impact on older people’s mental health.

Protective factors

Their attitudes to age suggest that baby boomers are already rejecting some earlier old age stereotypes. If baby boomers are to reinvent later life so that older people are seen as full and engaged citizens (and consumers) ageism needs to be ‘shown the red card’ and tackled with the same degree of commitment. There is no place for ageism in an ageing society of empowered people.

The Equality Act 2010 outlaws discrimination on the grounds of age (along with disability, race, religion or belief, sex (gender), sexual orientation, gender re-assignment, marriage or civil partnership, pregnancy and maternity). Its final provision, on age discrimination in the provision of services, came into effect on 1 October 2012. This provides a powerful tool with which to focus on ageism and age discrimination.

SECOND KEY FINDING

Ageism harms people’s mental health. We need to change attitudes to age and to older people with action reflected across all policy areas and with active promotion of older people as active citizens. ‘Baby boomers’ need to be supported to play active roles in promoting positive ageing and recognised for the social capital they provide to society more widely.

Mental health as a social asset

Baby boomers have survived their forties and fifties in greater numbers and are generally healthier than their parents. New health challenges and other significant life changes, such as bereavement and loss of social contacts, are often part of the ageing process. It has been suggested that having on the one hand been the vanguard of youth-orientated consumer society, and on the other of lived through enormous scientific and technological change that has conquered major health and social challenges, the baby boomers may not be prepared to meet the demands of ageing. This review has identified the contribution that good mental health can make to people’s mental resilience and their ability to deal with adversity. Current research is examining factors linked to resilience, and actions that may strengthen it. Supporting social engagement before people experience problems, for example, through enabling them to get out and about to meet friends and join in social activities, is one positive approach that has been identified. A wide range of policies have the capacity to contribute to good mental health.

THIRD KEY FINDING

Mental health in later life needs to be supported and protected as a valuable social asset. Public policy needs to recognise the enormous psychological, social and vocational resources within the baby boomer population, across all ethnic groups. Baby boomers should be encouraged and enabled to share this with each other as well as with other generations.

Cognitive health and cognitive ageing

The review has identified the importance of cognitive decline from midlife onwards, the incidence of dementia in older age groups, and the likely implications of this for the baby boomers in the future. Already many have the experience of caring for parents with these conditions and have awareness of its implications, including pressure on carers.

Evidence collected has shown the lifetime and life course factors associated with dementia, as well as the heritability of some dementia conditions. In particular the role of vascular health in protecting against both Alzheimer’s disease and vascular dementia has been noted, together with the contribution that measures to protect physical health can make to cognitive health. Research has identified increased engagement in activities to protect physical health among baby boomers, although they still fall short of ideal levels. Additional factors to support mental capacity are also noted.
This Inquiry recommends that health promotion messages include information about risk factors for cognitive health and ways in which people can protect their mental health, with a particular focus on people in midlife.

Research for the project has found high levels of concern about loss of mental capacity and experience of dementia in the future, among baby boomers, as well as younger people. However, people have generally little understanding of whether or how they can protect their mental capacity for the future. The review recognises that there is high awareness and fear of dementia or mental decline and this has highlighted the need for new ways of thinking about dementia: to ‘normalise’ it and remove associated stigma. It raises concerns about panic among baby boomers and older people about the ‘threat of dementia’, which can create unnecessary fear about ageing.

This Inquiry recommends a public health focus on ‘demythologising’ dementia, to promote messages about adjusting and living well with the condition, and not seeing sufferers as ‘different people’. At the same time the importance of early identification needs to continue to be promoted. Workplaces are identified as potential locations for such public health messages. The role of new local Health and Wellbeing Boards will also be important.

FOURTH KEY FINDING
There needs to be more and better public information about dementia that broadcasts messages in accessible formats to reach all ethnic groups that healthy lifestyles can protect against some forms of dementia and cognitive decline (as well as many other long-term conditions) and also that it is possible to live well with dementia.

Focus on inequalities
The review has identified a trend towards the widening of inequalities since the 1970s. This has created greater income and wealth disparities, as well as health inequalities including a social gradient in life expectancy that is maintained as overall life expectancy increases. There are also differences in life circumstances and relationships with some clear indications that some groups of women are at particular risk of experiencing mental illness because of loneliness and isolation. The review has also identified a relationship between overall levels of mental illness and health inequalities.

Overall improvements in life expectancy, experience of disabling conditions and mental illness cannot be achieved without addressing this inequality gap.

FIFTH KEY FINDING
Health and social inequalities in older generations, including baby boomers, have a negative effect on the health and wellbeing of the whole community, and on specific outcomes for older people, such as life expectancy and mental ill health. Policies and programmes that impact on older people need rigorous assessment at the development stage to determine their likely impact on inequalities in old age and their potential contribution to reducing them. This needs to apply both at UK, national and local levels.

A new attitude towards employment and retirement
Risk factors
Baby boomers have lived through major economic and labour market changes; the notion of a job for life has been transformed into flexible working and portfolio careers. The baby boomers have been defined as a group of people who see work as important – the project interviews and surveys confirm this. Women have been almost as strongly engaged in paid work as men, although more of them have worked part time. Improved education opportunities have helped them fill a wider range of roles. The effects of the retirement transition on mental health and the risk for mental illness have traditionally been seen as mostly affecting men; however, baby boomer women are increasingly vulnerable to the same loss of role and identity associated with retirement. Enabling people to be in control of their own retirement, through making decisions and perhaps easing themselves out of work, can protect their mental health.

Retirement can lead to loss of a valued role and status as well as anxieties about managing on a reduced income (as well as the actual experience of poverty, particularly for women). Evidence indicates that abrupt or enforced retirement is most likely to lead to mental illness.

Working and earning
Work is also important partly because it enables people to earn money. Most saving takes place after the age of 50, when people have fewer family and household responsibilities. In the current economic recession, with service cuts, price inflation and low interest rates, and the desire by many baby boomers to maintain their customary
lifestyles, the need continue working is even greater. There are growing signs that public service cuts are beginning to impact over 50s’ employment, particularly affecting women. The review has shown that people over 50 who become unemployed are unemployed for longer, and often give up looking for work. Unemployment has serious negative consequences for people’s mental health which are made worse by economic hardship.

**Protective factors - Extending working lives**

It is government policy to promote the employment of older people as part of its approach to an ageing population. There is evidence that while many people wish to continue working up to and beyond State Pension Age (65) many do not, for a variety of reasons. The abolition of the default retirement age (DRA) of 65 in 2011 has potentially opened the way for more flexible approaches to work. However employers appear to be making slow progress in offering more flexibility.

**SIXTH KEY FINDING**
The importance of employment and workplace practices in protecting mental health in an ageing workforce needs to be recognised. Governments, employers, employers’ organisations, trade unions and professional bodies need to develop policies that will protect and support older people in employment, promote workplace policies and practices that protect mental wellbeing, and support people to plan for the future.

**Financial policies for later life**

**Risk factors**

The review has identified a diversity of economic circumstances, with many people reaching their sixties with only the State Pension as a future source of income. While the past decade has seen improvement in the incomes of people at retirement, many baby boomers are moving into retirement uncertain about their likely future incomes. The value of the State Retirement Pension has eroded substantially over recent decades, so that people with no other pension source require Pension Credit to achieve a living income. Many baby boomers have annuity based pensions. The review has shown that both poor performance in the UK pensions industry and poor annuity rates linked to the current economic situation, have reduced the incomes people can expect. Additionally, as people are living longer, the period for which they plan to meet needs has grown, but people are mostly under-estimating their requirements. Recent Government policy has included benefits for pensioners that help supplement pensions. These are now threatened. It has been observed that financial adversity in later life can damage the health and mental health of people who have not previously experienced such adversity. Poverty and low incomes are strongly identified with poor mental health.

Living in poverty, particularly over a long term, provokes stress, worry, fear of getting into debt and loss of control over life. Being poor can impair people’s capacity to make choices, undermine independence and reduce participation in social life. It is a risk for loneliness.

**Protective factors**

Baby boomers born 1946-55 have been fortunate to live through economic times that have enabled them to access employment, build careers and buy housing. A number of financial and economic factors have led to increases in the value of the homes people have bought so that many have significant sums of housing wealth. This is, however, tied up on the places they live, so raises some questions about accessibility. For many baby boomers this housing equity is their main wealth. In terms of pensions, many have been members of defined benefit pension schemes, which pay pensions linked to final salaries. These have been substantially withdrawn now, in the private sector, and reduced in value in the public sector. While some baby boomers are affected by these changes, many will have built up entitlements under old rules and are more protected.

**SEVENTH KEY FINDING**

Adequate finance to cover the whole of people’s expected remaining life spans needs to be protected now. Governments need to recognise the importance of adequate income in protecting health and wellbeing in later life when developing their fiscal and financial policies affecting older people. These policies must clearly state how they will contribute to ensuring adequate incomes for older people and equality across gender.

**Social Care**

**Risk factors**

Many baby boomers are, or have been, involved in caring for their parents, other family members or people close to them, and have experienced the pressures on social care services and on themselves as carers.
Many people who participated in the project’s research recognised that they are unlikely to be able to count on public services for future care needs. There are also strongly expressed views about wishes for future independence, to continue to be in control of life and a wish not to burden family, plus a recognition of lack of availability of family in many cases (there are, however, also significant numbers who do believe family are likely to be there for them). In the case of reconstituted families, more baby boomers may be left outside of supportive family networks. The review notes that much provision of care in the future will fall on baby boomer spouses and partners; baby boomers are likely to become carers in large numbers. Public funding pressures look set to limit available care from local services even further in the future.

The costs of meeting care needs is a major issue of concern. The Government in England has recently announced its decision on the Dilnot Commission’s proposals for funding the care and support of older people and people with disabilities. Although there continues to be debate about where the cap should be set on how much individuals may have to contribute (the Government is proposing up to £75,000), the proposals provide more certainty to enable baby boomers approaching older age to plan for the future.

The review has noted the personalisation of social care budgets and the marketisation of care, and raised issues about care relationships and care quality if care becomes just a purchased commodity.

There is considerable evidence that caregiving is a risk factor for mental illness. The key factors are the loss of a carer’s own social networks, loss of leisure activity and duration of responsibilities.

Fear, including fear of compromised physical and mental health and of lack of appropriate support services, is also a significant threat to mental health.

Protective factors
The review notes that the personalisation of social care services is, in many ways, a baby boomer policy, with its origins in the disability movement. It has mainly been put in place by baby boomer professionals and policy makers. While some older people currently struggle with the idea of personal budgets, it is likely that more baby boomers will be comfortable with the notion of using funds to buy the care they need. Having control will help them retain independence.

The review recognises that caring is not merely about consumption of services, but also about interdependence and relationships between people giving and receiving care. Much care takes place in the context of reciprocal relationships which give meaning to people’s lives. People get personal satisfaction from giving care.

There is a growing view among some baby boomers that approaches to support and care could be different in the future, involving for example, shared and mutual arrangements, community care hubs and care co-operatives. It may be that baby boomers will find new approaches to retaining later life independence and control.

EIGHTH KEY FINDING
Care quality needs to be improved, as do monitoring and safeguarding mechanisms in an increasingly commercialised social care market. Innovative ways of providing care should be supported, or at least not inhibited by governments. The skills, expertise, resources and experience of baby boomers – ‘care capital’ – should be mobilised by engaging them as active participants in this process to help shape and deliver forward-looking health and social care policies and services.

Family, community and social relationships

Risks
The review has noted the effects of social change on family structures and relationships, on religious belief and participation, on community involvement and on friendship, which have shaped baby boomers’ lives and relationships. Loneliness and social isolation are identified as significant future risks for baby boomers whose social and family networks have been broken. The review identifies that some, particularly divorced and separated women and single people, and people with low incomes, are more likely to be at risk than others.

Loneliness and social exclusion are risk factors for depression. Interaction with others improves physical and psychological functioning.
Protective factors

A national campaign to end loneliness has identified actions that local authorities, the voluntary and community sector and others can do to help tackle loneliness. Baby boomers moving into retirement need to be harnessed to support such initiatives. Many may well themselves benefit from involvement.

The review has noted the capacity of baby boomers to build emotional attachment through family and friendship networks. This emotional commitment to others may help build new networks in their communities.

NINTH KEY FINDING
Tackling social isolation and loneliness in old age should be a priority for national and local government action. Investment in maintaining and developing public services and facilities that are known to promote social engagement and reduce risk of social exclusion will reduce spending on health and social care services further down the line. This investment needs to engage the resources of baby boomers, as they move into retirement, to support innovative initiatives and to help build protective networks at a local level that will become embedded for the present and the future.

Control and choice

A recurring theme among baby boomers is the need to control their lives, to be independent and to have choices. This reflects the individualism that has shaped their attitudes and their lives. The significance of this, for the future, is that baby boomers are likely to want to be part of all decisions that affect their lives. This relates both to the personal level and at a wider social level.

TENTH KEY FINDING
Policy makers need to recognise that baby boomers will want to go on being involved in shaping their lives and shaping the contexts in which their lives are lived. This means involving and engaging them at all levels.
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Appendix 1

Age-related data from YouGov survey

All figures, unless otherwise stated, are from YouGov Plc. Total sample size was 5444 adults. Fieldwork was undertaken between 12th - 15th March 2012. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+).

*Note: Percentages were rounded off

**Question 1:** In which year were you born?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years ('baby boomers')</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-44 years</td>
<td>50%</td>
<td>16%</td>
<td>17%</td>
<td>16%</td>
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</table>

**Question 2:** Do you consider yourself to be part of an ‘older’ generation?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>2%</td>
<td>4%</td>
<td>11%</td>
<td>33%</td>
</tr>
<tr>
<td>Agree</td>
<td>14%</td>
<td>30%</td>
<td>50%</td>
<td>48%</td>
</tr>
<tr>
<td>Neither</td>
<td>10%</td>
<td>32%</td>
<td>22%</td>
<td>13%</td>
</tr>
<tr>
<td>Disagree</td>
<td>42%</td>
<td>28%</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>20%</td>
<td>6%</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Question 3:** Which three, if any, of the following are you least looking forward to about being aged 70 plus? (If you are already over the age of 69, please think about how you currently feel.)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having poor health</td>
<td>38%</td>
<td>50%</td>
<td>49%</td>
<td>45%</td>
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<tr>
<td>Financial security</td>
<td>30%</td>
<td>39%</td>
<td>31%</td>
<td>23%</td>
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<tr>
<td>Physical disability/loss of mobility</td>
<td>38%</td>
<td>42%</td>
<td>44%</td>
<td>43%</td>
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<tr>
<td>Loss of mental abilities</td>
<td>45%</td>
<td>46%</td>
<td>46%</td>
<td>50%</td>
</tr>
<tr>
<td>Having to cope with the death of loved ones</td>
<td>31%</td>
<td>25%</td>
<td>25%</td>
<td>23%</td>
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<tr>
<td>Loss of independence/need for daily care</td>
<td>40%</td>
<td>37%</td>
<td>39%</td>
<td>42%</td>
</tr>
<tr>
<td>Isolation/possibility of loneliness</td>
<td>23%</td>
<td>16%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Poor public services/lack of NHS support</td>
<td>14%</td>
<td>20%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>Not applicable—Nothing worries me</td>
<td>2%</td>
<td>4%</td>
<td>6%</td>
<td>8%</td>
</tr>
</tbody>
</table>
**Question 4:** Which three, if any, are you most looking forward to about being 70+?

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing new interests</td>
<td>26%</td>
<td>30%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Being able to travel/go on holidays</td>
<td>43%</td>
<td>39%</td>
<td>39%</td>
<td>39%</td>
</tr>
<tr>
<td>Spending more time with my partner/family</td>
<td>42%</td>
<td>42%</td>
<td>41%</td>
<td>43%</td>
</tr>
<tr>
<td>Spending more time with friends</td>
<td>20%</td>
<td>17%</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>Being able to pursue my current hobbies</td>
<td>24%</td>
<td>29%</td>
<td>31%</td>
<td>43%</td>
</tr>
<tr>
<td>Having more time to relax</td>
<td>51%</td>
<td>52%</td>
<td>38%</td>
<td>37%</td>
</tr>
<tr>
<td>Moving to a new area</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Being able to pursue educational opportunities</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Being able to volunteer</td>
<td>7%</td>
<td>8%</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>Not applicable—nothing I am looking forward to</td>
<td>1%</td>
<td>14%</td>
<td>18%</td>
<td>14%</td>
</tr>
</tbody>
</table>

**Question 5:** I am concerned what my mental health will be like when I get older

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>17%</td>
<td>13%</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Agree</td>
<td>46%</td>
<td>49%</td>
<td>46%</td>
<td>45%</td>
</tr>
<tr>
<td>Neither</td>
<td>18%</td>
<td>25%</td>
<td>25%</td>
<td>26%</td>
</tr>
<tr>
<td>Disagree</td>
<td>10%</td>
<td>9%</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Question 6:** I am concerned about getting depressed when I get older

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>10%</td>
<td>7%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Agree</td>
<td>32%</td>
<td>26%</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>Neither</td>
<td>27%</td>
<td>34%</td>
<td>31%</td>
<td>27%</td>
</tr>
<tr>
<td>Disagree</td>
<td>22%</td>
<td>22%</td>
<td>29%</td>
<td>32%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6%</td>
<td>9%</td>
<td>11%</td>
<td>14%</td>
</tr>
</tbody>
</table>

**Question 7:** I am concerned about developing dementia when I get older

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>20%</td>
<td>19%</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>Agree</td>
<td>45%</td>
<td>46%</td>
<td>46%</td>
<td>43%</td>
</tr>
<tr>
<td>Neither</td>
<td>20%</td>
<td>24%</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>Disagree</td>
<td>9%</td>
<td>8%</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6%</td>
<td>3%</td>
<td>4%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Question 8: My own mental health is not something that particularly worries me

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>8%</td>
<td>8%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Agree</td>
<td>24%</td>
<td>26%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Neither</td>
<td>28%</td>
<td>31%</td>
<td>30%</td>
<td>22%</td>
</tr>
<tr>
<td>Disagree</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
<td>16%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6%</td>
<td>10%</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Question 9: I don’t think older people are more likely to get depressed than younger people

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>5%</td>
<td>6%</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>Agree</td>
<td>28%</td>
<td>30%</td>
<td>38%</td>
<td>45%</td>
</tr>
<tr>
<td>Neither</td>
<td>32%</td>
<td>36%</td>
<td>30%</td>
<td>22%</td>
</tr>
<tr>
<td>Disagree</td>
<td>23%</td>
<td>19%</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6%</td>
<td>7%</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Question 10: Thinking about if you were feeling stressed, anxious or low over a period of time...

Which of the following people would you be likely to talk to about your problems (tick all that apply)

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>58%</td>
<td>59%</td>
<td>61%</td>
<td>56%</td>
</tr>
<tr>
<td>Other family member</td>
<td>40%</td>
<td>36%</td>
<td>37%</td>
<td>42%</td>
</tr>
<tr>
<td>Friend</td>
<td>47%</td>
<td>40%</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>GP</td>
<td>28%</td>
<td>46%</td>
<td>53%</td>
<td>55%</td>
</tr>
<tr>
<td>Therapist/counsellor</td>
<td>14%</td>
<td>16%</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Other health/care</td>
<td>4%</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone at work</td>
<td>9%</td>
<td>9%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Someone from a charity/</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>helpline</td>
<td>4%</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>A religious leader</td>
<td>4%</td>
<td>3%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Not applicable—I would</td>
<td>10%</td>
<td>9%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>not be likely to talk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to anyone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Question 11: Have you ever visited your GP for advice because you were feeling stressed, anxious or low over a period of time?

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32%</td>
<td>42%</td>
<td>41%</td>
<td>28%</td>
</tr>
<tr>
<td>No</td>
<td>61%</td>
<td>55%</td>
<td>55%</td>
<td>69%</td>
</tr>
<tr>
<td>Can't recall</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>
How important, if at all, do you feel it is for people of your age to protect each of the following:

**Question 12: Mental health**

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very important</td>
<td>62%</td>
<td>69%</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Fairly important</td>
<td>31%</td>
<td>27%</td>
<td>17%</td>
<td>14%</td>
</tr>
<tr>
<td>Not very important</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Not at all important</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Question 13: Physical health**

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very important</td>
<td>63%</td>
<td>72%</td>
<td>81%</td>
<td>83%</td>
</tr>
<tr>
<td>Fairly important</td>
<td>31%</td>
<td>25%</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>Not very important</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Not at all important</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

How much, if any, do you feel you know about how getting older affects each of the following?

**Question 14: Mental health**

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know a lot</td>
<td>11%</td>
<td>14%</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>I know a fair amount</td>
<td>51%</td>
<td>51%</td>
<td>60%</td>
<td>64%</td>
</tr>
<tr>
<td>I don’t know very much</td>
<td>35%</td>
<td>33%</td>
<td>27%</td>
<td>21%</td>
</tr>
<tr>
<td>I know nothing at all</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Question 15: Physical health**

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know a lot</td>
<td>10%</td>
<td>16%</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>I know a fair amount</td>
<td>60%</td>
<td>60%</td>
<td>67%</td>
<td>70%</td>
</tr>
<tr>
<td>I don’t know very much</td>
<td>23%</td>
<td>23%</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>I know nothing at all</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>
**Question 16:** How much influence, if any, do you feel that you have over your mental health?

<table>
<thead>
<tr>
<th></th>
<th>18-44 years</th>
<th>45-54 years</th>
<th>55-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot of influence</td>
<td>13%</td>
<td>15%</td>
<td>15%</td>
<td>18%</td>
</tr>
<tr>
<td>A fair amount of influence</td>
<td>52%</td>
<td>54%</td>
<td>56%</td>
<td>53%</td>
</tr>
<tr>
<td>Not very much influence</td>
<td>25%</td>
<td>24%</td>
<td>24%</td>
<td>23%</td>
</tr>
<tr>
<td>No influence at all</td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7%</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>