

English Longitudinal Study of Ageing

Andrew Steptoe

Primary objectives

To collect longitudinal data on health, disability, economic circumstances, social participation, and well-being, from a representative sample of the English population aged 50 and older

To explore the unfolding dynamic relationships between health and functioning, social participation, and economic position and well-being, as people plan for, move into and progress beyond retirement

Timeline

Year	Modality	Sample	Refreshment
Wave 1 (2002/3)	CAPI	12,100	HSE 1998-2000
Wave 2 (2004/5)	CAPI + Nurse visit	9,432	
Wave 3 (2006/7)	CAPI	9,771	HSE 2001-04
Wave 4 (2008/9)	CAPI + Nurse visit	11,050	HSE 2006
Wave 5 (2010/11)	CAPI	10,274	
Wave 6 (2012/13)	CAPI + Nurse visit	10,437	HSE 2009-11
Wave 7 (2014/5)	CAPI	9,666	HSE 20011-12
Wave 8 (2016/17)	CAPI + Nurse visit (50%)	8,443	
Wave 9 (2018/19)	CAPI + Nurse visit (50%)	8,736	HSE 2014-15
COVID 1 (2020)	Internet + Telephone	7,040	
2 (2020)		6,794	
Wave 10 (2021/23)	CAPI/CAVI	7,242	HSE 2017-18

ELSA study features

- Multidisciplinary collaboration
 - Epidemiology, economics, psychology, sociology, clinical medicine, biology
- Representative sample
 - Representative geographically and demographically of people living in England aged 50 and over
- Open access
 - Data deposited in accessible archives within 8-12 months

ELSA organisation

- Department of Epidemiology and Public Health, UCL
Steptoe, Marmot, Zaninotto
- Institute for Fiscal Studies
Banks, Blundell, Cribb, Oldfield,
- Department of Sociology, University of Manchester
Nazroo
- Norwich Medical School, University of East Anglia
Steel
- NatCen Social Research
Wood, Taylor, Lloyd

ELSA measures

Demographic data

- Household membership
- Living relatives
- Marital status
- Ethnic group
- Country of birth
- Education
- Occupation of main carer when respondent was aged 14 years
- Proximity to closest child & grandchildren
- Citizenship

Income and assets

- Earnings
- Sources of income
- Pensions (private, state, contributions, etc)
- Financial and physical assets
- Housing wealth and mortgage debt
- Business wealth
- Debt
- Life insurance
- Lifetime inheritances and gifts
- State pension deferral
- Attitudes to financial risk

Employment and consumption

Employment

- Employment situation
- Job details
- Health limiting ability to work
- Retirement and reasons for retirement
- Job security
- Part-time working
- Place of work, travel to work

Consumption

- Housing and housing problems
- Vehicle and durables ownership
- Household outgoings/expenditures
- Transfers (charity, children)
- Clothing, leisure,
- transport expenditure
- Electronic banking

Future expectations and cognition

Expectations

- Survival
- Future health
- Employment
- Retirement
- Finance and future income
- Bequests and inheritances
- Housing situation
- **Future housing and care needs**

Cognitive Function

- Subjective and objective memory
- Executive function
- Numerical ability, literacy
- **Fluid intelligence**
- Proxy interview of cognitive functioning
- **HCAP**

Social and civic activity and participation

Social and civic participation

- Informal caregiving
- Volunteering/unpaid help
- Social networks/isolation
- Social clubs, organisations
- Social support
- Loneliness
- Use of Transport
- Social capital
- Accessing local amenities and services
- Perceptions of neighbourhoods
- Social and cultural participation
- Provision of grandparental child care
- Internet access and use
- Perceived discrimination
- Religiosity
- Time use yesterday

Psychosocial measures

Psychosocial factors

- Control and demand
- Effort-reward balance
- Subjective social status
- Relative deprivation and perceived financial difficulties
- Ages at which middle age ends and old age begins
- Self-perceived and desired ages
- Experience and perceptions of ageing
- Altruism, generativity
- Sense of collectiveness
- Pet ownership
- Experiences of mentoring
- Personality

Health measures

Physical Health

- Self-rated health
- Mobility
- Sensory function (hearing, eyesight)
- Physician diagnosed conditions
- Falls/balance
- Chronic pain
- Quality of health care
- Activities of daily living
- Diagnostic symptom assessments:
Rose Angina, MRC respiratory questionnaire, Edinburgh claudication questionnaire
- Hip, knee replacement
- Incontinence
- Social prescribing
- Cancer screening
- Dental health
- Polypharmacy
- Menopause
- Sensory function (taste, smell)
- Objective hearing test
- COVID-19, Long-COVID
- COVID vaccination

Mental well-being and health behaviour

Behavioural health

- Smoking/smoking history
- Alcohol consumption
- Physical activity (leisure, work)
- Consumption of fruit and vegetables
- Body weight
- Sleep duration and sleep disturbance
- Nutrition
- Sexual attitudes and behaviour
- Food poverty
- E-cigarettes

Mental health

- Psychiatric and emotional problems
- General Health Questionnaire (GHQ-12)
- CES-D depression scale
- Anxiety

Psychological well-being

- Quality of life (CASP-19)
- Satisfaction With Life
- Positive affect
- ONS wellbeing scales

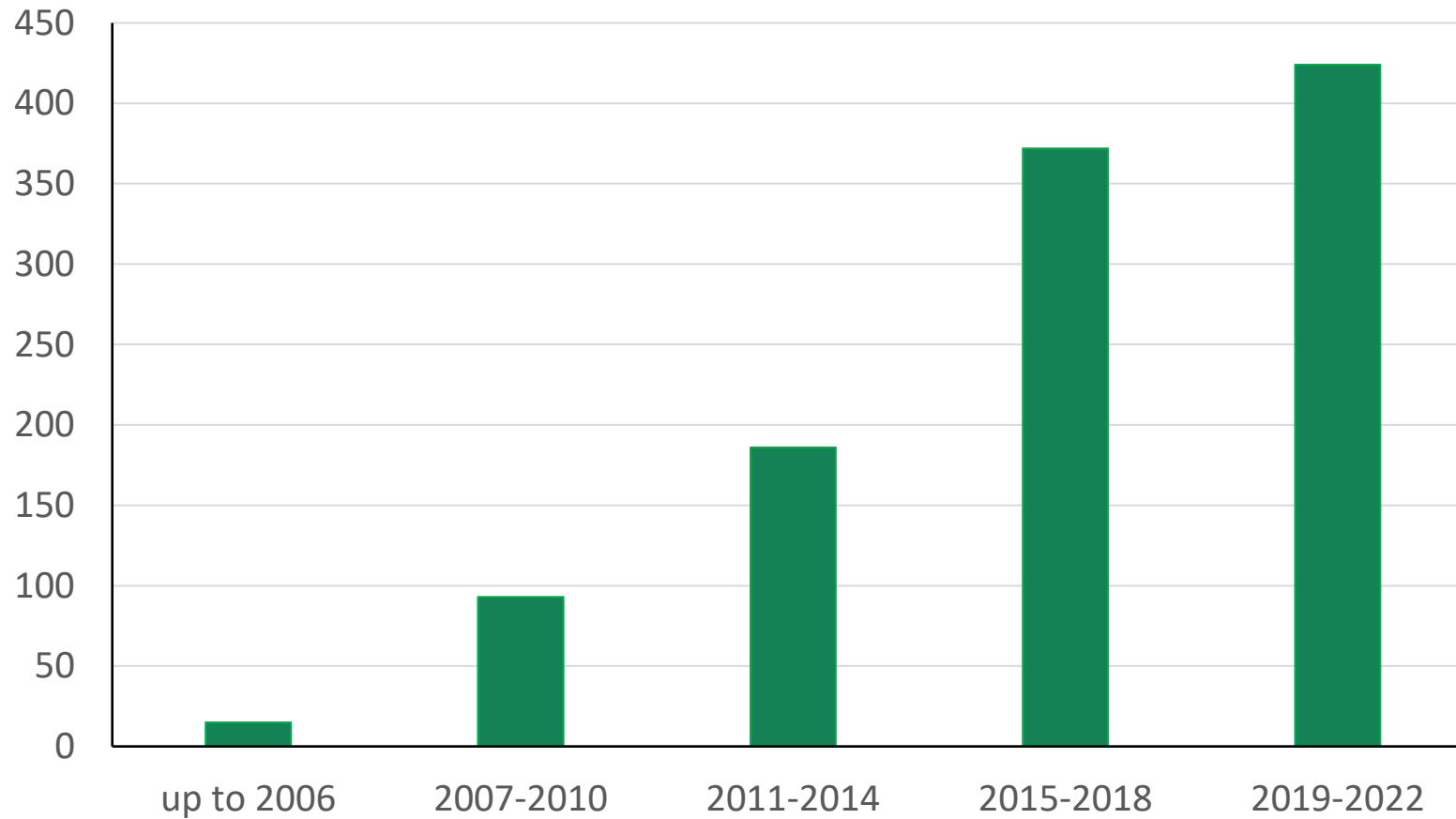
Biomarkers and physical performance measures

Wave 2 (2004/5)	Wave 4 (2008/9)	Wave 6 (2012/13)	Wave 8/9 (2016/19)
Weight, height, waist	Weight, height, waist	Weight, height, waist	Weight (in main interview) Waist (nurse visit)
Grip, balance, chair rise, tandem stand, leg raise, timed walk	Grip, balance, chair rise, tandem stand, leg raise, timed walk	Grip, balance, chair rise, tandem stand, leg raise, timed walk	Grip Timed walk
Blood pressure, lung function	Blood pressure, lung function	Blood pressure, lung function	Blood pressure
Lipids, triglycerides, HbA1c, glucose	Lipids, triglycerides, HbA1c, glucose	Lipids, triglycerides, HbA1c, glucose	Lipids, triglycerides HbA1c, glucose
C-reactive protein, fibrinogen	C-reactive protein, fibrinogen, white blood cell count	C-reactive protein, fibrinogen, white blood cell count	C-reactive protein, fibrinogen, white blood cell count
Haemoglobin, ferritin	Haemoglobin, ferritin	Haemoglobin, ferritin	Haemoglobin, ferritin
DNA	(DNA)	(DNA)	
	IGF-1, DHEAS	IGF-1, Vitamin D	IGF-1, Vitamin D
Apolipoprotein E		Cortisol, DHEA, cortisone, testosterone, progesterone (hair)	PAXgene tubes

Special features of ELSA

- Genetic data and polygenic risk scores
- Sexual attitudes and behaviour module (twice)
- Comprehensive nutritional assessment in 2018/19
- Harmonized Cognitive Assessment Protocol (HCAP)
- Two waves of data collection during the COVID-19 pandemic
- COVID-19 seropositivity (April/May 2021)
- Accelerometry in 2022/23
- Proteomics and metabolomics in subsamples

Growth of ELSA scientific outputs



ELSA involvement in policy

- Evidence to Parliamentary committees
- Briefings to central Government Departments: HM Treasury; Health and Social Care; Work and Pensions; Transport; Levelling Up, Housing and Communities; Digital, Culture, Media and Sport
- Work with Arm's Length Bodies: Centre for Ageing Better; Office for National Statistics
- Charities: Age UK; International Longevity Centre
- International: US National Academy of Sciences; Organisation for Economic Co-operation and Development (OECD); U.S. Surgeon General; EU DGs

Funding of ELSA

- Department of Health and Social Care
- Department for Work and Pensions
- Department for Transport
- National Institute for Health and Care Research
- Department for Education and Skills
- Department for Environment, Food and Rural Affairs
- HM Treasury
- Office for National Statistics
- Economic and Social Research Council
- National Institute on Aging

Structure of the conference

- Inequalities in later life
- Cross-national comparisons of ageing
- Experience during the COVID-19 pandemic
- Cognitive decline and dementia
- Economic activity and ageing
- Future plans

The significance of inequalities in later life Lessons from twenty years of ELSA

James Nazroo
University of Manchester, UK

Sociology
Cathie Marsh Institute
Manchester Urban Ageing Research Group

james.nazroo@manchester.ac.uk



NIHR

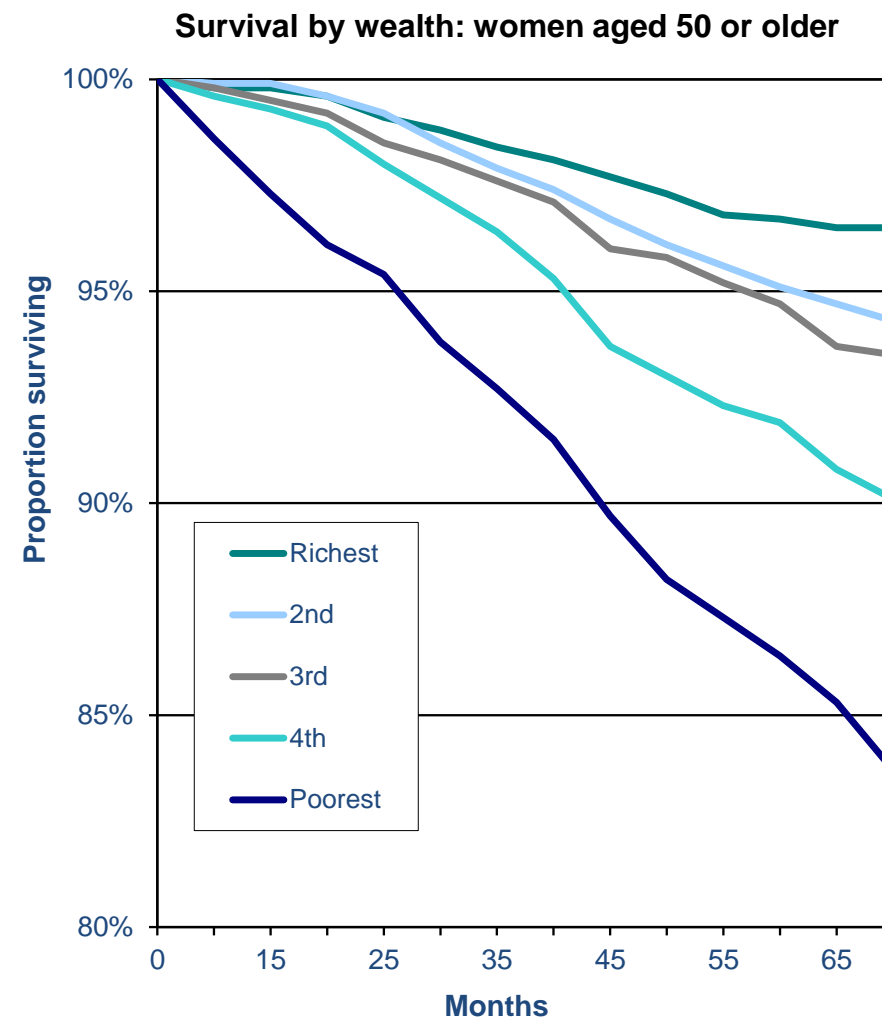


NIH National Institute on Aging



INEQUALITIES IN LATER LIFE: WHAT DO WE KNOW?

- Inequalities in later life are present in relation to any domain we focus on: health and wellbeing; employment, retirement and pensions; social engagement; citizenship and digital exclusion; engagement in caring roles, etc. There is nowhere where we do not see the outcomes of inequality.

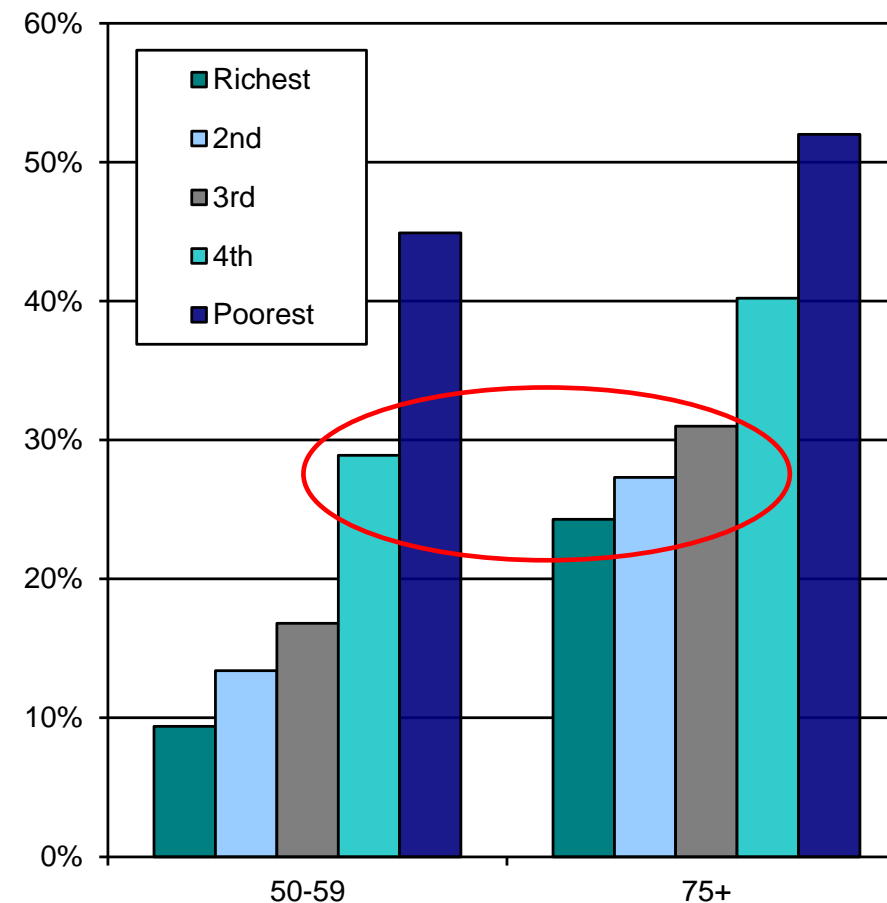




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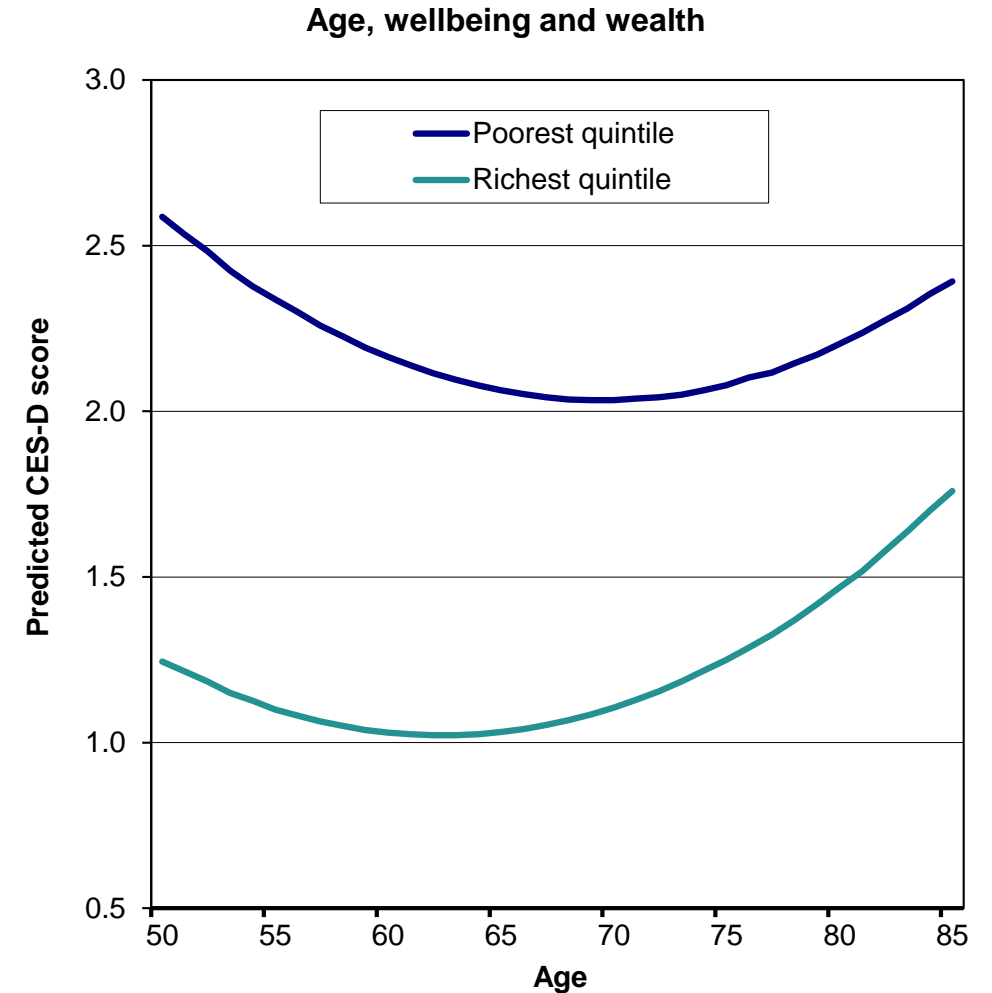
Fair/poor health by wealth and age: men





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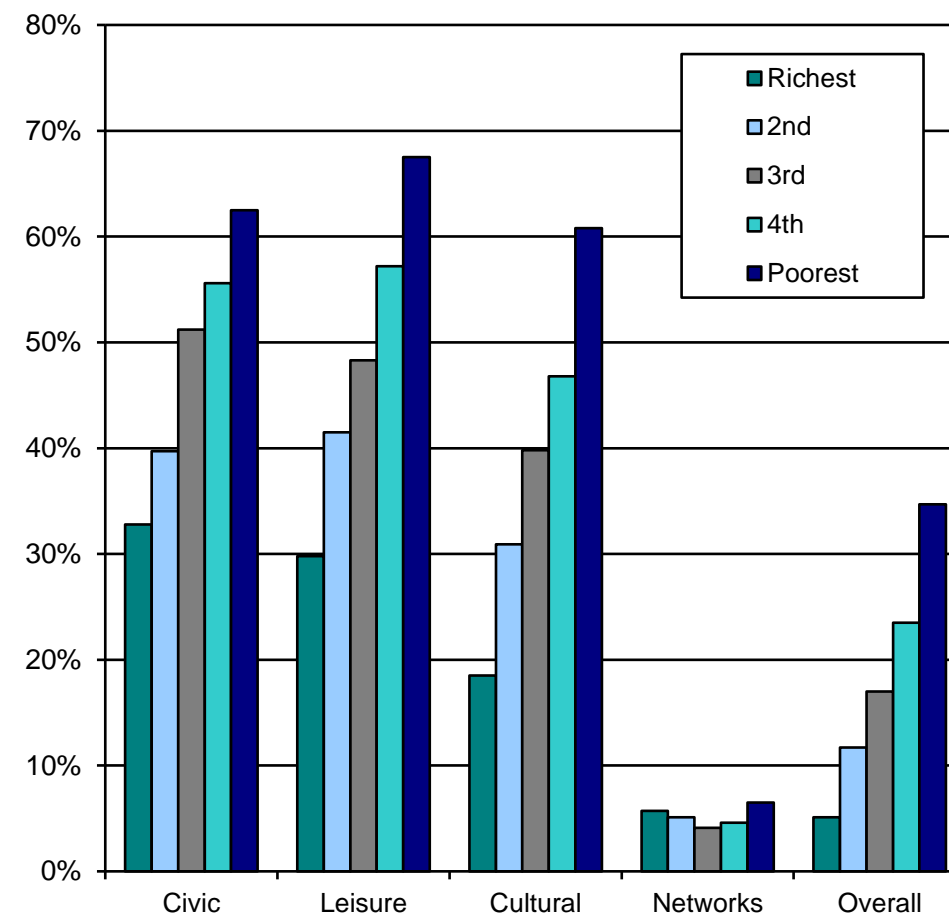




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Social detachment and wealth

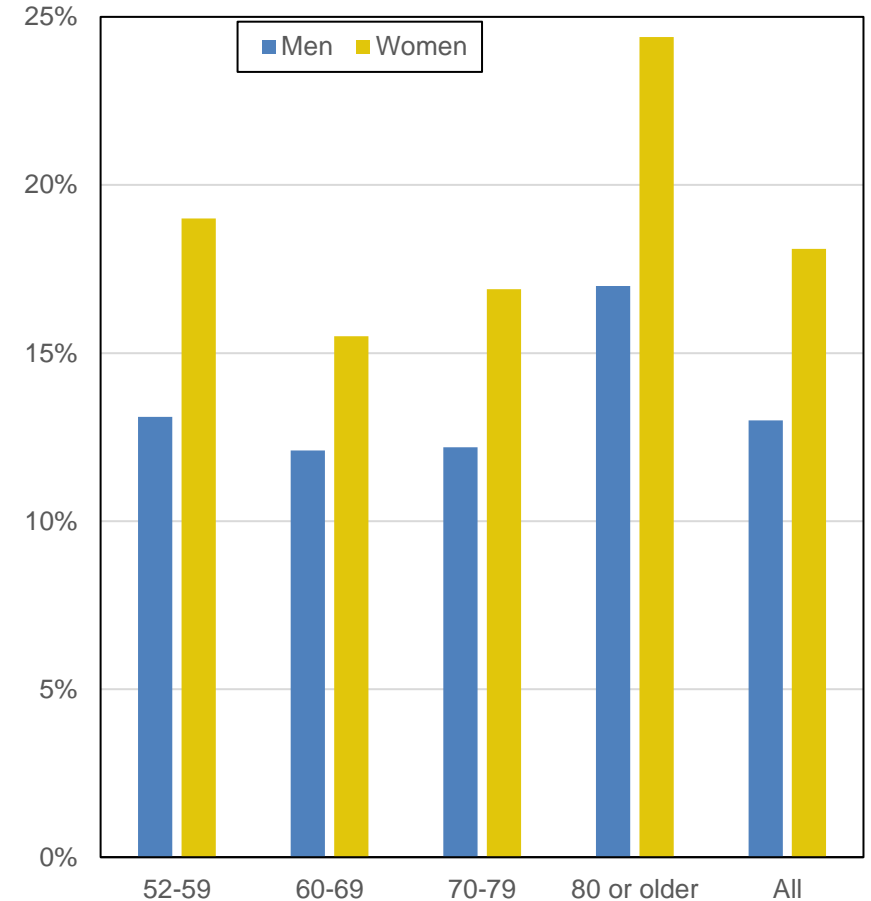




INEQUALITIES IN LATER LIFE: EXPANDING THE FOCUS

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- Inequalities have been thoroughly documented in relation to socioeconomic position, to a more limited extent in relation to gender, and, although much less thoroughly documented, they are also striking in relation to ethnicity, sexual identity and sexuality, etc.

Probable depression by gender and age

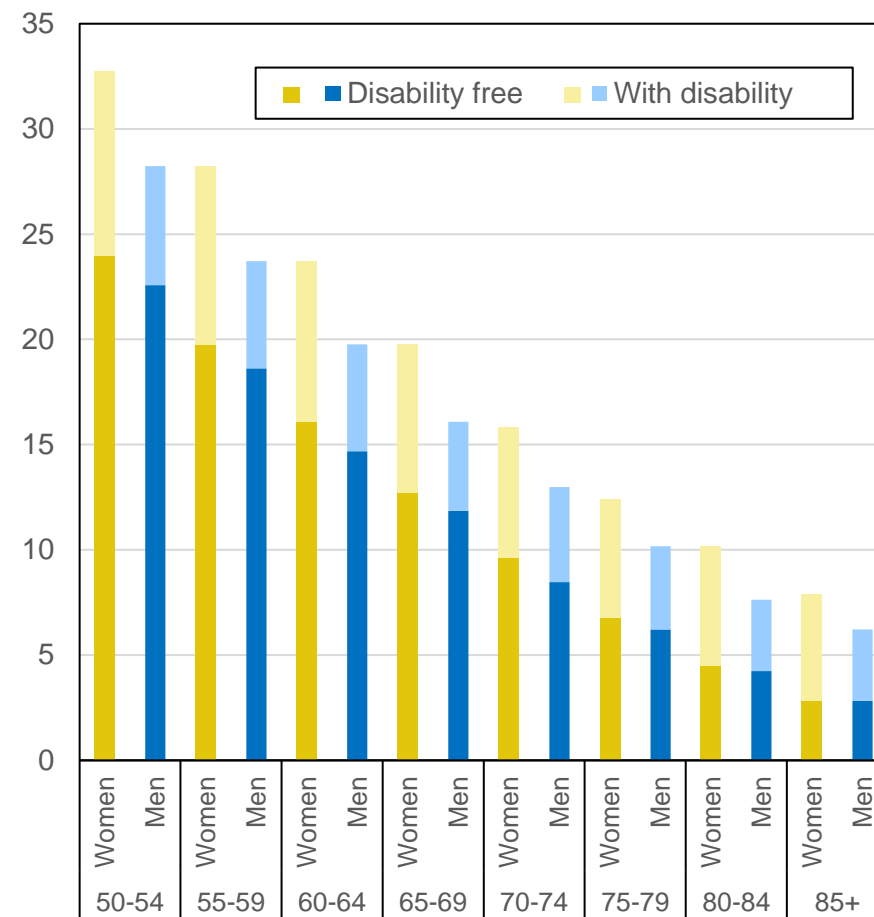




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Gender and life expectancy

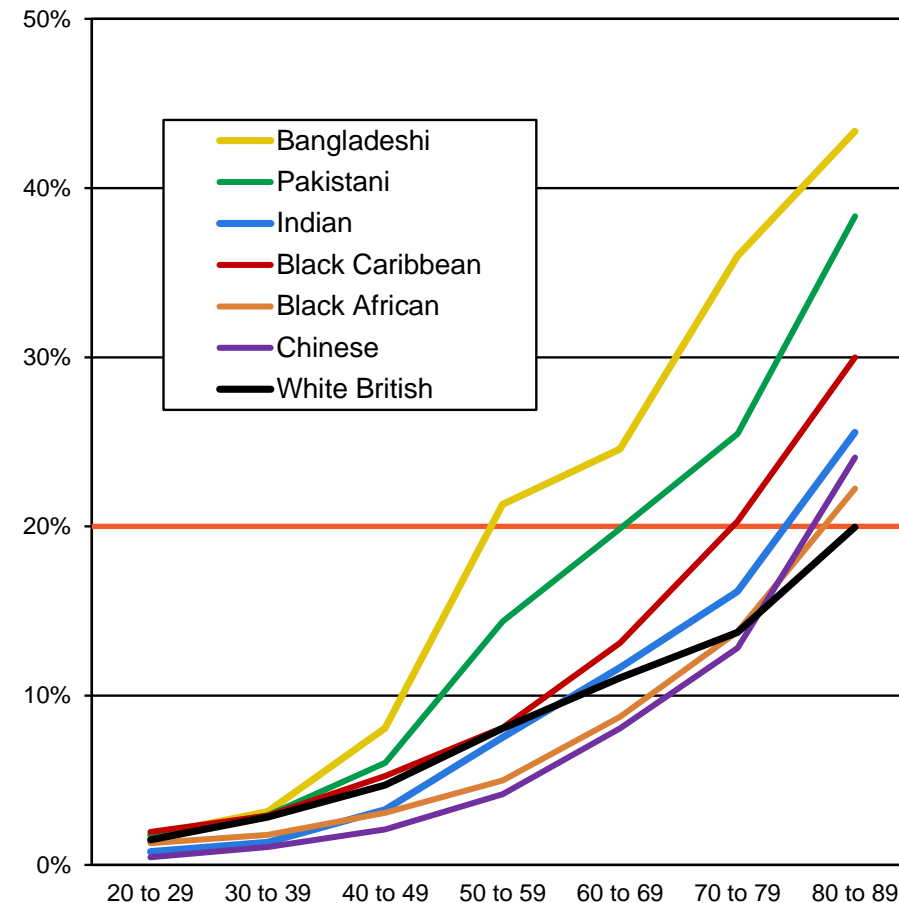




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Bad or very bad health by ethnicity and age

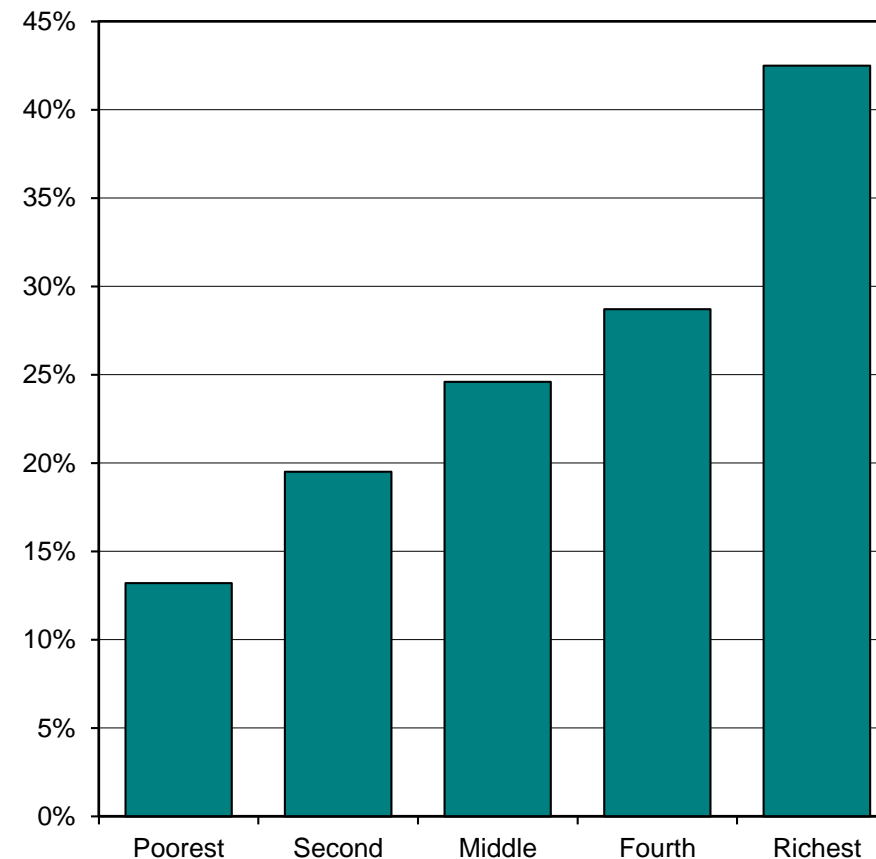




INEQUALITIES IN LATER LIFE: EXAMINING THE LIFE COURSE AND LATER LIFE EVENTS

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- Inequalities have been thoroughly documented in relation to socioeconomic position, to a more limited extent in relation to gender, and, although much less thoroughly documented, they are also striking in relation to ethnicity, sexual identity and sexuality, etc.
- Processes that operate across the life course are crucially relevant to these inequalities: critical periods, transition points, trajectories and accumulation. But what happens in later life is also relevant – retirement, partnership change, caring roles, new opportunities for volunteering and for leisure pursuits, etc.

Proportion who volunteer by wealth

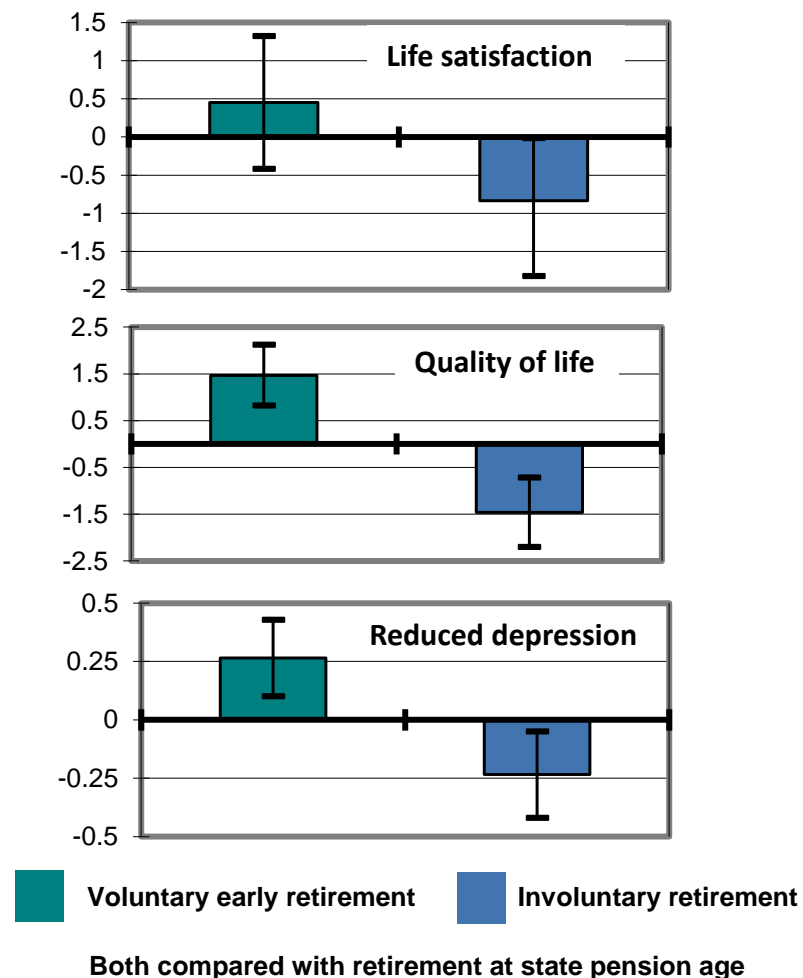




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- Such inequalities are increasingly the focus of centrally driven research and policy agendas.
- What do we need to pursue these agendas?

Retirement route and wellbeing

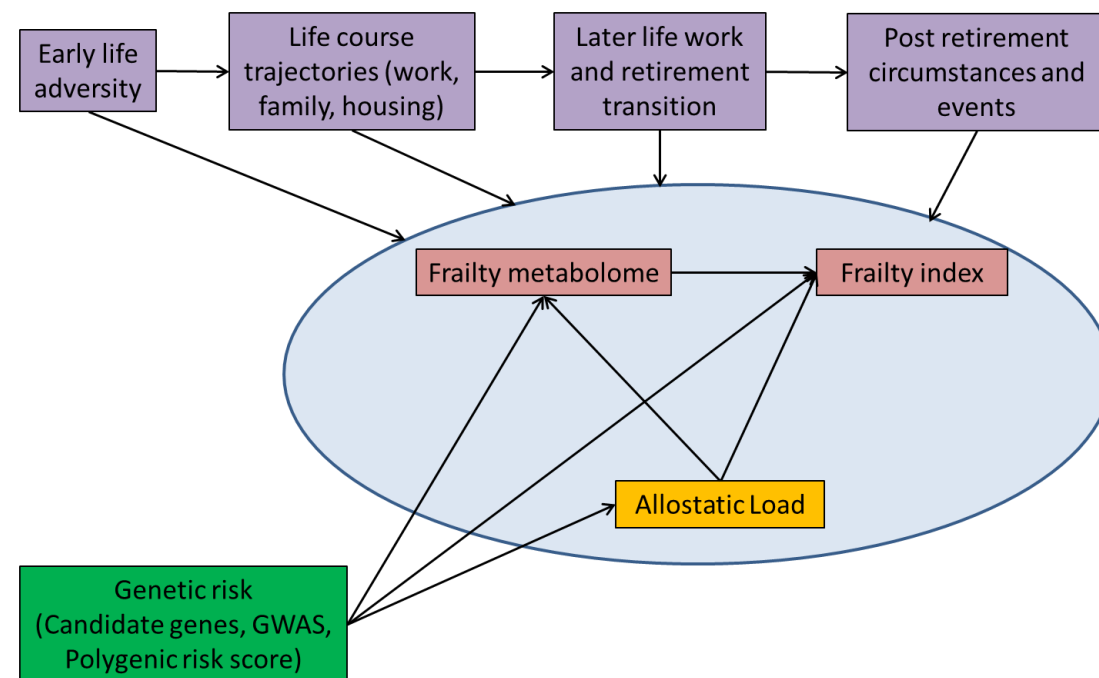




INVESTIGATING MECHANISMS SHAPING INEQUALITIES IN LATER LIFE

- Panel data to examine later life dynamics.
- Multi-disciplinary focus is crucial, cutting edge design providing detailed coverage of relevant mechanisms:
 - Evolving social and economic circumstances;
 - Psychological traits and outcomes;
 - Biological processes;
 - Access to and impact of health and social care;
 - Health, illness, disease and disability.

An interdisciplinary investigation of inequalities in risk of frailty

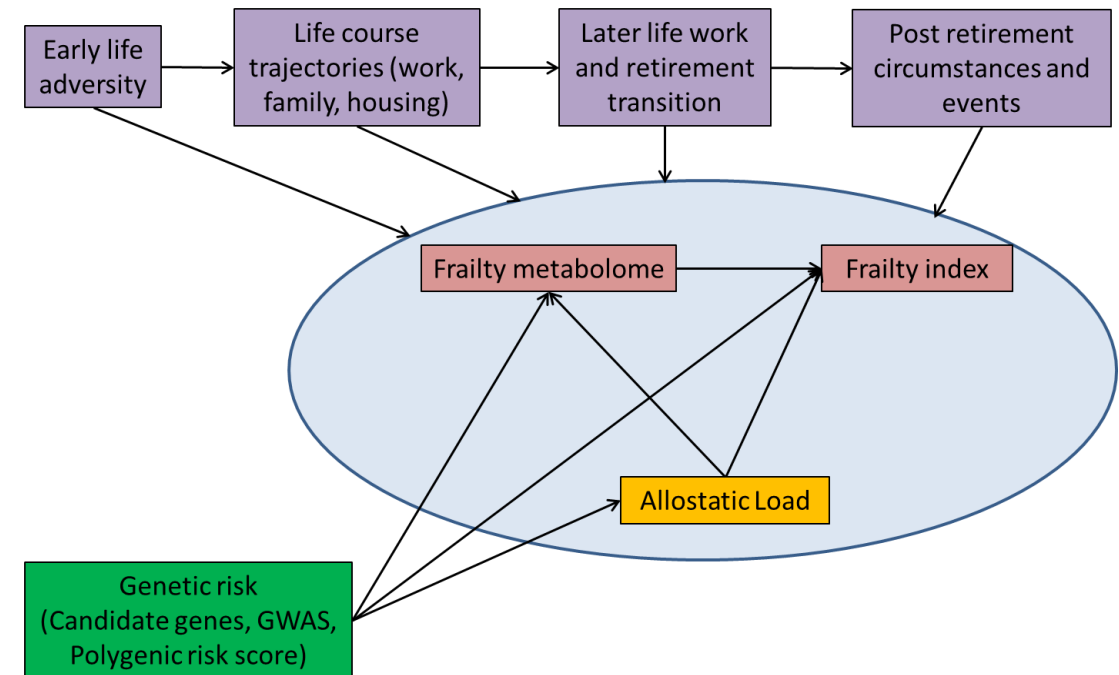




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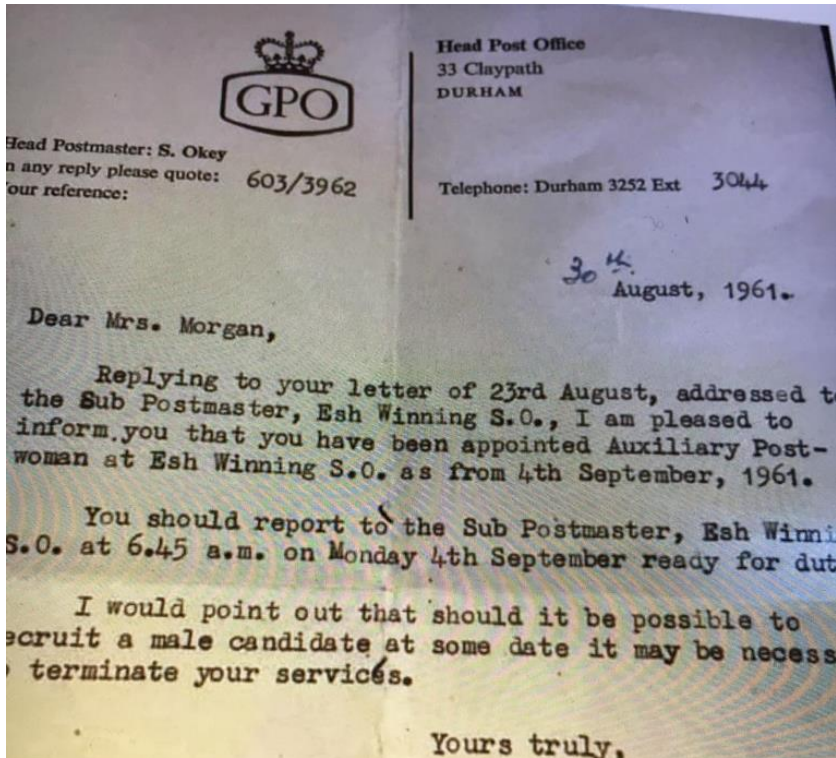
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- Data covering a range of cohorts to examine changes in systems and processes over time and across generations.
- Detailed life history data, to examine trajectories into later life and the accumulation of advantage/disadvantage.

An interdisciplinary investigation of inequalities in risk of frailty



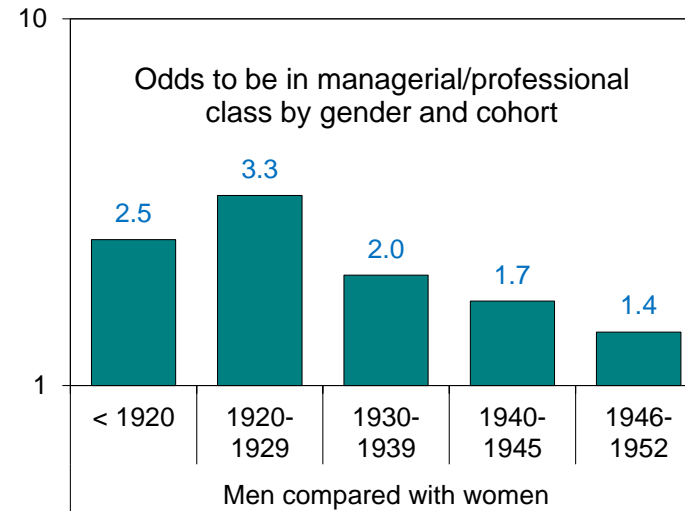


CHANGING (GENDER) INEQUALITIES?



I would point out that should it be possible to recruit a male candidate at some date it may be necessary to terminate your services.

(G. R. THOMPSON)
Asst. Head Postmaster



"The Coronavirus pandemic is exceptionally difficult ... Now schools and nurseries have closed their doors it will be women who take on most of the unpaid care work, reducing their hours or giving up paid work, turning the clock back on gender equality ... Many women will be trapped in their homes, self-isolating with an abusive partner. It's women who are also more likely to care for older or disabled relatives and neighbours. "

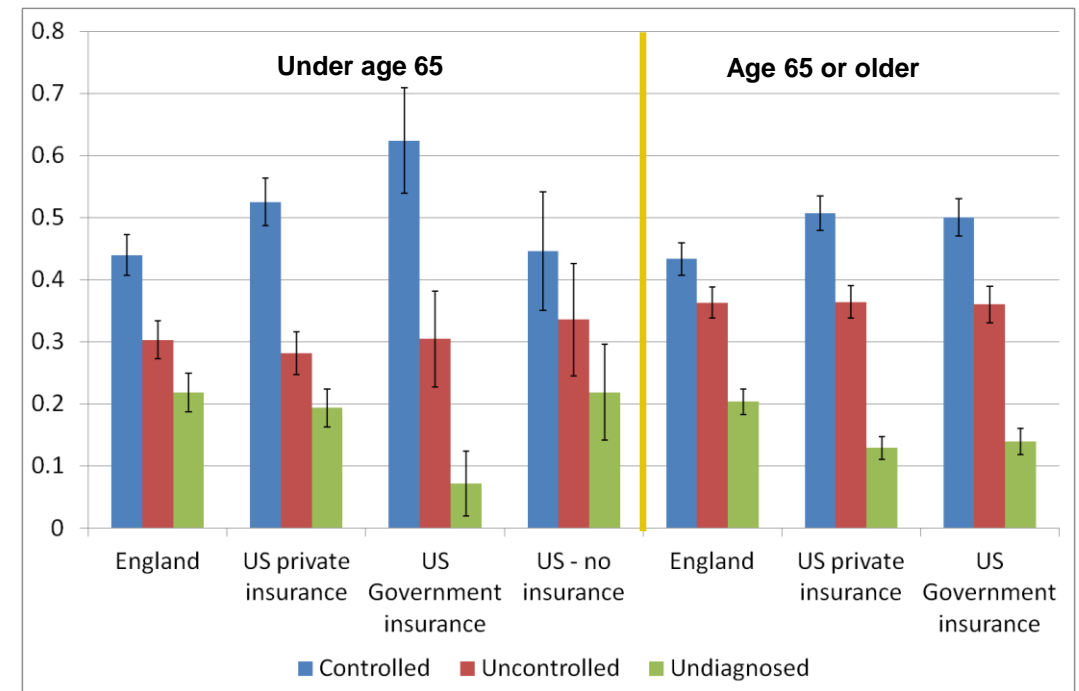
The Fawcett Society



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- Data covering a range of cohorts to examine changes in processes over time and across generations.
- Detailed life history data, to examine trajectories into later life and the accumulation of advantage/disadvantage.
- International data to explore system effects and varying economic and cultural contexts.

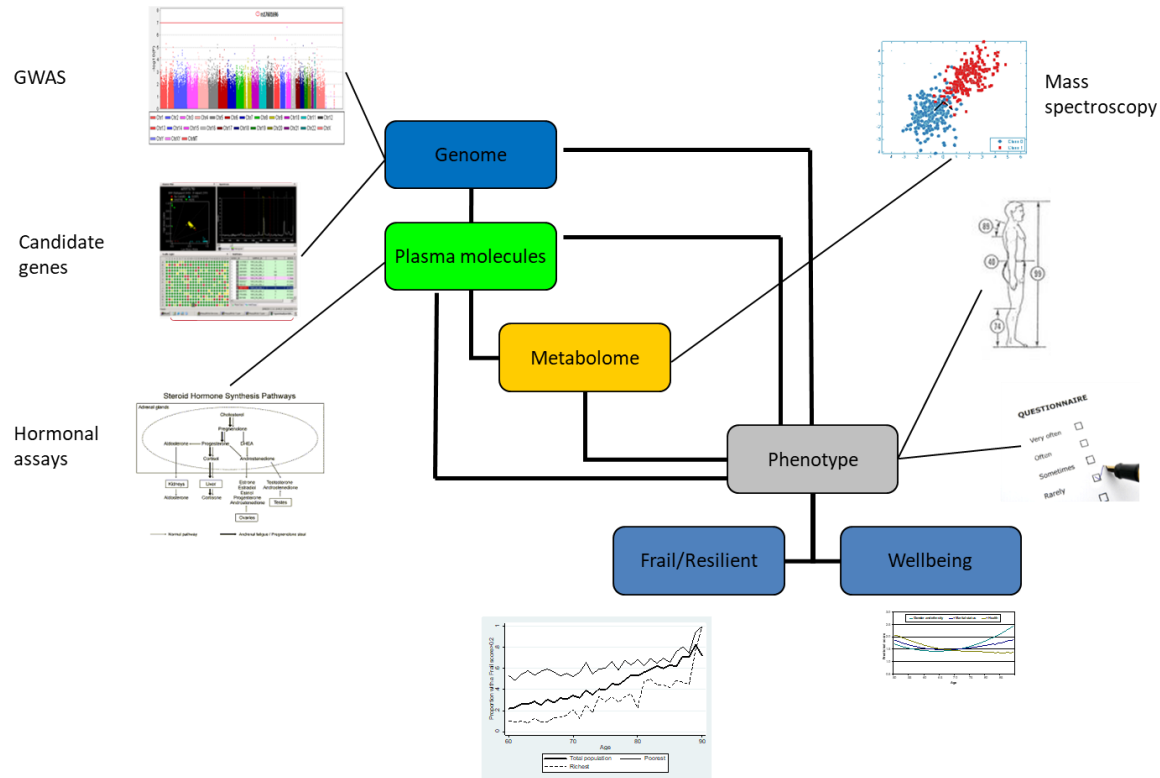
Outcomes of care for hypertension in the UK and the US



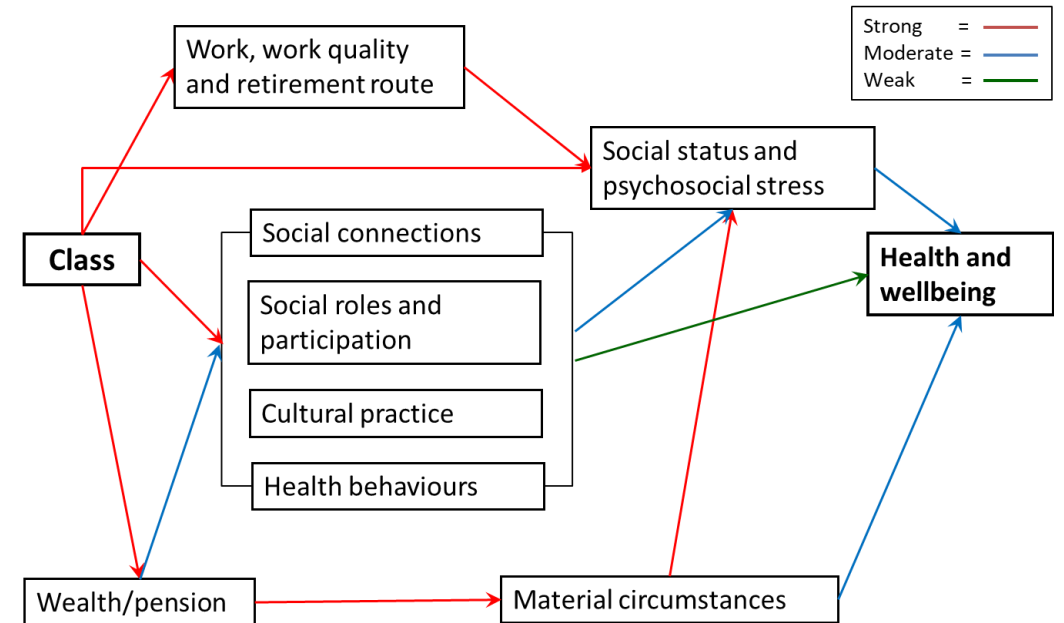


HOWEVER, A FOCUS ON INFORMING POLICY REQUIRES US TO PLACE BOTH THE DESCRIPTION OF INEQUALITY AND THE INVESTIGATION OF MECHANISMS IN CONTEXT

Investigating biological pathways



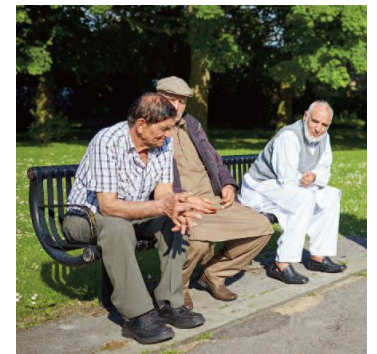
An empirical investigation of hypothesised processes shaped by class





CONCLUDING POINTS – LOOKING FORWARD

- Inequalities in later life are stark and they matter.
- An evolving research agenda, moving from description to an interdisciplinary investigation of pathways and on to an investigation of fundamental mechanisms.
- A focus on informing policy responses requires investigating how fundamental mechanisms shape trajectories, accumulation of advantage and proximal pathways.
- A starting point is to hypothesise, and test, how experiences related to class, racism and patriarchy, operating across the life course and into later life, determine the processes driving these inequalities.
- These fundamental causes shape social and economic structures and access to the resources they provide, shape interpersonal interactions, and shape the functions and processes of institutions.
- So, it is important to examine the ways in which class, racism and patriarchy operate across structural, interpersonal and institutional arenas to impact on the possession of social and economic resources.
- Structural conditions of socioeconomic disadvantage and interpersonal experiences of discrimination and violence create an increased risk of inequality across all domains.
- They also shape encounters with institutions that have policies and practices that lead to unequal outcomes – education, employment, housing, legal, politics, health and social care, etc.
- Institutional settings, then, are the sites where we see the concentration and mediation of structural forms of disadvantage and interpersonal encounters – and the potential for disruption.



Cross-national differences in health at older ages: The role of public policies

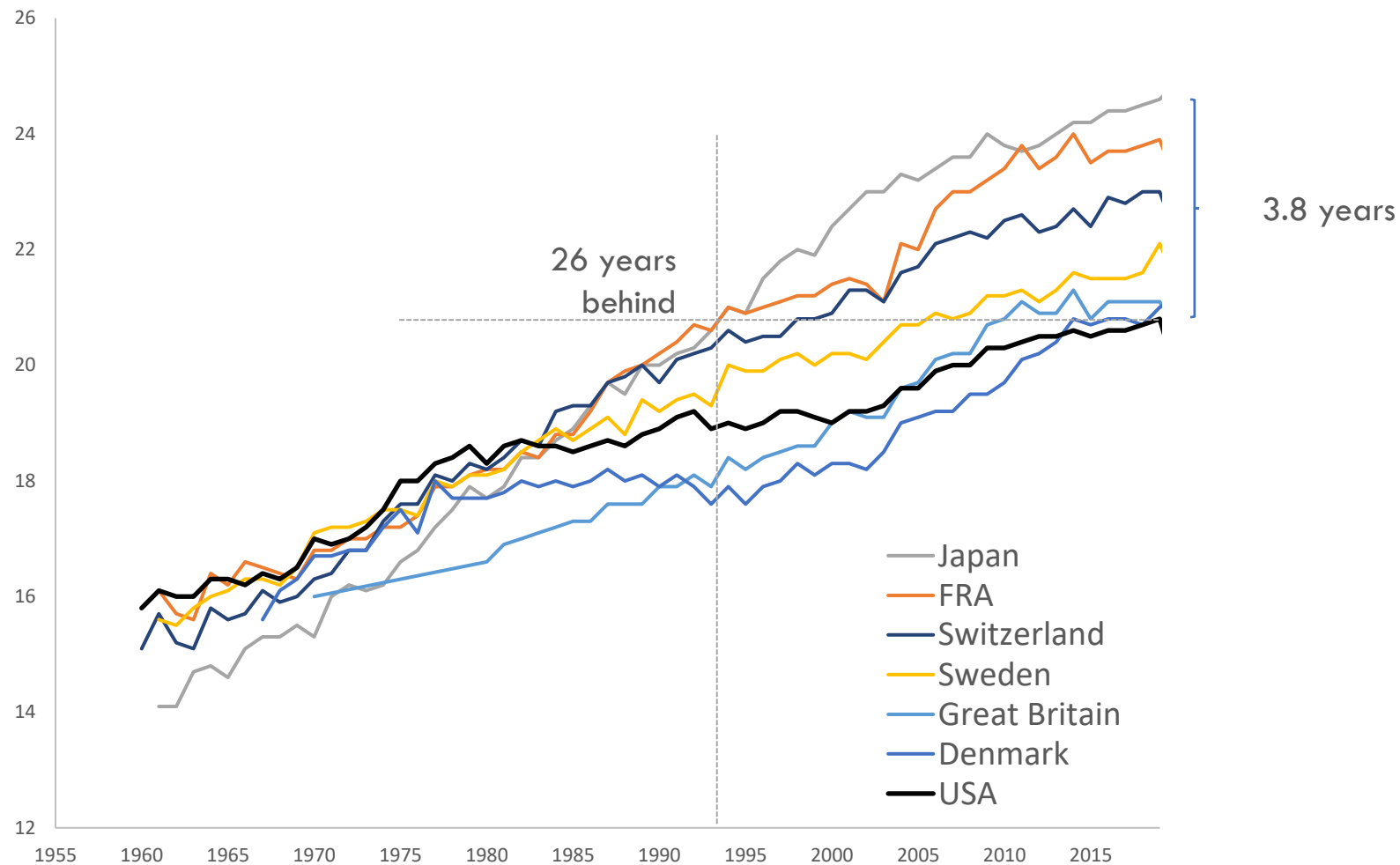
Mauricio Avendano

Unisanté - University of Lausanne

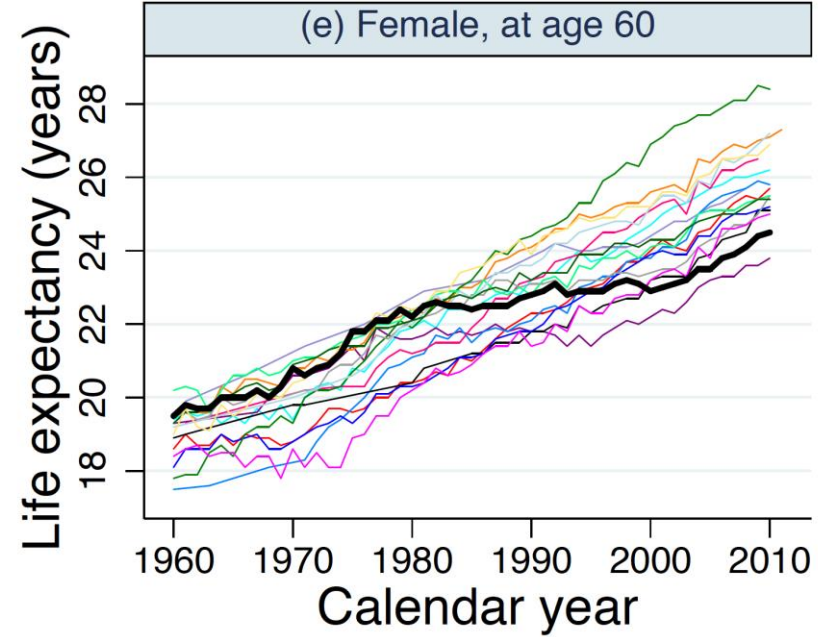
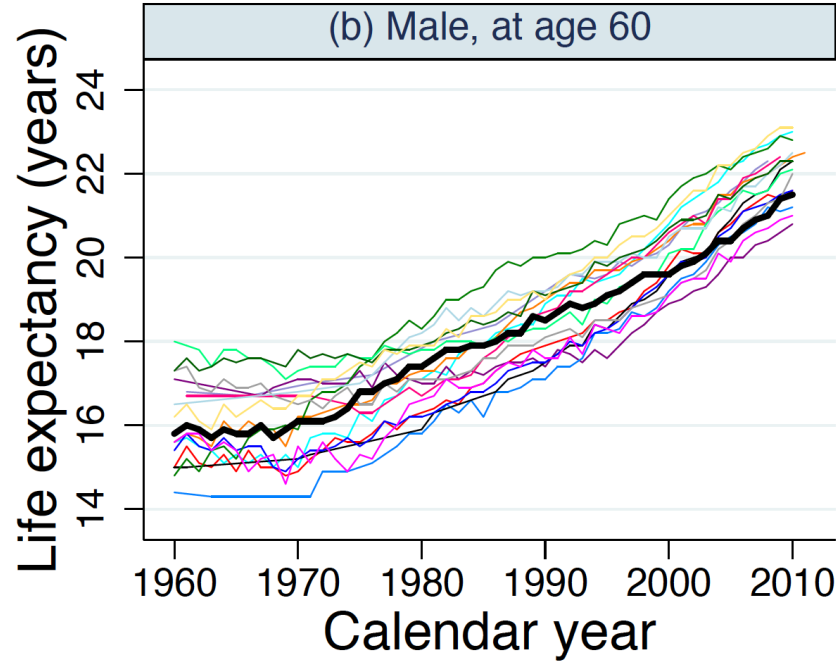
Harvard University

London, ELSA 20th Anniversary, 11th May 2023

Female Life Expectancy at age 65, 1960-2020



Life expectancy at 60, OECD countries, 1960-2010



- | | | | | | |
|-------------|-----------|----------|---------------|---------------|----------|
| — Australia | — Austria | — Canada | — Denmark | — Finland | — France |
| — UK | — Germany | — Italy | — Japan | — Netherlands | — Norway |
| — Portugal | — Spain | — Sweden | — Switzerland | — USA | |

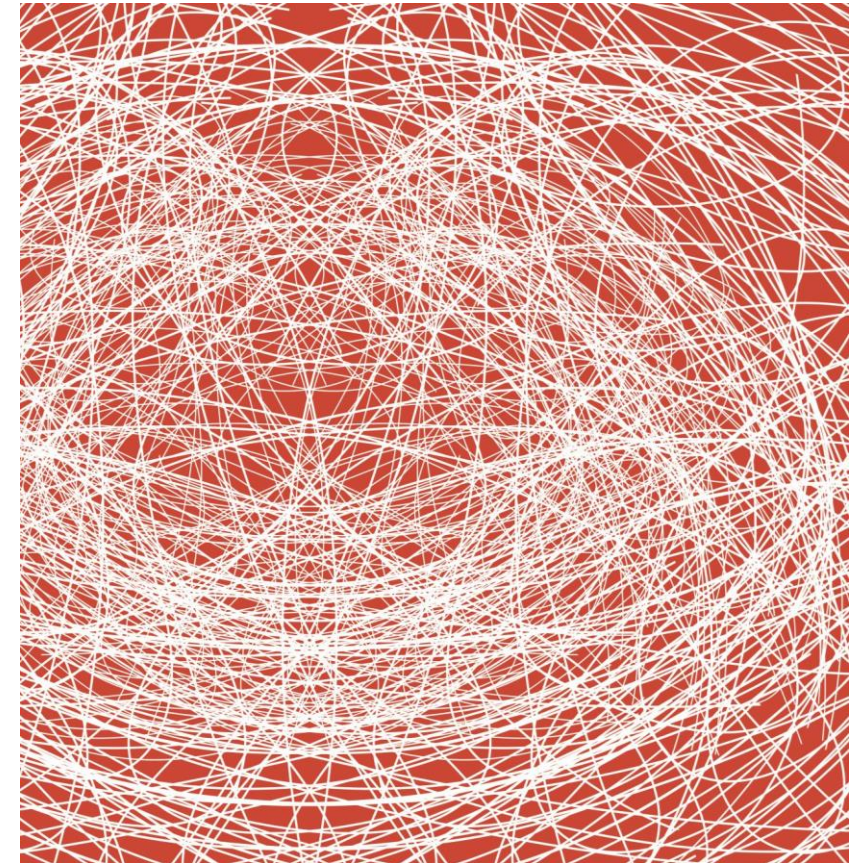
Avendano & Kawachi, Ann Review of Public Health, 2014





Outline

- **Why is this important**
- The 'Discovery' of cross-national differences in health
- The explanation of differences
- The contribution of **public policy**
- Perspective on **the future**





Why cross-national health comparisons

- **Policy relevance**

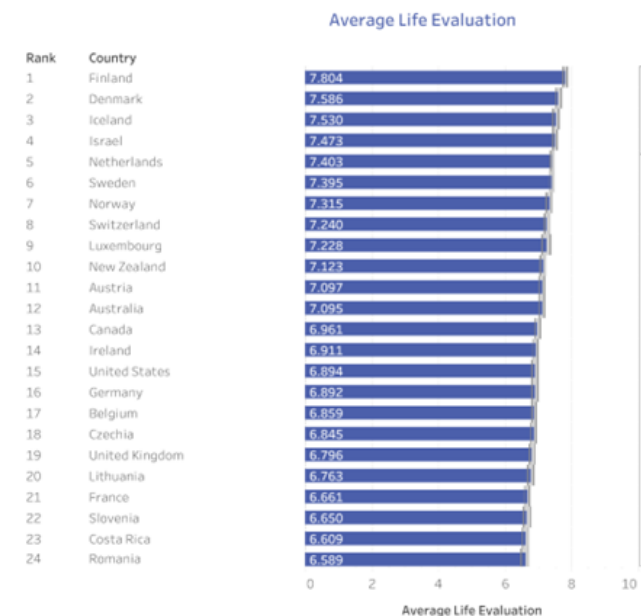
- ‘To improve in anything, we need inspiration.’ (Lucia Kossarova)
- ‘International shaming’ -motivate action
- Identify impact of public action

- **Scientific relevance**

- Going beyond the individual: understand impact of policy, culture, environment, political system, social context, family structures, work
- Causal identification: Country shocks produce potentially exogenous changes in individual behaviour (e.g., smoking, caring, going to school, working, owning a house)

World Happiness Report 2023

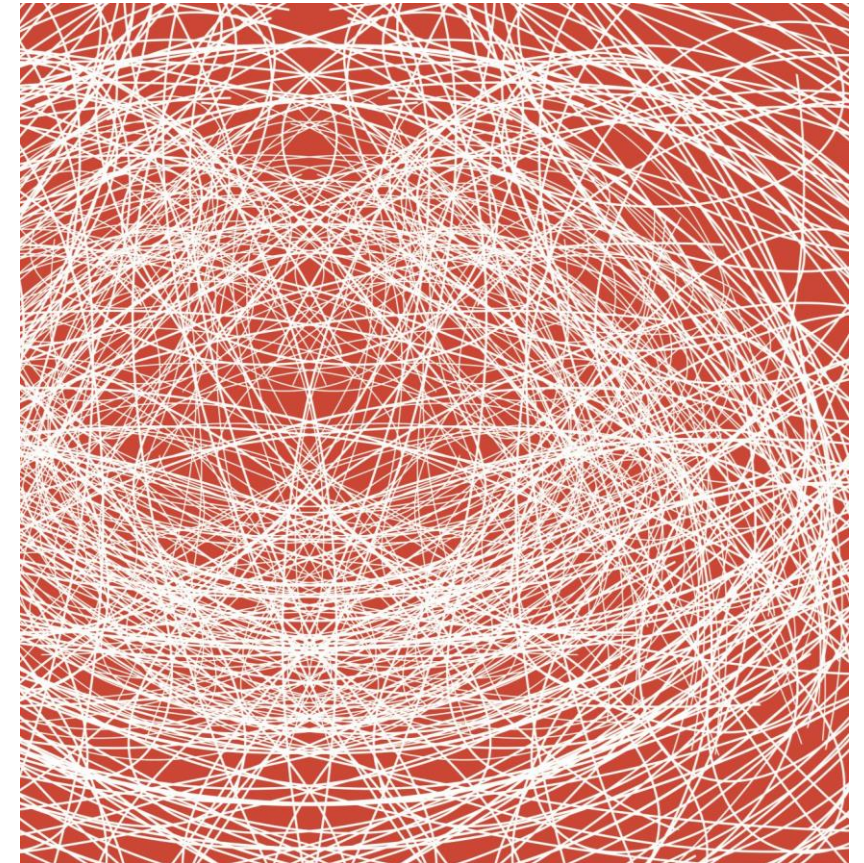
Figure 2.1 Ranking of Happiness based on a three-year-average 2020-2022





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The Journal of the American Medical Association

Disease and Disadvantage in the United States and in England

James Banks, PhD
Michael Marmot, MD
Zoe Oldfield, MSc
James P. Smith, PhD

Context The United States spends considerably more money on health care than the United Kingdom, but whether that translates to better health outcomes is unknown.

Objective To assess the relative health status of older individuals in England and the United States, especially how their health status varies by important indicators of socioeconomic position.

Design, Setting, and Participants We analyzed representative samples of residents aged 55 to 64 years from both countries using 2002 data from the US Health and Retirement Survey (n=4386) and the English Longitudinal Study of Aging (n=3681), which were designed to have directly comparable measures of health, income, and education. This analysis is supplemented by samples of those aged 40 to 70 years from the 1999-2002 waves of National Health and Nutrition Examination Survey (n=2097) and the 2003 wave of the Health Survey for England (n=5526). These surveys contain extensive and comparable biological disease markers on respondents, which are used to determine whether differential propensities to report illness can explain these health differences. To ensure that health differences are not solely due to health issues in the black or Latino populations in the United States, the analysis is limited to non-Hispanic whites in both countries.

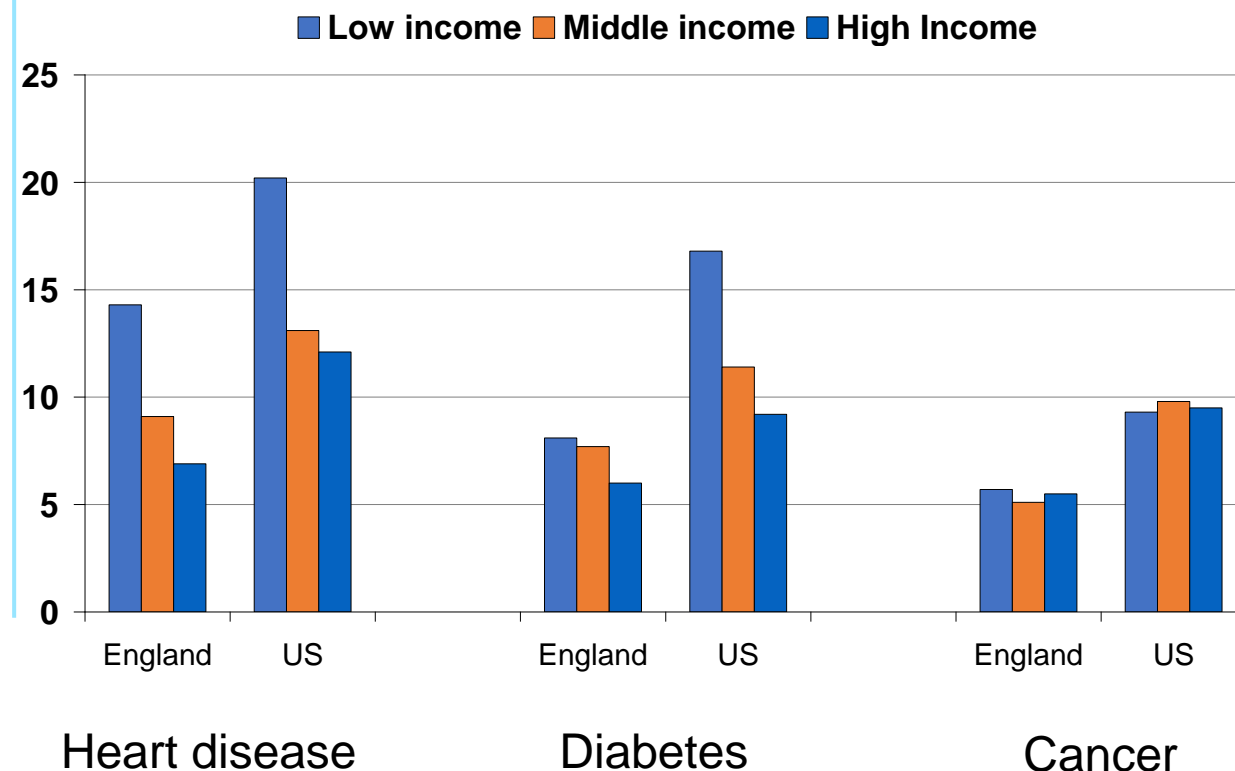
Main Outcome Measure Self-reported prevalence rates of several chronic diseases related to diabetes and heart disease, adjusted for age and health behavior risk factors, were compared between the 2 countries and across education and income classes within each country.

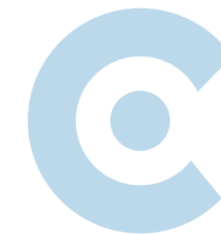
THE UNITED STATES HAS A CONSIDERABLY greater expenditure on medical care (US \$5274 per capita) than in the United Kingdom (US \$2164 adjusting for purchasing power).¹ To determine whether that expenditure translates into better health outcomes for the adult US population, data on the degree of morbidity in each country beyond the childhood years are needed.

Given the strong link between socioeconomic position and health in both countries, cross-country comparisons of morbidity should examine varia-

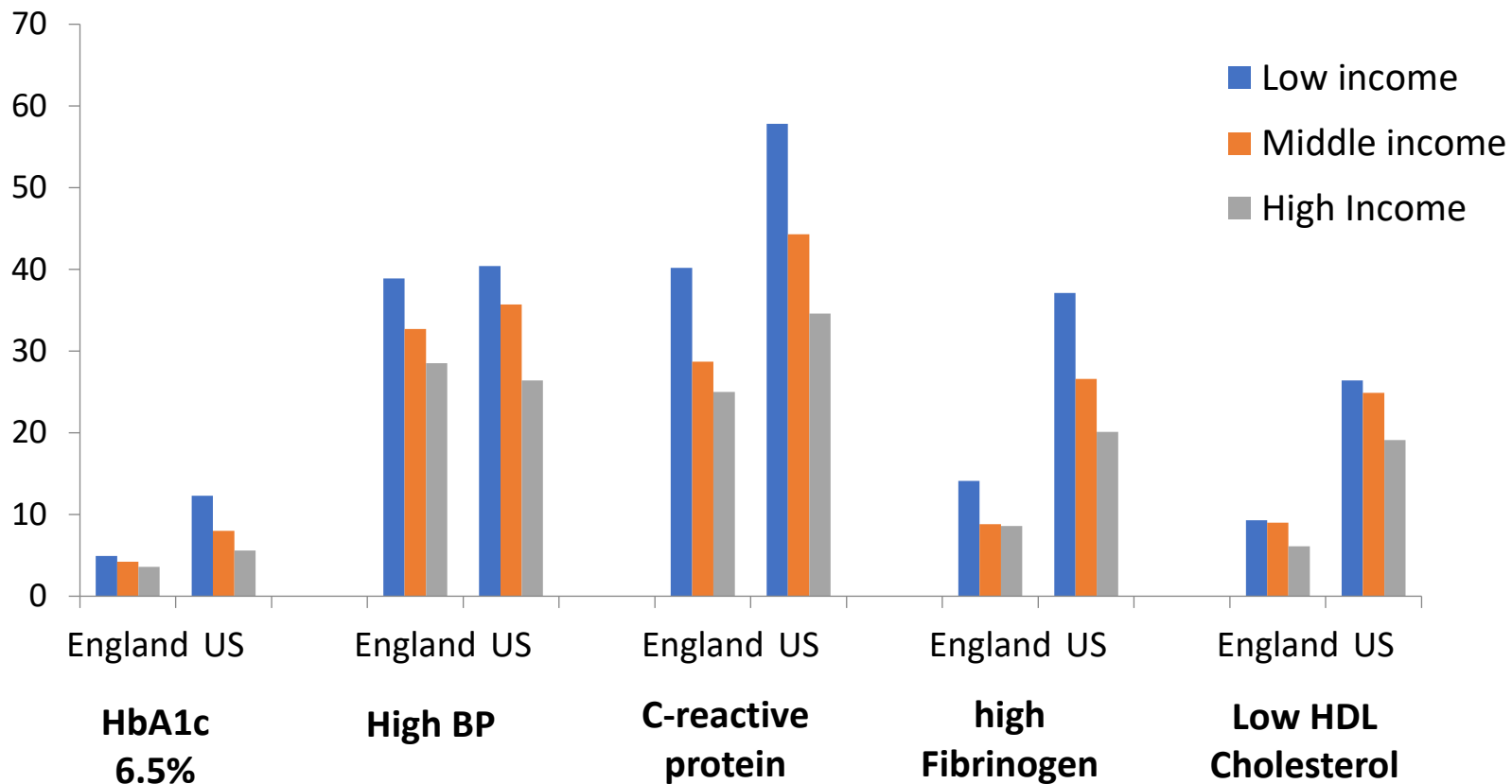
Source: Banks, Marmot, Oldfield and Smith; JAMA 2006

Differences in self-rated health between England and the US, 55-64 year olds





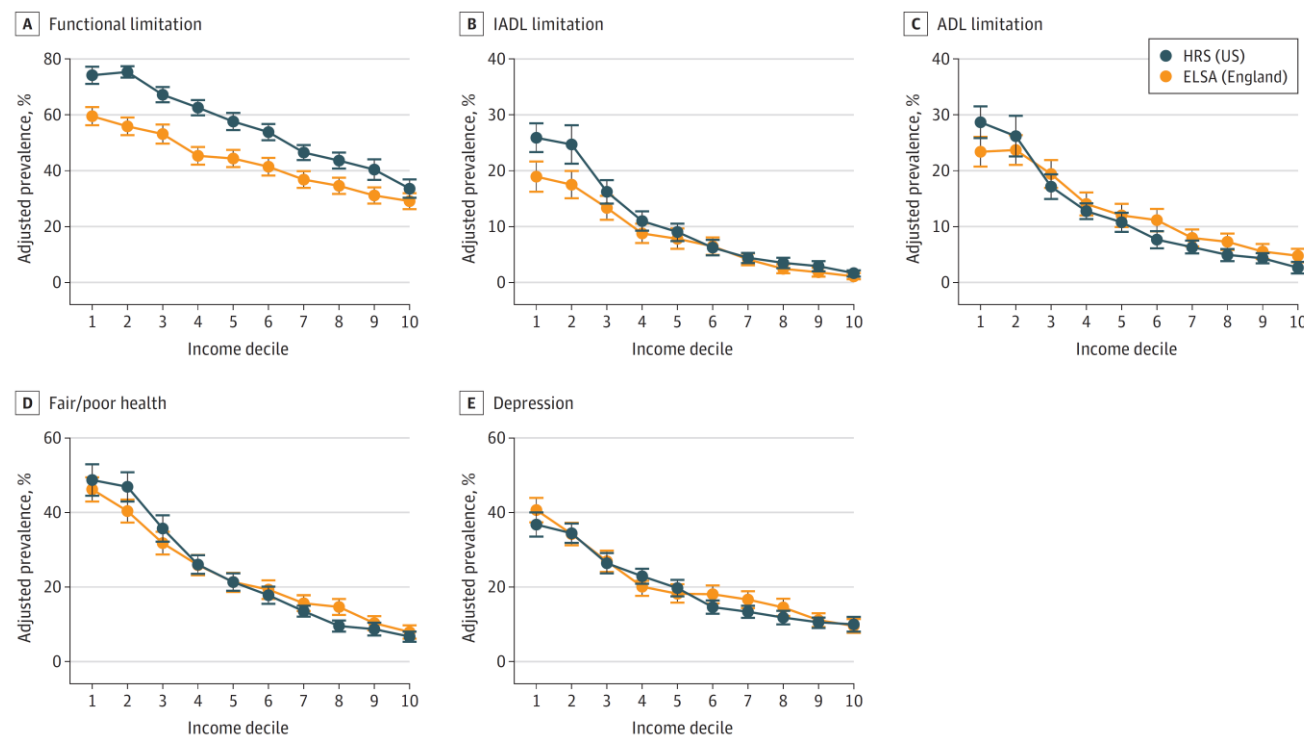
**DIFFERENCES IN
OBJECTIVE HEALTH
BETWEEN
ENGLAND AND THE
US, 55-64 year olds**



Source: Banks, Marmot, Oldfield and Smith; JAMA 2006



Adjusted Prevalence of Self-assessed Health Outcomes at Ages 55 to 64 Years for 2008-2016 by Country-Specific Income Decile



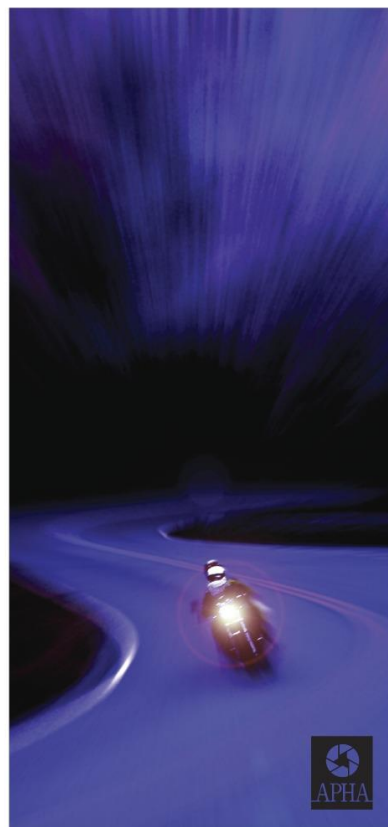
Source: Choi et al, JAMA Int Med, 2020

Health Disadvantage in US Adults Aged 50 to 74 Years: A Comparison of the Health of Rich and Poor Americans With That of Europeans

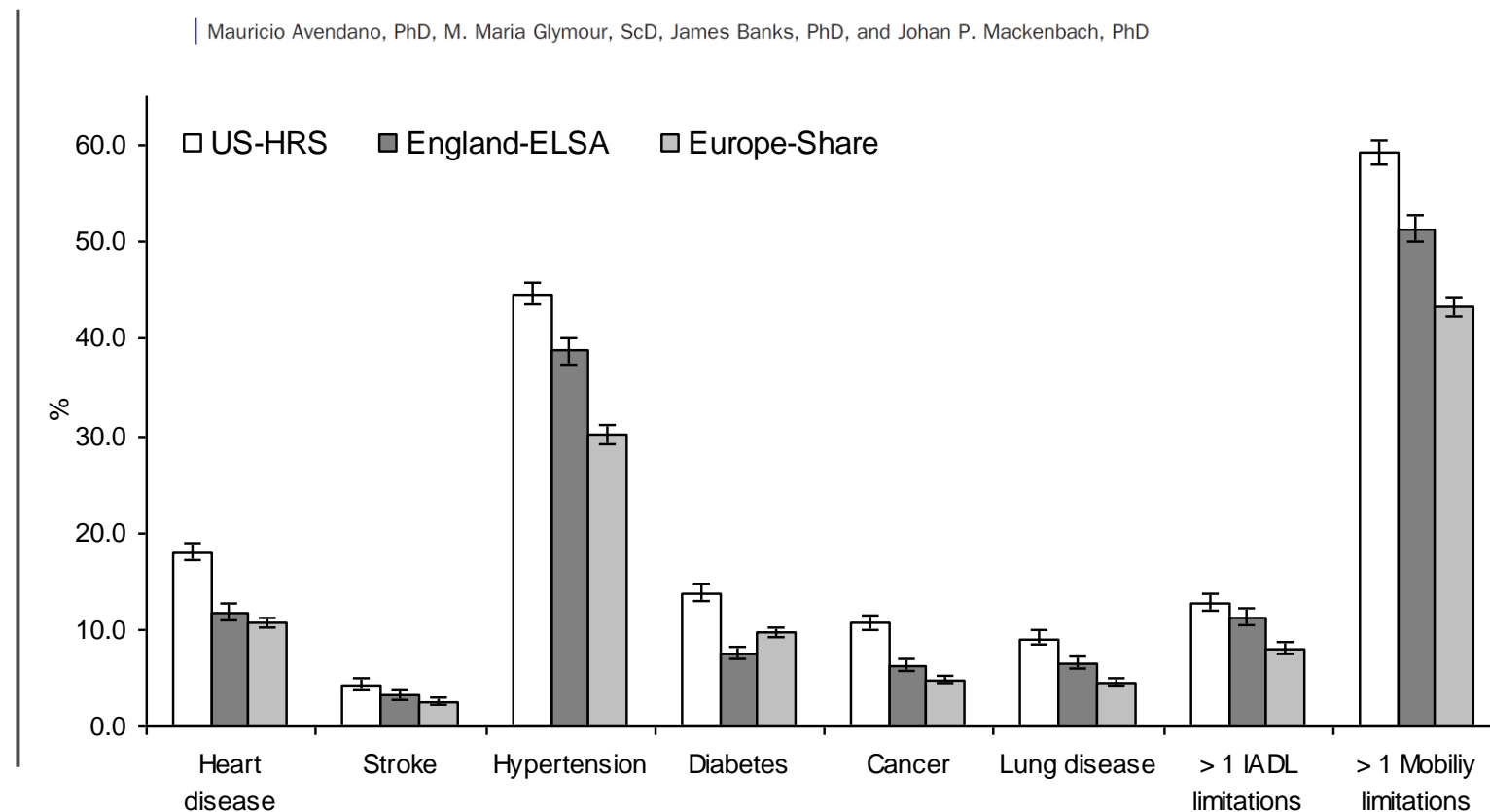
American Journal of
PUBLIC HEALTH

March 2009

Resolving Conflict | Crash Fatalities and the State
Regulation of Trucking | Legitimizing Disease
Promotion | THE POLITICS OF HEALTH | Fast-Food
Placement Around Schools and Youth Obesity |
Early Childhood Poverty and Adult Body Mass Index |
Improvement in Walking Limitation in the Older US
Population | The "Misión Barrio Adentro" Experiment |
Are Poor Europeans Healthier Than Wealthy Americans?



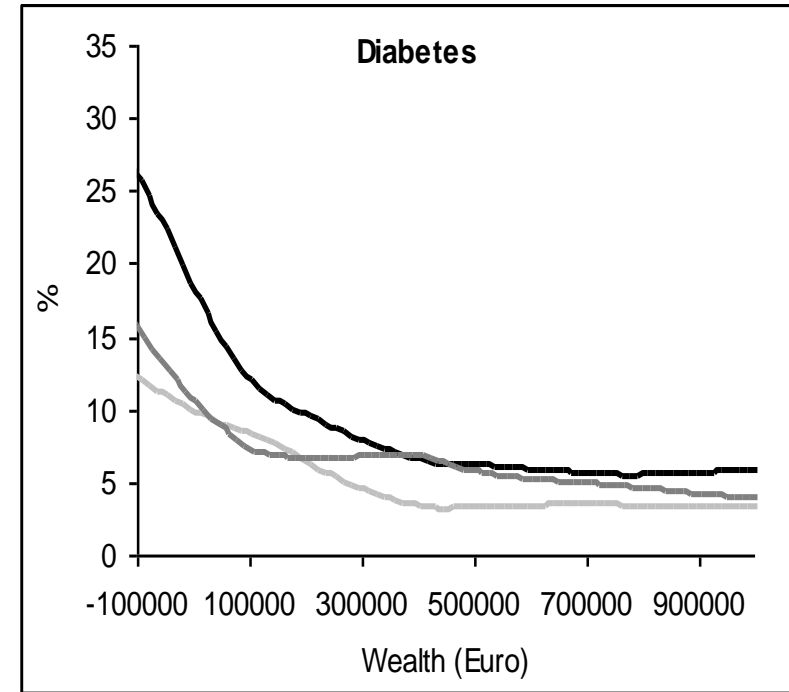
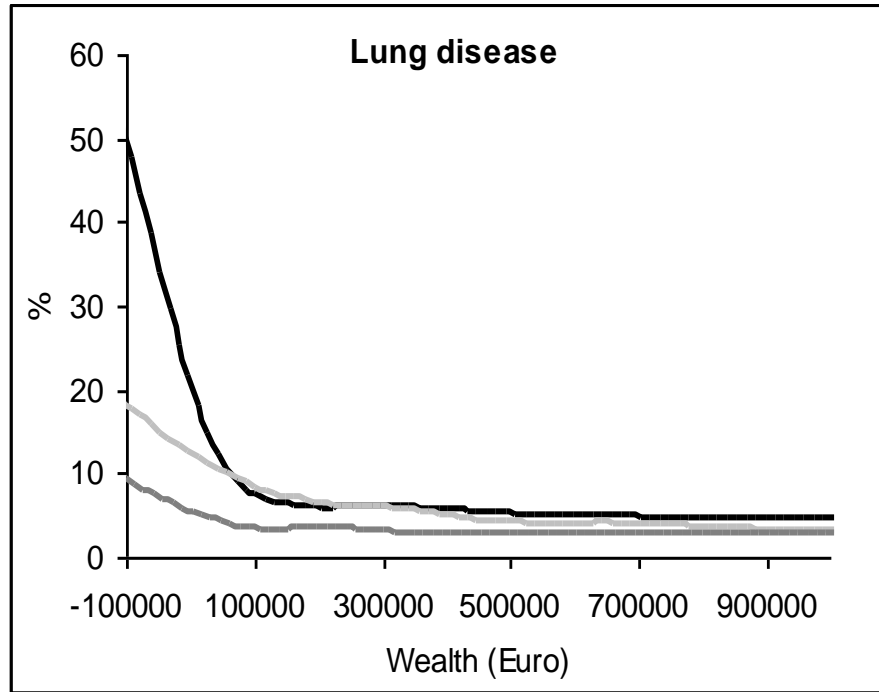
| Mauricio Avendano, PhD, M. Maria Glymour, ScD, James Banks, PhD, and Johan P. Mackenbach, PhD



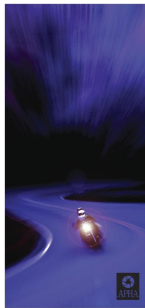
Source: Avendano et al Am J Public Health 2009

Health and Wealth in the US and Europe, aged 50-74

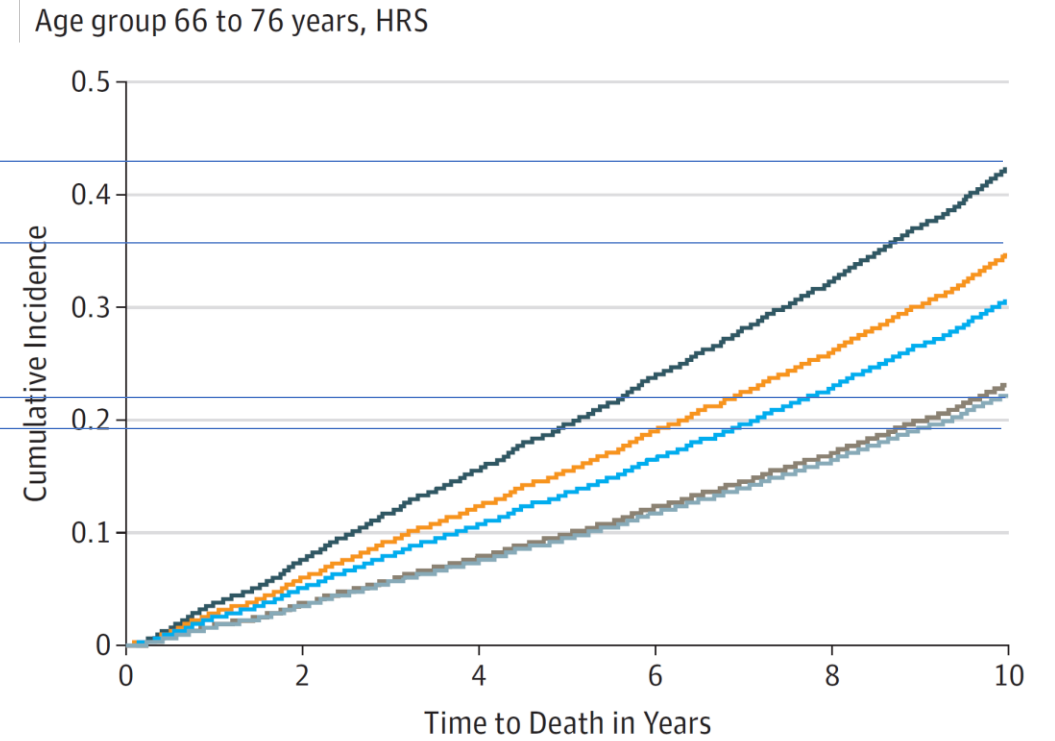
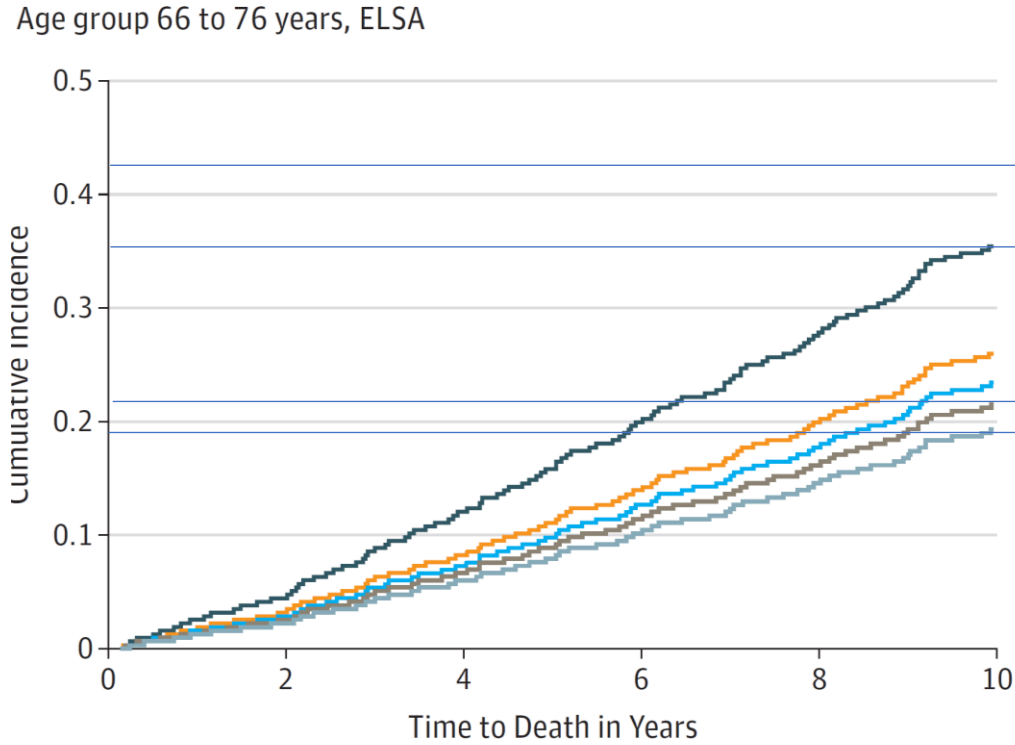
— US-HRS — England-ELSA — Europe-Share



Source: Avendano et al Am J Public Health 2009



Cumulative incidence of death by wealth quintile, 66-76, USA (HRS) and England (ELSA)

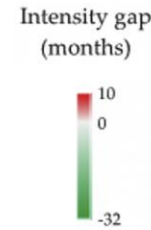
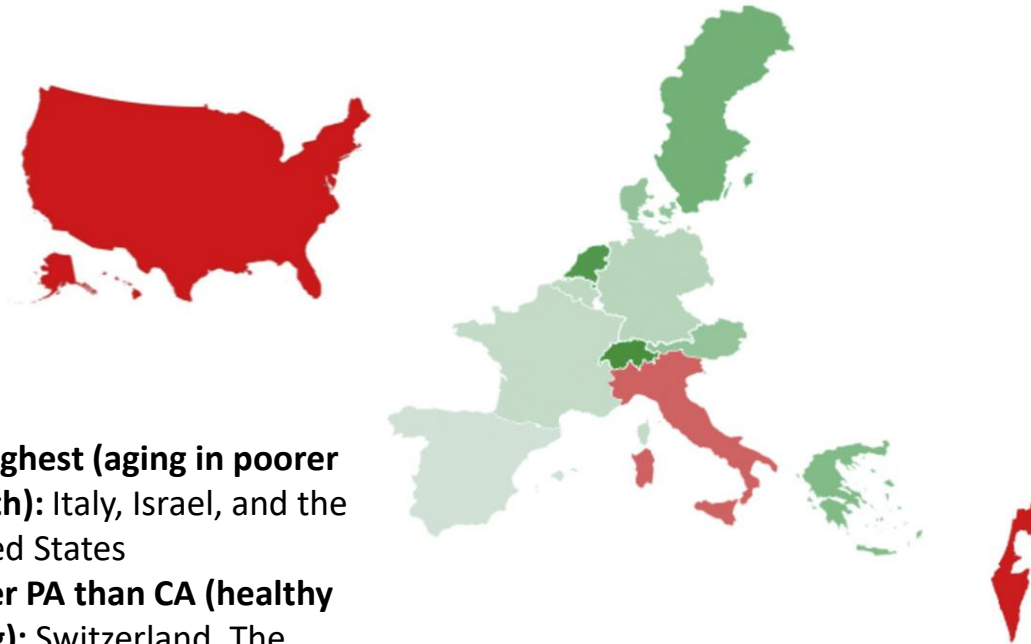


Source: Makaroun et al JAMA Int Med, 2017

Economic Evaluation

Where Are Populations Aging Better? A Global Comparison of Healthy Aging Across Organization for Economic Cooperation and Development Countries

Thomas Rapp, PhD, Jérôme Ronchetti, PhD, Jonathan Sicsic, PhD



Discrepancy between estimated physiological age (PA) and chronological age (CA)

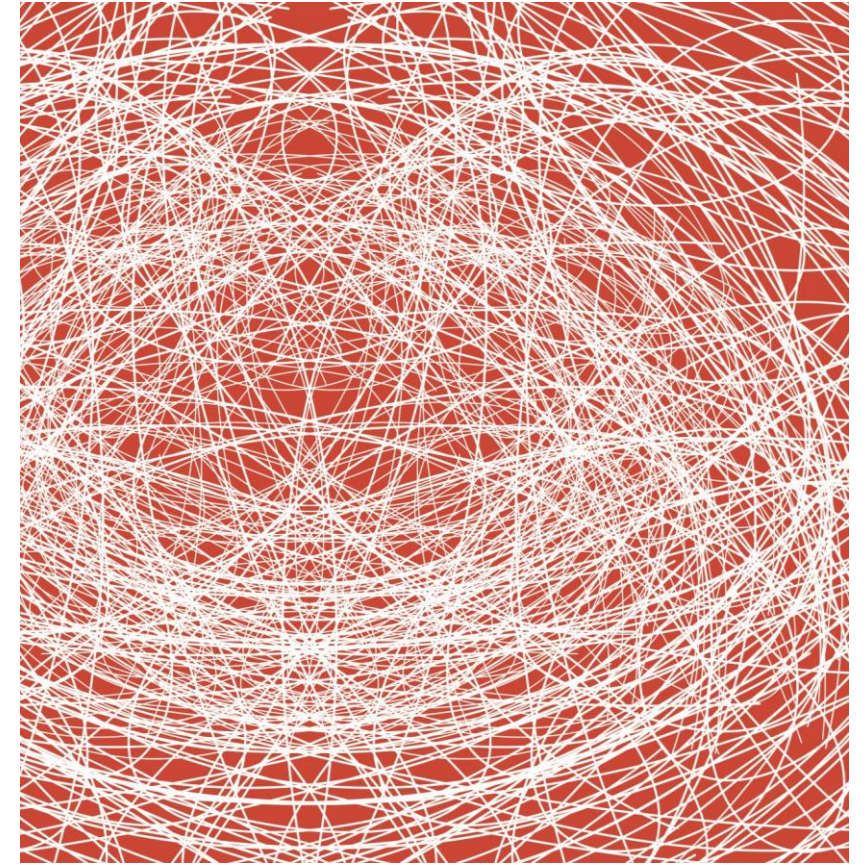
Rank (highest to lowest)	1	2	3	4	5	6	7	8	9	10	11	12	13	Mean
Chronological age (years)	USA 74.08	Spain 72.39	Greece 72.33	France 71.55	Belgium 71.49	Sweden 71.26	Switzerland 71.17	Israel 71.14	Netherlands 71.11	Italy 70.97	Austria 70.88	Denmark 70.75	Germany 70.26	72.15
Health depreciation indicators														
Frailty (%)	Italy 17.66	Spain 16.70	France 15.91	Belgium 15.08	Austria 12.88	Israel 11.25	Germany 11.09	Netherlands 10.98	USA 9.78	Denmark 9.62	Sweden 9.22	Greece 8.41	Switzerland 7.66	12.03
ADL index (mean)	Israel 0.45	USA 0.40	Spain 0.38	Belgium 0.31	Italy 0.30	France 0.25	Germany 0.24	Austria 0.23	Denmark 0.19	Greece 0.18	Sweden 0.16	Netherlands 0.15	Switzerland 0.11	0.30
IADL index (mean)	Israel 0.65	Spain 0.46	USA 0.44	Italy 0.31	Belgium 0.31	Greece 0.29	Austria 0.28	France 0.24	Denmark 0.22	Germany 0.18	Netherlands 0.17	Sweden 0.14	Switzerland 0.10	0.33
Comorbidity index (mean)	USA 1.30	Italy 1.21	France 1.18	Israel 1.16	Spain 1.16	Belgium 1.12	Germany 1.06	Denmark 0.98	Austria 0.97	Sweden 0.94	Greece 0.94	Netherlands 0.87	Switzerland 0.84	1.14
Number of Comorbidities														
High blood pressure (%)	USA 65.41	Israel 60.17	Italy 59.75	Greece 58.12	Spain 58.03	Germany 55.78	Austria 54.46	Belgium 49.02	Denmark 47.72	Sweden 46.81	France 46.32	Netherlands 42.52	Switzerland 41.43	56.13
Diabetes (%)	Israel 30.98	Spain 24.72	USA 24.07	Italy 18.58	Germany 17.66	Greece 17.53	Austria 15.46	Belgium 14.91	France 14.72	Netherlands 13.81	Sweden 12.97	Denmark 10.90	Switzerland 9.53	19.05
Cancer (%)	USA 19.46	Sweden 13.89	Germany 13.84	Denmark 12.95	Switzerland 11.75	Israel 11.55	France 11.25	Belgium 10.84	Austria 9.11	Israel 8.81	Italy 8.42	Spain 7.42	Greece 3.63	13.22
Lung diseases (%)	Italy 13.48	Denmark 11.84	USA 10.96	Spain 10.91	France 10.61	Germany 10.58	Netherlands 10.51	Belgium 9.65	Austria 9.38	Israel 8.21	Switzerland 7.64	Greece 6.74	Sweden 6.17	10.24
Heart problems (%)	USA 29.97	Israel 27.12	France 21.98	Belgium 21.69	Sweden 20.88	Italy 20.28	Spain 19.94	Austria 19.87	Greece 19.85	Germany 19.67	Netherlands 19.48	Denmark 17.87	Switzerland 13.21	23.23
Stroke (%)	Israel 10.43	USA 10.22	Austria 9.96	Denmark 8.48	Belgium 8.21	Germany 8.07	Netherlands 7.86	Sweden 7.38	France 7.19	Greece 6.74	Italy 6.49	Spain 5.47	Switzerland 4.58	8.31
Arthritis (%)	USA 67.74	Italy 53.83	France 51.55	Spain 49.08	Belgium 44.87	Denmark 42.02	Germany 33.34	Switzerland 33.22	Austria 29.15	Denmark 27.04	Netherlands 26.13	Israel 23.18	Netherlands 16.81	47.91
High cholesterol (%)	USA 52.23	Israel 42.44	France 38.64	Greece 38.33	Spain 34.06	Italy 29.78	Germany 29.40	Denmark 29.02	Austria 25.60	Netherlands 24.73	Germany 24.73	Sweden 20.75	Switzerland 19.08	36.71
Cataracts (%)	USA 33.00	Israel 17.36	Sweden 14.10	Spain 13.51	Denmark 13.19	Germany 13.10	Netherlands 12.97	Greece 12.56	Austria 11.65	Switzerland 11.32	France 11.20	Belgium 11.07	Italy 9.16	18.73

Source: Rapp, Ronchetti & Sicsic, Value in Health, 2022

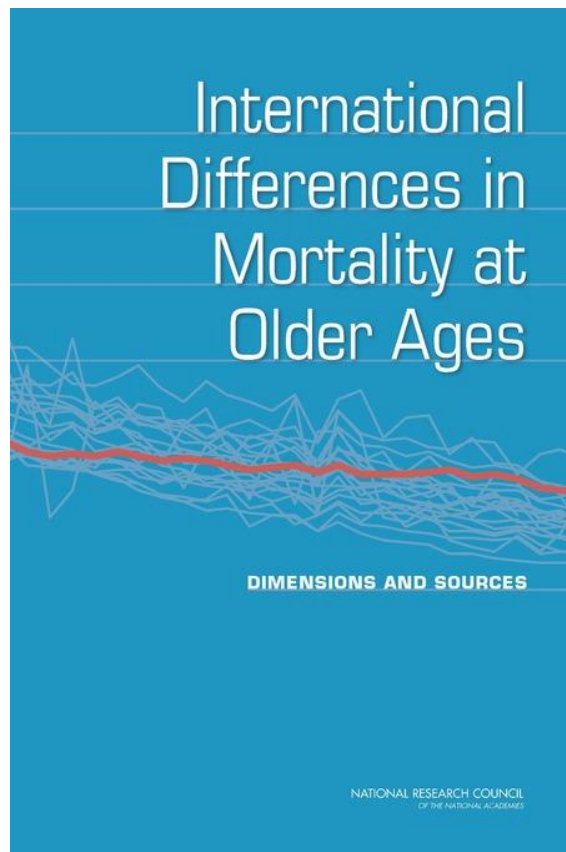


Outline

- Why is this important
- The 'Discovery' of cross-national differences in health
- **The explanation** of differences
- The contribution of **public policy**
- Perspective on **the future**



EXPLAINING THE US HEALTH AND MORTALITY DISADVANTAGE



Smoking histories (Preston et al; Pampel)

Obesity (Alley et al)

Physical activity (Steptoe & Wikman)

Social integration and social interactions (Banks et al)

The Health System (Preston & Ho)

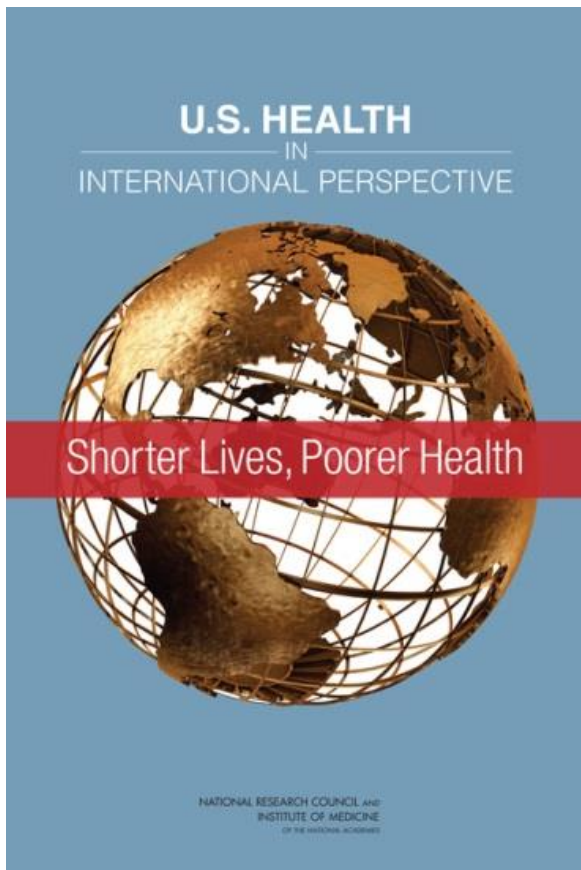
Hormone therapy (Goldman)

Socioeconomic Inequality (Avendano et al)

Geographical inequalities (Wilmoth et al)

*‘Having the **highest level of cigarette consumption per capita** in the developed world over a 40-year period (up to the mid-1980s) has left a very visible and continuing imprint on U.S. mortality’*

The US Health disadvantage across the life-course



Public Health and Medical care systems

Behaviour: Tobacco, diet, physical activity, alcohol & drug use, sexual practices, injuries

Social factors

Physical and social environments

Policies and Social values

*‘Given the pervasive nature of the low U.S. rankings..... Might **certain aspects of life in modern America** be part of the explanation for the U.S. health disadvantage? ‘*

*‘There are no definitive studies on this subject, but the public health literature certainly documents **the health benefits of strengthening systems for health and social services, education, and employment; promoting healthy life-styles; and designing healthier environments**’*

Why do Americans have Shorter Life Expectancy and Worse Health Than Do People in Other High-Income Countries?

Mauricio Avendano^{1,2} and Ichiro Kawachi²



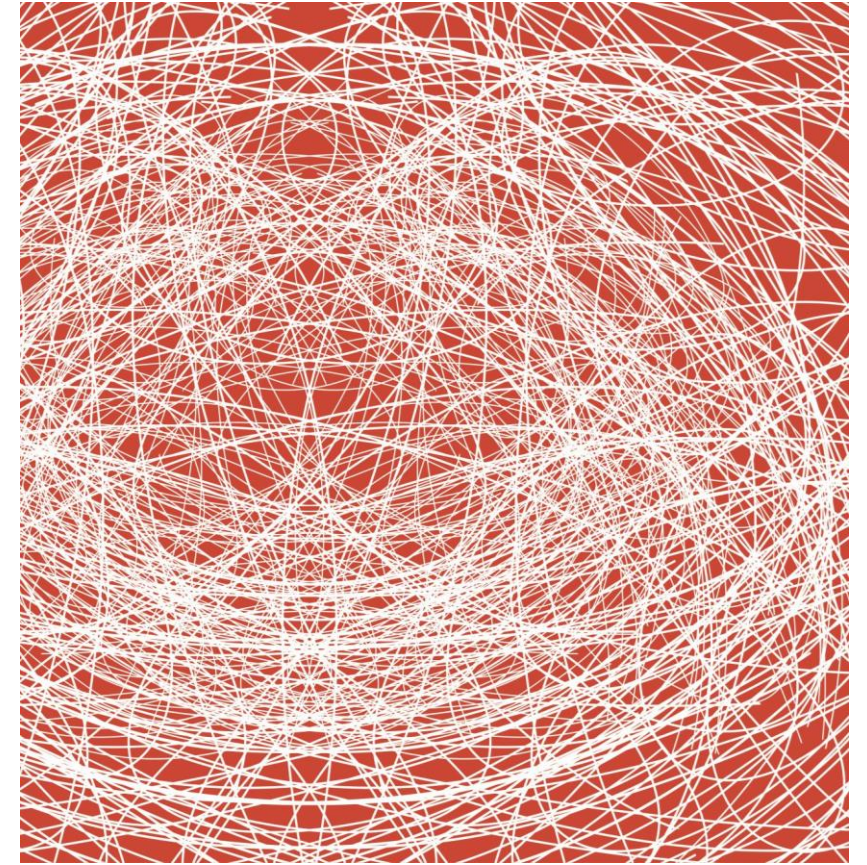
Review in Advance first posted online on January 9, 2014. (Changes may still occur before final publication online and in print.)

Annu. Rev. Public Health 2014. 35:23.1–23.19



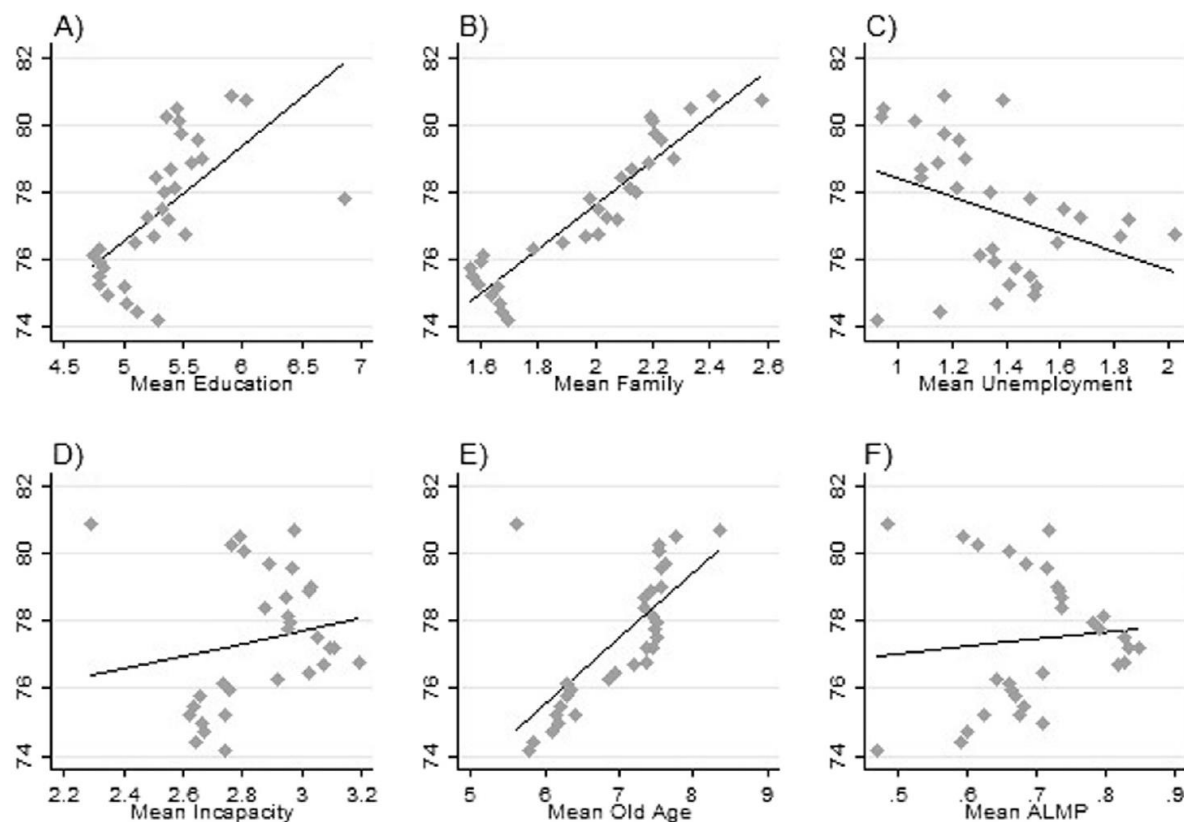
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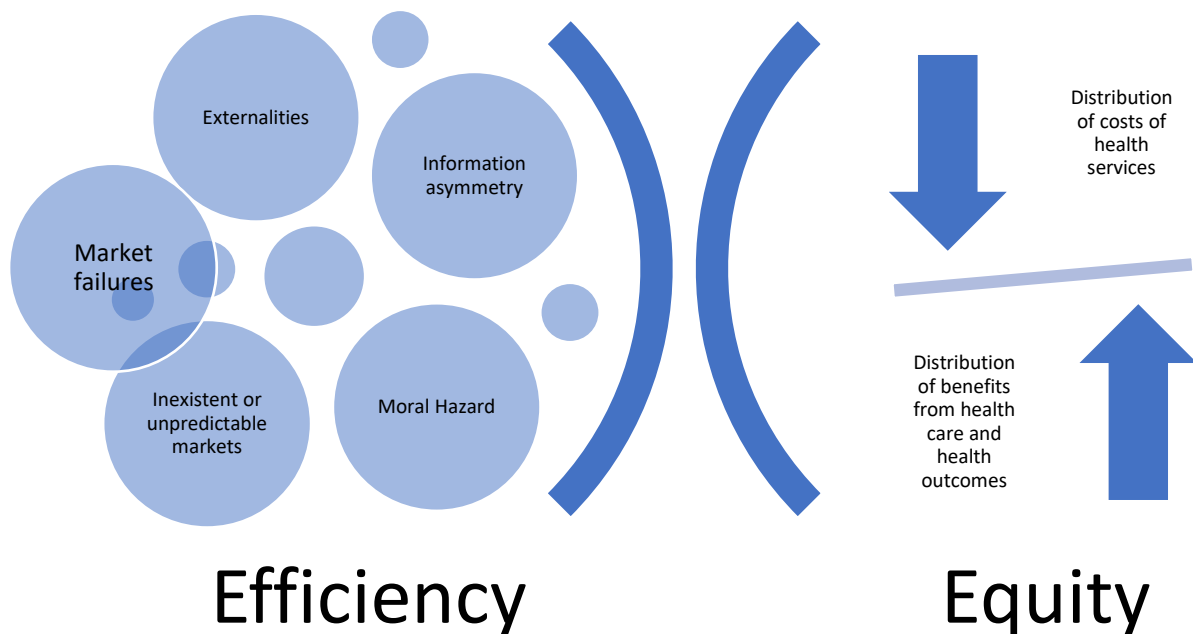
Social Policy Expenditures and Life Expectancy in High-Income Countries

Megan M. Reynolds, PhD,¹ Mauricio Avendano, PhD^{2,3}





Estimating the contribution of public policies



- Policies aim to maximise some dimension of wellbeing, but not necessarily health
- Two questions need to be addressed:
 - **Q1:** How do public polices influence health?
 - **Q2:** Are differences in health caused by policy sufficiently large to explain cross-national differences in health?

Public policies that may impact population health

Early childhood education

Education policy, e.g., compulsory schooling laws

Labour market policies, e.g., retirement and pension policy, unemployment benefits

Family policy, e.g., maternity leave policy, work-flexibility policies

Housing policies, e.g., relocation programmes

Anti-poverty policy, e.g., cash transfers, welfare benefits

Built environmental policies, e.g., transportation

Health policies, e.g., health insurance, regulation of drugs, public health

Long-term care policy



Public transport policy: The free Bus Pass



English Longitudinal
Study of Ageing, 2002 –
2014

Transport use and cognitive function ELSA scores in older age, ELSA

	Probability of transport use β (95% CI)
Eligible for free bus travel	0.074 (0.060, 0.089)***

7% increase in transport use if eligible to free bus pass

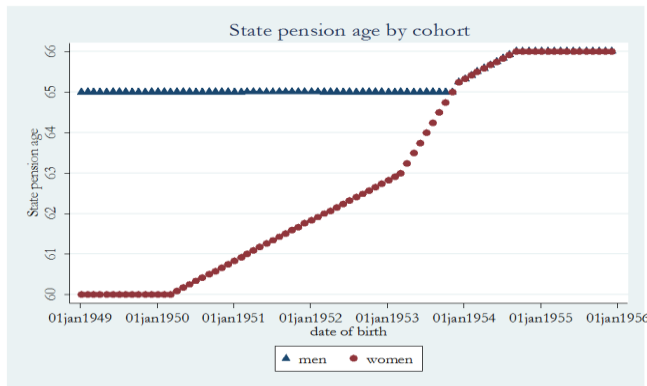
	IV 2nd Stage β (95% CI)
Total Cognitive Function	0.346 (0.017,0.674)*
Memory	0.546 (0.111,0.982)*
Executive Function	0.323 (-0.153,0.800)
Processing Speed	0.332 (-0.234,0.898)

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$



Should I Care or Should I Work? The Impact of work on Informal Care

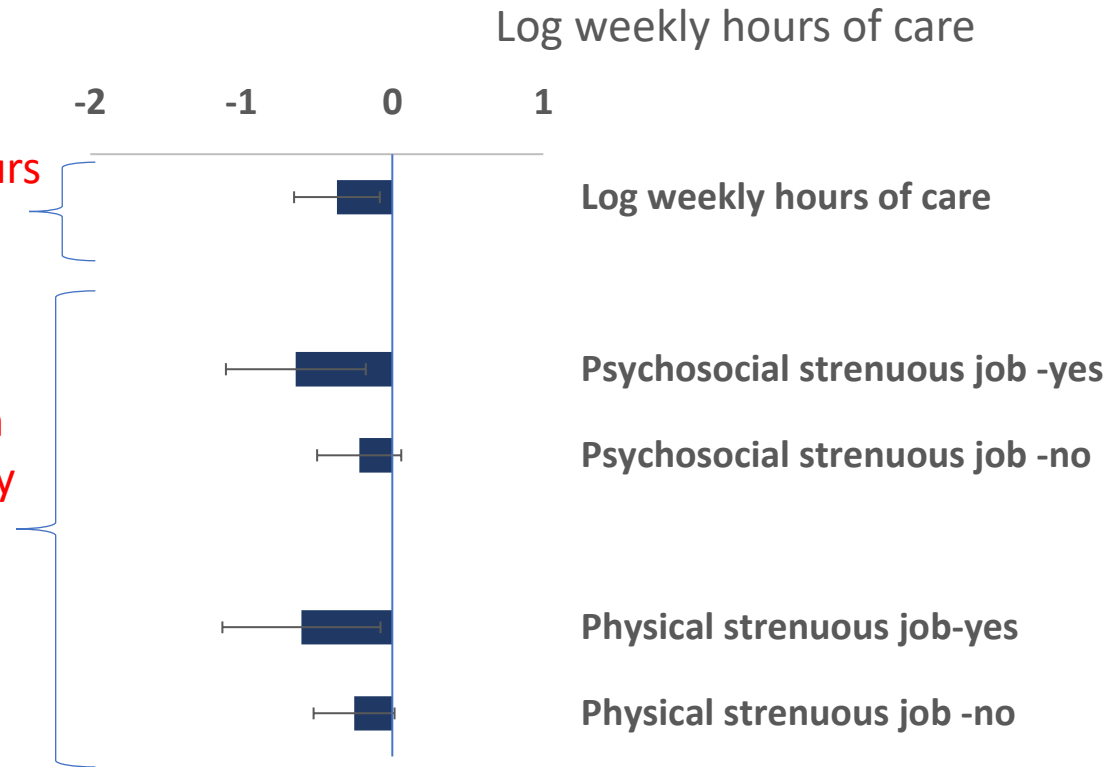
Ludovico Carrino^{a,b} Vahé Nafilyan^{c,d}, Mauricio Avendano^{e,f}



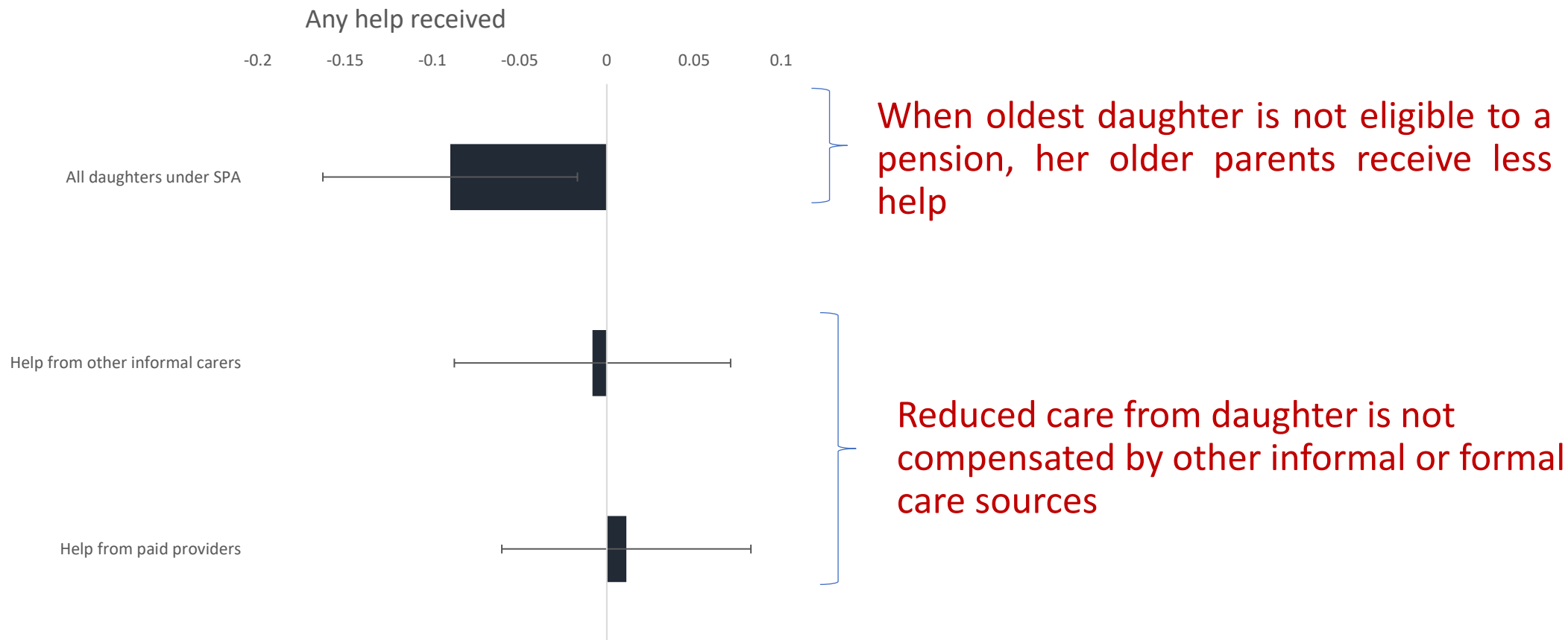
Prolonging work → lower caregiving: opportunity costs of time is higher

An increase of 10% in work-hours (+100mins/w) leads to 3.7% lower care hours (-21 mins/w)

Larger effect for women in psychosocially or physically strenuous jobs



The impact of reduced daughter's informal care on older parents' receipt of care



Campaign to
EndLoneliness
CONNECTIONS IN OLDER AGE

To watch the full video



Click here

Together, we can end loneliness

1.2 million people in the UK are chronically lonely.

Over half a million older people in the UK go up to a week without seeing anyone.

But we can all take action.

Sign up today and help us end loneliness in the UK.



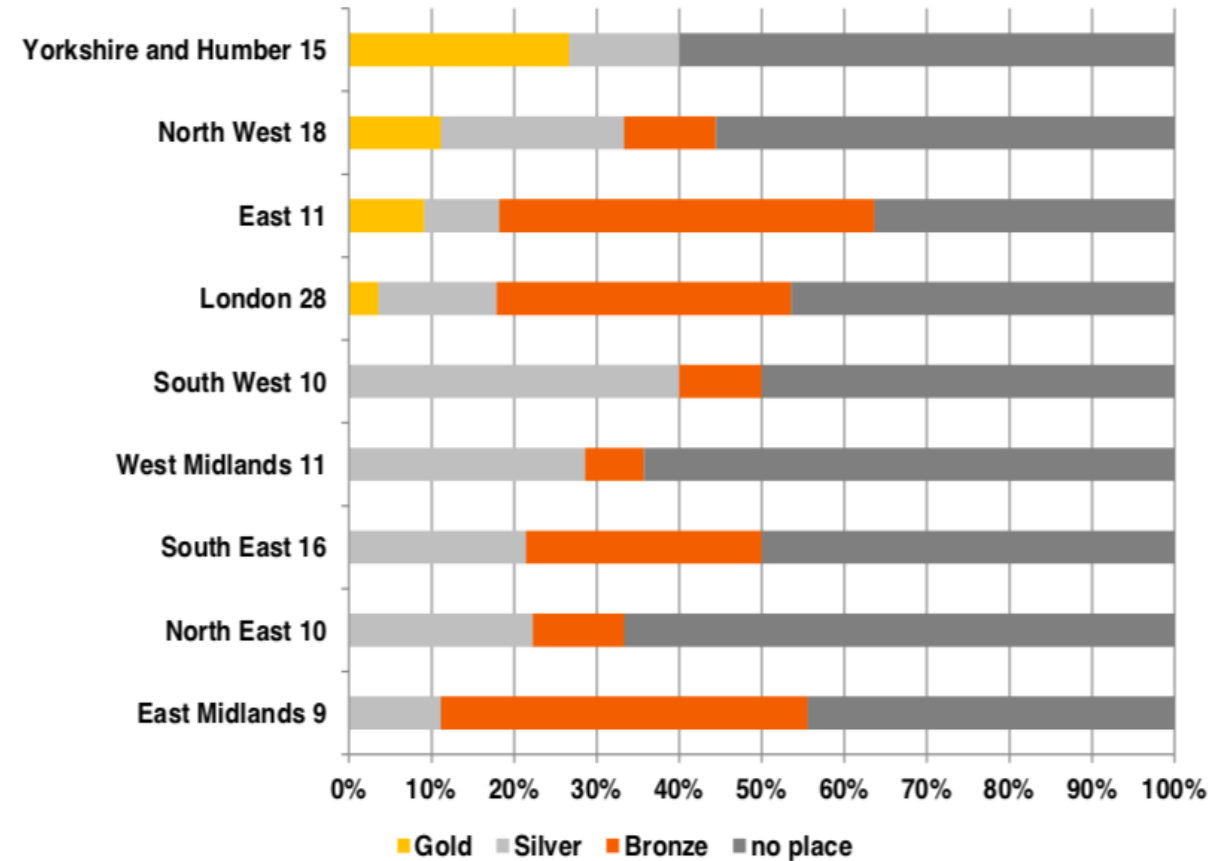
I want to end loneliness

*By clicking 'I want to end loneliness', you are signing up for The Campaign To End Loneliness mailing list. We will update you on the campaign's progress and let you know how you can make a difference. You can unsubscribe at any time.

Campaign to End Loneliness

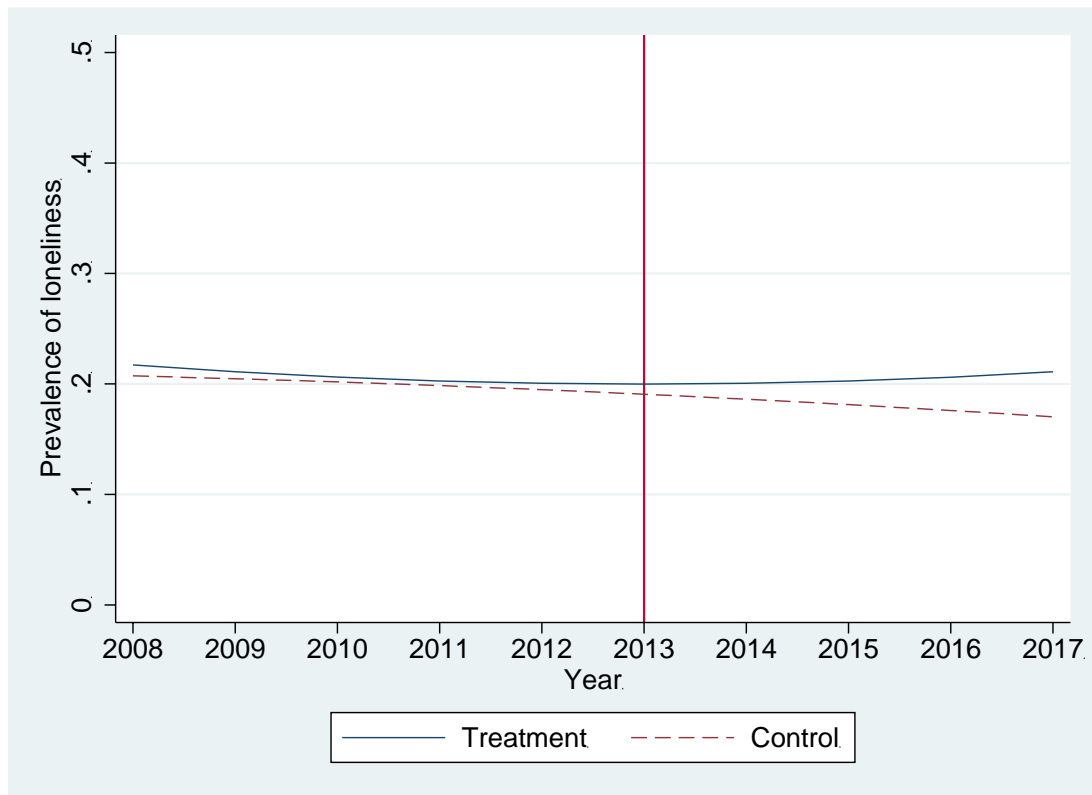
- **Main differences of strategies**
- Gold: measurable actions and targets on tackling issues of loneliness
- Silver: stated commitment to learning about the issue of loneliness in local areas and improving social relationships
- Bronze: recognition of loneliness as an issue and commitment to improving social relationships

Chart 2: Within-region distribution of ranked strategies
(Total number of HWBs in each region shown after region name)



Source: Cupitt 2013

Impact of End Loneliness campaign on feelings of loneliness



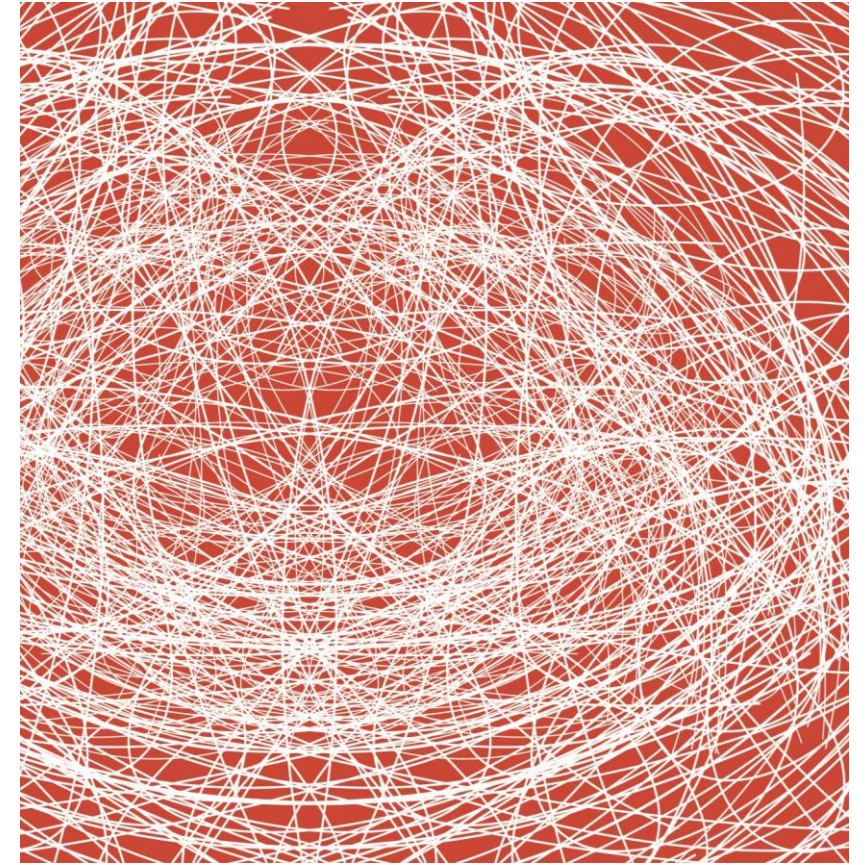
	Loneliness
Panel A: by education	(1)
Education (=A-level or above)	-0.113 (0.058)
Time* Treatment	0.134 (0.103)
Time* Treatment* Education	-0.379*** (0.104)

reduced levels of loneliness for higher educated (\geq A-level) older adults by 0.4 unit



Outline

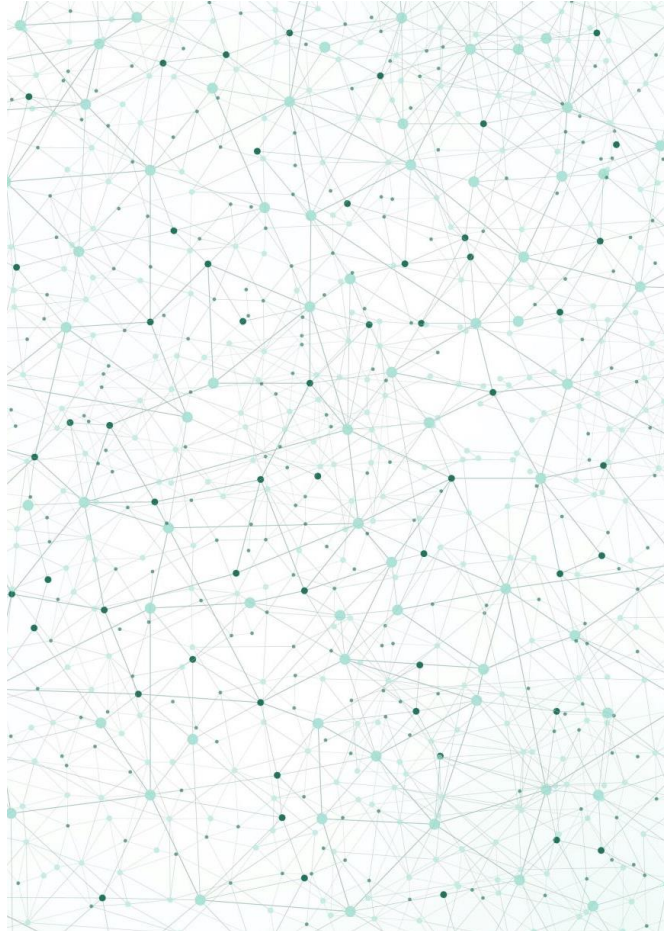
- Why is this important
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The future

- Link to more policies, consider time lag of policy effect operating across childhood, adult life and older age
- Examine the synergic effect of policies –and the contribution of multiple policies (or constellations of policies), rather than single policies
- Link specific outcomes to specific policies or exposures –e.g., link cancer survival to specific cancer prevention policies



Conclusions


- ELSA and HRS-sister studies have taught us that cross-national differences in health a) are large and real; b) apply too all SES groups, but are often larger for the bottom of the SES distribution
- There is no simple explanation: a) smoking likely important for historical trends, but behavioural differences not full explanation; b) health care unlikely to be a explanation for all differences
- Public policies likely important, but a) establishing causal impacts challenging, b) only local average treatment effects obtained; c) challenging to harmonise all policies across countries
- ELSA and HRS-sister surveys are unique resource to understand how public policies shape cross-national health differences by influencing the environment in which people age



Cross-Country Comparisons

2023 ELSA 20th Anniversary Conference

Jinkook Lee, University of Southern California



Aging changes, universal or heterogeneous?

Aging changes can be attributed to

- an inherent process, referred to as the aging process;
 - genetic defects;
 - disease processes; and
 - the environment.
-

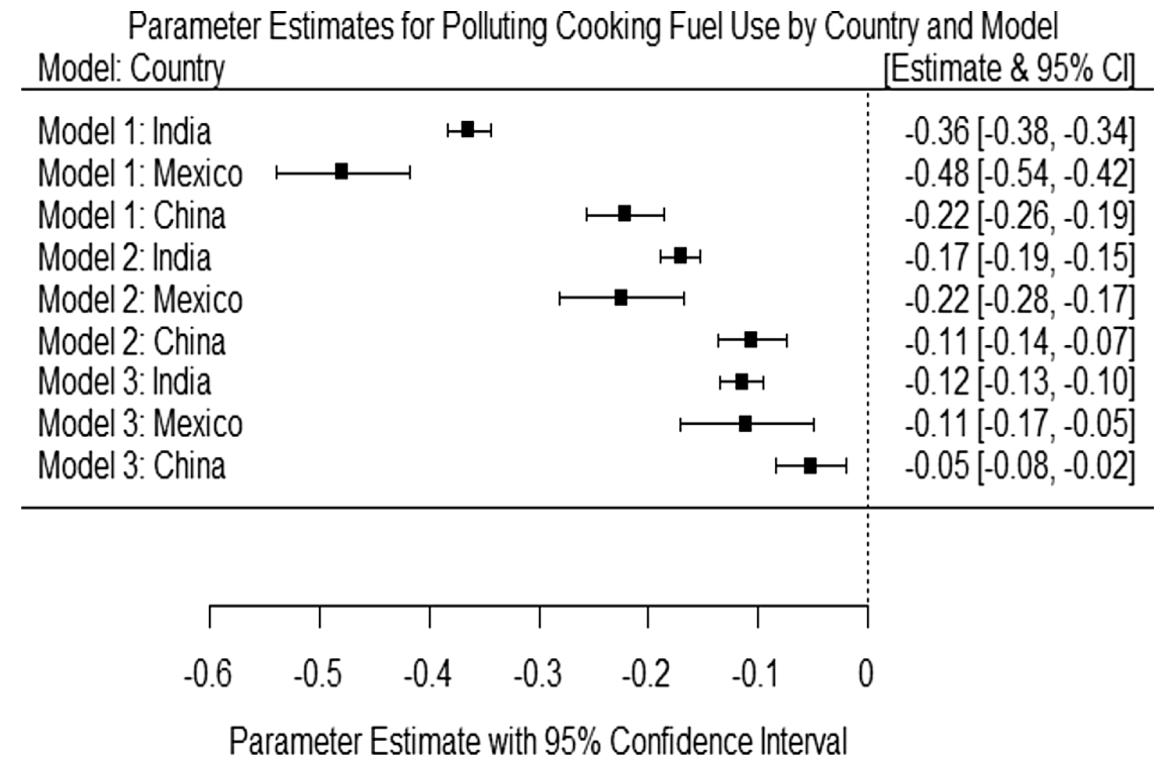
Opportunities to study what is universal



Household use of polluting cooking fuels and late-life cognitive function: A harmonized analysis of India, Mexico, and China

Joseph L. Saenz ^{a,*}, Sara D. Adar ^b, Yuan S. Zhang ^c, Jenny Wilkens ^d, Aparajita Chattopadhyay ^e, Jinkook Lee ^{d,f}, Rebeca Wong ^g

Fig. 1. Adjusted mean differences in cognitive functioning



Opportunity to study diverging trends

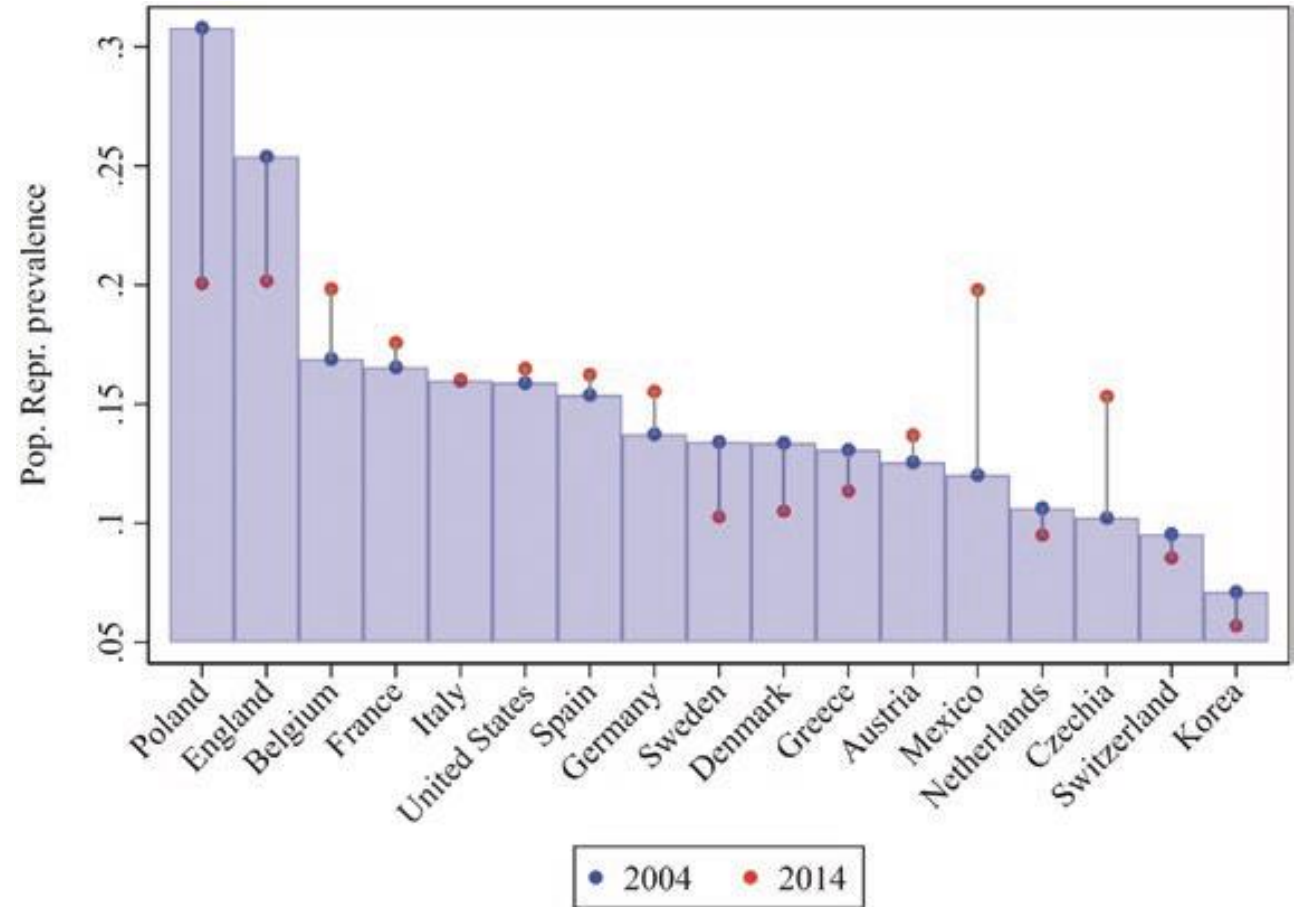
Living Longer, With or Without Disability? A Global and Longitudinal Perspective

Jinkook Lee, PhD, Samuel Lau, BA, Erik Meijer, PhD, Peifeng Hu, MD, PhD

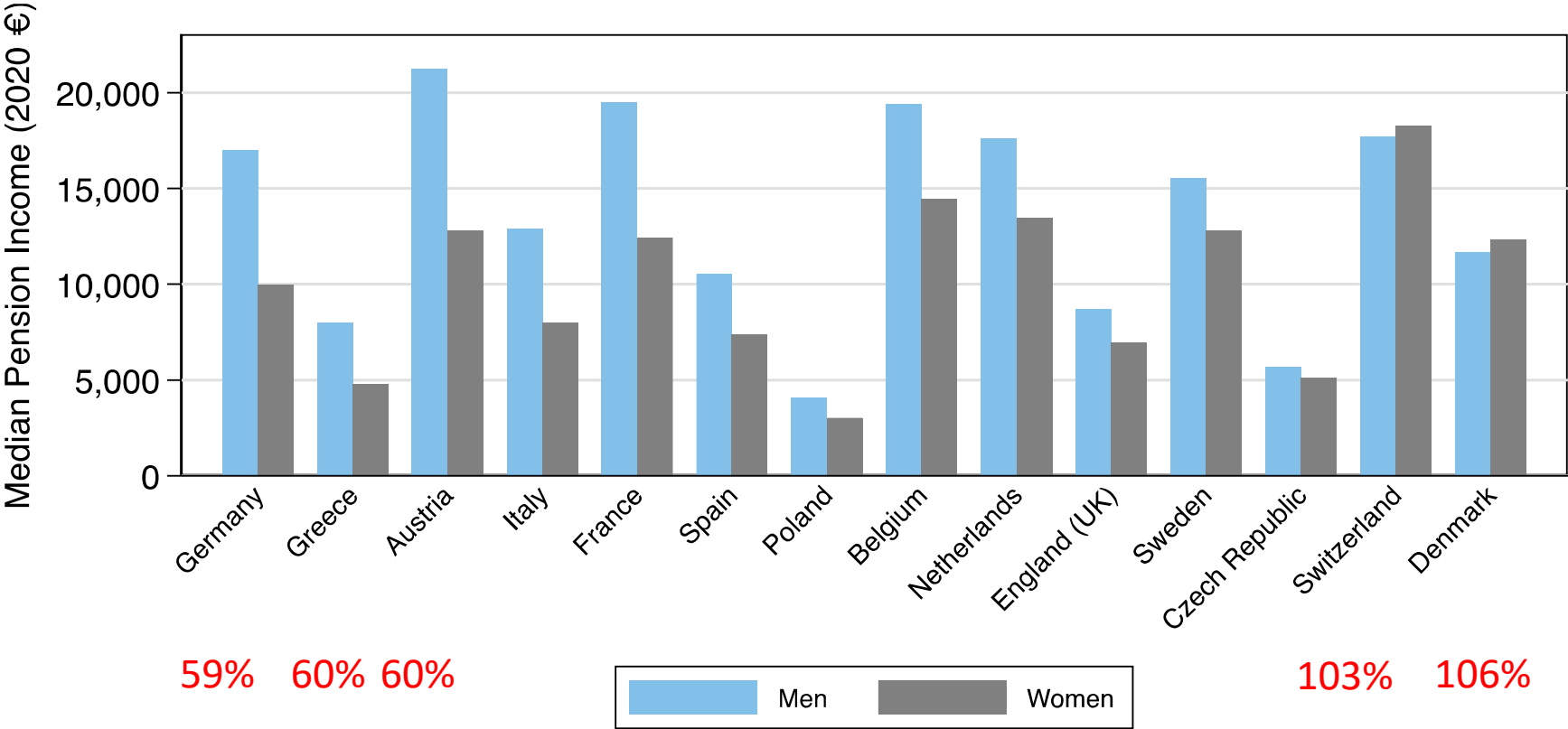
The Journals of Gerontology: Series A, Volume 75, Issue 1, January 2020, Pages 162–

167, <https://doi.org/10.1093/gerona/glz007>

Population representative disability prevalence rates



Opportunity to study disparity



Notes: Estimates are conditional on observing individuals at age 70 or older to avoid censoring on pension income level. Income depicted in 2020 euros. Values are computed by first taking the median of non-zero, inflation-adjusted annual after-tax pension income reported by individuals across interviews and then taking the median by sex and country.



What explains sex-based differences?

- Work history differences
 - Labor force participation over lifecycle
 - Earnings over lifecycle
- Policy differences
 - Retirement eligibility policies
 - Progressivity of benefits

Germany

Own Old-Age Benefits
Plan details 1992-2021[†]

Gesetzliche Rentenversicherung (GRV) is the German compulsory old age public pension system that provides a defined benefit to workers based on their contribution history. Contributions are converted in points in the year they are paid and those points are converted to an annual benefit based on a pension point value that is updated annually. Since 1992, the main design of the pension system has remained largely the same, but reforms have led to a gradual increase in benefit eligibility ages and the introduction of incentives to delay starting benefits.

Key Dates

First law: 1889
Major changes since 1992: 1999, 2001, 2004, 2007

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[†]If you have questions or suggestions, please contact policy@g2aging.org.

[†]Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "T".

/

Thank You!
Happy 20th Anniversary!

The experiences of older people during the COVID-19 pandemic

Dr Giorgio Di Gessa

g.di-gessa@ucl.ac.uk

Outline

- ELSA response to the COVID-19 pandemic
 - ELSA COVID-19 substudy
 - National core study (NCS)
- Key findings

Outline

- ELSA response to the COVID-19 pandemic
 - ELSA COVID-19 substudy
 - National core study (NCS)
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Background



23 March 2020 – PM announces lockdown in UK

- Closure of educational institutions, community facilities, and non-essential shops and services
- Public, and particularly older people, to “stay at home” and limit physical interactions with others
- 3.7m clinically vulnerable patients (74% aged 50+) were required to “shield”

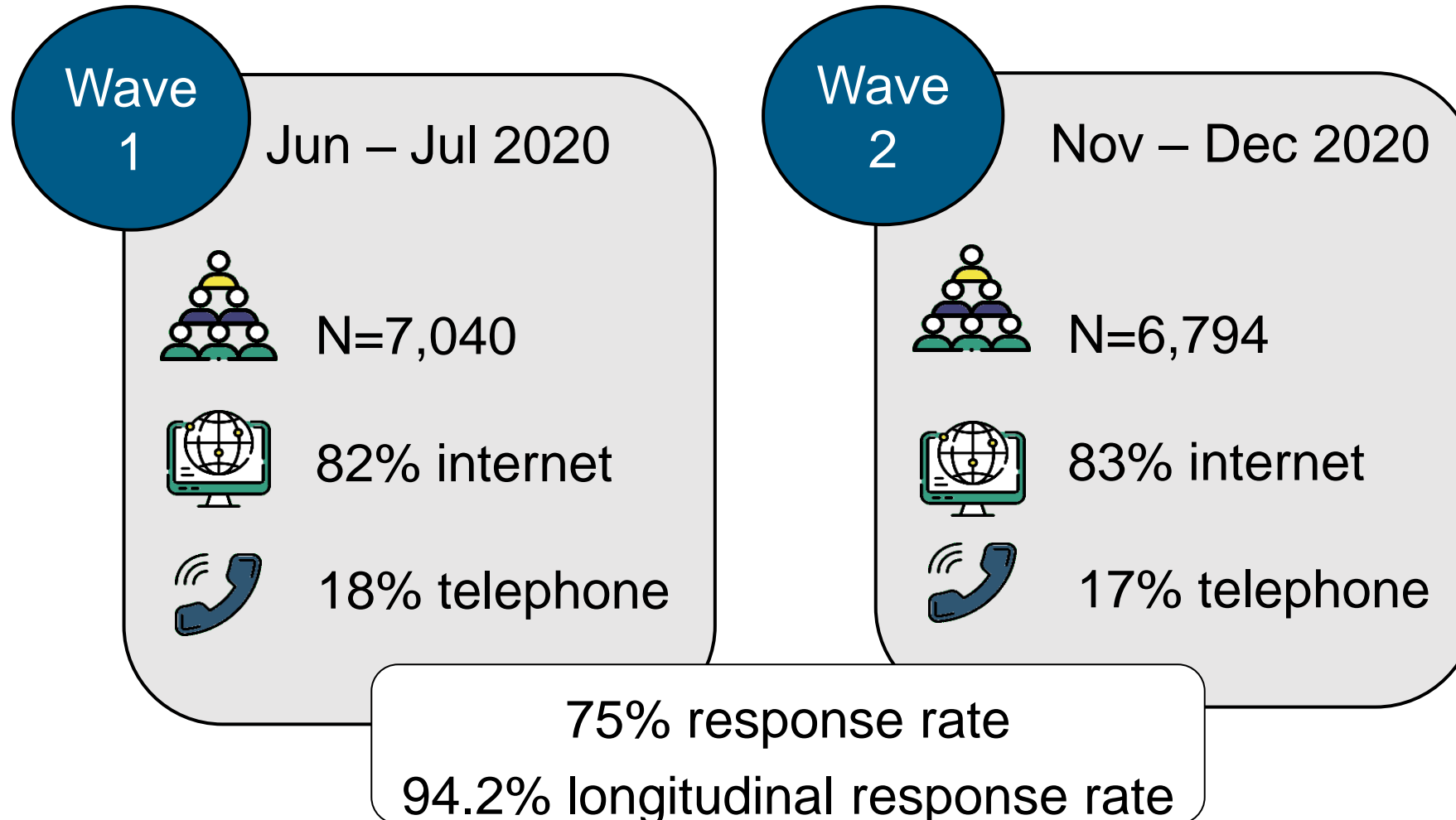
ELSA COVID-19 substudy

Developed to understand the experience of the pandemic among older people and whether and how this affected older people's health, finances, and social lives.



Funded by the Economic and Social Research Council via the UK Research and Innovation COVID-19 Rapid Response call

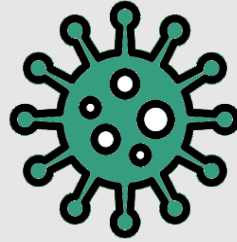
Data collection and participants



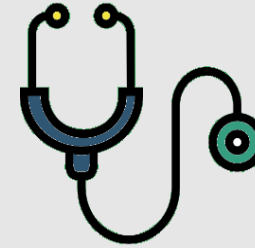
Measures



Household
characteristic



Covid-19



Health & health
behaviours



Employment



Financial
situation



Social participation
& connectivity

National Core Studies (NCS)



The National Core Studies (NCS) were established by Sir Vallance, UK Chief Scientific Adviser, in Oct 20 as part of the UK's response to the pandemic.

One of the six NCS created - **COVID-19 Longitudinal Health and Wellbeing NCS** - focussed on understanding the health, social, and economic impacts of the COVID-19 pandemic by uniting established population cohorts and anonymised electronic health records to inform policy.

Longitudinal Studies



Collaborative Team



LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



BRADFORD INSTITUTE
FOR HEALTH RESEARCH
| MAKING RESEARCH REAL



KING'S
College
LONDON



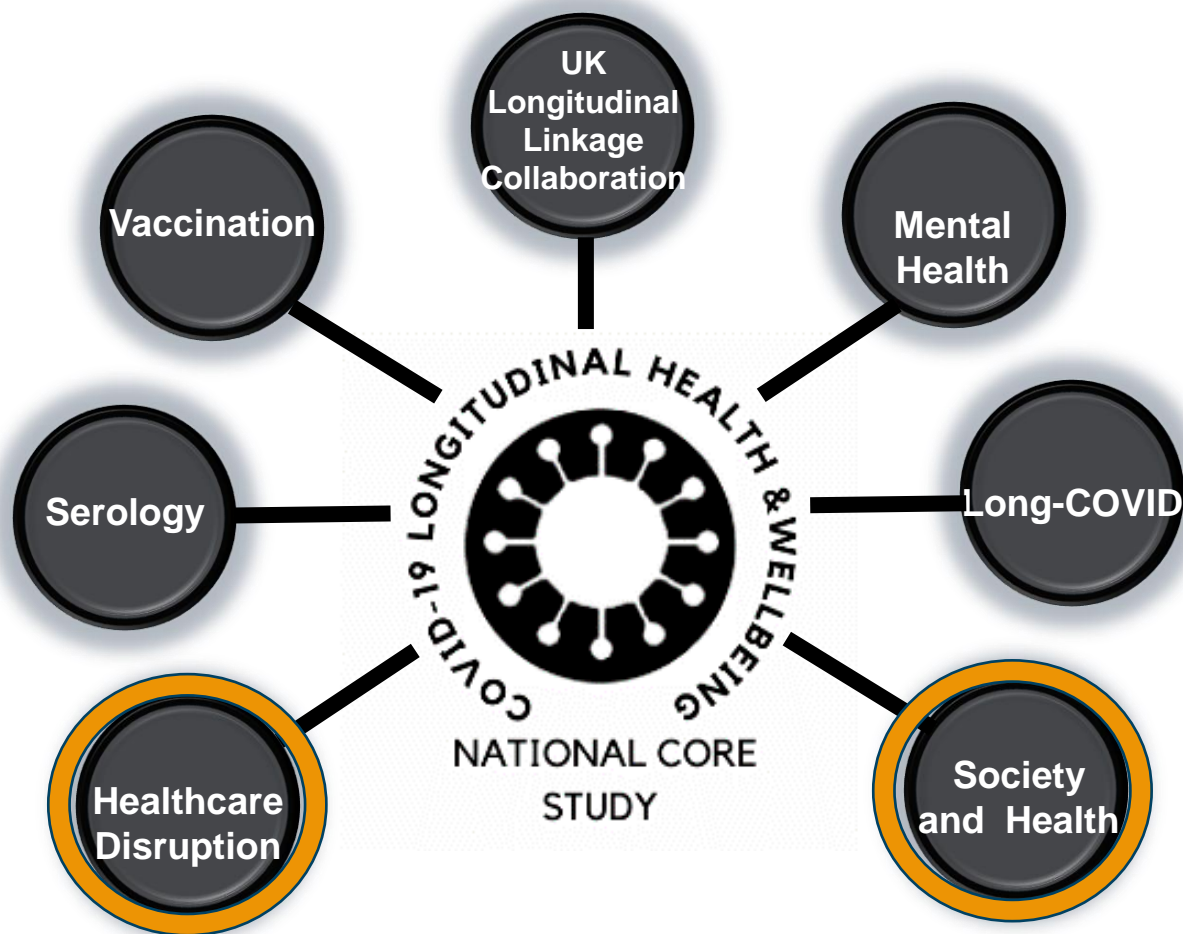
NUFFIELD DEPARTMENT OF
PRIMARY CARE
HEALTH SCIENCES
Medical Sciences Division



NICE National Institute for
Health and Care Excellence



Research Areas



The NIHR-UKRI funded **CONVALESCENCE** study to help define long-COVID, its determinants, and health, social and economic consequences to improve diagnosis, management, and support.

COVID-19 National Core Study

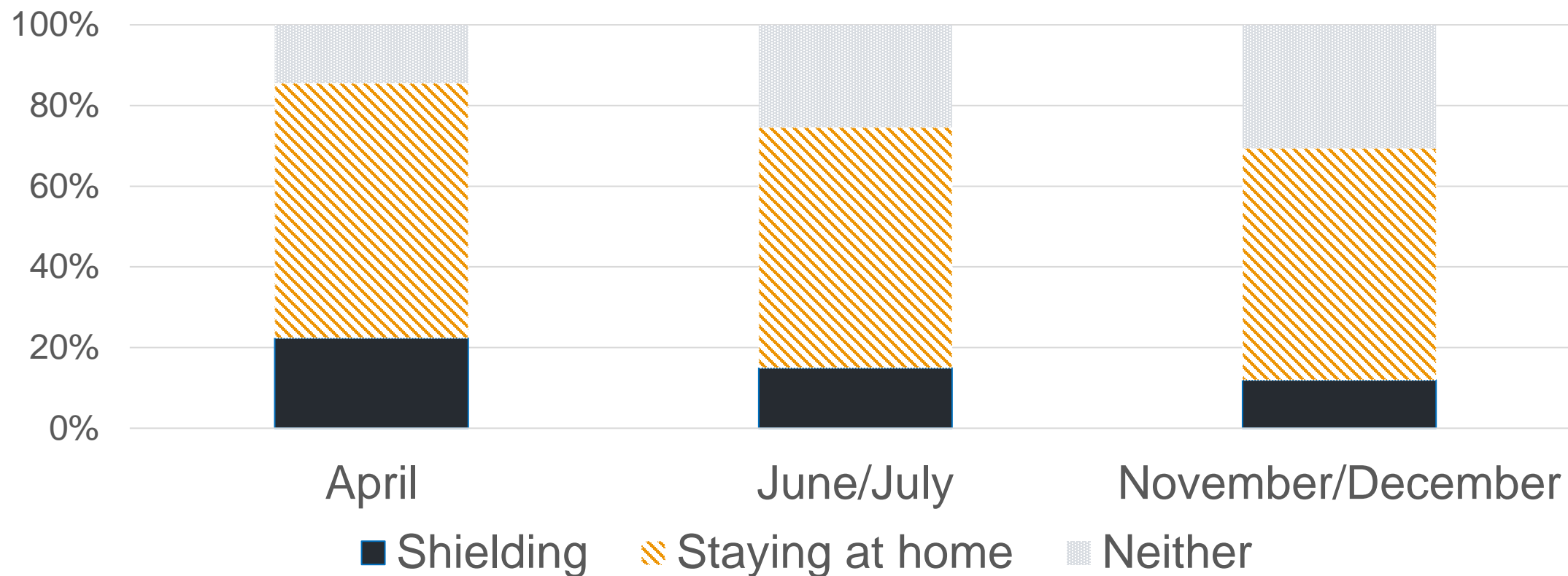


Coronavirus post-acute long-term effects: constructing an evidence base

Outline

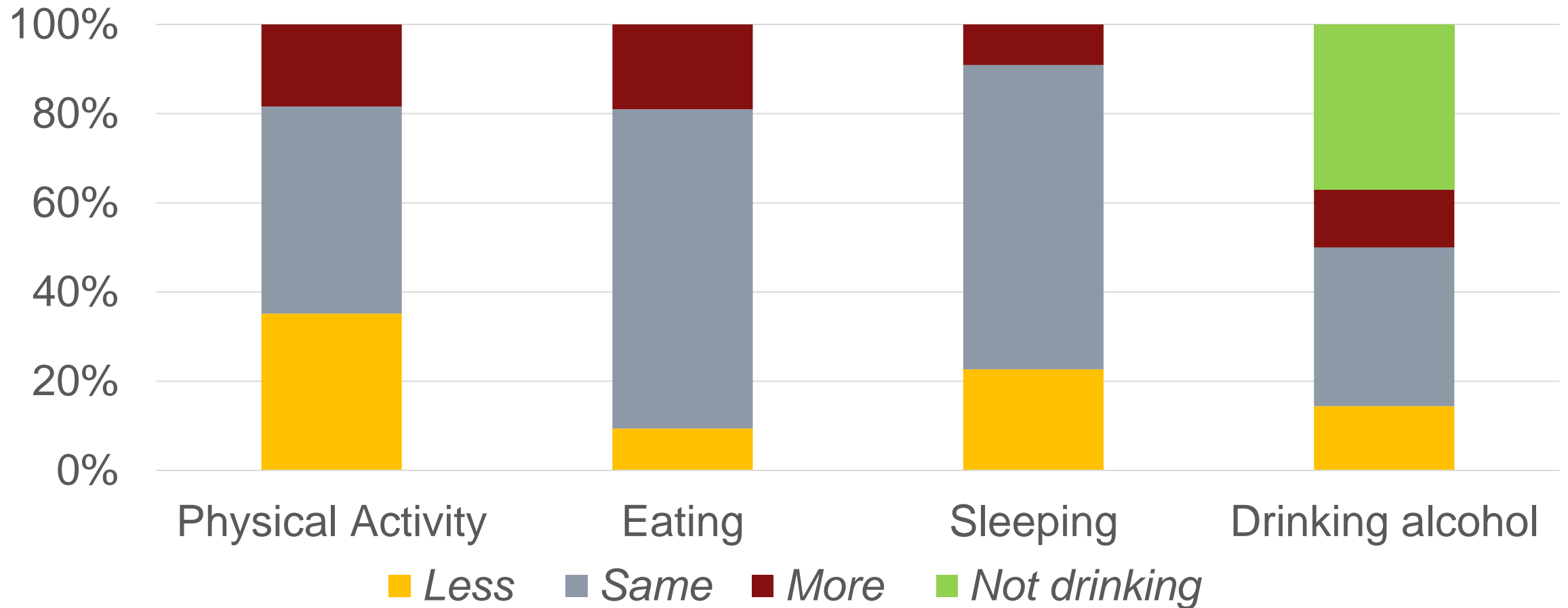
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 - ELSA COVID-19 substudy
 - National core study (NCS)
- Key findings

Shielding in 2020



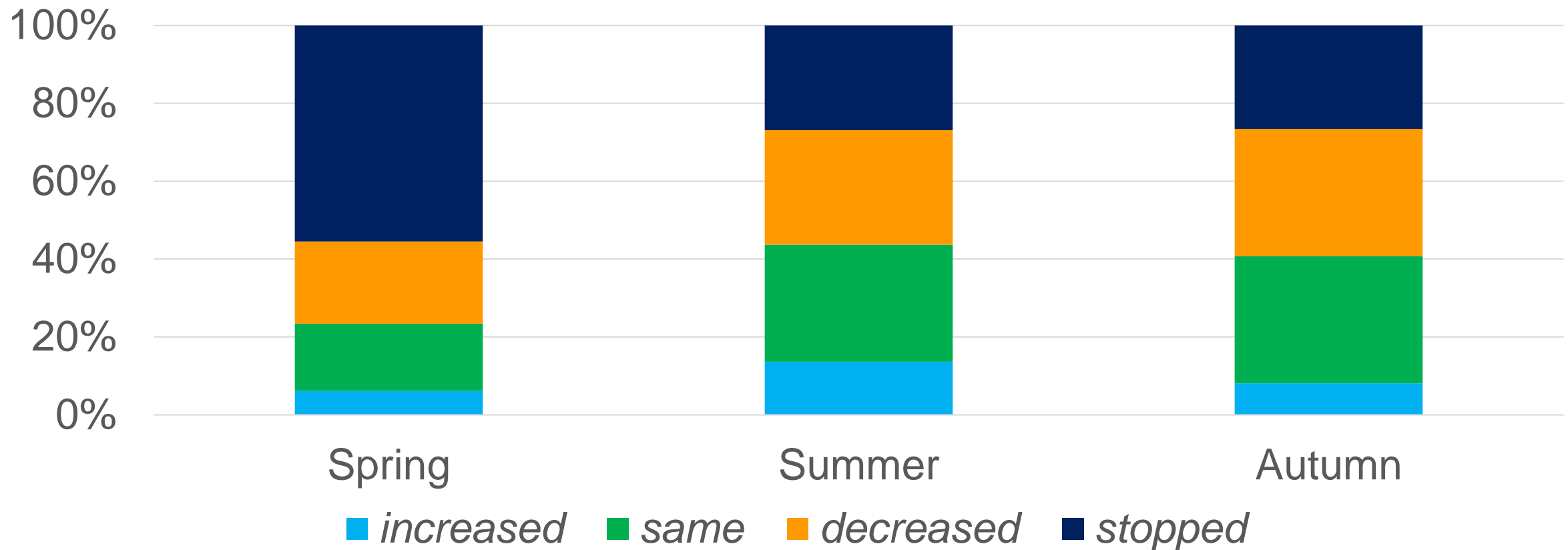
About 28% of respondents reported that they shielded at least once, with 5% shielding throughout

Changes in health behaviours - June/July 2020

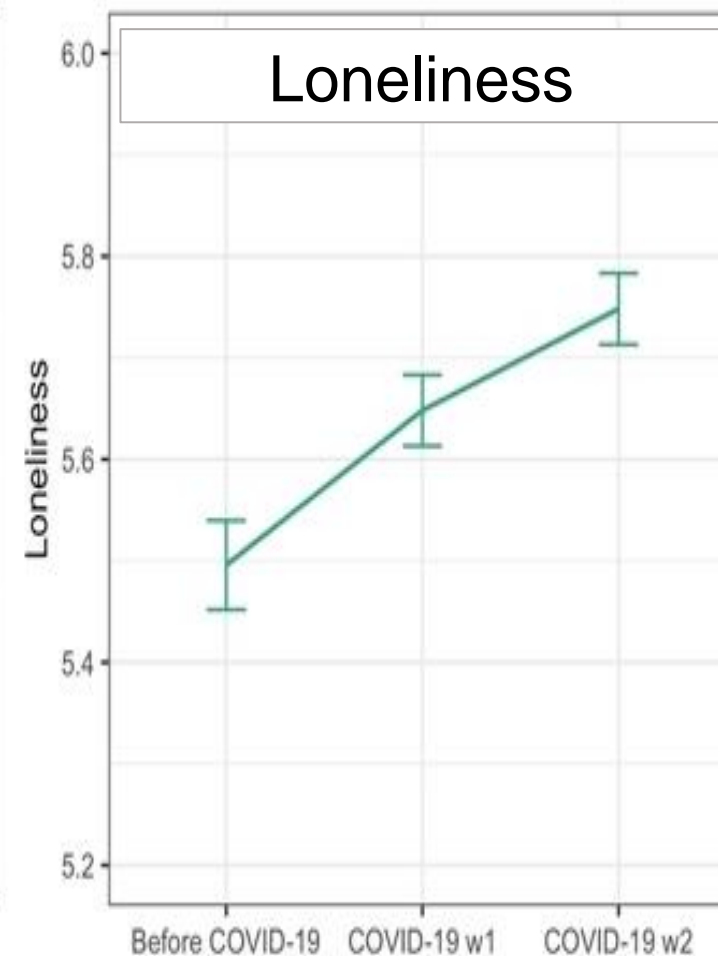
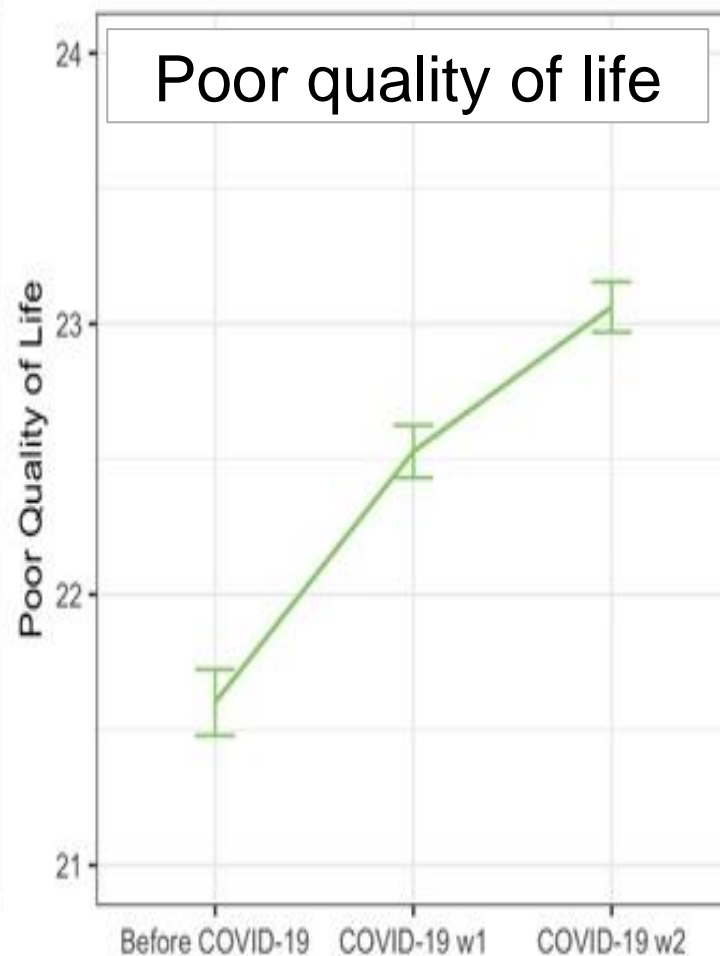
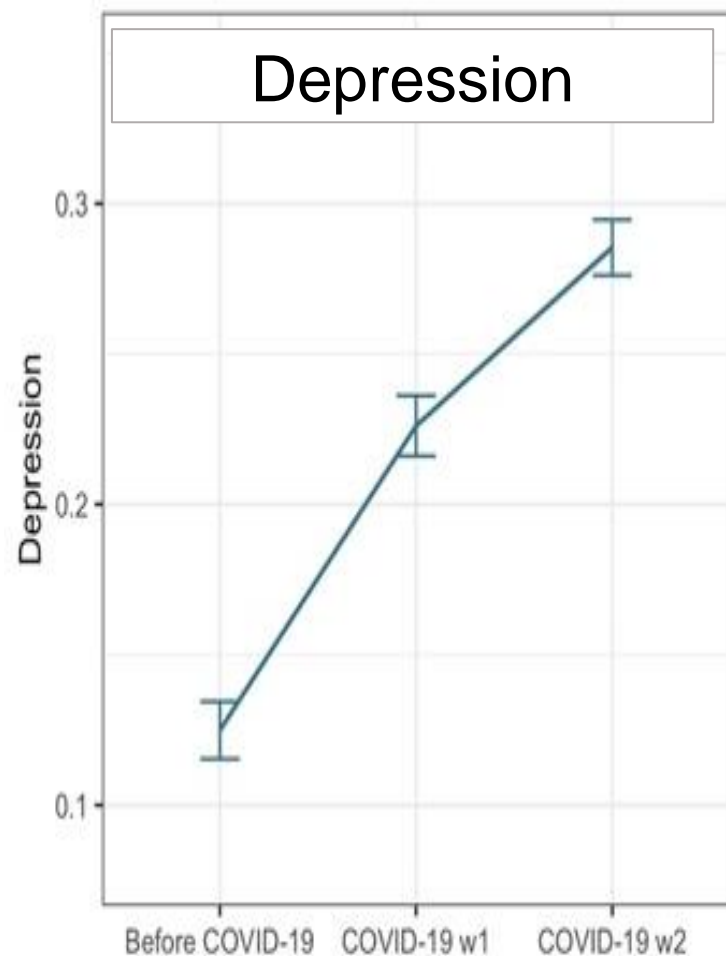


Changes in grandchild care provision in 2020

In Feb 2020, ~50% of grandparents provided grandchild care



Trends in mental health and wellbeing



Differential impact

Poorer mental health and well-being

- Particularly among those with disabilities; multimorbidities; shielding; who experienced changes in health behaviours, provision of informal care, and paid work
- Differences by socioeconomic groups, gender, and living arrangements (women, non-partnered, and low socioeconomic groups experienced greatest deterioration over time)

NCS Overall strategy

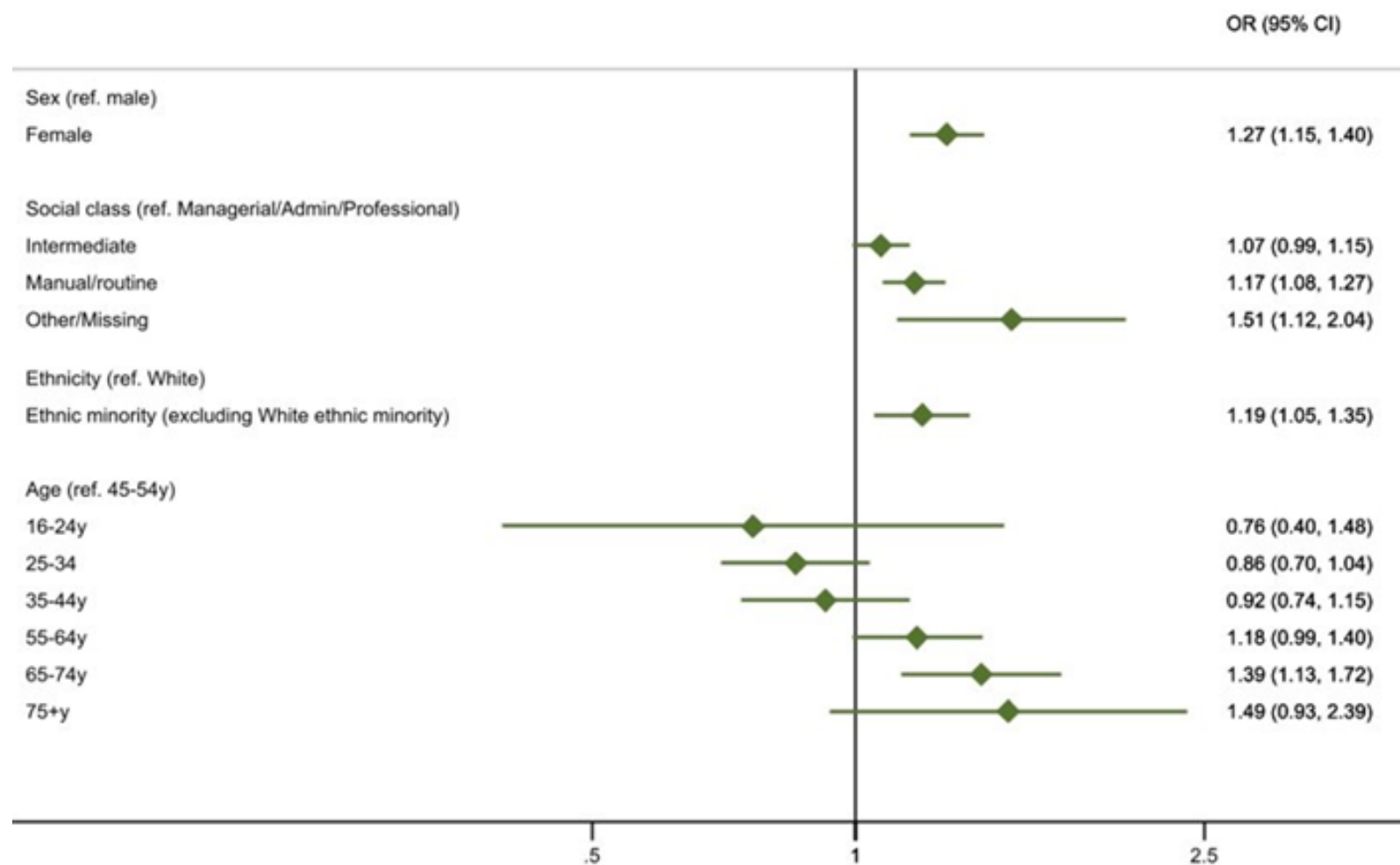
Data: Up to 12 of the UK's pop-based longitudinal studies (n= 68,912)

Method: Statistical analyses within studies then combined with RE meta-analysis. Stratified by age groups and gender

Over 20 publications (and counting)...

1. *Inequalities in healthcare disruptions*
2. *Coronavirus Job Retention Scheme and mental & social wellbeing*

Inequalities in healthcare disruptions



Times more likely to experience

PSYCHOLOGICAL DISTRESS



Stable employed



Furloughed



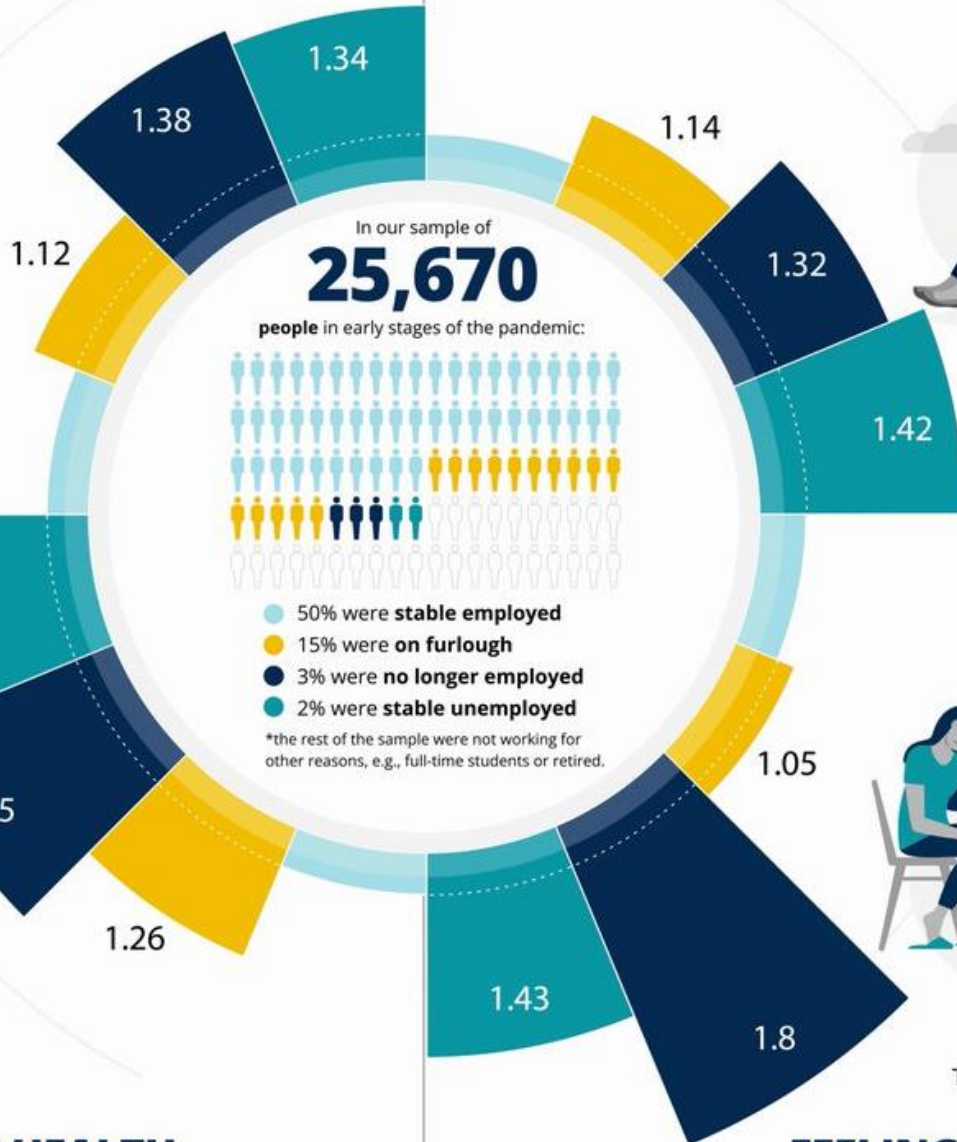
No longer employed



Stable unemployed

Times more likely to experience

LOW LIFE SATISFACTION



Furlough and mental and social wellbeing

Furlough was associated with better mental health outcomes compared to becoming unemployed

➤ *Not as good as employment*

Times more likely to experience

POOR OR FAIR HEALTH



Times more likely to experience

FEELING LONELY

Wels J, et al. Mental and social wellbeing and the UK coronavirus job retention scheme: Evidence from nine longitudinal studies. Soc Sci Med. 2022 DOI: 10.1016/j.socscimed.2022

Thank you for your attention



@COVID19_LHW
@ELSA_Study
@di_gessa





COVID Tracking in the Understanding America Study

Arie Kapteyn

We gratefully acknowledge financial support from the Bill & Melinda Gates Foundation, the National Science Foundation, and the National Institute on Aging (3U01AG054580-04S3)

Understanding America Study

- Since 2014, longitudinal, national probability-based internet panel of currently about 12,500 US residents (growing to 20,000+), collecting information at multiple time points each year on economic, labor, attitudinal, and health measures, etc.
- Tracking pandemic effects started March 10, 2020

Every day ~450 respondents answered our questions



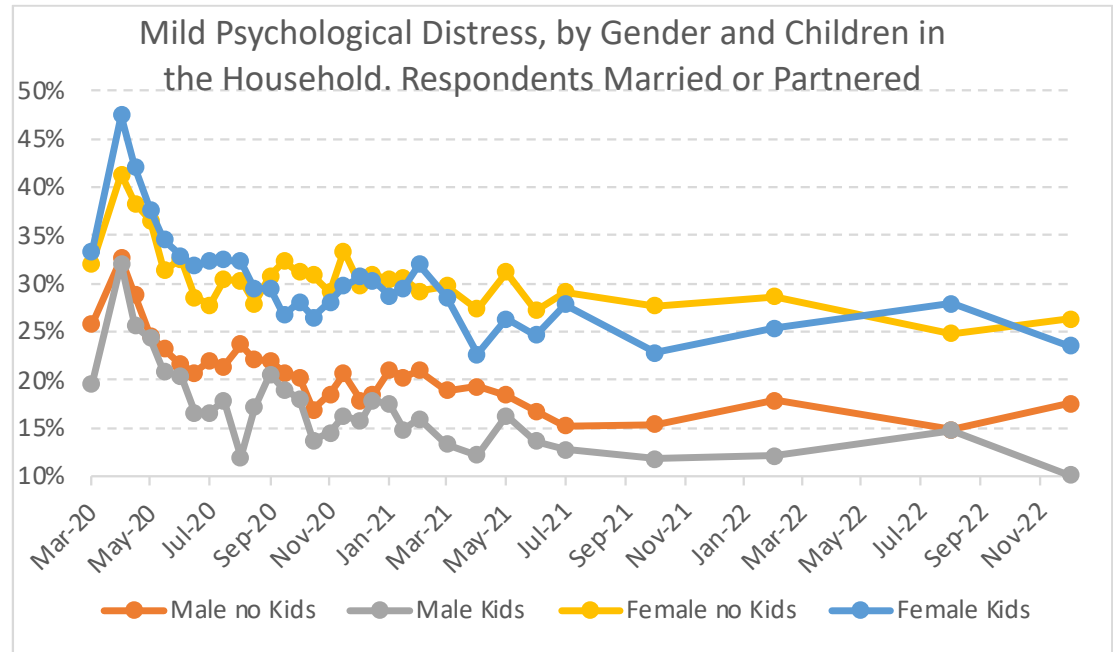
6,000-6,500 over two
weeks (Frequency
halved since
February 2021
summer 2021)

Every day ~450 respondents answered our questions



6,000-6,500 over two weeks (Frequency halved since February 2021 summer 2021)

Almost three thousand new graphs every day
<https://covid19pulse.usc.edu/>

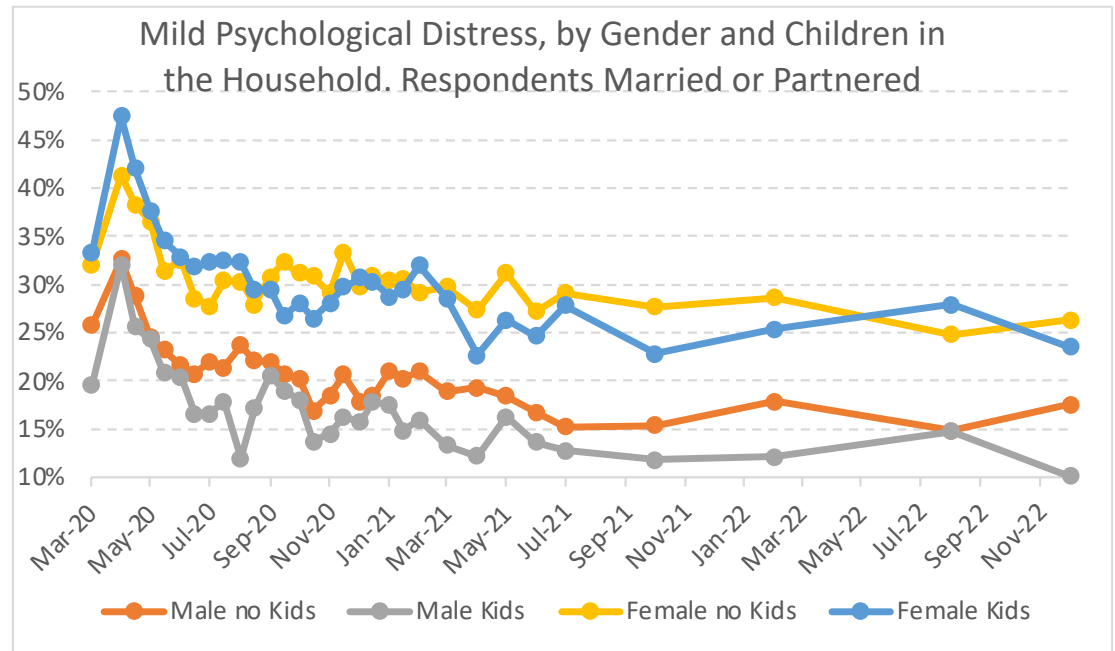


Every day ~450 respondents answered our questions



6,000-6,500 over two weeks (Frequency halved since February 2021 summer 2021)

Almost three thousand new graphs every day
<https://covid19pulse.usc.edu/>



High frequency tracking ended at the end of June 2021; since then one survey every four months (so far until November/December 2022)

Data Widely Available in Real Time

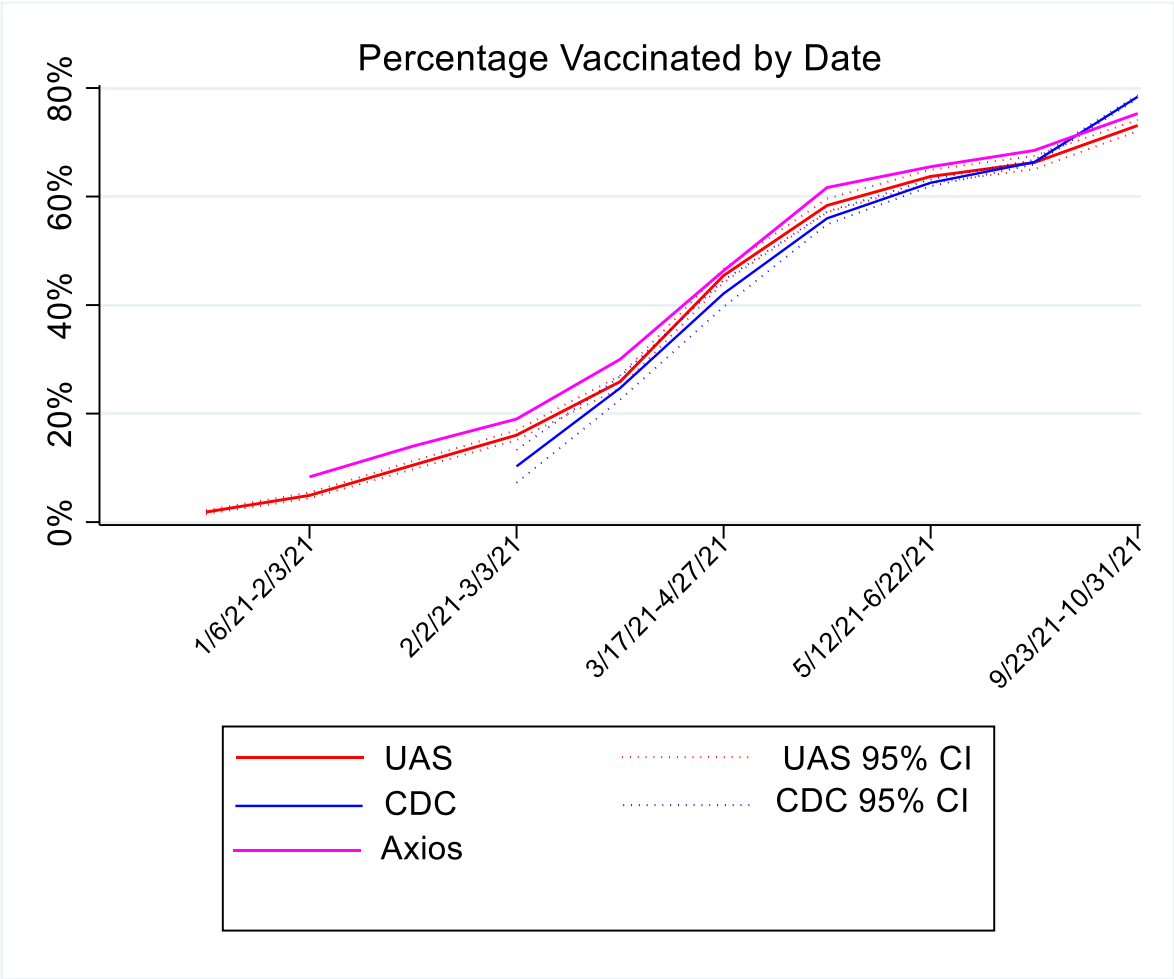


- Full wave data files released for public use every two weeks, including a harmonized longitudinal file and codebooks:
<https://uasdata.usc.edu/page/Covid-19+Home>
 - Thirty-three waves of national data and fifty-seven waves of LA County data available.
 - 208,858 completed surveys from 10,716 different respondents
 - Well over 500 research groups worldwide, comprising some 1,000 researchers are using UAS COVID19-related data
 - About 150 peer reviewed publications that we know of, so far.
 - We have added contextual data that can be downloaded with the longitudinal data



Accuracy of Population Estimates

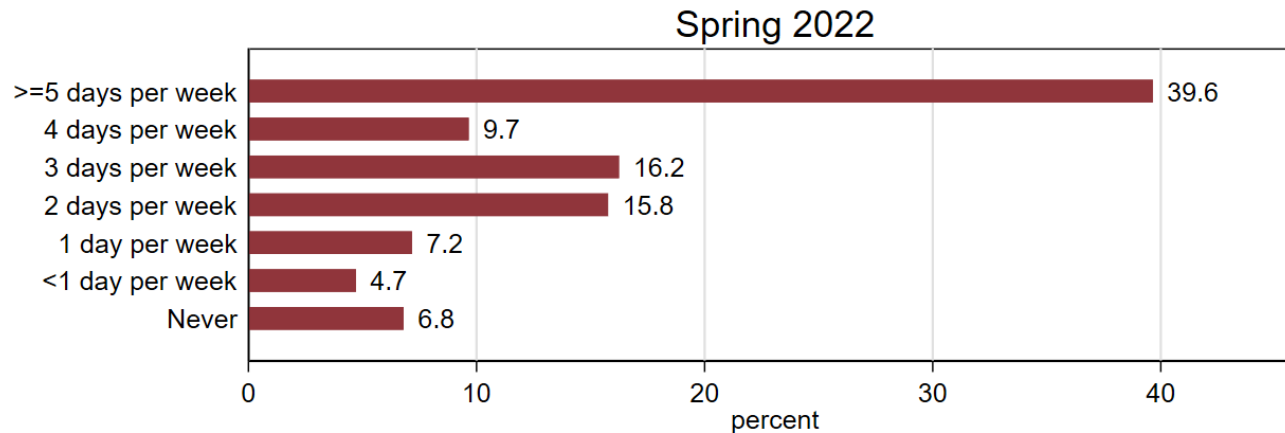
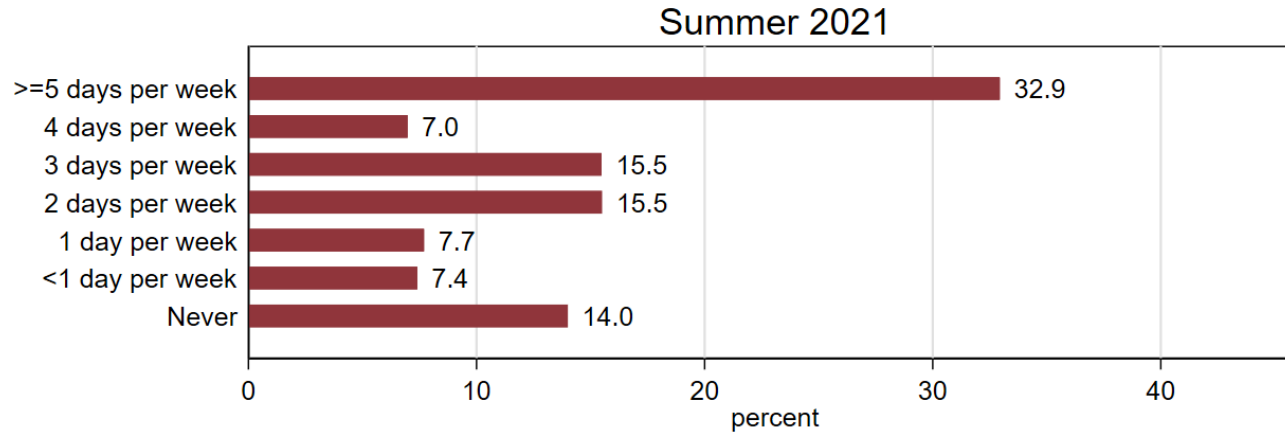
Comparing CDC, Knowledge Panel (Axios/Ipsos) and UAS



Preferences for Working from Home



(among those with jobs where that is technically possible)



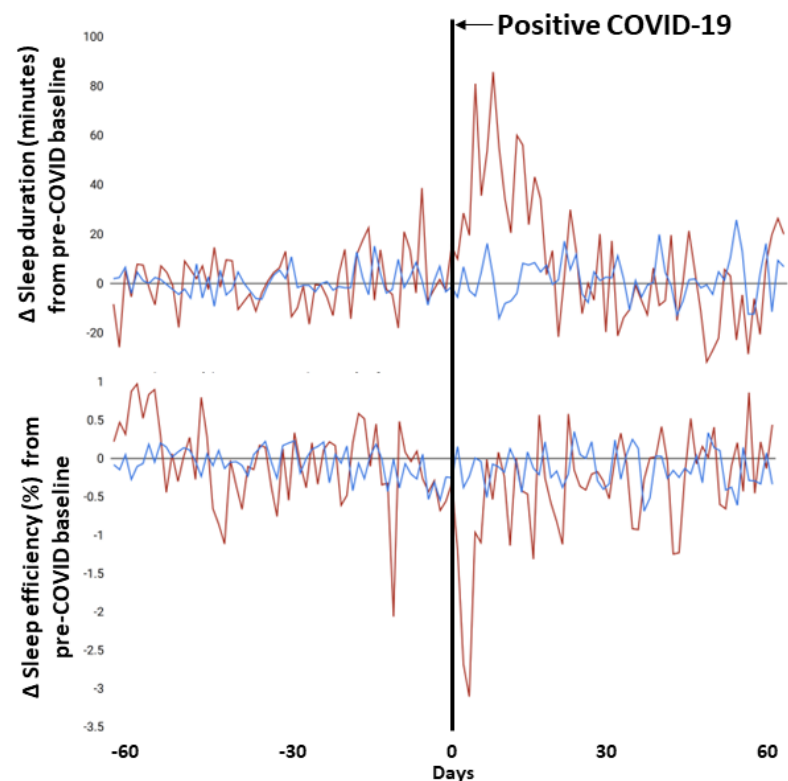
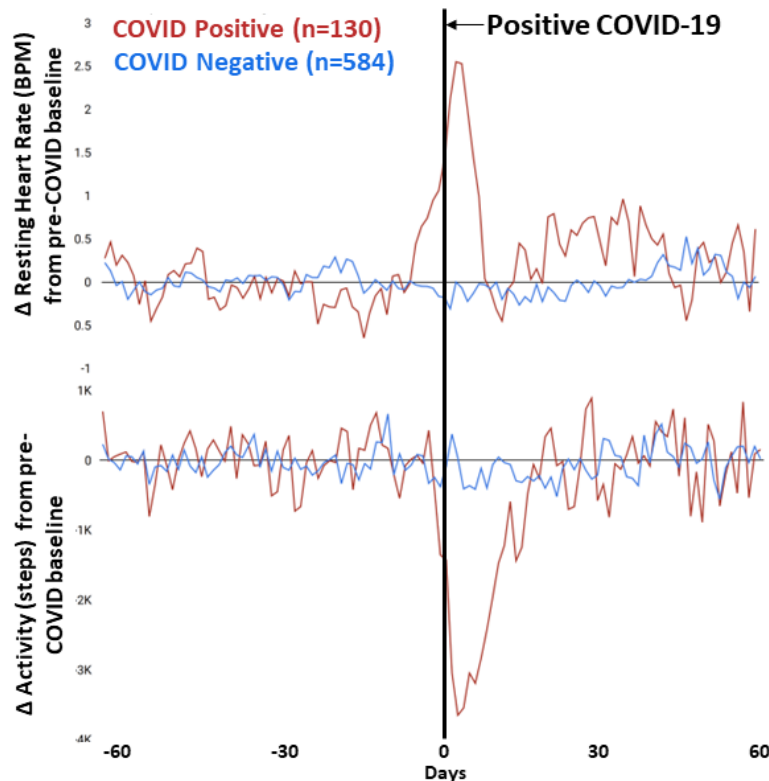
Accuracy of Self-Reported Infections



USC Schaeffer



Changes in biometrics from individual-specific baselines during COVID infection

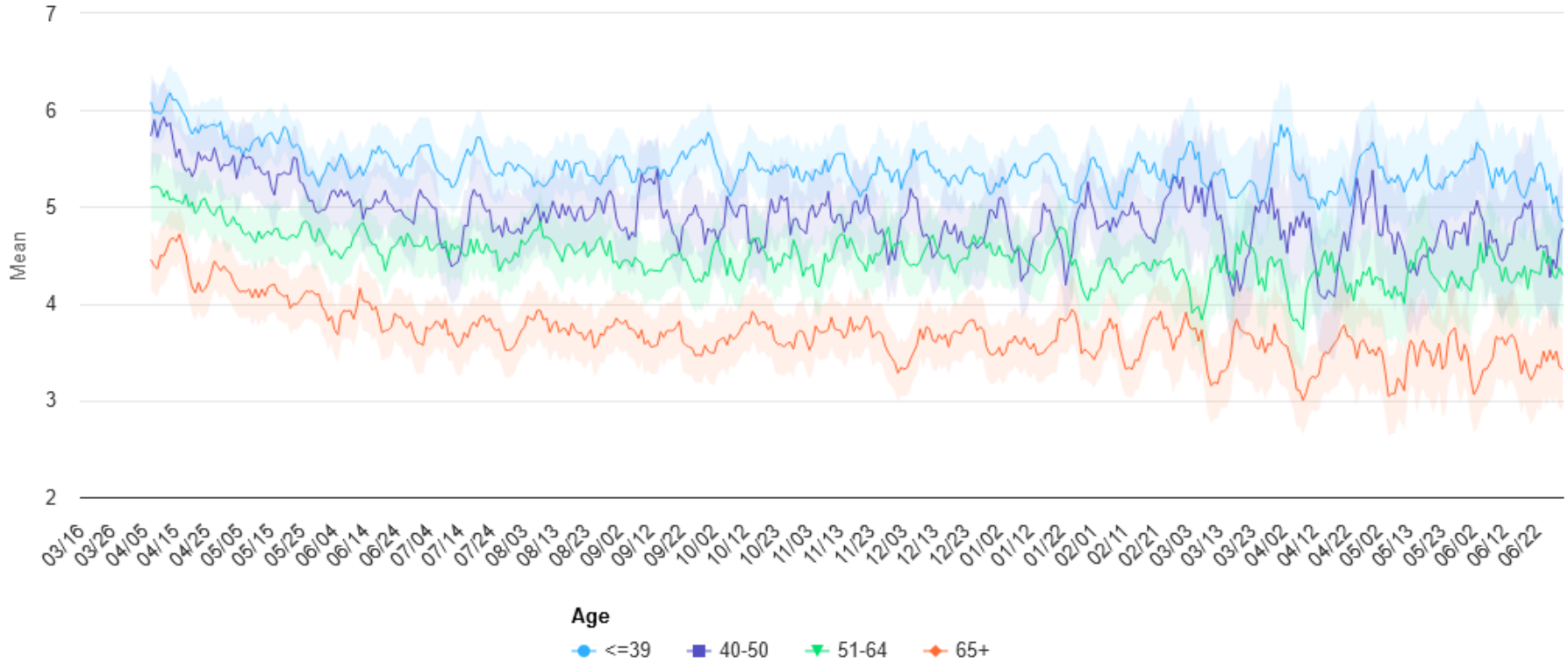


Stress and Age



Average perceived stress

National sample; 7-day window

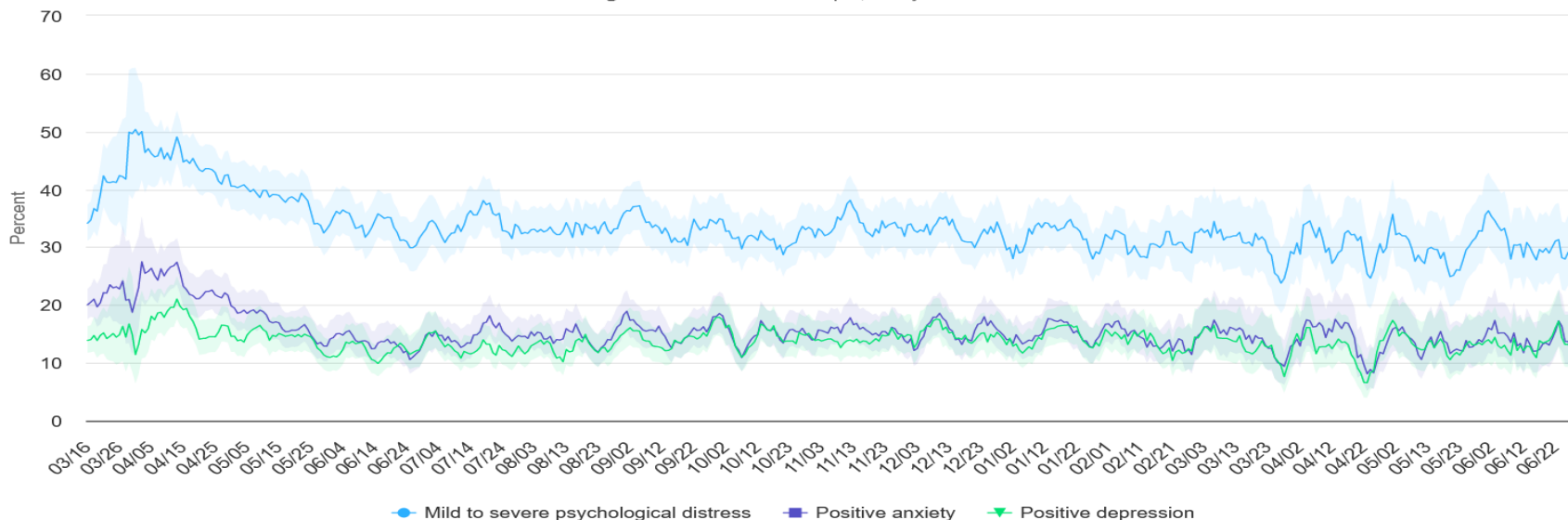


Depression and Anxiety by Age



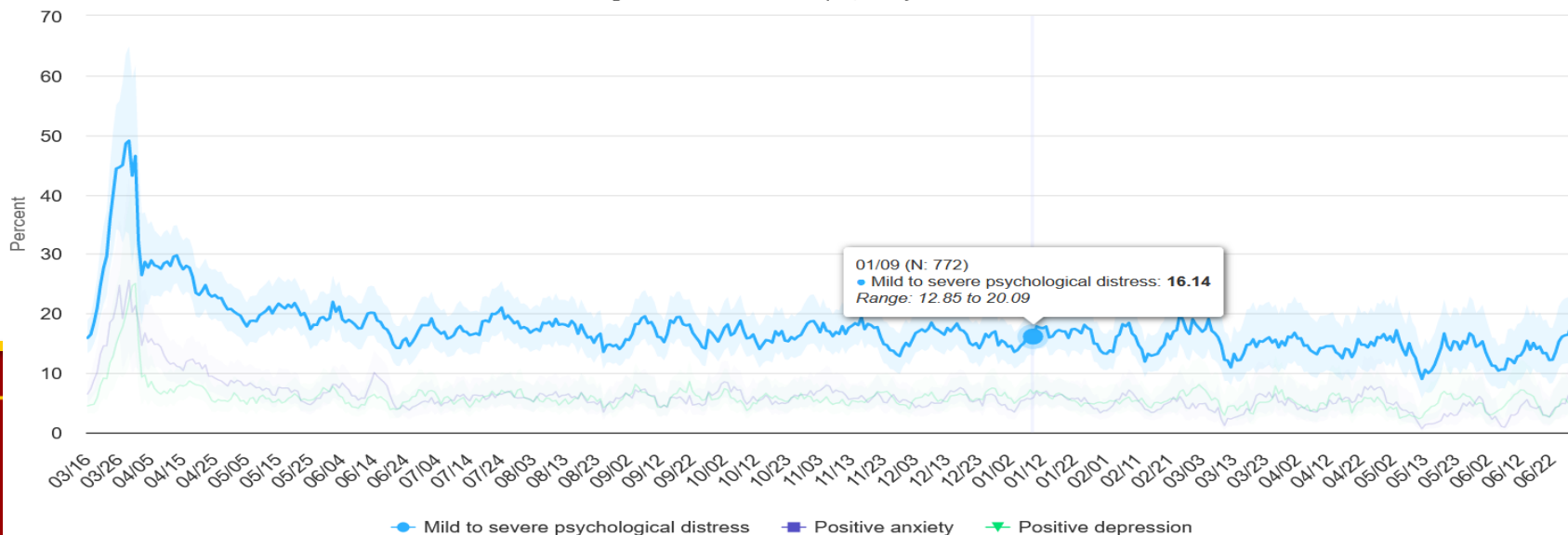
Depression and anxiety (PHQ-4)

Age = <=39 - National sample; 7-day window

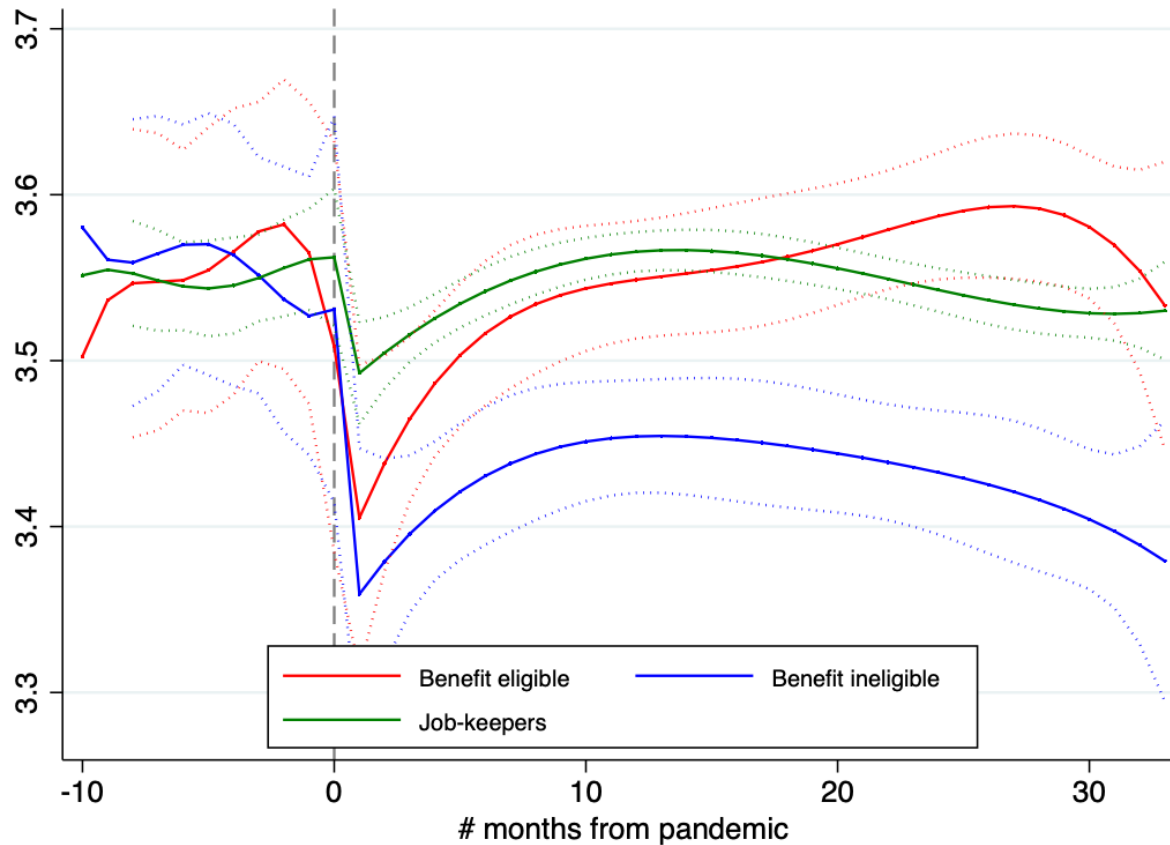


Depression and anxiety (PHQ-4)

Age = 65+ - National sample; 7-day window



Extended Benefits for Job Losers made all the difference (50+, 4th Degree Polynomials)



Miscellaneous Results



- Trump voters less likely
 - to get vaccinated
 - to exhibit protective behavior
- Trump voters estimate lower risks of infection and death
- Striking correspondence between self-reported long covid and associated symptoms



Thank you!

The contribution of ELISA to the study of cognitive ageing

Andrew Steptoe

Early findings on cognition

- Cognitive function relates to investments and understanding of pensions (Banks & Oldfield, 2007)
- Association between cognitive function and alcohol consumption (Lang et al, 2007)
- Cognitive function and psychological wellbeing (Llewellyn et al, 2008)

Emerging focus on Alzheimer's disease and related dementias

2011 Substantial increase in US Federal funding for AD/ADRD research

2012 UK Government launched dementia challenge

2014 Establishment of Dementias Platform UK

2015 Establishment of UK Dementia Research Institute

ELSA cognitive measures

	Wave 1 2002/03	Wave 2 2004/05	Wave 3 2006/07	Wave 4 2008/09	Wave 5 2010/11	Wave 6 2012/13	Wave 7 2014/15	Wave 8 2016/17	Wave 9 2018/19	Wave 10 2021/23
Self-rated memory	✓	✓	✓	✓			✓	✓	✓	✓
Orientation in time	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Immediate and delayed recall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prospective memory	✓	✓	✓	✓	✓			✓		
Word-finding (verbal fluency)	✓	✓	✓	✓	✓		✓	✓	✓	✓
Fluid intelligence (number series)						✓		✓	✓	
Letter cancellation	✓	✓	✓	✓	✓					
Numerical ability	✓			✓		(✓)	(✓)	✓		✓
Literacy		✓			✓	(✓)	(✓)	✓		✓
Backwards counting							✓	✓	✓	✓
Serial 7s							✓	✓	✓	✓
Object naming							✓	✓	✓	✓

Harmonized Cognitive Assessment Protocol (HCAP)

- Comprehensive battery of 20 tests assessing a broad range of cognitive functions
- Administered to 1,273 participants aged 65+ (75.6% RR) in 2018
- Informant interviews for 82.5%
- Protocol identical to HRS
- Algorithmic estimates of dementia and mild cognitive impairment (Manly et al, 2022)
- Data available from UK data service (SN 8502)

ELSA and dementia research

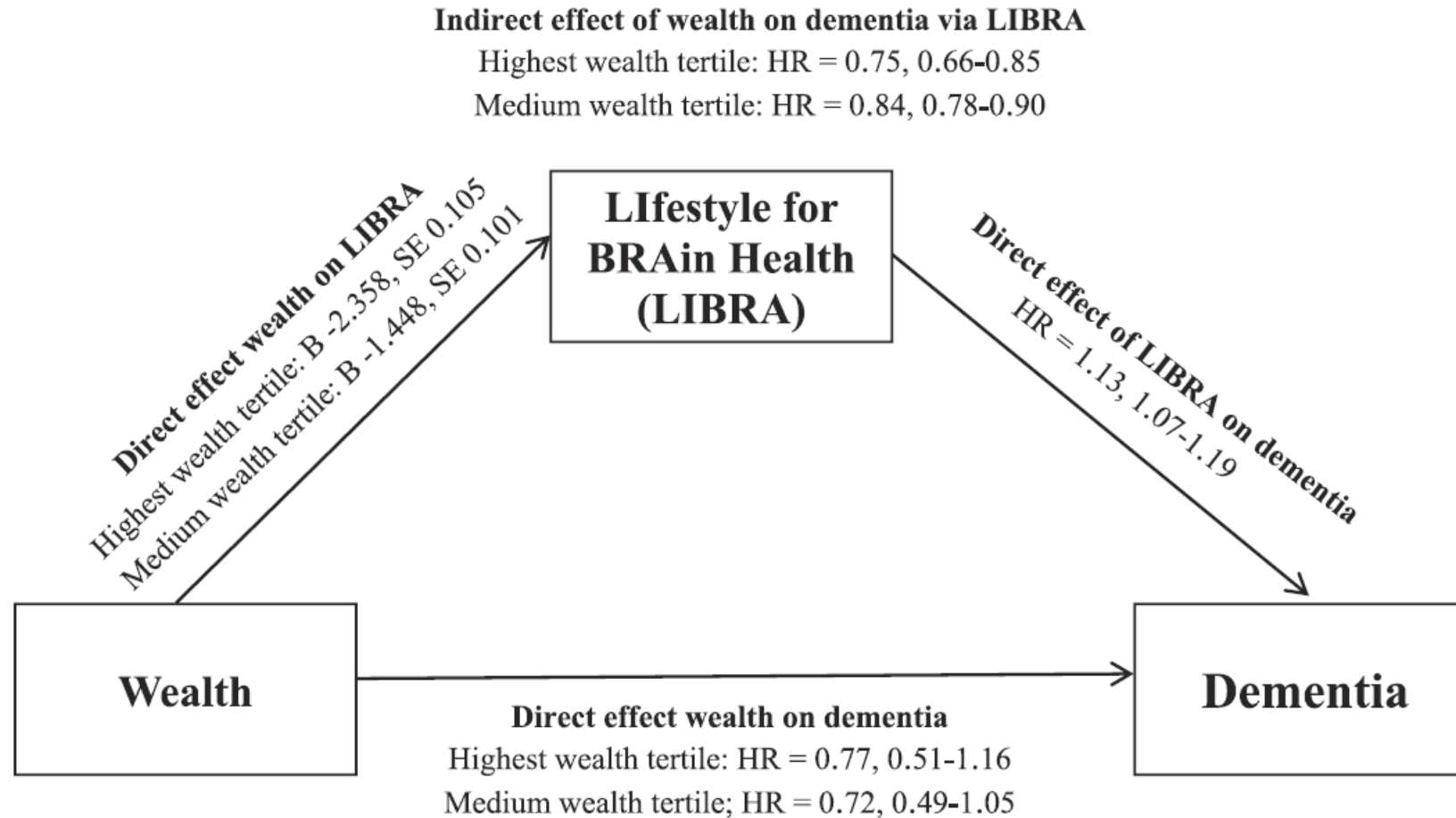
- Density of repeat measures of cognition
- Continued participation after dementia diagnosis
- Multidisciplinary perspective

Socioeconomic gradients and dementia risk

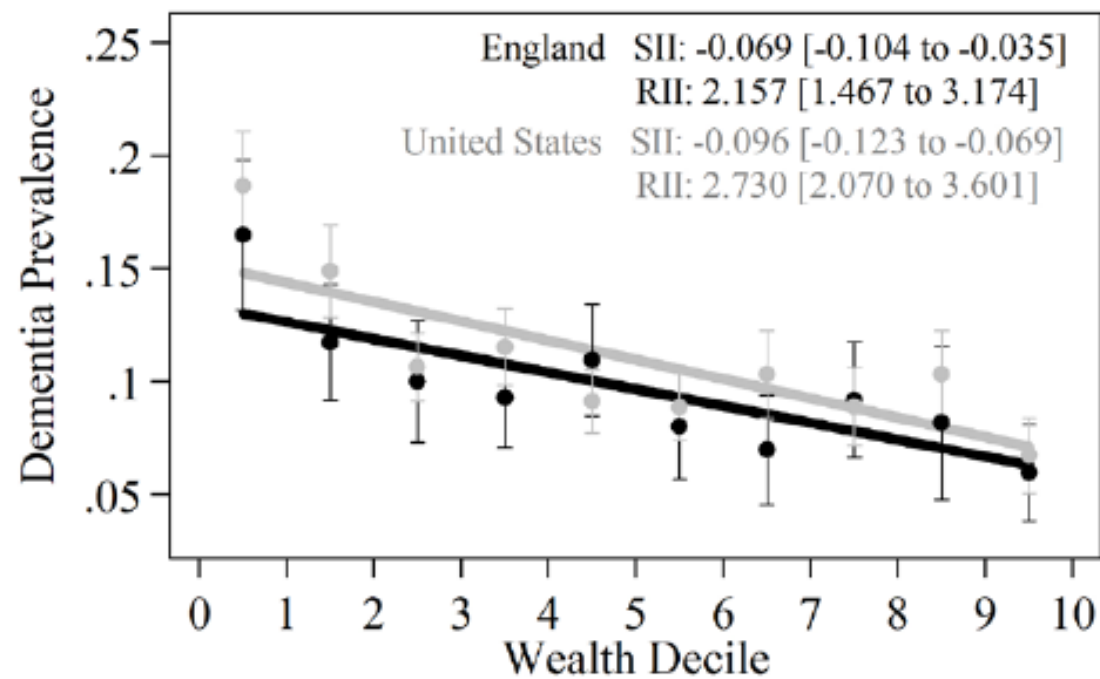
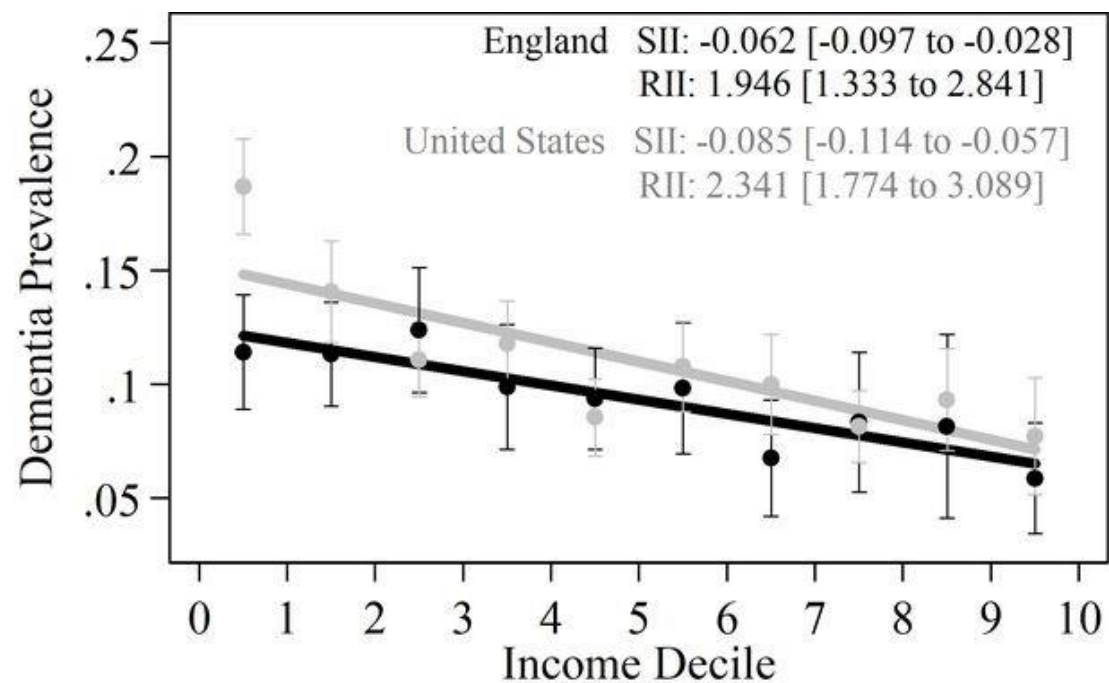
Individual and area-based measures of deprivation

- 12-year follow-up of 6,220 men and women aged 65+
- Relationship between dementia incidence and education, wealth, and index of multiple deprivation
- Financial resources more consistently related to dementia incidence than education, after adjustment for demographics and health indicators
- Area deprivation not robustly associated with dementia risk

Mediation of wealth gradient by lifestyle factors



SES gradients in England and USA



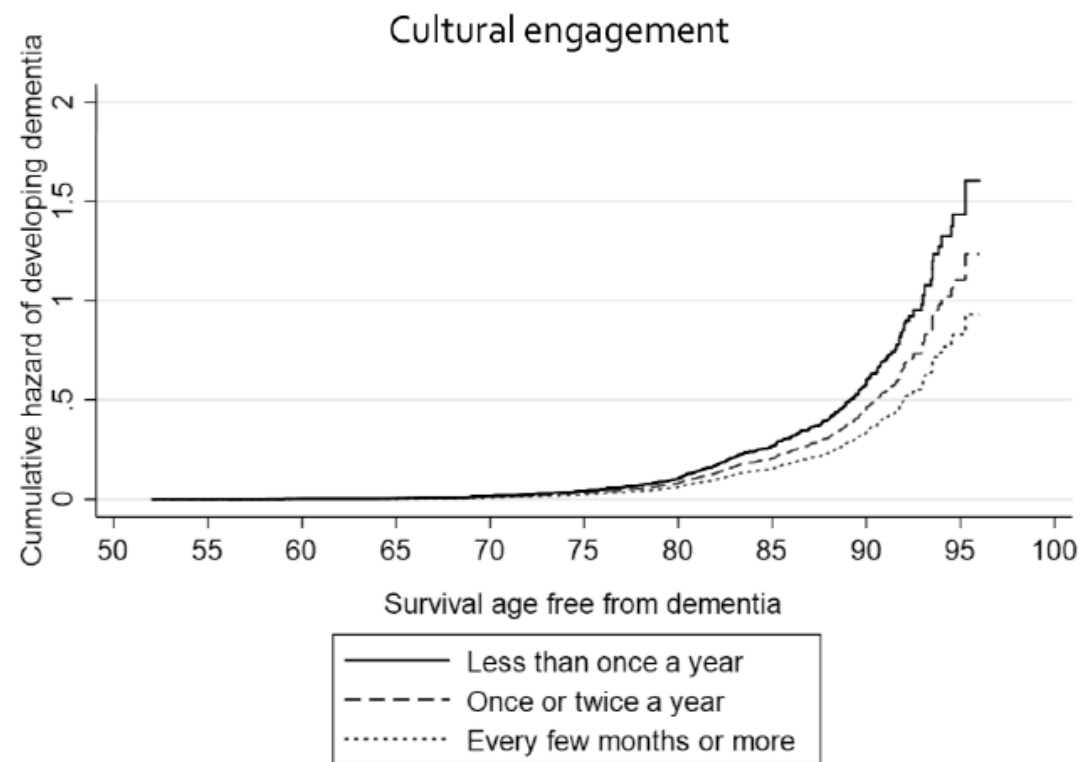
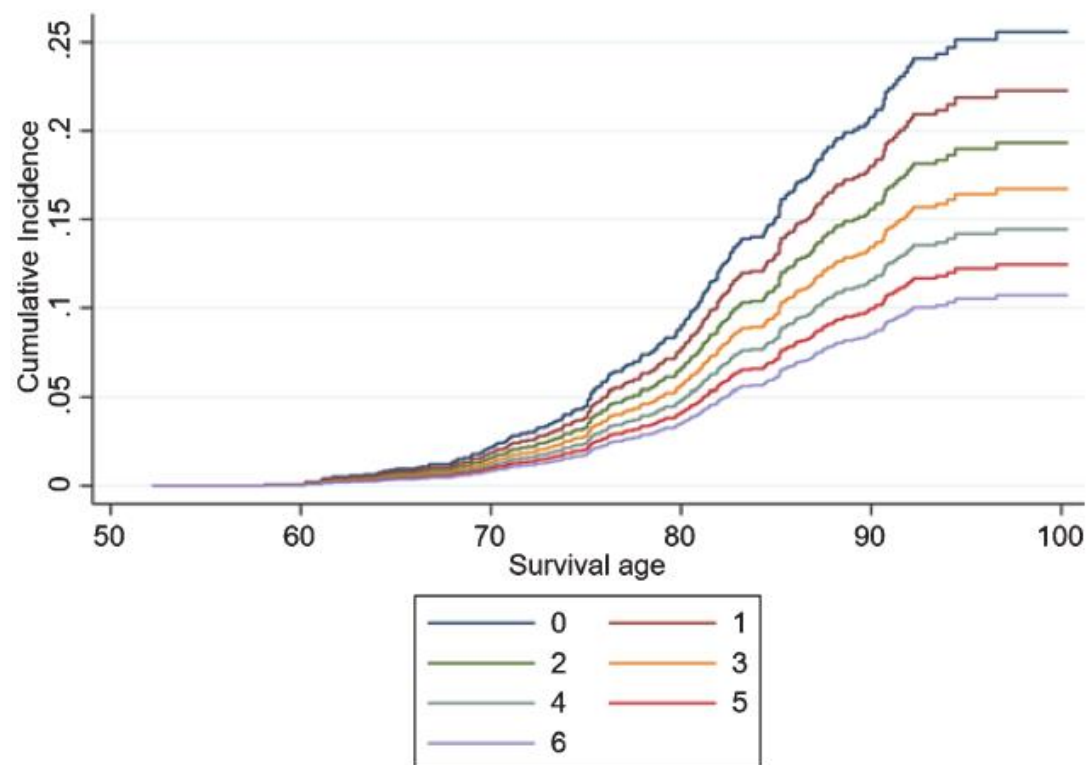
Health and health behaviours in dementia risk

- Cardiometabolic risk (Ji et al, 2022; Li et al, 2022; Kontari et al, 2023)
- Multimorbidity (Bendayan et al, 2021)
- Frailty (Rogers et al, 2017)
- Walking speed (Hackett et al, 2018)
- Sensory impairments (Maharani et al, 2018; Davies et al, 2017)
- Body weight (Ma et al, 2020)
- Physical inactivity (Feter et al, 2021; Li et al, 2022)
- Lung function (Qiao et al, 2020)
- Diet (Francis et al, 2022)
- Self-rated health (Stephan et al, 2021)

Cognitive stimulation and dementia risk

- Cognitive reserve (Almeida-Meza et al, 2021 a, b)
- Cognitively stimulating activities (Williams et al, 2020)
- Community group engagement (Fancourt et al, 2018)
- Cultural engagement (Fancourt et al, 2020)

Cognitive stimulation and cultural activity

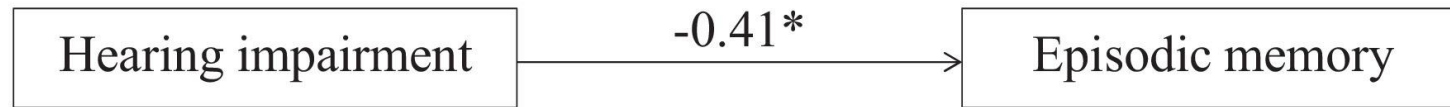


Social isolation and loneliness

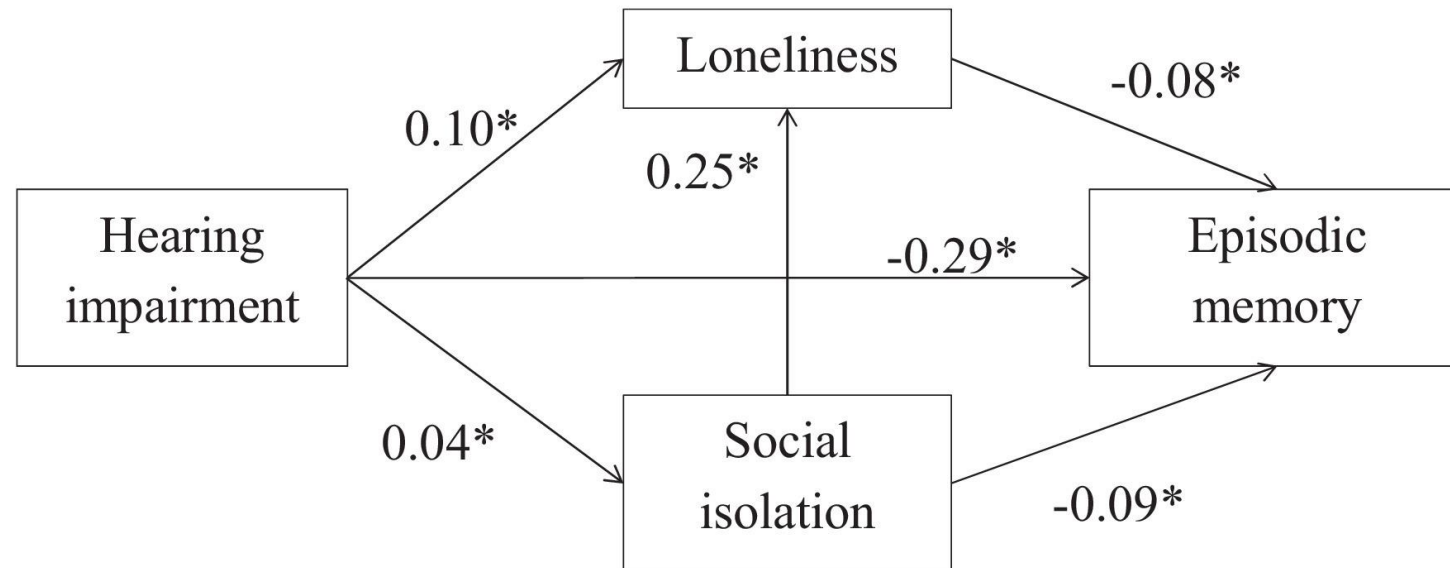
- Loneliness as a determinant of dementia (Rafnsson et al, 2020)
- Loneliness trajectories and dementia (Li et al, 2022)
- Negative social interactions with children, other family, and friends and dementia (Khondoker et al, 2017)
- Social isolation, memory decline, and dementia (Duffner et al, 2022; Read et al, 2020)
- Gender-specific associations for family relationships (Scholes & Liao, 2023)
- Loneliness and isolation partly mediate links between hearing impairment and memory decline (Maharani et al, 2019)

Hearing impairment, loneliness, isolation and memory

A



B



Other ELSA studies of dementia and cognitive decline

- Modelling research (Ahmadi-Abhari et al, 2017; Bandosz et al, 2020; Collins et al, 2022)
- Care and care needs (Read et al, 2021, 2022)
- Genetic and gene-environment interaction (Ajnakina, 2022; Kepinska et al, 2020)
- Adverse childhood experience (Lowry et al, 2022; O'Shea et al, 2021)
- Depression (Zhu et al, 2022; Jindra et al, 2022)
- Biomarkers (Santoso et al, 2022; Liu et al, 2022; Elpers et al, 2020; Jackowska et al, 2020)
- Air pollution (Wood et al, 2022)
- Job insecurity (Yu et al, 2022)
- Free bus passes and cognitive function (Reinhard et al, 2019)

Enhancements of the AD/ADRD exposome

- Repeat of HCAP study
- Objective measures of physical activity and sleep
- Proteomic profiling in ~5,000 with nested dementia case-control study
- Extension of life history assessments
- Linkage with air pollution data

Policy implications

- Understanding trajectories of AD/ADRD incidence and prevalence
- Better understanding of the determinants of AD/ADRD and cognitive decline
- Investigation of risk over 20-30 years
- Bringing together multiple perspectives on cognitive decline
- Modelling of health and social care needs
- Identification of new avenues for prevention and treatment



Jonathan Cribb, IFS

11 May 2023

ELSA 20th
Anniversary
Conference

The Royal Society

@TheIFS

Changing patterns of work at older ages



Economic
and Social
Research Council

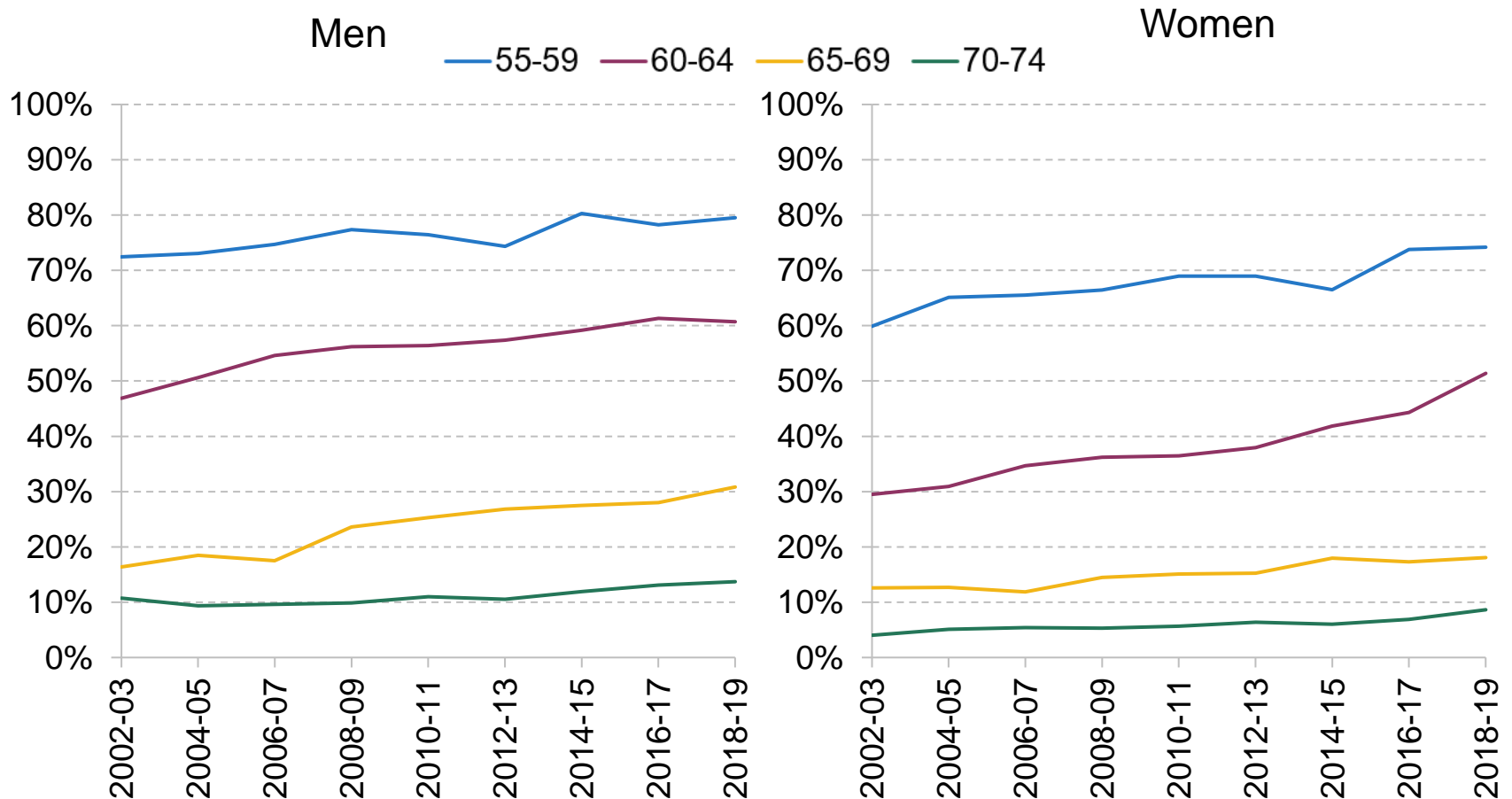
Examine three long-standing changing patterns of work at older ages

- Post-pandemic, some evidence of changes in those trends
1. Long run rises in employment at older ages
 2. Flat/lower rates of disability for those aged 55-74, rising employment for disabled; significant average additional health capacity to work
 3. More flexibility in work at older ages on a number of dimensions

ELSA will help researchers understand and explain these changes in the world of work

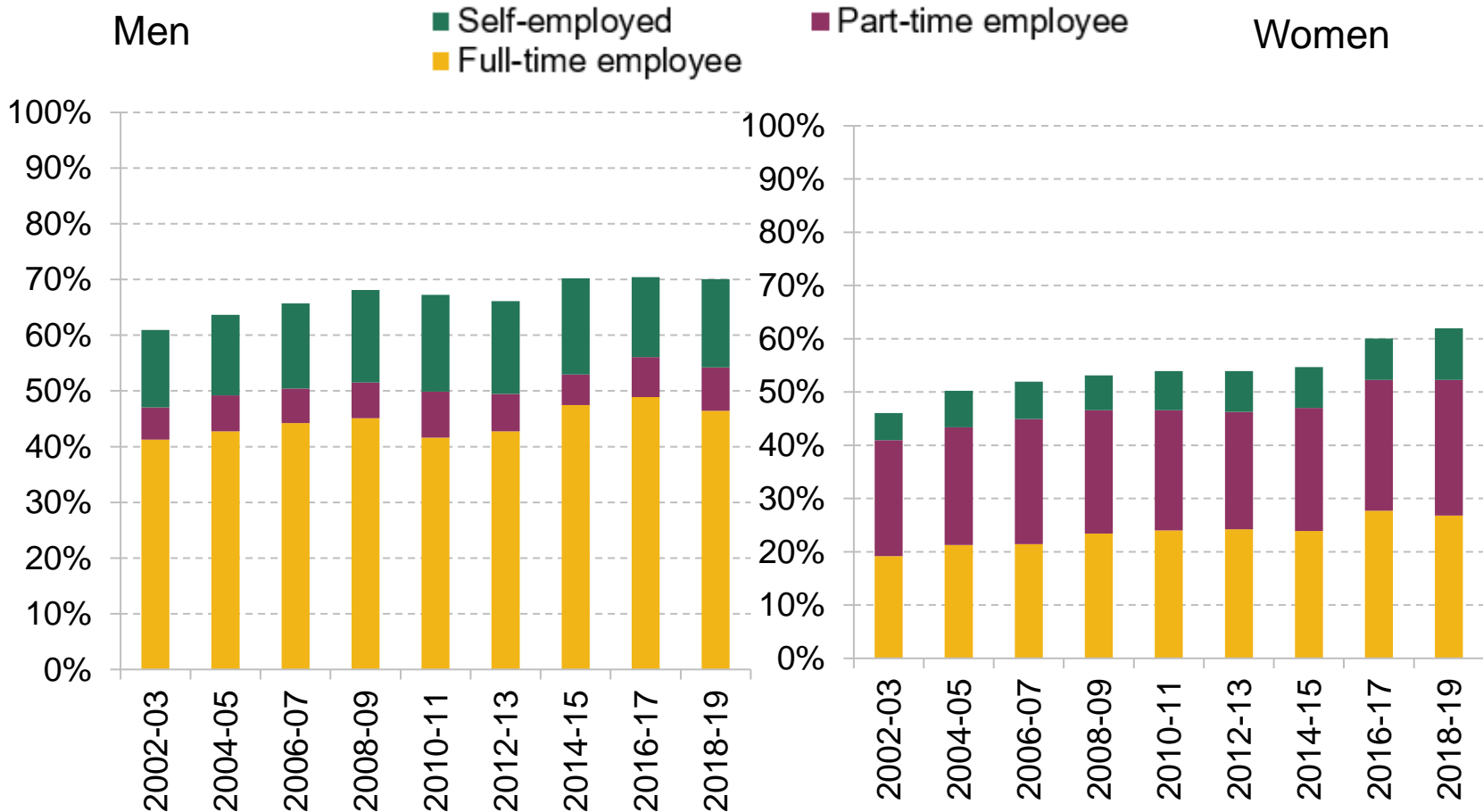
Rising employment rates since 2002; especially women 55-64

Employment rates of people aged 55 to 74, 2002 to 2019



Rises in full-time employment; big gender differences in hours

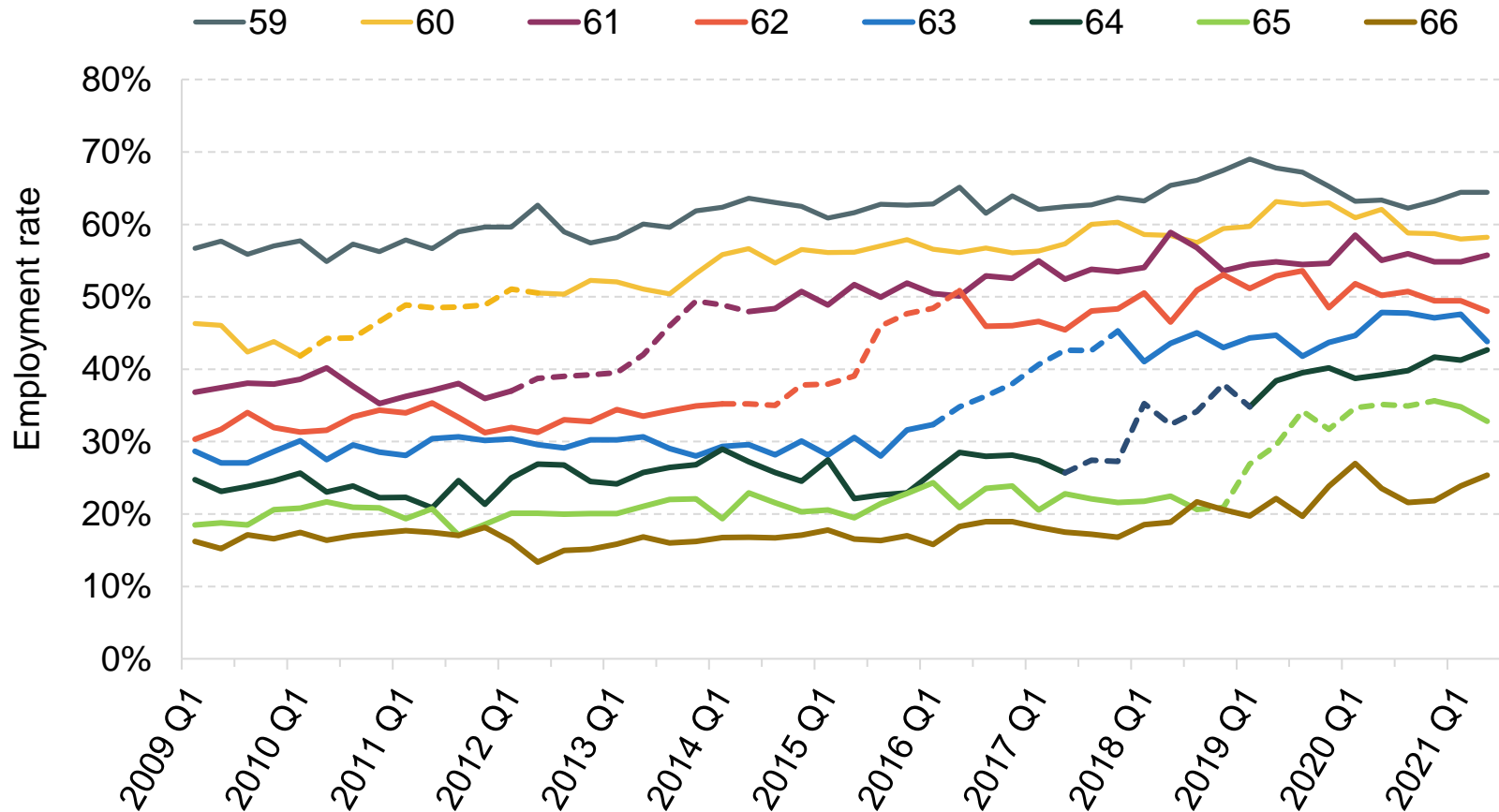
Full-time/ part-time/ self employment, people aged 55 to 64, 2002 to 2019



Note: Full-time is working at least 30 hours per week . Source: Author's calculations using ELSA, waves 1-9 © Institute for Fiscal Studies

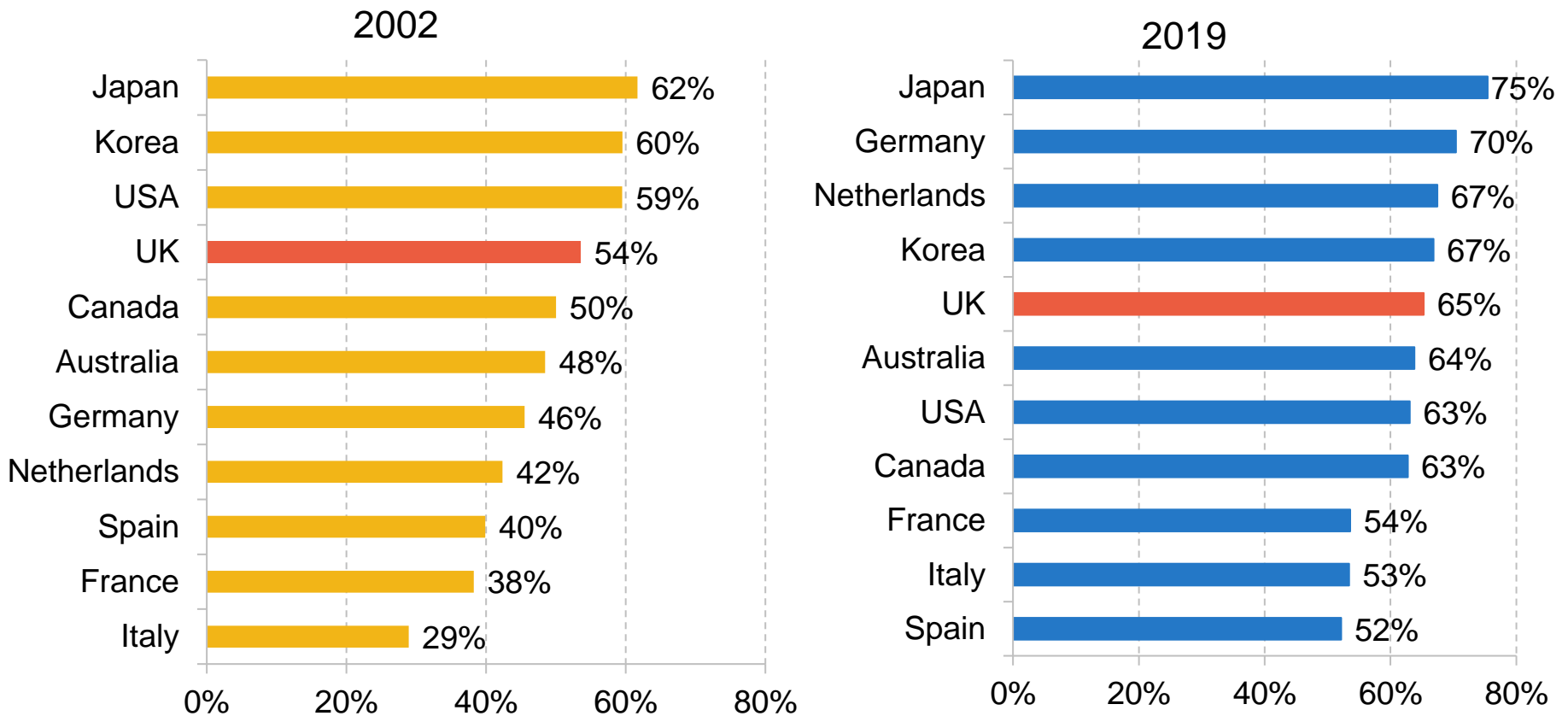
Some increases in employment caused by increases in state pension age

Employment rates of women, by single year of age, 2009 to 2021



Increases in employment not limited to the UK

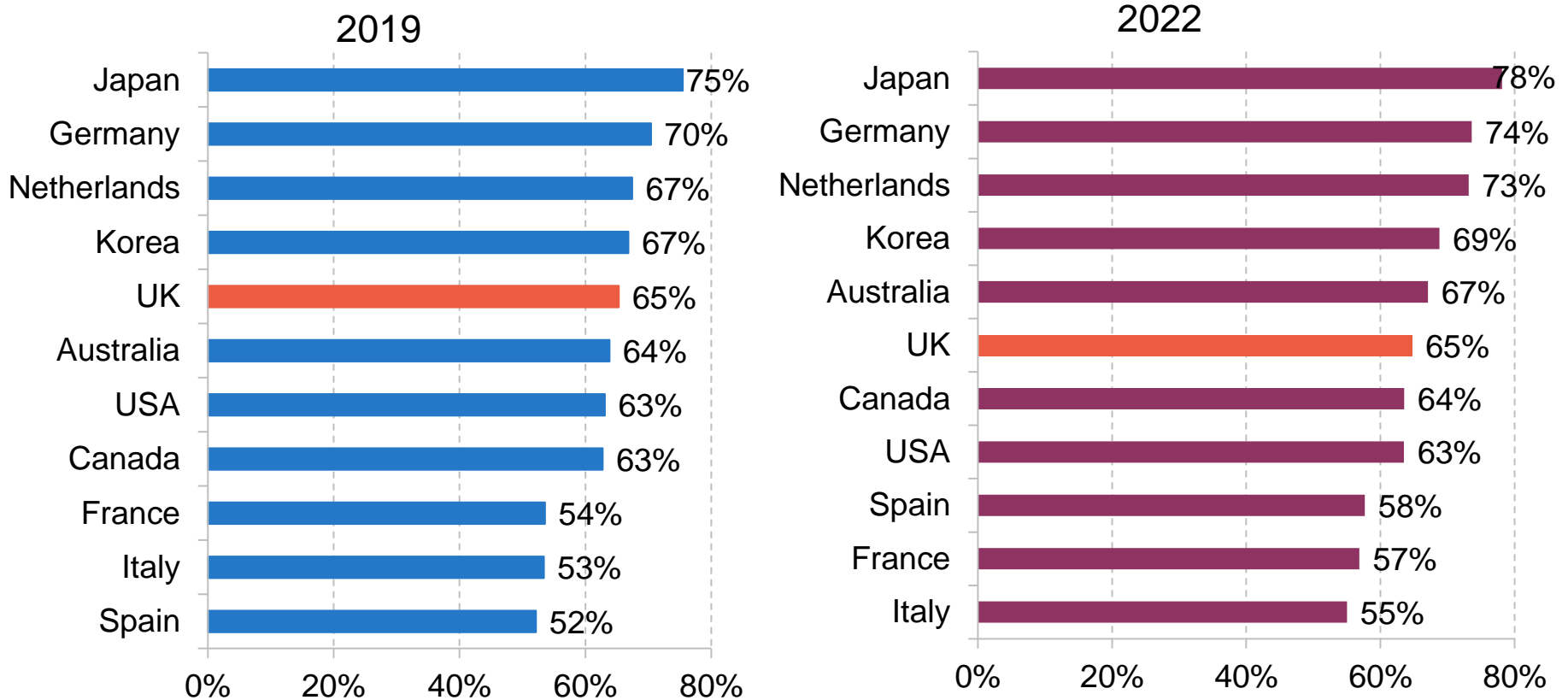
Employment rates of 55-64 year olds, 2002 and 2019, major high-income countries



Source: OECD data. 2002 data points for FRA, KOR, are from 2003. DEU data for 2002 from 2005.

But unusually not risen since pandemic

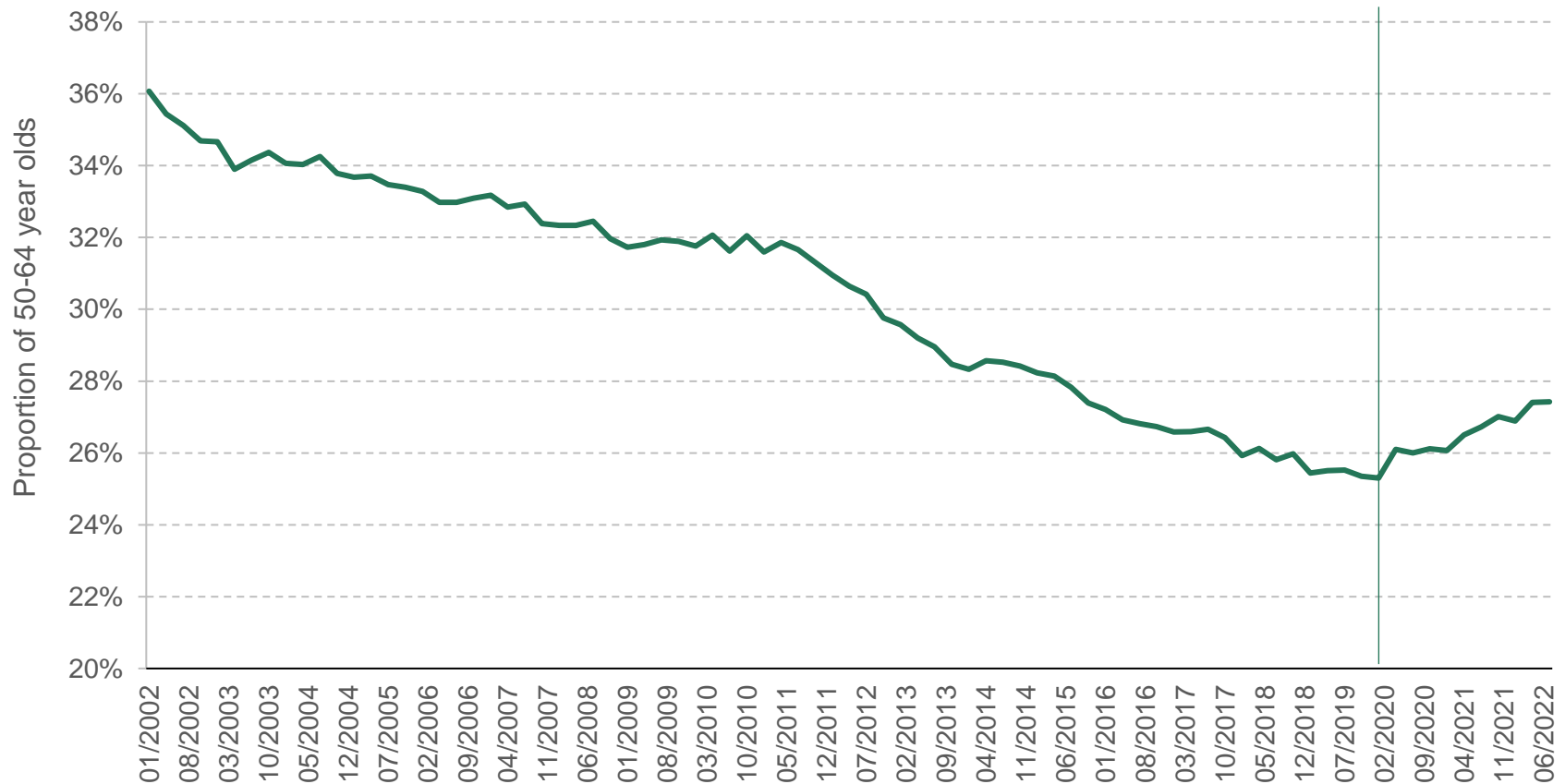
Employment rates of 55-64 year olds, 2002 and 2019, major high-income countries



Source: OECD data. 2002 data points for FRA, KOR, are from 2003. DEU data for 2002 from 2005.

Rise in people aged 50-64 out of labour force

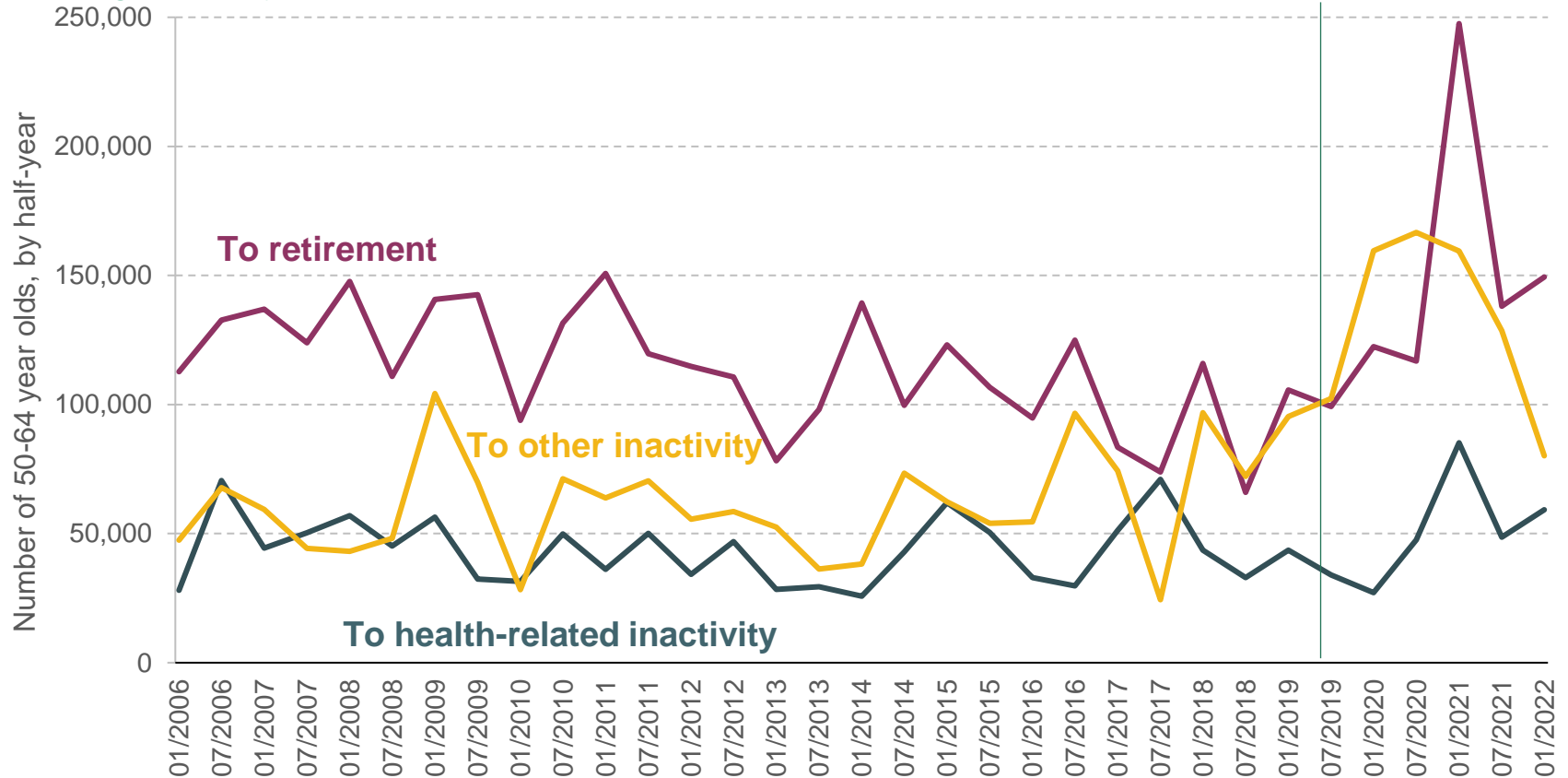
Inactivity (non- labour-force participation) rate among 50-64 year olds



Source: Updated version of Boileau and Cribb (2022), using Labour Force Survey. Vertical line indicates last data before pandemic.

Increased flows out of work to self-reported “retirement”, “other” inactivity

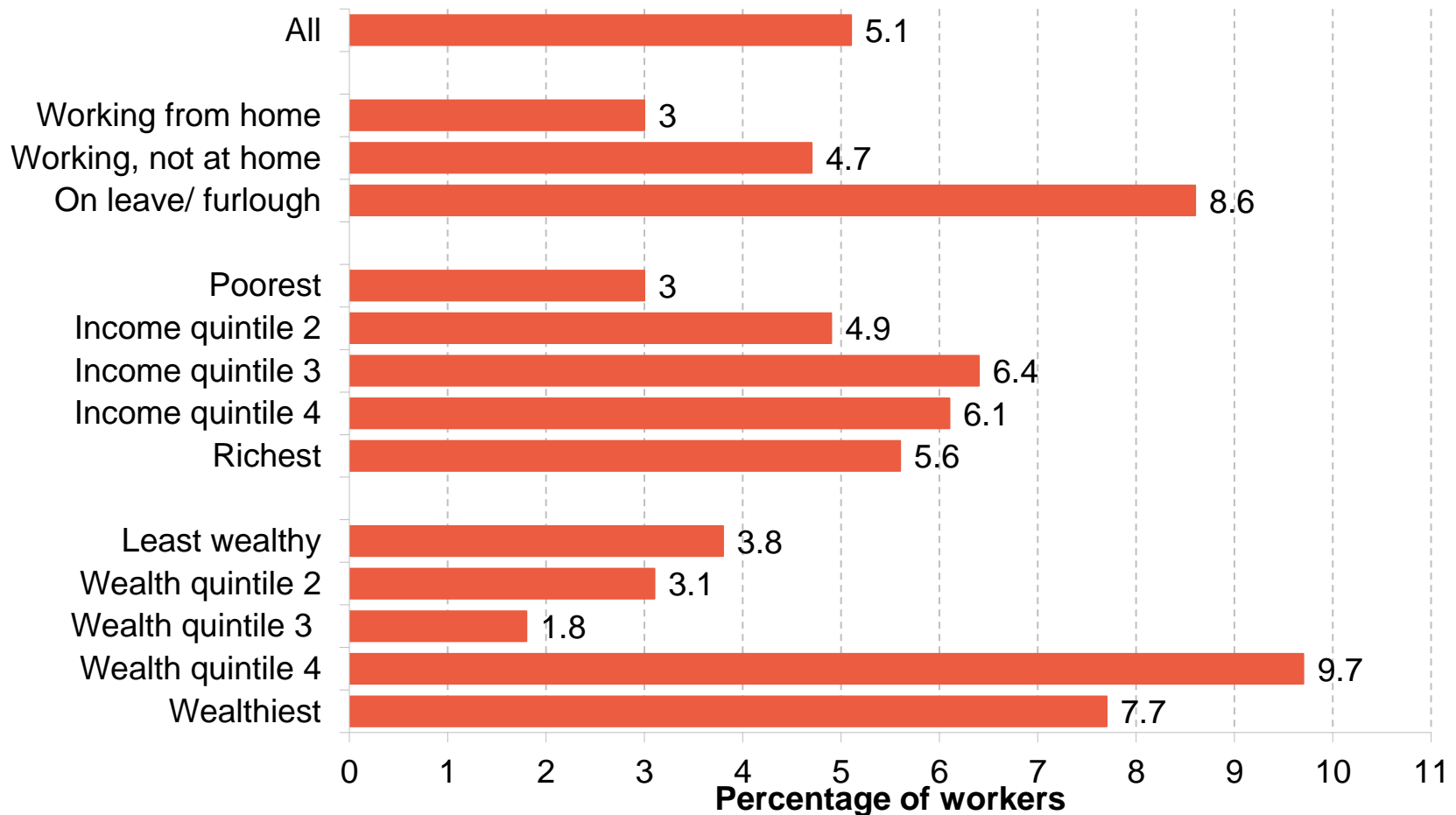
Outflows from employment over the course of three months, by half-year, among 50–64 year olds



Source: Boileau and Cribb (2022) using Labour Force Survey data. Vertical line indicates last data before pandemic.

Some groups more likely to plan to retire earlier

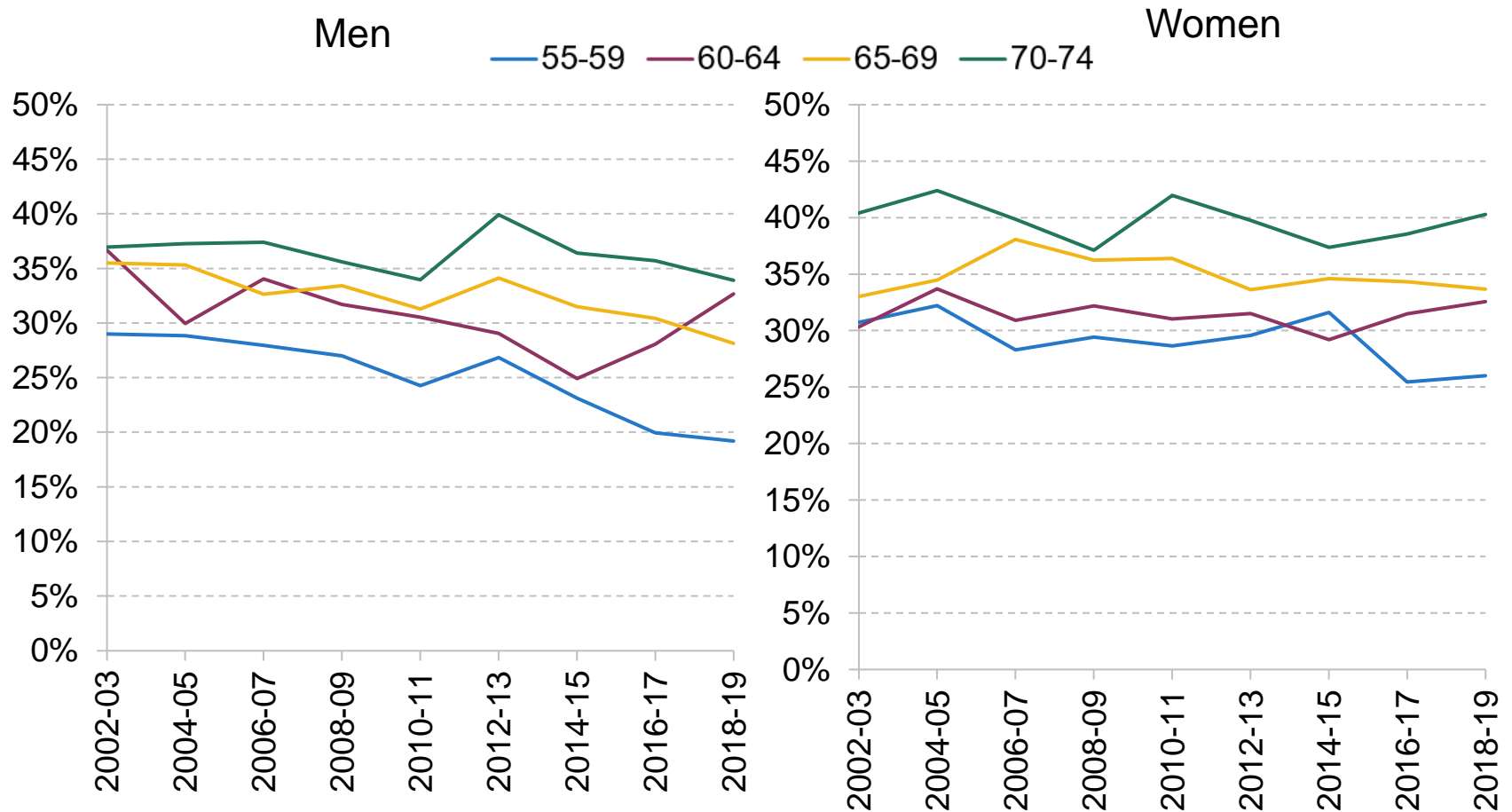
Percent of people in employment (age 54+) pre-pandemic who report the pandemic has caused them to plan to retire earlier



Source: Crawford and Karjalainen (2020) using ELSA covid study wave 1 (June/July 2020).

Disability rates for 55-74 year olds similar to, or lower, than in early 2000s IFS

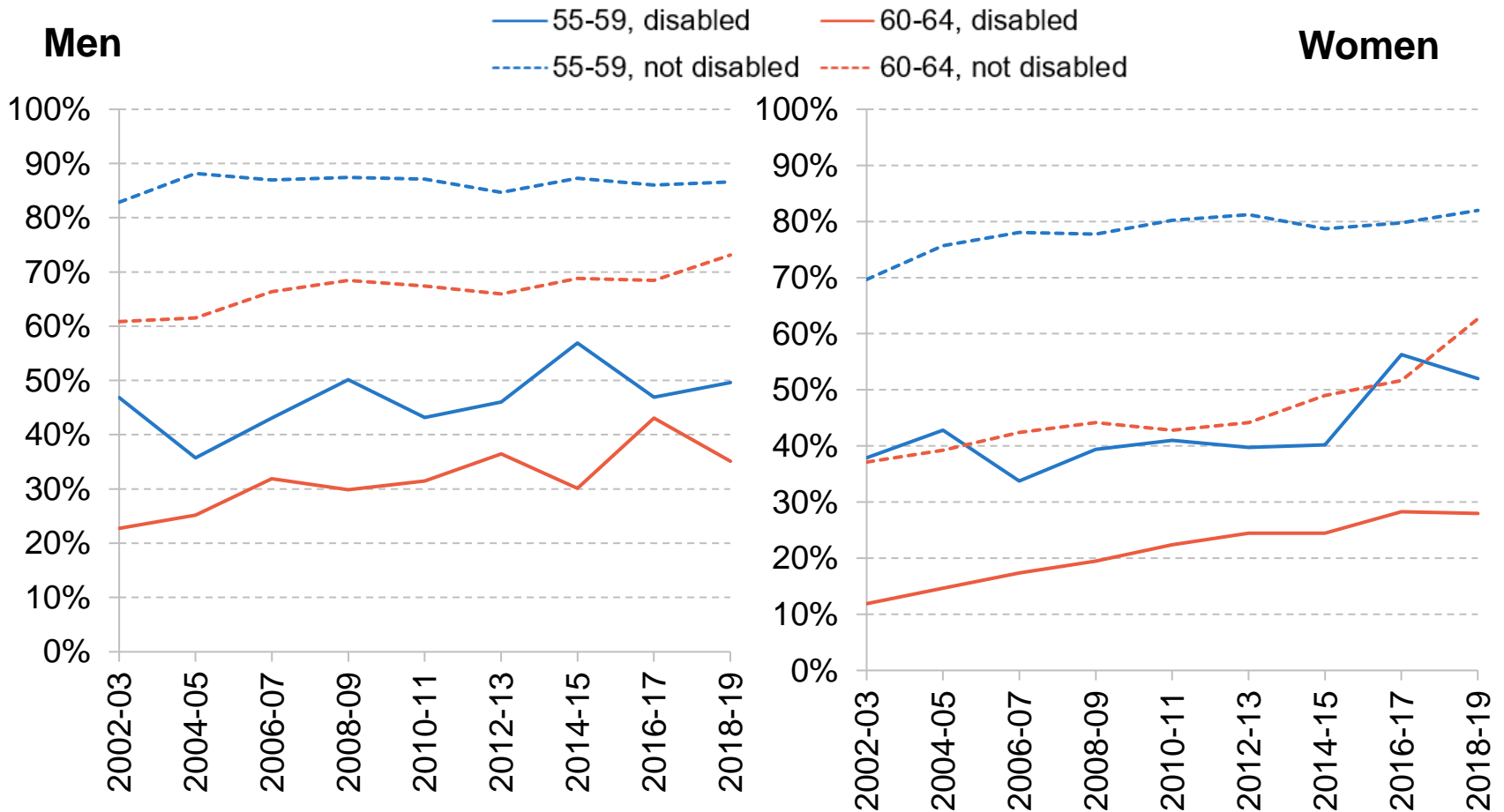
Disability rates (longstanding & limiting condition), by age and sex, 2002-19



Source: Author's calculations using ELSA, waves 1-9.

Employment rates of disabled people rising from low base

Employment rates by age, sex, and disability status

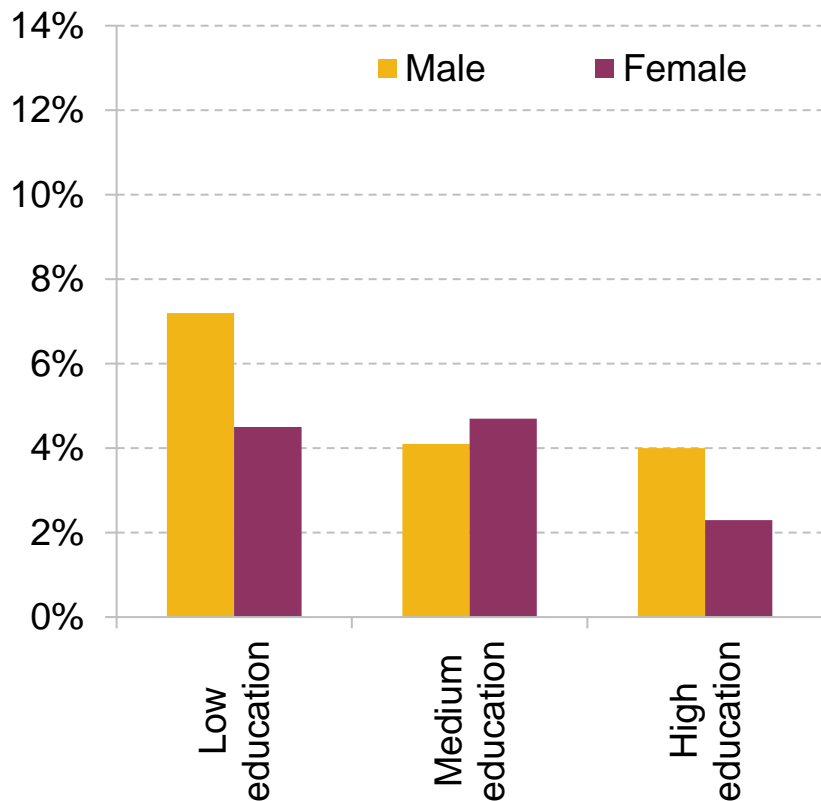


Source: Author's calculations using ELSA, waves 1-9.
 Disabled defined as having a longstanding condition which limits their activities.

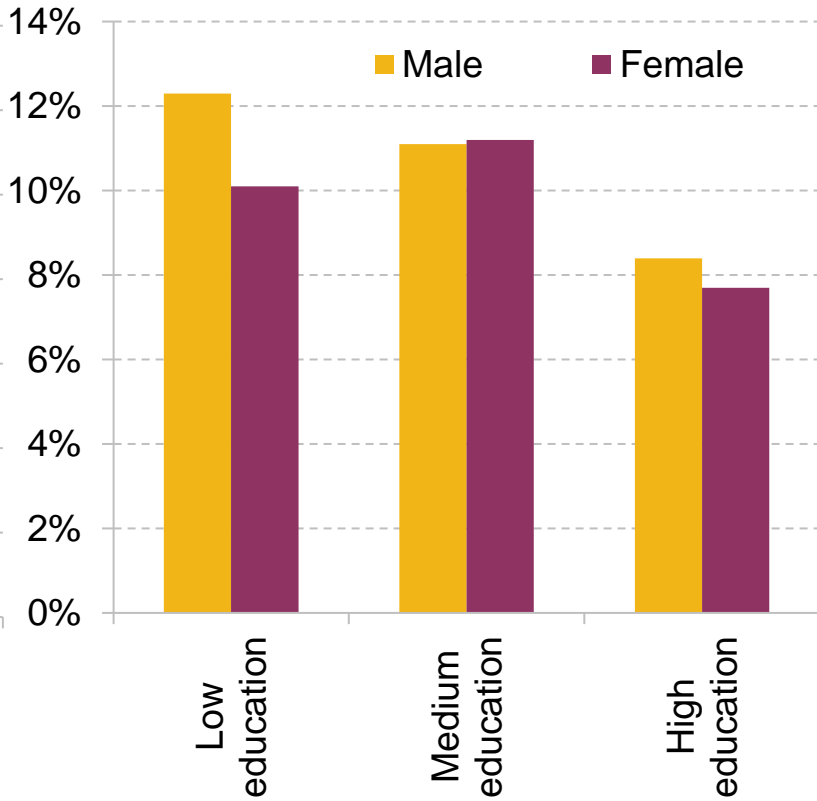
Small shares of employment decline explained by in health in England

Share of employment decline between ages of 50 and 70 explained by declines in health

England (ELSA)



United States (HRS)

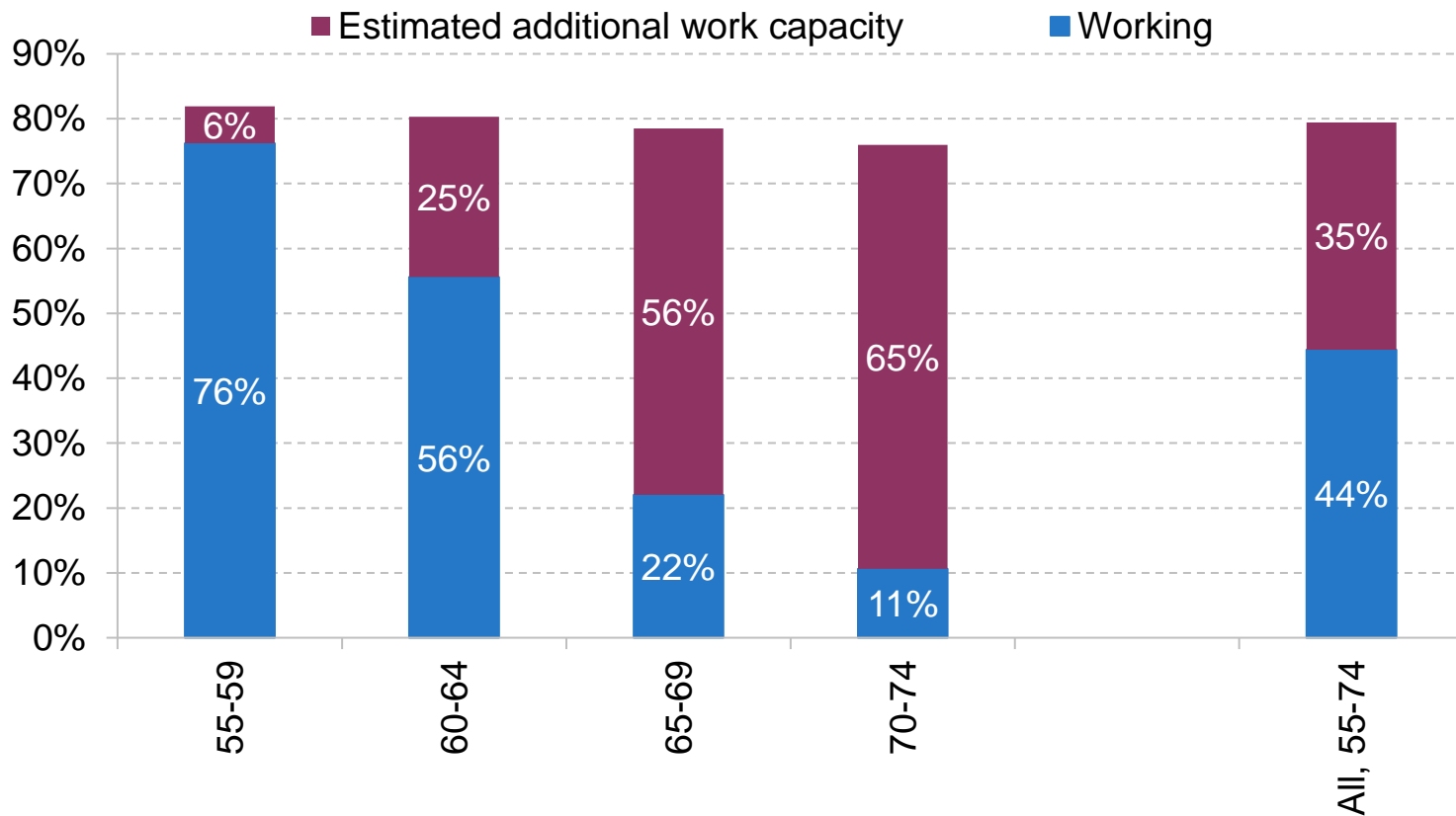


Source: Table 6, Blundell, Britton, Costa Dias, and French (2005);

Note: health measured using subjective health but results robust to various definitions and measures of health. .

Significant additional work capacity for people aged 60-74 in England

Share of men working and estimated additional work capacity for 55-74 year olds given relationship between health and employment of people aged 50-54



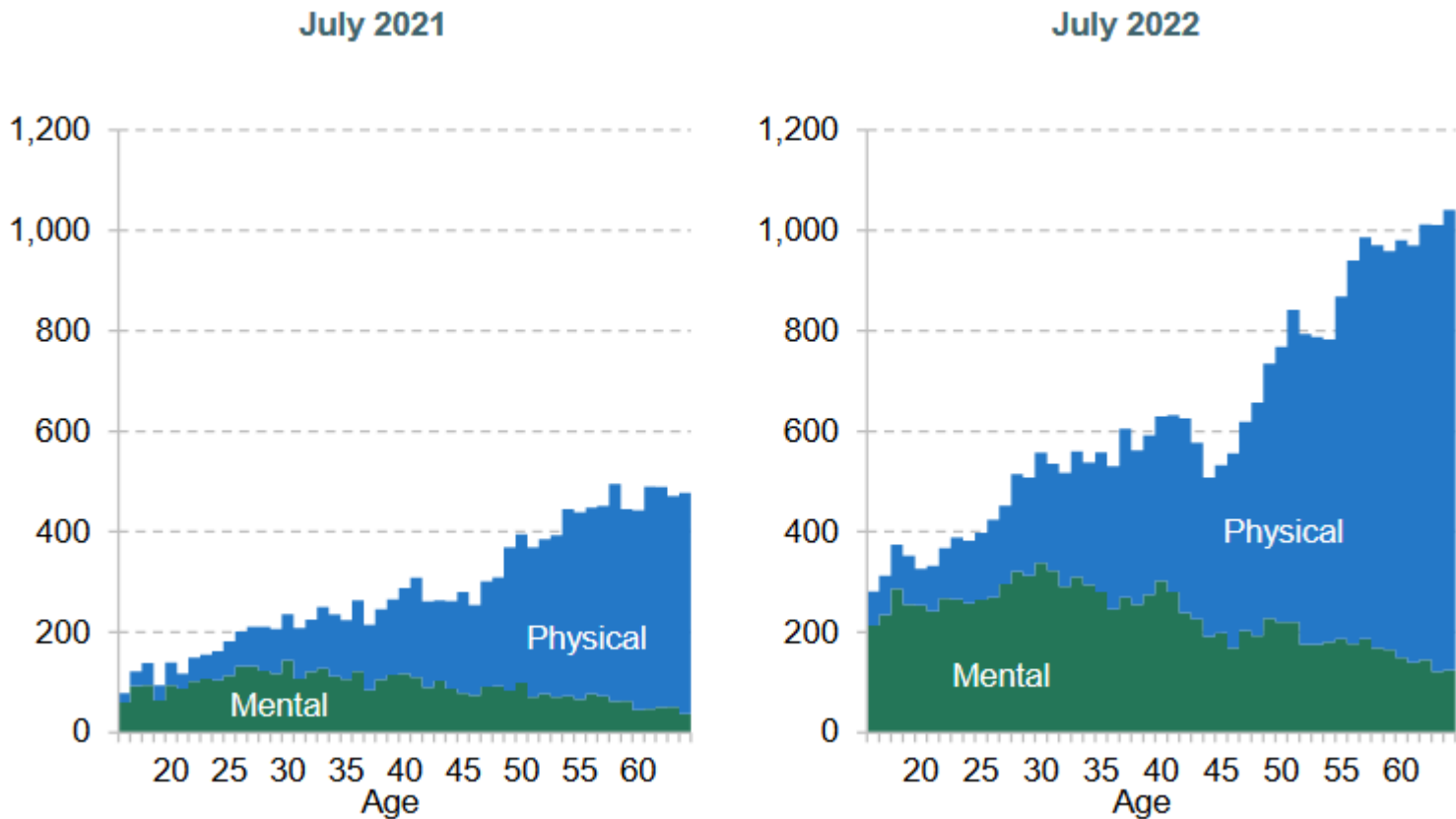
Source: Figure 16, Banks, Emmerson, and Tetlow (2018)

Note: similar results found for women. Other approaches also implies significant health capacity to work.

Are there changes post pandemic? IIFS

Large increases in disability ben caseload

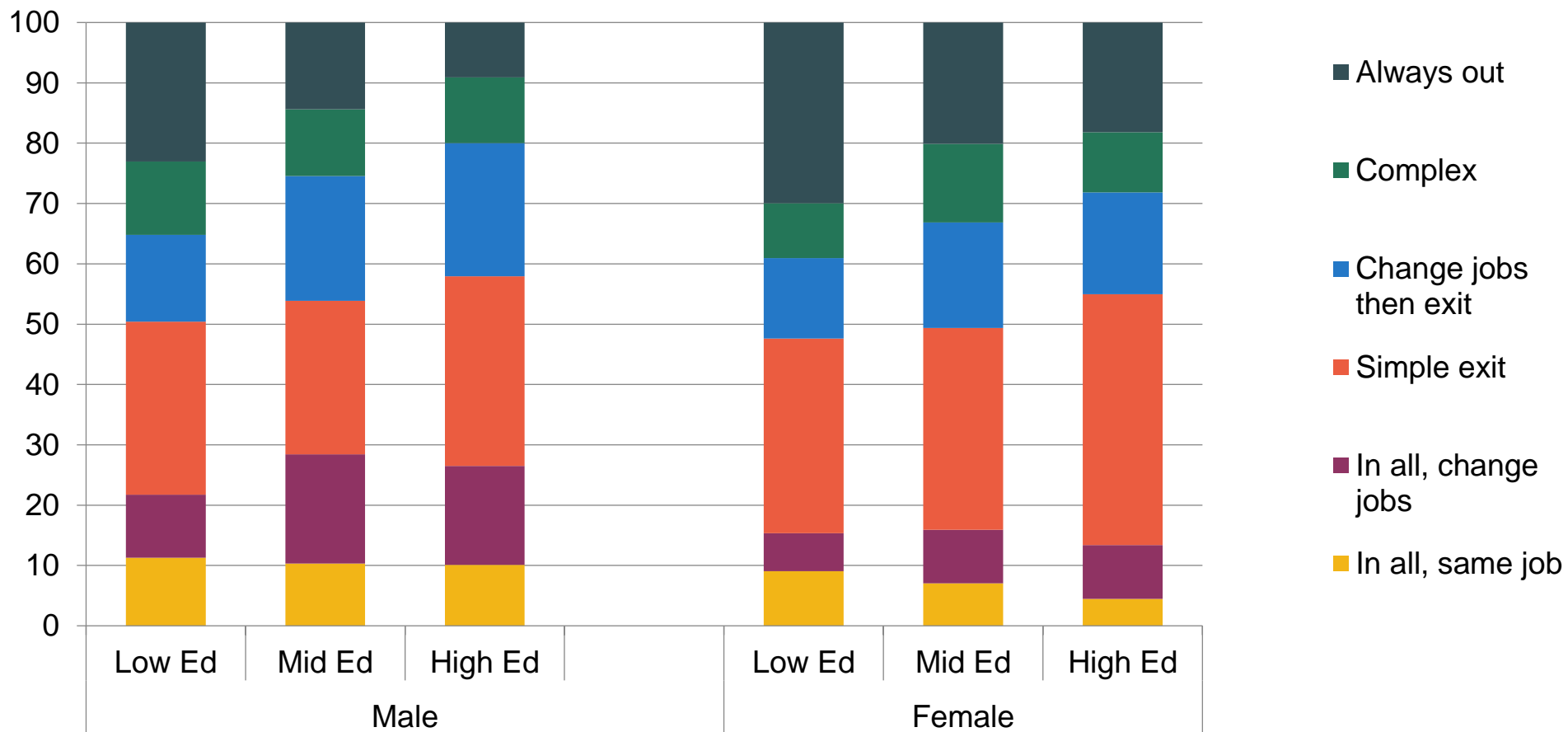
Monthly Personal Independence Payments awards by age and type of disability



Source: Joyce, Ray-Chaudhuri and Waters (2022) using DWP Stat-Xplore data.
Note: Excludes Scotland

Changing jobs in 50s/60s not uncommon, esp. for men with education

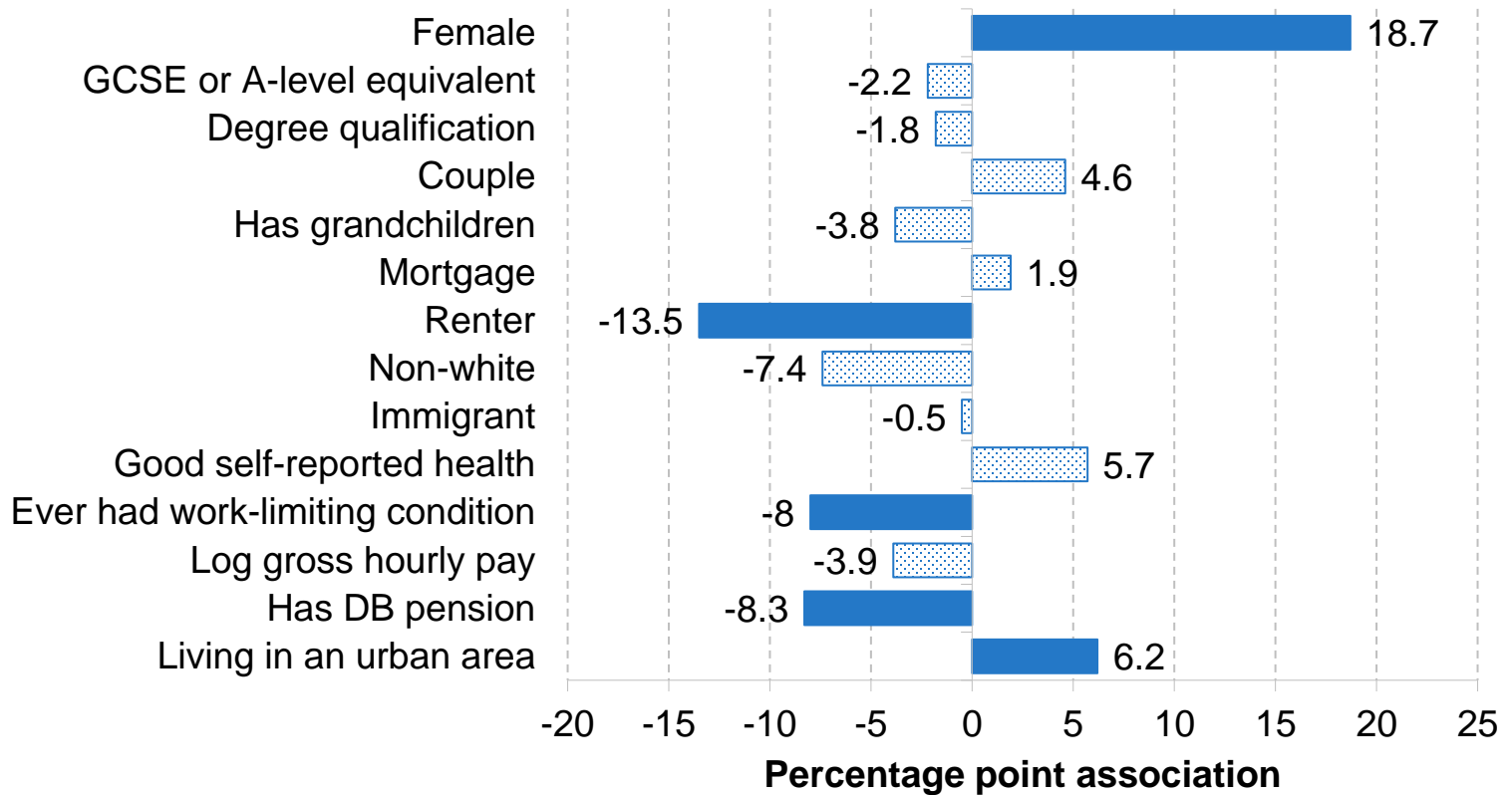
Employment trajectory types by sex and education, 2002-03 to 2014-15



Source: Banks (2016) using ELSA data waves 1-7.

People with DB pension less likely to retire via part-time work

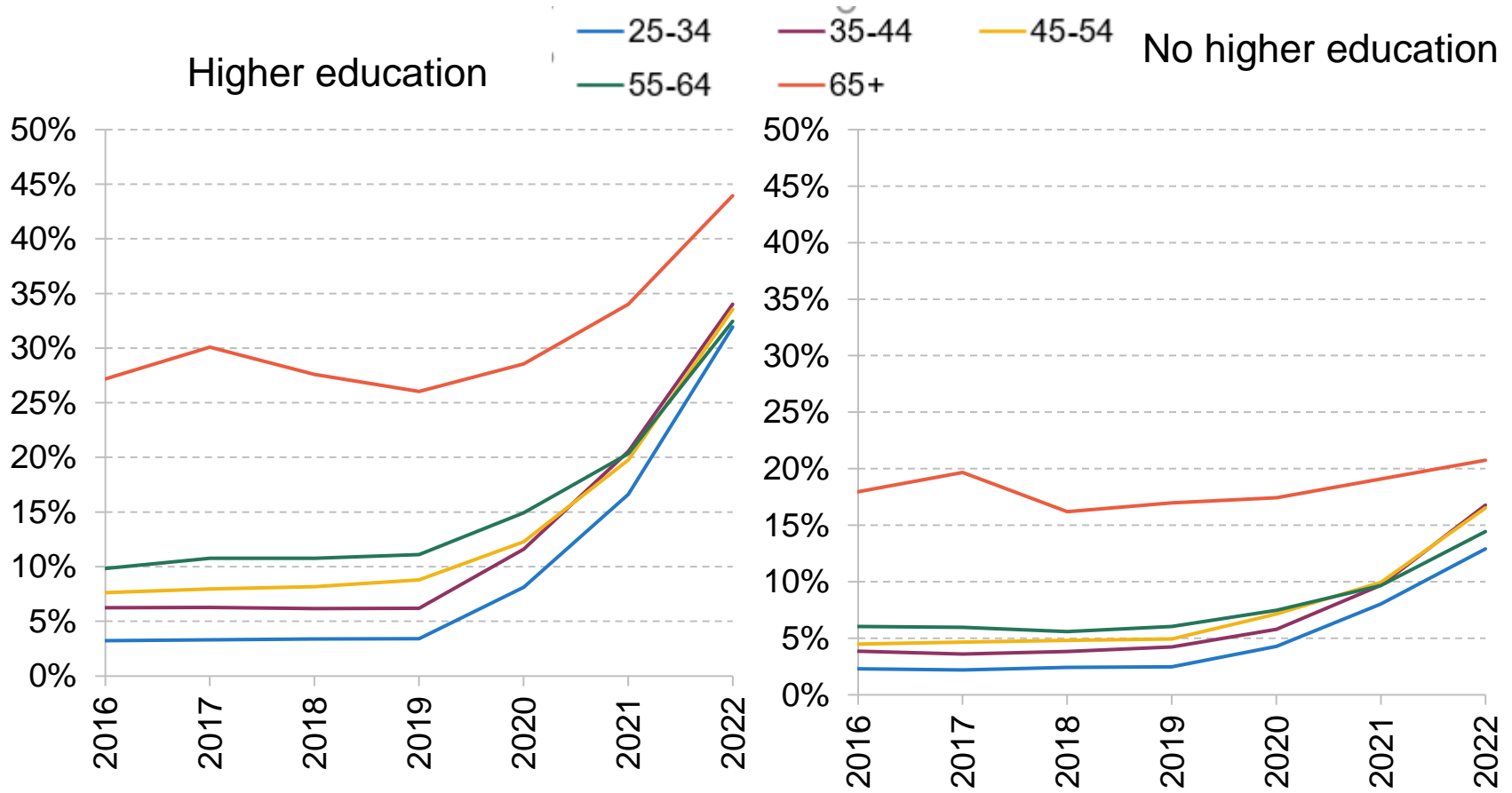
Characteristics associated with gradual retirement (via part-time work) among those aged 50-59 and working full-time in 2002-03



Source: Figure 3.7 of Crawford et al (2021). Also controls for job characteristics (not shown; not statistically different from zero at 5% significance level) . Solid bars show effects are statistically different from 0 at 5% significance level.

Increased remote work; though bigger growth for younger workers

Percentage of workers working at least one full day per week, by education



Source: Author's calculations using the Labour Force Survey

Falls in labour force participation partially reverses longer run trends towards more work around state pension age. Why?

- ELSA will allow to understand potential roles of furlough; health; access to pension wealth

Pre-pandemic significant potential health capacity to work; but there are inequalities: for sizeable group difficult to work to SPA

- Initial evidence of recent changes with \uparrow in disability benefit caseloads

Remote work is only one form of flexibility; potentially increased gradual retirement with decline of defined benefit pensions

- ELSA already updated to account for these trends; and will continue to evolve with a changing world of work for people aged 50+

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A look ahead

Professor Paola Zaninotto

Aim of ELSA

To provide a nationally representative population research platform for studying the dynamic relationships between

- Socioeconomic position
- Mental and physical health
- Cognitive function, Alzheimer's disease and other dementias
- Economic and social circumstances
- Well-being

as people move from work to retirement and into older age.

Sample

Wave 12 (2025/26) and Wave 13 (2027/28)



Interview approximately 11,000 respondents



Refreshment samples of younger people



Enhancing ethnic minority representation

Mode of data collection



Introduce web-first survey methods backed by face-to-face and telephone assessments.



Self completion questionnaire: online and paper



Health visit for the collection of biomedical, genetic and physical performance data



Between main-wave sequential web-CATI surveys

New modules



Climate change attitudes and behaviors



Questionnaire content relevant to the lives of ethnic minority people

migration histories, national, religious and ethnic identity, experiences of discrimination across the life course

Repeating modules

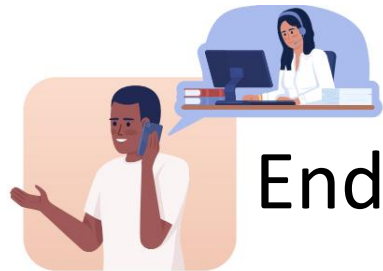


Accelerometers for objective sleep and physical activity

Objective Hearing tests



Online nutrition assessment



End of life interviews


Life history



Focus on Dementia: HCAP3

 2028 provide a 10-year interval from HCAP1 and 5-year interval from HCAP2

 Sample: HCAP1, HCAP2 and new people 65+ predominantly from ethnic minority groups

 Content of the interviews will be largely the same as in previous HCAPs to facilitate comparisons.

Linkages



Thank you for celebrating the 20th
anniversary of ELSA with us

