

General patterns of health inequality are repeated in the elderly population.

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There is no agreed definition of health or concept of health. Few, if any of us, would meet the criteria of “complete physical, mental and social well-being”, (ref WHO) and we all suffer from disease in some form or another. Naturalist notions of health leave plenty of scope for health norms for the elderly to be determined relative to their age, but may under-estimate potential because the norms are determined in relation to average health of a given population as it currently is, which may not be as good as it could be. Normative accounts of health are enjoying something of a renaissance particularly in combination with philosophies such as that proposed by Nussbaum, and contain both universalised notions of basic capabilities, which permit comparisons between individuals and therefore healthcare goals to be established, as well as functioning in relation to individual choices, which allow scope for more subjective assessments of health and appropriate health care

Ageing well is a 21st century challenge for global populations. Population ageing is often discussed in terms of risk and problems posed by the demographic challenge, with limited discussion and understanding about benefits and opportunities: “We talk about the years we have gained as if they are tacked on to the end of life, likely to be spent in ill health and dependency on children and the state” (Bartley, 2012: 14). The Commissioners were determine to understand how the population can age whilst flourishing and remaining as healthy as possible, but we did not minimize or underestimate the challenges, one of which was how to ensure that the benefits of ageing were felt across the population. We examined a wide range of literature and heard evidence from a range of organizations that were also occupied by inequalities. It is clear that patterns of inequality established even before we are born can manifest as we age and the issue of health inequality remains a challenge for policy makers in relation to healthy ageing.

The Commission heard evidence from [Professor Goldblatt](#) about work undertaken at UCL in relation to ageing and health inequalities, who reported that socio-economic disadvantage is an important feature of health inequality and is a predictor of inequality in ageing populations. Professor Goldblatt discussed the accumulation potential for both positive and negative factors that contribute to health and wellbeing patterns across the lifecourse to impact healthy ageing. His evidence explored the influence of lifecourse stages; of the wider society; and of the macro-level and systemic context in relation to inequality, finding that inequalities are not tied to one section of the lifecourse and that they persist into old age. Professor Goldblatt reported that “in terms of inequalities, there are striking differences between social classes in the proportions of people who enter retirement with health problems”, that this was an issue that “perpetuates through generations and communities” and called for targets on smoking, and people needing to remain occupied with work that is “useful” or remain engaged, supporting findings from other areas of the commission. Professor Goldblatt articulated that “there seems to be a gap between the dialogue of individual autonomy, decision-making and control, and community cohesion and support for health and positive ageing” and discussed how we need to look at these possible links in relation to advancing health interventions at a local level in a multi-cultural city such as Birmingham.

The Commission also heard from [Professor Tom Kirkwood](#) who supported this finding, and suggested that "it has long been known that socio-economic disadvantage is associated with shorter life expectancy of earlier risk and a spectrum of age-associated multi-morbidity". Professor Kirkwood argued using this finding against the use of age as a meaningful chronological marker, with particular relation to health and attitudes. Professor Kirkwood suggested that with increasing life expectancy there was increasing health expectancy and that "chronological age is less important than how healthy individuals are. Differences in socioeconomic class are still very marked".

Demographic change and healthy ageing

The ageing population structure is not a feature unique to the UK, it is an international trend with predictions that by 2017 "for the first time in history, the number of people aged 56 years and older will outnumber children younger than 5 years" (The Lancet, 2012: 1274). Attention to ageing well and how this can be achieved is rapidly becoming a global priority. In Europe, interest has been fuelled by predictions such as that "by 2025 more than 20% of Europeans will be 65 or over, with a particularly rapid increase in numbers of over-80s" (European Commission Ageing Policy website, 2013). The World Health Organisation (hereafter WHO), chose ageing well as the theme for their world health day in 2012 (The Lancet, 2012). Demographic change poses difficult questions to policy makers and governments, as "one of the greatest challenges currently facing Europe is how best to adapt EU policies and strategies to meet the demands associated with demographic change" (EuroHealthNet, 2010: 1).

Poverty within ageing populations is not uniformly distributed – it does not follow that if you are elderly you are poor. Instead the serious concern in relation to ageing and poverty is that those who have been socio-economically disadvantaged throughout their lives carry this disadvantage through to old age. And we know that "poverty is a significant socioeconomic health determinant, with negative effects on health, life expectancy and disability" (EuroHealthNet, 2010: 2).

Health inequalities are of particular concern in the UK as research has shown that "the burden of ill-health is carried by older people... Two thirds of the population with a limiting long-term illness or disability are aged 55 and over (Grundy and Holt, 2001: 4). In England and Wales most deaths (80%) occur in the population aged over 65, and just under half of all other deaths (8%) occur in those aged 55-64, although the extent of the disparities may actually be under-estimated (Grundy and Holt, 2001: 5).

One of the issues central to the Policy Commission, was how people could flourish in old age. Through the course of gathering evidence, it became clear that reducing inequality was integral to ensuring healthy ageing. We heard how the 'Inequalities in health in an ageing population research group' based at UCL has show that by 2020 those over fifty will represent 40% of the British population and 30% of us will be aged 60 or over by 2040. But this does not mean that we are all equally likely to live for longer: "socio-economic class I can expect to live an additional 17.5 years once they reach the age of 65, while those in social class V can expect to live only another 13.4 years" (UCL inequalities in health in an ageing population website, 2013). The importance of socio-economic status and inequality in the UK therefore has profound implications for health just as it does in all other age groups.

Socio-economic status has an important relationship with healthy ageing

This discussion about healthy ageing and inequality often features in economic debate. It has been noted that in the EU the ratio of those of working age to those over the age of 65 (previous retirement age) will reduce from 4:1 to 2:1 over the next 50 years and that countries will have to spend 15-40% more to preserve current healthcare provision (Fahy *et al.*, 2011: d.3815). The older people we spoke to during the lifetime of the Commission often talked about financial worries, and also about how money had been tight in younger years – especially raising children – making it extremely difficult to save for later life. Another Birmingham Policy Commission has already reported on wealth inequalities in relation to pension policy. It would be remiss not to mention financial hardship here because it was such a powerful concern for those who participated in the focus groups around the city.

“I think government should help us, because our men are in low paid jobs, well majority of them and it only pays for the family to barely keep afloat, so how can we save money for our old age? Just impossible to save when not much money is coming in to pay for basics”
(Arabic Women’s Awareness Group)

“I was working part-time but I always paid my full stamp, but it was late 50s before I started a pension with where I was working so I’ve only got a little pension but it’s a bit”
(Halesowen and Dudley Elders Group)

“Worry about those sort of things [money issues] drags you down mentally” (Halesowen and Dudley Elders Group)

“all I seem to have done in my life is paid enough in to give me a pension that just counts me out of all benefits. That’s all I see my contribution. The fact that I didn’t go and spend it all on wild living if you like when I was getting it and I put some aside, but all I seem to have achieved is just got me to that threshold where I’m not entitled to any benefits”
(Halesowen and Dudley Elders Group)

“Money is really important, because without adequate money you cannot eat good food, pay your bills, keep warm, enjoy going out than you do need money to survive instead of just existing” (Halesowen Asian Elderly Association)

Further, the Commission recognises that socio-economic status and financial hardship raise pertinent questions about quality of life and health inequalities specifically in relation to healthy ageing and the possibility for flourishing.

Huisman *et al.*, (2013) in their work on Socioeconomic Inequalities in Mortality Rates in Old Age in the World Health Organization Europe Region argue that “socioeconomic adversity is among the foremost fundamental causes of human suffering, and this is no less true in old age. Recent reports on socioeconomic inequalities in mortality rate in old age suggest that a low socioeconomic position continues to increase the risk of death even among the oldest old” (Huisman *et al.*, 2013: 84).

The impact of health inequality is keenly felt by the oldest old

The oldest old (defined as those over 85 years of age) are highly vulnerable. Age UK has reported that “individual differences have accumulated over the life-course, and socio-economic factors have a predominant influence. The sum total of problems or impairments means that individuals also differ in their ability to weather the next setback, illness or injury. Loss of reserve or resilience is called frailty, and this can be measured through a comprehensive assessment, which is more holistic

than a list of diseases” (Age UK, 2013: 14). Moreover ageing is not experienced equally by gender or chronologically. There is not (as is commonly assumed) heterogeneity in the older ageing population. More women than men live alone, in rented accommodation and experience the highest rates of poverty. (Age UK, 2013: 11).

Mental well being

There has also been an increasing interest in mental health in relation to quality of life in older age. Exploration of the health of older people has additionally been couched in terms of ‘wellbeing’, with research looking at how wellbeing changes across the life course. In order to mitigate some of the negative perceptions of ageing, Blanchflower and Oswald (2008) using a random sample of 500,000 Americans and Western Europeans charted how people felt across the life course and found (tentatively) what they characterized as a “u-shaped” pattern “over the life cycle” with mental distress reaching a maximum in middle age (with aggression equations allowing for confounders such as marriage, education and income) (Blanchflower and Oswald, 2008: 1746). They found that happiness increased for middle age, but the pattern flattened out towards the end of a person’s life. This fits with research conducted on socio-economic panel data from Germany that suggested that life satisfaction for the “oldest old” (those over the age of 75) was poor (Gwozdz and Sousa-Poza, 2009).

The tripartite relationship between health, ageing and inequality

Perhaps the most complex relationship the Commission unearthed, was the tripartite relationship between health, ageing and inequality. Here, building on the functional model of healthy ageing identified by Rowe and Khan in the 1980’s, the model established by Baltes and Baltes in 1990 (Baltes and Carstensen, 2008) described succinctly by Grundy *et al.*, (2007) as one of “selective optimisation with compensation” (Grundy *et al.*, 2007: 5) is helpful in considering this relationship. In their work, Grundy *et al.*, (2007) consider how “this model recognises that an individual’s experience of ageing is subjective and unique, and that individuals can remain mentally strong while physically frail and can adapt to limitations they experience as a result of ageing. For example, individuals can prioritise things important to them and use strengths in one domain and coping strategies to compensate for weaknesses in others” (Grundy *et al.*, 2007: 5). They show how these models have been used to identify factors associated with successful ageing: “increased physical activity; higher self-rated health (i.e. an individual’s opinion on their own health); increased social contact/activity/support” but also identify how “to a lesser extent, other factors have been found to be associated with successful ageing: fewer chronic illnesses; less hearing impairment; higher income; higher education; less cigarette smoking; personality; less depression; age identity; ethnicity” (Grundy *et al.*, 2007: 3-4). These factors latterly identified have clear links to socio-economic status identified in other research and begin to give us some clue as to the nature of the relationship between healthy ageing and health inequality.

This study was further interesting in relation to this relationship, as some of the key findings in relation to elderly people were that “individuals are able to ‘remain positive’ despite declining physical health; how we age mentally may not necessarily reflect how we age physically; there is some ‘compensation’ between domains, i.e., that whether consciously or subconsciously some people compensate mentally for their poor physical health” and that “social interaction was significantly associated with good mental QOL [Quality Of Life]” (Grundy *et al.*, 2007: 5). These findings are important and could be further investigated in relation to healthy ageing and people’s ability to flourish, further, they were supported and could be evidenced through the focus groups

and other evidence gathering of the commission.

The reason that this relationship is so essential to determine is “If people from disadvantaged social classes age faster in terms of declining health, this would result in widening health inequalities in later life. Reductions in inequalities in health are an important policy target in Britain. With an ageing population, the question of whether socioeconomic differences in health persist, increase, or decrease at older ages becomes increasingly salient” (Chandola *et al.*, 2007: 990). Chandola *et al.*'s study identifies the discrepancy between convergence and divergence in health inequality data for ageing populations and from their research found that “ageing in later life is not necessarily accompanied by steep decrements in health. Despite greater need, elderly people from disadvantaged social classes face barriers in accessing health services. Helping people from disadvantaged social classes to achieve the good health that is attained by more advantaged groups would help to reduce need and prevent the growing crisis in healthcare inequalities among elderly people as the population ages” (Chandola *et al.*, 2007: 997). Research such as this helps us to tailor policy response to the issue of healthy ageing and health inequality, however there is still work to be done on what these initiatives might look like and how they would work to target populations.

Health inequality is a vast research area, and the Commission was only briefly able to touch upon it through the work undertaken. However, **there is a particular and important relationship between inequality and healthy ageing. This relationship was identified as being of significance to the older old people who participated in the Commission's evidence gathering process.** Grundy *et al.*'s (2007) report into successful ageing and social interaction showed that there are few studies in this area. Their research also challenged the notion that it was not possible for there to be “a good quality of life among the older old, as the message of many previous studies seems to imply that ‘successful ageing’ is only possible for younger elderly people” (Grundy *et al.*, 2007: 2). These findings have positive connotations for the Commission and future work.

From the evidence reviewed, the Commission asserts that it is possible for the oldest old to achieve healthy ageing; and more needs to be done to ensure that the people who are socio-economically disadvantaged are as able to flourish in later life reducing later life inequalities.

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