Getting on... with life

mental health foundation

Baby boomers, mental health and ageing well

Summary Report

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Foreword

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

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

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

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

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

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

Baroness Lola Young, Chair of the Age Well Inquiry Panel

Dr Andrew McCulloch, Chief Executive, Mental Health Foundation

For full copy of report, please visit *www.mentalhealth.org.uk/agewell*

Introduction

Getting on... with life

A rapidly increasing number of people in the western, industrialised world are surviving into older age and living longer.

Currently UK society, like others in the western industrialised world, is facing what has been termed a 'demographic time bomb'. The first wave of the so-called 'baby-boomers' – the people born in the decade immediately after the end of World War II, in the years 1946–55 – are on the cusp of retirement or have already retired.

We live in an ageing society: the numbers of people aged 65+ are increasing steeply, and the number of children born in the UK has fallen consistently since its last peak in 1964. People are living much longer but they are not necessarily living more healthily, meaning a greater number of older people are living with chronic health conditions and disabilities and thus placing greater demands on our health and social care services, which the current working population must finance and sustain. The so-called old age dependency ratio of working age and people aged over 65 is projected to rise from around four working age people for every person aged 65 and over at present to around two working age people for every person aged 65 and over by 2060.[1] Alongside this is an increase in economic and health inequalities – the growing gap between the health and wealth of the very rich and the very poor; the rising numbers of worklessness and low income households set against households where both adults are employed, and increased social and family fragmentation and loss of community cohesion.

The baby boomers form the largest wave of older people to enter retirement – some have already retired, or are in the process of doing so; their care and support are expected to place huge demands on society and younger generations that some predict will be economically unsustainable. But they are a population cohort that is also associated with radical social and cultural change, with new ways of thinking and different ways of behaving towards their parents. Might they not be a source of equally radical and inventive solutions to the problems their ageing will present?

They are a group that is, often rightly, associated with greater affluence, greater purchasing power and greater willingness to use their affluence and consumer muscle to get what they want. Many will enjoy comfortable pension packages and health insurance that will support them in older age. Fewer may need to draw on the welfare state to support them in their old age. More may devise their own solutions to safeguard their independence and autonomy right through to their final years. And yet this group also contains huge disparities in income and opportunity and greater ethnic diversity than any previous generation. The income disparity between the richer and the poor and between north and south has grown ever-wider in their lifetime: in some parts of the country and some sectors baby boomers have suffered most from the decline of the UK's manufacturing industry and benefited least from the new technologies and service industries that have partially replaced it. Five per cent of the 1946–1955 population migrated into the UK in the post-war years: a much larger proportion compared to previous generations.

The baby boomers were the first population cohort to benefit from the NHS from birth, and from the subsequent huge advances in medical knowledge and technology – will their physical and mental health be better than those of preceding generations? Will they enjoy more years of health into old age, challenging the stereotype of disability and dependence in old age? Or will the socio-economic differences between them outweigh the benefits of the healthier start in life enjoyed by most?

[1] Since the abolition of the default retirement age in 2011 we recognise that 'working age' is no longer a suitable term in this context, but it was relevant when some of the publications cited in this report were published and refers here to people aged 20-64.

Greater numbers of baby boomers were able to access higher education and to benefit from the increased employment and career opportunities that the flourishing economy of the 60s and increased social mobility provided. Education, learning and occupation are closely linked to health and wellbeing throughout life. How will these opportunities affect the baby boomers' mental health and wellbeing in older age, the choices they make and how they make use of their retirement years? What of those who, for whatever reason, were not able to access these opportunities and their benefits?

These are all questions that the Mental Health Foundation's Age Well project set out to answer, and in particular:

- are the baby boomers an identifiable cohort or does the term gloss over wide and deep differences in outlook, experience, attitudes and expectations, as well as income, employment and family life?

- if there are differences, what are they, how might they influence the mental health and wellbeing of baby boomers post-retirement, and how might these in turn influence their experience of growing older and how they manage their old age?

In undertaking this project the Mental Health Foundation recognises that the term 'baby boomer' can be problematic. It is commonly used to describe people born in the two decades after World War II, in the period 1946–1964. There were unusually high birth rates in the UK in 1946/47 and 1964, and several years of higher than average births between these two peaks, creating a baby boom. A similar phenomenon occurred in the US, although the 'boom' was more sustained between the two peaks. The Age Well project is concerned with the first wave, born in the years 1946–1955, who are now in their late 50s to 60s. The term 'baby boomer' carries some negative connotations – the popular press tends, for example, to associate people born in those years with libertarian, anti-authoritarian and hedonistic values and has blamed them for some of the current social and economic ills (real or perceived) in society. Our intention here is not to stir up or discuss these pejorative views but to take a considered look at ageing in relation to this demographically significant and distinct group.

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

The Age Well project

The Age Well project was set up by the Mental Health Foundation to explore how the baby boomers are likely to weather the transition into old age, with a particular focus on their mental health and wellbeing.

The project aimed to:

- identify the potential mental health risks baby boomers are facing and the life factors that may protect them and help them deal with the challenges of ageing

- assess the role of mental wellbeing in ageing well and consider how it may be supported

- highlight issues around attitudes to ageing and older people that may affect wellbeing

- make recommendations for UK governments and other agencies to reflect the findings of this project and how better to promote the mental health of this and future generations.

The project was supported by an Inquiry Panel chaired by Baroness Lola Young of Hornsey (see Acknowledgements for the full list of panel members).

Research was commissioned to support the project, contained in the full Review, which is published separately online at *www.mentalhealth.org.uk/agewell* and a background literature review published in Quality in Ageing and Older Adults.[2] In addition, three surveys, both qualitative and quantitative, were conducted:

- 30 in-depth interviews with people born in the years 1946–55
- a YouGov Omnibus survey of over 5,000 people aged over 16 about their attitudes to mental health and mental illness in later life
- a qualitative survey of 127 respondents who signed up to the project's *talkingaboutourgeneration.org.uk* website.

The aim of these surveys and interviews was to throw further light on this generation's attitudes and values and how they might influence their health and health behaviours in old age.

A force for social change

Baby boomers are seen as having a distinctive set of experiences that set them apart from preceding generations. They 'broke the mould of the modern life course'.[3]

There is a perception that the baby boomers were the vanguard of today's consumer society and that they share characteristics of individualism and liberalism:[4] individualism in the form of less deference, more non-conformism and less trusting attitudes to those in authority; liberalism in their attitudes to sexual and moral issues, including cohabitation, sex before marriage, homosexuality and lone parenthood as well as to wider issues such as men's and women's roles, climate change and drug legalisation.[3] The individualism is linked to 'smart' consumerism: a sense of their right to make choices, which is carried over into attitudes to public services. As a 2003 Demos report concluded4: '[They] have transformed every station they have passed through and show no sign of stopping in old age.'

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

However, the generation born in the post-war baby boom years is not a homogeneous group. Theirs is a generation of huge diversity in income and wealth, ethnicity, education, family relationships, health and life expectancy and attitudes and beliefs. The affluence commonly associated with the baby boomer group has not been enjoyed by all. Income inequalities have grown greater in the post-war years, and particularly since the 1980s. Women's incomes continue to lag behind those of men. These inequalities are notably stark between north and south and between the four countries of the UK, with greater poverty and worklessness in the north, as well as in some parts of Wales, Scotland and Northern Ireland, due to their greater reliance on the manufacturing and coal mining industries. Some five per cent of the 1946–1955 population migrated into the UK after the war, either following their parents to the UK, largely from the Caribbean and South Asia, in the 1950s and 1960s, or from East Africa in the early 1970s, or as young workers in the 1960s and 1970s or adults in later life. Their experiences were different and often much harsher than those of the rest of that generation.

The web survey asked respondents if they identified with a particular generation; 78% said yes. Many identified specific shared values that they felt were born of their particular circumstances: respect for others, a strong sense of community and social responsibility, a sense of difference from preceding generations, of good fortune and gratitude for the opportunities available to them, and a greater emotional articulacy.

'I was bought up with respect for older people and to value their life experiences and knowledge. My generation was to work and save hard for my old age.'

'The post-war generation. The shared experiences of a generation who were optimistic and felt so different from their parents.'

'I think we grew up being more aware of others, a sense that we help each other and that things are done for the common good and to benefit most people. I feel it is a less selfish generation overall, unlike those who grew up during the Thatcher era.'

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

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

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

Some described their generation as, literally, the vanguard of political and social progress:

'I've been part of a great army of people who have made life perhaps a bit better for people who are less fortunate and weren't born with the kind of opportunities that I was born with. So it's a little bit about social justice, trying to equalise what is a horrendously unequal society.'

'We rode into the 60s and made lots of social changes and… pulled down barriers and I think there's a bit of, you always remember that period very fondly, and being a part of it.'

'A sense of mixed pride, privilege and wisdom due to the 70s – and being a feminist. And a great sense of social responsibility for the future.'

'... we genuinely believed we could change things for the better, we hadn't got this dreadful scepticism… we still believed in the perfectibility of people and society'

Others, however, made no such associations, and notably where they felt that their ethnic background distinguished them from their white UK-born peers:

'We do not in my generation have significantly shared experiences. I suppose I am comparing my generation to my parents' generation who were alive during the Second World War.'

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

Healthy ageing

The Foresight Mental Capital and Mental Wellbeing project[5] has identified the common factors that contribute to good mental health and wellbeing and create vulnerability to mental ill health. They are, in summary:

- **life events** – inequalities in childhood contribute to poor health in adulthood. Transitions, such as redundancy, retirement and bereavement, influence and are influenced by emotional, cognitive and social development. Mental resilience built up over the lifetime protects against the impact of adversity in older age

- **financial resources** influence the choices people make. A reasonable level of income and wealth is linked with good mental health. Poverty and uncertain income is linked with poor mental health. Poorer people are at greater risk of loneliness, have fewer choices and less freedom and control over life and less independence

- **healthy environments** including housing, transport, education, employment and accessible services contribute to good mental health

- **bereavement and loss** have a negative effect on mental health. Around 10–20% of people experience complicated grief that puts them at risk of depression

- **poor physical health** can affect mental health, particularly when it reduces mobility and limits participation in previously enjoyed activities and interests

- **good social and family relationships** enhance mental health and wellbeing. Having close friends helps maintain morale, self-esteem and mastery and helps people feel secure and loved. Social integration enables people to deal better with stress and psychological problems. Lack of social support is linked with higher risk of depression and reduced ability to recover from mental ill health

- **living in a supportive community** provides a sense of social support and belonging, and opportunities for active involvement in society

- **personal attributes** such as self-esteem, emotional resilience, the ability to deal with feelings, manage life and cope with stressful or adverse circumstances and an optimistic outlook are all aspects of good mental health

‘We rode into the 60s and made lots of social changes and… pulled down barriers and I think there’s a bit of, you always remember that period very fondly, and being a part of it.’

- age discrimination contributes to feelings of worthlessness, despair and being non-deserving, lowers self-esteem and expectations, limits access to services and underpins lack of respect shown to older people.

This report draws on statistical data, the literature and on the project survey and interview findings to explore how well prepared the baby boomers are for these challenges of old age, mentally, physically, financially and in terms of family and friendship networks and support.

The report is in three sections:

- Health and wellbeing
- Family, friends and relationships
- Work, occupation and retirement.

It ends with some overall conclusions and key findings for policy makers, influencers and implementers that will also be of wider interest to media and public affairs audiences.

The project is concerned with the future and the identification of possible trends for this generation. What will actually happen depends, of course, on the choices and actions of the individuals concerned; our analysis can only suggest possibilities.

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Section 1

Health and wellbeing

It could be argued that the 1946–55 wave of baby boomers should be the healthiest body of pensioners in history. They are the first population group for whom free healthcare from the cradle to the grave was a birthright. They have lived through a period of unparalleled increases in life expectancy. They have benefitted from increased post-war prosperity, better nutrition and housing, as well as huge leaps forward in medical treatment and health technology. Economic and industrial reform has reduced the incidence of industrial disease, injury and death.

In their mid-years, baby boomers have continued to benefit from health improvements and medical advances. There has been a massive drop in deaths from cardiovascular disease (CVD) – the biggest killer in all age groups – and survival rates have increased hugely.[1]

Based on current mortality rates (2008–10), men can expect to live another 17.8 years and women can expect another 20.4 years of life following retirement at age 65, just over half of which they will enjoy in good health (56% and 57% respectively) and with no long-term illness or disability (58% and 55% respectively).[2]

But, alongside these advances, many baby boomers are reaping the whirlwind of increasingly unhealthy lifestyles (see Box 1 – Baby boomer health).[3] The overall picture is of a population group risking heart disease, diabetes and early death through unhealthy diets, too much alcohol and smoking. Yet others are also eating more healthily and taking much more exercise than when younger, and mostly reporting good health. It is interesting to note that levels of self-reported good health are high despite the prevalence of longstanding illness[4], perhaps indicating an ability among many successfully to adapt and manage these conditions. Significantly, however, the increased incidence of lifestyle-related illness may be due in no small part to the widening gap between the health of the richest and poorest in society.

There is also a perception that the lives and experiences of the baby boomers in the 'vanguard' of modern consumer society[5] may make them less deferential, more non-conformist and less trusting of those in authority or with professional expertise, such as doctors. These attitudes are linked to 'smart' consumerism, and a rational and practical approach to making choices that may carry over into how they address their own health and their attitudes to public services.

Health and social care policies from the 1980s onwards have reflected (or pursued) this trend by introducing the internal market to both health and social care services and in making statutory services more consumer-driven and, in principle at least, more personalised. The watchwords of today's health and social care services are personalisation and choice. The trend is typified in the most recent Health and Social Care Act 2010, with its aims to:

- 'put patients at the heart of everything the NHS does;
- 'focus on continuously improving those things that really matter to patients – the outcome of their healthcare; and
- 'empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.'[6]

The legislation enacts patient choice of hospital and doctor and, by implication, treatment; shared decision-making and consultation between clinician and patient, and greater distance between the Government

and the NHS, with the aim to make local services more autonomous and more able to respond to local needs. The Payment by Results financing system similarly ties NHS providers into a much more consumerist system of US-style managed care packages.

Social care services have in many cases led the way towards this consumer and market-driven model of providing statutory services, with the introduction of care management, competitive tendering and greater use of private sector providers, and the development of direct payments and now personal budgets that grant care recipients a sum of money from the local authority social care budget to choose and contract their own care and support arrangements. Personal budgets are now being rolled out in the NHS too.

Box 1 - Baby boomer health

Longstanding illness – 55% of baby boomer men and women in England say they have a longstanding illness and 29% of men and 32% of women say their illnesses limits their activity in some way.[3]

Self-reported general health – 66% of men and 72% of women aged 55–64 in England report their health as good or very good; 11% of men and 19% of women report it as bad or very bad. Just two per cent in the highest household income quintile report bad or very bad health compared with 15% in the lowest quintile.[3]

Diabetes – 11% of men and eight per cent of women aged 55–64 in England have a diabetes diagnosis. Prevalence is lowest in the highest income groups and higher in the middle and low income groups. Since 1993 diabetes has doubled in men and more than doubled in women in the adult population as a whole, including the 55–64 age group.[3]

Blood pressure and hypertension – 51% of men and 41% of women aged 55–64 in England are hypertensive; 20% of men and 17% of women have untreated hypertension, and one per cent and eight per cent respectively have uncontrolled hypertension.[3]

Obesity and overweight – 81% of men and 71% of women aged 55–64 in England are either obese or overweight. Men in this age group have the highest obesity levels of any age group; women have the second highest, after those aged 65–74; 76% of men and 63% of women in the 55-64 age are at health risk for these reasons. Overall, obesity levels in the population have increased from 13% to 26% of men and from 16% to 26% of women since 1993.[3]

Health-related lifestyles – Men and women in the 55–64 age group in England are more likely than any others to eat any fruit or vegetables (96% compared with an average 93%) and the second most likely to eat the recommended five portions or more a day (28% men; 38% women). However 18% of men and 16% of women in this age group are current smokers; 43% of men and 28% of women aged 55–64 used to smoke and only 39% of men and 56% of women in this population group never smoked (the lowest percentage in any population group of women). This group of smokers smoke more heavily than any other age group.[3]

Physical activity – 32% of men and 28% of women aged 55–64 in England take the recommended levels of physical activity; 37% of men and women take little physical exercise. This population group is significantly more active than the 65–74 age group and, for women especially, fairly close to younger people in the amount of physical exercise they take regularly. Their activity levels have improved considerably since 1997, again especially those of the women.[3]

Mental health – around 14% of people in the baby boomer age group in the UK have a mental disorder.[4] While there has been no overall increase in mental illness prevalence over recent decades,[7,8] there was a clear 'step change' in prevalence among men born between 1943–1948 and 1950–56. The differences were less pronounced for women. This increase, in depression and anxiety rates but also in prevalence of sleep problems and fatigue, has been linked to this cohort's transition into adulthood in the 1960s, in a period of significant social change and upheaval.[7,8] Ethnicity and experience of depression in later life is poorly researched, but it seems likely that experience of discrimination and other negative experiences associated with migration are likely to increase psychosocial adversity effects in later life.

Suicide – National suicide rates began to rise again in 2008 and have remained high since, with worrying increases in middle-aged men in particular. The increase coincides with the start of the current recession. The highest suicide rate in 2011 was among males aged 30–44, but rates for those aged 45–59 increased significantly to 22.2 between 2007 and 2011, and the highest female rate in 2011 was in the 45–59 age group, at 7.3.[9] Chief risk factors for suicide attempts among older people are depression, social isolation and poor physical health. Risk of death at second suicide attempt among this age group is high.[10]

Drug dependence – older age groups are less likely than younger groups to have used drugs, but there is a rising gradient:[11] four per cent of people aged 65+ in the UK report having used drugs at any time in their lives, increasing to 11% of 55–64 year olds and 20% of 45–54 year olds.

Alcohol misuse – The baby boomer age group has the highest proportions of men and women who drink alcohol almost every day (26% and 13%) and the lowest

Box 1 - Baby boomer health (cont)

proportions of non-drinkers (8% men; 13% women). One in five men in this age group in England drink more than eight units of alcohol on their heaviest drinking day in a week, and nine per cent of women drink more than six units. People in the highest income groups are more likely to drink alcohol five days a week than those in the lowest income groups.[3] Hospital admissions of 55–74 year olds (454,317) for alcohol-related health problems are eight times higher than for 16– 24 year olds (54,682).12

Dementia – some 800,000 people in the UK have some form of dementia (2012 figures), including 17,000 with early onset dementia. Risk and prevalence of dementia increase with age, from one in 1400 of those aged 40–64 to one in 100 in the 65–69 age group, one in 25 aged 70–79 and one in six aged 80+. With the increasing numbers of people surviving later into old age, prevalence is predicted to rise one million by 2021 and to over 1.7 million by 2051.13

Wellbeing and longevity

People's sense of wellbeing is an important measure of how well a society is doing. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is used in population health surveys in England and Scotland to measure positive affect (optimism, cheerfulness, relaxation), positive interpersonal relationships and positive functioning (energy, clear thinking, self-acceptance, personal development, mastery and autonomy).

The maximum WEMWBS score is 70. In England the average score in 2010 was 51.0. People aged 55–64 scored on average 51.5 (51.2 for men; 51.8 for women). In Scotland the average score was 49.9, with the highest average scores among the 16–24 and 65–74 age groups.

The English Longitudinal Survey of Ageing (ELSA) research programme has been collecting data on consecutive samples of people aged 50+ since 2002/03. The surveys include questions about participants' satisfaction with life, sense of autonomy and control and loneliness and depression. The findings reveal a clear link between physical illness and disability and depression:[14] people aged 50–64 with physical illness or disability report the lowest levels of wellbeing and high levels of depression. In all the 50+ age groups, cardiovascular diseases and hypertension and diabetes are linked to almost double the rate of depressive symptoms.

There is also a link between enjoyment of life and the development of physical illness and disability.[15] People who reported the lowest levels of enjoyment of life in 2004–05 were at four times greater risk of developing physical illnesses and disabilities over the next six years than those with the highest levels of life enjoyment, and even the intermediate group had three times higher risk. Death rates among those reporting the least enjoyment of life were three times higher than among those with the greater enjoyment of life, independent of any socio-economic factors.

Attitudes to ageing

There is a clear link between attitudes to age and mental wellbeing. Research has shown a relationship between feeling younger than actual age and increased levels of life satisfaction[16] and that feeling older is associated with poorer psychological wellbeing among people who have more negative attitudes towards ageing.[17] It has also been found that older people with more positive self-perceptions of ageing live longer than those with less positive self-perceptions.[18] Other research[19] has found that people's age identity plays an important role in cognitive ageing: people with younger age identities tend to be more optimistic about their ability to maintain memory and other aspects of cognitive ability, regardless of their objective age, although the results were more significant for women.

These findings highlight the importance not just of positive attitudes to ageing but also of tackling age discrimination and ageism among younger people to protect mental health in older age.

Age discrimination

Age discrimination has been identified as a particular problem in mental health services. Frequently reported problems include withdrawal of adult mental health services at age 65 and automatic referral to older people's services regardless of the individual's needs and circumstances, restricted access to services available to the working age adult population, and failure to identify and treat depression and mental illness in older people who are at high risk.20 The Equality Act 2010, the last sections of which came into effect in October 2012, has made it illegal to discriminate on grounds of age in the provision of services across all sectors, including health and social care services. This represents a significant improvement for older people's rights to the same standards and quality of services and gives greater urgency to the work of addressing ageism and age discrimination. Department of Health guidance21 states that clinical decisions should be made on the basis of assessed need, not chronological age.

Health inequalities

The ELSA studies also demonstrate the stark differences in health and life expectancies in people aged 50+. Between 2004 and 2006 only 0.2% of the richest fifth of people in the sample aged 50–59 had died, compared with 2.5% of the poorest. This mortality difference was strongest in the younger groups.[22]

There is also clear evidence of health inequalities experienced by people from ethnic minority communities in the UK. These are due in part to greater risk of some preventable disorders among particular ethnic groups, but also to socio-economic factors and to inequalities in access to healthcare services and poorer quality of care received.[23] There is also evidence of (and criticism of the lack of research into) health inequalities among migrant populations in the UK, including the finding that the health of migrants may deteriorate over time following their move to a new country.[24]

The Whitehall longitudinal study of over 10,000 civil servants, initially aged 35–55 when the survey started in 1985, provides further evidence of health inequalities.[25] While physical health deteriorated in all occupational groups at older ages, and mental health tended to improve with age, people working in lower occupational grades aged faster in terms of health deterioration and their improvement in mental health was slower. Retirement was associated with improvement in mental health for people in the higher grade occupational groups, but not those in lower grades. The researchers suggest that low social status stifles social participation and autonomy, which in turn harms health by prompting chronic biological stress responses.[26]

Friedli[27] argues that inequality per se is associated with poorer health and wellbeing, greater risk of illness and more likelihood of early death, due to the body's stress responses and its effects on cardiac health. She cites the wealth of evidence showing that relative poverty is more harmful than absolute poverty.

Ageing well?

The Age Well research findings paint a mixed but broadly positive picture of the present and future health and wellbeing of the baby boomers in our samples, and the degree to which their lives have prepared them for and guarded them against the mental, emotional and physical challenges that ageing present.

Concerns about health

Health was a concern for some, but not for many others: the Getting On web survey found that overall 52% said they were concerned about their health now, but 40% were in good health, in their view, with no current health concerns. The number admitting to concerns rose when the survey asked about the future: 68% said they were worried about future health, and only one in ten (21%) continued to be confident of good health in older age.

'Painful hip, weak bladder, bad back, lack of energy etc.... husband's Parkinson's Disease limiting our joint activities. Awareness that most of life has passed.'

One said simply: *'My body is beginning to let me down...'*

The YouGov survey produced a similar but more detailed picture. It asked people to identify the three things they were least looking forward to in their later years, aged 70 and over. Poor health was the greatest concern for about half of people born 1946–1955, and particularly for men, who were also more worried than women about loss of mobility. A similar number were concerned about loss of mental abilities in later life (see Table 1).

Table 1: Concerns of people born 1946–55 for when older: physical and mental health

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

Source: YouGov survey, 2012

The YouGov survey asked people about their mental health as they got older. More than six out of ten in the 1946–55 cohort said they were concerned about their mental health in older age; 70% of women and 67% of men expressed a particular concern about dementia (Table 2). More than a quarter were also concerned about having depression but around half agreed with the statement that older people are no more likely to get depressed than younger people, suggesting a robust attitude that depression is not an inevitable feature of ageing.

Table 2: Concerns of people born 1946–55 about mental health when older

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

Source: YouGov survey, 2012

The survey sought to explore respondents' attitudes to help-seeking for emotional issues: are the baby boomers any more emotionally literate and articulate than previous generations? Respondents were asked whether they had ever visited their GP for advice because they were feeling stressed, anxious or low over a period of time. Some 43% of the 1946–55 cohort said they had, and significantly more women than men (52% v 32%). By comparison, 31% of people born in the 1936–45 population group and 19% of those born between 1925 and 1935 had sought help for emotional/mental health issues from their GP. While this may reflect an increase in prevalence of mental distress among the baby boomer group, it is more likely to reflect an awareness of psychological problems and a willingness to do something about them, particularly among women.

There was also a greater willingness to talk to family and friends about emotional troubles. When asked who they would be likely to talk to if they were feeling stressed, anxious or low over a period of time, the greatest number of the 1946–55 cohort said their spouse or partner (70% men; 50% women), followed by their GP, friends and other family members. Around 13% said they would seek help from a therapist or counsellor – almost twice the level of those born 1936–45 (7.7%) and still more than those in the 1926–35 group, of whom only five per cent ticked this option. Likelihood of consulting a therapist or counsellor was clearly an upward trend: it was highest among the 1956–65 age cohort, at 16.4%.

People were asked to rank the importance of both their physical and mental health. Eight out of ten considered both mental and physical health to be very important, but women gave them higher importance. This, and the 20 point difference between men and women in their willingness to seek help from a GP about mental health issues, demonstrates that the known difference between the genders in their awareness of and attitudes to health problems persists into old age.

The YouGov survey also sought to identify how much respondents felt it was in their power to act to protect their health, and here a clear knowledge divide emerged. More than a quarter (26%) said they didn't know much about the effects of ageing on mental health, in comparison with only 15% who said they knew little about the impact of ageing on physical health. Again, there were significant differences between men and women (8.5% v 13.3%). Asked about their ability to influence their mental health, 27% overall said 'not very much' (29.8% men; 24% women); only 17% (14.3% men; 15.2% women) thought they had a lot of influence. This suggests a worrying lack of knowledge and information about what protects and promotes good mental health in older age.

The in-depth interviews provided some insights into the experience of mental illness among this group. Bereavement, difficulties at work, children's illness or disability, relationship breakdowns, forced marriage, childbirth and caring responsibilities were all described as having contributed to periods of feeling low and depression. For many however, their experiences of feeling low were brief and few had thought about their mental wellbeing in old age, beyond a concern about the possibility of dementia. That said, those who had given it some thought offered very practical responses:

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

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

Health and social care

Concerns about the adequacy of NHS care in their older age were expressed in both the YouGov and web surveys. More than one in five people (23%) in the YouGov survey listed adequacy of health care services among their lists of concerns about ageing.

Among the in-depth interviewees, there was a strong appreciation of the importance of the welfare state, and especially the National Health Service, alongside concerns about what might be available for them, and clear sense of entitlement.

'... you're aware of what people don't have, in other countries, so it's not something I'd want to take for granted. It would be very helpful, for one's quality of life in the future, but… let's say I'm not counting on it – meaning that I'm aware that it might not be there.' Female, born 1955.

'I'm not one for private health insurance. I am expecting the National Health Service to look after me... because I've contributed towards that, and I have quite a simplistic view that, you know, that I've funded it and therefore I expect my sort of return'. Male, born 1953.

In the web survey, 60% overall said they were concerned about how their future care needs would be met, and only a quarter had no concerns. Nearly three quarters (73%) said they expected to get support from friends/ family in future. Only 12% had no expectation of this kind of help. Concerns included the numbers of people who would be looking for help, the availability of care and what would be provided:

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

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

A number mentioned their caring responsibilities for others, for example children with disabilities or health problems, and their worries about them in the future.

Independence and autonomy

The YouGov survey asked people to prioritise their greatest concerns about getting older. For 40% loss of independence and needing care for daily needs was a primary concern, with women more concerned than men (42% v 36%). People in the more affluent ABC1 social groups were slightly more concerned than those in C2DE (41% v 37%).

The face-to-face interviews also explored people's views about their own possible future needs for help and the sort of help they would want. Independence and autonomy featured strongly in their responses.

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

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

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

Some of the respondents to the web survey were already planning ahead to maximise their independence in old age.

'I would like to think I could arrange it, to anticipate and do something, rather than stick my head in the sand and assume others will sort it out for me. I think that's about staying in control, I suppose, and choosing where I go, rather than having to go somewhere in a crisis.'

'We now live in a nice area in a manageable house and can easily get to the bus, shops and supermarket which we couldn't do in our last, huge, freezing cold house.'

'I have my eye on this rather nice residential sitting, so you buy your own place but there is a warden. But if you actually leave it too late to get into that sort of accommodation, then you know, you have to go into the nursing home.'

One interviewee planned to apply the values of her youth to her plans for older age:

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

Attitudes to ageing

It was clear from the website survey responses that most of these baby boomers did not think of themselves as 'old' – 57% said people generally start to be described as 'old' at age 65+. Moreover, nearly a third (31%) were happy to be their current age (although 40% said they would like to be younger than 45 again). One respondent voiced a (arguably typical) refusal to conform to the conventions of old age:

'[My parents' generation] were brought up to think that they were old once they were past 40 and their attitude to life was that you reached a certain age and you only did certain things. They had a different attitude altogether. They would never have thought of going abroad or popping over to France for a day, it's a different attitude to life. They considered themselves old.'

Their descriptions of what old age meant clearly did not refer to them:

'[Old is] older than me! Most people have retired by this age and many are less active.'

Most of the website survey respondents (62%) said they thought about life mostly in terms of the time they thought they had left; just 38% said they thought mainly back to the life they have lived.

There was a sense too that, while the rest of society might be telling them they were old, they didn't feel it.

'Middle age seems to stretch further these days. I'm 61 but wouldn't see myself as fitting into the "older people" bunch.'

They valued what older age had brought in terms of (for these respondents, at least) money and the wisdom and confidence to live life as they wished:

'Old enough to have learned a bit about life and to have some money but young enough to be able to enjoy it.'

'Still looking good, not too many changes in energy, body etc and better job opportunities. Plus the wisdom and confidence that age brings.'

Other advantages of being their current age included greater self-confidence and confidence in their own values and beliefs:

'Life experience. Knowing my values and principles and sticking with them. Not being afraid to be "different". Not being afraid of being on my own, enjoying my own company.'

Some, however, spelled out the negatives of an ageing body and an awareness that they had fewer years ahead of them and many more behind:

'... not as agile. Frustrated because of all the things I would like to do but can't because of family responsibilities and will run out of time before I can do them. Lack of confidence.'

Conclusion

The cross-section of baby boomers represented in the Age Well surveys and interviews demonstrate a good level of awareness of health and mental health issues, but a worrying lack of knowledge and sense of urgency about what they might be doing now to avert cognitive decline and maintain physical and mental wellbeing in their later years.

As to their likely health in older age, the statistics tell a rather different story to their self-reports. Poor health behaviours and unhealthy lifestyles suggest that baby boomers will be no healthier than previous population groups, and may not enjoy a healthier old age: medical advances may be able to prolong their years of life but may not guarantee that they will enjoy these years in good health.

Occupation can significantly influence both health and healthy life expectancy; manual labour is, by definition, far more demanding physically and can carry greater health risk. Stress levels, which are a significant determinant of wellbeing at work, also vary widely, depending on occupation and workplace environments. Our surveys did not drill down to this level of detail. This is an area where more research is required.

These baby boomers are well aware of the challenges of old age; among their greatest concerns is loss of autonomy and independence. They are also anxious not to

burden their children with their care in old age, while also expressing confidence that this care and support will, in most cases, be readily forthcoming (see also chapter three). Yet, while some talked about making alternative plans for their future care needs because of their fears about the quality of NHS and social care and its ability to care adequately for them, none had taken any concrete steps to do so.

However their attitudes to ageing, their refusal to identify as old and the greater proportion that look forward to their years of life ahead, bode well for their mental health and wellbeing in older age, and their capacity to challenge and change ageist attitudes and assumptions.

The wider evidence base suggests that people from black and ethnic minority communities within this age group are likely to have poorer health, for a range of socio-economic reasons, not least of which may be racism and the experience of migration into the UK, with their risks to health and wellbeing. The evidence on health inequalities also highlights disparities between the health and life expectancies of richer and poor and between north and south in the UK, as well as between the four countries. These are all factors that will undoubtedly influence the health and life expectancy of the baby boomer group, despite the hugely improved healthcare they have received throughout their lives (for those born in the UK), thanks to the NHS.

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Section 2

Families and relationships

The 1960s and 1970s were a time of major social reforms affecting family relationships, including the limited legalisation of abortion, divorce and homosexuality and the introduction of the contraceptive pill. These have all had a major impact on the lives of the baby boomer group, particularly in comparison with older groups, and have also resulted in major social change in family relationships.

Family relationships and friendships are essential to mental health and wellbeing at any time in life, but arguably even more so in older age. Older people's vulnerability to social isolation and loneliness is much greater, and their capacity to increase their social engagement and networks is much more limited.

Family relationships

Contrary to their free-lovin' image, the 1946–1950 cohort of baby boomers married young and had the highest marriage rates in the 20th century. However divorce rates almost trebled in the 1960s and doubled again between 1970 and 1972, when divorce reform came into effect. Almost one in three marriages in the second half of the 1970s ended in divorce. The age at which people divorced also fell, and marriages ended in divorce much sooner. More than a quarter of people born between 1946 and 1950 had divorced by age 40 and one in four children born in 1979 had experienced the divorce of their parents before they reached age 16. But rates of remarriage were also high.[1]

Over the past decade there has also been a rise in divorce rates among people aged 50–59 and 60+, with a peak in 2004.

Cohabitation has also become much more common. In the 1960s fewer than one in 100 people cohabited: of the baby boomer group, 6.5% of men and 5.5% of women currently cohabit, mostly following a divorce or separation.[2]

Married people tend to enjoy better health and longevity.[3] Divorce in later life can lead to isolation, lack of support and care and loss of role. Divorced men are thought to experience more ill effects than widowed men as they are more likely to lose touch with support networks.

Baby boomers appear to be well-supplied with children to support them in their old age, although the high rate of divorce and remarriage means that some will be step-children. Around 75% of men in the 52–59 age group have natural children and 11.5% have step-children; 82% of women have natural children and eight per cent have step-children.[2] A similar pattern is found in the 60–69 age group. The higher percentage of men with step-children reflects their remarrying into families with children.

Surprisingly, lone parenthood is not characteristic of this baby boomer group; rather, baby boomers have married, divorced, cohabited and remarried, gathering children along the way. In 1977 ten per cent of births were outside marriage, double the level at the end of the war (although this continued to rise to 38% by 2000) and five per cent of the 1946–1950 cohort were lone parents at age 30. This increased to 12% of women born in the years 1961–65.

Support and care

Baby boomers have been described as a 'sandwich generation', responsible both for the care of their own children and that of their ageing parents, who are living longer at a time when public provision is failing to keep pace with their growing care and support needs.[4]

A national survey of carers in households[5] found that 12% of people aged 16 or over in England were informal carers for a sick, disabled or elderly person – some five million adults and three million households in England. But the highest levels of caring were provided by baby boomers aged 55–64: 18% were responsible for care, compared with some seven per cent of 16–34 year olds and 16% of 45–54 and 65–74 year olds. Only 18% of carers aged 55–64 who looked after someone in the same household received Carers' Allowance; 56% cared for someone who received Disability Living Allowance or Attendance Allowance. But 91% of carers in this age group said they had not been offered a carers' assessment. The overall picture is of a population group carrying a large burden of informal care with little recognition and at some personal cost.

Living alone

Living alone has been highlighted as an emerging social problem. National statistics show a trend towards people living in smaller households:[6] 29% of people now live on their own, up from 27.8% in 1996 and 17.7% in 1971. People aged 45–64 living alone are responsible for much of this increase: in 1996 1.59 million people of this age lived alone; in 2012 it was 2.42 million. Over the next 25 years an estimated two thirds of the projected increase in numbers of households in England will be people living alone and one third of them will be over 65.[7] In Scotland, one-person households are set to increase from 37% to 45%, with numbers of women over 65 living alone set to grow by 50% and men by 90%. Men comprise more than half of those living alone (59%) and their numbers have increased at a greater rate. There is also a clear income gradient: men with no educational qualifications are almost twice as likely as those with higher educational qualifications to live alone (18.7% v 9.5%).[8]

For some it will be a positive lifestyle choice. However living alone is known to pose risks to mental health and wellbeing, particularly in older age.

Loneliness

Relationships – intimate, with the wider family and with friends and colleagues – are good for all of us, regardless of age. Friendships complement family networks in providing support. A growing body of evidence recognises the role that informal personal relationships can play in preventing and reducing health problems and risk of depression.[9]

Loneliness affects people of all ages; it is not an inevitable symptom of ageing. However older people are much more vulnerable to loneliness, and its ill effects can be more devastating in older age.

Loneliness and isolation are linked with poor physical and mental health and wellbeing in old age.[10] Lonely middle-aged and older adults are at higher risk of hypertension and blood pressure. Lonely people are more at risk of depression, sleep problems and fatigue and low energy. Loneliness has also been linked to cognitive decline and dementia in older people.

There is evidence too that socially engaged older people are at lower risk of cognitive decline and are less likely to have dementia. Rates of Alzheimer's disease almost double among lonely older people. It is also a significant predictor of disability among older men living alone.[11]

The 2010 Mental Health Foundation report The Lonely Society[10] concludes that risk factors for loneliness accumulate in old age. Poverty is one of the main factors, reducing people's freedom to get out and ability to take part in social and leisure activities in the community. An Age Concern report in 2008 found that some 1.2 million people over 50 were severely socially excluded, meaning they had almost completely dropped out active engagement with their communities and society in general.[12]

'I enjoyed the year when I was 25 and in my head I am still that person'

However one survey[13] has found that baby boomers are less likely than younger age groups to say they are lonely (76% of 60–69 year olds said they were 'not lonely at all' compared with 40% of 18–29 year olds). The same survey found that, across all age groups, only three per cent said they were 'very lonely' and only a small minority (7%) of older people said they were lonely or isolated (11%). But there was a clear association between living alone and experiencing loneliness. Of those living alone, 17% rated themselves as often or always lonely, compared with two per cent of people living with others; similarly, 80% of people who described themselves as 'often lonely' lived alone. The most at risk of loneliness were the very old, women, the non-married, the physically and mentally frail, people with no educational qualifications and the very poor – factors that are often inter-related.

Social engagement

A sense of belonging to a community is equally important. A 2008 study found that 'anomie' – disengagement from any community – had increased in most parts of the UK in the previous 30 years.[14]

It is known that living in areas of high ethnic density is protective of health and wellbeing for people from that ethnic minority group, arguably because it protects against racism and provides supportive social, family and community networks.[15]

The latest report from the ELSA study[16] argues that access to public transport is essential to maximise wellbeing and reduce the risk of loneliness among older people. A local bus or train service gives older people (who may no longer be able to drive or afford to run a car) independence, autonomy, a means to keep in touch with friends and family and access to public, community and leisure facilities.

The 2008 Foresight Mental Capital and Wellbeing project makes a very clear statement about the need not only to improve diagnosis and treatment of mental ill health and cognitive decline in older people but also to take steps to enable older people to continue to stay engaged with and make an active contribution to society, in order to promote wellbeing.[17] The range of initiatives

'I hate the expression Baby Boomers, but that generation probably had more freedoms than any before or since'

it lists include promoting social networking (educational and social activities to address isolation and loneliness, volunteering, contacts with friends to improve quality of social relationships); continued learning in older age, which is protective of cognitive function, and employment beyond retirement age.

In the 50–59 age group, almost 40% of women and a third of men aged 50+ do not belong to any group or organisation, and this civic and community disengagement increases with age.[16] There is also a clear class and income divide: people in professional and managerial jobs are more likely to be members of organisations; organisational membership is lowest among women in routine and manual jobs and men in intermediate jobs. Fair or poor self-rated health is generally associated with lower organisational membership, particularly for women.

Participation in social and cultural activities is common in the 50–59 age group:[16] 94% eat out at least sometimes; 70% of women and just over 60% of men go the theatre or opera and 60% go to the cinema and art galleries.[16] However there is a falling off in all these activities over the age of 50 and this escalates with increasing age. Again, there are occupational group differences: men in routine and manual roles are least likely to take part in social and cultural activities; women in managerial and professional roles are the most social and culturally active. Poor health reduces social and cultural participation by over a third among men.

Baby boomers are increasingly well-connected in terms of new social media. Some 70% of people aged 55–59 and 80% of men and 75% of women aged 50–54 own a mobile phone and 60% of men and around half of women age 50–54 use the internet.[16]

Religion and spirituality

When discussing the question of the significance of spirituality for the 1946–1955 baby boomer group, it is important to make a distinction between spirituality and religious belief. Spirituality can be defined as a broader search for meaning and purpose in life; religious belief involves belief in a higher power or deity.

It is clear from the literature that religious and spiritual belief can make an important contribution to wellbeing and that belonging to a faith community can be protective of good mental health, for a range of reasons, not least of which is being able to call on their faith community for help in times of distress and need.[18] Their faith communities and beliefs will also have different meanings and importance to ethnic minority groups, and to different generations within these groups.

Findings from a British Social Attitudes survey[19] suggest that belief in God is highest among older age groups: 55% of respondents aged 55 to 64 expressed a belief in God compared with 66% of those aged over 75 and 44% of respondents aged 45 to 54. This is in the context of an overall decline in religious belief from 69% in 1983 to 46% in 2009.[20]

Ageing well?

Our research told us that friends and family are important to baby boomers.

Some three quarters (74%) of web survey participants said they had friends and family who would give them support in the future.

'The support of my family and my circle of friends helps me to feel positive about the future.'

Asked where they would turn in times of trouble, respondents said they would turn to their family and friends. However, only a minority felt that they should expect their children to provide care for them, if they needed it in the future.

'Pray and ask my family and friends to advice and help if they can offer either or both.'

'Knowing I am part of a mutually supportive network of family and friends.'

'Good advice and help from friends.'

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

That said, only some 40% in the YouGov survey said that spending more time with their partners and families was one of the top three things they looked forward to when they were older.

Loneliness was very real concern to a small proportion in the YouGov survey: 10.6% of baby boomer respondents flagged up isolation and the possibility of loneliness as a concern. Women were more likely than men to be worried about loneliness in old age (12.3% v 8.7%). Some baby boomers were particularly concerned about the loss of friendship when they retired from work.

'I suppose initially it seemed to be the human contact because at work there was like 100 people or so that you bumped into during the day and had those sort of relationships with, so it think that's something that's been of concern.'

'I suppose do what I can not to end up isolated. And it's like your significance becomes bound up in what your job is. You know, that's like when somebody gets labelled as a retired person, it's like, "Well they don't matter any more".'

In-depth interviewees described a huge array of different friendship models but not all were particularly close or necessarily ones on which they would call for support:

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

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

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

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

Reflecting the wider research findings, many people interviewed for the research did not attend a place of worship regularly, but religious or spiritual belief was important for some, and a source of emotional as well as spiritual comfort:

'It's (my belief) ongoing but very low key… it constitutes a rock in the background… a resting point. It's very helpful.' Female, born 1951.

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

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

Conclusion

The decline of the family, as evidenced by increasing divorce and cohabitation, has been cited as evidence of social destabilisation and moral decline, but this is not reflected in the baby boomers in our surveys and interviews. There was an awareness of the importance of family and also of friends and community networks in providing emotional support in later life.

Living within supportive community networks may be of particular importance to people from ethnic minority groups, for cultural and spiritual reasons. People who have migrated into the UK are also likely to have lost important family ties and networks, or may struggle to maintain or regain them.

Statistically, baby boomers may be at greater risk of isolation in older life; increasing numbers are even now living alone, and divorce and separation has meant that many are no longer in the marriage partnerships that were more common in their parents' generation. However many remain actively involved in societies and continue to take part in leisure activities and participate in their communities. Loneliness was not a major concern to most of those surveyed.

There is a clear income difference in the risk of loneliness and isolation in old age: the more affluent may be protected from social exclusion and disengagement by their greater ability to maintain participation in social, civic and leisure activities. The less affluent, and single men in particular, will not be so protected, and the growing withdrawal of essential public services, such as public transport and community centres such as libraries, is likely to make their plight rather worse. Another important protective factor, belonging to a faith community, is also much less common among baby boomers than in previous population cohorts.

New technology is helping to overcome the fragmentation of family networks and baby boomers are, for the most part, confident in its use. However electronic contact may be harder for less affluent older people to maintain, partly because of the cost but especially if local library services and public transport are withdrawn.

Changing family structures and relationships have implications for future support and care relationships. Divorce and remarriage rates raise questions about how much support will be provided by children and step-children in later life. But these baby boomers are anxious to maintain their independence and autonomy in old age and to avoid wherever possible, becoming dependent on others, whether family or friends. For those with money, this will always be more of a possibility than for those without.

'I grew up in an era when we genuinely believed we could change things for the better, we hadn't got this dreadful scepticism… we still believed in the perfectibility of people and society'

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Section 3

Work, occupation, retirement, and financial security

Being older used to be synonymous with being poorer. The financial circumstances of people above state pension age (SPA) have improved since 1979. However a significant proportion of those living on pensions continue to experience poverty, and rates of pensioner poverty in the UK remain above the EU average.[1] There is also a clear age gradient: older people get poorer as they get older.

Increases in average incomes in retirement have resulted from better occupational pensions for some, greater savings and investment for some and, very recently, improved indexation of state pensions with the cost of living. For baby boomers the question is whether these improvements will continue to hold true for them. The current economic crisis is likely to have affected baby boomers disproportionately by reducing the value of their savings and housing wealth and the returns they can expect from pension funds, and at a time when they are less able to make good any shortfalls.

Economic highs and lows

Baby boomers born between 1946 and 1955 have lived through a period of massive economic change. They were born into an age of austerity, as Britain and its economy were struggling to recover from total war. They have lived their lives against a background of innovation and expansion: new products, new technologies, and new ways of working; new skills and roles and huge social change driven by economic development. They are reaching retirement age in a time of growing global economic inequality, globalisation and international financial crisis and recession.

Post-war reconstruction in the 1950s led to a rapid growth in output and near full employment. For some 30 years the UK and other Western economies experienced a period of unprecedented prosperity. The 60s were described by commentators as the most prosperous decade in human history.[2]

There were jobs for all when the first members of the 1946–1955 age group were entering the labour market; young people were able to move easily into and out of work. Economic growth was reflected in new patterns of consumption as people began to have the income to buy more than the necessities of life. Science and technology transformed both the range of goods and services available and the processes for producing them. The consumer society was born. Many of the discoveries and innovations that are now shaping global business had their origins in research and development in these post-war decades.

Services also grew to support these new industries and to meet growing demand, including advertising, transport, communications, music and entertainment, and stores and supermarkets to sell the burgeoning range of consumer goods. Public services expanded and the UK began its transition from a manufacturing to a service economy.

The post-war boom came to an end in the UK with the 1973–75 recession, which brought massive job losses in the mining, steel and manufacturing industries, with a consequent further widening of the historic north/south divide. The early 1980s were again marked by recession, with falling output and unemployment that reached up to 20% in some areas, particularly traditional centres of manufacturing and mining, and remained high into the latter half of the decade.

The 1980s also saw a large rise in income inequality, resulting from rapidly growing incomes for people at the top of the income distribution, restrictions on trade union rights and the decline of unionisation, which reduced general levels of earnings.[3] The proportion of

workless households has also grown since the 1980s. This increase in inequality since 1979 represents the first reversal of a trend towards greater equality that began at the end of the 19th century. The inequalities are notably most stark between north and south and between the four countries of the UK, with greater poverty and worklessness in the north, as well as in some parts of Wales, Scotland and Northern Ireland, due to their greater reliance on the manufacturing and coal mining industries.

Education and social mobility

In the 1930s, less than 10 per cent of the population belonged to the professional and managerial class; it is now more than 40 per cent. The baby boomers were major beneficiaries of this very significant change. The expansion of higher education and the raising of the school leaving age from 15 to 16 in 1972 also benefited the younger members of the baby boomer cohort. The 1960s saw a general increase in the numbers of 18 year-olds who went to university, including the baby boomer cohort. Many also benefited from the development of the Open University and other opportunities to acquire academic and professional skills in later life. The baby boomers are, arguably, the most highly educated population cohort to enter their retirement years. This is an important factor in mental health, including mental capacity, where there is clear evidence of the positive effects of learning and education for wellbeing in later years.

Employment and the baby boomers

The overall number of people in employment in the UK has grown steadily since the end of the war, albeit with a significant dip in the 1980s. It now stands at just below 31 million.[4] The increasing involvement of women in paid employment has been an important element in this upward trend, and has been accompanied by a decrease in the economic activity of men.

Male employment began to fall in around 1973 and fell further through the 1980s and 1990s. Women's employment rates increased over the same period from about 59% to 71% in 2012; women now comprise some 45% of the working population. However, 93% of the total increase in women's employment between 1971 and 1993 was in part-time work[5], which is generally less well paid than full time work, with implications for women's earnings, savings and other wealth and pensions.

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

Working status

The trend for people to take early retirement or to become unemployed for other reasons has been declining in recent years. Labour Force statistics from 2011 show that 80% of 50–54 year olds are working, 70% of 55–59 year olds, 44% of 60–64 year olds and 20% of those aged 65–69. Part-time working increases with age: 66% of people still in employment over the age of 65 are working part-time, 30% of 55–59 year olds and 40% of those aged 60–64. The Labour Force survey4 asks people who are working whether they would prefer to work fewer or more hours. People aged between 50 and SPA are least likely to say they are under-employed and most likely to say they are over-employed, indicating they would like to work fewer hours.

A majority of 1946–1955 baby boomers are thus still working and, if they follow the trend among current 65–69 year olds, one in five is likely to continue to work, mostly part-time, after state pension age. One feature of the current recession is that, compared with previous recessions, people over 50 are not at higher risk of losing their jobs. The employment rate for people aged over 50 has fallen by just 0.7% from 2008, compared with 1.7% for people age 25–49. The employment rate among people aged over 65 has actually increased by 1.5%.6 But people with higher educational qualifications are much more likely to be in employment, across all the age groups.

Wealth and region also affects employment rates. Rates of employment are highest for those in the middle quintile for people age 50–64 and the highest quintile for people aged over 65. In other words, the most affluent are most likely to be able to continue in employment. In terms of region, employment rates are much lower in the least affluent North East and North West than in the East of England and the South East. That said, employment rates in Yorkshire and Humber

Moreover, the recession appears to be creating an increase in long-term unemployment among older workers, suggesting that people aged 50+ who lose their job are finding it much harder than other groups to find another one. Age UK analysed the 2010 labour market statistics and found that two in five unemployed people aged 50+ – some 170,000 people – had been out of work for over a year, and that this number had increased by more than half (52%) over the previous 12 months and by almost a fifth (18.6%) over the previous three months.[7] This was the highest percentage increase among all age groups. Significantly, this was the highest level in long-term unemployment among the over-50s since June 1997 when the early 90s recession caused a similar hike in unemployment among people aged 50 and over. The proportion of people aged 50+ who were long-term unemployed also rose sharply – approaching half (43.7%) were unemployed – to the highest level since 2000. While male workers were the worst affected (they comprised over three quarters of those aged 50+ who were out of work for more than a year), long-term unemployment among women aged 50 and over had increased more sharply than in any other population group in the previous quarter, Age UK pointed out.

One feature of the economic downturn in the 1970s and 1980s has been an increase in those not employed. The baby boomers are perhaps the first cohort to demonstrate this trend, which is a factor in growing inequality but also linked to structural changes in the economy. Analysis of economic activity data from 1971 to 2003 shows an increasing number of families had no one in employment and that two million adults who would have been likely to have had a job 30 years previously were out of work.[8] Those whose employment chances have deteriorated most are disabled men with poor educational qualifications and no working partner. There has been a steep increase, too, in the number of non-working adults without a partner or whose partner does not have a job. The proportion has doubled from seven per cent to 14 per cent over 30 years. Most of these 'work-poor' families live on social security benefits and have very low incomes. On the other hand, around two million adults are in work who would probably not have had a job in the mid-1970s. Those whose job prospects have improved most are mothers, especially those with adequate qualifications, good health and a working partner. This means that the number of 'work rich' couples who both have a job has increased.

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

Yet, despite the increasing numbers and growing role of baby boomer women in the workforce, both the income gap and work status differences between men and women remain. The gender pay gap will be particularly important for women who have children and are divorced or who never married, since these groups tend to lose out in private pension building.

Retirement decisions

The English Longitudinal Study of Ageing (ELSA) has highlighted some important factors in relation to employment in the 1946–1955 baby boomer group.[6] Baby boomers are likely to continue working longer, particularly beyond age 55, with the greatest increase coming from part-time work. They are more likely to work beyond state pension age, to be fitter (men) and less likely to have a work-related disability and to expect to continue working into the future.

For men over 50, the most reported reason for early retirement in 2008–09 was sickness or disability; for women it was looking after home or family. However there was a growing trend towards employment in the 55–64 age group between 2002–03 and 2008–09: fewer men retired early on grounds of sickness or disability, and fewer women aged 55–64 retired to look after family members. Broadly, early retirement was due either to a longstanding illness, or having a partner who had already retired (for women), or because they could afford to.[9]

Looking ahead, people were asked about their expectation of still being in work in the future. In 2008–09 48% of women aged 55–59 expected to be in work when they reached retirement age (60), compared with 36% in 2002; the figures for men were 62% and 56% respectively. Nearly a third (32%) of men expected to be working at age 65 in 2008–09 compared with 26% in 2002–03. These expectations were broadly reflected in behaviour.

Working longer

While some are actively choosing to continue to work in older age, longer life expectancy, increases in state pension age and the decline in expected value of some pensions mean many individuals in the 1946–1955 baby boomer group in 2012 are being forced to stay in employment longer.

Unemployment is linked with poor physical and mental health, but the links between unemployment and age-related retirement from the workforce are more complex. How well people manage the transition to retirement depends on a number of factors, including their individual circumstances, attitude to and enjoyment of work, the conditions of their current or past job and availability of suitable employment.

Moreover, leaving employment does not equate to inactivity: people may pursue leisure interests, travel, do voluntary work or take on family caring responsibilities. An important dimension of retirement diversity are the conditions under which individuals are employed and leave their job, including the timing and manner of transitions. What impairs wellbeing is lack of choice: either having little choice but to retire or little choice but to continue in a job perceived as stressful, unrewarding or requiring too long hours.[9,10]

A more recent study of 11 European countries[11] found that early exit from the labour market was associated with poorer wellbeing, especially when the retirement is forced, and that the effects lasted into later life. However, for those who chose early retirement, participation in voluntary activities was associated with higher wellbeing. Another study analysed preferred time use among men and women aged 50–69, using 1997 data from 20 OECD countries:[12] of those in full-time employment, 66% wanted more time to spend with the family or in leisure activities.

Recent research has found that people would be more willing to work beyond age 65[13] if a number of considerations were met: if the job provided flexibility for caring responsibilities, in terms of reduced responsibilities or hours, if they had clear information about their employment and state pension deferral rights after age 65, if their job was satisfying; if they received advice, guidance, help and information about career development and gradual retirement, and if their choices and preferences were paramount, not the agenda of government or employers.

The low chance of finding these conditions in most workplaces bodes ill for the mental health and wellbeing of those in the 1946–1955 baby boomer group who cannot afford to retire at the age they choose.

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

Volunteering

Participation in voluntary activity is known to build social capital and be good for individual mental wellbeing.[15] People who do voluntary work or some form of paid work after retirement, report a better quality of life and more life satisfaction and are less likely to be depressed. However the nature of the post-retirement paid or voluntary work is important: only those who feel that what they are doing is adequately rewarding derive these benefits. Some 10–15% of people aged 50+ interviewed in the fifth wave of the ELSA survey said they were doing paid or voluntary work after the state retirement age, with women more likely than men to be doing voluntary work.[14]

Robert Putnam, writing about the US, has identified a transition from a civically engaged society, where people are socially and politically involved, give to charity and trust each other, to a society of ‘personal communities’.[15] Single purpose organisations are replacing large groups and are more transient, and place-based organisations are being replaced by interest groups with narrower interests. Putnam argues that the baby boomers and their children are leading this decline in community engagement. The major contributing factors that he cites are pressure on time and money, including the particular pressures on two-career families, suburbanisation and commuting, the effect of electronic entertainment, above all television, and baby boomers’ libertarian attitudes and reduced respect for authority. How far this description of breakdown of community and growth of individualism relates to the UK is a topic of ongoing discussion and is particularly pertinent when considering the baby boomer group.

The National Council for Voluntary Organisations (NCVO) published a study of participation trends in 2011.[16] It says participation in volunteering and giving have remained largely stable over the past 30 years but some forms of participation, such as membership of political parties and trade unions, have declined.

Mental health and economic wellbeing

Progress on reducing pensioner poverty in recent decades suggests that fewer baby boomers are likely to be in serious financial need as they grow older. However, one in six is likely to face severe and increasing poverty in older age.

These assessments assume there will be no worsening of state support for pensioners and that baby boomers will draw on any wealth and resources available to them to support their old age. There is already evidence of baby boomers downsizing their housing and accessing their savings to meet the needs of their children, raising questions about whether their resources will be sufficient for all these needs over a longer life.

Having a reasonable level of income and wealth has a positive effect on mental health and mental wellbeing. Higher income and socio-economic status have been found to be associated with higher levels of wellbeing and lower rates of mental disorder, in a distinct social gradient.[17]

The ELSA study has found that greater wealth is associated with greater wellbeing in older age: richer people are less likely to be depressed and more likely to have higher levels of life satisfaction and a better quality of life.[18] The Newcastle cohort study of people born in 1947 similarly found links between mental illness and socio-economic status at birth and over the lifecourse.[19] This study found that women are more sensitive to disadvantage in childhood and men are more affected by their own lack of socioeconomic success in adult life.

As previously reported,[20] it is relative deprivation that appears to cause greatest harm, not absolute poverty per se. Inequality causes chronic low-level stress, which affects, for example, blood pressure and cholesterol levels. Baby boomers are moving into later life at a time when income inequality has never been greater.

Pensions

When people aged over 65 are asked what gives their lives quality, health and independence are a common priority but financial resources are seen as necessary to maintain these.[21] In particular, a car brings independence and the ability to keep in touch with family and friendship networks. An adequate income allows enjoyment of leisure activities and the sense of being a fully participating member of society. Being able to look forward to a secure and adequate pension is therefore likely to promote wellbeing.

It is no wonder that people aged between 50 and SPA are feeling uncertain and anxious about their pensions.[22] Recent changes in the rules on state and private pensions may be experienced as complex, confusing and unfair. The reforms to defined benefit occupational pension schemes have already generated anxiety and anger among public sector employees, while the private sector's shift to defined contribution schemes, in which employees bear the investment and annuity risks, inevitably creates uncertainty as to the adequacy of future pension income.

Many women in the baby boomer cohort are already subject to the reforms legislated in 1995 to increase their SPA gradually from 60 to 65 between 2010 and 2020. More recent legislation has brought forward the SPA for men and women to 66 by 2020 and 67 by 2028.[23] The Government has also recently announced its intention to review and revise SPA at five-yearly intervals, to reflect increased longevity. Many of those approaching SPA will feel that the goalposts are being shifted further and further away. Some 4.4 million men and women will have to wait up to a year longer than expected for their state pension, and about half a million women will wait between 12 and 18 months extra.

The value of the basic state pension (BSP) has also fallen sharply, from 26 per cent of average earnings in 1979 to an estimated 14 per cent in 2012, bringing a drastic reduction in the living standards of those reliant on the BSP. The switch in indexation from the Retail Price Index (RPI) to the Consumer Price Index (CPI), which excludes housing costs and is on average about 1.5 per cent lower than RPI, will further erode its value.[24] Thus baby boomers face declining living standards as they age, and inadequate indexation will affect women more than men because of their lower pensions, greater average longevity and higher likelihood of living alone.

Given the internationally low level of UK state pensions since 1980, policymakers and the pension industry alike have been concerned to promote private pensions. However, two thirds of private sector employers provide no occupational pension scheme and only 16% of private sector employees (three million) are contributing members of such a scheme.[25] Only public sector employees have widespread access to a good final salary pension scheme. But their schemes are under review, with employees facing higher contributions, reduced benefits, a switch from RPI to CPI indexation and having to work longer.[26]

Pension expectations

It has been estimated that about 85% of those aged between 50 and SPA will have sufficient pension income to meet a minimum income standard (MIS) at SPA. The MIS is £11,000 a year for a single person and £15,700 for a couple (at 2011 prices).[27] However, according to an industry survey, the proportion of people judged to be 'on track for a comfortable retirement' is rather lower. About half of employees aged over 50 were deemed to be saving enough – typically married men with stable employment in a large organisation.[28] As noted above, there is a large gender difference in accumulated pension savings at age 56; some in the baby boomer cohort, especially women, will only have entitlement to the state pension (not always the full amount) and may therefore face reliance on means-tested benefits or family members. Confidence that their private pensions will deliver what was promised has declined among employees[28] – an anxiety that baby boomers are likely to share.

Recent research by the Institute for Fiscal Studies[29] suggests that four out of ten people aged between 50 and SPA who are not yet retired will, on retirement, see their current income reduce by over a third from its current level, unless they draw on the capital values of their homes and savings.

ELSA also collected information about income in all the survey waves from 2002 onwards. The average incomes of people aged between 50 and SPA have grown in the five years 2002–03 to 2008,6 and the income gap between people below and above pension age has also narrowed. However there is a growing inequality in income distribution among both people aged 50 to SPA and people aged over SPA.

Housing wealth has been identified as the biggest, and perhaps most fortuitous asset of the 1946–55 baby boomer group. Home ownership is highest of all among this group, although a quarter are not owner-occupiers and will therefore not enjoy the benefits of home ownership and any increase in capital values that might support them in their retirement.

Recent reports from the housing property sector[30] suggest that baby boomers are trying to 'downsize', in some cases to help their adult children repay student debts or buy a house of their own. These baby boomer sellers are rich on paper – in terms of property wealth – but they are short of cash to maintain their lifestyles and family commitments.

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

Ageing well?

The YouGov national survey asked people which aspects of reaching age 70 most concerned them. Just under a third (31%) of the baby boomer group ticked 'financial insecurity' on the menu of major concerns. Finances ranked fifth out of nine options behind 'loss of mental abilities', 'having poor health', 'loss of independence' and 'physical disability'. Women were more likely to express concern about future financial insecurity than men (33% v 28%) as were people in lower social groups (35% C2DE v 28% ABC1). Overall, among all the population surveyed, the proportion of people concerned about future financial security rose with age, from 23% of people born 1926–35 to 34% of those born 1976–85, with women in all age groups reporting more concern than men.

The web survey respondents were also more likely to feel financially secure (50%) than not (39.7%) and to report having no worries about their future financial situation (48% v 41% who were worried).

Some in-depth interviewees described being born to financial hardship but now being fairly comfortably off, or at least better off than their parents.

'I've got enough money and that keeps me happy. I'm not rich, but I've got enough. I spend most of my money on my flat, to make it nice and comfy. Home.' Male, born 1955

'I will have a pension. I haven't got the financial concern which in earlier life I did have. You know, straining to make ends meet, the mortgage, if it went up, giving you a problem.' Male, born 1953

That said, nearly 14% of the web survey respondents were very worried about their financial future in old age. For this group of people, financial worries came second on the list of greatest overall personal concerns for the future, after health. Some specifically mentioned their financial responsibilities for elderly parents.

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

Employment

Work has clearly played an important role in forming the self-identities of the 1946–55 group, providing not just a sense of achievement in life but also friends and friendship networks, as these in-depth interviews showed:

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

'Work has been very, very important... It's not just the work, it's the people, and I'm not very good at separating the two things.' Male, born 1949

'I think doing work is extremely important. I loved being at home with my daughter when she was little, but it actually impacted on how I felt about myself... Yes, working at something is extremely important to me.' Female, born 1951

However for others it was simply a means to an end:

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

A number also identified employment as the cause of mental distress during their lives.

'I did have a situation where I did not get on with my line ... It did knock my confidence. This went on for nine months before I asked to be moved.' Female, born 1954

Around a third of those responding to the web survey were fully retired and one in six were semi-retired. But half were still employed, full time, part time or self-employed. One in ten was either caring for someone, looking after a home/family or long-term disabled (people gave several responses to this question).

Work was still clearly very important to those who continued to be employed. Some were anxious about, and deliberately delaying, the impact of retirement:

'It does a hell of a lot for you. Gives you purpose, maybe it gives you a bit of an identity, it gives you fulfilment. I mean, it gives you hope…work is very, very important.'

'Some of the busiest, most interesting people I know are retired people. It's just very sad that, once you stop working, it's as if for some people your significance has ended.'

'I've sort of consciously kept that role on and not said 'Now I'm retired I'm going to drop it' because that links me into my professional body and keeps an interest going around the profession, which I see … I still link with and also keeps me interested in that outside the home.'

The recent economic recession and reductions in public sector spending have impacted on some members of the baby boomer group, and some interviewees specifically raised the possibility of redundancy.

'I'm not really wanted, although I can see things that need doing in the place I work. They keep trying to match me for jobs I can't do... I'll probably be made redundant next month.' Male, born 1949

'My organisation is having to reduce its budget by a third... I want to go on to 60, but I'm in a good position that if I have to go now, then it's OK.' Female, born 1954

Retirement

Some in-depth interviewees had happily taken retirement, particularly where a pension was available.

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

'I think it's OK to retire at 60. I have a hundred and one projects. Books and articles I wanna write, research I wanna do. I've got a list of projects that will keep me busy for years. Male, born 1953

Others either preferred to continue working, for a range of reasons, or were financially unable to consider retiring.

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

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

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

'Originally I thought I wouldn't get my pension until I was 62. I loved working, but my husband's five years older than me and retired early because of his health. I got to thinking I should retire so we can do things together.' Female, born 1949

Plans for retirement

Only a minority of respondents to the web survey said they planned to retire before age 65 (about one in six). More commonly they said they either planned to work indefinitely/ never retire or to retire at age 70 or 65.

Those who were employed were also asked whether they had made any plans for retirement. Many responded that they had made no plans or mentioned only their pensions. Others had specific activities they were developing, while others were looking to reduce their working hours or were planning changes to work for the future. A number planned to move house, including those wishing to property down-size.

'Yes, paying into pensions and saving as much as possible'.

'I have bought a camper van and intend to travel when I retire'.

'Financial plans made from age 30 expecting to retire at 60 – fortunately on track. Have been developing other interests including voluntary work as part of phasing into full retirement – although I don't regard it as "retiring" as I plan to be active albeit unpaid.'

'When I do finally give up working I intend to down-size, be mortgage free and spend more time on leisure activities and holidays'.

Reasons people gave for taking retirement included ill health, caring responsibilities and to have free time for other interests. Some took advantage of retirement/ early retirement packages. Several mentioned stress and work pressures and others had been unable to find work as they got older.

'Care for family members, and spend more time with partner, and indulge in hobbies.'

'Semi-retirement – was offered early retirement/redundancy – saw it as an opportunity to do something different with my working life.'

'Made redundant, unable to obtain work (IT employment closes at 60).'

'The job (teaching) was becoming increasingly stressful and demanded all my time.'

Some were very clear that, while they were retiring from paid work, they had no plans to retire from life.

'Desire for freedom from deadlines and routine and lack of control over my own life.'

'Wanting time for myself and my family and time to put back something in the community by volunteering.'

'I was offered a good early retirement package and I am keen to travel and have freedom.'

'I had a good and sufficient pension and I wanted to give back but in my time with whom I wanted when I wanted....'

'Thinking about leaving my full-time job and doing a PhD.'

'I hope to sell my house and move to another country to be closer to family. I plan to start a counselling practice.'

For those who had retired, the main differences in their lives were having more time and not being under the same pressures as when working, and living healthier lives, although many mentioned having less money. Some mentioned that they were busier now than they had ever been and many were involved in voluntary work.

'I am in the jargon "time-rich". I have time to do more as a volunteer and to appreciate the company of family and friends.'

'I've had more time to spend with my family, been able to travel more and enjoy lots of different crafts and learning.'

'Less tired, less stress and aggravation from others. Mixing with people that I choose to be with rather than those I happen to work with.'

However those who took retirement on health grounds have had to come to terms with a long-term condition and for some retirement had indeed meant of loss of identity, interest and social life.

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

Some reported a ‘loss of interest in life in general’.

‘Even though I have kept myself busy working part-time, a feeling of unfulfilment or void.’

‘Loss of friends. Less confidence. Ill health.’

The majority (90%) of the web survey respondents said they had more than enough interests to keep them busy. Most (83%) said they had no concerns about having too much free time in retirement. But a small minority (7.7%) were concerned about the loss of what they perceived as purposeful activity in their lives. For these people retirement could be a major challenge, and a source of considerable mental and emotional stress.

‘One becomes less and less visible. The place I’m not invisible is at work.’

‘I think my difficulty really lies in just having one thing to do or two things to do. I can’t imagine never not being busy. That’s going to be my big challenge.’

‘Leaving work and moving away has led to feeling a loss of identity. We are deliberately making a “new life” in our new home area.’

Conclusions

Our survey participants and interviewees seem in the main to be confident of a moderately financially comfortable old age. That said, financial concerns followed close on the heels of health and disability concerns in the YouGov survey and the interview and web survey participants were not a statistically representative sample.

The affluence commonly associated with the baby boomer group has not been enjoyed by all. Income inequalities have grown greater in the post-war years, and particularly since the 1980s. Women’s incomes continue to lag behind those of men. A significant proportion of those interviewed and surveyed, and women in particular, were very concerned about how they would manage financially in their old age. Inequalities continue to apply in old age: a lifetime of low income, worklessness and inability to save or invest in property is inevitably reflected in people’s financial expectations in old age. More information needs to be gathered on the differing perspectives of people from more deprived areas and communities. Moreover, the current economic recession will unavoidably have implications for the annuity-based private pensions these baby boomers can expect to receive when they retire.

Financial necessity aside, some clearly have no wish to retire at all: they enjoy their jobs, find them meaningful and rewarding, and can choose to continue in paid employment. For those with this luxury of choice, and good health, the change to retirement may be a difficult transition and may be a point of high risk for mental health problems, with all their consequences for wellbeing over the ensuing years. It is of note that the proportion of women in employment has risen to almost equal that of men, even if many have worked only part-time (with its implications for their savings and pensions potential).

Others have chosen, or been forced through ill health or family responsibilities, to retire early. The reasons for and causes of early retirement merit further exploration: ill health, disability and that they have not chosen to stop working will inevitably colour a person’s ability to enjoy their retirement years, as will financial considerations.

Whether working or not, the baby boomers in our samples clearly intend to make constructive use of and enjoy their years of greater leisure. They have no intention of retiring from life. Rather, they talk about the greater freedom it will bring to travel, socialise, spend time with their families, and pursue with even more vigour their hobbies and interests, and take up new ones. Some, but not many, are actively engaged in volunteering.

These intentions suggest that the baby boomers, finances and health and caring responsibilities permitting, will age well and in good mental health, which bodes well for their physical health. Their intention is to remain connected, active and busy, which all contribute to greater wellbeing in old age.

But baby boomers forced by poverty and the changing state pension age to continue in employment beyond their preferred retirement age may be at high risk of the stress and mental ill health known to be linked with lack of choice, autonomy and control and psychologically damaging working conditions.

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Conclusions and policy implications

This report has demonstrated that baby boomers are as diverse in their later life as they were when younger. So too are their life experiences, their personal characteristics and their views and attitudes. It is impossible to make sweeping generalisations about a group of people who happen all to have been born within one decade. A number were not even born in the UK and some will have moved here in older childhood or adult life. The influences on their health and wellbeing will have differed greatly, and so in turn will their health and expectations in retirement.

Mental health in later life is shaped by our lifelong experiences, as is physical health. Later life brings new challenges; how we respond to and deal with these challenges is determined by patterns of behaviour, thinking and feeling that were laid down from conception.

Baby boomers have lived through a period of tremendous social change, which has inevitably shaped their life course experiences and their views and attitudes, but they have also shaped the society in which they have grown up and are now ageing. They have been a vanguard for social change; they have done things differently; they have also been the means whereby change has been effected.

The research conducted for this report suggests that some baby boomers are rewriting the meaning of 'old age'. Despite approaching state pension age, they do not regard themselves as 'old'; nor are they necessarily planning for their 'old age'. Rather, they regard growing older as a further stage in life, as a continuation of their present; many are barely contemplating retirement from paid work; many are already enjoying the quality time with their families and friends, travel and hobbies and activities that retirement with a reasonable pension and good health permits. In this respect they bear out observations about baby boomers 'reinventing' old age.

Later life has already changed from that experienced by many baby boomers' parents. In particular, the financial circumstances of older people have improved over the last decade or so, and fewer experience extreme poverty, although the income gap between the richest and poorest in society has widened. The policy focus has shifted towards 'active ageing', reflecting a wider concern with health, wellbeing and quality of life and a deeper understanding of what maintains health and wellbeing and sustains resilience in the face of adversity.

Nevertheless, later life does present a number of challenges, which this report has summarised, particularly for those who do not enjoy robust health or a comfortable income. These are the facts of growing older that baby boomers will need to manage if they are to 'age well'. Income disparities persist into old age, and pensions expectations vary hugely, depending on occupation, work history and gender. More information needs to be collected on the experience of growing old of socially and economically disadvantaged groups and people from ethnic minorities. Many of these challenges pose a risk to mental health but, as this report has made clear, mental illness is not an inevitable feature of growing older. Mental health, including cognitive health, is shaped by lifelong experience and behaviour and resilience accumulated over the life course. And, while we may not yet have discovered a cure or effective treatment for dementia, we do know what keeps us mentally well in later life, and how to achieve it.

Health and mental health

The evidence gathered for this report suggests that, despite the benefits of free health care throughout their lives and medical advances leading to reduced mortality from cardiovascular disease and cancer, baby boomers will be unlikely to enjoy more disability-free years of good health in their old age. Around one half of the baby boomers in the Age Well YouGov national survey were concerned about their future health. Sedentary lifestyles, poor diets, obesity, alcohol consumption and drug misuse place them at risk of diabetes, high blood pressure, heart disease and cancers. Greater risk of ill health is also associated with socio-economic inequalities. It is notable that income inequalities have grown in the decades since the war. For many baby boomers, their increased life expectancy, gained through improved health and medical care, will mean more years in poor health, which in turn puts them at risk of poor mental health. Some ethnic minority groups are at greater risk of certain illnesses, due partly to the adverse effects of racism and migration itself, especially in traumatic circumstances.

There is some evidence of a 'step change' in the prevalence of depression and anxiety at ages 25–34 among men born between 1950 and 1956, although not among women. This rise has been linked to their transition into adulthood at a time of rapid social change. This cohort will be entering another potentially difficult transition as they move from paid employment to retirement; they may carry with them an increased vulnerability to mental ill health, which the current economic climate may exacerbate.

However, this report has identified a number of characteristics of baby boomers that may be protective of their health, or that offer opportunities for protective intervention and policy development.

First, the project's YouGov survey shows that baby boomers rank the care and safeguarding of both their physical health and mental health very highly (women significantly more so than men, perhaps leaving men at greater risk). They are open to disclosing and discussing mental health issues and generally willing to consult their GP, including when feeling low or mentally distressed (women more so than men). This age group is now taking more exercise and eating more healthily. The interviews conducted for the report suggest that current public health messages about exercise and healthy eating are being heard and understood, if not always acted on.

The research for this report also indicates that baby boomers expect the NHS to meet their health needs, are likely to seek help when they need it, rather than ignore signs of ill health, and are also likely to be proactive in their expectations of services to meet their health needs. The implementation of the Equality Act 2010 will help ensure health and social care services are provided on the basis of need; in future older people cannot be barred from treatments available to working age adults. Continuing research is likely to improve treatments, particularly for conditions that are detected early. However the project has also found that many baby boomers are concerned that the NHS, which has supported them throughout their lives, may not be there for them in their old age.

This report has highlighted the need for improvements in the treatment of mental illness in later life. This includes a stronger focus on prevention, identification and treatment of mental illness among older people. The project has noted how the separation of adult mental and older people's mental health services at age 65 has not served older people well, and has often resulted in differential access to and standards of treatment in comparison with that available to working age adults. It is now widely accepted that there is no clinical or moral justification for this separation.

Adult mental health services should be integrated across all age groups and treatment for common mental disorders should be available on the basis of need. Monitoring arrangements are needed to ensure this happens and mechanisms should be put in place to identify and share good practice.

Substance misuse

Alcohol and drug use has been more socially accepted and more commonly used by baby boomers than by earlier cohorts. Excessive use of both alcohol and drugs is linked to poor mental and physical health. In later life it can exacerbate age-related health problems and interact with medication. Social relationships can also be damaged. The evidence shows that older users can be treated effectively but that drug services are not geared up to meet the specific needs of this age group.

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

Promoting mental wellbeing

There is a growing awareness at policy-making, professional and public levels of the importance of mental health and wellbeing to physical health. There is evidence that good mental health may help protect people from the onset of chronic, disabling health conditions and also reduce their disabling effects. This understanding of the relationship between mental and physical health offers opportunities for limiting the effects of chronic conditions by protecting baby boomers' mental wellbeing now. It also indicates the need to promote a more holistic approach in healthcare that recognises the interactions of mental and physical health throughout the life course and addresses both.

Levels of mental wellbeing and life satisfaction increase among people in their 60s but fall off over the age of 70. People aged 70-plus have some of the worst levels of mental health. There is little evidence of mental health promotion targeted at people in these age groups to enable people to protect their mental health. More research is needed on what influences mental health and wellbeing in later life. Current concepts of healthy ageing, and therefore of what works in public health promotion, are not based on the views and priorities of older people themselves but on those of academics and professionals.

Research for the report has suggested that, because of their attitudes to their own ageing, linked to individualism and self-identity, baby boomers are likely to be more responsive to such whole-person approaches and to finding personal solutions to problems.

There needs to be a greater public health focus on promoting good mental health among the baby boomers and older people more generally, supported by better research on factors linked to mental wellbeing in later life, for all ethnic groups. In particular baby boomers' views of healthy ageing and mental wellbeing should be sought. Public health policy makers and Health & Wellbeing Boards need to engage and mobilise baby boomers individually and collectively in activities to maintain good mental health in later life. There needs to be active efforts made to engage people from black and minority ethnic groups in these consultations.

First key finding

Adult health and mental health services should work in a way that integrates services across ages, recognises the relationship between physical and mental health, promotes good mental health throughout the life course and reflects the changing needs and preferences of different generations, and more specifically, the baby boomers as they grow older.

Ageism and mental health

One of the most significant underlying factors associated with mental illness among older people is loss of self-esteem. Self-esteem, optimism and a sense of mastery and coherence are aspects of good mental health that enable people to stay socially engaged and cope with stress and so protect them against mental ill health. Ageism has been identified as one of the greatest threats to older people's mental health. Like other stereotypes, ageism can be internalised by its victims and lead to negative self-perceptions. As one contributor to the project research commented: 'You can't make sexist or racist comments any more in this country… but it's still OK to make fun of older people' (Male born 1946).

Their attitudes to ageing, as expressed in the interviews and surveys reported here, suggest that baby boomers are already rejecting some old age stereotypes. If baby boomers are to reinvent later life so that older people are seen as full and engaged citizens (and consumers), ageism needs to be tackled head on.

The Equality Act 2010 outlaws discrimination on the grounds of age (along with disability, race, religion or belief, sex (gender), sexual orientation, gender re-assignment, marriage or civil partnership, pregnancy and maternity). The ban on age discrimination in the provision of services, its final provision, came into effect on 1 October 2012. This provides a powerful tool with which to focus on ageism and age discrimination.

Second key finding

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

Mental health as a social asset

Baby boomers have survived their 40s and 50s in greater numbers and are generally healthier than their parents. This report has identified the contribution that good mental health can make to people's resilience and their ability to deal with adversity. There is a growing body of evidence on the factors that promote resilience and that may strengthen it throughout the life course. Research has identified the factors linked with poor mental health and wellbeing, and consequently with poorer physical health. Social engagement is one such factor. Keeping socially active and engaged with their local communities and with their family and friendship networks, getting out and about and enjoying social activities and pursuits are known to help ward off cognitive decline and mental ill health and promote mental wellbeing. Keeping physically and mentally active and continuing to make a valued contribution to community and family life protect mental health and wellbeing in old age. A wide range of social and fiscal policies can contribute to good mental health in older age. Access to public transport and to the internet plays a vital role in keeping older people connected, especially those with limited mobility and income. Baby boomers tell us they do not intend to retire from life. They should be encouraged and enabled to continue to contribute their skills and experience outside paid employment. New policies should be evaluated and assessed for their contribution to promoting/impact on mental health.

Third key finding

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

Cognitive health and cognitive ageing

Cognitive decline is an unavoidable feature of ageing, from midlife onwards. Dementia is a well-recognised risk for baby boomers in the future. Already many have experienced caring for parents with dementia and know first-hand the implications, including the pressure on carers.

Research is beginning to identify the lifetime factors associated with dementia risk, as well as the heritability of some dementias. In particular, good vascular health can protect against both Alzheimer's disease and vascular dementia; measures that protect physical health also protect cognitive health; what is good for the heart is also good for the head, and vice versa. Baby boomers are taking more physical exercise and eating more healthily, although still fall short of recommended levels.

But, despite good levels of awareness of the importance of good physical and mental health in later life, research for this report has also found a worryingly low level of knowledge among baby boomers about the actions they can take to protect and promote their own health. Health promotion messages should address this by including information about risk and protective factors for cognitive health, with a particular focus on people in midlife.

Research for the project has also identified high levels of concern among baby boomers, and younger people, about loss of mental capacity and risk of dementia in old age. But there is little understanding of the factors involved and what action people can take. There is a clear need to 'normalise' dementia, and remove associated stigma. Living under the threat of dementia defined in terms such as 'a living death' can create unnecessary fear about ageing and fear of the old.

There should be a public health focus on demythologising dementia that promotes messages about the possibility of living well with the condition. At the same time the importance of early identification needs to continue to be promoted not just among GPs and in primary care but also in places where the general population can be reached, such as workplaces. The new Health & Wellbeing Boards will have an important role here.

Fourth key finding

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

Health and social inequalities

Economic, social and health inequalities have increased since the 1970s. This has created greater income and wealth disparities, a much larger heath divide between richer and poor people and a clear social gradient in life expectancy: poorer people die earlier and live more years in chronic ill health and disability; people in professional and managerial occupations enjoy a longer life in better health. Women, because they tend to live longer, may be more at risk of mental ill health because of their greater exposure to factors that affect this, such as loneliness, disability and pain. Some black and minority ethnic groups are at greater risk of ill health, for a range of socio-economic reasons, including poorer access to healthcare services. There is also evidence that inequality per se is associated with higher rates of mental ill health and, in consequence, physical ill health and early death

Overall improvements in life expectancy, years of disability-free life and mental health cannot be achieved without addressing this inequality gap.

Fifth key finding

Health and social inequalities in older generations, including baby boomers, have a negative effect on the health and wellbeing of the whole community, and on specific outcomes for older people, such as life expectancy and mental ill health. Policies and programmes that impact on older people need rigorous assessment at the development stage to determine their likely impact on inequalities in old age and their potential contribution to reducing them. This needs to apply at UK, national and local levels.

Employment and retirement

Baby boomers have lived through major economic and labour market changes; the notion of a job for life has been transformed into flexible working and portfolio careers. The baby boomers interviewed for this report see work as important. Employment among women has all but equalled that of men, although more of them have worked part-time, with implications for their savings and pension expectations.

The effects of retirement on mental health are well recognised for men. However baby boomer women as well as men are likely to experience the stresses associated with loss of role, status and identity and social networks that can be a feature of retirement.

Changes in state pension age also mean baby boomers will have to work longer than previous generations, with implications for mental wellbeing for those whose occupation or workplace conditions are detrimental to mental wellbeing. Abrupt or enforced retirement is known to be linked to poor mental health. Enabling people retain control of their own retirement, to retain choice about how long they work and what hours, and to move gradually into retirement are all likely to protect their mental health.

Work is also important because it enables people to earn money. Most saving takes place after the age of 50, when people have fewer family and household responsibilities. In the current economic recession, with service cuts, price inflation and low interest rates, and the desire by many baby boomers to maintain their accustomed lifestyles, the pressure to continue working is even greater. There are growing signs that unemployment among people over 50 is growing, particularly among women. Unemployment has serious negative consequences for people's mental health, which are made worse by economic hardship.

It is government policy to promote the employment of older people as part of its approach to an ageing population. There is evidence that, while many people wish to continue working up to and beyond State Pension Age, many do not, for a variety of reasons. The abolition of the default retirement age (DRA) in 2011 has potentially opened the way for more flexible approaches to work. However employers appear to be making slow progress in offering more flexibility.

Sixth key finding

The importance of employment and workplace practices in protecting mental health in an ageing workforce needs to be recognised. Governments, employers, employers' organisations, trade unions and professional bodies need to develop policies that will protect and support older people in employment, promote workplace policies and practices that protect mental wellbeing, and support people to plan for the future.

Finances in later life

Baby boomers born 1946–55 have been fortunate to live through economic times that have enabled them to access employment, build careers and invest in housing. Many have been members of final salary pension schemes, which have largely now been withdrawn or reduced in value. Many other baby boomers will retire with only the State Pension as their source of income, demonstrating still further the inequalities in incomes that typify this cohort. Baby boomers interviewed for this report were concerned about how they will finance their old age.

The value of the State Retirement Pension has eroded substantially over recent decades. Many baby boomers have annuity-based pensions. Both poor performance in the UK pensions industry and poor annuity rates linked to the current economic recession have reduced the incomes people can expect on retirement. Moreover, extended life expectancy means that pensions will have to cover more years of life, and research indicates that few people are saving adequately for their retirement. Financial adversity in later life can damage health and mental health. Poverty is linked with factors that directly erode wellbeing, such as social disengagement and isolation, stress, debt and loss of independence and autonomy.

Seventh key finding

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

Social care

Baby boomers are a 'sandwich' population group: many are, or have been, involved in caring for their parents, other family members, children or friends, and have experienced the pressures on social care services and on themselves as carers.

Many people who participated in the project's research recognised that they are unlikely to be able to rely on public services to meet their future care needs. Many also expressed very strong views about not wishing to lose autonomy, and about retaining their independence and not placing a burden of care on their own children – while expressing confidence that their family would be there for them. But the higher divorce rate among baby boomers and multiplicity of reconstituted and step-family relationships suggests a high proportion of baby boomers may not be confident that children will step into the breach to support them in old age. There is also a high level of concern among baby boomers about care relationships and care quality, in the light of the reduced contribution from the state and the 'marketisation' of social care services.

The Government in England has recently announced its decision on the Dilnot Commission's proposals for funding the care and support of older people and people with disabilities. Although there continues to be debate about where the cap should be set on how much individuals may have to contribute (the Government is proposing up to £72,000), the proposals provide more certainty to enable baby boomers approaching older age to plan for the future.

The personalisation of social care services is, in many ways, a baby boomer policy; its origins lie partly in the radical disabilities movements that were born in the 70s and 80s. Baby boomer professionals and policy makers have been involved in its implementation. It is likely that baby boomers will be more comfortable with the concept of individual budgets to buy the care they need. Keeping control of their care will help them retain independence.

A recurring theme among the baby boomers interviewed for this report is the need to control their lives, to be independent and to have choices. This reflects the individualism that has shaped their attitudes and their lives. Baby boomers will want to continue to be actively involved in decisions about their lives and how best to meet their care needs.

There is a growing view among some baby boomers that arrangements for support and care could be different in the future – they could, for example, include shared independent arrangements, community care hubs and care co-operatives. Given their experience in pioneering different forms of housing and disability care and support in their younger years, baby boomers may prove equally inventive in devising new ways to retain independence in later life. However those interviewed for this report had not progressed beyond thinking about the possibilities.

Eighth key finding

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

Family, community and social relationships

The report has noted the effects of social change on family structures and relationships, on religious belief and participation, on community involvement and on friendships. It has also noted the effects of migration and racism on black and minority ethnic communities within the wider white population. Loneliness and social isolation may be significant future risks for baby boomers whose social and family networks have been broken, for whatever reason. The report identifies that some, particularly divorced and separated women and single people and people with low incomes, are more likely to be at risk than others.

Research for this report suggests that baby boomers enjoy strong family and friendship networks that may extend into older age, offering protection against the ill effects of loneliness and social disengagement.

There is much that public services can do to help protect older people and keep them engaged in their local communities, including provision of free public transport, low-cost leisure facilities, community spaces, and access to computers and the internet.

Ninth key finding

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

Control and choice

A recurring theme among baby boomers is the need to control their lives, to be independent and to have choices. This reflects the individualism that has shaped their attitudes and their lives. The significance of this, for the future, is that baby boomers are likely to want to be part of all decisions that affect their lives. This relates both to the personal level and at a wider social level.

Tenth key finding

Policy makers need to recognise that baby boomers will want to go on being involved in shaping their lives and shaping the contexts in which their lives are lived. This means involving and engaging them at all levels.

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