PENSIONS POLICY INSTITUTE

PPI

Living through later life

Lauren Wilkinson, Senior Policy Researcher, Pensions Policy Institute

Lauren Wilkinson joined the PPI in September 2016 as a Policy Researcher. During her time at the PPI Lauren has produced research on a range of topics, including Defined Benefit, consumer engagement, pension freedoms and Collective Defined Contribution.

Lauren was promoted to Senior Policy Researcher in January 2019.

Prior to joining the PPI, Lauren achieved an undergraduate Masters in Politics and Philosophy at the University of Glasgow, followed by a Masters in Public Administration and Public Policy at the University of York.

Chetan Jethwa, Policy Modeller, Pensions Policy Institute

Chetan Jethwa joined the PPI modelling team in April 2018 as a Policy Modeller. He is responsible for maintaining and developing PPI models as well as producing modelling results and undertaking analysis to feed into the PPI's research.

Chetan has a BSc in Actuarial Science from the London School of Economics.

The Pensions Policy Institute (PPI)

The PPI is an educational, independent research organisation with a charitable objective to inform the policy debate on pensions and retirement income provision. The PPI's aim is to improve information and understanding about pensions and retirement provision through research and analysis, discussion and publication. It does not lobby for any particular issue or reform solution but works to make the pensions and retirement policy debate better informed.

Pensions affect everyone. But too few people understand them and what is needed for the provision of an adequate retirement income. The PPI wants to change that. We believe that better information and understanding will lead to a better policy framework and a better provision of retirement income for all. The PPI aims to be an authoritative voice on policy on pensions and the provision of retirement income in the UK.

The PPI has specific objectives to:

- Provide relevant and accessible information on the extent and nature of retirement provision
- Contribute fact-based analysis and commentary to the policy-making process
- Extend and encourage research and debate on policy on pensions and retirement provision
- Be a helpful sounding board for providers, policy makers and opinion formers
- Inform the public debate on policy on pensions and retirement provision.

We believe that the PPI is unique in the study of pensions and retirement provision, as it is:

- Independent, with no political bias or vested interest
- Led by experts focused on pensions and retirement provision
- Considering the whole pension framework: state, private, and the interaction between them
- Pursuing both academically rigorous analysis and practical policy commentary
- Taking a long-term perspective on policy outcomes on pensions and retirement income
- Encouraging dialogue and debate with multiple constituencies

The PPI is funded by donations, grants and benefits-in-kind from a range of organisations, as well as being commissioned for research projects. To learn more about the PPI, see: www.pensionspolicyinstitute.org.uk

This report has been sponsored by

A Research Report by Lauren Wilkinson and Chetan Jethwa

Published by the Pensions Policy Institute

ISBN 978-1-906284-84-8
www.pensionspolicyinstitute.org.uk

Table of Contents

Living through later life

Executive Summary

As life expectancies have increased, conceptions of retirement have evolved. With many people likely to live for twenty to thirty years beyond State Pension age (SPa), retirement is no longer simply a period of winding down at the end of the lifecourse. This shift has led more individuals to question what retirement is all about, whether they want to or can afford to retire, and if they do, how they want to spend their remaining time.[1]

The diversity of later life experiences reflects the heterogeneity of the population in terms of individual preferences and circumstances, including health, financial and familial considerations. While some older people have a considerable amount of freedom to choose how they spend retirement, many more find their choices restricted by financial, health and family concerns.

While some older people have a considerable amount of freedom to choose how they spend retirement, many more find their choices restricted by financial, health and family concerns.

As the average length of retirement has increased, alongside life expectancies, there is generally more variation in the experiences people will face over the course of later life. Many of these experiences are correlated with age and physical limitations. This report categorises individuals who are either above SPa or under SPa but already retired into three phases of later life:

The Independent Phase of later life in which individuals have low or no physical limitations

The Decline Phase of later life in which individuals have mild physical limitations

The Dependent Phase of later life in which individuals have severe physical limitations and difficulty performing activities needed for day-to-day independent living (Figure 1)

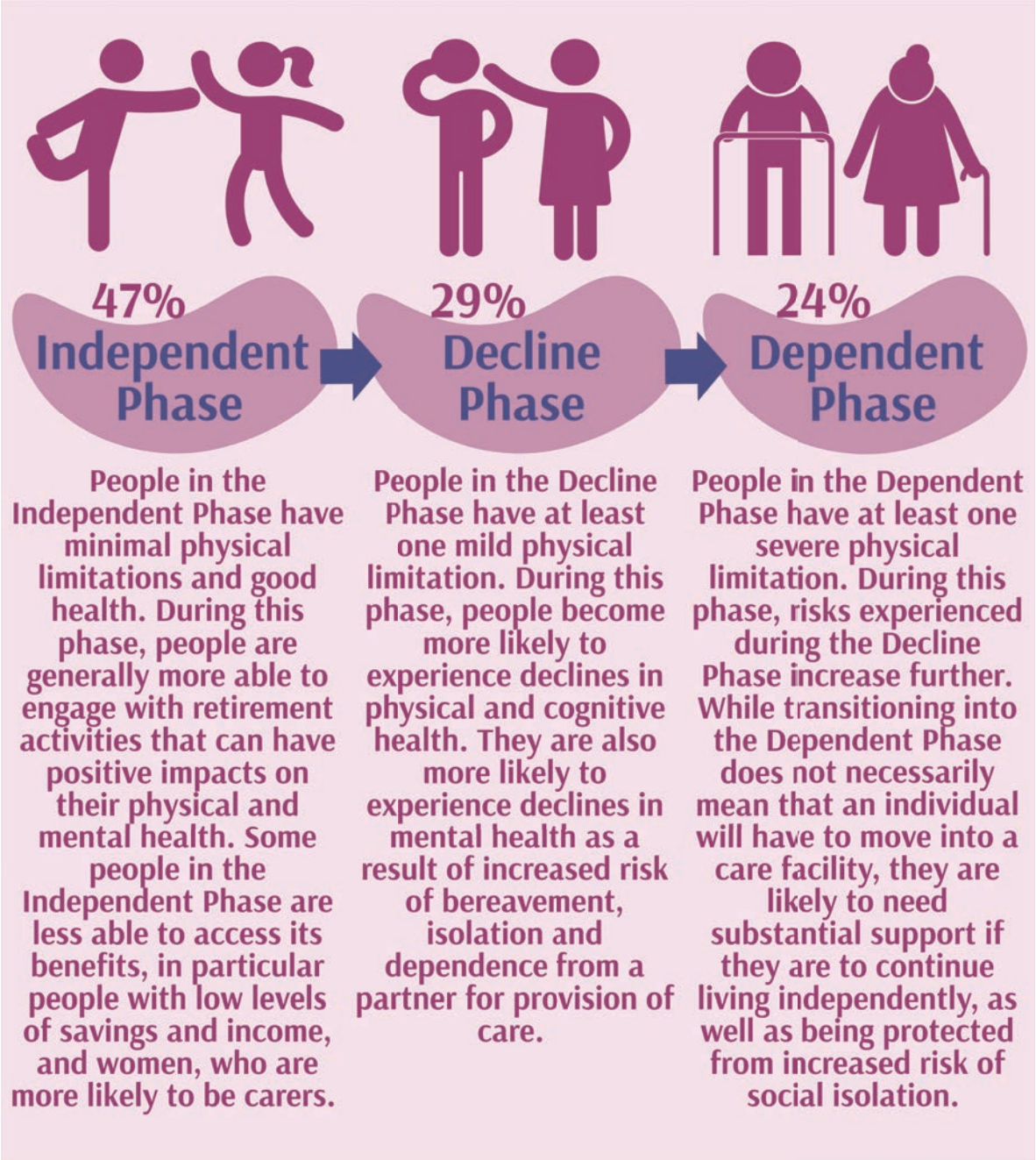
These phases are reflective of current life expectancies, work patterns and retirement provision, and may potentially change in the future depending on the way that these factors evolve.

This report uses data from the English Longitudinal Study of Ageing (ELSA) to identify which experiences and risks are associated with each phase of later life, as well as to analyse the demographic characteristics of each phase.

1. Sargent, Lee, Martin & Zikic (2012)

This is the first of two reports on the subject of Living through later life. The second report will further explore the trajectories of later life experiences as illustrated by a number of hypothetical individuals, particularly in regards to how individuals will fund these experiences and challenges. The second report will also identify where there are gaps in support and safeguards, particularly in terms of policy, industry, advice and guidance, and how these gaps may be best filled.

Figure Ex1



As people transition through the phases the risk of having poorer retirement experiences increases, beginning in the Decline Phase and worsening in the Dependent Phase.

Those who remain in the Independent Phase for as long as possible are likely to have better retirement experiences

The activities and experiences associated with the Independent Phase of later life can encourage healthy ageing, including decreased risk of frailty and physical decline, improved mental health and emotional wellbeing, and enable older people to maintain engagement with social networks and the broader community, all of which are important components of a positive retirement experience. In order to improve later life experiences, older people may need additional support to remain in the Independent Phase for as long as possible.

In order to improve later life experiences, older people may need additional support to remain in the Independent Phase for as long as possible.

Experiences in the Decline Phase are generally more positive than those in the Dependent Phase, but less positive than the Independent. This means that once individuals transition into the Decline Phase, they would benefit from support in maintaining physical health and where possible slowing declines in order to protect them from the more severe risks present in the Dependent Phase.

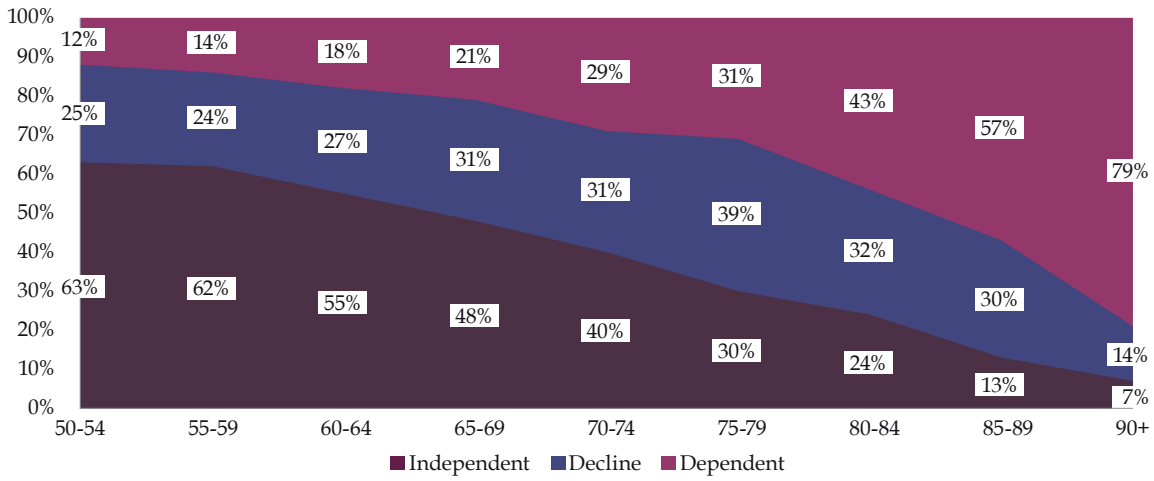
The likelihood of transitioning out of the Independent Phase and into either the Decline or Dependent Phase increases with age

The proportion of people in the Independent Phase is negatively correlated with age, with nearly half (48%) of people in the five years following SPa living within this phase, compared to 7% of those aged 90 and over (Chart Ex1).

Chart Ex1

People are increasingly likely to transition out of the Independent Phase as they age

Proportion in each phase of later life by age



While many older people transition from Independent Phase to Decline Phase to Dependent Phase over the course of their retirement, some die while still in relatively good health (Independent Phase), while others experience sudden declines in health that see them retiring directly into the Decline or Dependent Phase, or transitioning directly from the Independent Phase to the Dependent Phase. People who do not transition gradually through the stages, as a result of sudden health declines, may benefit more from support as they have less time to plan and adjust their behaviour to minimise the impact of declines. Some older people may also backslide between phases if their physical limitations are the result of temporary conditions, however this is less likely than progressing through the phases in order.

Variations in healthy life expectancy mean that some individuals are less likely to experience the benefits of the Independent Phase than others

While the Independent Phase characterises the early years of later life for many older people, others are not so fortunate. Between 37% and 52% of people retire directly into either the Decline or Dependent Phase, assuming they retire before age 70 (Chart Ex1). Those who retire, in some cases early, due to ill health, are less likely to experience the Independent Phase, and those who retire earlier also have, on average, a higher risk of early death, compared to those who retire later.[2]

Healthy life expectancy varies by as much as fifteen years for men and almost eighteen years for women, depending on region.[3] There are also variations in healthy life expectancy according to socioeconomic class. Among those aged 50 and over, one in five (20%) people in routine occupations in England say that age often prevents them from doing the things they would like to do, compared to just 7% of those in professional occupations.[4]

Lower socioeconomic position is associated with:

- Poorer functioning[5]
- Lower age of onset of disabilities[6]
- Steeper trajectories of functional decline[7]

Older people in a lower socioeconomic position or those in areas with lower life expectancies and lower healthy life expectancies are less likely to experience the freedom and benefits of the Independent Phase of later life, and those who do are likely to experience this phase for a shorter period of time than their more privileged peers. Those who worked in higher managerial and professional occupations remain in the Independent Phase until significantly older ages. For example, at age 85 to 89, 35% of this group are in the Independent Phase, compared to just 8% of those who worked in routine occupations.

Older people in a lower socioeconomic position or those in areas with lower life expectancies and lower healthy life expectancies are less likely to experience the freedom and benefits of the Independent Phase.

Because those with lower healthy life expectancies are more likely to skip the Independent Phase and retire directly into the Decline Phase, they are likely to require more support to prolong this phase for as long as possible and protect against the greater risks associated with the Dependent Phase.

Women are more vulnerable than men to poorer retirement experiences as they are more likely to be carers, as well as having a greater likelihood of being in the Decline and Dependent Phases at almost all ages

Carers, who are more likely to be women than men, may find it more difficult to access the benefits of the Independent Phase, even if they are in good health. 18% of women in the Independent Phase provide some form of informal care, compared to 12% of men. This means that women are at greater risk of missing out on the beneficial aspects of the Independent Phase and may experience poorer retirement outcomes in the long run.

2. Wu, Odden, Fisher & Stawski (2016)
3. Age UK (2018)
4. Centre for Ageing Better (2019)
5. Louie & Ward (2011)
6. Jagger et al. (2007)
7. Koster et al. (2006)

Women are at greater risk of missing out on the beneficial aspects of the Independent Phase and may experience poorer retirement outcomes in the long run.

Women, on average, are more likely to be in either the Dependent or Decline Phase than men of a similar age. This means that women in particular may need more support in extending the Independent and Decline Phases of later life. Targeting of support would also need to take into account life expectancies, healthy life expectancies and socioeconomic background.

People with higher levels of wealth are likely to remain in the Independent Phase for longer than those in lower wealth quintiles

Those in higher wealth quintiles are likely both to live longer and to spend a greater proportion of later life with minimal physical limitations. Nearly a third (29%) of those in the highest wealth quintile are in the Independent Phase at ages 85-89, compared to 13% of those in the lowest quintile. This means that people in lower wealth quintiles are likely to benefit most from support aimed at elongating the Independent Phase.

People in lower wealth quintiles are likely to benefit most from support aimed at elongating the Independent Phase.

While in the Dependent Phase, those in lower wealth quintiles are likely to need more support if they are to avoid having particularly poor later life experiences

Even while in the Dependent Phase, members of higher wealth quintiles are likely to have more positive later life experiences than those in lower quintiles. As well as the increased physical limitations associated with the Dependent Phase, the risk of social exclusion plays a significant role in determining the quality of later life experienced during this phase.

Many of the risk factors associated with experiencing social exclusion are also associated with having lower levels of wealth:

- Low income and/or benefits as the main source of income
- Live in rented accommodation
- No access to a private car and never use public transport

This means that those in the lower wealth quintiles are at greater risk of experiencing social exclusion while in the Dependent Phase. They are likely to need more support in order to experience the same standard of living as those in the Dependent Phase in higher wealth quintiles.

Introduction

As life expectancies have increased, conceptions of retirement have evolved. With many people likely to live for twenty to thirty years beyond State Pension age (SPa), retirement is no longer simply a period of winding down at the end of the lifecourse. This shift has led more individuals to question what retirement is all about, whether they want to or can afford to retire, and if they do, how they want to spend their remaining time.[8]

The diversity of later life experiences reflects the heterogeneity of the population in terms of individual preferences and circumstances, including health, financial and familial considerations. While some older people have a considerable amount of freedom to choose how they spend retirement, many more find their choices restricted by financial, health and family concerns.

As the average length of retirement has increased, alongside life expectancies, there is generally more variation in the experiences people will face over the course of later life. Many of these experiences are correlated with age and physical limitations. This report categorises individuals who are either above State Pension age (SPa) or under SPa but already retired into three phases of later life:

The Independent Phase of later life in which individuals have low or no physical limitations.

The Decline Phase of later life in which individuals have mild physical limitations.

The Dependent Phase of later life in which individuals have severe physical limitations and difficulty performing activities needed for day-to-day independent living.

These phases are reflective of current life expectancies, work patterns and retirement provision, and may potentially change in the future depending on the way that these factors evolve.

Many older people transition through these phases in sequence **(Independent>Decline>Dependent)** as their health declines with age. Some however, skip phases due to sudden declines in health, others remain in the

8. Sargent, Lee, Martin & Zikic (2012)

Independent Phase until the time of their death, and some transition backwards and forwards between phases.

This report uses data from the English Longitudinal Study of Ageing (ELSA) to explore the experiences of people who are either aged 65 and over or those under SPa who have already retired.

Chapter One explores the Independent Phase of later life. This is often the period immediately following retirement, and in this phase people have minimal physical limitations, which means they generally have more freedom to engage in leisure activities, continued paid employment, volunteering and informal care.

Chapter Two describes the Decline Phase of later life, during which time physical capacities begin to decline and people begin to be more likely to experience, physical and cognitive health declines, bereavement and isolation.

Chapter Three explores the Dependent Phase of later life, in which people experience more severe physical limitations. This phase sees people exposed to greater risk of isolation and exclusion.

Chapter Four explores the different trajectories that may be experienced by people in different wealth quintiles, in terms of when they are likely to transition between phases.

This is the first of two reports on the subject of Living through later life. The second report will further explore the trajectories of later life experiences as illustrated by a number of hypothetical individuals, particularly in regards to how individuals will fund these experiences and challenges. The second report will also identify where there are gaps in support and safeguards, particularly in terms of policy, industry, advice and guidance, and how these gaps may be best filled.

Chapter One: The Independent Phase of later life

This chapter describes the Independent Phase of later life, exploring the characteristics and health trajectories of people in this phase, as well as the ways in which they spend their time.

The Independent Phase of later life is associated with:

- The capacity to engage with more retirement activities, whether unstructured leisure or more structured employment or volunteering opportunities.
  - ➢ On average, people in the Independent Phase spend more on leisure activities and eating out than those in the Decline and Dependent Phases, £209 per month compared to £187 and £132 respectively. They're also less likely to express wanting to engage in more leisure but being unable to do so.
  - ➢ Almost half (47%) of those in the Independent Phase are in paid employment, compared to around a third (30%) or people in the Decline Phase and just 11% of those in the Dependent Phase. Although this declines steadily with age, between ages 70-74 one in ten (10%) people in the Independent Phase are still in paid employment.
  - ➢ 17% of people in the Independent Phase volunteer at least once a month, compared to 14% and 10% of those in the Decline and Dependent Phases respectively. Among those in all phases who volunteer, around 80% do so twice a month or more.
- Good levels of general physical health and no physical limitations.
- Low risk of accelerated cognitive declines; some normal age-related cognitive decline may begin to occur, however people in the Independent Phase are more able to engage in activities which may slow these declines.
- The potential for improved mental and emotional wellbeing, as a result of increased freedom and relief from the stress of working life, although this will not be the case for everyone in the Independent Phase.
  - ➢ Self-reported levels of personal wellbeing are typically lowest around mid-life but then start to rise around ages 60 to 64, peaking between the mid-60s and mid-70s before starting to decrease again with age. Similarly, anxiety levels are generally highest in mid-life and start to decline in

people's early- to mid-60s, dropping to their lowest levels in the mid- to late-60s, after which they remain relatively stable.[9]

- A lower risk of changing household composition as a result of bereavement and the negative effects this can lead to.
- Low risk of social exclusion as people in this phase are more likely to be actively involved in their community than those who are restricted in their mobility.

During the Independent Phase of later life individuals experience better health and wellbeing compared to those in the Decline and Dependent Phases

The Independent Phase of later life is characterised by having minimal physical limitations and good health. For many, this phase makes up the early years of later life, coinciding with newfound freedom and leisure time as they exit the labour market. Others remain in the labour market or engage in other organised activities such as volunteering.

Individuals in the Independent Phase generally experience better outcomes than those in the Decline and Dependent Phases:

- If they remain active, people who retire into the Independent Phase can experience improvements in physical health, which can in turn elongate their time in the Independent Phase.
- People retiring into the Independent Phase can also experience improvements in mental and emotional wellbeing, particularly if they are able to engage in positive leisure activities and more structured activities such as volunteering, which those in the Decline and Dependent Phases may be less able to engage with due to physical limitations.

Because the Independent Phase is associated with more positive later life experiences, older people could benefit from support with remaining in this stage for as long as possible. While cost must be a consideration when designing this support, helping older people to remain in this phase for as long as possible could also provide an associated reduction in costs to the exchequer as there may be less demand for state-provided benefits which are necessary for older people in poor health.

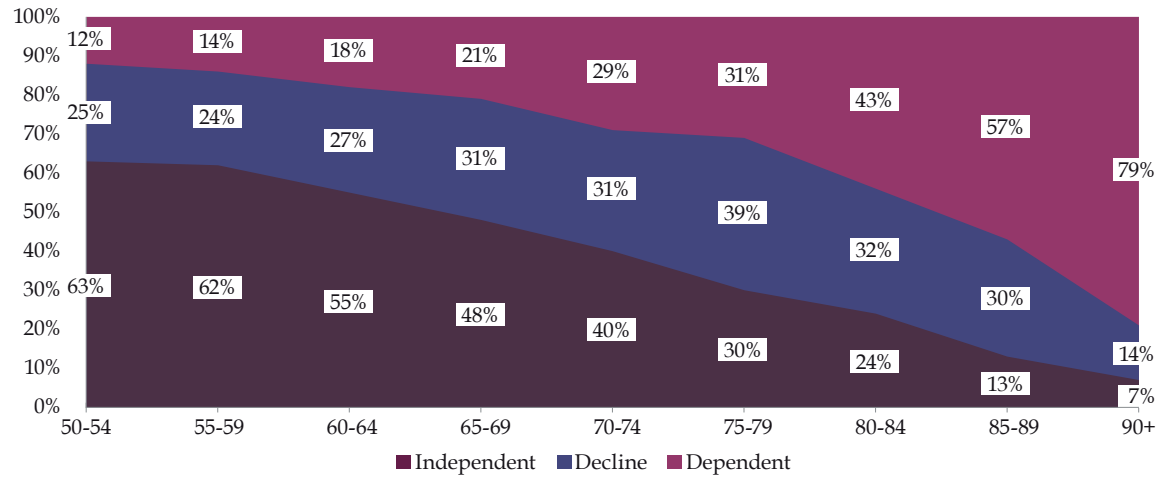
Because the Independent Phase is associated with more positive later life experiences, older people could benefit from support with remaining in this stage for as long as possible.

47% of people who are either aged above SPa or under SPa but already retired are in the Independent Phase of later life. The proportion of people in the Independent Phase is negatively correlated with age, with nearly half (48%) of people in the five years following SPa living within this phase, compared to 7% of those aged 90 and over (Chart 1.1).

Chart 1.1

People are increasingly likely to transition out of the Independent Phase as they age

Proportion in each phase of later life by age



9. ONS (2018a)

Variations in healthy life expectancy mean that some individuals are less likely to experience the benefits of the Independent Phase than others

While the Independent Phase characterises the early years of later life for many older people, others are not so fortunate. Between 37% and 52% of people retire directly into either the Decline or Dependent Phases, assuming they retire before age 70 (chart 1.1). Those who retire, in some cases early, due to ill health, are less likely to experience the Independent Phase, and those who retire earlier also have, on average, a higher risk of early death, compared to those who retire later.[10]

Regional differences in healthy life expectancy impact the likelihood of experiencing the Independent Phase. For example, at birth, males in Wokingham can expect to live 15.5 years longer in good health than males in Blackpool (70.5 years vs. 55.0 years). Similarly, at birth, females in Richmond upon Thames can expect to live almost eighteen years longer in good health than females in Manchester (72.2 years vs. 54.4 years).[11] This data presents an average based on birthplace and does not take into account changes that may arise if people move during their life. There are also variations in life expectancy according to socioeconomic class. Among those aged 50 and over, one in five (20%) people in routine occupations in England say that age often prevents them from doing the things they would like to do, compared to just 7% of those in professional occupations.[12] Life expectancy at age 65 follows a similar pattern; for those in the 'Higher Managerial and Professional' occupational class, it is around three years higher compared to those in 'Routine occupations', for both men and women.[13] The health gap between those with different educational levels increases with age.[14]

Lower socioeconomic position, identified by low levels of income, wealth and educational attainment or low-skilled occupation, is associated with:

- Poorer functioning[15]
- Lower age of onset of disabilities[16]
- Steeper trajectories of functional decline[17]

Older people in a lower socioeconomic position or those in areas with lower life expectancies and lower healthy life expectancies are less likely to experience the freedom and benefits of the Independent Phase of later life, and those who do are likely to experience this phase for a shorter period of time than their more privileged peers. Those who worked in higher managerial and professional occupations remain in the Independent Phase until significantly older ages. For example, at age 85 to 89, 35% of this group are in the Independent Phase, compared to just 8% of those who worked in routine occupations.

The Independent Phase of later life is associated with better health and wellbeing

For some people, particularly those retiring into the Independent Phase, retirement can lead to an improvement in physical health

While early retirement for reasons of poor health are associated with declines in physical health (discussed further in Chapter Two), and health generally declines with age, some people experience an improvement in physical health immediately following retirement.[18] This is particularly true for those who retire into the Independent Phase. For these people, planned and voluntary, in some cases early, retirement can result in improved physical health levels, with these improvements typically ascribed to better health behaviours and relief from work-related strain.[19]

10. Wu, Odden, Fisher & Stawski (2016)
11. Age UK (2018)
12. Centre for Ageing Better (2019)
13. Lloyd et al. (2014)
14. Leopold & Engelhartdt (2013)
15. Louie & Ward (2011)
16. Jagger et al. (2007)
17. Koster et al. (2006)
18. Westerlund et al. (2009)
19. Bloemen, Hochguertel & Zweerink (2017); Coe & Lindeboom (2008); Coe & Zamarro (2011); Jokela, Singh-Manoux, Ferrie & Gimeno (2010)

Jobs that are stressful or physically demanding can have a negative effect on health, leading to an improvement in health as a result of later life. However, if work and related activities are one of the primary forms of physical activity for an individual, their health is likely to decline after retirement, unless they make appropriate adjustments. Those in the Independent Phase, with minimal health issues and full physical functionality, are best positioned to make necessary adjustments, compared to those in the Decline or Dependent Phases who may be limited by their existing health conditions. Approaches to health and physical activity at the point of later life can impact health trajectories over the course of later life (Table 1.1), although some health issues will be unavoidable.

Table 1.1: Some people change their health behaviours at retirement, while others don't[20]

Retirement as a time for change	Retirement expected to make little difference
People who expect retirement to be more active than working life: those who see a direct link between work and specific negative health behaviours and expect retirement to alleviate health problems and improve health practices.	People who have changed their health behaviours before retirement: those who have already made substantive changes to their health behaviours prior to retiring, often in response to specific health issues.
People who use retirement as a chance to make changes: those who see a link between increased leisure and specific health behaviours and so expect a positive change in retirement.	People who don't intend to change their health behaviours at retirement: those who intend to continue existing patterns of behaviour, out of habit or enjoyment, whether because their behaviour is already healthy or regardless of health advice.
People who expect retirement to be less active than working life: those who see a direct link between retirement and potentially negative behaviours and plan to actively address these.	

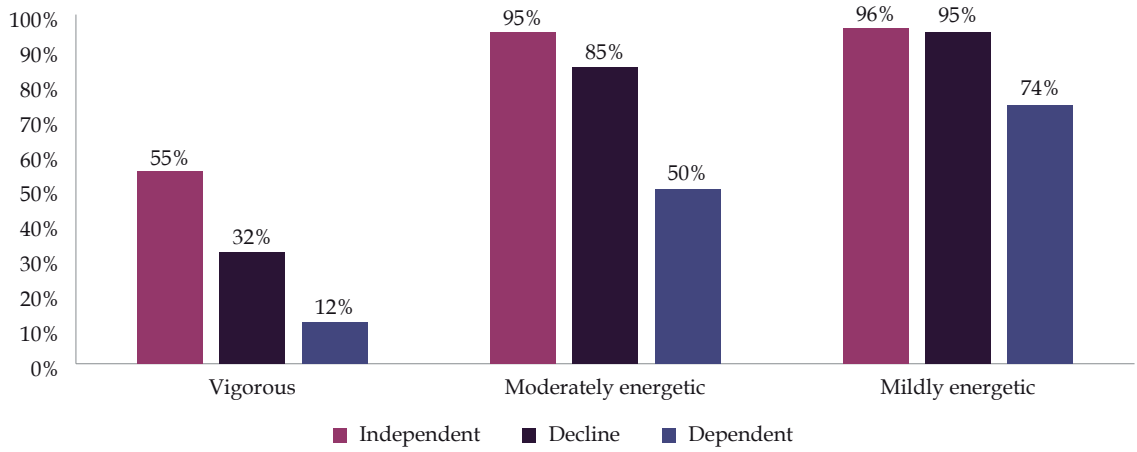
Maintaining or increasing physical activity in retirement may slow health declines, improve wellbeing and increase the time spent in the Independent Phase

Regular physical activity can bring significant health benefits to people of all ages and the need for physical activity does not end in later life, with evidence increasingly indicating that it can extend years of active independent living, reduce disability and improve the quality of life of older people.[21] Older people in the Independent Phase are significantly more likely to be physically active than those in the Decline and Dependent Phases (Chart 1.2). This is understandable given the physical limitations of people in the other two phases of later life.

Chart 1.2

More than half of people in the Independent Phase engage in some vigorous activity

Proportion aged 60+ who engage in vigorous, moderately energetic and mildly energetic physical activitiy, by phase



20. Smeaton, Barnes & Vergeris (2016)
21. Sun, Normal & While (2013)

Levels of physical activity in retirement may be impacted by:

- Social factors: Feeling like part of a group may provide older people with the motivation to regularly attend exercise classes, although this generally tends to be more of a factor among older women than men.
- Lifelong tendencies: Physical activity habits may be a continuation or expansion of habits practised earlier in the lifecourse, though injury and general declines in health (more common in the Decline and Dependent Phases) can lead to the abandonment of lifelong tendencies.
- Sense of purpose: Engagement in physical activity can provide older people with new challenges or goals to replace those which were previously provided by work, as well as a sense of daily purpose and routine.[22]

Interventions which encourage older people to set goals and monitor their behaviour in relation to their goals have been shown to increase physical activity, with a corresponding reduction in sedentary behaviour in some cases.[23] Fitness monitors, which assist in monitoring of physical behaviour, can also increase the amount of physical activity done by older people.[24] If these interventions can help to maintain older people's level of physical health, they will be enabled to remain in the Independent Phase for longer and have more positive retirement experiences.

Many people in the Independent Phase experience an improvement in mental health and emotional wellbeing

For many, retirement can have a beneficial effect on mental health and emotional wellbeing.[25] Retirement can remove many of the stressors that are experienced during working life, such as time constraints, stress at work and rigidity of routine. Many view retirement as a time for relaxation and pursuing hobbies which were limited during working life, which can contribute to improved emotional wellbeing.

Self-reported levels of personal wellbeing are typically lowest around mid-life but then start to rise around ages 60 to 64, peaking between the mid-60s and mid-70s before starting to decrease again with age. Similarly, anxiety levels are generally highest in mid-life and start to decline in people's early- to mid-60s, dropping to their lowest levels in the mid- to late-60s, after which they remain relatively stable.[26]

Continued engagement with paid work or volunteering can help to maintain physical health, wellbeing and social networks, all of which can extend the Independent Phase

Some older people engage in paid work beyond SPa, which can support improved wellbeing in the Independent Phase if it is engaged in voluntarily rather than due to financial pressures

While retirement is traditionally associated with the cessation of paid employment, as the retirement period lengthens and healthy life expectancies increase for many, some older people engage in paid employment beyond SPa, in some cases for quite some time. Among people aged over 65, nearly 1.3 million are in some form of paid employment, compared to more than 10 million who have exited the labour market entirely.[27] In 2006, 6.6% of people aged 65 and over were in employment, rising to 10.4% over the decade to 2016.[28] Almost half (47%) of those in the Independent Phase are in paid employment. Although this declines steadily with age, between ages 70-74 one in ten (10%) people in the Independent Phase are still in paid employment. Around a third (30%) of people in the Decline Phase report being in paid employment, and just 11% of people in the Dependent Phase.

Some people continue to work in their existing job beyond SPa, either full-time or increasingly part-time where employer flexibility permits. Others may leave the career in which they

22. Beck, Gillison & Standage (2010)
23. Gardiner, Eakin, Healy & Owen (2011)
24. Snyder, Colvin & Gammack (2011)
25. Van der Heide et al. (2013)
26. ONS (2018a)
27. ONS (2019a)
28. ONS (2016)

have previously worked and engage in part-time bridge employment, which may be less demanding than their previous full-time role. Around two-thirds of those in employment aged 65 and over work part-time, compared to 25% of those below SPa.[29]

Continued employment beyond SPa may be the result of:

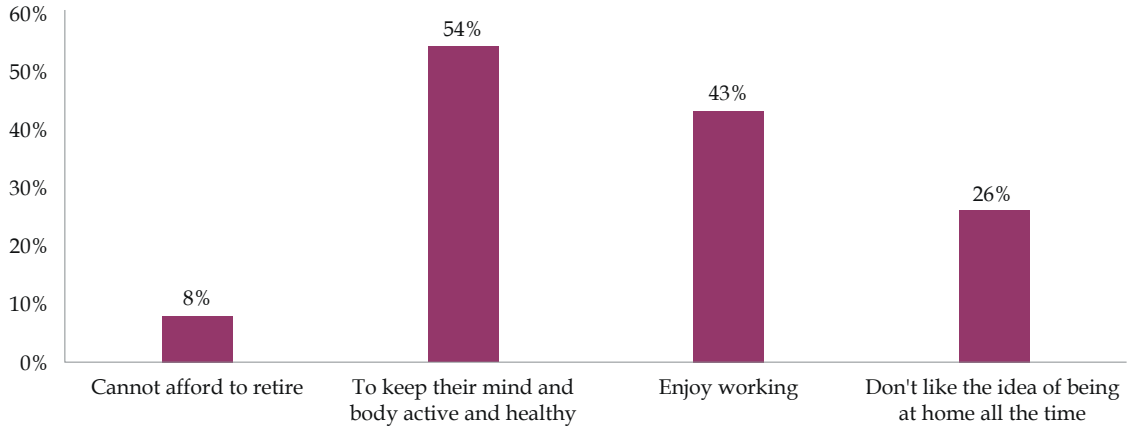
- Financial pressures: They need to retain the income it provides, particularly if they have low levels of private pension savings. Continuing to work beyond SPa may enable them to save more for retirement while supplementing their working income with State Pension entitlement.
- Job satisfaction: While some may continue working in retirement because of either a need or desire to supplement their retirement income, others may choose to do so because they enjoy their work or in order to maintain their pre-retirement professional identity.[30]

Half of those who reached SPa in 2018 were considering working past SPa. A quarter (26%) of those planning to delay their retirement would like to reduce their hours and go part-time with their current employer, one in seven (14%) would like to continue working by starting their own business. Around one in twelve (8%) of those scheduled to retire in 2018 said they postponed their plans because they could not afford to retire, with nearly half (47%) of this group putting this down to the cost of day-to-day living which their retirement income is unlikely to cover.[31] Among all those working beyond SPa in 2018, around a third reported financial issues as the main reason for continuing work.[32] However, the decision to work beyond SPa is not always a purely financial one (Chart 1.3).

Chart 1.3

Those who intend to work beyond SPa are more likely to attribute this to a desire to keep working than a financial need

Reasons for continuing working beyond SPa among those scheduled to retire in 2018



Those who report being 'tired of work' are more likely to transition fully into retirement in one step ('cliff-edge retirement') than to engage in bridge employment or volunteering as part of a gradual transition. Whereas, those who report being 'overloaded' at work are more likely to take this gradual approach to retirement.[33]

Transitioning more gradually can help to facilitate more effective and positive adjustment to retirement, as well as having beneficial effects for physical and mental health. However, those who continue to work beyond SPa involuntarily, because of financial need for instance, may experience lower general wellbeing and mental health.[34] Those who

29. IPPR (2014)
30. Sargent, Bataille, Vough & Lee (2011)
31. Prudential (2018)
32. Di Gessa, Corna, Price & Glaser (2018)
33. Griffin & Hesketh (2008)
34. Dingemans & Henkens (2013)

continue to work beyond SPa purely out of choice often experience a higher quality of life than their retired peers, while those who continue working out of necessity generally experience lower quality of life and feelings of low autonomy.[35]

Transitioning more gradually can help to facilitate more effective and positive adjustment to retirement, as well as having beneficial effects for physical and mental health.

A significant proportion of those who work beyond SPa are self-employed. Half (49%) of those aged over 70 who were still in employment in 2015 were self-employed, compared to two in five (40%) in 2001. The 65 and over age group accounted for 22% of all part-time self-employment in 2015, up from 14% in 2001.[36] Start-up businesses set up by older people tend be more successful in terms of surviving the first few years of business. 70% of start-ups founded by people aged over 50 last at least three years, compared to 28% of those created by younger entrepreneurs.[37]

During the Independent Phase some older people volunteer, which offers benefits to both the individual and society more broadly

Older people who have left the workforce by choice, with relatively good health (Independent Phase) and no financial pressures requiring continued paid employment, may choose to give up some of their free time to volunteering. Around 17% of people in the Independent Phase volunteer at least once a month, compared to 14% and 10% of those in the Decline and Dependent Phases respectively. Volunteering in the Decline and Dependent Phases is likely to be a continuation of volunteering in the Independent Phase.

Volunteering during retirement has the potential to benefit:

- Older volunteers themselves: experience increased wellbeing and a sense of purpose.
- Voluntary associations: gain resourceful helpers who are often able to volunteer more hours than middle-aged and young people.
- Society: contributes to an active voluntary sector, which increases social cohesion.[38]

Volunteering contributes to individual wellbeing through its association with better health, higher life satisfaction and a reduced risk of cognitive decline.[39] Formal volunteering, like bridge employment, can counteract feelings of having a lack of purpose and the shrinking social networks that some people experience upon retirement, by providing purpose, interaction and connectedness. It enables older people to continue to be productive and contribute to society, while keeping busy.[40] Older volunteers are generally motivated by the desire to help others and to stay active.[41] Volunteering can also help older people to feel more connected with their communities through an enhanced sense of belonging.[42]

Among those in the Independent Phase who volunteer, 80% do so twice a month or more, which is similar to the frequency among those in the Decline and Dependent Phases, however people in the latter phases are less likely to volunteer at all.

The benefits of volunteering are less accessible for some older people, in particular those with poor health (in the Decline or Dependent Phase), caring responsibilities or financial pressures. For example, volunteering is generally more common among those from a higher socioeconomic background (Chart 1.4). It is unclear whether this is solely because of demands on time from paid employment, or whether there may be other barriers to volunteering among those on lower incomes, for example cultural and tradition based barriers.

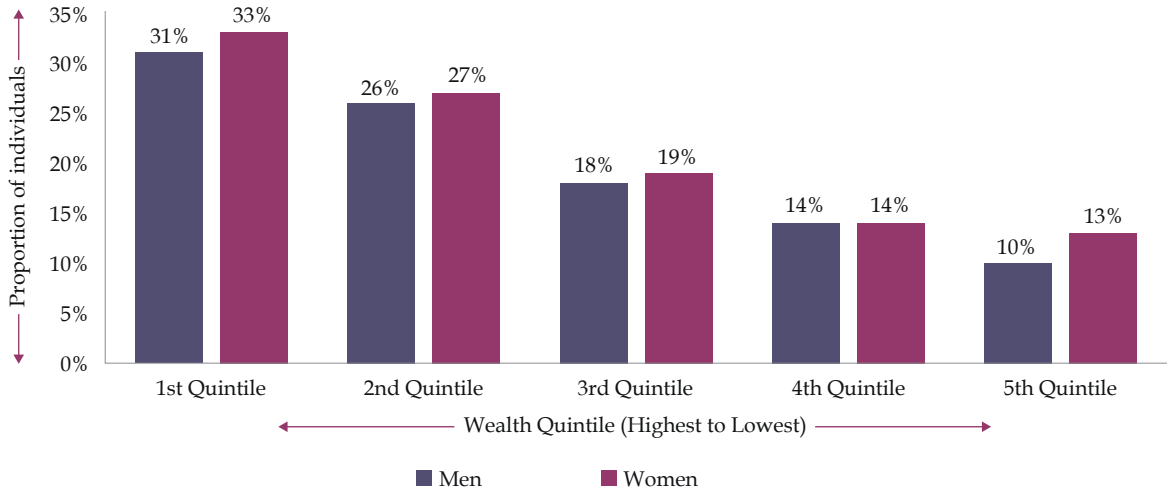
The benefits of volunteering are less accessible for some older people, in particular those with poor health, caring responsibilities or financial pressures.

35. Di Gessa, Corna, Price & Glaser (2018)
36. ONS (2016)
37. IPPR (2014)
38. Komp, Tilburg & Groenou (2012)
39. Carr, Fried & Rowe (2015)
40. Chambre & Netting (2018)
41. Morrow-Howell (2010)
42. Russell, Nyame-Mensah, de Wit & Handy (2018)

Chart 1.4[43]

Levels of volunteering are strongly correlated with socioeconomic position

Proportion of individuals aged 50 and over who volunteer at least once a month, by wealth quintile

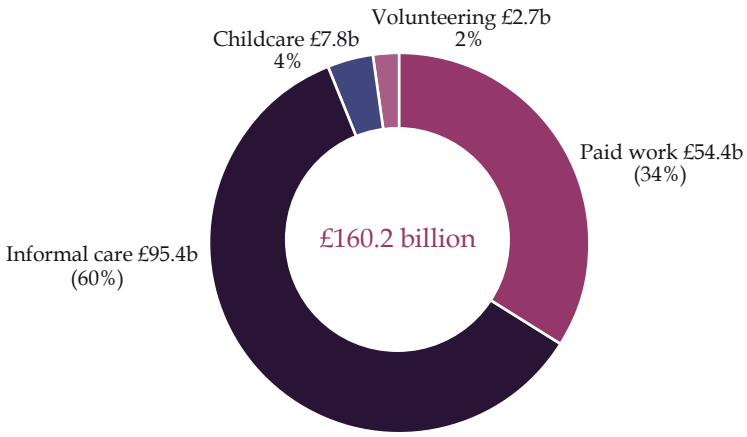


Whether in paid employment, providing informal care or volunteering, older people make considerable contributions to society

The contributions that older people, particularly those in the Independent Phase, make to society add significant financial value. When informal care is valued at the average hourly pay of professional care workers, people aged over 65 are providing more than £95 billion of care each year.[44] While this is the largest contribution, other activities, including paid work, childcare and volunteering also represent a significant amount of financial value added (Chart 1.5).

Chart 1.5[45]

People aged 65 and over contributed more than £160b in labour in 2016/17, of which two thirds is through unpaid work



43. Nazroo (2015)
44. Age UK (2017)
45. Age UK (2017)

The Independent Phase is associated with greater freedom to engage in positive leisure activities, continued employment and volunteering, all of which have the potential to slow declines in physical health and wellbeing

For those in the Independent Phase, retirement can be a time to relax and engage in leisure activities which may have been inaccessible during working life

Many older people see leisure as an important factor contributing to a good quality of life in retirement. Leisure is more frequently highlighted as an important aspect of quality of life for those aged over 65 (23.8%) than for those aged 15-25 (14.6%), for example.[46] Engagement with leisure activities can encourage healthy ageing through personal growth, interest renewal, identity reconstruction and an increased sense of meaning in life. Participating in new leisure activities can also enable older people to forge new social connections which can help to reduce feelings of loneliness in retirement.[47]

Retirement can provide increased opportunity for leisure for two reasons in particular:

- Increased time: Before retirement, leisure time is generally restricted to mostly evenings, weekends and holidays. After retirement, leisure time increases significantly as people transition out of full-time work. Similarly, during working life, travel time is often short, as necessitated by annual leave allocations, but after retirement, travel can be longer and more immersive.
- Changing purpose of leisure: Before retirement, leisure is often about relaxation and de-stressing, whereas afterwards, particularly during the Independent Phase, leisure is often more about engagement, connection and activity. Pre-retirement leisure is often treated as a respite from the structure of working, while in retirement, people are likely to want a balance of both structure and non-structure in their leisure time.[48]

For those who retire into the Independent Phase, the early years of later life can represent a sort of 'freedom zone', during which time they are likely to have the most optimal combination of time for leisure and good health which enables them to engage in the activities that they want to.[49] Although, those in the Independent Phase who have lower levels of retirement income and savings may have less autonomy to do as they please.

Leisure during the Independent Phase of later life may include:

- Developing interests from over the lifecourse and engaging in a wider range of activities in relation to those interests.
- Trying new activities that may have been difficult to engage in prior to retirement.[50]

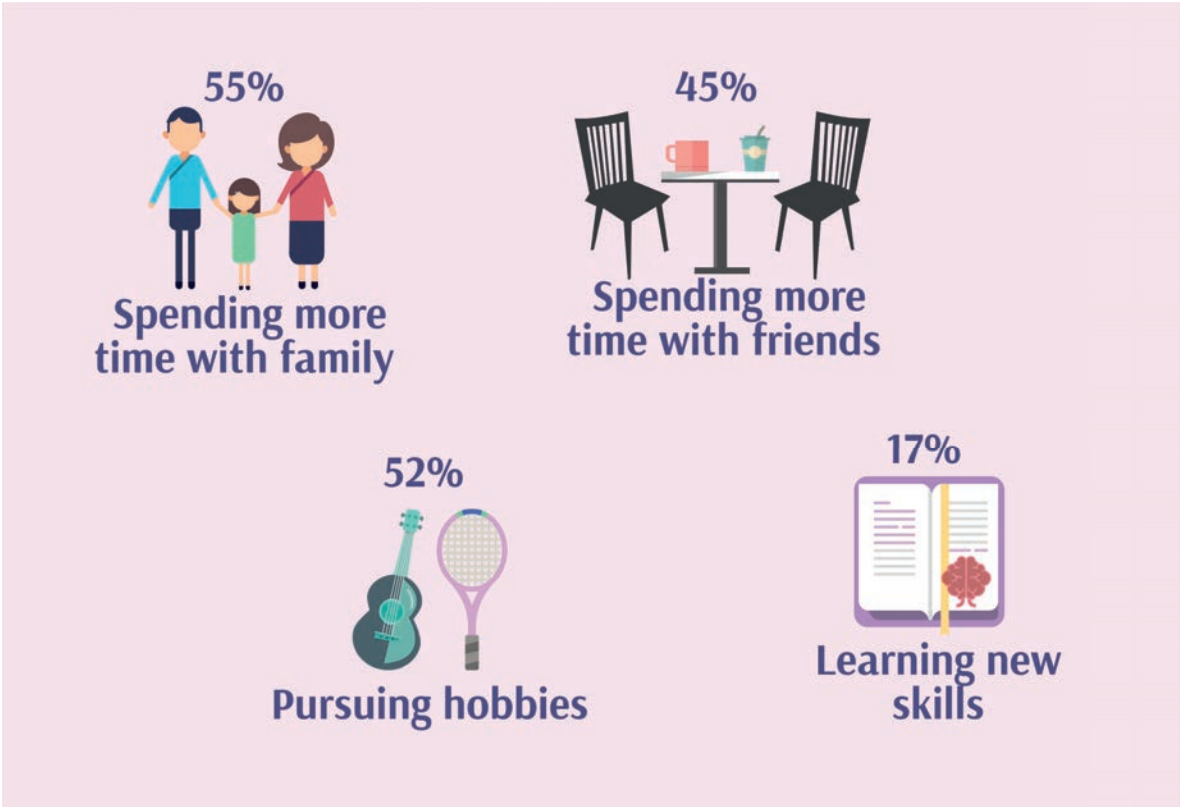
Leisure in retirement means different things to different people, with some seeing it as a time for continued growth and others as a time for relaxation and enjoyment

Even though the retirement period is now generally longer and perceptions about the kind of leisure activities retirees can do are widening, for some people leisure in retirement will still be about relaxation and enjoyment. This could include spending more time with family and friends (Figure 1.1), taking relaxing holidays such as cruises, and generally enjoying a slower pace of life with less rigid structure than they may have adhered to during working life. For some older people, engaging in these kinds of relaxed leisure activities will be a preference and they may choose to have a more passive retirement even when they are in the Independent Phase. For others, this more passive style of retirement leisure will be necessitated by health declines as they transition into the Decline and Dependent Phases.

46. Plagnol & Scott (2011)
47. Liechty, Yarnal & Kerstetter (2012)
48. Merrill Lynch & Age Wave (2016)
49. Merrill Lynch & Age Wave (2016)
50. Liechty, Yarnal & Kerstetter (2012)

Some of those in the Independent Phase may see retirement as a time for continued personal growth, including developing hobbies and learning new skills (Figure 1.1). Travel may also be a component of leisure time for retirees with this mindset, but it is likely to include more active travel which facilitates adventure and/or learning, for example cultural trips. These kinds of activities are less practical for people in the Decline and Dependent Phases.

Figure 1.1[51]



For most people in the Independent Phase, the way they choose to spend their leisure time in retirement will fall somewhere between the two, with some time spent on more relaxing, unstructured activities, and some spent on personal development and adventurous pursuits, while they are still in good health to do so.

Engagement with culture and leisure activities is highest during the Independent Phase

People in the Independent Phase, more likely to be those in the early years of later life, engage in cultural leisure activities outside of the home more frequently than those in the Decline and Dependent Phases of later life (Charts 1.6, 1.7, 1.8 and 1.9). People in the Independent Phase also spend more on these activities. Over the course of a month, they spend an average of £209 on leisure activities and eating out, compared to £187 in the Decline Phase and £132 in the Dependent Phase.

51. LV= (2017)

Chart 1.6

Engagement with cultural activities outside of the home declines as people transition into the Decline and Dependent Phases: Cinema

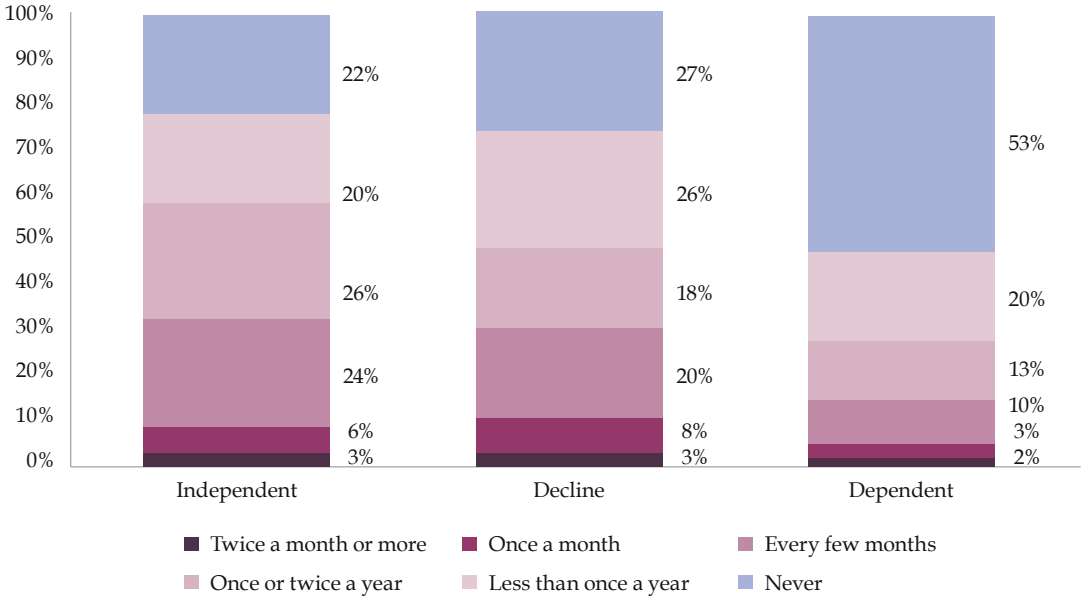


Chart 1.7

Engagement with cultural activities outside of the home declines as people transition into the Decline and Dependent Phases: Restaurant

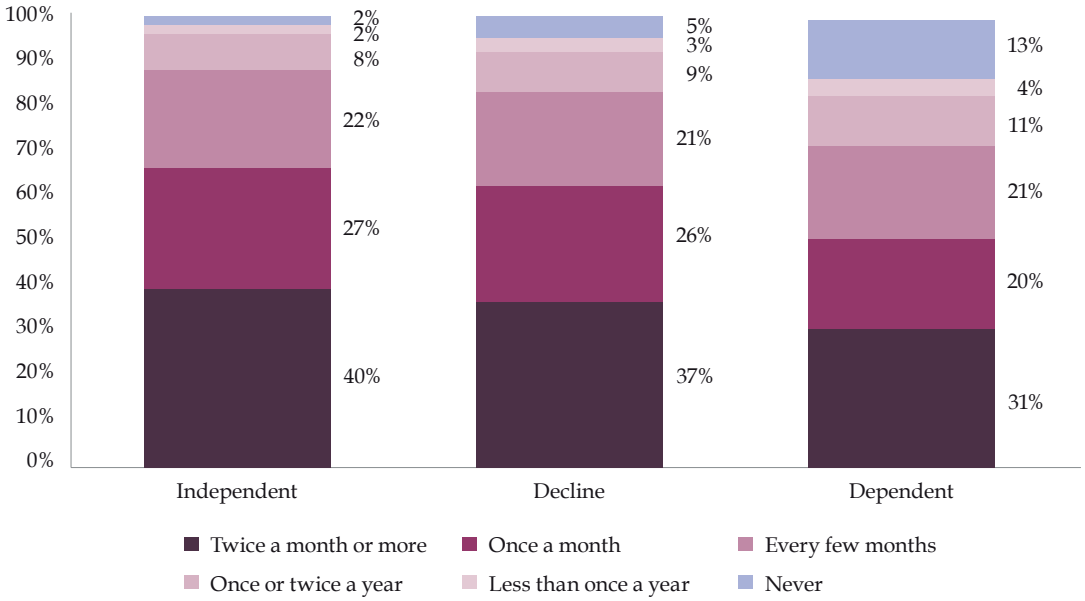


Chart 1.8

Engagement with cultural activities outside of the home declines as people transition into the Decline and Dependent Phases: Gallery/Museum

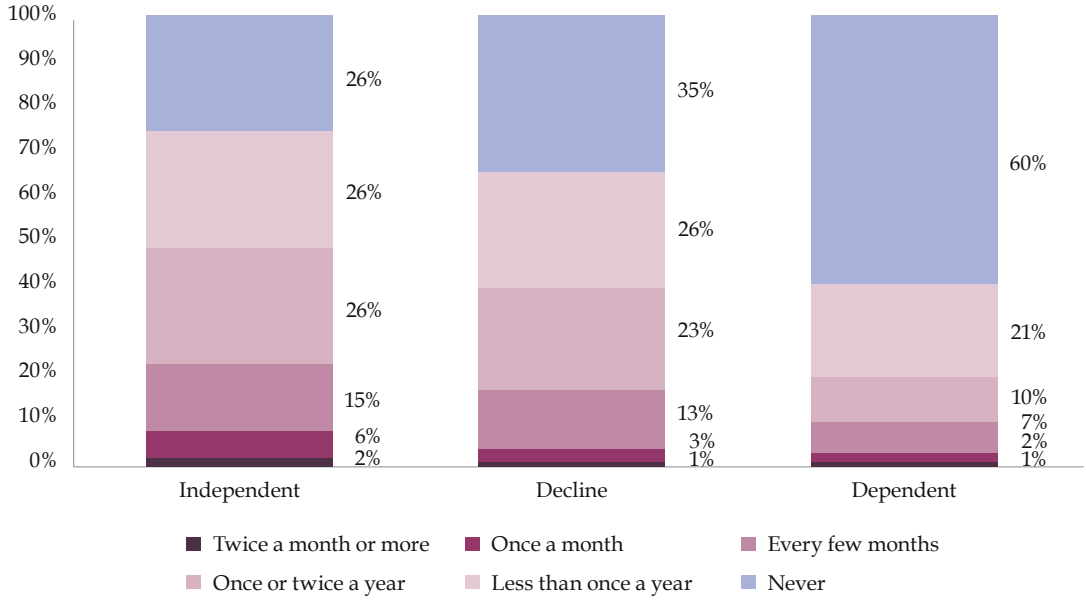
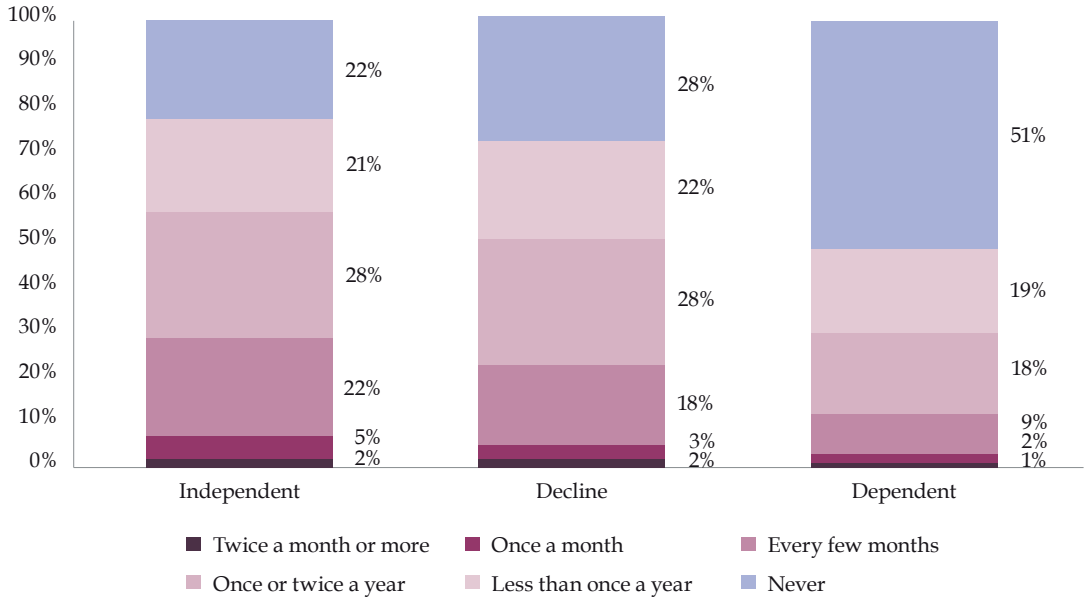


Chart 1.9

Engagement with cultural activities outside of the home declines as people transition into the Decline and Dependent Phases: Theatre/Concert Opera

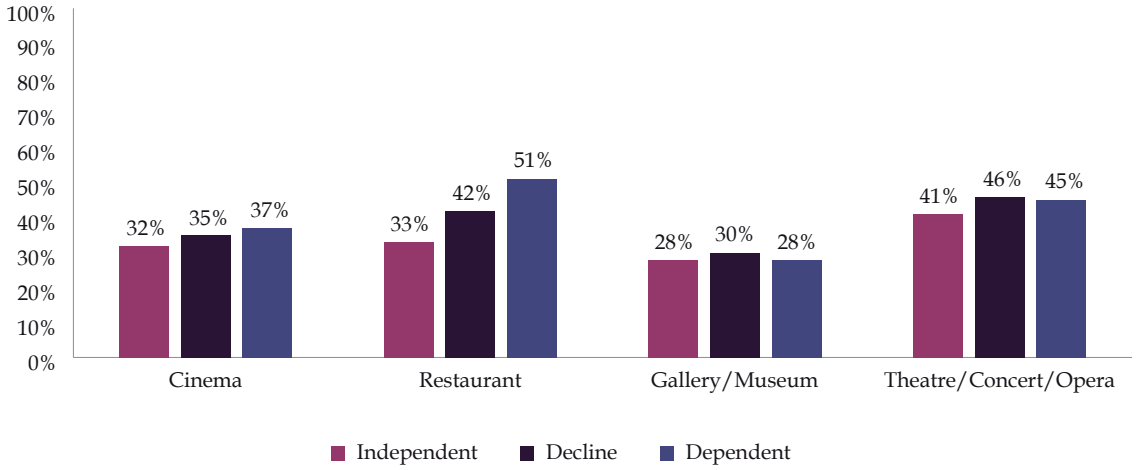


Those in the Independent Phase of later life are less likely to express wanting to do these activities more but for whatever reason being prevented from doing so than those in the other phases (Chart 1.10).

Chart 1.10

People in the Independent Phase are less likely to feel restricted from engaging with more activities outside of the home

Proportion who want to engage with more activities but are unable to do so, by phase



Engagement with cultural activities outside the home can be limited by low levels of income. Those with higher levels of wealth are likely to remain in the Independent Phase for longer than those in lower wealth quintiles, and are also likely to be less restricted by their finances.

Carers, who are more likely to be women than men, may find it more difficult to access the benefits of the Independent Phase

Caring is a strong element of the Independent Phase but can prevent people with grandchildren or disabled or elderly parents or partners from pursuing the activities that can have a positive impact on physical and mental health

Almost half (45.4%) of those who provide informal care in the home are aged 65 and over. Over a third of these carers provide 50 or more hours of informal care each week, with nearly 12% providing 100 hours or more.[52] 15.0% of people in the Independent Phase provide care for someone else, compared to 14.7% and 10% of those in the Decline and Dependent Phases. Providing informal care is more prevalent among women in the Independent Phase (18%) than men (12%). This means that women are at greater risk of missing out on the beneficial aspects of the Independent Phase and may experience poorer retirement outcomes in the long run.

As life expectancies increase, people are increasingly likely to provide informal care for a parent in retirement

Many people engage in informal caregiving during retirement. This may be for a spouse/partner, parents or grandchildren. During the Independent Phase of later life they are more likely to provide care for the two latter groups, while the likelihood of providing care for a spouse/partner increases with age and is therefore more likely in the Decline or Dependent Phases.

With parents increasingly likely to live to extremely old ages, and considering the average age at which they have their children, it is likely that many people will find themselves in a position where one or both of their parents require care around the time of their child's retirement. This care may be short-term and involve support with transition to and from hospital or into a residential care home, or it may be a long-term solution, in some cases involving the older parent moving in with the family.[53] 9% of multigenerational households feature older parents or elderly relatives who

52. Age UK (2018)
53. Dow & Meyer (2010)

have moved in with adult children. When asked to consider situations in which they might opt to live as part of a multigenerational household, the number one reason was to look after a relative who was unwell, with 71% of respondents saying they would share or already shared a home for this reason.[54]

Within families, it is generally the recently retired sibling who is most likely to be called on to care for a parent, as availability to care is an important factor in deciding which adult child will provide care.[55] In families where none of the children are recently retired, one may decide to retire a bit early in order to provide care. Because of preconceptions about gender divisions of labour, this may fall disproportionately to daughters, rather than sons, which would potentially explain the discrepancy in proportions of male and female carers aged between 50 and 69. For example, among those aged between 50 and 69, 15.5% of men provided care for someone compared to 26% of women. Although, variation in the time spent providing care is smaller.[56]

Many older people also provide childcare for grandchildren

In the UK, grandparents provide childcare to 42% of families with children over 9 months old. For families in which the mother is in work or education, 71% receive some childcare support from grandparents, and 35% rely on grandparents as the main providers of childcare.[57]

Financial pressures which mean people may need to continue to work beyond SPa decrease their capacity to provide informal care. This is likely to be the biggest barrier to providing informal care for those in the Independent Phase. For those who do not have particular financial pressures, there can still be negative aspects to providing informal care. Caring responsibilities can be extremely time intensive which can prevent the carer from engaging with voluntary work and other beneficial community-based activities, which can leave them feeling increasingly isolated.

Division of labour within the home can change at and during retirement as a result of evolving circumstances

There is a substantial increase in the hours of housework upon retirement. This increase is larger for men than women, an average increase of more than three hours on a weekday compared to two hours and forty minutes for women. Among those with a spouse or partner, retirement of a female partner reduces the housework done by her male partner, while retirement of a male partner has little effect on the time a female partner spends on housework. [58] It is unclear whether this additional time spent on housework during the week is a reallocation of time usually spent on weekends, taking responsibility for tasks previously carried out by a partner, or tasks which were previously outsourced, by employing a cleaner or gardener for example. The relationship between housework, retirement and gender may shift as gender divisions of labour more generally evolve. There is limited research on the way in which retirement impacts divisions of labour within same-sex partnerships.

People in the Independent Phase of later life are more likely to take responsibility for a greater amount of housework, particularly if they have a partner in the Decline or Dependent Phase. As people transition into the Decline and Dependent Phase, they become increasingly dependent on external support in carrying out these tasks.

54. Aviva (2016)
55. Dow & Meyer (2010)
56. Nazroo (2015)
57. IPPR (2014)
58. Stancanelli & Van Soest (2012)

Chapter Two: The Decline Phase of later life

This chapter explores the experiences more likely to be encountered during the Decline Phase of later life, including physical and cognitive declines, bereavement and increased risk of isolation. Experiences in this phase are generally more positive than those in the Dependent Phase, but less positive than the Independent. This means that once individuals transition into the Decline Phase, they could benefit from support in maintaining physical health and where possible slowing declines in order to protect them from the more severe risks present in the Dependent Phase. Some older people may backslide from this phase to the Independent Phase if their physical limitations are the result of temporary conditions, however this is less likely than progressing through the phases in order.

Once individuals transition into the Decline Phase, they could benefit from support in maintaining physical health and where possible slowing declines in order to protect them from the more severe risks present in the Dependent Phase.

The Decline Phase of later life[59] is associated with:

- Declines in physical health, though less severe than those associated with the Dependent Phase.
- Increased risk of accelerated cognitive declines, though again less severe than those associated with the Dependent Phase.
- Less freedom and control over how time is spent, as physical limitations begin to reduce people's ability to engage with more strenuous activities. Poor health, low incomes and competing demands such as caring responsibilities can be a barrier to many older people accessing the benefits of pursuing positive retirement activities, particularly as they transition into the Decline and Dependent Phases.
- Increased likelihood of losing a spouse or partner, which can lead to declines in mental and emotional wellbeing, loneliness and further physical declines, particularly if not adequately prepared for this loss.
  - ➢ The likelihood of being widowed increases significantly with age. Immediately following SPa, 5% of men are widowers and 14% of women widows. Whereas, among those aged 85 and over, a third (36%) of men and three quarters (77%) of women are widowed.[60]

59. For information on the physical limitations used to categorise someone as being in the Decline Phase see Appendix One.
60. ONS (2018b)

- Women are more likely to outlive a spouse than men (around twice as likely), primarily as a result of longer female life expectancies, as well as the diminishing trend towards marriages with age gaps (older man and younger woman). The average age of bereavement is around 73 for women and 77 for men.

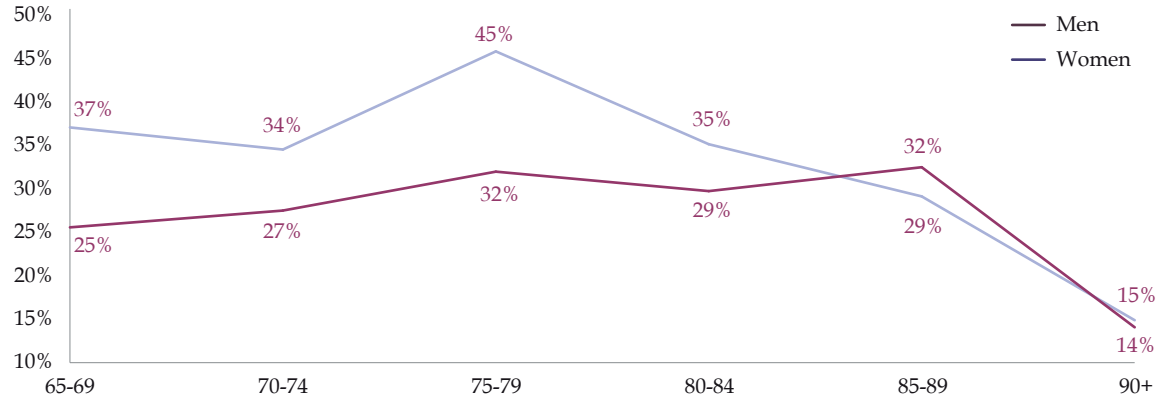
More than a quarter of people aged 65 and over are in the Decline Phase of later life

29% of people who are aged 65 and over and/or retired are in the Decline Phase of later life. Being in this phase is most common between the ages of 75 and 79, at which time two in five (39%) are in the Decline Phase, compared to around 30% in both the Independent and Dependent Phases. Women are more likely than men to be in the phase at all ages, with the exception of ages 85 to 89. For example, in the five years following SPa, 37% of women are in the Decline Phase, compared to 25% of men (Chart 2.1). The greater prevalence of women being in the Decline or Dependent Phase may be a result of women's greater involvement in informal caregiving, which effectively extends their working life beyond SPa and can lead to ongoing health problems which may otherwise be avoided. It may also be a result of women's longer life expectancies which could lead to them spending a longer period of time in these phases.

Chart 2.1

Women are more likely than men to be in the Decline Phase at most ages

Proportion in the Decline Phase by age and gender



Those with lower healthy life expectancies, for example those in lower socioeconomic classes, are more likely to skip the Independent Phase and retire directly into this phase. They are likely to require more support to prolong this phase for as long as possible and protect against the greater risks associated with the Dependent Phase.

Early retirement, particularly when necessitated by a shift into the Decline Phase, is associated with a higher risk of early mortality compared to those who retire later

Some people need to retire early as a result of poor health which may see them missing out on the Independent Phase of later life and transitioning straight into the Decline or Dependent Phase. Those who retire earlier have, on average, a higher risk of early death, compared to those who retire later.[61] Among those aged 65 and over, physical functioning difficulties appear to increase more rapidly for those who are retired compared to those still in employment, which may suggest that retirement accelerates decline.[62] However, since early retirement is often necessitated by declines in health, comparing the health of older people who have retired to those who have not yet retired will tend to exaggerate the negative effects of retirement on health, as those who are in better health or more likely to continue working for longer.[63] Early retirement, in general, increases the risk of a shrinking social network and the cognitive stimulation

61. Wu, Odden, Fisher & Stawski (2016)
62. Stenholm et al. (2014)
63. Bound & Waidmann (2007)

provided by social connections, and so may also increase the speed of cognitive decline. However, where early retirement occurs out of choice, rather than being necessitated by health declines, it is unlikely to be linked to increased risk of early mortality.

Poor health, low incomes and competing demands such as caring responsibilities can be a barrier to many older people accessing the benefits of pursuing positive retirement activities such as leisure, physical activity and volunteering, particularly as they transition into the Decline and Dependent Phases of later life. These pursuits can encourage healthy ageing, including decreased risk of frailty and physical decline, improved mental health and emotional wellbeing, and enable older people to maintain engagement with social networks and the broader community, all of which are important components of a positive retirement experience.

Poor health, low incomes and competing demands such as caring responsibilities can be a barrier to many older people accessing the benefits of pursuing positive retirement activities.

While an increasing proportion of older people are working beyond SPa, people in the Decline Phase will find this more difficult than those in the Independent Phase

Those with poorer health, particularly those who retire directly into the Decline Phase, are less able to continue working beyond SPa. Because health issues are more prevalent among those in lower wealth quintiles, there is often an overlap between those who need to continue working beyond SPa due to financial pressures and those who are less able to continue working due to poor health and physical limitations. More than one in five people aged between 55 and 64 in England have a health problem that limits the kind of or amount of work they can do. Half of men in this age group in the lowest wealth quintile find themselves limited in this way, compared to 10% in the highest wealth quintile.[64]

While caring for a parent is more likely in the Independent Phase, people in the Decline Phase are more likely to be providing informal care for a partner or spouse

More than 400,000 people aged 80 or older provide informal care for a partner or family member, and over a third of 80+ carers spend at least 35 hours a week providing care.[65]

The average amount of time spent providing informal care increases across the phases. Among people who provide informal care, those in the Independent Phase provide an average of 38 hours per week. This increases steeply between the Independent and Decline Phases, but less so between the Decline and Dependent Phases. Carers in the Decline Phase provide an average of 47 hours of care each week, while those in the Dependent Phase provide 49 hours on average.

Carers can experience negative effects on physical and mental health. Those who have provided care for a spouse with dementia, for example, have 41% higher odds of experiencing the onset of frailty by the time of their spouse's death, and 90% higher odds by two years later, compared to those who have lost a spouse without dementia.[66]

Bereavement of a partner has far-reaching effects on the partner left behind and could cause them to transition between phases of later life, particularly if they are not adequately prepared

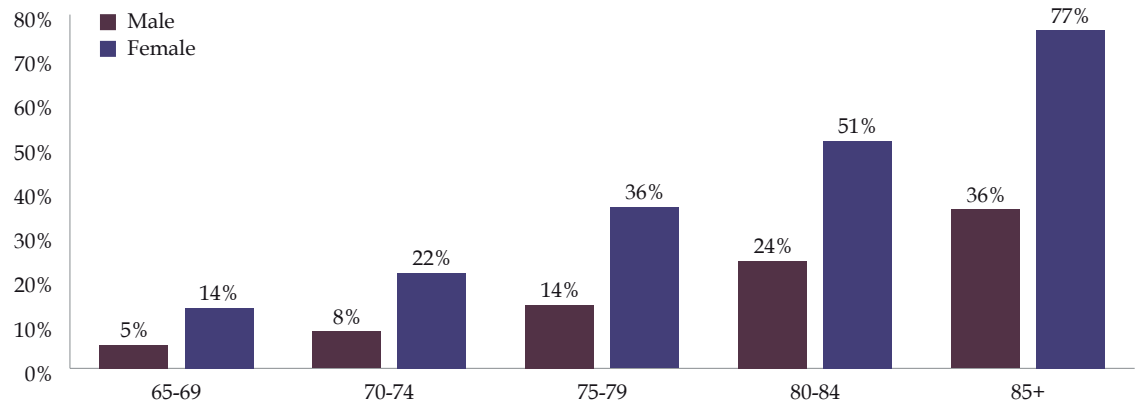
The likelihood of being widowed increases significantly with age. Immediately following SPa, 5% of men are widowers and 14% of women widows. Whereas, among those aged 85 and over, a third (36%) of men and three quarters (77%) of women are widowed (Chart 2.2).[67]

64. Centre for Ageing Better (2019)
65. Age UK (2018)
66. Dassel & Carr (2016)
67. ONS (2018b)

Chart 2.2[68]

Three quarters of women aged over 85 are widows

Percentage of widow(er)s by age and gender (2017)



Women are more likely to outlive a spouse than men (around twice as likely), primarily as a result of longer female life expectancies, as well as the diminishing trend towards marriages with age gaps (older man and younger woman). The average age of bereavement is around 73 for women and 77 for men.[69]

People often don't make adequate plans for how they will cope when they lose their partner

Bereavement of a spouse or partner necessitates readjustment of retirement plans, both financial and in terms of lifestyle more generally. Many couples make plans for retirement on the basis that they will do these things together, meaning that the partner left behind will likely need to make new plans upon bereavement and this can be especially difficult to face when still grieving.[70]

More than two thirds (69%) of those bereaved say they felt either financially (i.e. meeting costs or adapting to lower income) or practically (i.e. managing day-to-day tasks at home) unprepared for the death of their partner. Only a small minority say they were completely prepared for the financial and practical impacts of bereavement. Making financial and practical plans before the death of a partner may be more likely among older people, however it is still likely to be a difficult conversation to have.[71]

People who are able to carry out practical tasks independently are likely to cope more effectively following the death of their partner

Those who are able to carry out practical tasks (e.g. finances, minor domestic repairs, etc.) independently or alongside their partner prior to bereavement are more likely to be able to continue to live independently afterwards. This means that those with a more rigid view of gender divisions within household management may be more susceptible to becoming dependent on family members, friends or welfare and charitable organisations upon losing their partner.[72]

Providing widow(er)s with training in the areas that have previously been the domain of their spouse may help to support independence after bereavement. This could be offered before and/or after bereavement; although, given the positive effects of planning ahead for coping after the loss of a spouse, it may be more effective beforehand.[73] This support could be structured around the Dual Process Model of coping with bereavement, which teaches widow(er)s about:

- Coping with grief and expressing their feelings
- Goal setting and personal priorities
- Self-care and health care

68. ONS (2018b)
69. Corden, Hirst & Nice (2008)
70. Moffatt & Heaven (2017)
71. Corden, Hirst & Nice (2008)
72. Bennett, Stenhoff, Pattinson & Woods (2010)
73. Bennett, Gibbons & Mackenzie-Smith (2010)

- Finances and legal issues
- Household and vehicle responsibilities
- Nutrition for one
- Remaining socially connected[74]

As older people can be more susceptible to declines in health and onset of frailty following the death of a spouse, interventions such as these could help bereaved individuals to remain in the Independent or Decline Phases for longer, delaying the transition into the Dependent Phase and prolonging independent living. Without adequate support, some widow(er)s in the Independent Phase may shift into the Decline Phase, or from the Decline Phase to the Dependent Phase, particularly if they are unprepared for living independently without their partner.

The majority of marriages in retirement end as a result of bereavement, but a significant minority end as a result of divorce

While levels of divorce among older people are relatively low and decline steadily over the course of later life, there may be a small increase in divorce immediately following retirement. Children, who often hold couples together, are likely to have grown up and left home by the time of their parent's retirement, which may contribute to making some marriages more vulnerable to divorce.[75] Further strain may be placed by the increased amount of time spent together now that work does not occupy their time.

Although still relatively low, the prevalence of divorce in later life has increased slightly over the last decade.[76] Reasons for this increase include:

- A growing share of older people being in a higher order marriage (i.e. second or third marriage), reflecting divorce experienced at earlier stages in the life course. Remarriages are more likely to end in divorce than are first marriages.
- Divorce is a common occurrence, which means that older people are likely to become increasingly accepting of divorce as either they or people around them will have experienced divorce.
- Rising female labour force participation is also conducive to divorce in that women have the economic autonomy to support themselves outside of marriage.[77]

An increase in divorces at older ages may impact both the economy and society more broadly, particularly as older people are less likely to remarry. This means that older divorcees may depend more heavily on the welfare state, while family members who provide informal care may need to split their time between two parents.[78] However, the majority of marriages in retirement end as a result of bereavement rather than divorce.

While depression is not significantly higher among older people, common aspects of the retirement experience can trigger it, and there are low levels of access to support

In England depression affects 22% of men and 28% of women aged 65 and over. It is estimated that around 85% of older people with depression receive no help from the NHS at all.[79] Older adults are significantly less likely than younger ones to recognise depressive symptoms, which they may instead attribute to normal ageing of physical illness.[80]

Among older people who are married, spousal relationship quality is essential to emotional wellbeing in retirement, especially for men. Both men and women also appear to rely on both children and friends for support.[81]

Sedentary activities, such as longer time spent watching TV, become more common as people transition into the Decline Phase of later life, and are associated with higher risk of depression (Chart 2.3).[82] Time spent in these

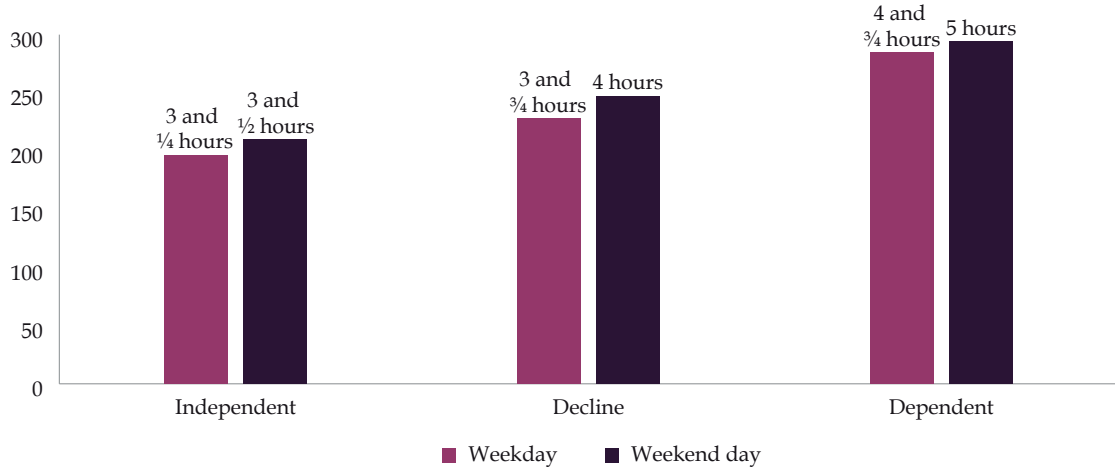
74. Lund, Caserta, Utz & De Vries (2010)
75. Stancanelli (2014)
76. ONS (2017)
77. Brown & Lin (2012)
78. Stancanelli (2014)
79. Age UK (2018)
80. BMJ (2011)
81. Santini et al. (2016)
82. Hamer & Stamatakis (2014)

sedentary activities is associated with higher mortality.[83] Increasing from no physical activity to two and a half hours a week of moderate intensity activity can reduce the likelihood of developing conditions linked to mortality by as much as 19%, while increasing to seven hours a week (equivalent to one hour each day) can reduce the likelihood by up to a quarter (24%) compared to no activity.[84] Even just replacing 30 minutes of sedentary time with light physical activity, such as walking, each day is associated with better health.[85] For those who retire from largely sedentary employment, such as an office job, in good health (particularly those in the Independent Phase with minimal physical limitations), a change of this magnitude should be easy to implement with the increased leisure time they will have in retirement. However for those in the Decline Phase, and even more so the Dependent Phase, making these changes is harder and increased time spent in sedentary activities is increasingly likely to be due to necessity rather than choice.

Chart 2.3

The average amount of time spent watching TV increases as people transition to the Decline and Dependent Phases

Average number of hours spent watching television (weekend day and weekday) by phase



The risk of experiencing depression following retirement may be correlated with an involuntary and/or sudden retirement, whereas a gradual transition can help people to better adjust to the leisure and freedom of retirement after a busy working life. However, for many there is limited opportunity to tailor their retirement transition in such a way, be this as a result of employer attitudes or declines in health.[86]

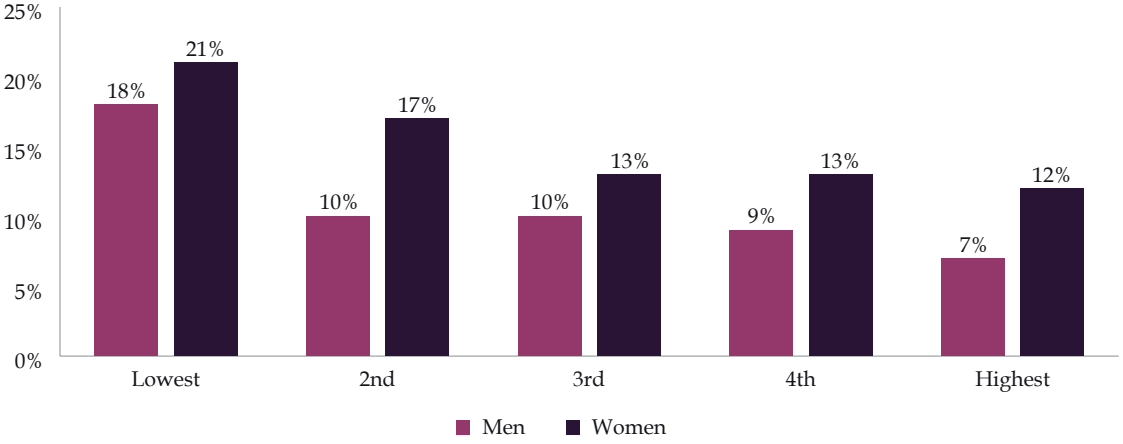
Depression in older adults is associated with increased risk of disability and earlier average age of death. Older adults with depression have an increased risk of suicide and are more likely than younger adults to complete suicide.[87] The proportion of older people diagnosed with depression is considerably higher for those in the lowest wealth quintile (Chart 2.4), although because this only covers those who have been diagnosed it may not be reflective of the actual proportion of depression sufferers in each group.

83. Matthews et al. (2012)
84. Woodcock, Franco, Orsini & Roberts (2011)
85. Buman et al. (2010)
86. Moffatt & Heaven (2017)
87. BMJ (2011)

Chart 2.4[88]

Diagnosed depression is significantly higher among those in the lowest wealth quintile

Proportion of individuals aged 50 and over diagnosed with depression, by gender and wealth



Satisfaction with life is highest in the Independent Phase and declines over the course of transitions through the Decline and Dependent Phases. 85% of people on the Independent Phase say that they are satisfied with life, compared to 77% of people in the Decline Phase and 63% of people in the Dependent Phase.

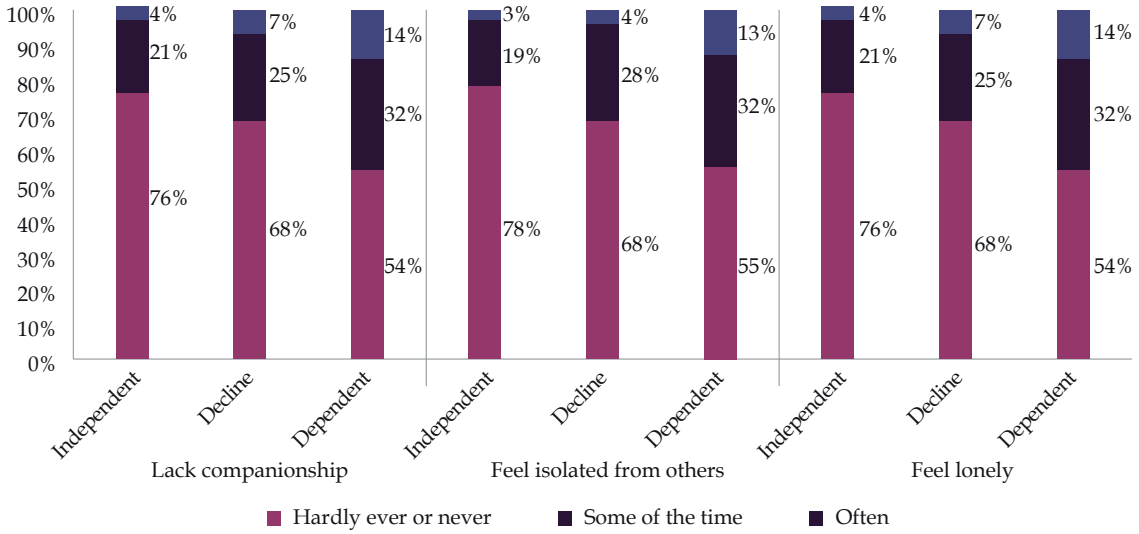
People in the Decline Phase of later life are more susceptible to loneliness than those in the Independent Phase, which can further exacerbate feelings of low emotional wellbeing

The prevalence of loneliness in older adults is estimated to be around 40%.[89] 32% of people in the Decline Phase say they feel isolated from others sometimes or often compared to 22% of people in the Independent Phase (Chart 2.5).

Chart 2.5

Isolation, loneliness and lack of companionship increases as people transition through the Phases

Proportion who express feeling isolated, lonely or having a lack of companionship, by phase



88. Banks et al. (2018)
89. Bekhet & Zauszniewski (2012)

Loneliness is positively correlated with a number of other retirement risks:

- Decline in ability to perform activities needed for daily living
- Decline in mobility
- Increased risk of early death[90]

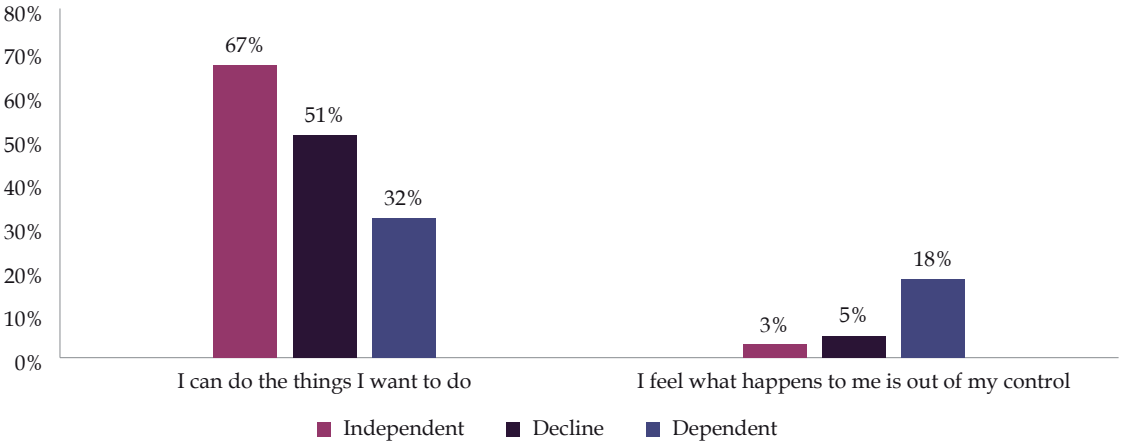
As people transition into the Decline Phase, they are more likely to feel that their age and health prevents them from doing the things they would like to

Only 51% of those in the Decline Phase of later life feel that they can often do the things they want to do, compared to 67% of those in the Independent Phase (Chart 2.6).

Chart 2.6

Those in the Decline and Dependent Phases are less likely to feel in control than those in the Independent Phase

Proportion who say they feel able to do the things they want to and those who say they feel what happens is out of their control, by phase

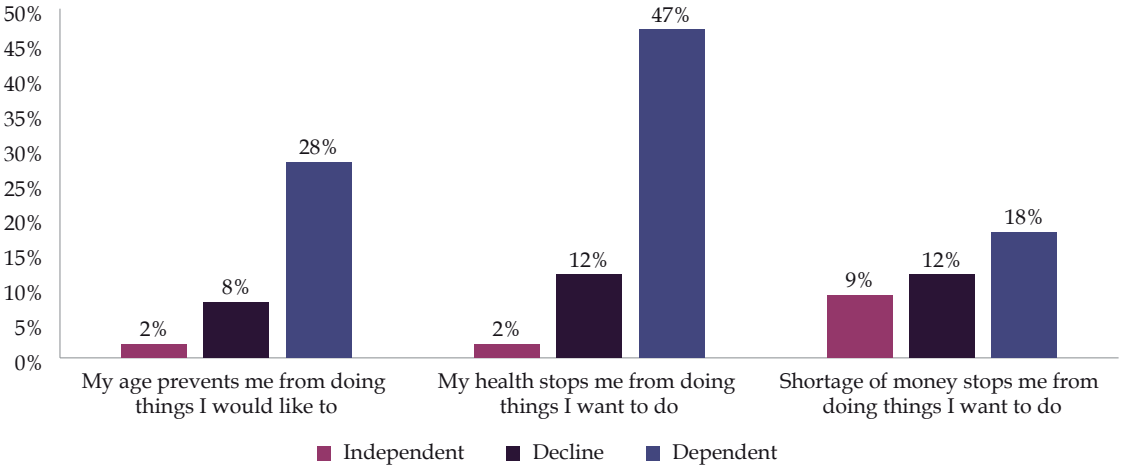


Nearly half of those in the Dependent Phase say their health stops them from doing things they want to do, compared to 2% of those in the Independent Phase. Age is also given as a reason why people in the Dependent Phase can't always do the things they want to, while perceived financial constraints increase at a slower rate between the phases (Chart 2.7).

Chart 2.7

Nearly half of those in the Dependent Phase say their health stops them from doing things they want to

Proportion who feel unable to do the things they want to, by reason and phase



90. Perissinotto, Cenzer & Covinsky (2012)

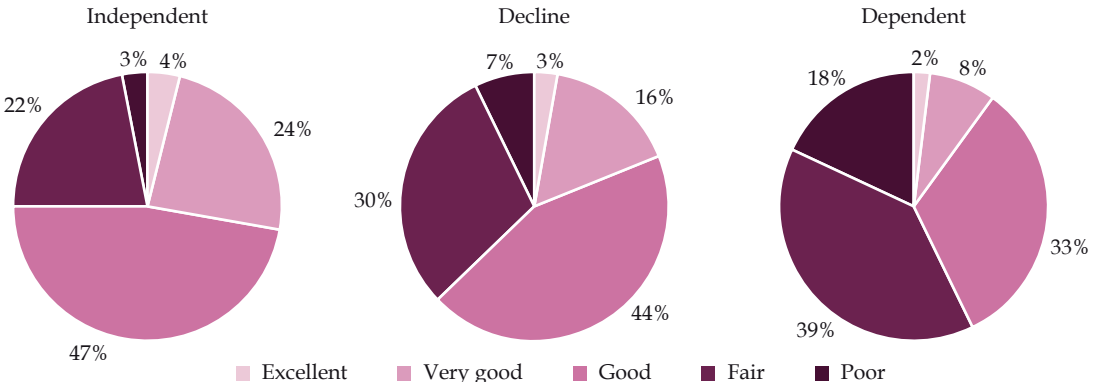
There is a trend towards cognitive decline as people reach older ages

Evidence suggests that there is a trend towards cognitive decline over the course of later life as individuals age.[91] Normal age-related cognitive decline tends to affect the speed at which older people process information and carry out cognitive processes (fluid intelligence), while knowledge accumulated over the lifecourse is generally less affected (crystallised intelligence). 7% of people in the Decline Phase rate their memory to be 'poor', compared to 3% of people in the Independent Phase. This increases to 18% for those in the Dependent Phase (Chart 2.8).

Chart 2.8

Memory declines as people transition through the phases

Self-rated memory by phase



The risk of experiencing accelerated cognitive declines increases as people transition into the Decline and then Dependent Phase

Accelerated cognitive declines become increasingly likely as people age through the phases of later life. There are currently around 808,000 people aged 65 and over with dementia in the UK. By 2025, the number is expected to rise to 1.14 million, and by 2051, it is projected to exceed 2 million.[92] However, this increase is largely driven by increased life expectancies.[93] The likelihood of suffering from dementia increases as people reach older ages (Figure 2.1).

Figure 2.1: The probability of suffering dementia increases with age[94]

91. Banks et al. (2018); Mazzonna & Peracchi (2009); Rohwedder & Willis (2010); Bonsang, Adam & Perelman (2012)
92. Age UK (2018)
93. BMJ (2017)
94. Age UK (2018)

Certain ethnic minority populations may be more at risk of cognitive decline. For example, African-Caribbean individuals aged 60 or over have been found to have a higher risk of dementia than white individuals of the same age (9.6% compared to 6.9%). They are also more likely to experience onset of dementia at younger ages.[95] However, it is unclear whether the cause of this increased risk is physical or cultural in origin. Policies aimed at reducing cognitive decline among this group would likely need to identify this as a starting point in order to be effective.

As with the Independent Phase, not everyone will experience the Decline Phase of later life

While many older people transition from Independent Phase to Decline Phase to Dependent Phase over the course of their retirement, some pass away while still in relatively good health (Independent Phase), while others experience sudden declines in health that see them skip the Decline Phase and transition directly from the Independent Phase to the Dependent Phase. People who do not transition gradually through the stages in order may need more support, as a result of sudden health declines, may require more support as they have less time to plan and adjust their behaviour to minimise the impact of declines.

95. Adelman et al. (2018)

Chapter Three: The Dependent Phase of later life

This chapter explores the Dependent Phase of later life and the risks that older people are increasingly exposed to during this phase.

The Dependent Phase[96] of later life is associated with:

- More severe physical declines and limitations, which may limit individuals in this phase from continued independent living. 12% of those aged 80 and over live in residential and nursing homes. Half (47%) of those in the Dependent Phase say that their health prevents them from doing the things they would like to do.
- A significantly increased risk of experiencing accelerated cognitive decline as the probability of suffering dementia increases with age. One in three people aged 95 and older suffer from dementia, compared to one in six aged over 80 and one in fourteen aged over 65.[97]
- High risk of loneliness and other experiences of adverse mental and emotional wellbeing. 14% of people in the Dependent Phase say they lack companionship, feel isolated from others or feel lonely often.
- High risk of social exclusion as severe physical limitations inhibit individuals from actively engaging with their community, as well as accessing basic services. Around one in five people in the Dependent Phase find it difficult or even impossible to access basic services such as banks, shops and GPs.

Approximately 24% of people over State Pension age (SPa) and/or retired are in the Dependent Phase. The proportion of people in this phase increases with age. Around 79% of people aged over 90 are in the Dependent. Like the Decline Phase, women are more likely to be in the Dependent Phase than men (Chart 3.1).

96. For information on the physical limitations used to categorise someone as being in the Dependent Phase see Appendix One.
97. Age UK (2018)

Chart 3.1

The likelihood of being in the Dependent Phase increases with age

Proportion of people in the Dependent Phase, by age and gender

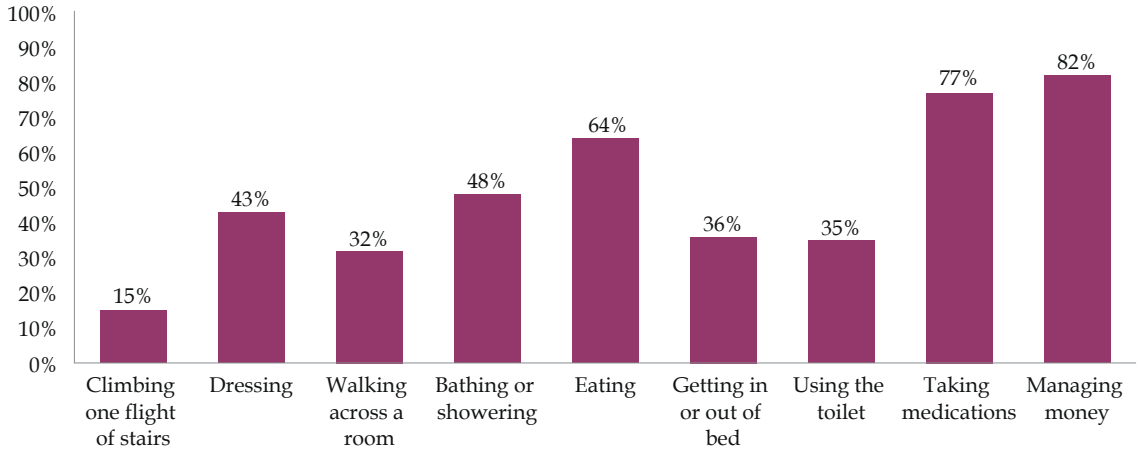
While those in the Dependent Phase are likely to need frequent assistance in performing basic daily tasks, not everyone in this phase is receiving the help they need

Those in the Dependent Phase have difficulty with at least one essential daily task and are likely to require frequent support in performing these (Chart 3.2).

Chart 3.2

People in the Dependent Phase are most likely to receive help with managing money and taking medications

Proportion of those in the Dependent Phase who receive help with physical limitations



Among those who do receive support, they are most likely to receive this from their spouse or partner; this means that single older people may be more at risk of not receiving the care they need.

Even those who do receive regular support, do not necessarily find that their needs are met. When thinking about the care they receive, 38% said that it met their needs all the time, 17% said it usually met their needs, 5% sometimes, and less than 1% said it hardly ever met their needs. However, 40% of people in the Dependent Phase are not receiving any care at all (Figure 3.1).

Figure 3.1

People aged 85 and over are less likely to have weekly social contact with friends and family, and face a higher risk of isolation and loneliness than younger retirees, particularly if they live alone.

Older people in the Dependent Phase of later life are at greater risk of social exclusion

Risk of social exclusion increases with age, as does the likelihood of being in the Dependent Phase of later life. People aged 85 and over are less likely to have weekly social contact with friends and family, and face a higher risk of isolation and loneliness than younger retirees, particularly if they live alone.[98] Older people are more likely to be widowed, live alone and experience bereavement of members of their wider social network of friends and family (e.g. siblings and cousins). They may also be less able to engage with the broader community due to physical declines and other aspects of social exclusion, for example poor transport links. Because older people are more likely to experience mobility difficulties and challenges with access to adequate transportation, their local neighbourhood is likely to become increasingly important to wellbeing, as the geographical area with which they can comfortably interact shrinks.[99] As those in the Dependent Phase are likely to be less able to travel widely, the quality of their home and local community becomes increasingly important to their standard of living. There are a number of ways in which older people may experience social exclusion which can be detrimental to their quality of life (Figure 3.2).

98. Key & Culliney (2016)
99. Burns, Lavoie & Rose (2012)

Figure 3.2[100]

Older people are at greater risk of experiencing social exclusion if they:

- Are 80 years old and over
- Live alone
- Have no children
- Have poor mental or physical health
- Have no access to a private car and never use public transport
- Live in rented accommodation
- Have a low level of income and/or benefits are their main source of income
- Have no telephone access[101]

Having access to decent housing is vital to ensuring wellbeing and social inclusion among older people

Older people, and particularly those in the Dependent Phase and to a lesser extent those in the Decline Phase, are likely to spend a greater proportion of their time at home than younger cohorts. They are also more likely to be living with chronic health conditions which may be exacerbated by poor quality housing. Ensuring that older people are housed in satisfactory accommodation is an important part of improving wellbeing among this group, as poor quality housing can:

- Impact both physical and mental health
- Affect carers' ability to care
- Fundamentally undermine older people's ability to live independently, safely and as part of the wider community[102]

While levels of home ownership are high among the retired, this does not necessarily indicate wealth as many homeowners may be asset rich (in the form of their home) but cash poor and unable to maintain their home to a decent standard. Around one in five people aged 65 or older lived in a home that failed to meet the Decent Homes Standard (Box 3.1) in 2012. The vast majority (79%) of these households were owner occupied. The main reason for homes failing to meet the Decent Homes Standard is risk of falls and excess cold.[103]

100. Barnes et al. (2006)
101. Barnes et al. (2006)
102. Care & Repair England (2016)
103. Care & Repair England (2016)

While levels of home ownership are high among the retired, this does not necessarily indicate wealth as many homeowners may be asset rich but cash poor and unable to maintain their home to a decent standard.

Box 3.1[104]

The Decent Homes Standard is a minimum standard council and housing association homes should meet according to the government.

Under the standard, homes must:

- Be free from any hazard that poses a serious threat to tenants' health or safety
- Be in a reasonable state of repair
- Have reasonably modern facilities
- Have efficient heating and insulation

A home fails the Decent Homes Standard if it doesn't meet all four criteria.

A home could fail to meet the criteria if, for example:

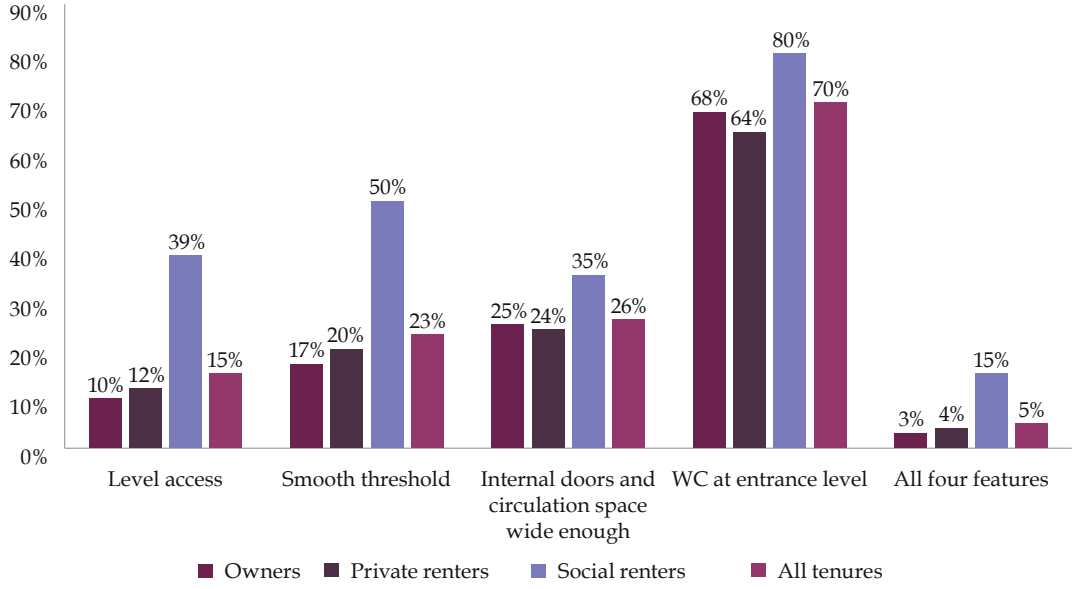
- There are hazards in the home such as persistent damp or a heating or electrical system that is in poor condition
- The bathroom has not been improved in the last 30 years
- The kitchen doesn't have enough space
- It isn't warm because of an inefficient heating system or ineffective insulation

95% of homes in the UK do not include the most basic characteristics that make homes accessible for older people, such as level access, ground floor WC etc. (Chart 3.3).[105] Between 20% and 40% of older homeowners could stand to benefit from some form of adapted or specialised housing, on account of having a longstanding disability or health issue.[106]

Chart 3.3[107]

95% of homes in the UK do not include all the necessary characteristics of an accessible home

Proportion of each accessibility feature among households aged 65 or older, by tenure, 2012



104. https://england.shelter.org.uk/housing_advice/repairs/what_counts_as_a_decent_home
105. Care & Repair England (2016)
106. The Strategic Society Centre (2015)

Policies aimed at relocating older people to more appropriate housing are often suggested as the solution to the problem of poor quality housing among this group. However, given the low proportion of homes currently available which would meet the accessibility needs of older people in the Dependent Phase of later life, this is likely not practicable on a large scale. Furthermore, four in five (80%) older homeowners wish to remain where they are and 85% plan to stay in their neighbourhood for a number of years.[108]

Without decent public transportation, many older people can find themselves isolated from accessing basic services and engaging with their community

Alongside adequate accommodation, the ability to engage with basic services and community are important to older people's quality of life. As well as availability, the ability to get to these services is vital. If older people do not have access to a private vehicle and public transport links are poor, they may be excluded from accessing and engaging.

People may find themselves excluded from transportation for a variety of reasons:

- Physical exclusion: whereby physical barriers, such as vehicle design, lack of disabled facilities or lack of timetable information, inhibit the accessibility of transport services.
- Geographical exclusion: where a person lives can prevent them from accessing transport services, for example in rural areas.
- Economic exclusion: the financial cost of travel, either public transport or maintenance of a private vehicle, can prevent or limit access to facilities.
- Time-based exclusion: other demands on time, such as household and caring duties, can reduce the time available for travel.
- Fear-based exclusion: where fears for personal safety preclude the use of public transport services.[109]

The 'walkability' of a neighbourhood, for example the availability of pavements and safe crossing points, can also have far-reaching effects of physical activity, and as a result physical health, as well as social inclusion and emotional wellbeing.[110]

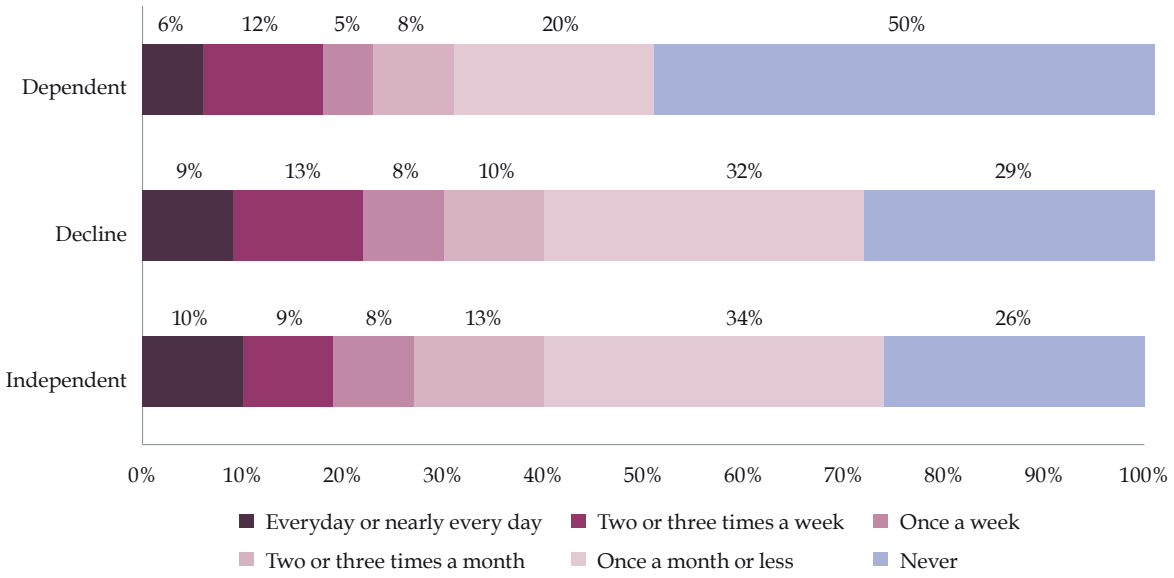
Those in the Dependent Phase of later life are the least likely to have access to a private vehicle, either as the driver or passenger, and are also less likely to use public transport frequently. Older people in the Dependent Phase are less likely to use public transport than those in the Independent and Decline Phases. Half (49.5%) of people in the Dependent Phase never use public transport, compared to around a quarter (26.2% and 28.8%) of those in the Independent and Decline Phases (Chart 3.4). Almost as many (48%) people in the Dependent Phase say they don't use public transport because they don't need to (Chart 3.5), suggesting that around 1.5% of people in the Dependent Phase are unable to do so, most likely because their physical limitations make this difficult (Chart 3.6).

107. Care & Repair England (2016)
108. The Strategic Society Centre (2015)
109. Church, Frost & Sullivan (2000)
110. Van Dyck et al. (2012)

Chart 3.4

Half of those in the Dependent Phase never use public transport

Frequency of public transport use, by phase



People in the Independent and Decline Phases are more likely to cite problems with public transport provision as the reason they don't use it more. Although, 70% say that they don't use it simply because they don't need to, likely because of higher levels of access to private vehicles (Chart 3.5). People in the Dependent Phase are significantly more likely to cite problems with health or mobility as the reason they do not use public transport more frequently (Chart 3.6).

Chart 3.5

People in the Independent and Decline Phases are more likely to say they do not use public transport more often because of problems with the transport itself or a lack of need

Reasons for not using public transport, by phase

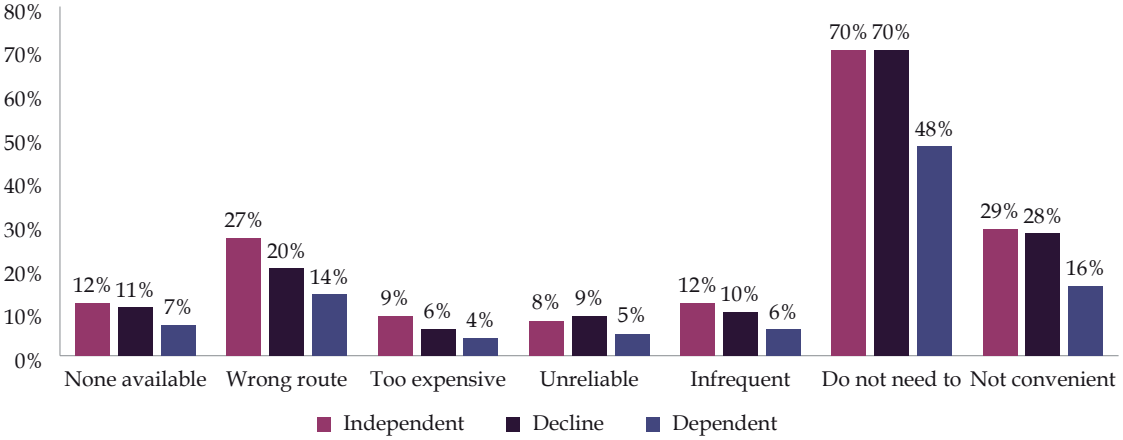
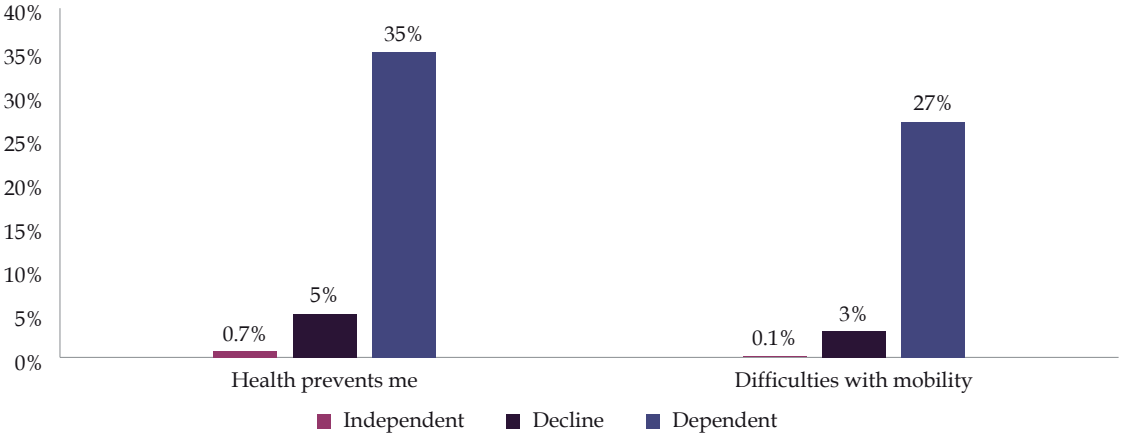


Chart 3.6

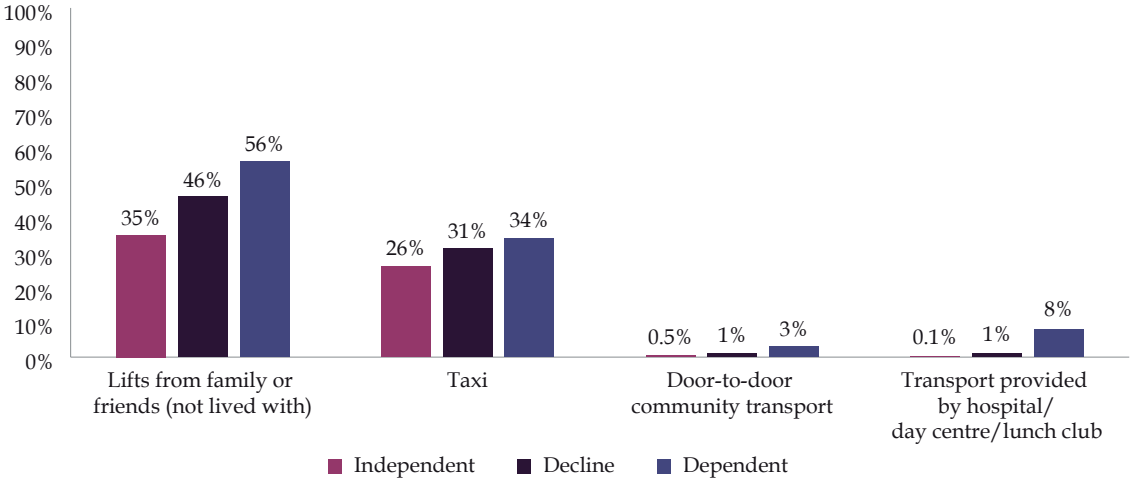
More than a third of people in the Dependent Phase say they do not use public transport more frequently because their health prevents them



Older people living in areas with poor public transport and/or low levels of walkability are likely to be more heavily dependent on lifts from friends/family or using taxis, in order to access basic services, particularly if they are in poor physical health. This can act as a barrier to social inclusion for those on low or fixed incomes. Among those in the Dependent Phase, use of alternative means of transport (other than own vehicle or public transport such as bus, train etc.) are more common (Chart 3.7).

Chart 3.7

Reliance on family or friends for lifts increases across the Phases, as does use of taxis and community-provided transport



The accessibility of basic services and amenities decreases as people transition through the phases

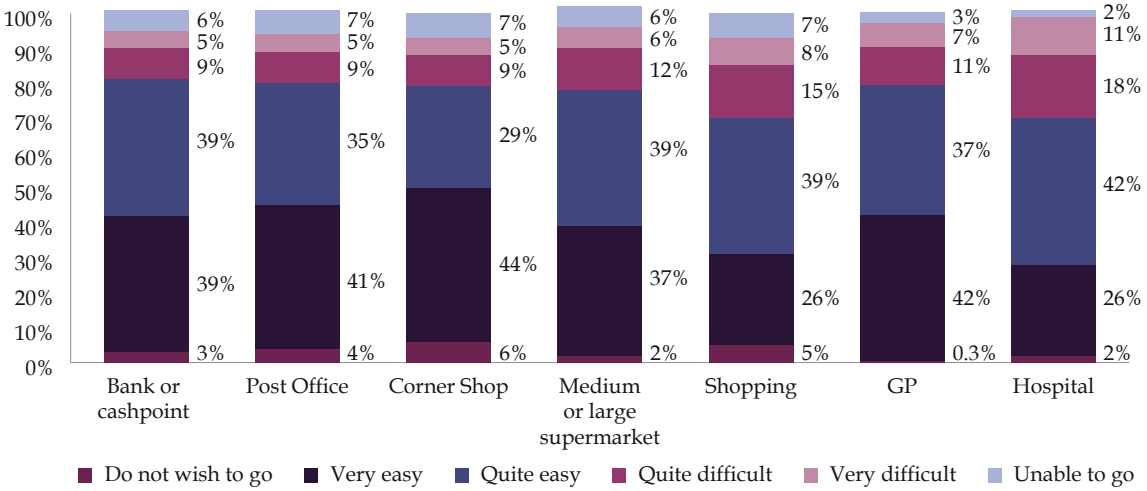
Older people in the Dependent Phase of later life are more likely to have difficulty accessing essential services, such as banks, doctors and food shops. Low mobility due to health problems, which are generally more severe in the Dependent Phase, or lack of access to adequate transport can be a significant barrier to older people accessing basic services and amenities.[111] Around one in five people in the Dependent Phase find it difficult or

111. Key & Culliney (2016)

even impossible to access basic services and amenities, including 3% who find themselves unable to visit a GP (Chart 3.8). People in the Independent Phase find it much easier to access these services, with around 2% finding them difficult to access. Ease of access decreases as people transition through the phases. Around 5% of people in the Decline Phase have difficulties accessing services. However, the decline is steepest between the Decline and Dependent Phases.

Chart 3.8

Around one in five in the Dependent Phase find it difficult, or even impossible, to access basic amenities



Changes to shopping areas that have occurred in recent years, with more larger supermarkets located on the fringes of towns and cities, have made it harder for some older people to access these amenities. They find themselves restricted to smaller, but more accessible shops, where there is less variety and produce is often more expensive than large out-of-town supermarkets.[112] These ongoing changes are likely to exacerbate inequalities in quality of life and financial stability, particularly between those in the Dependent Phase who are receiving the support that they need, whether from family and friends or formal support organisations, and those who are not.

Hospitals are, on average, more difficult for people to access using their usual form of transport. This may be less of an issue for people in the Independent and Decline Phases who are likely to need to visit the hospital less frequently. For people in the Dependent Phase, who are significantly more likely to attend the hospital on a regular basis, difficulty getting to and from the hospital has a greater detrimental impact on their quality of life, potentially alongside their finances, which can be impacted by the need to use taxis more frequently.

Older people in the Dependent Phase may be more susceptible to exclusion from financial services, as well as certain types of fraud which can be exacerbated by this exclusion

Older people, are on average, more financially capable than younger groups, perhaps because they have been managing their finances for a considerably longer period, and many are likely to have accumulated significantly more wealth. Those with substantial levels of wealth may also have engaged with more sophisticated financial instruments through investment, for example.

There is, however, considerable diversity in the financial capability of older people. This diversity spans their economic means, cognitive abilities, digital connectivity and competence, and access to appropriate support. These factors are not fixed and may change over the course

112. Clough et al. (2007)

of later life.[113] People in the Dependent Phase are more likely to have some difficulty with financial matters as they are at greater risk of having experienced significant cognitive decline than retirees in the Independent and Decline Phases.

Particular financial capability issues relevant to older people include:

- A tendency not to plan for long-term care
- Not shopping around for the best deals
- Reticence to talk about money
- Low levels of online literacy[114]

Older people may be especially susceptible to certain types of fraud, including investment fraud and other types of fraud which involve the victim being tricked into transferring money under false pretences.[115]

Older people's financial risks can be compounded by financial exclusion, which may include inability to access online banking services, due to lack of internet connection or low levels of computer literacy, and/or local bank branches, due to lack of mobility or scarcity of bank branches within reasonable distance, which is increasingly a problem with many branches closing around the country.

As older people transition in the Dependent Phase, they are more likely to need plans in place for powers of attorney so that a nominated person can make decisions on their behalf should they lack the mental capacity. There are two types of lasting power of attorney:

- Property and financial affairs: makes decisions on matters such as dealing with bank accounts, paying outstanding bills and selling their house.
- Health and welfare: makes decisions on matters such as where the individual lives, medical treatment and lifesaving care.[116]

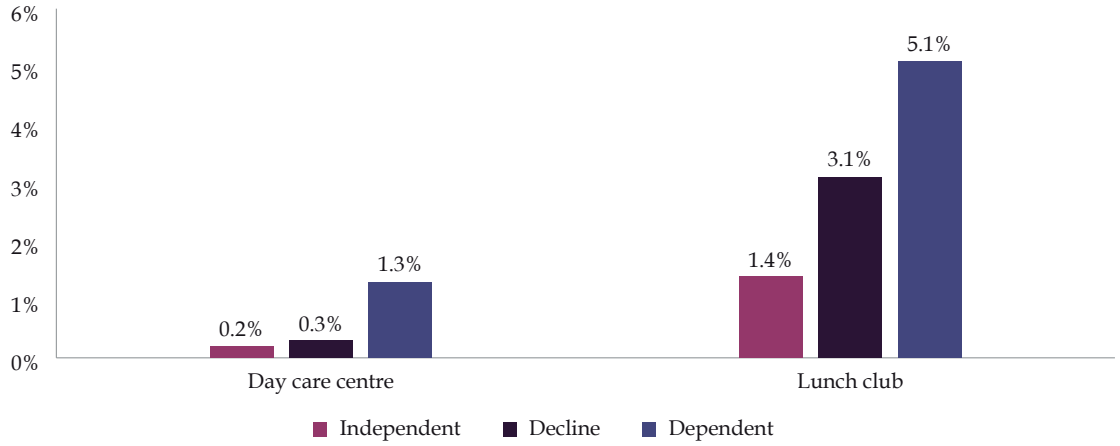
People in the Dependent Phase generally engage in different kinds of leisure to those in the Independent and Decline Phases

As discussed in Chapter One, those in the Dependent Phase of later life are less likely to engage with cultural leisure activities outside of the home than those in the Independent Phase. They are also more likely to express wanting to do these things more frequently but, for whatever reason, being unable to do so. Those in the Dependent Phase are more likely to engage in certain other activities, in particular attending day care centres and lunch clubs (Chart 3.9). However, even among those in the Dependent Phase, attendance is low, despite the fact that many older people could benefit from wider community engagement.

Chart 3.9

People in the Dependent Phase are more likely to attend day care centres and lunch clubs

Proportion of people who have attended a day care centre or lunch club in the last month, by phase



113. Collaborate Research [Age UK & FinCap UK] (2017)
114. Collaborate Research [Age UK & FinCap UK] (2017)
115. ONS (2018a)
116. Martins (2013)

As well as their physical limitations constraining them from engaging with a broader range of leisure activities, people in the Dependent Phase may be more likely to feel unable to engage in certain activities because they have no one to do them with, particularly if they live alone and have a limited social network.

Older people's perceptions of safety and the extent to which they feel they belong in their local community impact their willingness to engage in leisure and community activities outside of the home

Older people, particularly those in the Dependent Phase, can face isolation in their communities, especially if they feel fear of others or are resistant to change or apprehensive about taking part in new activities.[117] While older people may be more vulnerable than younger groups in some instances, they often have a disproportionately high perception of their risk of crime compared to how often they are victims, with older people, in fact, less likely to be a victim of crime than the population as a whole.[118] Although, older people are generally more vulnerable to certain types of crime, such as distraction burglary (criminals gain access to a property under false pretences, with the intention of committing theft) and particular types of fraud.

Neighbourhood exclusion is also related to whether older people feel connected to their surrounding area, the friendliness of local people and their ability to rely on people living close to them. In many cases, older people are more engaged with their communities. Compared to younger age groups, those aged 65 and over are more likely to say they:

- Feel they belong to their local area
- Regularly stop to talk with people in their neighbourhoods
- Trust their neighbours
- Would be willing to help their neighbours[119]

Older people have often been resident in a single neighbourhood for much of their adult lives, which may increase the extent to which they feel connected and safe within it.[120] If the neighbourhood has changed considerably during the time they have lived there, as a result of gentrification for example, or if they have recently relocated to a new neighbourhood, for example to move to more accessible housing, connectedness with the neighbourhood is likely to be lower.[121] Feelings of being connected to the wider community may also be lower during the Dependent Phase as low levels of mobility and physical capacity inhibit engagement.

The likelihood of moving into a residential care home increases as people transition into the Dependent Phase

While older people in the Dependent Phase may be able to continue living somewhat independently in their own homes with external support, as their frailty increases and capabilities decline, the need to move into long-term residential or nursing care increases. In England, there is, approximately, a 35% chance of a 65 year old female, and a 25% of a 65 year old male, having substantial care needs at some point in their life.[122] Around 4% of people aged 65 and over, and 12% of those aged 80 and over, live in residential and nursing homes.[123] The average stay is about 1.4 years in nursing homes and 2.3 years in residential homes. There is considerable variation in the length of stay, with those who stay longer than 75% of residents staying for around double the average (3.5 years in nursing homes and 4.3 years in residential homes).[124]

Expectations about the likelihood of needing long-term care change as people transition between phases

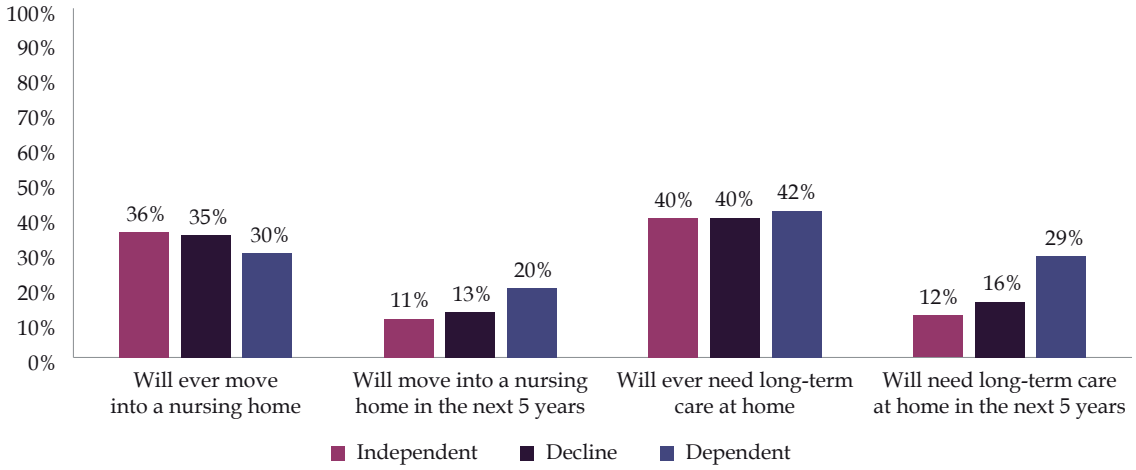
People in the Dependent Phase of later life are likely to estimate their probability of needing long-term care in the next five years as higher than those in the Independent and Decline Phases, but estimates of the likelihood of needing to move into a care home at all are lower among those in the Dependent Phase (Chart 3.10).

117. Age UK (2015)
118. ONS (2018a)
119. ONS (2018a)
120. Age UK (2015)
121. Burns, Lavoie & Rose (2012)
122. IFoA (2015)
123. Hancock et al. (2007)
124. Killik & Co (2014)

Chart 3.10

Expectations about the likelihood of needing long-term care change as people transition between phases

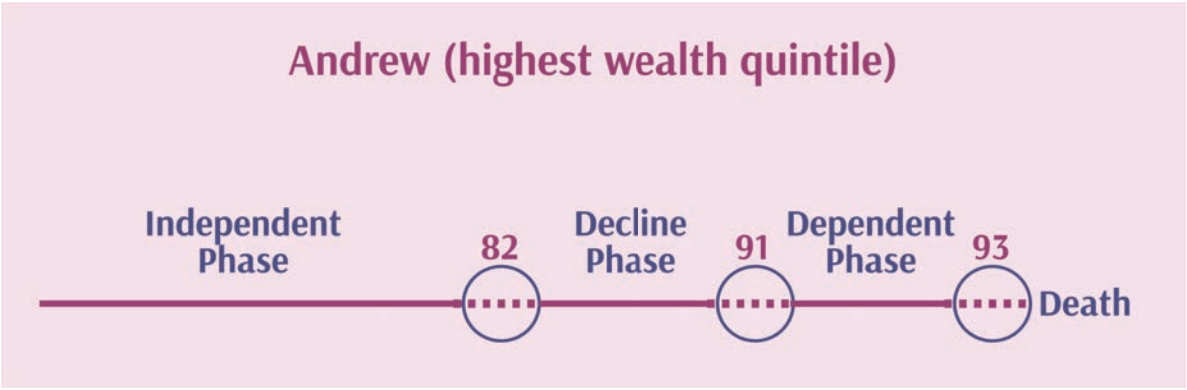
Expectations of needing nursing or long-term care, by phase



Chapter Four: Individual experiences of later life

While each older person will have a unique experience of later life, there are patterns in the way that people with similar characteristics transition through the phases of later life. Previous chapters have discussed the disparities that exist between people of differing socioeconomic backgrounds. Levels of wealth are a strong determinant of the phase trajectories individuals are likely to experience in later life, with wealthier individuals likely to remain Independent for longer and those in lower wealth quintiles more susceptible to the risk of early decline. This chapter explores the different trajectories that may be experienced by people in different wealth quintiles.

Hypothetical individual 1



People in the wealthiest quintile are likely to remain in the Independent Phase until much older ages than those in lower quintiles of wealth

Andrew enjoys good health for the majority of his later life and so has more freedom to choose how he spends his time. People in the wealthiest quintile, like Andrew, are unlikely to have financial pressures which require continuation of paid work, so any decision to do so is likely to be based on a desire to keep working rather than a need; for example, to maintain professional identity, keep busy or because of enjoyment of their job. Without financial pressure to keep working, people in the wealthiest quintile are less likely to continue working until a serious health decline forces them out of the labour market, compared to those in lower quintiles who may have greater need for continued income from employment.

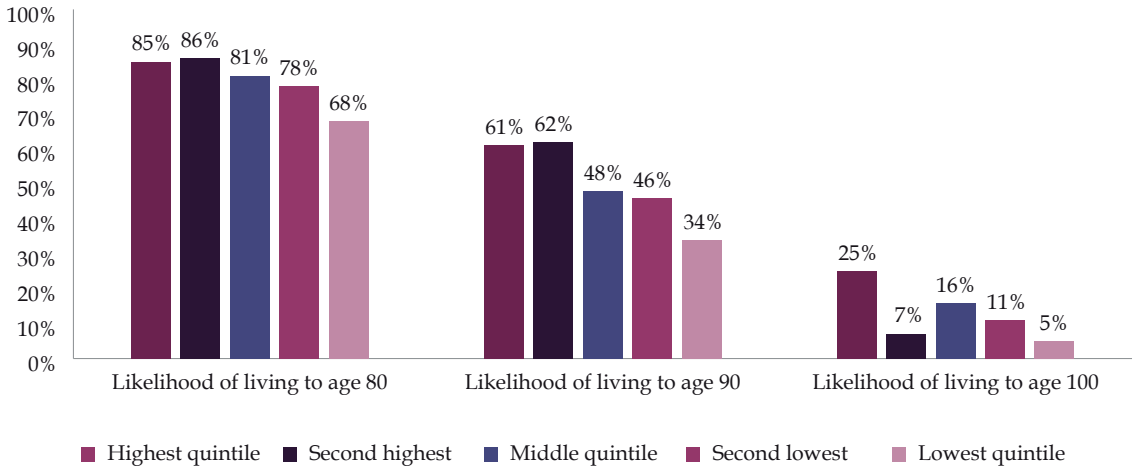
People in the highest wealth quintile are significantly more likely to live to older ages than those in lower wealth quintiles

Among those in the wealthiest quintile who are in the Independent Phase at age 60, nearly two-thirds (62%) will live until at least age 90, compared to less than half (46.5%) of the population as a whole. A quarter (25%) of people in the highest wealth quintile will live until they are 100, compared to 7% of those in the lowest wealth quintile (Chart 4.1).

Chart 4.1

People in the highest wealth quintile are significantly more likely to live to older ages than those in lower quintiles

Likelihood of living to ages 80, 90 and 100, by wealth quintile



Assumes individuals are in Independent Phase at age 60

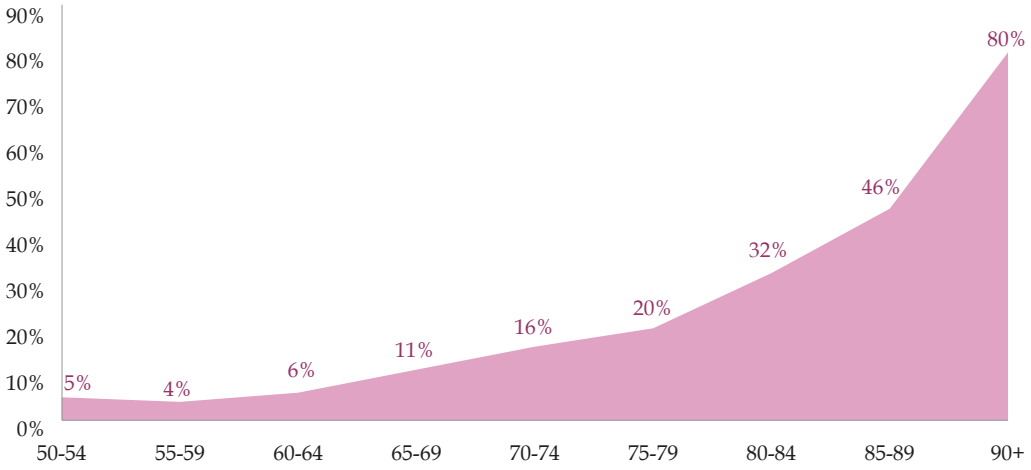
From age 90 onwards, people in the highest wealth quintile, who are likely to have experienced a relatively healthy later life thus far, experience a rapid shift towards the Dependent Phase

While people in the highest wealth quintile are generally less likely to be in the Dependent Phase than those in lower quintiles (9% compared to an average of 21% for all quintiles), they experience a rapid shift into this phase from age 90 onwards. At ages 85 to 89, less than half (46%) of this quintile are in the Dependent Phase, with nearly a third (29%) still in the Independent Phase, compared to around one in ten for all other quintiles. Among those in the wealthiest quintile who are aged 90 or older, eight in ten (80%) are in the Dependent Phase (Chart 4.2).

Chart 4.2

There is a rapid shift into the Dependent Phase among those in the highest wealth quintile following age 90

Proportion of those in the highest wealth quintile in the Dependent Phase, by age

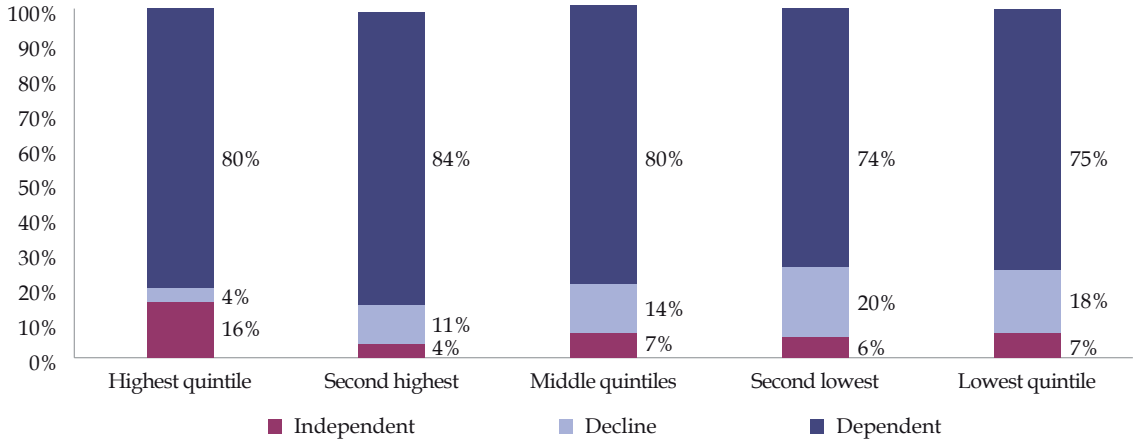


Among those aged 90 and over, those in the wealthiest quintile are the least likely to be in the Decline Phase compared to other quintiles (Chart 4.3). This suggests that the wealthiest quintile transition rapidly from Independent to Dependent after age 90, without spending much time in the Decline Phase. Andrew spends two years in the Dependent Phase (ages 91 to 93).

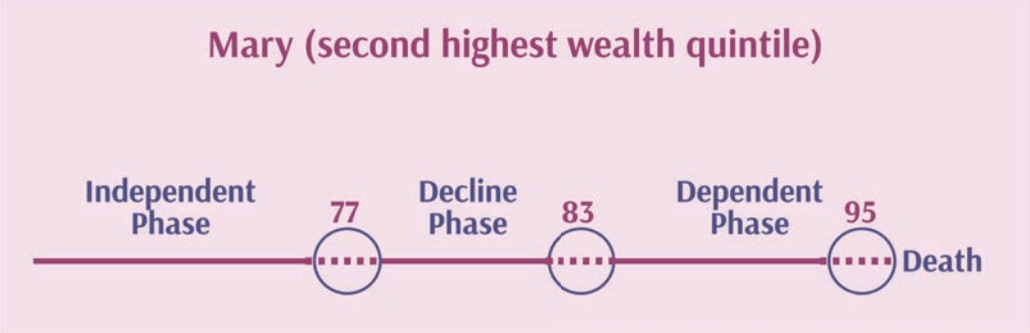
Chart 4.3

Among people aged 90 and over, those in the highest quintile are the least likely to be in the Decline Phase

Proportion of people aged 90+ in each phase, by wealth quintile



Hypothetical individual 2



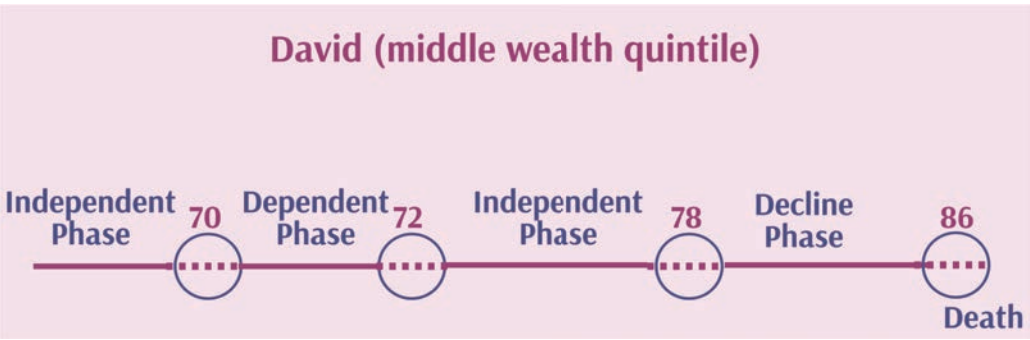
Like those in the highest wealth quintile, people in the second highest quintile are likely to remain in the Independent Phase for longer than those in lower quintiles

Mary remains in the Independent Phase until age 77. At this age around half (52%) of people in the second highest wealth quintile, like Mary, have transitioned out of the Independent Phase. Mary transitions into the Decline Phase because she has some minor physical limitations, including difficulty walking long distances, climbing stairs and bending or kneeling.

By ages 80 to 84, two in five people in the second highest wealth quintile are in the Dependent Phase. At age 83, Mary transitions from the Decline Phase into the Dependent Phase as her physical limitations increase. She finds it difficult to walk shorter distances, get herself out of bed or a chair after a period of sitting, and finds it increasingly difficult to bathe and dress herself.

As her mobility problems grow more severe, Mary finds it harder to engage with activities she used to enjoy outside of the home, and spends an increasing amount of time at home alone. Mary's risk of loneliness and social exclusion further increases with the death of her husband when she is age 85. Among women aged 85 and over, three quarters (77%) are widows.[125]

Hypothetical individual 3



People in the middle quintile are more likely than those in higher quintiles to have financial reasons for continuing to work for longer, although less likely than those in lower wealth quintiles. Half (51%) of those in the middle wealth quintile are in the Independent Phase, with no physical limitations at age 70.

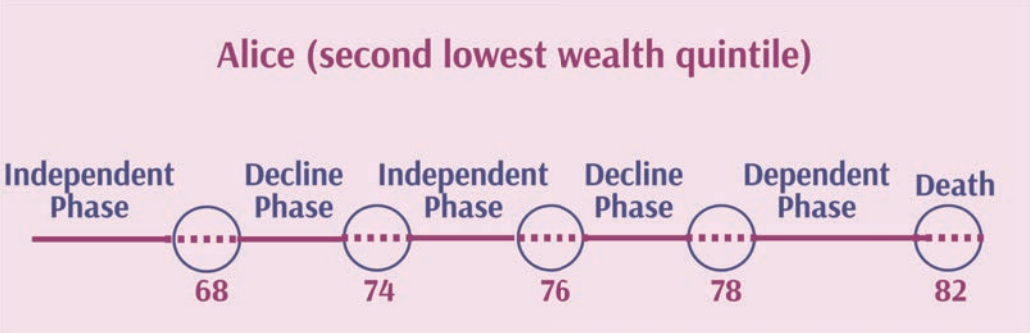
David has a stroke at age 70 and spends two years in the Dependent Phase. He recovers with rehabilitative support, and by age 72 he is back in the Independent Phase and is once again physically able to engage with hobbies and leisure activities outside of his home. However, having spent two years mainly at home, David

125. ONS (2018b)

finds it difficult to get back into the activities he used to enjoy regularly before his time spent in the Dependent Phase.

Between ages 75 and 79, two in five (40%) people in the middle wealth quintile are in the Decline Phase. David transitions from the Independent Phase to the Decline Phase at age 78.

Hypothetical individual 4

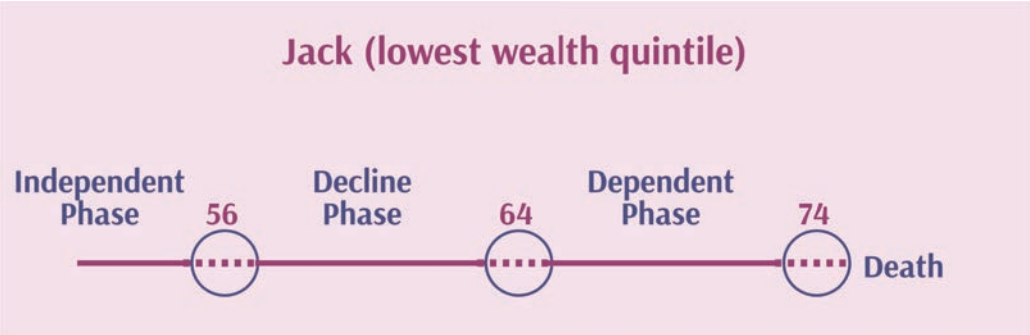


People in the second lowest wealth quintile are more likely to experience 'reverse transitions' compared to those in other quintiles. These reverse transitions can see them 'bouncing' back and forth between phases as their health deteriorates and improves. Alice experiences this type of unsteady trajectory as she transitions from the Independent Phase to the Decline Phase twice, with a reverse transition in between, before finally transitioning into the Dependent Phase four years before her death.

Alice had some minor physical limitations before her retirement at age 65, but found that these were alleviated when she left paid employment. She used some of her increased leisure time to engage in more moderate physical activities such as walking, which contributed to improvements in her health post-retirement.

When Alice was age 67, her 90 year old mother fell ill. Her younger brother (age 64) had not yet retired, so Alice took responsibility for providing informal care for their mother. The stress of this full-time commitment caused Alice's health to worsen and she transitioned into the Decline Phase at age 68 as a result. After her mother's passing when Alice was 73, her health once again improves and she transitioned back into the Independent Phase between ages 74 and 76.

Hypothetical individual 5



People in lower wealth quintiles are likely to have a greater need to continue working but are less likely to be in good health which allows them to do so without detriment

Among those in the lowest wealth quintile, there is a significant shift from the Independent Phase into the Decline Phase in the early- to mid-fifties. Those with poorer health, particularly those in the Decline or Dependent Phase in their fifties and sixties, are less able to continue working beyond SPa. Because health issues are more prevalent among those in lower wealth quintiles, there is often an overlap between those who need to continue working beyond SPa due to financial pressures and those who are less able to continue working due to poor health and physical limitations. Half of men currently aged between 55 and 64 in the lowest wealth quintile have a health problem that limits the kind or amount of work they can do, compared to 10% of those in the highest wealth quintile.[126]

Jack works until he is age 62, despite having transitioned into the Decline Phase at age 56. During his first few years in the Decline Phase, Jack has a small number of minor physical limitations but as he continues to work a physically demanding job, these issues increase relatively rapidly.

While in the Dependent Phase, those in lower wealth quintiles are likely to need more support if they are to avoid having particularly poor later life experiences

Even while in the Dependent Phase, members of higher wealth quintiles are likely to have more positive later life experiences than those in lower quintiles. As well as the increased physical limitations associated with the Dependent Phase, the risk of social exclusion plays a significant role in determining the quality of later life experienced during this phase.

Many of the risk factors associated with experiencing social exclusion are also associated with having lower levels of wealth:

- Low income and/or benefits as the main source of income
- Live in rented accommodation
- No access to a private car and never use public transport

This means that those in the lower wealth quintiles, such as Alice and Jack, are at greater risk of experiencing social exclusion while in the Dependent Phase. They are likely to need more support in order to experience the same standard of living as those in the Dependent Phase in higher wealth quintiles.

126. Centre for Ageing Better (2019)

Appendix One: Definitions of Phases

Individuals in the Independent Phase of later life have no physical limitations.

Individuals in the Decline Phase of later life have mild physical limitations, including difficulty with one or more of the following activities:

- Walking 100 yards
- Sitting for about two hours
- Getting up from a chair after sitting for long periods
- Climbing several flights of stairs without resting
- Stooping, kneeling or crouching
- Reaching or extending arms above shoulder level (either arm)
- Pulling or pushing large objects, like a living room chair
- Lifting or carrying weights over 10 pounds, like a heavy shopping bag of groceries
- Picking up a 5p coin from a table
- Using a map to figure out how to get around in a strange place
- Recognising when you are in physical danger
- Preparing a hot meal
- Shopping for groceries
- Doing work around the house or garden

Individuals in the Dependent Phase of later life have severe physical limitations, including difficulty with one or more of the following activities:

- Climbing one flight of stairs without resting
- Dressing, including putting on shoes and socks
- Walking across a room
- Bathing or showering
- Eating, such as cutting up food
- Getting in or out of bed
- Using the toilet, including getting up or down
- Making telephone calls
- Communication (speech, hearing or eyesight)
- Taking medications
- Managing money, such as paying bills and keeping track of expenses

They may also have some of the difficulties described in the Decline Phase, in addition to these difficulties.

Appendix Two: Individual experiences of later life (additional charts)

Chart AP2.1

Probability of being in each phase, by age: Highest wealth quintile

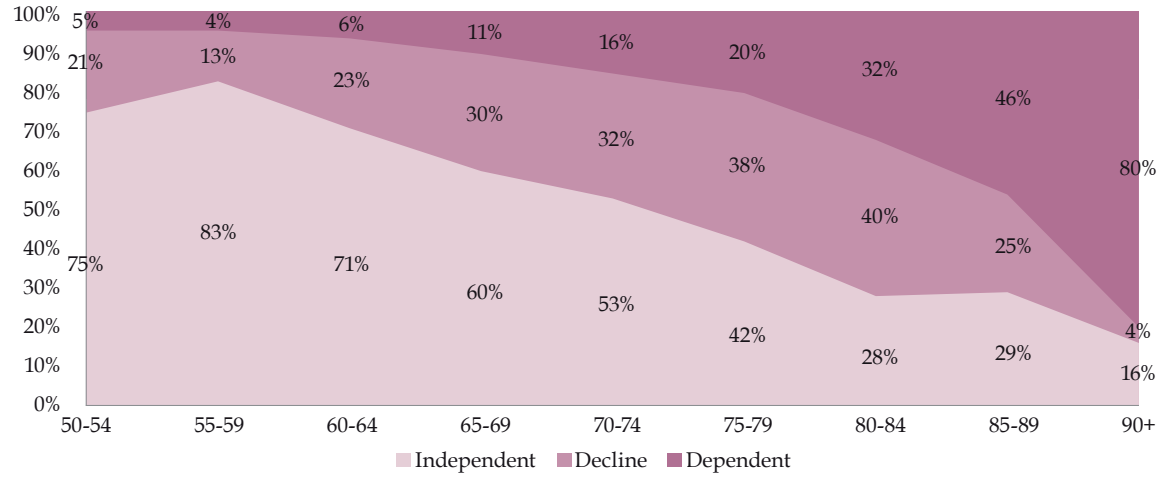


Chart AP2.2

Probability of being in each phase, by age: Second highest wealth quintile

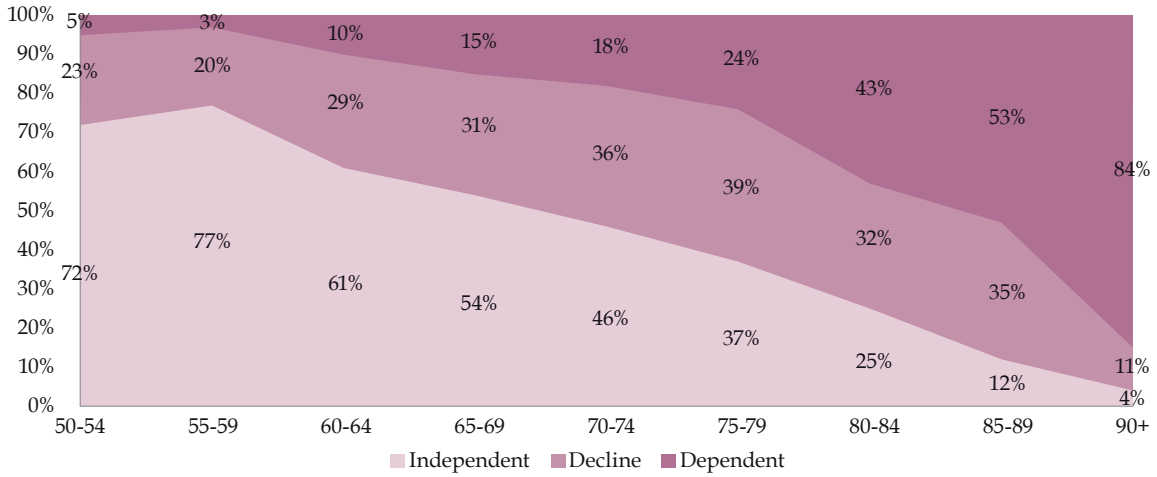


Chart AP2.3

Probability of being in each phase, by age: Middle wealth quintile

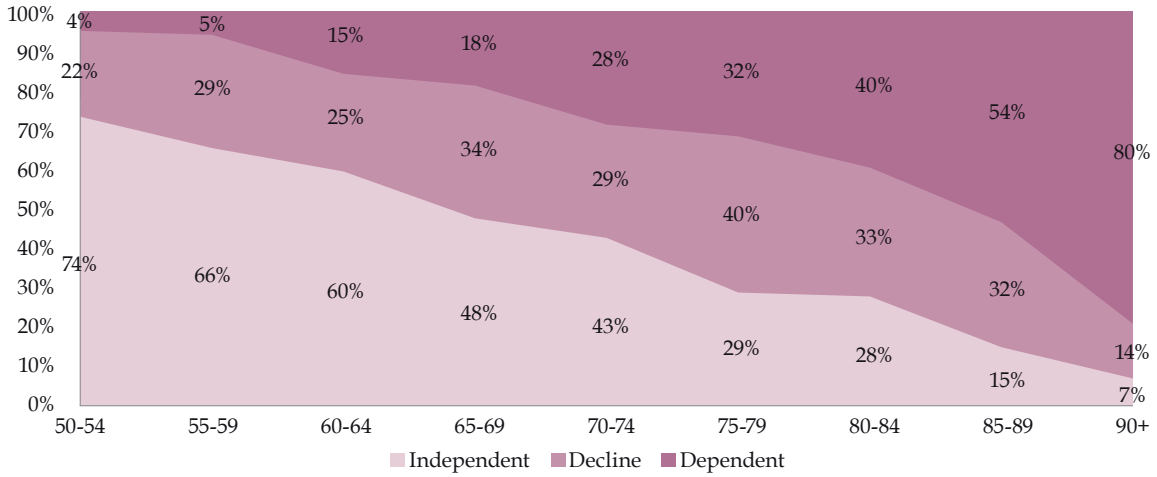


Chart AP2.4

Probability of being in each phase, by age: Second lowest wealth quintile

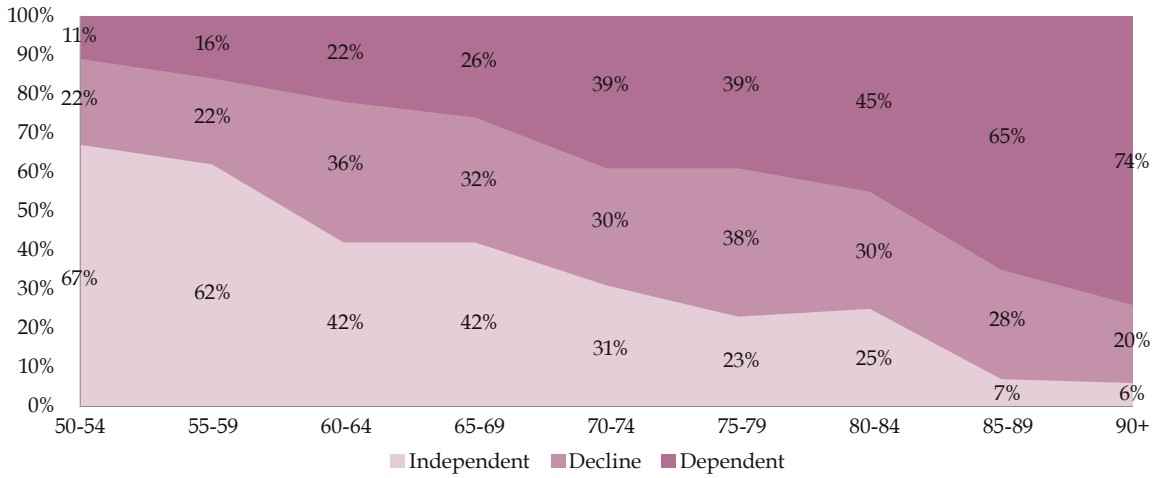
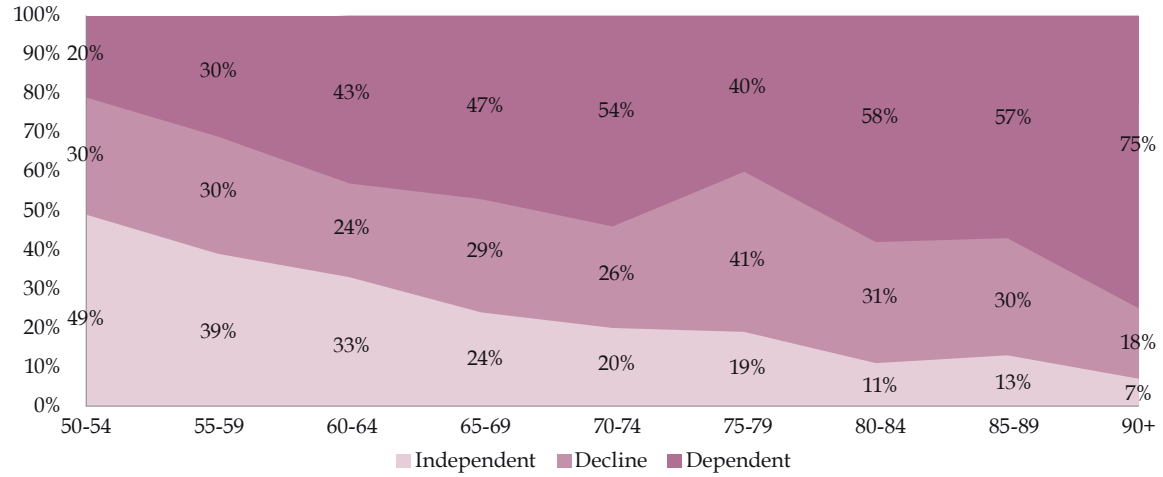


Chart AP2.5

Probability of being in each phase, by age: Lowest wealth quintile



Appendix Three: Technical Appendix

Modelling and the resulting analysis conducted in this report has been based on data from the English Longitudinal Study of Ageing (ELSA). Data from the English Longitudinal Study of Ageing (ELSA) was developed by researchers based at University College London, the Institute for Fiscal Studies and the National Centre for Social Research (NatCen) and are made available through the UK Data Authority (UKDA).

The survey tracks multiple complex characteristics, including health and social care, retirement and pensions policy, and social and civic participation, of individuals through later life (those aged 50 or over).

Data Collection Key: C = CAPI, S = Self Completion, U = Nurse

Wave/Year	Data Collection Key	Sample	Refreshment
Wave 1 (2002/3)	C	12,099	
Wave 2 (2004/5)	C + U	9,432 + 7,666	
Wave 3 (2006/7)	C	9,771	HSE 2001-4
Wave 4 (2008/9)	C + U	11,050 + 8,643	HSE 2006
Wave 5 (2010/11)	C	10,274	
Wave 6 (2012/13)	C + U	10,601 + 8,054	HSE 2009-11
Wave 7 (2014/15)	C	9,666	HSE 2011-12
Wave 8 (2016/17)	C + U(50%)	8,445 + 3,525	
Wave 9 (2018/19)	C + U(50%)		HSE 2013-15

HSE = Health Survey for England, CAPI = Computer Aided Personal Interviewing

Independent, Decline and Dependent phases

Individuals in the Decline Phase of later life have difficulty with one or more of the following activities:

- Walking 100 yards (Hemobwa)
- Sitting for about two hours (Hemobsi)
- Getting up from a chair after sitting for long periods (Hemobch)
- Climbing several flights of stairs without resting (Hemobcs)
- Stooping, kneeling or crouching (Hemobst)
- Reaching or extending arms above shoulder level (either arm) (Hemobre)
- Pulling or pushing large objects, like a living room chair (Hemobpu)
- Lifting or carrying weights over 10 pounds, like a heavy shopping bag of groceries (Hemobli)
- Picking up a 5p coin from a table (Hemobpi)
- Using a map to figure out how to get around in a strange place (Headlma)
- Recognising when you are in physical danger (Headlda)
- Preparing a hot meal (Headlpr)
- Shopping for groceries (Headlsh)
- Doing work around the house or garden (Headlho)

Individuals in the Dependent Phase of later life have difficulty with one or more of the following activities:

- Climbing one flight of stairs without resting (Hemobcl)
- Dressing, including putting on shoes and socks (Headldr)
- Walking across a room (Headlwa)
- Bathing or showering (Headlba)
- Eating, such as cutting up food (Headlea)
- Getting in or out of bed (Headlbe)
- Using the toilet, including getting up or down (Headlwc)
- Making telephone calls (Headlph)
- Communication (speech, hearing or eyesight) (Headlsp)
- Taking medications (Headlme)
- Managing money, such as paying bills and keeping track of expenses (Headlmo)

They may also have some of the difficulties described in the Decline Phase, in addition to these difficulties.

Individuals are defined as 'Dead' using the variable 'w8indout'. 'R7IntStat' was used for previous waves.

Individuals in the Independent Phase of later life are those who do not meet the criteria of the Decline or Dependent phases and are confirmed to have not died. Missing data is either ignored in the analysis or is attempted to be filled in with logic. For example:

"Independent", "Dead", "", "", "Dead"
turns into…. "Independent", "Dead", "Dead", "Dead", "Dead"

Missing values between two states are filled in with the status in the previous wave.
For example:

"Independent", "", "Decline", "" turns into….
"Independent", "Independent", "Decline", ""

A similar process is used to fill in ages and wealth quintiles of individuals where possible.

Each of these characteristics are given its own variable name and are defined as seen above. The variable names above are related to the names given in the wave 8 data dictionary or the last wave the variable was available. Variable names may differ in earlier waves however the description between waves are identical.

The four states (Independent, Decline, Dependent and Dead) are assumed to form a Markov jump process where a 10-year rolling average was used as the transition probabilities from one state to another for a certain period of time. The transition probabilities into the dead state were put in line with life tables for England and Wales from population projections published by the Office of National Statistics (ONS). The remaining probabilities were therefore adjusted to fit with the properties of a transition probability matrix.

Normalised weights have been used based on the cross-sectional weights in each wave.

An individual's wealth was split into quintiles with '1' being the bottom fifth and '5' being the top fifth of individuals with wealth. The ranking was conditional on individuals either being above SPa in the latest wave or are classified as in the independent phase in the previous wave. This was done to section out those who were in long-term illness during their working lives.

Acknowledgements and Contact Details

The Pensions Policy Institute is grateful for input from many people in support of this paper, including:

John Adams	Nicky Day	Tim Pike
Danielle Baker	Janine Harrison	Daniela Silcock
Chris Brooks	Mark Hewitson	Margaret Snowdon
Lawrence Churchill	Maritha Lightbourne	Alexandra Urdea
Chris Curry	Sarah Luheshi	Jonathan Watts-Lay

Editing decisions remained with the author who takes responsibility for any remaining errors or omissions.

The Pensions Policy Institute is an educational charity promoting the study of retirement income provision through research, analysis, discussion and publication. The PPI takes an independent view across the entire pensions system.

The PPI is funded by donations, grants and benefits-in-kind from a range of organisations, as well as being commissioned for research projects. To learn more about the PPI, see: www.pensionspolicyinstitute.org.uk

Contact: Chris Curry, Director
Telephone: 020 7848 3744
Email: info@pensionspolicyinstitute.org.uk

Pensions Policy Institute
King's College London
Virginia Woolf Building
1st Floor, 22 Kingsway
London WC2B 6LE

The PPI is grateful for the continuing support of its Supporting Members:

*A full list of all PPI supporting members can be found on our website:
https://www.pensionspolicyinstitute.org.uk/support-the-ppi/supporting-members/

References

Adelman et al. (2018) *Prevalence of dementia in African-Caribbean compared with UK-born White older people: two-stage cross-sectional study*

Age UK (2015) *Improving later life: Vulnerability and resilience in older people*

Age UK (2017) *The economic contribution of older people in the United Kingdom – An Update to 2017*

Age UK (2018) *Later life in the United Kingdom*

Aviva (2016) *Changing households*

Banks et al. (2018) *The Dynamics of Ageing: Evidence from the English Longitudinal Study of Ageing 2002-2016*

Barnes et al. (2006) *The social exclusion of older people: Evidence from the first wave of the English Longitudinal Study of Ageing*

Beck, Gillison & Standage (2010) *A theoretical investigation of the development of physical activity habits in retirement*

Bekhet & Zauszniewski (2012) *Mental health of elders in retirement communities: Is loneliness a key factor?*

Bennett, Gibbons & Mackenzie-Smith (2010) *Loss and restoration in later life: An examination of dual process model of coping with bereavement*

Bennett, Stenhoff, Pattinson & Woods (2010) *"Well if he could see me now": The facilitators and barriers to the promotion of instrumental independence following spousal bereavement*

Bloemen, Hochguertel & Zweerink (2017) *The causal effect of retirement on mortality: Evidence from targeted incentives to retire early*

BMJ (2011) *Depression in older adults*

BMJ (2017) *Temporal trend in dementia incidence since 2002 and projections for prevalence in England and Wales to 2040: modelling study*

Bonsang, Adam & Perelman (2012) *Does retirement affect cognitive functioning?*

Bound & Waidmann (2007) *Estimating the health effects of retirement*

Brown & Lin (2012) *The gray divorce revolution: rising divorce among middle-aged and older adults, 1990 - 2010*

Buman et al. (2010) *Objective light-intensity physical activity associations with rated health in older adults*

Burns, Lavoie & Rose (2012) *Revisiting the role of neighbourhood change in social exclusion and inclusion of older people*

Care & Repair England (2016) *Off the Radar: Housing disrepair & health impact in later life*

Carr, Fried & Rowe (2015) *Productivity & Engagement in Aging America: The Role of Volunteerism*

Centre for Ageing Better (2019) *The state of ageing*

Chambre & Netting (2018) *Baby boomers and the long-term transition of retirement and volunteering: Evidence for a policy paradigm shift*

Church, Frost & Sullivan (2000) *Transport and social exclusion in London*

Clough et al. (2007) *The support older people want and the services they need*

Coe & Lindeboom (2008) *Does retirement kill you? Evidence from early retirement windows*

Coe & Zamarro (2011) *Retirement effects on health in Europe*

Collaborate Research [Age UK & FinCap UK] (2017) *Financial resilience during retirement – Stage 1 research*

Corden, Hirst & Nice (2008) *Financial implications of death of a partner*

Dassel & Carr (2016) *Does dementia caregiving accelerate frailty? Findings from the Health and Retirement Study*

Di Gessa, Corna, Price & Glaser (2018) *The decision to work after state pension age and how it affects quality of life: evidence from a 6-year English panel study*

Dingemans & Henkens (2013) *Involuntary retirement, bridge employment, and satisfaction with life: A longitudinal investigation*

Dow & Meyer (2010) *Caring and retirement: Crossroads and consequences*

Gardiner, Eakin, Healy & Owen (2011) *Feasibility of reducing older adults' sedentary time*

Griffin & Hesketh (2008) *Post-retirement work: The individual determinants of paid and volunteer work*

Hamer & Stamatakis (2014) *Prospective study of sedentary behaviour, risk of depression and cognitive impairment*

Hancock et al. (2007) *Paying for long-term care for older people in the UK: Modelling the costs and distributional effects of a range of options*

IFoA (2015) *Pensions and the funding of long term care*

IPPR(2014) *Silver cities: Realising the potential of our growing older population*

Jagger et al. (2007) *Educational differences in the dynamics of disability incidence, recovery and mortality: findings from the MRC Cognitive Function and Ageing Study (MRC CFAS)*

Jokela, Singh-Manoux, Ferrie & Gimeno (2010) *The association of cognitive performance with mental health and physical functioning strengthens with age: the Whitehall II cohort study*

Key & Culliney (2016) *The oldest old and the risk of social exclusion*

Killik & Co (2014) *The cost of care in later life*

Komp, Tilburg & Groenou (2012) *Age, retirement and health as factors in volunteering in later life*

Koster et al. (2006) *Explanations of socioeconomic differences in changes in function in older adults: results from the Longitudinal Aging Study Amsterdam*

Leopold & Engelhartdt (2013) *Education and physical health trajectories in old age. Evidence from the Survey of Health, Ageing and Retirement in Europe (SHARE)*

Liechty, Yarnal & Kerstetter (2012) *'I want to do everything!': leisure innovation among retirement-age women*

Lloyd et al. (2014) *Look after yourself: active ageing, individual responsibility and the decline of social work with older people in the UK*

Louie & Ward (2011) *Socioeconomic and ethnic differences in disease burden and disparities in physical function in older adults*

Lund, Caserta, Utz & De Vries (2010) *Experiences and early coping of bereaved spouses/partners in an intervention based on the dual process model (DPM)*

LV= (2017) *State of retirement*

Martins (2013) *The importance of a "Lasting Power of Attorney"*

Matthews et al. (2012) *Amount of time spent in sedentary behaviours and cause-specific mortality in US adults*

Mazzonna & Peracchi (2009) *Aging, cognitive abilities and retirement*

Merrill Lynch & Age Wave (2016) *Leisure in retirement: Beyond the bucket list*

Moffatt & Heaven (2017) *'Planning for uncertainty': narratives on retirement transition experiences*

Morrow-Howell (2010) *Volunteering in later life: Research frontiers*

Nazroo (2015) *Volunteering, providing informal care and paid employment in later life: Role occupancy and implications for well-being (Future of ageing: evidence review)*

ONS (2016) *Five facts about… older people at work*

ONS (2017) *Marriage and divorce on the rise at 65 and over*

ONS (2018a) *Living longer: how our population is changing and why it matters*

ONS (2018b) *Population estimates by marital status and living arrangements, England and Wales: 2002 to 2017*

ONS (2019a) *UK labour market: February 2019*

Perissinotto, Cenzer & Covinsky (2012) *Loneliness in older persons: A predictor of functional decline and death*

Plagnol & Scott (2011) *What matters for well-being: Individual perceptions of quality of life before and after important life events*

Prudential (2018) *'Preretirement' the new norm as half of pensioners plan to work past retirement age*

Rohwedder & Willis (2010) *Mental retirement*

Russell, Nyame-Mensah, de Wit & Handy (2018) *Volunteering and wellbeing among ageing adults: A longitudinal analysis*

Santini et al. (2016) *Social relationships, loneliness, and mental health among older men and women in Ireland: A prospective community-based study*

Sargent, Bataille, Vough & Lee (2011) *Metaphors for retirement: Unshackled from schedules*

Sargent, Lee, Martin & Zikic (2012) *Reinventing retirement: New pathways, new arrangements, new meanings*

Smeaton, Barnes & Vergeris (2016) *Does retirement offer a "window of opportunity" for lifestyle change? Views from English workers on the cusp of retirement*

Snyder, Colvin & Gammack (2011) *Pedometer use increases daily steps and functional status in older adults*

Stancanelli (2014) *Divorcing upon retirement: A regression discontinuity study*

Stancanelli & Van Soest (2012) *Retirement and home production: A regression discontinuity approach*

Stenholm et al. (2014) *Age-related trajectories of physical functioning in work and retirement: the role of sociodemographic factors, lifestyle and disease*

The Strategic Society Centre (2015) *Open Plan: Building a strategic policy toward older owners*

Sun, Norman & While (2013) *Physical activity in older people: a systematic review*

Westerlund et al. (2009) *Self-rated health before and after retirement in France (GAZEL): a cohort study*

Van der Heide et al. (2013) *Is retirement good for your health? A systematic review of longitudinal studies*

Van Dyck et al. (2012) *Associations between perceived neighbourhood environmental attributes and adults' sedentary behaviour: Findings from the USA, Australia and Belgium*

Westerlund et al. (2009) *Self-rated health before and after retirement in France (GAZEL): a cohort study*

Woodcock, Franco, Orsini & Roberts (2011) *Non-vigorous physical activity and all-cause mortality: systematic review and meta-analysis of cohort studies*

Wu, Odden, Fisher & Stawski (2016) *Association of retirement age with mortality: a population-based longitudinal study among older adults in the USA*

PENSIONS POLICY INSTITUTE

PPI

Our history and why we exist

The Pension Provision Group, chaired by **Tom Ross OBE,** was asked in 1997 by the then Secretary of State to assess the likely trends in pensions provisions. They concluded that there was a need for "An organisation, independent of government, to have lead responsibility for accumulating, analysing and publishing information about current and future pension provision and its implication for pension policy."

Following these recommendations in 2001 the PPI was founded by the members of the Pensions Provision Group, so that a permanent expert organisation would undertake rigorous research from an independent, long-term perspective. This is helping all those interested to achieve a better, wider understanding of retirement provision issues. We achieve this in a number of ways.

Research reports

Describe, analyse and model all areas of pensions policy in depth to produce fact-based reports. Our reports are almost always sponsored by at least one organisation.

Briefing Notes

Provide short summaries and clarify topical pension policy issues. Briefing Notes are included in **core work**, though some are sponsored.

Modelling

PPI have developed a suite of economic models that allow modelling of the hypothetical individuals, aggregate costs and distributional implications or various pension policies.

The Pensions Primer

Contains a detailed description of the UK pensions system and is an invaluable reference tool. The Primer is part of the PPI's **core work**.

Pension Facts

Brings together the most up to date information and statistics on pensions and demographic data. Pension Facts is part of the PPI's **core work**.

Consultation responses

Respond to consultations and calls for evidence within the pensions and retirement area, and provide oral evidence when requested. Responses are part of the PPI's **core work**.

Knowledge Sharing Seminars

Training seminars held by the PPI to provide a basic overview of the pensions system and pensions policy.

Events

Our events include research launch events, roundtables, exhibitor stands at trade conferences, the annual House of Lords Dinner, Party Conference fringe events and members events.

Supporting Members

As a charity, the PPI rely on annual donations from Members to fund the **core work**. Without Supporting Members, the PPI would not exist.

Media engagement

The PPI produce press releases for research, write articles for trade press and appear on TV and radio to discuss pensions policy.

Speaking engagements

PPI staff speak at many external events to provide impartial, fact-based commentary on selected topics.

Industry engagement

Continuous communication on a range of topics with other organisations within the field. All organisations are eligible to sponsor research as long as it fits within the charitable objective.

Est. since 2001

Published by
PENSIONS POLICY INSTITUTE

PPI

www.pensionspolicyinstitute.org.uk
ISBN 978-1-906284-83-1