CARE CHALLENGES  OPINION: Cancer outcomes
DESIGN FOR OLDER PEOPLE  EFFECTS OF CRIME
GENOMIC SCIENCE  GETTING ACTIVE  ALCOHOL ABUSE
CUTTING CALORIES  SUPERMARKET OFFERS  FAMILY SEPARATION
OPINION: Sleep patterns  FIGURES: Your wellbeing

CARING for the ELDERLY

How well is Britain coping with looking after its ageing population? Sarah Womack takes a look at the challenges that lie ahead.
In a speech in 1963, John F Kennedy quoted the historian Arnold Toynbee who famously concluded that a society's quality can best be measured by the respect and care given to its vulnerable populations: the aged, children and those suffering with illness and disability. And while modernisation has brought many benefits to older people, most notably longer life, it has also brought challenges, particularly for those who are also disabled. With the UK population ageing, disability in old age is frequent and demands for care and rehabilitation are rising.

Ministers, already facing massive UK debts, must look at the efficacy of current systems, and the effect of potential changes in the balance of public funding for care services and disability benefits. Are there ‘revenue neutral’ improvements that can be made to how we fund care? Are disability benefits well targeted on those most in financial or disabled need, or should public funds be redirected to the care system?

It is against this background that a team – led by Professors Ruth Hancock at the University of East Anglia and Professor Stephen Pudney at the University of Essex – is undertaking an ESRC-funded study, ‘Disability and Care Needs in the Older Population: Disability Benefits, Social Care and Wellbeing’. It aims to provide independent, empirical evidence to sharpen policy judgements on reform. Among the team’s aims are to understand the impact of public support, including the effect of disability on wellbeing and the effects of cash benefits compared with care services.

THE IMPACT OF DISABILITY
At present, care services are available through local authorities, and cash disability benefits are provided by the national social security system. Individuals may be entitled to one, both or neither. Each element of the system operates its own assessments of an older person’s needs, and differs in how account is taken of whether the person has a partner. People who receive care via a local authority pay means-tested charges for their care, except in Scotland where there is a non-means-tested public subsidy towards the cost of care. Other than an element paid via the means-tested Pension Credit, entitlement to disability benefits is not affected by an older person’s income or financial assets.

Professor Pudney, an expert on the welfare benefit system and the disabled, says: “We’d like to see what impact disability has on various measures of wellbeing, and what the role is of various kinds of state support in moderating that. In particular, we want to get some sort of equivalence between income and disability – how much worse off are people who have some sort of disability compared to those who don’t? How much additional support would you have to give someone to put them on an equivalent level to a non-disabled person?”

One thing is clear: the cost of disability in terms of material deprivation (affording the basic things in life) is large compared to the public support people receive. If you want to look at how well off disabled people are, you must take account of these very large additional costs that are not fully covered by the services and benefits they receive from government.” Indeed, a preliminary estimate of the additional costs associated with disability comes in at an average of just under £100 a week. This far exceeds the average of what older disabled people receive in cash allowances.

Professor Pudney says it’s a decision for society just how well or badly off it wants its older disabled population to be. And if the government does spend more on supporting them, one of the main issues is whether the money is spent on disability benefits, or on more local authority services that go to a smaller group of more severely disabled people. But, as he points out: “You need to know something about
the costs of disability before you can decide how best to target support. My own view is that the cash benefits system, although not means-tested, is targeted reasonably well because a large number of people who receive money would have very low incomes if they didn't get it, and are quite severely disabled. Targeting works without a means test because low-income people tend to be more disabled than high-income people at any age, and to get these benefits you have to apply for them – and people who have little money have a stronger incentive to apply. Also, services delivered by local authorities vary in quality. And we know little about the targeting of those in terms of the incomes of recipients.”

MEASURING AGEING DIFFERENTLY
Professor Pudney and his colleagues are publishing a series of articles in 2014 after examining different sources of data covering random samples of thousands of disabled people over 65. One problem is that the survey data does not always offer good information about who gets what. “So we are using a couple of new developments in two surveys that involve much more detailed questions about the services people receive,” he says. “We will have new types of information available and our hope is that this will enable us to say something more precise about the effectiveness of providing cash support and services through local authorities. For example, the national system of cash benefits does not take into account whether you have someone who cares for you or not. Rules are different with local authorities that are allowed to take account of whether a partner is present. So two parts of public systems take a different line on that and it’s not obvious which approach is the most appropriate.”

Separate ESRC research – by Professor John MacInnes and Dr Jeroen Spijker from Edinburgh University, on ‘Flexible Ageing: New Ways to Measure the Diverse Experience of Population Ageing in Scotland’, with collaboration from Dr Tim Riffe from the University of California – also looks at data around ageing, but from the perspective of how to get the overall figure accurate so funding across pensions, health and welfare systems can be calculated.

For the first time, there are now more people aged 65 or older in the UK than there are children younger than 15. Currently, governments look at how many people have reached the State Pension Age and compare this with how many people are of ‘working age’. This is supposed to measure the size of the ‘dependent elderly’ population relative to those who pay for them. But the academics argue that this measure is no longer fit for purpose.

One problem is that the proportion of people of ‘working age’ who actually work changes over time. Young people enter the labour market much later than they did 30 years ago, while many older people retire well before they’re 65. Then there’s the more recent issue of millions of mothers returning to work. In fact the majority of ‘dependent’ (in the sense of not working) people are of working age rather than older.

The other problem is that using fixed ages to discuss population ageing becomes unreliable in an era of rapidly increasing life expectancies. The study suggests a different measure of the ‘dependent elderly’, which takes into account rising life expectancies, calculates as elderly those with a life expectancy of 15 years or less, and counts actual workers and not every single person of working age. Correcting for longer lives, and for changes in the proportion of ‘working age’ people actually at work, makes a substantial change to the dependency ratios used to estimate the fiscal or healthcare burden associated with population ageing. Indeed, using this method suggests that such burdens have recently been falling rather than rising.

Interestingly, the academics conclude that on this basis, and contrary to conventional policy assumptions, ‘rising life expectancy need not render current health and welfare systems unsustainable’. ■

www.iser.essex.ac.uk

Sarah Womack is the former Social Affairs Correspondent and Political Correspondent of the Daily Telegraph
WHY DOES AGE VARY WHEN INDIVIDUALS IN DIFFERENT SOCIAL CLASSES ARE DIAGNOSED WITH CANCER?

MUCH EXISTING RESEARCH on social inequality in cancer outcomes looks at lifetime probability of developing a form of the disease, finding little difference by social class. For example, work based on the Whitehall Studies of British civil servants failed to find any inequality in cancer outcomes, other than differences in lung cancer outcomes – explained by differences in smoking behaviours between social classes.

The 1984/5 Health and Lifestyle Survey (HALS) took a cross-sectional representative snapshot of the UK’s population, collecting data on individuals’ lifestyles, circumstances and different objective and self-reported measures of their health status. Since the initial survey, the individuals initially interviewed have all had deaths or cancer diagnoses logged from administrative data collected as a matter of course, and passed to the HALS team in Cambridge. Datasets with such information have been released at regular intervals since the initial study – the most recent being in July 2009. But research carried out using this study has previously not exploited these datasets for research into cancer outcomes, making them a rich and untapped source of new information on social inequality and cancer.

Research by the ESRC-funded Health, Econometrics and Data Group (HEDG), University of York, using HALS, has exploited the July 2009 dataset to explore social inequalities in cancer. This research has found that focusing on a lifetime probability of cancer masks social inequality in the age at which individuals in different social classes develop cancer.

AGE MATTERS

When replicating existing research, no obvious class-based differences in lifetime probability of the development of cancer were found, but important differences are found to exist when the age at which an individual is first diagnosed with cancer is also considered. A factor is said to be ‘confounding’ where it is associated with both an outcome we are seeking to examine, and another factor that we are seeking to use to explain this outcome. This causes difficulties in determining to what extent associations, or causal links, can be ascribed to each.

As differences in smoking by social class are likely to partially determine differences in health outcomes, analysis is carried out both including measures of smoking, and excluding all smokers from the sample. This removes any potential confounding arising when considering the link between social class and the onset of cancer. Even after the potential for any effect of differences in smoking habits by social class is excluded in this way (removing all smokers from consideration in the analysis) an important social gradient persists in cancer outcomes, with – given an explicit set of assumptions – a 15 per cent reduction in healthy time lived before cancer for those in the lowest social class, compared to those in the highest.

Class differences are also masked when individuals who die without having being diagnosed as cancer sufferers (but with a cancer presence recorded on their death certificate) are not included in analyses as having developed cancer. Individuals in lower social classes develop cancer at roughly the same rate as those in higher classes, but are more likely to develop cancer earlier in life and are, as research suggests, not being diagnosed with cancer before dying (of cancer, or another cause).

This research has a number of implications. The disproportionate post-mortem-only discovery of cancer among individuals in lower social classes implies a disproportionate failure to ensure healthcare is accessed equitably by such individuals. Social inequalities in cancer outcomes may well have been underestimated using existing methods which do not take account of the age at which individuals develop cancer.

Future research should investigate these ‘causes of the causes’. Why is being in a lower social class, even after smoking as a causative pathway is excluded, correlated with worse cancer outcomes? Are there unobserved lifestyles associated with lower social classes that cause worse cancer outcomes, or is being part of a lower social class an inherent cause of worse cancer outcomes?
A design for later life

By working with and learning from people in later life, good design can contribute to the wellbeing of older people

DESIGNERS, RETAILERS and the youth-obsessed market all display a degree of ageism. But research from RCUK’s New Dynamics of Ageing programme shows the importance of design to the health and wellbeing of people in later life.

Collaborative research teams have considered the home environment and ways of enhancing and supporting the body. A team led by Professor Sheila Peace from The Open University with Loughborough University Design School has explored the kitchen to show how reach, dexterity, vision and mobility can be enabled through design changes. Another group working with Professors Paul Chamberlain and Gail Mountain at Sheffield Hallam and Sheffield Universities is looking at the future bathroom, involving older people to understand private activities, and to then co-design prototypes that are usable, acceptable and sustainable. The majority of falls by the elderly occur on the stairs. Professor Constantinos Maganaris and colleagues at Manchester Metropolitan University are concerned about safety. By examining how the combination of muscle strength, joint mobility and balance can change, they propose design modification to the rise and step of stairs alongside personal exercises to improve confidence.

PERSONAL NEEDS

In work at Brunel University researchers led by Eleanor van den Heuvel have focused on supporting ageing continence through investigating services and environmental barriers to continence and also by designing two assistive devices – an odour sensor and wetness-sensing smart underwear.

With regard to clothing, co-design feedback from the ‘Design for Ageing Well’ project, directed by Jane McCann, University of Wales, Newport, provides direction for designers and product developers to address clothing needs and aspirations to respond to the gap in the market created by the rapidly growing demographic trend – the new consumer majority. There is a need to encourage a positive approach to design that enhances overall style, comfort and user satisfaction.

Across all these projects, by working with and learning from people in later life the health and wellbeing of all can be supported through inclusive or universal design.

www.newdynamics.group.shef.ac.uk

Wild walking

What effect does violent crime in a local area have on individual walking habits?

VIOLENT CRIME in England reduces the amount people are in their local areas. A study by Katharina Janke, ESRC Centre for Market and Public Organisation (CMPO), University of Bristol, Carol Propper, CMPO, University of Bristol and Imperial College, and Michael A Shields, Monash University, Australia, analysed data on walking and common forms of physical activity from a sample of nearly one million adults in all local authorities in England. The researchers mapped detailed government data on people’s physical activity to police-recorded violent crime offences over a six-year period to see if violent crime in the area where an individual lives deters them from walking and other physical activity.

After factoring in an extensive set of controls, including those for the weather, the amount of green space in an area, and the education, income and household characteristics of the individuals, research found that a doubling of the recorded violent crime in the local area was associated with a fall in the amount of walking by just under five per cent – equivalent to the effect of a 6°C drop in average minimum temperature. The main adverse effect was on walking to work and to do daily activities, rather than walking for leisure – more likely to take place outside of the local area.

To corroborate their findings the researchers also examined the impact on walking and physical activity of the riots in several English cities that occurred in the summer of 2011. They found that the riots led to a large fall in physical activity for women in the local area, but there was no effect on the behaviour of men. This parallels findings from Mexico, which showed that in response to increases in violent activity, men tended to ‘man up’ and go out more rather than less.

In addition to showing that crime deters one of the most common and important forms of exercise for the English, the results indicate a negative effect violent crime has on the wider community through people’s increased concern about safety. These findings suggest that attempts to tackle the amount of violent crime in society can have positive effects beyond the immediate victims.

www.bristol.ac.uk/cmpo
The 21st century is destined to be the era of the life sciences, in a similar way to how significant advances in engineering dominated the 19th century, and developments in information technology shaped the 20th century. Our understanding of genomics and cellular biology is ever-increasing, potentially leading to significant progress in medicine, biotechnology, agriculture and industry. Yet while the technological advances in the life sciences are likely to bring significant benefits, past experience indicates that they will also generate challenges for both individuals and societies.

A NEW BEGINNING

The ESRC Genomics Network has been one of the most significant groups of centres for research on the impact of new developments in the life sciences.

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For the last decade the ESRC Genomics Network has been dedicated to examining the social and economic impacts resulting from the development and use of life-science technologies. The Network was established in 2002 and came to an end in June 2013, and during the time it was operating its activities spanned the whole field of genomics, covering areas as diverse as plant and animal genetics, embryonic stem cell research, and associated health applications.

The Network was the most significant group of centres in the world for social scientific research on the socioeconomic impacts of the life sciences. Its research involved hundreds of academics, from professors to PhD students, and encompassed all aspects of developments in genomics and the wider life sciences, from synthetic biology through to DNA profiling and identity politics; from stem-cell research to plant and animal genetics.

The Network was set up at a key moment for modern biological science, shortly after the publication of the first draft of the human genome and when the promise of understanding genomes (whether of humans or of the crops and animals we depend on, or even of viruses and bacteria) was rich, but also vague and poorly defined. Investigators within the network have been able to track the development of the growing understanding of what our genomes do (and don’t) mean for us. This has been a key academic achievement for the social sciences, but also an important counter-balance to the mistaken notion of ‘genes for’ this or that trait.

There have been many research highlights over the 11 years with substantial contributions made to debates about bio-banks, the recognition of the value of ‘solidarity’ within bioethics, and intellectual property and genetic resources. There have also been distinctive interactions developed between...
WHAT IS GENOMICS?

Genomics is the study of genomes. Every living organism on the planet, from humans to rice to the flu virus has a genome, which contains a mass of information essential for the proper development of the organism. Genomes are made up of a nucleic acid, either DNA or RNA, arranged in sections called chromosomes. They contain vast amounts of information including the DNA or RNA sequence of individual genes, how genes are used and controlled and other factors that affect development. Comparing the genomes of different species provides an insight into how life evolved while comparing differences between individuals of the same species opens up the possibilities of ‘personalised knowledge’ about an individual’s unique genetic makeup. Genomics can play important roles in understanding your health.

the philosophy and the sociology of biology, which might be considered unusual.

Emerging sciences
There has been a strong tradition of analysing science, and promoting its understanding in a broader, more synoptic, context. This includes work on a range of emerging sciences – epigenetics, systems biology and synthetic biology – which has informed various aspects of social science. The Network has also undertaken a lot of work examining how life sciences might translate into future technologies, which may bring benefit in decades to come. They have examined regulation of life sciences, ensuring this is appropriate, but not overly complex – ‘smart regulation’. The research has also changed the nature of global health systems, and examined the benefits – or ‘goods’ – stem-cell research might ultimately deliver.

Researchers within the Network have not only completed social research studies but also pioneered ways of working collaboratively with scientists and clinicians on topics such as public participation in biobanks, initiatives to barcode life and to chart biodiversity, or ways to develop life-science research to address social and behavioural issues.

Although ESRC funding has now come to an end, thanks to the Network’s successes all three research centres will continue to operate as independent research units within their host universities. “When the ESRC supported the establishment of the Genomics Network a decade ago, all indications were that developments in biosciences would be significant, even if it was impossible to predict exactly how genomics and life sciences would advance in the succeeding ten years,” says ESRC Chief Executive Professor Paul Boyle.

“The impact of the EGN in influencing understanding of emerging bioscience developments has been of considerable significance and its work will undoubtedly continue to exert an influence in the future.”

www.genomicsnetwork.ac.uk

The ESRC Genomics Network consisted of three research centres based at five universities: Cesagen, at the universities of Cardiff and Lancaster; Egenis, at the University of Exeter; and Innogen at the University of Edinburgh and the Open University and a Genomics Forum.
Let’s get physical

The number of people who are physically inactive is building up a big future health problem for England

A STUDY BY RESEARCHERS from the ESRC Centre for Market and Public Organisation (CMPO) at the University of Bristol, and Monash, RMIT Melbourne and Lancaster universities, examined data on over one million adults in England and found very low levels of participation in physical activity. From 2005 to 2011 nearly 80 per cent of adults did not hit a government physical activity target of moderate exercise at least 12 times in a four-week period. The research team also found fewer than ten per cent of the adult population in England did not even walk for five minutes continuously in a four-week period.

Looking at the most common forms of activity undertaken by English adults, just under half of adults had not walked for leisure for 30 minutes continuously, while 88 per cent had not swum and 90 per cent had not used a gym. Around 20 per cent of the population over the age of 16 do minimal levels of physical activity. So, despite calls to do more from government agencies and even more stringent exercise targets, the English do not seem to be following advice and exercising more.

The reasons for this are complex, but the researchers did find strong evidence of an association between inactivity and socioeconomic status. Almost every aspect of socioeconomic status was correlated with lack of physical activity with clear evidence of independent disparities by gender, ethnic group, age, geographic area and socioeconomic position. Adults who were degree-educated had only a 12 per cent chance of being physically inactive, while those with no qualifications are three times as likely to be physically inactive. Similar gradients were found in household income.

The research also found that physical inactivity was related to local-area deprivation: those who live in more deprived areas are more likely to be inactive. But individuals who live in local authorities that have a greater number of sports facilities and higher rates of new

ALCOHOL

DRINK

RETHINK

Who is drinking more, and what effect is it having on children?

COULD MIDDLE-CLASS parents be setting the worst possible example to their children with their own excessive drinking habits? A new study by the ESRC Research Centre on Micro Social Change at the Institute of Social and Economic Research has found that teenagers who binge drink are more likely to have parents who drink heavily and that middle-class parents drink alcohol more frequently than parents who are poorer. Dr Cara Booker examined evidence of patterns of behaviour in families of 5,000 young people taking part in ‘Understanding Society’, the UK’s major academic study of 40,000 households since 2009.

The research found that one in ten teenagers has been involved in binge drinking in the last month and that girls are more likely to binge drink than boys. Twelve per cent of girls and eight per cent of boys admitted binge drinking in the last month and nearly one in three 16-year-olds admitted binge drinking in the last month, showing a marked increase in binge drinking over teenage years.

Young people whose parents drank weekly were five times as likely to report binge drinking in the past month compared to those whose parents did not drink in the past 12 months.

Among parents who were asked about frequency of drinking in the past 12 months and maximum daily alcohol consumption in the past seven days, fathers were more likely to drink alcohol weekly (59 per cent) than mothers (50 per cent). Mothers were also more likely than fathers to report drinking less than monthly, or not drinking in the past 12 months.

CHANGING A CULTURE

When asked about the frequency of their drinking, heavy drinkers were much more likely to also drink weekly (84 per cent) compared to regular (58 per cent) and light drinkers (15 per cent).

Children of parents who drank weekly over the previous 12 months were more than four times more likely to have binge drunk at least once in the past month.

Commenting on the findings, Dr Booker said: "The government says it wants to curb binge drinking, heavy drinking and binge drinking, particularly among young people, and change the drinking culture in the UK. This research helps us better understand the underlying drinking norms, which are transmitted through peer and family networks and indicates that the family might be an important place to start when it comes to formulating policies aimed at achieving this."
Household expenditure on food has changed significantly since the start of the economic crisis

THE UK ECONOMY has been stagnant since the start of the economic crisis in 2008. Prices have risen faster than wages and unemployment has increased, squeezing households’ disposable incomes. The recession followed large increases in world food prices. From 2007 to 2012, the relative price of food in the UK rose by 10.2 per cent more than the price of all goods (measured by the Consumer Price Index), and has remained high.

Several years of depressed incomes and higher food prices have led households to change spending patterns significantly. Research by Rachel Griffith, Martin O’Connell and Kate Smith at the Institute for Fiscal Studies describes how household spending patterns have changed. The researchers compare three time periods: before the recession (2005-7), the period covering the recession (2008-9) and the period since then (2010-12), when growth has been close to zero.

CALORIE COUNTING
Real expenditure on food (expenditure after stripping out the effect of rising prices) fell, on average, by 4.4 per cent from 2005-7 to 2008-9, and by 9.6 per cent from 2005-7 to 2010-12. Households could have purchased less food or substituted towards cheaper foods. The research shows that, between 2005-7 and 2010-12, households reduced the number of calories purchased by 4.6 per cent, on average, and they also reduced how much they paid per calorie by 5.2 per cent on average.

Households differ in the way they changed their food purchases. Households with young children slightly increased, on average, the number of calories they purchase. But this increase in calories was not enough to keep pace with the growing calorie requirement of household members, as children grew older. When calories purchased are adjusted for the calorie requirement of household members, the average decline for households with young children is larger than for other household types. All household types, on average, switched to buying cheaper calories, but households with young children responded most strongly.

In response to more expensive food and falling real wages, households, and particularly those with children, have markedly changed their food purchasing behaviour. They have reduced the amount of calories they purchase, and have shifted towards cheaper calories. In ongoing work the authors are investigating what implications these changes have had for the nutritional value of households’ diets.


depressed incomes and higher food prices have changed household spending patterns

Which parents set the worst example to their children with their drinking habits?

www.ifs.org.uk/publications/6531
Supermarket special offers are good for our wallets but at what price to our waistlines and health?

COUCHING PRICES as special offers help supermarkets generate over £50 billion in sales and accounts for two-fifths of all spending and over half of all food items sold in UK supermarkets. Price promotions can offer tempting savings for consumers, but are they good for our waistlines and health? Is there a tendency for supermarkets to over-promote foods high in fat, sugar and salt and encourage excessive consumption? With a quarter of the population classed as obese, are special offers helping to fuel the UK’s obesity epidemic?

Research led by Professor Paul Dobson, Head of Norwich Business School at the University of East Anglia, with Professor Eitan Gerstner of the Technion in Israel and Dr Jonathon Seaton of Loughborough University, addresses these questions with analysis of the nutrition of goods sold in major British supermarkets and the type of foods that are sold on promotion through price deals. Their research finds promotional bias towards unhealthy foods and particular concern about the types of food and drink sold with prominent deep discount offers.

THE BIGGEST TEMPTATIONS

The product categories that see the most price promotions are beverages and soft drinks, confectionery and sweets (tending to have high sugar levels), as well as dairy, chilled and frozen foods (often high in fat and sugar) and snacks (often high in salt and fat). It is the promotional bias towards high sugar content products that stands out, where special offers are 20 per cent more likely to have red traffic light levels of sugar compared to non-offers. This is troubling because excessively eating highly calorific sugared products might not only lead to weight gain but could be associated with the onset of Type 2 diabetes, and other medical conditions associated with obesity like hypertension, heart disease and certain cancers. Consumers might be aware of sugar consumption through sweets, chocolate, ice cream and chilled desserts, but might be less aware of how much sugar is contained in fruit juices, yoghurts and sweetened milk drinks – all of which are very heavily price promoted.

The research finds that, with an average of 20 per cent of items on special offer at any given time, it is the particularly prominent deep discounts that are most concerning in health terms. In particular, ‘buy-one-get-one-free’ (BOGOF) and other ‘two-for-one’ deals are heavily skewed towards less healthy products – being more than twice as likely to have red traffic light levels of fat and over 40 per cent more likely to have red traffic light levels of saturated fat and sugar than items as a whole.

Often the most frequently promoted products are high in combinations of concerning constituents such as fresh desserts and chocolate having high levels of both sugar and fat, and bacon, crisps and snacks, dips and fillers, and cheddar cheese with high levels of both salt and fat. Price promotions apply across almost all product categories – including fruit and vegetables and other fresh produce – so there is a healthy choice of offers available if consumers are prepared to shop carefully, check ingredients and fill their baskets for a balanced diet.

Recent industry agreement on a common standard for food labelling might help consumers with this task. But for shoppers in a rush, few will have the time or inclination to check the ingredients on every item. Instead they may find themselves drawn to the red-and-yellow offer signs where irresistible temptation lies.

With so much profit at stake, it would be unwise to think that voluntary agreement by supermarkets alone, even with government sponsorship through the Responsibility Deal, will be sufficient to rebalance the types of goods on special offer towards more healthy foods. More direct government pressure or intervention should not be ruled out.

business.uea.ac.uk/prof-paul-dobson

SPECIAL OFFERS

THE NEXT TIME YOU’RE TEMPTED BY A SPECIAL OFFER, THINK OF YOUR WAISTLINE FIRST

WHY SALT IS BAD FOR YOU

Salt can raise your blood pressure, which can increase risks of heart disease and stroke.

- Much salt is already in everyday foods, such as:
  - bacon, cheese, ham, yeast extract, pickles, prawns, soy sauce, gravy granules, salami, stock cubes, olives, smoked meat and fish

- You will also find varying levels of salt in the following foods, dependent on brand:
  - pasta sauces, crisps, pizza, ready meals, soup, sandwiches, sausages, breakfast cereals, tomato ketchup, mayonnaise, bread

To keep an eye on how much salt you are eating in bought food, check the nutrition labels. Look at the figure for salt per 100g. High is more than 1.5g salt per 100g.

Source: www.nhs.uk
THE PAIN OF SEPARATION

Parental separation or divorce is associated with poorer child outcomes, which may increase health risks

ACCORDING TO OFFICIAL statistics more than 100,000 couples with children aged 16 and under divorced in England and Wales in 2011. As the number of divorces has increased in the last few decades there has been a growing concern about the impact of parental separation or divorce upon child wellbeing, not just in the short-term but also as the child progresses through life.

New research by Dr Rebecca Lacey, Dr Meena Kumari and Dr Anne McMunn at the ESRC-funded International Centre for Life Course Studies at University College London found that children who experienced parental divorce or separation in childhood had higher levels of an inflammatory marker in their mid-forties.

The marker investigated – C-reactive protein – is associated with increased risk of coronary heart diseases and Type 2 diabetes if raised long-term. The researchers found that, on average, C-reactive protein levels were 16 per cent higher in participants who had experienced parental divorce or separation compared to those who grew up with two parents. This study used data from the National Child Development Study, which has followed a large group of people since their birth in 1958 in Great Britain, almost ten per cent of whom experienced parental divorce by the age of 16.

It has long been known that parental separation is associated with various poorer child outcomes across life, but does this mean that it is the experience of parental separation that is responsible, or is there something else going on? This study sought to investigate this, finding that it wasn’t actually parental separation per se that increased the risk of poorer health in adulthood, but actually a host of other social disadvantages.

In particular, the researchers found that children who experienced parental separation had subsequently higher levels of material disadvantage, and tended to achieve lower educational qualifications. Those who experienced parental separation also reported poorer quality parent-child relationships, increased symptoms of depression and anxiety, and tended to have higher BMIs. It was all of these social disadvantages in turn that increased the risk of having higher C-reactive protein levels in mid-life, not actually the experience of parental divorce or separation itself.

One of the most important findings was the value of educational attainment. Children who experienced parental divorce but who did well in education did not have increased levels of inflammation in adulthood. By supporting children through their education, perhaps by identifying those who are having problems at home, the risk of long-term health problems might be reduced.

www.icls.ac.uk

The research was funded by the European Research Council, the ESRC and the National Heart, Lung and Blood Institute, and has been published in the journal Psychoneuroendocrinology.

“IS THE EXPERIENCE OF PARENTAL SEPARATION RESPONSIBLE?”

A BETTER LIFE WITH DEMENTIA

People with dementia can still make decisions in their everyday lives and, with support from partners, can continue to do so as their condition advances. A study looked into how married couples living with dementia make daily decisions varying from what to eat or wear, or more complex decisions on who manages the finances and whether or not to attend a day centre. The researchers found that spouses generally involved their partners with dementia in decision-making processes but wives tended to help their husbands with dementia with minor decision-making (such as what to wear or eat), more than husband carers. Also, spouses did not always involve their partners with dementia in major decision-making if additional disabilities such as communication made it more challenging.

www.applied-social-research.brad.ac.uk

Dr Geraldine Boyle, University of Bradford, and Dr Lorna Warren, University of Sheffield
SLEEP IS VITAL TO HEALTH AND WELLBEING BUT HOW CAN PARENTS ENSURE THEIR CHILDREN GET ENOUGH?

MOST PEOPLE RECOGNISE that they do not function as well when they don’t get enough sleep or sleep patterns are disrupted, and anyone with young children will recognise that they’re in for a difficult day if children are sleep-deprived. Our need for sleep has intrigued scientists for centuries, and recent research in children and adolescents demonstrates more clearly than ever before the links between sleep and healthy development. At the same time there have been major advances in our understanding of how sleep influences what goes on in our bodies.

Parents and carers are faced with a barrage of research findings and a constant stream of advice from so-called experts, friends and family on how to best bring up their children. Some of this advice is based on scientific evidence, and some not. When new research breaks, how do we know whether to take note and do we really need research to tell us the blindingly obvious?

When it comes to children’s bedtimes there are two major parent camps. One sticks rigidly to fixed bedtimes in the belief that children need routine and so do they, if only to preserve sanity or provide a bit of ‘me time’. The other camp, perhaps appalled by convention, takes a more flexible approach allowing the children to set the pace and keep going until they drop. There are drawbacks to both approaches. Always having fixed bedtimes, particularly if too early, might curb development because children miss out on spontaneity and that increasingly rare commodity – family time. But not having fixed bedtimes, accompanied by a constant sense of flux, induces a state of body and mind akin to jet lag and this matters for healthy development and daily functioning.

DISRUPTIVE BEHAVIOUR
Research from our team at the ESRC International Centre for Lifecourse Studies in Society and Health shows powerful links between the consistent nature of bedtime schedules and various aspects of healthy development, including intellectual ability and behavioural problems. This happens because irregular bedtimes disrupt natural body rhythms leading to sleep deprivation, which undermines the brain’s ability to acquire and retain information and to regulate behaviour.

Given that early child development has profound influences on health and wellbeing across our lives, it follows that disruptions to sleep, especially at key times in development, could have long-term implications too. But how are parents to weigh up the evidence and maybe make changes in how they run things? After all, research findings from information on thousands of individuals is averaged out and can only be used to draw general conclusions.

And then there is the thorny issue of exceptions. We’re all familiar with the anecdote of a granny who smoked 40 a day since the age of ten and lived to the ripe old age of 100, but we don’t doubt the links between cigarette smoking and lung cancer. Neither should we ignore the evidence on sleep and health even if one of Britain’s previous Prime Ministers was reputed to get by on three hours’ sleep a night. Is it that easy to get children into a regular bedtime schedule, at least for most of the time? If we don’t are we storing up problems for later? It’s OK for those often smug, self-satisfied parents who believe they’ve found the perfect balance in what is the precarious act of parenting, but what about the reality for many of juggling working long, unsociable hours with the demands of family life?

The bottom line is that we can’t skimp on sleep. Getting enough regularly patterned sleep is crucial for healthy development and isn’t an optional extra. We should follow more closely the advice: get into a routine; don’t watch TV or use any screen-based devices for at least an hour before bedtime as this stimulates the brain in ways that interferes with proper sleep; have a bedtime story. And why not go the whole hog and take the TV out of the bedroom and park mobile devices at a safe distance outside the room.

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Life Gets Under Your Skin: www.ucl.ac.uk/ics/publications/booklets/lguy.pdf
REASONS TO BE CHEERFUL, OR NOT...?
Different factors affect wellbeing. We look at how a few particular sectors of society are faring.

LETS PLAY 
WINNERS & LOSERS!

OBESITY
39%
50% of women aged 16 and over were ‘normal weight’ in 1993 – this dropped to 39% in 2011. For men this has dropped from 41% to 31%. Source: HSCIC

8,740
In 2011-2012, there were almost three times as many female admissions as male with a primary diagnosis of obesity – 8,740 vs 2,990. Source: HSCIC

56%
Between 2000 and 2009, the average age for a young person (5-19-year-olds) admitted to hospital for obesity-related illness was 14 56% of these were girls. Source: NHS

MENTAL HEALTH SUFFERERS
1.25 million
In 2010/11 over 1.25 million adults accessed NHS services for severe or enduring mental health problems. Source: HSCIC

80%
Those who agreed that local friendships and associations meant a lot to them increased with age from 64% of those aged 50-54, to over 80% of those aged 70 and over. Source: ONS

82%
For older people aged 50 and over, about 82% of those who agreed that they belonged to their neighbourhood also reported that they were satisfied with their life overall compared with 53% of those who disagreed. Source: ONS

4,008 deaths
The mortality rate was 4,008 per 100,000 (83,390 deaths in total) for mental health services users, compared to the general population rate of 1,122 per 100,000. Source: HSCIC

77%
The percentage of people agreeing that ‘Mental illness is an illness like any other’ increased from 71% in 1994 (the first year this question was asked) to 77% in 2011. Source: HSCIC

80%
In 2012 young people in Great Britain reported that they were very optimistic about the next 12 months: between 80 and 85 per cent reported a medium to high level of optimism. Source: ONS

WHAT AFFECTS YOUR WELLBEING
Some factors affect personal wellbeing more than others. People’s self-reported health is the most important factor associated with personal wellbeing, followed by an individual’s work situation, relationship status, then a host of other factors. Source: ONS

WHAT AFFECTS PERSONAL WELLBEING

- Health
- Employment
- Relationship status
- Age
- Sex
- Occupation
- Home ownership
- Area live in
- Ethnic group
- Migration status
- Religious affiliation
- Level of qualification
- Presence of children
- Reasons for inactivity

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FACTORs AFFECTING PERSONAL WELLBEING

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WHAT AFFECTS YOUR WELLBEING

Factors that affect personal wellbeing more than others

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