

Ageing, living arrangements and subjective wellbeing

Life expectancy in Australia increased markedly over the last century, but what is the quality of most of these added years? Are people approaching so-called “retirement age” finding the prospect daunting? How do older people view their lives? New HILDA data are used to shed some light on these questions.

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In as far as life expectancy is a reasonable indicator of health-related quality of life at the national level, Australia is doing particularly well. Life expectancy has increased by more than 20 years since 1901 and is now 77.0 years for men and 82.4 years for women (ABS 2001; ABS 2003a). And for those who attain their 65th birthday, men can expect to live for another 17.2 years (until they are around 82) and women for another 20.7 years (until they are nearly 86).

Furthermore, of 175 countries, Australia’s life expectancy at birth ranked equal seventh in 2001 (United Nations 2003), and Australia came fourth in terms of the United Nations’ “Human Development Index”, a quality of life measure that is based on life expectancy at birth, literacy and education levels, and GDP per capita.

Nevertheless, while life expectancy may be an important indicator of quality of life at the national level, “quantity of life” may not necessarily have

much to do with quality at the individual level. Indeed, younger generations, the media and even health professionals appear to believe that life gets progressively worse upon reaching “retirement age”, and that older people tend to be frail, unproductive, incompetent, and unhappy (Ulysse 1997; Blaikie 1999; Gething et al. 2002). Consistent with such stereotypes, research on ageing tends to focus on negative outcomes (Maher and Cummins 2001; Rowland 2003).

Such preconceptions are understandable given that the elderly are more likely than younger people to experience health-related problems, and the loss of a partner and other close family members and friends. Some older people who were employed may also have difficulty in adjusting to life after retirement, and many of those who have lost their spouse have to adapt to living alone. As they advance in years, many have to give up their licence to drive a car and thus lose considerable autonomy and

MEASURES OF WELLBEING

In this article, older respondents are compared with younger age groups in terms of the following self-assessed aspects of quality of life.

Financial wellbeing. Respondents indicated whether, given their current needs and financial responsibility, they considered their family to be prosperous, very comfortable, reasonably comfortable, just getting along, poor, or very poor?

Level of adequacy of housing for current needs. Respondents indicated whether their housing in general was more/much more than adequate, adequate, or less/much less than adequate to meet their needs.

Self-assessed health measures. Eight measures are used in this article, all of which are sub-scales of the SF-36 measure (Ware et al. 2000). One of these is called *general health* and is based on five items including a rating of health from “excellent” to “poor”. The other seven measures focus on specific aspects of health. These are: *physical functioning* (the ability to perform ten different types of activities); *vitality* (four items covering energy level over the past four weeks); *social functioning* (two items covering the extent to which and amount of time physical health or emotional problems interfered with social activities during the past four weeks); *role-physical* (five items covering whether or not physical health imposed limitations on daily activities during the past four weeks); *role-emotional* (three items

covering whether or not emotional problems imposed limitations on work and daily activities during the past four weeks); *bodily pain* (two items covering the magnitude and extent to which pain interfered with “normal work” during the past four weeks); and *mental health* (five items covering the amount of time during the past four weeks that the respondent has felt nervous, down in the dumps and unable to cheer up, happy, calm and peaceful, “down”).

The SF-36 has also been used by the ABS in their *National Health Survey*. For each of SF-36 scales, the total score ranges from 0 to 100 with higher scores indicating better health.

A sense of loneliness. Respondents indicated the extent to which they agreed with the following statement: “I often feel very lonely”, with the use of a rating scale ranging from 1 “strongly disagree” to 7 “strongly agree”. In this article, ratings of 5 to 7 were treated as indicating a sense of loneliness.

Satisfaction with life as a whole. Respondents used a rating scale ranging from 0 “completely dissatisfied” to 10 “completely satisfied” to answer the question: “All things considered, how satisfied are you with your life?”



perhaps social contact. Furthermore, social isolation itself appears to increase the vulnerability of older men and women to experiencing health problems (Ham 2002).

But how do older individuals in private dwellings feel about their life? Do they view their life as one characterised by deteriorating health, financial strain, misery and loneliness? And are those who live alone especially vulnerable to such problems?

This article first examines the living arrangements of older people (aged 65 years and over) according to the ABS Census 2001. It then uses data from the first wave (in 2001) of the *Household, Income and Labour Dynamics in Australia (HILDA)* survey to shed light on older people's sense of personal wellbeing. This survey involved face-to-face interviews with 13,969 respondents aged 15 and over from 7,682 private households nationwide (see Watson and Wooden 2002 for a detailed description of the survey). Around 1850 participants were aged 65 or over.

In this article, older respondents are compared with younger age groups in terms of the following self-assessed aspects of quality of life: financial wellbeing and adequacy of housing; general health and some specific dimensions of health; sense of loneliness; and life satisfaction. These measures are described in the accompanying box. Older people who lived alone or with others are also compared in terms of each of these indicators of quality of life.

Living arrangements

It is important to emphasise that the HILDA sample is based on respondents in private dwellings. The analysis thus excludes older people who require the intensive assistance provided in nursing homes, or who live in boarding houses and other forms of non-private dwellings. According to the 2001 Census, only 7 per cent of all people aged 65 or more years lived in non-private dwellings, and while this proportion increases to 30 per cent for those aged 85 years or more (ABS 2003b), most people live out all their lives in private dwellings (Rowland 2003).

As older people advance in age, their likelihood of living with a partner lessens and they become increasingly likely to live alone (Table 1). For example, at the time of the 2001 Census, around three quarters of men aged 65–74 years were living with a partner, while the proportions of men living alone were around 15 per cent and 25 per cent respectively (ABS 2003b).

Because women are more likely than men to outlive their partners, older women are also more likely than older men to live alone. For example, according to the 2001 Census, 28 per cent of women aged 65–74 and 39 per cent of women aged 85 years or over were living alone, while the proportions living with a partner were 56 per cent and 9 per cent respectively. Older women are also more likely than older men to enter non-private dwellings as they advance in age. Just over one third of women and around 20 per cent of men aged 85 or over lived in non-private dwellings (ABS 2003b).

According to analysis by Rowland, Liu and Braun (2002), the probability of men and women aged 65 entering an aged care home for permanent care in the

Table 1 Living arrangements of older people by age, 2001 Census

	65-74 years %	75-84 years %	85+ years %	Total (65+ years) %
Men				
With partner	74.8	66.5	42.9	69.5
With other relatives	3.8	4.9	8.9	4.6
Alone	14.8	19.5	25.2	17.2
Non-private dwellings	1.9	5.3	19.8	4.4
Other ^a	4.7	3.8	3.2	4.3
Women				
With partner	56.0	31.8	9.0	40.7
With other relatives	10.6	13.4	15.8	12.3
Alone	27.5	43.3	39.0	34.9
Non-private dwellings	1.6	8.2	34.0	8.5
Other ^a	4.3	3.3	2.2	3.6

Source: ABS (2003b)

^a Includes persons living in other arrangements such as an unrelated individual or a member of group household and persons living in 'not classifiable' households.

future is .28 and .46 respectively. Nevertheless, the probability remains very low for the next 15 years (0.08 and 0.09 respectively) and increases to only 0.15 and 0.20 respectively by age 80. In other words, it is not until they are “very old” that individuals have much likelihood of entering aged care homes.

Among older people, the propensity to live with other relatives also increases as age advances, and women are more likely than men to experience this living arrangement (11 per cent of women and 4 per cent of men aged 65–74 years; 16 per cent of women and 9 per cent of men aged 85 or more years). These trends may be due not only to women outliving their partners, but also to women being more likely than men to retain close contact with their children, particularly after divorce (Millward 1998).

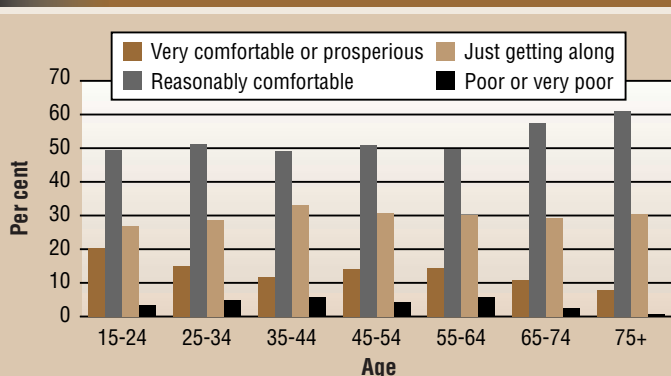
Table 2 Living arrangements of older people (in private dwellings) by age, HILDA 2001 survey

	65-74 years %	75+ years %	Total 65+ years %
Men			
With partner	82.1	69.9	77.5
With other relatives	2.3	4.0	3.0
Alone	13.9	24.6	18.0
Other ^a	1.6	1.4	1.5
Women			
With partner	63.9	31.3	49.3
With other relatives	8.9	11.7	10.2
Alone	26.3	56.2	39.8
Other ^a	0.8	0.8	0.8

Source: HILDA 2001 survey.

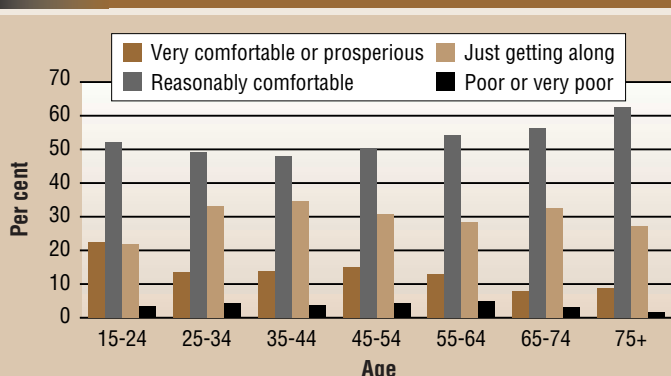
^a Includes persons living in households as an unrelated individual or a member of group household.

Figure 1a Men: self-assessed family financial circumstances by age



Source: HILDA 2001 survey.

Figure 1b Women: self-assessed family financial circumstances by age



Source: HILDA 2001 survey.

Living alone does not necessarily reflect sound health and the ability to manage everyday affairs without considerable help. While family members are a major source of support to older people who need it (Millward 1998), various assistance measures such as the provision of District Nursing and Meals on Wheels have been developed to help older people to avoid nursing home care for as long as possible. Thus, living alone may reflect varying combinations of levels of personal health and well-being and access to familial and public resources.

The HILDA survey provides important insights into how those living in private dwellings are faring across several dimensions of quality of life. Table 2 shows the proportions of older men and women in the survey who were living alone, with a partner, or with other relatives. Consistent with the ABS Census data, older men who participated in HILDA were more likely than older women to be living with a spouse, and less likely to be living with other relatives or with a spouse. These gender differences were particularly apparent for those aged 75 and over.

In the following sets of analyses, the older sample is divided into two age groups: 65–74 (comprising around 540 and 590 women) and 75 and over (comprising around 290 men and 430 women). These groups are compared with five younger age groups, each spanning 10 years. All these younger groups consisted of more than 750 men and women (taken separately).

It is important to note that differences between age groups do not necessarily reflect changes that occur with advancing age. To some extent, the differences may represent inherent variation between age cohorts that have persisted with the passage of time. Further, perceptions of wellbeing may be affected by expectations in systematically different ways.

For example, some older individuals who are relieved to find that their health has not deteriorated as much as they expected may be prone to understate their health problems, while others who also expected considerable deterioration in health may be particularly sensitive to signs of health problems and thereby provide a more negative assessment than they otherwise would have done. Again, those who have the psychosocial and material resources to enjoy their life despite some level of physical dysfunction may be more inclined than others to overlook their physical health problems. The same processes may occur in relation to perceptions of other dimensions of wellbeing.

Perceived financial wellbeing and housing adequacy

In total, between 61 per cent and 75 per cent of men and women in each age group described their financial circumstances as “reasonably comfortable”, “very comfortable”, or “prosperous”, with these positive evaluations being provided by 68 to 71 per cent of men and women in the two oldest groups (Figures 1a and 1b).

The most common response chosen by all age groups was “reasonably comfortable”, especially men and women aged 75 and over (61 to 63 per cent), followed by those aged 65–74 years (56 to 57 per cent). Most of the other respondents reported



The incidence of loneliness among older people varied significantly with their living arrangements.

that they were “just getting along” financially. Thus, respondents in all age groups were least likely to indicate that they were “poor” or “very poor” (applying to only 1 per cent of men and women in the oldest group, 3 per cent of men and women in the second oldest group, and 4 to 6 per cent of those in the younger groups).

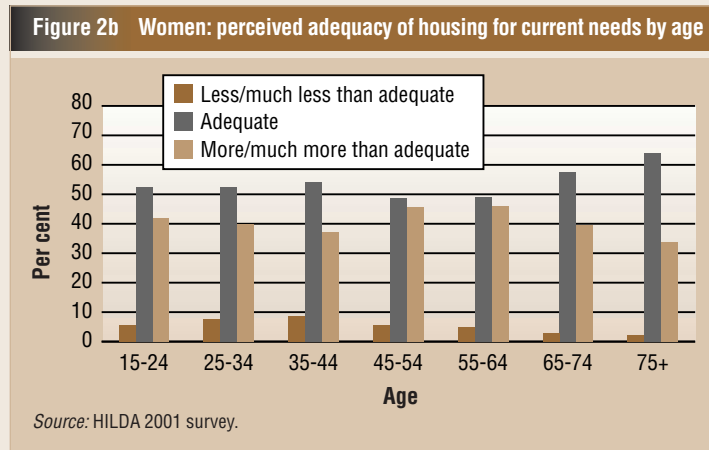
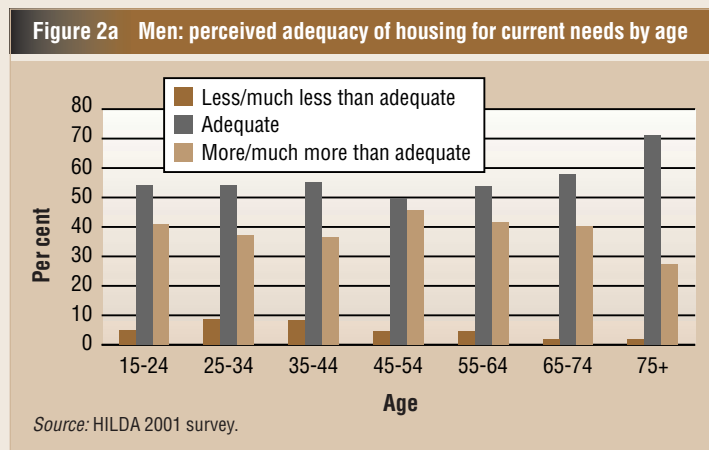
Most respondents also viewed their housing circumstances in a positive light (Figures 2a and 2b). Only 2 to 3 per cent of men and women in the two oldest groups and less than 10 per cent in the other age groups described their housing as inadequate for their needs. While men and women aged 45–54 and women aged 45–64 tended to be fairly evenly divided in seeing their housing as “adequate” or “more/much more than adequate”, the other age groups – especially those aged 75 and over – were more likely to describe their housing as “adequate” rather than “more/much more than adequate”.

Among the older respondents, perceived adequacy of housing did not vary according to whether they lived alone or with others. Nevertheless, older people who lived alone were less inclined than those who lived with others to describe their financial circumstances as “reasonably comfortable” or better (63 per cent compared with 70 per cent), with most of the others indicating that they were “just getting along” (35 per cent and 28 per cent respectively) rather than being in poverty. The same trend applied to men and women taken separately.

In summary, the vast majority of older men and women described their financial situation and housing positively, but were less likely than some younger age groups to consider themselves to be “very comfortable” or “prosperous”, or to see their housing as “more/much more than adequate”. While living alone or with others was not related to perceptions of housing adequacy, older people living alone viewed their financial situation less positively than their age peers who lived with others.

Self-assessed health

Health is obviously a central aspect of quality of life that is perhaps often taken for granted until illness strikes. There is some evidence to suggest that self-assessed health is an important predictor of survival in old age (McCallum, Shadbolt and Wang 1994). The HILDA survey tapped seven aspects of health as well as “general health”. Apart from the general





Being social animals, a sense of belonging and the maintenance of strong and supportive relationships represent important aspects of quality of life.

health and physical functioning measures, all those aspects of health examined below referred to experiences covering the past four weeks.

As noted above, the extent to which differences between age groups reflect changes that occur with advancing age remain uncertain. Nevertheless, for simplicity, the discussion below adopts this assumption. It is also assumed that differences and

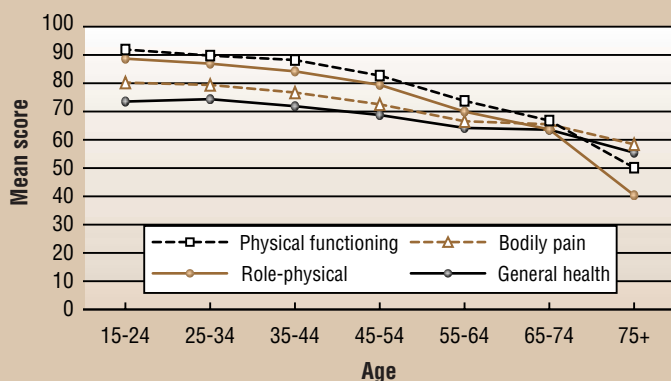
similarities in experiences indicated by the different age groups reflect trends that extend beyond the four week period focused upon.

In as far as these assumptions are correct, then it appears that not all aspects of health deteriorate progressively with advancing age. Figure 3a highlights those aspects of health that do appear to worsen with age. For simplicity the data for men and women are combined. While women appeared to have poorer health than men on all dimensions except general health, the age related patterns of results for older men and women did not differ significantly for most aspects of health.

Not surprisingly, the greatest extremes in average scores across the age groups occurred for the two measures of physical abilities: “physical functioning” and “role-physical”. The former refers to the ability to perform various physical tasks and the latter refers to the impact of physical health on the nature, amount and ease with which daily activities were accomplished. Average scores on these measures declined as age increased, with relatively sharp falls occurring from age 55 onwards and again from age 75 onwards. In relation to general health and freedom from bodily pain, average scores fell progressively from age 35 to 64, then appeared to “stabilise” before falling again from age 75 years. While small numbers do not permit disaggregation of people aged 75 and over, further analysis suggests that average scores decline sharply on these measures of physical abilities from those aged 75–84 to those aged 85 and over. (These results are not shown here.)

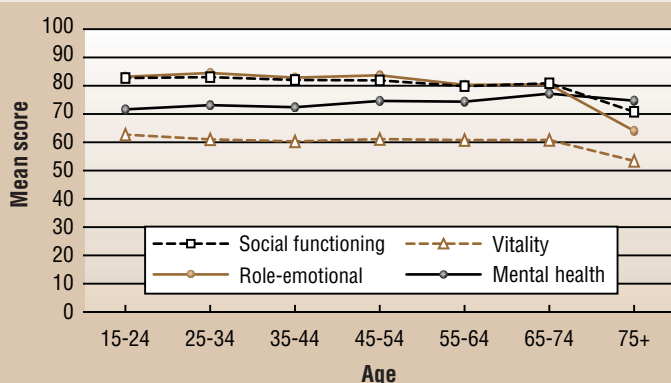
Figure 3b refers to the measures linked with emotional and social wellbeing. The so-called “mental health” measure simply taps a tendency to feel happy, peaceful, and not “down” or nervous. Average scores on this measure were lowest for the youngest age group (suggesting relatively poor wellbeing in this area) and highest for those aged 65-74 years. But the differences between age groups were small and there was no evidence of decline in this aspect of health for those aged 75 and over.

Figure 3a Average scores of self-assessed health measures by age



Source: HILDA 2001 survey.

Figure 3b Average scores of self-assessed health measures by age



Source: HILDA 2001 survey.

For the remaining health measures, average scores varied little across all groups up to age 65–74, but then fell for those aged 75 and over. These measures on which the oldest group did less well than others were called vitality (that is, energy), “social functioning” (that is, the impact of physical health or emotional problems on social activities), and “role functioning” (that is, whether or not emotional problems have interfered with work and other activities).

It should be pointed out that there is a greater variation among the oldest age group compared with younger age groups for all the health measures except mental health. The increase in the variation are greatest with two physical measures – physical functioning and role-physical.

Among the older men and women, average scores on only one health measure varied significantly with living arrangements: older women who lived alone were more inclined than older women who lived with others to indicate that their physical health interfered with everyday activities (the “role-physical” measure) (mean scores = 51 and 57 respectively for older women who lived alone and 52 and 54 for the older men in these two respective groups).

The overall pattern of these results is consistent with that derived by the ABS (1997). In as far as the results reflect changes that occur with advancing age, then they suggest that from age 75 on there is a clear deterioration of general health and most specific aspects of health measured. With the exception of the two measures that focus on physical health (“physical functioning” and “role physical”), those aged 65–74 years appeared to be doing at least as well as those aged 55–64, but not necessarily as well as younger groups. Vitality and social functioning appeared to remain fairly stable until age 75, while both groups of older people seemed at least as well off as other age groups in terms of the truncated “mental health” measure. While this measure is simplistic, the Australian Institute of Health and Welfare (AIHW) reports that the incidence of mental disorders is lower for older people than for the general population (AIHW 2002).

As mentioned above, the results reported here are derived from residents of private dwellings. Given that older people are more likely than younger people to move to non-private dwellings for health reasons, the picture for older people in general is not as rosy as that presented here. On the other hand, it seems worth reiterating that nursing home care tends to occur for only a short period of life (with the probability not increasing substantially until reaching “very old” age) and most older people never experience it (Rowland 2003; Rowland, Liu and Braun 2002).

Life satisfaction

Research into subjective wellbeing suggests that most people tend to express considerable satisfaction with their lives and except in extreme circumstances, appear to “recover” from misfortune (Cummins 2000). Various theories have been established to explain this process (for example, Brickman, Coates and Janoff-Bulman 1978; Cummins 2000; Headey and Wearing 1989). For example, Cummins (2000) proposes that individuals have their own “set point” to which they return after unusually fortunate or

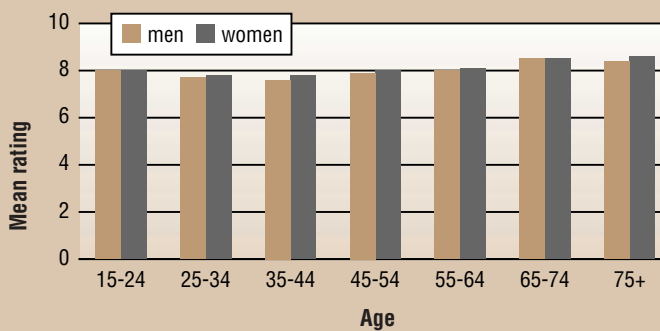
unfortunate experiences, and for most people this “set point” is quite positive. However, he also maintains that there are limits to this process: some circumstances are so adverse that they defeat this homeostatic response (that is, recovery).

Maher and Cummins (2002) maintain that this return to the status quo involves actions to improve objective circumstances and/or the use of various psychological devices directed towards maintaining or regaining a positive sense of wellbeing. Yet the negative stereotypes of old age outlined above would suggest that older people are no longer able to experience much enjoyment from life and are unable to either change or adapt to difficult circumstances. To what extent are older people dissatisfied with their lives?

Respondents rated their satisfaction with life on a scale ranging from 0 (“completely dissatisfied”) to 10 (“completely satisfied”). Figure 4 shows that average (mean) ratings of life satisfaction are marginally higher for the two older groups of men and women than for younger groups. Thus, consistent with the above-mentioned trends for the “mental health” measure, older people tend to maintain a positive sense of wellbeing – despite a decline in general health and most particularly in physical functioning.

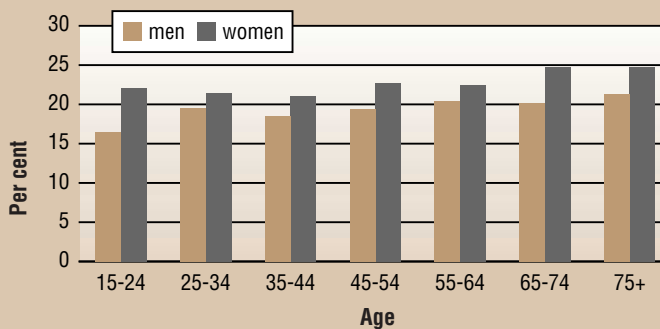
In fact, high satisfaction (here defined as ratings of 8–10 on this scale) was expressed by 79 to 80 per cent of men and women aged 65 and over, and by only 59 per cent men and 65 per cent of women aged 25–44. On the other hand, low satisfaction with life (ratings of 0–5) was expressed by only 7 per cent of older men and women and only 10 per cent of men

Figure 4 Average ratings of satisfaction with life as a whole by age and sex



Source: HILDA 2001 survey.

Figure 5 Proportion of people reporting feeling very lonely * by age and sex



Source: HILDA 2001 survey.

* Rating 5-7 on a scale ranging from 1 “Strongly disagree” to 7 “Strongly agree” for the statement, “I often feel very lonely”.

and women aged 25–44. These trends are consistent with the findings by Maher and Cummins (2002). Their research also suggested that, with advancing age, people tend to rely more on psychological processes that help them adapt to and accept their circumstances rather than attempt to change them.

Among older people, life satisfaction varied significantly with living arrangements for older men but not women. Although most older men expressed high satisfaction with life regardless of their living arrangements, this was less the case for those who lived alone than for those who lived with others. High life satisfaction was expressed by 66 per cent of men living alone and 82 per cent of men living with others, and by 77 per cent of older women who lived alone and 81 per cent who lived with others.

Sense of loneliness

Being social animals, a sense of belonging and the maintenance of strong and supportive relationships with others represent important aspects of quality of life, while feeling lonely tends to be a distressing experience (Baumeister and Leary 1995). Furthermore, as noted above, there is some evidence to suggest that a sense of social isolation, which includes feelings of loneliness, can have a negative impact on personal health (Ham 2002). Yet one of the defining features of older people according to stereotypes is that they are prone to strong feelings of loneliness (Kalish 1979).

Figure 5 presents the proportions of men and women in the different age groups who stated that they often felt very lonely. Across all age groups, 21 to 25 per cent of women and 17 to 21 per cent of men indicated such experiences.

Young men aged 15–24 were the least likely to feel very lonely while the two oldest groups of women were the most likely to experience loneliness. Although marginally higher proportions of women than men in each age group indicated that they often felt very lonely, a statistically significant gender difference was only apparent for the youngest group.

As expected, the incidence of loneliness among older people varied significantly with their living arrangements: older people who lived alone were more likely than those who lived with others to state that they often felt very lonely. This pattern was stronger for men than for women. Loneliness was reported by 39 per cent of older men who lived alone and by 17 per cent who lived with others, and by 30 per cent and 22 per cent of older women who lived alone and with others respectively.

The stronger apparent relationship between loneliness and living arrangements for men than women may be linked with the fact that women tended to have more social contacts than men. For example, of older people living alone, 77 per cent of women and only 64 per cent of men reported meeting up with friends or relatives at least once a week.

Summary

While perceptions about ageing tend to be negative even among health professionals, this analysis suggests older people in private dwellings tend to live a reasonably enjoyable life. Most older people in the HILDA survey appeared to feel comfortable financially, and considered their housing to be adequate

for their needs. They also seemed to be functioning at least as well as other age groups in terms of the truncated measure of “mental health” and indicated high satisfaction with life. In terms of vitality and social functioning, those aged 65–74 appeared to be doing as well as most other age groups and they provided as positive a picture of general health as those aged 55–64 years.

Although to some extent these trends may reflect a propensity for individuals to change their views about the defining features of “good health” as they age, there is some evidence to suggest that self-assessed general health is an important predictor of survival than medical records, as noted above.

The positive average picture for those aged 65–74 is consistent with research suggesting that post-retirement age is often a very enjoyable and productive period in life (Rowland 2003). While some older people work beyond retirement age (20 per cent of men and 9 per cent women aged 65–69 were employed in 2001) (ABS 2003b), others contribute to their families by looking after their spouse who may require intensive care, by caring for their grandchildren, and by caring for various sectors of the community through volunteering activities (see de Vaus and Qu 1997; and de Vaus, Gray and Stanton elsewhere in this issue). It seems that the stage of life characterised by severe incapacity and dependency is rare among those under 80, and is typically brief if it occurs at all (Rowland 2003).

The contrast between the negative stereotypes about ageing and the generally positive reports of many older people have been observed in other studies (see Bishop 1999, 2000) and are explained by Ford and Sinclair (1987) as follows: “The trouble is that old age is not interesting until one gets there, a foreign country with a unknown language” (quoted by Blaikie 1999: 1).

Nevertheless, this rosy picture needs to be tempered. In particular, older people appeared to experience a decline in physical functioning and those aged 75 or over indicated poorer health on all measures except “mental health”.

Furthermore, compared with older people who lived with others, those who lived alone reported significantly lower wellbeing in some areas. First, both men and women who lived alone were less inclined than their counterparts who lived with others to describe their financial circumstances as “reasonably comfortable” or better. Second, among the women, those living alone were more inclined than those living with others to report that their physical health interfered with their ability to undertake everyday activities.

Third, the older men who lived alone seemed more vulnerable than the other older men to loneliness and dampened satisfaction with life. Given that the majority of older people living alone are women, there is the danger that the difficulties faced by older men who live alone may slip attention or be under-emphasised.

Finally, it should be pointed out that it is beyond the scope of this article to provide a comprehensive picture of the quality of life of older people. Attention has mostly been directed to some of the more general aspects of life as assessed by the respondents: financial



“The trouble is that old age is not interesting until one gets there, a foreign country with a unknown language.”

wellbeing and housing, health, and indicators of emotional wellbeing. It may be that older individuals are more inclined than others to indicate reduced wellbeing when asked about specific issues than when asked about broad areas of life.

As Australia's older population continues to grow in size, an understanding of how well older people are faring in all key facets of life, and an appreciation of effective means of promoting “healthy ageing”, will become increasingly important for policy. The *National Strategy for an Ageing Australia* was developed in 1999 to ensure that the quality of life improves along with its quantity.

The Strategy recognises that the achievement of healthy ageing depends on a range of factors including healthy lifestyles both before and after individuals reach “old age”, access to adequate material and health resources, strong and supportive family relationships, and a caring community that rejects unfounded stereotypes and recognises and facilitates contributions of older people to community life (Bishop 1999, 2000).

Hopefully this Strategy, along with other programs, will enable Australia to achieve as well in terms of healthy ageing as it has in terms of the United Nations' “Human Development Index”.

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