British Academy & British Society for Population Studies

Policy Forum: Ageing Britain
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This is a summary of a discussion on Ageing Britain *held at the British Academy under the Chatham House Rule. Presentations were given by Richard Pereira, Jane Falkingham, Maria Evandrou and Athina Vlachantoni on ONS data on ageing demographics, informal care in England and Wales, the dynamics of social care and paid work in mid-life, and pension protection and ethnicity in the UK.*

Ageing Britain

Ageing is not a new issue but certainly not an easy one to address in terms of policy-making. The Office for National Statistics produces key statistics needed to address policy issues around ageing, and feeds in to the Government Office for Science Future of Ageing project, which was initiated in 2003, in view of the expected increasing ageing population over the coming decades. This covers many aspects of public life: housing, education, technology, wellbeing, welfare and so on.

Mortality has been declining steadily for both men and women since 2001. Regional life expectancy at age 65 is lowest in the North East, North West and Yorkshire and The Humber, and highest in the South West, South East and in London. This sort of data is used to help, for example, the Department of Health to determine regional NHS funds allocation. Life expectancy in general has risen and is projected to continue to do so. Many more people will reach the age of 100, with women having more of a chance of reaching 100 at every age than men. Many more people aged 65 will live over half their remaining life free of disability, approximately 10.5 years for men and 11 for women. However, looking at the role of deprivation in males with 'Not Good' health, health status amongst those aged 35-39 in the most deprived areas is equivalent to those aged 60-64 in the least deprived areas.

Internet usage is an example of the cross-cutting understanding of ageing, indicating social connectedness and ability to contribute to the economy in an increasingly tech-oriented labour market. Almost all adults aged 16-54 have used the internet in the last 3 months. This drops to 71% for 65-74 year olds, and 33% in the 75+ category.

In later life preparedness, there has been a small but fairly steady increase in the percentage of people with a saving orientation from the 16-24 to 55-64 brackets. As people mature, they begin to think more about the future, living less 'in the moment'. A similar trend occurs in private and occupational pension membership, notably with a 12% jump in the latter 18 months after the introduction of automatic enrolment, up from 47%. However, the rate at which the state pension age has increased since 1948 has not matched the rapid rate at which life expectancy has risen. This will have significant policy implications for work and pensions, including the ratio of working age people to those on pensions.

Informal caring in England and Wales – stability and transition between 2001 and 2011

2001 was the first time the Census included a question about caring. Over 6 million people in the UK provide informal caring, and over 1 million are aged over 65. Informal caring is of increasing importance in social care, and the 2011 Dilnot report highlighted the value of informal carers to the UK economy. From the 2001 Census, we know a lot about their health

and demographic characteristics also. It is more common in people in mid-life. Older people tend to care at higher intensities, and higher intensity care is associated with worse health.

In 2001 and 2011, for females, caring peaks at mid-life, but for those caring for 1-19 hours, the peak age bracket shifted from 35-44 to 45-54. There has been an increase, amongst older women in particular, who are providing 50+ hours of care per week. Caring in general is less prevalent amongst men, with the peak also occurring in mid-life. However, caring amongst men at all ages has decreased, except for those providing 50+ hours of care per week, which has risen sharply at older ages. It is highest at men aged 85+, which is linked to men's improved survivorship, and most likely caring for partners around the same age.

The characteristics associated with all levels of caring in 2001 and 2011 are fairly stable. Carers are more often female, aged 55-64, and married. Carers are more likely to be found in the North West, North East and Wales, and to be part-time or looking after the home. Carers are also more likely to rent from a Local Authority or Housing Association, to be in 'Good Health', and from Pakistani or Bangladeshi ethnic groups.

3.7% of people who reported caring in 2001 also reported caring at 2011. This is approximately 1.5 million people aged 16+. It is important to note that these are repeat, but not necessarily continuous, carers. Additionally, of those who were not caring in 2001, 9% started to provide care in 2011. Of those who were caring at both points in time, nearly 17% were providing care for 50+ hours per week. Of those already providing 50+ hours a week in 2001, 45.2% were still caring in 2011. Both statistics raise serious policy issues for the wellbeing and provision of those carers. It must also be noted that for those who reported not caring in 2001 and 2011, there could have been a period of care provided at some point in the intervening decade.

Amongst those caring in 2001, characteristics associated with repeated caring in 2011 are somewhat different. Being female is still significant; however being aged 45-54 is the most likely age, as well as owning property outright. In addition, being White British or Irish, married and looking after the home are key markers for repeated caring. Repeating carers report fairly good health, and to providing 50+ hours of care per week.

Dynamics of social care and paid work in mid-life

Most carers are partners or adult children, but an ageing population means greater flows of intergenerational support will be required. Policy tends to have a focus on extending the working life due to greater longevity, despite the fact that social care is on the rise. 1 in 7 economically active people in the UK juggle work and care, but nearly 1 in 3 carers reduced or stopped working to provide care. Certain factors are significant in determining who is most likely to reduce or stop working in order to care, for example: being female, providing intense care, and co-residential care.

The National Child Development Survey is a cohort study of children born in Great Britain in March 1958, and interviewed at ages 7, 11, 16, 23, 33, 42, 46, and 50. A sample of 6447 was derived of those at the last two interview stages, at risk of caring, with no missing data and in work at 46. More women provide care at both ages, increasing from 15% at 46 to 25% at 50. Care provision also increase for men, from 8% at 46, to 16% at 50. Out of those providing care at 46, 25% of men and 38% of women were providing 10+ hours per week, but this reduces at age 50 to 18% and 25% respectively, reflecting the fact that, although the overall

proportion of the cohort providing care has increased, the majority are providing lower intensity care.

Over 13% moved to part-time employment, or had stopped work entirely, and of those who were continuous carers, 18% reduced or stopped work. Those providing higher intensity care were more likely to reduce or stop working, with 19% of new and 25% of continuous carers experiencing this.

In general, the duration of caring matters but this effect is mediated by one’s own occupational category and health, and the employment status of the partner. In addition, the intensity of caring matters; high intensity carers are more likely to reduce or stop work. Finally, there is a gendered effect with women less likely to reduce or stop work at continuous high intensity care, although this effect is mediated by health, with women three times more likely to stop or reduce work than men.

Pension protection and ethnicity in the UK

The current debate has two key components: ageing population and increasing ethnic diversity. At the last Census, individuals from BME background comprise 14% of the population. Between the 2001 and the 2011 Census, the proportion of all ethnic categories except Irish has increased. 8% of the BME population is aged 65+, and there are specific policy challenges concerning ethnic minority financial adequacy, and differences in BME economic and social resources compared to the majority White populations.

Pakistani, Bangladeshi and then African ethnic groups had lower proportions in paid employment, and of those that were in paid employment, the Pakistani group had a lower proportion self-reporting as an employee, although there was not a huge difference across ethnic categories. Among those who were employees, Pakistani and Bangladeshi groups were among the least likely to respond that their employer offers a pensions scheme, and again, are the least likely to be members of such a scheme if it exists. However, this data is somewhat limited by under-reporting due to the conditional nature of answering three questions positively before arriving at the question on occupational pension scheme membership.

Ethnicity affects one’s chances of being in paid employment for all groups except the Polish group, and for those in paid work, ethnicity affects ones chances of being an employee but only for some groups; Indian, Caribbean and African. Once again, for those who are employees, the chances of working for an employer who offers a pension scheme is affected by ethnicity but only for some groups; Other White, Indian, Pakistani, and Bangladeshi. Finally, once all those conditions are satisfied, the effect of ethnicity is negligent on whether a person is actually a member of an offered scheme.

Data from the Department for Work and Pensions on the retired population uses less nuanced categories, although the data is still interesting. 97% of the White British population receive state pension, compared to 87% and 85% for the Black and Asian groups respectively. This disparity is starker for occupational pensions, with 62% for White British, 39% for Black and 31% for Asian groups, which is mirrored in the distribution of Income-related Benefits (White British 28%, Black 43% and Asian 49%).

There are also gender differences across ethnic categories for state, and occupational and private pensions. African and South Indian groups trail the other categories and especially

the White British majority. There are key differences between genders notably in Caribbean, Bangladeshi and African groups.

Amongst all represented categories, there are interesting gendered differences with significantly lower percentages of women receiving these types of pensions in nearly all categories, except for African and Bangladeshi groups in which the women outstrip the men. Twice as many Indian men as women receive an occupational or private pension. A greater proportion of those not doing so well in other indicators receive more Pension Credit, compared to other ethnic categories and to the White British majority.

Issues in population data analysis

The National Child Development survey specifically questions the provision of care for parents or parents-in-law. It does not account for care of a partner or sibling, both of which would have impacts on stopping or reducing work, possibly depending on age and continuation of care. It would also be helpful to look at the need for care, accounting for the disability, but large datasets don't provide that level of detail. Year on year analysis for those aged 50+ (adjusting for health and a number of other characteristics) using Understanding Society data shows that new caring can be more significant than intensity. Another potential data issue is the risk of those providing care at the first time point failing to respond at the second, and thus being excluded from the research. This presents some potential under-reporting.

Controlling for caring status, intense care providers who need to reduce or stop work are more likely to be men. This raises issues around work-life balance policy, and the ability of different groups to request flexible working arrangements from their employer, whether women are more able, or perhaps more willing, to make that request, or are perhaps already in work that allows for this. The data clearly indicates that more women care than men, but a lot of policy takes that gendered nature of caring for granted. There is a hidden group of male carers that policy need to consider.

The Census does not ask about who is being cared for, but it is possible to look at cohabitants and whether somebody in the residence has a long-term illness or disability, although this method may lead to inaccuracy. If somebody is caring for a number of years, there is a greater likelihood that they will be caring for more than one person, concurrently or consecutively, demonstrating 'caring careers'. Carers are very heterogeneous so the policies and interventions that are in place to support them should take into account whether that period of care is for one single episode for a month, a year or ten years; whether it indicates multiple dependents and also whether that is concurrent.

Rethinking policy

It is very difficult to sustain such intense amounts of care, without some effects on other aspects of life such as work, as well as on the carer's wellbeing and physical health. The ONS has 38 wellbeing indicators a number of which have been analysed by age. The subjective indicators indicate that the lowest wellbeing can be found at the peak caring age when a person may have young dependents and significant work commitments. Policies around social care appear to be in tension with the extension of working life in line with longevity. It is difficult to build a pension if you are in care or providing care.

This data is useful for those working in local policy implementation. Cuts to public services reduce the support, such as it has been, for carers, particularly for those who are reducing or stopping work. The position of older carers is particularly precarious. More evidence is needed about those who work flexibly, or would like to.

Cuts to funding and services influences caring in two ways: firstly on the provision of formal care, which has been cut by approximately £1bn in the last 4 or 5 years, but also by reducing other services accessed by care recipients such as other forms of community support and local level healthcare. Working life can be extended by providing formal care, which might reduce demand for informal care, but on the other end, those already caring ought to be supported.

Qualitative and quantitative research shows that, irrespective of whether organisations sign up to flexible employment policies, the reality is that workers don't request this unless their relationship with their line manager is conducive to that not having a negative impact. This is across different occupational categories. It is important to incentivise organisations to provide a broader range of flexible work-life balance policies, but practices across the labour market and the way in which these policies are acted upon also require more thought.