

Caring for carers

The lives of family carers in the UK

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FIRST PUBLISHED BY

The Social Market Foundation, July 2018

11 Tufton Street, London SW1P 3QB

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ISBN: 978-1-910683-46-0

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ACKNOWLEDGEMENTS

The publication of this report has been made possible by the generous support of Age UK. The authors would like to thank all individuals at Age UK and Carers UK for their insight into this report. Special thanks goes to the individuals who attended the roundtable that helped shape the concluding section of this work. At the SMF we would like to thank Nigel Keohane for his input. The SMF retains editorial independence over its outputs.

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EXECUTIVE SUMMARY

The current social care system is putting pressure on families to step in and provide care for relatives where the state does not. Such family care is an essential element of the overall system of social care yet is not often put at the centre of conversation about the care system. As we await the publication of a Green Paper on social care for older people, there is an opportunity to discuss the current provision of family care and its sustainability. This report focuses on the demographics of those who provide family care and the impact that it has on their economic activity and wellbeing.

The state of care

We estimate that there are 7.6 million family carers over the age of 16 in the UK. The number of carers has seen a large and significant increase over the decade. The majority of family carers are women: 16% of women and 12% of men provide family care.

Among carers, the proportion providing 20 or more hours a week has increased from 24% to 28% between 2005 and 2015. On average family carers provide 19.5 hours per week of care. This equates to an estimated 149 million hours of care a week being provided by family carers. For the formal care sector to provide that same level of care, providers would need to hire around 4 million full-time paid care givers. In 2017, the total number of people employed in social care in England was 1.45 million.

The nature of family care is changing, with relatives providing more intensive support. Alongside the increase in the hours of care provided, between 2011/13 and 2015/17 there was a 2-percentage point increase in the proportion of adults who help parents with activities of daily living (ADLs). Helping with these tasks on a regular basis requires a serious commitment from families and highlights how both the quantity and nature of family care is changing.

Who cares?

There is a clear gender difference in family care: six in ten (59%) carers are women. Over the last decade, the share of women providing care has increased by 11%. The share of men providing care has increased by 3%. Failure to support working carers could lead to a reduction in the number of women in professional occupations, due to the link between providing family care and leaving the labour market.

A substantial proportion of those who provide family care are of working age, with more than half of family carers being aged 40 to 64. These individuals are likely to be providing care to their parents outside of their home and many will also be caring for their own children. Combining family care and paid work can lead to increased stress, family conflict and financial pressures. Many of these factors can have negative implications on the individual's health, wellbeing and often their ability to remain in work.

However, one quarter of those who provide family care are 65 or over. Carers over the age of 65 may find themselves providing care for a relative whilst trying to manage health conditions of their own. More than half of those aged 65 or over provide care within the family home, and these individuals are likely to be providing care to a spouse or partner.

Providing care within the home means that care is often relentless: more than half of carers aged 70+ provide 10 or more hours a week.

Summary



More than half (59%) of family carers are women: 16% of women and 12% of men provide family care.

Women provide more hour of care than men: 45% of women carers provide 10 or more hours, compared to 40% of men.



More than half of carers are aged 40 to 64 and a quarter of carers are aged 65+.

More than half of carers aged 70+ provide more than 10 hours of care per week.

Caring in the home is more common amongst older people: more than half of carers aged 65+ care for someone they live with.



People working in routine occupations are the most likely to provide care, with 18% of those aged 40 to 64 doing so.

However, those working in management and professional occupations make up the largest occupational group of carers.

Carers are less likely to be in paid work and more likely to work part-time compared to non-carers.



Carers tend to have lower qualification levels than non-carers.

However, over one-third of carers aged 40 to 44 have a degree or other higher qualification.



Half (51%) of family carers provide care to someone they live with.

Almost half (49%) of those caring for someone they live with provide more than 20 hours of care per week.

The future of care

Given the changes underway in in the UK population, demand for care is set to increase. More than half (58%) of those aged over 60 have at least one long term condition (LTC) and a quarter (25%) have two or more. As the population ages the numbers affected by LTCs will increase, driving greater demand for care.

The current care system is serving a population of older people who were more likely than those born before or after them to have had children. As those who are in middle age now get older and need care, we can anticipate that a much higher proportion of those who need care will not have children who might be able to provide it.

It is important to remember that having children is not a guarantee that these children will be willing or able to provide care. Our research shows that whilst more than half of adults live within 30 minutes' travel of their parents, approximately one in five live more than two hours away. A growing reliance on the family to step in to provide care where the state does not will put great pressure on the individuals for whom distance may impair their ability to provide care to their parents or older relatives.

The lives of carers

The labour market

- Family carers who care for 20+ hours a week are 22% less likely to be in paid work than non-carers.
- Family carers who provide 20+ hours of care are 9% more likely to be working part-time than non-carers.
- These factors negatively influence an individual's immediate financial position and their pension in the future.

Earnings

- Family carers who remain in work earn less per hour than non-carers. (Men who provide family care earn 15% less per hour than men who don't. For women this difference is 4%. This does not control for industry or occupation.)
- Carers who provide 20+ hours of care a week still earn 5% less than non-carers, even when we take into account differences in hours of paid work, and sociodemographic differences between carers and non-carers.

Quality of life and health

- Carers are less satisfied with their lives than non-carers: those that provide 20+ hours of care are 7% less likely to be satisfied with their lives than non-carers.
- Among those aged under 55, carers are more likely than non-carers to have a longstanding illness or disability.

Conclusions

This report highlights the important role that family carers fulfil but also the negative impact it can have on these individuals. Family care is a vital component of the current social care system; without it, provision would either be unacceptably limited or unacceptably expensive. We need a sensible discussion of the policies required to support and assist family carers.

Given the negative impact caring can have on a carer's employment, there is a central role for employers to play in supporting workers combining employment with caring responsibilities:

- Policymakers should look to the maternity and paternity policy landscape to understand how social norms and expectations can encourage and reward better support for carers who are balancing providing care and work.

- More companies should count the number of their staff who have caring responsibilities, and put in place clear policies for supporting carers at work.
- Just as gender pay audits have been used to encourage employers to address inequalities, policymakers should consider the case for mandatory reporting of “care pay gap” data by large employers.

The state cannot continue its increasing reliance on the family. There is an ever-growing number of individuals ageing without children or for whom relying on their family for care is not an option. We need to ensure that policy supports these individuals. The report discusses the idea that a care navigator can seriously improve the lives of those providing family care and particularly help those without family. Given that, we recommend that the Green Paper should seek submissions on the role, value and delivery of care navigation services, both for care recipients who receive family care and for those who do not.

CHAPTER 1: INTRODUCTION

Autumn 2018 should see the launch of the Government's Green Paper on older people's social care, where there will be a focus on the provision of social care and the role of family carers. Previous estimates on the number of carers comes from the 2011 census which showed that there were 6.5 million people providing unpaid care in the UK, 620,000 more than in 2001.¹ This represents a significant growth in the number of people taking on care roles and is a figure that has likely continued to rise.

With growing numbers providing care there is a need for an honest discussion about the role of family carers, the likelihood that these individuals can continue to provide care at current rates and the support they require.

The demand for social care will continue to grow as the UK population ages. However, challenges will arise not only from an ageing population but also from the continued squeeze on local government finances. The local government funding gap for adult social care is predicted to rise to £2.3bn by 2019/20.² The reduced real-term spending on adult social care, in combination with an ageing population, will continue to lead to increased pressure on families to step in where the state does not.

To make policy based upon a realistic expectation of what support it is possible for family carers to provide, we need to understand who family carers are and how providing care is influencing their lives. The aim of this research is to contribute to the debate on what we can and cannot ask of family carers.

This report investigates the demographics of those who are providing family care in the UK and the consequences this has on their lives and the UK economy. We will address the following questions:

- Has family care provision changed over time?
- Who is providing family care?
- What factors will influence the supply and demand for care in the future?
- How are carers' lives impacted by providing care?

Research methods

The research was conducted by the SMF using the British Household Panel Survey and the more recent Understanding Society, most of the analysis is based upon data collected between 2015 and 2017.

Report structure:

The structure of the report is as follows:

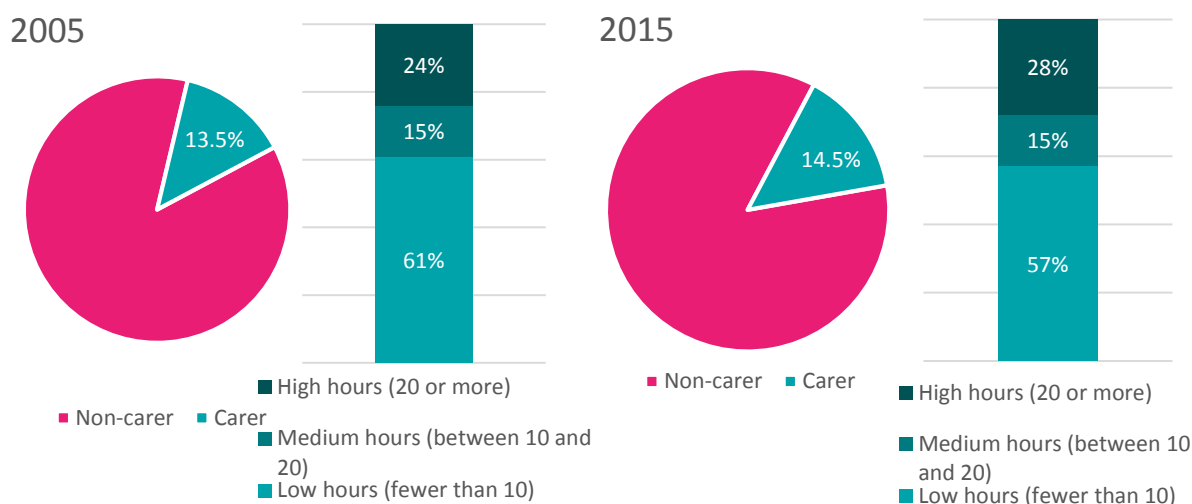
- Chapter 2: How the provision of care has changed over time.
- Chapter 3: The demographics of those who provide care.
- Chapter 4: How the demand and supply of care may change in the future.
- Chapter 5: The lives led by carers their labour market outcomes and their quality of life.
- Chapter 6: Conclusion and recommendations.

CHAPTER 2: TRENDS IN CARE PROVISION

In this chapter we explore how the provision of care has changed over time. When referring to ‘carers’ we are referring to those who provide family care. We define a family carer as someone who ‘cares for a sick, disabled or elderly individual’ within the household or a family member outside of the household. This includes those who are caring for a sick or disabled child, but does not include all individuals with dependent children who are not chronically ill or disabled. Whilst our analysis relates to those who provide family care, unpaid care is provided by a range of individuals, such as friends and neighbours, and we should not ignore the time and effort these individuals contribute. All the analysis that follows relates to 2015-17 unless otherwise stated.

In 2015/17, 14.5% of the UK adult population provide family care. This equates to 7.6 million family carers over the age of 16 in the UK. This represents an increase of half a million family carers over the last decade, a rise which is consistent with the increase seen between Censuses in 2001 and 2011.

Figure 1: Proportion of UK adults providing family care and hours of care per week



Source: SMF analysis of the British Household Panel Survey (BHPS) and Understanding Society (USoc)

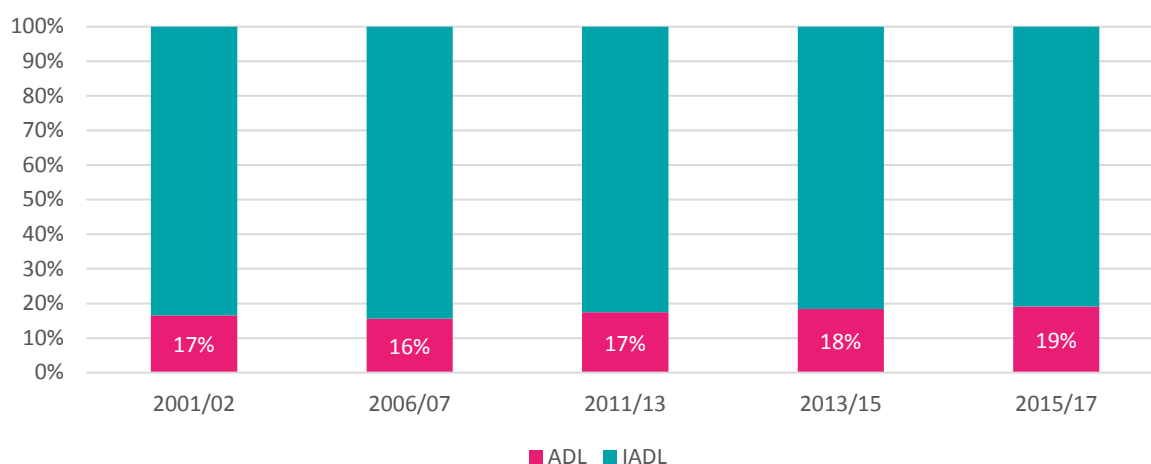
Alongside the increase in the number of family carers, there has been an increase in the hours of care provided, as is shown in figure 1. Whilst the proportion of individuals providing medium hours of care (between 10 and 20 hours a week) has remained constant over time, the proportion providing 20 or more hours a week has increased, from 24% to 28%. Providing 20 hours or more of care per week has a substantial impact on the amount of time the carer has available to engage with other aspects of their life, such as working, leisure activities and spending time with other family members.

Caring for a parent is common amongst the caring population. If we focus specifically on the tasks that adult children are completing for their parents, our analysis suggests that there has been an increase in the *intensity* of care.

The proportion of those caring for their parents who help with activities of daily living (ADLs) has increased from 16% to 19% over the last 10 years. ADLs are the fundamental personal care tasks associated with daily living: they include bathing, getting dressed and

feeding oneself. Figure 2 shows the proportion of individuals helping their parents with ADLs and IADLs. IADLs are instrumental activities of daily living, which are not necessary for fundamental functioning but help individuals live independently, and they include managing finances, cooking and shopping. Figure 2 shows that there was a two-percentage point increase in the proportion of adults who help their parents who are helping them with ADLs from 2011/13 to 2015/17, yet no substantial change over the ten years prior to this, which suggests a recent trend in intense care provision. Over a similar period (2009/10 to 2016/17) local authority spending on adult social care in England fell in real terms by 8%.³

Figure 2: Type of care provided to parents, of those who care for parents



Source: SMF analysis of BHPS and USoc

Helping with these tasks on a regular basis requires a serious commitment from families and highlights how both the quantity and nature of family care is changing.

Two thirds (65%) of those who had received help with ADLs in the past month received it from unpaid helpers only.⁴ Family carers are therefore playing a vital role in ensuring that older people have their care needs met. In summary, an increasing number of family carers are providing more hours of care and assisting with more intensive care needs.

Benefits to the government:

The government benefits considerably from the amount of unpaid care that is provided. Carers UK estimate that care provided by friends and family saves the state £132 billion each year.⁵

Family carers provide an average of 19.5 hours per week of family care and we estimate there to be 7.6 million family carers over the age of 16 in the UK.⁶ This translates into an estimated 149 million hours of care a week being provided by family carers. If these carers were unable to continue providing care, society would need to hire an extra 4 million full-time paid care-givers. For perspective, in 2017 the number of people working in social care in England was 1.45 million.⁷

CHAPTER 3: WHO IS PROVIDING CARE?

To fully appreciate the role that family carers play in society it is essential to look deeper at the demographics and characteristics of those who provide care.

Who is being cared for?

In 2013¹, two-thirds (67%) of those who provided family care in the UK did so for a parent or grandparent and nearly a quarter (23%) cared for a spouse or partner. This equates to 5.3 million caring for a parent or grandparent, 1.8 million caring for a spouse.

Table 1: Who is being cared for (2013/15)

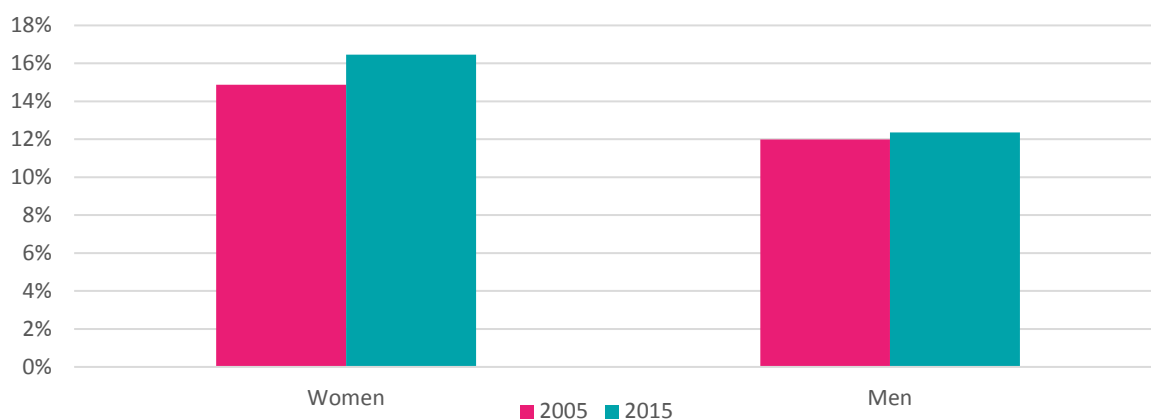
Who is being cared for?
67% are caring for an older relative
23% are caring for a partner or spouse
11% are caring for a sick or disabled child

Many family carers also have dependent children. Our analysis shows that almost a quarter (24%) of those who provide family care also have children under the age of 16. This group, often referred to as the ‘sandwich generation’, would benefit from additional support to enable them to balance the pressures of raising children and being a family carer.

The role of gender and age

More than half of those who are caring for a parent or older relative are women (59%). However, whilst two-thirds (65%) of those who care for a sick or disabled child are women, equal proportions of men and women care for a partner. Women are more likely than men to combine caring with raising children. Two thirds of those who have children under 16 and who provide family care are women.

Figure 3: Proportion of women and men providing care, 2005 and 2015/17



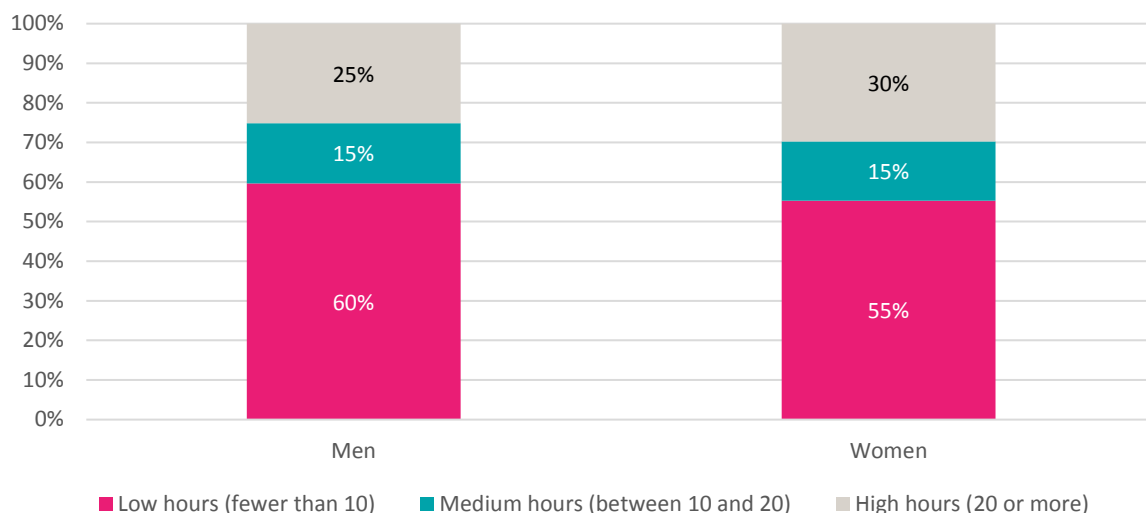
Source: SMF analysis of BHPS and USoc

¹ Due to data collection variation we are unable to use data from 2015/17 when analysing who is being cared for.

As shown in figure 3 above, 16% of women provide care, up from 15% in 2015. Among men, the figure is 12%. Over the last decade the proportion of women providing care has increased by 11% whereas the proportion of men providing care has increased by 3%.

The increase in the number of carers over the last decade has mainly comprised of women. And not only do a larger proportion of women provide care, but women are much more likely to provide high hours of care.

Figure 4: Hours of care provided per week by gender

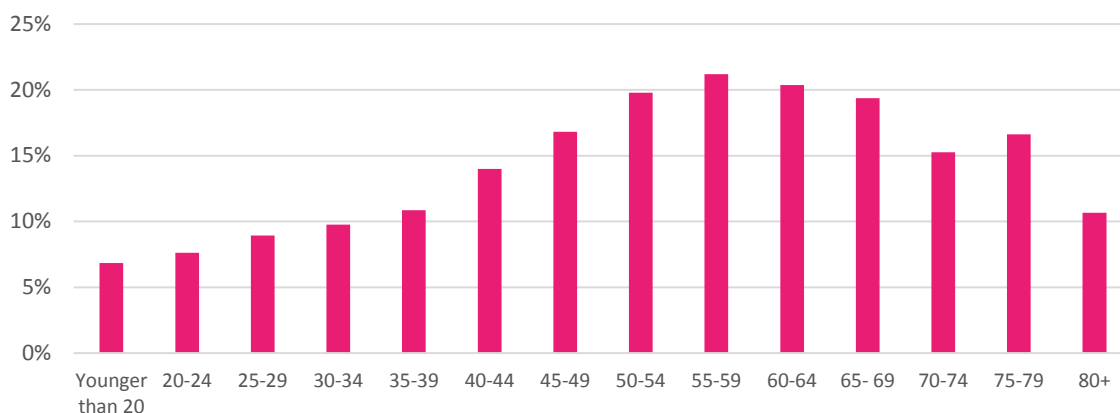


Source: SMF analysis of USoc

Figure 4 shows that three in ten (30%) women carers provide 20 hours or more of care a week, compared to one in four (25%) men. This combination of an increased propensity to provide care and the longer hours of care being provided suggests that the responsibility for caring is falling disproportionately on women.

Gender is not the only characteristic for which we see differences between carers and non-carers; age is also a strong predictor of the provision of care.

Figure 5: Proportion of individuals within each age group that provide family care



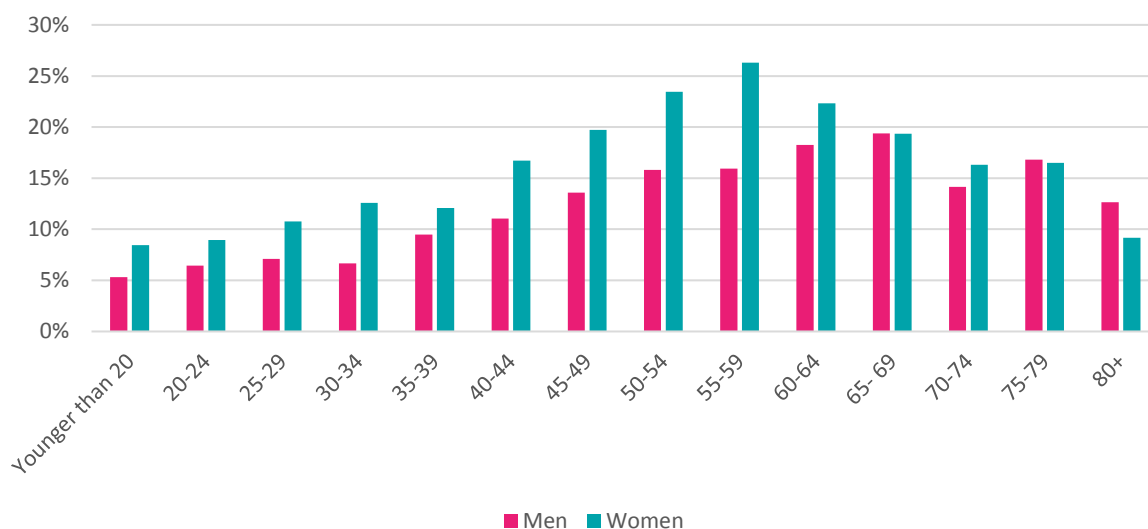
Source: SMF analysis of USoc

As shown in figure 5, one in five (21%) of those aged 55 to 59 provide family care, compared to 15% amongst the adult population as a whole. Whilst a substantial proportion of those who are of working age are providing care, the proportion of those above 65 who are providing care is also significant: 17% of those aged 75 to 79 are providing care.

The proportion of each age group providing care is only part of the story – more than half of those who provide care are aged 40 to 64. A quarter of those who provide care are over the age of 65. Carers over the age of 65 in particular may find themselves providing care for a relative whilst trying to manage health conditions of their own.

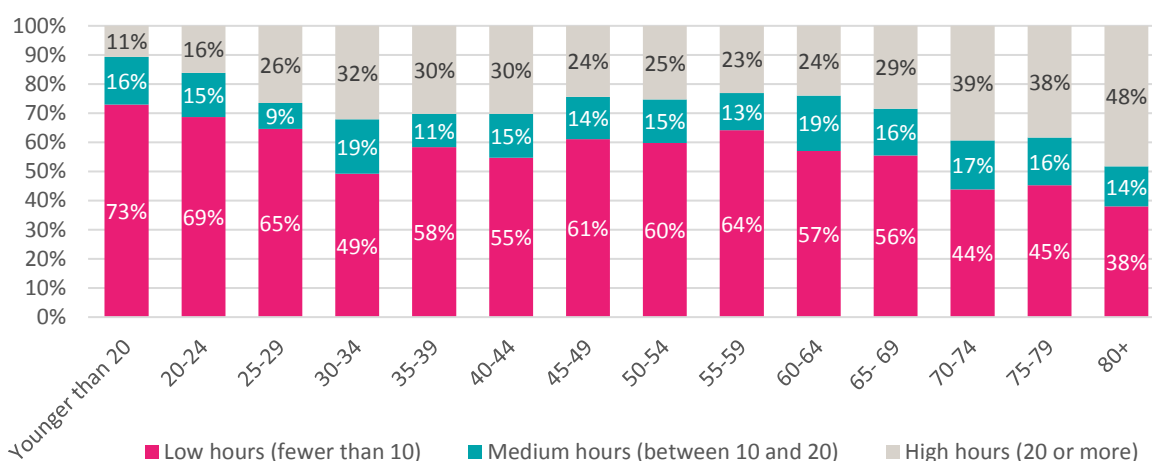
Figure 6 shows the proportion of individuals providing care by gender and age. Over a quarter (26%) of women aged 55 to 59 provide family care, whereas only 16% of men of the same age are family carers. The gap between men and women is most pronounced when individuals are of working age, where it is clear that women are more likely to provide care than men. In the older age groups, from 65 onwards the gap is considerably smaller and amongst those aged 75 and older men are more likely to be providing care than women, since a higher proportion of men than women have a surviving partner at this age.

Figure 6: Proportion of individuals providing care by gender and age



Source: SMF analysis of USoc

The cost of caring is likely to fall most heavily on those who provide the highest hours of care. Figure 7 below shows that the hours of care provided per week increases as individuals age. More than half of those aged 70 and above provide 10 or more hours of care each week, this is particularly important given that these carers may have ill health or require support themselves.

Figure 7: Hours of care provided per week by age of carer

Source: SMF analysis of USoc

Whilst the younger age groups are less likely to provide high hours of care they are more likely to be balancing paid work and raising a family with the pressures of providing care.

Socio-economic distribution

Evidence suggests that socioeconomic factors are associated with the likelihood of both providing and needing family care.⁸

Greater understanding of the socio-economic position of carers is needed to ensure that policy reflects the diversity of carers. Research by NHS England shows that those who live in the most deprived areas, based on the Index of Multiple Deprivation (IMD), are the most likely to require support with ADLs and IADLs.⁹ Research by the IFS suggests, however, that the average amount local authorities spend on social care per adult is lower in more deprived areas.¹⁰

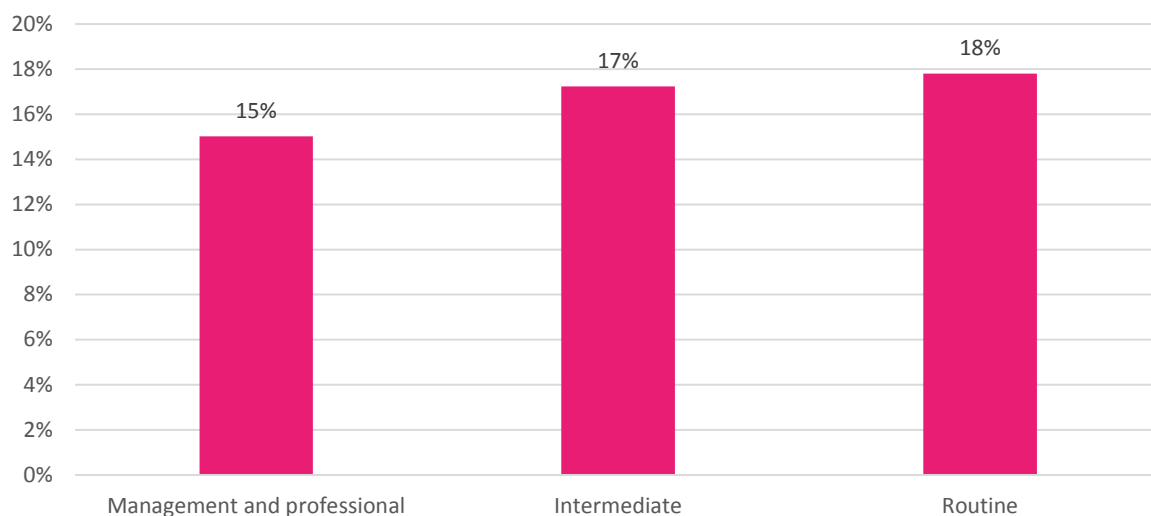
Family care is more commonly provided in more deprived areas, owing to greater need for care and the greater availability of potential carers.¹¹ We can hypothesise that those living in more deprived areas are less likely to have the resources to pay for formal care and therefore are more reliant on the state and their family. Those who find themselves needing to provide care are more likely to be on low pay meaning that the immediate financial cost of leaving the labour market is reduced.

Occupational social class

The analyses in this section of the paper focus on those who are in paid work, including the self-employed. To be categorised in an occupational social class, individuals must be in paid work. Only half of all family carers therefore have an occupational social class.

Our research shows that there is a relationship between an individual's age and their occupational social class, with those 30 to 44 more likely to work in management and professional occupations than older and younger individuals. Given the influence age has on the likelihood of providing care, the following analysis focuses only of those aged 40 to 64.

Figure 8: Proportion of all (male and female) in each occupational social class who provide care, those aged 40 to 64 in paid work



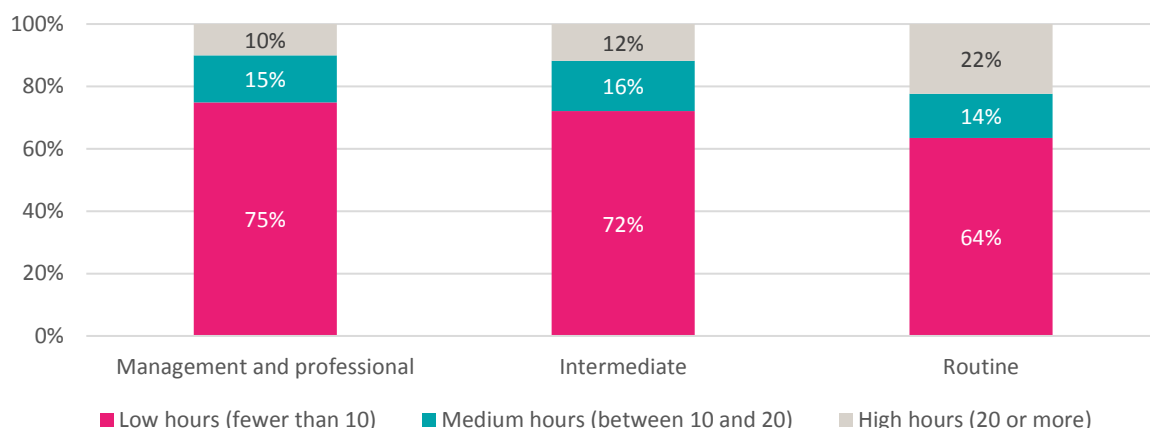
Source: SMF analysis of USoc

Figure 8 shows that those aged 40 to 64 who work in routine occupations are more likely than the other two occupational social classes to be providing family care. However, this figure does not show the prevalence of the classes amongst those who are balancing work and providing care. Our analysis shows that the largest occupational group amongst working carers is those working in managerial and professional occupations: 39% of family carers in paid work were in the “management and professional” group in 2015/17, while 36% were in “routine” jobs and 25% were in the “intermediate” occupations.

However, as shown in figure 9 they may provide fewer hours of care. This illustrates significant diversity even amongst working-age family carers. Those who balance paid work and family care cannot be placed into one box, and policy should reflect this.

The hours of care provided will have a significant impact upon an individual’s ability to remain engaged with all other aspects of life, particularly when combined with paid work. Figure 9 shows that over one in five (22%) of those who work in routine occupations are providing 20 hours or more of care per week. This in addition to the hours they spend at work and represents a considerable time commitment. Those who work in management and professional occupation are less likely to provide long hours with three quarters (75%) providing fewer than 10 hours of family care a week.

Figure 9: Hours of care provided by occupational social class, family carers aged 40 to 64 in paid work

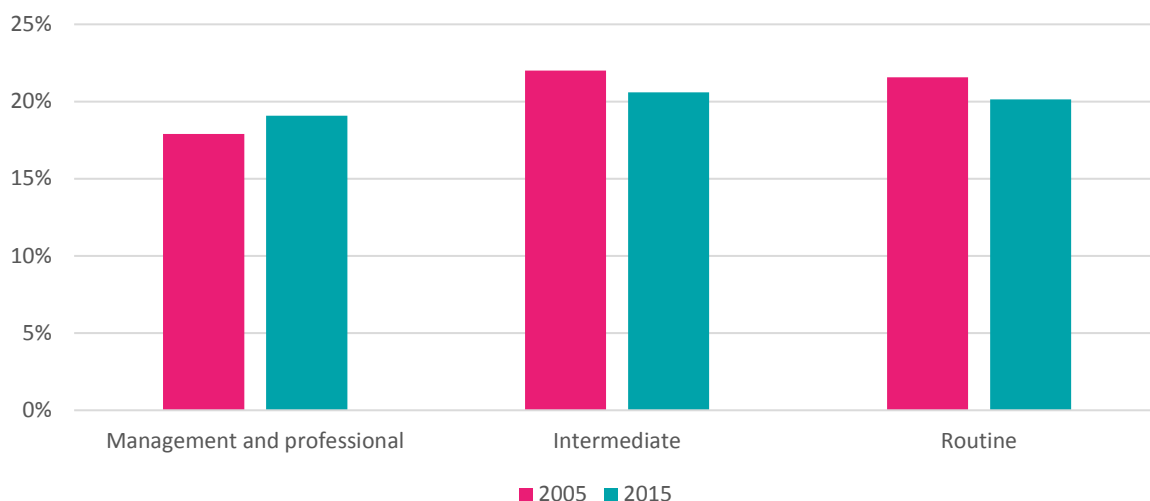


Source: SMF analysis of USoc

Given that women are more often family carers and provide more hours of care than men, it is important to understand the socio-economic position of women family carers. Our previous analysis has shown that over the past decade there has been an increase in the proportion of women providing care.

Figure 10 shows that between 2005 and 2015 the only occupational social class to see the proportion of women providing care increase was management and professional. While members of this group are still the least likely to provide care the differences between the occupational groups have reduced considerably over the decade.

Figure 10: Proportion of women in each occupational social class providing care in 2005 and 2015, those aged 40 to 64



Source: SMF analysis of USoc

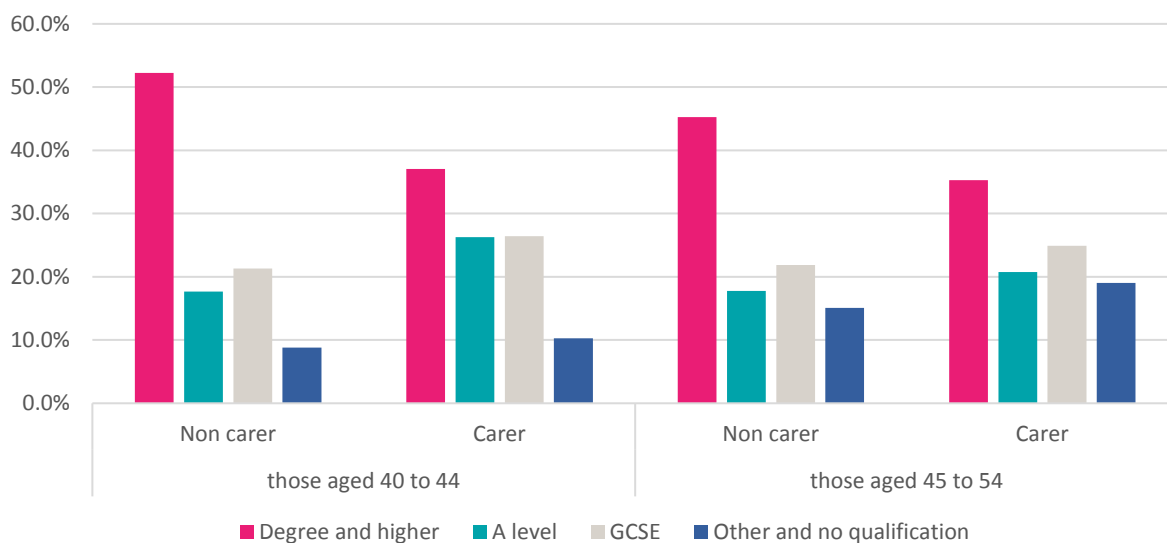
Other figures, for people of all ages, provide useful context here. Women working in professional and managerial roles make up a growing proportion of the overall population of women who do family care while in employment. Between 2005 and 2015, the total number of women carers in work was broadly steady at 2.2 million. But the balance of occupations tipped towards management and professional jobs. In 2005, women carers

in that occupational group were 30% of all women carers in paid work. In 2015, that had risen to 38%. Women who combine family care with employment are now more likely to work in the management and professional occupations than in any other occupational class. We expect the labour market to become increasingly concentrated in the management and professional occupations¹² and a failure to support working carers could lead to a reduction in the number of women in these roles.

Education

Only individuals who are in paid work are registered to an occupational social class, so the above findings only relate to the half of family carers who are in paid work. Research shows that providing family care can contribute to an individual leaving the labour market; those family carers who have given up paid work are not included in the occupational analysis.¹³ Since an individual’s educational qualifications are unlikely to change as a result of providing care this is a useful measure of the socio-economic position of carers. However, changes in educational opportunities over the last several decades reduce our ability to make comparisons between carers and non-carers across a wide range of ages, so these analyses are divided into age groups. Figure 11 is restricted to those aged 40 to 44 and 45 to 54.

Figure 11: Qualifications of those aged 40 to 44 and 45 to 54 by caring status



Source: SMF analysis of USoc

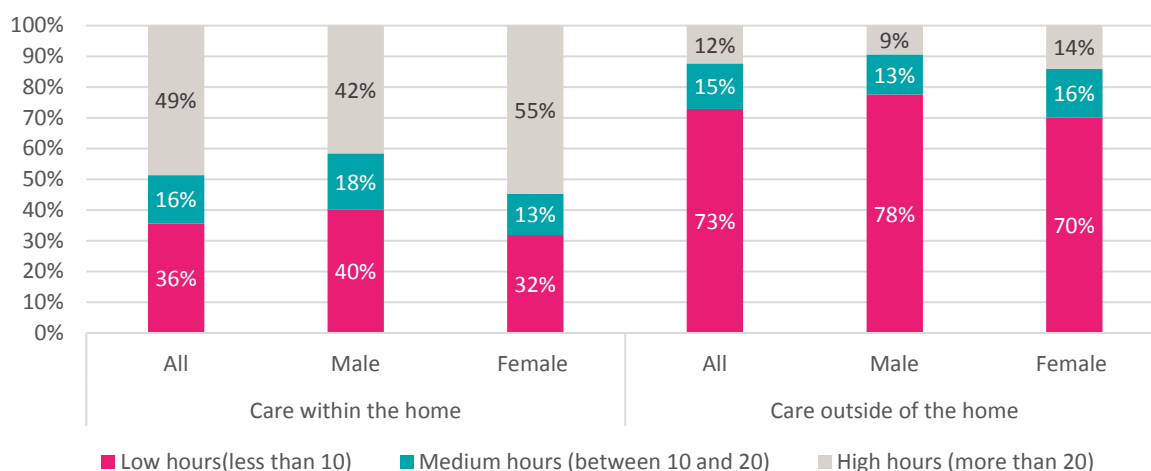
Figure 11 shows that, whilst carers are less likely to have degree and higher-level qualifications than non-carers, a substantial proportion of carers have these qualifications – over a third of carers aged 40 to 44 have a degree or higher level of qualification. Research shows that there is a link between education and the hours of care provided, with those with lower levels of education more likely to provide higher hours of care.¹⁴ Given the growth in higher education and the increase in the number of individuals providing family care, we can speculate that in the future the relationship between education and the likelihood of providing care will be less influential.

Providing care within the home

Around half (51%) of family carers provide care within their home. When we focus on care in the home we find that more equal proportions of men and women provide care than when we look at family care outside the household, which is done predominantly by women. This is because much of the care in the home is for a partner, and this care is undertaken by men and women in more equal numbers.

Those who provide care in the home do much longer hours of care than those who provide care outside the home; more than half of women (55%) provide 20 hours or more of care a week.²

Figure 12: Hours of care provided by care location and gender



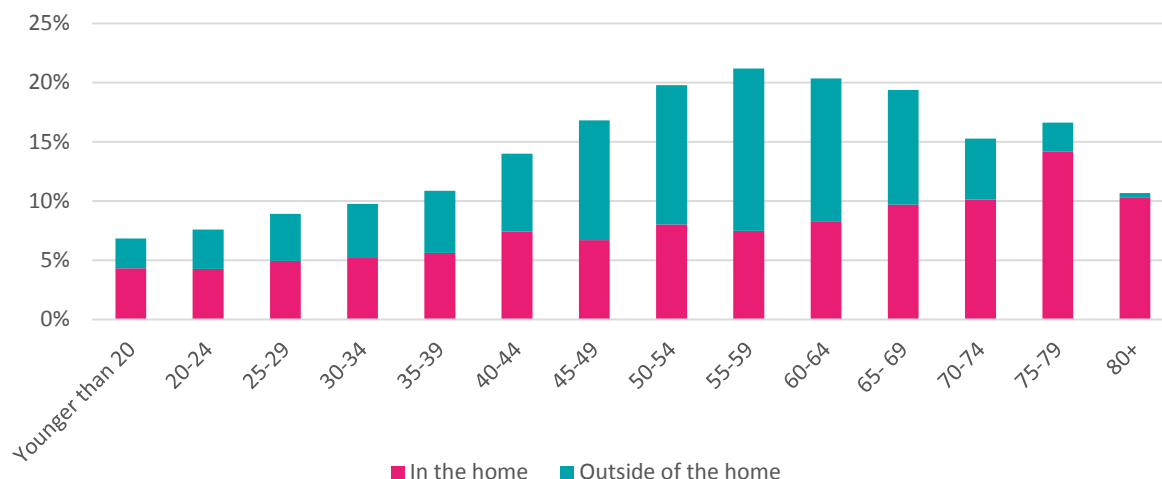
Source: SMF analysis of USoc

Those who provide care in the household are more likely to be in more disadvantaged socio-economic groups. Of those aged 45 to 54 who provide care in the household 30% have a degree or higher, compared to 39% of those who provide care to a family member outside the household. The same pattern appears when focusing on occupation, of those aged 45 to 54 who provide care in the household 41% work in routine occupations compared to 30% of those providing care outside the household.

Those who provide care in the home are typically older than those who provide care to someone who lives elsewhere. This is because much of the caring within households is for a partner – since partners are often of similar ages and many of those who need care are older people, those providing partner care are also more likely to be older people themselves. Figure 13 shows that more than half of those over the age of 65 who provide family care do so in their home and almost all (96%) of those aged over 80 who provide family care do so within the home. Family carers aged 45 to 64 are more likely to provide care outside of their home, with only 40% of those aged 45 to 49 providing care in the home. Family carers aged under 45 years are similarly likely to provide care inside or outside of their household.

² Note: This analysis focuses on those who provide care within the home at a minimum; those labelled as ‘within the home’ may also be providing care outside of the home.

Figure 13: Proportion caring by age group and whether this is provided within the home



Source: SMF analysis of USoc

Summary



More than half (59%) of family carers are women: 16% of women and 12% of men provide family care.

Women provide more hours of care than men: 45% of women carers provide 10 or more hours, compared to 40% of men.



More than half of carers are aged 40 to 64 and a quarter of carers are aged 65+.

More than half of carers aged 70+ provide more than 10 hours of care per week.

Caring in the home is more common amongst older people: more than half of carers aged 65+ care for someone they live with.



People working in routine occupations are the most likely to provide care, with 18% of those aged 40 to 64 doing so.

However, those working in management and professional occupations make up the largest occupational group of carers.

Carers are less likely to be in paid work and more likely to work part-time compared to non-carers.



Carers tend to have lower qualification levels than non-carers.

However, over one-third of carers aged 40 to 44 have a degree or other higher qualification.



Half (51%) of family carers provide care to someone they live with.

Almost half (49%) of those caring for someone they live with provide more than 20 hours of care per week.

CHAPTER 4: THE CHANGING NATURE OF CARE DEMAND AND SUPPLY

Chapter 3 focused on the demographics of those who currently provide care, however, given the changes occurring in the UK population, it is almost inevitable that the current demand for care will increase. What is less certain is whether this increase in demand for care can be met by an adequate increase in the supply of family care. This chapter looks to explore the factors that may influence the demand and supply of care in the future.

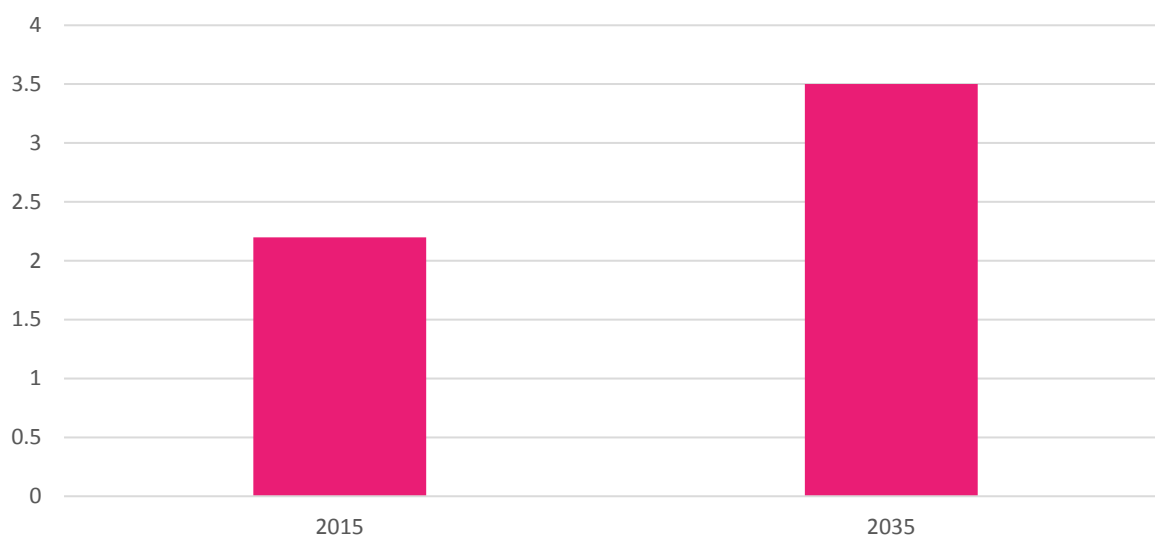
The demand for care

In 2016, it was estimated that 18% of the population in the UK were aged over 65. This is expected to increase to nearly a quarter of the population (24.7%) by 2046.¹⁵ The increase in the proportion of those over 65 disguises the even more rapid growth in those who are often referred to as 'older old', in 2016, there were more than three million individuals aged over 80 in the UK and by 2046 this is projected to more than double to almost seven million.¹⁶

How long we live is only part of the story; the period of life spent in poor health towards the end of life is also important. In the UK, people can currently expect to live for more than a fifth of their lives in poor health, equating to 19 years for women and 16 years for men.¹⁷ Increases in the period of life spent in poor health are likely to lead to increased demand for long-term care.

Over the next 20 years, if the probability of receiving informal care remains constant, the number of older people receiving informal care will rise by more than 60%.¹⁸

Figure 14: Current and forecasted number of disabled older people in households receiving informal care (millions)



Source: Raphael Wittenberg and Bo Hu (2015)^F

Older people are more likely than younger people to have a long-term condition (LTC). More than half (58%) of those aged over 60 have at least one LTC and a quarter (25%) have two or more.¹⁹ As the population ages the numbers affected by LTCs is likely to increase, and greater numbers with LTCs will lead to an increase in the demand for care, whether that be formal care provided by professionals or informal care provided by family and friends.

The supply of care

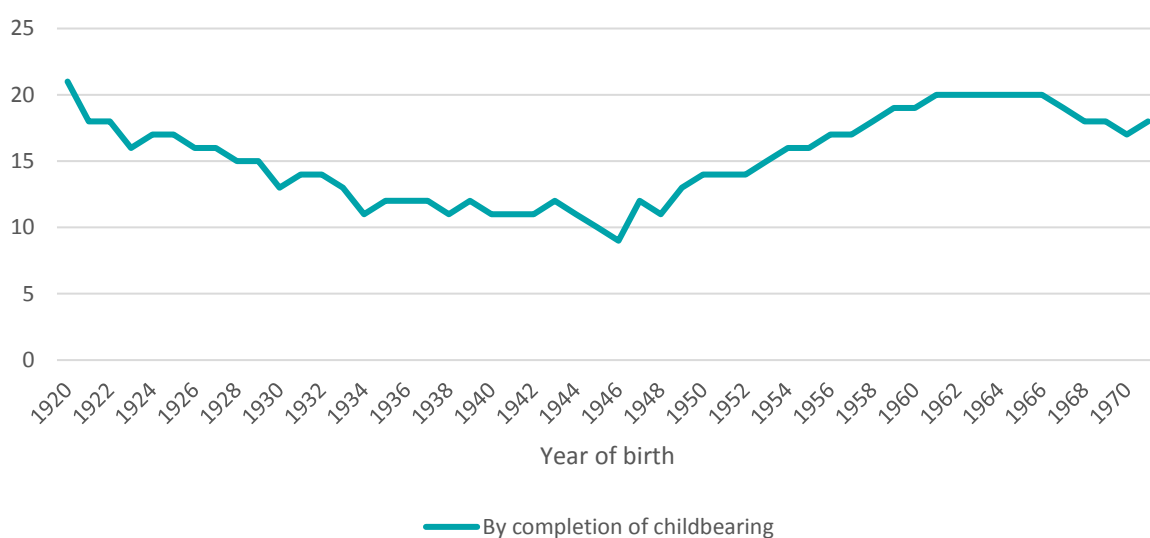
Given the current reliance on family carers there is a risk that the projected increase in the demand for care cannot be matched by an increase in family members able and willing to offer care. Previous SMF research shed light on the changing nature of family structures, concluding that there has been a trend towards greater heterogeneity of family types and a dramatic change in what is thought of as the typical ‘nuclear family’.²⁰ Historical increases in divorce rates, growing numbers of childless families and families living geographically further apart from each other are all factors that could influence the availability of family carers in the future.

There has been a significant increase in the number of older people who live alone and amongst those aged 45 to 64 there was an increase of 53% between 1996 and 2017.²¹ Whilst part of this can be attributed to population growth, it also reflects the increasing proportion of the population who are divorced or who have never been married. A large proportion of family care is currently provided by spouses: nearly a quarter of carers in our research are caring for a spouse. An increase in living alone would contribute to a reduction in the number of people who can rely on a partner to provide care as they age.

Two-thirds (67%) of carers in our research provide care to their parents or other older relatives. However, there is a substantial group of adults who are ageing without children. Women born in 1944, who are now aged 74, had an average of 2.2 children and 11% had no live-born children, whilst women born in 1971, who are now aged 47, had an average of 1.9 children and 18% had no live-born children.²² Although equivalent data is not available for men, we can assume that similar proportions of men to women do not have children.

Figure 15 highlights the growth in childlessness since the 1950’s. The current care system is serving a population of older people who were more likely than those born before or after them to have had children, and is heavily dependent upon adult children as carers. As those who are in middle age now get older, we can anticipate that a much higher proportion of those who need care will not have children to provide it.

Figure 15: Percentage of women remaining childless by birth year

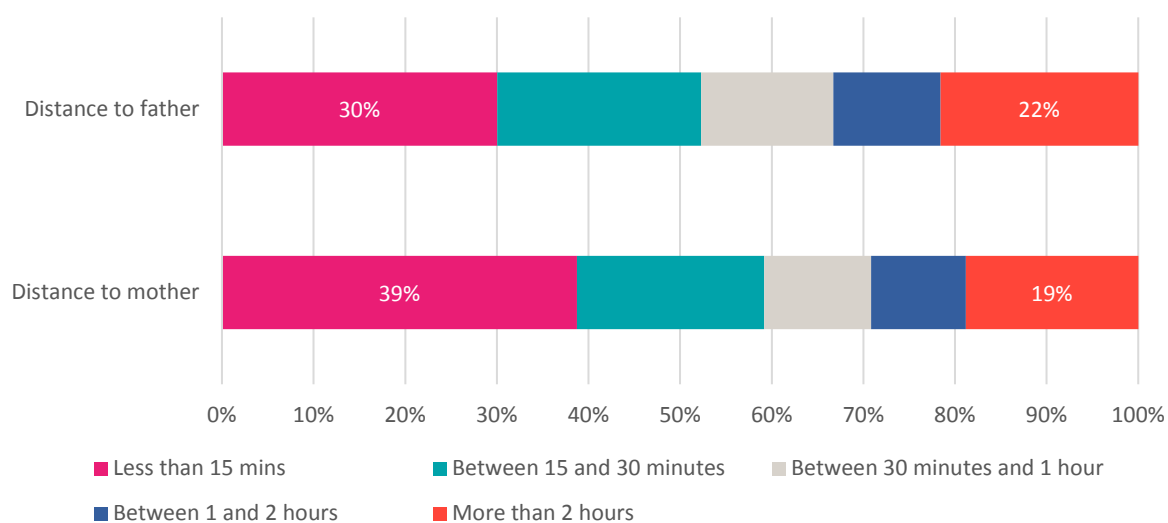


Source: ONS

For those that need care, having children is, however, not a guarantee that these children will be willing or able to provide care. Our research shows that whilst more than half of adults live within thirty minutes of their parents, approximately one in five live more than two hours away. A growing reliance on the family to step in to provide care where the state does not will put extreme pressure on the individuals for whom distance may impair their ability to provide care to their parents or older relatives.

In combination with this, our evidence (figure 16) suggests that people tend to live further from fathers than mothers. This analysis includes people whose mothers and fathers are alive as well as those with only one living parent. The distance between children and their father could impact the availability of care and interaction that fathers have with their children as they age.

Figure 16: Distance from individual to mother and father 2015/17, not including co-residence



Source: SMF analysis of Understanding Society Data (2015/17)

CHAPTER 5: THE LIVES OF CARERS

The act of providing care can be time consuming and stressful. In the preceding chapters we have identified those who provide care and the type of care being provided, in this chapter we will focus on the economic status of carers and their health and wellbeing. This will enable us to understand how providing care influences several aspects of an individual's life.

Economic status

Our research has shown that an increasing proportion of carers are providing long hours of care. This commitment may influence whether an individual can participate in the labour market or save for retirement. In this section of the report we evaluate the economic status of carers and the effect this may have on individuals.

Leaving the labour market

Research suggests that carers become at risk of leaving the labour market when they provide more than 10 hours of care.²³ Our analysis has shown that the proportion of carers who provide more than 10 hours has increased from 39% to 43% between 2005 and 2015 (figure 1). If this trend continues, we could expect to see larger numbers of carers leaving the labour market to become family carers.

In our research, almost a quarter (23%) of those who provide care within the household and who are not retired report that caring prevents them from working, and a further 15% report that they are unable to do as much work paid work as they would like. Our research also shows that carers are less likely to be in paid work than non-carers. This can have long-term consequences for the individual, particularly given that those who provide care are predominantly women and often working in semi-routine and routine occupations, who are at greatest risk of having low income in retirement.

Those that leave the labour market to provide care can find that their retirement income is affected as a result. The independent review of the state pension age (2017) made specific mention of carers as a group of concern, finding that, because carers are more likely to have time away from paid work, their income in retirement will suffer.²⁴

We have used a statistical model to understand whether carers are less likely to be in paid work than non-carers. The model takes into account the effects of a range of factors including age, gender, educational qualifications and region which may also differ between carers and non-carers.

Table 2: Results of statistical model of likelihood of being in paid work by hours of care³

Hours of care per week	Percentage difference in likelihood of being in paid work compared to non-carers
Low hours (fewer than 10 hours)	2.0%*
Medium hours (between 10 and 20 hours)	-4.6%*
High hours (20 hours or more)	-21.9%*

Note: *** represents significance at 15%, ** significance at 10% and * significance at 1%

³ Full results on the probit model are in the appendix.

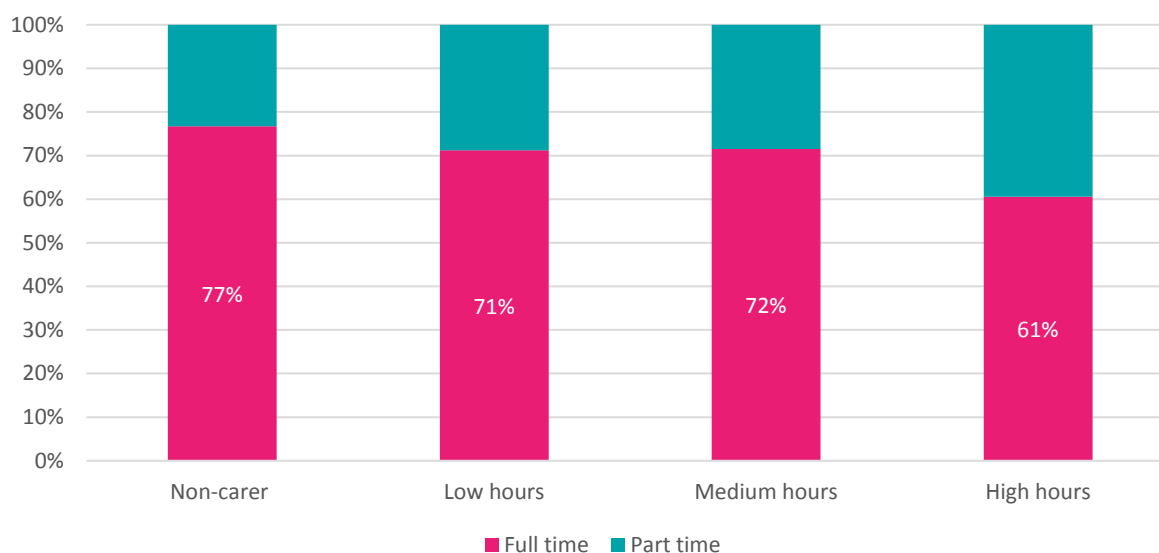
The results (table 2) show that those providing 10 hours or more of care are less likely than non-carers to be in paid work. Our analysis suggests that those who provide long hours of care (20 hours or more a week) are 22% less likely to be in paid work than non-carers.

As explored within chapter 3, a large proportion of family carers are of working age, with more than half of those who provide care aged 40 to 64. There is a risk that those who leave the labour market towards the later stages of their working lives may not be able to return to work if their caring responsibilities reduce or if they no longer need to provide care. This would have long-term financial consequences for the individual.

Reduced hours of work

Not all of those who provide family care will leave the labour market; many will combine paid work and caring responsibilities. Our analysis shows that carers are more likely to work part time than non-carers.

Figure 17: Proportion working full time vs. part time by caring status and hours of care, those aged 40 to 64



Source: SMF analysis of USoc

Figure 17 highlights how the hours of care impact the likelihood of working part-time. Over three quarters (77%) of non-carers aged 40 to 64 who are in work are working full time, compared to 70% of carers. Both men and women carers are more likely to work part-time than those without caring responsibilities.

Whilst there is very little difference in the proportion working full time between those who provide low and medium hours of care (fewer than 20 hours each week), those who provide 20 hours or more of care a week are much less likely to work full time, with only 61% doing so.

We used a statistical model to understand the relationship caring has with an individual's likelihood of working part time. Taking into account age, gender, educational qualifications and region, we find that providing care is associated with a higher likelihood of working part time, as is shown in table 3. Those who provide high intensity care are the

most likely to work part time. There is a clear trade-off between fully participating in the labour market and providing family care.

Table 3: Results of statistical model on likelihood of working part-time by hours of care⁴

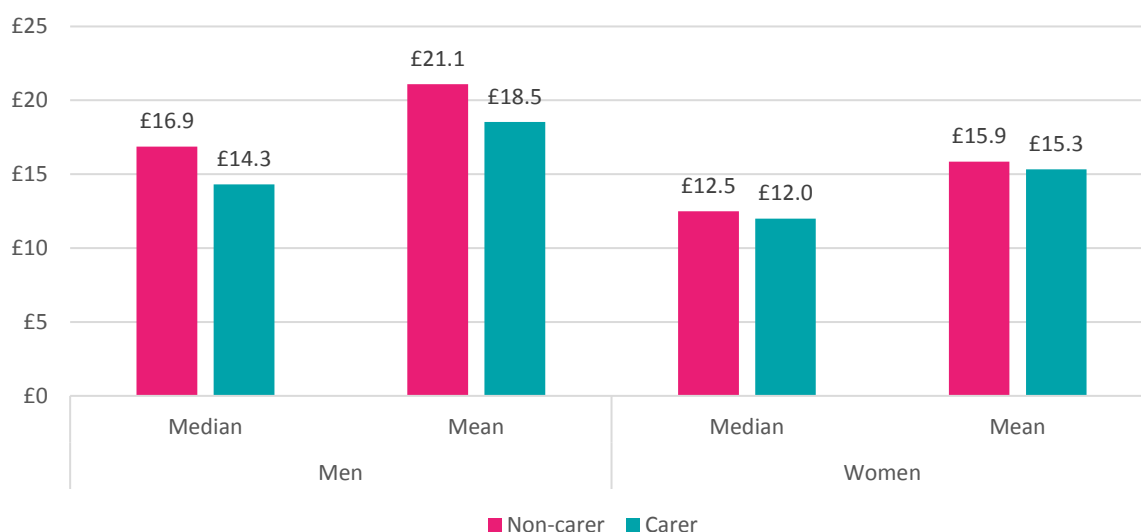
Hours of care	Percentage difference in part-time work compared to non-carers
Low hours (fewer than 10 hours)	2.9%*
Medium hours (between 10 and 20 hours)	3.9%*
High hours (20 hours or more)	9.0%*

Note: *** represents significance at 15%, ** significance at 10% and * significance at 1%

Earnings

The figure below shows that carers have a lower hourly pay than non-carers. Based on median figures, carers earned 13% less per hour than non-carers. The difference between carers and non-carers does not reflect the differences experienced between the genders. Men who are carers earn 15% less per hour than men non-carers, while women carers earn 4% less per hour than women non-carers. This does not control for the occupation or qualification of those in work. There is, however, a large gender pay gap between men and women regardless of their current carer status.

Figure 18: Hourly pay by caring status and gender in 2015/17, those aged 40 to 64



Source: SMF analysis of USoc data

Given the lower hours worked and lower hourly rates of pay amongst carers it is not surprising that we find evidence that carers earn less per month than non-carers. The median gross monthly salary of male non-carers aged 40 to 64 is £2,584 compared to £2,167 for male carers, representing a monthly difference of £417. The difference is less pronounced for women, with non-carers aged 40 to 64 earning a median gross monthly salary of £1,500 whereas carers earn £50 less at £1,450. However, there are a several factors in addition to hours that influence earnings. Our statistical models show that, even when these factors, including age, gender, occupational social class, hours worked and

⁴ Full results of the probit model are within the appendix.

educational qualifications, are accounted for, carers providing 20 or more hours of care a week earn 5% less per month than non-carers. Reduced earnings can have a significant impact on the individual’s pension, this includes reduced accumulation or even ineligibility due to earnings below company pension thresholds.

Table 4: Results from fixed effects model on monthly labour income by hours of care

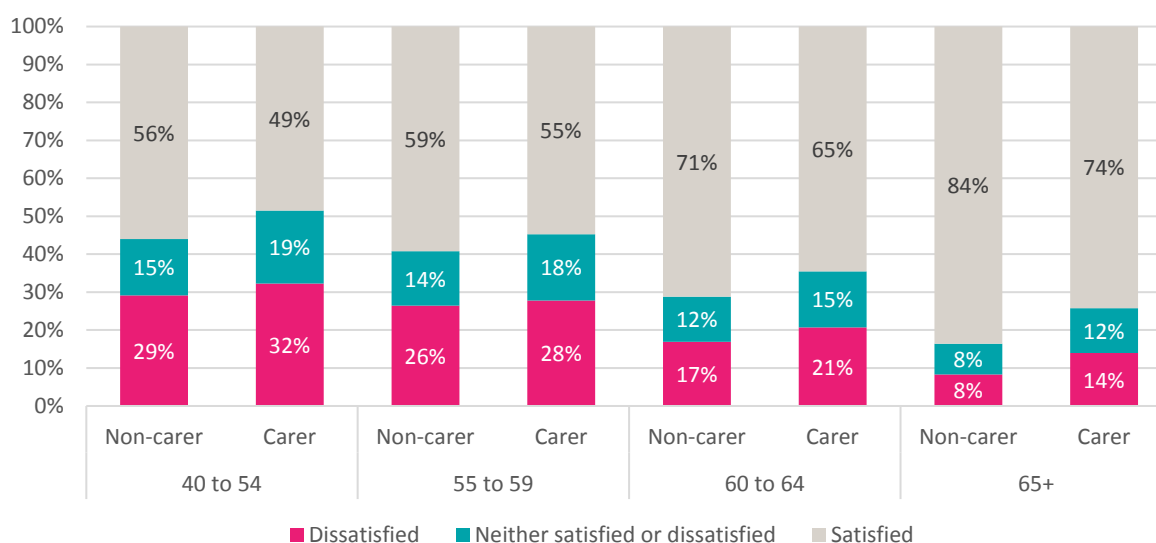
Hours of care per week	Percentage difference in monthly wages, compared to non-carers
Low hours (fewer than 10 hours)	-0.8%**
Medium hours (between 10 and 20 hours)	-2.4%*
High hours (20 hours or more)	-4.5%*

Note: *** represents significance at 15%, ** significance at 10% and * significance at 1%

Quality of life

Too often we limit the discussion of the impact of caring to the economic consequences, such as reduced working hours or lower pay, but the effect on quality of life of providing family care is also important. Our analysis shows that age can play a significant role in how an individual can feel towards their quality of life, with those aged 60 and above significantly happier with their leisure time than younger people, likely because of reduced working hours or retirement. As a result, the following analysis has been split into four age groups, those aged 40 to 54, 55 to 59, 60 to 64 and those aged 65 and over.

Figure 19: Satisfaction with leisure time by age and caring status

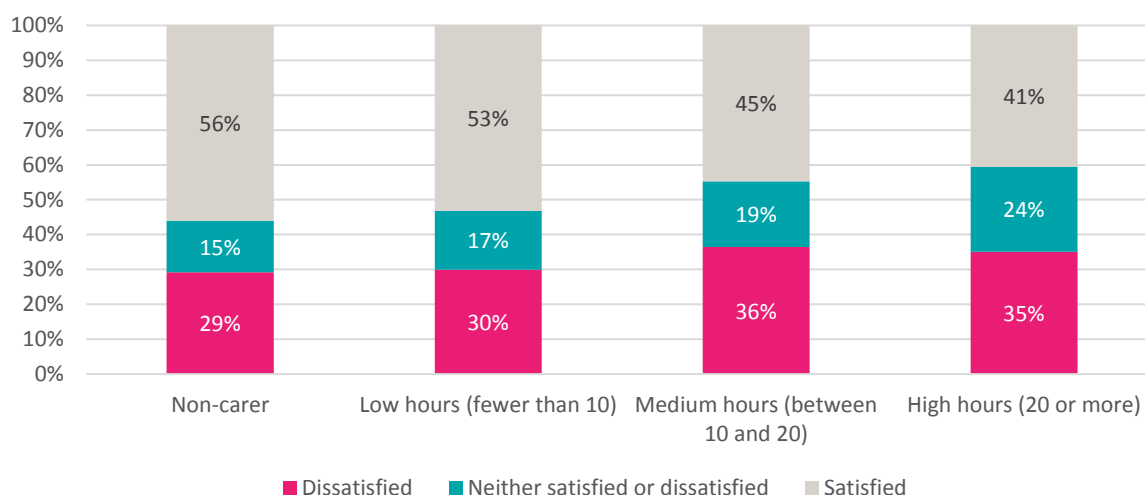


Source: SMF analysis of USoc

Figure 19 shows the level of satisfaction with leisure time for carers and non-carers in four age groups. The largest difference is in those aged 65+ where carers are 10 percentage points less likely to be satisfied with their leisure time than non-carers. The smallest difference is in those aged 55 to 59.

Focusing purely on the difference between carers and non-carers risks overlooking those who provide long hours of care, who are devoting a significant proportion of their time to providing care.

Figure 20: Satisfaction with leisure time by hours of care provided, those aged 40 to 54



Source: SMF analysis of USoc

Focusing on those aged 40 to 54 we can see that the difference between carers and non-carers is less stark than the difference between those that provide low and high hours of care. More than half of non-carers and those who provide low hours of care each week are satisfied with their leisure time, whilst fewer than half of those who provide more than 10 hours a week are satisfied with their leisure time. Providing high hours of care has a substantial impact on leisure time satisfaction; only four in ten (41%) of those who provide 20 hours or more are satisfied with their leisure time. They may find that they are unable to participate in social activities or to take time for themselves.

Leisure time is just one component of a range of factors that influence quality of life. When looking at ‘satisfaction with life overall’ we see that those who provide care are less satisfied than those who do not. The largest difference is apparent within the 40 to 49 age group, where those who provide care are 8% less satisfied within their lives overall.

There are, however, many factors that can influence how satisfied an individual is with the quality of their life. Through our analysis we are able to see how being a carer is linked to levels of satisfaction when taking into account other characteristics such as age, gender, and health status which may also influence life satisfaction (table 5). We ran statistical models to estimate the difference in life satisfaction between those providing different amounts of care. The results show that providing care is linked to lower life satisfaction, and those that provide high hours of care are 7% less likely to be satisfied with their lives than to non-carers.

Table 5: Results of statistical model estimating relationship between care and life satisfaction

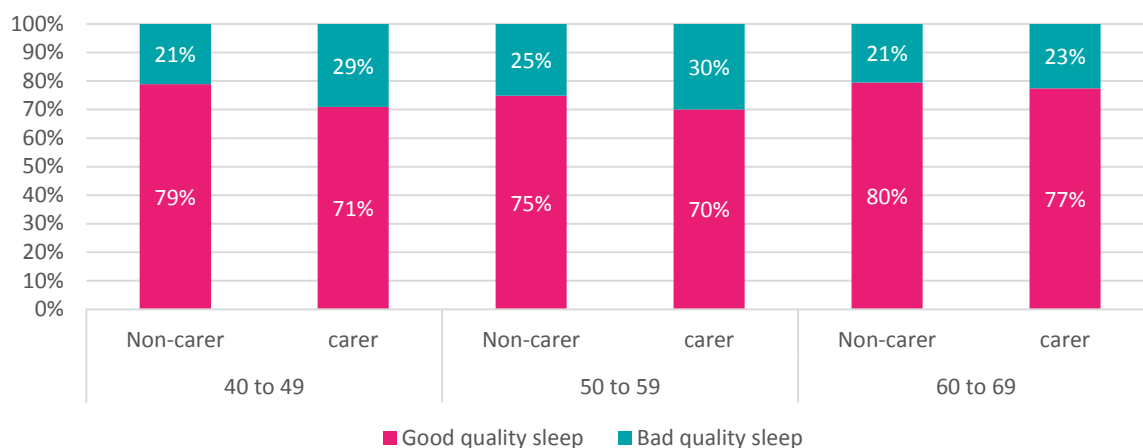
Hours of care per week	Percentage difference in likelihood of satisfaction with life, compared to non-carers
Low hours (fewer than 10 hours)	-0.6%*
Medium hours (between 10 and 20 hours)	-3.6%*
High hours (20 hours or more)	-6.9%*

Note: *** represents significance at 15%, ** significance at 10% and * significance at 1%

Health of carers

Research has shown that carers who are in paid work are likely to experience several difficulties including excessive stress, family conflict and financial pressures²⁵ all of which are linked to poorer quality sleep. The results shown in figure 21 suggest that family carers aged 40 to 49 are more likely to have a poorer quality of sleep. A lack of sleep can have a negative and significant impact on an individual’s productivity²⁶ and on their long-term health.

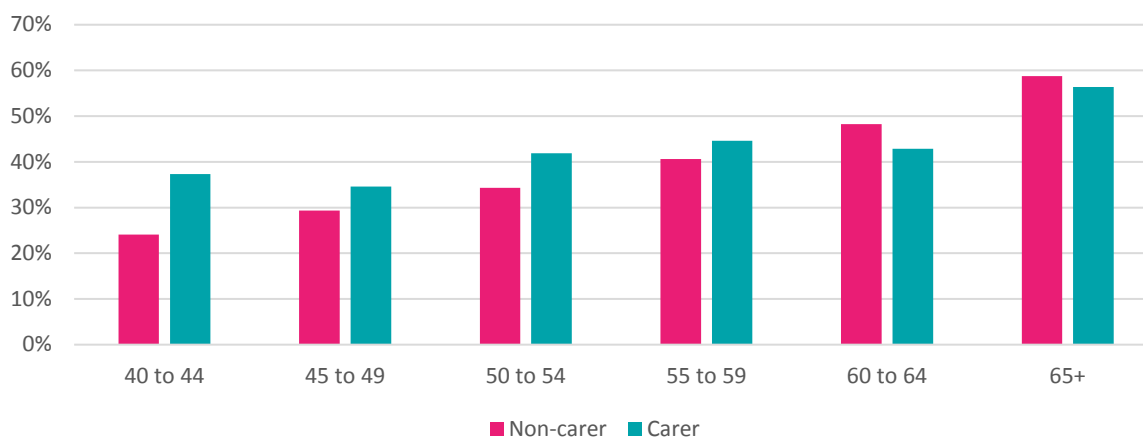
Figure 21: Quality of sleep by age and caring status



Source: SMF analysis of Usoc

Research suggests that carers tend to have poorer health than those who do not provide care.²⁷ Our analysis illustrates that, for those aged younger than 55 this is the case, as at these ages carers are more likely to report a limiting longstanding illness or disability than non-carers (figure 22). Over the age of 55, however, there is less of a clear distinction between the health of carers and non-carers, and carers aged 60 and older are less likely than non-carers to report having a long-standing illness or a disability. This may be because only those who are relatively healthy at these ages are able to provide care. There is also a risk that older carers do not regard themselves as ill compared to the person they are caring for, or that carers are less able to seek medical attention due to their caring responsibilities.

Figure 22: Proportion with long-standing illness or disability by age



Source: SMF analysis of USoc.

Summary

The labour market

- Family carers who care for 20+ hours a week are 22% less likely to be in paid work than non-carers.
- Those who provide 20+ hours of care are 9% more likely to be working part-time than non-carers.
- Both reduced working hours and movement out of paid work can negatively influence an individual's immediate financial position and their career prospects and pension in the future.

Earnings

- Carers earn less per hour than non-carers. Men who provide family care earn 15% less per hour than men who don't, whereas for women this difference is 4%.
- Carers who provide 20+ hours of care a week earn 5% less than non-carers, even when we take into account differences in hours of paid work, and sociodemographic differences between carers and non-carers.

Quality of life and health

- Carers are less satisfied with their lives than non-carers: those that provide 20+ hours of care are 7% less likely to be satisfied with their lives than non-carers.
- Among those aged under 55, carers are more likely than non-carers to have a longstanding illness or disability.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

Note: This chapter is, in part, based on a Chatham House-rule seminar held at SMF in May 2018 to discuss the findings set out in the earlier chapters of this report. Attendees included representatives of government, industry, the voluntary sector and academics, as well as SMF staff. The comments here reflect that discussion, but represent only the views of the paper's authors and not any of the attendees.

This report has been written as ministers prepare to publish a Green Paper on social care in England. The precise scope of the paper has not been made clear, but we note that the Government has said that “the Green Paper will include a focus on unpaid care and how our society supports carers as a vital part of a sustainable health and social care system”.²⁸

That is a welcome commitment, but not one that has had significant impact on the political debate around social care, where the overwhelming majority of political and media commentary continues to be on formal care provision, generally that provided by local authorities, and, specifically, how it might best be funded.

The case for a more sustainable funding settlement for social care is surely overwhelming, but the findings of this report underline one of the reasons change is needed. The failure of state provision to meet the full needs of the population is in large part falling on the families of care recipients. This report demonstrates that families are picking up the slack of a system that cannot provide adequate care. It also makes plain the impact that has on the people caring for relatives, impact that is particularly visible in their employment outcomes. The fact that significant numbers of people are having to work less (or not at all) in order to care for relatives should concern policymakers on several levels. The state's failure to devote sufficient resources to social care is reducing the economic activity of millions of people, something that will not just reduce the fiscal contribution they can make but deny them the economic and social benefits that work can offer. This is a vicious circle of public policy failure, and no social care settlement can be said to be sustainable if it does not take full account of the needs of family carers.

It is beyond the scope of this report to make detailed policy recommendations to remedy the issues we have identified. In any case, the imminent arrival of the Green Paper might make such recommendations ill-advised. Instead, we use the findings set out in the previous chapters to make recommendations about what questions the Green Paper must seek to answer. While these recommendations are of direct relevance to ministers and others preparing that paper, they are also relevant to all policymakers engaged in the debate around the Green Paper.

An honest conversation

No matter how much money the state finds for the formal care sector, family care will take place. By caring for relatives, family carers will both save the state some expenditure and face consequences for their own lives. None of these observations are controversial, yet politicians have not often been willing to embrace them publicly. The lack of forthright public debate about the optimum balance between state provision and family, and the “correct” role for family members to play in a relative's care has surely contributed to the

official neglect of the family care sector. The reasons for the constrained debate about family care are numerous and open to speculation, but we offer some observations arising from the data here.

The population of family carers has long been skewed towards women, older individuals, those with lower levels of education and those employed in lower-skilled, lower paid occupations, if they are employed at all. These characteristics have rarely been associated with political influence or prominence in national conversation; older, poorer women are less visible and less influential than other people. In that context, we note that the data in this report shows that the profile of the caring community is changing. For whatever reason, more people with higher levels of education and employment are providing care. While we do not endorse (and indeed, regret) the lack of political voice given to family carers in the past, we suggest that the changing profile of the family carer population should give political leaders additional cause to engage honestly with this issue.

Honest engagement would mean accepting that family care is a vital component of the social care system; without it, provision would either be unacceptably limited or unacceptably expensive. Accepting and admitting, publicly, is a necessary step to a sensible discussion of the policies needed to support and assist family carers. Many of those who provide family care want to help their relative in one way or another and we must support them with this. Note that accepting the importance of family care, and devising policies to support it, is not, per se, the same as advocating or demanding that people do so. Another reason politicians have been shy of debating this aspect of care is fear of being seen to tell people how they should or should not treat their relatives and how their families should work and live.

We do not take a position on that matter here, merely highlighting an area of public policy badly in need of better-informed and more candid political debate. We also suggest that it is perfectly possible for politicians who claim positions of public leadership to debate ways to support people who carry out an activity without demanding that other people carry out that activity. Nor must it be the case that support for family carers must be part of an attempt to reduce the load on the state and the formal care sector. Indeed, since we have demonstrated that family carers' activity has increased as the formal sector's troubles have grown, it could be argued that family carers have filled at least some of the shortfall. Further support for family carers, therefore, need not be an attempt to push families to do more so that the state can do less, but merely an overdue recognition of what has already been done.

Such questions need more comprehensive debate. As such, we recommend that the Green Paper should indeed give a central role to questions about family care, but those questions should start with this: given that unpaid care is indeed "vital" to a sustainable care system, how much care is it reasonable for society to expect family carers, as individuals and as a whole, to contribute to care? Only by seeking to answer that question can social care funding be properly costed, and family care support policies be properly constructed.

Employment and employers

A central point shown in Chapter 5 is that caring for a relative is associated with adverse effects on the carer's career and earnings.

We suggest that lessons can and should be drawn from the experience around maternity leave and, more recently, paternity leave, as well as the wider issue of how employers can and should accommodate the parenting needs of employees. However, these lessons must be broad and ambitious ones drawn from social and cultural experience, not narrow analysis of legislation. Simply, the experience of caring for an older relative is not sufficiently similar to the experience of parenting a child from birth to make direct comparisons of policy wholly useful. The timetable for parenthood is, largely, universal and predictable, a standard template around which employers and employees can plan with some certainty. The timetable for family care is neither standard nor predictable, something that must be accepted if policymakers are to have that honest debate we seek.

Indeed, a search for neat examples from childcare policy that can simply be transposed to the social care context may hamper the search for more helpful ideas. For instance, neither a fixed period of leave (modelled on maternity leave) nor the right to request part-time working may be entirely suitable for an employee facing the unpredictable needs involved in caring for a relative with dementia. And a system of tax-breaks for the costs of privately-provided social care (modelled on childcare vouchers) would raise new complications not found in the childcare context, including who would benefit from those incentives (given that care is generally funded by the recipient, not relatives) and who is ultimately responsible for paying for care.

Instead of seeking specific policy parallels, we suggest that the conversation around employment and care focuses on broader social and cultural issues.

One suitable area for consideration is the reasons that significant numbers of employers offer maternity packages that exceed the statutory minimum. There are, broadly, two reasons to do so: first, to seek the narrow self-interested benefits arising recruiting and retaining staff; second, to seek the wider benefits accruing from being seen to treat staff (and especially women) fairly and decently. How could such incentives be used to encourage employers to make it easier for workers to remain employed while providing care for a relative?

We suggest that the Green Paper should seek reflections and lessons from the recent experience of mandatory gender pay gap reporting for larger companies, a process that has intensified the social pressure on employers to account for their treatment and support of different groups of workers. At the very least, employers should monitor the number of their staff with caring responsibilities; anecdotal evidence from the CIPD suggests that many do not even record this data.

Proper monitoring might, in time, lead to mandatory "care pay gap" reporting, even generating data that could also be divided by gender, to highlight and facilitate exploration of the divergent experiences of men and women carers. At the very least, we suggest that the Green Paper seek views on the merits of requiring all significant

employers to report on whether they have a developed policy of support for employees who provide family care. According to the CIPD, fewer than 40% have such a policy.²⁹

Beyond even the scope of the Green Paper, we suggest that all politicians with an interest in sustainable care use whatever social leverage they can generate to celebrate good practice by employers, to help establish a social norm that supporting employees who care is the duty of a responsible employer. Central and local government could also do more to spread examples of successful policies and practices.

Progress towards employers adopting policies and practices that support mothers and, more recently, fathers have been driven only partly by legislation. At least as important has been social pressure. The Green Paper should seek to start a national conversation about how family care and employment can coincide sustainably.

Supporting those without family

This recommendation may appear counterintuitive for a paper about family carers, but we suggest that the Green Paper should pay close attention to people who do not have access to family care.

As noted in Chapter 4, a falling birth rate means that it will be increasingly common for older people to have no children who might provide unpaid care. The increasing physical dispersion of families may also reduce the number of older people who have children and other relatives able to provide care.

The growth in those without relatives able to care does not just present a challenge over how the state can provide adequate care. It also raises some broader questions of equity.

A degree of financial means testing already exists within the care system and will inevitably continue: the principle that those with greater financial wealth and/or income should contribute towards the costs of formal social care is too well-established to be abandoned, even if state resources allowed it.

But we suggest that the Green Paper must ask how and if state provision might be altered to take account of a person's family circumstances. Of course, such account is already taken, on an informal and often implicit way; anecdotal evidence abounds to suggest that formal care services feel able to devote less attention to those with relatives able and willing to provide care.

But the growth in the proportion of care recipients who do not have such relatives will only sharpen the questions that arise from such practices. Is it right that state services practice what amounts to a family membership means test on care services? Is there a risk of social tension between those who have children to provide care and those who do not, perhaps driven by an increasing awareness of the tax burden imposed to fund state provision? No matter how well funded it is, a care regime where family carers (whose caring is associated with lower wages, worse health and less leisure time) resent paying towards a system they perceive as devoting more resources to those who have no caring relatives than to those who do is not, in terms of legitimacy, a sustainable regime.

On the other side of the ledger, policies put in place to support family carers must also command the confidence of those who neither provide nor receive family care. The obverse of the resentment suggested above is unhappiness among those without caring relatives about the contributions they might make towards a system that includes more extensive support for family carers.

Demographic change means the importance of striking a sustainable balance between these two groups will only grow. Despite this report's focus on family carers, we do not take sides here or suggest any answers to that question of how the state should take account of family circumstances. Instead, we simply suggest that it is increasingly important that the state does, explicitly, offer an account of how or if family circumstances should affect formal care provision. Whatever the answer to that question, it is important that it is clearly explained, widely understood and broadly accepted.

The Conservative Party's experience over its 2017 manifesto commitment on care funding is a sharp reminder that perceptions of unfairness have great political power. Sensible policymaking will seek to anticipate such perceptions and prevent them arising.

Care Navigators

A related issue arising from consideration of those without access to family care is that of care navigation.

As NHS England has recognised, having a relative who is able to liaise effectively with different healthcare and social care providers can be vital to a person's wellbeing.

Moving between different care settings can be an especially vulnerable time with the risk of 'slipping through the gaps'. Often family or unpaid caregivers provide the only 'common thread' to access and coordinate care from a long list of health and social care providers.³⁰

To which we would also add the need to deal with financial, logistical and other more mundane aspects of needing care, activities that are partly recognised in the IADL figures in Chapter 2.

Can care navigators help support family carers, relieving some of the pressure on them and also delivering better outcomes for care recipients? And would access to a navigator be a partial answer to the needs of those without family members to provide care?

As with other areas, we do not propose to offer definitive answers to such questions here. Instead we note that the evidence base for the effectiveness of navigators in the English context remains limited, not least because provision of navigator services is inconsistent across England. Perhaps as a result, the policy framework around navigators is also poorly developed. It is not, for instance, clear whether navigators ought to be provided by the NHS, by local authorities, by voluntary bodies or by others. Nor is there is clear single model for funding navigation.

Given that, we recommend that the Green Paper should seek submissions on the role, value and delivery of care navigation services, both for care recipients who receive family care and for those who do not.

APPENDIX A

The appendix shows the full results of the statistical models used within this analysis. The first column shows the impact of the changeable variable on the outcome variable and a P-value of less than 0.05 shows statistical significance at a 5% level.

Results of probit model on life satisfaction

Variable	Dy/dx	P value
In comparison to non-carer		
Low hours of care	-0.006	0.042
Medium hours of care	-0.036	0.000
High hours of care	-0.069	0.000
age	-0.014	0.000
Age squared	0.000	0.000
In comparison to men		
Women	0.003	0.104
In comparison to self-employed		
employed	0.014	0.000
unemployed	-0.159	0.000
maternity leave	0.075	0.000
family care	-0.039	0.000
fulltime student	0.016	0.002
Long-term sick/disabled	-0.279	0.000
government training scheme	-0.137	0.000
unpaid, family business	-0.069	0.047
on apprenticeship	0.013	0.650
other	-0.063	0.000
In comparison to no health condition		
Health condition	-0.108	0.000
In comparison to never married		
married	0.072	0.000
in a civil partnership	0.110	0.000
separated	-0.049	0.000
divorced	-0.009	0.018
widowed	0.007	0.415
have a dissolved civi..	-0.179	0.006
separated from a civi..	-0.231	0.070
surviving partner of ..	-0.021	0.880
In comparison to Degree		
Other higher degree	-0.036	0.000
A-level etc	-0.042	0.000
GCSE etc	-0.060	0.000
Other qualification	-0.077	0.000
No qualification	-0.058	0.000
In comparison to 2009/11		
2010/12	-0.013	0.000
2011/13	-0.035	0.000
2012/14	-0.056	0.000
2013/15	-0.054	0.000
2014/16	-0.011	0.001
2015/17	-0.010	0.003

Results of probit models on labour market outcomes

Likelihood of being in employment

Variable	Dy/dx	Pvalue
In comparison to non-carer		
Low hours of care	0.020	0.000
Medium hours	-0.047	0.000
High hours	-0.219	0.000
Age	0.043	0.000
Age squared	0.000	0.000
In comparison to men		
Women	-0.049	0.000
In comparison to Degree		
Other higher degree	-0.027	0.000
A-level etc	-0.086	0.000
GCSE etc	-0.130	0.000
Other qualification	-0.202	0.000
No qualification	-0.375	0.000
In comparison to North East		
North West	0.005	0.295
Yorkshire & Humber	0.000	0.932
East Midlands	0.030	0.000
West Midlands	-0.001	0.887
East of England	0.027	0.000
London	-0.078	0.000
South East	0.030	0.000
South West	0.043	0.000
Wales	0.022	0.000
Scotland	0.027	0.000
Northern Ireland	-0.010	0.058
In comparison to never married		
Married	0.052	0.000
In a civil partnership	0.087	0.000
Separated	0.008	0.135
Divorced	0.009	0.015
Widowed	-0.013	0.077
Have a dissolved civil..	-0.048	0.366
Separated from a civil..	-0.051	0.604
Surviving partner of ..	0.090	0.525
In comparison to no health condition		
Health condition	-0.170	0.000
In comparison to having responsibility for children under 16		
No resp. children	0.141	0.000
In comparison to 2009/11		
2010/12	0.011	0.000
2011/13	0.013	0.000
2012/14	0.014	0.000
2013/15	0.019	0.000
2014/16	0.033	0.000
2015/17	0.028	0.000

Likelihood of working part-time

Variable	Dy/dx	Pvalue
In comparison to non-carer		
Low hours of care	0.029	0.000
Medium hours	0.039	0.000
High hours	0.090	0.000
Age	-0.048	0.000
Age squared	0.001	0.000
In comparison to men		
Women	0.187	0.000
In comparison to Degree		
Other higher degree	0.037	0.000
A-level etc	0.069	0.000
GCSE etc	0.095	0.000
Other qualification	0.104	0.000
No qualification	0.165	0.000
In comparison to North East		
North West	0.003	0.618
Yorkshire & Humber	0.021	0.001
East Midlands	0.016	0.011
West Midlands	0.021	0.000
East of England	0.012	0.044
London	0.034	0.000
South East	0.013	0.022
South West	0.033	0.000
Wales	-0.005	0.433
Scotland	0.010	0.107
Northern Ireland	-0.003	0.584
In comparison to never married		
Married	0.023	0.000
In a civil partnership	-0.032	0.035
Separated	-0.008	0.223
Divorced	-0.024	0.000
Widowed	0.012	0.169
Have a dissolved civil	0.012	0.870
Separated from a civil	-0.213	0.000
Surviving partner of ..	0.026	0.835
In comparison to no health condition		
Health condition	0.025	0.000
In comparison to having responsibility for children under 16		
No resp. children	-0.258	0.000
In comparison to 2009/11		
2010/12	0.005	0.109
2011/13	0.008	0.022
2012/14	0.007	0.064
2013/15	0.004	0.243
2014/16	-0.002	0.508
2015/17	0.003	0.494

Results from fixed effects model on monthly income

Variable	Coefficient	P-value
In comparison to non-carer		
Low hours of care	-0.008	0.066
Medium hours	-0.023	0.003
High hours	-0.045	0.000
Age	0.089	0.000
Age squared	-0.000	0.000
In comparison to men		
Women	0.084	0.380
In comparison to Degree		
Other higher degree	-0.048	0.033
A-level etc	-0.111	0.000
GCSE etc	-0.131	0.000
Other qualification	-0.143	0.000
No qualification	-0.148	0.000
In comparison to Higher managerial and professional		
Intermediate	-0.067	0.000
Lower supervisory & t..	-0.138	0.000
Semi-routine & routine	-0.230	0.000
In comparison to FT		
PT employee	-0.451	0.000
In comparison to no health condition		
No health condition	-0.008	0.013
In comparison to having dependent children under 16		
No	0.078	0.000
In comparison to 2009/11		
2010/12	0.017	0.007
2011/13	0.033	0.002
2012/14	0.053	0.001
2013/15	0.072	0.001
2014/16	0.119	0.000
2015/17	0.145	0.000

ENDNOTES

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