The London School of Economics and Political Science

No End of Care? Informal Care for Older Parents in Britain between 1985 and 2000

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Declaration of Authorship

I certify that the thesis I have presented for examination for the MPhil/PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

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Abstract

This study is concerned with the issue of substitution between formal and informal care in Britain between 1985 and 2000. This period provides the conditions for a 'natural experiment' in social policy. During the late 1980s/early 1990s, there was a rapid increase in long-stay residential care for older people, which came to an end around the mid-1990s. The key issues examined here are whether this increase in formal services led to a decline in provision of informal care, and whether this was subsequently reversed. For reasons identified in the literature review, the focus is on provision of intense informal care by adult children to their older parents, trends in which are identified using General Household Survey data.

The study shows that there was a significant decline in provision of intense and very intense co-resident care for older parents between 1985 and 1995, which came to an end in the mid-1990s. A number of potential explanations for these trends are explored, including supply-side explanations in terms of changes in socio-demographic factors and employment rates, and an alternative demand-side explanation in terms of changes in 'spouse care'. The study finds that, under certain circumstances, key trends in intergenerational care were negatively related to changes in long-stay residential care. In particular, the study finds evidence of substitution effects between nursing home/hospital care and very intense co-resident care for older parents provided by adult children for 50 hours a week or more.

A key policy implication is that an expansion of very intense formal services for older people could bring about a decline in some of the most intense forms of intergenerational care for older people. The study relates these conclusions to options around reform of the long-term care system currently under consultation in England following the recent Green Paper on social care.

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Glossary and Abbreviations

Glossary: Key terms used in the Study

Informal care	Unpaid family care, to be distinguished from formal, professional services.
Intense informal care	Informal care provided for 20 hours a week or more.
Intergenerational care	Informal care provided for parents or parents-in-law; also described as 'filial care'.
Long-stay residential care	All forms of residential care, including residential care homes, nursing homes and long-stay hospitals.
Long-stay hospital care	Long-stay care in primarily NHS hospitals
Nursing homes	Private and voluntary nursing homes
'Older' parents or spouses	Parents or spouses aged 65 and over
'Older old' parents or spouses	Parents or spouses aged 80 and over; also referred to as the 'very old' or the 'oldest old'.
Residential care homes	Local Authority, private and voluntary care homes
Very intense informal care	Informal care provided for 50 hours a week or more.

Abbreviations

ADLs	Activities of Daily Living (including bathing, transferring, feeding and getting to the toilet)
ADSS	Association of Directors of Social Services
AMA	Association of Metropolitan Authorities
BHPS	British Household Panel Survey
CIs or Conf. Intervals	Confidence Intervals
CSCI	Commission for Social Care Inspection
ELSA	English Longitudinal Study of Ageing
EPC	Economic Policy Committee (European Commission)
HOC	House of Commons
HMG	Her Majesty's Government
JRF	Joseph Rowntree Foundation
GHS	General Household Survey
HSE	Health Survey for England
LFS	Labour Force Survey
LLTI	Limiting long-term illness
NAHAT	National Association of Hospitals and Trusts
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
OPCS	Office for Population and Census Statistics (predecessor of ONS)
p.w.	Per week
RS	Survey of Retirement and Retirement Plans
SARs	Sample of Anonymised Records (derived from 1991 or 2001 Census)
SPA	State Pension Age
STG	Special Transitional Grant

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Material from the General Household Survey (GHS) is Crown Copyright and is made available by the Office for National Statistics (ONS) via the UK Data Archive. Permission to use the GHS data sets has been granted by the UK Data Archive. All responsibility for the analysis and views expressed in this study rests with the author.

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Chapter 1

Issues, Policy Debates and Research Gaps

1.1 Key Questions Addressed by the Study

This study is concerned with the issue of substitution between formal and informal care in Britain between 1985 and 2000. The period of the late 1980s and early 1990s in Britain provides the conditions for a 'natural experiment' in social policy. During the 1980s and early 1990s, there was a rapid increase in long-stay residential care for older people, which came to an end in the mid-1990s. The key issue examined here is whether this increase in formal services for older people led to a decline in the provision of informal care. The issue of substitution of formal for informal care is a key question in the current debate over long-term care for older people. Indeed, as this chapter will explain, the present study is directly relevant to discussion of the proposals contained in the government's recent Green Paper on care and support, *Shaping the Future of Care Together*, on which a White Paper is expected in 2010 (HMG 2009).

The present study is concerned with the impact of the changes in long-stay residential care in the 1980s and 1990s on the provision of a particular type of informal or unpaid care: intergenerational care provided by adult children to their older parents. The focus on intergenerational care of older people arises because, for reasons explored later in this chapter, this form of care is more likely than any other form of care to substitute for long-stay residential care.

In order to examine the relationship between long-stay residential care and intergenerational care for older people, the study uses data on provision of care from the 1985, 1990, 1995 and 2000 General Household Survey (GHS) datasets. The present study of trends in intergenerational care for older people using the four GHS datasets on provision of informal care is unique. There is no other study of trends in provision of intergenerational informal care for older people using the GHS in Britain. There have been other studies of intergenerational care using the GHS datasets (Agree *et al* 2003; Henz 2009) but none have been primarily concerned with changes over time. Indeed, the only published study of trends in provision of informal care by children for parents in Britain is a study by Hirst (2001), which utilises the British Household Panel Survey (BHPS). The BHPS, however, relates only to the period since 1991, whereas the GHS

covers the period since 1985.[1] Indeed, the GHS are the only data in Britain that allow for systematic analysis of trends in provision of informal care from the 1980s onwards.

The study will focus on two specific research questions relating to the substitution of formal for informal care: **(1) Was there, during the 1980s and early 1990s in Britain, some substitution of long-stay residential care for intergenerational care, associated with the increased access to long-stay residential care for older people at this time and, if so, what factors were responsible? (2) Was there, from the early 1990s onwards in Britain, a 'reverse substitution' of intergenerational for long-stay residential care, associated with the limitation in access to long-stay residential care for older people at this time and, if so, what factors were responsible?**

In investigating these questions relating to the substitution of formal for informal care, the study examines trends in intergenerational provision of care and provides a detailed examination of potential alternative explanations, both in terms of factors influencing the supply of care, such as changes in the demographic structure of the population and employment, and factors influencing demand for care, such as changes in the availability of 'spouse care'. The Hypotheses, Data Sources and Methodology section, below, explains further how the questions will be investigated. The rest of the present section looks at why the questions to be addressed are important, why they have not been researched before and how information derived from the study can be used to develop social policy for informal carers and older people.

It is important to comment at the outset on the use of the term 'informal care'. This term is used in this study to refer to care provided in the context of family relationships, which is distinct from "care provided in the formal sector: that is provided on an organised and paid basis" (Twigg 1992a: 2). The use of the term 'informal' is not intended to imply that the care provided is of low intensity or casual in nature.

1.1.1 Why Intergenerational Care of Older People Is Important

Intergenerational care of older people is important because children and children-in-law are the most important sources of care for disabled older people in Britain today (Pickard *et al* 2007; Marmot *et al* 2003). A recent study using the GHS data on older

[1] There is also an *unpublished* study by Glaser (2007) looking at trends in receipt of informal care by older people from their children, but this uses two different surveys to compare over time, the Survey of Retirement and Retirement Plans (the RS) in 1988/89 and the BHPS in 2001/02, and is restricted to the 'younger old' (aged 61 to 69).

people found that, in 2001, more older people with disabilities received informal care from their children than from any other source (Pickard *et al* 2007). The first wave of the English Longitudinal Study of Ageing (ELSA), collected in 2002, found that, for disabled older people aged 75 and over, daughters are the most important source of care (Marmot *et al* 2003: 283).

The importance of care by children for their parents is reflected in the GHS data on provision of informal care. Just over half (52%) of all people providing informal care in Britain are looking after a parent or parent-in-law (Maher and Green 2002: 13, Table 3.6). Adult children caring for their parents/parents-in-law constitute the largest group of care-providers, exceeding the proportions caring for spouses (18%), children (8%), other relatives (21%) or friends and neighbours (21%). Around a quarter of women and nearly a fifth of men, aged 45 to 59, provide informal care, and the vast majority of these 'mid-life carers' are providing care for a parent or parent-in-law (Evandrou and Glaser 2002).

Informal care of older people is particularly important at the present time because of the rising numbers of older people, especially very old people, in the population. There were 1.1 million people aged 85 and over in the United Kingdom in 2001, more than three times as many as in 1961 (ONS 2003). Moreover, the numbers of very old people are projected to rise rapidly in the future. The numbers of people aged 85 or more are projected to increase by over 220% over the next 35 years or so, from almost 1 million in England in 2005 to around 3.2 million in 2041 (Wittenberg *et al* 2008). The rise in the numbers of very old people is particularly important because it is these older people who have the greatest needs for care (Wittenberg *et al* 2001).

Intergenerational carers, however, occupy a unique position regarding the provision of informal care to older people. This is because most intergenerational carers of older people are below state retirement age. For intergenerational carers of older people, caring poses unique tensions, between employment and caring, and between paid work and unpaid labour. These tensions are especially acute where very long hours of unpaid caring are provided, and are therefore particularly acute for women, who are more likely to provide intense care to older people (Parker 1992). The analysis of intergenerational care of older people is particularly important at the present time when, following the community care changes of the early 1990s, an increasing emphasis is placed in

government policy on domiciliary care of older people and the integration of informal care-providers into the official care system (Twigg 1998a, 1998b).

Given the importance of intergenerational care of older people, it might be expected that there would be a considerable body of literature on the subject in Britain. There is certainly current interest in the problems posed by combining informal care and paid work (Arksey 2002, 2003; Evandrou and Glaser 2002, 2003, 2004; Mooney *et al* 2002; Phillips *et al* 2002; Henz 2004, 2006; Arksey and Glendinning 2008; Carmichael *et al* 2008; House of Commons Work and Pensions Committee 2008; Young and Grundy 2008) which continues a longer-term stream of research examining the relationship between caring and employment (Hancock and Jarvis 1994; Parker and Lawton 1994; Evandrou 1995; Joshi 1995; London Economics 1998).

There is, however, comparatively little current research concerning intergenerational care of older people in Britain. During the 1980s, there was considerable interest in intergenerational care in Britain and a sizeable literature on the subject developed (described in the next section). However, for reasons that are explored below, there has been a decline in research interest in intergenerational care since then and gaps in the research literature have developed.

1.1.2 Existing Literature on Intergenerational Informal Care

The early literature on intergenerational informal care in Britain developed as a central part of the growing identification of informal care as a subject for social analysis during the early 1980s (Parker 1990; Twigg 1992a; Bytheway and Johnson 1998). It was not until the late 1970s and early 1980s that caring shifted from being a "taken-for granted and unquantified" aspect of people's lives to its "identification as *problematic* – warranting conceptual analysis and empirical investigation" (Baldwin and Twigg 1991: 117). The interest in informal care was such that there was an "explosion of research on caring" in the subsequent decade (Twigg and Atkin 1994: 1).

The early analysis of informal care took intergenerational care of older people as its central focus (Nissel and Bonnerjea 1982; Hudson 1984; Qureshi and Walker 1986; Lewis and Meredith 1988; Hicks 1988). The emphasis in the early literature was not just on intergenerational care in general, however, but on daughters caring for their older parents in particular (Arber and Gilbert 1989; Arber and Ginn 1990, 1991; Parker 1993a; Twigg 1998a). Lewis and Meredith, for example, justified the focus of their

study, *Daughters Who Care*, in terms of "the widely shared and persistent expectation that it is daughters who will care" (Lewis and Meredith 1988: 3). The focus on daughters caring for older parents derived in part from the perception that most carers were women, a perception that was widely shared within social policy at the time (Allan 1985 cited in Arber and Gilbert 1989; Twigg 1998b).

The perception that most carers were women, however, assumed particular significance in the feminist analysis of informal care (Land 1978; Finch and Groves 1980, 1983; Wilson 1982; Graham 1983; Ungerson 1983, 1987; Land and Rose 1985; Dalley 1983, 1988; Baldwin and Twigg 1991). The feminist analysis has been identified as the "single most sophisticated body of theorizing" in the analysis of informal care in the 1980s and early 1990s (Twigg and Atkin 1994: 4). At its core, the feminist analysis argued that "in practice community care equals care by the family, and in practice care by the family equals care by women" (Finch and Groves 1980: 494). The focus of much of the feminist literature was on the situation of adult children, particularly daughters/in-law, caring for their older parents (Arber and Gilbert 1989; Arber and Ginn 1990, 1991; Parker 1993a; Twigg 1998a).

Feminist interest in informal care, however, has declined considerably in recent years for two main reasons (Twigg and Atkin 1994; Twigg 1998a). First, the initial publication of the 1985 GHS (Green 1988) disrupted the feminist analysis because it seemed to show that the gender bias in informal caring was not great (Twigg and Atkin 1994). The GHS data also questioned the focus on intergenerational care because it showed that many carers of older people were in fact spouse carers, many of whom were themselves elderly (Wenger 1990; Arber and Ginn 1990, 1991). More detailed analysis of the 1985 GHS showed that many of the feminist arguments had in fact been correct, confirming that women provided the bulk of care to older people and that middle-aged women made the greatest contribution (Arber and Ginn 1991). Nevertheless, there is no doubt, that the feminist analysis of informal care was initially disturbed by the 1985 GHS data (Baldwin and Twigg 1991). The second reason why the feminist interest in informal care has declined is the 'disability critique' (Twigg 1998a). The focus on informal carers was criticised during the 1990s by the disability movement because it was argued that the emphasis on informal care undermined the efforts of disabled and older people to obtain independence and adequate support in their own right (Oliver 1990; Wood 1991; Keith 1992; Campbell and Oliver 1996;

Morris 1991, 1992, 1993, 1997). The emphasis on the needs of carers, it was argued, diverted attention and resources from the real issue: the support of disabled people.

The impact of the disability critique has been extensive within the academic and research communities (Twigg 1998b; Parker and Clarke 2002). During the1990s, important sources of funding for research in Britain questioned the concern with informal carers in academic and policy research (Twigg 1998b). Partly under pressure from the disability critique, feminist concern with informal care changed (Twigg 1998a). Initially, some feminist analysis of informal care continued, with the focus on carers now matched by a focus on the cared-for person, giving recognition to what Twigg has called the 'dual focus of caring' (Twigg 1992b; Parker 1993b). Gradually, however, many of those who had been involved in the analysis of informal care in the 1980s and early 1990s, such as Graham, Ungerson and Twigg, moved onto other areas, although their ideas have remained influential (Graham 1991; Ungerson and Baldock 1991; Twigg and Atkin 1994; Ungerson 1995, 1997a, 1997b; Twigg 1997a, 1997b, 2007).

The decline of interest in informal care, particularly the decline of feminist interest in the subject, has meant that there is no longer a great deal of research interest in intergenerational informal care of older people in Britain. This does not mean that interest in care by adult children of their parents has disappeared completely. There is still some interest in intergenerational care, exploring such aspects as simultaneous care for parents and care for children (Agree *et al* 2003; Grundy and Henretta 2006), the impact of family disruption on receipt of care from children (Tomassini *et al* 2007) and the extent to which couples share care for parents and parents-in-law (Henz 2009). With regard to trends in intergenerational care, however, the concern has been primarily with the future supply of informal care by children (Allen and Perkins 1995; Evandrou 1998; Evandrou and Falkingham 2000; Evandrou *et al* 2001; Pickard *et al* 2000, 2007, 2008a). In contrast, little attention has been paid to past trends in intergenerational care for older people in Britain.

Indeed, there has been relatively little exploration of trends in the provision of informal care more generally, despite the availability of the four GHS datasets covering the period between 1985 and 2000. There has been considerable analysis of individual GHS datasets, particularly the 1985 dataset (Arber and Ginn 1991; Evandrou 1990;

Parker and Lawton 1994) and to a lesser extent, the 1990 dataset (Clarke 1995; Parker and Lawton 1993). There has also been some analysis of trends in informal caring between 1985 and 1990 (Clarke 1995; Parker and Lawton 1993) and between 1985 and 1995 (Parker 1998). As indicated earlier, there have been two studies of informal care for parents using multiple years of the GHS, although neither was concerned specifically with trends in intergenerational care (Agree *et al* 2003; Henz 2009). However, with the exception of the present author's work (Pickard 2002), the only analysis using all four GHS datasets to look at trends in informal care has been a study by Evandrou and Glaser (2002), which was concerned with changing economic and social roles of mid-life women, but did not look specifically at trends in provision of intergenerational care to older people. The absence of previous analyses of trends in intergenerational care using the GHS provides one of the main motivations behind the present study, which is concerned with the analysis of recent past trends in the provision of informal care to older parents, using the four GHS datasets.

1.1.3 Why the Substitution of Formal for Informal Care Is Important for Policy

The decline of interest in intergenerational care has affected not just the analysis of the GHS data but also the development of new directions for social policy affecting informal carers. One of the objectives of this study is to address this emerging 'policy gap' with respect to intergenerational carers of older people. With regard to the development of policies for both informal carers and older people, the issue of the substitution of formal for informal care is of great importance at the moment.

The substitution of formal for informal care is an important underlying theme in the feminist literature on informal care (Walker 1983). The feminist literature emphasised the need to reduce dependence on women's unpaid care, especially on intergenerational care. It was argued that, to the extent that unpaid caring necessitated women's withdrawal from the labour market, it was potentially inconsistent with equality of opportunities for women (Finch and Groves 1980, 1983). Arguments were, therefore, put forward in favour of replacing unpaid labour with provision of formal services to the older person. As Walker put it, "there is a need for services which support and *substitute for* family-based care" (Walker 1983: 127, emphasis added). These arguments drew in particular on examples from other countries, especially the Scandinavian countries (Jamieson 1990, 1991, 1996; Baldwin and Twigg 1991;

Glendinning and McLaughlin 1993a, 1993b; McLaughlin and Glendinning 1994; Baldwin 1994; Twigg 1996). With the decline of feminist interest in informal care, however, arguments of this kind have increasingly been absent from policy debate on long-term care for older people.

Current policies for informal carers in most of the UK derive from the community care reforms of the early 1990s, which set the agenda for the plethora of policy developments since then (Pickard 2001, 2004a). These include the *Carers (Recognition and Services) Act* 1995; the first National Strategy for Carers (HMG 1999); the *Carers and Disabled Children Act* 2000; the *Carers (Equal Opportunities) Act* 2004; the *Work and Families Act* 2006; the New Deal for Carers (2007); the Standing Commission on Carers (2007) and the latest National Strategy for Carers (HMG 2008). It has been argued elsewhere by the present author that current policies for informal carers embody a particular approach, one that is concerned with ensuring the continuation of caring and with sustaining the well-being of carers (Pickard 2001, 2004). The particular nature of the approach adopted in present policies towards carers in Britain can be identified most clearly by specifying what they do *not* do. What the current policies for carers clearly do not do is attempt to *replace* or *substitute* for the carer (Parker 1999; Twigg and Atkin 1994). Indeed, avoiding the substitution of formal for informal care has been identified as one of the defining characteristics of British social policy. As Davies *et al* point out, "Fear of escalating costs due….. to the substitution of publicly subsidised care for informal care has long been a major policy influence" (Davies *et al* 1998: 90). The predominant reality of social care in Britain has been characterised as one in which carers are treated as 'resources' (Twigg and Atkin 1994, CSCI 2006, Arksey and Glendinning 2007, 2008), where there is concern "lest service support undermine or take over from what is seen as a prior family responsibility" and where there is a "fear of substitution of formal for informal support" (Twigg and Atkin 1994: 14).

Nevertheless, there is currently a debate about the nature of long-term care for older people. The current debate on long-term care began partly as a result of the recommendations of the Royal Commission on Long Term Care (1999), which proposed that there should be 'free' personal care for older people at the point of use, funded by general taxation. This central recommendation was criticised by two dissenting members of the Commission partly because they believed that a policy of free personal care would lead to rising public expenditure costs, referring indeed to a "Croesian flood of expenditure" (Royal Commission on Long Term Care 1999: 119).

Public expenditure would rise, they argued, partly because a policy of free personal care would lead to a substantial increase in demand for care arising, in particular, from a substitution of formal for informal care. It was argued that **"s**ome older people might choose to go into residential care if the cost to them were reduced, to avoid burdening their children. As is increasingly the case in America, *their children may choose to put them in residential care to avoid burdening themselves*" (Royal Commission on Long Term Care 1999: 119, emphasis added).

The arguments of the dissenting members of the Royal Commission on Long Term Care were highly influential and the government in England rejected the central recommendation of the Royal Commission in favour of free personal care (Secretary of State for Health 2000). Similar decisions were made in Wales and Northern Ireland, though not in Scotland. In much of the UK, therefore, the fear of possible substitution of formal for informal care has been a key stumbling block to improving access to formal care for older people for the past decade.

The fact that there have been different policies on long-term care in different parts of the United Kingdom has been a major reason why the debate over long-term care has remained very much alive (Robinson 2001; Brooks *et al* 2002; Johnson 2002; JRF 2006; Wanless 2006). An influential proposal for reform of the long-term care system for older people was put forward in 2006 in the Wanless social care review, *Securing Good Care for Older People* (Wanless 2006). The Wanless proposals for long-term care for older people rely heavily on the continued provision of unpaid care. The Wanless report describes informal care as a "key building block" of social care and emphasises greater support for carers as a means of "sustaining and extending" the time that people are prepared to provide care (Wanless 2006: 283). However, within the Wanless report, there is acknowledgement that such proposals are unlikely to address the needs of 'filial carers' (Wanless 2006: 288). Indeed, with regard to filial carers, it is argued that there is a case for "possible substitution of informal care by formal services" (Wanless 2006: 22; Beesley 2006: 34). The Wanless report does not, however, pursue this and it is merely recommended that, for filial carers, "a range of options are considered and additional work is undertaken to ascertain the best approach" (Wanless 2006: 288).

More recently, a Green Paper on the future care and support system in England has been published by the government and a White Paper is expected in 2010 (HMG 2009). The

Green Paper proposes a National Care Service, which would provide some support for personal care needs to everyone who qualifies for care and support from the state (HMG 2009: 16). However, funding would be based on a 'partnership' approach, which would not cover the total costs of care (HMG 2009: 19). The Green Paper's 'partnership' approach to the funding of care for older people, which would only cover around a quarter to a third of the costs of personal care, seems partly founded on a fear of substituting for family care. Thus, the Green Paper argues, "We do not believe that, in the current economic climate, it would be affordable to have a system that completely replaced family care with state-funded care and support …" (HMG 2009: 119). Once more, then, a fear of possible substitution of formal for informal care is informing key policy arguments affecting older people, and their potential informal carers, in this country.[1]

In order to inform the current long-term care debate, and to develop policies for informal carers, it would therefore be very helpful to have more information on the substitution of formal for informal care in Britain. Is it the case that providing older people with improved access to formal care would lead to a substitution of formal for informal care? What would be the likely effects of some substitution of formal for intergenerational care? Is there any evidence of substitution elsewhere?

1.1.4 Existing Evidence Relating to Substitution between Informal and Formal Care

There is considerable evidence relating to substitution between informal and formal care internationally, particularly from the United States (US), although there is much less evidence relating to Britain. The international evidence suggests that the relationship between informal and formal care varies with a number of factors, including the type of service (long-stay residential versus domiciliary) and the direction of the relationship.

There is considerable evidence that informal care substitutes for formal care, whether residential or domiciliary. This evidence comes in two forms. First, there is a large body of literature internationally suggesting that informal care substitutes for long-stay residential care. Substitution has been examined most explicitly in the US, where a key theory is a hypothesis developed by Andersen (1968) stating that provision of informal

[1] There have been additional proposals for long-term care reform put forward by the Prime Minister and the Opposition during the autumn of 2009 (*Community Care* 29/9/09; *Health Service Journal* 7/10/09). The Prime Minister announced a policy of free personal care for people with the highest needs living at home from October 2010, while the Opposition proposed a voluntary insurance scheme for residential care. These proposals are discussed further at the end of the study (Chapter Nine).

care "*substitutes* for services that would otherwise need to be provided within an institution such as a nursing home" (Jette *et al* 1995: S4-5, emphasis added). The evidence suggests that older people living with others, including those co-residing with an adult child, are less likely to enter nursing homes (Hanley *et al* 1990; Jette *et al* 1995). More recent studies have shown that increased hours of informal care provided by adult children reduce nursing home admissions (Lo Sasso and Johnson 2002; Charles and Sevak 2005; van Houtven and Norton 2004, 2008). Although not located within an explicit focus on substitution, there is also evidence from Britain that family circumstances affect entry to long-stay residential care, with those living alone more likely to enter residential care than those living with others (Darton *et al* 2005; Grundy and Jitlal 2007). The second form of evidence that informal care substitutes for formal care comes from recent studies in Europe, including Britain (Johansson *et al* 2003, Patsios 2008, Bonsang 2009). A key result of these studies is to show that, as public provision of welfare for older people has been reduced in recent years, so informal care has increased (Johansson *et al* 2003, Patsios 2008). The evidence suggests that, in Sweden, this has led to an increase in care provided by the children, especially daughters, of older people in particular (Johansson *et al* 2003).

However, when the direction of the relationship is changed and the impact of formal services on informal care is examined, the weight of evidence suggests that there is only limited substitution of formal for informal care (see studies cited below). This is explained by suggesting, for example, that formal services primarily meet previously unmet service needs among the disabled elderly (Pezzin *et al* 1996; Penning 2002). The lack of evidence for the substitution hypothesis has led to assertions in the British literature to the effect that "increases in mainstream formal services to older people appear to have little impact on how much informal care is provided" (Beesley 2006: 28). Studies supporting this assertion have, however, tended to look only at *domiciliary* care. Thus, there is a large body of literature in North America showing that formal domiciliary services do not reduce, or substitute for, informal care to any great extent (Smith-Barusch and Miller 1985; Christianson 1988; Moscovice *et al* 1988; Edelman and Hughes 1990; Hanley *et al* 1991; Kelman *et al* 1994; Long 1995; Tennstedt *et al* 1993, 1996; Pezzin *et al* 1996; Penning 2002). Similar results have been obtained in European countries (Daatland and Herlofson 2003; Motel-Klingebiel *et al* 2005) and in Britain (Davies *et al* 1998). Evidence from Scotland has now also been examined to ascertain whether the rise in formal services, associated with the introduction of free

personal care, has led to a substitution of informal care, with the evidence suggesting that so far it has not (Bell and Bowes 2006). However, the effect of free personal care in Scotland has primarily been to increase the use of home-based rather than residential care (Bell and Bowes 2006; Dickinson and Glasby 2006; McNamee 2006) suggesting that the limited impact of free personal care on informal care in Scotland is consistent with the international literature showing that increases in formal domiciliary services appear to have relatively little impact on provision of informal care.

The international evidence relating to the effects of formal on informal care has therefore primarily been concerned with the effects of domiciliary rather than residential care. The impact of changes in *residential care* on informal care has received much less attention (Lingsom 1997: 251). It is here, however, that the experience of Britain in the 1980s and 1990s is of such importance in providing a 'natural social policy experiment'.

1.1.5 Why the 1980s and 1990s in Britain Are Important

The period of the 1980s and 1990s in British social policy offers a good opportunity to examine the relationship between long-stay residential care and informal care because there were, during this period, some quite dramatic changes in the provision of residential care to older people, which in turn may have been associated with changes in the provision of informal care, particularly care by children.

The period of the 1980s and 1990s can be divided into two sub-periods. In the first, covering the 1980s and early 1990s, there was a marked rise in long-stay residential care (Evandrou and Falkingham 1998, Laing and Saper 1999; OECD 1996; Knapp *et al* 2004). This increase in residential care, it has been argued, arose as a largely unintended consequence of the expansion of the private sector in residential care, which was in turn fuelled by changes in the rules governing social security payments to people in private homes (Estrin and Pérotin 1988).

The increased availability of long-term residential care during the 1980s and 1990s period is particularly important in the present context because it has been suggested that it may have promoted "the substitution of institutional for family care" (Grundy 1996a: 2). Grundy and colleagues, using data from the Office for National Statistics

longitudinal study, found that transitions to residential care by older people, particularly those aged 75 or more, were substantially higher in 1981-91 than they had been in 1971-81 (Grundy and Glaser 1997). At the same time, transitions by older people to other supported environments, such as the households of relatives, became less common. As Grundy observed, "for the older old, residence in institutions for the first time became more common than living with relatives or friends" (Grundy 1996a: 2). This evidence, together with the increase in long-term care places between 1981 and 1991, particularly for those aged 85 and over, indicated that there may have been "some substitution of institutional for family care" (Grundy 1996b: 19).

The research by Grundy and colleagues is particularly interesting because the decline in family care, which they suggest may have occurred during the 1980s, specifically includes a decline in care by children (Grundy 1996b, 1999). The decline in transitions to 'complex' households, which Grundy and colleagues link to the rise in transitions to long-stay residential care, refers to households that include those in which older people co-reside with their adult children (Grundy 1996b). No such decline in 'simple' households, which include households made up of spouse couples only, was found. The decline in family care that Grundy and colleagues suggest may have taken place is, therefore, likely to indicate a decline in co-resident care by children.

Not all analysts agree that the growth of long-stay residential care in the 1980s might have affected patterns of informal care in private households. Parker, for example, uses 1981 and 1991 census data to suggest that the number of older people in some form of long-stay care only grew by around 135,000 during the 1980s (Parker 1998). Parker argues that this number would have been insufficient to affect demand for care in the older population in private households.

In the second sub-period, from the early 1990s to 2000, there was a limitation in access to long-stay residential care, associated with the *1990 NHS and Community Care Act* which became fully operational in 1993 (Wistow *et al* 1996; Lewis and Glennerster 1996; Jacobzone 1999). What has been the effect of the control of entry to residential care on the provision of family care, especially the provision of intergenerational care? For, if *increasing* access to residential care in the 1980s may have promoted a substitution of residential care for family care, then *reducing* access to residential care

in the 1990s may have had the opposite effect and promoted a substitution of family care for residential care.

Evidence from elsewhere in Europe suggests that there may be a negative relationship between the supply of long-stay residential care and provision of co-resident intergenerational care. There is evidence, for example, from the Netherlands suggesting that a *limitation* in the availability of residential care during the 1980s was associated with an *increase* in the co-residence of very elderly people with their children and grandchildren (Steering Committee on Future Health Scenarios 1996). It is not, however, necessarily the case that a decline in the availability of residential care would lead to a rise in family care of older people in Britain in the 1990s. The impact of any decline in the availability of residential care on informal caring may be affected by levels of domiciliary services for frail older people living at home. Moreover, as Grundy points out, "it may prove difficult to reverse possible changes in the expectations of older people and their relatives" (Grundy 1996a: 11). Indeed, recent research by Grundy suggests that the "chances of living with relatives rather than alone or in an institution were lower in 1991-2001 than in the previous decade suggesting that ….. policy changes cannot reverse other influences driving a continued trend towards increased residential independence among older people" (Grundy 2008: 9).

The changes in long-stay residential care for older people in the 1980s and 1990s in Britain took place at a time when the GHS data on provision of informal care were also being collected. However, no one has yet used the GHS data to examine the impact of the changes in residential care on provision of intergenerational care for older people. The GHS data offer advantages over the data used in previous studies in Britain for two main reasons. First, the GHS data allow for informal care to be measured directly, rather than being implied from proxy variables, such as living arrangements. As Jette and colleagues point out in their US study of the impact of informal care on nursing home use, such imprecise indicators are not a sufficient basis for determining the amount or type of informal care (Jette *et al* 1995: S4). Second, the GHS was collected every five years between 1985 and 2000, whereas the census data are collected only every ten years. Since the implementation of the community care changes took place in the mid-1990s, it is possible that any impact of the reversal of the policies affecting residential care in Britain might be missed if the intervals between data capture points are too long. It is, therefore, proposed in the present study to utilise GHS data to

examine the relationship between formal and informal care in Britain between 1985 and 2000.

1.1.6 Summary: Addressing Research Gaps

In summary, the analysis presented here suggests that there are three important research gaps relating to informal care of older people in Britain that have emerged since the mid-1990s. First, there has been relatively little analysis of trends in the provision of informal care using GHS data published since the mid-1990s, and none of trends in intergenerational care for older people. Second, there is an emerging 'policy gap' with respect to intergenerational care for older people, with insufficient attention paid to policies for people likely to provide intergenerational care in current discussions about new directions for long-term care. In particular, there has been insufficient attention paid to the case for a "possible substitution of informal care by formal services", where 'filial' carers are concerned (Wanless 2006:151). And, finally, despite its potential importance, a possible substitution of long-stay residential care for family care during the 1980s and 1990s has not yet been analysed using the GHS data on provision of informal care.

The objectives of this study are to attempt to fill these three research gaps with respect to intergenerational carers. First, the study will utilise GHS data to examine trends in the provision of intergenerational care between 1985 and 2000. Second, the study will use the GHS data to examine the relationship between formal and informal care in the 1980s and 1990s, and explore whether there was some substitution of long-stay residential care for family care during this time. Finally, evidence from the study will be used to re-examine the issue of the substitution of formal for informal care within the context of changing long-term care policies for older people, and thereby, draw out implications for policy for both informal carers and older people.

1.2 Hypotheses, Data Sources and Methodology

1.2.1 Theoretical Considerations and Hypothesis Development

The hypothesis most commonly examined in studies of the relationship between informal and formal care is the *main effect* hypothesis developed by Newman *et al* (1990: S175). This hypothesis states that informal support reduces 'institutional risk'

directly, that is, informal support is believed to have an independent or main effect on risk of institutionalisation, net of background, health or other relevant factors (Newman *et al*: S175). The theoretical underpinning of this main effect hypothesis is the behavioural model of families' use of health services developed by Andersen (1968) and the main effect hypothesis can be regarded as a substitution hypothesis (Jette *et al* 1995). The central hypotheses of the present study build on this main effect hypothesis. Other hypotheses put forward by Newman and colleagues (1990), including the *buffering* and *complementary* hypotheses, are not examined directly in the present study, for reasons explained more fully later in this section.

The main effect hypothesis needs to be restated to address the concerns of the present study. Thus, the hypothesis that 'informal support reduces institutional risk' is restated in the present study as 'institutional care reduces informal care risk'. This restatement can be refined to address the concerns of the present study more fully to read 'long-stay residential care for older people is negatively related to provision of intergenerational care to an older person'. The international literature suggests that the type of care most likely to be negatively related to long-stay residential care is co-resident care (Hanley *et al* 1990; Jette *et al* 1995). Co-resident care is characterised in Britain by its high level of intensity (Arber and Ginn 1991; Parker 1992; Healy and Yarrow 1997; Tinker *et al* 1999). It can therefore be further theorised that long-stay residential care is negatively related to *intense* intergenerational care.

The main effect hypothesis states that there is a negative relationship between long-stay residential care and informal care, *net of relevant factors*. The relevant factors are often specified in the US research in terms of predisposing factors, such as age and gender; enabling factors, such as marital status and socio-economic status; and need-related factors, such as severity of disability (Andersen 1968). The present study takes into account key relevant factors likely to affect the relationship between long-stay residential care and intergenerational care (in ways described in more detail later).

In summary, in the context of Britain in the 1980s and 1990s, the following main effect hypotheses are tested in this study: (1) Controlling for relevant factors, during the 1980s and early 1990s in Britain, increased use of long-stay residential care by older people reduced intense intergenerational care for older people. (2) Controlling for relevant

factors, from the mid-1990s onwards in Britain, reduced use of long-stay residential care by older people increased intense intergenerational care for older people.

In Andersen's original formulation of the substitution hypotheses, it was argued that the factors affecting service use would vary for different types of service (Andersen 1968: 8). Long-stay residential care in Britain is not a uniform sector, but is comprised of two different types of care, which have been characterised as two different service sectors (Darton and Wright 1992). The first consists of 'residential care homes', including Local Authority, private and voluntary homes, while the second is comprised of facilities that offer 'nursing care', including private and voluntary nursing homes and long-stay hospitals. These facilities differ in the nature of the care offered and the characteristics of the residents. Facilities providing nursing care offer higher levels of care and accommodate people with greater levels of disability (Darton and Wright 1992, Bajekal 2002). Following Andersen, it can be theorised in advance that the relationship between long-stay residential care and provision of intergenerational care is likely to vary by type of residential care sector. Indeed, it can be stated *a priori* that it is likely that facilities offering greater amounts of care will substitute for intergenerational care of greater intensity.

As already indicated, the present study does not directly address the buffering and complementary hypotheses put forward by Newman and colleagues (1990). This is partly because these hypotheses have not generally been supported in empirical work (Newman *et al* 1990, Jette *et al* 1995) and therefore more recent studies of substitution in the US have tended to focus on the main effect hypothesis (Lo Sasso and Johnson 2002; Charles and Sevak 2005; van Houtven and Norton 2004, 2008). The buffering and complementary hypotheses should not, however, be disregarded because they suggest important relationships that will be examined in this study. The buffering hypothesis states that the individual's support system will moderate, or buffer, the effects of risk factors, primarily poor health, on the chances of entering long-stay residential care (Newman *et al* 1990). This hypothesis informs the present study in that it suggests the importance of controlling for poor health or disability in examining the relationship between informal and formal care. The complementary hypothesis states that formal, primarily domiciliary services, may complement care-giving, thereby delaying or preventing entry to long-stay residential care (Newman *et al* 1990). This hypothesis informs the present study in that it suggests that it is important to consider

the potential impact of home care, as well as residential care, on intergenerational care provision.

The central hypotheses of the present study suggest that changes in intense intergenerational care of older people are related to changes in long-stay residential care. The underlying assumption is that availability of long-stay residential care affects *demand* for informal care by older people. However, demand for care by older people from their children may be affected by the availability of alternative sources of informal care, in particular, care from a spouse or partner. After adult children, spouses or partners are the most important sources of informal care for disabled older people in Britain (Pickard *et al* 2007). Changes in the availability of spouse care, as a result of trends in marital status among older people, could affect demand for care by older people from their children. Consideration of the potential effects of changes in spouse care on intergenerational care is therefore an important part of the present study.

The central hypotheses of the study assume that changes in intense intergenerational care of older people are related to demand for care by older people, but it is also important to consider the impact of *supply*. It could also be hypothesised that changes in intense intergenerational care of older people are likely to be associated with changes in the availability of informal carers or their propensity to provide informal care. If there was a reduction in intense intergenerational care in the 1980s and 1990s, for example, then this might have been due to such factors as rising educational standards or increasing employment levels among mid-life women. Issues around the supply of informal care are therefore systematically addressed in the present study, in ways explained more fully below.

1.2.2 Data Sources

This study is primarily based on secondary analysis of the GHS. The GHS is a multipurpose continuous survey based each year on a large sample of the general population resident in private ('non-institutional') households in Great Britain. Questions on the provision of informal care were included in four years: 1985, 1990, 1995 and 2000 (Green 1988; OPCS 1992; Rowlands 1988; Maher and Green 2000). The GHS is the most comprehensive data source on informal care in Britain, described by one author as "setting the gold standard for gathering survey information about unpaid care" (Hirst 2005:1).

The present study will use all four GHS data sets on informal care. The numbers of people aged 16 and over who responded to the questions on informal care were 18,330 in the 1985 GHS; 17,535 in the 1990 GHS; 16,748 in the 1995 GHS (for which data were collected between April 1995 and March 1996); and 14,096 in the 2000 GHS (for which data were collected between April 2000 and March 2001). It should be noted that no GHS data on informal care were collected in 2005 and, although a new survey has now been commissioned, data will not be available until the end of 2010 (Information Centre 2009). The analysis reported in this study will be concerned only with the *provision of informal care to people aged 65 and over*.

Respondents in all four GHS data sets on the provision of informal care were asked similar questions (Box 1.1). They were asked whether they look after someone who is sick, disabled or elderly. In the survey, 'looking after' someone is defined as giving special help to them or providing some regular service or help to them. There has been concern that small changes in the wording of the questions in different years may have affected the comparability of the GHS data on informal care over time (Parker 1998). However, analysis of the first three GHS datasets for the Office for National Statistics (ONS) by Parker concluded that consistent trends in the more intensive forms of caring could be identified in all three surveys (Parker 1998; Evandrou and Glaser 2002).

It is with intensive forms of caring that this study is primarily concerned. As indicated above, the study is concerned in particular with intense forms of informal care that might constitute an alternative to long-stay residential care. The analysis will use two measures of intensity of care: care provided for 20 or more hours a week (described in the study as 'intense' care) and care provided for 50 or more hours a week (described as 'very intense' care). Intensity of informal care is often measured using care for 20 or more hours a week and care for 50 or more hours a week in the informal care literature in Britain (Hirst 2001; Evandrou and Glaser 2002; Carmichael *et al* 2008; Young and Grundy 2008). Indeed these definitions of intensity were incorporated into the question on unpaid care in the 2001 Census, when information on informal care was collected for the first time (Dahlberg *et al* 2007; Pickard 2007). The focus of the present study is on intergenerational care for older people, that is, care by adult children provided to parents aged 65 and over. In the study, care for older parents includes care for older parents-in-law and care by older people from their adult children includes care from children-in-law.

Box 1.1: Questions on the provision of informal care in the GHS, 1985-2000

1985 Some people have extra family responsibilities because they look after someone who is sick, handicapped or elderly.
….May I check, is there anyone **living with you** who is sick, handicapped or elderly whom you look after or give special help to (- for example, a sick or handicapped (or elderly) relative/husband/wife/child/friend, etc)?
….And how about people not living with you, do you provide some regular service or help for any sick, handicapped or elderly relative, friend or neighbour **not living with you**?

1990 Some people have extra family responsibilities because they look after someone who is sick, handicapped or elderly.
….May I check, is there anyone **living with you** who is sick, handicapped or elderly whom you look after or give special help to (- for example, a sick or handicapped (or elderly) relative/husband/wife/child/friend, etc)?
….And how about people not living with you, do you provide some regular service or help for any sick, handicapped or elderly relative, friend or neighbour **not living with you**?

1995 I'd like to talk now about caring informally for others. Some people have extra responsibilities because they look after someone who is physically or mentally sick, handicapped or elderly.
….May I check, is there anyone **living with you** who is sick, handicapped or elderly whom you look after or give special help to, other than in a professional capacity[1] (- for example, a sick or handicapped (or elderly) relative/husband/wife/child/friend, etc)?
….Is there anyone, either living with you or not living with you, who is sick, handicapped or elderly whom you look after or give special help to, other than in a professional capacity (- for example, a sick or handicapped (or elderly) relative/husband/wife/child/friend, etc)? [2]
….And how about people not living with you, do you provide some regular service or help for any sick, handicapped or elderly relative, friend or neighbour not living with you? CODE 2 'NO' IF GIVES FINANCIAL HELP ONLY.

2000 I'd like to talk now about caring informally for others. Some people have extra responsibilities because they look after someone who has long term physical or mental ill health or disability[3], or problems related to old age.
….May I check, is there anyone **living with you** who is sick, disabled or elderly whom you look after or give special help to, other than in a professional capacity (for example, a sick or disabled (or elderly) relative/husband/wife/child/friend/parent[4], etc)? CODE 'NO' IF GIVES FINANCIAL HELP ONLY.
….Is there anyone, (either living with you or) not living with you who is sick, disabled or elderly whom you look after or give special help to, other than in a professional capacity (for example, a sick or disabled (or elderly) relative/husband/wife/child/friend/parent, etc)? CODE 'NO' IF GIVES FINANCIAL HELP ONLY.

Notes

1 The phrase 'other than in a professional capacity' was added in 1995 in order to screen out a category of carers.

2 This question was addressed to respondents in one person households.

3 The term 'disability' was used in 2000 instead of 'handicapped'.

4 The example of parent was added in 2000.

This box replicates a box published in Evandrou and Glaser (2002: 20), with some additional observations derived from Henz (2009: 375)

In addition to the GHS, the study uses a number of other sources, which are described in more detail in later chapters. These include official population data from the Office for National Statistics (ONS) and the General Register for Scotland, as well as data on numbers of older people in long-stay residential care collected by government departments in England, Wales and Scotland. The study also utilises data on the disability of the older population derived from the 1985 and 2001/2 GHS data on people aged 65 and over. The numbers of people aged 65 and over who responded to the GHS questions in the module for older people in 1985 were 3,691 and in 2001/2 were 3,356 (with data collected between April 2001 and March 2002).

1.2.3 Methodology: Analysis of the Data

The analysis of the data is divided into three main parts: first, an analysis of trends in intergenerational care of older people between 1985 and 2000; second, an analysis of supply-side factors potentially affecting trends in intergenerational care; and third, an analysis of demand-side factors potentially affecting intergenerational care.

Trends in intergenerational care of older people, 1985-2000:

The first part of the analysis utilises GHS data on the provision of informal care to analyse trends over time in the provision of intense and very intense intergenerational care to older people, distinguishing co-resident and extra-resident care. This analysis is a core part of the study, since it describes the trends in intense intergenerational care that the study seeks to explain. The analysis begins by examining the characteristics of people providing intergenerational care, using variables relevant to the provision of informal care, including age, gender, marital status and socio-economic status (Parker 1993a). Logistic regression analysis is used to identify significant factors affecting provision of care. The analysis then identifies significant changes in the probability of providing care between 1985 and 2000, by intensity, locus of care and key characteristics.

Supply-side factors affecting trends in intergenerational care, 1985-2000:

The study next examines the potential role of supply-side factors in determining the trends in intense intergenerational care between 1985 and 2000. Two types of supply-side factors are considered: socio-demographic factors and economic factors.

First, there is an analysis of socio-demographic factors. This examines how far the trends in intense intergenerational care can be attributed to changes in the factors affecting provision of care, including trends in marital status and educational qualifications. The analysis controls for socio-demographic change by a method known as 'direct standardisation' (Newell 1988). This involves using the probabilities of providing care in 1985, 1990, 1995 and 2000 and applying these to official population data. The probability of providing intergenerational care to an older person is calculated by key variables for the GHS samples in each year (cf. Richards *et al* 1996). Official population data on the numbers of people by the same variables in Great Britain are then used to estimate the number of carers in each year. To control for demographic change over a particular time period, for example between 1985 and 1990, the 1985 probabilities of providing care are applied to the 1990 population data, and estimates 'expected' on the basis of the 1985 probabilities are then compared with estimates based on the 1990 probabilities.

The second type of supply-side analysis examines whether changes in employment rates affected the provision of intense intergenerational care between 1985 and 2000. Employment is treated separately from other variables in the analysis because of its potentially endogenous relationship with informal care provision. Trends in provision of intense intergenerational care are compared descriptively with trends in full-time employment.

Demand-side factors affecting trends in intergenerational care, 1985-2000:

The study next examines the potential role of demand-side factors in determining the trends in intense intergenerational care between 1985 and 2000. Two demand-side explanations are examined: whether changes in intergenerational care were associated with changes in the availability of care by the spouses of older people and whether

changes in intergenerational care were associated with changes in the provision of long-stay residential care.

The first demand-side explanation is addressed by using the GHS data on the provision of informal care to compare the probability over time of providing intense care to an older spouse with the probability of providing intense care to an older parent. This is followed by an analysis comparing the characteristics of the cared-for spouses and parents, using variables supplied in the GHS datasets. Information on the characteristics of cared-for people collected in the GHS include age, gender and type of impairment. To this list of characteristics is added the type of care provided by children and spouses, distinguishing personal care from other forms of care.

The second demand-side explanation explores the central hypotheses of the study directly, examining whether the changes in intense intergenerational care were associated with changes in the provision of long-stay residential care. For reasons that become clear as the study unfolds, this analysis is confined to co-resident care for parents. A crucial shift in the methodology of the study occurs at this stage. Using the household nature of the GHS, the analysis turns from a focus on the care-provider to a focus on the care-recipient. This shift in focus enables the study to analyse the probability that an older person receives intense co-resident care from an adult child and ultimately enables this probability to be compared with the probability of receiving long-stay residential care. The methodology adopted in this study for the analysis of co-resident care for older parents is, as far as the author is aware, unique in this country.

The analysis then proceeds in two stages. First, the study examines changes between 1985 and 2000 in the probability of an older person receiving intense co-resident care from a child. It then examines the characteristics of older people receiving intense co-resident care from children, by age, gender, marital status, health and socio-economic status, and compares these characteristics with those of older people in long-stay residential care. In the second stage of the analysis, the probability of an older person receiving care from a child is compared with the probability of receiving long-stay residential care. The comparison of receipt of intense co-resident care and long-stay residential care controls for key aspects affecting demand for care by older people (cf. Andersen 1968): age (a predisposing factor), type of residential service provided (an enabling factor) and functional disability (a need-related factor).

1.3 How the Analysis of the Data Relates to the Research Questions

For the purposes of the analysis, the data will be divided into two sub-periods, as follows. The first covers the period of the rise in long-stay residential care in Britain, which began during the 1980s and ended with the implementation of the community care reforms in the early 1990s. The second covers the period from the mid-1990s onwards, that is, the period when access to residential care was restricted following the introduction of the community care reforms.

The data sets that will be used for the first period will be the 1985, 1990 and 1995 GHS data on the provision of informal care, while the data sets that will be used for the second period will be the 1995 and 2000 GHS data. The 1995 GHS data is taken as the watershed because, essentially, the study will be comparing the period before and after the implementation of the community care reforms. The reforms were implemented in 1993 and it then took some time for the effects of the reforms to be reflected in household survey data. An analysis of GHS data on people aged 65 and over, for example, found patterns of formal domiciliary care consistent with the community care reforms in the 1998 data but not in the 1994 data (Pickard *et al* 2001). The 1995 GHS data on provision of informal care are, therefore, here taken as the dividing line between the two sub-periods.

A trend in the provision of intergenerational care for older people, which would be consistent with some substitution of long-stay residential care for intergenerational care, would be a decline in intense informal care provided by children to their older parents between 1985 and 1995. A trend in the provision of intergenerational care, which would be consistent with a 'reverse substitution' of intergenerational care for long-stay residential care, would be an increase in intense informal care provided by children between 1995 and 2000. The changes in intense intergenerational care are likely to take the form of co-resident care, but may not necessarily do so.

The trends in intense intergenerational care will be set out early on in the study and the remaining chapters will be dedicated to explaining these trends. In addition to the substitution hypothesis, the study also looks at a number of other possible explanations for trends in provision of informal care to parents. As already indicated, these include

supply-side factors and other demand-side factors. A brief chapter plan is set out below to show how the study will unfold.

1.4 Chapters to Follow

Chapter Two sets out the main changes in social policy affecting social care for older people in Britain between 1985 and 2000. It examines the effect of policy on provision of formal services for older people, in particular the effect on access to long-stay residential care for older people. Changes in policy for, and provision of, intensive home care services are also outlined. The chapter also identifies other key trends between 1985 and 2000 relating to supply-side and demand-side factors. Supply-side factors include changes in socio-demographic and socio-economic indicators relating to the provision of care, such as age, educational qualifications and employment rates of the potential care-giving population. Demand-side factors include trends in the numbers of older people, their age, marital status and prevalence of disability.

Chapter Three provides an overview of trends in provision of intense care for older parents between 1985 and 2000, identifying significant changes in the probability of providing care by intensity and locus of care and by key characteristics of care-providers. At the end of the chapter, there is a summary of the most important changes in intense intergenerational care for older people that took place during this period. The chapter concludes by outlining a number of possible explanations for the changes identified, which are subsequently examined in the study.

Chapters Four and Five examine how far changes in intense intergenerational care for older people between 1985 and 2000 can be attributed to changes in the supply of informal care. Chapter Four uses the 'direct standardisation' method (described earlier) to examine how far changes in numbers providing intense intergenerational care would have been 'expected' on the basis of changes in underlying socio-demographic and socio-economic factors affecting provision of care. An essential part of this analysis is the transformation of probabilities of providing care into numbers providing care, using official population estimates. Chapter Five examines how far changes in the provision of intense intergenerational care for older people were associated with changes in employment rates, particularly among mid-life women, between 1985 and 2000.

Chapters Six, Seven and Eight are concerned with demand-side explanations. Chapter Six explores how far changes in intense intergenerational care for older people were associated with changes in spouse or partner care. Chapters Seven and Eight look at how far changes in long-stay residential care account for changes in intense intergenerational care. Chapter Seven is a key chapter, marking the transition in the methodology from a focus on the care-provider to a focus on the care-recipient (described earlier). The chapter charts changes between 1985 and 2000 in the probability of older people receiving intense care from children. Chapter Eight compares these probabilities with the probabilities of receiving different forms of long-stay residential care.

The final chapter summarises the evidence relating to the two central hypotheses of the study, which have been set out in the present chapter (pages 15 and 29-30 above). Chapter Nine then uses evidence presented in the study to draw conclusions relating to the development of long-term care policy for older people and policy for informal carers in Britain today.

Chapter 2

Social Policy, Socio-Economic Trends and Care for Older Parents

This study is investigating whether there was a negative relationship between changes in long-stay residential care for older people and changes in the provision of intense intergenerational care for older people in Britain between 1985 and 2000, controlling for relevant factors. This chapter therefore begins by examining the changes in long-stay residential care that took place in Britain during the late 1980s and 1990s. Long-stay residential care is only one form of long-term care service that may affect provision of intense informal care and therefore the present chapter also looks at trends in domiciliary care services for older people between 1985 and 2000. Close attention is paid in this chapter to the likely *causes* of the changes in the numbers receiving formal services. This is important because, if there is a negative relationship between changes in long-stay residential care and changes in intense intergenerational care, then an important issue will be the direction of causality.

In addition to changes in formal services, the chapter also examines trends in other factors potentially affecting demand for intense care by older people from their children. The chapter looks at trends in three aspects of demand for intense intergenerational care: the numbers of older people, the marital status of older people and the prevalence of disability.

Finally, the chapter examines trends in factors likely to affect the supply of intense intergenerational care to older people during this period. Trends in three types of supply-side factor are considered: the numbers of potential care-givers by age and gender, their marital status and their socio-economic status, specifically educational qualifications and employment status.

In introducing key trends affecting intense intergenerational care for older people between 1985 and 2000, this chapter pays particular attention to the *timing* of the changes identified. The GHS data on informal care utilised in this study were collected at four points in time, 1985, 1990, 1995 and 2000. This generates three five-year time-periods, 1985/90, 1990/95 and 1995/2000. In attempting to explain changes in informal

care provision identified using the GHS data (to be described in the next chapter) it is important to identify changes in formal provision and socio-demographic changes occurring during each of these three time periods.

2.1 Trends in Long-Stay Residential Care, 1985-2000

This section traces trends in long-stay residential care in Britain between 1985 and 2000, using data derived from published sources, in particular Laing and Buisson (2002). Although these data relate to provision not just for older people but also for chronically ill and physically disabled people, and relate to the UK as a whole and not just to Britain (England, Scotland and Wales), they are often used in analyses relating to older people in the constituent countries of the UK (for example, Henwood 2006) and form a useful starting point for the present study.[1] This section pays close attention to trends in the different sectors that constitute long-stay residential care in Britain. Three different sectors are identified: 'residential care homes', including Local Authority, private (for-profit) and voluntary (independent, not-for-profit) homes; 'nursing homes', including private and voluntary nursing homes; and long-stay hospitals (cf. Laing and Buisson 2002; Wittenberg *et al* 1998). Analysis of trends by sector is potentially important because, as the previous chapter suggested, the relationship between long-stay residential care and provision of informal care may vary by sector.

2.1.1 Total Numbers in Long-Stay Residential Care by Sector, 1985-2000

An account of the changes in long-stay residential care that often appears in the literature identifies a sharp increase in long-stay residential care in the 1980s, leading to the introduction of the *NHS and Community Care Act* in 1990, which subsequently leads to a fall in the number of places in long-stay residential care during the 1990s (for example, Knapp *et al* 2004; Grundy 2008). There is widespread agreement in the literature about the increase in long-stay residential care during the 1980s. However, for the purposes of the present study, it is important to identify as precisely as possible when, during the 1990s, the decline in long-stay residential care occurred.

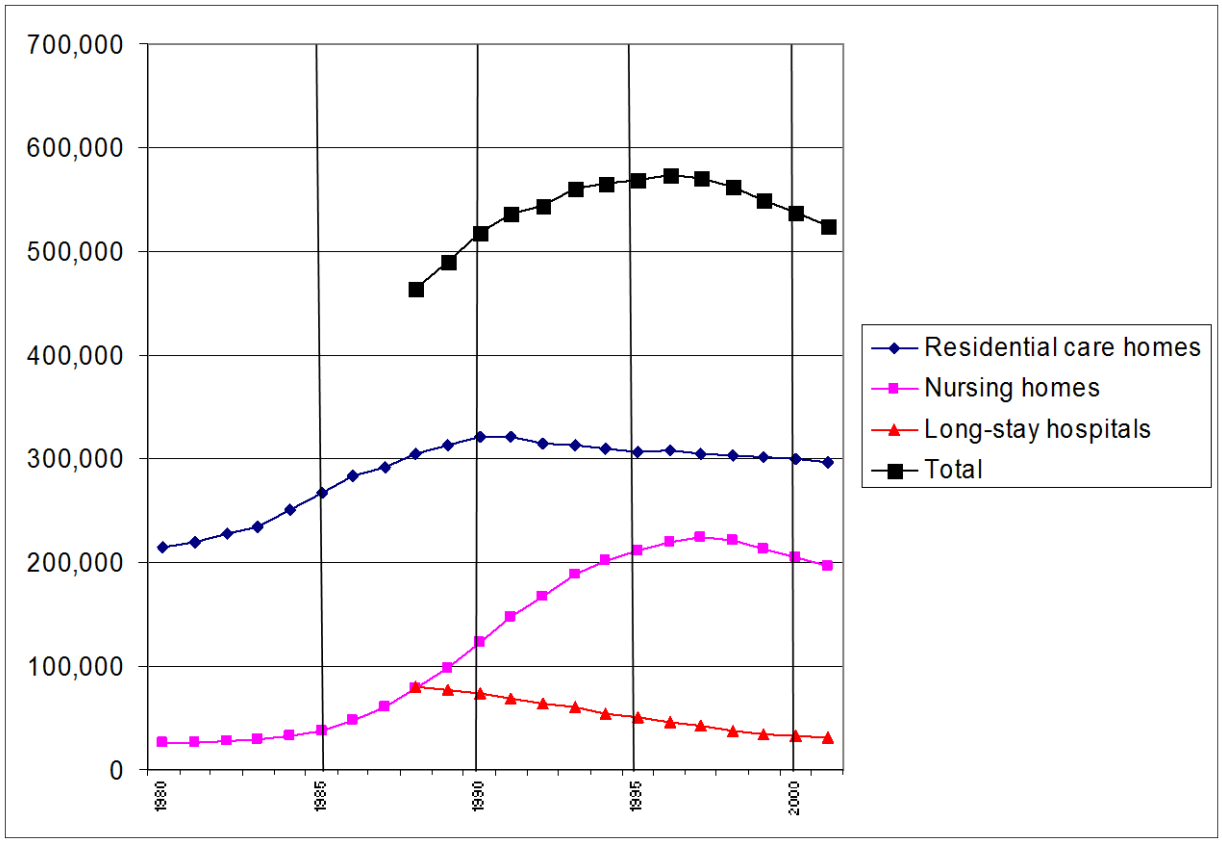
[1] Numbers and rates of people *aged 65 and over* in long-stay residential care *in Britain* in 1985, 1990, 1995 and 2000 are given in Chapter Eight (see Chapter Eight, section 8.1). Trends in long-stay residential care, identified in Chapter Eight, are similar to those described in this chapter.

Figure 2.1 below shows the number of 'elderly, chronically ill and physically disabled people' in all forms of long-stay residential care in the UK between 1980 and 2001, derived from Laing and Buisson's published data (Laing and Buisson 2002: 25). Data on the total number of places before 1988 are unavailable because of a lack of complete information on long-stay hospital places for the earlier period. Nevertheless, Figure 2.1 suggests that the three five-year periods between 1985 and 2000 were characterised by distinctive trends in the numbers of people in long-stay residential care.

Figure 2.1

Residential care home, nursing home and long-stay hospital places for elderly, chronically ill and physically disabled people, UK, 1980-2001

Number of places



Source: Laing and Buisson (2002): 25, Table 2.2
Notes: Figures on long-stay hospitals are only available from 1988. In 1988, there were similar numbers in nursing homes (78,300) and long-stay-hospitals (80,700) but in subsequent years, numbers in nursing homes rose while those in long-stay hospitals fell.

In the first period, between 1985 and 1990, the numbers in residential care homes and nursing homes rose sharply. Figure 2.1 indicates that the number of residential and nursing home places, taken together, rose from around 300,000 in 1985 to around 450,000 in 1990 (Figure 2.1). Although not shown on the figure above, it is well

established in the literature (described more fully in a later section) that the number of places in long-stay hospitals was falling during the 1980s (Darton and Wright 1993; House of Commons Health Committee 1995; Lewis and Glennerster 1996; Glendinning 1998). However, during the 1985 to 1990 period, the sharp increase in numbers in residential care homes and nursing homes was likely to have more than compensated for the decline in long-stay hospital beds. Thus, in the period between 1988 and 1990, when more complete information was available, the number of places in all forms of long-stay residential care rose from around 460,000 to 520,000, an increase of nearly 12 per cent (Figure 2.1).

In the second period, between 1990 and 1995, the numbers in long-stay residential care continued to rise. Figure 2.1 shows an increase in all forms of long-stay residential care from around 520,000 to 570,000 between 1990 and 1995, an increase of nearly 10 per cent. The increase in long-stay residential care during this period primarily took the form of a rise in nursing home places. Nursing home places rose from nearly 125,000 in 1990 to over 210,000 in 1995, an increase of over 70 per cent in five years (Figure 2.1). During this period, long-stay hospital places continued to fall and, in addition, residential care home places also fell. However, the rise in nursing home places more than compensated both for the continuing decline in long-stay hospital provision and the decline in residential care home places.

Finally, in the third period, between 1995 and 2000, the total number of places in all forms of long-stay residential care was falling (Figure 2.1). The NHS continued to shed long-stay hospital places for older people, but now private residential care homes and nursing homes were both also declining, albeit more slowly than long-stay hospital places. Residential care home places fell from around 305,000 in 1995 to just under 300,000 in 2000. Nursing home places continued to rise until 1997 and then fell quite rapidly, so that, if 1995 and 2000 are compared, there was a decline from around 210,000 to around 205,000.

There is evidence from the wider literature that the trends in each period, described above, also applied to the *rate* at which older people entered long-stay residential care, thereby controlling for changes in the numbers of older people during each period. Thus, in the first period, between 1985 and 1990, there is evidence that the proportion of older people in long-stay residential care as a whole was rising (Laing 1993; Darton

and Wright 1993; House of Commons Health Committee 1995; Parker 1998). Laing (1993), for example, shows a 27 per cent increase in the number of older people in long-term care establishments between 1981 and 1992, controlling for age (Laing 1993: 29). There is also evidence that the proportion of older people in long-stay residential care as a whole rose in the second period, between 1985 and 1990, although this varied by age. The House of Commons Health Committee (1995) produced a table, based on Department of Health data, showing that the proportion of people aged 75 and over in all forms of long-term care establishments rose by approximately 10 per cent between 1990 and 1994, although it also showed that the proportion aged 85 and over in residential care fell during this period (HOC 1995: ix). For the third period, between 1995 and 2000, there is evidence that the proportion of older people in long-stay residential care as a whole was falling. An OECD report, using data from the Department of Health (England) showed that the percentage of people aged 65 and over in long-stay residential care in England fell from 5.0 per cent in 1995 to 4.5 per cent in 2000, a fall of approximately 10 per cent (Lafortune *et al* 2007: 44).

In summary, the available evidence suggests that both the numbers of people in long-stay residential care, and the rate at which older people entered long-stay residential care, increased between 1985 and 1990 and between 1990 and 1995 and decreased between 1995 and 2000. The evidence also suggests that the three five-year periods between 1985 and 2000 were characterised by distinctive trends by sector. The three sections below examine each sector in turn, to identify the likely causes of these changes.

2.1.2 Changes in Numbers in Residential Care Homes, 1985-2000

Figure 2.2 below shows the number of elderly, chronically ill and physically disabled people in *residential care homes* in the UK between 1980 and 2001, derived from Laing and Buisson's data (Laing and Buisson 2002). As observed above, numbers in residential care homes increased between 1985 and 1990, and then declined between 1990 and 1995 and between 1995 and 2000.

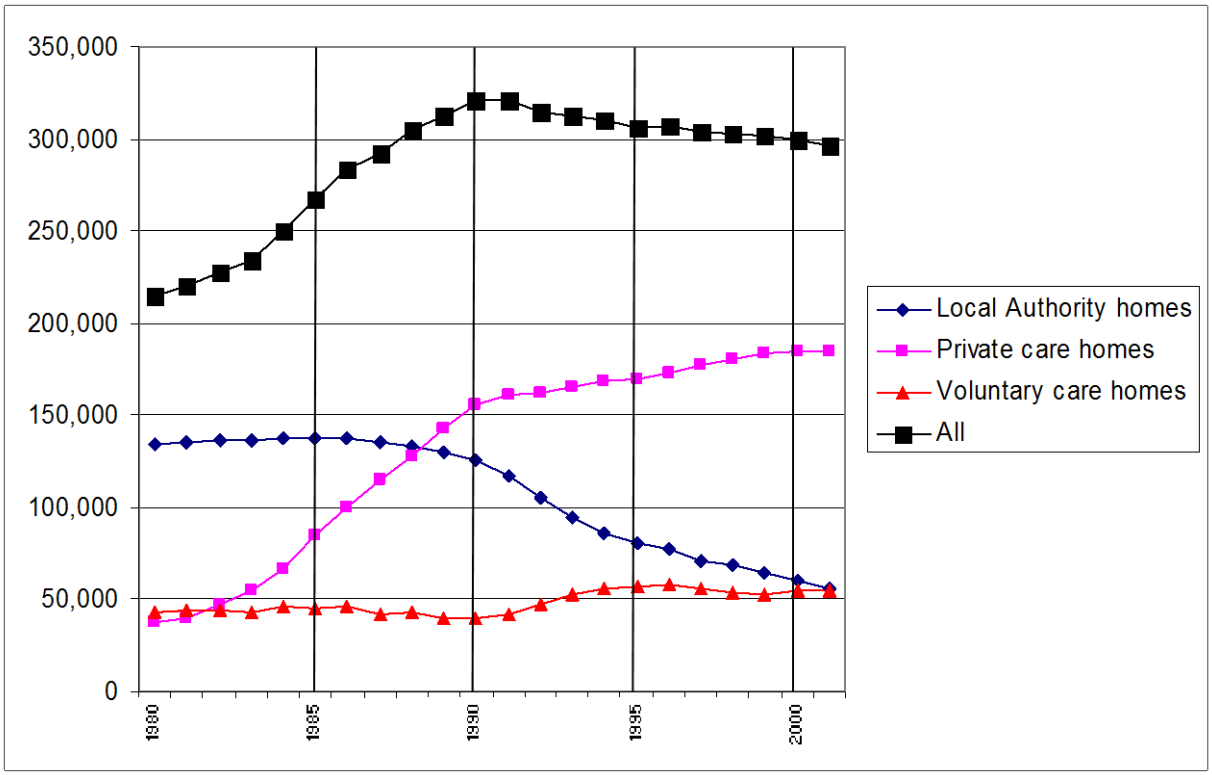
There seems general agreement in the literature that the increase in residential care home places during the 1980s was a largely unintended consequence of a change in the availability of social security benefits to fund places in private care homes (Estrin and

Pérotin 1988; Laing 1993; House of Commons Health Committee 1995; Lewis and Glennerster 1996; Audit Commission 1997; Glendinning 1998; Grundy 2008). Regulation of the rules governing 'board and lodging' expenses was introduced in November 1980 by statute under Parliamentary statutory instruments (Lewis and Glennerster 1996). The rules allowed someone who was a boarder to claim the full board and lodging charges plus an amount to cover personal expenses, with 'lodgers' including those living in residential care homes and nursing homes. Numbers in these care homes, particularly private sector homes, began to rise rapidly (Laing 1993; Lewis and Glennerster 1996). Social security payments, which were neither cash-limited nor needs-assessed, were available only in private and voluntary homes, and not in local authority residential care homes (Laing 1993).

Figure 2.2

Residential care home places for elderly, chronically ill and physically disabled people, UK, 1980-2001

Number of places



Source: Laing and Buisson (2002): 25, Table 2.2

The result was a rapid expansion in private residential care homes during the 1980s (Figure 2.2). Figures from Laing and Buisson show that the number of places in private residential care homes for elderly, chronically ill and physically disabled people in the

UK rose from around 55,000 in 1983 to around 155,000 in 1990. The number of places in Local Authority and voluntary care homes changed very little during this period, so that there was a net increase in numbers of places in residential care homes. The cause of the rapid increase in private care homes in the 1980s was clear. As the House of Commons Health Committee put it in 1995: "It was argued by the majority of our witnesses that *the availability of social security funding during the 1980s for residential and nursing home support was the main reason for the growth of the number of places in private nursing and residential homes*' (HOC Health Committee 1995: vii, emphasis added).

Increasing concerns over the rising social security bill, and a report by the Audit Commission in 1986 criticising the 'perverse incentives' against providing domiciliary care, led the government to ask Sir Roy Griffiths to review the funding of community care (Griffiths 1988). The 1988 Griffiths report recommendations, and the 1990 *NHS and Community Care Act* that followed them, meant that local authorities became responsible for funding residential and nursing home care. The care element of Income Support funding of residential care was transferred by central government to local authorities. Funding of long-term care became cash-limited and needs-assessed. The new arrangements came into effect in April 1993.

The total number of places in residential care homes in the UK peaked in 1990 (Figure 2.1). The number of private and voluntary residential care places generally continued to increase gradually until 2000, but Local Authority places fell sharply after 1990, so that the net effect was a decline in the total number of residential care places from 1990 to 2000. The reason for the rapid decline of Local Authority care home places after 1990 was because two mechanisms were put in place as part of the community care reforms that favoured 'independent' care homes. First, for three years after the reforms were introduced, local authorities received a 'Special Transitional Grant' (STG) from central government, 85% of which had to be spent on care provided by the 'independent' sector (Lewis and Glennerster 1996). Second, a new Residential Allowance was introduced which could be claimed by residents of care homes who received Income Support, but only if they were in private or voluntary, not Local Authority, homes (Laing 1993). The effect of these mechanisms was a huge fall in Local Authority care home places in the UK from around 125,000 in 1990 to 55,000 in 2000 (Laing and Buisson 2002). The impact of the community care reforms on the number of Local Authority care home

places preceded the actual implementation of the reforms in April 1993. This was primarily because the STG initially depended on past social security spending and many Local Authorities rushed to place people in the private and voluntary sector before the implementation of the reforms (Lewes and Glennerster 1996; Kenny and Edwards 1994).

The provisions put in place in favour of the 'independent' sector in the early 1990s did not, however, immediately discourage the use of long-stay residential care in all its forms. As Figure 2.1 above showed, there was an increase in the total number of places in residential care homes, nursing homes and long-stay hospitals in the UK until 1996 (Figure 2.1). Indeed, as will be examined in more detail below, the mechanisms put in place by the 1990 Act were, by the mid 1990s, considered to have created further 'perverse incentives' to place people in long-stay residential care rather than providing them with domiciliary care. However, the increase in care after 1990 primarily took the form of places in nursing homes rather than residential care homes, an issue explored in the section below.

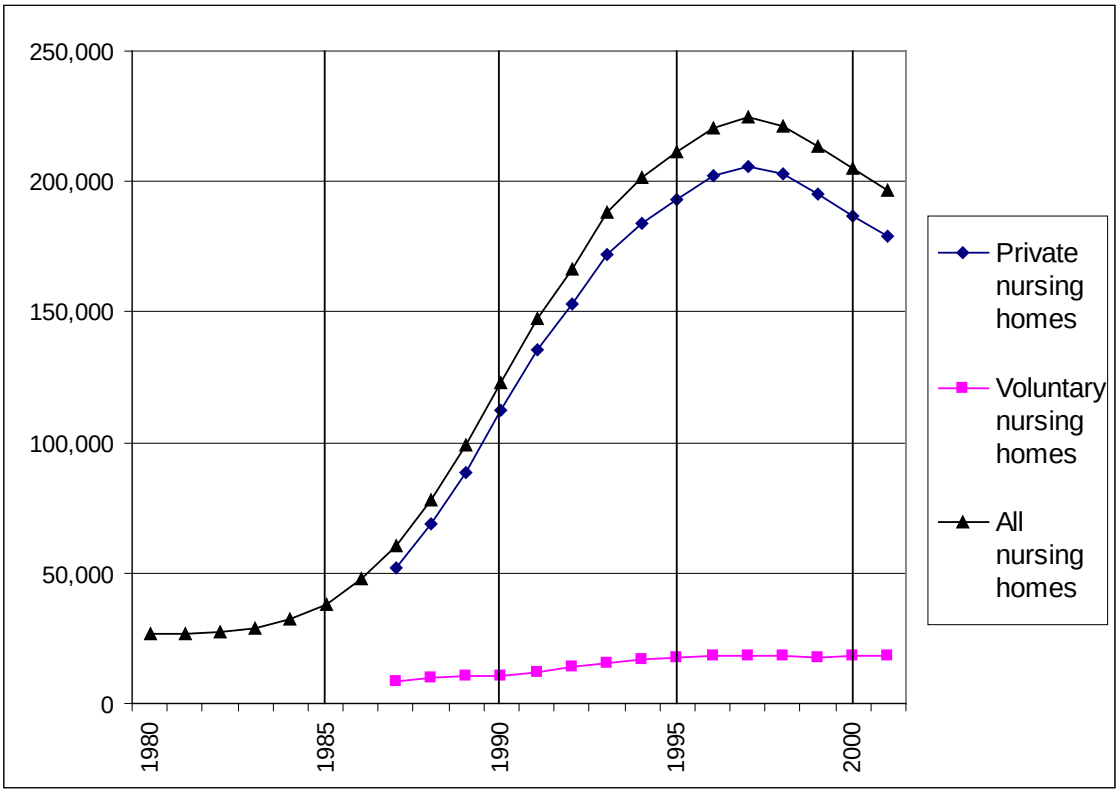
2.1.3 Changes in Numbers in Nursing Homes, 1985-2000

Figure 2.3 below, shows the number of 'elderly, chronically ill and physically disabled people' in *nursing homes* in the UK between 1980 and 2001, derived from Laing and Buisson's published data (Laing and Buisson 2002). As noted earlier, numbers in nursing homes increased between 1985 and 1990 and between 1990 and 1995, and then declined between 1995 and 2000 (Figure 2.3). Indeed, Laing and Buisson report that the main focus of growth in private care homes in the late 1980s and early 1990s was nursing homes (Laing and Buisson 1999: 21).

Figure 2.3

Nursing home places for elderly, chronically ill and physically disabled people, UK, 1980-2001

Number of places



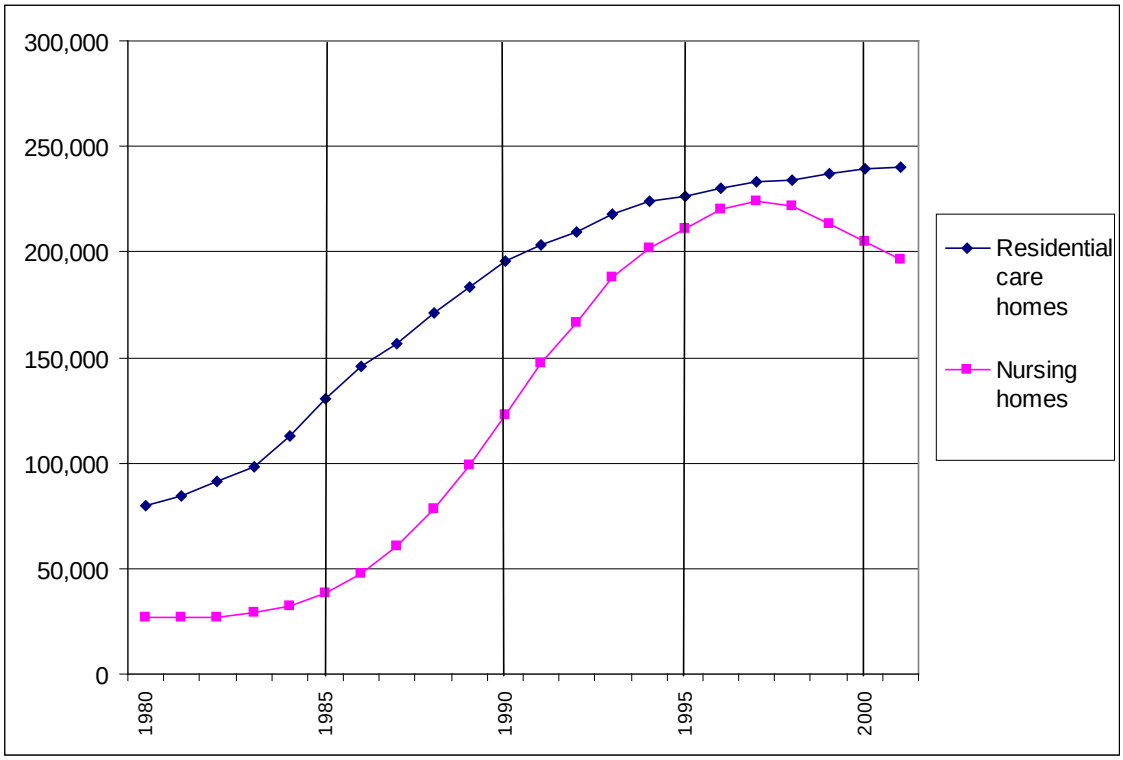
Source: Laing and Buisson (2002): 25, Table 2.2

The growth in nursing homes did not begin immediately access to supplementary benefit payments increased in the early 1980s and happened somewhat later than the rise in private residential care (Laing 1993: 27). In the early 1980s there was very little private or voluntary nursing home care, with nearly all long-stay nursing care provided in NHS hospitals (Glendinning 1998: 11). The rise in private and voluntary nursing homes began in the mid-1980s. Separate figures on private, as opposed to voluntary, homes were not initially collected. Laing and Buisson identify about 27,000 elderly, chronically ill and physically disabled people in private and voluntary homes in the UK in 1980, which rose to around 50,000 in 1986 and then began to rise very steeply until peaking in 1997 at around 225,000 places (Figure 2.3). At their peak, the number of nursing home places in the private and voluntary sector was nearly as great as the number of residential care places (Figure 2.4).

Figure 2.4

Places in private and voluntary sector residential care and nursing homes for elderly, chronically ill and physically disabled people, UK, 1980-2001

Number of places



Source: Laing and Buisson (2002): 25, Table 2.2

The increase in nursing home places from the mid-1980s was probably related to the structure of Supplementary Benefit payments introduced at that time. In 1985, in an attempt to curb Supplementary Benefit expenditure, the government introduced national limits on what could be paid for each resident, depending on the type of incapacity and type of facility (Lewis and Glennerster 1996: 5). A higher rate was paid for people in nursing homes than in residential care homes (Darton and Wright 1992: 230). It was thought that it was this differential in the rates for nursing home and residential care home places that encouraged the development of nursing homes rather than residential care homes (Darton and Wright 1993: 22). This seems to have become an increasingly important issue over time. By 1992, the income support rates for nursing homes had increased faster than for residential care homes. While the rates for nursing homes were broadly in line with the average fees in nursing homes, the rates for residential care homes were now considerably lower than average fees in residential care homes. The result, according to the Association of Directors of Social Services (ADSS), was "a drift towards nursing home care rather than residential care" (ADSS 1992: 9).

After the *NHS and Community Care Act* was passed in 1990, as Figure 2.1 above showed, long-stay residential care continued to grow. The main element of the community care changes under the new Act, the ending of the social security payments, was not in fact implemented until April 1993 (Lewis and Glennerster 1996: 10). Even then, the impact of the community care changes on the numbers in long-stay residential care was buffered by the use of the Special Transitional Grant (STG). Money transferred from the social security budget to Local Authorities was earmarked for community care purposes, for a limited period lasting from 1993/4 to 1995/6 (Lewis and Glennerster 1996: 9). As noted above, 85 per cent of the 'social security transfer element' of the STG had to be spent within the 'independent sector'. The effect of this was to restrict the extent to which Local Authorities could move away from using residential care to using domiciliary care. The reason was that there was very little 'independent sector' domiciliary care available, so that Local Authorities seeking care, but obliged to use the 'independent sector', were forced to place people in residential care homes or nursing homes (Lewis and Glennerster 1996: 9, 34, 41, 118, 200). As Lewis and Glennerster concluded " … the 85 per cent rule… had the effect of forcing authorities to continue spending more on institutional care because that was where the bulk of independent provision lay…" (Lewis and Glennerster 1996: 200). Although other 'perverse incentives' to place people in long-stay residential care remained (Browning 1999), it is noticeable that the numbers of people in long-stay residential care did not begin to fall until after the STG came to an end in April 1996 (Figure 2.1).

If the community care changes of the early 1990s did not remove incentives to place people in long-stay residential care, why did the rise in long-stay residential care take the form of nursing homes rather than residential care homes? There were probably two reasons for this. The first reason is suggested by Darton and Wright, writing in 1992 and anticipating the probable effects of the community care changes. Darton and Wright anticipated that there would be "mounting pressure to provide more places in nursing homes" as a result of the community care changes of the early 1990s (Darton and Wright 1992: 239). As the authors explained, "Under the new arrangements, local authority residential care, which currently accommodates a relatively larger proportion of severely disabled people, will be less likely to be used than private or voluntary residential care, because it suffers a relative cost disadvantage. Consequently, the pressure to take more dependent people will fall primarily on the independent sector, primarily on private homes. In turn, owners of private residential homes will have an

incentive to charge higher fees, to contemplate dual registration, *to convert from residential to nursing home car*e, or *to transfer their most dependent residents to nursing home care*" (Darton and Wright 1992: 239, emphasis added).

The second reason why the community care changes of the early 1990s led to pressure to provide more places in nursing homes was that they allowed for an acceleration in the decline of 'continuing care' in hospitals. This is described in the next section.

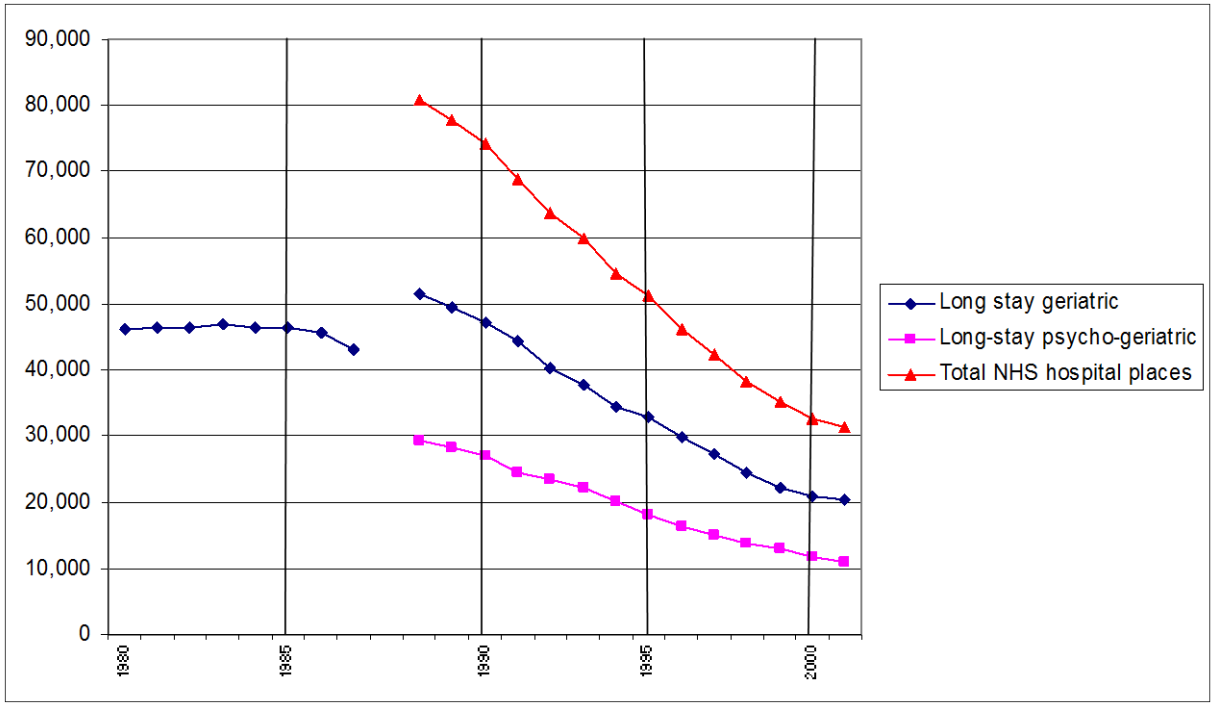
2.1.4 Changes in Numbers in Long-Stay Hospitals, 1985-2000

Figure 2.5 below, shows the number of 'elderly, chronically ill and physically disabled people' in *long-stay hospitals* in the UK between 1980 and 2001, derived from Laing and Buisson's data (Laing and Buisson 2002). Although the data are somewhat patchy and discontinuous (a point discussed in more detail below), Figure 2.5 suggests that, with respect to the three time periods under study here, numbers in long-stay hospitals declined between 1985 and 1990, between 1990 and 1995 between 1995 and 2000.

Figure 2.5

NHS long-stay geriatric and psycho-geriatric hospital places for elderly, chronically ill and physically disabled people, UK, 1980-2001

Number of places



Source: Laing and Buisson (2002): 25, Table 2.2
Note: There is a break in the data for long-stay geriatric places between 1987 and 1988.

The decline in provision of NHS long-stay hospital care for older people was a trend occurring throughout the 1980s and 1990s, but it happened initially with little public acknowledgement. The Audit Commission, in its report *The Coming of Age* (1997), observed that two of the legacies of the changes in long-term care provision in the 1980s and early 1990s were "a reduction in the role of the NHS" and "a growth in the role of the independent sector" (Audit Commission 1997: 12). The Audit Commission commented "Neither of these changes was planned; they happened by default as a direct result of the increase in social security payments. They represent *major shifts in policy that have never been debated or agreed*" (Audit Commission 1997: 12, emphasis added). The absence of open debate was also observed in the academic social policy literature (Glendinning 1998: 12).

The lack of debate about the decline in long-stay hospital care for older people took place in the context of poor quality information about the changes that were occurring. Figure 2.5 shows the data produced by Laing and Buisson for NHS long-stay geriatric and psycho-geriatric places between 1981 and 2001. No data on long-stay psycho-geriatric places were available between 1980 and 1988. As already observed, continuous data between 1981 and 2001 were absent for long-stay geriatric places. This was because of a reclassification of hospital types when 'Korner'[1] aggregates were introduced in 1988. After 1988, the Department of Health was unable to separate geriatric bed statistics between acute and non-acute hospitals, so that the long-stay data produced by Laing and Buisson depend on assumptions about the relationship between acute and long-stay provision (Laing and Buisson 2002: 35).

Nevertheless, in spite of the poor quality of the data over time, it is clear that NHS long-stay hospital provision was declining in the 1980s and 1990s. Even setting aside the break in the data in 1988, the Laing and Buisson data suggest that the number of long-stay geriatric places in the UK approximately halved between 1980 and 2001 from 46,100 to 20,300 (Laing and Buisson 2002: 25). The decline of NHS continuing care facilities for older people was arousing academic comment from the early 1990s onwards (Darton and Wright 1993: 18; Lewis and Glennerster 1996: 166) and official comment in the mid-1990s. The House of Commons Health Committee reported in 1995 on *Long-Term Care: NHS Responsibilities for Meeting Continuing Health Care*

[1] 'Korner' aggregates are statistics about hospital services and activity, including bed availability and occupancy and patients treated.

Needs. The Health Committee obtained information from the Department of Health, which it acknowledged had "limitations", showing that, in England, "between 1976 and 1994 the number of NHS beds specifically designated for elderly people fell from 55,600 to 37,500, a 33 per cent reduction" (HOC 1995:vii). Nor did the decline in NHS continuing care places end in 1994. The Audit Commission, reporting in 1997, produced a table showing that continuing health care provision in England continued to fall after 1994 and stated that "between 1983 and 1996, there was a 38 per cent reduction in acute and long-stay places for older people" (Audit Commission 1997: 12). As the House of Commons Health Committee put it in 1995, this "has gradually created a situation in which general, as distinct from specialist, long-term nursing care is no longer considered to be an NHS responsibility" (HOC 1995, cited in Audit Commission 1997:12).

There were several reasons for the decline in long-stay hospital provision during the 1980s and 1990s. Witnesses to the House of Commons Health Committee in 1995 suggested two reasons. First, it was argued by the National Institute for Social Work that the availability of social security funding provided an opportunity for the NHS to "improve the quality of care for patients by closing many geriatric and psychogeriatric long-stay hospitals" (HOC 95:vii). Others, however, suggested that the reduction in NHS provision was cost-driven. According to the Health Committee, the Association of Metropolitan Authorities (AMA) "felt that the reduction in NHS beds was driven by the potential cost-savings to the NHS through funding by social security of patients who would previously have been cared for by the NHS" (HOC 1995: vii). In addition, the Health Committee also suggested that NHS long-stay care was being over-shadowed by priorities in the acute sector. The Committee was told by the ADSS that "Government targets contained in the *Health of the Nation*, the *Patient's Charter* and the Waiting List initiative were adversely affecting the priority that health authorities give to purchasing community health services and continuing in-patient care" (HOC 1995: xxvi). It was the demands of the acute sector that the Audit Commission (1997) also considered to be most important, arguing that "throughout the 1980s and early 1990s, the increasing pressure on acute hospitals of rising emergency admissions and shorter lengths of stay, coupled with the ready availability of private residential and nursing home provision, may have encouraged a reduction of rehabilitation and recovery resources" (Audit Commission 1997: 41).

As the previous paragraph suggests, the policy mechanisms by which NHS long-stay hospital provision declined were linked to the same mechanisms by which private residential and nursing home provision increased. Indeed, there seems to have been some substitution between the long-stay hospital sector and the nursing home sector in the 1980s and early 1990s. During this time, the availability of social security funding encouraged the growth of private residential and nursing homes and also thereby enabled the NHS to reduce its own long-stay provision (HOC 1995: vii). As the Health Committee makes clear, it was in particular the growth of the nursing home sector that enabled NHS provision to decline. As the National Association of Health Authorities and Trusts (NAHAT) pointed out to the Health Committee, "during the 1980s the *social security budget* was in fact purchasing what for most people in this country would have been thought of as NHS provision because it was nursing home care" (HOC 1995: vi, emphasis added).

The 1993 reforms further encouraged the reduction of NHS long-stay provision and increased independent sector nursing home provision. Under the new arrangements, local authorities were given responsibility for admissions not just to residential care homes but also to nursing homes. As Lewis and Glennerster observed in their study of the implementation of the *NHS and Community Care Act*, "The NHS officers saw the new Act's clear identification of the social services departments as the *lead* community agencies as good grounds for getting rid of their long-term care responsibilities as soon as possible" (Lewis and Glennerster 1996: 16). It was nursing homes again that were seen as particularly important to this. As the witness from NAHAT told the Health Committee in 1995, the community care arrangements introduced in 1993 had "lead [*sic*] to the situation where *local authorities* are now funding services which possibly many people still think are part of the NHS because they are called 'nursing homes'" (HOC 1995: vi, emphasis added).

Indeed, the NHS reforms contained an additional mechanism that facilitated the decline of NHS continuing care and the increase in independent sector nursing homes. The payment of the STG monies to local authorities was linked to local agreements between health and social services departments about strategies for placing people in nursing home beds and about hospital discharge arrangements (Lewis and Glennerster 1996: 168). In what has been described by Lewis and Glennerster as "financial coercion", local authorities were required to reach agreements with health authorities by the end of

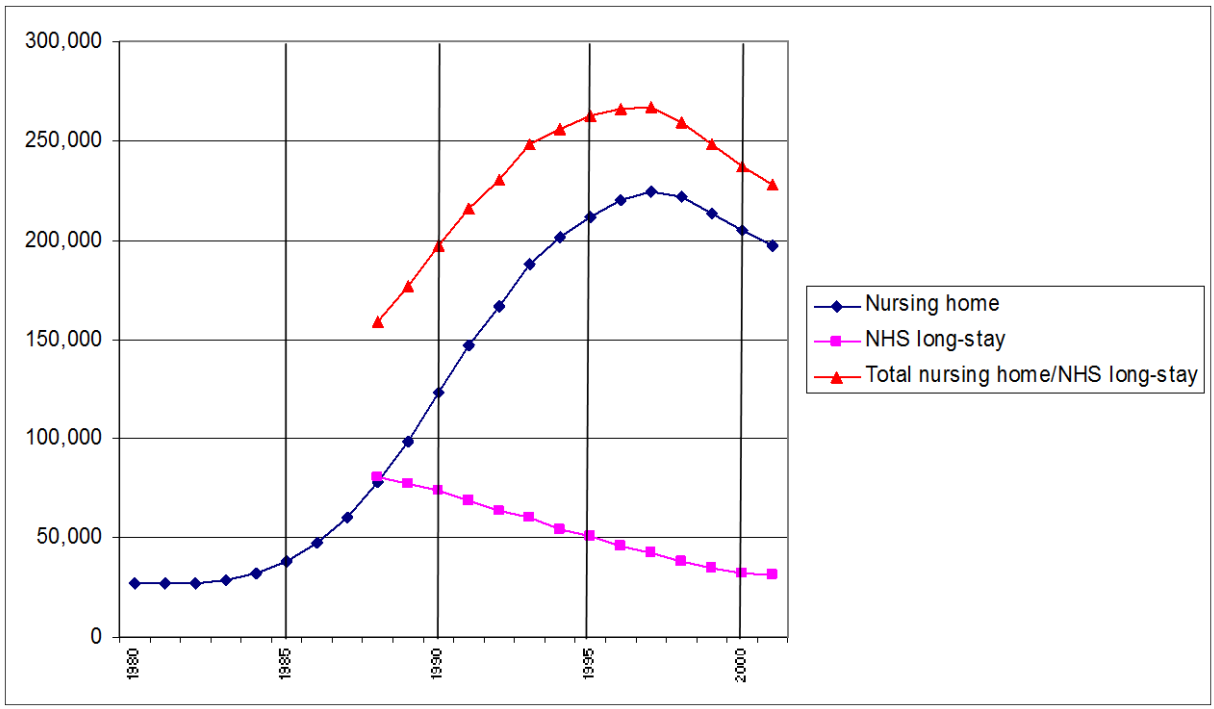
1992 or forfeit a substantial proportion of their STG monies (Lewis and Glennerster, 1996: 168, 191). It was this in particular that encouraged some people in the health authorities "to see an end to an NHS commitment to continuing care in the long run" (Lewis and Glennerster 1996: 193).

The decline of NHS long-stay provision for older people and increase in independent nursing home provision in the 1980s and early 1990s did not lead to a reduction of the number of nursing home and long-stay hospital places overall. On the contrary, as the Audit Commission observed, "between 1983 and 1996, there was a 38 per cent reduction in acute and long-stay beds for older people and an almost ten-fold increase in nursing home beds" (Audit Commission 1997:12). The increase in the total numbers of nursing home and hospital places continued until, as noted earlier, the transitional (STG) arrangements came to an end in 1996. After that, there was a decline not just in hospital provision but also in nursing home provision (Figure 2.6).

Figure 2.6

Places in nursing homes and NHS long-stay geriatric and psycho-geriatric places for elderly, chronically ill and physically disabled people, UK, 1980-2001

Number of places



Source: Laing and Buisson (2002): 25, Table 2.2
Notes: Figures on long-stay hospitals are only available from 1988. In 1988, there were similar numbers in nursing homes (78,300) and long-stay-hospitals (80,700) but in subsequent years, numbers in nursing homes rose while those in long-stay hospitals fell.

It was during the late 1990s, when the community care reforms were fully in place, that the Royal Commission on Long Term Care was established (in December 1997). The decline in NHS long-term care for older people was an important consideration affecting the central recommendations of the Royal Commission. The Royal Commission observed the sharp decline in NHS long-stay hospital provision for older people and the increase in private nursing home places, and commented that "only 8% of these additional private nursing home places are paid for by Health Authorities and Health Boards" (Royal Commission 1999: 34). It suspected that "in order to concentrate its resources on acute care, the NHS has been increasingly reluctant to provide long-term care for older people" (Royal Commission 1999: 34). The Royal Commission reported a "feeling that the Health Service is abnegating its responsibility for care and making people rely on their own resources" and that "a contract with the people has been broken" (Royal Commission 1999: 40). Underlying these feelings was the fact that long-stay hospital care for older people provided free at the point of use by the NHS had, with the on-going decline in long-term hospital provision and full implementation of the community care reforms, largely in effect been replaced by means-tested Local Authority provision. In the Royal Commission's view this led to inequity and it asked why, for example, someone suffering from cancer should be treated free in hospital while someone with Alzheimer's disease had to pay for care in a care home (Royal Commission 1999: 65). This inequity, it argued, provided a major justification for its central recommendation that personal care should be provided free at the point of use and be exempt from means-testing, and that this should be funded out of general taxation. The government's response to the Royal Commission was not published until 2000 (Department of Health 2000) and no changes were made to the long-term care system in England until the *Health and Social Care Act* was implemented in October 2001, while policy in Scotland did not diverge until July 2002.

The system of funding of long-stay residential care, to which the Royal Commission drew attention, therefore remained throughout Britain until the end of the period under study here. This system, which was associated with the full implementation of the community care reforms after the mid-1990s, had the effect of reducing access to long-stay residential care. The replacement of 'free' NHS care by means-tested Local Authority provision implied an effective price increase for those above the means-test, while for those below the means-test, access to care was constrained by Local Authority 'rationing' (Lewis and Glennerster 1996). Reduced access to long-stay residential care

was in turn reflected in reduced numbers in the 'nursing care' sector, comprising both long-stay hospitals and nursing homes (Figure 2.6) and in reduced numbers in all forms of long-stay residential care (Figure 2.1).

2.1.5 Summary: Trends in Long-Stay Residential Care, 1985-2000

In summary, the three five-year periods between 1985 and 2000 were characterised by distinctive trends in numbers of people in long-stay residential care. The changes in each five-year period can be linked directly to changes in social policy. In the first period, between 1985 and 1990, the overall numbers in long-stay residential care were rising, fuelled by the availability of social security board and lodging payments in private and voluntary homes. The sharp increase in numbers in private residential care homes and nursing homes more than compensated for the decline in numbers in long-stay hospital beds. The second period between 1990 and 1995 was a transitional period. Although legislation introducing the community care reforms had been passed in 1990, it was not implemented until 1993 and even then, until the mid-1990s, the reforms were buffered by the special transitional arrangements associated with the STG. During this transitional period, the numbers in long-stay residential care continued to rise, with the increase primarily taking the form of a rise in private nursing home places, which more than compensated both for the continuing decline in long-stay hospital provision and the decline in residential care home places. Finally, in the third period, between 1995 and 2000, the community care reforms were fully implemented and numbers in long-stay residential care began to decline. The NHS continued to shed long-stay hospital places for older people, but now there were also declines in both private residential care homes and nursing homes.

This section has also established that the three sectors comprising long-stay residential care as a whole were inter-linked. In particular, during the period under study, long-stay hospital places were largely replaced by independent nursing home places. Indeed, it makes sense to consider both long-stay hospital provision and nursing home provision as one 'nursing care' sector. As Figure 2.6 above illustrates, numbers of places in this 'nursing care' sector rose sharply between 1985 and 1990 and between 1990 and 1995, when the rise in nursing home places, fuelled by the availability of social security payments, more than compensated for the decline in long-stay hospital places. Numbers of places in the 'nursing care' sector fell between 1995 and 2000, when not

only did long-stay hospital places continue to decline but, with the full implementation of the community care reforms, access to nursing home places also declined. As will be suggested in Chapter Eight, it was changes in this 'nursing care sector', comprising both nursing homes and long-stay hospitals, that were to have particular relevance for trends in intense intergenerational care.

Finally, this section has established that changes in social policy played a key part in the changes in long-stay residential care for older people in Britain between 1985 and 2000. It is not clear, however, that these changes in social policy came about in order to meet changes in demand for care by older people. Rather, the evidence suggests that the expansion of residential care and nursing home places in the 1980s and 1990s was an unintended consequence of changes in the social security benefit system, which was subsequently used as a mechanism to reduce NHS costs. When efforts were made to curtail the expansion of residential care and nursing home places, implementation was slow. And this long-drawn out period of change, it has been argued, was primarily for *political* reasons, because the Conservative government (particularly Mrs Thatcher herself) both welcomed the expansion of private homes and was loath to give additional powers to local authorities (Lewis and Glennerster 1996: 6). Nevertheless, the rise in residential care and nursing home places in the late 1980s and early 1990s was clearly also related to changes in the numbers of older people, and this and other factors, potentially affecting demand for care, are examined later in the chapter.

2.2 Trends in Domiciliary Services for Older People, 1985-2000

2.2.1 Trends in Domiciliary Services for Older People, 1985-2000

Changes in the provision of domiciliary services are particularly important in the British context in the 1980s and 1990s because the community care reforms of the early 1990s aimed to increase the availability of intensive home care services for older people. To the extent that these intensive home care services substituted for long-stay residential care, as is sometimes suggested (for example, Knapp *et al* 2004), domiciliary services might have mediated any effect of changes in long-stay residential care on informal care provision.

It is clear that one of the main aims of the community care reforms of the early 1990s was to reduce reliance on (costly) long-term residential care and increase use of (less costly) domiciliary services. This was to be brought about by a number of mechanisms. One was the policy of "making one budget holder responsible for rationing all social care spending for those in need of community care" (Lewis and Glennerster 1996: 195). Under the 1990 *NHS and Community Care Act*, as already noted, local authority social services departments were given the lead role in assessing needs for care, and arranging packages of care, for their resident populations. Local authorities became 'gate-keepers' of publicly-funded care (Wistow *et al* 1996). Another policy mechanism by which the reforms aimed to shift the balance of care from residential to domiciliary care was through the introduction of 'care management'. The aim was to target resources on the most disabled people in the community, with the intention of improving the efficiency of domiciliary services and preventing or delaying admissions to long-term residential care (Davies *et al* 1990, 2000; Wistow *et al* 1996).

The effect of the community care reforms on the provision of domiciliary services seems to have occurred primarily in the final period of this study, that is, between 1995 and 2000. Analysts writing in the mid-1990s, and referring primarily to the period of the early 1990s, observed that the development of the 'independent' domiciliary care sector had been slow to follow the implementation of the reforms in 1993 (Lewis and Glennerster 1996; Glendinning 1998). This was partly because, as already noted, the Special Transitional arrangements encouraged the use of long-stay residential care rather than domiciliary care. It was not until the Special Transitional arrangements came to an end in 1996 that the impact of the reforms on domiciliary services seems to have strengthened. By the early 2000s, analysts were able to observe a clear impact of the community care reforms on domiciliary care (Knapp *et al* 2004). Indeed, it was suggested in 2004 that "the last few years have clearly shown the beginning of the achievements of the 1990 Act's aim of substituting home-based (domiciliary) care for (some) institutional provision" (Knapp *et al* 2004: 152).

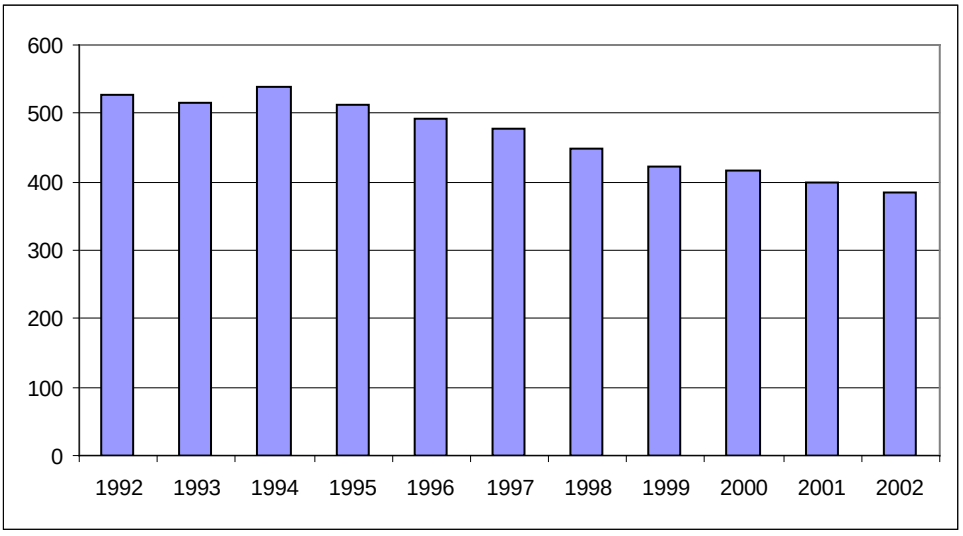
The key change in domiciliary services associated with the community care reforms was the 'targeting' of care on the most disabled people in the community. Targeting essentially involved the concentration of domiciliary services on a smaller number of recipients (Evandrou and Falkingham 2005). The effects of targeting on the home help/home care service receipt in England between 1992 and 2002 are illustrated in

Figures 2.7 to 2.9 below. Home help/care is illustrated here because of its importance in this country as "the foundation upon which most community care packages are built" (Bauld *et al* 2000: 249). Figure 2.7 shows that the number of households receiving home help or home care in England fell below half a million for the first time in 1996 and then fell steadily for the next five years. Between 1995 and 2000, the number of households receiving home help/care fell by 20 per cent from around 515,000 to around 415,000. At the same time, as Figure 2.8 shows, the intensity of home help/care increased. Between 1992 and 2000, the average utilisation of home help/care per household increased from 3.2 hours per week to 7.0 hours per week (Figure 2.8). The rise in intensity is most clear after 1996. As Figure 2.9 shows, it was in 1996/97 that the proportion of households receiving highly intensive home care services exceeded those receiving low intensity services for the first time.

Figure 2.7

Households receiving home help or home care provided by either Local Authorities or the 'independent' sector, England, 1992-2002

Households in thousands

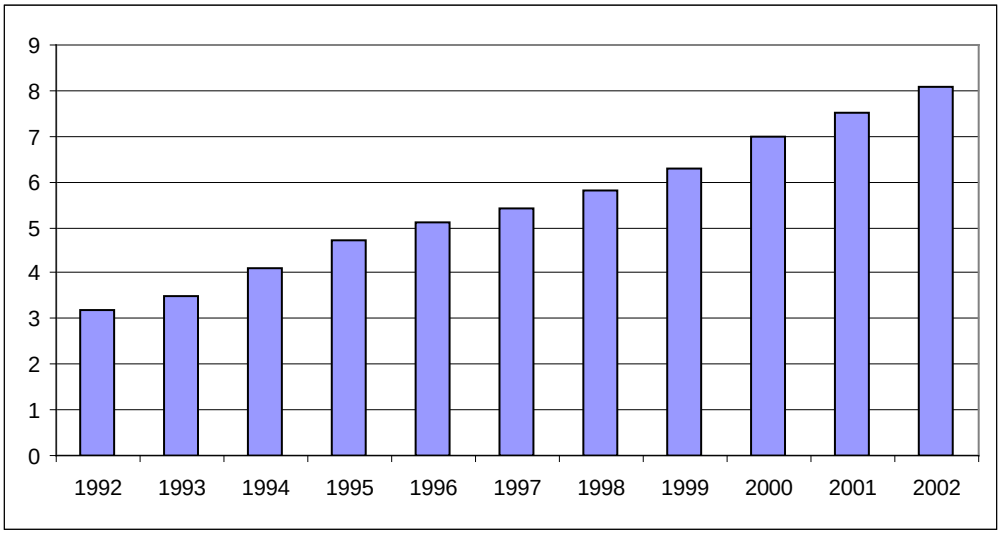


Source: Department of Health Community Care Statistics, 2002
Note: The figures include double-counting of those receiving home care from more than one sector (that is, the Local Authority and 'independent' sectors)

Figure 2.8

Average number of home help/home care contact hours per household per week, England, 1992-2002

Average contact hours per household per week

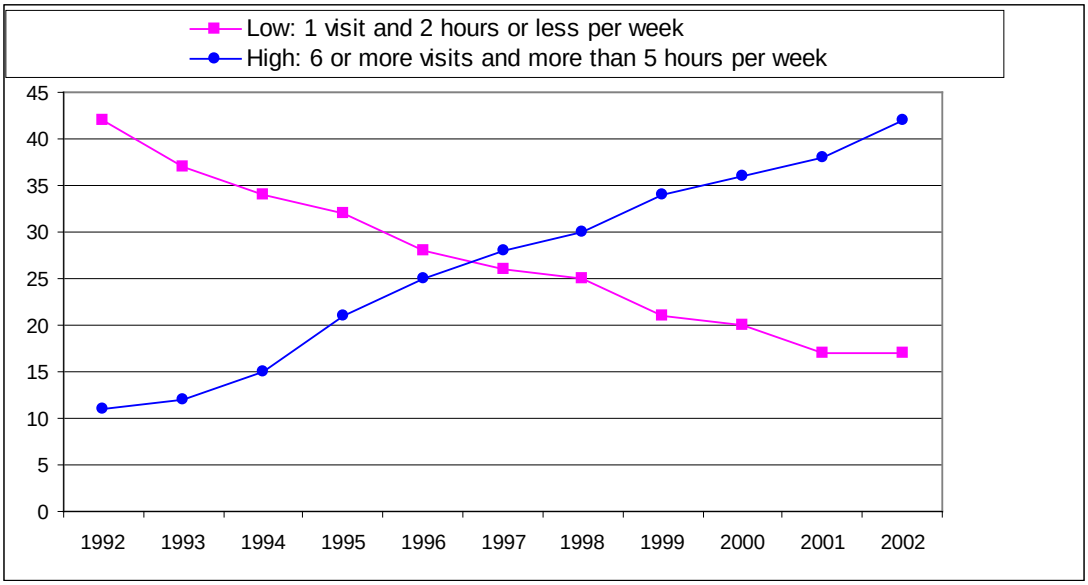


Source: Department of Health Community Care Statistics, 2002

Figure 2.9

Intensity of home help/home care, England 1992-2002

Percentage of households



Source: Department of Health: Community Care Statistics, 2002

The provision of publicly-funded home care services, both before and after the community care reforms, was controlled by local authority social services departments and 'rationed' using an approach that is particularly relevant in the present context.

The home help/care service in Britain is primarily directed at older people living alone and away from those living with others. The tendency to direct domiciliary services towards people living alone preceded the community care reforms (Evandrou *et al* 1986; Evandrou 1987; Arber *et al* 1988; Levin *et al* 1989; Bowling *et al* 1991, 1993; Davies *et al* 1990) and has continued since then (Wittenberg *et al* 1998; Pickard *et al* 2001; Pickard 1999, 2004a, Evandrou 2005; Evandrou and Falkingham 2005). The most intense forms of informal care tend to be provided on a co-resident basis by adults sharing a household with the care-recipient (Arber and Ginn 1991; Parker 1992; Healy and Yarrow 1997; Tinker *et al* 1999). Therefore, the bias of service provision towards those living alone has meant that services have tended to be directed away from those providing the most intense informal care. As Levin and colleagues found, people providing informal care who were dealing with faecal incontinence, disturbed behaviour and who showed the greatest strain were far *less* likely to receive home help than were those who provided less intense forms of care (Levin *et al* 1989). The community care reforms did not change this. Home care services have continued to be focused primarily on older people living alone and away from those living with others, who are more likely to receive intense informal care (Evandrou 2005). Evandrou and Falkingham (2005) using data from the GHS module on older people, show that, during the 1990s, publicly-funded home help to older people, who were unable to walk out of doors unaided, was 3 to 3.5 times more likely to be provided to those living alone than to those living with others.

2.2.2 Summary: Trends in Domiciliary Services, 1985-2000

The effects of the community care reforms on the provision of domiciliary services seem to have occurred primarily in the final period of this study, that is, between 1995 and 2000. The key change in domiciliary services associated with the community care reforms was the 'targeting' of care on the most disabled people in the community. 'Targeting' was associated with a decline in the total numbers of people receiving services, together with an increase in the intensity of services provided.

The rise in intensive home care services between 1995 and 2000 might potentially have substituted for long-stay residential care and might, therefore, have mediated any effect of changes in long-stay residential care on informal care provision during this period. However, there are *a priori* reasons for supposing that any direct effect of intensive

home care on intense informal care in Britain is likely to have been small. This is because, as this section has shown, home care in this country tends to be focused primarily on older people living alone and away from those living with others, yet it is those who are living with others who are more likely to receive intense informal care. It is of course possible that that there might have been indirect effects of intensive home care on intense informal care, and this issue will certainly be considered again later in the study.

2.3 Trends Affecting Demand for Care by Older People, 1985-2000

As Chapter One pointed out, the central hypotheses of the present study suggest that changes in intense intergenerational care of older people are related to changes in long-stay residential care. The underlying assumption is that the availability of long-stay residential care affects *demand* for intense informal care by older people from their children. However, the volume of demand may be affected by factors other than the availability of formal services. Relevant factors are likely to be those that are known to affect demand for long-term care in general. Demand for long-term care by older people has been found to be sensitive to two main factors: the number of older people, especially the number of 'older old' people, and the prevalence of disability (Wittenberg *et al* 2001). In addition, demand for care by older people from their children is potentially affected by the availability of alternative sources of informal care, in particular care from spouses or partners (Pickard *et al* 2007). This section therefore examines, in turn, trends in each of these factors: the number of older people, their marital status and the prevalence of disability.

2.3.1 Trends in the Number of Older People

This sub-section examines trends in the number of older people between 1985 and 2000 by age-band and gender. The population data utilised in this sub-section (and later chapters of the study) are official mid-year population estimates for Great Britain, by age and gender, published by the Office for National Statistics (www.ons.gov.uk). These estimates were revised in the light of the 2001 Census, and are summarised in Table 2.10 and Figure 2.11 below.

Table 2.10

People aged 65 and over, by age-band and gender, Britain, 1985–2000

Numbers in thousands and percentage change over time

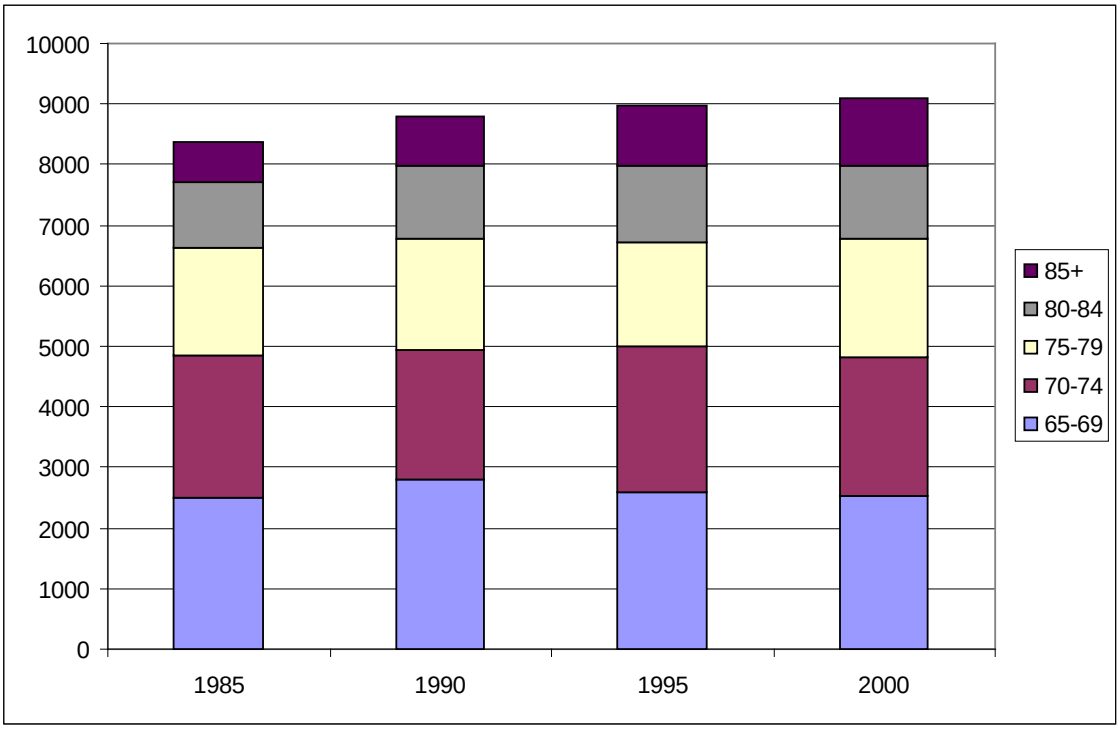
	65-69	70-74	75-79	80-84	85+	All 65+	All 80+
Numbers							
All people							
1985	2,490	2,350	1,785	1,090	675	8,385	1,765
1990	2,795	2,130	1,840	1,210	825	8,800	2,035
1995	2,595	2,420	1,700	1,280	985	8,980	2,265
2000	2,540	2,280	1,960	1,220	1,095	9,090	2,310
Men							
1985	1,125	995	675	345	155	3,295	500
1990	1,285	915	715	400	200	3,515	600
1995	1,215	1,060	680	445	250	3,650	695
2000	1,210	1,030	810	440	300	3,790	740
Women							
1985	1,360	1,355	1,110	745	520	5,090	1,265
1990	1,510	1,220	1,125	810	625	5,285	1,435
1995	1,380	1,360	1,025	840	735	5,330	1,570
2000	1,330	1,250	1,150	775	795	5,300	1,570
Percentage change over time							
All people							
85/90	12	-9	3	11	22	5	15
90/95	-7	13	-7	6	19	2	11
95/00	-2	-6	15	-5	11	1	2
85/00	*2*	*-3*	*10*	*12*	*63*	*8*	*31*
Men							
85/90	14	-8	6	16	29	7	20
90/95	-5	16	-5	11	27	4	16
95/00	-1	-3	19	-<1	19	4	7
85/00	*7*	*4*	*20*	*28*	*94*	*15*	*49*
Women							
85/90	11	-10	1	9	20	4	14
90/95	-9	11	-9	4	17	1	10
95/00	-4	-8	12	-8	9	-1	-<1
85/00	*-3*	*-8*	*4*	*4*	*53*	*4*	*24*

Source: Office for National Statistics and General Register Office for Scotland
Notes: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding. Percentage change over time is based on unrounded numbers.

Figure 2.11

People aged 65 and over, by age-band, Britain, 1985–2000

Numbers in thousands



Source: Office for National Statistics and General Register Office for Scotland

Table 2.10 and Figure 2.11 show that the number of older people, aged 65 and over, grew by approximately 8 per cent between 1985 and 2000. However, the increase in the number of 'older old' people, aged 80 and over, was much greater than this. The number of people aged 80 and over grew by over 30 per cent between 1985 and 2000, from approximately 1.8 million in 1985 to approximately 2.3 million in 2000 (Table 2.10). The most rapid increase in the older old population occurred during the periods 1985/90 and 1990/95, with a slowing down in the 1995/2000 period.

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During the period under study, the percentage increases in the number of older men exceeded the increases in the number of older women (Table 2.10). However, throughout the period, the number of women in the very old age-groups exceeded the number of men. In 1985, there were over two and a half times as many women aged 80 and over as men and, although this ratio decreased between 1985 and 2000, there were still over twice as many women aged 80 and over as men in 2000.

2.3.2 Trends in Marital Status of Older People

Trends in marital status are potentially important to demand for care by older people from their children because, as noted earlier, spouses or partners potentially offer an alternative source of informal care. Analysis of the 2001/02 GHS data on older people and the 2002 English Longitudinal Study of Ageing (ELSA) has shown that marital status is an important factor affecting sources of informal care for disabled older people (Pickard 2008c). Those who are married/cohabiting or single (never married) are considerably less likely to receive care from children than those who are widowed, divorced or separated. Assuming these relationships also applied to the period under study here, then it suggests that any increase in the numbers of older people with, in particular, spouses or partners between 1985 and 2000 could have reduced demand for care by children. Indeed, there is some evidence that informal care by spouses increased during the 1990s, although none of the studies reporting this trend has been concerned specifically with care for older people (Rowlands 1998; Hirst 2001).

Table 2.12 shows estimates of the legal marital status of people aged 65 and over by age and gender in Britain in 1985, 1990, 1995 and 2000. Information on legal, rather than *de facto*, marital status is utilised because *de facto* marital status information is not available for this cohort of older people, owing to their relatively low probability of cohabitation (Murphy 2000). The data on the legal marital status of older people utilised here (and in later chapters of this study) are based on data for England and Wales. The proportions in each marital status group in England and Wales, by age and gender, have been applied to the mid-year population estimates in Great Britain, by age and gender, to generate estimates of numbers in the population of Great Britain by marital status. The use of marital status data for England and Wales was necessary because of difficulty finding consistent time-series data for Scotland. The ONS marital status data for England and Wales for 1995 and 2000 are published data that have been revised in the light of the 2001 Census. However, ONS have not revised the marital status estimates for 1985 and 1990 in the light of the 2001 Census (ONS, personal communication). Therefore, the marital status data for 1985 and 1990, used here, are the original data prepared by OPCS (and kindly provided to the author by ONS).

Table 2.12

Legal marital status of people aged 65 and over, by age and gender, Britain, 1985–2000

Numbers in thousands and percentage change over time

	65+			80+		
	Married	**Single**	**Widowed/ divorced**	**Married**	**Single**	**Widowed /divorced**
Numbers						
All people						
1985	4,285	770	3,330	430	210	1,125
1990	4,580	740	3,480	550	220	1,270
1995	4,670	685	3,625	630	205	1,430
2000	4,815	635	3,640	670	185	1,460
Men						
1985	2,190	220	605	260	40	205
1990	2,340	240	650	325	50	230
1995	2,375	245	720	380	50	270
2000	2,450	250	765	410	50	285
Women						
1985	2,095	555	2,720	175	170	920
1990	2,245	500	2,825	225	175	1,040
1995	2,295	440	2,905	250	160	1,160
2000	2,365	385	2,875	265	135	1,175
Percentage change over time						
All people						
85/90	7	-4	5	27	6	13
90/95	2	-8	4	15	-6	13
95/00	3	-7	<1	6	-11	2
85/00	*12*	*-18*	*9*	*56*	*-11*	*30*
Men						
85/90	7	10	8	27	26	11
90/95	2	1	11	17	-2	18
95/00	3	3	6	8	7	5
85/00	*12*	*15*	*26*	*59*	*32*	*38*
Women						
85/90	13	-31	6	50	-21	28
90/95	7	-10	4	28	2	13
95/00	2	-12	3	13	-7	12
85/00	*13*	*-31*	*6*	*50*	*-21*	*28*

Sources: Mid-year population estimates (revised in the light of the 2001 Census) are published by ONS and General Register Office for Scotland; marital status estimates for 1985 and 1990 are based on unpublished data for England and Wales provided by ONS; marital status estimates for 1995 and 2000 and based on data for England and Wales published by ONS.
Notes: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding. Percentage change over time is based on unrounded numbers. For further details, see text.

Table 2.12 shows that, between 1985 and 2000, the percentage increase in the total number of married people aged 65 and over was greater than the percentage increase in the total number of widowed or divorced older people. The number of married people aged 65 and over increased by 12 per cent between 1985 and 2000, whereas the number of widowed or divorced people increased by only 9 per cent. The number of single

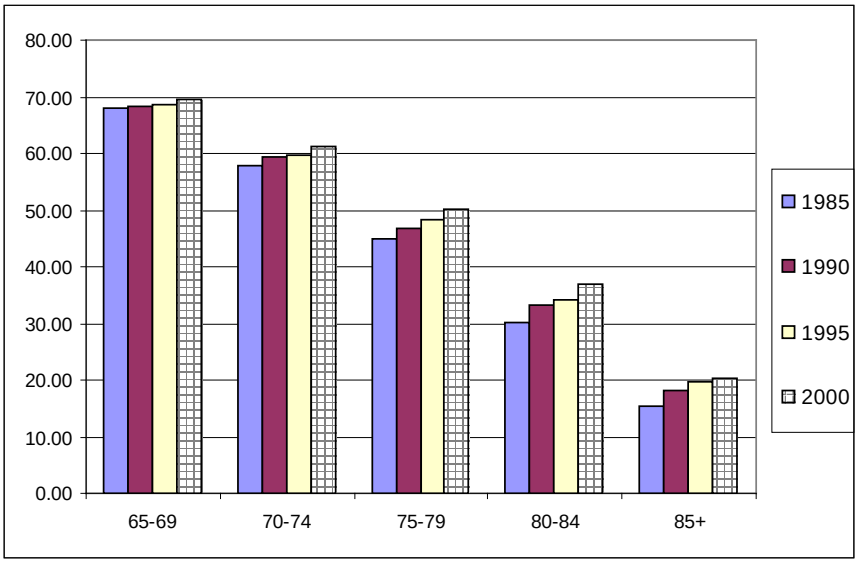
people declined between 1985 and 2000. These trends in marital status among the population aged 65 and over particularly reflected trends in women's marital status. The result of the trends was that the total number of married individuals aged 65 and over increased by over 500,000 between 1985 and 2000, whereas the total number of non-married individuals increased by less than 200,000. The trends among the older old population aged 80 and over were similar in that the percentage increase in married individuals exceeded the percentage increase in non-married individuals between 1985 and 2000 (Table 2.12). However, the absolute increase in the number of non-married individuals aged 80 and over (approximately 300,000) exceeded the absolute increase in the number of married individuals (approximately 250,000).

The effect of these marital status trends can be seen in Figure 2.13, which shows the proportion of older people by age-group over time who were legally married. The figure shows that, in each age-band, there was an increase in the proportion of older people who were married between 1985 and 2000. However, the increase in the proportion who were married over time appears to have been very gradual, suggesting that increases in spousal survival rates may have been offset by other factors, such as rising divorce rates. Moreover, among the older old population aged 80 and over, the overwhelming majority of people were non-married in all years examined between 1985 and 2000. Nevertheless, during the 1985/2000 period, the gradual increase in the percentage of older people who were married could have led to some substitution of care by spouses for care by children, an issue examined in Chapter Six.

Figure 2.13

People aged 65 and over who were legally married by age-band, Britain, 1985-2000

Percentage



Sources: See Table 2.12

2.3.3 Trends in the Prevalence of Disability among Older People

Demand for care by older people from their children is potentially affected not just by the numbers of older people and their marital status, but by their health status. Recent past trends in the health status of older people vary by severity. There is evidence that there was an increase in the prevalence of mild to moderate disability, or limiting long-term illness, among older people in Britain in the 1980s and 1990s (Bebbington and Darton 1996; Evandrou and Falkingham 2000; Kelly *et al* 2000). However, there is also evidence that the prevalence of more severe disability, measured in terms of the ability to perform Activities of Daily Living (ADLs) unaided, declined in the 1980s and 1990s (Bebbington and Darton 1996; Tallis 2003; Academy of Medical Sciences 2009).[1] This evidence is consistent with results from a number of other countries (Bone *et al* 1995; Manton *et al* 1997; Lafortune *et al* 2007). The trends in severe disability are particularly relevant to the present study since demand for long-term care is likely to be affected by the prevalence of severe disability (Wittenberg *et al* 2001).

Table 2.14 shows changes between 1985 and 2000 in more severe disability, by age and gender. The data are drawn primarily from Bebbington and Darton (1996), and are based on their analysis of the GHS data on older people living in private households in England and Wales between 1980 and 1995. Bebbington and Darton (1996: 10) define 'more severe' disability as *an inability to perform one or more ADLs or personal care tasks without help*, including an inability to perform bathing, transferring, feeding and getting to the toilet, using an amended version of an internationally recognised index of disability (Katz *et al* 1963). Bebbington and Darton's data have been supplemented here by the author's own analysis of the 2001/2 GHS data on older people. These disability prevalence rates will be utilised later in the study.

[1] Lafortune and colleagues report evidence from the Health Survey for England (HSE) that the proportion of disabled people in households rose between 1995 and 2000 in England (Lafortune *et al* 2007: 43-44). However, the trends in disability reported by Lafortune and colleagues include *difficulty* with personal care tasks, whereas the definition of severe disability more commonly used relates to an *inability* to perform personal care tasks unaided (Bebbington and Darton 1996, Tallis 2003). The results reported by Lafortune *et al* therefore include people with lower levels of disability than are more commonly included in the definition of severe disability.

Table 2.14

Prevalence of disability in the household population aged 65 and over, by age and gender, England and Wales, 1985-2000

Percentage

	1985	1990	1995	2000
men				
65-69	4	4	4	4
70-74	4	5	5	4
75-79	11	9	6	7
80-84	15	14	13	9
85+	23	21	18	16
women				
65-69	3	5	6	5
70-74	6	7	7	8
75-79	9	9	9	8
80-84	19	17	15	15
85+	33	29	25	24

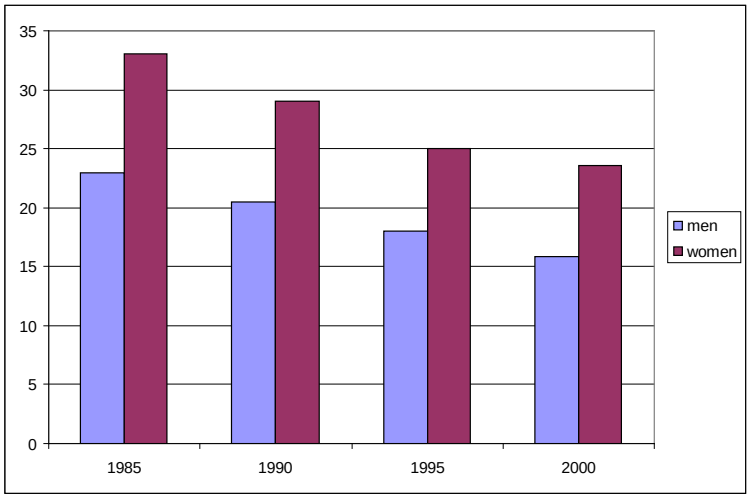
Sources: 1985 and 1995 are from Bebbington and Darton (1996), derived from GHS 1985 and 1994/5; 1990 is extrapolated from Bebbington and Darton's data for 1985 and 1995; 2000 is based on author's analysis of 2001/02 GHS.
Note: Disability is defined as an inability to perform at least one Activity of Daily Living (ADL), or personal care task, unaided.

Table 2.14 shows that the prevalence of more severe disability in the household population declined between 1985 and 2000, particularly among the older old population. Among men aged 85 and over, the proportion with severe disability declined from 23 per cent to 16 per cent, while among women of this age the prevalence of severe disability declined from 33 per cent to 24 per cent. (Figure 2.15).

Figure 2.15

Prevalence of disability in the household population aged 85 and over, by gender, England and Wales, 1985-2000

Percentage



Sources and Notes: see Table 2.14

The impact of declining disability rates on the absolute number of disabled older people in the household population between 1985 and 2000 is likely to have been affected by the changes in the characteristics of the older population, outlined in previous sections. The marked increase in the very old population would have had the effect of raising the number with severe disability, since disability rates rise sharply with age, whereas the changes in the gender balance of the older population might have had the opposite effect, since older men have lower levels of disability than older women (Tables 2.10, 2.14). Moreover, the total numbers of people with disability would have been affected by the disabled population in long-stay residential care. Changes in the total numbers of people in the older population with disability are examined in Chapter Eight.

2.3.4 Summary: Trends Affecting Demand for Care by Older People, 1985-2000

This section has examined trends in factors, other than changes in the availability of formal services, that are likely to have affected demand for intense informal care by older people from their children in the 1980s and 1990s in Britain. The section has identified factors that could have led to a rise in demand for care and factors that could have led to a fall in demand for care. On the one hand, the rise in the numbers of older people, particularly the rise in the numbers of people aged 80 and over, is likely to have *increased* demand for care. On the other hand, the increasing proportion of older people who were married, compared to those who were widowed or divorced, could have led to a *decline* in demand for care from children. The decline in the prevalence of severe disability might also have reduced demand for care. Finally, in addition to the effects observed in this section, the rise in long-stay residential care in the 1985 to 1995 period, and the rise in intensive home care in the 1995/00 period, could also have reduced demand for care. Analysis of the effects of these factors potentially affecting demand for care by older people from their children will form an important part of the empirical investigation conducted as part of this study (Chapters Six to Eight).

2.4 Trends Affecting the Supply of Informal Care, 1985-2000

If the central hypotheses of this study are correct, then changes in intense intergenerational care of older people would be related to demand for care by older people. However, as Chapter One indicated, it is also important to consider the impact of *supply*. It could also be hypothesised that changes in intense intergenerational care of older people are likely to be associated with changes in the availability of informal carers or the propensity of younger generations to provide informal care. Changes in the availability of informal carers are likely to be related to trends in factors affecting provision of informal care. The key factors affecting provision of informal care include age, gender, marital status and socio-economic factors (Parker and Lawton 1994; Richards *et al* 1996; Young *et al* 2005; Karlsson *et al* 2005). It is therefore trends in demography, marital status and socio-economic circumstances that are most likely to affect trends in informal care. These factors are explored in the three sections below in relation to the potential supply of intergenerational care between 1985 and 2000.

2.4.1 Demographic Trends Potentially Affecting Supply of Intergenerational Care

Provision of care to older parents is particularly associated with people in mid-life and the peak age-band for provision of care to parents is between the ages of 45 and 60 or 65 (OPCS 1992; Parker and Lawton 1994; Clarke 1995; Hirst 1999; Evandrou and Glaser 2002). Provision of intense intergenerational care is also particularly associated with gender, with daughters being more likely than sons to provide care to parents (Arber and Ginn 1991; Clarke 1995; Agree *et al* 2003). The literature suggests that women tend to be more involved than men in the 'heavy' end of care-giving to parents (Arber and Ginn 1991; Parker 1992; Parker and Lawton 1990, 1994).

Trends in the population in mid-life between 1985 and 2000 are affected by the baby boom generation. People aged 45 between 1985 and 2000, for example, were born between 1940 and 1955 and include the 'first baby boom generation'. As Evandrou and Falkingham (2000) point out, people born at this time share particular experiences: "The first baby boomers… were born in a period of post-war austerity, experiencing rationing and selective education. However, when they entered the labour market the economy was entering a period of relative *prosperity*. Not only was the job market buoyant, but the rapid expansion of higher education in the 1960s also meant that a

growing number stayed on at school and entered university. In addition to new opportunities in education and work, the introduction of the pill heralded a new sexual freedom" (Evandrou and Falkingham 2000: 28). Some of the implications of the rise of the baby boomers as potential care-providers will be examined in later sections. The point here is that the baby boomers represent a 'fat' cohort. To put it bluntly, there were a lot of them compared to earlier and later generations and this has implications for the numbers of people available to provide care to older parents at this time.

Table 2.16 below shows the numbers of people aged 16 and over, by age-band and gender, in Great Britain between 1985 and 2000. The source of the data in Table 2.16 is the same as that used earlier for the trends in numbers of older people, that is, official mid-year population estimates. The age-bands used in the table take State Pension Age into account. This prepares the ground for a later chapter (Chapter 5), which looks specifically at the relationship between trends in caring and employment. Five age-bands are used: 16-29; 30-44; 45-59/64; 60/65-74; and 75 and over.

The table shows that the number of people in mid-life, that is, between the ages of 45 and State Pension Age, rose by around 15 per cent between 1985 and 2000, with the increase primarily occurring between 1990 and 2000, particularly in the 1990/95 period. Similar trends were observed in the numbers of both mid-life women and men, although the proportionate rise in the number of mid-life women was slightly greater than that of mid-life men (Table 2.16).[1] The increase in the number of people in mid-life contrasts with trends in some earlier and later generations. For example, the numbers of people aged between 16 and 29 and between State Pension Age and 74 actually fell between 1985 and 2000.

Underlying demographic trends therefore imply that that there was, between 1985 and 2000, an overall increase in the number of people who were most likely to provide care for older parents, in particular, mid-life women. There was, in other words, a strong pool of potential care-providers, particularly during the 1990s, although consideration of other factors, like socio-economic circumstances, may present a somewhat different picture.

[1] The focus in this chapter is on people in mid-life, which the literature identifies as the peak age for caring for parents although, as the next chapter will show, the age-bands across which people provided care to older parents were somewhat broader than this.

Table 2.16

People aged 16 and over, by age-band and gender, Britain, 1985-2000

Numbers in thousands and percentage change over time

	Age-bands				
	16-29	**30-44**	**45-59/64**	**60/65-74**	**75+**
Numbers					
Men and women					
1985	12,110	11,040	10,525	6,460	3,550
1990	12,020	11,655	10,540	6,400	3,875
1995	10,790	12,100	11,490	6,410	3,970
2000	10,110	12,900	12,110	6,260	4,230
Men					
1985	6,130	5,545	5,965	2,120	1,175
1990	6,065	5,820	5,935	2,200	1,315
1995	5,420	6,010	6,380	2,280	1,375
2000	5,070	6,395	6,700	2,240	1,550
Women					
1985	5,985	5,495	4,560	4,335	2,375
1990	5,055	5,840	4,605	4,200	2,560
1995	5,375	6,090	5,110	4,130	2,595
2000	5,040	6,505	5,410	4,020	2,720
Percentage change over time					
Men and women					
85/90	-1	6	<1	-1	9
90/95	-10	4	9	<1	2
95/00	-6	7	5	-2	8
85/00	*-17*	*17*	*15*	*-3*	*20*
Men					
85/90	-1	5	-<1	4	12
90/95	-11	3	8	4	4
95/00	-6	6	5	-2	13
85/00	*-17*	*15*	*12*	*6*	*32*
Women					
85/90	-16	6	1	-3	8
90/95	6	4	11	-2	1
95/00	6	7	6	-3	5
85/00	*-16*	*18*	*19*	*-7*	*15*

Source: Office for National Statistics and General Register Office for Scotland
Note: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding. Percentage change over time is based on unrounded numbers.

2.4.2 Marital Status Trends Potentially Affecting Supply of Intergenerational Care

Marital status is related to provision of intense informal care. Analysis using the GHS has shown that the most heavily involved carers (those providing both physical and personal care) were very much more likely than non-carers to be single (Parker and Lawton 1994). This relationship is likely to apply particularly to care for older parents. Single (or divorced) offspring still living at home have been found to be more likely than married siblings to become involved in providing informal care for their parents (Glendinning 1992; Qureshi and Walker 1989). It has also been found that people providing co-resident care for parents, which tends to be more intense than extra-resident care, are more likely to be single than those with caring responsibilities elsewhere (Parker 1993a).

The key trends affecting changes in marital status of mid-life people between 1985 and 2000 are likely to have been the rise in the divorce rate and the rise in cohabitation, which meant that people increasingly preferred cohabitation to legal marriage (Haskey and Kiernan 1989; Kiernan and Estaugh 1993; Murphy 2000). These trends may have affected the pool of available care-providers in this period because of the relationship between marital status and provision of informal care. The rise in cohabitation raises an additional consideration, however, since the probability of providing care (not necessarily for a parent) is generally lower for people in cohabiting than marital unions (Pickard 2007).

Table 2.17 shows the trends in legal and *de facto* marital status among people aged 45 to 59/64 in Britain between 1985 and 2000. The table uses data on marital status from the GHS because the GHS contains information on cohabitation. However, analysis of trends over time using the GHS is complicated because information on *de facto* marital status was restricted in the 1985 GHS to adult women aged below the age of 50 (Murphy 2000). In subsequent years, information was collected on both adult men and women aged under 60. In Table 2.17, legal marital status is divided into single (including never-married, divorced, widowed or separated) and currently married, while *de facto* marital status is divided into single (never-married, divorced, widowed, separated and not cohabiting) and married or cohabiting.

Table 2.17

Legal and *de facto* marital status of population aged 45 to State Pension Age, Britain, 1985-2000

Percentage

	Legal marital status			*De Facto* Marital Status		
	Single	Married	Sample size	Single	Married/ Cohabiting	Sample size
1985	18.0	82.0	4,490	-	-	-
1990	19.4	80.6	4,310	18.1	81.9	4,360
1995	22.1	77.9	4,598	18.5	81.5	4,609
2000	25.8	74.2	4,006	20.5	79.5	4,006
1985/90	ns			-		
1990/95	**			ns		
1995/00	***			*		
1985/00	***			-		
1990/00	***			*		

Source: 1985, 1990, 1995, 2000 GHS (author's analysis).
*Notes: Asterix indicates significance of change over time at *(5%), **(1%) and ***(less than 1%), while 'ns' indicates no significant change over time. See text for definitions of legal and de facto marital status used in table.*

Table 2.17 shows that there were very large changes in the proportion of the population aged 45 to 60/64 by legal marital status between 1985 and 2000. The proportion of mid-life people who were legally single grew from 18 per cent to nearly 26 per cent, an increase that was statistically significant at less than one per cent. There was considerably less change in *de facto* marital status. Between 1990 and 2000, the proportion of people in mid-life who were *de facto* single rose from around 18 per cent to around 21 per cent, with most of the increase occurring between 1995 and 2000. Although not as large a change as that affecting legal marital status, there was nevertheless some statistically significant increase in the proportion of people who were *de facto* single in this period.

The increase in the single population between 1985 and 2000 would be expected to have had the effect of increasing the numbers of people likely to provide intense care because, as noted earlier, there is a relationship between being single and providing intense care. The fact that the rise in *de facto* single people was so much lower than the rise in legally single people may, however, have reduced the impact of these changes on informal care provision.

2.4.3 Socio-Economic Status Trends Potentially Affecting Supply of Intergenerational Care

Two indicators of socio-economic status are explored here, educational qualifications and employment status. Both are negatively associated with provision of intense informal care. In general, people with educational qualifications are less likely than those without educational qualifications to provide informal care for 20 hours a week or more (Young *et al* 2005; Pickard 2008b). However, the author is not aware of any studies in this country examining the relationship between education and intense care provision specifically for older parents. Agree and colleagues (2003), for example, look at the effect of educational qualifications on provision of care for parents, but do not look specifically at intense care. There is a substantial body of evidence showing a negative association between employment and provision of intense care (Joshi 1995; Carmichael and Charles 1998; Evandrou and Glaser 2002; Pickard 2004b; Arksey *et al* 2005; Young and Grundy 2008). It is likely that this negative association will particularly apply to people providing intense care to older parents because the majority of these are of 'working age' (Pickard 2008a). However, again the author is not aware of any studies in this country of the relationship between employment and intense intergenerational care specifically.

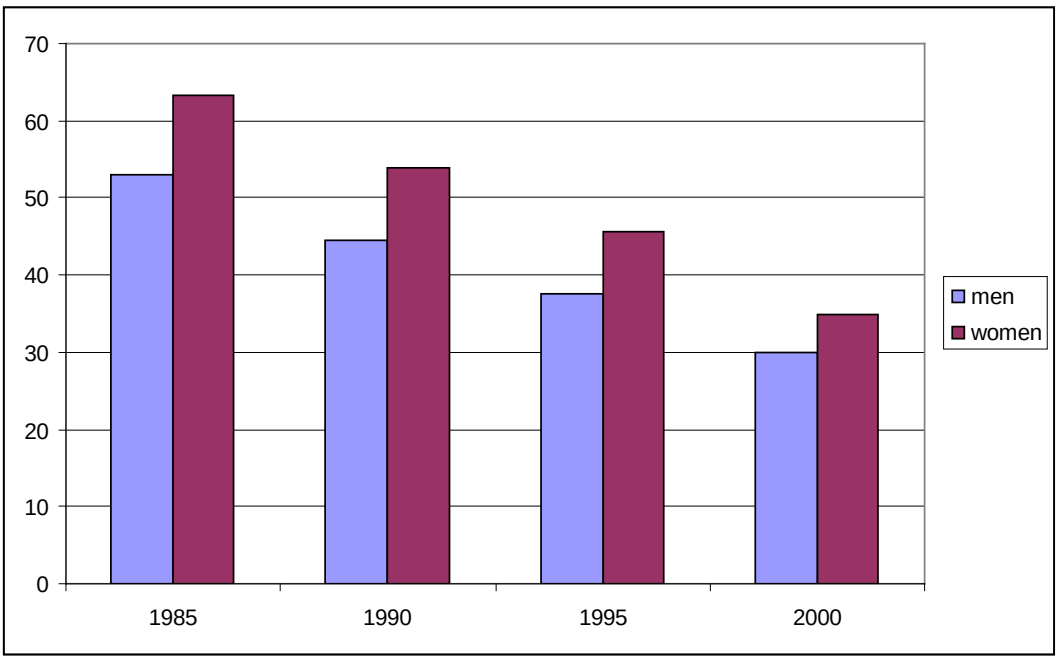
Trends in both education and employment are likely to be in the same direction in the period under study. There was, as noted earlier, a rise in both educational and employment opportunities for the 'first baby boom' generation. Rising educational standards are likely to reduce the probability of providing care (Pickard 2008b) while it is often argued that rising employment rates, especially among women and older workers, are likely to reduce provision of informal care (Allen and Perkins 1995; EPC 2001; Mooney *et al* 2002; Henz 2004; OECD 2006). The period of the 1980s and 1990s saw an increase in the labour market participation rates of mid-life women in particular, including an increase in the rates working full-time (Mooney *et al* 2002). Among men, on the other hand, there was a substantial decrease in economic activity during the 1980s, although this was accompanied by an increase in working hours for those who were at work and there was an increase in male economic activity after the mid-1990s (Mooney *et al* 2002: 8; Pensions Commission 2004).

Figure 2.18 shows the proportion of men and women aged 45 to 59/64 without educational qualifications between 1985 and 2000, using data derived from the GHS. There was a consistent, significant decline in the proportion of both men and women without educational qualifications between 1985 and 2000. The proportion of men without any qualifications fell from around half in 1985 to under a third in 2000. The change was even more pronounced for women. The proportion of women without educational qualifications fell from around two-thirds in 1985 to just over a third in 2000. These changes in educational qualifications were significant in each of the three five-year periods between 1985 and 2000. The meaning of educational qualifications, and hence their potential relationship with care provision is likely to have changed over time, however, and those without qualifications may have become increasingly marginalised as their proportions declined. Nevertheless, to the extent that educational qualifications were negatively associated with provision of intense informal care in this period then, other things being equal, it might have been be expected that these trends in education would have been associated with a decline in informal care provision.

Figure 2.18

Population aged 45 to State Pension Age without educational qualifications, by gender, Britain, 1985-2000

Percentage



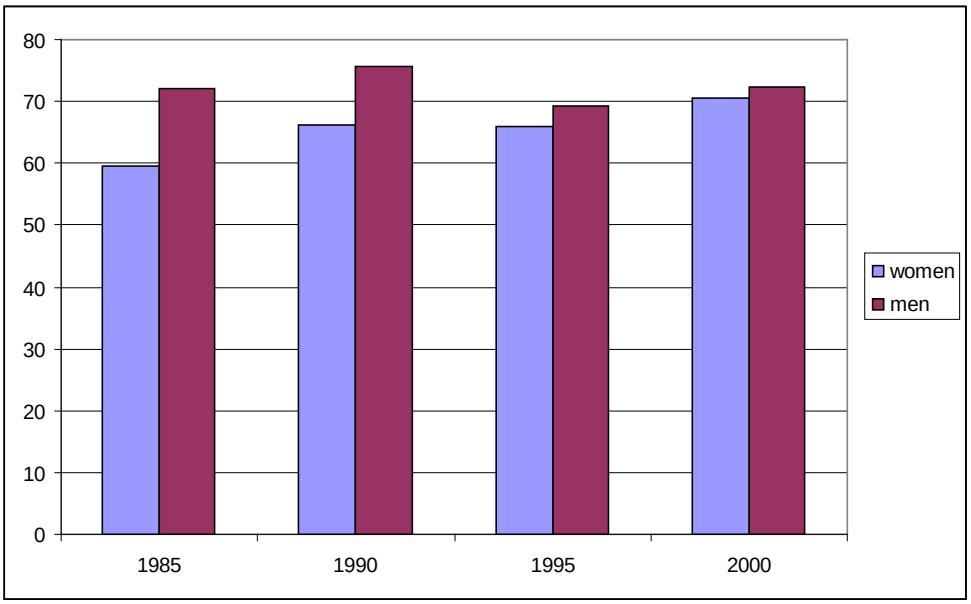
Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Figure 2.19 illustrates trends in the proportion of the mid-life population in employment by gender in Britain between 1985 and 2000, again using data from the GHS. The figure shows that the employment rates of women in mid-life increased significantly between 1985 and 2000, with significant rises between 1985 and 1990 and between 1995 and 2000. The trends in mid-life women's employment rates contrast to those of mid-life men in this period. The proportion of mid-life men in employment rose between 1985 and 1990 and between 1995 and 2000 but also fell significantly between 1990 and 1995. The result was that men's employment rates were approximately the same in 2000 as they had been in 1985, whereas women's rates had risen significantly. There is evidence from the GHS and the Labour Force Survey (examined in more detail in Chapter Five) that women's full-time employment rates followed similar trends. These trends in employment rates may have had implications for the provision of informal care. Those most likely to provide intense intergenerational care, that is, mid-life women, were experiencing increasing employment rates, including increases in full-time employment rates, particularly in the 1985/90 and 1995/2000 periods. Since employment, especially full-time employment, is negatively associated with provision of intense informal care, these trends might, other things being equal, have been associated with a decline in informal care provision.

Figure 2.19

Labour market participation rates of population aged 45 to State Pension Age, by gender, Britain, 1985-2000

Percentage



Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

2.4.4 Summary: Trends Affecting Supply of Informal Care, 1985-2000

The trends affecting the supply of informal care between 1985 and 2000 may potentially have been pulling in different directions. On the one hand, there was a rise in the absolute number of people in mid-life, among whom provision of care for parents is concentrated, particularly between 1990 and 2000. The availability of potential care-providers was increased by the rise in the probability of being single during this period, since single people in mid-life are more likely to provide intense care to parents than those who are married or cohabiting. On the other hand, the rise in both educational qualifications and employment rates, particularly among women in mid-life, was likely to have suppressed the probability of providing intense informal care, since intense informal care is associated negatively with both education and employment. The precise impact of these trends on the provision of intense care for parents is, however, likely to have depended partly on the strength of the association between each factor and intense care for parents. The existing literature has not addressed all of these associations, and this will be an area examined in later chapters of this study (Chapters Three, Four and Five).

2.5 Conclusions

This chapter has provided a descriptive account of trends in key factors that might potentially have affected provision of intense informal care to older parents in the period between 1985 and 2000 in Britain. Key demand-side factors considered include the availability of long-stay residential care, the availability of intense home care, the numbers of older people, particularly the 'older old', the prevalence of disability among older people and the marital status of older people. Key supply-side factors include the numbers, age and gender composition of potential care-givers and their marital status, educational qualifications and employment rates.

The trends in the key factors potentially affecting provision of intense care for older parents in Britain between 1985 and 2000 are summarised in Table 2.20 (at the end of the chapter). The table shows, for each demand-side and supply-side factor considered, its likely impact on intense intergenerational care provision, the nature of key trends and the period in which they operated. Blank boxes indicate that there was not likely to have been a strong or significant effect in either direction at that time. The table provides a useful summary of the trends in key factors potentially relevant to this study.

Many of the trends potentially affecting informal care provision continued throughout the period under study, but there were a number of trends that did not do so (Table 2.20). In particular, the increase in the availability of long-stay residential care, which might have affected demand for intense informal care, only occurred between 1985 and 1995; the increase in the employment rates of mid-life women, which might have affected the supply of intense informal care, only occurred in the 1985/1990 and 1995/2000 periods; the increase in the numbers of older people, a demand-side factor, was particularly concentrated in the 1985/1995 period; while the increase in the numbers of potential care-givers, a supply-side factor, was potentially most important in the 1990/2000 period.

The next chapter will examine the changes in provision of intense care for parents that took place between 1985 and 2000 in Britain. The trends identified in the present chapter (and summarised in Table 2.20) will then inform potential explanations of these changes. If, for example, there was a decline in intense intergenerational care between 1985 and 1990, then potential demand-side explanations would include the increase in long-stay residential care rate that took place at this time, the decline in prevalence of disability and the increase in the proportion of older people who were married, while potential supply-side explanations would include the rise in educational standards and the rise in employment rates among potential care-givers that were also taking place at this time (Table 2.20). Indeed, Table 2.20 provides a useful reference point throughout the study and there is reference back to the table at the end of Chapters Three, Four, Five and Six and in the final conclusions (Chapter Nine).

The summary presented in Table 2.20 suggests that there may have been greater forces tending towards a decline than an increase in intense informal care for older parents in Britain between 1985 and 2000. However, the precise impact of these forces depends on the strength of association between each factor and intense intergenerational care provision or receipt. Investigation of the associations between explanatory factors and both provision, and receipt, of intense intergenerational care will be an important part of the present study.

Finally, it should be noted that not every factor potentially affecting the supply of, and demand for, intense intergenerational care has been considered in this chapter. Chapters Three and Seven contain further details on other variables that might have been considered in the study and the theoretical, technical and practical reasons for the selection of the precise variables included.

Table 2.20

Trends in key factors potentially affecting provision of intense care for older parents, Britain, 1985-2000

Possible impact on provision of intense care for parents	Demand- or supply-side effect	Type of effect on intense care for parents	1985-1990	1990-1995	1995-2000
Decline	Demand-side	Trends in formal service provision for older people	Increase in long-stay residential care rate	Increase in long-stay residential care rate	Increase in intensive home care
		Trends in prevalence of disability among older people	Decline in prevalence of disability	Decline in prevalence of disability	Decline in prevalence of disability
		Trends in marital status of older people	Increase in proportion married	Increase in proportion married	Increase in proportion married
	Supply-side	Trends in education of potential care-givers	Increase in per cent with educational qualifications	Increase in per cent with educational qualifications	Increase in per cent with educational qualifications
		Trends in employ-ment rates of potential care-givers	Increase in employment rates of mid-life women		Increase in employment rates of mid-life women
Increase	Demand-side	Trends in numbers of older people	Increase in numbers of older people, especially 'older old'	Increase in numbers of older people, especially 'older old'	
		Trends in formal service provision for older people			Decline in numbers in long-stay residential care
	Supply-side	Trends in numbers of potential care-givers		Increase in numbers of people in mid-life, especially women	Increase in numbers of people in mid-life, especially women
		Trends in marital status of potential care-givers			Increase in proportion of mid-life people who were *de facto* single

Sources: see text

Chapter 3

Trends in Intense Informal Care for Older Parents, 1985-2000

As Chapter One observed, adult children make up the largest proportion of all carers in Britain today (Maher and Green 2002: 13). The objective of the present chapter is to identify key trends in the provision of intergenerational care for older people between 1985 and 2000. The chapter utilises the four General Household Survey (GHS) data sets on the provision of informal care, the 1985, 1990, 1995 and 2000 data sets, to look at changes between 1985 and 2000 in the provision of care for older parents.

The analysis of trends in intergenerational care in the present chapter takes place within the context of the key research issues of this study. As Chapter One indicated, a key concern of the study is to explore the relationship between changes in the provision of informal care and changes in the provision of long-stay residential care. The study therefore focuses particularly on *intense* forms of intergenerational caring that might constitute an alternative to residential care.[1] Particular attention is paid to the *timing* of identified trends in intergenerational care. If changes in the relationship between the provision of informal care and the provision of residential care are to be examined, then the timing of any changes in unpaid care is likely to be very important. As Chapter Two indicated, the GHS data used in the present study generate three five-year time periods, 1985/90, 1990/95 and 1995/2000, and particular attention is paid here to the timing of the trends in provision of intense intergenerational care during each of these three time periods. It should also be borne in mind that the trends identified here relate only to *informal care provided to older people aged 65 and over*.

Existing studies of trends in informal care have tended to identify an intensification of caring in this country in the recent past (Parker 1998; Hirst 2001, Evandrou and Glaser 2002). Evandrou and Glaser, for example, in a cohort study using the same GHS data as the present study, identified an increase in the probability of people in mid-life providing informal care for over 20 hours a week in Britain between 1985 and 2000, an increase that affected women more than men (Evandrou and Glaser 2002). However, Evandrou and Glaser's study was concerned with intense care provided for all types of care-recipients and was not focused particularly on care for older parents.

[1] Changes over time in the propensity to provide care by different types of carer are examined in Chapter Six, which compares trends in care for parents with trends in care for spouses.

Where studies have differentiated between care-recipients, the evidence suggests that trends in care for parents may have been somewhat different. For example, Hirst's analysis of British Household Panel Survey (BHPS) data between 1991 and 1998 found evidence of an increase in extra-resident care by women between 1991 and 1998 and this contrasted with Hirst's more general finding that there had been "an increase in the more intensive caring relationships within households" (Hirst 2001: 354). Indeed, Hirst noted that the increase in extra-resident care provided to parents was "the reverse of the overall shift from extra-resident to co-resident caregiving" (Hirst 2002: 353).[1] Studies of provision of informal care to parents and parents-in-law using multiple years of the GHS, carried out so far, have not been concerned primarily with trends over time but have nevertheless tested for changes between years and have found few differences (Agree *et al* 2003; Henz 2009). However, the studies by neither Agree and colleagues nor Henz controlled fully for locus of care. Moreover, none of the trends in care specifically for parents, described so far, relate to intense care and indeed only Hirst (2001) has looked at intense care for parents. In relation to 'heavy duty' carers providing care for 20 hours a week or more, Hirst could identify no significant changes between 1991 and 1998, either in extra-resident or co-resident forms of care (Hirst 2001: 353, Table 6). Hirst's analysis, however, relates to all intergenerational carers and is not specifically concerned with intergenerational carers of *older* people. Indeed, there has been no systematic study as yet of provision of intense care for older people specifically by their children that charts recent trends and changes.

The existing studies nevertheless suggest some key parameters affecting trends in caring that need to be taken into account in the present study. These parameters include, first, the characteristics of care-providers. Several studies suggest that trends in informal care provision may vary by such characteristics as age and gender (Hirst 2001, Evandrou and Glaser 2002). Second, the studies suggest that trends may vary by the intensity of care provided. Hirst, for example, found an increase in extra-resident care for parents in general, but not in intense forms of extra-resident care provided for 20 hours a week or more (Hirst 2001). Third, the studies suggest that trends in caring may vary by the locus of care, with Hirst's study suggesting an increase in women's extra-resident but not co-resident care for parents in the 1990s. Existing studies therefore suggest that

[1] Unpublished research by Glaser (2007) also suggests that there was an increase in care for older people by children living outside the household during the 1990s, although Glaser's study looks at receipt of care, not its provision; uses two different surveys to compare over time and is concerned only with 'younger old' people aged 61 to 69.

trends in informal care need to be analysed in terms of three parameters: the characteristics of care providers, the intensity of care provided and the locus of care provided.

These three parameters are taken into account in the present chapter in the following ways. The analysis of intense care for parents throughout this study distinguishes two different measures of the intensity of care. These are defined as care for 20 hours a week or more (described as 'intense' care) and care for 50 hours a week or more (described as 'very intense' care). These measures of intensity of care are utilised here primarily because, as Chapter One indicated, they are well established in the British literature on informal care. In particular, trends in informal care for 20 and/or 50 hours a week or more have been examined in other British studies of informal care during the 1985/2000 period (Hirst 2001, Evandrou and Glaser 2002), facilitating comparison between the results of the present study and those of previous research. A distinction between the two different loci of care, co-resident and extra-resident care, is also used. This means that the present chapter focuses on trends in four types of intense intergenerational care: intense co-resident, intense extra-resident, very intense co-resident and very intense extra-resident care. (The derivation of variables relating to these four types of care from the GHS data is described in Appendix 3A at the end of the chapter.) The key characteristics utilised to analyse trends in the four types of intense intergenerational care are age, gender, marital status and socio-economic circumstances. Their potential relevance to intense informal care provision has already been described (Chapter Two).

The first part of the present chapter undertakes a multivariate analysis of the relationship between these variables and each type of intense care for older parents between 1985 and 2000, in order to identify the variables significantly associated with each type of care. In the second part of the chapter, trends in each type of intense care for parents are analysed. The chapter identifies significant changes in the proportion of people providing care between 1985 and 2000, first, by intensity and locus of care, and then by intensity, locus and key characteristics. The chapter ends with a discussion of the results and, using the table given at the end of Chapter Two, identifies a number of possible explanations for the trends identified, which will then be systematically examined in the remainder of the study.

3.1 Characteristics of People Providing Intense Care to Older Parents

3.1.1 Identification of Factors Potentially Affecting Informal Care Provision

Four factors likely to affect provision of informal care are examined in this chapter: age, gender, marital status and education. As Chapter Two indicated, there are studies showing that age, gender and marital status are all associated with provision of intense care to older parents (Qureshi and Walker 1989; Arber and Ginn 1991; Glendinning 1992; Parker 1992; Parker 1993a; Parker and Lawton 1990, 1994; Clarke 1995; Hirst 1999; Agree *et al* 2003). There are also more general studies showing a relationship between education and intense informal care provision (Young *et al* 2005; Pickard 2008b) although the author is not aware of any earlier studies that have looked at the relationship between education and intense care for older parents specifically. The present chapter could have included a number of other variables, such as employment status, housing tenure, health and ethnicity (cf. Leontaridi and Bell 2001; Young *et al* 2005). However, the analysis here includes logistic regression analysis and there are analytical limitations restricting the extent to which some variables can be included in explanatory models. Indeed, modelling the provision of informal care is particularly difficult because many variables are potentially endogenously related to provision of care (Parker and Lawton 1994; Richards *et al* 1996). As Parker and Lawton point out: "Beyond those characteristics which are unchangeable – age and sex - we cannot be absolutely sure about the direction of the relationship between caring and other variables" (1994: 23-24). This suggests that, apart from age and gender, other variables might be endogenously related to informal care and therefore there is a need to justify the inclusion of all other variables in the analysis. The paragraphs below examine the reasons for including variables, other than age and gender, in the present analysis.

Careful consideration was given before including marital status in the analysis. As already indicated (Chapter Two), marital status is related to provision of care, with single people being more likely to provide 'heavy duty' care than married people (Parker and Lawton 1994). It may not be clear, however, in what direction the relationship lies: people may remain single because they are carers or may become carers because they are single (Parker and Lawton 1994). However, in the case of intense intergenerational care for older parents, where caring is provided at a relatively late stage in the life course, the main direction of the relationship is unlikely to be from

provision of care to marital status. As Parker and Lawton observe, caring is more likely to alter the chances of the carer's marrying when caring occurs at a relatively early stage in life (Parker and Lawton 1994: 25). Nevertheless, before including marital status in the analysis of informal care, the potential endogeneity in this relationship was examined. This was done by identifying single carers who had been caring for a long time and who may have started caring at a young age. The results, which use GHS data for 1985, 1995 and 2000, are reported in Appendix 3B at the end of the chapter. The results show that only around 4 per cent of single carers had both been providing care for a long time (5 years or more) and had started caring at a young age (under the age of 30). This suggests that the direction of any relationship between marital status and intergenerational care for older parents, in the period under consideration, is unlikely to be from care to marital status and it therefore seemed appropriate to include marital status in the analysis. This is consistent with other modelling of informal care, which includes marital status as an independent variable (e.g. Richards *et al* 1996).

A number of socio-economic variables were considered for inclusion in the analysis here. Education was chosen because it is unlikely to be related endogenously to informal care provision, given that educational qualifications tend to be acquired relatively early in the life course. Employment was excluded in the explanatory modelling here because of its potentially endogenous relationship to provision of informal care (Richards *et al* 1996) but is considered separately later (Chapter Five). Housing tenure was also excluded from the modelling because of its potentially endogenous relationship with informal care provision in this particular period of British history. During the time period under consideration, which included the late 1980s, housing tenure may have changed relatively late in the life course for very large numbers of people. This is because under the 'Right to Buy' scheme, introduced in 1980, many well-established public tenants became home owners. It is possible that, under these circumstances, providing care intensively may have prevented some tenants from becoming owner-occupiers and therefore, in any relationship between care and tenure, care may have assumed causal primacy, not tenure.

Finally, consideration was given to two further variables, health and ethnicity. Recent modelling elsewhere has included self-rated health in the determination of provision of informal care (Young *et al* 2005). The modelling suggests that people in poor health are more likely to provide care. However, the informal care literature suggests that health

may be an endogenous variable in relation to informal care. People with poor health may be more likely to provide informal care because they are already outside the labour market (Parker & Lawton 1994), but provision of informal care may also adversely affect health (Evandrou 1996, Hirst 1998). Given the potentially endogenous relationship between health and provision of care, health has been excluded from the modelling of informal care here. It would have been desirable to include ethnicity in the analysis since ethnicity has been found to be related to provision of intense informal care (Young *et al* 2005). However, the number of people in relevant age-groups of the ethnic minority population is too small to allow for consideration of ethnicity as a factor in provision of care to older parents using the GHS, particularly where trends over time are under consideration (cf. Evandrou 2000).

In summary, then, the analysis of intense informal care for older parents here includes four key variables; age, gender, marital status and education. Each of these variables can be justified for inclusion in an explanatory analysis of intense informal care for older parents in Britain between 1985 and 2000.

3.1.2 People Providing Intense Care to Older Parents: Bivariate Analysis

The definitions of the variables affecting provision of informal care follow on from the analysis in the previous chapter. As explained in Chapter Two, age is broken down into categories that take State Pension Age into account. Five categories are used here: 16-29; 30-44; 45-59/64; 60/65-74; and 75 and over. Analysis of marital status over time using the GHS is complicated by the fact that it seems important to take cohabitation into account, yet *de facto* marital status was not recorded in the 1985 GHS. The definition used here is therefore in terms of *de facto* marital status in 1990, 1995 and 2000 and legal marital status in 1985. However, as noted in Henz's study using multiple years of the GHS, the potential exclusion of cohabitation in 1985 is unlikely to have much effect because the proportions of cohabitants were "low in later years and had presumably been even lower in 1985" (Henz 2009: 376). *De facto* marital status is here divided into single (never married, divorced, widowed, separated and not cohabiting) and married or cohabiting. Legal marital status is divided into single (never married, divorced, widowed, separated) and currently married. Educational qualifications are divided into those with and without educational qualifications, but it should be noted that these data are not available in the GHS for people aged 70 and over. Education is coded as a dichotomy between no qualifications and some

qualifications because, although other research has shown differences in provision of intense informal care by type of qualification (Young *et al* 2005), in the period under study here, there was a high proportion of people without any qualifications in key potential care-giving groups, particularly in the early years (Chapter Two, Figure 2.18). As a corollary, sample sizes of those with, for example, higher educational qualifications were small.

Table 3.1 shows the proportion of adults providing different types of intense care to older parents in Britain between 1985 and 2000 by key characteristics. The table combines the data for 1985, 1990 1995 and 2000 in order to maximise sample size.[1] The underlying sample numbers for Table 3.1 are shown in Appendix C at the end of this chapter (Table 3C.1). The GHS is an approximately equal probability sample, but from 2000, the data have been provided with weights to compensate for sample design and known patterns of non-response (Agree *et al* 2003: 30). Because weights are not available in 1985, 1990 or 1995, for consistency, the analyses here utilise unweighted data.

The data show that most adults providing intense care to older parents were under State Pension Age (Appendix 3C, Table 3C.1). Indeed, among people providing care to older parents for 20 hours a week or more, 83 per cent were under State Pension Age (Table 3C.1). Nearly all adults aged 16 and over who were providing intense or very intense care to parents were in fact aged between 30 and 74 (Table 3C.1). Of the 735 people in the sample providing care for 20 or more hours a week, only 16 (2 per cent) were either under the age of 30 or aged 75 or more (Table 3C.1). For this reason, *it was decided to confine the analysis of provision of care to those aged between 30 and 74*. Other analyses of intergenerational care have also focused on a restricted age-range of the adult population, with Agree and colleagues (2003), for example, focusing on people aged 35 to 59.

Table 3.1 shows that the proportion of people aged between 30 and 74 providing intense and very intense care was highest among those in mid-life (aged between 45 and State

[1] The numbers of people providing intense care to older parents in the GHS samples is relatively small particularly if considered by intensity, locus and characteristics, as well as over time. The small sample numbers also mean that probabilities of providing care are also relatively small. This is a consideration in data analysis and (in later chapters) in the interpretation of the results.

Pension Age). It was higher for women than for men, for single than for married/cohabiting people and for those with no qualifications than for those with some qualifications. These relationships applied, with few exceptions, to both co-resident and extra-resident care, whether intense or very intense. One important exception was that the proportion providing extra-resident care for 20 or more hours a week was higher for married/cohabiting than single people (Table 3.1).

The overall proportions providing care by intensity and locus varied considerably. Table 3.1 shows that, in the 1985/2000 period, approximately 1.5 per cent of all people aged 30 to 74 provided intense care for 20 or more hours a week to older parents and this was fairly evenly divided between co-resident and extra-resident care. Table 3.1 also shows that the proportion of people aged 30 to 74 providing very intense care for 50 or more hours a week was around 0.5 per cent, but that nearly all of this care was provided on a co-resident basis. Indeed, approximately 85 per cent of all those providing very intense care for older parents did so on a co-resident basis (Appendix 3C, Table 3C.1). This suggests that, even among those providing intense care, there is still a strong relationship between intensity and co-residence.

Table 3.1

Proportion of the population aged 16 and over providing informal care to older parents for 20 and 50 hours a week or more, by locus of care and key characteristics, Britain, 1985-2000 (bivariate analysis)

(a) Intense care (20 hours a week or more) *Percentages*

Characteristics	Categories	Locus of care		All care for 20+ hours p.w.
		Co-resident	Extra-resident	
Age-group	16-29	0.05	0.05	0.10
	30-44	0.36	0.60	0.96
	45-59/64	1.08	1.26	2.32
	60/65-74	0.71	0.58	1.30
	75+	0.02	0.00	0.02
Gender[#]	Men	0.59	0.47	1.06
	Women	0.82	1.17	1.98
Marital status[#]	Married/cohabiting	0.48	0.89	1.37
	Single	1.48	0.68	2.16
Education[#]	Some qualifications	0.62	0.87	1.48
	No qualifications	0.97	0.97	1.93
All[#]		0.71	0.84	1.55

(b) Very intense care (50 hours a week or more)

Characteristics	Categories	Locus of care		All care for 50+ hours p.w.
		Co-resident	Extra-resident	
Age-group	16-29	0.01	0.01	0.03
	30-44	0.20	0.04	0.24
	45-59/64	0.56	0.12	0.68
	60/65-74	0.49	0.07	0.55
	75+	0.02	0.00	0.02
Gender[#]	Men	0.26	0.03	0.29
	Women	0.52	0.12	0.64
Marital status[#]	Married/cohabiting	0.25	0.07	0.33
	Single	0.89	0.08	0.97
Education[#]	Some qualifications	0.32	0.05	0.37
	No qualifications	0.59	0.13	0.72
All[#]		0.40	0.08	0.47

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: [#] indicates people aged 30 to 74. Marital status is de-facto marital status except in 1985 since only legal marital status is available in the 1985 GHS; 'single' people include single (never married), widowed, divorced, separated; 'married' people include those legally married and those cohabiting. Qualifications relate only to the population aged under 70 years in the GHS.

3.1.3 People Providing Intense Care to Older Parents: Multivariate Analysis

This section examines the factors affecting provision of intense and very intense care for older parents using multivariate analysis, controlling for age, gender, marital status and education. As in the previous section, the data for all four years covered by the GHS data on provision of informal care are pooled. Variable definitions follow those given at the beginning of the previous section.

The section reports on four separate models. One model covers co-resident and extra-resident care provided for 20 hours a week or more using multinomial regression. The second model uses a binary logistic regression model to look at all care for 20 hours a week or more. The third model covers co-resident and extra-resident care provided for 50 hours a week or more using multinomial regression. The fourth model uses a binary logistic regression model to look at all care for 50 hours a week or more. In the logistic regression analyses that follow, all the independent variables were initially entered into the model as main effects on a 'forced entry' basis. Any non-significant variables were then removed and the final results reported here. The reference category for the dependent variables in all models is either 'does not provide care for 20 hours week or more' or 'does not provide care for 50 hours a week or more'. The results are reported in Table 3.2 (on the next page).

The first part of Table 3.2 shows that provision of care for 20 hours a week or more for older parents was significantly associated with three variables, age, gender and marital status. Controlling for these variables, education was not significantly associated with intense care provision and was removed from the model. Age and gender were significantly associated with both co-resident and extra-resident care, but marital status was associated only with co-resident care (Table 3.2a). The second part of Table 3.2 shows that provision of very intense care for 50 or more hours a week was associated with all four variables, that is, age, gender, marital status and education. Again, the factors associated with co-resident care differed from those associated with extra-resident care. All four variables were significantly associated with co-resident very intense care provision, but marital status was not significant for extra-resident very intense care provision (Table 3.2b).

Table 3.2

Results from logistic regression models of proportion of the population aged 30 to 74 providing care to older parents for 20 and 50 hours a week or more, by intensity and locus of care, Britain, 1985-2000 (multivariate analysis, showing odds ratios)

(a) Intense care (20 hours a week or more) *Odds ratios*

Characteristic	Categories	Locus of care (model 1)		All care for 20+ hours p.w. (model 2)
		Co-resident	Extra-resident	
Age-group	30-44	1.0	1.0	1.0
	45-59/64	***3.18	***2.25	***2.62
	60/75-74	**1.60	0.91	1.16
Gender	Men	1.0	1.0	1.0
	Women	**1.36	***2.80	***2.01
Marital status	Married/cohabiting	1.0	ns	1.0
	Single	***3.23	ns	***1.61
Education	With qualifications	ns	ns	ns
	No qualifications	ns	ns	ns

(b) Very intense care (50 hours a week or more)

Characteristic	Categories	Locus of care (model 3)		All care for 50+ hours p.w. (model 4)
		Co-resident	Extra-resident	
Age-group	30-44	1.0	1.0	1.0
	45-59/64	***2.79	*3.04	***2.83
	60/75-74	***2.42	1.40	***2.22
Gender	Men	1.0	1.0	1.0
	Women	***1.84	**5.37	***2.13
Marital status	Married/cohabiting	1.0	ns	1.0
	Single	***3.45	ns	***2.96
Education	With qualifications	1.0	1.0	1.0
	No qualifications	*1.36	*2.15	**1.46

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
*Notes: Asterix indicates association at *(5%), ** (1%) and ***(less than 1%); ns indicates no significant association. Marital status is defined as legal marital status in 1985 and as de facto marital status in 1990, 1995 and 2000. In model 1, extra-resident and co-resident care for 20+ hours per week were modelled together using multinomial regression; in model 2, care for 20 hours a week or more was modelled using binary logistic regression; in model 3, extra-resident and co-resident care for 50+ hours per week were modelled together using multinomial regression; and in model 4, care for 50 hours a week or more was modelled using binary logistic regression. Models including education exclude those aged over 70.*

In summary, the key findings of this section are that, in the 1985/2000 period, age and gender were significantly associated with all forms of intense and very intense care for older parents (Table 3.2). People in mid-life were more likely than those in other age-groups to provide care, and women were more likely than men to do so. Marital status was associated with co-resident care only, with single people more likely to provide care than those who were married or cohabiting. Educational qualifications were associated with very intense care only. Those with no qualifications were more likely to provide care than those with some qualifications. The factors associated with the provision of the different types of intense care for parents are potentially important in the analysis of trends in care provision, and this is the subject of the next part of the chapter.

3.2 Trends in Provision of Intense Care to Older Parents, 1985-2000

3.2.1 Overall Trends in Provision of Intense Care to Older Parents

This section examines the overall trends in provision of intense care to older parents, with the following section looking at trends by key characteristics of care providers. The overall trends are summarised in Table 3.3, which shows the proportion of the population aged 30 to 74 providing care in 1985, 1990, 1995 and 2000, together with 95% Confidence Intervals. The significance of changes over time are examined using Chi-square associations over time in each of the three five-year periods, 1985/90, 1990/95 and 1995/2000, as well as during the 10-year period between 1985 and 1995 and during the fifteen year period between 1985 and 2000. Sample numbers and the underlying sample base for Table 3.3 are given in Appendix 3C, Table 3C.2. As explained in the previous part of the chapter, the focus is on care provided by people aged 30 to 74.

A key finding of Table 3.3 is that, between 1985 and 2000, *there were more changes affecting very intense care for older parents than intense care* (Table 3.3). All care for 50 hours a week or more declined significantly between 1985 and 2000, whereas there were no significant changes in provision of all care for 20 hours a week or more. During the fifteen year period between 1985 and 2000, there was a fall in the proportion of people providing very intense care of nearly 50 per cent, from 0.64 per cent of people aged 30 to 74 to 0.37 per cent. The decline in very intense care was concentrated in the ten-year period between 1985 and 1995 and in particular in the five-year period between 1990 and 1995.

Table 3.3

Proportion of the population aged 30 to 74 providing care to older parents for 20 and 50 hours a week or more, by locus of care and changes over time, Britain, 1985-2000

(a) Intense care (20 hours a week or more) *Percentages*

Year	Co-resident		Extra-resident		All care for 20+ hours pw	
	%	95% Confidence Intervals	%	95% Confidence Intervals	%	95% Confidence Intervals
1985	0.78	0.64-0.95	0.66	0.53-0.82	1.45	1.25-1.67
1990	0.85	0.70-1.03	0.86	0.71-1.04	1.71	1.49-1.96
1995	0.57	0.45-0.73	0.96	0.80-1.15	1.52	1.32-1.75
2000	0.62	0.49-0.79	0.92	0.75-1.12	1.52	1.30-1.77
All years	*0.71*	*0.64-0.79*	*0.84*	*0.77-0.93*	*1.55*	*1.44-1.67*
85/90	ns		ns		ns	
90/95	*		ns		ns	
95/00	ns		ns		ns	
85/95	*		*		ns	
85/00	ns		*		ns	

(b) Very intense care (50 hours a week or more)

Year	Co-resident		Extra-resident		All care for 50+ hours pw	
	%	95% Confidence Intervals	%	95% Confidence Intervals	%	95% Confidence Intervals
1985	0.58	0.46-0.73	0.06	0.03-0.12	0.64	0-51-0.79
1990	0.45	0.34-0.58	0.08	0.04-0.14	0.52	0.41-0.67
1995	0.25	0.18-0.36	0.09	0.05-0.16	0.34	0.25-0.46
2000	0.30	0.21-0.42	0.08	0.04-0.16	0.37	0.27-0.51
All years	*0.40*	*0.35-0.46*	*0.08*	*0.05-0.10*	*0.47*	*0.42-0.54*
85/90	ns		ns		ns	
90/95	*		ns		*	
95/00	ns		ns		ns	
85/95	***		ns		**	
85/00	**		ns		**	

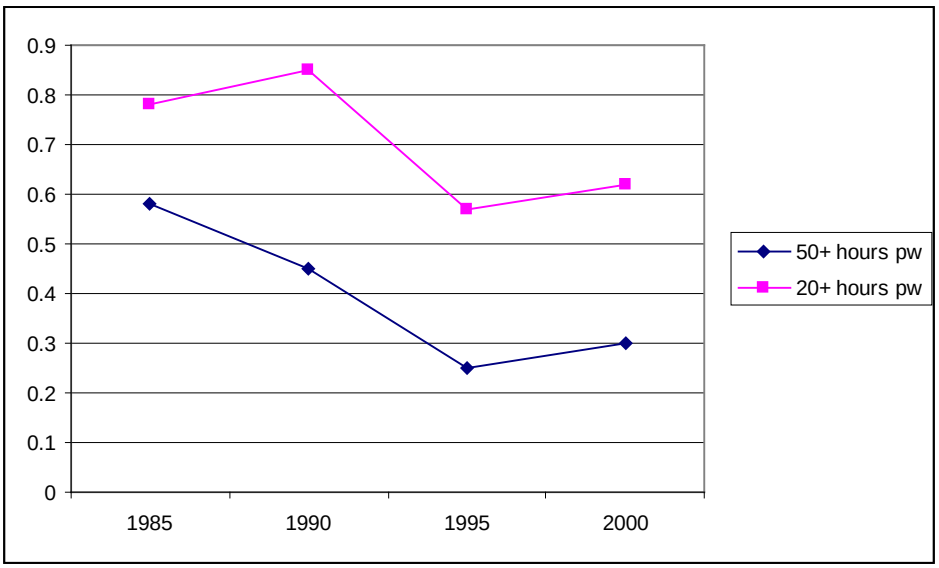
Source: 1985, 1990, 1995, 2000 GHS (author's analysis). See also Notes to Table 3.2
*Notes: Asterix indicates Ch-square association over time at *(5%), ** (1%) and ***(less than 1%); ns indicates no significant association.*

A second key finding of Table 3.3 is that the changes in care for older parents between 1985 and 2000 affected co-resident care more than they affected extra-resident care. There were no significant changes in extra-resident care provision in any five-year period between 1985 and 2000, but *there were declines in both intense and very intense co-resident care.* These latter changes both followed a similar pattern. The declines in very intense and intense co-resident care both occurred during the decade between 1985 and 1995 and were concentrated in the five-year period between 1990 and 1995. The declines in both forms of co-resident care came to an end in the mid-1990s and in the last five-year period between 1995 and 2000 there were slight (non-significant) increases in both forms of co-resident care (Table 3.3, Figure 3.4). The decline in very intense co-resident care, however, was more pronounced than the decline in intense co-resident care. There was a highly significant decline in very intense co-resident care between 1985 and 1995, whereas the decline in intense co-resident care was less significant (Table 3.3). The more marked nature of the decline in very intense co-resident care during the ten year between 1985 and 1995 arose because, whereas there was no decline in intense co-resident care between 1985 and 1990, there was a decline in very intense co-resident care both between 1985 and 1990 and between 1990 and 1995 (Figure 3.4).

Figure 3.4

Proportion of the population aged 30 to 74 providing co-resident care to older parents for 20 and 50 hours a week or more, Britain, 1985-2000

Percentage



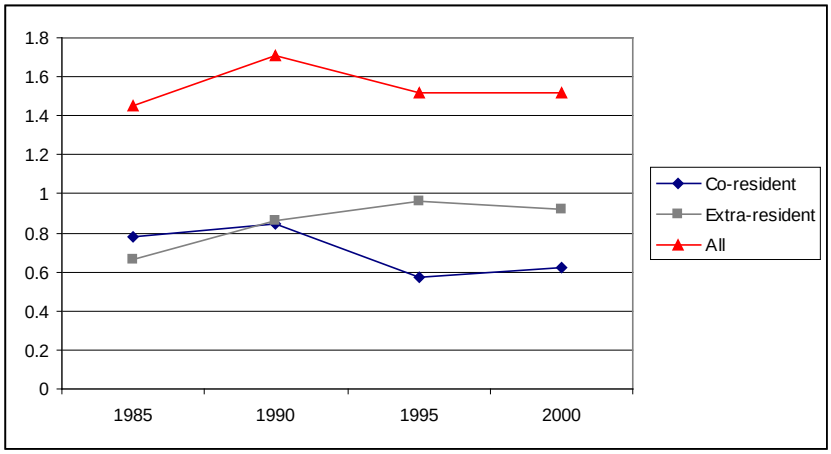
Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

The fact that there were more changes in co-resident care than extra-resident care for older parents did not mean that there were no changes at all in extra-resident care. Indeed, during the fifteen year period as a whole, there was in fact *an increase in intense extra-resident care*, which occurred during the ten-year period between 1985 and 1995 (Table 3.3). The increase in intense extra-resident care was, however, a gradual change and, as already noted, there were no sharp changes in this form of care during any five-year period between 1985 and 2000. The increase in intense extra-resident care therefore had a different shape from the decline in intense co-resident care, in which there was a sharp step-down between 1990 and 1995 (Figure 3.5). Nevertheless, the effect of the increase in intense extra-resident care and the decline in intense co-resident care was that the proportion of people providing care for 20 hours a week or more did not change significantly during the period under consideration (Table 3.3). Moreover, there was a remarkable shift during this period from intense co-resident to intense extra-resident care. Whereas in 1985, the proportion of people providing intense co-resident care to parents exceeded the proportion providing intense extra-resident care to parents, by 1995 the reverse was the case and intense extra-resident care exceeded intense co-resident care (Figure 3.5).[1]

Figure 3.5

Proportion of the population aged 30 to 74 providing intense care to older parents for 20 hours a week or more, by locus of care, Britain, 1985-2000

Percentage



Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

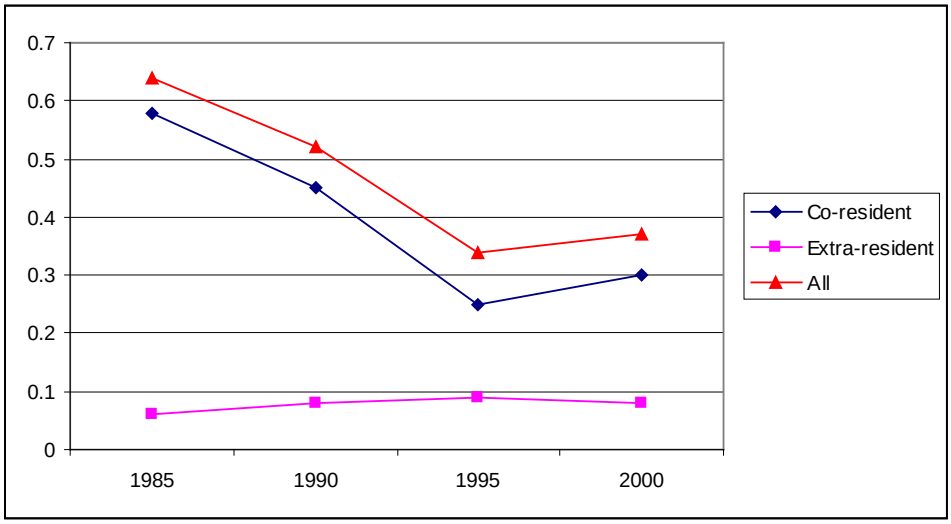
[1] As noted earlier in the chapter, most co-resident care for 20 hours a week or more was in fact provided very intensely (for 50 hours a week or more) whereas most extra-resident care for 20 hours a week or more was provided for less than 50 hours a week or more. It is therefore possible that the decline in very intense co-resident care might have been offset by the increase in relatively less intense extra-resident care. This is discussed in the conclusions, where the possibility of substitution of co-resident by extra-resident care is examined.

The same shift from co-resident to extra-resident care did not, however, affect very intense care for older parents. There was no significant increase in extra-resident care for 50 hours a week or more to compensate for the decline in very intense co-resident care (Table 3.3). The result was that very intense care for older parents fell during the 1985 to 2000 period (Figure 3.6). Indeed, because the changes in very intense care for older parents exceeded the changes in intense care, while the changes in co-resident care exceeded those in extra-resident care, the *greatest changes in care for older parents between 1985 and 2000 occurred in very intense co-resident care* (Figure 3.6)

Figure 3.6

Proportion of the population aged 30 to 74 providing care to older parents for 50 hours a week or more, by locus of care, Britain, 1985-2000

Percentage



Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

In summary, the key findings of this section are, first, that there was a decline in provision of very intense co-resident care for older parents between 1985 and 1995, especially in the 1990/1995 period (Table 3.3). Second, there was a decline in intense co-resident care between 1985 and 1995, which also occurred in the 1990/95 period. Third, there was an increase in intense extra-resident care for older parents between 1985 and 1995.

3.2.2 *Trends in Provision of Intense Care to Older Parents by Key Characteristics*

This section examines trends over time in provision of intense and very intense intergenerational care by the key characteristics of the people providing care. Table 3.7 summarises changes over time in provision of care by age, gender, marital status, and

educational qualifications during each of the three five-year time-periods between 1985 and 2000, that is, 1985/90, 1990/95 and 1995/2000. The table identifies significant changes over time in each type of care provided by people with each type of characteristic and shows the direction of change. Details of the proportions of people providing care and the sample numbers, on which Table 3.7 is based, can be found in Appendix 3C (Tables 3C.3 to 3C.6).

The key changes in provision of care to parents during the three five-year periods between 1985 and 2000, identified in the previous section, were significant declines in provision of very intense and intense co-resident care. Table 3.7 shows that these declines involved changes in provision of care by people with a wide range of characteristics. The significant decline in provision of very intense care for 50 hours a week or more between 1990 and 1995 involved significant falls in provision of care by people in mid-life, women and single people. The significant decline in provision of intense co-resident care for 20 hours or more between 1990 and 1995 involved significant falls in provision of care by women and single people. The fact that there were significant declines in either intense or very intense co-resident care by people in mid-life, women and single people reflects the importance of people with these characteristics in the provision of co-resident care for parents (identified earlier in the chapter). It is therefore noteworthy that there were no significant changes by those without educational qualifications in provision of very intense co-resident care, even though education was associated with this form of care provision. The implications of this finding will be examined later in the study (Chapter Four).

An important feature of the decline in very intense co-resident care, identified in the previous section (Figure 3.6), was that it occurred throughout the period between 1985 and 1995, even though it was only significant in the 1990/95 period. Table 3.7 shows that, even though the decline in co-resident care for 50 hours a week or more was not significant in the 1985/90 period, there were nevertheless significant falls in care provision by some sub-groups during this time. In particular, there were declines in provision of very intense co-resident care for parents by younger people (aged between 30 and 44) and men (Table 3.7).

Another feature of the trends in provision of both very intense and intense co-resident care for older parents during the period under consideration was that there was a slight

(non-significant) increase in both these forms of care between 1995 and 2000 (Figure 3.4). Table 3.7 shows that there were significant increases in provision of both forms of care by some sub-groups in the late 1990s. In particular, intense co-resident care by younger people (aged 30 to 44) and very intense co-resident care by single people both rose significantly between 1995 and 2000.

Table 3.7 confirms the evidence, presented in the previous section, suggesting that there were fewer changes in extra-resident than co-resident care for older parents between 1985 and 2000. The table shows that there was only one significant change in provision of extra-resident care, an increase by mid-life people in the period between 1985 and 1990. The fact that there was an increase in extra-resident care in the late 1980s reinforces the suggestion, made in the previous section, that there was a lack of correspondence between the changes in intense extra-resident and co-resident care. Thus, the only significant increase in intense extra-resident care during any of the three five-year periods between 1985 and 2000 occurred between 1985 and 1990, at a time when there were no significant changes by any sub-groups in provision of intense co-resident care. The implications of this finding will be discussed in the conclusions to this chapter.

Table 3.7

Trends in provision of care to older parents for 20 and 50 hours a week or more over time by key characteristics, Britain, 1985/1990, 1990/1995 and 1995/2000

(a) Intense care (20 hours a week or more) *Significance & direction of change*

Hours care pw week & years	All	Age-band			Gender		Marital status		Educational Qualifications	
		30-44	45-SPA	SPA-74	men	women	Mar-ried	single	none	some
co-resident										
1985/90	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	ns
1990/95	***(-)**	*ns*	*ns*	*ns*	*ns*	***(-)**	*ns*	****(-)**	*ns*	ns
1995/00	*ns*	*** (+)**	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	ns
extra-resident										
1985/90	*ns*	*ns*	*(+)	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
1990/95	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
1995/00	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
All care for 20+ hrs pw										
1985/90	*ns*	*ns*	***(+)**	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
1990/95	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*** (-)**	*ns*	*ns*
1995/00	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*

(b) Very intense care (50 hours a week or more)

Hours care pw week & years	All	Age-band			Gender		Marital status		Educational Qualifications	
		30-44	45-SPA	SPA-74	men	women	Mar-ried	single	none	some
co-resident										
1985/90	*ns*	*** (-)**	*ns*	*ns*	*** (-)**	*ns*	*ns*	*ns*	*ns*	*ns*
1990/95	*** (-)**	*ns*	*** (-)**	*ns*	*ns*	*** (-)**	*ns*	*** (-)**	*ns*	*ns*
1995/00	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*** (+)**	*ns*	*ns*
extra-resident										
1985/90	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
1990/95	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
1995/00	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
All care for 50+ hrs pw										
1985/90	*ns*	*** (-)**	*ns*	*ns*	***(-)**	*ns*	*ns*	*ns*	*ns*	*ns*
1990/95	*** (-)**	*ns*	*** (-)**	*ns*	*ns*	*** (-)**	*ns*	**** (-)**	*ns*	*ns*
1995/00		*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*** (+)**	*ns*	*ns*

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

*Notes: Asterix indicates Chi-square association over time at *(5%), **(1%),***(less than 1%); ns indicates no significant association. (+) indicates increase over time-period;(-) indicates decrease over time-period. Marital status is defined as legal marital status in 1985 and as de facto marital status in 1990, 1995 and 2000. Educational qualifications are for people aged 30-69. ' SPA' refers to State Pension Age. Underlying probabilities and sample numbers are in Appendix 3C, Tables 3C.3 to 3C.6.*

3.3 Discussion and Conclusions

This chapter has identified three key trends in intense intergenerational care for older people between 1985 and 2000 (Table 3.3). First, there was a significant decline in care for older parents provided for 50 or more hours a week. This decline in very intense intergenerational care was brought about through a decline in co-resident care, which took place between 1985 and 1995, with a significant drop occurring in the 1990/95 period. Second, between 1985 and 1995, there was a significant decline in co-resident care for 20 or more hours a week, which also occurred in the 1990/95 period. Third, there was a significant increase in intense extra-resident care for parents, which occurred between 1985 and 1995. The increase in intense extra-resident care and decline in intense co-resident care meant that there was no significant change in provision of care for 20 hours a week or more, but that there was, in effect, a shift from co-resident to extra-resident care. The remainder of this study will be concerned with an explanation of these trends.

The trends identified here are somewhat different from the findings of previous studies. These, as the introduction to this chapter suggested, have identified an increase in provision of intense informal care in the recent past. However, the results of the present study are not necessarily incompatible with previous research. For example, Evandrou and Glaser (2002) identified an increase in provision of intense care for 20 or more hours a week by people in mid-life between 1985 and 2000. The present study has also found an increase in provision of intense care to older parents by people in mid-life during the five-year period between 1985 and 1990 (Table 3.7). However, this did not mean that there was an increase in provision of intense care to older parents overall because provision of care by younger people (aged 30 to 44) declined, although this change was not statistically significant (Table 3.7, Appendix 3C: Table 3C.3). Moreover, the results of the present study are consistent with other evidence. For example, the decline in intense and very intense co-resident care, identified here, is consistent with the decline in co-residence of older people with their relatives, identified by Grundy and colleagues (Grundy and Glaser 1997; Grundy 2000). And the gradual increase in intense extra-resident care for older parents between 1985 and 1995 is consistent with Hirst's finding of an increase in extra-resident care by women for their parents between 1991 and 1998 (Hirst 2001).

In considering possible explanations for the trends identified here, the first issue that needs to be addressed is whether the trends in the different forms of intense intergenerational care might explain each other. Specifically, did extra-resident care *substitute* for co-resident care, thereby providing an explanation for the decline in intense and very intense co-resident care?

3.3.1 Possible Substitution of Co-Resident by Extra-Resident Care

The shift from intense co-resident to intense extra-resident care for older parents is an important result of the present study. The evidence has shown that, at the start of the period under consideration, in 1985, the proportion of people providing intense co-resident care for older parents exceeded the proportion providing intense extra-resident care, but by the end of the period, in 2000, this had reversed (Table 3.3). The fact that intense extra-resident care for older parents exceeds co-resident care means that care for older parents is very different from other forms of intense care, since care for 20 hours a week or more is typically provided on a co-resident basis (Maher and Green 2002; Young *et al* 2005). However, although the shift from co-resident care to extra-resident care is important, the issue of interest here is whether there was any *causal* connection between the rise in extra-resident care and the fall in co-resident care.

The possibility that different forms of intergenerational care might substitute for one another is hinted at by Hirst (2001) in his examination of trends in intergenerational care during the 1990s. Hirst linked an increase in extra-resident care for parents during the 1990s, identified in his study, to the decline in co-residence of older people with their children, identified by Grundy (2000). Hirst concluded that "A decline in multigenerational households, however, does not necessarily translate into a decrease in intergenerational caregiving" (Hirst 2001: 355). The implication seems to be that a decline in co-resident care might 'translate into' an increase in extra-resident care.

Was it the case then that, between 1985 and 1995, the decline in co-resident care for older parents, described in the present study, was 'explained' by the increase in extra-resident care? The first point to make here is that there was clearly little evidence of substitution between co-resident and extra-resident care where very intense care for 50 or more hours a week was concerned. The present chapter has shown that there was a

significant decline in very intense co-resident care between 1985 and 2000, but that this was not 'compensated for' by a comparable increase in very intense extra-resident care, and the result was that all care for 50 hours a week or more for older parents declined significantly between 1985 and 2000 (Table 3.3, Figure 3.6).

An explanation in terms of substitution between co-resident and extra-resident care for older parents seems more plausible with regard to intense care provided for 20 or more hours a week. The evidence shows that there was a significant increase in extra-resident care for 20 or more hours a week between 1985 and 1995, which occurred during the same ten-year period as a significant decline in intense co-resident care (Table 3.3, Figure 3.5). However, there were several indications, in the evidence presented in this chapter, that there was a lack of detailed correspondence in the trends in intense co-resident and extra-resident care. First, there were no significant changes in intense extra-resident care provided by adults aged 30 to 74 during any of the three five year-periods between 1985 and 1995, whereas there was a significant fall in intense co-resident care between 1990 and 1995 (Table 3.3). Second, the only significant change in intense extra-resident care by a sub-group of the population related to people in mid-life, whose provision of care for parents in another household increased between 1985 and 1990. This increase, however, did not correspond to a significant decrease in provision of intense co-resident care by people in mid-life during the same time-period (Table 3.7). The results of these differences were that the trends in intense extra-resident and co-resident care of older parents were also rather dissimilar. Intense extra-resident care increased gradually between 1985 and 1995 and then levelled off between 1995 and 2000, whereas intense co-resident care increased somewhat between 1985 and 1990, fell significantly between 1990 and 1995 and then increased slightly between 1995 and 2000 (Figure 3.5).

The results therefore suggest that the decline in intense co-resident care cannot be explained by the increase in intense extra-resident care, since the changes in each type of care did not correspond closely to each other during the 1985/00 period. [1] This means that it makes sense to treat the trends in each type of intense care separately. Indeed, the evidence suggests that the trends in co-resident care had a great deal in

[1] It is also possible, as noted earlier, that there might have been some substitution between *very intense* co-resident care for parents and *intense* extra-resident care. However, this also seems unlikely. The trends in very intense and intense co-resident care both followed a similar pattern (Section 3.2.1, Table 3.3). Therefore, the lack of detailed correspondence in the trends in intense co-resident and extra-resident care also applied to very intense co-resident and intense extra-resident care.

common with each other (Section 3.2.1, Table 3.3) and that therefore it seems plausible, initially at least, to examine the trends in intense and very intense co-resident care together. The remainder of this discussion looks at, first, the increase in intense extra-resident care and, second, the decline in intense and very intense co-resident care, and explores potential explanations for these changes. To identify potential explanations, the table at the end of Chapter Two (Table 2.20) is utilised.

3.3.2 Increase in Intense Extra-Resident Care for Older Parents, 1985/95

The trends in intense extra-resident care for older parents between 1985 and 2000 took the form of a gradual increase in care provision between 1985 and 1995, followed by a levelling off between 1995 and 2000. Reference back to Chapter Two suggests that, of the potential explanations for trends in care provision examined here, there were two possible explanations for an increase in intense care for older parents taking place during the 1985/95 period (Table 2.20). First, there was a demand-side explanation in terms of trends in the numbers of older people. Second, there was a supply-side explanation in terms of an increase in the availability of potential care-givers. This latter explanation will be explored in the next chapter (Chapter Four) which focuses specifically on the supply of informal care. At the end of that chapter, the implications of the results will be used to interpret the factors affecting the increase in extra-resident care.

The fact that there are plausible reasons for expecting an increase in intense care for older parents during this period is important. Previous studies have certainly approached the analysis of trends in informal care provision in the recent past with the expectation that care for parents would have increased (Hirst 2001; Evandrou and Glaser 2002). For example, Evandrou and Glaser anticipated an increase in informal care between 1985 and 2000 because "recent increases in life expectancy at older ages mean that a higher proportion of 'younger' cohorts are likely to have a surviving parent in need of care than 'older' cohorts" (Evandrou and Glaser 2002: 23). Indeed, trends in fertility, timing of childbearing and mortality suggest that the proportion of people in mid-life with living parents would have been increasing between 1985 and 2000 (Murphy and Grundy 2003).

In the context of plausible reasons for expecting an increase in intense intergenerational care for older people, the evidence of the present study that there was a *decline* in co-resident care for parents during the 1985/00 period is even more remarkable. Indeed, the emphasis in the present study will be primarily on explaining this remarkable decline.

3.3.3 Decrease in Co-Resident Care for Older Parents, 1985/95

Both intense and very intense co-resident care declined significantly between 1985 and 1995. Chapter Two identified five potential explanations for a decline in intense care for older parents occurring between 1985 and 1995: on the demand-side, an increase in long-stay residential care, a decline in the prevalence of disability and an increase in the proportion of older people who were married and, on the supply side, an increase in educational qualifications among potential care-givers and an increase in employment rates of mid-life women. The sections below explore whether the present chapter offers support to these explanations and, if so, how they will be pursued in this study. Supply-side explanations are examined first, followed by demand-side explanations.

Increase in Educational Qualifications of Potential Care-Givers

One potential supply-side explanation for a decline in provision of care in Britain between 1985 and 2000 is that this could have been associated with an increase in educational qualifications among potential care-givers (Chapter Two). The plausibility of this explanation would be increased if there was an association between education and care provision. Previous research has not before identified an association between socio-economic indicators and care for older parents in multivariate analysis (Glaser and Grundy 2002).[1] However, the specific relationship between intense care for older parents and *education* has not been examined before. The present study has shown, in multivariate analysis, that there was a significant negative association between educational qualifications and very intense care for older parents provided for 50 hours a week or more. Further, the chapter has shown that it was, specifically, very intense care for older parents that declined between 1985 and 2000 (Table 3.2). Therefore, it is possible that the increase in educational qualifications during the later 1980s and 1990s

[1] Arber and Ginn (1993) identified social class differences in provision of informal care, but Glaser and Grundy (2002) found that these did not hold in multivariate analysis of care for parents.

could have contributed to the decline in very intense care that occurred during this time. The possibility that the supply of very intense care might have been constrained by the rise in educational qualifications is certainly worth exploring further and is considered in the next chapter.

Increase in Employment Rates among Mid-Life Women

Another potential explanation for a decline in provision of care in Britain between 1985 and 2000 is that this could have been associated with the increase in paid employment among mid-life women during this period (Chapter Two). The present chapter has not looked at the relationship between provision of care and employment directly, but it has looked at two variables relevant to this relationship, age and gender. The chapter has shown that both age and gender were significantly associated with all forms of intense intergenerational care provision between 1985 and 2000 (Table 3.2). Indeed, provision of intense intergenerational care was highest among people in mid-life compared to people in other age-groups and among women compared to men. These findings may seem obvious but they are particularly important in the context of the current emphasis in the informal care literature (noted in Chapter One) on elderly people and men as carers of older people (Arber and Ginn 1990; Wenger 1990; Wanless 2006). In contrast, the present chapter has, for example, shown that nearly 85 per cent of people caring intensely for an older parent were in fact below State Pension Age and that over two-thirds were women (section 3.1.2, Table 3C.1). Moreover, the present chapter has also shown that there was a decline in either intense or very intense co-resident care for older parents among both people in mid-life and women at some time during the 1985/00 period (Table 3.7). Therefore, it is certainly worth exploring further whether the decline in intense and very intense co-resident care for older parents might have been associated with the rise in employment rates among mid-life women at this time. This is explored in Chapter Five.

Increase in ‘Spouse Care’

A potential demand-side explanation for the decline in co-resident care by children for their older parents is an explanation in terms of the increase in the proportion of older people who were married (Chapter Two, Table 2.20). This could have led to a substitution of care by spouses for care by children. This explanation has not been

addressed directly in this chapter. However, the fact that the decline in care for older parents, identified in the present chapter, only related to *co-resident* care might be associated with a rise in spouse care, since the latter, almost by definition, is also co-resident care. Indeed, as Chapter Two indicated, there is some evidence that informal care for spouses increased during the 1990s, although none of the studies reporting this trend was concerned with care specifically for older spouses (Rowlands 1998; Hirst 2001). Trends in intense care for older spouses, and their potential relevance for the decline in intense co-resident care for older parents, are examined in Chapter Six of the present study.

Trends in Severe Disability

A further potential demand-side explanation for the decline in co-resident care by children for their older parents is an explanation in terms of the decline in severe disability among older people during the 1980s and 1990s (Chapter Two, Table 2.20). The decline in severe disability could have been important in accounting for a decline specifically in co-resident care. This is because the evidence suggests that older people who co-reside with relatives, including their children, tend to be more disabled than those who live alone (Glaser and Grundy 1997; Murphy 2007). Therefore, the decline specifically in intense co-resident care for older parents could have been associated with the decline in severe disability. The relationship between provision of intense co-resident care and the disability of the older people receiving care is explored in Chapter Seven, while the potential role of trends in severe disability in explaining the decline in co-resident care is examined in Chapter Eight.

Changes in Formal Service Provision for Older People

The central hypothesis of the present study is exploring whether the increase in long-stay residential care in the 1980s and early 1990s in Britain might have led to a substitution of formal for informal care. The previous chapter established that there was an increase in long-stay residential care between 1985 and 1995 (Chapter Two, Table 2.20). The present chapter has now shown that there was a significant decline in intense and very intense co-resident care for older parents between 1985 and 1995 (Figure 3.4). Therefore, the decline in intense and very intense co-resident care occurred at the same time as the increase in long-stay residential care. The evidence so far therefore provides

some initial support for the hypothesis of a negative association between intense and very intense co-resident care and long-stay residential care. On the other hand, the present chapter has offered little support for the idea that there was a negative association between intensive *home care* and intense intergenerational care. At the time when intensive home care was increasing, between 1995 and 2000, there was no decline in intense or very intense co-resident care and indeed there was some increase in these forms of care, with significant increases among both younger and single people (Table 3.7). Trends in formal services, particularly long-stay residential care, as a potential explanation for trends in intense and very intense co-resident care are explored in Chapter Eight of this study.

Appendices to Chapter 3

Appendix 3A

Derivation of Key Variables Describing Intense Intergenerational Care from GHS

Informal carers are identified in the GHS as people who look after someone who is sick, disabled or elderly (Chapter One, Box 1.1). It is the GHS definition of a carer that is used in the present study, and this excludes certain types of caring: those caring for someone in their capacity as a volunteer; those caring for someone receiving care in residential/nursing homes or hospitals; those providing financial support only and (in 1995 and 2000) those caring for someone with a temporary illness or disability.

Respondents aged 16 and over who gave a full interview are included in the sample used in this study (cf. Agree *et al* 2003: 30). The main analyses are restricted to those aged 30 to 74 years old, among whom nearly all provision of care to older parents was confined (see section 3.1.2 of this chapter). The total sample size of people aged 30 to 74 in the four data collection years is 46,405 (Appendix 3C, Table 3C.1).

Intergenerational carers were identified using the GHS variable for the relationship between the cared-for person and the carer ('DRELINF'), with intergenerational care being defined as provision of care to a parent or parent-in-law. The GHS allows for up to six cared-for people to be identified and the derived variable, developed here, identifies someone who was caring for one or more parents or parents-in-law. (As noted in Chapter One, in this study, care for older parents includes care for older parents-in-law).

Only those caring for parents aged 65 and over are included in the present study. Provision of care for parents at this age was identified using a question in the GHS that specifically asks about the age of the person cared for ('DAGE'). This question is related to each person cared-for and the present study therefore identifies those caring for one or more parents aged 65 and over. It should be noted that no other survey of informal care provision in this country collects information on the age of the people cared for and that therefore, since the GHS ceased collecting information on informal care provision in 2000, this information has not been collected.

The identification of intense and very intense intergenerational carers uses information on the hours of care provided weekly for each cared-for person ('HELPHRS'). The questions asked about the time spent 'on average each week' looking after or helping the care-recipient (1985 and 1990 surveys) or about the time spent 'each week' looking after or helping the care-recipient (1995 and 2000 surveys) (cf. Henz 2009: 392). Information on the time spent caring allows for the identification of intense and very intense intergenerational carers, who provided care for 20 or 50 hours a week or more, respectively, to one or more parents aged 65 and over.

Finally, the locus of care was derived from questions identifying the unique 'person number' of those included in the surveys ('DPERSN'). A cared-for person has a person number of 1 to 14 if they are in the same household as the care-provider and of 15 if they are not in the same household. Information on the locus of care allows for the identification of intense and very intense co-resident and extra-resident care provided to one or more parents aged 65 and over. Small numbers of people cared for parents in the same and another household. This was, however, rare (Agree *et al* 2003) and only affected 3 of the 719 people caring for 20 hours a week or more in the present study and none of those caring for 50 hours a week or more. Nevertheless, in tables in which the locus of care is shown, the sum of co- and extra-resident care may exceed the sum of all care for 20 hours a week or more, and this is noted at the foot of the tables.

Information on the provision of care was combined with other data from the GHS, including age, gender, marital status and education (in the present chapter) and employment (in Chapter Five).

In addition, other variables relating to the provision of care are utilised in the study and are described as they arise. Thus, the length of time spent caring ('HELPYRS') is used in the present chapter to explore potential endogeneity between marital status and informal care provision (Appendix 3B); the average hours of care provided are estimated in Chapter Five (using 'HELPHRS'); the characteristics of the care recipients are examined in Chapter Six, including further details of their age ('DAGE'), as well as their gender ('DSEX') and type of impairment ('AFFECTED'); and the type of help provided for the care recipient (DHELP') is also examined in Chapter Six. Further analysis of the characteristics of older parents cared for is described in Chapter Seven.

Appendix 3B

Investigation of Potential Endogeneity between Marital Status and Provision of Care: Potential Impact of Provision of Care on Marital/Cohabitation Status

This appendix reports on an investigation into the potential impact of provision of intergenerational care on marital status. The investigation identifies intergenerational carers whose marital status might have been affected by their provision of care. It therefore identifies single carers, caring for a long time, who started caring at a young age. 'Caring for a long time' is defined as care for 5 years or more. 'Young age' is defined as below the age of 30. The rationale for defining 'young age' as those under 30 is that, in any one year between 1985 and 2000, at least 70 per cent of those in the GHS sample were either married or cohabiting by the age of 30. The analysis uses questions in the 1985, 1995 and 2000 GHS about the length of time for which care had been provided, but this question was not asked in the 1990 GHS. As explained in the main part of the chapter, marital status refers to legal marital status in 1985 and *de facto* marital status in other years. Table 3B.1 shows the results of the analysis.

Table 3B.1

Single people providing care for 20 hours a week or more to older parents: provision of care for 5 or more years started under the age of 30, Britain, 1985, 1995, 2000 (Sample numbers and percentages)

	All caring for 20+hours pw	**Single**	**Care for 5 or more (5+) years**	**Care for 5+ years and began caring under age 30**	***Singles caring for 5+ years & began caring under age 30***
		Sample numbers			*%*
1985	179	62	13	1	2
1995	183	45	20	0	0
2000	154	50	22	5	10
All years	*516*	*157*	*55*	*6*	*4*

Source: 1985, 1995, 2000 GHS (author's analysis)
Notes: Data not collected in 1990. Marital status refers to legal marital status in 1985 and de facto marital status in other years. Final column shows percentage of single people providing intense care for older parents who had been caring for 5+ years & started caring under age 30.

The table shows that, in the three years examined, only a small proportion (around 4 per cent) of single people providing intense care for older parents had both been caring for a long time and started caring under the age of 30. Although the percentage varied considerably between years, the results suggest that, to the extent that there is a relationship between marital status and provision of care for older parents, the direction of the relationship is unlikely to be from care to marital status. It therefore seemed appropriate to include marital status in the analysis.

Appendix 3C

GHS Sample Numbers Underlying Tables in Chapter Three

Table 3C.1

Provision of care to older parents for 20 and 50 hours a week or more, by locus of care and key characteristics, Britain, 1985-2000: sample numbers

(a) Intense care (20 hours a week or more)

Characteristics	Categories	Locus of care		All care for 20+ hours p.w.	Underlying sample base
		Co-resident	Extra-resident		
Age-group	16-29	8	7	15	14,868
	30-44	66	111	177	18,445
	45-59/64	189	220	406	17,465
	60/65-74	75	61	136	10,495
	75+	1	0	1	5,503
Gender[#]	Men	128	103	231	21,769
	Women	202	289	488	24,636
Marital status[#]	Married/cohabiting	173	320	490	35,805
	Single	157	72	229	10,600
Education[#]	No qualifications	165	165	330	17,061
	Some qualifications	158	221	376	25,479
All[#]		330	392	719	46,405

(b) Very intense care (50 hours a week or more)

Characteristics	Categories	Locus of care		All care for 50+ hours p.w.	Underlying sample base
		Co-resident	Extra-resident		
Age-group	16-29	2	2	4	14,868
	30-44	37	7	44	18,445
	45-59/64	97	21	118	17,465
	60/65-74	51	7	58	10,495
	75+	1	0	1	5,503
Gender[#]	Men	57	6	63	21,769
	Women	128	29	157	24,636
Marital status[#]	Married/cohabiting	91	26	112	35,805
	Single	94	9	103	10,600
Education[#]	No qualifications	100	22	122	17,061
	Some qualifications	81	12	93	25,479
All[#]		185	35	220	46,405

Source: 1985,1990, 1995, 2000 GHS (author's analysis)
Notes: [#] indicates people aged 30 to 74. The sum of co- and extra-resident care may exceed all care for 20 or more hours a week because small numbers of people cared for someone in the same and another household. Sample numbers differ from those shown in Pickard (2008a) because the latter is for England only. See also notes to Table 3.1.

Table 3C.2

Provision of care to older parents for 20 and 50 hours a week or more, by locus of care and data collection year, Britain, 1985-2000: sample numbers

(a) Intense care (20 hours a week or more)

Year	Co-resident	Extra-resident	All care for 20+ hrs pw	Underlying sample base
1985	97	82	179	12,387
1990	101	102	203	11,854
1995	69	115	183	12,002
2000	63	93	154	10,162
All years	*330*	*392*	*719*	*46,405*

(b) Very intense care (50 hours a week or more)

Year	Co-resident	Extra-resident	All care for 50+ hrs pw	Underlying sample base
1985	72	7	79	12,387
1990	53	9	62	11,854
1995	30	11	41	12,002
2000	30	8	38	10,162
All years	*185*	*35*	*220*	*46,405*

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: This table shows sample numbers aged 30 to 74 providing care to older parents, plus the underlying sample base of people aged 30 to 74. The sum of co- and extra-resident care may exceed all care for 20 or more hours a week because small numbers of people cared for someone in the same and another household.

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Table 3C.3

Provision of care to older parents for 20 and 50 hours a week or more, by locus of care and age-group, Britain, 1985-2000: percentages and sample numbers

(a) proportions (percentages) providing care

Categories	Year	Intense care (20+ hrs pw)			Very intense care (50+ hrs pw)		
		Co-resident	Extra-resident	All	Co-resident	Extra-resident	All
30-44	1985	0.54	0.75	1.29	0.38	0.04	0.42
	1990	0.32	0.62	0.94	0.15	0.04	0.19
	1995	0.15	0.51	0.65	0.08	0.04	0.13
	2000	0.43	0.50	0.93	0.18	0.03	0.20
	Total	*0.36*	*0.60*	*0.95*	*0.20*	*0.04*	*0.24*
45-59/64	1985	1.07	0.82	1.89	0.78	0.07	0.85
	1990	1.35	1.35	2.71	0.67	0.16	0.83
	1995	1.04	1.52	2.54	0.35	0.13	0.48
	2000	0.85	1.35	2.15	0.42	0.12	0.55
	Total	*1.08*	*1.26*	*2.32*	*0.56*	*0.12*	*0.68*
60/65- 74	1985	0.77	0.24	1.01	0.63	0.07	0.70
	1990	0.96	0.50	1.46	0.61	0.00	0.61
	1995	0.53	0.79	1.32	0.38	0.11	0.49
	2000	0.55	0.87	1.43	0.28	0.09	0.37
	Total	*0.71*	*0.58*	*1.30*	*0.49*	*0.07*	*0.55*

(b) sample numbers

Categories	Year	Intense care (20+ hrs pw)			Very intense care (50+ hrs pw)			Sample Base
		Co-resident	Extra-resident	All	Co-resident	Extra-resident	All	
30-44	1985	27	38	65	19	2	21	5,034
	1990	15	29	44	7	2	9	4,695
	1995	7	24	31	4	2	6	4,735
	2000	17	20	37	7	1	8	3,981
	Total	*66*	*111*	*177*	*37*	*7*	*44*	*18,445*
45-59/64	1985	48	37	85	35	3	38	4.490
	1990	59	59	118	29	7	36	4.360
	1995	48	70	117	16	6	22	4,609
	2000	34	54	86	17	5	22	4,006
	Total	*189*	*220*	*406*	*97*	*21*	*118*	*17,465*
60/65-74	1985	22	7	29	18	2	20	2,863
	1990	27	14	41	17	0	17	2,799
	1995	14	21	35	10	3	13	2,658
	2000	12	19	31	6	2	8	2,175
	Total	*75*	*61*	*136*	*51*	*7*	*58*	*10,495*

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: The table shows people aged 30 to 74. The sum of co- and extra-resident care may exceed all care for 20 or more hours a week because small numbers of people cared for someone in the same and another household.

.**Table 3C.4**

Provision of care to older parents for 20 and 50 hours a week or more, by locus of care and gender, Britain, 1985-2000: percentages and sample numbers

(a) proportions (percentages) providing care

Categories	Year	Intense care (20+ hrs pw)			Very intense care (50+ hrs pw)		
		Co-resident	Extra-resident	All	Co-resident	Extra-resident	All
Men	1985	0.64	0.48	1.12	0.46	0.00	0.46
	1990	0.64	0.55	1.20	0.16	0.02	0.18
	1995	0.45	0.45	0.90	0.16	0.07	0.23
	2000	0.63	0.40	1.02	0.25	0.02	0.27
	Total	*0.59*	*0.47*	*1.06*	*0.26*	*0.03*	*0.29*
Women	1985	0.91	0.82	1.74	0.69	0.11	0.79
	1990	1.04	1.13	2.17	0.70	0.13	0.83
	1995	0.68	1.40	2.06	0.33	0.11	0.43
	2000	0.61	1.38	1.96	0.34	0.13	0.47
	Total	*0.82*	*1.17*	*1.98*	*0.52*	*0.12*	*0.64*

(b) sample numbers

Categories	Year	Intense care (20+ hrs pw)			Very intense care (50+ hrs pw)			Sample Base
		Co-resident	Extra-resident	All	Co-resident	Extra-resident	All	
Men	1985	37	28	65	27	0	27	5,822
	1990	36	31	67	9	1	10	5,594
	1995	25	25	50	9	4	13	5,561
	2000	30	19	49	12	1	13	4,792
	Total	*128*	*103*	*231*	*57*	*6*	*63*	*21,769*
Women	1985	60	54	114	45	7	52	6,565
	1990	65	71	136	44	8	52	6,260
	1995	44	90	133	21	7	28	6,441
	2000	33	74	105	18	7	25	5,370
	Total	*202*	*289*	*488*	*128*	*29*	*157*	*24,636*

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: The table shows people aged 30 to 74. See also note to Table 3C.3

Table 3C.5

Provision of care to older parents for 20 and 50 hours a week or more, by locus of care and marital status, Britain, 1985-2000: percentages and sample numbers

(a) proportions (percentages) providing care

Categories	Year	Intense care (20+ hrs pw)			Very intense care (50+ hrs pw)		
		Co-resident	Extra-resident	All	Co-resident	Extra-resident	All
Married/ cohabiting	1985	0.52	0.71	1.23	0.36	0.04	0.40
	1990	0.55	0.84	1.39	0.26	0.07	0.33
	1995	0.47	1.04	1.50	0.23	0.12	0.35
	2000	0.37	1.02	1.36	0.14	0.07	0.21
	Total	*0.48*	*0.89*	*1.37*	*0.25*	*0.07*	*0.33*
Single	1985	1.74	0.49	2.23	1.40	0.11	1.51
	1990	1.89	0.95	2.84	1.10	0.11	1.21
	1995	0.93	0.68	1.61	0.32	0.00	0.32
	2000	1.39	0.60	1.99	0.76	0.12	0.88
	Total	*1.48*	*0.68*	*2.16*	*0.89*	*0.08*	*0.97*

(b) sample numbers

Categories	Year	Intense care (20+ hrs pw)			Very intense care (50+ hrs pw)			Sample Base
		Co-resident	Extra-resident	All	Co-resident	Extra-resident	All	
Married/ cohabiting	1985	51	69	120	35	4	39	9,737
	1990	51	77	128	24	6	30	9,211
	1995	43	96	138	21	11	32	9,209
	2000	28	78	104	11	5	16	7,648
	Total	*173*	*320*	*490*	*91*	*26*	*117*	*35,805*
Single	1985	46	13	59	37	3	40	2,650
	1990	50	25	75	29	3	32	2,643
	1995	26	19	45	9	0	9	2,793
	2000	35	15	50	19	3	22	2,514
	Total	*157*	*72*	*229*	*94*	*9*	*103*	*10,600*

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Notes: The table shows people aged 30 to 74. Marital status is de-facto marital status except in 1985 since only legal marital status is available in the 1985 GHS; 'single' people include single (never married), widowed, divorced, separated; 'married' people include those legally married and those cohabiting. See also note to Table 3C.3.

Table 3C.6

Provision of care to older parents for 20 and 50 hours a week or more, by locus of care and educational qualifications, Britain, 1985-2000: percentages and sample numbers

(a) proportions (percentages) providing care

Categories	Year	Intense care (20+ hrs pw)			Very intense care (50+ hrs pw)		
		Co-resident	Extra-resident	All	Co-resident	Extra-resident	All
With qualifications	1985	0.68	0.57	1.25	0.45	0.00	0.45
	1990	0.78	0.85	1.63	0.42	0.03	0.45
	1995	0.54	1.00	1.53	0.24	0.07	0.31
	2000	0.51	0.99	1.47	0.21	0.07	0.28
	Total	*0.62*	*0.87*	*1.48*	*0.32*	*0.05*	*0.37*
No qualifications	1985	1.00	0.86	1.85	0.79	0.12	0.91
	1990	1.05	1.01	2.07	0.56	0.14	0.70
	1995	0.77	1.10	1.87	0.31	0.13	0.44
	2000	1.04	0.92	1.96	0.62	0.12	0.73
	Total	*0.97*	*0.97*	*1.93*	*0.59*	*0.13*	*0.72*

(b) sample numbers

Categories	Year	Intense care (20+ hrs pw)			Very intense care (50+ hrs pw)			Sample Base
		Co-resident	Extra-resident	All	Co-resident	Extra-resident	All	
With qualifications	1985	38	32	70	25	0	25	5,591
	1990	47	51	98	25	2	27	6,013
	1995	38	71	108	17	5	22	7,075
	2000	35	67	100	14	5	19	6,800
	Total	*158*	*221*	*376*	*81*	*12*	*93*	*25,479*
No qualifications	1985	57	49	106	45	7	52	5,724
	1990	51	49	100	27	7	34	4,835
	1995	30	43	73	12	5	17	3,902
	2000	27	24	51	16	3	19	2,600
	Total	*165*	*165*	*330*	*100*	*22*	*122*	*17,061*

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: The table shows people aged 30 to 70. See also see note to Table 3C.3.

Chapter 4

The Supply of Care:
Socio-Demographic and Socio-Economic Factors

This chapter, and the succeeding chapter, are concerned with the extent to which trends in intense intergenerational care in Britain between 1985 and 2000 can be explained in terms of the supply of informal care. The present chapter considers the impact on care provision of trends in the four factors used in the explanatory models of Chapter Three, that is, age, gender, marital status and education. The following chapter considers the impact on care provision of trends in employment.

The previous chapter identified two contrasting trends in intense intergenerational care during the period between 1985 and 2000. On the one hand, there was a significant increase in intense extra-resident care between 1985 and 1995. On the other hand, there was a significant decline in intense and very intense co-resident care between 1985 and 1995, concentrated particularly in the 1990/95 period. These contrasting trends could have been associated with supply-side factors since, as Chapter Two observed, these too showed contrasting trends (Chapter Two, Table 2.20). On the one hand, trends in age and gender suggest that the pool of potential care-givers would have been *increasing*, particularly in the 1990s, since there was an increase in the numbers of people in mid-life, especially women, at this time. Moreover, the availability of potential care-providers was probably also increasing because there was a rise in the probability of being single in mid-life, particularly during the 1990s, and single people in mid-life are more likely to provide intense care to parents than those who are married or cohabiting. On the other hand, the rise in the proportion of people with educational qualifications between 1985 and 2000 could have had the effect of *reducing* the availability of people to provide intense informal care, particularly where provision of care was negatively associated with education,

The precise impact of trends in socio-demographic factors on provision of intense care for older parents is, as Chapter Two observed, likely to depend partly on the strength of the association between each factor and intense care for parents. Chapter Three showed

that the factors associated with each type of care varied. Thus, it showed that age and gender were significantly associated with provision of all forms of intense and very intense care for older parents, but marital status was associated only with provision of co-resident care and education only with very intense care. Therefore, the increase in extra-resident care, identified in Chapter Three, might have been associated with the increase in the availability of people in mid-life, especially women, during the period under consideration. On the other hand, the decline in very intense care might have been associated with the increase in the proportion of people with educational qualifications, which could have had the effect of decreasing the supply of care-providers. There are, however, also *a priori* reasons for expecting these supply-side explanations to be somewhat limited. In particular, there is no clear reason in supply-side terms for expecting a decline in intense co-resident care and indeed some reason for expecting an increase, since provision of co-resident care was associated, not just with age and gender, but also with being single, and the pool of single people was increasing during the 1990s in particular.

Supply-side explanations are explored in this chapter through a demographic method called 'direct standardisation' (Newell 1988). This methodology allows for an exploration of the extent to which changes in numbers providing intergenerational care would have been 'expected' on the basis of changes in underlying socio-demographic and socio-economic factors affecting provision of care. The methodology, which will be explained in more detail later in the chapter, involves comparing 'expected' numbers providing care with 'estimated' numbers. A first stage of the analysis is then to estimate the numbers of people providing each type of intense and very intense care for older parents in each year.

The first part of the present chapter therefore provides estimates of the numbers of people providing each type of intense intergenerational care. Numbers providing care are important, not just for the later stage of the analysis, but in their own right. The first part of the chapter considers the impact of the trends in the proportions of people providing care, first, on the numbers of care-providers overall and, second, on the numbers of care-providers in key sub-groups, such as women and those under State Pension Age. The second part of the chapter compares these 'estimated' numbers with numbers 'expected' on the basis of changes in socio-demographic factors.

The present chapter uses information on the proportions of people providing care, identified in Chapter Three, and combines these with population data to generate estimated and expected numbers of people providing informal care. As described in Chapter Two, the population data used in this study are official data, by age and gender, published by the Office for National Statistics (Chapter Two, Table 2.16). The data on marital status and education are derived from the GHS data for 1985, 1990, 1995 and 2000 (Chapter Two, Table 2.17 and Figure 2.18). The GHS data on care provision relate only to the household population and therefore numbers in private households were required. These numbers were calculated using information from the 1991 and 2001 Census, as described in the appendix at the end of the chapter.

4.1 Numbers of People Providing Intense/Very Intense Care for Older Parents

4.1.1 Total Numbers Providing Intense/Very Intense Care for Older Parents

Up to now, trends in the different forms of intergenerational care for older parents have been examined in terms of significant changes in the proportions of people providing care over time. What implications did these changes in proportions providing care have, however, for the estimated *numbers* of people providing care? Table 4.1 shows the estimated numbers of people providing care to older parents in Britain between 1985 and 2000, by intensity and locus of care, with 95 per cent Confidence Intervals.

Table 4.1

Estimated numbers of people providing informal care to older parents for 20 and 50 hours a week or more, by locus of care, Britain, 1985-2000

Numbers in thousands, range (95% Confidence Intervals) & % change over time

(a) Intense care (20 hours a week or more)

Year	Co-resident care		Extra-resident care		All care	
	Point	Range	Point	Range	Point	Range
Numbers						
1985	220	180-265	185	150-230	400	350-465
1990	240	200-295	240	200-295	485	425-550
1995	170	135-215	280	240-340	455	395-525
2000	190	150-245	280	235-350	470	400-550
% change						
1985/90	*11*		*33*		*21*	
1990/95	*-29*		*17*		*-7*	
1995/00	*12*		*0*		*4*	
1985/95	*-21*		*55*		*13*	
1985/00	*-12*		*54*		*17*	

(b) Very intense care (50 hours a week or more)

Year	Co-resident care		Extra-resident care		All care	
	Point	Range	Point	Range	Point	Range
Numbers						
1985	160	130-200	15	10-30	175	145-220
1990	125	95-165	20	10-40	145	115-190
1995	70	50-105	25	15-50	95	75-140
2000	90	65-130	20	15-50	110	85-160
% change						
1985/90	*-22*		*37*		*-16*	
1990/95	*-41*		*27*		*-31*	
1995/00	*23*		*-10*		*14*	
1985/95	*-54*		*74*		*-43*	
1985/00	*-43*		*56*		*-35*	

Sources: 1985, 1990, 1995, 2000 GHS (author's analysis), official population data and 1991, 2001 SARs

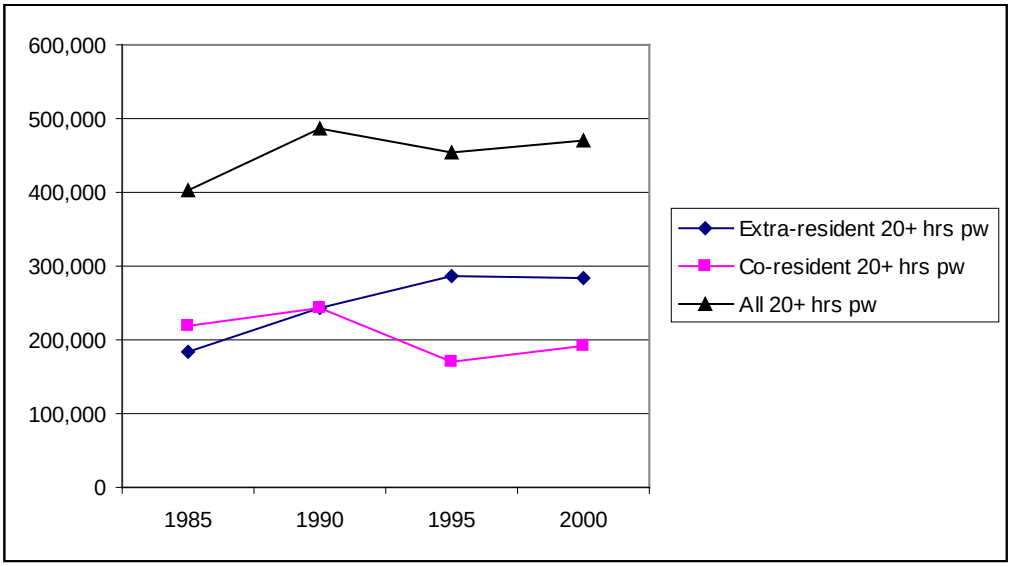
Notes: Numbers rounded to nearest 5,000. Percentage change based on unrounded numbers. Numbers relate to people aged between 30 and 74. Numbers providing co-resident and extra-resident care for 20 hours a week or more do not necessarily equal all care because some people provided care in both the same and another household

Between 1985 and 1995, the estimated numbers of people providing intense extra-resident care for older parents increased by around half (Table 4.1, Figure 4.2). Numbers providing care for 20 hours a week or more to parents in another household rose from around 185,000 to around 280,000 people. During the same period, intense co-resident care fell, although this decline occurred only between 1990 and 1995. Numbers providing care for 20 hours a week or more to parents in the same household fell from around 240,000 in 1990 to around 170,000 in 1995 (Table 4.1). The net effect of these changes was that the total numbers of people providing intense care rose by around 15 per cent between 1985 and 1995. The total numbers of people providing care for 20 hours a week or more to older parents rose from around 400,000 to around 455,000 between 1985 and 1995 (Table 4.1).

Figure 4.2

Estimated numbers providing intense care to older parents for 20 hours a week or more, by locus of care, Britain, 1985-2000

Estimated numbers



Sources and notes: see Table 4.1

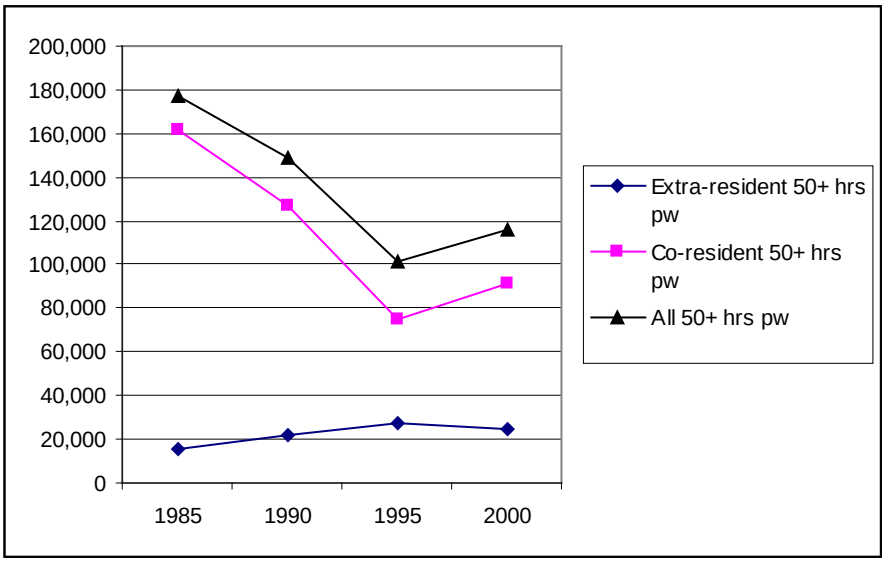
At the same time, between 1985 and 1995, the numbers of people providing very intense care for older parents for 50 hours a week or more fell (Table 4.1, Figure 4.3). Numbers providing very intense co-resident care to older parents fell by over half between 1985 and 1995. The number of people providing very intense care to parents in the same household fell from around 160,000 to around 70,000 in the space of a single decade (Table 4.1). Although most of this change occurred between 1990 and 1995, there was also a decline in numbers providing very intense co-resident care

between 1985 and 1990. The numbers providing very intense extra-resident care rose during this period but, although the proportionate increase was very large, this increase involved relatively small numbers of people. Therefore, the net effect of these changes was that all care for 50 hours a week or more to older parents fell by nearly half between 1985 and 1995 (Table 4.1, Figure 4.3).

Figure 4.3

Estimated numbers providing intense care to older parents for 50 hours a week or more, by locus of care, Britain, 1985-2000

Estimated numbers



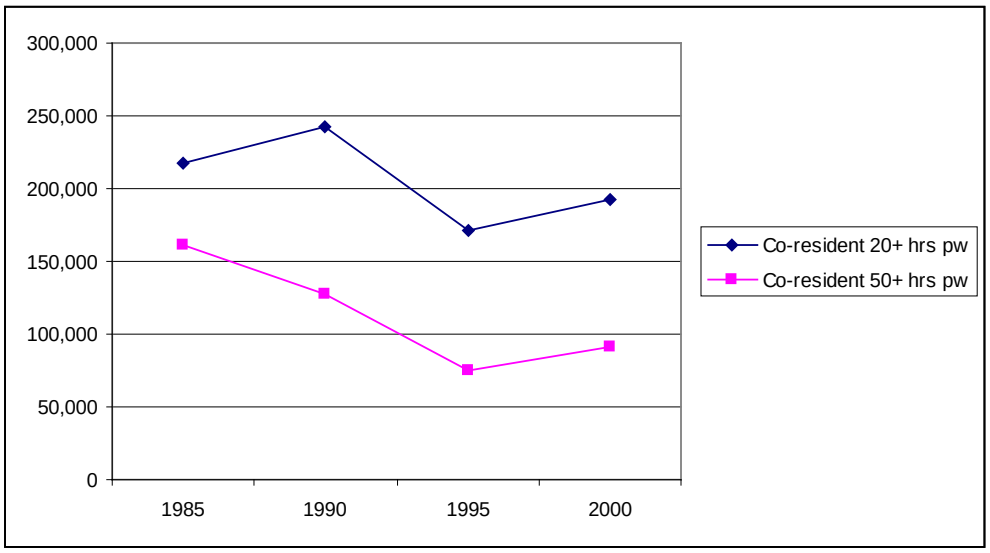
Sources and notes: see Table 4.1

As the last chapter suggested, the trends in provision of intense and very intense care for older parents living in the same household shared some key characteristics and these similarities are also apparent in the trends in the numbers of people providing intense and very intense co-resident care (Table 4.1, Figure 4.4). In both, there was a sharp fall during the 1990/95 period. Numbers providing intense co-resident care fell by nearly 30 per cent during this time, while numbers providing very intense co-resident care fell by over 40 per cent. Numbers of people providing co-resident care for 20 hours a week or more fell by approximately 50,000 during the five years between 1990 and 1995, while numbers providing co-resident care for 50 hours a week or more fell by around 55,000. Numbers providing co-resident care of both intensities rose slightly between 1995 and 2000 (Figure 4.4). These shared characteristics confirm the conclusion of the previous chapter that it is useful, initially at least, to analyse the trends in co-resident care of both intensities together.

Figure 4.4

Estimated numbers providing co-resident care to older parents for 20 and 50 hours a week or more, Britain, 1985-2000

Estimated numbers



Sources and notes: see Table 4.1

At the same time, the trends in numbers of people providing intense care for older parents also confirm the previous chapter's conclusion that there was a lack of detailed correspondence between changes in intense co-resident and changes in intense extra resident care. The period of time when intense extra-resident care was increasing most rapidly was between 1985 and 1990, during which time this form of care rose by about a third (Table 4.1, Figure 4.2). However, the period of time when co-resident care was decreasing most rapidly was between 1990 and 1995, when the numbers of people providing this form of care fell by just under a third.[1] The trends in numbers therefore suggest that the decline in intense co-resident care cannot be 'explained' by the increase in intense extra-resident care, since the changes in each type of care did not correspond closely to each other during the 1985/95 period. This means that it makes sense to treat the trends in each type of intense care separately.

The examination of trends in numbers providing care in this section therefore reinforces the conclusions of the previous chapter and suggests that there were two key trends in

[1] There was also a lack of detailed correspondence between changes in *very intense* co-resident care for parents and changes in *intense* extra-resident care. The period of time when numbers providing intense extra-resident care were increasing most rapidly was between 1985 and 1990, but the period of time when numbers providing very intense co-resident care were decreasing most rapidly was between 1990 and 1995 (Table 4.1).

intense intergenerational care that require explanation. On the one hand, there was a significant increase in intense extra-resident care between 1985 and 1995. On the other hand, there was a significant decline in intense and very intense co-resident care between 1985 and 1995, concentrated particularly in the 1990/95 period. This analysis will be carried forward into the second part of the chapter.

4.1.2 Numbers by Gender and Age Providing Intense/Very Intense Care

Before going on to the second part of the chapter, the present section looks at the impact of the changes in intense intergenerational care provision on the numbers of people providing care by gender and age. As the previous chapter showed, all forms of intense intergenerational care were significantly associated with both gender and age, with care provision greater for women than for men and for people in mid-life than for other age-groups.

Numbers by gender

Table 4.5 shows the estimated numbers of people providing different forms of intense and very intense intergenerational care by gender. Confidence Intervals are not shown in the table, which is intended to illustrate the broad effects of (previously identified) significant changes over time in numbers providing care by gender. The table clearly illustrates the predominance of women in provision of all forms of intense and very intense intergenerational care. For example, of the estimated 400,000 people providing intergenerational care for 20 hours a week or more in 1985, approximately 250,000 were women. Of the estimated 175,000 people providing intergenerational care for 50 hours a week or more in 1985, approximately 115,000 were women.

Partly because women were more likely than men to provide intense intergenerational care, the trends in care provision overall tended to be driven by the trends in women's provision of care. Numbers of women providing care for 20 hours a week or more to parents in the same household fell by approximately 45,000 in the five-year period between 1990 and 1995 alone (Table 4.5). This decline in absolute numbers of women providing care was approximately twice the decline in numbers of men providing intense co-resident care in the same period. For the same reason, however, the increase

in numbers of people providing intense extra-resident care between 1985 and 1995 also particularly affected women. Indeed, the increases in extra-resident care in 1985/90 and 1990/95 almost exclusively affected women. The net effect of these changes was therefore that the numbers of women providing intense intergenerational care rose by around 25 per cent during the 1985/2000 period as a whole, whereas the numbers of men providing intense care barely changed at all.

Table 4.5

Estimated numbers providing care to older parents for 20 and 50 hours a week or more by gender, Britain, 1985-2000

Numbers in thousands and % change over time

(a) Intense care (20 hours a week or more)

	Men			Women		
	Co-resident	Extra-resident	All men	Co-resident	Extra-resident	All women
Numbers						
1985	85	65	150	135	115	250
1990	90	75	165	150	165	315
1995	65	65	130	105	215	315
2000	95	60	150	100	220	310
% change						
1985/90	*2%*	*16%*	*8%*	*14%*	*41%*	*27%*
1990/95	*-27%*	*-15%*	*-21%*	*-31%*	*29%*	*0%*
1995/00	*45%*	*-10%*	*17%*	*-7%*	*3%*	*-2%*
1985/95	*-25%*	*-2%*	*-15%*	*-21%*	*82%*	*26%*
1985/00	*8%*	*-12%*	*0%*	*-26%*	*87%*	*24%*

(b) Very intense care (50 hours a week or more)

	Men			Women		
	Co-resident	Extra-resident	All men	Co-resident	Extra-resident	All women
Numbers						
1985	65	<5	65	100	15	115
1990	20	<5	25	100	20	120
1995	25	10	35	50	15	65
2000	35	5	40	55	20	75
% change						
1985/90	*-65%*	*n/a*	*-61%*	*3%*	*21%*	*5%*
1990/95	*5%*	*280%*	*34%*	*-51%*	*-11%*	*-45%*
1995/00	*60%*	*-69%*	*21%*	*7%*	*24%*	*11%*
1985/95	*-63%*	*n/a*	*-48%*	*-50%*	*7%*	*-42%*
1985/00	*-42%*	*n/a*	*-37%*	*-46%*	*34%*	*-36%*

Sources: 1985, 1990, 1995, 2000 GHS (author's analysis), official population data and 1991, 2001 SARs.

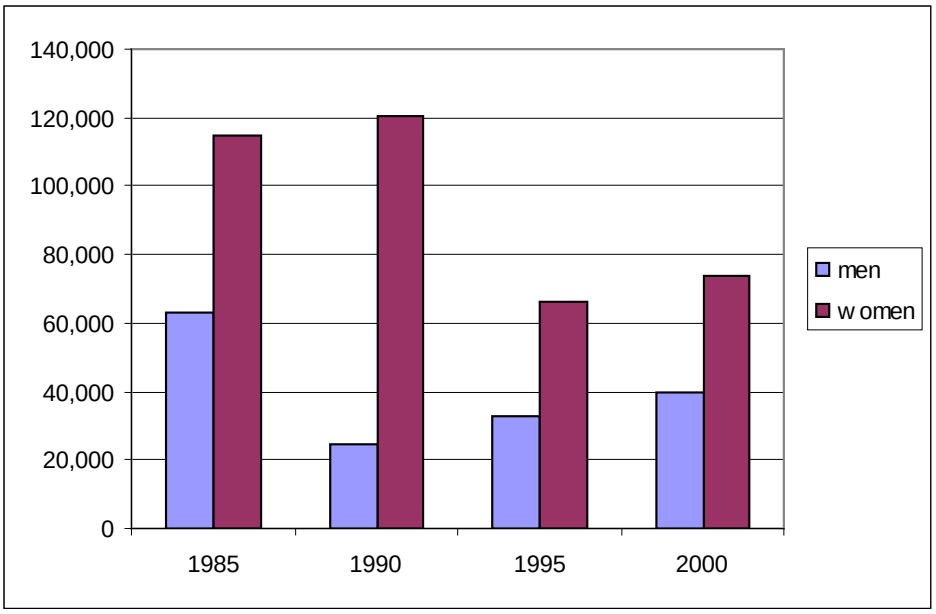
Notes: See Table 4.1. Also note that percentage changes in men providing very intense extra-resident care are not available where the base year is 1985, since there were no men in the sample providing this form of care in 1985 (see Chapter Three, Appendix B, Table 3C.4).

Partly again because of the predominance of women in provision of intergenerational care, however, it was trends in women's provision of care that particularly drove the decline in very intense care. Between 1985 and 1990, when there was a significant decline in men's provision of care for 50 hours a week or more, numbers of men providing very intense care dropped by around 40,000 from around 65,000 in 1985 to around 25,000 in 1990 (Table 4.5, Figure 4.6). However, between 1990 and 1995, when there was a significant decline in women's provision of very intense care, numbers of women providing this form of care dropped even more. Numbers of women providing care for 50 hours a week or more dropped by around 55,000 from around 120,000 in 1990 to around 65,000 in 1995 (Table 4.5, Figure 4.6).

Figure 4.6

Estimated numbers (in thousands) providing care to older parents for 50 hours a week or more by gender, Britain, 1985-2000

Estimated numbers



Sources and notes: see Table 4.1

Numbers by gender and age

Table 4.7 shows the estimated numbers of people providing different intensities of care for older parents by gender and age. Confidence Intervals are not shown in the table, which is again intended to illustrate broad effects of changes in numbers providing care

by gender and age. Table 4.7 illustrates the predominance of people under State Pension Age in the provision of all forms of intense and very intense intergenerational care. For example, there were nearly three times as many women under the age of 60 providing care for 50 hours a week or more in 1985 as there were women of State Pension Age providing this form of care (Table 4.7).

Table 4.7

Estimated numbers providing care to older parents for 20 and 50 hours a week or more by gender and age, Britain, 1985-2000

(a) Intense care (20 hours a week or more) *Numbers in thousands*

	30-44		45-SPA		SPA-74		All under SPA	
	men	women	men	women	men	women	men	women
Numbers								
1985	50	90	85	115	20	45	130	205
1990	30	80	115	170	20	70	145	245
1995	15	60	105	180	10	70	120	245
2000	30	85	105	155	20	70	130	240
% change								
85/90	*-40*	*-16*	*36*	*48*	*8*	*60*	*8*	*19*
90/95	*-52*	*-21*	*-9*	*9*	*-46*	*1*	*-18*	*-1*
95/00	*102*	*42*	*0*	*-15*	*68*	*-4*	*12*	*-1*
85/95	*-71*	*-33*	*24*	*61*	*-41*	*62*	*-11*	*19*
85/00	*-42*	*-5*	*24*	*36*	*-2*	*55*	*0*	*18*

(b) Very intense care (50 hours a week or more)

	30-44		45-SPA		SPA-74		All under SPA	
	men	women	men	women	men	women	men	women
Numbers								
1985	15	30	35	55	15	30	50	85
1990	<5	20	20	65	<5	35	20	85
1995	<5	10	20	35	10	20	25	45
2000	<5	20	35	35	<5	20	35	55
% change								
85/90	*-84*	*-36*	*-41*	*20*	*-84*	*18*	*-55*	*0*
90/95	*6*	*-37*	*5*	*-49*	*332*	*-41*	*5*	*-47*
95/00	*26*	*78*	*62*	*-1*	*-70*	*-7*	*58*	*20*
85/95	*-83*	*-60*	*-38*	*-39*	*-30*	*-31*	*-53*	*-46*
85/00	*-78*	*-28*	*0*	*-40*	*-79*	*-35*	*-25*	*-36*

Sources and notes: see Table 4.1; also note that 'SPA' refers to 'State Pension Age'

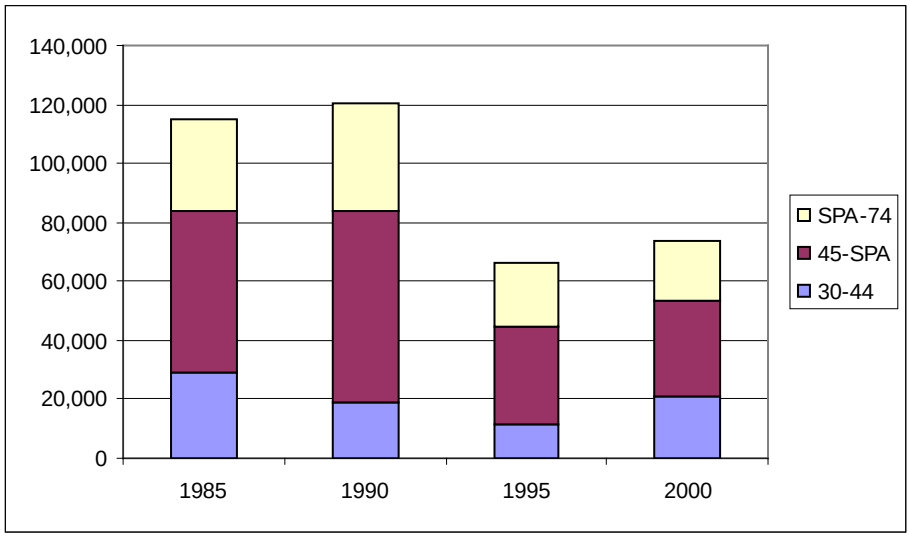
The previous chapter identified a significant increase in provision of intergenerational care for 20 hours a week or more by people in mid-life between 1985 and 1990. Table 4.7 shows that numbers of mid-life women providing intense care rose by nearly 50 per cent between 1985 and 1990, while numbers of mid-life men providing this form of care rose by around a third in the same period. However, the table also shows that numbers of both younger women and men, aged between 30 and 44, providing intense care for parents also fell during this period. The fall in provision of intense care by younger people therefore tended to offset the increase in intense care by people in mid-life and this helps to explain why, as Chapter Three identified, there was no significant increase in care for 20 hours a week as a whole during the 1985/90 period.

Table 4.7 also illustrates that the decline in care for 50 hours a week or more to older parents affected men and women of all age-groups in the 1985 to 1995 period. However, because the majority of those providing very intense care were under State Pension Age, the decline in very intense care particularly affected people of 'working age'. There was around a 50 per cent decline in provision of care for 50 hours a week or more to older parents by people under State Pension Age between 1985 and 1995. During this time, numbers of men of 'working age' providing very intense care fell from around 50,000 to around 25,000, while numbers of women of 'working age' providing this form of care fell from around 85,000 to around 45,000. The percentage decline in numbers providing very intense care who were under State Pension Age (around 50 per cent) was greater than the percentage decline in numbers providing very intense care who were of State Pension Age or above (around 30 per cent) (Table 4.7). The decline in the numbers of women providing very intense care by age-group is illustrated in Figure 4.8 and shows the impact of the decline in very intense care on women under State Pension Age in particular. The impact of the decline in very intense care on women of 'working age' will be important in the next chapter, which looks at the possible effect of trends in employment on provision of intense and very intense care .

Figure 4.8

Estimated numbers (in thousands) of women providing care to older parents for 50 hours a week or more by age, Britain, 1985-2000

Estimated numbers



Sources and notes: see Table 4.7

4.1.3 Summary of Numbers Providing Intense/Very Intense Care for Older Parents

In summary, this part of the chapter has examined changes in the numbers of people providing different types of intense care for older parents between 1985 and 2000. It has shown that there was a large increase in the number of people providing intense care for 20 hours a week or more to older parents outside the household between 1985 and 1995. However, it has also shown that there was a large decline in number of people providing intense care to older parents inside the household between 1985 and 1995, concentrated in the 1990/1995 period. Moreover, there was a very large decline in the number of people providing care for 50 hours a week to older parents inside the household between 1985 and 1995, again particularly in the 1990/1995 period. These changes particularly affected women and people under State Pension Age.

4.2 The Role of Supply-Side Factors in Explaining Trends in Care Provision

The purpose of the second part of this chapter is to examine how far changes in numbers providing intergenerational care would have been 'expected' on the basis of changes in the underlying socio-demographic and socio-economic factors affecting

provision of care. As indicated earlier in the chapter, this part of the analysis relies on direct standardisation. In this methodology, the proportions of people providing care in one year, for example 1985, are applied to the population numbers in a later year, for example 1995, to produce an estimation of 'expected' numbers of people providing care in 1995. These 'expected' numbers providing care in 1995 are then compared with estimated numbers, using 1995 proportions and 1995 population numbers.

The analysis that follows has four sections. The first three each examine a significant change in intense intergenerational care provision that took place between 1985 and 2000. The first section looks at the significant rise in intense extra-resident care between 1985 and 1995. The second section looks at the significant declines in intense and very intense co-resident care between 1990 and 1995. The third section looks at the significant declines in intense and very intense co-resident care that took place in the ten-year period between 1985 and 1995. Reference back to Chapter 3 will show that this analysis will cover all the significant changes that occurred in intense and very intense intergenerational care between 1985 and 2000 (Chapter Three, Table 3.3). Finally, a fourth section of the chapter looks at the changes in intense extra-resident and intense/very intense co-resident care in the whole fifteen year period between 1985 and 2000, in order to compare the expected and the estimated changes overall. No analysis is made here of changes in very intense extra-resident care, partly because there were no significant changes in this form of care between 1985 and 2000 (Table 3.3) and partly because sample numbers in any one year were too small for analysis (Table 3C.2).

The socio-demographic and socio-economic variables included in the analysis of expected numbers providing care are likely to be important for the results. The previous chapter showed that different variables were associated with each type of intense and very intense intergenerational care (Chapter Three, Table 3.2). Age and gender were significantly associated with provision of intense extra-resident care; age, gender and marital status, with provision of intense co-resident care; and age, gender, marital status and education, with provision of very intense co-resident care. In the analyses that follow, therefore, age and gender are taken into account in examining changes in intense extra-resident care; age, gender and marital status are taken into account in examining changes in intense co-resident care; and age, gender, marital status and education are taken into account in examining changes in very intense co-resident care. To illustrate the methodology, in the second section below (Section 4.2.2) the percentages of people

providing very intense co-resident care by age, gender, marital status and education (defined as those with and without educational qualifications) derived from the 1990 GHS, are applied to the 1995 population numbers by age, gender, marital status and education, to generate expected numbers providing care in 1995. These expected numbers are compared with estimated numbers providing care, using 1995 proportions and 1995 numbers.

4.2.1 Expected Numbers Providing Intense Extra-Resident Care, 1985/95

As Chapter Two showed, there was likely to have been an increase in the pool of potential care-givers by age and gender between 1985 and 2000. Numbers of people most likely to provide care for older parents, in particular numbers of mid-life women, rose during this period (Chapter Two, Table 2.16). As Chapter Three went on to show, there was a very strong association between provision of extra-resident care for older parents and both age and gender (Table 3.2). In logistic regression, people in mid-life were over twice as likely to provide extra-resident care for older parents as people in younger age-groups, and women were nearly three times as likely as men to provide this form of care. Therefore, the issue to be examined here is how far the significant increase in numbers of people providing intense extra-resident care between 1985 and 1995 was associated with the underlying increase in the numbers of people in mid-life, especially mid-life women. Table 4.9 shows the numbers of people estimated to be providing intense extra-resident care in 1985 and 1995. It also shows the numbers that would have been expected to be providing this form of care in 1995 if the proportion of people providing care had remained constant between 1985 and 1995.

Table 4.9

Estimated and 'expected' numbers of adults providing extra-resident care for 20 hours a week or more to older parents, Britain, 1985-1995

Numbers in thousands

	Point estimate	95% Confidence Intervals	
		Low	High
1985 (estimated)	185	150	230
1995 (estimated)	280	240	340
1995 ('expected')	200	160	250

Source: see Table 4.1

Notes: 'Expected' numbers are based on 1985 proportions of people providing care and 1995 numbers in the population, by age and gender. Adults refer to people aged 30 to 74. Numbers are rounded to nearest 5,000.

Table 4.9 shows that a moderate increase in extra-resident care would have been expected due to the rise in the underlying population of potential care-givers. It would have been expected that numbers providing extra-resident care would have increased from around 185,000 to around 200,000 between 1985 and 1995, that is, by approximately 15,000. However, the estimated increase was considerably higher than this. Indeed, the numbers of people providing extra-resident care are estimated to have increased by nearly 100,000 between 1985 and 1995. Numbers are estimated to have been around 280,000 in 1995, rather than the expected 200,000. In other words, the increase in numbers providing extra-resident care far exceeded the expected numbers. Indeed, the increase in the underlying population of potential care givers, by age and gender, 'explains' only around 15 per cent of the overall increase in the numbers of people providing intense extra-resident care between 1985 and 1995.

The analysis therefore suggests that underlying demographic trends explain only a small proportion of the change that took place in numbers providing intense extra-resident care between 1985 and 1995. This is an important result since there were only two plausible explanations for the rise in extra-resident care hypothesised in Chapter Two (Table 2.20) and this result will be discussed again in the conclusions to this chapter.

4.2.2 Expected Numbers Providing Intense/Very Intense Co-Resident Care, 1990/95

As Chapter Three concluded, a supply-side explanation for the decline in very intense co-resident care seems plausible. Chapter Two had shown that the probability of having an educational qualification was rising among men and women in mid-life in the period between 1985 and 2000 (Chapter Two, Figure 2.18). Yet, as Chapter Three went on to show, education was negatively associated with provision of very intense co-resident care for older parents (Chapter Three, Table 3.2). People without educational qualifications were approximately a third more likely to provide very intense co-resident care to older parents than those with educational qualifications. The increase in the probability of having educational qualifications might then plausibly have been associated with a decline in provision of very intense co-resident care.

A supply-side explanation for the decline in intense co-resident care seems rather less plausible. This latter form of care was not significantly associated with the likelihood of having an educational qualification (Chapter Three, Table 3.2). Indeed, the factors

associated with provision of intense co-resident care, that is, age, gender and marital status, were all likely to be associated with an increase in care provision, not a decline. As the previous section showed, trends in age and gender were likely to lead to a moderate increase in care provision. In the same way, the rise in the probability of being single, particularly during the 1990s, might plausibly also have been associated with an increase in care provision, since being single was significantly associated with providing intense co-resident care (Chapter Two Table 2.17, Chapter Three Table 3.2).

The analyses that follow examine empirically how far supply-side explanations were able to account for the changes in the numbers of people providing intense and very intense co-resident care between 1990 and 1995. Trends in age, gender and *de facto* marital status are taken into account in examining intense co-resident care and trends in age, gender, *de facto* marital status and education are taken into account in examining very intense co-resident care. The present section looks at the five-year period between 1990 and 1995, when significant falls in both intense and very intense co-resident care took place.

Table 4.10 shows the numbers of people estimated to be providing intense and very intense co-resident care in 1990 and 1995. It also shows the numbers that would have been expected to be providing this form of care in 1995 if the proportion of people providing care had remained constant between 1990 and 1995.

The results shown in Table 4.10 are not very surprising with regard to trends in intense co-resident care. Table 4.10 suggests that, controlling for trends in age, gender and marital status, a moderate increase (of around 8 per cent) in the numbers of people providing co-resident care for 20 hours a week or more would have been expected between 1990 and 1995. This result is not surprising given that, as just noted, there was little plausible reason to suppose that expected numbers of intense co-resident care-providers would have declined. Indeed, as Table 4.10 suggests, rather than the decline of approximately 70,000 care-providers than is estimated to have occurred between 1990 and 1995, a moderate increase of around 20,000 care-providers would have been expected. Perhaps unsurprisingly then, supply-side factors appear to have played little role in the decline in intense co-resident care between 1990 and 1995.

Table 4.10

Estimated and 'expected' numbers of adults providing co-resident care for 20 and 50 hours a week or more to older parents, Britain, 1990-1995

Numbers in thousands

	Point estimate	95% Confidence Intervals	
		Low	High
Intense co-resident care (20+ hrs pw)			
1990 (estimated)	240	200	295
1995 (estimated)	170	135	215
1995 ('expected')	260	215	315
Very intense co-resident care (50+ hrs pw)			
1990 (estimated)	125	95	165
1995 (estimated)	70	50	105
1995 ('expected')	135	90	160

Sources: see Table 4.1.

Notes 'Expected' numbers are based on 1990 proportions of people providing care and 1995 numbers in the population, by age, gender and de facto marital status for intense co-resident care and by age, gender, de facto marital status and education for very intense co-resident care. Adults refer to people age 30 to 74 (care for 20 hours a week or more) and people aged 30 to 69 (care for 50 hours a week or more). Numbers are rounded to nearest 5,000.

Rather more surprisingly, however, Table 4.10 also shows that a moderate increase (again of around 8 per cent) would also have been expected between 1990 and 1995 in very intense co-resident care. Table 4.10 shows that a slight increase of around 10,000 very intense co-resident care-providers would have been expected between 1990 and 1995. The results suggest, then, that a decline in co-resident care for older parents for 50 hours a week or more would not have been expected between 1990 and 1995, in spite of the fact that education, as well as age, gender and marital status, was taken into account in the analysis.

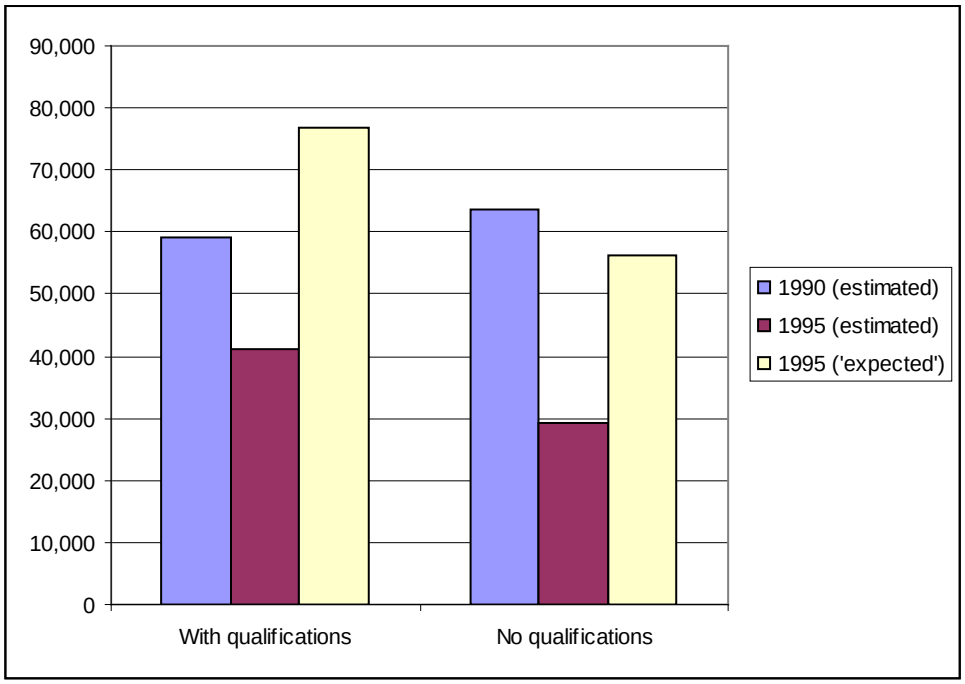
Because it was anticipated that trends in education would have had a constraining effect on care provision in this period, the estimated and expected numbers in 1995 by educational qualifications were specifically examined. The results are shown in Figure 4.11. The figure shows that a constraining effect of trends in education has been captured in the modelling. A decline would have been expected in the numbers of people without any educational qualification who were providing very intense co-resident care (Figure 4.11). However, the figure also shows that this decline would have been more than compensated by an expected increase in the numbers of people with educational qualifications providing very intense co-resident care. Therefore, a

change in the composition of care-providers would have been expected, but not a decline in numbers.

Figure 4.11

Estimated and 'expected' numbers of adults aged 30 to 69 providing co-resident care for 50 hours a week or more to older parents by educational qualifications, Britain, 1990-1995

Estimated & expected numbers



Sources and notes: see Table 4.10

4.2.3 Expected Numbers Providing Intense/Very Intense Co-Resident Care, 1985/95

The present section looks at estimated and expected numbers of people providing intense and very intense co-resident care for older parents over the ten-year period between 1985 and 1995. During this decade, numbers providing both intense and very intense co-resident care fell sharply. The present section looks at a longer time-period than the previous section, which examined trends in the numbers providing the same types of care in the five-year period between 1990 and 1995. It might be argued that the impact of the trends in educational qualifications on care provision, in particular, might not become clear during a five-year period but might become more apparent over a longer time-scale.

The approach to the analysis in the present section is, in other respects, similar to the previous section. Trends in age, gender and marital status are taken into account in examining co-resident care and trends in age, gender, marital status and education are taken into account in examining very intense co-resident care. A complication in looking at care provision, controlling for marital status, in the ten-year period between 1985 and 1995 is that, because of the nature of the GHS data, legal marital status in 1985 is in effect compared with *de-facto* marital status in 1995. The effect of this is likely to underestimate the potential impact of changes in marital status on care provision and needs to be borne in mind in the analysis that follows.

Table 4.12 shows the numbers of people estimated to be providing intense and very intense co-resident care in 1985 and 1995. It also shows the numbers that would have been expected to be providing this form of care in 1995 if the proportion of people providing care had remained constant between 1985 and 1995.

Table 4.12

Estimated and 'expected' numbers of adults providing co-resident care for 20 and 50 hours a week or more to older parents, Britain, 1985-1995

Numbers in thousands

	Point estimate	95% Confidence Intervals	
		Low	High
Intense co-resident care (20+ hrs pw)			
1985 (estimated)	220	180	265
1995 (estimated)	170	135	215
1995 ('expected')	245	200	295
Very intense co-resident care (50+ hrs pw)			
1985 (estimated)	160	130	200
1995 (estimated)	70	50	105
1995 ('expected')	165	120	195

Sources: see Table 4.1.

Notes: 'Expected' numbers are based on 1990 proportions of people providing care and 1995 numbers in the population, by age, gender and marital status for intense co-resident care and by age, gender, marital status and education for very intense co-resident care. Marital status is legal marital status in 1985 and de facto legal marital status in 1995. Adults refer to people age 30 to 74 (care for 20 hours a week or more) and people aged 30 to 69 (care for 50 hours a week or more). Numbers are rounded to nearest 5,000.

As with the findings in the previous section, the results shown in Table 4.12 are not very surprising with regard to trends in intense co-resident care. Table 4.12 suggests that, controlling for trends in age and gender, and controlling as far as possible for changes in marital status, a moderate increase in the numbers of people providing co-resident care for 20 hours a week or more would have been expected between 1985 and 1995. Numbers providing care for 20 hours a week or more to older parents in the same household would have been expected to increase by around 10 per cent, from around 220,000 to around 245,000 between 1985 and 1995. Indeed, this moderate expected increase might have been somewhat greater if a consistent definition of marital status had been possible. This is because the trends in marital status in this period, with the increase in the probability of being either legally or *de facto* single, were likely to have had the effect of increasing the availability of care-providers. Certainly, trends in socio-demographic factors do not seem to account for the 20 per cent decline in the numbers of people providing intense co-resident care that is estimated to have occurred between 1985 and 1995.

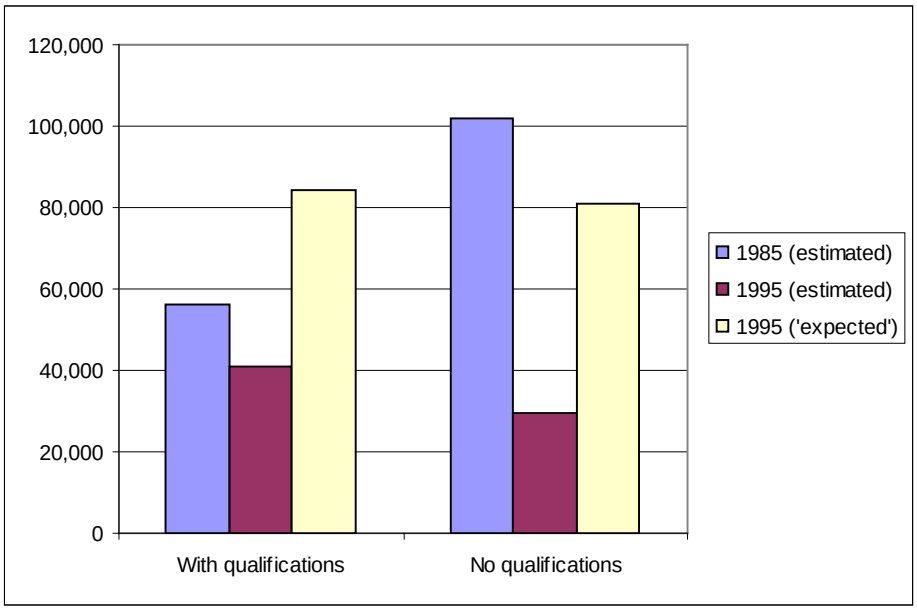
Again, rather more surprisingly, however, Table 4.12 also shows that a slight increase in very intense co-resident care would also have been expected between 1985 and 1995. Table 4.12 shows that an increase of around 5,000 very intense co-resident care-providers would have been expected between 1985 and 1995. Indeed, this increase might again have been higher if a consistent definition of marital status had been possible. The results suggest then that a decline in co-resident care for older parents for 50 hours a week or more would not have been expected between 1985 and 1995, despite the inclusion of trends in education in the analysis.

Because it was anticipated that trends in education would have had a constraining effect on care provision in this period, the estimated and expected numbers in 1995 by educational qualifications were again specifically examined. The results are shown in Figure 4.13. The figure suggests that a decline would have been expected in the numbers of people without any educational qualification who were providing very intense co-resident care. However, this decline would have been compensated by an expected increase in the numbers of people with educational qualifications providing very intense co-resident care. Therefore, consistent with the findings of the previous section, a change in the composition of care-providers would have been expected, but not a decline in overall numbers providing co-resident care for 50 hours a week or more.

Figure 4.13

Estimated and 'expected' numbers of adults aged 30 to 69 providing co-resident care for 50 hours a week or more to older parents by educational qualifications, Britain, 1985-1995

Estimated & expected numbers



Sources and notes: see Table 4.12

4.2.4 Expected Numbers Providing Extra-Resident and Co-Resident Care, 1985/00

The present section looks at estimated and expected numbers of people providing intense extra-resident and intense or very intense co-resident care in the whole fifteen year period between 1985 and 2000, in order to compare the expected and the estimated changes overall. During this period, estimated numbers providing intense extra-resident care increased, while estimated numbers providing both intense and very intense co-resident care fell (Table 4.1). The present section looks at the whole time-period covered by the study partly in order to check whether there were any large expected changes in numbers providing care during periods where estimated numbers did *not* change significantly, which might affect the interpretation of the results obtained so far.

The approach to the analysis in the present section is, in other respects, similar to the previous sections. Trends in age and gender are taken into account in examining intense extra-resident care; trends in age, gender and marital status are taken into account in examining co-resident care and trends in age, gender, marital status and education are

taken into account in examining very intense co-resident care. As in the previous section, there is a complication in looking at care provision, controlling for marital status, in the period between 1985 and 2000 since, because of the nature of the GHS data, legal marital status in 1985 is in effect compared with *de-facto* marital status in 2000. This needs to be borne in mind in the analysis that follows.

Table 4.14 shows the numbers of people estimated to be providing intense extra-resident care and intense or very intense co-resident care in 1985 and 2000. It also shows the numbers that would have been expected to be providing these forms of care in 2000 if the proportion of people providing care had remained constant between 1985 and 2000.

Table 4.14

Estimated and 'expected' numbers of adults providing extra-resident care for 20 hours a week or more and co-resident care for 20 or 50 hours a week or more to older parents, Britain, 1985-2000

Numbers in thousands

	Point estimate	95% Confidence Intervals	
		Low	High
Intense extra-resident care (20+ hrs pw)			
1985 (estimated)	185	150	230
2000 (estimated)	280	235	350
2000 ('expected')	210	165	265
Intense co-resident care (20+ hrs pw)			
1985 (estimated)	220	180	265
2000 (estimated)	190	150	245
2000 ('expected')	265	215	325
Very intense co-resident care (50+ hrs pw)			
1985 (estimated)	160	130	200
2000 (estimated)	90	65	130
2000 ('expected')	175	135	225

Sources: see Table 4.1.

Notes: 'Expected' numbers are based on 1985 proportions of people providing care and 2000 numbers in the population, by age and gender for intense extra-resident care, age, gender and marital status for intense co-resident care and by age, gender, marital status and education for very intense co-resident care. Marital status is legal marital status in 1985 and de facto legal marital status in 2000. Adults refer to people age 30 to 74 (extra-resident and co-resident care for 20 hours a week or more) and people aged 30 to 69 (co-resident care for 50 hours a week or more). Numbers are rounded to nearest 5,000.

Table 4.14 confirms the results of the previous three sections, which showed that the estimated changes would not, on the whole, have been expected as a result of changes in the population of potential care-givers. Thus, the table shows that, controlling as far as possible for relevant variables, a moderate increase of approximately 10 to 20 per cent would have been expected in all forms of intense care for older parents between 1985 and 2000. However, this increase was lower than the increase in intense extra-resident care that is estimated to have taken place, while the numbers providing intense and very intense co-resident care were not estimated to have increased at all but rather to have declined during this period. The expected increase in intense and very intense co-resident care might have been somewhat greater if a consistent definition of marital status had been possible.

4.3 Discussion and Conclusions

4.3.1 Summary and Discussion of Results

The chapter has systematically examined how far changes in provision of intense intergenerational care between 1985 and 2000 were associated with changes in supply-side factors. The impact of changes in four factors, age, gender, marital status and education, has been analysed. The results suggest that the changes in the numbers of people providing intense intergenerational care provision in Britain during the period under study do not seem to be much explained by underlying trends in the socio-demographic and socio-economic composition of the population. Controlling for age and gender, some increase in numbers providing intense extra-resident care for older parents would have been expected in 1985/95 and 1985/2000, but the estimated increase in numbers providing extra-resident care far exceeded these expected numbers. Controlling for age, gender and marital status, no decline in numbers providing intense co-resident care for parents would have been expected in 1990/1995, 1985/1995 or 1985/2000, yet there were declines in numbers providing this form of care at these times. Controlling for age, gender, marital status and education, no decline in numbers providing very intense co-resident care for parents would have been expected in 1990/1995, 1985/1995 or 1985/2000, yet there were very large declines in numbers providing this form of care at these times.

The finding that trends likely to affect the supply of care seem to have played little part in the changes in intense intergenerational care provision was not particularly surprising with regard to some forms of care. Thus, as indicated at the outset of this chapter, there were no clear reasons, in terms of socio-demographic trends, for expecting a decline in intense co-resident care for parents and indeed some reasons for expecting an increase. Provision of intense co-resident care was associated with age, gender and marital status and, as indicated at the beginning of this chapter, trends in all three factors would have suggested an increase in the availability of care-providers in this period. It was not always possible to capture fully the effects of changes in marital status on expected care provision in the analysis carried out here, notably in the 1985/95 or 1985/2000 periods. Yet, had this been possible, the effects are unlikely to have contradicted the results but reinforced them further.

Other findings were more surprising. In particular, it was anticipated at the beginning of this chapter that the increase in extra-resident care might have been associated with the increase in the availability of people in mid-life, especially women, during the period under consideration. However, the results suggest that, although the rise in the pool of potential care-givers did contribute to the rise in the numbers of people providing extra-resident care between 1985 and 1990 and between 1985 and 2000, most of the increase in numbers providing this form of care was not explained by these supply-side factors. Although not anticipated at the beginning of the chapter, this finding is however consistent with other evidence presented in this study so far. Thus, the present chapter has shown that the greatest increase in numbers providing intense extra-resident care for older parents occurred in the period between 1985 and 1990 (Table 4.1). Yet, it was shown in Chapter Two that the greatest increase in numbers of mid-life women in the population occurred in the period between 1990 and 1995 (Chapter Two, Table 2.16). The large increase in numbers providing intense extra-resident care between 1985 and 1990 was therefore unlikely to have been a result of changes in the population of mid-life women, whose numbers in fact changed very little during the late 1980s.

Perhaps most surprising was the finding that trends in education seem to have contributed little to the decline in numbers providing very intense care. It was anticipated at the beginning of this chapter that the decline in very intense care might have been associated with the increase in educational qualifications. This seemed

plausible because there was a significant association between provision of very intense care for older parents and a lack of educational qualifications (Chapter Three, Table 3.2). Therefore as the probability of having educational qualifications in the population rose, so the numbers providing very intense care might have been expected to fall. However, the evidence presented in this chapter has shown that, even allowing for the trends in education, small *increases* in the numbers providing very intense co-resident care would have been expected in the 1990/95, 1985/95 and 1985/2000 periods. However, this finding is again consistent with other evidence presented in the study so far. Thus, the evidence presented in the present chapter has shown that the numbers of people providing very intense co-resident care for older parents fell sharply between 1985 and 1995 and then rose slightly between 1995 and 2000 (Figure 4.3). However, Chapter Two showed that changes in education did not share these trends. Rather, among key potential care-providers, there was a consistent trend downwards in the proportion of people without educational qualifications between 1985 and 2000 (Chapter Two, Figure 2.18). Moreover, although a decline in numbers providing very intense care might have been expected as a result of trends in education, trends in all the other factors with which this form of care was associated, that is, age, gender and marital status, might have been expected to have the opposite effect. In other words, any downward pressure on care provision due to trends in education were more than offset by upward pressure on care provision due to trends in age, gender and marital status. Finally, it should also be recalled that there were no significant changes by those without educational qualifications in provision of very intense co-resident care during any of the three five-year sub-periods between 1985 and 2000 (Chapter Three, Table 3.7). This contrasted to significant changes in all the other factors, that is, age, gender and marital status, with which very intense care for older parents was associated.

4.3.2 Implications for Explanation of Trends in Care Provision

The examination of trends in numbers of people providing different forms of intense intergenerational care in the present chapter has reinforced the conclusions of the last chapter, which suggested that the trends in extra-resident and co-resident care should be analysed separately. The two sections below explore how far the results of the present chapter help to explain, first, the trends in intense extra-resident care and, second, the trends in intense and very intense co-resident care.

Increase in intense extra-resident care for older parents

This chapter has shown that underlying demographic changes explain only a small proportion of the increase in numbers providing intense extra-resident care between 1985 and 2000. This increase was concentrated in the 1985/95 period, yet it has been estimated here that only approximately 15 per cent of the increase in numbers of people providing care for 20 hours a week or more to older parents in another household between 1985 and 1995 would have been accounted for by the underlying increase in the numbers of potential care-providers. In other words, most of the increase in numbers of intense extra-resident care providers must have been due to other factors.

Reference back to Chapter Two, however, suggests that, of the key factors considered here, there was only one other factor likely to explain an increase in intense care for older parents specifically during the 1985/95 period (Chapter 2, Table 2.20). This was a demand-side explanation in terms of trends in the numbers of older people. Indeed, trends in the numbers of older people, identified in Chapter Two, show a remarkable correspondence with trends in the numbers of people providing intense extra-resident care in the 1985/2000 period as a whole. Thus, there were increases in the numbers of older people, especially the 'older old', between 1985 and 1995, which levelled off between 1995 and 2000 (Table 2.20). These trends almost exactly match the trends in numbers of people providing intense extra-resident care which, as the present chapter has shown, also increased between 1985 and 1995, before levelling off between 1995 and 2000 (Table 4.1).

Indeed, the details of the trends in the numbers of older people and the trends in the numbers of people providing intense extra-resident care also match each other closely. The trends in older people that are likely to be most relevant to intense care provision are the trends in the numbers of 'older old' people, those aged 80 and over who are both most likely to have disabilities and least likely to have alternative sources of intense informal care (Chapter Two, Sections 2.3.1-2.3.3). Reference back to Table 2.10 in Chapter Two shows that the numbers of people aged 80 and over rose most rapidly (by 15 per cent) between 1985 and 1990, also rose rapidly between 1990 and 1995 (by 11 per cent) but levelled off between 1995 and 2000 (rising by only 2 per cent). The trends in intense extra-resident care to older parents showed a very similar pattern (Table 4.1). The numbers of people providing intense care to older parents in another household also

rose most rapidly (by 33 per cent) between 1985 and 1990, again rose rapidly between 1990 and 1995 (by 17 per cent) but again levelled off between 1995 and 2000 (rising by less than 0.5 per cent).

It therefore seems plausible to suggest that the main reason why intense extra-resident care for older parents increased between 1985 and 1995 was because the numbers of older people, especially the numbers of 'older old' people, were increasing at this time. In other words, it seems plausible to suggest that the numbers of people providing intense extra-resident care to older parents rose with the numbers of older people. As pointed out at the end of Chapter Three, previous studies have certainly approached the analysis of trends in informal care provision in the recent past with the expectation that care for parents would have increased due to the rise in numbers of older people (Hirst 2001, Evandrou and Glaser 2002) and demographic trends also suggest that the proportion of people in mid-life with living parents would have been increasing between 1985 and 2000 (Murphy and Grundy 2003). Projections of informal care in future years also often assume, in effect, that the numbers of people providing informal care will rise with the numbers of older people (Wittenberg *et al* 2001). The present study confirms that the rise in some forms of intense informal care for older people in the recent past can most probably be attributed to the increase in the numbers of older people. This explanation of the rise in intense extra-resident care will be explored again later in the study, in particular, when demand-side factors are explored in more detail in Chapter Six.

However, if the rise in extra-resident care for older parents can be explained primarily as a response to the increase in the numbers of older people, then this raises even more starkly the question as to why *co-resident* care for older parents did not also increase at this time.

Decrease in co-resident care for older parents

The present chapter has found that the supply-side factors examined so far do not explain the decline in numbers of people providing intense and very intense co-resident care to older parents between 1985 and 2000. Four supply-side factors have been examined in the chapter, that is, trends in age, gender, marital status and education. Reference back to the end of Chapter Two (Table 2.20), however, shows that there was

another potential supply-side explanation that might have affected provision of intense care to older parents in the 1985/00 period, that is, the increase in employment rates of mid-life women. The present chapter has shown that both women and people under State Pension Age predominated in the provision of all forms of intense intergenerational care between 1985 and 2000. Moreover, the present chapter has shown that the trends in care provision particularly affected women and people under State Pension Age. For example, as the first part of the chapter showed, numbers of women under State Pension Age providing very intense care to older parents nearly halved in the space of the ten years between 1985 and 1995. Therefore, it certainly seems worth examining how far the decline in intense and very intense co-resident care for older parents might have been explained in terms of trends in the employment rates of potential care-givers. This is the subject of the next chapter (Chapter Five).

Appendix to Chapter 4

Numbers of People Aged 30 to 74 in Private Households

The calculation of the numbers of people in private households was based on the probability of being in a private household, by age and gender, derived from 1991 and 2001 Census data. The probability of being in a private household in 1985, 1990 and 1995 was derived from the 1991 Census (Sample of Anonymised Records (SARs) and the probability of being in a private household in 2000 from the 2001 SARs. The reason why the 1991 Census was utilised for most years is because it is more reliable than the 2001 Census, when some residents were mistakenly classified as staff (Bajekal *et al* 2006, Grundy & Jitlal 2007). The estimated population of men and women aged 30 to 74 in private households by age is shown in Table 4A.1. The table shows that at least 99 per cent of people aged between 30 and State Pension Age (SPA) were in private households and, even among those of State Pension Age (but under the age of 75) nearly 99 per cent were in private households. The percentage of the older population in communal establishments increases sharply with age and is analysed in detail in Chapter Eight of this study.

Table 4A.1

Number of men and women in private households and in population aged 30 to 74, by age, Britain, 1985-2000

Numbers in thousands (rounded to nearest 5,000)

	30-44		45-SPA		SPA-74	
	Private households	Total	Private households	Total	Private households	Total
Men						
1985	5,500	5,545	5,920	5,965	2,090	2,120
1990	5,770	5,820	5,895	5,935	2,170	2,200
1995	5,960	6,010	6,340	6,380	2,245	2,280
2000	6,335	6,395	6,660	6,700	2,215	2,240
Women						
1985	5,480	5,495	4,550	4,560	4,290	4,335
1990	5,820	5,840	4,590	4,605	4,150	4,200
1995	6,070	6,090	5,095	5,110	4,085	4,130
2000	6,485	6,505	5,395	5,410	3,990	4,020

Source: Office for National Statistics and General Register for Scotland; 1991, 2001 Census (SARs)

Note: Numbers are rounded to nearest 5,000. The total numbers in the population by age-bands correspond to Table 2.16 (Chapter Two).

Chapter 5

Care for Older Parents and Employment: The Case of Mid-Life Women

This chapter explores how far trends in intense intergenerational care in Britain between 1985 and 2000 can be explained in terms of changes in the employment rates of potential care-givers. The theoretical underpinning for the chapter arises from studies of the relationship between the provision of intense unpaid care and employment. There is, as Chapter Two indicated, a substantial body of literature showing a negative association between employment and provision of intense informal care (Joshi 1995, Carmichael and Charles 1998; Evandrou and Glaser 2002; Pickard 2004b; Arksey *et al* 2005; Carmichael *et al* 2008; Young and Grundy 2008). The relationship between intense care provision and employment is, as Chapter Three indicated, potentially endogenous and it is not clear in which direction the relationship lies (Richards *et al* 1996; Henz 2004; Heitmueller 2007; Young and Grundy 2008).

Nevertheless, it is often argued that changes in employment rates are likely to affect provision of informal care, particularly in the future. Thus, it is often argued that the future of informal care is uncertain because of rising rates of employment, especially among women and older workers (Allen & Perkins 1995, EPC 2001, Mooney *et al* 2002, Henz 2004, Lundsgaard 2005, OECD 2006). As a study of 'informal care and work after fifty' in the UK concluded, "There is likely to be an increasing demand for ….. care for older people. Yet …. there will be fewer people available to provide informal care. Women are increasingly moving into the labour market and working longer hours than in the past" (Mooney *et al* 2002: 39). Indeed a recent Organisation for Economic Co-operation and Development (OECD) study measured the availability of informal care in future years by the labour force participation rates of the population aged 50 to 64 (OECD 2006: 22). The impact of rising employment rates is often specifically related to provision of intergenerational care to older parents by women in mid-life. For example, as one study observed, the children of older people are increasingly likely to be employed "… and therefore can hardly be expected to provide care to the same extent as *daughters* have done previously" (Lundsgaard 2005: 32, emphasis added). Theoretically, then, there are reasons to expect that, as labour market

participation rates increase, informal care provision to older parents may decline, and that this is particularly likely to affect women in mid-life.[1]

In addition, as Chapter Two observed, the employment rates of women in mid-life in Britain were increasing in the period between 1985 and 2000, and this is borne out by a number of other studies (Mooney *et al* 2002, Tomassini *et al* 2004, Pensions Commission 2004). One study in the UK using the Labour Force Survey (LFS) has shown that the proportion of women aged between 50 and 54 who were in employment increased from 62 per cent to 69 per cent between 1979 and 1999 (Mooney *et al* 2002: 8). The same study also showed that there was a significant rise in the proportion of women who were working full-time, particularly among those in their early fifties. The proportion of women aged 50 to 54 years who were working for 31 hours a week or more rose from 31 per cent to 38 per cent between 1979 and 1999 (Mooney *et al* 2002: 9). The same trends in employment have not been evident among men. Indeed, there was a substantial decrease in economic activity among older men during the 1980s, although this was accompanied by an increase in working hours for those who were at work and there was an increase in male economic activity after the mid-1990s (Mooney *et al* 2002: 8, Pensions Commission 2004).

For both theoretical and empirical reasons, therefore, it might be expected that changes in employment rates in Britain between 1985 and 2000 might particularly affect the provision of informal care by *women in mid-life*. The upward trend in employment rates among mid-life women in the 1985/2000 period could plausibly help to explain the decline in intense and very intense co-resident care for older parents. This is partly because, as Chapter Three showed, age and gender were significantly associated with both these forms of intense intergenerational care provision (Table 3.2). Provision of intense intergenerational care was greatest among people in mid-life compared to people in other age-groups and among women compared to men. Moreover, as Chapter Four showed, because of the strong association between age/gender and intense informal care provision, key trends in care for older parents were effectively driven by changes in provision of care by women and by those under State Pension Age, the overwhelming majority of whom were in mid-life (Table 4.7).

[1] An increase in full-time employment rates might not be associated with a decline in informal care if, as Evandrou and Glaser (2002) identified, there was an increase in 'multiple role occupancy', with more people combining both employment with informal care. The issue of increasing 'multiple role occupancy' is discussed further in the conclusions to this chapter.

An explanation of trends in intense intergenerational care provision in terms of employment trends does, however, need to be developed somewhat further before it can be utilised in the present context. This is because not all forms of intense care for older parents declined between 1985 and 2000 and some forms, in particular, extra-resident care, in fact increased. Why, it might be asked, would upward trends in employment rates among mid-life women lead to a decline in intense co-resident care but not in intense extra-resident care?

The literature on trends in informal care does, however, put forward a possible answer to this because it suggests that increases in women's employment might in fact encourage extra-resident care. Thus, Hirst argues that "women's increasing labour market participation might also encourage between household care if having a job increases mobility and other resources to provide informal care for parents 'at a distance'" (Hirst 2001: 355). A key feature of extra-resident care, identified in the present study, is that it tends to be of lower intensity than co-resident care. As Chapter Three observed, even where care for 20 hours a week or more is concerned, a strong relationship between intensity and co-residence exists, with nearly all very intense care for older parents being provided on a co-resident basis in the 1985/2000 period. It could therefore be argued that extra-resident care, because it tends to be of lower intensity than co-resident care, might be compatible with higher employment rates. One way of capturing both the decline in more intense co-resident care and the increase in relatively less intense extra-resident care is by using a measure of central tendency, and the most appropriate measure in the present context seems to be a measure of the *intensity* of informal care, that is, the average or mean hours per week of care provided.

The first part of this chapter looks at trends in the intensity of care provided by mid-life women caring for older parents for 20 hours a week or more between 1985 and 2000. The second part of the chapter examines how far these changes in intensity were related to trends in mid-life women's employment rates between 1985 and 2000. Finally, the third part of the chapter looks at changes in employment among mid-life women providing care for 20 hours a week or more to older parents and asks how far these changes might have been associated with trends in the hours of care provided. Following the definitions used in Chapters Three and Four, 'mid-life' women are defined here as those aged between 45 and State Pension Age, which was 60 years of age for women at this time.

5.1 Trends in Intensity of Care for Older Parents by Mid-Life Women, 1985/2000

This part of the chapter presents an analysis of the intensity of care provided by mid-life women caring for 20 hours a week or more for their older parents between 1985 and 2000. The information on weekly hours of informal care provided, derived from the GHS, is recorded in intervals which, in 1990, 1995 and 2000, were as follows: 20-34 hours per week; 35-49 hours per week; 50-99 hours per week; 100 or more hours per week; and "varies, 20 hours a week or more". The average weekly hours presented here are based on the mid-points of the intervals, with 100 hours a week or more classified as 100 hours and variable hours of 20 hours a week or more classified as 20 hours. The 1985 GHS used slightly different intervals for care provided between 20 and 49 hours a week, namely 20-29 hours and 30 to 49 hours, and the data in this year also lacked the category, "varies, 20 hours a week or more". This difference in the way the hours of care were recorded probably had the effect of slightly underestimating hours of care in 1985 compared to other years and this needs to be borne in mind in the analysis that follows.

Table 5.1 shows the average weekly hours of care provided by mid-life women caring intensely for their older parents between 1985 and 2000. Sample numbers relating to this table are given in Appendix 5A (Table 5A.1). Although the intensity data relating to the locus of care over time have small sample sizes, the data relating to care provided for 20 hours a week or more as a whole (shown in the last two columns of Table 5.1) are based on a larger sample size. The last two columns of the table show that the average weekly hours of intense intergenerational care declined significantly between 1985 and 2000. In 1985, care provided intensely by mid-life women to older parents amounted to 56 hours a week on average, but by 2000 this had fallen to 41 hours a week (Table 5.1). This significant decline in average weekly hours of care occurred between 1985 and 1995, and was concentrated particularly in the 1990/95 period. Had the hours of care been recorded in 1985 in exactly the same way as in other years, then the extent of the decline in intensity of care after 1985 might have been even greater.

Table 5.1 also shows that the intensity of care provided on an extra-resident basis was considerably lower than the intensity of care provided on a co-resident basis. Taking the intensity of care for all years together, on average, mid-life women provided 36 hours a week of care to older parents living in another household in the 1985/2000 period, but

they provided nearly twice as much (65 hours a week on average) to older parents living in the same household. The F-statistic for the difference between these two means for all years combined was statistically significant at the highest level (F = < 0.001).

Table 5.1

Average hours per week of care provided by women aged 45 to 59 caring intensely (for 20 hours a week or more) for older parents, by locus of care and changes over time, Britain 1985-2000

Mean and standard deviation

	Co-resident		Extra-resident		All care for 20+ hrs pw	
	Mean	*Standard deviation*	Mean	*Standard deviation*	Mean	*Standard deviation*
1985	[70	*28]*	[37	*21]*	56	*30*
1990	[71	*31]*	[40	*21]*	54	*30*
1995	[53	*28]*	34	*16*	41	*22*
2000	[62	*33]*	[34	*15]*	41	*23*
All years	65	*30*	36	*18*	48	*27*
1985/90	[ns]		[ns]		ns	
1990/95	[*]		[ns]		**	
1995/00	[ns]		[ns]		ns	
1985/95	[*]		[ns]		**	
1985/00	[ns]		[ns]		**	

Sources: 1985, 1990, 1995, 2000 GHS (author's analysis)
*Notes: Decimal points are not shown for mean and standard deviation because of the derivation of the data from range mid-points. Asterix indicates F-statistic for difference between means over time at *(5%), **(1%); ns indicates no significant association. Square parentheses indicate an underlying sample base of less than 30 in 1985 and less than 50 in other years (see Appendix 5A, Table 5.1).*

The decline in intensity of care provided by mid-life women to their older parents between 1985 and 2000 was brought about partly by the conflicting trends in the proportions providing intense extra-resident and co-resident care. These trends, as they relate to women aged 45 to 59, are summarised in Table 5.2. The trends in the proportions of mid-life women providing intense intergenerational care were similar in key respects to the trends in care provision by people aged 30 to 74, already identified in Chapter Three (Table 3.3). Between 1985 and 2000, the proportion of mid-life women providing intense extra-resident care to their older parents increased significantly, while the proportion providing intense and very intense co-resident care decreased significantly (Table 5.2). Therefore, in the period between 1985 and 2000,

there was a significant increase in the form of care, extra-resident care, where the average intensity was relatively low, and a decrease in the form of care, co-resident care, where the average intensity was relatively high (Tables 5.1 and 5.2). The increase in intense extra-resident and decline in intense co-resident care were therefore both consistent with a fall in the average hours of care.

Another key reason why the intensity of care fell significantly during the 1985/2000 period was that there was a decline in the intensity of co-resident care (Table 5.1). Although the analysis of intensity by locus of care is affected by small sample sizes (see Appendix 5A), Table 5.1 suggests that average weekly hours of co-resident care fell sharply between 1985 and 1995, while average weekly hours of extra-resident care changed little. The large drop in the mean hours of intense co-resident care occurred between 1990 and 1995. It therefore coincided with the significant decline in the proportion of mid-life women providing very intense co-resident care for 50 hours a week or more (Table 5.2). It can, therefore, be concluded that the significant decline in intensity of care provided by mid-life women to older parents between 1990 and 1995 was due, not just to the shift from intense co-resident to intense extra-resident care, but also to the decline in provision of very intense co-resident care.

In summary, the average weekly hours of care provided by mid-life women caring intensely for their older parents fell significantly between 1985 and 1995, particularly in the 1990/1995 period. This decline in intensity was consistent with the contrasting trends in the probability of providing extra-resident and co-resident care that have been identified in this study. Provision of comparatively less intense extra-resident care increased, while provision of comparatively more intense co-resident care decreased. The concentration of the decline in intensity of care in the 1990/95 period was particularly associated with the decline in the probability of providing care for 50 hours a week or more on a co-resident basis. The question to be addressed in the next part is whether the decline in the average hours of intense intergenerational care was linked to a rise in mid-life women's employment rates.

Table 5.2

Proportion of women aged 45 to 59 providing care to older parents for 20 and 50 hours a week or more, by locus of care and changes over time, Britain, 1985-2000

(a) Intense care (20 hours a week or more) *Percentages*

Year	Co-resident		Extra-resident		All care for 20+ hours pw	
	%	95% Confidence Intervals	%	95% Confidence Intervals	%	95% Confidence Intervals
1985	1.44	1.01-2.07	1.05	0.69-1.59	2.49	1.90-3.27
1990	1.62	1.15-2.28	2.03	1.50-2.75	3.65	2.91-4.58
1995	1.25	0.86-1.82	2.37	1.81-3.10	3.57	2.87-4.44
2000	0.72	0.42-1.22	2.26	1.67-3.05	2.86	2.19-3.73
All years	0.74	1.05-1.54	1.92	1.65-2.25	3.16	2.80-3.56
85/90	ns		*		*	
90/95	ns		ns		ns	
95/00	ns		ns		ns	
85/95	ns		**		*	
85/00	*		**		ns	

(b) Very intense care (50 hours a week or more)

Year	Co-resident		Extra-resident		All care for 50+ hours pw	
	%	95% Confidence Intervals	%	95% Confidence Intervals	%	95% Confidence Intervals
1985	1.05	0.69-1.59	0.15	0.05-0.44	1.20	0.81-1.77
1990	1.07	0.70-1.62	0.36	0.18-0.73	1.42	0.99-2.05
1995	0.46	0.25-0.85	0.19	0.08-0.47	0.65	0.39-1.09
2000	0.39	0.19-0.79	0.22	0.09-0.56	0.61	0.34-1.08
All years	0.74	0.58-0.96	0.23	0.14-0.36	0.97	0.78-1.21
85/90	ns		ns		ns	
90/95	*		ns		*	
95/00	ns		ns		ns	
85/95	*		ns		ns	
85/00	*		ns		ns	

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
*Note: This table shows the proportion of women aged 45 to 59 providing care to older parents; asterix indicates Chi-square association over time at *(5%), **(1%); ns indicates no significant association.*

5.2 Employment Rates and Care Provision, 1985-2000

This part of the chapter explores the relationship between trends in mid-life women's employment rates and trends in the intensity of care provided by mid-life women to their older parents between 1985 and 2000. It begins by establishing whether there was a relationship between employment status and intense intergenerational care provision by women in mid-life in the 1985/2000 period in Britain. It then looks at changes in national employment rates for mid-life women between 1985 and 2000, before going on to explore whether these changes were associated with changes in the intensity of care provided by mid-life women to their older parents.

In this part of the chapter, employment status is classified by whether mid-life women were in paid employment or not and, if they were in paid employment, whether they worked full- or part-time. Attention is given to full-time versus part-time, as well as overall employment, status because, as indicated earlier in the chapter, the literature suggests that a key change during this period was an increase in the proportion of mid-life women who worked full-time (Mooney *et al* 2002). Following conventions in the field, full-time work is defined in the present study as employment for over 30 hours a week (cf. Evandrou & Glaser 2002).

With respect to hours of work, however, it should be noted that there was a change in the way in which this information was collected in the GHS between 1995 and 2000, and this may have affected the boundary between full-time and part-time employment status. The potential impact of the change in definition of working hours between 1995 and 2000 has been investigated here in some detail and the results reported in Appendix 5B. A comparison was made between full-time and part-time employment rates in the GHS and the Labour Force Survey (LFS). The appendix shows that there were differences between the LFS and the GHS in the percentage of women in their 50s who were in full-time and part-time employment. However, the 95% Confidence Intervals around the GHS rates suggests that these were not significantly different from the LFS rates and that both sets of data showed similar trends. It was therefore decided to utilise the GHS rates in this chapter, while bearing in mind the break in definition between 1995 and 2000 in the analysis.

5.2.1 Relationship between Employment and Hours of Care Provided, 1985/2000

Table 5.3 shows the relationship between employment status and average weekly hours of care provided by mid-life women caring intensely for older parents in the 1985/2000 period. Sample numbers are given in Appendix 5C (Table 5C.1).

Table 5.3 shows that there was a significant negative association between employment and intensity of care. Those in employment provided significantly fewer hours of care to older parents than those not in employment. Among those providing intense care to parents as a whole (last two columns of Table 5.3) those in employment provided between 41 and 44 hours a week of care per week, compared to those not in employment who provided on average 53 hours a week of care. In other words, among those in employment, average weekly provision of care was between 20 and 49 hours, whereas among those not in employment it was over 50 hours. There was little difference in the hours of care provided by mid-life women in full-time versus part-time employment.

Table 5.3

Average weekly hours of care provided by women aged 45 to 59 to older parents for 20 hours a week or more by employment status, Britain, 1985-2000

Mean and standard deviation

Employment Status	Co-resident		Extra-resident		All care for 20+ hrs pw	
	Mean	*Standard deviation*	Mean	*Standard deviation*	Mean	*Standard deviation*
Full-time	[57	*28]*	[32	*12]*	44	*25*
Part-time	[57	*28]*	[33	*15]*	41	*23*
Not in paid work	[73	*73]*	41	*21*	53	*30*
F statistic	*		*		**	

Sources: 1985, 1990, 1995 GHS (author's analysis)
*Note: Asterix indicates F-statistic for difference between means at *(5%), **(1%). There was a change in definition of working hours between 1995 and 2000 (see Appendix 5B). Square parentheses indicate a small underlying sample base (see Appendix C, Table 5C.1).*

In one respect, the results shown in Table 5.3 appear to be somewhat anomalous. The average weekly hours of care were considerably higher among those caring on a co-resident than on an extra-resident basis (as shown in Table 5.1). Although sample sizes by locus of care are small, Table 5.3 suggests that those in employment caring for

someone in the same household provided on average more hours of care a week (approximately 57 hours) than those not in employment caring for someone in another household (approximately 41 hours) (Table 5.3). Nevertheless, controlling for locus of care, there was a significant negative relationship between employment and intensity of care. And because of this, co-resident and extra-resident care, when taken together, also showed a significant negative association between employment and intensity of care.

The general implication that can be drawn from Table 5.3 is therefore that, because being in either full-time or part-time employment was associated with lower hours of intense intergenerational care provision, an increase in employment rates among mid-life women could have led to a decline in the hours of care provided. This is investigated in the next section. A later section (section 5.3.2) explores the reverse causality, examining whether a decline in hours of care provided could have led to an increase in employment rates.

5.2.2 Trends in Employment Rates over Time, 1985-2000

Table 5.4 shows the employment rates of all women aged 45 to 59 in the period between 1985 and 2000 in Britain. Sample numbers for this table are given in Appendix 5C (Table 5C.2). A line is shown between 1995 and 2000 to indicate the change in definition of working hours that affected full-time and part-time employment status at this time (see Appendix 5B).

The table shows that, as Chapter Two indicated, there was a significant increase in the proportion of women aged 45 to 59 who were in employment in Britain between 1985 and 2000 (Table 5.4). The proportion in employment rose from around 60 per cent in 1985 to around 71 per cent in 2000. The greatest increase was in full-time employment rates, which rose from around 27 per cent in 1985 to around 37 per cent in 2000. The increase in full-time employment rates occurred during two periods, in 1985/1990 and 1995/2000. Table 5.4 shows that the changes in the employment status of mid-life women between 1985 and 2000 were primarily driven by changes in full-time employment rates. The significant rises in employment rates between 1985 and 1990 and between 1995 and 2000 were both accompanied by significant rises in full-time employment rates. Although the change of definition in working hours may have exaggerated the increase in full-time employment rates in the GHS between 1995 and

2000, the LFS data also show an increase in full-time employment rates among mid-life women between 1995 and 2000 (see Appendix 5B).

Table 5.4

Employment rates of women aged 45 to 59, by full-time and part-time status, Britain, 1985-2000

Percentages

	Full-time	Part-time	All in employment	Not in employment
1985	27.1	32.6	59.6	40.4
1990	30.4	35.6	66.3	33.9
1995	31.2	34.6	66.0	34.1
2000	37.3	33.1	70.5	29.5
85/90	*	*	***	
90/95	ns	ns	ns	
95/00	[***]	[ns]	**	
85/95	**	ns	***	
85/00	[***]	[ns]	***	

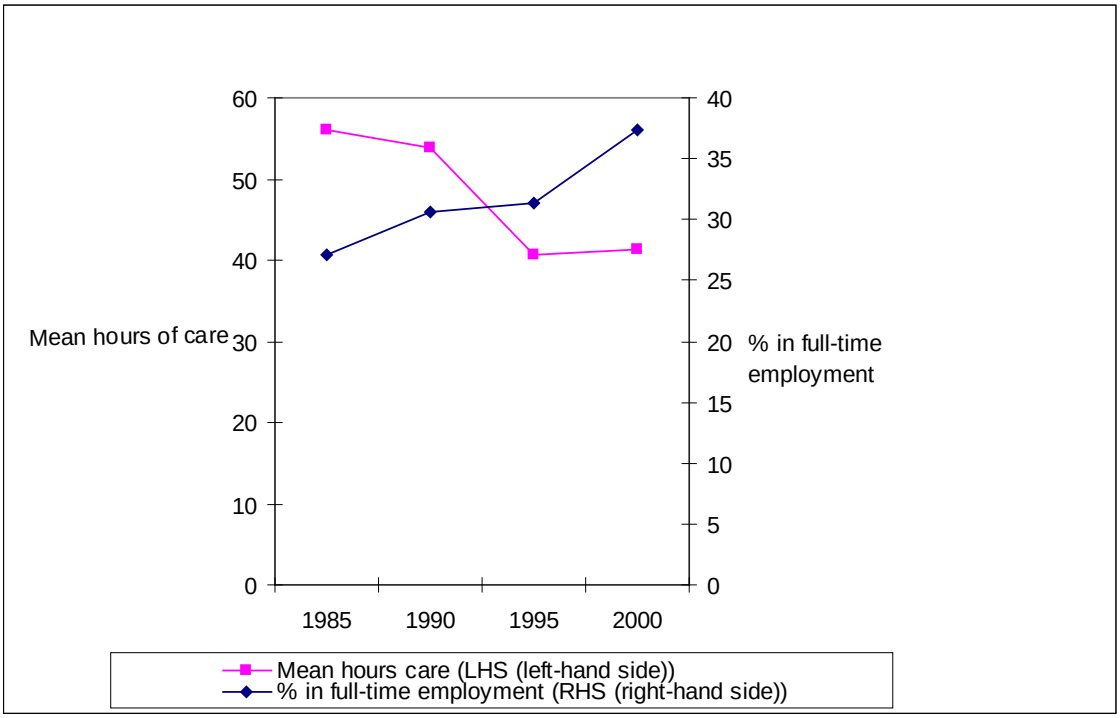
Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
*Notes: Asterix indicates Chi-square association over time at *(5%), **(1%),***(less than 1%); ns indicates no significant association. The break in the data between 1995 and 2000, and the square parentheses, indicate a change in definition of working hours (see Appendix 5B).*

5.2.3 Trends in Employment Rates and Intensity of Care over Time, 1985-2000

Figure 5.5 compares the changes in national full-time employment rates of mid-life women with trends in the mean hours of care provided by mid-life women to their older parents between 1985 and 2000. The figure focuses on full-time employment rates because of the evidence (Table 5.4) that the changes in employment status during this period were particularly associated with changes in full-time employment rates. Figure 5.5 brings together data from Tables 5.1 and 5.4. It should be noted that, in Figure 5.5, different scales are used to express mean hours of care and the percentages in full-time employment.

Figure 5.5

Women aged 45 to 59: national full-time employment rates and mean hours of intense care provided to older parents (for 20 hours a week or more), Britain, 1985-2000



Source: 1985, 1990, 1995, 2000 GHS (author's analysis); data from Tables 5.1, 5.4
Note: There was a break in the employment data between 1995 and 2000 (see Table 5.1 and Appendix 5B)

Figure 5.5 shows that, in the period between 1985 and 2000, there was a general negative relationship between changes in the full-time employment rates of mid-life women and changes in the mean hours of intense intergenerational care. On the whole, full-time employment rates rose, while the intensity of care fell.

However, detailed examination of the trends in each five-year sub-period shows little correspondence between trends in full-time employment rates and trends in the intensity of care (Figure 5.5). It is true that, when full-time employment rates rose between 1985 and 1990, there was a decline in the intensity of care. However, there was little evidence of any relationship after 1990. Thus, the greatest decline in intensity of care occurred between 1990 and 1995, at a time when there was little change in women's full-time employment rates. Moreover, there was little change in the intensity of care between 1995 and 2000, at a time when full-time employment rates were rising. Even in the period between 1985 and 1990, the extent of the changes in intensity and employment did not correspond closely. Thus, there was no significant fall in intensity

of care between 1985 and 1990, whereas full-time employment rates rose significantly during this period (Tables 5.1 and 5.4).

In summary, then, there appears to have been little relationship between the time patterns of the trends in the employment rates of mid-life women and the time patterns of the trends in the intensity of care they provided to older parents between 1985 and 2000.

5.3 Employment Rates of Intense Intergenerational Carers and Intensity of Care

5.3.1 Employment Rates of Intense Intergenerational Carers

So far, the focus of the analysis has been on a comparison of changes in the overall employment rates of women aged 45 to 59 and trends in the intensity of care provided by mid-life women to their older parents. No attention has yet been paid, however, to the *employment rates of intense intergenerational carers*. It is important to theorise in advance the expected relationships between the employment rates of mid-life women and those of intense carers. It seems likely that, if employment had been a big driver of trends in care provision, then in a situation of rising employment rates of mid-life women, the employment rates of carers would probably have remained unchanged. This is because the people providing intense care would still have been drawn primarily from those in little or no employment.

Table 5.6 shows the employment rates of women aged 45 to 59 who provided care for 20 hours a week or more to their older parents in the period between 1985 and 2000 in Britain, together with 95% Confidence Intervals. The significance of changes over time is examined using Chi-square associations. Sample numbers for this table are given in Appendix 5C (Table 5C.3). It should be noted that the sample base, composed of mid-life women providing intense care, is less than 100 in each year (Appendix 5C, Table 5C.3). For this reason, proportions in Table 5.6 are expressed without decimal points, as one full percentage point would represent less than one person.

Table 5.6

Employment rates of women aged 45 to 59 providing care for 20 hours a week or more to older parents, by full-time and part-time status, Britain, 1985-2000

Percentages and 95% Confidence Intervals

	Full-time		Part-time		All in employment	
	%	95% Confidence Intervals	%	95% Confidence Intervals	%	95% Confidence Intervals
1985	16	8 - 29	30	19 - 44	46	33 - 60
1990	19	12 - 31	28	19 - 40	49	37 - 59
1995	36	27 - 48	16	9 - 25	52	41 - 63
2000	21	12 - 34	35	23 - 48	56	42 - 68
1985/90	ns		ns		ns	
1990/95	*		ns		ns	
1995/00	[ns]		[*]		ns	
1985/95	*		ns		ns	
1985/00	[ns]		[ns]		ns	

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
*Notes: Asterix indicates Chi-square association over time at *(5%); 'ns' indicates no significant association. The break in the data between 1995 and 2000, and the square parentheses, indicate a change in definition of working hours (see Appendix 5B). Sample sizes are given in Appendix 5C, Table 5C.3.*

Table 5.6 suggests that there was no significant change in the employment rates of mid-life women providing intense intergenerational care between 1985 and 2000 (last two columns of Table 5.6). It also suggests, however, that there were some quite large changes in their full-time and part-time employment rates. It suggests that there was a significant increase in the full-time employment rates of women providing intense intergenerational care between 1985 and 1995, which was concentrated in particular in the five-year period between 1990 and 1995.[1] In addition, there was a significant increase in the part-time employment rates of women providing intense intergenerational care between 1995 and 2000 (Table 5.6). Although there were overlapping Confidence Intervals between the proportions over time in relation to both of these findings, Chi square associations indicate significant differences over time.

It is, however, necessary to be somewhat cautious about the trends shown in Table 5.6 because, as already noted, the sample size of employed carers is small in each year

[1] It is possible that the rise in full-time employment rates between 1990 and 1995 was due to small changes around the boundary between part-time and full-time employment. However, examination of the distribution of hours of employment among employed carers, reported in Appendix 5D, suggests that this was unlikely.

under investigation (see Appendix 5C.3). The small sample size means that it may be difficult to interpret trend data. For example, the overall employment rates of intense intergenerational carers did not change significantly between 1985 and 2000, yet their employment rates rose by 10 percentage points during this period, from around 46 per cent in 1985 to around 56 per cent in 2000 (Table 5.6). This was the same percentage point increase as for mid-life women generally, whose employment rates rose from around 60 per cent in 1985 to around 70 per cent in 2000, a rise that was statistically significant (Table 5.4). It is possible that, with a larger sample size, it would be seen that the employment rates of intense intergenerational carers also rose significantly.

However, although the trends shown in Table 5.6 need to be interpreted cautiously, they do suggest that there were some quite large changes in the full-time and part-time employment rates of intense intergenerational carers between 1985 and 2000. As suggested earlier, such large changes would not necessarily have been expected if employment conditions had been a big driver of trends in care provision.

5.3.2 Employment Rates of Carers and the Intensity of Care

Although this chapter has not so far provided much evidence that employment conditions were a major driver of trends in intense intergenerational care provision, the relationship between care and employment is potentially endogenous. It is therefore possible that there may have been a relationship between the trends in intensity of care provided and the trends in the employment rates of carers. In other words, there may been an effect of care on employment.

Table 5.7 brings together the information on trends in intensity of care and on trends in employment rates of mid-life women providing care to older parents for 20 hours a week or more between 1985 and 2000. (The table is a summary of data previously presented in Tables 5.1 and 5.6.)

Table 5.7 suggests that there was a negative relationship between changes in the intensity of care provided and changes in the full-time employment rates of mid-life women providing intense care for their parents. Between 1985 and 1995, there was a sharp fall in the intensity of care provided to parents by mid-life women and, at the same time, there was a sharp rise in their full-time employment rates. These changes

were both concentrated in the same five-year period, that is, between 1990 and 1995. There was not the same relationship between intensity of care and part-time employment. Part-time employment rates increased between 1995 and 2000, at a time when there was no significant change in the intensity of care.

Table 5.7

Changes over time in intensity of care and employment rates of women aged 45 to 59 caring intensely (for 20 hours a week or more) for older parents, Britain, 1985-2000

Significance and direction of change over time

	Changes in average weekly hours of care	Changes in full-time employment	Changes in part-time employment
1985/90	ns	ns	ns
1990/95	** (-)	* (+)	ns
1995/00	ns	[ns]	[*(+)]
1985/95	** (-)	*(+)	ns
1995/00	** (-)	[ns]	[ns]

Source: 1985, 1990, 1995, 2000 GHS (author's analysis); Table 5.1 and Table 5.6
*Notes: Asterix indicates Chi-square association over time at *(5%), **(1%); ns indicates no significant association. The square parentheses indicate a change in definition of working hours (see Appendix 5B).*

The negative relationship between intensity of care and full-time employment rates among mid-life women carers between 1990 and 1995 does not of course help to identify the direction of causality. However, as already noted, the evidence presented in this chapter has not been consistent with causation running from employment to care. It is therefore tempting to suggest that causal primacy lay with changes in caring rather than changes in employment. In other words, it is tempting to suggest that, as the hours of care provided by mid-life women to their older parents declined, so their hours of employment increased. However, because of the small sample sizes of employed mid-life carers (see Appendix 5C, Table 5C.3), caution is needed in interpreting these results and the relationships cannot be established with much certainty.

With these provisos in mind, however, it is possible to explore the impact that the decline in intensity of care might have had on employment. Changes in the estimated numbers of intense intergenerational carers in full-time employment are shown in Table 5.8. The table draws on information presented in Chapter Four, showing the estimated

numbers of women aged 45 to State Pension Age providing care to older parents for 20 hours a week or more (Table 4.7) and on information presented earlier in the present chapter, giving employment rates of intense intergenerational carers (Table 5.6). Table 5.8 shows that the numbers of mid-life women providing intense intergenerational care in full-time employment rose from around 20,000 in 1985 to around 65,000 in 1995, an increase of over 250 per cent in ten years. Although the total number of mid-life women providing intense care to parents also rose in this period, the increase in numbers in full-time employment far exceeded the increase in the number of carers (Table 5.8).

Table 5.8

Estimated numbers of women aged 45 to 59 providing care to older parents for 20 hours a week or more, by employment status, Britain, 1985-2000

Numbers in thousands

	Full-time	Part-time	Not in employment	All
1985	20	35	60	115
1990	35	50	90	170
1995	65	30	85	180
2000	35	55	70	155
% change				
1985/90	80%	40%	45%	50%
1990/95	95%	-40%	-5%	5%
1995/00	-50%	90%	-20%	-15%
1985/95	255%	-20%	40%	60%
1985/00	80%	55%	10%	35%

Sources: see Chapter Four, Table 4.7 and Table 5.6.
Notes: see Tables 4.7, 5.6. Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding.

In summary, although the main focus of the present study is on the reasons for the changes in provision of intense intergenerational care, it is possible that the decline in intensity of care during the period under study may have had some important consequences. It is possible to interpret the findings in the present section to suggest that it may have been *because* of the sharp fall in the intensity of care that the full-time employment rates of mid-life women carers rose. However, because of small sample sizes, caution is needed in interpreting these results and the relationships cannot be established with much certainty.

5.4 Discussion and Conclusions

5.4.1 Summary and Discussion of Results

This chapter has examined how far trends in intense intergenerational care in Britain between 1985 and 2000 can be explained in terms of changes in the employment rates of potential care-givers. For both theoretical and empirical reasons, the chapter has focused on mid-life women aged between 45 and State Pension Age and on the trends in the intensity (average weekly hours) of care that they provided to their older parents.

The chapter has found that, between 1985 and 2000, there was a marked decline in the intensity of care provided by mid-life women caring for 20 hours a week or more for older parents. This decline in intensity was brought about partly by the contradictory trends in intense intergenerational care provision observed in this study, that is, the increase in comparatively less intense extra-resident care and decline in comparatively more intense co-resident care. The decline in intensity was also particularly associated with the sharp decline in provision of co-resident care for 50 hours a week or more. The decline in the intensity of care took place between 1985 and 1995, particularly in the five-year period between 1990 and 1995. The chapter has examined whether this decline in intensity of care was associated with the rise in employment rates of mid-life women.

The results suggest that changes in the employment rates of mid-life women during the period between 1985 and 2000 provide only a limited explanation for the changes in intensity of care provided by intense intergenerational carers. It is true that employment, particularly full-time employment, rates of mid-life women rose between 1985 and 2000, while the intensity of care declined. However, the period when the intensity of care dropped most sharply, between 1990 and 1995, was a period when full-time employment rates of mid-life women did not increase significantly. Moreover, a rise in full-time employment rates between 1995 and 2000 was not accompanied by any decline in the intensity of care. It was only in the initial five-year period under study, the period between 1985 and 1990, that some effect of employment on care could be identified, with a rise in full-time employment rates coinciding with some decline in the intensity of care.

An explanation of trends in intergenerational care in terms of changes in the employment rates of mid-life women seemed plausible at the start of the chapter for

both theoretical and empirical reasons. However, the limited nature of this explanation is consistent with other evidence presented in this study so far. As Chapter Three showed, the decline in provision of intense and very intense co-resident care occurred particularly in the period between 1990 and 1995 (Table 3.3). Yet, as Chapter Two showed, the increase in employment rates of mid-life women occurred particularly in the periods between 1985 and 1990 and between 1995 and 2000 (Figure 2.19). Therefore, the decline in intense and very intense care occurred during the only five-year period when the employment rates of mid-life women did *not* rise significantly. Moreover, the changes in the employment rates of mid-life women were associated with more general economic changes. Thus, the period between 1990 and 1995, when mid-life women's employment rates did not increase significantly, was also a time when there was a recession in the British economy in the early 1990s. The decline in intense and very intense intergenerational care therefore occurred during a period of recession. It seems unlikely, then, that it was primarily because of favourable employment conditions that provision of intense care to older parents fell during the early 1990s in Britain.

Although the main focus of the present study is to explore the reasons for the trends in intense intergenerational care, it has been suggested in this chapter that the decline in intensity of care in the late 1980s and early 1990s in Britain may have had some important consequences. The chapter found that, between 1990 and 1995, the fall in the intensity of care provided to parents by mid-life women was accompanied by a rise in their full-time employment rates. This latter finding is consistent with other research relating to full-time employment rates among people providing intense informal care in Britain in the 1980s and 1990s (Evandrou and Glaser 2002). Evandrou and Glaser found that there was an increase in 'multiple role occupancy' in Britain between 1985 and 2000, with an increasing percentage of mid-life people combining both working full-time with caring intensely for a sick or elderly person (Evandrou and Glaser 2002: 27). In the present study, it has been tentatively suggested that it may have been *because* of a sharp fall in the intensity of care that the full-time employment rates of mid-life women caring for older parents increased. This finding would be consistent with other recent studies showing that caring responsibilities have an impact on employment (Henz 2004, 2006; Carmichael *et al* 2008). However, in the case of the present study, because of small sample sizes and a change in the definition of working hours between 1995 and 2000, it is difficult to draw firm conclusions.

5.4.2 Implications for Explanations of Trends in Care Provision

This chapter has two important implications for the analysis of trends in care provision. First, the present chapter has suggested that a key supply-side factor, that is, trends in employment, provides only a limited explanation for changes in intense intergenerational care between 1985 and 2000 in Britain. The previous chapter (Chapter Four) showed that other supply-side factors, that is, trends in age, gender, marital status and education, also provide only a limited explanation for changes in provision of intense intergenerational care. The study has therefore now considered the key supply-side explanations potentially affecting intense care for older parents that were identified at the end of Chapter Two (Table 2.20). The remainder of the study will now turn to the examination of demand-side explanations.

Second, in order to explore the potential impact of changes in employment on care provision, the present chapter has, in effect, applied a unitary explanation for both the increase in extra-resident care and the decline in co-resident care. As explained at the beginning of the chapter, an increase in employment rates might have provided an explanation for both the rise in extra-resident care and the decline in co-resident care, both of which were potentially consistent with a fall in the intensity of care. However, the use of a single explanation for the trends in intergenerational care has not been successful, in the sense that changes in employment provide only a limited explanation for changes in the intensity of care. The conclusions of the present chapter therefore reinforce those of Chapters Three and Four, which suggested that there were probably different explanations for the trends in intense extra-resident and co-resident care. The remainder of the study therefore pursues different demand-side explanations for the rise in intense extra-resident care and the fall in intense and very intense co-resident care.

With regard to intense *extra-resident* care, the conclusions to Chapter Four (with reference back to Chapter Two) suggested that there was only one demand-side factor that was likely to explain an increase in intense care for older parents during the period in which this occurred, that is the 1985/95 period. This was an explanation in terms of trends in the numbers of older people, particularly the numbers of ‘older old’ people. Indeed, Chapter Four suggested that the main reason why intense extra-resident care for older parents increased between 1985 and 1995 was probably because the numbers of older people, especially the numbers of ‘older old’ people, were increasing at this time.

This explanation of the rise in intense extra-resident care will be explored further in the next chapter, Chapter Six, which includes an examination of the characteristics of older parents cared for by their children.

However, as Chapters Three and Four have both suggested, if the rise in extra-resident care for older parents can be explained primarily as a response to the increase in the numbers of older people, then this raises even more starkly the question as to why *co-resident* care for older parents did not also increase at this time. The next chapter takes the decline of intense and very intense co-resident care as its central focus. It looks at a key demand-side explanation which, as Chapter Three suggested, might be associated specifically with a decline in co-resident care. This is an explanation in terms of a potential substitution of care by spouses for care by children. In exploring this explanation, Chapter Six first compares trends in 'spouse care' with trends in intergenerational care and then compares the characteristics of cared-for older spouses with those of cared-for older parents.

Appendices to Chapter 5

Appendix 5A

GHS Sample Numbers Underlying Tables in Chapter 5, Section 5.1

Table 5A.1

Provision of care to older parents for 20 and 50 hours a week or more by women aged 45 to 59, by locus of care and data collection year, Britain, 1985-2000: sample numbers

(a) Intense care (20 hours a week or more)

Year	Co-resident	Extra-resident	All care for 20+ hrs pw	Underlying sample base
1985	29	21	50	2,007
1990	32	40	72	1,971
1995	26	51	77	2,156
2000	13	41	52	1,817
All years	101	153	251	7,951

(b) Very intense care (50 hours a week or more)

Year	Co-resident	Extra-resident	All care for 50+ hrs pw	Underlying sample base
1985	21	3	24	2,007
1990	21	7	28	1,971
1995	10	4	14	2,156
2000	7	4	11	1,817
All years	59	18	77	7,951

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: This table shows sample numbers of women aged 45 to 59 providing care to older parents, plus the underlying sample base of women aged 45 to 59.

Appendix 5B

Comparison of GHS and LFS employment rates of mid-life women, 1995 to 2000

There was a change in the way in which information on hours of employment was collected in the GHS between 1995 and 2000. Between 1985 and 1995, respondents were asked how many hours a week they usually worked in their main job, excluding meal breaks and overtime. In 2000, respondents were asked the same question, but were asked to include any paid or unpaid overtime that they usually worked. This change in definition would not have affected whether or not a respondent was defined as employed, but it could have affected whether employment was defined as full- or part-time. By including more time in the definition of employment hours, the change in definition could have raised full-time employment rates in 2000.

Since trends in employment rates are important in this chapter, full-time and part-time employment rates in the GHS were compared with rates derived from the Labour Force Survey (LFS). The latter survey was not affected by a change in variable definition at this time. Published LFS data were used, which give results for women aged 50 to 59 (not 45 to 59, as in this study). The results of the comparison of published LFS employment rates for women aged 50 to 59 with similar data from the GHS in 1995 and 2000 are shown in Table 5B.1.

Table 5B.1 shows that there were differences between the LFS and the GHS in the percentage of women in their 50s who were in full-time and part-time employment. Full-time employment rates in 1995 and 2000 were slightly higher in the LFS than equivalent GHS rates, while part-time rates in the LFS were slightly lower than equivalent GHS rates. However, the 95% Confidence Intervals around the GHS values suggests that the GHS rates were not significantly different from the LFS rates (Table 5B.1). Moreover the trends between 1995 and 2000 in both sets of data were similar, with both showing an increase in full-time, but not part-time, employment rates in this period. It was therefore decided to utilise the GHS rates in this chapter, while drawing attention to the break in definition between 1995 and 2000.

Table 5B.1

Percentage of women aged 50 to 59 in full-time and part-time employment: comparison of GHS and LFS, Britain, 1995-2000

Percentages & 95% Confidence Intervals (CIs)

Year	Full-time			Part-time		
	LFS	GHS		LFS	GHS	
		Point	95% CIs		Point	95% CIs
1995	29.7	28.1	25.7-30.6	31.0	32.2	29.7-34.8
2000	33.5	32.8	30.2-35.5	30.4	32.2	29.6-34.9

Sources: GHS - 1995, 2000 (author's analysis); Labour Force Survey (LFS) - Labour Market Trends, March 1996:10, February 2001:106)

Table 5B.2

Women aged 50 to 59 in full-time and part-time employment, Britain, 1995-2000: sample numbers (GHS)

	Full-time	Part-time	Underlying sample base
1995	364	417	1,295
2000	387	380	1,181

Source: GHS - 1995, 2000 (author's analysis)

Appendix 5C

GHS Sample Numbers Underlying Tables in Chapter 5, Sections 5.2 and 5.3

Table 5C.1

Employment status of women aged 45 to 59 providing care to older parents for 20 hours a week or more, by locus of care, Britain, 1985/2000: sample numbers

Employment status	Co-resident care	Extra-resident care	All care for 20+ hrs pw
Full-time	31	32	61
Part-time	22	43	65
Not in paid work	48	77	124
Total	101	153	251

Source: 1985, 1990, 1995 GHS (author's analysis)

Table 5C.2

Employment status of women aged 45 to 59, Britain, 1985-2000: sample numbers

	Full-time	Part-time	All in employment	Not in employment	Total
1985	543	654	1197	810	2,007
1990	599	697	1296	664	1,960
1995	673	744	1417	733	2,150
2000	677	601	1278	535	1,813

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Table 5C.3

Employment status of women aged 45 to 59 providing care to older parents for 20 hours a week or more, by data collection year, Britain, 1985/2000: sample numbers

	Full-time	Part-time	Not in employment	Total
1985	8	15	27	50
1990	14	20	37	71
1995	28	12	37	77
2000	11	18	23	52

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Appendix 5D

Investigation of Hours of Employment of Women Aged 45 to 59 Providing Intense Care to Older Parents, Britain, 1985-2000

It is possible that the rise in full-time employment rates of mid-life women caring intensively for their parents/in-law between 1990 and 1995 (shown in Table 5.6) might have been caused by small changes around the boundary between part-time and full-time employment, which is defined here as over 30 hours a week. The distribution of hours of employment was therefore examined more closely. In the 1985, 1990 and 2000 GHS datasets, actual hours of employment are included in the published data but, in the 1995 dataset, hours of employment are given in intervals as follows: 0-9; 10-15; 16-24; 25-30; 31-36; 37-42; 43-48; 49-54; 55+. Hours of employment for all years were therefore initially divided into intervals based on those given in the 1995 GHS and then aggregated into the categories shown in the Table 5D.1.

Table 5D.1

Hours of employment per week of women aged 45 to 59 providing care for 20 hours a week or more to older parents, Britain, 1985-2000 (percentages)

Row percentages

	Hours of employment per week			Not in	Total
	37+ hours	25-36 hours	<25 hours	employment	
1985	10	12	24	54	100
1990	18	11	20	51	100
1995	25	16	12	48	100
2000	15	12	29	44	100

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: The definition of working hours changed in the GHS between 1995 and 2000; for base sample sizes see Appendix 5C, Table 5C.3

Table 5D.1 shows that, between 1990 and 1995, there was a relatively large decline in the proportion of intense carers who were employed for less than 25 hours a week, which fell by 8 percentage points, and a relatively large increase in the proportion employed for 37 hours a week or more, which grew by 7 percentage points. In other words, the changes in hours of employment between 1990 and 1995 were not primarily around the boundary between full-time and part-time employment. Indeed, in all years except 1995, the modal hours of employment of intense intergenerational carers in employment were 16 to 24 hours a week, whereas in 1995, the modal hours of employment were 37 to 42 hours a week (not shown in table).

Chapter 6

Care for Parents, Care for Spouses

This chapter, and the succeeding two chapters, are concerned with the extent to which trends in intense intergenerational care in Britain between 1985 and 2000 can be explained in terms of demand for informal care. The present chapter considers the potential impact on intergenerational care of changes in the provision of care by spouses or partners. The following two chapters consider the impact on intergenerational care of changes in the availability of long-stay residential care and trends in the prevalence of disability among older people.

Changes in the availability of spouses or partners are potentially important to demand for care by older people from their adult children because, as Chapter Two observed, spouses and partners may offer an alternative source of informal care for older people. During the period between 1985 and 2000, as Chapter Two showed, the proportion of older people with a spouse increased and this could have led to some substitution of care by spouses for care by children. The possibility that such a substitution occurred is increased by the nature of the trends in intense intergenerational care that took place between 1985 and 2000. The fact that the decline in intense care for older parents, identified in Chapter Three, only related to *co-resident care* increases the potential relevance of an explanation in terms of changes in 'spouse care', since care by spouses is, almost by definition, also co-resident care.

Indeed, as Chapter Two indicated, there is some evidence from previous studies that informal care for spouses in Britain increased particularly during the 1990s (Rowlands 1998, Hirst 2001). The ONS report on the 1995 GHS observed that "the most striking change" since 1990 was the increase in the proportion of people who were looking after spouses (Rowlands 1998: 21). Hirst's study of trends in informal care during the 1990s in Britain also concluded that "spouse care increased more than any other caring relationship" (Hirst 2001: 354). It should be noted, however, that neither of these studies reporting an increase in provision of care for spouses was concerned specifically with care for spouses aged 65 and over.

The present chapter explores the hypothesis that the decline in provision of intense and very intense co-resident care for older parents, which took place between 1985 and 1995 in Britain, was associated with a corresponding increase in the provision of intense and very intense care for 'older' spouses. *Care for 'older' spouses, throughout this chapter, refers to care provided to a spouse aged 65 and over*. The hypothesis of substitution of care for parents by care for spouses is explored by first comparing over time the proportion of people providing intense co-resident care to an older parent with the proportion providing intense co-resident care to an older spouse or partner. This is followed in the second part of the chapter by a comparison of the characteristics of the cared-for parents and spouses, using variables supplied in the GHS datasets (and described in the second part of the chapter). The characteristics of the people cared for are important in the present context because it can be hypothesised that substitution between care for parents and spouses is more likely to have occurred if the cared-for older spouses and parents shared similar characteristics.

Although the main focus of the present chapter is on the decline in co-resident care for older parents, the analysis of the characteristics of the cared-for older parents in the second part of the present chapter also relates to the potential explanation of the trends in extra-resident care. As the last chapter concluded, the most plausible explanation for the rise in extra-resident care in the 1985/95 period was the rise in the numbers of 'older old' people in Britain at this time. This explanation would be supported if the people cared for by their children were in fact primarily the 'older old', that is, those aged 80 and over. The second part of this chapter explores the age, as well as other characteristics, of older parents cared for on an extra-resident, as well as a co-resident, basis. However, as Chapter Five observed, if the rise in extra-resident care for older parents can be explained primarily as a response to the increase in the numbers of older people, then this raises even more sharply the question as to why *co-resident* care for older parents did not also increase at this time. This is the primary focus of the present chapter.

6.1 Trends in Provision of Co-Resident Care for Older Parents and Spouses

This part of the chapter compares the probability over time of providing intense co-resident care to an older parent with the probability of providing intense co-resident care

to an older spouse or partner. A hypothesis of substitution of care for parents by care for spouses would be supported if care for parents and spouses varied negatively with each other over time.

In order to compare the probability of providing care to older parents and spouses, a single underlying sample base is required. The sample base used to analyse the provision of care to older parents in this study so far has encompassed those aged between 30 and 75 (or, as in Chapter Five, a sub-set of this broad age-band). However, people providing care to older spouses tend to be themselves over the age of 65 and a broader sample base is therefore required to encompass spouse carers. Analysis of the sample data indicates that 99% of all people providing intense or very intense care for either older parents or spouses were themselves aged between 30 and 90 in the period under study (Appendix 6A, Table 6A.1). The analysis in the present chapter therefore focuses on people providing informal care who were between the ages of 30 and 90.

Analysis of those providing care to spouses also suggests that over 99 per cent of those providing care to an older spouse did so on a co-resident basis. Indeed, all but 2 of the 477 individuals aged 30 to 90 in the sample who provided care to an older spouse in the years 1985 to 2000 combined did so on a co-resident basis (Appendix 6B, Table 6B.1). This confirms that spouse care is almost synonymous with co-resident care. The analysis therefore compares co-resident care for spouses and for parents between 1985 and 2000.

Table 6.1 shows the proportion of adults aged between 30 and 90 who provided intense and very intense co-resident care to older people, by the relationship of the care-receiver to the care-provider, between 1985 and 2000. The table shows the probability of providing care to older parents and spouses, and also includes ‘other’ people. These are primarily other relatives, such as siblings and grandparents, although the GHS does not enable a further breakdown of ‘other relatives’ to be made. By including this category, however, a complete picture of care provided to all older people in the same household is provided. Sample numbers relating to Table 6.1 are shown in the Appendix to this chapter (Appendix 6, Table 6A.2).

Table 6.1

Proportion of population aged 30 to 89 providing co-resident care to older people for 20 and 50 hours a week or more, by relationship of care-receiver to care-provider and changes over time, Britain, 1985-2000

(a) Intense care (20 hours a week or more)

Percentages

Year	Parent		Spouse		Other		All	
	%	95% Conf. Intervals	%	95% Conf. Intervals	%	95% Conf. Intervals	%	95% Conf. Intervals
1985	0.71	0.58-0.86	0.79	0.65-0.95	0.16	0.11-0.24	1.66	1.46-1.88
1990	0.76	0.63-0.92	0.75	0.62-0.92	0.13	0.08-0.21	1.64	1.44-1.87
1995	0.52	0.42-0.66	0.96	0.81-1.14	0.04	0.02-0.10	1.53	1.34-1.75
2000	0.55	0.43-0.71	1.22	1.04-1.44	0.08	0.04-0.15	1.85	1.62-2.12
All years	0.64	0.58-0.71	0.92	0.84-1.00	0.10	0.08-0.14	1.66	1.56-1.78
85/90		ns		ns		ns		ns
90/95		*		ns		*		ns
95/00		ns		*		ns		*
85/95		ns		ns		**		ns
85/00		ns		*		ns		ns

(b) Very intense care (50 hours a week or more)

Year	Parent		Spouse		Other		All	
	%	95% Conf. Intervals	%	95% Conf. Intervals	%	95% Conf. Intervals	%	95% Conf. Intervals
1985	0.52	0.42-0.66	0.58	0.46-0.72	0.11	0.07-0.18	1.21	1.04-1.41
1990	0.40	0.31-0.52	0.52	0.41-0.66	0.10	0.06-0.17	1.02	0.86-1.20
1995	0.23	0.16-0.33	0.63	0.51-0.78	0.02	0.01-0.07	0.88	0.74-1.06
2000	0.26	0.19-0.38	0.69	0.55-0.85	0.03	0.01-0.08	0.97	0.81-1.17
All years	0.36	0.31-0.42	0.60	0.54-0.67	0.07	0.05-0.09	1.03	0.94-1.12
85/90		ns		ns		ns		ns
90/95		*		ns		*		ns
95/00		ns		ns		ns		ns
85/95		***		ns		**		***
85/00		**		ns		*		ns

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
*Notes: In 2 cases, where people provided intense or very intense care to both a parent and a spouse, intergenerational care was given priority. Care for either parents or spouses was given priority over care provided for 'others' For sample numbers see Appendix 6, Table 6A.2. Asterix indicates Chi-square association over time at *(5%), **(1%),***(less than 1%); ns indicates no significant association.*

The trends in provision of co-resident care shown in Table 6.1 relate to people aged between 30 and 90. Therefore, the probabilities of providing co-resident care to an older parent are all slightly lower than the probabilities of providing care by people aged between 30 and 75, which have been shown previously in this study (Chapter Three, Table 3.3). However, the trends in co-resident care for older parents shown in Table 6.1 are similar in key respects to the trends already identified. Thus, Table 6.1 shows a significant decline in both intense and very intense co-resident care for parents between 1990 and 1995. The table also shows that the decline in co-resident care provision for parents was more marked in relation to very intense than intense care, with very intense care falling more sharply than intense care and resulting in significant drops in care provision in both the 1985/1995 and 1985/2000 periods, as well as the 1990/95 period (Table 6.1).

The results shown in Table 6.1 suggest that intense co-resident care for spouses aged 65 and over increased significantly during the period under study. Between 1985 and 2000, the probability of providing care for 20 hours a week or more to a spouse rose significantly from 0.8 to 1.2 per cent of people aged between 30 and 90. This increase in spouse care occurred after 1990 and was concentrated particularly in the period between 1995 and 2000. However, there were no significant changes in the probability of providing very intense co-resident care for 50 hours a week or more to a spouse during any of the periods between 1985 and 2000 shown in Table 6.1.

Detailed examination of the time-periods when care for parents and for spouses changed significantly between 1985 and 2000 does not suggest a close negative correspondence between them (Table 6.1). Thus, during none of the periods when intense or very intense care for parents fell significantly did intense or very intense care for spouses rise significantly. When intense care for parents fell significantly between 1990 and 1995, intense care for spouses did not rise significantly. And when very intense care for older parents fell significantly in the 1990/95, 1985/95 and 1995/2000 periods, there were no corresponding significant increases in very intense care for older spouses. As a corollary, during none of the periods when intense spouse care increased significantly, that is, in 1995/2000 and 1985/2000, did intense care for parents decrease significantly (Table 6.1).

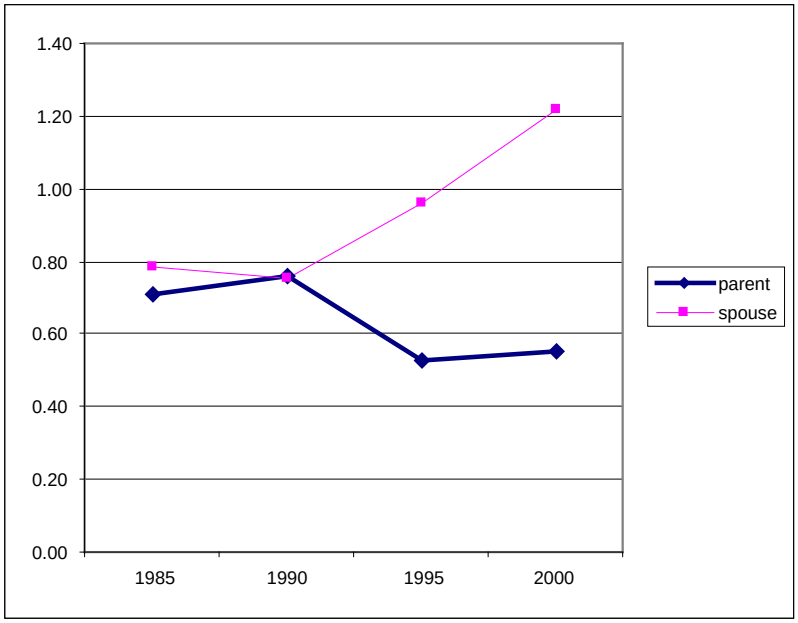
The changes in care for parents and for spouses can best be illustrated graphically. Figures 6.2 and 6.3 compare changes over time in the probability of providing co-resident care to older parents and spouses between 1985 and 2000 for intense and very intense care provision respectively.

Figure 6.2 shows that there was some evidence of a negative relationship between provision of intense care (for 20 hours a week or more) to older parents and spouses, but that it was not consistent over the whole time period. There was little change in either care for older parents or spouses in the 1985/90 period but, between 1990 and 1995, care for spouses rose while care for parents fell. However, in the 1995/2000 period, care for spouses continued to rise sharply, but there was no corresponding fall in care for parents. Indeed, care for parents also rose slightly during this period.

Figure 6.2

Proportion of population aged 30 to 89 providing intense co-resident care to older parents and spouses for 20 hours a week or more, Britain, 1985-2000

Percentage

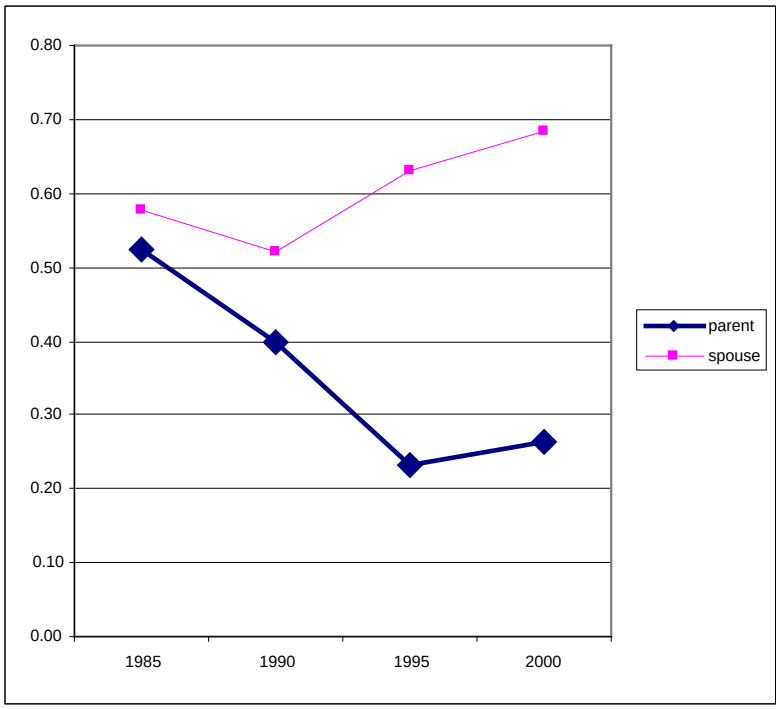


Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: see notes to Table 6.1

Figure 6.3

Proportion of population aged 30 to 89 providing very intense co-resident care to older parents and spouses for 50 hours a week or more, Britain, 1985-2000

Percentage



Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: see notes to Table 6.1

Figure 6.3 shows the same relationships as Figure 6.2 but this time focuses on the probability of providing very intense care for 50 hours a week or more. The figure again shows that there was some evidence of a negative relationship between provision of very intense care to older parents and spouses, but that it was not consistent over the whole time period. There was no negative relationship between care for spouses and parents between 1985 and 1990, when both care for spouses and care for parents fell. In the 1990/95 period, there was some evidence of a negative relationship between care for spouses and care for parents, with care for spouses rising while care for parents fell. However, the extent of the rise in spouse care did not match the extent of the fall in care for parents. And in the 1990/95 period, both care for spouses and care for parents again moved in the same direction, this time both increasing slightly.

The potential relationship between care for parents and care for spouses can also be explored by examining the probability of providing co-resident care for all older people

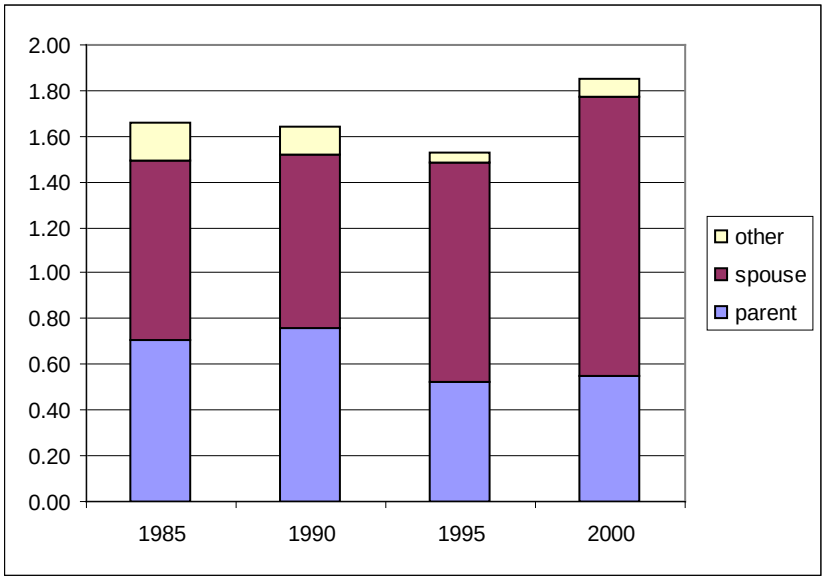
(last column of Table 6.1). Provision of care to parents and spouses made up nearly 95 per cent of all intense and very intense co-resident care for older people (Table 6.1). Therefore, changes in provision of intense and very intense co-resident care for older people as a whole were largely determined by changes in provision of care to parents and spouses. Figures 6.4 and 6.5 illustrate the probability of providing co-resident care to all older people by the relationship of the care receiver to the care-provider, showing the results for intense and very intense care provision respectively.

Figure 6.4 shows that the probability of providing co-resident care for 20 hours a week or more to an older person remained fairly flat between 1985 and 1990, dipped slightly between 1990 and 1995, and then rose steeply between 1995 and 2000. This latter increase was brought about because the significant rise in intense care for older spouses was *not* accompanied by an equivalent reduction in care for parents (or others) and the net effect was therefore a rise in care for all older people in the same household.

Figure 6.4

Proportion of population aged 30 to 89 providing intense co-resident care to older people for 20 hours a week or more, by relationship of care-receiver to care-provider Britain, 1985-2000

Percentage



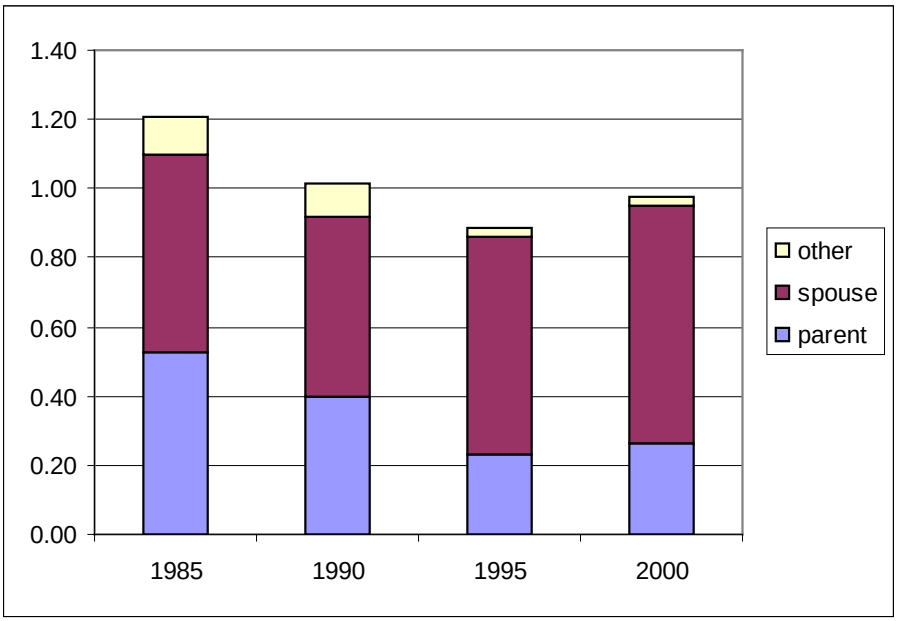
Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: see notes to Table 6.1

The results for very intense care (50 hours a week or more) are even more striking (Figure 6.5). Here, the probability of providing very intense co-resident care for an older person fell significantly in the decade between 1985 and 1995 (Table 6.1). This decline was brought about because the significant fall in provision of very intense co-resident care for parents (and others) was *not* accompanied by an equivalent increase in provision of very intense spouse care and as a result, all very intense care to older people provided on a co-resident basis fell. In the 1995/2000 period, care for parents, spouses and others all increased, so that there was a rise in very intense co-resident care for older people during this period.

Figure 6.5

Proportion of population aged 30 to 89 providing very intense co-resident care to older people for 50 hours a week or more, by relationship of care-receiver to care-provider Britain, 1985-2000

Percentage



Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: see notes to Table 6.1

In summary, even though care for parents declined while care for spouses increased between 1985 and 2000, the detailed results presented here do not provide much support for the hypothesis that the decline in intense and very intense co-resident care for parents was primarily brought about by an increase in care for spouses. The next section explores the possible reasons for this by examining the characteristics of older parents and spouses cared for between 1985 and 2000.

6.2 Characteristics of Cared-for Parents and Spouses

This part of the chapter examines the characteristics of older parents and spouses who were cared for intensely or very intensely between 1985 and 2000. The analysis initially focuses on the characteristics of cared-for older parents and then compares cared-for older parents with cared-for older spouses. The characteristics of the cared-for older people are important in the present context because it can be hypothesised that substitution between care for parents and spouses is more likely to occur if the cared-for older spouses and parents share similar characteristics. Absence of similar characteristics would, in turn, help to explain the findings of the first part of the chapter, which did not suggest that the decline in care for parents was primarily brought about by an increase in care for spouses

There have been few previous analyses of the characteristics of older people cared for informally using the GHS data. Indeed, the only previous study, of which the author is aware, is an analysis by Parker (1993a) using 1985 GHS data. However, Parker's analysis was concerned with all care provided to older people and not with care provided on an intense or very intense basis. Other analyses, for example the study by Arber and Ginn (1991), have described the characteristics of older people cared for on an informal basis using the GHS module on people aged 65 and over, rather than the GHS data on provision of informal care. The advantage of using the latter data, however, is that a direct link may be made between the characteristics of the person providing care and those of the person receiving it.

The analysis of the characteristics of the cared-for older parents and spouses, undertaken here, therefore uses information on the cared-for person included in the GHS. Questions were asked not only about the cared-for person's age, but also about their gender and type of impairment, as well as the type of help given to them. The GHS data do not contain much detail about the type of impairment of people cared for informally, classifying impairment in terms of physical impairment, mental impairment or both physical and mental impairment. Parker (1993a) used these data primarily to identify whether the cared-for older person had a mental impairment, and the analysis here takes a similar approach. The variable measuring the type of help given is analysed here to identify whether help was provided with 'personal care'. Previous studies have varied in their approach to the analysis of the type of help given. Parker

(1993a) focused on provision of both personal and physical care, whereas Henz (2009) examined personal care separately. The analysis here focuses on personal care because the definition of personal care used in the GHS corresponds quite closely to help with ADLs (Activities of Daily Living), a measure of disability already introduced in the present study (Chapter Two) and one that will be used again later in Chapters Seven and Eight. Consistent with analyses presented in the first part of this chapter, the analyses of care provided to older parents and spouses relates to care provided by adults aged 30 to 89 to people aged 65 and over.

6.2.1 Characteristics of Older Parents Cared for Intensely and Very Intensely

The characteristics of older parents cared for intensely and very intensely, both inside and outside the household, in the 1985/2000 period in Britain are summarised in Table 6.6. The underlying sample bases used in the table are the numbers of people aged 30 to 89 providing a given type of care; details of sample sizes are given in Appendix 6B (Table 6B.1). In Table 6.6, where someone provided intense or very intense care to more than one parent, the characteristics of the *oldest* parent are shown. This means that the characteristics of only one older parent are described in relation to each care-provider. In Table 6.6, the four years in which data on informal care were collected in the GHS are combined.

Table 6.6 shows that people providing intense care for older parents between 1985 and 2000 were primarily caring for the 'older old'. The mean age of parents cared for intensely for 20 hours a week or more in the period between 1985 and 2000 as a whole was 82 years, while the mean age of those cared for very intensely for 50 hours a week or more was 84 years (Table 6.6). Around two thirds of those providing care to a parent on an intense basis during this period, and around three-quarters of those doing so on a very intense basis, were caring for someone aged 80 or over (Table 6.6).

Consistent with the relatively advanced age of the people cared for, the overwhelming majority of those caring intensely or very intensely for older parents were looking after women, that is, they were caring for their mothers or mothers-in-law. During the years between 1985 and 2000 combined, over three quarters of those caring intensely for parents were caring for women, while over 85 per cent of those caring very intensely

were caring for women (Table 6.6). A substantial minority of those caring for older parents intensely and very intensely between 1985 and 2000 were looking after someone with a mental impairment. Table 6.6 shows that around one in four (24.6 per cent) of those caring intensely for older parents between 1985 and 2000 were caring for people with some degree of mental impairment, while nearly one in three (28.8 per cent) of those caring very intensely were doing so. Approximately half of all those caring for parents intensely between 1985 and 2000 were providing personal care, while nearly two-thirds of those caring for parents very intensely were doing so (Table 6.6). This relatively high proportion of people providing personal care to parents between 1985 and 2000 was consistent with the age and type of impairment of the parents cared for.

Substitution of care for parents by care for spouses was, for reasons already given, more likely to affect co-resident than extra-resident care. It is therefore important to note that those cared for on a co-resident basis tended to be the oldest and most vulnerable of the cared-for parents. In comparison with parents cared for intensely on an extra-resident basis, those cared for on a co-resident basis were older, more likely to be women, more likely to be mentally impaired and more likely to be given personal care (Table 6.6). Nevertheless, it should be noted that parents cared for on an extra-resident basis were still primarily the ‘older old’. Parents cared for in another household for 20 hours a week or more were on average over 80 years old, and over half were aged 80 years or over (Table 6.6).

Table 6.6

Characteristics of cared-for older parents and type of help provided, by locus and intensity of care, Britain, 1985-2000 (all years combined)

(a) Intense care (20 hours a week or more)

Mean age and (column) percentages

Characteristics of cared-for parent/type of help provided		Categories	Locus of care		All care for 20+ hours pw
			Co-resident	Extra-resident	
Characteristics of cared-for person	Mean age		83.7	80.4	81.9
	Age-group (column %)	65-69	3.9	6.4	5.3
		70-74	65.7	16.1	11.4
		75-79	16.9	23.7	20.7
		80-84	22.1	20.9	21.4
		85+	51.4	32.9	41.2
	Gender	% women	82.8	71.6	76.9
	Type of impairment	% affected mentally	29.3	20.7	24.6
Type of help provided	If personal care is provided	% providing personal care	56.8	38.3	46.7

(b) Very intense care (50 hours a week or more)

Characteristics of cared-for parent/type of help provided		Categories	Locus of care		All care for 50+ hours pw
			Co-resident	Extra-resident	
Characteristics of cared-for person	Mean age		84.2	[82.3]	84.1
	Age-group (column %)	65-69	5.4	[5.7]	5.0
		70-74	4.3	[8.6]	5.0
		75-79	14.0	[22.9]	15.4
		80-84	21.0	[20.0]	19.5
		85+	55.4	[42.9]	55.2
	Gender	% women	86.0	[88.6]	86.4
	Type of impairment	% affected mentally	28.8	[28.6]	28.8
Type of help provided	If personal care is provided	% providing personal care	65.1	[54.3]	63.3

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Notes: The table relates to people aged 30 to 89 providing care to older parents. Where someone provided intense or very intense care to more than one parent, the characteristics of the oldest parent are shown. Square parentheses indicate a small underlying sample base (see Appendix 6B, Table 6B.1).

6.2.2 Characteristics of Parents and Spouses Cared for on a Co-Resident Basis

This section compares the characteristics of cared-for older parents and spouses, focusing on co-resident care. As already indicated, substitution between care for older parents and spouses is more likely to have occurred where the cared-for older parents and spouses shared similar characteristics. As a corollary, absence of similar characteristics would help to explain the findings of the first part of the chapter, which did not provide much evidence that the decline in care for parents was primarily brought about by an increase in care for spouses.

Table 6.7 compares the characteristics of older parents and spouses cared for on an intense and very intense co-resident basis between 1985 and 2000. The underlying sample bases used in the table are the numbers of *people aged 30 to 89 providing co-resident care to parents or spouses aged 65 and over*, and details of the sample sizes are given in Appendix 6B (Table 6B.1). The degree of association between the characteristics of cared-for older parents and spouses is shown in the final column of the table.

Table 6.7 shows that there were significant differences in the characteristics of the older parents and spouses who were cared for intensely and very intensely between 1985 and 2000. First, cared-for spouses were significantly younger than cared-for parents (Table 6.7). The mean age of spouses cared for either intensely or very intensely was around 75 years, compared to a mean age of cared-for parents of around 84 years. Indeed, cared-for spouses can be characterised as the 'younger old' rather than the 'older old'. Three-quarters of cared-for spouses were under the age of 80, whereas three-quarters of cared-for parents were over this age (Table 6.7). Second, the gender of cared-for spouses was more evenly distributed than the gender of cared-for parents (cf. Parker 1993a: 158). Overall, in the period between 1985 and 2000, less than half of all spouses cared for on an intense or very intense co-resident basis were women, compared to over 80 per cent of parents (Table 6.7). Consistent with their greater age, cared-for parents were also more likely to have a mental impairment than cared-for spouses, although this difference was only significant in the case of intense care provision (Table 6.7). Around one in five (21 per cent) of cared-for spouses had a mental impairment, compared to nearly one in three (29 per cent) of cared-for parents. Finally, despite the greater age and impairment of cared-for older parents, they were less likely to receive personal care

than cared-for spouses, although again this difference was only significant in the case of intense care provision. Nearly three-quarters (70 per cent) of those caring for elderly spouses for 20 hours a week or more were providing personal care in the 1985/2000 period, compared to under two-thirds (57 per cent) of those caring for older parents (Table 6.7).

In summary, there were important differences in the characteristics of older parents and spouses cared for intensely and very intensely in Britain between 1985 and 2000. Had the cared-for parents and spouses been more similar, then this might have offered some support for a hypothesis of substitution between care for parents and spouses. The absence of similar characteristics among the cared-for parents and spouses both supports, and helps to explain, the findings of the first part of the chapter, which did not provide much evidence that the decline in care for parents was primarily brought about by an increase in care for spouses.

Table 6.7

Characteristics of older parents and spouses cared for on a co-resident basis, by intensity of care, Britain, 1985-2000 (all years combined)

(a) Intense care (20 hours a week or more) *Mean age & (column) percentages*

Characteristics of cared-for person/type of help provided		Categories	Relationship of care-receiver to care-provider		Chi square
			Parent	Spouse	
Characteristics of cared-for person	Mean age		83.7	74.4	***
	Age-group (column %)	65-69	3.9	28.6	
		70-74	5.7	24.0	
		75-79	16.9	24.2	***
		80-84	22.1	16.0	
		85+	51.4	7.2	
	Gender	% women	82.8	45.5	***
	Type of impairment	% affected mentally	29.3	21.3	*
Type of help provided	If personal care is provided	% providing personal care	56.8	69.4	***

(b) Very intense care (50 hours a week or more)

Characteristics of cared-for person/type of help provided		Categories	Relationship of care-receiver to care-provider		Chi square
			Parent	Spouse	
Characteristics of cared-for person	Mean age		84.2	74.8	***
	Age-group (column %)	65-69	5.4	25.8	
		70-74	4.3	24.5	
		75-79	14.0	22.9	***
		80-84	21.0	20.0	
		85+	55.4	6.8	
	Gender	% women	86.0	41.9	***
	Type of impairment	% affected mentally	28.8	26.5	ns
Type of help provided	If personal care is provided	% providing personal care	65.1	72.3	ns

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

*Notes: The table relates to people aged 30 to 89 providing care to parents and spouses aged 65 and over. Where someone provided intense or very intense care to more than one parent, the characteristics of the oldest parent are shown. In 2 cases, where people provided intense or very intense care to both a parent and a spouse, intergenerational care was given priority Asterix indicates Chi-square association at *(5%), **(1%),***(less than 1%); ns indicates no significant association. For sample sizes, see Appendix 6B, Table 6B.1.*

6.3 Discussion and Conclusions

6.3.1 Summary and Discussion of Results

This chapter has explored a *demand-side* explanation for the trends in intergenerational care. It has examined the hypothesis that the decline in intense and very intense co-resident intergenerational care for older parents was associated with an increase in care for spouses aged 65 and over. For the purpose of this analysis, the focus has been on people providing care who were themselves between the ages of 30 and 90. This wider age-band encompasses nearly all those providing either intergenerational or spouse care intensely.

The results suggest that it is unlikely that an increase in care for spouses aged 65 and over was a key factor explaining the decline in intense or very intense care for older parents between 1985 and 2000. It is true that the present chapter identified an increase in intense care for elderly spouses, particularly during the 1990s, and this is consistent with the findings of other studies (Rowlands 1998, Hirst 2001). However, there was little evidence of a consistent negative relationship between the timing of changes in the probability of providing either intense or very intense care to an older spouse and the timing of changes in the probability of providing these forms of care to an older parent. Thus, the greatest increase in intense spouse care in fact occurred during the late 1990s, at a time when there was no decline in intense co-resident care for parents. Even more striking, there was no significant increase in very intense care for spouses between 1985 and 2000 to compensate for the significant decline in very intense co-resident care for parents.

An explanation of the trends in intergenerational care in terms of a substitution by spouse care would have been given some support if the cared-for older parents and spouses had shared similar characteristics. However, this was not generally the case. The characteristics of cared-for parents were significantly different in key respects from those of cared-for spouses. Cared-for parents were significantly older than cared-for spouses, more likely to be women and, particularly with regard to intense care, more likely to suffer a mental impairment. The finding that cared-for older parents and spouses were dissimilar in important respects is consistent with earlier research by Parker (1993a). However, the current study has taken this analysis forward by

controlling for the intensity of care and by examining in more detail the age of the cared-for older people. One of the most important findings of the present chapter is that cared-for older parents were predominantly the *'older old'* whereas cared-for older spouses were predominantly the *'younger old'*. Around three-quarters of older parents cared for either intensely or very intensely were over the age of 80, whereas around three quarters of older spouses were under this age. Many of the other characteristics of the cared-for older parents, particularly their gender distribution and degree of disability, were probably associated with their greater age. Indeed, a further important finding of the present chapter is that cared-for older parents were predominantly women. Although this finding is not new (cf. Arber and Ginn 1991, Parker 1993a), when combined with the earlier results of Chapter Three, it indicates the extent to which intense care for older parents is primarily *care by women for women*.

It might be argued that, even though the average characteristics of cared-for parents and spouses were different, there might still have been some substitution at the 'margins', due perhaps to the longer survival rates of spouses, which could have delayed the onset of intense care by children (cf. Parker 1993a). Taken together with the evidence relating to the detailed timing of changes in care for parents and spouses presented in this chapter, however, the differences between the cared-for parents and spouses suggests that, even if some marginal substitution did take place, replacement of intergenerational care by spouse care was unlikely to have been a *key* factor explaining the decline in care for older parents.

An explanation of trends in co-resident intergenerational care in terms of changes in spouse care seemed plausible at the start of the chapter. This was because of the increase in the proportion of older people who were married between 1985 and 2000, described in Chapter Two. However, the limited nature of this explanation is consistent with other evidence presented in the study so far. Thus, the decline in provision of intense and very intense care for older parents was concentrated primarily in the period between 1990 and 1995. However, as Chapter Two showed, the increase in the proportion of older people who were married occurred throughout the period between 1985 and 2000 (Chapter Two, Table 2.12, Figure 2.13). Moreover, it was a gradual change, which was barely perceptible even in the fifteen year period covered by this study. For example, the proportion of people aged 65 and over who were married rose from 51 per cent in 1985 to 53 per cent in 2000 (Table 2.12). The gradual nature of the

increase in the proportion of older people who were married in turn relates to its causes, which are associated with long-term improvements in male relative to female mortality rates, which are in turn leading to a gradual decline in the proportion of widows (ONS 2005). Gradual, long-term changes of this kind, however, are unlikely to explain the fairly sharp changes in provision of care, occurring over relatively short time-periods, observed in this study.

Moreover, the finding that care for spouses and parents did not appear to substitute for each other is consistent with research elsewhere. Research by the present author and colleagues into future demand for informal care by disabled older people from their spouses and adult children found that, even in the longer term over the next thirty years or so, "large increases in the numbers of older married/cohabiting people are needed to effect comparatively modest reductions in demand for care by disabled older people from their children" (Pickard *et al* 2007: 362). The research, which was concerned with *receipt* (rather than provision) of informal care by disabled older people, based on analysis of the 2001/02 GHS module on older people, concluded that "there may be limits to the extent to which care by spouses *can* substitute for care by children" (Pickard *et al* 2007: 362). A key reason for this is that informal care by children was found to be the most important source of informal care for the 'oldest old', and the oldest old in turn constitute the fastest growing age-group in the country (Tomassini 2005). The rapid growth of the oldest old was also occurring in the 1985/2000 period, as Chapter Two observed, raising stark questions as to why the provision of intense informal care to older parents declined when the numbers of very old people were increasing (discussed at the end of the chapter).

The findings of this chapter have suggested that there may have been some tensions between the needs for care of older parents who were cared for and the type of care that was provided for them. The chapter has found that, despite the greater age and impairment of cared-for older parents, they were less likely to receive personal care than cared-for older spouses. This discrepancy may have been due to tensions in the provision of personal care to older parents (Ungerson 1983, Twigg 2000). As Twigg has observed, there is a "particular charge" around personal care for kin, which relates in part to the "dangerous qualities" of the intimacy involved, and this feeling is "strongest in relation to parental tending" (Twigg 2000: 72-3). The implications of the

tension between the needs of older parents and the ability of adult children to meet them are considered more in the conclusions to this study (Chapter Nine).

6.3.2 Implications for Explanations of Trends in Intergenerational Care Provision

The conclusions of the previous three chapters have all suggested that there were probably different explanations for the trends in intense extra-resident and co-resident care for older parents between 1985 and 2000. The present chapter has primarily been concerned with explaining the decline in intense and very intense co-resident care. However, the findings of this chapter also relate to the potential explanation for the rise in intense extra-resident care. The two sections below explore how far the results of the present chapter help to explain, first, the trends in intense extra-resident care and, second, the trends in intense and very intense co-resident care.

Increase in intense extra-resident care for older parents, 1985-1995

It was suggested at the end of Chapter Five that the most plausible explanation for the rise in extra-resident care in the 1985/95 period was the rise in the numbers of 'older old' people in Britain at this time. This was because, as Chapter Four concluded, the trends in intense extra-resident care for older parents showed a very similar pattern to the trends in the numbers of people aged 80 and over. Both the numbers of people aged 80 and over and the numbers of people providing extra-resident care for older parents rose rapidly between 1985 and 1995 and then levelled off between 1995 and 2000. An explanation for the rise in extra-resident care for parents in terms of the numbers of people aged 80 and over would be supported if it was the case that people caring for older parents in another household were primarily caring for the 'older old'. The present chapter has shown that this was indeed the case. The mean age of parents who were cared for intensely on an extra-resident basis was approximately 80 years old (Table 6.6). Although on average younger than parents cared for intensely on a co-resident basis, nevertheless, the majority of parents cared for in another household were over the age of 80 (Table 6.6). The findings of this chapter therefore add support to an explanation of the rise in intense extra-resident care in terms of the rise in the numbers of very old people in the population.. This explanation will be revisited in the conclusions to this study (Chapter Nine).

Decrease in co-resident care for older parents 1985-1995

However, as observed previously, if the rise in extra-resident care for older parents can be explained primarily as a response to the increase in the numbers of older old people, then this raises even more starkly the question as to why *co-resident* care for older parents did not also increase at this time. The present chapter has found that it is unlikely that an increase in care by spouses was an important factor explaining the decline in intense or very intense co-resident care for older parents. Reference back to the end of Chapter Two (Table 2.20), however, shows that there are two other demand-side explanations that could have contributed to a decline in co-resident care for older parents. These are explanations in terms of trends in formal service provision for older people and trends in the prevalence of disability among older people. The next two chapters examine these remaining explanations.

Appendices to Chapter 6

Appendix 6A

GHS Sample Numbers Underlying Tables in Chapter 6, Section 6.1

Table 6A.1

Provision of informal care to older parents and spouses for 20 and 50 hours a week or more by age-group, Britain, 1985-2000: sample numbers

(a) Intense care (20 hours a week or more)

Age-group	Parent	Spouse	Underlying sample base
16-29	15	0	14,868
30-44	177	3	18,445
45-59/64	406	37	17,465
60/65-74	136	267	10,495
75-89	1	172	5,295
90+	0	3	208
Total	735	482	66,776

(b) Very intense care (50 hours a week or more)

Age-group	Parent	Spouse	Underlying sample base
16-29	4	0	14,868
30-44	44	2	18,445
45-59/64	118	21	17,465
60/65-74	58	176	10,495
75-89	1	112	5,295
90+	0	2	208
Total	225	313	66,776

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Table 6A.2

Provision of co-resident care to older people for 20 and 50 hours a week or more, by relationship of care-receiver to care-provider, Britain, 1985-2000: sample numbers

(a) Intense care (20 hours a week or more)

Year	Parent	Spouse	Other	All	Underlying sample base
1985	97	108	22	227	13,715
1990	101	100	17	218	13,264
1995	70	128	6	204	13,335
2000	63	139	9	211	11,386
All years	331	475	54	860	51,700

(b) Very intense care (50 hours a week or more)

Year	Parent	Spouse	Other	All	Underlying sample base
1985	72	79	15	166	13,715
1990	53	69	13	135	13,264
1995	31	84	3	118	13,335
2000	30	78	3	111	11,386
All years	186	310	34	530	51,700

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Notes: The table relates to people aged 30 to 89 providing care to older parents, spouses or others; see also notes to Table 6.1.

Appendix 6B

GHS Sample Numbers Underlying Tables in Chapter 6, Section 6.2

Table 6B.1

Provision of care to older parents and spouses, by intensity and locus of care provision, Britain, 1985-2000: sample numbers (all years combined)

Intensity of care provided	Relationship of care-receiver to care-provider	Co-resident	Extra-resident	All
20+ hrs pw	Parent	331	392	720
	Spouse	475	2	477
50+ hrs pw	Parent	186	35	221
	Spouse	310	1	311

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Notes: The table relates to people aged 30 to 89 providing care to older parents and spouses; see also notes to Tables 6.7.

Chapter 7

From Carer to Cared-for:
Older People Cared for by their Children

This chapter, and the succeeding chapter, are concerned with the extent to which the decline in co-resident care for older parents was associated with changes in formal service provision. Evidence presented earlier in the study suggested that the decline in intense and very intense co-resident care, which occurred during the period between 1985 and 2000, coincided with an increase in long-stay residential care (Chapters Two and Three). The present chapter begins then the exploration of the hypothesis that the decline in intense intergenerational care of older people was associated with an increase in long-stay residential care. The current chapter looks in greater detail than the previous chapter at the characteristics of older parents cared for intensely or very intensely in the same household and asks how far these characteristics were similar to those of older people in long-stay residential care. The next chapter makes a direct comparison between the trends in intense and very intense co-resident care for older parents and trends in long-stay residential care.

The first part of this chapter makes two important shifts in the methodology of the study. These shifts are important both to the present chapter and to the succeeding chapter. First, the chapter introduces a systematic analysis of care for the 'older old'. Up to now the study has focused on care for people aged 65 and over. However, the previous chapter has shown that around three-quarters of all care provided to older parents on an intense or very intense co-resident basis was in fact provided to someone who was aged 80 and over. The present chapter therefore carries out an analysis of care for the older old, comparing trends in provision of care to older parents with trends in provision of care to older old parents.

The second methodological development in the present chapter is that it makes a profound shift in the analysis, moving from the provision of care to its receipt, from the carer to the cared-for. It does this by utilising the household nature of the GHS in an analysis that is explained fully later in the chapter (section 7.1.2). Shifting the focus to

the receipt of care allows for the derivation of probabilities that an older, or older old, person receives intense or very intense care from a co-resident child. This probability is used in the present chapter in ways that are described below. It is also very important, however, in the next chapter, when the probability of an older person receiving co-resident care from a child is compared with the probability of an older person receiving long-stay residential care.

The second part of the chapter then carries out an analysis of the characteristics of the older people receiving intense and very intense intergenerational care from children living in the same household. The derivation of probabilities of receiving care, undertaken in the first part of the chapter, allows for the characteristics of older people receiving care to be analysed in much greater depth than was possible in the previous chapter. This is because the previous chapter used information about the cared-for person that was derived indirectly from questions asked of the person providing care. Once the focus has shifted to the cared-for person, however, a more complete analysis of the characteristics of people receiving care is possible because any of the variables collected at the individual level in the GHS, including marital status, health and socio-economic status, may be utilised.

The characteristics of people receiving intense and very intense co-resident care from their children are then compared with the characteristics of people in long-stay residential care. Information on the characteristics of people in long-stay residential care in the 1980s and 1990s in this chapter are drawn primarily from a review of the literature. The key underlying hypothesis examined here is that substitution between care for parents and long-stay residential care is more likely to have occurred if the cared-for older parents and those in long-stay residential care shared similar characteristics. While not, in itself, necessarily evidence of substitution, similarity between the characteristics of cared-for parents and those in long-stay residential care would suggest that the substitution hypothesis is worth pursuing further.

The analysis in this chapter takes as its starting point the trends in provision of care by people aged between 30 and 74, described in Chapter Three and analysed further in Chapter Four. The particular reasons for focusing on a narrower age-range in Chapter Five, and a broader age-range in Chapter Six, do not apply to the present chapter.

7.1 The Old and the 'Older Old': from Carer to Cared-for

7.1.1 Intense and Very Intense Co-Resident Care for Older and 'Older Old' Parents

So far, this study has examined trends in provision of intense and very intense informal care for parents *aged 65 and over* and, as Chapter Three showed, has identified a significant fall between 1985 and 1995 in the provision of care on a co-resident basis for 20 and 50 hours a week or more. However, as already indicated, the previous chapter showed that care provided to older parents on an intense and very intense co-resident basis was in fact primarily provided to someone who was *aged 80 and over*. The analysis in the previous chapter therefore raises the question: how did the trends in provision of intense co-resident care to people aged 80 and over compare with the trends in provision of care to people aged 65 and over?

Table 7.1 compares the probability of providing intense and very intense co-resident care to parents aged 65 years and over and aged 80 years and over. (Sample numbers are given in Appendix 7A). The table shows that, between 1985 and 2000, the trends in the probability of providing care to a parent aged 65 and over and the trends in the probability of providing care to a parent aged 80 and over were similar. Thus, between 1990 and 1995, there was a significant decline in intense and very intense co-resident care provided to parents aged 80 and over, as there was to those aged 65 and over. There was no significant decline in provision of intense care to older old parents between 1985 and 1995, as there was in provision of care to older parents. However, the trends in provision of very intense care to parents aged 80 and over were essentially the same as the trends in provision of this form of care to parents aged 65 and over. Care provided for 50 or more hours a week to older old parents and to older parents declined significantly between 1985 and 2000, all of the decline occurring between 1985 and 1995. Table 7.1 confirms an observation made before in this study, that the decline in provision of co-resident care for 20 hours a week or more was less marked than the decline in provision of this form of care for 50 hours a week or more.

Figures 7.2 and 7.3 respectively illustrate the decline in provision of intense and very intense care to older and older old parents between 1985 and 2000. The figures confirm that the trends in provision of care to older old parents were similar to the trends in provision of care to older parents. The greatest differences seem to have been in the period between 1995 and 2000. During this period, intense care for parents aged 80 and

over continued to fall slightly, while provision of intense care to parents aged 65 and over rose slightly (Figure 7.2). Provision of very intense care for people aged 80 and over was flatter than for parents aged 65 and over between 1990 and 1995 (Figure 7.3). In no case, however, was the difference in provision of care in 2000 significantly different from that in 1995 (Table 7.1).

It is not surprising that trends in provision of care to older and older old parents were similar, given that most care for people aged 65 and over was in fact care for people aged 80 and over. However, in the light of this important finding, the distinction between care for older and older old people will now be made in all subsequent analyses.

Table 7.1

Proportion of the population aged 30 to 74 providing co-resident care to parents aged 65 and over and aged 80 and over for 20 and 50 hours a week or more, Britain, 1985-2000

(a) Intense care (20 hours a week or more) *Percentages*

	Provision of care to parents aged 65+		Provision of care to parents aged 80+	
	%	95% Confidence Intervals	%	95% Confidence Intervals
1985	0.78	0.64-0.95	0.56	0.44-0.70
1990	0.85	0.70-1.03	0.65	0.52-0.81
1995	0.57	0.45-0.73	0.45	0.35-0.59
2000	0.62	0.49-0.79	0.41	0.31-0.56
All years	0.71	0.64-0.79	0.52	0.46-0.59
85/90	ns		ns	
90/95	*		*	
95/00	ns		ns	
85/95	*		ns	
85/00	ns		ns	

(b) Very intense care (50 hours a week or more)

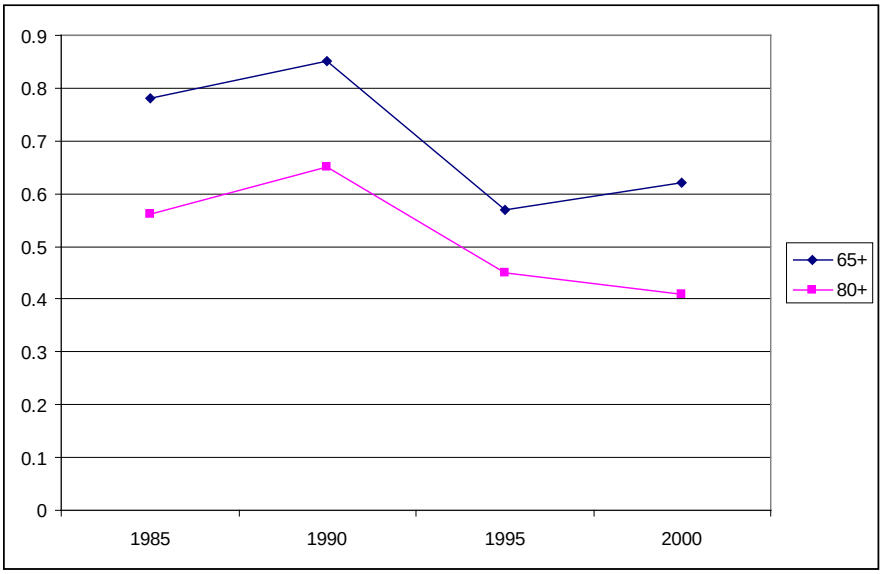
	Provision of care to parents aged 65+		Provision of care to parents aged 80+	
	%	95% Confidence Intervals	%	95% Confidence Intervals
1985	0.58	0.46-0.73	0.46	0.36-0.60
1990	0.45	0.34-0.58	0.35	0.26-0.48
1995	0.25	0.18-0.36	0.20	0.13-0.30
2000	0.30	0.21-0.42	0.20	0.13-0.30
All years	0.40	0.35-0.46	0.31	0.35-0.46
85/90	ns		ns	
90/95	*		*	
95/00	ns		ns	
85/95	***		***	
85/00	**		**	

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
*Note: Chi-square association over time at *(5%), **(1%),***(less than 1%); ns indicates no significant association. For sample numbers, see Appendix 7A..*

Figure 7.2

Provision of co-resident care for 20 hours a week or more to parents aged 65 and over and aged 80 and over, Britain, 1985-2000

Percentage

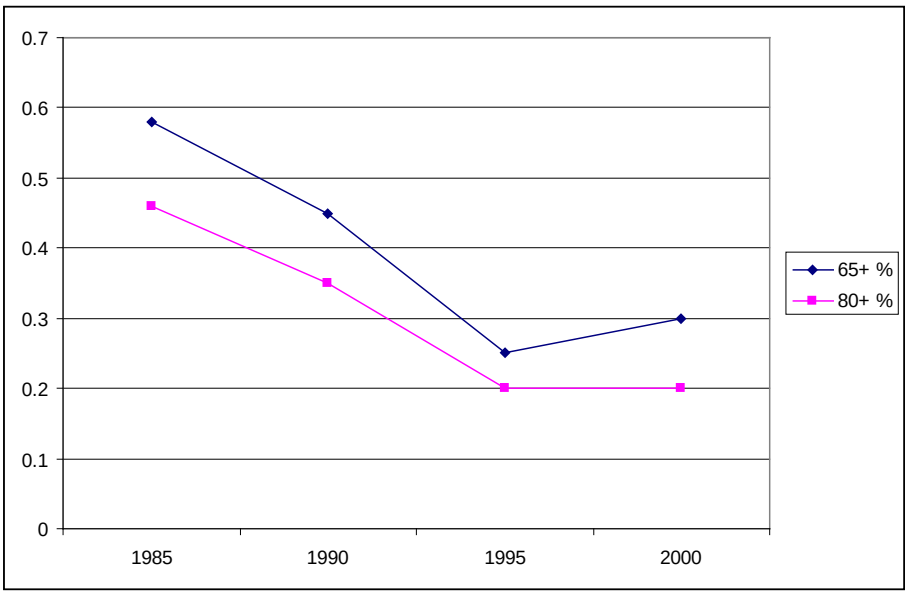


Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: The figure shows the proportion of the total population aged 30 to 74 providing care to older and older old parents.

Figure 7.3

Provision of co-resident care for 50 hours a week or more to parents aged 65 and over and aged 80 and over, Britain, 1985-2000

Percentage



Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: The figure shows the proportion of the total population aged 30 to 74 providing care to older and older old parents.

7.1.2 From Carer to Cared-for: the Probability of Receiving Co-Resident Care

As suggested at the beginning of the chapter, if the characteristics of older and older old parents receiving intense and very intense intergenerational care from co-resident children are to be analysed in detail, then it is necessary to turn from the provision of care to its receipt.

The structure of the GHS allows for the analysis to move from the person providing care to the person receiving care under certain circumstances, and in particular, where the carer and the cared-for share a household. This is because the GHS is a sample of households and includes in the survey all adults living in a surveyed household. In the GHS datasets, the people in the household to whom the care-provider gives help are identified by a unique 'person number'. Therefore, where the carer and the cared-for share a household, it is possible to identify unambiguously the cared-for person in the household. In this way, double-counting of the people cared for is avoided because, if two people in a household care for the same person, the cared-for individual will be counted only once. Such an approach is not possible where the cared-for person does not share a household with the person providing care. Where care is extra-resident, as the official reports on the GHS carers data point out (for example Green 1988: 16), there is no way of controlling for double-counting of the cared-for individuals.

The ability to move from the carer to the cared-for in the analysis of co-resident care is of great importance in the present chapter because it is precisely carers who share a household with the cared-for person with which the analysis is concerned. This in turn is because the decline in provision of care between 1985 and 2000, identified in this study, only affected care provided on a co-resident basis. By moving from the carer to the cared-for, the present study is able to turn its focus from, on the one hand, people providing co-resident care to older parents to, on the other hand, *older people receiving intense and very intense care from co-resident children.*

Although moving from the care-provider to the care-receiver, the analysis here nevertheless retains a link between the receipt of care and its provision. The cared-for individuals examined here are older parents who were looked after by children providing intense and very intense co-resident care for them. Thus, the cared-for parents are all older people receiving care from an intense or very intense care-provider.

As will be suggested in the final chapter, there are particular reasons why there may be a connection between people providing care at high levels of intensity and demand by older people and their families for formal service provision.

As far as the author is aware, no other studies have utilised the household nature of the GHS to move from the carer to the cared-for in the analysis of co-resident informal care. This may be because, in other studies, co-resident care is not of such great interest as it is in the present study. Arber & Ginn, for example, used the 1985 GHS to look at provision of care for older people (using the GHS carers module) and also looked at older people receiving care (using the GHS module on older people), but they did not make a direct connection between the care-provider and the care-receiver (Arber & Ginn 1991). A recent analysis of the 2004 English Longitudinal Study of Ageing (ELSA) has looked at the relationship between the characteristics of cared-for older spouses and the well-being of spouses providing care (Ross *et al* 2008). However, the author is not aware of any analyses of intergenerational care of older people in this country that link the care-provider and the care-receiver.

The analysis that follows makes the transition from the carer to the cared-for. The analysis begins by examining the ratio of care-receivers to care-providers and then compares the trends in receipt of care with the trends in provision of care. Trends in receipt of care will form the foundation of the analyses in the next chapter.

Table 7.4 shows the ratio of care-receivers to care-providers, with data shown separately for parents aged 65 and over and aged 80 and over. The first part of the table relates to care for 20 or more hours a week and the second part to care for 50 or more hours a week. The table, which utilises sample numbers, shows that there were fewer people cared-for than carers (Table 7.4). The shared caring of the older people on a co-resident basis primarily arose because care was being provided by a married or cohabiting couple, the parent of one of whom was living in the same household. The numbers of co-resident carers who shared care in this way was greater than the numbers of carers providing care for more than one parent, so that the total numbers of cared-for parents was lower than the total number of carers.

The results show that the ratio of both older and older old parents cared-for to people providing care tended to be higher for very intense care than for intense care (Table

7.4). Indeed, there was nearly a one-to-one ratio between people providing co-resident care for 50 or more hours a week to older parents and parents cared-for on this basis. When all four years between 1985 and 2000 are considered together, the ratio of older parents cared-for to people providing care for 50 or more hours a week was 0.93, while the equivalent figure for older old parents was 0.90. The ratio of older parents cared-for to people providing care for 20 or more hours a week was 0.86, while the equivalent figure for older old parents was 0.84.

Table 7.4

Co-resident care for parents aged 65 and over and aged 80 and over: ratio of numbers receiving care to numbers providing care, Britain, 1985-2000 (sample numbers)

(a) Intense care (20 hours a week or more) *Sample numbers*

	Parents aged 65+			Parents aged 80+		
	Numbers providing care to parents	Numbers of parents receiving care	Ratio of cared-for: carers	Numbers providing care to parents	Numbers of parents receiving care	Ratio of cared-for: carers
1985	97	84	0.87	69	58	0.84
1990	101	87	0.86	77	65	0.84
1995	69	60	0.87	54	46	0.85
2000	63	52	0.83	42	34	0.81
All years	330	283	0.86	242	203	0.84

(c) Very intense care (50 hours a week or more)

	Parents aged 65+			Parents aged 80+		
	Numbers providing care to parents	Numbers of parents receiving care	Ratio of cared-for: carers	Numbers providing care to parents	Numbers of parents receiving care	Ratio of cared-for: carers
1985	72	65	0.90	57	47	0.82
1990	53	51	0.96	42	41	0.98
1995	30	28	0.93	24	22	0.92
2000	30	29	0.97	20	19	0.95
All years	185	173	0.93	143	129	0.90

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: 'Numbers providing care to parents' refers to people aged 30 to 74 providing care to parents for 20 or 50 hours a week or more. 'Numbers of parents receiving care' refers to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child.

A key advantage of shifting the focus of the analysis from the carer to the cared-for is that the numbers of older people cared-for can be expressed as a percentage of the older population to give a probability of an older person receiving co-resident care. Table 7.5 expresses the numbers of older people cared for by their children on a co-resident basis

as a percentage of the household population aged 65 and over and aged 80 and over, using the GHS data for 1985, 1990, 1995 and 2000. The first part of the table shows the probability of being cared-for intensely for 20 or more hours a week and the second part the probability of being cared-for very intensely for 50 or more hours a week. (Sample numbers are given in Appendix 7B).

Table 7.5

Proportion of people aged 65 and over and aged 80 and over being cared for by adult child(ren) on a co-resident basis for 20 and 50 hours a week or more, Britain, 1985-2000

(a) Intense care (20 hours a week or more) *Percentages*

	Percentage of people cared for by adult child(ren) on co-resident basis for 20 hours a week or more			
	aged 65+		aged 80+	
	% cared for	95% Confidence Intervals	% cared for	95% Confidence Intervals
1985	2.02	1.64-2.50	7.92	6.18-10.11
1990	2.06	1.67-2.53	7.39	5.84-9.31
1995	1.68	1.31-2.15	6.15	4.65-8.11
2000	1.72	1.32-2.25	5.35	3.86-7.39
All years	1.89	1.68-2.12	6.78	5.93-7.74

(b) Very intense care (50 hours a week or more)

	Percentage of people cared for by adult child(ren) on co-resident basis for 50 hours a week or more			
	aged 65+		aged 80+	
	% cared for	95% Confidence Intervals	% cared for	95% Confidence Intervals
1985	1.56	1.23-1.99	6.42	4.87-8.44
1990	1.21	0.92-1.58	4.66	3.46-6.26
1995	0.78	0.54-1.13	2.94	1.96-4.41
2000	0.96	0.67-1.38	2.99	1.93-4.63
All years	1.16	1.00-1.34	4.31	3.64-5.10

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: 'People cared for' refers to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child. For sample numbers, see Appendix 7B.

The results show that around 2 per cent of the household population aged 65 and over was cared-for intensely (for 20 or more hours a week) by their adult children on a co-resident basis between 1985 and 2000 and around 1 per cent was cared-for very intensely (for 50 or more hours a week) (Table 7.5). The probability of being cared-for was higher for those aged 80 and over. Around 7 per cent of the household population aged 80 and over was cared-for intensely between 1985 and 2000, while around 4 per

cent was cared-for very intensely (Table 7.5). Table 7.5 shows a trend downwards over time in receipt of intense and very intense care by both older and older old people and this is analysed further in Table 7.6.

Table 7.6 compares changes over time in the probability of *providing* very intense care to an older parent with changes over time in the probability of an older person *receiving* very intense care from an adult child. The table distinguishes between different intensities of care and between older people aged 65 and over and aged 80 and over. Before looking at the changes over time, it is important to make an observation about the relationship between the probabilities of providing and receiving care. It is particularly striking how, as Table 7.6 shows, a relatively small probability of *providing* care corresponds to a much higher probability of *receiving* care. The magnification of the effect of small probabilities of providing care arises primarily because of the difference in the numbers of people in the underlying base populations: the base population of potential care providers aged 30 to 74 is much greater than the base population of potential care-receivers aged 65, or 80, and over (Appendix 7A and Appendix 7B). The 'magnification' effect is most marked in relation to the older old population. For example, a probability of providing very intense care of less than 0.5 per cent to a parent aged 80 and over in 1985 translates into a probability of receiving care by an older old person of over 6% (Table 7.6).

Table 7.6

Provision of co-resident care to parents aged 65 and over and aged 80 and over and receipt of co-resident care from adult child(ren) by people aged 65 and aged 80 and over, by intensity, Britain, 1985-2000

Percentages

	Provision of care to parent aged 65 and over & receipt of care by persons aged 65 and over		Provision of care to parent aged 80 and over & receipt of care by persons aged 80 and over	
	Providing care to parent aged 65+	Persons aged 65+ being cared for	Providing care to parent aged 80+	Persons aged 80+ being cared for
Intense care (20+ hours a week)				
1985	0.78	2.02	0.56	7.92
1990	0.85	2.06	0.65	7.39
1995	0.57	1.68	0.45	6.15
2000	0.62	1.72	0.41	5.35
1985/90	ns	ns	ns	ns
1990/95	*	ns	*	ns
1995/2000	ns	ns	ns	ns
1985/1995	*	ns	ns	ns
1985/2000	ns	ns	ns	ns
Very intense care (50+ hours a week)				
1985	0.58	1.56	0.46	6.42
1990	0.45	1.21	0.35	4.66
1995	0.25	0.78	0.20	2.94
2000	0.30	0.96	0.20	2.99
1985/90	ns	ns	ns	ns
1990/95	*	ns	*	ns
1995/2000	ns	ns	ns	ns
1985/1995	***	**	***	**
1985/2000	**	*	**	**

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: 'Providing care' refers to people aged 30 to 74 providing care to parents for 20 or 50 hours a week or more. 'Being cared for' refers to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child. For sample numbers, see Appendices 7A and 7B.

Turning now to the trends over time presented in Table 7.6, the table shows that the changes in the probabilities of receiving care between 1985 and 2000 were much more pronounced for very intense compared to intense care. These differences are illustrated in Figures 7.7 and 7.8. Figure 7.7 shows the trends in probabilities of providing and receiving intense care in relation to parents aged 65 and over and aged 80 and over, while Figure 7.8 shows the same information in relation to very intense care. To reflect the 'magnification' effect, described above, the scales for providing and receiving care are different in the figures.

Looking first at very intense care, Figure 7.8 shows that there was a marked decline in the probability of an older or older old person receiving very intense co-resident care from a child for 50 or more hours a week between 1985 and 2000. The probabilities of both older and older old people receiving very intense co-resident care fell significantly between 1985 and 2000, with the decline concentrated entirely in the period between 1985 and 1995. The probability of an 80-year old person receiving very intense care fell particularly sharply, from around 6% in 1985 to 3% in 1995. Unlike the trends in provision of care, however, the changes in receipt of very intense care were not statistically significant in any of the five-year periods between 1985 and 2000 (Table 7.6). Indeed, this difference almost implies that virtually no change in receipt of care over a relatively short period of time would have been large enough to be statistically significant. Thus a decline of 0.15 per cent in provision of very intense care to people aged 80 and over between 1990 and 1995 was significant, whereas a decline that was over ten times as large (a decline of 1.72 per cent) in receipt of care by people aged 80 and over in the same time period was not (Table 7.6, Figure 7.8). This difference in significance between the trends in provision and receipt of care over relatively short time-periods can be attributed partly to the smaller underlying sample base of the older population, compared to the sample base of the population providing care, and partly to differential changes in the underlying base populations. The effect was that there was no marked step down in receipt of very intense care between 1990 and 1995, and the decline in receipt of care between 1985 and 1995 was smoother than the decline in provision of care.

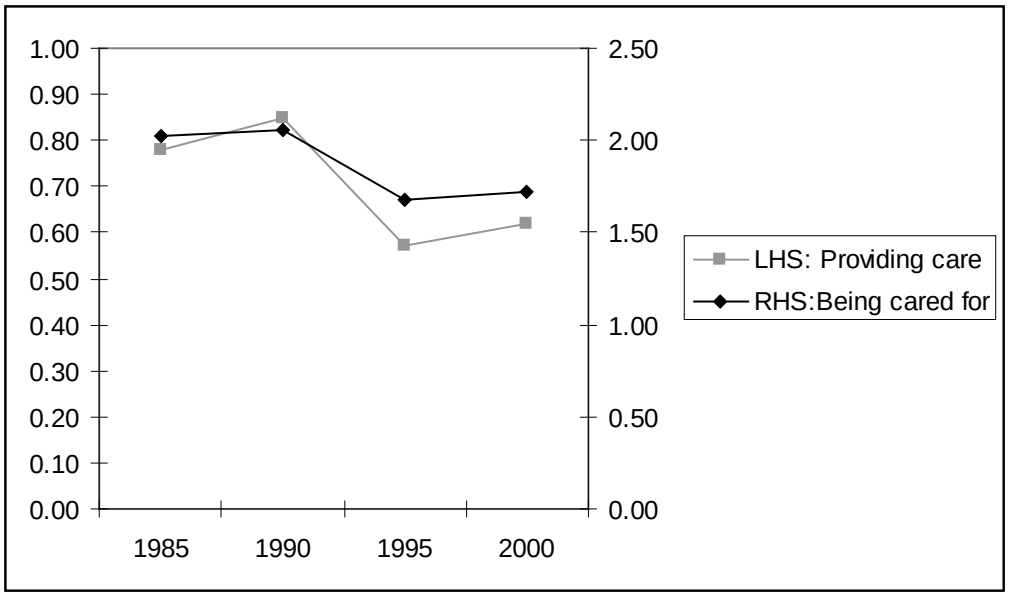
The smoother trend in receipt, compared to provision, of care is also noticeable in relation to intense care for 20 or more hours a week (Figure 7.7). This is particularly the case in relation to the older old, where a somewhat erratic pattern of change in provision of care translates into a gradual slope downwards in receipt of care by people aged 80 and over between 1985 and 2000 (Figure 7.7).

The changes in the probability of receiving care, shown in Figures 7.7 and 7.8, will form the basis of the trends analysed in the next chapter. However, before moving onto the next chapter, the shift from the carer to the cared-for also unlocks the potential for some further analysis of the cared-for older population and this is the subject of the next part of this chapter.

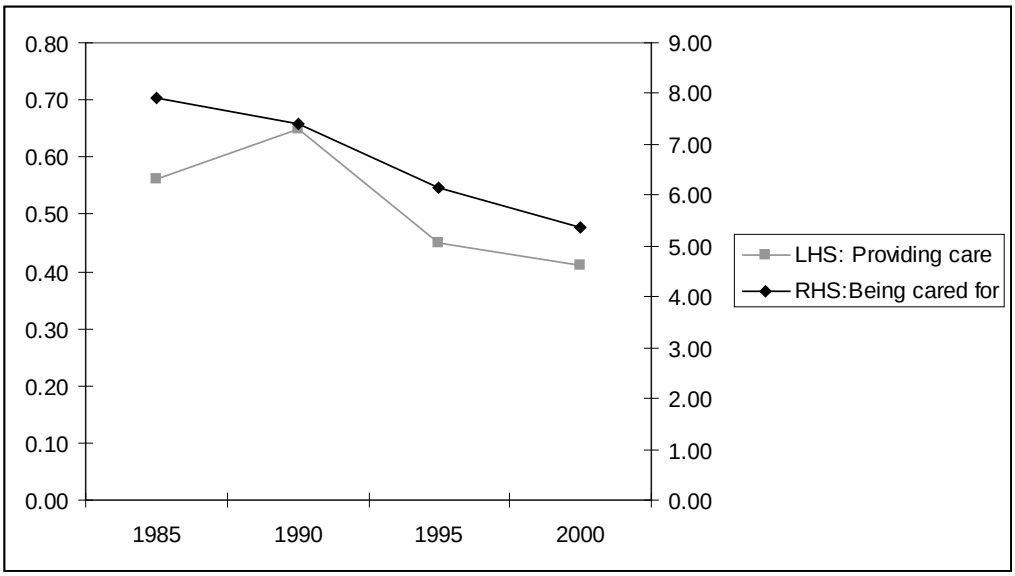
Figure 7.7

Provision of co-resident care to an older parent for 20 hours a week or more and receipt of co-resident care from adult child(ren) by older people for 20 hours a week or more, Britain, 1985-2000

(a) Provision of care to parent aged 65+ & receipt of filial care by people aged 65+



(b) Provision of care to parent aged 80+ & receipt of filial care by people aged 80+

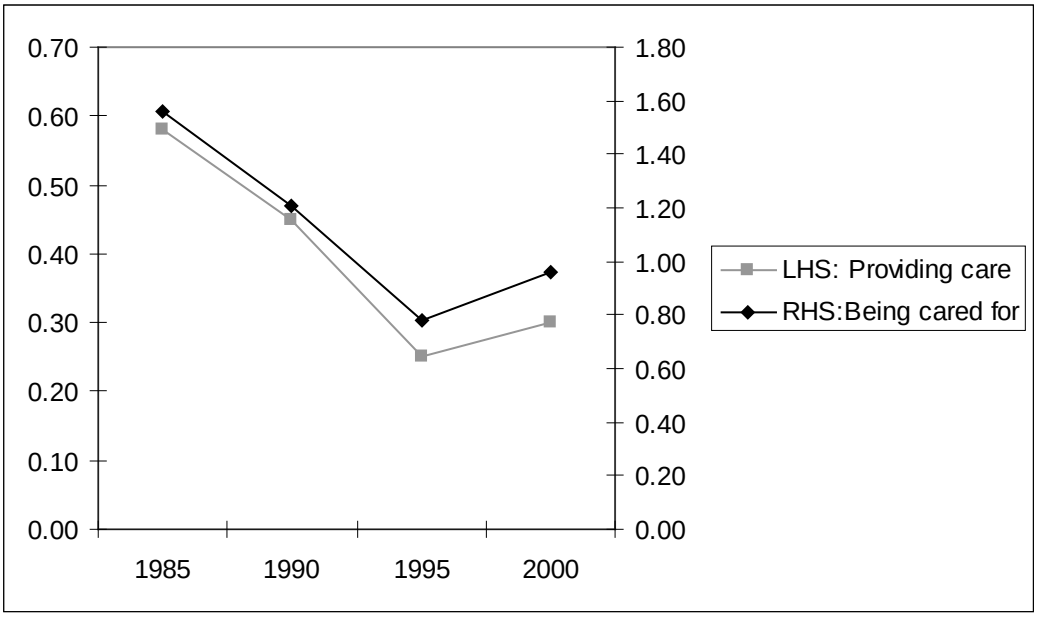


Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: LHS (left-hand side) refers to people aged 30 to 74 looking after co-resident parents for 20 hours a week or more. RHS (right-hand side) refers to older people receiving care that was provided for 20 hours a week or more by a co-resident child.

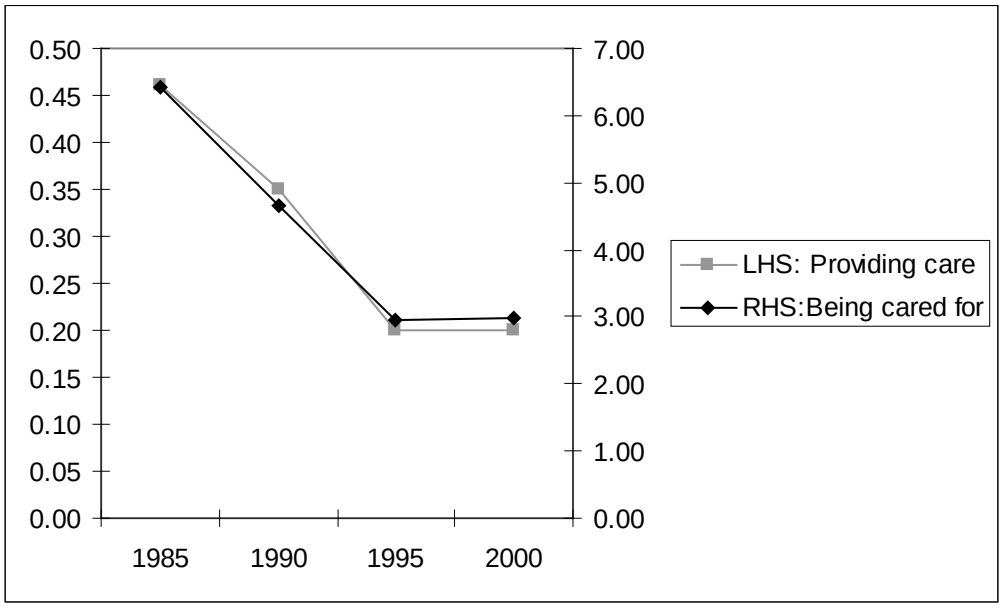
Figure 7.8

Provision of co-resident care to an older parent for 50 hours a week or more and receipt of co-resident care from adult child(ren) by older people for 50 hours a week or more, Britain, 1985-2000

(a) Provision of care to parent aged 65+ & receipt of filial care by people aged 65+



(b) Provision of care to parent aged 80+ & receipt of filial care by people aged 80+



Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: LHS (left-hand side) refers to people aged 30 to 74 looking after co-resident parents for 50 hours a week or more. RHS (right-hand side) refers to older people receiving care that was provided for 50 hours a week or more by a co-resident child.

7.2 Co-Resident Care by Children and Long-Stay Residential Care

In the previous chapter, three characteristics of older people cared for by their adult children were considered: age, gender and type of impairment. However, having now shifted the analysis from the carer to the cared-for, it is possible to examine a much wider range of characteristics of the cared-for older people. This is because, as indicated earlier, once the focus has shifted to the cared-for person, any of the variables collected at the individual level in the GHS may be utilised in the analysis. A more detailed consideration of the factors associated with older people's receipt of intense co-resident care is potentially important in the present context because it allows for a comparison to be made with the characteristics of people in long-stay residential care. As indicated at the beginning of the chapter, the key underlying hypothesis examined here is that substitution between intense intergenerational care and long-stay residential care is more likely to have occurred if the cared-for older parents and those in long-stay residential care shared similar characteristics. This part of the chapter analyses the factors associated with older people's receipt of intense co-resident care (section 7.2.1) and considers changes over time by key characteristics of the older people receiving care (section 7.2.2). It then makes a comparison between the characteristics associated with receipt of intense co-resident care and those associated with long-stay residential care (section 7.2.3).

7.2.1 Characteristics of Older People Receiving Co-Resident Care from Children

Although the factors associated with receipt by older people of care from their adult children have not been well studied in Britain, there is evidence that, as well as age and gender, factors such as marital status, disability and socio-economic status are all important. Older people cared for by their children are particularly likely to be the older old. A study by the present author and colleagues, to which reference has already been made, found that the most important source of informal care for disabled older people aged 85 and over in 2002 was care from an adult child (Pickard *et al* 2007). The same study also showed that a central factor affecting sources of informal care for people aged 65 and over was their marital status, and that the most important source of informal care for single (including widowed, divorced and separated) older people with a disability was their adult children (Pickard *et al* 2007). Clearly co-resident care is associated with sharing a household, but the evidence suggests that this varies by gender

and disability. A study using the 1985 GHS data on older people found that one in five very severely disabled older women lived with their adult children, a proportion that was much higher for women than for men and which increased sharply with disability (Arber & Ginn 1991: 145). A more recent study using the 2001 GHS data on older people found that single older women with high levels of disability in private households were found to be considerably less likely to live alone than those with lower levels of disability (Wittenberg *et al* 2006). In general, older people who co-reside with relatives, including their children, tend to be in poorer health than those who live alone (Glaser *et al* 1997; Murphy 2007). There is some evidence that older people with fewer socio-economic resources are more likely to receive informal care (Wittenberg *et al* 2006).

The characteristics of older people cared for intensely or very intensely by their children on a co-resident basis between 1985 and 2000 are examined here using bivariate and multivariate analysis. Data on the characteristics of the care recipients for 1985, 1990 1995 and 2000 are pooled in order to maintain an adequate sample size. However, with regard to one characteristic, disability, data are only available for one year (1985) because this is the only year in which the GHS contained modules on both the provision of care and on people aged 65 and over. There is therefore also some separate analysis carried out here for 1985 only. (Trends over time by key characteristics of care-recipients are examined in the next section).

In the analysis that follows, broad categories are used. For those aged 65 and over, age is divided into those aged 65 to 79 and those aged 80 and over. Marital status is a two-fold category, defined in terms of legal marital status and divided into single (including never married, widowed and divorced) and married (including currently married and separated). Two different variables describe the health/disability of older people. First, health is defined in terms of whether or not an individual has a limiting long-term illness, that is, whether someone has a long-standing illness that limits their ability to undertake normal activities. In addition, as already noted, data on disability are available for one year only, 1985. The measure of disability used here relates to severe disability, defined as an inability to perform unaided at least one Activity of Daily Living (ADL), including bathing, feeding oneself, getting to the toilet and/or getting in

and out of bed (cf. Bebbington & Darton 1996:10, 19).[1] Finally, socio-economic status is indicated by socio-economic group, measured by the distinction between non-manual and manual occupational groups. A third category "never employed" is also included since a relatively high proportion of those receiving intense co-resident care from children fell into this category. (See Appendix 7C for further discussion of the variable used for socio-economic status).

Table 7.9 summarises the characteristics of older people cared for on an intense and very intense co-resident basis by their children between 1985 and 2000 using bivariate analysis. The table shows separately the characteristics of older people aged 65 and over and older old people aged 80 and over. The table shows that, during the 1985/2000 period, the probability of an older person receiving co-resident care intensely or very intensely from a child varied by age, gender, marital status, health, disability and socio-economic group. Relationships were similar for both intense and very intense co-resident care. Among the population aged 65 and over, the probability of being cared for was greater for those aged 80 and over than those aged under 80; greater for women than men; greater for non-married individuals than married; greater for those with a limiting long-standing illness than those without; and greater for those who had been in manual occupations, or had never been employed, than those who had been in non-manual occupations. Table 7.9 also shows that, in 1985, the probability of receiving intense or very intense co-resident care from a child was much greater for a disabled than a non-disabled older person. Between 13 and 15 per cent of people aged 65 and over with an ADL disability in private households in 1985 received intense or very intense care from a co-resident child, compared to around 1 per cent of those without a disability.

Among people aged 80 and over, the relationships between the characteristics of older people and receipt of care were similar to those of people aged 65 and over, the main difference being that the probabilities of receiving care were considerably greater for the older old (Table 7.9). This was particularly noticeable where health-related variables were concerned. Thus, 11 per cent of people aged 80 and over with a limiting long-term illness received intense co-resident care from children and 7 per cent received very intense care. Moreover, in 1985, around one in four people aged 80 and over with an

[1] The focus in the present study is on severe disability because it was the prevalence of this form of disability that declined between 1985 and 2000 (Chapter Two, Section 2.3.3) and the decline in severe disability therefore offers a potential explanation for the decline in intense informal care (Chapter Two, Table 2.20). This explanation is further explored in the next chapter (Chapter Eight, Section 8.4).

ADL disability received intense co-resident care from a child and one in five received very intense care. The very high probability of a disabled older old person receiving very intense and intense care from a co-resident child contrasts to the comparatively low probability, observed earlier, of providing this form of care. Thus a probability of providing care for 50 or more hours a week of less than 0.5 per cent in 1985 (Table 7.6) translates into a probability of an ADL-disabled older old person receiving very intense care of around 20 per cent (Table 7.9).

Table 7.9

Characteristics of people aged 65 and over and aged 80 and over receiving intense and very intense co-resident care from children, Britain, 1985-2000 (bivariate analysis)

Percentages

		Receiving co-resident care from children for 20+ hrs p.w.		Receiving co-resident care from children for 50+ hrs p.w.	
		65+	80+	65+	80+
All		1.89	6.78	1.16	4.31
Age	Aged 65-79	0.67	-	0.37	-
	Aged 80+	6.78	-	4.31	-
Gender	Men	0.75	3.02	0.41	1.81
	Women	2.72	8.65	1.67	5.55
Marital status	Married	0.25	1.13	0.13	0.68
	Non-married	3.86	9.12	2.37	5.79
Limiting Long-Term Illness (LLTI)	No LLTI	0.56	2.93	0.28	1.47
	With LLTI	3.92	10.64	2.50	7.16
Socio-economic group	Non-manual	1.09	4.40	0.65	2.78
	Manual	2.28	7.82	1.39	4.91
	"Never employed"	7.90	14.51	5.16	9.80
ADL disability (1985 only)	Not disabled	1.01	4.40	0.71	3.26
	Disabled	15.31	23.28	12.81	20.55

Source: 1985, 1990, 1995, 2000 GHS (author's analysis).
Notes: Unless otherwise indicated, the table shows all years combined. The table relates to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child. For sample numbers, see Appendix 7D.For definitions of variables, see text.

The factors affecting receipt of intense and very intense co-resident care from children by older and older old people were then analysed using logistic regression (Table 7.10). Four separate models were analysed examining, for both the older and the older old populations, the factors associated with receipt of intense care provided for 20 or more hours a week and very intense care provided for 50 or more hours a week. In Table 7.10, all years (1985, 1990, 1995 and 2000) are analysed together (and therefore the analysis excludes disability, data on which were only available in 1985). Because nearly all those who had 'never been employed' were women (Appendix 7C), interaction effects between socio-economic group and gender were explored in the models. However, controlling for all other variables, none of the interaction effects between class and gender were significant and they are therefore excluded from the reported results.

Table 7.10

Logistic regression results showing factors associated with receipt of intense and very intense co-resident care from children by people aged 65 and over and aged 80 and over, Britain, 1985-2000

Odds ratios

		Older people receiving co-resident care from children for 20+ hrs p.w.		Older people receiving co-resident care from children for 50+ hrs p.w.	
		65+	80+	65+	80+
Age	Aged 65-79	1.0	n/a	1.0	n/a
	Aged 80+	***5.26	n/a	***5.70	n/a
Gender	Men	1.0	1.0	1.0	ns
	Women	**1.53	*1.55	*1.66	ns
Marital status	Married	1.0	1.0	1.0	1.0
	Non-married	***8.08	***7.09	***8.22	***8.37
Limiting Long-Term Illness (LLTI)	No LLTI	1.0	1.0	1.0	1.0
	With LLTI	***4.78	***3.29	***5.81	***4.23
Socio-economic group	Non-manual	1.0	1.0	1.0	1.0
	Manual	***1.81	**1.70	**1.80	*1.61
	"Never employed"	***3.39	***2.80	***3.38	***3.07

Source: 1985, 1990, 1995, 2000 GHS (author's analysis).
Notes: The table shows all years combined; see also notes to Table 7.9.

As Table 7.10 shows, among the population aged 65 and over, receipt of co-resident care from children for both 20 or more hours a week and 50 or more hours a week was significantly associated with age, gender, marital status, limiting long-term illness and socio-economic group. In the models for the population aged 80 and over, the broad age category distinguishing those aged 65 to 79 from those aged 80 and over was omitted. Gender was not significantly associated with receipt of very intense co-resident care and was also omitted from this model. The resulting models showed that, among people aged 80 and over, receipt of intense and very intense co-resident care from children was significantly associated with marital status, limiting long-term illness and socio-economic group, with gender also significant in receipt of intense care.

Because of the potential importance of disability in receipt of intense co-resident care from children (Table 7.9), the factors affecting receipt of intense and very intense co-resident care from children by older people *in 1985 only* were also analysed using logistic regression models incorporating disability (Table 7.11). This analysis was felt to be justified by the fact that, in the light of the trends in receipt of care already described, the sample size of older people receiving care in 1985 was comparatively large (Appendix 7B). As in the earlier multivariate analysis in this section, four separate models were again analysed examining, for both the older and the older old populations, the factors associated with receipt of intense and very intense care.

The results show that, among the population age 65 and over, controlling for age, marital status, limiting long-term illness and (where relevant) gender, receipt of co-resident care from children for both 20 or more hours a week and 50 or more hours a week was significantly associated with disability (Table 7.11). Controlling for relevant variables, disabled older people were around eight times more likely than non-disabled older people to receive intense care from a co-resident child and around nine times more likely to receive very intense care. Among the population aged 80 and over, once disability was taken into account, limiting long-term illness was no longer significant and was omitted from the models. Indeed, Table 7.11 shows that there were only two variables that were significant in the models for both intense and very intense care and these were disability and marital status. Of these variables, the strongest association was between disability and receipt of care ($p<0.001$). It is also notable that, once disability was taken into account, the effect of socio-economic group was reduced and, indeed, social class was not significant in any of the models for receipt of care, except

for intense care received by people aged 80 and over (Table 7.11). The reduced effect of social class once disability was taken into account is discussed in the conclusions to the chapter.

Table 7.11

Logistic regression results showing factors associated with receipt of intense and very intense co-resident care from children by people aged 65 and over and aged 80 and over, Britain, 1985 only

Odds ratios

		Older people receiving co-resident care from children for 20+ hrs p.w.		Older people receiving co-resident care from children for 50+ hrs p.w.	
		65+	80+	65+	80+
Age	Aged 65-79	1.0	n/a	1	n/a
	Aged 80+	***3.35	n/a	***3.91	n/a
Gender	Men	1.0	ns	ns	ns
	Women	*2.13	ns	ns	ns
Marital status	Married	1.0	1.0	1.0	1.0
	Non-married	***11.55	**18.54	***13.85	**15.65
Limiting Long-Term Illness (LLTI)	No LLTI	1.0	ns	1.0	ns
	With LLTI	**2.96	ns	**2.85	ns
Socio-economic group	Non-manual	ns	1	ns	ns
	Manual	ns	*2.13	ns	ns
	"Never employed"	ns	ns	ns	ns
ADL disabled	Not disabled	1.0	1.0	1.0	1.0
	Disabled	***8.08	***6.11	***8.86	***7.48

Source: 1985 GHS (author's analysis).
Notes: The table relates to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child; for definitions of variables, see text.

In summary, key factors affecting older people's receipt of intense and very intense co-resident care from children in Britain in the late 1980s and 1990s included older age, disability, having a long-term illness, not being currently married and having fewer socio-economic resources (having been in a manual occupation or never having been employed), with women being more likely than men to receive most forms of care in the period as a whole.

7.2.2 Changes over Time by Key Characteristics of Older Recipients of Care, 1985-95

The characteristics of the older people receiving intense and very intense co-resident care need to be considered dynamically, that is, over time. This is because, as the first part of the chapter showed, there were large changes in the probability of receiving some forms of intense/very intense co-resident care during the 1985/2000 period (Table 7.6). This section therefore considers trends over time in receipt of intense and very intense co-resident care by key characteristics of the older people receiving care.

Table 7.12 summarises changes over time in receipt of care by age, gender, marital status, limiting long-term illness and socio-economic group during the decade between 1985 and 1995. (Disability is not included because information on this variable was only available in 1985.) The focus is on the period between 1985 and 1995 because it was during this time that significant changes in receipt of co-resident care occurred (Table 7.6). The table identifies significant changes over time in receipt of intense and very intense care by older and older old people with each type of characteristic and shows the direction of change. Details of the probabilities of receiving care and the sample numbers, on which Table 7.12 is based, can be found in Appendix 7E.

Table 7.12 confirms that the key change in receipt of co-resident intergenerational care between 1985 and 1995 was the decline in very intense care for 50 hours a week or more by older and older old people and also shows that this decline affected people with a wide range of characteristics. Among the population aged 65 and over, the decline in receipt of very intense care affected people aged 65 to 79 and people aged 80 and over; women; non-married individuals; those with and without a limiting long-term illness and those with backgrounds in manual employment. Among the population aged 80 and over, the decline in receipt of very intense co-resident care affected women; non-married individuals; those with a limiting long-term illness and those with backgrounds in manual employment. The fact that there were significant declines in very intense co-resident care by people with these characteristics largely reflects their importance in determining receipt of care (identified in Table 7.10).

With regard to receipt of intense co-resident care for 20 hours a week or more over time, Table 7.12 confirms that there was no significant change in receipt of intense care between 1985 and 1995 and shows that this was true of almost all the characteristics examined. Indeed, the only significant change in receipt of intense co-resident care in

the 1985/95 period was an increase in care received by never employed individuals, which was partly due to a large decline in the underlying sample base of people who had never been employed (Table 7.12, Appendix 7E). The increase in receipt of care by never employed older people went against the trend in receipt of intense care, which was largely downwards between 1985 and 1995 (Table 7.6; Appendix 7E, Table 7E.1).

Table 7.12

Trends in receipt of co-resident care for 20 and 50 hours a week or more by people aged 65 and over and aged 80 and over: changes over time by key characteristics, Britain, 1985-1995

Significance and direction of change

		Older people receiving co-resident care from children for 20+ hrs p.w.		Older people receiving co-resident care from children for 50+ hrs p.w.	
		65+	80+	65+	80+
All	-	ns	ns	** (-)	** (-)
Age	Aged 65-79	ns	n/a	* (-)	n/a
	Aged 80+	ns	n/a	** (-)	n/a
Gender	Men	ns	ns	ns	ns
	Women	ns	ns	** (-)	** (-)
Marital status	Married	ns	ns	ns	ns
	Non-married	ns	ns	** (-)	** (-)
Limiting Long-Term Illness (LLTI)	No LLTI	ns	ns	* (-)	ns
	With LLTI	ns	ns	** (-)	** (-)
Socio-economic group	Non-manual	ns	ns	ns	ns
	Manual	ns	ns	** (-)	** (-)
	"Never employed"	* (+)	[ns]	ns	[ns]

*Notes: Asterix indicates Chi-square association over time at *(5%), **(1%); ns indicates no significant association; n/a indicates not applicable.(+) indicates increase over time-period; (-) indicates decrease over time period. Square parentheses indicate a small sample base. The table relates to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child. Underlying probabilities and sample numbers are given in Appendix 7E.*

The key point to emerge from this analysis is that the decline in receipt of very intense co-resident care from children between 1985 and 1995 was a generalised trend affecting older people with a wide range of characteristics, including older age, having a long-term illness, not being currently married and having fewer socio-economic resources (having been in a manual occupation), with the trend primarily affecting women. The characteristics of the older people whose receipt of care declined therefore largely reflected the characteristics that determined receipt of co-resident care from children. To what extent, then, were these characteristics also associated with entry to long-stay residential care in Britain at this time?

7.2.3 Receipt of Co-Resident Care from Children and Long-Stay Residential Care

This section compares the characteristics of older people receiving intense and very intense care from their co-resident children with the characteristics of people in long-stay residential care in the 1985/2000 period in Britain. As indicated earlier, the key hypothesis examined here is that substitution between intense intergenerational care and long-stay residential care is more likely to have occurred if the cared-for older parents and those in long-stay residential care shared similar characteristics.

The British literature suggests that key factors affecting admissions to long-term residential care in the 1980s and 1990s were age, gender, marital status, disability, health and socio-economic circumstances (Bajekal 2002; Darton & Wright 1992; Darton *et al* 2005; Grundy 1996b; Grundy & Jitlal 2007; Wittenberg *et al* 1998). The analysis presented in this chapter has suggested that the key factors affecting receipt of intense co-resident care from a child during the late 1980s and 1990s also included age, gender, marital status, long-term illness, social class and disability.

Age is usually cited as one of the most important factors affecting entry to long-stay residential care. Older old people have a significantly higher probability of entering residential care than younger old people (Bajekal 2002; Darton & Wright 1992; Darton *et al* 2005; Grundy 1996b; Grundy & Jitlal 2007; Wittenberg *et al* 1998). A survey of admissions of older people to care homes, carried out in 1995, showed that around 70% of those admitted were aged 80 or over (cited in Darton *et al* 2005: 69). As the present chapter has shown, older old people aged 80 and over were also significantly more

likely to be recipients of intense and very intense co-resident care from their children in the 1985/2000 period (Table 7.10).

Along with older age, disability is also often cited as one of the most important factors affecting admissions to long-stay residential care. A recent review of the literature in a study of entry to institutional care in the 1990s begins by pointing to the relatively high probability of older old people entering institutional care and then points out that "serious disability is the major driver of institutional admission" (Grundy & Jitlal 2007: 1-2). Similarly, the analysis presented here has suggested that disability is an important factor affecting receipt of intense and very intense co-resident care. Although the analysis including disability, reported here, could only be carried out for 1985, it suggested that, of all the factors included in the models for receipt of intense co-resident care by the older old population in that year, the strongest association was between disability and receipt of co-resident care (Table 7.12).

In many studies of entry to institutional care, information on disability is not available and other measures of health status, such as limiting long-term illness, are included (for example, Darton *et al* 2005; Grundy & Jitlal 2007). Results from these studies of entry to long-stay residential care suggest that similar factors as those affecting receipt of intense and very intense co-resident care from children are important. In a recent analysis, for example, Grundy and Jitlal found that admissions to long-stay residential care in the 1990s were associated with factors including older age, fewer socio-economic resources (living in rented accommodation), being unmarried and having a long-term illness, with women having higher risks than men (Grundy & Jitlal 2007). This list of factors affecting moves to long-stay residential care could almost as well describe the factors affecting receipt of intense co-resident care by people aged 65 and over, shown in Table 7.10.

Clearly, the populations from which recipients of intense co-resident care and those living in institutional care are drawn are not identical. Older people without children, for example, are more likely to enter institutions than those with children (Grundy & Jitlal 2007), whereas, by definition, older people cared for by their children are not childless. However, the overwhelming majority of both older and older old people have children, with about 80 per cent of people aged 60 and 70 per cent of those aged 80 having at least one living child and with the proportions with children at age 60 rising in

cohorts relevant to the present study (Murphy and Grundy 2003: 40). Those living alone are also often described in the literature as being at particular risk of entering institutions (Darton *et al* 2005; Grundy & Jitlal 2007) whereas again, by definition, older people cared for on a co-resident basis are not living alone. The impact of housing composition on care home entry does, however, seem to have varied in Britain over time. Data relating to the mid-1990s suggest that, at that time, single older people (that is, those not married) living with others were at a comparatively high risk of needing a care home place and indeed this risk at that time was greater than the risk for people living alone (Darton *et al* 2005: 18).

The results presented here therefore suggest that, in important respects, older people cared for intensely and very intensely on a co-resident basis by their children shared key characteristics with those described in the literature as entering long-stay residential care. This lends some support to a hypothesis of substitution. Shared characteristics between people receiving intense co-resident care and people in long-stay residential care may not be a sufficient condition for substitution between them, but it may be a necessary condition. Therefore, while not in itself evidence of substitution, these results suggest that it is worth pursuing further the substitution hypothesis.

Moreover, since the decline in receipt of very intense co-resident care was a generalised decline, affecting people with a wide range of characteristics, and since they shared these characteristics with those entering long-stay residential care, then this means that the decline in receipt of very intense care occurred among people with the same type of characteristics as those most likely to have entered long-stay residential care. This again suggests that that the substitution hypothesis is worth pursuing further.

7.3 Discussion and Conclusions

7.3.1 Summary and Discussion of Results

This chapter has started to explore the hypothesis that the decline in intense intergenerational care of older people was associated with an increase in long-stay residential care. It has done so by making a number of important shifts in the methodology of the study. First, it has introduced a systematic analysis of provision,

and receipt, of care for the older old population, aged 80 and over. This analysis was introduced because the previous chapter had shown that intense and very intense co-resident care for parents was primarily provided to people aged 80 and over. However, what has emerged during the course of the present chapter is that this characteristic also suggests an immediate link with the population in long-stay residential care, who are also predominantly aged 80 and over. Second, the present chapter has made an important shift in the analysis, moving from the provision of care to its receipt, from the carer to the cared-for. Shifting the focus to the receipt of care has allowed for the derivation of probabilities that an older or older old person receives intense or very intense care from a co-resident child.

The methodological advances in this chapter have in turn allowed for a systematic analysis of the characteristics of the older people receiving intense and very intense intergenerational care from children living in the same household. This analysis has shown that key factors affecting older people's receipt of intense and very intense co-resident care in Britain in the late 1980s and 1990s included older age, disability, having a long-term illness, not being currently married and having fewer socio-economic resources (having been in a manual occupation or never having been employed), with women being more likely than men to be recipients of care. The literature suggests that similar factors were also key determinants of entry to long-stay residential care at this time. The results presented here therefore suggest that, in important respects, older people cared for intensely and very intensely on a co-resident basis by their children shared key characteristics with those described in the literature as entering long-stay residential care. This lends some support to a hypothesis of substitution.

Moreover, the chapter has shown that there was a significant decline in receipt of very intense co-resident care by older and older old people between 1985 and 1995, which occurred among people with the same type of characteristics as those likely to have entered long-stay residential care. The decline in receipt of very intense co-resident care from children between 1985 and 1995 particularly affected the older old, women, those with a long-term illness, those not currently married and those with fewer socio-economic resources. Since these characteristics are also associated with entry to long-stay residential care, this also suggests that that the substitution hypothesis is worth pursuing further.

In addition, the present chapter suggests some advances to the literature on informal care in this country in two respects. The first, arising from the shift in focus from the carer to the cared-for, concerns the relationship between the intensity of informal care and the disability of the cared-for person. As far as the author is aware, there has never before been an analysis of this issue in this country. A study by Glaser and Grundy (2002) examined caring and disability using the 1988/89 Retirement Survey, but the analysis did not examine the intensity of informal care and could examine the disability of the cared-for person only in relation to care for spouses. Yet the relationship between intense care and disability is very important. It might be thought that, because the hours of informal care are self-reported in the GHS, they lack validity. The evidence presented here, however, suggests that there was an association between receipt of long hours of co-resident care and severe disability, that is, an inability to perform one or more personal care tasks without assistance. These results are consistent with the findings of the 'Channeling Experiment' (National Long Term Care Demonstration) in the United States carried out in the 1980s, which also found an association between hours of informal care and disability (Kemper 1992). The relationship between long hours of care and the disability of the older person cared-for is particularly important in the present context because it is older people with high levels of disability who are also more likely to enter long-stay residential care.

The second issue addressed in this chapter concerns the relationship between social class and intense informal care. The author is not aware of any other British studies of the intensity of informal care and the social class of the person being cared for. As indicated earlier in Chapter Four, the only previous study of class and caring, relating specifically to care for parents, examined the class of the person providing care, not the person receiving it, and did not look at the intensity of care (Glaser & Grundy 2002). The study by Glaser and Grundy concluded that there were few social class differences in the provision of co-resident care to a parent. The evidence presented here, however, has shown that, under certain conditions, there is an association between receipt of intense co-resident care by older parents and the latter's social class. Older people who had worked in manual occupations were more likely to be recipients of intense co-resident care from their children than older people who had worked in non-manual occupations. However, this relationship only held in models excluding disability. Once disability was taken into account, which was only possible in one year (1985) and with a relatively small sample size, the relationship with class diminished or disappeared

altogether. One reason for this is likely to be that there is an underlying association between disability and socio-economic status (Bajekal & Prescott 2003, MRC CFAS 2000). The results presented here suggest that the greater chances of a working class older person receiving intense co-resident care from a child may be primarily because his or her health is likely to be poorer. Again, the association between receipt of intense co-resident care and socio-economic status is particularly important in the present context because of the similar association between long-stay residential care and socio-economic status.

7.3.2 Implications for Next Stage of Analysis

The next stage of the analysis is a direct comparison between trends in receipt of intense and very intense co-resident care by older people from their children and trends in long-stay residential care. The analysis in the present chapter has prepared for this comparison, through its analysis of trends in the probability of older and older old people receiving intense and very intense co-resident care from their children. In addition, the chapter has suggested that a number of key factors, particularly age and disability, may be particularly important in determining receipt of *both* intense/very intense co-resident care *and* long-stay residential care. This suggests that consideration of these factors may also be important when comparing trends in receipt of care by older people from their children with trends in long-stay residential care. Finally, although the chapter has found that only receipt of very intense co-resident care declined significantly between 1985 and 2000, the analysis still needs to continue to consider receipt of intense care, partly because of the underlying decline in *provision* of this form of care and partly because trends in receipt of intense care, even if not significant over time, might still be related to trends in long-stay residential care.

So far, the analysis has been concerned with sample data relating to the *household* population. If comparison is to be made with trends in long-stay residential care, however, the trends in the probability of receiving intense co-resident care from children will need to be expressed in terms of the entire population of older people, that is, the household and non-household populations, and will therefore require an estimate of the non-household population. This is where the next chapter begins.

Appendices to Chapter 7

Appendix 7A

GHS Sample Numbers Underlying Tables in Chapter 7 (Section 7.1.1)

Table 7A.1

Provision of co-resident care to parents aged 65 and over and aged 80 and over, by intensity, Britain, 1985-2000: sample numbers

	Intense care (20 hours a week or more)		Very intense care (50 hours a week or more)		Underlying sample base
	Aged 65+	Aged 80+	Aged 65+	Aged 80+	
1985	97	69	72	57	12,387
1990	101	77	53	42	11,854
1995	69	54	30	24	12,002
2000	63	42	30	20	10,162
All years	330	242	185	143	46,405

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: This table shows numbers in the samples aged 30 to 74 providing care to older and older old parents, plus the underlying sample base of people aged 30 to 74.

Appendix 7B

GHS Sample Numbers Underlying Tables in Chapter 7 (Sections 7.1.2)

Table 7B.1

Numbers of older people cared for by adult child(ren) on a co-resident basis for 20 and 50 hours a week or more (and underlying sample base of older people), Britain, 1985-2000: sample numbers

	Aged 65+			Aged 80+		
	Cared-for for 20+ hours pw	Cared-for for 50+ hours pw	Sample base aged 65+	Cared-for for 20+ hours pw	Cared-for for 50+ hours pw	Sample base aged 80+
1985	84	65	4,156	58	47	732
1990	87	51	4,226	65	41	880
1995	60	28	3,580	46	22	748
2000	52	29	3,016	34	19	635
All years	283	173	14,978	203	129	2,995

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Note: The table refers to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child (aged 30 to 74).

Appendix 7C

Note on the variable for socio-economic group used in the analysis of characteristics of cared-for older people

Occupationally derived social class is widely used as an index of socio-economic circumstances in both official statistics and medical and social research (Glaser & Grundy 2002). The allocation of individuals to social class categories in the present study is based on a variable utilised in the 1990 and 1995 GHS, which divides socio-economic groups into non-manual and manual occupations. This categorisation was applied by the author to the 1985 and 2000 GHS datasets to produce comparable variables. 'Non-manual' includes professional, managerial and other non-manual occupations, while 'manual' includes skilled, semi-skilled and unskilled manual occupations. The third category, 'never employed' is used here because, as indicated in the chapter, a relatively high proportion of those receiving intense co-resident care from children (around 20 per cent) had never been employed. The separate identification of those who have never been employed is based on a similar categorisation used elsewhere by Glaser & Grundy (2002) who distinguish those with 'no usual occupation' from other socio-economic groups. With one exception, all older people in the GHS sample used here, who were cared for intensely and had never been employed, were women, and the interaction between socio-economic group and gender is therefore explored in the analysis.

Other socio-economic variables were also considered but were rejected. Educational qualifications, for example, could not be used for the socio-economic categorisation of older people because these data are only collected on people aged under 70 in the GHS. Equally, housing tenure was considered. However, this was also regarded as unsuitable because the majority of older people cared for on an intense co-resident basis by children (nearly 60 per cent) are not themselves the head of household and are indeed living in their children's households. Therefore, housing tenure is likely to reflect the status of the children rather than the older person. If older people living in their children's households are regarded as tenants, then the variable risks becoming endogenously related to co-residence with children and hence with co-resident care by children.

Appendix 7D

GHS Sample Numbers Underlying Tables in Chapter 7 (Section 7.2.1)

Table 7D.1

People aged 65 and over and aged 80 and over by key characteristics, Britain, 1985-2000: sample numbers

		65+	80+
All		14,978	2,995
Age	Aged 65-79	11,983	-
	Aged 80+	2,995	-
Gender	Men	6,309	995
	Women	8,669	2,000
Marital status	Married	8,151	885
	Non-married	6,789	2,108
Limiting Long-Term Illness	No LLTI	9,060	1,501
(LLTI)	With LLTI	5,918	1,494
Socio-economic group	Non-manual	6,150	1,114
	Manual	7,123	1,445
	"Never employed"	620	255
ADL disability (1985 only)	Not disabled	3,359	522
	Disabled	320	146

Source: 1985, 1990, 1995, 2000 GHS (author's analysis).
Notes: The table shows all years combined; for definitions of variables, see text.

Appendix 7E

Underlying probabilities and GHS Sample Numbers Underlying Tables in Section 7.2.2

Table 7E.1

Proportions of older people aged 65 and over and aged 80 and over cared for by adult child(ren) on a co-resident basis for 20 and 50 hours a week or more, by key characteristics, Britain, 1985 & 1995

Percentages

			Older people receiving co-resident care from children for 20+ hrs p.w.		Older people receiving co-resident care from children for 50+ hrs p.w.	
			65+	80+	65+	80+
Age	65-79	1985	0.76	-	0.53	-
		1995	0.49	-	0.21	-
	80+	1985	7.92	7.92	6.42	6.42
		1995	6.15	6.15	2.94	2.94
Gender	Men	1985	0.59	2.37	0.53	2.37
		1995	0.91	4.96	0.39	2.29
	Women	1985	2.99	10.17	2.26	8.06
		1995	2.25	4.96	1.07	3.29
Marital status	Married	1985	0.19	0.58	0.14	0.58
		1995	0.15	0.88	0.15	0.88
	Non-married	1985	4.00	10.16	3.10	8.20
		1995	3.62	8.29	1.55	3.66
LLTI	No LLTI	1985	0.65	3.89	0.46	2.85
		1995	0.52	3.09	0.10	0.56
	LLTI	1985	4.35	12.43	3.44	10.40
		1995	3.31	8.93	1.76	5.10
Socio-economic group	Non-manual	1985	1.36	4.65	1.00	3.72
		1995	0.72	3.57	0.48	2.27
	Manual	1985	2.62	10.60	2.07	8.60
		1995	2.02	6.72	0.90	3.10
	Never employed	1985	4.52	9.09	1.39	9.09
		1995	10.17	[18.37]	8.90	[6.12]

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: The table refers to older people aged 65 and over and aged 80 and over receiving care that was provided for 20 or 50 hours a week or more by a co-resident child (aged 30 to 74). Sample numbers are given in Table 7E.2 and sample bases in 7E.3. Square parentheses indicate a small sample base.

Table 7E.2

Older people aged 65 and over and aged 80 and over cared for by adult child(ren) on a co-resident basis for 20 and 50 hours a week or more, by key characteristics, Britain, 1985 & 1995: sample numbers

			Older people receiving co-resident care from children for 20+ hrs p.w.		Older people receiving co-resident care from children for 50+ hrs p.w.	
			65+	80+	65+	80+
Age	65-79	1985	26	-	18	-
		1995	14	-	6	-
	80+	1985	58	58	47	47
		1995	46	46	22	22
Gender	Men	1985	10	5	9	5
		1995	14	13	6	6
	Women	1985	74	53	56	42
		1995	46	33	22	16
Marital status	Married	1985	4	1	3	1
		1995	3	2	3	2
	Non-married	1985	80	57	62	46
		1995	56	43	24	19
LLTI	No LLTI	1985	17	15	12	11
		1995	11	11	2	2
	LLTI	1985	67	43	53	36
		1995	49	35	26	20
Socio-economic group	Non-manual	1985	19	10	14	8
		1995	12	11	8	7
	Manual	1985	52	37	41	30
		1995	36	26	16	12
	Never employed	1985	12	8	9	8
		1995	12	9	4	3

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)
Notes: see Table 7E.1

Table 7E.3

Numbers of older people aged 65 and over and aged 80 and over by key characteristics, Britain, 1985 & 1995: sample numbers

			65+	80+
Age	65-79	1985	3,424	-
		1995	2,832	-
	80+	1985	732	732
		1995	748	748
Gender	Men	1985	1,683	211
		1995	1,533	262
	Women	1985	2,473	521
		1995	2,047	486
Marital status	Married	1985	2,154	171
		1995	2,009	227
	Non-married	1985	2,002	561
		1995	1,546	519
LLTI	No LLTI	1985	2,617	386
		1995	2,100	356
	LLTI	1985	1,539	346
		1995	1,480	392
Socio-economic group	Non-manual	1985	1,399	215
		1995	1,658	308
	Manual	1985	1,985	349
		1995	1,782	387
	Never employed	1985	221	88
		1995	118	49

Source: 1985, 1990, 1995, 2000 GHS (author's analysis)

Chapter 8

Long-Stay Residential Care and Demand for Intergenerational Care

This chapter explores directly the hypothesis that the decline in intense co-resident care for older parents between 1985 and 2000 in Britain was associated with the rise in long-stay residential care for older people during this time. It therefore examines directly the hypothesis that long-stay residential care substituted for intense/very intense co-resident care. The present chapter builds on the previous chapter by comparing trends in *receipt* of intense and very intense co-resident care from children, on the one hand, with trends in *receipt* of long-stay residential care, on the other hand.

The examination of the substitution hypothesis in the present chapter requires the analysis to go beyond the GHS data, with which the study has so far largely been concerned, because people in long-stay residential care are, by definition, not included in the household population. The potential substitution between long-stay residential care and intense/very intense co-resident care by children, explored in this chapter, cannot therefore be examined in the same way as the potential substitution between care by spouses and care by children (explored in Chapter Six). In order to compare trends in intense intergenerational care and trends in long-stay residential care, both have to be expressed in similar terms. Both have to be expressed in terms of the total population of older people, both those in households and those not in households. This will allow the rate of receipt of long-stay residential care to be compared with the rate of receipt of intense and very intense intergenerational care.

The first two parts of the present chapter are concerned with developing rates of receipt of long-stay residential care and of intense/very intense co-resident care. The first part of the chapter separates the population aged 65 and over in long-stay residential care from the household population of older people. This results in both an estimate of the numbers in private households and a rate of receipt of long-stay residential care. The second part of the chapter uses the estimate of the household population, from the first part of the chapter, together with information from Chapter Seven, to generate an

estimate of numbers of older people receiving intense and very intense co-resident care from their adult children. These numbers are then expressed as a percentage of the whole (household and the non-household) population of older people, to produce a rate of receipt of intense/very intense co-resident care. The third part of the chapter then compares rates of receipt of intense and very intense co-resident care by older people from their adult children and rates of receipt of long-stay residential care. It looks first at people aged 65 and over and then at people aged 80 and over. For each age-group, receipt of intense and very intense care is compared to the long-stay residential care rates by sector. The fourth part of the chapter examines the results in the light of key characteristics of both older people receiving co-resident care and older people in long-stay residential care, in particular, trends in their disability prevalence. The chapter ends with a discussion of the results.

8.1 Long-Stay Residential Care Rate among Older People in Britain, 1985-2000

8.1.1 Numbers in Long-Stay Residential Care

The trends in numbers of people in long-stay residential care were described in Chapter Two, using data collected by Laing & Buisson in their annual market surveys of care for elderly people (Laing & Buisson 2002: 25). However, while useful as indicators of overall trends, these data suffer from two problems. First, the Laing & Buisson data do not relate specifically to older people but to 'elderly, *chronically ill and physically disabled* people' and, second, the data relate to the UK not to Britain. It was therefore apparent that the data for the present chapter would have to be obtained from its original sources, that is, primarily statistics collected by government departments in England, Wales and Scotland.

Table 8.1 summarises the data on the total numbers of *older people* in residential care homes, nursing homes and long-stay hospitals in Britain in the four years for which GHS data on informal care provision are available, that is, 1985, 1990, 1995, and 2000.

Table 8.1

Numbers of people aged 65 and over in residential care homes, nursing homes and hospitals, Britain, 1985-2000

Numbers in thousands

	Residential Care Home	Nursing Home	Long-stay Hospital	Total
1985	220	35	80	335
1990	265	105	50	425
1995	260	165	35	455
2000	235	160	15	410

Sources: For sources, see text.
Notes: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding. There are no data available for numbers in nursing homes in Scotland in 1985, the earliest data being for 1990 when there were less than 10,000 places in nursing homes in Scotland (see text).

Table 8.1 shows that the total number of people aged 65 and over in residential care homes (including Local Authority, private and voluntary homes) in Britain rose from approximately 220 thousand in 1985 to approximately 265 thousand in 1990 and then fell to around 235 thousand in 2000 (Table 8.1). Information on the numbers in residential care homes in England was obtained from the Department of Health & Social Security (1992) and Department of Health (2001a, 2001b); in Wales from the Welsh Office (1991, 1994) and National Assembly for Wales (2002); and in Scotland from the Scottish Executive (2002). The trends in the numbers of people in residential care homes, shown in Table 8.1, are comparable to those using Laing and Buisson data reported in Chapter Two (Section 2.1.2). Laing & Buisson (2002) also show that the number of places in residential care homes increased between 1985 and 1990 and then declined between 1990 and 2000, with the peak year for numbers in residential care homes being 1990.

The total number of people aged 65 and over in nursing homes (private and voluntary) in Britain rose from around 35 thousand in 1985 to 165 thousand in 1995 and then fell to around 160 thousand in 2000 (Table 8.1). The numbers of older people in nursing homes (private and voluntary) in England and Wales in 1985 and 1990 was derived from Darton and Wright (1993); in England in 1995 from Wittenberg *et al* (1998) and in 2000 from the Department of Health (2001a); in Wales in 1995 from the Welsh Office (1997) and National Assembly for Wales (2002); and in Scotland for 1990, 1995 and 2000 from the Scottish Executive (2002). No data were collected on older people in nursing homes in Scotland in 1985 (Table 8.2). However, since there were less than

10,000 older people in nursing homes in Scotland in 1990, and since the numbers in nursing homes were growing rapidly in other parts of Britain between 1985 and 1990 (Table 8.2), it seems likely that there were comparatively few people in nursing homes in Scotland in 1985 and that the absence of these data is unlikely to have had an important effect on the trends shown. Indeed, the trends in the numbers of people in nursing homes, shown in Table 8.1, are consistent with those using Laing and Buisson data reported in Chapter Two (Section 2.1.3). Laing and Buisson (2002) also show that the number of places in nursing homes increased between 1985 and 1995 and then declined between 1995 and 2000, with the peak year for the number of places in nursing homes being 1997.

Table 8.2

Numbers of people aged 65 and over in residential care homes and nursing homes, by country, Britain, 1985-2000

Numbers in thousands

	England	Wales	Scotland	Britain
Residential care				
1985	195	10	15	220
1990	235	15	15	265
1995	230	15	15	260
2000	210	10	15	235
Nursing homes				
1985		35	not available	35
1990		95	10	105
1995	135	15	15	165
2000	130	10	20	160

Sources: For sources, see text.
Notes: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding.

The estimation of numbers of older people in residential care homes and nursing homes is complicated in the period between 1990 and 2000 by the fact that some homes were registered as both care homes and nursing homes (Laing and Buisson 2002). 'Dual registration' homes are reported in the government data relating to both residential care homes *and* nursing homes, leading to a potential problem of double-counting. Since information on numbers of older people in 'dual registered' homes is given in the government statistics relating to residential care homes but not in the statistics relating to nursing homes, the problem of double counting has been addressed here by using figures for residential care homes that exclude those in dual registered homes. This is the approach adopted, for example, in the 2002 Personal Social Services Research Unit

(PSSRU) model of demand for long-term care (Wittenberg *et al* 2006). The 2002 model gives a total of 207,000 people aged 65 and over in residential care homes in England in 2003, which is the figure for older people in residential care homes, excluding those in dual registered homes.

Finally, the total number of older people in long-stay hospitals in Britain fell from around 80 thousand in 1985 to around 15 thousand in 2000 (Table 8.1). Information on numbers aged 65 and over in long-stay hospitals in Table 8.1 was derived from 1981, 1991 and 2001 Census data. Census data were used in the absence of any alternative reliable data source covering the whole time period. The 1991 Census data on numbers of older people in hospitals were used for 1990 and the 2001 Census data for 2000. Estimates were made of the total numbers of older people in long-stay hospitals in 1985 and 1995 based on trends between 1981 and 1991 and between 1991 and 2001 respectively (Table 8.3). It is hard to compare the numbers in long-stay hospital places over time with other sources because of the lack of consistent time-series data (discussed in Chapter Two, Section 2.1.4). Nevertheless, what is clear from the figures on numbers of people in long-stay hospital places, reported both here and elsewhere, is that these declined between 1985 and 2000.

Table 8.3

Numbers of people aged 65 and over in long-stay hospitals, by country, Britain, 1985-2000

Numbers in thousands

	England & Wales	Scotland	Britain
1981	90	20	105
1991	35	15	50
2001	10	5	15
1985 (estimate)	65	15	80
1995 (estimate)	25	10	35

Sources: 1981 Census, Table 3 (Britain); 1991 Census Table 4 (Britain); 2001 Census Tables S126 (England & Wales) and S232 (Scotland).
Notes: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding.

8.1.2 Long-Stay Residential Care Rates: Trends over Time

This section uses the information in Table 8.1 to estimate the *percentage* of people aged 65 and over who were in long-stay residential care between 1985 and 2000, by age and type of establishment.

The total numbers of people in residential homes/hospitals of each type (shown in Table 8.1) were broken down into five age-bands and by gender using 1991 and 2001 Census data. Information from the 1991 Census was used to break down the totals in residential care in 1985 and 1990 and information from the 2001 Census was used to break down the totals in residential care in 1995 and 2000. Data on trends between 1981 and 1991 were not utilised for the 1985 breakdown by age and gender because of the absence of key categories of care homes in 1981. In particular, there was no information on nursing homes in the 1981 Census, whereas this category was included in the 1991 Census. Equally, data on trends between 1991 and 2001 were not utilised for the 1995 breakdown by age and gender because the breakdowns by age and gender were very similar in 1991 and 2001. The results are reported for each year in Appendix 8A. The long-stay residential care rates were then calculated. The rates utilise not just the data on numbers in long-stay residential care, reported above, but the total numbers of older people in the population. The statistics on numbers of older people used here are official mid-year population estimates, described in Chapter Two (Table 2.10).

Table 8.4 shows the percentage of older people in all forms of residential care (residential care homes, nursing homes and long-stay hospitals) between 1985 and 2000, at different ages. The rates are expressed as the proportion of older people in long-stay residential care by broad age-band, that is, aged 65 and over, aged 75 and over, aged 80 and over and aged 85 and over. This is partly because these rates will be utilised later in the chapter and partly to facilitate comparison with other sources, in which rates are often expressed in these terms.

Table 8.4 shows that the proportion of older people in long-stay residential care rises with age. At the beginning of the period under study, in 1985, the proportion of people in residential care aged 65 and over was 4 per cent; the proportion aged 75 and over was 8 per cent; the proportion aged 80 and over was 13 per cent and the proportion aged 85 and over was 22 per cent (Table 8.4). The variations in the proportions in residential

care by age, shown here, are similar to proportions reported elsewhere. For example, the House of Commons Health Committee reported that, in 1994, the percentage of the population in residential or nursing home care aged 65 and over was 5%, aged 75 and over was 10% and aged 85 and over was 23% (HOC 1995: 259). These rates are the same as those reported for 1995 in Table 8.4.

Trends over time in the proportion of older people in long-stay residential care also varied by age. Table 8.4 shows that that the rates for people aged 65 and over and aged 75 and over rose most rapidly between 1985 and 1990, continued to rise somewhat until 1995 and then fell by 2000 to a level below that in 1990. The rates for people aged 80 and over and aged 85 and over rose between 1985 and 1990, levelled off between 1990 and 1995 and then fell to 2000.

Table 8.4

Percentage of the population in all forms of residential care (residential care homes, nursing homes and long-stay hospitals), aged 65 and over, aged 75 and over, aged 80 and over and aged 85 and over, Britain, 1985 to 2000

Numbers in thousands and percentages

	Number in all forms of residential care (thousands)	Number in population (thousands)	*Percentage in all forms of residential care (%)*
Aged 65 and over			
1985	335	8,385	*3.97*
1990	425	8,800	*4.81*
1995	455	8,980	*5.07*
2000	410	9,090	*4.49*
Aged 75 and over			
1985	280	3,550	*7.96*
1990	365	3,875	*9.42*
1995	400	3,970	*10.03*
2000	365	4,270	*8.50*
Aged 80 and over			
1985	230	1,765	*13.11*
1990	300	2,035	*14.86*
1995	335	2,265	*14.69*
2000	305	2,315	*13.25*
Aged 85 and over			
1985	150	675	*21.83*
1990	195	825	*23.63*
1995	230	985	*23.40*
2000	225	1,095	*20.61*

Sources: Table 8.1, Appendix 8A and ONS population data (Chapter Two, Table 2.10)
Note: Numbers are rounded to nearest 5,000. Rates are based on un-rounded numbers.

The trends in the proportion of older people in all forms of long-stay residential care, shown in Table 8.4, seem comparable to those reported elsewhere. Thus, Table 8.4 shows that, between 1985 and 1990, long-stay residential care rates for all age-groups rose, and this is consistent with trends in rates reported elsewhere (Laing 1993: 29; Darton and Wright 1993: 15, 19; HOC 1995: ix; Parker 1998: 45). Table 8.4 also shows that, between 1990 and 1995, long-stay residential care rates for those aged 65 and over and aged 75 and over increased, while rates for those aged 80 and over and aged 85 and over fell slightly. Again, this is consistent with evidence reported elsewhere (HOC 1995: ix). Finally, the rates shown in Table 8.4 show that, between 1995 and 2000, there was a decline in the proportion of older people in all forms of long-stay residential care. This too is consistent with evidence reported elsewhere. Thus, Table 8.4 shows that, between 1995 and 2000, long-stay residential care rates for people aged 65 and over fell from 5.1 per cent to 4.5 per cent. These figures are comparable to rates published by the OECD, showing that there were 5.0 per cent of people aged 65 and over in 'institutions' in 1994/5 and 4.5 per cent in 2001/02 (Lafortune *et al* 2007: 44).

As the previous section indicated, however, there were also differences in trends between residential care homes, nursing homes and hospitals. Table 8.5, Figure 8.6 and Figure 8.7 below summarise the trends in the proportions of older people in the different sectors between 1985 and 2000. The rates are shown for people aged 65 and over (Figure 8.6) and for people aged 80 and over (Figure 8.7) since, as indicated above, trends over time varied between the younger and older age-groups. The 'older old' age-group is indicated here by those aged 80 and over, who (as noted in Chapter Seven) represented approximately three quarters of older people in all forms of residential care between 1985 and 2000. People aged 80 and over have been taken to indicate the older old elsewhere when examining trends in long-stay residential care in the 1990s (Grundy and Jitlal 2007: 3).

Table 8.5 and Figures 8.6 and 8.7 show that there were differences in the trends in the rates of entering different types of long-stay residential care between 1985 and 2000. The proportions of people aged 65 and over and aged 80 and over in *residential care homes* rose between 1985 and 1990, but fell between 1990 and 2000. However, the proportions of older and older old people in *nursing homes* rose between 1985 and 1995, and only fell during the late 1990s. The table and figures also combine rates for nursing homes and long-stay hospitals because, as indicated in Chapter Two, nursing

homes were increasingly treated as an alternative to hospitals for older patients in the 1980s and 1990s, so that it makes sense to consider these two forms of care as one 'nursing care' sector (Chapter Two, Sections 2.1.4, 2.1.5). The rate of entering either a nursing home or long-stay hospital, both for older people and for the older old, increased between 1985 and 1995 and then declined between 1995 and 2000 (Table 8.5, Figures 8.6 and 8.7).

Table 8.5

Numbers and percentages of the population in residential care homes, nursing homes and long-stay hospitals, aged 65 and over and aged 80 and over, Britain, 1985 to 2000

Numbers in thousands and percentages

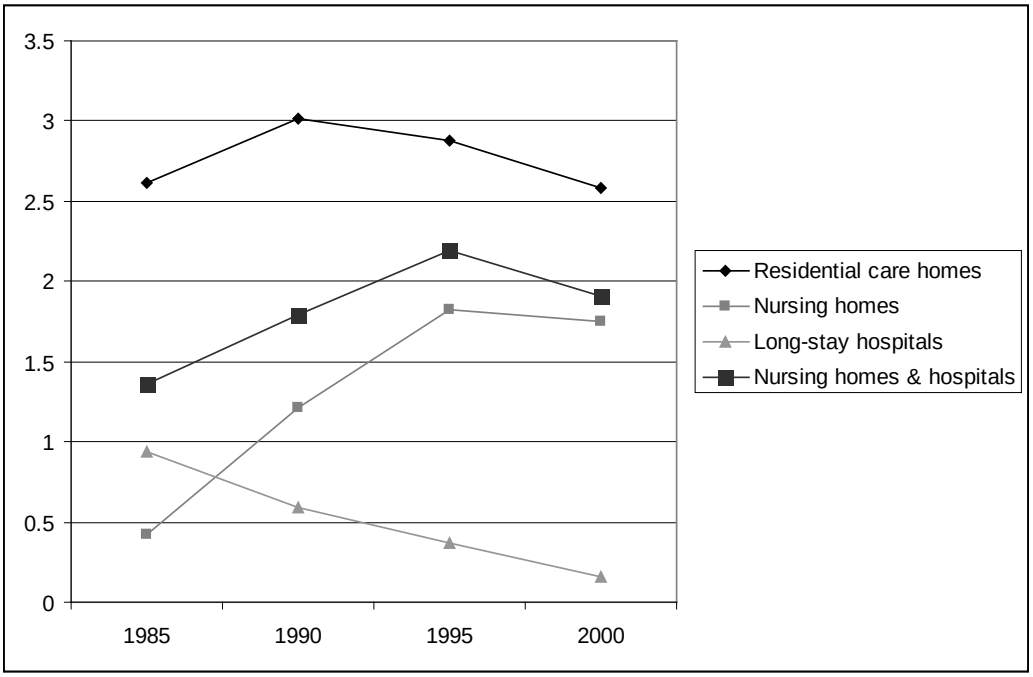
	Numbers (thousands):				Percentages (%):			
	Residential care homes	Nursing homes	Long-stay hospital	Population	Residential care homes	Nursing homes	Long-stay hospital	Nursing home/ hospital
65+								
1985	220	35	80	8,385	2.61	0.42	0.94	1.36
1990	265	105	50	8,800	3.02	1.21	0.59	1.79
1995	260	165	35	8,980	2.88	1.82	0.37	2.19
2000	235	160	15	9,090	2.58	1.75	0.16	1.91
80+								
1985	160	25	45	1,765	9.16	1.47	2.48	3.95
1990	195	80	30	2,035	9.64	3.83	1.40	5.23
1995	195	120	20	2,265	8.62	5.29	0.78	6.07
2000	180	115	10	2,315	7.84	5.08	0.33	5.41

Sources: Appendix 8A, ONS population data (Chapter Two, Table 2.10)
Notes: Numbers are rounded to nearest 5,000. Rates are based on un-rounded numbers.

Figure 8.6

Percentage of the population in residential care homes, nursing homes and long-stay hospitals, aged 65 and over, Britain, 1985 to 2000

Percentage

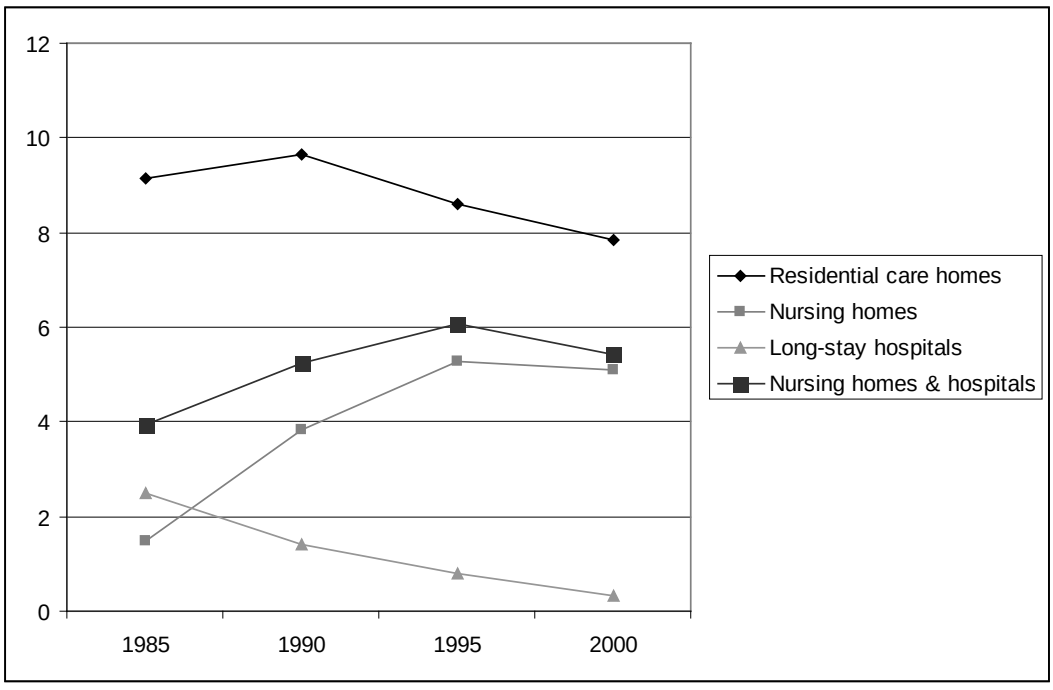


Sources: See Table 8.5

Figure 8.7

Percentages of the population in residential care homes, nursing homes and long-stay hospitals, aged 80 and over, Britain, 1985 to 2000

Percentage



Sources: See Table 8.5

8.2 Rate of Receipt of Intense & Very Intense Co-Resident Care from Children

The previous section expressed the proportion of older people in long-stay residential care in terms of the total population of older people. If this proportion is to be compared with the proportion cared for on a co-resident basis by children, then the latter data also needs to be expressed as a percentage of the total population of older people. In the previous chapter, the probabilities were given of older people in private households receiving intense and very intense co-resident care from their children, derived from the GHS data (Chapter 7, Table 7.5). The purpose now is to turn these data into probabilities of receiving care expressed in terms of the total (household and non-household) population of older people. There are three steps to this analysis. The first step is to estimate the household population; the second is to estimate numbers in households receiving care; and the third is to use these numbers to estimate the probability of receiving care as a percentage of the total population.

Table 8.4 above gave figures for the non-household population of older people and the total population of older people between 1985 and 2000. These two sets of information can now be used to estimate the numbers of older people in private households (Table 8.8).

Table 8.8

Total population of older people, non-household and household, by age-group, Britain, 1985-2000

Numbers in thousands

	Numbers in population		
	Total	Non-household	Household
Aged 65+			
1985	8,385	335	8,050
1990	8,800	425	8,375
1995	8,980	455	8,525
2000	9,090	410	8,680
Aged 80+			
1985	1,765	230	1,535
1990	2,035	300	1,735
1995	2,265	335	1,930
2000	2,315	305	2,005

Sources: Tables 8.1 and 8.5

Note: Numbers are rounded to nearest 5 thousand. Figures may not add exactly due to rounding.

The probability of an older person receiving care from an adult child on an intense and very intense co-resident basis was multiplied by the household population in each year to generate estimates of the numbers of older people receiving each type of co-resident care. The probabilities were taken from Table 7.5 in the previous chapter, which also gave 95 per cent Confidence Intervals around the probabilities. The results are shown in Table 8.9. The table shows that the numbers of older people receiving intense care (for 20 or more hours a week) fell somewhat between 1985 and 2000, but that the biggest decreases were in very intense care (for 50 or more hours a week). Numbers of older people aged 65 and over receiving very intense co-resident care from their adult children fell by around half between 1985 and 1995, declining from around 125 thousand in 1985 to around 65 thousand in 1995. The numbers of people aged 80 and over receiving very intense co-resident intergenerational care fell from nearly 100 thousand in 1985 to around 55 thousand in 1995.

Table 8.9

Numbers of older people cared for by adult children on an intense co-resident basis, by age-group and intensity, with 95% Confidence Intervals, Britain, 1985-2000

Percentages and estimated numbers in thousands

	Proportion cared for in households		Numbers cared for in households (thousands)			
	Intense care (20 hours a week or more)	Very intense care (50 hours a week or more)	Intense care (20 hours a week or more)		Very intense care (50 hours a week or more)	
			Point estimate	Confidence Intervals	Point estimate	Confidence Intervals
Aged 65+						
1985	2.02	1.56	165	130-200	125	100-160
1990	2.06	1.21	175	140-210	100	75-130
1995	1.68	0.78	145	110-185	65	45-95
2000	1.72	0.96	150	115-195	85	60-120
Aged 80+						
1985	7.92	6.42	120	95-155	100	75-130
1990	7.39	4.66	130	100-160	80	60-110
1995	6.15	2.94	120	90-155	55	40-85
2000	5.35	2.99	110	80-150	60	40-95

Sources: Tables 7.5 and 8.8

Notes: This table relates to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child (aged 30 to 74). Numbers are rounded to nearest 5,000.

The numbers of older people receiving care were then expressed as proportions of the total population of older people, to give the rates at which older people received intense co-resident care from their children (Table 8.10). Table 8.10 shows that the proportion of older people receiving very intense intergenerational care on a co-resident basis was smaller when expressed as a proportion of the total population (that is, the household plus the non-household population) than when expressed as a proportion of the household population alone (as in the GHS sample data) (Table 8.10 cf. Table 8.9). Table 8.10 confirms previous results in the sense that it shows that the decline in receipt of care was greater for very intense than intense care. The probability of an older person aged 65 and over receiving very intense co-resident care from an adult child fell from around 1.5 per cent (1.2-1.9 per cent) in 1985 to 0.75 per cent (0.5 to 1.1 per cent) in 1995. The probability of an older old person aged 80 and over receiving this form of care fell from around 5.5 per cent (4.2 to 7.3 per cent) in 1985 to around 2.5 per cent (1.7 to 3.8 per cent) in 1995.

Table 8.10

Percentage of older people receiving care from adult children on an intense co-resident basis, by age-group and intensity, with 95% Confidence Intervals (CIs), Britain, 1985-2000

Percentages

	Percentage receiving intense care (20+ hrs p.w.) (%)			Percentage receiving very intense care (50+ hrs p.w.) (%)		
	Point	Lower CI	Upper CI	Point	Lower CI	Upper CI
Aged 65+						
1985	1.94	1.57	2.40	1.50	1.18	1.91
1990	1.96	1.59	2.41	1.15	0.88	1.51
1995	1.59	1.24	2.04	0.74	0.52	1.07
2000	1.65	1.26	2.15	0.92	0.64	1.32
Aged 80+						
1985	6.89	5.35	8.79	5.58	4.23	7.33
1990	6.29	4.97	7.92	3.97	2.94	5.33
1995	5.25	3.96	6.92	2.51	1.67	3.76
2000	4.64	3.35	6.41	2.60	1.68	4.01

Sources: Tables 7.6 and 8.8

Notes: This table relates to older people receiving care that was provided for 20 or 50 hours a week or more by a co-resident child (aged 30 to 74). Numbers are rounded to nearest 5,000. Rates are based on unrounded numbers.

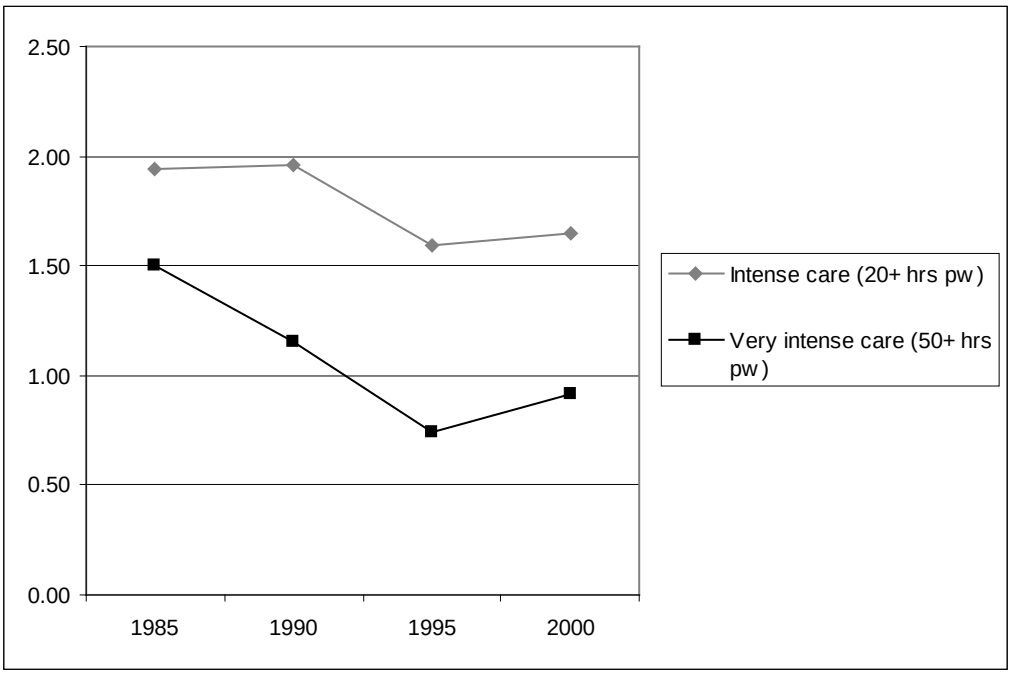
The changing rates of receipt by older people of intense and very intense co-resident care from children are illustrated in Figures 8.11 and 8.12. The figures derive from Table 8.10, with Figure 8.11 showing rates for people aged 65 and over and Figure 8.12 showing rates for people aged 80 and over.

As previously noted in Chapter Seven, the trends in receipt of intense care were different from the trends in receipt of very intense care. On the one hand, receipt of intense care by people aged 65 and over shows a marked step-down between 1990 and 1995, while receipt of this form of care by people aged 80 and over shows a steady decline between 1985 and 2000 (Figures 8.11 and 8.12). On the other hand, receipt of very intense care, both by people aged 65 and over and by people aged 80 and over, shows a marked decline between 1985 and 1995, followed by a slight increase between 1995 and 2000 (Figures 8.11 and 8.12). Reference back to Table 8.10 suggests that the decline in receipt of very intense care between 1985 and 1995 was likely to have been statistically significant. Both in relation to care received by people aged 65 and over and people aged 80 and over, the upper confidence interval in 1995 was below the lower confidence interval in 1985. It is the rates illustrated in Figure 8.11 and 8.12 that will now be compared with long-stay residential care rates.

Figure 8.11

Percentage of the population aged 65 and over receiving intense care from children on a co-resident basis, by intensity, Britain, 1985 to 2000

Percentage

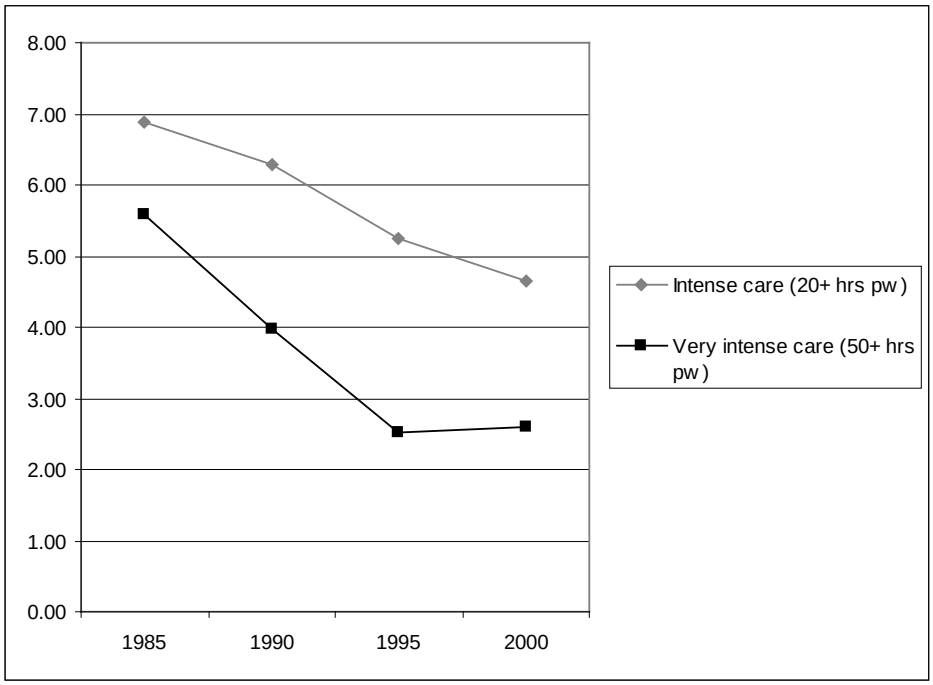


Sources and notes: see Table 8.10

Figure 8.12

Percentage of the population aged 80 and over receiving intense care from children on a co-resident basis, by intensity, Britain, 1985 to 2000

Percentage



Sources and notes: see Table 8.10

8.3 Intense & Very Intense Co-Resident Care and Long-Stay Residential Care

This part of the chapter explores how far there was a negative relationship between co-resident care from children and long-stay residential care. The analysis compares receipt of intense and very intense co-resident care by older people from their adult children with receipt of long-stay residential care, that is, care in residential care homes, nursing homes and long-stay hospitals. The analysis looks first at people aged 65 and over and then at people aged 80 and over. For each age-group, receipt of care at both levels of intensity is compared with the long-stay residential care rates by sector, that is, the rate for residential care homes and the rate for nursing homes/long-stay hospitals. The residential care rate by sector is used here because, as the first part of the chapter showed, trends in long-stay residential care rate varied by sector (Figures 8.6 and 8.7).

8.3.1 Intense/Very Intense Intergenerational Care & Long-Stay Residential Care: People Aged 65 and Over

Table 8.13 below gives the proportions of people aged 65 and over in long-stay residential care and in receipt of intense and very intense co-resident care from their children between 1985 and 2000. The table shows the proportions in different types of residential care (that is, residential care homes and nursing homes or hospitals) and in receipt of different intensities of co-resident care (that is, care for 20 and 50 hours a week or more). Confidence intervals are shown for receipt of co-resident care since this is based on GHS sample data. Table 8.13 forms the basis of all the analyses in this section.

Table 8.13

Population aged 65 and over receiving long-stay residential care and intense/very intense co-resident care from adult children, Britain, 1985-2000

Percentage

	Long-stay residential care			Co-resident care from children (95% Confidence Intervals (CIs))			
	Residential homes	Nursing/ hospital care	All forms residential care	Intense 20+ hrs p.w.		Very Intense 50+ hrs p.w.	
				Point	CIs	Point	CIs
1985	2.61	1.36	3.97	1.94	1.57-2.40	1.50	1.18-1.91
1990	3.02	1.79	4.81	1.96	1.59-2.41	1.15	0.88-1.51
1995	2.88	2.19	5.07	1.59	1.24-2.04	0.74	0.52-1.07
2000	2.58	1.91	4.49	1.65	1.26-2.15	0.92	0.64-1.32

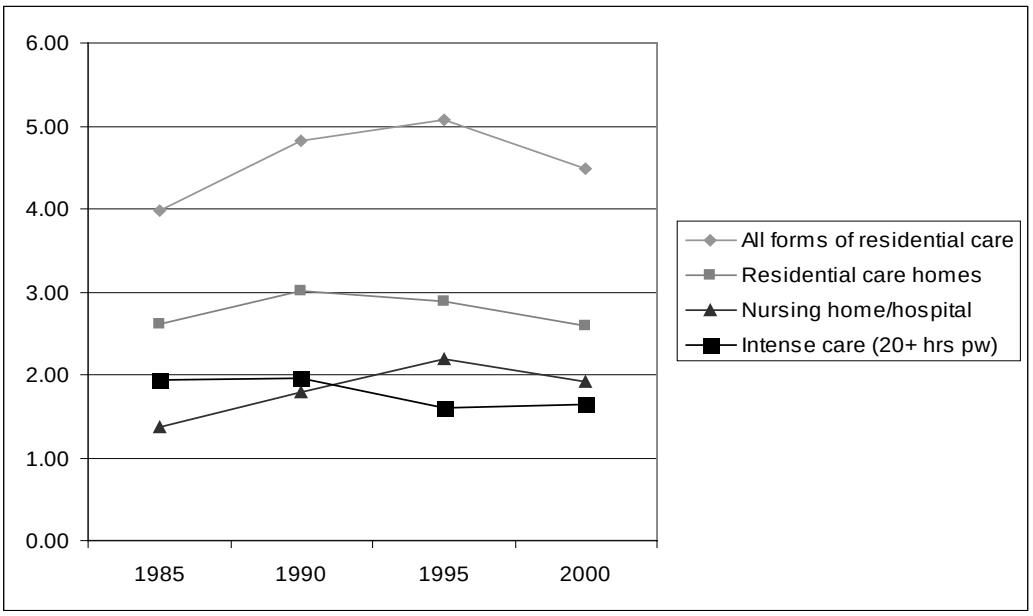
Sources: Tables 8.4, 8.5 and 8.10

Figure 8.14 shows changes over time in receipt of long-stay residential care by sector and *intense* co-resident care (for 20 or more hours a week) from children. The figure shows little evidence of a relationship between the rate for residential care homes and the rate for intense co-resident care between 1985 and 2000. There is some evidence of a negative relationship between nursing home/hospital care and intense co-resident care but it was not consistent over the whole period. The proportion of people aged 65 and over in nursing home or hospital care rose in the decade between 1985 and 1995. Intense co-resident care, on the other hand, fell between 1990 and 1995 but did not fall between 1985 and 1990.

Figure 8.14

Percentage of population aged 65 and over receiving long-stay residential care and intense co-resident care from adult children, Britain, 1985-2000

Percentage

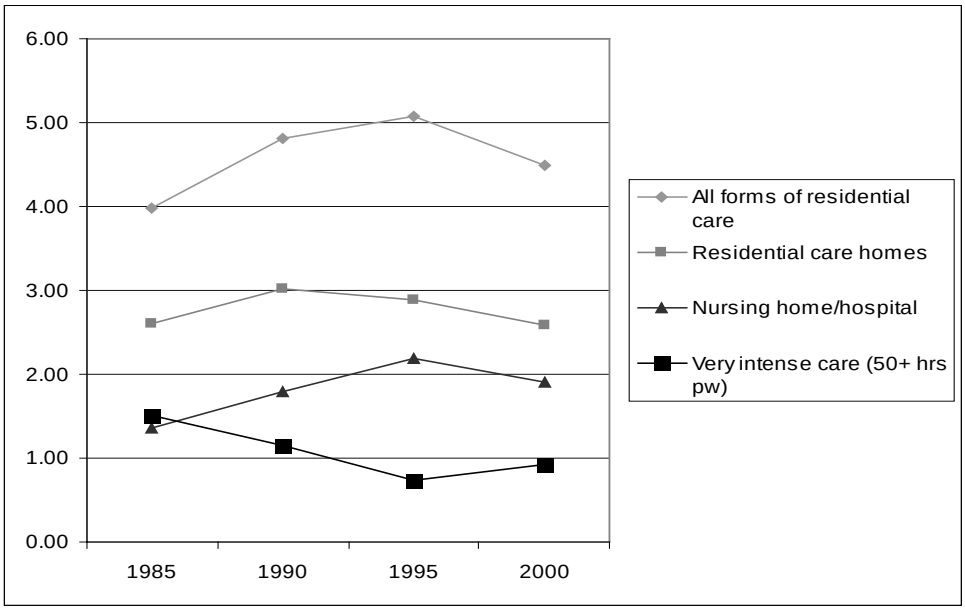


Source: Table 8.13
Notes: : This chart relates to older people receiving care that was provided for 20 hours a week or more by a co-resident child (aged 30 to 74). All rates are expressed as a percentage of the total (household and non-household) population aged 65 and over.

Figure 8.15

Percentage of population aged 65 and over receiving long-stay residential care and very intense co-resident care from adult children, Britain, 1985-2000

Percentage



Source: Table 8.13
Notes: : This chart relates to older people receiving care that was provided for 50 hours a week or more by a co-resident child (aged 30 to 74) See also note to Figure 8.14..

Figure 8.15 above repeats the relationships shown in Figure 8.14 but this time focuses on receipt of *very intense* care for 50 hours a week or more. Figure 8.15 shows that there was a negative relationship between the rate for all forms of long-stay residential care combined and the rate for very intense co-resident care between 1985 and 2000. When the former rose between 1985 and 1995, the latter fell, with these trends beginning to reverse between 1995 and 2000. This negative relationship did not, however, seem to be associated with the trends in residential care homes, but with the trends in nursing home/hospital care. As Figure 8.15 shows, there was a close negative relationship between nursing home/hospital care and very intense co-resident care by children throughout the period between 1985 and 2000. The proportion of people in both of these forms of care begins in 1985 at approximately the same rate, around 1.50 per cent of the population aged 65 and over. The percentage receiving very intense co-resident care falls to 0.75 per cent between 1985 and 1995, while those receiving nursing home/hospital care rises to 2.20 per cent. Between 1995 and 2000, the percentage receiving very intense care rises to nearly 1% while the percentage receiving nursing home/hospital care falls below 2 per cent.

Table 8.13 above includes the Upper and Lower Confidence Intervals (95%) for the probability of receiving very intense co-resident care among people aged 65 and over and the probability of receiving residential care by sector. The table shows that, in 1985, the Upper and Lower Confidence Intervals for receipt of very intense care were between 1.2 and 1.9 per cent and overlapped with the probability of receiving nursing home/hospital care, which was 1.4 per cent in 1985. Thereafter, in 1990 and 1995, the Upper Confidence Interval for the probability or receiving very intense co-resident care was below the probability of receiving nursing home/hospital care. The Upper Confidence Interval begins to creep up again towards the probability of receiving nursing home/hospital care after 1995.

The negative relationship between very intense intergenerational care and nursing home/hospital care suggests that there may have been some substitution between them. This is further suggested by the bar chart (Figure 8.16), which shows that, taken together, the probability of being cared for on a very intense co-resident basis and the probability of being cared for in a nursing home/hospital was between 2.8 and 2.9 per cent between 1985 and 2000. As nursing home/hospital care increases between 1985

and 1995, very intense co-resident care decreases. The reverse occurs between 1995 and 2000.

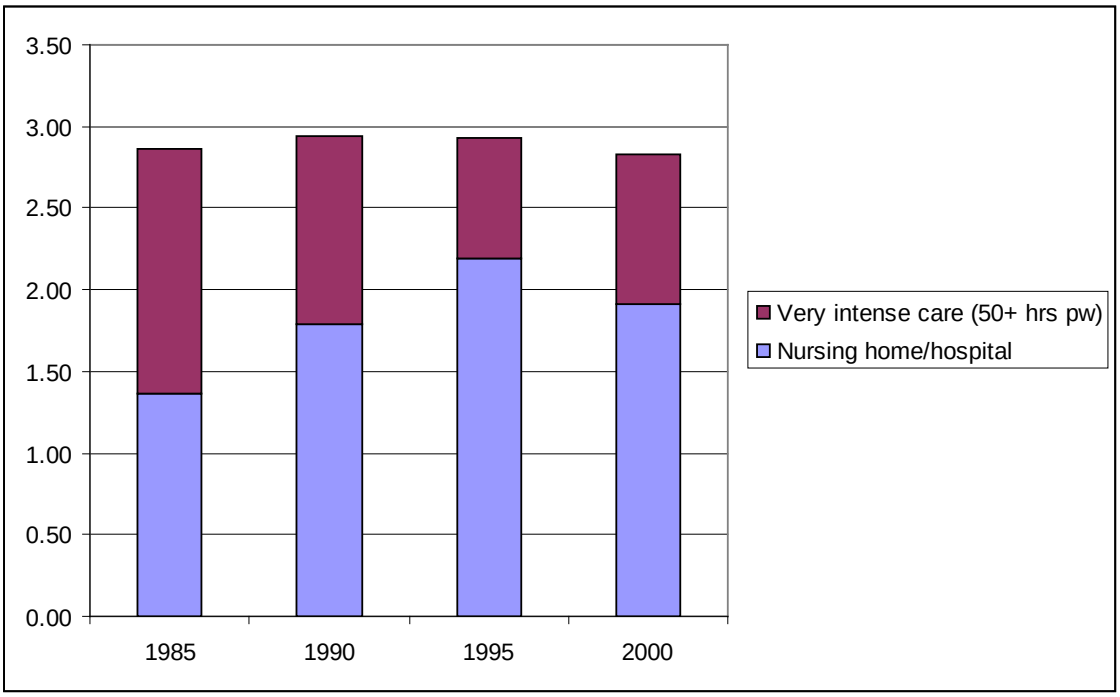
These results suggest that, in the population aged 65 and over as a whole, there was some substitution between very intense co-resident care by children and nursing home/hospital care. The latter forms of care represent the most intense forms of social care for older people.

The majority of both those receiving intense/very intense co-resident care and those receiving long-stay residential care are, however, older old people aged 80 and over. Therefore, any substitution effects observed in the older population are likely to be determined primarily by relationships affecting the older old population. It is to the older old population that the analysis therefore now turns.

Figure 8.16

Percentage of population aged 65 and over receiving care in nursing homes or long-stay hospitals and from adult child(ren) on a co-resident basis for 50 or more hours a week, Britain, 1985-2000 (bar chart)

Percentage



Sources and notes: See Figure 8.14 above

3.2 Intense/Very Intense Intergenerational Care & Long-Stay Residential Care: People Aged 80 and Over

Table 8.17 below gives the proportions of people aged 80 and over in long-stay residential care by sector and in receipt of intense and very intense co-resident care from their children between 1985 and 2000.

Table 8.17

Population aged 80 and over receiving long-stay residential care and intense/very intense co-resident care from adult children, Britain, 1985-2000

Percentages

	Long-stay residential care			Co-resident care from children (95% Confidence Intervals (CIs))			
	Residential homes	Nursing/ hospital care	All forms residential care	Intense 20+ hrs p.w.		Very Intense 50+ hrs p.w.	
				Point	CIs	Point	CIs
1985	9.16	3.95	13.11	6.89	5.35-8.79	5.58	4.23-7.33
1990	9.64	5.23	14.86	6.29	4.97-7.92	3.97	2.94-5.33
1995	8.62	6.07	14.69	5.25	3.96-6.92	2.51	1.67-3.76
2000	7.84	5.41	13.25	4.64	3.35-6.41	2.60	1.68-4.01

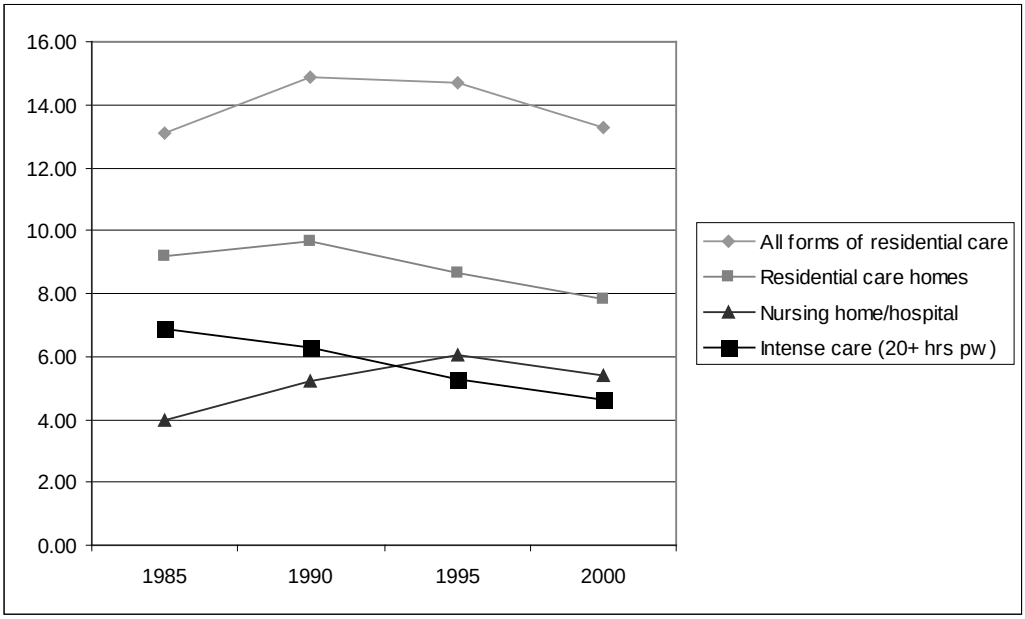
Sources: Tables 8.4, 8.5 and 8.10 above

Figure 8.18 shows the relationship between the proportion of the population aged 80 and over receiving different forms of long-stay residential care by sector and the proportion receiving *intense* care on a co-resident basis from adult children between 1985 and 2000. The trend in receipt of intense co-resident care is consistently downwards between 1985 and 2000 and this corresponds negatively neither with the trends in residential care homes nor with the trends in nursing home/hospital care. As with the population aged 65 and over, there is little evidence for the older old of a negative relationship between the rate for residential care homes and intense co-resident care, except during the five-year period between 1985 and 1990. There is some evidence of a negative relationship between nursing home/hospital care and intense co-resident care between 1985 and 1995, but it did not hold for the period between 1995 and 2000.

Figure 8.18

Percentage of population aged 80 and over receiving long-stay residential care and intense co-resident care from adult children, Britain, 1985-2000

Percentage



Sources and notes: Table 8.17

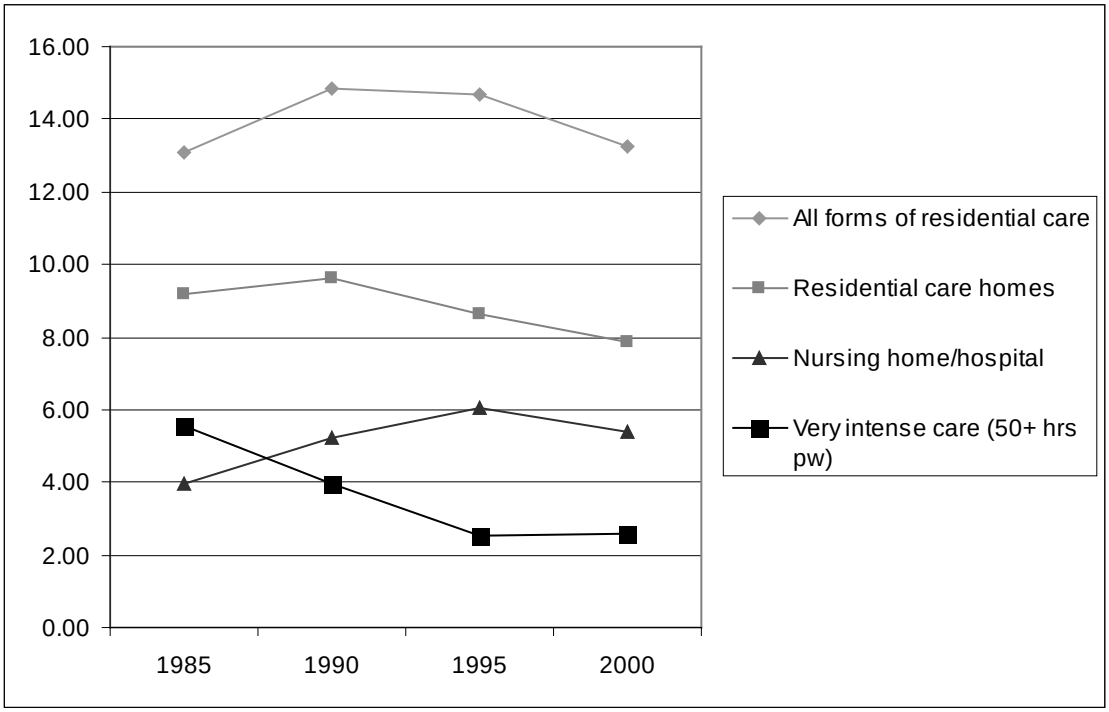
Figure 8.19 shows the relationship between the proportion of the population aged 80 and over receiving long-stay residential care by sector and the proportion receiving *very intense* co-resident care from children. There is some negative relationship between the rate for residential care homes and the rate for very intense co-resident care between 1985 and 2000, but the relationship does not hold for the period between 1990 and 1995.

However, there is a strong negative relationship between nursing home/hospital care and very intense care in the 80-plus population (Figure 8.19). The percentage receiving very intense co-resident care falls from around 5.5 per cent to around 2.5 per cent between 1985 and 1995, while the percentage receiving nursing home or hospital care rises from around 4 per cent to around 6 per cent. Between 1995 and 2000, the percentage receiving very intense co-resident care rises slightly while the percentage receiving nursing home/hospital care falls. It is this strong negative relationship between nursing home/hospital care and very intense care in the 80-plus population that likely underlies the similar relationship, observed above, in the 65-plus population as a whole.

Figure 8.19

Percentage of population aged 80 and over receiving long-stay residential care and very intense co-resident care from adult children, Britain, 1985-2000

Percentage



Sources and notes: Table 8.17

Table 8.17 included the Lower and Upper Confidence Intervals for the probability of receiving very intense co-resident care among people aged 80 and over, together with the probability of receiving nursing home/hospital care. The table shows that in 1985 the Confidence Intervals for the probability of receiving very intense intergenerational care were between 4.2 per cent and 7.3 per cent and were slightly higher than the probability of receiving nursing home/hospital care, which was around 4.0 per cent in 1985. By 1990, there was some overlap between the two forms of care, with the probability of receiving very intense co-resident care being between 2.9 per cent and 5.3% and the probability of receiving nursing home/hospital care being 5.2 per cent. By 1995, however, the Upper Confidence Interval for the probability of receiving very intense co-resident care (1.7 to 3.8 per cent) is clearly below the probability of receiving nursing home/hospital care (6.1 per cent). The Upper Confidence Interval begins to creep up again towards the probability of receiving nursing home/hospital care after 1995.

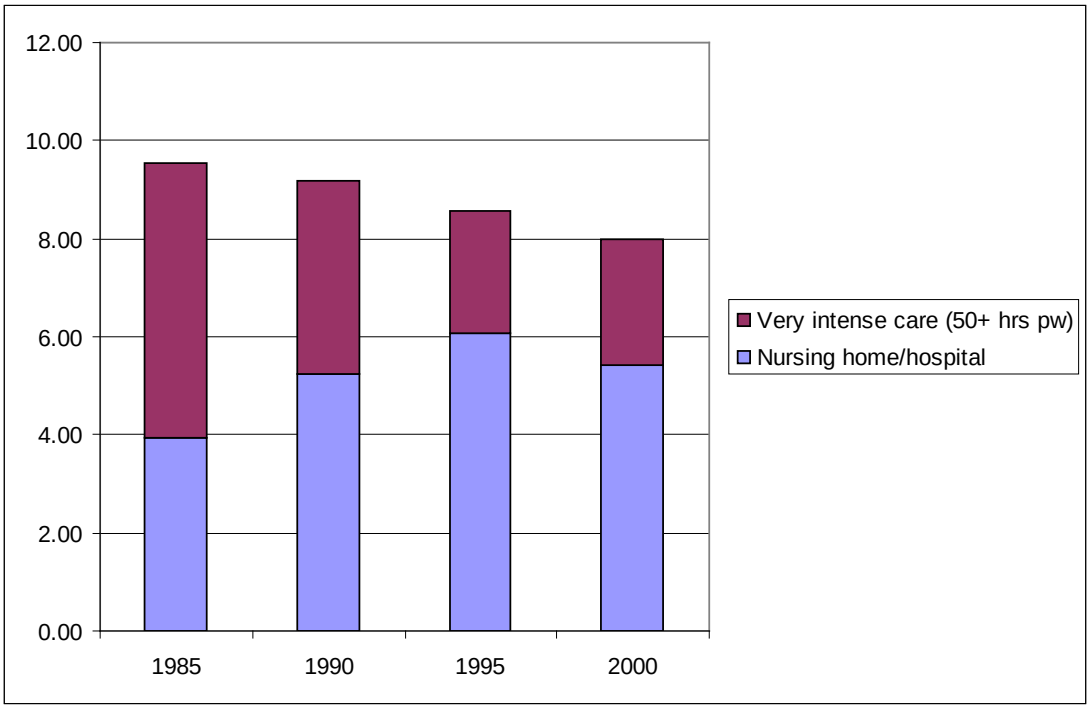
The negative relationship between very intense intergenerational care and nursing home/hospital care among the population aged 80 and over suggests that there is some substitution between them. In order to examine this further, the results are displayed as a bar chart (Figure 8.20). The bar chart shows that, taken together, the probability of being cared for on a very intense co-resident basis and of being cared for in a nursing home/hospital, is around 9.5 per cent in 1985, but that this percentage gradually slopes downwards, so that, by 2000, it is only around 8 per cent. Within this gradually declining probability of being cared for on a very intense basis, whether by children in the same household or in a nursing home/hospital, the balance between the two forms of care changes in a way compatible with the substitution hypothesis. Thus, in 1985, the majority of very intense care is co-resident intergenerational care, whereas in 1995, the opposite is the case, and the majority of very intense care is nursing home/hospital care. Between 1995 and 2000, there is some evidence of a reversal of these trends.

However, the fact that there is a gradual decline in the probability of people aged 80 and over receiving very intense care, whether at home or in long-stay residential care, suggests that some other factor is also operating. This is pertinent here because it suggests that the substitution of long-stay residential care for co-resident care was taking place in the context of an overall decline in receipt of very intense care, whether formal or informal. Whatever caused this gradual decline, therefore, may also have contributed to the decline in very intense co-resident care.

Figure 8.20

Percentage of population aged 80 and over receiving care in nursing homes or long-stay hospitals and from adult child(ren) on a co-resident basis for 50 or more hours a week, Britain, 1985-2000 (bar chart)

Percentage



Sources and notes: See Table 8.17

8.4 Very Intense Co-Resident Care and Disability Trends among the Older Old

Severe disability is the most important factor affecting receipt of very intense co-resident care by older old people from their children. This was one of the key findings from the previous chapter. It was also observed in the previous chapter that, after age, serious disability is regarded as the major driver of 'institutional' admission (Grundy & Jitlal 2007). It was, therefore, decided to explore the potential relevance of changes in severe disability as an explanation for the gradual decline in the proportion of the older old receiving very intense care, whether at home or in an institution, shown in Figure 8.20.

Trends in disability in the older old population suggest that the prevalence of severe disability declined during the 1980s and 1990s (Bebbington and Darton 1996). These trends were described earlier in Chapter Two, where it was observed that the decline in prevalence of disability might have reduced demand for long-term care.

Given these trends, it was hypothesised that the gradual decline in the receipt of very intense forms of care, whether care by co-resident children or in nursing homes/hospitals, could have been related to the decline in the prevalence of severe disability in the older old population in the 1980s and 1990s. This part of the chapter explores this hypothesis, by examining trends in receipt of co-resident care by children and in long-stay residential care *among the disabled population* aged 80 and over. There are two stages to the analysis. First, the numbers of disabled people in households, in long-stay residential care and receiving intense co-resident care are estimated, and this allows for rates of receipt of care (both formal and informal) among the disabled older old population to be estimated. Then, a comparison is made between the trends in the rates of receipt of formal and informal care among the disabled population aged 80 and over. Trends in receipt of care by non-disabled people are also examined.

8.4.1 Receipt of Formal and Informal Care among Disabled Older Old People

In order to derive numbers of people with severe disability in households, information about the disability of the older household population was applied to the household population aged 80 and over (Table 8.21). Table 8.21 is based on disability prevalence rates between 1985 and 2000, by age and gender, reported earlier in the study (Chapter Two, Table 2.14). These rates, in turn, are based on analyses of GHS data on the disability of the older household population between 1980 and 1995, carried out by Bebbington and Darton (1996) and supplemented by the author's own analysis of the 2001/02 GHS data on older people. As noted in Chapter Two, Bebbington and Darton (1996: 10) define 'more severe' disability as an inability to perform one or more Activities of Daily Living (ADLs) or personal care tasks without help. The age/gender-specific disability rates in Table 2.14 were applied to the household population aged 80 and over to obtain an estimate of the numbers of people with severe disability in the household population. Since these estimates of the disabled household population are largely based on disability rates published by Bebbington and Darton (1996), and since these published rates do not include confidence intervals, confidence intervals are not shown in Table 8.21. The figures on numbers of people with severe disability should therefore be regarded as approximate estimates.

Table 8.21

Estimation of numbers of people aged 80 and over with severe personal care disability in households, Britain, 1985-2000

Percentages and estimated numbers in thousands

	Men		Women		Total
	80-84	85+	80-84	85+	
Severe disability rate					
1985	*15*	*23*	*19*	*33*	-
1990	*14*	*21*	*17*	*29*	-
1995	*13*	*18*	*15*	*25*	-
2000	*9*	*16*	*15*	*24*	-
Numbers in households					
1985	325	130	680	395	1,535
1990	375	170	725	460	1,735
1995	420	215	750	540	1,925
2000	425	250	715	610	2,005
Numbers with severe disability in households					
1985	50	30	130	130	340
1990	50	35	125	135	345
1995	55	40	115	135	340
2000	35	40	110	145	330

Sources: Bebbington & Darton (1996) (disability rates for 1985 and 1994/95); 2001/02 GHS (author's secondary analysis). Notes: Disability rates for 1990 based on trends between 1985 and 1994/5. All disability rates are for England & Wales. Numbers in households based on official population data and numbers in long-stay residential care. Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding.

In order to derive numbers of people with severe disability in long-stay residential care, information about the disability of the older population in long-stay residential care from the Health Survey for England (HSE) (Bajekal 2002) was applied to the long-stay residential care population aged 80 and over (Table 8.22). Data from the 2000 HSE, rather than data from earlier years, were utilised because published analyses from the 2000 HSE provide information, by type of long-stay residential care establishment, using a definition of disability comparable to that utilised by Bebbington and Darton for the household population (Bajekal 2002: 49, Table 20). The report on care homes from the 2000 HSE defines severe disability in terms of the "personal care disability dimension of the WHO protocol" as "persons requiring assistance with self-care tasks including activities of daily living such as washing, dressing, feeding, using the toilet, and requiring help getting in and out of a bed or a chair" (Bajekal 2002: 24). Other published data on disability rates for the long-stay residential care population, relating to the late 1980s and early 1990s, either do not use a comparable definition of disability (Martin *et al* 1988; Darton and Wright 1992; Challis *et al* 2000), do not provide information on different types of long-stay care establishment (Bebbington & Darton 1996) or provide information on a sub-set of the residential care population (Netten *et al*

2001). An assumption is made in the present study that disability rates in long-stay residential care remained unchanged between 1985 and 2000.[1] Published disability rates in long-stay residential care from the 2000 HSE are given for older people by gender but not age, and therefore the disability rates for people aged 65 and over have here been applied to the population aged 80 and over. The predominance of the older old in long-stay residential care, with around two-thirds of men and 80 per cent of women in all types of care homes being aged 80 and over (Bajekal 2002: 38, Table 8), means that the disability rates of the older population in long-stay residential care are likely to be largely determined by the rates for the older old population.

Table 8.22

Estimation of numbers of people aged 80 and over with severe personal care disability in long-stay residential care, Britain, 1985-2000

Percentages and estimated numbers in thousands

	Residential care homes			Nursing homes/hospital			Total
	Men	Women	Total	Men	Women	Total	
Severe disability rates[+]							
2000	*33.0*	*42.5*	-	*69.5*	*74.0*	-	-
1985	*33.0*	*42.5*	-	*69.5*	*74.0*	-	-
1990	*33.0*	*42.5*	-	*69.5*	*74.0*	-	-
1995	*33.0*	*42.5*	-	*69.5*	*74.0*	-	-
2000							
Numbers in long-stay residential care							
1985	30	130	160	15	55	70	230
1990	35	160	195	20	90	105	300
1995	35	160	195	30	110	140	335
2000	35	150	180	25	100	125	305
Numbers with severe disability in long-stay residential care							
1985	10	55	65	10	40	50	115
1990	10	70	80	15	65	80	160
1995	10	70	80	20	80	100	180
2000	10	65	75	20	75	90	165

Sources: Bajekal (2002: 49, Table 20), Table 8.5 above

Notes: [+] Severe disability rates are assumed constant at 2000 rates.[1] Bajekal (2002) gives disability rates for residential (Local Authority, voluntary and private), dual registered and nursing homes. The rate used in Table 8.22 above for residential care homes is the mid-point of observed rates for the three types of residential care homes and the rate for nursing home/hospital is the mid-point of observed rates for dual registered and nursing homes. All disability rates are for people aged 65 and over in England (see text for further explanation). Numbers are rounded to nearest 5 thousand. Figures may not add exactly due to rounding.

[1] The assumption of unchanging disability rates in long-stay residential care is a strong one but has been made elsewhere in analyses of long-stay residential care over time in Britain (for example, by Bebbington and Darton (1996: 10-11). Because of its importance in the present study, however, the assumption of unchanging disability is examined here using *sensitivity analysis* (see Appendix 8B) and the implications of the sensitivity analysis for key findings are described in the text. The conclusions to the chapter discuss further the assumption of unchanging disability rates (see Section 8.5)..

The numbers of people with severe personal care disability in long-stay residential care were added to the numbers with severe personal care disability in households to derive estimated figures for the numbers with severe personal care disability in both the household and non-household populations (Table 8.24). The numbers receiving very intense and intense co-resident care from children and the numbers in different types of long-stay residential care were then expressed as a proportion of the total population with severe disability. Severe personal care disability among older old people cared for intensely on a co-resident basis by their children was derived from the 1985 GHS and it was assumed that these rates remained unchanged between 1985 and 2000 (Table 8.23).

Table 8.23

Estimation of numbers of people aged 80 and over with severe personal care disability receiving intense/very intense co-resident care from children, Britain, 1985-2000

Percentages and estimated numbers in thousands

	Severe disability rate		Numbers receiving co-resident care		Numbers with severe disability receiving co-resident care	
	Intense	*Very intense*	Intense	Very intense	Intense	Very intense
1985	*59.6*	*63.8*	120	100	75	65
1990	*59.6*	*63.8*	130	80	75	50
1995	*59.6*	*63.8*	120	55	70	35
2000	*59.6*	*63.8*	110	60	65	40

Sources: 1985 GHS (author's analysis); Table 8.9 above.
Notes: Disability rates derived from 1985 GHS are for people aged 80 and over in Britain. Numbers are rounded to nearest 5,000.

Table 8.24

People aged 80 and over with severe personal care disability receiving long-stay residential care and intense/very intense co-resident care from children, Britain, 1985-2000

Estimated numbers in thousands and percentages

	Estimated numbers with severe disability in:			*Percentage of estimated total severely disabled:*			
	Households	Long-stay residential care	Total	*in long-stay residential care*		*receiving co-resident care from children*	
				Residential	*Nursing/ hospital*	*Intense*	*Very intense*
1985	340	115	455	*14.5*	*11.2*	*15.9*	*13.8*
1990	345	160	500	*15.9*	*15.5*	*15.2*	*10.3*
1995	340	180	520	*15.3*	*19.2*	*13.6*	*6.9*
2000	330	165	495	*15.0*	*18.5*	*13.0*	*7.7*

Sources: Tables 8.21-8.23 above.
Notes: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding.

8.4.2 Very Intense Co-Resident Care & Long-Stay Residential Care: Disabled and Non-Disabled People Aged 80 and Over

Having assembled estimates of severe disability among the older old, it is now possible to examine the hypothesis, set out at the beginning of this part, that the gradual decline in receipt of very intense forms of care, whether by co-resident children or in nursing home/hospital care, was related to the decline in prevalence of severe disability in the older old population in the late 1980s and early 1990s. The analysis begins with the table above (Table 8.24) which sets out the rates of receipt of care by disabled people aged 80 and over between 1985 and 2000. Later in the section, trends in receipt of care by non-disabled people are also examined.

Table 8.24 confirms the downward trend in severe disability rates. Numbers of severely disabled older old people rose from around 450 thousand in 1985 to around 500 thousand in 2000, an increase of around 10 per cent (Table 8.24). This can be compared to the rise in the total numbers of older old people, whose numbers increased from around 1.8 million to around 2.3 million in the same period (Table 8.4). The prevalence of disability therefore fell from around one in four of the 80-plus population in 1985 to around one in five in 2000.

Table 8.24 also suggests that the proportion of the severely disabled population in any form of long-stay residential care rose between 1985 and 2000. The proportion of severely disabled older old people in long-stay care rose from around 25 per cent in 1985 to around 33 per cent in 2000. The greatest increase was in nursing home/hospital care, with the proportion of severely disabled people nearly doubling between 1985 and 1995. At the same time, the proportion of very old severely disabled people receiving very intense co-resident care fell by around a half.

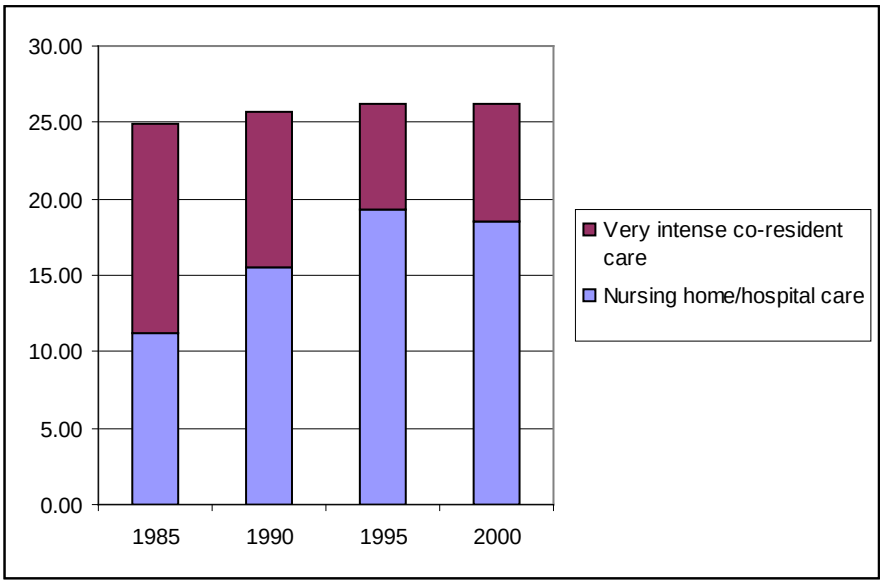
Figure 8.25 compares receipt of very intense co-resident care by children and nursing home/hospital care among severely disabled people aged 80 and over. The figure shows that, taken together, the probability of a severely disabled older old person being cared for on a very intense co-resident basis or being cared for in a nursing home/hospital was around 25 per cent (25.0 to 26.2 per cent) between 1985 and 2000. Therefore, controlling for severe disability in the population, there was little change between 1985 and 2000 in the percentage of older old people receiving very intense forms of care

either at home or in long-stay residential care. The sensitivity analysis, reported in Appendix 8B, suggests that, even quite large increases or decreases in the numbers of severely disabled people in long-stay residential care in 1985, would not substantially alter this finding.

Figure 8.25

Percentage of estimated severely disabled population aged 80 and over in nursing homes/hospitals and receiving very intense co-resident care from children, Britain, 1985-2000 (bar chart)

Percentage



Sources and notes: Table 8.24 above

Figure 8.25 clearly shows that, in the period between 1985 and 2000, the balance between very intense co-resident care and nursing home/hospital care for the disabled population changed in a manner consistent with the substitution hypothesis. In 1985, the proportion cared for very intensely by co-resident children exceeded the proportion cared for in nursing homes/hospitals. However, over the next decade, these proportions changed and, by 1995, the proportion cared for in nursing homes/hospitals exceeded the proportion cared for very intensely by children living in the same household. After 1995, there were signs that these trends were reversing.

Although there was a clear substitution relationship among the severely disabled population, the prevalence of disability was declining in the population aged 80 and over between 1985 and 2000. Therefore, it might be expected that, taken together, severely disabled people either in nursing homes/hospitals or receiving very intense co-

resident care would also have been declining as a percentage of the population aged 80 and over. This was indeed the case. Using data already presented in this chapter, it can be shown that, between 1985 and 2000, the proportion of severely disabled people either in nursing homes/hospitals or receiving very intense care from co-resident children fell gradually from 6.4 per cent to 5.6 per cent of the 80-plus population (Appendix 8C, Table 8C.1). It was this gradual fall that primarily accounted for the gradual decline in the proportion of people receiving either nursing home/hospital or very intense co-resident care, shown in Figure 8.20. This suggests that part of the reason for the decline in very intense co-resident care between 1985 and 2000 period was the decline in the prevalence of severe disability.

Furthermore, controlling for severe disability also shows that the substitution relationship extended still further. Indeed, among the severely disabled population, the substitution effects can be seen to extend to long-stay residential care more generally. Figure 8.26 includes residential care homes, as well as nursing home/hospital care, and allows for a comparison between the total long-stay residential care rate and the very intense co-resident care rate. The results suggest that, as long-stay residential care rose between 1985 and 1995, very intense care fell, and that, as long-stay residential care began to fall between 1995 and 2000, very intense co-resident care began to rise (Figure 8.26). The sensitivity analysis, reported in Appendix 8B, again suggests that, even quite large increases or decreases in the numbers of severely disabled people in long-stay residential care in 1985, does not substantially alter the finding that, between 1985 and 2000, around 40 per cent of severely disabled older people were either cared for very intensely by children or in long-stay residential care.

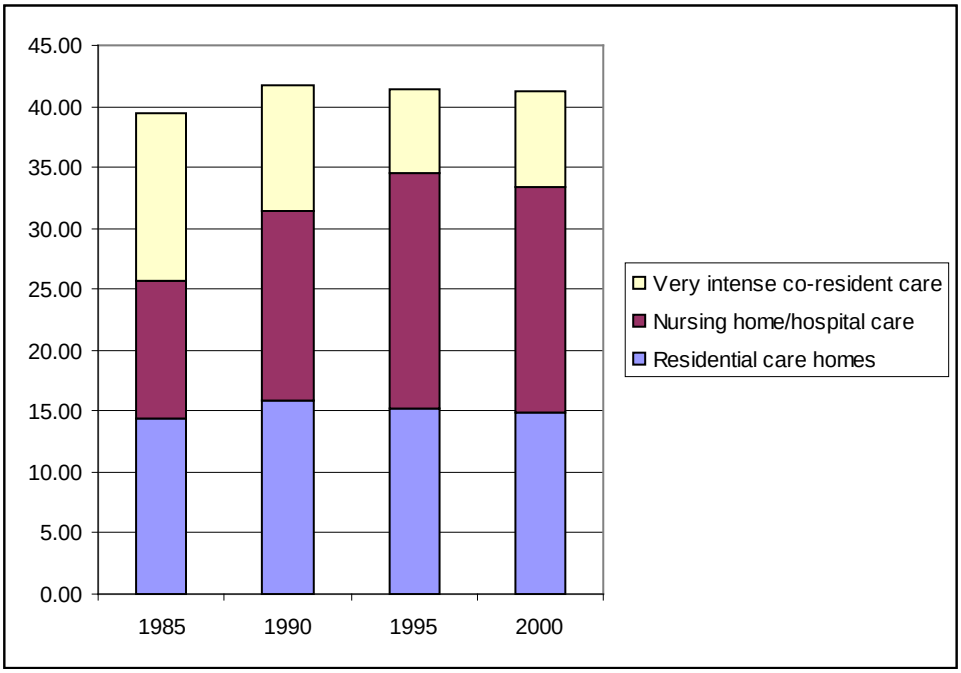
The reason why the substitution relationship appears more strongly in relation to the severely disabled population, compared to the 80-plus population overall (Figure 8.19), is because the long-stay residential care rate for the severely disabled continued to rise between 1990 and 1995, whereas the rate for the 80-plus population as a whole did not. And this in turn was because the form of care that was rising between 1990 and 1995 was nursing home/hospital care, a form of care in which the severely disabled predominated (Table 8.22). Indeed, it is clear from Figure 8.26 that the proportion of severely disabled very old people in residential care homes remained fairly static between 1985 and 2000. It was primarily nursing home/hospital care that was rising and, as it did so, very intense co-resident care fell (Figure 8.26). Therefore, the

substitution effects between long-stay residential care and very intense co-resident care among the disabled population were primarily due to changes in nursing home/hospital care.

Figure 8.26

Percentage of estimated severely disabled population aged 80 and over in long-stay residential care and receiving very intense co-resident care from children, Britain, 1985-2000 (bar chart)

Percentage



Sources and notes: Table 8.24 above

Trends in receipt of care among the *non-disabled* population were very different (Table 8.27). Table 8.27 shows that, among non-disabled people aged 80 and over, there was little evidence of a consistent substitution relationship between long-stay residential care (including all forms of residential care) and very intense co-resident care from children between 1985 and 2000. Although there was some evidence of a negative relationship between all long-stay residential care and very intense co-resident care, this was not consistent throughout the whole period. In particular, between 1990 and 1995, very intense co-resident care from children fell, but all long-stay residential care also fell, so that there was no negative relationship between them (Table 8.27).

The lack of substitution between formal and informal care among non-disabled people arose primarily from the trends in *residential care homes*. Between 75 per cent and 85 per cent of all non-disabled people aged 80 and over in long-stay residential care were

in residential care homes, not nursing homes or hospitals (Table 8.27). It was therefore the trends in residential care homes that dominated the trends in long-stay residential care among the non-disabled. Thus, it was the proportion of non-disabled people in residential care homes that declined between 1990 and 1995, not the proportion in nursing homes/hospitals (Table 8.27). And it was this that meant that there was no consistent negative relationship between the long-stay residential care rate and the rate of receiving very intense co-resident care among the non-disabled older old population in the 1985/2000 period. Trends in receipt of care by non-disabled older old people therefore confirm findings, reported elsewhere in this chapter, showing that there was little evidence of substitution between residential care homes and very intense co-resident care from children between 1985 and 2000. This finding is discussed in the conclusions at the end of the chapter.

Table 8.27

People aged 80 and over <u>without severe personal care disability</u> receiving different types of long-stay residential care and intense/very intense co-resident care from children, Britain, 1985-2000

Estimated numbers in thousands and percentages

	Without severe disability	Long-stay residential care			Co-resident care from children	
		Residential care homes	Nursing homes/ hospitals	All in long-stay residential care	Intense	Very intense
Estimated numbers						
1985	1,305	95	20	115	50	35
1990	1,535	115	30	145	50	30
1995	1,745	115	40	155	50	20
2000	1,820	110	35	140	45	20
% of those without severe disability						
1985	*100*	*7.3*	*1.4*	*8.7*	*3.8*	*2.7*
1990	*100*	*7.6*	*1.9*	*9.4*	*3.4*	*1.9*
1995	*100*	*6.6*	*2.1*	*8.8*	*2.8*	*1.2*
2000	*100*	*5.9*	*1.9*	*7.8*	*2.4*	*1.2*

Sources/Notes: Numbers of people without a severe disability were estimated from information on disabled people aged 80 and over and all people aged 80 and over, given in Tables 8.5, 8.9, 8.21, 8.22 and 8.24. Numbers are rounded to nearest 5 thousand. Figures may not add exactly due to rounding.

Finally, can the evidence for the substitution relationship between very intense co-resident care from children and nursing home/hospital care among people aged 80 and over, shown in this chapter so far, be extended to include *intense* co-resident care (for 20 or more hours a week)? The answer seems negative, at least in terms of a direct relationship between intense care and different forms of long-stay residential care. Previous sections of this chapter have shown little evidence that trends in intense co-resident care by children were related to trends in long-stay residential care among either the 65-plus or the 80-plus populations (sections 8.3.1, 8.3.2). The evidence from the present section suggests that controlling for disability does not change these conclusions. Tables 8.24 and 8.27 show that the proportions of both severely disabled and non-disabled people aged 80 and over cared for intensely on a co-resident basis fell consistently between 1985 and 2000. This persistent decline in intense care continued into the late 1990s and it therefore coincided with declines in both long-stay residential care and nursing home/hospital care. In turn, this suggests that there was no consistent negative relationship between receipt of co-resident care for 20 hours a week or more and either long-stay residential care or nursing home/hospital care.

8.5 Discussion and Conclusions

The central finding of this chapter is that, within the context of a declining prevalence of severe disability in the older old population, between 1985 and 2000, there was evidence of *substitution* effects between very intense co-resident care by children and long-stay residential care. As care in nursing homes/hospitals rose in the late 1980s and early 1990s, very intense co-resident care by children fell. When care in nursing homes/hospitals began to fall in the late 1990s, very intense co-resident care by children began to rise.

It seems likely that the numbers of older old people cared for very intensely by co-resident children fell *because of* the rise in numbers in nursing homes/hospitals. The direction of causality is likely to have been from the rise in nursing home/hospital care to the fall in very intense co-resident care. This is because, as described in detail in Chapter Two, the rise in nursing home/hospital care can be attributed primarily to the changes in social policy that occurred during this period. It follows, therefore, that the fall in very intense co-resident care by children for their older parents between 1985 and

2000 can also be attributed to changes in social policy, mediated by their effect on the availability of nursing care in long-stay residential settings during this period.

The decline in prevalence of disability is important in understanding the relationship between very intense co-resident care by children and care in nursing homes/hospitals. The evidence presented in this chapter has suggested that around two-thirds or more of older people cared for very intensely on a co-resident basis by children and in nursing home/hospital care were severely disabled. What the evidence presented here suggests is that the declining prevalence of severe disability in the older old population during the period between 1985 and 2000 affected demand for care both at home and in nursing homes/hospitals. The decline in prevalence of disability during the period under consideration therefore accounts in part for the decline in co-resident care by children.

Data limitations have imposed certain assumptions on the analysis of disability in this chapter. In particular, the prevalence of severe disability between 1985 and 2000 in nursing homes and long-stay hospitals has been measured here using the rate for nursing homes reported in the 2000 HSE (Bajekal 2002). The rate for nursing homes in 2000 might, however, be considered too high for previous years, given evidence of rising disability rates in nursing homes in the late 1980s and 1990s (Darton *et al* 2003). However, one of the reasons that rates in nursing homes were rising during the late 1980s and 1990s was because, as Chapter Two showed, nursing homes were increasingly substituting for long-stay hospitals during this period. This process was, to a large extent, complete by 2000. By then, many older people, who might in the past have entered long-stay hospitals, were entering nursing homes instead. The 2000 rate for nursing homes is likely to reflect this and, for this reason, is likely to be a valid measure of the disability rate for nursing homes and hospitals in the late 1980s and 1990s.

This chapter has found little evidence of substitution between residential care homes and very intense co-resident care. A key reason underlying this is likely to be that the majority of older people in residential care homes did not have a severe disability. The evidence suggests, however, that the majority of older people cared for very intensely by their children did have a severe disability. This suggests that one reason why residential care homes did not substitute for very intense care is that they did not, on the whole, have the facilities to look after people with the severity of disability of those cared for very intensely by their children.

The evidence presented in this chapter therefore suggests that the relationship between very intense informal care and long-stay residential care was highly specific. It suggests that there was a negative relationship between *very intense care on a co-resident basis* received by older people from their children and *care in nursing homes or long-stay hospitals*. Given this specificity, it is important to consider further the reasons why a relationship might have existed between these two forms of care in particular.

The connection between very intense co-resident care and nursing home/hospital care is likely to be the intensity and type of care offered in both settings. Both co-resident care by children and long-stay residential care potentially provide 24-hour support at a high level of intensity. Very intense care received by older people at home from their co-resident children amounted, at a minimum, to 50 hours a week, while nursing homes and hospitals provide the most intense form of formal services available to older people. What distinguishes nursing homes and hospitals from other long-stay residential care homes, however, is the availability of *nursing care* (Darton *et al* 2005). If nursing homes offer essentially nursing care, was this also a feature of the very intense co-resident care received by older people from their children? The GHS data, analysed in Chapter Six, showed that the majority of those providing co-resident care for 50 hours a week or more to parents were providing personal care. The GHS coding and editing notes make it clear that personal care could include nursing care. The notes for 1990/91, for example, describe personal care tasks in terms of the following examples: "getting into a bath; cutting hair; *nursing care*; pump his back to get phlegm up; dealing with incontinence; physiotherapy" (OPCS 1991: 393, emphasis added). Therefore, very intense co-resident care is a form of care that potentially included nursing care.

The idea that very intense co-resident care might substitute for nursing home or hospital care is also supported by a qualitative study of daughters caring for mothers on a co-resident basis, which was carried out in the mid-1980s in Britain (Lewis & Meredith 1988). The authors found that residential care homes did not cater for the needs of the older people cared for by the daughters at home. As the authors explained, "One of the main problems posed by residential care for carers and persons cared for in this study was that it did not normally provide *nursing care*, nor did it accept people who could not care for themselves, such as those with senile dementia. Some of our carers had unsuccessful experiences with residential homes for this reason. The alternative for our carers considering institutional care for their mothers thus became focused on nursing

homes or hospitals." (Lewis & Meredith 1988: 187, emphasis added). However, the authors also found that long-stay hospitals were not generally considered suitable alternatives to care at home by the carers in the study: "Much hospital geriatric care is provided in large, old-fashioned wards in former, or partly run-down psychiatric hospitals. However high the quality of care, the surroundings are often depressing for patients and relatives alike." (Lewis & Meredith 1988: 187). Moreover, the authors found that, at the time, the availability of nursing home care was limited: "Difficulties in finding the 'right' place, and variations in the quality of care provided caused problems for our respondents who chose to seek this form of care (private and voluntary nursing homes) rather than use hospital-based geriatric care." (Lewis & Meredith 1988: 188). Lewis and Meredith's study was undertaken just before the rapid rise in nursing home places which, as Chapter Two earlier showed, took place between the mid-1980s and the mid-1990s. The rise in nursing homes at this time would have been capable of meeting the needs for long-stay residential care of severely disabled older people cared for by their children at home, which Lewis & Meredith's study suggest had previously been unmet.

The idea that the rise in nursing home care met previously-unmet needs for formal care by older people cared for very intensely by children at home may also be supported by another piece of evidence. This is the study of admissions to long-stay residential care carried out in the mid-1990s by the PSSRU (Darton *et al* 2005). As mentioned at the end of Chapter Seven, the authors of the study found that single older people living with others were at comparatively high risk of needing a care home place and indeed this risk at that time was greater than the risk for people living alone (Darton *et al* 2005). A similar study carried out ten years later by the same authors found that this had changed and that now the risk of entering a care home was greater for people living alone. Single older people sharing a household would include older people living in the same households as their children. The PSSRU studies would therefore be consistent with the evidence in the present study, suggesting that older people co-resident with their children (and receiving very intense care) might have been particularly likely to enter long-stay residential care (including nursing homes) in the mid-1990s, but that this may subsequently have changed.

The substitution effects observed in the present study relate specifically to the most intense forms of informal care, that is, care provided on a co-resident basis for 50 or

more hours a week. Nevertheless, the trends in very intense care are also likely to have had a wider impact on trends in intense co-resident care for 20 or more hours a week. To the extent that much intense co-resident care was in fact very intense care, then the trends in intense care were clearly affected by the trends in very intense care. The downward trend in very intense care, associated with the increase in nursing home/hospital care, is therefore likely to have contributed to the downward trend in intense co-resident care by children between 1985 and 1995. The downward trend in intense co-resident care during this period is an important social observation. It differentiated the trend in intense co-resident care from the upward trend in intense extra-resident care and accounts for the overall stability in provision of care for 20 or more hours a week in this period. What the evidence presented here suggests is that the rise in nursing home/hospital care in the late 1980s and early 1990s led to a decline in very intense co-resident care by children, which in turn contributed to the decline in intense co-resident care by children during this time.

Nevertheless, what is also clear from the evidence presented in this chapter is that the trends in very intense care were not the only factors affecting trends in intense co-resident care for older people, even controlling for older age and severe disability. It is likely that an important factor affecting intense co-resident care between 1985 and 2000 was the long-term decline in co-residence of older people with their children, (Grundy 1995, 1996a, 2008). This trend has been associated with such factors as increasing home ownership among more recent cohorts of older people, compared with earlier cohorts (Askham *et al* 1999; Disney *et al* 1997; Hirst 2001). It is consistent with other evidence presented in this study, including the upward trend in intense extra-resident care. What is important in the present context, however, is that, while the long-term decline in co-residence may help to explain the persistent downward trend in intense co-resident care between 1985 and 2000, it did not prevent an increase in very intense co-resident care between 1995 and 2000. And this may have implications for future trends in very long hours of co-resident care, to be discussed in the concluding chapter.

The trends in neither very intense nor intense co-resident care are likely to have been directly affected by the increase in intensive home care services, which followed the community care changes of the early 1990s. As Chapter Two showed, the increase in intensive home care did not begin to take effect until the middle of the 1990s. Enhanced home care services were therefore likely to have offered a substitute for very

intense or intense co-resident care only in the period between 1995 and 2000. With regard to very intense care, however, it was precisely during this time that care was no longer declining but had in fact begun to increase. And with regard to intense co-resident care, a direct effect of home care services seems unlikely since, as Chapter Two observed, these services tend to be directed at those living alone rather than with others (Evandrou 2005). An indirect effect of intensive home care services on co-resident care is possible, via an impact on the tendency of disabled older people to co-reside with their children, which, if it occurred, might have reinforced a tendency towards residential independence among older people. It is, however, beyond the scope of this study to examine the potential impact of intensive home care services on the living arrangements of older people.

Finally, it should be noted that the conclusions of the present study are reinforced by the wider international literature. As indicated in Chapter One, there is an extensive body of literature in the United States showing a negative association between informal care and nursing home use (Hanley *et al* 1990; Jette *et al* 1995; Lo Sasso & Johnson 2002; Charles and Sevak 2005; Van Houtven & Norton 2004, 2008). Some of these studies, such as those by Jette *et al* and Lo Sasso & Johnson, have looked specifically at the impact of informal care provided by children on nursing home use, and in one case has looked at the impact of co-resident care by children (Jette *et al* 1995). These studies have, however, been concerned with the impact of informal care on nursing home use. The present study has not just extended the analysis to Britain in the 1980s and 1990s, but examined the relationship from a different perspective and identified an impact of nursing home/hospital care on provision of very intense informal care by children.

Appendices to Chapter 8

Appendix 8A

Numbers of Older People in Long-Stay Residential Care, by Age, Gender and Type of Home

Table 8A.1

Numbers of people aged 65 and over in residential care homes, nursing homes and long-stay hospitals, by age and gender, Britain, 1985-2000

Numbers in thousands

	Care Homes		Nursing Homes		Hospital		Total		Total
	men	women	men	women	men	women	men	women	
1985									
65-69	5	5	<5	<5	5	5	10	10	20
70-74	5	10	<5	<5	5	5	15	15	30
75-79	10	20	<5	5	5	10	15	35	50
80-84	15	40	<5	5	5	15	20	65	85
85+	15	90	<5	15	5	20	25	125	150
Total	50	170	5	30	25	55	80	250	335
1990	5	5	<5	5	<5	5	10	15	25
65-69	10	10	5	5	5	5	15	20	35
70-74	10	25	5	10	5	5	20	45	60
75-79	15	50	5	20	5	10	25	85	110
80-84	20	110	5	45	<5	10	30	165	195
85+	60	205	25	80	15	35	100	325	425
Total									
1995									
65-69	5	10	5	5	<5	<5	15	15	30
70-74	5	10	5	5	<5	<5	15	15	30
75-79	10	25	10	15	<5	5	20	50	65
80-84	15	45	10	30	<5	5	25	80	105
85+	25	115	15	65	<5	10	40	190	230
Total	60	200	40	125	10	20	110	345	455
2000									
65-69	5	5	5	5	<5	<5	10	15	20
70-74	5	5	5	5	<5	<5	10	15	25
75-79	10	20	10	15	<5	<5	20	40	55
80-84	10	35	10	25	<5	<5	20	60	80
85+	25	115	15	70	<5	<5	40	185	225
Total	55	180	40	120	5	10	100	310	410

Sources: Table 8.1 and Sample of Anonymised Records (SARs) drawn from 1991 and 2001 Census

Note: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding.

Appendix 8B

Sensitivity Analysis around Numbers of Severely Disabled Older People in Long-Stay Residential Care

A key assumption utilised in this chapter is that there was no change between 1985 and 2000 in the proportion of severely disabled people aged 80 and over in long-stay residential care. The assumption of unchanging disability rates in long-stay residential care over time is a strong one and is made here because of a lack of consistent data on the prevalence of disability in long-stay residential care facilities over time. Because of the lack of data, the assumption of unchanging disability in long-stay residential care has been made in other studies in Britain, for example, by Bebbington and Darton (1996).

In order to test the assumption of constant disability rates, *sensitivity analysis* around the numbers of severely disabled older people in long-stay residential care was undertaken. The estimates given in Table 8.24 of this chapter suggested that there were, in 1985, around 115 thousand severely disabled people aged 80 and over in long-stay residential care in Britain. Sensitivity analysis explored the results if the numbers were substantially greater or less than this estimate. It was assumed that the numbers in long-stay residential care in 1985 were 20 thousand greater or less than 115 thousand. A figure of 20,000 was adopted because it encompassed a 1 per cent increase or decrease in numbers over a fifteen-year period, and 1 per cent has been used elsewhere to test the sensitivity of changes in the numbers of older people over time (Wittenberg *et al* 2001). Since approximately half of severely disabled people in long-stay residential care were in residential care homes and half in nursing homes/hospitals in 1985, the assumption was made that there were 10,000 fewer disabled older people in both residential care homes and nursing homes/hospitals. The results are shown in Table 8B.1.

Table 8B.1

Sensitivity analysis around people aged 80 and over with severe personal care disability receiving long-stay residential care, Britain, 1985-2000

Estimated numbers in thousands and percentages

	Estimated numbers with severe disability in:			Percentage of estimated severely disabled people:			
	Households	Long-stay residential care	Total	in long-stay residential care		receiving co-resident care from children	
				Residential	Nursing/ hospital	Intense	Very intense
1985 (low)	*340*	*95*	*435*	*12.8*	*9.4*	*16.6*	*14.4*
1985 (point)	340	115	455	14.5	11.2	15.9	13.8
1985 (high)	*340*	*135*	*475*	*15.9*	*12.8*	*15.2*	*13.2*
1990	345	160	500	15.9	15.5	15.2	10.3
1995	340	180	520	15.3	19.2	13.6	6.9
2000	330	165	495	15.0	18.5	13.0	7.7

Sources: Tables 21-23 above
Notes: Numbers are rounded to nearest 5,000. Figures may not add exactly due to rounding; The 1985 'low' estimate assumes that numbers of severely disabled people in residential care homes and nursing homes/hospitals were each 10,000 lower in 1985, while the 'high' estimate assumes that they were each 10,000 higher in 1985.

The results show that, even allowing for substantially higher or lower estimates of severely disabled older old people in long-stay residential care in 1985, the probability of being cared for either on a very intense co-resident basis or in a nursing home/hospital was between 24 per cent and 26 per cent between 1985 and 2000 (23.8 – 26.2 per cent), that is, the probability was 25 per cent, plus or minus around one per cent. The sensitivity analysis does not, therefore, substantially alter the findings illustrated in Figure 8.25 of this chapter.

The results in the table above also show that, even allowing for substantially higher or lower estimates of severely disabled older old people in long-stay residential care in 1985, the probability of being cared for on a very intense co-resident basis, in a nursing home/hospital or in a residential care home was between 37 per cent and 42 per cent between 1985 and 2000 (36.6 – 42.0 per cent), that is, the probability was 40 per cent plus or minus around three per cent. The sensitivity analysis does not, therefore, substantially alter the findings illustrated in Figure 8.26 of this chapter.

Appendix 8C

Receipt of care by severely disabled people aged 80 and over

Table 8C.1

Estimated severely disabled population aged 80 and over in long-stay residential care and receiving very intense co-resident care from children, expressed as a percentage of all people aged 80 and over, Britain, 1985-2000

Estimated numbers and percentages

	Numbers aged 80 and over				*Percentage in nursing home/hospital or receiving very intense co-resident care (%)*
	Severely disabled			Total aged 80 and over	
	(a) In nursing home/hospital	(b) Receiving very intense co-resident care	(a) + (b)		
1985	50	65	115	1,765	*6.45*
1990	80	50	130	2,035	*6.36*
1995	100	35	135	2,265	*6.04*
2000	90	40	130	2,315	*5.61*

Source: Tables 8.4, 8.22, 8.24

Chapter 9

Conclusions and Implications for Social Policy

9.1 Substitution Of Long-Stay Residential Care For Intergenerational Care

This study has been concerned with the issue of substitution between formal and informal care in Britain between 1985 and 2000. The issue of substitution is of great importance to social policy in this country at the present time. There is currently a debate on the long-term care system for older people in England, which has recently intensified in response to the publication in July 2009 of the government's Green Paper on the future of social care (HMG 2009). However, the options being considered in the current debate on long-term care seem constrained by lack of evidence about substitution. On the one hand, proposals to substitute formal for informal care, such as those put forward in the Wanless review, have been undermined by lack of information about substitution and, indeed, a view that substitution does not in fact occur (Wanless 2006: 151, 188). On the other hand, the options put forward in the Green Paper seem constrained by fears that increases in state-funded care and support will lead to the complete replacement of family care (HMG 2009: 119). The present study therefore provides much-needed evidence about substitution that is relevant to the current debate on long-term care for older people.

The study has focused on the period of the late 1980s and early 1990s in Britain because, as stated early on, this provides the conditions for a 'natural experiment' in social policy (Chapter One). During the 1980s and early 1990s, there was a rapid increase in long-stay residential care for older people, which came to an end around the mid-1990s. Arising from this 'natural' policy experiment, the key questions that have been examined in this study are as follows: **(1) Controlling for relevant factors, during the 1980s and early 1990s in Britain, did increased use of long-stay residential care by older people lead to a reduction in intense intergenerational care for older people? (2) Controlling for relevant factors, from the mid-1990s onwards in Britain, did reduced use of long-stay residential care by older people lead to an increase in intense intergenerational care for older people?**

The first part of these conclusions summarises the evidence from the study relating to each of these two hypotheses, in the context of the international literature on the substitution issue. The second part of the conclusions then examines some important limitations to the substitution relationship identified here. The third and fourth parts of the chapter draw out the implications of the results for social policy relating to informal care provision and the long-term care system for older people. The final part briefly identifies further research.

9.1.1 Substitution of Long-stay Residential Care for Intense Intergenerational Care

The international literature suggests that there is only limited substitution of formal for informal care (Chapter One). As just noted, this has led to assertions in the British literature to the effect that "increases in mainstream formal services to older people appear to have little impact on how much informal care is provided" (Beesley 2006: 28). However, previous studies have tended to focus on domiciliary care and the impact of changes in long-stay residential care on informal care has received much less attention. It is here, however, that the experience of Britain in the late 1980s and 1990s is of such importance in providing a 'natural social policy experiment'.

During the late 1980s and early 1990s, there was a marked rise in long-stay residential care in Britain, which has been documented in many previous studies (Chapter One) and which was described here in Chapters Two and Eight. The rise in long-stay residential care during the 1980s was a largely unintended consequence of changes in the rules governing social security payments to people in private care homes (Chapter Two). The increase in long-stay residential care in turn led to the introduction of the *NHS and Community Care Act* in 1990, which led to a fall in the number of places in long-stay residential care during the 1990s (Chapter Two). Long-stay residential care in Britain is not, however, a uniform sector and is comprised of two main forms of care services: residential care homes and nursing homes/long-stay hospitals (Chapter Two). These two forms of care followed somewhat different trajectories in the early 1990s. While the availability of residential care homes declined after 1990, the nursing home/hospital sector continued to grow until the mid-1990s (Chapters Two and Eight)[1].

[1] Nursing homes and hospitals are considered together here because nursing homes were increasingly treated as an alternative to long-stay hospitals in the 1980s and 1990s (Chapter Two). Numbers in long-stay hospitals were in fact falling throughout the period between 1985 and 2000, but numbers in nursing homes more than compensated for this in the late 1980s and early 1990s, leading to an increase in the 'nursing home/hospital sector' between 1985 and 1995, which only came to an end in the late 1990s (Chapter Eight).

It is with the increase in nursing homes/hospitals that, this study has found, there was a substitution relationship with informal care. As the numbers of older people in nursing homes or hospitals rose in Britain in the late 1980s and early 1990s, so there was a fall in very intense co-resident care (provided for 50 hours a week or more) for older parents (Chapter Eight). Between 1985 and 1995, the numbers of people in nursing homes or hospitals in Britain rose from approximately 115,000 to 200,000 (Chapter Eight). At the same time, the numbers of older people receiving very intense co-resident care from their children fell by around a half, from approximately 125,000 in 1985 to 65,000 in 1995 (Chapter Eight). Correspondingly, the numbers of people providing very intense co-resident care for their parents fell by over half between 1985 and 1995, reducing from approximately 160,000 in 1985 to 70,000 in 1995 (Chapter Four).

The substitution relationship, identified in this study, varied for different types of service. As hypothesised at the beginning of the study (Chapter One), facilities offering greater amounts of care substituted for intergenerational care of greater intensity, and it was nursing homes/hospitals that substituted for co-resident care for 50 hours a week or more. In addition, key factors affecting the substitution relationship between nursing home/hospital care and very intense co-resident care from children were the age (a pre-disposing factor) and severity of disability (a need-related factor) of the older people (cf. Andersen 1968). The majority of those in nursing homes or hospitals and the majority of those receiving very intense co-resident care from children were older old people aged 80 and over (Chapters Six and Seven). The majority were also ADL-disabled in that they were unable to perform one or more personal care tasks without help (Chapters Seven and Eight). The substitution relationship between those in nursing homes/hospitals and those receiving very intense co-resident care from children was therefore also affected by the decline in the prevalence of ADL-disability among older old people during the 1980s and 1990s (Chapters Two and Eight). It has been estimated here that approximately 25 per cent of people aged 80 and over with an ADL-disability received either nursing home/hospital care or very intense co-resident care from children during the period between 1985 and 1995. During this period, however, the proportion receiving nursing home/hospital care rose from approximately 11 per cent to 19 per cent, while the proportion receiving very intense co-resident care fell from approximately 14 per cent to 7 per cent (Chapter Eight).

The central hypotheses of this study did not just imply a negative relationship between formal and informal care, but a *causal* relationship. The first hypothesis anticipated that it was increases in long-stay residential care that would lead to reductions in intense intergenerational care. Two types of evidence have been identified in this study to suggest that the causal direction flowed from the rise in long-stay residential care to the fall in intergenerational care in Britain in the 1985/95 period. First, as Chapter Two described in detail, the rise in provision of long-stay residential services between 1985 and 1995 in Britain can be attributed primarily to changes in social policy. Second, the study has failed to identify any other consistent explanation for the decline in provision of very intense co-resident care for parents between 1985 and 1995. A number of potential explanations were explored systematically in the study, including an alternative substitution hypothesis in terms of a rise in extra-resident care for parents (Chapter Three), supply-side explanations in terms of the rise in the proportion of potential care-givers with educational qualifications[1] (Chapter Four) and the rise in employment rates of mid-life women (Chapter Five) and an alternative demand-side explanation in terms of the rise in provision of care to spouses (Chapter Six), but all were unsatisfactory. Indeed, of the potential explanations for a decline in informal care, identified early on in the study (Chapter Two, Table 2.20), only the increase in long-stay residential care, in the context of a decline in the prevalence of disability, has been found to have played a part in the decline in provision of very intense care for co-resident parents between 1985 and 1995.

The substitution of nursing home/hospital care for very intense intergenerational care, identified in this study, has not before been identified in the British literature relating to the 1980s and early 1990s. As Chapter One observed, some analysts thought that the growth of long-stay residential care in Britain was unlikely to have affected informal care. Parker (1998), for example, argued that the rise in numbers of older people in long-stay residential care between 1981 and 1991 would have been too small to affect demand for care for older people in private households. However, the present study has found that there was a surprisingly close correspondence between the rise in numbers in nursing homes/hospitals and the decline in numbers receiving very intense co-resident care. Thus, between 1985 and 1995, numbers of older people in nursing

[1] People with educational qualifications were significantly less likely to provide very intense co-resident care to older parents (Chapter Three). Therefore, the rise in the proportion of potential care-givers with educational qualifications could have contributed to the decline in very intense co-resident care. However, trends in education seem to have contributed little to the decline in numbers providing very intense care (Chapter Four).

homes/hospitals rose by around 85,000, while numbers receiving very intense co-resident care fell by around 60,000 (Chapter Eight). Moreover, although these numbers may appear relatively small, the older people affected nevertheless represented a substantial minority of those who were oldest and most frail. In 1985, around 10 per cent of people aged 80 and over with an ADL-disability received nursing home/hospital care and nearly 15 per cent received co-resident care from children for 50 hours a week or more. Over the next decade these proportions changed, as the proportion in nursing homes/hospitals rose, while the proportion receiving very intense co-resident care from children fell. By 1995, nearly 20 per cent of older old people with a severe disability received nursing home/hospital care and around 5 per cent received very intense co-resident care from children (Chapter Eight).

Even where a potential substitution relationship has been hypothesised in Britain, the precise nature and form of this relationship has not before been identified. As observed in Chapter One, previous research by Grundy and colleagues has suggested that the increase in long-term care places during the 1980s may have brought about "some substitution of institutional for family care" (Grundy 1996a, 1996b; Grundy and Glaser 1997). However, Grundy and colleagues were unable to identify more precisely the amount or type of family care that might have been substituted, partly because their analysis measured family care in terms of a proxy variable, living arrangements, rather than directly through the intensity of informal care. Moreover, Grundy and colleagues treated 'institutional' care as a homogenous form of care and therefore were unable to identify the relationship between the rise in the availability of nursing homes/hospitals and the decline in provision of informal care. Finally, the longer intervals between data capture points meant that the changes in both long-stay residential care and informal care during the 1990s, which Grundy (2008) subsequently examined, were not apparent. For all these reasons, the substitution relationship between nursing homes/hospitals and very intense intergenerational care in Britain between 1985 and 1995 was not identified in Grundy's research.

Yet, the identification of this substitution relationship in Britain in the 1985/95 period is of great importance for the international literature on substitution. It is important because it suggests that, contrary to the findings of most existing studies, an increase in formal services to older people has, under certain circumstances, a considerable impact on how much informal care is provided.

The key reason for the difference between the findings of the present study and those of previous studies is likely to be the *form* of the services that have been examined. The present study has examined the impact of long-stay residential care on informal care whereas, as Chapter One showed, the existing literature on substitution has tended to focus almost exclusively on the impact of domiciliary services on informal care. As the author of a rare study examining the impact of residential care on informal care has put it, "Research on family care has traditionally focused on the community care setting, stopping at the doors of the institution" (Lingsom 1997: 251). However, where studies have not stopped at 'the doors of the institution', their results seem consistent with that of the present study. Thus, Lingsom examined the impact of the expansion of the welfare state in Norway on the provision of family care, exploring whether public services (including both community and residential care services) reduced family care obligations (Lingsom 1997). Although Lingsom's overall conclusion was that there was "no net transfer of care obligations from families to the welfare state" in Norway between 1960s and the 1990s, her findings are much more mixed than those focusing only on community settings (Lingsom 1997: 251-2). Indeed, in relation to the effects of 'institutionalisation' on care provided by the children of older people, Lingsom finds some support for substitution theory (Lingsom 1997: 236, 251). Lingsom's findings show that "children provide significantly less help when parents are in institutional care than when dependent parents live in the community…." and suggested that this "would be predicted by substitution theory" (Lingsom 1997: 232, 236).

Moreover, although the international literature has not focused to any great extent on the substitution of long-stay residential care for informal care, as Chapter One noted, there is considerable evidence that informal care substitutes for long-stay residential care (Hanley *et al* 1990, Jette *et al* 1995, Lo Sasso & Johnson 2002, Charles and Sevak 2005, Van Houtven & Norton 2004, 2008). Indeed, as Chapter Eight concluded, some of this literature seems particularly consistent with the findings of the present study, in that it suggests that the provision of intense informal care by children reduces older people's use of nursing homes specifically (Jette *et al* 1995, Lo Sasso & Johnson 2002). Given this relationship, it is not surprising that the relationship also operates in the opposite direction. In other words, it is not surprising to find that increases in the availability of nursing homes/hospitals reduce the provision of intense intergenerational care.

9.1.2 Substitution of Intense Intergenerational Care for Long-stay Residential Care

As the end of the previous section observed, the existing international literature suggests that informal care substitutes for formal care. One strand of this literature (as Chapter One noted) is made up of recent studies in Europe showing that, as public provision of welfare for older people has been reduced in recent years, so informal care has increased (Johansson *et al* 2003; Patsios 2008). One study in Sweden describes this as a 'reverse' substitution (Johansson *et al* 2003: 269). The second hypothesis that has been examined in the present study addresses the issue of a 'reverse' substitution in Britain in the late 1990s. As noted at the beginning of the chapter, the present study has asked whether, controlling for relevant factors, from the mid-1990s onwards in Britain, reduced use of long-stay residential care by older people led to an increase in intense intergenerational care for older people.

The results of the present study support the 'reverse' substitution hypothesis. Specifically, the study has found that, when numbers in nursing homes/hospitals began to fall in the late 1990s, very intense co-resident care by adult children began to rise. Between 1995 and 2000, the numbers of older people in nursing homes and hospitals fell from around 200,000 to around 175,000 (Chapter Eight). At the same time, the numbers of older people receiving very intense co-resident care from their children began to rise, increasing from approximately 65,000 in 1995 to 85,000 in 2000. Correspondingly, the numbers of people providing very intense co-resident care for their parents began to increase in the late 1990s, from approximately 70,000 in 1995 to 90,000 in 2000 (Chapter Four).

The 'reverse' substitution of informal for formal care in Britain between 1995 and 2000 took place under specific conditions. As with the substitution relationship, discussed in the previous section, the 'reverse' substitution varied for different types of service/care. It was again specifically very intense co-resident intergenerational care that substituted for nursing homes/hospitals (Chapter Eight) and again the key factors affecting the 'reverse' substitution were the age and disability of the older people (Chapter Eight). Furthermore, the evidence suggests that the relationship was a causal one, in which causation flowed from the decline in nursing homes/hospitals to the increase in very intense co-resident care. Thus, the decline in the availability of nursing homes/hospitals, which occurred in the 1995/2000 period, can be linked to the eventual implementation of the *NHS and Community Care Act*. As Chapter Two showed, partly

for political reasons, the community care changes were not finally implemented until 1993 and even then, until the mid-1990s, the reforms were buffered by special transitional arrangements. Numbers in nursing homes/hospitals peaked in around 1997 and did not start to fall until the late 1990s (Chapter Two). Moreover, further evidence for the direction of causation flowing from the changes in formal services to the changes in informal care comes from the absence of alternative explanations for the rise in very intense co-resident care for older parents between 1995 and 2000. Indeed, the only other potential explanations for an increase in informal care provision at this time, set out in Chapter Two (Table 2.20), were supply-side explanations in terms of trends in the numbers and marital status of potential care-givers, and these were found to be unsatisfactory in Chapter Four.

The 'reverse' substitution of family care for long-stay residential care in Britain during the late 1990s, identified in the present study, has not before been identified. The only other study to have considered a similar issue is the recent work by Grundy (2008), who has examined the potential impact of the decline in long-stay residential care in the period between 1991 and 2001 on the living arrangements of older people in England and Wales. If there had been a 'reverse' substitution of formal for informal care, it might have been expected that the decline in long-stay residential care in the 1990s would have led to an increase in co-residence of older people with their families. However, as observed in Chapter One, Grundy found no evidence of this. Rather, Grundy found that the "chances of living with relatives rather than alone or in an institution were lower in 1991-2001 than in the previous decade" (Grundy 2008: 9). The difference between Grundy's conclusion and that of the present study, however, is likely to have arisen from methodological differences. In particular, as already noted in these conclusions, Grundy measures the extent of family care by a proxy variable, the living arrangements of older people. Yet this indicator is unlikely to be sufficiently precise to identify the changes in intense and very intense co-resident care for older parents that have been described in the present study. In particular, the present study has shown that, among the oldest and most frail, very intense co-resident care for parents (provided for 50 hours a week or more) increased between 1995 and 2000, yet intense co-resident care (provided for 20 hours a week or more) declined (Chapter Eight). The implications of these trends in intense co-resident care will be discussed in the next section. The important point in the present context is that trends in the intensity of co-resident care may not necessarily follow trends in living arrangements.

The finding of the present study that the decrease in long-stay residential care in the late 1990s in Britain led to an increase in informal care seems consistent with wider international evidence, but also represents an important new departure from it.. The 'reverse' substitution identified in the present study is consistent with the existing international literature, which shows that reductions in welfare provision for older people in recent years have led to increases in informal care (Johansson *et al* 2003; Patsios 2008). However, the existing studies showing a 'reverse' substitution have been concerned with domiciliary care. Thus, Patsios (2008) uses GHS data in Britain between 1980 and 2001 to examine the relationship between formal and informal care for disabled older people living at home, showing that "receipt of informal care to meet functional limitations need increased over the period of investigation to compensate for a sizeable decline in receipt of formal services" (Patsios 2008:1). Johansson and colleagues (2003) address a similar issue in Sweden and identify a "rise in family support that 'matches' the decline in statutory service home help provision between 1994 and 2000" (Johansson *et al* 2003: 272). However, to the author's knowledge, there have been no previous studies showing a 'reverse' substitution between long-stay residential care and informal care. In other words, this is the first time that it has been demonstrated that a decline in long-stay residential care for older people has resulted in an increase in informal care.

Yet, the results of the present study appear consistent with the wider substitution literature, which takes as its central problematic the effects that provision of informal care have on receipt of long-stay residential care. As the concluding paragraph of the previous section observed, this literature shows that increased provision of informal care reduces the use of long-stay residential care (Hanley *et al* 1990, Jette *et al* 1995, Lo Sasso & Johnson 2002, Charles and Sevak 2005, Van Houtven & Norton 2004, 2008). Given this well-established substitution relationship, it is not surprising to find that it also operates in the opposite direction. In other words, it is not surprising to find that reductions in provision of long-stay residential care increase the use of informal care. However, what the present study has added to this literature, by viewing the relationship from a different perspective, is an understanding of the nature of the informal care that increases if long-stay residential care declines, showing specifically that, when nursing homes/hospitals declined in Britain at the end of the 1990s, it was very intense co-resident care for older parents that increased.

9.2 Limitations to Substitution of Residential Care for Intergenerational Care

This part of the chapter examines two important limitations to the substitution relationships identified in this study. The first concerns the limitation of substitution to the most intense forms of co-resident intergenerational care provided for 50 hours a week or more. The second concerns a possible limitation of substitution to intergenerational care. These limitations are important because they suggest that the applicability of substitution to other caring relationships may be limited and that, for example, an expansion of formal services is unlikely to lead to a substitution of all forms of intense informal care for older people. This point will be taken up again later in the chapter, when the policy implications of the present study are explored.

9.2.1 Limitation of Substitution to Very Intense Co-Resident Care for Parents

The substitution effects observed in the present study relate specifically to the most intense forms of intergenerational care for older people, that is, care provided on a co-resident basis for 50 or more hours a week. There was less evidence of substitution effects in relation to intense co-resident care provided for 20 hours a week or more to older parents, and no evidence of substitution effects in relation to intense extra-resident care.

Thus, there was no consistent negative relationship between *intense co-resident care for parents provided for 20 hours a week or more* and either care in long-stay residential homes or nursing home/hospital care (Chapter Eight). Indeed, controlling for age and disability, there was a persistent downward trend in intense co-resident care between 1985 and 2000, which matched the trends in availability of neither residential care homes nor nursing homes/hospitals (Chapter Eight). Other potential explanations for the trends in intense co-resident care, identified in Chapter Two (Table 2.20), including a supply-side explanation in terms of trends in education (explored in Chapter Four) and a demand-side explanation in terms of trends in provision of care to spouses (explored in Chapter Six) were also unsatisfactory.

The conclusions to Chapter Eight nevertheless pointed to some possible reasons for the trends in intense co-resident care for parents between 1985 and 2000. It was suggested that, controlling for age and disability, the downward trend in receipt of intense co-resident care from children between 1985 and 1995 may have been due in part to the

indirect effect of the downward trend in very intense care, which was in turn associated with the increase in nursing home/hospital care. In addition, it was suggested that there might have been an indirect effect of intense home care services on co-resident care in the period between 1995 and 2000. The increased availability of home care services to the most disabled older people at this time might have enabled some disabled older people to retain their residential independence for longer and this might have reduced demand for intense co-resident care from children. Although it was not possible to explore this hypothesis further in the present study, it does suggest that the absence of substitution effects between intense co-resident care and long-stay residential care might have been due to the greater availability of alternative sources of care at relatively lower levels of intensity. In turn, this highlights a key conclusion of the present study, namely, that changes in availability of long-stay residential care affected provision of very intense, but not intense, co-resident care for older parents.

In addition, the substitution effects observed in the present study did not extend to care provided on an *extra-resident basis* which, as Chapter Three showed, tended to take the form of relatively less intense care provided for 20 hours a week or more. There was no evidence of a decline in extra-resident care during the time that long-stay residential care was increasing between 1985 and 1995. Indeed, intense extra-resident care for older parents increased at this time, before levelling off between 1995 and 2000 (Chapter Three). Supply-side explanations of the trends in intense extra-resident care, including explanations in terms of the numbers and marital status of potential care-givers, which were set out in Chapter Two (Table 2.20) and explored in Chapter Four, were unsatisfactory.

Indeed, the explanation for the rise in intense extra-resident care for older parents that seems most plausible is a demand-side explanation, set out in Chapter Two (Table 2.20) in terms of the rise in the numbers of older old people between 1985 and 2000. As Chapter Six showed, the majority of people providing care to an older parent in another household did so to an older person aged 80 and over. Moreover, it was observed in Chapters Two and Three that the trends in intense extra-resident care for older parents showed a very similar pattern to the trends in the numbers of people aged 80 and over. Previous studies have certainly approached the analysis of trends in informal care provision in the recent past with the expectation that care for parents would have increased due to the rise in numbers of older people (Hirst 2001, Evandrou and Glaser 2002). Demographic trends also suggest that the proportion of people in mid-life with

living parents would have been increasing between 1985 and 2000 (Murphy and Grundy 2003). It therefore seems plausible to conclude that the numbers of people providing intense extra-resident care to older parents in Britain between 1985 and 2000 changed in response to changes in demand for care from older old people. The rise in demand for intense extra-resident care from older old people did not, on the other hand, translate into increased demand for *very intense co-resident care* because demand for care at this intensity in private households was reduced by the increased availability of nursing home/hospital places for disabled older old people (Chapter Eight).

The evidence therefore suggests that the substitution relationships identified in this study did not affect all forms of intense intergenerational care, but only *its most intense forms.* This is important because it suggests that the impact of these substitution relationships is likely to be limited to certain forms of care for older people. This point potentially has important policy implications, explored later in the chapter.

9.2.2 Limitation of Substitution to Intergenerational Care?

The focus of the present study on trends in intense intergenerational care for older people arose partly because the literature suggested that substitution was likely to have been particularly relevant to this form of care (Chapter One). However, in the course of the present study, trends in the other main form of intense informal care for older people, spouse care, have also been examined (Chapter Six). The purpose of the analysis of trends in care for spouses in Chapter Six was primarily to ascertain whether spouse care might have substituted for care for parents and, as Chapter Six concluded, this was unlikely to have been the case. Nevertheless, the results of Chapter Six also suggest further implications for the relationship between formal and informal care. The analysis in the present study showed that trends in the provision of spouse care were very different from trends in the provision of intergenerational care in Britain between 1985 and 2000. In particular, very intense co-resident care for older parents declined significantly between 1985 and 1995, but there was no such decline in very intense care for older spouses (Chapter Six). The implication of this finding is that, if very intense intergenerational care declined because of the increase in nursing homes/hospital care, but very intense spouse care did not also decline, then this suggests that the expansion of long-stay residential care did not affect all forms of informal care, and in particular, did not affect spouse care.

These results may then suggest a further boundary to the impact of, in particular, an expansion of formal services on informal care. They suggest that the expansion of long-stay residential care between 1985 and 1995 replaced very intense co-resident care for parents but not this type of care for spouses. This conclusion is consistent with extensive national and international evidence suggesting that older people with spouses are significantly less likely than those without spouses to enter long-stay residential care (Wiener *et al* 1994; Mustard *et al* 1999; Darton *et al* 2005; Grundy and Jitlal 2007; Sarma and Simpson 2007).

The results of the present study suggest a number of reasons why the impact of the expansion of services might have been restricted primarily to intergenerational care. The first reason is familiar from the literature reviewed in Chapter One. This suggested that substitution of formal for informal care might be particularly relevant to people providing intergenerational care partly because most intergenerational carers of older people are below State Pension Age. Therefore, for intergenerational carers of older people, caring poses unique tensions, between employment and caring, and between paid work and unpaid labour (Finch and Groves 1980, 1983). In the course of the present study, it has been shown that people of 'working age' (that is, under State Pension Age) predominated in the provision of all forms of intense and very intense intergenerational care in the 1985/2000 period in Britain (Chapters Three and Four). Moreover, as Chapter Five showed, there was a negative association between intensity of care and employment among mid-life women providing intense intergenerational care. Service expansion might, therefore, have offered people, who would otherwise have provided very long hours of care, the opportunity to engage in more paid employment. And indeed, there was some evidence of this in Chapter Five which (although based on small sample sizes) suggested that, among mid-life women providing intense intergenerational care, when the intensity of care fell significantly between 1985 and 1995, full-time employment rates rose.

The present study has also suggested another reason why intergenerational care for older people is likely to be particularly susceptible to service expansion. This reason relates to the age-group of the older parents to whom care was provided. As Chapter Six showed, the average age of people cared for intensely and very intensely by co-resident children was 84 years. The cared-for older parents were significantly older

than cared-for older spouses, who were on average between 74 and 75 years old. However, the greater age of older parents cared for was associated with a high prevalence of disability. As Chapter Six showed, parents cared for very intensely on a co-resident basis were more likely than spouses to have a mental impairment. Nevertheless, despite the greater age and impairment of cared-for older parents, they were less likely to receive personal care than cared-for older spouses (Chapter Six). The reasons for this, as the conclusions to Chapter Six discussed, may have been associated with underlying tensions in the provision of personal care to older parents (Ungerson 1983, Twigg 2000). The literature suggests that adult children can experience considerable "embarrassment and distaste" when they provide personal care to older parents, and that this can also be experienced as humiliating by the older parent (Lewis and Meredith 1988: 46), particularly when cross-gender caring is involved (Twigg 2000: 72-3). Although personal care is also difficult for spouses to provide, the literature suggests that the tensions are "strongest in relation to parental tending" (Twigg 2000: 72-3). Service expansion might, therefore, have offered an alternative form of care to adult children and their older parents, in situations where there would have been great difficulty in both the giving and receiving of informal care (cf. Twigg 2006: 138-9).

The evidence therefore suggests that the expansion of long-stay residential care in the 1980s and early 1990s in Britain did not lead to a decline in all types of very intense informal care for older people. *Substitution affected very intense intergenerational care but not spouse care.* This is important because it suggests that any expansion of formal services is unlikely to replace all very intense informal care. And again, this point will be taken up again later in the conclusions, when the policy implications of the present study are explored.

9.3 Implications for Policy: Substitution of Informal for Formal Care

Both the substitution and 'reverse' substitution effects, identified in this study, have implications for social policy relating to informal care provision and social policy relating to older people. This part of the chapter, and the succeeding part, explore these implications for the current policy debate on long term care. This part looks at the policy implications of the finding that informal care substituted for long-stay residential care in the late 1990s in Britain. The next part looks at the policy implications of the

finding that long-stay residential care substituted for informal care in the 1985/95 period. The implications are explored in this order because the first set of findings relate primarily to *current* social policy in England, whereas the second set of findings relate particularly to issues around the *reform* of current policy. Although the findings are examined here primarily with English social policy in mind, they also relate to wider international experience.

9.3.1 Policies for Carers Associated with Substitution of Informal for Formal Care

This study has shown that the effect of the decline in long-stay residential care in Britain in the late 1990s was to increase informal care. The decline in long-stay residential care was, in turn, a result of the delayed implementation of the *NHS and Community Care Act* of 1990, which set out to shift services away from long-stay residential services towards domiciliary services (Chapter Two). In effect, the reforms resulted in approximately 20,000 extra people in Britain having to provide co-resident care for 50 hours a week or more in the five-year period between 1995 and 2000. In order to draw relevant policy implications, it is also important to indentify the policies relating to informal care that existed during the late 1990s in Britain and to ask whether these policies were also related to the substitution of informal for formal care at that time and whether these policies have continued since the 1990s.

Policies relating to the provision of informal care in Britain during the late 1990s, as Chapter One pointed out, had their origins in the community care changes of the late 1980s and early 1990s (Pickard 2001). The agenda for the 1990s with respect to community care in the UK was self-consciously set by the White Paper, *Caring for People*, which preceded the *NHS and Community Care Act* 1990 (Secretaries of State 1989). This broke new ground in policy terms by moving informal carers "from a position where they were all but ignored in health and social care policy to one where they were almost centre stage" (Parker 1999: 52). The White Paper set as a key objective for service delivery that "service providers make practical support for carers a high priority" (Secretaries of State 1989: 1.11). However, the concern with carers was essentially instrumental, with the view that "helping carers to maintain their valuable contribution to the spectrum of care is both right and a sound investment" (Secretaries of State 1989: 2.3). As Parker has observed, despite the increased profile of carers in *Caring for People*, "the main purpose of any intervention was to support carers to

continue caring, not to replace them" (Parker 1999: 52). The agenda for the 1990s was therefore informed by policies for carers that were essentially of an instrumental nature. This emphasis continued with the change of government in 1997, with the Carers' Strategy (HMG 1999) also exhibiting an instrumental approach to informal carers, albeit tempered by an approach emphasising the well-being of informal carers in their own right (Pickard 2001).

Policies placing carers at 'centre stage' adopted in the 1990s went hand-in-hand with policies for the reduction of long-stay residential care and, indeed, both can be linked back to the community care changes of the early 1990s. However, an explicit connection between them was rarely made. Indeed, efforts seem to have been made to keep policy for informal carers separate from policy relating to the long-term care system more generally. Thus, at the end of the 1990s, two important policy statements relating to the provision of informal care and the long-term care system were published, the Carers' Strategy, to which reference has just been made, and the report of the Royal Commission on Long Term Care (1999). The government chose to publish the Carers' Strategy separately from the Royal Commission report, and indeed the former was published in February 1999 (HMG 1999), just weeks before the latter was published in March.

However, although efforts were made to keep separate the policies for informal carers and for older people, it was clear that there were links between them. Thus, the instrumental approach to policy for carers had a potential relevance to reducing admissions to long-stay residential care, as those who advanced these policies understood. An instrumental approach to carers was particularly evident in the note of dissent to the report of the Royal Commission (Pickard 2001). The note of dissent argued that support for carers could enable them to continue to provide care, thereby saving expenditure on long-stay residential care, as the following quotation illustrates: "… it is more likely that people will continue to care if they are valued, supported and given incentives to do so. And this is particularly so at the crucial point where the carer is struggling to cope. Prompt help then could forestall a breakdown in the caring relationship. Besides its social benefits, this could save many years of expenditure on expensive residential care. (Royal Commission on Long Term Care, 1999: 133).

In addition, the mechanisms introduced by the community care changes extended local authority practices in relation to service allocation to long-stay residential care, as well

as domiciliary care. As already observed in this study (Chapter Two), it had long been the practice of local authorities in Britain to restrict access to publicly-funded domiciliary care services primarily to those without informal care (Evandrou *et al* 1986, Evandrou 1987, Arber *et al* 1988, Levin *et al* 1989, Davies *et al* 1990, Bowling *et al* 1991, 1993). This 'rationing' preceded the introduction of the community care reforms of 1990 and continued after their implementation (Royal Commission on Long Term Care 1999, Evandrou 2005). However, the implementation of the *NHS and Community Care Act* made Local Authorities the gate-keepers to *all* forms of services, and therefore this rationing of services applied not just to domiciliary care but also to long-stay residential care. The virtual exclusion of older people with informal carers from access to formal services amounted, in effect, to the use of informal care as a substitute for services.

The policies relating to the provision of informal care during the 1990s in Britain therefore included two key mechanisms consistent with a substitution of informal for formal care. These were, first, national policy that included an instrumental approach to carers, aiming to support carers as a mechanism for prolonging the provision of informal care and, second, the virtual restriction at local authority level of access to long-term residential care and other services to those lacking informal care.

Since the late 1990s, the policies relating to both long-stay residential care and informal carers have continued to operate in England, where there has as yet been no fundamental reform of the long-term care system (HMG 2009). The number of places in long-stay residential care has continued to fall since around 1997 (Laing 2004, Henwood 2006, Information Centre 2008). In relation to informal care policy, although there has been a great deal of policy activity (Pickard 2004a, Beesley 2006, HMG 2008), there have been no fundamental changes in approach since the 1990s.

Indeed both of the policy mechanisms identified here as consistent with a substitution of informal care for formal care have been strengthened in recent years. Thus, the instrumental approach to informal carers, evident in the 1999 Carers' Strategy seems even more prominent in the latest Carers' Strategy (HMG 2008). The instrumental approach to informal carers is associated with a particular model of informal care policy, the 'carers as co-workers' model (Twigg 1989: 58). The latest Carers' Strategy very much takes this model as its own, describing its "vision" of carers as "expert care partners" (HMG 2008: 41). Moreover, in the 2008 Strategy, there is frequent reiteration

of the need in policy terms to "support them [carers] in their caring role" (HMG 2008: 9, 11, 12, 16, 27, 39, 41, 46, 55, 60, 64, 68, 115, 128). There is also a new emphasis in the 2008 Strategy on the cost-effectiveness of support for carers, with the Strategy stressing the importance of establishing how far carer-specific services like breaks from caring and health checks for carers "enable them [carers] to care for longer periods", though little attention is paid to whether carers themselves might want to care for longer periods (HMG 2008: 106 and 74, 81). In addition, since the late 1990s, local authority practices of restricting access to services largely to people without informal care have been formalised in the FACS (*Fair Access to Care Services)* framework. This is issued nationally by the Department of Health and is mandatory for local authorities (CSCI 2008: 37). Since 2003, under the FACS framework, there have been explicit rules restricting eligibility for formal services where an older or disabled person receives informal care (DH 2003: #44). Recently proposed revisions to FACS are unlikely to change this substantially (Department of Health 2009a).

Policies consistent with a substitution of informal for formal care have not just continued over the past decade, but it is envisaged that they are also likely to continue in the future. In a revealing statement, the latest Carers' Strategy states that "……the positive shift to independent living and care at home, away from institutionalisation, will continue to *require a greater contribution from carers*" (HMG 2008: 8, emphasis added). In this statement, the government seems to acknowledge that its policies of 'de-institutionalisation' involve a substitution of informal care for long-stay residential care. Moreover, this process of substitution, the statement suggests, is not new but is a continuation of past policies and, the statement suggests, will continue in the future. This latter point is important because the policy for carers set out in the 2008 Strategy is a ten-year programme that is intended to co-exist with any reform of the long-term care system for older people. Thus, the Strategy states that the policies it contains will run alongside the "long-term reform of the care and support system" (HMG 2008: 9). In turn, the Green Paper on the care and support system, published a year later, contains only six paragraphs on 'supporting carers' and refers instead to the Carers' Strategy for the government's approach to carers (HMG 2009: 119-20). The implication seems to be that policies for informal carers are regarded as outside the reform of the long-term care system for older people. It is therefore particularly important to use the evidence from the present study to evaluate these policies.

9.3.2 Evidence to Inform Policies Associated with Substitution of Informal for Formal Care

A major justification for policies advocating the substitution of informal care for long-stay residential care is on the grounds of cost. As already noted earlier in these conclusions, there is a body of recent research in the US suggesting that informal care by adult children reduces nursing home use (Lo Sasso & Johnson 2002, Charles and Sevak 2005, Van Houtven & Norton 2004, 2008). Some recent examples of this US-based research have suggested that the capacity of informal care to substitute for nursing home care could facilitate a policy of 'de-institutionalization', since it is likely to be cost-effective to replace nursing home care with informal care, even if some financial incentives are offered to informal carers. A paper by Van Houtven and Norton, for example, recently concluded that "informal care by children reduces Medicare expenditures on long-term care and on inpatient care, adding further evidence that informal care is a cost-saving alternative to paid long-term care" (2008: 154). Another paper by Charles and Sevak concludes that "…. an effective and possibly efficient way to reduce nursing home expenses may be to subsidize informal caregivers" (Charles and Sevak 2005: 1175).

There is a considerable research literature in Britain suggesting that the costs of informal care are 'hidden' costs and that, were these to be taken into account, it is unlikely that it would be cost-effective to replace long-stay residential care with informal care (Spoor 1988, Kavanagh *et al* 1995, Schneider *et al* 2003). However, the present study also suggests that policies advocating the substitution of informal care for long-stay residential care raise other issues, which arise specifically from the substitution relationship.

The present study has suggested that, when nursing home/hospital care declined in the late 1990s in Britain, the form of care that increased was very intense care, that is, care for 50 or more hours a week. Because the care provided was also co-resident, it could mean that it was continuous and the person providing care could in effect be on-call for 24 hours a day (Chapter Eight). This level of intensity meant that, to a large extent, it precluded other activities, in particular paid employment (Chapter Five). It was suggested, at the end of Chapter Eight, that it was not accidental that the substitution of informal care for long-stay residential care took a very intense form. The intensity of the

informal care that increased reflected the intensity of the care in the nursing homes/hospitals that it was replacing.

However, it could be argued that such extensive provision of informal care is 'unacceptable' because of the demands placed on the carer. The view that certain forms of unpaid care are 'unacceptable' has been expressed in the British social policy literature for over a decade (Keith and Morris 1996, Twigg 1996). Twigg, for example, describing the costs that informal caring can impose on the person providing care, argues that "certain burdens are beyond the acceptable and deserve to be alleviated of themselves" (Twigg 1996: 85). More recently, there is evidence that the government in England has also recognised that "excessive levels of care" are "inappropriate" (HMG 2008:137). This view was initially expressed in the 2008 Carers' Strategy in relation to care provided by children and young people ('young carers') (HMG 2008: 137-8), but in the Green Paper, a year later, it is extended to informal care provision more generally (HMG 2009). Thus, the Green Paper acknowledges the serious effects on the health and employment opportunities of "carers in England who care for more than 50 hours a week" and sets this against a statement from a carers' organisation to the effect that families should be protected from "unmanageable and dangerous levels of caring" (HMG 2009: 119).

There is another sense in which the present study suggests that the type of informal care substituting for nursing home care could be described as 'inappropriate'. This is because it was care by adult children for their parents that typically involved help with personal care tasks. Two thirds of those providing care for 50 or more hours a week to an older parent were providing help with personal care, while two thirds of the older people cared for had a severe personal care disability (Chapters Six and Seven). Intimate personal care tasks, such as bathing, toileting, wiping and dressing have been described as 'unacceptable' for children and young people to perform for their disabled parents (Keith and Morris 1996: 110). The government's strategy for carers also uses intimate care for a disabled parent to illustrate what it regards as 'inappropriate' forms of unpaid care by children and young people (HMG 2008: 133). Although intimate care is regarded as particularly unacceptable for children and young people to perform for their parents, it is also often regarded as inappropriate for adult children to perform. As already indicated, the research literature suggests that personal care provided to older parents is often experienced as upsetting both for the adult child and the parent,

particularly when it involves incontinence or bathing (Lewis & Meredith 1988: 46-7). Many of the problems of providing intimate personal and nursing care for parents at home are likely to be magnified where cross-gender caring is involved (Ungerson 1983, Twigg 2000).

It might be supposed that an increase in very intense informal care is not a necessary consequence of a reduction in nursing homes/hospitals in that policies could perhaps be introduced to encourage the sharing of care, either by the use of formal home care services or among those providing informal care. However, the extensive international literature on substitution shows that formal domiciliary care services do not tend to substitute for informal care (Chapter One). Moreover, the encouragement of shared informal care is likely to be difficult for reasons associated with the relationships involved. The evidence from the present study shows that sharing of very intense intergenerational care (for 50 hours a week or more) was rare, but sharing of intense care (for 20 hours a week or more) was also unusual (Chapter Seven). The study shows that there was nearly a one-to-one ratio between people providing co-resident care for 50 or more hours a week to older parents and parents cared for on this basis, and the equivalent ratio for care for 20 hours a week or more was only a little lower. This lack of evidence of sharing of intense informal care is consistent with the research literature. In Britain, it is a well-established characteristic of the provision of informal care that it tends not to be shared (Townsend 1957; Nissel and Bonnerjea 1982; Lewis and Meredith 1988; Parker 1990). As one analyst in Britain wrote, "it appears that shared care between family members is uncommon; once one person has been identified as the main carer other relatives withdraw" (Parker 1990: 43).

In the case of the care provided by adult children to their older parents, the reasons for the absence of shared care can be related to the characteristics of the people providing care, which have been described in this study and elsewhere (Chapter Three). Thus, in the present study, people providing intense and very intense co-resident care to older parents were, controlling for age, gender and education, significantly more likely to be *de facto* single than non-carers (Chapter Three) and they therefore tended to lack a spouse or partner who could help them in the provision of care. Recent evidence suggests that, even where a spouse or partner is available, provision of personal care to parents is rarely shared between couples (Henz 2009). Single people are often selected among siblings to provide care precisely because they lack the alternative caring

commitments of their married siblings, so that sharing of care between single and married siblings seems rare (Lewis and Meredith 1988: 25). In addition, since the care that increased was intergenerational care provided primarily by women (Chapter Three), if care was to be shared, then it implies that the adult child would need to have a sibling, preferably a sister, and this is not always the case (Lewis and Meredith 1988: 25-6).

The evidence in the present study therefore raises questions about policies aiming to encourage informal care as a means of reducing long-stay residential care.
In relation to the development of policy in England, the evidence presented here suggests an inconsistency between the Carers' Strategy (HMG 2008) and the Green Paper on the reform of the care and support system (HMG 2009). The Strategy acknowledges that current social care policies in England are likely to lead to a substitution of informal care for long-stay residential care (HMG 2008: 9) yet, the present study suggests, such a substitution is likely to take the form of an increase in informal care for 50 hours a week or more, which the Green Paper implies would be considered 'excessive' (HMG 2009). This inconsistency between the Carers' Strategy and the Green Paper in turn reinforces analyses contained in the social policy literature in Britain, which suggest that policy should not lose sight of the 'dual focus of caring' and that policy for informal carers cannot therefore be separated from policy for the older people to whom care is provided (Twigg 1992b, Parker 1993b). Reform of the care and support system for older people, this suggests, therefore needs to include reform of policy for carers.

9.4 Implications for Policy: Substitution of Formal for Informal Care

Over the last fifteen years or so, there has been increasing interest in a different approach to policy for informal carers in the UK. It is an approach that takes as its starting point the 'dual focus of caring'. It begins with policy for older and disabled people and argues that services should be 'carer-blind', in the sense that they do not take into account the availability of informal support. The carer-blind approach has been described as a "version of the substitution argument" (Twigg and Atkin 1994: 150).
This section of the chapter begins by examining the development of the concept of a carer-blind approach to long-term care policy for older people in the UK. It then uses evidence from the present study to evaluate this approach.

9.4.1 The 'Carer-Blind' Approach and Substitution of Formal for Informal Care

The term 'carer-blind' in relation to social care policy was first used in the UK by Twigg and Atkin in 1994 and refers to "treating a disabled person with a carer in exactly the same way as a disabled person without" (Twigg and Atkin 1994: 150). The underlying implication of allocating services on a carer-blind basis is the partial substitution or displacement of the carer. This is because the potential allocation of services to all older people, irrespective of their receipt of informal care, would reduce older people's dependence on informal care. There is an affinity between the carer-blind approach and what Twigg (1992) describes as the 'superseded carer' model (Pickard 2001: 446-7).

The first occasion when a carer-blind policy was recommended in social policy in the UK was in the report of the Royal Commission on Long Term Care in 1999 (cf. Pickard 2001). As the report of the Royal Commission stated: "We recommend that the Government ensure services become increasingly 'carer blind'….", meaning that "…. the existence of a carer will not lead to the failure to offer services" (Royal Commission on Long Term Care 1999: 90). The Royal Commission, in making its recommendations for carer-blind services, did not spell out the implications for the potential substitution of family care. However, as the present author has argued elsewhere, it is clear from other parts of the Royal Commission's report that the Commission understood these implications (Pickard 2001). For example, the research on policy options for informal carers, prepared for the Royal Commission, described carer-blind services as a form of substitution of formal for informal care and located this within the context of welfare systems in which there is a high level of public service support for older people, such as those in some of the Scandinavian countries (Pickard 1999: 38-9).

Arguments in favour of carer-blind policies were also made in the Wanless report, *Securing Good Care for Older People* (2006), and again awareness of the potential relationship with substitution of formal for informal care was shown. The Wanless report explored a 'filial carer-blind' scenario, which it described as a scenario in which "formal services ….. replace the informal care provided by filial carers" (Wanless 2006: 206). A filial carer-blind scenario is explored precisely because substitution of formal for informal care is seen as potentially relevant for filial carers. Thus, the report argues that, for filial carers, there is a "case for possible substitution of informal care by formal

services for the care recipient" (Wanless 2006: 151). The reason why substitution is regarded as relevant to filial carers is because of the potential conflict between unpaid care and paid work for these carers (Wanless 2006: 150, 201). As the Wanless review argues "with regard to filial carers ….. the level of informal care provided and the likelihood of returning to the labour market [is] influenced to a greater degree by the support that is received" (Wanless 2006: 149). Moreover it is argued that "opportunity costs are …….especially significant for filial carers who might otherwise be at work, often at a critical time with regard to maximising their own earning and pension situation" (Wanless 2006: 201). The proposals for substitution of formal services for filial care are, however, not developed in the Wanless report, which merely recommends that "a range of options" should be considered for filial carers and that "additional work is undertaken to ascertain the best approaches" (Wanless 2006: 288).

Particularly since the report of the Royal Commission on Long Term Care, there has been increasing interest in carer-blind policies, not just as part of specific policy proposals, but more generally within the social policy literature in England (Arksey and Glendinning 2008; Carmichael *et al* 2008). In the lead-up to the government's recent Green Paper on long-term care, there has been a stream of social policy analysis supporting the development of carer-blind policies in England. Himmelweit and Land (2008), for example, argue that, from the perspective of gender equality, "the Government needs to rethink its refusal of carer-blind assessment" primarily because it does not give carers, the majority of whom are women, a choice about provision of care (Himmelweit and Land 2008: 9). Glendinning and Bell (2008) also argue that "eligibility for collectively provided social care should not depend on whether or not a carer is available" (Glendinning and Bell 2008: 1). Long-term care systems are now evaluated in terms of the extent to which they are carer-blind (Wanless 2006, Fernandez *et al* 2009). From this literature, it emerges that long-term care systems that are carer-blind are typically universalistic, either based on an 'entitlement'(insurance-based) approach, such as in Japan, or on high levels of public provision for older people, such as in Denmark (Wanless 2006: 246, Fernandez *et al* 2009: 23). Many countries that have reformed their long-term systems in the last twenty years have adopted carer-blind policies (Fernandez *et al* 2009).

It is therefore also possible to evaluate whether recent proposals to reform the long-term care system in England are carer-blind (HMG 2009). As Chapter One indicated, as well

as the government's Green Paper (discussed below) the latest proposals now also include a policy of free personal care for people with the highest needs living at home, which was proposed by the Prime Minister in September 2009. Indeed, at the time of writing, the *Personal Care at Home Bill* has already been introduced into Parliament and consultation on the proposals is taking place until February 2010 (Department of Health 2009a, b). At first sight, it might be supposed that free personal care at home would be a carer-blind policy, in other words, that everyone with the highest needs living at home would qualify. However, the proposed mode of administration of the policy suggests that this is unlikely to be the case. A key principle underlying the proposed approach to free personal care is that it will build on "existing arrangements for determining Fair Access to Care Services" (FACS) (DH 2009a: 5). However, as already noted in these conclusions, under FACS, disabled people who receive unpaid family care are 'less eligible' for publicly-funded support than those without family care (Department of Health 2003; 2009a). The policy of free personal care is, however, intended to be short-lived and to be superseded by the more through-going reform of the system outlined in the Green Paper. The Green Paper proposals, therefore, continue to remain important.

The Green Paper, as Chapter One observed, proposes a National Care Service, which would provide some support to everyone who qualifies for care and support from the state (HMG 2009: 16). However, it is founded on a 'partnership' approach and would not cover the total costs of care, only around a quarter to a third of these costs (HMG 2009: 19). Partnership models are not carer-blind because there is universal publicly-funded access to only a proportion of the care needed. Indeed, the fact that partnership models are not carer-blind was made clear in the Wanless report, which also proposed a partnership approach (Wanless 2006: 246).

Nevertheless, the Green Paper also proposes three ways in which the remainder of the costs of social care could be funded, and one of these would be carer-blind. The three funding options in the Green Paper are: a continuation of means-testing, an insurance model and a comprehensive model (HMG 2009: 17-18). The proposal to continue means-testing is implied in the description of the 'partnership' model where no new mechanism is indicated for meeting the remainder of the care costs. Thus, the Green Paper explains that, under this option, "people who were less well-off would have more care and support paid for… while the least well-off would *continue* to get all their care

and support for free" (HMG 2009: 17, emphasis added). A continuation of current means-testing would not be carer-blind, however, if it also continued to use existing eligibility criteria for access to state-funded care since, as already indicated, these criteria largely exclude disabled people with informal carers. The insurance model proposed in the Green Paper would also not be carer-blind, since it would be voluntary (HMG 2009: 17) and in cases where insurance systems are carer-blind, as in Japan, long-term care insurance is mandatory (Campbell and Ikegami 2003, Ikegami and Campbell 2003). Uptake of voluntary long-term care insurance tends to be extremely low so that it is likely that most people would remain without cover (Royal Commission on Long Term Care 1999: 53) and presumably means-tested care would need to continue.[1] Indeed, the only proposal in the Green Paper that is likely to be carer-blind is the 'comprehensive' model, since this would involve a requirement to pay into a state insurance scheme (HMG 2009:18). In this option, "everyone who was able to pay would pay their contribution and then everyone whose needs meant that they qualified for care and support from the state would get all their basic care and support for free when they needed it" (HMG 2009: 18).

The next section explores how far evidence from the present study can contribute to the development of carer-blind polices, since these policies involve "a version of the substitution argument" (Twigg and Atkin 1994) and the present study has been centrally concerned with the substitution issue.

9.4.2 Evidence to Inform Policies Associated with Substitution of Formal for Informal Care

There are two main problems around the substitution of formal for informal care in carer-blind policies. The first problem is related to a lack of evidence that formal services do in fact substitute for informal care. As Chapter One indicated, lack of evidence seems to have been a major problem in developing proposals for substitution in the Wanless report, despite the report's view that there was a case for some substitution of filial care by formal services (Wanless 2006). Thus, the report states that "the evidence suggests that levels of informal care do not diminish much, if at all, when

[1] The proposal made by the Conservative Party in October 2009 for voluntary insurance to cover residential care, noted in Chapter One, can be seen as a variant of the Green Paper's insurance model.

formal services are provided" (Wanless 2006: 188). It is therefore not surprising that, as the conclusions to the present study have already pointed out, the Wanless report ends by making no specific recommendations relating to the substitution of filial care (Wanless 2006). Indeed, in the subsequent years, the idea of allowing for some substitution of filial care seems to have been forgotten. The 'Caring Choices' initiative, led by the King's Fund as part of a strategy to publicise the Wanless review recommendations and influence public opinion and the government, described the key question relating to informal care as 'How do we support the provision of informal care?", with no reference to a possible substitution of filial care (Caring Choices 2008).

The second problem with carer-blind policies relates to costs. As Chapter One pointed out, a main concern in British social policy has been to avoid substitution of formal for informal care, primarily because of a "fear of escalating costs" (Davies et al 1998: 90). As Chapter One also indicated, the arguments against free personal care by the two dissenting members of the Royal Commission on Long Term Care were also primarily on the grounds of costs. Public expenditure would rise, it was argued, partly because a policy of free personal care would lead to substitution of formal for informal care. Indeed, the authors of the note of dissent referred specifically to a fear of a rise in access to long-stay residential care, such as occurred in Britain in the 1980s, leading to a decline in care by the children of older people and a subsequent "flood of expenditure" (Royal Commission on Long Term Care: 119). Similar concerns are found in the latest government Green Paper (HMG 2009). The Green Paper argues that only part of the costs of social care can be met by the state because, to meet the full costs, would be too great, partly because it would lead to a substitution of family care. Thus, the Green Paper argues, "We do not believe that, in the current economic climate, it would be affordable to have a system that completely replaced family care with state-funded care and support…" (HMG 2009: 119).

The evidence from the present study helps to address these two issues. Indeed, it can be argued that the issues are related. The lack of evidence about the substitution of formal for informal care seems to have had the effect of fuelling concerns about the potential impact that universal social care provision might have. The present study provides evidence about substitution of family care during a period in British social policy when there was an increase in access to publicly-funded long-term care services. Access to these services was provided as part of the Social Security benefits system and the

availability of family care was not taken into account in determining eligibility. Access was therefore on a carer-blind basis. So, what then happened to the substitution of family care for older people during that time?

One of the most important points to emerge from the present study is that access to services provided on a more universalistic basis did not result in the wholesale replacement of family care. The study has shown that there was some substitution of family care by formal services in the 1985/95 period, but that it was constrained by a number of limitations, already outlined in these conclusions (Section 9.2). As this study began by pointing out, there are only two main groups of people who provide informal care to disabled older people: adult children and spouses (Pickard *et al* 2007). However, of these two groups, as these conclusions have suggested, only the care provided by adult children was partially substituted in the 1985/95 period (Section 9.2.2). Moreover, of the intense care provided by adult children for their older parents, substitution effects could not be identified among those providing care for 20 hours a week or more, either on a co-resident or extra-resident basis (Section 9.2.1). Indeed, the substitution effects were confined to only a relatively small sub-group of intense intergenerational carers of older people: those who provided care for 50 hours a week or more on a co-resident basis (Chapter Eight).

A key policy conclusion is that, if care and support is offered on a carer-blind basis, substitution of informal care by formal services is likely to affect only a small proportion of disabled older people and would not constitute a replacement of family care. Indeed, it can be estimated that less than 4 per cent of all informal care hours are provided for 50 hours a week or more to an older parent and it is likely to be only in relation to the older people receiving this relatively small amount of care that there might be substitution of formal for informal care under a carer-blind policy.[1]

The conclusion that it is only some groups of disabled older people, for whom there is likely to be a substitution of formal for informal care, is supported by evidence from elsewhere. Thus, Lingsom's study of the effects of universalistic welfare provision in Norway concludes that "service utilization patterns suggest that the care-givers

[1] Using 2001 Census data, it has been estimated that around 6 billion hours of informal care are provided annually (derived from Buckner and Yeandle 2007). There were 90,000 people providing informal care to an older parents for 50 hours a week or more in 2000/01 (Chapter Four). Assuming that they provide 50 hours a week for 52 weeks, then they each provide 2,600 hours per year, which amounts to a total of 234 million hours a year. This represents 3.9 per cent of the total hours of informal care provided.

benefitting from service expansion have primarily been middle-aged adults with aging parents. Parents with disabled children, persons with disabled spouses and other types of family caregivers have been far less affected by service development. The impact of policy expansion is therefore expected to be greatest in reference to filial care (i.e. the care adult children provide to aging parents)." (Lingsom 1997: 249).

One policy implication of this is that, although people providing filial care to older parents are particularly likely to benefit from service expansion, there is no need to develop separate policies specifically for filial carers, as the Wanless review in England did (Wanless 2006). If services are provided on a universalistic, or carer-blind, basis then it is older people with filial carers themselves who are particularly likely to take them up. The reasons why an expansion of services for older people is particularly relevant to filial carers have already been explored in these conclusions (Section 9.2.2). They relate to both the increasing wish of many women of 'working age' to participate in full-time employment and the difficulties that many adult children experience in giving intense personal care to older parents. The corollary is that there are also some care-providers who would not benefit from services provided on a universal basis to older people and it is these people who are most likely to need the kind of support offered in the government's Carers' Strategy. In other words, there is a need for *both* universalistic provision or carer-blind services *and* a need to provide support to those continuing to provide informal care.

There are other consequences flowing from the likelihood that universalistic provision would not be taken up by all disabled older people with informal care, particularly for the potential costs of replacement services, and these will be explored below. However, before looking at the issue of costs, it is important to address a related issue, the *form* of the services needed to substitute for very intense informal care.

The services that substituted for very intense co-resident care for older parents in Britain in the late 1980s and early 1990s themselves took the form of very intense care, that is, care provided in nursing homes and long-stay hospitals, and these are the most costly forms of services to provide. However, the form taken by the services that replaced informal care in Britain in the 1985/95 period can perhaps be seen as a product of its time. In the last two decades, it has become evident, from experience elsewhere, that other less costly types of formal services can act as substitutes for nursing homes and

hospitals. The clearest example here is Denmark, which has been described as "a model in the development of home- and community-based systems for the frail elderly" (Stuart and Weinrich 2001: 474). In Denmark, alternative formal services have substituted for 'institutional' care (Daatland 1997, cited in Pedersen 1998: 91). The form taken by services substituting for nursing homes in Denmark has been an integrated system of specialised housing, assisted living facilities, 24-hour home care, day care and rehabilitation (Pedersen 1998, Stuart and Weinrich 2001). The substitution of nursing homes in Denmark by alternative formal services has not been accompanied by any increase in the proportion of Gross Domestic Product (GDP) spent on long-term care (Stuart and Weinrich 2001: 478). Indeed, there is evidence of a decline in long-term care expenditure as a percentage of GDP in Denmark in recent years, which has been attributed to the fact that the services substituting for nursing homes constitute a slightly cheaper mode of care (Stuart and Weinrich 2001: 479). Therefore, although the 'natural experiment', examined in the present study, has shown that it was specifically an increase in nursing homes/hospitals that allowed for some informal care to be replaced in Britain between 1985 and 1995, it is likely that other very intense forms of service provision, of the form introduced in Denmark, would have the same effect.

The potential costs of a universalistic carer-blind long-term care system are affected by both the likely take-up of services and the form taken by replacement services. There have been a number of studies exploring the likely costs of a more universalistic carer-blind system in the UK, in addition to the Wanless review already mentioned (Royal Commission on Long Term Care 1999, Pickard *et al* 2000, Wittenberg *et al* 2002, 2006, Wanless 2006, Forder and Fernandez 2009). However, these studies have been carried out in the absence of much evidence about the substitution of formal for informal care (Forder and Fernandez 2009: 24).

The evidence from the present study, and elsewhere, suggests that service utilisation in a universal long-term care system is likely to be greatest by people providing filial care to older parents. The most relevant type of carer-blind scenario is therefore likely to be one that focuses on take-up of services by filial carers. To the author's knowledge, there is only one published filial carer-blind scenario in this country, that produced by the Wanless review (Wanless 2006: 205-6). The scenario is described as one in which there is "zero informal care from children carers" although in fact it is limited to the substitution of personal care and therefore does not cover all the filial care provided

(Wanless 2006: 201). The total cost of the scenario is estimated to be approximately £0.8 billion in 2002 prices, amounting to around 0.06 per cent of GDP (Wanless 2006: 203, 205). Only domiciliary care services are assumed to be provided as a substitute for filial care (Wanless 2006: 203, 205). However, the evidence in the present study suggests that the Wanless filial carer-blind scenario is likely to underestimate the intensity of services needed by a relatively small proportion of filial carers providing very intense co-resident care. These are likely to need "care with housing", as long-stay residential care and its equivalents are described in the review (Wanless 2006). The present study has estimated that the total numbers of disabled older people aged 80 and over, who received very intense co-resident informal care from children, amounted to around 40,000 in Britain in 2000 (Chapter Eight). To provide 'care with housing' as a substitute for this number of people would probably double the costs of the Wanless filial carer-blind scenario.[1] Even so, the annual costs of the scenario would still only amount to around 0.115 per cent of GDP.

The evidence from the present study, taken together with other research, therefore suggests that the costs of allowing for a more universal carer-blind social care system in England is unlikely to lead to a 'flood of expenditure', as the authors of the note of dissent to the report of the Royal Commission on Long Term Care (1999) seemed to fear. Assuming that a carer-blind approach would primarily benefit filial carers, the costs of introducing such a policy would be substantial. However, even in the present economic climate, 0.115 per cent of GDP does not amount to a 'flood of expenditure', still less a Croesian one. Moreover, a carer-blind system would not entail the replacement of family care, as the government's Green Paper seems to suggest (HMG 2009). Indeed, the idea that full substitution would follow from carer-blind policies is fundamentally misconceived. When Twigg and Atkin first described carer-blind service allocation, they argued precisely that it was a "*less* thorough going version of the substitution argument" and that it involved "*not* attempting to substitute wholly for the carer" (Twigg and Atkin 1994: 150, emphases added).

In conclusion, the evidence from the present study strengthens the case for a universal social care system, in which publicly-funded care would not depend on the availability

[1] This estimate assumes that 40,000 severely disabled older people receive nursing home care, at a cost each of around £570 a week, of which approximately 70 per cent would be attributable to Local Authority or NHS funding under current arrangements, amounting to around £21,000 a year per person (based on data in Curtis 2008, Hancock *et al* 2007).

of informal care. If the long-term care system for older people was carer-blind in this sense, the evidence suggests that there is likely to be full substitution only of the most intense types of informal care, that is, care provided on a co-resident basis for 50 hours a week or more. The government has itself suggested that informal care of this intensity is 'excessive' and implied that it should be discouraged in social policy (HMG 2009). It could be argued that no one should be *expected* to provide care at this level of intensity and it should always be a matter of choice. The choice of whether to provide informal care is, however, greatest in what Twigg (1992) refers to as the 'superseded' model of care (Arksey and Glendinning 2007: 172), a model of care with which carer-blind policies have an affinity. The costs of substituting for highly intense care would be relatively limited and would certainly not involve a 'flood of expenditure'. The evidence presented here suggests that substitution does not occur at lower levels of intensity, so that a carer-blind option would not be an 'open door' policy, likely to lead to a massive increase in demand. Indeed, substitution is most likely to affect only some sub-groups of people providing informal care, in particular, filial carers providing very intense care to older disabled parents. A carer-blind policy would certainly not lead to the complete replacement of family care for older people but, it has been estimated here, might displace less than 4 per cent of the total hours of informal care provided in this country. Of the options under discussion in England at present, both those in the Green Paper and in the *Personal Care at Home Bill*, the only one that seems to be carer-blind is the 'comprehensive' model (HMG 2009).[1] A comprehensive model of social care on its own is, however, not sufficient and there also needs to be support for those who choose to continue providing informal care, of the type described in the government's Carers' Strategies (HMG 1999, 2008a).

A final conclusion follows from this analysis. The Green Paper suggests that funding of a comprehensive social care system should be through a contribution from "everyone over retirement age who (has) the resources to do so" and specifically rules out funding through general taxation (HMG 2009: 18). The present study has traced how provision of very intense formal services for frail older people in this country has shifted from NHS long-stay hospitals, funded out of taxation and free at the point of use, to provision in private nursing homes, initially funded out of social security payments, but then subject to Local Authority means-tested support (Chapter Two). It has been further

[1] It has also been argued that the Green Paper's comprehensive option would also be the preferred option on fairness grounds not relating to informal care provision (Keen and Bell 2009: 11).

shown that, during the 1995/2000 period, provision began to shift from nursing homes to very intense co-resident care provided by the children of older people (Chapter Eight). The government seems to envisage that this will continue in the future (HMG 2008: 8). A comprehensive social care and support system would move some of the care of frail older people from the sphere of the family back into the public domain. Given that this is a form of care that has in the past been funded out of taxation as part of the NHS, the present study raises the question: why should a comprehensive social care system not be funded out of general taxation?

9.5 A Note on Further Research

The present study has examined trends in intense intergenerational care for older parents between 1985 and 2000, but what has happened to these trends beyond 2000? In the last five years covered by the present study, the 1995/2000 period, the numbers of older people aged 80 and over receiving intense co-resident care for 20 hours a week or more from their children declined, but the numbers receiving very intense co-resident care for 50 hours a week or more increased. Which of these trends has dominated since 2000? For, if very intense co-resident care continued to increase, perhaps as a consequence of the continuing fall in nursing home/hospital care, it might eventually lead to an increase in intense co-resident care. If, on the other hand, intense co-resident care continued to decline, perhaps as a consequence of long-term trends in the living arrangements of older people, it might constrain any increase in very intense co-resident care.

These questions are not just important in their own right, but are important for the analysis of future trends. This study has shown that, in the 1985/2000 period, the decline in intense co-resident care for parents was offset by an increase in extra-resident care and the result was that all care for 20 hours a week or more remained fairly stable (Chapter Three). If these trends continued in the future, then there would be a gap between the supply of intense care for older parents and demand for care from disabled older people from their children (Pickard 2008a). It is likely that increased formal services would be required, even without a change in long-term care policy. However, if intense care has been increasing since 2000, perhaps as a result of an increase in very intense co-resident care, and continues to do so in the future, then the gap between supply and demand might not be as great. Any such increase in very intense care for

older parents would, however, raise even more urgently the concerns about the impact of existing long-term care policy on provision of very intense care that these conclusions have identified.

It will soon be possible to examine trends in intense and very intense intergenerational care since 2000. Although the GHS no longer collects information on provision of informal care, as a result of a recommendation in the Carers' Strategy (HMG 2008), the NHS Information Centre has recently commissioned a new survey of informal care provision, along the lines of the GHS, and these data will be available at the end of 2010 (Information Centre 2009). The new survey should provide the opportunity to investigate trends in provision of intense intergenerational care between 2000 and 2009. It is important that such an investigation takes place and that the issues identified in the present study continue to be examined.

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