

A Picture of the Work and Well-Being of Working Age Carers in Wales: Evidence from the Welsh Health Survey

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Introduction

This paper considers the implications for the Welsh labour market of carers: those individuals who are restricted as a result of caring for someone who is limited by age or disability. Relative to other regions in the UK it is well established that Wales has a higher rate of working-age disability (Jones *et al.*, 2006). Whilst the reasons for this are difficult to distinguish, Wales appears to compare unfavourably in terms of the distribution of industry, the age structure of the population, average levels of education and the prevalence of low income, which are all identified by Smith and Twomey (2002) as important influences on regional variations in disability.¹ Moreover, Wales also has a higher concentration of the population above standard retirement age (20.6% compared with 18.7% for the UK as a whole in 2005²). Therefore the need for care may be anticipated to be greater in Wales, and it is likely that part of this demand will be met by informal care. Indeed, Maher and Green (2004) and Young *et al.* (2006) both report that Wales is close to the top of the UK regional league table of caring prevalence, and as such this phenomenon is likely to be especially important in terms of its impact on the Welsh labour market. The evidence also suggests carers are especially vulnerable (Heitmueller, 2007), so that understanding their wider situation is an endeavour of some consequence. In particular, we consider the health and well-being of carers in Wales.

Informal care

The adverse effect caring may have on an individual's labour market opportunities has only been recognised by economists very recently in the UK. Heitmueller and Inglis (2004) find that informal carers represent about 14% of the working age population and their labour market participation rates are 8% lower than non-carers, while increasing the number of caring hours is associated with lower carer participation rates.³ This last result confirms the earlier work of Carmichael and Charles (1998) who found that those caring for more than 20 hours each week were less likely to work than non-carers, but that those whose caring involved a more

modest time commitment were more likely to do, albeit they worked fewer hours. Carmichael and Charles (2003) suggest there is a gender dimension to the care-giving phenomenon, with female participation rates being more sensitive to caring than otherwise similar males. The effect of informal care is not however, restricted to participation, and carers experience an hourly earnings gap relative to non-carers after controlling for personal characteristics (Carmichael and Charles, 2003; Heitmueller and Inglis, 2004). Importantly, Heitmueller (2007) considers the potential influence of endogeneity between work and care and finds that failure to control for this effect may result in underestimation of the impact of care on the participation decision.⁴

The Welsh Health Survey

The 1998 Welsh Health Survey (WHS) contains information from individual self-completion questionnaires for almost 30,000 adults aged 18 and over in Wales (National Assembly for Wales, 2000).⁵ This cross-sectional survey contains extensive self-assessed information on health and, importantly, is able to identify carers. A carer is defined in this survey as "someone whose life is restricted in some way because they look after a person who is mentally or physically disabled, or who is limited in what they can do by illness or old age". The labour market analysis of this group to date has been modest, but this survey can be used to provide some additional, quantitative evidence on the indirect effect of ill health on the labour market through the channel of caring.⁶ It is important to note that the analysis here focuses on those of working age. A weighting scheme is applied to render figures representative of the population.

Caring and labour market outcomes

Table 1 details some basic information about both the incidence of caring and the time spent by carers. As can be seen, slightly fewer than 7% of the working age population act in this capacity in the present survey. This figure, which includes caring for the elderly (and not just the disabled) is lower than for example in both Young *et*

al. (2006) and Maher and Green (2004), primarily due to the fact the WHS definition requires a carer to experience lifestyle restrictions. Confirming previous work, the role is more commonly played by females: almost 9% of working age women in Wales are carers compared with fewer than 5% of men. As for the UK more generally (Carers UK, 2004), the prevalence of caregiving among the working age population rises monotonically with age, peaking for the 45-64 group.⁷ The time commitment of this activity is not insignificant: almost two thirds of all working age carers in Wales devote 20 or more hours to caring each week, and for more than a fifth the activity is literally full-time (100 or more hours).⁸

Table 2 shows summary information concerning the labour market status of working age male and female carers and non-carers. The decision to care clearly affects labour market choices. Confirming the results of Heitmueller and Inglis (2004), Young *et al.*, (2006) and Heitmueller (2007), employment rates are lower for those acting as carers, both for men and women. However, this is the consequence of low employment rates amongst those where the intensity of caring is greater than 20 hours each week; in this case the employment rate drops to (just) 46%. Nonetheless, around 55% of carers manage to combine work with caregiving. Among those who do work, 31% of carers work part-time compared to 18% of non-carers, suggesting that for many, this type of work is chosen so as to allow them to (continue to) work. Part-time work has previously been found to be an important 'accommodating device' among the disabled themselves (Jones, 2008), and the WHS suggests this is mirrored for carers. A similar logic has also been proposed for the higher incidence of self-employment among the disabled (Jones and Latreille, 2006), and this too receives some support from the data.

The well-being of carers

An important issue in respect of carers is the impact that such activity might have on health and well-being, and this is examined in Table 3. The inter-relationships among caring, health/well-

Table 1: Incidence Of Caring And Time Spent

	Incidence
<i>Carer (%):</i>	
Male	4.89
Female	8.66
<i>Aged:</i>	
Aged 18-24	2.03
Aged 25-44	5.20
Aged 45-64	10.74
All	6.67
<i>Time spent caring (as % of carers):</i>	
<5 hours per week	5.12
5-9 hours per week	9.52
10-19 hours per week	10.19
20-34 hours per week	10.39
35-49 hours per week	10.48
50-99 hours per week	11.85
≥100 or more hours per week	21.26
Varies, but usually <20 hours per week	5.85
Varies, but usually >20 hours per week	11.29
Other	4.07

Source: Welsh Health Survey, 1998. Working age population only. Data are weighted.

Table 2: Employment Outcomes By Carer Status

	Carers		Non-carers	
	Males	Females	Males	Females
<i>Employment rate (%):</i>				
All	53.59	56.30	74.47	66.92
<20 hours caring per week	77.12	70.40	n/a	n/a
>20 hours caring per week	42.72	47.27	n/a	n/a
<i>As % of those in employment:</i>				
Self-employed	20.22	9.88	17.13	8.09
Full-time employee	71.52 [89.64]	44.99 [49.92]	78.50 [94.73]	56.88 [61.88]
Part-time employee	8.26 [10.36]	45.13 [50.08]	4.37 [5.27]	35.04 [38.12]

Source: Welsh Health Survey, 1998. Working age population only. Breakdown by self-employment and full-time/part-time status excludes those on government training schemes. Figures in square brackets are percentage full-time/part-time among employees only. Data are weighted.

being and employment are complex, and Table 3 accordingly reports separate figures in respect of a number of measures of health/well-being by carer and employment status. In the existing literature, Doran *et al.* (2003) identify a concentration of poor health among carers, with only 56% of carers (not restricted to working age) self-reporting good health compared to 70% of non-carers. A similar ranking is evident in the WHS. As Table 3 reveals, health is

typically better among those in work compared to those not in employment, reflecting the strong causal link between health and work capacity. However, controlling for employment status, the health of carers is consistently worse than that of non-carers: almost two-thirds of non-carers in employment describe their health as excellent or very good compared with just over half of carers, while at the opposite end of the health scale, carers are more likely to

report their health is only fair or poor compared with non-carers.⁹ Carers are also substantially more likely to be disabled or have a limiting long-term illness themselves, and many thus combine the caregiving function with the management of their own impairment(s). Not surprisingly, carers are also more likely to report feeling 'worn out' all or most of the time.

In addition to broad health indicators

such as those above, the WHS also contains a question asking whether "In the past year, have you had 2 weeks or more during which you felt sad, unhappy or depressed; or when you lost all interest or pleasure in things that you usually cared about". This permits an examination of the way in which caring impacts on psychological well-being. Again, as Table 3 indicates, it is important to control for both employment and carer status. Being in work is associated with a lower propensity towards psychological distress for both carers and non-carers, confirming an established finding in the literature (see for example, Clark and Oswald, 1994; Theodossiou, 1998; and the wider psychology literature reviewed by, *inter alia*, Bartley, 1994; Owen and Watson, 1995; Murphy and Athanasou, 1999)¹⁰. Strikingly, carers are substantially more likely to report feeling sad/depressed than their non-caring equivalents.

A similar pattern emerges when considering other, more short-term, self-reported measures of mental well-being (i.e. relating to the last 4 weeks) such as feeling nervous; downhearted and low; inconsolably 'down in the dumps'; and happy. These and the questions in the previous paragraph are in fact part of a battery of so-called 'SF-

36 questions' which can be combined to produce physical and mental summary health measures (see <http://www.sf-36.org> for details). These are widely accepted and used by health economists and epidemiologists, have minimum and maximum bounds of 0 and 100 respectively, and mean values of 50. The lower psychological well-being of carers is revealed by comparing mean Mental Component Summary (MCS) scores among the groups, which conform to the same pattern described above, and thus confirm the adverse impact of caring on carers.

Intra-regional variation

Whereas Young *et al.* (2006) and Maher and Green (2004) show that the incidence of caring varies among UK regions, it is interesting to note that variation also exists within Wales. Thus, 8% of the working age population act as caregivers in the Neath and Port Talbot UA, compared with just 5.25% in Torfaen. The relationship between disability and caring at the UA level is shown graphically in Figure 1. This reveals there to be a positive correlation between the incidence of carers in the working age population and the disabled population by UA ($r=0.461$, p -value=0.031), but also substantial variability, with some areas having relatively high proportions of carers and

low disability rates (for example, Powys) and vice versa (for example, Torfaen). This may be expected given the multitude of factors affecting the care decision including the closeness of family ties, availability of formal care and the economic opportunities available to individuals in the area. However, the correlation between the 2000 Welsh Index of Multiple Deprivation¹¹ (WIMD) and the proportion of working age carers however, at 0.427 indicates that informal care is significantly more prevalent in more disadvantaged areas¹². Whereas previous work has highlighted the role of ill health as a driver of low rates of economic activity in some of the most disadvantaged areas in Wales (Blackaby *et al.*, 2004), it is evident too that policymakers need to recognise the associated implications in terms of caring and the limitations these may imply. Indeed, this is likely to be associated with the acute incidence of workless households identified as a particular cause of concern in some of these areas (Blackaby *et al.*, 2004)

Conclusion

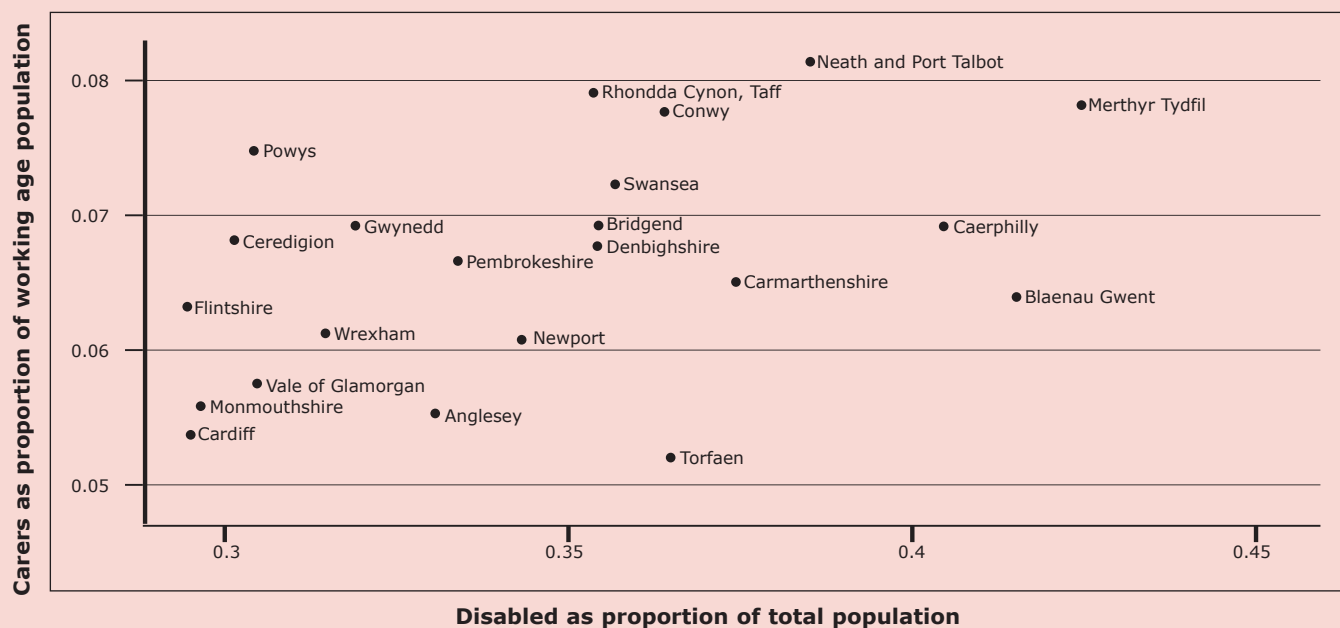
Relative to other areas in the UK individuals are more likely to undertake informal care in Wales. Moreover, the evidence presented from the WHS suggests that two thirds of carers care

Table 3: Health and Well-being by Carer Status and Employment

	Carers		Non-carers	
	Employed	Not employed	Employed	Not employed
General health excellent or very good (%)	51.88	31.98	64.10	40.43
General health fair or poor (%)	13.28	35.15	7.54	33.55
Disabled/limiting long-term health problem	22.79	49.68	13.62	44.70
Felt worn out all or most of the time in last 4 weeks (%)	12.66	21.06	8.26	19.57
Felt sad/depressed for 2 or more weeks in last year (%)	45.50	55.52	29.97	49.01
Felt full of life all or most of the time in last 4 weeks	35.38	29.47	50.38	35.28
Been a very nervous person all or most of the time in last 4 weeks	6.24	12.94	2.90	10.87
Felt so down in dumps that nothing could cheer them up all or most of the time in last 4 weeks	4.37	10.42	2.97	9.52
Felt calm and peaceful all or most of the time in last 4 weeks	31.46	29.12	40.25	30.51
Felt downhearted and low all or most of the time in last 4 weeks	5.39	13.12	2.73	12.15
Been a happy person all or most of the time in last 4 weeks	56.81	49.44	63.25	52.96
Mental Component Summary (MCS) score (mean)	47.45	44.79	50.40	46.26

Source: Welsh Health Survey, 1998. Working age population only. For a brief description of the Mental Component Summary score, see text. Data are weighted.

Figure 1: Working Age Carers And Total Disability By Unitary Authority



Source: Welsh Health Survey, 1998.

for more than 20 hours each week. Caring at this intensity is found to be negatively associated with labour market participation, consistent with the findings from the small existing literature. Working age carers are also found to experience worse health outcomes than non-carers, and in particular in relation to mental health/well-being. Both of these suggest that informal care imposes significant costs on those who perform such a role. Moreover, intra-regional examination indicates the incidence of caring is generally higher in more disadvantaged areas. It is in these areas where the impact of caring on labour market outcomes and well-being may be particularly acute.

Given the contribution made by carers to the UK economy (estimated at £22 billion in 1999 (Laing and Buisson, 2003, cited in Heitmueller and Inglis, 2004)), together with the wider social impact of caring, it would seem there is a strong case for additional policy measures to support carers. The Government has recently established an 80% employment target (see next feature article by Victoria Winkler) and much of the focus of policy has been on encouraging the participation of individuals on incapacity benefit. Clearly however, progress towards this target could also be enhanced by facilitating labour market participation by carers. Flexibility in employment appears vital, and this has been recognised by giving carers the legal right to be able to request flexible working under the Work and Families Act 2006. Moreover, the

provision of reliable and affordable support services to aid informal carers is fundamental in creating the opportunity to combine work with care and improving the well-being of carers. Given the population is ageing and the demand for care is accordingly likely to increase, recognising and responding to the work and welfare implications of informal care is likely to be even more important for the future.

Endnotes

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¹ Senior (1998) using the 1991 Census, found observable factors such as working environment, lifestyle, deprivation and area demographics under-predicted the observed level of illness and hence argues cultural factors may also be an explanation for the higher rates of disability in Wales.

² Authors' calculations based on Office for National Statistics data in *Table 8: Mid-2005 population estimates: Selected age groups for local authorities in the United Kingdom; estimated resident population* (URL <<http://www.statistics.gov.uk/statbase/Expodata/Spreadsheets/D9394>

.xls> 10/10/2006 [Accessed 20/05/2007]).

³ It is important to note that the direction of causation is not clear: individuals who care may have to work fewer hours, or individuals who are not in work may have greater time to care.

⁴ Heitmueller and Michaud (2006) also explore the mechanism through which the effect of caring impacts on labour force participation in England, finding evidence of a causal relationship from caring to work, but only for co-resident carers.

⁵ Despite more recent data collection undertaken in a revised WHS from 2003-2006, at the time of writing, this information was not in the public domain and hence the 1998 survey represents the most recent data available. Whilst precise figures may change over time, the 1998 data highlights the important features, which are also consistent with more recent UK wide evidence.

⁶ Unfortunately, the information on labour market outcomes is largely restricted to labour market participation in the WHS, since other important indicators such as earnings from employment or benefit income and education (a potentially important predictor of the care decision) are omitted from this survey.

⁷ The figure for the 45-64 age group including women of retirement age (i.e. 60-64) is 10.74%. Corresponding figures for those aged 65-74 and 75 and over are 9.64% and 9.01% respectively.

⁸ This figure is substantially higher than reported in Heitmueller and Inglis (2004) using BHPS data, while incidence is lower due to the lifestyle restriction criterion noted previously. Heitmueller and Inglis also provide a useful discussion of the benefit position in relation to caring, a topic which lies outside the scope of the present paper, not least since, as noted, benefit data are absent from the WHS.

⁹ It should be noted that this is not explicable in terms of the fact that carers are typically older: within each of the age bands in Table 1, carers typically report worse health than non-carers.

¹⁰ Note however, that causality can run in both directions depending on the characteristics of work itself (e.g. stress). The relationship is also confounded by factors such as age, gender, education, location, social capital/networks, etc. That unemployment impacts adversely on various measures of mental wellbeing, including parasuicide however, is widely accepted.

¹¹ Nearest available year. The actual measure used is the population-weighted average of the combined scores across the electoral divisions comprising each UA of the WIMD.

¹² An interesting recent paper by Fone and Dunstan (2006) using the same survey as here examines the associations between mental health, deprivation, economic inactivity and social class. Multilevel modelling reveals significant spatial effects. Although not a focus of the paper, caring is confirmed to be associated with worse mental health.

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