

Social participation and health outcomes among carers in Great Britain

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POLICY BRIEFING

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As the population ages, individuals in mid-life are increasingly likely to provide informal care to their parents. The Carers Trust notes that currently in the UK, one in ten people (around 7 million) are providing informal care. This is predicted to rise to over 10 million by 2030.

A recent survey by Carers UK found 72% of carers reported mental health problems and 61% said they had physical health problems as a result of caring. However, social participation can potentially alleviate the adverse effects of care provision.

Against this background, we investigate the health and social participation of carers to inform public policy design. This study adopted a mixed-methods approach and used data from the National Child Development Study to explore the associations between the carers' social participation patterns and their health outcomes, distinguishing between more and less intense care providers.

Key Points:

- *Social participation has a potentially protective effect on carers' mental health and quality of life. It is important to ensure that carers do not become isolated as a result of their caring duties.*
- *Carers and non-carers who did not engage in social activities were more likely to report fair or poor general health, mental health and quality of life.*
- *Carers' health is not significantly different from non-carers' health when we compare self-reported health, health problems, mental health, locus of control, autonomy, self-realisation, and quality of life.*
- *Carers providing 10 or more hours of caring per week were more likely to describe their health as fair or poor than those caring for fewer hours.*
- *Among carers, time, energy and finances are the main barriers to social participation.*

Introduction

Existing academic literature has suggested that informal caregiving can negatively affect carers' physical and mental health. Social participation, where carers are able to access emotional support and companionship, may counteract such negative effects. However, carers often miss out on opportunities to socialise because of the demanding nature of providing care.

The study

This study used data collected in the 1958 National Child Development Study (NCDS). The NCDS is a cohort study that collected data from 17,000 children born in Britain, in a single week in 1958. These individuals have been surveyed throughout their lives. In 2008, quantitative data on individual characteristics were collected from 9,789 of the participants at age 50, and in-depth interviews were carried out with 220 among those. The interviews covered a range of topics including leisure activities and social participation. This rich data allowed us to combine quantitative data on the provision of informal care in mid-life and a range of individual-level characteristics with qualitative data reflecting the participants' views and perspectives on social participation. Our quantitative analysis compares social participation and health outcomes among mid-life carers and non-carers, as well as looking at the differences according to intensity of caring. Our qualitative analysis explores the key barriers preventing carers from taking part in social activities.

Main findings

Health of carers and non-carers

Our study found no significant difference in the health of carers and non-carers. This is partly consistent with previous studies showing that carers are healthier than non-carers, or that there are no differences in health outcomes. This is also consistent with the "healthy carer effect" whereby those with physical limitations or poor health self-select out of the caring role.

Health differences of "intense carers" and "non-intense carers"

Intense carers are those that provide more than 10 hours of care a week, while non-intense carers provide less than 10 hours. We found that intense carers were more likely to report fair or poor self-rated general health than non-intense carers. However, we found no difference on a number of other measures including health problems, mental health and locus of control, autonomy, self-realisation, and quality of life (CASP) between the two

groups. This is consistent with the analysis, showing that poor health outcomes among intense carers are explained by their disadvantaged status (such as being economically inactive, not being an owner-occupier, being in a difficult financial situation, and not having a car).

Social participation, health outcomes and carers

Social participation is positively associated with the mental health and quality of life (CASP) of all groups in our study; non-carers, intense carers and non-intense carers. Those who did not engage in social participation were more likely to have a low mental health and CASP score, implying that social participation could have an influence on one's mental health. Indeed, social participation could provide emotional support and companionship for carers and help protect them against health risks.

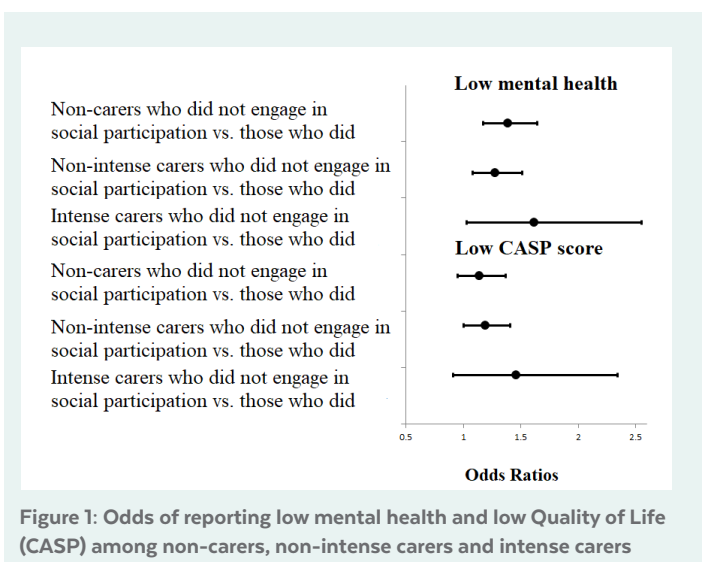


Figure 1: Odds of reporting low mental health and low Quality of Life (CASP) among non-carers, non-intense carers and intense carers

Barriers to engaging in social participation

Our analysis focused on 48 in-depth interviews out of the total 220 interviewed NCDS participants, who mentioned providing care. This analysis revealed that time, energy and finances were the key barriers to social participation among carers, as indicated in the quotes below.

Time issue

Q: And do you do any voluntary or charitable work?

Interviewee replied: I've not got time to do that [laughs].

Q: No, [laughs], I know after what you said.

Interviewee replied: I'm not saying I wouldn't like to, but I just don't have enough time for myself to devote a day or hours to do such a thing, you know. (Case 187, female, providing full-time care)

Energy issue

Q: And why did you stop?

A: I got a bit fed up of it then 'cause it was like--, I didn't mind but it was every Saturday, you see, all day every Saturday.

Q: Hmmm. And you were working all week.

A: So I was only getting Sunday off so--, and I started doing the legal practice course last year, last September, and as I said I backed out because me mum wasn't well and I was tired...

(Case 052, female)

Finance issue

Q: Okay. Do you do any, hmmm, voluntary or charitable work at all?

Interviewee replied: No. Well apart from being my mother's carer. You know, looking after my mother, I don't do any charitable work... hmmm, I had to stop a couple of them cause I couldn't afford them... I joined them all when I was working, hmmm, and I just keep--, I've stopped two or three of them but I just keep the ones going.

(Case 183, male)

Policy implications

Our findings show that intense carers are in a more vulnerable economic position (i.e. economically inactive and more likely to be in a difficult financial situation) which contributes to the differences in the self-reported health between intense and non-intense carers. This may be related to the fact that the value of the Carer's Allowance is relatively low. Currently, this benefit stands at £64.60 per week and only those who care for at least 35 hours per week and do not earn over £120 a week after tax and expenses are eligible to receive it.

Intense caregiving is associated with lower levels of employment and fewer working hours. A lack of financial resources for some carers could result in their own poorer health and, in turn, adversely affect the health of those they are caring for.

Social participation has a potentially protective effect on carers' mental health and quality of life. It is important to ensure that all carers (both intense and non-intense) are able to engage in social activities. To address the time, energy and finance issues preventing informal carers from socialising, the government could facilitate access to respite services by covering the relevant expenditure.

The eligibility for the Carer's Allowance could be amended to entitle more carers to this benefit and the amount could be increased.

Finally, to address the intense carer's health disadvantage, local councils and GP surgeries could more closely monitor the health status both of the person providing the care and the person receiving it.

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