GENDER, OLDER PEOPLE AND SOCIAL EXCLUSION. A GENDERED REVIEW AND SECONDARY ANALYSIS OF THE DATA

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ISER Working Paper
2007-13

Acknowledgement:

We are grateful to Steve Pudney for the assistance, the advice and the comments provided throughout the duration of the project.

Readers wishing to cite this document are asked to use the following form of words:

> Del Bono Emilia, Sala Emanuela, Hancock Ruth, Gunnell Caroline and Parisi Lavinia, (June 2007) 'Gender, older people and social exclusion. A gendered review and secondary analysis of the data', ISER Working Paper 2007-13. Colchester: University of Essex.

The on-line version of this working paper can be found at http://www.iser.essex.ac.uk/pubs/workpaps/

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The support of both the Economic and Social Research Council (ESRC) and the University of Essex is gratefully acknowledged. The work reported in this paper is part of the scientific programme of the Institute for Social and Economic Research.

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ABSTRACT

This study describes the conditions of older men and women in the UK and highlights gender differences in their degree of social inclusion, here defined with respect to: (i) use of services, (ii) provision of care, and (iii) participation in social networks. Using the 2001 Sample of Anonimised Records (SARs) we look at the current situation of older people (here defined as people aged 65 and over) in Britain. We document important gender imbalances in the age structure and marital status of older people, but point out that these differences will become less marked in the future according to the Government Actuary's projections. Using data from the General Household Survey we then investigate the extent of gender differences in older people's degree of social inclusion. We find evidence that differences among older men and women with respect to service utilization, provision of informal care and participation in social networks are often the consequence of differences in marital status and living arrangements rather than gender differences *per se*.

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1 Introduction

1.1 Background and rationale of the research

Like many other Western countries, the UK has an ageing population. In 2001 the proportion aged over 60 had reached 21%. It is estimated that by 2025 this percentage will rise above 25% of the total population, with more than 33% aged over 75 (Office for National Statistics, 2005).

These demographic changes have come about through a combination of improved health care and living standards, with a consequent increase in longevity and decrease in mortality. To give some figures: life expectancy at birth has risen from 70.8 years for men and 76.9 years for women in 1980 to 75.3 and 80.1 years in 2000, respectively, with most of the difference due to decreases in mortality at relatively high ages (Tomassini, 2005).

As the number of older people (defined here and throughout this report as those aged 65 and over) rises both in absolute and relative terms, the needs and problems posed by an ageing population acquire more weight in the social and political debate. The influential cohort of the baby boomers, today in their 50s and 60s, is often thought to represent a group of more demanding health and social care users in the future, strongly objecting to age discrimination and expecting greater choice and quality of services.

Quality and choice are undoubtedly important, but financial considerations are equally paramount. In 2003/04 the National Health Service spent around £16 billion on people aged 65 and over, accounting for 43% of the total budget. In the same year, social services spent £7 billion, which represented 44% of their budget (Healthcare Commission, 2006). It is therefore not only important to offer choice and quality, but to do so in a cost-efficient way.

In order to address these issues, a number of highly important policy initiatives have been already put forward in the last few years. The National Service Framework for Older People (Department of Health, 2001) set national standards to ensure that services of high quality are available to all older people. Since its implementation there have been significant steps forward in government policy, including the publication of a Green Paper proposing radical reforms of adult social care (Department of Health, 2005), and a White Paper on future plans for the whole health and social care system (Department of Health, 2006). The Department for Work and Pensions is looking at new ways in which people's working lives can be extended and how to best support active ageing and independent living in the community (Department for Work and Pensions, 2005). The Social Exclusion Unit is setting up plans to create a new programme to tackle social exclusion among older people, called Link-Age Plus, based on the Sure Start model (Social Exclusion Unit, 2006a). Finally, a review on social services for older people was commissioned by the King's Fund and its findings were published as recently as March 2006 (King's Fund, 2006). In response to the recommendations of that review, the Department of Health has set up a ministerial group to consider the issue further.

However, an aspect of the debate which has been overlooked so far is that related to gender. Yet, differences between older men and women inform current and future demographic dynamics and represent a central aspect in the evaluation of the service needs of the older population. Just to mention a few well-known facts: (i) women live longer and spend a higher proportion of their old age in poor health compared to men; (ii) the economic and social conditions of older people are significantly different across gender; (iii) older men and women bear a different share of caring responsibilities; (iv) men and women develop and maintain different social networks in later life.

All these differences have important consequences in terms of the demand for and access to social and health services and should be adequately discussed and taken into account. Moreover, ignoring these imbalances would be inconsistent with the goals of the Gender Equality Duty, another building block of the government policy, which became law in the spring of 2007.

The Gender Equality Duty (GED) requires public authorities to pay due regard to promoting gender equality and eliminating sex discrimination. This means that service providers and public sector employers will have to design employment and services with the different needs of women and men in mind. The GED will ask public bodies to set their own gender equality goals in consultation with their service users and to take action to achieve them.[1]

It is against this background that the Equal Opportunities Commission decided to engage more actively in the debate on older people. After conducting some scoping work on gender differences among people aged 65 and over, the Commission decided to pursue a more detailed analysis of the situation of older men and women in Britain.

In particular, the Commission was interested in a study which would look at the existing literature and quantitative evidence on the situation of older people, both in Britain and the devolved administrations of Scotland and Wales. The specific aim of the study was to draw informative comparisons between older men and women belonging to different subgroups defined in terms of various demographic characteristics, such as: age, ethnicity, family and residential arrangements. In addition to this, the Commission highlighted the importance of uncovering existing gender differences when looking at provision of services, pointing out areas in which a gendered approach could not be adopted because of lack of adequate data.

1.2 Aims and objectives of the present study

In response to the EOC initiative, we offered to conduct a study of British men and women aged 65 and over with two main objectives in mind. First we look in detail at the current and future situation of older people in Britain from a gender perspective. Secondly, we investigate the extent of gender differences in older people's degree of social inclusion.

[1] See http://www.eoc.org.uk/Default.aspx?page=17686, for more information on the gender equality duty.

The first part of our project consists of a detailed description of the characteristics of older people in Britain according to various demographic and socio-economic variables. We look at differences across gender, decomposing the older population according to age, country of residence, living arrangements, ethnicity, socio-economic characteristics and health.

The second part of the project focuses on social inclusion, here defined with respect to older people's needs for, and access to, services, provision of care, and type of social networks. This way we intend to capture some of the elements emphasised in the current debate on older people, such as use and quality of services, and bring them into a wider picture.

Specifically, we want to depart from the standard analysis of older people as users of services and consumers of resources provided by others, and emphasise their contribution to society. The latter often consists in the provision of long hours of informal and intensive care, whose economic and social value is too often not adequately taken into account in the public debate. As the utilisation and provision of services can also be seen as a form of interaction between the individual and his or her community, we extend the research to explore other types of relationships, such as contact with relatives, friends and neighbours and involvement in local affairs.

1.3 Description of the methodology

This report offers an analysis of the social inclusion of older men and women in Britain and attempts to bring together a review of policy and research literature on gender and older people as well as a specific analysis of existing datasets. This section gives a brief explanation of the main steps followed in conducting this research.

The literature review

The focus of the literature review is on social inclusion, gender and older people. The concept of social inclusion is articulated within three main themes and takes into account: (i) older men and women as service users; (ii) older men and women as providers of care; and (iii) older men and women and their social networks and social participation.

The literature review is limited to studies carried out in the UK and published between 2000 and 2006. We focus our attention on quantitative studies, leaving aside qualitative analyses, as the latter are more difficult to generalise to the entire population.

In conducting the review, a wide range of data sources were consulted. These can be broadly divided into non-academic and academic publications.

a) Non academic publications

We looked at existing reports published by: the Equal Opportunities Commission, Help the Aged, the Joseph Rowntree Foundation, the Social Exclusion Unit, the Fawcett Society, the Department for Work and Pension, the Department of Health, and the BUPA Foundation.

b) Academic publications

We consulted existing reports and working papers published by: the ESRC Gender Equality Network, the Gender Institute of the London School of Economics, the Oxford Institute of Ageing, and the Centre for Research on Ageing and Gender of the University of Surrey.

In addition to these specific sources, we consulted the ISI Web of Knowledge and the RePEc databases, which focus on articles published in academic journals and monographs. A thorough search of the literature on gender and older people and on the aforementioned aspects of social inclusion was commissioned from the Centre for Policy on Ageing, London. This allowed us access to their unique database (AgeInfo), which offered further material to add to our report.

The choice of the data sets

Before addressing our main research questions we carried out some preliminary analysis of existing datasets and chose those most relevant to our purposes.

In order to provide a description of the conditions of British older people we decided to consider the information in the 2001 Sample of Anonymised Records (SARs). The SARs is a 3% sample of individual records drawn from the 2001 UK Census and made available by the Office for National Statistics. Its very large sample size makes it the ideal setting in which to analyse the situation of older men and women according to different demographic and socio-economic characteristics. These advantages come at a cost, however, as we found little on the socio-economic status of those aged 65 and over and scarce information on the geographic distribution of individuals, which did not allow us for example to explore other dimensions, such as the urban versus rural divide.

The SARs does not contain variables on social inclusion, so that we used a separate dataset in order to conduct our investigation of service needs, access and quality, provision of informal care and social networks. Before focusing on one specific source, we confronted a variety of existing and publicly available large surveys. Four surveys were looked at in detail: the Health Survey for England (2000), the British Household Panel Survey (2001 and 2002), The English Longitudinal Study of Ageing (2002), and the General Household Survey (2000-01). The criteria which were given most weight in our decision were the sample size, the presence and quality of variables on social inclusion, and country coverage.

According to these aspects, the 2000-01 wave of the General Household Survey emerged as the most appropriate dataset for our analysis. This source contains very detailed information about older people and social inclusion, as it collects data on health conditions, use of health services, and - thanks to a specific module on Informal Care - it allows a detailed analysis of older people as care providers. Many interesting variables on neighbourhoods and social networks have also been collected through the new module on Social Capital. In addition, the dataset covers England, Scotland and Wales and it has a relatively good sample size.

1.4 Structure of the paper

The remainder of the report is divided into four chapters. In chapter 2 we draw a gendered portrait of older men and women living in Britain using information provided in the 2001 Sample of Anonymised Records (SARs) and tables and statistics published by the Government Actuary's Department. We first analyze older people's living arrangements and describe their main demographic and socio-economic characteristics. We then explore their self-reported health conditions. The chapter concludes with a short overview of the demographic projections for the older population in Britain, where we draw mainly on tables and statistics published by the Government Actuary's Department.

Chapter 3 introduces the concept of social inclusion, looking at the way in which it has been interpreted by others, and explaining our own approach. We then focus on studies which have addressed the provision of services directed to older people, looking in particular at whether gender differences have been identified in this respect. The remaining sections deal with older people and their provision of informal care and with the literature on social participation, loneliness and quality of life.

Chapter 4 explores the situation of older men and women in Britain with respect to their degree of social inclusion through secondary analysis of the 2000-01 General Household Survey. We focus, in particular, on three dimensions of social inclusion: (i) need, access and quality of services; (ii) provision of informal care; and (iii) social participation and social networks. The analysis aims not only to identify gender differences in these areas, but to investigate what other characteristics of older people – apart from gender - can be associated with the observed patterns, and therefore what are the groups most at risk of experiencing social exclusion also within each gender category.

Chapter 5 concludes this report with some comments and observations on the main challenges to a gender approach in the analysis of older men and women. Data limitations are identified as one of the most important obstacles to adopting a gender

perspective in this area, where issues of sample size often arise. Yet, the availability of adequate data constitutes only the first step in making sure that gender enters the debate on older people. A second and equally important element is to raise awareness of the existence of gender differences in the older population among policy makers and researchers and provide examples of why a gender perspective can offer real value added.

2 A picture of older men and women living in Britain

The aim of this chapter is to draw a portrait of older men and women living in Britain in order to set the stage for our analysis on social inclusion. The chapter is divided into six parts. After a brief description of the dataset, we look at the extent to which older men and women have different living arrangements, distinguishing between those who live in private households from those who reside in nursing or care homes. Next, we explore the main demographic and socio-economic characteristics of people aged 65 and over and their self-reported health conditions. We then present some of the most recent demographic projections for the population in Britain in order to highlight the key trends likely to affect those aged 65 and over. The final section concludes, with a short overview of the main findings.

2.1 The data

In what follows we rely entirely on the information contained in the 2001 Sample of Anonimised Records (SARs), a 3% sample of individual records drawn from the 2001 UK Census. This dataset offers a large sample size and collects a useful set of demographic, health and socio-economic variables which allow us to analyse in great detail the situation of older men and women in Britain.[2] The Census gathers information on all individuals, including those who live in institutions and who do not usually take part in surveys. By virtue of its large sample size and the information it collects, we are able to analyse the situation of British people aged 65 and over according to a set of important demographic and socio-economic characteristics as well as gender, age group and country of residence.[3]

2.2 Living arrangements

We start our analysis with a description of the living arrangements of older people in Britain. In particular, we are interested in distinguishing people residing in private

[2] The UK 2001 Census collects data on residents in England, Scotland, Wales and Northern Ireland. In this report, unless otherwise indicated, we restrict our attention to Great Britain and therefore exclude Northern Ireland.

households from those living in hospitals, nursing and care homes. The latter are very often not included in the reference population of smaller-scale surveys, but represent a significant proportion of older people and are therefore of particular interest in this study.

Table 2.1 presents the distribution of older men and women living in communal establishments or in private households for a set of socio-demographic characteristics. Overall, 95.4% of British people aged 65 and over live in private households, while 4.6% live in communal establishments. These percentages do not differ much by country of residence, although we do find a higher percentage of older people living in communal establishments in Scotland.

The greatest variation in living arrangements is seen with respect to age, ethnicity, marital status and general health conditions. In particular, we see that the percentage of people living in communal establishments increases with age, and quite dramatically so among people aged 80 or above. We also see that there are important differences according to ethnicity, as White people are more likely to reside in a communal establishment than Asian or Black people. Marital status is another key discriminating factor; those who are most likely be without a spouse – because they are never married or widowed – are also more likely to live in an institution. Not surprisingly, we also note a strong correlation between health status, as measured by the presence of a limiting long term illness, and being in a hospital or in a care home.

The table also shows the degree of gender differences in the living arrangements of older people. If we look at the overall distribution, we see that women are twice as likely as men to live in a communal establishment (5.9% against 2.8%). A similar ratio is to be found also among the oldest old, in particular for the group aged 80-89, for White people and Other ethnic groups, and for those affected by a limiting long term illness. Gender differences according to marital status are less marked, although even in this case we find that women are more likely to be found in institutionalized care facilities.

[3] See also http://www.ccsr.ac.uk/sars/2001/indiv/index.html, for more information.

Older men and women also differ with respect to the type of communal establishment they live in. As shown in Table 2.2, women are more likely to be in residential care homes and less likely to be in hospital than men. For example, 50.1% of women and 44.2% of men are in residential care homes. This pattern is also quite stable over different age groups, as we can see from Graph 2.1, which also shows a steep age gradient in the propensity to be found in care homes across gender.

Table 2.1 Older people by sex and living arrangements

	Male		Female		Total	
	Private household	Communal establishment	Private household	Communal establishment	Private household	Communal establishment
Age group						
65-69	99.2	0.8	99.2	0.8	99.2	0.8
70-74	98.6	1.4	98.6	1.4	98.6	1.4
75-79	97.5	2.5	96.5	3.5	96.9	3.1
80-89	93.5	6.5	88.7	11.3	90.3	9.7
90+	76.2	23.8	66.5	33.5	68.7	31.3
Country of residence						
England	97.2	2.8	94.1	5.9	95.4	4.6
Scotland	96.6	3.4	93.8	6.2	95.0	5.0
Wales	97.4	2.7	94.3	5.7	95.6	4.4
Ethnicity						
White	97.1	2.9	94.0	6.0	95.3	4.7
Asian	98.5	1.5	98.1	1.9	98.3	1.7
Black	97.2	2.8	97.5	2.5	97.3	2.7
Others	97.1	2.9	95.2	4.8	96.0	4.0
Marital status						
Single	91.1	8.9	87.5	12.6	89.0	11.0
Married	98.9	1.1	98.8	1.3	98.8	1.2
Remarried	99.2	0.8	99.3	0.7	99.2	0.8
Separated or divorced	97.0	3.0	97.5	2.5	97.3	2.8
Widowed	92.6	7.4	90.8	9.3	91.1	8.9
Limiting long term illness						
Yes	94.8	5.2	89.7	10.3	91.8	8.2
No	99.5	0.5	99.1	0.9	99.3	0.8
Total	97.2	2.8	94.1	5.9	95.4	4.6
N. obs.	114,902	3,360	155,142	9,742	270,044	13,102

Source: Census (2001) Office of National Statistics

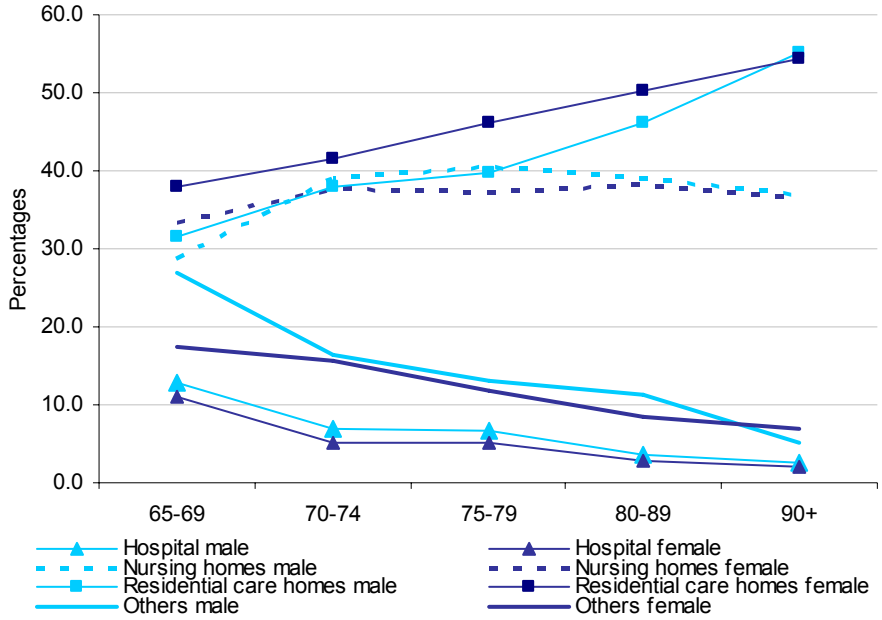
Table 2.3 shows how the composition of the older population by type of communal establishment varies across countries. It is very interesting to see that compared to England the percentage of people aged 65 and over who are in hospital is much higher in Wales and particularly so in Scotland. About 16.7% of men living in communal establishments in Scotland are in a hospital, while the percentage for England is only about 3.7. Despite this striking difference, in all the three countries men are more likely to be in hospital, while women are mainly found in nursing or care homes.

Table 2.2 Older people living in CE by sex and type of CE

	Male	Female	Total
Type of establishment			
Hospital	5.3	3.3	3.8
Nursing homes	38.0	37.4	37.6
Residential care homes	44.2	50.1	48.6
Others	12.6	9.1	10.0
Total	100.0	100.0	100.0
N. obs.	3,360	9,742	13,102

Source: Census (2001) Office of National Statistics

Graph 2.1 Older people living in CE by sex, age and type of CE



Source: Census (2001) Office of National Statistics

Table 2.3 Older people living in CE by sex, type of CE and country

	England			Scotland			Wales		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Type of establishment									
Hospital	3.7	2.2	2.6	16.7	11.5	12.9	7.7	5.6	6.1
Nursing homes	37.0	36.0	36.3	45.2	49.8	48.6	40.0	37.2	37.9
Residential care homes	46.5	52.3	50.8	28.8	33.1	31.9	38.2	46.6	44.6
Others	12.9	9.5	10.3	9.3	5.6	6.6	14.1	10.6	11.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N. obs.	2,836	8,268	11,104	354	955	1,309	170	519	689

Source: Census (2001) Office of National Statistics

2.3 Demographic characteristics

In the remaining part of this chapter we focus on the sample of older people living in private households. This allows us to be more consistent with the analysis that we carry out in chapter 4, where we focus on social inclusion and use data from the General Household Survey, a survey of people living in private households. Since the number of older people living in communal establishments is relatively small (only 4.6% of the total British population), the results presented here generalize easily to the entire population, perhaps with the only exception of the group of people aged 90 or above.

Table 2.4 shows the distribution of older men and women according to different age groups. As we can see, the age structure of older people in Britain is characterised by very strong gender differences. Women are more likely than men to be in the older age groups. In particular, older women above 75 are 49.2% of the 65+ population; the corresponding percentage for men is only 42.2%. If we focus on the very extreme of the distribution, we see that 3.8% of women aged 65 and older are aged 90 or above compared with only 1.7% of men.

Table 2.4 Older people by sex and age

	Male	Female	Total
Age group			
65-69	32.1	26.4	28.8
70-74	27.5	24.4	25.7
75-79	21.2	21.8	21.6
80-89	17.4	23.6	21.0
90+	1.7	3.8	2.9
Total	100.0	100.0	100.0
N. obs.	114,902	155,142	270,044

Source: Census (2001) Office of National Statistics

These gender differences in the age distribution are mainly due to two factors, a cohort factor and a demographic factor. The former refers to the fact that the present cohort of older men is the one who survived the Second World War and its numbers have been affected by those events. The second aspect pertains to basic demographic trends, and we will see later on in this chapter that this is due to the fact that women have a higher life expectancy than men on average.

Table 2.5 shows that there are some important differences in the age distribution of older men and women according to country of residence. The most interesting and well-known fact is that within the 65+ population, Scottish men tend to be younger than English or Welsh men. For example, the percentage of men in the 65-69 age group is 34.8% in Scotland versus 31.9% in England and 31.6% in Wales. The same applies to women, although in this case the difference across countries is less striking.

Table 2.5 Older people by sex, age and country

	England			Scotland			Wales		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Age group									
65-69	31.9	26.1	28.6	34.8	29.0	31.4	31.6	26.2	28.5
70-74	27.5	24.4	25.8	27.6	24.4	25.7	27.4	23.8	25.3
75-79	21.2	21.9	21.6	20.7	21.8	21.4	22.0	21.5	21.7
80-89	17.6	23.8	21.1	15.5	21.5	19.1	17.5	24.7	21.7
90+	1.7	3.9	3.0	1.4	3.3	2.5	1.5	3.9	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N. obs.	98,534	131,958	230,492	10,130	14,542	24,672	6,238	8,642	14,880

Source: Census (2001) Office of National Statistics

In Table 2.6 we look at the distribution of older men and women according to ethnicity.[4] It is clear that the overwhelming majority of the population consists of Whites and that there are no major differences according to gender. Looking also at the age decomposition, we can say that the ethnic background of British women is slightly more homogeneous than that of their male counterpart (Graph 2.2).

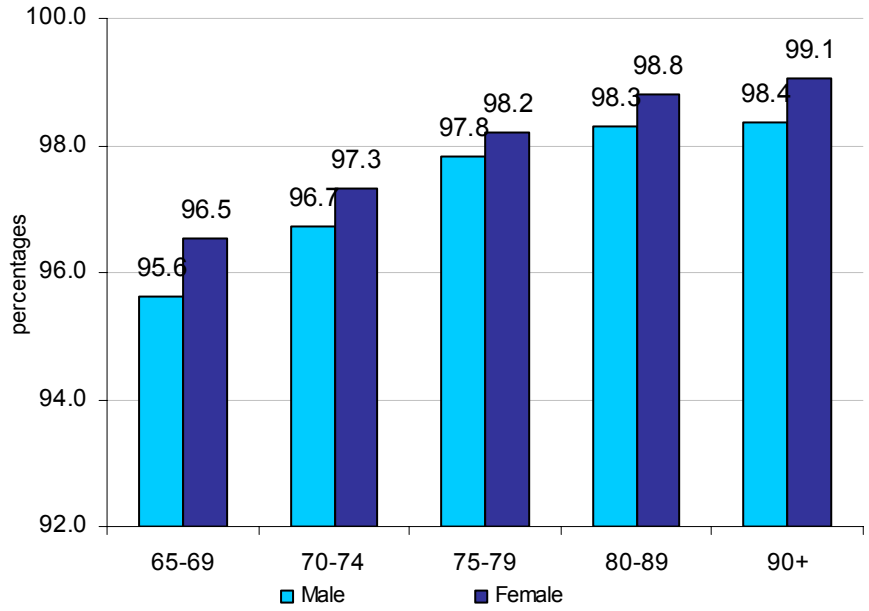
Table 2.6 Older people by sex and ethnicity

	Male	**Female**	**Total**
Ethnicity			
White	96.9	97.7	97.4
Asian	1.8	1.3	1.5
Black	1.0	0.7	0.8
Other	0.3	0.3	0.3
Total	100.0	100.0	100.0
N. obs.	114,902	155,142	270,044

Source: Census (2001) Office of National Statistics

[4] Ethnic groups are categorised as follows: “White” as British, Irish, Scottish and other white ethnic group; “Asian” as Indian, Pakistani, Bangladeshi, Chinese and other Asian ethnic group; “Black” as Caribbean, African and other Black ethnic group; “Other ethnic group” as any mixed background and other not specified ethnic groups. We recognise that within these categories there is an ample degree of variation (especially looking at Asian it would be important to distinguish Indians from Pakistani and Bangladeshi), however the sample size is too small to operate further distinctions.

Graph 2.2 Percentage of White older people by age and sex



Source: Census (2001) Office of National Statistics

If we look at ethnicity by country of residence, we see that compared to England the population is more homogeneous in Scotland and Wales (Table 2.7). However, as far as gender is concerned, there seem to be no significant aspects to take into account.

Table 2.7 Older people by sex, ethnicity and country

	England			Scotland			Wales		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Ethnicity									
White	96.6	97.4	97.0	99.2	99.5	99.4	98.9	99.3	99.1
Asian	2.0	1.5	1.7	0.6	0.4	0.5	0.5	0.3	0.4
Black	1.1	0.8	0.9	0.0	0.1	0.0	0.2	0.2	0.2
Other	0.3	0.3	0.3	0.1	0.1	0.1	0.4	0.2	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N. obs.	98,534	131,958	230,492	10,130	14,542	24,672	6,238	8,642	14,880

Source: Census (2001) Office of National Statistics

2.4 Socio-economic characteristics

In order to analyse the situation of British older men and women with respect to their social and economic background, one would need detailed information on their income, education level, social class, and - ideally - their employment history. Unfortunately, such information is not available in the Census. The questionnaire does not ask the respondents about their income and information on education level is only elicited for those aged 16 to 74. Questions about the actual or most recent job held are asked of the entire sample of adults and are used in order to classify individuals into different social classes. However, a closer analysis of the data reveals that for almost half the population of people aged 65 and over this variable is coded as missing because the individual held his or her last job more than 10 years before the interview.

As a consequence, the socio-economic characteristics we can consider here are limited to current marital status and tenure of household accommodation. Strictly speaking, marital status is a demographic characteristic of the individual. Since we have so little information on income or social class, here we prefer to emphasise the correlation between marital status and household income and include this variable among the socio-economic indicators.

Marital status

The data in Table 2.8 show that 47.0% of older people are married while 33.5% are widowed. The remaining population is more or less equally divided among the other categories: (i) single and never married, (ii) remarried, and (iii) divorced or separated. In terms of gender differences, we see that a much higher proportion of men than women are married or remarried (70.5% for men and 53.7% for women). By contrast, women are much more likely to be widowed.

Table 2.8 Older people by marital status and sex

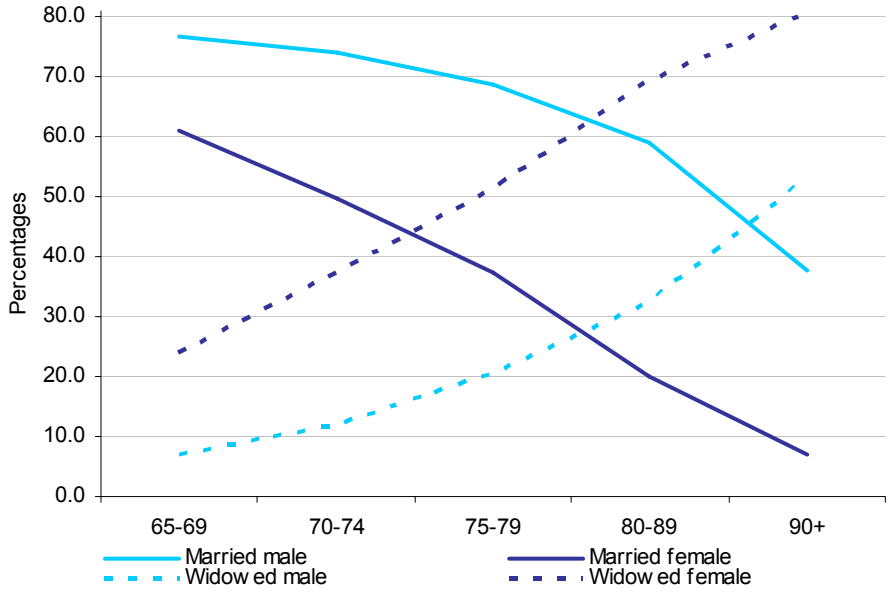
	Male	Female	Total
Marital status			
Single	6.8	6.5	6.6
Married	61.0	36.7	47.0
Remarried	9.5	4.7	6.7
Divorced or separated	6.2	6.2	6.2
Widowed	16.5	46.1	33.5
Total	100.0	100.0	100.0
N. obs.	114,902	155,142	270,044

Source: Census (2001) Office of National Statistics

The reason for these differences is at least partly due to cultural and social norms that regulate union formation. Partnership is a social process and, as such, is influenced by a set of social norms about age and age differences within the couple. According to the social norms prevailing in many countries, men should not be younger than their partners. Furthermore, social and economic constraints are such that women are less likely to marry again following divorce or loss of a partner. As a consequence of these behavioural factors and of the above cited biological and cohort differences, women are much more likely to experience widowhood than men.

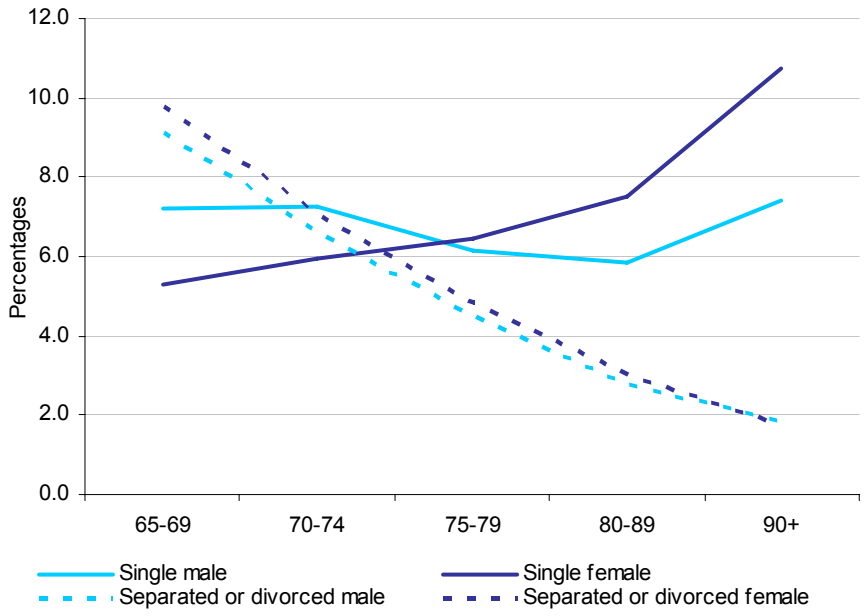
The pattern of gender differences in marital status is also dependent on age. Graph 2.3 and Graph 2.4 show that gender differences are not constant but that they increase with age. For example, the difference in the proportion of married men and women increases from 12 to 33 percentage points moving from the youngest to the oldest age group. There is a corresponding widening of the difference in the proportions who are widows and widowers. On the other hand, the age pattern of single and divorced or separated older people does not exhibit major gender effects.

Graph 2.3 Older people married and widowed by sex and age



Source: Census (2001) Office of National Statistics

Graph 2.4 Older people single, divorced or separated by sex and age



Source: Census (2001) Office of National Statistics

There is also evidence of small differences across countries in the distribution of older men and women by marital status. Table 2.9 shows that there is a higher

percentage of widowers in Scotland as compared to England and Wales, and that there is a lower percentage of men who remarry. In Scotland we also find a higher than average percentage of single women (8.7% against 6.6% for Britain as a whole) and widows. While the distribution of men by marital status in Wales is fairly similar to what we observe for England, among women we find a higher proportion of widows. This seems to be explained by a lower percentage of single, remarried, and divorced or separated women and indicates that marriage is more common and stable in Wales than in the rest of the country.

Table 2.9 Older people by sex, marital status and country

	England			Scotland			Wales		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Marital status									
Single	6.7	6.3	6.5	6.9	8.7	7.9	7.2	5.6	6.2
Married	60.9	36.8	47.1	61.7	35.6	46.3	61.2	36.1	46.6
Remarried	9.8	4.9	7.0	7.3	3.1	4.8	8.7	4.3	6.1
Divorced or separated	6.3	6.3	6.3	5.3	5.4	5.4	6.1	5.2	5.6
Widowed	16.2	45.8	33.1	18.8	47.2	35.5	16.8	48.9	35.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N. obs.	98,534	131,958	230,492	10,130	14,542	24,672	6,238	8,642	14,880

Source: Census (2001) Office of National Statistics

Table 2.10 shows that there is a high correlation between marital status and household composition. The vast majority of those who live alone are widowed, although this percentage is much higher for women than men. The distribution of those who live with a partner (the vast bulk of older people) is pretty similar between men and women and consists mainly of married or remarried individuals. By contrast, the category “living with others” is quite heterogeneous. Men are more likely to be married, perhaps living with a younger wife, while women in this group are for the most part widowed.

Table 2.10 Older people by sex, marital status and household composition

	Family type								
	Living alone			Living only with partner			Living with others		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Marital status									
Single	20.6	9.9	12.7	0.4	0.3	0.4	11.1	9.9	10.4
Married	2.8	1.0	1.5	84.2	86.2	85.1	55.5	28.0	39.6
Remarried	0.6	0.2	0.3	13.1	11.3	12.3	8.4	2.5	5.0
Divorced or separated	18.8	9.9	12.2	1.4	1.0	1.2	6.8	7.2	7.0
Widowed	57.2	79.0	73.2	0.9	1.2	1.0	18.2	52.4	38.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N. obs.	25,803	71,597	97,400	69,752	56,616	126,368	19,165	26,339	45,504

Source: Census (2001) Office of National Statistics. Note: The category "living with others" includes single parents or couples with cohabiting children, couples with cohabiting relatives, cohabiting unrelated adults.

Tenure of household accommodation

Tenure of accommodation is often considered an indicator of economic status as it is usually highly correlated with income. We should however point out that the Census collects information on tenure of accommodation at the household and not at the individual level, and we cannot determine who in the household owns or rents the dwelling. So, although this indicator can still help us to describe the economic situation of older people, we should be careful in the interpretation.

Table 2.11 shows the distribution of tenure of household accommodation for people aged 65 and over living in Britain. Overall, 70.4% of older people are homeowners - including those who are still paying a mortgage - while 22.7% rent their house from the council or from a housing association.[5] There is a significant difference in the distribution of men and women by this indicator, as we see that women are less likely to be home owners than men (68.0% against 73.8%), and more likely to be social tenants (24.5% against 20.2%).

[5] The social tenants include people paying part rent and part mortgage, people renting from the Council (or Local Authority), Scottish Homes, Housing Association/ Housing Co-operative, or Charitable Trusts. For Scotland this group also includes those renting from non-profit housing companies. The private tenants include those who rent on the private market and those who live rent-free, as originally coded by the Census questionnaire.

Table 2.11 Older people by sex and tenure of household accommodation

	Male	Female	Total
Tenure of household accommodation			
Owner	64.0	59.2	61.2
Owner with mortgage	9.8	8.8	9.2
Social tenants	20.2	24.5	22.7
Private tenants	6.0	7.5	6.8
Total	100.0	100.0	100.0
N. obs.	114,720	154,552	269,272

Source: Census (2001) Office of National Statistics

As we would expect, the distribution of tenure of household accommodation varies by age, as shown in Table 2.12. Here we see that the percentage of home ownership (outright ownership or ownership with a mortgage) decreases from 76.7% for those aged 65-69 to a much lower 62.3% for those aged 80 or above. We observe this negative age gradient possibly because of income differences but also because of cohort effects, as policies aimed at promoting home ownership have changed through time. At the other side of the spectrum, we see that the percentage of people living in social housing among the older population is 18.3% for the 65-69 year olds and 27.4% and 29.2% for the 80-89 year olds and 90+, respectively.

Table 2.12 Older people by age and tenure of household accommodation

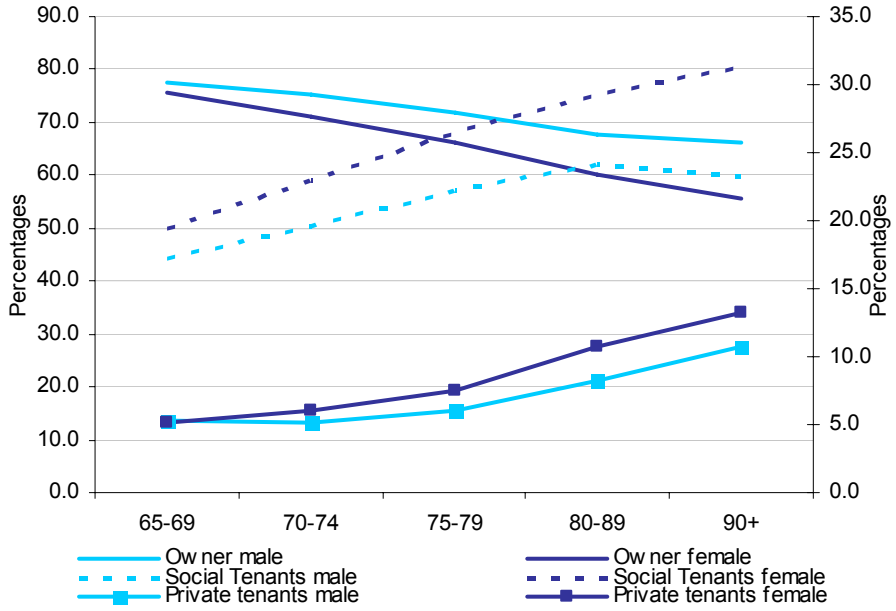
	65-69	70-74	75-79	80-89	90+	Total
Tenure of household accommodation						
Owner	63.9	64.1	61.1	55.7	50.9	61.2
Owner with mortgage	12.7	8.8	7.4	7.0	7.4	9.2
Social tenants	18.3	21.4	24.7	27.4	29.2	22.7
Private tenants	5.2	5.6	6.9	9.8	12.6	6.8
N. obs.	77,719	69,380	58,275	56,623	7,275	269,272

Source: Census (2001) Office of National Statistics

The pattern of tenure of household accommodation by sex and age is shown in Graph 2.5. It is very interesting to see how gender differences are almost non

existent for those aged 65-69, but widen progressively with age. So that, while the initial difference between men and women who are home owners is only about 1%, the gap reaches 8 percentage points by the time individuals are aged 80 or above.

Graph 2.5 Older people by sex, age and tenure of household accommodation



Source: Census (2001) Office of National Statistics. Note: owners (including those paying a mortgage) are plotted against the left-hand side axis, while social and private tenants are plotted against the right-hand side axis.

Table 2.13 Older people by sex, tenure of household accommodation and country

	England			Scotland			Wales		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Tenure of household accommodation									
Owner	64.8	60.1	62.1	52.5	48.3	50.1	69.9	64.6	66.8
Owner with mortgage	9.6	8.5	9.0	12.8	10.5	11.4	8.9	9.1	9.1
Social tenants	19.7	23.9	22.1	28.5	33.1	31.2	15.4	19.5	17.8
Private tenants	6.0	7.5	6.8	6.2	8.1	7.3	5.8	6.7	6.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N. obs.	98,363	131,454	229,817	10,125	14,495	24,620	6,232	8,603	14,835

Source: Census (2001) Office of National Statistics

In Table 2.13 we look at the situation by country of residence. The data show that in Scotland there is a much lower percentage of home owners compared with England and Wales. Since the share of people who rent in the private market is the same across countries, this implies that in Scotland there is a higher than average proportion of older people who live in social housing (31.2% against a national average of 22.7%). In terms of gender comparisons, there seem to be no marked differences across countries.

2.5 Health conditions

Two measures of health are considered here: the presence of a limiting long term illness and self-reported general health status. Both these indicators are subjective measures of health, but they are generally considered good predictors of the use of health and social services.

Table 2.14 reports the distribution of older men and women by whether they are affected by a limiting long term illness. We do not notice very significant differences across gender, although looking at general health status reveals that women are less likely than men to feel in good health and more likely to report fairly good or not good health conditions (Table 2.15).

Table 2.14 Older people by sex and limiting long term illness

	Male	Female	Total
Limiting long term illness			
Yes	48.8	50.8	49.9
No	51.3	49.2	50.1
Total	100.0	100.0	100.0
N. obs.	114,902	155,142	270,044

Source: Census (2001) Office of National Statistics

Table 2.15 Older people by sex and general health status

	Male	Female	Total
General health			
Good	37.8	33.7	35.5
Fairly good	40.5	42.4	41.6
Not good	21.7	23.9	22.9
Total	100.0	100.0	100.0
N. obs.	114,902	155,142	270,044

Source: Census (2001) Office of National Statistics

Despite these differences, the two indicators are quite strongly correlated. As we can see from Table 2.16, among those who do not report the presence of a long term limiting illness the vast majority of men and women report good or fairly good health (97.0% men versus 96.7% women). On the other hand, 41.3% men and 43.7% women who report having a long term illness also report poor health conditions. We carried out our analysis on both health indicators, but, since the two indicators are so strongly correlated, in what follows we will only comment on the relationship between reporting a limiting long term illness and the demographic and socioeconomic characteristics of the respondents.

Table 2.16 Older people by sex, general health status and limiting long term illness

	Limiting long term illness					
	Yes			No		
	Male	Female	Total	Male	Female	Total
General health						
Good	12.7	11	11.7	61.7	57.2	59.16
Fairly good	46.1	45.3	45.6	35.3	39.5	37.63
Not good	41.3	43.7	42.7	3	3.4	3.21
Total	100	100	100	100	100	100
N. obs.	56,020	78,799	134,819	58,882	76,343	135,225

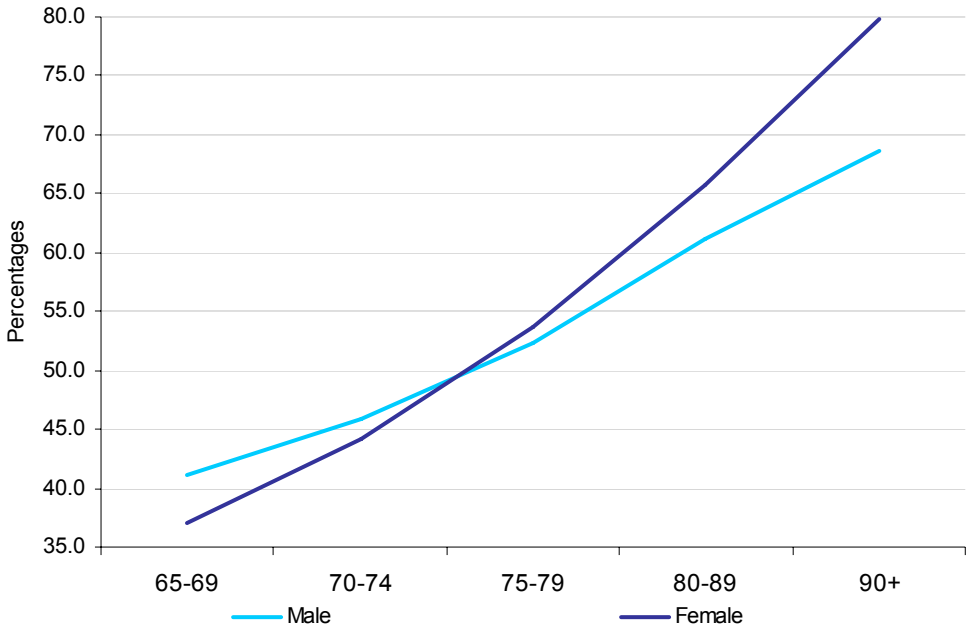
Source: Census (2001) Office of National Statistics

As we would expect, there is a clear association between health and age. This is exemplified in Graph 2.6, which reports the percentage of those with limiting long

term illness by age group and sex. It is very interesting to see not only a steep age gradient for both men and women, but also that the two lines cross in the middle. This indicates that while among the youngest old men have poorer health, the opposite holds true for the oldest old (especially for the ones who are over 80). This reversal of the gender difference in health status is most likely due to differential mortality and morbidity patterns between men and women. In other words, we can think that men who survive to later stages in life are more likely to be a group with better health.

Looking at Table 2.17, we see that there is some variation in the percentage of older people who report a limiting long term illness by country of residence. Overall, the proportion of people affected by some form of disability of infirmity is 50.1 % in England, 52.9% in Scotland and 56.6% in Wales. However, apart from the fact that older people are overall more likely to report poorer health in Scotland or in Wales, we do not observe any country-specific difference by gender.

Graph 2.6 Older people by sex, age and limiting long term illness



Source: Census (2001) Office of National Statistics

Table 2.17 Older people by sex, limiting long term illness and country

	England			Scotland			Wales		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Limiting long term illness									
Yes	47.9	50.1	49.2	52.6	53.1	52.9	56.1	57.0	56.6
No	52.1	49.9	50.8	47.4	46.9	47.1	43.9	43.0	43.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Census (2001) Office of National Statistics

The next table shows the relationship between ethnicity and health status, for men and women separately as well as the total British population of older people. For each ethnic group we calculate the percentage of those who report being affected by a limiting long term illness (Table 2.18). As we can see, there is some variation in health status according to ethnicity, with White people (49.8%) being less likely than Asians (59.1%) and Blacks (53.8%) to be in poor health. Disaggregating by gender reveals that this difference is to a large extent due to the poorer health status of Asian and Black women, who are disproportionately more likely to be in poor health.

Table 2.18 Older people by sex, ethnicity and limiting long term illness

	Limiting long term illness								
	Male			**Female**			**Total**		
	Yes	**No**	**Total**	**Yes**	**No**	**Total**	**Yes**	**No**	**Total**
Ethnicity									
White	48.6	51.4	100.0	50.6	49.4	100.0	49.8	50.3	100.0
Asian	55.1	44.9	100.0	63.2	36.8	100.0	59.1	40.9	100.0
Black	49.3	50.7	100.0	58.4	41.6	100.0	53.8	46.2	100.0
Other	53.6	46.4	100.0	47.8	52.2	100.0	50.4	49.6	100.0
Total	48.8	51.2	100.0	50.8	49.2	100.0	49.9	50.1	100.0

Source: Census (2001) Office of National Statistics

In Table 2,19 and Table 2.20 we look instead at the relationship between health and socio-economic characteristics. We see that divorced or separated, and widowed individuals have worse health conditions compared to other categories, but that this pattern is the same by gender. Similarly, when looking at tenure of household

accommodation we clearly see a positive association between health and socio-economic status, but no major impact of gender *per se*.

Table 2.19 Older people by sex, limiting long term illness and marital status

	Limiting long term illness								
	Male			Female			Total		
	Yes	No	Total	Yes	No	Total	Yes	No	Total
Marital status									
Single	44.9	55.1	100.0	47.5	52.5	100.0	46.4	53.7	100.0
Married	46.5	53.5	100.0	43.4	56.6	100.0	45.1	54.9	100.0
Remarried	49.0	51.0	100.0	47.8	52.2	100.0	48.5	51.5	100.0
Divorced	51.7	48.3	100.0	51.3	48.9	100.0	51.3	48.7	100.0
Widowed	57.3	42.7	100.0	57.4	42.6	100.0	57.4	42.6	100.0
Total	48.8	51.3	100.0	50.8	49.2	100.0	49.9	50.1	100.0

Source: Census (2001) Office of National Statistics

Table 2.20 Older people by sex, limiting long term illness and tenure of household accommodation

	Limiting long term illness								
	Male			Female			Total		
	Yes	No	Total	Yes	No	Total	Yes	No	Total
Tenure of household accommodation									
Owner	44.8	55.3	100.0	44.9	55.1	100.0	44.8	55.2	100.0
Owner with m.	47.3	52.7	100.0	52.0	48.0	100.0	49.9	50.1	100.0
Social Tenants	60.7	39.3	100.0	61.6	38.4	100.0	61.3	38.7	100.0
Private Tenants	52.8	47.2	100.0	58.8	41.2	100.0	56.5	43.5	100.0
Total	48.7	51.3	100.0	50.6	49.4	100.0	49.8	50.2	100.0
	56,020	58,882	114,902	78,799	76,343	155,142	134,819	135,225	270,044

Source: Census (2001) Office of National Statistics

2.6 Demographic projections

Future demand for services will depend on the future age distribution of the population. Life expectancy shows a secularly increasing trend and we can expect there will be an even higher number of older people in the next decades. But, how

many of these extra years will be spent in good health? And, can we expect things to be different for men and women?

In this section we look at some demographic projections. We first consider the life expectancy and the healthy life expectancy of older men and women. Then we look at what these trends mean in terms of the age structure of the population. In the final part of the section we analyse briefly some projections by marital status. All the projections presented in this chapter are based on the work carried out by the Government Actuary's Department (GAD).

Life expectancy

Table 2.21 shows life expectancy and projections of future life expectancy for men and women conditional on having attained a specific age. Three findings clearly stand out: the overall increase in life expectancy, the different pace of such an increase by different age groups, and the higher life expectancy of women.

For each attained age, life expectancy for both older men and women is expected to increase over time. For example, the number of years a man aged 65 is expected to live will rise from 19.5 years in 2006 to 22.2 years in 2031. Scholars agree that the reasons for such an increase are mainly due to improvements in medical treatments, changes in social and cultural behaviour (e. g. improved living standards and quality of life, greater awareness about the importance of an healthy diet) and improvements in the quality of the environment (Christensen and Vaupel, 1996; Defra, 2006).

Older men and women's expectations of life are different. For each attained age women are expected to live longer than men. As we can see from Table 2.21, in 2006 a man aged 70 is expected to live for another 15.3 years while a woman of the same age is expected to live for an extra 17.6 years.

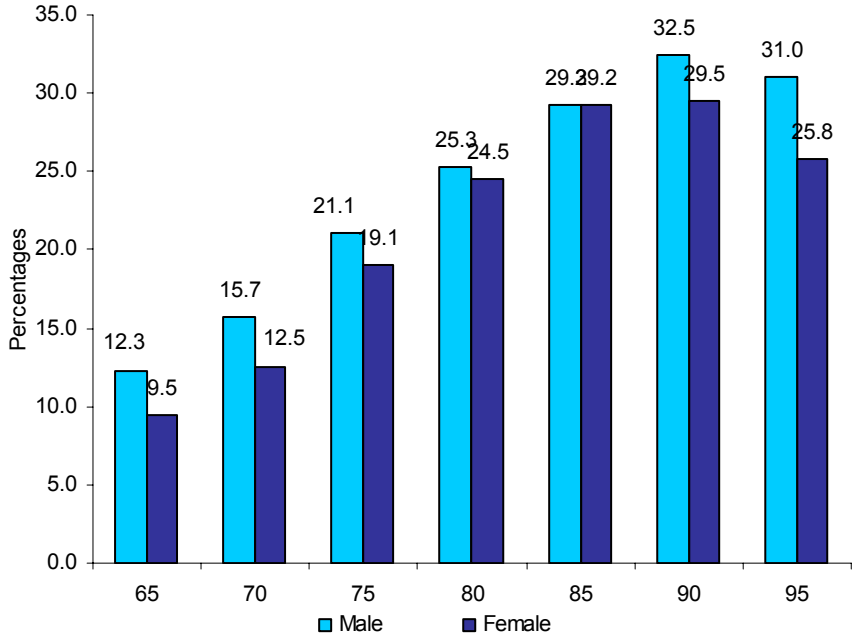
Table 2.21 Life Expectancy, United Kingdom

	2006		2031	
	Male	**Female**	**Male**	**Female**
Attained age (years)				
65	19.5	22.2	21.9	24.3
70	15.3	17.6	17.7	19.8
75	11.4	13.1	13.8	15.6
80	8.3	9.4	10.4	11.7
85	5.8	6.5	7.5	8.4
90	4	4.4	5.3	5.7
95	2.9	3.1	3.8	3.9

Note: Cohort expectations of life (in years) based on assumed calendar year mortality rates from the 2004-based principal projections and historical rates (all UK). Source: Government Actuary Department (GAD), 2004 principal projections.

Life expectancy increases at a different pace according to age. For example, the life expectancy of a woman who has reached age 65 increases from 22.2 years in 2006 to 24.3 years in 2031 (a jump of about 9.5%), while life expectancy of an 80 year old woman increases by about 2.3 years (from 9.4 years in 2006 to 11.7 years in 2031), almost a quarter more. At each different age, however, the gains in life expectancy are higher for men than women, as we can see from Graph 2.7.

Graph 2.7 Percentage increase in life expectancy by sex and age, United Kingdom



Note: Based on data presented in Table 2.22. Source: Government Actuary Department (GAD), 2004 principal projections.

Projections on current and future life expectancy can be a useful indicator of the future demand for health and social services. However, it would be even more important to know whether living longer means living longer and disease-free or whether it means spending more time in poor health conditions. For this reason, the Office for National Statistics has produced estimates of healthy life expectancy (HLE), a measure of life expectancy (LE) which takes into account the onset of disability and infirmity.

The predictions are based on calculations which combine the Government Actuary Department's predictions of life expectancy with measures of self-reported general health conditions and disability extracted from the General Household Survey. In particular, two measures of healthy life expectancy are constructed: healthy life expectancy in self perceived good or fairly good health, and healthy life expectancy free from limiting long term illness.

As we can notice in Table 2.22, at age 65 women have both a higher LE and a higher HLE than men in 1981 and in 2001. However, if we express the years older

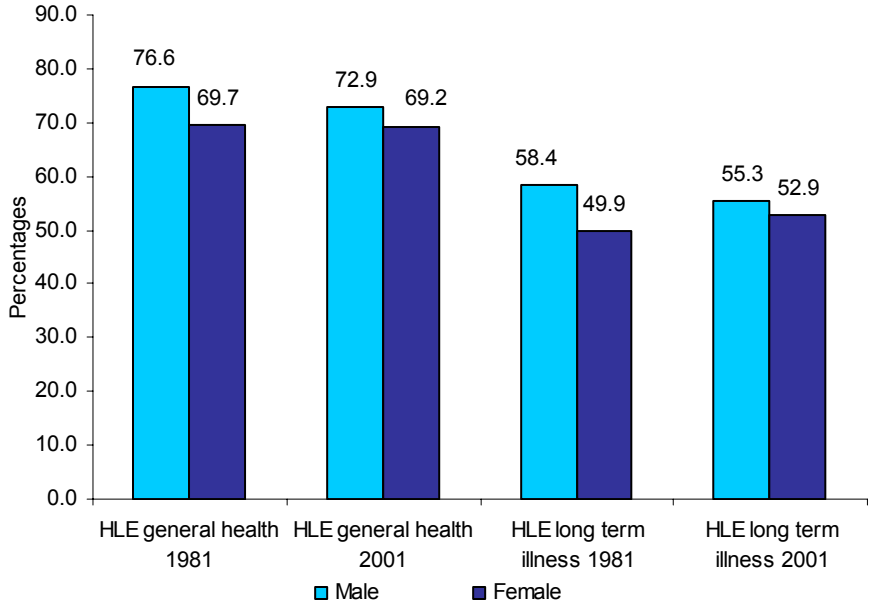
men and women could expect to spend free of health problems or disability as a proportion of total years of life, the situation is different. In both years, older men could expect to spend a higher proportion of their remaining lives in good health than women. Stated differently, this implies that women spend a greater portion of their longer life span in poor health conditions than men (Graph 2.8). However, between 1981 and 2001 the gender gap in proportionate HLE narrowed. The proportion of remaining life that could be expected to be spent in good health fell for men on both definitions of HLE. For women it changed little if based on self-reported health, and rose if based on limiting long-standing illness.

Table 2.22 Life Expectancy and Healthy Life Expectancy, Great Britain

	1981		2001	
	Male	**Female**	**Male**	**Female**
Measures of life expectancy				
Life expectancy at 65	13.0	17.0	15.9	19.0
HLE at 65 (self-perceived good or fairly good general health)	9.9	11.9	11.6	13.2
HLE at 65 (free from limiting long term illness)	7.6	8.5	8.8	10.1

Source: data from the Office for National Statistics, 2006. Note: Life Expectancy calculation based on projections provided by the Government Actuary's Department. Healthy Life Expectancy based on projections provided by Office for National Statistics on the basis of a question on general health and limiting long term illness asked in the 2000, 2001 and 2002 waves of the General Household Survey.

Graph 2.8 Health Life Expectancy as a percentage of Life Expectancy, Great Britain



Source: data from the Office for National Statistics, 2006. Note: Life Expectancy calculation based on projections provided by the Government Actuary's Department. Healthy Life Expectancy based on projections provided by Office for National Statistics on the basis of a question on general health and limiting long term illness asked in the 2000, 2001 and 2002 waves of the General Household Survey.

Projections of the age structure

The increase in life expectancy of older people together with the decrease in fertility rate occurred after the baby boom of the mid 1960s will have strong implication for the age structure of the British population in the next decades.

Table 2.23 compares the projected distribution of British population in 2006 with that in 2031. Such projections are based on assumptions on recent trends in fertility, mortality and net migration.[6] The data show a strong rise in the number of people who are 65 and over. In absolute numbers, we expect that the total population of older people will increase from 9.7 million in 2006 to over 15.3 million in 2031. Specifically, older men will go from the current figure of 4.2 million to more than 7 million, while the number of women will increase from 5.5 million to 8.3 million. The data also show that at present as well as in 25 years time women are more likely than men to belong to the group of the oldest old (above 75 years of age).

[6] Further details on the assumptions on which such projections are based can be found at: http://www.gad.gov.uk/Population/2004/methodology/assumptions.htm

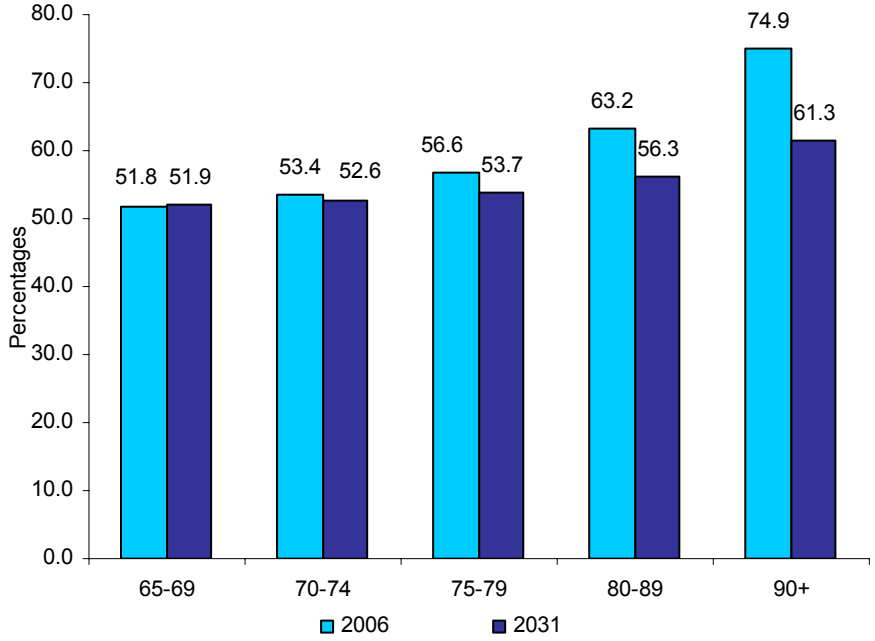
Table 2.23 Projected older population by sex and age, United Kingdom

	2006			2031		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
Age groups						
65-69	31.1	25.4	27.9	28.1	25.7	26.8
70-74	26.1	22.7	24.2	23.2	21.8	22.4
75-79	20.3	20.1	20.2	18.2	17.9	18.1
80-89	20.0	26.1	23.4	25.0	27.2	26.2
90+	2.5	5.7	4.3	5.5	7.4	6.6
Total	100	100	100	100	100	100
N. obs. (000)	4,190	5,517	9,707	7,031	8,309	15,340

Source: Government Actuary Department (GAD), 2004 principal projections.

Although the gender differences in the structure by age of the older population is expected to persist in the future, things will slowly change. As a result of the faster increase in life expectancy of men, gender differences in the composition of the older age groups will most likely shrink over time. This is shown in Graph 2.9, where we represent the percentage of women for each age group in both 2006 and 2031. As we can see, women are always the majority, but their share is due to decrease. For example, the percentage of women aged 80-89 is expected to decrease from 63.2% in 2006 to 56.3% in 2031.

Graph 2.9 Projected percentage of older women by age, United Kingdom



Source: Government Actuary Department (GAD), 2004 principal projections.

Projections on marital status

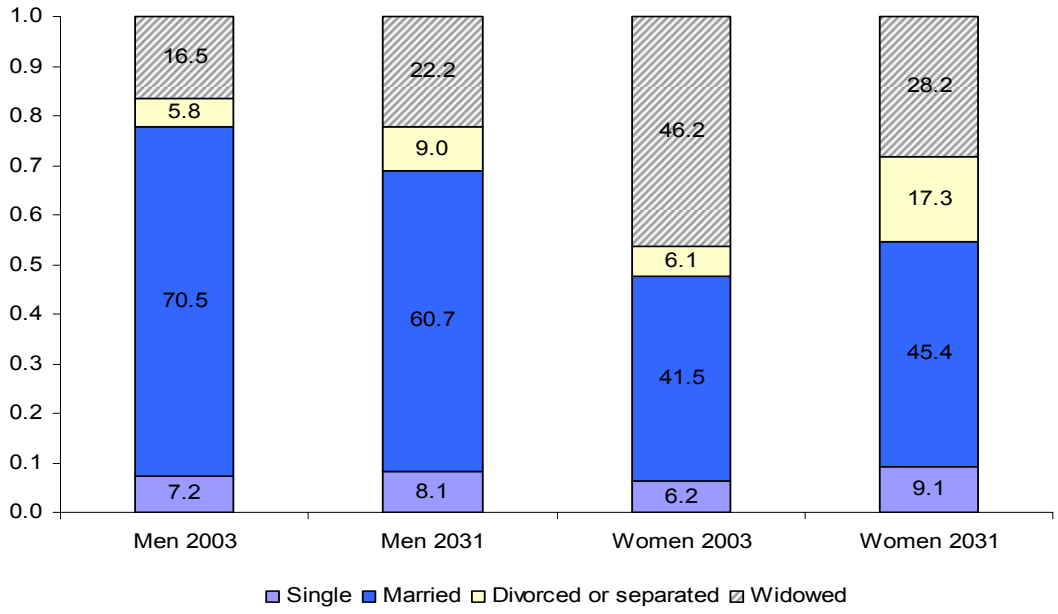
In the last part of this chapter we focus on projections of the distribution of older men and women by marital status. These projections are available only for England and Wales, and assume recent trends in marriage and divorce will persist in the future.[7]

As shown in Graph 2.10 the structure of the older population in 2031 will look very different from the one in 2003. The current trends predict that the percentage of single, and especially of divorced or separated men and women will increase over time. For women this change will be quite remarkable, as the proportion of divorced or separated will more than double, rising from 6.1% to 17.3%. The share of married older men will decrease quite substantially, while the share of widowers will increase. The opposite will occur for women, with the percentage married increasing from 41.5% to 45.4% and the percentage of widows decreasing from 46.2% to 28.2%. This is for two reasons. Older people in their 80s in 2030 will have married around

[7] Further details on these assumptions can be found at http://www.gad.gov.uk/marital_status_projections/2003/index_principal.htm

1970, the peak of the marriage boom. At the same time, the increased survival of their husbands means they will be less likely to be widowed.

Graph 2.10 Projected percentage of older people by sex and marital status, England and Wales



Source: Population Trends, 121, 2005, pp. 77-78 table 1

Table 2.24 shows in detail the changes in the composition by marital status of the older population that are expected to occur between 2003 and 2031 according to the GAD projections. The data show a dramatic increase in the share of divorced and separated individuals in the younger age groups. Among the 65-74 year olds, one in five women will belong to this group, while now the percentage stands around 8.7. The increase in the proportion of divorced and separated men will not be as significant, also because men have a higher propensity to remarry, but the proportion of single men will reach a very high 16.7%. In short, for both genders, but particularly so for men aged 65-74, the proportion married will diminish while the proportion of those in other groups will increase.

Table 2.24 Projected older population by sex, age and marital status, England and Wales

	2003					
	Male			Female		
	65-74	75+	65+	65-74	75+	65+
Marital status						
Single	7.4	6.9	7.2	5.3	7.1	6.2
Married	76.5	62.3	70.5	58.0	26.2	41.5
Divorced or separated	7.6	3.4	5.8	8.7	3.6	6.1
Widowed	8.6	27.4	16.5	28.0	63.1	46.2
Total	100	100	100	100	100	100
N. obs. (000)	2,092	1,516	3,608	2,335	2,520	4,855

	2031					
	Male			Female		
	65-74	75+	65+	65-74	75+	65+
Marital status						
Single	16.7	8.8	12.9	12.9	5.7	9.1
Married	62.8	59.9	61.4	54.6	37.0	45.4
Divorced or separated	15.9	11.8	14.0	20.2	14.7	17.3
Widowed	4.5	19.5	11.7	12.3	42.6	28.2
Total	100	100	100	100	100	100
N. obs. (000)	3,249	2,979	6,228	3,489	3,869	7,358

Source: Population Trends, 121, 2005, pp. 77-78 table 1

2.7 Summary

- 4.6% of the overall British population aged 65 and over lives in communal establishments whereas 95.4% lives in households. Women are twice as likely as men to live in communal establishment (5.9% against 2.8%).
- The age distribution of older men and women is very different, especially in the oldest age groups. For example, 3.8% of older women compared to 1.7% of older men are aged 90 and above. This situation is expected to persist for some time, but gender differences according to age will become less marked in the future.
- About 97.4% of the British older population consists of Caucasian or other white ethnic groups. There is no significant gender variation in this respect.
- Older men and women are very different with respect to their marital status: 61% of men are married compared to 36.7% of women while 16.5% of men are widowed compared to 46.1% of women. This gender imbalance varies by age, becoming more marked with time or among older cohorts. In the future these differences are expected to decrease dramatically.
- Older men and women differ with respect to their socio-economic status. 73.8% men compared to 68% women are home owners while 20.2% men and 24.5% women are social tenants. These differences are not constant through age, but increase over time.
- There are no apparent gender differences in the health conditions of the overall group of people aged 65 and over. Disaggregating by age however reveals that among men aged 65-74 exhibit poorer health, while the opposite occurs among the oldest old (and especially those aged 80 and over).
- Older women spend a higher percentage of their remaining lives in poor health than men. However, since men's life expectancy has grown faster than improvements in their health status, the gender imbalance in the proportion of remaining life that older people could expect to spend in poor health decreased between 1981 and 2001.

3 The literature on social inclusion

3.1 Gender, older people and social inclusion

Social inclusion is a concept that has been widely used by researchers and policy-makers to describe the difficulties of groups of young people (Pavis *et al.*, 2000; Social Exclusion Unit, 2005; Webster *et al.* 2004), particularly with respect to teenage pregnancy (Social Exclusion Unit, 1999a) and education (Social Exclusion Unit, 1999b). Social inclusion is also often mentioned in relation to poverty (Palmer *et al.*, 2005), and issues concerning health and care (Social Exclusion Unit, 2004a), transport (Social Exclusion Unit, 2003), and employment (Social Exclusion Unit, 1999c; Social Exclusion Unit, 2004b). In spite of its wide use, the concept of social inclusion has only recently been introduced in the research on the conditions and the needs of older people. Therefore it is important to consider to what extent existing definitions of social inclusion can be applied to issues affecting the older population.

Social inclusion is a very broad and multidimensional concept that usually refers to lack of economic and social resources. A comprehensive definition is offered by Burchardt *et. al.* (1999), who see social inclusion as being associated with participation in five key social areas: (i) consumption (e.g., goods and services considered normal for a society), (ii) saving (e.g. the accumulation of savings, property ownership), (iii) production (e.g. earnings, social status), (iv) politics (e.g. social status, feeling of being part of a group), and (v) social activities (e. g., support, mutual help, sense of togetherness).

However, in applying Burchardt *et. al.*'s operational definition of social inclusion to older people some distinctions need to be made (Social Exclusion Unit, 2004c). First, their definition implicitly assumes that social inclusion is a dynamic process. One could enter and exit from a condition of social inclusion by varying the amount and the type of resources owned. In the case of older men and women, by contrast, the lack of social and economic resources could be a permanent state rather than a temporary one. Secondly, Burchardt *et. al.*'s definition does not take into consideration the "local" dimension of social inclusion. As older people have a much

lower degree of geographical mobility than the young, the neighbourhood and the local area in which they live play a key role in their lives. Finally, Burchardt *et. al.*'s identify production as a key dimension of social inclusion, but this obviously cannot apply to older people as they are in the vast majority of cases economically inactive. Instead of emphasising earnings or economic status, a definition of social inclusion specifically targeted towards older people should take into account wealth or non-labour income and their associations with measures of social engagement.

A good example of a different and yet equally comprehensive approach for addressing the condition of social inclusion of the older population is a study recently published by the Social Exclusion Unit (Social Exclusion Unit, 2006b). Using data from the first wave of the English Longitudinal Study of Ageing, seven dimensions of social inclusion were identified and separately analysed: social relationships, cultural and leisure activities, civic activities, basic services, neighbourhood, financial products and material goods. The resulting analysis identifies the main socio-economic determinants of social inclusion according to the various dimensions considered and offers a very useful insight in the situation of older people in England, although it does not emphasise the extent of gender differences.

In this report we depart slightly from the above definitions and consider social inclusion as exemplified by the way in which older people engage with their families and broader community. Specifically we focus on: (i) the utilization of services, (ii) the provision of informal care, and (iii) social networks and participation.

Being excluded from basic services (e.g. transports, health services, and welfare services) captures the disadvantage that older people face when unable to access facilities crucial to their quality of life (Social Exclusion Unit, 2006b). Providing care, especially towards living-in partners in ill health, could be such a demanding task that it may prevent the carer from taking part fully in the social life of the community and this, in some cases, might result in depression, poor health, and loneliness. Withdrawal from economic activity, the loss of a partner, poor health, reduced mobility, fear of crime and similar factors may increase the sense of isolation that many older people perceive. The deterioration of social relationships which very often accompanies the onset of old age might increase the risk of social inclusion.

These aspects are thought to be interrelated to each other, as it is widely recognised that an active engagement in family and social networks is one of the elements which facilitates the access of older people to services. Feelings of loneliness and depression may in turn stop people from interacting with their local community and, crucially, accessing services they need. It is therefore very important to consider all these different indicators of social inclusion within the same framework.

Other aspects are obviously relevant to a gender analysis of older people's needs, such as health and income. Rather than engaging in a detailed analysis of these factors, we would keep such considerations in the background as they have been already widely studied (Bath, 2003; Costigan et al., 1999; Marmot et al., 2003; Rowlinson et al., 1999). However, with respect to the financial situation of older people, it is worth mentioning that income in retirement reflects decisions taken during a pensioners' working life: people with fragmented work histories are less likely to have built up rights to high levels of pensions (Office for National Statistics, 2005).

In the next paragraphs we review British evidence on older men and women and their degree of social inclusion. We first look at studies that address issues related to the provision of services. We then present evidence on older people as care providers. Finally, we look at social participation and social networks. In the course of the literature review we shall highlight whether gender differences have been identified for each of the three aspects of social inclusion that we address here and, if no evidence on gender is available, why it is so.

3.2 Health and social services for older people

Residential care in Britain has typically been seen as a provision of last resort (Means and Smith, 1994). The majority of care for older people takes place in their own home and is usually provided informally by relatives and friends (Barnes, 1997; Goddard, 1998). Public services make an important contribution though, especially

for people with smaller networks and less adequate social support (Chappell, 1985; Nelson, 1993).

With the publication in March 2001 of the National Service Framework (NSF) for Older People (Department of Health, 2001), the Government has put the health and social care needs of older people high on the political agenda. The NSF for Older People set up a 10 year programme for the improvement of services for older people, focusing on rooting out age discrimination, providing person-centred care, promoting older people's health and independence, and fitting services around people's needs. This programme was meant to be a response to the growing recognition that, despite many achievements, services too often failed older people. It was hoped that by defining clear objectives and strategies it would be possible to achieve significant improvements in the provision of health and social care and ensure fair, high quality and integrated services for older people.

After the publication of the National Service Framework for Older People, new initiatives in this area were launched by the Department of Health, the Department for Work and Pensions and the Social Exclusion Unit. The first major step came with the publication of a Government Green Paper in 2005 (Department of Health, 2005), which announced an overhaul of adult social care in England. This document was soon followed by a White Paper announcing future plans for both health and social care systems (Department of Health, 2006). The White Paper set out a challenging agenda for change, with a commitment to more integrated services built around the individual, a promise to tackle inequality and bring services closer to home, and a focus on greater support for people with long-term needs.

On a parallel track, the Department for Work and Pensions started looking in detail at the issues facing British society as people live a longer and healthier life. The publication of *Opportunity Age: meeting the challenges of ageing in the 21st century* (Department for Work and Pensions, 2005) defined the Government thinking about the role of older people in the modern world. The new strategy was centered around the values of *active independence*, *quality* and *choice*; the main goals being: achieving higher employment rates and greater flexibility for the over 50s in continuing their careers, enabling older people to play a full and active role in society

by removing obstacles generated by income and housing differences, and allowing people to keep their independence as they grow older.

Building on *Opportunity Age*, the Social Exclusion Unit set up a new research agenda to analyse the various aspects of social exclusion among older people. The resulting report detailed government plans to mitigate the poverty and isolation experienced by older people and aimed at doing so using the model pioneered by the Sure Start programme (Social Exclusion Unit, 2006a). To this effect, a pilot scheme called Link-Age Plus will be launched in the next future and will test the Sure Start approach for older people, trying to identify problems as soon as they develop and preventing them from becoming worse.

Recently, the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission have worked together to carry out a review of the progress of the NHS, local authorities and other partners in meeting the standards set out in the NSF for Older People, taking specifically into account other developments in Government Policy since the NFS was launched (Healthcare Commission, 2006). This review found that progress had been made in some of the key areas. Specifically, significant steps forward were noticed in tackling age discrimination, although the development of single assessment practices - which require integration of different organisations in providing services to older people in order to implement a person-centered approach – was still found to be at a very early stage.

The National Service Framework for Older People and the developments in government policy that have followed have placed an unprecedented focus on services used by older people. But quality and choice in the delivery of services come at a cost, and the controversy on how these changes will be funded is already gaining momentum in the public debate. More than one million older people currently use publicly funded social care services in England.[8] Local authorities spent £7

[8] Following the recommendations of the Sutherland Commission published in 1999, as from 1st July 2002 people aged 65 and over in Scotland have their personal care costs met by the state if they live at home and receive a substantial contribution to their expenses if they are in care homes. By contrast, personal care in the rest of the United Kingdom continues to be means tested (Pudney *et al.*, 2006; Hancock *et al.*, 2003; Wittenberg *et al.*, 2002).

billion in 2003/04 and £8 billion the following year on personal social care services, getting back approximately 20% of this amount though means-tested charges. The National Health Services is currently devoting about 43% of its budget to address the needs of those aged 65 and over (King's Fund, 2006).

In order to address some of these issues, the King's Fund commissioned Sir Derek Wanless to undertake a review of social care. The review sought to determine how much should be spent on social care for older people in England over the next 20 years and what funding arrangements need to be in place to ensure that this money is available and will produce high-quality outcomes. In particular, since there is widespread criticism of the current means-testing system because of its complexity and because it tends to penalise savers and people with modest assets, the Review commissioned a specific research paper to look at different funding options under a range of different population and spending scenarios (Malley *et al.*, 2006).

All these developments are very welcome. However, considering the degree of attention that has been paid to the service needs of older people and all the related emphasis on tackling inequality and discrimination, it is perhaps surprising that hardly anything has been written on the different needs of older men and women. The Gender Equality Duty has recently become law, and so it is necessary to start considering the gender implications of current and future social and health policies directed towards older people. Will one size fit all? Or should we expect gender differences in the access to care? Do older men and women have different expectations about what public care services can and should deliver?

The answer to these questions is very difficult to anticipate. As we saw in chapter 2, older men and women living in Britain are very different:

- Women are more likely than men to live in communal establishments
- Women are older than men, for example the percentage of older women above age 75 is 49.2, while it is only 42.2% among men

- The average life expectancy at birth for females in Britain is 80.4 years compared with 75.7 years for males
- Older men are much more likely than older women to be married and much less likely to be widowed
- Economic resources are very unequally distributed among men and women in old age

Yet, despite all we know about gender differences in older age, very little time has been spent in analysing their implications. For instance, the Wanless Review commissioned a second special piece of research in order to forecast the number of people in need of social care in the future (Jagger *et al.*, 2006). The research was conducted in three stages. The first step was to set up a baseline model which articulated the relationship between the onset of disability and certain types of health conditions or diseases (both physical and cognitive), age, sex, social class and smoking behaviour. The second stage reviewed the existing literature on recent treatments and advances in medical knowledge and used this information to develop different disease-specific scenarios. In the third stage each scenario was applied to the basic model in order to simulate age-specific disability prevalence from 2001 to 2025.

Although sex was a variable explicitly considered in the model, none of the simulations presented and later on used in the Wanless Report showed disaggregated numbers for men and women. Moreover, even if we are all aware of gender differences in age, social class and smoking behaviour, none of these variables was interacted with gender in the basic model as it would have been appropriate. Finally, although the authors noticed the different prevalence of certain diseases among men and women and cited evidence that certain types of treatments may lead to differential rates of improvement across gender, this aspect was not taken into account in the formulation of the different scenarios or in the model set up.

Indeed, studies which analyse gender differences in the degree of access, use and quality of services are extremely hard to find. Very often the available evidence is only qualitative, which implies that the results are difficult to generalise to the entire population (Welsh Consumer Council, 2006). Quantitative studies have their own

problems. On the one hand there are “population studies”, i.e. studies of users and non-users of the service; on the other hand there are so-called “panel studies”, i.e. studies which specifically focus on sample of users (Field and Briggs, 2001). Population studies would appear more appropriate to investigate differential needs and barriers to access; in practice however the required sample size is exceedingly large and therefore they are often too costly. Panel studies are easier to conduct, but present an inherent disadvantage in that they exclude those who might have the need for a certain service but are not granted access to it, so that at best these studies provide information on the use of a certain service, but cannot say anything about need and access.

Examples of panel studies which focus on gender differences are in Field and Briggs (2001) and Stoddart *et al.* (2002). The first study investigates differences in the rate of utilisation of primary healthcare services among asthmatics and diabetics patients. The choice of these specific groups was intended to control for differences in the type of disability in order to focus the analysis on other aspects of utilisation. The study finds that the young, the elderly and women report higher rates of utilization of services, as do non manual workers and the unemployed. Only a weak correlation is found between gender and perceptions of service accessibility, while age plays here a much more important role. Unfortunately the study considers each individual characteristic separately and therefore it does not provide direct evidence on gender differences among older people. However this analysis represents a good example of research on gender and age related issues in the area of health service utilisation.

Stoddart *et al.* (2002) focus on older people and emphasise differences across men and women. Their analysis sets the benchmark of what we would ideally like to see more of in the future. The study aims at exploring the factors determining the use of home care services (both private and statutory) by older people. It was based on a postal survey, carried out among a stratified random sample of 2,000 persons aged 65 years and over registered with general practices in a British city.[9] Of the surveyed

9 The response rate was 79%. Non-response was greater among the oldest of the sample and among women, so the results may be biased in that the non-responders may be in poorer health and more isolated. The authors themselves advise caution on generalising their results to the broader national population since the communities sampled were more affluent and with smaller proportions of ethnic minorities than the national averages.

sample, 14.4% used statutory home care services and 10.7% used private home care services.

The utilization of statutory home care services was found not to be significantly different according to gender (13.2% of men and 15.8% of women utilized these services), while the use of private services was found to be more widespread among women (8.1% and 13.7% for men and women, respectively). Logistic regression was used to explore potential determinants of the use of these services and the analysis was conducted separately on men and women. The main findings were quite similar for both private and statutory services. Age, car ownership and widowhood affected service utilization for men and women alike. Being single, divorced or separated was shown to be correlated with a higher incidence statutory services utilization for men only. For both types of services, utilization increased with poorer self-reported health status. It was also found that weaker or smaller social networks were associated with greater use of statutory services, but these effects were shown to disappear once demographic factors were controlled for.

Apart from differences in utilisation or access to services, it is important to know something more about gender differences in the quality of social or health services. Good quality care is fundamental in supporting older and disabled people and encouraging them to live more independent and fulfilling lives. The mechanisms through which quality is to be raised include training, inspecting and encouraging providers to meet the National Minimum Standards, and enforcing them by law to comply with the regulations.[10] Other mechanisms include the publication of performance indicators and star ratings (Department of Health, 2002).

However, learning about quality of services from the perspective of service users is thought to be increasingly important, and it represents the only way in which differences among various categories of users can be highlighted. Defining service quality from a user point of view is however a difficult task, as it invariably requires the researcher to take into account the very complex set of preferences and decision

[10] Relevant references are to be found on the Department of Health website and specifically on: http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/NationalCareStandardsCommission/fs/en.

criteria that people adopt, often unconsciously. In addition, quantitative evidence is difficult to collect as it requires access to a sufficiently high number of people and issues such as cost and ethical approval may arise.

Nevertheless, some efforts in this direction have been made. Professor Ann Netten and her colleagues at the University of Kent conducted a pioneering study in this area which shows how existing information collected by the Government can be integrated at a relatively low cost in order to explore in more detail the factors associated with variation in quality of services (Netten *et al.*, 2004). This study provides an excellent example of how we could learn more about gender differences in service quality using quantitative analysis on a nationally representative scale.

Since 2001 all councils with social care responsibilities have been required to carry out user satisfaction surveys. In 2002-03 the survey focused on older users of home care and, for a sample of participating councils, the questionnaire was extended to include a number of more detailed questions about the use of these services and their quality. Netten *et al.* (2004) analysed this additional information to derive four dichotomous indicators that best explained overall variation in service user experiences: service quality, positive and negative care worker characteristics, and outcome. It was then possible to investigate user-specific and council-specific factors associated with perceptions of home care services. The analysis revealed that better experiences of service quality were significantly associated with being male (24% of the users in the sample were men), especially when looking at quality of carers and overall service quality.

As this study does not specifically focus on gender differences, it is impossible from these results to say anything more about the reasons for observed variation between male and female experiences of home care services. However, the analysis is informative in that it highlights the possibility of using mechanisms for data collection which are already in place, like the user satisfaction surveys, and adapt them in order to investigate variation in service quality experiences among different group of users, such as men and women. It is hoped that more effort in this direction will be made in the future.

Our own analysis of General Household Survey data on service use, disaggregated by gender, is presented in Chapter 4.

3.3 Care in the community, older people's multiple roles

This section reviews British evidence on older men and women as carers. Given the potential importance of this aspect for the life of people aged 65 and over, it is quite surprising that there is little empirical research on this topic. Much of the literature on carers either regards carers as a homogeneous group (e.g. all individuals aged 16 and over) or focuses on middle aged (female) carers. Non-academic research, in particular, tends to address issues that concern the needs and the social role of the carers as a homogeneous group (Maher and Green, 2002), while academic studies tackle more specific issues, such as the impact of caring on work commitments (Evandrou and Glaser, 2003; Spiess and Schneider, 2003) or the effect of caring on the carers' health (Hirst, 2005; Singleton *et al.*, 2002). Very little is known on the conditions of older carers (Maher and Green, 2002) and even less is known on the needs of older men and women as carers. This part of the literature review will therefore mainly highlight the need for further research in this field.

Caring in the UK

Existing analysis of the most recent General Household Survey data on caring (Maher and Green, 2002) shows that caring is a quite common activity in the UK. In 2000, 16% of people aged 16 and over were caring for a sick, disabled or elderly person and 21% of households contained a carer. These figures represent around 7 million adult carers in 5 million households. In Britain, those most likely to be carers are: women (18% compared to 14% of men taking all ages together); middle-aged, (24% compared to 8% of 16-29 year old and 16% amongst those aged 65 and over); and married or co-habiting (19% compared to 10% of single people).

Maher and Green (2002) also provide information on the nature of care provided. They find evidence suggesting that caring is a very demanding activity: a third of carers were the only support for the main person cared for (with women being more

likely than men to be the main support). In addition, caring is also a very time-consuming commitment that in some cases becomes long-term: 28% of carers spent at least twenty hours per week on their caring responsibilities and 21% had been caring for someone for at least 10 years. Furthermore, caring is a very intense activity: 18% of carers were looking after someone with both a mental and a physical disability.

The support provided to the carers or the person cared for by the state or the voluntary sector seems to be quite limited. Only 41% of people being cared for received visits from health, social and voluntary sector. This could be one of the reasons why 39% of carers left alone to deal with such a demanding task reported that their physical or mental health had been affected as a result of caring.

The impact of caring on carers' lives

Two recent studies looked at the impact of caring on the health conditions of British carers aged 16 and over. Singleton *et al*. (2002) analysed the effect of caring on the mental health of English carers. Hirst (2005) studied the consequences of caring on psychological distress. In both studies it was found that caring is a strong determinant of mental disorder and distress.

Singleton *et al*. (2002), in particular, found that high levels of neurotic syndromes were more likely to be found in female carers, people caring for a spouse or a partner, carers of people with physical and mental problems, people looking after a co-resident person and carers with limited social networks.[11] Hirst (2005) found that carers providing long hours of care over extended spells present raised levels of distress, and that this applied to women more than men. In addition, he found that adverse effects on the psychological well-being of heavily involved carers are most pronounced around the start of their care episodes and when caregiving ends.

[11] In this study, older carers refer to people who are 65 and over. The findings cannot be broken down by older age group.

Academic researchers have also looked at the impact of caring on the work arrangements of middle aged (mainly) female carers. Spiess and Schneider (2003) examine the relationship between care-giving and employment among women aged 45-59 years in Europe, while Evandrou and Glaser (2003) analyse the impact of the provision of care upon the employment and the subsequent state and private pension entitlement among middle aged men and women.

In both studies it was found that in Britain caring is often associated with a reduction in the number of working hours. Spiess and Schneider (2003), in particular, found that starting care-giving significantly reduces working hours for women in Britain and, more in general, for women living in northern European countries (except Ireland). The reduced working pattern of British carers has serious implications for their levels of pension income in later life.

Evandrou and Glaser (2003) found that towards the end of their working lives carers had accumulated fewer years of contributions than the non-carers. They suggest that the extension of employers' schemes to help workers balance paid work and family responsibilities would facilitate more carers remaining in the labour market for longer, as would an explicit carers' dimension within the new Working Tax Credit. The authors also call for consideration to be given to extending credits for second-tier pensions to working carers who provide care for over 16 hours a week and who earn below the lower earnings limit. Announcements in the recent White Pensions paper propose changes to the basic and second state pension which will make it easier for carers to accumulate full state pension rights (Secretary of State for Work and Pensions, 2006).

Older carers

Although 16% of people aged 65 and over are carers, very little is known about the role, the conditions and the needs of older carers. In this respect, non-academic institutions have shown a greater interest in tackling this issue than academic ones. In a study commissioned by Help the Aged and Carers UK, Milne *et al.* (2001) bring together previous evidence and supplement it with new analysis of the 1995 General Household Survey to describe the conditions and the needs of carers aged 60 and

over. Given the relevance of this piece of work, we present here in details the main findings of their research. They found that:

- In 1995, nearly one third of all carers were aged 60 and over. Within this “old” group, 4/5 was relatively young, aged 65-74, and 1/5 were aged 75 and over. The latter group is expected to expand in the future, given the ageing of the British population. About half of older carers are female and half male.

- Older carers predominantly looked after older care-recipients. In particular, one third of older carers supported their spouses. Those caring outside the home offered care to parents, friends/neighbours and other relatives.

- Nearly half of all carers who looked after parents/parents-in-law were aged over 60, the majority of these being women.

- For older carers, caring could be a very demanding activity. Nearly 40% of older carers were providing support for over 20 hours a week. In addition, the older the carer was, the more likely he/she was to be spending long hours providing care. There were no gender differences with respect to either the amount of time spent providing care or the range of caring tasks.

- Because of such intense commitment, the consequences of caring in terms of physical, social and economical well-being are far-reaching and long-term. There is evidence that suggests that this is true for both men and women. Support from health and social care services is therefore welcome.

- Issues related to caring in minority ethnic populations still need to be addressed. There are, in particular, many gaps in the present understanding of the structure and dynamics of informal care within ethnic communities.

In Chapter 4 we present new and more up-to-date analysis of General Household Survey data on caring, contrasting the position of men and women.

3.4 Social participation in later life

Numerous studies of what older people say is most relevant for both their social lives and as potential sources of help have attested the importance of family ties and other types of social networks (Bowling, 1995; Scott, 1997). Social participation and the support drawn from the family and other relationships are found to be associated with differentials in health, life satisfaction and mortality, and have been shown to have a significant influence on quality of life in old age (Bond and Corner, 2004; Grundy and Bowling, 1999). This suggests that the promotion and the enhancement of social participation in later life should be given great consideration and, indeed, this has become one of the main objectives of the Government social policy for older people (Social Exclusion Unit, 2006b).

The term social participation refers to the advantages that come with developing and maintaining a variety of social relationships and involvement in the community. Aspects of social participation include contact with a partner, adult children or other family members, interactions with neighbours and friends, as well as engagement in voluntary work and local leisure and social activities. The extent to which an individual is excluded from this set of networks and activities is often defined using concepts such as loneliness, isolation, or vulnerability.

There are well documented gender differences in the structure of families and social networks. Women are consistently found to have larger and more complex networks than men; they report having more friends and receiving more support from their networks. Men, on the other hand, tend to maintain close, intimate relationships only with a few people, primarily their spouse. These gender differences in patterns of social participation appear to be consistent across the adult life span (Shye *et al.*, 1995).

Older people are diverse, however, and the availability of relatives and frequency of family contacts differ greatly among their subgroups. Most obviously, older men and women differ in terms of their *marital status* and their *living arrangements*. As we saw in chapter 2, 61.0% older men are currently married against 36.7% older women

(Table 2.8), while the percentage of widowed men is only 16.5% against 46.1% for women. Similarly, if we look at living arrangements or household composition, we see that the percentage of older men who live with a partner is about 60.8, while the corresponding number for women is only 36.6. As the percentage of men and women who live with others is almost equal, these numbers automatically imply that more older women than men live alone, 46.3% against 22.5% (data not shown).

It is almost impossible not to consider differences in marital status when analysing the extent of older people's social networks and their level of social embeddedness. Empirical research on older people has repeatedly shown striking variation in the social networks and social well-being of older men and women in relation to their marital status (de Jong Gierveld, 1998). In a recent study on loneliness among older people in the UK, Victor *et al.* (2006) show that crude gender differences in reporting feelings of loneliness disappear when controlling for marital status. In particular, widowhood is found to be the single most important factor associated with vulnerability of older people to loneliness.

The reasons why marital status is so strongly associated with measures of social participation among older people are rather intuitive. Living with someone else provides companionship and is a potentially important source of informal care. But the loss of a partner not only brings with it feelings of bereavement, it can also have potentially important consequences on the level of income, particularly when the woman is the surviving member of the couple. A sufficient level of income is necessary for engagement in society. It determines the ability to socialise outside the home, visit friends, buy presents for family members and go on holiday. Income differences among older men and women are one of the mechanisms through which gender differentials in social participation arise (Arber *et al.*, 2006)

Car ownership too is differentiated by marital status. While owning a car indicates that a household has sufficient material resources to run and maintain a car, it represents far more than that to many people. It may indicate independence, the ability to shop, visit friends and family members, attend hospital appointments and so forth (Arber *et al.*, 2006). Yet, older cohorts of women, particularly those over 70, came from generations where it was unusual for them to obtain a driving licence

(Dale, 1986). Even when they are able to drive, research has shown that older women tend to stop driving at a younger age than men, despite similar physical and mental abilities (Rabbitt *et al.*, 1996). Thus, for women, widowhood or divorce may represent more than the loss of a breadwinner and a partner, it may include the loss of mobility.

Whether older people live alone or not is closely related to marital status, but it is interesting to notice that the relationship between social participation and living arrangements is not as clear-cut as the relationship with marital status. This is probably because living arrangements are also strongly associated with the health status of older people, itself a strong influence on the degree to which individuals interact with others and with their community.

Studies of older people show that those who live alone, at least in the oldest age groups, are healthier than their counterparts who live with adults other than a spouse, and a few studies have shown that they are even healthier than married individuals (Crimmins and Ingegneri, 1990; Glaser *et al.*, 1997; Hebert *et al.*, 1999). This association is likely to be the effect of a selection mechanism, as we can expect that those with serious health problems are no longer able to live separately. But, even though living with others can provide support and care and can compensate for the negative effects of health deficiencies, the overall effect on quality of life can be negative if people value their independence highly enough. So, it is possible to observe relatively high rates of loneliness among people living with their relatives (Wenger, 1984) or among those who have frequent contact with family or friends (Victor *et al.*, 2005).

Although differences among older people according to their marital status and living arrangements can explain part - if not all – of the gender difference in measures of social participation (Victor *et al.*, 2006), it would be precipitate to argue that these compositional effects are all that matters. In particular, looking at marital status shows that not only are there interesting and very important differences *within* male and females, but that the relationship between marital status and feelings of isolation, perceptions of loneliness and the type and extent of social networks is very different according to gender.

For example, a recent analysis conducted on data from the Health Survey for England shows that never-married older men in England are at much higher risk of reporting poor social support than ever-married men, and that this differential is greater than the difference between those living alone and those living with others. Among women, on the other hand, the associations between marital status and perceived social support were less marked among those aged 65-79 years, and insignificant among those aged 80 or more years (Grundy, 2006). Using data from the General Household Survey, Arber *et al.* (2006) find that there is much greater variation in the frequency of social contacts with friends, relatives and neighbours among men according to marital status than among women.

Another common finding in this area is that older men who are never-married or divorced (or separated) engage in considerably less social interaction than married and widowed older men. Consequently, it could be argued that they are more likely to be susceptible to social isolation in their later years. Divorced men in particular are less likely to have large social networks and to keep in touch with their adult children and other family members (Doherty *et al.*, 1998; Amato, 2000). This difference can be related to factors such as non-resident parent's lack of involvement, the failure to pay child support and feelings of anger, particularly from children, towards the father who left the family. Qualitative studies also show that divorced men are the least content about their situation and view their future as characterised by feelings of loneliness (Davidson *et al.*, 2006)

These results bear two important messages. First, it seems that women 'do friendship' differently compared to men, so that life-events which modify their partnership situation – such as widowhood and divorce or separation – do not have the same devastating consequences on the degree of social participation we see for men. Secondly, despite the fact that on average men have an inherent advantage in maintaining their social networks, as they are more likely to be married and to be in good health than women in their later years, there are groups of men who suffer disproportionately from feelings of loneliness and isolation, such as never married men and divorced or separated men.

3.5 Summary

- Social inclusion is a very broad and multidimensional concept that has been recently introduced in the literature on older people. By social inclusion we refer here to the way in which older people engage with their families and broader community through the utilization of services, the provision of informal care, and by taking part in leisure and social activities.
- Issues related to the health and social services for older people have been gaining a wider space in the agenda and in the activities of politicians and civil servants. In spite of this, studies which analyse gender differences in the degree of access, use and quality of services are extremely hard to find. The very few studies carried out on this topic seem to suggest that gender differences in the access and use of services may be important and should be given further consideration.
- Very little is known on the role of older men and women as carers. Much of the literature either regards carers as a homogeneous group or focuses on middle age (female) carers.
- The literature on social inclusion in later life is quite rich. There is wide consent amongst scholars that indicators of social participation are highly associated with marital status of older people. In particular, some groups of men – i.e. separated and divorced men – seem to report disproportionately strong feelings of isolation and loneliness.

4 Older people and social inclusion: a secondary analysis of the data

This chapter explores the situation of older men and women in Britain with respect to their degree of social inclusion. The analysis is carried out using the General Household Survey, a nationally representative survey of individuals living in private households conducted on an annual basis by the Office for National Statistics (ONS). This survey began in 1971 and has been administered continuously since then, except for breaks in 1997-1998, when the survey was reviewed, and in 1999-2000, when the survey was redeveloped. Since then, data are continuously collected on five core topics, namely: education, employment, health and use of health services, housing, population and family information. Special topics are added and changed from year to year according to a modular structure.[12]

Our analysis is based on the 2000-01 wave of the GHS, which includes a special module on informal care and a special module on social capital. The total sample consists of approximately 14,000 adults living in Great Britain, a fifth of which aged 65 and over.

This chapter focuses on the three specific themes in which our analysis of social inclusion is articulated, and is organised as follows. Section 4.1 addresses gender differences among older people in terms of service needs, access and quality, section 4.2 draws a picture of older people as informal carers, while section 4.3 analyses gender patterns in social participation. The last section summarises the main results.

4.1 Service needs, access and quality

As explained in section 3.2, policy makers have shown an increasing interest in issues related to the provision, the access and the quality of social and health

[12] See also http://www.statistics.gov.uk/ssd/surveys/general_household_survey.asp for more information on this survey.

services for older people (see, for example, Healthcare Commission, 2006 and Malley *et al.*, 2006). In spite of this, very little effort has been made to disentangle the role of gender with respect to the health and service needs of older people. However, there seems to be evidence that suggests that service utilisation is not dependent on gender *per se* but it is rather affected by age, car ownership and marital status (Stoddart *et al*., 2006), while the evaluation of service quality seems to be related to gender (experiences of better service quality tend to be reported more frequently by men). In this section we describe the experiences and the conditions of older men and women with respect to the needs, the use and the quality of health and transport services.

Health services

The GHS asks a series of questions about health and the use of health services. Periodic changes have been made to the content of the health section, but since 1972 respondents have been consistently asked whether they have a long term illness or disability, and if so (and since 1973) they have been asked whether this limits their activities in any way. The answers to these two questions provide a measure of "limiting long term illness", which is a widely used indicator of health status and has been shown to be an accurate predictor of early mortality, psychological health problems and hospital utilisation. This variable is often analysed in order to assess the service needs of certain groups of the population.

The first thing to notice is that there are no gender differences in the percentage of people aged 65 and over who report a limiting long term illness (see Table 4.1). On the other hand, when we disaggregate by age, we can see that men are more likely to report health problems in the younger age group while the opposite occurs among the oldest old. Although the overall percentage of those reporting a limiting long term illness is lower than what it appears to be in the 2001 Census (40.2% against 49.9% in the Census data), the general picture that emerges is the same we saw in section 2.5. Looking at general health status, another commonly used measure of self-reported health, we find that the same considerations apply (Table 4.2).

Table 4.1 Limiting long term illness by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Limiting long term illness									
No	61.6	65.6	63.7	57.4	53.5	55.0	60.0	59.8	59.8
Yes	38.4	34.4	36.3	42.6	46.6	45.0	40.1	40.2	40.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N.obs.weighted(000)	2,126	2,452	4,578	1,395	2,259	3,654	3,521	4,711	8,232
N.obs.unweighted	779	843	1,622	526	738	1,264	1,305	1,581	2,886

Source: General Household Survey (2000-01).

Table 4.2 General health status by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
General health									
Good	42.3	44.5	43.5	36.4	30.1	32.5	40.0	37.6	38.6
Fairly good	35.4	34.6	35.0	38.3	43.7	41.6	36.6	39.0	38.0
Not Good	22.2	20.9	21.5	25.4	26.2	25.9	23.5	23.5	23.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N.obs.weighted(000)	2,126	2,452	4,578	1,395	2,259	3,654	3,521	4,711	8,232
N.obs.unweighted	779	843	1,622	526	738	1,264	1,305	1,581	2,886

Source: General Household Survey (2000-01).

It is questionable, however, whether we can consider these measures of health as an indication of *need*, and hence of the demand for health and social services. The concept of need is much wider and more articulated. Broadly speaking, need should be determined with respect to the outcomes that individuals and society as a whole aim to achieve, and its definition should not be restricted to disability or infirmity (King's Fund, 2006).

Yet, knowing the numbers of people in ill health, who have some form of disability or are in some way or another impaired is undoubtedly important in order to understand the current and expected demand for health and social care. While the definition of

limiting long term illness is perhaps too restrictive, there are other ways in which a measure of need could be elicited.

For example, an alternative way to address this problem is to ask questions about people's ability to carry out Activities of Daily Living (ADLs) - such as getting in and out of bed, getting dressed or showered, etc. – or to collect measures of physical performance – such as grip strength and lower limb mobility. Unfortunately, the 2000-01 wave of the GHS does not contain any such indicator, so we are unable to offer here a full gender analysis of these aspects.

However, the first report on the 2004 wave of ELSA provides some information on these variables and on the extent of gender differences found (Banks *et al.*, 2006). This wave of the survey collects information on ADLs and on several measures of physical performance (walking/gait speed, time to complete chair stands, balance tests and grip strength). While ADLs are self-reported measures of disability, performance tests are carried out in the presence of a nurse and therefore represent a more objective measure of disability. Gender differences in measures of disability derived using these different methods may reflect differential attitudes to reporting problems between men and women.

Preliminary analysis of the data shows that physical performance declines with age and that those limitations are more common among women than men, although the differences found are usually not very large. The survey also highlights a greater tendency for women to report problems with ADLs than men at a given level of performance. This would seem to indicate the presence of gender-specific attitudes in reporting difficulties with everyday tasks, which is in itself a very important aspect to take into account when thinking about service access and provision.

Despite the fact that there are problems with the definition and the measurement of service needs, some evidence is indeed available. By contrast, we cannot say the same when we come to analyse *access* to services. This is because it is extremely difficult to gain a meaningful picture of the supply or availability of certain kinds of services from data collected at the individual level, whether or not a gender approach is warranted.

Although in principle aggregate data should be more appropriate in this respect, in practice this is not always the case. *Community Care Statistics*, an annual publication of the Department of Health, contains detailed tables on the number of contact hours of home help and home care provided by the local authorities or the independent sector and the number of households receiving these services. *Patient Care in the Community: NHS District Nursing*, also published by the Department of Health, reports the number of patient contacts with the NHS district nursing services. Informative as they are, these data are a measure of service use, rather than service accessibility or availability and all the main findings are not disaggregated by gender.[13]

The GHS, on the other hand, routinely provides data about the use of health services among children and adults although, regrettably, the 2000-01 wave does not collect information on the use of social services. Since the data are collected at the individual level, gender and age can be adequately controlled for. Some of the most interesting questions asked in the survey include: (i) consultations with NHS General Practitioner or specialist in the past two weeks, (ii) consultations with practice nurse in the past two weeks, (iii) number of hospital inpatient stays in the last year, and (iv) number of hospital outpatient visits in the past three months. Table 4.3 below presents the percentages of individuals who used these types of health services at least once in the period of time considered. As we can see, there is not much of an age gradient in the likelihood of having consulted a GP, a specialist doctor or a nurse. By contrast, the percentage of those experiencing an outpatient or an inpatient stay increases with age.

As far as gender differences are concerned, we see that women are generally more likely to consult a doctor than men. This difference is however rather small here, especially if compared to the gap observed in the age group 16-44 (9% of men

[13] For example, *Community Care Statistics* collects data on supported residents by type of care (residential or nursing), age group (18-64 and 65+), type of client (people with mental health problems, people with learning disabilities, physically/sensorily disabled), type of stay (permanent or temporary) and location. As we can see, there is no attempt to disaggregate the data according to sex. For more information on these publications and recent data see http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/StatisticalWorkAreas/fs/en in the areas of health care and social care.

against 18% of women, data not shown), when doctor consultations are more likely to be associated with pregnancy or birth control issues, and when women are more likely to consult the doctor on behalf of their children. If we look at outpatient attendances, we actually see that the gender difference is of opposite sign, with men being more likely than women to use this service. This is especially so for the group of men aged 65-74, where the difference between male and females is statistically significant. Looking at inpatient stays, on the other hand, we do not notice any relevant gap between sexes.

Table 4.3 Type of health service used by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Type of service									
% NHS doctor[a]	19.2	22.1	20.8	19.3	22.1	21.0	19.3	22.1	20.9
% NHS specialist[a]	1.4	2.0	1.7	1.5	0.8	1.1	1.5	1.4	1.4
% Nurse[a]	9.9	10.2	10.1	8.9	9.6	9.3	9.5	9.9	9.7
% Inpatient[b]	13.0	12.4	12.7	16.8	16.6	16.7	14.5	14.4	14.4
% Outpatient[c]	24.2	20.5	22.2	25.0	24.4	24.6	24.6	22.3	24.2
N. obs. weighted (000)	2,126	2,452	4,578	1,395	2,259	2,259	3,521	4,711	8,232
N. obs. unweighted	779	843	1,622	526	738	738	1,305	1,581	2,886

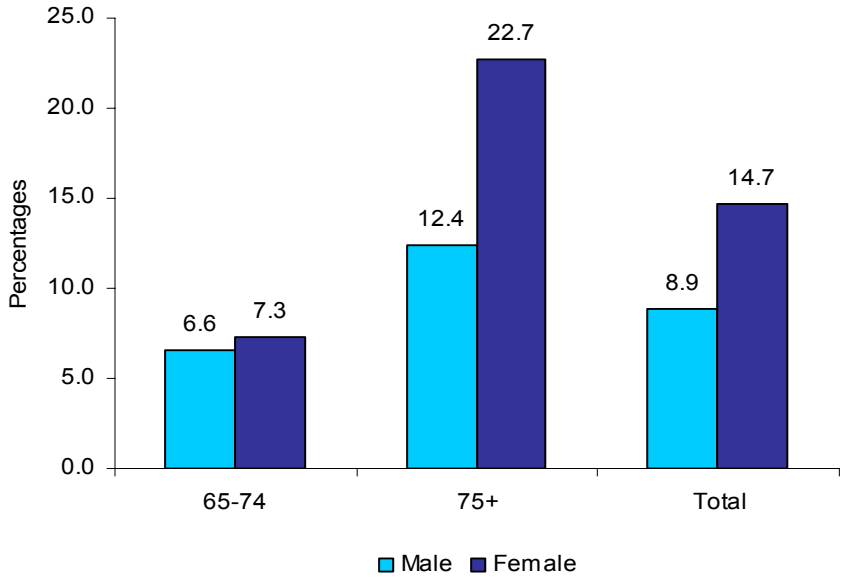
Source: General Household Survey (2000-01). Notes: a = last year, b = last two weeks, c = last three months.

What is very interesting in analysing the use of health services are the observed differences in the type of consultation by age and gender. As we see from Graph 4.1, the percentage of women who consult a doctor at home is 14.7%, whereas men who opt for this type of consultation are only 8.9% of those who contacted their GP in the two weeks before the survey. Disaggregating by age reveals that the gender difference in the type of doctor consultation is to be attributed to the behaviour of the oldest old, in particular those aged 75 or above. A similar picture emerges when looking at GP consultations by phone (Graph 4.2).

This significant gender difference in the modality of access to doctors among the oldest old might be due to differences in the health status of men and women of a certain age. As we saw in Table 4.1 and Table 4.2, women aged 75 or above are generally in worse health conditions compared with men of the same age. However, even if we consider only those who do not report a limiting long term illness we still

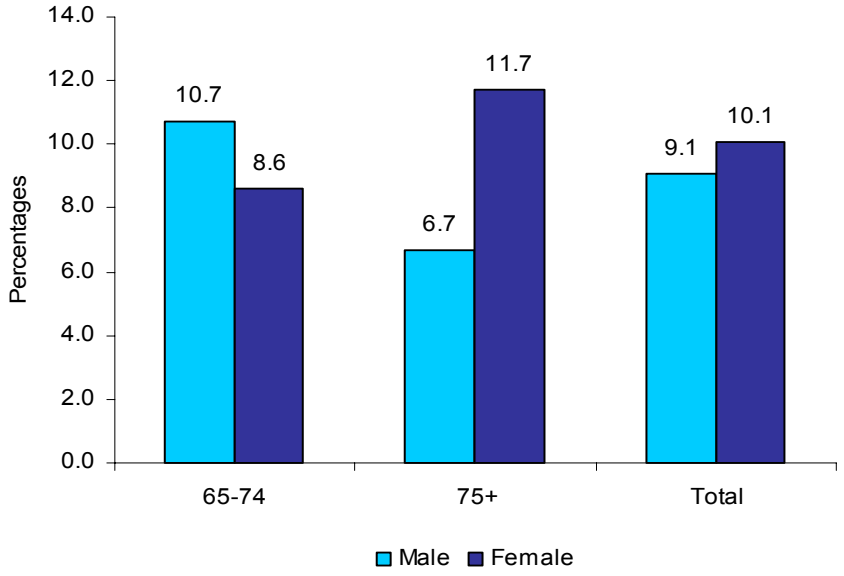
find that women are much more likely to receive a home or a telephone consultation in this age group (8.9% versus 31.8%, data not shown).

Graph 4.1 Consultation with doctor at home by sex and age



Source: General Household Survey (2000-01).

Graph 4.2 Consultation with doctor by phone by sex and age

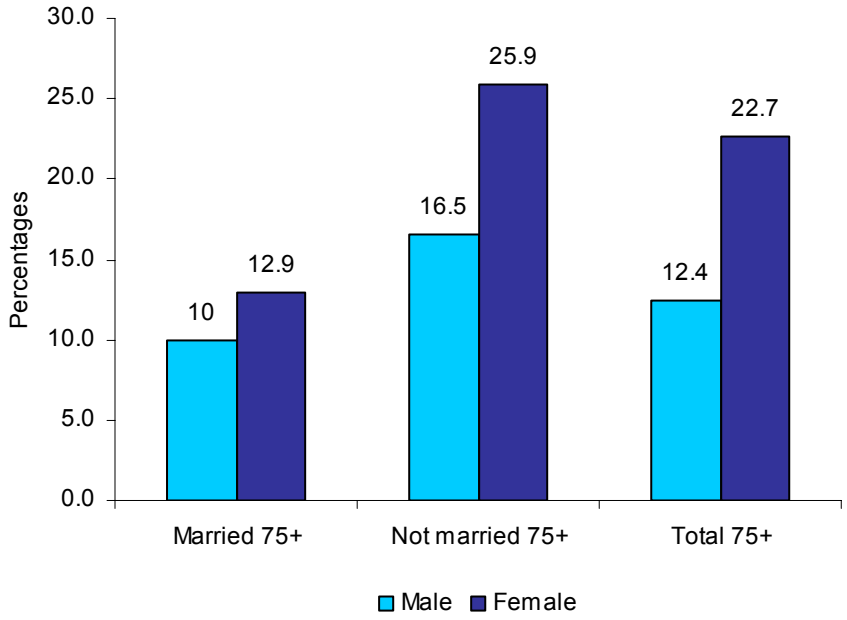


Source: General Household Survey (2000-01).

Further analysis reveals that these gender differences are mainly correlated to differences in marital status. In particular, Graphs 4.3 and 4.4 plot the percentages of men and women aged 75 or above who consult their doctor at home or by phone, respectively, according to whether they are married or not. As we can see, the differences are not large for those who are still currently married, while they are much more marked for those who are single, widowed, divorced or separated.[14] As we shall see shortly, marital status is strongly associated with access to transport and this indicates that it is this aspect, rather than gender *per se*, that explains why women are more likely to receive domiciliary consultations compared with men.

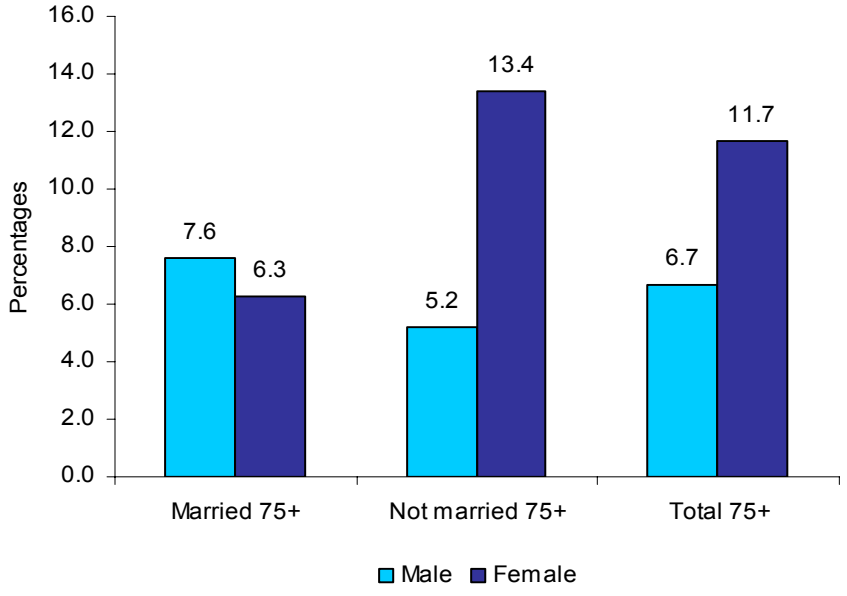
[14] Here we consider single, widowed, divorced or separated older people as a single group because the numbers are too small to divide the sample into separate categories. We should keep in mind, however, that the largest proportion of people in this group is represented by widowers and widows.

Graph 4.3 Consultation with doctor at home, by sex and marital status – 75+



Source: General Household Survey (2000-01).

Graph 4.4 Consultation with doctor by phone, by sex and marital status - 75+



Source: General Household Survey (2000-01).

Transport services

Apart from information on health services, the 2000-01 wave of the GHS offers some insight on the availability and use of different forms of transport. For example, Table 4.4 shows that men who have access to a car are about 70.5% of the population aged 65 and over, while women are only about 47.3%. This difference is quite large, statistically significant and is observed for all the different age subgroups, although it is considerably more relevant for those aged 75 or above.

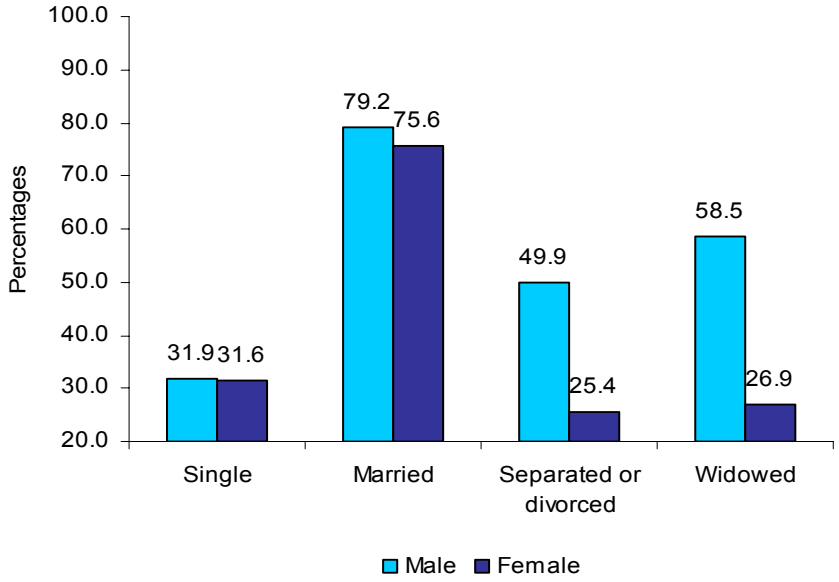
Table 4.4 Access to car in the household by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Access to transport									
% access to car	75.8	59.3	66.9	62.5	34.3	45.1	70.5	47.3	57.2
N. obs. weighted (000)	2,126	2,452	4,578	1,395	2,259	2,259	3,521	4,711	8,232
N. obs. unweighted	779	843	1,622	526	738	738	1,305	1,581	2,886

Source: General Household Survey (2000-01).

As this variable is collected at the household level, it is important to look at its distribution by type of living arrangement and here we use marital status as a proxy. Graph 4.5 reveals that most of the gender differential is to be found among those who are separated, divorced or widowed. Since the percentage of women who are widowed is very significant among older people, it follows that most of the overall gender differential is due to the particularly low access to this means of transport among this group.

Graph 4.5 Availability of car in the household by sex and marital status



Source: General Household Survey (2000-01).

Table 4.5 Main form of transport by sex and marital status

	Single			Married			Divorced or separated			Widowed		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Type of transport												
Car	37.5	41.8	39.6	74.6	68.3	71.7	55.7	32.3	41.3	50.1	36.3	39.4
Public transport	43.9	39.7	41.9	17.5	20.1	18.7	36.6	38.0	37.5	29.9	42.6	39.8
Ciclyng	3.1	2.0	2.6	0.6	0.8	0.7	0.0	3.1	1.9	1.7	0.7	0.9
Walking	10.3	7.4	8.9	4.1	6.8	5.3	7.7	14.5	11.9	8.3	9.5	9.2
Other	2.1	6.6	4.3	2.2	3.0	2.6	0.0	9.0	5.5	6.0	7.1	6.9
Never goes out	3.0	2.5	2.8	1.1	0.9	1.0	0.0	3.2	2.0	4.2	3.8	3.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N. obs. weig. (000)	277	259	536	2,452	2,044	4,496	188	298	486	596	2,056	2,652
N. obs. unw.	82	77	159	426	348	774	61	91	152	208	634	842

Source: General Household Survey (2000-01).

The GHS also asks questions about the main form of transport used to all individuals who answered the social capital module of the questionnaire. As Table 4.5 shows, there is a significantly higher percentage of women using public transport among those divorced or separated and among those who are widowed. On the other hand, there are much smaller and not significant gender differences among married individuals. The gender differential works even in the opposite direction in the group of single (never married), although given the small number of individual concerned this is not a statistically significant result.

The results of our analysis on gender differences among older people in the use of health and social services are consistent with earlier findings. In particular, as described by Stoddart and colleagues (2002), the use of such services does not depend on gender *per se* but is associated with marital status of older people.

Satisfaction with local services

It is extremely interesting, and important from a gender perspective, to analyse whether there are significant differences between men and women in the quality of services used by the older population in Britain. The 2000-01 GHS offers some information in this respect. Those who answered the special social capital module were asked several questions related to their level of satisfaction with local services (Office for National Statistics 2002a). The measure of quality we have at our disposal is therefore a subjective measure and it inevitably reflects the preferences and the subjective criteria individuals use in judging their experience with service utilisation.

The first thing we can say looking at Table 4.6 is that there is a wide difference in the levels of satisfaction experienced compared with various kinds of services. Generally speaking, and irrespective of gender and age groups, levels of satisfaction are higher for local transport and health services while they are considerably lower for local leisure facilities and the local police services.

Table 4.6 Satisfaction with local services by sex and age

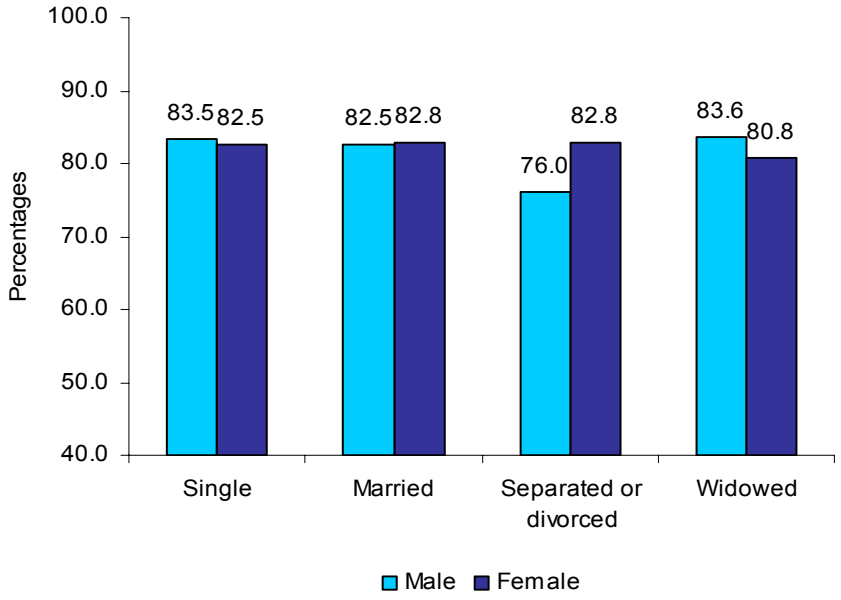
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Local health									
Good or very good	81.6	78.8	50.1	83.8	85.1	84.6	82.4	81.8	82.1
Local transport									
Satisfied	63.5	61.8	62.6	62.3	63.2	62.9	63.0	62.5	62.7
Local leisure facilities									
Good or very good	37.1	33.0	34.9	37.1	37.5	37.4	37.1	35.2	36
Local police									
Good or very good	23.9	26.4	25.2	31.2	33.5	32.6	26.8	29.7	28.5
N. obs weighted (000)	2,129	2,437	4,566	1,384	2,220	3,604	3,513	4,657	8,170
N. obs unweighted	426	572	998	351	578	929	777	1,150	1,927

Source: General Household Survey (2000-01).

We also notice that for women there is always an age gradient, with the level of satisfaction increasing over time, while for men the situation is much less clear-cut. In particular, for both men and women satisfaction with local health services and local police increase with age, while contrasting gender trends are seen with respect to local transport. In terms of strict gender comparisons, we do not observe any significant differences, only a tendency for men to be generally less satisfied than women with the quality of police services.

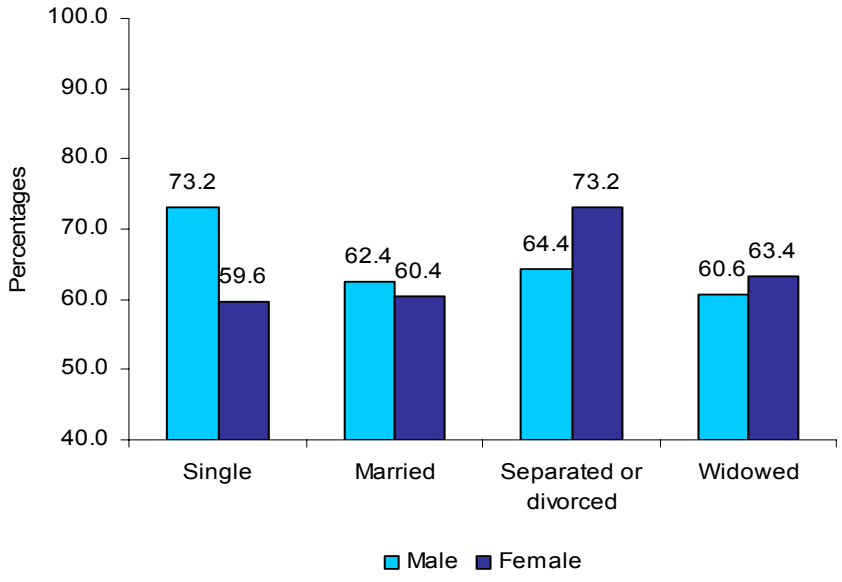
Further analysis of these variables by marital status confirms these results. We see almost no statistically significant differences across men and women among the various subgroups (Graph 4.6 and Graph 4.7). Such findings seem to contradict previous results. A study carried out by Nettern and colleagues (2004) has shown that male are more likely to express a better evaluation with respect to the quality of services.

Graph 4.6 Satisfaction with local health services by sex and marital status



Source: General Household Survey (2000-01).

Graph 4.7 Satisfaction with local transport by sex and marital status



Source: General Household Survey (2000-01).

4.2 Provision of informal care

As pointed out in section 3.3, there is very little empirical research on older men and women as providers of care. The attention has mainly focused on men and women carers in the 50-64 age range. In this section we try to address this gap and describe the main characteristics of older carers, which according to recent statistics account for one in five unpaid carers in Britain (Office for National Statistics 2002b).

It has often been emphasised that while women are more likely to provide care overall, men are the dominant proportion of carers in the age group 65 or above (Social Exclusion Unit, 2006a). This is shown clearly in Table 4.7, where we see that the percentage of men providing one or more hours of care per week is almost 2.5% points higher than the percentage of women in the entire group aged 65+.

This fact is however at least partly the result of a relatively larger proportion of women among the oldest old, who are likely to be the recipients rather than the providers of care. Indeed, if we look at more detailed age groupings, we see that the percentage of male and female carers is virtually identical in the group aged 65-74, while it differs only for those aged 75 or above.

Table 4.7 Provision of informal care by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Carers									
% carers	19.0	19.1	19.1	15.3	10.8	12.5	17.5	15.1	16.1
N. obs. weighted(000)	2,126	2,452	4,578	1,395	2,259	3,654	3,521	4,711	8,232
N. obs. unweighted	779	843	1,622	526	738	1,264	1,305	1,581	2,886

Source: General Household Survey (2000-01).

The same considerations apply in terms of care intensity, as measured by the number of hours of care provided per week and by whether the respondent is the main carer or not. In particular, Table 4.8 shows that if we look at the total group of older people, women provide less hours than men (35.6% of women offer more than 20 hours per week against 42.5% of men). However, care intensity is much more

equally distributed by gender in the group aged 65-74, where – if anything – women are seen to provide slightly more hours than men. A similar pattern emerges when looking at the distinction between main carers, joint carers and other types of carers, as shown in Table 4.9.

Table 4.8 Number of hours of informal care by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Hours provided									
0-19	59.3	58.8	59.0	54.2	74.9	65.3	57.5	64.3	61.1
20-49	19.8	19.9	19.8	28.0	12.5	19.7	22.6	17.4	19.8
50+	21.0	21.4	21.2	17.9	12.6	15.1	19.9	18.4	19.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N. obs. weighted(000)	404	469	873	211	242	453	616	712	1,328
N. obs. unweighted	148	165	313	79	84	163	227	249	476

Source: General Household Survey (2000-01). Sample restricted to carers.

Table 4.9 Main carers by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Type of carer									
Main carer	63.1	62.3	62.7	77.1	66.3	71.3	67.9	63.7	65.6
Joint carer	6.2	7.3	6.8	2.2	6.1	4.3	4.8	6.9	6.0
Not main carer	30.7	30.3	30.5	20.7	27.6	24.4	27.3	29.4	28.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N.obs.weighted(000)	404	469	873	211	242	453	616	712	1,328
N.obs.unweighted	148	165	313	79	84	163	227	249	476

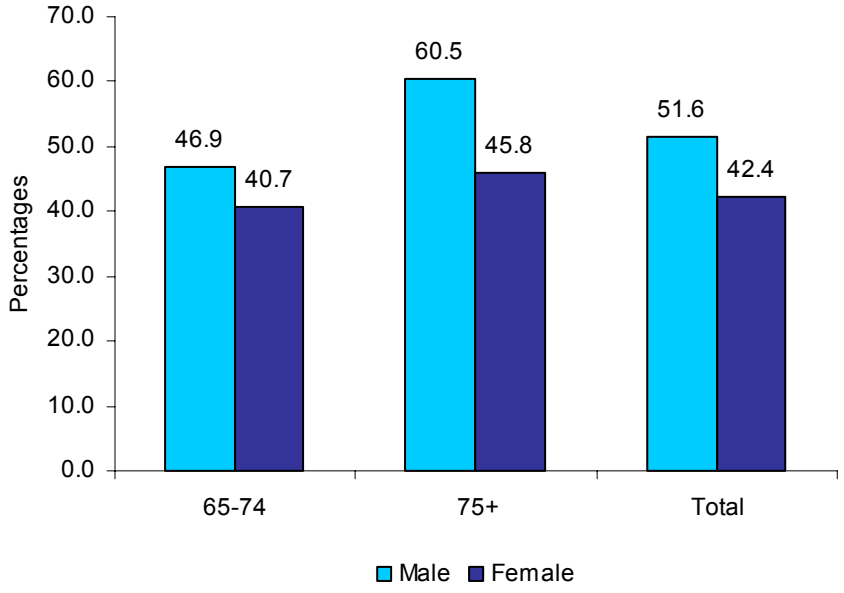
Source: General Household Survey (2000-01). Sample restricted to carers.

It is interesting to consider also whether the main person cared for resides inside or outside the household. As we can see in Graph 4.8, there are interesting gender differences in this respect, especially among the group aged 75+, where we incidentally observe most of the gender differences in terms of care intensity. Here we see that the majority of men who provide care look after someone who co-resides with them, whereas up to 54.2% of women cares for someone who lives in another

household. Since the percentage of women who lives alone is much higher than the percentage of men in this age group, it is clear that the propensity to provide care must be strongly correlated with household composition or marital status.

Table 4.10 addresses this issue by examining how gender affects the likelihood of being a carer keeping constant age, marital status and other characteristics of the individual which might be associated with care provision. Each reference category is set to a baseline value of 1.00, so that any category which appears with an odds ratio greater (lower) than 1.00 indicates that the likelihood of being a carer for that group is greater (lower) than that of the reference category.

Graph 4.8 Provision of care in the same household



Source: General Household Survey (2000-01). The distinction in/out of the household is with respect to the main person cared for by the respondent.

In Model 1 we see that women are overall less likely to be a carer than men, and that this difference is statistically significant. Once we control for age, however, we see that women still have a lower odds ratio than men but that this effect is not as strong as it was before. It is very interesting to observe what happens when we introduce marital status as an additional control variable. Women have now a higher odds ratio

than men, i.e. they are more and not less likely to be care providers (Model 3).[15] We also find that not being currently married is always associated with a much lower odds ratio of being a carer. The last model takes into account other characteristics of the individual, such as country of residence, presence of a limiting long term illness and tenure of accommodation, but the results remain virtually unchanged.

According to these findings, it would be more appropriate to look at gender differences in the likelihood of providing informal care *within* the same marital status or residential arrangement. This is exactly what we show in Graph 4.7, where we see that the odds ratio of men and women within each marital status category are very similar and never statistically different from each other.[16]

[15] Notice that, strictly speaking, this effect is not statistically significant, so theoretically the odds are not different from 1.00. However, a parallel analysis conducted on data from 2001 Census reveals a significant difference in this case.

[16] Even if quite large in terms of magnitude, the difference between male and female odds ratio in the category of single individuals is not significant from a statistical point of view. This is because this group is very small as it includes only 22 male and female carers on a total of 467.

Table 4.10 Odds ratio of care provision

	Model 1	Model 2	Model 3	Model 4
Male	1.00	1.00	1.00	1.00
Female	0.84**	0.88	1.12	1.11
Age 65-74		1.00	1.00	1.00
Age 75+		0.61***	0.75**	0.76**
Married			1.00	1.00
Single			0.51***	0.52***
Divorced or separated			0.36***	0.37***
Widowed			0.35***	0.36***
Other controls				√
Pseudo R2	0.0012	0.0100	0.0390	0.0420

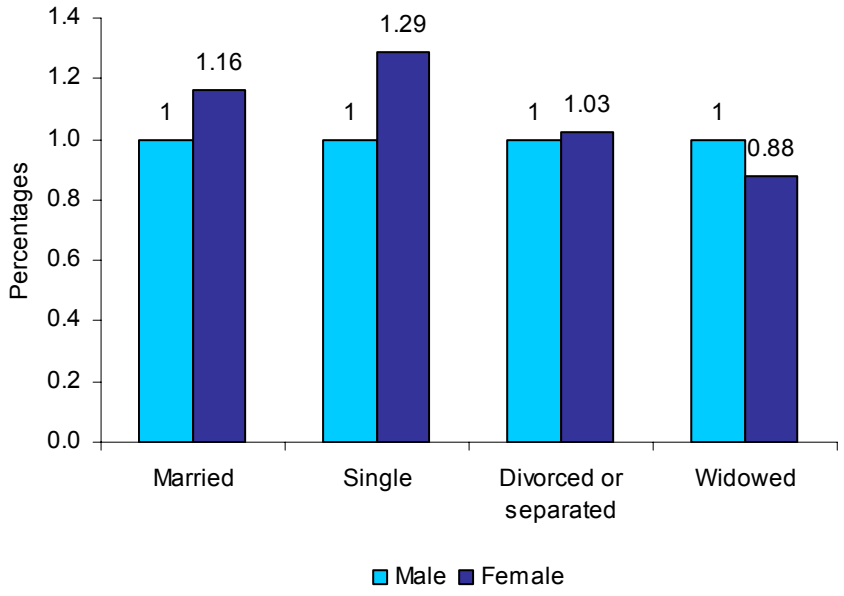
Source: General Household Survey (2000-01). Logistic regression of carer status on variables shown. Other controls include: country of residence, health status, tenure of household accommodation. Sample weights applied. Significance level based on standard errors clustered at the household level. Sample consists of 2,886 unweighted observations and 8,232 weighted observations. Symbols: *** statistically significant at the 1% level; ** statistically significant at the 5% level;* statistically significant at the 10% level.

This exercise shows that informal care provision towards sick, disabled and older people is an activity which is strongly associated with marital status, which we can think of also as a proxy for living arrangements. Older people who live with someone else, in most cases a partner, are much more likely to provide care than those who live alone. Since men and women are very different in terms of their living arrangements because of their different life expectancy, it is tempting to interpret differences in the proportions who are carers as gender differences but gender *per se* would appear not to be the main discriminating factor.

We saw in the previous chapter that caring has been found to have adverse effects on the well-being of the carers with some evidence that female carers suffer greater consequences than male carers (Singleton *et al*. 2002; Hirst 2005). In addition to considering gender differences in he extent of caring, it would therefore be useful to examine whether at older ages there are gender differences in the economic, social

and health consequences for carers. This is not possible with the GHS mainly because it is a cross-sectional survey.

Graph 4.9 Odds ratios of care provision by sex and marital status



Source: General Household Survey (2000-01). Logistic regression of carer status on: sex dummy, age group dummy, marital status dummies, interactions between sex and marital status dummies, country of residence, health status, tenure of household accommodation. Sample weights applied. Significance level based on standard errors clustered at the household level. Sample consists of 2,886 unweighted observations and 8,232 weighted observations. Symbols: *** statistically significant at the 1% level; ** statistically significant at the 5% level;* statistically significant at the 10% level.

4.3 Social participation

Issues related to the social participation and social inclusion of older people, as explained earlier in section 3. 4, have been widely debated in the literature. The findings of the studies carried out on such topics have highlighted the strong differences between men and women with respect to the degree of interactions with relatives and friends. On average, women are part of a more developed and structured social network than men. Empirical research has also shown that much of the gender variation in the degree of social inclusion is mainly due to a compositional effect: gender differences in social participation of older men and women with the same marital status tend, indeed, to shrink.

The majority of older people mention good social relationships as key to a good quality of life. However, for some, getting older makes it harder to maintain contact with existing friends and relatives. Withdrawal from economic activity, loss of a partner, poor health, reduced mobility, fear of crime and many other factors increase the sense of isolation that many older people perceive. A greater degree of exclusion may have repercussions on quality of life and lead to depression and loneliness. These feelings can stop people from interacting with their local community and accessing services they need (Social Exclusion Unit, 2006a).

There are well-documented gender differences in the structure of social networks (Shye *et al.* 1995). For example, there is substantial evidence that women have a primary role in maintaining family relationships, and this may represent a major advantage, especially after the dissolution of marriage through death or divorce. Men, on the other hand, are more likely to live a larger part of their life with a spouse, although demographic trends show that an increasing proportion of men over 65 will be single, divorced or separated in their latter years. Moreover, men are frequently seen as less likely to establish new relationship or to frequent facilities designed to provide company or support. Differential onset of disability and unequal access to economic resources contribute to make the relationship between gender and social participation in the community a very complex one to analyse.

The social capital module of the GHS 2000-01, the first one of its kind, was commissioned by the Health Development Agency as part of a larger research designed to explore the meaning and measurement of social capital, and its links with health (Office for National Statistics 2002a). The aim of the questions was to develop a new set of indicators relating to the social environment in which people live in. Five main aspects of social capital were investigated: (i) social networks, (ii) neighbourliness, (iii) civic engagement, (iv) social support, and (v) perception of the local area. This part of the questionnaire was asked of one randomly selected individual aged 16 or over in each household. About 8,200 individuals answered these questions, almost 2,000 of them aged 65 or older at the time of the interview.[17]

Table 4.11 Speaking to relatives on the phone by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Frequency of contact									
Daily	20.6	33.8	27.7	20.3	33.8	28.6	20.5	33.8	28.1
3-6 days p.w.	20.2	23.5	21.9	24.8	21.9	23.0	22.0	22.7	22.4
1-2 days p.w.	34.7	32.0	33.2	35.2	32.8	33.7	34.9	32.3	33.4
<once p.w.	24.5	10.8	17.2	19.7	11.5	14.7	22.6	11.1	16.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N.obs.weighted(000)	2,129	2,437	4,566	1,384	2,220	3,605	3,513	4,657	8,170
N.obs.unweighted	426	572	998	351	578	929	777	1,150	1,927

Source: General Household Survey (2000-01).

The first aspect we take into consideration is the degree of gender difference in contacts with relatives, as this is likely to be a major factor in defining older people's social networks. As we would expect, we see in Table 4.11 that women's interaction with their kin is much more regular than that of men. About 33.8% of women phones relatives daily, whereas only 11.1% contacts them less than once per week. The corresponding percentages for men are 20.5% and 22.6%, respectively, indicating much less frequent interaction. Similar differences emerge when considering more disaggregated age groupings. Our findings are consistent with the ones of previous studies (Shye *et al.*, 1995).

As discussed above, partnership status is likely to have a paramount influence on the degree of social contacts between older people and their relatives. In order to examine this aspect, we run a logistic regression and look at the odds of phoning a relative at least once per week by gender and marital status. We also control for age, country of residence, the presence of a limiting long term illness and tenure of household accommodation. Instead of comparing differences between men and women within each different partnership status, here we consider married men as the baseline category (odds ratio equal to 1.00) and look at the odds of all the other

[17] The data are weighted in order to compensate for differential non-response between this section and the other parts of the questionnaire.

different gender-marital status combinations in relation to it. This gives us the opportunity to examine differences according to marital status within gender.

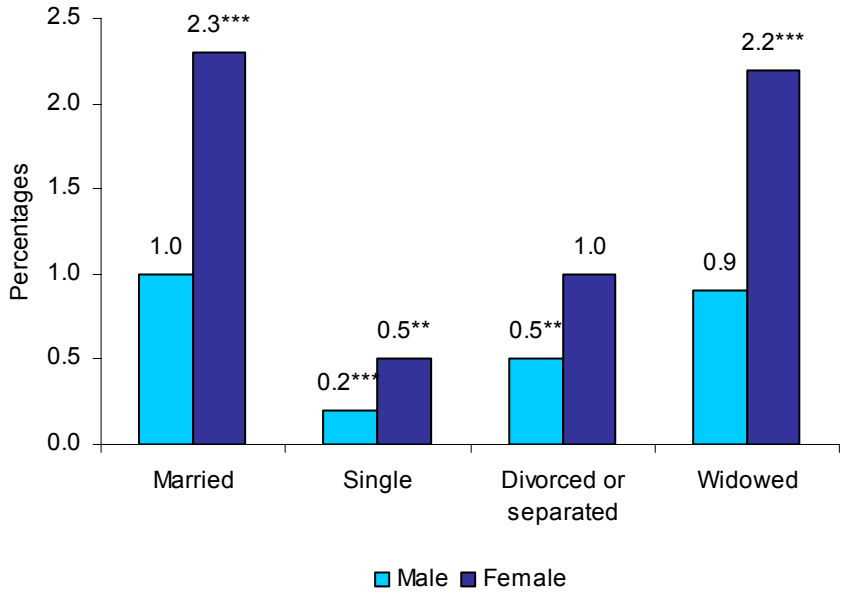
Graph 4.10 shows that even among those currently married, women are significantly more likely to contact their kin regularly. Interestingly, marked differences emerge within men in relation to their marital status. In particular, we see that single and divorced or separated men are much less likely to contact their relatives compared with married men, while the difference is not significant for widowers. As single (never married) men, may have a much smaller relatives network to begin with, it is clear that the group which is most at risk of losing contact with relatives is represented by divorced or separated men. Such results seem to support the results obtained by Amato (2000) and Doherty and colleagues (1998).

We observe a very similar pattern when looking at frequency of contact with friends. As shown in Table 4.12, women are more likely to regularly call their friends and this difference is usually statistically significant. In this case we also notice a progressive worsening of the degree of interaction of men with their friends over time, whereas the opposite occurs for women.[18]

While men seem to have less frequent interactions with relatives and friends, they appear to be more likely to speak to their neighbours. Table 4.13 shows that the percentage of men who speak to their neighbours every day is 4% points higher than that of women among the 65+. However, we also notice that men see these contacts deteriorating rapidly with age, a clear sign that these kinds of networks are rather fragile.

[18] Further analysis in terms of marital status broadly confirms what we have just shown with respect to contacts with relatives and is therefore not reported here.

Graph 4.10 Odds ratios of phoning relatives at least once a week



Source: General Household Survey (2000-01). Logistic regression of phoning relatives at least once a week on: sex dummy, age group dummy, marital status dummies, interactions between sex and marital status dummies, country of residence, health status, tenure of household accommodation. Sample weights applied. Significance level based on standard errors clustered at the household level. Sample consists of 1,927 unweighted observations and 8,170 weighted observations. Symbols: *** statistically significant at the 1% level; ** statistically significant at the 5% level;* statistically significant at the 10% level.

Table 4.12 Frequency of speaking to friends on the phone by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Frequency of contact									
Daily	12.4	14.1	13.3	10.3	16.9	14.4	11.5	15.4	13.7
3-6 days p.w.	19.2	21.0	20.1	14.3	19.7	17.7	17.3	20.4	19.0
1-2 days p.w.	32.4	36.7	34.7	35.6	37.1	36.5	33.7	36.9	35.5
<once p.w.	36.1	28.3	31.9	39.7	26.3	31.5	37.5	27.3	31.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N.obs.weighted(000						3,605	3,513	4,657	8,170
)	2,129	2,437	4,566	1,384	2,220				
N.obs.unweighted	426	572	998	351	578	929	777	1,150	1,927

Source: General Household Survey (2000-01).

Table 4.13 Frequency of speaking to neighbours by sex and age

	65-74			75+			Total		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Frequency of contact									
Daily	46.4	39.8	42.9	41.8	40.9	41.2	44.5	40.3	42.1
3-6 days p.w.	22.8	20.3	21.5	25.5	21.7	23.2	23.9	21.0	22.2
1-2 days p.w.	23.1	26.3	24.8	21.6	24.2	23.2	22.5	25.3	24.1
<once p.w.	7.8	13.6	10.9	11.1	13.3	12.5	9.1	13.5	11.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N.obs.weighted(000						3,605	3,513	4,657	8,170
)	2,129	2,437	4,566	1,384	2,220				
N.obs.unweighted	426	572	998	351	578	929	777	1,150	1,927

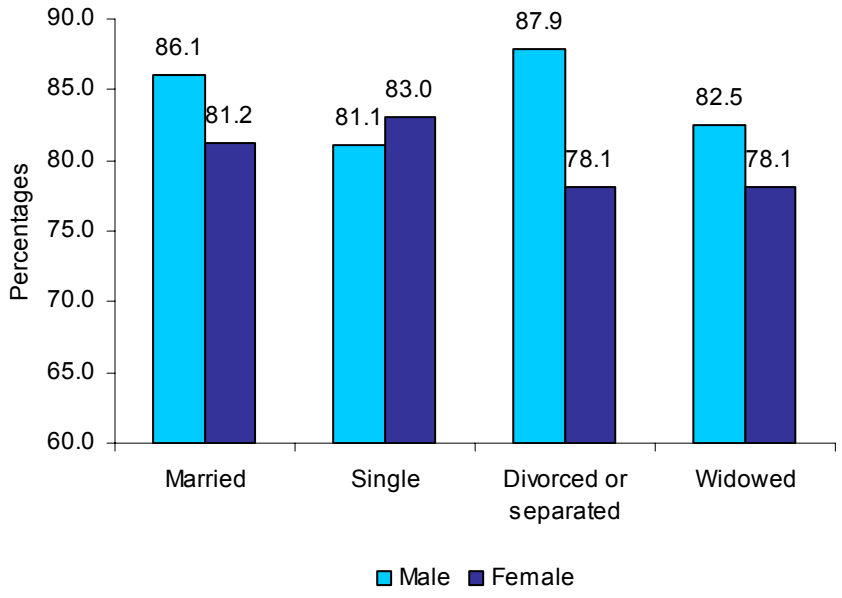
Source: General Household Survey (2000-01).

A different dimension of social inclusion in the community is captured by the degree of civic engagement. This is a special measures indicating whether a subject: (i) has not been involved in a local organisation in the last three months before the interview, (ii) has not taken action to solve local problems, (iii) does not feel well informed about local issues, and (iv) does not feel that he or she can influence decisions that affect the neighbourhood, alone or with others. On several of these aspects men show a higher level of involvement with local affairs and therefore it is not surprising that significant differences emerge in the overall indicator. For example, we find that 85% of men feel civically engaged against 79% of women, and similar gaps are observed across age groups (not shown) and marital status (Graph 4.11).

While the indicators of social participation analysed so far provide a useful sketch of the social life older men and women, it is important to know to what extent these relationships - with relatives, friends and the community in general - translate into a concrete source of support, should the need arise. The social capital module suggests a series of questions related to this aspect. Here the respondent is asked to indicate his or her most likely source of help in case of illness or the emergence of financial problems.

Perhaps not surprisingly, the vast majority of older people indicate their partner or another relative as their most likely source of support. Table 4.14 also shows that there seem to be marked gender differences, in that women are much less likely to rely on their partner and even less so in old age. As women are more likely be widowed and therefore not to have a partner, it is necessary to look at this variable while conditioning on marital status. Graph 4.12 shows that among those who are still currently married there is no significant gender difference in the proportion that would choose their partner in case of need. Similar results are obtained when looking at sources of support in case of financial difficulties (data not shown). Thus, once again, partnership status is the most important source of observed gender differences.

Graph 4.11 Civic engagement by sex and marital status



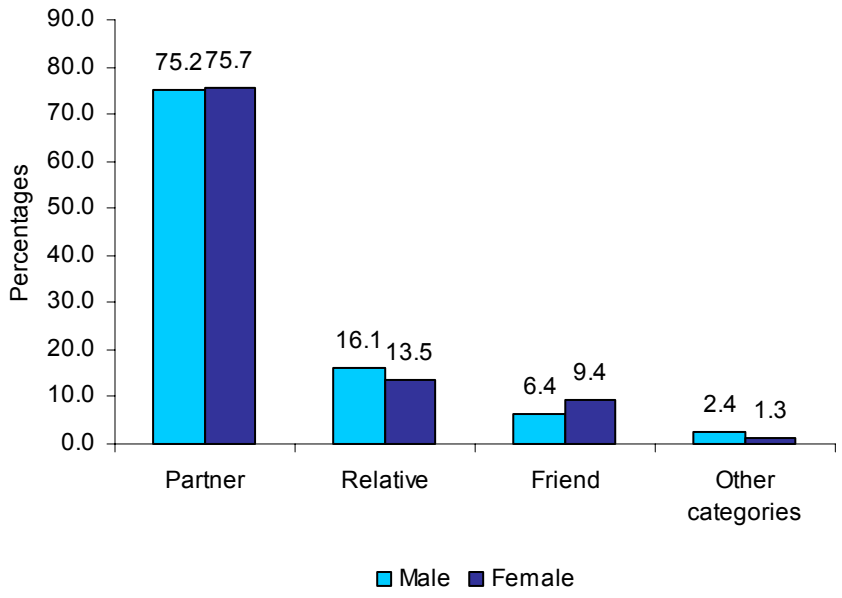
Source: General Household Survey (2000-01).

Table 4.14 Most likely source of help if health problem by sex and age

	65-74			75+			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Relationship with respondent									
Partner	61.3	46.3	53.3	40.7	19.8	27.9	53.2	33.7	42.1
Relative or hh. member	22.3	30.8	26.8	36.7	46.4	42.7	27.9	38.2	33.8
Friend	10.7	17.7	14.4	15.8	20.8	18.9	12.7	19.2	16.4
Other	3.0	1.0	1.9	3.5	7.6	6.0	3.2	4.1	3.7
Prefers not to ask	0.4	1.0	0.7	0.2	1.2	0.8	0.3	1.1	0.8
Missing	2.2	3.3	2.8	3.1	4.2	3.8	2.6	3.7	3.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N.obs.weighted (000)	2,129	2,437	4,566	1,384	2,220	3,605	3,513	4,657	8,170
N.obs.unweighted	426	572	998	351	578	929	777	1,150	1,927

Source: General Household Survey (2000-01).

Graph 4.12 Most likely source of help if health problem by sex - married



Source: General Household Survey (2000-01).

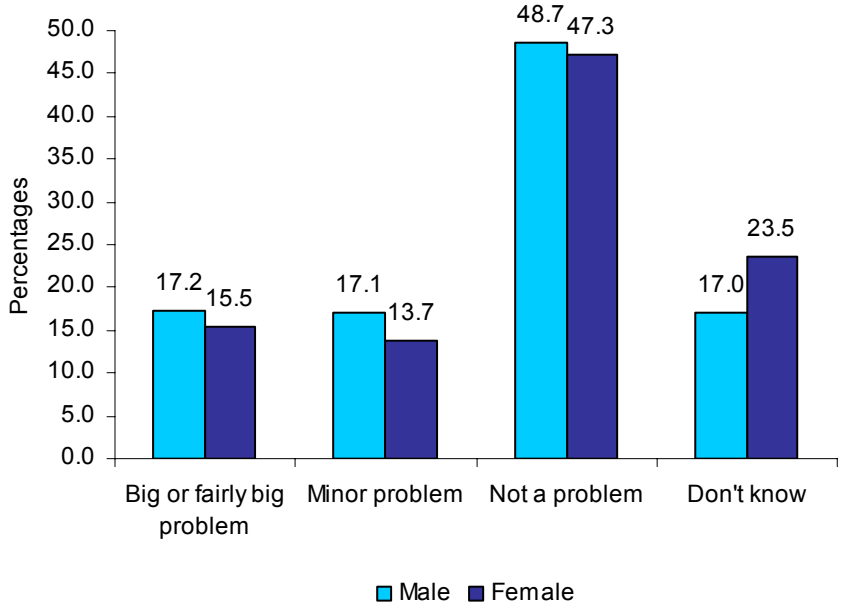
To conclude this chapter, we look briefly at indicators of perception of problems in the local area, which were collected as part of the social capital module. The questions which were asked are most varied, ranging from problems with traffic, car crime, drug and alcohol, to issues such as the level of noise in the streets,

vandalism, or problems with rubbish collection. For brevity, here we focus only on alcohol and drug problems and perception of vandalism, as all the other indicators follow a similar pattern.

We would expect to observe marked gender differences in these variables, which are supposed to capture perception of crime. This might be, for example, because people who live alone or who are in poorer health are more likely to feel anxious about their surroundings and express greater preoccupation with their neighbourhood. Since women are more likely to be widowed, to live alone, and to be affected by ill health, we would anticipate that perception of crime is higher among women than men.

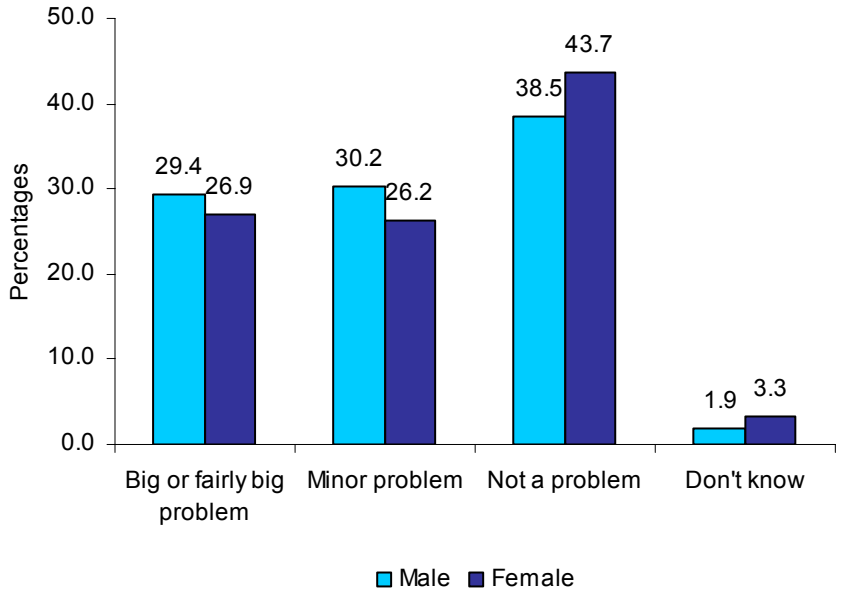
Quite surprisingly, Graph 4.13 shows that this is not the case. For example, the percentage of men who think that alcohol or drugs are a big or fairly big problem is about 17.2%, while the corresponding number for women is a very close 15.5%. Graph 4.14 reports the answer to the question related to vandalism, where – if anything – men appear more worried about this problem than women. Further analysis by age or marital status substantially confirms these findings.

Graph 4.13 Perception of alcohol and drug problems by sex



Source: General Household Survey (2000-01).

Graph 4.14 Perception of vandalism by sex



Source: General Household Survey (2000-01).

4.4 Summary

- Significant gender differences emerge with respect to older people's use of health services. Women are more likely than men to consult their GP at home or by phone, and this difference is very marked among the oldest old.
- A major factor determining access to health services is the availability of an adequate means of transport. The 2000-2001 GHS shows that men who have access to a car are more than two thirds of the population aged 65 and over, while the corresponding percentage for women is only 47.3. Older women are also found to be more likely to use public transport than older men.
- Satisfaction with the quality of local amenities and services does not seem to differ according to gender.
- Men are more likely than women to be providers of care in the group aged 65 and over, but this difference disappears when considering individuals aged 65-74 and when controlling for marital status.

- Older men providing care are more likely to look after someone residing in their own household with respect to women.
- Women's frequency of social interactions is higher than men's. About 33.8% of older women talks to relatives daily, while this percentage falls to 20.5 for men. Similarly, up to 15.4% of older women phones their friends daily, compared to only 11.5% of older men.
- Older men seem to enjoy a wider social network than older women. They are more likely to speak to their neighbours or to feel civically engaged. However, the frequency of these types of contacts declines rapidly with age.
- Despite differences in type of social networks, the most likely source of help in case of ill health is always a partner or a relative, irrespective of gender.
- There seem to be no major gender differences in the perception of crime and local area problems.

5 Conclusions

The aim of this study was to contrast the situation of older men and older women in Britain, paying particular attention to their degree of social inclusion. This has been achieved through a review of the previous literature, and new analyses of existing data. The latter entailed comparing the demographic and socio-economic characteristics of current and future older men and women, their use of services and perceptions of the quality of available services, their involvement in informal care and their social participation.

The literature review identified a lack of systematic attention to gender within relevant research on older people. Our new analysis of existing data found gender differences in some aspects of older people's degree of social inclusion but also highlighted the role that characteristics other than gender - such as age, health and marital status – play in this context. In some cases, gender differences all but disappeared once these other characteristics were taken into account, raising a number of issues for the interpretation and policy implications of gender differences.

This chapter has three main aims. First we synthesise the main findings from previous research on older people, gender and social inclusion and our own new analysis of this topic. In particular we pose the question: 'Is gender what matters?' Secondly we raise issues for policy which emerge from the findings. Finally we identify gaps in our knowledge and available data, and suggest promising avenues for future analysis.

Older people, gender and social inclusion: is gender what matters

For gender to inform policy initiatives targeted at older people it is important to establish that a gender-based approach provides real value added. In other words, it is necessary to understand the extent to which gender differences in the circumstances and needs of older people affect their quality of life by limiting access to health and social care services, by calling for different care roles, or by creating different patterns of social participation.

This report collects evidence on gender differences among older people in their degree of use and satisfaction with social and health care services. In particular, we saw in chapter 4 that women are more likely than men to consult their GP and to do so at home or by phone. Consistently with the findings in Stoddart *et al.* (2002) - who focus on different types of services, however - we also find that these differences are highly correlated with differences in age, car ownership and marital status. By contrast, our analysis does not reveal significant gender differences with respect to feelings of satisfaction with local health services, whereas there is some evidence in the literature that shows how men are more likely to report better experiences of service quality than women (Netten *et al.*, 2004).

Although about 16% of people aged 65 and over care for someone else, there is surprisingly little research in this area. The only study we found which analyses the situation of older people as carers was conducted by Milne *et al*. (2001). This study shows that caring for someone else in older age is a very intense activity, although no significant gender differences were found in respect of hours of care or caring tasks. This is consistent with our own analysis in chapter 4, which shows how gender differences in caring responsibilities generally disappear when controlling for age and especially when considering marital status. Unfortunately, very little is known about gender differences in the impact of caring on the quality of life of the carer. Some studies show that women are more likely to suffer psychological stress than men (Singleton *et al.*, 2002; Hirst, 2005), but these findings apply to the general population rather than older people.

A substantial amount of research has been conducted on social networks and social participation of older men and women. From this body of evidence and from our own analysis in chapter 4 it emerges that men and women enjoy a different level of social participation in older age but that these differences are strongly correlated with marital status and living arrangements (Victor *et al.*, 2006). This is not to say however that there are no significant gender differentials in this area. It is generally found that never-married men and divorced or separated men suffer disproportionately from feelings of social isolation and loneliness in old age. In other words, gender differences reveal themselves much more strongly *within* specific

marital status categories, to signify that events such as divorce or separation have a more disrupting impact on men rather than women.

In sum, the main findings of this report reveal that whereas it is possible to find significant gender differences in the degree of older people's social inclusion (as defined in this study), it is also important to explore to what extent these differences can be explained by other characteristics of the individual and in particular by differences in marital status. In some cases, it would appear that gender stands simply as a proxy for marital status and is not in itself the main discriminating factor; in other cases controlling for different partnership arrangements reveals even more significant differences across men and women which would not have emerged otherwise.

Policy implications and lessons for the future

A recurring theme in our analysis was that what appear at first sight to be gender differences within the older population, were subsequently identified as stemming from differences in patterns of marital status and related living arrangements. Such patterns are in a large part due to differences in the age structure of the populations of older men and women, and the social norm of women marrying men who are older than themselves, despite the tendency for women to live longer than men. The role of marital status and living arrangements in 'explaining' gender differences brings with it important considerations. From a policy perspective, we can think of at least two main aspects worth further reflection.

First, it is necessary to consider to what extent policy initiatives should take into account differences in marital or family circumstances rather than considering the individual as such. Taking as an example the evidence on the provision of informal care, we may ask whether men should be given preferential access to support services as they are found to be more likely to be care providers than women, or whether any carer who looks after a disabled or elderly partner should be given equal consideration. Emphasising the gender dimension in this case might be risky, in that we would not pay adequate attention to the needs of women simply because in this case they appear to be a minority. On the other hand, by focusing only on family circumstances and assuming that an individual would always be the main

carer of an elderly or disabled partner we might unduly invest the family with social responsibilities which should be assumed by the state instead.

The Gender Equity Duty places an obligation on public service providers to be sensitive to the different needs of men and women. It would clearly be wrong to assume that while there may be some identifiable differences in the 'average' older man and the 'average' older woman, the needs of all women are alike and of all men are alike. All research on older people emphasises their diversity and while it is helpful for policy makers and service providers to be aware of general differences, the risk of replacing one form of stereotyping (in relation to gender) with another (linked to marital status) needs to be avoided.

Secondly, as chapter 2 shows, in the near future gender differences by marital status will become less marked. In particular the share of single and especially of divorced or separated women will increase substantially, while the percentage of married men will decrease. These trends imply that gender differences in the degree of social inclusion which are mainly due to differences in marital circumstances are likely to be significantly reduced or disappear altogether. In some cases, however - as in the analysis of social networks and participation - there is the danger that gender differences might become more difficult to find, as they mainly reveal themselves within each marital status category.

Future studies of social inclusion among older men and women should therefore be even more explicitly concerned with differences in partnership status not only as a control variable, but as an additional element of analysis. Furthermore, since family formation and dissolution is a dynamic process, it would be extremely important to explore not only the *current* partner position of older people, but also their *partnership histories* (de Jong Gierveld, 2006). This would imply embedding the analysis of social inclusion in older age within a life course perspective. This type of analysis is clearly beyond the aims of the present study, but it represents in our view its natural extension and a very important research question to address in order to anticipate the future needs and circumstances of the older population in Britain.

A further important unknown for the future is the extent to which gender differences in the proportions of older age spent in poor health will persist or narrow. We saw in Chapter 2 that in the last twenty years of the twentieth century they appear to have narrowed in Britain, but women still tend to spend a higher proportion of their longer old ages in poor health. There is no clear consensus on whether this trend will continue. There is more information on the likely future differences in male and female life expectancy than in differences in their healthy life expectancy, yet the latter is key for service providers.

Gaps in data and analysis

One of the main conclusions from the literature review of Chapter 3 was that while there have been welcome initiatives which have brought the situation of older people into the policy debate on social inclusion, the gender dimension is often lacking. Analyses may be presented according to age *or* gender but less frequently by age *and* gender. This is rarely because the data on which analyses are conducted do not distinguish age and gender, although small sample sizes may inhibit detailed breakdowns. Moreover a gender breakdown is nearly always used as an input to projections of future need for services, but gender is not always distinguished in results.

As our discussion in chapter 3 highlights, even after the launch of the National Service Framework for Older People (Department of Health, 2001) and the various initiatives which followed it and which aimed at tackling inequality and discrimination, the gender dimension has been conspicuous by its absence. The recently published Wanless report, which considered the issue of social care and its funding, is a very striking example of how issues related to gender have been totally neglected in this area.

The scoping work on older people and their service needs conducted by the Equal Opportunities Commission in 2005 is a first step forward. The findings from this report are a useful extension of that work and provide additional information on the degree of gender differences in the provision of care and in the extent of social networks and social participation among older people in Britain. The introduction of

the Gender Equity duty represents an opportunity to promote the routine inclusion of gender breakdowns in all research and analysis of older people's needs.

Within the scope of this study, it was not feasible to analyse every relevant data source. Our approach was to choose data sources according to sample size, topic coverage and country coverage. Inevitably this involved trade-offs. At present, there is only one major survey explicitly addressed to older people, the English Longitudinal Study of Ageing (ELSA). As the name suggests, however, this survey does not cover all the countries in Britain. Other nationally representative surveys (such as the BHPS, the Health survey for England and the GHS) not specifically targeted at older people offer much smaller sample sizes of people aged 65+, so that only some information can be disaggregated by gender.

We chose to use the Sample of Anonymised Records from the 2001 UK Census for its large sample size and country coverage, and the 2000-01 General Household Survey for its topic and country coverage. Large scale surveys (like the Census) tend to have more limited topic coverage than smaller surveys. Thus we were able to use the 2001 Census to examine the situation of older men and women according to characteristics such as gender, residential status, age, country of residence, self-reported health, marital status and tenure of household accommodation but no information was available on the use of social or health care services or on the extent of social networks. Therefore, in chapter 4 we turned to the 2000-01 wave of the General Household Survey, which considers information on the aspects of social inclusion we are interested in, albeit at the expense of a much smaller sample size.

Neither the Census nor the GHS provided suitable information on older people's social class. This is a common problem since social class is defined by reference to occupation and most older people are retired from work. Attempts to define social class by last or main occupation are often problematic especially for those in late old age (whose last occupation may have been a long time ago) and women (whose main occupation may have been looking after their children and their home).

Combining different data sources is by no means an ideal solution. This approach was possible in our case because the objective of our analysis was rather broad and

our definition of social inclusion encompassed a variety of indicators which were more or less satisfactorily covered by the datasets chosen. In other contexts such an approach might not be viable.

As we discussed in chapter 3, some studies are restricted to samples of existing service users (Field and Briggs, 2001). They therefore tell us nothing about people who do not use services but who might benefit from them. Knowing that there is a significant gender difference among the users of a particular service cannot tell us whether this difference is the result of gender differences in: (i) the need for, (ii) access to, or (iii) propensity to use the services in question. So, although these studies provide some interesting information, they are often unable to offer policy recommendations as we do not know where the problem lies or indeed whether there is a problem in the first place.

It would be much more informative to use so-called population studies, i.e. samples drawn from the entire population for which a certain service may be relevant, and consider gender differences in the use of that service controlling at the same time for indicators of need. However, even here problems arise because 'need' is not an objective and observable characteristic and use results from the interaction of what potential users want and what services providers supply, rather than being an indication of demand.

Both data sources that we have used are cross-sectional, providing data relating to a single time point. In contrast, longitudinal data offer the possibility of taking a longer-term perspective and the recent introduction of ELSA provides new avenues for future research in this respect. As yet only two waves of ELSA are available and it will become more valuable as subsequent waves materialise.

Another possibility is to use existing large scale administrative surveys and introducing a few specific questions on a modular basis. This is a relatively low-cost procedure and allows the collection of nationally representative data on very large samples. As we saw in chapter 3, the research conducted by Professor Ann Netten and her colleagues at the University of Kent is an example of this approach. Their

study shows how we could obtain very useful information on quality of services from the perspective of the service user taking advantage of the user satisfaction surveys currently run every year by councils with social care responsibilities. All that was required was the administration of few additional questions on a subsample of the population interviewed.

To conclude, this study represents an attempt to address the lack of research on older people, gender and social inclusion but there is a limit to what can be achieved with existing data. As the English Longitudinal Study of Ageing matures, it will become an important new source of data. However, an exciting new development is on the horizon. The Office for Science and Innovation (OSI) has recently announced that it has agreed to fund in the next years a request from the ESRC to facilitate the development of a new UK Household Longitudinal Study.[19] This new study will have a very large sample size (some 40,000 household and 100,000 individuals) and therefore will allow researchers to carry out very detailed analysis on gender, older people and social inclusion. The research possibilities that open up with this new study are, as one might imagine, immense.

[19] For further information on the UK Household Longitudinal Study, see http://www.iser.essex.ac.uk/ukhls/.

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