Government Office for Science

Foresight

Current and future challenges of family care in the UK

Future of an ageing population: evidence review

Foresight, Government Office for Science

Current and future challenges of family care in the UK

Andreas Hoff

Zittau/Goerlitz University of Applied Sciences

March 2015

This review has been commissioned as part of the UK government's Foresight Future of an Ageing Population project. The views expressed do not represent policy of any government or organisation.

Contents

Executive summary

Population ageing challenges the ways in which family care to older people is provided.

Demographic context of family care

Population ageing: The British population is ageing. Between the census in 2001 and that in 2011 the number of older people (65+ years) in England and Wales increased from 8.3 to 9.2 million, or 16% of the population, which is projected to increase to 21% by 2030 and 23% by 2040. However, the UK is experiencing moderate population ageing compared to its European neighbours. A major challenge for the UK is regional variation – one-tenth of the London population is aged 65+ years, but the proportion in Cumbria, Devon, Dorset, Lincolnshire and Somerset is more than twice as much.

The fastest growing age group: The 'oldest old' (80+ years), who have a substantial risk of requiring long-term care, are the fastest growing age group in the UK. Their numbers increased by 250,000 to 1.25 million in England and Wales between 2001 and 2011. Two-thirds of the 'oldest old' are women, but the proportion of men in this age group has grown faster than that of women over the past decade. The proportion of the 'oldest old' is projected to double between 2000 and 2040, from 3.9 to 7.7%.

The drivers of demographic change: Population ageing in the UK is caused by a combination of rising longevity and medium fertility. Immigration, although substantial, is insufficient to counterbalance the effect of population ageing but is essential for maintaining the care workforce in the UK health and social care sectors, particularly in the South East of England.

Changing family values, family formation and intergenerational family relations

Normative assumptions about female employment, marriage/divorce and family formation changed within a generation, which has repercussions on intergenerational family relations and the family's caregiving capacity.

Female employment is the norm: Two-thirds of British women are employed, mainly as a result of increasing female tertiary education, and encouraged by employment-oriented family policies in combination with rising housing costs. There is, however, variation in female labour market participation depending on ethnic background.

Plurality of family forms: Parenthood is increasingly detached from marriage, and divorce is more acceptable throughout the life course, resulting in a plurality of family forms. Although divorce at advanced ages is more common than before, the majority of older people still live as married couples.

Childlessness: The majority of British older people have children and grandchildren, but childlessness is increasing. Pathways leading into childlessness vary, but postponed lifetime transitions as well as tertiary education play an important role.

Changing intergenerational family relations: Increasing longevity and lower fertility than in past generations result in intergenerational family structures characterised by more vertical than horizontal linkages. Older Britons nowadays spend more years with grandchildren than they spent with their own young children. However, intergenerational relationships are increasingly lived across a geographical distance, which has implications for the nature of intergenerational interaction as well as that of family care.

Intergenerational or spousal care?

The 'oldest old' are predominantly cared for by their children, whereas married older people predominantly receive spousal care.

Intergenerational family care: Although the number of men involved in family care is increasing, intergenerational care is still predominantly a female preoccupation. When sons provide care for their parents, they are often the only child. But daughters remain the most important source of support for older people aged 75+ years. Intergenerational family care is more common in the rural areas of North and South Wales, and parts of North West, North East and East England.

Spousal care: Spouses are the most important support source for married older people in need of care. Spouses are the fastest growing group of informal care providers. Despite growing numbers of older men providing spousal care it is still predominantly provided by women. In future, spousal care is likely to become more important than it is at present.

Grandchild care: Grandparental childcare on an occasional basis is an important back-up solution for parents with small children in the UK. Mothers from socio-economically disadvantaged backgrounds, particularly lone parents, rely on regular childcare provision by grandparents in order to facilitate employment. Grandfathers play a more active role in childcare provision than before but grandmothers continue to play the central role. As the frequency of divorces/separations increases, there are more step-grandparents, but step-grandparents are only rarely involved in childcare provision.

Challenges of family care

Gendered caregiving: Although caregiving is still predominantly a female occupation, there is growing evidence of a greater role played by men in caregiving. But, despite increasing care provision by sons and husbands, daughters and wives continue to provide more care. Likewise, grandfathers are increasingly involved in childcare provision but not to the same extent as grandmothers.

Health and well-being of caregivers: Informal carers are 2.5 times more likely to experience psychological distress than non-carers, and working carers are two to three times more likely to suffer poor health than those without caregiving responsibilities.

Ethnic minority caregiving: There are about 130,000 family carers from ethnic minority backgrounds providing care for a minimum of 20 hours per week in England and Wales. Whereas intergenerational care is predominantly delivered by women, men are mainly involved in spousal care. Family carers from ethnic minorities are less likely to access health care or social services, which is a result of lack of awareness in combination with perceived

personal/family responsibility, experiences of stigmatisation and past negative experiences with health and social care services, particularly in the case of dementia.

Regional variation in caregiving: Family care is more often provided in the rural areas of North and South Wales, and in parts of North West, North East and East England, as well as in socio-economically deprived areas, which is a reflection of both greater need and greater availability of informal caregivers. Family care provided by ethnic minority carers is more common in the urban areas of Greater London and the West Midlands.

Working carers: Working carers are typically aged 52–64 years. Difficulties experienced by working carers include lack of time, restricted opening hours, excessive stress and resulting health problems, family conflicts, work-related conflicts and financial pressures. Reconciling employment and caregiving commitments is generally easier in the public than in the private sector, as well as in larger companies than in SMEs. Working carers stress the importance of their managers being approachable, flexible and sympathetic – but they also demand more legal rights, such as paid care leave, flexible working hours, flexible opening hours, respite care and use of day-care centres.

Dementia care: One of the greatest challenges of family care is caregiving for someone suffering from dementia. As the illness progresses the caregiving burden grows, and the relationship with the care recipient becomes increasingly strained, often resulting in communication problems and conflicts. Social isolation follows. Eventually, many dementia carers need professional help from care services and rely on them to an increasing extent. The annual costs of dementia in the UK amount to £26.3 billion in care costs, of which £12.4 billion are met by informal carers. Numbers of dementia patients have been projected to double from currently 800,000 to more than 1.7 million by mid-century (although recent evidence suggests that the increase may be smaller due to reduced risk factors).

Policy implications

Combining paid work and unpaid care: A successful reconciliation of employment and caregiving for both sexes is a precondition for securing future family caregiving. Flexible working hours and home–office solutions are the most successful means of combining paid work and unpaid care at present. Legal entitlement to care leave and paid care leave for a limited period of time would enable future working carers to continue caregiving while contributing to economic growth.

Regional care networks: Future family care provision in remote rural areas can be effectively supported by regional care networks linking the various players in home, social and health care, which could be supplemented through assistive technologies.

Culturally sensitive care: The specific needs of ethnic minority caregivers and care recipients need to be considered by services supporting family carers. Greater efforts are needed to raise the awareness of ethnic minority carers about their entitlements and services available to them.

1. Introduction

Population ageing challenges the ways in which family care is provided to older people. At times of growing need, due to rising numbers of people in their 80s, 90s and 100s requiring long-term care, the supply of family carers decreases, due to a combination of reduced fertility and changing family values concerning female employment and family formation. The economic value of care provided by the 5.8 million informal carers in England and Wales (Office for National Statistics, 2013a) exceeds that provided by the formal care sector by several times (Fernández and Forder, 2010). The average lifetime expenses for social care faced by people aged 65 years and over exceed £30,000 (Comas-Herrera and Wittenberg, 2009; Fernández and Forder, 2010). Long-term care provision expenses have increased since 2000 and are projected to continue rising in the future (Wanless *et al*., 2006; Fernández and Forder, 2010; Curtis, 2014).

Section 2 considers the demographic trends causing the need for long-term care, as well as those reducing the availability of family carers. Section 3 focuses on changing family values and their implications for family formation and intergenerational family relations, before implications for current and future family care provision are discussed in Section 4. The Evidence Review concludes with some policy recommendations on how to support family care more effectively.

2. Demographic context of family care

Demographic change has an impact on both demand for and supply of family care. In this section, the effects of the three drivers of demographic change (mortality, fertility and migration) on the population structure that results in population ageing are described. Thereby, regional variation across the UK is considered. While the focus is on the UK, an international comparison with other European countries is added to highlight differences in (the speed of) demographic trends.

2.1 Rising life expectancy

The first demographic factor influencing the situation of family carers is mortality, namely rising life expectancies which result in increasing numbers of older people. Although the gap between male and female life expectancy has narrowed since the early 1980s – life expectancy at birth increased by 8.1 years for men compared to 5.9 years for women (Office for National Statistics, 2014a) – women can still expect to live longer than men. According to the latest figures from the Office for National Statistics (ONS), life expectancy at birth for boys born in 2011–13 is 78.9 years compared to 82.7 years for girls (Office for National Statistics, 2014a). In comparison to the 28 EU countries, male life expectancy in the UK is above the EU average of 77.8 years for men and slightly below the EU average of 83.3 years for women (Eurostat, 2015a).

Some regional variation within the UK is noteworthy, with England having above-average life expectancies (men 79.4, women 83.1 years) and Wales having below-average life expectancies (men 78.3, women 82.3 years) (Office for National Statistics, 2014b). Furthermore, there is substantial variation within England. Gains in life expectancy between 1991–93 and 2011–13 are most significant in London, amounting to nearly seven years for men and almost five years for women (Office for National Statistics, 2014c). The situation is less advantageous in Wales and in South West England, where only slightly more than five years were added to the male lifespan. Likewise, women gained only 3.5 years on average in Wales, Yorkshire and South West England over the same period (Office for National Statistics, 2014c). Further gains in life expectancy are expected. The ONS projects male life expectancy to reach 83.4 years by 2035 and 86.8 years by 2060; the equivalent projections for female life expectancy are 87.0 years by 2035 and 90.1 years by 2060 (Office for National Statistics, 2011).

All figures discussed so far use the concept of *period* life expectancy, which is an estimate of the average number of years a person would live assuming that age-specific mortality rates experienced at the time of birth (for example, in 2011–13) would remain constant until the end of life. In contrast, the concept of *cohort* life expectancy considers projected changes in mortality throughout a person's life, which results in higher life expectancy estimates (assuming that mortality will continue to fall). By 2035, male cohort life expectancy is projected to reach 94.2 years and female cohort life expectancy 97.2 years; by 2060 male cohort life expectancy is estimated to reach 98.0 years and female cohort life expectancy 100.6 years (Office for National Statistics, 2011).

2.2 Medium fertility

Decreasing fertility rates over previous decades reduced the numbers of potential caregivers. However, fertility rates in the UK recovered during the 2000s to reach near-reproduction level at almost two births per woman (Eurostat, 2011a; Office for National Statistics, 2014d). In 2013, the total fertility rate for England and Wales was 1.85, down from 1.94 in 2012 (Office for National Statistics, 2014e).

An analysis of the underlying causes of this recent recovery in British fertility rates reveals that this is mainly due to an increase in births to UK-born women since the turn of the millennium (up from 1.56 to 1.84 children per woman between 2001 and 2011, whereas it remained stable at 2.21 for women born outside the UK) (Office for National Statistics, 2014d). However, non-UK born women are responsible for an increasing proportion of all births in England and Wales (up from 16.4% in 2001 to 26.5% in 2013) (Office for National Statistics, 2014d,e).

A limitation of the fertility data presented above is that it uses the concept of *period* fertility, which estimates the average number of births per woman in a given year. The total number of births realised will only be known once a birth cohort of women completed their reproductive phase, which is assumed to be the case by an age of 45 years. Comparing the average completed family size for women born in 1967 with that of women born in 1940, a reduction in birth numbers from 2.36 to 1.91 children per woman is noticeable (Office for National Statistics, 2013b).

2.3 Internal and international migration

In the following, data on international migration to/from the UK will be presented first, followed by a discussion of care worker migration trends. In the second part the focus is on internal migration and its effect on regional variation in population ageing.

2.3.1 International migration

Net long-term migration into the UK was 298,000 in the 12 months to September 2014, up from 210,000 in the previous 12 months. A total of 624,000 people immigrated into the UK (up from 530,000 in the previous year); 327,000 emigrated from the UK (about the same level as before) over the same period (Office for National Statistics, 2015).

The impact of international migration on British population ageing depends on the age structure of migration flows. Migration statistics do not always provide this information but the 2011 census contained information on status of residence prior to the census, differentiated by age: 5.8% of *older* British people had an address abroad prior to the 2011 census (compared to 9.2% of younger people). The most common countries of previous residence for older people were Spain (17% or 3300) and France (11% or 2,000). Considering regional variation in return migration of older British people, Rushmore in Hampshire was the local authority with the highest proportion of those aged 65 years and over who had a different address outside the UK one year before the census (Office for National Statistics, 2014f).

A total of 271,000 people immigrated into the UK for work reasons up to September 2014 (up from 217,000). This increase was due to increases in EU and non-EU immigration as well as British citizens returning to the UK (Office for National Statistics, 2015). Since the 1960s, the NHS and social care services have relied on foreign-born staff. According to the Labour Force Survey, 18% of all care workers in the UK were foreign-born by the end of 2008, up from 8% in

1998; 23% of all nurses were born abroad, up from 13% in 1998. A survey conducted by the COMPAS research centre at Oxford University found that 35% of the workforce caring for older adults was foreign-born (Cangiano *et al*., 2009); other studies confirmed this over-representation of migrant care workers in the eldercare sector (Ball and Pike, 2007). They are concentrated in certain regions of the UK, representing 30% of all nurses and 25% of all care workers in London and 25% of all nurses and 17% of all care workers in the South East. Migrant care workers are over-represented in low-paid jobs and in the private sector, more than three-quarters of them being female (Cangiano *et al*., 2009; Shutes and Chiatti, 2012).

Despite increased efforts in the past to train UK-born care professionals, self-sufficiency could not be realised (Department of Health, 2000). Formal care services were encouraged to recruit abroad, resulting in rising numbers of work permits given to healthcare professionals, peaking at 26,568 in 2004 (Salt, 2007). Following EU enlargement in 2004, 23,580 Eastern Europeans had registered for low-skilled jobs in the social care sector by March 2009. Projections of future demand for foreign-born care workers predict the need for future increases. Assuming a constant ratio of foreign-born care workers looking after older people in the UK, the number of foreign-born carers is projected to increase from 122,000 in 2006 to 195,000 in 2030 (Cangiano *et al*., 2009).

2.3.2 Internal migration

In the year before the 2011 census, 331,000 (3.6%) of older people in England and Wales moved home. This is relatively few compared to the population aged under 65, of whom 6.4 million (14%) moved over the same period. The majority (57%) of older people who moved did so within the same municipality (Office for National Statistics, 2014f). Older people are most likely to change address in late middle age (50–59) and aged 90 years and over. Causal factors include changes in marital/family status (divorce, widowhood), health and economic status (Evandrou *et al*., 2010).

There is considerable regional variation in migration flows. In absolute numbers, South East England was the region with the highest proportion of older people who moved to a different address in the year before the 2011 census (61,000), followed by South West England (44,000), North West England (38,000) and East England (37,000). Looking at percentages of the regional resident population aged 65 years and over, the South West (4.3%) and the South East (4.1%) were leading, as they did in regard to moves amongst people aged 75 years and over (Office for National Statistics, 2014f).

Over half of the local authorities in England and Wales (54%) had increased their resident population aged 65 years and over due to migration within England and Wales. Cornwall/Isles of Scilly showed the greatest gains, followed by Arun/West Sussex and North Somerset; Gwynedd and Conwy in Wales both also featured in the top 10. The greatest losses were experienced by Birmingham, followed by Brent and Bromley. The City of London/Westminster was home to the highest proportion of moves by people aged 65 years and over within the past year (6.5%), followed by Kensington and Chelsea (6.3%) and Eastbourne/East Sussex (6.2%). Contrarily, Knowsley had the lowest proportion of people aged 65 years and over who moved in the year before the 2011 census (1.8%). Considering moves by people aged 75 and over, both Eastbourne and Hastings had the highest proportions of older movers (6.1% each), followed by East Hampshire and Worthing (6.0% each); Knowsley once again had the lowest proportion (2.2%) (Office for National Statistics, 2014f).

2.4 Population ageing

Continuous gains in life expectancy in the context of relatively stable fertility rates contribute to population ageing. Immigration numbers of younger people are insufficient to counterbalance population ageing. At regional level, however, internal migration of older people has an impact on regional and local age structures. In this section, the proportion of older people aged 65 years and over will be considered first as an indicator of overall population ageing, before attention is turned to the 'oldest old', i.e. those aged 80+ years, who run a substantial risk of needing long-term care.

2.4.1 Proportion of older people (aged 65+ years)

According to the 2011 census, 9.2 million people or 16% of the population in England and Wales are 65 years and over, up from 8.3 million 10 years before (Office for National Statistics, 2013c). Between 2002 and 2031 their numbers are projected to increase by 60% (Pickard *et al*., 2007). There is significant regional variation in population ageing across the UK. The regions with the highest proportions of older people include Cumbria, Devon, Dorset, Lincolnshire and Somerset, where more than 20% of the population is 65 years and older (Bayliss and Sly, 2010) (see Figure 1).

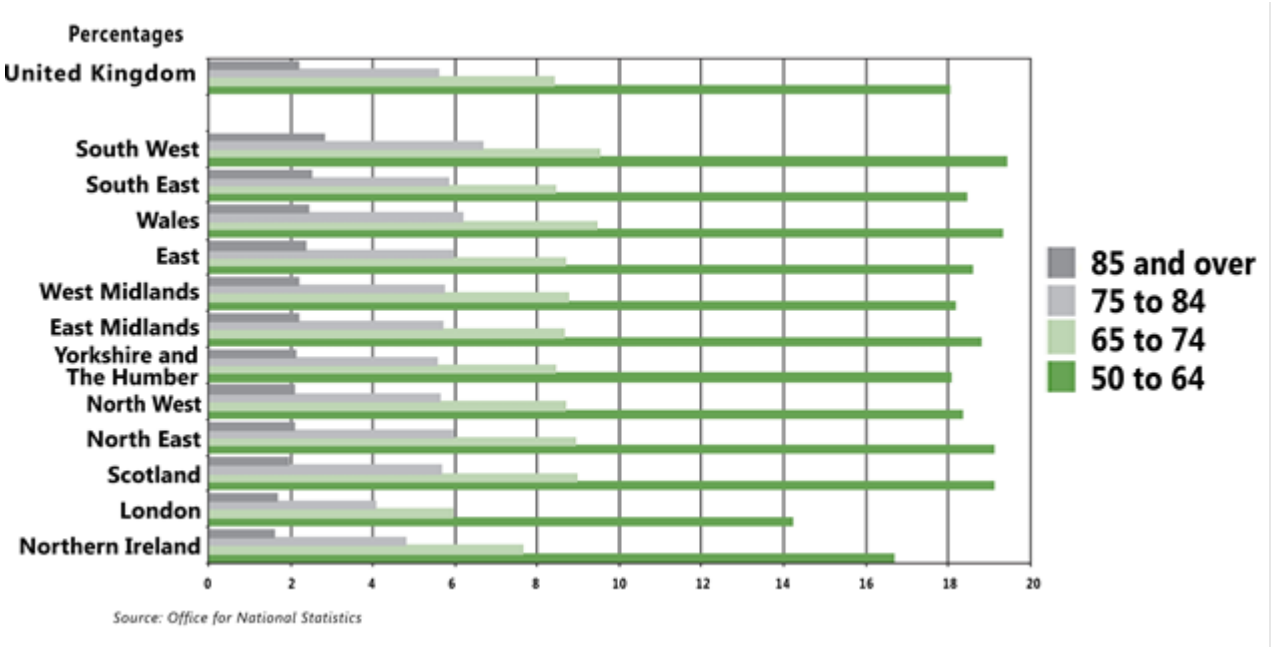

Figure 1: Percentage of population in key age groups by region, 2008 (Bayliss and Sly, 2010, map 1.2, p. 5)

Figure 2 allows a century-long view (1960 to 2060) of population ageing for both the UK and EU member states (Eurostat, 2011b). As Figure 2 (left-hand side) shows, the 2010s mark the beginning of gradual continuous population ageing in the UK: within the next decade the proportion of older people will reach 20% of the British population and will continue to rise beyond 23% by 2040.

However, the process of population ageing occurs at a relatively modest pace in Britain compared with most European countries (see right-hand side of Figure 2). In the currently oldest society in Europe, Germany, almost 21% of the population is aged 65 years and older today. The proportion of older people in Germany is projected to rise to 23% by 2020, 30% by

2033, and to approach 33% of the population by mid-century. Another case worth pointing out is Poland, which is representative of similar demographic trends across Central/Eastern Europe. Poland is currently experiencing an acceleration of population ageing. By 2060, Poland, Romania and Slovakia are projected to reach levels of nearly 35% of older people and Latvia nearly 36%.

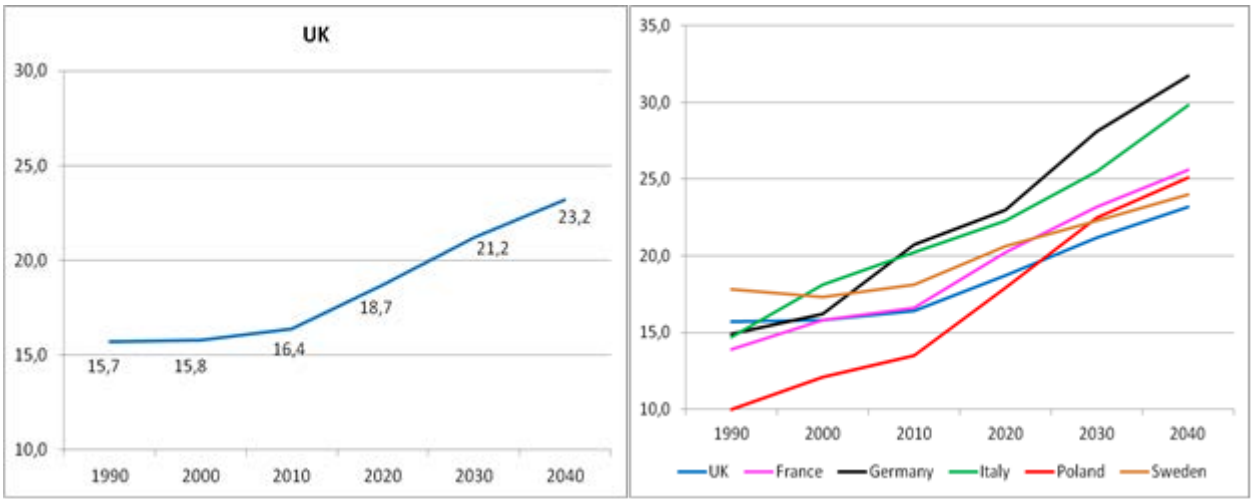

Figure 2: Change in the proportions of older people (65+) in the UK and selected European countries, 1990 to 2040 (based on data from Eurostat, 2011b)

2.4.2 Proportion of the 'oldest old' (80+ years)

The 'oldest old', i.e. those aged 80 years and older, are of great significance for discussing family care because the long-term care risk increases with age. In Germany, less than 2% of people aged 60–65, less than 5% of 70–75 year olds and just below 10% of 75–80 year olds require long-term care, compared to 20.5% amongst 80–85 year olds, 38% of 85–90 year olds and 58% of those aged 90 years and older (Statistisches Bundesamt, 2013). Wittenberg *et al*. (2001) confirm similar trends for the UK.

In 2011, 1.25 million people aged 85 years and older were living in England and Wales, up by nearly 250,000 compared to 2001. The 'oldest old' are the most rapidly growing age group in the UK (Tomassini, 2005), as well as in many European countries (Eurostat, 2011b). The numbers of disabled older people are expected to rise accordingly (Pickard *et al*., 2007). Two-thirds of the 'oldest old' are women. However, the proportion of men in this age group has grown faster than that of women over the past decade (by 45% vs 16% for women) (Office for National Statistics, 2013d).

Half a million of the 'oldest old' living in the UK are 90 years and above, with higher numbers of them living in England and Wales (840 per 100,000 inhabitants) than in Scotland (707) or Northern Ireland (620). Almost 14,000 centenarians (people aged 100 and over) live in the UK (Office for National Statistics, 2014g). People aged 85 and over are over-represented in South West England, in Wales, in the South East and East of England and under-represented in Northern Ireland and London (see Figure 1) (Bayliss and Sly, 2010).

Taking a look into the near future, the proportion of the 'oldest old' in the British population is projected to double between 2000 and 2040 from 3.9 to 7.7% (Figure 3). The same process will take a decade less in France, where the share of the 'oldest old' is expected to double by 2030 and then to continue rising to reach 9.4% by 2040 (see Figure 3, right-hand side). Germany has

shared the same levels of the ‘oldest old’ with the UK and France until the present day but is projected to see accelerating growth in the proportion of the ‘oldest old’, to reach more than 10% by 2040.

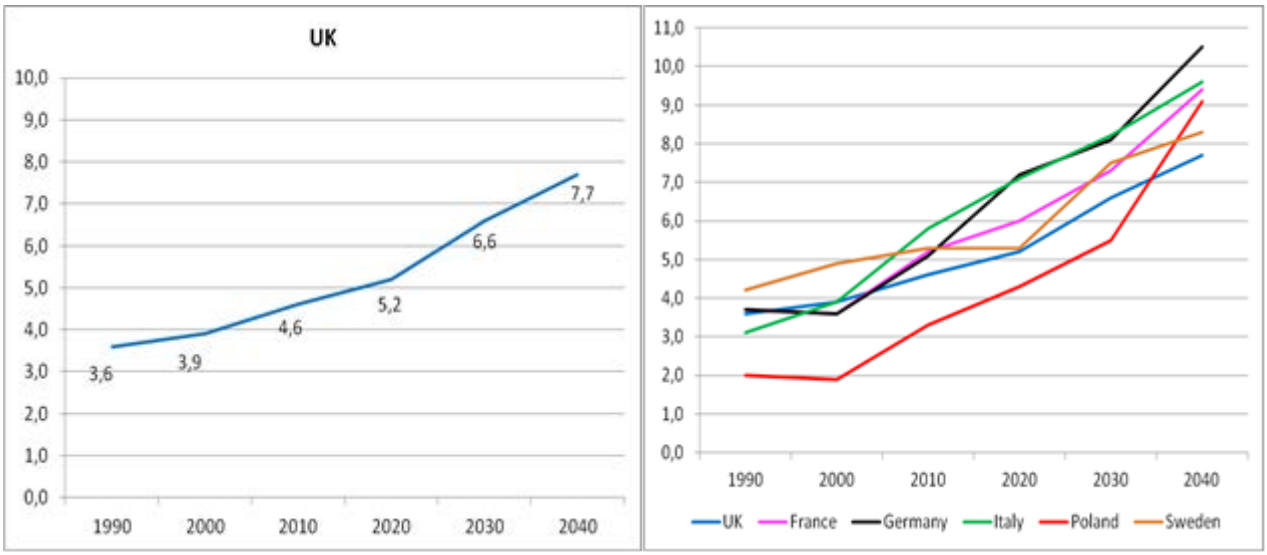

Figure 3: Change in proportions of the ‘oldest old’ (80+ years) in the UK and in selected European countries, 1990 to 2040 (based on data from Eurostat, 2011b)

3. Changing family values, family formation and intergenerational family relations

Traditionally, it was taken for granted that the family would take care of family members in need of care. This traditional family care model has been substantially eroded due to changes in family values impacting upon family formation and lived intergenerational relations.

3.1 Changing family values and family formation

The focus of this section is on the normative drivers of changes in family formation over recent decades; there is growing acceptance of female labour market participation and of divorce/separation as well as the resulting pluralism of family forms.

3.1.1 Female employment is the norm

Since the 1970s there has been a substantial increase in female labour market participation rates in Britain, up from 53% in 1971 to 67% in 2013 (Office for National Statistics, 2013e). This is a long-term consequence of female emancipation and equal access to education for both sexes. However, 42% of all employed women are working part-time, compared to only 12% of men (Office for National Statistics, 2013e). Female labour market participation rates vary depending on ethnic background. Women of Bangladeshi or Pakistani origin have lower levels of economic activity than Black Caribbean and White women (Dale *et al*., 2006).

Female employment is likely to continue rising in future. This is mainly an effect of highly qualified women entering the labour market. The proportion of British women aged 30–34 years who completed tertiary education increased from 33% in 2004 to 49.3% in 2014 (Eurostat, 2015b). Today, female graduates outnumber their male counterparts (Office for National Statistics, 2013f). However, some academics argue that current cuts in public sector jobs in the UK affect women disproportionally and may reduce their employment prospects again (see, for example, Rubery and Rafferty, 2013).

Increasing female employment propensity occurs in the context of employment-oriented family policies, which encourage labour market participation by all adults in society (Orloff, 2006; Fleckenstein and Seeleib-Kaiser, 2011). A return to the traditional male breadwinner model is also unrealistic in the light of female investment in higher education, as well as the rising costs of buying a family home, which often require substantial earnings from two partners and are projected to continue rising. In 2013/14, UK house prices increased by 10% – by 17.2% in London and by 6.7% in the rest of the UK (excluding London and the South East) (Office for National Statistics, 2014h).

3.1.2 Growing acceptance of divorce/separation

Parenthood has become increasingly detached from the institution of marriage. Marriage numbers have steadily decreased in England and Wales since the 1970s and only very recently slightly recovered. The waning popularity of marriage is due to increasing numbers of people choosing to cohabit (Beaujouan and Bhrolcháin, 2011). The reduction in the number of divorces during the 2000s reflects the decreasing numbers of marriages from which to divorce (Office for National Statistics, 2014i).

On average, marriages last longer nowadays than in the past due to the effect of longevity. Nevertheless, more people are divorced at an advanced age than before. In 2011, 73% more older men divorced than in 1991 (Office for National Statistics, 2013g).

As a consequence, relationships with children have changed as well. Older parents may have relationships with biological as well as with stepchildren. This results in a greater variety of parent–child relationships, but could also imply decreased reliability of support at times of need (Ferguson, 2004).

3.1.3 Pluralism of living arrangements

Alongside family forms based on marriage, other family forms have become acceptable, including lone parents, cohabiting couples with children, families 'living-apart-together' (so-called 'patchwork families'), 'blended families' or 'reconstituted families' (families headed by two parents with children from a previous relationship), or same-sex families (Haskey, 2005). The increasing number of families over the past decade is almost entirely due to rising numbers of lone parents and cohabiting couples with children. The number of opposite-sex cohabiting-couple families increased from 2.2 million to 2.9 million and that of lone parent families from 2.6 million to 2.9 million (Office for National Statistics, 2013h).

Married couples have remained the dominant family form in Britain nevertheless. They account for the majority of families with dependent children (63%), down from 67% in 2003 (Office for National Statistics, 2013h). Amongst the children in the Millennium Cohort Study, 60% were born to married parents, 25% to parents not married but cohabiting, and 15% to single mothers (Holmes and Kiernan, 2010).

The vast majority of older people live as married couples (Hirst and Corden, 2010; Jivraj and Nazroo, 2012). According to the English Longitudinal Study of Ageing (ELSA), 62.4% of men and 49.2% of women aged 52 years and older are married or living in a civil partnership. The lower figure for women is explained by the greater proportion of widows (22.7%, compared to 8.3% of men) due to their higher life expectancy. More than a fifth (22%) of both sexes experienced a divorce or separation; about half of them remarried. These figures have remained relatively stable since the first wave of ELSA in 2002/03, with the exception of a decline in widowhood (down from 25.8 to 22.7%) and an increase in the proportion of divorced/separated women (from 11.1 to 13.4%) (Jivraj and Nazroo, 2012).

Plurality of living arrangements is much more common in socio-economically disadvantaged groups of older people. In the lowest income quintile, 34.5% of the older men are married/in civil partnership and 26.1% are divorced/separated (plus 11% who remarried); 23.3% of the older women in the lowest income quintile are married/in civil partnership (plus 7.2% remarried) and 27.8% are divorced/separated. In this lowest-income quintile 33.4% of older women are widowed (compared to 23% as a national average), as well as 14.6% of men (8.5% as a national average) (Jivraj and Nazroo, 2012).

The trend towards plurality of family forms has influenced the relations between ageing partners, older parents and their adult children, and between grandparents and grandchildren (Dimmock *et al*., 2004). Grandchildren could have relationships with eight grandparents (father's and mother's parents and the parents of their respective new partners). Moreover, it remains unclear to what extent reconstituted families would be able to care for older family members, because they could have responsibility for eight (or more) parents/parents-in-law.

3.1.4 Childlessness

Although the vast majority of British older people have children, childlessness is becoming more common (Evandrou and Falkingham, 2000). The proportion of childless people in the UK increased from 11% for those born in 1941 to 18% for those born in 1968 (Office for National Statistics, 2014j). Pathways leading into childlessness vary but postponed lifetime transitions play an important role (Hagestad and Call, 2007).

Childlessness has become more acceptable in younger birth cohorts: whereas 73% of British men and 63% of British women born before 1930 would agree with the statement “A marriage without children is not fully complete”, only 35% of British men and 29% of British women born between 1950 and 1970 would agree with this statement (Dykstra and Hagestad, 2007).

There is considerable variation in childlessness depending on educational background: better-educated women are more likely to remain childless. It is estimated that just under 30% of graduate women born in 1965 (Ratcliffe and Smith, 2006) or born in 1970 (Joshi, 2007; Kneale and Joshi, 2010) will remain childless.

3.2 Changing family structures and intergenerational relations

In this section the focus is on changes in family structures and the timing of life transitions, which influence intergenerational family relations. The section concludes with a discussion of childlessness, which also affects family structures and intergenerational relations and reduces the caregiving capacity of families.

3.2.1 Postponement of births and other life transitions

Young adults are on average leaving the parental home later than in previous cohorts, forming their first stable adult unions later, are getting married later, and postponing the birth of their first child (Berrington *et al*., 2009). Age at birth of the first child has risen from 27 to 30 years between 1990 and 2012 (Office for National Statistics, 2014j). This trend is in line with other European countries, with the highest ages at first childbirth in Spain (31.6 years), Ireland, Switzerland (both 31.5 years) and Italy (31.4 years) (Eurostat, 2014).

Postponement of first childbirth has implications for the generational structure of families. Whereas rising life expectancy increases the number of generations within the family network, postponement of births reduces it again and results in generations covering more years until the emergence of the subsequent generation.

Postponed life transitions are not a phenomenon characteristic of the family formation phase only. The male life expectancy gains discussed in Section 2.1 result in a postponement of widowhood (Smith *et al*., 2005), which implies greater potential for spousal care.

3.2.2 The emergence of the ‘beanpole family’

Increasing longevity and lower fertility than in past generations result in the emergence of the so-called ‘beanpole family’ (Bengtson *et al*., 1990), i.e. a family structure characterised by increasing numbers of generations within the same family network but with fewer members per generation: “Individuals will thus grow older having more vertical than horizontal linkages in the family” (Harper, 2006: 181). Family structures change from “laterally extended family forms” into “long vertical multi-generational families” (Harper and Levin, 2005).

This is evident in the finding that 43% of the first wave of UK baby boomers (born in 1945–52) still have a mother and 20% a father alive (Leach *et al*., 2008; Phillipson, 2010). Another implication is that older people spend 25 years on average in a grandparenting role compared to 18 years of responsibility for dependent children (Harper and Levin, 2005).

3.2.3 The multi-local multigenerational family

The German family sociologist Hans Bertram (2000) coined the term 'multi-local multigenerational family' for characterising the reality of contemporary family networks spanning vast geographical areas. Thus, intergenerational interaction between family members can only rarely be experienced face-to-face.

Whereas nearly half (48%) of older people aged 55 years and over live with adult children in Ireland, parts of Spain, Italy, Hungary or Poland, less than 15% do so in Norway, Sweden, Finland, Denmark, Germany, the Netherlands, Belgium, France and the UK (Dykstra and Komter, 2012). Research evidence from Germany (Hoff, 2006a; Mahne and Motel-Klingebiel, 2010), Sweden (Fors and Lennartson, 2008) and covering several EU member states (Hank, 2007) indicates that geographical distances between the generations are increasing on average.

This has implications for intergenerational contact frequency: whereas the majority of older people in Southern Europe are in touch with their grown-up children on a daily basis, the majority of their Western, Northern and Central European contemporaries are in touch with their adult children several times per week (Abuladze and Sakkaeus, 2013). As a consequence, higher proportions of frail older people receive family care in Southern European than in Nordic countries, the Netherlands or Switzerland (Haberkern and Szydlik, 2010). However, Dykstra and Fokkema (2011) emphasise that there is variability within countries.

These trends were confirmed by British studies which stressed their implications for the provision of family care and the formation of care networks (Bell and Rutherford, 2013), as well as for grandparent–grandchild interactions (Chambers *et al*., 2009; Tarrant, 2009).

4. Family care

In this section three patterns of family caregiving are considered: intergenerational caregiving by the younger to the older generation (adult children to their parents/parents-in-law), intergenerational caregiving by the older to the younger generation (grandparents to their grandchildren), and intragenerational caregiving (spousal care). This is followed by a discussion of regional variation in family caregiving across the UK and concluded with a section on current and future challenges to family care.

4.1 Patterns of family caregiving

According to a recent review of current family care practices, privatisation and informalisation of family care is on the rise across Europe (Della Giusta and Jewell, 2014). More than 80% of the disabled older people receiving informal care and living in private homes are being cared for either by adult children or by spouses or by both of them. Considering the two alternative sources, just over half receive support from a child and just under half from a spouse (Pickard *et al*., 2007). In England, 15.1% of older women and 10.9% of older men cared for someone in the last month. The greatest propensity of caregiving is found amongst 55–59 year old women (22.5% of them provide family care) and 52–54 year old men (12.4% of them provide family care). Care receipt is most common amongst the 'oldest old' (80+), with 66% of women and 51.6% of men receiving help with mobility, self-care or instrumental activities of daily living (Jivraj and Nazroo, 2012).

4.1.1 Intergenerational caregiving I: Adult children caring for their parents

Only when parents reach an age of 70 years and over do they begin to receive more care than they give (Saraceno and Keck, 2008; Dykstra and Komter, 2012). Disabled older people aged 85 years and over predominantly receive support from their children, which is an effect of the much greater likelihood of being widowed in this age group. The single most important source of informal support for widowed, disabled older people is their children (Pickard *et al*., 2007). This is in line with caregiving norms in the UK: more than half of the British participants in the 2008 Eurobarometer study agree that adult children should care for their old parents, and 46% strongly agree with that statement, which represents a 9% increase compared to 1992 (Della Giusta and Jewell, 2014). There is some regional variation: in the rural areas of North and South Wales, parts of the North East (Durham, Tyne and Wear) and North West England (Derbyshire, Merseyside, South Yorkshire) as well as in Lincolnshire, intergenerational caregiving to older people is more common than in other areas (Young *et al*., 2005).

Daughters are the most important source of support for disabled older people aged 75 years and over (Marmot *et al*., 2003), which was recently confirmed using British Household Panel Survey (BHPS) data (Della Giusta and Jewell, 2014). Although the number of men involved in family care is increasing, family care is still predominantly a female preoccupation. When sons provide care for their parents, they are often the only child (Phillips, 2007).

Caregiving by adult children will have to rise in order to cope with the increasing demand for informal care. Projections suggest that by 2031, 400,000 more older people will have to receive care from their children than today in order to cope with rising demand from growing numbers of the 'oldest old' (Pickard *et al*., 2007).

4.1.2 Intergenerational caregiving II: Grandparents as childcare providers

Another aspect of family care relating to older people is their role as grandparents providing childcare. Grandparental childcare on an occasional basis is an important back-up solution for parents with small children in the UK (Dench and Ogg, 2002; Lewis *et al*., 2008) and elsewhere in Europe (e.g. Hank and Buber, 2009; Dimova and Wolff, 2011; Igel and Szydlik, 2011). In the UK grandparents are not full-time carers but often complement formal part-time childcare (Gray, 2005; Herlofson and Hagestad, 2012). The UK Grandparents' Association estimates that the 13.5 million British grandparents provide 60% of all childcare (Tan *et al*., 2010).

Whereas grandmothers are commonly seen as playing the central role in providing childcare (Chambers *et al*., 2009; Barnett *et al*., 2010), there is increasing evidence of a greater involvement of grandfathers in childcare (Mann and Leeson, 2010; Tarrant, 2012).

As the frequency of divorces/separations increases, there are more step-grandparents. But step-grandparents are only rarely involved in childcare provision and only so if the step-grandchild is young and living in the household of the step-parent when the step-family was formed (Allan *et al*., 2008, 2013).

Mothers from socio-economically disadvantaged backgrounds rely on regular childcare provision by grandparents in order to gain employment (Gray, 2005). Lone mothers are particularly affected (Hoff, 2006b; Glaser *et al*., 2010; Harper and Ruicheva, 2010). The most challenging role for grandparents is that of 'custodial parents' or 'surrogate parents' when the biological parents are unable to fulfil this role. This is, however, relatively rare in the UK where only an estimated 0.5% of all grandparents are acting as custodial parents (Clarke and Roberts, 2004).

4.1.3 Intragenerational caregiving: Spousal care

The single most important support source for married disabled older people are their spouses (Pickard *et al*., 2007). Increasing life expectancies result in a growing prevalence of spousal care (Hirst, 2001; Henz, 2004; Pickard *et al*., 2007). Spouses are the fastest growing group of informal care providers (Hirst, 2001). Despite growing numbers of older men providing spousal care, it is predominantly provided by women (Corden and Hirst, 2011). In future, spousal care is likely to become more important than it is at present (Pickard *et al*., 2007).

There is some variation in the intensity of care provided depending on socio-economic background. Manual workers or spouses of manual workers are more likely to provide intensive spousal care (Hutton and Hirst, 2001).

4.1.4 Regional variation in family care

There is substantial cross-regional variation in unpaid caregiving in England and Wales. In the early 2000s, the proportion of people providing unpaid care for 20 hours or more per week was highest in parts of North Wales (Conwy, Denbighshire, Isle of Anglesey), most local authorities in South Wales, parts of the North East (Durham, Tyne and Wear) and North West England (Derbyshire, Merseyside, South Yorkshire), as well as parts of Lincolnshire. Differentiated by local authorities, the highest prevalence of caregiving was found in Neath Port Talbot (7.7%), Merthyr Tydfil (7.4%) and Easington (7.4%). In these areas, intergenerational caregiving was also more common than in other areas (Young *et al*., 2005).

Family caregiving is generally more common in socio-economically deprived areas, which is a reflection of both greater need and greater availability of informal caregivers. Furthermore, regional differences are also reflected in the health conditions of family carers, ranging from slightly more than 10% reporting poor self-rated health to 25% in parts of South Wales, the North East (Durham, Tyne and Wear) and North West England (Leeds, Manchester, Sheffield) (Young *et al*., 2005).

On the other hand, family care provided by people from ethnic minority backgrounds is more common in the urban areas of Greater London and the West Midlands. Nearly half of them live in Greater London, and another 15% in the West Midlands. Considering the number of caregivers in the capital, 30% are from ethnic minority backgrounds; 8.4% of these are of Indian origin and 6.4% of Bangladeshi or Pakistani origin, thus representing the largest groups (Young *et al*., 2005).

4.2 Challenges of contemporary and future family care

In this section, current and future challenges to family care provision are discussed, focusing on gender differences in caregiving, the well-being of family carers, ethnic minority caregiving, difficulties in reconciling employment and caregiving, and caring for someone suffering from dementia.

4.2.1 Gendered division of labour

Gender is the most important factor in determining whether an individual alters their working arrangements or quits employment altogether to provide care (Crompton *et al*., 2003). Although caregiving is still predominantly a female occupation, there is growing evidence of a greater role played by men in caregiving (Dahlberg *et al*., 2007). Amongst ELSA respondents, 15.1% of female and 10.9% of male respondents reported having cared for someone in the last month (Jivraj and Nazroo, 2012).

But despite increasing care provision by sons and husbands, daughters and wives continue to provide more care (Marmot *et al*., 2003; Phillips, 2007; Corden and Hirst, 2011; Della Giusta and Jewell, 2014). Likewise, grandfathers are increasingly involved in childcare provision, but not to the same extent as grandmothers (Chambers *et al*., 2009; Barnett *et al*., 2010; Mann and Leeson, 2010; Tarrant, 2012).

4.2.2 Health and socio-economic well-being of family carers

The focus of this section is on health and well-being of the family carer rather than the care recipient. Family carers experience a subjective burden that has detrimental effects on their health (Mackenzie *et al*., 2007; Simon *et al*., 2009), especially when there is little support available or when the condition causing the need of care is particularly severe, as is the case with dementia (Leggett *et al*., 2010). Informal carers are 2.5 times more likely to experience psychological distress than non-carers (Simon *et al*., 2009). Working carers are two to three times more likely to suffer poor health than those without caregiving responsibilities (Buckner and Yeandle, 2006).

Evidence of the effect of socio-economic background on caregiving is inconclusive. Whereas previous evidence indicated that unpaid long-term care was more commonly provided by manual workers or spouses of manual workers (Hutton and Hirst, 2001; Glaser and Grundy, 2002), more recent evidence from ELSA shows that both women and men from the lowest income categories are least likely to have cared for someone in the last month (Jivraj and

Nazroo, 2012). This is likely to be an effect of poorer health amongst people from deprived backgrounds who on average need more support with mobility, self-care and instrumental activities of daily living.

4.2.3 Ethnic minority caregiving

There are about 130,000 family carers from ethnic minority backgrounds who provide care for a minimum of 20 hours per week in England and Wales. Both women and men are involved in caregiving, although female caregiving is more common. Whereas intergenerational care is predominantly delivered by women, men are mainly involved in spousal care (Sin, 2006). Compared to the White majority, women are more likely to provide family care in Bangladeshi, Indian and Pakistani minorities, even when controlling for age, sex or socio-economic background (Young *et al*., 2005).

Family carers from ethnic minorities are less likely to access health care or social services (Merrell *et al*., 2006; Lawrence *et al*., 2008), which is mainly a result of lack of awareness (Mir and Tovey, 2003; Katbamna *et al*., 2004; Sin, 2006). This situation is aggravated for dementia caregivers due to lack of awareness of the illness in combination with experiences of stigmatisation, perceived personal/family responsibility of caring for a person with dementia, and negative experiences with health and social care services (Mukadam *et al*., 2011). Recognition of dementia as an illness and knowledge about dementia facilitated accessing help.

Socio-economic disadvantages experienced by caregivers from ethnic minority backgrounds are aggravated by poor health and poor housing conditions, often in deprived areas (Nazroo, 2006).

There are differences in the strength and structure of family care support networks across different ethnic minority groups (Phillips, 2007). Whereas Caribbean family carers could rely on extended support networks, carers from South Indian backgrounds are confined to support from other household members (Butt and Moriarty, 2004).

4.2.4 Reconciling family care and employment

The aggregate cost of providing eldercare in lost productivity to US businesses is estimated to exceed $17 billion per year (MetLife Mature Market Institute and National Alliance for Caregivers, 2006). For Germany, the annual costs of not reconciling employment and eldercare is estimated at €14,200 per employee (Schneider *et al*., 2011).

Yeandle *et al*. (2007) found that more than one-third of those combining work and care had considered giving up work altogether before reducing their working hours in order to better cope with both demands. Women can be trapped in low-paid part-time jobs because this enables them to combine paid work with caregiving tasks (Buckner and Yeandle, 2006).

Working-age women and men aged 52–64 years are most likely to provide family care for older family members (Jivraj and Nazroo, 2012). Typical difficulties experienced by working carers include lack of time, restricted opening hours, excessive stress and resulting health problems, family conflicts, work-related conflicts and financial pressures (Hamblin and Hoff, 2011; Hoff *et al*., 2014).

Reconciling employment and caregiving commitments is generally easier in the public than in the private sector, as well as in larger companies than in SMEs (Demetriades *et al*., 2006). In the private sector, industries which can easily replace staff (e.g. in the retail sector) are more

likely to implement flexible working policies than those in which that is less possible (e.g. banking) (Bernard and Phillips, 2007). Working carers stress the importance of their managers being approachable, flexible and sympathetic. However, they also comment that too much is left to the discretion of line managers (Hamblin and Hoff, 2011; Hoff *et al*., 2014). The most effective means of support from the perspective of family carers are paid care leave, flexible working hours, flexible opening hours, respite care and day-care centres (Hoff *et al*., 2014).

4.2.5 Dementia caregiving

One of the greatest challenges of family care is caregiving for someone suffering from dementia. Dementia is one of the main causes of disability in later life (Thompson *et al*., 2007). The onset of dementia is often associated with negative emotions about the unpredictable burden of dependence (Williams, 2011). Dementia is a neurodegenerative disease that results in memory loss and cognitive decline and subsequently increasing dependence of the care recipient and increasing care tasks over time for caregivers (Chiong-Rivero *et al*., 2011). As the illness progresses, the caregiver's relationship with the care recipient becomes more and more strained and the caregiving burden grows. Cognitive decline and increasing loss of social and role functioning can cause 'relational deprivation' (Dean and Wilcock, 2012; Roland and Chappell, 2015), often resulting in communication problems and conflicts (Roberto *et al*., 2011). Social isolation and stigmatisation follow (Chiong-Rivero *et al*., 2011). Eventually, many dementia carers need professional help from care services and rely on them to an increasing extent (Roland and Chappell, 2015).

The annual care costs of dementia in the UK amount to £26.3 billion – of which £11.6 billion are met by informal carers (Alzheimer's Society, 2014: ix). Expenditure on long-term care for dementia patients is projected to rise from 0.6% of GDP in 2002 to 0.82–0.96% of GDP in 2031 (Comas-Herrera *et al*., 2011). There are 850,000 people with dementia in the UK, and caring for each of them has an economic impact of almost £32,250 (Alzheimer's Society, 2014: ix). Projections forecast an increase in patient numbers to over 1 million by 2025 and more than 2 million by 2051 (Alzheimer's Society, 2014: viii), although some recent evidence suggests that the dementia prevalence in the UK and other high-income countries declined in line with reduced risk factors (better education, prevention and treatment) (Matthews *et al*., 2013).

5. Conclusion and policy recommendations

This report has reviewed the evidence on the state of family care in the UK. The economic value of family care provision exceeds that of formal care provision by several times. The numbers of people aged 80 years and over who are at greatest risk of requiring long-term care will double by mid-century. It remains to be seen to what extent lifestyle and medical treatment improvements will reduce the slope of rising care need.

Both the numbers of formal carers and family carers will have to increase in order to cope with increasing demand. Spousal care is set to become more important, and men are projected to play a greater role in caregiving. While the numbers of husbands/male partners and sons giving care are rising, informal care provided by wives/female partners and daughters are likely to continue to play the dominant role in caregiving.

In an employment-oriented social environment in which the generations within a family are separated geographically, families and couples, women and men, wives and husbands, daughters/daughters-in-law and sons/sons-in-law, as well as grandmothers and grandfathers, need support to deliver family care. A successful reconciliation of paid work and unpaid care work is a precondition for mastering the family care challenge ahead. Reducing working hours to zero in order to cope with the demands of caregiving is not an alternative if carers have to earn their current livelihood and their future pensions, as well as pay for additional care services.

Employers benefit from workers who manage to combine work and care effectively and can focus on employment-related tasks without distraction. The annual costs of not reconciling employment and eldercare is estimated at €14,200 per employee in Germany (Schneider *et al*., 2011). Enabling flexible working hours is the key support employers can provide. The introduction of 'working-life time accounts', i.e. an arrangement between employer and employee by which workers could save part of their monthly wage/salary for sabbatical leave, would be an innovative alternative available throughout a worker's life course. It could be administered by social security institutions or a quango to enable workers to change jobs without losing their entitlements. These so-called 'working-life time accounts' (in German: *'Lebensarbeitzeitkonten'*) were first introduced in Germany as a result of collective bargaining in the steel industry in October 2000 (Franke, 2011). Today, this option is protected by the Code of Social Law (*Sozialgesetzbuch SGB IV §§ 7.a-e*) and is intended as flexible leave of absence to be used as long-term care leave, parental leave, for part-time work or early retirement.

For the purpose of organising care, legal entitlements to unpaid as well as paid care leave are useful because they clarify the working carer's position in the workplace and thus help to prevent conflicts with line managers and work colleagues. If care leave payments cover a substantial part of the worker's salary for the limited period of time needed to organise care (for 10 working days, for example), it would allow them to focus on organising care effectively and to focus on work after their return.

Examples from the two societies in Europe with the oldest people, Germany and Italy, illustrate how paid leave schemes could be implemented: employees in Italy are entitled to three paid leave days per month to care for a disabled relative up to the third degree (i.e. spouse, children, parents, brothers and sisters, grandfather–grandchild, uncle–nephew) under the Care Act 104. Twenty-five of these 36 days of leave per year count towards pension benefits (Santini *et al*., 2011). In Germany, the 2012 Family Care Act introduced a paid family-care leave scheme

(*Familienpflegezeitgesetz*), which entitles full-time working carers to reduce their working hours from full-time to part-time (50%) for two years to care for a family member part-time while earning 75% of their previous wages. After these two years, employees would return to full-time employment but would continue earning 75% of their wages until their 'virtual account' is rebalanced.

Despite stabilising a working carer's financial situation, this legislation was greeted with widespread criticism. Employers perceived it as placing substantial financial risks with them; carers' representatives claimed that it still reduced carers' incomes substantially, which they could not afford; and other critics pointed out that only workers in permanent positions could take advantage of this initiative – and not the growing numbers of employees on temporary contracts. In January 2015, a reformed Family Care Act was implemented, which includes a paid care leave element for organising care, the care support allowance (*Pflegeunterstützungsgeld*) and an interest-free loan to cover half of the forfeit income due to a reduction in working time. Carers are legally entitled to receive Care Support Allowance for up to six months for full-time care provision and for up to two years to cover lost income due to reducing their working hours to a minimum of 15 hours per week. Working carers are protected against job loss during that time (Hoff and Hamblin, 2015).

Several large employers in the UK have front-line staff dealing with working carers' issues and have in place policies that provide some degree of flexibility for carers, such as carers' leave, and mobility within the organisation to more suitable roles. Working carers employed by a publicly recognised 'best practice employer' are reluctant to leave their jobs there, even at the expense of better earnings or career prospects elsewhere (Hamblin and Hoff, 2011).

Greater efforts are needed to raise the awareness of line managers/work colleagues as well as the general public of the conflicting demands faced by people combining employment and caregiving. More awareness-raising activities need to target ethnic minority carers who are often unaware of care-related services available to them. This includes better preparation of care providers for the specific needs of care recipients and carers from ethnic minority backgrounds as well as establishing culturally sensitive care provision.

Improvements in assistive technologies and in home-office technologies may contribute to a better reconciliation of paid work and family care in future, particularly if telecare/assistive technologies are integrated in care networks (Yeandle, 2014). Care networks link a variety of informal care, home care, social care, health care, geriatric care and auxiliary services. They hold the key to good-quality service provision in remote rural areas (Hoff, 2012).

Regional variation poses a substantial challenge in the UK. Whereas Greater London in particular, as well as the South East and the West Midlands, have relatively young populations, the demographic profiles of some rural areas in North and South Wales, North West, North East and South West England are characteristic of advanced ageing societies. There is a mismatch between demographic need and rural infrastructure that needs to be addressed in future. Assistive technologies and care networks have the potential to address some of these needs but require nationwide high-speed broadband connections.

References

Abuladze, L. and Sakkaeus, L. (2013) Social networks and everyday activity limitations. In Börsch-Supan, A., Brandt, M., Litwin, H. and Weber, G. (eds) *Active Ageing and Solidarity between Generations in Europe.* de Gruyter: Berlin, pp. 311–322.

Allan, G., Hawker, S. and Crow, G. (2008) Kinship in stepfamilies. In Pryor, J. (ed.) *The International Handbook of Stepfamilies.* Wiley: Hoboken, NJ, pp. 323–344.

Allan, G., Hawker, S. and Crow, G. (2013) *Stepfamilies*. Palgrave Macmillan: Basingstoke.

Alzheimer's Society (2014) *Dementia UK: Update*. Alzheimer's Society: London.

Ball, J. and Pike, G. (2007) *Black and Minority Ethnic and Internationally Recruited Nurses: Results from RCN Employment/Working Well Surveys 2005 and 2002.* Royal College of Nursing: London. Available at: www.rcn.org.uk/__data/assets/pdf_file/0006/78729/003104.pdf (accessed 14 July 2015).

Barnett, M., Scaramella, L., Neppl, T., Ontai, L. and Conger, R. (2010) *Intergenerational relationship quality, gender and grandparent involvement*. Family Relations 59, 28–44.

Bayliss, J. and Sly, F. (2010) *Ageing across the UK*. Regional Trends No 42: 2010 edition. Office for National Statistics: London.

Beaujouan, E. and Bhrolcháin, M. N. (2011) *Cohabitation and marriage in Britain since the 1970s*. Population Trends 145, Autumn 2011. University of Southampton: ESRC Centre for Population Change.

Bell, D. and Rutherford, A. (2013) *Individual and geographic factors in the formation of care networks in the UK*. Population, Space and Place 19, 727–737.

Bengtson, V. L., Rosenthal, C. and Burton, L. (1990) Families and aging: Diversity and heterogeneity. In Binstock, R. H. and George, L. (eds) *Handbook of Ageing and the Social Sciences.* Academic Press: San Diego, CA, pp. 263–287.

Bernard, M. and Phillips, J. (2007) *Working carers of older adults. What helps and what hinders in juggling work and care?* Community, Work and Family 10, 139–160.

Berrington, A., Stone, J. and Falkingham, J. (2009) *The changing living arrangements of young adults in the UK*. *ESRC Centre for Population Change, Briefing 7.* Available at: www.cpc.ac.uk/publications/cpc_briefing_papers/pdf/BP7_Living_Arrangements_of_Young_Adults_in_the_UK.pdf (accessed 27 July 2015).

Bertram, H. (2000) Die verborgenen familiären Beziehungen in Deutschland: Die multilokale Mehrgenerationenfamilie [The hidden family relations in Germany: the multi-local multigenerational family]. In Kohli, M. and Szydlik, M. (eds) *Generationen in Familie und Gesellschaft [Generations in Family and Society].* Leske + Budrich: Opladen, pp. 97–121.

Buckner, L. and Yeandle, S. (2006) *More than a Job. Working Carers: Evidence from the 2001 Census*. Report for Carers UK. University of Leeds: Leeds.

Butt, J. and Moriarty, J. (2004) Social support and ethnicity in old age. In Walker, A. and Hennessy, C. (eds) *Growing Older: Quality of Life in Old Age.* The Open University Press: Buckingham, pp. 167–187.

Cangiano, A., Shutes, I., Spencer, S. and Leeson, G. (2009) *Migrant Care Workers in Ageing Societies: Research Findings in the United Kingdom*. COMPAS: Oxford.

Chambers, P., Allan, G., Phillipson, C. and Ray, M. (2009) *Family Practices in Later Life*. Policy Press: Bristol.

Chiong-Rivero, H., Ryan, G. W., Flippen, C., Bordelon, Y., Szumski, N. R., Zesiewicz, T. A. and Vickrey, B. G. (2011) *Patients' and caregivers' experiences of the impact of Parkinson's disease on health status*. Patient-related Outcome Measures 2, 57–70.

Clarke, L. and Roberts, C. (2004) The meaning of grandparenthood and its contribution to the quality of life of older people. In Walker, A. and Hagan Hennessy, C. (eds) *Growing Older: Quality of Life in Old Age.* Open University Press: Maidenhead, pp. 188–208.

Comas-Herrera, A. and Wittenberg, R. (2009) *Expected Life Time Costs of Social Care for People Aged 65 and Over in England. Report to the Department of Health*. PSSRU, Discussion Paper 2638, London School of Economics and Political Science: London.

Comas-Herrera, A., Northey, S., Wittenberg, R., Knapp, M., Bhattacharyya, S. and Burns, A. (2011) *Future costs of dementia-related long-term care: Exploring future scenarios*. International Psychogeriatrics 23(01), 20–30.

Corden, A. and Hirst, M. (2011) *Partner care at the end-of-life: Identity, language and characteristics*. Ageing and Society 31(2), 217–242.

Crompton, R., Dennett, J. and Wigfield, A. (2003) *Organisations, Careers and Caring*. The Policy Press for the Joseph Rowntree Foundation: Bristol. Available at: www.jrf.org.uk/sites/files/jrf/jr155-organisations-careers-caring.pdf (accessed 29 July 2015).

Curtis, L. (2014) *Unit Costs of Health and Social Care 2014*. PSSRU: Canterbury.

Dahlberg, L., Demack, S. and Bambra, C. (2007) *Age and gender of informal carers: A population-based study in the UK*. Health and Social Care in the Community 15(5), 439–445.

Dale, A., Lindley, J. and Dex, S. (2006) *A life-course perspective on ethnic differences in women's economic activity in Britain*. European Sociological Review 22(3), 323.

Dean, K. and Wilcock, G. (2012) *Living with mild cognitive impairment: the patient's and carer's experience*. International Psychogeriatrics 24(6), 871–881.

Della Giusta, M. and Jewell, S. (2014) *Unpaid work and conformity: Why care?* Cambridge Journal of Economics, doi: 10.1093/cje/beu061 [advance access].

Demetriades, S., Meixner, M. and Barry, A. (2006) *Reconciliation of Work and Family Life and Collective Bargaining in the European Union. An analysis of EIRO articles*. European Foundation for the Improvement of Living and Working Conditions: Dublin.

Dench, J. and Ogg, J. (2002) *Grandparenting in Britain: A Baseline Study.* Institute of Community Studies: London.

Department of Health (2000) *Shaping the Future NHS: Long-term Planning for Hospitals and Related Services*. DoH: London.

Dimmock, B., Bornat, J., Pearce, S. and Jones, D. (2004) Intergenerational relationships among UK stepfamilies. In Harper, S. (ed.) *Families in Ageing Societies*. Oxford: Oxford University Press, pp. 82–94.

Dimova, R. and Wolff, F.-C. (2011) *Do downward private transfers enhance maternal labor supply? Evidence from around Europe*. Journal of Population Economics 24(3), 911–933.

Dykstra, P. A. and Fokkema, T. (2011) *Relationships between parents and their adult children: A West European typology of late-life families*. Ageing and Society 31(4), 545–569.

Dykstra, P. A. and Hagestad, G. O. (2007) *Childlessness and parenthood in two centuries*. Journal of Family Issues 28(11), 1518–1532.

Dykstra, P. A. and Komter, A. E. (2012) *Generational interdependencies in families*. Demographic Research 27, 487–506.

Eurostat (2011a) *Demography Report 2010: Older, More Numerous and Diverse Europeans*. European Commission: Brussels.

Eurostat (2011b) The greying of the baby boomers: A century-long view of ageing in European populations. *Eurostat statistics in focus,* 23/2011.

Eurostat (2014) *Mean age of women at childbirth*. Available at: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=edat_lfs_9912&lang=en (accessed 31 July 2015).

Eurostat (2015a) *Mortality and life expectancy statistics*. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Mortality_and_life_expectancy_statistics (accessed 31 July 2015).

Eurostat (2015b) *Population by educational attainment level, sex, age and country of birth*. Available at: http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do (accessed 15 July 2015).

Evandrou, M. and Falkingham, J. (2000) *Looking back to look forward: Lessons from four birth cohorts for ageing in the 21st century*. Population Trends 99, 27–36.

Evandrou, M., Falkingham, J. and Green, M. (2010) *Migration in later life: Evidence from the British Household Panel Survey*. Population Trends 141, 77–94.

Ferguson, N. (2004) *Grandparenting in Divorced Families*. Policy Press: Bristol.

Fernández, J. L. and Forder, J. (2010) *Equity, efficiency, and financial risk of alternative arrangements for funding long-term care systems in an ageing society*. Oxford Review of Economic Policy 26(4), 713–733.

Fleckenstein, T. and Seeleib-Kaiser, M. (2011) *Business, skills and the welfare state: The political economy of employment-oriented family policy in Britain and Germany*. Journal of European Social Policy 21(2), 136–149.

Fors, S. and Lennartson, C. (2008) *Social mobility, geographical proximity and intergenerational family contact in Sweden*. Ageing and Society 28, 253–270.

Franke, A. (2011) *Carers@Work. The Reconciliation of Work and Care in Europe: The Social Policy Context.* TU Dortmund: Dortmund. Available at: www.carersatwork.tu-dortmund.de/download/Social_Policy.pdf (accessed 15 July 2015).

Glaser, K. and Grundy, E. (2002) *Class, caring and disability: Evidence from the British Retirement Survey*. Ageing and Society 22(3), 325–342.

Glaser, K., Montserrat, E., Waginger, U., Price, D., Stuchbury, R. and Tinker, A. (2010) *Grandparenting in Europe.* Grandparent Plus: London.

Gray, A. (2005) *The changing availability of grandparents as carers and its implications for childcare policy in the UK*. Journal of Social Policy 34(4), 557–577.

Haberkern, K. and Szydlik, M. (2010) *State care provision, societal opinion and children's care of older parents in 11 European countries*. Ageing and Society 30(2), 299–323.

Hagestad, G. O. and Call, V. R. A. (2007) *Pathways to childlessness*. Journal of Family Issues 28(10), 1338–1361.

Hamblin, K. A. and Hoff, A. (2011) *Carers@Work. Carers Between Work and Care – Conflict or Chance? UK National Report*. Oxford Institute of Ageing: Oxford.

Hank, K. (2007) *Proximity and contacts between older parents and their children: A European comparison*. Journal of Marriage and the Family 69(1), 157–173.

Hank, K. and Buber, I. (2009) *Grandparents caring for their grandchildren*. Journal of Family Issues 30(1), 53–73.

Harper, S. (2006) *Ageing Societies*. Hodder Arnold: London.

Harper, S. and Levin, S. (2005) *Family care, independent living and ethnicity*. Social Policy and Society 4(2), 157–169.

Harper, S. and Ruicheva, I. (2010) *Grandmothers as replacement parents and partners: the role of grandmotherhood in single parent families*. Journal of Intergenerational Relationships 8(3), 219–233.

Haskey, J. (2005) *Living arrangements in contemporary Britain: having a partner who usually lives elsewhere and living apart together (LAT)*. Population Trends 122, 35–45.

Henz, U. (2004) *The effects of informal care on paid-work participation in Great Britain: A lifecourse perspective*. Ageing and Society 24: 851–880.

Herlofson, K. and Hagestad, G. O. (2012) Transformations in the role of grandparents across welfare states. In Arber, S. and Timonen, V. (eds) *Contemporary Grandparenting: Changing Family Relationships in Global Contexts*. Policy Press: Bristol, pp. 27–50.

Hirst, M. (2001) *Trends in informal care in Great Britain during the 1990s*. Health and Social Care in the Community 9(6), 348–357.

Hirst, M. and Corden, A. (2010) *Change in living arrangements following death of a partner in England and Wales, 1971 to 2001*. Population Trends 141, 130–150.

Hoff, A. (2006a) *Geographical proximity and contact frequency between older parents and their adult children in Germany: Cross-cohort and longitudinal perspectives*. Generations Review Journal of the British Society of Gerontology 16(2), 16–22.

Hoff, A. (2006b) *Lone Mothers between the Welfare State and Informal Support: A Cross-National Comparison of Germany and the UK*. The Edwin Mellen Press: Lewiston, NY.

Hoff, A. (2012) *Ergebnisbericht der Ersten Netzwerkbefragung im Rahmen des Evaluationsprojekts "Modellregionen für die geriatrische Versorgung in Sachsen" [Findings report of the first network evaluation of the "Model regions of geriatric care provision in Saxony"].* Zittau/Goerlitz University of Applied Sciences: Goerlitz.

Hoff, A. and Hamblin, K. (2015) Comparing working carers' reconciliation strategies in Germany, Italy, Poland, and the UK. In Reichert, M., Perek-Bialas, J. and Hamblin, K. (eds) *Carers@Work. Carers between Work and Care.* VS Verlag für Sozialwissenschaften: Wiesbaden.

Hoff, A., Reichert, M., Hamblin, K., Perek-Bialas, J. and Principi, A. (2014) *Comparing working carers' reconciliation strategies and company-based reconciliation policies and their effect on working carers' well-being*. Vulnerable Groups and Inclusion 5, 1–25.

Holmes, J. and Kiernan, K. (2010) *Fragile Families in the UK: Evidence from the Millennium Cohort Study*. University of York: York. Available at: www.york.ac.uk/media/spsw/documents/research-and-publications/HolmesKiernan2010FragileFamiliesInTheUKMillenniumCohort.pdf (accessed 15 July 2015).

Hutton, S. and Hirst, M. (2001) *Caring Relationships over Time*. Social Policy Research Unit: York.

Igel, C. and Szydlik, M. (2011) *Grandchild care and welfare state arrangements in Europe*. Journal of European Social Policy 21(3), 210–224.

Jivraj, S. and Nazroo, J. (2012) Social domain tables. In Banks, J., Nazroo, J. and Steptoe, A. (eds) *The Dynamics of Ageing: Evidence from the English Longitudinal Study of Ageing 2002–2010 (Wave 5)*. Institute for Fiscal Studies: London, pp. 259–293.

Joshi, H. (2007) *Social Polarization in Reproduction. From Boom to Bust? Fertility, Ageing and Demographic Change*. Centre Forum: London.

Katbamna, S., Ahmad, W., Bhakta, P., Baker, R. and Parker, G. (2004) *Do they look after their own? Informal support for South Asian carers*. Health and Social Care in the Community 12, 398–406.

Kneale, D. and Joshi, H. (2010) *Postponement and childlessness: Evidence from two British cohorts*. Demographic Research 19(58), 1935–1964.

Lawrence, V., Murray, J., Samsi, K. and Banerjee, S. (2008) *Attitudes and support needs of Black Caribbean, south Asian and White British carers of people with dementia in the UK*. The British Journal of Psychiatry 193(3), 240–246.

Leach, R., Phillipson, C., Biggs, S. and Money, A. (2008) *Sociological perspectives on the baby boomers: An exploration of social change*. Quality in Ageing 9(1), 19–26.

Leggett, A. N., Zarit, S., Taylor, A. and Galvin, J. A. (2010) *Stress and burden among caregivers of patients with Lewy body dementia*. The Gerontologist 51(1), 76–85.

Lewis, J., Campbell, M. and Huerta, C. (2008) *Patterns of paid and unpaid work in Western Europe: Gender, commodification, preferences and the implications for policy*. Journal of European Social Policy 18(1), 21–37.

Mackenzie, A., Perry, L., Lockhart, E., Cottee, M., Cloud, G. and Mann, H. (2007) *Family carers of stroke survivors: Needs, knowledge, satisfaction and competence in caring*. Disability and Rehabilitation 29(2), 111–121.

Mahne, K. and Motel-Klingebiel, A. (2010) Familiale Generationenbeziehungen [Intergenerational family relations]. In Motel-Klingebiel, A., Wurm, S. and Tesch-Römer, C. (eds) *Altern im Wandel [Changing Ageing]*. Verlag W. Kohlhammer: Stuttgart, pp. 188–214.

Mann, R. and Leeson, G. (2010) *Grandfathers in contemporary families in Britain*. Journal of Intergenerational Relationships 8(3), 234–248.

Marmot, M., Banks, J., Blundell, R., Lessof, C. and Nazroo, J. (eds) (2003) *Health, Wealth and Lifestyles of the Older Population in England: The 2002 English Longitudinal Study of Ageing.* Institute for Fiscal Studies: London.

Matthews, F. E., Arthur, A., Barnes, L. E., Bond, J., Jagger, C., Robinson, L. and Brayne, C. (2013) *A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: Results of the Cognitive Function and Ageing Study I and II*. Lancet 382, 1405–1412.

Merrell, J., Kinsella, F., Murphy, F., Philpin, S. and Ali, A. (2006) *Accessibility and equity of health and social care services: Exploring the views and experiences of Bangladeshi carers in South Wales, UK*. Health and Social Care in the Community 14(3), 197–205.

MetLife Mature Market Institute and National Alliance for Caregiving (2006) *The MetLife Caregiving Cost Study: Productivity Losses to U.S. Business*. MetLife Mature Market Institute: Westport, CT; National Alliance for Caregiving: Bethesda, MD. Available at: www.caregiving.org/data/Caregiver%20Cost%20Study.pdf (accessed 29 July 2015).

Mir, G. and Tovey, P. (2003) *Asian carers' experiences of medical and social care*. British Journal of Social Work 33, 465–479.

Mukadam, N., Cooper, C. and Livingston, G. (2011) *A systematic review of ethnicity and pathways to care in dementia*. International Journal of Geriatric Psychiatry 26(1), 12–20.

Nazroo, J. (2006) Ethnicity and old age. In Vincent, J., Phillipson, C. and Downes, M. (eds) *The Futures of Old Age.* Sage: London, pp. 62–72.

Office for National Statistics (2011) *2010-based Period and Cohort Life Expectancy tables.* ONS: London. Available at: www.ons.gov.uk/ons/dcp171780_238828.pdf (accessed 15 July 2015).

Office for National Statistics (2013a) 2011 Census Analysis: Unpaid Care in England and Wales, 2011 and Comparison with 2001. ONS: London. Available at: www.ons.gov.uk/ons/dcp171766_300039.pdf (accessed 15 July 2015).

Office for National Statistics (2013b) *Cohort Fertility, England and Wales, 2012*. ONS: London. Available at: www.ons.gov.uk/ons/rel/fertility-analysis/cohort-fertility--england-and-wales/2012/index.html (accessed 15 July 2015).

Office for National Statistics (2013c) *What Does the 2011 Census Tell Us About Older People?* ONS: London. Available at: www.ons.gov.uk/ons/dcp171776_325486.pdf (accessed 15 July 2015).

Office for National Statistics (2013d) *What does the 2011 Census Tell Us about the "Oldest Old" living in England & Wales?* ONS: London. Available at: www.ons.gov.uk/ons/dcp171776_342117.pdf (accessed 15 July 2015).

Office for National Statistics (2013e) *Full report – Women in the Labour Market*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171776_328352.pdf (accessed 15 July 2015).

Office for National Statistics (2013f) *Full report – Graduates in the UK Labour Market 2013*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171776_337841.pdf (accessed 15 July 2015).

Office for National Statistics (2013g) *Older People Divorcing Infographic*. ONS: London. Available at: www.ons.gov.uk/ons/rel/family-demography/older-people-divorcing/2011/info-older-people-divorcing.html (accessed 15 July 2015).

Office for National Statistics (2013h) *Families and Households*, 2013. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_332633.pdf (accessed 15 July 2015).

Office for National Statistics (2014a) *National Life Tables, United Kingdom, 2011–2013*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_377972.pdf (accessed 15 July 2015).

Office for National Statistics (2014b) *Life Expectancy at Birth and at Age 65 by Local Areas in England and Wales, 2011–13*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_385458.pdf (accessed 15 July 2015).

Office for National Statistics (2014c) *Mind the Gap: London and Northern Regions Closing the Gap in Regional Life Expectancy*. ONS: London. Available at: www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2011-13/sty-mind-the-gap.html (accessed 15 July 2015).

Office for National Statistics (2014d) *Childbearing of UK and Non-UK Born Women Living in the UK – 2011 Census Data*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171766_350433.pdf (accessed 15 July 2015).

Office for National Statistics (2014e) *Births in England and Wales, 2013*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_371129.pdf (accessed 15 July 2015).

Office for National Statistics (2014f) *2011 Census Analysis: Internal and International Migration of Older Residents (Aged 65 and Over) in England and Wales in the Year Prior to the 2011 Census*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171776_377047.pdf (accessed 15 July 2015).

Office for National Statistics (2014g) *Estimates of the Very Old (including Centenarians) for England and Wales, United Kingdom, 2002 to 2013*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_378107.pdf (accessed 15 July 2015).

Office for National Statistics (2014h) *House Price Index, October 2014*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_388533.pdf (accessed 15 July 2015).

Office for National Statistics (2014i) *Divorces in England and Wales 2012*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_351693.pdf (accessed 15 July 2015).

Office for National Statistics (2014j) *Childbearing for Women Born in Different Years, England and Wales, 2013*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_387280.pdf (accessed 15 July 2015).

Office for National Statistics (2015) *Migration Statistics Quarterly Report, February 2015*. ONS: London. Available at: www.ons.gov.uk/ons/dcp171778_396645.pdf (accessed 15 July 2015).

Orloff, A. S. (2006) From maternalism to "employment for all". In Levy, J. D. (ed.) *The State after Statism.* Harvard University Press: Cambridge, MA, pp. 230–270.

Phillips, J. (2007) *Care.* Polity Press: Cambridge.

Phillipson, C. (2010) Globalisation, global ageing and intergenerational change. In Izuhara, M. (ed.) *Ageing and Intergenerational Relations.* Policy Press: Bristol, pp. 13–28.

Pickard, L., Wittenberg, R., Comas-Herrera, A., King, D. and Malley, J. (2007) *Care by spouses, care by children: Projections of informal care for older people in England by 2031*. Social Policy and Society 6(3), 353–366.

Ratcliffe, A. and Smith, S. (2006) *Fertility and Women's Education in the UK:* A Cohort Analysis. Working Paper No. 07/165. University of Bristol: Bristol. Available at: www.bristol.ac.uk/media-library/sites/cmpo/migrated/documents/wp165.pdf (accessed 15 July 2015).

Roberto, K. A., Blieszner, R., McCann, B. R. and McPherson, M. C. (2011) *Family triad perceptions of mild cognitive impairment*. Journals of Gerontology 66B(6), 756–768.

Roland, K. P. and Chappell, N. L. (2015) *A typology of care-giving across neurodegenerative diseases presenting with dementia*. Ageing and Society, available on CJ02014. doi: 10.1017/S0144686X1400066X

Rubery, J. and Rafferty, A. (2013) *Women and recession revisited*. Work, Employment and Society 27(3), 414–432.

Salt, J. (2007) *International Migration and the United Kingdom: Report of the United Kingdom SOPEMI Correspondent to the OECD 2007*. Migration Research Unit, University College London: London.

Santini, S., Lamura, G. and Principi, A. (2011) *Carers@Work. Carers between Work and Care – Conflict or Chance? Results of Interviews with Working Carers in Italy*. INRCA: Ancona.

Saraceno, C. and Keck, W. (2008) *The Institutional Framework of Intergenerational Family Obligations in Europe: A Conceptual and Methodological Overview*. WZB: Berlin. Available at: www.multilinks-project.eu/wp-content/uploads/2009/04/Report_Saraceno_Keck_Nov081.pdf (accessed 15 July 2015).

Schneider, H., Heinze, J. and Hering, D. (2011) *Betriebliche Folgekosten Mangelnder Vereinbarkeit von Beruf und Pflege [Company-based Follow-up Costs of Lacking Reconciliation of Employment and Eldercare]*. Steinbeis University: Berlin. Available at: www.carersatwork.tu-dortmund.de/download/Expertise_final.pdf (accessed 15 July 2015).

Shutes, I. and Chiatti, C. (2012) *Migrant labour and the marketisation of care for older people: The employment of migrant care workers by families and service providers*. Journal of European Social Policy 22(4), 392–405.

Simon, C., Kumar, S. and Kendrick, T. (2009) *Cohort study of informal carers of first-time stroke survivors: Profile of health and social changes in the first year of caregiving*. Social Science and Medicine 69(3), 404–410.

Sin, C. H. (2006) *Expectations of support among white British and Asian-Indian older people in Britain*. Health and Social Care in the Community 14, 215–224.

Smith, C., Tomassini, C., Smallwood, S. and Hawkins, M. (2005) *The Changing Age Structure of the UK Population: Focus on People and Migration*. UK National Statistics: London.

Statistisches Bundesamt (Destatis) (2013) *Pflegestatistik 2011 [Long-Term Care Statistics 2011]*. Wiesbaden: Statistisches Bundesamt.

Tan, J. P., Buchanan, A., Flouri, E., Attar-Schwartz, S. and Griggs, J. (2010) *Filling the parenting gap? Grandparent involvement with UK adolescents*. Journal of Family Issues 31(7), 992–1015.

Tarrant, A. (2009) *Constructing a social geography of grandparenthood: A new focus for intergenerationality*. Area 42(2), 190–197.

Tarrant, A. (2012) Grandfathering: The construction of new identities and masculinities. In Arber, S. and Timonen, V. (eds) *Contemporary Grandparenting. Changing Family Relationships in Global Contexts*. Policy Press: Bristol, pp. 181–202.

Thompson, C. A., Spilsbury, K., Hall, J., Birks, Y., Barnes, C. and Adamson, J. (2007) *Systematic review of information and support interventions for caregivers of people with dementia*. BMC Geriatrics 7, 18, doi: 10.1186/1471-2318-7-18

Tomassini, C. (2005) *The demographic characteristics of the oldest old in the United Kingdom*. Population Trends 120, 15–22.

Wanless, D., Forder, J., Fernández, J.-L., Poole, T., Beesley, L., Henwood, M. and Moscone, F. (2006) *Securing Good Care for Older People: Taking a Long Term View*. The King's Fund: London.

Williams, C. (2011) *Marriage and mental health: When a spouse has Alzheimer's disease*. Archives of Psychiatric Nursing 25(3), 220–222.

Wittenberg, R., Pickard, L., Comas-Herrera, A., Davies, B. and Darton, R. (2001) *Demand for long-term care for older people in England to 2031*. Health Statistics Quarterly 12, 5–17.

Yeandle, S. (2014) *Frail Older People and their Networks of Support: How does Telecare Fit In?* AKTIVE Working Paper 2. CIRCLE (Centre for International Research on Care, Labour and Equalities), University of Leeds: Leeds. Available at: www.aktive.org.uk/downloads/AKTIVE_Paper-2.pdf (accessed 29 July 2015).

Yeandle, S., Bennett, C., Buckner, L., Fry, G. and Price, P. (2007) *Managing Caring and Employment*. Carers, Employment and Services Report Series, Report No. 2. Carers UK/University of Leeds: Leeds. Available at: http://circle.leeds.ac.uk/files/2012/08/carers-uk-report-2.pdf (accessed 29 July 2015).

Young, H., Grundy, E. and Kalogirou, S. (2005) *Who Cares? Geographic Variation in Unpaid Caregiving in England and Wales: Evidence from the 2001 Census*. Population Trends 120, 23–34.

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication available from www.gov.uk/go-science

Contacts us if you have any enquiries about this publication, including requests for alternative formats, at:

Government Office for Science
1 Victoria Street
London SW1H 0ET
Tel: 020 7215 5000
Email: contact@go-science.gsi.gov.uk

GS/15/18