Changes in older people's experiences of providing care and of volunteering during the COVID-19 pandemic

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EXECUTIVE SUMMARY

Engagement in socially productive activities, such as care provision and voluntary work, make important contributions to society, and may have been especially important during the coronavirus pandemic. They have also been associated with better health, well-being, and longer survival for older people. The ELSA COVID-19 Substudy provided data to allow for an exploration of how changes in caring and volunteering may have occurred during the pandemic, and to examine this in relation to factors such as sex, age, employment status, wealth, COVID-19 vulnerability and symptoms, and pre-pandemic experiences of health.

Overall, there have been important changes in both the level of care provided by older people and the extent of their involvement in volunteering, with, on average, care provision more likely to have increased or stayed the same (65% of older carers reported this), and volunteering more likely to have decreased or stopped (61% of older volunteers reported this). However, a large number of older people took on new caring roles for someone outside the household (12%) and 4% of older people registered to volunteer as part of the NHS scheme. Both economic characteristics (such as paid employment and wealth) and health-related characteristics (such as being vulnerable, self-isolating, having experienced COVID-19 symptoms, and reporting functional limitations) were related to changes the frequency of caring and voluntary work.

It is yet unclear how these changes in caring and volunteering have influenced older people's health and well-being during the coronavirus outbreak.

Investigating the impact of the pandemic on broader health and well-being outcomes for older people, the role of changes in care provision and volunteering in this, and how we might respond to this, is a crucial next step.

Key findings

- During the pandemic, 42% of carers reported no change inthe level of care they provided; 23% increased; and 35% either decreased or stopped the amount of care provided.
- Women were more likely than men to stop caring during the pandemic and less likely to report providing the same level of care.
- Participants aged 80 and older were less likely to stop or reduce care, compared with younger counterparts; however, they were also less likely to increase the amount of care they provided.
- Participants without paid employment, those in the lowest wealth quintile, and those identified as NHS vulnerable, or who were self-isolating, were more likely than others to have kept the same level of caring responsibilities.
- During the coronavirus outbreak 11% of men and 12% of women became new carers for someone outside the household.
- Becoming a new carer of someone outside of the household was strongly related to age, with 17% of participants between 50-59 of age becoming a new carer compared with 2% of those over 80 years.
- Participants in lower wealth quintiles, those who were NHS vulnerable, those who were self-isolating, and those with functional limitations, were less likely to start caring responsibilities outside the household.
- Among ELSA participants who volunteered before the coronavirus pandemic, 18% reduced their activity and 43% stopped completely; only 9% increased their level of engagement in volunteering.
- Most ELSA participants were aware of the Health Service England call for volunteers (82%) and of these 4% registered to volunteer. Those aged between 50-59 were more likely than others to register.
- Participants without paid employment were more likely than those in paid employment to stop volunteering while those in the highest wealth quintile were more likely to decrease their level of voluntary work.
- Self-isolating participants, those experiencing functional difficulties, and those reporting COVID-19 symptoms, were less likely than others to have increased their voluntary activities.

Introduction

The COVID-19 pandemic has had, and is having, a particularly significant impact on older people. At the beginning of the outbreak the World Health Organisation[1] highlighted the importance of supporting older people during the pandemic, as old age is considered a risk factor for developing severe illness and for risk of mortality. However, the coronavirus pandemic, and the public health responses to it, have had wider impacts on the lives of older people. One area where this has been important is the impact on socially productive activities, such as providing care and volunteering. These activities involve responsibilities to meet the needs of others who, in the case of providing care, are often close family members. Being able to maintain these activities is a challenge in the context of lockdown and social isolation, but carrying out such roles fulfils an important need for those receiving care, and potentially provides important returns for the older person giving care and volunteer.[2,3] Moreover, during the coronavirus pandemic there have been additional opportunities, and need, to provide care and to volunteer. Consequently, there may have been changes in the patterns of care giving and volunteering during the coronavirus pandemic. However, while providing care and volunteering present similar challenges and rewards, there is more discretion, or flexibility, in the volunteering role, so there may have been important differences in changes in volunteering and providing care during the coronavirus pandemic. Here we set out to describe these changes and the factors that predict them.

To do this we use data provided by the ELSA COVID-19 Substudy. This is a representative sample of older men and women that includes measures of changes in caring responsibilities and voluntary work during the pandemic. We explored the changes in older people's experience with caring and volunteering responsibilities during the pandemic in relation to economic and health-related characteristics.

Results

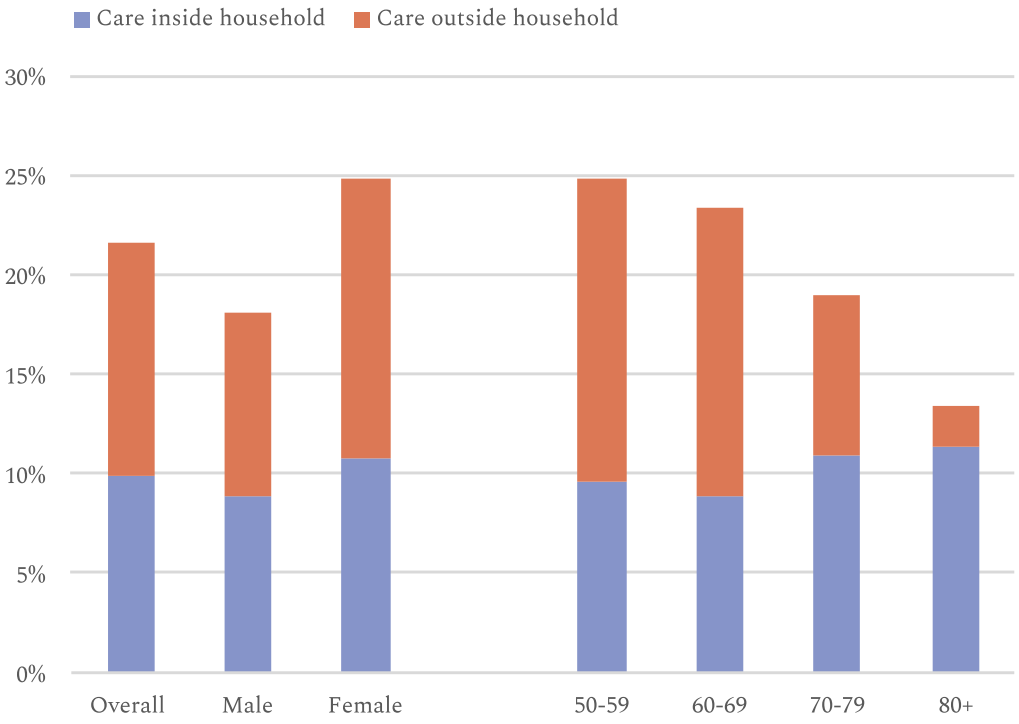
Some 7,040 participants responded in the ELSA COVID-19 Substudy in June/July 2020. The analyses reported in this briefing were carried out on 6,448 participants with full information on care provision, and on 6,443 participants with full information on their experiences of volunteering.

Caring

Overall, 22% of ELSA participants reported looking after anyone once a week or more, inside or outside the household, prior to the coronavirus outbreak (in February 2020). Figure 1 shows percentages of participants with or without caring responsibilities by sex and broad age-groups. As expected, women were more likely to be carers than men both inside (11% vs 9%) and outside the household (14% vs 9%). The percentage of older people who provide care decreases with age, with a quarter of those aged 50-59

reporting that they provided care, compared with one in eight among those aged 80 and older. However, this is entirely a result of reductions in the prevalence of providing care for someone outside the household; the percentage of older people caring for someone inside their household is broadly similar across age groups, and, in fact, tends to be slightly higher in the oldest age groups.

Figure 1: Percentage of participants with pre-pandemic caring responsibilities, by sex and age groups



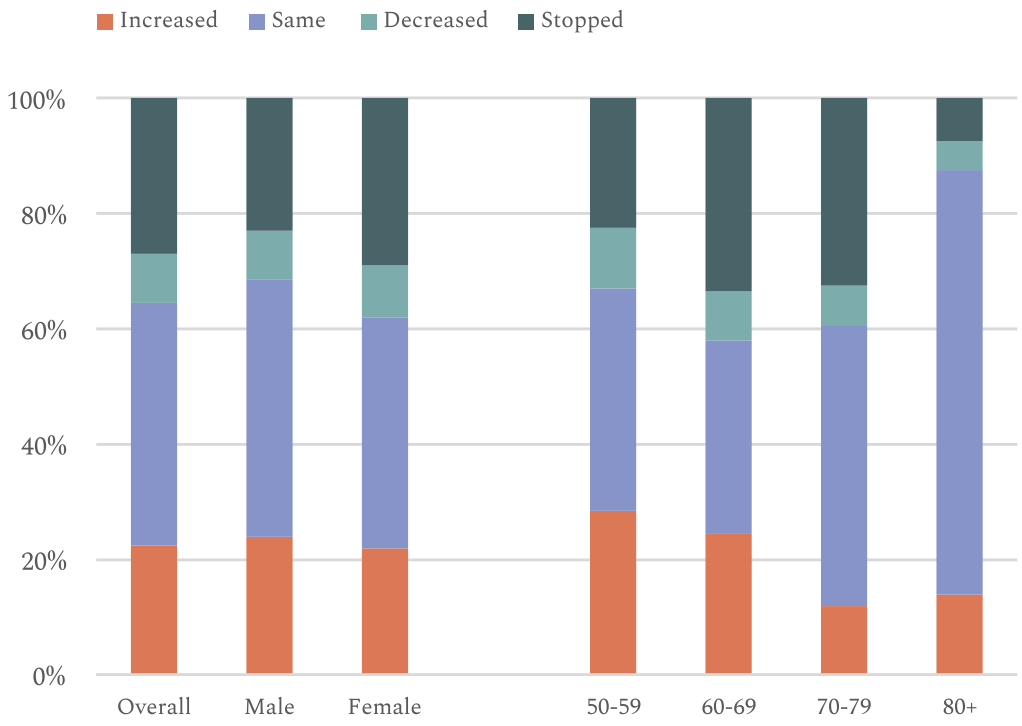
Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

Those who provided care before the pandemic were asked how the amount of care that they provided changed since the COVID-19 outbreak, that is whether it increased, or remained the same, or decreased, or stopped. As shown in Figure 2, 42% of carers reported no change; 23% increased the amount of care provided; and 35% either decreased the amount of care they provided, or stopped it altogether. Some sex differences were observed, with women being more likely than men to stop caring during the pandemic (29% and 23% respectively) and less likely to report providing the same level of care provided as before the pandemic (40% and 45% respectively).

Changes also differed by age, with a perhaps unexpected pattern. For instance, people aged 80 and older were less likely to stop or reduce care (13%) than both those in their 50s (33%) and those in their 60s and 70s (about 40%). Indeed, almost three quarters of

those 80+ provided the same level of care as they did before the coronavirus pandemic. However, older people were less likely to increase the amount of care that they provided, with, for example 14.5% of those in the 80 or older group increasing the care they provided, compared with 28.2% of those in their 50s. These findings might well be related to the fact that the majority of carers aged 80 or older looked after someone inside the household.

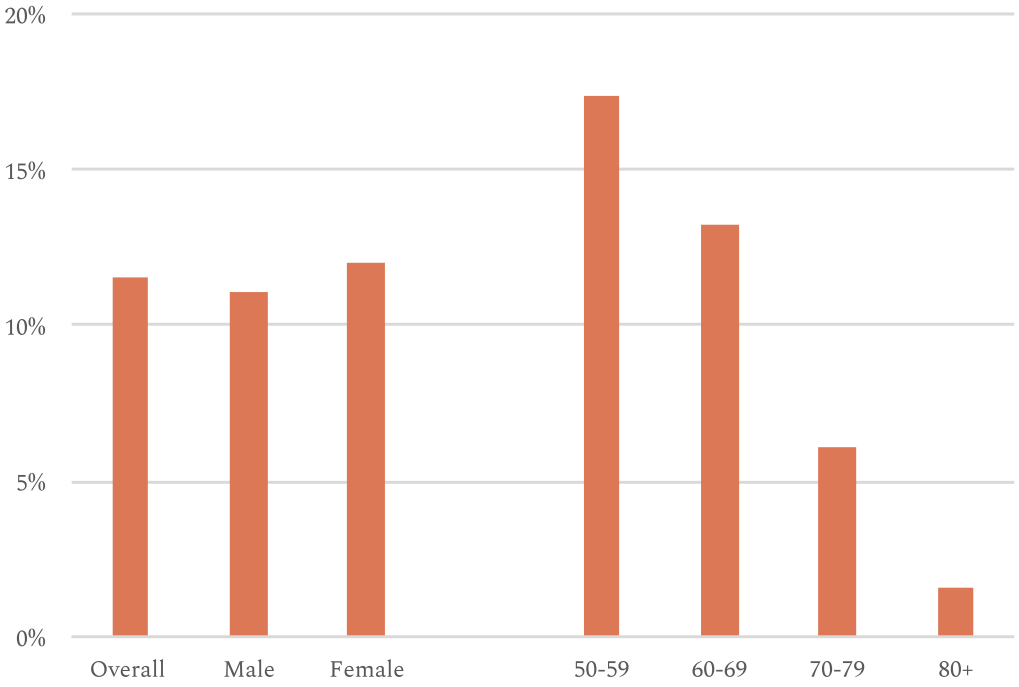
Figure 2: Changes in caring for those participants with caring responsibilities before the outbreak, by sex and age groups



Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

ELSA participants were also asked if they had started providing care for someone outside of their households, who they had not cared for previously, because of the coronavirus outbreak. As shown in Figure 3, almost 12% of participants reported doing this, with a slightly higher percentage of new carers among women than men. When this additional provision of care is considered, a clear age gradient emerges, with 17% of those aged 50-59 reporting newly providing care, compared with 13% of those in their 60s, 6% of those in their 70s, and less than 2% among those aged 80 and older.

Figure 3: Percentage of participants who became new carers of someone outside the household during the pandemic, by sex and age groups



Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

Predictors of changes in the provision of care

Table 1 shows how specific socio-economic and health-related characteristics related to changes in the provision of care during the coronavirus pandemic. Percentages show the distribution of participants with specific characteristics across changes and p-values from logistic regression models adjusted statistically for sex, age, respondent's marital status, and number of people in the respondent's household were used to estimate the likelihood of each change in the provision of care.

Table 1: Selected economic characteristics and changes in caring among carers before the outbreak (N=1,420)

	Increased	Same	Decreased	Stopped
Employment status				
In paid employment	33.0%	31.5%	10.4%	25.1%
Not in paid employment	16.6%	47.9%	7.8%	27.7%
Significance[1]	0.001	0.020	n.s.	n.s.
Wealth				
Highest wealth quintile	23.9%	38.2%	12.4%	25.5%
2nd	20.4%	40.0%	11.0%	28.7%
3rd	22.6%	43.3%	7.8%	26.3%
4th	21.1%	40.8%	10.0%	28.1%
Lowest wealth quintile	24.4%	45.4%	4.8%	25.3%
Significance[1]	n.s.	0.010	0.004	n.s.
NHS Vulnerability				
No	23.9%	39.2%	10.0%	26.9%
Yes	17.1%	53.0%	3.8%	26.1%
Significance[1]	n.s.	0.010	0.036	n.s.
Self-Isolating				
No	24.7%	37.9%	10.0%	27.5%
Yes	16.6%	53.2%	5.5%	24.7%
Significance[1]	n.s.	0.012	n.s.	n.s.
ADLs-IADLs				
No difficulties	23.7%	39.7%	8.8%	27.7%
At least one difficulty	18.5%	49.7%	8.6%	23.3%
Significance[1]	n.s.	n.s.	n.s.	n.s.
COVID symptoms				
None	21.2%	44.7%	8.0%	26.2%
One or more	26.1%	34.9%	10.8%	28.2%
Significance[1]	n.s.	0.032	n.s.	n.s.
Total (N)	**287**	**578**	**125**	**430**

Notes:[1]to assess changes in caring for each economic and health indicator/predictor.

Every logistic regression model for each predictor was adjusted for age, sex, marital status and number of people in the household. Statistically significant p values are shown in bold text.

ADLs stands for basic activities of daily living (such as using the toilet and dressing) and IADLs stands for Instrumental ADLs (such as making telephone calls, managing money, and taking medications).

Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

Among those who were engaged in caring activities before lockdown, 33% of those in paid employment increased caring compared with only 17% of those in paid employment (p=0.001). Those participants not in paid employment were, however, more likely to have kept the same level of caring responsibilities (48% versus 31% respectively, p=0.020). There is also some evidence to suggest an inverse relationship between wealth quintile and changes in caring. Those in the highest quintile reporting the highest percentage of decrease (12%) and the lowest percentage with the same level of care (38%), compared with 5% and 45% respectively for those in the bottom wealth quintile. There were few differences across wealth quintiles in relation to increases in the level of care provision, or stopping care provision.

Participants who have been identified as vulnerable by the NHS or their GPs were also more likely than those who were not vulnerable to have kept the same level of caring responsibilities (53% and 39% respectively, p=0.010) and less likely to have decreased their provision of care (4% versus 10%, p=0.036). Similarly, participants who were self-isolating were more likely to have kept the same level of care provision (53%), compared with 38% of those who were not self-isolating (p=0.012). Functional limitations were not associated with changes in levels of care provision for those who were providing care prior to the coronavirus pandemic. However, ELSA participants who experienced symptoms of COVID-19 were less likely to keep the same level of provision of care compared with those without symptoms (35% compared with 45% respectively, p=0.032).

When examining factors that might relate to taking on a new caring role outside the home (see Table 2), similar socio-economic patterns are observed. ELSA participants in the lower wealth quintiles were less likely to start caring compared with those in the most affluent group (for example, 9% of those in the lowest quintile compared with 15% for those in the highest quintile). As for health, participants who were NHS vulnerable, self-isolating, and with one or more functional limitation were less likely to take up a new caring role. However, experiencing COVID-19 symptoms was unrelated to this.

Table 2: Selected economic characteristics and new carers outside the household during the pandemic (N=6,497)

	Not a new carer	New carer	Significance[1]
Employment status			
In paid employment	82.9%	17.1%	n.s
Not in paid employment	91.8%	8.2%	
Wealth			
Highest wealth quintile	85.4%	14.6%	<0.001
2nd	87.1%	12.9%	
3rd	88.9%	11.1%	
4th	89.4%	10.6%	
Lowest wealth quintile	90.7%	9.3%	
NHS Vulnerability			
No	87.0%	13.0%	<0.001
Yes	95.4%	4.6%	
Self-Isolating			
No	86.0%	14.0%	<0.001
Yes	96.0%	4.0%	
ADLs and IADLs			
No difficulties	88.8%	13.2%	<0.001
At least one difficulty	94.2%	5.9%	
COVID-19 symptoms			
No	88.4%	11.6%	n.s
One or more	88.6%	11.4%	
Total (N)	**5,783**	**714**	

Notes: [1]to assess changes in caring for each socio-economic and health indicator/predictor.

Every logistic regression model for each predictor was adjusted for sex, age, marital status, and number of people in the household. Statistically significant p values are shown in bold text.

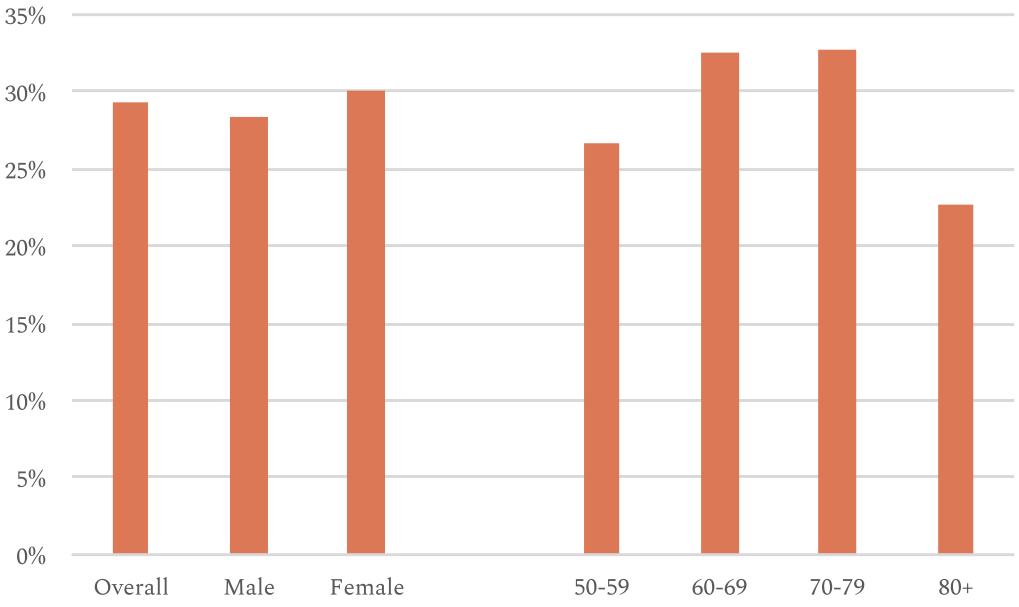
ADLs stands for basic activities of daily living (such as using the toilet and dressing) and IADLs stands for Instrumental ADLs (such as making telephone calls, managing money, and taking medications).

Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

Volunteering

Figure 4 shows that 29% of ELSA participants reported that prior to the coronavirus outbreak they were engaging in voluntary work, with only small differences for men compared with women. Those aged in their 60s and 70s reported higher levels of volunteering than those in their 50s and those aged 80 or older (33% compared with 27% and 23% respectively).

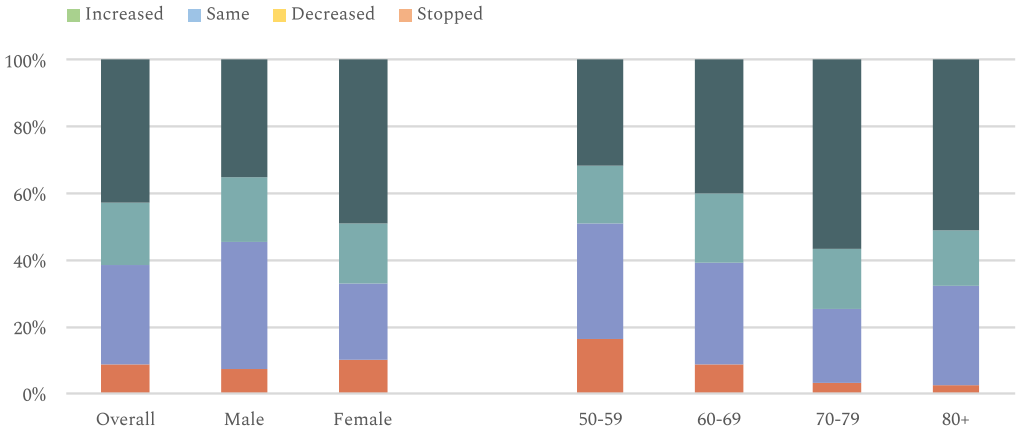
Figure 4: Percentage of participants who reported voluntary work before the outbreak, by sex and age groups



Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

Participants who were volunteering prior the COVID-19 outbreak were asked whether and how their volunteering activities changed. Almost 61% of volunteers said that they either reduced (18%) or stopped (43%) taking part in voluntary work, with only 9% increasing their level of engagement. The drop-in volunteering (either partial or complete) was more pronounced in women. Almost 50% of women stopped volunteering compared to 35% of men, and a larger percent of men compared with women maintained their pre-pandemic level of volunteering (38% and 23% respectively). In terms of age, those in their 50s were more likely than those in other age groups to increase their level of volunteering, or to maintain their level of volunteering, and less likely to reduce their level of volunteering, or to stop volunteering all together. More than half of those participants in the 70-79 and the 80 or older age groups stopped volunteer work, as did two-fifths of those in their 60s.

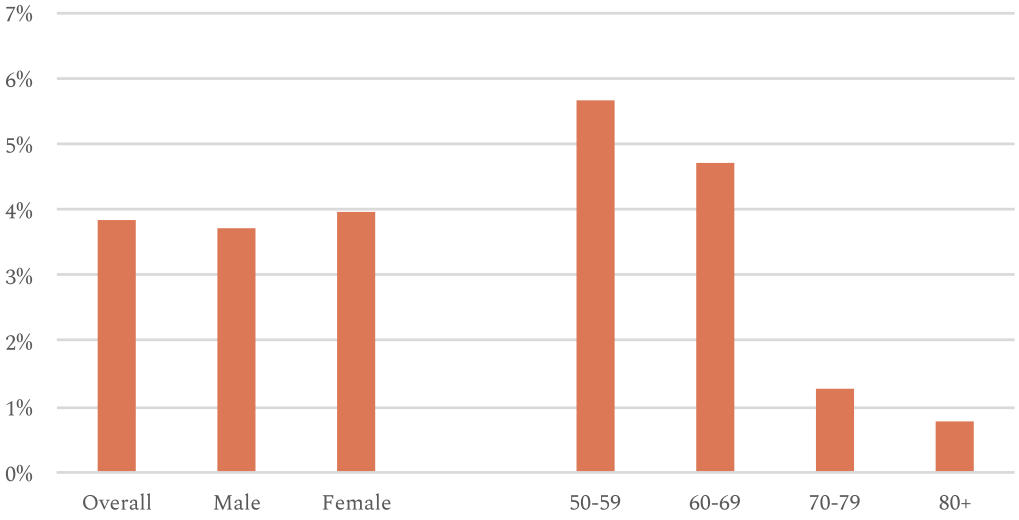
Figure 5: Changes in volunteering during the outbreak, by sex and age groups



Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

All ELSA participants were also asked if they were aware of the call by the Health Service England for volunteering during the coronavirus outbreak, and if so whether they had registered to volunteer. Out of 6,497 participants, 5,335 (82.1%) reported that they were aware of the call, but only 196 of those who were aware (3.9%) registered to volunteer. Among those who were aware of the call, the percentage who signed up was higher among participants in their 50s (6%) and 60s (5%) than among those aged 70 or older (~1%).

Figure 6: Percentage of people who registered to volunteer in the Health Service England during the pandemic, by sex and age groups



Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

Table 3 shows how specific economic and health-related characteristics relate to changes in volunteering during the coronavirus pandemic. Percentages show the distribution of participants with specific characteristics across changes and p-values from logistic regression models adjusted statistically for sex, age, respondent's marital

status, and number of people in the respondent's household were used to estimate the likelihood of each change in volunteering according to this range of economic and health characteristics.

Table 3: Selected economic characteristics and changes in volunteering (N=2,119)

	Increased	Same	Decreased	Stopped
Employment status				
In paid employment	16.0%	37.2%	16.8%	30.0%
Not in paid employment	5.4%	26.0%	19.2%	49.4%
Significance[1]	0.012	0.032	n.s.	0.002
Wealth				
Highest wealth quintile	9.5%	29.4%	22.1%	39.0%
2nd	7.0%	27.1%	22.4%	43.5%
3rd	7.4%	27.2%	15.5%	49.9%
4th	11.9%	32.4%	13.6%	42.0%
Lowest wealth quintile	9.1%	33.4%	16.6%	41.0%
Significance[1]	n.s.	n.s.	0.022	n.s.
NHS Vulnerability				
No	9.8%	29.6%	19.4%	41.2%
Yes	4.5%	31.0%	12.4%	52.1%
Significance[1]	n.s.	n.s.	0.011	0.039
Self-Isolating				
No	10.4%	30.3%	19.2%	40.1%
Yes	4.0%	27.8%	15.3%	52.9%
Significance[1]	0.011	n.s.	n.s.	0.023
ADLs-IADLs				
No difficulties	10.1%	29.6%	19.4%	40.9%
At least one difficulty	4.5%	30.5%	13.7%	51.3%
Significance[1]	0.031	n.s.	0.04	n.s.
COVID symptoms				
None	9.7%	29.4%	18.5%	42.5%
One or more	7.1%	31.1%	18.1%	43.8%
Significance[1]	0.020	n.s.	n.s.	n.s.
Total (N)	**156**	**561**	**408**	**994**

Note: [1]to assess changes in volunteering for each socio-economic and health indicator/predictor.

Every logistic regression model for each predictor was adjusted for sex, age, marital status, and number of people in the household. Statistically significant p values are shown in bold text.

ADLs stands for basic activities of daily living (such as using the toilet and dressing) and IADLs stands for Instrumental ADLs (such as making telephone calls, managing money, and taking medications). Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

Source: ELSA COVID-19 Substudy (June/July 2020). Weighted data

Volunteers who were in paid employment were more likely to increase their voluntary work compared with those not in paid employment (16% and 5.4% respectively, p=0.012) and to maintain the same level of volunteering (37% and 26% respectively, p=0.032). In contrast, those participants not in paid employment were more likely to stop volunteering completely compared to those in paid employment (49% and 30% respectively, p=0.002). Those in the highest two wealth quintiles were more likely to report a decrease in their level of volunteering (22% each), than those in the poorer three wealth quintiles (16%, 14% and 17% respectively, p=0.022).

Volunteers who have been identified as vulnerable by the NHS or their GPs were less likely than those who were not vulnerable to have decreased their level of volunteering (12% and 19% respectively, p=0.011), but were more likely to have had stopped voluntary work completely (52% versus 41%, p=0.039). Participants who were self-isolating were less likely to have increased volunteering compared with of those who were not self-isolating (4% and 10% respectively, p=0.011) and were more likely to have stopped volunteering completely (53% versus 40%, p=0.023). Also, ELSA participants who reported functional limitations (p=0.031), and experienced COVID-19 symptoms (p=0.020) were less likely to have increased the level of volunteering. For instance, only 5% of volunteers with one or more ADL or IADL limitation increased voluntary work, compared with 10% who did not have functional limitations.

Similar trends emerge when we compared economic and health characteristics of ELSA participants who were aware of the NHS call, by whether they registered to volunteer for the NHS or not (data not shown). Those in paid employment, in the highest wealth quintile and in better health (not NHS vulnerable, not self-isolating and without experiencing limitations) were more likely to have responded to this call.

References

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The ELSA COVID-19 Substudy is funded by ESRC as part of UK Research and Innovation's rapid response to COVID-19. Funding has also been received from the National Institute on Aging in the US and a consortium of UK government departments: Department for Health and Social Care; Department for Transport; Department for Work and Pensions, coordinated by the National Institute for Health Research (NIHR). Co-funding from the ESRC-funded Centre for the Microeconomic Analysis of Public Policy (ES/M010147/1) is gratefully acknowledged.

The ELSA COVID-19 Substudy has obtained full ethical and data protection approval and is fully GDPR compliant. For further information, please contact ELSA@ucl.ac.uk

This report and other ELSA publications, including the ELSA COVID-19 Substudy methodological report, are available from www.elsa-project.ac.uk

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