
Poverty, Caring and Older Age

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Abstract

Due to the high incidence of disability amongst their contemporaries, older people are likely to be involved in informal caring relationships. Due to the limited nature of post-retirement incomes, such carers are also likely to be relatively poor. In spite of this, little attention has been given to the role of older carers of disabled people or to the influence of poverty upon this role. It is therefore the purpose of this paper to help to redress this neglect by examining the influence of material circumstances on the role of older carers aged over sixty. With this aim in mind a sample of 34 older co-resident carers were asked a series of questions relating to their access to resources and their caring role.

Introduction

The redefinition of community care from care *in* to care *by* the community combined with the demands of an ageing population has led to increased recognition and research into the needs of informal carers. The material costs incurred as a result of their role have been highlighted, both in terms of day-to-day expenses and lost employment opportunities (Glendinning, 1992). The influence of social divisions have also been well recognised, especially in the large body of feminist literature examining the extra costs incurred by women as

a result of their ascribed caring role (Finch and Groves, 1983). However, as Arber and Ginn (1992) point out, relatively little is known of other ways in which caring responsibilities are socially structured with much research tending to adopt a classless analysis serving to ignore the influence of pre-existing material inequities on the role of informal carers. The limited research which has taken place in this area has tended to focus on the impact of poverty on younger carers, especially the mothers of young children (Graham, 1992). However, due to the close association between disability, older age and poverty (Townsend, 1981) many older people are likely to be involved in caring for a disabled person, particularly within the spousal relationship, and the influence of material deprivation upon this role is likely to be especially significant, with households headed by an older person or a disabled person being more likely to be poor than other groups (Oppenheim and Harker, 1996).

The review of existing literature tends to indicate that poverty is likely to significantly exacerbate the demands upon informal carers. This is not only due to the increased incidence of disability found amongst deprived social groups (Office of Population Censuses and Surveys, 1990). It is also due to the role of poverty in promoting the dependence of disabled people while, at the same time, reducing the capacity of informal carers to cope with this dependence (Borsay, 1990). For example, the secondary analysis of General Household Survey statistics has found that older people and lower socio-economic groupings are much more likely to be involved in demanding co-resident care than their younger and more affluent counterparts amongst whom extra-resident care is more common (Arber and Ginn, 1992; Milne et al, 2001). In order to explain this differential Arber and Ginn (1992) use the term 'leverage' to refer to the way in which the possession of material resources can reduce the demands upon informal carers and promote choice in caring strategies utilised. It is the aim of this paper to 'look behind' these statistics by examining the influence of material circumstances on the role of older co-resident carers. In focussing specifically on older carers, this paper will help to redress the 'ageless' analysis of much existing informal care research and will challenge the traditional problem

orientated approach towards older people by recognising the positive social contribution which they make (Arber and Evandrou, 1993). The first section of the paper will discuss the research methods used in the study. This will be followed by a review of the research findings including the impact of material resources on the caring role, transitions and reciprocity within this role and the impact of formal support provision.

Research Methods

Access to participants in this research was negotiated via a number of voluntary and statutory welfare agencies in Sheffield. From these sources 34 older carers were identified as willing and able to take part in the research. Eighteen of the carers were women and sixteen were men with their ages ranging from 60 to 94, all were retired and lived in two person households with the cared-for person. The majority, 27, were caring for spouses, five were caring for adult children with disabilities and two were looking after their aged parents. These carers were interviewed in their own home with the use of a semi-structured questionnaire, incorporating a series of open and closed- ended questions relating to their material circumstances and their caring role. From these initial interviews, full transcripts, statistical data and analytical memos were produced and an ongoing analysis of qualitative material was carried out. This analysis involved the coding and categorising of interview texts with the assistance of winMAX computer-aided qualitative data analysis software and the subsequent comparison of relationships between categories and between carers. Themes emerging from this analysis were further pursued in follow-up interviews with carers. Throughout the fieldwork, ethical principles of confidentiality and informed consent were strictly adhered to as cited in the British Sociological Association's Statement of Ethical Practice (1996) and all respondents were allocated a pseudonym in order to preserve their anonymity.

Research Findings

Material Resources and the Caring Role

The average weekly income of respondents was £198 per week for a two-person household, well below the recommended minimum of £150 per person advocated by Age Concern at the time the fieldwork was carried out (Parker, 2000). In accordance with the suggestions of Arber and Ginn (1992), the low incomes of many carers in the sample increased the practical demands on carers and reduced the choice in caring strategies utilised. For example, Mr Cicourel, a 69-year-old carer described how he turned down the idea of a home sitting service for his wife as his relatively low income meant that he did not feel able to afford the hourly fee which he was being asked to pay. This contrasted with the position of better off carers who were more able to purchase outside help and who also tended to be more financially rather than practically orientated in the care which they provided. This is well illustrated by Mrs Field, a middle class spouse carer who was able to employ live in help from a private agency to assist in the care of her husband:

It's a firm based in Oxford and they send out people to take over the whole house but they are extremely expensive. Anyway, my daughter said that we shall have to regard it as a holiday, don't do anything, just let the staff get on with it.

Other carers spoke of the way in which their limited incomes promoted their material interdependence with the cared-for person in order to meet the household's financial commitments. As Mrs Flude said of her disabled husband:

If he had gone into care I would have lost my home. They would have taken his occupational pension, his attendance allowance and his old age pension, so that would have left me with nothing except my old age pension.

Like access to income, access to other material resources had an impact on the experience of caring with savings, good quality housing and car ownership all emerging in the qualitative component of the interviews as resources highly valued by carers. However, while higher incomes appeared to alleviate caring

costs, the possession of such material resources had a less clear cut effect with carers reporting on one hand enjoying the possession of such assets while, on the other, having difficulty in affording them. Thus many carers spoke of the burdens of attempting to maintain their houses or cars on their limited post retirement incomes, as Mrs Gibbons, another spouse carer stated:

We've got a car stuck in the garage. It's never been out since he had this stroke. It needs repairing but I can't afford to get the mechanic in, I don't know how much it's going to cost.

Others spoke of the way in which their possession of savings meant they were denied free access to some goods and services due to the practice of means testing. For example, Mrs Hudson was an elderly widow caring for her mobility impaired son, David. She described how for many years she had unsuccessfully tried to persuade social services to supply her son with a stair-lift which she felt unable to afford herself, leaving her with the onerous task of manoeuvring him up and downstairs herself:

Oh we tried for years to get them to put one in but no they wouldn't put it in. They said that we'd got to pay for it because it was our house. We said that it was for David's benefit alone and he didn't have any money in the bank but they didn't go by that, they said it was our house and it went on the money that we'd got, so we had to buy it ourselves...I wish I'd had it ten years ago.

Carers did not simply passively react to their material situation but actively adapted to it with a financially cautious approach being characteristic of all the carers interviewed. For example, a word search of interview transcripts revealed the very high incidence of the words 'cope' and 'manage' when carers were asked about their financial situation and such words were always used in a positive rather than a negative context. Thus in contrast to poorer carers under 60 amongst whom credit has been found to be widely used (Ford, 1991), all had adapted to their reduced post-retirement income through a process of economic downsizing, utilising a cautious or 'tight control' approach to money management (Chattoe and Gilbert, 1999) in which expenditure was routinised and debt problems were subsequently avoided. As Mr Cicourel maintained:

You just cut out the trimmings, there's a hell of a lot that you don't really need.

While this financial caution meant that carers successfully made ends meet it also potentially exacerbated their caring costs by rendering them unwilling to pay for goods and services, which would help them in their role. Moreover, the perceived sense of financial well being which arose from this financial caution, possibly exacerbated by ignorance or pride, prevented some from applying for benefits to which they were entitled, thus compounding their objective levels of poverty. For others, this financial caution and corresponding process of economic downsizing led to feelings of relative deprivation. For all it led to social isolation and a subsequent avoidance of the financial expenditure that going out would involve, as Mr Tumin, an 84-year-old spouse carer maintained:

We manage as far as money's concerned because we don't go anywhere or do anything so you can't spend anything can you.

However, this relationship between financial expedience and social withdrawal was a complex one and was mediated by the social divisions of age, disability and poverty. Thus while all of the carers in the sample were relatively isolated, this isolation was especially pronounced amongst the poorest carers and amongst the very old due to their own health and mobility problems as well as due to the death and declining health of friends and relatives. Indeed, contrary to mutually supportive portrayals of working class life traditionally espoused by sociologists (Young and Willmott, 1962), more recent research has suggested that poverty and social marginalisation can actually undermine the supportive capacities of informal networks (Oakley and Rajan, 1991)

Role Transitions and Reciprocity

The financial adaptations exercised by older carers illustrate that, contrary to the perception of older age as being a time of passivity and even stagnation, the lives of respondents were characterised by high levels of adaptation in order to

accommodate their reduced financial circumstances. Similar role transitions were evident in other areas of respondents' lives, with carers experiencing a blurring of the traditional gender role divisions, which had characterised their younger lives. Thus not only did women assume the often-unfamiliar task of financial control, male carers also assumed responsibility for housework. This role adaptation tended to be a gradual and insidious process accompanying the increasing disability of the cared-for person. It was therefore most pronounced amongst very old carers who were likely to be also suffering from disabilities and health problems of their own. As Mr Tunstall, a 90-year-old spouse carer described:

She used to do the shopping and things like that, cooking and looking after the house, I was just the provider, the gardener and the helper but she developed this arthritis of the spine which meant that shopping was getting very, very difficult, so I just took over.

As such, contrary to the claims of feminist research which maintains that women are more likely to be highly involved carers than men (Finch and Groves, 1983), this was not substantiated by this sample. Thus all but one carer, a woman, claimed to be caring on a full-time basis and all but two performed personal care tasks such as washing, dressing and feeding. Neither was there a significant gender difference in the duration of caring with men being involved in caring for an average of 15 years as compared to 14.5 for women.

This blurring of gender role divisions experienced by older carers, as well as the impact of material circumstances on their role serves to highlight the omissions of feminist analyses into caring, which in focusing upon issues of gender have tended to overlook the influence of poverty and older age upon the caring experience. As Barnes (1997) maintains, this feminist analysis and its predominantly able-bodied and middle-class perspective has also tended to portray caring as being generally oppressive and burdensome thereby ignoring the potential satisfactions to be gained by carers from this role. Many carers in this research expressed such rewards including the feeling of sustained purpose,

companionship and the fulfillment of a sense of duty. This theme has been further elaborated by Bytheway (1986) who maintained that older male spouse carers were motivated by a deep sense of reciprocal obligation and a subsequent concern to respond to the needs of care receiving wives as a means of 'paying them back'. As Mr Tumin said of his wife:

I just enjoy looking after her, I'm grateful, she had to look after me, she looked after me for six months when I had my hip done, now it's my turn.

Female carers, such as Mrs Harris, expressed a similar devotion towards their husbands:

I can't lead a life of my own, it's all taken up with looking after Pete. I don't mind you see. We've been married nearly fifty years and we still love each other in sickness and in health.

Consequently, caring among older people can be understood as an expression of the expectations and attitudes that underpin marriage, particularly the assumption that a couple will remain together until death (Manthorpe, 1994). This marital devotion amongst respondents was further highlighted by the fact that only four in the entire sample of 34 had ever been divorced or separated. This compares to social trends which now predict that out of every ten new marriages, four will end in divorce (Pahl, 1999)

Not only was the caring relationship characterised by reward and reciprocity, due to the disability of the carer, it was often characterised by a practical as well as material interdependence. Due to this interdependence, it was not always possible to maintain a clear distinction between the carer and cared-for person with many respondent households being mutually interdependent in their giving and receiving of care (Morris, 1993). For example, Mr Dale, a 94-year-old amputee described how he and his son, who had cerebral palsy, performed mutually complimentary household roles. Mr Dale took charge of household correspondence and financial management while his son

performed the physically demanding housework tasks, which his father was unable to do due to his mobility impairment. As Mr Dale said of his son:

He's very good with his memory. I have to rely on him sometimes...I couldn't cope without him.

This practical, emotional and material interdependence between caregiver and care receiver was further highlighted in follow-up interviews with respondents. For many, their position had changed since the initial interview, the cared-for person having died. All of the respondents in this situation claimed to experience, not a relief from burden, but a significant decline in their quality of life. This was partly due to their reduced household income, which had typically fallen by over fifty per cent. It was also due to feelings of boredom, isolation and a sense of loss, not only of the person but also of their caring role. As, Mr Caplow, an 87-year-old former spouse carer said:

I'm lonely, there's nothing that fills the space. I go out three or four times a week to the church hall to play snooker but when you come back the place is empty.

Access to Formal Sources of Support

In accordance with the many positive benefits which carers gained the caring relationship and the interdependence which characterised this relationship, all but one respondent refused to consider the possibility of permanent care for the care recipient. Many respondents also perceived long-stay hospital care and respite care negatively. These findings suggest the need for flexible and affordable sources of formal provision, aiming to support disabled people at home rather than remove them from it. Domiciliary support seemed to go some way towards meeting this need and, as the majority of respondents had been accessed via the home care service, most households were in receipt of this service. However, some felt ill equipped to afford the subsidised fee that they were being asked to pay for this support. Similar objections were raised to the payment of means-tested services, with older carers' relative poverty and cautious approach to money management forming a barrier to many such

sources of help. This role of means-tested provision and charging policy in hindering access to formal provision serves to highlight the inadequacy of the newly evolved system of welfare pluralism and 'targeting' in meeting the needs of disabled people and their carers. While the practice of charging for services can run counter to older people's financial caution and culturally derived 'habits of the heart' (Baldock and Ungerson, 1994). Moreover, few carers received or expressed the desire to receive the more innovative forms of non-statutory support which have emerged from these developments, with practical assistance rather than 'user led involvement' appearing to be their overwhelming priority. However, the availability of this practical assistance remains inadequate with provision aimed at disabled people, especially older disabled people, continuing to be under-resourced. As Miss Howard, a woman in her sixties caring for her aged mother described:

Nobody sort of helps you into this situation. If a woman's expecting a baby she gets all sorts of help in advance. She gets antenatal care, she also gets advice on how to look after a young baby. Nobody tells you how to look after an elderly person, nobody tells you how to lift them out of a chair, nobody tells you about the best way to go about bathing them, you know, you've got to do this for yourself.

Not only is relevant provision inadequately resourced but it is also implicitly based on a negative and conflictual perception of the caring relationship as illustrated in assessments which see the needs of the carer and the cared for person as distinct and mutually opposed (Olsen, 1996). As Barnes (1997) observes, this conflictual perception has been further compounded by the development of campaigning user groups such as those for disabled people and informal carers. For while such groupings facilitate the collective identity of their members, they also impose a one-dimensional analysis on complex and overlapping interests, failing to recognise the way in which these interests may coincide. A further important point to note with regard to attempts at measuring the formal support needs of older carers is that, as with respondents accounts of their financial management strategies, transcripts revealed the high incidence of the words 'cope' and 'manage' when speaking of their caring role:

Were coping aren't we, we could be better off but it could be a lot worse (Mr MacLellan).

This could be seen as evidence of the same resourcefulness and adaptation, which had characterised respondent's financial management strategies. This picture of resourcefulness in the face of difficulties amongst older people is supported by a number of other studies. For example, Langan et al (1996) identified themes of 'making the best of things' and 'making an effort' to be prominent amongst the older people they interviewed. Similarly, there is long history of work in social gerontology that shows how, in later life and particularly with the onset of disabilities, older people engage in 'identity work' in order to readjust their 'sense of self' to new circumstances and to maintain their sense of self-worth (Tanner, 2001). As Barnes (1997) observes, the renegotiation of self-identity taking place as a result of the onset of disability is likely to be compounded for those in a co-resident caring role, especially within a spousal relationship. For this renegotiation will not only involve the older persons own sense of self but also their sense of self in relation to those closest to them.

In the light of these observations, it should be recognised that, in an interview, participant responses are only partial revelations (Kaufman, 1994) and that all that may be available to the interviewer are 'the contours of the masquerade'. This 'masquerade' is likely to be particularly apparent amongst older people for whom the maintenance of independence, autonomy and the appearance of being able to 'cope' or 'manage' is crucial in maintaining their positive identity and sense of self (Tanner, 2001). This in turn has implications for the assessment process used by service providers and the subsequent production process of personal care in which us carers and service providers all play a part (Twigg, 2000). Such assessments tend to be focussed on the levels of dependence of the person being assessed and their ability to perform 'activities of daily living' (Barnes, 1997). However, as the above discussion suggests, older people may be unwilling to admit to such dependence, especially

within a preset interview format (Baldock et al, 2001). These observations on the tendency of older people to put on a 'brave face' are applicable both to all types of assessment and the accuracy of information gained from these. However, this research would suggest that relatively unstructured rather than structured methods of assessment are more likely to get through older people's 'masquerade' and transcend the qualitative divide between user and provider.

Conclusion

Contrary to Arber and Ginn's (1992) speculation that a co-resident caring role is often unwillingly assumed as a result of financial expedience, for this sample of older carers, it was a role which was largely willingly adopted and from which many positive benefits were gained. As such, material factors were mediated by the influence of such things as generationally based culture as well as by the increased incidence of ill health and disability in older age, serving to facilitate a practical and emotional interdependence within the caring relationship. However, material factors did influence the way in which care was performed. Thus, the decreasing access to material resources which tends to accompany the ageing process could be seen to reduce the choice in caring strategies utilised by respondents while exacerbating the practical demands upon them, serving to potentially diminish the quality of the experience both to carer and care recipient alike (Abrams, 1978). Statutory support has tended to reinforce rather than relieve these problems, with the ageist nature of the benefits system failing to fully compensate for this material deprivation (Walker, 1996). Moreover, policies of means testing and charging for formal support provision can lead to a further reduction in the choices available to older people and run counter to their cultural preferences (Baldock and Ungerson, 1994). At the same time, the focus of such provision on the diverse and potentially conflicting needs of informal carers, on one hand and disabled people on the other, overlooks the way in which their interests and identities coincide and their common need for adequate, affordable and accessible help (Williams, 1992). As Barnes (1997) observes, the wider context of structural inequality, which forms a barrier to the effective

implementation of an inclusive community care policy for disabled people and their carers, is also ignored.

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