Mitigating **I**ncreases in the **S**tate **P**ension **A**ge – **MISPA* group**

Possible public health implications of raising the State Pension Age and how to mitigate them

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*__MISPA__ is an informal grouping of specialists in public health who are concerned about the possible unintended consequences for health & health services of raising the state pension age and wish to contribute to discussions of how to mitigate these.

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Section A: OVERVIEW

The UK Parliament has increased the State Pension Age by eight years for women and three years for men, to both reach 66 years by 2020, 67 years by 2027 and 68 years by 2038, during which period there will be many changes in the nature of work.

We estimate[1] that raising the state pension age to 66 years will add annually some 760,000 older women and men to the workforce, of whom 10 per cent (76,000) will report at least one limiting longstanding illness.

The MISPA group wishes to draw attention to the possible unintended consequences of these changes and seeks to mitigate particularly those which may affect public health.

Possible public health implications include:

1. Worsening the health of those already ill.
2. Overwhelming sparse occupational health services and adding new demands on primary medical care services.
3. Worsening the crisis in social care through loss of informal carers.
4. Damaging the NHS and charity sector through loss of volunteers.
5. Increasing the mortality rate of those employed in the most demanding occupations, particularly those requiring long hours of work.

Mitigation

1. The health risks of extended working need to be medically supervised and the benefits of retirement for those in poor health recognised.
2. Evidence-based triage criteria need to be identified in order for the occupational health services and primary medical care services to meet this challenge.
3. Older employees who also act as informal carers require flexible hours of work to accommodate fluctuation in the chronic diseases of those for whom they care.
4. Certified volunteering should be recognised by the Department for Work & Pensions as a legitimate alternative to continuing in paid employment.
5. Older employees appear conscious of such health risks because they want flexible working hours, to accommodate the relapse & remission of their own symptoms, and to avoid compulsory shift working and overtime, with the option of re-training for tasks free of such hazards[2]. The alternative – loss of employment – should not involve *fitness for work* testing and possible benefit sanctions.

1 The numbers are estimates – please do not be deceived by their apparent precision: we do not defend any specific number, but we do believe that their orders of magnitude (number of noughts) are sound. Official statistics used to generate these estimates include the Decennial Census 2011, Labour Force Survey 2018, Office for National Statistics Opinions & Lifestyle Survey 2013, Office for National Statistics Longitudinal Study 2001, Study of Health, Ageing and Retirement in Europe 2010.

2 Fleischmann M, Koster F, Schippers J. How and under what conditions employers provide employability-enhancing practices to their older workers. *The International Journal of Human Resource Management* 2015;26:2908-25.

Section B:
IN THEIR OWN WORDS

Women aged 60-65 years were the first to be affected by the increase in the UK state pension age, so they have more personal experience than anyone else of the changes involved. Here are some of the things they told the WASPI website, which with their permission we have edited and reproduced.

"I was 64 in May 2019, in April I realised I could no longer continue with my job as it was. I had an episode of depression and anxiety in 2013 due to the deaths of several family and friends, my relationship ended and I was totally overworked in an unsupportive work environment. Something had to give, so I took a few weeks off work. I had never had any mental health issues and this came as a complete shock to me as I was always the strong one. I also have high blood pressure, thyroiditis, arthritis, a shoulder injury resulting in a tear in the tendon and bursitis. The thyroiditis particularly impacted on several areas of my life.

I went back to work and, initially, things were OK but slowly I was again being pushed further and further into the 'flogging a dead horse' scenario." *(Julie Connell)*

"I am 61 and still having to work full time due to the pension changes. I have worked all of my life and now struggle some days with arthritis and other health issues. I feel I shouldn't be forced to work to 66 and when I do finally retire my grandchildren will be grown up, I have missed their young lives.

I have no private pension either. Hope I can do something to help other women in my situation." *(Julie Rhodes)*

"For the past 46 years I have worked continuously, either part-time or full-time, only taking 9 months off to have a child. By 2010, I had paid full stamp and therefore I was shocked not to get my full pension at 60.

I currently work 10-16 hours a week and cannot work full time due to suffering from anxiety and stress which affects my health. I have recently been in A&E for a racing heart. At work I am required to use a computer, do heavy lifting and deal with the public, all of which I find stressful.

The nature of work has changed enormously over the past 15 years. There are less employees doing much more work, with less breaks. Most people I work with, mainly women, have had work stress related physical and mental health problems." *(Anonymous)*

"I worked in the NHS for 42 years doing both general nursing and midwifery. I felt I had to retire from work, as deputy manager of an outpatient department, in 2012 due to rheumatoid arthritis. I went back to work as a staff nurse in 2013 for 3 years doing 2 half days a week. This was to supplement my NHS pension. But in 2016 I felt I could no longer continue as the pain was too much after being on my feet during these short shifts." *(Zoe Foster)*

"I had to leave work at 61 due to ill health but wasn't due to receive my state pension till I was 64 and 9 months. I had a very small works pension which I took when I finished work. My works pension was £84 per calendar month. This was difficult to live on. My husband and I had to use all our savings and borrow to meet daily needs. The result of the stress led me to having a heart attack in 2017 plus the ongoing health problems I already had." *(Marilyn Jennings)*

"At the age of 51 found myself on my own, after losing my family home due to my husband's bankruptcy and then his death due to serious illness. Sadly, we had separated before his death aged 66 (10 years older than me).

I personally managed to fight the bank and come out with a sum to enable me to buy a flat. I had to relocate to Gosport, 80 miles from my family in Surrey, in order to get a job in a call centre and find cheap housing. Until that point, I had been a stay at home mum, working part time, helping out in school and being a carer for my mother who died aged 62, after retiring at age 60.

From May 2005 onwards I have worked at the call centre. It is a stressful job and at the age of 60, it became too much and I had a breakdown. I also suffer with rheumatoid arthritis, high blood pressure and an underactive thyroid, I was in very poor health." *(Janet Kane)*

"Between 1972 and 1994 I worked in horticulture. I often lifted weights that they don't even let men lift today, working in hot, cold and wet conditions. This has taken its toll on my muscles, joints and skin. I had 3 children during this time. I then worked in house restoration and running buy to lets. I had another child in 1999. I have also worked as a cleaner, clerk and manager of holiday lets.

Since 2017 I have been the main carer of my parents, now 95 and 98 who are housebound and a cleaner of holiday lets 2 days a week.

My health problems are from all my manual occupations. My joints are painful, particularly my knees, feet, ankles and knuckles, they swell after heavy days. I have to visit a chiropractor two or three times a year to realign the worn joints around my shoulders, neck and upper back from lifting the heavy weights. This is made worse by the lifting in my current cleaning job. I get so tired. I never thought I could feel this way.

I'm beginning to think that by the time I get to retirement I won't be in a fit state to actually have a life after work. I am 63 now, so will not get the state pension until May 2022." *(CB)*

Section C:
PUBLIC HEALTH IMPLICATIONS

The sections below provide a little more detail on MISPA's concerns about the possible public health implications of raising the state pension age.

C1. Worsening the health of those already ill

A significant minority of people already work beyond the State Pension Age; these tend to be healthier and wealthier than their peers and to enjoy their work[3]. Legislation to increase the state pension age adds an element of compulsion to what previously had been a personal choice, pushing women who may be in poor health or find their work burdensome to continue for a further eight years (men, three years) in paid employment.

The first good evidence of what will happen in UK suggests that household income will fall and personal pleasures will be lost but that, importantly, health – at least as measured by clinical depression, cognitive function and self-assessed health – will not suffer[4]. Whether or not this lack of impact on health will survive prolonged exposure to an extended working life remains to be seen, as does whether objective physical health is equally unaffected and whether those already in poor health are at increased risk of deterioration.

The GAZEL Study found that the heath of those who assessed their health as *poor* improved after retirement[5], suggesting that any extension of working life may risk depriving those in poor health of remission of their symptoms. Two recent contributions suggest that such concerns may apply to the UK. The United Nations identified change in the UK state pension age & its administration as affecting the financial circumstances of older women[6]. And The Academy of Medical Royal Colleges acknowledged that poor quality work – unengaging and unrewarding jobs which deny people a voice and treat them unfairly – can lead to increased levels of ill health[7].

What is certain is that there are reasonable grounds for caution and that the health risks of extended working need to be medically supervised; and that the benefit of retirement for those in poor health needs to be recognised.

3 Di Gessa G, Corna L, Price D, Glaser K. The decision to work after the state pension age and how it affects quality of life: evidence from a 6-year English panel study. *Age and Ageing* 2018;47:450-457.
4 Amin-Smith N, Crawford R. State pension age increases and the circumstances of older women. In: Banks J, Batty D, Nazroo J, Steptoe A, eds. *The Dynamics of Ageing: evidence from the English Longitudinal Study of Ageing, 2002-2016 (Wave 8).* London, The Institute of Fiscal Studies 2018:9-39.
5 Westerlund H, Kivimaki M, Singh-Manoux A, Melchior M, Ferrie J, Pentti J, Leineweber C, Goldberg M, Zins M, Vahtera J. Self-rated health before and after retirement in France (GAZEL): a cohort study. *The Lancet* 2009;374:1889-1896.
6 *Report of the Special Rapporteur on extreme poverty and human rights on his visit to the United KIngdon of Great Britain and Northern Ireland.* United Nations General Assembly Human Rights Council, Fourty-first session 2019:17 (Paragraph 79).
7 Thakrar S. Promoting work as a health outcome – Summary of the Conference *Good Work is Good for You.* Academy of the Royal Medical Colleges, May 2019:3.

C2: Overwhelming sparse occupational health services and adding new demands on primary care

Who will medically supervise those working up to eight years longer and identify whether those suffering from a pre-existing limiting longstanding illness are at greater risk?

Occupational health services remain outside the National Health Service; and only a minority of the UK workforce has access to them, mainly those employed by large companies with their own in-house facilities and staff. The majority of the UK workforce does not have access to an occupational health nurse or physician because they are employees of small or medium sized companies (SMEs) which lack such facilities. The proportion of SMEs providing occupational health support could be as low as six per cent, with those employees on low incomes in areas of widespread job insecurity at highest risk[8].

Recently the President of the Faculty of Occupational Medicine quantified the medical resources available in UK to meet such a challenge. There are 571 accredited specialist Occupational Physicians (less than one per cent of General Medical Council-registered doctors) and some 2,000 suitably qualified Occupational Health Nurses (less that one per cent of Nursing & Midwifery Council-registered nurses and midwives)[9]. This challenge is exacerbated by the geographical mismatch between the location of the occupational nurses and physicians, concentrated in large companies in southern England, and the large number of low paid employees with insecure jobs in small and medium-sized companies in northern England.

Both civil servants and the medical and nursing professions are noticeably vague about who is going to fill this gap between the large number of older workers and the limited occupational health resources although, when pressed, all imply that the general medical practitioners and practice nurses of primary care will do so. For this to be anything more than a pious hope will require, at the very least, research to identify evidence-based triage criteria, so that the available resources can be directed to the older employees who are most at risk of exacerbation of pre-existing disease or acceleration of pre-clinical pathology.

8 Lisle J. Occupational health & wellbeing. *Personnel Today* 1st May 2009:3.
9 De Bono A. Quoted in: Thakrar S. Promoting work as a health outcome – Summary of the Conference *Good Work is Good for You*. Academy of the Royal Medical Colleges, May 2019:5.

C3: Worsening the crisis in social care through loss of informal carers

Formal social care services are under-staffed in relation to the number of dependent older people and are likely to rely increasingly on informal carers, who may also be supplying the child care that allows their younger relatives to take paid employment. Older people who combine such informal caring with their own fulltime or part-time employment may be forced to choose between these socially productive activities. A large proportion of those facing this dilemma are the women who now are expected to remain in paid employment for an additional eight years.

The Office for National Statistics (ONS) estimates that one in five people over the age of 50 provides unpaid care and that one in four older female workers and one in eight older male workers are carers[10]. The proportions in mainland Europe may be somewhat higher: 37% of women and 30% of men in paid employment at ages 60-65 report having supplied personal care to someone outside their own household during the past year (Morten Wahrendorf – personal correspondence 9/5/2019).

Despite legislation intended to make it easier for carers to stay in work, such as the Work and Families Act 2006 and the Care Act 2014[11], caring responsibilities are a major barrier to keeping older people in employment, with nearly 50 per cent of people reaching their state pension age year having already stopped working, largely due to caring for others[12].

Furthermore, the physical and mental health of older workers who continue to combine caring and work needs attention, given that in addition to caring for younger and older generations they are likely to be managing a long term health condition of their own[13,14]. Research has found that people who combine paid work with informal caregiving are more likely to experience stress[15,16].

Promising strategies to keep older people, who combine caring responsibilities with employment, healthy and happy are being developed. For example, an experimental study demonstrates how a self-help intervention reduces the levels of stress of older workers who care for others[17]. And Carers UK are supporting companies to retain their ageing and skilled workforce by encouraging them to sign up to *Employers for Carers*[18], an initiative which provides guidance and advice on how to develop flexible workplace policies that can meet older worker's needs, such as giving them the opportunity to take periods of leave and return to the same job.

Older employees appear conscious of such health risks because they want flexible working hours, to accommodate the relapse & remission of their own symptoms, and to avoid compulsory shift working & overtime, with the option of re-training for tasks free of such hazards (Fleischmann et al 2015 – see Section A, Footnote 2). The alternative – loss of employment – should not involve *fitness for work* testing and possible benefit sanctions.

10 https://www.ons.gov.uk/releases/livinglongercaringinlaterworkinglife.
11 https://ilcuk.org.uk/the-emotional-well-being-of-older-carers.
12 https://www.ageing-better.org.uk/news/response-ons-statistics-carers-and-working
13 https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/atwhatageispersonalwellbeingthehighest.
14 https://www.ageing-better.org.uk/news/small-changes-can-make-every-workplace-more-understanding.
15 http://wels.open.ac.uk/research-project/caren/node/2128.
16 https://academic.oup.com/eurpub/article/28/3/485/4953815.
17 Ibid.
18 https://www.employersforcarers.org.

C4: Damaging the NHS and charity sector through loss of volunteers

The National Health Service depends on volunteers to support hospital employees (in a ratio of up to one volunteer to six paid workers) and to staff the many disease-specific patient support groups. Many charities are equally dependent on volunteers to provide services relevant to public health (Citizens' Advice Bureaux giving access to health-related benefits; AgeUK delivering meals-on-wheels & luncheon clubs; RSPB providing access to nature). Like informal carers, such volunteers may be forced to choose which socially productive activity to abandon: paid employment or volunteering.

Seventeen per cent of women aged 60-65 years in Europe who are in paid employment or self-employed report having done voluntary work during the past year; the equivalent figure for men is 18 per cent (Morten Wahrendorf – personal communication 9/5/2019).

Levels of volunteering are difficult to count because some voluntary activities may not be seen as volunteering by those performing them but as pursuit of a vocation or duty; for example a retired academic who pursues her research without pay or a member of the Baptist Church who cares for a dependent elder as the normal response to the vulnerability of a co-congregationist.

Volunteering appears to be a lifetime activity which increases or decreases in intensity depending on the other demands of any given stage of life. Retirement from paid employment is one such change of demands. It does not trigger volunteering but increases the time available for volunteering in those who have previously acquired the habit[19,20], from which it follows as a reasonable corollary that extending the working life of women by eight years and men by three years may reduce the volunteering of those who have the habit.

19 Caro F, Bass S. Receptivity to volunteering in the immediate post-retirement period. *Journal of Applied Gerontology* 1997;16:
20 https://www.ageing-better.org.uk/news/volunteering-better-later-life

C5: Increasing the mortality rate of those employed in the most demanding occupations

Contemporary increases in the state pension age are being enacted at the same time as other changes which may modify its effects. Many occupational pension schemes are moving from Defined Benefit to Defined Contribution but, as this change affects mostly new entrants, it may not be relevant to most pensioners up to 2038 when for both women and men the state pension age moves to age 68 years. It is also the case that currently annuity rates are unusually low and that savers recently have been given open access to their pension pots. Finally, the rate of increase in life expectancy appears to be slowing markedly and even reversing in some sub-populations such as women of great age.

On present trends UK life expectancy might flat-line, in which case the increase in the state pension age to 68 years might be the last for several decades, because it is UK government policy that the state pension age should rise in line with increases in life expectancy which it claims increases in line with healthy life expectancy. If an increase beyond 68 years is ever considered, it is worth remembering that the government used the wrong measure of health when calculating healthy life expectancy (HLE): self-assessed health rather than *free of disability*, which is more relevant to the physical & mental functioning required of an employee. If HLE had been measured as disability-free life expectancy, a growing divergence over time between life expectancy and healthy life expectancy would have been seen, which is more than a technical point because it makes unreasonable the policy that the state pension age should rise in line with life expectancy. Instead, disability-free life expectancy should be used.

A further challenge to the policy of raising the State Pension Age comes from research conducted at the University of Torino which suggests the policy itself could be contributing to the flat-lining of life expectancy. In the Work History Italian Panel-Health Study, each additional year of paid employment at older ages increased by two per cent the risk of hospitalisation for heart attack or stroke, with this relationship confined to those employed in the most disadvantaged occupations[21,22]. The Ministry of Health in Rome has now funded the University of Torino to conduct further research into this issue.

21 Ardito C, Leombruni R, Blane D, d'Errico A. To work or not to work? The effect of higher pension age on cardiovascular health. *LABORatorio Revelli Working Paper* Series 150. LABORatorio Revelli Centre for Employment Studies 2016.
22 Ardito C. *Three Essays in Labour Economics*. Doctoral Thesis, University of Torino 2017.

Section D: RECOMMENDATIONS

We have identified two fairly straightforward strands of mitigation: commissioning research and *fine-tuning* administrative regulations.

Research may be required to establish (a) evidence-based triage criteria to guide occupational health services – and where these are sparse or non-existent, general medical practitioner services – in deciding which older employees are most at risk; and (b) whether extending working lives will increase the mortality rate of older employees in the most disadvantaged occupations.

Administrative regulations may need to be made more flexible in the age range 65-68 years to accommodate patterns of relapse & remission in chronic diseases and to accept that paid employment is not the only type of socially productive activity at these ages.

From a public health perspective: pending identification of evidence-based triage criteria, interim guidance can be based on the probability that any health-damaging effects of raising the state pension age will be most prevalent among those who spent their working lives in the most disadvantaged occupations. These are the employees about whom the occupational health services should be most vigilant and, where such services are scarce or absent, the patients about whom primary care should be most concerned.

Section E: APPENDICES

E1: Estimated numbers* affected each year, in various ways, as each new cohort works into its 66th year; by Decennial Census labour market categories & their proportions in 2011[23].

*Please remember these numbers are estimates (see Section A, footnote 1 on page 3) – the apparently precise numbers are merely those which come out of the calculator when high quality data are analysed using our hopefully robust but we acknowledge *rough & ready* assumptions.

Those potentially affected include:

169,607 older people each year whose health will be at increased risk of damage. Of the 391,400 people who will continue in paid employment, 39,140 will have at least one pre-existing limiting longstanding illness (at risk of exacerbation or deterioration) and a further 130,467 people may be at increased risk of premature death.

140,600 older people each year who will be at risk of fitness for work testing & sanctioning, comprising 19,000 unemployed people who are seeking paid employment and the 121,600 who are permanently sick.

The potential loss each year of 114,000 informal carers from the social care services, of whom 28,500 will be at the highest risk of leaving the labour market or abandoning informal care or damaging their own health. The Cridland Review (UK Parliament March 2017:63-65) reports the prevalence of informal caring as highest among those aged 55-64 years, when some 15 per cent of women have taken on such responsibilities, of whom 20-30 per cent are doing so for 35 or more hours per week. The Review cites the Office for National Statistics that informal carers commit a minimum of 8.1 billion hours per year, with a predicted shortfall of 160,000 informal carers in England by the early 2030s – an estimate which does not include any effect of increasing the state pension age.

Similarly, the potential loss each year of 129,200 volunteers from the NHS and charities.

Increased demand for occupational health services & primary care services from the 169,607 people each year at increased risk of either exacerbation-deterioration of a pre-existing limiting longstanding illness or raised mortality risk.

Department for Work & Pensions (DWP), responsible for the 140,600 people each year who are either unemployed or permanently sick and thereby at risk of *fitness for work* testing & sanctioning. Detailed work required of DWP includes: (1) being more precise about the characteristics of *good* and *bad* work; (2) estimating the proportion of all UK jobs which are *good*; (3) explaining how their *fitness for work* testing evolves to match rapidly changing patterns of work & employment such as increasing workloads, longer commutes, multiple jobs, increasing automation, insecure employment; (4) explaining why, in their view, paid employment is the only form of socially productive activity appropriate for those aged 65-68 years.

23 Akinwale B, Lynch K, Wiggins R, Harding S, Bartley M, Blane D. Work, permanent sickness and mortality risk: a prospective cohort study of England and Wales, 1971-2006. *Journal of Epidemiology and Community Health* 2011;65:786-792 (doi: 10.1136/jech.2009.099325).

E2: What will be the income source of those aged between 60 years and 65/66/67/68 years; and what are its implications?

At present:

- Around 15 per cent of older people are dependent solely on the state old age pension, in which case they are eligible to apply for the additional Pension Credit Guarantee that the *triple lock* has brought up to somewhere near a conservative estimate of an older person or couple's minimum income for healthy living[24] although, unfortunately, this means-tested pension supplement has a relatively low take-up rate.
- A further roughly 15 per cent of older people have a small occupational or private pension which does little more than bring their income to ineligibility for the Pension Credit Guarantee.
- Most older people have a Defined Contribution occupational or private pension, the size of which depends on the size of their *pension pot* which in turn depends on the amount they could save regularly from their wages or salary throughout most of their working life (the median size of Defined Contribution pension pots is around £26,000 which, when annuitised, produces each year a sum similar to the state pension).
- Those employed in occupations in the most advantaged social classes tend to have a Defined Benefit pension, which usually is final salary-linked, so that salary differences when in employment are replicated post-retirement[25].

From this distribution we can speculate plausibly that:

1. Those who were employed in a well-paid job with membership of a final salary defined benefit pension scheme will not be affected by the increase in the state pension age because they can take their occupational pension when they leave the labour market early due to poor health or to volunteer or to do something else of their choosing.
2. Those employed in occupations in disadvantaged social classes without an occupational pension scheme and wages or a salary that was too low to make significant contributions to a private pension scheme will be the most vulnerable victims of conscription into continuing in paid employment until age 68 years, with the threat of *fitness for work* testing and sanctioning if they fail to do so for reasons of unemployment, informal caring or chronic ill health & disability.
3. The rest of those extending their working lives will be graded between these extremes in line with the wages or salary in their main adult occupation.

24 Watts P, Blane D, Netuveli G. The minimum income for healthy living and frailty at older ages. *BMJ Open* Feb 2019, 9, (2) e025334 (DOI: 10.1136/bmjopen-2018-025334).
25 Glickman M, Bartley M, Blane D. Social class differences in membership and type of occupational pension scheme. ESRC *International Centre for Life Course Studies in Society and Health* Working Paper 2018.