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Geographies of the impact of retirement on health in the United Kingdom

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ABSTRACT

This paper explores how the impact of retirement on self-assessed illness varies spatially across the UK. Curves of age-specific limiting long term illness rates reveal a 'retirement kink'—where the rise in illness rates with age slows or declines at retirement age indicating possible health improvement after retirement. The kink is negligible in the affluent South East and most prominent in the coalfield and former industrial districts. It is likely that the kink is attributable to hidden unemployment and health-related selective migration but additionally that in certain areas retirement is associated with improvements in self-assessed health.

1. Introduction

The challenges posed by population ageing and the persistence (and expansion) of health inequalities between social groups and areas are important international issues (Pearce et al., 2007; Kunst, 2005; Dorling and Thomas, 2004; Shaw et al., 2002). Population ageing is a result of low fertility and increasing longevity that leads to a growing proportion of the population at the older ages. Population ageing is a concern because it is feared that rising costs associated with healthcare provision and pensions will result, creating a greater burden on the diminished working age population through increased taxation (Thane, 1989; Bos and Weizsacker, 1989). The extent of the challenge associated with population ageing is debated and more positive outlooks have been proposed (Mullan, 2000; Sanderson and Scherbov, 2010; Herrmann, 2011; Emery, 2011).

In the UK, strong health inequalities exist between socio-economic groups and sub-national areas for a number of health indicators including mortality (and many specific causes of mortality), self-reported morbidity and disability, clinical measures (such as blood pressure and body mass index) and administrative measures (such as sickness absences and doctor consultations) (Marmot and Feeney et al., 1995; Graham, 2000; Shaw et al., 2002; Bajekal and Prescott, 2003; Bellaby, 2006). Research suggests that absolute health inequalities are greatest at the older ages (Huisman et al., 2004) and the accumulation of disadvantage (or advantage) over the lifecourse provides an explanation for this (Berney, et al., 2000).

The impact of retirement is a central question within research on both population ageing and health inequalities. A common policy response to the issue of population ageing in Western countries is to postpone retirement to older ages (Hamblin, 2010; Pond et al., 2010). For example, in the UK, under the Pensions Act 2011, the state pension age for women will increase from 60 to 65 by 2018. From 2018 the state pension age for both men and women will increase, reaching 68 by 2046. A concern surrounding such policies is that they might have negative consequences for the extent of health inequalities between social groups and areas (Bellaby, 2006; Harper et al., 2011). Harper et al. (2011) propose alternative retirement cut-offs based on lifetime earnings or time spent in the labour market that provide a means to respond to the challenge of population ageing without exacerbating health inequalities.

Proposals to increase the retirement age rest on the assumption that sufficient jobs are available or creatable for a larger working age population to fill. However, levels of economic participation have declined across most Organisation for Economic Cooperation and Development (OECD) countries over the past two decades (Delson, 1996) partly as a result of a collapse in the demand for unskilled labour (Burstrom, 2000). A common feature of the rise in economic inactivity in OECD countries has been an increase in the proportion of the population classed as inactive due to disability and poor health (Delson, 1996). Marin and Prinz (2003) compare rates of disability benefit claims in

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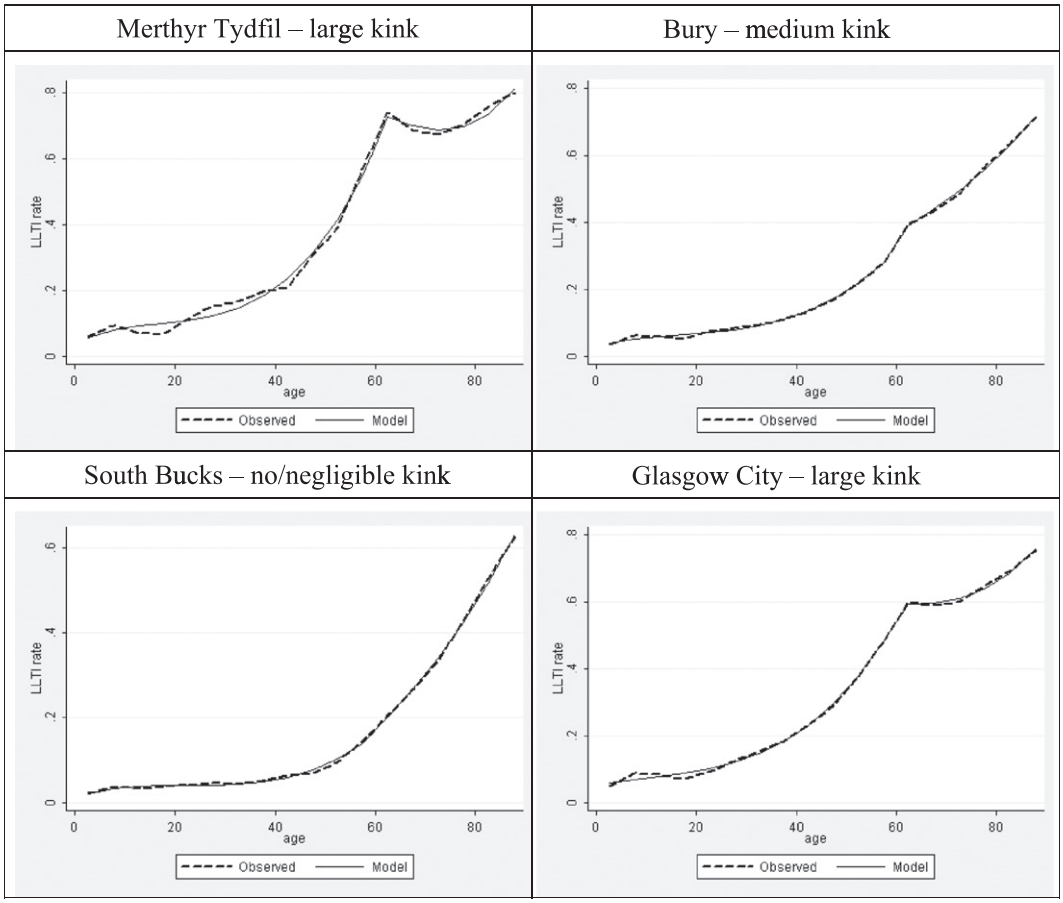

Fig. 1. Observed and modelled LLTI schedules (males) in a selection of districts.
Source: Authors' own calculations based on data from the 2001 census.

1999 amongst those aged 16 to 64 in a number of OECD countries finding similarly high levels in the UK, Norway, The Netherlands, Denmark, Sweden and Portugal (7–9% of population aged 16 to 64) with lower levels of disability benefit claimants in France, Germany, Spain and the USA (4–5% of population aged 16 to 64).

Banks and Smith (2006) provide an excellent analysis of retirement in the UK with the following key observations. First, there are several ways in which retirement might be defined including: as a complete and permanent withdrawal from the labour market; through receipt of income from a state or private pension; or through self-definition. According to any of these definitions, the majority of people in the UK retire before the statutory retirement age. Second, retirement tends to be abrupt rather than gradual and is almost always permanent. Third, there are two distinct groups of retirees for which the observations above apply. The first group comprises well-qualified retirees who draw a private income whilst the second group are less well-qualified people who are usually supported by disability benefits, may be relatively young (in their 50s) and who may not classify themselves as being retired.

Findings on the impact of retirement on health are mixed and it is thought that the nature of analysis (cross-sectional or longitudinal), the timing and the reason for retirement, the circumstances of an individual before retirement and the health measure under investigation are responsible for the lack of consistency (Behnkce 2012; Gall et al., 1997). Research on objective measures of physical health and mortality do not appear to show evidence of improvement associated with retirement (Behnkce 2012; Litwin, 2007; Johnston and Wang-Sheng, 2009). However, a number of studies demonstrate improvements in both mental health and self-assessed measures of health after retirement (Mein et al., 2003; Westerlund et al., 2009; Gall et al., 1997; Bellaby, 2006; Mojon-Azzi et al., 2007). An important result for the analysis undertaken here is that that the retirement-related improvements in self-reported health are greatest for those in lower occupational grades or poor work environments (e.g., high demands and low job satisfaction) and for those who are in poor health prior to retirement (Westerlund et al., 2009). Hyde et al. (2004) investigate the impact of pre-retirement factors and retirement routes on circumstances after retirement finding that pre-retirement circumstances are more important to post-retirement health and life satisfaction than retirement route. They conclude that the main causes of health inequality in retirement are work-based rather than the nature of retirement.

In this paper we extend the existing research on the impact of retirement on health to explore spatial variations in self-assessed limiting long term illness (LLTI). We investigate the extent to which districts within the UK exhibit a 'retirement kink' whereby the increase in limiting long term illness rates with age slows (or even declines) after retirement age for some areas but not others. Using 2001 Census data, Fig. 1 illustrates male LLTI rates for example districts which have this kink to different degrees. The kink coincides with the ages at which most male retirement occurs (60–64) (Banks and Smith, 2006). We also observe a kink in the LLTI curve for females that occurs at a younger age (55–59) perhaps reflecting the younger statutory retirement age for women in 2001 (see Fig. 2). For presentational purposes we focus on the male retirement kink in this paper but note that results for women, while less strong, are very similar to those for men. Where there are differences we point them out.

The retirement kink may be attributable to an improvement in self-assessed health for the populations living in certain areas.