Written evidence submitted by the International Longevity Centre-UK (ILC)

About the International Longevity Centre-UK (ILC)

1. The International Longevity Centre-UK (ILC) is the UK's specialist think tank on the impact of longevity on society, and what happens next. ILC was established in 1997 as one of the members of the International Longevity Centre Global Alliance, an international network on longevity. We are submitting to this call for evidence because we want a society that works for everyone, regardless of their age, but also regardless of their gender, their ethnicity, their sexual identity, their abilities or their beliefs.

Not everyone is benefitting from increasing longevity

2. One of the UK's great achievements is that people are living longer than they did just a few decades ago. But not all people have benefited equally from this increased longevity. Inequalities can be seen in different parts of the UK, manifesting themselves in shorter working lives, higher healthcare costs, higher welfare payments and income poverty:

    - **Disability-free life expectancy (DFLE):** Inequalities between socioeconomic groups at age 65 in terms of DFLE tripled between 1991 and 2011.[1] This growing gap is mainly explained by the most advantaged people seeing reduced onset and improved recovery from disability.
    - **Life expectancy (LE)**: People in the top 1% of the population, who live in the least deprived districts, live on average 12 years longer than those in the bottom 1%, who live in the most deprived districts.[2]
    - **Healthy life expectancy (HLE)**: People in areas with the lowest life expectancy live on average 10% more of their lives in poor health than those areas with higher life expectancy.[3]
    - **Working life expectancy (WLE):** Working lives are 6 years fewer in the 5% of districts with poorest health compared with the 5% in best health. Additionally, the average gap between ending work and health-span is only 2.5 years, compared with 8.5 years in the top 5% - indicating fewer healthy retirement years.[4]

3. These inequalities have been further exposed and exacerbated during the COVID-19 pandemic. According to ONS data, among people aged 50 or over, those living in more deprived areas; those who have never worked or are long-term unemployed; those with no qualifications; and those who do not own their own home are all less likely to have had their first dose of the COVID-19 vaccine and more likely to be vaccine hesitant than their more socio-economically advantaged counterparts.[5,6]

4. The Centre for the Study of Financial Innovation (CFSI), in partnership with ILC and The Business School at City University, London, have recently conducted research using an innovative new way of measuring inequalities that links health to wealth and the economy.[7] The research imagined a situation in which each local area is responsible for financing its own health and welfare services, including the state pension, and that the tax base is people's earnings. In this scenario, a local tax would be levied to cover healthcare costs, welfare benefits for those sick and unable to work, and state pensions.

5. The findings indicated that the average imputed tax rate across all regions would be 26%, but that these tax rates would range from 21% to 34% between the most

advantaged and disadvantaged districts.[8] This therefore puts an economic cost on inequalities – and one that is felt by everyone, including the wealthiest in society.

6. Good health is a necessary condition for reducing this inequality. Areas with the lowest WLE also have the lowest HLE, meaning that poor health is likely to be the biggest obstacle to working longer. Therefore, policies aimed only at extending life without extending health are likely to be expensive and counterproductive. In fact, a two-year increase in life expectancy with no other changes would increase the average tax rate from 26% to 29%.[9]

7. Improving HLE, however, by one year would lead to an approximate 3.4-month increase in WLE and a 4.5-month increase in LE – therefore supporting longer working lives and healthy retirements.[10] Good health also reduces the cost of services such as health and social care. As a result, increasing HLE by two years would reduce the average tax rate by around 1%.[11] Finally, better health outcomes after retirement would also enable higher participation in non-remunerated activities, such as volunteering or caring.[12] Therefore, not only do inequalities cost everyone, but addressing them through promoting better health outcomes would have a financial dividend for all regions.

COVID-19 has disrupted and increased inequalities in retirement income security

8. Intergenerational inequalities in retirement income remain prevalent in the UK and have been further increased by the pandemic. For example, among Generation X (those born between 1965 – 1985):
    - 1 in 3 risk facing bleak retirement prospects.[13]
    - The majority (57%) want to save more but can't.[14]
    - 1 in 5 are now saving less or spending down their savings as a result of the COVID-19 pandemic.[15]

9. Some groups in society face particular challenges in preparing for retirement:
    - **Renters and first-time buyers**: Within Generation X, renters are more likely to say they'd "like to save more for retirement but [are] struggling to do so," compared to homeowners (71% vs 52%).[16]
    - **The self-employed**: A quarter of self-employed Gen Xers have no pension savings and nearly 4 in 10 are barely saving enough to achieve a minimum income in retirement – compared to 19% of employees.[17]
    - **Low earners:** Gen Xers with relatively low levels of education and income, as well as those who are unemployed or on benefits, are exceptionally likely to have inadequate or no pension savings, and expect to mainly rely on the state pension in retirement.[18]
    - **Carers**: 1.7 million Gen X carers are at risk of retirement poverty, which may be down to the fact that less than half (43%) of current Gen X care providers are employed full-time (compared to 61% of non-carers).[19]
    - **Women:** Female Gen Xers are more likely to say they would like to save more but struggle to do so (62% vs 52%) and more worried about retirement (54% vs 46%) than their male counterparts, due in part to the disproportionate caring responsibilities they face, which restrict their ability to work.[20]

10. Without urgent support, the reality will be widening inequalities, severe financial hardship and even pensioner poverty for many of the next generation of retirees.

Older people have been locked out of working, earning and spending by the pandemic

11. During the COVID-19 pandemic, older people have been disproportionately locked out of working and spending:

    - Between December 2020 and February 2021, employment rates of 50-64 year-olds fell from 72.6 to 71.1%, and from 11.5 to 10.4% for those aged 65+, despite an increase in the population aged 50 years and over in this period.[21]

    - Older workers still in work reported working fewer working hours than usual during this time period, and a quarter of all employees on furlough (1.3 million) were aged 50 or over.[22]

    - Older workers who find themselves unemployed as a result of COVID-19 are twice as likely to be out of work for 12 months or more as younger workers.[23]

12. This doesn't have to be the case. Many of the barriers to older people's economic contributions are avoidable – the most important being poor health:

    - People who report being in good rather than poor health are over four times more likely to be in work between the ages of 50 and 65, and over 10 times more likely between 65 and 74.[24]

    - Across the G20, countries that spend more in health, older people work, volunteer and spend more.[25]

    - Increasing preventative health spend by just 0.1% can unlock a 9% increase in annual spending by people aged 60+.[26]

13. Addressing barriers to spending and working for longer could add 2% to UK GDP every year.[27] Therefore, an equal recovery from the pandemic will rely on older people being supported to return to work and spend in safe, age-friendly environments.

Recommendations

14. **Invest in health:**
    - Invest at least 6% of the health budget in preventative health interventions, such as vaccinations, screening and early detection of disease.

    - Once this has been accomplished, adopt more ambitious targets, such as the 15% target called for by the UK All Party Parliamentary Group (APPG) on Longevity.[28]

    - Prioritise investment in digital health technology on interventions that democratise access to healthcare and meet the needs of disadvantaged groups.

15. **Encourage and enable longer working lives:**

    - Extend the Kickstart scheme, which has successfully funded jobs for a quarter of a million younger people, to older workers made redundant due to COVID-19.

    - Require employers to make all jobs flexible by default so that employees can alter their working patterns throughout their lives.

- Invest in lifelong learning through expanding the Lifetime Skills Guarantee to cover adults of all ages.

16. **Support retirement planning among disadvantaged groups:**
    - Develop a new tax-incentivised savings vehicle to allow first-time buyers to save for a housing deposit via regular contributions from earnings before tax, while also contributing to a pension.
    - Explore mechanisms for extending auto-enrolment to self-employed adults – potentially via the tax system – with an option to save into either a traditional pension or a sidecar savings vehicle.
    - Remove the Lower Earnings Limit for auto-enrolment contributions so that employer contributions start from the first pound earned.
    - Introduce a right to 10 days of paid carers' leave, with a longer unpaid leave period of up to six months.

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