Brief Report


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Abstract

Objectives: Research on unretirement (retirees who re-enter the workforce) is burgeoning. However, no longitudinal study has examined how informal care relates to unretirement. Utilizing role theory, this study aims to explore the heterogeneity of informal care responsibilities in retirement and to examine how informal care informs re-entering the workforce in later life.

Method: Data were drawn from the Health and Retirement Study of fully retired individuals aged 62 years and older in 1998 (n = 8,334) and followed to 2008. Informal care responsibilities included helping a spouse/partner with activities of daily living (ADLs) or instrumental activities of daily living (IADLs); helping parent(s) or parent-in-law(s) with ADLs or IADLs; and single or co-occurrence of care roles. Covariates included economic and social factors. Cox proportional hazard models were utilized.

Results: When compared with noncaregivers, helping a spouse with ADLs or IADLs reduced the odds of returning-to-work in the subsequent wave by 78% and 55%, respectively (hazard ratio [HR]: 0.22, confidence interval [CI]: 0.06–0.87; HR: 0.45, CI: 0.21–0.97). There was no statistical difference to returning-to-work between noncaregivers and helping parents with ADLs/IADLs or multiple caregiving responsibilities.

Discussion: Role theory provided a useful framework to understand the relationships of informal care and unretirement. Aspects of role strain emerged, where, spousal caregivers were less likely to come out of retirement. Spousal caregivers may face challenges to working longer, and subsequently, opportunities to bolster their retirement security are diminished. Research and policy implications are discussed.

Keywords: Employment—Informal caregiving—Role theory—Unretirement

Working longer has been proposed as the key to a secure retirement (Munnell, 2015; Munnell & Sass, 2008), and current U.S. retirement policy encourages and financially rewards formal labor force participation longer into the life span (e.g., reduced benefits for early retirement, increased age eligibility for full-retirement benefits, and delayed retirement credits from Social Security). Simultaneously, long-term services and support policies encourage the provision of informal care in the community and rely heavily on unpaid informal care providers. Currently, millions of older adults are caring for their spouses, partners, parent(s), or parent-in-law(s) (Feinberg, Reinhard, House & Choula, 2011; Lee & Tang, 2015; Reinhard, Levine, & Samis, 2013; Wolff & Kasper, 2006), and these informal caregiving roles may undermine the opportunities and capacity to work longer.
Although research in this area is complex, there is some evidence to suggest that informal caregivers are more likely to be forced into retirement and retire earlier when compared with noncaregivers (Dentinger & Clarkberg, 2002; Pavalko & Artis, 1997; Szinovacz & Davey, 2005). Whether informal caregivers unretire, that is, go back to work after retirement, has yet to be examined with longitudinal population-based data, and thus, knowledge of the causal relationship is unknown.

Unretirement is an emerging phenomenon that is likely to continue with population aging, retirement policies encouraging working longer, shortfalls of retirement savings, and/or personal desires to remain socially engaged (Munnell & Sass, 2008; Freedman, 2008). Re-entering the workforce after retirement can bolster older adults’ economic security. Research in this area suggests that individuals with high levels of resources return-to-work (e.g., high levels of health and education, high-skilled occupational status, and married/partnered to an employed spouse); and theoretically, retirees return-to-work for additional income, although the literature is mixed (Cahill, Giandrea, & Quinn, 2011, 2015; Gonzales, 2013; Lahey, Kim, & Newman, 2006; Maestas, 2010; Schlosser, Zinni, & Armstrong-Stassen, 2012). To our knowledge, this emergent body of research has not examined the heterogeneity of informal care responsibilities in retirement with longitudinal population-based data, and we do not know how assisting a spouse, partner, parent(s), or engagement in multiple caregiving responsibilities has any effect on returning-to-work after retirement.

Theory and Evidence

Role enhancement and role strain are two theoretical orientations that may explain how informal caregiving roles relate to unretirement. Role enhancement suggests that individuals aim to occupy as many social roles as possible because it fosters rights, power, and privileges and enriches ego and personality (Moen, Robison, & Dempster-Clay, 1995). It has been found that the occupancy of multiple roles helps to buffer against unanticipated events such as health, economic, and social shocks. Yet, concepts such as time squeeze and time allocation imply that multiple roles can cause role strain (Kamakura, 2009; Southerton & Tomlinson, 2005).

A large body of research supports the role strain perspective. For example, negative employment outcomes of informal care include rearrangements of the work schedule, absenteeism, unpaid leave, constrained careers, reduced work hours, and the likelihood of being unemployed (Evandrou, Glaser, & Henz, 2002; Fredriksen-Goldsen & Farwell, 2004; Scharlach, Gustavson, & Dal Santo, 2007; Stephens, Townsend, Martire, & Druley, 2001). Informal caregivers are often forced into retirement (Pavalko & Artis, 1997; Szinovacz & Davey, 2005).

Conversely, an equally compelling body of literature stemming from the role enhancement perspective indicates that occupying multiple roles may be beneficial (Adelmann, 1994a, 1994b; Hinterlong, Morrow-Howell, & Rozario, 2007). For example, employment may buffer stresses from caregiving demands by providing respite and links to additional economic and social resources (Chumbler, Pienta, & Dwyer, 2004; Norton, Stephens, Martire, Townsend, & Gupta, 2002; Stoller & Pugliesi, 1989). Rozario, Morrow-Howell, and Hinterlong (2004) found that caregivers who were employed had better self-rated health than those without multiple roles, thus supporting the role enhancement perspective.

Informal care may take the form of assisting a partner with activities of daily living (ADLs, e.g., bathing, dressing, eating, moving from bed to chair, or going to the toilet) or instrumental activities of daily living (IADLs, e.g., preparing meals, shopping for groceries, making telephone calls, assisting with medications); and/or helping a parent or parent-in-law with ADLs or IADLs; or a combination of these multiple caregiving responsibilities. How this heterogeneity of informal caregiving relates to going back to work after retirement is unknown. Thus, we aim to explore the heterogeneity of informal caregiving demands in retirement and examine how each of these roles, as well as the combination of these roles, informs returning-to-work.

Data and Method

Data Source

Six waves of data were drawn from the Health and Retirement Study (HRS, 1998–2008). The HRS is a large-scale, longitudinal project collecting information biennially from a national random sample of persons born between 1942 and 1953 and in addition to people born in 1941 or earlier under a multistage area probability design. Person level weights were utilized in all analyses to maintain the representativeness of the U.S. older adult population. Inclusion criteria for this study are (i) individuals aged 62 years or older in 1998, (ii) claimed retirement status (stated “retired” to the question, “Now I’m going to ask you some questions about your current employment situation. Are you working now, temporarily laid off, unemployed and looking for work, disabled and unable to work, retired, a homemaker, or what?”), and (iii) reported not working any hours or any weeks at baseline. This resulted in a sample of 8,334 at baseline.

Variables

Dependent variable

Study participants were coded as “unretired” (1 = yes), if they reported partly retired and reported working part- or full-time, and reported any hours or weeks of paid work in subsequent waves, 2000–2008.
Help spouse with ADLs
If respondents reported difficulty with ADLs (e.g., bathing, dressing, eating, moving from bed to chair, or going to the toilet), then they were asked “Who helps?” If their spouse/partner was identified, then their spouse was coded as spousal caregivers with ADLs (1).

Help spouse with IADLs
Respondents were asked: “Who most often helps you prepare meals, shop for groceries, make telephone calls, take medications?” If they identified their “spouse/partner,” then their spouse was coded as caregiver with IADLs (1).

Help parent(s) with ADLs
Respondents were asked: “How about another kind of help: Did you [or your partner] spend a total of 100 or more hours (since Previous Wave) helping your ((deceased) parents/mother/father)/((late) husband’s/wife’s/partner’s) (deceased) parents/mother/father) with basic personal activities like dressing, eating, and bathing?” If they answered, “yes,” then they were coded as parental caregivers with ADLs (1).

Help parent(s) with IADLs
Respondents were asked: “Did you [or your partner] spend a total of 100 or more hours (since Previous Wave) helping your ((deceased) parents/mother/father)/((late) husband’s/wife’s/partner’s) (deceased) parents/mother/father) with other things such as household chores, errands, transportation, etc.?” If they answered, “yes,” then they were coded as parental caregivers with IADLs (1).

Single and co-occurrence of caregiving demands
A sum measure of caregiving roles was utilized where the reference group was “no caregiving,” compared with occupancy of one care role or occupancy of two care roles or more.

All of the caregiving variables were treated as time variant and lagged by one interval to address issues of endogeneity.

Sociodemographic, economic, and social variables were included as covariates because they have proven to be empirically significant in predicting unretirement (see Cahill et al., 2011; Choi, 2000; Gonzales, 2013; Lahey et al., 2006; Maestas, 2010; Ozawa & Lum 2005; Singh & Verma 2003).

Age is used as a continuous variable. Women were coded as 1. Race was transformed to Non-White = 1. Education is measured in years. Lifetime occupational status was trichotomized: high skills (e.g., managerial specialty operations and professional specialty operator/technical support), midrange skills (e.g., clerical/administrative, mechanics/repair, and handlers), and low skills (e.g., service occupations such as cleaning and food preparation); where low-skill occupations was the reference group. All are taken at baseline and treated as time invariant.

Self-rated health was measured with “Would you say your health is excellent, very good, good, fair, or poor?” (1 = poor to 5 = excellent) and treated as time variant. Total household income was log-transformed (see Gonzales, 2013, for full descriptions of total household retirement wealth and income). Pension possession was measured with “Are you (or your husband/wife/partner) currently receiving an income from retirement pensions?” (1 = yes). Respondents were coded as 1 if they indicated that they received employer-sponsored health insurance. Married/partnered (1 = yes). For people who were married and whose spouse/partner was employed were coded as 1. Time-variant factors were lagged by one interval to address issues of causality.

Statistical Analysis
The Cox proportional hazard model (Allison, 1995; Cox & Oaks, 1984) was used to estimate the effects of independent variables on the hazards of unretirement. Survival curves were parallel, meaning that they did not crossex.

Results
The average age at baseline was 74 years (range 62–102 years, \(SD = 7.37\)). More than half (53.8%) were women. Most (88.5%) of the sample were white. About three fifths (57%) were married or partnered. Approximately one out of four (29%) was a single, never-married person. Respondents were coded as 1 if they indicated that they received employer-sponsored health insurance. Married/partnered (1 = yes). For people who were married and whose spouse/partner was employed were coded as 1. Time-variant factors were lagged by one interval to address issues of causality.

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Statistical Analysis
The Cox proportional hazard model (Allison, 1995; Cox & Oaks, 1984) was used to estimate the effects of independent variables on the hazards of unretirement. Survival curves were parallel, meaning that they did not crossex.
The overall percentage of respondents unretiring is lower than what is found in the literature and is likely due to two reasons. Many studies use self-report labor force status which is an unreliable measure (Cahill et al., 2011). The current study verified whether the respondent had worked any hours or weeks in subsequent waves, which is a more rigorous method. Secondly, most studies examine individuals as young as 50 years of age; we restricted our analyses to individuals aged 62 years of age and older as most people retire in their early 60s (Munnell, 2015). Implications of this criterion are deliberated in the Discussion and Limitations sections.

Retirees were helping spouses, partners, parents, and parent-in-laws with ADLs or IADLs (Table 1). As expected, there was more assistance to recipients with IADL limitations than ADL limitations; and more assistance was given to spouses/partners than to parents.

Multivariate analyses suggest that informal care operated differently with returning-to-work (Models I–V). When compared with noncaregivers, helping a spouse/partner with ADLs or IADLs reduced the odds of returning-to-work by 78% and 55%, respectively (Table 2, Model I, hazard ratio [HR]: 0.22, confidence interval [CI]: 0.06–0.87; Table 2, Model II, HR: 0.45, CI: 0.21–0.97). There was no statistical difference to returning-to-work between noncaregivers and helping a parent with ADLs (Table 3, Model III) or IADLs (Table 3, Model IV). Finally, there was no statistical difference in returning-to-work between noncaregivers and multiple caregiving responsibilities (Table 3, Model V).

The direction and significance of covariates were stable across models and are similar to the literature previously cited. Covariate factors that reduced the odds of returning-to-work included age, gender, pension presence, and marital status. For example, the odds of returning-to-work were reduced by 12% to 13% with every unit increase in age across models. However, covariate factors that pulled older adults out of retirement and back to work were health, high- and mid-skilled lifetime occupational status, and partnered with a working spouse. For example, the odds of going back to work increased by approximately 27% to 30% with every unit increase in self-rated health across models. Nonsignificant factors at the multivariate level included race, total household income, employer-sponsored retiree health insurance, and education.

### Discussion

Overall, retirees were engaged in a variety of informal caregiving roles in retirement, and the nature of the care functioned differently with returning-to-work. The findings point to role strain among spousal caregivers. It is likely that they remain retired due to the personal, private, and demanding nature of care, especially for partners who have difficulty with the most essential aspects of living such as eating, bathing, dressing, and getting out of bed. It is also evident that the odds of returning-to-work decrease as the health of their significant other worsens, which is in line with the role strain perspective.

Interestingly, there was no significant difference to returning-to-work between noncaregivers and helping a parent with ADLs or IADLs. There may be a proximal–distal dimension influencing caregiving responsibilities. Parents might rely on others (e.g., other children if they are available, their own spouse/partners, friends, or formal help). Previous research suggests that parental caregiving was negatively associated with labor force participation only for women, but the relationship was not significant for men (Lee, Tang, Kim, & Albert, 2015b). It is also possible that the current models are statistically underpowered, as there were fewer respondents helping parents with ADLs or IADLs when compared with helping their partners with the same activities. There was no statistical difference between noncaregivers when compared with individuals with single or multiple caregiving responsibilities. This is possibly due to the mixed results with which each caregiving role functioned with unretirement (e.g., spousal caregiving was negatively related and helping a parent was nonsignificant).

Retirement security and long-term services and supports (LTSS) are two major themes for the White House Conference on Aging in 2015 and will be of major concern.

### Table 1. Percentage of Respondents Engaged in Informal Caregiving Roles Across Waves

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<tbody>
<tr>
<td>Helping a spouse/partner with ADLs</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
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<td>Helping a spouse/partner with IADLs</td>
<td>6%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
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<tr>
<td>Help parent(s) with ADLs</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Help parent(s) with IADLs</td>
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<td>Multiple care roles</td>
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<tr>
<td>No caregiving role</td>
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<td>96%</td>
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<tr>
<td>Occupancy of 1 care role</td>
<td>8%</td>
<td>6%</td>
<td>4%</td>
<td>4%</td>
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<tr>
<td>Occupancy of 2+ care roles</td>
<td>4%</td>
<td>3%</td>
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Notes: ADL = activities of daily living; IADL = instrumental activities of daily living.
for the foreseeable future. Informal caregivers are often regarded as the backbone of LTSS and are highly regarded for their valuable unpaid work. Informal caregiving by older adults saves our nation approximately $100 billion annually (Johnson & Schaner, 2005). Yet, retirement policies encourage and financially reward formal labor force participation longer into the life span. Unfortunately, there is a large body of research evidencing the challenges of

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<th>Table 2. Informal Caregiving and Its Impact on Returning-to-work After Formal Retirement (Models I and II)</th>
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<td>Education (years)</td>
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<td>Help spouse with ADLs</td>
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<td>Help spouse with IADLs</td>
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Notes: ADL = activities of daily living; CI = confidence interval; HR = hazard ratio; IADL = instrumental activities of daily living.

*aReference group = low-skill occupations.

<.10. *p < .05. **p < .01. ***p < .001.

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<th>Table 3. Informal Caregiving and Its Impact on Returning-to-work After Formal Retirement (Models III, IV, and V)</th>
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working and providing care to family members (Dentinger & Clarkberg, 2002; Pavalko & Artis, 1997; Szinovacz & Davey, 2005). Consequently, the overall weaker relationship caregivers have with the labor force puts them at greater risk of living in poverty in later life (Greenfield, 2013; Lee, Tang, Kim, & Albert, 2015a; Wakabayashi & Donato, 2006). The extant body of research suggests that spousal caregivers’ work careers are constrained in terms of intensity and duration. Results from this study are in line with this body of research and contribute to the current knowledge base by clearly demonstrating that they are less likely to retire. Subsequently, opportunities to bolster their retirement security are diminished. Spousal caregivers may be highly regarded for the unpaid and valuable work they perform, yet economically disadvantaged.

Policies that directly compensate caregivers (e.g., social security credits or direct cash transfers), combined with offering tax credits for purchasing long-term care insurance (Mellow, 2000), can support spousal caregivers. Moreover, expanding paid leave and flexible work options in combination with strengthening LTSS may bolster opportunities to work longer which can improve caregivers’ retirement security. Proposed legislation in Congress warrants discussion, debate, analysis, and votes (e.g., Family and Medical Insurance Leave Act of 2013 [H.R. 3712, S. 1810] which will provide paid leave; Schedules that Work Act [H.R. 5159, S. 2641] which can expand workplace flexibility; and Social Security Caregiver Credit Act of 2014 [H.R. 5024] which aims to remunerate caregiving). Evidence of the feasibility and favorable outcomes of paid leave exists with state-wide initiatives and demonstration projects (Appelbaum & Milkman, 2011; National Alliance for Caregiving and AARP, 2009). And it appears that companies perform better with flexible work options and paid leave that support elder and child care (Executive Office of the President Council of Economic Advisers, 2010; Moen, Kelly, & Hill, 2011). Moreover, there is public support for the Social Security Caregiver Credit Act of 2014 (Lake Research Partners, 2014), and research in this area (D’Addio & Whitehouse, 2009; Herd, 2006; Jankowski, 2011) can inform discussions.

Future research can overcome the limitations in this study. For example, the results suggest that the odds of spousal caregivers returning-to-work are significantly lower when compared with nonspousal caregivers—an alternative interpretation is that spousal caregivers overwhelmingly choose to remain retired. The themes of coercion, choice, and constraint have been enduring in the literatures of productive aging (Morrow-Howell, Hinterlong, & Sherraden, 2001), economics (Bassanini & Caroli, 2014; Schultz, 1961), sociology (Crompton & Harris, 1998), and public policy (Doty, Jackson, & Crown, 1998; Szinovacz & Davey, 2005). Research that contextualizes the themes of individual and structural factors that enable or undermine opportunities to occupy single and multiple productive roles between and among caregivers is warranted. Second, we did not examine the important dimension of intensity of informal care of spousal assistance with ADLs/IADLs due to the unavailability of information in the HRS and leave it for future research. Third, we examined individuals aged 62 years and older at baseline with the rationale that most people retire at these ages and later (Munnell, 2015). In fact, the median and most frequent (mode) self-report retirement age for the overall sample and for caregivers specifically was 62 years, which justified our assumption. However, the average self-report retirement age was 61.30 years for the overall sample and 60.30 years for caregivers. Thus, a limitation to this study is that we did not examine individuals who were younger than 62 years at baseline. Consequently, this may have reduced the sample of respondents caring for parent(s), a role that can begin much earlier in life. Future studies can examine multiple employment/retirement entrances and exits with a specific focus on informal care and including younger populations. For example, it is possible to utilize two decades of data on individuals aged 50 years and older from the HRS and model divergent pathways of employment–retirement–employment statuses with a specific focus on how informal care impacts the overall strength of labor force attachment. Further, future research can examine how economic inequality may grow in the context of some individuals having more resources to continuously work longer and/or re-enter the workforce, whereas others do not. In addition, role theory did not point to important resources that are unevenly distributed based on gender, race, ethnicity, or socioeconomic position. We performed some preliminary analyses on this sample, where we stratified the data by gender and race. Findings suggest a different set of factors that predict returning-to-work by social status and offered evidence supporting social stratification theory. Finally, examining the interplay of meso-, exo-, and macro-systems may be equally important (Bronfenbrenner, 2005).

In conclusion, this longitudinal population-based study highlights aspects of role strain within the context of informal care and retirement among spousal caregivers. Findings can help to inform policy conversations on working longer. Policies that bolster the economic standing of spousal caregivers and maximize the opportunities for occupying multiple roles (e.g., working and providing care) while minimizing or eliminating the possible negative economic consequences are highly encouraged.

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References


