# Partner caregiving in older cohabiting couples

Claire Noel-Miller
University of Wisconsin – Madison

## Introduction

Aging of the baby boom generations and the resulting substantial increase in the size of the chronically disabled community-dwelling population have heightened interest in issues relating to frail elderly's receipt of care. It is well established that family caregivers provide the bulk of long-term care provision in the United States (Wolff and Kasper, 2006). In particular, an extensive body of research documents that spouses typically assume the role of caregiver when they are available (e.g. Jette et al., 1992). For example, in a recent study, Wolff and Kasper (2006) find that 39.8% of all primary informal caregivers to chronically disabled elderly care recipients are spouses, that spouses are the most likely to be primary caregivers to their partner, provide more hours of care for longer periods of time on average than any other primary caregiver and that two thirds of spousal primary caregivers to elderly adults are sole caregivers.

## Study Aims

Our current knowledge about spousal caregiving is based on studies of older *married* couples. To date, the caregiving literature has ignored issues relating to the provision and the receipt of personal and routine care by middle aged and older partners in cohabiting unions. This is partly because cohabitors are typically conceived of as belonging to younger age categories than those usually considered in caregiving research (Brown et al., 2006). Yet, recent evidence suggests that such union types are rapidly becoming increasingly common among older Americans (Brown et al., 2005; Brown et al., 2006; Chevan, 1996; Hatch, 1995; King and Scott, 2005). Chevan (1996) estimated that whereas fewer than 10,000 people aged 60 and above were cohabiting in 1960, more than 400,000 were in such unions by 1990. According to the 2000 Census, of the roughly 10 million individuals currently cohabiting, more than 1 million are older than age 50 (Brown et al., 2006). Similarly, Brown and colleagues (2005) report that in 2000, more than 500,000 cohabitors were aged 60 and older.

Using data from five waves (2000, 2002, 2004, 2006, 2008) of the Health and Retirement Study (HRS), this study aims to investigate differences in cohabiting and married partners' involvement in the care of community-dwelling older Americans with functional limitations. To my knowledge, this is the first study to focus specifically on elderly cohabiting partners' patterns of spousal care receipt when one member of the cohabiting couple requires assistance. Specifically, this paper examines differences between married and cohabiting elderly with similar levels of disability and associated need for care in (a) the likelihood of receiving any care from their partner, (b) the likelihood that their partner will serve as their primary caregiver and (c) the number of care hours provided by caregiving partners.

## Background and Justification

Several demographic processes are responsible for the increase in cohabitation among middle-aged and older persons. First, the baby-boom cohorts, that were the first to experience substantial increases in cohabitation at young ages are now aging into their late to middle-years, with relatively favorable attitudes towards cohabitation (De Jong Gierveld, 2004). Second, a combination of high divorce rates and decreasing remarriage rates among members of these cohorts (Cooney and Dunne, 2001), results in relatively greater numbers of unpartnered middle aged and older adults available for cohabitation. Finally, cohabitation is more prevalent amongst Black and Hispanic minorities than among Caucasians (Raley, 1996). Because these groups represent an increasing proportion of the older American population, a greater fraction of future generations of elderly Americans will be cohabiting. However, even studies of caregiving explicitly focused on ethnic minorities among whom cohabitation is more common have essentially ignored this form of union (e.g., (Pinquart and Sorensen, 2005)).

Although they are younger, on average than the married population, cohabitors have poorer physical health (Brown et al., 2005), and are therefore likely to be at a greater need for personal and instrumental care. Among older men, poor health is positively related to cohabitation versus being single (Hatch, 1995), perhaps because older-age cohabitation is selective of less healthy individuals. Consequently, the issue of cohabitors' receipt of care from a spouse is particularly salient.

Moreover, later-life cohabitation likely bears a unique meaning and plays a different role in the life course of older adults than it does in that of younger adults (Chevan, 1996; Hatch, 1995; King and Scott, 2005). The motivations for cohabitation among the older population are likely to differ from those of young adults. Several researchers assert that older adults are not especially interested in remarriage (Bulcroft et al., 1989; Bulcroft and Bulcroft, 1991; Chevan, 1996; Hatch, 1995; Talbott, 1998). For women, this may partly be due to their reluctance to assume the burden of caregiving that is likely to follow from remarriage at older ages (Talbott, 1998) . These authors suggest that a partner's provision of care to their frail spouse may depend on the type of union, with cohabiting elderly women in particular being less likely to care for a frail partner since cohabiting unions typically require a weaker commitment from partners.

In summary, there are important demographic and theoretical reasons for investigating older frail cohabitors' receipt of care from a partner and for assessing how this group compares with married elderly.

## Methods

*Data Source*

The HRS is a biennial longitudinal study designed to examine health and retirement decisions in older Americans as well as the ways in which older Americans and their families respond to the decline in health that is characteristic of later life. The first wave of the study was collected in 1992. In 1998, the HRS merged with the Study of Assets and Health Dynamics Among the Oldest Old (AHEAD) and two new cohorts were added, thus creating a nationally representative sample (N=21,384) of non-institutionalized persons born in 1947 and earlier (i.e. aged 51 and older) and their

spouses (regardless of age). Although earlier waves gathered some information on the composition of frail elderly's caregiving networks, starting in 2000 the HRS has collected extensive additional information on the amount of care provided by spousal caregivers. Reflecting the still relatively small fraction of cohabitors in the US older population, the wave-specific sub-sample of cohabitors in the HRS are relatively small (e.g. N=520 cohabitors in the 2000 HRS sample). Therefore, the present analysis relies on five waves of data from the 2000, 2002, 2004, 2006 and 2008 waves of the survey.

*Sample*

In each data wave, the analysis is restricted to respondents who reported some difficulty performing at least one activity of daily living (ADL) or instrumental activity of daily living (IADL) and consequently received some help with one or more of these activities. ADLs include walking, dressing, eating, bathing, toileting, and transferring in and out of bed; IADLs include managing money, preparing meals, getting groceries, using the telephone, and taking medications. Among those who received assistance with one or more activities, the sample is further limited to respondents who reported being married or cohabiting at the time of the survey. Therefore, each respondent contributed at least one data point to the analysis and could contribute up to five data points depending on their wave-specific status.

*Outcome variable*

The study examines three main outcomes. Among frail cohabiting and married respondents who received at least a minimum of care I examine whether the respondent's partner provided any care and whether the respondent's partner served as a primary caregiver. Furthermore, for those respondents who did receive care from a partner, the analysis examines the number of hours of care provided by those partners in the month prior to the survey. Respondents who received help with any ADL or IADL could report multiple caregivers, making it possible to fully reconstitute the composition of a frail elderly's caregiving network. In addition, respondents were asked to report the number of days in the previous month during which they had received help and the approximate number of daily hours of assistance. In a few cases, respondents reported the number of days of help received in the previous week. Weekly values were translated into monthly values by multiplying them by 4.33, the average number of weeks in a month. Similarly, when respondents reported receiving assistance every day of the month, they were considered to have received assistance 29.53 days, the average number of days in a month. Monthly hours of help were calculated by multiplying the number of days of help by the daily hours of received care. Primary caregiver status was assigned to the helper who was reported as providing the greatest number of monthly caregiving hours. Missing data on the number of hours of care provided were imputed using hot-deck imputation methods.

*Independent variable*

Union status was self-reported by all HRS respondents at the time of the interview. Interviewers were instructed not to prompt respondents for cohabitor status, which was thus volunteered. Prior research has established that estimates of the size of the older cohabiting population based in the HRS variable are largely consistent with estimates

based on Census data, thus lending strong support to the valididity of the HRS measure (Brown et al., 2006).

*Care recipient characteristics*
The analysis controls for a number of care recipient characteristics that both differ between the married and the cohabiting sub-samples and are associated with receipt of assistance, thus possibly confounding the relationship between cohabitor status and receipt of partner care. These are gender, race/ethnicity, education, availability of health insurcance, current work status, income and several measures of disease, functional disability and cognitive impairment.

*Spousal characteristics*
In addition to a respondent's own characteristics, the models control for characteristics of a potential caregiving partner that may facilitate or hamper the provision of care. Models include measures of spousal functional disability, current work status and whether the spouse is currently caring for dependent elderly parents.

*Analytical strategy*
As mentioned above, examining older cohabitors receipt of care from a partner poses particular challenges due to the small sub-sample of cohabitors in the HRS. The analytical strategy adopted for this study takes advantage of several waves of data to overcome this limitation. The three outcome variables of interest are modeled using a nonlinear mixed model (multi-level model with unobserved heterogeneity). The models contain time-period fixed effects along with a six-component random effect. In particular, for the fist outcome considered in the analysis, I model care recipient *i*'s receipt of care from a partner (1=received care from a spouse; 0=did not receive care from a spouse) at time *t*, using a binary logistic regression:

$$\text{logit}\,(\Pr[Y_{it}=1]) = \alpha_1 + \alpha_2 T_2 + \alpha_3 T_3 + \alpha_4 T_4 + \alpha_5 T_5 + \beta' X_{it} + u_i + e_{it} \qquad (1)$$

In equation (1), the variables $T_2$ though $T_5$ are dummy indicators of data from 2002 ($T_2$=1), 2004 ($T_3$=1), 2006 ($T_4$=1) and 2008 ($T_5$=1). Thus, the constant term $\alpha_1$ represents the intercept in the first time period (2000). The parameter vector $\beta'$ represents the effects of explanatory variables ($X_{it}$) on the outcome variable. The random effects $u_i$ and $e_{it}$ (t=1, 2, 3, 4, 5) are independent normally distributed effects with variance to be estimated. The person-level heterogeneity term $u_i$ represents a measure of fixed personality traits and characteristics that manifest themselves in a greater (or smaller) likelihood than expected of receiving assistance from a partner, conditional on the measured explanatory variables $X_{it}$. Each of the time-specific random terms $e_{it}$ represent transitory influences on a care-recipient's likelihood of receiving assistance from their partner. For instance, work or family stressors experienced by the couple in the first time period of observation may lead frail elderly to rely more (or less) on assistance from a partner in that year than expected given the $X_{i1}$ variables, but not in other years.

For the second outcome variable of interest, the model mirrors that described in equation (1) with ($\Pr[Y_{it}=1]$) representing the probability that care recipient *i*'s primary caregiver

is their partner. Finally, the hours of care received from a partner were modelled using a corresponding continous mixed model. So far, preliminary models have been estimated using aML software (Lillard and Panis, 2003).

## Preliminary results

For waves 2000-2006 of the survey, Table 1 shows sample sizes for married and cohabiting respondents receiving help with at least one ADL or IADL. In addition, the Table reports the proportions among these receiving assistance from a partner. The small sample size in the cohabitors' column confirms the need for panel data. Moreover, these preliminary results indicate that the proportions of cohabitors receiving assistance from a partner is typically smaller than the corresponding proportion of marrieds.

**Table 1**: Number of married and cohabiting respondents receiving help with at least one ADL or IADL and proportion of these respondents receiving assistance from a partner, HRS 200-2006.

| | Married | | Cohabitors | |
|---|---|---|---|---|
| Year | Number receiving help | % receiving help from partner | Number receiving help | % receiving help from partner |
| 2000 | 1,331 | 85.7 | 62 | 82.2 |
| 2002 | 1,260 | 86.8 | 48 | 77.1 |
| 2004 | 1,384 | 85.4 | 75 | 80.0 |
| 2006 | 1,325 | 88.0 | 85 | 87.0 |

### References


Brown S.L., Bulanda J.R., Lee G.R. (2005) The Significance of Nonmarital Cohabitation: Marital Status and Mental Health Benefits Among Middle-Aged and Older Adults. J Gerontol B Psychol Sci Soc Sci 60:S21-29.

Brown S.L., Lee G.R., Bulanda J.R. (2006) Cohabitation Among Older Adults: A National Portrait. J Gerontol B Psychol Sci Soc Sci 61:S71-79.

Bulcroft K., Bulcroft R., Hatch L., Borgatta E.F. (1989) Antecedents and Consequences of Remarriage in Later Life. Research on Aging 11:82-106. DOI: 10.1177/0164027589111004.

Bulcroft R.A., Bulcroft K.A. (1991) The Nature and Functions of Dating in Later Life. Research on Aging 13:244-260. DOI: 10.1177/0164027591132007.

Chevan A. (1996) As Cheaply as One: Cohabitation in the Older Population. Journal of Marriage and Family 58:656-667.

Cooney T.M., Dunne K. (2001) Intimate Relationships in Later Life: Current Realities, Future Prospects. Journal of Family Issues 22:838-858. DOI: 10.1177/019251301022007003.

De Jong Gierveld J. (2004) Remarriage, Unmarried Cohabitation, Living Apart Together: Partner Relationships Following Bereavement or Divorce. Journal of Marriage and Family 66:236-243.

Hatch R.G. (1995) Aging and Cohabitation Garland, New York.

Jette A.M., Tennstedt S.L., Branch L.G. (1992) Stability of Informal Long-Term Care. Journal of Aging and Health 4:193-211.

King V., Scott M.E. (2005) A comparison of cohabiting relationships among older and younger adults. Journal of Marriage and Family 67:271-285.

Pinquart M., Sorensen S. (2005) Ethnic Differences in Stressors, Resources, and Psychological Outcomes of Family Caregiving: A Meta-Analysis. Gerontologist 45:90-106.

Raley R.K. (1996) A Shortage of Marriageable Men? A Note on the Role of Cohabitation in Black-White Differences in Marriage Rates. American Sociological Review 61:973-983.

Talbott M.M. (1998) Older widows' attitudes towards men and remarriage. Journal of Aging Studies 12:429-449. DOI: 10.1016/s0890-4065(98)90028-7.

Wolff J.L., Kasper J.D. (2006) Caregivers of Frail Elders: Updating a National Profile. The Gerontologist:344-356.