

The health of grandparents caring for their grandchildren: the role of early- and mid-life conditions

Glaser, K.; Di Gessa, G.; Tinker, A.

King's College London

Grandparents play an important role in looking after grandchildren. For example, in Britain, nearly two thirds (63%) of grandparents with grandchildren under 16 report providing care for a grandchild, and 17% provide higher levels of care of at least 10 hours per week.¹ Grandparents share responsibility for grandchildren as a response to their child's financial need, work commitments, or family disruptions (such as divorce). Increasing co-residence between grandparents and grandchildren in the US (from 3.2% in 1970 to 5.5% of children in 2003) suggests a rise in the share of grandparents raising or helping to raise grandchildren.² Thus grandparents provide vital support to families. However, concerns have been raised that caring for grandchildren may come at the cost of grandparents' own health and well-being. Such concerns arise from the recognition that looking after grandchildren may be demanding, both physically and emotionally.³ However, it is also recognised that grandchild care brings benefits: grandparents caregivers may have more active lifestyles.⁴

Whether grandchild care affects health is still unclear. A growing literature suggests that grandparents in skipped-generation households are more likely to report activity limitations than other grandparents.⁵ Similarly, custodial grandparents report more depressive symptoms than non-residential grandparents or non-caregivers.⁵ However, some studies found a higher quality of life among grandparents actively caring for a grandchild,⁴ describing better health including weight loss and reduction in smoking.⁶

Similar mixed results have been found in longitudinal studies where baseline health and socio-economic conditions had been taken into account. Baker and Silverstein (2008) found health prevention behaviours to be less common among recent custodial grandmothers; however, the effects disappeared over time, suggesting adaptation after a period of adjustment.⁷ Hughes and colleagues' (2007) study, however, did suggest that grandmothers in skipped-generation households may experience poorer health outcomes.⁸ As these households are often among the poorest, the authors acknowledge that the relationship between grandparental caregiving and health and wellbeing may be different for more disadvantaged groups. Findings suggest that the relationships found between health and caregiving might reflect prior variations in socio-economic status, rather than being the consequences of

childcare provision. In particular, grandparents in poor health who provide care to grandchildren might be at greater risk of health decline compared to those who were in better conditions at baseline.

Our study aims to decrease uncertainty about the link between grandchild care and grandparents' health using a life course approach, and in particular the cumulative advantage/disadvantage framework ⁹. This postulates that those who start out with fewer advantages will have less opportunity to accumulate resources thus falling farther behind in later life. Thus, we aim to examine the effects of caring for grandchildren on mental and physical health among European grandparents, controlling for cumulative experiences across the life course (e.g. partnership and paid work histories; health and socio-economic position in childhood).

We used data from the Survey of Health, Ageing and Retirement in Europe (SHARE, 2004-2010) and the English Longitudinal Study of Ageing (ELSA, 2002-2008). Both surveys are nationally representative longitudinal studies of persons aged 50 and over and their partners. SHARE's sample size in the first wave was 29,917 people (ranging from 1,707 in Denmark to 3,193 in France); close to 12,000 people were initially interviewed for ELSA. Both surveys include detailed measures of socio-economic circumstances and health as well as whether respondents are grandparents (and if so the number of grandchildren and/or great grandchildren). Information on co-resident grandchildren for both surveys is available from the household rosters. In ELSA respondents were asked whether active care was provided in the past week and if so who this was for (e.g. a grandchild) and the number of hours of care provided; in SHARE grandparents were asked whether they regularly or occasionally looked after their grandchild(ren) without the presence of the children's parents. In addition, SHARE also collected information on how often respondents looked after their grandchildren (e.g. almost daily, almost every week, almost every month or less often) and the number of hours of care provided. Both surveys also have retrospective life history interviews where respondents were asked about childhood conditions (socio-economic background such as whether any parent died before the respondent was aged 16, and the main breadwinner's social class, health such as whether respondent spent more than a month in hospital or was absent from school for extended period because of health reasons) as well as life events in adulthood (number of illnesses, unemployment spells, family disruptions). Finally, both surveys provide information on baseline socio-demographic characteristics such as age, marital status, housing tenure, social class, and

possession of an educational qualification, as well as health behaviours such as smoking, drinking and physical exercise.

To disentangle how childhood and adulthood factors as well as baseline characteristics influence the link between grandchild care and grandparent’s health, structural equation models (SEM) were used. We considered various physical and psychological dimensions of health among grandparents as outcomes in our study. In particular, we examined (1) self-rated general health (2) mental health (e.g. depressive symptoms) and a combination of physical health measures (e.g. chronic conditions, functional limitations).

For each of the health outcomes, bivariate models showed differences between grandparents who provided various types of care and those who did not. For instance, grandparents who co-resided with their grandchildren or provided intensive grandparent childcare (i.e. daily care, or 15 hours or more per week) were more likely to report depressive symptoms compared to grandparents who did not provide care. However, grandparents who looked after grandchildren less intensively (i.e. on monthly basis or less often) reported fewer depressive symptoms. This is also illustrated in Table 1 in ELSA, which shows that grandparents who co-resided with a grandchild at two waves reported higher mean depression scores and functional limitations. However, such differences disappeared with the introduction of baseline socio-economic covariates and health (as is also apparent in Table 1, that is close to 60% of those who co-reside with a grandchild at two time points were in the poorest tercile).

Table 1 Stability and change in grandparental childcare over two waves in ELSA by selected health characteristics, life history and socio-economic indicators

	Health at wave 2		Life history & socio-economic variables	
	CES-D (0-8)	Functional limitations (0-13)	No. unions	Poorest tercile %
Not co-reside with grandchild	1.68	0.98	1.25	33
Co-reside with grandchild at wave 1 or wave 2	1.85	1.15	1.27	55
Co-reside at both waves 1 & 2	2.15	1.71	1.19	58

In particular, preliminary SEM analyses suggest that such health differences are primarily due to grandparents' prior characteristics. For example, among grandparents a lower parental status during childhood is associated with poorer health during adulthood; contributing to lower wealth and income over the life course but also to poorer health at older ages, both directly and indirectly. Our findings suggest that poorer health among grandparents who provide intensive grandchild care, or who coreside with their grandchildren, does not appear to be a consequence of care provision, but rather of their initial health and socio-economic disadvantage. Caring for grandchildren does not seem to make the health of grandparents worse; on the contrary our evidence suggests that occasional grandparental childcare may benefit grandparent's self-rated and mental health. However, for grandparents in poor health who provide grandchild care, concerns remain for their well-being, the quality of grandchild care provided, and their ability to maintain it over time.

References

1. Wellard S. Grandparents and childcare. *Policy Briefing 04*. London: Grandparents Plus, 2013.
2. U.S. Census Bureau. Table CH-7. Grandchildren Living in the Home of Their Grandparents: 1970-Present: <http://www.census.gov/population/socdemo/hh-fam/tabCH-7.pdf> 2004.
3. Grinstead LN, Leder S, Jensen S, Bond L. Review of research on the health of caregiving grandparents. *Journal of Advanced Nursing* 2003;44(3):318-326.
4. Breeze E, Stafford M. *Receipt and giving of help and care*. London: Institute of Fiscal Studies, 2010.
5. Minkler M, Fuller-Thomson E. African American grandparents raising grandchildren: A National Study using the Census 2000 American Community Survey. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences* 2005;60(2):S82-S92.
6. Minkler M, Fuller-Thomson E, Miller D, Driver D. The physical and emotional health of grandmothers raising grandchildren in the crack cocaine epidemic. *The Gerontologist* 2000;32:752-761.
7. Baker LA, Silverstein M. Preventive health behaviors among grandmothers raising grandchildren. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences* 2008;63(5):S304-S311.
8. Hughes ME, Waite LJ, LaPierre TA, Luo Y. All in the family: The impact of caring for grandchildren on grandparents' health. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences* 2007;62(2):S108-S119.
9. Dannefer D. Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences* 2003;58(6):S327-S337.