Research on Aging
Volume 28 Number 3
May 2006 359-374
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10.1177/0164027505285848
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Combining Care Work and Paid Work

Do Workplace Policies Make a Difference?

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Demographic shifts mean that workers will increasingly face challenges of caring for ill or disabled family members. The authors use data from the National Longitudinal Survey of Young Women to assess whether employed women are more likely to leave the labor force when they start care work and whether access to workplace policies alters these patterns. They found that, as with earlier cohorts, employed women are more likely to leave the labor force after they start care work. Workers in jobs that provide access to flexible hours, unpaid family leave, and paid sick or vacation days are more likely to remain employed and maintain work hours over a two-year period, but access to job benefits has little impact on women's distress. Although most policies do not provide additional benefits for employed caregivers than for other workers, unpaid family leave does increase their employment retention.

Keywords: *caregiving; workplace policies; women and work; work and family*

The dramatic rise in women's labor-force participation over the past half century has been well documented, and the implications of this demographic shift for families and workplaces have been debated by researchers, policy makers, and the lay public. Much of the focus of this transformation

Authors' Note: This research is supported by grant R01-AG11564 from the National Institute on Aging (Eliza K. Pavalko, principal investigator). A prior version of this article was presented at the conference "Changing Demographics: Stagnant Policies" at Syracuse University, and we thank Madonna Harrington Meyer for organizing the conference and the conference participants and anonymous reviewers for their comments. Correspondence regarding this article should be addressed to Eliza K. Pavalko, Indiana University, Department of Sociology, 744 Ballantine Hall, Bloomington, IN 47405; e-mail: epavalko@indiana.edu.

has been on the implications for the care of young children as working men and women struggle to manage family demands while workplaces are structured around the assumption that all workers have a source of unpaid labor to care for their families. However, a second demographic trend, the aging of the workforce, suggests that employers and workers will face new challenges as more recent cohorts of workers age. As workers move through the life course, so do the families in which they are embedded. For most workers, this means that the demands of caring for young children will subside, but responsibility for the care of ill or disabled parents or spouses will increase.

Recent national studies have estimated that at any point in time, roughly one in five adults between the ages of 35 and 64 is providing care to an ill or disabled family member either inside or outside the home (Marks 1996) and that as the population ages, demand for informal care is likely to grow. Although the percentage of U.S. adults providing care at any given time is relatively small compared with those caring for young children, adults, especially women, are more likely than not to provide care to ill or disabled family members one or more times during their adult life courses (Marks 1998; Robison, Moen, and Dempster-McCain 1995). Furthermore, there is strong evidence that the work of caring for an ill or disabled family member has a substantial impact on health and well-being. For example, caregivers consistently have higher rates of depression than noncaregivers, although there is some question of whether this effect is due to the care work itself or the impact of having an ill or disabled family member (Amirkhanyan and Wolf 2003). The effect of care work on physical health is less conclusive, but several studies have found that caregivers have more disease symptoms, physical limitations, and chronic conditions and poorer immune function (Pavalko and Woodbury 2000; Scharlach 1994; Schulz, O'Brien, Bookwala, and Fleissner 1995).

Although cases of adults "sandwiched" between the demands of caring for very young children and elderly parents are less common (Brody 1981; Spitze and Logan 1990), the challenge of balancing demands of care work with other roles remains significant (Aneshensel, Pearlin, Mullan, Zarit, and Whitlatch 1995; Franks and Stephens 1992; Scharlach 1994). Recent studies have estimated that 52% of caregivers are employed full-time and another 12% are employed part-time (Fredriksen and Scharlach 1999; National Alliance for Caregiving and American Association of Retired Persons 1997). Likewise, a review of studies conducted in the 1980s estimated that 7% to 12% of employees have elder-care responsibilities (Gorey, Rice, and Brice 1992). Care work remains strongly gendered, in both the amount and the type of care (Fredriksen 1996; Marks 1998).

The reality of workers who must combine care work and employment has led to two concerns. The first is whether combining paid employment and care work creates even greater strains on individuals than either of these roles on their own. Recent research has indicated that negative health effects of care work are generally reduced by other roles and that employment appears to be particularly beneficial for moderating the demands associated with care work (Hong and Seltzer 1995; Martire, Stephens, and Atienza 1997; Pavalko and Woodbury 2000). However, the demands of care work for ill or disabled family members remain substantial, and these demands may affect individuals, their families, and their workplaces (Scharlach 1994; Stephens, Franks, and Atienza 1997). We know relatively little about whether workplace policies ease this burden, and to date, what we do know has been based on small, nonrepresentative samples or employees from a single workplace.

The second concern is whether workers, when faced with care work for ill or disabled family members, are more likely to leave the labor force or reduce their hours of employment. In an earlier study of midlife women in the 1980s, we found that whether women were employed had little influence on whether they subsequently assumed the responsibilities of care work (Pavalko and Artis 1997) but that the initiation of care work did increase the likelihood of reducing employment or leaving the labor force (see also Dentinger and Clarkberg 2002; Ettner 1996). In addition to the obvious short-term effects of leaving the labor force for family income, these exits have significant long-term effects on primary insurance amounts, which serve as the basis for determining Social Security benefits in later life (Harrington Meyer and Bellas 1995; Kingson and O'Grady-LeShane 1993). Labor-force exits are also a concern for employers because of the loss of valuable midlife workers.

Although studies of earlier cohorts of women have suggested that care work does put women at greater risk for reducing hours or leaving the labor force, it is not clear whether this trend will continue for more recent birth cohorts of women. More recent cohorts represent women who were pioneers in remaining in the labor force while raising young children, and as they move through midlife, they may continue this trend when they take on other forms of care work. Furthermore, although it is often assumed that workplace policies such as flexible hours and family leave provide one solution to the challenges of combining care work and employment, relatively few studies have specifically examined the impact of these policies on the employment behaviors and well-being of those doing care work.

Workplace Polices: What Do We Know and What Do We Need to Find Out?

Attention to the impact of workplace family policies, particularly family leave, has increased in recent years (e.g, Baum 2003; Kossek and Ozeki 1999; Ruhm 1998, forthcoming; Schaie and Schooler 1998). Many of these studies have shown that policies such as family leave, flextime, and child care assistance are associated with better labor-market outcomes, work commitment, and other employment outcomes (Baum 2003; Kossek and Ozeki 1999; Ruhm 1998, forthcoming). However, most prior research has methodological limitations that constrain the ability to draw conclusions about the impact of these policies (for reviews, see Kossek 2005; Kossek and Ozeki 1999; Ruhm 2005). Many studies have compared outcomes for users and nonusers of policies, but users may differ from nonusers in systematic ways. Research focusing on the impact of access to benefits has addressed this concern but may have failed to account for the selection of workers who need benefits into "good" jobs (but see Baum 2003; Ruhm 1998; Waldfogel 1999). Research on benefits is also frequently limited to a single firm or a small number of firms, is based on aggregate state or national data, or is cross-sectional (Kossek and Ozeki 1999). Our use of a national longitudinal study of employed women, to consider access to various policies before care work, and to examine subsequent labor market outcomes thus address important gaps in the existing literature.

Another limitation is that prior work has focused on policies related to the care of young children, with relatively little attention to workers managing the care of ill or disabled family members (but see Scharlach 1994). Unlike the care of children, which follows a fairly predictable time schedule (i.e., heaviest during infancy and the preschool period, with reductions when children enter the formal schooling period), care for ill or disabled spouses or parents is unpredictable and may take place over a short or long period of time. The need for care may be sporadic or sustained; it may involve daily contact and personal care, or it may involve the long-distance management of health care and other support. And, unlike caring for children, in many cases of care for those who are ill, the amount and intensity of care work increase over the course of the care episode.

The variation and unpredictable nature of the care experience makes it especially difficult to identify specific policies that are most likely to help workers manage care work and remain in the labor force, but it is often assumed that policies that allow flexibility in work schedules or opportunities to take time out to provide care while remaining employed will be

effective. Considerable attention has been given to the impact of unpaid family leave after the passage of the Family and Medical Leave Act, which assures workers that they can return to their jobs after a leave of up to 12 weeks to care for family members with serious health conditions. Although the act ensures that this option is available to large numbers of workers, the impact of this policy may be limited because it ensures only unpaid leave and applies only to workers in larger establishments. The availability of paid sick or vacation time, although limited, may provide an even more valuable resource for workers trying to balance care work and employment.

Access to flexible work schedules is also often assumed to be helpful for workers managing the demands of work and family care. Prior research suggests that workers with access to flexible scheduling have reduced absenteeism and turnover (Kossek and Ozeki 1999), and these policies have been cited as useful by employed caregivers (Scharlach 1994). However, to our knowledge, no studies have examined whether caregivers who have access to these policies are more likely to remain in the labor force or maintain higher levels of well-being. Understanding the impact of flexible hours is further complicated by widely varying definitions of this policy. Data from the 1997 Current Population Surveys suggest that 27% of workers report that they can make changes in the times they begin or end work, but this greater access to flexibility coincides with an increase in unpredictable work hours and hours worked per week (Golden 2001). A more limited definition of a "flexible workplace" in the 2000 National Compensation Survey estimated that only 5% of private industry workers have access to flexible workplaces as a specific employee benefit (Bureau of Labor Statistics 2002).

In this article, we examine the effects of care work on the employment and well-being of employed midlife women and explore whether workplace policies that provide some form of flexibility for care work, such as unpaid leave, paid sick or vacation days, or flexible hours, alter these effects. We used data from the 1995 to 2001 waves of the National Longitudinal Survey of Young Women (NLSYW) to address the following questions. First, what percentage of employed women started care work over a two-year period, and what percentage of employed women had access to workplace policies such as flexible hours, paid sick and vacation days, and unpaid family leave? Second, among more recent cohorts of midlife women who were employed at a given time point, were those who subsequently started care work more likely to leave the labor force, reduce hours of employment, or become more distressed than those who did not start care work? Third, were women working in jobs that provided access to "family-friendly" policies less likely to leave the labor force, reduce

hours, or become distressed? Finally, for employed women who did start care work, did the presence of those benefits reduce the likelihood of stopping work or diminish the reduction in hours of employment, and did those benefits reduce the impact on their psychological distress?

Data and Methods

Data from the 1995 to 2001 waves of the NLSYW were used to examine the relationship between employment, workplace policies, and care work. The NLSYW is a nationally representative sample of U.S. women who were 14 to 24 years of age in 1968 (U.S. Department of Labor 1999). Since the initial survey in 1968, 21 follow-up surveys have been conducted in 1- to 2-year intervals. We used the 4 most recent available survey waves, which include the 1995, 1997, 1999, and 2001 follow-ups. In 1995, 59.7% of the original sample remained in the survey, and the women were between 41 and 52 years of age. Although Black women were slightly more likely to have left the sample by 1995, detailed comparisons between the NLSYW and nonimmigrants in the Current Population Survey in 1995 concluded that the NLSYW remained highly comparable with the Current Population Survey (Zagorsky and Rhoton 1999).

Our analyses focused on the effects of starting care work in a two-year interval on employment and psychological distress at the end of that interval. On average, in any two-year period, approximately 6% of employed women started care work. To increase our power to disentangle the effects of workplace benefits for women who started care work, we pooled the 1995-1997, 1997-1999, and 1999-2001 intervals. Our primary interest was in the effects of workplace policies on the implications of care work for women, and we thus limited our sample to women who were employed and not doing care work at the start of each interval. A woman who was employed in 1995 and started doing care work in 1996 and continued until 1998 would be included in the 1995-1997 sample but would be excluded from the 1997-1999 sample because she was already doing care work at the beginning of that interval. If she was still employed and had not resumed care work in 1999, she would also be included in the 1999-2001 sample. Thus, we could have up to three observations per woman. After the loss of cases from missing data on independent variables, we were left with a total of 2,021 women who produced 4,185 observations. We deleted these cases rather than use a mean imputation because deletion has been found to produce the least biased estimates of parameters and standard errors (Allison 2002).

Pooling the sample violates assumptions that cases are independent of one another, and our models thus corrected for clustering among cases.

Our analyses included three outcomes. Employment status assessed whether employed women who started care work were less likely than noncaregivers to still be employed at the end of the two-year interval. The second outcome was usual hours worked per week. These models controlled for hours worked at the start of the time period, thus providing an estimate of the average change in hours. We restricted these models to women who remained in the labor force to allow us to focus specifically on changes in hours and to provide a contrast to the previous models estimating labor-force exits. Because of this restriction, the sample size for these models was smaller. The final dependent variable was psychological distress, measured by a subset of seven items from the Center for Epidemiologic Studies Depression Scale. Higher values on this scale indicate greater levels of distress. These models also controlled for psychological distress at the start of the interval. Logistic regression was used to estimate models for employment status, and ordinary least squares regression was used to estimate usual hours worked and psychological distress. Stata 8.2 was used to estimate the models.

The key independent variable was whether women started providing care to ill or disabled family members and were still providing that care at the end of the interval. Women were defined as doing care work if they were caring for someone inside the home or if they were caring for someone outside the home for 6 or more hours per week.

The second set of theoretically important variables were measures of workplace benefits. A woman's main job at the beginning of each interval was identified, and the availability of benefits at that job was assessed. Benefits that provided flexibility to meet care needs were of particular interest, and we thus focused on whether a woman reported having access to the following benefits: flexible hours, unpaid family leave, and paid sick or vacation days. Whether health insurance was available was also included to provide a comparison with policies that did not necessarily provide flexibility but may be critically important to caregivers. Controlling for access to health insurance also provided a control for unmeasured characteristics of "good" jobs, thus allowing us to assess any influence of benefits providing flexibility over and above access to other types of benefits.

Finally, our models controlled for occupational and demographic characteristics at the beginning of the interval. These controls included occupation, job sector, job tenure, logged income, marital status, the number of dependents in the household, and race.

Results

In each time period, between 6% and 7% of employed women started caring for ill or disabled family members. Of the 2,021 employed women included in our sample, 13% had at least one spell of care work in the six-year period (analyses not shown). Thus, although the percentage of employed women who started care work in any two-year period was relatively small, the likelihood of doing care work at some point in the six-year period was substantially larger.

Descriptive analyses in Table 1 also provide comparative estimates of the percentage of women who had access to various benefits in their jobs. On average, 71% of the sample reported access to unpaid family leave, and 79% reported access to health insurance. Nearly three quarters of the pooled sample reported having six days or more of paid vacation or sick leave, whereas 19% reported that they did not have any paid vacation or sick leave. Thirty-seven percent of the pooled sample reported access to flexible hours as a job benefit. Our estimates of workers covered by family leave and flexible hours were slightly higher than estimates of coverage in national samples (Golden 2001; Ruhm 1997), which may reflect the fairly high proportion of women in white-collar occupations.

Model 1 for each of the three outcomes in Table 2 confirmed that, as with earlier cohorts (Pavalko and Artis 1997), women who started care work were more likely to stop employment and have greater increases in psychological distress than women who did not start care work. For example, after controlling for demographic and workplace characteristics, we estimated that a woman's likelihood of remaining in the labor force was reduced by 50%. However, estimates of change in hours showed that among women who remained employed, caregivers were not more likely to reduce their hours than noncaregivers. This suggests that if caregivers make employment changes when doing care work, they typically exit the labor force completely rather than reducing hours. Finally, consistent with prior studies, women who started care work had significantly greater increases in psychological distress than women who did not start care work.

Interestingly, these models also point to the influence of several types of job benefits on women's attachment to employment. Controlling for other job characteristics, women who reported access to flexible hours had 50% greater odds of still being employed two years later than those who did not have access to this benefit. Women with at least six days of paid sick or vacation leave were also marginally more likely to remain employed

Table 1
Descriptive Statistics on Employment and Care Work: National Longitudinal Survey of Young Women, 1995 to 2001 Waves

Variable	1995-1997	1997-1999	1999-2001	Pooled Sample
Dependent variables				
In labor force at time 2[a]	0.92	0.90	0.89	0.91
Hours worked at time 1[b]	32.83	39.08	38.51	36.48
Hours worked at time 2[a]	36.37	35.53	34.67	35.53
Distress at time 1[b]	9.34	9.61	9.67	9.53
Distress at time 2[a]	9.80	9.68	9.92	9.80
Care work at time 2[a]	0.06	0.07	0.06	0.06
Control variables				
White	0.73	0.75	0.75	0.76
Married	0.64	0.63	0.63	0.65
Number of children	0.80	0.65	0.49	0.66
Education	13.61	13.65	13.54	13.62
Occupation				
Professional	0.39	0.42	0.41	0.41
Technical	0.39	0.36	0.37	0.37
Service	0.11	0.11	0.10	0.11
Manual	0.11	0.11	0.11	0.11
Class of worker				
Government	0.31	0.29	0.30	0.30
Private	0.56	0.58	0.58	0.57
Nonprofit	0.12	0.13	0.12	0.12
Self-employed	0.01	0.01	0.00	0.01
Wages (logged)	7.01	7.21	7.16	7.06
Employer tenure	0.76	0.86	0.77	0.80
Firm size	5,696.86	3,778.18	2,218.73	4,037.81
Workplace benefits				
Health insurance	0.80	0.82	0.79	0.79
Flexible hours	0.34	0.39	0.40	0.37
Family leave	0.72	0.74	0.70	0.71
Sick and vacation time				
None	0.18	0.17	0.19	0.19
One to five days	0.10	0.10	0.09	0.10
Six or more days	0.72	0.72	0.72	0.72
n	1,601	1,351	1,406	4,185

a. The sample size for the pooled sample was 4,064 for these variables.
b. The sample size for the pooled sample was 3,571 for these variables.

Table 2
Logistic and Ordinary Least Squares Regressions of Workplace Policies and Care Work on Labor Force Behavior and Distress

	Odds of Staying in the Labor Force		Change in Hours		Change in Distress	
Variable	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
Care work	0.50***	0.49*	–0.98	–1.40	0.94***	1.04
Control variables						
Hours at time 1	—	—	0.24***	0.24***	—	—
Distress at time 1	—	—	—	—	0.44***	0.44***
White	1.15	1.14	0.49	–0.50	0.06	0.07
Married	0.72**	0.72**	–1.33***	–1.33***	0.06	0.07
Number of children	1.07	1.07	0.04	0.04	–0.04	–0.04
Education	0.94*	0.94*	0.23***	0.23***	–0.07*	–0.07**
Occupation[a]						
Professional	0.139*	1.37	1.34***	1.34***	0.11	0.11
Service	0.92	0.92	–0.81*	–0.80	0.20	0.20
Manual	0.87	0.88	0.89*	0.89	0.42	0.40
Class of worker[b]						
Government	0.93	0.93	–0.68	–0.69*	–0.08	–0.08
Nonprofit	1.16	1.16	–2.13***	–2.14***	–0.17	–0.18
Self-employed	0.71	0.72	–1.54	–1.48	0.14	0.20
Wages (logged)	1.16	1.17	–0.42	–0.43	–0.32**	–0.32**
Employer Tenure	1.46**	1.46**	–0.00	–0.02	–0.32*	–0.32**
Firm Size × 10,000	0.03	1.00	–0.11	–0.11	0.01	0.01
Workplace benefits						
Health insurance	0.76	0.77	2.33***	2.32***	0.19	0.34
Flexible hours	1.50***	1.56***	–0.49	–0.43	0.03	0.05
Family leave	1.14	0.99	1.41**	1.38**	0.10	0.07
Sick and vacation time[c]						
One to five days	0.97	1.04	1.12	0.98	–0.38	–0.51
Six or more days	1.51	1.63	2.28**	2.28**	–0.24	–0.36
Interaction terms						
Health Insurance × Caregiving		0.95		0.22		–1.92
Flexible Hours × Caregiving		0.67		–1.04		–0.23
Family Leave × Caregiving		3.74**		0.87		–0.37

(continued)

Table 2
(continued)

Variable	Odds of Staying in the Labor Force		Change in Hours		Change in Distress	
	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
Sick and vacation time						
One to Five Days × Caregiving		0.58		2.99		1.92
Six or More Days × Caregiving		0.39		–0.35		1.47
Constant			26.98***	27.01***	8.84***	8.85***
Model fit	$\chi^2 = 83.93$	$\chi^2 = 16.88$	$R^2 = .26$	$R^2 = .26$	$R^2 = .19$	$R^2 = .19$
n	4,185	4,185	3,571	3,571	4,064	4,064

a. Technical occupation is the omitted category.
b. Private employer is the omitted category.
c. No paid time off is the omitted category.
*$p < .05$. **$p < .01$. ***$p < .001$.

($p = .08$). We found a slightly different pattern of benefit influences on changes in hours among women who remained in the labor force. Those with access to health insurance, unpaid family leave, and paid sick or vacation days in their jobs all had greater increases in hours than those who worked in jobs without these benefits. However, access to these benefits did not affect psychological distress. These findings are largely consistent with findings from prior studies based on smaller, firm-specific samples and cross-sectional data showing that access to work-family policies is associated with better labor market outcomes (Kossek and Ozeki 1999).

The second model for each outcome in Table 2 shows the interactions between workplace benefits and care work, allowing us to assess whether access to these benefits altered the labor-force behavior or psychological distress of those doing care work. We found that although there was an impact of these benefits for all workers, in most cases, they did not provide additional protection for women who took on the care of ill or disabled family members. For example, women who started care work and had flexible hours were no more likely to remain in the labor force and have similar changes in hours than caregivers who did not have flexible hours. The one exception to this pattern was, however, notable. Consistent with the work on the care of young children (Ruhm 1998), caregivers who had access to unpaid

family leave were more likely to remain employed than caregivers who did not have this benefit. However, among noncaregivers, access to family leave had no impact on the likelihood of remaining employed. Access to benefits also did not reduce the psychological distress of caregivers.

Conclusions

Two intersecting trends—increases in women's labor-force participation and the aging of the workforce—suggest that workers and employers will increasingly be faced with challenges stemming from the need for workers, both male and female, to manage the care of ill or disabled family members and their work lives. We find that in just a six-year window, 13% of our sample of employed women provided substantial levels of care for ill or disabled family members. In contrast to concerns that these intersecting trends would lead to a crisis of care (Brody, Kleban, Johnsen, Hoffman, and Schoonover 1987), even the most recent cohorts of employed women are still taking on this unpaid care work (see also Pavalko and Artis 1997).

The public "crisis of care" is not that no one is providing care but rather that this care is costly for those who provide it. We find that midlife women in the late 1990s continued to be at greater risk for leaving the labor force if they took on unpaid care work. In addition to the well-documented personal costs of providing care, there are significant short- and long-term public costs associated with this care. Care work increases labor turnover for employers, and the increases in psychological distress may reduce productivity among those who remain employed. Workers who leave the labor force to provide care lose immediate access to the income and benefits of their jobs, and throughout the life course, labor-force exits have a significant impact on the basis for Social Security benefits, thus increasing the risk of income insecurity in later life (Harrington Meyer 1996).

Given these potential costs of care work to both workers and employers, do workplace policies that provide flexibility make a difference? Our analyses suggest that these policies are good business, because workers who report that they have access to flexible hours, unpaid family leave, and paid sick or vacation days are more likely to remain in the labor force or maintain or increase their hours of employment. These effects are particularly notable because policies such as unpaid family leave are relatively low cost for employers, but they may have a substantial pay-off if they help retain employees. Although none of these policies directly reduces the effects of care work on psychological distress, there is some evidence that they could

have an indirect benefit for well-being if they allow women to remain in the labor force while providing care.

However, our findings also suggest that these policies may be most effective if they made are available to all employees rather than targeted to specific groups of workers. Although we found that caregivers who had unpaid family leave were more likely to remain employed, other policies, such as flexible hours and paid sick or vacation time, do not provide any greater benefits for caregivers than they do for all workers. It is possible that even when there is formal access to these policies, informal work cultures may discourage their use, thus weakening their impact. However, our findings are consistent with those assessing policies for new parents (Kossek and Ozeki 1999; Ruhm 1997), suggesting that the most effective policies may be those that apply to workers in all age groups.

Although the NLSYW data provide a rare opportunity to study changes in employment and care work over time, these data are limited in several important respects. We were unable to compare gender differences in the effects of care work on employment or the influences of workplace policies on employment behaviors. Men's care work is increasing, and we suspect that their strategies for combining paid employment and unpaid care work differ from those used by women. Second, although the NLSYW is based on a national sample of women, sample attrition has reduced the representativeness of this sample. Although these data are still an improvement over the select samples of caregivers or workers used in many prior studies, we cannot consider the data to be representative of all U.S. women, even in these age cohorts.

It is also important to note that our analyses focused on whether women had formal access to workplace policies, not whether they took advantage of these policies. Although attention to access avoids problems associated with the nonrandom selection of policy users, we had no information on how many of those with access actually took advantage of these policies, nor did we know whether informal cultures discouraged their use. If we assume that not all those with access took advantage of these policies, our estimates on the basis of access provide a conservative estimate of the impact of these policies. Finally, although the longitudinal design allowed us to examine the onset of care work and employment changes over a two-year period, we were unable to pinpoint the exact sequence of those transitions, and it is possible that for some women, employment change may have occurred first.

Despite these limitations, this study contributes to a growing body of research on work-family policies. Although we often point to family-friendly policies as a solution to the competing demands of care work and employment, we cannot assume that all policies provide a magic bullet to solve these

complex problems. As this article suggests, some policies may have more of an effect than others, and at least among the very general policies examined here, we found little evidence that these policies provided caregivers with additional benefits over and above those seen for all workers. One possibility is that the policies considered in this article are too basic to be of special benefit to caregivers, and we hope that future research will assess whether more extensive policies or attention to the informal workplace culture might yield greater benefits for caregivers. It is also possible that the relatively young ages of women in this sample mean that the likely care recipients were themselves still relatively young and may have had less demanding care needs. It is possible that the impact of these policies may shift as the women and their care recipients age.

Finally, our attention to midlife workers and our finding that employment outcomes for workers are affected by policies such as flexible hours and family leave serve as a reminder that work-family challenges do not disappear as children grow older. Continued attention to older workers and policies that affect their labor force behavior are likely to become increasingly important as the labor force ages and the cohorts of men and women who forged new work-family patterns in early adulthood move through the life course.

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