The Health of Very Early Retirees

by Eric R. Kingson*

This study examines the health of a sample representative of 1.8 million men aged 45–59 in 1969 who permanently withdrew from the labor force before age 62 between 1966–1975. The analysis concentrates on comparing the health of men receiving Social Security disability benefits with that of men reporting work-limiting health conditions at labor force withdrawal but not receiving Social Security disability benefits. The data suggest that the health of these groups is more similar than dissimilar.

The major policy implication of the study is that consideration should be given to liberalizing the eligibility criteria for the Social Security and Supplemental Security Income (SSI) disability programs as they apply to older workers.

Men who leave work before age 62 are a special group of early retirees. Their uniqueness arises from the fact that they are not eligible for early entitlement benefits under Old Age and Survivors Insurance (OASI) at the time of their labor force departure. Consequently, their labor force exit is less likely to be influenced by the availability of OASI than older groups, and many are likely to experience major income losses.

It is well known that health problems are one of the major precipitating factors of early labor force withdrawal (Andrisani, 1977; Bixby, 1976; Parnes and Meyers, 1972; Parnes and Nestel, 1977; Reno, 1971; Schwab, 1976; Sheppard, 1977). For example, Schwab's analysis of the Retirement History Study data (U.S. Department of Health, Education and Welfare, 1977) found that 65 percent of the men aged 58 to 63 who were out of the labor force in 1969 cited health as their main reason for withdrawal. Subsequent analysis by Bixby of the data when these men were 62–65 found that nonemployment in 1973 of men who worked in 1969 "was influenced much more by self-assessment of health-related work limitations than any of the other seven factors" employed in the analysis.

It should be noted that other factors, most notably expected retirement income, influence early labor force withdrawal behavior.

This paper examines the health of men who leave

Health and Early Retirement: Two Views

The influence of health on a worker's decision to withdraw from the labor force is a subject of continuing research. In this issue of the **Bulletin**, two members of the staff of the National Commission on Social Security Reform examine the extent to which ill health prompts workers to leave the labor force.

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—Editor.

*Dr. Kingson is an Assistant Professor of Social Policy at the School of Social Work and Community Planning, University of Maryland at Baltimore. He is currently on leave to serve as an advisor to the National Commission on Social Security Reform. The findings presented in this article are based on research funded by the Department of Labor. The article draws on information presented in the health findings chapter of a monograph entitled **The Early Retirement Myth: Why Men Retire Before Age 62**, published by the House Select Committee on Aging in October 1981. The author wishes to express his appreciation to Professor James H. Schulz of the Florence Heller School at Brandeis University for his advice and assistance during the course of the research.

work before age 62—very early retirees (VERs). The term "very early retirees" includes persons certified as disabled before age 62. In fact, much of the analysis involves a comparison between the health of persons certified disabled by the Social Security Disability Insurance Program to those with work-limiting health problems at labor force withdrawal but not receiving Social Security disability benefits. This analysis leads to the conclusion that significant social inequities may exist as a result of the differential treatment of these two groups in terms of eligibility to the Disability Insurance Program.

Another aspect of the analysis concerns an investigation of an interaction between health and retirement income. Previous analysis (Quinn, 1978) finds an interesting interaction between health and retirement finances for white married men, finding that men in poor health are more likely to take advantage of pension incentives to retire early. This analysis explores a slightly different interaction that suggests health limitations reported at withdrawal may be more severe for men expecting to receive smaller pensions than for those expecting larger incomes.

National Survey Data Used

The data used have been collected as part of the National Longitudinal Survey (NLS) of labor market experience of men. The data consist of the responses of men aged 45-59 in 1966 to personal, mail and telephone interviews in 1966, 1967, 1968, 1969, 1971, 1973 and 1975. The cohort of men aged 45 to 59 in 1966 is represented by a national probability sample of 5,020 men. The sample is representative of approximately 15 million noninstitutionalized men aged 45-59 in 1966. Black men have been oversampled to allow for more accurate comparisons between blacks and whites.

The findings reported in this article are based on four subsamples created from the NLS data. Two subsamples represent white (n = 222) and black (n = 115) men aged 53-59 in 1966 and permanently out of the labor force before age 62. If alive, the members of these subsamples would have been at least 62 by 1975. Two other subsamples represent white (n = 183) and black (n = 125) men aged 45-52 in 1966 and permanently out of the labor force before age 62. If alive, the members of these groups would *not* be 62 in 1975.

Combined, these four subsamples represent all noninstitutionalized men between the ages of 45 and 59 in 1966 who had permanently withdrawn from the labor force before age 62 during the nine-year period in which the data were collected, 1966-1975. Though the distinction between black and white very early withdrawees is maintained, the distinction between younger and older VERs is ignored in the following analysis.

Assignment of cases to the subsamples is based on similar criteria: "Race"; "Age at Beginning of Survey"; "Permanent Withdrawal Status," and "Age at Permanent Withdrawal." The definition of "Permanent Withdrawal" is based on being out of the labor force for at least two consecutive surveys as of 1975.*

By using conservative definitions of "Permanent Labor Force Withdrawal," only men who are highly unlikely to return to work have been selected. Another advantage of this method of creating subsamples is that even though someone may have been over 62 or deceased during the 1975 survey, he was included in a subsample if he met the appropriate criteria. This approach maximizes sample sizes and allows for analysis of mortality rates. It also develops subsamples that approximate the men aged 45-59 in 1966 who left the labor force before age 62 between 1966-1975.

Three Groups of VERs Compared

The present analysis involves comparisons between groups of very early retirees in terms of their health. Accordingly, very early retirees have been disaggregated into three groups: 1) those who receive Social Security disability benefits—the Disabled group; 2) those reporting work-limiting health conditions at withdrawal but not receiving Social Security disability benefits—the Unhealthy group, and 3) those who do not report work-limiting health conditions at withdrawal—the Healthy group. Most of the findings reported here involve comparisons between the Disabled and Unhealthy groups.

Occasionally, it is necessary to base the comparisons on different subsamples of very early retirees. For example, much of the analysis involves comparisons between VERs defined as leaving work between 1966-1973. However, at some points we are only concerned with men who leave work in 1967 or later. The

*Two criterion variables were used to develop a definition of permanent labor force withdrawal. The major one was a question that was repeated in 1966, 1967, 1968, 1969, 1971, 1973 and 1975—"What were you doing during most of last week—working, looking for work or something else?" Two of the categories used for coding purposes were "retired" and "unable to work." The other criterion variable was "Reason for Non-interview." This question was repeated in 1967, 1968, 1969, 1971, 1973 and 1975. The reasons given for not interviewing a member of the NLS sample were: "deceased"; "institutionalized"; "refused," and "unable to locate or contact."

All permanent labor force withdrawees were out of the labor force for at least two consecutive surveys as of 1975. At the beginning of the consecutive surveys, they indicated they left the labor force due to "retirement" or being "unable to work." After the first year of permanent withdrawal, being out of the labor force was defined as being either "retired," "unable to work," "deceased" or "institutionalized."

One exception was allowed. Men were also included in the subsample if they met the following rules: They had to be out of the labor force for at least three consecutive surveys as of 1975. At the beginning of the consecutive survey periods, they indicated for at least two periods in a row that they were out of the labor force due to "retirement" or being "unable to work." After the first two survey periods of permanent withdrawal, being out of the labor force was defined as either "retired," "unable to work," "unable to locate or contact," "refused," "institutionalized" or "deceased."

reasons for changing the subsampling structure are presented at the appropriate point in the description of the findings.

Table 1 gives a breakdown of the three types of VERs. It shows that 85 percent of white and 91 percent of black very early withdrawees have either reported that health prevents or limits their work and/or have medically certified disabilities that have enabled them to receive Social Security disability benefits.

Considering the conservative definition of "permanent labor force withdrawal," the subsamples are quite large. They represent about 12 percent (1.8 million) of the 15,020,000 noninstitutionalized men who were aged 45-59 in 1966.

Findings Have Policy Implications

Determining the distribution of health problems among VERs has important policy implications. For example, if we find that the health of the Disabled group is much worse than that of the Unhealthy group, we would be forced to conclude that there is very little reason to "liberalize" eligibility requirements for Disability Insurance to meet the needs of Unhealthy VERs.

Mortality rates provide a direct means of illustrating the effect of health problems. One would expect high death rates to be associated with health conditions that limit the ability to work. In terms of VERs, the expectation is that the mortality rates of the Disabled and Unhealthy groups should be high if their work-limiting conditions are legitimate.

A very large proportion of Disabled and Unhealthy VERs is dead by 1975 (see Table 2). Even more notable is the finding that the incidence of death is greater among Unhealthy in contrast to Disabled VERs. It would seem the reported health problems of the Unhealthy group are quite real.

What explains this surprising finding? The simplest explanation may be that many VERs die while in the process of applying for disability benefits or before they get a chance to apply. This notion is supported by the data showing three times as many Unhealthy as opposed to Disabled VERs die within two years of being recorded by our study as permanent labor force withdrawees. An unintended outcome of the administrative process associated with disability insurance claims may be to deny needed income to a few unhealthy VERs in the final months of their lives.

Table 1 THREE TYPES [a] OF VERY EARLY RETIREES (VERs)

	Disabled VERs	*Unhealthy VERs*	*Healthy VERs*
White (n = 397)	51%	34%	15%
Black (n = 234)	55%	36%	9%

[a] "Disabled" very early retirees receive Social Security disability insurance benefits. "Unhealthy" VERs report at labor force withdrawal that health limits their work but do not receive Social Security disability insurance benefits. "Healthy" VERs do not report health limitations on work at labor force withdrawal.

Table 2 MORTALITY RATES FOR THREE TYPES [a] OF VERs

	Disabled VERs	*Unhealthy VERs*	*Healthy VERs*
Percent Deceased by 1975			
White*	33% (n = 191)	42% (n = 129)	15% (n = 59)
Black	37% (n = 123)	52% (n = 82)	48% (n = 21)
Percent Deceased Within Two Years of Permanent Labor Force Withdrawal [b]			
White	7% (n = 191)	26% (n = 129)	10% (n = 59)
Black	11% (n = 123)	28% (n = 82)	29% (n = 21)

* Significant at ALPHA = .01

[a] See footnote a in Table 1.

[b] This section of the table presents the proportion of men who died within two years of the survey year in which they are recorded as permanently withdrawing from the labor force.

There are other plausible explanations. Disability insurance recipients are eligible for Medicare benefits, and they are assured of a steady stream of income. It is possible that the health and income benefits connected to receipt of disability insurance translate into fewer deaths than would otherwise be the case. Another explanation may be that people who are adept at successfully negotiating the disability claims process are also adept at negotiating the medical system to receive life-sustaining services. Finally, psychological benefit may also be derived from being officially declared disabled and, therefore, unable to work. The psychological effect of validating illness may have positive physical effects, leading to reduced death rates among persons with health limitations. *In any event, the reported findings make it crystal clear that the Unhealthy group of VERs is not composed of malingerers.*

Blacks' Mortality Rate Is High

Another finding is that one-half (48 percent) of the Healthy black very early retirees are dead by 1975. It is possible that this finding is an artifact of a small subsample (n = 21). However, despite the small sample size, it is highly unlikely that random error can explain the fact that 10 out of 21 Healthy blacks as opposed to nine out of 59 Healthy whites died by 1975. Another explanation could be that black men aged 45-65 have somewhat shorter life expectancies than similarly aged white men. But the differences in mortality rates between Healthy white and black VERs are too great to accept this as an explanation.

The most interesting notion is that the high rate of death among Healthy black VERs is related to lack of income and medical care opportunities. Unlike the Disa-

bled black VERs, Healthy black VERs do not have access to Medicare benefits; they therefore may be less likely to receive hospital care should the need arise. Also, disability recipients are assured a steady stream of income, whereas many Healthy black VERs are not. Unlike Healthy white VERs, other study findings show that the aggregate income position of the Healthy black group is quite small (Kingson, 1981). In addition, among Healthy black VERs there is a high correlation (r = .53) between life status in 1975 and retirement income at an earlier date, suggesting the likelihood that being alive in 1975 among Healthy black VERs is positively associated with retirement income. (Though this finding is significant at the .05 level, it should not be over-emphasized since it is based on a sample of 11 and, therefore, is likely to be unstable.)

Functional Health Limitations of Surviving VERs

Table 2 shows that a large proportion of Disabled and Unhealthy VERs die by 1975. It also suggests that, as a group, Unhealthy VERs may actually be "sicker" (defined in terms of propensity to die) than Disabled VERs. But what can be said about the relative health of those Disabled and Unhealthy VERs who are alive in 1975? Table 3 presents data on the health of Disabled and Unhealthy VERs who live until 1975. The Table 3 sample consists of men who meet the following three conditions: 1) permanently withdrawn from the labor force by 1971; 2) report a health problem at withdrawal, and 3) are alive in 1975.

The findings show *no significant difference in the degree of functional limitation between Disabled and Unhealthy VERs* who have withdrawn from the labor force in 1971 or earlier and survive until 1975. However, there is a comparatively high rate of functional dependence and a low rate of minor loss among Disabled whites. Though not statistically significant, the findings hint that health limitations among Disabled white VERs may, in fact, be more severe than those among Unhealthy whites.

Table 3 DEGREE OF FUNCTIONAL LIMITATION [a] IN 1971 FOR DISABLED AND UNHEALTHY VERs [b] WHO REPORT WORK-LIMITING HEALTH CONDITIONS IN 1971 [c, d]

Degree of Functional Limitation	WHITE Disabled VERs n = 83	WHITE Unhealthy VERs n = 49	BLACK Disabled VERs n = 51	BLACK Unhealthy VERs n = 25
Functionally Dependent	34%	16%	29%	32%
Severe Loss	27%	27%	31%	20%
Moderate to Severe Loss	18%	27%	16%	24%
Moderate Loss	7%	6%	6%	8%
Minor Loss	11%	22%	16%	16%
No Loss	4%	2%	2%	0%

[a] The Functional Limitation Index is constructed from detailed questions concerning physical limitations and their effect on the ability to work.
[b] See footnote a in Table 1.
[c] The men included in the sample have withdrawn from the labor force in 1971 or earlier.
[d] The findings reported in this table show that no significant difference (ALPHA = .05) exists between Disabled and Unhealthy VERs in terms of functional limitation.

Onset of Health Problems Examined

Are the work-limiting health problems of Unhealthy VERs of long duration, or do they occur quite suddenly? Examination of the question facilitates speculation about whether health problems associated with very early withdrawal are unexpected obstacles to continued work and whether the problems have limited the ability of Unhealthy VERs to earn income throughout a major portion of their work lives.

The findings presented in Table 4 show that the Disabled and Unhealthy groups of VERs are heterogeneous in terms of the duration of health problems. Many experience sudden onset of health problems that seem likely to quickly limit their ability to work and probably result in rapid labor force withdrawal. Still others work for many years in spite of health problems. It is likely that the retirement of these men comes on more gradually.

Though not significant, the findings presented in Table 4 also suggested *the health limitations of men in the Unhealthy VER subsamples are of greater duration than the limitations of the Disabled.* Of course, we should not overlook the large proportions of all groups reporting in 1966 the onset of their health limitation to be within the previous five years. Among white VERs reporting work limitations in 1966, Table 4 shows that 52 percent of the Disabled VERs, in contrast to 40 percent of the Unhealthy ones, have experienced the limitations for less than six years. For blacks the contrast is still greater.

Table 4 DURATION, AS OF 1966, OF REPORTED HEALTH LIMITATIONS ON WORK IN 1966 BY ALL DISABLED AND UNHEALTHY VERs [a, b]

Number of Years Health Has Limited Ability to Work [d]	WHITE Disabled VERs n = 114	WHITE Unhealthy VERs [c] n = 88	BLACK Disabled VERs n = 92	BLACK Unhealthy VERs n = 58
Years				
1-2	20%	16%	21%	14%
3-5	32%	24%	35%	19%
6-10	27%	19%	21%	28%
11-15	7%	18%	10%	7%
16-20	4%	11%	9%	16%
21 +	10%	11%	4%	17%

[a] The subsample includes men who permanently withdraw from the labor force by 1973 and are classified as either Disabled or Unhealthy VERs.
[b] "Disabled VERs" refers to men who receive disability insurance benefits by 1973.
[c] See footnote a in Table 1.
[d] The findings presented are not significant at ALPHA = .05.

Work Limitations Precede Withdrawal

Prior to permanent labor force withdrawal, only two-fifths of the Unhealthy white and black VERs report in 1966 that health did not limit their ability to work (see Table 5). The statistics are virtually the same for black Disabled VERs. However, a significantly higher proportion (53 percent) of the white Disabled group reports health has no effect.

The finding suggests that most Disabled and Unhealthy VERs experience work limitations at least one year in advance of their permanent labor force withdrawal. More surprisingly, *it seems that among whites a significantly larger proportion of Unhealthy VERs as opposed to Disabled VERs experiences work limitations at least one year in advance of permanent labor force withdrawal.* This supports the notion that the Disabled are more likely to move quickly into a position of being unable to work, whereas it is more likely that the work abilities and opportunities of Unhealthy VERs decline over a longer period of time.

Interaction Between Health and Retirement Income

Now, let us turn attention to a slightly different analysis that does not distinguish among the three groups of VERs. The analysis involves a test of the following hypothesis:

> The health problems associated with VERs who report a work-limiting health condition at withdrawal are more severe for economically disadvantaged as opposed to advantaged withdrawees. This is also true when controlling for occupational status.

The hypothesis is based on the reasoning that men with minimal retirement income expectations will accept greater physical discomfort at work to maintain their flow of earnings than those with adequate retirement income expectations. It was expected an association would be found among men reporting work limitations at withdrawal, indicating a tendency for the health limitations of men with high retirement incomes to be less severe than those of men with low retirement incomes.

Table 5 REPORTED HEALTH LIMITATIONS ON WORK IN 1966 BY DISABLED AND UNHEALTHY VERs WHO WITHDREW FROM THE LABOR FORCE IN 1967 OR LATER [a]

Degree of Health Limitations on Work	*WHITE**		*BLACK*	
	Disabled VERs [b] *n = 135*	*Unhealthy VERs* [c] *n = 100*	*Disabled VERs* [b] *n = 79*	*Unhealthy VERs* *n = 58*
Prevents Work	6%	6%	6%	12%
Limits	42%	57%	54%	50%
No Effect	53%	37%	39%	38%

* Significant at ALPHA = .05.

[a] The subsample does not include VERs who were permanently withdrawn from the labor force during the 1966 survey.

[b] "Disabled VERs" refers to men who receive disability insurance benefits by 1973.

[c] See footnote a in Table 1.

The analysis sample consists of men who report work limitations in 1971. The health measure is the Functional Limitations Index. The income measure is the ratio of family retirement income in the survey after labor force withdrawal to the combined median income for American families and individuals in that year. Occupational status (Duncan Scale) on the withdrawee's longest job is used as a control.

The Functional Limitations Index is a six-point scale that for the purpose of analysis is assumed to be interval. Occupational status is used as a control because of known associations between occupational and health problems. It, too, is assumed to be interval. Though the U.S. Department of Labor (DOL) Occupational Classification would be preferable as a control, the sample size is too small to allow its use.

The findings are all significant at the .05 level. Among white men reporting health problems at withdrawal, there is a −.19 correlation between their relative income positions after retirement and the degree of functional limitations experienced in 1971. When controlling for occupational status on their longest jobs, the correlation remains significant but is reduced to −.16. Among similar black men, the correlations are −.25 without a control and −.24 when occupational status is used as a control.

The findings suggest the research hypothesis is true. Among white and black VERs reporting a work-limiting health condition at withdrawal, the findings show there is a negative and significant correlation at the .05 level between retirement income and degree of functional limitation in 1971. Among these men, high retirement incomes are associated with less severe health problems in 1971, and low retirement incomes are associated with more severe disabilities. The relationships remain significant when controlling for occupational status on the withdrawee's longest job.

This analysis implies that the health limitations reported at withdrawal tend to be more severe for VERs expecting to receive smaller retirement pensions than for those with higher income expectations.

There seems to be a trade-off between willingness to persevere at work despite health problems and expected retirement income. *It appears that men with low retirement income expectations are willing to endure greater physical discomfort to maintain earnings than men with greater retirement income expectations.*

The finding also has implications for the interpretation of retirement "decision" research. As previously discussed, we know that "health" is often reported in retirement decision research as a reason for labor force withdrawal. *This finding suggests that, even when controlling for occupational status, a "rich man's" re-*

ported work-limiting health problem has a tendency to be less severe than that of a "poor" man. If the suggested interaction between the degree of functional limitation and expected retirement income exists, then the confounding influence of this interaction needs to be recognized in retirement decision models.

Another interesting, complementary interpretation of the findings can be made. The association between the degree of functional limitation and retirement income can also be attributed to the probability that people with major disabilities are less likely to receive large retirement incomes than people with limited disabilities. In fact, both explanations are plausible, and they are not mutually exclusive. For men reporting work limitations at withdrawal, the amount of retirement incomes may be causally linked to the severity of their health problems, and willingness to endure physical discomfort may be causally linked to expectations concerning the amount of retirement income.

Groups' Differences Summarized

The foregoing analysis shows that the health of the Unhealthy group of VERs, when measured in terms of mortality rates and duration of work limitations, is slightly worse than that of the Disabled group. In terms of the degree of functional limitation, it seems the Disabled group may experience slightly more functional dependency. On balance, it would appear that the major difference between the two groups is that one receives Social Security disability benefits and the other does not. Comparisons between Healthy VERs and those defined as either Disabled or Unhealthy generally show significant differences between the health of the groups. The findings also support the research hypothesis that health problems associated with VERs who report work-limiting conditions at withdrawal are more severe for the economically disadvantaged than advantaged withdrawees.

More specifically, the analysis shows:

- A large proportion of Disabled and Unhealthy VERs is dead by 1975, suggesting that the health problems of these groups are quite real.
- As of 1975, the mortality rates of Unhealthy VERs (white—42 percent; black—52 percent) are higher than that of Disabled VERs (white—33 percent; black—37 percent).
- Surprisingly, half of the Healthy black men are dead by 1975. This is three times the rate for Healthy whites and approximately equal to the rate for Unhealthy blacks.
- Among VERs who withdrew from the labor force in 1971 or earlier and are alive in 1975, there is no significant difference in the degree of functional disability as of 1971 between Disabled and Unhealthy VERs. About 75 percent of both groups are rated in 1971 as experiencing moderately severe to total disabilities.
- As of 1966, the reported health limits of Unhealthy VERs are of greater duration than that of Disabled VERs. However, within both groups, there is considerable variation in terms of duration.
- Among Unhealthy and Disabled VERs who withdrew from the labor force between 1967–1973, about three-fifths reported in 1966 that health limited their ability to work.
- Among white and black VERs reporting a work-limiting health condition at withdrawal, high retirement incomes are associated with less severe health problems in 1971. This finding can be interpreted to indicate that men with low retirement income expectations are willing to endure greater physical discomfort to maintain earnings than are men with better retirement income outlooks.

Social equity—the treating of groups in similar circumstances in a similar manner—is a commonly agreed on goal of income maintenance policy. Comparisons between the Disabled and Unhealthy groups of VERs suggest gross violations of this principle may exist as it relates to eligibility in the Social Security disability program among men leaving work before age 62 and reporting work-limiting health problems.

Social Security Treatment Questioned

Based on several measurements of health, the findings suggest there may be insufficient differences in the health of the groups termed Disabled and Unhealthy to justify differential treatment under the Social Security disability program. Moreover, the high mortality rate of the Unhealthy group suggests it is not composed of malingerers and has a legitimate claim to disability benefits.

This inequity seems to be compounded by the actuarial reduction in benefit levels that many members of the Unhealthy group experience on early receipt of Social Security retirement benefits and the arithmetical reduction in benefits resulting from a shortened period of contribution into the system. So, not only is the Unhealthy group ineligible for Social Security disability benefits, but its OASI benefits are permanently reduced as well.

The major policy implication of the findings is that consideration should be given to changing the eligibility criteria for the Social Security and SSI disability programs in a manner that is more favorable to the interests of disabled and partially disabled VERs who currently do not receive disability insurance benefits. The ad-

vantage of liberalizing the criteria in the SSI disability program in addition to the Social Security program is that protection would be extended to a small, but very vulnerable, group of Unhealthy very early retirees who presumably are subject to the same inequity under SSI eligibility procedures.

The implications of the findings do not complement current efforts to curtail the expansion of the Disability Insurance Program. However, it should be pointed out that the data are supportive of recommendations by the 1979 Advisory Council on Social Security to liberalize eligibility criteria in the Social Security and SSI disability programs in recognition of the special problems confronting older workers with health problems.

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