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How the Law's Neglect of Caregiving across the Life Course Fuels Inequality

When Marcos began to decline, it was unexpected and unpredictable. The diagnosis of amyotrophic lateral sclerosis (ALS) came out of nowhere. The time course of ALS varies widely from one individual to the next. Marcos's wife, Valentina, was the primary caretaker, but she needed to keep working as she rapidly became the sole earner for the family. Marcos also knew that time for work and time for friendships would help Valentina get through what would be an excruciating period for her as well as for Marcos. The fact that Marcos's sister, Graciela, had a job that gave leave to care for sick siblings made a world of difference. As Marcos became increasingly dependent on others for every kind of care, from showering to dressing, his wife Valentina had few breaks. His sister's visits brought respite. For Graciela, it brought a chance to know she was there for her brother when he needed her and to relive and reshare parts of their lives that only the two siblings knew well. There was joy in being able to get Marcos outside in a wheelchair to the mountains and ocean that meant so much to him. And the days recounting childhood experiences and hearing the other's perspective were filled with both tears and laughter.

François knew he was lucky to live in a country that provided him paid leave to care for his parents when they grew sick. His father had just been diagnosed with pancreatic cancer. The prognosis was poor, and he was given only a few months to live. But nothing would replace the time that François had with his father. At first, it was long walks, and then it was long talks by a fireplace. They shared everything: stories from François's youth that he hadn't known, stories from his father's childhood and adulthood that he had never heard, and what it was like to live through the changes he was going through. The time they spent together not only was an expression of the depth of their love but led to a deepening of François's understanding of his whole family's history and his own story. This time with his father simultaneously made François intensely live the moment in which he found himself and changed his understanding of the future.

What distinguished the experiences of Graciela and François from those of many workers caring for ill or aging family members was neither the importance of the care they provided nor their desire to provide care and to continue to work, but rather their access to conditions that made doing both possible. Graciela's supportive workplace policies and François's paid leave coverage under national laws allowed each of them to both provide care that would change the life of their family member and continue to contribute successfully at work.

Governments are in the position to ensure that working conditions making it possible to economically succeed while giving family care are available to all—but too often, government leaders neglect care and rely on women to provide care without pay or for low wages. The consequences are deep for economic inequality. Moreover, when employers are allowed to discriminate against people for providing care (including by not hiring them or firing them), when laws and social policies do not support taking needed time to provide care while continuing to work, and when the absence of social supports places all the care burden on family members, women's economic outcomes suffer disproportionately, and women from marginalized groups are disadvantaged the most.

This chapter begins with the recognition that nearly every person needs care at some point if not multiple points in their life—and that most countries currently rely on the unpaid and largely invisible work of women to meet the bulk of those needs, with profound consequences for women's economic opportunities. This chapter goes on to examine how laws and social supports can shape our ability to care for each other and, in so doing, improve gender equality across the life course. Finally, this chapter looks at how supporting aging adults to continue to engage fully in their communities can not only improve economic outcomes but also improve their health, benefiting us all.

WHO CARES? WOMEN'S DISPROPORTIONATE ROLE IN UNPAID CARE WORK ACROSS THE LIFE COURSE

On average, women spend around four hours and twenty-five minutes on unpaid care work each day, three hours more daily than men.[1] While often invisible, care work is the backbone of economies. Global definitions of care work typically include directly caring for a person and providing help for them to meet basic needs.[2] Unlike other forms of work, however, a substantial share of care work is unpaid. In the aggregate, this work has tremendous economic value: if all unpaid care work were suddenly compensated at the hourly minimum wage, it would account for around 9 percent of global GDP, or over $7 trillion in 2021.[3]

Critically, care needs extend across the life course, and women continue to provide the majority of nurturing care at each stage, whether for elderly parents, spouses with disabilities, children with serious illnesses, family members recovering from an operation, or other ailing relatives. As prior chapters have explored,

women's disproportionate role in caregiving is not inevitable—people of all genders can and do play critical caregiving roles in their families and societies, and providing care is a profound source of meaning for many men as well as women. However, societal expectations, unequal or absent policies, and broader inequalities in the economy have made it more likely that women take on the majority of caregiving responsibilities worldwide, making gaps in support for care across the life course especially consequential for women.

The data bear this out: around the world, women comprise the majority of unpaid caregivers and support for family members with disabilities or serious illnesses and for aging relatives. An analysis of the World Health Organization Study on Global Ageing and Adult Health, a longitudinal survey of adults providing and receiving care across six countries, found that among households with a long-term sick adult, women were more likely to report being the primary caregiver in nearly all countries with data available, including 63 percent of female respondents in India, 66 percent in South Africa, 69 percent in Russia, and 75 percent in Mexico.[4] Across Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama, women comprised 71 percent of people who reported having caregiving responsibilities for someone with an illness or disability.[5] Numerous other studies focused on caregivers for adult family members with particular conditions in specific countries—including Argentina, Brazil, Canada, China, Colombia, Iran, Mexico, Pakistan, South Korea, and the United States—find that those providing care are overwhelmingly women.[6]

Women are not only more likely to provide care generally but also more likely to devote greater hours to care. Research spanning different regions provides a glimpse of these dynamics. Across Austria, Belgium, Denmark, France, Germany, Greece, Italy, the Netherlands, Spain, Sweden, and Switzerland, women make up approximately 60 percent of caregivers for aging parents overall and 73 percent of caregivers for those with "intensive needs," that is, those that require at least weekly care.[7] In South Korea, daughters, daughters-in-law, and other female family members (excluding spouses) provide twenty-four hours of the unpaid care received per month by adults ages sixty-five and older who have limitations in daily activities; male relatives provide just seven hours. As a person ages, spousal care decreases and care by other family members increases, but the gender gap remains: female relatives provide fifty hours of unpaid care per month to those eighty or more years of age, while male relatives contribute fourteen hours.[8] In Mexico, female caregivers of relatives with multiple sclerosis devote approximately seventy-nine hours per week to care, compared to men's forty-eight.[9] Women also play a larger role in caring for aging spouses. In the same study from South Korea, for instance, spousal caregivers devoted around seventy hours per month to care if the recipient was male, but just sixteen hours if the recipient was female.[10]

Women also play an outsized role in caregiving for children with serious illnesses or disabilities, which, like caregiving for adults with serious health conditions, can require many hours of care and/or care for a significant duration

of time. A study examining the experiences of caregivers for children undergoing chemotherapy at two large hospitals in Brazil, for instance, found that 89 percent were women, and that they spent on average 142 hours each week caring for their child including overnight care.[11] In Sweden, among a sample of 200 parents of children with Down syndrome, 70 percent of women spent three hours or more each day on direct care for the child, compared to 30 percent of men.[12] In Canada, an analysis of the well-being of caregivers for children with cerebral palsy, which asked the 468 participant families to designate who was the "primary caregiver," found that women fulfilled this role in 94 percent of households;[13] similarly, in Japan, a nationwide survey of caregivers found that women comprised 87 percent of the "main caregivers" for children with disabilities.[14] And in Malawi, a random sample of primary caregivers of children with HIV/AIDS who had registered for home-based care found that thirty-four of the thirty-six caregivers in the sample (94 percent) were women, and that women in the extended family played an important role: alongside biological mothers (58 percent), grandmothers (25 percent) and aunts (8 percent) were also taking responsibility for children's care.[15]

Public Responses Lag Far Behind

Even as major gaps persist across countries in support for caregivers of healthy young children, support to care for family members with serious illnesses and injuries, family members with disabilities, and aging adults is even harder to come by. For example, a survey of thirty-three European countries found that just 12 percent of households reported an unmet need for formal childcare services, whereas over 32 percent reported an unmet need for professional home care.[16] Across these countries, the share reporting an unmet need for home care reached a high of 85 percent in Portugal. In contrast, the highest share reporting an unmet need for childcare was 22 percent (United Kingdom). And for countries with fewer resources, publicly subsidized care services during old age are often practically nonexistent: a study of forty-six countries found that most devoted less than 1 percent of GDP to long-term care, while the majority of lower-income countries invested nothing at all.[17] This gap in support is particularly challenging given that the intensity of caregiving for a person with a progressive illness or who is nearing the end of life increases rather than diminishes over time as the individual declines.[18]

IMPACTS ON WORK AND ECONOMIC EQUALITY OF GENDER DISPARITIES IN CARE ACROSS THE LIFE COURSE

Like gender inequality in caregiving for infants, inequality in other stages of care has documented consequences for women's economic outcomes. Globally, according to the International Labour Organization (ILO), 606 million working-age women are out of the labor force due to unpaid care work, while just forty-one million men—less than a tenth as many—report being unavailable for employment

for the same reasons.[19] None of these consequences are preordained and instead are shaped by policy environments; however, understanding the effects of current policy choices is an important step toward recognizing the urgency of taking action.

Earnings and Employment

Studies from a range of countries have found that the provision of unpaid care for aging adults and adult family members with disabilities is associated with lower levels of employment. For example, in a survey of unpaid caregivers for someone who was ill, aging, or had a disability across Australia, France, Germany, Italy, Spain, the United Kingdom, and the United States, 12 percent said they had had to leave their jobs due to their caregiving responsibilities, while 21 percent reduced their hours;[20] women were the majority of caregivers across the countries studied. In Australia, data from a national survey showed that women ages forty-five to sixty-nine who were providing at least seven hours per week of informal care were 22 percentage points less likely to be employed than women without care responsibilities,[21] while in China, researchers found that among married women over age thirty-five, caring for parents-in-law was significantly associated with lower employment and fewer paid work hours.[22] In Nigeria and Ghana, loss of employment and material hardship were common consequences of caring for family members with mental disabilities; women were a majority of those affected in both countries.[23] The role of gender is also evident in whether women have other female family members to share the load. A US study, for instance, found that women caring for their parents on average reduced their paid work hours by 367 per year, but that women with sisters spent fewer hours on care; for women with only brothers, however, there was no effect.[24]

Significant impact is also observed in care for children with disabilities. For example, one study spanning Austria, Belgium, Bulgaria, France, Georgia, Hungary, Italy, Lithuania, Poland, Romania, and Russia found that in families with a child with a disability, women were less likely to report being employed (57 percent of mothers in families with a child with disabilities, compared to 70 percent of those in families without a child with disabilities). Among fathers, no significant impact was observed.[25] And in Colombia, a study of parents of children with trisomy 21, also known as Down syndrome, found that 36 percent of mothers, compared to just 5 percent of fathers, spent at least 85 hours per week with their child; at the same time, just 30 percent of mothers, compared to 89 percent of fathers, had full-time jobs.[26]

Women's overrepresentation in more high-intensity caregiving roles (e.g., roles that demand more weekly hours of caregiving) also has impact. For example, a systematic review of studies covering the United States, United Kingdom, Europe, and Canada found that caregivers of adults with an illness or disability

were more likely to work fewer hours and that those performing intensive care were likely to withdraw from the labor force.[27] In Australia, a longitudinal survey of employed women ages forty-five to fifty found that those who began providing 7–14 hours of care per week were more likely to leave the workforce in the next three years than women the same age who did not take on new care responsibilities, but less likely to leave than women who newly took on 14+ hours of weekly care.[28] A systematic review of studies examining the economic impacts on families of childhood cancer, which spanned fourteen countries, found that women were more likely than men to decrease their work hours to manage their child's care.[29]

These impacts on women's employment have broader consequences for gender equality in the economy. Caregiving responsibilities at all stages contribute to women's overrepresentation in part-time work. In Australia, for example, 37 percent of women with children under the age of thirteen work part-time while their male partner works full-time, while in just 3 percent of families do fathers work part-time while mothers work full-time.[30] Similarly, across Europe—where women are approximately four times as likely as men to be employed part-time[31]—27 percent of women who work part-time do so because of the need to care for children or elderly family members, compared to just 4 percent of men who work part-time.[32] These gender imbalances in work hours make it more difficult for women to hold leadership positions, with long-term impacts on earnings and career advancement. Similarly, women providing care to older relatives are often at the peak of their careers; gender disparities in withdrawal from the workforce at this stage consequently diminish women's representation in decision-making roles in both the public and private sectors.

Further, in the absence of adequate public services, caregiving's impacts on work are often disproportionately experienced by marginalized women. For example, for lower-income women, securing professional care support is more likely to be unaffordable. In Australia, for instance, women aged forty-five to sixty-nine with professional or managerial jobs were more likely to remain employed after taking on informal care responsibilities than women working in lower occupational status jobs.[33] Likewise, migrant women, who are often concentrated in low-wage, inflexible jobs with limited access to the social safety net due to their migration status, may have few options but to fulfill care needs on their own. In the United States, for example, immigrant caregivers are more likely than their US-born counterparts to report that they had to quit work, reduce hours, or retire early to meet caregiving needs.[34] In this way, insufficient public support for caregiving across the life course—just like insufficient support for early childcare—exacerbates not only gender gaps in the economy but also inequalities across social class, race and ethnicity, and migration status.

Discipline, Poor Evaluations, and Terminations

Even for women who stay in the workforce, care responsibilities without adequate supports can have consequences at work. A family member's sudden illness or hospitalization can require time off from work on little notice, while longer-term care needs of both children and adult family members can require intermittent leave. These types of absences can easily lead to poor performance reviews, disciplinary action, or even termination.

Examples abound across countries and increasingly show up in the courts. For example, mothers of children with disabilities report being singled out at work across contexts. In Brazil, a study based on interviews of mothers of children with Congenital Zika Syndrome found that employer pressure to quit their jobs due to their child's care needs—or even outright termination—was a "constant." As one woman described: "She said she was just firing me because the baby needed more care. I talked to her, 'Why does my daughter have anything to do with it?'"[35] Meanwhile, in a landmark case from the United Kingdom, a woman who worked at a London law firm brought a discrimination claim after her employer treated her requests for flexible work arrangements and time off to care for her infant son—who suffered from serious congenital respiratory conditions that required specialized care—less favorably than similar requests from parents whose children did not have disabilities. The woman was also threatened with dismissal for her occasional late arrivals, even as other parents who were sometimes late faced no such warnings. After a few years of this treatment, she left the firm through a voluntary redundancy and alleged in her claim that she had resigned because of the hostile work environment. The case eventually reached the European Court of Justice, which held that the employer's actions had constituted discrimination on the basis of association with someone with disabilities—an interpretation that ultimately influenced UK legislation.[36]

Sometimes discrimination against caregivers is even embedded in official company policies. In 2016, a class action suit against Walmart—the largest private employer in the world[37]—challenged its "points" policy, whereby employees were punished for their absences from work without three weeks' notice, even for emergency situations. Once the employee reached nine points, they would be fired. In a report documenting the policy's impacts, dozens of employees, mostly women, described how attending to their own health needs and those of their family members—from a spouse experiencing a life-threatening complication from diabetes to an elderly mother rushed to the hospital due to heart complications—resulted in point accumulation.[38] Others tried to adhere to the policy in order to keep their jobs, but at great personal cost. One woman described being denied access to leave while her mother, who was in hospice care, died alone.

Longer-term care needs can result in retaliation by employers just as short-term ones do. For example, in a 2015 case from Washington State, Rebecca Snow, a software developer who had always received positive reviews, was suddenly

demoted after she began taking intermittent leave to care for her elderly parents. According to court filings, Snow's supervisor was instructed to give her a negative evaluation because she was no longer "100% committed" to the company. Several years later, when she applied for a promotion, during the interview process she faced questions about her use of leave and was asked whether she had siblings who could share the responsibility for caring for her parents. The promotion ultimately went to a younger candidate.[39]

Moreover, as with other areas of discrimination and retaliation, the cases that make it to court represent but a fraction of the consequences faced by workers—predominantly women—whose care responsibilities become evident to their employer. In the aggregate, these types of employer actions targeting workers with caregiving responsibilities for the health needs of children and adults increase women's risks of unemployment, income loss, and missed opportunities for advancement.

Involuntary Early Retirement and Its Consequences

Finally, caregiving responsibilities contribute to gender gaps in the age of retirement. For example, in China, a study based on a questionnaire and interviews with over 200 manufacturing workers found that women were nearly twice as likely as men to be considering early retirement due to their eldercare responsibilities.[40] Similarly, a Canadian study found that 21 percent of women, compared to just 8 percent of men, retired in order to meet caregiving needs.[41] Women who have no choice but to retire sooner than planned may be compelled to step back from leadership positions, reducing their ability to have voice in decision-making and to have an impact in a wide range of fields.

Early retirement age can leave women less financially prepared to sustain themselves in older age, particularly since women's average life expectancy exceeds men's, further extending the years they need to rely on retirement income. Moreover, involuntary early retirement can have consequences for health, as reduced social engagement, physical activity, and intellectual engagement can contribute to depression and physical and mental decline.[42] This can compound the health impacts of caregiving, which are marked. For example, high-intensity caregiving has also been found to increase caregivers' risks of depression and poor health. In Japan, women who provided 20 to 69 hours per week on unpaid care were at higher risk of heart disease.[43]

For women and families, the financial vulnerabilities created by early retirement are compounded by gender inequalities earlier in life. Due to career gaps linked to caregiving, reduced income trajectories due to part-time work, and broader patterns of discrimination in pay and promotions, women often have lower levels of personal savings and qualify for lower pension benefits when payments are based on prior earnings. In the United States, for instance, the average monthly social security payment for a retired woman in 2019 was $1,125, compared to $1,447 for a retired

man.[44] Likewise, a recent report from the European Commission found that men on average are eligible for pension benefits that are 40 percent higher than women's.[45] Together, these disparities put women at greater risk of poverty in old age.

WHAT CAN BE DONE? TAKING STEPS TO ADDRESS CARE GAPS, GENDER EQUALITY, AND JOB QUALITY

Policies around care—or the lack thereof—play a direct role in perpetuating gender disparities in caregiving for both children and older adults and in compelling many workers to choose between their jobs and meeting the health needs of their loved ones. While caring for aging adults and other family members can be rewarding and fulfilling, inadequate policy support means that many workers have no choice but to meet care needs on their own, and broader gender inequalities in the economy and in families leave women taking on the substantial majority of unpaid care work. Making different choices at the policy level can encourage more men to take on the rewards and challenges of care, ensure that the need to provide care doesn't have disproportionate impacts on women's employment, and guarantee that professional caregiving is high-quality and adequately remunerated.

Broadly speaking, caregiving needs across the life course fall into three categories: more routine short-term needs, such as the need to take a family member to the doctor or help a child recover from a minor illness that requires missing school; time-limited needs that nonetheless can be serious, such as supporting a family member during a major illness or operation or providing care and comfort as they are approaching the end of life; and long-term needs, such as the need to provide ongoing care and support to a family member with a long-term illness or serious disability. While there is not always a bright-line distinction between short-term and routine, serious but time-limited, and long-term needs—as health can be unpredictable and needs vary significantly depending on a person's specific circumstances—identifying approaches to support each of these three common types is key to meeting family needs.

The sections that follow explore some approaches currently in practice as well as others that could be transformative if adopted on a broader scale. For episodic care—such as that needed to recover from a major illness or complete a course of treatment for a serious condition—paid leave can play a powerful role. For long-term care for chronic or progressive illnesses or disabilities, supports are needed to ensure that all workers who would like to continue working full-time while helping a family member meet care needs are able to do so; this requires both flexible workplace policies and public investments to make care services available and affordable as well as effective use of new technologies to broaden access to low-cost care supports. To support gender equality, policies addressing care needs must not reinforce the idea that women should be the primary caregiver, and care jobs must be fairly and adequately paid.

Supporting Workers with Time-Limited Caregiving Needs: Impacts of Paid Leave and Current Approaches Worldwide

As soon as Liwen heard that her younger brother had had a bleed in his brain, she was on an airplane to go see him. She was fortunate to have paid leave that covered caring for siblings. Single, living alone, her brother had no one else to care for him. Liwen moved into his small apartment and helped ensure he could sleep, eat, and be safe when he came home from the brain surgery that left him alive but with a long recovery ahead. At first, he was able to talk but only in short sentences, and was unable to listen to any stories or news. Liwen played music in the background when he could tolerate it. After two weeks passed, he was gradually feeling well enough to listen to stories. As she read them, her brother began to remake connections in his brain.

Paid time off can make a critical difference for ensuring workers can keep their jobs while providing care to a loved one with serious health needs, again with particular benefits for women given their overrepresentation in caregiving. For example, in Japan, where 99,000 workers—76 percent of them women—left their jobs due to care responsibilities in 2017, the availability of ninety-three days of paid leave under the Child Care and Family Care Leave Act was associated with a 7 percentage-point reduction in the likelihood that a worker would need to leave their job within a year after their parent first needed care.[46]

Paid leave has clear benefits for care recipients. Children whose parents have access to leave they can use to meet their child's health needs benefit from more hands-on parental care, which evidence shows leads to quicker recovery following an illness or injury.[47] Likewise, leave for adult health needs can improve recovery after an illness or operation and provide a powerful source of instrumental and emotional support.

Around the world, 55 percent of countries take some approach to providing paid leave that could be used to meet the health needs of a child with a serious illness, injury, or chronic condition. These approaches include broader types of leave, such as leave for emergencies, discretionary needs, or family needs (twenty-four countries) or leave generally available for children's health (twenty-four countries), as well as paid leave that is available only when a child has a serious illness, injury, or disability or is hospitalized (twenty-nine countries). In twenty-nine countries, there are paid leave entitlements for both general and serious health needs. High-income countries are more likely to guarantee some form of leave that can be used to meet children's serious health needs than low- or middle-income countries.

In many countries, even when paid leave is available, it may not be sufficient to meet the health needs of all children. For example, children with cancer often require three to six hospitalizations per year of around twelve days each.[48] A child who needs an uncomplicated surgery for congenital heart disease may be in the hospital eight to eleven days, while more complex procedures could require up to five times as long for recovery.[49] However, only 23 percent of countries globally make at least six weeks of paid leave available to a working parent to meet

their five-year-old child's serious health needs. For children with disabilities, only 18 percent of countries guarantee at least four weeks of paid leave that could be used to meet their ongoing disability-specific needs.[a]

Moreover, in some countries, paid leave is available only to care for younger children. Whereas 55 percent of countries guarantee paid leave that can be used to meet a two-year-old's serious health needs, only 49 percent do so for fifteen-year-olds. While a fifteen-year-old may be able to be left home unsupervised with a minor illness, parental presence is needed for children during hospitalizations and management of serious illnesses.

In the vast majority of countries providing paid leave that can be used to meet children's serious health needs, payments are at full or nearly full (80 percent) of wages. However, while leave that is provided by employers is more likely to be fully paid, it is often too short to address more serious health needs that are more likely to affect parents' ability to remain employed. In fourteen of the 106 countries with paid leave available for children's serious health needs, payments can be less than 60 percent of wages or paid at a flat rate not tied to working wages.[b]

Although adults are more likely to face serious illness, around the world, paid leave for adult health needs is less common than paid leave for children's health: just 42 percent of countries guarantee paid leave that can be used to meet adult health needs. Of the eighty-two countries that make some form of paid leave available to meet adult family members' needs, fifty-seven countries guarantee leave specifically for adult family members' health needs. Twenty-five provide only general types of leave that are not specific to family health, such as discretionary, family needs, and emergency leave. In two countries, paid leave is limited to end-of-life care. In an additional eight countries, legislation provides leave generally for adult family member needs with additional leave available for specific cases, such as serious illness or end of life care.

As with leave for serious child health needs, identifying a precise minimum duration for leave for adult health needs is difficult given the wide variation in health circumstances and care options across countries; nevertheless, some research and background on common courses of treatment offer insights into likely use. For example, older adults face far higher rates of cancer diagnoses, and chemotherapy treatment can last as long as six months.[50] While adults may not need daily help for the duration, severe side effects commonly mean they need care repeatedly over time. A review of the evidence from low- and middle-income countries found that a stroke can result in an average hospital stay of five to twenty days,[51] and recovery

a. This includes both disability-specific health leave and more general paid leave that can be used to meet children's everyday health needs. It does not include any leave specifically for hospitalization or other serious health needs that would also be available to parents of children with disabilities.

b. These are the lowest payment rates for paid leave. In some countries, higher wage replacement rates are available based on the number of children, family structure, type of illness, parental income level, parental employment history, duration of leave, or other factors.

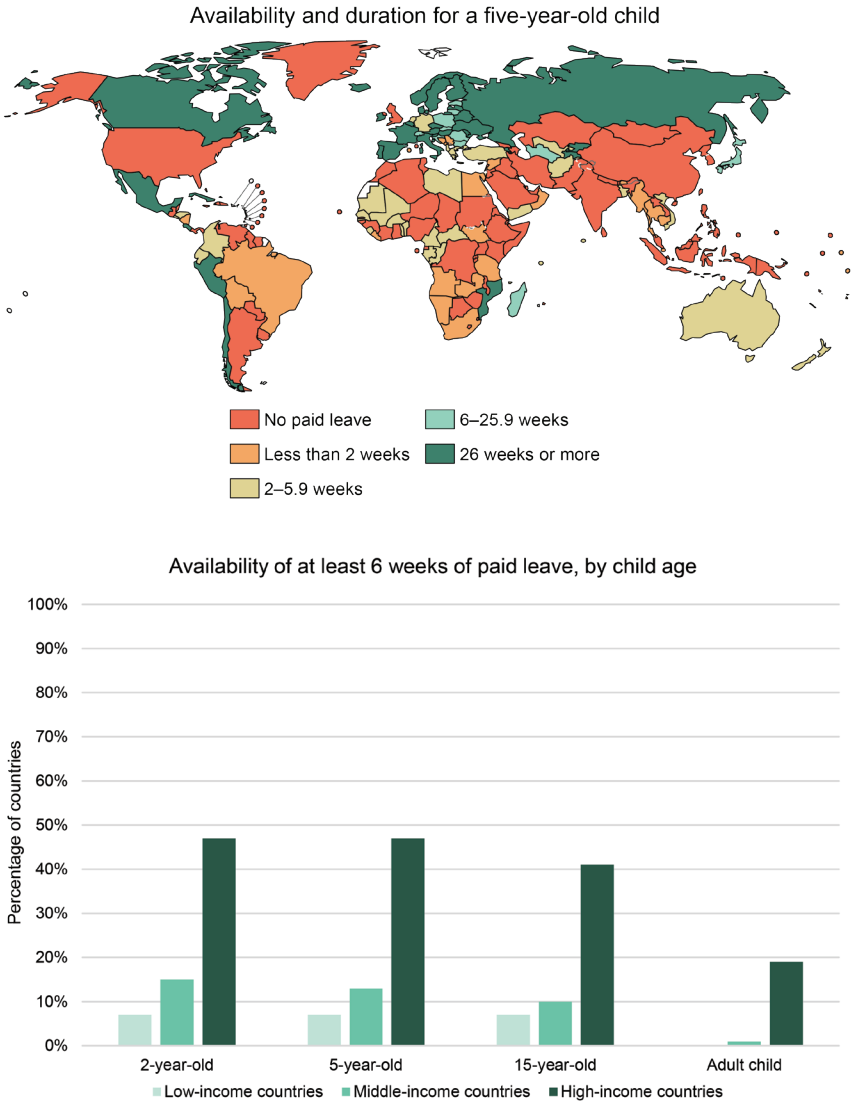

FIGURE 17. Is paid leave available to meet children's serious health needs?

NOTE: Duration of leave for adult child is based on leave available for adult children still living in the same household as their parent.

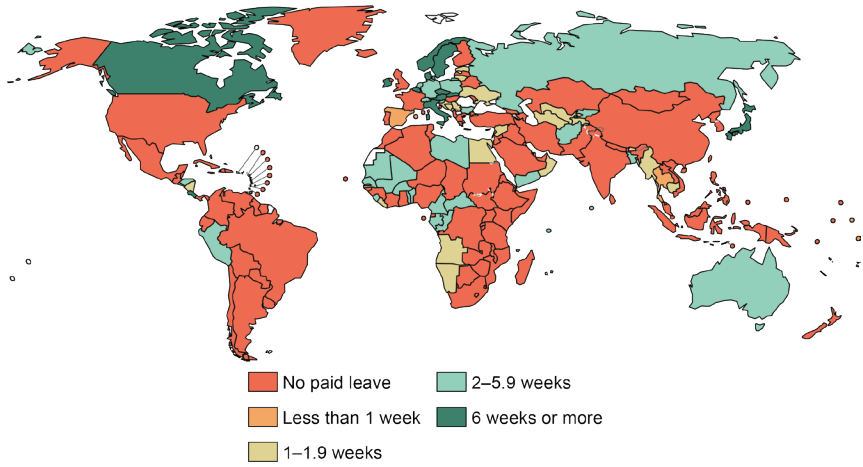

FIGURE 18. How much paid leave is available to workers to meet a parent's serious health needs?

to full function can take months to years. Here, too, while family care may not be needed for the full duration of recovery, family care can be critical both acutely and long-term to access health care providers. For neurosurgery, hospital stays average seven days in Jordan, nine days in Egypt, and seventeen days in China, while recovery at home can last several months.[52] In the United States, older adults are between 2.5 and 4.6 times as likely as working-age adults to be hospitalized overall, with an average duration of 5.6 days; moreover, nearly a quarter of elderly adults do not recover full functionality within a year of discharge.[53] The median duration of hospice care covered by federal health insurance for older adults in the United States is eighteen days, and 79 percent of hospice stays are less than six months, though they are often preceded by hospitalizations when an adult needs care.[54]

Paid leave available for adult family members' health needs is generally short. Only twelve countries make at least six weeks of paid leave available that could be used by workers caring for a seriously ill parent.[c] An additional thirty countries guarantee at least two weeks of paid leave. Whether this amount of paid leave is adequate to meet adult health needs often depends on how many people are available to care for someone. Countries can support caregivers and their employers by allowing families and loved ones to share care responsibilities across multiple people. However, many countries place restrictions on whom workers can take paid leave to care for. While the majority of countries with paid leave available for adult family members' health needs allow for the care of a spouse or parent, far fewer allow workers to care for their sibling, parent-in-law, or unmarried partner. Further, countries may place limitations on leave available to care for family members such as when provisions to care for extended family members depend on their living

c. One country (Israel) requires that parents be at least sixty-five years old for workers to be eligible for paid leave.

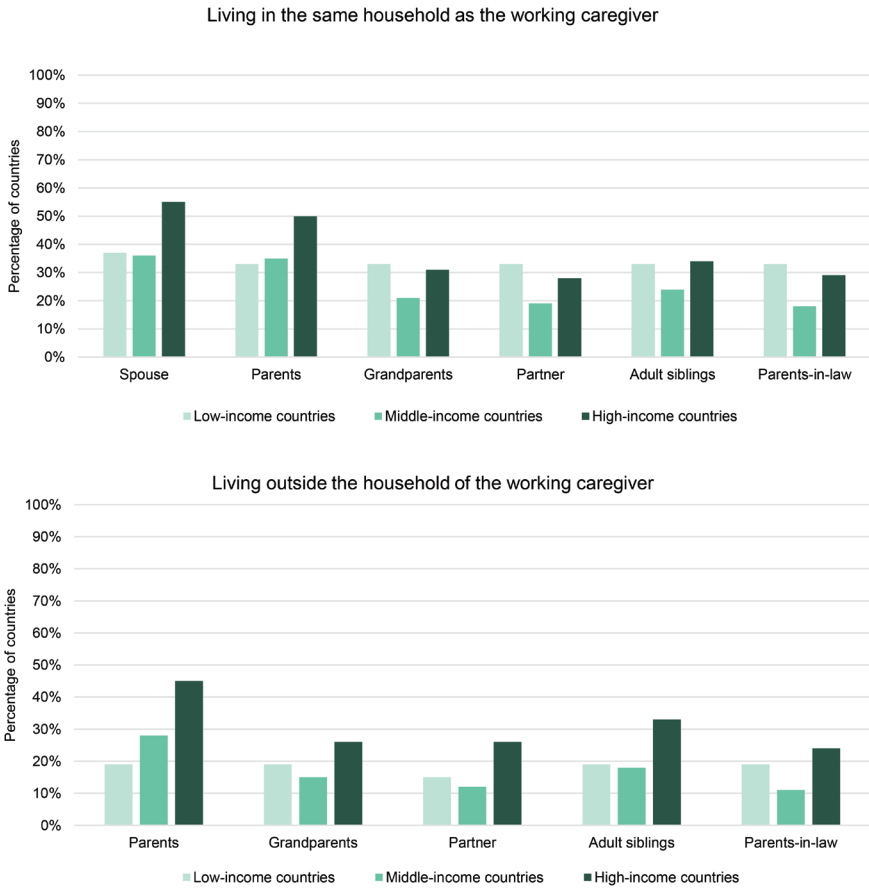

FIGURE 19. Is paid leave available to meet the health needs of all adult family members?

arrangements. Fifteen countries that have paid leave available for parents' health needs require that they be living in the worker's household. Three countries do not have provisions that allow workers to broadly take paid leave for parents but do allow for paid leave to care for dependent family members, which may create barriers to taking leave for parents who are still able to live independently.

A few countries have taken a more expansive approach to enabling workers to care for loved ones. For example, the Netherlands guarantees workers the right to paid leave for "the person with whom the employee otherwise has a social relationship," though the leave is limited to care that "results directly from that relationship and must reasonably be provided by the employee."

Although most countries with paid leave available for adult family members' health needs have a high wage replacement rate of full or nearly full (80 percent) wages, ten countries have wage replacement rates as low as 40–59 percent or pay workers a flat rate that is not directly tied to their existing earnings.[d] Similar to paid leave to meet children's health needs, lengthier leaves are generally paid at much lower rates. While no country explicitly limits paid leave for adult family members' health needs to women, the unaffordability of taking paid leave may contribute to women's higher uptake of leave than men's.

Addressing Long-Term Care: Improving Care Access, Care Experiences, and Care Jobs

When Rebekah's mother Joanne called her while driving to the salon, panicked because she had forgotten where she was going, Rebekah knew that something was wrong. After a painstaking series of doctor's visits, Joanne was diagnosed with Alzheimer's disease at age sixty-five. To assist with her care, Rebekah and her family relocated, where they would have a larger family network to support caregiving needs. Nevertheless, after Joanne started having regular seizures, in the absence of adequate long-term care Rebekah felt she had no choice but to quit both her jobs to provide care full-time, while her husband continued to financially support the family. Only after she was able to access some in-home care support was Rebekah was able to return to work part-time.[55]

Rebekah's story is illustrative of many women's experiences, which collectively offer a key lesson; in addition to leave to support workers to meet time-limited care needs, solving long-term care—just like solving childcare—is essential to eliminating gender inequalities in the economy. Indeed, research suggests that adequate support for acute and ongoing care needs is essential for women's work outcomes. In the United States, the enactment of a state-level paid family leave program in California, which provides eight weeks of paid leave to care for a fam-

d. These are the lowest payments guaranteed. In some countries, wage replacement rates vary based on family structure, type of illness, worker's income, worker's employment history, duration of leave, or other factors.

ily member with a serious health condition, increased the private-sector employment of forty-five- to sixty-four-year-old women with a spouse with disabilities by 3 percent, compared to women in the same age group in states that did not enact such a policy.[56] At the same time, a recent study examining Belgium and Denmark found that the enactment of paid family medical leave did not increase employment rates, leading the authors to conclude that affordable long-term care was also critical to significantly improve labor market outcomes for caregivers.[57]

In the absence of adequate supports for long-term care, individual caregivers and entire economies suffer. The time in many women's lives when eldercare needs arise is a critical period in their careers when they are at the peak of their earning potential, often have the greatest autonomy and opportunities for impact at work, and are most likely to be occupying leadership positions. Insufficient support to meet long-term care needs disproportionately affects the longevity of women's careers, their earnings and preparation for retirement, and their capacity to have influence across sectors.

Yet the gaps in access to long-term care are significant across countries. Both workplace accommodations and national investments in caregiving infrastructure are critical to meet long-term care needs and to ensure that these needs don't leave workers—and overwhelmingly women, due to broader inequalities—with no options but to leave the workforce. What would it take to meet long-term care needs for everyone—and how can we do so in a way that increases gender equality in paid and unpaid caregiving alike?

The Potential and Limitations of Workplace Flexibility to Meet Long-Term Care Needs. Sebastian was successful in his job in tech and an amazing father and caregiver to a daughter with disabilities. A wheelchair user for decades, he had long since learned how to succeed in a world that too often did not adapt to the range of physical abilities and constraints that individuals have. As he reached midlife, he began to have more health problems himself, as is not uncommon for wheelchair users with mobility constraints. His mother, Maria, was still working but able to arrange a flexible schedule, so that when Sebastian needed surgery she could come and help provide her grandchild with the care she needed. Their experience was not unusual. People can be caregivers one month and care recipients the next, and then return to being caregivers.

Workplaces have a role in supporting workers to meet time-limited and long-term care needs through greater flexibility with respect to work schedule, location, and total hours:

- **Flexible Schedules:** Surveys of employees with eldercare responsibilities show a high desire for flexible work, and it's easy to understand how greater flexibility in one's work schedule could greatly improve workers' abilities to respond to care needs.[58] In Austria, researchers found that flextime increased the labor force attachment of women with eldercare responsibilities.[59] Studies

from individual countries have also found that flex work can support mothers' labor force attachment and job satisfaction.[60]

- **Remote Work:** In certain circumstances, remote work can also make a critical difference for workers with caregiving responsibilities. As the COVID-19 pandemic underscored, working from home while simultaneously providing full-time care for a baby or young child is next to impossible; the same is true for adults who need constant care, such as those with advanced dementia. Yet for a family member who needs only light assistance, such as with meals or going to the bathroom, the ability to work remotely at least a few days each week can allow a worker to help meet care needs, particularly when shared with another family member or professional caregiver, while maintaining full-time hours.
- **Part-Time Work:** The ability to work part-time can enable more caregivers of aging adults and family members with serious illnesses or disabilities to stay in the workforce while meeting care needs, when their other option would be to drop out entirely. A study of nineteen European countries, for example, found that an increase in available part-time work between 1992 and 2011 significantly increased women's labor market participation. The caveat, though, was that it mattered most in countries that hadn't already adopted other policies supporting equal work and care by women and men.[61] Evidence from some countries also suggests that the availability of part-time work can reduce work-family conflict.[62]

However, despite the potential benefits of flexible, remote, and part-time options, if it is women who primarily take these up due to gender-unequal norms—as evidence indicates is the case—workplace accommodations will likely further entrench rather than diminish gender inequality in the economy overall. Data from a range of countries suggest that women are more likely than men to take advantage of flexible work arrangements when they are available,[63] while women have long been overrepresented in part-time work.[64] Given these disparities in uptake, flexible work arrangements may support women's labor force attachment but, without broader norm change, could also reinforce broader patterns of gender inequality and stereotypes about women's commitment to their jobs.[65]

Past efforts to implement these strategies as stand-alone mechanisms for increasing gender equality in the economy have borne this out. This is particularly evident when it comes to part-time work. In Spain, for example, the introduction of a right to work part-time for parents with children under seven in 1999 led to reductions in hiring and promotions of women of child-bearing age, since only women were taking advantage of the option.[66] Moreover, while some women genuinely prefer to work part-time, many are seeking but unable to secure full-time jobs; across the Organisation for Economic Co-operation and Development, women comprise nearly two-thirds of those who are in "involuntary" part-time work.[67]

Meanwhile, working part-time is generally incompatible with holding the highest-level or best-compensated positions in either government or the private

sector; the same is true for permanent remote work. For example, studies spanning countries at all income levels have found that most professional, senior, or managerial positions are full-time.[68] Research has also documented that workers often face significant challenges in returning to full-time work after transitioning to part-time, and that remote workers face higher barriers to promotion despite comparable or greater productivity.[69] In the aggregate, the impacts on women's leadership at work are substantial.

Moreover, flexible work options are likely to be inaccessible to the majority of workers in lower-wage jobs whose tasks require in-person presence. A 2020 analysis of 800 occupations across nine countries—China, France, Germany, India, Japan, Mexico, Spain, the United Kingdom, and the United States—found that just 20 percent of jobs could effectively transition to remote work long-term, and that these jobs were concentrated in higher-income countries and higher-wage occupations.[70] Over-relying on flexible work options to meet long-term care needs is thus likely to reinforce not only gender but also socioeconomic and racial disparities.

None of this is to say that these options are not valuable, or that they cannot be designed in a way to promote more gender-equal uptake and to reduce long-term career consequences. For example, increasing the availability of part-time work at higher hours—such as three-quarters time jobs—could be worth exploring as a strategy for freeing up time for caregiving without as significant economic or potential professional disadvantages as dropping to half-time work. Similarly important are effective on-ramps for workers who do work part-time or take time out of the workforce for caregiving; some studies suggest that temporary subsidies can make a difference.[71] Yet when layered on top of restrictive gender norms and broader inequalities in the labor market, flexible work approaches have the potential to reinforce rather than dismantle gender inequalities and occupational segregation.

Gender Equality and Long-Term Care: Public Investment Is Essential. Ensuring that workplace and national policy approaches advance gender equality requires that they create true choices for families and work to counteract some of the deeply embedded inequalities that position women as society's default caregivers. Ultimately, in seeking to fill care gaps across the life course, countries should seek to realize three goals: (1) meeting care needs for all; (2) ensuring that no one needs to leave the workforce to provide care, since the evidence is clear that women's employment will be disproportionately affected when the full responsibility for care falls to each individual family; and (3) ensuring that it is equally affordable and viable for men and women to take time away from work for periods of caregiving and then to return to quality jobs. Both workplaces and national governments have important roles to play in ensuring all workers can balance work and caring for family members of all ages. Doing so brings economic and family benefits. For employers, ensuring workplaces are inclusive allows for the recruitment and retention

of the most talented employees, thereby improving performance and reducing turnover costs. For countries, ensuring all people can participate in the labor force equally has extensively documented benefits for economic growth.

Yet none of these goals will be achieved without public investment. All too often, what long-term supports and care exist in countries are unaffordable or of disastrously poor quality. Countless horror stories from across countries during the COVID-19 pandemic underscored how limited long-term care options have left millions of aging adults vulnerable to neglect, maltreatment, and even abuse, while many others simply lack access to a caregiver with adequate training. Amid the pandemic, the human toll was catastrophic, but also simply an extension and predictable consequence of the systematic and long-standing underinvestment by governments in eldercare across countries.

Eldercare supports within the home, as well as residential care for those for whom living at home is no longer feasible, needs public investment just as health care does. Alongside public investments designed to make supports affordable and accessible to all who need it, ensuring adequate training for care workers is essential. Investments in education and support for care workers can improve quality of care on a broad scale, with tangible benefits for care recipients. Formalizing care jobs, including by establishing minimum qualifications and competencies, can support these efforts, provided that trainings and pathways to care careers are accessible to all, and existing care workers' experience is not disregarded due to a lack of formal credentials.

New assistive technologies also have a role to play. When thoughtfully designed, new technologies can support aging in place and increase dignity and autonomy in aging. For example, apps and sensors that allow for remote monitoring by family members can give caregivers peace of mind while enabling their family members to live independently.[72] These types of technologies can also help meet long-term needs at scale, given their cost effectiveness. Nevertheless, there will always be a fundamental need for person-to-person care, and many aspects of care cannot be automated; using technology where it is appropriate—for example, to replace more passive observation—can free up resources for more of the direct and skilled care activities that require a human touch.

Improving Care Jobs. Beyond their overrepresentation in family caregiving, women are overrepresented in the care workforce. Around the world, 249 million women and 132 million men are in care professions, accounting for 19 percent of female employment and 7 percent of male employment. This gender segregation in turn shapes job quality; care-focused jobs in general are low paid, reflecting how jobs that are performed primarily by women and involve care are often undervalued, and how sectors become more poorly remunerated as they become female-dominated.[73] Moreover, even within the care sector, women are concentrated in lower-wage jobs; for example, women comprise 88 percent of personal care workers and 76 percent of associate health workers globally,[74] but a minority of doctors, dentists, and pharmacists. And even within higher-paid occupations,

roles involving more interpersonal care are often paid less; pediatricians and geriatricians, for example, earn far less than radiologists and surgeons. Addressing the pervasive undervaluing of work that involves nurturing care is a critical undertaking for advancing gender equality in the economy.

Further, these roles are often disproportionately held by migrant women and women from marginalized racial and ethnic groups, widening other types of inequalities. For example, a survey of eighty-six countries by the World Health Organization found that over one in eight nurses was working in a country other than where they were born or trained,[75] while studies of individual countries suggest migrants comprise an even greater share of the eldercare workforce. In the United Kingdom, for instance, around 35 percent of nurses providing long-term care are migrants,[76] while in the United States, migrants account for 28 percent of nursing, home health, and personal care aides.[77] And within countries, it's common for women to migrate from rural areas to urban areas for work in care sectors. In India, lower-caste women and teenage girls are particularly likely to migrate internally for financial reasons, and many end up performing long hours of household and care work within private homes—highlighting another way that social class and related statuses continue to influence the demographics of the care workforce as well as conditions of the work itself.[78]

Investing more in health and social supports across the life course has the potential not only to improve the quality of care jobs but also to grow economies and reduce occupational segregation. Indeed, while the creation of new jobs through greater investments in care will disproportionately increase women's employment, the benefits will extend to all. For example, a study covering forty-five countries estimated that by investing an additional 3.5 percent of GDP in education and health, governments could create 117 million jobs, with women likely to occupy around 55 percent of these new positions; this is slightly lower than women's current representation in those fields in the countries studied, indicating a step toward greater gender equality at the same time that investment has outsized impacts on women.[79] Meanwhile, if history is any indication, reducing occupational segregation and creating more gender balance in care jobs will likely make a difference for job quality. Further, with care a growing sector of economies and an area where there is a shortage of workers, integrating more men into professional care will be important to meet increasing demand. It also provides important job openings as automation is reducing the jobs in several large male-dominated sectors, while care continues to grow.

Indeed, globally, the ILO estimates that total employment in the care economy will increase by nearly a quarter by 2030, adding 248 million jobs. Further, if countries invest adequately to meet the commitments to health and social supports they made by universally adopting the Sustainable Development Goals, even greater growth in the care sector is expected, with job gains concentrated in early childhood care and education (thirty-nine million new jobs) and long-term care (thirty million new jobs).[80] Against this backdrop, caregiving as a skill is becoming increasingly important in employment opportunities.

Improving the quality of care jobs now—whether the sector becomes more gender-equal in composition rapidly or slowly—is urgent for equality. Moreover, getting care jobs right lays vital groundwork to ensure that the coming shift in the economy creates millions of high-quality jobs rather than low-wage jobs with minimal protections. Public investment has a pivotal role to play in creating care jobs that provide adequate wages and benefits, which will in turn improve standards across the sector. As noted by the ILO, "public provision of care services tends to improve the working conditions and pay of care workers, whereas unregulated private provision tends to worsen them, irrespective of the income level of the country."[81]

At the same time as improving the quality of formal economy care jobs, it is critical to strengthen labor protections for informal care workers. Ensuring that all care workers are covered by minimum wage, paid leave, antidiscrimination and harassment protections, and occupational safety laws, among others, is fundamental to gender equality as well as ensuring that care jobs are not characterized by exploitation. The clear need to extend labor protections to informal care and household workers has been increasingly recognized by the courts. Building on the examples of many countries that have taken steps to explicitly include care and household workers and the informal economy in their labor and social security legislation is an essential step toward valuing paid caregivers appropriately and dismantling legacies of structural inequality.

VALUING ALL

Core to the solutions is valuing everyone's ability to contribute and recognizing the likelihood of every individual's need for care at different points across the life course. As people age, the probability of having a health problem and needing care increases, but so too does the ability to contribute to the workforce. Older people across countries play critical roles as caregivers and workers.

Shelo was in her late sixties when her daughter Dikeledi grew sick and died from AIDS. She took over raising five newly orphaned grandchildren. Shelo's son-in-law had been sick first and died before her daughter. As soon as her daughter grew sick, the grandchildren along with Dikeledi had moved in with her. Shelo needed to continue to work because she had rapidly become the only source of financial support. For Shelo, the flexibility of her work meant that she could be home when Dikeledi needed her most. Her relationship with her grandchildren was what kept her going after the deep loss of her daughter. Just as there would never be anything to replace the loss, there was no mistaking either the complete joy in having her grandchildren in her life or her need to work to support them.

Opportunities to continue working for pay later in life can be transformative for families, including intergenerational households like Shelo's. Yet the benefits of enabling older people who wish to keep working to stay engaged in the workforce also extend to employers and society as a whole. The benefits for workplaces

are significant; employers report that older employees bring important skills, the desire to lead, and extensive professional networks.[82] A systematic review found that older workers are also more likely to engage in positive "organizational citizenship behaviors," such as helping coworkers and refraining from complaining about trivial matters; at the same time, older workers are less likely to be tardy, to violate safety rules, or to exhibit aggression at work.[83]

Research also finds that older workers demonstrate just as much productivity and innovation as younger workers, despite stereotypes suggesting otherwise.[84] Indeed, an analysis of ninety-eight empirical studies found no evidence that older workers engage in less innovation than their more junior colleagues.[85] Meanwhile, a study examining error rates among workers on the assembly line at a large car manufacturing plant found that productivity actually steadily rose from ages twenty-five to sixty-five when both speed and accuracy are taken into account.[86] In another study, researchers found that a three-year increase in the average age of labor court judges in Germany corresponded to a slight decline (5 percent) in the number of cases processed, but a higher likelihood (11 percent) that judgments would be affirmed on appeal—indicating an improvement in the accuracy and quality of work with age.[87] Moreover, retaining older workers can benefit the bottom line by lowering annual turnover costs.[88]

Further, ensuring individuals have the opportunity to stay engaged in paid work as well as in caregiving and community service improves their physical and mental health.[89] For example, in the United States, a study of nearly 3,000 workers found that a one-year increase in the age of retirement was associated with an 11 percent decline in all-cause mortality among "healthy" workers, as well as a 9 percent decline among "unhealthy" retirees.[90] One study spanning eleven European countries found that working for pay was associated with higher cognitive performance among people ages sixty to sixty-four, whereas retirement lowered scores on a 20-point memory test by 4.9 points, on average.[91]

To be sure, the effects vary depending on the nature of the job; remaining in a job that entails poor working conditions, requires long hours, or imposes infeasible physical demands is unlikely to benefit health.[92] Yet broadly speaking, opportunities for ongoing social and intellectual engagement improve health outcomes.[93] Increasing the availability of part-time work is one strategy that can facilitate continued employment. In New Zealand, for instance, growth in part-time work between 1986 and 2006 accounted for over half the increase in employment among people sixty-five and older.[94]

Yet as people age, they are also significantly more likely to face discrimination in the workplace. When this discrimination leads to job loss and the inability to get rehired, it not only lands individuals and their families in poverty but also contributes to deteriorating health for the individuals and worse economic outcomes at a company and country level. Indeed, in contrast to the potential health benefits of working later in life, experiences of ageism—including encounters with age

TABLE 6 Legal approaches to paid leave to meet family health needs across the life course, by country income level

	Low-income countries	Middle-income countries	High-income countries
How much paid leave is available to meet the everyday and disability-specific health needs of a two-year-old child?			
No paid leave	19 (70%)	66 (61%)	26 (45%)
Less than a week	1 (4%)	5 (5%)	3 (5%)
1–1.9 weeks	1 (4%)	7 (6%)	1 (2%)
2–3.9 weeks	5 (19%)	15 (14%)	7 (12%)
4 weeks or leave available as needed	1 (4%)	15 (14%)	21 (36%)
How much paid leave is available to meet the everyday and disability-specific health needs of a five-year-old child?			
No paid leave	19 (70%)	68 (63%)	26 (45%)
Less than a week	1 (4%)	6 (6%)	3 (5%)
1–1.9 weeks	1 (4%)	7 (6%)	1 (2%)
2–3.9 weeks	5 (19%)	15 (14%)	7 (12%)
4 weeks or leave available as needed	1 (4%)	12 (11%)	21 (36%)
How much paid leave is available to meet the everyday and disability-specific health needs of an eight-year-old child?			
No paid leave	19 (70%)	70 (65%)	27 (47%)
Less than a week	1 (4%)	5 (5%)	2 (3%)
1–1.9 weeks	1 (4%)	7 (6%)	1 (2%)
2–3.9 weeks	5 (19%)	14 (13%)	7 (12%)
4 weeks or leave available as needed	1 (4%)	12 (11%)	21 (36%)
How much paid leave is available to meet the everyday and disability-specific health needs of a fifteen-year-old child?			
No paid leave	19 (70%)	71 (66%)	31 (53%)
Less than a week	1 (4%)	6 (6%)	2 (3%)
1–1.9 weeks	1 (4%)	8 (7%)	3 (5%)
2–3.9 weeks	5 (19%)	12 (11%)	6 (10%)
4 weeks or leave available as needed	1 (4%)	11 (10%)	16 (28%)
What is the lowest wage replacement rate of paid leave available for children's serious health needs?			
No paid leave	15 (56%)	54 (50%)	18 (31%)
Flat rate, adjusted flat rate, or percent of unemployment benefits	0 (0%)	1 (1%)	5 (9%)
25%–59%	0 (0%)	3 (3%)	5 (9%)
60%–79%	1 (4%)	10 (9%)	9 (16%)
80%–100%	11 (41%)	40 (37%)	21 (36%)

TABLE 6 *(continued)*

	Low-income countries	Middle-income countries	High-income countries
How much paid leave could be used for spouses' health needs?			
No paid leave	17 (63%)	69 (65%)	26 (45%)
Less than a week	1 (4%)	5 (5%)	4 (7%)
1–1.9 weeks	2 (7%)	15 (14%)	5 (9%)
2–5.9 weeks	7 (26%)	16 (15%)	11 (19%)
6 weeks or more	0 (0%)	1 (1%)	12 (21%)
How much paid leave could be used for elderly parents' health needs?			
No paid leave	18 (67%)	70 (66%)	29 (50%)
Less than a week	0 (0%)	4 (4%)	4 (7%)
1–1.9 weeks	2 (7%)	15 (14%)	7 (12%)
2–5.9 weeks	7 (26%)	16 (15%)	7 (12%)
6 weeks or more	0 (0%)	1 (1%)	11 (19%)
How much paid leave could be used for grandparents' health needs?			
No paid leave	18 (67%)	86 (81%)	40 (69%)
Less than a week	0 (0%)	2 (2%)	2 (3%)
1–1.9 weeks	2 (7%)	5 (5%)	4 (7%)
2–5.9 weeks	7 (26%)	12 (11%)	5 (9%)
6 weeks or more	0 (0%)	1 (1%)	7 (12%)
How much paid leave could be used for adult children's health needs?			
No paid leave	17 (63%)	70 (66%)	29 (50%)
Less than a week	1 (4%)	5 (5%)	4 (7%)
1–1.9 weeks	2 (7%)	14 (13%)	5 (9%)
2–5.9 weeks	7 (26%)	16 (15%)	9 (16%)
6 weeks or more	0 (0%)	1 (1%)	11 (19%)
How much paid leave could be used for partners' health needs?			
No paid leave	18 (67%)	88 (83%)	42 (72%)
Less than a week	0 (0%)	2 (2%)	0 (0%)
1–1.9 weeks	2 (7%)	4 (4%)	3 (5%)
2–5.9 weeks	7 (26%)	11 (10%)	6 (10%)
6 weeks or more	0 (0%)	1 (1%)	7 (12%)
How much paid leave could be used for siblings' health needs?			
No paid leave	18 (67%)	83 (78%)	38 (66%)
Less than a week	0 (0%)	4 (4%)	3 (5%)
1–1.9 weeks	2 (7%)	8 (8%)	4 (7%)

(contd.)

TABLE 6 *(continued)*

	Low-income countries	Middle-income countries	High-income countries
2–5.9 weeks	7 (26%)	10 (9%)	5 (9%)
6 weeks or more	0 (0%)	1 (1%)	8 (14%)
How much paid leave could be used for health needs of parents-in-law?			
No paid leave	19 (70%)	90 (85%)	41 (71%)
Less than a week	0 (0%)	1 (1%)	0 (0%)
1–1.9 weeks	1 (4%)	4 (4%)	4 (7%)
2–5.9 weeks	7 (26%)	10 (9%)	5 (9%)
6 weeks or more	0 (0%)	1 (1%)	8 (14%)
What is the lowest wage replacement rate during paid leave for adult family members?			
No paid leave	17 (63%)	69 (64%)	25 (43%)
Flat rate or adjusted flat rate	0 (0%)	1 (1%)	3 (5%)
40%–59%	0 (0%)	2 (2%)	4 (7%)
60%–79%	0 (0%)	5 (5%)	5 (9%)
80%–100%	10 (37%)	31 (29%)	21 (36%)

discrimination in everyday life and the internalization of stereotypes and negative feelings about growing older—exacerbate health conditions, at the cost of $63 billion annually in the United States alone.[95]

Women are particularly likely to face intersectional discrimination on the basis of gender and age. For example, in Australia, a study based on interviews with over 2,100 workers ages fifty and older found that women (51 percent) were more likely than men (38 percent) to report that they faced discrimination due to the perception that their skills were outdated, they were too slow to learn new things, or their performance would be unsatisfactory.[96] Similarly, in Poland, a poll of 1,000 workers ages forty-five to sixty-five found that more women (36 percent) than men (29 percent) had experienced some kind of age discrimination at work.[97] And in Israel, an analysis of older workers' likelihood of reemployment after job loss found that age begins to reduce women's likelihood of reemployment at a much earlier age than it does for men, with the impacts beginning around age forty and a sharp decline becoming evident after age fifty.[98]

Addressing discrimination is a first step. Yet only a subset of countries guarantee protections against discrimination for aging women: just 65 percent explicitly prohibit discrimination on the basis of both sex and age. Closing these gaps in the law matters to ensuring women can remain in the workforce as they get older.

CONCLUSION

While policy makers have begun bringing critical attention to how to ensure workers can balance work and infant caregiving in recent decades, other caregiving needs—and in particular health across the life course, adult care, and eldercare—have received far less attention and are often grossly underaddressed. This lack of support for caregiving needs across the life course undermines gender equality at home and at work, as evidence from across countries shows that caregiving for the health needs of all ages disproportionately falls to women, with significant consequences for employment and wages.

Further, unlike emerging trends in policy support for infant and early childhood caregiving, current policies addressing care for other populations reflect little recognition of the gendered economic impacts of care at these later life stages. Virtually no countries provide incentives for men's take-up of leave for other caregiving needs, while some aspects of countries' policies directly discourage gender-equal leave-taking. And as with care in the first years of life, the need for care across the life course is twofold: workers of all genders need support and time to care, in the form of paid leave and workplace accommodations and public services to support meeting longer-term care needs.

Filling these voids will be critical to advancing gender equality at work and in care. Only through policies that fully support paid and unpaid caregiving can countries demonstrate they value all workers and all families at each stage of life.

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