ADVANCE-Purdue

ELDER CARE AND WOMEN IN THE STEM DISCIPLINES: AN ISSUES PAPER

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Introduction

The challenges that women face in the STEM disciplines, especially in connection with work/family balance, are well-documented.[2] A recent report by the National Research Council (NRC) of the National Academy of Sciences confirmed that women who received their Ph.D. in the sciences were less likely than men to seek academic research positions—the path to cutting-edge discovery—and they were more likely to drop out before attaining tenure if they did take on a faculty post. The surveys did not, however, shed light on the primary reasons why women were more likely to drop out: "The report does not explore the impact of children and family obligations (including elder care) on women's willingness to pursue faculty positions in R1 institutions or the duration of postdoctoral positions" (Goulden, Frasch, and Mason 2009: 1). Using the national Survey of Doctorate Recipients, Mason et al. (2005) found that married women with or without children are least likely of all doctorate recipients to secure a tenure-track faculty position. This would suggest a link between traditional gender expectations and the academic pipeline leakage.

For those women who do obtain tenure, additional work/family balance issues lie ahead, especially in connection with elder care. Working women – and especially those considered part of the "sandwich generation" who care for both elderly relatives and their own children – face the challenge of negotiating work and care-giving in an environment that is not structured to support working women.

Elder care is increasingly a challenge as the baby boom generation becomes the 65 and older population. With increased quality of life, people are living longer, and it is expected that the 65+ population will constitute 30% of the total population by 2050. This is not only a problem in the U.S., but across developed countries as well. Peterson

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[2] See the following briefs by Moghadam and Burbrink: "Purdue University's Work/Family Policies: A Comparative Assessment"; and "Women Faculty Success and Work/Family Balance: An Issues Paper", available at http://www.purdue.edu/dp/advance/worklife.php

(1999) asserts that while globalization has increased concerns about nuclear, biological, and chemical weapons, as well as deadly viruses, terrorism, global warming, economic challenges, and violent ethnic uprisings, we have yet to understand the impact of the "graying of the population" in the industrialized world. In Japan, for example, the older population has now exceeded the younger population, and has created a labor deficit. Since women are the primary caregivers, they will also increasingly face the challenges of caring for aging family members. In the U.S., the needs of such family caregivers are largely unmet, inside the academy and outside it.

This paper examines elder care challenges for women, with a focus on women in the academy. It compares the health care system for elder care in the United States to health care systems in other countries, and it makes recommendations to provide institutional support for families who care for aging family members.

Gender and Elder Care in the U.S.

In 2008, the Federal Interagency Forum on Aging reported that the older population represented 12.8% of the U.S. population, or over one in every eight Americans. Further, the number of Americans aged 45-64 – who will reach age 65 over the next two decades – will increase by 31% between 2010 and 2030, and the age group 85 and older will triple by 2050.

There is a myth that frail elderly family members typically reside in nursing homes. In fact, in 2000 only 5% of older people lived in nursing homes (Cancian and Oliker, 2000). According to Caro (2006), because elder care issues occur in a family context, families incur the responsibility of caring for an aged family member, and this entails the provision of health care as well as financial support. "For elders who need long-term care, unpaid relatives tend to be the first source of care and the most important source of long-term care" (Caro, 2006: 2). Swanberg, Kanatzar, Mendiondo, and McCoskey's (2006: 417) study of the elder care situation for working people found that "more than 22 million households provide care for an older adult." It is estimated that 80% of the care provided to aged adults is provided by family members

Importantly, women continue to be primary caregivers for aged family members. According to Abrahamson (2010), the most common dyads of elder care for families are daughters caring for an older parent or a wife caring for a husband. In a study of the stressors that affect primary caregivers of the aged, Koerner and Keynon (2007) found that although men are increasingly sharing in elder care, women remain the primary caregivers. And the type of care provided is different. Men are more likely to do tasks such as writing checks and mowing the lawn, while women are delegated to the more physically demanding care tasks like bathing and housework. Nevertheless, women still contribute about 75% of caregiving for elders (Philipsen, 2008).

Another study, which examined the cultural construction of gender and elder care-giving, found that caregiving disproportionately falls on women (Brewer, 2001). The cultural construction of caregiving is such that women automatically take on the role of caring for

elders. Brewer further reports that studies showed that the caregivers of older individuals "endured high levels of stress, fatigue, and exhaustion in addition to financial hardship, isolation, and loneliness" (p. 20). Women are more likely to experience the negative effects of caregiving.

Of course there are cultural differences in attitudes toward elder care. Indeed, some studies find differences across ethnicities in values and norms about the care of aged family members. Spira and Wall (2009) report that African Americans, Latinos, and Chinese families view taking care of older adults as a family obligation, and therefore experience fewer negative effects. This does not mean, however, they would not benefit from more social support for caregiving.

In her study of the global problem the aging population, Stark (2005: 7) asserts:

> "Today, care for the elderly is deeply gendered, both in terms of the care that aging women and men receive and regarding those who perform care work and their working conditions. Women provide both unpaid and paid care work, often with great skill and creativity, and often with much satisfaction to the care worker herself and to the person needing care. But unacceptable situations also exist: overworked carers who receive little emotional or financial support, carers who lack skill and motivation, and old people whose care needs are largely unmet."

Even in countries that have public health care systems, such as in Europe, women remain the primary caregivers for aged individuals. Thus elder care needs to be viewed with a gender lens, and the appropriate policies enacted to permit working women to balance family and work responsibilities.

Working Women and Elder Care: The Academy and Beyond

As the number of working adults caring for an older adult is projected to increase, elder care is now becoming a work-related issue, and as the older population increases, so does the number of employees who provide care to aging family members. According to Swanberg, Kanatzar, Mendiondo, and McCoskey (2006), more than 64% of those providing care in the year 2000 were employed. They add: "Workplaces may be ill prepared to handle the growing number of employees who will provide informal care to a family member or friend over the next 20 years" (p. 418). For working women, the challenges of caring for an older adult can be especially difficult. Boaz, Hu, and Ye (1999) found that working women experience a loss of income when caring for ill elderly patients. Wisendale's (2006) study of the FMLA policy found that approximately 66% of those surveyed did not take FMLA because they could not afford it. Philipsen's (2008) study of the challenges for women academics found that costs to the working family caregiver include absenteeism, more distractions at work, more physical and mental problems, and loss of career advancement.

Women in the academy who face elder care issues usually have achieved tenure but are also likely to have assumed administrative responsibilities in addition to teaching and research (Philipsen, 2008). This is especially true for the "sandwich generation" (Wujcik, 2008), the population of women aged 45 to 55 who care for both their children and their elderly parents. Caring for older family members can be even more emotionally and physically exhausting than caring for children, and especially so for the women of the sandwich generation (Koerner and Keynon, 2007).

In a 2006 survey of Purdue faculty members by the Faculty Affairs Committee, fully 47% of the respondents reported stress over elder care issues, compared with 43% who reported stress over child care. At the ADVANCE-Purdue Work/Family workshop on elder care (26 March 2010), we found that women in the STEM disciplines at Purdue are also facing elder care challenges.[3] In some cases, attending to elder care can meet with lack of understanding or worse by colleagues and supervisors. According to one senior faculty member, after taking time off to care for a mother with Alzheimer's disease, she lost her lab and had an increase of additional responsibilities. The reasoning, as she explained, was that "you can't get grant money to secure your position if you are not able to be here." Other faculty members agreed that there was very little support for faculty members who need to take time off from work to care for an aging family member. "It's not like having a child. You can't prepare for elder care because it happens in times of crisis and you don't have time to plan ahead," stated another faculty member.

Elder care frequently occurs in a time of crisis. According to Shellenbarger (2008: D1):

> "While child-care problems get more attention in the workplace, the emergencies that beset the aged—a fall, a stroke, the errant behavior of dementia—tend to be more disruptive, forcing working caregivers to drop everything and rush to the scene."

Working individuals cannot plan for a crisis event. Although some larger corporations are beginning to recognize the increasing challenges of employees who care for an aged family member, many institutions do not have provisions in place to support faculty members who need to take time off to care for an aged family member. Currently, except for the Family Medical Leave Act (FMLA) which allows employees 12 weeks unpaid leave, unless an employer offers a special benefit for caring for elders, workers must take personal time, sick time, and holiday pay when missing work. As Philipsen (2008: 139) asserts, long-term care options for older adults have yet to be "designed or effectively implemented."

At the March workshop on Elder Care, several of the faculty members commented on the challenges of dealing with a disjointed medical system. How does the United States compare with other industrialized countries? In particular, what policies are in place to support work/family balance with respect to elder care?

[3] For additional information on the workshop, visit http://www.purdue.edu/dp/advance/worklife.php.

A Comparative Perspective: Europe and other Industrialized Countries

The European model generally takes a more active role in elder care. European policies, although some still based on the male traditional bread-winner model, extend more governmental support for families expected to take care of older family members. Most national health care systems in the countries of the European Union (EU) recognize the services provided to aging adults in three distinctive categories: income support, health care, and personal or 'social care'" (Wolf and Ballal, 2006). Income support and health care are self-explanatory; social care refers to needs and services such as bathing, dressing, feeding and transportation (Wolf and Ballal, 2006: 694). The national policies also often provide support for families who care for older adults. Some of the policies may be in the form of financial support with home-health care to assist with social care and/or respite care. Industrialized countries such as Sweden, Japan, Canada, Australia and the U.K. all provide various care packages, welfare laws, grants, and long−term care insurance that support elder care. (See Appendix 1 for a comparative table.)

Sweden offers its sick elders a care manager who assesses the needs of the patient and determines the services needed (Hokenstad, 1996). These care managers help deploy the resources available more effectively. Home help services and senior homes are also available to assist elderly individuals (Sweden Institute, 2007). Municipalities in Sweden cover 90% of all elder care, and revenue from taxes pays for about 75% of all health and medical care (Sweden Institute, 2007).

Japan's Welfare Law for the Elderly collects taxes to cover services for the elderly. The municipalities decide how much coverage is given and services are determined by level of need (Ihara, 2010). Japan also provides Long Term Care Insurance that directly and indirectly compensates the patient for their financial obligations (Harvey, 2006).

The Canadian government provides Old Age Security and pays qualifying members up to $516.96 a month. Canada also provides a Pension Plan that offers retirement plans, disability benefits, death benefits, survivor benefits, and benefits for children. Canadian workers, the employers, and self-employed worker contribute funds to the Pension Plan through their investments earnings. Direct and indirect financial compensation is provided for caregivers who qualify, as is a tax benefit if the caregiver has a certain income level (Canada News Centre, 2010).

In Australia, a variety of care packages are offered to elder patients, including the Home and Care Program (HACC), the Community Aged Care Package (CACPs), and the Extended Aged Care At Home Package (EACH). The government program "Commonwealth" aids in financial counseling and rehabilitation services (Parliament of Australia, 2010).

The U.K. addressed the needs of sick and elderly citizens through the National Health Service and Community Care Grants. Community Care Grants are awarded to clients who meet specific requirements. The government finances the costs of the national health

system (Taber, 2010). Also, a caretaker can receive a Council Tax reduction if they are eligible (Funding Caring [UK]).

As seen from the data in the attached table, many industrialized countries are providing their elderly residents with the care and support they need. The comparative perspective and cross-national examples further highlight the gaps in elder care support in the United States.

In her article "Caring for Mom, Mum and Maman", Taber (2010) illustrates the reality of the differences in support for elder care comparatively across the U.S., U.K. and France. She compares her experience caring for her mother in the U.S. to that of two friends with mothers in the U.K. and France. Taber's mother lived in an assisted living community that cost $4,069 per month. Private aides, medications, and transportation were additional charges. Since Medicare pays very little, Taber's mother had to liquidate all of her assets to pay for her care.

In contrast, the *mum* of Taber's U.K. friend receives care support from the National Health Service. In the U.K., *mum* is charged nothing for doctors, nursing care, ambulances, diabetic clinic visits, medications, and hospitalizations. Further, *mum's* son is paid the equivalent of $350 a month by the government to help care for his mother. In turn, the family pays approximately $785 per month for a private aide, which allows the *mum* to stay in her home. In France, Taber's friend's, *maman*, has Alzheimer's disease but is able to stay at home through the Personal Autonomy Allocation program which refunds Taber's friend 560 of every 1,200 euros spent for medical care. This program makes it affordable to hire a professional to care for *maman* round-the-clock 3 ½ days a week, which gives the family some respite. Additionally, the program allocates for one free in-home doctor visit per month, and in-home doctor visits as needed. A physical therapist visits *maman* four days a week for a mere one euro co-pay which, as Taber points out, is less than a than the cost of a cup of coffee. The total monthly cost of in-home care for *maman* is $2,205.

Taber points out that her U.S.-based mother had to spend the last part of her life in an assisted living arrangement and had little quality of life, while the French and British mothers were able to stay at home due to the differences in the long-term health care systems across the three nations.

The shortcomings of the elder care system in the U.S. go beyond cost and include the fragmentation of services. The U.S. has a two tier system: short-term care and long-term care (Abrahamson, 2010). Medicare and Medicaid are the only options for financial support for older individuals. To qualify for these services, individuals must meet strict criteria. Even then, the amount of reimbursement is rarely enough to cover the necessary costs of health care.

According to Abrahamson (2010), the system in the United States is extremely fractured and complex which makes coordination difficult and actually drives up the cost of medical care. Care is centered on the primary doctor, who has the exclusive power to

diagnose, and that diagnosis has a direct effect on medical care reimbursement. Only skilled services (such as licensed professionals) are reimbursed by Medicare.

Daily needs of older individuals are the responsibility of the individual or their families. However, the U.S. health care system is not equipped to help families with elder care issues, and family members often find themselves negotiating with various units in the complex health care system over elderly family care (Caro, 2006: 2). In the U.S., it is healthcare system expects family to care for elder family members; however, the system does not provide any support for such families. Without a system of public support in sight, it will devolve upon U.S. employers to address the needs of employees faced with elder care issues. This reality pertains equally to academic institutions, where women (and some men) increasingly face the challenges of elder care in addition to the responsibilities of an academic career.

Conclusion and Recommendations

Philipsen's study of academic women across their career stages found that elder care is a "particular challenge" (2008: 266). Our own research confirms this. Faculty women face such problems as being penalized for having to take time off of work, the difficulties of coordinating care of an older adult with providers, and the lack of financial support. Unpaid FMLA is the only available option currently for most faculty members. The realities of the growing proportion of the 65+ population and the challenges faced by working families and women academics highlight the need to create support structures for caregivers.

McNamara (2007) reported that the cost to U.S. businesses for workers who care for aging family members has induced corporations to provide supports not afforded by a national initiative. The most prevalent practice is to allow employees to add an aging family member to the insurance plan; another is to give extra benefits toward home care which is only covered by Medicare if prescribed by a doctor.

As with the employee-friendly corporate models, universities can approach the issue of elder care as a strategy to retain talented and experienced faculty and staff. Because of the shortcomings of FMLA, and in the absence of national policies on, and public options for, elder care, it is incumbent upon academic institutions to help their employees balance family and work. The appropriate policies should have the support of the academic leadership, to ensure that faculty members may use the policies without fear of reprisal.

Because elder care usually occurs during a crisis, academic faculty may have no alternative but to take time off from teaching and research, which could be detrimental to their careers. Universities could help with in-home care and transportation even for those who have an older family member who lives some distance away. This type of assistance could allow a faculty member to take less time off of work and allow her to stay competitive and on-track in her career. Departments also need to take into account the unpredictable nature of elder care issues and have some sort of contingent plan for emergencies. As Philipsen (2008: 236) suggests, "Faculty would benefit from increased

institutional attention and flexibility, as well as release time and load adjustments for elder care."

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Purdue Resources

Center for Families: http://www.cfs.purdue.edu/CFF/

Center on Aging and the Life Course: http://www.purdue.edu/aging/

Work-Life Programs: http://www.purdue.edu/hr/WorkLife/

Appendix 1

Elder Care: Cross-National Examples			
Country	**Policies for Elder Individual**	**Family Care Providers**	**Source of Financing**
Australia	• Home and Community Care Program (HACC) • Community Aged Care Packages (CACPs) • Extended Aged Care At Home Package (EACH)	• Carers Package • Commonwealth helps aid in financial planning and counseling.	• Government programs including: Commonwealth, State and Local governments, and community groups support elder care • Australian Institute of Health and Welfare
Canada	• Government of Canada, through Old Age Security (OAS), pays $516.96 monthly to people aged 65 and older. • Personal care, in-home care, and nursing • The Canada Pension Plan provides retirement plans, disability benefits, death benefits, survivor benefits, and benefits for children.	• Compassionate Care Benefits • Tax benefits if caregiver has a certain income level • Direct and Indirect financial compensation for those who qualify. • Canadian Labor Code: Benefits for employment insurance and job security for absences in work.	• Tax revenues • Canadian Government
Japan	• Welfare Law for the Elderly • Health Service System for the Elderly • Elder homes, home care aid services, • Municipalities decide coverage given, services are determined by level of need.	• Long Term Care Insurance (LTCI) supports family caregivers • Caregiver leave- 40% of usual salary available to those who qualify • Coverage is determined by relationships or if patient has people to depend on. • Direct and Indirect financial compensation for those who qualify.	• Welfare Law for the Elderly collects taxes from central and local governments to cover services for the elderly.
Sweden	• Home-help services are provided and help with home and medical care • Senior homes available on open market through landlords, municipal housing, and foundations.	• A care manager assesses the elder's needs and determines what services will be needed. • Care managers help use the available resources more effectively.	• Municipalities provide about 90% of all elder care. • Tax revenue pays for about 75% of health and medical costs.
UK	• Through the National Health Service patients are provided: general practitioners, nursing care, ambulance services, medications and hospitalization at no charge. • Home visits are available by both doctors and nurses.	• Community Care Grants are awarded to clients who fit into certain circumstances. • Amount a person is eligible for is determined on a case-by-case basis. • A caretaker can receive a Council Tax reduction if they are eligible.	• National health system- Government finances costs • Higher taxes that cover most medical care