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Unready: The state of preparedness of current and future caregivers

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Introduction

Like most developed nations, the United States is experiencing rapid population aging. Between 1920 and 2020, the number of Americans over the age of 65 grew roughly five times faster than the general population (US Census Bureau 2023). As households age and experience changes in health status, they face increasingly complex decisions regarding the management and provision of long-term care (LTC), particularly for aging parents or relatives. Johnson (2019) estimated that upwards of 70% of older adults will require some form of LTC during their lifetimes, exposing many to potentially high expenses.

LTC needs can arise gradually, as in the case of Alzheimer's disease and related dementias (ADRD), or suddenly following acute events such as a stroke. These needs often trigger caregiving responsibilities within families. Adult children frequently assume the role of caregiver, making difficult decisions about who bears responsibility for care, who provides care, how the care is delivered, and who pays for the care. Many families rely on unpaid caregiving from one or more adult children, and the scale of this unpaid labor is significant. An estimated 37.1 million Americans over the age of 15 were providing unpaid elder care in 2023 (Bureau of Labor Statistics BLS 2023).

To assess the preparedness of future caregivers, we surveyed US adults between 40 and 64 with at least one living parent. Our goal was to investigate how individuals plan for potential caregiving needs, the impacts they expect, and the resources they anticipate using. We captured responses from both current caregivers and non-caregivers to compare levels of preparedness and knowledge across these groups. We also examined variation among caregivers based on whether caregiving began as a result of a crisis event. Our analysis focuses on the reported impact of caregiving (both actual and anticipated) on retirement planning, saving behavior, employment, and self-reported measures of financial well-being. We also examine potential barriers to planning for caregiving, including emotional reluctance to initiate difficult conversations, and explore respondents' awareness of their parents' own preparations for aging and care.

Respondents are segmented based on their belief about whether they will need to become caregivers in the future as well as their knowledge of available public and private resources that might support such care.

Our objective is to understand how and why US adults anticipate becoming caregivers, how they prepare for this role, and whether the expectation of caregiving costs (financial or otherwise) motivates them to plan. While this study represents only an initial step in assessing household readiness for caregiving, several key findings emerge. Future caregivers generally have reasonably accurate expectations about the time and financial costs associated with caregiving. Similarly current caregivers report a fair understanding of the steps their parents have taken to prepare for aging and care. Both groups, however, significantly overestimate the availability of resources and external support once caregiving begins (e.g., paid care services, sibling assistance, and parental preparedness). For example, while 39% of future caregivers expected to use paid care to supplement their unpaid time, fewer than 20% of current caregivers do so. We also find that future caregivers often underestimate the negative impacts of caregiving on their employment and finances, and such impacts are especially pronounced among caregivers who were less prepared at the onset of their caregiving responsibilities. Despite accurately recognizing the potential burdens, many future caregivers reported spending little time to plan for caregiving. They additionally tended to overestimate the extent to which their parents had taken concrete preparatory steps, such as drafting a will or creating a health care power of attorney. These findings point to a gap between awareness and action that may leave many households vulnerable to financial burdens following the onset of caregiving.

Prior literature

We build on prior research on caregiving in a number of ways. Previous studies examining how caregiving affects labor supply suggest that its impact depends on the care recipient's level of need as well as the labor market conditions (Crespo and Mira 2014). Informal caregiving has varying rates of duration and intensity. In the US, 30% of caregivers provide less than six months of care; 75% provide care for up to five years, and 24% provide care for longer than five years (CareScout 2024). Regarding the time spent caregiving, individuals spend an average of 24.4 hours per week providing care, and 23% spend over 41 hours per week (CareScout 2024).

For women in particular, there is evidence that caregiving reduces both current and future labor market outcomes (Skira 2015) via lower wages and reduced hours of employment. Unfortunately, these effects can be endogenous and difficult to isolate. A key concern is that caregiving may be correlated with unobserved characteristics, such as individuals who were already marginally attached to the labor force may have taken on caregiving roles simply because they had more non-labor time (Coe et al. 2013). As a result, a growing body of literature has focused on identifying the causal impacts of caregiving on the labor market.

Labor force participation can drop up to 3.5 percentage points within the first year of caregiving, and this increases over the length of time spent providing care (Maestas et al. 2021). Almost 70% of caregivers report needing to make modifications to their work schedule to accommodate caregiving (Family Caregiving Alliance 2016). As a result, informal caregivers can be subjected to long-term earnings losses due to missed work or delayed career progression. Among adults ages 20–64, informal caregivers worked an average of 2.1 fewer hours per week than non-caregivers, culminating in total lost wages of $67 billion (in $2016) which translates to approximately $5,251 per caregiver (Mudrazija 2019). Total opportunity cost is also impacted, with informal elder caregiving costing an annual $522 billion (in $2012; Chari et al. 2015). When only daughters providing caregiving are considered, they see a median loss in wages of around $24,500 over a two-year period (Coe et al. 2018). Females represent 60% of informal caregivers and are thus disproportionately affected by the consequences of caregiving (CareScout 2024).

When labor force participation is significantly reduced, the risk of poverty in later life increases among informal caregivers, especially when caring for a spouse (Butrica and Karamcheva 2014). With reduced earnings and asset accumulation, a caregiver's retirement saving may be negatively impacted as well, with 24% of caregivers holding less than $1,000 in retirement savings (Copeland and Greenwald 2023). Overall, caregivers' retirement savings see deficits between 40% and 90% by age 65—depending on the length of time caregiving is required, individuals would need between eight and 24 additional years of work to recover lost contributions (Columbia Mailman School of Public Health 2024). Recently, bipartisan bills have been introduced in an attempt to offset the financial impacts of caregiving (e.g., Roth IRA Exception Bill and Catch-Up Contributions Bill); however, these bills have not been passed.

Despite the breadth of literature examining the adverse effects of informal caregiving on the caregiver, relatively little is known about how US adults anticipate the possibility and need of future caregiving. Our study focuses on this pre-caregiving stage, aiming to assess how well potential caregivers understand and prepare for the role of a caregiver. Understanding the preparedness of non-caregivers may help inform policies to better support and equip them in mitigating negative impacts on their employment, health and wellness, and retirement security.

An overview of caregiving

Caregiving for adults generally becomes necessary once individuals are no longer able to manage their activities of daily living (ADLs). This term refers to six tasks that healthy individuals are expected to be able to complete independently, including walking, eating, dressing, maintaining personal hygiene, continence, and toileting (Edemkong et al. 2023). Physical and/or cognitive impairments, such as those caused by Alzheimer's disease or a stroke, may limit one or more of these functions and trigger the need for caregiving.

Scales and indices, such as the Katz Index of Independence in ADLs (McCabe 2019), provide doctors, nurses, and other clinicians with the ability to assess where and how individuals are functionally limited in order to make more informed decisions regarding how care should be delivered (e.g., in a facility or in the home). An additional set of metrics, the Instrumental Activities of Daily Living (IADLs), include more complex tasks, such as grocery shopping, taking medications, or managing personal finances, which are also necessary for independent living. Parents' medical conditions, their ADL/IADL limitations, their living environments, and preferences all influence the level and type of care needed. Even when health challenges emerge, older adults frequently resist inpatient care. When surveyed, 75% of adults age 50+ preferred to receive care within their home rather than move into an assisted living community or a nursing home (Binette 2024). Yet, many of the respondents also reported that home modifications would be necessary in order for the home to stay accessible over time. As a result, adult children often face logistically, financially, and emotionally complex decisions and challenges when caregiving becomes necessary.

Caregiving commitments can come in many forms. They may involve time-intensive tasks, such as assisting with ADLs/IADLs and providing transportation to and/or companionship during medical appointments, or financial contributions, such as home modifications based on mobility needs, cleaning services, hiring home health aides, or covering facility-based care.

Care provision. There are several different avenues for the provision of adult care. For example, families can opt for informal care, which is typically unpaid and provided by family members, or formal care, which includes paid services for inpatient or outpatient care. The type of caregiving required depends on the recipient's level of need, the family's financial resources, and the availability of local care services. In general, inpatient care (e.g., nursing facilities and memory care unites) is more expensive than outpatient care, but both can be very costly. In 2024, the national median rate for home health aides was $34 per hour or $70,720 annually (assuming a 40-hour work week; CareScout 2024). Nursing home costs also varied, costing $9,277 per month for a semi-private room and $10,646 per month for a private room (or $111,300–$127,750 a year; CareScout 2024). Memory-care units often cost 20–30% more.

Cost of formal caregiving. The cost of outpatient care is primarily determined by the number of hours provided and the level of services provided. For example, a live-in aide is likely to cost more than one who visits for a few hours a day, and medically skilled workers (e.g., nurses or therapists, who sometimes require specialized equipment) cost more than aides assisting with basic ADLs. Licensed professionals in this space include nurses, physical and occupational therapists, and certified home health aides. There are also non-medical providers who assist with housekeeping, mobility, and other daily tasks and routines. Inpatient care is similarly varied, ranging from assisted living facilities to memory care units and full-time nursing care. The appropriate level of care depends on the patient's condition and may be temporary or long-term.

Coverage for paid caregiving. In the US, caregiving expenses are partly covered through a mix of Medicare, Medicaid, long-term care insurance (LTCI), and employer-sponsored health insurance. Medicare is available to Americans age 65+, and it is federally funded and operated. It generally covers caregiving services only when they are tied to a medical event or condition. For example, Medicare may cover home visits by a physical therapist following a broken leg, but it does not cover full-time caregiving or assistance with ADLs. As well, Medicare will generally not cover stays longer than 100 days in a nursing home unless it is related to an acute medical condition rather than chronic decline as a result of dementia or another long-term condition. As a result, most long-term caregiving costs must be paid out-of-pocket or through sources other than Medicare.

Medicaid covers long-term stays in skilled nursing facilities and offers some support for outpatient care, and it is jointly funded and administered by state and federal governments. This creates a complex patchwork of coverage differences for caregiving services and programs across state lines. Access to Medicare is subject to two key eligibility criteria: means-based eligibility and functional eligibility. Means-based eligibility requires Medicaid beneficiaries to have very limited assets. The potential beneficiary must have nearly zero assets, with the exception of their primary home, and must have maintained that financial status for at least five years. Assets held in trust are potentially vulnerable to estate recovery efforts from state Medicaid programs to recoup care costs. Functional eligibility requires applicants to have a specified categorical disability, such as blindness or end-stage renal disease. For greater in-depth coverage of Medicaid waiver variation by state, see Miller et al. (2025).

Because Medicaid is state-administered, coverage for caregiving services varies widely across states: dome states offer benefits beyond federal minimums while others do not. For example, a federal program called Community First Choice covers in-home assistance with ADLs and IADLs so that beneficiaries can remain at home instead of having to move into nursing homes. To date, however, only nine states participate. Other programs, including waiver-based systems for nursing home diversion, also vary across states and often require a needs-based assessment. Some are entitlement programs and hence have no waiting list (generally those associated with the original base Medicaid plan), while others operate with limited capacity, resulting in long waits for services (American Council on Aging 2025).

Long-term care insurance. Alternatively, individuals can purchase LTCI to help cover some or all of the costs of long-term care in exchange for a monthly premium. Unfortunately, adverse selection has significantly driven up costs in the LTCI market, creating a self-reinforcing cycle. Because policyholders are more likely than the general population to need long-term care, they are also more likely to file claims. To offset these costs, insurers raise premiums which in turn deters lower-risk individuals from purchasing coverage. As a result, the risk pool becomes even more concentrated with high-risk individuals, which only further drives up premium costs. This cycle, combined with the complexity and variability of LTC needs, makes such care challenging to insure effectively.

Other notable factors that affect the LTCI market include the role of family members and other decision makers in LTC arrangements, high administrative fees and costs due to the individual (rather than the aggregate market), and the crowd-out effects of Medicaid, which provides a safety net for those who meet eligibility requirements. For a more detailed overview of LTC and insurance, see Braun and Kopecky (2024) and Fang (2016). While an exhaustive list of paid care resources is beyond the scope of this chapter, it is clear that the demand for and supply of paid care is highly idiosyncratic, the care is very costly, and insurance options to cover these costs are limited.

Informal care costs and impacts. Paid and unpaid caregiving is sometimes grouped under the broader category of long-term services and support (LTSS), which includes inpatient, outpatient, formal, and informal care. In our context, informal care refers to unpaid caregiving, typically provided by family members or friends, and it may evolve as the recipient's needs change over time. A large body of research has examined the emotional, physical, and financial impacts of caregiving on those who provide it. Emotional effects on outcomes can include both negative impacts (e.g., chronic stress, depression, and social isolation) and positive ones (e.g., greater appreciation for life or stronger familial bonds). For example, Haley et al. (2009) surveyed family caregivers of stroke victims and found increased levels of stress but also increased appreciation for life. Similarly, Wolff et al. (2017) found that between 1995 and 2015, family caregivers increasingly utilized respite services and were more likely to remain in the workforce. Their study also noted that the type and extent of financial and health impacts differed depending on whether the caregiver was a spouse or an adult child. Interestingly, the meta-analysis by Roth et al. (2015) provided evidence of increased longevity among caregivers, challenging previous assumptions that caregiving increased mortality. Still, the financial impacts of caregiving are substantial. Time spend on care may force caregivers to reduce work hours or exit the workforce, which can delay the caregiver's ability to save for their own retirement, spend down personal debt, or pay for a child's education (Kolluri and Naylor 2023).

To alleviate some of these concerns, some employers provide caregiving-related benefits for their employees. These can include the ability to take paid or unpaid leave, flexible work arrangements, coverage for mental health services, or caregiving supports like backup care coverage. One example is the Family and Medical Leave Act (FMLA), whereby eligible US employees can take up to 12 weeks of unpaid, job-protected leave per year for caregiving responsibilities. Using survey data, Harrington and McInturf (2021) explored employer benefits in greater detail, including how often employees made use of them. They found that employee usage rates were relatively low despite a majority of surveyed employers offering some form of support for caregivers, highlighting the importance of communicating benefits and how to access them. Clearly merely making these programs available does not convert to high utilization rates.

Data and methodology

Survey and exclusion criteria. We partnered with Edge Research to field a survey of 1,249 US adults age 40–64 who had at least one living parent; this was conducted in September–October 2024. Table 1 provides summary statistics, where Column 1 reports results for the full sample. Columns 2–4 break the sample into three subgroups: current caregivers (about 43% of respondents), future caregivers (31%), and non-caregivers (26%). We define current caregivers as respondents who answered "Yes" when asked if they currently provided unpaid care to a parent, stepparent, or spouse's parent/stepparent needing assistance with physical, mental, or daily tasks. A follow-up question asked if they received pay for such caregiving via Medicare, Medicaid, or other sources. If they responded "Yes" or "Not sure," they were excluded from the sample. The sample population was weighted to be representative of the US population age 40–64. Caregiver status was not a targeted recruitment criterion, so the proportion of respondents in the sample who reported being caregivers reflect the actual population.

TABLE 1. DEMOGRAPHIC, ECONOMIC, AND FAMILY CHARACTERISTICS BY CAREGIVING STATUS

	Total			Current caregivers			Future caregivers			Non-caregivers		
Variable	**Mean**	**Median**	**SD**	**Mean**	**Median**	**SD**	**Mean**	**Median**	**SD**	**Mean**	**Median**	**SD**
Female (Yes=1)	0.63	1	0.48	0.63	1	0.48	0.61	1	0.49	0.66	1	0.47
Age	51.61	52	7.05	52.12	52	6.91	51.04	51	7.04	51.42	53	7.25
White	0.71	1	0.45	0.76	1	0.43	0.75	1	0.43	0.59	1	0.49
Black	0.11	0	0.32	0.09	0	0.29	0.08	0	0.28	0.19	0	0.39
Hispanic	0.10	0	0.31	0.10	0	0.29	0.09	0	0.29	0.13	0	0.34
Full-time worker	0.58	1	0.49	0.65	1	0.48	0.61	1	0.49	0.44	0	0.50
Part-time worker	0.08	0	0.28	0.07	0	0.26	0.10	0	0.30	0.08	0	0.28
Unemployed or retired	0.33	0	0.47	0.28	0	0.45	0.29	0	0.45	0.48	0	0.50
Income < $35,000	0.27	0	0.44	0.17	0	0.38	0.28	0	0.45	0.42	0	0.49
Income ≥ $35,000, <$50,000	0.20	0	0.40	0.19	0	0.39	0.19	0	0.40	0.22	0	0.42
Income ≥ $50,000, <$100,000	0.28	0	0.45	0.33	0	0.47	0.28	0	0.45	0.21	0	0.41
Income ≥ $100,000	0.25	0	0.43	0.31	0	0.46	0.24	0	0.43	0.15	0	0.36
No savings	0.20	0	0.40	0.15	0	0.36	0.17	0	0.38	0.29	0	0.46
Savings < $10,000	0.27	0	0.44	0.24	0	0.43	0.29	0	0.45	0.29	0	0.45
Savings ≥ $10,000, <$100,000	0.22	0	0.41	0.24	0	0.43	0.22	0	0.42	0.18	0	0.39
Savings > $100,000	0.24	0	0.43	0.29	0	0.45	0.26	0	0.44	0.14	0	0.35
Savings unknown/ Prefer not to say	0.08	0	0.26	0.07	0	0.26	0.06	0	0.04	0.10	0	0.30
Living father, stepfather, father-in-law	0.65	1	0.48	0.62	1	0.49	0.70	1	0.46	0.64	1	0.48
Living mother, stepmother, mother-in-law	0.89	1	0.32	0.91	1	0.28	0.88	1	0.33	0.85	1	0.36
Has sister(s)	0.70	1	0.46	0.69	1	0.46	0.70	1	0.46	0.72	1	0.45
Has brother(s)	0.67	1	0.47	0.67	1	0.47	0.64	1	0.48	0.69	1	0.46
Age of oldest parent receiving care	79.71	80	7.74	79.71	80	7.74	-	-	-	-	-	-
Duration of caregiving in years	4.59	3	6.31	4.59	3	6.31	-	-	-	-	-	-
Age of older living parent	76.53	76	8.16	-	-	-	76.33	76	7.78	76.76	76	8.59
Age of younger living parent	74.25	75	8.36	-	-	-	74.02	75	8.25	74.51	74	8.49
N	1249	-	-	543	-	-	381	-	-	325	-	-

Source: Authors' computations; see text.

Survey participants who answered that they were not current caregivers were further subdivided into two groups (see Columns 3 and 4). Column 3 contains respondents who reported that they anticipate providing unpaid care to a parent, stepparent, or parent-in-law in the future. The remainder of this chapter will refer to this group as ‘future caregivers.’ Column 4 contains the remaining respondents who reported that they did not expect to provide care in the future. The remainder of this chapter will refer to this group as ‘non-caregivers.’

Caregivers and future caregivers showed similar observable characteristics. Future caregivers had slightly lower income and savings and were slightly younger than current caregivers, but those were the only statistically significant differences. Non-caregivers differed more substantially. They were more likely to be Black, unemployed, report less income and lower savings, and slightly more likely to be female. The survey did not ask why they did not expect to become caregivers. The similarities between current and future caregivers suggest that prospective caregivers have a realistic sense of their future role.

Current caregivers were asked a series of questions regarding their caregiving experience. These included questions about the number of hours and amount of money they spent per week on caregiving, whether they were the primary caregiver or if another person did most of the work, whether they were providing care for one or multiple people, and whether the person or people receiving care also received some form of paid care. If paid care was involved, responders were additionally asked to explain how it was funded. Other questions addressed the personal and financial costs of caregiving. These included whether respondents had to delay financial goals, take time off work, or experienced negative impacts in areas of their life, such as personal time, physical health, mental health, financial status, or relationships. Some questions also asked respondents about the steps they or their families had taken to prepare for caregiving.

We also offered respondents a list of various preparatory steps that the respondents’ aging parents might have taken and asked respondents to indicate whether their parents had completed them. Some of these were basic, such as writing a will, saving for retirement, or making a budget. Others were more advanced, such as consulting an elder care attorney or enrolling in a continuing care retirement community. Respondents were also asked whether their parents had discussed their health, future care plans, or the possibility of changing living arrangements to receive care from family members. Finally, responders were asked about specific documents or arrangements that their parents might have made, such as enrolling in Medicare or other insurance, designating a financial or health care power of attorney, creating an advanced directive, obtaining LTC insurance, or developing a caregiving plan.

The ‘future caregiver’ respondents were provided a similar set of questions, phrased in terms of the future. For example, while current caregivers were asked whether they supplemented their caregiving with paid care and how they paid for it, future caregivers were asked whether they anticipated using paid care and how they would pay for it. Current caregivers were asked about conflicts with siblings over medical decisions, whereas future caregivers were asked if they anticipated such conflicts.

This structure allowed us to compare current caregivers’ experiences with the expectations of those who anticipated future caregiving. Across several domains, future caregivers were often optimistic about both the burdens of caregiving and their parents’ levels of preparation, relative to the experience reported by current caregivers. In some cases, future caregivers correctly anticipated the ordering of caregiving’s impacts, even if they underestimated their intensity. In other areas, future caregivers were generally accurate in the sense of the overall distribution of caregiving’s effects.

We found that future caregivers were often optimistic, typically underestimating burdens and overestimating external support. In some areas, they were correct about the prevalence of burdens in providing care (e.g., time and financial costs), but they underestimated the magnitude of such burdens. In other areas, they accurately perceived the distribution of caregiving effects across the group.

Survey findings

Hours and money spent on (anticipated) caregiving. The clearest examples of the cost of caregiving are the time and out-of-pocket expenses that caregivers devoted to their work. Table 2 (Panel A) compares current caregivers’ actual weekly hours and future caregivers’ expected hours on these tasks, revealing statistically significant differences in the share of hours between the two groups. Future caregivers closely aligned with current caregivers in terms of the time commitment of caregiving, although there was a substantial segment of the future caregiver segment who were unsure of or underestimated the likelihood of the highest time commitment. This suggests that those who expect to become caregivers have a generally accurate sense of the time they will need to invest in the work.

TABLE 2. CAREGIVING TIME COMMITMENT AND MONTHLY OUT-OF-POCKET COSTS AMONG CURRENT AND FUTURE CAREGIVERS

	Panel A	
	Current caregiver	Future caregiver
Hours	**Share (%)**	**Share (%)**
Less than 1 hour	2.21	0.97
At least 1 but less than 3 hours	14.55	12.58
At least 3 but less than 10 hours	30.02	30.00
At least 10 but less than 20 hours	25.41	24.52
Over 20 hours	26.34	20.00
Not sure	1.47	11.94
	Panel B	
	Current caregiver	**Future caregiver**
Monthly out-of-pocket costs	**Share (%)**	**Share (%)**
No cost	16.21	13.91
Less than $100	21.92	9.71
At least $100 but less than $500	35.73	32.81
At least $500 but less than $1,000	16.57	10.24
At least $1,000 but less than $2,000	5.71	6.82
At least $2,000 but less than $3,000	0.74	2.89
At least $3,000 but less than $4,000	0.74	0.52
At least $4,000 but less than $5,000	0.00	0.26
Over $5,000	0.18	0.79
Not sure	2.21	22.05

Source: Authors' computations; see text.

Next, we turn our attention to out-of-pocket expenses. Table 2 (Panel B) shows a similar pattern for monthly out-of-pocket costs: future caregivers often lacked precise expectations or underestimated the costs. In other categories, the future caregivers were generally distributionally accurate. Overall, Table 2 shows that approximately 12% of future caregivers did not know how much time caregiving would require and 20% did not know how much money it would cost. Those who offered guesses were generally distributionally accurate, though not precise in terms of expected magnitudes of costs.

One of the most important areas where current and future caregivers differed had to do with the availability of paid care and the extent to which the respondent would bear the biggest burden of the work. Of those who expected to be future caregivers, 42% expected to make use of paid care and 37% were unsure. Among current caregivers, only 21% reported using paid care. Future caregivers anticipated coverage from their parents' health insurance, Medicare, savings, retirement plans, LTCI, or other sources. Current caregivers, however, cited cost (44%) and the inability to find qualified or trustworthy paid help (29%).

Who provides care? A related question has to do with whether the caregiving work is shared across family members. Table 3 shows current and future caregivers' responses to questions about help from other family members. Future caregivers tended to overestimate help from siblings and underestimated the risk of receiving no assistance. Among current caregivers, 44% reported that other family members were unable to help, and 43% cited family unwillingness to help.

TABLE 3. EXPECTED SOURCES OF SUPPORT AMONG CURRENT AND FUTURE CAREGIVERS

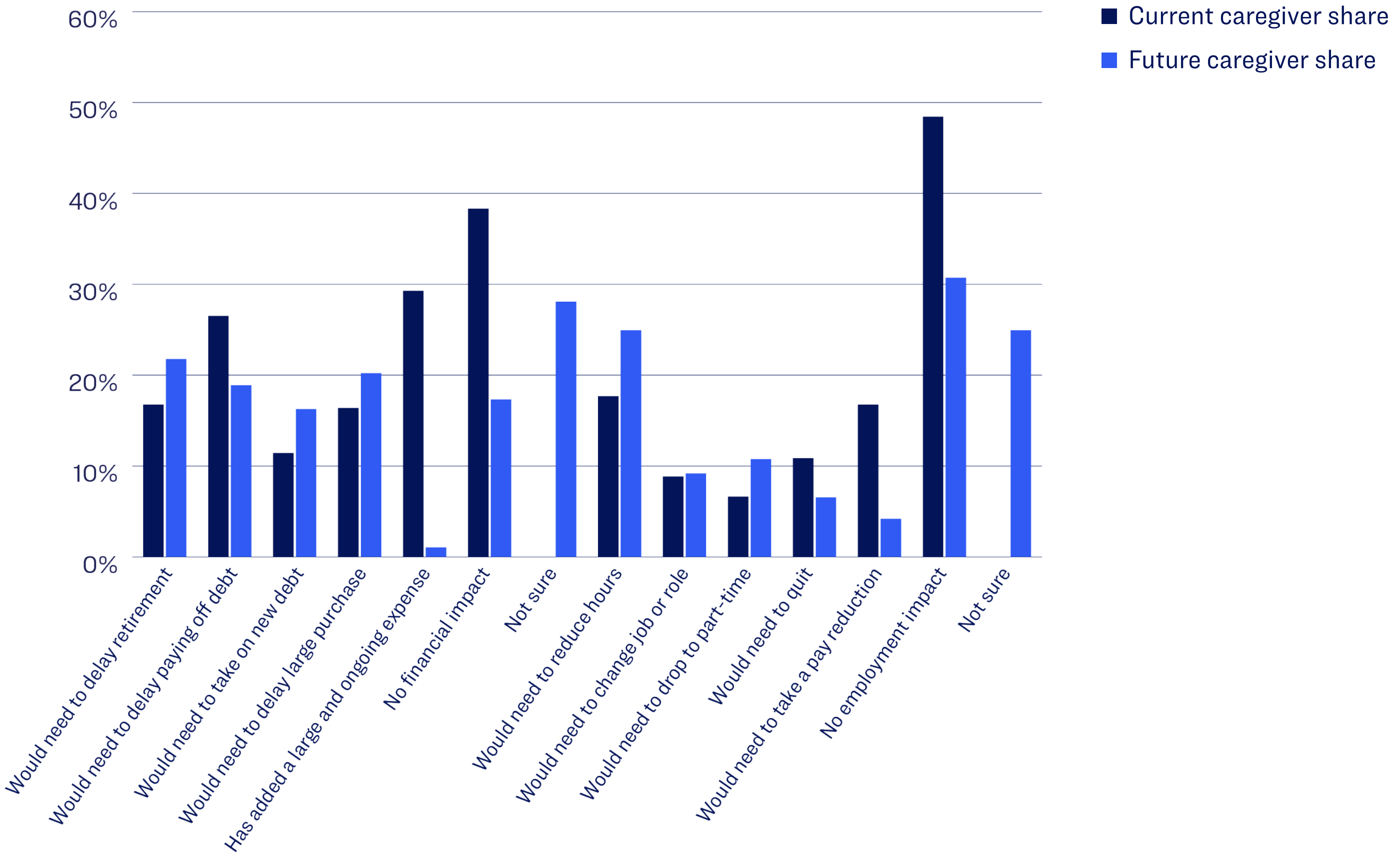
	Current caregiver	Future caregiver
Expect help from...	**Share (%)**	**Share (%)**
Brother	27.75	39.75
Sister	34.13	35.21
Spouse	19.34	22.31
In-laws	12.24	17.91
Other parent	7.51	5.15
Nobody else	31.31	24.41

Source: Authors' computations; see text.

Impacts of (expected) caregiving

Financial and labor market impacts. Respondent answers to the qualitative questions about the anticipated personal impact of caregiving were also informative. We asked both current and future caregivers about a range of possible negative impacts to their financial situations resulting from caregiving, and results appear in Figure 1. Again, future caregivers reported less certainty than current caregivers about future impacts, but they were also less likely to report zero expected impacts; in comparison, almost half of current caregivers reported zero impacts. This suggests that, at least in some dimensions, future caregivers overestimated the negative anticipated impacts of caregiving. Similar patterns held for employment-related impacts: about a quarter of future caregivers were unsure about the specific challenges they might face, and they also overestimated the prevalence of some negative impacts.

FIGURE 1. SHARE REPORTING NEGATIVE FINANCIAL AND EMPLOYMENT IMPACTS OF CAREGIVING



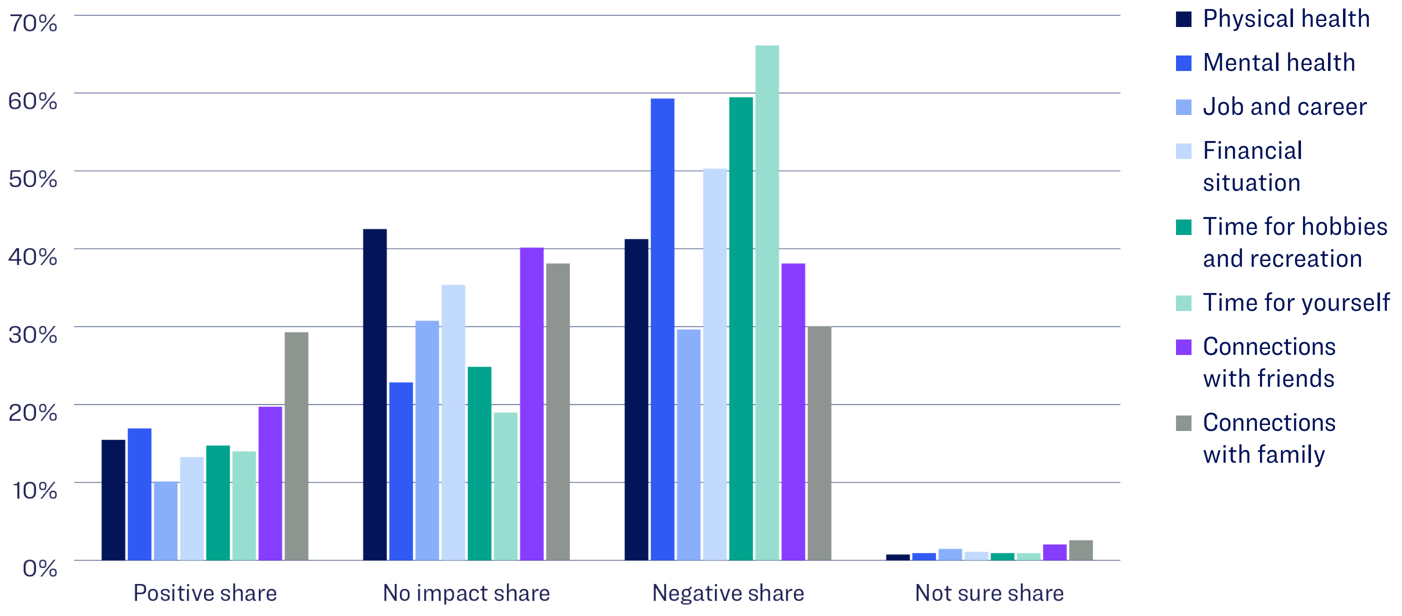
Notes: The bars indicate the share of current (dark blue) and future (blue) caregivers reporting that they have experienced or expect to experience a given negative financial or employment impact as a result of caregiving. Current caregivers were not offered a 'Not sure' option.

Source: Authors' computations; see text.

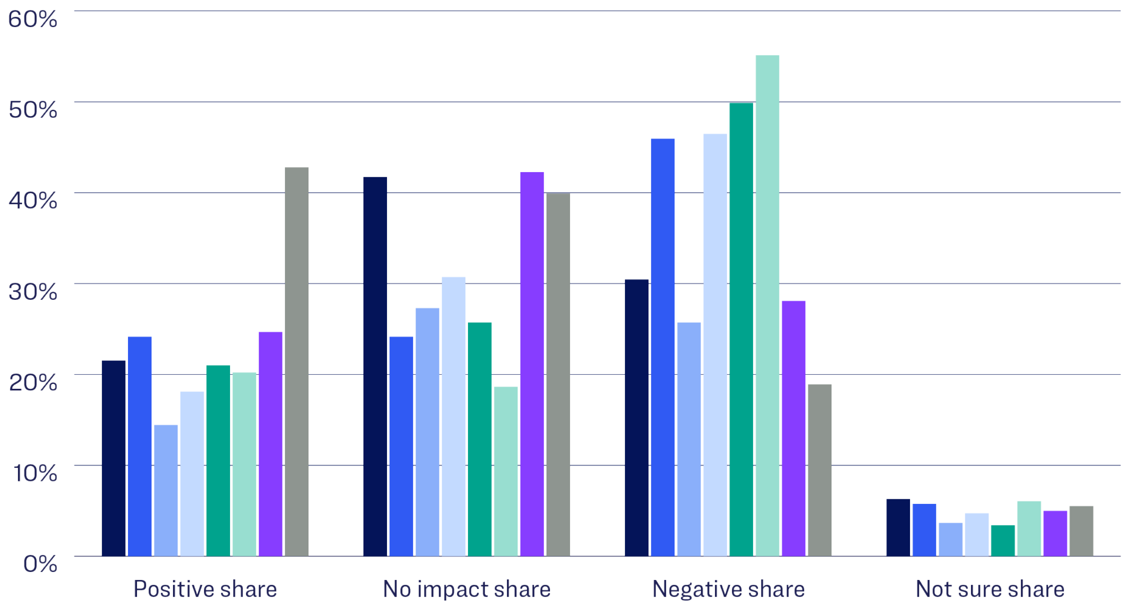
Personal impacts. A related set of questions asked respondents to consider the actual or anticipated non-financial effects of caregiving on their quality of life across several domains: physical health, mental health, job and career, financial situation, time for hobbies or recreation, time for themselves, and relationships with friends and family. Figure 2 presents these results, with separate panels for current (A) and future (B) caregivers. Across all categories, future caregivers consistently underestimated the likelihood of negative impacts and overestimated the likelihood of positive impacts.

FIGURE 2. SHARE OF CAREGIVERS AND THEIR REALIZED IMPACTS FROM CAREGIVING

Panel A. Current caregivers



Panel B. Future caregivers



Note: The bars indicate the share of current caregivers reporting a positive, zero, or negative impact from caregiving across a number of personal domains.
Source: Authors' computations; see text.

Planning for caregiving. One area of divergence between current and future caregivers concerned perceptions of their own preparedness and that of their parents. There was no difference between current caregivers' assessments of their own readiness at the start of caregiving, versus future caregivers' feelings of preparedness. Nevertheless, future caregivers believed their parents were much better prepared than current caregivers found them to be. Thus, 69% of future caregivers believed their parents were 'Very prepared' or 'Somewhat prepared' to plan for their own care should they need it, versus just under 50% of current caregivers (and the difference was statistically significant).

To illustrate the adult children's understanding of their parents' preparedness, Table 4 presents responses to questions about whether parents had discussed their health, consulted with a wills or estate lawyer, or engaged in similar conversations. Table 5 indicates whether parents had specific documents or assets in place such as a retirement plan, a will, a power of attorney for health care and finances, or LTCI. Across nearly all categories, future caregivers overestimated the preparedness of their parents (compared to current caregiver reports). For instance, future (current) caregivers believed that 64% (58%) of their parents had saved for retirement; 48% (43%) respectively had a will or estate plan; and 51% (49%) respectively had discussed plans for growing older or requiring care with family members. Regarding retirement planning, 51% (45%) of future (current) caregivers believed their parents had adequately planned for retirement (a statistically significant difference). Still, a substantial portion of future caregivers indicated uncertainty, including 31.5% who did not know if their parents had made any sort of caregiving plan. In conjunction with the broader findings on perceived preparedness, it appears that future caregivers were overly confident in how well their parents' preparation would translate into reality.

TABLE 4. PARENTAL RETIREMENT, LEGAL, AND CARE PLANNING ACTIVITIES REPORTED BY CURRENT AND FUTURE CAREGIVERS

	Current caregiver			Future caregiver		
Have your parents ...	**Did**	**Did not**	**Not sure**	**Did**	**Did not**	**Not sure**
	Share (%)	**Share (%)**	**Share (%)**	**Share (%)**	**Share (%)**	**Share (%)**
Planned adequately for retirement	**44.75**	**44.75**	**10.50**	**51.44**	**33.07**	**15.49**
Saved for retirement/will have income in retirement as a pension or annuity	57.64	**35.54**	**6.81**	63.78	**23.36**	**12.86**
Come up with a plan or budget for living on a fixed income	42.36	**47.70**	**9.94**	48.82	**33.07**	**18.11**
Talked to an accountant or financial advisor	28.18	**60.77**	**11.05**	33.60	**46.46**	**19.95**
Talked to an eldercare attorney	9.94	**77.90**	**12.15**	6.82	**68.50**	**24.67**
Talked to a will or estate-planning attorney	42.54	**48.80**	8.66	48.29	**34.38**	**17.32**
Arranged to have a home health aide come help them	16.94	**78.45**	**4.60**	13.39	**66.14**	**19.42**
Moved to, or signed up for waiting list of assisted living facility/continuing care retirement community	12.89	82.32	**4.79**	10.76	77.69	**11.55**
Discussed their health situation with you or your siblings	58.56	38.12	**3.31**	57.48	33.86	**8.66**
Made plans with you or a sibling to live together if needed	32.60	**61.33**	**6.08**	36.75	**53.02**	**10.24**
Had discussions with you/your siblings about plans for growing older or requiring care	48.80	47.70	3.50	51.18	42.78	6.04
Had discussions with someone else (not you or your siblings) about plans for growing older or requiring care	29.65	**54.33**	**16.02**	28.08	**42.26**	**29.66**

Source: Authors' computations; see text.

TABLE 5. PARENTAL PLANNING AND INSURANCE STATUS REPORTED BY CURRENT AND FUTURE CAREGIVERS

	Current caregiver			Future caregiver		
Do your parents have ...	**Did**	**Did not**	**Not sure**	**Did**	**Did not**	**Not sure**
	Share (%)	**Share (%)**	**Share (%)**	**Share (%)**	**Share (%)**	**Share (%)**
A caregiving plan	19.15	**70.72**	**10.13**	22.31	**46.19**	**31.50**
A financial plan	37.94	**49.54**	**12.52**	44.36	**27.30**	**23.10**
A will or estate plan	57.27	**35.36**	**7.37**	62.20	**23.10**	**14.70**
A healthcare power of attorney	45.67	**43.28**	**11.05**	41.73	**35.17**	**23.10**
Advanced directive	43.65	**45.67**	**10.68**	40.16	**35.70**	**24.15**
Financial power of attorney	46.22	**45.12**	**8.66**	44.88	**30.71**	**24.41**
Primary health insurance	75.51	20.07	**4.42**	72.70	15.75	**11.55**
Supplemental health insurance	40.52	**51.75**	**11.42**	40.94	**27.56**	**31.50**
Medicare	**83.06**	13.26	**3.68**	**74.28**	12.34	**13.39**
Retiree Health Savings Plan	23.20	**60.96**	**15.84**	20.73	**43.83**	**35.43**
Long-term care insurance	27.26	**58.56**	**14.18**	36.75	**40.42**	**32.28**
Savings, retirement, and/or investment accounts	63.90	**29.28**	**6.81**	66.40	**21.78**	**11.81**

Source: Authors' computations; see text.

Another major area of divergence emerged when we asked respondents how much thought and planning they were dedicating to a variety of financial and personal goals (e.g., maintaining their health, paying off debt, funding education, or buying a house). Three of these goals were directly related to caregiving: planning for the decline or death of a parent; making time for the care of a parent needing physical, mental, or ADL assistance; and financing the care of a parent requiring such assistance. Table 6 shows that responses from future caregivers and current caregivers were almost identical for all categories except for caregiving-related categories. Although future caregivers were informed about the costs and risks of caregiving and had an understanding of their parents' preparation, they did not appear to be actively planning for or thinking about caregiving responsibilities.

TABLE 6. EXTENT OF PLANNING AND CONCERNS AMONG CURRENT AND FUTURE CAREGIVERS ACROSS KEY LIFE DOMAINS

	Current caregivers			Future caregivers		
How much are you planning for/ thinking about...	**A lot/great deal**	**Not much/ Not at all**	**Not sure**	**A lot/great deal**	**Not much/ Not at all**	**Not sure**
	Share (%)	**Share (%)**	**Share (%)**	**Share (%)**	**Share (%)**	**Share (%)**
Decline or death of a parent	**81.58**	**14.73**	**7.37**	**66.14**	**27.30**	**6.56**
Financing the care of a parent	**72.56**	**23.94**	**3.50**	**44.62**	**45.67**	**9.71**
Making time for care of a parent	**92.45**	**6.63**	**0.92**	**58.27**	**32.02**	**9.71**
Buying or financing a new home	63.17	51.93	9.39	65.88	51.97	8.14
Financing a child's education	43.28	32.78	23.94	39.37	38.06	22.57
Financing your retirement	53.59	16.94	2.58	53.81	19.42	4.20
Paying off debt	72.01	20.81	7.18	69.55	22.83	7.61
Advancing in your career	54.88	34.81	10.31	50.39	38.32	11.29
Maintaining or addressing your own health	93.19	6.81	0.55	92.39	7.61	1.05
Day-to-day bills and making ends meet	82.32	15.84	1.84	89.76	13.91	1.57

Source: Authors' computations; see text.

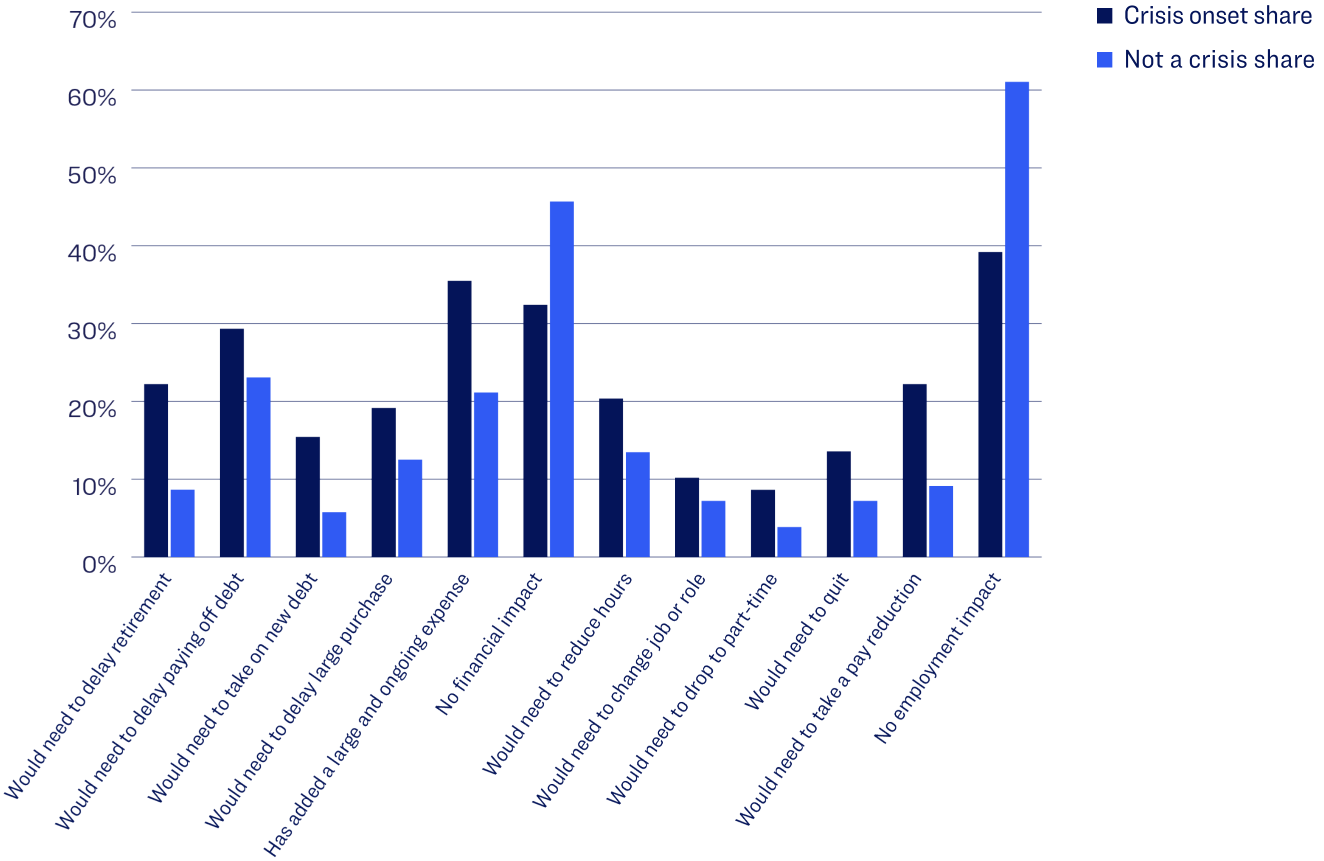
Further discussion

The costs of caregiving measured in time, money, skill, and duration are, of course, highly variable and difficult to predict, which makes it unsurprising that adult children often have incomplete or inaccurate expectations, even when they believe that they are likely to become caregivers. Despite having similar levels of information about their parents' aging and retirement planning, future caregivers were notably more optimistic about their parents' preparedness. They also tended to live farther away from their parents, which could influence both expectations and actual caregiving involvement. Current caregivers consistently reported more negative impacts of caregiving and received less support (both paid and unpaid) than future caregivers anticipated.

In line with our results, Pillemer and Suitor (2014) also found that future caregivers tended to overestimate the likelihood of receiving help from their siblings, noting that the burden of caregiving typically fell on one child, most often a daughter. Societal gender norms place a disproportionately greater burden on daughters, who typically spend twice the amount of time caregiving than sons (Grigoryeva 2017). As discussed in the literature on informal caregiving, disproportional responsibilities of duties and financial commitments can have long-term negative consequences.

We also show that current caregivers consistently report more negative impacts of caregiving and receive less support (both paid and unpaid) than future caregivers anticipate. In particular, these effects can be exacerbated if caregiving is in response to a sudden health crisis or an acute decline. Figure 3 revisits the financial and employment impacts from Figure 1, focusing only on current caregivers. We segment this population by their answer to whether caregiving began as the result of a crisis (excluding 11 respondents who were 'Not sure'). With the exception of delaying debt repayment, every financial hardship was more prominent among those who began caregiving after a crisis. Around a third (32%) reported no financial impact, compared to 46% of those whose caregiving began under non-crisis conditions. Employment impacts followed a similar pattern: 39% of crisis-induced caregivers reported no negative impacts versus 61% among non-crisis caregivers.

FIGURE 3. SHARE OF CAREGIVERS REPORTING NEGATIVE FINANCIAL AND EMPLOYMENT IMPACTS BY CRISIS ONSET



Note: The bars indicate the share of current caregivers reporting negative financial and employment impacts by whether (gray) or not (black) their caregiving experience began as the result of a crisis.

Source: Authors' computations; see text.

In addition to financial strain, caregivers are also impacted by psychological strains as a result of their caregiving. Burnout, anxiety, and depression (Gérain and Zech 2019) often result, in addition to feeling isolated, exhausted, or guilty (Schulz and Sherwood 2008), especially for those providing high-intensity or spousal care. Again, these burdens are unevenly distributed across caregivers (see Cohen et al. 2019, 2021; Willert and Minnotte 2019). Though some caregivers may adapt over time by modifying their work arrangements or consolidating care within the home, others find prolonged caregiving more difficult to sustain. These commitments can potentially force caregivers out of full-time work and into part-time work or even unemployment.

The scale and breadth of the negative effects reported by caregivers in this survey highlight the fact that many have an overly optimistic view of future caregiving and lack preparation for the task. Taking concrete steps such as setting aside money, moving closer to aging parents who may need help, researching the availability and cost of paid care options, and adjusting expectations around the availability of support from other family members, could help prepare future caregivers and mitigate adverse effects. With greater preparation and a more realistic understanding of what caregiving entails and the limitations of paid caregiving sources, adult children with aging parents may be more inclined to take more steps to prepare, even if those steps are simply a reassessment of their expectations. As the population ages and more working-age adults are likely to become caregivers, the impact on the labor force and family wellbeing will grow.

Conclusions

As the share of older adults continues to rise in the US, it is becoming increasingly important to understand whether working-age adults will be able to provide informal care to their aging relatives. Informal caregiving can have a wide range of unpredictable consequences, from out-of-pocket expenditures to time commitments, and many future caregivers are only partially aware of these effects. Our survey of US adults age 40–64 revealed that, although many expect to become caregivers, few have taken meaningful steps to plan for that role. Specifically, when comparing future to current caregivers, the expectations of the former often do not reflect reality. Current caregivers note potential adverse financial and employment consequences, highlighting the value of proactive planning. Yet with better information and planning, many will be able to better prepare for the burden in the years ahead.

Several policy options could help provide generalized support. For example, health savings accounts (HSAs) can be used for some caregiving expenses, including LTCI premiums and home health services from licensed providers, but not for basic caregiving wages (Banerjee 2025). Expanding HSA-eligible expense categories could open additional avenues for support. State-level caregiving policies also vary widely, and additional evidence on best practices could help identify cost-efficient insights and scalable solutions.

There are several potential areas for future research. One to explore is the difference between those who do and do not expect to become caregivers. While our analysis compared current caregivers with those expecting to become caregivers in the future, we did not examine what shapes those expectations. Understanding why some individuals do not anticipate caregiving could also help identify underprepared groups. Further research could also benefit from a more nuanced classification of caregivers, including those with repeated or long-term caregiving experiences, in order to assess how preparation, experience, and outcomes interact over time. Such work could help identify which preparations and policies have the greatest long-term impact.

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