

# Long-term Care in Latin America and the Caribbean





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Decade of Healthy Aging in the Americas  
**situation and challenges**

## *Long-term Care in Latin America and the Caribbean*

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The purpose of the series is to provide regular updates on the different areas of action of the Decade of Healthy Aging (2021-2030) in the Region, as well as on other related aspects.

The collaboration of the experts from PAHO, the United Nations and the Inter-American System, and the academic world who participated in the initiative and formulated essential feedback and recommendations for the project to see the light is appreciated.

## Acronyms

<b>BADL</b>	Basic activity of daily living
<b>GDP</b>	Gross domestic product
<b>IADL</b>	Instrumental activity of daily living
<b>PAMI</b>	National Institute of Social Services for Retirees and Pensioners (PAMI) (Argentina)
<b>SABE</b>	National Survey on Health, Well-being, and Aging (Colombia)
<b>SNAC</b>	Intersectoral Social Protection System (Chile)
<b>SNIC</b>	National Integrated Care System (Uruguay)

## Introduction

Long-term care includes a series of activities carried out by caregivers and care workers to optimize function and compensate for the permanent or temporary loss of a person's intrinsic capacity and promote a degree of functional ability compatible with basic rights, fundamental freedoms, and human dignity (1).

According to the World Health Organization (WHO) (1), a caregiver is a person who provides care to one or more family members, friends, or community members on an informal basis and generally receives no compensation. In contrast, care workers (e.g., nurses and social workers) provide care through formal long-term care systems.

Reviewing current knowledge about health and aging, this report provides an update on the long-term care situation in the Region. The data paint a detailed picture of long-term care in Latin America and the Caribbean, the burden and effects of care dependency, and existing long-term care systems and services in the subregion.

The report begins with a discussion of the concept of long-term care and why it is important for healthy aging. The next section measures the care dependency burden in the subregion, the different ways of measuring it, its prevalence among older persons, and the factors related to its development. It then describes the effects of the growing need for care not only on individuals and their families but on society as a whole. Next, it looks at the strategies for meeting the care needs of older persons in the different countries, distinguishing between the role of the public sector (in policy design and institutionalization, as well as service delivery and quality assurance), families, and the private sector. Finally, it offers some thoughts about what the next steps in the subregion's care agenda should be.



## Long-term care and its importance for healthy aging

Long-term care is critical to promoting healthy aging, as it helps older persons maintain the highest possible level of functional ability. It is also at the heart of the global agenda and the WHO response to population aging. It is considered a key area of action for the Decade of Healthy Aging, established by the World Health Assembly in May 2020 and subsequently by the United Nations General Assembly, in the same year (2).

Long-term care can be provided by different actors in different settings under multiple conditions. Most commonly, it is the women of the household who are responsible for providing unpaid care in the home where the care-dependent person lives (3, 4). However, care arrangements based solely on family ties are strained by smaller families, growing recognition of the gender inequalities in caregiving, and women's greater participation in the labor market. These circumstances call for governments, the market, and civil society organizations to get involved in the delivery of care.

In addition to family care, the most typical long-term care services include (5):

- **Nursing home services:** Services provided to older persons in facilities that include temporary or permanent accommodations. They can offer a comprehensive package of support for activities of daily living, physical and cognitive stimulation, family support, and certain health services.
- **Home support services:** Services provided in the person's home. These generally include a care worker to assist the older person with activities of daily living and trained professionals to provide certain health services.
- **Day services:** Services in day centers that do not provide accommodations. These centers can offer a comprehensive package of assessment, stimulation, and social, physical, psychological, cognitive, and nutritional support services.
- **Telecare services:** Services provided using information and communication technologies to monitor dependent people in their own homes, respond in emergencies, and encourage self-care and independence.

- **Caregiver support services:** Support services or training designed to improve not only the quality of care but the quality of life of those who provide the care, freeing up their time and mitigating the emotional and physical toll implicit in caregiving. These services include psychological counseling, training, and relief services (also called “respite care”). Economic benefits may also be included to cover the cost of care.

The decision regarding which service is the most appropriate should be based on the person’s degree of care dependency and the caregivers’ needs, as well as the situation of each. Support services and home care, day centers, telecare, and caregiver support enable dependent people to remain at home as long as possible and caregivers to preserve their physical and mental well-being. The evidence indicates that remaining at home is not only what older persons prefer but helps preserve their degree of independence and has physical, social, and emotional health benefits (1,6).

Latin America and the Caribbean is currently the fastest-aging subregion in the world (7). Although people differ widely, as a rule, it can be said that aging is associated with a higher risk of disease, a decline in functional ability, and therefore, the need for care (2). The growing proportion of older persons in the subregion will substantially increase the demand for the care services that the countries will have to provide in the coming decades (7).

Added to the higher demand is the shrinking supply of unpaid care provided by families. While families are still the main source of support, it is increasingly inadequate, and there is growing recognition that the burden of care is not gender equitable. Women’s greater participation in the labor market, coupled with smaller families, means that the network of family members able to provide unpaid care is shrinking (5, 8). Governments therefore have a critical role to play in ensuring access to affordable, quality services through the creation of national systems for the care of dependent older persons and their caregivers (5). These systems can also provide support to persons with disabilities who have special care needs.

Regardless of how these systems are structured, WHO (1,9) states that they must: 1) optimize functional ability over time and compensate for the loss of intrinsic capacity; 2) be people-centered and consistent with the values and preferences of both care recipients and caregivers; and 3) provide integrated, comprehensive ongoing services with active

community participation. Critical aspects of this strategy are the creation and maintenance of a properly trained workforce and caregiver support (10). Furthermore, long-term care must be considered in the context of social and health integration and insofar as possible, an important part of a universal integrated coverage strategy (11).

## The dependency burden

### Measuring the dependency burden

In practice, the need for care services should be measured by the prevalence and degree of dependency - that is, the degree of difficulty that people have performing both basic activities of daily living (BADL) and instrumental activities of daily living (IADL) (1, 12). The former include basic self-care activities, such as bathing or showering, dressing, eating, getting into or out of bed or a chair, using the bathroom, and moving about the house. IADLs are more complex activities requiring a higher degree of cognitive capacity and that, while not necessarily essential to survival, facilitate independent living; they include using the telephone, taking medications, managing money, purchasing food, preparing meals, and using a map (1).

Measurement can be approached from two perspectives. The first is from the micro level, in which each person's degree of dependency is assessed using a scale that includes a wide range of activities with different weights based on their impact on the person's care needs (13). In countries with fairly developed long-term care systems (such as many members of the Organization for Economic Co-operation and Development), the scale is used to determine beneficiary eligibility. Countries use different scales (the Barthel and Katz indexes being some of the most well-known) based on criteria such as their policy objectives, the type of benefits, and the feasibility of their use (14).

The second approach to measurement is from the macro level, with a statistical estimate of the prevalence of care dependency for analytical purposes. This can contribute to multiple objectives, such as determining the size of the demand for services to plan their supply, analyzing correlations between different variables to select the target population for the services, or designing prevention policies. Some countries conduct nationwide surveys that include specific modules for measuring functional ability and the need or availability of care services for the respondent population. Some Latin American and Caribbean countries conduct

surveys of this type, among them Argentina, Brazil, Chile, Costa Rica, the Dominican Republic, El Salvador, Mexico, Paraguay, and Uruguay.

The surveys in the subregion vary widely. The countries conceptualize and measure BADLs and IADLs differently (for example, in terms of the number and type of activities considered and how question-and-answer options are formulated). This variation is even seen in the same country when there is more than one survey. At present, there is no globally harmonized method for measuring care dependency, making comparisons between countries and over time difficult. It should be noted that, as part of an interinstitutional working group headed by the Pan American Health Organization (PAHO), activities to achieve greater harmonization among national instruments are under way in Latin America and the Caribbean.

Finally, it is important not to confuse care dependency with disability. The definition of dependency does not merely address the biological dimension; a person's context can promote or limit their functional independence, beyond the presence of physical, sensory, or cognitive impairments. To put it another way, the presence of functional limitations does not necessarily equate to care dependency (7). The data from Uruguay, for example, show that, among while 82% of functionally dependent people over 60 report some physical or mental limitation, roughly half are fully able to perform their daily activities on their own (3).

## Prevalence of care dependency in older persons

In Latin America and the Caribbean, 14.4% of the population aged 65 and over is care-dependent- almost 8 million people (15). Figure 1 shows the prevalence of care dependency by sex and age for the countries in the subregion with available data. Based on the definition of Aranco et al. (7) and the availability of data for the purposes of this study, a person is considered care-dependent if he has difficulty or needs help performing at least one BADL<sup>1</sup>.

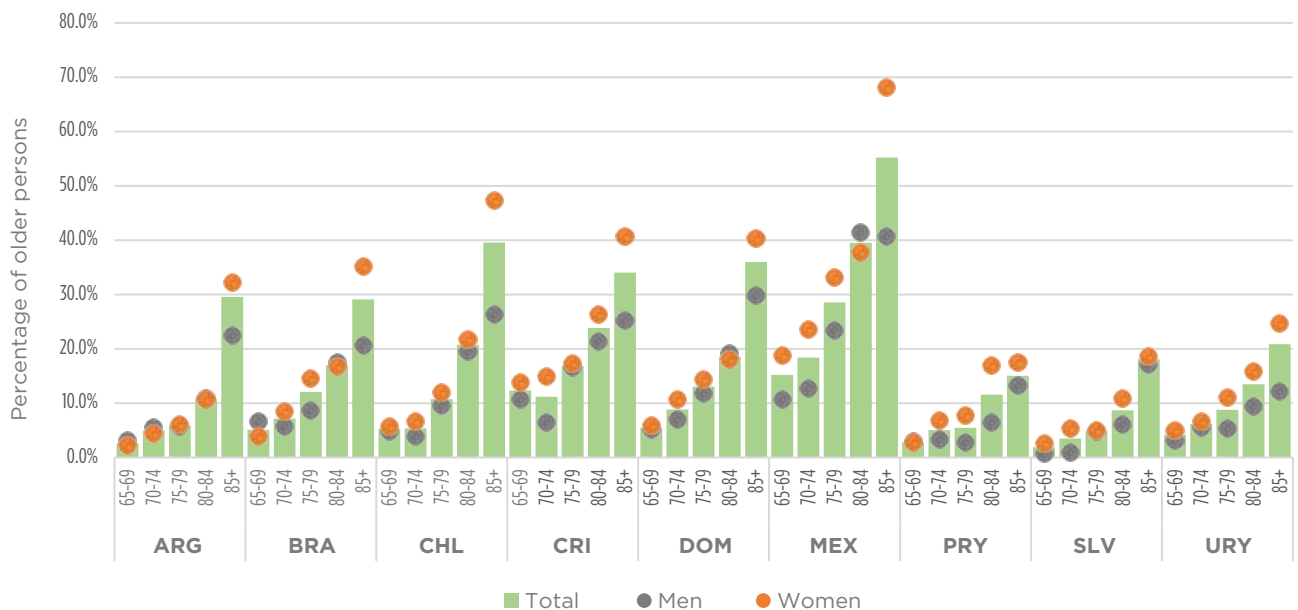
Figure 1 shows the vast differences between countries in the prevalence of care dependency in the older population. For example, in El Salvador, Paraguay, and Uruguay, the figure ranges from 15% to 20% in people aged 85 and over; in Argentina, Brazil, Chile, Costa Rica, and the Dominican Republic, it ranges from 30% to 40%; and in Mexico, it is over

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<sup>1</sup> Although it is critical to consider difficulties performing IADLs, especially as an early sign of cognitive decline (see Guo HJ, Sapra A. Instrumental Activity of Daily Living). StatPearls Publishing; 2020. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK553126/>), their inclusion in surveys in the countries of the subregion is less common than the inclusion of difficulties performing BADLs, and even more varied.

55%. While some of this variation may be due to genuine differences between countries, lack of harmonization among data collection tools is also an underlying factor in the differences observed.

**Figure 1.** Prevalence of care dependency in the population aged 65 and over in Latin American and Caribbean countries, by sex and age group, 2012–2018



*Notes:* This shows the percentage of the population that indicates having difficulty or needing help with performing at least one BADL. The number of activities considered varies from country to country: Costa Rica considers three; El Salvador, four; Chile, the Dominican Republic, and Paraguay, five; Argentina, Mexico, and Uruguay, six; and Brazil, seven. In Argentina, Chile, the Dominican Republic, El Salvador, and Paraguay, the difficulty is measured dichotomously (yes or no). In Brazil, the surveyed individuals must select a level of difficulty on a scale of 1 to 4; they are considered dependent if they report “considerable difficulty” performing the activity or cannot do so. In Mexico, a scale of 1 to 4 is also used: a person is considered dependent if they indicate that “yes, I have difficulty”, “cannot perform the activity”, or “cannot perform the activity due to health problems”. In Costa Rica, a scale of 1 to 5 is used: a person is dependent if they select a value over 3 for any of the activities, except getting out of bed (for which a limit of 4 is imposed). In Uruguay, the range is 1 to 3, and the person is considered dependent if they report often or always having difficulty.

ARG: Argentina; BRA: Brazil; CHL: Chile; CRI: Costa Rica; DOM: Dominican Republic; MEX: Mexico; PRY: Paraguay; SLV: El Salvador; URY: Uruguay.

*Source:* Data processed using the most recent available data from the Longitudinal Social Protection Survey (LSPS) in Chile (2015), El Salvador (2013), Paraguay (2015), and Uruguay (2013); the National Study on Health and Aging (ENASEM) in México (2018); the National Survey on Multipurpose Households (ENHOGAR) in the Dominican Republic (2013); the National Disability Survey (ENADIS) in Costa Rica (2018); the National Survey on Quality of Life of Older Persons (ENCAVIAM) in Argentina (2012); the National Time Use Survey (ENUT) in Colombia (2017); and the Longitudinal Study on the Health of Brazilian Older Persons (ELSI) in Brazil (2016).

Whatever the differences in functional levels between countries, certain patterns are clear. First, although a high percentage of the older care-dependent population is under 65, prevalence sharply increases with age, particularly after the age of 85. The pronounced age gradient reflects the fact that, from a biological standpoint, as age advances, the likelihood of developing complex health problems and, therefore, of experiencing a gradual loss of function, increases (1). Assuming that age-related dependency ratios remain constant, population aging alone will lead to a tripling of the number of care-dependent older persons in Latin America and the Caribbean in 30 years (7). This underscores the urgency of designing and implementing support policies for care-dependent older persons.

Second, women have higher care-dependency ratios than men. This could be because women are more likely to suffer from highly debilitating diseases, although with low mortality levels (16). The data show that since women provide more than 70% of the care for older persons (17), care dependency has a dual gender dimension that should be taken into account in policy design (5).

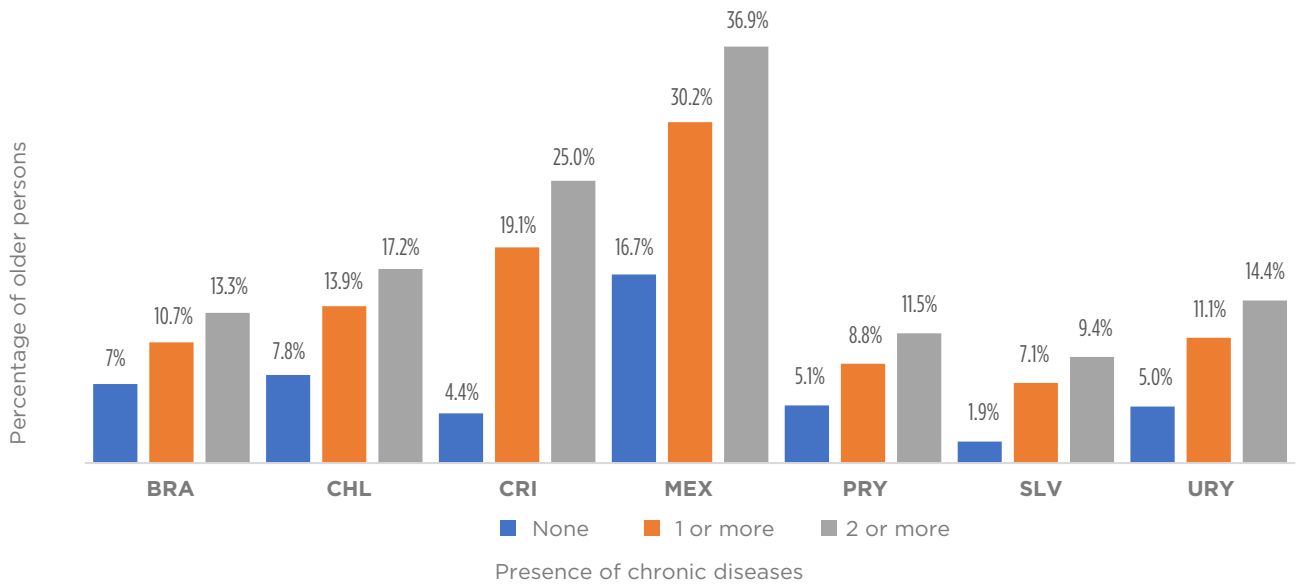
## Factors related to care dependency

In addition to age and sex, a wide array of factors are related to care dependency in older persons, ranging from their socioeconomic context or degree of participation in society to their physical and mental health status. It is hard to establish clear cause-and-effect relationships between these factors, as causality relationships are complex and often bidirectional, multidimensional, and mutually reinforcing. With this in mind, a summary of some of the contextual, behavioral, and epidemiological factors related to care dependency in older persons is presented below.

### Diseases

The presence of disease and cognitive decline, as well as impairments, both physical and sensory, can affect a person's ability to lead a self-sufficient independent life. Figure 2 shows that the probability of an older person being care-dependent increases with the presence of chronic diseases, particularly in people with some degree of comorbidity. The difference between people with no disease and those with more than one ranges from 6 percentage points in Brazil to more than 20 in Costa Rica.

**Figure 2.** Prevalence of care dependency among people aged 65 and over, by educational level, 2012–2018



Note: BRA Brazil; CHL: Chile; CRI: Costa Rica; MEX: Mexico; PRY: Paraguay; SLV: El Salvador; URY: Uruguay.

Source: Data processed from the most recent data available from the Longitudinal Survey of Social Protection (ELPS) in Chile (2015), El Salvador (2013), Paraguay (2015) and Uruguay (2013); National Study of Health and Aging (ENASEM), in Mexico (2018); National Survey on Disability (ENADIS), in Costa Rica (2018); and Longitudinal Study of Health of Brazilian Elderly People (ELSI), in Brazil (2016).

There is a general consensus that the care dependency risk attributable to chronic diseases is substantial and that this causality can also occur in the opposite direction – that is, an older person’s dependence on care can lead to the development of chronic diseases due to lack of physical mobility, development of depression or nutritional deficiencies, or other consequences that generate a feedback loop (18).

Longitudinal studies, such as that of González-González et al. (19), have found that older persons diagnosed with hypertension, arthritis, diabetes, or cerebral embolism are at higher risk of becoming care-dependent in the succeeding 11 years than other people with the same characteristics (in terms of sex, age, socioeconomic status, and lifestyle) but no chronic diseases. Similarly, a diagnosis of cognitive decline has been associated with the likelihood of having difficulty performing IADLs in the succeeding four years (20).

This is alarming, as the prevalence of certain chronic diseases, such as diabetes, neoplasms, and musculoskeletal diseases has been increasing in older people (21). If steps are not quickly taken to reverse the rising trend in some diseases, the increase in future care needs will be proportionally greater than the increase in the older population. Certain evidence already

points to this: in Mexico, for example, the percentage of people aged 80 and over with difficulty performing BADLs rose from 29.7% in 2001 to 47.2% in 2018 and was accompanied by an increase in the prevalence of the main chronic diseases, hypertension and diabetes among them (22).

In addition to chronic diseases, the existence of physical or sensory impairments is also considered a predictor of care dependency. Data from Chile show that 35.8% of people over 60 with at least one physical or sensory impairment are care-dependent, versus 6.3% of older persons without impairments (7).

Moreover, the number of chronic diseases and physical or sensory impairments influences the likelihood that older persons will have falls, which can also render them care-dependent (18, 23). Data from Mexico show an increase of more than 20 percentage points in the probability of care dependency among older persons who had fallen at least once in the previous two years, compared to those who had not had any falls (24).

## Socioeconomic status

The likelihood of becoming care-dependent varies with socioeconomic status: on average, people from disadvantaged socioeconomic groups experience higher levels of functional loss. Moreover, people in worse socioeconomic situations have less access to care services. Table 1 shows the relationship between educational level and care dependency in older persons in six Latin American and Caribbean countries, using educational level as a proxy for socioeconomic status.

**Table 1.** Prevalence of care dependency among people aged 65 and over, by educational level, 2012–2018

	Argentina	Chile	El Salvador	Paraguay	Uruguay
Did not attend school	11.2	22.1	6.8	9.8	15.3
Completed primary	6.9	14.2	3.6	6.3	10.2
Completed secondary	6.1	7.7	8.0	3.3	6.8
Completed tertiary	2.9	7.8	n/a	n/a	5.1

Note: Most recent available data for each country, expressed in percentages.

n/a: Cases in which the number of observations is less than 10.

Source: Aranco N, Bosch M, Stampini M, Azuara O, Goyeneche L, Ibarrarán P, et al. Aging in Latin America and the Caribbean: social protection and quality of life of older persons. Washington, D.C.: Inter-American Development Bank; 2022. Available from: <https://socialdigital.iadb.org/en/sph/resources/research-publications/19447>



The mechanisms underlying the association between socioeconomic status and care dependency vary widely. The way people age is a product not only of their current conditions, but of an accumulation of factors and habits over the life course that are markedly influenced by their socioeconomic status and that of their families (25–27). People with lower socioeconomic status are generally exposed to more risk factors for certain diseases and have a harder time obtaining quality social assistance and health care. They also have less knowledge about the health effects of some of their habits and activities and lack the necessary means to effectively apply this information in their daily lives (for example, adequate space for physical activity and economic resources for a healthy diet).

In the case of chronic diseases and their risk factors, a negative correlation with socioeducational level is well-documented for high-income countries, but the evidence for low- and middle-income countries (like most of the countries in the subregion) is less clear (28). The evidence is quite strong in the case of dementia, one of the diseases in older persons entailing the highest burden of care (29). Numerous regional and international studies show that educational level (a proxy for socioeconomic status) is inversely correlated with the probability of developing dementia (29, 30). At the same time, the probability of having more than one chronic disease at the same time, a condition positively correlated with care dependency (Table 1), appears to be higher among people with low educational levels (31), demonstrating the complex interaction between socioeconomic factors and the presence of multiple health problems over time.

Once a person is care-dependent, higher socioeconomic status facilitates access to higher-quality care services that encourage self-sufficiency and prevent even higher levels of dependency. In a context of scarce subsidized care services, as in Latin America and the Caribbean (see section on long-term care systems and services), this underscores the need for public care policies focused particularly on the population in situations of greatest economic vulnerability.

### **Social engagement, interpersonal relationships, and household arrangements**

The sense of having a social support network (whether family-, neighborhood-, or friendship-based) has a positive impact on quality of life and health and decreases the likelihood of dependency in older persons by increasing their sense of control and emotional

well-being and lowering stress levels (32, 33). The literature shows a positive correlation between loneliness and social isolation on the one hand, and care dependency on the other (1). Socially isolated older persons are therefore more likely to become care-dependent. At the same time, lack of the self-sufficiency and independence required to perform certain activities makes interaction with others difficult (particularly for older persons living alone), which, in turn, increases their risk of isolation (34, 35). Again, the causal relationship between factors can occur in both directions.

Colombia's National Survey on Health, Well-being, and Aging (SABE) shows that approximately 60% of care-dependent older persons do not participate in social groups and that this is associated with a 50% increase in their likelihood of care dependency (36). In Mexico, care dependency is more prevalent among widowed older persons with less support from social networks (37).

Information on social engagement, interpersonal relationships, and household arrangements is also important for understanding care contexts and support in the community. In Brazil, data from the national study on frailty in older Brazilians (FIBRA) show that, while women are more care-dependent and have worse health and lower socioeconomic status, they are less likely to have someone to help them with BADLs and IADLs than men are (38). This indicates that even though they are more likely to need care, women have fewer community and informal resources and therefore need more support from formal dependency-care services.

## Effect of care dependency on older persons, their caregivers, and their families

### Quality of life of care-dependent older persons

The evidence shows a negative correlation between care dependency and older persons' quality of life. In Colombia, several studies based on the SABE survey showed that loss of function is associated with a lower quality of life (39). In Mexico, the National Study on Health and Aging in Mexico (ENASEM) showed a positive association between functional dependency and depression (40).

While care dependency can lead to a poor quality of life in older persons, difficulty accessing care services make this situation even worse. Lower socioeconomic status accentuates this relationship:

the prevalence of care dependency is higher in people from lower socioeconomic strata, who, moreover, have fewer opportunities to obtain the care services they need.

## Caregivers and families

At regional level, no study has been conducted on unpaid family care for dependent older persons, so evidence on this type of care in the cultural and socioeconomic context of Latin America and the Caribbean is scarce. However, the analysis of time use surveys shows that women from the poorest households have the heaviest burden of unpaid domestic work (which also includes long-term care for older persons). In Uruguay, for example, women in the lowest income quintile spend roughly 39% more hours per week on unpaid work than those in the highest quintile (41). The COVID-19 pandemic reaffirmed this and revealed, moreover, the unsustainability of the current situation (41, 42).

Women's significant contribution to unpaid care often obliges them to remain outside the labor market and withdraw from social and educational activities; this, added to the costs of care (such as health, medicine, and transportation expenses) can lead to their impoverishment (43) and a poor quality of life (1). In a study conducted in Mexico, Stampini et al. (17) found that, for women aged 50–64, the responsibilities of tending to a care-dependent father or mother are associated with a significantly lower probability of participating in the labor market and a reduction in the number of paid hours worked. For men, in contrast, no effect was observed on participation in the labor market or the number of paid hours worked. In Brazil, more than 70% of caregivers are women, and 25.8% indicated that they had stopped working or quit school to provide care (4). In Colombia, 18% of caregivers stated that they had had to reduce their working hours due to caregiving responsibilities, and 15% indicated that they could not work outside the home for the same reason (44).

Data from a three-year longitudinal study in Mexico and Peru show that in households where older persons required care during the study period, the family economy suffered. Income from paid work and government transfers was lower, consumption was 12% lower, health expenditures were higher, and catastrophic health expenditures were more frequent than in households with no care needs (45).

Another study in Mexico measured the level of out-of-pocket expenditure on health and the care of older persons with difficulty performing activities of daily living. Care dependency was associated

with a higher level of health and care expenditure – 107% more than for non-dependent people (46). In monetary terms, the level of health and care expenditure is equivalent to 10 times the non-contributory pension for older persons. This shows the difficulties involved in providing care services to people living in conditions of poverty and vulnerability in the context of low public supply, as López-Ortega et al. also noted (22).

In addition to the socioeconomic impact on families, care itself can have a negative impact on the physical and mental well-being and overall quality of life of unpaid caregivers (47). Psychological stress and the caregiver burden is high in Latin America and the Caribbean, especially among the caregivers of people with dementia (48). There is a wealth of research around the world on the physical and mental well-being of caregivers that shows they are more likely to suffer from physical and mental illness and have a poorer quality of life than non-caregivers (49, 50). Coe and van Houtven (51), for example, estimated that caring for a sick mother increased symptoms of depression in caregivers by 47%. Other studies reveal greater use of antidepressants, tranquilizers, analgesics, and gastrointestinal agents among caregivers (52, 53).

## **Impact on society and economic opportunities in the care sector**

At the macro level, the growing number of care-dependent people requires investment in the development and financing of public services and policies to meet the higher demand (5). One of the most significant obstacles to implementing a national long-term care policy is its financing. Public expenditure on long-term care policies and programs in Latin America and the Caribbean is still low, whether it comes mostly from national or local fiscal resources, or both.

Medellín (54) estimated what it would cost to provide services to care-dependent people in seven Latin American and Caribbean countries. Depending on the cost of the benefits, the figure ranges from 0.3% to 1% of the gross domestic product (GDP). For comparison purposes, Uruguay spends 0.04% of its GDP on care programs for dependent persons (2017 data) and Chile, 0.02% (2019 data) (3, 55).

The direct expenditure associated with providing such services to care-dependent people should be evaluated against the savings it generates. Here, it is argued that a care system implies two types of potential savings: the value of caregivers' freed-up time and cost

savings in the health services. First, caregivers' freed-up time can be invested in the labor market or spent on leisure activities. Simulations in Mexico show that this social saving ranges from 0.04% to 0.07% of GDP (19). Second, health savings can be generated by a decrease in preventable hospitalizations and shorter unavoidable hospital stays. There is international evidence on the amount of these savings. In the case of Spain, for example, expanding care services for dependent persons led to fewer hospital admissions and shorter stays, with a consequent 11% reduction in costs (5).

Barriers associated with aging and the growing demand for care also create opportunities for growth, business and job creation, and the formalization of care services. These opportunities are part of what has come to be known as "the silver economy," defined as the economy related to the demand of older persons for goods and services (56). The silver economy can be an engine of economic growth. In Latin America and the Caribbean, the over-60 population will be responsible for 30% of the increase in consumption between 2015 and 2030 (57). Examples of business creation can be found in specially designed housing to enable mildly or moderately dependent people to live independently despite functional impairments (such as vision, hearing, or mobility problems) and in technology-based care services (telecare) (56).

Finally, the development of services for care-dependent people is an important source of job creation and the formalization of this work, especially for women. In South Korea, the care sector has generated almost half a million jobs, 95% which are held by women (58). In Latin America and the Caribbean, due to the absence of a formal, structured care dependency system, the impact on quality job creation in the field of care is still very low and has yet to be quantified. Policy and systems development in the subregion can provide an opportunity in this regard.

## Long-term care systems and services

Strategies to meet the older persons' need for care in any society are based, above all, on the role of three key actors: the public sector, the private sector, and families.

In general, the public sector is responsible for the design and implementation of policies and systems for care to dependent people and for the supervision, quality assurance, and guarantee of equitable service coverage. In many Latin American and Caribbean countries,

the public sector is also responsible for directly providing many of these services.

The private sector also participates in service delivery, either through the paid services of for-profit companies or through non-profit organizations that provide care and training services free of charge or co-financed by the public sector. The development of the sector varies widely in the subregion in terms of quantity, variety, and quality. This diversity is seen not only between but within countries, based on the ability of service recipients to pay and the availability of government cofinancing.

Currently, in a context marked by a lack of public sector coverage and limited access to quality private services (especially, but not solely, among the lowest socioeconomic strata) (59), families provide most of the care required by dependent people, with very little institutional support.

It should be noted that, in many countries, civil society plays an important role in guaranteeing that the needs, rights, and voices of older persons and their families are considered in policy-making and services and in guaranteeing coverage for those who need them most. Here, community groups, nongovernmental organizations (NGO), trade unions, indigenous groups, professional associations, and foundations are critical.

The following is a brief description of the role and characteristics of each of these actors in Latin America and the Caribbean.

## **The role of the public sector**

### **Design and implementation of care policies**

Today, many Latin America and Caribbean countries lack support services coordinated by a national policy for the care of dependent older persons.

Uruguay was the first country in the subregion to adopt a national care policy. The National Integrated Care System (SNIC) commenced operations in 2015 as a universal system, providing access to quality care, regardless of a person's age, income, or place of residence (60). The target population includes older persons who need support, persons with disabilities, and children. In the case of care-dependent people, the system focused first on heavily care-dependent people under 30 and over 80 and mildly or moderately care-dependent people over 65.

Services for the eligible population are based on age and functional ability and include subsidies for hiring personal care aides (for heavily care-dependent people), telecare, and day centers (for mildly or moderately care-dependent people). Another population prioritized in the system is paid caregivers; the SNIC is committed to improving the quality of services and invests in the training and professionalization of this population (3). The system is financed with general revenues. For personal care aides and telecare services, there is a system of copayments based on the income of dependent persons and their families. It should be mentioned, however, that, up to now, a very low percentage of users (14.6%) are in the income range for receiving copayments.

In Chile, the care system (Chile Cuida), established in 2017, is considered a subsystem of the Intersectoral Social Protection System (SNAC). It currently operates in only 22 of the country's 346 municipalities. Its beneficiaries are people with moderate or severe care dependency and their caregivers, provided that they are members of the 60% most vulnerable households in the country. Municipalities are responsible for coordinating access to services through individualized care plan drafted in collaboration with dependent persons and their families. The services include home care, day centers, nursing home care, technical aids, retrofitting homes, and caregiver support and respite services. The system is financed with fiscal resources from the national government, supplemented with resources from local governments. Unlike Uruguay, Chile does not have a national law that regulates the operations of its care subsystem, which makes it hard to provide basic coverage, ensure the length of the coverage needed, and guarantee the quality of the services provided (55).

In both Chile and Uruguay, the involvement of more than one ministry, civil society, the public and private sectors, and users of the services in the design and implementation of care policies shows the willingness of the social and health systems to coordinate efforts (3, 55). However, the evidence shows that much remains to be done in the field of social and health integration.

This issue is becoming increasingly important and has appeared on the public agenda of other countries in the subregion. Costa Rica recently published a 10-year gradual plan to develop, integrate, strengthen, and expand a long-term care system, increasing coverage and equity both for older persons and their caregivers (61). Right now, Costa Rica is one of the first middle-income countries in the world to have a national long term care policy. Eligibility for the services is based on functional

ability levels. The plan provides for a system of governance; integrated information systems; improved service delivery, including workforce training; measures to tackle gender inequality; and a quality assurance system (61).

Other countries, such as Argentina, Colombia, the Dominican Republic, Panama, and Peru, have national plans for the care of dependent people in the discussion or preparation phase. Most of these countries have announced their intention to design care policies with a gender-equity approach. It is important to note their interest in developing home care services, in line with the trend toward the emerging global trend toward the deinstitutionalization of care, due not only to costs but primarily to the preferences of care-dependent people (6).

## Service delivery

While most of the countries lack a consolidated system coordinated by a national policy, in some of them the public sector is already responsible for providing care to dependent older persons. This can be done through direct services or indirectly, through the financing of providers or even cash transfers to dependent persons to pay for services.

In this regard, some countries have policies and programs that are directly or indirectly relevant for the older care-dependent population. These programs are generally part of the national health or social protection systems. Argentina, for example, has a wide range of public care policies under the Ministry of Health (through the National Institute of Social Services for Retirees and Pensioners of the Comprehensive Medical Care Program [PAMI]) and the Ministry of Social Development (62). In Brazil, the Unified Health System (SUS) provides universal comprehensive medical care to everyone who needs it; this includes services to meet the health needs of older persons (e.g., physical therapy, home health support, medication, and health education on chronic diseases) as part of primary care (63). The Unified Social Assistance System (SUAS), in turn, offers some services to care-dependent older persons in vulnerable situations through nursing homes and day centers (64, 65).

Worth noting are the activities in several countries in the subregion to improve home care services following good practices for the care of dependent older persons (6). In Uruguay, for example, the support provided by personal home aides – who provide 80 hours of home care per month – is the main service offered by the SNIC. Chile's system has also emphasized home care, and the Ministry of Health even has a home care program for heavily care-dependent people (55). In Argentina,



PAMI provides subsidies to care-dependent older persons to hire an accredited home caregiver. These systems help promote healthy aging at home.

Despite these activities and the trend toward home services, nursing home services, are still one of the main types of care offered by the public sector, though their coverage is limited (for example, in Mexico, only 8% of nursing homes are public, while in Brazil the figure is only 2%) (22, 66).

Day centers are also a relatively common type of public care in the subregion and generally focus on mild- or moderately dependent older persons. In the case of Chile, for example, the Ministry of Health is responsible for the Community Support Centers for People with Dementia, which are day centers for people over 60 with mild or moderate dementia (55).

Services such as telecare are less developed, at least in the public sector. Currently, only Uruguay includes such services in the system's benefits package. There are some local initiatives for cooperation between the public sector and civil society organizations. For example, in the Argentine city of Tigre, where many people live in hard-to-reach areas, the service was brought to people over 60 living alone, thanks to a joint local government-Red Cross initiative. In Chile, some municipalities also provide this service free of charge to older residents, contracting private companies for this purpose.

In some cases, instead of directly providing dependency care services, governments issue targeted cash transfers (i.e., a kind of voucher to purchase services) or unrestricted transfers. An example of the former is Argentina's cash transfers for hiring home aides; an example of the latter is Chile, where the Ministry of Health issues a cash transfer (US\$35 per month) to the caregivers of heavily care-dependent socioeconomically vulnerable persons (55). Unrestricted cash transfers have been criticized by part of the literature because they reinforce the traditional model of unpaid family care, squandering the opportunity to support formal job creation in the care economy and contribute to the reduction of gender inequality in the labor market (5).

Indirect support through the financing of providers is common in the subregion. Argentina, Colombia, Costa Rica, the Dominican Republic, Ecuador, and Uruguay are examples of countries that offer some public sector support through transfers to non-profit institutions that provide nursing home or day services (3, 62, 67–70).

In most countries (for example, Colombia, the Dominican Republic, Ecuador, Jamaica, and Mexico), whether provided directly or through cofinancing, public sector care and support services target the population in situations of socioeconomic vulnerability (68–71). Institutional services are often a mix of support services (whose priority is poor or homeless older persons) and care services (72).

Even in countries where the care system is relatively developed, access to services is determined not only by people's degree of dependency but their degree of economic vulnerability as well. In Chile, for example, beneficiaries of the Chile Cuida program must be members of the most vulnerable 60% of the country's population (55). Even in Uruguay, where system coverage is not determined by a person's economic vulnerability (although copayments are), data on the beneficiary population show that 87% are members of low-income households and therefore receive the full subsidy (3).

Due to beneficiary eligibility criteria and the limited resources allocated, coverage levels are low. In Uruguay, if SNIC services and services in public nursing homes or those that receive public funding are considered, the percentage of the population aged 65 and over with covered dependency care is 11% (73). In Chile, the Dominican Republic, and Ecuador, State-funded services cover 5%–6% of care-dependent older persons.

Among the countries for which data are available, Argentina and Costa Rica have the best coverage of the older dependent population (approximately 20%) (59). In both cases, high coverage levels are the result of cash transfers from the State to dependent people (in Argentina) or to service providers (in Costa Rica)--not direct delivery of services.

## **Guaranteeing the quality of services**

The public sector also has an important role in guaranteeing the quality of care services through the licensing, regulation, and supervision of institutional providers, on the one hand, and training strategies for human resources, on the other. In both areas there is still significant room for improvement. A recent study of 26 countries in the subregion reveals the poor quality both of institutional and home-based care services (59).

## Regulation and supervision

Regulation and supervision of services is essential for guaranteeing the quality of care (5). The public sector is responsible for setting quality standards for providers by establishing building specifications, the ratio of available staff to the target population, training profiles, and the basic services that should be offered, among other factors. It is also responsible for ensuring that these standards are adhered to, issuing operating licenses, and conducting regular inspections of providers.

For nursing homes that provide long-term care, most of the countries have uniform standards that include minimum infrastructure and staffing requirements, based on the number of residents or services provided. However, they do not have criteria for the type of care provided or the expected outcomes in terms of older persons' well-being; and the competent agencies' lack of resources, in some cases coupled with the absence of a national registry of institutions, makes oversight difficult. In Uruguay, for example, it is estimated that in 2019, only 2% of the more than 1000 facilities in the country were authorized to operate, and just over 10% were in the process of obtaining authorization (3). In other countries, such as Argentina and Chile, it is impossible even to calculate the percentage of nursing homes operating without authorization due to the lack of a register (55, 62).

The problem is even greater when it comes to the quality of home care services, where uniform standards are less common and supervision conditions more complicated. In this regard, Chile conducts a biannual satisfaction survey of households benefitting from SNAC's home care service. It also expects a supervisor to visit each home at least once every three months to evaluate the care provided (55).

In short, information on the quality of long-term care in the subregion is scarce for care provided in the home and community (including unpaid care), as well as residential care. This is generally due to lack of mechanisms for measuring and supervising the existing services.

## Human resources education

The number, education, and training of human resources in the field of care is essential for ensuring quality services. However, this is an area characterized by poor working conditions, where compensation and high informality and turnover rates are the norm (74). In Uruguay, for example, 44% of people working in the dependency care sector in 2014 did not pay into social security (3).

Given these working conditions, the care sector has trouble attracting and retaining skilled labor. Globally, the human resource deficit in the elder care sector is estimated at 13.6 million people (75). In Latin America and the Caribbean, an estimated 5 million care workers will be needed in 2020, a figure that could increase to more than 14 million by 2050 (76).

In many cases, caregiving tasks are performed by the same people that are hired to provide domestic services. For example, according to the results of the Longitudinal Survey on Social Protection in Uruguay (2013), 16% of the domestic service personnel hired by households perform caregiving tasks, with two thirds of their time devoted to caring for older persons.

This may reflect the shortage of affordable skilled labor, but also the general view that care does not require any special training and is simply an extension of household domestic chores.

Notwithstanding, some progress in the subregion points to the reassessment and formalization of caregiving and an increase in capacity building. The goal is not only to improve the quality of the care provided, thus increasing the well-being of dependent older persons, but to increase the well-being of workers in the sector. Uruguay, for example, has taken significant steps in this regard, imposing mandatory training or accreditation requirements for people who wish to serve as SNIC personal care aides, as well as deadlines for staff in nursing homes and other facilities providing institutional care to complete mandatory training (3).

Another example is Argentina, where the National Directorate of Policies for Older Persons offers training courses for home caregivers. People who complete the course are enrolled in the National Registry of Home Caregivers, created in 2016, which currently has 6400 registered caregivers (62). This registry, an online platform where anyone can find and contact trained and certified care workers from across the country, serves as an incentive for formalization (77). Similarly, in Chile, home aides in the Chile Cuida program also receive training from the National Service for Older Persons (55).

Despite this progress, guaranteeing the quality of services through human resources education remains one of the subregion's major problems. Most of the staff in residential long-term care facilities are not formally certified or trained. The available data show that in Colombia,

only 30% of the staff in these institutions are properly trained, and in Mexico, the figure is less than 3% (22, 70). In Uruguay, even though the SNIC has imposed training requirements, they have not been accompanied by an increase in the supply of training, resulting in long waiting lists for the courses; data from 2017 show that, of the 18 000 people who had applied to take the personal aide course accredited by the SNIC, only 1000 (3) had graduated.

In a context in which most of the care is provided by the family without compensation, it is important to note the lack of training programs for these caregivers. In Chile, the Ministry of Health includes training for family caregivers as part of its home care program for people heavily dependent on care; there are also public initiatives that encourage family caregivers to join support groups and attend psychoeducational workshops (55). However, beyond this and some good practice manuals for these caregivers (in Argentina, for example) (62), policies to support family caregivers are lacking in most of the countries in the subregion.

Investing in training is a basic strategy for the development of care systems in Latin America and the Caribbean that also has positive indirect effects. As mentioned in the subsection on the impact on society and economic opportunities for the care sector, the field of elder care has great development potential and, given its high degree of feminization, can be an important driver of the labor market, especially for women. On the one hand, it can create quality job opportunities in the sector itself; and on the other, the existence of affordable, quality care services facilitate women's greater insertion in the labor market by freeing up caregivers' time (5).

The formalization and training of caregivers is not only key to redistributing the household burden of care but to ensuring that women caregivers have social protection and receive fair wages.

## **The role of the private sector**

Service delivery in the private sector (which includes the for-profit and non-profit subsectors) varies widely in the subregion in terms of its development, prices, and quality of services. The overall picture is that of an unregulated sector (see subsection on guaranteeing the quality of services) in which only middle- and upper-income people can access quality services.

In the majority of countries in the subregion, nearly all long-term care facilities are privately operated. In Uruguay, according to 2015 data

published by the National Institute for the Elderly's Information System on Old Age and Aging, 82% of the extended-stay facilities registered throughout the country are private for-profit enterprises; they are complemented by a small percentage of private non-profit facilities (3). In the Brazilian state of Minas Gerais, 85% of nursing homes are private non-profit organizations and 10.4%, private for-profit enterprises (66); in Mexico, only 8% of nursing homes are public (22). The cost of a stay in these facilities is generally high, depending on the quality of care, amenities, and range of services offered. Data for Uruguay from 2015 show that the average contributory pension payment (US\$600) would not cover the monthly cost of a facility that meets basic quality standards (US\$800) (3). Likewise, a study conducted in Mexico concludes that less than 9% of the population aged 50 and over can afford a high-quality temporary-stay facility (22).

The private sector has also shown growing interest in home care services (6), and significant growth of this market is expected in the medium term. Companies in several countries in the subregion offer older persons support, caregiving, nursing care and even help with household chores. The cost depends on the services contracted.

The private sector is also beginning to provide telecare services in the subregion. In addition to the telecare companies in Uruguay promoted by the Integrated Care System and financed by the public sector, there are local initiatives in other countries – for example, those in the municipality of Tigre in Argentina and the department of Antioquia in Colombia (78).

The development of business opportunities promoted by the private sector is part of the silver economy, which has significant growth potential (see the subsection on the impact on society and economic opportunities in the care sector). The public sector's role in promoting this part of the economy through financing agreements or subsidies to the beneficiary population is essential, especially considering the cost of services and the limited role that private insurance can play in this market. In this regard, the uncertainty implicit in this type of insurance (the probability of an accident occurring, the length of coverage, and associated costs) makes the traditional private insurance model unworkable in the case of long-term care (79). Nonetheless, in some developed countries (such as the United States and France), private insurance supplements dependency risk coverage provided by the public sector. This is not the case in the subregion, however – at least to date.

Due to the lack of coverage offered by the public sector, the few affordable quality options in the private sector, and the dwindling

number of family members who act as unpaid care providers, a high percentage of care-dependent older persons do not receive the support they need.

## The role of family care

In almost every country in the world, most of the long-term care and support for older persons with functional impairments is provided through unpaid care by families, with very little practical or financial support from the State (3, 4).

In Costa Rica, approximately 6% of the population often helps a family member or friend perform a basic or instrumental activity of daily living. In most cases, the caregiver is the son or daughter (43%) or spouse (32%) of the person requiring care (54). Paid caregivers are relatively common only in urban areas and among middle- and upper-income groups. However, most of the people who provide this service do so on an unregulated informal basis and are often untrained and inexperienced care workers (48).

In Argentina, 77% of people over 60 who need care receive it from a family member; only 16% receive help from a specialized care worker (3.4%), or from a domestic worker or untrained caregiver worker (12.2%) (62). In Uruguay, 82% of people requiring care and support are cared for by unpaid caregivers: 58.9% by a family member living in the same household; 16.8 per cent by a family member living elsewhere; and 6.3 per cent by someone outside the family. In Brazil, 35.1% of people aged 50 and over who have difficulty performing at least one BADL receive help and support from others, nearly always from family members (94.1%), 72.1% of whom are women. Only 9.2% of caregivers, including non-family members, receive payment for this work (4).

Family caregivers and care workers remain overwhelmingly female. Moreover, in the Region of the Americas, women still devote around 64% of their total hours worked to unpaid caregiving activities, compared to 37% for men (74). While these data also include care for children and people with disabilities, as the population continues aging, the burden of caring for older persons will also increase. In Mexico, for example, women are responsible for 71% of the hours of care devoted to people over 60 (22).

## Priorities and recommendations

In general, the care needs of dependent older persons should be met by engaging public and private actors, with the participation of government, families, the market, and communities. The preceding sections have highlighted the absence of integrated national care systems in the majority of Latin American and Caribbean countries, which leads to insufficient and fragmented service delivery, as well as the lack of a holistic vision that would integrate the role of each of these actors. The COVID-19 pandemic exposed families' lack of access to quality caregiving services—especially, but not exclusively, for people belonging to vulnerable socioeconomic groups.

This underscores the need for the countries of the subregion to give priority on the public agenda to the provision of caregiving services for dependent older persons and their caregivers. This will require some fundamental decisions, which are discussed below.

### Establish long-term care systems

Establishing national long-term care systems is key to protecting and promoting the rights, dignity, and well-being of care-dependent older persons and their caregivers. This can be done gradually—for example, by restricting coverage to certain populations and then gradually expanding it, or by identifying existing services and expanding them before creating new ones, thus avoiding the potential duplication of services and inefficient use of resources.

Medellín et al. (54) identify four elements critical to the design of a care system: 1) definition of the target population and eligibility criteria; 2) definition of the services to be provided and the delivery modality; 3) determination of how the services will be financed; and (4) the design of mechanisms to guarantee the quality of the services.

First, when defining the target population, it is necessary to identify care-dependent people in order to set the system's eligibility criteria and priorities, based on the policy objectives and available resources, seeking always to ensure equitable access to services. It should be borne in mind in this process that, despite its importance, age is not the only factor leading to care dependency; therefore, it would make sense to prioritize the degree of dependency over age when offering access to services (5).



Second, when determining the services to provide, it is important to know what the existing services are and identify any gaps, in order to inform decisions to expand them, create new ones, or both. When considering the range of services that can be offered, it is important to design them on a continuum that covers not only care for dependent older persons, but prevention, promotion, protection, and rehabilitation services, as well as palliative and end-of-life care and caregiver support services. The delivery of integrated, people-centered services that take the specific needs of dependent people and their caregivers into account is key to the design of the benefits package.

Third, to ensure the continuity of the system, it is essential to establish sustainable financing mechanisms (e.g., compulsory social insurance, taxes, and copayments) and determine the contribution of public and private actors to the financing plan. In 17 countries in the subregion, a dependency care system covering 50% of the dependent older population would entail an average cost equivalent to 0.48% of GDP, on a scale ranging from 0.21% in Paraguay to 1.02% in the Plurinational State of Bolivia (80). Each country will need to determine the mix of viable sources of financing, based on its particular situation. It is important to try to reduce out-of-pocket expenditure, especially by the most vulnerable population, to ensure that everyone in need of long-term care can receive it regardless of their ability to pay, without causing economic hardship to dependent people and their families. With this same objective, it is important that the financing plan take into account any strategy for gradual expansion of the system.

Finally, as already mentioned, guaranteeing the quality of services is a critical element of policy design. This will require not only standards for service delivery but the adoption of oversight and accountability mechanisms.

Identification, training, and certification of the paid long-term care workforce, both formal and informal, is another key element for guaranteeing the quality of services. To make care work more attractive, it is important to ensure social protection and the rights of care workers, introduce measures to reduce turnover, and recognize the value of these workers.

All this should be accompanied by robust institutionalization with sound governance mechanisms, in which a state agency is named as the focal point responsible for formulating long-term care policies, legislation, objectives, and strategies. This focal point should engage all ministries and secretariats with competencies in this area (including

those responsible for health, social development, older persons, women, and people with disabilities) to ensure coordination among them and define the role and responsibilities of each actor.

Regular information gathering and the use of that information are also key elements for guaranteeing equitable service delivery and quality assurance. It is therefore important to invest in an integrated, well-coordinated information and monitoring system that involves both the social and health services and includes data on older persons and their caregivers (both paid and unpaid).

As part of the information generation system, a good strategy would be to guarantee investment in research and innovation in long-term care and in particular, to have a specific funding plan to meet national and local needs, involve all stakeholders and service users in identifying knowledge gaps, and put mechanisms in place to support innovative programs.

## **Recognize, reduce, and redistribute the burden of unpaid care to close gender gaps**

In line with the Santiago Commitment, signed by the Member States of the Economic Commission for Latin America and the Caribbean at the XIV Regional Conference on Women in Latin America and the Caribbean in January 2020 (81), it is urgent that the countries recognize that the burden of care falls primarily on women. They should also promote the redistribution of caregiving responsibilities between men and women and between families and systems, and reduce the burden on women, who were especially affected by the COVID-19 pandemic (82).

The first step in recognizing the work of unpaid caregivers is to make it visible. Here, for example, governments could ensure that aspects of this work (time, circumstances, cost of care, well-being) are addressed in population surveys and service evaluations. Some Latin American and Caribbean countries have made progress in this area by calculating the contribution of unpaid work to GDP. Estimates for the subregion put this contribution at between 15% and 25%, with women being responsible for 70% of it (83). While these estimates do not refer exclusively to the care of older persons, current demographic shifts suggest that this component will continue to grow.

Recognition of the work of unpaid caregivers has led certain countries to search for ways to remunerate them. Denmark, Norway, and the United Kingdom of Great Britain and Northern Ireland, for example, compensate unpaid carers (in certain circumstances) for lost income or extraordinary expenses associated with caring for a dependent person. In addition to payments, some countries (such as Germany, Spain, Finland, and the United Kingdom) cover the social security contributions of caregivers (6). As mentioned earlier, these measures are controversial, as it is argued that they could have the opposite of the desired effect and reinforce existing gender roles.

Ensuring the visibility of this work must be accompanied by other measures to redistribute caregiving responsibilities (between men and women and between families and systems) and reduce the burden of care on families, especially women. Here, governments can take overall responsibility for providing long-term care and support to older persons who need it, promoting the redistribution of household caregiving responsibilities between men and women (co-responsibility for care), introducing flexible work arrangements for allow for caregiving needs, and providing paid care leave for workers and home support for unpaid caregivers (e.g., respite services, as in Chile, or personal care aides, as in Uruguay).

There are also programs focused on changing social perceptions of caregiving and promoting “masculinities with solidarity.” One such example is the Manzanas del Cuidado program in Bogota, Colombia. These initiatives can help change perceptions of the caregiving profession and encourage male involvement in it. A training program on gender norms and co-responsibility launched by a supermarket chain in Honduras has resulted in greater productivity and efficiency, as well as less workplace absenteeism among women (84).

The COVID-19 pandemic has heightened the impact of unpaid care on families, especially women, and increased the need for protection programs targeting households headed by women, informal and domestic workers who lack social protection, and unemployed women (85).

## **Strengthen social and health integration**

At the macro level, lack of coordination and integration between health and social services and long-term care means that responsibility for the overall well-being and functional ability of older persons does not lie with either sector. Designating a long term care focal point (see the

section on establishing long-term care systems) with specific roles and responsibilities, as well as introducing accountability measures for the various actors, could help ensure that the quality of care provided is constantly verified, monitored, and improved.

Most of the available evidence from around the world shows that, as structured today, health and care systems focus primarily on managing serious health problems and are less equipped to deal with the chronic and functional needs that tend to affect older persons (86, 87). Health services and workforce training are still focused on curing or treating disease. They are less prepared to provide care for older persons living with chronic health conditions and difficult social situations and to take steps to preserve their functional ability and well-being (59).

Each older person is unique, with their own intrinsic capacities. Long-term care systems must take a people-centered approach, rather than a disease- or service-centered one, to meet each individual's needs. It is critical for home and residential care services to adopt this approach and engage and empower older persons to make key decisions about their care (1).

## **Invest in the care economy**

The care economy can provide a significant opportunity for economic growth (57). By doubling current investment in the care economy, 269 000 000 jobs could be generated worldwide, for a total of 475 000 000 jobs by 2030 (74). In addition to improving care and creating jobs, investment in the care economy could make the sector more attractive to health professionals and social workers, which would reduce the currently high turnover among the long-term care workforce (74).

Investing in the care economy was also an important measure both during and after the COVID-19 pandemic, mitigating its adverse impact on the women who provide care and the people who receive it (85).

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This report provides updated information on long-term care in the Region of the Americas, summarizing current knowledge about the health and aging of older persons in the Region at the start of the Decade of Healthy Aging 2021-2030. The data paint a detailed picture of the long-term care situation in Latin America and the Caribbean, the burden and effects of care dependency, and current long-term care systems and services in the subregion.

The rapid aging of the population in Latin America and the Caribbean is fueling a substantial increase in the demand for care services at a time when the supply of unpaid care provided by families—currently the main providers of dependency care—is shrinking.

This detailed report can serve as the foundation for the design of strategies that formalize this dimension of health care, with the idea that developing national long-term care systems is essential for protecting and promoting the rights, dignity, and well-being of care-dependent older persons and their caregivers.