WHO CARES?

How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean

Marco Stampini, Ana Llena-Nozal, Carlos Soto Iguarán, Natalia Aranco, Fiorella Benedetti, Beatrice Fabiani de Leva, Milagros García Díaz, Karolin Killmeier, Carina Lupica, Judit Rauet Tejeda

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The remaining photos used in this report come from an IDB database compiled during the ninth meeting of the Long-Term Care Policy Network in Latin America and the Caribbean (RedCUIDAR+), held in Costa Rica in 2023.

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Foreword

Building long-term care services is a priority as Latin America and the Caribbean develops its care systems. An aging population and declining fertility rates in the region are increasing the demand for care, which will grow exponentially in the next few decades (to 23 million people over age 65 requiring care in 2050). This demographic transition—driven by longer life expectancies, improvements in health, and higher living standards—is a sign of collective achievement.

Yet this shift also brings challenges for individuals, families, and societies. At the individual level, aging is associated with increased health and care needs, and with the imperative to protect people from the risks linked to longer life spans. For societies, aging poses questions about public policy and financial sustainability. Adapting social protection systems to these new realities has become an urgent priority. Both the coverage and the quality of long-term care services in the countries of the region is low, with less than 20% of older people in need of care receiving public services, which means that there is much left to do.

A key step toward tackling this issue is recognizing the people who provide care, ensuring that both paid and unpaid caregivers are supported, trained, and valued for their essential contributions. Human resources are a key pillar in building long-term care systems. This publication provides the most complete analysis to date of the status of paid and unpaid caregivers of older people in Latin America and the Caribbean. It also provides an in-depth assessment of the policies and programs that are in place to support them, recognize their work, and contribute to their well-being and professional development. This pioneering analysis is a fundamental input for policymakers and civil society stakeholders that are working to improve long-term care in Latin America and the Caribbean. It highlights lessons learned, good practices, and innovative approaches that can inspire future reforms across countries in the region, as well as in other OECD countries.

It is important to consider the needs of both paid professional caregivers and unpaid family caregivers. Nearly 25 million unpaid caregivers in the region, 60% of which are women and family members, play a crucial role in providing day-to-day care, yet their contributions are undervalued or under-supported. To maintain caregiver well-being and sustain long-term care systems, it is essential to strengthen support measures like respite care, training, and financial incentives. At the same time, countries need to invest in formal care services to meet growing demand and ensure high standards of care. Long-term care workers, often women in vulnerable employment arrangements, are central to sustainable and quality care. Supporting them means ensuring decent working conditions and adequate training, as well as recognizing their contribution to society. This dual focus on paid and unpaid care helps build a comprehensive and resilient long-term care system while creating jobs. At the same time, it addresses the time poverty that keeps millions of people, mostly women, out of education, work, and civil life.

This report seeks to foster closer dialogue on long-term care between countries in the Latin America and Caribbean region, including those that are OECD members or accession countries, and the wider OECD community. It does so by providing an overview of the state of paid and unpaid caregivers for older people, recognizing their role in long-term care systems. It builds on previous OECD work on the topic, namely Who Cares? (2020) and Beyond Applause (2023), and it adds emphasis on the aspects that are particularly relevant for the region. It draws on evidence from both countries in Latin America and the Caribbean and OECD countries with well-developed long-term care systems. It highlights current initiatives, successful practices, and areas for improvement.

The three organizations that worked together to make this report possible – the Inter-American Development Bank (IDB), the OECD, and the Agence Française de Developpement (AFD)- are committed to raising the profile of long-term care workers and improving care for older people. The IDB has recently added developing care systems to its operational priorities. It has launched the IDB Cares initiative to increase funding, technical assistance, and knowledge for creating care systems, expanding high-quality care services, and promoting shared responsibility for care work. The OECD, as part of its Ministerial Meeting 2024, received a mandate to keep the long-term care workforce on its policy agenda and monitor policy developments and indicators in this area. By promoting inclusive and sustainable investments, the AFD seeks to contribute to achieving the Sustainable Development Goals, support the development of more equal and inclusive societies, and champion equality between men and women, all goals that are supported by enhancing the long-term care workforce.

Ferdinando Regalia
Manager, Social Sector, Inter-American Development Bank

Stefano Scarpetta
Director for Employment, Labour and Social Affairs, OECD

Agnès Soucat
Director of Health and Social Protection Agence Française de Développement

'When we put people at the center of care, we come alongside them with compassion and empathy, and every gesture or word has the potential to change their lives. Technical know-how is important, but so too are emotional connection and genuine understanding. Care—the beating heart of life—is where science meets compassion.'

Enrique V. Iglesias
Founder, ASTUR Foundation
Former President of the Inter-American Development Bank

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Acronyms and abbreviations

ADL	Activities of daily living
AFD	Agence Française de Développement
IADL	Instrumental activities of daily living
IDB	Inter-American Development Bank
OECD	Organisation for Economic Co-operation and Development

List of country-specific institutions

COUNTRY	ACRONYM	FULL NAME	TRANSLATION
Argentina		*Observatorio Integral del Sistema de Cuidado de Personas Adultas y Mayores*	Comprehensive Observatory of the Long-Term Care System for Older People
Argentina	FATSA	*Federación de Asociaciones de la Sanidad Argentina*	Federation of Associations of Argentine Health Workers
Argentina	INAES	*Instituto Nacional de Asociativismo y Economía Social*	National Institute for Associations and Social Economy
Bolivia		*Consejo de Coordinación Sectorial 'Por una Vejez Digna'*	Sectoral Coordination Council for a Dignified Old Age
Brazil	IPEA	*Instituto de Pesquisa Econômica Aplicada*	Institute of Applied Economic Research
Chile	SENCE	*Servicio Nacional de Capacitación y Empleo*	National Training and Employment Service
Colombia	CONPES	*Consejo Nacional de Política Económica y Social*	National Council for Economic and Social Policy
Colombia	SENA	*Servicio Nacional de Aprendizaje*	National Learning Service
Costa Rica	CCSS	*Caja Costarricense del Seguro Social*	Costa Rican Social Security Fund
Costa Rica	IMAS	*Instituto Mixto de Ayuda Social*	Joint Social Welfare Institute
Costa Rica	INA	*Instituto Nacional de Aprendizaje*	National Training Institute
Costa Rica	SINCA	*Sistema Nacional de Cuidados y Apoyos para Personas Adultas y Personas Adultas Mayores en Situación de Dependencia*	National Care and Support System for Care-Dependent Adults and Older People

COUNTRY	ACRONYM	FULL NAME	TRANSLATION
Costa Rica	UNED	*Universidad Estatal a Distancia*	Public Distance Learning University
Dominican Republic	CONAPE	*Consejo Nacional de la Persona Envejeciente*	National Council for Older People
Dominican Republic	FENAMUTRA	*Federación Nacional de Mujeres Trabajadoras*	National Federation of Women Workers
Dominican Republic	INFOTEP	*Instituto nacional de Formación Técnico Professional*	National Technical and Vocational Training Institute
France	AFPA	*Agence Nationale pour la Formation Professionnelle des Adultes*	National Agency for Adult Vocational Training
France	CESU	*Chèque Emploi Service Universel*	Universal Service Employment Voucher
France	URSSAF	*Unions de Recouvrement des Cotisations de Sécurité Sociale et d'Allocations Familiales*	Organizations for the Collection of Social Security and Family Benefit Contributions
Honduras	CEM-H	*Centro de Estudios de la Mujer*	Center for Women's Studies
Italy	DOMINA	*Associazione Nazionale Datori di Lavoro Domestici*	National Association of Families as Domestic Employers
Mexico	CONOCER	*Consejo Nacional de Normalización y Certificación de Competencias Laborales*	National Council for the Standardization and Certification of Labor Competencies
Mexico	IMSS	*Instituto Mexicano del Seguro Social*	Mexican Social Security Institute
Mexico	INAPAM	*Instituto Nacional de las Personas Adultas Mayores*	National Institute for Older People
Mexico	INEGI	*Instituto Nacional de Estadística y Geografía*	National Institute of Statistics and Geography
Mexico	INGER	*Instituto Nacional de Geriatría*	National Institute of Geriatrics
Mexico	ISSSTE	*Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado*	Social Security Institution for State Employees
Peru	EsSalud	*Seguro Social de Salud*	Social Security for Health
Peru	PADOMI	*Programa de Atención Domiciliaria*	Home Care Program
Uruguay	INEFOP	*Instituto Nacional de Empleo y Formación Profesional*	National Institute of Employment and Vocational Training
Uruguay	SNIC	*Sistema Nacional Integrado de Cuidados*	National Integrated Care System

Executive Summary

Providing adequate care in one of the world's most rapidly aging regions is an ambitious objective. In Latin America and the Caribbean, about eight million individuals over age 65 currently require help with daily activities, from basic tasks like eating and bathing to more complex responsibilities such as managing medications and finances. This number is projected to nearly triple to 23 million by 2050 due to longer lifespans and the growing prevalence of chronic diseases. Under this shift, the traditional model of family-based, unpaid care provided mainly by women becomes unsustainable.

Latin America and the Caribbean will soon face a crisis in the supply of both paid and unpaid carers. By 2050, the demand for family long-term care will more than double, putting pressure on the labor force. Factors like declining fertility, increased female workforce participation, and more dispersed families will exacerbate the crisis by reducing the potential number of family caregivers. While a few countries have developed national long-term care systems, most of the region has incipient public long-term care services; unregulated, not-for-profit care arrangements; and expensive private options. The current workforce of three million paid caregivers will need to expand to approximately 14 million by 2050 to meet the growing demand for care.

The unequal distribution of unpaid care between women and men continues to take its toll. Unpaid caregiving remains widespread, with nearly 25 million caregivers in the region spending an average of 7.5 hours per week providing care to older relatives. To keep pace with demographic trends, this number will need to grow to 60.5 million by 2050. Unpaid care responsibilities are not shared equally: nearly 60% of caregivers are women. Women also spend more time on intensive, less flexible tasks like bathing and feeding, and they provide more "passive caregiving," meaning they simultaneously supervise dependents and do other tasks. This limits their time for paid work or rest. In Mexico, for example, women spend 20 hours per week on passive care, while men spend 17. Educational attainment does not shield women from this imbalance: on average, people with a secondary education or higher spend the same amount of time on unpaid care per week as those with lower levels of education. While caregiving can foster emotional bonds and personal growth, evidence shows that unpaid caregivers are less likely to have paid jobs and that those who do tend to have lower-quality jobs and poorer emotional and physical health.

Paid caregivers often experience precarious working conditions and limited training opportunities. The paid care sector in Latin America and the Caribbean is under-resourced and largely informal. Most of the sector's three million workers are middle-aged women. Many are Afro-descendants. Caregivers tend to work part-time, without contracts or social protection, and most earn below minimum wage (90% of minimum wage, on average). Most training available is fragmented or non-formal, and 37% of paid caregivers work without any training. Less than half have completed a caregiving course.

Towards a Comprehensive Policy Response

Supporting unpaid family carers will reduce their burden as they continue to play a key role. Support for unpaid caregivers in the region is slowly developing in three areas. The first is access to information, training, and emotional support. Online caregiver registries and information hubs in Costa Rica or Mexico offer promising models for this area. The second is financial compensation through cash transfers, as offered by Chile and Costa Rica, as well as pension credits, an area being discussed in several countries. The third area of support is enabling work-life balance through leave policies, like Mexico's or Ecuador's, and flexible work arrangements, as in Chile and Bogotá (Colombia), to help mitigate the physical, emotional, and financial toll of caregiving.

The paid workforce needs to be professionalized and expanded to increase care quality. Current efforts to improve the working conditions of paid caregivers in the region focus on training, increasing formal employment, and safety standards. In most countries, minimum salaries in the sector are regulated by general labor laws. A lack of formal recognition for the caregiving profession remains a significant challenge in many countries, hindering regulation, organization, and labor protections.

In this context, collective agreements are crucial to improving working conditions. However, low unionization rates and a fragmented workforce hinder the achievement of collective agreements in the long-term care sector. Official registries are another tool to boost the standing of the profession. They also provide information about job and training opportunities and support services available to caregivers. Argentina, Costa Rica, and Uruguay have implemented national registries.

Countries like Argentina, Chile, Colombia, and Uruguay are developing training systems through occupational profiles and competency frameworks. However, most existing training still falls short of international standards. To bridge the training gap, countries could standardize curricula, promote practical experience, and ensure affordable and flexible access to training, including online options.

Innovative models offer pathways to more formal employment and better conditions. These include care cooperatives (for example, the Care Cooperatives and Mutual Societies Incubator[1] in Argentina), government-sponsored digital hiring platforms, and voucher systems, which have been implemented, for example, by Brazil (eSocial tool) and Colombia (Integrated Contributions

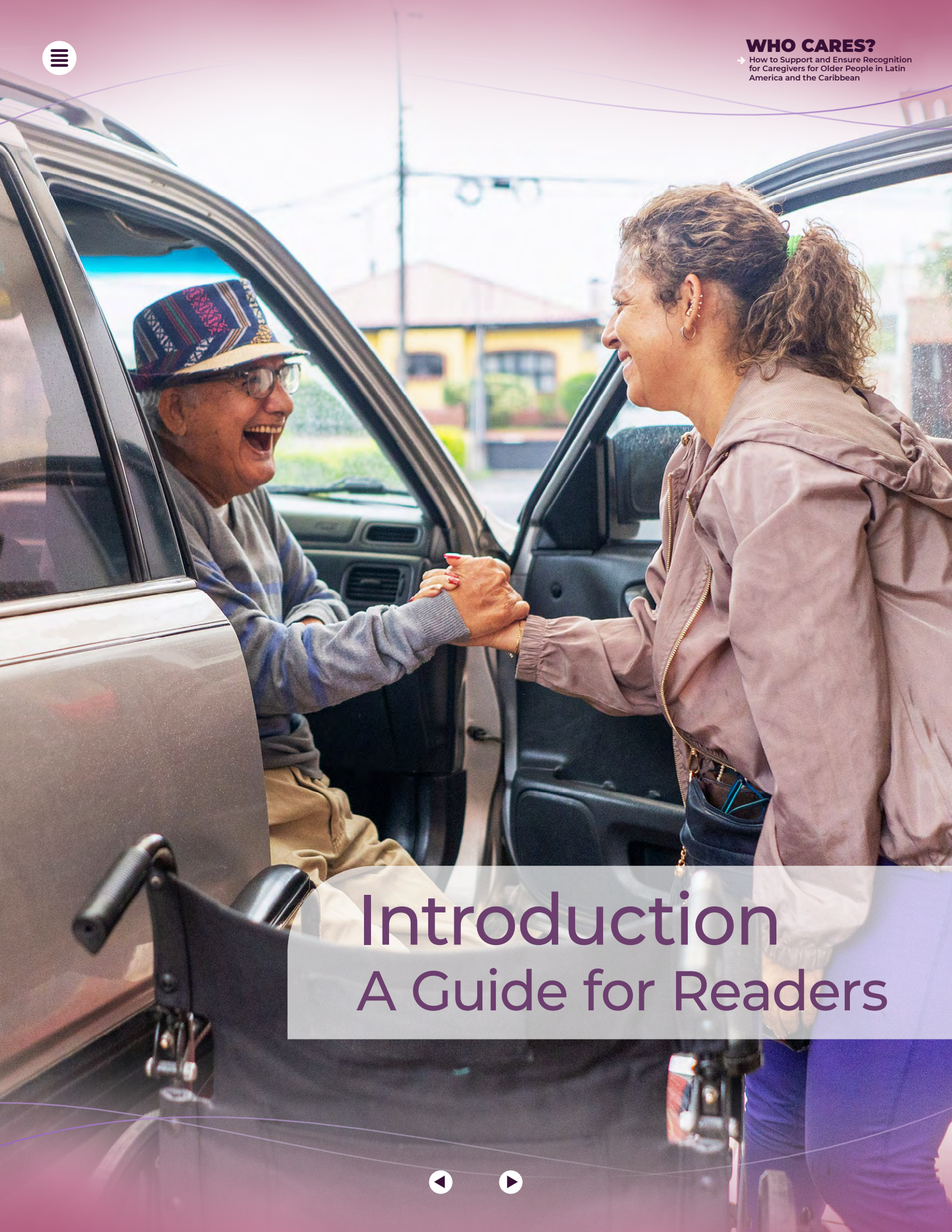
1. *Incubadora de Cooperativas y Mutuales de Cuidados.*

Payment Form[2]). So far, working conditions are mostly regulated via general regulations, most commonly safety regulations. Improving caregivers' training and working conditions is crucial not only to enhance their well-being—since many report symptoms of depression and stress—but also to ensure the quality and continuity of care.

A strong foundation of well-equipped human resources makes long-term care systems resilient. To improve working conditions for the next generation of unpaid and paid carers and address the sector's human resources gap, countries could expand or replicate good practices on access to social security to protect caregivers. For example, they could make care expenses tax deductible (as in Argentina, Mexico, and France), or enhance enforcement through inspections and regulatory practices (as in Argentina, Chile, and Uruguay). It is also important to foster a redistribution of long-term care responsibilities between women and men and empower workers to manage emergencies and extreme events. Promoting men's involvement in care roles through policy and cultural shifts could also help redistribute responsibilities and elevate the profession's status, as shown by examples from Bogotá's School of Men in Care, and, in Europe, Belgium's Men in Childcare campaign or Norway's staffing incentives.

The COVID-19 pandemic exposed existing systems' vulnerability, underscoring the need for long-term investment in planning, workforce capacity, and inter-sectoral coordination. Good practices in this area include Ontario's Long-Term Care Emergency Preparedness Manual and Sweden's awareness-raising materials for managers and supervisors in the health and social care sectors. Although some of these policies are not widespread or mature in Latin America and the Caribbean, there are promising initiatives that can be replicated, and countries can also draw inspiration from good practices that have emerged in other parts of the world.

2. *Planilla Integrada de Liquidación de Aportes.*



Introduction
A Guide for Readers

This study sheds light on the situation of caregivers for older people in Latin America and the Caribbean, and on the policies and programs that can improve their status and well-being. It builds on the report by the Organisation for Economic Co-operation and Development (OECD) entitled *Who Cares? Attracting and Retaining Care Workers for the Elderly* (2020), but it shifts the focus to Latin American and Caribbean countries. This study promotes a policy agenda that fosters high-quality long-term care jobs and expands support services for family caregivers.

The report is organized as follows.

- **Chapter 1** provides an overview of the whole study. It presents the key findings and figures of the chapters that follow. For readers with limited time, it serves as an extended executive summary.

- **Chapter 2** presents the facts underlying this report. It starts by discussing the longevity trends driving up demand for long-term care. It then analyzes how the supply of long-term care struggles to meet the current and growing demand due to several factors, including (i) low natality and increasing labor market participation that reduce the availability of unpaid family care; (ii) limited development of publicly financed long-term care services; and (iii) the high cost of good-quality private long-term care services. This supply shortage will create a crisis in the existing care model.

- **Chapters 3** and **4** present the most up-to-date and comprehensive cross-country assessments of unpaid and paid long-term caregivers, respectively. They analyze their sociodemographic characteristics, job characteristics and quality, the tasks they perform, and how caregiving affects their well-being. The analysis is based on time-use surveys for unpaid caregivers, labor force surveys for paid caregivers, and data from an Inter-American Development Bank (IDB) survey of both paid and unpaid caregivers.

- **Chapters 5** and **6** detail the policies and programs implemented by Latin American and Caribbean countries to support and improve the well-being of unpaid and paid long-term caregivers, respectively. **Chapters 5** focuses on initiatives to provide information, training, and emotional support; policies that reduce the economic impact on caregivers; and policies that improve caregivers' work-life balance. **Chapter 6** analyzes employment regulations, labor rights, safety standards, and initiatives to raise the standing and productivity of the caregiving profession. The analysis is based on interviews with government representatives and key stakeholders, and on a literature review.

- **Chapter 7** concludes the study by highlighting good practices that help build a sustainable and competent long-term care workforce. Good practices from Latin American and Caribbe-

an countries are complemented by others from OECD countries that can inspire policies and programs in the region. The chapter discusses policies and programs that improve the quality of long-term care jobs, training with a person-centered approach (for both paid and unpaid caregivers), services that support family caregivers, the need to promote men's participation in family and paid caregiving, and the need to adapt the long-term care workforce to the effects of increasing extreme weather events. This concluding chapter does not include a summary of the findings of the previous chapters, which are already included in the overview in **Chapter 1**. Rather, it focuses on proposing a way forward for the countries of Latin America and the Caribbean.

- The Annexes describe the data and methodology used in **chapters 3** and **4** to analyze unpaid caregivers and long-term care workers (**annexes A**, **B**, and **C**). They also contain further insights from the interviews with government representatives and stakeholders used in **chapters 5** and **6** (**Annex D**).

The policies and programs discussed in this report were mentioned in interviews with government representatives and experts conducted between March and October 2024, or retrieved from official documents. They do not necessarily provide a complete picture of the policies and programs in the region. The state of policy implementation was last confirmed in July 2025.

The IDB conducted its caregivers survey between November 2023 and March 2025.

1 Overview

1.1 Latin America and the Caribbean will need more paid caregivers to fill the gap in unpaid caregiving

Latin America and the Caribbean is one of the fastest-aging regions in the world. Currently, around eight million people over age 65 in the region require support with daily activities, a number projected to reach 23 million by 2050. These activities are generally classified as basic activities of daily living (ADL) and instrumental activities of daily living (IADL). Basic activities of daily living are essential for survival and include eating, bathing, using the toilet, dressing, and moving around a room. Instrumental activities are more complex and include, for example, taking medications, doing chores, cooking, or managing personal finances.

As populations age, care needs become more complex due to higher levels of functional dependence and an increasing prevalence of chronic conditions. This shift is straining the current model of caregiving, which relies mainly on female family caregivers. Increased female labor force participation, declining fertility rates, and more dispersed family structures are reducing the availability of unpaid care. By 2050, unless government programs are developed or paid caregiver programs become more accessible, the demand for family long-term care will put pressure on labor force participation, as one in three people aged 45–64 will be required to provide family care.

Although some countries in the region, like Uruguay and Costa Rica, have developed national long-term care systems, the region is still characterized by incipient public services, low-quality services provided by non-profit organizations, and unaffordable private-sector services. As care needs grow and the availability of family caregivers declines, both governments and markets will need to strengthen their involvement in the long-term care sector. Governments may need to develop financially sustainable long-term care systems that expand coverage and improve quality, with a focus on enabling aging in the community and using long-term care facilities only as a last resort. At the same time, the private sector may expand the supply of long-term care services, generating employment and offering care options, whether through public contracts or directly to families who can afford them. Governments will have to play a crucial role in setting quality standards and overseeing private care provision.

Care workers are key to meeting the growing demand for long-term care. The region will need to expand its long-term care workforce from three million to an estimated 14 million by 2050. Countries must invest in training and professionalizing caregivers to ensure the quality of long-term care services. This investment need not be limited to paid caregivers, since families will still assume a significant share of care responsibilities. Supporting family caregivers (through training, emotional counseling, or flexible work or leave policies, for example) will be crucial to protect their physical and emotional well-being.

1.2 Unpaid caregivers likely cannot meet the increase in demand

Unpaid caregiving[3] is widespread in Latin America and the Caribbean countries. Currently, an estimated 25 million unpaid caregivers support older people in the region, spending an average of 7.5 hours per week on these activities. To maintain the current caregiver-to-older-person ratio, the number of unpaid caregivers would need to increase to 60.5 million by 2050. Declining fertility and shrinking families make it difficult to achieve these figures.

Approximately 60% of unpaid caregivers are women. Because of social norms, attitudes, and stereotypes, women spend more hours on caregiving duties than men (2.4 hours more per week). They take on the least flexible and most demanding tasks, such as support with basic activities of daily life (like cooking meals and feeding older people at fixed times, bathing them, or taking them to medical appointments). Women are also more likely than men to engage in "passive caregiving," where they oversee a dependent person while doing other activities. This practice increases their caregiving responsibilities and limits their time for paid work, education, or leisure. Participation in unpaid care for older people does not vary by level of education.

Although caregiving offers a sense of purpose and satisfaction, it also negatively impacts employment and physical and mental health. Caregiving fosters closer relationships, promotes solidarity, and strengthens interpersonal skills such as empathy and communication. However, when these tasks become excessive and are not properly supported, they can have negative effects. Unpaid caregivers are eight percentage points less likely to have a paid job, and those who remain employed work two hours less per week, on average. Additionally, many caregivers experience stress (71%), loneliness (55%), and depression (34%) as a result of insufficient sleep and neglected self-care. These negative health effects are stronger when caregiving is an obligation rather than a choice. Training and psychological support can mitigate these negative impacts.

3. Family members provide most unpaid caregiving, so this report uses the terms "family caregivers" and "unpaid caregivers" interchangeably.

1.3 The region lacks paid and qualified caregivers, and working conditions are poor

The supply of long-term care workers in Latin American and Caribbean countries falls short of the demand for care. The sector employs approximately three million paid caregivers for older people, which accounts for 1% of total employment and 2.3% of female employment. Given the current demographic trends, including rapid population aging and shrinking informal care networks, the number of paid care workers will need to increase to approximately 14 million by 2050.

Most paid care workers (95%) are women, typically in their forties. Paid caregivers are ethnically diverse: Afro-descendants comprise more than half of the workforce, and Indigenous peoples make up 3%. Compared to OECD countries, the Latin American and Caribbean region has a lower share of migrant workers in the long-term care sector, which currently draws mostly from the national workforce.

Paid caregivers lack training: 37% of caregivers do their job without any training, and 16% rely on self-study. Less than half of paid caregivers have completed a caregiving course: 10% took a short course of less than 60 hours, 12% took a medium-length course of 60 to 150 hours, and 25% completed a course of more than 150 hours.

Care work is complex and involves several heterogeneous tasks. Home caregivers primarily focus on hygiene and personal care—with 71% of respondents to the IDB survey reporting that they perform these duties—and household chores, performed by 47% of respondents. In contrast, institutional caregivers emphasize tasks related to hygiene (reported by 75%) and healthcare (45%).

Paid caregivers work an average of 31 hours per week, which suggests that their job is often part-time. Part-time work tends to make workers more vulnerable and restrict their opportunities and access to employment and social protection benefits.

Paid caregivers often work in precarious and insecure conditions. Informality and lack of social protection are widespread: only 26% of paid caregivers pay contributions to social security, and just one-third have a written contract. When informally employed, paid caregivers tend to earn less than the minimum wage. Despite these precarious conditions, 45% of caregivers have been in the profession for over six years, and almost 60% of paid caregivers believe they will remain in the profession. Training is a key tool to improve working conditions in the sector, increase salaries, and provide a career path that impacts earnings.

Training is also a crucial tool to improve paid caregivers' well-being and mental health, which can be affected by the job's high emotional burden. Paid caregivers, especially female caregivers, experience symptoms of depression (20%) and stress (45%).

1.4 Policies to support family caregivers are slowly emerging and focus on training and information

The policies to support unpaid caregivers fall into three categories: (i) information, training, and psychological support; (ii) income support and pension credits; and (iii) leave and flexible work schedules that allow workers to combine employment and unpaid caregiving.

1.4.1 Information and training help unpaid carers provide better care

Promising initiatives to create online information hubs are underway. Providing unpaid caregivers with information and knowledge is key to improving their lives. Both Costa Rica and Mexico have launched online information hubs to raise awareness about family caregivers. These websites include important resources such as labor rights and information on training opportunities.

Several countries are creating caregiver registries, which are gateways to information and support services. In Chile and Costa Rica, those who join these registries gain preferential access to public services.

Training for family caregivers is available in most countries in the region, often free of charge. It aims to enable families to better manage caregiving responsibilities and improve caregivers' well-being and the quality of the care they provide. Some countries make training more affordable through allowances and grants. Chile, for example, offers a daily attendance allowance for a course on basic care for older people, and an additional allowance for purchasing tools for those who complete the training.

The region has few comprehensive initiatives to support caregivers through psychosocial interventions and counseling. These initiatives are designed to help caregivers deal with stress, loneliness, and depression. In Brazil (Bahia), caregivers can receive therapeutic group sessions and individual counseling from the Caregiver Support Program.[4] Other examples can be found in Peru and Colombia.

4. *Programa de Apoio ao Cuidador.*

1.4.2 Policies can reduce the negative economic impact of caregiving

Cash transfers can alleviate the financial burden associated with providing care, and a few countries have introduced this benefit for family caregivers. However, these transfers must be carefully designed to ensure that they do not perpetuate the traditional care model (which relies on unpaid female care), and that they respect the preferences and autonomy of older people. In Chile, those providing care to people with disabilities can receive a small amount of cash. In Costa Rica, a cash-for-care program supports low-income households, with a severely dependent member.

Countries in the region do not currently offer pension credits for family members caring for older people, but they are considering this benefit. Pension credits can effectively mitigate the impact of career interruptions on the value of contributory pensions and limit the risk of poverty in old age. They are uncommon in the region, although some countries, such as Bolivia, Chile, Mexico, and Uruguay, offer them to compensate for time spent caring for children. Colombia is exploring a similar measure to subsidize the pension and healthcare contributions of people caring for older family members experiencing care dependency.

1.4.3 Policies can improve family carers' work-life balance

Paid and unpaid leave options are scarce for the region's caregivers. Long-term care leave only exists in Mexico, Ecuador, and Chile. In many cases, people rely on general leave schemes, such as personal days, to cover periods of care, since these are often the only options available. Leave schemes specifically for providing care exist in Costa Rica (for critically ill individuals), Peru (for family members), and Honduras (general caregiving). Ensuring access to caregiving leave for both men and women helps foster a more equitable distribution of responsibilities.

Flexible work arrangements and respite care options that help caregivers balance employment, caregiving responsibilities, and personal well-being are also scarce. These schemes help carers reconcile work responsibilities with caregiving duties and allow them to continue both activities without burning out. In Chile, part-time or full-time teleworking is available for employees caring for children under fourteen, people with disabilities, or people with severe or moderate care dependency. Respite care is available in Bogotá, Colombia, under the Care Blocks[5] program, and in Chile under the Chile Cares[6] program.

5. *Manzanas del Cuidado.*
6. *Chile Cuida.*

1.5 Policies to support the long-term care workforce tend to focus on skills and training more than on recruitment and productivity

The long-term care workforce is relatively small in Latin America and the Caribbean. Part of what makes it challenging to improve the sector's working conditions is the lack of a clear definition and official recognition of the care worker profession. As a result, the long-term care sector is regulated by general labor regulations in most countries. However, some countries have recently adopted policies that target long-term care workers.

1.5.1 Few countries are improving labor rights through specific policies for long-term care workers

A few countries in the region have specific wage regulations for formal workers in the long-term care sector. Uruguay, Argentina, and Costa Rica have explicit regulations that directly concern long-term care workers, while Argentina and the Dominican Republic achieve the effect indirectly through regulations on domestic care work.

Collective agreements are an important way to improve working conditions. However, the region has no major caregiver unions, which may also be due to the fact that many countries lack an official definition of the caregiving profession. Official caregiver registries are another tool to bring more recognition to the caregiving profession and make it more attractive, with advantages for caregivers, employers, and governments alike. However, only three countries in the region have national registries (Argentina, Costa Rica, and Uruguay).

Informal employment is widespread in the long-term care sector and correlates with a lack of training. Some countries seek to expand formal employment through training strategies, which are most effective when caregivers, once they finish training, are placed on an official caregivers registry that gives them access to job opportunities. Argentina and Uruguay follow this practice. Some countries also seek to increase formal employment among home care workers indirectly through policies designed to formalize domestic paid work (as is the case in Argentina, Brazil, and Uruguay). Some training courses in Chile, Mexico, and Argentina also promote new enterprises by having participants develop a business plan that lays the groundwork for formalizing care services, either by obtaining the necessary permits to operate or by providing care services in a formal manner. In addition, certification can serve as a positive signal for informal workers, and it can potentially improve their income.

1.5.2 Health and safety measures increase retention, worker well-being, and quality of care

Health and safety measures that prevent emotional and physical strain among caregivers are fundamental, since they improve workers' well-being and the quality of care. Most countries have health and safety regulations for long-term care facilities, but not for household settings. Regulatory measures for long-term care facilities usually include capacity limits, mandatory authorization processes, detailed specifications for staff qualifications, resident-to-worker ratios, infrastructure requirements, and safety standards. In most countries, care services must meet these standards to be authorized to function. Compliance inspections are conducted with varying degrees of regularity. However, these standards are implemented primarily to guarantee safety for residents. While they also have a substantial direct or indirect impact on worker health and safety, countries still lack regulations in basic areas (e.g., on how to lift people to avoid back pain).

An example of health and safety measures is staff ratios, which define the number of caregivers per resident. Ten countries in the region have this type of regulation (Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Peru, and Uruguay). In most of them, the number of caregivers required increases with residents' degree of care dependency and varies by time of the day (daytime or night). These countries also usually issue regulations on the specific type of workers (or mix of workers) needed in each facility.

1.5.3 The region cultivates skills as a strategic way to build a sustainable, long-term care workforce

Training and educational programs are critical to developing the long-term care workforce. The first step towards better-targeted and standardized training is defining occupational profiles. Several countries have already taken this step—Argentina, Barbados, Brazil, Chile, Colombia, Ecuador, Mexico, Trinidad and Tobago, and Uruguay—while El Salvador is in the process of doing so.

The second key step is creating competency frameworks, which define the core skills that workers in each occupational profile need in order to do their jobs well. Eight countries have these frameworks—Argentina, Chile, Colombia, Costa Rica, Ecuador, Mexico, Trinidad and Tobago, and Uruguay—and El Salvador is currently developing one.

Despite progress, there is still much room for improvement, and care worker training levels are low. Most countries require personal care workers to have minimum training or to certify their knowledge before authorizing them to work in official long-term care services. However, the duration of these official training programs varies greatly, and only a few countries have programs longer than the 260 hours recommended by the Ibero-American Protocol for Caregiver Training[7] (Argentina, Barbados, the Dominican Republic, and Ecuador).

Due to the lack of official training curricula, in many countries caregivers who want training rely on non-formal courses. These courses may be structured and lead to a certificate but take place outside the formal education system. They do not usually result in a government-recognized qualification. They are imparted by a range of organizations, including public and private universities, NGOs, public institutions, and the for-profit private sector, creating a heterogeneous training landscape.

In this context, many countries in the region have programs that recognize care workers' prior learning and working experience to acknowledge the skills they have acquired (Chile, Colombia, Ecuador, the Dominican Republic, Guyana, and Uruguay). In Colombia, for example, the National Training Service (SENA) [8] provides free professional certifications for caregivers. This type of recognition officially endorses the expertise, abilities, and aptitudes needed to perform a specific occupation, regardless of whether the knowledge and skills have been acquired through formal training or by informal means. For caregivers, many of whom work informally, often within households, it provides an opportunity for their skills to be valued and recognized, making it easier for them to secure formal employment.

1.5.4 There are incipient efforts to increase productivity in the long-term care sector

The region is not currently prioritizing policies to increase productivity in the long-term care sector. A possible explanation for this is that workforce shortages are not yet as pressing as in most OECD countries, and Latin American and Caribbean countries have limited resources to spend on innovative approaches. Uruguay and Chile are the only countries in the region that have adopted technological solutions in publicly financed long-term care services.

7. *Protocolo iberoamericano de formación en cuidados.*
8. *Servicio Nacional de Aprendizaje.*

The lack of coordination between health care and long-term care can increase people's workloads, duplicate tasks, decrease efficiency, and diminish workers' overall well-being. Brazil, Colombia, Costa Rica, Peru, and Trinidad and Tobago included the topic of coordination in their national aging and care policies, acknowledging its importance in providing long-term care. However, care coordination is a relatively new concept and is still being implemented.

1.6 The way forward: how countries can improve conditions for future caregivers

To improve conditions for the next generation of unpaid and paid caregivers and address the sector's human resources gap, countries need to promote comprehensive policies that: (i) improve the quality of long-term care jobs; (ii) scale up training opportunities, ensuring they use a person-centered approach; (iii) provide additional support to unpaid caregivers; (iv) foster a redistribution of long-term care responsibilities between women and men; and (v) empower long-term care human resources to address the effects of emergencies caused by extreme events. Although some of these policies are only recently beginning to emerge in the region, there are promising initiatives that can be replicated, and countries can also draw inspiration from good practices in other parts of the world.

1.6.1 Improve the quality of long-term care jobs to professionalize the sector

Improving the quality of long-term care jobs requires raising the status of the profession, enhancing access to social security, and leveraging the potential of private-sector initiatives (including workplace platforms and caregivers cooperatives).

A key strategy in this area is investing in professionalizing long-term care jobs. Three good practices in Latin American and the Caribbean or other regions are (i) having national institutions (generally ministries of education or labor) register and recognize occupational profiles; (ii) certifying competencies; and (iii) providing professional guidance and job placement services, which includes helping people define their professional objectives and develop career paths, as well as supporting job seekers through services that match the demand and supply of long-term care jobs. Italy sets an inspiring example of recognizing the occupational profile of caregivers: it has a national collective agreement for home-based caregivers (including a standardized work contract).

Formalizing long-term care jobs is a second fundamental objective that countries can pursue through digital platforms, care vouchers, and tax incentives. Simplifying access to social security systems is one straightforward strategy to increase formal employment among care workers. This can be achieved by developing flexible and user-friendly affiliation systems, for example, through digital platforms and care vouchers. Tax exemptions, tax credits, or reductions in social security contributions (targeting either side of the employment contract) are another important way to promote more formal arrangements for long-term care workers by reducing the cost of social security contributions.

France offers a good example of a platform that helps formalize long-term care jobs—the Pajemploi platform and Universal Service Employment Vouchers (CESU[9] for its French acronym), which are compatible systems that streamline the process of hiring and paying care workers. The Pajemploi platform enables employers of childcare workers to digitally manage their contracts, wages, and working hours, while seamlessly handling social security contributions. The platform is restricted to services for children aged six and under and is managed by the Organizations for the Collection of Social Security and Family Benefit Contributions (URSSAF[10] for its French acronym). It makes transactions traceable, reducing the use of cash for improved financial oversight and control. URSSAF also implements the CESU, a voucher mechanism that makes it easier to declare and make salary payments and social security contributions for employment relationships for regular or occasional personal services, including care services.

Platforms for matching supply and demand for long-term care services are a new option with the potential to improve the quality of care jobs. These platforms enroll paid caregivers (who are often hired as domestic workers, without access to social security), offer them training options, and connect them with families looking for services. So far, they exist in Argentina (developed by the private sector) and Costa Rica (promoted by the government). The Brazilian state of Paraná will soon launch a platform of this kind.

Cooperatives, an increasingly popular model for providing long-term care, also improve the quality of long-term care jobs. They can potentially mitigate some of caregivers' most pressing challenges, such as precarious and insecure working conditions, emotional and physical strain, and lack of training. Cooperatives are among the leading employers of long-term care workers in some high-income countries and are also being adopted as one of the models for organizing caregivers within the national care systems in Argentina, Uruguay, and the Dominican Republic.

9. *Chèque Emploi Service Universel.*
10. *Unions de Recouvrement des Cotisations de Sécurité Sociale et d'Allocations Familiales.*

1.6.2 Scale up training, with a person-centered approach

Training plays a key role in shifting long-term care from a traditional medical-assistance, service-oriented model to a holistic, person-centered approach that emphasizes the rights, preferences, and quality of life of care recipients, with dignity and personalized care as foundational principles. This new paradigm will require training carers to develop a blend of technical, relational, and self-care skills.

Training should be designed to promote the quality of long-term care while accommodating the time constraints and preferences of caregivers. Countries may consider gradually increasing the duration of training courses in order to reach the desired 260-hour threshold. In terms of methodology, theoretical knowledge, while valuable, should be complemented with practical knowledge and on-the-job training.

Training programs need to adjust to evolving care needs. Key areas for adaptation include supporting healthy aging and providing care for individuals with higher care dependency levels, which requires more specialized training. One good practice is offering caregivers who have completed basic training the option to expand their skills by specializing in assisting highly care-dependent individuals, including people with neurodegenerative and neurological conditions. Other specializations are coordinating health care and social services and organizing service delivery.

It is important to establish official curricula for caregivers to address the region's low levels of training. This requires interinstitutional coordination, as well as collaboration among public agencies, private sector actors, and civil society stakeholders. Another key to expanding high-quality training programs is having qualified trainers, who should have a deep understanding of the person-centered care model.

To increase caregivers' participation in training, courses must be affordable and have a flexible schedule. Subsidized programs can help attract workers to the care sector and improve the skills and competencies of unpaid caregivers. Training programs can be made more flexible by organizing them into modules. E-learning is also a promising tool to ensure flexibility, but it should be complemented with practical training.

1.6.3 Strengthen support to family caregivers

Without practical and emotional support, caregiving can harm people's physical and mental health. This is particularly relevant for family caregivers, who take on care responsibilities with hardly any training. Given how central family caregivers are to providing long-term care, it is essential to support them with (i) information, psychological support, and carer assessments; (ii) respite care; (iii) leave and flexible work for caregivers who continue to work; and, when possible, (iv) a combination of cash benefits and tax and pension credits.

Giving family caregivers information on how to provide care and on services available to them is an important first step toward reducing the emotional distress they may feel and keeping them from feeling lost and isolated. Psychosocial support or counseling services also address the emotional strain of caregiving and build family caregivers' resilience. Carer assessments are another good practice that can guide individualized support. The Australian government's Carer Gateway is a good example of an online information hub with information on caregivers' rights, entitlements, and support options. A carer assessment is required to access the Gateway's services.

Respite services are another good practice that can reduce the negative effects of family caregiving. Respite services allow caregivers to take short breaks from caregiving. Beyond the region, care-dependent people in Denmark, Finland, Germany, and the Netherlands are entitled to short periods of residential, daycare, or home care services. For example, they can use these services for six weeks per year in Germany and two weeks per year in Israel. These government services give family caregivers time for self-care and to recharge.

Work flexibility, such as reduced working hours and remote work, helps family caregivers keep their jobs. Access to care-related leave or the option to temporarily switch to a part-time schedule are also good practices that help carers stay employed while providing long-term care to a family member. Outside the region, Canada sets an inspiring example: the Critical Illness Leave offers up to 17 weeks for caring for an adult, with financial aid of approximately 55% of the forgone salary.

Cash transfers targeting caregivers to compensate for the economic impact of their care responsibility can be considered a good practice when they ensure full access to social security benefits, including health care and pensions. Germany, Spain, the United Kingdom, and Finland offer these types of transfers. Tax relief is an alternative way to financially support family caregivers, but it is most relevant in countries with high levels of formal employment. Pension credits can also mitigate the impact of family long-term care on entitlement to and the value of contributory pensions, thus limiting the risk of poverty at older ages.

1.6.4 Include men as family and paid caregivers

Pressure on existing caregiving arrangements makes it essential to engage men as both unpaid and paid caregivers. In addition to care leave and flexible work arrangements, two complementary strategies can support this objective: (i) transforming traditional gender norms (e.g., Bogotá's School of Men in Care[11]) and (ii) increasing men's participation in care-related occupations (e.g., Belgium's Men in Childcare campaign or Norway's staffing incentives in education and care services).

Fostering men's participation in caregiving has multiple benefits. At the individual level, it can enhance men's sense of purpose, personal fulfillment, and emotional connection, while strengthening communication and empathy skills that are transferable across personal and professional domains. At the systemic level, having more men in care roles helps diversify and professionalize the care workforce, increasing the social standing of these occupations.

1.6.5 Build a more resilient long-term care workforce

Older people are particularly vulnerable to the health impacts of weather-related events, natural disasters, or health emergencies. Both health and care systems are poorly prepared to respond adequately to unexpected shocks, as highlighted during the COVID-19 pandemic. In many countries, this crisis revealed insufficient financing and planning, a lack of adequate response strategies and protocols, and a workforce that was too small and insufficiently trained.

As the risks of these adverse events increase, it becomes more pressing for long-term care systems and their workforce to adapt to external shocks. Countries should focus on disaster preparedness, risk reduction and prevention, relief and response, reconstruction, and recovery. They should create the skills to reduce the adverse impacts of hazards and minimize the risk of disasters. To build a more resilient workforce, occupational profiles and training curricula should incorporate measures for adapting to extreme events.

11. *Escuela de Hombres al Cuidado.*

2 Supply and Demand for Long-Term Care, and the Human Resources Gap

2.1 Population aging is increasing the demand for long-term care

2.1.1 Rapidly aging populations leave little time to adjust economic systems and public policies

Latin America and the Caribbean is one of the fastest-aging regions in the world. Due to longer life expectancy and decreasing fertility rates, the share of the total population that is over age 65 is projected to grow from 9.5% in 2023 to 18.9% in 2050. By the year 2046, the share of older people will surpass that of children ages 0 to 14. The share of people over 80 is also growing rapidly and is projected to increase from 1.8% of the total population in 2023 to 4.9% in 2050.[12] In 1995, a 65-year-old person in the region could expect to live 15 additional years. This added life expectancy grew to 18 years in 2023 and is projected to reach 20 years in 2050. This important achievement is due to significant improvements in socioeconomic conditions, public health, and diagnosing and managing chronic health conditions.

Women live longer than men, causing a trend called the feminization of aging. Life expectancy at birth is 78.6 years for women compared to 72.8 for men—a difference of almost six years. This difference in life expectancy falls to 2.5 years at age 65, and to 1.1 years at age 80.

Although a few countries are still enjoying the tail end of the demographic bonus, the entire region will experience population aging, and countries will grow old before achieving high income. Some countries (e.g., Argentina, Barbados, Chile, Costa Rica, and Uruguay) already have a high share of older people (between 12% and 16% of the total population). In other countries, the older population makes up a lower share but is growing at an accelerated pace due to sharp drops in fertility and progress in extending life expectancy. This second group of countries will have the fastest demographic transition and will have less time to adjust their economic systems and public policies to the transition's challenges.

12. Similar trends are expected in Asia, where the share of the population over age 65 is expected to grow from 10% in 2023 to 19% in 2050, while the share of the population over age 80 is expected to go from 1.8% to 5.2% in the same period. Europe, a region further along in the demographic transition, is expected to see the share of the population over age 65 grow from 20% in 2023 to 33% in 2050, while that of the population over age 80 is expected to increase from 5.4% to 10.4%. Meanwhile, in North America, which is also further along in the demographic transition, projected population aging trends are less pronounced: the share of the population over age 65 will grow from 18% in 2023 to 23% in 2050, and that of the population over age 80 from 4% to 8.8%. In Africa, the share of the population over age 65 is expected to grow from 4% in 2023 to 6% in 2050, while the share of those over age 80 is expected to grow from 0.5% to 0.9%. All reported population projections are based on the United Nations' "Medium variant" scenario. All data in this section is from the United Nations' World Population Prospects (UNDESA 2024), retrieved from https://population.un.org/wpp/.

2.1.2 The older population will need more support

The fact that people are living longer is good news. At the same time, it means more people will require care. As people age, their sensory, physical, or cognitive functions may start to deteriorate as chronic health conditions progress or as a result of "lifelong accumulation of molecular and cellular damage" (WHO 2015, 52). They may therefore lose the ability to live independently and need help performing daily activities. In other words, they require long-term care, which is any personal care or social or health actions that help people who have, or are at risk for, losses in their intrinsic capacity maintain a level of functional ability that is consistent with their basic rights, fundamental freedoms, and human dignity (WHO 2015).

In Latin America and the Caribbean, approximately eight million people over age 65 (one in seven) currently need support to perform basic activities of daily living, such as eating or bathing (Aranco, Ibarrarán, and Stampini 2022).[13] Women make up two-thirds of this population (Aranco et al. 2018). Driven mostly by an increase in the number of older people (and to a lesser degree by an increase in the prevalence of functional dependence), this figure is expected to triple over the next few decades.[14] By 2050, the region will have approximately 23 million older people who require support for basic activities of daily living.

These figures are an underestimation of the demand for long-term care, as many more people need support for instrumental activities of daily living such as cooking or taking medications (see **Box 2.1** ➔). For example, the percentage of older people with difficulties with at least one instrumental activity is 36% in Brazil, 25% in Colombia, 18% in Argentina, and 14% in Mexico (Matus-López and Chaverri-Carbajal 2021). Unfortunately, few surveys include data on difficulties performing instrumental activities of daily living. Consequently, most figures reported in this chapter refer to care needs for basic activities of daily living.

13. The prevalence of functional dependence varies by country, ranging from a minimum of 5.3% in El Salvador to a maximum of 25.5% in Mexico. Part of this heterogeneity may be due to (i) cultural differences that shape how people rate their own level of functional dependence and (ii) differences in survey design and implementation (Aranco et al. 2018; Aranco, Ibarrarán, and Stampini 2022).

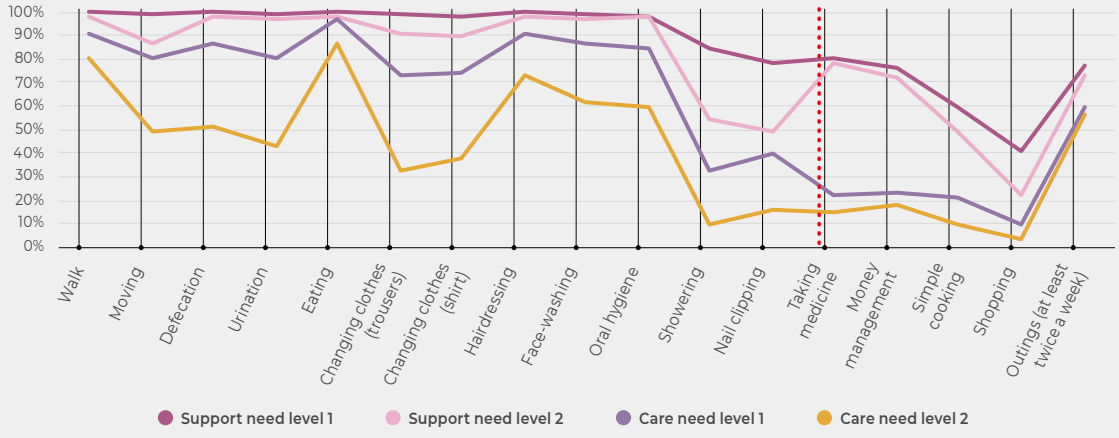
14. In the estimates of Aranco, Ibarrarán, and Stampini (2022), the prevalence of care dependency in the over-65 population in Latin America and the Caribbean is projected to increase from 14.3% in 2020 to 15.7% in 2050. This accounts for 6% of the increase in the number of older people with care needs. The increase in the number of older people accounts for the remaining 94%.

BOX 2.1 BASIC AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Functional dependence describes a situation where a person experiences difficulty and requires support to perform certain everyday activities, permanently or temporarily. These activities are subdivided into basic activities of daily living (ADL) and instrumental activities of daily living (IADL). The former are essential for survival and include eating, bathing, using the toilet, dressing, and moving around a room. The latter involve greater cognitive and motor complexity and include, for example, doing chores, cooking, taking transportation to move around outside the home, taking medications, or managing personal finances.

Because instrumental activities are more complex, people usually lose the capacity to perform them on their own first (Katz 1963; Dunlop et al. 1997). This can be seen in **Figure 2.1**, which is based on data from Japan's long-term care insurance. The figure shows the percentage of people in the long-term care system's different care needs categories who can perform each activity independently. Persons in the "support need level 1" category can generally perform ADL independently but need help with IADL (purple line, at the top). At the other extreme, people in the "care need level 2" category require support for both ADL and IADL (orange line, at the bottom). Within each category, there is always a higher need for support for IADL than for ADL.

FIGURE 2.1 PERCENTAGE OF PEOPLE WHO CAN INDEPENDENTLY PERFORM ADL AND IADL (BY CARE NEED CATEGORY IN JAPAN'S LONG-TERM CARE INSURANCE)



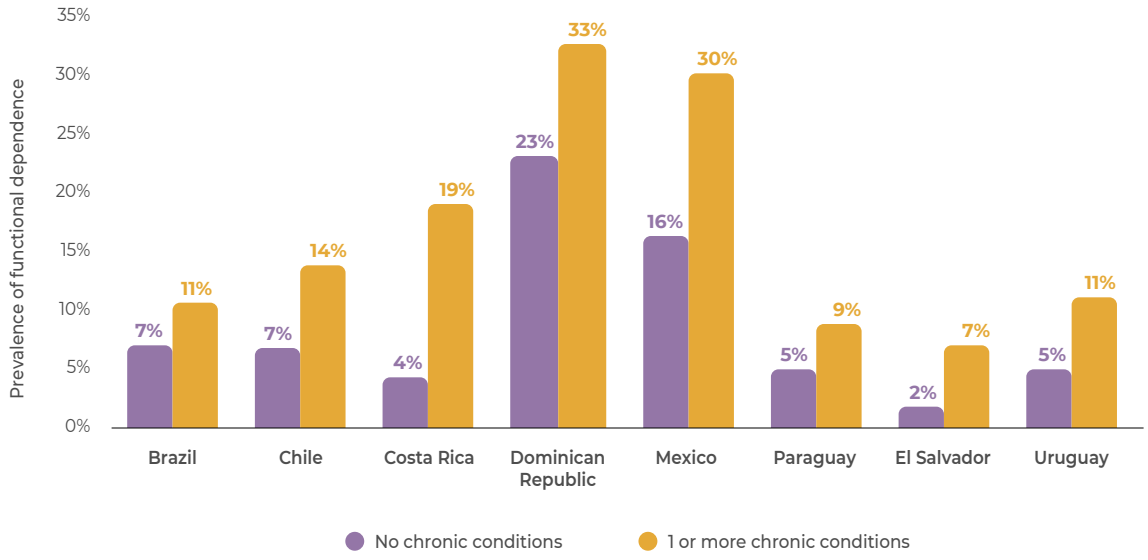
Source: MHLW (2013).
Notes: the red-dotted vertical line separates basic activities (on the left) from instrumental activities (on the right). Individuals are placed into seven categories according to the level of support or care they need. From lowest functional dependence level to highest, these categories are: support level 1; support level 2; care need level 1, care need level 2, care need level 3, care need level 4, care need level 5 (Yamada and Arai 2020). Support and care levels reflect the assessment method used by the Japanese long-term care system.

2.1.3 Long-term care needs will become more complex

Across all countries with available data, both the prevalence and severity of functional dependence consistently increase with age. However, there is considerable variation between countries. For example, in Mexico, 15.2% of people in the 65–69 age group have care needs, while 55.2% of those older than 85 do. In Costa Rica, these figures are 12.4% and 34%, respectively, while in Brazil, they range from 5.1% in the 65–69 age group to 29.1% among those over 85 (Aranco, Bosch et al. 2022). Additionally, in Mexico, care-dependent people ages 65–79 require support with an average of 2.2 basic activities of daily living, versus 2.6 in the care-dependent population over age 80. These figures are 1.5 and 1.9, respectively, in Costa Rica, and 2.8 and 3.4 in Brazil.

Care needs and chronic health conditions are correlated in both directions. On one hand, chronic conditions increase future care needs. Evidence from Mexico shows that hypertension, arthritis, diabetes, and stroke are good predictors of care needs later in life (González-González et al. 2019). On the other hand, people with functional dependence are more likely to develop chronic health conditions, since they tend to do less physical activity and can show signs of nutritional issues and depression (Maresova et al. 2019). As a result, people with chronic health conditions can be more than twice as likely to be care-dependent as those with no chronic conditions (**Figure 2.2**). The rise in the prevalence of chronic conditions in many countries in the region explains the expectation that care needs will become more prevalent in the future (Aranco, Ibarrarán, and Stampini 2022).

FIGURE 2.2 PREVALENCE OF FUNCTIONAL DEPENDENCE BY PRESENCE OF CHRONIC CONDITIONS
BY COUNTRY, PEOPLE OVER AGE 65



Source: Aranco, Bosch et al. (2022).

Another factor associated with increasing care needs is the rapid rise in the number of people living with dementia in the region. This group is expected to grow from 4.5 million in 2019 to 13.7 million by 2050, a rate of increase that exceeds the projected global average. Currently, an estimated 9% of people over 65 in the region are living with dementia. However, this figure is likely an underestimate due to underdiagnosis. Dementia is a leading cause of disability and care dependency among older people, since it progressively impairs multiple cognitive functions, ultimately diminishing autonomy and the ability to perform everyday tasks (PAHO 2023). This condition also places significant emotional and financial strain on families. In most cases, family members are the primary caregivers, and they often experience diminished mental and physical well-being (see **Chapter 3**).

Care needs differ for every person, evolve with time, and can be prevented or delayed. They develop along a continuum that spans full intrinsic capacity, pre-frailty, frailty, and functional dependence.[15] Demand for long-term care starts with pre-frail older people, who can still pre-

15. Although there is more than one definition of frailty, the concept generally refers to a clinical state in which older people's ability to cope with daily or acute stressors is compromised due to age-related functional decline and failure. Pre-frail people are at a high risk of becoming frail (Chen et al. 2014). Functional dependence means a person has difficulties performing at least one activity of daily living.

vent the occurrence of frailty through a combination of physical exercise, cognitive stimulation, nutritional interventions, social connections, and other activities. Frail older people will benefit from the same types of interventions but may start requiring additional personal care for support with instrumental activities of daily living, such as buying groceries or cleaning their homes. Care-dependent older people require additional services to support their basic activities of daily living (e.g., bathing). Timely interventions can effectively reduce future care needs and increase the quality of life of older people and their families, even at high levels of functional dependence.

2.1.4 Long-term care needs will become more concentrated in certain population groups

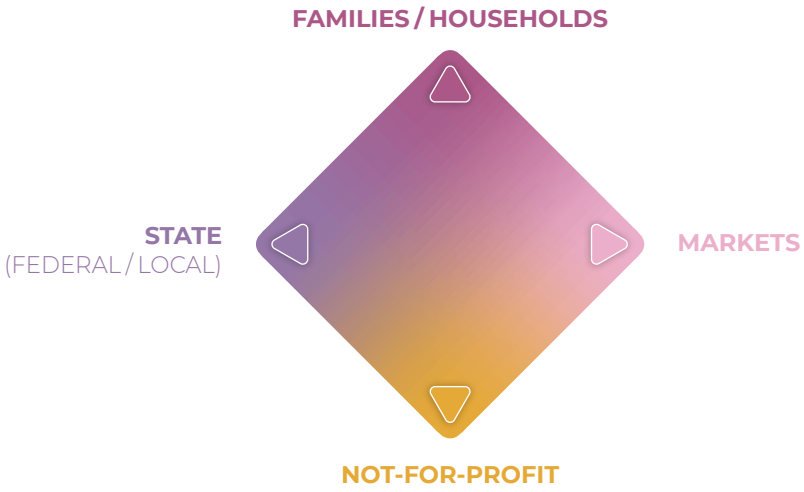
Care needs are more prevalent among women at all ages. For example, among people aged 65–69 in Chile, 5.8% of women and 4.8% of men are functionally dependent. In Uruguay, the figures are 5.0% for women and 3.2% for men. This may be explained at least in part by the fact that women are more likely to suffer from debilitating health conditions (Luy and Minagua 2014). Combined with women's longer life expectancy, the more prevalent functional dependence among women explains why the region has, on average, two older women with care needs for each older man with care needs (Aranco et al. 2018).

Care needs are also more frequent among the economically vulnerable. Low income is associated with worse health and less access to quality health care throughout one's life (Blas and Kurup 2010). Both of these factors increase the likelihood of a progressive loss of functional capacities.

2.2 The supply of care struggles to match demand

Long-term care services can be provided by the state, the market, non-profit organizations, or families, a set of options known as the "care diamond" (**Figure 2.3**) (Razavi 2007). Latin America and the Caribbean is characterized by incipient public services, scarce and low-quality non-profit services, unaffordable private sector services, and an overreliance on family care that is quickly becoming unsustainable.

FIGURE 2.3 THE CARE DIAMOND: ACTORS INVOLVED IN PROVIDING CARE



Source: Razavi 2007.

2.2.1 Public services are very limited

Long-term care is slowly gaining relevance in the region's policy agenda. At the moment, Uruguay and Costa Rica are the only countries that have approved a national-level long-term care system by law and implemented it on a large scale (the National Integrated Care System[16] in Uruguay and the National Care and Support System for Care-Dependent Adults and Older People[17] in Costa Rica). Other countries are advancing in the same direction. As shown in **Table D.1**, many have approved national care or aging policies that cover older people and seek to improve care for both carers and care recipients. Panama approved a law establishing a national care system in 2024. Brazil recently approved a law on care that includes long-term care. Colombia approved a national plan. Honduras created the Care Cabinet within the Social Cabinet to guide the development of a national care system. Chile, the Dominican Republic, Ecuador, Mexico, and Peru are discussing similar plans (**Box 2.2**).[18] Argentina has established a Comprehensive Observatory of the Long-Term Care System for Older People,[19] under the Minis-

16. *Sistema Nacional Integrado de Cuidados.*
17. *Sistema Nacional de Cuidados y Apoyos para Personas Adultas y Personas Adultas Mayores en Situación de Dependencia.*
18. Smaller-scale or local programs are in place in Chile (Chile Cuida), Colombia (Care Blocks in Bogotá), Brazil (Assistants for Older People Program in São Paulo; Better Care for Older People Program [Programa Maior Cuidado] in Belo Horizonte).
19. *Observatorio Integral del Sistema de Cuidado de Personas Adultas y Mayores.*

try of Health of the Nation, to study the long-term care system. However, it is worth noting that long-term care services do exist in most countries in the region, even if not officially organized under a national system or law.[20]

In practice, the coverage of publicly funded long-term care services is still low. In the countries with the highest coverage, i.e., Argentina, Costa Rica, and Barbados, 20% of the older people who need assistance with basic activities of daily living receive services (Aranco, Bosch et al. 2022). To contain expenditure and avoid exceeding their capacity, these services complement care needs assessments with eligibility criteria related to age or socioeconomic vulnerability. In Uruguay, for example, only people with severe care needs who are younger than 30 or older than 80 are eligible to receive the services of personal assistants at home (the system's flagship program). Although anyone who meets the age and functional dependence requirements can receive the services, household income is taken into account to set the amount of the government subsidy. People in middle or high income brackets can receive the services of the National Integrated Care System, but are required to pay a share of their costs. In contrast, only the economically vulnerable are eligible for the benefits of Chile Cares or the Assistants for Older People Program[21] in Sao Paulo, Brazil.

20. For more information on care systems in Latin America and the Caribbean, see: Rachter et al. (2024) and UN Women and ECLAC (2021).
21. *Programa Acompanhante de Idoso.*

BOX 2.2 PENDING REFORMS AMID DEBATES

Over the past few years, Chile, the Dominican Republic, Ecuador, Mexico, and Peru have made efforts to advance care reforms. Some of these efforts, in the form of legislative bills or proposals, are still under consideration, while others have been shelved, which points to the ongoing debates and disagreements surrounding care policies (Comisión de la Mujer y la Familia 2024a).

In Chile, Draft Law No. 16905-31, which recognizes the right to care and establishes the National Support and Care System,[1] has been approved by the Chamber of Deputies and awaits passage in the Senate. In the Dominican Republic, a bill presented in 2024 seeks to create a national care system, recognizing the rights to care and self-care, as well as to provide care and receive care, covering both paid and unpaid caregivers. Similarly, in Ecuador, a 2021 bill proposing the National Integral Care System is still under review. Passing this law would add to the current Organic Law on the Right to Human Care from 2023, which primarily focuses on the right to care for children "and other dependents," without specifically mentioning older people.

In Mexico, various initiatives have been proposed. In 2020, the Chamber of Deputies passed a proposal to reform Articles 4 and 73 of Mexico's constitution to include a national care system, but the initiative remained pending in the Senate. In 2024, the Senate declared that all pending matters sent before September 1, 2021 were closed, so a legislative process would be required to resume this reform. Despite this failed attempt, both the general law initiative for a national care system (presented in 2021) and the modifications to the General Law on Social Development, which integrates the national care policy into the social development policy, remain under review. The latter was approved by the Chamber of Deputies in 2024.

Peru drafted four laws to create and regulate a national care system (2735/2022-PE, which proposes recognizing the right to care and creating a national care system; 3242/2022-CR, which proposes creating and national care system for older people; 4705/2022-CR, which proposes recognizing caregivers and the right to care through a national care system; and 5308/2022-CR, which proposes recognizing, regulating, and guaranteeing the right to care through a national care system). However, these bills were rejected by the Congressional Women and Family Commission[2] in 2024.

1. Sistema Nacional de Apoyos y Cuidado.
2. Comisión de la Mujer y Familia.

2.2.2 Few can afford good-quality private services

The private sector plays a key role in providing long-term care, but only high-income families can afford for-profit services if they are not subsidized by the government. In Mexico, for example, less than 9% of older people can afford to pay for high-quality residential care (López-Ortega and Aranco 2019). In Uruguay, the average contributory pension does not cover the cost of a residential care facility that meets minimum quality standards (Aranco and Sorio 2019). Non-profit organizations have traditionally operated in the sector, but with a focus on charity that leads them to target poverty, neglect, and domestic violence rather than care dependency. The quality of their services is often low.

2.2.3 Family care is becoming less available

Traditionally, and still today, most responsibility for long-term care falls on families, especially the women within those families. However, several demographic and social changes are reducing the availability of unpaid family care and making this arrangement unsustainable. Women's participation in the labor market—a fundamental element of equality—has been growing steadily. The percentage of women (over age 15) who work or are looking for a job in the region grew from 35% in 1990 to 52% in 2023.[22] This means that many families already have no member permanently devoted to domestic work, including care.

Meanwhile, fertility rates are dropping dramatically. The number of children per woman decreased from 2.6 in 2000 to 1.8 in 2023. In 16 out of 26 countries in the region, fertility rates are below the replacement rate of 2.1 children per woman.[23] This means that the current generation of adults—who are tomorrow's older people with care needs—will have fewer children who could be available to provide long-term care. A trend toward smaller households and more geographically dispersed families further worsens the situation. The average household size has decreased from 4.3 members in 2000 to 3.3 in 2023.[24] Migration and divorce, in addition to lower fertility, help account for this trend.

22. Data for 2025 from the International Labour Organization Department of Statistics, retrieved from https://ilostat.ilo.org/.
23. Data for 2023 from the United Nations Population Division 2024, retrieved from https://population.un.org/wpp/.
24. Data for 2024 from CEPALSTAT, retrieved from https://statistics.cepal.org/portal/cepalstat/index.html.

Already today, a high percentage of older people live alone. Approximately 30% of people over age 80 live alone in Argentina (2019), as do 20% in the Dominican Republic (2019) and Suriname (2018).[25] This share is even higher among women, reaching 35% in Argentina, for example.

2.2.4 The demand for family long-term care will more than double, putting pressure on the labor force

Almost 25 million people currently provide family long-term care (see **Chapter 3**). This is approximately 5% of the working age population (14–64) and 18% of the population aged 45–64, which is the age group in which children typically need to provide long-term care for their parents. For labor market participation, this is a critical age at which it becomes difficult for people to find a new job if they lost their old one because they had to care for a parent.

According to a back-of-the-envelope projection based on current care arrangements, the region will need 60.5 million family caregivers by 2050, constituting 13% of the working-age population and 32% of those aged 45–64.[26] This trend is expected to continue, with low fertility rates and changing living arrangements driving up demand for family long-term care and shrinking the pool of family caregivers.

The figures above indicate that relying solely on family members to support older people will create increasing pressure on the labor supply, and may soon become unsustainable. As discussed in **Chapter 3**, family caregivers often take great satisfaction from their roles, but an absence of support—either from the government or the market—can lead to excessive workloads. This can ultimately harm their financial, emotional, and physical health.

2.3 Countries need to invest in human resources for long-term care

In this context, care workers play a crucial role in meeting the demand for long-term care. According to Villalobos et al. (2024), the region will require 14 million workers in 2050 to meet older people's long-term care needs, far more than the current estimate of three million (presented

25. Data for 2023 from the United Nations Population Division 2022, retrieved from https://www.un.org/development/desa/pd/household-size-and-composition.

26. The estimate of 60.5 million family caregivers is calculated by multiplying the current ratio of family caregivers to older persons (25 million to 57 million) by the projected number of older people in 2050 (138 million; data from United Nations Population Division 2024, retrieved from https://population.un.org/wpp/).

in **Chapter 4**). This workforce must have a multidisciplinary composition that includes paid caregivers, nursing assistants, nurses, physicians, and care coordinators, among others.

Given the higher care needs and scarcer family care, both governments and markets will have to step up their engagement in the sector. Governments, in particular, will be called on to develop long-term care systems that improve current levels of coverage and quality, focusing on services that allow people to age in their communities and use care homes as a last resort (**Box 2.3**).

BOX 2.3 LONG-TERM CARE SERVICES THAT SUPPORT AGING AT HOME

In response to a universal preference for aging in place, all countries are transitioning away from institutional care (care homes, nursing homes) and prioritizing services provided at home or in the community.

Day care centers, home personal assistants, and telecare are typically combined to support aging at home and delay institutionalization. Day centers can provide different intervention models that target older people in situations ranging from pre-frailty to moderate care needs (Benedetti, Sancho et al. 2024). In all cases, they aim to promote social and community connections to prevent loneliness and prevent or delay the progression of care needs. When care needs are more severe, the intervention model may shift from day centers to services provided at home by personal care workers (Aranco and Ibarrarán 2020; Lloyd-Sherlock et al. 2024; Jara and Chaverri-Carvajal 2020). Telecare or teleassistance is understood in this report as support with long-term care as opposed to health care and can be combined with all other services to reduce the number of hours of home care (provided by either care workers or family caregivers) (Benedetti, Acuña, and Fabiani 2022). Institutional care may be the only possible arrangement when older people require around-the-clock care (for example, when cognitive decline is combined with severe physical disability).

While in some countries a single caregiver is tasked with providing a service user with all the care they need, this is not an ideal arrangement, and care plans should be delivered by teams with multidisciplinary skills. In all systems, care managers should play a fundamental role in designing the care plans, monitoring their implementation, coordinating the work of other professionals, and ensuring the satisfaction of service users and their families. Eventually, the type of long-term care workforce countries need will depend on the services and solutions they prioritize.

There is limited literature on the cost of the reforms discussed in this report. Estimating net costs is complicated by the fact that many policies have indirect effects on budgets, for example, through savings in health care or a contribution to economic growth (**Box 2.4**). Additionally, long-term care systems will not need to be financed solely from government budgets. Countries will need social insurance models and co-payments to increase financial sustainability (Fabiani et al. 2025).

The private sector will be called on to increase the supply of long-term care services, exploiting business opportunities and creating employment. Some of these services will be supplied to governments as part of long-term care systems, and others will be purchased directly by families that can afford them. Governments will need to play a central role in setting standards for this private supply, supervising its quality, and ensuring access to it.

Whatever the path chosen, investing in human resources will be essential to guarantee that older people's care needs are met. One key investment will be in training and professionalizing caregivers to ensure the quality of long-term care services (Cafagna et al. 2019). Investment in human resources need not be limited to paid caregivers. Families will still assume an important share of care responsibilities. Supporting family members (through training, emotional counseling, or flexible work or leave policies, for example) will be crucial to protect their physical and emotional well-being.

BOX 2.4 THE COST OF INVESTING IN HUMAN RESOURCES FOR LONG-TERM CARE

Increased formal employment and improved working conditions overall can be expected to drive up spending in long-term care systems. This raises the question of financial sustainability.

Despite growing attention to long-term care expenditures, evidence on the impact of such spending is still scarce. Much of the available evidence focuses on related outcomes such as labor market participation or care availability, and the impact on expenditures can only be inferred. While offering more and better publicly supported services may require prioritizing long-term care over other spending, some initiatives have proven to contribute to economic growth and social security contributions, offsetting part of the public investments. This may mean higher costs in the short term, but lower staff turnover and better care outcomes in the long term.

For example, recent evidence on leave policies suggests they have a positive effect on both care and labor supply because they help carers reconcile care and job tasks. Saad-Lessler (2020) found that California's paid family leave policy increased care supply among working women and workers with higher education. The policy also increased labor market supply by limiting reductions in hours worked or drop-outs (Anand, Dague et al. 2022; Coile, Rossin-Slater et al. 2022; Kim 2020). Concretely, in California, New Jersey, and New York State, access to paid family leave led to a seven-percentage-point reduction in women leaving their jobs to provide care to their spouses. Evidence on unpaid leave policies in Korea shows that allowing informal carers to take unpaid leave for up to 90 days with job protection has effectively kept people in the labor force amid new caregiving demands. This particularly benefited women, who traditionally assume primary caregiving roles.

For the formal long-term care workforce, improving working conditions can reduce costly turnover. A study found that for the average facility in the United States, the marginal cost savings associated with a ten percentage point drop in turnover were 3% of total annual costs (Mukamel et al. 2009). Experience in New Zealand illustrates that improving working conditions by increasing wages can improve recruitment and retention, although appropriate budgetary allocations must accompany these measures. Without alignment with budgets, the outcomes may include reduced hours, increased workload and duties, and sometimes reduced quality of care (Douglas and Ravenswood 2022).

Based on the potential of technological advancements, along with changing work arrangements, it can also be assumed that in the future fewer workers would be needed to take care of the same number of older people. The Netherlands has produced projections along these lines (Ministry of Health, Welfare and Sport of the Netherlands 2018).

Some studies also show the positive impact of training on efficiency and, ultimately, cost. For example, the Enhanced Home Care pilot program in California showed that additional training in medication management, mental health, and nutrition for personal care workers resulted in lower medication non-compliance rates and improved health (OECD 2020). Other evidence from Australia supports the idea that appropriately trained and supervised care workers can help nurses with medicine management in home care settings, particularly for those at low risk of adverse medication errors (Lee et al. 2015).

Overall, evidence on the impact of unpaid and paid leave policies on reducing the negative effect of providing care on labor market supply is still limited. Further data and research would be useful to better estimate this impact in specific national contexts.

3 The Importance of Family Caregivers

Families play a fundamental role in caring for older people. In Latin America and the Caribbean, approximately 80% of older people who need assistance for daily activities receive it from an unpaid carer. This proportion ranges from 76.4% in Uruguay to 98.6% in Mexico (Aranco, Bosch et al. 2022). Most unpaid caregiving is provided by family members, so this report uses the terms "family caregivers" and "unpaid caregivers" interchangeably.

Unpaid caregiving is predominant in all countries, regardless of their income level or the availability of public and private care services. For comparison, unpaid care also predominates in data for the OECD, although the share is 20 percentage points lower than in Latin America and the Caribbean: on average, 60% of care-dependent older people in OECD countries rely on unpaid long-term caregivers (Llena-Nozal and Rocard 2022). While time spent on indirect unpaid care, such as house cleaning or meal preparation, tends to decline with countries' income levels, direct unpaid care work, which involves assistance with personal care activities, does not (Folbre and Yoon 2008; Grantham et al. 2021). This is primarily due to cultural norms regarding the role that families—and women, in particular—should play in caring for their members (Watkins and Overton 2024).

This chapter analyzes unpaid caregiving for older people in Latin America and the Caribbean. We estimate the number of people providing unpaid care for older people and analyze their demographic and socioeconomic characteristics; the time spent on unpaid caregiving tasks, highlighting the differences between men and women; and potential consequences for unpaid caregivers if they do not receive the support they need. This chapter's data sources are explained in **Box 3.1**.

BOX 3.1 DATA AVAILABLE AND MAIN CHALLENGES FOR ANALYZING UNPAID CAREGIVERS

Time use surveys are a key source of data on unpaid care for older people. They provide rich information on caregivers' characteristics and tasks. Respondents are asked how much time they spend on specific activities on a particular day or week. Many findings presented in this chapter are based on the latest time use surveys from nine countries (Argentina, Brazil, Chile, Colombia, Costa Rica, El Salvador, Mexico, Paraguay, and Uruguay), which account for approximately 70% of the region's population.[1] **Annex A** presents information on the surveys used, the questions considered, and the methodological choices behind this chapter's results.

It can be hard to compare data from different time use surveys. In some cases, care for older people cannot be separated from the care provided to younger persons with disabilities. Surveys differ in terms of whether they include care for people outside the household, what care tasks they include, the reference period, and the age of the surveyed population. **Annex A** discusses these limitations in more detail.

This chapter also uses data from an IDB caregivers survey. The survey covers the whole region, including many countries that have no time use survey. It also provides information on emotional well-being, physical well-being, and training that is not captured in time use surveys. This IDB caregivers survey collected data on 48,016 unpaid caregivers of older people in 26 countries in the region. **Annex B** presents basic information on the survey, the questions used, and the methodological choices behind this chapter's results.

It is important to acknowledge that the IDB caregivers survey is not designed to be representative of the population of unpaid and/or paid caregivers of older people in Latin America and the Caribbean. As discussed in Fabiani et al. (2024), this survey was disseminated through social media platforms and self-administered, which may have caused, for example, older caregivers or caregivers from more remote areas to be underrepresented. **Annex C** discusses the validity and limitations of this data source. It compares descriptive statistics from the IDB survey with figures from nationally representative time-use, labor force, and household surveys, and it discusses possible explanations for the differences. It also argues that the fact that the results and trends remained stable as the number of observations grew (from the 27,000 used in Fabiani et al. (2024) to the 64,592 analyzed in this report) points to the credibility of the analysis.

1. Data for 2023 from United Nations Population Division 2024, retrieved from https://population.un.org/wpp/.

3.1 How many family caregivers for older people does the region have?

In Latin America and the Caribbean, 25 million people over age 14 provide unpaid care to older people (**Table 3.1**).[27] This is 4% of the population over age 14. In other words, there is one family caregiver for every two older people in the region. This ratio varies substantially among the countries with time use surveys, from a minimum of one caregiver for every 13 older people in Colombia to approximately one caregiver per older person in El Salvador. Of the 25 million family caregivers in the region, approximately 60% (14.7 million) provide care to an older person from their own household, and 40% (10.3 million) care for an older person outside the household.

Many factors may explain why the prevalence of unpaid care varies across countries. One is the availability of a close family network. This is affected not only by the size and composition of families, but also by cultural beliefs about the role of women and children. Another key factor is the availability, affordability, and quality of public or private long-term care services, which affects the feasibility of covering care needs outside the family, thus reducing the need for unpaid caregivers. Finally, data quality could be another reason for the large differences across countries. The quality of the data collected through time use surveys is mixed, possibly because these surveys are not specifically designed to measure care for older people.

27. This figure is underestimated, as time-use surveys do not allow identifying the caregivers for older people with disabilities (see **Annex A**). The threshold is set at 14 because it is the legal minimum working age in many countries in the region (e.g., Brazil, El Salvador, and Paraguay).

TABLE 3.1 NUMBER OF UNPAID CAREGIVERS
BY COUNTRY, LATEST YEAR AVAILABLE

COUNTRY	WITHIN HOUSEHOLD (THOUSANDS)	OUTSIDE HOUSEHOLD (THOUSANDS)	TOTAL (THOUSANDS)
Argentina	226	972*	1,198
Brazil	5,308	3,879*	9,187
Chile	568	427	995
Colombia	283	35	318
Costa Rica	163	51	214
El Salvador	400	89*	488
Mexico	4,514	2,564	7,078
Paraguay	125	64*	189
Uruguay	69	36	104
Other countries	3,079*	2,144*	5,223
Latin America and the Caribbean (total)	14,735	10,260	24,995

Source: authors' own calculations based on time use survey data from Argentina (2021), Chile (2023), Colombia (2020), Costa Rica (2022), El Salvador (2022), Mexico (2019), Paraguay (2016), and Uruguay (2021); data from the Institute of Applied Economic Research (*Instituto de Pesquisa Econômica Aplicada*—IPEA) Survey in Brazil (2022); and the United Nations Populations Division Data (2024).
* For each group (within household; outside household), the number of caregivers is estimated based on the ratio of unpaid caregivers to older people in countries with available data. See Annex A for more details.

3.2 A majority of unpaid caregivers are women and lack training

3.2.1 A majority of caregivers are middle-aged women

Women constitute approximately 60% of unpaid caregivers for older people. The share is highest in Colombia, at 76%, followed by Paraguay, at 66% (**Table 3.2**). The gender dimension of care—and unpaid work in general—is widely documented in the literature (Hanna et al. 2023; Alonso et al. 2019). It is ingrained in traditional gender stereotypes that assume that women have a natural advantage over men when it comes to taking on care and domestic responsibilities (Watkins and Overton 2024).

Unpaid caregivers are 48 years old on average. They are youngest in Mexico, with an average age of 45, and oldest in Colombia, at 55 years old (**Table 3.2**). They are substantially older than

caregivers for children (35 years old on average) and people with disabilities (38).[28] This reflects the fact that the responsibility to care for older people usually comes later in life, when parents and spouses age. One-fifth of the caregivers are older persons themselves (compared to 3% of those caring for children).[29] This is a source of concern, given the negative consequences of unpaid care on caregivers' health (see Section 3.5).

TABLE 3.2 DEMOGRAPHIC CHARACTERISTICS OF UNPAID CAREGIVERS FOR OLDER PEOPLE

COUNTRY	WOMEN (%)	AVERAGE AGE (YEARS)	LEVEL OF EDUCATION		ETHNICITY	
			PRIMARY EDUCATION (% COMPLETED)	SECONDARY EDUCATION OR HIGHER (% COMPLETED)	INDIGENOUS (%)	AFRO-DESCENDANT (%)
Argentina	58	52	39	53		
Brazil	62	50	14	50	0.3	10
Chile	62	53	23	71		-
Colombia	76	55	19	59	1	5
Costa Rica	60	51	39	49		
El Salvador	56	46				
Mexico	57	45	46	39	41	
Paraguay	66	49	27	50		
Uruguay	62	[45–49]	42	47	1	7
Average	59	48	31	46	23	4

Source: see Table 3.1.
Note: in Uruguay, data on the age of respondents is provided in 5-year brackets. The average is weighted by the number of unpaid caregivers in each country; empty cells indicate that the figure is not available.

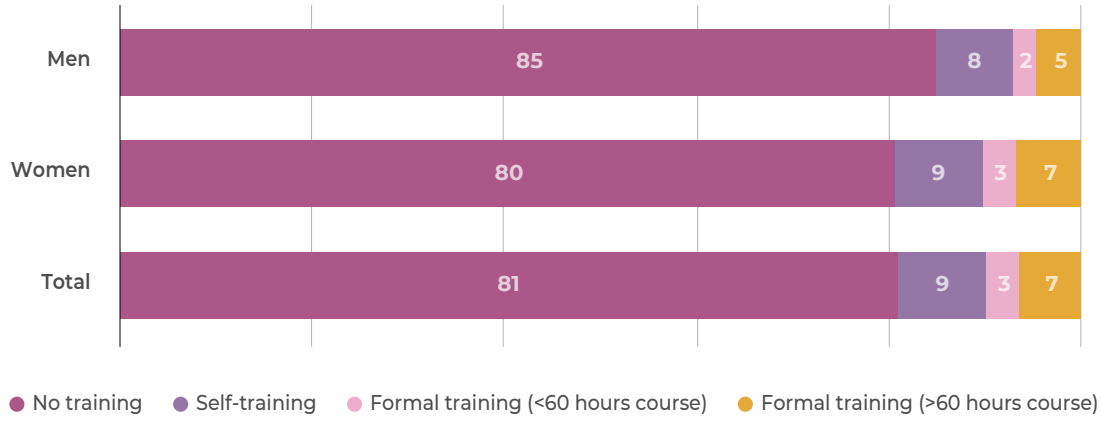
3.2.2 Most caregivers have no care-related training

Less than half (46%) of unpaid caregivers have completed secondary education, and 31% have only completed primary education (Table 3.2); the remaining 23% have not completed primary education. These education levels are similar to those of the total population and those of caregivers for children.

28. All differences discussed in the report are statistically significant based on the available data.
29. In contrast, people under age 18 make up only 6% of the caregivers of older people.

Unpaid caregivers have very little care-related training. Less than 20% report having received some type of caregiving training, and only 7% completed a course of more than 60 hours (**Figure 3.1**). Most training was obtained through self-learning. These findings point to a challenge, since training for caregivers is associated with higher quality of care and better health among caregivers themselves (Fabiani et al. 2024). As shown in **Section 3.5** below, trained caregivers report lower levels of stress and depression relative to untrained caregivers.

FIGURE 3.1 PERCENTAGE OF UNPAID CAREGIVERS ACCORDING TO LEVEL OF TRAINING
BY SEX



Source: Authors' own calculations based on data from the IDB caregivers survey.

3.3 Men and women support older people in different ways

On average, unpaid caregivers in the region spend 7.5 hours per week caring for older people. This figure varies significantly among countries, from a maximum of 19 hours per week in Argentina to a minimum of five hours in Costa Rica (**Figure 3.2**). Interestingly, caregivers for older people living outside their household spend more time on caring activities than those caring for older people within the household (8.9 hours per week compared to 6.6 hours, on average).

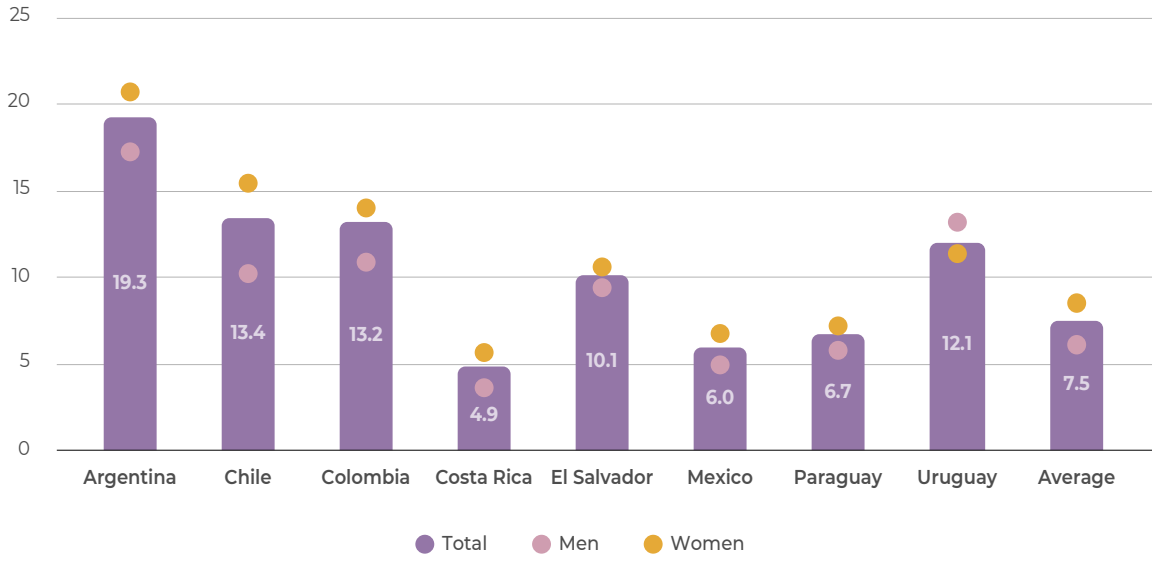
As noted in **Section 3.1**, the variation in the total number of hours spent on care may be due to the number and types of care activities included in each survey, as well as the level of accuracy in identifying older people as care recipients (see **Annex A** for details). Additionally, respondents may report some of their care work as domestic work, since it can at times be challenging to distinguish between the two.

3.3.1 Women provide care for more hours and assist with more basic activities

Women provide 71% of the total hours of care for older people in the nine countries with time use surveys. This is because women are more likely to be caregivers, and when they are, they devote more time to caregiving than men.

Female caregivers spend an average of 8.5 hours per week providing care for older people, which is 2.4 hours more than their male counterparts, who spend 6.1 hours on average (**Figure 3.2**). Uruguay is the only country where male caregivers spend more time caring for older people than female caregivers. These results are consistent with the findings of Amarante and Rossel (2018), who analyze indicators measuring the population's attitudes towards women's roles in Colombia, Mexico, Peru, and Uruguay and argue that Uruguay is the most egalitarian country.

FIGURE 3.2 TIME CAREGIVERS SPEND PROVIDING CARE FOR OLDER PEOPLE
HOURS PER WEEK, BY SEX AND COUNTRY



Source: see Table 3.1.
Notes: the average is weighted by the number of unpaid caregivers in each country.

In addition to spending more hours on caregiving, women take on the least flexible and most demanding tasks.[30] They spend consistently more time supporting older people with basic activities, which are more physically demanding and less flexible in terms of schedule, such as feeding, dressing, or bathing. Men, in contrast, focus on instrumental activities, such as keeping the person company or running errands (**Table 3.3**). This is the case in all countries. Men and women spend a similar amount of time on health-related tasks, on average, although this result varies by country. This analysis shows another important gender dimension of unpaid long-term care: the activities that women take on more involve providing support every day, several times a day, and they are therefore more difficult to combine with paid work.

30. Information on time spent by type of activity is only available for caregivers who provide long-term care within their household.

TABLE 3.3 TIME SPENT PROVIDING UNPAID CARE TO OLDER PEOPLE, BY TYPE OF ACTIVITY

HOURS PER WEEK, BY SEX AND COUNTRY

		ADL	IADL	HEALTH	PERSONAL	TRANSPORTATION	TOTAL
Argentina	men			3.3	13.8	0.1	17.3
	women			3.8	16.0	1.0	20.7
Chile	men	3.2	2.1	2.3			7.6
	women	10.2	1.3	2.9			14.4
Colombia	men	4.3		4.5			8.8
	women	6.7		6.0			12.6
Costa Rica	men	1.1	1.6	0.8			3.5
	women	3.3	1.7	1.0			5.9
El Salvador	men	0.0	8.4	1.2			9.6
	women	0.1	9.4	1.2			10.6
Mexico	men	2.2	0.9	0.9			4.0
	women	4.5	0.5	0.8			5.8
Paraguay	men	0.7	0.7	4.5			5.9
	women	2.8	0.5	3.9			6.7
Uruguay	men	2.0	15.0	1.1			18.1
	women	5.1	8.0	2.7			15.8
Average	men	2.1	1.7	1.3			5.4
	women	4.9	1.3	1.5			7.6

Source: see Table 3.1.

Notes: not all types of activities are included in all surveys (see Annex A for details). For a definition of ADL and IADL, see Box 2.1. "Health" refers to activities that support the health of the care recipient; "personal activities" are personal care activities, including basic and instrumental activities; "transportation" includes the time spent transporting older people. Brazil was excluded because its survey does not allow for measuring the number of hours spent on caring for older people. The average is weighted by the number of unpaid caregivers in each country.

Caregivers who live with the care recipient, particularly women, also spend several hours a week on "passive care," meaning they are on call but are not performing any specific task. In Mexico, caregivers spend an average of 20 hours per week on passive care (with a three-hour difference between women and men caregivers). These figures are not reported in **Table 3.3**. Few time use surveys collect information on passive care. Since this aspect is omitted, the total amount of unpaid caregiving is underestimated, and the analysis of the gap between men and women may be biased.

3.3.2 Higher education levels do not necessarily mean less time spent caring for older people

The effect of education on unpaid time spent supporting older people does not seem to follow a clear pattern. On average, people with secondary education or more spend the same time on unpaid care per week as those with lower levels of education.

These results vary by country: in Costa Rica, Mexico, and Paraguay, higher education levels are associated with shorter care hours per week, while in Uruguay and Colombia, the opposite is true. In Argentina and Chile, both groups of caregivers spend virtually the same amount of time supporting older people (data is not available for Brazil and El Salvador). This finding is consistent with Ferrant and Thim (2019), who analyze data from Bangladesh, Ethiopia, Peru, and South Africa and show that education does not correlate with less time spent on unpaid work.

3.4 Who receives their care?

In most cases, unpaid caregivers care for their mother (59%) or father (22%). In 13% of cases, they provide care for their partner. Approximately 30% care for other relatives or friends, including in-laws, siblings, or neighbors.[31] The recipients of unpaid care are 81 years old, on average, and are mostly women (71%). They often have chronic health conditions and physical disabilities (more than 40% each); 28% have some type of dementia, a percentage that reaches 35% in Brazil and almost 40% in Chile. Caregivers for people with dementia are more likely to be mentally and physically overburdened and require special support (see **Section 3.5**).

Data from time use surveys show that approximately one-fourth (26%) of caregivers for older people also provide care to children, whether in the same household or in other households. Those who provide care for both children and older people are known as “sandwich” or “pivot” generation carers (Burke and Calvano 2017). As life expectancy increases and childbirth is delayed, the number of sandwich generation caregivers will grow, as will the challenge of balancing multiple caregiving responsibilities, work, and other life demands.

31. The total exceeds 100%, since people may provide care for more than one person.

3.5 The consequences of unpaid caregiving

Caring for a family member or a friend—either out of duty, affection, or both—can be very rewarding. At the same time, caregivers bear significant costs in terms of time and physical and emotional well-being (Watkins and Overton 2024). There is ample worldwide evidence that unpaid caregiving has at least two consequences: (i) unpaid caregivers are less likely to have paid jobs or, when they do, they tend to have poorer quality jobs; and (ii) unpaid caregivers tend to have poorer emotional and physical health (Watkins and Overton 2024; Brimblecombe et al. 2018). The intensity of these effects depends on the characteristics of the caregiver; the type and intensity of care provided; the availability, affordability, and quality of professional care services; and labor market features that facilitate or complicate combining paid work and unpaid care (Spann et al. 2020; Lightman and Link 2021; Brimblecombe and Cartagena 2022).

3.5.1 Unpaid caregivers are less likely to participate in the labor market

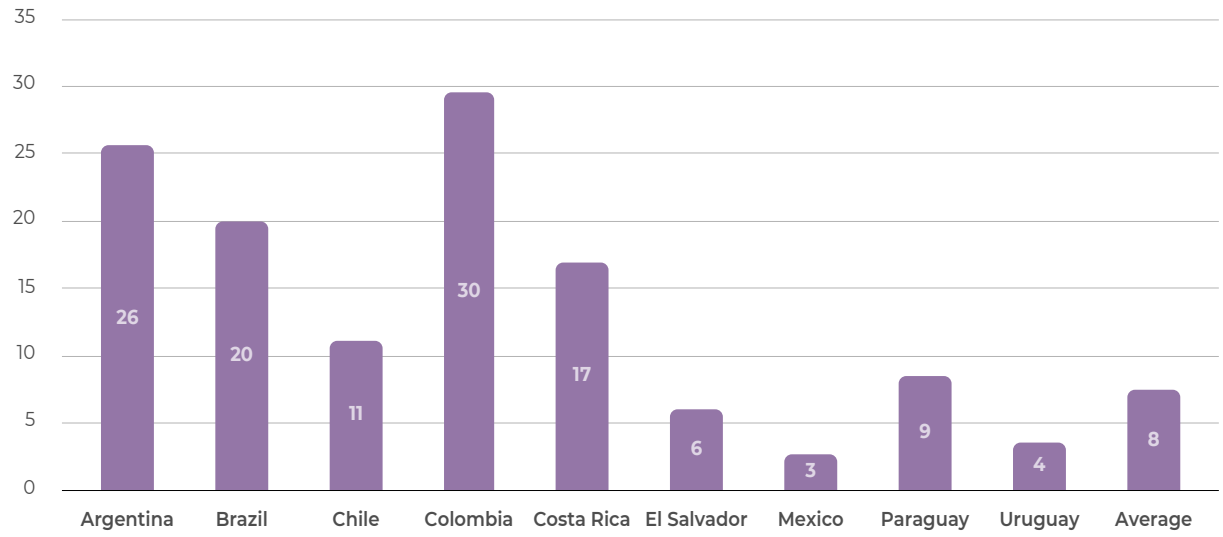
Since they have less time, unpaid carers are less likely to have a job. When they work, they are more likely to have a part-time job or be self-employed, less likely to contribute to social security, and more likely to retire early (Watkins and Overton 2024; Charmes 2019).

This study finds that 51% of unpaid caregivers for older people have a job, versus 60% of those who do not have responsibilities related to caring for older people (considering only people over age 18 in both cases). This result may be due in part to the fact that caregivers are older than the total adult population (49 versus 43 years old, on average), so they are less likely to be of working age. To control for this factor, the analysis is repeated, looking only at people aged 30–59, who have presumably completed their education and have not reached retirement age. In this case, providing care for older people is still associated with an eight percentage point decrease in the likelihood of employment, on average. The gap is largest in Colombia (30 percentage points), Argentina (26 percentage points), and Brazil (20 percentage points) (**Figure 3.3**).[32]

32. A preliminary analysis was conducted for this report to assess whether the employment participation gap between caregivers and non-caregivers is somehow related to countries' overall employment levels. Time use surveys and International Labour Organization data on employment rates for the population aged 15–65 did not show a clear pattern.

FIGURE 3.3 DIFFERENCE IN EMPLOYMENT RATE, BY RESPONSIBILITY FOR CARING FOR OLDER PEOPLE

Percentage point difference in employment rate between non-caregivers and caregivers aged 30–59, by country



Source: see Table 3.1 ➔.
Note: the average is weighted by the number of unpaid caregivers in each country.

Caregiving responsibilities cause gaps between men and women in labor markets

The unequal distribution of caregiving responsibilities between men and women is a key cause of gaps in labor market participation and earned incomes between men and women. Although most evidence focuses on childcare—and what has been termed the motherhood penalty—studies on caregiving for older people show similar findings.

Approximately 25% of women in 22 countries in the region worked part-time in 2019, compared to only 11% of men (Araujo et al. 2024). In an analysis covering Chile, Colombia, Costa Rica, and Mexico, Stampini et al. (2020) show that women who care for their parents are less likely to participate in the labor market. Having a parent with care needs reduces women's probability of employment in Mexico (but not men's), and for women who keep working, it reduces the number of hours worked (Stampini et al. 2022). Similarly, Brito and Contreras (2024) find that daughters of parents with ill health have lower employment and earnings in Chile, but sons do not, which increases the income gap between men and women. Along the same lines, Lightman and Link (2021) study 25 countries (including Brazil, Chile, Colombia, Mexico, Paraguay, Peru,

and Uruguay) and find that in households with older members, women's share of household income decreases by 22%. They found this to be the case in all countries except Peru, where women's share remains constant, and Paraguay, where it increases slightly.

Data from the National Care System Survey in Mexico (2022) shows that 68.4% of women who do not work but would like to report that they cannot work due to the lack of care options. Time use surveys provide evidence consistent with these findings. Among women who do not work, 31% in Colombia and 43% in Uruguay specify family responsibilities as the main reason for not having a job. For men, these percentages are 1% and 4%, respectively. Giacomin et al. (2019), using data from the Brazilian Longitudinal Study of Aging, find that 26% of caregivers for older people stopped working or studying due to care responsibilities, with a significant gender differential (30% for women and 14.5% for men).

Caregiving responsibilities reduce paid working hours, particularly among people with lower levels of education

Among caregivers who remain employed, caring for older people reduces the number of paid hours worked. Caregivers for older people who hold paid jobs work two hours less per week, on average, than workers without caregiving responsibilities. This result is entirely driven by the difference in paid working hours between women caregivers and non-caregivers, which reaches three hours per week. Caring for older persons does not appear to impact the number of paid working hours for men. This effect is consistent across sexes in all countries except Argentina and Uruguay, where female caregivers report working more hours in paid jobs than non-caregivers (**Table 3.4**).

TABLE 3.4 TIME SPENT ON PAID WORK BY CAREGIVER STATUS
HOURS PER WEEK AMONG EMPLOYED INDIVIDUALS AGED 30–59

	MEN			WOMEN			TOTAL		
	NON-CAREGIVER	CAREGIVER	GAP	NON-CAREGIVER	CAREGIVER	GAP	NON-CAREGIVER	CAREGIVER	GAP
Argentina	46	44	1	37	41	-4	42	43	-1
Brazil	42	40	2	38	36	1	40	38	2
Chile	45	43	2	38	36	2	42	39	3
Colombia	49	47	1	43	40	3	46	42	4
Costa Rica	56	52	4	44	40	4	51	46	6
El Salvador	56	49	8	48	42	5	53	46	7
Mexico	51	50	1	40	36	4	46	42	4
Paraguay	46	36	10	37	34	2	42	35	7
Uruguay	43	41	2	36	37	-2	40	39	1
Average	46	46	0	39	36	3	43	41	2

Source: Table 3.1 ➔.
Note: the average is weighted by the number of unpaid caregivers in each country.

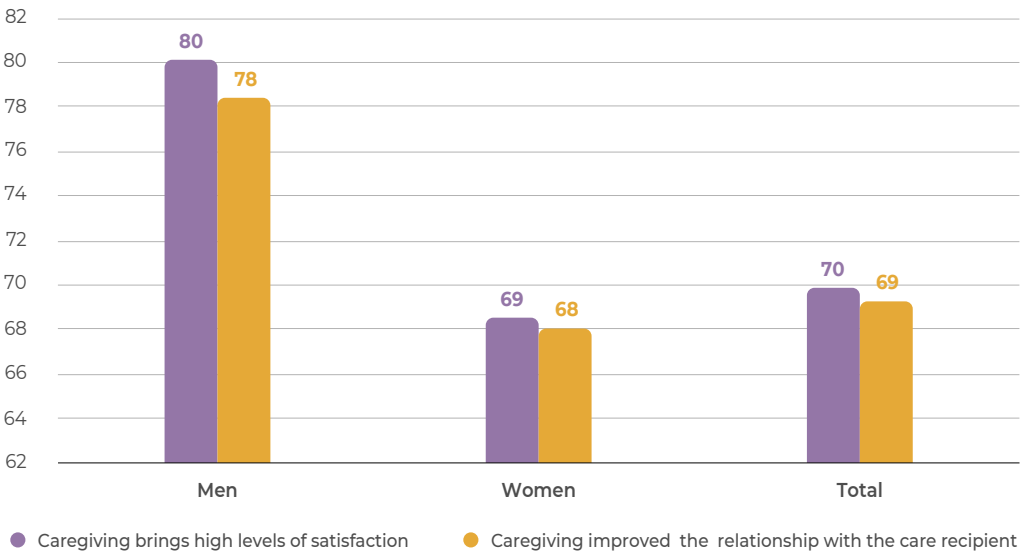
On average, caregiving has a stronger negative effect on paid working hours among people with less than a secondary education than among those with a secondary education or higher. This finding is in line with existing evidence that monetary and time poverty coexist and reinforce each other.[33]

3.5.2 Caregiving can cause satisfaction but can also strain caregivers' emotional and physical well-being

Caregiving is, most often, a source of satisfaction. Almost 70% of respondents to the IDB caregivers survey (see **Box 3.1** ➔) reported that caregiving brings high levels of satisfaction, and a similar share say it improved their relationship with the care recipient. Both of these percentages are higher among male caregivers (**Figure 3.4** ➔), which may be because men are more likely to take on caregiving tasks on their own initiative rather than as an obligation: 61% of male unpaid caregivers said they took on the responsibility because they wanted to, compared to 53% of female ones.

33. Monetary poverty is usually measured as having an income below a certain threshold (called the poverty line). Although monetary poverty does not capture all the dimensions of poverty, it is an indicator of a person's or household's ability to meet certain critical needs (such as food or shelter) through the market. Time poverty is defined as the persistent feeling of not having enough time to complete everything one has (or wants) to do (Giurge et al. 2020).

FIGURE 3.4 POSITIVE EFFECTS OF CAREGIVING ON CAREGIVERS' WELL-BEING
% OF CAREGIVERS



Source: Prepared by the authors based on the IDB caregivers survey.

However, feelings of satisfaction are only one facet of the experience. Caregivers also report high levels of stress, loneliness, and depression. More than 70% of respondents reported at least some level of stress, more than half of them feel lonely, and one-third experience symptoms of depression (as measured by PHQ-2[34]). Moreover, almost 40% of caregivers say their caregiving responsibilities negatively impacted their health (**Table 3.5**).

The health consequences of unpaid care responsibilities are well documented in the literature (Watkins and Overton 2024; Brimblecombe et al. 2018). Those caring for older people are more likely than the general population to experience episodes of depression and report a higher use of medications such as antidepressants, tranquilizers, painkillers, and gastrointestinal agents (Coe and van Houtven 2009).

These negative effects on health and emotional well-being are more frequent among women caregivers, as shown in **Table 3.5**. This result is in line with previous findings in the literature (Brimblecombe et al. 2018; Bom et al. 2019; Pinquart and Sörensen 2003).

34. The Patient Health Questionnaire-2 asks about the frequency of depressed mood and loss of interest and pleasure in activities that were previously enjoyable, with reference to the preceding two weeks.

The higher levels of stress and depression reported by women (**Table 3.5**) may be explained, at least in part, by ingrained cultural beliefs that shape how genders perceive caregiving roles and responsibilities within the household. Qualitative evidence suggests that women's "sense of duty" towards family is stronger than men's, making them more likely to feel "trapped" in their caregiver role (Watkins and Overton 2024; Zygouri et al. 2021). In Mediterranean countries, where family ties are stronger and long-term care policies are weaker, daughters caring for their parents experience higher mental health impacts than their counterparts in countries with stronger long-term care systems (Brenna and Di Novi 2016).

The more pronounced negative impacts for women are also consistent with evidence that points to differences in coping strategies between men and women. A qualitative systematic review by Zygouri et al. (2021) finds that cultural stereotypes influence not only the probability of providing care, but also the approaches used to perform care duties and the strategies used to cope with the burden of care. Women feel more restricted when it comes to asking for help or finding personal time for self-care, which intensifies the emotional strain of caregiving.

TABLE 3.5 NEGATIVE EFFECTS OF CAREGIVING ON CAREGIVERS' WELL-BEING
% OF CAREGIVERS WITH CONDITION

SEX	SOME STRESS	SYMPTOMS OF DEPRESSION	FEELINGS OF LONELINESS	NEGATIVE HEALTH IMPACT
Men	60	26	49	27
Women	73	35	56	40
Total	71	34	55	39

Source: Prepared by the authors based on the IDB caregivers survey.

The consequences of caregiving on unpaid caregivers' emotional and physical health also depend on the care recipient's condition (e.g., severity of long-term care needs, cognitive decline). For example, caregivers for older people with dementia or mental health problems are more likely to experience stress or depression, as shown in **Table 3.6**. This is in line with previous findings in the literature. For example, in a meta-analysis including evidence from Colombia and Brazil, Magaña et al. (2020) find that negative health outcomes intensify among unpaid caregivers for people with dementia or stroke.

TABLE 3.6 NEGATIVE EFFECTS OF CAREGIVING ON CAREGIVERS' WELL-BEING
% OF CAREGIVERS WITH CONDITION, BY HEALTH CONDITION OF CARE RECIPIENT

	SOME STRESS	SYMPTOMS OF DEPRESSION	FEELINGS OF LONELINESS	NEGATIVE HEALTH IMPACT
Mental health illness	81	43	64	55
Dementia	80	41	64	53
Physical disability	77	38	60	47
Vision and hearing loss	76	37	60	44
Chronic condition	75	34	58	40
Terminal illness	71	36	60	39
No disease	47	23	35	14
Total	71	34	55	39

Source: Prepared by the authors based on the IDB caregivers survey.

Caring for older people is physically demanding and rarely allows for substantial breaks. Data from time use surveys support the argument that caregiving can negatively affect health by leaving less time for sleep and personal care. Caregivers for older people sleep two hours less per week than people who do not have this caregiving responsibility, with little difference between men and women (**Table 3.7**). Interestingly, caring for an older person impacts sleep more than caring for a child, a responsibility often associated with sleep deprivation. Children's caregivers sleep approximately one hour more per week, on average, than caregivers for older people.

TABLE 3.7 EFFECTS OF CAREGIVING ON SLEEP TIME
HOURS SLEPT PER WEEK

	PEOPLE NOT PROVIDING CARE TO OLDER PEOPLE	CAREGIVERS FOR OLDER PEOPLE	TOTAL
Men	53	51	53
Women	54	52	54
Total	54	52	54

Source: Table 3.1.

Data from the IDB caregivers survey suggests that negative effects on health, stress, and depression are more likely when care is an obligation rather than a choice. People who provide care for older people because no one else is available to do it are much more likely to experience stress (84% versus 64%), loneliness (69% versus 46%), and feelings of depression (46% versus 25%), relative to people who provide care of their own initiative. They are also much more likely to report negative impacts on their health (55% versus 28%) (**Table 3.8**).

TABLE 3.8 NEGATIVE IMPACTS ON CAREGIVERS' HEALTH, BY REASON FOR CAREGIVING
% OF CAREGIVERS WITH CONDITION

REASONS FOR CAREGIVING	SOME STRESS	SYMPTOMS OF DEPRESSION	FEELINGS OF LONELINESS	NEGATIVE HEALTH IMPACT
My own initiative	64	25	46	28
I was the only person who could do it	84	46	69	55
Others asked	70	39	58	46
Other reasons	75	40	62	39
Total	72	34	55	39

Source: Prepared by the authors based on the IDB caregivers survey.

Training can mitigate health impacts for caregivers

Training can mitigate caregiving's negative impacts on health. Unpaid caregivers who received some kind of training report experiencing lower levels of stress and depression and are less likely to state that caregiving negatively impacts their health. The benefits from training are found among both men and women (**Table 3.9**). These results are consistent with evidence from small-sample interventions that show improvement in various measures of caregivers' wellbeing as a result of their participation in training and support programs (Aksoydan et al. 2019). This is one reason why countries in the region have worked to develop training opportunities for unpaid caregivers (see **Chapter 5**).

TABLE 3.9 NEGATIVE IMPACTS ON CAREGIVERS' HEALTH, BY TRAINING STATUS
% OF CAREGIVERS WITH CONDITION

SYMPTOM	SEX	DID NOT RECEIVE TRAINING	RECEIVED SOME TRAINING	TOTAL
Some stress	Men	61	53	60
	Women	75	68	73
	Total	73	67	72
Symptoms of depression	Men	26	23	26
	Women	36	31	35
	Total	35	30	34

Source: Prepared by the authors based on the IDB caregivers survey.

4 The Role of Paid Long-Term Care Workers

Paid long-term care workers provide care—whether at a care facility, in the recipient's home, or in the caregiver's own residence—in exchange for monetary compensation. They include paid caregivers and nursing aides who are not qualified or certified as nurses but provide long-term care services. They also include domestic workers who provide care to older people. This chapter estimates the number of paid caregivers in Latin America and the Caribbean and analyzes their demographic and socioeconomic characteristics, providing a detailed profile of the workforce; their level of training; the tasks they perform and who receives their care; their working conditions; and the effect of caregiving on their emotional well-being. **Annex B** explains this chapter's methodology for identifying paid caregivers using labor and household surveys, and Box 4.1 below provides information about the data used and its limitations.

BOX 4.1 DATA AVAILABILITY AND THE MAIN CHALLENGES OF ANALYZING PAID CAREGIVERS

Microdata from both household surveys and labor force surveys can be used to estimate the number of paid caregivers for older people in the region. Household surveys provide a comprehensive perspective on living conditions, encompassing demographics, education, health, housing, and consumption patterns. In contrast, labor force surveys offer insights into employment, occupational distribution, and wage structures. This chapter analyzes household or labor force surveys conducted between 2013 and 2024 in 17 countries. **Annex B** discusses the estimation methods in more detail. The analysis also draws on data from the IDB caregivers survey. For a discussion of this data source and its limitations, see **Box 3.1** and **Annex C**.

Our analysis has two limitations. First, labor force and household surveys do not allow for separating paid caregivers for older people from paid caregivers for younger people with disabilities. This lack of granularity may lead to inaccuracies in estimating how many workers specifically provide care for older people and in analyzing their conditions. Second, these data sources do not allow for identifying domestic workers who provide care for older people. This study estimates their number based on the percentage of domestic workers with long-term care responsibilities reported in the literature (Fabiani 2023), but it cannot analyze how these workers' characteristics differ from those of domestic workers in general.

4.1 How many paid caregivers does the region have?

In Latin America and the Caribbean, there are approximately three million paid caregivers for older people: 1.2 million work in home settings, 289,000 work in residential care facilities, and 1.5 million are domestic workers with adult care responsibilities (**Table 4.1**). These statistics reflect the predominance of home care in the region. The high number of domestic workers with care responsibilities (relative to institutional or home caregivers) suggests that caregiving is often not recognized as a distinct profession.

TABLE 4.1 NUMBER OF PAID CAREGIVERS FOR OLDER PEOPLE IN LATIN AMERICA AND THE CARIBBEAN

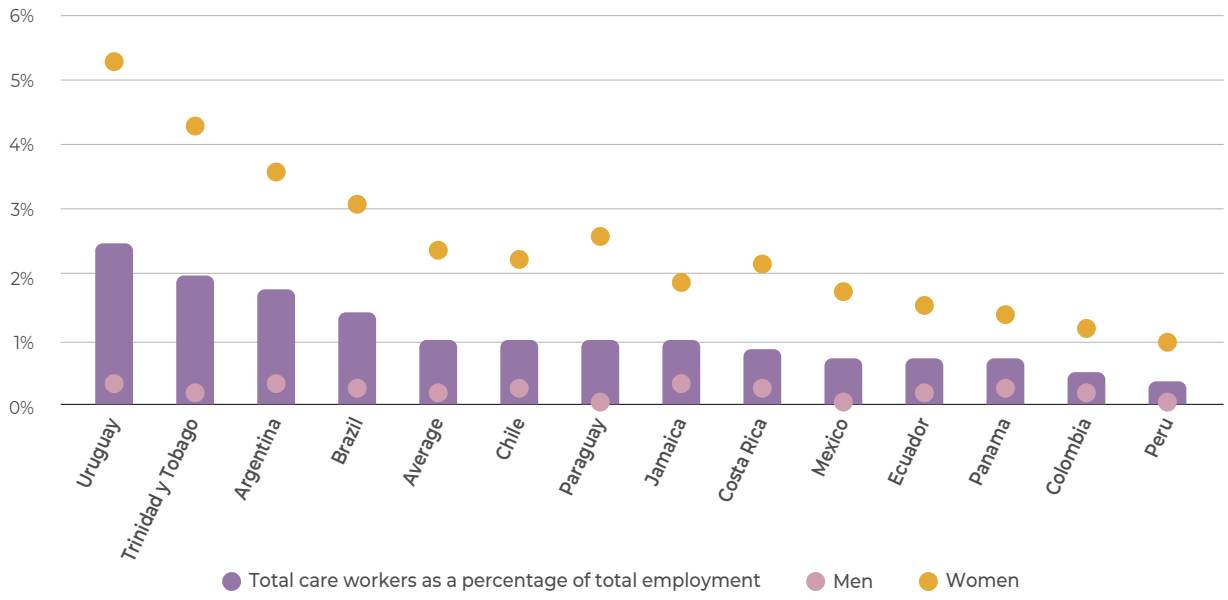
COUNTRY	PAID INSTITUTIONAL CAREGIVERS	PAID HOME CAREGIVERS	PAID DOMESTIC WORKERS WITH CARE RESPONSIBILITIES	TOTAL PAID CAREGIVERS
Argentina	39,586	79,001	111,027	229,614
Bolivia	974	693	10,465	12,132
Brazil	89,614	697,227	612,756	1,399,596
Chile	14,938	46,467	33,363	94,768
Colombia	17,749	5,412	88,177	111,337
Costa Rica	4,778	5,044	10,295	20,117
Ecuador	517	22,097	34,709	57,322
El Salvador	190	1,232	17,723	19,145
Guyana	448	451	726	1,625
Honduras	458	3,011	13,954	17,423
Jamaica	4,668	2,012	4,576	11,256
Mexico	47,355	110,149	274,161	431,664
Panama	1,204	4,121	7,492	12,817
Paraguay	1,060	6,543	26,159	33,762
Peru	7	14,055	52,627	66,688
Trinidad and Tobago	5,962	4,514	2,178	12,654
Uruguay	14,275	17,808	9,911	41,994
Total	248,781	1,019,835	1,310,299	2,573,915
Latin America and the Caribbean (total)	289,225	1,187,681	1,537,734	3,014,641

Source: Authors' calculations using data from household and labor force surveys (see **Annex B**).
Note: To estimate the total number of paid caregivers in the region, the combined total number of paid caregivers for all countries listed in the table was calculated (2.57 million), and this figure was then extrapolated to the entire region (3 million) based on the average ratio of paid caregivers to total population per country. Population estimates are from the United Nations World Population Prospects (2023) for the year of each household survey. For the estimates in this table, personal care workers were identified using the task-based approach, except in Argentina and Colombia (which use the industry-based approach). Mexico's classification groups together childcare workers and personal care workers, and both fall under personal care. For this table's estimates for Mexico, it was assumed that half of personal care workers work with adults, in line with Fabiani (2023).

Overall, the long-term care sector accounts for 1% of total employment in the region, and 2.3% of female employment. The sector's share of overall female employment is largest in Uruguay (at 5.2% of female employment), Trinidad and Tobago (4.2%), Argentina (3.5%), and Brazil (3%). At the other end of the distribution, the sector contributes approximately 0.9% of female employment in Peru and 1.1% in Colombia (**Figure 4.1**). These figures highlight how key the care economy is in women's employment in the region. Differences across countries can be explained by several factors, including demographic and economic aspects, labor force participation, and policies and systems that shape the care economy.

In OECD countries, the long-term care sector makes up 1.9% of total employment (OECD 2023a), approximately twice the share observed in Latin America and the Caribbean. This comparison highlights the limited development of the long-term care sector in the region, reflecting structural differences in labor market dynamics, social protection systems, and policy frameworks. In OECD countries, the long-term care workforce benefits from a more robust institutional framework, higher levels of public and private investments, and more formal employment, all of which contribute to the sector having a larger share of overall employment.

FIGURE 4.1 PAID CARE WORK AS A PERCENTAGE OF EMPLOYMENT



Source: Authors' calculations using data from household and labor force surveys (see **Annex B**).
Note: the average is weighted by the number of paid caregivers in each country.

4.2 Caregivers' gender, age, education, ethnicity, and migratory status

4.2.1 Most paid caregivers are middle-aged women with limited education

Women constitute 95% of paid care workers in the region. This figure is very high, given that women make up only 43% of the total workforce. Colombia reports the lowest percentage of female caregivers, at 92%, while Paraguay has the highest, at 99% (**Table 4.2**). Women have historically taken on caregiving responsibilities within their families, and this socially accepted role has extended to and solidified in labor markets.

Paid caregivers are typically in their forties, with an average age of 44 (**Table 4.2**). This is four years older than the average age of employed individuals (40). There are significant differences among countries. The average paid caregiver is younger in Paraguay (35) and older in Trinidad and Tobago (53). Paid caregivers in Latin America and the Caribbean have a similar age profile to those in OECD countries, where the median age is 45 years, a year and a half older than the general workforce (OECD 2020).

On average, four out of 10 paid caregivers have completed secondary education. Mexico reports the highest percentage of caregivers with a secondary education (56%), followed by Peru and Chile (48%). In contrast, Uruguay has notably lower rates of secondary education (10%). There are significant differences in educational level between institutional and home paid caregivers: in Argentina, 38% of institutional caregivers have primary education or less, compared to 60% of home caregivers (INDEC 2024); in Chile, the percentages are 15% and 33% (Ministerio de Desarrollo Social y Familia de Chile 2022). Caregivers' educational levels reflect the distinct structure of care systems in each country. For example, in countries where assistant nurses tend to provide care for older people (often in the absence of a clearly defined caregiver profile), caregivers' average educational level tends to be higher, since these roles require more advanced qualifications. In contrast, the average educational level is lower in countries like Uruguay that have developed the professional profile of caregivers and have low educational requirements for specific training at entry (see **Chapter 6**).

4.2.2 Ethnic and migrant minorities have mixed importance for caregiving across countries

The ethnic composition of the paid care workforce varies significantly among the different countries in the region. More than half (54%) of paid caregivers identify as Afro-descendants. Countries like Brazil and Trinidad and Tobago have the highest proportions: 67% and 52%, respectively (**Table 4.2**). The regional average is heavily influenced by Brazil, which has a large care workforce and a substantial Afro-descendant population. The regional figure should thus be interpreted with attention to country-specific contexts and demographic weights. Indigenous peoples account for 3% of paid caregivers, a percentage not significantly different from their share in the entire workforce (5.5%). This percentage is estimated based on data from seven countries. The highest figure is observed in Peru, where Indigenous peoples account for 26% of the paid care workforce (**Table 4.2**).[35] These differences across the region may be influenced by historical, cultural, and demographic factors specific to each country.

On average, international migrants constitute 8% of paid care workers.[36] The highest shares are observed in Costa Rica (23%) and Chile (22%), indicating that cross-border migration is a key component of the care labor supply in these countries. In contrast, countries like Ecuador and Paraguay report much lower shares (2%). Migration patterns among the care workforce have not changed substantially from those observed for 2019 by Fabiani (2023). Further information on these changes can be found in **Box 4.2**.

Migration patterns in the region's care sector differ from those observed in OECD countries. In the OECD, migrants constitute 20% of the long-term care workforce, on average, with peaks in Israel (71%), Ireland (48%), Canada (34%), and Switzerland (31%) (OECD 2020). Italy also relies heavily on foreign-born workers to meet the demand for care services, with 72% of its personal care workers coming from abroad (Domina National Observatory on Domestic Work 2024). **Table 4.2** suggests that, unlike in high-income countries in other areas of the world, the number of national care workers in Latin America and the Caribbean may still be sufficient to meet the current demand for paid care services, resulting in lower shares of migrant workers in the sector. In contrast, OECD countries have a higher demand for care services but struggle to make care work attractive for national workers, so the demand is mainly met by international migrants.

35. This is consistent with data on paid domestic work. Indigenous women comprise 28.4% of domestic workers in Mexico and 27.6% in Guatemala (ILO 2021).

36. International migrants constitute 8% of paid care workers, compared to 6% of the overall employed population. However, this difference is not statistically significant.

TABLE 4.2 DEMOGRAPHIC CHARACTERISTICS OF PAID CAREGIVERS

COUNTRIES	WOMEN (%)	AVERAGE AGE (YEARS)	SECONDARY EDUCATION (%)	INDIGENOUS (%)	AFRO-DESCENDANT (%)	INTERNATIONAL MIGRANT (%)
Argentina	95	43	39			8
Brazil	93	45	21	1	67	
Chile	96	50	48	12		22
Colombia	92	44	35	5	10	5
Costa Rica	97	47	18			23
Ecuador	94	44	42	3	6	2
Jamaica	94	45	33			
Mexico	97	44	56			
Panama	94	43	31	6	25	17
Paraguay	99	35	31			2
Peru	98	44	48	26	8	
Trinidad and Tobago	98	53	34		52	9
Uruguay	97	46	10	3	9	3
Average	95	44	39	3	54	8

Source: Authors' calculations using data from household and labor force surveys (see Annex B ➔).
Notes: the average is weighted by the number of paid caregivers in each country. Empty cells indicate a lack of data or an insufficient number of observations.

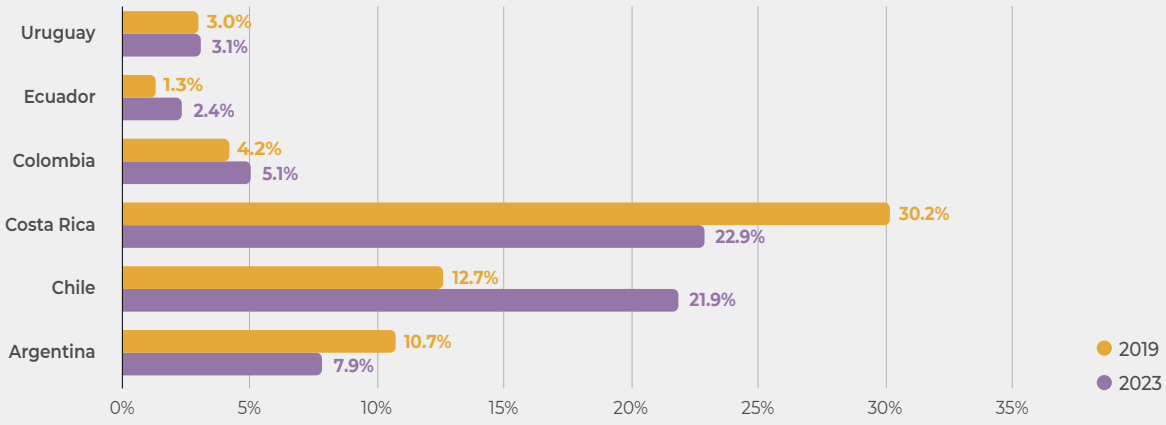
BOX 4.2 INTERNATIONAL MIGRATION AND CARE WORKFORCE, ~ 2019 VERSUS 2023

The percentage of paid caregivers who are international migrants has remained relatively stable in recent years, increasing only slightly from 7.9% in 2019 to 8.2% in 2023. This is more than their share in total employment (6%), but the difference is not statistically significant. This average hides significant variations across countries that reflect various migration patterns in response to the COVID-19 pandemic.

The percentage of international migrants in the paid care workforce increased in Chile, Colombia, Uruguay, and Ecuador in recent years. In Chile, the share rose from 12.7% in 2017 to 21.9% in 2022; in Colombia, it grew from 4.2% to 5.1% between 2019 and 2022. In contrast, Costa Rica saw a seven-percentage-point decline in the share of international paid caregivers, which dropped from 30.2% to 22.9%. Likewise, in Argentina, the share of international migrants among paid caregivers decreased from 10.7% in 2019 to 7.9% in 2024 (**Figure 4.2**).

These trends may be caused by changes in the net benefits of migration and care employment (domestically or internationally) during the COVID-19 pandemic. In some countries, the growing demand for care for older people may have attracted international caregivers to fill gaps in local human resources. Political, economic, and social instability in nearby countries may also explain the increase in the international caregiving workforce, as workers seek better employment conditions abroad. Additionally, changes in immigration policies may have impacted the international flow of workers, with consequences for the composition of the long-term care workforce.

FIGURE 4.2 PERCENTAGE OF PAID CAREGIVERS WHO ARE INTERNATIONAL MIGRANTS, ~2019 VS 2023



Source: Prepared by the authors based on household and labor surveys (see **Annex B**).

4.3 Paid caregivers lack training

Thirty-seven percent of paid caregivers work without any training, and only one-fourth have completed an extended, care-specific course (of 150 hours or more). Courses of 60–150 hours account for 12% of the total, while self-study and short courses of less than 60 hours make up the remaining 26% (**Table 4.3**). As discussed below in **Chapters 6** and **7**, courses of less than 150 hours may not adequately prepare caregivers for the challenges of their work (Aldaz Arroyo et al. 2023). The Ibero-American Protocol for Caregiver Training recommends a course duration of at least 260 hours (Organización Iberoamericana de Seguridad Social 2022). These data confirm the enormous training deficit in the region's long-term care human resources.

The countries with the highest level of training are in the Southern Cone and the Caribbean. For example, 40% of caregivers in Argentina, and almost 42% in Trinidad and Tobago, have completed an extended course of more than 150 hours. The countries that rely most heavily on untrained caregivers are in Central America (**Table 4.3**).

On average, paid caregivers who work in institutions are more likely to have taken some care-specific training (of any length) than paid caregivers who work in home settings (59% versus 45%, respectively). In some countries, the difference in training levels between institutional and home care workers is larger. In Barbados, for example, 82% of institutional workers have taken a care-specific training course, compared to 56% of home care workers, and double the percentage of institutional caregivers have taken a course of more than 150 hours compared to home caregivers (75% versus 35%). In Jamaica, more than 80% of workers in care facilities have some type of training, a share 31 percentage points higher than that among home care workers. In Ecuador, the figures are 62% and 34% respectively. Ecuador, as discussed in **Chapter 6**, is taking steps to improve the training status of its care workforce.

Other surveys in Latin America and the Caribbean confirm the training deficit among paid caregivers. In Chile, a 2020 survey of paid caregivers working in 17 residential care facilities found that only half had participated in training courses, on topics like first aid or using personal protective equipment, during the previous two years. Moreover, there was no specific program to train workers on interacting with patients or developing the necessary skills, leading caregivers to see themselves as poorly qualified (SENADIS 2021). In Uruguay, López Gómez (2021) conducted a survey in 80 long-term care facilities in Montevideo and found that 55% of the interviewed workers reported having no training, while only 17% had attended courses longer than 90 hours.

In a small sample of paid long-term care workers in Peru, only 12% had received more than 60 hours of training (Navarrete-Mejía et al. 2020). In Jamaica, a 2016 survey of caregivers providing

non-institutional care to older people found that 92% received no formal training. Only 8% reported doing short courses in school or practical nursing. Among those without training, over 30% (particularly those under age 45) expressed a desire to enroll in nursing or other specialized training (Holder-Nevins et al. 2018). In Colombia, the high cost of training appears to be the main driver of this gap (Ministerio de Salud y Protección Social de Colombia 2013).

TABLE 4.3 LEVEL OF TRAINING
% OF CAREGIVERS, BY COUNTRY

COUNTRIES	NO TRAINING	SELF-STUDY	SHORT COURSE (<60 HOURS)	MEDIUM-LENGTH COURSE (60–150 HOURS)	EXTENDED COURSE (>150 HOURS)
Argentina	24	13	9	14	40
Barbados	39	3	11	9	39
Belize	44	13	8	12	23
Bolivia	48	22	7	4	19
Brazil	27	11	13	20	29
Chile	45	16	12	8	19
Colombia	42	21	9	8	20
Costa Rica	45	16	10	6	22
Ecuador	45	18	8	7	21
El Salvador	60	24	4	3	9
Guatemala	38	30	7	7	17
Guyana	38	13	9	10	30
Honduras	54	22	7	3	14
Jamaica	42	6	11	8	33
Mexico	54	20	6	5	15
Panama	58	15	9	7	10
Paraguay	48	21	6	4	21
Peru	39	20	7	10	23
Dominican Republic	45	22	9	6	18
Trinidad and Tobago	29	6	11	12	42
Uruguay	27	11	14	16	32
Venezuela	40	22	9	6	24
Average	37	16	10	12	25

Source. Prepared by the authors based on the IDB caregivers survey.
Notes: Observations for the Bahamas, Haiti, and Suriname are limited and therefore not reported individually in the table. However, these countries are included in the calculation of the regional average. The average is weighted by the number of paid caregivers in each country.

4.4 Paid caregivers perform multiple tasks

Care work is complex and involves a broad mix of tasks. Paid caregivers support care recipients with daily care needs, help maintain a clean environment, report changes in recipients' condition, and provide emotional support (ILO 2018). Their responsibilities may include attending to personal and therapeutic care needs such as hygiene, feeding, dressing, physical mobility, exercise, communication, administering oral medications, and changing dressings. They must also monitor the care recipient's condition, reporting any changes to health or social service professionals. Also, as part of their tasks, they may need to keep up the client's environment by changing bed linens, washing clothes and dishes, and cleaning living quarters. They also offer emotional and psychological support through conversation or activities like reading aloud.

Evidence from the IDB caregivers survey indicates that the main activities performed by paid caregivers include hygiene and personal care (72% of respondents report performing these tasks), household chores (45%), companionship and recreation (40%), health care activities (34%), and practical support (17%) (**Table 4.4**).[37] These tasks vary between paid home caregivers and institutional caregivers. Both types of caregivers primarily assist older people with hygiene and personal care, which includes activities like dressing, bathing, using the toilet, diapering, eating, and drinking. However, workers in institutional settings are more likely to assist with health care (which includes tasks like glucose measurement, home oxygen management, and wound care) than home care workers (45% versus 33%). Conversely, home care workers are more likely to perform household chores (such as food preparation, cleaning, and shopping) than those working at institutions (47% versus 25%) (**Table 4.4**).

TABLE 4.4 TASKS PERFORMED BY PAID CAREGIVERS
% OF CAREGIVERS

WORKPLACE	HYGIENE AND PERSONAL CARE	PRACTICAL SUPPORT	HEALTH CARE	COMPANIONSHIP AND RECREATION	HOUSEHOLD CHORES
Home	71	17	33	39	47
Institutions	75	16	45	44	25
Total	72	17	34	40	45

Source: Prepared by the authors based on the IDB caregivers survey.

37. The percentages do not add up to 100% because respondents could select multiple activities, so the same caregiver may report performing more than one type of task. For instance, a paid caregiver may assist with both hygiene and personal care, as well as household chores.

4.5 Who receives their care?

As in the case of unpaid care (see Chapter 3), paid care has a double gender dimension: women make up the majority of the sector's workforce and also comprise 77% of paid care recipients, according to data from the IDB caregivers survey (Table 4.5).[38] Male paid caregivers are relatively more likely to provide care to men. Caregivers of other gender identities constitute just 4% of paid caregivers but account for 12% of those providing care to older individuals with other gender identities (Table 4.5). Encouraging greater participation of men—and all genders—in paid caregiving could help address workforce shortages and promote gender equality in long-term care (OECD 2020) (see Chapter 7).

TABLE 4.5 SEX OF PAID CAREGIVERS AND RECIPIENTS OF PAID LONG-TERM CARE

SEX	GENDER OF CARE RECIPIENT, % BY ROW (% BY COLUMN IN PARENTHESIS)			
	FEMALE	MALE	OTHER	TOTAL
Female	80 (96)	20 (80)	0.3 (82)	100 (92)
Male	36 (3)	63 (18)	0.3 (6)	100 (6)
Other	70 (1)	26 (1)	4 (12)	100 (1)
Total	77 (100)	23 (100)	0.4 (100)	100 (100)

Source: Prepared by the authors based on the IDB caregivers survey.
Notes: Figures outside the parentheses are percentages by row. For example, women constitute 80% of recipients of care from female caregivers. Figures in parentheses report percentages by column. For example, 96% of female care recipients receive care from female caregivers. Percentage estimates for the other gender identities group may be imprecise, given the small number of observations in the sample (102 individuals receiving care are classified as having other gender identities).

Recipients of paid long-term care are, on average, 83 years old and have multiple health conditions. The most common conditions are physical disabilities (48%), followed by dementia, Alzheimer's, or cognitive impairment (40%), and chronic diseases (30%). Although they are similar in age to recipients of unpaid care (Section 3.4), the prevalence of dementia among paid care recipients is much higher (40% versus 28%). According to the IDB caregivers survey, the prevalence of dementia and cognitive conditions is much higher in residential care settings

38. Aranco et al. (2018) estimated that two-thirds of older people with care needs are women, but their analysis was restricted to people with difficulties with basic activities of daily living rather than focusing on recipients of paid long-term care.

than in home settings. Specifically, 54% of caregivers working in long-term care facilities provide care to people with dementia, Alzheimer's, or cognitive impairment, compared to 37% of paid home caregivers.

These findings align with a 2016 survey in Jamaica, which examined caregivers of older people receiving non-residential care. The study revealed that the average age of care recipients was 82, with women comprising 60% of those needing care. It also found a high prevalence of chronic conditions, such as hypertension and diabetes, among older people. Furthermore, 45% of caregivers reported providing daily assistance with one or more activities of daily living (Holder-Nevins et al. 2018).

4.6 Working conditions are precarious and insecure

4.6.1 Paid care is often a part-time job

Paid care is often part-time, with a regional average of 31 hours per week. In Argentina and Uruguay, professional carers work even fewer hours—21 and 26 hours per week—(**Table 4.6**). Data from Chile also indicates that part-time occupations are more common in home settings than in residential care: its paid caregivers work an average of 33 and 38 hours, respectively (Ministerio de Desarrollo Social y Familia de Chile 2022). Jamaica, Colombia, and Peru are exceptions, with 40 or more working hours on average.

The predominance of part-time work holds across OECD countries, where 45% of long-term care workers are employed part-time (OECD 2020). Further evidence from Italy reveals that 58% of paid caregivers for older people work less than 40 hours per week (Domina National Observatory on Domestic Work 2024). These employment conditions matter: part-time workers are more vulnerable to poverty, have limited prospects for career growth, and, in some countries, face restricted access to employment benefits and social protection (OECD 2018).

TABLE 4.6 HOURS PER WEEK WORKED BY PAID CARE PROFESSIONALS
WEEKLY HOURS, BY COUNTRY

COUNTRY	PAID CAREGIVERS	ALL EMPLOYED PEOPLE
Argentina	21	33
Brazil	31	39
Chile	31	38
Colombia	41	44
Costa Rica	27	43
Ecuador	29	35
Jamaica	44	43
Mexico	29	41
Panama	36	37
Paraguay	37	43
Peru	40	39
Trinidad and Tobago	37	39
Uruguay	26	38
Average	31	39

Source: Prepared by the authors based on household and labor surveys.
Note: the average is weighted by the number of paid caregivers in each country.

4.6.2 Paid caregivers usually earn low wages

On average, paid caregivers earn 90% of the minimum wage (**Table 4.7**). Information from the IDB caregivers survey highlights that paid caregivers who work in home settings earn less than those who work at institutions (Fabiani et al. 2024). These figures underscore the precarious conditions that paid care professionals face, particularly compared to the general population, which earns nearly twice the minimum wage (1.9 times) on average.

TABLE 4.7 MONTHLY LABOR INCOME OF CARE PROFESSIONALS AND ALL EMPLOYED PEOPLE
As a proportion of the national minimum wage

COUNTRIES	EMPLOYED PEOPLE	TOTAL CAREGIVERS
Argentina	1.6	0.6
Brazil	2.3	0.9
Chile	2.3	1.1
Colombia	1.3	0.6
Costa Rica	1.5	0.6
Ecuador	1.0	0.6
Jamaica	1.5	0.4
Mexico	1.7	1.2
Panama	1.2	0.6
Paraguay	1.1	0.6
Peru	1.2	0.8
Trinidad and Tobago	2.6	1.3
Uruguay	2.7	0.8
Average	1.9	0.9

Source: Prepared by the authors using data from household and labor force surveys.
Note: This table uses the minimum wage in force during the year of the household or labor surveys and is based on the IDB's Information System on Labor Markets and Social Security (2024). For Mexico and Costa Rica, it uses the minimum wage for 2022 (the latest one available). For Trinidad and Tobago, it uses a minimum wage of T$12.50 per hour (US$1.84), as reported by Mahabir et al. (2013) for 2011. This value was multiplied by 160 hours to make it comparable with monthly labor income statistics. For Argentina, Brazil, Peru, and Uruguay, the minimum wage figures were obtained from each country's official gazette according to the year of the labor or household survey. The average is weighted by the number of paid caregivers in each country.

4.6.3 Paid care jobs are often informal, with no access to contributory social protection

Informal employment and lack of social protection are widespread among paid caregivers. Only 26% contribute to social security, compared to 54% of all employed people. Formal employment is highest in Uruguay (61%), and lowest in Mexico, Paraguay, and Peru, where 6% or less of paid caregivers contribute to social security (**Table 4.8**). As shown in **Chapter 6**, higher formal employment rates in Uruguay can be linked to its efforts to improve domestic workers' job conditions and establish a national care system. This underscores how important care and labor policies are for improving conditions in the sector.

Only 33% of paid caregivers have a written contract (**Table 4.8**). This may be partly explained by the fact that more than half of paid caregivers are self-employed (56%). This finding is con-

sistent with the existing literature. Information from the Chilean household survey reveals that one out of two personal care workers has a written contract (Ministerio de Desarrollo Social y Familia de Chile 2022). In Panama, 65% of personal care workers lack a formal contract (INEC 2019), while in Mexico, as much as 78% do (INEGI 2024).

Home caregivers often face more precarious job conditions than institutional caregivers. According to the IDB caregivers survey, among caregivers working in home settings, 29% contribute to social security, 30% have a written contract, and 58% are self-employed, compared to 42%, 57%, and 35%, respectively, for institutional workers.

TABLE 4.8 SOCIAL SECURITY CONTRIBUTIONS, TYPE OF CONTRACT, AND EMPLOYMENT RELATIONSHIP

% OF CAREGIVERS, BY COUNTRY

COUNTRY	CONTRIBUTE TO SOCIAL SECURITY		WRITTEN CONTRACT / PAY STUB	EMPLOYMENT RELATIONSHIP		
	EMPLOYED PEOPLE	PAID CAREGIVERS		SELF-EMPLOYED/ INDEPENDENT CONTRACTOR	EMPLOYEE (HOURLY OR SALARIED)	OTHER
Argentina	48	28	27	64	27	9
Barbados		34*	41	32	56	12
Belize		19	34	46	37	17
Bolivia		12*	32	69	24	7
Brazil	65	35	43	48	39	13
Chile	70	47	36	45	34	21
Colombia	41	19	40	51	34	15
Costa Rica	70	37	36	47	37	16
Ecuador	29	17	30	57	30	12
El Salvador		14*	21	62	26	12
Guatemala		9*	27	69	21	10
Guyana		17*	21	38	43	19
Honduras		7*	23	56	30	14
Jamaica		21*	19	27	46	27
Mexico	38	5	17	71	14	14
Panama	58	37	32	50	34	16
Paraguay	22	6	30	61	26	14
Peru	19	4	19	70	20	10
Dominican Republic		14*	29	54	34	12
Trinidad and Tobago		16*	26	38	47	15
Uruguay	77	61	67	32	57	11
Venezuela		22*	27	70	23	7
Average	54	26	33	56	30	14

Source: Social security contributions (columns 2 and 3) are calculated based on data from household and labor force surveys. The type of contract (column 4) and employment relationship (columns 5, 6, and 7) are based on the IDB caregivers survey.
Note: For countries marked with an asterisk (*), data on social security contributions come from the IDB caregivers survey. Empty cells indicate a lack of data. Observations for the Bahamas, Haiti, and Suriname are limited and therefore not reported individually in the table. However, these countries are included in the calculation of the regional average. The average is weighted by the number of paid caregivers in each country.

4.6.4 Verbal and physical abuse are frequent

Paid caregivers experience significant levels of verbal and physical abuse, with no discernible differences across sexes: 38% of paid caregivers report experiencing verbal abuse, while 16% report physical abuse (**Table 4.9**).[39] According to information from the IDB caregivers survey, both types of abuse are more prevalent in care facilities than in care recipients' homes. Paid caregivers identifying as Afro-descendants report experiencing higher levels of verbal and physical abuse than those identifying with other ethnicities. Levels of abuse seem to vary little across countries.

These levels of abuse align with findings from the 2019 New Zealand Care Workforce Survey, which documented frequent verbal aggression and physical violence by clients and their families. According to the survey, nearly half of managers, care workers, and support staff reported experiencing occasional to frequent physical violence from clients. Nearly two-thirds of nurses reported similar experiences (Ravenswood et al. 2021). This violence can manifest as verbal and physical abuse, intimidation, degradation, humiliation, or persistent criticism from patients, colleagues, or management. Many long-term care workers refrain from reporting these incidents for fear of retaliation or losing their jobs (Fasanya and Dada 2015), so our results may underestimate the true magnitude of the problem.

TABLE 4.9 PERCENTAGE OF PAID CAREGIVERS WHO EXPERIENCE ABUSE (%)

WORKPLACE	VERBAL ABUSE	PHYSICAL ABUSE
Home	38	15
Institution	45	25
Total	38	16

Source: Prepared by the authors based on the IDB caregivers survey.

39. A significant proportion of respondents, equal to 10% in the case of verbal abuse and to 7% in the case of physical abuse, selected the option "I prefer not to answer."

4.6.5 Despite precarious employment conditions, caregivers do not expect to change careers

Even though their job conditions are often inadequate, 45% of caregivers have been in the profession for over six years. Caregiving is thus a stable and enduring career for many (**Table 4.10**). The profession is most stable in countries like Uruguay and Argentina, where 56% and 60% of caregivers have worked in the sector for more than six years, respectively. Furthermore, data from the IDB caregivers survey indicate that 59% of paid caregivers believe they will remain in the profession: 62% of caregivers working at institutions and 59% of paid home caregivers say they wish to continue to work as a caregiver in the next few years.

It is difficult to obtain information to assess how retention levels in the long-term care sector compare to the average for countries' workforces. However, data from OECD countries indicate that the average tenure in the sector is two years shorter than in other sectors (except in the Netherlands and Norway). Evidence from Germany reveals that it is particularly difficult to retain care workers in the first year after they complete training. Data from the German Socio-Economic Panel indicate that only 68% of long-term care workers remain in the profession from the first year to the second. But after this high turnover in the first year, retention tends to stabilize (OECD 2020).

TABLE 4.10 EMPLOYMENT TENURE AND CAREER EXPECTATIONS

COUNTRIES	TENURE IN CURRENT JOB		TENURE IN PROFESSION		EXPECTS TO CONTINUE WORKING AS CAREGIVER IN NEXT FEW YEARS
	1 YEAR OR LESS	MORE THAN 1 YEAR	6 YEARS OR LESS	MORE THAN 6 YEARS	
Argentina	38	62	40	60	67
Barbados	23	77	51	49	64
Belize	43	57	70	30	75
Bolivia	43	57	71	29	58
Brazil	40	60	52	48	57
Chile	38	62	61	39	58
Colombia	40	60	61	39	63
Costa Rica	36	64	53	47	60
Ecuador	42	58	68	32	60
El Salvador	40	60	71	29	61
Guatemala	40	60	57	43	68
Guyana	36	64	57	43	67
Honduras	47	53	73	27	51
Jamaica	37	63	55	45	58
Mexico	38	62	57	43	58
Panama	35	65	63	37	49
Paraguay	31	69	59	41	61
Peru	43	57	57	43	58
Dominican Republic	46	54	67	33	63
Trinidad and Tobago	39	61	46	54	63
Uruguay	29	71	44	56	71
Venezuela	45	55	55	45	68
Average	39	61	55	45	59

Source: Prepared by the authors based on the IDB caregivers survey.
Note: Observations for the Bahamas, Haiti and Suriname are limited and therefore not reported individually in the table. However, these countries are included in the calculation of the regional average. The average is weighted by the number of paid caregivers in each country.

4.7 The emotional and physical strain of caregiving

Paid work in caregiving is associated with high levels of stress and depressive symptoms, like unpaid caregiving, as discussed in **Chapter 3**. In the IDB caregivers survey, one out of five caregivers reports experiencing symptoms of depression, and more than 45% of respondents report feelings of stress.

Paid caregivers experience high rates of depression and stress compared to those measured by research on the general population. For example, Brito et al. (2022) estimate that 10.2% of Brazilians over age 18 self-report depressive symptoms. This figure is 16 percentage points lower than the rate reported among paid caregivers. Chile is an exception. In this country, the general prevalence of depressive symptoms is estimated to be between 15.8% (Ministerio de Salud de Chile 2018) and 18.1% (Daray et al. 2017), in line with the 17% reported among paid caregivers in the IDB caregivers survey.

Negative impacts on emotional health are lower among workers with specific care training. Evidence from the IDB caregivers survey shows that training positively correlates with lower levels of stress and depression (Fabiani et al. 2024). This suggests that providing caregivers with the tools and knowledge they need to perform their tasks optimally and care for themselves is crucial to enhancing their well-being. As discussed in **Chapter 6**, countries in the region are realizing the importance of training in the long-term care sector and are working to design training options for paid caregivers.

5 Policies for Family Caregivers

As seen in **Chapter 3**, family caregivers are the main providers of long-term care in Latin America and the Caribbean. This arrangement for caring for older people is culturally ingrained and, in some countries, even set down in law.[40]

Care by family and friends contributes substantially to society, but it takes a heavy toll. It supports aging at home and helps contain the public costs of long-term care (Costa-Font et al. 2015), but when caregiving is intense and not appropriately supported, it negatively affects caregivers' financial autonomy and mental and physical health. It also lowers employment rates and causes a loss of social protection contributions and taxes.

Countries in the region are increasingly recognizing the vital role of unpaid family caregivers and are scaling up their efforts to support their work. They are explicitly including them in national care or aging policies; providing them with information, training, and emotional support; introducing job flexibility that allows them to combine care and work responsibilities; and recognizing care work through direct financial support. This chapter analyzes the policies that countries in the region have implemented to help unpaid caregivers take better care of themselves and the people they care for.[41]

5.1 Policy agendas increasingly include family caregivers

5.1.1 Some national care or aging policies explicitly address family caregivers

Several countries—such as Brazil, Colombia, Costa Rica, El Salvador, and Uruguay—have specifically included unpaid caregivers as a target population in their national care policies or plans (see **Table D.1**). The extent of this acknowledgement and the specific actions outlined in these plans vary from country to country. Some simply recognize this group, a first step to understanding their characteristics and needs. Others establish measures to reduce and redistribute their caregiving load (Brazil, Colombia, Uruguay) or explicitly focus on interventions that support their mental, emotional, and physical well-being (El Salvador). Lastly, Costa Rica's national care

40. For example, in Mexico, Article 9 of the Law on the Rights of Older Adults states that families must fulfil their social role by consistently and permanently caring for their older members (Gobierno de México 2024).

41. Part of the information presented in this chapter was collected through interviews with government representatives and experts (see **Introduction**). This information is referenced to as OECD-IDB Long-Term Care Workforce Questionnaire.

policy mentions supporting unpaid carers in managing and combining their care responsibilities and labor market participation. While Chile so far lacks a national care or aging policy that could highlight the importance of informal carers, the Chile Cares program discussed below does address their importance and offers them benefits.

Unpaid carers are also recognized in policies related to aging in Barbados, Trinidad and Tobago, Costa Rica, and Colombia. These policies stress, to different extents, the need to support, train, and provide resources to better enable family caregivers to deliver high-quality care to older people. More countries have attempted to set up similar policies but have not yet approved them.

5.1.2 Countries recognize the economic value of unpaid care

The value of unpaid care and domestic work is becoming an important topic in Latin America and the Caribbean, and countries are working to have this work legally recognized. It is officially acknowledged in the constitutions of Ecuador,[42] Bolivia,[43] and the Dominican Republic (Güezmes García and Vaeza 2023). Other countries are attempting to follow the same path. In Chile, for example, the Women and Gender Equality Commission has introduced a parliamentary bill that recognizes domestic and care work (Senado de la República de Chile 2019). Recognizing and valuing unpaid domestic and care work, which is often overlooked in economic and social policies, lays a foundation for policies that support caregivers, such as social security benefits, pension rights, or compensation for unpaid labor through public assistance programs. It affirms that all forms of labor, including those performed at home without monetary compensation, have intrinsic value and contribute to national well-being.

There have also been regional efforts to recognize unpaid caregivers and improve their well-being. One significant development was the approval of the Care Economy Framework Law by the Latin American and Caribbean Parliament in 2013. This law recognizes unpaid domestic caregiving work as productive labor (PARLATINO 2013). More recently, in 2022, the Inter-American Commission of Women of the Organization of American States developed the Inter-American Model Law on Care[44] to recognize unpaid care work as legitimate labor (OAS 2022). It promotes

42. The 2008 constitution states: "Se reconoce como labor productiva el trabajo no remunerado de autosustento y cuidado humano que se realiza en los hogares" [The unpaid work of subsistence and caregiving done in the home is recognized as productive labor.]

43. "El Estado reconoce el valor económico del trabajo del hogar como fuente de riqueza y deberá cuantificarse en las cuentas públicas." [The State recognizes the economic value of domestic work as a source of wealth, and it must be quantified in the public accounts.]

44. This model law is a regional tool to address the care crisis and establish the basis for a new covenant in the social organization of care; to redefine care's role in society; to respect, promote and protect the economic rights of women; to redefine unremunerated care as work; and to protect, ensure and guarantee the rights of dependents by promoting care policies that foster job creation and gender equality and making it easier for full-time unremunerated caregivers, particularly from underprivileged groups, to join the labor force.

policies that create jobs, advance gender equality, and provide opportunities for unpaid caregivers—especially from disadvantaged groups—to enter the paid workforce. In 2025, the Inter-American Court of Human Rights recognized care as an autonomous human right in three dimensions: the right to be cared for, the right to care, and the right to self-care.[45]

Countries in the region are also increasingly measuring the economic value of unpaid caregiving. Colombia,[46] Costa Rica,[47] and Mexico (INEGI 2013) are doing so by incorporating the care economy into national account systems, creating "satellite national accounts" that measure how much unpaid work contributes to economic and social development. Time use surveys, available in Argentina, Chile, Colombia, Costa Rica, El Salvador, Mexico, Paraguay, Peru, Uruguay, and Brazil (through a module in the national household survey), are another valuable tool to measure the economic value of unpaid work (including care work). Even though their accuracy and comparability for measuring unpaid long-term care are far from perfect, as discussed in **Box 3.1**, these surveys are valuable for analysis and policy making.

Some countries also have local initiatives to recognize the value of family caregiving. In Mexico, the constitution of Mexico City established the right to care in 2017 and emphasizes the need to support unpaid caregivers.[48] Jalisco established similar provisions in 2024.[49] Also in Mexico, the state of Nuevo León introduced the Caring for Nuevo León[50] strategy in 2024 as part of its Care Law.[51] The initiative is built on three key pillars: recognizing, reducing, and redistributing care work.[52]

In Bolivia, the municipality of Cochabamba went a step further than the national law and implemented a municipal Solidarity Care Economy Law in 2015 to raise the societal status of unpaid care work.[53] In 2019, another municipal law was passed to encourage co-responsibility in unpaid care work to guarantee equal opportunities for all.[54] The law mandates the creation of care centers and services for children, adolescents, older people, and people with disabilities (Consejo Municipal de Cochabamba 2019; Consejo Municipal de Cochabamba 2016).

45. See https://www.corteidh.or.cr/docs/comunicados/cp_55_2025.pdf.
46. Law 1413 of 2010, Colombia.
47. Law 9325 of 2015, Costa Rica.
48. Mexico City Political Constitution, 2017.
49. Integral Care System Law (Jalisco 2024).
50. *Cuidamos Nuevo León.*
51. Integral Care System Law, Nuevo León, 2024.
52. See www.nl.gob.mx/es/boletines/gobierno-de-nuevo-leon-presenta-estrategia-para-el-sistema-integral-de-cuidados.
53. Municipal Law on Solidarity Care Economy, Cochabamba, 2015.
54. Municipal Law on Co-Responsibility in Unpaid Care Work for Equality of Opportunities, Cochabamba, 2019.

5.2 Information, emotional support, and training help informal carers perform their tasks better

Giving caregivers easy-to-access information, practical training, and emotional support is essential to improve their overall well-being and the quality of the care they provide. As described in **Chapter 3**, trained caregivers report less stress and depression than untrained ones. Clear and reliable guidance empowers caregivers to navigate the complexities of their roles and seek support when needed. Additionally, tailored training improves skills and confidence. Emotional support mechanisms are also crucial because they help reduce the psychological and physical strain of caregiving, ensuring that caregivers are better prepared to sustain their efforts in the long term.

5.2.1 Information services have recently emerged, but counseling remains scarce

Information campaigns raise awareness about the challenges faced by unpaid caregivers and the support resources available to them. They can also promote societal recognition of the role of caregiving. Information for family caregivers is possibly the foundational element for providing support and is particularly important because people might not think of themselves as family caregivers. They often transition into the role gradually, without realizing it, which means they may be unaware of the support measures designed for them.

Several countries have conducted informational campaigns. While they have mostly focused on caregivers for children, they have also helped spotlight caregiving for people with disabilities and older people. Argentina's former Ministry of Women, Gender and Diversity provided good examples, with the "Let's Count the Carers"[55] and "Care in Equality"[56] campaigns in 2021–2022. Chile and Ecuador (Quito) also ran campaigns to acknowledge the work of unpaid carers in 2023: "Let's Make the Invisible Visible"[57] and "Care for Those Who Care for You,"[58] respectively (Quito Informa 2024). In Costa Rica, the campaign "Take Care of Yourself to Provide Good Care"[59]

55. *Contemos los Cuidadores.*

56. *Cuidar en Igualdad,* a national campaign by Argentina's Ministry of Justice. See: www.argentina.gob.ar/generos/cuidados/camp-nac-cuidar-en-igualdad.

57. *Hagamos visible lo invisible.* See the video posted by Red Local de Apoyos y Cuidados on Nov. 7, 2023 at www.youtube.com/watch?v=37zwYR-BvHUY.

58. *Cuida a quien te cuida.*

59. *Cuidate para Cuidar Bien.*

implemented by the Joint Social Welfare Institute,[60] offered information on the importance of respite services and the available programs. These include the Cared-for Caregiver[61] program run by the Costa Rican Social Security Fund[62] and workshops on self-esteem and empowerment.

Information campaigns can be complemented by online information hubs that give caregivers access to detailed information on their rights, entitlements, and the support services they can access. The Joint Social Welfare Institute in Costa Rica[63] and the Mexican Social Security Institute[64] have developed examples of such information hubs.

Registries of unpaid caregivers go one step further than informational campaigns, since they not only provide information but also collect data that can be used to tailor support for caregivers. Currently, only Chile (Social Registry of Households) and Costa Rica (Law 10.192) have national systems where family caregivers can register to gain preferential access to public services.[65] In Brazil, the state of Paraná has started building a registry as part of the Paraná, Friend to Older People[66] program. Colombia and Peru have similar plans (Comisión de la Mujer y la Familia 2024; Ministerio de Igualdad y Equidad de Colombia 2024; Congreso de la República del Perú 2024).

A few countries offer some psychosocial services and counseling to caregivers. These services equip caregivers with coping strategies, such as self-care, stress management, problem-solving, and decision-making guidance, enhancing caregivers' emotional well-being and improving care quality (Brimblecombe et al. 2018; Larkin et al. 2019). Brazil has some pioneering initiatives at both the national and state levels. At the national level, care recipients' families can receive psychological support services via the Better at Home program of the Ministry of Health[67] (OECD-IDB Long-Term Care Workforce Questionnaire). At the state level, Bahia's Caregiver Support Program targets vulnerable informal caregivers and offers them respite care, acupuncture, meditation,

60. *Instituto Mixto de Ayuda Social.*
61. *Cuidador Cuidado.*
62. *Caja Costarricense del Seguro Social.*
63. See www.imas.go.cr/cuidateparacuidarbien for more information.
64. *Instituto Mexicano del Seguro Social.* See www.imss.gob.mx/personamayor/cuidados/personas-cuidadoras.
65. See https://registrosocial.gob.cl/cuidados.
66. *Paraná amigo da pessoa idosa.*
67. Brazil's Better at Home (Melhor em Casa) initiative is part of the innovative Compassionate Communities approach to care promoted by the Ministry of Health. It mobilizes civil society and health services to create community support networks for those facing frailty, life-threatening illness, or grief, emphasizing that care is a shared societal responsibility that extends beyond traditional clinical limits. See: https://www.gov.br/saude/pt-br/composicao/saes/cuidados-paliativos/comunidades-compassivas.

psychoeducational and therapeutic group sessions, and individual counseling.[68] Peru and Colombia implement similar initiatives through their ministries of health (OECD-IDB Long-Term Care Workforce Questionnaire; Ministerio de Salud y Protección Social de Colombia 2022).

5.2.2 Training for family caregivers is available in more than half of the countries

As seen in **Chapter 3**, family caregivers often lack training, which can increase their emotional strain and diminish the quality of their care. Training should cover a wide range of topics, including appropriate ways of interacting with people with dementia, responding to aggression, managing medication intake, and safely lifting individuals without risk of injury to carers or care recipients (Cès et al. 2019). Training should also include relational skills (such as end-of-life support and dealing with depression), self-care, and tools to help family caregivers rejoin the workforce after their care responsibilities have ended. Finally, training programs should adopt a person-centered care approach by equipping caregivers to build meaningful relationships with care recipients, supporting care recipients' autonomy in daily activities, encouraging their involvement in decision-making, and promoting engagement in purposeful activities. This approach is essential to fostering the well-being of both care recipients and their family caregivers (see **Section 7.2**).

In Latin America and the Caribbean, the scope, duration, and modality of training for unpaid caregivers vary widely (**Table 5.1**). Comprehensive training is only available in a few countries. In Chile, the National Training and Employment Service[69] offers a 140-hour comprehensive program for caregivers for older people. In Medellin, Colombia, there is a 120-hour Diploma in Training for Caregivers of Older People.[70] Also, Hospital das Clínicas of the Federal University of Minas Gerais in Brazil[71] and the Mexican Social Security Institute both offer courses for caregivers for frail older people.[72]

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68. Information from the presentation delivered at the 11th meeting of the Long-Term Care Policy Network in Latin America and the Caribbean (RedCUIDAR+): see https://vimeo.com/1040202108. The program targets informal caregivers enrolled in the Model State Health Care Center for Older People (Centro de Referência Estadual de Atenção à Saúde do Idoso—CREASI), run by the Ministry of Health. See www.saude.ba.gov.br/atencao-a-saude/comofuncionaosus/centros-de-referencia/creasi/.

69. *Servicio Nacional de Capacitación y Empleo.*

70. *Diplomado de cuidadores de personas mayores.*

71. *Universidade Federal de Minas Gerais.*

72. See: https://www.gov.br/ebserh/pt-br/hospitais-universitarios/regiao-sudeste/hc-ufmg/comunicacao/noticias/inscricoes-para-curso-de-cuidador-de-idosos-estao-abertas.

Other countries offer shorter training. Ecuador has the Certification for Informal Caregivers of Older Adults[73] offered by the School of Medicine at the University of San Francisco in Quito, which costs US$250 and lasts two months. In Colombia, Antioquia University and Pontificia Javeriana University offer 20-hour training programs for family caregivers (Gómez 2023; Pontificia Universidad Javeriana n.d.). In addition, Chile's Severe Care Dependency Program[74] offers a 15-hour training course for both care recipients and their families (ChileAtiende 2024). In Mexico, both the National Institute of Geriatrics[75] and the Social Security Institution for State Employees[76]—in partnership with the National Autonomous University of Mexico—offer short online training programs.[77] Thus far, Costa Rica has focused on self-care training, provided through the Cuidar.cr web portal.

Training is sometimes offered as part of a home care service program. This is the case, for instance, of Mexico's Health in Your Home[78] program and Peru's Home Care Program[79] (OECD-IDB Long-Term Care Workforce Questionnaire). The Peruvian program also offers a four-week specialized workshop sharing practical knowledge about caring for older adults. This program focuses on major conditions affecting older people and teaches essential home care techniques (EsSalud 2015).

Most training programs for family caregivers are free. In some cases, especially for longer courses, they even include compensation for the time spent. In Chile, those participating in the 140-hour National Training and Employment Service course are eligible for a daily attendance subsidy of CLP$4,000 (US$4.25), plus a top-up of CLP$5,000 (US$5.31) if they are caring for a severely care-dependent person (SENCE n.d.). Participants are also entitled to accident insurance, and those who complete the training are eligible for an additional subsidy worth CLP$360,000 (US$382.76) for training tools and supplies. In Medellín (Colombia), those who complete the 120-hour diploma for family caregivers qualify for a subsidy worth COL$1,323,174 (US$316.17) (Galvis 2023). Lastly, in Barbados, the Care of the Elderly skills training program offers participants who attend all sessions a stipend of BB$125 (US$63.62) per week.

73. *Certificación para Cuidadores Informales de Adultos Mayores.*
74. *Programa de Atención Domiciliaria para Personas con Dependencia Severa.*
75. *Instituto Nacional de Geriatría.*
76. *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado.*
77. See https://www.gob.mx/issste/prensa/issste-y-unam-disenan-exitoso-curso-para-cuidadores-de-personas-envejecidas and https://www.gob.mx/inger/acciones-y-programas/curso-basico-de-cuidadores for more information.
78. See: https://www.salud.cdmx.gob.mx/servicios/servicio/salud-en-tu-casa.
79. *Programa de Atención Domiciliaria.*

Recently, there have been initiatives to certify family caregivers at the end of training to ensure they possess the basic qualifications and competencies required to perform their tasks. Beyond quality assurance, certification also helps build recognition for informal caregivers' vital role in society and the economy (Llena-Nozal et al. 2022). Certifying family caregivers can be considered a step toward professionalizing care work, since it can encourage further training and open pathways to employment in the long-term care, healthcare, or social sectors. In the region, this practice is incipient but growing. For example, Colombia's virtual program "You Get Care, I Get Certified,"[80] which lasts four to six weeks, allows family carers to certify their skills (SENA 2024).

80. *Te cuido y me certifico.*

TABLE 5.1 TRAINING AND CERTIFICATIONS AVAILABLE IN LATIN AMERICAN AND CARIBBEAN COUNTRIES

COUNTRY	TRAINING	ORGANIZER	TARGET GROUP AND ELIGIBILITY	DURATION	OTHER INFORMATION (CONTENT, MODALITY, COST)
Barbados	Skills Training Program: Care of the Elderly	Barbados Vocational Training Board	>16 years old, completed nine years of formal education	2 semesters	Free for Barbadian nationals, non-nationals pay a course fee. Stipend of BB$125 per week if participant attends all sessions. Content: bathing, dressing, cooking, cardiopulmonary resuscitation (CPR), basic first aid
Brazil	Fundamentals of Caring for Frail Older People: Caregivers for Older People Program (Fundamentos do Cuidado com o Idoso Frágil: Programa Cuidador de Idosos)	Hospital das Clínicas of the Federal University of Minas Gerais, administered by the Brazilian Hospital Services Company (Empresa Brasileira de Serviços Hospitalares), and the Unimed Foundation (Fundação Unimed), in partnership with the Public Ministry of Labor	> 18 years old	60 hours over three months	Online, free of charge, including access to the Caregiver Kit for Frail Older People (with materials on care and health for older people) Taught by a doctor, nurse, psychologist, and social worker
Chile	Comprehensive Basic Care for Older People (Cuidados básicos integrales para personas mayores)	Ministry of Labor and Social Security, through the National Training and Employment Service (Servicio Nacional de Capacitación y Empleo)	>16 years old, from a household among the 60% of the population with the lowest income or highest socio-economic vulnerability at the national level, according to the Social Registry of Households No requirements for migrants	140 hours	Includes a daily attendance allowance of CLP$4,000, accident insurance, tools allowance valued at CLP$360,000 for those who complete the training, and an additional care subsidy of CLP$5,000 per day for those caring for severely care-dependent people
	Home Care for the Severely Care-Dependent Program (Programa de Atención Domiciliaria para Personas con Dependencia Severa)	Ministry of Health	Caregivers for people registered at a primary care health center, classified as severely care-dependent (Barthel index), part of the Severe Care Dependency Program	<15 hours	Tailored to individual needs, focus on learning by doing Available year-round with no enrollment limits

COUNTRY	TRAINING	ORGANIZER	TARGET GROUP AND ELIGIBILITY	DURATION	OTHER INFORMATION (CONTENT, MODALITY, COST)
Colombia	National Certification: You Get Care, I Get Certified (Yo te cuido y me certifico)	National Learning Service (Servicio Nacional de Aprendizaje)	>18 years old, identity card (citizenship, foreigner's identity card, or the Temporary Protection Permit) and at least 6 months of experience in the work to be certified	4 to 6 weeks	Online recognition of prior learning program
	Diploma in Training for Caregivers of Older People (Diplomado de cuidadores de personas mayores)	Municipality of Medellin, University of Antioquia, School of Medicine	Informal caregivers	120 hours	Addresses personal aspects, family, health, recreational and social aspects, mental health, family and aging Additional benefits: educational kits, first aid kits, hygiene kits, basic and primary care kits
	Course on Elder Care for Informal Caregivers (Cuidado al adulto mayor para cuidadores no formales)	Pontificia Javeriana University and University of Antioquia School of Medicine	Non-formal caregivers for older people (family and non-family carers)	20 hours	Javeriana: Online. Cost: COL$352 000 (US$83.87) Antioquia: free
Ecuador	Certification for Informal Cargivers for Older People (Certificación para Cuidadores Informales de Adultos Mayores)	University of San Francisco in Quito	Informal carers	2 months	Online. Cost: US$250 Content: caring for older people and self-care
Jamaica	Older Adult Caregiver Training Program	MONA aging center	Caregivers, family members of older people, older people, and anyone interested in providing care for older people	<20 hours	Provide information and skills on caring for older people, insights on the aging process Two new courses planned: Understanding Mental Health and First Aid and CPR

COUNTRY	TRAINING	ORGANIZER	TARGET GROUP AND ELIGIBILITY	DURATION	OTHER INFORMATION (CONTENT, MODALITY, COST)
Mexico	Health in your home (Salud en tu Casa) patient and caregiver training	Health Secretary of Mexico City	Affiliation with Mexico City's Free Medical Services and Medicine program	Tailored to each household's needs	Health professional brigades visit households in the 16 municipalities of Mexico City, assessing patients and caregivers Training on health issues and follow-up for patients and caregivers
	Workshop for informal carers	Mexican Social Security Institute	Caregivers who provide support for activities of daily living for older people	-	Face-to-face workshops Content: developing a care plan; daily care, observation, and physician support; geriatric syndromes and how to manage them; providing medications, nutrition, and well-being; sleep and rest for older adults; dressing, bathing, and other care, moving around and transportation; ADLs; support to prevent caregiver collapse
	Initial training for caregivers of older people	Mexican Social Security Institute	Open to everyone	40 hours	Massive online course: Theoretical and practical elements to improve care for older people Modules: Care plan, hygiene and care, feeding, exercise, mobility, support in pharmaceutical treatments, caring for caregivers
	Training Program (Programa de Capacitación)	National Institute for Older People (Instituto Nacional de las Personas Adultas Mayores)	Caregivers	5 hours every Friday	Theoretical and practical tools, mainly on the equitable distribution of care for older people and self-care
Peru	Home Care Program (Programa de Atención Domiciliaria)	Social Security for Health (Seguro Social de Salud—EsSalud)	Family caregivers	4 weeks	Individualized support for family caregivers

Source: OECD-IDB Long-Term Care Workforce Questionnaire, complemented with: Governo do Brasil (n.d); UNASUS (n.d.); Ministério da Educação (2016); ChileAtiende (2024); SENCE (n.d.); Pontificia Universidad Javeriana (n.d.); SENA (2024); Gómez (2023); Galvis (2023); UWI (2019); SEDESA (2023); IMSS (n.d.); Gobierno de Mexico (2017); Tobago House of Assembly (2024).

5.3 Few policies are in place to reduce the economic impact of caregiving

Financial support for family caregivers is particularly important for low-income families and for those who have to leave their jobs to provide care. This support helps protect them from poverty, as income support for family caregivers offsets lost wages. Additional measures are needed to ensure these caregivers' participation in social security and protect them from the risk of old-age poverty.

5.3.1 A few limited cash benefits exist for family caregivers

At the national level, only Chile and Costa Rica offer financial support to family caregivers to alleviate the economic impacts associated with providing care (**Table 5.2**). In Chile, the Ministry of Health implements a home care program for people who are severely dependent on care. This program offers a monthly cash transfer of CLP$32,991 (US$35.07) to unemployed caregivers from socially vulnerable households (ChileAtiende 2024). In Costa Rica, persons who provide care to severely care-dependent older people are eligible to receive a transfer of US$184 per month if they are over age 55, are heads of household, and live in poverty or extreme poverty (IMAS 2020b). Also, as part of the Care for Families program of the Joint Social Welfare Institute, vulnerable families can receive assistance (up to twice per year) for technical tools or medicines for people with chronic, degenerative, or terminal illnesses or disabilities.

At the local level, Mexico has several examples of cash benefits for family caregivers: in Mexico City, in the municipality of Cuauhtémoc, and in the state of Coahuila. In Brazil, the state of Paraná has approved a monthly stipend for family caregivers of older people, as part of the Paraná, Friend to Older People program. Implementation is planned to begin in December 2025.

TABLE 5.2 CASH TRANSFERS FOR INFORMAL CARERS

COUNTRY	NAME OF CASH BENEFIT	CASH RECIPIENT	AMOUNT
Brazil (Paraná)	Family Caregiver Stipend (Bolsa Cuidador Familiar)	Caregivers from vulnerable households caring for older people	Half of national minimum wage
Chile	Home Care Program for People with Severe Care Dependency (Programa de Atención Domiciliaria para personas con Dependencia Severa)	Unemployed caregivers from vulnerable households who are caring for severely dependent individuals	Maximum monthly payment of CLP$32,991
Costa Rica	Transfer for Caregiving (Transferencia por Cuidados), Joint Social Welfare Institute (Instituto Mixto de Ayuda Social)	Caregivers who head a poor household, are over age 55, and provide care for severely care-dependent people	US$184, monthly
	Care for Families (Atención a Familias), Joint Social Welfare Institute	Vulnerable families with members with a chronic, degenerative, or terminal illness, or with disabilities	Two payments per year—CRC$125,000 in April and CRC$100,000 in June—for purchasing technical support or medicines
Mexico	Municipality of Cuauhtémoc. Economic Support for Household Guardians Providing Care to Direct Relatives with Cognitive or Oncological Diseases or Disabilities 2024 (Apoyo Económico para Personas Guardianes del Hogar que Cuidan Familiares Directos con Enfermedades Cognitivas, Oncológicas o Discapacidad 2024)	Caregivers in a situation of vulnerability who reside in the Cuauhtémoc municipality and provide care to immediate family members	MXN$1,800, monthly (US$93)
	Coahuila. Integral Well-Being for Older People Program (Programa Bienestar Integral del Adulto Mayor)	People over age 60 in a situation of vulnerability	Single cash payment at the end of the fiscal year, and a monthly stipend for caregivers

Source: OECD-IDB Long-Term Care Workforce Questionnaire; Dirección de Desarrollo Social (2023); INAPAM (2021); Gobierno de Colombia (n.d.); IMAS (2020a); IMAS (2020b); Observatory of Social Development/Pacific Alliance (2022); ChileAtiende (2024); Ministerio de Inclusión y Economía Social de Ecuador (n.d.); PROASOL (n.d.).
Note: this table focuses on transfers that explicitly target family caregivers. It does not include cash benefits conditional on the purchase of formal care services.

5.3.2 Other countries have developed different types of support for family caregivers

Countries in the region have found other creative ways to support family carers with their limited funding for long-term care. In Colombia, Bogotá has developed the Care Blocks program, described in more detail in the next section. Among other services, this program helps caregivers continue with their studies to reduce the long-term economic impact of caregiving.

The Costa Rican Care Network,[81] a "progressive network for comprehensive care for older people," coordinates initiatives by individuals, families, organized community groups, non-governmental organizations, and state institutions.[82] It is implemented locally, in cantons or communities where various actors are interested in and committed to forming the social structure needed to carry it out (CONAPAM 2023).

5.4 Policies to improve family caregivers' work-life balance are scarce

Leave for providing long-term care, flexible work arrangements, and respite services can help people combine unpaid care and employment, thus reducing the economic impact of unpaid caregiving. If these policies are effectively implemented for both men and women, they may also help address the gender inequality in caregiving.

5.4.1 Only a few countries have paid and unpaid leave for providing family care

Leave schemes that allow days off work explicitly for caring for older relatives exist only in Mexico, Ecuador, and Chile.[83] In a few other countries, the legislation allows employees to take leave days to care for sick relatives of any age. This is the case in Costa Rica, El Salvador, Honduras, and Peru (Güezmes García and Vaeza 2023). Brazil and Peru are working towards including leave options in their national care policies.

Where specific family care leave is not available, employees have to rely on more general leave schemes, such as personal or emergency leave days, to bridge care periods. Barbados has a personal unpaid leave scheme of six to 12 months for personal reasons. Shorter paid emergency leaves are available, for example, in Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Paraguay, Peru, and Uruguay (ILO 2022). These special leaves for urgent family reasons are short (no more than a few days) and can be paid or unpaid. Under national laws, employees may be entitled to emergency leave in situations such as an accident or sudden illness of a family member or during significant family events like births or deaths.

81. *Red de Cuidado.*

82. The network provides long-term care services: basic and specialized home care, community housing, and up to two years of residential care. It also provides support with administrative procedures and subsidies for food, hygiene, technical aids, and home equipment and improvements.

83. See: https://webapps.ilo.org/globalcare/.

Peru has approved a law (30795/2018) that allows workers who care for family members with diseases like Alzheimer's and other dementias to take leave without risking being penalized or having their pay reduced.

Flexible work arrangements are available in three countries, and others are considering them. These schemes are another way to help caregivers reconcile work responsibilities with caregiving duties. In Chile, for example, teleworking is available to those who care for an older person.[84] In Costa Rica, the option is available to caregivers for people with disabilities, but efforts are underway to include caregivers for older people. In Peru, the 2022 teleworking regulation has given all public- and private-sector workers the choice to adopt this employment modality. The aim is to make it easier for them to accompany and provide timely care to more vulnerable individuals (Congreso de la República del Perú 2022).

5.4.2 The availability of respite care is mixed across and within countries

Respite care services give unpaid carers a break from normal caregiving duties. They support caregivers' physical and mental health and help address social isolation. Evidence from high-income countries shows that uptake of these services is high only when they are high-quality, accessible, affordable, and adjusted to the needs of unpaid caregivers. The most common forms of respite care include residential, day, or home care services. They vary in duration and frequency: some services only offer short stays (for example, in day-care centers) while others offer the option of longer stays (for example, in residential care facilities for caregiver vacations or illnesses). Respite services are limited in time, on-demand, and serve as relief during specific dates or events.

There are a few examples of respite care services in Latin America and the Caribbean.[85] In Chile, for example, respite services are offered through Chile Cares, a program currently implemented in 151 out of 345 municipalities. All services available under the umbrella of Chile Cares must be coordinated and interlinked by a coordinating program known as the Local Support and Care Network Program.[86] As part of this program, socially vulnerable family members provid-

84. Work Reconciliation Law 21645 (2023), Chile.

85. All home or institutional long-term care services that do not require the presence of a family caregiver also provide respite. This report does not describe the long-term care services available in the region because it focuses on caregivers. This section gives examples of services that provide respite for a limited time, focusing on caregivers more than care recipients. These services can be seen as complementary to more intensive long-term care services that primarily focus on care recipients or focus equally on care recipients and caregivers.

86. *Red Local de Apoyos y Cuidados.*

ing care to people with moderate or severe functional dependence can access an average of two home visits by a personal assistant per week, each lasting four hours (Gobierno de Chile/ Dirección Sociocultural 2016; Ministerio de Desarrollo Social y Familia de Chile 2024a; Molina et al. 2020). At the sub-national level, Las Condes municipality in Chile offers a respite service for unemployed individuals who are permanently caring for a family member with severe physical or cognitive dependency. The caregiver must have a high risk of caregiver stress, be unable to meet their own needs, and lack opportunities for self-care due to the demands of their caregiving responsibilities. On the one hand, care recipients are taken care of via regular visits from a multidisciplinary team (physical therapist, speech therapist, psychologist, social worker, and nursing technician); on the other, caregivers are monitored two to three times a week and one weekend per month and receive biweekly team visits, depending on the results of the evaluation in each case.[87] Respite services are also implemented in Costa Rica.[88]

There are two other examples at the municipal level. Bogotá, Colombia, has Care Blocks across the city that concentrate various care services, allowing people to access them within a 20-minute walk. The program targets caregivers (particularly women) and their families and offers them activities and workshops that promote personal, physical, and intellectual growth while their older care recipients are cared for. The Care Blocks also enable participants to complete high school and receive medical consultations and psycho-legal advice.[89] There are currently 25 of these spaces in Bogotá.[90] Mexico City is replicating the Care Blocks experience through a program called Utopias.[91] Also in Mexico, the Social Security Institute has recently started to offer respite through subsidized tourist trips for caregivers and care recipients. It also uses these trips to provide information and counseling related to long-term care.

87. See https://www.lascondes.cl/inicia-programa-el-respiro-para-apoyar-a-cuidadores-de-adultos-mayores/ for more information.
88. See https://www.imas.go.cr/cuidateparacuidarbien/servicios-de-respiro.html.
89. See https://manzanasdelcuidado.gov.co/ for more details.
90. See https://manzanasdelcuidado.gov.co/donde-encontrarlas/.
91. *Utopías.*

6 Building a Sustainable and Competent Long-Term Care Workforce

The formal long-term care workforce is relatively small in Latin America and the Caribbean, and, as explained in **Chapter 2**, population aging will soon put additional pressure on it. Worldwide, low wages, precarious working conditions, lack of societal recognition, and limited opportunities for career advancement make the profession unattractive, leading to retention problems and high turnover (Vadean and Saloniki 2020; Hussein et al. 2016). High turnover, in turn, is associated with lower quality of care and increased mortality rates among nursing home residents (Akosa et al. 2016).

This chapter presents a comprehensive overview of the policies in place to improve the working conditions, well-being, and training of paid workers in the region's long-term care sector. The analysis highlights the diversity of countries' approaches and underscores the critical importance of continued investment and policy innovation to strengthen the formal long-term care workforce.[92]

6.1 Employment regulations influence the long-term care sector

Employment regulations shape the relationship between employers and employees and delimit both parties' rights and responsibilities. They define worker profiles for each sector and regulate aspects such as maximum working hours, minimum wages, benefits, social protection coverage, and workplace safety. The objective is to promote decent work, where international labor standards, social protection, and workers' fundamental rights go hand in hand with job creation.

Many countries lack a clear definition of the long-term care sector and official recognition of the care worker profession, which is a challenge for designing and implementing regulations and laws specific to the sector. Without sector-specific laws, long-term care workers are often governed by general employment regulations or, in the case of home care workers, domestic work regulations. This section therefore describes employment regulations in the region that apply to long-term care workers, whether or not they were designed explicitly for those workers. Several regulations also cover paid workers without a formal contract, but this chapter does not provide an exhaustive account of these policies.

92. Part of the information presented in this chapter was collected through interviews with government representatives and experts (see **Introduction**). This information is referenced to as OECD-IDB Long-Term Care Workforce Questionnaire.

6.1.1 Most countries regulate long-term care through labor laws rather than sector-specific legislation

Eight out of seventeen Latin American and Caribbean countries included in this analysis have included policies regulating the status of long-term care workers within national care policies and plans (Colombia, Costa Rica, Ecuador, El Salvador, the Dominican Republic, and Uruguay) or within national policies on aging (Barbados and Trinidad and Tobago). Also, all countries analyzed have broader policies applicable to all workers in the formal economy, which indirectly impact long-term care workers through regulations on minimum wages, employment protection, safety standards, and the right to training.

The content of the specific-sector long-term care regulations that are in place varies widely (**Table 6.1**). The regulations generally cover four areas:

1. Labor rights and working conditions. Countries have enacted policies to regulate labor rights for formally employed caregivers. Examples include minimum wage standards in Costa Rica and Uruguay, sectoral collective agreements for hospital and care staff in Argentina and Uruguay, and protections under employment rights acts in Argentina, Barbados, and Honduras. Colombia, Barbados, and Argentina also more broadly regulate labor rights and working conditions for all types of care staff.

2. Safety standards and quality of care. Bolivia, Brazil, Costa Rica, Chile, Colombia, Ecuador, Guyana, Uruguay, and Argentina have implemented measures to ensure the safety and quality of care in residential care facilities. Barbados ensures health and safety compliance under the Safety and Health at Work Act and the Health Services Regulations. Guyana's training for healthcare workers also aims to improve care quality.

3. Caregiver training. Several countries (e.g., Chile, Guyana, and Uruguay) have chosen to regulate caregiving training via laws or as part of their national care and aging plans. They aim to harmonize the availability, quality, or access to training for carers and, in the long term, to professionalize caregiving and address labor shortages.

4. Productivity. Some countries are making efforts to increase the productivity of long-term care workers by using technology and improving coordination between social, health, and long-term care workers.

TABLE 6.1 LEGISLATION AND REGULATIONS AFFECTING LONG-TERM CARE WORKERS

COUNTRY	POLICIES, REGULATIONS, AND AGREEMENTS	INSTITUTION RESPONSIBLE	POLICY FOCUS	TYPE OF CARE COVERED
Argentina	Labor Regulations for People Who Carry Out Home Care and/or Multipurpose Activities, 2021 (Mendoza, Río Negro, Entre Ríos, and Chaco provinces, government of the City of Buenos Aires)	Former Ministry of Women, Gender, and Diversity	Labor rights and working conditions	Home, day, and residential care
	Law I - No. 5670: Establishments for Older People (Buenos Aires), 2016	Ministry of Health of the City of Buenos Aires	Labor rights and working conditions, safety standards and quality of care, training	Residential and day care
	National Law No. 26844 of 2013: Special Employment Contract Regulations for Private Household Staff	Ministry of Labor, Employment and Social Security	Labor rights and working conditions	Home care
	Resolution 3315 /2023: Guidelines for Organizing and Operating Residential Care Facilities for Older People	Ministry of Health	Safety standards and quality of care, labor rights and working conditions	Residential and day care
Barbados	National Policy on Ageing: Making Healthy and Active Ageing a Reality for all (2022–2033)	Ministry of People Empowerment and Elder Affairs	Labor rights and working conditions	Paid (institutional) and unpaid care
	Health Services Regulations, 2005	Ministry of Health	Labor rights and working conditions, safety standards and quality of care	Residential care (nursing homes)
Bolivia	Resolution No. 002/2021: Basic Standards for the Care of Older People in Long-Stay Care Centers	Ministry of Justice and Institutional Transparency	Safety standards and quality of care, labor rights and working conditions	Residential care
Brazil	Law 15069: National Care Policy, 2024	Ministry of Development and Social Assistance, Family and Fight against Hunger; Ministry of Women; and Ministry of Human Rights and Citizenship	Labor rights and working conditions, training	Paid and unpaid care
	Board Resolution No. 502: Operating Institutions for the Long-Term Care of Older People, 2021	Ministry of Health	Labor rights and working conditions, safety standards and quality of care	Residential care
Chile	Bill No. 16905-31, which recognizes the right to care and establishes the National Support and Care System (first constitutional procedure) 2024	Ministry of Social Development and Family; Ministry of Finance; Ministry of Women and Gender Equity	Labor rights and working conditions, training	Paid and unpaid care
	Decree 20 of Law 19828: Regulations on Long-Stay Establishments for Older People, 2021	Ministry of Health	Labor rights and working conditions, safety standards and quality of care	Residential care

COUNTRY	POLICIES, REGULATIONS, AND AGREEMENTS	INSTITUTION RESPONSIBLE	POLICY FOCUS	TYPE OF CARE COVERED
Colombia	Law 2281 of 2023: Including the creation of the National Care System	Ministry of Equality and Equity	Labor rights and working conditions	Paid and unpaid care
	Law 1251/08: Whereby regulations are issued to ensure the protection, promotion, and defense of the rights of older people	Ministry of Social Protection	Training	Paid and unpaid care
	Decree 681: National Public Policy on Aging and Old Age 2022–2031	Ministry of Health and Social Protection	Training	Paid and unpaid care
	Law 1315: Minimum Conditions for Older People's Stays in Protection Centers, Day Centers, and Care Institutions, 2009	Ministry of Social Protection	Labor rights and working conditions, safety standards and quality of care	Residential and day care
	Law 2297/2023, by which effective and timely measures are established for the benefit of the autonomy of persons with disabilities and their caregivers or personal assistants	Ministry of Health and Social Protection	Training and working conditions	Paid and unpaid care
Costa Rica	Law 10192: Creation of the National Care and Support System for Care-Dependent Adults and Older People, 2022	Ministry of Human Development and Social Inclusion	Labor rights and working conditions, training	Paid and unpaid care
	National Strategy for Healthy Aging 2022–2026	Ministry of Health	Labor rights and working conditions, training	Paid and unpaid care
	Executive Decree No. 44730-S: Standard for Authorizing Long-Stay Homes for the Comprehensive Care of Older People, 2024	Ministry of Health	Safety standards and quality of care, labor rights and working conditions	Residential care
	Minimum Wage Decree	Ministry of Labor and Social Security; National Wages Council	Labor rights and working conditions	Formal care
Dominican Republic	Bill for Creating National Care System (presented to the Human Rights Commission in December 2024)	National Secretariat for Care	Labor rights and working conditions, training	Paid and unpaid care
	National Wages Council Resolution number 11/2022: Minimum wage for domestic work	Ministry of Labor	Labor rights and working conditions	Domestic work
	Collective Agreement for Carers, 2023	National Federation of Women Workers; National Council for Older People	Labor rights and working conditions	Public sector
	Regulations for Comprehensive Care Centers for Older People	National Council for Older People	Safety standards and quality of care	Formal care
Ecuador	Technical Standard for Implementing and Providing Care Services for Older People, 2019	Ministry of Social and Economic Inclusion	Labor rights and working conditions, safety standards and quality of care	Residential, home, and day care
El Salvador	National Policy on Shared Responsibility for Care 2022–2030	Social Welfare Office	Safety standards and quality of care, training	Paid and unpaid care
Guyana	Minimum Standards for Care Facilities for Older People, 2017	Ministry of Social Protection	Labor rights and working conditions	Residential care

COUNTRY	POLICIES, REGULATIONS, AND AGREEMENTS	INSTITUTION RESPONSIBLE	POLICY FOCUS	TYPE OF CARE COVERED
Honduras	Comprehensive Law for the Protection of Older People and Retirees, 2007	Secretariat of Social Development	Safety standards and quality of care, training	Residential and daycare
Mexico	Draft Reform of the General Law on the National Care System, 2021	To be determined	Labor rights and working conditions, training	Paid and unpaid care
Peru	Supreme Decree No. 007/2018 of Law 30490 on older people	Ministry of Health; Ministry of Women and Vulnerable Populations	Labor rights and working conditions, safety standards and quality of care, training	Paid care (residential and daycare)
Trinidad and Tobago	National Policy on Ageing, 2006/7	Ministry of Health and of Social Development and Family Services	Safety standards and quality of care, training	Paid care
Uruguay	Law No. 19353: Creation of the National Integrated Care System, 2015	Ministry of Social Development	Labor rights and working conditions	Paid care
	Decree No. 117/016—Regulations of the Personal Assistant Service for Long-Term Care for People with Severe Care Dependency	Social Security Bank	Labor rights and working conditions	Paid care (domestic and residential care)
	Decree No. 356/016: Regulation, Authorization, and Oversight in Care Facilities for Older People	Ministry of Public Health	Labor rights and working conditions, safety standards and quality of care, training	Residential and day care
	Wage Council No. 21, Domestic Service	Ministry of Labor and Social Security	Labor rights and working conditions	Domestic work

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

The following sections provide a more detailed description of these policies, laws, and regulations affecting long-term care workers in the region.

6.2 Few countries strengthen labor rights through specific policies for long-term care workers

Labor rights, such as minimum wages, social protection policies, and sectoral collective agreements, enhance caregivers' working conditions by guaranteeing them a decent income and protection in the event of illness, disability, unemployment, and old age (Vadean and Allan 2020).

A current policymaking challenge is achieving an official definition and recognition of the long-term care worker profession. For example, until recently, in Jamaica, caregiving was not recognized as a formal job but is now included in the labor force statistics, covering paid per-

sonal care workers, many of whom were formerly domestic workers and have transitioned into full-time caregiving roles. Several countries officially recognize carers by including them in the public registries shown in **Table 6.4**. In general, a range of other formal professions provide long-term care in practice, such as nurses, assistant nurses, personal care workers, personal assistants, therapists, and domestic workers.[93]

6.2.1 In most countries, salaries in the long-term care sector are governed by general regulations

Laws regulating salary levels in the formal sector also affect long-term care workers' pay. Each country's laws set minimum wages and define how they should be periodically adjusted based on a benchmark (for example, the inflation rate). Since long-term care workers' salaries are often close to the minimum wage, these regulations are particularly significant for the sector.

A few countries have additional wage regulations that apply specifically to formal workers in the long-term care sector (**Table 6.2**). These regulations affect long-term care workers directly (in Uruguay, Argentina, and Costa Rica) or indirectly through regulations for domestic work (in Argentina, the Dominican Republic, and Uruguay).

TABLE 6.2 MINIMUM SALARIES AND ADJUSTMENTS

COUNTRY	POLICY	TYPE OF WORKER	TYPE OF MEASURE
Argentina	National Law No. 26844 of 2013: Special Employment Contract Regulations for Private Household Staff	Domestic workers who are private staff in households	Minimum salary, updated monthly. The recent increase in monthly salary from December 2024 to January 2025 was 1.2%
Costa Rica	Minimum Wage Decree	Private sector workers	Minimum salary for home assistants (¢15,983.96), updated annually. From 2024 to 2025, the increase was 2.37%
Dominican Republic	National Wages Council Resolution No. 11/2022	Domestic workers	Minimum salary of 10,000 pesos per month
Uruguay	Personal Assistant Program. Law 19353 and Decree 117/016	Personal assistants	Minimum salary ($U23,354 per month. This implies an hourly wage of $U292, which is more than twice the hourly national minimum wage of $U118)

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

93. While Colombia currently lacks specific research on its long-term care workforce, Law 2297 of 2023, though focused on disability, provides a framework of guiding principles for caregiving.

6.2.2 Countries indirectly tackle informality and the lack of social protection in long-term care

As seen in **Chapter 4**, the long-term care sector has widespread informality. In countries where caregivers are hired through a public program or system (like Brazil's Better at Home, Chile's Home Care Program for People with Severe Care Dependency,[94] Peru's Home Care Program, or Uruguay's National Integrated Care System home care programs), they are formally employed and contribute to social security. Similarly, workers at accredited and registered care institutions (residential or day care facilities) are usually hired formally. However, the number of caregivers hired through a public program or working in an accredited institution is relatively small, resulting in low overall levels of formal employment.

Some countries seek to increase formal employment through training strategies (discussed in **Section 6.4**). These are most effective when caregivers, once they finish training, are added to an official caregiver registry that gives them access to job opportunities. Argentina and Uruguay follow this practice.

Some countries also attempt to expand formal employment among home care workers indirectly through policies designed to formalize the domestic sector. Since 2007, Uruguay has implemented several measures to increase domestic workers' social security contributions, medical coverage, and access to parental leave.[95,96] Brazil and Argentina have taken similar steps (Global Deal 2023). In Argentina, a tripartite agreement led to a progressive increase in minimum wage for domestic workers, with a particular category including care workers. Jamaica has also introduced special social security contribution rules for domestic workers to ease their tax burden and promote formal employment. In Colombia, the National Care Policy plans to design and implement a roadmap to facilitate performing labor inspections and enrolling domestic workers in a national registry to guarantee their labor rights and fair compensation (OECD-IDB Long-Term Care Workforce questionnaire).

A few countries also provide incentives for formally employing household workers. Families that hire home care workers may avoid formal contracts to reduce administrative work and contain costs. To lower the administrative burden, Brazil and Colombia implemented platforms (the eSocial tool and Integrated Contributions Payment Form, respectively) that streamline the various labor, tax, and social security obligations from the employer-caregiver relationship. To reduce

94. *Programa de Atención Domiciliaria para personas con Dependencia Severa.*
95. Decree No. 224/007, Uruguay.
96. Law No. 19161 of November, 2013.

the financial cost of formalizing employment, Mexico and Argentina introduced tax deduction schemes for care-related expenses reported in annual income tax returns (ILO 2018). However, these measures remain limited in scope and impact.

6.2.3 Collective agreements and national registries can improve working conditions

The lack of an official definition of the caregiver profession is one reason why, in most countries, workers in the caregiving sector are not organized. The region has no major unions for caregivers, whose demands are often included alongside those of domestic workers. In this context, collective agreements are crucial to improving working conditions.

Low unionization rates and the fragmented workforce hinder the achievement of collective agreements in the long-term care sector. Many caregivers work in private homes or small facilities, making it difficult to organize and represent them effectively. High informal employment rates further weaken bargaining power and limit efforts to secure wages, benefits, and working conditions that are standardized across the sector. Only three countries in the region (Argentina,[97] the Dominican Republic, and Uruguay) have collective agreements impacting long-term care workers (see **Table 6.3** for details).

97. In Argentina, the Federation of Associations of Argentine Health Workers (Federación de Asociaciones de Trabajadores de la Sanidad Argentina) has two collective bargaining agreements that include caregivers working in different settings. Collective Bargaining Agreement 743/16 for Home Care and Home Hospitalization requires home care companies to formally hire all of their employees. Collective Bargaining Agreement 122/75 for Technical, Administrative, and Janitorial Staff at Clinics, Sanatoriums, Institutes with Inpatient Care, Long-Term Care Establishments, and Neuropsychiatric Sanatoriums has the same requirement for residential long-term care facilities. Its enforcement is high: 70% of these facilities have formally registered their employees (Ministerio de Salud de Argentina 2025). The latter agreement has two employee categories exclusive to residential long-term care facilities: "geriatric assistant" and "floor, outpatient office, and nursing home housekeeper."

TABLE 6.3 COLLECTIVE AGREEMENTS

COUNTRY	COLLECTIVE AGREEMENTS	AREAS OF FOCUS
Argentina	Collective Bargaining Agreement for Home Care and Home Hospitalization of the Federation of Associations of Argentine Health Workers (Convenio Colectivo de Trabajo Atención, Cuidado e Internación domiciliaria de la Federación de Asociaciones de Trabajadores de la Sanidad Argentina CCT 743/16), 2025 (renewed yearly)	Basic salary, maternity allowance, childcare benefit, solidarity fee
	Collective Bargaining Agreement for Technical, Administrative, and Janitorial Staff of Clinics, Sanatoriums, Institutes with Inpatient Care, Long-Term Care Establishments, and Neuropsychiatric Sanatoriums (Convenio Colectivo de Trabajo CCT 122/75 que comprende al Personal Técnico, Administrativo y de Maestranza de Clínicas, Sanatorios, Institutos con Internación, Establecimientos Geriátricos y Sanatorios de Neurosiquiatría. Federación de Asociaciones de Trabajadores de la Sanidad Argentina), 2025 (renewed yearly)	Basic salary, maternity allowance, solidarity fee
Dominican Republic	Collective Agreement, National Federation of Women Workers and National Council for Older People, 2023	Training for 200 care workers
Uruguay	Collective Agreement Group 15. Health Services. Decree 540/006. Nursing Homes and Residential Care Facilities for Older People (for-profit) (Casas de Salud y Residenciales de Ancianos (con fines de lucro)), 2006	Minimum salary, rest periods, biosecurity, night shifts, and uniforms
	Collective Provision Plan of the Personal Assistants Program (Plan de Provisión Colectiva del Programa Asistentes Personales), No. 117/2016	Collective responsibility and an integrated and humanized model of care, individualized care plan, registry of care providers, contractual frameworks, containment and support frameworks through association processes, new options for training and job placement

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

Official registries are another tool for bringing more recognition to the caregiving profession and making it more attractive. In addition to formally recognizing caregivers, registries can also inform them about job opportunities by matching them with potential employers. Registries can also be a source of information about training and other support services for caregivers.

Caregiver registries can also help employers and governments. For employers, they ensure that the person they hire meets the required professional standards (e.g., no history of abuse, neglect, or misconduct). Governments can use them to monitor the quality of care provided, enforce regulations in the caregiving sector, and track caregiver availability, demand, and shortages to plan future care needs.

Argentina, Costa Rica, and Uruguay have national registries (**Table 6.4**). Caregivers who meet the requirements (training, certification, and others) and wish to be officially recognized need to be enrolled. Peru also had plans to establish such a registry.[98] Registries can comprise care

98. 7893/2023-CR, 2023, Peru, legislative bill.

workers only, as in Argentina, or can be broader and include other public or private care services like institutional providers, as in Costa Rica and Uruguay.

In some cases, such as in Argentina, national registries can be a gateway to training. Those who have earned an 80- to 199-hour home carer's certificate can start the registration process. However, to appear in the registry, they must complete the recommended minimum training of 200 hours (see **Section 6.4**) by attending a standardized course.[99] In other cases, as in Costa Rica, registries offer information on self-care, training opportunities, and other public support services.[100]

TABLE 6.4 NATIONAL REGISTRIES OF FORMAL CAREGIVERS

COUNTRY	NATIONAL REGISTRIES OF CAREGIVERS AND CARE SERVICES	
Argentina	National Registry of Home Caregivers	Requirements: >18 years old, home caregiver certificate, ID card
Costa Rica	Cuidar.cr	Platform that facilitates communication, transactions, and management for care service providers and users, including at least: a directory of formal caregivers, an integrated portal of existing national care system services, and self-care management resources for caregiver well-being
Uruguay	National Care Registry	Open to: providers of long-term care services (home care and residential care facilities), day care services for children, day care services for older people and those with disabilities, home care services (e.g., personal assistants), remote care services (e.g., teleassistance), caregiver training services

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

99. *Curso curricular complementario.* See https://www.argentina.gob.ar/sites/default/files/presentacion_curso_ccc1_0.pdf for more details.
100. See https://www.imas.go.cr/es/comunicado/nueva-plataforma-digital-permite-acceder-servicios-de-cuido-para-personas-adultas-en.

6.3 Safety measures are common and improve workers' well-being, enhance retention, and increase the quality of care

Safety measures to prevent emotional and physical strain for caregivers are essential to improving worker well-being. They also boost retention by positively impacting job satisfaction and reducing health complaints (Miranda et al. 2011; Etti et al. 2025; Okros and Virga 2022). Additionally, these measures increase the quality of care. Health-related safety measures like regulations on how to lift older people without accidents and strain would be particularly important for carers but are not yet addressed beyond trainings that include safe handling practices.

Most countries have health and safety requirements for long-term care facilities (**Table 6.5**). These measures usually include capacity limits, mandatory authorization processes, detailed specifications for staff qualifications, resident-to-worker ratios, infrastructure requirements, and safety standards. In most countries, care providers are required to meet these standards to receive an operating permit.[101] Compliance inspections are conducted with different degrees of regularity.

101. Argentina has an ongoing program to improve the quality of care in public and private residential long-term care facilities. This program aims to improve processes, resource management, work quality, and older people's quality of life. Resolution 3315/2023 of the National Ministry of Health approved the document "Guidelines for Organizing and Operating Residential Care Facilities for Older People. Person-Centered Care Model," which includes Annexes V and VI, "Good Practices at Residential Long-Term Care Facilities and Tool for Self-Assessment of Good Practices for Quality Improvement" and "Processes for Recognizing Establishments Committed to Quality—Residential Long-Term Care Facilities." Section 2 of Annex V, "Human Resources," states that residential long-term care facilities must ensure sufficient quantity and quality of resources to provide the support and care that residents require. This intervention should foster interdisciplinary teams of competent technical and professional staff with the knowledge and ethical and relational attitudes to provide person-centered care. The National Ministry of Health has begun implementing this quality assessment tool through a pilot test in public and private nursing homes (Ministerio de Salud de Argentina 2025).

TABLE 6.5 HEALTH AND SAFETY MEASURES

COUNTRY	NAME	REGULATION	SECTOR COVERED
Argentina	Resolution 3315/2023 Guidelines for Organizing and Operating Residential Care Facilities for Older People	Infrastructure, materials, protocols, personnel (education, tasks), worker-to-residents ratio, questionnaire for self-assessment of quality of care	Residential care facilities and day care centers
	Law I - No. 5670 on Establishments for Older People of the City of Buenos Aires	Inspections	Private residential care facilities and day care centers
	Resolution RESOL-2023-896-INSSJP-DE#INSSJP - Comprehensive Care Program in Long-Stay Residential Facilities for Older People	Minimum standards for infrastructure, human resources, services, costs, and payments for residential long-term care facilities that are service providers for the National Institute of Social Services for Retirees and Pensioners	Residential care facilities and psycho-gerontological residential care facilities
Barbados	Health Services Regulations, 2005	Regulations on infrastructure for each type of establishment	All healthcare workers
Bolivia	Ministry of Health, National Health Surveillance Agency, Resolution No. 002/2021, Basic Standards for the Care of Older People in Long-Term Residential Facilities	Regulations on infrastructure, materials and services provided, inspections, and human resources	Residential care facilities
Brazil	Ministry of Health, Board Resolution No. 502, Operating Long-Term Care Institutions for Older People, 2021	Minimum standards on infrastructure, human resources, and safety conditions for workers	Residential care facilities
Chile	Regulations on Long-Stay Establishments for Older People, 2021	Minimum standards on infrastructure, safety conditions for workers, minimum required training, and number of care workers (title IV, art. 14–20)	Residential care facilities
Colombia	Law 1315 of 2009 Establishing the Minimum Conditions for a Decent Stay for Older People	Entry criteria, regulations on personnel	Protection centers, day centers, and residential care facilities
	Quality standards	Regulations on human resources, education, training, and the state of facilities	Day centers, geriatric homes, home care, and tele-assistance
Costa Rica	Executive Decree N° 44730-S: Standard for Authorizing Long-Stay Homes for the Comprehensive Care of Older People, 2024	Minimum requirements on human resources (qualifications, quantity of staff per specialty, etc.), safety/ infrastructure measures	Residential care facilities
Dominican Republic	Regulations for Comprehensive Care Centers for Older People	Minimum requirements for care centers	Residential care facilities, day care centers
Ecuador	Technical Standard for Implementing and Providing Care Services for Older People, 2018	Provisions on human resources (characteristics, management, change, hiring) and safety and quality measures	Day and residential care, home care, and social centers
El Salvador	National Policy on Shared Responsibility for Care 2022–2030	Provisions on expanding and improving the infrastructure of care centers for care-dependent individuals	Residential care facilities and day care
Honduras	Comprehensive Law for Protecting Older People and Retirees 2007	Training for technical and professional human resources, supervising organizations, human resources, infrastructure, and equipping institutions for caring for older people and retirees	Day care and residential care facilities

COUNTRY	NAME	REGULATION	SECTOR COVERED
Peru	Supreme Decree no 007/2018 of Law 30490 on Older People	Minimum standards on infrastructure, human resources, and hygiene	Day care and residential care facilities
Trinidad and Tobago	National Policy on Ageing, 2006/7	Healthcare and standards for hospitals and care facilities	Residential care facilities
Uruguay	Decree No. 356/016 Regulating, Authorizing, and Overseeing Services Providing Care for Older People	Regulations, authorization, and oversight of care facilities for older people based on geriatric criteria, ensuring compliance with sanitary conditions	Residential care facilities

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

An example of health and safety measures is staff ratios, which define the number of caregivers per resident. Proper staff ratios are crucial for ensuring that residents receive the care they need and preventing negative mental, physical, and emotional consequences for caregivers. However, there is no clear international agreement on appropriate staff ratios.

Ten countries in Latin America and the Caribbean regulate this issue (Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Peru, and Uruguay), as shown in **Table 6.6**. In most of them, the number of caregivers required increases with the residents' degree of care-dependence and varies depending on whether it is daytime or nighttime. For example, in Chile, there must be one caregiver per shift for every six older residents with severe care dependency, while the ratio is one to 12 during daytime and one to 15 at night for older people with mild or moderate care dependency. Similarly, in Bolivia, the required number of auxiliary nurses increases with the people's care dependency level: two for 20 residents with mild needs, five for 20 residents with moderate needs, and even more for more severe care dependency. In Colombia, staff ratios are set by the Ministry of Health and Social Protection based on the center's scope.[102] Ecuador has different ratios for caregivers in residential care facilities compared to those working in day care centers. The ratios are one to 10 during the day and one to 15 at night in residential facilities, compared to one to 35 in day care centers. Uruguay sets a staff ratio of one to 10 for day care centers. For residential care facilities, it sets a staff ratio of one staff member for every five care-dependent residents during the day, and one to 10 during night shifts. In Barbados, senior citizen homes require one caregiver per 10 residents, while nursing homes require one registered nurse per eight residents. In Peru, nursing homes require one caregiver for every 10 users, with the same ratio for day care centers. For night care centers, the number of caregivers depends on the center's needs.

102. Law 1315/2009.

Countries that establish staff ratios usually also set requirements for workforce composition. For example, for severely care-dependent residents in Argentina, the per-shift requirement is one licensed nurse for every 30 residents, one nursing assistant per seven residents, and one gerontological care assistant per 10 residents.[103] Other countries, such as Costa Rica, do not specify staff ratios but have rules regarding workforce composition at care facilities. For example, long-term care homes must have access to professionals in psychology, nutrition, physical therapy, occupational therapy, social work, general medicine, geriatric medicine, and dentistry.

TABLE 6.6 STAFF RATIOS AND REQUIREMENTS

COUNTRY	REGULATION ON STAFF RATIOS AND COMPOSITION	
Argentina	Resolution 3315/2023: Guidelines for Organizing and Operating Residential Care Facilities for Older People	Staffing requirements for long-term care institutions increase with residents' level of care dependency
Barbados	Health Services Regulations, 2005	Staffing requirements for senior citizen homes and nursing homes
Bolivia	Resolution No. 002/2021, Basic Standards for the Care of Older People in Long-Term Residential Facilities	Staffing requirements for long-term care institutions increase with residents' level of care dependency
Brazil	Ministry of Health, Board Resolution N° 502: Operating Long-Term Care Institutions for Older People, 2021	Staffing requirements for long-term care institutions increase with residents' level of care dependency
Chile	Regulations on Long-Stay Establishments for Older People, 2021	Staffing requirements for long-term care institutions increase with residents' level of care dependency
Colombia	Law 1315: Minimum Conditions for Older People's Stays in Protection Centers, Day Centers, and Care Institutions, 2009	Staffing requirements for long-term care institutions increase with residents' level of care dependency
Costa Rica	Executive Decree N° 44730-S on Establishing Long-Stay Homes for Older People, 2024	Staff composition in residential care homes
Ecuador	Technical Standard for Implementing and Providing Care Services for Older People, 2018	Staff requirements for day, home, residential care, and social centers
Peru	Supreme Decree No. 007/2018 of Law 30490 on Older People	Staff requirements for residential and day care centers
Uruguay	Decree No. 356/016 Regulating, Authorizing, and Overseeing Services Providing Care for Older People, Article 19	Staffing requirements for day care centers and residential care facilities increase with residents' level of care dependency

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

A significant challenge for the health and safety of care workers is defining and implementing measures in home settings. This is intrinsically difficult given the nature of the job, which is performed in the privacy of care recipients' homes.

103. Resolution 3315/2023, Argentina. Most provinces of Argentina have local regulations for operating long-term care facilities for older people, which usually define caregiver-to-resident ratios.

6.4 Countries build a sustainable long-term care workforce through skills development

One critical strategy for developing the long-term care workforce is providing, improving, and expanding training and education programs. Countries in the region have significantly improved the availability, accessibility, and content of training and education programs. As detailed in **Table D.1**, four of them have explicitly included improving and expanding training and certification opportunities in their care or aging policies: Colombia, El Salvador, Trinidad and Tobago, and Uruguay.

6.4.1 Countries in Latin America and the Caribbean still struggle to build caregivers' skills to match labor market demands

Matching workers' skills with skills demand in the long-term care sector remains challenging in the region. One reason is the lack of a clear definition of the caregiving profession (see **Section 6.2**), which makes it difficult to identify the necessary skills.

Many countries in the region have designed occupational profiles as a first step towards better-targeted and more standardized training

Countries often develop occupational profiles when they seek to identify and map the demand for specific skills in a specific profession. These profiles describe in detail the roles, duties, and job characteristics of specific occupations. They are usually developed based on experiences in the labor market (long-term care providers) and the characteristics of the population in need of services (age, prevalence of care needs, availability of family carers, etc.). For instance, a mildly care-dependent person living at home requires different skills and training than a severely care-dependent person living in a long-term care facility. Once a country defines an occupational profile, it can then develop competency frameworks and standardized curricula (see the following subsection) to steer the supply of skills toward labor market demands.

Several countries in the region already have occupational profiles for caregivers for older people (Argentina, Barbados, Brazil, Chile, Colombia, Ecuador, the Dominican Republic [public sector only], Mexico, Trinidad and Tobago, and Uruguay). These profiles are described in more detail in **Table 6.7**. El Salvador is in the process of developing a profile, in implementation of its National

Policy on Shared Responsibility for Care (ISDEMU 2024).[104] In addition, Bolivia and Mexico have developed an occupational profile for paid domestic workers with responsibilities that overlap with those of caregivers. Jamaica and Honduras have job profiles for medical staff only.

Argentina, Brazil, and Uruguay have the same occupational profile for both home and residential care workers, while other countries, like Mexico and Ecuador, define separate profiles for different services. Colombia has also defined two occupational profiles distinguished not by the work environment (home, residential) but by the focus of the care provided: personal care workers are more concerned with support in daily living activities, while institutional care workers are more concerned with health-related support and usually work under the supervision of healthcare personnel. The same distinction exists in Costa Rica. Some provinces in Argentina (Mendoza, Rio Negro, and Entre Ríos) defined specific occupational profiles for polyvalent caregivers, which are workers who can provide service in both care settings (homes, residential facilities) and healthcare settings. In other countries, caregivers' occupational profiles are tied to only one working environment: for example, to home care workers in Barbados and to residential care workers in Trinidad and Tobago.

Chile has gone one step further by outlining a path for career advancement for each profile (ranging from primary caregiver to residential care director) (ILO 2023). Chile is also working on defining new occupational profiles to add to the previous list, such as gerontological caregivers, social community assistants, and caregivers for individuals with severe care dependency.

TABLE 6.7 OCCUPATIONAL PROFILES

COUNTRY	OCCUPATIONAL PROFILE	SETTING	TASKS INCLUDED
Argentina	Caregiver for adults	Private homes, residential and non-residential care institutions	Assist people with ADLs and IADLs, administering medication or other health-related duties under the supervision of nursing or medical staff
	Polyvalent caregiver profiles in Mendoza, Río Negro, Entre Ríos, Chaco, and the city of Buenos Aires	Private homes and/ or public or private healthcare facilities	Support people with ADLs, IADLs, access to health services, and physiological needs; cooperate with health care workers and other professionals; inform older people and connect them with the community
Barbados	Home help workers	Private homes	Assist/ supervise people with ADLs, IADLs, and administer medication
Bolivia	Paid domestic worker	Private homes	Support people with ADLs, assistance to family members
Brazil	Caregiver for older people	Private homes and residential/day care settings	Support people with ADLs, IADLs; supervise medical treatments; social activities

104. Strategic line 6.

COUNTRY	OCCUPATIONAL PROFILE	SETTING	TASKS INCLUDED
Chile	Socio-community assistant	Non-governmental organizations, private and public facilities	Support people with socio-community assistance services
	Private home worker	Private homes	Support people with ADLs, IADLs
	Primary caregiver	Non-governmental organizations, private and public facilities	Support people with ADLs; provide primary care services
Colombia	Personal home care workers	Geriatric homes, residential care facilities, hospitals, clinics	Support people with ADLs; with physical and emotional health self-care, and with social activities
	Institutional personal care worker	Nursing homes, residential care facilities, hospitals, clinics	Support people with ADLs; provide personal care services under the supervision of doctors or mid-level healthcare professionals
Costa Rica	Home assistant for older people	Private homes	Administer medications; health monitoring; support people with ADLs and injections
	Nursing professional in comprehensive care services for older people	Private homes, day centers, and other care facilities for older people	The role of nurses in comprehensive care services for older adults was created to allow nursing professionals working in institutions to standardize and optimize their functions and professional competencies, aiming to increase the quality of services provided in these centers
Ecuador	Caregiver	Residential gerontological centers	Support people with ADLs, rehabilitation; administer medications, health monitoring
	Caregiver/workshop facilitator	Day care gerontological center	Support people with ADLs and social activities
Mexico	Caregiver for older people in institutions	Residential care facilities	Support people with ADLs, IADLs, rehabilitation, and cognitive stimulation
	Caregiver for older people in private homes	Private homes	Plan assistance and basic care activities; support basic and instrumental daily living activities; assist in health care at home
Trinidad and Tobago	Patient care assistant	Residential long-term care facilities and geriatric homes	Communicate in the workplace, work in a culturally diverse environment, follow the organization's health and safety policy, plan and organize work, support clients with activities of daily living, support assessment procedures for clients, help keep the environment clean, prepare and maintain beds, perform clinical measurements, apply basic first aid
Uruguay	Caregivers	Residential and home care settings	Assist people in situations of care dependency, emphasizing a rights-based approach that promotes personal autonomy and well-being; address basic, instrumental, and advanced needs of daily living, while ensuring service quality and improving care conditions

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

Many countries are also working to create competency frameworks

Competency frameworks define the core skills that workers in each occupational profile need in order to perform well. Occupational profiles thus form the basis for developing competency frameworks, which in turn can be used to design nationwide standardized curricula (see **Section 7.2**). Eight countries in the region already have competency frameworks for the long-term care sector: Argentina, Chile, Colombia, Costa Rica, Ecuador, Mexico, Uruguay, and Trinidad and Tobago. El Salvador is currently developing one.

The occupational profiles described above already include the competency frameworks for each specific occupation in Argentina, Chile, Colombia, and Uruguay. In other countries (Costa Rica,[105] Ecuador,[106] Mexico, and Trinidad and Tobago), competency frameworks are defined separately. The number and type of competencies vary by country. For example, Argentina and Uruguay both define five competency areas, but with very different approaches. Argentina chose cognitive, psychomotor, physical, sensory, and digital competencies, each weighted by its level of importance for the profession. Uruguay chose organizing resources to optimize care, supporting daily activities based on individual needs, promoting social integration, understanding care facility regulations, and ensuring knowledge of labor laws, with detailed descriptions of the skills, knowledge, and responsibilities required for each area.

Some countries define very distinct roles in the long-term care workforce, while others adopt a more unified framework across care settings. In Chile, the competencies required for each of the long-term care profiles are very different. Primary caregiver competencies include assisting care-dependent people with daily activities, supporting health maintenance, and monitoring the application of intervention plans. In contrast, the socio-community assistant's competencies should include managing access to social services, coordinating network support, and providing respite for primary caregivers. In Colombia, the competency frameworks for personal home care workers and institutional care workers are very similar. Both require communication, active listening, critical thinking, interpersonal relations, and teamwork. The only difference is that personal care workers must be able to follow instructions, while institutional care workers need to evaluate and monitor activities.

105. Qualifications Framework for Comprehensive Care for Older People of the Ministry of Public Education (*Marco de cualificaciones para la Asistencia Integral para la persona adulta mayor del Ministerio de Educación Pública*), Costa Rica.

106. Comprehensive Protocol for the Care of Older People in Gerontological Centers and Services (*Protocolo de Atención Integral para Personas Adultas Mayores en Centros y Servicios Gerontológicos*), Ecuador.

Mexico takes a more practical approach to defining the competencies required for formal caregivers. Its competency framework for home caregivers (Basic Home Care for Older People[107]) describes the tasks that workers are expected to perform in the role instead of defining broad areas of competencies. Recently, the National Institute of Geriatrics and the National Council for the Standardization and Certification of Labor Competencies[108] launched the Competency Standard for Person-Centered Care for Functionally Dependent Older People[109] to advance the professionalization of caregivers (CONOCER 2024). A different framework is in place for caregivers for older persons in permanent or temporary social assistance establishments.[110]

Finally, El Salvador and Costa Rica are currently developing a national curriculum for training personal care workers (Marco Nacional de Cualificaciones 2019). As a preliminary step, these countries are working to characterize and define competency profiles for care workers and the tasks they will need to perform.

6.4.2 Countries require very different qualifications to work in the long-term care sector

As seen in **Chapter 4**, paid caregivers have relatively little training in most Latin American and Caribbean countries. Approximately one in three paid caregivers works without training, and another third has only done self-study and short courses of less than 60 hours (see **Section 4.3**). Extended courses of 150 hours or more are rare, especially in Central America and parts of the Caribbean.

Most countries have low minimum schooling requirements for starting training

Several countries—including Chile, Honduras, Jamaica, Peru, Mexico, the Dominican Republic, and Uruguay—allow individuals with only primary or no formal education to enroll in a training course to become a personal care worker (**Table 6.8, Panel A**). Other countries require a high school diploma: Argentina, Barbados, Bolivia, Colombia, Ecuador, Guyana, and Trinidad and Tobago. In Costa Rica, educational requirements vary depending on the institution offering the

107. *Cuidado básico de la persona adulta mayor en domicilio.*

108. *Consejo Nacional de Normalización y Certificación de Competencias Laborales.*

109. Competency Standard EC1519.01. Providing Care Centered on the Older Person with Functional Dependence [*Prestación de cuidados centrados en la persona mayor con dependencia funcional*].

110. Competency Standard EC0665. Care for Older People in Permanent/Temporary Social Assistance Facilities [*Atención a personas adultas mayores en establecimientos de asistencia social permanente/temporal*].

training. Public institutions and universities like the National Training Institute[111] and Public Distance Learning University[112] require a high school diploma, while private institutions may only require a primary school education.

In contrast, nurses in the long-term care sector have higher enrollment requirements, ranging from high school diplomas to technical degrees. A high school diploma is a common requirement for starting a nursing degree in Argentina, Brazil, Bolivia, Chile, Colombia,[113] Costa Rica, the Dominican Republic, Ecuador, El Salvador, Honduras, Jamaica, Peru, and Trinidad and Tobago. A smaller group of countries, such as Barbados and Guyana, expects more specialized skills and requires a technical degree after high school for nurse training. Mexico requires nurses to have a *bachillerato*—a degree from an educational step between secondary school and university, where students are typically between 15 and 18 years old.

Many countries only set minimum formal education and training requirements for nurses who provide long-term care

Most countries do not require personal care workers to have a minimum level of training or certification of knowledge to work in official long-term care services (**Table 6.8, Panel B**). For education and training to be considered formal, it has to be recognized under national standards or regulations and meet certain criteria approved or accredited by a government authority (like a ministry or department of education, health, or labor). It results in a formal certification, qualification, or license that is valid for employment or professional recognition. Several countries (Argentina, Costa Rica, the Dominican Republic, Barbados, Trinidad and Tobago, and Uruguay) require caregivers to complete such formal training (as opposed to non-formal or informal training[114]) to be able to work at an accredited institution. In Uruguay, caregivers have two options to gain official recognition: they can complete the formal training or undergo a series of steps to obtain a job skill certification based on previous experience/knowledge (see below).

Official training programs, when they exist, vary widely in duration (**Table 6.9**). Few programs last more than the 260 hours recommended by the Ibero-American Protocol for Caregiver Training. Barbados requires both formal training and a job skill certification to work as a personal

111. *Instituto Nacional de Aprendizaje.*

112. *Universidad Estatal a Distancia.*

113. In 2013, the National Learning Service, in alliance with the Ministry of Health, created a program for basic care operators for people with functional dependence. The entry requirement was having completed primary school.

114. Informal training is learning by doing without a curriculum or certification and is not intentional training. Non-formal training is organized and structured learning that takes place outside the formal education system and might lead to a certificate, but not usually a government-recognized qualification.

care worker. The Barbados Vocational Training Board offers a two-semester course as the main training program, though other institutions provide similar courses. Regardless of where the training is completed, all candidates must pass the same job skill certification exam to qualify. In Costa Rica, the 700-hour course for personal care workers is offered by the National Training Institute. Accredited public and private institutions offer shorter formal courses in Uruguay (152 hours, including a 62-hour practical training component) and the Dominican Republic (200 hours, with 120 hours devoted to practice).[115] In Ecuador, the official training is a two-year university-level technical degree consisting of a minimum of 240 hours, including practical training in long-term care facilities, day centers, or a hospital specialized in caring for older people. It is only mandatory for work in public sector services. In addition, personal care workers must certify their competencies through a training center recognized by the Ministry of Labor to obtain a license that must be renewed every three years.

As seen in **Section 6.2**, home caregivers in Argentina must be registered in the National Registry of Home Caregivers.[116] They must meet the nationwide minimum requirement of 200 hours of training to be registered. Once registered, the exact number of hours of training required for obtaining certification (an official permit to work in the profession) is not centralized at the national level and is instead established by each provincial or municipal jurisdiction. For example, as mentioned above, the city of Buenos Aires offers a mandatory, in-person, 400-hour training course that includes practical experience in homes, institutions, and communities. Upon completion, graduates receive a national certificate that is recognized by the Ministry of Education and enables caregivers to register in the National Registry of Home Caregivers. This practice also contributes to increasing formal employment in the caregiving field.

Chile and El Salvador are working to define minimum training requirements for personal care workers. Chile is developing a formal training program for personal care workers that will require a minimum of 120 hours, including practical components. El Salvador is developing a new curriculum and practical labs for hands-on training and is expected to set minimum requirements to increase the current low educational levels among caregivers.

Many countries with formal training courses offer them free of charge (e.g., Argentina or Uruguay) or at a subsidized fee (e.g., Barbados and Ecuador). In Barbados, people taking the course part-time pay a fee. In Ecuador, workers affiliated with the Ministry of Economic and Social Inclusion receive discounts. In Trinidad and Tobago, the educational requirements for a patient care assistant—the profession most comparable to care worker but with a relatively strong

115. By the National Technical and Vocational Training Institute.
116. *Registro Nacional de Cuidadores Domiciliarios.*

health focus—are set by an agency of the Ministry of Education called the Youth Training and Employment Partnership Program.[117] Participants pay a fee of TT$200 (US$29.46). Table 6.9 provides more details about these programs.

For nurses (**Table 6.8, Panel B**), most countries require formal education. Trinidad and Tobago requires formal education with specific training in geriatrics, but only for workers at geriatric homes. In Barbados and Jamaica, nurses who complete their education receive a license from the Nursing Council that has to be renewed every two years (Parliament of Barbados 2008; The Nursing Council of Jamaica 2018).

TABLE 6.8 MINIMUM QUALIFICATIONS

PANEL A: MINIMUM QUALIFICATIONS TO START TRAINING OR AN EDUCATIONAL COURSE TO BECOME A LONG-TERM CARE WORKER	
Personal care workers in long-term care	**Nurses in long-term care**
Primary education or no minimum education level: Chile, Costa Rica, Honduras, Jamaica, Peru, Mexico, Dominican Republic (primary), Uruguay (primary)	High school: Bolivia, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Honduras, Jamaica, Peru, Trinidad and Tobago
High school diploma: Argentina, Barbados, Bolivia, Costa Rica (National Training Institute, National Distance Learning University), Colombia, Ecuador, Guyana, Trinidad and Tobago	Technical degree after high school: Barbados, Guyana
	Bachillerato: Mexico
PANEL B: MINIMUM QUALIFICATIONS NEEDED TO BE A LONG-TERM CARE WORKER	
Personal care workers in long-term care	**Nurses in long-term care**
Formal education/training: Argentina, Barbados, Costa Rica, Dominican Republic, Ecuador (public sector), Trinidad and Tobago, Uruguay	Formal education/training: Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guyana, Honduras, Jamaica, Mexico, Peru, Trinidad and Tobago
No minimum qualification: Brazil, Bolivia, Chile, El Salvador, Honduras, Jamaica, Mexico, Peru	Licensing: Barbados, Jamaica

Source: OECD-IDB Long-Term Care Workforce Questionnaire.
Notes: Licensing usually has to be renewed periodically, e.g., by passing an exam, demonstrating continuing learning, proving experience through long-term employment in the field, or simply paying a fee.

117. See https://health.gov.tt/careers/nursing and https://www.ytepp.edu.tt/k-course/patient-care-assistant/ for more information.

TABLE 6.9 DURATION AND COST OF FORMAL AND MANDATORY EDUCATION PROGRAMS

COUNTRY	TRAINING	DURATION	COST	INSTITUTION	ADDITIONAL INFORMATION
Argentina	Home Caregiver Training Course (Curso de Formación de Cuidadores Domiciliarios)	Min. 200 hours	Free	National Registry of Home Caregivers (Registro Nacional de Cuidadores Domiciliarios); Ministry of Human Capital	Each provincial or municipal jurisdiction establishes the exact number of hours of training required for the certification (e.g., 400 hours in the city of Buenos Aires)
Barbados	Care of the Elderly	Two semesters	Fee subsidized for full-time students only	Barbados Vocational Training Board	
Dominican Republic	Caring for Older People (Cuidados y atención a personas adultas mayores)	200 hours (including 120 hours of practice)	Free	National Technical and Vocational Training Institute (Instituto Nacional de Formación Técnico Profesional)	Face-to-face or virtual
Ecuador	Two-year university-level technical degree	200 hours	Fee subsidized for workers affiliated with the Ministry of Economic and Social Inclusion	Several providers	Including practical training in long-term care facilities, day centers, and a hospital specialized in the care of older people Only mandatory to work in public-sector services
Trinidad and Tobago	Patient Care Assistant Training Course	Information not available	TT$200	Youth Training and Employment Partnership Program	
Uruguay	Basic Course on Care Dependency (Curso Básico en Atención a la Dependencia)	152 hours (including 62 hours of practice)	Free	National Integrated Care System (Sistema Nacional Integrado de Cuidados); Ministry of Social Development	

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

6.4.3 Countries strengthen and acknowledge skills acquired over the life cycle

Non-mandatory courses are available in many countries, leading to a heterogeneous training landscape

Due to the lack of official training curricula, in many countries, caregivers have to rely on non-formal courses for training. These courses may be organized and structured but take place outside the formal education system. While they may lead to a certificate, they are usually not accredited by public bodies. In countries where no other formal training exists, individuals use these courses for initial training, while in others, they are used as continuous learning opportunities

and specializations throughout people's careers.[118] Formal standardized courses are the ideal format for training carers, but if none are available, non-formal courses can provide some knowledge and skills. The courses are given by various types of organizations, including public and private universities, NGOs, public institutions, and the for-profit private sector, leading to a heterogeneous training landscape. Given the comparatively low educational requirements and relatively high share of workers in the sector with primary education, ongoing training and skill-building are particularly important in the region.

Several countries, like Barbados, Guyana, and Ecuador, have rich educational options, with non-formal courses that meet the Ibero-American Protocol's length recommendation (260 hours). For example, the Barbados Community College offers a one-year post-graduate diploma in gerontological nursing.[119]

Shorter non-formal courses are available in Bolivia, Brazil, Chile, El Salvador, Guyana, and Uruguay (OECD-IDB Long-Term Care Workforce Questionnaire). In El Salvador, both public and private providers offer training programs for personal care workers. They typically last 200 hours, with 20% devoted to practice. Guyana has many training options for caregivers, although none are mandatory for working in the sector. Continuous education is provided by the Ministry of Health (training for community health workers), the University of Guyana (60-hour Care of the Elderly program), Carnegie School of Home Economics (one-year-long Certificate in Care for Older People), and Adult Learning Centers.

In Chile, the Ministry of Labor and Social Welfare, through the National Training and Employment Service, offers a free program called Comprehensive Basic Care for Older People.[120] This initiative certifies caregiving competencies and supports increasing formal employment in caregiving services, including creating business plans. In Bolivia, the Plurinational School of Government Administration[121] provides a virtual, asynchronous course on long-term care for older people in residential care centers. This 50-hour course, backed by the Ministry of Justice, costs Bs. 100 (US$14.5) and is open to both civil servants and personnel from private institutions. As part of its strategy to support caregivers working in its National Integrated Care System, Uruguay has launched a series of workshops to share knowledge, good practices, and tools for better relational and job performance, to improve the quality of services (Balsa et al. 2025). In Brazil, personal

118. Initial training, also called entry-level training, refers to pre-employment training for an occupation and is generally divided into two parts: basic training, followed by specializations. In contrast, continuous/further training is targeted training typically provided after initial vocational training to supplement, improve, or update knowledge, skills, and/or competencies acquired during previous training.

119. See https://bcc.edu.bb/Divisions/HealthSciences/Academics/Programmes/HSDPGYR1PT/ for more information about this training program.

120. *Servicio de Cuidados Básicos Integrales para Personas Mayores.*

121. *Escuela de Gestión Pública Plurinacional.*

care worker training is primarily conducted by civil society organizations. The Ministry of Health occasionally offers distance learning courses, but they are sporadic and not standardized.

In Argentina, Jamaica, Honduras, Peru, and Trinidad and Tobago, the options are more limited. In Argentina, those registered in the National Registry of Home Caregivers can access continuing online gerontological training and broader career opportunities. In Jamaica, the Mona Campus of the University of the West Indies has introduced long-term care training, initially in Kingston and now expanding to other regions. However, personal care worker training in the country remains unstandardized, with private schools developing their own curricula. In Honduras, the Center for Women's Studies[122] provides diploma programs in long-term care for domestic workers.

The training providers in the region are a mix of public, private, and civil society organizations. In Peru, the social security for health (EsSalud) is the main provider of training on care for older people. This training is complemented by the Red Cross, which also offers training with a health care focus. In Trinidad and Tobago, the Geriatric Adolescent Partnership Program—a short-term training program—connects young individuals with older people. It helps bring this profession closer to younger people by equipping participants, aged 17 to 35, with the skills to provide geriatric care and companionship.

Training courses in the region typically prioritize technical competencies and tend to overlook other essential aspects such as self-care, emotional resilience, communication, and encouraging life projects in old age. These gaps remain a critical challenge for long-term care training (**Box 6.1**).

122. *Centro de Estudios de la Mujer.*

BOX 6.1 TRAINING PROGRAMS LACK IMPORTANT CONTENT ON EMOTIONAL CARE AND SELF-CARE

In Latin American and Caribbean countries, most training programs focus on technical skills and less on dealing with the emotional burden of caring. They also lack important components on self-care and emotional resilience. Previous research has shown that in Colombia, Costa Rica, and Uruguay, training programs for long-term care workers tend to focus primarily on technical skills related to health care or hygiene and comfort. They place considerably less emphasis on competencies such as communication, time management, self-care, and encouraging life projects in old age—key components of the Person-Centered Care approach. In other words, some elements of this approach are present, but they are not systematically integrated into the curricula (Aldaz et al. 2023). **Chapter 7** explores the Person-Centered Care approach in greater detail and highlights the importance of fully mainstreaming it into training programs.

As mentioned in **Chapter 4**, paid caregivers are exposed to significant levels of verbal and physical abuse, and one out of five experience symptoms of depression. While these outcomes are not uncommon in OECD countries, workers in Latin American and Caribbean countries are underprepared to manage the emotional demands of their roles, as confirmed by research in Chile. Combining quantitative and qualitative methods, researchers from the Ministry of Social Development and Family find that caregivers identify three main areas where their skills need to be developed: technical or professional assistance for caregiving (61%); sharing caregiving responsibilities with others (57%); and psychosocial support or health care for themselves (52%) (Ministerio de Desarrollo Social y Familia de Chile 2024b).

A few countries in the region are addressing this gap. For example, Uruguay produced the Manual on Humanizing Care (Ministerio de Desarrollo Social de Uruguay 2022). This manual gives caregivers practical tools for self-care to mitigate the physical and emotional toll of their responsibilities. The Costa Rican system has proposed a collaboration with the Board of Psychologists to implement psychometric testing to ensure the suitability of hires at long-term care facilities (OECD-IDB Long-Term Care Workforce Questionnaire).

Continuous education in the sector is mainly mandatory for nurses

In Ecuador, Barbados, and Jamaica, continuous training programs are mandatory for nurses working in the long-term care sector, once they have obtained a certification or license (Ministry of Health of Barbados 2015; OECD-IDB Long-Term Care Workforce Questionnaire). In Ecuador, this requirement only applies to nurses working in social services provided by the Ministry of Economic and Social Inclusion. In Argentina, caregivers (called gerontological assistants) must take mandatory continuous training to renew their credentials, but only in the city of Buenos Aires.

Several countries recognize prior learning for accessing training and jobs

Initiatives to recognize the prior learning, skills, and experience of workers in the caregiving sector are common. They officially endorse a person's expertise, abilities, and aptitudes for a specific occupation, regardless of whether they acquired that knowledge and skill through formal training or by informal means. Since many caregivers work informally, these initiatives allow their skills to be valued and recognized, facilitating their entry into the formal labor market. They can be a first step toward offering progressive learning pathways that support their progress in the labor market. Initiatives to recognize prior learning may support candidates in verifying their previous experiences, conduct assessments based on the standards for the selected qualification, and ultimately provide certification. When candidates lack certain competencies, training programs should be offered to close skill gaps.

Chile, Colombia, Ecuador, the Dominican Republic, Guyana, and Uruguay have these types of programs, and El Salvador is developing one. In all these countries, workers who can prove a certain number of years of previous experience in the sector undergo a competency evaluation process. If they pass this process, they receive a certification that allows them to work in accredited institutions. In addition to prior experience, Colombia and Uruguay consider previous training, even if it is not the official mandatory training.

Costa Rica and Uruguay have special provisions for certifying institutional caregivers (people working in residential long-term care facilities or day care centers). In Uruguay, for example, personal care workers employed for more than two years by residential long-term care facilities can obtain a job skill certification. The institution has to apply directly, submitting a list of workers to be evaluated. There are 300 slots annually.[123] Similarly, in Costa Rica, a collaboration between the Ministry of Health's Human Resources unit, the Joint Social Welfare Institute, and

123. See: https://www.inefop.uy/uruguay-certifica-cuidados and https://universidad.claeh.edu.uy/blog/cuidadores-recibieron-certificados-de-competencias-uclaeh-fue-el-centro-evaluador/.

the National Training Institute will aim to certify experienced workers in long-term care homes and day centers. They will assess workers through exams, and those who meet the required knowledge standards will receive certification and a license. The training and certification will be provided free of charge, both in person and online.

6.5 The region has taken early steps to increase productivity in the long-term care sector

Countries are currently exploring three broad strategies to improve productivity in the long-term care sector: improving the skills composition of the workforce, promoting the use of technology, and freeing up resources by improving coordination between social, health, and long-term care services. **Section 6.4** addressed efforts to improve the skills composition of the workforce, especially by standardizing training and upskilling. This subsection focuses on the other two strategies: technology and improved coordination with healthcare services.

6.5.1 Some countries promote technology, but approaches are varied

Policies for increasing productivity in the long-term care sector are not currently a priority in the region. A possible explanation is that workforce shortages are not yet as pressing as in most OECD countries, and the resources for innovation are limited. Also, promoting productivity gains is not straightforward in the labor-intensive long-term care sector. Many of the tasks done by health and social workers are difficult to automate and must be performed by a person.

Nevertheless, leveraging technology to increase productivity—by using sensors and alarms, by making it easier to share information electronically, or by minimizing repetitive and physically demanding tasks—can help caregivers focus on providing personal service to those under their care. **Chapter 7** provides examples of these initiatives from the long-term care sector in OECD countries, as well as from the health sector in Latin America and the Caribbean. In long-term care specifically, Chile offers telecare (see **Box 2.3**). In Uruguay, the National Integrated Care System offers a subsidized teleassistance service for people over age 70 with mild or moderate functional dependence.[124]

124. See https://www.gub.uy/sistema-cuidados/tramites-y-servicios/servicios/teleasistencia-casa for more information.

6.5.2 There are few policies to enhance coordination with health or social services

Coordination between long-term care and health and/or social services is particularly important for older people, whose diverse care needs often require multidisciplinary attention. Lack of coordination between long-term care and healthcare systems increases the risk of unnecessary hospitalizations, long hospital stays, and readmissions (OECD 2024; Steventon et al. 2018). Aranco et al. (2024) estimate that having long-term care services could prevent 7% of hospitalization days among older people in Mexico, and 12% in Brazil. Lack of coordination also affects the well-being of long-term care professionals, as it can duplicate tasks and increase workloads (OECD 2020).

Despite its relevance, coordination between long-term care and health and/or social services is rare in the region. It is challenging to achieve, as different services are provided by different institutions (sometimes even different ministries) and have different rules, legislations, and funding mechanisms. Yet there are examples worth highlighting, and **Box 6.2** presents additional examples of intra-care sector coordination efforts.

In 2011, Costa Rica launched a Progressive Care Network for Comprehensive Care for Older People[125] (CONAPAM 2012). It aims to organize care with a patient-centered approach, providing support for (instrumental) activities of daily living and other needs the person may have, whether emotional, health-related, economic, or cultural. An evaluation of the network concluded that it matches the population's needs, and further efforts could extend its coverage, e.g., via awareness campaigns and training for administrative staff (Villavicencio Salas 2017; MTSS and FODESAF 2023).

In Colombia, the National Public Policy on Aging and Old Age 2022–2033 aims to strengthen services and promote communication between health and socio-sanitary services to use resources more efficiently. One way to do this is to adjust the definition of socio-sanitary services and develop a national registry of socio-sanitary service providers (Ministerio de Salud y Protección Social de Colombia 2024).

In Brazil, a local initiative in Belo Horizonte—*Maior Cuidado*—highlights the benefits of integrating social and health services. The program, which was developed jointly by the municipal Department of Health and the Department of Social Assistance, provides home care assistance for vulnerable, care-dependent older people. Inter-sectoral teams of nurses, social assistants, and community health workers work together to review new and existing cases and design

125. *Red de Atención Progresiva para Cuido Integral de las Personas Adultas Mayores.*

individual care plans. Independent evaluations show that the program improved older people's health and family caregivers' well-being, while generating healthcare savings (Lloyd-Sherlock et al. 2024; Lloyd-Sherlock et al. 2025).

BOX 6.2 COORDINATING CARE IN THE LONG-TERM CARE SECTOR OF LATIN AMERICA AND THE CARIBBEAN

In many countries in the region, care coordination is a relatively new concept that is still being implemented. Brazil,[1] Colombia,[2] Costa Rica, Peru,[3] and Trinidad and Tobago[4] included it in their national aging and care policies, acknowledging its importance for long-term care. Many countries have established a coordinating body. For example, the Colombian National Council for Economic and Social Policy[5] balances territorial autonomy with maintaining a unified framework for care delivery in a decentralized health system where all services are provided at the municipal level. Similarly, Costa Rica's national care policy led to the creation of the National Care and Support System,[6] which facilitates intersectoral and interinstitutional coordination among the different organizations involved in delivering long-term care (e.g., the ministries, the National Training Institute, the Joint Social Welfare Institute).

Bolivia[7] established the Sectoral Coordination Council for a Dignified Old Age[8] to centralize the regulation and supervision of Adult Day Care Centers (Ministro de Justicia y Transparencia Institucional 2021). In Peru, the Ministry of Women and Vulnerable Populations created a temporary sectoral working group to coordinate care actions and improve services and conditions for both paid and unpaid caregivers. Finally, Guyana has no policy specifically for improving the coordination of services, but its programs use the Integrated Care for Older People criteria and tools, which offer guidance on how to deliver integrated care (WHO 2024).

1. The National Care Policy (*Política Nacional de Cuidados*) promotes the integration and coordination of public policies across key sectors, including health, social assistance, and social security.
2. The objective of Colombia's National Strategy for Healthy Aging is to harmonize the health system and enable it to better respond to the needs of older people based on a life course approach.
3. The bill proposing to create the national care policy includes a provision on care coordination.
4. Aging Policy.
5. *Consejo Nacional de Política Económica y Social.*
6. *Sistema Nacional de Cuidados y Apoyos.*
7. No. 369 General Law on Older People (Ley General de las Personas Adultas Mayores), Article 14.
8. *Consejo de Coordinación Sectorial Por una Vejez Digna.*

7 The Way Forward: Towards Stronger Human Resources in Long-Term Care

Caregivers are the backbone of long-term care. Whether unpaid or paid, in an institutional setting or in private homes, they are essential to guaranteeing the quality of care. Despite this crucial role, their job is often undervalued. Both unpaid and paid caregiving are associated with lower income levels. This is true of unpaid caregivers because caregiving responsibilities affect their labor market participation rate, the number of hours they work, and the type of work they can have (**Chapter 3**). For paid caregivers, the drivers are low wages in the sector, low formal employment rates and labor security levels, and part-time jobs (**Chapter 4**). As explained previously, both unpaid and paid caregivers are more likely than the general population to experience depression symptoms and high stress levels when not adequately supported.

Countries in the region are increasingly recognizing the importance of supporting caregivers. **Chapter 5** highlights their progress on designing support mechanisms to allow family caregivers to better combine care and labor responsibilities and be more prepared to deal with the challenges of caring for a functionally dependent person. **Chapter 6** describes the policies in place to improve working conditions for paid caregivers, which range from setting minimum salary levels to increasing social security coverage to designing and implementing training curricula. But despite significant progress, many challenges still lie ahead.

This chapter focuses on the way forward and discusses additional initiatives that countries could implement to improve the situation of paid and unpaid caregivers.

7.1 Improve the quality of long-term care jobs

7.1.1 Investments in professionalizing long-term care jobs are key to improving quality

Countries should invest in professionalizing long-term care jobs to improve their quality. Employment and skills development policies, training (discussed in **Section 7.2**), and certification play a central role in this process (ILO 2023).

A key step toward professionalizing the care workforce is for national institutions to register and recognize occupational profiles and certify competencies. **Chapter 6** discussed examples of progress in this area in the region. In Brazil, for instance, establishing an occupational profile for caregivers increased their levels of formal employment (Valenzuela et al. 2020). Latin American and Caribbean countries that have not yet engaged in this process can take a more structured approach, following examples like Italy's. The Italian National Association of Families as Domestic Employers[126] played a central role in shaping the national collective agreement and defining a standardized work contract for domestic workers, including long-term care workers, babysitters, and housekeepers. Complementary to this effort, the association established the National Observatory on Domestic work to monitor and analyze trends within the sector, supporting evidence-based policymaking and contributing to the ongoing development of the national collective agreement. These initiatives have significantly advanced the professionalization and regulation of long-term care and domestic workers in Italy: as of 2023, there were 834,000 formal domestic workers, almost half of whom (49.6%) were care workers (DOMINA, 2024).

Career counseling and job placement services are also crucial. This aspect includes helping people define their professional objectives and develop career trajectories by analyzing their personal circumstances (interests, skills, attitudes, education, and experience) and the local labor market dynamics. It also includes supporting job seekers through services that match the demand and supply of long-term care jobs. This matching can be achieved in collaboration with the private sector, as discussed later in this section.

126. *Associazione Nazionale Datori di Lavoro Domestici.*

7.1.2 Caregivers need enhanced social security coverage

Promoting formal employment in the sector improves caregivers' quality of life by providing them and their families with income protection in old age or in the event of unemployment, illness, disability, or death. It also makes the sector more attractive for prospective workers.

As seen in **Chapter 6**, countries in the region have made progress on increasing formal employment in the sector, either through specific actions targeting care workers (as in the Dominican Republic or Uruguay) or indirectly through wider efforts to boost formal employment among domestic workers in general (Argentina, Brazil, Uruguay). However, several structural challenges have hindered further progress: lack of coordination across policies, the heterogeneity of informal workers' profiles, the prevalence of part-time jobs, limited institutional capacity, low worker participation in policymaking, and the fact that much care work is done inside people's homes, where it is difficult to perform inspections (ILO 2018).

Use digital platforms and care vouchers as innovative models for increasing formal employment in the sector

Simplifying access to social security systems is one straightforward strategy to formalize employment among care workers. Countries can develop flexible and user-friendly affiliation systems that reflect the diversity of employment conditions in the sector (part- and full-time, single or multiple employers, cooperatives, etc.). These systems reduce administrative complexity and simplify the bureaucratic processes that often pose barriers for both employers and employees.

Digital platforms and care vouchers are ways to achieve this simplification. These innovative tools offer a unified mechanism to streamline transactions and promote transparency, accountability, and traceability. To establish these platforms, countries need both technical capacity and political will to create integrated databases with broad coverage and robust security and storage systems (ILO 2024). Good examples of this from the region include the eSocial tool in Brazil, or the Integrated Contributions Payment Form in Colombia, mentioned in **Chapter 6**.

Beyond the region, France's Pajemploi platform enables employers to digitally manage care workers' contracts, wages, and working hours, while seamlessly handling social security contributions. Although limited to care for young children (up to age six), this experience could be adapted to the long-term care sector. Beneficiaries must hire a certified childcare assistant or a childcare provider under a permanent contract, and they receive a childcare allowance that partially covers wages and employers' contributions. Pajemploi provides an online written contract template that specifies the working conditions (salary, working hours, vacation, etc.)

and that both parties must sign. Each month, employers pay their workers and declare online the period worked and the corresponding compensation. Based on this information, Pajemploi withdraws the net salary, after accounting for contributions and subsidies, from the employer's bank account. Workers receive an electronic pay slip with personalized information about their entitlements. There is a simplified system called Pajemploi+, for which both parties must jointly agree to register. In this case, the employer only declares the salary, and Pajemploi handles the direct payment to the employee. This reduces administrative burdens, enhances transparency, minimizes cash-based transactions, and improves regulatory compliance. By digitizing payment processes, the platform ensures greater traceability of transactions, reducing the use of cash and offering improved financial oversight. The platform is managed by the Organizations for the Collection of Social Security and Family Benefit Contributions (*Unions de Recouvrement des Cotisations de Sécurité Sociale et d'Allocations Familiales*—URSSAF).

Also in France, the Universal Service Employment Voucher (*Chèque Emploi Service Universel*—CESU) is a compelling example of using a voucher system to declare and manage employment arrangements, whether full-time or part-time, regular or occasional, for personal services, including care services. The CESU, also managed by URSSAF, is designed to simplify the process of employing and paying care workers by integrating wage payments with social security contributions. People register as employers on the CESU website, reporting the hours worked by their employees and the compensation, and the platform processes the information. URSSAF calculates and collects social security contributions, and employers can request tax deductions. Similar to *Pajemploi+*, there is a simplified mechanism called CESU+ where employers only need to declare the salary for a given period. As non-wage benefits, some companies provide their employees with pre-financed CESU vouchers, which can be used to pay for personal services. By streamlining these processes, the CESU reduces administrative complexity for employers while ensuring that care workers gain access to essential protections, including health insurance, unemployment benefits, and pensions.

Boost formal employment among long-term care workers with tax incentives

Tax incentives targeting both sides of the employment contract are another key strategy for increasing formal employment of long-term care workers because they reduce the cost of social security contributions. Governments can implement measures such as tax exemptions, tax credits, or reductions in social security contributions for both employers and care workers.

Though limited in scope, the examples from Argentina and Mexico discussed in **Chapter 6** are noteworthy because they involve tax deduction schemes that explicitly target care-related expenses (ILO 2018). Outside the region, in France, residents of long-term care facilities may

qualify for tax deductions on expenses related to care dependency, provided they meet specific conditions.[127] France also has a tax deduction for home-based caregivers (OECD 2024).[128] These targeted incentives not only reduce the financial burden on families and individuals requiring care but also encourage compliance with formal employment standards, contributing to a more robust and regulated long-term care workforce.

Enhance enforcement to increase formal employment of caregivers

To be effective, policies to increase formal employment must be paired with mechanisms to ensure that they are correctly applied. This means providing government authorities with the necessary human and financial resources to inspect and regulate long-term care institutions and designing creative ways to enable such policies to be enforced within private homes (Suaya et al. 2023).

The domestic work sector can provide good examples of how to achieve this. In the region, Chile, Uruguay, and Argentina have moved towards increasing the share of formal jobs in this sector by better equipping their governments to ensure that employers comply with the law (for a detailed description of these policies, see Suaya et al. 2023).

Adjust regulations to account for self-employment

Self-employed individuals tend to have multiple jobs and irregular working days and schedules, which makes regulatory compliance and calculating social security contributions difficult (Azuara et al. 2023).

As shown in **Chapter 4**, many paid caregivers are self-employed (see **Table 4.8**), making it difficult to include them in the social insurance system. However, there are a variety of strategies for improving their social protection. Tax incentives (discussed above) effectively encourage formal employment. Other mechanisms can enhance governments' control mechanisms, such as automatic deductions and interoperable information systems that allow governments to estimate total income from different sources.

127. The tax reduction is 25% of expenses incurred during the year, with a ceiling of 10,000 euros (US$11,700) per person.
128. The tax credit can amount to 50% of the expenses incurred in the year, with a ceiling of 12,000 euros (US$14,000).

7.1.3 Leverage private sector initiatives that improve the quality of long-term care jobs

The private sector plays a crucial role in providing long-term care services, whether funded by the public sector or by families. Even in countries where governments have not taken steps to create care systems, for-profit or not-for-profit entities in the private sector supply long-term care services that families consume. These entities are a growing part of the silver economy (Okumura et al. 2020; Jimenez et al. 2022). They bring investments, expertise, and innovation that can help address the forecasted increase in demand for long-term care. The private sector also holds the potential to generate millions of jobs in the care economy in the coming decades. To complement public services, governments can foster the growth of private long-term care services, regulate their quality, and promote their affordability.

De Anca et al. (2025) created a roadmap for developing an entrepreneurial ecosystem for long-term care in Latin America and the Caribbean. This plan is designed for governments (for example, at the municipal level) that aim to harness the private sector's potential. Two important elements of this plan help improve the quality of long-term care jobs. The first is the creation of platforms that connect caregivers with the demand for long-term care services. The second is the creation of caregivers' cooperatives. This report explores these two elements in more detail below.

Platforms could improve access to jobs by connecting caregivers with the demand for long-term care

In the last few years, both start-ups and governments have started developing platforms (webpages or apps) to connect the services provided by individual caregivers with families that can afford their services. When promoted by governments, these platforms can be part of larger efforts to map the existing supply of long-term care services (including care homes, nursing homes, day centers, etc.).

These platforms enroll paid caregivers and record information that is key for those looking to hire them. For example, families can verify their identity, perform background checks, and learn and verify their level of training. The platforms typically include training micro-modules to enhance caregivers' skills. They may allow employers to rate the quality of the services received so caregivers can build a professional reputation. This rating can be viewed by other families looking for caregiving services, filling an informational gap that can otherwise only be addressed locally through personal referrals.

Families looking for a caregiver select search criteria (e.g., days and time of service, experience with specific conditions like dementia, type of training completed) and access a list of caregivers that meet those requirements. They can then contact them and start a conversation (e.g., through a chat within the platform) that may lead to a contract. Alternatively, families can create a job opening and wait to be contacted by applicants.

Governments that foster these initiatives aim to increase individual caregivers' employment opportunities and progressively formalize their work. Currently, many caregivers are employed as domestic workers, have no written contract, and do not participate in social security schemes. After registering on the platforms, they can access training and transition more easily to jobs that offer better employment conditions. Governments may gain access to information on caregivers and their employment history.

While platforms have significant potential to expand caregivers' employment opportunities, there are concerns about the quality of the employment they generate. The overall experience of platform work in the region is characterized by precarious conditions, including job and income insecurity, and a lack of social and labor protections (ECLAC/ILO 2021). For this reason, governments that encourage care employment through platforms should develop or enforce appropriate regulatory frameworks that protect care workers.

An example of this type of platform is Cuidarlos, a marketplace for home-based long-term care services in Argentina. The platform serves as an intermediary between caregivers and families that employ them. It also offers long-term care training using content developed in collaboration with the INECO Foundation.[129] Currently, over 10,000 trained caregivers are registered on the platform, making it the largest database of caregivers for older people in Argentina. Cuidarlos has also partnered with municipal governments (in the city of Buenos Aires and the province of San Juan) to promote the enrollment, training, and employment of individual caregivers.

Private-sector entities have been developing other platforms that operate as intermediaries between families and caregivers, earning a percentage of the caregiver's salary. For example, the Brazilian Nonno connects families and companies with over 850 registered professionals for both home care and long-term care facilities. Unlike Cuidarlos or Cuidar.cr, Nonno is responsible for matching users and caregivers. Nonno operates in 56 municipalities across four states in southern Brazil.

129. Instituto de Neurología Cognitiva (https://www.ineco.org.ar/).

Cooperatives make the care market less atomized and increase caregivers' career development opportunities

Cooperatives are an increasingly popular model for long-term care services, benefitting both caregivers and older people and their families. They can potentially mitigate some of caregivers' most pressing challenges, such as precarious and insecure working conditions, emotional and physical strain, and lack of training. Since they act as intermediaries between caregivers and users, cooperatives can supervise essential aspects of employment relationships, such as contracts, access to social security, and working hours. This can give caregivers greater support and security, which is paramount in their stressful and demanding job. Cooperatives also foster the professionalization of their members, providing training opportunities.

From a user perspective, hiring caregiving services through cooperatives relieves families from legal and administrative responsibilities as employers. It also minimizes service interruptions due to contingencies (such as sick leave or vacation periods) because cooperative members can fill in for each other. From a public policy perspective, it is easier to oversee and regulate all parties involved when services are provided through organizations instead of individuals.

An example of this type of organization is the Spanish cooperative Suara, based in Catalonia and operating since before 1990. Suara has over 5,500 professionals providing assistance at all life stages, offering nearly 300 services spanning childcare, schools, employment, housing, professional training, health care, and long-term care. It is governed by an assembly of members that engages each member in the company's decision-making process. In 2023 alone, Suara delivered services to over 49,000 people.

Care cooperatives are also growing in Latin America and the Caribbean. Since 2021, the government of Argentina, through the National Institute for Associations and Social Economy,[130] has implemented the Care Cooperatives and Mutual Societies Incubator. This initiative fosters cooperatives and mutual societies focused on care for older people, childcare, support for people with disabilities, and the inclusion of vulnerable social groups in society and work. In its first year, the incubator engaged with 66 registered cooperatives and supported associations transitioning into cooperative structures. The initiative also organized training workshops and courses for caregivers for older people, provided financial aid for essential purchases, and offered other forms of support to help these cooperatives grow and be sustainable.

130. *Instituto Nacional de Asociativismo y Economía Social.*

Uruguay's National Integrated Care System started promoting caregiver cooperatives in 2022 to complement the individual service provider model in the Personal Assistants Program.[131] Since its inception in 2016, this program has relied on private employment agreements between caregivers and users. This created a difficult situation for families that wanted to switch caregivers, as they were financially responsible for severance costs. It also created some instances of contract irregularities and isolation. In response to these issues, in 2022, the Uruguayan government launched a pilot program to allow users to hire personal assistants through cooperatives. In Uruguay, cooperatives participate in the Wage Councils system and therefore can participate in collective bargaining agreements, as mentioned in **Chapter 6**. Users, in turn, can rely on cooperatives as intermediaries in their relationship with caregivers. Currently, there are 12 care cooperatives operating in Uruguay.

Cooperatives are also the service provision model that the Dominican Republic's government has chosen for its Care Communities program, which began in 2021.[132] Care Communities develops solutions for the care needs of low-income and vulnerable families, alleviating their economic strain and increasing the participation of women in the labor market. In addition to identifying families with care needs, the initiative gives men and women affiliated with the Pull Ahead[133] program the opportunity to be trained and certified as caregivers, creating employment and expanding the supply of qualified care workers. The program subsidizes home care for poor and vulnerable populations through the cooperatives, while also enabling these cooperatives to offer services to families that can afford the cost.

7.1.4 Other policies to improve caregivers' working conditions

A range of additional tools can improve working conditions in the long-term care sector, starting with those that promote work safety. Some caregiving tasks are physically demanding (moving a person in and out of bed, bathing, etc.) and can cause musculoskeletal disorders among caregivers. It is therefore important to design workplace guidelines and management support techniques, such as protocols with requirements for handling patients safely by, for example, using technological devices (Evanoff et al. 2003). Similarly, changes to living spaces like appropriate seat heights to aid sit-to-stand transfers can reduce staff injury (Coman et al. 2018). Norway offers good examples of workplace interventions, including ergonomics, physical training, and

131. *Programa de Asistentes Personales.* This program subsidizes 80 hours of home care per month for people with severe care dependency who are under 30 or over 80 years old. See: https://www.gub.uy/ministerio-desarrollo-social/node/9769.

132. Comunidades de Cuidado. See: https://mepyd.gob.do/wp-content/uploads/drive/VAES/Informes/Resumen%20ejecutivo%20Comunidades%20de%20Cuidado_MEPyD_WEB.pdf; see also: https://www.youtube.com/watch?v=zoJdWj2EQRI.

133. *Supérate.*

cognitive behavioral therapy, with positive results for preventing lower back pain for personal care workers who have physically demanding jobs (Rasmussen et al. 2013).

Using technology, including digital technologies (e.g., sensors and tablets), also helps improve and increase the productivity of long-term care jobs. Technology can streamline administrative tasks, coordination, monitoring, and transport, maximizing the time workers can spend on direct caregiving (OECD 2023a; Eurocarers, 2024; NHS 2019). In Finland, the telecare scheme called "remote care" helped long-term care workers reduce travel time. In Japan, artificial intelligence software is increasingly being used to help long-term care workers optimize their schedules to pick up and drop off daycare users. Using artificial intelligence to detect falls has also helped reduce the care workers' monitoring burden. Additionally, artificial intelligence has been considered or already implemented to avoid preventable harms in long-term care settings (OECD 2023a). As the prices of advanced equipment like robots decrease, innovative technological solutions may be prioritized outside the region (OECD 2024) and are expected to grow in Latin America and the Caribbean as well.

Some countries in the region are beginning to integrate technology into their public sectors, with initiatives that could be useful for long-term care services if extended to that area. For instance, Brazil established a Digital Information Secretariat within its Ministry of Health in 2023, while Chile launched the Digital Hospital to increase access to specialists through digital infrastructure (Ministerio de Salud de Chile 2022). Chile's use of asynchronous telemedicine enables geriatric specialists to deliver care remotely across the country, addressing complex conditions such as multimorbidity and Alzheimer's (Congreso Nacional de Chile 2024). Colombia and Peru have also introduced tele-consultations, although they remain limited to the general health sector. These technologies have not yet been implemented for long-term care but have demonstrated potential to improve service delivery. Expanding such technologies into long-term care could improve working conditions by offering greater flexibility through remote services, enabling professionals to manage workloads more efficiently and work from home when appropriate.

7.2 Use a person-centered approach to train paid and unpaid care workers

As described in **Chapters 3** and **4**, lack of training reduces both the quality of long-term care and the well-being of caregivers. It is associated with higher stress and anxiety, lower salaries, and less job satisfaction (Husebø et al. 2019; Gresham et al. 2018; Rajamohan et al. 2019). To protect, promote, and develop the long-term care workforce, it is essential to ensure that both paid and unpaid caregivers can access good-quality training.

As discussed in **Chapter 6**, countries in the region have made progress on training the long-term care workforce. Further progress requires mainstreaming a person-centered approach in training frameworks, designing training programs that cater to the needs of both caregivers and care recipients, and adapting training to older people's evolving care needs. These advances can be achieved while expanding the availability and accessibility of training programs.

7.2.1 Mainstream a person-centered approach in training frameworks

A person-centered approach to care emphasizes the rights, preferences, and quality of life of care recipients, based on the principles of dignity and personalized care (Bermejo 2021). Person-centered care models have been shown to significantly reduce the amount of medication administered to care recipients (Galiana et al. 2019; Huberbø et al. 2019) and to delay the need for institutionalization (Gresham et al. 2018). The latter outcome is particularly important, since most care recipients prefer to age in the comfort of their own homes and remain connected with their surroundings.

Shifting from a traditional medical-assistance, service-oriented care model to a holistic, person-centered approach requires funding to ensure appropriate staff ratios, as well as specifically designed training programs. By integrating these values into training programs, care systems can better meet people's complex and evolving needs, ultimately delivering a higher standard of care. **Table 7.1** highlights the key differences between the person-centered and service-centered approaches.

TABLE 7.1 SERVICE-CENTERED VERSUS PERSON-CENTERED APPROACHES

SERVICE-CENTERED APPROACH (THE PAST SYSTEM)	PERSON-CENTERED APPROACH (THE OBJECTIVE)
Focuses on care recipients' impairments and weaknesses	Focuses on each person's dignity and value: their values, abilities, skills, and desires
Decisions are made by professionals	Decisions are made by older people and/or by those whom they choose
Focuses on developing programs, plans, therapies, and protocols	Develops a meaningful life project, a plan for a possible and desirable future
Disorder-based view of older people	Developmental and holistic view of older people
Focuses on solving "problem situations" (conduct disorders, altered behaviors) with approaches focused on avoiding and minimizing deviant behaviors	Identifies unmet needs and helps get them met (listening to and respecting the person)
Includes ageist beliefs with stereotypes and prejudices about older people	Identifies and values the differences between subjects—their uniqueness. Adopts human diversity as a value
Uses technical-professional language that is sometimes derogatory and ageist	Uses non-negative, non-discriminatory, and inclusive language

Source: Bermejo (2021).

While certain countries in Latin America and the Caribbean are beginning to incorporate some elements of the person-centered model into their training programs, the approach is not yet prevalent in the region's curricula. A person-centered approach to care requires a blend of technical, relational, and self-care skills. Technical skills include practical techniques, such as moving a person safely and adjusting their posture. Relational skills encompass, for example, effective communication and providing end-of-life support. Finally, this approach places special emphasis on caregivers' well-being, teaching them self-care skills to identify signs of burnout and improve their physical and emotional health (Aldaz et al. 2023).

An evaluation of the training programs in Colombia, Uruguay, and Costa Rica shows that they have only partially incorporated a person-centered approach. Core elements of the approach, such as communication, time management, promoting life plans in old age, and human rights, receive limited attention and time. To address these shortcomings, the evaluators propose four training curricula for caregivers in day and residential care centers. Countries in the region could also look to countries with more advanced care systems, such as Spain, Finland, or France, for examples of how to mainstream the person-centered approach in their training frameworks (Aldaz et al. 2023).

The European Union's Skills Partnership for Long-Term Care provides a good example from outside the region. This program aims to train at least 60% of long-term care professionals (or 3.8 million workers) in areas related to person-centered care and digitalization by 2030. This strategy aligns with the targets set by the European Pillar of Social Rights Action Plan.

7.2.2 Design training to meet the needs of both caregivers and care recipients

The training load should strike a balance between ensuring service quality and accommodating caregivers' time constraints. On one hand, more training hours are preferable to improve the quality of care. On the other hand, many caregivers' limited educational background, combined with the challenge of balancing work, family, and study time, makes it unlikely that they can commit to extended training programs.

As discussed in **Chapter 6**, the load of training hours varies significantly across the region's countries, and in most cases, the standards fall short of European benchmarks. Spain, for example, requires 450 hours of training, while Italy requires 1000 hours. Aldaz et al. (2023) recommend at least 300 hours for people without experience, and 260 hours for people with prior experience. Similarly, the Ibero-American Social Security Organization[134] recommends a course duration of between 260 and 380 hours (OISS 2022). Countries in the region can gradually move toward these targets.

The training curricula should effectively combine theory and practice. Although theoretical knowledge is valuable, it should be complemented with practical knowledge and on-the-job training. For effective learning, theoretical content must serve as a foundation for practice-based training, enabling caregivers to apply their knowledge in real-world scenarios. Integrating theory and practice increases the relevance of training (Surr et al. 2017).

Not all training programs in the region include on-the-job training. Some do, but spend insufficient time on this component. A good practice can be found in South Korea, which allocates equal time to each type of training: 80 hours for theory, 80 hours for practical training, and 80 hours for on-the-job experience. In France, 50% of care workers' training is on-the-job (Aldaz et al. 2023).

Competency-based training is better suited to care workers than traditional learning methods. Traditional methods are typically course-based or subject-oriented; students are given information to memorize and are then tested. In contrast, competency-based training is a structured training and assessment system that allows individuals to acquire skills and knowledge in order to perform work activities to a specified standard (ILO 2020). It focuses on assessing the skills required for a specific job. Theoretical and practical training sessions are designed based on competency standards, and participants work to master these competencies to meet the standards of a real workplace environment.

134. *Organización Iberoamericana de Seguridad Social.*

7.2.3 Adjust training programs to evolving care needs

The content of training programs needs to be dynamically adjusted to reflect emerging priorities in care needs. Occupational profiles should also be adapted accordingly. Key areas for adaptation include supporting healthy aging and providing care for people with higher care dependency, which requires more specialized training. The growing prevalence of neurodegenerative or multi-pathological conditions also calls for a change in the skill mix of long-term care workers (Fujisawa and Colombo 2009). These adaptations ensure that occupational profiles and training programs stay relevant, responsive, and aligned with the evolving needs of long-term care systems.

Most care needs can be met by training caregivers to support dependent people with their activities of daily living. However, training for more complex tasks is required in cases of severe care dependency or specific health and rehabilitation needs (OECD 2020). These tasks are typically part of the profile of nursing assistants, nurses, occupational therapists, and caregivers who work with severely care-dependent people.

Along these lines, a good practice is offering caregivers who have completed basic training the option to increase their skills by specializing in the care of people with severe care dependency, including people with neurodegenerative and neurological conditions, as well as people with reduced mobility.[135] These trainings aim to equip caregivers to address complex behaviors and identify changing needs, such as those of people with dementia. These programs should also include specialized competencies related to maintaining autonomy, fostering communication, and enhancing social interaction for people living with dementia.

To address the demands of an aging population, nursing programs should include courses on geriatrics and gerontology. Some OECD countries have taken steps in this direction and could serve as an example for countries in the region. For instance, Austria and Japan have introduced scholarship programs to incentivize specialization in this field (OECD 2020).

Finally, training has to be adapted to the needs of coordinating health care and social services, which is essential for ensuring continuous care and saving resources in both sectors (**Box 7.1**). The care manager role is the professional coordination mechanism that is most widely used to achieve this integration and coordinate care across the healthcare and long-term care systems with a person-centered and a life course approach (Hofmarcher et al. 2007).

135. An example of this type of training can be found in Program 3 of Aldaz et al. (2023).

Care managers form the core of the Japanese long-term care system.[136] Professionals in this position, which was introduced after establishing the system in 2000, play a vital role in helping people choose the services that best suit their needs, such as home-based care, health care, and community activities. Care managers help older people and their families identify the challenges and needs in daily life. They then propose a personalized care plan with the services best suited to maintaining autonomy. They also oversee the implementation of these care plans through regular home visits, monitoring people's physical and mental well-being to ensure the plan is appropriate.

In France, the National Agency for Adult Vocational Training[137] has implemented a specialized training program for "Home Service Coordination Managers." This program emphasizes the skills needed to design and organize in-home service delivery, manage and coordinate teams of home-care workers, and enhance overall service quality. The United Kingdom's Health and Social Care Coordinators play a similar role, helping individuals with complex care needs navigate their care pathways (NHS 2025).

136. The Japan International Cooperation Agency (JICA) produced a video explaining the role of care managers. It is available in English and Spanish.

137. *Agence Nationale pour la Formation Professionnelle des Adultes.*

BOX 7.1 COORDINATING LONG-TERM CARE AND HEALTH CARE

In addition to establishing the care manager role, several countries have attempted to promote integrated care programs that combine health care and long-term care. Belgium and Luxembourg connect patients and caregivers with hospitals, care coordinators, home care providers, outpatient physicians, and other professionals in one joint network. Belgium has done so via 19 programs for alternative forms of care for older people in 2019 and is currently integrating the findings into a new plan on integrated care.[1] Luxembourg is building teams of providers for certain diseases, such as diabetes and neurodegenerative diseases (Ministère de la Santé et de la Sécurité Sociale 2023).

France has experimented with different iterations of integrated care programs for older people. In 2014, it launched the Health Pathways for Older People[2] program for people aged 75 and above and their caregivers in nine French regions. The program helps older people to stay at home for as long as possible, improving care coordination and quality of life. A new pilot program, the Pilot of a Lump Sum Payment for a Team of Healthcare Professionals in the City[3] builds on this experience. The program allocates an overall budget to a group of at least five medical professionals, with at least three general practitioners and one nurse, to provide care for a certain population group, such as people over age 65.

Japan provides community-based integrated care services that are centered on the patient and bring together providers from health care, social services, and long-term care. The coordination starts with evaluating the level of care dependency. First, an evaluator from the municipality's social services administers a standard questionnaire to assess the person's level of autonomy in performing everyday activities. At the same time, a medical doctor evaluates their health condition. A multidisciplinary commission of experts (from the health care, social services, and long-term care sector) considers these two inputs and issues a decision on the level of support or care that a person is entitled to. Afterwards, the cross-sector coordination continues through the care manager, who is responsible for preparing the care plan, combining services from both long-term care and healthcare professionals.

1 See https://www.inami.fgov.be/fr/themes/qualite-des-soins/soins-aux-personnes-agees/formes-alternatives-de-soins-aux-personnes-agees-projets for more details.
2. Parcours Santé des Aînés
3. Expérimentation d'un paiement forfaitaire en équipe de professionnels de santé en ville. See https://sante.gouv.fr/systeme-de-sante/parcours-des-patients-et-des-usagers/article-51-lfss-2018-innovations-organisationnelles-pour-la-transformation-du/les-experimentations/article/experimentation-d-un-paiement-en-equipe-de-professionnels-de-sante-en-ville for more details.

7.2.4 Standardize and expand the availability of training programs

Establishing an official curriculum for caregivers is important to address the low levels and heterogeneity of training observed in the region. It requires inter-institutional coordination, as well as collaboration among public agencies, private sector actors, and civil society stakeholders. As seen in **Chapter 6**, several countries in the region (Argentina, Barbados, Costa Rica, the Dominican Republic, Ecuador [public sector], Trinidad and Tobago, and Uruguay) have training programs that personal care workers must complete to be officially recognized as such. Even more countries have these requirements for nurses working in long-term care. Ideally, completing this course should be associated with higher earnings. For example, in Italy, the minimum hourly wage for caregivers of people with functional dependence is €7.91 (US$9.2) if the caregiver has no training (level CS), and €9.5 (US$11) if the caregiver has completed training (level DS).[138]

Official training may be defined around the courses already provided by technical and vocational training institutions. This was the path chosen in the Dominican Republic, which involved the National Technical and Vocational Training Institute in piloting the Communities of Care strategy described in **Chapter 6**. Training supply may also be expanded through partnerships with for-profit and not-for-profit private institutions. In these arrangements, governments remain responsible for defining training standards and ensuring quality, while private institutions are responsible for delivery.

Uruguay expanded its training supply through agreements between the National Institute of Employment and Vocational Training[139] and training institutions accredited by the Ministry of Education. The government delivers courses both directly and through 40 authorized private training entities (Sistema de Cuidados 2020). Another successful example, from outside the region, is South Korea. In just 14 years, it trained and certified 2.2 million caregivers through 1,187 government-accredited educational institutions offering caregiver training courses. Due to careful planning, these training efforts started two years before the National Care System was launched.

Finally, a key factor for expanding high-quality training programs is the availability of qualified trainers. Trainer training programs that give trainers the pedagogical skills, up-to-date knowledge, and practical competencies needed to effectively prepare care workers for their job are

138. Values for 2025. See *Associazione sindacale nazionale dei datori di lavoro domestico* for the definitions of professional categories and the table of minimum salaries.

139. *Instituto Nacional de Empleo y Formación Profesional.*

thus essential. The Ibero-American Protocol for Caregiver Training, which provides a curriculum framework for caregivers of care-dependent people, defines specific trainer profiles for its recommended modules. For the primary care module, for instance, trainers are required to have formal technical or professional education in health, a minimum of one year of recent work experience in the health sector, and demonstrated expertise in facilitation techniques and in evaluating training programs, particularly those focused on older people (OISS 2022). Trainers must also have a deep understanding of the person-centered care model presented earlier in this chapter.

7.2.5 Increase workers' participation in training opportunities

To increase caregivers' participation in training opportunities, courses should be affordable and have a flexible schedule to combine studying with work.

Governments should prevent training costs from becoming a barrier for prospective care workers. Government-subsidized programs can help attract workers to the care sector and improve the skills and competencies of informal caregivers. In the region, many countries with officially recognized training courses offer them free of cost (Uruguay, Argentina) or for a subsidized fee (Barbados, Chile, and Ecuador). This is also the case outside the region. Japan, for instance, significantly increased the number of caregivers through a financial support program for long-term care training aimed at integrating or reintegrating care workers into the labor market. Other OECD countries have implemented similar policies (OECD 2020).

Time barriers that limit caregivers' ability to participate in training programs are just as important as financial obstacles. To address this challenge, training courses should be designed with enough flexibility to accommodate participants' schedules and learning paces. This makes e-learning a promising tool because of its potential to create inclusive and equitable learning environments. Mobile applications and learning platforms are increasingly being developed to expand access to online training modules for care workers, offering innovative ways to enhance their skills. For these tools to be effective, they should feature well-designed content and appropriate learning environments tailored to caregivers' needs. A controlled study has demonstrated the cost-effectiveness of mobile e-learning compared to traditional instructor-led lectures for training home care workers in dementia care. A hybrid approach, where e-learning was complemented by mentor-led online support networks and face-to-face mentoring support group meetings, was also a successful way to develop skills (Su et al. 2021).

A good practice is the online training course on personalized care with a person-centered approach launched by the Spanish government. The course is free, self-paced, and lasts 25 hours. It

features engaging audiovisual educational resources designed to encourage reflection on caregiving practices for both paid and unpaid caregivers. Another good example from Europe is the App for Dem, which provides free open educational resources to address the daily challenges faced by caregivers for persons with dementia. It emphasizes a person-centered approach to dementia care, giving users practical strategies to improve the quality of care. Finally, Argentina's cuidabien.org platform offers training and support for family caregivers, focusing on building their capacity to deliver effective care. However, e-learning does have some caveats, like the need to complement it with on-the-job training.

Another strategy for achieving flexibility is to organize training into progressive modules, allowing greater adaptability to individual needs and schedules. For care workers, structuring training programs into modules offers a path that combines initial education with lifelong learning. Workers with prior experience or specific skill gaps can select targeted modules that meet their immediate needs, avoiding redundancy and focusing on the competencies they choose. This approach ensures that care workers' skills remain up-to-date and aligned with the evolving needs of care-dependent people, fostering a more responsive and adaptable care workforce.

The European Union has endorsed this approach through a Council Recommendation on a "European approach to micro-credentials for lifelong learning and employability." Micro-credentials certify the outcomes of short-term learning experiences, supporting a process of continually developing and updating skills and knowledge. This framework enhances the quality, transparency, accessibility, and flexibility of learning programs while promoting inclusiveness, access, and equal opportunities (Council of the European Union 2022).

To attract people to training and employment in the care sector and ensure that they do not drop out shortly after they start working, it is also essential to support informed career decisions. Prospective workers need to assess their suitability for the role—taking into account all the challenges and skills it involves—before entering the sector. In France, for example, the public employment service[140] provides clear and accessible information on key aspects of caregiving professions, including an overview of core tasks, required skills and competencies, expected working conditions, and compensation levels. In addition, the Immersion Program[141] gives people the opportunity to do short-term, unpaid observation internships with firms and care institutions. These placements allow prospective workers to experience what the profession is like in a real setting so they can make an informed decision about whether to pursue a career in caregiving.

140. *France Travail.*
141. *Immersion Facilitée.*

7.3 Support family caregivers to prevent negative consequences from caregiving

Without proper practical and emotional support, caregiving can negatively affect caregivers' physical and mental health. This is particularly true for family caregivers, who take on the responsibility of care with very little training. Given their central role in providing long-term care, it is essential to offer family caregivers a range of support that helps them perform their duties in a safe and fulfilling way. In addition to training, discussed in **Section 7.2**, there are other measures countries can take to reduce the negative impacts of unpaid caregiving. While countries in Latin America and the Caribbean are still in the early stages of developing these mechanisms, some promising experiences are worth highlighting, and countries outside the region also offer valuable examples.

7.3.1 Information, psychological support, and carer assessments

Family members may have to assume the responsibility of caregiving with no prior experience or useful information. They may not know how to organize care or perform technical tasks. Their information on the resources offered by the public or private sector may be limited. They may have no idea what type of physical or cognitive stimulation to give their family member with care needs and may not realize the importance of increasing their social interactions.

For these reasons, providing information on how to care and on the available services is a first and vital step toward reducing family caregivers' emotional distress and preventing them from feeling lost and isolated. The Australian government's Carer Gateway is a good example of an online information hub on caregivers' rights, entitlements, and support options. The French government also has a website with information on long-term care and caregiving.

Psychosocial support or counseling services are another key strategy to address the emotional strain of caregiving and build family caregivers' resilience. The region provides some promising examples. As described in **Section 5.2**, the Caregiver Support Program in Bahia, Brazil shares knowledge and offers support to improve care for older people. It organizes weekly meetings with group activities, topic-based discussions about care, exchanges of experiences, and individual support.[142] Beyond the region, Denmark and Latvia, for example, partially subsidize mental health counseling for family carers.

142. See: www.saude.ba.gov.br/atencao-a-saude/comofuncionaosus/centros-de-referencia/creasi/programa-de-apoio-ao-cuidador.

Carer assessments are another good practice that can guide individualized support. An assessment evaluates how caregiving responsibilities are impacting a carer's physical and mental health, paid job, free time, and relationships. It is the first step in designing a support plan that is adapted to each caregiver's context.

A few OECD countries perform caregiver assessments, including England, Scotland, the Netherlands, Australia, and some municipalities of Sweden. In Australia, an assessment is required to access services through the Carer Gateway. England's system evaluates carers' needs alongside care recipients' needs, though not necessarily at the same time. Carer assessments are performed regardless of the outcomes of the care recipients' evaluations (Government of the United Kingdom 2016). In Canada, caregiver burden is assessed using the Caregiver Risk Evaluation algorithm, which identifies caregivers at risk of distress or burnout. The tool is based on the interRAI Home Care assessment (CIHI 2021). Latin American and Caribbean countries are encouraged to follow these examples, since this type of assessment can be used to adjust support to caregivers' needs and work proactively with them to avoid crises (Hanson et al. 2008).

When designing support for family caregivers, it is good practice to consider their specific needs based on their age. For instance, it is important to ensure that young people can continue with their education. One model that can serve as an inspiration for countries in the region is the "Me-We" project funded by the European Union under the Horizon 2020 Program.[143] The project seeks to build the resilience of adolescent caregivers (ages 15–17) in six European countries (Sweden, Slovenia, Italy, the Netherlands, Switzerland, and the United Kingdom), with the long-term objectives that include reducing school dropouts, enhancing their employability, and reducing mental disorders. Although it is not ideal for adolescents to be responsible for caring for their family members, these mechanisms can be helpful in countries where this is an unavoidable reality.

7.3.2 Respite care

Respite services are another good practice for mitigating the negative effects of family caregiving by allowing caregivers to take short breaks from caregiving.[144] Although the evidence is not conclusive (Brimblecombe et al. 2018), some studies show significant benefits for caregivers'

143. See https://me-we.eu/ for more information.

144. All long-term care services that do not require the presence of family caregivers, whether at home or in centers, also provide respite. This report does not describe the long-term care services available in the region's countries because it focuses on caregivers. This section mentions some examples of services that provide respite for a limited time, focusing on caregivers more than on care recipients. These services can be seen as complementing more intensive long-term care services that are primarily focused on care recipients.

well-being. For instance, Yeandle and Wigfield (2012) find that respite care allowed 50% of carers to have more time for themselves, and that the health of those without access to respite care deteriorated more rapidly.

These practices are limited in the region (see **Chapter 5**). Outside the region, public support for respite care is mainly provided in-kind. In eight European countries (Denmark, Finland, France, Iceland [Reykjavik], Ireland, Luxembourg, Lithuania, and Portugal), along with Australia, Korea, and the United States, respite care is available in-kind, for example, via residential, day, or home care services. In Canada, all provinces support respite care, mostly in-kind. Germany and the Slovak Republic are the only European countries that support respite care with cash rather than in-kind. France offers an option to receive a cash transfer to cover care needs when the main caregiver is unavailable (Spasova et al. 2018). There are typically limits to these services; for example, they can be used for six weeks per year in Germany, or up to EUR 500 (US$590) in France (Rocard and Llena-Nozal 2022).

A key consideration when designing respite services is making them accessible and flexible enough to be tailored to the needs of both caregivers and care recipients. Evidence from various countries suggests that uptake can be low when potential beneficiaries see services as inadequate or not aligned with their preferences.

7.3.3 Leave and flexible work for family caregivers who continue to work

Access to care-related leave or the option to temporarily switch to a part-time schedule are good practices that help people keep their jobs while providing long-term care to a family member. While these practices are common in the region for childcare, only Mexico, Ecuador, and Chile have some type of paid leave for providing long-term care. None of the other countries has long-term care leave (paid or unpaid).[145]

In Germany, caregivers for care-dependent people are entitled to up to six months of unpaid leave or up to 24 months of part-time schedule (European Commission 2018). They are also entitled to receive an interest-free loan (conditional on employer size) while their income is reduced. In France, caregivers can take up to three months of unpaid leave at a time, with a lifetime maximum of 12 months (Directorate-General for Economic and Financial Affairs 2016). Similar provisions are in place in Spain and in Belgium through its "time credit" program (Triantafillou et al. 2010).

145. See https://webapps.ilo.org/globalcare/ and select the option "Long-term care leave."

In Canada, the Compassionate Care Leave allows employees to take up to 28 weeks off within a 52-week period to care for a terminally ill family member, with eligibility for employment insurance benefits. Canada also has the Critical Illness Leave, which offers up to 17 weeks for caring for an adult. This leave is compensated, with financial aid amounting to approximately 55% of the lost salary (Government of Canada 2025). However, since this leave is only for caring for terminally ill relatives, it cannot accommodate other caregiving needs. The Netherlands has a similar policy with an official leave duration and compensation of 10 days that can be increased under collective agreements. Paid family leave is also in place in some states in the United States (e.g., California, New York, and New Jersey).

There is compelling evidence that leaves for care positively affect labor supply, particularly among women (Saad-Lessler 2020; Coile et al. 2022). But implementing these leaves can be challenging. Limited leaves (e.g., a few days or leave restricted to cases of terminal illness) do represent progress on recognizing caregivers' rights, but they may not provide meaningful support, especially if the leave is unpaid.

Employees might be reluctant to take leave for long-term care due to concerns about how it might affect their career advancement and household income. Usage of statutory care leave may thus depend on the intensity of caregiving responsibilities and the generosity of leave compensation. Caregivers with less demanding care obligations may prefer to use vacation or sick days, particularly if requesting care leave could jeopardize their career opportunities. In contrast, those providing intensive care are likely to be more inclined to take statutory care leave, even if it is unpaid. Notably, lower compensation rates will likely lead to reduced uptake, so adequate financial support is needed for care leave policies.

Unlike care for young children, care for ill or disabled relatives is unpredictable in duration and intensity (OECD/European Commission 2013). Leave for caring for older people should therefore take into account the episodic nature of illnesses, deteriorations or improvements in health, and even changes in the availability of formal care (Oldenkamp et al. 2017). Workers can thus benefit from leave that can be split across several occurrences.

A particular challenge for the region is introducing these schemes amid high levels of labor informality. Countries may need to explore decoupling entitlement and benefits from formal employment and the contributions system. For example, they could offer a basic set of social protection benefits to all workers, formal or informal. Two additional challenges are enforcing statutory rights to return to work after leave and finding the right leave length to keep leaves from becoming a pre-retirement option (De Brouwer 2023).

Work flexibility, such as reduced working hours and teleworking, also helps family caregivers keep their jobs (Arksey and Glendinning 2007; Yoshini et al. 2023). This flexibility helps people balance work and caregiving responsibilities, reducing the likelihood that they will have to cut back on working hours more drastically (Arksey and Glendinning 2007). In the United Kingdom, for example, all employees—including caregivers—may request a flexible working arrangement after an initial 26-week qualifying period. These types of policies may be a promising option in Latin America and the Caribbean, where flexible working arrangements are on the rise: 67% of the companies surveyed across 24 countries in the region began using flexible work arrangements after the COVID-19 crisis (Alaimo et al. 2022).

Care leave and flexible work can also play a crucial role in equitably redistributing caregiving responsibilities between men and women. They not only improve the balance between work and family care, but they also serve as an incentive for women to engage more in formal employment. To drive meaningful change in social norms, it is essential to promote labor flexibility for both men and women across all sectors and occupations. If these agreements are implemented based on unequal gender patterns, they could reinforce traditional roles and keep women from accessing high-level jobs and professional development opportunities (Araujo et al. 2024).

7.3.4 Cash benefits, and tax and pension credits

Some countries offer income support to family caregivers who cannot be employed due to their caregiving responsibilities (see **Section 5.3**). This arrangement risks replicating the traditional model in which caregiving responsibilities fall to women, and it does not recognize older people's autonomy to select the long-term care services they prefer. Additionally, these benefits often do not cover the full cost of care and so cannot be seen as full compensation for carers' efforts.

A possible solution to the autonomy of choice issue is to target care recipients directly with cash allowances, allowing them to hire a family or professional caregiver. The Medicaid-funded Cash and Counseling program in the United States uses this model (Doty 2023). This program gives eligible participants a monthly allowance that can be used to purchase a wide range of goods and services based on their individual needs. All expenses must receive prior approval from a care manager. These goods and services may include hiring a family caregiver, who is formally employed (and therefore has access to social security benefits).

When cash transfers target caregivers (accepting that care recipients will lose autonomy of choice), it is important to design schemes where the work of family caregivers is fully recognized as formal employment. This ensures access to social security benefits, including health care and pensions. Germany, Spain, and Finland take this approach (Spasova et al. 2018). To differentiate

these cash transfers from other income support schemes, eligibility must be based on the recipient's level of care needs, as measured by an officially approved assessment tool.

Tax relief is another way to support family caregivers financially. This tool has not yet been used in Latin American or Caribbean countries. In most cases outside the region, the main eligibility criterion is the older person's degree of care dependency, combined with other criteria like their age and relationship to the caregiver (e.g., in Belgium, Canada, Finland, France, Ireland, Spain, and the United States). Some schemes (e.g., in Japan and France) tie tax relief to spending on nursing home services. Spain has developed a tax deduction program for people who combine paid employment and family care responsibilities.

For family caregivers who need to reduce their working hours or leave the job market entirely to care for a dependent person, offering pension credits is also a good practice. Pension credits can mitigate the impact of family long-term care on caregivers' entitlement to contributory pensions and on the value of those pensions, thus limiting the risk of poverty when they are older. These credits can be designed in multiple ways, from adjustments to pension formulas to allocating a lump sum at retirement or having provisions that allow unpaid caregivers to contribute to social security.

The social security systems of some countries in the region have introduced pension credits or equivalent mechanisms to account for periods of childcare (Bolivia, Chile, and Uruguay, for instance) (OISS 2019). However, this practice is not common for long-term care. A bill was introduced in Colombia in 2019 to subsidize the pension and healthcare contributions of people caring for older family members experiencing care dependency, but it has not been passed into law (Aranco, Bosch et al. 2022).

One challenge in designing these credits is correctly identifying the beneficiaries. Unlike childcare credits, long-term care credits need to be linked to some type of functional or health evaluation, so they require a high degree of coordination between the pension and long-term care systems. The design may take into account additional eligibility requirements, such as the number of hours of care provided by the caregiver. Examples can be drawn from OECD countries, such as Belgium, Estonia, France, Finland, Germany, Hungary, Ireland, Italy, Poland, the Slovak Republic, Spain, and Sweden.

7.4 Promoting men's participation in family and paid caregiving

As described throughout this report, in Latin America and the Caribbean, paid and unpaid care work disproportionately falls to women, and demographic and social trends put significant pressure on the existing caregiving model. Care therefore needs to be redefined based on the principle of shared responsibility, where societies recognize the value of care work and redistribute caregiving tasks among the public sector, the market, the community, and families. This approach also emphasizes ensuring fair distribution of responsibilities between men and women within households. This restructuring will yield numerous benefits for men themselves, including a heightened sense of being valued and appreciated by the individuals they care for, a stronger sense of purpose and personal fulfilment from contributing to the well-being of loved ones, and essential communication and empathy skills, which can apply across various life domains, including professional settings.

The previous section discussed how effectively implementing care leave and flexible work policies can help enhance men's participation in caregiving tasks for older people. This section explores additional strategies for (i) transforming traditional gender norms and (ii) increasing male participation in care-related sectors.

7.4.1 Develop policies to transform traditional norms regarding the roles of men and women

Achieving shared responsibility in caregiving requires challenging traditional gender and masculinity norms to foster behavioral change. Using tools that encourage male participation in caregiving is essential, but these tools must be supported by widely accepted social norms that promote their application. Traditional norms and stereotypes perpetuate the idea that, for men, family care is primarily limited to economic contributions. They also reinforce the expectation that women be the primary caregivers. Therefore, countries must address the cultural dimensions underlying traditional gender patterns.

Although researchers have not documented substantial changes in traditional gender norms, there are encouraging signs: various surveys show that men report providing a significant amount of care, even though the actual number of hours they spend on caregiving tasks may be lower. This suggests that more men are recognizing caregiving as a responsibility that also pertains to them (Van der Gaag et al. 2023). Data from the IMAGES survey for Brazil, Chile, and Mexico reveal that men who observed their fathers participating in household tasks are more

likely to engage in domestic work. This "intergenerational transfer of care" can play a crucial role in transforming gender relations and reducing inequality, while also opening up a range of future possibilities for both boys and girls (IPPF/WHR 2017).

Policies that advocate for gender equality or that aim to change social norms for caregiving seek to lessen the burden of care work for women and encourage greater male involvement in these activities. Information, education, and awareness-raising are key to fostering an equitable distribution of caregiving responsibilities between men and women.

Latin American and Caribbean countries have implemented some initiatives to challenge traditional caregiving roles and encourage greater male participation in care work. However, most of these programs were primarily designed to encourage greater male participation in childcare, without considering other life stages for which men should also assume caregiving responsibilities, such as caring for their own parents or in-laws. However, these initiatives provide valuable frameworks that could be adapted to increase male participation in long-term care.

In the region, several governmental strategies designed to transform social norms are worth mentioning. In Argentina, the Ministry of Labor developed a guide and training course on masculinities in the workplace, which includes a section on fatherhood and shared responsibility (MTESS 2022). This initiative challenges traditional gender roles and promotes a more equitable distribution of caregiving responsibilities in professional environments.

Bogotá launched the School for Caregiving Men in 2021. This initiative seeks to help equitably redistribute the direct, indirect, emotional, and environmental benefits of caregiving work by encouraging men to participate. The strategy is implemented through three services: a mobile unit that uses artistic activities and pedagogical tools to engage men and change perceptions about caregiving, in-person training cycles, and online classes.

In Chile, the Ministry of Women and Gender Equity organizes workshops on masculinities for companies seeking certification in gender equality management and work-life balance. These workshops foster a more inclusive approach to caregiving within the workplace, encouraging both men and women to share caregiving responsibilities.

In Panama, the Dominican Republic, and Uruguay, governments have developed guidelines, tools, and good practice guides and have also conducted training activities and workshops for worker and employer organizations. These initiatives promote the idea of shared caregiving responsibility, particularly in the context of a more formal labor market.

Lastly, the H Program, created by Promundo (coordinator), Instituto PAPAI and ECOS (Brazil), and Salud y Género (Mexico), offers workshops for young men on new masculinities, sexuality,

and caregiving. It includes socio-educational programs, manuals, and tools for promoting gender equality among youth. Evaluations of the program's impact in 12 countries show significant changes in attitudes toward gender norms, with observable shifts in behavior as a result. In Brazil and Chile, these programs positively impacted gender attitudes, reduced violence, and increased self-care behaviors among men (Doyle and Kato-Wallace 2021).

Despite these advancements, these programs are limited in their ability to cause care for older people to be redistributed between men and women. Evidence regarding their impact on traditional gender norms is scarce and has shown mixed results. Greater experimentation and rigorous evaluations are needed to understand which policies and incentives produce lasting changes to norms and promote a more balanced distribution of care, both at home and in society (Bustelo et al. 2024).

7.4.2 Policies to increase male participation in care-related sectors

Men are sharply underrepresented in fields traditionally associated with caregiving, such as early childhood education, long-term care, and health care. To challenge gender stereotypes, promote workforce diversity, and address the growing need for trained professionals, some high-income countries have implemented strategies to increase male participation in these sectors. While some focus exclusively on childcare, these initiatives could potentially be extended or adapted to care for older people.

Efforts to increase men's presence in caregiving include recruitment campaigns and marketing strategies that highlight job opportunities for men. An example is the Men in Childcare program launched by the Flemish Community of Belgium in 2002 to increase male participation in childcare. The program ran an appealing advertising campaign, distributed a recruitment manual, and held events to discuss men's role in caregiving. Male enrollment in training centers increased after the first year (Litjens and Taguma 2017).

Some countries implemented affirmative action to encourage men to participate in training and employment in care-related sectors. In 1997, Norway set a goal for at least 20% of staff in education and childcare to be male by 2000. Its policies were multifaceted and included incentives for high school students and hiring preferences in cases of equal qualifications. The country did not meet its target, but male participation in the sector did gradually increase from 5.7% to 10.8% between 2003 and 2022 (Engel et al. 2015; OECD 2019a; SSB 2023). This approach can also be relevant for long-term care services.

Improving working conditions in the caregiving sector, through the actions highlighted in Chapters 6 and 7, is another strategy for encouraging male participation. Ensuring decent work for caregivers, highlighting the value of their work, providing social protection, and advancing formal employment and professionalization in the sector are key to fostering participation, including male participation, in caregiving.

Increased male participation in paid caregiving roles can enhance both the social value and compensation of these jobs. Evidence shows that when women dominate a profession, wages tend to be lower—even when controlling for education, work experience, and skills. Because of population aging, this sector presents a critical opportunity to create jobs for both women and men. Encouraging more men to enter caregiving professions can help elevate the status and wages of these jobs while ensuring a more diverse and skilled workforce.

7.5 Build a more resilient long-term care workforce

7.5.1 Effects of extreme events on aging populations

Extreme events, like weather-related events, natural disasters, or health emergencies, are expected to intensify in the future. Older people and people with disabilities are among those most vulnerable to the health impacts of these threats, due to reduced mobility, debilitated immune systems, social isolation, and limited access to services (IPCC 2023; HelpAge 2015; Charveriat et al. 2023).

Long-term care systems and their workers must become better prepared to face these risks by investing in resilience and adaptability. Health and care systems are currently ill-prepared to face these types of unexpected shocks, as became clear during the COVID-19 pandemic. In many countries, the crisis revealed insufficient financing and planning, inadequate response strategies and protocols, and a shortage of well-trained workers. The lack of preparedness and response capacity contributed in many cases to the loss of human lives.

Table 7.2 summarizes how extreme weather and adverse natural events impact the care workforce, drawing from the work of Curtis et al. (2017) and Tsakonas et al. (2024). Curtis et al. (2017) propose adaptation strategies for health and care systems based on a conceptual framework covering three dimensions: physical, institutional, and social infrastructure. Tsakonas et al. (2024) review existing literature on the implications of extreme weather events for the healthcare workforce. The analysis is based on OECD countries, although the findings have global implications. Their findings and recommendations can be extended to the care sector.

Care workers are directly impacted, to the same extent as residents of nursing homes or private households, by physical infrastructure such as buildings, facilities, utilities, and transport networks that cannot adequately withstand adverse natural events. This infrastructure directly shapes how and where health workers provide care, influencing their efficiency and mobility. For example, construction materials that do not guarantee buildings' thermal comfort during extreme temperatures pose an occupational hazard, leading to stress, fatigue, and physical and mental discomfort, all of which can constrain workers' efficiency and emergency response capacity. On the other hand, restricted access to workplaces or the unavailability of essential products and technologies during or after disasters can hinder effective service delivery in institutional and home care settings. Adaptation involves measures to make structures resilient to any type of disaster.

TABLE 7.2 IMPACTS OF EXTREME EVENTS ON THE CARE WORKFORCE, BY TYPE OF INFRASTRUCTURE

TYPE OF INFRASTRUCTURE	ROLE/IMPLICATIONS FOR WORKERS	IMPACTS OF ADVERSE EVENTS
Physical infrastructures: buildings, utilities, and transportation networks	Determines where and how workers operate	Poorer working conditions and increased occupational risks if buildings are not properly built to withstand adverse events
Institutional Infrastructure: Institutional policies, human resources, and professional practices	Policies influence regulation, recruitment, and professional standards for service delivery	Inadequate planning limits capacity to prevent and respond to disasters Inadequate training for proper disaster risk management Increased workload
Social Infrastructure: Social and community groups and networks	Collaboration with community organizations, informal carers, and in-home services	Disrupted care services Increased workload

Source: adapted from Curtis et al. (2017) and Tsakonas et al. (2024)

7.5.2 Lessons and actions implemented in the aftermath of shocks

Countries generally design and implement measures to mitigate and adapt to external shocks and emergencies reactively, only after such events have occurred. This was the case in France following the 2003 heatwave, which led to the deaths of over 13,000 older people.

The French National Assembly's inquiry report emphasized proactive prevention, early warning systems, and coordinated institutional responses. In the heatwave's aftermath, the Ministry of Health issued a decree specifying an organizational response plan for social and long-term care establishments in the event of a health or climate crisis. The country also developed national

guidelines for creating "Plan Bleu" documents, which are comprehensive risk management plans that prepare facilities for a wide range of crises or exceptional public health situations. These plans designate a crisis response coordinator, establish formal agreements with nearby healthcare institutions, and lay out preventive good practices and protocols outlining how the institution should respond during alert and emergency phases.

Similarly, Ontario's Ministry of Long-Term Care issued the *Long-Term Care Emergency Preparedness Manual* to help care homes develop effective emergency and evacuation plans, ensure legal compliance, improve quality by sharing good practices, and connect care homes with external resources. In Sweden, the government has produced materials to raise the awareness of managers and supervisors in the health and social care sectors, offering guidance on how to prepare for heatwaves and extreme climate events, including available tools and practices. While planning is essential, it should be complemented by training and capacity building to enhance staff's ability to anticipate, plan for, and respond effectively to crises.

An effective way to prepare the workforce for shocks is by incorporating resilience and adaptation measures into the occupational profiles and the curricula for both initial and continuing training. The COVID-19 pandemic revealed significant crisis management challenges within Europe's care services, largely due to an insufficient number of care workers, many of whom were inadequately prepared and employed under precarious contractual arrangements (Ortega et al. 2021). To respond effectively to future crises, training initiatives must be complemented with efforts to improve working conditions for care workers. Enhancing job satisfaction, boosting retention rates, and prioritizing care workers' physical and mental well-being results in a workforce more capable of effectively implementing adaptation and risk management strategies.

7.5.3 Adapting skills and competencies to address extreme adverse events and emergencies

The long-term care workforce must adapt its skills to meet the challenges caused by extreme weather-related events, health crises, or natural disasters. The focus should be on disaster preparedness, risk reduction and prevention, relief and response, reconstruction and recovery. Adaptation initiatives should create the skills to reduce the adverse impacts of hazards and minimize the risk of disasters (UNISDR 2009).

The World Health Organization (2023) proposes a set of steps to build a more resilient healthcare workforce. The first focus of this operational framework, which extends here to care systems, is enhancing organizational capacity. This involves (i) drawing up contingency plans that in-

clude deploying sufficient personnel during acute shocks; (ii) workers participation in making decisions about, planning for, and managing extreme weather-related events; and (iii) capacity-building that integrates climate change and health into training programs that address gaps.

Introducing transformational leadership is a first layer to strengthen workforce capacity in this area. This type of leadership requires competencies related to creating space for organizational culture change, accountability to real-time decision-making, risk navigation, agile planning, communication, and collaboration (Tsakonas et al. 2024). These competencies are particularly important for people in management and governance who contribute to the strategic and crosscutting implementation of adaptation and disaster management policies. For other workers, these competencies also play a crucial role in raising awareness among care recipients and the general public about how to effectively prepare for and respond to disasters.

A second layer, related to workers' technical and professional capacity, includes training in core extreme weather events competencies and disaster preparedness. Jagals and Ebi (2021) identify four domains for these competencies. For care workers, this means having the capacity to:

a. Understand extreme weather-related events, their drivers, and potential impacts. This means using and interpreting climate information to take preventive action in case of disasters.

b. Conduct assessments to identify the consequences of these events for older people. This means incorporating weather-related factors that may exacerbate care dependency into people's evaluations.

c. Understand and implement adaptation, resilience, and risk management actions to support older people: for instance, ensuring hydration during heatwaves.

d. Work within a coordinated and structured network, in collaboration with third parties, to raise community awareness and support amily caregivers.

There is still a significant gap in information and concrete proposals on how to adapt care systems and the long-term care workforce to the impacts of external shocks and disasters. The recommendations outlined in this section come from analysis focused primarily on health workers and healthcare systems. It is crucial to adapt these proposals to the specific characteristics of care systems and care workers.

Figure 7.1 summarizes the key recommendations for supporting and recognizing caregivers of older adults in Latin America and the Caribbean.

FIGURE 7.1 KEY RECOMMENDATIONS FOR SUPPORTING AND RECOGNIZING CAREGIVERS OF OLDER PEOPLE IN LAC

1 Improve the quality of long-term care jobs

- Invest in the professionalization of long-term care jobs to raise service quality.
- Expand and strengthen social security coverage for caregivers.
- Promote private-sector initiatives (e.g., platforms and cooperatives) that enhance job quality and career development for caregivers.
- Implement complementary policies (tax incentives, enforcement, and regulation for self-employment) to improve caregivers' working conditions and formalization.

2 Use a person-centered approach to train paid and unpaid caregivers

- Embed a person-centered approach across training frameworks and curricula.
- Design training that addresses the needs of both caregivers and care recipients.
- Update training content and modalities as care needs evolve over time.
- Standardize training requirements and expand program availability and reach.
- Increase participation in training by reducing barriers and offering flexible opportunities.

3 Support family caregivers to prevent negative consequences from caregiving

- Provide accessible information, psychological support, and structured carer assessments.
- Offer respite care options to alleviate caregiver burden and prevent burnout.
- Ensure access to caregiving leave and flexible work arrangements for employed family caregivers.
- Provide cash benefits and tax/pension credits to mitigate the financial costs of caregiving.

4 Promote men's participation in family and paid caregiving

- Adopt policies that transform traditional gender norms around care roles.
- Implement targeted measures to increase men's entry and retention in care-related occupations.

5 Build a more resilient long-term care workforce

- Assess and address the impacts of extreme events on older populations and care systems.
- Apply lessons learned and institutionalize response actions after shocks.
- Adapt workforce skills and competencies for extreme adverse events and emergencies.

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Annexes

Annex A • Time Use Surveys

Time use surveys measure the time people spend on paid work, unpaid work, and academic, leisure, or cultural activities. Historically, they have been used to analyze the economic contribution of unpaid work.

This report uses the latest time use survey data[146] from nine countries: Argentina (2021), Brazil (2022),[147] Chile (2022), Colombia (2020), Costa Rica (2022), El Salvador (2017), Mexico (2019), Paraguay (2016), and Uruguay (2021). The surveys are nationally representative, with the exception of Chile's (which only covers urban areas), Colombia's (which excludes the departments of Otinoquía and Amazonia), and Uruguay's (which covers Montevideo and towns or cities with a population of over 5,000 people). In total, they include 555,269 individuals over age 14.

This report defines caregivers for older people as respondents who report having spent time supporting older people with their activities of daily living during the reference period. All the surveys ask about the time respondents spent providing support to three population groups: children, people with disabilities or in permanent need of support, and older people. Regrettably, most surveys do not allow identifying the caregivers for older people with disabilities (because they do not ask about the age of these care recipients). As the prevalence of disability is highest among older people, this leads to an important underestimation of the number of caregivers for older people.

Ideally, the reported time spent caring for an older person should include the care provided to both persons inside the household and to persons residing in other households. The latter could be particularly relevant in the case of older people who still live alone but have a child or another relative to support them with specific tasks, for example. Only five out of the nine countries included in this analysis have information on the time spent taking care of an older person who lives in another household: Chile, Colombia, Costa Rica, Mexico, and Uruguay. For countries that do not have this information (Argentina, Brazil, El Salvador, and Paraguay), the estimates presented in **Table 3.1** are based on the assumption that the ratio of older persons to caregivers providing support for other households is the same as in countries with available data.

146. As of May 2025.
147. Data from Brazil comes from a special module in the *Pesquisa Nacional por Amostra de Domicílios Contínua*.

The surveys include questions on the tasks performed by family caregivers only when they pro-vide long-term care to a member of their own household. The same information is not available for care provided outside the household. Questions generally cover three types of activities: basic activities (such as feeding or bathing), instrumental activities (which can involve, for example, providing companionship and conversation, or doing errands), and healthcare-related activities (e.g., taking someone to the doctor, administering medicines). For Argentina, Chile, Colombia, Costa Rica, and Uruguay, the number of hours of long-term care is equal to the number of hours of support provided to older people for basic activities, instrumental activities, and healthcare-related tasks.

In Mexico, El Salvador, and Paraguay, the surveys do not collect information on support with basic activities provided to older people. This information is only gathered for persons who need permanent support. For these countries, we assume that support with basic activities is provided to older people when the household has at least one older member. The number of hours of long-term care is therefore the sum of the hours of support with instrumental activities provided to older members, support with healthcare-related tasks provided to older members, and support with basic activities provided to members who need permanent support (conditional on the household having at least one older member). In other words, the assumption is that the "person with permanent care needs" is an older person. This assumption is not ideal and can lead to overestimating the time spent caring for older people. However, since the prevalence of functional dependence increases with age, this bias is expected to be small.

The survey for Brazil only allows identifying caregivers for older people, not estimating the time spent providing long-term care or identifying caregivers' activities.

There are other methodological caveats when analyzing the results, particularly for cross-country comparisons. First, the age at which a person receiving care is considered older varies by country. In El Salvador, Mexico, and Paraguay, it is 60, in Argentina and Uruguay, 65, and in Chile, 66. For Colombia and Costa Rica, the care recipient's age can be deduced from the database, so researchers can set the age limit. For these countries, the threshold was set at age 65.

Second, the activities included in each activity category (basic, instrumental, and healthcare-related) differ in type and number from country to country. **Table A.1** summarizes the activities included in each survey. The reported hours of long-term care may be lower in countries with surveys that cover fewer activities.

TABLE A.1 SPECIFIC CARE ACTIVITIES FOR OLDER PEOPLE INCLUDED IN SURVEYS, BY COUNTRY

GROUP	VARIABLE	ARGENTINA	CHILE	COLOMBIA	COSTA RICA	EL SALVADOR	MEXICO	PARAGUAY	URUGUAY
Basic activities	Feeding	✓	✓	✓		✓*	✓*	✓*	✓
	Bathing/cleaning		✓	✓	✓		✓*		✓
	Dressing		✓						
	Toileting		✓						
	Putting to bed/ changing position		✓				✓*		
Healthcare-related activities	Administering medicines	✓	✓	✓	✓	✓	✓	✓	✓
	Giving therapy						✓		✓
	Taking to the doctor		✓	✓			✓	✓	✓
Instrumental activities	Reading or keeping company		✓			✓			✓
	Doing errands/ transportation	✓	✓	✓		✓	✓	✓	✓
	Using electronic devices		✓		✓		✓		✓
	Communication		✓						

Source: Prepared by the authors based on time use surveys.
Note: the symbol ✓ identifies countries whose surveys include at least one question in that category; * reported under "people with permanent care needs"; combined cells mean that the activities fall under a single question.

Third, the reference period for recalling time spent on care activities also differs by country. This study reports the total number of hours per week spent on caring for older people. When respondents are asked to recall the total number of hours spent on a certain activity during an entire week (Costa Rica, Paraguay), this analysis reports that number. When people are asked to respond about a particular day (Argentina, Colombia, El Salvador, Uruguay), we multiply the number they report by seven, on the assumption that "particular day" is equal to the weekly average. Finally, in cases like Mexico, where respondents are asked about two representative days—a weekday and a weekend day—the weighted sum of both figures (hours spent on a weekday*5 + hours spent on a weekend day*2) is calculated.[148]

Fourth, some caregivers can do more than one task simultaneously (for example, keeping company and feeding), potentially leading to more than 24 care hours in a single day. For these cases, the hours are capped at 24.

148. For a methodological guide to analyzing time-use survey data, see: https://genlac.econo.unlp.edu.ar/wp-content/uploads/2024/12/Gui%C-C%81a-Metodolo%CC%81gica-Uso-del-Tiempo_ESP_2024-12.pdf.

Annex B • Methodology for Identifying Care Workers

To identify care workers, this study uses the most recent microdata from both household surveys and labor force surveys for countries with occupational codes and a sufficient sample size. In general, labor force surveys are better than household surveys for analyzing paid care professionals' characteristics and working conditions, so the report relies on them whenever possible. The years of the surveys used in the analysis range from 2013 in Trinidad and Tobago to 2024 in Costa Rica (**Table B.1**).

TABLE B.1 DATA SOURCES USED FOR IDENTIFYING CARE WORKERS

COUNTRY	SOURCE	YEAR	TYPE
Argentina	Encuesta Permanente de Hogares	2024	LFS
Bolivia	Encuesta Continua de Hogares	2017	HS
Brazil	Pesquisa Nacional por Amostra de Domicílios Contínua	2023	HS
Chile	Encuesta de Caracterización Socioeconómica Nacional	2022	HS
Colombia	Gran Encuesta Integrada de Hogares	2022	LFS
Costa Rica	Encuesta Continua de Empleo	2024	LFS
Ecuador	Encuesta Nacional de Empleo Desempleo y Subempleo	2023	LFS
El Salvador	Encuesta de Hogares de Propósitos Múltiples	2023	HS
Guyana	Labour Force Survey	2021	LFS
Honduras	Encuesta Permanente de Hogares de Propósitos Múltiples	2018	HS
Jamaica	Labour Force Survey	2014	LFS
Mexico	Encuesta Nacional de Ocupación y Empleo	2024	HS
Panama	Encuesta de Hogares de Propósitos Múltiples	2019	HS
Paraguay	Encuesta Permanente de Hogares	2017	HS
Peru	Encuesta Nacional de Hogares	2023	HS
Trinidad & Tobago	Continuous Sample Survey of the Population	2013	LFS
Uruguay	Encuesta Continua de Hogares	2023	HS

Source: Prepared by the authors.
Note: HS = household survey; LFS = labor force survey

According to the International Labour Organization (2013), there are two different approaches to identifying caregivers:

- The task-based approach classifies caregivers and domestic workers using the International Standard Classification of Occupation (ISCO-88 and ISCO-08).
- The industry-based approach categorizes employment by industry using the International Standard Industrial Classification of all Economic Activities (ISIC, Revision 3 or 4).

This study uses the task-based approach (or occupational codes). This information can be used to identify which persons provide care to older people. The approach focuses on the specific tasks performed by professionals rather than looking at the industry.

The best codes for categorizing activities relevant to this analysis were selected from the official classification for all occupations in each country. In line with OECD (2020), this study defines paid caregivers (or personal care workers) as those who assist with routine personal care at home or institutions other than hospitals, without being qualified or certified as nurses. Nurses are not included in this definition or in our estimates in this study.

This study estimates the total number of paid care workers in 17 countries. It also analyzes the characteristics of paid caregivers in the 14 countries that had 30 or more observations for each category.[149] **Table B.2**, which is based on the International Labour Organization (2012), describes the specific tasks and occupations included in this group.

TABLE B.2 CARE PROFILES ANALYZED

CODE	PROFESSION	DEFINITION
5321, 5322(a)	Personal care workers	People who provide personal care and assistance with mobility and activities of daily living to patients and older people, convalescents, and people with disabilities in healthcare and residential settings

Source: Prepared by the authors based on information from the International Labour Organization (2012).
Notes: The code "5329 - Personal care workers in health service not classified elsewhere" was not included because most of the activities it covers are part of health care and beyond the scope of the analysis.

149. The sample size is often too small to analyze descriptive statistics. According to the central limit theorem, the distribution of sample means approaches a normal distribution as the sample size increases, regardless of the population's distribution. A sample size of 30 or more is typically considered sufficient for this theorem to hold true.

Annex C • The IDB Caregivers Survey

Survey design

The IDB Caregivers Survey was developed and implemented by the Inter-American Development Bank in two phases. First, the IDB hired the Institute for Clinical Effectiveness and Health Policy[150] to design and pilot the questionnaire. The process started with an extensive review of existing surveys on paid and unpaid care work in Latin America and the Caribbean. The team drafted and validated the questionnaire with a panel of experts from the disciplines of statistics, gerontology, clinical research, economics, and survey design. Additionally, the instrument was tested to evaluate its clarity and acceptability.

Following the design phase, the team from the institute conducted an initial pilot in three languages (English, Spanish, and Portuguese) across six countries (Argentina, Barbados, Bolivia, Brazil, the Dominican Republic, and Mexico). This pilot targeted paid and unpaid caregivers who care for people over age 60, either in institutions or care recipients' homes. The survey was distributed online and by email, SMS, and WhatsApp messages. It was also administered offline by trained interviewers. Prado et al. (2024) contains a detailed description of the process of developing and testing the questionnaire.

Once the questionnaire was finalized, the IDB hired the firm SENSATA SAS to scale up data collection. SENSATA disseminated the survey through platforms like Facebook, Instagram, and WhatsApp, using marketing and communication techniques. The survey was launched in November 2023. The questionnaire is presented in Annex 3 of Fabiani et al. (2024), which analyzes the first 27,000 observations collected as of May 2024.

From November 2023 to March 2025, the survey collected information on 64,592 caregivers from 26 Latin American and Caribbean countries. Of them, 74.3% (48,016 people) are unpaid caregivers, and 25.7% (16,576 people) work as paid caregivers (86% in people's homes, and 14% in institutional settings).

150. *Instituto de Efectividad Clínica y Sanitaria.*

Computing weights

To correct the fact that some countries are overrepresented in the IDB caregivers survey, which affects calculations of regional averages, this study weights the observations based on the distribution of the older population in the region's countries. Ideally, the weights would be based on the distribution of paid and unpaid caregivers across the region's countries, but this information is only available for some countries (see **Table 3.1** and **Table 4.1**).

Additionally, paid caregivers are weighted within each country based on the assumption that 9.4% of paid caregivers work in institutional settings and 90.6% in people's homes. These proportions are based on the regional ratio in the data in **Table 4.1**. This ratio is similar to the one observed in the data collected by the IDB Caregivers Survey (13.6%).

The following equation gives the weight for caregivers in category j (j=1 for unpaid, j=2 for paid in institutional setting, and j=3 for paid in homes) in country c:

$$w_{jc} = \frac{N_j * \frac{olderpop_c}{olderpopLAC}}{n_{jc}}$$

Where:

- n_{jc} is the number of observations of caregivers in category j in country c in the IDB caregivers survey.
- N_j is the total number of caregivers in category j in Latin America and the Caribbean. This equals 25 million for unpaid caregivers (see **Table 3.1**); 289,225 for paid caregivers in institutional settings (see **Table 4.1**); and 2,725,415 for paid caregivers in homes (see **Table 4.1**);
- $olderpop_c$ is the number of older people in country c, as reported in the United Nations World Population Prospects dataset.
- $olderpopLAC$ is the total number of older people in the 26 Latin American and Caribbean countries included in the analysis, as reported in the United Nations World Population Prospects dataset.

Analysis of survey representativeness

To assess the representativeness of the survey, the analysis compares basic descriptive statistics on age and sex from the IDB caregivers survey with figures from nationally representative sources: time-use surveys in the case of unpaid caregivers (see **Chapter 3**) and labor and household surveys for paid caregivers (see **Chapter 4**). **Table C.1** contains the results of this exercise, showing that:

- Caregivers in the IDB survey are relatively older than in nationally representative surveys. This is true for all countries with available data, for both paid and unpaid caregivers.
- The percentage of female caregivers in the IDB survey is higher than in nationally representative surveys, a difference that is particularly large among unpaid caregivers.

These differences may reflect bias in reaching the population of interest, possibly due to self-administration through an online survey. Applying a questionnaire exclusively online creates a risk of three types of biases in the sample. The first is a coverage bias, because people without access to the internet or with limitations in using technology are excluded from the survey, making it difficult to generalize the results to the target population. The second is a selection bias: since participation is voluntary, the sample obtained through a survey with these characteristics may not represent the general population of caregivers. Lastly, there can be a non-response bias, because the characteristics of people who do not respond or provide incomplete responses may differ from those of people who choose to respond. Non-response or incomplete-response rates are usually higher for online surveys than for other modalities.

TABLE C.1 COMPARISON OF BASIC CHARACTERISTICS IN THE IDB SURVEY AND NATIONALLY REPRESENTATIVE SURVEYS

		AGE (YEARS)		% WOMEN	
COUNTRY	PAID OR UNPAID	IDB CAREGIVERS SURVEY	NATIONALLY REPRESENTATIVE SURVEYS	IDB CAREGIVERS SURVEY	NATIONALLY REPRESENTATIVE SURVEYS
Argentina	Paid	49.6	41.2	92.5	76.9
	Unpaid	55.9	52.4	91	58.0
Brazil	Paid	53.9	44.1	91.9	93.6
	Unpaid	57.5	49.9	90.8	61.7
Chile	Paid	57.7	43.8	95.3	87.3
	Unpaid	60	56.5	90.6	59.8
Colombia	Paid	50.2	41.3	91.1	92.7
	Unpaid	54.5	55.9	87.1	76.3
Costa Rica	Paid	50.6	42.1	89.9	64.2
	Unpaid	55.2	51.2	87.6	57.7
Ecuador	Paid	49.6	43.1	93.2	93.7
	Unpaid	53.8	n.a.	84.6	n.a.
Jamaica	Paid	51.1	40.4	96.7	68.9
	Unpaid	55.8	n.a.	89.8	n.a.
Mexico	Paid	52.6	37.3	91.5	96.6
	Unpaid	54.5	46.9	85.8	54.9
Panama	Paid	51.9	41.0	88,5	60.3
	Unpaid	54.7	n.a.	90.7	n.a.
Paraguay	Paid	48.6	36.4	93.8	90.2
	Unpaid	52.5	48.6	87.2	65.5
Peru	Paid	53	36.3	93.0	98.0
	Unpaid	56.8	n.a.	84.9	n.a.
Trinidad and Tobago	Paid	50.5	44.4	93.9	97.6
	Unpaid	55.2	n.a.	86.5	n.a.
Uruguay	Paid	54.4	45.5	93.9	90.0
	Unpaid	54.5	60-64	94.0	60.7
Average	Paid	52.4	41.3	91.92	85.7
	Unpaid	56.3	49.1*	91.8	59.0

Source: Prepared by the authors.
Notes: nationally representative estimates come from time use surveys (see Annex A ➔) and household and labor force surveys (see Annex B ➔).
*Average does not include Uruguay, as age is reported in ranges in the Uruguayan data. N.a. = not available.

Annex D • National Care Policies

TABLE D.1 STATUS AND OVERVIEW OF NATIONAL CARE POLICY IMPLEMENTATION IN LATIN AMERICA AND THE CARIBBEAN

BILLS OR PROPOSALS ARE COLORED ORANGE, AND APPROVED POLICIES AND LAWS ARE COLORED GREEN

COUNTRY	POLICY	ENTITY RESPONSIBLE	PURPOSE AND TARGET GROUP	INCLUSION OF PAID AND UNPAID CARE
Argentina	Care in Equality Bill	Former Ministry of Women, Genders and Diversity	Create the Integral System of Care Policies (Sistema Integral de Políticas de Cuidados de Argentina) to comprehensively address care, including for older people	Yes (addresses the need to formalize care)
Barbados	National Policy on Ageing (2022–2033): Making Healthy and Active Ageing a Reality for All	Ministry of People Empowerment and Elder Affairs	Long-term care as key priority: design, coordination, and provision of high-quality and accessible long-term care systems, services, facilities, and supporting resources for older people	Yes (Strategy G.1.2)
Brazil	Organic Law 15069/2024	Ministry of Development and Social Assistance, Family and Fight against Hunger; Ministry of Women; and Ministry of Human Rights and Citizenship	Establish the National Care Policy, with care workers (formal and informal) as two of the five priority groups	Yes
Chile	Bill 16905-31 Recognizing the Right to Care and Creating the National Support and Care System	Ministry of Social Development and Family	Gradually and progressively guarantee people's right to care, paid or unpaid; framing care broadly, including older people	Yes (art. 3, art. 7 f.)
Colombia	Law 2281 of 2023 Creating the National Care System, with an Institutional Mission Mandated by the National Development Plan Colombia World Power of Life (2022–2026)	Ministry of Equality and Equity	Strengthen and integrate services for training, welfare, income generation, and capacity building for paid and unpaid caregivers, capacity-building services	Yes
	National Public Policy on Aging and Old Age 2022–2031	Ministry of Health and Social Protection	Target group: everyone residing in Colombia, particularly those 60+	Yes. Strategic line of action 6, line of action 3
Costa Rica	National Care Policy (2021–2031)	Ministry of Human Development and Social Inclusion	Create a care system for care-dependent people: focus on people with care dependency, understood as a permanent or prolonged situation	Strategic line of action 5

COUNTRY	POLICY	ENTITY RESPONSIBLE	PURPOSE AND TARGET GROUP	INCLUSION OF PAID AND UNPAID CARE
Dominican Republic	National Care Policy	-	-	-
Ecuador	Organic Law on the Right to Human Care	Ministry of Social and Economic Inclusion	Establishes the right to care for children, direct dependents, or other family members who need care or protection	Only unpaid
	National Integral Care System Bill, 2021	Commission on the Right to Work and Social Security	Target group: everyone who needs care including older adults and carers (especially female)	Yes
El Salvador	National Policy on Shared Responsibility for Care 2022–2030	Social Welfare Office	Target population includes adults (18+) who require care due to disability or aging, and care workers, both paid and unpaid	Yes
Mexico	Several bills are currently undergoing the legislative approval process	-	Recognize the right to care and create the National Care System	-
Peru	Bill 2735, Bill 3242/2022-CR, Bill 4705/2022-CR, Bill 5308/2022-CR	Ministry of Women and Vulnerable Populations	All four of these bills have been tabled. They propose to recognize the right to care and create the National Care System	Yes
Trinidad and Tobago	National Policy on Aging	Ministry of Health and of Social Development and Family Services	Target population: older people. Managed by the Division of Ageing	Yes
Uruguay	National Care Plan 2021–2025	Ministry of Social Development	Not specifically focused on older people but includes them and their care workers as target populations	Yes

Source: OECD-IDB Long-Term Care Workforce Questionnaire.

The report quantifies the rising demand for long-term care workers in one of the most rapidly aging regions worldwide. It highlights the precarious working conditions of paid care workers, the consequences of caring for unpaid carers as well as the limited training opportunities and the particular burden on women for both groups of workers. It also describes policies and best practices to support family caregivers, expand and professionalize the care workforce, and build more resilient care systems for the Latin American and the Caribbean region, also building on the experience of OECD countries.

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