

POLICY ON LONG-TERM CARE

Introduction

1. The Region of the Americas has experienced a significant increase in life expectancy at birth. However, healthy life expectancy has not achieved the same gains, causing a gap of approximately 12 years between these 2 indicators. This translates into an increase in years lived with disability and dependency, a period during which many people will require long-term care (LTC) (1, 2). LTC needs, however, may arise at any age throughout the life course (3).
2. Declines in a person's functional ability typically give rise to chronic and complex needs for support. Long-term care includes a series of activities carried out by paid or unpaid caregivers to optimize functioning and compensate for permanent or temporary loss of capacities, consistent with a person's rights, fundamental freedoms, and human dignity (4). In light of demographic and epidemiological trends, countries of the Region, and their health systems in particular, will face significant additional costs for LTC services (5). Moreover, the lack of LTC policies and institutional capacity across the Region will impact its human, economic, and social development.
3. To tackle the challenges related to care dependency¹ and its impact on individuals, health systems, and societies, countries urgently need to invest in increased access to LTC and disability prevention services across the life course. These services must be organized and coordinated by the health and social care systems. This Policy on Long-term Care, covering the period 2025–2034, provides the Member States of the Pan American Health Organization (PAHO) with strategic and technical guidance for the development, strengthening, and expansion of LTC capacities in the Region.

Background

4. Several policies and strategies approved by PAHO Member States recognize the importance of LTC. For example, the Strategic Plan of the Pan American Health Organization 2020–2025 highlights the need to monitor the proportion of people aged 65+ who are dependent on care (6). The Strategy for Universal Access to Health and Universal Health Coverage acknowledges the importance and value of unpaid care and support, provided mostly by women, to individuals living with a disability, chronic health condition, and/or frailty who have limited capacity to care for their health and well-being

¹ Care dependency arises “when functional ability has fallen to a point where an individual is no longer able to undertake the basic tasks that are necessary for daily life without assistance” (4).

independently (7). PAHO is leading the United Nations Decade of Healthy Aging (2021–2030) initiative in the Americas, which has LTC as one of its key areas of action (8).

Situation Analysis

5. Although more data is needed, the World Health Organization (WHO) estimates that 1.3 billion people—about 16% of the global population—experience significant disability.² An important proportion of them require long-term care. The global prevalence of disability increases with age, rising from 5.8% in children and adolescents aged 0–14 years to 34.4% among older adults aged 60 and above. The prevalence of disability with severe functional limitation and LTC needs is increasing in part because of a rise in noncommunicable diseases, including neurological and mental health conditions (10). As of 2020, at least 8 million older people required LTC in Latin America and the Caribbean (LAC), and this figure is likely to triple, reaching 23 million, by 2050 (11).

6. Meeting LTC needs constitutes a major challenge for health and social protection systems in the Region of the Americas. It is estimated that financing LTC in the Region would cost, on average, 0.27% of gross domestic product (GDP) in a low-coverage scenario,³ and that this figure will increase to 0.77% of GDP by 2050 (12). Global evidence suggests that investing in LTC results in cost savings for the health system. In Spain, for example, expanding care services for dependent persons led to fewer hospital admissions and shorter stays, with a consequent 11% reduction in costs (13).

7. On average, people from disadvantaged socioeconomic groups, including those with less formal education, experience higher levels of functional decline. In Uruguay, for example, care dependency among people 65 and over was observed in 15.3% of individuals who did not attend school compared to 5.1% of those who completed tertiary education (14). In Chile, 28.4% of dependent older people belong to the lowest income quintile (15).

8. Despite the current and projected demand for LTC, the formal provision of such care is currently insufficient in the Region, with excessive reliance on unpaid care provided by family members (14, 16). In Argentina, for example, family members provide 77% of care for dependent older adults (17). Women are the main informal caregivers, representing more than 70% of the unpaid care for older people in the Region (18).

9. While informal caregiving can lead to a sense of fulfillment and accomplishment, it has substantial negative impact on caregivers' health and well-being. Recent data from the United States shows that 19.2% of caregivers report being in fair or poor health (19). Moreover, unpaid caregiving imposes an economic cost on households when caregivers are obliged to leave paid employment or scale back their hours to accommodate their care duties. In Brazil, 25.8% of caregivers indicated that they had stopped working or quit school to provide care (20). Reduction of the caregiving workload can have economic and societal benefits that go beyond the health sector, as it allows greater participation of caregivers, especially women, in other activities, including in the labor market (21, 22).

² Disability serves as an umbrella term for impairments, activity limitations, or participation restrictions. It is important to point out that the presence of functional limitations does not necessarily equate to care dependency (9, 3).

³ The study estimated the potential cost of low, medium, high, and full LTC coverage for 17 countries in the Region. The low-coverage scenario envisioned covering 35% of the population over age 65 who are experiencing care dependence.

10. Although unpaid family caregiving still accounts for the majority of LTC, its contribution is shrinking due to smaller family sizes and the increased participation of women in the labor market. The declining availability of family care at a time when demand for LTC is rising means a steadily increasing need for formal care workers, who may provide care in homes or in institutional settings. It is estimated that LAC requires close to 5 million formal care workers to meet the current demand for LTC. This figure will increase to nearly 9 million workers by 2035 and to more than 14 million by 2050 (23). There is a need to increase training and human resource education to improve LTC services. In Mexico, for example, less than 3% of the staff working in LTC facilities are properly trained (24).

11. Appropriate staffing levels, effective training and professional development for care workers are among the key elements that contribute to quality care in LTC facilities (25). Staffing is one of a number of challenging issues that these institutions face. These issues became apparent during the COVID-19 pandemic, when many institutions appeared ill prepared to protect older people; nearly half of all deaths worldwide during the early phase of the pandemic occurred in these settings (26).

12. LTC services are provided by the health and/or social care sectors, but frequently with no coordination between them. Due to the increased demand, the private sector is assuming an important role in LTC provision, but its involvement is poorly regulated (3). When LTC is based on the primary health care strategy, as part of a continuum of integrated care, this can promote better coordination between sectors and the delivery of services that meet the needs of care-dependent individuals and their caregivers (5). This structure supports LTC provision in the community, fosters aging in place,⁴ and improves health equity. It also contributes to the prevention of care dependency through specific interventions, such as assistive technology, that help to optimize and monitor a person's functional ability (5, 27). Provision of adequate LTC options can reduce the use of acute health services associated with LTC needs, contributing to the sustainability of the entire system. In Brazil, the public health system spends a minimum of US\$ 123 million per year on prolonged hospitalizations, including those not directly linked to a medical cause (28).

13. Countries including Argentina, Brazil, Canada, Chile, Colombia, Costa Rica, the Dominican Republic, Uruguay, and the United States of America have advanced in the development and implementation of care policies. However, there are challenges in defining the scope of LTC and improving its integration into broader care structures in countries, which include gender equity and poverty relief initiatives. The continued development of LTC policies and effective coordination between the social and health care systems are necessary to address the needs of a growing population dependent on care, as well as the needs of caregivers.

Proposal

14. This policy proposes priority actions for the development, strengthening, and expansion of long-term care in the Region. It proposes five lines of action to support the delivery of integrated and sustainable long-term care across the life course.

⁴ Aging in place is the ability of older people to live in their own home and community safely, independently, and comfortably, regardless of age, income or level of intrinsic capacity (4).

Line of Action 1: Strengthen governance, accountability, and stewardship through intersectoral policies to meet long-term care needs

15. A national intersectoral policy should form the basis for the organization and provision of LTC, with multiple sectors⁵ participating through structured governance mechanisms. A leading ministry, department, or other government entity should be designated to coordinate the various sectors and actions. The health care sector must play a significant role in designing, planning, implementing, and monitoring the delivery and integration of LTC across sectors, as well as in developing strategies to prevent care dependency, particularly for populations in conditions of vulnerability.

16. National LTC policy, strategies, and plans should define the responsibilities of each sector, addressing priority health and social needs and organizing models of care to address them. Each country should assess its current capacity for LTC delivery and identify the measures needed to respond to current and future needs.

Line of Action 2: Strengthen workforce capacity for long-term care, including health and social care workers and unpaid caregivers

17. The LTC paid workforce needs to be formalized and certified, expanded in number, sustained, valued, and strengthened through continuous training along with the establishment of minimum professional competencies. PAHO's Policy on the Health Workforce 2030 (29) offers a framework for strengthening workforce capacities to provide LTC through interprofessional and collaborative team-based care.

18. Unpaid care must be recognized and valued as a key part of LTC, but it should also be counterbalanced by the delivery of formal LTC to reduce the care workload currently placed on families, especially women. Training and support mechanisms for informal caregivers need to be implemented, expanded, and assessed. The integration of LTC within primary health care can promote community outreach, engagement, and the provision of services for informal caregivers, such as assistive technologies, respite care, and psychological support.

Line of Action 3: Strengthen the organization and delivery of person-centered and integrated long-term care, responding to the different needs of care recipients and caregivers

19. Needs and outcome assessments that are comprehensive, reliable, equity-focused, ethical, and culturally acceptable are required to inform LTC practices and achieve continuous improvement. An evidence-based and person-centered model of care should be in place to guide the integration, assessment, and delivery of LTC along a continuum that stretches from prevention of disability to end-of-life care.⁶

⁵ Includes all relevant sectors: government (ministries, technical groups, legislators, and others), nonprofit organizations, philanthropic organizations, volunteer groups, civil society organizations, private sector entities, multilateral organizations, academia, and others.

⁶ The continuum of long-term care "emphasizes coordination across health and social sectors through effective governance, seamless transition across settings (home-based, community, facility care, acute care), and coordinated provision and collaboration across various care roles (prevention, rehabilitation, palliative care, acute care) spanning all levels of intensity of care and providing care in a timely manner" (5).

20. Decisions regarding the delivery of person-centered and culturally appropriate LTC interventions and services must be informed by guidelines grounded in the best available evidence. Efforts should be made to reach populations whose voices, needs, and priorities have been historically excluded and marginalized as well as those without social protection, promoting equitable access to LTC.

21. Community and home-based LTC provides physical, social, and emotional health benefits and should be strengthened and expanded to promote aging in place. Health centers at the first level of care that are strategically located and inserted within communities can provide an entry point and facilitate access for people with LTC needs and their families in the community, from prevention of LTC needs to end-of-life care.

22. Standards for quality in LTC need to be implemented in every context and must apply to all relevant sectors. It is necessary to invest in designing adequate, culturally appropriate standards for different care settings (community-based, home-based, facility-based, hospital-based, etc.) and to implement a quality management/monitoring approach.

Line of Action 4: Increase and optimize sustainable and equitable financing for long-term care

23. National budgets should allocate public funding across social care and health systems to meet the need for LTC, taking into consideration its multisectoral characteristics. Countries should develop multisectoral budgets for LTC based on planning processes in accordance with the national context.

24. Countries need to urgently increase the level of funding for LTC from multiple sources, with priority to public funding, recognizing that failure to invest now will lead to greater costs in the future. In addition, immediate investments in LTC will reduce the risk of catastrophic expenditure for households, impoverishment, and other inequities for those needing care and for caregivers.

25. Health authorities need to increase investment in health and improve the efficiency of the health system, with a focus on preserving functional ability to prevent disabilities and care dependence. These investments need to be mainstreamed throughout the health system, in particular through primary health care, to ensure an integrated care approach.

Line of Action 5: Strengthen information systems for long-term care and improve data collection and research

26. There is an urgent need to develop robust and transparent information systems to guide evidence-based policymaking on LTC and inform appropriate care decisions. LTC data must capture the needs of all populations, including care recipients and caregivers; it should be disaggregated, collected continuously, and stratified by degrees of dependency. In addition, an increase in LTC research is essential for continuous improvement in quality, efficiency, and effectiveness of LTC.

Monitoring and Evaluation

27. The monitoring and assessment of this policy will be aligned with the results-based management frameworks of both PAHO and WHO and with their performance, monitoring, and assessment processes. The Governing Bodies of PAHO will be informed of the progress made and

challenges encountered in the implementation of the policy through a midterm review in 2029 and a final report in 2035.

Financial Implications

28. Member States should prioritize the allocation of resources toward the implementation of this policy as appropriate. The Pan American Sanitary Bureau will endeavor to mobilize additional resources for the implementation of this policy to support Member States (see Annex B).

Action by the Directing Council

29. The Directing Council is invited to review the information presented in this document, provide any comments it deems pertinent, and consider approving the proposed resolution presented in Annex A.

Annexes

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Proposed Resolution

POLICY ON LONG-TERM CARE

The 61st Directing Council,

(PP1) Having reviewed the *Policy on Long-term Care* (Document CD61/8);

(PP2) Considering that addressing needs in long-term care (LTC) presents challenges for economies and for health and social protection systems in the Region of the Americas, given current and future demographic and epidemiological trends;

(PP3) Noting that in order to achieve universal access to health and universal health coverage, comprehensive, continuous, person-centered, and integrated LTC capacity is required to address needs, increase healthy life expectancy, improve equity, and reduce catastrophic expenditures for individuals, families, and systems;

(PP4) Recognizing that the formal provision of LTC in the Region is currently insufficient, with strong reliance on the unpaid care provided by family members, especially women, and that future demand for LTC will increase significantly and rapidly, with an expected increase in levels of care dependency;

(PP5) Recognizing the urgent need to advance the development of intersectoral LTC capacity and strengthen the capacity of ministries of health to optimize functional ability and prevent functional loss, integrating action across health and social care sectors to address the needs of both care recipients and caregivers;

(PP6) Noting the need to improve data collection and information systems that can detect and monitor needs and prioritize actions effectively, particularly for populations in conditions of vulnerability;

(PP7) Considering the need to invest in formal LTC provision and the cost of inaction in terms of health outcomes, healthy life expectancy, impact on caregivers, and increased risk of household catastrophic expenditure,

Resolves:

(OP)1. To approve the *Policy on Long-term Care* (Document CD61/8).

(OP)2. To urge all Member States, considering their national contexts, needs, vulnerabilities, and priorities, to:

- a) develop, implement, and monitor intersectoral policies that prioritize, create, and expand LTC capacity in line with current and projected population health needs, and formalize the provision of this type of care within health and social care sectors to increase access to LTC, especially for people in conditions of vulnerability;
- b) strengthen governance and stewardship capacities across all relevant sectors to meet LTC needs, with effective participation of ministries of health in the planning, regulation, intersectoral coordination, and provision of LTC;
- c) strengthen the organization and delivery of culturally appropriate, person-centered, and integrated LTC, responding to the different needs of care-dependent individuals and their caregivers and prioritizing the delivery of community and home-based LTC, based on the primary health care strategy;
- d) strengthen workforce capacity for LTC and the formalization and organization of health and social care collaborative teams, and increase training and support for unpaid caregivers who are integral to the delivery of LTC;
- e) increase and optimize sustainable LTC financing across all sectors as a strategic investment in health, equity, and financial and social protection of the population;
- f) increase data collection and research on LTC and include more LTC-relevant information in national monitoring systems.

(OP)3. To request the Director to:

- a) provide technical cooperation to Member States to strengthen capacities that contribute to the implementation of the policy and the achievement of its objectives;
- b) support the strengthening of interagency coordination and collaboration mechanisms to achieve synergies and efficiency in technical cooperation, including within the United Nations system, the inter-American system, and other stakeholders working in LTC;
- c) support the development of national intersectoral policies, regulatory frameworks, and national capacities that will increase access to LTC in the Region;
- d) report periodically to the Governing Bodies of Pan American Health Organization on the progress made and challenges faced in the implementation of the policy through a midterm review in 2029 and a final report in 2035.

Analytical Form: Programmatic and Financial Implications

1. Agenda item: 4.5 - Policy on Long-term Care																
2. Responsible unit: Health Systems and Services, Life Course Unit																
3. Preparing officers: Dr. James Fitzgerald, Dr. Enrique Vega, and Ms. Patricia Morsch																
4. List of collaborating centers and national institutions linked to this Agenda item: N/A																
5. Link between Agenda item and the Sustainable Health Agenda for the Americas 2018–2030: Goal 1: Expand equitable access to comprehensive, integrated, quality, people- family- and community-centered health services, with an emphasis on health promotion and disease prevention Goal 9: Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders Goal 11: Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and subregional approaches to the social and environmental determinants of health																
6. Link between Agenda item and the Strategic Plan of the Pan American Health Organization 2020–2025: Impact indicator 8: Proportion of adults 65+ who are care dependent Outcome 2: Health throughout the life course Outcome 3: Quality care for older people																
7. Time frame for implementation and evaluation: This policy covers the period 2025–2034.																
8. Financial implications: a) Total estimated cost for implementation over the lifecycle of the resolution (including staff and activities): <table border="1" style="margin-left: 20px; width: 60%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Areas</th> <th style="text-align: right;">Estimated cost (US\$)</th> </tr> </thead> <tbody> <tr> <td>Human resources</td> <td style="text-align: right;">1 500 000</td> </tr> <tr> <td>Training</td> <td style="text-align: right;">400 000</td> </tr> <tr> <td>Consultants/service contracts</td> <td style="text-align: right;">500 000</td> </tr> <tr> <td>Travel and meetings</td> <td style="text-align: right;">500 000</td> </tr> <tr> <td>Publications</td> <td style="text-align: right;">350 000</td> </tr> <tr> <td>Supplies and other expenses</td> <td style="text-align: right;">250 000</td> </tr> <tr> <td>Total</td> <td style="text-align: right;">3 500 000</td> </tr> </tbody> </table>	Areas	Estimated cost (US\$)	Human resources	1 500 000	Training	400 000	Consultants/service contracts	500 000	Travel and meetings	500 000	Publications	350 000	Supplies and other expenses	250 000	Total	3 500 000
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b) Estimated cost for the 2024–2025 biennium (including staff and activities): US\$ 700 000.																
c) Of the estimated cost noted in b) above, what can be subsumed under existing programmed activities? All of the costs noted in b) can be subsumed under existing programmed activities.																