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GLOBAL STANDARDS FOR LONG-TERM CARE

Working draft for public consultation

May 2026

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Department of Sexual, Reproductive, Maternal, Child, Adolescent Health and Ageing

World Health Organization

Global Standards for Long-Term Care

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2 organizations, providers of long-term care, older people and their carers, and all interested
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Abbreviations

The following abbreviations appear five or more times across the document. Acronyms used fewer than five times in any single chapter are spelled out at each occurrence within that chapter.

62 **Table 1.** *Abbreviations used in this document*

Abbreviation	Full term
ASEAN	Association of Southeast Asian Nations
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIHI	Canadian Institute for Health Information
CMS	Centers for Medicare & Medicaid Services (United States)
COVID-19	Coronavirus disease 2019
CQC	Care Quality Commission (United Kingdom)
CRPD	Convention on the Rights of Persons with Disabilities
HCBC	Home and community-based care
HIQA	Health Information and Quality Authority (Ireland)
ICOPE	Integrated Care for Older People
ILO	International Labour Organization
IPC	Infection prevention and control
LMIC (LMICs)	Low- and middle-income country (countries)
LTC	Long-term care
LTCF (LTCFs)	Long-term care facility (facilities)
OECD	Organisation for Economic Co-operation and Development

Abbreviation	Full term
PCCP (PCCPs)	Person-centred care plan(s)
UN	United Nations
WHO	World Health Organization

Introduction

Background and rationale

Box 1. *Why standards matter: family experiences*

> *When Mrs Chen, 78, needed help after a stroke, her family struggled to find reliable care services. Without clear standards, they had no way to assess quality, understand what services should provide, or know what questions to ask. They felt lost navigating an unfamiliar system at a moment of crisis. In contrast, when Mr Okonkwo's family sought care for their father, they found that national standards gave them a framework: they knew what trained care workers should be able to do, what rights their father had, and what to expect from services. The standards did not guarantee perfect care, but they provided a common language and clear expectations that helped the family advocate for their father's needs.*

The global imperative

By 2050, the number of people aged 60 years and over will reach 2.1 billion globally. The need for long-term care is growing rapidly across all regions, yet the systems to deliver quality care have not kept pace. Many countries lack any national framework defining what long-term care should look like, what people receiving care can expect, or what responsibilities governments and providers hold.

Long-term care encompasses the range of services and supports that people with significant functional limitations need to live with dignity, autonomy and participation in society. It includes care provided in homes and communities, in residential facilities, and crucially, the often invisible work of millions of unpaid carers, predominantly women, who provide the majority of care worldwide.

The gap

Evidence from the 2025 United Nations (UN) Decade of Healthy Ageing progress survey indicates that a significant proportion of World Health Organization (WHO) Member States still lack comprehensive standards for long-term care. Where standards exist, they often focus narrowly on residential facilities while neglecting home- and community-based services and the recognition and support of unpaid carers. This fragmentation leaves older people and their families without clear expectations and accountability mechanisms.

The absence of standards creates wide variation in care quality within and across countries. Without agreed expectations, service users cannot know what they are entitled to, providers lack guidance for quality improvement, and governments cannot effectively regulate or

26 monitor care systems. The result is an unequal provision of care, where the quality of
27 support a person receives depends more on geography and resources than on their needs
28 and rights. In the absence of clear standards, the quality of care becomes dependent on the
29 individual commitment of healthcare workers, leading to a personalized pattern of provision
30 in which some professionals remain up to date with guidelines and strive for high-quality
31 care while others do not, resulting in marked variability in practice and outcomes.

32 Building on WHO's work on healthy ageing and long-term care

33 This document builds upon WHO's ongoing work to support healthy ageing and strengthen
34 long-term care systems globally. It forms part of the continuum of integrated care for older
35 people that WHO has been developing over the past decade.

36 **The Integrated Care for Older People (ICOPE) approach** (2017 guidelines, 2019
37 implementation framework for service and system managers, 2024 guidance for health and
38 care workers) provides evidence-based recommendations for optimizing intrinsic capacity
39 and functional ability in older age. ICOPE supports prevention and early interventions in
40 primary care including community settings — detecting and addressing declines in
41 locomotor capacity, vitality, sensory capacities (vision and hearing), cognitive capacity, and
42 psychological capacity . The ICOPE approach emphasizes person-centred, integrated
43 continuum of care that places the needs and preferences of older people at the centre.

44 **These global standards for long-term care** address the care and support needed when
45 the loss of intrinsic capacity is significant and sustained, when people require ongoing
46 assistance to maintain their functional ability. While ICOPE focuses on maintaining and
47 optimizing capacity, long-term care standards address the quality and rights dimensions of
48 care for those who need regular support. Together, ICOPE and long-term care standards
49 form a continuum: from prevention and early intervention to quality long-term care when
50 needed.

51 This document also builds on:

52 - **The 2021 WHO long-term care framework** establishes the conceptual foundation
53 and defines what long-term care encompasses and how it relates to health and
54 social systems.

55 - **The 2024 WHO long-term care package for UHC** provides practical tools and
56 guidance for countries developing and strengthening long-term care services.

57 Together, these guidance documents offer Member States a comprehensive suite of
58 resources to build, strengthen, and sustain integrated systems that support healthy ageing
59 and quality long-term care.

60 WHO mandate

61 The development of global standards for long-term care responds to commitments in the UN
62 Decade of Healthy Ageing 2021–2030, which identifies long-term care as a priority action
63 area. Multiple World Health Assembly resolutions have called on WHO to support Member
64 States in strengthening long-term care systems. These standards fulfil that mandate by
65 providing an evidence-informed, globally applicable framework that can be adapted to
66 diverse country contexts.

67 Purpose and scope of this document

68 What this document provides

69 These standards offer a framework applicable across diverse settings and adaptable to
70 different country contexts and resource levels. They articulate *what should exist* — the
71 expectations, principles, and components of quality long-term care — while allowing
72 flexibility in *how* countries implement them.

73 The standards address:

74 • definitions and foundational principles

75 • home and community-based care

76 • long-term care facilities

77 • support for unpaid carers

78 • workforce

79 • governance

80 • financing

81 • quality monitoring

82 **Figure 1.** *Provisional structure of the Global Standards for Long-Term Care*

83

84 How implementation will be supported

85 These standards are intended to be used alongside a growing suite of WHO resources for
86 long-term care. The 2021 WHO long-term care framework and the 2024 WHO long-term
87 care package for universal health coverage already provide foundational tools. Further

materials are envisaged to support country adaptation and progressive realization, including assessment tools, implementation guidance and training resources.

Country examples appear throughout this document to illustrate how individual standards have been approached in different settings. These examples are not offered as models for replication; rather, they serve as concrete entry points for collective learning and dialogue on how globally relevant expectations can be translated into context-specific practice. Their selection is illustrative and is expected to expand through the consultation and post-publication phases.

What this document is not

These standards are not a regulatory instrument. Countries will adapt them to their legal and institutional contexts. They do not prescribe quantitative targets (such as specific staffing ratios) that would be inappropriate across different resource settings. They provide a normative framework, not a compliance checklist.

The standards are not guidelines for clinical care services. Detailed guidance on specific conditions (such as dementia care or palliative care in long-term care settings) can be sought in existing or future guidelines or training materials from WHO.

Scope and boundaries

The standards focus on long-term care for older people while recognizing that long-term care systems often serve people of all ages with functional limitations. The principles and many standards are broadly applicable, though specific guidance for other populations may require supplementary materials.

Some standards in this document describe foundational expectations that every long-term care system should pursue immediately, in line with the rights-based approach that anchors universal health coverage and the UN Decade of Healthy Ageing. Other standards describe capacities that countries may develop progressively over time, in sequences and at paces shaped by their resources, governance arrangements and existing care systems. Both are global standards: the first establish what cannot be deferred — including dignity, autonomy, protection from abuse, and recognition of unpaid carers — while the second describe the direction of system strengthening that countries should be supported to pursue. Country-level adaptation is expected, and equivalent system functions may be achieved through different institutional arrangements. The standards do not assume any single model of formal services as the starting point, and apply across formal and informal care, including family, home, community and residential settings.

Intended audience

These standards are designed for multiple audiences, each of whom can use the document in different ways.

124 **Table 2.** *Audiences for these standards*

Audience	How to use these standards
Primary users	
Policy-makers and legislators	Developing or revising national long-term care frameworks, legislation, and strategic plans
Regulatory and accreditation bodies	Establishing or updating standards for licensing, inspection, and quality assurance
Long-term care service providers (public and private)	Improving service quality, self-assessment, and continuous improvement
Health and social care professionals	Understanding quality expectations and professional competencies
Other key audiences	
Older people and their families	Understanding their rights and what to expect from care services; holding governments and providers accountable
Unpaid carers	Knowing what support they are entitled to; advocating for recognition and resources
Organizations of older people and carers	Advocacy, monitoring, and participating in governance of long-term care systems
The general public	Understanding what quality long-term care looks like — as future care recipients, carers, or citizens holding systems accountable

125 **Box 2.** *Voices from a national consultation*

During Canada's national consultation on long-term care standards, over 18,000 people — including residents, family members, and care workers — shared their experiences and priorities. One unpaid carer reflected: "For years, I didn't know what questions to ask or what good care should look like. When I finally saw the standards, I realized there was a benchmark — something I could use to understand what my mother deserved and to

have meaningful conversations with the care home about her needs." This feedback underscored a consistent theme: people want and deserve care that is high-quality and safe, and clear standards help families navigate an unfamiliar system during some of life's most difficult moments.

How this document was developed

Development process

These standards were developed through a rigorous, multi-stage process:

- **Evidence synthesis:** Landscape analysis of existing national standards across regions; literature review of evidence on long-term care quality; analysis of gaps and common elements across jurisdictions.
- **Expert consultation:** Technical working groups comprising international experts in each domain (home and community-based care, facilities, unpaid carers, workforce, governance, financing, quality monitoring) contributed to drafting and review.
- **Advisory Committee:** A multi-stakeholder Advisory Committee provided strategic guidance throughout development, ensuring diverse perspectives were incorporated.
- **Global public consultation:** Broad engagement with stakeholders worldwide to ensure the standards reflect diverse contexts and priorities (see below).

The importance of global consultation

Before finalization, these draft standards are being released for global public consultation. This consultation is a defining feature of the development process — not an afterthought, but essential to the legitimacy and eventual success of the standards.

Experience from countries that have developed national standards for long-term care demonstrates that broad consultation does far more than improve document quality. It builds the coalitions and shared understanding necessary for implementation. When stakeholders participate in developing standards, they become advocates for their adoption. Consultation creates ownership, surfaces implementation challenges early, and ensures that standards reflect the realities faced by those who will use them.

- **Canada:** The CSA Group and Health Standards Organization engaged over 18 000 Canadians through surveys, consultation workbooks, town halls, and virtual visits with residents. This participatory process, going well beyond regulatory requirements, resulted in standards shaped by lived experience. Families reported that participating in development helped them understand what quality care should look like, while providers gained clarity on expectations.

155 - **Australia:** The development of the Aged Care Quality Standards involved extensive
156 consultation with older people, families, providers, and the workforce. This process
157 contributed to standards that older Australians understood and could use to hold
158 providers accountable. The consultation also built awareness that supported
159 subsequent implementation.

160 - **Ireland:** The Health Information and Quality Authority developed national standards
161 through working groups that included service users, providers, and advocacy groups,
162 ensuring a shared vision across stakeholders. Ongoing engagement through national
163 experience surveys continues to inform how standards are monitored and refined.

164 - **Republic of Korea:** Public consultation on long-term care insurance reforms
165 incorporated input from older people's organizations, contributing to policies that
166 better reflected user needs and priorities.

167 These experiences show that consultation serves multiple purposes: improving content
168 quality, building legitimacy, creating implementation champions, and raising public
169 awareness of what quality long-term care should look like.

170 WHO's consultation approach

171 The global consultation for these standards aims to:

172 - Gather input from all six WHO regions, with materials available in WHO official
173 languages

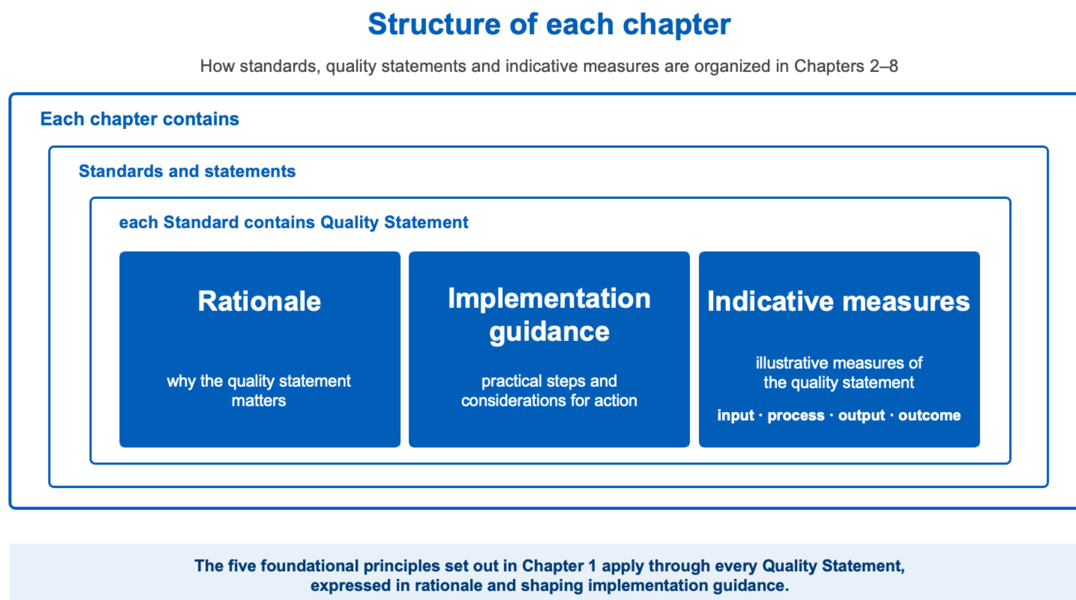
174 - Engage not only technical experts but older people, carers, and civil society
175 organizations

176 - Ensure that standards reflect the realities and priorities of both high-income and low-
177 and middle-income countries

178 - Build awareness and ownership that will support implementation

179 How to use this document

180 **Figure 2.** *Structure of each chapter*



181

182 Reading guidance

183 • **All readers** should begin with Chapter 1, which establishes the principles that apply
184 across all domains.

185 • **Readers with specific interests** may then navigate directly to relevant chapters.

186 • Each chapter follows a consistent structure: introduction → background → standards
187 → implementation considerations.

188 • An overview of the standards across all chapters appears in the table that precedes
189 Chapter 1; this can serve as a navigation aid throughout reading.

190 About the indicative measures

191 The indicative measures presented at the end of each quality statement are developmental
192 and illustrative. They are intended to support countries in monitoring their own
193 implementation of these standards. They are not finalized global benchmarking
194 requirements, accreditation criteria, or reportable global indicators. The set of indicative
195 measures, and the levels at which they should be reported, will be refined through the public
196 consultation and subsequent technical work.

197 Adaptation to national context

198 These standards articulate globally relevant expectations for quality long-term care systems
199 while recognizing that implementation pathways, timelines, and institutional arrangements

200 will differ across countries; they are a framework for adaptation, not a rigid template.
201 Countries should:

202 • Assess current long-term care systems against the standards to identify priorities

203 • Adapt standards to reflect national legal frameworks, health system structures, and
204 cultural contexts

205 • Consider **phased implementation** (Foundation → Development → Comprehensive)
206 to achieve progressive realization

207 • Engage national stakeholders in adaptation to build ownership and ensure feasibility

208 **Box 3.** *Adapting standards to local context*

When adapting global standards to local context, meaningful engagement matters. In one country's experience, the ministry convened working groups including village health volunteers, district health officers, and older people's representatives. "We couldn't simply translate," explained one official. "We had to ask: what does this principle mean in our villages? How do we achieve the same intent with our resources? The conversation itself was valuable — it helped everyone understand why these standards matter."

209 Applying these standards across countries with different long-term care 210 system maturity

211 Countries are at different stages of long-term care system development. Table 3 shows what
212 application of these standards can look like at three illustrative stages of long-term care
213 system maturity. The three columns are illustrative and do not represent income groupings
214 or a development hierarchy; countries may sit between columns or apply different columns
215 to different system functions.

216 **Table 3.** *Application of the standards across countries with different long-term care system*
217 *maturity*

	No or limited formal long-term care system	**Long-term care system being established**	**Established long-term care system, maturing toward integration**
Hypothetical national scenario	The country has no national long-term care policy or financing arrangement. Care is provided	A national long-term care framework or strategy exists, with limited public financing concentrated on the	A long-term care system is in place with statutory entitlements and pooled financing, covering the majority of

	No or limited formal long-term care system	Long-term care system being established	Established long-term care system, maturing toward integration
	overwhelmingly by family members, neighbours and community or faith-based networks. Primary health care and community health workers identify older people with care needs but have no dedicated long-term care role. A small number of residential facilities exist, mostly faith-based or private; no national licensing system. Population ageing is increasing rapidly and the government is considering whether and how to begin building a long-term care response.	most severe needs. Standardized assessment is being piloted in selected districts. Provider registration is in place for residential facilities, but home and community-based care remain largely unregulated. Workforce training pathways have been introduced but coverage is uneven. Carer support is recognized in policy but not consistently delivered.	people with assessed care needs. Home and community-based care is the default and is integrated with primary health care. National quality monitoring is in place, with public reporting of provider quality. Workforce specialization and career structures exist. Carer rights, social protection entitlements and respite are codified. The next priority is integration across health, social care and housing.
Where to focus when applying these standards	**Build foundational capacities (Chapter 1, Chapter 4).** Use Chapter 1 to anchor an early national conversation on dignity, autonomy and protection from abuse, drawing on the	**Strengthen and connect existing arrangements (Chapters 2, 3, 5, 6, 8).** Use Chapter 2 to standardize entry, assessment and care coordination, including	**Integrate, refine and sustain (all chapters).** Use Chapter 2 and Chapter 3 to align home, community and residential care around the person and their carer.

	No or limited formal long-term care system	**Long-term care system being established**	**Established long-term care system, maturing toward integration**
	five foundational principles. Use Chapter 4 to recognize the unpaid carers already providing the bulk of care, and to introduce simple identification at routine service contacts (Standard 1). Use Chapter 2 to embed brief identification of care needs into existing primary health care and community contacts (Standard 1). Use Chapter 7 to set initial safeguarding rules and a simple coordinating function (Standards 4 and 5). Begin collecting minimal data on who is providing care and where (Chapter 8 Standard 1).	in home and community-based care (Standard 1). Use Chapter 3 to introduce or upgrade licensing and inspection of residential facilities (Standards 2 and 4). Use Chapter 5 to formalize a care workforce role with training, supervision and protections (Standards 1, 3 and 4). Use Chapter 6 to expand pooled financing and design protections against catastrophic costs (Standards 1, 3 and 5). Use Chapter 8 to introduce quality monitoring proportionate to capacity (Standards 1 and 2).	Use Chapter 5 to specialize the workforce and address migration, retention and gender equality (Standards 3 and 5). Use Chapter 6 to refine purchasing arrangements and link financing to quality (Standards 4 and 6). Use Chapter 7 to integrate health and social care governance and to align inter-sectoral accountability (Standard 5). Use Chapter 8 to drive continuous improvement through public reporting and learning across providers (Standards 4 and 5).
Where to start with measure-ment	Minimal mapping of existing care actors, including unpaid carers, community health workers,	Coverage of standardized assessment among identified people with care needs.	Equity in access to long-term care across population groups (income, geography, sex, disability).

	No or limited formal long-term care system	Long-term care system being established	Established long-term care system, maturing toward integration
	volunteer networks and faith-based providers. Routine identification of care needs in existing primary health care contacts. Recorded cases of safeguarding concerns and how they were resolved.	Provider registration completeness in the regulated sectors of long-term care. Proportion of identified carers offered assessment and support. Workforce composition and training coverage.	Quality and safety outcomes reported publicly across providers. Financial protection: out-of-pocket spending on long-term care, catastrophic expenditure rates. Carer well-being and employment continuity indicators.

218

219 How countries can start

220 These standards are designed to be useful from the earliest stages of long-term care
221 system development. Countries with no formal long-term care system, with emerging
222 arrangements, or with mature systems can each find entry points in this document. The set
223 of starter actions below describes practical ways to begin, drawn from what has worked in
224 different country contexts.

225 **Foundational starter actions that any country can take include:**

226 • Identify existing care actors — including unpaid family carers, neighbours,
227 community health workers, volunteers, faith-based organizations, older people's
228 associations, and any small-scale public or private providers — and make this map
229 visible at sub-national level.

230 • Strengthen protections against abuse, neglect, financial exploitation and coercion of
231 older people receiving care, including in the home, in community settings and in
232 residential settings, through simple national rules and routes for reporting and
233 response.

- Support unpaid carers through recognition, access to basic information, and connection to existing health and social services, even in the absence of dedicated carer programmes.
- Establish basic coordination pathways across primary health care, community-based services and any available long-term care actors, so that people can move between them without losing continuity of care.
- Collect minimal data on who is providing long-term care, who is receiving it, and where safeguarding concerns are arising, so that policy responses can be informed by evidence rather than assumption.

Detailed implementation guidance — including phased pathways, country case examples and tools — will be developed as a complement to these standards during and after the public consultation, drawing on the experience of countries at different stages of long-term care system maturity.

Limitations and future directions

This is the first edition of the WHO global standards for long-term care. It establishes the normative framework — what long-term care systems should provide and protect — and identifies a set of indicative measures to support countries in monitoring their own implementation. Further work will be needed during and after the public consultation to refine the indicative measures, to develop fuller implementation guidance and tools, and to create mechanisms for sharing country experience as countries apply and adapt these standards.

Living document

WHO welcomes ongoing feedback from Member States, stakeholders, and the public. These standards will evolve based on implementation experience and emerging evidence. The consultation process that accompanies this draft is the first of ongoing opportunities for input.

Standards at a glance

These standards are organized across eight chapters. Chapter 1 sets out definitions and foundational principles that apply across the document. Chapters 2 to 8 each set out standards on a specific component of the long-term care system: home and community-based care; long-term care facilities; support for unpaid carers; workforce; financing; governance; and quality monitoring. The standards are summarized below; full standard statements, rationales, implementation guidance and indicative measures are set out in the chapters that follow.

Table 4. *Standards at a glance: overview of all chapters*

Chapter	Theme	Foundational principles or standards
1	**Definitions and foundational principles**	Rights-based care Person-centred integrated care Carer recognition and support Ageing in the right place Quality
2	**Home and community-based care**	Standard 1: Entry, assessment and care coordination Standard 2: Supporting independent living at home Standard 3: Community-based health services Standard 4: Social support and community participation
3	**Long-term care facilities**	Standard 5: Respect for fundamental human rights Standard 6: Adequate service provision Standard 7: Safe and empowering environments Standard 8: Transparency and accountability
4	**Support for unpaid carers**	Standard 9: Early identification and needs assessment Standard 10: Respite care Standard 11: Education and skills training Standard 12: Social protection and financial security

Chapter	Theme	Foundational principles or standards
		Standard 13: Engagement and recognition
5	**Workforce**	Standard 14: Workforce competencies and training Standard 15: Staffing and workload Standard 16: Working conditions, well-being, and rights Standard 17: Supervision, teamwork, and accountability Standard 18: Workforce profile considerations
6	**Financing**	Standard 19: Coverage of entitlements Standard 20: Needs-oriented allocation Standard 21: Shared responsibility Standard 22: Equity Standard 23: Financial protection Standard 24: Adequacy and quality alignment
7	**Governance**	Standard 25: Regulatory framework Standard 26: Licensing and registration Standard 27: Oversight and enforcement Standard 28: Rights protection Standard 29: Coordination across sectors and levels of government
8	**Quality monitoring**	Standard 30: Quality measurement and data systems Standard 31: Inspection and assessment Standard 32: Complaints and feedback Standard 33: Quality improvement Standard 34: Public transparency and accountability

Chapter 1. Definitions and foundational principles

1. Introduction

Long-term care needs arise in every community, in every country, regardless of resources or formal systems. The following scenarios illustrate how the principles in this chapter apply across diverse contexts.

Scenario A: Rural Kenya

Following a recent fall, Mrs Amina, 72, struggles with daily tasks such as preparing meals, fetching water, and walking to collect her medications for diabetes and hypertension from the health facility 15 kilometres away. She is becoming increasingly isolated. Her children migrated to Nairobi years ago for work. A neighbour checks on her when possible, but has her own family responsibilities. Mrs Amina's son sends money monthly, but there are no home care services in her area. She worries about what will happen when she can no longer manage alone, and fears becoming a burden or having to leave the home where she has lived for 50 years.

Scenario B: Ho Chi Minh City, Viet Nam

Mr Nguyen, 75, lives in an apartment with his wife, who has moderate dementia. He manages most of her care with help from a part-time domestic worker who comes three mornings a week. Their daughter visits on weekends but works long hours and has young children. Mr Nguyen has heard that day care services and home nursing exist, but feels overwhelmed by the options and does not know where to start or what his wife would qualify for. He is exhausted and his own health is suffering; his blood pressure is poorly controlled and he rarely leaves the apartment. He wonders whether his wife would be better cared for in a facility, but she becomes distressed whenever they discuss leaving home.

Scenario C: Rural Brazil

Mrs Santos, 68, cares for her husband who had a stroke two years ago. A community health agent visits monthly as part of the primary health care system, but the agent's training focuses on maternal and child health, not older people. Mrs Santos has learned to manage her husband's care through trial and error. She has developed back pain from lifting him and rarely sees her friends anymore. Recently, a new programme began training community health agents in basic care for older people with functional limitations. The agent now asks about Mrs Santos as well as her husband, and has connected her with a local church group that provides occasional respite.

Scenario D: Rural Romania

Mr Popescu, 79, lives alone in a village where most younger people have migrated to cities for work. His daughter lives in Bucharest, four hours away, and visits monthly. He manages reasonably well but worries about winter when mobility becomes difficult and heating is a concern. The village has a small health post but no social services. A neighbor brings groceries twice a week in exchange for help Mr Popescu provides with her vegetable garden – a reciprocal arrangement that maintains his sense of contribution and connection.

Reflection

Despite vast differences in available resources, these individuals and families face similar challenges: declining functional ability, care needs that exceed what informal support can easily provide, uncertainty about options, and a desire to maintain dignity and connection to their lives. The principles established in this chapter apply to all these situations and to the full spectrum of contexts between them.

1.2 Purpose of this chapter

This chapter establishes:

- Core concepts that define long-term care and its goals within the healthy ageing framework
- Foundational principles that guide all long-term care standards across all contexts
- A framework that can be adapted to and implemented in diverse settings, from the most resource-limited to the most resource-rich

The foundational principles are both guiding ideals and operational requirements. They describe what should be achieved and can be assessed, measured, and progressively realized regardless of starting point. Countries at all stages of long-term care system development can use these principles to guide action.

1.3 How to use this chapter

The five foundational principles in this chapter apply across all subsequent standards domains: home and community-based services, long-term care facilities, support for unpaid carers, workforce, governance, financing, and quality monitoring. Each domain-specific chapter builds upon these principles and should be read in conjunction with this foundational chapter.

Countries and communities should adapt implementation approaches to their context while maintaining alignment with core principles. The principles describe what should be achieved; how it is achieved will vary based on available resources, existing systems, cultural context, and local priorities. Standards should support the development of locally appropriate approaches, not the replication of models from other contexts.

Readers already familiar with WHO's healthy ageing and long-term care frameworks may proceed directly to Section 3: Foundational Principles after reviewing the terminology in Section 1.4 and the long-term care definition in Section 2.2, referring back to Core Concepts as needed.

1.4 A note on terminology

Terminology for long-term care varies significantly across countries, regions, and languages. This chapter provides WHO's recommended operational definitions while acknowledging that countries may use different terms for similar concepts. What matters is conceptual alignment – the underlying meaning and intent – rather than identical terminology.

For example, "carers" may be called "caregivers", "informal carers", "family carers" or "care partners" in different contexts. "Residential care" may be called "nursing homes", "care homes", "aged care facilities", or other terms. The Annex provides a mapping of WHO terminology to common regional alternatives.

While long-term care is most commonly associated with older age, the same principles apply to younger people with significant and ongoing loss of intrinsic capacity due to disability, injury, or chronic illness.

2. Core concepts

2.1 Healthy ageing

Healthy ageing is the process of developing and maintaining the functional ability that enables well-being in older age. It is WHO's foundational framework for understanding ageing and the primary lens through which long-term care should be understood.

Two key components interact with each other and with the environment:

Intrinsic capacity is the composite of all physical and mental capacities an individual can draw on at any point in time. It includes locomotor capacity, vitality, sensory capacities (vision and hearing), cognitive capacity, and psychological capacity. Intrinsic capacity is not fixed: it can be built up, maintained, restored, or may decline over time. Many factors influence intrinsic capacity, including diseases, injuries, and age-related changes, but also health behaviours, access to health care, and social determinants.

Functional ability comprises the health-related attributes that enable people to be and do what they have reason to value. Functional ability results from the interaction between intrinsic capacity and the environment (physical, social, policy), which includes the support available to the person.

Functional ability encompasses five domains:

370 • **Meeting basic needs:** ability to afford and access adequate food, clothing, shelter,
371 and health care

372 • **Mobility:** ability to move around, independently, including outside the home

373 • **Learning, growing, and making decisions:** ability to continue developing, making
374 choices, and exercising autonomy

375 • **Building and maintaining relationships:** ability to connect with others, maintain
376 social ties, and experience intimacy

377 • **Maintaining agency and contributing to society:** ability to engage in meaningful
378 activities, assist others, and participate in community life

379 **Relevance to long-term care:** People may need long-term care when they experience
380 significant, ongoing decline in intrinsic capacity that affects their functional ability. The goal
381 of long-term care is not merely to address basic care needs, but to maintain functional ability
382 across all five domains to the greatest extent possible. Standards should therefore address
383 the full spectrum of functional ability, enabling people to keep doing what they need to do
384 and what brings their life meaning, not just meeting basic needs such as assisting with
385 activities of daily living.

386 Even in contexts where formal services are available, older people, family and community
387 members provide most support for optimizing and maintaining functional ability. Standards
388 should strengthen and support these existing arrangements, recognizing them as legitimate
389 and valuable components of long-term care systems. Moreover, standards should support
390 older people's autonomy, helping them to do what they can for themselves and to seek the
391 help they need from others.

392 2.2 Long-term care

393 **Operational definition:** Long-term care comprises the activities undertaken with and by
394 carers to ensure that people with, or at risk of, significant ongoing loss of intrinsic capacity
395 can maintain a level of functional ability consistent with their basic human rights,
396 fundamental freedoms, and human dignity. Within this definition, "at risk of" refers to people
397 whose loss of intrinsic capacity is anticipated to become significant and sustained in the
398 near term, rather than to the broader at-risk populations addressed through preventive and
399 early-intervention approaches such as ICOPE. Long-term care and ICOPE sit on a
400 continuum: ICOPE addresses prevention and the optimization of intrinsic capacity earlier in
401 the trajectory, while long-term care addresses the support needed when the loss of intrinsic
402 capacity is significant and sustained.

403 Key characteristics that distinguish long-term care from other forms of care:

404 **Duration:** Long-term care addresses ongoing needs for support, though the intensity and
405 type of support may change over time.

406 **Purpose:** Long-term care aims to maintain functional ability or delay its decline, not to cure
407 underlying diseases. While health care interventions may be part of long-term care, the
408 overall goal is to enable people to live well with their conditions. Declines in intrinsic capacity
409 should be addressed to reverse, stabilize, or prevent further decline where possible.

410 Prevention, therapy and reablement should be integrated into long-term care, not replaced
411 by it. Long-term care can be considered to be the "long tail of prevention" with an important
412 role in preserving quality of life, in maintaining or restoring abilities where possible, and in
413 preventing adverse consequences, including accelerated decline in intrinsic capacity and
414 functional ability.

415 **Scope:** Long-term care encompasses health, personal, social, legal and environmental
416 support. It is not limited to medical or nursing care, but includes assistance with daily
417 activities, social support and connection, meaningful engagement, and modifications to the
418 living environment. Long-term care is caring with people who need and provide care, rather
419 than caring for them unilaterally.

420 **Foundation:** Long-term care is grounded in human rights, dignity, and respect for
421 autonomy. People receiving long-term care retain all their rights regardless of their care
422 needs or cognitive capacity.

423 **Understanding long-term care broadly:** Long-term care is any activity that meets the
424 above criteria, whether provided by family members, community volunteers, paid care
425 workers, or professionals at home or in facilities. That means that long-term care is not a
426 specific type of service, institution, or programme. This understanding is important: many
427 existing activities and actors contribute to long-term care without being labelled as such, and
428 strengthening long-term care often means better recognizing, coordinating, and supporting
429 what already exists in family, community and service networks.

430 In many contexts, particularly in low- and middle-income countries, most long-term care is
431 provided by families without formal recognition or support. Standards should not impose
432 unfamiliar structures or burdens but should strengthen existing care arrangements, provided
433 they are not abusive, while progressively building additional capacity. Gaps identified
434 between existing arrangements and these standards can form the starting point for further
435 development of long-term care systems.

436 2.3 Services supporting long-term care

437 **Operational definition:** Services supporting long-term care are health care, personal
438 assistance, social support, and/or environmental support provided to individuals with
439 significant ongoing loss of intrinsic capacity in order to maintain their functional ability. They
440 are organized and coordinated such that multiple components are complementary and can
441 be adjusted over time as needs change.

442 **Categories of services supporting long-term care:**

443 **Health care:** Management of long-term conditions, nursing care, rehabilitation, medication
444 management, preventive care, and health monitoring. In long-term care contexts, health
445 care for long-term conditions focuses on optimizing function and quality of life while acute
446 intercurrent problems are addressed with curative intent where appropriate. It should be
447 closely integrated with medical care (acute or chronic) to ensure timely access to the
448 services required to meet health needs, with decisions based on a person-centred
449 approach.

450 **Palliative and end-of-life care:** Relief of suffering, symptom management, and support for
451 dying with dignity. The principles of palliation, relief of suffering and management of
452 symptoms that threaten quality of life, should be applied across the continuum of long-term
453 care, not only at the very end of life. No one should suffer unnecessary pain at any stage.

454 **Social care and support:** Personal care assistance (bathing, dressing, eating, toileting),
455 household support (cleaning, cooking, shopping), social connection and companionship,
456 and support for meaningful activities and community participation.

457 **Carer support:** Training, information, emotional support, respite, legal and financial
458 assistance for unpaid carers. Actively identifying carers should be a priority of long-term care
459 systems, as part of carer support. It is addressed in detail under Principle 3.

460 **Environmental support:** Assistive technology (the ecosystem of devices, services, and
461 systems that enable function), home modifications, accessibility improvements, and
462 adaptations that enable people to function more independently in their homes and in public
463 spaces. It includes not only providing assistive technology or home modifications but also
464 facilitating the development of new skills and supporting the use of additional
465 tools/equipment/home modifications to improve function and safety.

466 **Care needs assessment:** Initial and repeated estimation of a person's functioning and
467 need for help, including current state, the person's own priorities, the resources already
468 available to them, potential to maintain or regain abilities, available supports, and anticipated
469 future needs.

470 The specific mix of services varies by country context, available resources, cultural
471 preferences, and individual needs. What matters is that services, whatever form they take,
472 are organized and coordinated around the person's goals and responsive to changing
473 needs. In some settings, this organization and coordination happens through formal care
474 managers; in others, through family coordination, community health workers, or volunteers.

475 2.4 Long-term care systems

476 **Operational definition:** A long-term care system is the coordinated structure of
477 governance, financing, service delivery, workforce, information systems, and quality
478 assurance designed to ensure that accessible, appropriate, and quality long-term care is
479 available to those who need it.

480 **Core system functions:**

481 **Participation and consultation:** Meaningful, active and continuing engagement of older
482 people, carers, and their support networks in developing policies, legislation, and services.
483 Policies and standards should be developed with, not just for, people, to make long-term
484 care person-and community-centred.

485 **Governance and stewardship:** Policy frameworks, legislation, regulation, and oversight
486 that establish expectations, accountabilities, and protections for long-term care. This
487 includes coordination with independent oversight bodies (such as ombudsmen or public
488 prosecutors) that can support quality improvement rather than serving only punitive
489 functions.

490 **Financing and resource allocation:** Mechanisms for funding long-term care services,
491 whether through taxation, social insurance, private payment, or mixed approaches, and for
492 allocating resources equitably. In many low- and middle-income countries, long-term care
493 relies heavily on out-of-pocket payments, and private insurance rarely covers residential
494 care. Systems should consider support for families without adequate income and work
495 toward more sustainable financing mechanisms.

496 **Service delivery:** The organizations, programmes, and arrangements through which long-
497 term care services are actually provided across home, community, and residential settings.

498 **Workforce development:** Training, deployment, support, and retention of paid care workers
499 and health professionals involved in long-term care, as well as support for unpaid carers.

500 **Capacity building**: Helping people build awareness and skills in knowing when and how to
501 seek care, and how to manage the care they receive so they can continue to live out their
502 later lives; and within the context of caring and compassionate communities that are free
503 from ageism.

504 **Quality assurance and improvement:** Standards, licensing/registration requirements
505 (including rules specific to non-profit status), monitoring, inspection, and continuous
506 improvement mechanisms that ensure long-term care meets acceptable quality levels,
507 including for the identification and registration of non-profit facilities. Organizational culture,
508 leadership, and appropriate incentives shape providers' motivation and ability to invest in
509 quality. Norms around safety, learning, and error reporting influence whether monitoring
510 data are used for improvement rather than solely for punishment.

511 **Safeguarding and protection:** Mechanisms to prevent, identify, report, and respond to
512 abuse, neglect, and exploitation in all long-term care settings.

513 **Emergency and crisis response:** Contingency planning, emergency respite, and clear
514 escalation pathways. The COVID-19 pandemic exposed emergency response as a major
515 failure point in long-term care systems globally.

516 **Information and monitoring:** Data systems that enable tracking of long-term care needs,
517 service provision, outcomes, and system performance.

518 **Implementation considerations:** Strategies for implementing standards should be co-
519 designed with stakeholders and communities, considering contextual factors including
520 organizational characteristics, the environment, relevant policies, market forces, regulatory
521 frameworks, community resources, and sustainability.

522 In many countries, long-term care “systems” are fragmented across health and social
523 sectors, or are largely informal with limited government involvement. Standards should guide
524 both the strengthening of existing systems and the development of new capacities,
525 appropriate to each country’s starting point. Not every country needs the same system
526 architecture; what matters is that core functions are adequately addressed in some form.

527 Many countries have existing resources that are not often thought of as part of the long-term
528 care system – such as primary health care services, community health workers, or faith-
529 based organizations. Often, core functions of long-term care can begin to be addressed
530 through identification of existing resources that can be reoriented toward serving the needs
531 of older people with intrinsic capacity challenges. It is not always about creating new
532 resources but about redistribution or reorientation of existing ones.

533 2.5 Assessment and care organization

534 Two essential functions underpin all long-term care, regardless of setting or resources:

535 **Care needs assessment** is the process of understanding what a person needs, what they
536 want, what resources they have, and what support would help them maintain functional
537 ability. Assessment should be:

538 • **Comprehensive:** Covering functional ability across domains, health conditions,
539 social circumstances, environment, and personal goals

540 • **Person-centred:** Incorporating the person’s own priorities and preferences, not just
541 professional judgment

542 • **Inclusive:** Identifying carers and assessing their situation and needs alongside the
543 care recipient, explicitly considering social determinants, racial and ethnic identity,
544 language, culture, gender, religion, and other factors that may shape their access to
545 and experience of care

546 • **Routinely repeated**: anticipating changing needs and assessing risk factors.

547 Care organization is ensuring that whatever support exists works together around the
548 person. This includes identifying who will provide what support, how different contributors
549 will connect and communicate, and how care will adapt as needs change.

550 How these functions are fulfilled varies dramatically by context:

551 • In well-resourced settings: Formal care managers using standardized assessment
552 tools, digital care plans, multi-disciplinary team meetings

553 • In less-resourced settings: Community health workers and other appropriately
554 trained community volunteers using simplified screening questions, family members
555 coordinating informally, village health volunteers checking on vulnerable neighbours

556 The core principle is universal: every person receiving care should have their needs and
557 preferences understood and their support organized around those needs. The sophistication
558 of the tools and processes will differ; the underlying function should not.

559 **Education and awareness**: Many older people do not recognize when they need support,
560 often because they assume functional decline is simply a “normal part of ageing” rather than
561 something that can be addressed. Long-term care systems should include education and
562 awareness initiatives that help older people and their families identify needs, understand
563 available options, and access support. Self-screening tools can support this awareness.
564 People help themselves and help each other long before they come to the attention of
565 formal care systems; policy and programmes should support this self-help and mutual aid.

566 **Illustrative example.** In Thailand’s community-based long-term care programme, village
567 health volunteers use a simple screening tool to identify older people with functional
568 limitations. The sub-district health promotion hospital then conducts a more detailed
569 assessment and creates a basic care plan in consultation with older people and carers. The
570 volunteer visits regularly, the family provides daily care, and the health team provides
571 backup and supervision. This support system is not the same as Singapore’s
572 comprehensive care management system, but it fulfils the same essential functions at a
573 level appropriate to the context.

574 3. Foundational principles

575 Five principles guide all long-term care standards. They apply across all settings, all
576 resource levels, and all subsequent chapters of this document. These five principles are
577 presented in a logical sequence but are equally important and interconnected. The ordering
578 reflects a conceptual flow from foundational rights through to operational quality assurance,
579 579 but does not imply hierarchy or prioritization.

580 3.1 Rights-based care

581 **What it means**

582 Long-term care is provided in ways that uphold human rights, including dignity, autonomy,
583 freedom from abuse and neglect, privacy, and the right to participate in decisions affecting
584 one’s life, and that ensure equitable access to appropriate care regardless of personal
585 circumstances. Services must actively organize care to respect and protect these rights in
586 everyday practice.

People receiving long-term care retain all their human rights regardless of their care needs or cognitive capacity. These rights must be actively respected, protected and fulfilled, not merely assumed.

Human rights are indivisible, interrelated, and interdependent. Rights-based care encompasses:

- Civil and political rights: Dignity, autonomy, freedom from abuse and degrading treatment, privacy, legal capacity, participation in decisions
- Economic, social, and cultural rights: Right to health, adequate standard of living, social security, participation in cultural life

Concrete examples of rights in long-term care include:

- The right to be treated with dignity and respect in all interactions
- The right to privacy in personal care, communications, and living space
- The right to make decisions about one's own care and daily life
- The right to be free from physical, psychological, sexual, and financial abuse
- The right to access care that meets one's needs regardless of ability to pay
- The right to maintain relationships and community connections
- The right to complain and seek redress without fear of retaliation

Why it matters for long-term care

People receiving long-term care are at heightened risk of rights violations. They depend on others for basic needs. They may have cognitive impairments that limit their ability to advocate for themselves. They may be isolated from family and community oversight. Power imbalances between care providers and care recipients create conditions where abuse, neglect, and loss of autonomy and respect can occur.

Rights violations in long-term care are prevalent. Studies across countries document concerning rates of physical and emotional abuse, inappropriate restraint, financial exploitation, neglect of basic needs, and removal of meaningful choice in daily life. These violations often go unreported because those affected cannot speak up or fear retaliation.

Rights cannot be assumed. They must be actively protected through clear standards, monitoring systems, accessible complaints mechanisms, and a culture that treats rights as non-negotiable.

The equity dimension is equally important. In many contexts, quality long-term care is available only to those who can pay or who live in urban areas with services. A rights-based

619 approach demands that appropriate care be accessible to all, with priority attention to those
620 currently underserved.

621 **In practice**

622 **Protecting individual rights:**

- 623 Shared decision-making is the norm for all: decisions are made collaboratively 624 between the person and care providers, with full information provided
- 625 Supported decision-making is available for people with diminished capacity: 626 additional support enables participation in decisions to the greatest extent possible
- 627 The ability to exercise autonomy may be affected by cognitive or communication 628 impairments; long-term care should include specialist support, assistive 629 technologies, and communication aids to enable participation
- 630 Dignity of risk: People have the right to make choices about their own lives, including 631 choices that others may consider risky, provided they have capacity and understand 632 the consequences
- 633 Policies and safeguards against abuse and neglect are in place and monitored
- 634 Complaints mechanisms are accessible, safe, and effective
- 635 Privacy is protected: personal information, physical privacy, and private life

636 **Restraint-free care:**

637 Restraint-free care is the goal. Physical and chemical restraints should be eliminated. Where
638 they currently exist, any use must be solely in the person's interest (never for staff or
639 institutional convenience), fully documented, regularly reviewed, and subject to active
640 reduction plans with clear timelines toward elimination. This aligns with the Convention on
641 the Rights of Persons with Disabilities.

- 642 Legal support mechanisms (such as advance directives, lasting power of attorney, or 643 guardianship with safeguards) are available and accessible

644 **Ensuring equitable access:**

- 645 Services reach underserved populations, not only those who can pay or access 646 easily
- 647 Quality does not depend on personal characteristics or geography
- 648 Barriers to access (financial, geographic, informational, cultural) are identified and 649 addressed
- 650 Data are disaggregated to monitor equity

651 **Illustrative example.** In a township outside Johannesburg, community care workers were
652 trained to recognize signs of elder abuse and neglect during home visits. When they
653 identified an older woman whose family was withholding her pension and leaving her without
654 adequate food, they knew how to report it safely and connect her with social services and a
655 community advocate. The training cost little, such as a half-day workshop and simplified
656 reference materials, but it created a basic protection system where none had existed. The
657 care workers now understand that protecting rights is part of their role, not someone else's
658 responsibility.

659 **Guidance for implementation**

660 • Define what abuse and neglect look like in your context

661 • Ensure everyone involved in care knows how to recognize and report concerns

662 • Create accessible ways for people to raise concerns safely

663 • Monitor whether care is reaching those who need it, not only those who can access it
664 easily

665 • Remember that human rights are universal and apply in every setting

666 **What to watch for**

667 • Consent assumed or ignored rather than obtained

668 • People with cognitive decline and dementia treated as having no voice in their care

669 • Complaints dismissed or discouraged

670 • Restraints routinely used for staff convenience rather than for genuine safety needs

671 • Quality care available only to those who can pay

672 • Abuse and neglect hidden because there is no monitoring or no one to tell

673 • Family care that comes at the expense of the older person's rights and autonomy

674 3.2 Person-centred integrated care

675 **What it means**

676 Person-centred integrated care is care organized around what matters to the person – their
677 unique needs, circumstances, values, and goals – with services coordinated to work
678 together and adapt as needs change over time.

679 Person-centred care recognizes the relational nature of caregiving. Care happens within
680 relationships – between the person and their family, between the person and care providers,
681 and among care providers themselves. The quality of these relationships affects both the
682 experience and outcomes of care.

This principle combines three interconnected elements:

Person-centredness: The person (and their family, where appropriate) is at the centre of all decisions. Care responds to individual meaning and preference, not just clinical categories or service availability. The person is treated as a care partner and active agent in their own life, not a passive recipient of care.

This includes:

- Personhood: Recognizing the whole person, their biography, identity, preferences, and values, not just their care needs
- Meaningful engagement: Embracing and responding to the person's emotions, including anxiety and distress; adapting communication to sensory, mental, and physical capacities; considering preferences when designing care approaches
- Communication: Explaining assessment processes and components, listening to older people's and carers' concerns, providing feedback on assessment results, and sharing the assessment and defining the care plan with them and all people involved.

Integration: Different types of support (health, personal, social) work together across all relevant sectors and providers, with multiple actors communicating and aligning their efforts. The person experiences care as coherent, not fragmented. Services follow the person rather than requiring the person to navigate between disconnected services.

Continuum and adaptation: Care is not a one-time arrangement but an ongoing interaction that adapts as the person's needs, preferences, and circumstances change over time. Transitions between levels of support are managed smoothly. People can step up to more intensive support when needed and step down when needs lessen – long-term care is not necessarily permanent.

Integration means services work together coherently. Continuum means care adapts over time as needs change, with smooth transitions between levels of support. Both are essential: integration without continuity leaves people unsupported as needs evolve; continuity without integration creates fragmented care at each stage.

Why it matters for long-term care

People with long-term care needs are diverse. Two people with similar declines in capacity or diagnoses may have completely different goals, living situations, and interpretations of "living well." Unlike acute care, where clinical protocols can be largely standardized, LTC must respond to personal meaning and context. Developing the care plan should not only include approaches such as SMART goals (Specific, Measurable, Achievable, Relevant, Time-bound) within comprehensive geriatric assessments to create effective, personalized support plans for older people, but also incorporate meaningful and relevant elements, such

as discussions about what truly matters, life purpose, and fulfilling needs, desires, and expectations.

Long-term care responds to the biological, psychological, social, and spiritual needs of a person, and balances the requirements of each of these domains. A medical diagnosis is only one facet that needs to be managed for healthy ageing to continue.

Long-term care is, as its name indicates, long-term. It affects many aspects of a person's life over extended periods. Without person-centred approaches, care defaults to provider convenience or system efficiency rather than individual well-being.

Long-term care needs evolve. A care arrangement that works today may not work in six months. Without integration and continuity, people fall through gaps during transitions or as their conditions progress.

In practice

Person-centredness:

- Care plans reflect personal goals, preferences and expectations, not just clinical needs or service categories
- The person (or their representative) participates meaningfully in decisions
- Staff have skills and time for relationship-building, not just task completion
- Care adapts to the person's routines and preferences, and the services follow the client and their family, rather than the other way round
- System enablers: Person-centred care requires that providers have adequate time, training, and support to build relationships and respond to individual needs. Achieving person-centred care depends not just on individual practice but on system conditions including staffing levels, training, and organizational culture.

Integration:

- Someone holds responsibility for the overall picture, not just individual services
- Providers communicate with each other and with the person and family
- Care plans are shared and accessible to all involved
- Transitions between settings or services are planned and coordinated

Continuity and adaptation:

- Regular review of whether care is still meeting the person's needs
- Clear pathways for adjusting care and systems of support as needs change

749 • Relationships are maintained even as specific services change

750 • Recognition that people can exit long-term care as they improve, with clear pathways
751 back if needed

752 **Illustrative example.** When Mrs Devi in rural India was visited by the community health
753 worker, she was asked not just about her health problems but about what mattered to her.
754 She said she wanted to continue tending her small garden and to see her grandchildren
755 regularly. Her care plan focused on maintaining her mobility so she could garden, and her
756 daughter-in-law agreed to bring the grandchildren weekly. When Mrs Devi's mobility
757 declined further six months later, the plan was updated: a neighbour now helps her to the
758 garden in a chair, and she directs the planting while her grandchildren do the physical work.
759 The goals remained constant; the approach adapted. Rehabilitation support helped maintain
760 her upper body strength for directing and light tasks.

761 **Guidance for implementation**

762 • Always ask: "What matters to you?" and document the answer

763 • Identify everyone involved in the person's care and create a way for them to
764 communicate

765 • Review regularly: "Is this still working? What needs to change?"

766 • Ensure someone – whether a professional care manager or a family member – holds
767 the overall picture

768 **What to watch for**

769 • Care plans that list only medical problems and services, not personal goals,
770 preferences and expectations about life

771 • Multiple providers with no communication between them

772 • Care that stays the same even as the person's situation changes

773 • Decisions made for administrative or services' convenience rather than individual
774 benefit

775 • Older people treated as objects of care rather than agents of their own lives

776 • Missing balanced biological, psychological, social, and spiritual perspectives

777 ## 3.3 Carer recognition and support

778 **What it means**

779 People who provide unpaid care and support, typically family members, but also friends and
780 neighbors, are recognized as essential partners in the long-term care system who have their

781 own needs for support, training, respite, and protection. Carers also have rights that must be
782 respected.

783 A carer is an individual who provides ongoing care and support to a person with long-term
784 care needs, without a formal employment contract and regardless of whether the carer
785 receives social transfers such as carer allowances, and often alongside other life
786 responsibilities such as employment, childcare, or their own health challenges. Carers are
787 often "older people" themselves with their own care needs.

788 Recognition means that carers are visible to the system – identified, acknowledged, and
789 included. Support means that carers receive what they need to sustain their caring role and
790 protect their own well-being.

791 Many carers do not identify themselves as such, particularly when caring for a spouse or
792 sibling. For many carers the caring role is experienced as a natural extension of the
793 relationship, while for others it represents a marked change in role and identity. Services
794 should approach carer identification with sensitivity, recognizing that the transition to being
795 seen as a "carer" can involve grief and a sense of loss of the previous relationship dynamic.

796 **Why it matters for long-term care**

797 **Carers provide the majority of long-term care globally.** In most countries – high-income
798 and low-income alike – unpaid carers provide 70–90% of all care. A standards framework
799 that ignores carers ignores most of the care system.

800 **Without supporting carers, *formal long-term care services alone* cannot succeed.**
801 When carers are unsupported, they face burnout, health problems, and financial difficulties.
802 Care quality suffers, and family conflicts and interpersonal disruptions may arise. In some
803 cases, neglect and violence may even occur. Care recipients are often placed in institutions
804 if their carers are not able to manage and there is no support system in place.

805 **Carers are both providers of care and people with their own needs.** Caring can be
806 deeply meaningful, but it also takes a toll. Carers have higher rates of depression, anxiety,
807 and physical health problems than the general population. Many reduce employment or
808 leave the workforce, with long-term consequences for their economic security.

809 **The responsibility of caring falls disproportionately on women**, who provide
810 approximately 75% of unpaid care globally. Failing to recognize and support carers
811 perpetuates gender inequality and social injustice.

812 **In practice**

813 **Recognition:**

814 • Carers are actively identified whenever someone enters the long-term care system

815 • Carers are acknowledged as partners in care, not obstacles or afterthoughts

816 • Carers are included in care planning and decision-making, but not at the expense of
817 the rights and autonomy of the older person

818 • Carers have voice in governance and policy

819 **Assessment:**

820 • Carers receive their own needs assessment, separate from the care recipient

821 • Assessment covers carer health, caring responsibilities, other commitments, support
822 needs, and preferences about their caring role

823 **Support:**

824 • Training in care skills relevant to the person they support

825 • Respite care (regular or emergency) allowing carers to take breaks

826 • Emotional support, including peer support and counselling where available

827 • Information and navigation assistance on services, medical and assistive technology,
828 and social benefits. It means structured support that helps carers find, understand,
829 and access relevant health, social, and financial resources for themselves and the
830 person they care for.

831 • Financial support where feasible: cash transfers, allowances, tax credits, pension
832 credits, paid care leave at work

833 **Protection:**

834 • Recognition that carers may themselves be at risk of exploitation or harm, including
835 burnout, distress, and abuse

836 • Services and policies should include mechanisms to identify carer vulnerability

837 • Employment protections and carer-friendly workplace cultures, including flexible work
838 policies (such as adaptable hours, remote or hybrid working, job-sharing, and
839 emergency leave)

840 • Monitoring of carer well-being, not just care recipient outcomes

841 **Illustrative example.** In Thailand's community-based long-term care programme, Mrs
842 Somchai's daughter provides most of her mother's daily care. The village health volunteer
843 visits weekly – not to replace the daughter's care, but to check on both of them. She noticed
844 the daughter had developed back pain from lifting and showed her safer techniques. She
845 connected the daughter with a monthly support group at the local temple where carers share
846 experiences and advice. She also monitors for signs of carer burnout and can arrange
847 temporary help if needed. The daughter says: "I felt invisible before – just expected to
848 manage. Now someone sees what I do and asks how I am."

Guidance for implementation

- Ask “Who provides care to this person?” and “How are you managing?” at every contact
- Do not underestimate the value of simplified forms of support that can be created: recognition, peer groups, and basic training. These can prevent adverse outcomes for both carers and care recipients.
- Monitor carer health and well-being, in addition to care recipient well-being
- Ensure services support family care rather than ignoring or replacing it

What to watch for

- Assessment processes that focus only on the care recipient
- Assumptions that family will provide care without any support
- Services that exclude families rather than partnering with them
- Carer burnout, health decline, or withdrawal that goes unnoticed
- Gender blindness, not recognizing that caring responsibilities fall mainly on women
- Neglect of carer needs in care planning and review

3.4 Ageing in the right place

What it means

People receive care in settings that best match their needs, goals, preferences, circumstances, and available support, with recognition that the “right place” may change over time and that appropriate options should be available across the range from home to residential care.

This principle reframes “ageing in place” to emphasize:

Appropriateness: The setting matches the person’s actual needs – not too little support, not more intensive than necessary.

Informed choice: People and families can make genuine choices among available options, with clear information about what each entails, including the levels of care (for example, from supervision and light hands-on assistance for balance, through moderate or maximal help with activities of daily living, to full assistance).

Equity: Appropriate settings are accessible regardless of wealth or location. Ageing in the “right place” should not be a privilege only for those who can afford it.

Flexibility: As needs change, people can move to more or less intensive settings without crisis. This includes transitional care facilities that bridge gaps between home and full residential care.

While most people prefer to remain at home, and home and community-based care should generally be prioritized, some people may be better served in residential settings and that choice, when it is an informed choice without undue influence, should be respected and supported. The goal is appropriate care in appropriate settings, which for most people, most of the time, will be home or community-based.

Why it matters for long-term care

One of the most significant shifts in long-term care globally is the movement away from institutional care as the default toward home and community-based options. This shift reflects both the preferences of most older people and evidence that community-based care can be more cost-effective and supportive of well-being. The principle of ageing in the right place is intended to be applied in three ways: home- and community-based care remain the preferred and priority approach; residential care is recognized as one component within a continuum of settings rather than a separate or last-resort track; and the principle as a whole is intended to support informed, individualized decisions that respond to each person's needs, preferences and circumstances.

However, "ageing in place" is a static concept that can be misapplied:

- Keeping people at home when they may need more support than home can provide
- Assuming home is best regardless of isolation, safety concerns, carer burden or abuse
- Leaving people with no real choice because alternatives do not exist or are not affordable

In practice

Developing a range of options:

- Home-based care services that support people living at home and that can be stepped up in intensity
- Community-based options (day services, respite) that support people living at home to stay within their neighborhoods
- Transitional care facilities for recovery and rehabilitation
- Residential options for those who need or genuinely prefer them

Supporting informed decisions:

- Information about available options is accessible
- Shared assessment helps people understand what they need
- Decisions are revisited as circumstances change
- People are not trapped in settings that no longer fit or are not what they had expected or been promised

Ensuring equity in access:

- Options exist beyond urban centres
- Cost does not determine which settings are available
- Infrastructure development considers long-term care needs

Practical considerations:

- "Right place" may mean strengthening care in the home where that is where care happens
- It may mean developing relevant and appropriate community supports before residential alternatives
- Infrastructure and environment matter – ensuring villages have what people need to age there

Illustrative example. Mr Okonkwo, 80, lived alone in his family compound in rural Nigeria after his wife died. His children in Lagos urged him to move to the city, where services existed and they could help. He resisted – his life, his friends, his identity were in the village. When his health declined, Mr Okonkwo faced a difficult decision, supported by his family: move to Lagos, where there were hospitals and paid helpers but he knew no one, or stay in the village where he had community but no formal services. Mr Okonkwo chose to stay. With help from a local NGO, the family arranged support: a neighbor was engaged to provide daily assistance, funded by the family; the community health worker increased her visits; the children arranged a mobile phone so they could check in daily. This was not "ageing in place" by default. It was a deliberate decision that the village was the right place for Mr Okonkwo, with supports intentionally arranged. Two years later, when he needed more intensive care than this arrangement could provide, he moved to live with his daughter in Lagos – and that, too, was the right place for that stage.

Guidance for implementation

- Do not assume home is always best or that facility is always wrong
- Ask what the person needs, what they want, and what is genuinely available

944 • Revisit the question as circumstances change – the right place now may not be right
945 later

946 • Work toward creating options where they do not exist

947 • Consider infrastructure: can people access what they need where they are?

948 **What to watch for**

949 • People stuck at home without adequate support because alternatives do not exist

950 • People stuck in residential care who could manage at home with less intensive
951 options

952 • “Choice” constrained entirely by what is affordable or available

953 • Decisions made once and never revisited

954 • Rural or poor communities with no viable options at all

955 ## 3.5 Quality

956 **What it means**

957 Long-term care is safe, effective, person-centred, and continuously improving, regardless of
958 setting, provider type, or resource level.

959 Quality in long-term care encompasses multiple dimensions:

960 • **Safety:** Freedom from avoidable harm, including falls, pressure injuries, medication
961 errors, infections, abuse, and neglect

962 • **Effectiveness:** Care achieves its intended purpose, maintaining functional ability,
963 meeting the person’s goals, and providing comfort and dignity

964 • **Person-centredness:** Care is responsive to individual needs, preferences, and
965 goals (reinforcing Principle 2)

966 • **Timeliness:** Care is available when needed, without harmful delays

967 • **Equity:** Quality is consistent regardless of who the person is, where they live, or
968 what they can pay (reinforcing Principle 1)

969 • **Evidence and data-informed:** Care approaches are based on the best available
970 evidence; data are used to monitor and improve

971 • **Continuous improvement:** Systems exist to monitor quality, identify problems, and
972 improve care over time

973 **Why it matters for long-term care**

People receiving long-term care are often vulnerable and may have difficulty advocating for themselves or recognizing when care is substandard. Active quality assurance protects them.

Quality applies in all settings, not only formal services. Family care at home, community volunteer programmes, and small residential facilities (both for-profit and non-profit) all have quality dimensions that can be defined, assessed, and improved.

Quality is not only about preventing harm (safety) but also about achieving good outcomes. Long-term care that is “safe” but deprives people of dignity, autonomy, or meaningful life is not quality care.

The care plan is “the older person’s care plan”; it is owned by the older person and their family rather than by the institution or service. It is not simply a tool to maintain the quality standards of the institution or service. There is a balance between service quality relevant to person-centred outcomes and service quality that pertains to regulatory standards and institutional requirements.

In practice

Defining quality:

- Clear standards for what acceptable care looks like and feels like in each setting
- Standards that are appropriate to the context, not imposing requirements that cannot be met
-

Monitoring quality:

- Mechanisms to assess whether care meets standards
- Indicators that can be tracked over time
- Continuous feedback from people receiving care and their families

Responding to quality concerns:

- Processes for addressing problems identified through monitoring
- Accountability when care falls below acceptable levels
- Support for improvement, not only censure for failure

Continuous improvement:

- Learning from what works and what does not
- Sharing good practices across providers

- Regular review and updating of standards

Illustrative example. In rural Mozambique, community health workers conducting home visits were given a simple quality checklist: "Is the person clean?" "Are there signs of pressure sores? Is medication being taken as prescribed?" "Is there enough food?" "Are there signs of abuse or neglect?" "Is the unpaid carer coping?" "Is the person maintaining social connections?" Each month, they report findings to the health post, where a nurse reviews the data and follows up on concerns. This is not a formal inspection system, but it creates accountability and has identified problems – untreated infections, carers in crisis, food insecurity, and social isolation – that previously went unnoticed. One month, the worker noticed Mrs Fatima had stopped attending the community gathering she used to enjoy, prompting a conversation about mobility support and resulting in arrangements for a neighbour to accompany her. Problems identified are problems that can be addressed.

Guidance for implementation

- Define what "good enough" care looks like in your context
- Create simple ways to check whether care meets that standard
- Ensure someone reviews the findings and acts on problems
- Ask people receiving care: "Is this working for you?"
- Celebrate and share examples of good practice, not only problems

What to watch for

- No defined expectations for quality
- Quality monitoring that exists on paper but does not happen in practice
- Data collected but never reviewed or acted upon
- Quality defined only as absence of harm, not presence of good outcomes
- Standards set so high they cannot be met, leading to cynicism
- Quality attention only for formal services, ignoring family and community care

4. Additional definitions

Brief definitions of key terms used throughout this document. A comprehensive glossary is provided separately.

4.1 Settings of care

Home-based care: Long-term care services delivered in an individual's private residence. May include personal care assistance, nursing care, rehabilitation, household support, and

1036 companionship, provided by unpaid carers, paid care workers, or health professionals. It
1037 also includes the provision of adequate supplies such as oxygen therapy, assistive
1038 technology and other services (meals on wheels, safety check-ins, home repair, etc.)

1039 **Community-based care:** Long-term care services delivered in non-residential community
1040 settings – such as day centres, community health centres, or local gathering places – that
1041 people attend for defined periods while continuing to live at home. Includes day
1042 programmes, respite services, meal programmes, social activities, and health services.

1043 **Residential care:** Long-term care provided in facilities where individuals live and receive
1044 24-hour accommodation, personal care, and supervision. Includes nursing homes, care
1045 homes, residential aged care facilities, and assisted living (terminology and regulatory
1046 categories vary by country).

1047 **Transitional care**: Time-limited care provided in dedicated facilities or programmes to
1048 support recovery and rehabilitation between acute care and return home, or to provide
1049 assessment and planning before longer-term arrangements are made.

1050 4.2 People involved in long-term care

1051 **Carers** (also: caregivers, informal carers, family carers, care partners): Individuals who
1052 provide ongoing care and support to a person with long-term care needs, without a formal
1053 employment contract, regardless of whether the carer receives social transfers such as
1054 carer allowances. Usually family members, partners, friends, or neighbors. May provide
1055 direct care, arrange and coordinate care, or both.

1056 **Long-term care workforce** (also: care workers, paid carers, formal carers): People
1057 employed and remunerated to provide long-term care services. Includes personal care
1058 workers, nursing staff, allied health professionals, and support staff across all settings.

1059 **Care coordinator** (also: care manager, case manager, key worker): A designated person
1060 responsible for assessing needs, developing care plans, arranging services, and ensuring
1061 coordination across providers. May be a professional role or a function performed by family
1062 members or community workers.

1063 4.3 System functions

1064 **Quality assurance:** Systematic processes through which responsible authorities monitor
1065 long-term care services against defined standards and take action to maintain and improve
1066 quality. May include regulation, inspection, accreditation, and complaints systems.

1067 **Safeguarding:** Actions to protect older people receiving long-term care from abuse, neglect,
1068 financial exploitation, coercion, abandonment, institutional violence and ageism.
1069 Safeguarding applies across all settings of care — home, community and residential — and
1070 across all provider types, and operates as a cross-cutting concern throughout the
1071 foundational principles and the standards of this document.

1072 **Care coordination:** The deliberate organization of care activities among multiple providers,
1073 settings, and time periods to facilitate appropriate service delivery, smooth transitions, and
1074 coherent care experience for the person and family.

1075 5. Annex: terminology across regions

1076 This annex maps WHO terminology to common alternatives used in different regions,
1077 supporting conceptual alignment while acknowledging linguistic and cultural variation.

1078 **Table 5.** *WHO terminology and common alternatives across regions*

WHO term	Common alternatives
Older person	Senior, elderly (note: WHO prefers "older person", reflecting UN General Assembly resolution A/RES/50/141 of 30 January 1996, which established the preference for "older persons" over "elderly", and the WHO Global report on ageism (2021), which identifies "elderly" as an ageist term in many contemporary contexts), elder, senior citizen
Carer	Caregiver, informal carer, family carer, care partner
Long-term care	Aged care, elder care, continuing care, social care
Residential care	Nursing home, care home, aged care facility, long-term care facility
Home-based care	Home care, domiciliary care, in-home support
Community-based care	Day care, adult day services, community care
Care worker	Personal support worker, care aide, care assistant, aged care worker
Intrinsic capacity	Functional capacity (note: these are distinct concepts in WHO framework)
Functional ability	Function, independence, autonomy (note: these have related but distinct meanings)

1079

1080
Chapter 2. Home and community-based care

1081 **Table 6.** *Standards and quality statements: Chapter 2, Home and community-based care*

Standard	Quality statements
Standard 1. Entry, assessment and care coordination	**1.1** Accessible entry to services **1.2** Comprehensive needs assessment **1.3** Personalized care planning **1.4** Care coordination
Standard 2. Supporting independent living at home	**2.1** Timely and responsive services **2.2** Person-centred and dignified care **2.3** Safe and competent care **2.4** Home modifications and assistive devices
Standard 3. Community-based health services	**3.1** Access to health services in the home and community **3.2** Coordination and continuity of care
Standard 4. Social support and community participation	**4.1** Formal community support services **4.2** Community activities and participation **4.3** Social connection and isolation prevention

1082
1. Introduction

1083 Home and community-based care enables older people who require long-term care to
1084 receive services while remaining in their own homes and communities. For most people, this
1085 aligns with their preference to age in place rather than move to residential facilities. HCBC
1086 encompasses a range of formal services – from personal care assistance and home nursing
1087 to day centres and home modifications – that together support older people with care needs
1088 to live as independently as possible.

1089 The shift toward HCBC is a global policy priority, yet quality standards for these services
1090 remain less developed than those for residential care. Services delivered in private homes,
1091 often by multiple providers, present distinct challenges for quality assurance. Coordination
1092 across health, social care, and housing sectors is often fragmented. And ensuring safety
1093 and accountability when care occurs behind closed doors requires different approaches than
1094 in facility settings.

1095 **Scope of this chapter.** This chapter establishes standards for formal HCBC services
1096 delivered by trained providers. It covers how people access and are assessed for services
1097 (Standard 1); support for daily living and the home environment (Standard 2); health
1098 services delivered in home and community settings (Standard 3); and social participation
1099 and community connection (Standard 4). The standards apply to services for older people
1100 with long-term care needs, though many elements are relevant to younger adults with
1101 disabilities or chronic conditions. Informal care provided by family and other unpaid carers is
1102 addressed separately in Chapter 4, though effective HCBC depends on coordination
1103 between formal services and unpaid carers. Formal HCBC services are one important part
1104 of this continuum. In many settings — particularly in low- and middle-income countries and
1105 Pacific Island contexts — long-term care functions are progressively built by strengthening
1106 and coordinating existing primary health care and community structures, including
1107 community health workers, village health volunteers, older people's associations and faith-
1108 based and community-based organizations, before stand-alone formal HCBC services are
1109 established. The standards in this chapter are designed to be applicable to both
1110 arrangements and to settings that combine the two.

1111 2. Background

1112 2.1 Global situation

1113 The development of formal HCBC varies substantially across countries. Some have mature
1114 systems with dedicated financing, regulatory frameworks, and diverse service options –
1115 Japan's Long-Term Care Insurance, the Netherlands' home care system, and Australia's
1116 aged care system is a well-established example. Others are at earlier stages, with HCBC
1117 delivered primarily through community health workers or integrated into primary health care,
1118 as in Thailand and the Philippines. This diversity reflects differences in health system
1119 structures, demographic pressures, and available resources – but also presents
1120 opportunities for cross-country learning.

1121 2.2 Key challenges

1122 • **Equitable access to services.** Many people who need HCBC cannot access
1123 services due to cost, location, lack of information, or insufficient supply – with
1124 underserved populations facing the greatest barriers.

1125 - **Coordination across sectors.** HCBC involves multiple providers across health,
1126 social services, and housing, yet these sectors often operate separately, leaving
1127 individuals to navigate fragmented systems on their own.

1128 - **Quality and safety in home settings.** Ensuring quality care and protecting people
1129 from abuse or neglect is more difficult when services are delivered in private homes,
1130 particularly for those who are isolated.

1131 2.3 Policy and legal frameworks for HCBC

1132 Countries have established HCBC through diverse governance mechanisms, reflecting
1133 differences in health system structures, administrative capacity, and policy traditions. At one
1134 end of the spectrum, some countries embed standards in legislation with regulatory
1135 enforcement – Australia's Aged Care Act and South Africa's Older Persons Act establish
1136 legally binding requirements backed by penalties for non-compliance. Others rely on
1137 independent regulatory bodies with powers to register providers, conduct inspections, and
1138 publish performance ratings, as in the United Kingdom and Netherlands. In some other
1139 countries, standards are integrated within government health programmes, with oversight
1140 through programme administration – though often combined with licensing requirements for
1141 providers. In practice, many countries blend elements across these approaches.

1142 No single governance model is optimal for all contexts. What matters is that standards exist,
1143 are appropriate to local capacity, and are effectively implemented. The standards in this
1144 chapter are designed to be applicable across these different governance approaches –
1145 providing a common framework for quality while allowing flexibility in how countries
1146 establish, monitor, and enforce them.

1147 **Box 4.** *Country example: three approaches to establishing HCBC in law and policy*

Countries have established quality frameworks for HCBC through different governance mechanisms.

Australia – statutory framework

The Aged Care Act 2024, which commenced on 1 November 2025, establishes legal requirements for all government-funded aged care services, covering service quality, user rights, and accountability. The Aged Care Quality and Safety Commission, an independent statutory authority, is responsible for provider approval, compliance monitoring, and enforcement, with powers to impose sanctions for non-compliance.

United Kingdom (England) – independent regulatory system

The Care Quality Commission (CQC) operates as an independent regulator. All home care providers must register with CQC and meet fundamental standards. CQC conducts inspections, publishes performance ratings, and can cancel registration where standards

are not met.

Thailand – programme-based system with licensing requirements

Thailand's 2016 Long-term Care Policy integrates HCBC into the primary health care system, with family care teams delivering home-based services coordinated through sub-district health promotion hospitals. A 2020 Ministerial Regulation added licensing requirements for elderly care service providers, including mandatory staff training and certification, and facility standards. Quality oversight combines programme supervision with these regulatory requirements.

1148 **LMIC adaptation.** These models demonstrate that HCBC quality assurance can be
1149 achieved through different pathways. Countries with limited regulatory capacity may find
1150 programmatic approaches more feasible, building quality oversight into existing supervision
1151 structures.

1152

1153 3. Standards

1154 This section presents four standards for home and community-based care. These standards
1155 are interconnected, spanning from initial access and assessment through to ongoing service
1156 delivery. Together, they work toward the overarching goals of HCBC: to enable people with
1157 long-term care needs to live safely in their homes and communities, to maintain functioning
1158 and delay avoidable decline, to uphold dignity and autonomy, and to reduce reliance on
1159 hospital and institutional care.

1160 Safeguarding – protecting people from abuse, neglect, and exploitation – is a foundational
1161 requirement that cuts across all standards. Because HCBC is delivered in private homes,
1162 often to individuals who may be isolated or vulnerable, the risks of abuse, neglect, and
1163 exploitation require particular attention. Regardless of resource constraints, all HCBC
1164 systems must establish basic mechanisms for prevention, detection, and response to
1165 safeguarding concerns. This includes clear reporting channels accessible to service users
1166 and their families, staff training in recognizing signs of harm, and accountability processes
1167 when concerns arise.

1168 Standard 1: Entry, assessment and care coordination

1169 *People who need HCBC can access services through clear pathways, receive a*
1170 *comprehensive assessment of their needs, and have a personalized care plan developed in*
1171 *partnership with them and coordinated across providers.*

1172 **Overview**

1173 Entry and assessment are the gateway to long-term care services. While these processes
1174 apply across all care settings, home and community-based care is typically the starting point
1175 for most people entering the long-term care system. A well-designed entry system ensures
1176 that people can find and access services when they need them, that their needs are
1177 assessed holistically, and that care is planned and coordinated around their individual goals
1178 and preferences.

1179 This standard addresses how people access information and request support (Quality
1180 Statement 1.1), how their needs are assessed (Quality Statement 1.2), how care plans are
1181 developed (Quality Statement 1.3), and how services are coordinated across providers
1182 (Quality Statement 1.4).

1183 *Quality Statement 1.1: Accessible entry to services*

1184 People who may need HCBC can access clear information about available services through
1185 health, social care, and community settings, and have a defined pathway to request support.

1186 Rationale

1187 Many people who could benefit from long-term care services do not know what is available,
1188 how to access it, or whether they are eligible. This is particularly true for those who are
1189 isolated, have cognitive impairments, have limited literacy, or are unfamiliar with formal
1190 service systems. Entry points located within existing health and social care contacts – such
1191 as primary care, hospital discharge, or community services – enable earlier identification
1192 and reduce barriers to access.

1193 Implementation guidance

1194 • Provide information about long-term care services in accessible formats and
1195 languages, through multiple channels including health facilities, community centres,
1196 and digital platforms.

1197 • Train health and care workers in health, social care, and community settings to
1198 identify people who may benefit from long-term care and refer them appropriately.

1199 • Establish clear referral pathways so that people can access assessment and
1200 services regardless of where they first seek help.

1201 • Ensure entry processes are accessible to people with cognitive or sensory
1202 impairments, and to those without family support to navigate the system.

Type	Indicative measure
Input	Entry points and referral pathways for HCBC are formally defined in policy or guidance.

Type	Indicative measure
Process	Health and care workers in primary care, hospitals, and community settings are trained to provide information about HCBC and to refer people who may need support.
Output	Information materials about HCBC are produced and disseminated through health, social care, and community settings; proportion of frontline services equipped to provide information and make referrals.
Outcome	People who may need HCBC, including those from groups at risk of exclusion, are aware of available services and know how to request support.

1203 ### *Quality Statement 1.2: Comprehensive needs assessment*

1204 People referred for HCBC receive a comprehensive assessment that covers their health,
1205 functional, social needs, their resources and support networks, as well as their preferences
1206 and goals.

1207 **Rationale**

1208 Effective care planning depends on understanding the whole person – not only their
1209 functional limitations but also their health conditions, living situation, social support, and
1210 what matters most to them. Standardized assessment tools support consistency and equity,
1211 while allowing for individualized responses.

1212 **Implementation guidance**

1213 • Use validated, multidimensional assessment tools covering physical function,
1214 cognition, health status, social circumstances, and carer capacity.

1215 • Ensure assessments are conducted by trained personnel, and involve the person
1216 and their family in the process.

1217 • Link assessment findings directly to eligibility determination and care planning, and
1218 reassess regularly or when circumstances change.

Type	Indicative measure
Input	Validated, multidimensional assessment tools covering functional, health, social, and preference domains are adopted for use in HCBC.
Process	Proportion of people referred for HCBC who receive a comprehensive assessment conducted by trained personnel, with documented involvement of

Type	Indicative measure
	the person and family.
Output	Assessment records document needs across functional, health, social, and preference domains; reassessments are conducted at defined intervals or when circumstances change.
Outcome	People's needs are accurately identified and reflected in service provision; assessment quality is consistent across population groups and providers.

1219 **Box 5.** *Example: interRAI Home Care Assessment*

The interRAI Home Care (HC) is a standardized, multidimensional assessment tool covering functional, cognitive, clinical, and social domains, implemented in over 30 countries. **Hong Kong SAR (China)** mandates interRAI-HC for all applications to subsidized long-term care services through its Standardized Care Need Assessment Mechanism for Elderly Services (SCNAMES). **New Zealand** requires interRAI assessment for publicly funded home support. **Belgium** has implemented BelRAI, including a shorter screening version for initial identification.

1220 **LMIC adaptation.** Countries can start with shorter screening instruments covering core
1221 domains. A South African study demonstrated that lay interviewers can accurately
1222 administer simplified versions, extending reach without requiring large numbers of trained
1223 professionals.

1224 *Quality Statement 1.3: Personalized care planning*

1225 People eligible for HCBC have a personalized care plan developed in partnership with them,
1226 reflecting their assessed needs, preferences, and goals, and reviewed regularly as
1227 circumstances change.

1228 Rationale

1229 Care plans translate assessment findings into a concrete package of services tailored to the
1230 individual. When developed in genuine partnership with the person and their family, care
1231 plans are more likely to reflect what matters most to them and to be followed in practice.
1232 Regular review ensures care remains appropriate as needs change over time.

1233 Implementation guidance

1234 • Develop care plans in consultation with the person and, where appropriate, their
1235 family, documenting agreed goals and how services will address them. Consider the
1236 person's own resources, capabilities, and social support when planning services.

1237 • Specify which services will be provided, by whom, and how often, with clarity on
1238 roles and responsibilities.

1239 • Establish a process for regular review of care plans, and ensure plans can be
1240 updated promptly when circumstances change.

Type	Indicative measure
Input	Standards or protocols for care planning are established, specifying required elements of a care plan and the expectation of partnership with the person and family.
Process	Proportion of care plans developed with documented involvement of the person and family members.
Output	Proportion of HCBC recipients with a documented, up-to-date care plan; proportion of plans reviewed within defined timeframes.
Outcome	Services delivered reflect the person's assessed needs and stated preferences; people experience care as coherent and responsive to changing circumstances.

1241 ***Quality Statement 1.4: Care coordination***

1242 People receiving HCBC have a designated point of contact responsible for coordinating their
1243 care across services and providers, ensuring continuity and preventing fragmentation.

1244 **Rationale**

1245 Long-term care often involves multiple providers across health, social care, and community
1246 services. Without clear coordination, people may receive duplicated or conflicting services,
1247 experience gaps in care, or be left to navigate complex systems on their own. A designated
1248 coordinator – whether a care manager, social worker, or other trained person – helps ensure
1249 services work together around the individual.

1250 **Implementation guidance**

1251 • Assign a named person or team responsible for coordinating each individual's care
1252 and serving as the main point of contact for the person and their family.

1253 1254
- Establish mechanisms for communication and information sharing among providers involved in an individual's care.

1255 1256
- Ensure coordinators have appropriate training and manageable caseloads to fulfil their role effectively.

Type	Indicative measure
Input	Care coordination roles are defined, with clear responsibilities, training requirements, and caseload expectations.
Process	Proportion of HCBC recipients assigned a named coordinator or coordination team serving as their main point of contact.
Output	Mechanisms for communication and information sharing among providers are operational; coordinator caseloads are within defined limits.
Outcome	People receiving HCBC experience care as coordinated rather than fragmented; transitions between providers and settings occur without gaps.

1257
Standard 2: Supporting independent living at home

1258 1259 1260
People receiving HCBC are supported to live independently at home through timely, dignified personal care from competent workers, and through home modifications and assistive devices that enable safe daily living.

1261
Overview

1262 1263 1264 1265
For most people requiring long-term care, home is the preferred setting – and often where care is provided. This standard addresses both dimensions of home-based support: the personal assistance provided by care workers, and the environmental adaptations that make the home safer and more accessible.

1266 1267 1268 1269 1270
Effective home-based support is timely and responsive to changing needs (Quality Statement 2.1), respects the person's dignity and preferences (Quality Statement 2.2), and is delivered by workers with appropriate skills (Quality Statement 2.3). Home modifications and assistive devices complement personal care by enabling people to manage daily activities more safely and with less reliance on others (Quality Statement 2.4).

1271
Quality Statement 2.1: Timely and responsive services

1272 1273
People receive personal care and daily living support when they need it, with services that respond promptly to changes in their circumstances or care needs.

1274
Rationale

1275 When services are delayed or unresponsive, people may experience preventable falls,
1276 hospitalizations, or deterioration that could have been avoided with earlier support. Timely
1277 access and flexibility to adjust services as needs change are essential – both to protect the
1278 person and to support unpaid carers who may otherwise bear the burden of unmet needs.

1279 **Implementation guidance**

1280 • Establish clear timeframes for initiating services following assessment, with priority
1281 pathways for urgent needs.

1282 • Build flexibility into service arrangements so that care intensity can be adjusted as
1283 needs change, without requiring full reassessment.

1284 • Ensure people and families know how to request changes to their care and who to
1285 contact in urgent situations.

Type	Indicative measure
Input	Defined timeframes for initiating services following assessment; priority pathways for urgent needs established.
Process	Proportion of HCBC recipients receiving services within defined timeframes; mechanisms in place for adjusting service intensity in response to changing needs.
Output	Average time from care plan approval to service initiation; proportion of service adjustment requests actioned within defined timeframes.
Outcome	HCBC recipients experience services as timely and responsive to their changing needs.

1286 ***Quality Statement 2.2: Person-centred and dignified care***

1287 Personal care and daily living support is delivered in a way that respects people's dignity,
1288 privacy, and preferences, and enables them to maintain choice and control over how care is
1289 provided.

1290 **Rationale**

1291 Personal care involves intimate activities such as bathing, dressing, and toileting. Common
1292 problems include care workers entering without knocking, performing care in front of others,
1293 following rigid schedules regardless of the person's preferences, or frequent changes of
1294 care worker that undermine trust and continuity. Giving people choice and control over how
1295 their care is delivered – including who provides it – is fundamental to protecting dignity.

1296 **Implementation guidance**

1297
1298
- Involve people in decisions about how their care is delivered, including timing, routines, and choice of care worker where feasible.

1299
1300
- Where possible, offer people choice among providers or enable them to select and retain consistent care workers.

1301
1302
- Train care workers to provide personal care in ways that protect privacy and respect individual preferences.

1303
1304
- Establish feedback mechanisms so that people can raise concerns about how their care is provided without fear of negative consequences.

Type	Indicative measure
Input	Expectations for person-centred and dignified care delivery are established in standards or provider requirements; training curricula for care workers include privacy and person-centred practice.
Process	Proportion of care workers trained in privacy and person-centred personal care; feedback mechanisms enabling people to raise concerns are operational.
Output	Care plans and service arrangements document individual preferences regarding care delivery (for example, timing, routines, choice of worker where feasible); care recipient feedback is systematically collected.
Outcome	People receiving HCBC report that care is delivered with respect for their dignity, privacy, and preferences; continuity of care workers is maintained where feasible.

1305 **Box 6.** *Country example: consumer-directed care*

Consumer-directed care (also called self-direction) gives people control over how their care is delivered, including who provides services and when. This operationalizes person-centred principles by placing decision-making authority with the individual.

The **Netherlands** *Persoonsgebonden budget* (PGB), introduced in 1995, allows people to manage a personal budget to purchase care from providers of their choice, including family members. **Australia** introduced Consumer Directed Care for Home Care Packages from 2015, emphasizing flexibility and choice. Under the Aged Care Act 2024, which commenced on 1 November 2025, this approach has evolved into a broader

consumer-centred, rights-based framework: the Support at Home programme allocates an individual care budget that recipients use across approved providers and services according to their assessed needs and preferences. In the **United States**, self-directed options are available through Medicaid HCBS waivers in many states, allowing participants to recruit, hire, and supervise their own care workers, though availability and design vary significantly by state.

1306 **LMIC adaptation.** Full personal budget systems require administrative infrastructure. The
1307 core principle – choice and control – can be implemented progressively: offering choice
1308 among registered providers; allowing people to select specific workers; and involving people
1309 in service planning.

1310 *Quality Statement 2.3: Safe and competent care*

1311 Personal care and daily living support is provided by workers with appropriate training and
1312 skills, following safe practices that protect people from harm, neglect, or abuse.

1313 **Rationale**

1314 Care workers often work alone in private homes with limited direct supervision. Without
1315 adequate training, workers may cause unintentional harm – through improper moving and
1316 handling, medication errors, or failure to recognize signs of deterioration. The private nature
1317 of home care also creates risks of abuse or neglect that are harder to detect than in facility
1318 settings. Competency requirements and safeguarding mechanisms are essential.

1319 **Implementation guidance**

1320 • Establish minimum training requirements for care workers, covering core skills such
1321 as safe moving and handling, personal hygiene support, and recognizing signs of
1322 abuse or deterioration.

1323 • Require providers to have clear protocols for common risks in home care, including
1324 medication management, infection prevention, and fall prevention.

1325 • Establish incident reporting systems so that accidents, near-misses, and
1326 safeguarding concerns are documented and addressed.

1327 • Ensure people receiving care and their families know how to raise concerns and
1328 have access to independent channels for complaints.

Type	Indicative measure
Input	Minimum training requirements for HCBC care workers defined; provider protocols for common home care risks established; incident reporting and

Type	Indicative measure
	complaint channels in place.
Process	Proportion of care workers who have completed required training; incident reporting systems in active use.
Output	Incidents, near-misses, and safeguarding concerns are documented and investigated.
Outcome	HCBC recipients are protected from avoidable harm, neglect, and abuse

1329 ### *Quality Statement 2.4: Home modifications and assistive devices*

1330 People have access to assessment and provision of home modifications and assistive
1331 devices that enable them to live safely and independently at home and maintain connection
1332 with others.

1333 **Rationale**

1334 Many functional limitations can be addressed through environmental adaptations – such as
1335 grab rails, ramps, and accessible bathrooms – and assistive devices including walking aids
1336 and wheelchairs. These interventions can prevent falls, reduce dependence on personal
1337 care assistance, and enable people to remain at home longer. Common barriers include
1338 limited awareness of available options, lack of affordable provision, long waiting times,
1339 restrictions faced by people living in rented accommodation, and lack of rehabilitation teams
1340 to identify, prescribe and train the use of devices.

1341 **Implementation guidance**

1342 • Include home environment assessment as part of comprehensive needs
1343 assessment, identifying hazards and opportunities for adaptation.

1344 • Establish clear pathways for accessing home modifications and assistive devices,
1345 with funding mechanisms or subsidies to address affordability.

1346 • Prioritize high-impact, low-cost modifications such as grab rails and non-slip surfaces
1347 that can be implemented quickly.

1348 • Ensure people receive assessment, prescription, training in use, fit assessment, and
1349 follow-up monitoring of assistive devices, delivered by appropriately trained
1350 rehabilitation personnel where available.

Type	Indicative measure
Input	Defined pathways for accessing home modifications and assistive devices; funding mechanisms or subsidies established to address affordability.
Process	Home environment assessment is included as part of comprehensive needs assessment; people receive instruction in the safe use of assistive devices.
Output	Proportion of HCBC recipients with identified needs who receive home modifications or assistive devices; average waiting time from assessment to provision.
Outcome	HCBC recipients are able to live safely and independently at home; falls and other preventable incidents related to the home environment are reduced.

1351 ## Standard 3: Community-based health services

1352 *People receiving HCBC can receive health services in their homes and community settings*
1353 *to address health needs and maintain functioning, with continuity and coordination across*
1354 *the health system.*

1355 **Overview**

1356 Many people receiving long-term care have ongoing health needs – chronic conditions
1357 requiring monitoring, wounds requiring nursing care, or functional decline requiring
1358 rehabilitation. This standard addresses the delivery of health services in home and
1359 community settings, rather than requiring people to attend hospitals or clinics. Effective
1360 community-based health services depend on integration between health and social care
1361 sectors, which often operate under separate governance, funding, and information systems.
1362 Without deliberate coordination mechanisms, people may experience fragmented care, gaps
1363 in service, or repeated assessments as they navigate between systems.

1364 ### *Quality Statement 3.1: Access to health services in the home and community*

1365 People can receive health services – including nursing care, rehabilitation, and clinical
1366 support – in their homes or community settings, enabling them to address health needs
1367 without requiring admission to hospital or other health facilities.

1368 **Rationale**

1369 For people with limited mobility or complex care needs, accessing health services through
1370 hospital or clinic visits can be difficult, costly, and disruptive. Community-based health
1371 services – including home nursing, physiotherapy, occupational therapy, and medication
1372 management – enable people to receive clinical care where they live. This can prevent

1373 unnecessary hospitalizations, support recovery after acute illness, and help maintain
1374 functioning over time.

1375 **Implementation guidance**

1376–1380
- Ensure community nursing and rehabilitation services are available to people receiving HCBC, with clear referral pathways from primary care and hospitals, and continue these services for as long as clinically needed; short, time-limited rehabilitation often fails to support full recovery (for example, recovery from hip fracture commonly requires more than six months of rehabilitation).

1381–1382
- Establish protocols for health interventions that can be safely delivered at home, including wound care, medication administration, and rehabilitation.

1383–1384
- Integrate community health services with personal care provision, ensuring health and social care workers communicate and coordinate around the individual.

Type	Indicative measure
Input	Community nursing, rehabilitation, and clinical support services available for HCBC recipients; referral pathways and protocols for home-based health interventions established.
Process	Proportion of HCBC recipients with identified health needs who receive community-based health services.
Output	Range and coverage of health services delivered in home and community settings.
Outcome	HCBC recipients address health needs in their home and community settings, without avoidable hospital admissions.

1385 ***Quality Statement 3.2: Coordination and continuity of care***

1386 Health services provided within HCBC are coordinated with primary health care providers,
1387 hospitals, and specialist services, ensuring that health information is shared appropriately
1388 and care transitions are managed safely.

1389 **Rationale**

1390 People receiving HCBC often interact with multiple parts of the health system – primary
1391 care, specialists, hospitals – as well as social care providers. Poor coordination leads to
1392 duplicated assessments, conflicting advice, medication errors during transitions, and gaps in
1393 follow-up care. Effective coordination requires clear responsibilities, information sharing, and
1394 structured processes for managing transitions, particularly hospital discharge.

1395 **Implementation guidance**

1396 • Establish mechanisms for sharing relevant health information between community
1397 health providers, primary care, and hospitals, with appropriate consent.

1398 • Develop structured discharge planning processes that involve community health and
1399 social care providers before the person leaves hospital.

1400 • Ensure primary health care providers are informed of and involved in the ongoing
1401 care of people receiving HCBC.

1402 • Where health and social care operate under separate governance, establish formal
1403 coordination mechanisms, such as joint protocols, shared care plans, or designated
1404 liaison roles, to bridge the two systems.

Type	Indicative measure
Input	Mechanisms for health information sharing across providers established; formal coordination arrangements between health and social care in place.
Process	Discharge planning from hospital routinely includes HCBC providers; primary care providers are informed of and engaged in HCBC recipients' care.
Output	Health information is shared among providers involved in each person's care.
Outcome	HCBC recipients experience continuity across health and social care; gaps in follow-up care are reduced.

1405 ## Standard 4: Social support and community participation

1406 *People receiving HCBC have access to community-based services and opportunities that*
1407 *promote social connection, meaningful activity, and participation in community life.*

1408 **Overview**

1409 Long-term care addresses not only health and functional needs but also social well-being.
1410 Social isolation is associated with poorer health outcomes, cognitive decline, and reduced
1411 quality of life. This standard covers three dimensions of social support: formal community
1412 services such as day centres and meal programmes (Quality Statement 4.1); opportunities
1413 for participation in community activities and civic life (Quality Statement 4.2); and targeted
1414 support for those at risk of isolation (Quality Statement 4.3). Effective social support involves
1415 both formal services provided by governments and organizations, and informal opportunities
1416 that exist within communities – including activities organized by community groups, religious
1417 institutions, and older people themselves.

1418 ### *Quality Statement 4.1: Formal community support services*

1419 People can access community-based services, including day centres, meal services, and
1420 transport assistance, that support their daily living and enable participation outside the
1421 home.

1422 **Rationale**

1423 Formal community services provide structured support that enables people to maintain
1424 nutrition, access activities outside the home, and receive supervision during the day. Day
1425 centres can also provide respite for unpaid carers. Common barriers to accessing these
1426 services include lack of transport, cost, limited availability in rural areas, and services that do
1427 not accommodate people with cognitive impairment or complex needs.

1428 **Implementation guidance**

1429 • Include community support services as part of the continuum of long-term care, with
1430 clear pathways for referral from assessment and care planning.

1431 • Ensure services are accessible to people with varying levels of need, including those
1432 with cognitive impairment or physical disabilities.

1433 • Address common barriers to access, including transport, cost, availability in
1434 underserved areas, and service design that excludes people with complex needs.

Type	Indicative measure
Input	Community support services (such as day centres, meal services, transport assistance) are available as part of the LTC service continuum.
Process	Referral pathways from assessment and care planning to community services are in use; services are designed to accommodate people with cognitive impairment, physical disabilities, or complex needs.
Output	Coverage and geographic distribution of community support services; proportion of HCBC recipients accessing community services based on assessed needs.
Outcome	HCBC recipients engage in daily life beyond their homes, supported by accessible community services.

1435 ### *Quality Statement 4.2: Community activities and participation*

1436 People are supported to participate in community activities and civic life, including
1437 educational, recreational, cultural, and volunteer opportunities.

1438 **Rationale**

1439 Participation in community life extends beyond formal services. Many older people wish to
1440 continue learning, pursue interests, contribute through volunteering, or participate in
1441 religious and cultural activities. These opportunities – often organized by community groups,
1442 educational institutions, or older people themselves – provide purpose and social
1443 connection. However, people receiving long-term care may face barriers to participation,
1444 including physical accessibility, lack of information, or assumptions that they are no longer
1445 able to contribute. HCBC services have a role not in creating these opportunities, but in
1446 connecting people to them and helping to remove barriers to participation.

1447 **Implementation guidance**

1448 • Provide information about community activities – such as senior learning
1449 programmes, interest groups, religious gatherings, and volunteer opportunities – as
1450 part of care planning.

1451 • Support community organizations to make their activities accessible to people with
1452 care needs, including through physical accessibility and accommodations for
1453 cognitive impairment.

1454 • Recognize and facilitate older people's continued contribution to community life,
1455 including through intergenerational programmes and volunteer roles appropriate to
1456 their capacity.

Type	Indicative measure
Input	Mechanisms in place to connect HCBC recipients with community activities and participation opportunities.
Process	Information about community activities is included in care planning; HCBC providers work with community organizations to support accessibility.
Output	HCBC recipients are linked to community activities across different types (educational, recreational, cultural, volunteer).
Outcome	HCBC recipients remain engaged in community life, maintaining purpose and social connection.

1457 **Box 7.** *Country example: Singapore*

Singapore's Active Ageing Centres (AACs) are community drop-in centres for people aged 60 and above, offering group exercise, social and recreational activities, and

health-related information. For seniors who are isolated or homebound, AACs provide befriending services through regular home visits and phone calls. The centres also serve as a point of contact for information and referral to other care services, and are located across Singapore to ensure accessibility within neighbourhoods.

1458 **LMIC adaptation.** The core elements – a neighbourhood drop-in point combining social
1459 activities with volunteer outreach to isolated seniors – can be adapted using existing
1460 community facilities such as community centres or religious institutions.

1461 ### *Quality Statement 4.3: Social connection and isolation prevention*

1462 People at risk of social isolation receive proactive outreach and support to maintain social
1463 connections and emotional well-being.

1464 **Rationale**

1465 Some people receiving HCBC are at heightened risk of isolation – those living alone, without
1466 family nearby, with limited mobility, or who have recently lost a spouse or close family
1467 member. Isolation may not be identified unless services actively look for it. Proactive
1468 outreach through befriending services, regular contact, and home visits can identify unmet
1469 needs early and maintain social connection for those who cannot easily leave their homes.

1470 **Implementation guidance**

1471 • Identify people at risk of social isolation as part of assessment and care review,
1472 using indicators such as living alone, recent bereavement, or limited social contact.

1473 • Establish or support befriending and regular contact services, which may be
1474 delivered through trained volunteers, community organizations, or telephone/digital
1475 outreach.

1476 • Train care workers to recognize signs of isolation and loneliness and to report
1477 concerns through appropriate channels.

1478 • Ensure isolated individuals are prioritized for home visits and proactive follow-up.

Type	Indicative measure
Input	Indicators for identifying social isolation risk defined; befriending or regular contact services available (through volunteers, community organizations, or telephone/digital outreach).
Process	Isolation risk is assessed as part of HCBC assessment and care review; care workers are trained to recognize and report signs of isolation.

Type	Indicative measure
Output	HCBC recipients identified as at risk of isolation receive befriending services, regular contact, or prioritized home visits.
Outcome	HCBC recipients at risk of isolation maintain social connection; loneliness and emotional distress are reduced.

1479 **Box 8.** *Example: Meals on Wheels*

Meals on Wheels is a home-delivered meal model that originated in the United Kingdom during the Second World War and now operates in countries including Australia, Canada, Ireland, New Zealand, the United Kingdom, and the United States. The model combines delivery of prepared meals to homebound older people with regular social contact and a well-being check by the volunteer or staff member making the delivery. In the United States, approximately 5,000 community-based providers form a nationwide network supported by more than two million staff and volunteers, with many local programmes partly funded under the federal Older Americans Act. A defining feature of the model is that meal delivery doubles as routine face-to-face contact: when a recipient cannot be reached, local programmes follow up through established protocols. This combined function of nutrition support, friendly visits, and safety checks helps identify unmet needs and reduces isolation among older people living alone.

1480 **LMIC adaptation.** The core elements of this model, routine home visits combining simple
1481 meal support with a well-being check, can be adapted without large-scale infrastructure.
1482 Existing community structures such as community health worker networks, religious
1483 organizations, or neighbourhood associations can be mobilized to deliver regular contact
1484 with isolated older people, with basic protocols for following up when a recipient cannot be
1485 reached.

1486 4. Implementation considerations

1487 **LMIC considerations.** In many low- and middle-income countries, formal HCBC services
1488 are limited or only recently emerging. These standards are designed to be implemented
1489 progressively, with guidance on phased approaches that build from basic services toward
1490 more comprehensive systems. Core principles – a rights-based approach, person-centred
1491 care, safety, coordination – apply across all resource contexts, while specific service models
1492 can be adapted to local capacity and existing infrastructure.

1493 Context adaptation

1494 These standards require adaptation to diverse national contexts. Countries differ in their
1495 health system structures, administrative capacity, cultural expectations around care, and
1496 existing service traditions. In some contexts, formal HCBC services are well-established; in
1497 others, care is provided almost entirely by families with limited formal support.
1498 Implementation should build on existing strengths, such as community health worker
1499 networks, primary health care infrastructure, or strong family and community traditions,
1500 rather than imposing uniform models.

1501 No single governance or delivery model is optimal for all settings. What matters is that core
1502 principles are upheld while allowing flexibility in how services are organized, financed, and
1503 monitored. Countries at earlier stages of HCBC development may focus initially on
1504 establishing basic services and entry pathways, while those with more mature systems may
1505 prioritize integration, quality improvement, and consumer choice.

1506 Phased implementation for resource-limited settings

1507 A phased approach allows countries to build HCBC systems progressively, starting with
1508 foundational elements and expanding as capacity develops. The following phases are
1509 illustrative rather than prescriptive; countries may adapt the sequence based on their
1510 starting point and priorities.

1511 *Phase 1 – Foundation*

1512 The initial phase focuses on establishing basic services using existing infrastructure and
1513 workforce:

1514 • Identify people needing care through existing primary health care contacts,
1515 community health workers, or social welfare systems.

1516 • Deliver basic personal care and daily living support through trained community health
1517 workers or volunteers, building on existing programmes.

1518 • Provide social activities through existing community gathering points such as
1519 community centres, religious institutions, or village meeting places.

1520 • Establish simple safeguarding mechanisms, including a designated contact for
1521 complaints and basic incident reporting.

1522 **Box 9.** *Country example: Philippines*

> The HCSSSC, implemented by the Department of Social Welfare and Development, demonstrates how HCBC can be delivered in a lower-middle-income setting by leveraging existing community structures. The programme identifies frail, sick, and bedridden senior citizens through local social welfare offices and existing primary health-care structures, including barangay health centres and community health workers, rather than establishing new intake systems. Trained community volunteers provide basic

personal care assistance – bathing, grooming, meal preparation, and medication support – in beneficiaries' homes, while also serving as companions for recreational and socialization activities. Local social workers oversee case management and monitor individualized "helping plans" co-developed with home care volunteers, the senior, and their family, providing a simple safeguarding mechanism with clear accountability. Between 2013 and 2019, the programme was replicated across 96 local government units in 13 regions.

1523 ***Phase 2 – Development***

1524 The second phase expands service range and establishes more systematic processes:

1525 • Establish dedicated entry points for HCBC services with clear referral pathways from
1526 health and social care settings.

1527 • Introduce standardized assessment tools adapted to context, enabling consistent
1528 identification of needs and eligibility determination.

1529 • Expand service types to include community nursing visits, basic rehabilitation, and
1530 structured day programmes.

1531 • Begin home modification programmes, prioritizing individuals with highest need and
1532 greatest risk of institutionalization.

1533 • Introduce provider registration and basic oversight mechanisms.

1534 **Box 10.** *Country example: China*

China's 2016–2020 national pilot programme on home- and community-based elderly care services, implemented by the Ministry of Civil Affairs and Ministry of Finance across 203 cities with 5 billion yuan in central funding, illustrates systematic HCBC expansion. The programme established community elderly care service centres as dedicated entry points, working toward "15-minute service circles" (15 分钟养老服务圈) that locate services within walking distance of older residents. Standardized assessment tools were developed, culminating in the 2023 national standards for elderly ability assessment and at-home care services (GB/T 43153-2023). Building on these pilots, the integration of medical and elderly care services has been adopted as national policy, with community nursing and rehabilitation increasingly embedded in elderly care facilities. Community-based services have expanded significantly, with over 363,000 community aged care service facilities established by end of 2023. Home modification programmes (适老化改造) have completed adaptations for approximately 1.7 million households of older people with the highest needs, per the 2024 State Council report. The phased pilot approach – with competitive city selection, evaluation, and gradual standards development –

established the foundation for provider registration and oversight. |

1535 ### *Phase 3 – Comprehensive*

1536 The third phase develops an integrated, quality-assured system:

1537 • Establish integrated entry points with care navigation support, enabling people to
1538 access information and services through a single pathway.

1539 • Implement multidisciplinary assessment and individualized care planning, with
1540 regular review and adjustment.

1541 • Offer a full range of services with consumer choice among registered providers.

1542 • Develop systematic home modification and assistive technology programmes with
1543 clear access pathways and funding mechanisms.

1544 • Establish quality accreditation systems, outcome monitoring, and public reporting of
1545 provider performance.

1546 **Box 11.** *Country example: Japan*

Japan's Long-Term Care Insurance, implemented in 2000 with major reforms in 2006 and 2012, is designed to enable older people to live in their own communities. Comprehensive Community Support Centres (地域包括支援センター) in every municipality serve as integrated entry points, staffed by multidisciplinary teams of social workers, care managers, and public health nurses. Certified care managers conduct standardized needs assessments, then develop individualized care plans in consultation with users and families. Services include home-visit care, home-visit nursing, rehabilitation, day care, short-stay respite, and – since 2006 – small-scale multifunctional home care (小規模多機能型居宅介護) that flexibly combines day services, home visits, and overnight stays within a single neighbourhood-based facility. Users select their own care manager and providers from among licensed agencies. Home modification grants and assistive device rental are integrated as standard components of care planning. |

1547 ## Common challenges

1548 Evidence from national HCBC quality frameworks reveals persistent challenges that cut
1549 across income levels and governance models, reflecting the inherent complexity of assuring
1550 quality in home and community settings.

1551 **Translating principles into practice.** Person-centred care, dignity, and autonomy appear
1552 as guiding principles across national frameworks, yet operational definitions are typically
1553 absent. Most frameworks lack guidance on how these principles should be demonstrated in

daily care, assessed during monitoring, or reconciled when they conflict with safety requirements.

Monitoring in private settings. Service delivery in private homes limits direct observation and requires care recipient consent for inspection. Quality assurance must rely more heavily on documentation review, user feedback, and outcome measures – each with its own limitations.

Coordinating fragmented systems. HCBC typically involves multiple providers across health, social care, and community services, yet accountability structures focus on individual providers rather than the coordination between them. No single entity may have responsibility for ensuring the person receives coherent support.

Developing feasible monitoring systems. Countries have developed sophisticated performance indicators, yet implementation capacity often lags behind. Frameworks may require data that providers cannot feasibly collect, or inspection expertise unavailable at scale.

Key enablers

Cross-sectoral coordination. Because HCBC spans health, social care, and community sectors, implementation requires deliberate coordination through joint planning, shared funding, or designated liaison roles.

Workforce development. HCBC depends on workers with appropriate skills, training, supervision, and working conditions – addressed in detail in Chapter 5.

Information systems. Effective care coordination and quality monitoring depend on systems that can track individuals across providers and settings.

Sustainable financing. HCBC requires funding mechanisms that ensure affordability for users while providing adequate payment to providers and workers.

1578
Chapter 3. Long-term care facilities

1579 **Table 7.** *Standards and quality statements: Chapter 3, Long-term care facilities*

Standard	Quality statements
Standard 5. Respect for fundamental human rights	**5.1** Ethical admission **5.2** Freedom from restraint and coercion
Standard 6. Adequate service provision	**6.1** Person-centred care plans (PCCPs) for all residents **6.2** Adequate staffing, facilities and access to external services for compliance with PCCPs **6.3** Nutrition and hydration **6.4** Opportunity to engage in meaningful activities
Standard 7. Safe and empowering environments	**7.1** Effective infection prevention and control (IPC) **7.2** LTCFs are safe environments **7.3** LTCFs are empowering environments
Standard 8. Transparency and accountability	**8.1** LTCFs are accountable to residents and their families **8.2** Regulatory agencies effectively monitor and support LTCFs **8.3** LTCFs are accountable to the public

1580
1. Introduction

1581 In all countries, most long-term care for older people is provided within home settings.
1582 Nevertheless, there are growing numbers of residential facilities offering long-term care for
1583 older people who do not remain in their own homes. Residential long-term care facilities
1584 (LTCFs) take diverse forms but share some common characteristics. Firstly, they are, to
1585 some degree, communal settings with shared facilities. Second, they address residents'
1586 care needs in specific ways, deploying paid care workers rather than unpaid carers. Third,
1587 they are distinct from health care facilities providing inpatient hospital care.

1588 Within these parameters, LTCFs take a range of forms and are categorized in different
1589 ways. There is no standard definition or categorization of LTCFs across countries, and there
1590 is considerable variation in official nomenclature and colloquial terms. In some countries, a
1591 broad distinction is made between LTCFs that only offer general care (sometimes called
1592 "care homes") and those offering more specialist nursing ("nursing homes"). General care
1593 services typically include assistance with personal care (washing, dressing, taking
1594 medication and going to the toilet), as well as social activities. Nursing homes typically offer
1595 continual support from professional nurses, with a sub-category of facility providing
1596 specialist support for people with complex conditions like dementia. Other types of LTCF
1597 include assisted living facilities and retirement villages, which provide limited general care
1598 support and have independent living areas. Within these categories, there is further
1599 diversity, in terms of the scale of facilities, their resources, funding arrangements and legal
1600 status – care homes may range from small, informal shared living units with few services to
1601 facilities offering luxury living and state-of-the-art care.

1602 **Scope of this chapter.** This chapter presents standards which apply to all these varied
1603 forms of LTCF and for all countries. The chapter acknowledges many LTCFs operate in
1604 contexts of scarce resources relative to the needs of their residents and that this can
1605 constrain the quality of the services they offer. This is true in all countries, not just LMICs. As
1606 such, these standards are intended to be applied alongside wider strategies for service
1607 improvement rather than simply as punitive benchmarks. They complement other chapters
1608 in this document, particularly those addressing the long-term care workforce, and on
1609 monitoring, quality assurance, and data.

1610 2. Background

1611 6.1 Global situation

1612 There are no reliable global estimates for numbers of LTCFs or their residents, which itself
1613 represents an important information gap. In high-income countries, around three to five per
1614 cent of people aged 65 or more live in LTCFs and about one third will do so at some point in
1615 their life. Limited data for LMICs indicate rapid growth in the numbers of LTCFs. In China, for
1616 example, the number of LTCFs roughly trebled between 2012 and 2017 and now stands at
1617 over 350,000. Globally, this growth is set to accelerate, especially in LMICs, reflecting
1618 demographic trends, as well as social, economic and cultural change.

1619 6.2 Key challenges

1620 **Funding/resourcing:** Providing long-term care in residential settings is never cheap. Key
1621 requirements include adequate numbers of trained staff, suitable physical infrastructure and
1622 equipment, and all the things required to provide residents with an acceptable quality of life.
1623 Many LTCFs lack the resources to meet these needs. On their own, standards cannot
1624 resolve this challenge.

1625 **Regulation and stewardship:** Very few LTCFs are directly funded and operated by
1626 government agencies. Most facilities are run by private for-profit and not-for-profit
1627 organizations. All governments have a duty to ensure the welfare and human rights of LTCF
1628 residents, as well as wider regulatory responsibilities such as labour rights and consumer
1629 protection. These roles are highly challenging and require well-resourced, institutionally
1630 coordinated state action.

1631 **Negative social attitudes:** In all countries to varying degrees, LTCFs are stigmatized
1632 institutions. LTCFs are widely perceived as representations of societies' failure to address
1633 care needs in more culturally acceptable ways. Facilities are often portrayed in popular
1634 culture as dehumanizing institutions which limit residents' freedoms and offer low quality
1635 care. Yet these depictions are often inaccurate, despite the constraints many facilities face.
1636 Tackling LTCF stigma is an essential step for improving service quality.

1637 **6.3 Conceptual framework**

1638 These standards are grounded in a rights-based approach recognizing that older people
1639 living in LTCFs have the same human rights as people of any age living in any setting.
1640 These human rights are universal minimum standards and apply to all LTCFs, regardless of
1641 their resource availability.

1642 As well as minimum standards, this chapter presents service improvement standards. These
1643 are aspirational targets which LTCFs can seek to reach over time, as they become feasible.

1644 The chapter acknowledges that standards are only effective when supported by wider sets
1645 of implementation, compliance and accountability mechanisms. Rather than by top-down
1646 imposition, this requires a shared endeavor between all stakeholders.

1647 **6.4 Normative foundations**

1648 International human rights instruments provide the legal basis for these standards. **The**
1649 **Universal Declaration of Human Rights** establishes the rights to liberty (Article 3), to not
1650 be subjected to arbitrary detention (Article 9), and in accordance with the organization and
1651 resources of each State, of the economic, social and cultural rights indispensable for their
1652 dignity (Article 22).

1653 **The UN Convention on the Rights of Persons with Disabilities** (Article 14) mandates
1654 that states ensure that persons with disabilities, on an equal basis with others, are not
1655 deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in
1656 conformity with the law, and that the existence of a disability shall in no case justify a
1657 deprivation of liberty. Article 22 mandates no person with disabilities, regardless of place of
1658 residence or living arrangements, shall be subject to arbitrary or unlawful interference with
1659 their privacy.

1660 Regional commitments reinforce these principles. **The Buenos Aires Commitment**
1661 recognizes the right to be cared for as a responsibility that must be shared by people of all
1662 sectors of society, including communities, businesses and the state, with appropriate
1663 regulatory frameworks

1664

1665 3. Standards

1666 This section presents four residential LTCF standards. Each standard follows the WHO
1667 Quality of Care structure, with quality statements, implementation rationale, country
1668 examples demonstrating feasibility, and indicative measures. The development of full
1669 measures is planned for Phase 2 (2026).

1670 Standard 5: Respect for fundamental human rights

1671 *All LTCF residents have the same human rights as people of any age living in any setting,*
1672 *and these must be guaranteed in practice.*

1673 *Quality Statement 5.1: Ethical admission*

1674 The decision to be admitted to an LTCF (and to subsequently remain there) is made by the
1675 person in question. The decision occurs with informed consent and without coercion from
1676 another party. The only exception is when legally mandated power of attorney is
1677 established, based on an individual's assessed diminished mental capacity to make
1678 decisions in their best interests.

1679 **Rationale** The LTCF admission decision is sometimes made or influenced by a different
1680 person, such as a family member or hospital worker, even when the individual in question
1681 has full capacity and without power of attorney. This represents a fundamental deprivation of
1682 liberty. In some cases, consent is not fully informed because the individual does not have
1683 adequate information about the services or quality of care offered by the LTCF.

1684 **Implementation guidance**

1685 Monitor facilities for documentary evidence of ethical admissions and verify this with
1686 testimony from residents. Raise awareness of LTCF managers about their legal
1687 responsibilities to ensure ethical admissions and how to obtain and document informed
1688 consent.

1689 **Box 12.** *Country example: Canada (British Columbia)*

This Act mandates prospective residents are given the opportunity to make an informed decision about admission. LTCFs must provide information about services, forms of care provision and opportunities to leave the facility building. LTCFs must share

this information in a way that fits the skills and abilities of the older person or their legal representative. LTCFs must document the resident's consent to admission in writing, using a standardized form (Government of British Columbia, 1996).

1690

Type	Indicative measure
Input	Unless they lack capacity, all individuals admitted to LTCFs have taken this decision entirely themselves, on a fully informed basis.
Process	LTCF staff and the public are made aware of ethical admission requirements. Monitoring of appropriate practice. Support legal processes to prevent unethical admissions.
Output	Documentary evidence supported by resident testimony of ethical admission.
Outcome	Resident-reported experience of ethical LTCF admission.

1691 ### *Quality Statement 5.2: Freedom from restraint and coercion*

1692 Physical restraints (such as bed rails, belts or fixed chairs) and chemical restraints (such as
1693 sedatives or antipsychotics used primarily to control behaviour) are never used as a means
1694 of managing residents or for staff convenience. Restraints are only considered in
1695 exceptional circumstances where there is immediate risk of serious harm, and all
1696 alternatives have been exhausted. Any use is time-limited, documented, and subject to
1697 independent review.

1698 **Rationale** The use of restraint restricts liberty and violates fundamental rights to autonomy,
1699 dignity, and freedom of movement. Physical restraints cause significant harms including
1700 injuries, pressure ulcers, muscle weakness, and increased mortality; chemical restraints
1701 carry risks of over-sedation, falls, and cognitive decline. Both cause psychological harm
1702 including anxiety, depression, and loss of dignity. Restraint can also be counterproductive,
1703 as individuals who are restrained may become more agitated or distressed. Despite these
1704 harms, restraint remains common in many settings, driven by misconceptions about safety,
1705 inadequate staffing, or institutional routines rather than clinical need.

1706 **Implementation guidance**

1707 Establish a facility-wide policy with restraint-free or restraint-minimal care as an explicit goal.
1708 Modify environments to reduce risks without restricting freedom (for example, lower beds,
1709 improved lighting, reduced noise) and conduct individual assessments to identify factors that

may contribute to distress or agitation. Train staff in person-centered care approaches and non-restrictive responses to behaviours. Restraint use requires mandatory documentation, time limits, and review by an independent party.

Box 13. *Country example: United States*

> The United States addressed restraint use through successive regulatory reforms (CMS, 2009; CMS, 2017; CMS, 2019). In 1987 the Omnibus Budget Reconciliation Act established residents' right to be free from restraints imposed for discipline or convenience, with compliance enforced through state inspections and linked to facility funding. Physical restraint rates declined from over 30% to below 5%. When antipsychotic use emerged as a persistent concern (reaching 23.9% by 2011), the Centers for Medicare & Medicaid Services launched the National Partnership to Improve Dementia Care (2012), adding public reporting of facility-level prescribing rates and strengthening surveyor guidance. Antipsychotic use declined by 40% over seven years. Both initiatives combined clear regulatory standards with accountability mechanisms and provider education. The United States experience demonstrates that sustained policy attention is needed as new forms of restraint emerge, and that transparency through public reporting can be a powerful driver of change.

Type	Indicative measure
Input	Existence of facility-wide policy establishing restraint-free or restraint-minimal care as an explicit goal
Process	Proportion of staff who have received training on alternatives to restraint
Output	Prevalence of physical restraint use; prevalence of psychotropic medications used primarily for behavioural control rather than clinical indications
Outcome	Resident-reported experience of autonomy and freedom of movement

Standard 6: Adequate service provision

LTCFs meet residents' fundamental needs in people-centered ways, respecting personal preferences.

Quality Statement 6.1: Person-centred care plans (PCCPs) for all residents

1719 All LTCFs agree, document and implement PCCPs in consultation with residents and, when
1720 appropriate, families. PCCPs reflect residents' specific needs and preferences.

1721 **Rationale**

1722 LTCF residents have different needs and preferences, and they have the right to be involved
1723 in decisions about their care routines. PCCPs should not only consider physical and clinical
1724 needs -they should aim to optimize residents' quality of life.

1725 **Implementation guidance**

1726 Identify and share good examples of PCCPs. Refer to WHO's Integrated care for older
1727 people approach (ICOPE) guidance (WHO, 2024). Ensure LTCF staff are familiar with them
1728 and understand their importance. Develop systems for documenting, periodically reviewing
1729 and monitoring compliance with PCCPs. Include more advanced care planning to enable
1730 compliance with residents' wishes.

1731 **Box 14.** *Country example: Singapore*

Mandating Person-centered care plans

Singapore's Ministry of Health has developed service requirements and standards for LTCFs to follow when creating PCCPs, including for residents living with dementia. These include (i) upon admission, preliminary assessments and creation of a care plans; (ii) documentation of residents' assessments, care needs and personal goals; (iii) ongoing assessment and periodic review of care plans (Government of Singapore, Ministry of Health, 2025).

1732

Type	Indicative measure
Input	Appropriate tools and training to support the production of PCCPs. Awareness of their importance across LTCFs, residents and other stakeholders.
Process	Develop evidence-based tools and training. Extend these to all LTCFs, promote awareness and monitor compliance.
Output	Documentary evidence of appropriate and updated PCCPs for all LTCF residents and of compliance.
Outcome	LTCF residents receive person-centered care, which reflects their specific needs and preferences.

1733 ### *Quality Statement 6.2: Adequate staffing, facilities and access to external services for*
1734 ### *compliance with PCCPs*

1735 All LTCFs provide sufficient numbers of suitably competent staff and appropriate equipment
1736 to optimize residents' independence and safety, and to ensure compliance with PCCPs.
1737 LTCF residents have appropriate access to health care and other necessary services not
1738 directly provided by LTCFs.

1739 **Rationale** PCCP compliance requires sufficient staff with the requisite skills. Different types
1740 and levels of staff skills are required, depending on the needs of residents and their PCCPs.
1741 Staff numbers and competencies should be sufficient to prevent worker exploitation or burn-
1742 out. LTCF staff do not have the competency or capacity to meet all residents' needs,
1743 including many health needs. LTCFs should ensure that residents have access to these
1744 services. Often, PCCPs require access to specific forms of equipment, such assistive
1745 technologies and personal hygiene products.

1746 **Implementation guidance** LTCF managers should be aware of the staff competencies and
1747 staffing ratios needed to comply with PCCPs. They should have access to the required
1748 resources to meet these needs, and this should be monitored. Specific staff skills include
1749 clinical and technical competencies, including specific competencies for residents with
1750 challenging conditions, such as dementia. All staff must understand the need to treat
1751 residents with dignity, respect and humanity. This should apply the principle of **"Do With,**
1752 **Not Do To"**, supporting residents to perform tasks at their own pace whenever possible.
1753 These skills should be refreshed and developed through ongoing training based on
1754 participatory learning models.

1755 External services, including health care, should be available to residents through a
1756 combination of on-site and accessible off-site provision. LTCF managers should be aware of
1757 the most appropriate equipment and assistive technologies to enable PCCP compliance and
1758 should have access to the necessary resources to obtain these. *This includes access to*
1759 *palliative and end-of-life care services, ensuring residents can receive appropriate comfort*
1760 *care and symptom management in accordance with their wishes and care plans.*

1761 **Box 15.** *Country example: Australia*

Royal Commission into Aged Care Quality and Safety

This 2021 report included specific staffing recommendations for LTCFs which have been enacted into national legislation. They include a minimum care-time staff provision of 215 minutes on average per resident, with 44 minutes daily provided by a registered nurse. At Australia's standard 38-hour work week (the ordinary work week under the Fair Work Act, applying nationally across all sectors), one full-time worker provides approximately 325 minutes of work time per day averaged across seven days – the equivalent of around 1.5 residents' care minutes per day at the 215-minute requirement. The Federal

Government is providing LTCFs with additional funding to comply with the new staffing requirement. Allied health and lifestyle services are excluded from this requirement and are funded separately.

1762

Type	Indicative measure
Input	Knowledge about current staff, facilities and external resources, and what is required to comply with PCCPs. Support and resources to address gaps and monitor progress.
Process	Identify gaps between current staffing, facilities and access to external resources and PCCP requirements. Develop feasible strategies to reduce these gaps, with necessary resources and support. Monitor compliance.
Output	Evidence that necessary staff and resources are available in LTCFs to enable compliance with PCCPs.
Outcome	Evidence of compliance with PCCPs.

1763 ***Quality Statement 6.3: Nutrition and hydration***

1764 Nutrition and hydration practices in LTCFs address both clinical requirements and personal
1765 preferences.

1766 **Rationale** Overly standardized meal plans and rigid schedules may reduce appetite,
1767 enjoyment, and nutritional intake. Respecting preferences enhances dignity, satisfaction,
1768 and overall well-being. There is evidence of high rates of dehydration among LTCF
1769 residents and of major health consequences.

1770 **Implementation guidance** LTCF managers and staff should be aware of specific residents'
1771 nutrition and hydration requirements, should have the resources to address them and this
1772 should be monitored. Choices of food and drink and how they are provided should consider
1773 residents' preferences. Resident nutrition and hydration should never be managed through
1774 force or coercion. Residents and families should be involved in menu planning and
1775 feedback. Hydration should never be limited as a strategy to manage resident incontinence
1776 or reduce frequency of toilet use. Nutrition risk screening should be conducted on admission
1777 and at defined intervals, with results documented in the resident's record. Nutritional
1778 supplements should be prescribed and provided where clinically indicated, in consultation
1779 with the resident, family and clinical staff. Awareness of nutrition risk and its management

1780 should be audited and reported in line with the national quality monitoring system. (See:
1781 Prevention and Treatment of Malnutrition in Older Adults Living in Long-Term Care or the
1782 Community: An Evidence-Based Nutrition Practice Guideline, J Acad Nutr Diet 2024, DOI:
1783 10.1016/j.jand.2024.03.013.)

1784 **Box 16.** *Country example: Brazil*

LTCF residents face particular risks of dehydration. Academics collaborated with a national network of LTCFs to assess current knowledge and practice (Lloyd-Sherlock, et al 2025). Opportunities for improvement were developed and piloted collaboratively with providers. These strategies include increasing the range of drinks offered to residents and adapting the ways they are provided to reflect preferences and promote enjoyment. They have been incorporated into training for inspectors from the State of Rio de Janeiro's regulatory agency to support improved practice across the State's 250 LTCFs.

1785

Type	Indicative measure
Input	Staff awareness about residents' nutrition and hydration needs and preferences, and about effective ways to address them. Related resources and monitoring.
Process	Staff training related to nutrition and hydration, including both what is provided and how it is provided.
Output	Appropriate types of food and drink provided to residents in ways that address their needs and respect their preferences.
Outcome	Adequate nutritional and hydration status of residents. Resident-reported satisfaction.

1786 ***Quality Statement 6.4: Opportunity to engage in meaningful activities***

1787 LTCFs actively support residents' social relationships, emotional bonds and participation in
1788 meaningful activities, both within and beyond the facility. These activities are explicitly
1789 included in PCCPs.

1790 **Rationale** LTCFs often focus on the residents' physical needs more than their social ones.
1791 Meaningful social relationships and activities are human rights and are essential for good
1792 health and quality of life. Living in an LTCF is sometimes associated with social isolation, in
1793 terms of meaningful relationships within the facility, continued social engagement with loved
1794 ones and participation in external communities.

Implementation guidance LTCFs should provide appropriate social and leisure activities, reflecting residents' preferences. This may include access to specific facilities, such as gardens or communal activity rooms. LTCF managers should facilitate visits from families and community members and promote their participation in daily activities and special events. As well as in-person interaction, LTCFs should provide residents with appropriate means for meaningful digital and telephonic engagement. External monitoring and quality assessment should pay attention to the quality of social relationships and to residents' opportunities to engage in activities they value.

Box 17. *Country example: Norway*

Mandating a daily one-hour minimum for meaningful activity.

Norway's Ministry of Health and Care Services has included the provision of meaningful activities an indicator of LTCF quality since 2003. These include social interaction and participation in community activities, as well as opportunities for peace and personal privacy. Inspections revealed incomplete compliance and led to new guidance in 2018, stipulating that residents participate in physical, social and cultural activities for at least one hour a day (Government of Norway, Ministry of Health and Care Services, 2018). However, research indicates that some LTCFs continue to lack the resources to meet these requirements (Trollebø et al, 2024).

Type	Indicative measure
Input	LTCF staff awareness of residents' rights to meaningful lives. Mechanisms to facilitate proactive engagement by families and external community.

Related resources and monitoring (as part of PCCP compliance). | | **Process** | Identify residents' preferences for meaningful activities and include these in their PCCPs. | | **Output** | Diverse sets of social activities and other meaningful activities provided in ways that reflect resident preferences and are accessible to them. | | **Outcome** | Resident-reported satisfaction with opportunities to engage in meaningful activities. |

Standard 7: Safe and empowering environments

LTCFs are safe environments, both for residents and people who work there. These environments also facilitate residents' freedom to live as they wish.

Quality Statement 7.1: Effective infection prevention and control (IPC)

1814 LTCFs follow robust protocols to prevent and manage different kinds of infections, and have
1815 the necessary supplies, training and resources to do so. LTCF residents and staff are fully
1816 vaccinated against appropriate conditions. LTCFs are clean and hygienic environments.

1817 **Rationale**

1818 LTCF residents face specific risks for infection. This includes respiratory conditions such as
1819 influenza and COVID-19. It also includes infections associated with care dependency and
1820 frailty, such as skin and urinary infections.

1821 **Implementation guidance**

1822 Considerable IPC information is available for COVID-19, including WHO guidelines (WHO,
1823 2021). Separate technical guidance is available for prevention and management of other
1824 infections.

1825 **Box 18.** *Country example: Ireland*

Following the COVID-19 pandemic, Ireland's Nursing Homes Expert Panel (established 2020) published 86 recommendations which helped inform comprehensive regulatory reforms, which took effect in March 2025 (Government of Ireland, 2024; HCI Care, 2025). The amended regulations included requiring nursing homes to implement national IPC and outbreak management guidance, ensure staff receive appropriate IPC training, and include infectious disease control measures in their risk management policies. Incident reporting timelines were reduced from three to two working days. Critically, the reforms balance IPC with residents' rights: even during outbreaks, residents retain the right to receive visits from a nominated support person. The Health Information and Quality Authority now inspect all nursing homes at least annually against these standards (HIQA, 2025).

1826

Type	Indicative measure
Input	Existence of facility-wide IPC policy aligned with national guidelines; designated staff member responsible for IPC
Process	Proportion of staff who have received IPC training; vaccination coverage among residents and staff
Output	Incidence of healthcare-associated infections (respiratory, urinary, skin)
Outcom	Resident infection rates; infection-related hospitalizations; infection-related

Type	Indicative measure
e	mortality

1827 ***Quality Statement 7.2: LTCFs are safe environments***

1828 All states have enacted building regulation legislation that is evidence-based and specific to
1829 LTCFs. All LTCFs comply with these regulations.

1830 **Rationale** Some countries do not have specific legislation for LTCFs, or it is not put into
1831 practice. Some LTCFs are not purpose-built and may therefore require considerable
1832 adaptation to be fit-for-purpose.

1833 **Implementation guidance**

1834 Regulations should consider the safety of all people in LTCFs: residents, staff, visitors, etc.
1835 Costs of complying with regulations can be high and so facilities should have access to the
1836 necessary resources and prioritize issues with most effects. Risk reduction strategies should
1837 avoid measures which limit residents' freedoms and impair their quality of life.

1838 **Box 19.** *Country example: United States (long-term care provider standards)*

Research in US LTCFs demonstrates that replacing unchanged ambient lighting with lighting that varies through day and night is associated with a 43% reduction in resident falls risk (Grant et al, 2022). These forms of lighting are affordable and cost-effective, but their use is not currently mandated by legislation in any country.

1839

Type	Indicative measure
Input	Evidence of good practice specific to LTCF safety. Awareness of opportunities to enhance building safety and wherewithal to apply this awareness.
Process	Update reviews of evidence, incorporate evidence into legislation and regulatory protocols. Develop mechanisms to monitor and support compliance.
Output	Evidence-based legislation is enacted and compliance mechanisms are in place.
Outcome	Evidence that LTCFs are low risk environments.

1840 ### *Quality Statement 7.3: LTCFs are empowering environments*

1841 LTCF environments optimize residents' intrinsic capacity and freedom to live life on their
1842 own terms. They optimize residents' freedom to move around and interact both within and
1843 beyond the facility, according to their preferences. Residents are permitted privacy and
1844 LTCF environments reflect resident preferences, such as personalized, home-like aesthetics
1845 rather than institutional ones.

1846 **Rationale** Most LTCF residents have diminished intrinsic capacity which may continue to
1847 decline over time. Even so, appropriate LTCF environments can sustain and sometimes
1848 restore this capacity.

1849 **Implementation guidance** Legislation should mandate a minimum set of requirements,
1850 informed by first-hand evidence of (i) residents' preferences and (ii) how these can be
1851 feasibly respected. Also, aspirational specific service improvement targets should be
1852 identified, and LTCFs offered guidance and support to achieve them.

1853 **Box 20.** *Country example: Hong Kong SAR (China)*

In 2023 the Legislative Council amended existing legislation for LTCFs. This included several new requirements related to the freedoms and privacy of residents, such as increasing the minimum amount of floor space per resident and protecting residents' dignity and privacy. The Social Welfare Department provides LTCFs with briefing sessions and subsidized training schemes, to support full compliance and accreditation over the following years (Government of Hong Kong (2024).

1854

Type	Indicative measure
Input	Evidence of good practice. Awareness of importance of optimizing resident intrinsic capacity and freedom, and wherewithal to apply this awareness.
Process	Update reviews of evidence, incorporate evidence into legislation and good practice protocols. Develop mechanisms to monitor and support compliance.
Output	Implementation of environmental measures to correspond with residents' preferences and optimize their intrinsic capacity.
Outcome	Resident-reported experience and other evidence of environmentally optimized intrinsic capacity and freedom.

1855 ## Standard 8: Transparency and accountability

1856 *LTCFs are fully accountable to all stakeholders, especially residents.*

1857 ***Quality Statement 8.1: LTCFs are accountable to residents and their families***

1858 LTCFs enable all residents to actively participate in decisions which personally affect them,
1859 including care preferences and routines. Where residents lack capacity, their interests are
1860 effectively represented by nominated others, such as family members or voluntary
1861 organizations. LTCFs have robust complaint procedures.

1862 **Rationale**

1863 Decisions taken by LTCF management often have profound effects on residents' lives and
1864 well-being. Decisions are usually influenced by a range of considerations, such as cost and
1865 convenience. Sometimes residents are afraid to complain or challenge decisions, or their
1866 actions are ignored.

1867 **Implementation guidance**

1868 Raise awareness of LTCF staff and residents about LTCF accountability to service users.
1869 LTCFs establish and support formal mechanisms for residents (or nominated
1870 representatives) to participate in decision-making. LTCFs share all non-confidential
1871 information with residents. LTCFs have clear complaints protocols which are monitored by
1872 independent regulators.

1873 **Box 21.** *Country example: Canada (Ontario)*

In 2021 the Canadian province of Ontario mandated that all LTCFs have a Residents' Council and provide them with necessary support (Government of Ontario, 2021). Residents' Councils are formal mechanisms for residents to voice concerns, suggest improvements, plan activities and provide mutual support. Residents' Councils have privileged access to regulators' inspection findings and LTCF financial reports. They advocate for residents through a unified voice and promote a culture of mutual support both with fellow residents and with staff (The Ontario Association of Residents' Councils, 2025).

1874

Type	Indicative measure
Input	Protocols and mechanisms to support accountability to residents.
Process	Establish and uphold robust participation and complaints procedures that are accessible to residents.
Output	LTCF residents participate in decisions and can take action when they are

Type	Indicative measure
	dissatisfied with services.
Outcome	LTCFs are demonstrably accountable to residents. Complaints are handled robustly.

1875 ***Quality Statement 8.2: Regulatory agencies effectively monitor and support LTCFs***

1876 All LTCFs are registered with and certified by regulatory agencies. These agencies are
1877 adequately designed and resourced to monitor and support LTCF compliance with the
1878 quality statements in this report.

1879 **Rationale**

1880 In some countries many LTCFs are not registered with or effectively monitored by regulatory
1881 agencies. These agencies are often fragmented, under-resourced and focus on monitoring
1882 compliance without supporting improvement.

1883 **Implementation guidance**

1884 Regulators obtain relevant data on LTCFs, their compliance with human rights and service
1885 quality. Regulators take appropriate action if agreed standards are not met. Regulatory
1886 practices are agreed between regulators, service providers, LTCF residents and other
1887 stakeholders, based on a shared commitment to human rights and service quality.

1888 **Box 22.** *Country example: Chile*

In Chile the Ministry of Health (MoH) has formal responsibility for regulating LTCFs. On the eve of the pandemic, it was estimated around half of LTCFs did not comply with MOH standards and were therefore unregistered. A separate government department (the National Service for Older Adults, SENAMA) does not have regulatory powers but maintains its own list of facilities, both registered and unregistered. MoH and SENAMA developed an ad hoc intersectoral response which permitted emergency support provision to many informal LTCFs as well as registered ones (Palacios et al, 2021).

1889

Type	Indicative measure
Input	Regulatory agencies which both monitor and promote human rights and service quality in LTCFs.
Process	Establish coordinated, adequately resourced regulatory systems. Ensure all

Type	Indicative measure
	LTCFs are registered with appropriate regulators. All stakeholders coproduce and support agreed regulatory practice.
Output	Regulators have robust information about LTCF services and quality, and act on this to promote service improvement.
Outcome	LTCFs are monitored and supported by the state, within a framework of shared commitment to human rights and service quality.

1890 ***Quality Statement 8.3: LTCFs are accountable to the public***

1891 The public has access to clear, accurate and up-to-date information about services provided
1892 by individual LTCFs, as well as costs. The information is provided in forms that are suited for
1893 people with disabilities or impaired function. It is complemented by monitoring information
1894 published by regulators.

1895 **Rationale** Good public information is essential for admissions based on informed consent. It
1896 is also a consumer right, enabling selection of a preferred LTCF. There may be gaps in this
1897 information or it may be intentionally or unintentionally misleading. The practice of regulators
1898 in publishing findings varies considerably between countries.

1899 **Implementation guidance** Regulators make all non-confidential data available to the public
1900 and update it. Regulators and consumer protection agencies check (and respond to
1901 complaints about) the accuracy of information published by LTCFs in advertisements, etc.

1902 **Box 23.** *Country example: United Kingdom*

The CQC was created in 2009 as the official body with statutory powers to regulate health and adult social care in England, including LTCFs. CQC monitors, inspects and rates service quality, and is authorized to take various actions when quality is below accepted standards. Actions include supporting quality improvement and, as a last resort, closing facilities (Government of the United Kingdom, Care Quality Commission, 2012). CQC publishes service quality information for each provider in user-friendly formats (Government of the United Kingdom, Care Quality Commission, 2022). In countries without similar models, private sector LTCF “recommender sites” increasingly offer a similar service. However, these are usually unregulated and focus on high-cost services.

1903

Type	Indicative measure
Input	Effective and adequately resourced mechanisms to obtain and manage reliable information.
Process	Collection, compilation, publication and updating of relevant information.
Output	Clear and accessible information about the type and quality of services provided by LTCFs.
Outcome	LTCF residents and other stakeholders are fully informed about the type and quality of services.

1904 ## 4. Implementation considerations

1905 ### Context adaptation

1906 These standards require adaptation to diverse national and local contexts, recognizing
1907 variations in both the forms LTCFs take and their levels of resource. Variation exists not only
1908 between countries but within them — a well-resourced urban facility and a small rural care
1909 home in the same country may face very different implementation realities. Information
1910 should be shared through channels and media most likely to reach different stakeholders
1911 (specific social media platforms, radio, etc.). The standards in this chapter are designed to
1912 be universally applicable while acknowledging that pathways to achieving them will differ.

1913 **Adapting to resource availability**

1914 In settings with limited financial, human, or infrastructural resources, implementation may
1915 need to be phased and prioritized. Key principles include:

1916 - **Start with rights-based foundations.** Ethical admission, freedom from restraint,
1917 and accountability to residents require policy and practice changes rather than major
1918 financial investment. These can be prioritized regardless of resource level.

1919 - **Use low-cost environmental modifications.** Many safety and quality
1920 improvements — such as improved lighting to reduce falls, removal of trip hazards,
1921 flexible daily routines, and allowing personal belongings — can significantly enhance
1922 resident well-being at minimal cost.

1923 - **Adapt staffing approaches to context.** While specific staffing ratios may not be
1924 feasible in all settings, the principle of adequate staffing relative to resident acuity
1925 should guide workforce planning. Task-shifting, training of community health

1926 workers, and involvement of family members in care planning can extend workforce
1927 capacity.

1928 • **Leverage community resources.** Meaningful activities need not be resource-
1929 intensive. Involving community volunteers, faith organizations, and family members
1930 can enrich social programming. Activities should reflect local cultural practices and
1931 residents' life histories.

1932 **Adapting to regulatory and system maturity**

1933 Where formal long-term care systems or regulatory frameworks are still developing:

1934 • **Begin with basic registration and monitoring.** Governments can start with facility
1935 registration and essential safety requirements, progressively strengthening oversight
1936 as institutional capacity grows.

1937 • **Develop simple, locally appropriate procedures.** For example, informed consent
1938 processes can use community witnesses where formal legal documentation systems
1939 are limited, and information can be provided in local languages and accessible
1940 formats.

1941 • **Build on existing structures.** Partnerships between health and social welfare
1942 agencies can extend reach. Community-based monitoring involving local leaders and
1943 civil society can supplement formal regulatory oversight where inspector capacity is
1944 limited.

1945 • **Support informal facilities toward formalization.** Many countries have significant
1946 numbers of unregistered facilities. Rather than exclusion, regulatory approaches can
1947 create pathways toward compliance, as demonstrated during the COVID-19
1948 pandemic when emergency support was extended to both formal and informal
1949 facilities.

1950 **Adapting to cultural context**

1951 Standards must be implemented in ways that respect local values while upholding universal
1952 rights:

1953 • **Person-centered care planning** can be adapted by involving family members in the
1954 care planning process, reflecting cultural norms around family involvement in
1955 decision-making.

1956 • **Nutrition and hydration practices** should use locally available foods reflecting
1957 cultural preferences and dietary traditions.

1958 • **Meaningful activities** should reflect local cultural practices, religious observances,
1959 and residents' life histories rather than imported models.

1960 1961 1962
- **Resident participation mechanisms** can take forms appropriate to local context — where formal councils are not feasible, regular family meetings, suggestion systems, and designated resident advocates can ensure accountability.

Fundamental human rights, minimum standards and aspirational targets

This chapter identifies standards that are to be universally applied and where action must be taken if they are not. These include respect for residents' fundamental human rights. With reference to service quality, it is useful to distinguish between **minimum** standards and **aspirational** levels of quality.

Minimum standards should be based on informed stakeholder consensus about what is acceptable and possible. They must be accompanied by the provision of means to achieve these standards, including appropriate forms of support as well as monitoring and punitive measures. Aspirational standards are voluntary and are used to assess quality and to direct LTCF service improvement.

Key enablers across all settings

- **Promote public understanding:** Recognize LTCFs can perform positive roles as part of wider systems of long-term care, and that poor service quality is not inevitable. Promote public realism about the funding needed to ensure residents' human rights and acceptable standards.
- **Develop and apply realistic service improvement mechanisms.** These should consider constraints faced by LTCFs. Achieving and sustaining improvement in LTCFs is often highly challenging and requires genuine buy-in from staff.
- **Establish effective regulatory systems:** Systems should be coherent, non-fragmented and properly resourced. Regulation should be understood as part of a shared endeavor of service improvement rather than top-down "policing."
- **Recognize that standards alone have little effect:** Many countries already have ambitious sets of LTCF standards, but these frequently fail to affect outcomes.

Common challenges

The following challenges are encountered across diverse settings and require attention in implementation planning:

- Addressing stigmatization of LTCFs services and people who use them.
- Ensuring adequate funding for both LTCFs and regulators.
- Achieving adequate status, training and remuneration for LTCF workers.
- Developing effective linkages between LTCFs and mainstream health services, including health promotion, rehabilitation and management of chronic conditions.

1994 1995
- Balancing infection prevention and control measures with residents' rights to social connection and freedom of movement.

1996 1997
- Supporting residents requiring palliative and end-of-life care, including access to appropriate services and advance care planning.

1998
Linkages and cross-cutting considerations

1999
Connections to other domains

2000 2001 2002 2003 2004 2005
- **Home and community-based care:** LTCFs should complement services provided in home settings with carers and care-receivers understanding when it represents an appropriate alternative**.** Family involvement should continue when caregiving shifts to institutional settings. *Smooth transitions between home-based care and LTCF admission should be supported through coordinated assessment and care planning processes (see Chapter on Home and Community-Based Care).*

2006 2007 2008
- **Workforce:** LTCF staff often face similar disadvantages to those experienced by paid carers in other LTC settings, as well as by unpaid carers. Improving staff conditions usually enhances service quality.

2009 2010
- **Governance:** LTCFs must be accountable to residents and meet responsibilities to regulators and the general public.

2011 2012 2013
- **Data and information-sharing:** There should be a minimum set of updated information for all providers, provided in accessible forms to relevant stakeholders. Any other information provided by LTCFs should be accurate.

2014
Cross-cutting considerations

2015 2016 2017
- **Abuse and human rights:** Elder abuse occurs in all settings, including LTCFs. Residents and staff often experience specific forms of vulnerability, which exposes them to abuse of fundamental rights.

2018 2019 2020
- **Person-centered care:** LTCFs should minimize dependence on rigid routines and one-size-fits-all care regimes. They should regard residents as individuals and address their preferences.

2021 2022
- **Empowerment:** LTCFs can potentially be empowering institutions for residents, promoting capacity and opportunities to engage in meaningful activities.

2023 2024 2025 2026
- ***Palliative and end-of-life care:*** *A significant proportion of LTCF residents will require palliative care and end-of-life support. LTCFs should ensure access to appropriate palliative care services and support residents and families in advance care planning.*

2027

2028 # Chapter 4. Support for unpaid carers

2029 **Table 8.** *Standards and quality statements: Chapter 4, Support for unpaid carers*

Standard	Quality statements
Standard 9. Early identification and needs assessment	**9.1** Opportunistic identification **9.2** Comprehensive assessment **9.3** Administrative recognition
Standard 10. Respite care	**10.1** Diverse respite models **10.2** Integrated support **10.3** Emergency respite
Standard 11. Education and skills training	**11.1** Comprehensive training content **11.2** Accessible delivery **11.3** Skills recognition
Standard 12. Social protection and financial security	**12.1** Income support **12.2** Pension protection **12.3** Work-life balance
Standard 13. Engagement and recognition	**13.1** Partners in care **13.2** Participatory governance **13.3** Outcome measurement

2030 ## 1. Introduction

2031 Unpaid carers, mostly family members, friends, and neighbours who provide care without
2032 formal employment contracts, form the backbone of long-term care systems worldwide.
2033 They assist with daily activities, coordinate health and social services, manage medications,
2034 provide emotional support, and enable people with long-term conditions or disabilities to
2035 remain at home. Despite their essential contributions, unpaid carers have historically been
2036 overlooked in quality standards for long-term care, treated as resources fulfilling assumed

2037 family, moral and social obligations rather than as individuals with their own rights, needs,
2038 and well-being.

2039 This chapter addresses a critical gap in global health governance. While the WHO
2040 Framework on Integrated People-Centred Health Services emphasizes the centrality of
2041 people and communities, existing long-term care standards have largely failed to
2042 incorporate explicit provisions for those providing unpaid care. A review of national LTC
2043 quality standards revealed that only a few explicitly address unpaid carers, which is a
2044 significant omission given that unpaid carers provide the majority — by widely cited
2045 estimates, between 70 and 95 per cent — of all long-term care in most regions (estimates
2046 vary by setting, by definition of care work, and by measurement method; figures are
2047 illustrative and not directly comparable across studies). Without recognition and support,
2048 carers face deteriorating health, financial insecurity, and eventual breakdown of their
2049 capacity to continue providing care, with consequences for both themselves and those they
2050 support.

2051 **Scope of this chapter**

2052 This chapter establishes standards for recognizing, supporting, and engaging unpaid carers
2053 within long-term care systems. It applies to all settings where unpaid care is provided, such
2054 as homes, communities, and in coordination with formal services. The five standards
2055 address: early identification and needs assessment; respite care; education and skills
2056 training; social protection and financial security; and engagement and recognition. Together,
2057 these standards aim to ensure that unpaid carers are visible within long-term care systems,
2058 supported to maintain their own health and well-being, and engaged as partners in care
2059 delivery and system governance.

2060 2. Background

2061 10.1 Global situation

2062 The world faces an unprecedented demographic transition. By 2050, the global population
2063 aged 60 years and over will double to reach 2.1 billion, with the most rapid increases
2064 occurring in low- and middle-income countries. This demographic shift, combined with the
2065 rising prevalence of chronic conditions and functional limitations requiring long-term support,
2066 places extraordinary demands on care systems. At the same time, declining fertility rates,
2067 increasing female labour force participation, urbanization, and changing family structures
2068 are reducing the traditional pool of unpaid carers available to meet these growing needs.

2069 Currently, the informal care workforce provides the vast majority of long-term care globally.
2070 In OECD countries, approximately 13 per cent of adults aged 50 and over provide informal
2071 care. In many low- and middle-income countries, virtually all long-term care is provided
2072 informally by families and communities. This care work falls disproportionately on women,

2073 who represent 60 to 70 per cent of unpaid carers worldwide, with significant implications for
2074 gender equality, economic participation, and lifetime earnings. The economic value of
2075 unpaid care is substantial, estimated at 10 to 39 per cent of GDP across countries, yet it
2076 remains largely invisible in national accounts and policy frameworks.

2077 Without adequate recognition and support, the informal care system faces a sustainability
2078 crisis. As populations age faster than formal care infrastructure can develop, the risk of
2079 significant strain on care systems grows. This would have profound consequences not only
2080 for those requiring care but for health systems, economies, and societies as a whole.

2081 10.2 Key challenges

2082 **Invisibility in policy frameworks.** Unpaid carers rarely appear in health system planning,
2083 workforce projections, or quality standards. Many carers do not self-identify as such, viewing
2084 caregiving as a natural extension of family relationships and moral or social obligations
2085 rather than a distinct role warranting recognition or support. This invisibility means that
2086 carers' needs often remain unaddressed until crisis points – too late for preventive
2087 intervention.

2088 **Health impacts.** Carers experience elevated rates of depression, anxiety, physical strain,
2089 and chronic health conditions compared to non-carers. The demands of caregiving, often
2090 combined with paid employment and other family responsibilities, lead to chronic stress,
2091 sleep disruption, social isolation, and neglect of carers' own health needs. Without respite
2092 and support, these health impacts compound over time, ultimately threatening carers'
2093 capacity to continue in their role.

2094 **Financial vulnerability.** Caregiving responsibilities frequently lead to reduced employment,
2095 career interruptions, and inadequate pension accumulation, resulting in higher rates of
2096 poverty in later life. Carers often face direct costs (transportation, medical supplies, home
2097 modifications) alongside indirect costs from foregone earnings. The financial penalties of
2098 caregiving fall disproportionately on women, perpetuating gender inequalities across the life
2099 course.

2100 **Skills and information gaps.** Many carers assume their role without preparation or training,
2101 learning through trial and error while managing complex medical conditions, medications,
2102 and care needs. Lack of knowledge about the care recipient's condition, available services,
2103 and caregiving techniques increases stress and reduces care quality. Carers often report
2104 feeling unprepared, unsupported, and excluded from communication with health
2105 professionals.

2106 **Gendered dimensions.** Cultural norms in many settings frame caregiving as women's duty,
2107 normalizing strain and delaying help-seeking. Evidence across regions shows higher mental
2108 health burden among women carers, particularly daughters, unmarried women, and those

with low income. Without gender-responsive approaches to identification and support, these inequities persist and deepen.

Relationships across the life course. Caregiving relationships do not emerge in isolation; they evolve from existing family, friendship, or neighbourhood bonds that span decades. A daughter caring for her mother, a spouse supporting a partner with dementia, or a neighbour helping an older friend: these are not new relationships but continuations of lifelong connections that have entered a new phase. Long-term care approaches risk fragmenting these relationships by treating the caring dyad as a distinct category separate from the broader relationship. Standards and services should recognize and support the continuity of these relationships rather than isolating the caregiving phase as something fundamentally different.

10.3 Conceptual framework

These standards are grounded in a rights-based approach that recognizes unpaid carers as rights-holders, not merely resources to be utilized. This represents a fundamental shift from the residual model that treats family care as a private matter, or as part of a system of social and moral obligations and relies on gendered assumptions that women will naturally assume caregiving roles without support or compensation.

The framework adapts the International Labour Organization’s “5R” principles for decent care work to the context of unpaid carers: **Recognize** the value and contribution of unpaid care work through formal identification and acknowledgment; **Reduce** the burden of care through accessible services, respite, and support; **Redistribute** care responsibilities more equitably between women and men, and between families and the state; **Reward** care work with adequate financial security, including income support and pension protection; and **Represent** carers in governance, policy development, and decision-making at all levels.

This framework acknowledges that care is a collective social responsibility, not a private burden to be borne by individuals without support. It positions unpaid carers as essential partners in care whose well-being is intrinsically linked to the quality and sustainability of long-term care systems.

Definition of unpaid carer:

For the purposes of these standards, an unpaid carer is a person who provides regular care and support to a family member, friend, or neighbour who has a long-term illness, disability, mental health condition, or care needs related to ageing or functional decline. This care is provided without a formal employment contract, regardless of whether the carer receives social transfers such as carer allowances. The definition encompasses diverse relationships and living arrangements, recognizing that caregiving occurs across households and extends beyond traditional family structures. The standards in this chapter were developed in parallel with WHO’s forthcoming Policy Guidance on Integrated Health and Care Workforce.

2146 ## 10.4 Normative foundations

2147 These standards are grounded in the rights-based approach outlined in Chapter 1 on
2148 definitions and foundational principles. The following instruments address the specific
2149 situation of unpaid carers. The key legal basis provisions for carers in global and regional
2150 human rights instruments are outlined in **Table 9**.

2151 The rights included in these instruments underpin the provisions and standards for unpaid
2152 carers, even if unpaid carers are not explicitly mentioned in the text. For instance, the
2153 Universal Declaration of Human Rights establishes the right to rest and leisure (Article 24),
2154 which underpins respite care provisions. The UN Convention on the Elimination of All Forms
2155 of Discrimination against Women (CEDAW) forms the basis for gender equality in care by
2156 for instance, mandating States to prohibit discrimination against women (Article 2) and
2157 guarantee the full development and advancement of women (Article 3).

2158 Complementing these instruments are reports and recommendations that explicitly provide
2159 for unpaid carers. The report of the United Nations High Commissioner for Human Rights on
2160 the "Human Rights Dimension of Care and Support" recommends that States should
2161 recognize the rights of providers of unpaid care and support, including the right to social
2162 security, health, education and to work. The Report also establishes that care and support
2163 systems must enable women's equal enjoyment of human rights, and care and support
2164 systems should be "gender-responsive, disability-inclusive and age-sensitive."

2165 In 2010, the Committee on the Elimination of Discrimination against Women adopted
2166 General Recommendation 27 on the protection of the human rights of older women, which
2167 explicitly calls upon States to address the provision of unpaid care by older women, and its
2168 financial and emotional costs.

2169 Regional commitments reinforce these international principles. The regional commitments
2170 share a common focus on emphasizing the right to care, valuing unpaid care, providing
2171 support for unpaid carers, and promoting shared responsibility for care.

2172 **Table 9.** *Global and regional instruments for carers*

Instrument	Year	Key provisions for carers
Global		
UDHR	1948	Right to rest (Art. 24); adequate standard of living (Art. 25); social security (Art. 22)
CEDAW	1979	Gender equality in work, social security; recognition of non-monetized care work (Article 11); Modify stereotyped roles for

Instrument	Year	Key provisions for carers
		men and women (Article 5);
CEDAW General Rec. 27	2010	Explicitly addresses unpaid care by older women
UN High Commissioner Report “Human Rights Dimension of Care and Support”	2025	Rights of unpaid care providers (including right to social security); gender-responsive, disability-inclusive, age-sensitive systems; Intersectionality of identities of carers
CRPD	2006	Right to community support (Art. 19) — care cannot be forced on families without support
ILO Convention 156	1981	State duty to provide services enabling workers to meet family responsibilities
Regional		
Buenos Aires Commitment	2017	Right to care, to be cared for, and to self-care
European Care Strategy	2022	Legal definition and comprehensive support for unpaid carers
ASEAN Declaration on Strengthening the Care Economy and Fostering Resilience Towards the Post-2025 ASEAN Community	2024	Value unpaid care; social protection; respite; equal sharing of care responsibilities
APEC Non-binding Care Compact	2025	Data collection; shared responsibility; social protection for unpaid carers; labour practices that are sensitive to needs of unpaid carers

2173 These instruments converge on common principles: recognition of unpaid care as valuable
2174 work, social protection for carers, gender equality, and shared responsibility between
2175 families and the state.

2176

2177 3. Standards

2178 **Note on indicative measures in this chapter.** In this consultation draft, indicative
2179 measures for the support of unpaid carers are presented at the standard level (one
2180 indicative measures table per standard), rather than at the quality statement level as in other
2181 chapters. This reflects the current state of measurement development in this area, where
2182 many indicators are still being refined and not all quality statements have established
2183 measurement approaches. Further development of quality-statement-level indicative
2184 measures for Chapter 4 is one of the priorities for the post-consultation revision.

2185 Standard 9: Early identification and needs assessment

2186 *Every unpaid carer is identified early through routine health and social care pathways and*
2187 *receives a proportionate, comprehensive assessment of their needs, capacities, willingness,*
2188 *and preferences.*

2189 **Overview**

2190 In many countries, caring for family members is commonly seen as a normal part of
2191 everyday life, shaped by strong cultural, moral and religious expectations. Because of this,
2192 people who provide ongoing and demanding care – especially women, older people, and
2193 children – are rarely recognized as carers or seen as needing support. This often leaves
2194 them invisible within health, social and education systems, even when care responsibilities
2195 are intense and long-term. Opportunistic identification does not undermine family
2196 responsibility; instead, it helps identify when usual family care becomes overwhelming or
2197 risky. It is a simple, low-cost approach that uses brief questions during routine contacts such
2198 as clinic visits, community outreach, hospital discharge, or school interactions. In settings
2199 where formal carer systems are limited and services are overstretched, this approach makes
2200 caregiving visible without adding bureaucracy and supports early access to information,
2201 advice, and referrals, helping to prevent crises for both families and services.

2202 The purpose of this standard is to ensure that unpaid carers are recognized early and
2203 supported before caregiving demands escalate to crisis. Caring roles often develop
2204 gradually and informally, meaning many carers do not recognize themselves as carers or
2205 seek support until they experience significant strain. Early identification and assessment are
2206 therefore essential components of sustainable long-term care systems.

2207 Unpaid carers provide day-to-day support that enables people with long-term conditions,
2208 disabilities, or declined functions to remain at home. When carers are not identified early in
2209 the care plan, their needs remain invisible, increasing the risk of physical and mental health
2210 deterioration, care breakdown, and avoidable use of acute or institutional services. This
2211 standard sets out how carers can be systematically identified early and assessed in a way
2212 that respects their autonomy, well-being, and limits.

2213 *Quality Statement 9.1: Opportunistic identification*

2214 Unpaid carers are proactively identified during routine contacts, either when they present on
2215 their own or when accompanying care recipients across health, social care, and education
2216 services, including chronic disease management, hospital admission and discharge,
2217 community health assessments, and child- and youth-facing services.

2218 **Rationale** Many carers do not self-identify and remain hidden until demands become
2219 overwhelming. Evidence shows that relying on self-declaration alone misses a substantial
2220 proportion of carers, particularly spouses, cohabiting partners, and those who view care as
2221 part of family life rather than a distinct role (Urwin et al., 2022; Whitley & Benzeval, 2025).
2222 Early identification allows preventive support at a stage when it is most effective and
2223 reduces the risk of carer distress and breakdown (Schulz & Sherwood, 2008). In settings
2224 where caregiving is culturally expected as a family or social obligation, carers may be even
2225 less likely to seek support or identify themselves as needing assistance. This makes
2226 proactive, systematic identification through routine service contacts particularly important to
2227 surface unspoken burdens before they reach crisis point.

2228 **Implementation guidance**

2229 • Embed brief, activity-based screening questions into routine workflows (for example,
2230 "Do you regularly help someone with a long-term illness or disability?").

2231 • Train frontline staff to recognize caregiving patterns and understand that many
2232 people do not adopt the "carer" label.

2233 • Prioritize identification of carers supporting people with significant functional or
2234 cognitive impairment.

2235 • Integrate identification mechanisms into schools and youth services to reduce the
2236 invisibility of young carers.

2237 **LMIC example.**

2238 A community health worker supporting a stroke survivor learns that his wife provides all care
2239 while also farming and caring for grandchildren. A brief assessment identifies exhaustion,
2240 lack of information, and fear of refusing care. Acknowledging her limits enables targeted
2241 advice and referral, reducing risk of collapse.

2242 ***Quality Statement 9.2: Comprehensive assessment***

2243 Identified carers receive a holistic, proportionate assessment that considers their needs,
2244 well-being, capacity, willingness, risks, and preferences.

2245 **Rationale** Carers are entitled to an assessment of their needs. Guidance emphasizes that
2246 assessment must consider not only what carers can do, but also what they are willing and
2247 able to sustain over time (Department of Health & Social Care, 2025; NHS England, 2023).
2248 Evidence shows that carers who are not assessed, or whose assessments are incomplete,

2249 experience higher levels of distress, fatigue, isolation, and unmet need (Micklewright &
2250 Farquhar, 2020).

2251 Assessments that focus solely on practical and care-related tasks risk overlooking emotional
2252 strain, information gaps, relationship pressures, and concerns about future contingencies. A
2253 comprehensive approach supports carers' well-being and helps prevent crisis-driven
2254 transitions (Micklewright & Farquhar, 2020; Ewing et al., 2020).

2255 In many LMIC settings, a "comprehensive assessment" can seem unrealistic given staff
2256 shortages and limited resources. However, the aim is not to introduce lengthy or formal
2257 processes, but to ensure that key aspects of carers' well-being are not missed. Even short,
2258 proportionate conversations can reveal serious concerns such as fatigue, emotional strain,
2259 lack of information or doubts about continuing care, which are often hidden by expectations
2260 of family duty. This approach recognizes that a carer's ability and willingness to provide care
2261 cannot be assumed, especially in contexts shaped by poverty, insecure work, gender
2262 inequality and limited services. Without exploring these factors, care arrangements may
2263 become harmful or unsustainable, particularly for women and young carers. A flexible,
2264 holistic approach, built into existing services and adapted to local contexts, helps protect
2265 carers' well-being and supports care that is realistic, safe and sustainable over time.

2266 • Emotional and mental well-being

2267 • Information and training needs

2268 • Respite and enabling supports

2269 • Relational dynamics and communication

2270 • Willingness, limits, and preferences

2271 **Implementation guidance**

2272 • Assess emotional and mental well-being, information needs, and physical fatigue.

2273 • Identify enabling supports such as training, respite, and navigation of services.

2274 • Explore relationship dynamics and communication challenges.

2275 • Explicitly assess willingness, personal limits, and preferences to avoid coercive or
2276 unsustainable care arrangements.

2277 ***Quality Statement 9.3: Administrative recognition***

2278 Systems establish simple administrative mechanisms to formally recognize unpaid carers
2279 and support their inclusion in communication, care planning, and decision-making.

2280 **Rationale**

Without formal recognition, carers often remain peripheral to clinical communication and discharge planning despite their central role in sustaining care. Administrative recognition ensures that unpaid carers are formally acknowledged within health and care systems so they are not overlooked or excluded. Its purpose is not simply to label carers, but to make their role visible in everyday practice, allowing them to be included in communication, care planning, and decision-making. Even where services are limited, recognition can lead to practical benefits such as clearer information, better coordination, and greater respect for carers as partners in care.

Implementation guidance

- Introduce simple recognition tools, such as a carer record or carer passport, that identify carers across services.
- Ensure recognition mechanisms support information-sharing and involvement in care planning.
- Promote staff awareness so carers are viewed as as part of a care dyad with the person they support, not as visitors or afterthoughts.
- Ensure that recognition is linked to at least basic information and referral pathways, even where comprehensive services are not yet available. Identifying carers without any corresponding support risks raising expectations that cannot be met and may undermine trust in the system.

Box 24. *Country example: United Kingdom*

In the United Kingdom, many NHS services use Carer Passports to formally recognize unpaid carers across health and community settings. The passport is supported by the United Kingdom Government's Carers' Conversation Map and is reviewed regularly so that carers' roles, needs, and pressures are recorded and understood by care teams. It supports carers' involvement in decisions such as hospital discharge planning and enables practical arrangements, including flexible visiting, access to clinical areas, and clearer communication with staff. At an organizational level, the passport provides a consistent way to identify carers, improves information-sharing between services, and acts as a portable record across settings. The scheme requires policy commitment and staff awareness rather than new infrastructure and helps position carers as partners in care (Gov United Kingdom Carer's Passport, 2023a, b).

The Carer Passport model can work well in low- and middle-income countries because it does not need large amounts of funding. It mainly requires clear policies that recognize unpaid carers, a simple paper or digital passport, and short training for health and care workers. In many of these countries, community health workers already visit homes, identify care needs, and connect families to services, so they are well placed to issue and update

2306 carer passports. This makes the approach practical and low cost. The most significant
2307 change required is attitudinal, recognizing carers as partners in care rather than just visitors.
2308 Giving carers formal recognition can make their role more visible, reduce stigma, and
2309 improve continuity of care between the home, clinics, and hospitals (MacRae et al., 2020).

2310 **Gender-sensitive identification and assessment**

2311 Unpaid caregiving is highly gendered, with women disproportionately assuming caring roles
2312 that emerge informally and remain unrecognized. Cultural norms often frame caregiving as
2313 women's duty, normalizing strain and delaying help-seeking (Limpawattana et al., 2012;
2314 Yeung & Thang, 2018). Evidence across Asia and cross-national studies shows higher
2315 psychological burden among women carers, particularly daughters, unmarried women, and
2316 those with low income (Kwon et al., 2023; Noh et al., 2017; Saito et al., 2018).

2317 Gender-sensitive approaches require proactive identification of the primary support person,
2318 explicit assessment of willingness and hidden strain over time, and early referral to
2319 information, respite, and financial support. Without such measures, gendered inequities in
2320 health, well-being, and economic participation persist (Mair et al., 2016; Chai et al., 2021).

2321 **Indicative measures**

Type	Indicative measure
Input	Existence of policies or protocols requiring routine identification of unpaid carers within health and social care pathways, especially in primary health care.
Process	Proportion of identified carers receiving a needs assessment appropriate to their caring role within a defined timeframe.
Output	Proportion of carers with documented assessments covering needs, enabling supports and willingness and limits.
Outcom e	Carer-reported experience of recognition, inclusion, and involvement in care planning.

2322 Reduction in reports of carer distress, crisis, or unplanned care breakdown. |

2323 ## Standard 10: Respite care

2324 *Every unpaid carer has access to flexible, quality respite services that give them a*
2325 *restorative break from caregiving and support their ability to continue in their role. Respite is*
2326 *delivered as part of a multicomponent support package that protects their health, well-being,*
2327 *employment, and social participation.*

2328 **Overview**

2329 The purpose of this standard is to recognize respite as a necessary part of long-term care
2330 models and to describe the elements required for it to be accessible and effective.

2331 Carers provide day-to-day support that enables people with various conditions to live at
2332 home. Respite services provide carers with a meaningful break from their duties to help
2333 maintain their own health, remain in paid work if they choose, and participate in family and
2334 community life.

2335 Respite must be available in various forms and times alongside other carer supports such
2336 as up-to-date, accurate information, basic skills related to the needs of the person that they
2337 care for and psychosocial assistance.

2338 This standard outlines respite services that are reliable, flexible, and responsive to the
2339 diverse situations of carers.

2340 ***Quality Statement 10.1: Diverse respite models***

2341 Respite services are available in various forms, including in the home, adult day centers,
2342 and short-stay residential care, to meet the needs of carers' circumstances, preferences,
2343 and care needs.

2344 **Rationale**

2345 Carers manage caregiving alongside paid work or income-generating activities, their own
2346 health needs, and other family responsibilities. Respite is only useful if it is flexible and
2347 offers different forms at different times, making it easier for carers to access support and
2348 choose options that fit their circumstances, environment, and cultural background.

2349 **Implementation guidance**

2350 • Develop respite options starting with at least two types, such as in-home support,
2351 day respite services, while also considering longer-term placement in a LTC facility.

2352 • Use existing infrastructure, such as day centre programmes, primary health-care
2353 centers, and faith-based programmes to offer accredited day or group respite.

2354 • Ensure that referral pathways to respite services are interconnected with entry points
2355 to health, social, and community services so that carers can be linked without
2356 navigating multiple entry points.

2357 ***Quality Statement 10.2: Integrated support***

2358 Respite care is part of a broader support package for carers that may include education,
2359 psychosocial support, and skills development, recognizing that time away from caregiving
2360 alone is not enough to maintain their health and well-being.

2361 **Rationale**

2362 Respite is likely to be more effective when offered alongside psychosocial support and
2363 activities that meet specific needs. Respite alone may offer short-term relief, but it might not
2364 sufficiently address ongoing stress, limited skills, or the emotional strain on the carer.

2365 **Implementation guidance**

2366 • Link respite with additional supports such as information on the care-recipient's
2367 condition, stress-management techniques, peer support, and basic problem-solving
2368 skills.

2369 • Integrate carer education and psychosocial support into routine respite, for example,
2370 through short group sessions during day respite or brief counselling at the beginning
2371 or end of a respite period.

2372 • Develop group-based or digital education delivered by trained volunteers, health
2373 workers, and carer support groups.

2374 • In settings where formal psychosocial services are limited, community-based peer
2375 support, volunteer networks, and faith-based organizations can provide effective
2376 emotional support and practical guidance alongside respite.

2377 ***Quality Statement 10.3: Emergency respite***

2378 Systems have clear arrangements for providing emergency respite when carers are unable
2379 to continue their role because of burden, sudden illness, accidents, or family emergencies.

2380 **Rationale**

2381 Timely emergency respite protects both the carer and the person receiving care and helps
2382 reduce avoidable use of acute health and social services. Without emergency respite,
2383 unexpected events can lead to unsafe care, abandonment, or unplanned admission to
2384 institutional care.

2385 **Implementation guidance**

2386 • Identify a service or authority responsible for coordinating emergency respite, such
2387 as a municipal office, long-term care coordination unit, or community health center.

2388 • Maintain a pool of trained respite workers, supervised volunteers, or contracted
2389 providers who can be deployed at short notice.

2390 • Ensure carers know how to request emergency respite by having health-care
2391 professionals, government services, carer-support organizations, and community
2392 service announcements share contact routes. These may include a telephone
2393 number, text service, dedicated helpline, or community focal point. Frontline staff
2394 should be trained to activate these arrangements

Box 25. *Country example: India (Kerala)*

> Kerala's community-based palliative programme uses trained local volunteers to provide respite and support to families caring for people with serious illness. Volunteers from the same neighbourhood, teachers, shopkeepers, and homemakers receive training and offer home visits, sitting services, and emotional support. The model works through existing local government (Panchayat) structures with minimal formal health system resources, covering over 90% of Kerala's population.

LMIC adaptation. This demonstrates that respite does not require expensive professional services or dedicated facilities. Community volunteers, trained in basic skills and supervised by health workers, can provide meaningful relief. The model leverages existing social structures (neighbourhood networks, local government, religious institutions) rather than creating parallel systems. Similar approaches have been adapted in Bangladesh, Malawi, and Rwanda.

Box 26. *Country example: Colombia (Bogotá)*

> Bogotá's Manzanas del Cuidado ("Care Blocks") co-locate respite and practical supports for carers and care recipients within neighbourhood centres. These centres offer day respite alongside training programmes, psychosocial support, and spaces for household tasks. Locating multiple supports together reduces travel time and makes it easier for carers to access the services they need while care recipients participate in day activities. The programme has continued to operate through changes in municipal administration and remains a reference example of the spatial co-location approach to carer support.

LMIC adaptation. The Care Blocks model demonstrates how existing community infrastructure can be repurposed to deliver integrated carer support. Locating services close to where carers live reduce time burdens, which is particularly relevant in LMICs where they often combine caregiving with income-generating work.

Type	Indicative measure
Input	Existence of policies or guidelines that state respite care, including emergency respite, as part of the long-term care system.

Availability of at least two types of respite services within a given catchment area. | | **Process** | Proportion of carers identified through health and social care services who received information on available respite options.

Proportion of emergency respite requests that receive a response within an agreed time frame. | | **Output** | Hours or days of respite utilized per carer annually

2412 Proportion of carers who use respite at least once within a defined period | | **Outcome** |
2413 Carer-reported impact on well-being and ability to continue caring after using respite.

2414 Carer-reported change in stress or burden after using respite and related supports.

2415 Proportion of carers who report that respite helped them remain in employment or
2416 education, if appropriate.

2417 Reduction in reports of care breakdown or unplanned institutional admission linked to carer
2418 crisis. |

2419 Standard 11: Education and skills training

2420 *Unpaid carers require structured education and skills training to provide safe, high-quality*
2421 *care while maintaining their own well-being. Training must recognize caregiving as skilled*
2422 *work and move beyond information provision to develop practical competencies, coping*
2423 *capacity, and system navigation skills. Education should be accessible, culturally*
2424 *appropriate, and linked to opportunities for formal skills recognition where desired.*

2425 **Overview**

2426 The purpose of this standard is to ensure that unpaid carers have access to structured
2427 education and training that builds their practical skills, supports well-being, and recognizes
2428 caregiving as skilled work.

2429 Unpaid carers often assume their role without preparation, learning through trial and error
2430 while managing complex health conditions, medications, and care needs. Lack of
2431 knowledge about the care recipient's condition, available services, and caregiving
2432 techniques increases stress, reduces confidence, and can compromise both care quality
2433 and carer well-being. Evidence shows that information alone is insufficient; carers benefit
2434 from structured training that develops practical competencies and coping strategies.

2435 This standard outlines the content, delivery, and recognition elements needed to support
2436 carers through accessible, culturally appropriate education. It emphasizes that training
2437 should be available in multiple formats to accommodate carers' time constraints, geographic
2438 location, and varying levels of digital access, ensuring equity across diverse settings.

2439 *Quality Statement 11.1: Comprehensive training content*

2440 Training programmes for unpaid carers address comprehensive content, including
2441 understanding the care recipient's condition, practical caregiving skills, managing
2442 challenging situations, carer self-care and stress management, and navigating health and
2443 social care systems.

2444 **Rationale**

2445 Evidence shows that short, fragmented, or information-only training does not adequately
2446 meet carers' needs, particularly in dementia care. Caregiving involves managing complex
2447 symptoms, emotional distress, and system demands. Multidimensional training improves
2448 carers' confidence, coping, and care quality and supports the sustainability of caregiving
2449 over time.

2450 **Implementation guidance**

2451 Training programmes should address five core domains:

2452 1. **Understanding the condition** – Practical knowledge of the illness, symptom
2453 progression, and reasons for behaviours reduces distress and supports
2454 compassionate responses (Baruah U et al., 2021a).

2455 2. **Practical caregiving skills** – Step-by-step guidance on communication, personal
2456 care, and recognizing health changes improves safety, confidence, and collaboration
2457 with professionals (Tasseron-Dries et al., 2024).

2458 3. **Managing challenging situations** – Problem-solving and coping strategies
2459 strengthen self-efficacy when responding to agitation, aggression, or emotional
2460 distress (Baruah U et al., 2021a).

2461 4. **Carer self-care and stress management** – Tools for stress management,
2462 emotional support, and help-seeking are linked to better well-being and coping
2463 (Telles et al., 2020).

2464 5. **Navigating health and social care systems** – Clear guidance on services,
2465 entitlements, and professional roles reduces confusion and supports effective care
2466 partnerships (Tasseron-Dries et al., 2024).

2467 The WHO iSupport for dementia training programme demonstrates how these domains can
2468 be delivered together through a structured, modular framework adaptable across cultures
2469 and settings and applicable beyond dementia care.

2470 ***Quality Statement 11.2: Accessible delivery***

2471 Carer education and training is delivered through multiple formats, including digital, in-
2472 person, and community-based approaches, to ensure accessibility for carers across diverse
2473 circumstances, locations, and levels of digital literacy.

2474 **Rationale**

2475 Many carers face barriers to attending in-person training, while digital-only delivery risks
2476 excluding those with limited access or skills. Equity requires multiple delivery options that
2477 reflect carers' time constraints, geography, and digital literacy. Accessibility also depends on
2478 cultural relevance, trust, and human connection.

2479 **Implementation guidance**

2480 Training should be delivered through blended models combining digital, in-person, and
2481 community-based formats (Pot AM et al., 2019).

2482 In Indonesia and India, the WHO iSupport programme was adapted for smartphone use,
2483 translated, and culturally tailored, enabling carers to complete modules at their own pace at
2484 home. Partnerships with Alzheimer's associations provided peer groups and in-person
2485 support, helping carers apply learning in practice (Turana Y et al., 2023).

2486 Evidence shows digital tools are most effective when supported by human contact. Barriers
2487 such as low digital skills, limited internet access, and low confidence are common and
2488 reduce uptake (Madeira R et al., 2025). Helplines, community health workers, and peer
2489 support improve use and sustainability.

2490 Where smartphone or internet access is limited, content can be delivered via SMS, radio
2491 programmes, or printed materials distributed through primary care and community services,
2492 particularly in rural and underserved areas (Pot AM et al., 2019).

2493 Policy implications include investing in blended delivery; ensuring cultural and linguistic
2494 adaptation; embedding training within existing health and community platforms; providing
2495 basic technical support; and recognizing that accessibility extends beyond technology.

2496 **Box 27.** *Country example: Indonesia and India*

WHO's iSupport for dementia training course has been adapted for delivery through smartphone applications in Indonesia and India, extending access to carers of people with dementia in both urban and rural settings. The programme delivers structured education across five modules that carers can complete at their own pace. In Indonesia, implementation included translation and cultural adaptation of content and case examples, alongside partnerships with local Alzheimer's associations that provided in-person peer support groups to complement digital learning.

2497 **LMIC adaptation.** Literature shows that digital delivery substantially reduces costs and
2498 increases reach, particularly for carers who are unable to leave home. However, evidence
2499 indicates that effectiveness and equity depend on combining digital tools with a human
2500 touchpoint, such as community health workers, peer support groups, or telephone helplines.
2501 In contexts where smartphone or internet access is limited, iSupport content and similar
2502 training materials can be adapted for feature phones using SMS, radio programming, or
2503 printed materials distributed through primary healthcare and community services.

2504 (Baruah U et al., 2021 a,b) (Pot AM et al., 2019). (Turana Y et al., 2023).

2505 **Box 28.** *Country example: WHO European Region*

In October 2025, WHO/Europe launched a free online course designed specifically for unpaid carers, developed in collaboration with Eurocarers, the Swedish Family Care Competence Centre at Linnaeus University, and the National Institute on Health and Sciences of Ageing in Italy. The course supports implementation of the European Care Strategy and is hosted on the WHO Academy platform.

The course is structured in two complementary parts that can be completed independently:

- **Part 1: Caring for yourself** focuses on carers' own well-being, offering guidance on recognizing personal limits, managing stress, maintaining mental and physical health, and balancing caregiving with work and family responsibilities.
- **Part 2: Caring for another** provides practical guidance on supporting an older person with daily needs related to personal hygiene, mobility, nutrition, cognitive health, and safe use of assistive devices. It emphasizes collaboration with family members, fellow carers, and professional care services.

The course is available in English through the WHO Academy, with French and Spanish translations planned. It demonstrates how comprehensive training content (Quality Statement 11.1) can be delivered through accessible digital formats (Quality Statement 11.2) at no cost to carers.

2506 **LMIC adaptation.** The WHO Academy platform provides a model for free, scalable digital
2507 training that can reach carers across diverse settings. The modular, self-paced structure
2508 accommodates carers' time constraints. Content focusing on practical skills and self-care is
2509 transferable across contexts. Countries can adapt the approach by partnering with regional
2510 WHO offices to develop culturally appropriate versions, or by using the course structure as a
2511 template for locally developed content delivered through national health education platforms
2512 or community health worker networks.

2513 ### *Quality Statement 11.3: Skills recognition*

2514 Unpaid carers acquire substantial competencies through lived caregiving experience.
2515 Systems should formally recognize these skills and provide pathways for those who wish to
2516 transition into paid care roles, where appropriate.

2517 **Rationale**

2518 Carers acquire substantial skills through lived experience, yet these remain largely
2519 unrecognized. Formal recognition values caregiving work, supports workforce development,
2520 and creates voluntary pathways into paid care roles without undermining carers' choice.

2521 In many countries, unpaid carers gain valuable practical skills simply by meeting everyday
2522 care needs, often compensating for limited formal services. Despite their importance, these
2523 skills usually go unrecognized. In LMIC settings, skills recognition can be kept simple and
2524 low cost, using approaches such as basic competency lists, community health worker
2525 confirmation, or portable records. For carers who choose this option, recognition can open
2526 voluntary routes into paid care roles, supporting local workforces while respecting choice
2527 and avoiding pressure. Valuing carers' skills in this way supports livelihoods and
2528 strengthens care systems without the need for major new infrastructure.

2529 **Implementation guidance**

2530 Systems should:

2531 - Recognize caregiving competencies using clear, trusted standards
2532 - Embed Recognition of Prior Learning (RPL) to convert existing skills into credentials
2533 - Use portable credentials (for example, skills passports) to support mobility
2534 - Offer micro-credentials and short modules to bridge into paid care roles
2535 - Link skills recognition to workforce recruitment and retention strategies
2536 - Ensure participation is voluntary and non-coercive

2537 In LMIC settings, recognizing carers' skills should be simple and affordable, build on existing
2538 community and health services, and remain entirely voluntary, with clear safeguards to
2539 prevent pressure or exploitation.In settings without formal credentialing systems, recognition
2540 may take simpler forms such as certificates of participation, letters of reference from health
2541 workers, or community acknowledgment of expertise that can support employment or
2542 volunteer opportunities.

2543 **Indicative measures**

Type	Indicative measure
Input	Availability of training and skills-recognition pathways, including topics, formats, languages, and agreed recognition routes (for example, RPL, skills passports, credential frameworks)
Process	Proportion of identified carers offered training and skills assessment, including access to recognition routes
Output	Number of carers completing training; number issued recognized credentials (for example, care certificates or skills passport entries)

Type	Indicative measure
Outcome	Carer confidence in skills; evidence of safe care practices; transitions into paid care roles where desired, linked to workforce development pathways

2544 ## Standard 12: Social protection and financial security

2545 *Every unpaid carer has access to social protection, which protects them from financial*
2546 *hardship resulting from care responsibilities. Social protection systems should be gender*
2547 *sensitive, enable access to health and social care, ensure adequate work-life balance,*
2548 *protect employment, and provide life-long income security through non-contributory*
2549 *allowances or contributions to pensions for unpaid carers.*

2550 **Overview**

2551 The purpose of this standard is to highlight that social protection is necessary to recognize
2552 and compensate unpaid carers for their critical contributions to long-term care. This standard
2553 outlines the main elements required for ensuring the financial security and well-being of
2554 unpaid carers.

2555 Unpaid carers provide the vast majority of care for older people, even in countries with well-
2556 developed long-term care systems, yet this contribution is not well recognized or
2557 compensated. Unpaid care work limits carers' ability to work, resulting in loss of income,
2558 pensions, and lifetime earnings. The bulk of unpaid care work is done by women,
2559 perpetuating gender inequality.

2560 Well-designed social protection systems would enable carers to reconcile paid employment
2561 with unpaid care work, compensate the financial penalties incurred due to caregiving, and
2562 provide carers with financial security throughout the life-course.

2563 Social protection must be gender-sensitive, which involves creating systems where women
2564 are not penalized for the choices they make between caregiving and paid employment, and
2565 caregiving in earlier life stages does not result in financial insecurity in old age.

2566 ### *Quality Statement 12.1: Income support*

2567 Carers with significant care responsibilities have access to financial support mechanisms,
2568 which may include cash allowances, tax credits, or inclusion in social assistance
2569 programmes, to mitigate income loss from reduced employment.

2570 **Rationale**

2571 The time- and labour-intensive nature of care makes it difficult for carers to combine care
2572 work with paid employment, self-employment, or other income-generating activities,
2573 resulting in carers leaving employment, reducing their work hours, or scaling back their

2574 businesses or informal economic activities. Income support can compensate carers for the
2575 income foregone from reducing their work hours or leaving employment and prevent carers
2576 from falling into poverty due to reduced earnings.

2577 **Implementation guidance**

2578 The choice of income support will depend on the socio-economic context of the country.
2579 However, the design of income support measures should consider:

2580 • The level of payment should safeguard against poverty and be set at income
2581 replacement levels appropriate for the country.

2582 • Means-testing should recognize and include the costs of care-related expenses.

2583 • The system of accessing income support should be simple and easy to navigate and
2584 can be integrated with other social security infrastructure.

2585 • There should be clear rules on how the income support measures interact with other
2586 benefits so that carers are not penalized in accessing other social security benefits.

2587 ***Quality Statement 12.2: Pension protection***

2588 Social protection systems include provisions to protect carers' long-term financial security,
2589 such as credited pension contributions during caregiving periods, to prevent old-age poverty
2590 resulting from career interruptions or periods spent outside the labour force.

2591 **Rationale**

2592 Caregiving often results in gaps in employment as carers have to leave employment or work
2593 part-time due to care responsibilities. This impacts their entitlement to pensions, limiting
2594 carers' ability to save for old age or retirement, which in turn increases their risk of financial
2595 insecurity and poverty.

2596 Pension protection in social protection systems is necessary to prevent gaps in pension
2597 contributions for unpaid carers and allow for smooth income flows through the life course.

2598 **Implementation guidance**

2599 • Pension entitlement should not be related only to time spent in the labour market.
2600 Carers' time spent on care provision could also contribute to entitlement to pensions.
2601 Care provision may be recognized as employment.

2602 • Coverage should start with formal employment and gradually expand to the informal
2603 sector, as well as self-employed, part-time workers and gig workers. These groups
2604 can be reached through awareness campaigns and voluntary sign-ups.

2605 • The level of pension entitlement should be calibrated to employment history and
2606 should not distort the willingness to return to employment.

2607 ### *Quality Statement 12.3: Work-life balance*

2608 Legal frameworks support carers' labour market attachment through provisions such as
2609 flexible work arrangements, care leave entitlements, and protection from discrimination
2610 based on care responsibilities.

2611 **Rationale**

2612 Care has a significant impact on the time use of carers in paid employment, who struggle to
2613 balance care work with the demands of paid work. The demands of care reduce the time
2614 carers can spend on professional or career development. Carers also often sacrifice their
2615 own leisure or rest time to fulfil their caregiving responsibilities, leading to longer-term
2616 consequences for their health and well-being. Legal frameworks can mitigate these impacts
2617 and also help improve retention of working carers.

2618 **Implementation guidance**

2619 • While the scope and type of work-life balance provisions can vary based on the
2620 industry's needs and structures, legal provisions must require employers provide a
2621 clear process and rationale for implementing work-life balance.

2622 • Legal provisions should be complemented by clearly defined compliance and
2623 enforcement mechanisms, with penalties included for non-compliance.

2624 • Legal provisions can build upon existing employment legislation.

2625 **Gender equality consideration.** Social protection policies should be designed through a
2626 gender lens, addressing gender-specific vulnerabilities. They support genuine choice rather
2627 than reinforce gender-biased assumptions that inadvertently incentivize women's withdrawal
2628 from the labour market. Gender-neutral entitlements and adequate compensation for care
2629 work help ensure equitable distribution of care responsibilities. Social protection systems
2630 should be made more gender-responsive by taking into account the structural specificities of
2631 women's labour market trajectories, as well as gender power dynamics within and beyond
2632 households.

2633 **Box 29.** *Country example: Uruguay*

Uruguay's National Integrated Care System, established in 2015, positions care as the "fourth pillar" of social protection alongside health, education, and social security. The system provides cash transfers to carers of people with severe dependency, subsidized access to formal care services, and training programmes. Critically, it frames support for carers within a broader commitment to shared social responsibility for care, explicitly addressing gender inequities in care distribution. The system has demonstrated that care is a societal issue and has raised awareness of the gendered dimensions of care. It illustrates how Standard 4.1 can be approached through a comprehensive, targeted

programme, while implementation progress has been uneven since 2020 in the face of fiscal pressures and shifting political priorities.

2634 **LMIC adaptation.** Uruguay demonstrates that comprehensive carer social protection is
2635 achievable in a middle-income country context. The phased implementation – starting with
2636 identification and training, then expanding to cash transfers and services – offers a model
2637 for progressive realization. Integration with existing social protection infrastructure (rather
2638 than creating parallel systems) reduces administrative costs and improves coverage.*

2639 **Box 30.** *Country example: Costa Rica*

Costa Rica's 2021 National Care Policy establishes a comprehensive framework recognizing the right to give and receive care. The policy includes provisions for carer allowances, respite services, and pension credits for those providing intensive care. Implementation prioritizes carers in poverty and those caring for people with highest dependency levels, demonstrating targeted approaches within resource constraints. The policy has expanded access to care and enhanced gender equality by enabling more women to work, illustrating the impact of Standards 4.1 and 4.2.

2640 **LMIC adaptation.** Costa Rica shows how middle-income countries can establish rights-
2641 based frameworks while managing fiscal constraints through targeting. The emphasis on
2642 integrating care policy across multiple ministries (health, social development, labour,
2643 education) enables comprehensive support without requiring large new bureaucracies.*

Type	Indicative measure
Input	Existence of social protection provisions that focus on carer needs for employment and income security (allowances, pension credits, leave)

2644 Availability of at least one type of social security provision (allowances, pension credits or
2645 leave) | | **Process** | Proportion of eligible carers who received financial support or access
2646 work-life balance provisions | | **Output** | Value of financial transfers or benefits received by
2647 carers

2648 Number of carers who received pension contributions during caregiving periods | | **Outcome**
2649 | Carer poverty rates

2650 Labor force participation among carers

2651 Increase in working hours of carers in employment

2652 Increase in retirement savings of carers

2653 Carer-reported change in stress after using work-life balance provisions

2654 Proportion of carers who reported that work-life balance provisions helped them remain in
2655 employment |

2656 Standard 13: Engagement and recognition

2657 *Unpaid carers are recognized as essential partners in care and are meaningfully included in*
2658 *individual care decisions, service design, governance, and quality monitoring. Recognition*
2659 *and practices that support the carers' role strengthen care continuity and help ensure that*
2660 *long-term care systems reflect the realities of those who provide day-to-day support.*

2661 **Overview**

2662 The purpose of this standard is to formally acknowledge carers as essential partners in the
2663 care continuum whose perspectives and experiences reflect the daily realities of the person
2664 receiving care.

2665 Carer representatives contribute significant insight and nuance regarding their role in
2666 advisory groups, quality committees, and consultations. Their unique experiences can
2667 identify gaps in services, barriers to quality care, and pressures that influence their ability to
2668 continue in their role.

2669 This standard presents the structures and practices needed to support carers' involvement
2670 in care planning, service delivery and system development.

2671 *Quality Statement 13.1: Partners in care*

2672 Health and social care providers involve carers as partners in care planning, treatment
2673 decisions, and transitions of care, with information sharing aligned to the care recipient's
2674 preferences.

2675 **Rationale**

2676 Carers often coordinate all manner of appointments and care across health and social care
2677 systems and hold critical information about the care recipient's daily routines, functional
2678 changes, and risks. Continuity of care is enhanced when carers are involved from the
2679 outset, including in the initial assessment and development of the care plan.

2680 **Implementation guidance**

2681 • Integrate carer involvement into care planning protocols with clear guidance on
2682 consent and privacy.

2683 • Ensure carers receive timely, accurate information about care options, including
2684 respite, transitions from acute to mid- and long-term care settings, and expected
2685 responsibilities.

2686 • Standardize communication pathways so carers know whom to contact when needs
2687 change or concerns arise.

2688 ***Quality Statement 13.2: Participatory governance***

2689 Long-term care systems have processes that encourage and value carer representation in
2690 policy development, service design, monitoring, and evaluation, recognizing that this
2691 representation is critical for system improvement.

2692 **Rationale**

2693 Carers can identify practical issues in care delivery that are not visible through routine
2694 reporting or administrative data. Their involvement helps detect barriers to access, gaps in
2695 coordination, and challenges that arise in the daily care routine. This experience in policy
2696 and service discussions supports more accurate planning and ensures that changes reflect
2697 what is happening in homes and communities.

2698 **Implementation guidance**

2699 • Establish carer advisory councils at the national, regional, or facility level.

2700 • Include carers or carer organizations in quality improvement committees and policy
2701 consultations.

2702 • Use tools such as the WHO State of LTC Toolkit to create structured participation
2703 processes that are transparent, accessible, and inclusive.

2704 ***Quality Statement 13.3: Outcome measurement***

2705 National and subnational health information systems, or the equivalent data-collection
2706 arrangements where formal systems do not yet exist, include carer-reported outcomes that
2707 capture carers' experience, well-being, and the impact of support services.

2708 **Rationale**

2709 Caregiving affects an individual's health, daily life, and often financial situation, which cannot
2710 be captured through routine clinical data. Insights from carers through various methods can
2711 help identify where support is insufficient, guide planning and also evaluation across long-
2712 term care settings.

2713 **Implementation guidance**

2714 • Incorporate validated carer-reported outcome and experience measures into routine
2715 monitoring and evaluation to assess carers' well-being, experience of partnership
2716 with services, and the impact of support on their ability to sustain their role.

2717 • Use indicators on carer well-being, experience of partnership, and the impact of
2718 support services to improve carer support.

- Ensure data collection is simple and accessible across diverse settings.

Box 31. *Country example: Australia*

> The Carer Recognition Act (2010) is an Australian federal law (and a separate NSW state act) designed to recognize, support, and raise awareness of the significant contribution unpaid carers make to society by providing care for people with disabilities, chronic illnesses, mental health conditions, or frailty.
>
> Carer representative bodies participate formally in aged care quality monitoring, advisory structures, and policy consultations. Aged Care Quality Standards require providers to involve carers in care planning and to consider their well-being as part of service quality.

Legislative recognition and formal consultation mechanisms can be implemented with limited financial resources. Key elements, statements of principles, requirements for engagement, and inclusion of carers in standards, can be adapted to diverse legal and institutional contexts. The primary shift is conceptual acknowledging carers as stakeholders, not adjuncts.

Type	Indicative measure
Input	Existence of legislation / policies formally acknowledging carers

Formal representation of carers in governance structures | | **Process** | Proportion of care planning processes that document carer involvement

Number of policy consultations that include carer organizations | | **Output** | Policies, standards, or quality reports demonstrating carer input

Use of carer-reported outcome and experience measures | | **Outcome** | Carer-reported experience of recognition, partnership, and meaningful involvement in care and system decisions |

4. Implementation considerations

LMIC considerations. LTC familialism is a social justice issue because it distributes the responsibility for care unevenly across households, reinforcing gendered and socioeconomic inequalities in both caregiving and access to care. In low- and middle-income countries, where formal long-term care infrastructure may be limited or absent, unpaid carers often assume even greater responsibility. These standards recognize diverse family structures, multigenerational caregiving arrangements, and varying levels of state capacity. Implementation guidance throughout this chapter emphasizes scalable approaches that can be adapted to resource-constrained settings, by leveraging existing primary health care platforms, community health workers, volunteer networks, and digital

technologies, while maintaining core principles of carer recognition and support. Country examples demonstrate that meaningful carer support is achievable across income levels through phased implementation and integration with existing systems, even with limited resources.

Context adaptation

These standards require adaptation to diverse national and subnational contexts, recognizing variations in family structures, cultural expectations around caregiving, existing social protection systems, health system capacity, and resource availability. No single model of carer support will be appropriate for all settings. Implementation should build on existing strengths, such as community networks, primary health care platforms, or social protection infrastructure, while progressively expanding coverage and depth of support.

Cultural norms around family obligation, gender roles, and intergenerational relationships shape how caregiving is understood and organized. In some contexts, formal recognition of carers may be welcomed as validation of an invisible contribution; in others, it may be perceived as interference in family matters or as implying that families cannot manage caregiving without external support. Implementation strategies should be developed through consultation with carers, families, and communities to ensure approaches are culturally appropriate and locally owned.

Legal and administrative frameworks also vary considerably. Some countries have existing legislation recognizing carers or establishing entitlements to assessment and support; others have no specific legal provisions. Implementation may involve new legislation, amendments to existing laws, or administrative measures within current frameworks. The appropriate pathway will depend on the national context and policy priorities.

Phased implementation for resource-limited settings

The country examples throughout this chapter demonstrate that meaningful carer support is achievable across income levels. A phased approach supports progressive realization of these standards, starting with foundational elements that require minimal resources and building toward more comprehensive support as capacity and financing allow.

While this chapter focuses specifically on support for unpaid carers, the phased approach outlined below also provides a template for progressive development of long-term care systems more broadly. Countries can adapt this framework to sequence investments across all domains of long-term care according to available resources and priorities.

Phase 1: Foundation

The first phase focuses on recognition, identification, and low-cost support mechanisms that can be implemented within existing systems:

2778 • **Values articulation**: Implementation should begin with understanding the values
2779 and expectations that shape caregiving in the local context, including family
2780 obligations, gender norms, and cultural views on care responsibilities. This values
2781 assessment helps ensure that policies and programmes are grounded in local
2782 realities rather than imported models.

2783 • **Policy recognition:** Formal acknowledgment of unpaid carers in health and social
2784 care policies, establishing their status as partners in care. This requires no new
2785 funding but creates the foundation for subsequent measures.

2786 • **Mapping existing infrastructure:** Identify existing resources that can support carer
2787 identification and services, including primary health care facilities, community health
2788 worker programmes, chronic disease management systems, social protection
2789 registries, and community organizations. Many countries have relevant infrastructure
2790 that is not currently connected to carer support.

2791 • **Identification through existing pathways:** Integration of brief screening questions
2792 into routine primary health care encounters, chronic disease management, and
2793 hospital discharge planning. The United Kingdom's Carer Passport scheme
2794 demonstrates how simple administrative mechanisms can formalize carer recognition
2795 without new infrastructure.

2796 • **Community-based respite and peer support:** Mobilization of trained volunteers to
2797 provide basic respite and emotional support, building on existing community
2798 structures. Kerala's Neighborhood Network in Palliative Care shows how volunteer
2799 networks operating through local government can extend support to over 90 per cent
2800 of a population with minimal formal health system resources.

2801 • **Information and basic training:** Provision of accessible information about the care
2802 recipient's condition, available services, and basic caregiving techniques through
2803 printed materials, community health workers, or peer networks.

2804 ***Phase 2: Development***

2805 The second phase expands support through more structured programmes and begins to
2806 address financial security:

2807 • **Structured training programmes:** Development of comprehensive carer education
2808 using blended delivery models. The WHO iSupport programme, adapted in
2809 Indonesia and India, demonstrates how digital platforms combined with peer support
2810 groups can deliver structured training at scale while maintaining human connection.

2811 • **Formal needs assessment:** Implementation of proportionate assessment
2812 processes that evaluate carers' needs, capacities, willingness, and preferences,
2813 linked to referral pathways for support services.

- **Targeted respite services:** Development of day respite programmes and emergency respite protocols, potentially through repurposing existing community infrastructure. Bogotá's Manzanas del Cuidado (Care Blocks) model shows how co-locating services reduces time burden and improves accessibility.
- **Carer representation in governance:** Establishment of mechanisms for carer participation in policy development and service design, including carer advisory councils and inclusion in quality improvement processes.

Phase 3: Comprehensive

The third phase moves toward comprehensive social protection and integrated care systems:

- **Financial transfers and allowances:** Introduction of income support for carers with significant care responsibilities, targeted initially to those in poverty or providing intensive care. Costa Rica's National Care Policy demonstrates how middle-income countries can establish carer allowances within fiscal constraints through careful targeting.
- **Pension protections:** Credited pension contributions for caregiving periods to prevent old-age poverty resulting from career interruptions.
- **Diverse formal respite options:** Expansion of respite services to include in-home support, day centers, and short-stay residential care, with multiple options to accommodate diverse carer circumstances.
- **Integrated care systems:** Development of comprehensive national care systems that position care as a pillar of social protection. Uruguay's National Integrated Care System demonstrates how care can be framed as a shared social responsibility, with coordinated policies across health, social development, labour, and education sectors.

Key enablers

Successful implementation across diverse settings depends on several cross-cutting enablers:

Leverage existing infrastructure. Integrate carer identification and support into primary health care, community health worker programmes, and existing social protection systems rather than creating parallel structures. This reduces costs, improves sustainability, and reaches carers where they already interact with services.

Community mobilization. Train and support community volunteers, peer support groups, and carer associations to extend reach beyond formal services. Community-based

2848 approaches are particularly important in settings with limited formal care infrastructure and
2849 can provide culturally appropriate support that complements professional services.

2850 **Digital solutions with human touchpoints.** Use mobile technology for training,
2851 information, and peer connection while ensuring offline alternatives for those without access.
2852 Evidence consistently shows that digital tools are most effective when combined with human
2853 support, whether through community health workers, peer groups, or helplines.

2854 **Cross-sector coordination.** Coordinate across health, social services, labour, and
2855 education sectors to avoid fragmentation and maximize resources. Carers' needs span
2856 multiple domains, and siloed responses result in gaps, duplication, and burden on carers to
2857 navigate complex systems.

2858 **Gender-sensitive design.** Embed gender analysis throughout policy design and
2859 implementation. This includes proactive identification of women who may not self-identify as
2860 carers, assessment of hidden strain and willingness, and social protection policies that
2861 support genuine choice rather than reinforcing gendered assumptions about care.

2862 **Carer involvement in design and monitoring.** Engage carers and carer organizations in
2863 the design, implementation, and evaluation of support services. Carers bring essential
2864 expertise about what works in practice, and their involvement increases the relevance,
2865 acceptability, and effectiveness of interventions.

2866 Common challenges

2867 Implementation commonly encounters several challenges that require attention:

2868 **Carers not recognizing themselves.** Many people providing substantial care do not
2869 identify with the term "carer," viewing their role as a natural part of family life. Identification
2870 strategies should use activity-based questions ("Do you regularly help someone with daily
2871 activities?") rather than relying on self-declaration as a carer.

2872 **Reluctance to seek or accept support.** Carers may be reluctant to seek help due to
2873 perceived stigma, concern about being seen as unable to cope, or worry that accepting
2874 support implies failure in their family duty. Framing support as enabling better care, rather
2875 than as charity or welfare, can reduce resistance.

2876 **Care recipients' concerns.** People receiving care may resist external support due to
2877 concerns about being a "burden," losing family-provided care, or having strangers in their
2878 home. Implementation should address both carers' and care recipients' perspectives,
2879 emphasizing that supporting carers helps sustain family-based care.

2880 **Fragmentation across sectors and services.** Carer support often falls between health,
2881 social care, and employment sectors, with no single ministry or agency responsible. Clear
2882 governance arrangements, including designated lead agencies and coordination
2883 mechanisms, are essential to prevent carers from falling through gaps.

Balancing carer support with care recipient autonomy. Tension may arise between supporting carers and respecting care recipients' preferences about who provides their care and how. Implementation should include mechanisms for understanding and balancing both perspectives, recognizing that the interests of carers and care recipients usually, but not always, align.

Sustainability of funding. Pilot programmes and donor-funded initiatives may demonstrate effectiveness but fail to be sustained or scaled. Implementation planning should include a realistic assessment of long-term financing and integration into mainstream budgets from the outset of implementation.

2893 # Chapter 5. Workforce

2894 **Table 10.** *Standards and quality statements: Chapter 5, Workforce*

Standard	Quality statements
Standard 14. Workforce competencies and training	**14.1** Defined competencies for long-term care roles **14.2** Foundational training before independent practice **14.3** Continuing professional development
Standard 15. Staffing and workload	**15.1** Staffing matched to assessed care needs **15.2** Skill mix appropriate to needs **15.3** Workloads enable person-centred care and sustainable work
Standard 16. Working conditions, well-being, and rights	**16.1** Fair compensation **16.2** Safe and supportive working environment **16.3** Stable, secure, and dignified employment
Standard 17. Supervision, teamwork, and accountability	**17.1** Supervision and reflective practice **17.2** Teamwork, communication, and care coordination **17.3** Worker conduct, safeguarding, and channels for raising concerns
Standard 18. Workforce profile considerations	**18.1** Gender equity **18.2** Protections for migrant care workers **18.3** Pathways for young workers

2895 ## 1. Introduction

2896 This chapter establishes standards for the long-term care workforce – the people whose
2897 paid work delivers long-term care in homes, communities, and residential settings.

2898 Workforce factors are consistently identified across reviews and country experiences as
2899 among the strongest determinants of long-term care quality: training, staffing, working
2900 conditions, supervision, teamwork, and the structural circumstances of the workforce shape
2901 every encounter between a worker and an older person receiving care.

2902 **Scope of this chapter.** "Long-term care workers" in this chapter refers to all paid workers
2903 engaged in delivering long-term care to older people, across medical, social, and personal
2904 care. Following WHO's framing of long-term care, the workforce includes both the broad
2905 range of health workers – physicians, nurses, allied health professionals such as
2906 physiotherapists, occupational therapists, dieticians, and social workers – and care workers
2907 in personal care, home-care, and care-aide roles, alongside supervisors, care managers,
2908 and other paid staff supporting hands-on care or care coordination. The definition spans
2909 both professional and non-professional roles, regulated and less formally regulated, and
2910 applies across home and community-based, residential, and integrated settings. Unpaid
2911 carers, whose contribution remains foundational to long-term care globally, are addressed in
2912 the dedicated Carers chapter; this chapter complements that one rather than substituting for
2913 it.

2914 2. Background

2915 15.1 Global situation

2916 The long-term care workforce – physicians, nurses, allied health professionals, social
2917 workers, personal care workers, supervisors and care managers paid to deliver care to older
2918 people – is one of the largest and fastest-growing labour forces in health and social systems
2919 worldwide. The OECD reports that long-term care workers already represent a substantial
2920 share of the total social and health workforce in high-income Member States, with persistent
2921 shortages reported across the great majority of countries surveyed. The World Health
2922 Organization has identified an enabled and skilled workforce as one of the foundational
2923 elements of long-term care systems, alongside governance, sustainable financing, service
2924 delivery, and innovation and research.

2925 The workforce is characterized by several recurring features. Women predominate in nearly
2926 every setting, often comprising 80 per cent or more of personal care, home-care and care-
2927 aide roles. Migrant workers fill an increasing share of long-term care positions in high-
2928 income receiving countries, with implications for both receiving and source-country health
2929 systems – in OECD countries, the share of foreign-born workers in long-term care rose from
2930 14 per cent to 21 per cent between 2014 and 2024. Pay levels for personal care workers
2931 and care assistants are typically below those of comparable workers in acute health care,
2932 despite the growing complexity and intensity of care needs in long-term care. Informal
2933 employment arrangements – including domestic-worker contracts, agency placements and
2934 self-employment – remain common, particularly in home-based care. Across all of these
2935 settings, the long-term care workforce is being asked to expand, professionalize and

improve working conditions simultaneously, even as the populations it serves grow older and live with more complex health and social needs.

15.2 Key challenges

Workforce shortages and high turnover. Across systematic reviews and country surveys, recruitment and retention difficulties are the most consistently reported workforce problem. Turnover at provider level is associated with poorer continuity of care, higher rates of avoidable harm, and increased reliance on agency and overtime working.

Undertraining and unclear competency standards. In many countries, no national framework defines what long-term care workers in different roles should be able to do. Training quality varies unpredictably across providers, and workers cannot demonstrate or transfer their qualifications when moving between employers or settings.

Pay undervaluation and poor working conditions. Pay levels, hours, scheduling, social protection and workplace safety are often substantially worse than in comparable health roles. Heavy workload, exposure to musculoskeletal injury, psychological strain and harassment, and limited collective voice all contribute to attrition and to compromised care.

Inadequate supervision and team-based working. Care work is frequently solitary, particularly in home-based settings, with limited access to clinical supervision, peer support or multidisciplinary input. Where supervision is in place, it is often narrowly task-focused rather than developmental.

Gendered concentration and gender inequalities. The strongly gendered character of the workforce both reflects and reinforces the wider undervaluation of care work, with consequences for pay equity, career progression and protection from harassment.

Migrant workers and recruitment ethics. Long-term care systems in many high-income countries depend substantially on migrant care workers. These workers face distinct risks, including recruitment debt, language and accreditation barriers, dependence on individual employers for visa status, and isolation from peer support. International recruitment also carries equity implications for source countries, including for their own ageing populations.

Workforce data gaps. In many Member States, the size, composition, qualifications and working conditions of the long-term care workforce are not reliably known, complicating workforce planning, monitoring and equity analysis.

15.3 Conceptual framework

These standards take a dual approach to the long-term care workforce, recognizing that it is at once the means through which good care is delivered and a workforce of people whose own rights, working lives and well-being matter in their own right.

2970 The first dimension treats the workforce as a determinant of care quality. For older people
2971 and families, the workforce is the most direct point of contact with the long-term care
2972 system. The competence, continuity, conduct and well-being of workers shape every aspect
2973 of the care experience: whether physical needs are met safely; whether dignity, privacy and
2974 individual preferences are respected; whether changes in condition are observed and acted
2975 upon in time; whether abuse, neglect or distress are prevented or detected; whether
2976 handovers between workers and across services preserve what matters about the person;
2977 and whether the relationship between worker and care recipient is one of trust. Investing in
2978 training, staffing, supervision and working conditions is therefore a precondition for the
2979 quality and safety standards set out in other chapters of this document.

2980 The second dimension treats the workforce as rights-holders entitled to decent work – fair
2981 pay, safe and supportive working conditions, freedom from exploitation, harassment and
2982 discrimination, voice in how care is organized, social protection, and opportunities for
2983 professional development. These entitlements are owed to workers because they are rights-
2984 holders, not only because protecting them sustains care quality. The two dimensions are not
2985 in tension; the conditions that protect workers' rights also tend to be the conditions in which
2986 good care can be sustained.

2987 This dual approach is consistent with the International Labour Organization's framing of
2988 decent care work and the "5R" principles – recognize, reduce, redistribute, reward and
2989 represent – also applied in Chapter 4 of this document to unpaid carers. It is grounded in the
2990 WHO Framework for countries to achieve an integrated continuum of long-term care, which
2991 identifies an enabled and skilled workforce as foundational, and in the WHO Global Strategy
2992 on Human Resources for Health: Workforce 2030, which sets out the policy directions for
2993 building, sustaining and protecting health and care workforces globally.

2994 15.4 Normative foundations

2995 International instruments establish the basis both for the rights of care recipients to a
2996 competent, accountable workforce and for the rights of long-term care workers as workers.

2997 The Universal Declaration of Human Rights affirms the rights to work, to just and favourable
2998 conditions of work, and to a standard of living adequate for health and well-being (Articles
2999 23–25). The International Covenant on Economic, Social and Cultural Rights elaborates
3000 these rights, including fair wages, safe and healthy working conditions, freedom of
3001 association (Article 7) and the right to social security (Article 9). The International Labour
3002 Organization's core conventions – covering freedom of association, collective bargaining,
3003 forced labour, child labour and discrimination – apply to long-term care workers as to all
3004 workers. ILO Convention 156 (Workers with Family Responsibilities, 1981) and Convention
3005 189 (Domestic Workers, 2011) are particularly relevant, given the prevalence of domestic-
3006 worker contracts in home-based care and the family-care responsibilities that long-term care
3007 workers themselves frequently carry.

3008 Instruments addressing equality reinforce these protections. The Convention on the
3009 Elimination of All Forms of Discrimination against Women obliges States to address
3010 discrimination against women in employment and to ensure equality of treatment, including
3011 in social protection. The Convention on the Rights of Persons with Disabilities places
3012 obligations on States to support a workforce capable of enabling community living (Article
3013 19). Recent regional commitments – including the European Care Strategy (2022), the
3014 ASEAN Declaration on Strengthening the Care Economy and Fostering Resilience Towards
3015 the Post-2025 ASEAN Community (2024) and the APEC Non-binding Care Compact (2025)
3016 – further specify expectations regarding decent work, social protection and recognition of
3017 care workers.

3018 Together, these instruments establish that the long-term care workforce is a matter of
3019 human rights, gender equality and labour protection, as well as service delivery. The
3020 standards in this chapter are designed to give effect to those obligations in the specific
3021 context of long-term care for older people. The standards in this chapter were developed in
3022 parallel with WHO's forthcoming Policy Guidance on Integrated Health and Care Workforce.

3023

3024 3. Standards

3025 This section presents five standards for the long-term care workforce: training and
3026 competencies (Standard 14); staffing and workload (Standard 15); working conditions, well-
3027 being, and rights (Standard 16); supervision, teamwork, and accountability (Standard 17);
3028 and workforce profile considerations addressing gender, migrant care workers, and young
3029 workers (Standard 18). Each standard is structured around three Quality Statements, each
3030 with its own Rationale, Implementation guidance, and Indicative measures, and is illustrated
3031 where appropriate by a country example. The standards are intended to support adaptation
3032 across diverse settings rather than to prescribe a single model.

3033 Standard 14: Workforce competencies and training

3034 *Long-term care workers possess the knowledge, skills, and attitudes required to provide*
3035 *safe, effective, and person-centred care appropriate to their role and care setting, supported*
3036 *by initial training and continuing professional development.*

3037 **Overview**

3038 Workforce competencies and training together form the foundation for safe and dignified
3039 long-term care. The workforce is broad – spanning physicians, nurses, allied health
3040 professionals, social workers, personal care workers, supervisors, and care managers – and
3041 the competencies required correspondingly cover foundational knowledge of common health
3042 conditions of older people, practical caregiving skills, person-centred and relational
3043 competencies, ethical and rights-based practice, and the capacity to recognize abuse,

neglect, and clinical deterioration. For older people, defined competencies underpin trust that workers know what they are doing; for workers, they underpin recognition of long-term care as a distinct field of professional practice.

This standard addresses how the competencies expected of long-term care workers are defined for each role (Quality Statement 14.1), how workers acquire those competencies through initial training before they begin independent practice (Quality Statement 14.2), and how competencies are sustained and updated through continuing professional development across a worker's career (Quality Statement 14.3).

Quality Statement 14.1: Defined competencies for long-term care roles

A nationally or subnationally defined competency framework specifies the knowledge, skills, and attitudes required for each long-term care role, covering clinical, safety, rights and ethical, person-centred, and relational and psychosocial domains.

Rationale

Competency definition is the precondition for everything else in the workforce system: training curricula, certification requirements, supervision benchmarks, accountability for conduct, and staffing decisions all rely on a clear specification of what each role is expected to do. Without defined competencies, training quality varies unpredictably across providers, workers cannot demonstrate their qualifications when moving between employers or settings, and older people and families have no basis for confidence in the workforce. Defined competencies also support recognition of long-term care as a distinct field of practice rather than an undifferentiated extension of family care, which is foundational to attracting and retaining workers and to giving workers themselves a recognized professional identity. Competency frameworks should cover not only clinical and safety domains but also rights and ethical practice – including the duty of care and prohibition of any form of abuse or exploitation – person-centred and dignified care delivery, and the relational and psychosocial dimensions that distinguish high-quality long-term care from task-based service delivery.

Implementation guidance

- Define competencies for each role in the long-term care workforce – including physicians, nurses, allied health professionals, personal care workers, supervisors, and care managers – covering clinical and safety domains, rights and ethical practice, person-centred care, and relational and psychosocial competencies.

- Differentiate competencies by role and setting where appropriate, recognizing that competencies needed in private homes differ in some respects from those needed in residential facilities, and that specialized areas such as dementia care and palliative care require additional competencies.

3080 3081 3082
- Develop and revise competency frameworks through engagement with workers, providers, regulators, training institutions, older people, and family representatives, drawing on national context and on regional or international references.

3083 3084 3085
- Review competency frameworks periodically as care models evolve, to keep pace with community-based and integrated care delivery, and the growing role of technology and assistive devices.

Type	Indicative measure
Input	A competency framework for long-term care roles is formally adopted at national or subnational level.
Process	Competency frameworks are developed and reviewed with engagement of workers, providers, regulators, and older person and family representatives.
Output	Competencies for long-term care roles are publicly available and used to guide training, certification, supervision, and accountability for conduct.
Outcome	Workers, providers, older people, and families understand what each long-term care role is expected to do, supporting consistent and accountable practice across settings.

3086 ***Quality Statement 14.2: Foundational training before independent practice***

3087 3088
Long-term care workers complete a foundational training programme aligned with their role's competency requirements before providing care without direct supervision.

3089 **Rationale**

3090 3091 3092 3093 3094 3095 3096 3097 3098 3099 3100 3101 3102
Long-term care is delivered in settings where errors and omissions can cause serious harm – from incorrect moving and handling that injures both worker and care recipient, to medication mistakes, to failure to recognize signs of deterioration, abuse, or neglect. Foundational training before independent practice protects older people from avoidable harm, reduces injuries among workers themselves, and gives workers the confidence and competence to deliver person-centred care rather than retreating to rigid task completion. Evidence indicates that workers who complete structured pre-service training perform better on care safety, communication, symptom recognition, and person-centred practice, and report higher self-efficacy and lower turnover intention. Foundational training requirements are organized differently across countries – some define minimum hours and curricular content, others rely on certification examinations or accredited apprenticeship pathways – but the principle in common is that workers should not be placed in independent caring roles before they have demonstrated the competencies their role requires.

3103 **Implementation guidance**

3104–3108
- Establish minimum training requirements for each long-term care role, covering core competencies including safe moving and handling, personal care and hygiene support, medication safety, infection prevention, recognition of clinical deterioration, communication with people with cognitive or sensory impairment, ethical and rights-based practice, and recognition and prevention of abuse and neglect.

3109–3111
- Combine classroom or online instruction with supervised practical experience, and ensure that workers do not assume independent care responsibilities before the supervised practical component is complete.

3112–3115
- Where workforce supply pressures lead to entry into care roles before formal training is complete, structure progressive scopes of practice so that untrained workers operate only under direct supervision and within restricted task lists until training milestones are met.

3116–3119
- Make training accessible to workers entering the sector from diverse backgrounds – including older workers, mid-career entrants, migrant workers, and workers with limited formal education – through flexible delivery formats, language support, and recognition of prior learning where appropriate.

3120–3122
- Designate responsibilities for training accreditation, instructor qualification, and assessment so that training quality does not vary unpredictably across providers or regions.

Type	Indicative measure
Input	Minimum foundational training requirements are defined for each long-term care role, with content, duration, and assessment expectations specified.
Process	Proportion of long-term care workers who have completed required foundational training before commencing independent practice.
Output	Documentation of training completion is recorded and verifiable across employers and settings, for example through certification or workforce registry entries.
Outcome	New entrants to the long-term care workforce demonstrate the competencies required by their role; rates of avoidable harm linked to inadequate training are monitored and reduced over time.

3123 ### *Quality Statement 14.3: Continuing professional development*

3124 Long-term care workers have access to ongoing training and professional development that
3125 updates and extends their competencies across their working life.

3126 **Rationale**

3127 Foundational training equips workers to begin independent practice but cannot anticipate
3128 the full range of situations they will face over a career. Care needs evolve as the populations
3129 served age and as new conditions become more common; clinical practice, infection
3130 prevention, and assistive technologies advance; workers move between settings and
3131 acquire new responsibilities; and accumulated stress and isolation can erode practice
3132 quality if not addressed through reflective learning. Continuing professional development
3133 sustains competence, supports adaptation to new models of care, and is consistently
3134 associated with improvements in worker knowledge, care recipient outcomes, and worker
3135 well-being. Evidence suggests that the design and organizational conditions of continuing
3136 development matter as much as its existence: management support, paid time for learning,
3137 access to a structured learning environment, and integration with supervision and career
3138 progression all shape whether continuing development translates into improved practice.
3139 Without these enabling conditions, training requirements risk becoming a compliance
3140 exercise that adds workload without strengthening care or supporting workers' professional
3141 growth.

3142 **Implementation guidance**

3143 • Define continuing professional development expectations for each long-term care
3144 role, including content domains and minimum frequency or hours, calibrated to the
3145 responsibilities of the role.

3146 • Provide continuing development through accessible formats – including peer-led
3147 learning, on-the-job mentoring, structured workshops, and online or distance learning
3148 – to reach workers across geographical areas and shift patterns.

3149 • Enable continuing development to be undertaken during paid working time wherever
3150 feasible, and ensure providers are not penalized financially or operationally for
3151 releasing staff to learn.

3152 • Link continuing development to supervision, performance review, and career
3153 progression so that learning is reinforced in daily practice and recognized in
3154 advancement opportunities.

3155 • Prioritize topics that respond to identified gaps and emerging needs, including
3156 dementia care, palliative care, recognition and prevention of abuse and neglect,
3157 person-centred and rights-based practice, and use of assistive and digital
3158 technologies.

Type	Indicative measure
Input	Continuing professional development expectations for long-term care roles are defined, including content domains and minimum frequency.
Process	Proportion of long-term care workers participating in continuing professional development annually; provision of paid time and access for learning.
Output	Records of continuing development undertaken are maintained at provider and individual level and recognized across employers.
Outcome	Long-term care workers maintain and update competencies throughout their careers; reported confidence and competence in evolving care domains improve over time.

3159 **Box 32.** *Country example: Japan*

Japan's Long-Term Care Insurance system, introduced in 2000, established the certified care worker (Kaigo Fukushishi) as the recognized professional qualification for long-term care personnel. Workers enter the profession by one of two main routes: completing a designated two- to three-year training programme at a specialized welfare college, or combining at least three years of practical care experience with a preparatory course and the national certification examination. The examination assesses theoretical knowledge across geriatric care, dementia care, communication, and care planning, alongside practical caregiving skills. Beyond initial qualification, continuing professional development is supported through specialized tracks within the certification system, including the Certified Care Worker Practitioner (Nintei Kaigo Fukushishi) qualification, which provides a structured pathway from frontline practice into supervisory and instructional roles. Certification is portable across employers and settings, and is linked to wage levels and career advancement opportunities.

3160 Standard 15: Staffing and workload

3161 *Long-term care services are staffed at levels and with a skill mix sufficient to meet the*
3162 *assessed needs of care recipients safely and effectively, with workloads that allow time for*
3163 *person-centred care and that are sustainable for workers.*

3164 **Overview**

3165 This standard addresses the quantity and composition of the workforce deployed by long-
3166 term care services, and the workload of individual workers. While Standard 14 establishes
3167 the competencies workers should have, this standard addresses whether enough workers

3168 with the right mix of competencies are available to meet the needs of the older people being
3169 cared for, and whether their workloads enable both safe, dignified care delivery and
3170 sustainable working lives. Older people and families experience staffing decisions directly:
3171 whether workers have time to listen and respond, whether the same worker returns over
3172 time, whether care needs at night and on weekends are covered, and whether the worker
3173 arriving today is exhausted from impossible workloads yesterday.

3174 This standard addresses how staffing levels are matched to assessed care needs (Quality
3175 Statement 15.1), how skill mix is aligned to the population served (Quality Statement 15.2),
3176 and how the workloads of individual workers are organized so that person-centred care is
3177 feasible in practice and sustainable for workers (Quality Statement 15.3).

3178 *Quality Statement 15.1: Staffing matched to assessed care needs*

3179 Staffing levels in long-term care services are determined on the basis of the assessed care
3180 needs of the population served, with mechanisms in place to monitor adequacy over time.

3181 **Rationale**

3182 Lower staffing in long-term care is consistently associated with adverse outcomes for older
3183 people, including falls, pressure injuries, malnutrition, missed care, and lower self-reported
3184 quality of life. Inadequate staffing also drives unsustainable workloads that injure workers
3185 and accelerate turnover. There is, however, no universal staffing ratio that fits every setting:
3186 the right level depends on the acuity, complexity, and dependency of the people being cared
3187 for. Staffing decisions made without reference to assessed needs – for example by applying
3188 flat ratios irrespective of population characteristics – risk both unsafe under-staffing in high-
3189 needs services and inefficient over-staffing in lower-needs ones. Linking staffing to
3190 assessment also makes the system responsive to demographic and acuity shifts over time.
3191 National and subnational systems play different roles: some specify minimum staffing levels
3192 in regulation, others set expectations through funding mechanisms tied to assessed needs,
3193 and others rely on accreditation or inspection to verify adequacy. The principle in common is
3194 that staffing decisions should be informed by an explicit assessment of care needs rather
3195 than left implicit.

3196 **Implementation guidance**

3197 • Establish a method for translating assessed care needs into expected staffing levels,
3198 whether through validated acuity tools, dependency classification systems, or care-
3199 need-based funding.

3200 • Where minimum staffing requirements are set in regulation, communicate that these
3201 represent floors rather than optimal levels, with higher staffing required for services
3202 caring for people with higher acuity.

3203 3204 3205
- Apply staffing expectations across both residential and home-based services, recognizing that home-based services may need to express adequacy in terms of hours per care recipient and travel time rather than ratios on shift.

3206 3207
- Monitor staffing levels routinely against expected levels, and intervene where chronic understaffing is identified.

3208 3209
- Use workforce-planning data to project future staffing needs as the population ages and acuity rises.

Type	Indicative measure
Input	A defined method for relating staffing expectations to assessed care needs is in place, applicable to residential and home-based settings.
Process	Proportion of long-term care services routinely assessing care needs and adjusting staffing on that basis.
Output	Provider-level reporting of staffing relative to expected levels, by care setting and acuity.
Outcome	Staffing in long-term care services is aligned with assessed care needs across the system, with chronic understaffing identified and addressed.

3210 ***Quality Statement 15.2: Skill mix appropriate to needs***

3211 The skill mix of long-term care services includes professionally trained staff in proportions
3212 appropriate to the care needs of the population served, with arrangements in place for
3213 clinical and other professional input where required.

3214 **Rationale**

3215 Staffing quantity alone does not determine care quality; the alignment between skill mix and
3216 the needs of older people receiving care is consistently identified as a critical determinant of
3217 outcomes. Higher availability of professionally trained staff – particularly registered nurses –
3218 and a more favourable balance between licensed and unlicensed care workers are more
3219 consistently associated with improved safety indicators including reduced pressure injuries,
3220 falls, and avoidable hospitalizations. In residential settings, around-the-clock access to
3221 nursing oversight protects against deterioration in residents with complex health needs. In
3222 home-based services, even where most care is delivered by personal care workers, access
3223 to nursing, medical, and allied health input enables timely response to changes in clinical
3224 condition. Skill mix decisions should therefore reflect not only the average needs of the
3225 population but also the need for accessible higher-skilled input when situations change.

3226 **Implementation guidance**

3227 • Define expectations for skill mix in long-term care services, differentiated by setting
3228 and the acuity of the population served, covering personal care workers, nurses,
3229 physicians, and allied health and social work input.

3230 • In residential services for people with complex health needs, ensure access to
3231 registered nurse oversight on a continuous basis where feasible, with clearly defined
3232 arrangements for clinical input when not.

3233 • In home-based services, ensure that personal care workers have defined access to
3234 nursing, medical, and allied health input for care planning, clinical observation, and
3235 response to changes in condition.

3236 • Where workforce supply constraints make professionally trained staff scarce, define
3237 clear protocols for delegation, supervision, and escalation that maintain safety; do
3238 not treat unlicensed substitution as a permanent replacement for professional
3239 capacity.

3240 • Plan workforce development and training pipelines to address skill-mix gaps
3241 progressively over time.

Type	Indicative measure
Input	Skill-mix expectations for long-term care services are defined and reflect the acuity of the population served.
Process	Arrangements for nursing, medical, and allied health input to long-term care services are documented and operational, including in home-based settings.
Output	Composition of the long-term care workforce in residential and home-based services, including ratios of professionally trained to support staff.
Outcome	Older people with higher clinical needs receive timely professional input; safety indicators sensitive to skill mix improve over time.

3242 ***Quality Statement 15.3: Workloads enable person-centred care and sustainable work***

3243 Workloads of individual long-term care workers are organized to allow time for safe, person-
3244 centred care delivery – including time for communication, dignity in personal care, and
3245 observation of changes in condition – and to be sustainable for workers across their working
3246 lives.

3247 **Rationale**

3248 Even where overall staffing is adequate, the way workload is distributed at individual worker
3249 level shapes both care quality and worker well-being. Excessive workload – too many
3250 residents per shift, too many home visits per day, or schedules that combine direct care with
3251 administrative or domestic tasks without adequate time allocation – drives missed care,
3252 rushed personal care, and inability to notice early signs of deterioration. Workload pressures
3253 concentrate on tasks that are most easily measured (such as medication rounds and
3254 physical care) at the expense of tasks that are equally important but less visible (such as
3255 conversation, reassurance, and observation). Person-centred care depends on workers
3256 having time to know the people they care for, to respect individual preferences, and to
3257 respond to changing needs. Sustainable workloads also matter for workers themselves:
3258 chronic overwork drives injury, exhaustion, and attrition, with workers leaving the sector
3259 entirely when working lives become unmanageable.

3260 **Implementation guidance**

3261 • Establish workload expectations that reflect the full scope of care, including relational
3262 and observational components, not only discrete tasks.

3263 • In home-based care, ensure visit schedules include adequate time for travel between
3264 visits and for the actual care to be delivered without compression.

3265 • Avoid scheduling practices that concentrate workload pressures predictably – such
3266 as understaffed weekend or night shifts in residential services – without
3267 compensating arrangements.

3268 • Ensure continuity arrangements where feasible so that the same workers care for the
3269 same people over time, supporting both quality of care and worker satisfaction.

3270 • Use information from workers, older people, and incident data to identify points
3271 where workload pressures are degrading care or driving worker attrition, and adjust
3272 accordingly.

Type	Indicative measure
Input	Workload expectations for long-term care roles are defined and account for relational and observational components of care.
Process	Workforce scheduling practices in residential and home-based services support continuity and adequate time for person-centred care.
Output	Reported indicators of workload pressure (for example, missed care, rushed care, schedule overruns) are monitored at provider level.
Outcom	Older people report that long-term care workers have time to listen, respond,

Type	Indicative measure
e	and provide care with dignity; worker-reported workload sustainability improves over time.

3273 **Box 33.** *Country example: Brazil*

The municipality of Belo Horizonte has operated for over a decade a community-based long-term care scheme in lower-income neighbourhoods, funded through municipal resources. Care support workers are recruited from local communities and complete an initial customized training programme before deployment. Working at minimum wage, each care support worker is matched with a small number of families and provides between 10 and 40 hours of care support per week per family, calibrated to the care needs of the older person and the family's existing care capacity. Care support workers do not replace unpaid carers; they provide respite, build the care skills and confidence of family members, and contribute to personalized care plans agreed between the older person, the care support worker, and the family. The scheme is jointly supervised by staff from health and social assistance centres, with monthly interagency case reviews. Evaluations have found that the scheme improved care outcomes for dependent older people, eased carer burdens, and reduced unplanned health-service use, and the scheme has informed expansion supported by the Federal Ministry of Health.

3274 Standard 16: Working conditions, well-being, and rights

3275 *Long-term care workers have safe, fair, and supportive working conditions that recognize*
3276 *them as rights-holders entitled to dignity at work, including fair compensation, working*
3277 *environments that protect their physical and psychosocial well-being, and stable*
3278 *employment with meaningful voice in the organization of care.*

3279 **Overview**

3280 Long-term care workers are not only the means through whom care is delivered; they are
3281 people whose working lives matter in their own right. The conditions under which long-term
3282 care work is performed – pay, occupational health, psychosocial support, employment
3283 security, and the everyday experience of work – therefore matter both intrinsically (because
3284 workers are entitled to dignified, fairly remunerated work) and instrumentally (because they
3285 shape the workforce on which care quality depends). For older people and families, the
3286 working conditions of the workforce are also experienced indirectly through continuity,
3287 attentiveness, and morale; a workforce that is exhausted, exploited, or constantly turning
3288 over cannot sustain the care relationships that older people rely on.

This standard addresses fair compensation that reflects the value and demands of long-term care work (Quality Statement 16.1), safe and supportive working environments that protect both physical and psychosocial well-being (Quality Statement 16.2), and stable, secure, and dignified employment with meaningful voice in workplace decisions affecting care (Quality Statement 16.3).

Quality Statement 16.1: Fair compensation

Long-term care workers receive compensation that reflects the value, complexity, and demands of their work, with pay structures that are transparent and free from undervaluation linked to gender or migration status.

Rationale

Long-term care workers in many countries are paid substantially below average wages – international data show personal care workers in long-term care earning around two-thirds to three-quarters of average national hourly wages, and lower than comparable workers in acute care. Low pay drives high turnover, undermines retention of experienced workers, and discourages new entrants, weakening the workforce that systems depend on. Pay is also a marker of the value societies attach to long-term care work; persistently low pay signals that the work is undervalued, contributing to recruitment difficulties and to the gendered and racialized concentration of low-wage workers in the sector. Fair compensation does not require uniform global wage levels – local labour markets vary widely – but it does require that pay reflect the skill and responsibility of the role, that pay structures be transparent, and that pay equity be actively monitored across gender and migration status.

Implementation guidance

- Set or support pay levels for long-term care work that reflect the skill, responsibility, and physical and emotional demands of the role, in line with national wage-setting mechanisms.
- Address pay differentials between long-term care work and comparable work in acute or primary health care where these reflect undervaluation rather than legitimate differences in role.
- Promote transparent wage structures that make pay rates and progression criteria visible to workers and applicants.
- Monitor pay equity by gender, migration status, and other relevant dimensions, and act on identified gaps.
- Where unpaid or under-recognized care work is being formalized as paid roles, ensure that formalization is accompanied by fair pay rather than entrenching low-wage status.

Type	Indicative measure
Input	Pay levels for long-term care roles are set or guided by transparent mechanisms that reflect skill, responsibility, and demands of the role.
Process	Pay equity in the long-term care workforce is monitored by gender, migration status, and other relevant dimensions.
Output	Average and entry-level pay for long-term care roles, in absolute terms and relative to comparable roles in acute and primary care.
Outcome	Long-term care work attracts and retains workers; turnover and vacancy rates linked to pay are monitored and addressed.

3324 ### *Quality Statement 16.2: Safe and supportive working environment*

3325 Long-term care workers are protected from physical, infectious, and psychosocial
3326 occupational risks through workplace policies, training, equipment, and reporting systems,
3327 with accessible support for the emotional and psychosocial demands of long-term care
3328 work.

3329 **Rationale**

3330 Long-term care work exposes workers to physical risks (musculoskeletal injury from lifting
3331 and moving, slips and falls), infectious risks (close personal contact in multi-resident settings
3332 or intimate care), psychosocial risks (sustained emotional labour, exposure to behaviours
3333 linked to cognitive impairment, exposure to grief and dying, isolation in lone home-care
3334 work), and risks of violence and harassment by colleagues, care recipients, or family
3335 members. The COVID-19 pandemic exposed the consequences of inadequate occupational
3336 protections in long-term care, with disproportionately high rates of infection and death
3337 among workers. Protection from these risks is owed to workers as a matter of right; it also
3338 protects older people themselves, since workers who are injured, infected, or overwhelmed
3339 cannot provide safe care. Beyond preventing harm, supportive working environments
3340 include accessible support for the cumulative emotional and psychosocial demands of the
3341 work – peer support, employee assistance, and access to professional support when
3342 needed – particularly for workers caring for people at end of life, those exposed to grief and
3343 bereavement, and those working in isolation. The cumulative and gendered nature of
3344 emotional labour in long-term care should be recognized in how support is designed and
3345 made available.

3346 **Implementation guidance**

- Apply national occupational health and safety frameworks fully to the long-term care workforce, including workers in home and community-based care and those working through informal or non-standard employment arrangements.
- Provide equipment and training for safe moving and handling, infection prevention and control, and management of behaviours linked to cognitive impairment.
- Establish accessible incident reporting systems for workplace injuries, infections, violence, and harassment, with non-punitive use of reports to drive improvement.
- Address psychosocial risks systematically, including emotional workload, exposure to grief and dying, isolation in home-based work, and risks of bullying or harassment by colleagues, care recipients, or family members.
- Provide accessible peer support, employee assistance, or equivalent professional support, including for workers in home-based or community-based arrangements, and pay particular attention to the support needs of workers facing acute or sustained emotional distress.
- Plan for occupational health protections in disease outbreaks and emergencies, drawing on the lessons of the COVID-19 pandemic.

Type	Indicative measure
Input	National occupational health and safety frameworks explicitly cover long-term care workers across all settings and employment arrangements; arrangements for psychosocial support are in place.
Process	Provider-level systems for reporting and acting on workplace injury, infection, violence, and harassment are operational; peer support and professional support are accessible to workers.
Output	Reported rates of workplace injury, infection, and harassment incidents in the long-term care workforce; coverage of peer and professional support arrangements.
Outcome	Long-term care workers are protected from preventable occupational and psychosocial harm; sickness absence, injury-related attrition, and emotional-distress-linked attrition are monitored and reduced over time.

Quality Statement 16.3: Stable, secure, and dignified employment

Long-term care workers are employed under stable contractual arrangements with access to social protection, with meaningful voice in workplace decisions affecting care delivery, and with protections that recognize them as rights-holders.

Rationale

Beyond pay and physical safety, the terms and texture of employment shape both worker well-being and care quality. Insecure contracts, fluctuating hours, and exclusion from decisions about care delivery are consistently associated with higher turnover, lower job satisfaction, and reduced care continuity. Long-term care work has historically relied heavily on part-time, casual, and non-standard employment arrangements, often concentrated among women and migrant workers, with limited access to social protection, sick leave, parental leave, or pension entitlements. These arrangements weaken the workforce as a whole and disadvantage particular groups within it. Worker voice in the organization of care – through participation in care planning, team meetings, and feedback mechanisms – also matters as a matter of right and as a practical contribution to care quality: hierarchical structures that exclude direct care workers from decision-making waste their daily knowledge of the people they care for and contribute to the sense of being undervalued that drives attrition.

Implementation guidance

- Move long-term care employment progressively toward stable contractual arrangements with predictable hours and access to social protection, sick leave, parental leave, and pension entitlements.
- Where non-standard employment arrangements are used, ensure they do not exclude workers from core protections; address the use of casual or zero-hours contracts where these are functioning to externalize labour-market risk to workers.
- Establish mechanisms for worker voice in workplace decisions affecting care delivery, including involvement in care planning, team meetings, and improvement initiatives.
- Recognize and support the role of unions, professional associations, and worker representatives in long-term care.
- Pay particular attention to employment terms for workers in groups historically subject to less favourable arrangements, including migrant workers and workers entering through informal routes.

Type	Indicative measure
Input	Frameworks governing long-term care employment provide for stable

Type	Indicative measure
	contractual arrangements, predictable hours, and access to social protection.
Process	Mechanisms for worker voice in care planning and workplace decisions are operational at provider level.
Output	Distribution of long-term care employment by contract type, hours, and access to social protection.
Outcome	Long-term care workers report stable, secure employment and meaningful involvement in workplace decisions; turnover linked to employment instability is reduced.

3396 **Box 34.** *Country example: Germany*

Working conditions for long-term care workers in Germany are shaped by the long-term care insurance system (Pflegeversicherung) introduced in 1995, which establishes pay, training, and employment expectations that providers must meet to participate. Following sustained debate over pay levels and working conditions in the care sector, Germany has progressively strengthened pay floors for long-term care work, including the requirement from 2022 that providers pay either according to a collective agreement or at a level equivalent to a regional collective agreement to qualify for long-term care insurance reimbursement. Vocational training pathways were unified in 2020 across nursing, geriatric care, and paediatric nursing, providing a common professional foundation. The system also relies substantially on migrant workers – in 2021 around 13 per cent of the long-term care workforce held foreign nationality – and workplace and employment protections under federal labour law apply across the workforce regardless of national origin. Persistent challenges include staff shortages, retention, and the need to extend protections to the substantial informal home-care workforce.

3397 Standard 17: Supervision, teamwork, and accountability

3398 *Long-term care workers receive ongoing supervision and reflective practice support, work in*
3399 *teams that enable communication and care coordination across roles and sectors, and*
3400 *operate under clear standards of conduct with safeguarding mechanisms and accessible*
3401 *channels through which concerns can be raised by workers, older people, or families*
3402 *without fear of reprisal.*

3403 **Overview**

Long-term care depends on relationships: between supervisor and worker, among workers in a care team, between staff in different services and sectors, and between workers and the older people they care for. These relationships are the day-to-day mechanisms through which care quality is sustained or eroded. Supervision provides the channel through which workers receive guidance, develop reflective practice, and have their conduct overseen. Teamwork and care coordination connect workers to each other and to staff across health and social services, supporting integrated care for older people whose needs span both. Accountability mechanisms – including clear standards of worker conduct, safeguarding, and channels for raising concerns – protect older people from abuse and neglect, protect workers from exploitation and harassment, and surface problems early enough to address them.

This standard addresses how supervision and reflective practice are structured (Quality Statement 17.1), how teamwork, communication, and care coordination among workers and across services are supported (Quality Statement 17.2), and how worker conduct, safeguarding, and channels for raising concerns operate (Quality Statement 17.3).

Quality Statement 17.1: Supervision and reflective practice

Long-term care workers receive regular supervision from appropriately qualified supervisors, structured to include both oversight of care quality and conduct and opportunities for reflective practice on the experience of caring.

Rationale

Supervision serves multiple purposes simultaneously: it provides oversight of care quality and worker conduct; it supports professional development through reflection on practice; and it offers an accessible source of guidance for workers facing clinical, ethical, or relational challenges. Evidence consistently associates structured supervision with improvements in care processes, lower staff burnout, and higher retention. Without the reflective dimension, supervision can collapse into compliance checking; without the oversight dimension, it can lose its connection to accountability for care quality and conduct. Both are needed. Supervision is particularly important in long-term care because much of the work is performed in private homes or away from continuous oversight, by workers carrying significant emotional and clinical responsibility. Effective supervision systems depend on identifying who supervises whom, equipping supervisors for the role, ensuring time for supervision is protected from being absorbed by direct care, and adapting supervision to the realities of community-based and home-care contexts.

Implementation guidance

- Define supervision expectations for each long-term care role, including frequency, format, and the qualifications expected of supervisors.

3440 • Equip supervisors for the supervisory role through training in supervision skills,
3441 reflective practice, feedback, and oversight of conduct, and protect supervisor time
3442 from being absorbed by direct care responsibilities.

3443 • Build reflective practice into supervision arrangements, with structured opportunities
3444 to discuss the experience of caring, ethical complexity, and difficult interactions.

3445 • Adapt supervision to home-based and community-based work, including scheduled
3446 in-person supervision, joint home visits, and remote supervision where appropriate.

3447 • In settings where supervision is shared across organizations – for example where
3448 long-term care services are jointly delivered by health and social assistance
3449 agencies – establish interagency supervision arrangements, including joint case
3450 reviews.

3451 • Document supervision arrangements at provider level so that gaps and patterns of
3452 inadequate oversight can be identified and addressed.

Type	Indicative measure
Input	Supervision expectations for long-term care roles are defined, including frequency, format, supervisor qualifications, and reflective-practice components.
Process	Proportion of long-term care workers receiving scheduled supervision at the defined frequency, including reflective practice elements.
Output	Provider-level reporting of supervision arrangements, including arrangements for home-based and community-based workers and interagency supervision where applicable.
Outcome	Long-term care workers report receiving timely, useful supervision; supervision is associated with sustained care quality and reduced burnout.

3453 ***Quality Statement 17.2: Teamwork, communication, and care coordination***

3454 Long-term care workers work in teams that enable communication, peer support, and care
3455 coordination across roles, settings, and sectors, including across health and social care.

3456 **Rationale**

3457 Long-term care is rarely delivered by a single worker in isolation. In residential settings,
3458 personal care workers, nurses, allied health staff, supervisors, and physicians share
3459 responsibility for residents across shifts and across professional boundaries. In home-based
3460 care, a single older person may receive support from a personal care worker, a community

nurse, a social worker, unpaid carers, and a primary care doctor – each of whom holds different information about the person and contributes different expertise. Without effective teamwork and communication, this fragmentation produces gaps and contradictions in care, missed observations, and exhausting demands on unpaid carers to coordinate the system themselves. With effective teamwork, the same diversity of input becomes integrated care: information shared across handovers, observations communicated to those who need them, decisions made with the right professional input, and workers supported by peer relationships that sustain well-being as well as practice. Teamwork also matters across health and social sectors, where structural separation often hinders integrated care for older people whose long-term care needs span both. Building teamwork is therefore not optional flavour on top of staffing arrangements; it is the operational mechanism through which care for individual older people becomes coherent.

Implementation guidance

- Establish team structures with explicit roles, communication routines (such as handovers, briefings, case discussions), and shared documentation, in both residential and home-based services.
- Ensure team structures span health and social care where care recipients have needs across both sectors, with named coordinating roles such as case managers where appropriate.
- Recognize personal care workers as full members of the care team, including their daily knowledge of the people being cared for, in care planning and team discussions.
- Provide time and protected space for team-based working, including handover periods between shifts in residential services and case-discussion time in home-based services.
- In home-based and community-based services where workers may rarely meet face to face, establish digital and asynchronous channels that enable communication without imposing additional unpaid time on workers.
- Pay attention to peer relationships between workers as a source of practical support and well-being alongside structural arrangements for team-based work.

Type	Indicative measure
Input	Team structures, communication routines, and shared documentation are defined for long-term care services across residential and home-based settings.

Type	Indicative measure
Process	Care for older people with needs spanning health and social sectors is organized through interdisciplinary teams with named coordinating roles.
Output	Provider-level evidence of team-based working, including handover, case-discussion, and interdisciplinary coordination practice.
Outcome	Older people experience coordinated care across workers and sectors; workers report meaningful team-based working and peer support.

3491 3492 ### *Quality Statement 17.3: Worker conduct, safeguarding, and channels for raising concerns*

3493 Long-term care services maintain clear standards of worker conduct including the prohibition
3494 of abuse, neglect, and exploitation of older people, supported by safeguarding mechanisms
3495 and accessible channels through which workers, older people, and families can raise
3496 concerns without fear of reprisal.

3497 **Rationale**

3498 The vast majority of long-term care workers approach their work with care and
3499 professionalism. The conditions under which long-term care is delivered, however – close
3500 personal contact, often behind closed doors, with people whose dependency limits their
3501 ability to report problems – create heightened risks of abuse, neglect, and exploitation, and
3502 require explicit safeguards. Worker conduct standards should make clear that abuse,
3503 neglect, and exploitation of older people are incompatible with the role, supported by
3504 training, supervision, and accountability when they occur. Safeguarding mechanisms should
3505 be in place to detect and respond to concerns, including those raised by other workers,
3506 older people themselves, and families. At the same time, workers themselves are exposed
3507 to harassment, abuse, and reprisal – by colleagues, supervisors, employers, care recipients,
3508 or family members. Accessible channels for raising concerns are therefore needed for
3509 concerns flowing in both directions: from older people and families about worker conduct or
3510 other care concerns, and from workers about care quality, safeguarding of older people,
3511 their own working conditions, or harassment. Channels should be independent of immediate
3512 supervisors, provide whistleblower protection, and be accessible to workers across
3513 employment arrangements. Bringing both directions together in a single mechanism reflects
3514 the reality that the same workplace conditions that enable abuse of older people often
3515 coexist with conditions that silence workers; addressing one without the other is incomplete.

3516 **Implementation guidance**

3517 3518 3519
- Establish clear standards of worker conduct, including a duty of care, rights-based and person-centred practice, and explicit prohibition of any form of abuse, neglect, or exploitation of older people.

3520 3521 3522
- Embed conduct standards in induction, training, supervision, and provider-level expectations, with proportionate consequences applied where conduct standards are breached.

3523 3524 3525
- Maintain accessible safeguarding mechanisms that respond to concerns about the safety of older people, including concerns raised by other workers, by older people themselves, and by families, with timely investigation and response.

3526 3527 3528 3529
- Establish clear, accessible channels for workers to raise concerns about care delivery, safeguarding of older people, working conditions, and harassment – including channels independent of immediate supervisors, with whistleblower protection and assurance of follow-up.

3530 3531 3532
- Ensure these channels are accessible across employment arrangements (including part-time, casual, agency, and migrant workers), and communicate their existence through induction and continuing training.

3533 3534
- Document and review the use of safeguarding and concern-raising mechanisms to identify systemic issues and drive system-level improvement.

Type	**Indicative measure**
Input	Worker conduct standards prohibiting abuse, neglect, and exploitation of older people are formally adopted; safeguarding mechanisms and concern-raising channels are established.
Process	Conduct standards are embedded in induction, training, and supervision; safeguarding and concern-raising channels are accessible and communicated to workers, older people, and families.
Output	Documented use and follow-up of safeguarding mechanisms and concern-raising channels at provider and system level.
Outcome	Older people are protected from abuse, neglect, and exploitation; workers report confidence that concerns can be raised safely and acted upon; safeguarding, quality, and working-condition problems are surfaced earlier.

3535 **Box 35.** *Country example: Thailand*

Thailand's long-term care policy for dependent older people, established in 2016, illustrates how supervision and team-based working can be embedded in a long-term care workforce delivered through the primary health care platform. Care workers are recruited at the subdistrict level, complete a structured training programme, and are deployed under the supervision of subdistrict health-promoting hospitals. Each care worker is supervised by a care manager – typically a nurse – who is responsible for assessment, care planning, and clinical input, and who coordinates the care worker's work with other team members including the long-standing village health volunteer network active since the late 1970s. The team-based structure brings together formal long-term care, primary health care, and community-level workforce in a coordinated model: the care manager provides clinical and supervisory continuity; care workers provide regular hands-on support to dependent older people in their homes; and the village health volunteer network supports outreach and community linkage. The integration with the primary health care platform also enables continuity between long-term care services and other primary health care for older people, with shared supervision and information across the team.

3536 ## Standard 18: Workforce profile considerations

3537 *Systems address the specific needs and protections required for distinct groups within the*
3538 *long-term care workforce, including women, migrant care workers, and young workers,*
3539 *alongside structural pathways into the sector.*

3540 **Overview**

3541 The long-term care workforce is shaped by who does the work – predominantly women in
3542 most countries, increasingly migrant workers in many, and frequently entered via under-
3543 recognized informal routes. Aggregate workforce policies do not always reach the specific
3544 needs and risks faced by these groups. For older people and families, the profile of the
3545 workforce is reflected directly in the composition of the staff who provide their care; for
3546 workers, it determines whether the protections set out in Standards 1 to 4 reach them in
3547 practice or stop at the margins of the formal workforce.

3548 This standard addresses gender equity in the long-term care workforce (Quality Statement
3549 18.1), protections and conditions for migrant care workers (Quality Statement 18.2), and
3550 pathways for younger workers entering the sector (Quality Statement 18.3). Workforce
3551 profile considerations apply across all settings and intersect with the standards on training,
3552 staffing, working conditions, and supervision.

3553 ### *Quality Statement 18.1: Gender equity*

3554 The long-term care workforce is supported by policies that promote gender equity, including
3555 pay equity, freedom from discrimination and harassment, work–life balance, and fair access
3556 to leadership and progression.

3557 **Rationale**

3558 The long-term care workforce is overwhelmingly female in most countries. Where care work
3559 is concentrated among women, undervaluation of the work is intertwined with broader
3560 patterns of gender-based wage gaps, unequal distribution of unpaid care, and limited
3561 access to leadership. Gender-blind workforce policies risk reproducing these patterns.
3562 Gender equity in long-term care therefore requires both general protections – pay equity,
3563 freedom from discrimination and harassment – and targeted attention to the conditions that
3564 disproportionately shape women's experience of the workforce, including work–life balance,
3565 maternity protection, and access to progression. Gender equity in the workforce is also
3566 linked to gender equity in care recipients' experience: a workforce that is supported and
3567 respected is better placed to deliver dignified, person-centred care.

3568 **Implementation guidance**

3569 • Apply pay-equity frameworks to long-term care work, ensuring equal pay for work of
3570 equal value and active monitoring of gender pay gaps in the sector.

3571 • Provide effective protection from discrimination and harassment in the long-term care
3572 workplace, including from colleagues, care recipients, and family members.

3573 • Support work–life balance through scheduling practices, maternity protection,
3574 parental leave, and family-friendly arrangements that recognize the disproportionate
3575 share of unpaid care responsibilities carried by women.

3576 • Promote fair access to progression and leadership roles, addressing barriers
3577 identified in workforce data.

3578 • Integrate gender analysis into workforce planning, including disaggregated
3579 monitoring of pay, working conditions, and progression.

Type	Indicative measure
Input	Pay-equity, anti-discrimination, and work–life balance frameworks apply explicitly to the long-term care workforce.
Process	Gender-disaggregated monitoring of pay, working conditions, and progression is in place across the sector.
Output	Reported gender pay gap, gender distribution at supervisory and leadership

Type	Indicative measure
	levels, and incidence of harassment in the long-term care workforce.
Outcome	Gender equity in the long-term care workforce improves over time, with progress visible in pay, conditions, and progression.

3580 ### *Quality Statement 18.2: Protections for migrant care workers*

3581 Migrant care workers in the long-term care workforce are protected by ethical recruitment,
3582 clear and enforceable employment terms, occupational and rights protections equivalent to
3583 those of domestic workers, and access to language and integration support.

3584 **Rationale**

3585 In some settings, migrant domestic workers and live-in care workers provide substantial
3586 long-term care under arrangements that sit between unpaid family care (Chapter 4),
3587 domestic work and formal long-term care employment. These workers should not be missed
3588 between Chapters 4 and 5: where their work meets the definition of long-term care work in
3589 this chapter, the protections, training, supervision, safeguarding and quality-of-care
3590 expectations set out here apply to them, regardless of contract form. Migrant workers
3591 represent a substantial and growing proportion of the long-term care workforce in many
3592 countries, with the share of foreign-born workers in long-term care in OECD countries rising
3593 from 14 per cent to 21 per cent between 2014 and 2024, and with high concentrations in
3594 residential and home care. Migrant care workers fill genuine workforce gaps and contribute
3595 substantially to care quality and continuity, particularly in countries facing persistent
3596 shortages. They also face distinctive risks: predatory recruitment practices that impose debt
3597 or fees on workers; employment terms that link visa status to a single employer, increasing
3598 vulnerability to abuse; language and cultural barriers that limit access to redress; and live-in
3599 arrangements that blur the boundaries between work and personal life. Protections for
3600 migrant care workers are therefore needed across recruitment, employment, occupational
3601 health, and integration. Ethical recruitment frameworks that prohibit fees on workers, require
3602 transparent terms, and provide for verification of language competence have been
3603 established in some countries; broader application of these principles is needed to protect
3604 migrant care workers internationally.

3605 **Implementation guidance**

3606 • Adopt and enforce ethical recruitment frameworks for migrant care workers, including
3607 prohibition on charging recruitment fees to workers, transparent employment terms in
3608 advance of recruitment, and verification of qualifications.

3609 3610 3611
- Ensure that employment terms for migrant care workers provide protections equivalent to those of domestic workers, including access to occupational health and safety, social protection, and channels for raising concerns.

3612 3613 3614
- Avoid visa or work-permit arrangements that tie workers to a single employer in ways that increase vulnerability to abuse; provide pathways for workers to change employer where necessary.

3615 3616
- Provide language support, cultural induction, and integration support to migrant care workers entering long-term care.

3617 3618
- Pay particular attention to live-in care arrangements, where work–life boundaries, working hours, and protections require explicit definition and enforcement.

Type	Indicative measure
Input	Ethical recruitment and employment frameworks for migrant care workers are in place, prohibiting fees on workers and requiring transparent terms.
Process	Employment, occupational, and rights protections apply to migrant care workers on terms equivalent to those of domestic workers.
Output	Reported indicators of recruitment practice, employment terms, and access to redress for migrant care workers.
Outcome	Migrant care workers report protected, fair employment; abuses linked to recruitment or contractual ties to a single employer are surfaced and addressed.

3619
Quality Statement 18.3: Pathways for young workers

3620 3621 3622
Structured pathways exist for young workers entering the long-term care workforce, including recognized training routes, age-appropriate employment protections, and clear opportunities for career development.

3623
Rationale

3624 3625 3626 3627 3628 3629 3630
Population ageing increases demand for long-term care while shrinking the working-age population in many countries, making pathways for younger entrants into the workforce strategically important. Evidence on workforce development indicates that structured pathways combining education with paid work experience – apprenticeships, school-to-work transitions, and supervised practical training – improve early labour-market attachment and skills acquisition, and provide more stable entry-level workforce supply. At the same time, young workers in long-term care need explicit protections: international labour standards

recognize that younger workers may face heightened risks from physical and emotional demands of care, and that hours, supervision, and exposure to occupational risks should be calibrated accordingly. The absence of clear career progression also drives early attrition among younger workers; structured career ladders, mentoring, and continuing education pathways are associated with longer retention and stronger occupational identity.

Implementation guidance

- Develop recognized training and apprenticeship pathways for young workers entering the long-term care workforce, combining structured instruction with supervised practical experience.
- Apply age-appropriate employment protections in line with international labour standards, including limits on hazardous tasks, working hours, and unsupervised practice for younger workers.
- Establish career progression structures that enable young workers to advance through additional training and credentialing, with mentoring and continuing education support.
- Communicate long-term care careers in schools, training institutions, and career services in terms that reflect the skill, value, and progression opportunities of the work.
- Monitor entry, retention, and progression of younger workers as part of overall workforce planning.

Type	Indicative measure
Input	Recognized training or apprenticeship pathways for young workers in long-term care are established, with age-appropriate employment protections.
Process	Younger workers entering the long-term care workforce receive structured training, supervision, and progression opportunities.
Output	Entry, retention, and progression rates for younger workers are monitored across the long-term care workforce.
Outcome	Younger workers enter and remain in the long-term care workforce in numbers sufficient to support workforce sustainability; early attrition is reduced over time.

4. Implementation considerations

Workforce constraints span every long-term care system. They take different forms – chronic shortages of professionally trained staff in some countries, undervaluation and high turnover in others, dependence on migrant or informal labour in many – but the commonality is that no country has a fully resourced long-term care workforce that does not also face structural challenges. The standards in this chapter are therefore presented as directions of progressive realization rather than thresholds to be achieved at a single point in time.

Several considerations shape implementation across diverse settings.

Progressive realization across system maturity. Long-term care systems differ widely in how far they have developed formal workforce policy. In settings where formal long-term care provision is at an early stage, foundational priorities include defining basic competencies, establishing minimum training requirements, and bringing care workers within the protections of national labour law. In more mature systems, attention can extend to advanced competencies, structured supervision and reflective practice, integrated team-based care across health and social sectors, and pay equity. The standards apply across this spectrum; what varies is the starting point and the sequencing.

Adaptation to labour-market conditions. Workforce supply and labour-market conditions differ substantially across countries and regions, and these conditions shape which workforce strategies are feasible. In some settings, formalization of existing community-level care roles is a higher-leverage path than expansion of professional training; in others, migration is a structural feature that requires explicit ethical management; in others again, demographic constraints drive an early focus on younger entrants and retention. Implementation should be informed by an explicit understanding of the labour-market context, rather than transposing strategies designed for different conditions.

Avoiding binary framings. Workforce challenges do not divide cleanly along income lines. Pay undervaluation, gendered concentration of care work, dependence on migrant labour, and difficulties recruiting younger workers all appear across high-, middle-, and low-income settings. Implementation guidance should therefore describe the constraints and adaptations that apply in particular contexts – community-based deployment where formal facility infrastructure is limited, language and cultural support where migrant workers are concentrated, formal recognition pathways where care work is presently informal – rather than assigning standards to particular country types.

Coherence across system functions. Workforce standards interact closely with governance, financing, and quality monitoring. Training requirements depend on financing for training places, instructor capacity, and paid release time. Pay levels depend on financing arrangements that recognize the cost of fair compensation. Supervision and team-based working depend on governance structures that give clarity over who supervises whom and which agencies share responsibility for integrated care across health and social sectors. Quality monitoring depends on workforce data infrastructure to know who is working

3690 where, in which roles, with what training. Coordinated implementation across these system
3691 functions is essential.

3692 **Engagement of workers, older people, and families.** Workforce standards are unlikely to
3693 be effectively implemented without the engagement of workers, their representatives, and
3694 the organizations that train, employ, and supervise them, alongside meaningful input from
3695 older people and families. Mechanisms for voice – at provider level, in policy development,
3696 and in monitoring – improve both the realism and the legitimacy of workforce policy.

3697 **Key enablers**

3698 Across these considerations, several enabling conditions support implementation:

3699 • Workforce data infrastructure, including registries and routine reporting, that supports
3700 planning, monitoring, and pay-equity analysis.

3701 • Education-sector linkages, including training institutions and credentialing bodies that
3702 can deliver competencies aligned with care needs.

3703 • Financing mechanisms that recognize the cost of fair pay, training, paid release time,
3704 and supervision and team-based working capacity.

3705 • Regulatory frameworks that bring all categories of long-term care work – including
3706 informal and home-based work – within the scope of protections.

3707 • Cross-sectoral coordination between health, social protection, labour, and education
3708 sectors, supporting integrated team-based care for older people whose needs span
3709 health and social services.

3710

3711 # Chapter 6. Financing

3712 **Table 11.** *Standards and quality statements: Chapter 6, Financing*

Standard	Quality statements
Standard 19. Coverage of entitlements	**19.1** Defined public entitlement **19.2** Coordination across publicly financed programmes **19.3** Periodic review of financed scope
Standard 20. Needs-oriented allocation	**20.1** Needs-based assessment for eligibility **20.2** Graded benefits across severity and settings **20.3** Periodic review of eligibility, benefits and contributions
Standard 21. Shared responsibility	**21.1** Pooled financing across multiple actors **21.2** Capacity-aligned contributions
Standard 22. Equity	**22.1** Income-related contributions and co-payments **22.2** Geographic equity of entitlements
Standard 23. Financial protection	**23.1** Protection from catastrophic costs **23.2** Protection for those with limited resources
Standard 24. Adequacy and quality alignment	**24.1** Funding adequate to deliver quality standards **24.2** Funding for care complexity **24.3** Financing supports quality improvement and accountability

3713 ## 1. Introduction

This chapter establishes standards for the financing of long-term care. It addresses two related questions: what makes long-term care financing arrangements themselves equitable, adequate, and sustainable; and how financing should be structured to make the entitlements established in the other chapters of these standards real for older people and their families.

Scope. This chapter therefore has a dual scope. First, it addresses how long-term care financing arrangements should themselves be designed: how resources are mobilized, pooled, allocated, and used, and how older people and their families are protected from catastrophic costs (the “quality of financing” perspective). Second, it addresses the level and structure of public funding required to make deliverable the workforce, services, infrastructure, and support to unpaid carers established as entitlements elsewhere in this document (the “financing of quality” perspective). These two perspectives are interdependent: financial protection for care recipients is itself a dimension of quality, and adequate, well-designed financing is the means by which the other quality standards become attainable in practice.

What this chapter means for older people, families, and unpaid carers. A well-designed long-term care financing system should ensure that:

- older people receive the long-term care they need, regardless of their ability to pay;
- the scope of services and supports that public financing covers is clearly defined and made known, so older people and their families understand what they are entitled to;
- the cost of long-term care does not fall predominantly on older people, their families, and unpaid carers, and the unpaid contribution of unpaid carers – predominantly women – is recognized and supported rather than relied on as a hidden substitute for public financing;
- older people can choose the care setting that best fits their needs and preferences, without being pushed in one direction by how financing is structured;
- older people and their families are protected from catastrophic costs and from impoverishment due to long-term care; and
- funding for providers is adequate to deliver the quality of care to which older people are entitled.

The standards that follow set out what governments, regulators, and providers should do to make these expectations real, and what older people, families, unpaid carers, and their representative organizations can expect and claim.

Relationship to other chapters. Financing arrangements operate within the institutional framework and stewardship responsibilities established in the Governance chapter, and draw on the performance measurement, public reporting, and improvement mechanisms

3750 established in the Quality Monitoring chapter — both of which provide the basis on which
3751 financing can be linked to quality. Financing also conditions what is achievable under the
3752 Workforce, Home and Community-based Care, Long-Term Care Facilities, and Carers
3753 chapters; the standards in this chapter are intended to support the entitlements set out in
3754 those chapters rather than duplicate them.

3755 2. Background

3756 **Global situation.** Formal long-term care financing arrangements vary widely across
3757 Member States. A relatively small group of countries operates mature, dedicated long-term
3758 care financing schemes, mostly through social insurance, tax-funded universal coverage, or
3759 mixed models, with the bulk of these concentrated in Europe and East Asia. Most other
3760 countries finance long-term care through fragmented combinations of out-of-pocket
3761 payments, social assistance, disability benefits, and unpaid family caregiving, with limited
3762 risk-pooling. In low- and middle-income countries, formal long-term care financing is often
3763 absent, narrowly targeted, or restricted to social assistance for the lowest-income groups,
3764 and households bear the bulk of care costs directly or indirectly through forgone income for
3765 unpaid carers. Population ageing, rising prevalence of dementia and multimorbidity,
3766 changes in family structure, and labour-market participation by women – historically the
3767 primary providers of unpaid care – are increasing demand for long-term care across all
3768 income groups *(72, 73, 74)*.

3769 **Key challenges.** Long-term care financing faces challenges that distinguish it from health
3770 financing more broadly. Long-term care needs are often prolonged and unpredictable in
3771 duration, generating exposure to catastrophic costs over many years rather than discrete
3772 episodes. Services span health and social sectors, which are typically financed and
3773 governed separately, so that financing fragmentation translates directly into service
3774 fragmentation for care recipients and their families. A large share of care is provided by
3775 unpaid carers, predominantly women, whose contribution is rarely recognized in national
3776 health and care expenditure accounts but generates substantial fiscal externalities through
3777 reduced labour-market participation and forgone tax revenue. Many countries lack basic
3778 data on long-term care expenditure, utilization, and unmet need, making it difficult to design
3779 financing arrangements grounded in actual demand. And because long-term care has
3780 historically been treated as a residual claim on public budgets – funded only after acute
3781 health and pension obligations – long-term care financing in many systems is more
3782 vulnerable to short-term fiscal pressure than other social-protection commitments *(72, 73,*
3783 *75, 76)*.

3784 **Why this matters.** The way long-term care is financed shapes what older people and their
3785 families experience: whether they receive the care to which they are entitled; whether they
3786 are protected from catastrophic costs; whether they can choose the care setting that fits
3787 their lives; and whether the workforce providing their care has the resources to do so well.

Financing affects workforce capacity, infrastructure quality, service availability, and access to care, and the scope and design of public financing determines whether the entitlements set out in this document are real or notional. Standards for long-term care that are not matched by financing arrangements adequate to deliver them risk undermining the legitimacy of the standards themselves.

3. Standards

Standard 19: Coverage of entitlements

Public long-term care financing covers the services and supports that older people are entitled to under these standards, with the scope explicitly defined, periodically reviewed, and coordinated with adjacent publicly financed programmes.

Quality Statement 19.1: Defined public entitlement

Older people have a clear, publicly defined entitlement to long-term care services and supports, with public financing aligned to deliver the entitlements set out in these standards.

Rationale

Standards establish what older people are entitled to expect from a long-term care system. Whether those entitlements are actually deliverable depends on whether the scope of public financing matches them. A long-term care entitlement that is established in policy or legislation but not backed by public financing – for example, a stated right to home modifications, assistive products, or respite care without a corresponding budget line – leaves the practical burden with older people and their families. Mature long-term care systems therefore define the scope of publicly financed services and supports explicitly, in legislation or formal regulation, and align that scope with the substantive entitlements set out in their long-term care policy framework. Where new entitlements are introduced or strengthened, the matching financing scope is identified at the same time, rather than being left as a residual question. Public visibility of the financed scope is itself part of the entitlement: older people and their families need to know what they can claim, through what process, and from which authority, in order to exercise their rights.

Implementation guidance

- Define the scope of publicly financed long-term care in legislation or formal regulation, covering services and supports across home and community settings, residential settings, and support to unpaid carers.
- Align the financed scope explicitly with the entitlements set out in the Home and Community-based Care, Long-Term Care Facilities, Workforce, and Carers chapters

3822 of these standards, including services, assistive products, home modifications,
3823 respite, and information and case-management functions.

3824 • Where central and subnational governments share responsibility for financing, define
3825 their respective contributions in legislation or formal agreement, so that the scope
3826 does not depend on subnational fiscal capacity.

3827 • Make the financed scope publicly accessible in plain language, alongside information
3828 on how older people and their families can exercise their entitlements.

3829 • Where existing financing scope falls short of the entitlements established in policy,
3830 set out a public trajectory for closing the gap.

3831 **Indicative measures**

Type	Indicative measure
Input	A defined scope of publicly financed long-term care, codified in legislation or regulation and aligned with substantive entitlements
Process	The financed scope is reviewed against substantive entitlements when entitlements are introduced or revised; gaps are addressed through defined trajectories
Output	Public, plain-language information on the financed scope and how to access it, alongside expenditure data showing actual coverage of entitled services
Outcome	Older people and their families can exercise their entitlements in practice; the gap between policy entitlements and financed scope narrows over time

3832 ***Quality Statement 19.2: Coordination across publicly financed programmes***

3833 Where older people's long-term care needs are addressed through multiple publicly
3834 financed programmes – including health, social protection, housing, and disability –
3835 coordination ensures continuous and integrated coverage for individual care recipients and
3836 their families.

3837 **Rationale**

3838 In most countries, the services and supports that older people need to live well with care
3839 needs are not financed by a single programme. Health insurance covers some elements;
3840 social protection programmes cover others; housing and disability programmes may cover
3841 home modifications, accessibility supports, or income protection for unpaid carers. The
3842 boundaries between these programmes are often invisible to the older person and their
3843 family but generate real consequences: services that fall in the gaps between programmes

3844 go unfunded, and benefits that fall in the overlaps are duplicated or contested. Coordination
3845 across publicly financed programmes – at the design, eligibility-determination, and delivery
3846 stages – is therefore not a residual administrative concern but a substantive condition for
3847 older people to receive continuous and integrated coverage. This is particularly important for
3848 home-based care, where housing, health, social services, and disability supports often need
3849 to operate together for a single care recipient.

3850 **Implementation guidance**

3851 • Map the publicly financed programmes that contribute to long-term care coverage in
3852 each Member State, identifying scope, eligibility, and points of coordination or
3853 fragmentation.

3854 • Establish coordination mechanisms – joint eligibility assessment, shared case
3855 management, agreed financial responsibility for cross-programme services – so that
3856 older people do not have to navigate multiple systems separately.

3857 • Where home modifications, assistive products, or accessibility supports are needed
3858 for older people receiving home-based care, ensure that responsibility for financing is
3859 clearly assigned, whether to long-term care, housing, disability, or a coordinated
3860 arrangement.

3861 • Provide a single accessible point of information and application where possible, even
3862 where multiple programmes finance the underlying services.

3863 • Monitor coverage gaps and overlaps at programme boundaries and use the findings
3864 to adjust programme design and coordination arrangements.

3865 **Indicative measures**

Type	Indicative measure
Input	Documented mapping of publicly financed programmes contributing to long-term care, with coordination arrangements at programme boundaries
Process	Joint or coordinated assessment, case management, and financing arrangements operate at programme boundaries
Output	Single accessible information and application points for older people and families; documented resolution of cross-programme cases
Outcome	Older people experience continuous coverage across publicly financed programmes; gaps and double-coverage at programme boundaries decline over time

3866 ### *Quality Statement 19.3: Periodic review of financed scope*

3867 The scope of publicly financed long-term care is reviewed and updated as care needs and
3868 entitlements evolve.

3869 **Rationale**

3870 The scope of long-term care that older people need is not fixed. Demographic change,
3871 advances in assistive technology, evolving understanding of dementia and cognitive
3872 impairment, and progress in home-based care models all reshape what should reasonably
3873 fall within the financed scope of long-term care. Financing scope that is set once at
3874 programme inception drifts progressively out of alignment with what older people are entitled
3875 to expect. Mature systems therefore embed scheduled review of financing scope in
3876 legislation or regulation, alongside review of eligibility, benefits, and contribution rates.
3877 Anchoring this review in statute reduces political volatility, signals long-term commitment to
3878 entitlements, and provides a predictable cadence for stakeholder consultation, including with
3879 older people's organizations and unpaid carers.

3880 **Implementation guidance**

3881 • Embed scheduled review of financing scope in legislation or regulation, alongside
3882 review of eligibility, benefits, and contribution rates, with cycles typically of three to
3883 five years.

3884 • Use review cycles to incorporate emerging needs (for example, dementia-specific
3885 services, technology-enabled supports) and emerging service models (for example,
3886 community-based dementia care, integrated home-based care).

3887 • Engage older people, families, unpaid carers, and their representative organizations
3888 in review processes, alongside providers, workforce representatives, and finance
3889 authorities.

3890 • Document the rationale for each review-cycle adjustment publicly, including services
3891 added to and (where applicable) removed from financed scope.

3892 • Anticipate the fiscal implications of scope expansion and design transitional
3893 arrangements to maintain scheme sustainability while extending coverage.

3894 **Indicative measures**

Type	Indicative measure
Input	Statutory or regulatory provision for periodic review of financing scope, with a defined review cycle and stakeholder-engagement requirement
Process	Reviews conducted on schedule, with documented rationale, evidence base,

Type	Indicative measure
	and engagement of older people, carers, and their representative organizations
Output	Periodic adjustments enacted (for example, addition of new financed services, revision of existing service definitions)
Outcome	The financed scope tracks changes in entitlements, care models, and population needs; gaps for emerging needs are progressively closed

3895 **Box 36.** *Country example: France*

Through the *Allocation personnalisée d'autonomie* (APA), in force since 2002, France finances a comprehensive scope of long-term care for people aged 60 and over assessed as having a loss of autonomy. APA is co-financed by national government – through the *Caisse nationale de solidarité pour l'autonomie* (CNSA) – and the *départements*, with the *départements* administering the benefit at local level and CNSA harmonizing eligibility, assessment, and benefit rules nationally. Eligibility is determined on the basis of multidimensional assessment using the AGGIR grid, classifying functional autonomy from GIR 1 (most severe loss) to GIR 6 (autonomous), with APA covering GIR 1 to 4. The benefit funds a personalized care plan developed by the medico-social team during a home visit. Within this plan, APA can finance home help and care services, technical aids, home adaptations, telecare, day care, and respite for unpaid carers; in residential settings, it covers part of the dependency component of fees. Eligibility is universal in the sense that there is no income threshold, but the user contribution is graduated by income, with full coverage at lower incomes. The benefit is not recoverable from the recipient's estate. Approximately 1.4 million people received APA at the end of 2022, of whom around 60% lived at home. The financing scope and benefit ceilings are reviewed periodically, most recently through major adaptations including the 2015 Adaptation of Society to Ageing Act, and CNSA's role in scope harmonization and information provision has progressively strengthened over time *(77, 78)*.

3896 **LMIC adaptation.** The structural feature of central-local co-financing with nationally
3897 harmonized scope can be implemented at any level of fiscal capacity. What scales is the
3898 breadth of services covered, not the principle of explicit, harmonized, publicly defined scope.

3899 Standard 20: Needs-oriented allocation

3900 *Long-term care financing is allocated according to assessed care needs, focuses public*
3901 *resources on the population groups with the highest needs, and adapts over time as*
3902 *demographic and disease patterns evolve.*

3903 *Quality Statement 20.1: Needs-based assessment for eligibility*

3904 Older people receive long-term care entitlements based on transparent, needs-based
3905 assessment, applied consistently and accessibly.

3906 Rationale

3907 Needs-based eligibility is a foundational design choice. It determines who is covered, with
3908 what degree of protection, and at what fiscal cost. Established long-term care financing
3909 schemes anchor eligibility in standardized assessment of functional and cognitive limitations
3910 rather than diagnosis or chronological age alone, with minimum duration thresholds to
3911 distinguish long-term care needs from short-term post-acute or rehabilitative needs that fall
3912 under other parts of the health system. Where formal financing is being introduced under
3913 fiscal constraint, focusing initial coverage on those with the most severe limitations
3914 concentrates limited public resources where unmet need and risk of impoverishment are
3915 greatest. Eligibility design also has equity implications: criteria that require navigation of
3916 complex application procedures, or that rely heavily on family-mediated proxies, can
3917 systematically exclude isolated older people and those with cognitive impairment.

3918 Implementation guidance

3919 • Define eligibility through standardized, validated assessment of functional ability and
3920 cognitive status, applied by trained personnel, rather than diagnosis or age alone.

3921 • Establish a minimum duration threshold for sustained limitations to distinguish long-
3922 term care needs from short-term post-acute or rehabilitative care, in coordination
3923 with adjacent health and social-protection schemes.

3924 • Where formal financing is being introduced under fiscal constraint, prioritize
3925 population groups with the most severe limitations and lowest household resources,
3926 and document the prioritization criteria transparently.

3927 • Make application and eligibility-determination procedures accessible to people with
3928 cognitive or sensory impairments and to those without family support to navigate the
3929 system; provide assistance where required.

3930 • Coordinate eligibility criteria with adjacent benefit schemes (disability allowances,
3931 social assistance, health insurance) to avoid both gaps and overlaps.

3932 Indicative measures

Type	Indicative measure
Input	Defined eligibility criteria specifying prioritized population groups and minimum duration thresholds, supported by validated assessment instruments
Process	Eligibility determined through standardized needs assessment by trained personnel, with accessible application procedures
Output	A defined eligible population that demonstrably prioritizes individuals with severe functional or cognitive limitations
Outcome	Coverage reaches the population groups with the highest long-term care needs; unmet need among prioritized groups decreases over time

3933 ***Quality Statement 20.2: Graded benefits across severity and settings***

3934 Long-term care cost coverage arrangements are differentiated by severity of need and by
3935 care setting, supporting the care arrangement that best matches older people's needs and
3936 preferences.

3937 **Rationale**

3938 Long-term care needs are heterogeneous in both intensity and configuration. A binary
3939 "covered / not covered" benefit design cannot accommodate the range from intermittent
3940 assistance with instrumental activities of daily living to round-the-clock support for severe
3941 physical and cognitive impairment. Mature financing schemes therefore stratify benefits
3942 across multiple care levels, each with distinct ceilings calibrated to the resource intensity
3943 that different levels of need require. Differentiation by care setting matters for two reasons.
3944 First, costs vary substantially across home, community, and residential settings; uniform
3945 benefit rules tend to under-compensate the most resource-intensive care or to over-
3946 compensate the least. Second, cost coverage arrangements can either support or distort
3947 older people's choice of setting. Where residential care is more generously funded than
3948 equivalent home- or community-based care, financing creates an avoidable bias toward
3949 institutionalization, contrary to most countries' stated commitment to ageing in place and to
3950 most older people's stated preferences.

3951 **Implementation guidance**

3952 • Adopt a graded benefit structure linked to assessed severity, rather than binary
3953 coverage, with benefit ceilings calibrated to the resource intensity of each level.

3954 • Set cost coverage arrangements separately for home-based, community-based, and
3955 residential settings, taking actual cost differentials into account.

3956 3957 3958 3959
- Avoid creating financial incentives that bias older people's choice of setting toward institutional care; where the policy goal is to support ageing in place, ensure home- and community-based benefits are at least equivalent in protective value to residential equivalents.

3960 3961 3962
- Adjust benefit packages for population groups with distinct care profiles, particularly people living with dementia and people with severe cognitive impairment, where standard activities-of-daily-living indicators may underestimate care intensity.

3963 3964
- Periodically review funding levels against the cost of meeting quality standards in each setting, to prevent erosion of benefit adequacy over time.

3965 **Indicative measures**

Type	Indicative measure
Input	Codified graded benefit structure differentiating severity levels and care settings, with validated severity-classification instruments
Process	Severity classification applied at intake and at regular reassessment intervals; benefits adjusted accordingly
Output	Differentiated benefit allocation across severity levels and across home, community, and residential settings
Outcome	Benefit value corresponds to assessed care needs; the share of expenditure on home- and community-based services is balanced relative to residential care, consistent with population care preferences

3966 ***Quality Statement 20.3: Periodic review of eligibility, benefits and contributions***

3967 3968 3969 Long-term care financing arrangements adapt over time to evolving demographic, epidemiological, and care-need patterns, through scheduled review of eligibility, benefits, and contributions.

3970 **Rationale**

3971 3972 3973 3974 3975 3976 3977 Long-term care needs are not static. Population ageing, rising prevalence of dementia and multimorbidity, changing patterns of family caregiving capacity, and shifts in service costs reshape demand within the lifespan of a single financing scheme. Financing systems that fix eligibility and benefits at programme inception risk progressive misalignment: thresholds that were appropriate at launch become too narrow as the at-risk population grows and as evidence accumulates on conditions, such as severe cognitive impairment, that may not have been adequately recognized in original eligibility rules. Mature schemes embed

3978 periodic review cycles in legislation or regulation, rather than leaving adjustment to
3979 discretionary policy. Anchoring review in statute reduces political volatility, signals long-term
3980 commitment to scheme integrity, and provides a predictable cadence for stakeholder
3981 consultation.

3982 **Implementation guidance**

3983 • Embed scheduled review of eligibility criteria, benefit levels, and contribution rates in
3984 legislation or regulation, with review cycles typically of three to five years.

3985 • Build in capacity for additional review when emerging evidence identifies categories
3986 of need (such as dementia or severe cognitive impairment) that are not adequately
3987 recognized under existing rules.

3988 • Use review cycles to update benefit indexation, severity classification, and benefit
3989 bands in light of cost developments and service-mix changes.

3990 • Anticipate the fiscal implications of expansion and design transitional safeguards to
3991 maintain scheme sustainability when eligibility broadens.

3992 • Document the rationale for each review-cycle adjustment publicly, with engagement
3993 of older people, families, unpaid carers, and their representative organizations.

3994 **Indicative measures**

Type	**Indicative measure**
Input	Statutory or regulatory provision for periodic review, with a defined review cycle
Process	Reviews conducted on schedule, with documented rationale, evidence base, and stakeholder engagement
Output	Periodic adjustments enacted (for example, expansion of eligible conditions, revision of severity bands, indexation of monetary benefits)
Outcome	Eligibility and benefits track changes in population needs and disease patterns; coverage gaps for emerging needs are progressively closed

3995 **Box 37.** *Country example: China*

Since the launch of social long-term care insurance pilots in 2016, China has progressively expanded both the scope and the design of needs-oriented financing. Initial pilot schemes concentrated coverage on individuals with severe functional

disabilities, with eligibility typically requiring sustained disability of at least six months – concentrating limited public financing on the highest-need groups. Subsequent expansion in selected pilot cities has extended coverage to include moderate disability and people living with dementia, illustrating how needs-oriented financing can adapt as demographic and disease patterns evolve. Differentiated benefit rules apply across home-, community-, and facility-based care, supporting the development of less expensive home- and community-based services without diverting resources from those with the highest needs. Pilot cities also adjust financing levels in light of local care needs and economic conditions, providing a mechanism for context-specific calibration within a broadly common framework *(79, 80, 81)*.

3996 **LMIC adaptation.** Countries beginning to develop formal long-term care financing can
3997 prioritize tightly defined high-need groups and minimum duration thresholds at the outset,
3998 expanding eligibility incrementally as fiscal capacity and assessment infrastructure mature.

3999 Standard 21: Shared responsibility

4000 *Long-term care financing distributes responsibility across multiple actors – including*
4001 *government, individuals and households, employers, and other contributors – through*
4002 *coordinated, capacity-aligned participation, so that the cost of long-term care is genuinely*
4003 *shared rather than concentrated on older people and their families.*

4004 *Quality Statement 21.1: Pooled financing across multiple actors*

4005 Long-term care is financed through pooled resources drawing on multiple actors, so that the
4006 cost of care is shared across society rather than borne by older people and their families
4007 alone.

4008 **Rationale**

4009 Long-term care costs, when incurred, are typically large relative to household income and
4010 prolonged in duration. Financing models that place the full burden on individuals or
4011 households fail the most basic test of social protection: they leave households exposed to
4012 catastrophic expenditure, distort decisions about whether to seek care, and shift costs onto
4013 unpaid carers, predominantly women. Risk-pooling across a broad base – through
4014 compulsory contributions, general taxation, or some combination – converts an
4015 unpredictable individual risk into a manageable collective one. The choice between social-
4016 insurance, tax-funded, and mixed models reflects historical, fiscal, and institutional context
4017 rather than a universally optimal design; what matters for this quality statement is that
4018 responsibility is genuinely shared, that the share of household out-of-pocket payment is
4019 contained, and that risk-pooling is sufficiently broad to absorb individual-level cost variation.
4020 Recognizing the implicit financing role of unpaid carers – and progressively reducing it

4021 through public financing rather than treating it as a permanent feature of the system – is part
4022 of genuine responsibility-sharing.

4023 **Implementation guidance**

4024–4027
- Establish a financing structure in which a substantial and growing share of long-term care costs is met through pooled public sources – whether contributory social insurance, general taxation, or a defined combination – rather than through household out-of-pocket payment.

4028–4030
- Avoid financing models in which long-term care is treated as a residual claim on health or social-protection budgets, since these are vulnerable to short-term fiscal compression.

4031–4033
- Where social-insurance financing is used, design risk-pooling at a scale sufficient to absorb regional, demographic, and cost variation; where tax financing is used, define long-term care as a protected budget line.

4034–4037
- Recognize and progressively reduce the implicit financing role of unpaid carers, including through cash benefits, respite care, pension-credit mechanisms, and other measures established under the Carers chapter; in the absence of such measures, "shared responsibility" in practice means burden-shifting onto families.

4038–4039
- Coordinate with the Carers chapter on mechanisms that recognize, support, and where appropriate compensate unpaid carers as part of the financing architecture.

4040 **Indicative measures**

Type	Indicative measure
Input	Defined statutory financing sources for long-term care, with a stated public-share floor or planned trajectory
Process	Financing flows allocated according to defined sources and shares; long-term care expenditure protected from discretionary in-year reallocation
Output	Public share of total long-term care expenditure; out-of-pocket share; estimated value of unpaid carer contribution
Outcome	Households are not the residual financiers of long-term care; out-of-pocket share trends downward and remains within a defined ceiling (recognizing that unpaid family care and household time costs are not captured in out-of-pocket measures and require complementary indicators)

4041 ***Quality Statement 21.2: Capacity-aligned contributions***

4042 Contribution proportions across financing actors are aligned with capacity to pay, with
4043 explicit protection for those with limited contribution capacity.

4044 **Rationale**

4045 How financing responsibility is distributed across actors – government, employees,
4046 employers, pensioners, and others – has both equity and sustainability implications.
4047 Distribution must be aligned with capacity to pay so that financing is not regressive, but it
4048 must also reflect the long-term commitments that contributory schemes imply: contributions
4049 set too low at programme launch generate sustainability problems within a generation as the
4050 eligible population grows, while contributions set too high relative to working-age capacity
4051 invite political backlash and erode scheme legitimacy. Mature schemes therefore fix
4052 contribution proportions in legislation or regulation, with explicit mechanisms for periodic
4053 adjustment, and combine this with provisions that protect those with limited contribution
4054 capacity – through exemptions, reductions, or full subsidies for low-income groups, and
4055 through indexation of contribution thresholds.

4056 **Implementation guidance**

4057 - Codify contribution rules across financing actors in primary or secondary legislation,
4058 with documented review and adjustment provisions.

4059 - Calibrate contribution rules with reference to the actuarial profile of the scheme, not
4060 only to short-term political feasibility, to avoid early-stage under-contribution that
4061 compromises later sustainability.

4062 - Provide explicit reductions, exemptions, or full subsidies for low-income contributors,
4063 the long-term unemployed, and other groups with limited contribution capacity.

4064 - Where pensioners are required to contribute, set contribution rules with reference to
4065 pension income levels and to the protection of minimum incomes.

4066 - Ensure that contribution arrangements for working-age people, including those with
4067 caregiving responsibilities, are designed transparently and with attention to gender
4068 equality.

4069 **Indicative measures**

Type	Indicative measure
Input	Codified contribution structure setting rates and shares across actors, with documented adjustment provisions
Process	Contribution rules applied as codified; reductions and exemptions extended to defined groups

Type	Indicative measure
Output	Contribution incidence by income decile and by financing actor; coverage of exemption provisions
Outcome	Contribution structure remains broadly consistent with capacity to pay and with scheme sustainability; eligible non-contribution remains low

4070 **Box 38.** *Country example: Germany*

Germany introduced statutory long-term care insurance (*Pflegeversicherung*) in 1995 as a fifth pillar of social insurance, alongside health, pension, unemployment, and accident insurance. Coverage is mandatory and universal: those in statutory health insurance are automatically enrolled in the statutory long-term care fund, while those with private health insurance must hold equivalent private long-term care insurance. Financing is shared between employees and employers through earnings-related contributions, with pensioner contributions, and with a higher contribution rate for childless adults that reflects the implicit reliance of long-term care financing on the working-age population. Contributions are collected through the existing health-insurance contribution infrastructure, which substantially reduces administrative costs and avoids construction of a parallel system. Benefits are graded across five care levels, and the scheme operates as an explicit complement to family caregiving rather than a full substitute, with cash benefits available to support care provided by relatives. Periodic statutory review adjusts contribution rates, benefit levels, and care-grade definitions in light of cost developments and demographic change *(72, 82)*.

4071 **LMIC adaptation.** In Thailand, the Long-Term Care for Older Persons with Dependency
4072 programme builds long-term care delivery and basic financing onto existing primary health
4073 care and local administrative infrastructure, with contributions from the National Health
4074 Security Office and local administrative organizations, demonstrating how shared
4075 administrative infrastructure can support introduction of formal long-term care financing
4076 without a stand-alone system (83).

4077
Standard 22: Equity

4078 *Long-term care financing is designed to balance equity across population groups,*
4079 *household types, and regions, with monitoring of equity in financing inputs, access, and*
4080 *outcomes.*

4081
Quality Statement 22.1: Income-related contributions and co-payments

4082 Older people and their families pay according to their ability, through differentiated
4083 contribution and co-payment rules calibrated to income and household circumstances.

4084 **Rationale**

4085 A single, flat contribution or co-payment rule is rarely equitable in long-term care. Income,
4086 age, and household composition all affect both ability to pay and care-need profile, and rules
4087 that ignore these differences can produce regressive incidence even within nominally
4088 universal schemes. Differentiated contribution rates, graduated co-payments, and
4089 household-aware means-testing allow financing arrangements to remain progressive while
4090 preserving universal coverage. The challenge is to calibrate differentiation finely enough to
4091 track ability to pay without generating administrative complexity that itself becomes a barrier
4092 to access – particularly for older people with cognitive impairment, limited literacy, or no
4093 family support to navigate documentation requirements.

4094 **Implementation guidance**

4095 • Set co-payment rules on a graduated basis according to income, with defined bands
4096 and explicit rules for transition between bands.

4097 • Calibrate contribution rules by income, with consideration of household composition
4098 where this materially affects contribution capacity (for example, for pensioner
4099 couples and for households with caregiving responsibilities).

4100 • Avoid differentiation rules so complex that eligibility or payment determination
4101 becomes a barrier to access in itself; where complexity is unavoidable, invest in
4102 accessible information and assisted application procedures.

4103 • Coordinate co-payment rules with the protection mechanisms set out under Standard
4104 23, so that graduated co-payments do not, in combination with other costs, generate
4105 catastrophic exposure for any income band.

4106 • Periodically review differentiation rules against observed contribution incidence and
4107 out-of-pocket exposure, and adjust where data show regressive outcomes. Equity
4108 monitoring is established under the Quality Monitoring chapter and applies here.

4109 **Indicative measures**

Type	Indicative measure
Input	Codified differentiated contribution and co-payment rules, with defined income bands and household-level provisions
Process	Differentiation applied through verifiable assessment of household income and composition; transition between bands handled transparently

Type	Indicative measure
Output	Distribution of contributions and co-payments across income deciles
Outcome	Long-term care contribution incidence is broadly proportional or progressive across the income distribution; out-of-pocket exposure does not rise more steeply at lower incomes

4110 ***Quality Statement 22.2: Geographic equity of entitlements***

4111 Older people receive equivalent long-term care entitlements regardless of where they live,
4112 supported by financing arrangements that address geographic disparities in service
4113 availability and cost.

4114 **Rationale**

4115 Even where national rules are uniform, real access to long-term care services often is not.
4116 Costs vary across regions, service supply is typically thinner in rural and remote areas, and
4117 population profiles differ in ways that affect both demand and capacity to contribute.
4118 Financing arrangements that ignore geographic variation tend to reinforce existing
4119 disparities: uniform funding rates leave high-cost regions with insufficient supply, while
4120 uniform contribution rules can be regressive in lower-income regions. Equity-aligned
4121 financing therefore combines national-level standardization of core entitlements – so that
4122 what older people are entitled to does not depend on where they live – with regional
4123 flexibility on contribution rates, supply-side support, and service-development financing,
4124 calibrated to local conditions.

4125 **Implementation guidance**

4126 • Standardize core entitlements (eligibility criteria, benefit levels, quality requirements)
4127 at national level, so that equivalent need confers equivalent entitlement regardless of
4128 region.

4129 • Permit regional variation in contribution rates within a national framework where this
4130 is needed to reflect local economic conditions, with transparent rules to limit
4131 divergence.

4132 • Use targeted supply-side financing – subsidies for service development, workforce-
4133 deployment incentives, infrastructure grants – to address underserved regions and
4134 rural areas.

4135 • Monitor regional variation in service availability, utilization, and out-of-pocket
4136 exposure, and use the data to inform supply-side and demand-side adjustments.

4137 • Coordinate with subnational authorities to ensure that regional flexibility supports
4138 rather than undermines the equity goals of the national scheme.

4139 **Indicative measures**

Type	Indicative measure
Input	National framework standardizing core entitlements, with defined provisions for regional variation; supply-side financing instruments for underserved areas
Process	Regional variation applied within national rules; supply-side financing deployed to regions with documented underservice
Output	Geographic distribution of services, workforce, and utilization; regional variation in out-of-pocket exposure
Outcome	Geographic disparities in service availability and access narrow over time; entitlement is not effectively contingent on region of residence

4140 **Box 39.** *Country example: Japan*

Japan's long-term care insurance system, established in 2000, provides universal coverage for people aged 65 and older and for younger persons aged 40 to 64 with specified age-related conditions. Financing is shared between insured-person premiums and tax revenues from three levels of government (national, prefectural, and municipal), each contributing approximately half. Cost-sharing is graduated by income, with co-payment rates ranging from 10% for average-income users to 20–30% for higher-income users, and premium reductions or exemptions available for low-income groups. Service prices are nationally standardized, while premium levels vary modestly across municipalities to reflect local cost and demographic differences – striking a deliberate balance between national equity and regional fiscal responsibility. The scheme is reviewed every three years, with co-payment, premium, and benefit-band adjustments enacted through this cycle *(74, 75, 82)*.

4141 **LMIC adaptation.** Countries with limited capacity for fine-grained income assessment can
4142 begin with a simpler two- or three-tier co-payment structure linked to broad income brackets
4143 and to social-assistance status, refining differentiation as administrative infrastructure
4144 matures.

4145 Standard 23: Financial protection

4146 *Older people and their families are protected from catastrophic costs and from*
4147 *impoverishment due to long-term care, through defined limits on out-of-pocket exposure and*
4148 *targeted protection for low-income and vulnerable populations.*

4149 *Quality Statement 23.1: Protection from catastrophic costs*

4150 Older people and their families can access long-term care without being exposed to
4151 catastrophic costs, through defined limits on what individuals can be required to pay.

4152 Rationale

4153 Long-term care expenditure can accumulate over years and routinely exceeds household
4154 savings, making it one of the most consistent drivers of health-related impoverishment
4155 among older people in countries without strong financial protection. Financial protection in
4156 long-term care therefore requires not only mean reductions in out-of-pocket payments but
4157 explicit limits on cumulative exposure: monthly or annual ceilings on total user payments;
4158 lifetime caps where appropriate; and protection of a minimum disposable income so that
4159 residential care fees do not deplete the resources needed for everyday living. Because long-
4160 term care is typically prolonged, the design of these limits matters more than their headline
4161 level: a high monthly ceiling that resets annually can still generate catastrophic cumulative
4162 exposure over a multi-year care episode.

4163 Implementation guidance

4164 • Establish defined monthly or annual ceilings on total out-of-pocket payments for
4165 long-term care, including co-payments, accommodation, and consumable charges
4166 where these fall on the user.

4167 • Where residential care involves accommodation and living-cost charges, protect a
4168 defined minimum disposable income for older people, so that mandatory fees do not
4169 deplete resources needed for personal expenditure.

4170 • Consider lifetime or rolling-window caps where multi-year care episodes are
4171 common, to prevent cumulative exposure from exceeding household capacity even
4172 where individual-month exposure is bounded.

4173 • Coordinate out-of-pocket protection across long-term care, health, and
4174 pharmaceutical financing schemes, since older people with long-term care needs
4175 typically face simultaneous exposure across all three.

4176 • Make protection-mechanism eligibility automatic where possible, rather than
4177 dependent on individual application, which is a particular barrier for people with
4178 cognitive impairment.

4179 Indicative measures

Type	Indicative measure
Input	Codified limits on out-of-pocket spending for long-term care, with defined ceiling levels and protected-income provisions
Process	Out-of-pocket charges capped at codified levels; protection mechanisms applied automatically where data permit
Output	Distribution of monthly and annual out-of-pocket exposure across the care-recipient population
Outcome	The incidence of catastrophic long-term care expenditure declines and remains low

4180 ***Quality Statement 23.2: Protection for those with limited resources***

4181 Older people are not excluded from long-term care because of inability to pay; targeted
4182 protections ensure that those with limited resources receive the care to which their needs
4183 entitle them.

4184 **Rationale**

4185 Universal coverage in name is not universal in practice if low-income older people cannot
4186 meet contribution or co-payment obligations, or if access depends materially on private
4187 resources. Mature long-term care financing schemes therefore provide explicit protections
4188 for vulnerable groups – full or partial waivers of contributions, reductions or waivers of co-
4189 payments, and supplementary subsidies for those whose household resources fall below
4190 defined thresholds – and ensure that a defined basic package of services is available to
4191 everyone who is eligible, regardless of household resources. Where access depends in
4192 practice on ability to pay private fees, ability to navigate complex application procedures, or
4193 willingness of unpaid carers to compensate for shortfalls, financing has failed in its primary
4194 protective function regardless of how its formal architecture is described. The design
4195 challenge is to set protections generously enough to reach intended beneficiaries while
4196 retaining sufficient simplicity that take-up is high; historically, complex application
4197 requirements have been a major barrier to take-up of means-tested protections among older
4198 people.

4199 **Implementation guidance**

4200 • Provide clearly defined waivers, reductions, and subsidies for low-income
4201 contributors, recipients of social assistance, the long-term unemployed, and other
4202 groups with limited resources, with thresholds set in reference to national income
4203 distributions.

4204 • Define a basic package of long-term care services that all eligible older people are
4205 entitled to receive regardless of household resources, and protect this package from
4206 supplementary charges that would in practice make it conditional on ability to pay.

4207 • Make eligibility for protection mechanisms as automatic as possible – for example,
4208 by linking to existing social-assistance status – to maximize take-up.

4209 • Where application is required, design procedures with cognitive-accessibility,
4210 language, and disability considerations from the outset.

4211 • Monitor take-up of protection mechanisms among eligible populations and unmet
4212 need disaggregated by income; act on identified gaps. Coordinate with the
4213 Governance chapter on regulation that prevents informal charging by providers, and
4214 with the Carers chapter on mechanisms that prevent unmet need from defaulting
4215 silently onto unpaid carers.

4216 **Indicative measures**

Type	Indicative measure
Input	Defined waiver, reduction, and subsidy provisions for vulnerable populations; defined publicly financed basic package available to all eligible older people
Process	Eligibility determined automatically where possible; informal charging regulated; unmet need monitored
Output	Take-up rate among eligible populations; unmet-need rates disaggregated by income
Outcome	Vulnerable populations are not excluded from coverage on grounds of inability to contribute; receipt of long-term care services is not materially differentiated by household resources

4217 **Box 40.** *Country example: Sweden*

Sweden operates a tax-funded universal model in which responsibility for long-term care services lies primarily with municipalities, financed through local and national taxation. Universal access is established in social services legislation: entitlement to elder care is based on assessed need, and services are provided regardless of ability to pay. User charges are levied for services and for residential accommodation, but a national maximum monthly fee – set in legislation and indexed annually – caps the user contribution that any individual can be required to pay for elder care, and a minimum-disposable-income rule protects a defined sum for personal expenditure after fees and

accommodation costs are deducted. Together, these mechanisms convert what might otherwise be open-ended cumulative exposure into a bounded, predictable household commitment, even for multi-year residential care episodes *(84, 85)*.

4218 **LMIC adaptation.** Even where universal tax-funded coverage is not yet feasible, the
4219 structural device of a national fee ceiling combined with a protected minimum disposable
4220 income is administratively simpler than full means-testing and offers strong catastrophic-cost
4221 protection that can be extended progressively.

4222 Standard 24: Adequacy and quality alignment

4223 *Funding for long-term care is sufficient for providers to deliver care that meets quality*
4224 *standards, reflects differences in care complexity, and supports continuous quality*
4225 *improvement and accountability without creating access barriers for older people with high*
4226 *or complex needs.*

4227 *Quality Statement 24.1: Funding adequate to deliver quality standards*

4228 Funding levels enable providers to deliver long-term care that meets quality standards and
4229 that the workforce can sustainably provide.

4230 **Rationale**

4231 Quality standards cannot be implemented if funding does not cover the cost of meeting
4232 them. Where funding falls persistently below the cost of compliant care, providers compress
4233 staffing, training, and infrastructure investment in ways that erode quality directly and
4234 increase regulatory non-compliance over time. Adequate funding is therefore not only a
4235 question of provider sustainability but a substantive condition for the entitlements
4236 established in this document. Determining adequacy requires costing approaches that
4237 explicitly include the resource implications of the quality requirements set out elsewhere in
4238 these standards – particularly the staffing, training, and working-condition requirements
4239 under the Workforce chapter, the infrastructure and safety requirements under the Long-
4240 Term Care Facilities chapter, and the assessment and care-coordination requirements
4241 under the Home and Community-based Care chapter. Funding levels that are not regularly
4242 updated drift below adequate levels as wages, capital costs, and quality requirements
4243 evolve; this drift is faster than for many other sectors because long-term care is wage-
4244 intensive, and wage trends in the predominantly female occupations that dominate long-
4245 term care therefore translate quickly into adequacy gaps.

4246 **Implementation guidance**

4247 • Build funding methodologies on transparent costing approaches that explicitly
4248 include the resource implications of national quality standards, including staffing,
4249 training, and infrastructure requirements.

4250 • Embed scheduled review of funding levels in legislation or regulation, with cycles
4251 short enough to track cost developments (typically annual indexation with periodic
4252 methodological review).

4253 • Engage providers, workers, older people, families, and unpaid carers in the
4254 development and review of costing approaches and funding levels, to support
4255 legitimacy and reduce information asymmetries.

4256 • Where new or strengthened quality standards are introduced, model the funding
4257 implications in advance and provide transitional financing as appropriate, rather than
4258 imposing standards on a financing structure calibrated to lower expectations.

4259 • Where review identifies funding levels that have fallen materially below standards-
4260 compliant cost, set out a defined trajectory for restoration rather than treating the gap
4261 as a permanent feature.

4262 **Indicative measures**

Type	Indicative measure
Input	Transparent costing methodology linking funding levels to the resource implications of national quality standards; statutory or regulatory provision for regular review
Process	Costing approaches developed and reviewed with stakeholder input; reviews conducted on schedule, with methodology and outcomes published
Output	Funding levels and their cost basis published; documented adjustments over successive review cycles; gap between funding and standards-compliant cost
Outcome	Provider compliance with quality standards rises and is sustained; provider exit driven by under-funding of compliant care declines

4263 ***Quality Statement 24.2: Funding for care complexity***

4264 Funding reflects differences in care complexity, supporting access for older people with high
4265 or complex needs.

4266 **Rationale**

4267 Within any care setting, costs vary substantially with the acuity and complexity of older
4268 people's needs. Flat per-resident or per-hour funding creates two predictable distortions: it
4269 under-compensates providers caring for the highest-acuity recipients, encouraging selection
4270 against them, and it over-compensates providers serving lower-acuity populations,
4271 generating windfall margins. Both effects can undermine access for older people with high

4272 or complex needs – precisely the population that public long-term care financing is meant to
4273 protect. Acuity-adjusted funding, based on validated case-mix classification, addresses
4274 these distortions when properly designed. The classification system used must reflect long-
4275 term care realities rather than being borrowed wholesale from acute care, and must include
4276 cognitive impairment and behavioural complexity alongside physical care requirements,
4277 since these are major drivers of long-term care cost that activities-of-daily-living-only
4278 classifications miss.

4279 **Implementation guidance**

4280–4281
- Adopt a validated case-mix classification system for long-term care funding, reflecting both physical care needs and cognitive and behavioural complexity.

4282–4283
- Apply case-mix classification consistently at intake and at scheduled reassessment, with audit mechanisms to deter classification gaming.

4284–4285
- Calibrate case-mix payment weights to actual cost differentials by acuity, and review weights periodically as care patterns and cost structures evolve.

4286–4289
- Monitor access patterns and case-mix distribution across providers for evidence of selection against older people with high or complex needs; deploy supplementary financing – risk-pool adjustments, targeted grants, or specialized service contracts – where adverse selection is identified.

4290–4291
- Coordinate with the Quality Monitoring chapter on use of case-mix data for risk-adjusted quality comparison across providers.

4292 **Indicative measures**

Type	Indicative measure
Input	Validated case-mix classification system with payment weights calibrated to acuity-related cost differentials; access-monitoring framework for high-need populations
Process	Case-mix classification applied at intake and reassessment, with audit; access patterns monitored continuously
Output	Distribution of acuity-adjusted funding and of high-need older people across providers and settings
Outcome	Provider selection against older people with high or complex needs declines; funding tracks actual cost variation by acuity

4293 ***Quality Statement 24.3: Financing supports quality improvement and accountability***

Financing arrangements support continuous quality improvement and accountability, without creating access barriers for older people with high or complex needs.

Rationale

Funding methodologies that compensate providers identically regardless of quality performance, and that have no financial response to persistent non-compliance, miss two opportunities. The first is to align financial arrangements with stated quality goals through performance-related elements, capacity-building grants conditional on quality milestones, or differentiated funding bands. The second is to create proportionate consequences when providers persistently fail to meet quality standards, through graduated responses ranging from improvement support to rate adjustments and, in severe cases, withdrawal of public funding. Both kinds of arrangement must be designed with care. Performance metrics must be valid, risk-adjusted where appropriate, robust against gaming, and meaningful to older people; otherwise, they generate adverse-selection effects against high-need recipients. Financial consequences for non-compliance must be coordinated with continuity-of-care planning so that withdrawal of public funding does not leave older people without care, particularly in areas with limited supply alternatives.

Implementation guidance

- Identify a small, well-validated set of quality indicators on which financial arrangements can be based, drawing on the indicator set established under the Quality Monitoring chapter.
- Risk-adjust performance metrics to account for case-mix differences; monitor for selection effects against high-need older people, and deploy supplementary financing where needed.
- Couple performance-related arrangements with capacity-building support – training, technical assistance, peer learning – particularly where lower performance reflects capacity gaps rather than effort.
- Establish a graduated framework linking severity and duration of non-compliance to proportionate financial consequences, codified in legislation or regulation, and coordinated with the inspection and follow-up framework set out in the Quality Monitoring chapter.
- Make continuity-of-care planning integral to financial enforcement responses, so that withdrawal of public funding does not leave older people without care.

Indicative measures

Type	Indicative measure
Input	Defined quality-indicator set used in financing arrangements, with risk-adjustment methodology; codified graduated framework for financial consequences of persistent non-compliance
Process	Performance assessment and financial differentiation applied as defined; financial consequences applied following documented inspection findings, with continuity-of-care planning integrated
Output	Distribution of performance-related funding across providers; number and type of financial enforcement actions; trajectory of compliance among providers subject to financial response
Outcome	Performance on prioritized quality indicators improves; persistent non-compliance is reduced over successive cycles; arrangements do not generate access barriers for older people with high or complex needs

4327 **Box 41.** *Country example: Australia*

The Aged Care Act 2024, which commenced on 1 November 2025, establishes a comprehensive rights-based framework for aged care in Australia, replacing the previous legislation following the Royal Commission into Aged Care Quality and Safety. The reform combines strengthened quality standards with a redesigned funding architecture: residential care is funded through a case-mix model that classifies residents by acuity and complexity, including cognitive and behavioural factors, and pays providers at rates calibrated to the cost of meeting strengthened quality requirements. A separate framework supports home- and community-based services, with means-tested co-payments and protections for low-income recipients. Periodic independent review of provider costs and pricing is built into the design, in recognition that sustaining standards-compliant care over time requires funding that tracks cost developments rather than being set once and indexed mechanically. Quality monitoring, public reporting, and graduated regulatory and financial responses to non-compliance are integral to the framework *(86, 87, 88)*.

4328 **LMIC adaptation.** The principle of linking funding methodology explicitly to documented
4329 quality standards, and reviewing it on a defined cycle, can be applied at any level of fiscal
4330 capacity; what scales is the depth of the costing model, not the discipline of linking funding
4331 to standards.

4. Implementation considerations

Contextual adaptation. Long-term care financing systems vary enormously across Member States, from social-insurance models to tax-funded universal models to mixed and predominantly out-of-pocket arrangements. The standards in this chapter are intentionally model-agnostic: they specify what financing arrangements should achieve, not which model achieves them. Countries with strong fiscal capacity and mature social-insurance or tax-funded infrastructure can leverage these to implement higher-coverage, higher-protection models with relatively rapid review cycles. Countries with more constrained fiscal capacity will typically progress through more modest initial coverage, focused on the highest-need groups, with progressive expansion as economic capacity, demographic profile, and administrative infrastructure mature. In both cases, the standards apply: the trajectory differs, not the destination.

Phased implementation for resource-limited settings. Countries establishing formal long-term care financing for the first time may consider a phased approach: (1) define a tightly bounded eligible population (typically those with severe functional or cognitive limitations and limited household resources), supported by a basic publicly financed service package aligned with core entitlements set out in these standards; (2) introduce risk-pooling mechanisms – through social insurance, tax-financed coverage, or mixed sources – that move long-term care off household budgets and onto a broader collective base; (3) develop graduated severity classification, differentiated funding rules, and basic quality-related financial arrangements as data infrastructure matures; and (4) extend coverage progressively to moderate-need populations and to less severe forms of impairment, with the timing determined by fiscal capacity and demographic profile. Each phase delivers protective value to those covered; later phases expand the protected population without requiring complete re-engineering of the scheme.

Leveraging existing administrative infrastructure. Most countries already have administrative infrastructure for collecting health-insurance contributions, paying pensions, processing means-tested benefits, and maintaining beneficiary registries. Constructing parallel infrastructure for long-term care duplicates fixed costs, slows implementation, and creates seams between schemes that beneficiaries must navigate. Where compatible administrative infrastructure exists, it should be used for long-term care contribution collection, enrolment, and where possible benefit disbursement. At the same time, full institutional merger with adjacent schemes risks subordinating long-term care priorities – for example, treating long-term care as a residual claim on a health-insurance budget. The design challenge is to leverage shared infrastructure while protecting the functional autonomy and budgetary identity of long-term care, with a clearly identified long-term care budget line and scheme governance, distinct from adjacent schemes. In low- and middle-income countries, primary health care and community-based service infrastructure offer a natural platform for both basic delivery and basic financing functions.

4371 **Key enablers.**

4372 - **Political commitment.** Sustainable long-term care financing requires durable
4373 political commitment, since the protective and fiscal payoffs accrue over many years
4374 and can be undermined by short-cycle compression of spending.
4375 - **Data systems.** Costing, utilization, and equity-monitoring data are essential inputs to
4376 the periodic review processes built into Standards 1, 2, 3, 4, and 6; routine equity
4377 monitoring established under the Quality Monitoring chapter directly supports
4378 adjustment of financing rules.
4379 - **Institutional integration.** Alignment with health-financing and social-protection
4380 infrastructure reduces administrative cost and supports continuity of coverage across
4381 schemes.
4382 - **Stakeholder engagement.** Involvement of older people, families, unpaid carers,
4383 providers, workers, and their representative organizations in financing design and
4384 review supports legitimacy and reduces information asymmetries.
4385 - **Cross-chapter linkages.** Quality-related financial arrangements depend on the
4386 indicator set, inspection mechanisms, and public reporting established in the Quality
4387 Monitoring chapter; funding adequacy depends on the workforce, infrastructure, and
4388 assessment requirements set out in the Workforce, Long-Term Care Facilities, and
4389 Home and Community-based Care chapters; recognition of unpaid carers as part of
4390 the financing architecture depends on the carer-support arrangements set out in the
4391 Carers chapter.

4392 **Common challenges.** Three challenges recur across countries at all income levels. First,
4393 long-term care financing tends to be politically vulnerable to fiscal compression, particularly
4394 in periods of broader public-spending restraint, and standards-compliant capacity once
4395 eroded is slow to rebuild. Second, funding adequacy is in continual tension with
4396 sustainability, and the resolution of this tension cannot be settled once but must be revisited
4397 periodically through transparent review. Third, the implicit financing role of unpaid carers,
4398 predominantly women, is rarely recognized in formal financing arrangements; making this
4399 contribution visible – and progressively reducing its scale – is a long-term project that few
4400 systems have completed.

4401 # Chapter 7. Governance

4402 **Table 12.** *Standards and quality statements: Chapter 7, Governance*

Standard	Quality statements
Standard 25. Regulatory framework	**25.1** Legal foundation and oversight authority **25.2** Quality standards defined and publicly available **25.3** Eligibility and entitlements **25.4** Periodic review and reform of the regulatory framework
Standard 26. Licensing and registration	**26.1** Registration and conditions for service provision **26.2** Public information on registered providers **26.3** Provider engagement and capability development
Standard 27. Oversight and enforcement	**27.1** Regular inspection across settings **27.2** Graduated and proportionate enforcement **27.3** Regulatory body capacity and independence **27.4** Public reporting of inspection and enforcement **27.5** Channels for concerns and complaints
Standard 28. Rights protection	**28.1** Statutory recognition of rights **28.2** Independent complaints, investigation and response to abuse **28.3** Advocacy and support across settings **28.4** Legal capacity and supported decision-making

Standard	Quality statements
Standard 29. Coordination across sectors and levels of government	**29.1** Cross-sector coordination at national, subnational and community levels **29.2** Continuity across care transitions **29.3** Stakeholder participation in governance **29.4** Coordination of roles, responsibilities and standards across levels of government

4403 ## 1. Introduction

4404 This chapter establishes standards for the governance of long-term care systems – the legal
4405 foundations, institutional arrangements and accountability mechanisms that determine
4406 whether quality care is consistently delivered to those who need it.

4407 For the people who depend on long-term care, governance is not an abstract architecture; it
4408 directly shapes whether they receive care at all, the quality of that care and whether they are
4409 protected from harm. Where governance functions are clear, adequately resourced and
4410 enforced, systems are better able to deliver equitable access, consistent quality and
4411 protection of rights. Where they are fragmented, weakly enforced or under-resourced, the
4412 consequences fall disproportionately on the most dependent care recipients.

4413 **Scope of this chapter.** This chapter addresses system-level governance across five
4414 domains: the legal and regulatory foundation for long-term care (Standard 25); provider
4415 licensing and registration (Standard 26); oversight and enforcement (Standard 27);
4416 protection of the rights of care recipients (Standard 28); and coordination across sectors and
4417 levels of government (Standard 29). These domains apply to all long-term care settings –
4418 including residential, home-based and community-based services – and to all provider
4419 types, whether public, private or voluntary. Organizational-level governance of individual
4420 providers is addressed in the service-delivery chapters (Chapters 2 and 3); governance of
4421 the workforce is addressed primarily in Chapter 5; measurement and improvement
4422 mechanisms are addressed in Chapter 8.

4423 ## 2. Background

4424 ### 26.1 Global situation

4425 Long-term care governance – the legal foundations, institutional arrangements and
4426 accountability mechanisms that enable consistent, equitable and rights-respecting care – is
4427 at a moment of significant change globally. A growing number of Member States have

4428 moved to embed long-term care in primary legislation, including Australia (Aged Care Act
4429 2024) *(101)*, Argentina, Brazil, Japan and the Republic of Korea, alongside a number of
4430 European Member States. Other countries are revising existing statutory frameworks: South
4431 Africa enacted the Older Persons Amendment Act in 2025, strengthening rights protections
4432 and oversight provisions *(110)*. Comparative analyses by the OECD and others
4433 nevertheless document substantial variation in how core governance functions –
4434 entitlement, regulation, inspection, enforcement, complaints handling and cross-sectoral
4435 coordination – are organized across countries, and the governance evidence base remains
4436 skewed toward high-income systems with established regulatory infrastructure *(93, 106)*.

4437 The COVID-19 pandemic exposed governance weaknesses with consequences for the
4438 people most dependent on long-term care. In many high-income countries, deaths among
4439 long-term care facility residents accounted for approximately 40 per cent of total COVID-19
4440 deaths; subsequent commissions of inquiry across multiple Member States identified
4441 governance failures – inadequate regulation, fragmented authority across health and social
4442 sectors, weak inspection regimes and limited rights protection – as systemic contributors
4443 *(107)*. Several countries have since enacted far-reaching governance reforms in response.
4444 Knowledge gaps remain particularly significant for governance arrangements in low- and
4445 middle-income Member States and for the regulation of home and community-based care;
4446 both are addressed as priorities for the global consultation on this draft.

4447 26.2 Key challenges

4448 **Fragmentation across sectors and levels of government.** Long-term care sits at the
4449 intersection of health, social care, housing, social protection, labour and other sectors, and
4450 is typically governed across multiple levels of government. Where roles and coordination
4451 mechanisms are not clearly specified, accountability disperses: providers face conflicting
4452 requirements, regulators overlap or leave gaps, and care recipients and their families have
4453 no clear authority to which they can turn.

4454 **Variable regulatory capacity.** Many Member States lack the legal mandate, institutional
4455 infrastructure or human resources to register providers, set and enforce standards and
4456 protect the rights of care recipients consistently across the territory. Capacity gaps are
4457 particularly pronounced for home and community-based care.

4458 **Gaps in regulation of home and community-based care.** Most existing regulatory
4459 frameworks were designed for residential settings and translate imperfectly to services
4460 delivered in private homes or community settings. As long-term care systems shift toward
4461 home and community-based provision, the regulatory architecture has not consistently kept
4462 pace.

4463 **Uneven enforcement and limited graduated response.** Even where standards are
4464 defined, enforcement is often binary and rarely commensurate with risk. Inspection regimes
4465 may target compliance with documentation rather than outcomes for care recipients, and

4466 graduated responses to non-compliance – improvement notices, supervised remediation,
4467 restrictions on admission, sanction – are often missing or inconsistently applied.

4468 **Rights protection deficits.** Independent complaints mechanisms, protected channels for
4469 raising concerns, accessible advocacy and effective safeguarding from abuse and neglect
4470 are uneven in their coverage. Care recipients with cognitive impairment or in social isolation
4471 are at particular risk.

4472 **Weak workforce and data infrastructure for oversight.** Governance functions depend on
4473 workforce capacity to inspect, advise and respond, and on data systems that record who is
4474 providing care, to whom, with what outcomes. Both are underdeveloped in many systems,
4475 limiting the ability of regulators to act on emerging risks.

4476 26.3 Conceptual framework

4477 These standards adopt a rights-based approach to long-term care governance. They
4478 recognize older people as rights-holders entitled to consistent, equitable and rights-
4479 respecting care, and they identify governance as the system function that converts those
4480 rights from principle into practice. Where governance is clear, adequately resourced and
4481 enforced, systems are better able to deliver equitable access, consistent quality and
4482 protection from harm. Where it is fragmented, weakly enforced or under-resourced, the
4483 consequences fall disproportionately on the most dependent care recipients.

4484 The standards describe what governance functions should be in place rather than how they
4485 must be institutionally organized. The same functions – legal foundation, provider regulation,
4486 oversight and enforcement, rights protection, and coordination across sectors and levels of
4487 government – can be achieved through diverse institutional arrangements, from a single
4488 integrated regulator to networks of sectoral and rights-based bodies operating under shared
4489 frameworks. This functional approach is intended to be applicable across constitutional
4490 structures, administrative traditions, regulatory maturity and stages of long-term care system
4491 development. Regulation of long-term care providers and workers should be designed
4492 proportionally — calibrated to the risks that different provider types, settings and roles
4493 present to care recipients. Not every form of long-term care provision requires the same
4494 regulatory intensity: regulatory levers (registration, licensing, accreditation, inspection,
4495 scope-of-practice rules, conduct standards) should be selected and combined based on the
4496 risk profile of the activity and the maturity of the surrounding system, drawing on the WHO
4497 Health practitioner regulation: design, reform and implementation guidance (WHO, 2024).
4498 This proportionality principle applies across Standards 1 to 3 of this chapter and should
4499 guide adaptation to context.

4500 The framework treats governance as multi-level. National authorities are typically
4501 responsible for legal foundations, minimum guarantees and overall stewardship, while
4502 subnational and local authorities deliver many regulatory and oversight functions in practice.
4503 Where this multi-level architecture is explicitly delineated and coordinated, it can deliver the

benefits of local responsiveness without producing fragmentation, inequity across the territory, or displaced accountability between levels of government *(93, 95, 106)*.

26.4 Normative foundations

International and regional human rights instruments provide the normative basis for these standards.

At the global level, the Universal Declaration of Human Rights (Articles 22 and 25), the International Covenant on Economic, Social and Cultural Rights *(113)*, and the Convention on the Rights of Persons with Disabilities together establish rights to social security, an adequate standard of living, the highest attainable standard of health, community living and freedom from discrimination, all of which apply to older people receiving long-term care *(99)*. The Convention on the Elimination of All Forms of Discrimination against Women, including General Recommendation 27 on the human rights of older women, addresses gender dimensions of care and ageing. In 2025, the Human Rights Council established an intergovernmental working group to draft a convention on the rights of older people; once adopted, that instrument will further specify obligations relevant to long-term care governance *(100)*.

At the regional level, the Inter-American Convention on Protecting the Human Rights of Older Persons (2015) was the first legally binding regional instrument focused on older people's rights, including rights to long-term care, and is incorporated in domestic law in several Member States in the Americas *(112)*. The Buenos Aires Commitment *(114)*, the European Union Council Recommendation on access to affordable high-quality long-term care (2022) *(97)*, the ASEAN Declaration on Strengthening the Care Economy and Fostering Resilience Towards the Post-2025 ASEAN Community (2024) and the APEC Non-binding Care Compact (2025) further specify regional commitments relevant to long-term care governance.

These instruments converge on common principles that the standards in this chapter operationalize: that long-term care is a public responsibility, that older people are rights-holders, that governance must be exercised in ways that protect the most dependent care recipients, and that public authorities have positive duties to ensure consistent and accountable care across the territory.

3. Standards

This section presents five standards for the governance of long-term care systems. The standards are interconnected: the regulatory framework (Standard 25) establishes the legal foundation; licensing and registration (Standard 26) and oversight and enforcement (Standard 27) operationalize that framework; rights protection (Standard 28) ensures that

4540 the system serves the people within it; and coordination across sectors and levels of
4541 government (Standard 29) addresses the multi-sectoral and multi-level nature of long-term
4542 care governance. Together, they describe the governance functions that should be in place;
4543 the institutional forms through which these functions are achieved will appropriately vary
4544 across countries.

4545 Standard 25: Regulatory framework

4546 *A clear legal and regulatory framework establishes the basis for long-term care provision,*
4547 *defining standards, responsibilities, entitlements and accountability mechanisms.*

4548 **Overview**

4549 The legal foundation for long-term care exists so that older people have an enforceable
4550 entitlement to the care they need, providers understand the obligations against which they
4551 will be held, and public authorities have clearly assigned duties they can be held to. Where
4552 this foundation is clear and complete, regulators can act, providers know what is expected of
4553 them, and older people and their families have a basis on which to claim and contest the
4554 care they receive. Where the foundation is partial, fragmented or unenforceable,
4555 accountability collapses into ad hoc arrangements that leave the most dependent care
4556 recipients least protected.

4557 This Standard addresses the elements of that foundation: the constitutional or legislative
4558 basis for long-term care as a public responsibility and the designation of oversight authority
4559 (Quality Statement 25.1); the quality standards against which providers are accountable
4560 (1.2); the eligibility criteria and entitlements that determine who can access care and on
4561 what terms (1.3); and the public mechanisms by which the framework is reviewed and
4562 reformed as populations, conditions and care models change (1.4).

4563 *Quality Statement 25.1: Legal foundation and oversight authority*

4564 The constitution, legislation or formal policy establishes long-term care as a public
4565 responsibility, defines the rights and entitlements of care recipients, sets out the duties of
4566 public authorities and providers, and designates the authority or authorities responsible for
4567 oversight.

4568 **Rationale**

4569 A clear legal foundation converts long-term care from a discretionary service into a public
4570 responsibility with named owners. Where the constitution recognizes care, social protection
4571 or the rights of older people, this provides the supreme legal anchor on which primary
4572 legislation, sectoral policy and regulation rest; care recipients can invoke a constitutional
4573 right rather than an administrative concession, and the political durability of the long-term
4574 care system is reinforced. A growing number of countries have moved in this direction,
4575 including Argentina, where the 1994 constitutional reform recognized the rights of older

4576 people and the State subsequently incorporated the Inter-American Convention on
4577 Protecting the Human Rights of Older Persons into domestic law; Brazil, whose Constitution
4578 (Article 230) places a duty on the family, society and the State to support older people,
4579 operationalized through the 2003 Statute of the Elderly; and South Africa, whose Bill of
4580 Rights and statutory framework on older people together establish the rights basis for care.
4581 At the operational level, primary legislation and regulation must specify which authority is
4582 accountable for which functions – entitlement, provider registration, inspection, enforcement,
4583 complaints – so that providers know what is expected, regulators have explicit powers to
4584 act, and older people and their families have an institution to which they can address
4585 questions, concerns and claims. Where the legal foundation is partial or contested,
4586 accountability disperses across ministries and levels of government, and the people who
4587 depend on the system most can find no one with clear authority to intervene on their behalf
4588 *(90, 93, 106)*.

4589 **Implementation guidance**

4590 • Anchor long-term care, the rights of older people and the duties of the State in
4591 constitutional or formal legislative provisions, and operationalize these in primary
4592 legislation defining the public responsibility for long-term care, the rights and
4593 entitlements of care recipients, and the duties of public authorities and providers.

4594 • Designate one or more authorities with explicit legal mandate and powers for the
4595 core governance functions – including standards-setting, registration, inspection,
4596 enforcement and complaints handling – and make their respective responsibilities
4597 and points of coordination unambiguous in law.

4598 • Make the legal and policy framework, the names and functions of responsible
4599 authorities, and the channels for raising concerns available to the public in
4600 accessible formats and languages, so older people, families and unpaid carers can
4601 identify whom to contact, what to expect, and how to seek redress.

4602 • Where governance is shared across levels of government (national, regional, local),
4603 specify in law how responsibilities are allocated and how minimum guarantees apply
4604 across the territory, to prevent disparities in entitlement by where a person lives.

4605 **Indicative measures**

Type	Indicative measure
Input	Constitutional, legislative or formal policy provisions establish long-term care as a public responsibility, with the rights of care recipients and the duties of public authorities and providers defined.
Process	Roles, responsibilities and coordination arrangements among designated

Type	Indicative measure
	authorities are documented and operational across the levels of government concerned.
Output	The legal framework, the institutions responsible for each governance function and the channels for redress are publicly accessible in formats and languages appropriate to older people, families and unpaid carers.
Outcome	Care recipients and their families can identify the public authority with responsibility for each governance function and access it; legal and regulatory accountability is exercised in practice.

4606 **Box 42.** *Country example: Argentina*

Argentina has built a long-term care framework on a strong rights basis. The 1994 constitutional reform recognized the rights of older people (Article 75 inc. 22 and 23), and Argentina subsequently became a State Party to the Inter-American Convention on Protecting the Human Rights of Older Persons, which has constitutional standing in domestic law. This rights foundation provides the supreme legal anchor for entitlements, oversight and rights protection across the long-term care system.

Implementation is distributed across several national institutions. The Instituto Nacional de Servicios Sociales para Jubilados y Pensionados (PAMI), a large public social insurer, covers a majority of older people in Argentina and both funds and regulates residential providers, home-care workers and community programmes under its remit. The Dirección Nacional de Políticas para Adultos Mayores (DINAPAM) within the national ministry of social development is responsible for policy development, carer training, service provision and coordination with provincial authorities through a Federal Council for Older People *(111)*.

The Argentine example illustrates how a rights-based constitutional framework, a regional human-rights convention with constitutional standing and a set of coordinating public institutions can together address the governance functions of entitlement, oversight, coordination and rights protection in a decentralized federal system. It also surfaces the governance challenges common to federal systems, including variable provincial capacity, fragmented data and the need for sustained coordination between a dominant social insurer and the ministries responsible for social policy.

4607 ***Quality Statement 25.2: Quality standards defined and publicly available***

4608 Comprehensive quality standards for long-term care services are defined in legislation or
4609 formal policy, are publicly available, and address the dimensions of person-centred care,
4610 safety, dignity, autonomy and continuity.

4611 **Rationale**

4612 Quality standards make it possible to govern long-term care for outcomes that matter to
4613 people, rather than only for inputs and process compliance. Where standards explicitly
4614 address person-centred care, safety, dignity, autonomy and continuity, they direct provider
4615 behaviour toward what care recipients themselves identify as meaningful, and equip
4616 regulators with substantive criteria against which to inspect and enforce. Comparative
4617 evidence shows that the structured definition and use of quality standards is associated with
4618 reductions in pressure injuries, falls and avoidable hospitalizations, and with improvements
4619 in resident-reported quality of life and care-recipient experience *(91, 104, 106)*. Where
4620 standards are absent, vague, or address only structural inputs, regulators are left with no
4621 firm basis on which to act on substandard care, and care recipients have no public
4622 benchmark against which to assess what they are entitled to expect. Public availability of the
4623 standards is an essential complement: standards that exist only inside regulatory systems
4624 cannot be invoked by older people and families, and cannot inform the choices they are
4625 increasingly being asked to make.

4626 **Implementation guidance**

4627 • Define quality standards in legislation, regulation or formal policy, covering at
4628 minimum person-centred care, safety, dignity, autonomy, continuity and the
4629 prevention of abuse and neglect.

4630 • Address the full continuum of long-term care settings, including residential, home-
4631 based and community-based care, with adaptations appropriate to each setting
4632 rather than facility-derived standards applied uniformly.

4633 • Develop and publish the standards through processes that include older people,
4634 families, unpaid carers, care workers and providers alongside regulators and
4635 technical experts.

4636 • Make the standards available to the public in plain-language formats and in the
4637 languages used by the populations served.

4638 **Indicative measures**

Type	Indicative measure
Input	Quality standards are formally adopted in legislation, regulation or policy and cover the dimensions of person-centred care, safety, dignity, autonomy and

Type	Indicative measure
	continuity across all care settings.
Process	Standards are reviewed and updated through processes that include the structured participation of older people, families, unpaid carers and care workers.
Output	Standards are publicly available in plain-language formats and in relevant languages, and are referenced in licensing, inspection and complaint mechanisms.
Outcome	Care recipients and their families are aware of the quality they are entitled to expect; regulators and providers reference the standards consistently in oversight, contracting and improvement activities.

4639 ***Quality Statement 25.3: Eligibility and entitlements***

4640 Eligibility criteria and entitlements for long-term care are clearly defined, publicly accessible,
4641 and applied consistently, with a standardized process for assessing care needs.

4642 **Rationale**

4643 Eligibility criteria and entitlements determine who can access publicly supported long-term
4644 care, what services or benefits they will receive, and on what terms – including any cost-
4645 sharing or means-testing. When these criteria are clearly defined, publicly accessible and
4646 applied through a standardized needs assessment used consistently across the country,
4647 decisions about access become predictable and contestable. Older people and their families
4648 know whether they qualify, can plan accordingly and can challenge decisions they believe
4649 are wrong; providers know which services public funding will cover; and equity is supported
4650 because similar needs receive similar entitlements regardless of geography or income.
4651 Where eligibility is opaque, inconsistently applied, or determined by negotiations whose
4652 criteria are not in the public domain, the people most reliant on long-term care – those with
4653 the fewest resources to navigate complex systems – are systematically disadvantaged.
4654 Standardized needs assessment is the operational link between abstract entitlement and
4655 concrete service: without it, eligibility decisions vary with the assessor rather than with the
4656 person *(94)*.

4657 **Implementation guidance**

4658 • Define eligibility criteria for publicly supported long-term care in legislation or formal
4659 policy, specifying both the population covered and the conditions of access
4660 (functional need, residence, cost-sharing arrangements and similar).

4661 4662 4663
- Adopt a standardized, validated needs-assessment instrument and process, used consistently across the country, with explicit links between assessment outcomes and entitlement decisions.

4664 4665 4666
- Publish eligibility criteria, the needs-assessment process and the rights to challenge or appeal an eligibility decision in formats accessible to older people, families and unpaid carers, including in minority languages where relevant.

4667 4668 4669
- Monitor consistency of eligibility decisions across geographic areas and population groups, with disaggregation that can identify systematic disparities; act on the findings.

4670 **Indicative measures**

Type	Indicative measure
Input	Eligibility criteria and entitlements are defined in legislation or formal policy; a standardized needs-assessment process is adopted nationally.
Process	Eligibility decisions for publicly supported long-term care are based on standardized needs assessment by trained personnel, with documented rights of appeal.
Output	Information on eligibility, entitlements, the assessment process and appeal rights is available to older people and families in accessible formats and languages.
Outcome	Older people with comparable needs receive comparable eligibility decisions across the country; appeal mechanisms are used and result in substantive review; care recipients report awareness of what they are entitled to and how to claim it.

4671 ***Quality Statement 25.4: Periodic review and reform of the regulatory framework***

4672 4673 4674
Public mechanisms exist for the periodic review and reform of the regulatory framework, with structured participation of older people, families, unpaid carers and care workers, so that the framework keeps pace with demographic, epidemiological and service-delivery change.

4675 **Rationale**

4676 4677 4678 4679
Long-term care systems sit within demographic, epidemiological and social environments that change steadily – populations age, the prevalence of conditions requiring care shifts, family structures evolve, and care models develop, with home and community-based care now expanding faster than facility-based care in many countries. A regulatory framework set

4680 without provision for review and reform will, over time, regulate a system that no longer
4681 exists: standards designed for facility care will not reach home-based providers; eligibility
4682 criteria designed for one demographic will mis-target another; oversight powers designed for
4683 an earlier generation of providers will not bind on emerging ones. The countries that have
4684 sustained credible long-term care systems over decades – including those that have
4685 undertaken major reforms following commissions of inquiry, demographic transitions or fiscal
4686 pressure – share an institutional capacity for periodic, public reform of the framework. The
4687 structured involvement of older people, families, unpaid carers and care workers in these
4688 reform processes keeps the framework anchored in the lived experience of those it is
4689 intended to serve, and gives the people who depend on the system a meaningful place to
4690 shape its future direction.

4691 **Implementation guidance**

4692 • Establish in legislation or policy a defined cycle for review and reform of long-term
4693 care legislation, regulations and quality standards – for example, every five to seven
4694 years – and a public process by which reforms are proposed, debated and adopted.

4695 • Define triggers for reform outside the cycle, such as findings from a commission of
4696 inquiry, sustained patterns in complaints data or systemic failure events.

4697 • Include in review and reform processes the structured participation of older people,
4698 families, unpaid carers and care workers, alongside providers, regulators and
4699 technical experts; provide accessible channels for public input.

4700 • Publish the outputs of each review and reform process – proposed amendments,
4701 evidence drawn on, decisions taken and rejected – so care recipients and the public
4702 can see how the framework has been adjusted and why.

4703 **Indicative measures**

Type	Indicative measure
Input	Legislation or policy specifies a defined cycle and conditions for the periodic review and reform of the long-term care regulatory framework.
Process	The most recent review or reform was conducted within the defined cycle, with documented participation of older people, families, unpaid carers and care workers, and accessible public input mechanisms.
Output	Outputs of the most recent reform process (amendments adopted, rationale and evidence base, decisions not adopted) are publicly available.
Outcom	The regulatory framework reflects current demographic, epidemiological and

Type	Indicative measure
e	service-delivery contexts; adjustments made in response to identified gaps are visible to care recipients and the public.

4704 ## Standard 26: Licensing and registration

4705 *All providers of long-term care services are subject to mandatory registration or licensing,*
4706 *with clear conditions for service provision, transparent public information and mechanisms*
4707 *for ongoing engagement to support service-quality improvement.*

4708 **Overview**

4709 Licensing and registration is the entry point through which the regulatory framework reaches
4710 the providers of care. It is also where public authorities accept the responsibility, on behalf of
4711 older people and their families, that any organization permitted to operate has been held to
4712 a defined standard before delivering care. Where this entry point is well designed, only
4713 providers meeting basic conditions enter the system, the public has a reliable account of
4714 who is authorized to provide care, and providers benefit from active engagement and
4715 capability-building support that helps them improve over time rather than only being
4716 inspected after the fact.

4717 This Standard addresses three core elements: the registration or licensing of providers and
4718 the conditions under which they may provide services (Quality Statement 26.1); the public
4719 availability of information on registered providers (2.2); and the mechanisms through which
4720 public authorities engage with providers on a continuing basis to develop their capability and
4721 improve service quality (2.3).

4722 ### *Quality Statement 26.1: Registration and conditions for service provision*

4723 All providers of long-term care services – across home, community and residential settings,
4724 and across public, private and not-for-profit ownership – are required to register with or be
4725 licensed by the designated authority before commencing service delivery, and must meet
4726 defined conditions covering legal status, financial viability, governance, workforce, premises
4727 (where applicable), safeguarding and the capacity to meet adopted quality standards.

4728 **Rationale**

4729 Mandatory registration with substantive conditions of service is the regulatory mechanism by
4730 which public authorities decide which organizations may provide long-term care to older
4731 people and on what terms. Where coverage is universal across settings and ownership
4732 types, registration prevents the most dependent care recipients from being placed with
4733 providers who have not been assessed against any standard. Where the conditions of
4734 registration are substantive – covering not only legal and financial fitness but also

4735 governance arrangements, workforce capacity, safeguarding and the capability to meet
4736 adopted quality standards – registration becomes a meaningful threshold rather than an
4737 administrative formality. Where registration is partial – for example, applying only to facility-
4738 based care while home-care providers operate without similar requirements – significant
4739 parts of the long-term care system remain outside any quality assurance, with predictable
4740 consequences for the older people receiving care from unregulated providers *(91, 93, 103)*.

4741 **Implementation guidance**

4742 - Require all providers – public, private, not-for-profit, faith-based, community-based –
4743 to register with or be licensed by the designated authority before commencing
4744 service delivery, with the requirement applying across home, community and
4745 residential settings.
4746 - Define registration conditions covering legal status; financial viability; governance
4747 and accountability arrangements; workforce sufficiency, qualifications and
4748 supervision; premises (for facility-based care); safeguarding; and the capability to
4749 meet adopted quality standards.
4750 - Require providers to maintain compliance with registration conditions on a continuing
4751 basis, including notification to the regulator of material changes in ownership,
4752 management, capacity or service profile.
4753 - Set proportionate registration arrangements for smaller community-based and home-
4754 care providers that maintain substantive conditions while not creating barriers that
4755 exclude appropriate providers in under-served areas.

4756 **Indicative measures**

Type	Indicative measure
Input	Legislation or regulation requires the registration or licensing of all long-term care providers across home, community and residential settings, with defined conditions for service provision.
Process	Applications for registration are assessed against the defined conditions; ongoing compliance with conditions is required and monitored.
Output	Registration covers public, private and not-for-profit providers across all settings; the proportion of the long-term care market operating outside the regulatory perimeter is minimized.
Outcom e	Care recipients and their families can be assured that any provider they engage has met defined conditions of service; provision by unregistered

Type	Indicative measure
	providers is rare and consequential.

4757 **Box 43.** *Country example: Ireland*

Ireland's Health Act 2007 created the Health Information and Quality Authority (HIQA) and made registration of designated centres for older people mandatory. To register, a provider must demonstrate compliance with regulations covering governance, workforce, premises, person-centred care and safeguarding; registration is granted for a defined period (currently three years) with conditions, and continued registration depends on continuing compliance. HIQA combines registration with risk-based inspection and the public reporting of inspection findings, including the application of conditions or restrictions on registration, generating a cumulative public record on each registered service *(103)*.

Over more than fifteen years of operation, the Irish model has demonstrated how the combination of mandatory registration, substantive conditions, transparent inspection and the public reporting of findings can drive measurable improvements in compliance with standards over time. It also illustrates a broader system-level lesson visible across countries: where registration is established but is not accompanied by sustained inspection capacity, public reporting and rights-protection mechanisms, registration alone cannot guarantee quality — a lesson Member States have drawn from regulatory experience in many settings, including in their response to the COVID-19 pandemic.

4758 ***Quality Statement 26.2: Public information on registered providers***

4759 Information on registered or licensed long-term care providers – including service profile,
4760 ownership, capacity, registration status and any conditions or restrictions on registration – is
4761 publicly accessible and kept current.

4762 **Rationale**

4763 Public information on registered providers is the practical means by which the registration
4764 system serves people who depend on long-term care. Older people, families and unpaid
4765 carers making decisions about care need to be able to verify that a provider is authorized,
4766 understand what services it is permitted to deliver, and identify any conditions or restrictions
4767 on its registration. Public information also supports the wider accountability of the regulatory
4768 system: independent advocacy organizations, researchers, journalists and other
4769 stakeholders can use the registry to monitor patterns and surface concerns that might
4770 otherwise go unaddressed. Where registry information is incomplete, out of date or

4771 accessible only through bureaucratic channels, registration becomes a regulatory
4772 transaction invisible to the people it is meant to protect.

4773 **Implementation guidance**

4774-4777
- Maintain a publicly accessible register of all licensed or registered long-term care providers, including service profile, ownership, capacity, registration status, conditions or restrictions, and the contact details of the regulator for queries and complaints.

4778-4779
- Update the register in a timely manner following decisions on new registrations, changes in registration status, and the imposition or lifting of conditions.

4780-4782
- Make the register accessible in plain-language formats and in the languages used by the populations served, including non-digital channels for older people without internet access.

4783-4785
- Link registration information to inspection and complaints information where these are publicly reported, so that the picture available to the public is integrated rather than fragmented across separate systems.

4786 **Indicative measures**

Type	**Indicative measure**
Input	A publicly accessible register of licensed or registered long-term care providers is maintained by the designated authority, with required content defined.
Process	Register entries are updated in a timely manner following changes in registration status; non-digital access channels are available.
Output	Older people, families and unpaid carers can readily identify whether a provider is registered, the scope of its registration and any conditions or restrictions.
Outcome	Use of the public register by care recipients, families, advocates and the wider public is supported by evidence of awareness and access; registration information visibly informs decisions about care.

4787 ***Quality Statement 26.3: Provider engagement and capability development***

4788 Public authorities maintain ongoing mechanisms for engagement with registered providers
4789 and for the development of provider capability, so that compliance with standards is

4790 supported and improved through guidance, peer learning and technical support, alongside
4791 oversight.

4792 **Rationale**

4793 Compliance with quality standards is supported not only by the prospect of inspection and
4794 enforcement, but by the active engagement of public authorities with providers on a
4795 continuing basis. Mechanisms for guidance, peer learning, capability development and
4796 technical support – including good-practice guidance, structured forums for providers,
4797 training programmes for managers and care workers, and targeted support for providers in
4798 difficulty – help raise the average level of provision and reduce the proportion of cases that
4799 escalate to enforcement action. This is particularly relevant in countries where the long-term
4800 care market includes many small providers and where capability constraints, rather than
4801 wilful non-compliance, are the predominant cause of substandard care. Engagement
4802 mechanisms also create channels through which providers can raise practical
4803 implementation issues with regulators, supporting the periodic reform of the framework (see
4804 Quality Statement 25.4). They are not a substitute for inspection or enforcement but operate
4805 alongside them, addressing problems before they cause harm and reducing the
4806 disproportionate burden of repeated enforcement on care recipients in poorly performing
4807 services.

4808 **Implementation guidance**

4809 • Establish public mechanisms for ongoing engagement with registered providers,
4810 including structured forums, advisory groups and consultation channels that include
4811 public, private and not-for-profit providers.

4812 • Issue good-practice guidance, training materials and implementation support tied to
4813 the adopted quality standards, and update these in response to inspection findings
4814 and emerging issues.

4815 • Provide targeted capability-development support for providers identified as at risk,
4816 before recourse to enforcement action where possible and consistent with the
4817 protection of care recipients.

4818 • Document and publish the use of engagement and capability-development
4819 mechanisms, including the relationship between these mechanisms and inspection
4820 and enforcement findings.

4821 **Indicative measures**

Type	Indicative measure
Input	Public authorities maintain mechanisms for ongoing engagement with registered providers and for capability development, with defined remit and

Type	Indicative measure
	resources.
Process	Guidance, peer learning and technical support are provided on a continuing basis; targeted support is available for providers identified as at risk.
Output	Provider engagement mechanisms cover public, private and not-for-profit providers across settings; capability-development activity is documented and reviewed.
Outcome	Substandard provision attributable to capability gaps is identified and addressed before causing harm; over time, the proportion of cases requiring formal enforcement is reduced.

4822 ## Standard 27: Oversight and enforcement

4823 *Routine oversight of registered providers, with graduated and proportionate enforcement,*
4824 *supports continuing compliance with standards, identifies risks early and protects care*
4825 *recipients from harm.*

4826 **Overview**

4827 Oversight and enforcement are the mechanisms by which the conditions agreed at
4828 registration are honoured in the day-to-day delivery of care. They are also the mechanisms
4829 most visible to care recipients when something goes wrong: the inspector who attends, the
4830 regulator who intervenes, the public report that follows. Where oversight is regular, risk-
4831 aware and substantive, problems are identified and corrected before they cause harm, and
4832 the public has a credible basis on which to trust the system. Where oversight is infrequent,
4833 narrowly focused on documentary compliance or detached from enforcement, the most
4834 dependent care recipients carry the cost of regulatory weakness.

4835 This Standard addresses regular inspection across all settings (Quality Statement 27.1);
4836 graduated and proportionate enforcement, including the most serious sanctions where
4837 required (3.2); the capacity and independence of the regulatory body (3.3); the public
4838 reporting of inspection and enforcement (3.4); and accessible channels for older people,
4839 families, unpaid carers and care workers to raise concerns and complaints (3.5).

4840 ### *Quality Statement 27.1: Regular inspection across settings*

4841 Registered or licensed long-term care providers are subject to regular, risk-informed
4842 inspection across all settings – residential, home-based and community-based – by trained
4843 inspectors against the adopted quality standards.

4844 **Rationale**

4845 Regular inspection is the most visible mechanism through which the regulatory framework
4846 reaches the front line of care. Inspections that are conducted on a defined cycle,
4847 supplemented by risk-triggered visits, and structured against the adopted quality standards
4848 provide regulators with current information on whether providers are meeting their
4849 obligations, and care recipients with the protection of an external observer with the powers
4850 and competence to hold providers to account. Comparative evidence across regulatory
4851 systems indicates that the frequency and quality of inspection is associated with improved
4852 compliance and improved resident-reported experience over time, with greater effect where
4853 inspection focuses on outcomes for care recipients rather than only on documentary
4854 compliance *(91, 103, 106)*. Where inspection is rare, narrowly focused on facility settings, or
4855 limited to scheduled visits with no risk-based component, providers in difficulty are not
4856 identified before harm occurs. The expansion of home and community-based care has
4857 increased the importance of inspection methods adapted to settings where regulators do not
4858 have the access they have to facilities, including outcome tracking, complaints analysis and
4859 sample-based reviews.

4860 **Implementation guidance**

4861 • Establish a regular cycle of inspection for all registered providers across home,
4862 community and residential settings, with risk-based scheduling that targets resources
4863 to higher-risk providers and settings.

4864 • Train inspectors in the adopted quality standards, in evidence-based inspection
4865 methods, and in how to engage directly with care recipients, families, unpaid carers
4866 and care workers as part of the inspection process.

4867 • Combine scheduled inspection with risk-triggered visits prompted by complaints,
4868 monitoring data, peer alerts or systemic intelligence; develop adapted inspection
4869 methods for home and community-based care that do not depend on physical
4870 inspection of premises alone.

4871 • Document inspection findings consistently, with an explicit link to the adopted quality
4872 standards and to the experience of care recipients.

4873 **Indicative measures**

Type	Indicative measure
Input	A regular inspection regime is established for all settings of long-term care, with risk-based scheduling and adapted methods for home and community-based care; inspectors are trained in the adopted standards.

Type	Indicative measure
Process	Inspections are conducted on the defined cycle and triggered by risk factors; engagement with care recipients, families, unpaid carers and care workers is documented as part of the inspection.
Output	Inspection findings are recorded consistently against the adopted quality standards; coverage of registered providers across all settings is achieved within the inspection cycle.
Outcome	Compliance with quality standards as observed at inspection improves over time; substandard provision is identified earlier; care recipients report that inspectors have engaged directly with them.

4874 ### *Quality Statement 27.2: Graduated and proportionate enforcement*

4875 The regulatory authority has, and uses, a graduated range of enforcement powers – from
4876 formal advice and improvement notices through conditions on registration, financial
4877 penalties and, where necessary, the suspension or revocation of registration – proportionate
4878 to the seriousness, persistence and risk of identified non-compliance, with safeguards for
4879 the continuity of care for affected care recipients.

4880 **Rationale**

4881 Enforcement that is proportionate to the seriousness and persistence of non-compliance
4882 protects care recipients without creating perverse incentives. A regulator with only a single,
4883 severe sanction available – facility closure, for example – will use that sanction reluctantly
4884 and rarely, leaving most non-compliance unaddressed. A regulator with only minor
4885 sanctions available will not be able to protect care recipients in the most serious cases. A
4886 graduated set of powers – formal advice, improvement notices, conditions on registration,
4887 financial penalties, suspension and, in the most serious cases, revocation of registration –
4888 allows the regulator to match the response to the risk and to escalate where providers fail to
4889 act on earlier interventions. The use of suspension or revocation, where required, must be
4890 paired with explicit safeguards for the continuity of care of affected residents and home-care
4891 recipients, including alternative placements, transition support and protection of legitimate
4892 expectations. Without such safeguards, the most serious enforcement actions can
4893 themselves harm the people they are intended to protect.

4894 **Implementation guidance**

4895 • Define in legislation or regulation a graduated range of enforcement powers –
4896 including formal advice, improvement notices, conditions on registration, financial

4897 penalties, prosecution where applicable, suspension of registration and revocation –
4898 with criteria for the use of each.

4899 • Set out the safeguards that apply where suspension or revocation is contemplated or
4900 implemented, including alternative placements, transition support for care recipients
4901 and families, and notification arrangements.

4902 • Use enforcement powers in proportion to the seriousness, persistence and risk of
4903 identified non-compliance; document the rationale for the action taken and for
4904 actions not taken.

4905 • Apply enforcement consistently across public, private and not-for-profit providers; act
4906 on patterns of non-compliance across providers under common ownership or
4907 management.

4908 **Indicative measures**

Type	Indicative measure
Input	A graduated range of enforcement powers is defined in legislation or regulation, including criteria for each level of enforcement and continuity safeguards for the most serious sanctions.
Process	Enforcement decisions follow documented criteria; rationales for action and inaction are recorded; continuity safeguards are applied where suspension or revocation is implemented.
Output	Enforcement is applied consistently across providers, settings and ownership types; suspension and revocation are used where the seriousness of non-compliance requires, with continuity arrangements in place.
Outcome	Care recipients are protected from serious or persistent non-compliance; the use of severe enforcement does not lead to displacement, loss of continuity or harm to the affected care recipients.

4909 **Box 44.** *Country example: Australia*

Australia's Royal Commission into Aged Care Quality and Safety (2018–2021) found systemic failures in oversight, enforcement and rights protection, leading to a comprehensive reform programme culminating in the Aged Care Act 2024. The Act establishes a rights-based framework for older people receiving aged care, including a statutory Statement of Rights; replaces multiple legacy quality frameworks with a single set of strengthened quality standards; and consolidates oversight under the Aged Care

Quality and Safety Commission with expanded enforcement powers, including civil penalties and compensation orders. The Act applies across residential, home and community-based aged care; introduces new provider-registration and worker-registration requirements; and establishes mechanisms for the participation of older people in governance, including advisory bodies and consumer engagement requirements *(101)*.

The Australian reform illustrates how a combination of independent inquiry, statutory rights, expanded enforcement powers and the consolidation of oversight authority can transform the governance of long-term care, while also illustrating the scale and duration of effort required: full implementation is staged over several years, with substantial transition support for providers and care recipients, and continuing public reporting on implementation progress.

4910 ***Quality Statement 27.3: Regulatory body capacity and independence***

4911 The regulatory authority responsible for inspection and enforcement has the legal mandate,
4912 technical and human resources, and structural independence required to carry out its
4913 functions impartially.

4914 **Rationale**

4915 A regulator without sufficient capacity cannot inspect at the cycle required, cannot pursue
4916 enforcement action through to conclusion, and cannot resist the regulatory capture that
4917 arises when a small number of large providers account for most of the market. A regulator
4918 without structural independence cannot inspect public providers as rigorously as private
4919 ones, cannot resist political pressure on individual decisions, and cannot maintain the public
4920 trust on which its authority depends. Capacity and independence are the structural
4921 conditions under which inspection and enforcement deliver on their stated purpose. Where
4922 one or both is absent, the regulatory framework becomes nominal: the standards exist, the
4923 powers exist, but the capacity to act on them does not.

4924 **Implementation guidance**

4925 • Establish the regulatory authority in legislation or regulation, with explicit functions,
4926 powers and accountability arrangements.

4927 • Provide the authority with the technical and human resources required for the scale
4928 and complexity of the long-term care market it oversees, with the resourcing
4929 reviewed periodically against demand.

4930 • Establish structural arrangements that protect the authority's independence in
4931 individual decisions, including from the parts of government that fund or commission
4932 long-term care provision.

4933 • Make the authority accountable through regular public reporting and through scrutiny
4934 by an independent oversight body or the legislature.

4935 **Indicative measures**

Type	Indicative measure
Input	The regulatory authority is established in law with defined functions, powers and structural independence; resourcing is reviewed periodically against the scale of the long-term care market.
Process	The authority exercises its functions impartially; mechanisms for protecting individual decisions from political or commercial pressure are operational.
Output	The authority publishes annual reports on its activity, capacity and findings; it is subject to scrutiny by an independent oversight body or the legislature.
Outcome	The authority is able to discharge its inspection and enforcement functions across the long-term care market within the established cycles; public confidence in the authority's impartiality and effectiveness is maintained.

4936 ***Quality Statement 27.4: Public reporting of inspection and enforcement***

4937 The findings of inspection and enforcement, including the performance of individual
4938 providers against the adopted quality standards and any enforcement actions taken, are
4939 publicly reported in formats accessible to older people, families, unpaid carers and the wider
4940 public.

4941 **Rationale**

4942 Public reporting of inspection and enforcement findings is the means by which the regulatory
4943 system is accountable to the people on whose behalf it acts. Reports that are accessible,
4944 timely and structured against the adopted quality standards allow older people and families
4945 to make informed decisions about care, support advocacy organizations and researchers to
4946 monitor the system, and create reputational consequences for providers that operate at the
4947 margins of compliance. Public reporting complements, rather than duplicates, the public
4948 registry of providers (Quality Statement 26.2): the registry establishes who is authorized to
4949 provide care, while inspection and enforcement reporting establishes how providers are
4950 performing. Where reporting is delayed, fragmented across separate systems or written in
4951 technical language inaccessible to non-specialists, this accountability dimension of the
4952 regulatory system is weakened, and the most dependent care recipients are the least
4953 equipped to navigate it.

4954 **Implementation guidance**

4955 4956 4957
- Publish inspection findings for each registered provider in a timely manner following inspection, with the report structured around the adopted quality standards and the experience of care recipients.

4958 4959
- Publish enforcement actions taken, including conditions imposed, financial penalties, suspensions and revocations, and the rationale for them.

4960 4961 4962
- Provide accessible summary information at provider level alongside the full reports, in plain language and in the languages used by the populations served, with non-digital access channels for older people without internet access.

4963 4964
- Aggregate and publish inspection and enforcement findings periodically at system level to enable analysis of patterns across providers, regions and ownership types.

4965 **Indicative measures**

Type	Indicative measure
Input	Public reporting of inspection findings and enforcement actions is required in legislation or regulation, with formats and accessibility specified.
Process	Inspection reports and enforcement decisions are published in accessible formats within defined timeframes; system-level analyses are produced periodically.
Output	The performance of individual providers against the adopted standards, and any enforcement actions taken, are visible to older people, families, advocates and the wider public.
Outcome	Care recipients and families use public reporting to inform decisions; reputational consequences of public reporting contribute, alongside formal enforcement, to improvements in compliance.

4966 ***Quality Statement 27.5: Channels for concerns and complaints***

4967 4968 4969
Accessible, timely and protective channels exist for older people, families, unpaid carers and care workers to raise concerns and complaints to the regulator about long-term care services, with safeguards against retaliation and a defined response protocol.

4970 **Rationale**

4971 4972 4973 4974
Inspection alone cannot detect every form of substandard care. Many of the most consequential concerns – about staff conduct, about the experience of individual residents, about practices that change when inspectors are present – surface only through the people who are present every day: care recipients themselves, their families and unpaid carers, and

4975 the workers who provide the care. Channels for these stakeholders to raise concerns and
4976 complaints with the regulator are therefore essential to the integrity of the oversight system.
4977 To be effective, these channels must be accessible (including for people with cognitive or
4978 communication impairments and in the languages used by the populations served), timely in
4979 their response, protective against retaliation and credibly resourced for follow-up. Where
4980 they are absent, slow or perceived to be unresponsive, the people best placed to identify
4981 substandard care will not raise it, and the regulator will not see what it most needs to see.
4982 These regulatory channels complement, but do not replace, the independent complaints and
4983 abuse-response mechanisms in Quality Statement 28.2 (Standard 28, Rights protection):
4984 the two operate together, with this Quality Statement focused on surfacing concerns to the
4985 oversight system and Quality Statement 28.2 focused on independent investigation and
4986 redress, particularly in cases of suspected abuse, neglect or exploitation.

4987 **Implementation guidance**

4988 • Establish accessible channels for raising concerns and complaints to the regulator,
4989 including non-digital channels and channels appropriate for people with cognitive or
4990 communication impairments.

4991 • Communicate the existence and use of these channels actively to care recipients,
4992 families, unpaid carers and care workers, including through the public registry and
4993 inspection reports.

4994 • Operate the channels under a defined response protocol with timeframes, including
4995 triage, investigation and feedback to the person raising the concern.

4996 • Establish protections against retaliation for those who raise concerns, including
4997 residents, family members, unpaid carers and care workers; act on credible reports
4998 of retaliation.

4999 **Indicative measures**

Type	Indicative measure
Input	Accessible channels for raising concerns and complaints to the regulator are established, with defined response protocols and protections against retaliation.
Process	Concerns and complaints are triaged, investigated and acted on within defined timeframes; protections against retaliation are enforced.
Output	Information on use of the channels – volumes, response times, outcomes – is publicly reported; the use of intelligence from the channels in inspection and

Type	Indicative measure
	enforcement is documented.
Outcome	Care recipients, families, unpaid carers and care workers report confidence in raising concerns; concerns inform regulatory action and surface substandard care that inspection alone would miss.

5000 ## Standard 28: Rights protection

5001 *The rights of care recipients are recognized in legislation and policy, supported by*
5002 *independent complaints, investigation and abuse-response mechanisms, accessible*
5003 *advocacy across all settings and arrangements that protect autonomy and supported*
5004 *decision-making.*

5005 **Overview**

5006 The rights protection function of governance exists because the people most dependent on
5007 long-term care are also the people most vulnerable to having their rights overridden – by
5008 providers, by family members, by the institutions that fund and regulate care. A regulatory
5009 framework that produces high-quality care on average but cannot protect the rights of
5010 individual care recipients in the worst situations has not done what the framework is for. This
5011 Standard establishes the elements that, together, constitute the rights-protection function:
5012 the statutory recognition of the rights themselves (Quality Statement 28.1); independent
5013 mechanisms through which complaints and abuse can be investigated and addressed (4.2);
5014 advocacy and support across all settings of care (4.3); and the legal capacity and supported
5015 decision-making arrangements that respect the autonomy of older people, including those
5016 with cognitive impairment (4.4).

5017 ### *Quality Statement 28.1: Statutory recognition of rights*

5018 The rights of older people receiving long-term care, and of their families and unpaid carers,
5019 are recognized in legislation or formal policy, including rights to dignity, autonomy, privacy,
5020 freedom from abuse, participation in decisions about their own care, and equal access
5021 regardless of personal characteristics or geographic location.

5022 **Rationale**

5023 Statutory recognition converts what would otherwise be aspirational standards of care into
5024 rights that care recipients and their representatives can invoke. Where rights are clearly
5025 named in law – drawing where applicable on constitutional foundations and on international
5026 instruments such as the Convention on the Rights of Persons with Disabilities and the
5027 regional human-rights conventions – providers are obliged to respect them, regulators have
5028 an explicit basis on which to act, and care recipients have a basis on which to challenge

5029 breaches. Where rights are recognized only in policy guidance or in the language of provider
5030 obligation, they remain dependent on the discretion of those who deliver and oversee care,
5031 and the people whose rights are most likely to be overridden are precisely those least able
5032 to assert them informally *(99, 100)*.

5033 **Implementation guidance**

5034 - Recognize the rights of older people receiving long-term care in legislation or formal
5035 policy, drawing where applicable on constitutional provisions, the Convention on the
5036 Rights of Persons with Disabilities and regional human-rights instruments.

5037 - Address the full range of relevant rights, including dignity, autonomy, privacy,
5038 freedom from abuse and neglect, participation in decisions about one's own care,
5039 equal access without discrimination and the right to redress.

5040 - Recognize the rights of unpaid carers and family members in their own right,
5041 including rights to information, consultation and support.

5042 - Make the rights of care recipients available in plain-language formats and in the
5043 languages used by the populations served, including in the materials given to people
5044 on entry to care.

5045 **Indicative measures**

Type	Indicative measure
Input	The rights of care recipients, and of unpaid carers and family members, are recognized in legislation or formal policy, with reference to applicable constitutional and international instruments.
Process	Information on rights is provided to care recipients on entry to care, in accessible formats and relevant languages; provider obligations to respect rights are reflected in registration conditions and quality standards.
Output	Statutory rights are referenced in inspection, complaints handling and enforcement processes.
Outcom e	Care recipients and their representatives are aware of their rights and able to invoke them; breaches of rights are identified and acted on through the available mechanisms.

5046 **Box 45.** *Country example: South Africa*

South Africa's Older Persons Amendment Act, 2025 (Act No. 1 of 2025), which amended

the Older Persons Act 2006, strengthens the statutory rights basis for long-term care and the mechanisms for protecting those rights. The Amendment Act broadens the abuse offences framework, introduces provisions for rapid intervention to protect older people identified as at imminent risk, strengthens registration and monitoring requirements for residential and community-based services, and clarifies the responsibilities of provincial departments of social development for inspection and oversight *(102, 110)*.

The South African example illustrates several governance points relevant to other countries: the Bill of Rights anchor in the Constitution provides the supreme legal basis on which the statutory framework rests; substantive amendment of an existing Act, rather than the adoption of an entirely new framework, is sometimes the most feasible route to strengthened rights protection; and the integration of abuse-protection provisions with the registration, monitoring and oversight machinery established under the parent Act allows rights protection to operate as part of the regulatory system rather than in parallel with it.

5047 ***Quality Statement 28.2: Independent complaints, investigation and response to abuse***

5048 Independent mechanisms exist to receive, investigate and respond to complaints from older
5049 people receiving long-term care and their representatives, including complaints alleging
5050 abuse, neglect or exploitation, with mandatory reporting obligations, multi-agency response
5051 arrangements and follow-through to prevention, support and redress.

5052 **Rationale**

5053 Independent complaints and investigation mechanisms are the institutional embodiment of
5054 the right to redress. They are independent of providers because providers cannot impartially
5055 adjudicate complaints against themselves, and independent in their funding and reporting
5056 lines from the parts of government that commission care, so that complaints touching on
5057 systemic issues can be investigated without conflict. Their scope must explicitly include
5058 allegations of abuse, neglect and exploitation – the most serious breaches of rights and the
5059 breaches that older people in care, particularly those with cognitive impairment, are least
5060 able to disclose unaided. The evidence base on the prevention of elder abuse indicates that
5061 effective response combines mandatory reporting by relevant professionals, multi-agency
5062 investigation linking regulators, social services, health services and police where required,
5063 support for the person affected, and follow-through to preventive measures at provider and
5064 system level *(108)*. Where complaints mechanisms are absent, weak or located within the
5065 providers complained against, the most serious breaches of rights remain hidden, and the
5066 people least able to advocate for themselves are the least protected. This independent
5067 rights-protection function operates alongside the regulator-side channels established in
5068 Quality Statement 27.5 (Standard 27, Oversight and enforcement): the two mechanisms are
5069 complementary but distinct, with Quality Statement 27.5 focused on surfacing concerns to

5070 the regulator and this Quality Statement focused on independent investigation and
5071 response, including for the most serious breaches.

5072 **Implementation guidance**

- 5073–5076 Establish independent mechanisms – through the regulator, an ombuds office, a designated commissioner or equivalent – to receive, investigate and respond to complaints from older people receiving long-term care and their representatives, including those alleging abuse, neglect or exploitation.
- 5077–5079 Require mandatory reporting of suspected abuse, neglect or exploitation by care workers, providers and other relevant professionals; protect those who report against retaliation.
- 5080–5082 Establish multi-agency arrangements for the investigation of serious cases, linking the regulator, social services, health services and police where criminal conduct may be involved.
- 5083–5085 Ensure that the response includes support for the person affected, redress where appropriate, and follow-through to preventive measures at provider and system level – including, where indicated, regulatory action under Standard 3.

5086 **Indicative measures**

Type	Indicative measure
Input	Independent mechanisms for complaints handling, investigation and abuse response are established, with multi-agency arrangements and mandatory reporting obligations defined.
Process	Complaints, including those alleging abuse, are triaged, investigated and acted on within defined timeframes; multi-agency response is invoked for serious cases; support and redress are provided.
Output	Findings from complaints and abuse investigations feed regulatory action, provider improvement and system-level prevention; the activity of independent mechanisms is publicly reported.
Outcome	Older people whose rights have been breached, including through abuse, are identified earlier and supported; preventive action visibly follows individual cases; the use of independent mechanisms is supported by evidence of awareness and access.

5087 ***Quality Statement 28.3: Advocacy and support across settings***

5088 Independent advocacy and support are available to older people receiving long-term care,
5089 and to their families and unpaid carers, across residential, home-based and community-
5090 based settings.

5091 **Rationale**

5092 Advocacy and support compensate for the asymmetry of power between care recipients and
5093 the institutions that provide and fund care. Older people receiving long-term care,
5094 particularly those with cognitive or communication impairments, may be unable to navigate
5095 complaints procedures, identify breaches of rights or articulate preferences about their own
5096 care without independent support. Advocacy services – independent of providers and of
5097 public commissioners – equip individuals to participate in decisions about their care, to
5098 engage with the rights-protection mechanisms established in this Standard, and to challenge
5099 institutional practices that may otherwise go unquestioned. Where advocacy is available
5100 only in residential settings, the growing population of older people receiving home and
5101 community-based care is left without comparable support; coverage across settings is
5102 therefore part of the standard, not an enhancement of it.

5103 **Implementation guidance**

5104 • Establish or commission independent advocacy and support services for older
5105 people receiving long-term care, with explicit independence from providers and from
5106 the parts of government that commission care.

5107 • Make advocacy services available across residential, home-based and community-
5108 based settings, with adapted approaches for people with cognitive or communication
5109 impairments.

5110 • Make information on the availability of advocacy and support routinely available to
5111 older people on entry to care, on transitions between settings and through the public
5112 registry and inspection reports.

5113 • Resource advocacy services adequately for the scale of demand and review
5114 resourcing periodically.

5115 **Indicative measures**

Type	Indicative measure
Input	Independent advocacy and support services are established and resourced for older people receiving long-term care across all settings.
Process	Information on advocacy and support is provided to older people on entry to care and on transitions; adapted approaches are available for people with

Type	Indicative measure
	cognitive or communication impairments.
Output	Coverage of advocacy and support across residential, home-based and community-based settings is documented; use of services by older people and their representatives is supported by evidence.
Outcome	Older people are able to participate in decisions about their care, raise concerns and access redress; advocacy contributes to identified improvements in provider practice and in the broader system.

5116 ### *Quality Statement 28.4: Legal capacity and supported decision-making*

5117 Older people, including those with cognitive impairment, are presumed to have legal
5118 capacity, with supported decision-making arrangements available to enable participation in
5119 decisions about their own care, and with substituted decision-making used only as a last
5120 resort, time-limited and subject to safeguards.

5121 **Rationale**

5122 Decisions about long-term care – where to live, how care is delivered, who provides intimate
5123 personal care, what risks to accept – are deeply personal. Default arrangements that
5124 remove decision-making authority from older people on the basis of cognitive impairment
5125 alone deny their autonomy and, in many cases, exceed what is actually required to keep
5126 them safe. The Convention on the Rights of Persons with Disabilities establishes the
5127 principle that persons with disabilities, including older people with cognitive impairment,
5128 retain legal capacity on an equal basis with others, and that supported decision-making –
5129 arrangements that enable a person to make and communicate decisions with whatever
5130 support is needed – is the appropriate response in most cases *(99)*. Substituted decision-
5131 making, where used, must be a last resort, time-limited, narrowly scoped to specific
5132 decisions and subject to safeguards including periodic review and the right to challenge.
5133 Where these principles are not embedded in legislation and practice, the autonomy of older
5134 people in long-term care is routinely overridden, often informally and without recourse.

5135 **Implementation guidance**

5136 • Establish in legislation the presumption of legal capacity for older people, including
5137 those with cognitive impairment.

5138 • Establish supported decision-making arrangements as the primary mechanism for
5139 assisting older people to make decisions about their care, with substituted decision-
5140 making available only where necessary, time-limited, narrowly scoped and subject to
5141 safeguards.

5142 5143 5144
- Train care workers, advocates and family members in supported decision-making approaches, and integrate these approaches into care planning under Standards 1 and 2.

5145 5146
- Establish mechanisms for the review of substituted decision-making arrangements at defined intervals and on request, with the right to challenge.

5147 **Indicative measures**

Type	Indicative measure
Input	Legislation establishes the presumption of legal capacity and supported decision-making as the primary mechanism; conditions and safeguards for substituted decision-making are defined.
Process	Care planning, complaints handling and rights-protection processes apply supported decision-making approaches; substituted decision-making is reviewed at defined intervals and on request.
Output	The use of supported decision-making across long-term care settings is documented; substituted decision-making is used as a last resort and time-limited.
Outcome	Older people, including those with cognitive impairment, participate in decisions about their care; arrangements that override autonomy are confined to the cases where they are genuinely required.

5148
Standard 29: Coordination across sectors and levels of government

5149 5150 5151 5152
Governance arrangements enable coordination across sectors and across levels of government – from national to community level – to support integrated, person-centred care, with structured participation of older people, families, unpaid carers and care workers in governance processes.

5153 **Overview**

5154 5155 5156 5157 5158 5159 5160
Long-term care is delivered at the intersection of many sectors and at multiple levels of public administration. The experience of integration or fragmentation that care recipients have therefore depends on whether the governance system has constructed working coordination across those sectors and levels – not only at national headquarters, but in the towns, neighbourhoods and homes where care is actually delivered. This Standard addresses cross-sector coordination at all levels (Quality Statement 29.1); accountability for continuity at the points of transition between services (5.2); the meaningful participation of

5161 care recipients, families, unpaid carers and care workers in governance processes (5.3);
5162 and the coordination of roles, responsibilities, principles and standards across national and
5163 subnational levels of government to safeguard equity across the territory (5.4).

5164 ### *Quality Statement 29.1: Cross-sector coordination at national, subnational and*
5165 ### *community levels*

5166 Mechanisms exist for coordination among the sectors relevant to long-term care – including
5167 health, social care, housing, social protection and labour – at national, subnational and
5168 community levels, with structured arrangements for joint planning, shared information and
5169 aligned resources.

5170 **Rationale**

5171 Long-term care that fits the lives of older people requires sectors that, in most public
5172 administrations, have grown up apart from one another – health, social care, housing, social
5173 protection, sometimes labour and education. In the absence of structural mechanisms to
5174 coordinate across these sectors, the burden of coordination falls on care recipients and their
5175 families, who must navigate separate referral systems, repeated assessments and
5176 inconsistent eligibility rules. Coordination mechanisms – designated coordinating bodies,
5177 shared assessment tools, pooled or aligned funding, care management roles, interoperable
5178 information systems – convert these separate sectoral inputs into a coherent response. The
5179 evidence is consistent that effective coordination requires both horizontal mechanisms
5180 across sectors at the same level and vertical mechanisms that link national, subnational and
5181 community levels *(95)*; concentrating on one without the other typically reproduces the
5182 fragmentation it was intended to address. The community level is critical and often the
5183 weakest: it is where the care is received, where multiple providers and informal networks
5184 intersect in the lives of individual older people, and where coordination, when it is achieved,
5185 takes the form of multi-sectoral partnerships among municipal authorities, primary health
5186 care, social services, community organizations and families.

5187 **Implementation guidance**

5188 • Establish formal cross-sector coordination arrangements at national, subnational and
5189 community levels, with defined remit, membership, decision rights and resources.

5190 • Strengthen multi-sectoral coordination at the community level specifically – linking
5191 municipal or local authorities, primary health care, social services, housing, civil
5192 society organizations and unpaid carer networks – through mechanisms appropriate
5193 to local context.

5194 • Develop and adopt shared assessment tools, aligned eligibility processes,
5195 interoperable information systems and pooled or aligned funding mechanisms across
5196 sectors, to reduce the coordination burden on care recipients and their families.

5197 5198 5199
- Define accountability arrangements that hold the coordination mechanisms themselves to account, with structured participation of older people, families and unpaid carers in monitoring how the mechanisms are working in practice.

5200 **Indicative measures**

Type	Indicative measure
Input	Formal cross-sector coordination arrangements are established at national, subnational and community levels; community-level multi-sectoral mechanisms are explicitly resourced.
Process	Shared assessment tools, aligned eligibility processes and information-sharing mechanisms are operational across sectors; community-level mechanisms convene and act on a continuing basis.
Output	Documented evidence of cross-sector coordination across the levels concerned; coverage of integration arrangements across the care continuum and across the territory.
Outcome	Care recipients experience coordinated rather than fragmented care; navigation burden on care recipients and unpaid carers is reduced; community-level coordination is visible to those receiving care.

5201 **Box 46.** *Country example: Costa Rica*

Costa Rica demonstrates how a middle-income country can establish long-term care coordination mechanisms anchored at the community level. The National Council of the Older Person (CONAPAM) coordinates national policy under the Ley Integral para la Persona Adulta Mayor, while the Red de Cuido (National Care Network) organizes community-based care delivery through local committees that bring together municipal authorities, primary health-care services, social welfare organizations, community organizations and families. CONAPAM transfers funding to certified social welfare organizations and local governments to provide care, prioritizing older people in situations of poverty or vulnerability *(95)*.

The Costa Rican model achieves both vertical coordination – from national policy to local delivery – and horizontal multi-sectoral coordination at the community level across health, social welfare and community services, without depending on a dedicated social insurance mechanism. It illustrates that effective coordination does not require the institutional complexity or fiscal resources of insurance-based systems, and that community governance structures can mobilize local resources – including family and

volunteer networks – within a coordinated national framework. It also illustrates the recurring challenge of variation across territories within decentralized arrangements, addressed in Quality Statement 29.4.

5202 ### *Quality Statement 29.2: Continuity across care transitions*

5203 Governance arrangements support continuity for care recipients at the points of transition
5204 between services and settings – including admission, discharge, change of provider and
5205 movement between residential, home and community-based care – with assigned
5206 responsibility for transitions and protected information flows.

5207 **Rationale**

5208 Transitions are the points at which fragmented systems most often fail care recipients. A
5209 person discharged from hospital to home care may experience a gap in medication
5210 management, an unmet need for housing adaptation, or the loss of services from a previous
5211 provider – each a foreseeable consequence of transition, each preventable by governance
5212 arrangements that assign responsibility, define information requirements and support the
5213 affected person through the change. Continuity at transitions is a governance function
5214 because it requires the coordination of actors who, in most administrations, do not share a
5215 single chain of accountability. It is also a rights-protection function: the people most likely to
5216 be harmed by failures at transition are those least able to compensate for those failures
5217 themselves *(95, 109)*.

5218 **Implementation guidance**

5219 • Establish governance arrangements that assign responsibility for the management of
5220 transitions between services and settings, with defined accountability for the
5221 continuity of the care recipient's experience.

5222 • Adopt protocols and information-sharing arrangements that support transitions,
5223 including discharge planning from hospital, transitions between providers and
5224 movements between settings.

5225 • Make information about transitions available to care recipients, families and unpaid
5226 carers in advance, and provide support during and after the transition.

5227 • Monitor the experience and outcomes of transitions and act on identified failures at
5228 system level.

5229 **Indicative measures**

Type	Indicative measure
Input	Governance arrangements for the management of care transitions are

Type	Indicative measure
	established, with assigned responsibility and information-sharing protocols.
Process	Transitions are managed under the established arrangements; information flows protect continuity; care recipients and families are informed and supported.
Output	Coverage of transition arrangements across the relevant pathways is documented; failures at transition are systematically identified.
Outcome	Care recipients experience continuity of care across services and settings; foreseeable harms at transition (medication errors, gaps in care, lost entitlements) are prevented or rapidly addressed.

5230 ***Quality Statement 29.3: Stakeholder participation in governance***

5231 Older people, families, unpaid carers and care workers participate meaningfully in the
5232 governance of long-term care – in the development and reform of standards and policies, in
5233 oversight processes and in the institutions through which long-term care is governed –
5234 through structured, resourced and accountable mechanisms.

5235 **Rationale**

5236 Meaningful participation in governance is both a principle and a practical determinant of
5237 system quality. Older people are the people whose lives the system most directly shapes;
5238 unpaid carers and families are the people who carry the largest share of long-term care
5239 provision worldwide; and care workers are the people who deliver paid care. Decisions
5240 made without their structured participation systematically miss what each of these groups
5241 can see and others cannot. Participation is also a foundational principle of the United
5242 Nations Decade of Healthy Ageing (2021–2030), which calls for the voice and meaningful
5243 engagement of older people in shaping the policies and services that affect their lives – a
5244 principle reflected in the global consultation that informs these standards. Mechanisms for
5245 participation must be structured (so that they operate consistently rather than at the
5246 discretion of individual decision-makers), resourced (so that participants have the time,
5247 information and support to contribute substantively) and accountable (so that the
5248 relationship between participation and the decisions that follow is visible) *(97, 100)*. Where
5249 participation is reduced to consultation on decisions already taken, or to the involvement of
5250 a small number of designated representatives, it does not deliver what it is intended to
5251 deliver, and the people whose participation matters most disengage.

5252 **Implementation guidance**

5253 • Establish in law or formal policy structured mechanisms for the participation of older
5254 people, families, unpaid carers and care workers in the governance of long-term
5255 care, including in standards development and reform, in oversight, and in the
5256 institutions responsible for governance functions.

5257 • Resource participation mechanisms with the time, information and support required
5258 for substantive contribution, including remuneration where appropriate, accessibility
5259 supports and language access.

5260 • Establish participation arrangements that reach beyond a small number of
5261 designated representatives, including community-level participation and
5262 arrangements adapted for older people in residential care or with cognitive or
5263 communication impairments.

5264 • Document and publish the relationship between stakeholder participation and the
5265 decisions taken, so that the impact of participation on governance is visible.

5266 **Indicative measures**

Type	Indicative measure
Input	Structured mechanisms for the participation of older people, families, unpaid carers and care workers in long-term care governance are established and resourced.
Process	Participation mechanisms operate on a continuing basis, with accessibility supports and language access; structured opportunities for input are provided at defined points in standards development, reform cycles, and oversight processes.
Output	The relationship between stakeholder participation and the decisions taken is documented and publicly available; participation reaches beyond designated representatives.
Outcome	Older people, families, unpaid carers and care workers report that their participation is meaningful and consequential; the governance of long-term care visibly reflects the perspectives of those it serves.

5267 **Box 47.** *Country example: Brazil*

Brazil has institutionalized the participation of older people in long-term care governance through the *Conselhos dos Direitos da Pessoa Idosa* (Councils for the Rights of the Older Person), established under the constitutional framework for older people (Article

230) and the Statute of the Elderly (Lei nº 10.741/2003). The councils operate at federal, state and municipal levels with statutory mandates that include policy formulation, monitoring of public policies and services, and oversight of fund allocation for older people. By statute, council membership is shared between government representatives and civil society representatives, the latter including older people themselves and the organizations that represent them.

The Brazilian model illustrates several governance points: statutory councils with defined mandates and shared membership convert the principle of participation into a continuing institutional practice rather than episodic consultation; the multi-level structure (federal, state, municipal) enables participation to operate at the levels at which decisions are taken; and the inclusion of monitoring and oversight functions, alongside policy formulation, gives the councils a substantive role in accountability. The model also illustrates the recurring challenge – common to participatory mechanisms in many countries – of ensuring that resourcing, technical support and reach are adequate at subnational levels, where capacity varies.

5268 5269 ***Quality Statement 29.4: Coordination of roles, responsibilities and standards across levels of government***

5270 Where governance is shared across national and subnational levels of government, the
5271 allocation of roles and responsibilities, the coordination of principles and standards, and the
5272 safeguarding of equity across the territory are explicitly addressed, so that minimum
5273 guarantees apply to care recipients regardless of where they live.

5274 **Rationale**

5275 Many countries deliver long-term care through governance arrangements distributed across
5276 national, regional, provincial and municipal levels. This is sometimes a legal necessity in
5277 federal or strongly decentralized systems, and is often desirable on grounds of subsidiarity,
5278 local responsiveness and policy experimentation. But unmanaged decentralization produces
5279 predictable harms: variable entitlements depending on where a person lives, fragmented
5280 data, regulatory standards interpreted inconsistently across jurisdictions, and the
5281 displacement of accountability between levels of government when systems fail. Multi-level
5282 governance is, therefore, itself a governance task. Where roles and responsibilities are
5283 explicitly delineated, where principles and standards are coordinated rather than imposed
5284 uniformly or left to drift, and where equity across the territory is treated as a national-level
5285 commitment rather than a subnational accident, decentralization can deliver the benefits of
5286 local responsiveness without the harms of fragmentation *(93, 95, 106)*. This Quality
5287 Statement is the counterpart to Quality Statement 29.1: 29.1 addresses cross-sector
5288 (horizontal) coordination at every level; 29.4 addresses vertical coordination between levels
5289 of government.

Implementation guidance

- Define in legislation or formal intergovernmental arrangements the allocation of roles and responsibilities for long-term care between national and subnational levels of government, including for entitlement, registration, inspection, enforcement, complaints and rights protection.
- Establish national-level minimum guarantees – covering entitlement to care, quality standards, rights protections and oversight – that apply across the territory regardless of subnational variation.
- Coordinate principles and standards across levels through mechanisms appropriate to the constitutional context, including intergovernmental councils, framework legislation, model standards or comparable arrangements; provide technical support to subnational governments with limited capacity.
- Monitor variation in access, quality and rights protection across subnational jurisdictions, with disaggregated data sufficient to identify systematic disparities, and act on the findings.

Indicative measures

Type	Indicative measure
Input	Allocation of roles and responsibilities across levels of government is defined in law or formal intergovernmental arrangements; national minimum guarantees are established.
Process	Mechanisms for the coordination of principles and standards across levels are operational; technical support is provided to subnational governments with limited capacity.
Output	Disaggregated data on access, quality and rights protection across subnational jurisdictions are produced and published; identified disparities are acted on.
Outcome	Minimum guarantees apply to care recipients across the territory; variation in access, quality and rights protection between subnational jurisdictions is reduced over time.

4. Implementation considerations

Adapting to institutional context

Governance arrangements vary significantly across countries based on constitutional structures, administrative traditions, regulatory capacity and system maturity. These standards describe what governance functions should be in place, not the specific institutional forms they must take. The same governance functions – legal authority, provider regulation, oversight, rights protection and coordination – can be achieved through diverse institutional arrangements, from a single integrated regulator to networks of sectoral and rights-based bodies operating under shared frameworks.

Progressive development

Countries at earlier stages of long-term care system development may implement these governance standards progressively. A common developmental sequence, drawn from the comparative evidence, moves through several phases: establishing basic provider registration and conditions of service; defining quality standards in legislation or policy; building inspection and monitoring capacity; developing graduated enforcement mechanisms; establishing independent complaints and advocacy mechanisms; and building coordination systems across sectors and levels of government. Countries need not complete one phase before beginning the next – many elements can be developed in parallel – but the sequence reflects a logical progression from the most foundational governance functions to the more complex.

Regulatory maturity and resource constraints

Countries with limited regulatory capacity face particular challenges in implementing comprehensive governance frameworks. In these settings, priorities should focus on establishing constitutional or legislative foundations for long-term care; building basic registration systems for providers; developing core quality standards adapted to home and community-based as well as residential care; and establishing complaints and rights-protection mechanisms. Risk-based approaches that target oversight to the highest-risk providers and settings can use limited inspection capacity efficiently.

Cultural and social factors strongly influence governance approaches – including expectations of family responsibility, the role of community institutions, and approaches to ageing and disability. Standards should be designed to accommodate these contextual variations while maintaining core requirements of care quality and rights protection.

Home and community-based care

A critical cross-cutting challenge for governance is the regulation and oversight of home and community-based care. Most existing regulatory frameworks were designed for facility-based care and do not transfer directly to services delivered in private homes or community settings. Countries should consider how each governance standard applies to home and community-based care specifically: registration and conditions of service (Standard 26) should extend to home and community-based providers; oversight methods (Standard 27)

5345 may include outcome tracking, complaints analysis and sample-based reviews rather than
5346 facility inspections; rights protections (Standard 28) should cover all care settings; and
5347 coordination mechanisms (Standard 29) – particularly multi-sectoral arrangements at
5348 community level – are particularly important where multiple providers deliver services to the
5349 same individual. Addressing this regulatory gap is a priority for governance development in
5350 all countries, given the global shift toward home and community-based care.

5351

5352
Chapter 8. Quality monitoring

5353 **Table 13.** *Standards and quality statements: Chapter 8, Quality monitoring*

Standard	Quality statements
Standard 30. Quality measurement and data systems	**30.1** Defined quality indicators across domains **30.2** Care recipient experience as core measurement **30.3** Standardized data collection and reporting **30.4** Data quality, completeness and timeliness
Standard 31. Inspection and assessment	**31.1** Regular external inspection **31.2** Inspection methods include direct observation **31.3** Inspection findings drive improvement
Standard 32. Complaints and feedback	**32.1** Accessible complaints processes **32.2** Timely investigation and response **32.3** Analysis of complaints data
Standard 33. Quality improvement	**33.1** Provider quality improvement programmes **33.2** System-level support for improvement **33.3** Identification and dissemination of good practice
Standard 34. Public transparency and accountability	**34.1** Regular provider reporting of quality data **34.2** Public access to provider quality

Standard	Quality statements
	information **34.3** Publication of inspection reports and ratings

5354 ## 1. Introduction

5355 The indicative measures presented in this chapter, and across the other chapters of the
5356 document, are developmental and illustrative. They are not finalized global benchmarking
5357 requirements, accreditation criteria, or reportable global indicators for Member States. The
5358 public consultation that accompanies this draft will be used to refine which measures are
5359 most useful at which level — country, provider, or person receiving care — and to assess
5360 their feasibility across diverse settings.

5361 This chapter establishes standards for quality monitoring in long-term care systems,
5362 focusing on the measurement, assessment, and improvement mechanisms that enable
5363 continuous quality enhancement. Effective quality monitoring provides information for
5364 accountability, identifies areas for improvement, and supports learning across the system.

5365 **Scope:** This chapter addresses system-level quality monitoring – how quality is measured,
5366 reported, and improved across LTC systems. It encompasses both external monitoring
5367 (inspection, audit, public reporting) and internal quality improvement processes. Service-
5368 specific quality measures are addressed within the relevant service chapters (HCBC, LTCF,
5369 Carers).

5370 **Relationship to Governance:** While the Governance chapter addresses the institutional
5371 framework and regulatory authority for LTC, this chapter focuses on the technical
5372 mechanisms for measuring and improving quality within that framework. Governance
5373 establishes who is responsible; Quality Monitoring addresses how performance is assessed
5374 and improved.

5375 ## 2. Background

5376 **Global situation.** Quality monitoring in LTC remains underdeveloped in most countries.
5377 While many high-income countries have established regulatory frameworks, inspection
5378 systems, and public reporting for residential care facilities, monitoring of home- and
5379 community-based care is considerably less advanced. In low- and middle-income countries,
5380 formal quality monitoring of LTC is often absent or limited to basic licensing requirements.
5381 The COVID-19 pandemic exposed critical gaps in LTC quality monitoring across all income
5382 levels, with devastating consequences for care recipients and staff.

Key challenges. Quality monitoring in LTC faces several challenges that distinguish it from health care quality assurance more broadly. LTC services span health and social care sectors, which are often governed and monitored separately. The private and informal nature of much LTC provision, particularly home-based care and family caregiving, makes systematic monitoring more difficult than in hospital or clinic settings. Many countries lack basic data on LTC provision, making it impossible to assess quality at a population level. And in settings where formal LTC systems are only beginning to develop, the priority is often establishing basic services rather than building monitoring infrastructure.

Why this matters

Quality monitoring is essential for accountability, improvement, and informed choice. Without systematic measurement, quality variations go undetected, poor performers escape scrutiny, and good practices are not identified for spread.

Effective quality monitoring serves multiple functions:

- **Accountability:** Holding providers responsible for meeting standards
- **Improvement:** Identifying deficiencies and driving quality enhancement
- **Choice:** Enabling informed decisions by care recipients and families
- **Learning:** Generating evidence on what works to improve care

3. Standards

Standard 30: Quality measurement and data systems

A comprehensive system of quality indicators and data infrastructure is in place to measure, collect, and analyse quality information across LTC services.

Quality Statement 30.1: Defined quality indicators across domains

Quality indicators are defined for key domains including safety, effectiveness, and person-centredness, incorporating both process measures and outcome measures.

Rationale A well-defined set of quality indicators is the foundation of any quality monitoring system. Indicators should capture meaningful aspects of care across multiple domains – including safety, effectiveness, and person-centredness. Including both process measures (what care is delivered and how) and outcome measures (what results are achieved for care recipients) provides a more complete picture of quality than either alone. Indicator sets should be evidence-based, periodically reviewed, and adapted to the types of LTC services being monitored, including both home and community-based care and residential facilities.

Implementation guidance

5415 5416 5417
- Establish a core set of quality indicators that are feasible to collect across care settings, using an established conceptual framework (for example, structure–process–outcome) to organize the indicator set.

5418 5419 5420
- Ensure indicators cover both HCBC and LTCF settings; many existing indicator sets focus primarily on institutional care, leaving gaps in monitoring of home-based services.

5421 5422
- Consider alignment with internationally recognized indicator domains where feasible, to facilitate cross-country learning and benchmarking.

5423 5424
- Involve care recipients, providers, and relevant experts in the selection and periodic review of indicators.

5425 **Indicative measures**

Type	Indicative measure
Input	Designated responsibility and resources for quality indicator development and review
Process	Systematic selection and periodic review of indicators across quality domains, with stakeholder input
Output	A defined national quality indicator set for LTC, covering safety, effectiveness, and person-centredness, with both process and outcome measures
Outcome	Quality indicators are in routine use and enable meaningful comparison across providers and over time

5426 ***Quality Statement 30.2: Care recipient experience as core measurement***

5427 5428 Care recipient experience and satisfaction are systematically assessed as a core component of quality measurement.

5429 5430 5431 5432 5433 5434 5435 5436 **Rationale** Clinical and process indicators alone do not capture whether care is delivered in a way that matters to the people receiving it. Systematic assessment of care recipient experience – including perceived dignity, responsiveness, communication, and involvement in decisions – provides essential information that complements clinical quality data. This is consistent with WHO's emphasis on user engagement as a cornerstone of effective quality management in long-term care. Experience measures should be collected directly from care recipients where possible, with appropriate adaptations for people with cognitive impairment or communication difficulties.

5437 **Implementation guidance**

5438 5439
- Use validated experience and satisfaction instruments that have been developed or adapted for LTC populations.

5440 5441 5442
- Ensure assessment methods are accessible to people with cognitive or communication difficulties, including through proxy reporting or observational approaches where necessary.

5443 5444
- Collect experience data at regular intervals – not only at discharge, admission, or in response to complaints.

5445 5446
- Use results to inform both provider-level care planning and system-level quality improvement.

5447 **Indicative measures**

Type	Indicative measure
Input	Validated approaches for assessing care recipient experience, with adaptations for cognitive impairment
Process	Proportion of LTC providers that regularly assess care recipient experience and satisfaction
Output	Care recipient experience data is collected, documented, and reported alongside clinical quality data
Outcome	Care recipient-reported experience improves over time; experience data demonstrably informs care delivery

5448 **Box 48.** *Country example: Ireland*

The Health Information and Quality Authority (HIQA) conducts national experience surveys of people receiving health and social care services, including LTC. These surveys collect information directly from care recipients on their experience of care quality, communication, dignity, and involvement in decisions. Survey results are published and used to inform policy, monitoring, and quality improvement. HIQA also developed its national standards through working groups that included service users, providers, and advocacy groups, ensuring that care recipient perspectives are embedded in both standard-setting and ongoing quality assessment.

5449 5450 ***Adaptation for resource-limited settings****: Where national-level surveys are not yet feasible, experience data can be collected at provider level through brief, structured*

5451 *feedback tools administered by community health workers during routine visits, building a*
5452 *practice of systematic user input from the earliest stages of quality monitoring*.

5453 ***Quality Statement 30.3: Standardized data collection and reporting***

5454 LTC providers collect and report quality data using standardized approaches, with data
5455 systems enabling analysis at provider, regional, and national levels.

5456 **Rationale** Quality indicators are only useful if data is collected consistently and can be
5457 aggregated for meaningful comparison. Standardized data collection enables benchmarking
5458 across providers, tracking of trends over time, and identification of outliers requiring
5459 attention. Data systems should support analysis at multiple levels – from individual provider
5460 performance to regional patterns and national overviews – to inform both operational
5461 improvement and policy decisions.

5462 **Implementation guidance**

5463 • Establish standardized data collection tools and reporting formats for all LTC
5464 providers, drawing on internationally validated assessment instruments where
5465 available.

5466 • Invest in data infrastructure that allows linking and analysis across settings and
5467 administrative levels.

5468 • Provide training and technical support to providers, particularly in settings with limited
5469 data capacity.

5470 • Consider phased implementation, starting with a minimum data set for all providers
5471 and expanding as capacity develops.

5472 **Indicative measures**

Type	Indicative measure
Input	Standardized data collection tools and national LTC data infrastructure
Process	Proportion of LTC providers collecting and submitting quality data using standardized approaches
Output	Quality data is available for benchmarking at provider, regional, and national levels
Outcome	Quality data is routinely used for trend analysis, outlier identification, and evidence-based policy decisions

5473 **Box 49.** *Country example: Canada*

> The Canadian Institute for Health Information (CIHI) maintains national data systems for LTC, including the Continuing Care Reporting System (now transitioning to the Integrated interRAI Reporting System). Using standardized assessment instruments, facilities report data on resident characteristics and quality indicators across 34 tested measures of care quality. CIHI publishes comparative reports enabling benchmarking across provinces and facilities, and provides authorized users with secure tools to view, trend, and compare quality indicators across organizations.

5474 ***Adaptation for resource-limited settings:*** Countries with limited data infrastructure may
5475 begin with provider self-assessment against minimum standards, as in Romania, where
5476 provider scores against minimum standards determine licensing and influence budget
5477 allocations. India monitors community-based care through financial audits and quarterly
5478 programme reviews, linking continued funding to compliance.

5479 ***Quality Statement 30.4: Data quality, completeness and timeliness***

5480 Data quality, completeness, and timeliness are systematically monitored and validated.

5481 **Rationale** Poor data quality undermines the entire quality monitoring system. Incomplete,
5482 inaccurate, or delayed data can lead to misleading conclusions about provider performance
5483 and misallocation of improvement resources. Systematic validation processes – including
5484 completeness checks, consistency audits, and timeliness monitoring – are essential to
5485 ensure that quality data is trustworthy and actionable.

5486 **Implementation guidance**

5487 • Define minimum standards for data completeness and reporting timeliness.

5488 • Implement routine data validation checks at point of collection and at system level.

5489 • Provide regular feedback to providers on their data quality performance.

5490 • Where data is used for public reporting or benchmarking, publish data quality metrics
5491 alongside quality indicators to support transparent interpretation.

5492 **Indicative measures**

Type	Indicative measure
Input	Defined standards for data completeness, timeliness, and accuracy
Process	Routine data validation and feedback to providers on reporting performance
Output	Data completeness and timeliness rates across reporting providers

Type	Indicative measure
Outcome	Quality data is sufficiently reliable for public reporting and decision-making

5493 ## Standard 31: Inspection and assessment

5494 *External inspection or assessment processes evaluate provider compliance with quality*
5495 *standards and identify areas requiring improvement.*

5496 ### *Quality Statement 31.1: Regular external inspection*

5497 Regular external inspections assess provider compliance with quality standards.

5498 **Rationale** External inspection provides independent verification of quality that goes beyond
5499 self-reported data. Regular inspections – whether announced, unannounced, or a
5500 combination – help ensure that providers consistently meet defined quality standards.
5501 Unannounced inspections are particularly important for capturing everyday practices rather
5502 than prepared performance. The frequency and intensity of inspections should be
5503 proportionate to risk, with providers demonstrating persistent non-compliance subject to
5504 more frequent review.

5505 **Implementation guidance**

5506 • Establish a clear legal basis for external inspection of LTC providers, including the
5507 authority to conduct unannounced visits.

5508 • Adopt a risk-based approach to determine inspection frequency, targeting more
5509 frequent inspections for higher-risk providers.

5510 • Develop standardized inspection protocols and train inspectors to ensure
5511 consistency across regions and over time.

5512 • Ensure inspections cover all types of regulated LTC providers, including HCBC, not
5513 only residential facilities.

5514 **Indicative measures**

Type	Indicative measure
Input	Legal authority, standardized inspection protocols, and trained inspection personnel
Process	Frequency and coverage of inspections across all regulated LTC settings,

Type	Indicative measure
	including proportion conducted unannounced
Output	Proportion of regulated LTC providers inspected within the defined cycle
Outcome	Providers consistently meet defined quality standards; non-compliance rates decrease over time

5515 **Box 50.** *Country example: England (United Kingdom)*

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. All LTC providers – including home care agencies and residential facilities – must register with CQC and meet fundamental standards. CQC conducts both announced and unannounced inspections, assessing services against five key questions: Is it safe? Effective? Caring? Responsive? Well-led? Providers receive an overall rating (Outstanding, Good, Requires Improvement, or Inadequate) as well as individual ratings for each domain. Inspection reports and ratings are published online, enabling public comparison of providers. CQC employs a graduated enforcement approach, ranging from improvement requirements to sanctions and, in serious cases, cancellation of registration.

5516 ***Adaptation for resource-limited settings:*** Where dedicated inspection bodies are not yet
5517 established, countries may embed quality oversight within existing programme supervision
5518 or local government structures. Singapore conditions provider subsidies on standard
5519 adherence, combining financial oversight with quality monitoring.

5520 ***Quality Statement 31.2: Inspection methods include direct observation***

5521 Inspection methodologies include direct observation and engagement with care recipients.

5522 **Rationale** Inspections based solely on documentation review may not capture the actual
5523 experience of care. Direct observation of care practices and living conditions, combined with
5524 engagement with care recipients and their families, provides richer and more reliable
5525 information about the quality of care as it is actually delivered. This approach also signals to
5526 care recipients that their perspectives are valued in the regulatory process.

5527 **Implementation guidance**

5528 • Include direct observation of care delivery, living environments, and staff–resident
5529 interactions as a standard component of inspections.

5530 • Incorporate structured interviews or conversations with care recipients and families
5531 into inspection methodologies, with appropriate accommodations for those with
5532 cognitive or communication difficulties.

5533 • Train inspectors in person-centred assessment approaches that go beyond
5534 regulatory checklists.

5535 **Indicative measures**

Type	Indicative measure
Input	Inspection methodologies incorporating observation, care recipient interviews, and person-centred assessment
Process	Inspectors observe care delivery, living conditions, and staff-resident interactions, and speak with care recipients and families during visits
Output	Inspection findings incorporate information from observation and care recipient perspectives, not solely from documentation review
Outcome	Inspection assessments identify gaps between documented care plans and observed care delivery; care recipient-reported concerns are reflected in inspection findings.

5536 ***Quality Statement 31.3: Inspection findings drive improvement***

5537 Inspection findings inform improvement requirements and follow-up.

5538 **Rationale** Inspections are only effective if findings lead to action. When deficiencies are
5539 identified, clear improvement requirements should be communicated to providers, with
5540 defined timelines for corrective action and systematic follow-up to verify compliance. A
5541 graduated enforcement approach – ranging from improvement support to sanctions and, in
5542 serious cases, suspension of operations – helps balance accountability with encouragement
5543 of improvement.

5544 **Implementation guidance**

5545 • Establish a graduated response framework that links the severity of findings to
5546 proportionate enforcement actions.

5547 • Require providers to submit improvement plans in response to identified deficiencies
5548 and conduct follow-up inspections to verify implementation.

5549 • Track patterns of non-compliance across providers and over time to identify systemic
5550 issues requiring policy-level action.

5551 **Indicative measures**

Type	Indicative measure
Input	A graduated response framework linking severity of findings to proportionate enforcement actions
Process	Providers receive clear improvement requirements with defined timelines; follow-up inspections verify compliance
Output	Proportion of providers with identified deficiencies that have documented improvement plans and completed follow-up
Outcome	Persistent non-compliance is reduced; quality trajectories improve across inspection cycles

5552 **Box 51.** *Country example: Germany*

In 2019, Germany reformed its nursing home quality assessment system, replacing the previous “Pflege-TÜV” grading system, which had been widely criticized for lacking sensitivity to quality differences. Under the new system, nursing homes collect and report standardized quality indicators covering domains such as mobility, cognitive function, pain management, and nutrition. The Medizinischer Dienst (MD), an independent body, conducts regular unannounced inspections that assess both indicator data and observed care quality. Inspection findings are published in publicly accessible transparency reports. Studies of earlier public reporting reforms found that the introduction of quality transparency was associated with measurable improvements in selected care quality indicators, particularly among lower-performing facilities.

5553 ***Adaptation for resource-limited settings****: Where independent inspection bodies are not*
5554 *yet established, countries may begin by linking quality compliance to existing administrative*
5555 *processes such as provider licensing renewal or programme funding eligibility, creating a*
5556 *basic incentive structure for responding to identified deficiencies.*

5557 Standard 32: Complaints and feedback

5558 *Accessible mechanisms exist for care recipients, families, and staff to provide feedback and*
5559 *raise concerns, with assurance of appropriate response.*

5560 *Quality Statement 32.1: Accessible complaints processes*

5561 Clear, accessible complaints processes are available to care recipients and families.

5562 **Rationale** Complaints and feedback provide crucial intelligence about quality problems that
5563 may not be captured through routine data collection or inspection. Many care recipients –
5564 particularly those with cognitive impairment, limited literacy, or dependency on the provider –
5565 face significant barriers to raising concerns. Effective complaints systems must be genuinely
5566 accessible, available through multiple channels, and designed to protect complainants from
5567 retaliation. Independent complaints mechanisms – such as ombudsman programmes – can
5568 provide an important alternative where care recipients may not feel safe raising concerns
5569 directly with their provider.

5570 **Implementation guidance**

5571 • Ensure complaints processes are available through multiple channels (in person,
5572 telephone, written, digital) and in accessible formats.

5573 • Establish independent complaints mechanisms, such as ombudsman services, to
5574 provide a safe alternative to provider-internal processes.

5575 • Provide clear, plain-language information about how to make a complaint and what
5576 to expect from the process.

5577 • Implement safeguards to protect complainants from retaliation, including anonymous
5578 reporting options.

5579 **Indicative measures**

Type	Indicative measure
Input	Complaints processes available through multiple channels, including independent mechanisms
Process	Care recipients and families are informed of how to raise concerns and are protected from retaliation
Output	Complaints are received from across population groups, including vulnerable individuals and those with cognitive impairment
Outcome	Care recipients and families report satisfaction with the accessibility and responsiveness of complaints processes (for example, through periodic user experience surveys)

5580 **Box 52.** *Country example: Netherlands*

Under the Healthcare Quality, Complaints and Disputes Act (Wkkgz), all care providers in the Netherlands are required to appoint an independent complaints officer. If the

complaints officer cannot resolve the issue, clients can escalate to an independent complaints committee. The Health and Youth Care Inspectorate (IGJ) provides additional oversight, conducting risk-based supervision including unannounced visits and, in some cases, deploying mystery guests to assess the quality of care for vulnerable groups such as older people. Providers are also required to maintain internal incident reporting systems and to notify the IGJ of serious adverse events.

5581 ***Adaptation for resource-limited settings:*** Where independent complaints bodies are not
5582 feasible, countries can establish escalation pathways beyond the provider, such as through
5583 local government offices or community health committees. Thailand integrates feedback
5584 channels within its primary health care network at the sub-district level.

5585 ***Quality Statement 32.2: Timely investigation and response***

5586 Complaints are investigated and addressed within defined timeframes.

5587 **Rationale** A complaints system that does not respond promptly and effectively will quickly
5588 lose the trust of care recipients and families. Defined timeframes for acknowledgement,
5589 investigation, and resolution help ensure accountability and demonstrate that concerns are
5590 taken seriously. The process should be transparent, with complainants kept informed of
5591 progress and outcomes.

5592 **Implementation guidance**

5593 • Define maximum timeframes for each stage of the complaints process
5594 (acknowledgement, investigation, resolution).

5595 • Ensure complainants receive written confirmation and are kept informed of progress.

5596 • Provide appeal mechanisms for complainants who are dissatisfied with the outcome.

5597 **Indicative measures**

Type	Indicative measure
Input	Defined procedures and maximum timeframes for complaint acknowledgement, investigation, and resolution
Process	Complaints are investigated and complainants kept informed of progress and outcomes
Output	Proportion of complaints investigated and resolved within defined timeframes

Type	Indicative measure
Outcome	Complaints are resolved in a timely, fair, and transparent manner; complainants are informed of outcomes and available recourse.

5598 ### *Quality Statement 32.3: Analysis of complaints data*

5599 Complaint data is analysed to identify systemic issues and trends.

5600 **Rationale** Individual complaints often reflect broader systemic problems. Aggregating and
5601 analysing complaint data can reveal patterns – by provider, service type, region, or issue
5602 category – that would not be visible from individual cases alone. This intelligence should
5603 feed into both regulatory oversight and system-level quality improvement planning.

5604 **Implementation guidance**

5605 • Establish standardized complaint categorization and recording systems.

5606 • Analyse complaint data regularly to identify systemic issues, high-risk providers, and
5607 emerging trends.

5608 • Share aggregate findings with regulatory authorities and quality improvement bodies.

5609 **Indicative measures**

Type	Indicative measure
Input	Standardized complaint categorization and recording systems
Process	Regular analysis of complaint data to identify patterns by provider, region, or issue type
Output	Systemic issues and high-risk providers identified through complaint trend analysis
Outcome	Complaint intelligence informs regulatory oversight, policy action, and system-level quality improvement

5610 ## Standard 33: Quality improvement

5611 *Systematic quality improvement processes are in place at provider and system levels to*
5612 *drive continuous enhancement of care.*

5613 ### *Quality Statement 33.1: Provider quality improvement programmes*

5614 Providers are required to maintain quality improvement programmes.

5615 **Rationale** Quality monitoring should not only identify problems but actively drive
5616 improvement. Provider-level quality improvement programmes – incorporating structured
5617 methodologies such as plan–do–study–act (PDSA) cycles, root cause analysis, and clinical
5618 audit – help translate quality data into tangible improvements in care delivery. Quality
5619 improvement should be embedded in routine practice, not treated as a separate activity.

5620 **Implementation guidance**

5621 - Require all regulated LTC providers to implement and document quality improvement
5622 activities.
5623 - Promote the use of structured quality improvement methodologies appropriate to the
5624 provider's capacity and context.
5625 - Integrate quality improvement requirements into licensing and accreditation
5626 processes.

5627 **Indicative measures**

Type	Indicative measure
Input	Requirements and guidance for providers to undertake quality improvement
Process	Providers implement structured improvement activities informed by quality data, inspection findings, and care recipient feedback
Output	Proportion of providers with documented quality improvement programmes
Outcome	Measurable improvement in quality indicator performance over time

5628 **Box 53.** *Country example: Australia*

Following the Royal Commission into Aged Care Quality and Safety, Australia strengthened quality improvement requirements. The Strengthened Aged Care Quality Standards (effective November 2025), introduced under the Aged Care Act 2024, require providers to implement continuous improvement systems, demonstrate outcomes improvement, and participate in sector-wide quality initiatives. The Aged Care Quality and Safety Commission conducts audits against the new standards, provides improvement resources and support, and employs a graduated enforcement approach proportionate to risk.

5629 ***Adaptation for resource-limited settings:*** Quality improvement may be integrated into
5630 existing programme supervision rather than established as a separate function. Thailand

5631 embeds quality oversight within primary health care structures at the sub-district level. India
5632 enables suspension of programme funding for non-compliance, creating an enforcement-
5633 based pathway to improvement.

5634 ***Quality Statement 33.2: System-level support for improvement***

5635 System-level support is available for quality improvement activities.

5636 **Rationale** Individual providers, particularly smaller or less-resourced ones, may lack the
5637 capacity to design and implement effective quality improvement on their own. System-level
5638 support – including training, technical assistance, improvement collaboratives, and shared
5639 learning platforms – helps build quality improvement capacity across the sector. This is
5640 especially important in LMICs and in home-based care settings where providers may be
5641 small and geographically dispersed.

5642 **Implementation guidance**

5643 • Establish or designate national or regional bodies to provide quality improvement
5644 support to LTC providers.

5645 • Facilitate learning networks, improvement collaboratives, and peer-to-peer exchange
5646 among providers.

5647 • Provide targeted capacity-building support to smaller and less-resourced providers.

5648 **Indicative measures**

Type	Indicative measure
Input	National or regional bodies designated to provide quality improvement support
Process	Provision of training, technical assistance, learning networks, and peer exchange for LTC providers
Output	Providers, including smaller and less-resourced ones, participate in quality improvement support activities
Outcome	(1) Quality improvement capacity is strengthened across the LTC sector (2) Providers in underserved and low-resource settings have access to and participate in quality improvement support

5649 ***Quality Statement 33.3: Identification and dissemination of good practice***

5650 Good practices are identified and disseminated across the system.

5651 **Rationale** Effective quality improvement depends not only on identifying problems but also
5652 on recognizing and spreading what works well. Systematic identification, documentation,
5653 and dissemination of good practices across providers and regions accelerates improvement
5654 across the system as a whole. This includes both evidence-based innovations and locally
5655 developed practices that have demonstrated positive outcomes.

5656 **Implementation guidance**

5657 • Establish mechanisms for identifying and documenting good practices, including
5658 through inspection findings, quality data analysis, and provider nominations.

5659 • Disseminate good practices through accessible channels such as practice guides,
5660 case studies, and learning events.

5661 • Consider recognition or incentive programmes that reward quality improvement
5662 achievements.

5663 **Indicative measures**

Type	Indicative measure
Input	Mechanisms for identifying good practices through inspection findings, quality data, and provider networks
Process	Good practices are documented and shared through accessible channels (for example, practice guides, case studies, learning events)
Output	Documented good practices are available and disseminated across the system
Outcome	Effective practices are adopted beyond the originating provider, contributing to sector-wide improvement

5664 ## Standard 34: Public transparency and accountability

5665 *Quality information is systematically reported by providers and made publicly available to*
5666 *support accountability and enable informed choice by care recipients and families.*

5667 ### *Quality Statement 34.1: Regular provider reporting of quality data*

5668 LTC providers are required to report quality data to designated authorities on a regular
5669 basis.

5670 **Rationale** Systematic quality reporting by providers is essential for system-level monitoring
5671 and accountability. Without it, quality information remains fragmented and unavailable for
5672 oversight. Where regulatory authority is strong, reporting can be mandated with

5673 standardized formats and defined frequency. Where private providers predominate,
5674 reporting may be linked to licensing, accreditation, or funding eligibility to ensure shared
5675 accountability between providers and authorities.

5676 **Implementation guidance**

5677 • Establish regulatory requirements for all LTC providers to report defined quality data
5678 at specified intervals.

5679 • Define standardized reporting formats to ensure comparability across providers.

5680 • Implement mechanisms to monitor reporting compliance and follow up on non-
5681 reporting providers.

5682 **Indicative measures**

Type	Indicative measure
Input	Regulatory requirements specifying reporting content, format, and frequency for LTC providers
Process	Providers submit quality data to designated authorities at defined intervals
Output	Proportion of regulated providers complying with quality data reporting requirements
Outcome	Providers and authorities have shared access to quality information, enabling both regulatory oversight and collaborative improvement.

5683 ***Quality Statement 34.2: Public access to provider quality information***

5684 Quality information about providers is publicly accessible and presented in formats
5685 understandable to care recipients and families.

5686 ***Rationale*** *Public reporting of quality information creates accountability pressure on*
5687 *providers and enables care recipients and families to make informed choices. However,*
5688 *public availability alone is not sufficient — technical reports and statistical data may be*
5689 *valuable for professionals but are often inaccessible to older people and their families.*
5690 *Quality information should be published through accessible platforms, presented in plain*
5691 *language with clear visual formats, and where possible include summary ratings or*
5692 *comparisons that enable non-expert users to make meaningful distinctions between*
5693 *providers.*

5694 **Implementation guidance**

5695 • Make provider-level quality information available through publicly accessible
5696 platforms, such as government websites or dedicated quality portals.

5697 • Present information in plain language with clear visual formats (for example,
5698 summary ratings, comparative displays), tested with intended audiences.

5699 • Update public quality information regularly to reflect the most recent available data.

5700 • Provide information in multiple languages and accessible formats where relevant to
5701 the population served

5702 **Indicative measures**

Type	Indicative measure
Input	Effective and adequately resourced mechanisms to compile, present, and publish provider quality information
Process	Quality information is compiled, presented in user-friendly formats, published, and regularly updated
Output	Provider-level quality information is publicly available, current, and understandable to non-expert users
Outcome	Care recipients and families are informed about provider quality and use this information in care decisions

5703 ***Quality Statement 34.3: Publication of inspection reports and ratings***

5704 Inspection reports and quality ratings are published.

5705 **Rationale** The publication of inspection reports and, where applicable, quality ratings
5706 provides a powerful transparency and accountability mechanism. Published inspection
5707 findings allow care recipients and families to assess not only current quality levels but also
5708 compliance trajectories over time. Quality ratings or summary scores can further simplify
5709 comparison. However, published information should be accompanied by sufficient context to
5710 avoid oversimplification or unfair characterization of providers.

5711 **Implementation guidance**

5712 • Publish inspection reports for all regulated LTC providers, including both summary
5713 findings and, where appropriate, detailed reports.

5714 • Where quality rating systems are used, ensure that rating methodologies are
5715 transparent and publicly documented.

5716 • Include contextual information alongside published reports and ratings to support fair
5717 interpretation.

5718 **Indicative measures**

Type	Indicative measure
Input	Mechanisms to compile, quality-assure, and publish inspection results and quality ratings
Process	Inspection reports and quality ratings are published and regularly updated for all regulated providers
Output	Publication rate of inspection reports; availability of quality ratings for regulated providers
Outcome	Providers, care recipients, and the public can track quality performance and compliance trajectories over time

5719 **Box 54.** *Country example: Republic of Korea*

Following the introduction of mandatory Long-Term Care Insurance (LTCI) in 2008, the Republic of Korea rapidly established a nationwide quality evaluation system administered by the National Health Insurance Service (NHIS). Quality monitoring covers five domains: management of institutions, environment and safety, rights and responsibilities, process of services, and outcome of services. Evaluation scores (grades A–E) are publicly disseminated through an official LTCI website, enabling care recipients and families to compare providers. High-performance institutions receive financial incentives of 1–2% additional reimbursement. The quality of nursing homes is assessed every three years, with results publicly available. This demonstrates how a relatively recently established LTC system can build quality evaluation and public disclosure mechanisms within a centralized insurance framework.

5720 ***Adaptation for resource-limited settings:*** Where comprehensive public reporting
5721 platforms are not yet feasible, countries may begin by publishing basic provider registration
5722 information and summary inspection results through existing government websites or local
5723 authority channels.

5724 4. Implementation considerations

5725 **Contextual Adaptation**

5726 Quality monitoring approaches should be adapted to system context, including regulatory
5727 capacity, data infrastructure, and provider maturity. More advanced systems may emphasize
5728 outcome measurement and public reporting; developing systems may focus first on
5729 establishing basic compliance monitoring and data collection. The goal is continuous
5730 improvement regardless of starting point.

5731 Countries may consider a phased approach: (1) establishing provider registration and basic
5732 safety requirements; (2) introducing standardized data collection and regular inspection; (3)
5733 developing public reporting and quality improvement support; (4) building toward outcome
5734 measurement and system-level benchmarking. Not all phases need to be completed before
5735 benefits are realized, even basic registration and inspection can drive significant
5736 improvement.

5737 **Balancing Functions**

5738 Quality monitoring serves both accountability and improvement functions, which can create
5739 tensions. Punitive approaches may discourage honest reporting; purely supportive
5740 approaches may lack accountability teeth. Effective systems combine clear standards with
5741 graduated responses and support for improvement. The balance between these functions
5742 should reflect the maturity of the system: in early stages, emphasis on support and capacity-
5743 building may be more productive than strict enforcement; as the system matures, stronger
5744 accountability mechanisms become both feasible and necessary.

5745 **Monitoring HCBC**

5746 Most existing quality monitoring frameworks have been developed for facility-based care.
5747 Applying these approaches to home- and community-based care presents distinct
5748 challenges: care is delivered in private residences, providers may be individual workers
5749 rather than organizations, and direct observation is more intrusive. Quality monitoring for
5750 HCBC may need to rely more heavily on care recipient experience data, routine outcome
5751 reporting, and targeted risk-based oversight rather than scheduled facility inspections.

5752 **Key Enablers**

5753 • **Data infrastructure:** Systems for collecting, storing, and analysing quality data

5754 • **Workforce capacity:** Trained inspectors and quality improvement specialists

5755 • **Standardized tools:** Validated assessment instruments and indicator definitions

5756 • **Culture of quality:** Provider and system commitment to continuous improvement

5757 • **Linkages across system functions:** Quality monitoring is most effective when
5758 connected to governance (Chapter 7), workforce development (Chapter 5), and
5759 financing mechanisms (Chapter 6) that create aligned incentives for quality

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5761

5762 # Annex: All standards and quality statements

5763 This annex provides the complete list of standards and quality statements set out across
5764 Chapters 2 to 8. It is intended as a quick reference and navigation aid. Each chapter's
5765 detailed standard statements, rationales, implementation guidance, and indicative measures
5766 are presented in the relevant chapter.

5767 **Table 14.** *Complete list of standards and quality statements (Chapters 2–8)*

Standard	QS no.	Quality statement
Chapter 2. Home and community-based care		
Standard 1. Entry, assessment and care coordination	**1.1**	Accessible entry to services
	1.2	Comprehensive needs assessment
	1.3	Personalized care planning
	1.4	Care coordination
Standard 2. Supporting independent living at home	**2.1**	Timely and responsive services
	2.2	Person-centred and dignified care
	2.3	Safe and competent care
	2.4	Home modifications and assistive devices
Standard 3. Community-based health services	**3.1**	Access to health services in the home and community
	3.2	Coordination and continuity of care
Standard 4. Social support and community participation	**4.1**	Formal community support services
	4.2	Community activities and participation

Standard	QS no.	Quality statement
	4.3	Social connection and isolation prevention
Chapter 3. Long-term care facilities		
Standard 5. Respect for fundamental human rights	**5.1**	Ethical admission
	5.2	Freedom from restraint and coercion
Standard 6. Adequate service provision	**6.1**	Person-centred care plans (PCCPs) for all residents
	6.2	Adequate staffing, facilities and access to external services for compliance with PCCPs
	6.3	Nutrition and hydration
	6.4	Opportunity to engage in meaningful activities
Standard 7. Safe and empowering environments	**7.1**	Effective infection prevention and control (IPC)
	7.2	LTCFs are safe environments
	7.3	LTCFs are empowering environments
Standard 8. Transparency and accountability	**8.1**	LTCFs are accountable to residents and their families
	8.2	Regulatory agencies effectively monitor and support LTCFs
	8.3	LTCFs are accountable to the public
Chapter 4. Support for unpaid carers		
Standard 9. Early identification	**9.1**	Opportunistic identification

Standard	QS no.	Quality statement
and needs assessment		
	9.2	Comprehensive assessment
	9.3	Administrative recognition
Standard 10. Respite care	**10.1**	Diverse respite models
	10.2	Integrated support
	10.3	Emergency respite
Standard 11. Education and skills training	**11.1**	Comprehensive training content
	11.2	Accessible delivery
	11.3	Skills recognition
Standard 12. Social protection and financial security	**12.1**	Income support
	12.2	Pension protection
	12.3	Work-life balance
Standard 13. Engagement and recognition	**13.1**	Partners in care
	13.2	Participatory governance
	13.3	Outcome measurement
Chapter 5. Workforce		
Standard 14. Workforce competencies and training	**14.1**	Defined competencies for long-term care roles

Standard	QS no.	Quality statement
	14.2	Foundational training before independent practice
	14.3	Continuing professional development
Standard 15. Staffing and workload	**15.1**	Staffing matched to assessed care needs
	15.2	Skill mix appropriate to needs
	15.3	Workloads enable person-centred care and sustainable work
Standard 16. Working conditions, well-being, and rights	**16.1**	Fair compensation
	16.2	Safe and supportive working environment
	16.3	Stable, secure, and dignified employment
Standard 17. Supervision, teamwork, and accountability	**17.1**	Supervision and reflective practice
	17.2	Teamwork, communication, and care coordination
	17.3	Worker conduct, safeguarding, and channels for raising concerns
Standard 18. Workforce profile considerations	**18.1**	Gender equity
	18.2	Protections for migrant care workers
	18.3	Pathways for young workers
Chapter 6. Financing		
Standard 19. Coverage of	**19.1**	Defined public entitlement

Standard	QS no.	Quality statement
entitlements		
	19.2	Coordination across publicly financed programmes
	19.3	Periodic review of financed scope
Standard 20. Needs-oriented allocation	**20.1**	Needs-based assessment for eligibility
	20.2	Graded benefits across severity and settings
	20.3	Periodic review of eligibility, benefits and contributions
Standard 21. Shared responsibility	**21.1**	Pooled financing across multiple actors
	21.2	Capacity-aligned contributions
Standard 22. Equity	**22.1**	Income-related contributions and co-payments
	22.2	Geographic equity of entitlements
Standard 23. Financial protection	**23.1**	Protection from catastrophic costs
	23.2	Protection for those with limited resources
Standard 24. Adequacy and quality alignment	**24.1**	Funding adequate to deliver quality standards
	24.2	Funding for care complexity
	24.3	Financing supports quality improvement and accountability
Chapter 7. Governance		

Standard	QS no.	Quality statement
Standard 25. Regulatory framework	**25.1**	Legal foundation and oversight authority
	25.2	Quality standards defined and publicly available
	25.3	Eligibility and entitlements
	25.4	Periodic review and reform of the regulatory framework
Standard 26. Licensing and registration	**26.1**	Registration and conditions for service provision
	26.2	Public information on registered providers
	26.3	Provider engagement and capability development
Standard 27. Oversight and enforcement	**27.1**	Regular inspection across settings
	27.2	Graduated and proportionate enforcement
	27.3	Regulatory body capacity and independence
	27.4	Public reporting of inspection and enforcement
	27.5	Channels for concerns and complaints
Standard 28. Rights protection	**28.1**	Statutory recognition of rights
	28.2	Independent complaints, investigation and response to abuse
	28.3	Advocacy and support across settings

Standard	QS no.	Quality statement
	28.4	Legal capacity and supported decision-making
Standard 29. Coordination across sectors and levels of government	**29.1**	Cross-sector coordination at national, subnational and community levels
	29.2	Continuity across care transitions
	29.3	Stakeholder participation in governance
	29.4	Coordination of roles, responsibilities and standards across levels of government
Chapter 8. Quality monitoring		
Standard 30. Quality measurement and data systems	**30.1**	Defined quality indicators across domains
	30.2	Care recipient experience as core measurement
	30.3	Standardized data collection and reporting
	30.4	Data quality, completeness and timeliness
Standard 31. Inspection and assessment	**31.1**	Regular external inspection
	31.2	Inspection methods include direct observation
	31.3	Inspection findings drive improvement
Standard 32. Complaints and feedback	**32.1**	Accessible complaints processes
	32.2	Timely investigation and response

Standard	QS no.	Quality statement
	32.3	Analysis of complaints data
Standard 33. Quality improvement	**33.1**	Provider quality improvement programmes
	33.2	System-level support for improvement
	33.3	Identification and dissemination of good practice
Standard 34. Public transparency and accountability	**34.1**	Regular provider reporting of quality data
	34.2	Public access to provider quality information
	34.3	Publication of inspection reports and ratings

5768 # References

5769 *Document-wide consolidated reference list. References are listed in numerical order*
5770 *corresponding to their first compilation by chapter source. Cross-chapter duplicates remain*
5771 *in the current draft and will be deduplicated in the post-consultation reference pass.*
5772 *Reformatting to full Vancouver style — NLM-abbreviated journal titles, author surname +*
5773 *initials with no full points, IRIS handles for WHO publications, Licence: CC BY-NC-SA 3.0*
5774 *IGO suffixes where applicable, and DOIs where available — is in progress.*

5775 *Chapter 1 (Definitions and foundational principles) and Chapter 4 (Support for unpaid*
5776 *carers) reference compilations are pending and will be added during the review period and*
5777 *into the public consultation phase.*

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