World Health Organization

WHO Global Standards for Long-Term Care

Summary of the consultation draft

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About this summary

This summary presents the key content of the consultation draft of the WHO Global Standards for Long-Term Care, to support review and comment. The full consultation draft is available on the WHO website and is the authoritative text. For each chapter, this summary gives the chapter's scope, illustrative country examples, and every standard with its standard statement and its quality statements. The detail set out beneath each quality statement in the full draft – rationale, implementation guidance and indicative measures – is not reproduced here.

What the full draft contains beyond this summary

To keep this summary concise, the detail beneath each quality statement — the rationale, implementation guidance and indicative measures (the measures tables across all chapters) — and the draft's implementation considerations are not reproduced here. These elements will shape how the standards are applied and monitored after publication, and comments on them are equally welcome. Please refer to the full consultation draft, available in English on the consultation web page: https://www.who.int/news-room/articles-detail/call-for-public-consultation-on-global-standards-for-long-term-care. In the online survey, Part C includes "Indicative measures" among the parts you can comment on.

Standards at a glance

The eight chapters contain 34 standards and 106 quality statements. Chapter 1 sets out definitions and five foundational principles; Chapters 2–8 each set standards for one component of the system. The 34 standards are listed below; each is set out in full, with its quality statements, in the chapter sections that follow.

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1. Introduction

1.1 Background and rationale

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 provide, what users can expect, and 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 and in residential facilities, and, crucially, the often invisible work of unpaid carers, who provide most care worldwide.

Evidence from the 2025 UN Decade of Healthy Ageing progress survey indicates that a significant proportion of WHO Member States still lack comprehensive standards for long-term care. Where standards exist, they often focus narrowly on residential facilities and do not address system-level dimensions such as home and community-based care, support for unpaid carers, workforce, financing, governance and quality monitoring.

These are the first WHO global standards for long-term care, developed to fill this gap as a key deliverable of action area 4 of the UN Decade of Healthy Ageing (2021–2030).

1.2 Purpose and scope

These standards offer a framework applicable across diverse settings and adaptable to different country contexts and resource levels. They articulate what should exist – the expectations, principles and components of quality long-term care – while allowing flexibility in how countries implement them. They address eight domains: definitions and foundational principles; home and community-based care; long-term care facilities; support for unpaid carers; workforce; financing; governance; and quality monitoring.

What this document is not. These standards are not a regulatory instrument; countries 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. They are also not clinical guidelines; detailed guidance on specific conditions can be sought in other WHO materials.

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, so that the principles and many of the standards are broadly applicable. Some standards describe foundational expectations that every system should pursue immediately – including dignity, autonomy, protection from abuse, and recognition of unpaid carers – while

others describe capacities that countries develop progressively over time. Both are global standards, and equivalent system functions may be achieved through different institutional arrangements.

These standards are intended to be used alongside a growing suite of WHO resources, including the 2021 WHO long-term care framework and the 2024 WHO long-term care package for universal health coverage.

1.3 Intended audience

These standards are designed for multiple audiences, each of whom can use the document in different ways: policy-makers and legislators; regulatory and accreditation bodies; long-term care providers and managers; the health and social care workforce; and older people, families, unpaid carers, their representative organizations and the wider public.

1.4 How to use this document

The standards are designed to be useful from the earliest stages of system development; countries with no formal system, with emerging arrangements, or with mature systems can each find entry points. All readers should begin with Chapter 1, which sets out the principles that apply across all domains, and may then turn to the chapters most relevant to their work. Each chapter follows a consistent structure: introduction, background, standards, and implementation considerations.

2. Chapter 1 – Definitions and foundational principles

Chapter 1 defines long-term care and related concepts and sets out the five foundational principles that apply across all the standards, regardless of resource environment. The full chapter also provides additional definitions and a note on terminology across regions.

Principle 1 – Rights-based care. Long-term care is provided in ways that uphold human rights, including dignity, autonomy, freedom from abuse and neglect, privacy, and the right to participate in decisions affecting one's life, and that ensure equitable access to appropriate care regardless of personal circumstances. Services must actively organize care to respect and protect these rights in everyday practice.

Principle 2 – Person-centred integrated care. Person-centred integrated care is care organized around what matters to the person – their unique needs, circumstances, values, and goals – with services coordinated to work together and adapt as needs change over time.

Principle 3 – Carer recognition and support. People who provide unpaid care and support, typically family members, but also friends and neighbors, are recognized as essential partners in the long-term care system who have their own needs for support, training, respite, and protection. Carers also have rights that must be respected.

Principle 4 – Ageing in the right place. 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.

Principle 5 – Quality. Long-term care is safe, effective, person-centred, and continuously improving, regardless of setting, provider type, or resource level.

3. Chapter 2 – Home and community-based care

Scope. Home and community-based care enables older people who need long-term care to receive services while remaining in their own homes and communities, which for most people aligns with their preference to age in place rather than move to residential care. This chapter sets standards for formal services delivered by trained providers; care by unpaid carers is addressed in Chapter 4.

Country examples (illustrative):

- **Singapore:** Active Ageing Centres – community drop-in centres for people aged 60 and over offering group activities and health information, with befriending home visits for those who are isolated or homebound.
- **Philippines:** a home care and support programme showing how home and community-based care can be delivered in a lower-middle-income setting by building on existing community structures.
- **Japan:** Long-Term Care Insurance (2000), with Comprehensive Community Support Centres in every municipality acting as integrated entry points staffed by multidisciplinary teams.

Standard 1 – Entry, assessment and care coordination

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

- **1.1 Accessible entry to services:** People who may need HCBC can access clear information about available services through health, social care, and community settings, and have a defined pathway to request support.
- **1.2 Comprehensive needs assessment:** People referred for HCBC receive a comprehensive assessment that covers their health, functional, social needs, their resources and support networks, as well as their preferences and goals.
- **1.3 Personalized care planning:** People eligible for HCBC have a personalized care plan developed in partnership with them, reflecting their assessed needs, preferences, and goals, and reviewed regularly as circumstances change.
- **1.4 Care coordination:** People receiving HCBC have a designated point of contact responsible for coordinating their care across services and providers, ensuring continuity and preventing fragmentation.

Standard 2 – Supporting independent living at home

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.

- **2.1 Timely and responsive services:** 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.
- **2.2 Person-centred and dignified care:** Personal care and daily living support is delivered in a way that respects people's dignity, privacy, and preferences, and enables them to maintain choice and control over how care is provided.
- **2.3 Safe and competent care:** Personal care and daily living support is provided by workers with appropriate training and skills, following safe practices that protect people from harm, neglect, or abuse.
- **2.4 Home modifications and assistive devices:** People have access to assessment and provision of home modifications and assistive devices that enable them to live safely and independently at home and maintain connection with others.

Standard 3 – Community-based health services

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

- **3.1 Access to health services in the home and community:** People can receive health services – including nursing care, rehabilitation, and clinical support – in their homes or community settings, enabling them to address health needs without requiring admission to hospital or other health facilities.
- **3.2 Coordination and continuity of care:** Health services provided within HCBC are coordinated with primary health care providers, hospitals, and specialist services, ensuring that health information is shared appropriately and care transitions are managed safely.

Standard 4 – Social support and community participation

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

- **4.1 Formal community support services:** People can access community-based services, including day centres, meal services, and transport assistance, that support their daily living and enable participation outside the home.
- **4.2 Community activities and participation:** People are supported to participate in community activities and civic life, including educational, recreational, cultural, and volunteer opportunities.

- **4.3 Social connection and isolation prevention:** People at risk of social isolation receive proactive outreach and support to maintain social connections and emotional well-being.

4. Chapter 3 – Long-term care facilities

Scope. In all countries most long-term care is provided at home, but growing numbers of older people who cannot remain at home live in residential facilities. This chapter sets standards for residential long-term care, which exists in diverse forms and sizes across countries and cultures.

Country examples (illustrative):

- **Australia:** staffing recommendations from the Royal Commission into Aged Care Quality and Safety enacted in national law, including a minimum average care time per resident.
- **Norway:** meaningful activity has been a facility quality indicator since 2003, including a daily one-hour minimum.
- **Brazil:** academics and a national network of facilities working together to improve hydration practices for residents.

Standard 5 – Respect for fundamental human rights

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

- **5.1 Ethical admission:** The decision to be admitted to an LTCF (and to subsequently remain there) is made by the person in question. The decision occurs with informed consent and without coercion from another party. The only exception is when legally mandated power of attorney is established, based on an individual's assessed diminished mental capacity to make decisions in their best interests.
- **5.2 Freedom from restraint and coercion:** Physical restraints (such as bed rails, belts or fixed chairs) and chemical restraints (such as sedatives or antipsychotics used primarily to control behaviour) are never used as a means of managing residents or for staff convenience. Restraints are only considered in exceptional circumstances where there is immediate risk of serious harm, and all alternatives have been exhausted. Any use is time-limited, documented, and subject to independent review.

Standard 6 – Adequate service provision

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

- **6.1 Person-centred care plans (PCCPs) for all residents:** All LTCFs agree, document and implement PCCPs in consultation with residents and, when appropriate, families. PCCPs reflect residents' specific needs and preferences.

- **6.2 Adequate staffing, facilities and access to external services for compliance with PCCPs:** All LTCFs provide sufficient numbers of suitably competent staff and appropriate equipment to optimize residents' independence and safety, and to ensure compliance with PCCPs. LTCF residents have appropriate access to health care and other necessary services not directly provided by LTCFs.
- **6.3 Nutrition and hydration:** Nutrition and hydration practices in LTCFs address both clinical requirements and personal preferences.
- **6.4 Opportunity to engage in meaningful activities:** LTCFs actively support residents' social relationships, emotional bonds and participation in meaningful activities, both within and beyond the facility. These activities are explicitly included in PCCPs.

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.

- **7.1 Effective infection prevention and control (IPC):** LTCFs follow robust protocols to prevent and manage different kinds of infections, and have the necessary supplies, training and resources to do so. LTCF residents and staff are fully vaccinated against appropriate conditions. LTCFs are clean and hygienic environments.
- **7.2 LTCFs are safe environments:** All states have enacted building regulation legislation that is evidence-based and specific to LTCFs. All LTCFs comply with these regulations.
- **7.3 LTCFs are empowering environments:** LTCF environments optimize residents' intrinsic capacity and freedom to live life on their own terms. They optimize residents' freedom to move around and interact both within and beyond the facility, according to their preferences. Residents are permitted privacy and LTCF environments reflect resident preferences, such as personalized, home-like aesthetics rather than institutional ones.

Standard 8 – Transparency and accountability

LTCFs are fully accountable to all stakeholders, especially residents.

- **8.1 LTCFs are accountable to residents and their families:** LTCFs enable all residents to actively participate in decisions which personally affect them, including care preferences and routines. Where residents lack capacity, their interests are effectively represented by nominated others, such as family members or voluntary organizations. LTCFs have robust complaint procedures.
- **8.2 Regulatory agencies effectively monitor and support LTCFs:** All LTCFs are registered with and certified by regulatory agencies. These agencies are adequately designed and resourced to monitor and support LTCF compliance with the quality statements in this report.

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

5. Chapter 4 – Support for unpaid carers

Scope. Unpaid carers – mostly family members, friends and neighbours who provide care without a formal employment contract – form the backbone of long-term care systems worldwide, yet their contribution is often invisible and they are seldom recognized as individuals with their own rights, needs and well-being.

Country examples (illustrative):

- **United Kingdom:** Carer Passports that formally recognize unpaid carers across NHS and community settings.
- **India (Kerala):** a community-based palliative programme using trained local volunteers to provide respite and support to families.
- **Uruguay:** the National Integrated Care System (2015), which positions care as the "fourth pillar" of social protection, with cash transfers to carers of people with severe dependency.

Standard 9 – Early identification and needs assessment

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

- **9.1 Opportunistic identification:** Unpaid carers are proactively identified during routine contacts, either when they present on their own or when accompanying care recipients across health, social care, and education services, including chronic disease management, hospital admission and discharge, community health assessments, and child- and youth-facing services.
- **9.2 Comprehensive assessment:** Identified carers receive a holistic, proportionate assessment that considers their needs, well-being, capacity, willingness, risks, and preferences.
- **9.3 Administrative recognition:** Systems establish simple administrative mechanisms to formally recognize unpaid carers and support their inclusion in communication, care planning, and decision-making.

Standard 10 – Respite care

Every unpaid carer has access to flexible, quality respite services that give them a restorative break from caregiving and support their ability to continue in their role. Respite is delivered as

part of a multicomponent support package that protects their health, well-being, employment, and social participation.

- **10.1 Diverse respite models:** Respite services are available in various forms, including in the home, adult day centers, and short-stay residential care, to meet the needs of carers' circumstances, preferences, and care needs.
- **10.2 Integrated support:** Respite care is part of a broader support package for carers that may include education, psychosocial support, and skills development, recognizing that time away from caregiving alone is not enough to maintain their health and well-being.
- **10.3 Emergency respite:** Systems have clear arrangements for providing emergency respite when carers are unable to continue their role because of burden, sudden illness, accidents, or family emergencies.

Standard 11 – Education and skills training

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

- **11.1 Comprehensive training content:** Training programmes for unpaid carers address comprehensive content, including understanding the care recipient's condition, practical caregiving skills, managing challenging situations, carer self-care and stress management, and navigating health and social care systems.
- **11.2 Accessible delivery:** Carer education and training is delivered through multiple formats, including digital, in-person, and community-based approaches, to ensure accessibility for carers across diverse circumstances, locations, and levels of digital literacy.
- **11.3 Skills recognition:** Unpaid carers acquire substantial competencies through lived caregiving experience. Systems should formally recognize these skills and provide pathways for those who wish to transition into paid care roles, where appropriate.

Standard 12 – Social protection and financial security

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

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

- **12.2 Pension protection:** Social protection systems include provisions to protect carers' long-term financial security, such as credited pension contributions during caregiving periods, to prevent old-age poverty resulting from career interruptions or periods spent outside the labour force.
- **12.3 Work-life balance:** Legal frameworks support carers' labour market attachment through provisions such as flexible work arrangements, care leave entitlements, and protection from discrimination based on care responsibilities.

Standard 13 – Engagement and recognition

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

- **13.1 Partners in care:** Health and social care providers involve carers as partners in care planning, treatment decisions, and transitions of care, with information sharing aligned to the care recipient's preferences.
- **13.2 Participatory governance:** Long-term care systems have processes that encourage and value carer representation in policy development, service design, monitoring, and evaluation, recognizing that this representation is critical for system improvement.
- **13.3 Outcome measurement:** National and subnational health information systems, or the equivalent data-collection arrangements where formal systems do not yet exist, include carer-reported outcomes that capture carers' experience, well-being, and the impact of support services.

6. Chapter 5 – Workforce

Scope. This chapter sets standards for the paid long-term care workforce – those whose paid work delivers care in homes, communities and residential settings. Workforce factors, including training, staffing, working conditions, supervision and teamwork, are consistently among the strongest determinants of care quality. Unpaid carers are addressed in Chapter 4.

Country examples (illustrative):

- **Japan:** the certified care worker (Kaigo Fukushishi) qualification, recognized since the introduction of Long-Term Care Insurance in 2000.
- **Germany:** long-term care insurance (Pflegeversicherung, 1995), which sets pay, training and employment expectations that providers must meet to participate.
- **Thailand:** the 2016 long-term care policy, which embeds supervision and team-based working in a workforce delivered through the primary health care platform.

Standard 14 – Workforce competencies and training

Long-term care workers possess the knowledge, skills, and attitudes required to provide safe, effective, and person-centred care appropriate to their role and care setting, supported by initial training and continuing professional development.

- **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.
- **14.2 Foundational training before independent practice:** Long-term care workers complete a foundational training programme aligned with their role's competency requirements before providing care without direct supervision.
- **14.3 Continuing professional development:** Long-term care workers have access to ongoing training and professional development that updates and extends their competencies across their working life.

Standard 15 – Staffing and workload

Long-term care services are staffed at levels and with a skill mix sufficient to meet the assessed needs of care recipients safely and effectively, with workloads that allow time for person-centred care and that are sustainable for workers.

- **15.1 Staffing matched to assessed care needs:** Staffing levels in long-term care services are determined on the basis of the assessed care needs of the population served, with mechanisms in place to monitor adequacy over time.
- **15.2 Skill mix appropriate to needs:** The skill mix of long-term care services includes professionally trained staff in proportions appropriate to the care needs of the population served, with arrangements in place for clinical and other professional input where required.
- **15.3 Workloads enable person-centred care and sustainable work:** Workloads of individual long-term care workers are organized to allow time for safe, person-centred care delivery – including time for communication, dignity in personal care, and observation of changes in condition – and to be sustainable for workers across their working lives.

Standard 16 – Working conditions, well-being, and rights

Long-term care workers have safe, fair, and supportive working conditions that recognize them as rights-holders entitled to dignity at work, including fair compensation, working environments that protect their physical and psychosocial well-being, and stable employment with meaningful voice in the organization of care.

- **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.

- **16.2 Safe and supportive working environment:** Long-term care workers are protected from physical, infectious, and psychosocial occupational risks through workplace policies, training, equipment, and reporting systems, with accessible support for the emotional and psychosocial demands of long-term care work.
- **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.

Standard 17 – Supervision, teamwork, and accountability

Long-term care workers receive ongoing supervision and reflective practice support, work in teams that enable communication and care coordination across roles and sectors, and operate under clear standards of conduct with safeguarding mechanisms and accessible channels through which concerns can be raised by workers, older people, or families without fear of reprisal.

- **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.
- **17.2 Teamwork, communication, and care coordination:** Long-term care workers work in teams that enable communication, peer support, and care coordination across roles, settings, and sectors, including across health and social care.
- **17.3 Worker conduct, safeguarding, and channels for raising concerns:** Long-term care services maintain clear standards of worker conduct including the prohibition of abuse, neglect, and exploitation of older people, supported by safeguarding mechanisms and accessible channels through which workers, older people, and families can raise concerns without fear of reprisal.

Standard 18 – Workforce profile considerations

Systems address the specific needs and protections required for distinct groups within the long-term care workforce, including women, migrant care workers, and young workers, alongside structural pathways into the sector.

- **18.1 Gender equity:** The long-term care workforce is supported by policies that promote gender equity, including pay equity, freedom from discrimination and harassment, work–life balance, and fair access to leadership and progression.
- **18.2 Protections for migrant care workers:** Migrant care workers in the long-term care workforce are protected by ethical recruitment, clear and enforceable employment terms, occupational and rights protections equivalent to those of domestic workers, and access to language and integration support.

- **18.3 Pathways for young workers:** 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.

7. Chapter 6 – Financing

Scope. This chapter sets standards for financing long-term care, addressing two related questions: what makes financing arrangements themselves equitable, adequate and sustainable; and how financing should be structured to realize the workforce, service, infrastructure and carer-support expectations set out in other chapters.

Country examples (illustrative):

- **France:** the Personalized Autonomy Allowance (APA), in force since 2002, which finances comprehensive long-term care for people aged 60 and over assessed as having a loss of autonomy.
- **Germany:** statutory long-term care insurance (Pflegeversicherung, 1995), a universal fifth pillar of social insurance.
- **Sweden:** a tax-funded universal model in which municipalities hold primary responsibility for long-term care services.

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.

- **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.
- **19.2 Coordination across publicly financed programmes:** Where older people's long-term care needs are addressed through multiple publicly financed programmes – including health, social protection, housing, and disability – coordination ensures continuous and integrated coverage for individual care recipients and their families.
- **19.3 Periodic review of financed scope:** The scope of publicly financed long-term care is reviewed and updated as care needs and entitlements evolve.

Standard 20 – Needs-oriented allocation

Long-term care financing is allocated according to assessed care needs, focuses public resources on the population groups with the highest needs, and adapts over time as demographic and disease patterns evolve.

- **20.1 Needs-based assessment for eligibility:** Older people receive long-term care entitlements based on transparent, needs-based assessment, applied consistently and accessibly.
- **20.2 Graded benefits across severity and settings:** Long-term care cost coverage arrangements are differentiated by severity of need and by care setting, supporting the care arrangement that best matches older people's needs and preferences.
- **20.3 Periodic review of eligibility, benefits and contributions:** Long-term care financing arrangements adapt over time to evolving demographic, epidemiological, and care-need patterns, through scheduled review of eligibility, benefits, and contributions.

Standard 21 – Shared responsibility

Long-term care financing distributes responsibility across multiple actors – including government, individuals and households, employers, and other contributors – through coordinated, capacity-aligned participation, so that the cost of long-term care is genuinely shared rather than concentrated on older people and their families.

- **21.1 Pooled financing across multiple actors:** Long-term care is financed through pooled resources drawing on multiple actors, so that the cost of care is shared across society rather than borne by older people and their families alone.
- **21.2 Capacity-aligned contributions:** Contribution proportions across financing actors are aligned with capacity to pay, with explicit protection for those with limited contribution capacity.

Standard 22 – Equity

Long-term care financing is designed to balance equity across population groups, household types, and regions, with monitoring of equity in financing inputs, access, and outcomes.

- **22.1 Income-related contributions and co-payments:** Older people and their families pay according to their ability, through differentiated contribution and co-payment rules calibrated to income and household circumstances.
- **22.2 Geographic equity of entitlements:** Older people receive equivalent long-term care entitlements regardless of where they live, supported by financing arrangements that address geographic disparities in service availability and cost.

Standard 23 – Financial protection

Older people and their families are protected from catastrophic costs and from impoverishment due to long-term care, through defined limits on out-of-pocket exposure and targeted protection for low-income and vulnerable populations.

- **23.1 Protection from catastrophic costs:** Older people and their families can access long-term care without being exposed to catastrophic costs, through defined limits on what individuals can be required to pay.

- **23.2 Protection for those with limited resources:** Older people are not excluded from long-term care because of inability to pay; targeted protections ensure that those with limited resources receive the care to which their needs entitle them.

Standard 24 – Adequacy and quality alignment

Funding for long-term care is sufficient for providers to deliver care that meets quality standards, reflects differences in care complexity, and supports continuous quality improvement and accountability without creating access barriers for older people with high or complex needs.

- **24.1 Funding adequate to deliver quality standards:** Funding levels enable providers to deliver long-term care that meets quality standards and that the workforce can sustainably provide.
- **24.2 Funding for care complexity:** Funding reflects differences in care complexity, supporting access for older people with high or complex needs.
- **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.

8. Chapter 7 – Governance

Scope. This chapter sets standards for the governance of long-term care systems – the legal foundations, institutional arrangements and accountability mechanisms that determine whether quality care is consistently delivered. Where governance is fragmented or weakly enforced, the burden falls on the most vulnerable; the COVID-19 pandemic made this stark.

Country examples (illustrative):

- **Argentina:** a rights-based framework, with the 1994 constitutional reform recognizing older people's rights and the Inter-American Convention given constitutional status.
- **Ireland:** the Health Act 2007, which created the Health Information and Quality Authority and made registration of designated centres for older people mandatory.
- **Australia:** the Aged Care Act 2024, following the Royal Commission into Aged Care Quality and Safety, establishing a rights-based framework with strengthened oversight.

Standard 25 – Regulatory framework

A clear legal and regulatory framework establishes the basis for long-term care provision, defining standards, responsibilities, entitlements and accountability mechanisms.

- **25.1 Legal foundation and oversight authority:** The constitution, legislation or formal policy establishes long-term care as a public responsibility, defines the rights and entitlements of care recipients, sets out the duties of public authorities and providers, and designates the authority or authorities responsible for oversight.

- **25.2 Quality standards defined and publicly available:** Comprehensive quality standards for long-term care services are defined in legislation or formal policy, are publicly available, and address the dimensions of person-centred care, safety, dignity, autonomy and continuity.
- **25.3 Eligibility and entitlements:** Eligibility criteria and entitlements for long-term care are clearly defined, publicly accessible, and applied consistently, with a standardized process for assessing care needs.
- **25.4 Periodic review and reform of the regulatory framework:** 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.

Standard 26 – Licensing and registration

All providers of long-term care services are subject to mandatory registration or licensing, with clear conditions for service provision, transparent public information and mechanisms for ongoing engagement to support service-quality improvement.

- **26.1 Registration and conditions for service provision:** All providers of long-term care services – across home, community and residential settings, and across public, private and not-for-profit ownership – are required to register with or be licensed by the designated authority before commencing service delivery, and must meet defined conditions covering legal status, financial viability, governance, workforce, premises (where applicable), safeguarding and the capacity to meet adopted quality standards.
- **26.2 Public information on registered providers:** Information on registered or licensed long-term care providers – including service profile, ownership, capacity, registration status and any conditions or restrictions on registration – is publicly accessible and kept current.
- **26.3 Provider engagement and capability development:** Public authorities maintain ongoing mechanisms for engagement with registered providers and for the development of provider capability, so that compliance with standards is supported and improved through guidance, peer learning and technical support, alongside oversight.

Standard 27 – Oversight and enforcement

Routine oversight of registered providers, with graduated and proportionate enforcement, supports continuing compliance with standards, identifies risks early and protects care recipients from harm.

- **27.1 Regular inspection across settings:** Registered or licensed long-term care providers are subject to regular, risk-informed inspection across all settings – residential, home-based and community-based – by trained inspectors against the adopted quality standards.
- **27.2 Graduated and proportionate enforcement:** The regulatory authority has, and uses, a graduated range of enforcement powers – from formal advice and improvement

notices through conditions on registration, financial penalties and, where necessary, the suspension or revocation of registration – proportionate to the seriousness, persistence and risk of identified non-compliance, with safeguards for the continuity of care for affected care recipients.

- **27.3 Regulatory body capacity and independence:** The regulatory authority responsible for inspection and enforcement has the legal mandate, technical and human resources, and structural independence required to carry out its functions impartially.
- **27.4 Public reporting of inspection and enforcement:** The findings of inspection and enforcement, including the performance of individual providers against the adopted quality standards and any enforcement actions taken, are publicly reported in formats accessible to older people, families, unpaid carers and the wider public.
- **27.5 Channels for concerns and complaints:** 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.

Standard 28 – Rights protection

The rights of care recipients are recognized in legislation and policy, supported by independent complaints, investigation and abuse-response mechanisms, accessible advocacy across all settings and arrangements that protect autonomy and supported decision-making.

- **28.1 Statutory recognition of rights:** The rights of older people receiving long-term care, and of their families and unpaid carers, are recognized in legislation or formal policy, including rights to dignity, autonomy, privacy, freedom from abuse, participation in decisions about their own care, and equal access regardless of personal characteristics or geographic location.
- **28.2 Independent complaints, investigation and response to abuse:** Independent mechanisms exist to receive, investigate and respond to complaints from older people receiving long-term care and their representatives, including complaints alleging abuse, neglect or exploitation, with mandatory reporting obligations, multi-agency response arrangements and follow-through to prevention, support and redress.
- **28.3 Advocacy and support across settings:** Independent advocacy and support are available to older people receiving long-term care, and to their families and unpaid carers, across residential, home-based and community-based settings.
- **28.4 Legal capacity and supported decision-making:** Older people, including those with cognitive impairment, are presumed to have legal capacity, with supported decision-making arrangements available to enable participation in decisions about their own care, and with substituted decision-making used only as a last resort, time-limited and subject to safeguards.

Standard 29 – Coordination across sectors and levels of government

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.

- **29.1 Cross-sector coordination at national, subnational and community levels:** Mechanisms exist for coordination among the sectors relevant to long-term care – including health, social care, housing, social protection and labour – at national, subnational and community levels, with structured arrangements for joint planning, shared information and aligned resources.
- **29.2 Continuity across care transitions:** Governance arrangements support continuity for care recipients at the points of transition between services and settings – including admission, discharge, change of provider and movement between residential, home and community-based care – with assigned responsibility for transitions and protected information flows.
- **29.3 Stakeholder participation in governance:** Older people, families, unpaid carers and care workers participate meaningfully in the governance of long-term care – in the development and reform of standards and policies, in oversight processes and in the institutions through which long-term care is governed – through structured, resourced and accountable mechanisms.
- **29.4 Coordination of roles, responsibilities and standards across levels of government:** Where governance is shared across national and subnational levels of government, the allocation of roles and responsibilities, the coordination of principles and standards, and the safeguarding of equity across the territory are explicitly addressed, so that minimum guarantees apply to care recipients regardless of where they live.

9. Chapter 8 – Quality monitoring

Scope. This chapter sets standards for monitoring and improving the quality of long-term care – measurement, assessment and improvement. The indicative measures throughout the document are developmental and illustrative; they are not finalized global benchmarking requirements, accreditation criteria or reportable global indicators.

Country examples (illustrative):

- **Canada:** the Canadian Institute for Health Information, which maintains national long-term care data systems based on standardized interRAI assessment instruments.
- **England (United Kingdom):** the Care Quality Commission, the independent regulator of health and adult social care, which registers and inspects providers and publishes ratings.
- **Republic of Korea:** a nationwide quality evaluation system administered by the National Health Insurance Service since Long-Term Care Insurance began in 2008, covering five domains.

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.

- **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.
- **30.2 Care recipient experience as core measurement:** Care recipient experience and satisfaction are systematically assessed as a core component of quality measurement.
- **30.3 Standardized data collection and reporting:** LTC providers collect and report quality data using standardized approaches, with data systems enabling analysis at provider, regional, and national levels.
- **30.4 Data quality, completeness and timeliness:** Data quality, completeness, and timeliness are systematically monitored and validated.

Standard 31 – Inspection and assessment

External inspection or assessment processes evaluate provider compliance with quality standards and identify areas requiring improvement.

- **31.1 Regular external inspection:** Regular external inspections assess provider compliance with quality standards.
- **31.2 Inspection methods include direct observation:** Inspection methodologies include direct observation and engagement with care recipients.
- **31.3 Inspection findings drive improvement:** Inspection findings inform improvement requirements and follow-up.

Standard 32 – Complaints and feedback

Accessible mechanisms exist for care recipients, families, and staff to provide feedback and raise concerns, with assurance of appropriate response.

- **32.1 Accessible complaints processes:** Clear, accessible complaints processes are available to care recipients and families.
- **32.2 Timely investigation and response:** Complaints are investigated and addressed within defined timeframes.
- **32.3 Analysis of complaints data:** Complaint data is analysed to identify systemic issues and trends.

Standard 33 – Quality improvement

Systematic quality improvement processes are in place at provider and system levels to drive continuous enhancement of care.

- **33.1 Provider quality improvement programmes:** Providers are required to maintain quality improvement programmes.
- **33.2 System-level support for improvement:** System-level support is available for quality improvement activities.
- **33.3 Identification and dissemination of good practice:** Good practices are identified and disseminated across the system.

Standard 34 – Public transparency and accountability

Quality information is systematically reported by providers and made publicly available to support accountability and enable informed choice by care recipients and families.

- **34.1 Regular provider reporting of quality data:** LTC providers are required to report quality data to designated authorities on a regular basis.
- **34.2 Public access to provider quality information:** Quality information about providers is publicly accessible and presented in formats understandable to care recipients and families.
- **34.3 Publication of inspection reports and ratings:** Inspection reports and quality ratings are published.

10. How countries can start

These standards are designed to be useful from the earliest stages of long-term care system development; countries with no formal system, with emerging arrangements, or with mature systems can each find entry points. Foundational starter actions that any country can take include:

- identify existing care actors – unpaid family carers, neighbours, community health workers, volunteers, faith-based organizations, older people's associations, and any small-scale public or private providers – and make this map visible at sub-national level;
- strengthen protections against abuse, neglect, financial exploitation and coercion of older people receiving care, in home, community and residential settings, through simple national rules and routes for reporting and 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; and

- 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.

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.

11. 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.

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

12. How to submit comments

Comments on this consultation draft can be submitted through the following channels, and more than one may be used:

Channel	Notes
Online survey	now open until 30 October 2026, in eight languages: https://extranet.who.int/dataformv6/index.php/947261
Written submissions	ltc@who.int – accepted in all WHO official languages, with no length limit
Institutional responses	coordinated within your organization and submitted as a single response

Consultation closes: 30 October 2026.

Contact: WHO, Hyobum Jang (jangh@who.int); general consultation: ltc@who.int.

Input received will be analysed and synthesized in November–December 2026 and reflected in the final standards, planned for publication in 2027.