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Care Needs and Family Care for Older Persons in Brazil

Necesidades de atención y cuidados familiares para las personas mayores en Brasil

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Abstract

Introduction

With populations aging and associated fiscal pressures, care provision has become an important issue in economics and policy. However, our understanding of care provision and care gaps still has important limitations. Effective policy formulation is not possible, and continued reliance on family care limits women's employment options, perpetuating social and gender inequalities.

Objective

We use the 2019 National Health Survey to identify care needs and family care loads in Brazil, extending earlier work and contributing to current debates about care policy in Brazil and Latin America.

Methodology

We describe how much help Brazilians over 60 years need with activities of daily living and develop first estimates of the time required for this care. We use an OLS regression to identify the characteristics of individuals who need more help and measure the availability of family members to meet these needs.

Results

Of the approximately 20% of Brazilians over 60 years who report difficulty with at least one ADL, around 25% would require more than 10 hours a week of assistance. Those needing more assistance are likely to be older, urban women living in a house (as opposed to an apartment), not in the highest income quartile, and living with more adults, more non-working adults, and more non-working women.

Conclusions

For many working women in care-needing households without non-working women, care loads are very significant. In the context of discussions about Brazil's National Care Plan, these findings highlight the costs of family care and show that state policy is needed to complement family care.

Keywords:

care; older people; Brazil; social policy and welfare; women's employment; gender division of labour; gender roles, family policy; family care; activities of daily living; OLS model; care loads.

Resumen

Introducción

Con el envejecimiento de la población, la provisión de cuidados se ha convertido en un tema crucial en las políticas públicas. Sin embargo, nuestra comprensión de las brechas en este ámbito aún presenta importantes limitaciones. La formulación de políticas eficaces no es posible, y la continua dependencia del cuidado familiar limita las opciones laborales de las mujeres, perpetuando las desigualdades sociales y de género.

Objetivo

Utilizamos la Encuesta Nacional de Salud para identificar las necesidades de cuidados y la carga del cuidado familiar en Brasil, contribuyendo a los debates actuales sobre las políticas de cuidados en Brasil y América Latina.

Metodología

Describimos cuánta ayuda necesitan los brasileños mayores de 60 años para las actividades de la vida diaria (AVD) y elaboramos estimaciones iniciales del tiempo necesario para estos cuidados. Utilizamos una regresión por mínimos cuadrados ordinarios (MCO) para identificar las características de las personas que necesitan más ayuda y medimos la disponibilidad de familiares para atender estas necesidades.

Resultados

De los brasileños mayores de 60 años que reportan dificultades con al menos una AVD, alrededor del 25% requeriría más de 10 horas semanales de asistencia. Quienes necesitan más ayuda suelen ser mujeres mayores, urbanas, que no pertenecen al cuartil de ingresos más alto y que viven con más adultos y más mujeres que no trabajan.

Conclusiones

Para muchas mujeres, la carga de cuidados es muy significativa. Estos hallazgos resaltan los costos de los cuidados familiares y la necesidad de políticas estatales que complementen dichos cuidados.

Palabras clave:

cuidado; personas mayores; Brasil; política social y bienestar; empleo de las mujeres; división sexual del trabajo; roles de género; política familiar; cuidado familiar; actividades de la vida diaria; modelo OLS; cargas de cuidado.

1. Introduction

With populations aging and associated fiscal pressures leading to increased focus on women's labor force participation, care provision has become an important issue in economics and policy (UN Women, 2023; IMF, 2022). New macroeconomic models now include both paid and unpaid care sectors, allowing for analysis of the links between care and other economic sectors, between care provision and inequality, and between the expansion of paid care and economic growth, among other topics (Cicowiez & Lofgren, 2023; Ilkkaracan et al., 2021). However, our understanding of care provision and care gaps still has important limitations.

Globally, the vast majority of care is provided at home and by women (UN Women, 2023). Over the past two decades, time-use surveys have significantly improved our understanding of unpaid work done by household members. The time individuals spend providing care, however, appears to be significantly underestimated in most surveys (Folbre, 2021). Alternative methods have been proposed to estimate the time required for childcare, based on the assumption that very young children require continuous supervisory care (Ironmonger, 2004; Fender, 2013). The care needs of older persons, however, are much more difficult to determine: some 60-year-olds may need substantial assistance, while some 90-year-olds may need none. Without a clear understanding of the extent of care needs, family care work remains underappreciated (Camarano, 2013). Effective policy formulation to support care for older persons thus remains limited, and continued reliance on family care constrains women's employment opportunities, perpetuating social and gender inequalities.

In this paper, we draw on the 2019 Brazilian National Health Survey (PNS) to better identify care needs and family care burdens in Brazil, extending earlier work (Camarano, 2013; 2022; Ottaviani et al., 2020; Krug Wendt et al., 2015). This study contributes to current debates on care policy in Brazil and Latin America (Ministry of Work and Employment, 2024; UN Women, 2022). We provide a more detailed description of how much assistance Brazilians over age 60 (the WHO definition of older persons) (IBGE, 2009) require with activities of daily living—such as eating, bathing, dressing, using the toilet, moving about the house, and taking public transport—than in previous studies (Camarano, 2013; Krug Wendt et al., 2015; Ottaviani et al., 2020). We then develop initial estimates of the time required for this care and use an OLS regression to statistically identify the characteristics of individuals most likely to need help. Finally, we assess the availability of co-resident family members to meet these care needs.

Brazil does not collect data on unpaid care time through a time-use survey or other household surveys. As noted, responses to time-use questions in any case appear to significantly underestimate time spent on care, particularly care for older persons (Folbre, 2021). We draw on unique data from a small survey conducted in another middle-income country, South Korea, to provide an estimate of the care time required. The survey collected responses from family caregivers regarding the frequency with which they provided assistance to older relatives needing support with activities of daily living (ADL), and we supplement these data with assumptions about the time needed per event.

We find that around 20% of Brazilians aged 60 and over reported having significant difficulty with (or being unable to perform) at least one activity of daily living. Using public transportation was the most commonly reported task with which people experienced difficulty. Our estimates suggest that the average amount of time required to provide care is relatively small. Still, among Brazilians aged 60 and over who report difficulty with at least one activity, about 25% would require more than 10 hours of assistance per week. Individuals needing greater assistance are more likely to be urban women living in a house (as opposed to an apartment), not belonging to the highest income quartile, and co-residing with more adults, more non-working adults, and particu-

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larly with more non-working women. Working and non-working women face similar potential care loads, although the loads of non-working women are slightly higher.

Given the lack of panel data, we are unable to determine whether non-working women are out of the labor force because they must be available to provide care, or whether care-needing adults live with them precisely because they are not working and therefore available to provide care. Previous research in other countries suggests that living with care-dependent older persons can reduce women's employment (Ettner, 1996; Skira, 2015; Meurs & Giddings, 2021).

In the next section, we review legislation related to the care of older persons in Brazil and recent research on care needs and family caregiving. Section 3 describes individual care needs as reported in the 2019 PNS and provides estimates of the time required for this care. Section 4 evaluates household-level care loads per potential caregiver, and Section V concludes with a discussion of policy implications and broader context.

2. Background

People aged 60 years or older represented 14% of Brazil's population in 2020 and are projected to be more than twice the size of the young population by 2060. The share of the very old will also rise dramatically: people aged 80 years and over will increase from under 2% of men and under 3% of women to around 7% and 12%, respectively (IBGE, 2019). Brazilian legislation attributes the primary responsibility for caring for older persons in need of assistance to the family. Within families, caregivers are predominantly women, often the wife or daughter of the care recipient (Camarano, 2022; Ottaviani et al., 2020).

The main legal framework regulating care for older persons in Brazil is the 1988 Federal Constitution. The *Elderly Statute* (Law No. 10.741 of 2003, as cited in Vieceli & Rodrigues, 2025) further establishes a set of fundamental rights for older persons, ensuring their physical, mental, moral, intellectual, spiritual, and social well-being under conditions of freedom and dignity. Both the Constitution and the Statute assign broad responsibility for the well-being of older persons to the family, the community, society, and the state (Law No. 8.842 of Jan. 4, 1994; Arts. 3 and 4 of the National Policy; Arts. 1 and 3 of the Statute, as cited in Vieceli & Rodrigues, 2025). However, the legislation does not clearly define the state's specific responsibilities. Policies provide public support for care only when family support is not possible, leaving families with the primary responsibility for older persons requiring assistance[4].

Institutional care has traditionally been an option for families and individuals only when the family's capacity to provide care has been exhausted. However, demand for institutional care may be increasing. Government data indicate that between 2012 and 2017, the number of men and women aged 60 and over in public care institutions rose by 33%, from 45,800 to 60,800. An additional 40,000 older persons were in private institutions (Ministry of Citizenship, 2018). Still, the population in institutional care represented well under 1% of Brazilians aged 60 and over in 2018 (calculation based on IBGE; PNADC, 2019).

Existing long-term care institutions are distributed very unevenly across Brazil's regions. They are heavily concentrated in the Southeast, which accounts for 60% of Brazilian institutions and 46% of the older population. By contrast, the Northeast accounts for 26% of the older population but only 7% of care institutions (Table 1) (Lacerda et al., 2018). Camarano (2022) estimates that around 2.7 million people—approximately 22% of the population aged 60 and over— would demand institutional care if it were available.

Changing demand for institutional care may be linked to evolving family dynamics (Camarano, 2013). Women—who are expected to provide most of the care for

4 Typologies focused on European cases have described these care regimes as forms of "familialization" (Saraceno & Keck, 2010).

Table 1. Distribution of long-term care institutions (LCTIs), population aged 60 and over, and ratio between population and LCTIs by region, Brazil, 2021

Region	LTCI		Population > 60 years		Population > 60 years/Number of LTCI
	number	% total	number (1,000)	% total	
Southeast	4,232	60.21%	15,094	45.9%	3,566.64
South	1,874	26.66%	5,201	15.8%	2,775.35
Northeast	493	7.01%	8,445	25.7%	17,129.82
Central-West	351	4.99%	2,155	6.6%	6,139.60
North	79	1.12%	1,959	6.0%	24,797.47
Total	**7,029**	**100.00%**	**32,854**	**100.0%**	**4,674.06**

Source: taken from Lacerda et al. (2021, p. 3).

older persons in need—entered the labor force rapidly between the 1970s and the 1990s, with female labor force participation rates rising from around 20% in 1970 to 47% in 1992. Growth in female labor force participation slowed in the 2000s, reaching a peak of 55.6% in 2005. The subsequent deceleration may be partly due to women facing the limits of institutions providing care for children and older persons (Meurs et al., 2025). Since 2005, female labor force participation has fluctuated between 52% and 55%, with a 20-year low of 49.5% recorded during the pandemic year of 2020.

Previous analyses of older persons' care needs and care provision in Brazil have emphasized the importance of expanding state support for both institutional and family care (Camarano, 2013; Roquete et al., 2017). Using the 2008 PNS, Camarano (2013) projected the number of persons aged 70 and over who would need assistance with activities of daily living (ADL), and the availability of women aged 20-69 who might provide this care, for the year 2020. She predicted a significant shortfall, highlighting the need to expand institutional care. Camarano (2013) and others (Ventura-Dias, 2012; Travasos et al., 2020) used the 2010 Census and the 2008 and 2019 PNS, respectively, to describe the living conditions of older persons in Brazil—including location, household composition, gender of household head, and income. Comparing households of older persons with ADL needs in 2008 to those in 1998, Camarano (2013) found that an increasing share of such older persons were living alone or only with their spouse compared to a decade earlier.

Smaller, regional surveys have also shown that a significant proportion of people over 60 years of age need support with ADL or IADL (Instrumental Activities of Daily Living, such as cooking, cleaning, and managing finances). A small 2013 survey of 260 people over 60 in Rio Grande do Sul found that 31% had some degree of need, and that many older people lived alone (Krug Wendt et al., 2015). Reviewing the literature on care for older persons in Southern Brazil up to 2010, Ottaviani et al. (2020) reported substantial ADL and IADL care loads among older caregivers.

In the context of current debates in Brazil about expanding care policy—particularly regarding care for older adults[5] (Ministry of Work and Employment, 2024)—we update and extend this earlier research. In the next section, we use data from the 2019 PNS to provide a more detailed analysis of the living situations and ADL support needs of persons aged 60 and over in Brazil.

3. Care needs of Brazilians aged 60 and older

The Brazilian National Health Survey (PNS) 2019 is a nationally representative household survey which uses a special module to collect detailed information on health and care needs of individuals 60 or older. There were 32,433

5 Brazil approved a new Care Policy Law (Law 15.069/2024), which identifies as a priority group older adults who need assistance, support or aid to perform basic and instrumental activities of daily living.

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sampled households that included individuals 60 or older. In these households, 43,554 individuals responded to the module for people 60 or older. These households and individuals form the sample on which we base our analysis.

The individuals 60 and older were asked whether they had any difficulties with activities of daily living. The standard list included eating, bathing, toileting, dressing, getting in and out of bed or a chair, moving around the house, and using transport to get to shopping, appointments and other needs. A four-level scale was used to collect responses: no difficulty, some difficulty, significant difficulty, or unable to do the activity alone. Individuals were additionally asked about their ability to conduct three Instrumental Activities of Daily Living (IADL): managing their finances, shopping for food and medicine, and taking medicines. These lists provide a measure of the most fundamental care needs, although, as Wolf (2004) emphasizes, such a list does not account for social and psychological needs that older people often report as highly significant (Afful-Mensah, 2022; Camarano, 2013). It therefore provides only a partial (conservative) estimate of care needs.

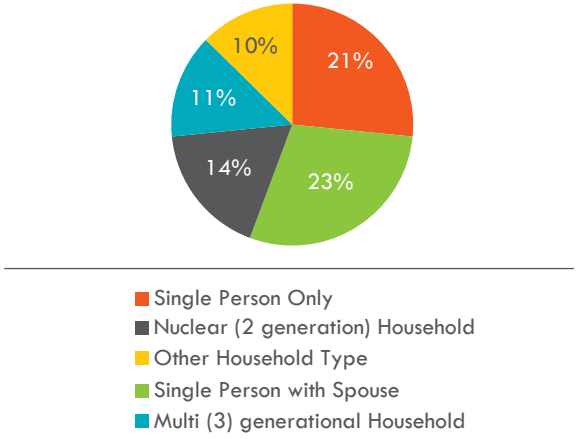
In response to the questions about ADL, around 20% of the respondents aged 60 years and over reported being unable to do at least one activity alone or having significant difficulty doing at least one of the activities. Across five of the seven categories asked about, a consistent 5-6% of the sample reported being unable to do the activity alone or having significant difficulty. Among the remaining two categories, a much larger share (17%) reported being unable to take, or having difficulty with taking public transport. Less than 3% of people reported being unable to eat alone or having significant difficulty. Over a third of the respondents had at least some difficulty with one or more of these activities, mainly with taking transport (an additional 10% of respondents compared to those having significant difficulty or unable to do the activity alone), followed by getting in or out of a bed or chair, dressing and moving around the house (an additional 7-8%), and eating, bathing and toileting (an additional 3-5%). Among elders 75 and older, more help is needed: 43% needed help with at least one activity, and 10% needed help with four or more activities.

A significant share of seniors over 60 years also reported not being able to do or having significant problems with Instrumental Activities of Daily Living. 10% percent reported significant problems managing their finances (an additional 6% reported some difficulties), 13% reported significant problems with shopping (an additional 8% had some problems), while 7% taking medicines (an additional 6-7% reported some problems).

Potential care provision is affected by living arrangements. Figure 1 presents the structure of households with at least one person aged 60 or older (about 35% of surveyed households). Of the households with older individuals, 21% were households in which the older individual lived alone, and 23% were households in which the older person lived alone with their spouse (of which 68% were also 60 or older). 14% lived in a nuclear household (defined as two generations with spouse), of which 82 households included only people over 60 (that is, older individuals with their parent(s)). 11% of households with older persons were multigenerational households, while 10% consisted of another arrangement (an older person living with a younger sibling, other family members, or hired help) (Figure 1). Summing all households made up entirely of people aged 60 and over, these made up 37% of all households with people over 60.

Of course, older adults living alone or only with other adults aged 60 and older may not need care, and living independently may be a goal of many people. In addition, living without younger people in the household does not mean that these individuals receive no care from family members. Older people who live alone often live near their children—indeed, this may be a reason they are able to continue living alone (Ventura-Dias, 2012). While people reporting that they need assistance with ADL activities report having fewer friends and family members to call on in times of need than

Figure 1. Types of households with persons aged 60 or older, 2019



Source: own elaboration with data from PNS (2019).

those who do not report requiring help, 94% of those needing assistance report that they do get some help. The majority (74%) report that the help is given by co-resident family members. Another 14% report that non-resident family members help. 6% report getting assistance from a domestic worker, and another 6% receive care from another source.

3.1 How much time is needed for this care?

Understanding the amount of time needed for this care is central to understanding related policy issues, particularly the likely effect on women's labor force participation. However, estimating care time needed for those over 60 is complicated. While all very young children need care by definition[6], the time needed for assistance for older persons is much more difficult to determine. It depends on individual health, as well as household access to supporting equipment (walkers, grab bars, and so on) and the type of housing and infrastructure available.

Time use surveys do not seem to have made a significant contribution to our understanding of time needed for care for older persons. In her review of international time use research, Nancy Folbre (2021) notes that a very small share of adult women and men report participating in care for older persons, even when limiting the sample to households with at least one member over 75 years. In China, for example, only 3% of women and 2% of men in such households report participating in the care of older persons (using the 2017 Time Use Survey), 4% of women and 3% of men do so in South Africa (2010 data), and 11% of women and 3% of men in Ghana (2009 data). Reported time in care is also very low: 3-8 minutes per day for participating women in Ghana, South Africa, and China, and around 1 minute for participating men. The Mexican Time Use Survey (2014), which collects data using a different methodology (pre-coded activity lists, as opposed to time diaries) (Folbre, 2021), finds much higher rates of participation in this care: 45% of women in households with members over 75 years of age and 38% of men. Reported time is also higher—46 minutes per day for women and 29 minutes for men.

Other evidence also suggests that time spent is likely greater than most time use surveys report. Looking only at those over 65 who report needing help with ADL, Wolf (2004) finds that individuals required an average of 28 hours of care per week in the U.S. (based on 1999 data). Wolf (2004) notes that this is likely a low estimate of actual care needed, as it does not include other kinds of support (social support or supervisory care for those affected by dementia). Studies of care provision in 2013 in Southern Brazil noted the need for emotional and social support and reported very high levels of care (5-10 hours per day, probably also influenced by dementia care) (Ottavani et al., 2020). At the same time, numerous international studies find that those providing care report significant physical and mental effects (Amirthanyan & Wolf, 2003; 2006; Khalaila & Litwin, 2011; Camarano, 2013) and that co-residence with an older person reduces women's labor force participation, controlling for other factors (Meurs & Giddings, 2021; Lan Liu & Zheng, 2010; Skira, 2015).

6 Although perspectives on the care-age relationship for children vary greatly by culture (Boldbaatar et al., 2025), a residual method (Fender et al., 2013) can be adjusted for social expectations.

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Brazil does not implement a time-use survey[7], and while the PNS collects data on ADL needs of individuals over 60 years of age, it does not ask how much time is required for the needed assistance. To our knowledge, there are no surveys in Brazil or Latin America that collect data on the amount of time needed to care for individuals with ADL needs, nor any that collect such data by type of ADL[8]. We draw on a recent, unique small survey of caregivers in another middle-income country, South Korea (Center for Transnational Migration and Social Inclusion, 2018). Researchers collected data from 500 randomly selected caregivers of individuals over 65 who needed help with at least two activities of daily living. The survey asked, for each specific activity, how frequently help was provided ("many times a day", "once a day", "1-2 times per week", "3 or more times a week", "1-2 times per month", or "never").

This unique survey allows us to estimate the amount of time that might be required to provide care to those needing help in activities of daily living. The frequencies of care are reported for people who have ADL needs. This is the group for which we estimate care needs for the Brazilian population, making the two samples comparable despite differences in country context. Still, the frequency of care provision for two individuals with the same ADL needs could vary depending on their specific mental and physical limitations. The South Korean sample is slightly older than the Brazilian one (65 years and older, compared to 60 years and older), but South Koreans have a longer life expectancy (better health)[9] than Brazilians, which might make care needs of the two groups more similar. Nevertheless, these estimates should be understood as preliminary, pending the collection of similar data in Brazil.

The South Korea survey did not collect data on how much time was spent in each episode of helping in each type of activity. To obtain a rough estimate of the total time needed to provide care, we assumed the following average times per occurrence for each task: 20 minutes for help dressing, 30 minutes for bathing, 15 minutes for toileting, 30 minutes for eating, and 1 hour for transport. For help moving around the house (the Korean survey combined two categories used in the PNS—moving in and out of a bed or chair, and moving around indoors), we assumed 10 minutes per occurrence. Where help was needed "many times a day", we assumed 4 times; for "3 or more times a week", 4 times; and for "1-2 times per week or month", 1.5 times. These choices are, of course, arbitrary. The time needed will vary depending on many individual factors—type of dwelling, infrastructure access, and mobility and psychological challenges of the care recipient. In making assumptions about the time needed for each activity, we sought to reflect an average, and our calculations are adaptable to different assumptions. Our purpose is to provide some initial approximations of possible care needs, which may be refined with additional data on care provision.

Table 2 reflects the distribution of frequencies with which assistance was given on the six ADL tasks, reported by South Korean caregivers of people with two or more ADL needs. The task with the highest frequency of help provision was eating (more than once a day in 31% of cases), followed by moving around indoors and using the toilet (more than once a day in 20% of cases). However, many people never needed help with these tasks (29%-53% of cases). Not surprisingly, help taking public transportation was needed least frequently, although most people (77%) required some help with this.

To estimate the average time demand per week for an ADL activity, we weight the assumed time for each activity (for example, 30 minutes for one instance of help with eating) by the share

7 The PNAD-C survey (2019) does collect some data on time use, but it asks about the combined time spent on housework and care.

8 The only study we know of that collected data on time spent on ADL is that analyzed by Wolf (2004) for the United States.

9 Remaining life expectancy at age 60 in Brazil in 2020 was 20.0 years for men and 23.5 years for women. In South Korea in 2020, remaining life expectancy at age 60 was 23.4 years for men and 28.2 years for women (KOSTAT, 2020; IBGE, 2024).

Table 2. Estimated time needed for ADL support, based on data from South Korea, 2018

ADL task	Frequency of help (% of cases)						Time per event (assumed)	Weekly hours (estimated)
	>1 x per day	1 x per day	1-2 x per week	≥ 3 x per week	1-2 x per month	Never		
Eat	31%	18%	8%	12%	2%	29%	30	7.3
Bathe	3%	14%	29%	20%	13%	21%	30	1.4
Toilet	20%	9%	7%	8%	3%	53%	15	1.2
Dress	10%	30%	10%	10%	4%	36%	20	1.6
Mobility Indoors	20%	22%	7%	10%	4%	37%	10	1.3
Public Transport	2%	6%	23%	8%	38%	23%	60	1.5
							Total	**14.5**

Source: own elaboration with data from South Korea Care Work Family Surveys (2018), plus assumed times per event (see text).

of cases reporting each frequency. We exclude the cases that do not need this help, as we aim to estimate the time required by those who do need assistance. This exercise suggests that, for the population requiring care, the time needed can be quite significant. Helping with eating takes the most time, partly due to the high reported frequency of this type of ADL support—an estimated 7 hours per week for those who need such help. Other activities are estimated to require about one to one and a half hours per week. Of course, individuals may need help with more than one activity. Considering individuals who need help with all activities, total estimated care time is just over 14 hours per week. This is significantly less than the average of 28 hours reported by Wolf (2004) for persons over 65 needing help in the U.S., or the 5-6 hours per week reported for those with at least one ADL need in Southern Brazil (Ottavani et al., 2020). This suggests that our assumed times per occurrence are not excessive.

If we apply these average times needed for each activity to the Brazilian population over 60 reporting a need for support for that activity (those who could not perform the activity alone or only with significant difficulty), we find that, among those reporting a need for support with at least one ADL, 50% would need assistance for four hours or fewer per week, another 25% would require help for 4.1 to 10 hours per week, and 25% would need help for more than 10 hours per week. The majority of those needing help were 75 years or older. For these older Brazilians, the time required for care may be substantial.

We use an Ordinary Least Squares regression to analyze the individual and household characteristics associated with greater estimated care needs among Brazilians aged 60 years and older. We employ two measures of care need: (1) an ADL score, a standard unweighted sum of ADL activities (each valued at 1) with which help is needed (Shelkey, 2013), calculated from the PNS; and (2) the estimated time needed for ADL care, based on the needs reported in the PNS and the South Korea data on frequency and assumed time per task.

The regression is described in Equation 1, where X_i is a vector of individual and household characteristics, and ε_i is a robust standard error. For individual characteristics, we include age; a categorical variable for male (versus female); standard Brazilian race categories—indigenous, preta (Black), amarela (Yellow), and parda (Brown)—versus the omitted variable White; and whether the individual lives in a house (versus an apartment, omitted). Household characteristics include the income quartile of the household (high income omitted) and whether it is in an urban (versus rural, omitted) area.

As a transition to the next section of the paper, in which we examine the availability of potential carers in the households of individ-

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uals aged 60 years and older, we include (in three different regressions) the number of working-age adults (18-59 years of age) in the household, the number of non-working adults, and the number of non-working women, as women are traditionally more responsible for care. We include a full set of 27 regional dummies to control for infrastructural and labor market differences that might affect care needs and caregiver availability. We use robust errors clustered at the sampling unit to correct for possible correlation of error terms due to unobserved similarities among people in the same unit. The resulting equation is:

$$Care\ Needed_i = \beta_0 + \beta_1 X_i + \varepsilon_i \qquad [1]$$

An OLS model is appropriate for this exercise. As noted, available data do not allow for an analysis of the potentially causal relationship between care needs and household members' employment; our goal is descriptive. The distribution of the outcome variables is slightly left-skewed. Using a log transformation normalizes the distribution of both the data and residuals but does not improve model fit. Model results with log-transformed outcome variables differ little from those using the untransformed data, and the transformation complicates interpretation of marginal effects. Therefore, we report here the results using untransformed variables. Correlations among independent variables are low; the highest binary correlation (0.29) is between upper income and total working adults in the household.

Descriptive statistics are presented in Table 3 and regression results in Table 4. As shown in Table 3, the average ADL score for adults aged 60 years and older is very low—0.48. The estimated average time needed to support this need is less than one hour of care per week. However, some individuals require help with all six ADL activities, totaling about 13 hours of care per week. Adults in the sample are, on average, 70 years old, ranging from 60 to 112 years. Brown (mixed-race) and white individuals together account for about 87% of the sample, while Black individuals represent 10%, and yellow and indigenous groups a small share. The sample is 44% male, likely reflecting men's shorter life expectancy.

89% of individuals live in a house rather than an apartment. Households containing a member aged 60 or older are fairly evenly distributed across income quartiles (defined for the full sample of households), with a slight overrepresentation among low-income households (36%). On average, there is nearly one adult under 60 years per household, fewer than half a non-working adult, and about a quarter of a non-working female. The number of individuals potentially available for care provision varies widely—up to nine total adults, seven non-working adults, and five non-working females per household.

The regression results are presented in Table 4. The first three columns report the individual and household characteristics associated with the ADL score, while the second three columns report the characteristics associated with the estimated time needed for care. Looking first at the results presented in columns 1-3, we see that, controlling for other factors, men report less need for help with ADL than women—they are 13-14 percentage points less likely to report an additional ADL need. Age, not surprisingly, is highly correlated with the need for assistance, although the coefficients are relatively small. An additional year of age is associated with about half of an additional ADL care need. Race is not associated with the need for care, except for a weakly significant negative correlation between time needed for care and identifying as yellow.

Living in a house is strongly correlated with needing more care. Those living in a house are 9-13 percentage points more likely to report an additional ADL need, perhaps because houses tend to be larger than apartments, making mobility more challenging. Compared to individuals in high-income households, those living in households in other income quartiles are more likely to report an additional care need, although the coefficients, not surprisingly, vary with the controls for working and non-working adults in the household. Those living in urban areas report more care needs (7-8 percentage points more likely to report an additional need), perhaps because public transportation challenges are greater and more frequent.

Table 3. Descriptive statistics for Brazilians aged 60 and over

	2019 n=43,554		
	Mean (s.d.)	Min	Max
ADL score	0.4748 (1.3273)	0	7
Time needed for care activities	0.6985 (1.3273)	0	12.97
Male	0.4409 (0.4965)	0	1
Age (years)	70.05 (8.08)	69	112
Race brown	0.4454 (0.4970)	0	1
Race yellow	0.0094 (0.0967)	0	1
Race black	0.1059 (0.3076)	0	1
Race white	0.4321 (0.4954)	0	1
Lives in a house	0.8947 (0.3070)	0	1
High income	0.2499 (0.4330)	0	1
Upper-middle income	0.2479 (0.4318)	0	1
Lower-middle income	0.1441 (0.3512)	0	1
Low income	0.3577 (0.4793)	0	1
Urban	0.7642 (0.4245)	0	1
Total adults under 60	0.9106 (1.0689)	0	9
Total non-working adults under 60	0.4178 (0.7117)	0	7
Total non-working females under 60	0.2446 (0.5025)	0	5

Source: own elaboration with data from PNS (2019).

Overall, we see that those needing more help, on average, are older, urban, females not in the richest quartile and living in a house.

Considering the availability of the three types of potential carers, we see that individuals reporting greater care needs live with more potential caregivers, as might be expected. Having an additional ADL need is correlated with living with 0.11 more adults under 60 years of age. The correlation is stronger with co-residents under 60 who are not employed. This is again not surprising, as these individuals are potentially more available to provide care and might be chosen from among different family members, if possible. Having an additional care need is correlated with living with 0.13 more adults under 60 who do not report any engagement in paid work. Those with more care needs are particularly likely to live with non-working women—perhaps the family members most likely to provide care. Having an additional care need is correlated with living with 0.18 more women under 60 who do not report any engagement in paid work.

Comparing the results of the first three columns of Table 4, which look at the individual and household characteristics associated with the number of ADL needs, with the second three columns, which look at the characteristics associated with estimated time needed for care, we see the same general patterns. Each additional year of age is associated with about 8 additional minutes of needed care, on average. However, the association between estimated time and living with potential caregivers is stronger than the association with ADL score, suggesting that estimated time may offer a better measure of care need than the ADL score. We find that an additional hour of care need is associated with living with 0.18 more adults under 60 years, 0.21 more non-working adults, and 0.30 more non-working women.

The correlation between greater ADL needs and living in a household with more non-working women might suggest that care needs are limiting women's labor force participation. In the simplest models of the relationship between care and labor force participation, the adult child takes the care demand as given and chooses labor supply accordingly. However, demand for care may not be fixed. Older persons needing care may choose to reside with those children most able to provide care, or sibling children may collectively make such a decision, favoring care in households with members who are already out of the labor force or unemployed (Ettner, 1996; Camarano, 2013).

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Table 4. OLS regression: care need and characteristics of households with individuals over 60 years in Brazil, 2019

Dependent variable	ADL score	ADL score	ADL score	Time needed in care activities	Time needed in care activities	Time needed in care activities
R^2	n=43,554 0.12	n=43,554 0.12	n=43,554 0.12	n=43,554 0.11	n=43,554 0.11	n=43,554 0.11
Independent variables	Coeff. (s.e.)	Coeff. (s.e.)	Coeff. (s.e.)	Coeff. (s.e.)	Coeff. (s.e.)	Coeff. (s.e.)
Male	-0.1279*** (.0113)	-0.1357*** (0.0114)	-0.1479*** (0.0117)	-0.1677*** (0.0190)	-0.1805*** (0.0191)	-0.2005*** (0.0196)
Age	0.0530*** (0.0111)	0.0529*** (0.0011)	0.0531*** (0.0011)	0.0820*** (0.0019)	0.0818*** (0.0019)	0.0820*** (0.0019)
Race brown	-0.0186 (0.0149)	-0.0073 (0.0148)	-0.0048 (0.0148)	-0.0236 (0.0244)	-0.0050 (0.0243)	-0.0009 (0.0243)
Race yellow	-0.0753 (0.0625)	-0.0719 (0.0630)	-0.0062 (0.0634)	-0.1708* (0.0871)	-0.1652* (0.0878)	-0.1157* (0.0884)
Race black	-0.0235 (0.0125)	-0.0167 (0.0215)	-0.0161 (0.0215)	-0.0236 (0.0348)	-0.0199 (0.0348)	-0.0189 (0.0347)
Lives in a house	0.0934*** (0.0205)	0.1243*** (0.0203)	0.1287*** (0.0203)	0.1284*** (0.0317)	0.1789*** (0.0315)	0.1861*** (0.0314)
Upper-middle income	0.0944*** (0.0186)	0.0644*** (0.0184)	0.0649*** (0.0184)	0.1751*** (0.0298)	0.1257*** (0.0296)	0.1266*** (0.0296)
Lower-middle income	0.1141*** (0.0224)	0.0521** (0.0220)	0.0515** (0.0220)	0.01963*** (0.0355)	0.0946** (0.0350)	0.0935** (0.0340)
Low income	0.1357*** (0.0189)	0.0436** (0.0180)	0.0434** (0.0179)	0.2224*** (0.0297)	0.0714** (0.0283)	0.0709** (0.0283)
Urban	0.0747*** (0.0154)	0.0832*** (0.0154)	0.0830*** (0.0154)	0.1133*** (0.0247)	0.1272*** (0.0247)	0.1268*** (0.0267)
Total adults under 60	0.1066*** (0.0071)			0.1749*** (0.0115)		
Total non-working adults under 60		0.1292*** (0.0104)			0.2126*** (0.0171)	
Total non-working females under 60			0.1844*** (0.0159)			0.3039*** (0.0248)
Constant	-3.4738*** (0.0914)	-3.4087*** (0.0910)	-3.4086*** (0.0909)	-5.4258*** (0.1550)	-5.3192*** (0.1538)	-5.3191*** (0.1537)

Note: The regression includes a full set of region dummies.
Source: own elaboration.

Scholars have sought to control for the complex relationship between care and work decisions using simultaneous equation approaches, individual fixed effects to capture unobserved individual characteristics (including caring or paid work preferences), and dynamic models with panel data to capture the long-term labor market impacts of care-related absences from employment. In many cases, care situations appear to influence employment choices (in the United States: Ettner, 1996; Johnson & LoSasso, 2006; in Europe: Ciani, 2012; Meurs & Giddings, 2021; in China: Liu et al., 2010), but in other cases (Southern Europe: Ciani, 2012; Japan: Oshio & Usui, 2017) researchers find no relationship. Lacking suitable data for testing this relationship in Brazil, we note only the possibility of this dynamic and, in the next section, evaluate the potential care load given existing employment decisions.

4. Who is available to provide care?

In this section, we shift our analysis to the household level to consider the potential of households to meet care needs. We focus only on households in which some ADL needs are reported. Considering first the 38% of such households composed entirely of members 60 years of age or older, 22% had at least one member with ADL needs. In these cases, other people aged 60 or older provide the care. In half of such cases, help was needed with only one activity, but in others, help was needed with several activities, and the burden on the other, older household members was significant. In 5% of cases, help was needed with five or more activities.

For households with working-age adults, we evaluate the care load, a measure of care need per person potentially available to provide care. We consider four categories of potential caregivers: working adults and working adult women in households with no non-working members, and non-working adults and non-working women in households with working-age adults who are not employed. The PNS does not collect information on who specifically provides care, and information on household members' engagement in paid work outside the home is limited to whether the individual worked at least one hour in the past week. To focus on employment that is more likely to be regular and away from home—thus reducing the household member's availability to provide care—we consider only work for pay, excluding work remunerated in-kind, done as exchange, or for a family member.

Figure 2 presents the measures of care load on potential carers. For this analysis, we use our two measures of care need, now assessed at the household level. We calculate an ADL score for the household by summing the total number of reported needs among all adults aged 60 or older, and we calculate a time need by summing the estimated time associated with the specific reported ADL needs across all individuals over 60.

Looking first at households with no non-working adult available to provide care, we see that in most cases the ADL needs are relatively light—one need or fewer per working adult. However, in 9% of cases, there are 3.1-5 ADL needs per working individual, and in 14% of cases there are 5.1 or more. Based on our estimates of the time required for specific ADL tasks, we find that in 11% of these households this corresponds to a time commitment of 5.1-10 hours per week per working adult, while in 10% of households the commitment exceeds 10 hours and reaches up to 25 hours (the highest possible load given the coding) in two households. As noted above, we do not know how many hours per week the working individuals are employed. It is possible that some of them work only part time or a few hours a week. Still, it is likely that in some households, working individuals face significant challenges in balancing these care needs with paid employment.

If we consider only women as potential caregivers and calculate the care need per working woman in households with no non-working women, we find that few such households faced the low care load of one ADL need per working woman. Many (26% of such households) faced a load of 5.1 or more ADL needs. The estimated time for these activities is still generally low. 66% of households required an estimated three hours or less per woman per week to complete them. However, in 12% of cases, 5.1-10 hours per working woman per week were needed, and in 14% of cases, each working woman faced a load of 10 or more hours per week, reaching up to 25 hours per week in five households. These are heavy care loads to balance with paid work, even if it is part-time (Figure 2).

Looking at households in which there are non-working members potentially available to focus on care, we see heavier burdens per non-working member. In only a small share of cases (15%) is there just one ADL need per non-working member, whereas in 29% of households non-working members each face a load of 5.1 or more ADL needs. It is likely, as noted above, that care-needing family members live in households where someone is out of the labor market or willing to leave the labor

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market to provide care. Estimated time for this care is still most often three hours or less (57% of cases), but we see a somewhat greater share of potential carers facing a load of 10 hours a week or more (14%) than we saw in households with no non-working members (10%).

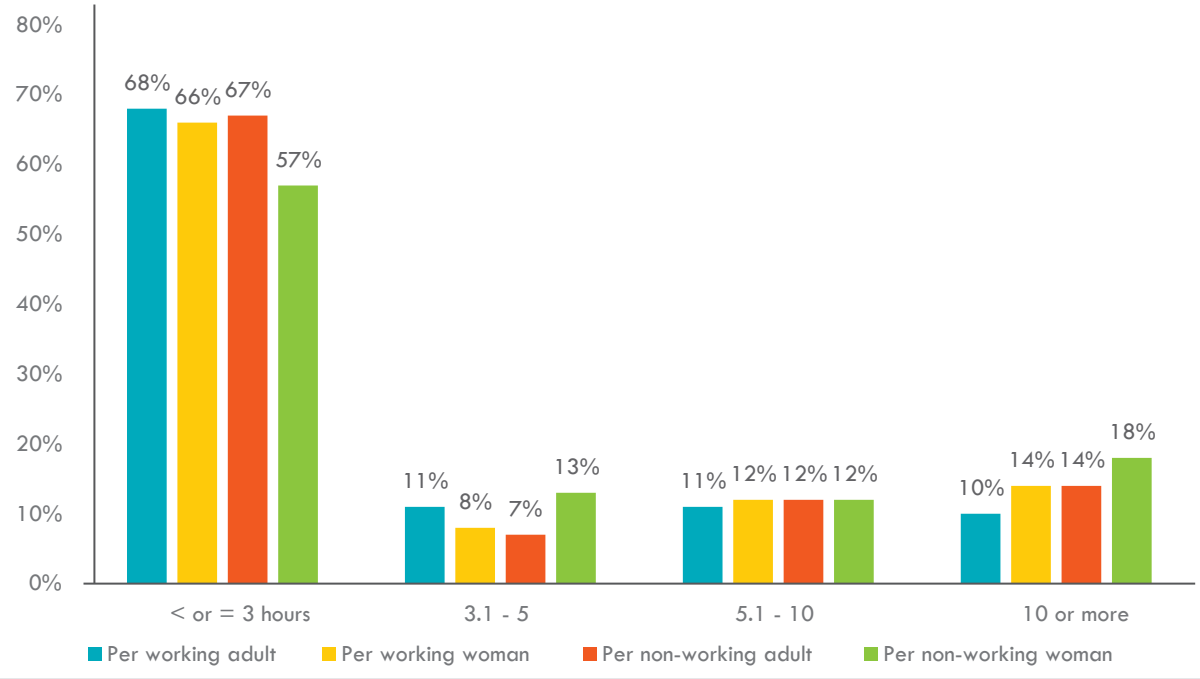
Considering only women as the caregivers does not change the per-person ADL load much, although we do see a smaller share of households with the lightest load per potential caregiver and more households in which caregivers face loads of 1.1-3 ADL needs or over 5.1 per non-working woman. The time load per non-working woman is much greater than the load per total non-working adults, however. A much smaller share of women face time loads of three hours or less, and more face loads of 3.1-5 hours and 10 hours or more. Comparing working women in households with no non-working women to non-working women, we see little difference in the care loads. For all adults, however, those in households with non-working members face lower care burdens than those with no non-working members. Care-needing individuals are more likely to live in households with non-working members—non-working women in particular—and this is especially the case for those requiring more time-consuming care.

5. Discussion and conclusion

Understanding care provision and care gaps is crucial for accurately incorporating care into emerging gender-sensitive macroeconomic models and for formulating effective policies to support care and expand women's choices regarding employment. In this paper, we have sought to advance understanding of the care needs of older persons in Brazil and of the potential care loads that households face.

We highlight that 23% of persons over 60 live alone, and that 37% of persons over 60 live in households without younger persons who might be available to provide help. Although many of these individuals may not need or desire assistance, and many who report a need for assistance also report that they receive it, this population may be particularly vulnerable.

Figure 2. Potential carer load in estimated time, Brazilian senior households with ADL needs



Source: own elaboration with data from PNS (2019).

Sérgio Paschoal (2013) describes a program offered in the city of São Paulo that focuses on providing support to frail older persons with ADL needs who live without family support. Our analysis suggests that more policies of this type are needed.

Using unique data from South Korea to provide initial estimates of time needed for help with ADL needs in Brazil, we showed that, of the approximately 20% of Brazilians over 60 years of age who report difficulty with at least one ADL, around 25% would require over 10 hours a week of assistance.

We showed that Brazilian seniors needing more assistance are likely to be older, urban women living in a house (as opposed to an apartment), not in the highest income quartile, and living with more adults, more non-working adults, and particularly more non-working women. Evaluating the care load this implies for family members, we show that working and non-working women in households with older persons needing assistance face similar potential care loads, although the loads of non-working women are slightly higher. While we were unable to establish whether the non-working women are not working because they need to be available to provide care, previous research in other countries suggests that this may be the case (Ettner, 1996; Skira, 2015; Meurs & Giddings, 2021). For many working women in care-needing households without non-working women, care loads are very significant (10 or more hours per week for 14% of these women). Non-working women face even higher loads which, while not needing to be juggled with paid work, can also imply significant personal costs (Amirthanyan & Wolf, 2003; 2006; Khalaila & Litwin, 2011).

By adding important detail on specific care needs and care time demands, these findings provide new and additional support for arguments by other researchers. As Camarano (2013) has argued, presenting family care as a less expensive alternative to institutional care in policy debates ignores the high costs of the unpriced labor of family, particularly women, caregivers. State policy to complement family care with options such as day care centers or home visits by paid care workers would help reduce these costs without radically changing social arrangements. Garcez-Leme and Deckers Leme (2014) highlight another, even more accessible, way to potentially reduce these burdens on household members, supported by our results. They report a strong demand for training and excellent responses to printed materials. Similarly, Minayo (2021) argues that care for dependent older persons should be officially incorporated into the public health system. She further suggests that informal caregivers should be recognized as health agents, receiving training and guidance to promote adequate care and delay increased dependency. Providing training and support to family members may reduce both the time needed and the stress caregivers face in supporting older persons with ADL needs.

Our results must be considered preliminary given the potential impact of differences in care frequency between South Korea and Brazil, as well as the need to rely on assumptions about care occurrence duration. The collection of additional data on family care provision in Brazil should be a key step in developing care policy.

Although we did not focus on regional differences in our analysis, the data reviewed in the background section and previous studies point to significant inequalities between regions and even among cities within the same region (Krug Wendt, 2015; Ottaviani, 2020). While the wealthiest regions tend to have a higher proportion of people over 60, poorer areas—such as the Northwest—are also experiencing demographic aging (Lacerda et al., 2021) in a context of severe shortage of long-term care facilities. These challenges are often compounded by high levels of informality and low wages, particularly affecting women. This issue also warrants further investigation to better understand the specific differences in needs among the aging population.

In the context of ongoing discussions in Brazil about the new National Care Plan, whose main goals include establishing shared social responsibility between the State and families

and promoting gender co-responsibility, our research highlights the importance of advancing gender co-responsibility in care. Many families face heavy care loads, a situation exacerbated when only women, particularly working women, provide care. As the population continues to age, with more older adults moving into the group over 75 years of age, care needs can be expected to increase significantly. To promote better care and gender equality, public policy must define care as a gender-neutral responsibility. At the same time, dedicated funding and the creation of a structured institutional support network would contribute to reducing the disproportionate burdens on caregivers—particularly women—while advancing the principles and objectives of Brazil's new National Care Plan.

Author Contributions

Mieke Meurs: conceptualization, investigation, formal analysis, methodology, project administration, writing (original draft), and writing (review and editing).

Cristina Vieceli: conceptualization, investigation, writing (original draft), and writing (review and editing).

Rafaela Rodrigues: conceptualization, investigation, writing (original draft), and writing (review and editing).

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Conflicts of Interest

The authors declare no conflicts of interest regarding this article's writing and publication.

Ethical Implications

The authors have no ethical implications that need to be declared in the writing and publication of this article.

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