

What works in long-term care?

Support resources for non-professional caregivers



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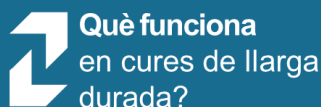
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A project to compile, analyse, and transfer information in order to
improve public long-term care policies.

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1. Introduction

The goal of this report is to help design and implement better long-term care policies and services to support non-professional caregivers. To do so, it presents a systematised review of the scientific evidence available: collecting, filtering, and organising it, and presenting the key findings in an accessible format. The report is part of the "What Works in Long-Term Care?" project, led by Ivàlua and the Barcelona Provincial Council, with the support of the Taula d'entitats del Tercer Sector Social de Catalunya and La Confederació.

Specifically, this report asks **what works in terms of support resources for non-professional caregivers**. To answer this question, the systematised review is structured around three premises. First, it highlights the need to clarify that resources and services can serve different objectives depending on the meanings attributed to the word "support" and to the role of non-professional caregivers. For this reason, the review is framed by the question **what works in terms of...?**, identifying three potential impacts on caregivers:

- Helping non-professional caregivers fulfil their caregiving responsibilities.
- Helping balance caregiving with work responsibilities to ensure people remain in paid work.
- Improving carers' quality of life to foster personal well-being beyond the caregiving role.

Second, and emphasising a **gender perspective**, these impacts are made more visible through the spheres of life that they represent (caregiving responsibilities, career trajectories, and personal lives). On the one hand, the wide range of tasks and time commitments that make up the daily lives of individuals is highlighted, to look beyond their roles as non-professional caregivers. On the other hand, an analysis is made of impacts based on the resources' intended objectives rather than the specific content of each of them. For instance, it is considered more meaningful to group training resources according to whether they help the non-professional caregiver manage the specific dependency situation¹ or instead help them manage their time to improve their own quality of life. For this reason (and unlike other reports in the What Works series) **the decision has been made to organise the findings based on whether the impact affects the dependent person's care, or the caregiver's own career path and personal life.**²

As the report demonstrates, **the findings reveal that most resources focus on the care and support of the dependent person. Consequently, the lion's share of resources goes toward enabling non-professional caregivers fulfil their care responsibilities, i.e. they serve a functional caregiving purpose.** As a result, the fact that these individuals also lead professional and personal lives is overlooked: a point underscored by the scarcity of evidence regarding these areas. Although certain resources (particularly those related to information, training, and guidance) can have an indirect yet positive impact on the well-being and quality of life of caregivers, these resources are not designed with this impact as a key goal. Ultimately, this gap reveals that

¹ A situation of dependency, either due to age, disability, and/or mental illness.

² To improve readability, the three areas will from now on be referred to as: care, employment and personal.

resources prioritise facilitating caregiving without considering the impact this responsibility has on the working lives and well-being of non-professional caregivers. This impact is often difficult to capture, as it manifests through sacrifice or withdrawal – such as deciding to leave paid employment or using days off to caring for a dependent person. In any case, an analysis of the specialised literature reveals that there are **more support resources available for improving caregiving than for fostering caregivers' own well-being**. In this regard, it appears that the **primary policy objective of these interventions (especially within Central European and Mediterranean welfare models) is to provide care to the recipient, even though the resources themselves are directed towards the caregiver**.

Thirdly, the report adopts a **critical perspective that highlights that most of the evidence found fails to question the role of non-professional caregivers: these are predominantly women responsible for care within the family setting**. In other words, the feminisation and familial nature of the care provision model are taken for granted. Consequently, non-professional caregivers are simply seen as an integral part of the social organisation of long-term care, with no examination of the inequalities involved, particularly in terms of gender, social class, and origin. **Most interventions focus on addressing the care needs of the dependent person while overlooking the needs of the caregiver. Although services such as respite care exist to address the need for personal free time, the sporadic nature of this resource means it cannot be considered an effective tool for fostering the caregiver's own life project**. This invisibility of non-professional caregivers leads to them being viewed as merely one more resource within a provision model which is largely based on family responsibility and the home environment. All of this reinforces the family's role in long-term care for granted as something that is taken for granted, without questioning the moral obligation non-professional caregivers may feel, nor the professional and personal sacrifices they make to fulfil this role.

Based on what has just been set out, the results of the systematised review are presented according to the three areas identified; each includes empirical evidence regarding the range of resources and services identified through the review of scientific literature. As explained in the final section on implications, in addition to reflecting the impact of various support resources and services, **the results also reveal persistent inequalities in the provision model**, particularly from a gender perspective. The predominant profile of non-professional caregivers is that of women over fifty, although a trend towards diversification has been observed (Imsero, 2026). Consequently, a set of reflections is offered to help guide policy design and implementation, given that support resources for non-professional caregivers can either reinforce women's caregiving roles or, conversely, help **prevent their lives from being taken over by the responsibility of caring** for dependent individuals.

2. Motivation

The **long-term care provision model is undergoing a strategic transition** that requires empirical evidence to inform public policy design. The mismatch between care needs and the resources available to meet them poses a challenge that has been exacerbated by the impact of

the 2008 economic recession and the 2020 health and social crisis. On the one hand, the **financial crisis coincided with the initial implementation of Spanish Law 39/2006** on the Promotion of Personal Autonomy and Care for Dependent Persons (LAPAD in its Spanish acronym). This led to funding difficulties – combined with austerity policies – eroding the transformative potential of the new legal framework. Consequently, long-term care provision has tended towards commodification (Martínez-Buján, 2019; Artiaga, 2021). Furthermore, the interpretative framework of the new legislation exhibits a **bias towards familialism** by providing financial benefits for non-professional care, while health measures implemented in response to the COVID-19 pandemic, alongside the crisis in residential care facilities, have **reinforced the private home as the primary setting for care**. All of this is taking place against a backdrop where a care ideal defined by the slogan "at home and with the family" prevails (Moreno et al., 2017). Consequently, **the role of markets and families in care provision has intensified** in recent years. At the same time, public policy promotes new care strategies that seek to strengthen the community networks of the recipients. In this context, **following the COVID-19 crisis, a strategy for the deinstitutionalisation of long-term care** emerged under the umbrella of the European Care Strategy (European Commission, 2022). In Spain, the State Strategy for a New Model of Community-Based Care: a Deinstitutionalisation Process was presented in 2023. While deinstitutionalisation is understood as a shift to foster social participation, community-based settings, and home-based support tailored to individuals' needs and preferences, it must be noted that in Spain and Catalonia, this strategy unfolds against a **backdrop of familialism that is typical of Mediterranean welfare states** (Saraceno & Keck, 2010). This care model is characterised by a welfare-oriented view of public services, that are perceived as substitutes for the family rather than as a universal right for all (Moreno et al., 2017). From this perspective, the approval of the LAPAD represents a shift toward a universalist discourse, but one that fails to translate into practice, given the persistence of a model rooted in the family and in the market. **One element of this model is the use of women's unpaid domestic work**, as well as the strong presence of migrant women whose labour meets a significant portion of these needs (Díaz-Gorfinkel and Martínez-Buján, 2018; Molero, 2020).

Against this backdrop, a critical review is proposed here regarding the effectiveness of support resources for non-professional caregivers.

Box 1. Conceptual framework

Palomera's work (2024) serves as our theoretical reference; he presents support for non-professional caregivers as an essential resource in the Catalan context, where **the family continues to play a central role in the provision of long-term care**. This perspective highlights the familialism inherent in the LAPAD, insofar as it includes a financial benefit for non-professional caregivers. Although this is one of the main measures in the LAPAD, it conflicts with the purported goal

Box 1. Conceptual framework

of greater public administration involvement in long-term care. Among other aspects, the preamble mentions the aim of fostering professional care work and shifting responsibility away from the family.

The social reality reflected in the large number of people – predominantly women – who take on non-professional care responsibilities within the family setting urges a deeper understanding of the impact of available support resources. **These responsibilities affect the caregivers' quality of life (encompassing its physical, emotional, relational, economic, and material dimensions).** These dimensions cut across the three areas identified for our review into effective measures: caregiving, employment, and personal life.

This review aims to provide empirical groundwork regarding support resources, adopting a gender perspective and a critical view of the current model. In this regard, it is important to note that **the services and resources under study can reinforce the family's role in long-term care and, consequently, risk perpetuating inequalities based on gender, social class, and origin. Financial benefits are the primary demand made by non-professional caregivers, yet they often become the main reason for assuming caregiving responsibilities and justifying that decision,** thereby precluding any consideration of alternatives to family-based care.³ Nevertheless, it is true that public services have also been implemented, such as training, information, respite care, temporary residential care, and psychological support; these can help caregivers balance caregiving with employment and improve their overall well-being.

3. Description of the service being analysed

This summary analyses the range of support resources aimed at non-professional carers within the private domestic sphere. These are **individuals within the family or the family's close social circle who provide ongoing care to a person with whom they share an emotional bond, who is dependent due to their age, disability, and/or mental illness.**

Based on this definition, a review is carried out of the available evidence regarding the impact of benefits and support services for non-professional caregivers. Specifically, the four types of

³ In Palomera's words (2024:27): "In December 2023, non-professional caregivers looking after a person with a Grade I dependency level received an average of 174 euros per month, while those caring for a person with Grade II dependency received an average of 283 euros per month, and those caring for a person with Grade III dependency received 384 euros. These amounts are remarkably low, especially considering the waiting lists for access to public services and the opportunity cost of providing care regarding one's ability to participate in the labour market. Indeed, the most sorely needed form of support for caring for dependent individuals is financial assistance (cited by 43.7% of households)."

resources identified by Palomera (2024) are considered, although the classification is adapted according to the areas defined and the results obtained, as detailed in Box 1.

- **Information, guidance, training, and support resources** for non-professional caregivers. These are resources that provide guidance on existing services and training on how to care for dependent individuals.
- **Financial benefits.** The primary benefit in this area is the Financial Benefit for Family-Based Care (PECEF), provided for under the Law on the Promotion of Personal Autonomy and Care for Dependent Persons; however, other types of benefits may also be offered by local authorities, such as caregiver cards or sliding-scale pricing for certain services.⁴
- **Respite services.** These are resources designed to improve the quality of life of non-professional caregivers. They provide carers with a period of rest while the care recipients receive care from other people. Respite services can often help in unforeseen circumstances or emergencies. Most are designed to provide temporary stays for the dependent person, either in a residential setting (including overnight stays) or for a few hours a day.
- **Services focused on emotional and psychological support, mutual aid, and support networks.** These individual or group psychosocial resources aim to reduce the negative impact that caregiving activities can have on non-professional caregivers: an impact that generally manifests as stress and anxiety. These resources may also aim to create mutual support networks among **caregivers**.

Below is a table showing the three areas: caregiving, employment, and personal life, along with resources identified and examples given for clarification.

Table 1. Key of the criteria used to distinguish between the various areas and resources

	Caregiving aspects	Employment aspects	Personal aspects
Information and guidance	Knowledge about the health conditions of the dependent individual	Knowledge about work-life balance measures and labour resources	Knowledge about respite services and other available support services
Training	Competencies and skills linked to physical care tasks	Careers advice and self-help courses	No specific evidence identified
Emotional wellbeing	Therapy and psychological support	Explicit support from managers, group therapy and a caring company culture	Respite services, home help services, financial benefits and supervised exercise programmes
Problem-solving and coping strategies	Skills to set appropriate goals and make decisions in times of stress	Participatory approaches to managing conflicts between work and care tasks	Methods to manage overload and maintain well-being

⁴ This is a free card that identifies caregivers and grants them access to subsidised services and specific resources. While most of these resources are aimed at facilitating caregiving for the dependent person, the scheme also includes services and resources for self-care and well-being. It should be noted that a reform of the *Law on the Promotion of Personal Autonomy and Care for Dependent Persons* is scheduled for approval in October 2026; this reform will expand the definition of a non-professional caregiver to include individuals beyond the immediate family.

Work-life balance measures	No specific evidence identified	Flexible working hours, leave, breaks, professional promotion and work adaptations.	Respite services that free up personal time and make everyday life easier
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4. Questions guiding the review

Based on the description of resources outlined in the introduction, the report uses **premises that help organise it into three spheres shaping the lives of non-professional caregivers: caregiving, employment, and personal life**. The responsibility of caring for a dependent person can lead to spells of physical and emotional exhaustion, which can sometimes become open-ended. This makes an impact on health, interpersonal relationships, employment status, quality of life, and life plans; it can cause the carer's physical, psychological, and social well-being to deteriorate and negatively affect their living conditions on personal, professional, and material levels.

From this perspective, the report adopts the concept of **"total workload", defined as the sum of all daily or weekly time dedicated to work, whether paid or unpaid** (Durán 2006). This approach highlights the volume of responsibilities a single individual takes on, regardless of whether the tasks are performed professionally or not. It also makes the phenomenon of women's "double presence" (Balbo, 1994) or "triple presence" visible (Sagastizaval and Legarreta, 2016). These situations are characteristic of female non-professional caregivers: scenarios where responsibilities accumulate and spheres of paid and unpaid work overlap, often at the expense of personal time. Among other issues, the consequences can manifest as an excessive workload, the absence of personal life goals, and the inability to have any time for oneself. All of this explains why, for non-professional caregivers, the most relevant aspects for measuring the impact of policies are the ability to make their own choices, a reduction of caregiving burdens, more ease in organising their time, and training and support provided by public institutions (Palomera, 2024).

Accordingly, the questions guiding this review have been framed around the impact made by resources and services on three key areas of caregivers' daily lives: caregiving, employment, and personal life. First is the sphere of reproductive work, which encompasses the **activities and tasks involved in helping dependent individuals meet their daily needs**. Second is the sphere of paid work, referring to the caregiver's **employment activity in terms of both content and conditions**. Finally, there is the personal sphere, which includes aspects related to the **ability to make decisions regarding time management, living conditions, and life goals**.

However, it must be noted that specific interventions in one area can affect another area, sometimes in contradictory ways. For instance, flexible working hours might facilitate work-life balance and alleviate emotional distress, yet might simultaneously increase the caregiving burden. Similarly, training to learn about the progression of cognitive decline might ease a non-professional caregiver's anxiety and improve their emotional well-being, while potentially reducing their availability for paid work. **In this way, a single resource or service can have a dual impact, affecting different areas more or less directly.**

The set of questions **guiding the search for evidence is formulated by considering the resources and impacts regarding each of the three aspects**, even though the impacts may manifest in an interrelated manner.

4.1. Caregiving aspects

This first section focuses on the effectiveness of resources and support services for non-professional carers to better attend to the person in a situation of dependency. In other words, all the things that **seek to facilitate care**. The specific questions that have guided the review are:

- What support resources exist for non-professional carers to help them fulfil their caring responsibilities?
- What transversal variables influence access to and use of these resources?
- How do the resources improve the caregivers' knowledge about the dependent person's health issues and their skills for caring for them?
- What indirect impact do the resources have on the physical health, emotional well-being and workload of non-professional caregivers?

4.2. Employment aspects

This second section focuses on the effectiveness of support services and resources for non-professional caregivers in ensuring they can combine paid employment with their caregiving responsibilities, preventing them dropping out of the labour market and helping them work effectively. In other words, it addresses everything that makes work and caregiving (both paid and unpaid work) compatible. The questions guiding this review are:

- What resources exist to support non-professional caregivers so that they can continue in paid employment and to facilitate the balance between employment and caregiving?
- What cross-cutting variables influence access to and use of these resources?
- How do these resources impact caregivers' career paths, ongoing employment, and working conditions? And what is their impact in terms of workload?

4.3. Personal life

This third block focuses on the effectiveness of resources and support services for non-professional carers to guarantee their quality of life and their physical, psychological and social well-being. In other words, it includes everything that contributes to them **maintaining personal life goals beyond their care responsibilities**. The questions that have guided the review are:

- What resources exist to support non-professional caregivers guarantee a decent quality of life and personal well-being?
- What transversal variables influence access to and use of these resources?
- What impact do these resources have on health and personal time available?⁵
- What impact do they have on living conditions, both in terms of the ability to choose how to organise their daily lives, and the process leading to permanent institutionalisation?

5. Evidence review

5.1. Methodology

5.1.1. Search strategy

The identification of evidence focused on systematic reviews and meta-analyses of evaluations, although the analysis also included articles presenting impact evaluations considered to be of particular interest.

Initially, an exploratory search was conducted in English and Spanish, combining keywords (*resources, impacts, social inequalities*,⁶ and *family profiles*) with specific terms derived from the types of resources, impacts, social inequalities, family profiles, and study types with *informal caregiver*,⁷ this yielded a total of **2,820** references (including duplicates) from the specialised [Web of Science](#) database. By way of example, the following term combination was used to look for information and training resources: *Informal caregiver* 'OR' *Cuidador(a) informal* 'AND' *Information and training* 'OR' *Información y formación*, yielding a total of 76 references. For further details on the combinations of terms used, see Annex 10.1.1.

The methodology followed for identifying and selecting available evidence prioritised academic studies that (insofar as possible) provide rigorous evidence of a causal nature regarding the capacity of these interventions to achieve their objectives. Specifically, preference was given, firstly, to **impact evidence reviews involving causal identification** (systematic reviews, meta-analyses, and scoping reviews) and, secondly, to **impact evaluations involving causal identification** (experimental and quasi-experimental studies). Third came **causal studies demonstrating methodological rigour, even if they were not based on the evaluation of a**

⁵ Initially, it was seen as worthwhile to include the impact on housing, given that many non-professional caregivers live with the dependent person. This situation can give rise to housing-related issues, such as a lack of adapted spaces or a loss of autonomy and privacy, among other difficulties. However, the lack of empirical evidence regarding this question led to it being discarded when the initial questions were formulated.

⁶ It is important to mention that no references with LGTBIQ+ perspectives were found.

⁷ This combination of words was used because it initially yielded 13,154 results in the database used (compared to 294 when using the term "non-professional caregiver"). References where the study population consisted of professional caregivers who were working in the informal economy were discarded manually.

specific intervention. And finally came **non-causal evaluations** that nonetheless possessed high methodological **robustness**.

Subsequently, these results were expanded upon using articles and reviews from the [ProQuest](#) database to fill information gaps regarding causal evidence and to obtain more localised evidence.

While prioritising systematic reviews and meta-analyses might be seen as the way to ensure appropriate methodological rigour, this approach also entails certain limitations, as noted in Section 8. To overcome these limitations, the decision was made to include case studies – presented as specific evaluations or research projects – that help fill information gaps or add more nuance to some of the insights derived from analysing the reviews.

5.1.2. Selection strategy

The references were selected based on the eligibility criteria detailed below.

- **Timeframe:** studies published between 2006 and 2026 were included, since the LAPAD was approved in 2006.
- **Context:** results were restricted to the European continent, with a particular focus on Mediterranean welfare states.
- **Document types:** only academic articles and academic review articles were considered, with priority given to the latter.
- **Research areas:** categories very far removed from the social sciences (such as engineering, medicine, or technology) were excluded.
- **Language:** only references in English or Spanish were selected; the Web of Science database does not offer an option to include references in Catalan, and while ProQuest does offer this option, only references in Spanish and English appeared in the results.

The literature selection process was reported following the **PRISMA** 2020 statement guidelines (Page et al., 2021), as outlined in Annex 1. A total of **56** references were included in the review: **38** review articles and **18** research articles.

5.2. Analysis of the evidence

This section presents the analysis of the empirical evidence based on the three identified domains: caregiving, employment, and personal life, considering the characteristics and types of resources or services, the identification of what works, and the risks and barriers to access.

5.2.1. The effectiveness of support resources for non-professional caregivers in terms of the caregiving aspect

5.2.1.1. Classification of resources

The following section summarises the available evidence regarding the impact of support resources for non-professional caregivers on their **caregiving responsibilities**, as well as on their living conditions in terms of health and workload. Specifically, it analyses whether these resources improve the conditions under which they perform their caregiving role. This covers aspects such as knowledge of health conditions, the competencies and skills needed to care for the dependent person, and the impact of caregiving on the caregiver's own quality of life. It also examines barriers to access and risks associated with the resources analysed, based on the various caregiver profiles.

This section encompasses the bulk of the reviewed literature (a total of **29 reviews of studies examining causal impact**), which highlights and reinforces the fact that these resources are primarily aimed at facilitating caring for the dependent person.

The reviews selected make it possible to identify various support resources that are available to non-professional caregivers to help them carry out their caregiving responsibilities. Broadly speaking, the analysis of the scientific literature reveals **four distinct approaches**:

- Resources providing **information on the dependent person's health**. For example, educational programmes regarding medication and blood pressure monitoring.
- Resources offering **training in competencies and skills** related to physical caregiving tasks, such as how to move a dependent person safely.
- **Therapy and psychological support** resources aimed at alleviating the emotional distress of non-professional caregivers coping with caregiving responsibilities.
- **Problem-solving resources and coping strategies**. For example, interventions focused on strengthening goal-setting and decision-making skills in times of stress.

These resources appear either in isolation or in combination, most commonly in combination. Beyond their specific approach, the resources can also be classified by other relevant features:

- **If they address the health condition of the dependent person**. Some interventions focus on a specific condition, such as dementia or stroke,⁸ while others group various conditions under a single category, such as palliative care needs (Usai et al., 2025).

⁸ These two specific conditions were those most frequently reported in the literature reviewed (Wang et al., 2021; Camino et al., 2025; Li et al., 2026; Encinas-Monge et al., 2024; Yang et al., 2025; Qureshi et al., 2023; Panzeri, 2019; Smith et al., 2019; Farrell et al., 2026; Wiegelmann et al., 2021).

- **The person targeted.** Some interventions are aimed solely at caregivers, while others also include the dependent person.
- **The delivery channel.** This can be online (either in real time or at the caregiver's own pace) or in person, taking place in the home, a day centre, a residential care facility, or a hospital.
- **The format.** Individual, group-based, or a combination of the two.
- **The team of professionals involved.** On the one hand, resources featuring a network of professionals with an emphasis on nurses; on the other, resources provided by a single professional.
- **Duration.** Either more or less than eight weeks, or highly variable across the references within a single review.

Table 2. Summary of types of resources (caregiving aspect)⁹

	Information on health conditions (n = 16)	Training in necessary skills (n = 7)	Therapy and psychological support (n = 13)	Problem-solving and coping strategies (n = 7)
How these appear	Individually or combined			
Health condition addressed	One specific condition or various conditions together			
Target	Caregiver only, or also including the dependent person			
Channel	Online in real time, online at the user's pace, or in person			
Format	Individual, group-based or a combination of the two			
Professional team	A single professional or a network of professionals with an emphasis on nurses			
Duration	More or less than 8 weeks, less than 8 weeks or variable			

⁹ The total number of references regarding resource content (n = 43) is higher than the number of articles reviewed (n = 29) because, as previously noted, a single article may combine different resources.

5.2.1.2. What resources work?

Based on the observed focus of the resources and the evidence reviewed, it is possible to highlight what works in supporting non-professional caregivers in their caregiving responsibilities.

Generally speaking, resources providing **information on the health condition** of the dependent person yield more positive outcomes for non-professional caregivers compared to other types of resources. This is particularly true when such resources are combined with **training in competencies and skills** which have a **direct, instrumental impact** on care. This all helps caregivers handle everyday situations related to the physical tasks required to care for dependent individuals. On the one hand, having more information available increases their knowledge regarding medication, diet, nutrition, weight control, blood pressure monitoring, vascular access care, pain management, specialised equipment, local support services, and emergency procedures.¹⁰ On the other, training improves techniques for transfers and mobility, as well as self-efficacy and communication skills.¹¹ Furthermore, both types of resources have an **indirect impact on emotional well-being** by enhancing quality of life, self-esteem, and mental health, while reducing the burden on the caregiver, their levels of distress, and depressive symptoms. However, this reduction in emotional distress is limited to alleviating the burden of caregiving, rather than improving the caregiver's overall quality of life or helping them work towards their life goals. Moreover, this effectiveness is not constant over time because **information about an illness** is much more readily available during the initial stages of the illness, whereas in the **final stages**, caregivers require specific information regarding the dying process and symptom management. This is support that is often **not provided** (Usai et al., 2025).

Regarding other types of resources, **therapy and psychological support** alleviate anxiety, fatigue, and stress, and thus have a positive impact on the mental health and emotional well-being of non-professional caregivers;¹² however, the effect is once again sporadic rather than constant. In addition, **problem-solving resources and coping strategies** improve psychological well-being. These goal-setting and decision-making skills reduce stress and caregiver burden.¹³ Nevertheless, both types of resources often appear as add-ons to information or training initiatives, the ultimate goal of which is to equip informal caregivers to carry out the tasks and responsibilities inherent to their role as carers.

¹⁰ The specific references are: Wang et al., 2021; Winter et al., 2024; Camino et al., 2025; Qureshi et al., 2023; Ghizzardi et al., 2025; Nittas et al., 2026; Hernández et al., 2025; Panzeri, 2019; Becqué et al., 2019; Frias et al., 2020; Bártolo et al., 2022; Folder et al., 2024; Raemdonck et al., 2022; Usai et al., 2025; Vartiainen et al., 2025; Raemdonck et al., 2022.

¹¹ The specific references are: Wang et al., 2021; Winter et al., 2024; Hernandez et al., 2025; Becqué et al., 2019; Bártolo et al., 2022; Folder et al., 2024; Raemdonck et al., 2022.

¹² The specific references are: Wang et al., 2021; Winter et al., 2024; Li et al., 2026; Rodrigues et al., 2024; Qureshi et al., 2023; Ghizzardi et al., 2025; Nittas et al., 2026; Hernández et al., 2025; Panzeri, 2019; Becqué et al., 2019; Frias et al., 2020; Bártolo et al., 2022; Raemdonck et al., 2022.

¹³ The specific references are: Winter et al., 2024; Camino et al., 2025; Qureshi et al., 2023; Hernández et al., 2025; Frias et al., 2020; Smith et al., 2019; Davies et al., 2013; Raemdonck et al., 2022; Usai et al., 2025; Bom et al., 2019.

Thus, these seemingly positive results mask an underlying issue: the resources analysed prioritise the caregiving role of non-professional caregivers, neglecting their professional and personal well-being. This bias is reinforced by the prevailing **biomedical perspective** among the teams responsible for promoting such policies, since they **prioritise** the health issues of the **dependent person** over the well-being of the caregiver (Frias et al., 2020).

In addition to the specific focus of the resources themselves, other characteristics also influence their effectiveness. A key point to highlight is that **interventions combining different resources** yield **more positive results** than those relying on a single resource, as they allow for a more comprehensive and holistic approach that addresses the diverse needs of caregivers.¹⁴ Similarly, **resources that are tailored to a specific medical condition** perform better than those covering multiple conditions, as the content is more precise, specific, and relevant.¹⁵

Regarding the people targeted, interventions **focused solely on the caregiver** are **more effective** than those addressing both the caregiver and the dependent person; this suggests that focusing on two individuals with distinct needs can diminish the specific impact on each of them.¹⁶

As for the delivery channel, **more flexible resources** achieve **better results** in terms of both the practical aspects of caregiving and the emotional well-being of informal caregivers.¹⁷ This is true whether they operate exclusively remotely at the user's own pace, combine self-paced and real-time modalities, or integrate various channels (online, in-person, and by telephone). However, exclusively remote interventions do present significant risks and barriers:

- **Digital exclusion**, linked to a lack of language options, complex language used, or the absence of adjustments for cognitive or physical limitations. This phenomenon is closely tied to **low digital literacy**, low confidence in using technology, and a lack of experience and support. These are factors also clearly linked to social inequalities (Ghizzardi et al., 2025; Nittas et al., 2026; Yang et al., 2025).
- **Ethical concerns** regarding data privacy and security, alongside the fear of losing social interaction.

¹⁴ The specific references are: Wang et al., 2021; Winter et al., 2024; Camino et al., 2025; Qureshi et al., 2023; Encinas-Monge et al., 2024; Ghizzardi et al., 2025; Nittas et al., 2026; Hernandez et al., 2025; Panzeri, 2019; Becqué et al., 2019; Frias et al., 2020; Bártolo et al., 2022; Folder et al., 2024; Raemdonck et al., 2022; Usai et al., 2025; Vartiainen et al., 2025; Farrell et al., 2026.

¹⁵ The specific references are: Wang et al., 2021; Camino et al., 2025; Li et al., 2026; Encinas-Monge et al., 2024; Yang et al., 2025; Qureshi et al., 2023; Panzeri, 2019; Smith et al., 2019; Farrell et al., 2026; Winter et al., 2024; Hernández et al., 2025; Bártolo et al., 2022; Rodrigues et al., 2024.

¹⁶ The specific references are: Murfield et al., 2021; Li et al., 2026; Qureshi et al., 2023; Encinas-Monge et al., 2024; Ghizzardi et al., 2025; Nittas et al., 2026; Hernández et al., 2025; Becqué et al., 2019; Frias et al., 2020; Bártolo et al., 2022; Davies et al., 2013; Raemdonck et al., 2022; Usai et al., 2025; Vartiainen et al., 2025; Bom et al., 2019; Farrell et al., 2026.

¹⁷ The specific references are: Wang et al., 2021; Camino et al., 2025; Davies et al., 2013; Li et al., 2026; Nittas et al., 2026; Winter et al., 2024; Qureshi et al., 2023; Encinas-Monge et al., 2024; Ghizzardi et al., 2025; Frias et al., 2020; Yang et al., 2025; Smith et al., 2019; Vartiainen et al., 2025; Farrell et al., 2026.

- The **burden of learning new technologies**, added to **technical and usability issues**, which in some cases generate feelings of depending too much on the system (Camino et al., 2025; Davies et al., 2013).
- The **difficulty of measuring the intensity and frequency** of sessions (Frias et al., 2020).

Interventions conducted exclusively **in person** also have their limitations, such as **difficulties in attending** arising from scheduling conflicts faced by caregivers (Murfield et al., 2021), but the findings suggest that an **online channel** should serve **as a complement** to in-person sessions rather than a substitute; while it can alleviate daily time constraints, it may also exacerbate existing social inequalities (Qureshi et al., 2023).

Regarding the format used, **one-on-one interventions** appear most frequently in the reviewed literature;¹⁸ they are **more personalised** and tailored to each caregiver's profile, albeit at a higher cost (Panzeri, 2019). In contrast, **group-based interventions** foster **mutual support** and a sense of belonging to a new community (Raemdonck, 2022). However, they are less personalised and make it harder to establish meaningful individual connections (Yang et al., 2025). This prevalence of the personalised one-on-one format may, once again, reflect an instrumental bias, with these interventions focusing more on reinforcing caregivers' competence and efficiency in their caregiving role than on providing a support network that addresses their own personal well-being needs.

Regarding the professional team, compared to resources involving only a single type of professional, resources delivered by a **multidisciplinary group of professionals** (with **nurses** playing a significant role) have a **more positive impact** on the care required by dependent individuals and on the psychological well-being of non-professional caregivers.¹⁹ Specifically, they enable caregivers to identify with the professionals, have their feelings validated, ask questions, and offer each other mutual support and encouragement (Ghizzardi et al., 2025).

Finally, regarding duration, interventions lasting **more than eight weeks** show **effective** results,²⁰ although **no definitive conclusions can be drawn** given that most of the reviewed studies do not report this parameter.

To conclude this section, it is essential to critically analyse the results from two perspectives. On one hand, non-professional caregivers continue to express their **unmet needs**, particularly regarding how to manage **daily living activities** such as household chores, meal preparation, or assisting dependent individuals with **mobility**. This indicates that some care-related resources are effective, although they do leave significant gaps (Usai et al., 2025). On the other hand, the

¹⁸ The specific references are: Wang et al., 2021; Winter et al., 2024; Camino et al., 2025; Li et al., 2026; Nittas et al., 2026; Panzeri, 2019; Becqué et al., 2019; Folder et al., 2024; Smith et al., 2019; Davies et al., 2013; Raemdonck et al., 2022.

¹⁹ The specific references are: Hernandez et al., 2025; Folder et al., 2024; Wang et al., 2021; Ghizzardi et al., 2025; Panzeri, 2019; Smith et al., 2019; Farrell et al., 2026.

²⁰ The specific references are: Frias et al., 2020; Farrell et al., 2026; Raemdonck et al., 2022; Nittas et al., 2026.

caregiver role involved in these resources is **not gender neutral**. Although caregivers have a predominantly female profile in almost all the reports of reviewed literature, generally as partners or daughters, there is no critical examination carried out sufficiently well of the risks associated with the reproduction of inequalities inherent in the feminisation of care within the family sphere. **Ultimately, the resources that work best, according to the bulk of the literature reviewed, are those that adapt to the caregiver's practical needs; however, they do so by taking their caregiving role for granted, without attempting to directly improve the carer's personal and professional well-being**, aspects that are addressed in the following sections.

Box 2. Summary of evidence related to the impact made by support resources for non-professional carers in terms of their caregiving responsibilities

→ **What resources are available to support non-professional caregivers in carrying out their caregiving responsibilities?**

The results of the systematic literature review identify four types of care-related resources: **information** regarding the dependent person's health condition; **training** in competencies and skills; **therapy and psychological support**; and resources for **problem-solving** and coping **strategies**.

→ **What cross-cutting variables influence access to and use of these resources?**

The effectiveness of these resources is primarily conditioned by six factors: the approach to the dependent person's **health condition**, the person **targeted**, the delivery **channel**, the **format**, the professional **team**, and the **duration**.

If the resource is delivered online, the identified risks include **digital exclusion**, ethical concerns regarding data **privacy**, less social **interaction**, the challenge of **learning** a new technology, and technical issues, all of which are influenced by **axes of social inequality**.

If the resource is delivered in person, the non-professional caregivers' lack of **time** is a factor that can lead to scheduling conflicts.

→ **What impact do these resources have on caregivers' conditions, in terms of both their knowledge of the health situation of the dependent person and their skills for caring for them?**

Information resources regarding health conditions have a positive impact on **knowledge** concerning medication, nutrition, available resources, and emergency procedures.

Training resources are effective in developing the physical **skills** needed for caregiving, such as helping move dependent individuals safely.

Box 2. Summary of evidence related to the impact made by support resources for non-professional carers in terms of their caregiving responsibilities

Furthermore, resources focused on **problem-solving** and coping **strategies** (often linked to other resources) improve **goal-setting** and **decision-making** skills during stressful situations.

→ **What indirect impact do these resources have on the physical health, emotional well-being, and workload of non-professional caregivers?**

The three types of resources mentioned above (information, training, and problem-solving/coping strategies) **indirectly** impact emotional well-being by improving mental health and reducing caregiver burden and distress.

Therapy and **psychological** support resources (often linked to information or training services) reduce **anxiety**, fatigue, and stress, enabling non-professional caregivers to continue in their role.

5.2.2. The effectiveness of support resources for non-professional caregivers in terms of the work aspect

This section presents the available empirical evidence regarding the impact of support resources for non-professional caregivers on their employment situation. It should be noted at the outset that not many reviews were found on the results of causal evaluations concerning the impact of such interventions. Of the thirteen articles identified, three are reviews, while the remainder are evaluations or case studies. This lack of systematised evidence suggests that **a clear policy approach aimed to help carers balance caregiving duties with employment is lacking**. Conversely, there is abundant evidence that analyses the consequences of caregiving responsibilities on non-professional caregivers' career paths. It could be said that **the problem has been well diagnosed, yet there is a lack of evidence regarding the impact of the measures implemented as possible solutions** (Sibera et al., 2018).

In any case, it should be borne in mind that the resources and services presented here are the ones identified in the scientific literature reviewed and should not be considered an exhaustive list of all existing options. For instance, a significant portion of the systematised evidence relates to the impact of flexible working times. In contrast, virtually no studies were found evaluating the impact of measures aimed at workplace flexibility, despite the availability of teleworking as a resource.

5.2.2.1. Features of the resources

The selected reviews and articles make it possible to identify various support resources for individuals to help them balance the dual responsibility of providing non-professional care while

maintaining paid employment. Broadly speaking, the analyses gathered from the literature review reveal three distinct approaches:

- Support resources for **transitions between work and non-professional caregiving responsibilities**. For example, through flexible work schedule arrangements.
- Resources addressing the impact of non-professional caregiving responsibilities on **work performance**. For example, through personalised support to manage each specific situation.
- The evaluation of interventions aimed at **reducing workload and psychosocial strain**. For example, through emotional well-being support services.

Table 3. Summary of types of resources (employment aspect)²¹

	Transition between caregiving and work (n= 7)	Work performance (n = 5)	Overload and emotional wellbeing (n = 3)
Employment measures	Work-life balance measures Flexible working (hours and days) Career advancement for non-professional caregivers	Promote workplace autonomy Breaks	Workplace support Supportive company culture
Training and guidance	Counselling and therapy Case manager	Self-help courses Counselling and therapy Continuing education	Participatory approach Counselling and therapy Self-help courses
Services	Public long-term care services		

5.2.2.2. What resources work?

The results of the systematic review provide insights into what works regarding support for individuals who balance work and caregiving responsibilities. Broadly speaking, **resources that facilitate balancing employment with non-professional caregiving duties are considered effective**. Interventions that help **alleviate the workload** that is associated with combining a caregiving role with paid employment (as well as the **resulting psychosocial effects**) are also beneficial. The following section examines the impact of these resources in greater detail, based on the specific approach of each.

The sudden increase in caregiving responsibilities borne by the employed population has varying impacts depending on the care regime of the European country in question and the individual's gender. There is a **correlation between the degree of familialism in a long-term care system and the employment trajectories of non-professional caregivers** over the age of 50 (Spijker

²¹ The total number of references regarding the content of the resources (n = 15) is higher than the number of articles reviewed (n = 11) because a single article may combine different resources.

et al., 2025). While retirement is generally the most likely employment transition (regardless of gender) when caregiving responsibilities coincide with this stage of the life cycle, differences emerge based on the type of care regime. In countries with a moderate strategy of "defamilialisation" of care, **non-professional caregivers reduce their paid working hours more significantly than non-caregivers**. Conversely, in regimes where the family plays a major role by default, **men tend to remain in the labour market while women leave it**. The results point to a lack of financial support as the explanation for this: men tend to remain in the workforce because they take on the role of primary breadwinner, whereas women tend to leave it because they take on the role of primary caregiver.

Thus, it is clear that caregiving responsibilities influence labour market transitions based on gender, the caregiving arrangements in place, and material conditions. In Spain, for instance, the **employment rate among non-professional caregivers is lower than that of the general population, particularly among women over the age of 50 with low levels of education who serve as the primary caregivers for dependent household members** (Moya-Martínez et al., 2012; Ruiz-Adame, 2015). Consequently, this model of intensive home-based caregiving emerges as the main obstacle to maintaining employment (Agulló et al., 2018). Evidence suggests a **need for policies that facilitate balancing non-professional caregiving and paid work through measures such as flexible working hours combined with the provision of formal care services**. Both approaches are considered essential to ensuring stable employment for women who are non-professional caregivers, mirroring the situation in countries with non-familialistic care provision models, such as the Nordic countries.

The impact of caregiving responsibilities on the professional lives of non-professional caregivers also involves **financial costs that can lead to impoverishment**. In this regard, a distinction is made between **direct costs (related to public or private care systems) and indirect costs, related to the time required for care-related activities (medical appointments, hands-on care, shopping, etc.) at the expense of regular working hours**. A key factor in these indirect costs is the loss of wages resulting from reduced hours in paid employment, a result of the time demands of the specific dependency situation (Weyer-Wendl et al., 2016). Regarding direct costs, evidence shows that individuals with private health insurance incur significantly higher expenses than those receiving public care, regardless of the severity of the illness or the level of dependency involved. **To prevent this loss of purchasing power – in a context where caregiving often entails significant financial expenditure – it is crucial to provide support resources for non-professional caregivers, such as leave and flexible working arrangements** (Spann et al., 2020). In addition to recommending and justifying these interventions, the research also highlights how a robust public system can reduce economic costs by providing universal care for people with disabilities or chronic conditions, such as visual impairments (Weyer-Wendl et al., 2016). A weak public provision exacerbates social inequalities regarding both the delivery and receipt of care. In other words, the financial impact on caregivers and individuals with dependency needs from lower socioeconomic backgrounds is proportionally greater, in terms of both direct and indirect costs.

Regarding non-professional carers who do remain employed, evidence shows that **resources aimed at ensuring workplace autonomy help them stay fully active**, particularly women and older age groups. In this regard, the positive impact of flexible working hours and workweeks is evident. Specifically, this involves allowing workers who are also informal caregivers to **take short breaks during the workday to communicate with the dependent person or to request occasional time off to handle emergencies**. Such measures **reduce the fear of being dismissed while also facilitating the ability to concentrate on work** (Spann et al., 2020). However, it is also underlined that this flexibility – which fosters self-management of work hours and schedules – cannot always be put in place; it depends on the characteristics of each job and the caregiver's professional role.

Furthermore, the effectiveness of company-led measures that ensure **work environments that are supportive of balancing employment with caregiving responsibilities** is highlighted. Key examples include flexible work arrangements and **explicit support from management for non-professional caregivers, such as facilitating leave or streamlining the associated administrative processes**. Furthermore, emphasis is placed on fostering a **care-friendly work culture**, for instance, by boosting the career progression of employees who are also long-term non-professional caregivers or by facilitating their continuous training (Kunz, 2025; Spann et al., 2020). Demonstrating that a family member's dependency does not pose an obstacle to an employee's career path serves as a model and, at the same time, influences the decisions made by non-professional caregivers.

Other studies provide evidence regarding resources that are effective in mitigating the consequences arising from the conflict between work and caregiving responsibilities. Treanor (2020) presents a systematic review of 15 studies analysing the impact of **psychological support resources on reducing the emotional burden associated with caring for individuals undergoing cancer treatment**. Psychosocial interventions (such as training, counselling, and group therapy) **have a positive impact: they improve quality of life and reduce psychological symptoms**. Evidence also shows that **workplace-based self-help courses grounded in a role-based approach help alleviate emotional distress** (stress, anxiety, depression, etc.) among non-professional caregivers; however, they do not resolve issues related to work performance or caregiving duties interfering with work (Boezeman et al., 2018).

The evidence highlights the importance of receiving **support and guidance within the workplace to manage conflicts and perceived incompatibilities between one's career and caregiving responsibilities**. On one hand, a case manager can prove effective in addressing the particular tensions involved in each caregiver's career progression and caregiving duties. On the other hand, a **workplace environment that offers practical and emotional support to caregivers (from both management and peer groups) helps prevent withdrawal from the labour market, involuntary reductions in working hours, and a diminished capacity to deal with problems or meet work demands**. In this regard, a workplace culture characterised by strong relationships between colleagues stands out; these relationships can even lead to self-organised arrangements to cover occasional absences due to caregiving needs. **Peer support at work** creates a safe environment for caregivers and fosters a culture that encourages the

sharing of caregiving experiences. This can generate positive dynamics, promoting mutual support between caregivers and others who have faced similar situations.

Addressing the challenge of **ensuring continued employment for non-professional caregivers**, Vos et al. (2025; 2025b) evaluate various strategies designed to facilitate a better balance between caregiving, personal life, and employment. Specifically, they present evidence regarding an intervention based on a participatory workplace approach implemented in certain Dutch business organisations. The study is based on an intervention aimed at managing and resolving issues related to balancing work, personal life, and caregiving duties; this works by **encouraging informal conversations between workers and their supervisors. Although the intervention does not reduce caregivers' workloads and eliminate the stress of trying to balance their challenges, it does lead to improved emotional well-being, as the perception of managerial support reduces anxiety.** Caregivers view this improvement (which varies depending on company characteristics) in a positive light, even though it does not resolve the underlying work-care balance issues. **Understanding and empathy in the workplace have a positive effect on reducing the psychological distress arising from the difficulties of reconciling caregiving responsibilities with work.**

Finally, Liu et al. (2026) analyse the transition from caregiving responsibilities back to work. They show that most studies focus on the employment changes entailed by the sudden onset of caregiving duties; this justifies the need for empirical evidence regarding **the resources that facilitate a return to work. The few existing studies on this topic yield contradictory results.** To overcome these limitations, the authors consider a range of profiles based on intensity of care and the demographic and socioeconomic characteristics of the caregivers. Broadly speaking, they demonstrate that returning to work is easier for employed individuals on care-related leave, those who provide fewer than ten hours of care, and those with caregiving responsibilities that are less ongoing. Conversely, unemployed individuals, those providing over ten hours of care, and those with more ongoing caregiving responsibilities face significant difficulties in returning to the workforce. These results highlight the importance of **offering support resources to non-professional caregivers: either to help them stay in work while they take on these new caregiving duties, or to assist them in times of transition to prevent them permanently leaving the labour market, taking into account that the difficulty of returning to work is inversely proportional to the intensity of care provided.**

Box 3. Summary of evidence related to the impact made by support resources for non-professional carers in terms of employment

→ **What support resources exist for non-professional caregivers to ensure they continue in employment? And what resources exist to help them balance their work and caregiving duties?**

Two types of support resources have been identified to help caregivers continue in employment: ones guaranteeing **flexible working hours and workweek** (such as **short breaks** during the workday) and ones allowing **time off** to handle emergencies.

Box 3. Summary of evidence related to the impact made by support resources for non-professional carers in terms of employment

In terms of resources that facilitate the balance of work and caregiving, a distinction is made between two types: those focused on workplace **flexibility** through work-life balance measures, and those aimed at fostering a care-friendly work **culture** by offering **support** from **supervisors** or **peer** groups.

→ **What cross-cutting variables influence access to and use of these resources?**

The use of these resources depends primarily on **workplace characteristics** and the caregiver's **professional** role. For instance, depending on the job, it might be possible to implement flexible working so that they can self-manage their working day and work-week; in addition, they might benefit from a care-friendly work culture. These are factors that are clearly influenced by **axes of social inequality**.

→ **How do these resources impact caregivers' career trajectories, continuity in employment, and working conditions? And what is their impact in terms of workload?**

Resources that help caregivers **continue in employment** have a positive impact on **work performance**, as they facilitate the ability to **concentrate** on the job while simultaneously reducing the **fear of dismissal**.

Conversely, resources that facilitate **balancing** work and caregiving (such as **practical** and **emotional** support for caregivers) help prevent withdrawal from the labour market, involuntary reductions in working hours, or a diminished capacity to solve problems and handle work demands.

On the one hand, explicit **support** from **supervisors** has a positive impact on using **leave** and easing **administrative processes**, leading to improved emotional **well-being** and reduced **anxiety**.

On the other hand, **peer support** in the workplace creates a **safe environment** for caregivers and fosters a culture that encourages sharing experiences related to caregiving.

5.2.3. The effectiveness of support resources for non-professional caregivers in terms of their personal lives

This section analyses the available evidence regarding resources that have an **impact on the personal lives** of non-professional caregivers, in terms of their **health**, the availability of personal **time**, and **living conditions**. Once again, in contrast to the caregiving aspect, the body of literature reviewed on this topic is notably more limited: of the fourteen studies identified, nine analyse **respite services**, three focus on **other resources** affecting caregivers' personal well-being, and two do not analyse specific resources.

5.2.3.1. Classification of resources

Most of the evidence focuses on analysing the impact of **respite services**, generally defined as the provision of a break or temporary relief from the responsibilities of non-professional caregiving. Typically, this involves the primary caregiver taking a break to promote their own well-being and, ultimately, to delay the dependent person's transition to permanent institutional care, which is often associated with admission to a residential care facility (Shaw et al., 2009; Tang et al., 2011; Phillipson et al., 2014).

The review highlights the **lack of a single, consensus-based definition** of what constitutes a respite service. The term encompasses a wide range of interventions that share the goal of temporarily alleviating caregiving responsibilities, but that differ significantly in **content, duration, location, and mode of delivery**. This **heterogeneity** complicates making comparisons between studies and makes it difficult to identify which specific types of services produce certain outcomes.

The respite services identified in the literature include resources that are provided outside the home, such as **day centres** or **temporary residential stays**; **in-home** services, ranging from general support to specialised care for people with dementia; services (generally **home-based or at day centres**) that combine care with **leisure activities** for individuals with dependency or disabilities; and, to a lesser extent, **community-based programmes in various settings** or **alternatives** such as **host families**. They can be classified according to various parameters (Tang et al., 2011):

- **Time**, i.e. the **duration** of the care provided (in hours, days, months, or years).
- **Location** of the service provided: at **home**, in a **day centre**, or **elsewhere**.
- **How regularly** the service is used: in **crisis** situations, on an **occasional** basis, or **regularly**.

Table 4. Summary: classification of respite resources²²

	Respite services in day centres (n = 3)	Temporary residential respite services (n = 2)	Residential care in nursing homes (n = 1)	Problem-solving & coping strategies (n = 7)	Ordinary in-home day/night respite services (n = 1) and those specialised in dementia (n = 2)	In-home or day centre respite services combined with leisure activities (n = 4)	Alternative models: community programmes or host families (n = 1)
Time	Hours	Months	Months	Months	Hours	Days or weeks	Hours or months
Location	Day centre	Nursing home	Clinic	House in countryside	Home	Home or day centre	Home or others

²² The total number of references regarding the types of resources (n = 21) is higher than the number of articles reviewed (n = 14) because a single article may combine different resources.

This same body of evidence also includes **Home Help Services (SAD**, in its Catalan acronym) and the **financial benefits** provided under the System for Autonomy and Care for Dependency (SAAD). Strictly speaking, these resources are not usually classified as respite services, since their primary objective is not to provide temporary relief for caregivers, but rather to support the care of the dependent person through services or financial benefits. However, they have been included in this review for two reasons. First, Costa-Font and Vilaplana-Prieto's study (2022), included in the review, conceptualises them as respite services, since it evaluates their impact on the mental health of non-professional caregivers. Consequently, including them reflects a methodological criterion specific to this evidence review, which synthesises the resources actually analysed in the selected studies. Second, these resources can indirectly affect caregivers on a personal level, as will be discussed in the following section.

Nevertheless, the wide array of services and programmes grouped under the "respite" umbrella **highlights the lack of a single, consensus-based model of respite care**. In this regard, a chart is presented uniquely for respite services, as these are the resources with the most available evidence and the greatest heterogeneity.

Beyond this type of resource, the literature review identifies other interventions aimed at improving caregivers' living conditions. These include **supervised physical exercise programmes, psychological support resources** (both individual and group-based) and **services that incorporate technological tools** to provide information, guidance, and emotional support. Although some of these resources have also been analysed within the context of caregiving for their role in enhancing caregivers' skills and knowledge, they are included here because evidence shows that they also have an impact on the well-being of non-professional caregivers.

5.2.3.2. What resources work?

The impact of respite services on caregivers' health and personal time

Overall, the studies agree that these resources help **generate personal time, reduce the burden** associated with caregiving tasks, and **improve the physical and emotional well-being** of caregivers; ultimately, they are associated with delaying permanent institutionalisation (Shaw et al., 2009; Tang et al., 2011; Phillipson et al., 2014; Vandepitte et al., 2016). However, a significant methodological limitation must be considered regarding this aspect. Several studies describe interventions in imprecise and non-specific terms, attributing the results to respite services in general, instead of distinguishing between their specific modalities. In some cases, this lack of precision makes it difficult to accurately identify which respite models work best, for which caregiver profiles, and under which conditions. At the same time, this limits the transferability of the results and makes it difficult to formulate recommendations for public policy design.

Nevertheless, the effectiveness of respite services is primarily conditioned by four factors: the **duration** of the intervention, the **setting** where the service is provided, the **intensity** of the care undertaken by the caregiver, and the **characteristics of each dependent person**.

First, the literature reviewed demonstrates that the caregiver **gaining some personal time is the primary impact of using respite services, even when the interventions are one-off or are brief (lasting only hours or days)**. Being relieved of their caregiving responsibilities allows individuals to reclaim time for rest, social relationships, and leisure, thereby strengthening their ability to decide how to organise their daily lives. Although this aspect is not always explicitly assessed, most studies agree that **having time for oneself is the primary mechanism through which respite services contribute to improving caregivers' well-being**.²³ Specifically, respite services combined with **leisure activities** for dependent individuals or those with disabilities offer an added benefit: they allow caregivers to **focus on family relationships** (such as with their partner) and to **socialise with friends** without the dependent person's health being the central focus of the interactions (White et al., 2016).

Secondly, evidence shows that respite services generally **contribute to improving the emotional well-being of informal caregivers**. The main benefits identified include **reduced perceived burden, depressive symptoms, stress, and anxiety, as well as improved quality of life in terms of health**.²⁴ In the case of **respite services linked to leisure activities**, the impact on emotional well-being is bidirectional, benefiting both the dependent individuals and their caregivers. For individuals with dependency needs, taking part in leisure activities **coordinated by healthcare professionals familiar with their health status** creates opportunities for **sensory stimulation and social participation** within a **safe, inclusive environment**. Similarly, therapeutic camps are offered for children with disabilities, featuring socio-educational activities supported by professionals. Crucially, for caregivers, the presence of professionals fosters a **feeling of relief and peace of mind**; knowing that the person they care for is in the hands of an expert team allows them to **leave behind their caregiving role for a while** (White et al., 2016). Furthermore, non-professional caregivers who use this service report **improved communication** with the dependent or disabled person, **greater satisfaction with family life**, and the **opportunity to be less overprotective and restrictive** in their daily interactions with the dependent person (Nagai et al., 2026).

However, the improvement in the personal well-being of caregivers who utilise the wide range of respite services tends to diminish once the temporary service ends and the caregiving burden returns in full: a situation that could be mitigated through public strategies involving coordinated resources. Particularly in cases of dementia, a temporary disruption in established routines can create adjustment difficulties for both the care recipient and the caregiver; the latter often experiences feelings of worry, guilt, and stress, even during the respite period (Tang et al., 2011;

²³ The specific references are: Shaw et al., 2009; Tang et al., 2011; Phillipson et al., 2014; Vandepitte et al., 2016; Nagai et al., 2026; Hernández et al., 2026; Renee et al., 2016; White et al., 2016.

²⁴ The specific references are: Shaw et al., 2009; Tang et al., 2011; Phillipson et al., 2014; Vandepitte et al., 2016; Costa-Font i Vilaplana-Prieto, 2022; Nagai et al., 2026; Hernández et al., 2026; Renee et al., 2016; White et al., 2016.

Phillipson et al., 2014). Non-professional caregivers associate this state of constant vigilance with an inability to rest mentally and truly free up personal time (Shaw et al., 2009).

This situation is strongly influenced by gender inequalities, since women (especially wives acting as caregivers) tend to experience a more intense sense of moral obligation regarding care and more reluctance to delegate it (Phillipson et al., 2014). This phenomenon is particularly significant in contexts of family caregiving overload. Those in the so-called "sandwich generation" (people simultaneously caring for dependent relatives and children under 18) exhibit higher levels of emotional strain and an increased risk of depression (Brenna, 2021). In this regard, there is a stark lack of studies focusing on dual caregiving and on specific resources (or combinations of various resources) to address this issue.

In contrast, **resources that offer sustained support over time show more consistent results in terms of caregivers' mental health.** Both home care services (SAD) and financial caregiver benefits are associated with a reduction in depressive symptoms and emotional burden, although their effects vary depending on the **intensity of care.** While home care services have a greater impact on those with more intensive caregiving roles (by reducing their direct care hours), financial benefits appear to particularly benefit those with less intensive caregiving roles, as they help alleviate financial constraints and facilitate access to other support resources (Costa-Font & Vilaplana-Prieto, 2022).

Finally, the **location** of the service also influences outcomes. Some studies suggest that **home-based interventions generate greater emotional well-being for the caregiver than temporary stays away from home for the dependent person, especially in cases of dementia. This is primarily because** they reduce the care recipient's disorientation, minimise disrupting established routines, and offer **caregivers strategies to cope with complex care situations** (Shaw et al., 2009; Vandepitte et al., 2016).

Unlike the impacts on health and personal time, the literature reviewed offers very little evidence regarding the effects of support resources on the material living conditions of non-professional caregivers. In this regard, the only dimension analysed is the relationship between respite services and the institutionalisation of the dependent person. Although some studies link the use of day centres and temporary residential stays to a higher likelihood of subsequent admission to a nursing home, evidence suggests that these resources tend to be used when dependency levels are already very high and families are already considering institutionalisation. Respite services appear to act primarily as a transitional mechanism rather than as a factor that accelerates the process (Shaw et al., 2009; Tang et al., 2011; Vandepitte et al., 2016). Conversely, **when these services are combined with ongoing home-based support, they can help delay institutionalisation and enable the dependent person to remain at home** (Phillipson et al., 2014; Vandepitte et al., 2016).

Impact of other types of support on caregivers' health and personal time

In addition to respite services, the literature identifies other resources that contribute to improving the well-being of non-professional caregivers, although there is less available evidence about them.

On one hand, **supervised physical exercise programmes show consistent benefits for caregivers' physical and emotional health** (Fernández-Costa et al., 2023). The literature identifies improvements in functional capacity and quality of life, as well as reductions in stress, perceived burden, and depressive symptoms. **Furthermore, these programmes can provide opportunities for personal time, although their impact is more limited when they are conducted exclusively in the home.**

On the other hand, **information, guidance, and psychological support services also contribute to improving caregivers' well-being** (Hartmann et al., 2012). As explained in the section on caregiving, access to specialised information, professional guidance, and emotional support increases the know-how and confidence caregivers need to handle caregiving situations. Indirectly, this reduces uncertainty, stress, anxiety, and perceived burden, thereby improving emotional well-being and quality of life. Here, the evidence suggests that psychological support serves as a resource to facilitate the caregiving role rather than a resource to improve the caregiver's own living conditions. In other words, the primary objective of this support is to ensure effective provision of non-professional care rather than to support the caregiver's own life goals.

In contrast, the review does not identify specific evidence regarding the impact of these resources on the material living conditions of caregivers. Overall, most evaluations continue to focus on individual outcomes, such as physical and emotional health, perceived burden, or time freed up. Conversely, very few studies analyse the effects of resources on structural dimensions such as economic status, housing conditions, social participation, or the redistribution of caregiving responsibilities. This gap is particularly significant given that the available evidence shows that non-professional caregiving can lead to processes of impoverishment and social exclusion that extends beyond the deterioration of individual well-being (Savela et al., 2025). Although no studies were identified that analyse the impact of resources on material living conditions, other reviews **indicate that non-professional caregivers face a higher risk of material deprivation, food insecurity, housing difficulties, and economic vulnerability, especially when undertaking high-intensity care or when they are younger** (Savela et al., 2025). Consequently, while the literature demonstrates that caregiving can impair material living conditions, there remains very little evidence regarding which resources effectively contribute to preventing or mitigating these situations of vulnerability.

Box 4. Summary of evidence related to the impact made by support resources for non-professional carers on personal life aspects

→ **What resources exist to support non-professional caregivers maintain their quality of life and personal well-being?**

Box 4. Summary of evidence related to the impact made by support resources for non-professional carers on personal life aspects

The body of literature reviewed identifies five resources: **respite services**, **home care services (SAD)**, **financial** benefits, **physical** exercise programmes, and services providing **information**, guidance, and **psychological** support.

→ **What cross-cutting variables influence access to and use of these resources?**

The effectiveness of respite services is primarily conditioned by four factors: the **duration** of the intervention, the **setting** where the service is provided, the **intensity** of the care duties undertaken by the caregiver, and the **characteristics** of each **dependent person**.

→ **How do these resources impact caregivers' health and personal time?**

Respite services help free up personal **time**, reduce the **burden** associated with caregiving tasks, and improve the physical and emotional **well-being** of caregivers.

At the same time, both **home care services** and **financial** benefits are associated with a reduction in **depressive** symptoms and emotional **strain**; home care services offer a greater impact for those with more caregiving commitments, while financial benefits offer more help to caregivers with less caregiving commitments.

Furthermore, supervised **physical** exercise programmes and services offering **information**, guidance, and **psychological** support demonstrate consistent benefits for caregivers' physical and emotional **health**.

→ **What impact do the resources have on caregivers' living conditions (specifically their ability to choose how to manage their time and organise their daily lives, as well as on the process of permanent institutionalisation?)**

Non-professional caregivers who provide **high-intensity** care or when they are **younger** face higher **risks** of material deprivation, food insecurity, housing difficulties, and economic vulnerability.

In this context, the role of **respite services** is noteworthy; while often associated with permanent **institutionalisation** – acting as a transitional mechanism – they also offer **relief** from caregiving responsibilities and create **opportunities** for rest, **social interaction**, and **leisure**, thereby strengthening caregivers' ability to decide how to **organise** their **time**.

6. Summary

An analysis of the evidence shows that most of the reviewed literature focuses on the **sphere of caregiving** itself. In general, the resources available are designed to **enable caregivers to**

continue performing care tasks, rather than to ensure their continued employment, protect their quality of life, or promote their personal well-being.

Information and guidance resources yield the **most positive results** within the **caregiving sphere**. These resources provide **knowledge regarding the health condition** of the dependent person and, when they are complemented by **training in caregiving competencies and skills**, they generate both direct and indirect results. On one hand, they improve **understanding** of the dependency situation and strengthen skills for managing aspects such as **mobility** or **lifting and transferring**. On the other, and in relation to the **personal life sphere**, **they contribute to boosting caregivers' self-esteem and quality of life**. However, this **effectiveness diminishes as the illness progresses**. While sufficient information about an illness is usually available during its initial phases, in its **final stages there is often a lack of specific guidance on the end-of-life process or symptom management**, even though these are among the most common needs expressed by caregivers.

In the **employment sphere**, information and guidance resources take a different approach. They focus primarily on raising awareness about **work-life balance measures, labour rights, and available resources**, as well as offering guidance through **self-help courses or support programmes**. Although these initiatives contribute to **reducing some negative psychological symptoms** and improving caregivers' **quality of life**, their impact **is limited** because they **do not resolve the difficulties associated with balancing** work responsibilities with caregiving duties.

Resources aimed at emotional well-being yield the most favourable results in the **personal life** sphere. Their primary objective is to provide caregivers with **time for themselves** and to reduce the **burden** associated with caregiving tasks, particularly through respite services. These resources enable caregivers to reclaim **time for rest, social interaction, or leisure activities**, thereby increasing their ability to manage their daily schedules. However, these benefits tend to **diminish once the temporary service ends** and the caregiving burden returns. This is an issue that could be mitigated through **coordinated public resource strategies**. Similarly, **workplace** resources that offer **explicit support from supervisors** are also significant, such as **facilitating leave** and fostering **peer support**. Such environments encourage a company culture where **caregiving experiences can be shared**, although they **do not eliminate the stress** arising from the challenge of balancing work and caregiving responsibilities.

Resources focused on problem-solving and coping strategies also show **particularly positive results in the realm of caregiving responsibilities**. They assist caregivers in **setting goals, making decisions, and managing the complex or stressful situations** associated with caregiving tasks. However, these resources are often provided alongside information or training programmes, **making it difficult to isolate the specific impact of each resource**. In the **workplace**, the **role of the case manager** stands out as particularly effective for addressing the **tensions between the career path and caregiving responsibilities** of each caregiver. However, this help does not resolve the overload associated with balancing both spheres. **On a personal level**, these resources are often combined with interventions aimed at emotional well-being, providing **tools to better cope with the physical and emotional burden** of caregiving.

Regarding **work-life balance measures**, the evidence indicates that the most effective are those **offering organisational flexibility and flexible hours and workweeks**. The ability to **adjust schedules, take occasional breaks during the workday**, or take **time off** to handle unforeseen situations makes it easier to reconcile work with caregiving responsibilities. Furthermore, these measures help maintain **employment continuity**, foster **concentration**, reduce the **fear of dismissal**, and lower the risk of having to **involuntarily reduce working hours or leave the labour market altogether**.

Finally, the analysis highlights a particularly significant issue. Although almost all the literature reviewed notes that **caregivers are predominantly women, the gender inequalities this entails are not analysed critically**. In particular, **the feminisation of care tends to be taken for granted**, and the fact that women continue to shoulder this responsibility within the family sphere is rarely questioned. This is particularly evident in the case of **wives who are carers for their husbands**, as they often experience a deeper **sense of moral obligation regarding caregiving** and find it more difficult to delegate these responsibilities.

7. Implications for practice

In conclusion, we can draw up a set of ideas for the design and implementation of public policies, based on the review's findings regarding what works according to the scientific evidence selected. Here we firstly outline the main ideas stemming from the critical perspective that has guided the analysis, then formulate a series of guidelines on how interventions can be developed.

7.1. Critical analysis of the results

- **Organising the review by domain rather than by resource** type proves to be the correct approach, as it highlights that **research activity is significantly higher in the caregiving sphere** compared to the professional and personal ones.
- This gap in empirical evidence is highlighted to illustrate that **most interventions focus on facilitating care** for the dependent person rather than ensuring the non-professional caregiver's continued employment and quality of life.
- Evidence shows that **the resources examined function more as support for caregiving than as support for self-care**. While they largely reduce anxiety and improve emotional well-being by facilitating care, the burden of work (and its negative impact on both professional and personal life) persists.
- **Specific information and training resources** which enable caregivers to adapt to the new situation are most effective **during the initial phase of non-professional caregiving**. This is particularly true for resources offered in a flexible way, given the caregivers' limited time.

- **Beyond the initial phase of non-professional caregiving, the most effective measures are social support from the workplace and ongoing respite services** (which free up personal time). Caregivers value both measures highly. However, these resources are not designed to relieve them of caregiving responsibilities but rather to make the role somewhat easier through sporadic interventions that fall short of a holistic approach to the caregivers' lives.
- **The most effective resources are those that have the most immediate and practical impact** on the act of caregiving; however, there is a lack of evidence addressing the tensions between caregiving and the caregivers' work and their personal lives.
- **The review reveals that the resources analysed tend to reinforce the role of non-professional caregivers** – predominantly women – to the detriment of their personal well-being and professional lives. Most of these resources fail to critically examine family responsibilities or the fact that non-professional caregiving is gendered as female and linked to moral obligations.

7.2. Implications for policy design and implementation

Based on a critical analysis of the review findings regarding support resources for non-professional caregivers, **four groups of implications are outlined, each addressing various policy stakeholders.**

First, **at the level of conceiving and designing the service provision model, there is a clear need to rethink the goals and target groups of the available resources and services.** As is explained throughout the report, most interventions focus on guaranteeing the provision of non-professional care, without questioning the responsibility of families as well as the gendered nature of the labour involved. The dependent person is placed at the centre of the intervention, while the non-professional female caregiver becomes merely another resource within the provision model. From the perspective of democratising care, it is proposed that the social organisation of care be re-examined, given that it perpetuates social inequalities: particularly those related to gender, social class, and origin.

Along these same lines, once we have acknowledged the heavy burden of care tasks borne by non-professional caregivers, **it is also necessary to recognise and value the unpaid work they perform: work that often goes unseen.** To make progress in this direction, data is required to measure and acknowledge the true extent of unpaid care work. In this regard, satellite accounts serve as a tool for incorporating these tasks into the macroeconomic analysis of national accounts and the calculation of Gross Domestic Product (GDP), with the aim of quantifying their economic contribution to the social structure (Durán, 2020).

Secondly, **from a practical and public policy implementation standpoint,** translating this conceptual approach into action requires treating the **caregiver's right to their own life project as a policy objective.** Two lines of action emerge in this context: one concerning the workplace and the other the personal sphere. On the one hand, a review of the evidence highlights the

importance of a workplace culture that facilitates balancing caregiving with employment. This might work through empathetic workplace relationships or measures that promote flexible working hours and work-life balance. It is important to emphasise that all this must be seen clearly as a **recognition of labour rights** rather than as personal favours performed. Furthermore, the needs of non-professional caregivers vary according to the stage of the dependency situation; consequently, work-life balance measures involving flexible scheduling should be adapted to the specific phase of caregiving.

On the other hand, the evaluations underscore the potential of respite care services, although the absence of a clear, stable model hinders their transformative capacity. In this regard, there is a **need to define a service model that goes beyond sporadic** (hourly) respite care and – by centring on the ongoing needs of caregivers – **guarantees them regular daily personal time**. The review of the model must also encourage them to use the service **without the guilt** often felt by non-professional caregivers when they are away from the dependent person. Furthermore, the model should incorporate **leisure activities**, which offer an opportunity to improve individuals' health in many cases of dependency or disability.

Thirdly, **regarding direct support for non-professional caregivers, the review highlights the importance of continuing to provide information, training, guidance, and psychological support**. Collectively, these resources make a significant positive impact on caregivers. Although they reinforce caregiving roles and responsibilities (often at the expense of the caregiver's own life projects) they also clearly improve the carer's emotional well-being, affected by the dependent family member's situation. However, it must be noted that these resources cannot be designed as one-off interventions. The needs of non-professional caregivers constantly evolve; therefore, **support regarding information, training, guidance, and therapy must adopt a comprehensive approach that accompanies caregivers through every stage of the caregiving process**. While training at the onset of the caregiving role has a recognised positive impact, ongoing support as the dependent person's illness progresses is also crucial, especially when there is a sudden change in their health that has perhaps not been considered or that is not addressed by existing resources. Furthermore, it is important to recognise that the role of non-professional caregivers is often a transitional phase; consequently, information and guidance should also cover resources that may eventually replace or complement this care in the medium term, and should thereby prepare caregivers for potential transitions to other forms of care. This approach aligns with the **paradigm shift from the Home Help Service (SAD) to the Home-Based Care Service (SAED)**, which, among other aspects, rethinks the role of non-professional caregiving.

Regarding the formats used, the resources that emerge as being most effective are online, one-on-one, and flexible; however, this mode offers the fewest opportunities for socialising with others who share similar non-professional caregiving responsibilities. Consequently, one of the immediate challenges facing support resources for care is **overcoming caregiver isolation by fostering social interaction**.

Finally, **in terms of raising social awareness, evidence indicates that guilt is a widespread issue among non-professional caregivers, particularly women**. Indeed, support resources,

such as respite care, are sometimes not used due to the guilt associated with being apart from the dependent person for a few hours. **Therefore, it is necessary to launch awareness campaigns that make non-professional care work visible and recognised, and that free it of a sense of moral obligation.** In this regard, **promoting research into the real experiences of those involved in non-professional care is recommended.** The findings from qualitative and quantitative studies provide a solid empirical basis for designing awareness campaigns aimed at challenging the way that caregiving responsibilities tend to be placed on the individual, and for advocating for a more equitable distribution of that responsibility among families, institutions, and society as a whole.

8. Limitations of the study

Finally, mention needs to be made of the limitations identified throughout the review and regarding the analysis of the scientific literature selected according to the criteria explained in the methodology section:

- **The reviews selected based on the established criteria do not always include research conducted within the timeframes set.** A significant portion of the evidence comes from studies carried out over a decade ago, in social and institutional contexts that are very different from the current ones. This bias in timeframe needs to be treated with caution when interpreting certain results, particularly in a landscape marked by demographic changes, transformations in family models, and the evolution of long-term care policies.
- **A large proportion of the reviewed articles were published in specialised health science journals with an individual-focused approach.** Consequently, the review includes fewer references from the field of social sciences, and no references that incorporate a gender perspective or an intersectional lens.
- **The quantitative and biomedical approach shapes how the impact of resources is viewed,** since it prioritises the dependent person's health issues over the caregiver's well-being.
- Consequently, another significant limitation is **the lack of analysis regarding the structural impacts of support resources.** The reviewed literature tends to focus on individual effects: particularly on physical and emotional health, subjective burden, or time availability. Conversely, there are practically no studies that analyse the tensions between caregiving responsibilities and work-life balance.
- **The evidence reviewed does not allow us to determine the extent to which these resources and services contribute to processes of defamilialisation or defeminisation of care,** nor whether the resources foster deeper transformations in the social organisation of care. Consequently, their actual capacity to reduce gender inequalities associated with care work remains unknown.

- It is also important to bear in mind that **the resources and services studied here do not necessarily represent an exhaustive list of what is available**. In other words, a lack of evidence regarding certain resources should not be interpreted as an indication that they are ineffective; rather, it simply means that no evidence about them has been found.

These limitations **highlight the need for more specific, comparable, and up-to-date research that can distinguish the impacts made by different types of resources and services across the three areas analysed**. This research would allow for a more thorough examination of the structural implications for the social organisation of care and for social inequalities.

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9.2.1. Caregiving aspect

9.2.1.1. Reviews

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Annex

Web of Science database – search strategy

Combination of thematic terms

This section lists the combinations of terms used in the Web of Science search, grouped according to the four established thematic blocks (resources, impacts, social inequalities, and family profiles), excluding terms related to the study type.²⁵

Specifically, regarding resources, the following term combinations were used:

- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Resources 'OR' Recursos* (n = 354)
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Information and training 'OR' Información y formación* (n = 76)
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Economic benefits 'OR' Beneficios económicos* (n = 38)
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Respite care services 'OR' Servicios de respiro* (n = 76)
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Emotional support 'OR' Apoyo emocional* (n = 265)

In terms of the impacts:

- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Impacts 'OR' Impactos 'AND' Resources 'OR' Recursos* (n = 114)²⁶
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Burnout 'OR' Sobrecarga* (n = 39)

²⁵ Annex 10.1.2 details the specific word combinations that worked and those that were discarded in relation to the type of study.

²⁶ The search using the combination of the words *Informal caregiver 'AND' Impacts* yielded a total of 969 results, and it was decided to add a third keyword to reduce that number.



Què funciona en cures de llarga durada?

- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Physical health 'OR' Salud física 'AND' Emotional well-being 'OR' Bienestar emocional (n = 23)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Leisure time 'OR' Tiempo de ocio (n = 25)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Paid work 'OR' Trabajo remunerado (n = 109)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Housing 'OR' Vivienda (n = 31)*

In terms of social inequalities:

- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Social Inequalities 'OR' Desigualdades sociales (n = 43)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Gender 'OR' Género (n = 332)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Immigrants 'OR' Inmigrantes (n = 30)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Socioeconomic 'OR' Socioeconómico (n = 51)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Education 'OR' Educación 'OR' Educational level 'OR' Nivel educativo (n = 352)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Occupation 'OR' Ocupación (n = 24)*

As for family profiles:

- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Family profile 'OR' Perfil familiar (n = 40)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Spouse 'OR' Esposa (n = 204)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Mother 'OR' Madre (n = 62)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Daughter 'OR' Hija (n = 62)*

Combinations of terms relative to the type of study

This section details the term combinations used to filter results based on study type, specifying which combinations proved effective for the search and which were excluded for failing to yield relevant results.

The combinations of terms that worked were as follows:

- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Causal inference 'OR' Inferencia causal 'OR' Causal effect 'OR' Efecto causal 'OR' Causal identification 'OR' Identificación causal (n = 18)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Impact evaluation 'OR' Evaluación de impacto (n = 114)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Random d controlled trial 'OR' Ensayo controlado aleatorio 'OR' RCT (n = 196)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Quasi-experiment 'OR' Cuasi-experimento 'OR' Quasi-experimental 'OR' Cuasi-experimental (n = 31)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Difference-in-differences 'OR' Diferencias en diferecias 'OR' Diff-in-diff 'OR' Dif-en-dif (n = 11)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Instrumental variables 'OR' Variables instrumentales 'OR' IV 'OR' VI (n = 48)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Matching 'OR' Emparejamiento 'OR' Propensity score matching 'OR' Emparejamiento por puntuación de propensión (n = 52)*

The discarded word combinations are detailed below. The reasons for excluding them were the duplication of articles from previous searches, the absence of results, or the lack of relevance of the references regarding long-term care or the required study type:

- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Identification strategy 'OR' Estrategia de identificación (n = 13)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Experimental methods 'OR' Métodos experimentales (n = 45)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Field experiment 'OR' Experimento de campo (n = 1)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Natural experiment 'OR' Experimento natural (n = 1)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Regression discontinuity 'OR' Discontinuidad de regresión 'OR' RD 'OR' DR (n = 2)*
- *Informal caregiver 'OR' Cuidador(a) informal 'AND' Synthetic control 'OR' Control sintético (n = 0)*

Diagram of the selection process for the systematic review

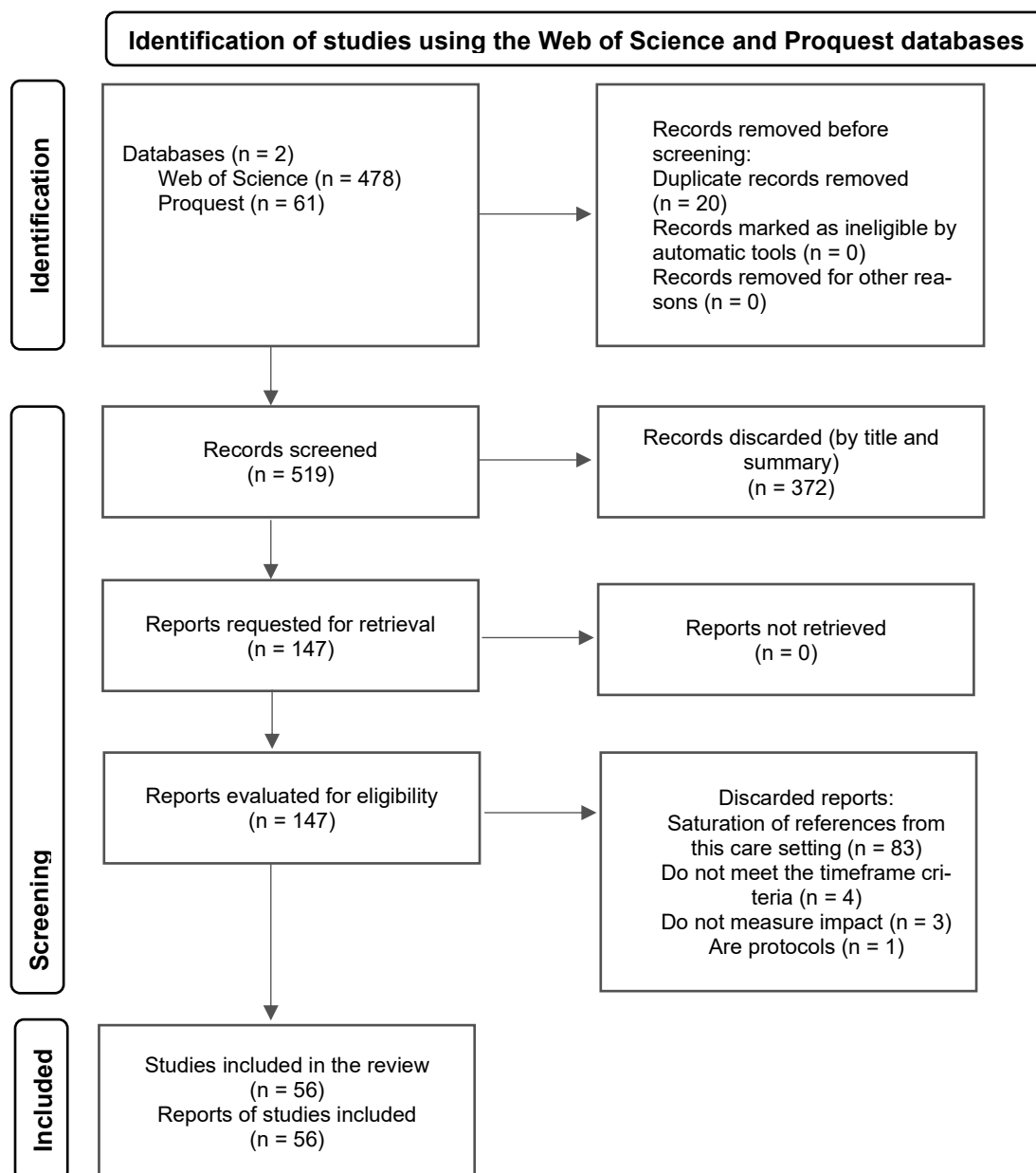


Figure 1. Diagram of the selection process for the systematic review. Source: authors, using Page et al. (2021) as a model

Què funciona
en cures de llarga
durada?

A project to compile, analyse, and transfer information in order to
improve public long-term care policies.

A project participated in by:

