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Essential and Unseen: The Health and Well-Being of Family Caregivers

The Caregiving in the US 2025 Series



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Executive summary

Across the United States, 63 million people care for a family member or friend. They manage medications, coordinate appointments, and navigate insurance. They lift, bathe, and drive. Day to day, they make it possible for someone living with a serious illness or disability to keep living their life.

What is less often asked is how they are doing themselves.

This report examines the health and well-being of the 59 million US family caregivers who care for an adult. It draws on the *Caregiving in the US 2025* survey, a nationally representative study of family caregivers in the United States conducted by AARP and the National Alliance for Caregiving (NAC).[1] This report examines caregiver health across nine indicators from the survey: self-rated health, physical health, mental health, limited activities, physical strain due to caregiving, stress due to caregiving, isolation, self-care, and sense of purpose. For the first time, the survey includes the Centers for Disease Control and Prevention Healthy Days measure, which allows direct comparison between family caregivers and the general adult population.

In this report, we examine caregivers' health and well-being based on four factors:

- Caregiver characteristics, such as age, income, and choice in caregiving
- Caregiving intensity, such as tasks performed and time dedicated to caregiving
- Work and financial strain, such as work status and workplace benefits
- Health care system services and supports, such as health insurance status and caregiver training

The findings demonstrate the ways in which caregiving is a determinant of health. Like income, education, and employment, caregiving is a circumstance that shapes health, which makes caregiver well-being a matter for policy and practice, not only for individual families.

Key Takeaways

Family caregivers carry a measurable health burden, and it is not easing

- ✓ One in five caregivers (20 percent) rate their health as fair or poor, which has remained unchanged since 2020. On average, caregivers report 5.4 poor physical health days and 7.0 poor mental health days in the prior month.
- ✓ Family caregivers report about 40 percent more poor mental health days than the general adult population. This gap exists in every age and income group examined and is widest among younger caregivers (8.7 days vs. 6.0 nationally) and lower-income caregivers, those with a household income under $50,000 (9.5 days vs. 6.3).
- ✓ Nearly half of caregivers (45 percent) report moderate to high physical strain, and nearly two-thirds (64 percent) report moderate to high emotional stress, both unchanged since 2020. Isolation is the one indicator that has moved: 24 percent say caregiving makes them feel alone, up from 21 percent.
- ✓ Caregivers report fewer days when poor health limited their usual activities than the general population does. Limiting activities may not be an option when those activities include caregiving.

1 AARP and National Alliance for Caregiving, *Caregiving in the US 2025* (AARP, 2025), https://doi.org/10.26419/ppi.00373.001.

Health differs both by caregiving situation and caregiver characteristics

- ✓ Choice in caregiving is the only factor examined in which one group—caregivers who felt they had no choice in taking on the role—fares worse on all nine indicators, including sense of purpose. Those with no choice report about 50 percent more poor mental health days (8.2 vs. 5.6).
- ✓ No matter how intensity is measured, more demanding situations mean poorer health. Caregivers providing 21 or more hours a week are nearly three times as likely to report high physical strain as those providing 20 hours or less (32 percent vs. 11 percent). The 44 percent of caregivers in high-intensity situations fare worse on eight of nine indicators than those in moderate- or low-intensity situations.
- ✓ Caregivers who find medical and nursing tasks difficult stand out: 56 percent report high physical strain, and 74 percent report high emotional stress. Living with the care recipient shows a similar pattern, with the widest gaps in difficulty caring for one's own health (30 percent vs. 18 percent) and feeling alone (32 percent vs. 19 percent).
- ✓ Nearly one in five caregivers have a disability; they fare worse on eight of nine indicators, including more than three times the rate of fair or poor health (51 percent vs. 14 percent).
- ✓ By contrast, differences by race, ethnicity, and geography are comparatively few.

Caregivers who fare worse are often those with the fewest supports

- ✓ Women report poorer health and well-being than men on seven of nine indicators. They more often provide constant care, perform medical and nursing tasks, and spend more hours caregiving.
- ✓ LGBTQ+ caregivers report poorer health on six indicators and are more often sole caregivers (47 percent vs. 32 percent of non-LGBTQ+ caregivers), with less paid or unpaid help.
- ✓ Lower-income caregivers and those with a high school education or less fare worse in most indicators. Caregivers reporting high financial strain from caregiving show the sharpest divide of any group: 76 percent report high emotional stress compared with 30 percent of other caregivers, and they experience more than 12 poor mental health days a month compared with fewer than 6 among other caregivers.
- ✓ Uninsured caregivers and those on Medicaid report poorer health than those with employer coverage.
- ✓ Unemployed caregivers fare worse than employed caregivers across multiple indicators; salaried full-time workers show better health and well-being, whereas part-time workers show worse health and well-being.
- ✓ Caregivers with more workplace benefits tend to report better health and well-being. Hourly workers have less access than salaried workers to every caregiver-friendly workplace benefit examined.

A sense of purpose coexists with strain; it does not offset it

- ✓ About half of caregivers (51 percent) find a sense of purpose in caregiving.
- ✓ A sense of purpose is more common in more demanding situations among caregivers, such as those who provide 21 or more hours of care (54 percent vs. 49 percent of those providing less than 21 hours); those who perform medical and nursing tasks (54 percent vs. 47 percent of those who do not); and those with a disability, lower income, or less education.
- ✓ The exception is choice in caregiving. Among caregivers who felt they had no choice in the caregiver role, a sense of purpose is considerably less common (42 percent vs. 62 percent of those who had a choice).

Caregivers are doing the health system's work; those carrying the most are in the poorest health

- ✓ Sixty-one percent of caregivers who find coordinating care difficult report high emotional stress, compared with 31 percent of those who find it easy, and they experience 9.1 poor mental health days a month compared with 6.2 days.
- ✓ Caregivers who communicate with providers about their recipient's care report worse health than those who do not, including 47 percent who experience high emotional stress compared with 22 percent who do not.
- ✓ Training for caregivers is rare and rarest where it is most needed. Only 22 percent of caregivers performing medical and nursing tasks were trained for them. Trained caregivers fare better: Among those performing medical and nursing tasks, fewer of those trained report feeling alone (19 percent vs. 30 percent) or have difficulty caring for their own health (23 percent vs. 30 percent), and more report a sense of purpose (61 percent vs. 52 percent).
- ✓ Caregivers who struggle to afford services fare worse across the board: 30 percent rate their health fair or poor compared with 16 percent of those who do not find services hard to afford, 57 percent report high emotional stress compared with 31 percent, and 38 percent report difficulty caring for their own health compared with 17 percent.

Policies and practices to support caregiver health and well-being

For policymakers, health systems leaders, and clinicians, this report clarifies and quantifies the reality that caregivers across the United States experience every day: Family caregivers carry a heavy load in health and well-being. Every group of caregivers examined shows it, though some carry considerably more than others. Because these impacts are both widespread and patterned, they lead to the following specific recommendations for policy and practice interventions to improve the health and well-being of family caregivers.

1. Build family caregiver support into how health care is paid for

Caregivers perform health system work that the system rarely pays to support. Expanding use of the Centers for Medicare & Medicaid Services' Caregiver Training Services (CTS) codes and extending that model to caregiver health risk and needs assessments would make caregiver support a routine part of care.

2. Treat caregiver assessment, readiness, and support as part of care quality

Care recipients' outcomes depend on their caregivers' capacity to provide care. Identifying caregivers in the medical record, assessing their needs as well as their readiness for caregiving at discharge, and measuring their inclusion in quality programs would incorporate caregivers into how care quality is judged.

3. Guarantee paid family and medical leave and extend caregiver benefits to hourly workers

Access to leave and other employment supports should depend on caregiving needs, rather than job type. A national paid family and medical leave (PFML) program, along with employer benefits offered equally to hourly and salaried staff, would close that gap.

4. Make respite care easier to reach

Far more caregivers want respite care than use it. Expanding funding, simplifying eligibility, and offering more flexible formats, paired with evaluation, would improve reach and show what works.

5. Strengthen self-direction in Medicaid home and community-based services

Family caregivers are part of the care workforce. Self-direction lets people who receive Medicaid home and community-based services choose who provides their care, including family members, and pays those caregivers for their work. Making it a standard option, with support for paid family caregivers and strong program integrity safeguards, would sustain the essential care they provide.

6. Build evidence on how caregiving and health change over time

These findings describe caregivers at a single point in time. Longitudinal data collection would show how health and well-being change across the course of caregiving and how caregivers differ before they take on the role.

Background

Family caregivers in the United States care for parents and friends, spouses and partners, and children with complex medical conditions or disabilities. In 2025, the number of family caregivers in the United States was 63 million, a dramatic 45 percent increase over 10 years.[2] Of these caregivers, 59 million care for adults.

This report provides an in-depth view of the health and well-being of the 59 million caregivers of adults. Caregiver health and well-being is described using nine indicators drawn from the *Caregiving in the US 2025* survey. The survey included the Centers for Disease Control and Prevention (CDC) Healthy Days measure,[3] which enabled comparison to the general population.

Indicators of Caregiver Health and Well-Being
Caregiving in the US 2025

- Physical Strain
- Emotional Stress
- Feeling alone
- Difficulty caring for own health
- Sense of Purpose

From the CDC Healthy Days measure

- Self-rated health
- Days in poor physical health
- Days in poor mental health
- Days that poor health limited usual activities

2 AARP and National Alliance for Caregiving, *Caregiving in the US 2025*.

3 David G. Moriarty et al., "The Centers for Disease Control and Prevention's Healthy Days Measures—Population Tracking of Perceived Physical and Mental Health Over Time," *Health and Quality of Life Outcomes* 1, no. 37 (2003), https://doi.org/10.1186/1477-7525-1-37.

Findings in this report are organized into four categories: caregiver characteristics; the context in which caregivers provide care, including the intensity of care they provide; the ways in which caregivers' work and finances connect to their health and well-being; and the ways in which the broader health care system relates to caregiver health and well-being. See figure 1 for a summary of these four sections.

Figure 1. Understanding Caregiver Health and Well-Being

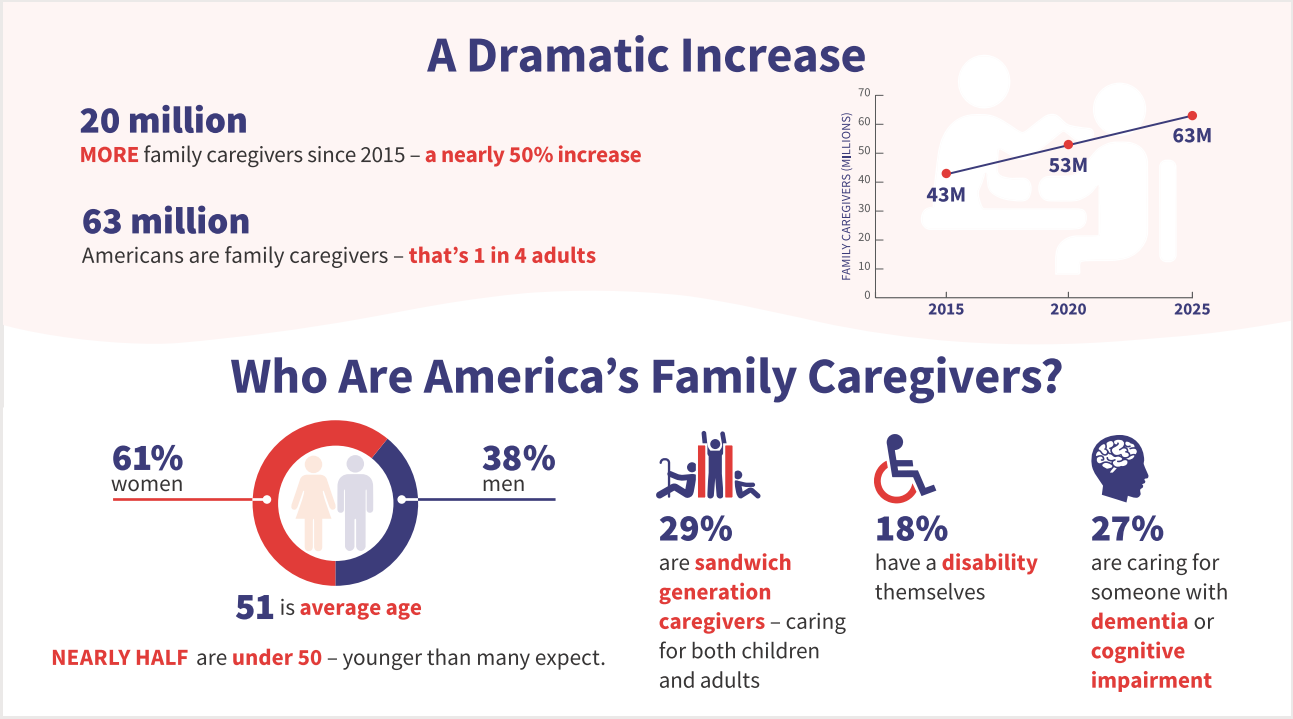


Source: *Caregiving in the US 2025. Four columns correspond to the four sections of the report; the colored band and tint identify each section.*

Who are family caregivers?

This report focuses on the 59 million adult caregivers who have provided care to an adult 18 years or older through the prior year. The average caregiver is 51 years old, and most caregivers are women (61 percent). Thirteen percent are African American/Black, 16 percent are Hispanic/Latino, 6 percent are Asian American/Native Hawaiian/Pacific Islander, and 61 percent are non-Hispanic white. Most (89 percent) care for relatives, especially parents or spouses; 24 percent of family caregivers support more than one care recipient. For additional details, see *Caregiving in the US 2025*.[4] See figure 2 for a summary of family caregivers from the survey.

Figure 2. 59 Million Americans Care for an Adult Family Member or Friend



Source: *Excerpt from AARP and National Alliance for Caregiving,* Caregiving in the US 2025: A National Portrait of Family Caregivers *(AARP, 2025), https://doi.org/10.26419/ppi.00373.002.*

Note: *Women (61%) and men (38%) do not sum to 100% because 0.6% of caregivers described their gender in another way.*

4 AARP and National Alliance for Caregiving, *Caregiving in the US 2025*.

Understanding caregiver health and well-being

Family caregiving is demanding work–physically and emotionally–and impacts on the caregiver can be dramatic. To understand the full scope of the effects on caregivers themselves, this report uses nine health and well-being indicators from the *Caregiving in the US 2025* survey. Together, these indicators provide a comprehensive portrait of how providing care shapes the caregiver's own well-being.

See table 1 for a description of each of the nine indicators.

Table 1. Health and Well-Being Indicators for Family Caregivers

Variable	Indicator
1. Self-rated health *(CDC Healthy Days)*	Fair/poor health: percentage of respondents rating fair or poor on a 5-point self-rated health scale
2. Physical health *(CDC Healthy Days)*: Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?	Number of days in prior 30 days with physical health rated as not good
3. Mental health *(CDC Healthy Days)*: Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?	Number of days in prior 30 days with mental health rated as not good
4. Usual activities limited *(CDC Healthy Days)*: During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	Number of days in prior 30 days that poor health limited usual activities
5. Physical strain: How much of a physical strain would you say that caring for your [care recipient] is/was for you?	High physical strain: rating 4 or 5 on 5-point self-rated physical strain scale with 1 = Not a strain at all and 5 = Very much a strain
6. Emotional stress: How emotionally stressful would you say that caring for your [care recipient] is/was for you?	High emotional stress: rating 4 or 5 on 5-point self-rated emotional stress scale with 1 = Not at all stressful and 5 = Very stressful
For questions 7–9: How much do you agree or disagree with each statement below about being a caregiver for your [care recipient]?	5-point scale with 1 = Strongly disagree, 2 = Disagree, 3 = Neither agree nor disagree, 4 = Agree, 5 = Strongly agree
7. Feeling alone: I feel alone.	Rating of 4 or 5, Agree or Strongly agree
8. Difficulty caring for own health: I find it difficult to take care of my own health.	Rating of 4 or 5, Agree or Strongly agree
9. Sense of purpose: My role as a caregiver gives me a sense of purpose or meaning in my life.	Rating of 4 or 5, Agree or Strongly agree

The health and well-being of family caregivers

This section provides an overview of findings for each of the nine health and well-being indicators, along with comparison of specific measures to other national data.

Key Takeaways

Insights on caregiver health and well-being based on nine specific indicators from the *Caregiving in the US 2025* survey

- ✓ About one in five caregivers report fair or poor health with more than four days per month of activity limitations due to health, on average.
- ✓ Compared to the broader US population, caregivers report about 40 percent more poor mental health days than the general population. The gap exists across every age and income group and is widest among younger caregivers (8.7 days vs. 6.0 days for ages 18–49) and lower-income caregivers (9.5 days vs. 6.3 days).
- ✓ Despite more days with poor mental and physical health compared to the general population, caregivers tend to report fewer days when poor health limited their usual activities. Limiting activities may not always be possible when those activities include caregiving.
- ✓ Physical strain from caregiving is substantial and similar to levels found in 2020: 45 percent report moderate to high strain, consistent with the physically demanding nature of many caregiving tasks.
- ✓ Emotional stress is widespread, with 64 percent of caregivers reporting moderate or high stress and 38 percent reporting high stress.
- ✓ Nearly one in four caregivers report that caregiving makes them feel alone.
- ✓ Nearly one in four caregivers report difficulties caring for their own health while caring for someone else, putting them at elevated risk for deferred care and preventable health decline.
- ✓ About half of caregivers find a sense of purpose in caregiving.

Self-rated health and healthy days

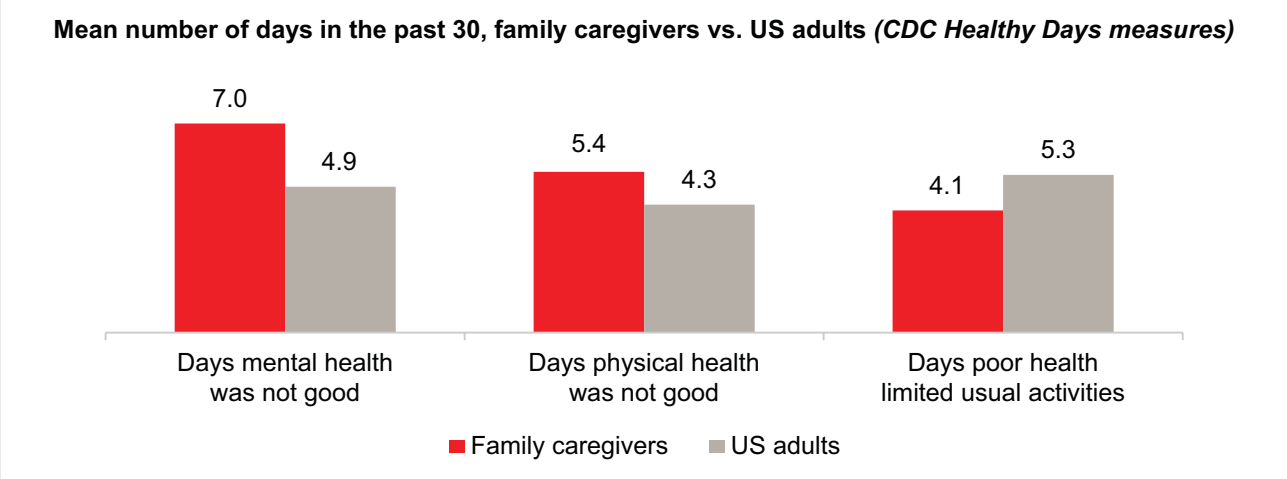
One in five caregivers report being in fair or poor health, a proportion similar to that found in 2020.[5] Most caregivers rate their health as good (37 percent), very good (33 percent), or excellent (10 percent), although different types or subgroups of caregivers show variation across these categories. On average, family caregivers report experiencing poor physical health 5.4 days in the past 30 days; 7.0 days of poor mental health; and 4.1 days in which poor health of any kind limited their usual activities. These figures underscore the substantial day-to-day health strain caregivers carry.

5 AARP and National Alliance for Caregiving, *Caregiving in the US 2020* (AARP, 2020), https://doi.org/10.26419/ppi.00103.001.

Family caregivers compared to the US population: mental health, physical health, and limitations in activities

Knowing how family caregivers' experiences compare to that of others helps us understand how to best address caregiver needs. For the first time, the *Caregiving in the US 2025* survey includes the four-item CDC Healthy Days measure—a validated four-question series measuring health-related quality of life that has been in use for over 30 years.[6] Inclusion of this measure enables direct comparison of caregiver health with the general US adult population measured via the national Behavioral Risk Factor Surveillance System (BRFSS).[7] The overall comparison uses BRFSS data adjusted to match the age and gender distribution of family caregivers (for more details, see Methodology and Reporting appendix). See figure 3.

Figure 3. Caregivers Report More Poor Mental and Physical Health Days but Fewer Days Limited by Poor Health Than the General Population



Base: Caregivers *n* = 6,549; US adults from BRFSS 2024 (*n* = 114,714)

Note: *Differences between caregivers and US adults are not tested for statistical significance.*

6 Moriarty et al., "The Centers for Disease Control and Prevention's Healthy Days Measures."

7 "2024 BRFSS Survey Data and Documentation," data from the Behavioral Risk Factor Surveillance System 2024, Centers for Disease Control and Prevention, US Department of Health and Human Services, accessed April 16, 2026, https://www.cdc.gov/brfss/annual_data/annual_2024.html.

Benchmarking against the general population

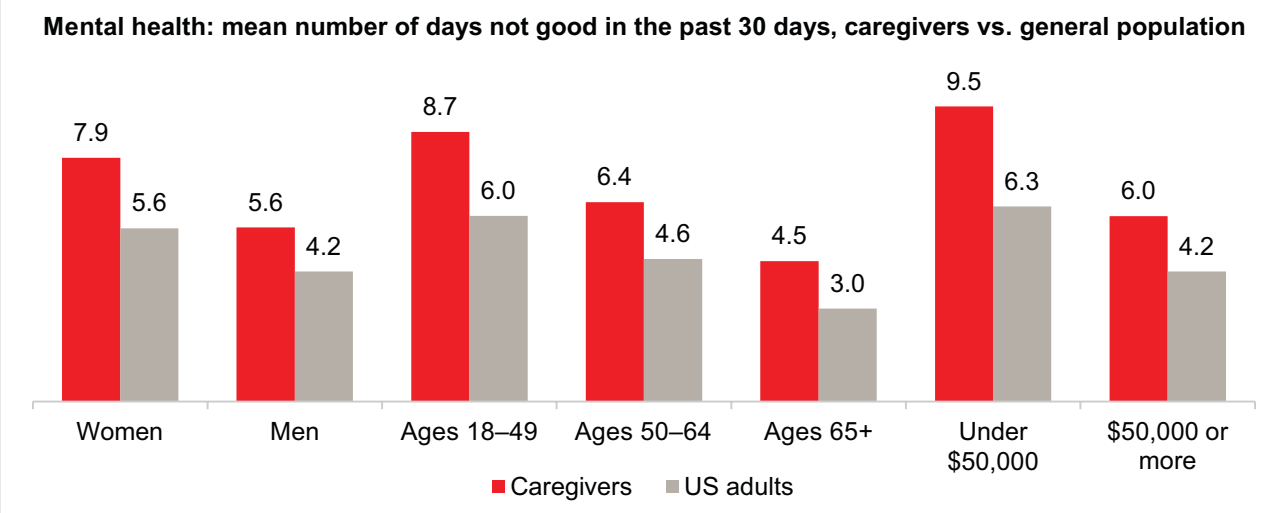
Family caregivers report about 40 percent more poor mental health days than the general adult population. This gap exists across every age and income group examined and is most striking among younger caregivers: Those 18 to 49 average 8.7 poor mental health days per month, compared with 6.0 days for same-aged adults in the general population. See figures 4 and 5.

Women caregivers report more poor mental health days than women in the general population (7.9 days vs. 5.6 days). Lower-income caregivers, those with a household income under $50,000, average 9.5 poor mental health days—notably higher than lower-income adults nationally (6.3 days).

The pattern for poor physical health days varies by age. Caregivers ages 18 to 49 report more days with poor physical health than do their peers. On the other hand, midlife and older adults from the general population, many of whom have high rates of chronic illness themselves, on average report more days when physical health was poor than do caregivers in the same age group.

It is noteworthy that despite more days with poor mental and physical health compared to the general population, caregivers tend to report fewer days when poor health limited their usual activities. For example, among people age 65-plus, caregivers report 3.3 days with limited activities due to poor health vs. 6.3 days among the general population. Limiting activities may not always be possible when those activities include caregiving.

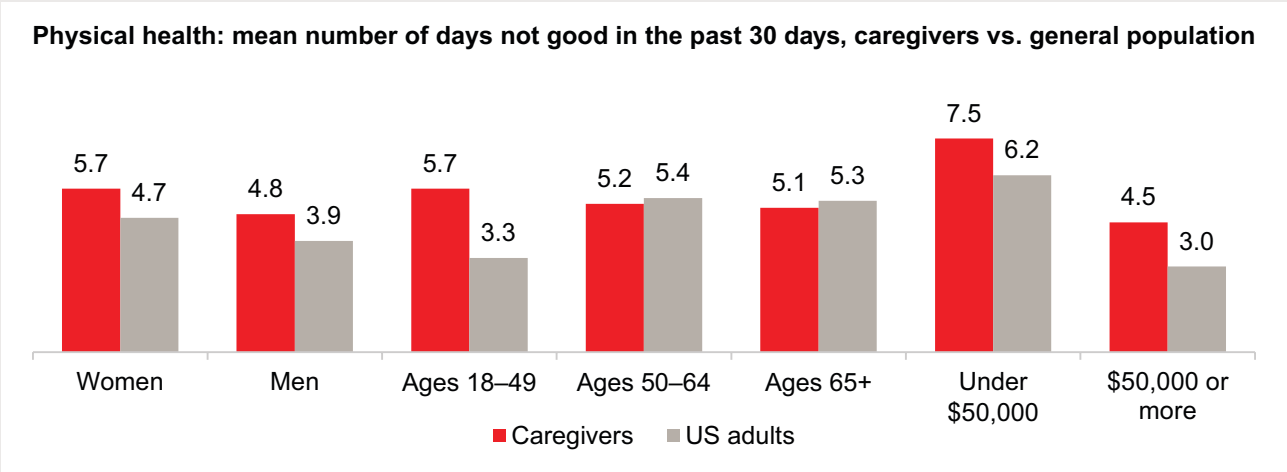
Figure 4. Family Caregivers Report More Poor Mental Health Days Than Do Other Adults in Every Age and Income Group



Base: Caregivers from Caregiving in the US 2025; US adults from BRFSS 2024 (*n* = 114,714)

Note: *Differences between the two are not tested for statistical significance.*

Figure 5. The Physical Health Gap Is Widest Among Younger Caregivers; Caregivers 50 and Older Report About as Many Poor Physical Health Days as Their Peers



Base: Caregivers from Caregiving in the US 2025; US adults from BRFSS 2024 (*n* = 114,714)

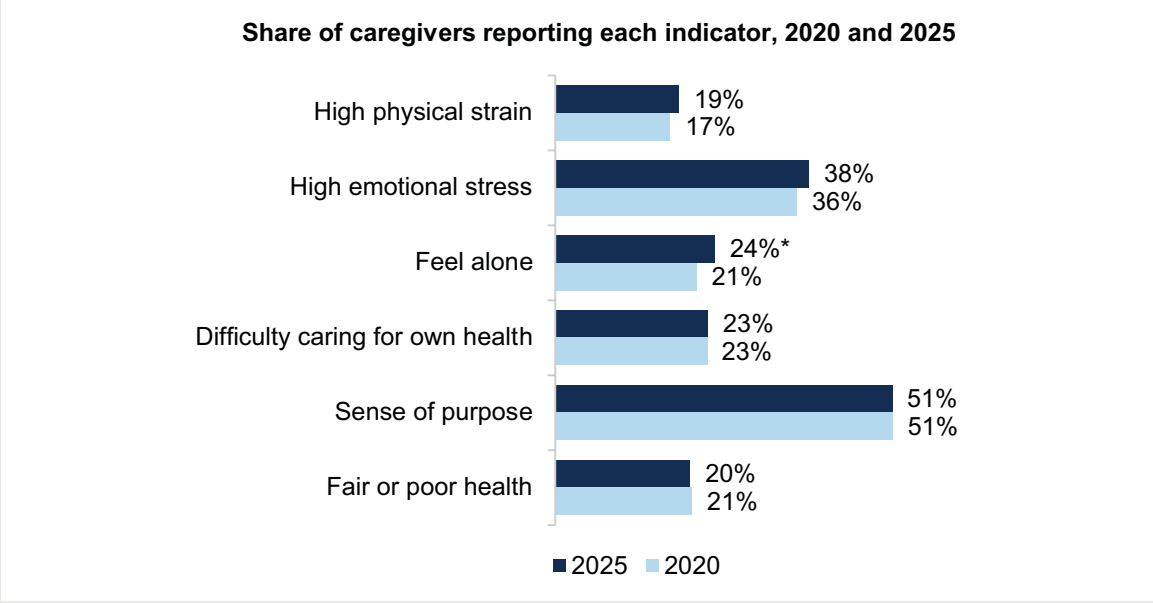
Source: *CDC Behavioral Risk Factor Surveillance System 2024*

Notes: *n = 114,714 responses collected in late 2024 to align with the Caregiving in the US 2025 fielding period. Differences between the two are not tested for statistical significance.*

Physical strain of caregiving

Caregiving exacts a real physical toll. Nearly half of all family caregivers (45 percent) report moderate to high physical strain from caregiving; nearly one in five report high physical strain—a proportion similar to 2020. Only 30 percent of caregivers say the work is not a physical strain at all. These results are not surprising given that many caregivers regularly assist with physically demanding tasks, from helping with bathing and dressing to managing mobility and transfers. Similar results in 2020 and 2025 signal the persistent, unaddressed physical strain of caregiving. See figure 6.

Figure 6. Strain, Stress, and Isolation Among Caregivers Have Not Eased Since 2020



2020 Base: *n* = 1,392
2025 Base: *n* = 6,549

** Significantly different from 2020 at the 95% level (Greenwald test). No other 2020–2025 change is significant.*

Emotional stress of caregiving

The emotional weight of caregiving is even more pronounced. Nearly two-thirds of family caregivers (64 percent) report moderate or high emotional stress from caregiving, and 38 percent report high stress (not a significant change from 2020). Emotional stress is common among caregivers; most contend with substantial emotional strain.

Isolation and feeling alone

Nearly one in four family caregivers (24 percent) agree that caregiving makes them feel alone—an increase from 21 percent in 2020. The upward trend may mark increasing caregiver social isolation postpandemic. Caregiving can shrink social worlds. Time constraints, the emotional weight of care, and the logistical complexity of managing another person's health leave many caregivers with little room for relationships outside of caregiving.

Caregivers' difficulty caring for their own health

For nearly one in four caregivers, the demands of caring for another person mean less attention to their own well-being. Importantly, caregivers are at an elevated risk of deferred care and preventable health deterioration.

Caregiving and sense of purpose

Against the backdrop of strain and stress, most family caregivers (51 percent) agree that caregiving gives them a sense of purpose or meaning in life. Caregiving can be a challenge but also a source of meaning, particularly for caregivers who have a close relationship with or feel connected to their care recipient.

A sense of purpose, however, is not a buffer that cancels out strain. Caregivers who find meaning in their role can also report high levels of stress, physical strain, isolation, and health difficulties.

These high-level results across the nine indicators provide a foundation for understanding the health and well-being of family caregivers in the United States. Caregiver characteristics–gender, age, income, education, race and ethnicity, and more–also tell a story about the health and well-being of today's caregivers, as the next section shows.

1. Health and well-being by types of caregivers

The ways in which caregiving affects caregivers' health and well-being vary across the types of people who are caregivers.

Key Takeaways

Across nine indicators of health and well-being, several patterns emerge.

- ✓ Women show significantly worse health on seven of the nine indicators. LGBTQ+ caregivers experience worse health and well-being on six of the indicators, particularly in mental health, isolation, and difficulty maintaining their own health. Lower-income caregivers fare worse on seven of the nine indicators.
- ✓ Mental health is worst for caregivers 18 to 34 years old. They report an average of 9.6 poor mental health days a month, more than double the rate among caregivers 75 and older.
- ✓ The broader group of younger caregivers ages 18 to 49 report challenges with mental health and difficulty caring for their own health.
- ✓ Midlife caregivers ages 50 to 64 carry the highest emotional stress of any age group.
- ✓ Unemployed caregivers have significantly worse health and well-being than employed caregivers on five of the nine indicators, although employment type matters. Salaried full-time workers generally report better health, whereas part-time workers show lower health and well-being.
- ✓ Hispanic/Latino caregivers report physical strain at significantly higher rates than do other racial/ethnic groups in the study but also significantly higher rates of feeling a sense of purpose in caregiving.
- ✓ Caregivers with a disability show significantly poorer health outcomes on eight of nine indicators, especially self-rated health and days limited due to poor health.
- ✓ Caregivers who live with their care recipient report significantly worse health than caregivers who live separately from their care recipient, on eight of the nine measures. Rural caregivers report health and well-being as broadly comparable to their urban and suburban counterparts—a finding that suggests the need for caregiver-focused supports in all communities.
- ✓ Family caregivers who felt they had no choice in taking on their caregiving role report significantly worse health on every indicator analyzed.

Caregiver demographics

Sex and gender

More women than men are family caregivers, 61 percent vs. 38 percent, and some aspects of caregiving differ by sex. For example, more women than men provide constant, around-the-clock care (22 percent vs. 16 percent of men).

Women report poorer health and well-being than do men on seven of the nine indicators. Women report more days of poor mental health (7.9 days vs. 5.6 days for men), more days of poor physical health (5.7 days vs. 4.8 days), and more days when poor health limited their activities (4.5 days vs. 3.4 days). The differences are evident in high physical strain (21 percent women vs. 16 percent men); high emotional stress (41 percent vs. 33 percent); feeling alone (26 percent vs. 20 percent); and difficulty caring for their own health (26 percent vs. 18 percent).

Other differences between men and women in their caregiving may underlie these findings. For example, women perform more activities of daily living (ADLs) and instrumental activities of daily living (IADLs) on average than do men. In addition, more women than men perform medical or nursing tasks as part of their caregiving (57 percent vs. 51 percent); communicate with health care professionals and advocate on their care recipient's behalf; and spend more time caregiving.

Caregiver age

More caregivers ages 50 to 64 report high emotional stress compared to younger caregivers ages 18 to 49 and older caregivers age 65-plus. A range of factors may explain this finding, including workplace pressures and demands such as sandwich generation caregiving.

Younger caregivers showed unique patterns of findings, with more of them reporting poor mental health and difficulty caring for their own health relative to older caregivers. Mental health ranks worst for caregivers ages 18 to 34. They report experiencing an average of 9.6 poor mental health days a month, more than double the rate among caregivers ages 75 and older.

LGBTQ+ caregivers

Eight percent of family caregivers identify as LGBTQ+. Although they do not differ from other caregivers in sense of purpose from caregiving, they report more days when poor health limited their activities and more days of poor physical and mental health. Proportionately more LGBTQ+ caregivers report fair or poor self-rated health (28 percent vs. just 19 percent of non-LGBTQ+ caregivers), and 32 percent report feeling alone, compared to just 23 percent of other caregivers. LGBTQ+ caregivers also report less access to paid or unpaid help, and more are sole caregivers (47 percent vs. 32 percent).

Caregivers by income level

The health and well-being of caregivers with a household income under $50,000 is worse compared to those with a higher household income on nearly every indicator. Lower-income caregivers experience substantially worse physical and mental health, and more of them report high strain, isolation, and difficulty maintaining their own health. Notably, more lower-income caregivers report a sense of purpose from caregiving (56 percent vs. 49 percent).

Caregiver education level

Caregivers with high school or less education tend to have statistically significant poorer health and well-being than those with at least a bachelor's degree. However, more caregivers at the lowest level of education report a sense of purpose from caregiving (55 percent), more than caregivers with higher levels of education (47 percent). More caregivers with lower levels of education rate their health as fair or poor compared with those with the highest level of education: 26 percent of those with high school education or less, compared to 14 percent of those with a bachelor's degree or higher.

Caregiver race and ethnicity

The *Caregiving in the US 2025* survey collected information from four race and ethnicity groups: African American/Black, Hispanic/Latino, Asian American/Native Hawaiian/Pacific Islander, and non-Hispanic white.

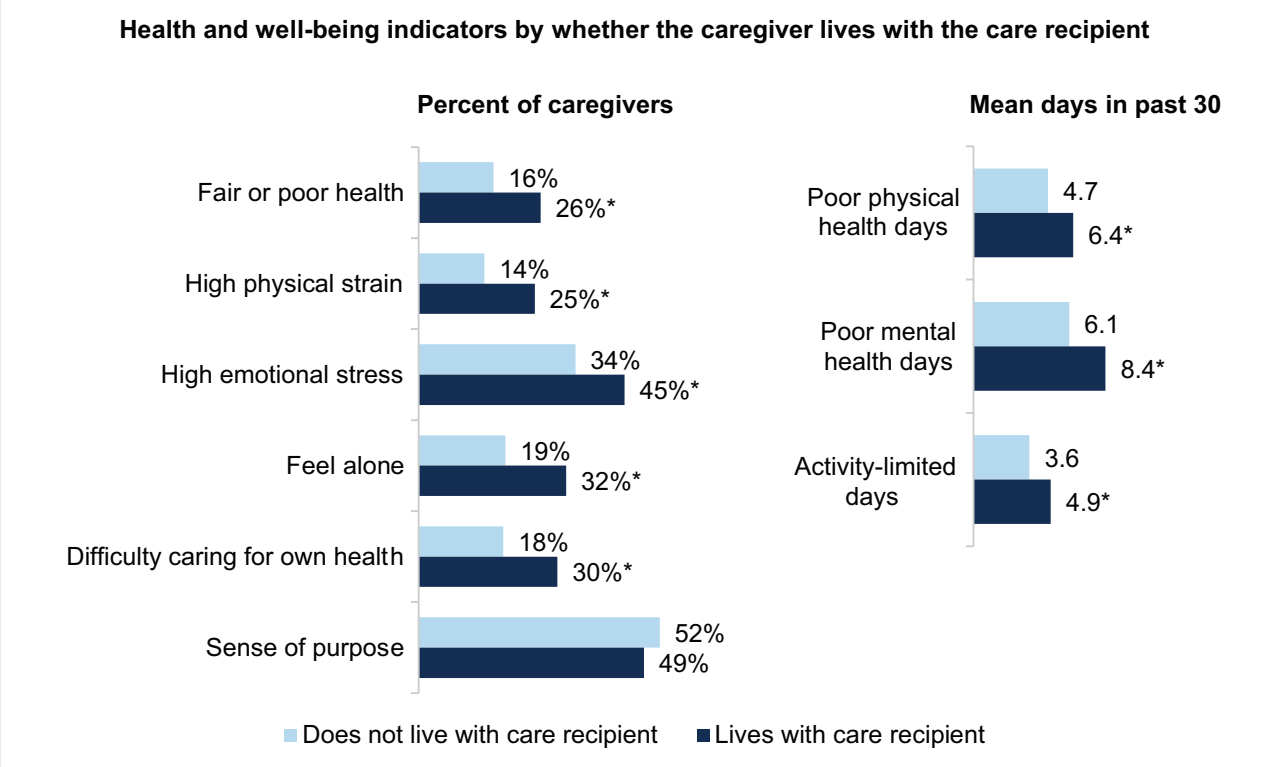
Across the nine indicators, some differences by race and ethnicity are notable. African American/Black caregivers report the least difficulty caring for their own health, and Hispanic/Latino caregivers report the most difficulty relative to all caregivers (17 percent and 27 percent, respectively, with the other two groups at 22 percent). African American/Black caregivers also report the least emotional stress relative to all caregivers. Non-Hispanic white caregivers report more days of poor mental health than did Asian American/Native Hawaiian/Pacific Islander caregivers. Finally, more Hispanic/Latino caregivers report a sense of purpose from caregiving.

Caregiver geography and living arrangement

Health and well-being are similar for family caregivers whether they live in rural areas or in urban or suburban areas. One exception is that rural caregivers report more days of poor mental health than do caregivers in urban or suburban areas (7.7 days in the prior 30 days vs. 6.9 days).

Caregivers who live with their care recipient report worse health and well-being across eight of the nine indicators—all except getting a sense of purpose from caregiving. Among the most dramatic differences are those reporting difficulty caring for their own health (30 percent vs. 18 percent not living with the care recipient) and those reporting feeling alone (32 percent vs. 19 percent). See figure 7.

Figure 7. Caregivers Who Live With the Person They Care for Are Likely to Be Isolated and to Find It Harder to Care for Their Own Health



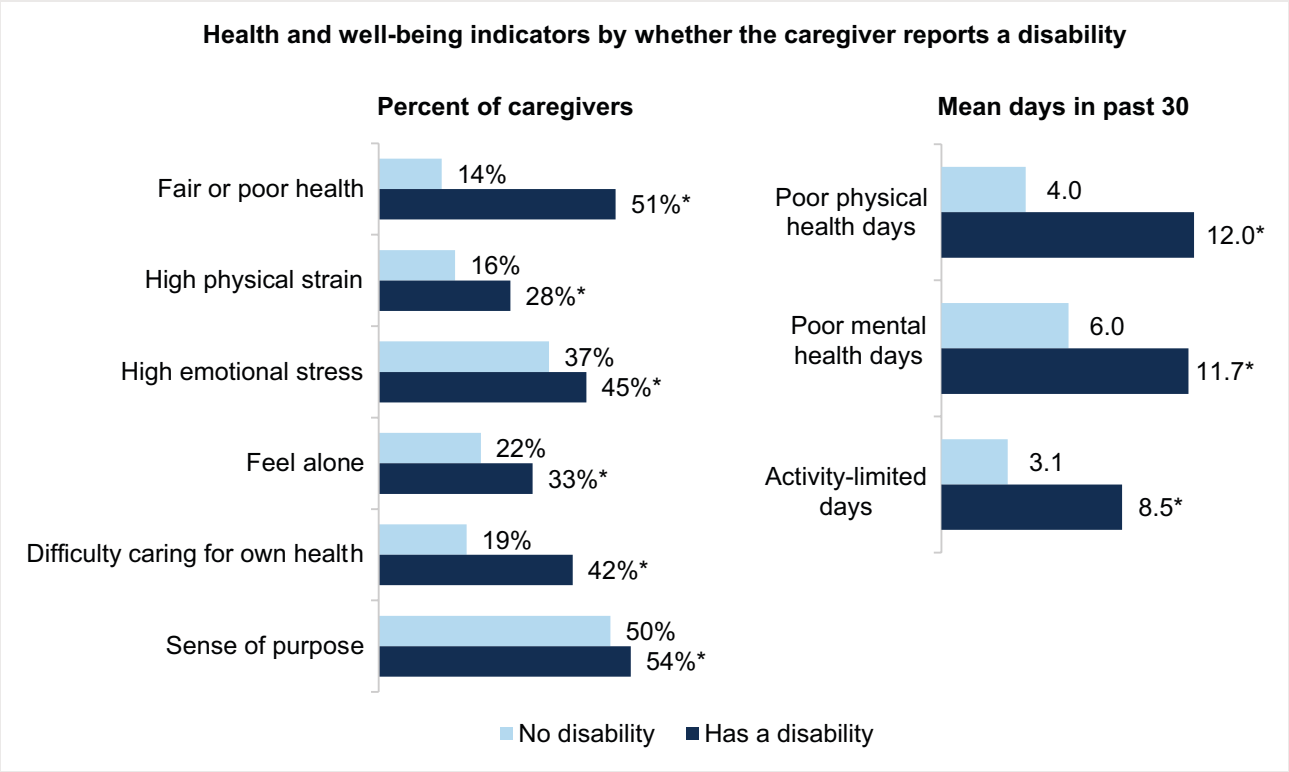
Base: *n* = 2,711/3,824

** Significantly different from caregivers who do not live with the care recipient (95%).*

Caregiver disability status

Nearly one in five family caregivers (18 percent) report that they have a disability that prevented full participation in work, school, housework, or other activities. These caregivers report worse health and well-being across eight indicators. As shown in figure 8, caregivers with a disability are more than three times as likely to report fair or poor health compared to those without a disability (51 percent vs. 14 percent). Caregivers with a disability also report three times as many poor physical health days per month (12.0 days vs. 4.0 days) and substantially more poor mental health days (11.7 days vs. 6.0 days). On the other hand, more caregivers with a disability derive a sense of purpose from caregiving (54 percent vs. 50 percent).

Figure 8. Caregivers With a Disability Are More Than Three Times as Likely to Be in Fair or Poor Health



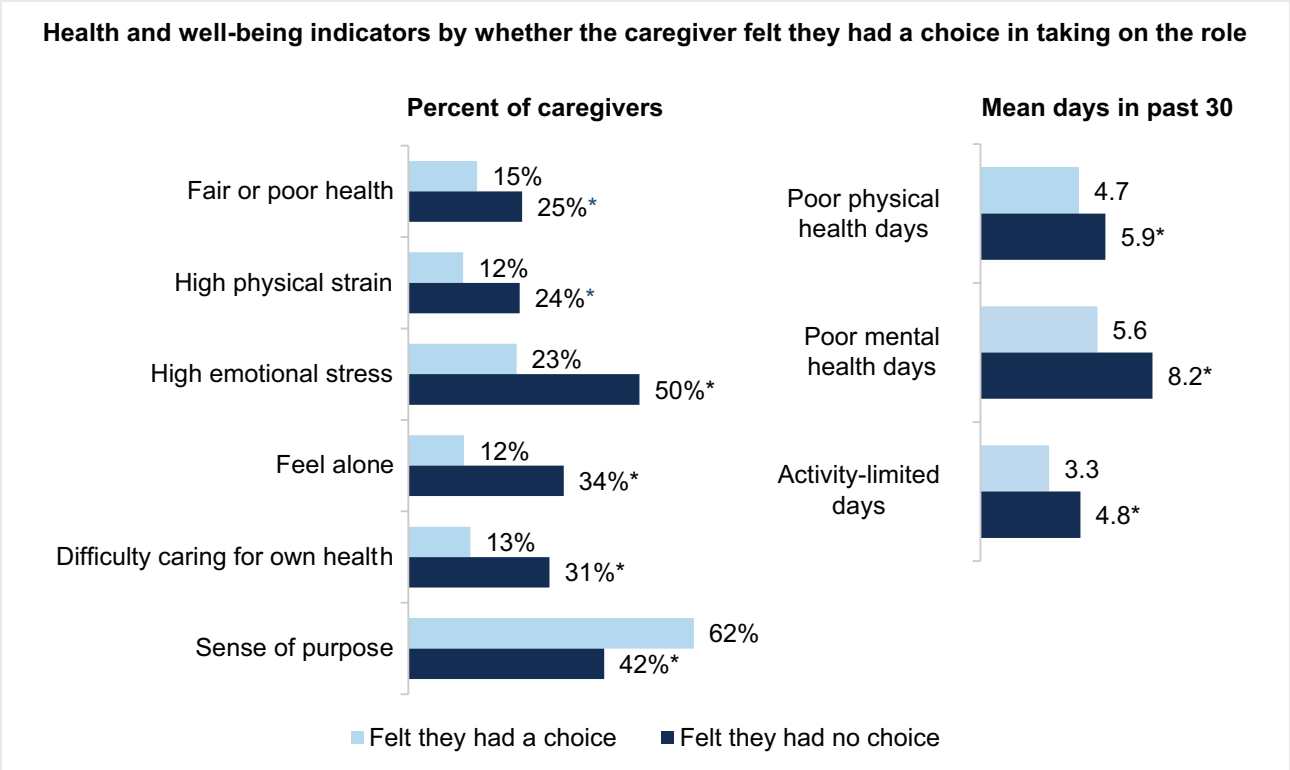
Base: *n* = 1,326/5,204

** Significantly different from caregivers without a disability (95%).*

Caregiver choice

Caregivers who reported having a choice in their caregiving role reported better health and well-being across all nine of the indicators. Some differences are particularly striking. Those reporting no choice had about 50 percent more poor mental health days in a month (8.2 days vs. 5.6 days). See figure 9. Finding a sense of purpose in caregiving was reported by only 42 percent of those with no choice in caregiving, compared with 62 percent of those who had a choice.

Figure 9. Caregivers Who Felt They Had No Choice Fare Worse in All Nine Indicators



Base: *n* = 3,069/3,446

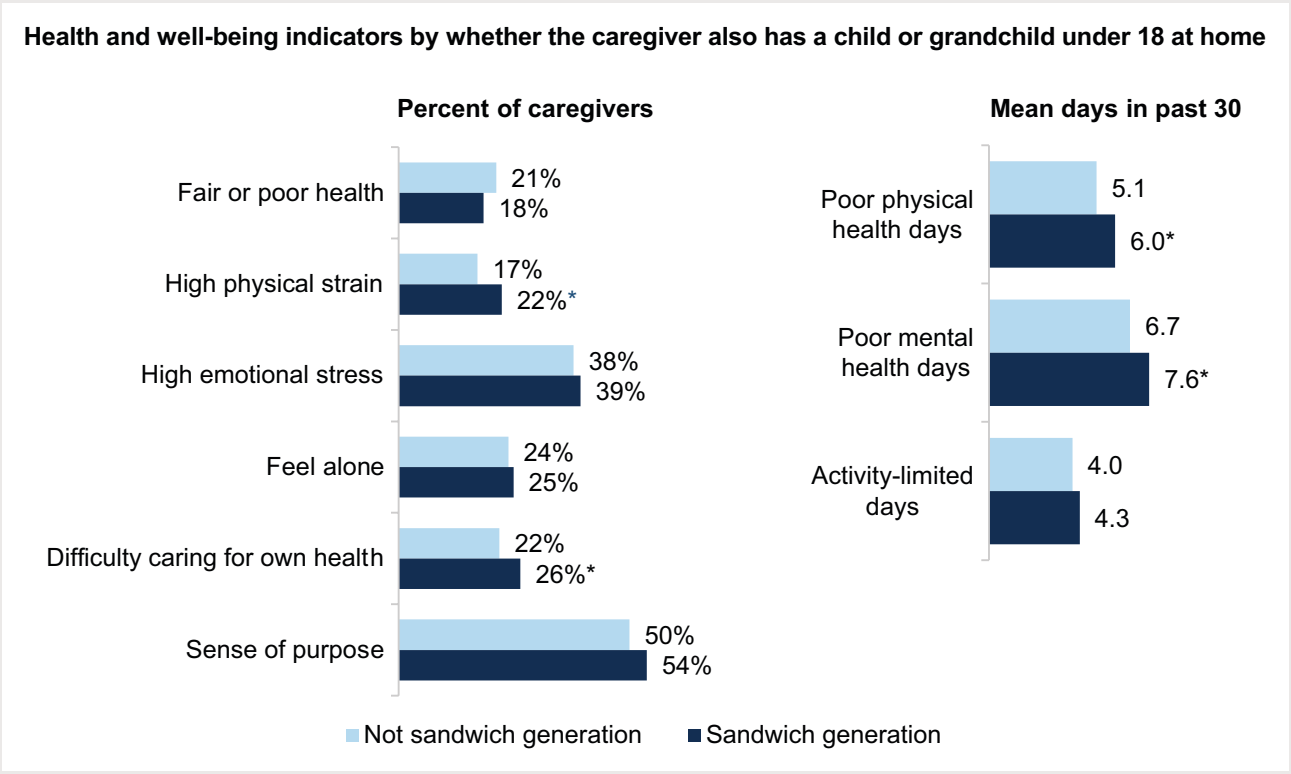
** Significantly different from caregivers who felt they had a choice (95%).*

Sandwich generation caregivers

Seventeen million family caregivers, nearly one-third of all family caregivers (29 percent), are in the sandwich generation, that is, caregivers to an adult with disabilities or a complex medical condition who also have children or grandchildren under age 18 in their household. About three-quarters of sandwich generation caregivers are under 50. Across all caregivers, nearly half of those under age 50 (47 percent) are sandwich generation caregivers.

Sandwich generation caregivers report more days of poor physical health (6.0 days vs. 5.1 days for caregivers who are not in the sandwich generation) and more days of poor mental health (7.6 days vs. 6.7 days), and more sandwich generation caregivers report high physical strain (22 percent vs. 17 percent). More sandwich generation caregivers also report difficulty caring for their own health (26 percent vs. 22 percent). See figure 10. For a detailed report on sandwich generation caregivers, see *Caught in the Middle: The Crucial Role of Sandwich Generation Caregivers*.[8]

Figure 10. Sandwich Generation Caregivers Report More Poor Health Days and Higher Rates of Physical Strain



Base: *n* = 1,750/4,726

** Significantly different from caregivers who are not sandwich generation (95%).*

8 AARP and National Alliance for Caregiving, *Caught in the Middle: The Crucial Role of Sandwich Generation Caregivers,* Caregiving in the US 2025 Series (AARP, 2025), https://doi.org/10.26419/ppi.00421.001.

2. Caregiving intensity and caregiver health and well-being

Caregiver health and well-being varies by the types and intensity of caregiving activities.

Key Takeaways

- ✓ Caregiving intensity can be measured in many ways: number of condition types, hours spent each week in caregiving, help with medical and nursing tasks, and number of years in the caregiving role. No matter how intensity is measured, caregivers in more demanding situations report poorer health and well-being.
- ✓ Caregivers in high-intensity situations, 44 percent of all caregivers, report poorer health and well-being in eight of the nine indicators.
- ✓ More than half of caregivers (55 percent) perform medical and nursing tasks, and 21 percent of those find the tasks difficult. Those who find these tasks difficult stand out sharply: More than half report high physical strain, and three-quarters report high emotional stress.
- ✓ Caregivers providing 21 or more hours of care a week are nearly three times as likely to report high physical strain.
- ✓ A sense of purpose is more common, not less, among caregivers in more demanding situations. It is less common among caregivers who felt they had no choice in the role.

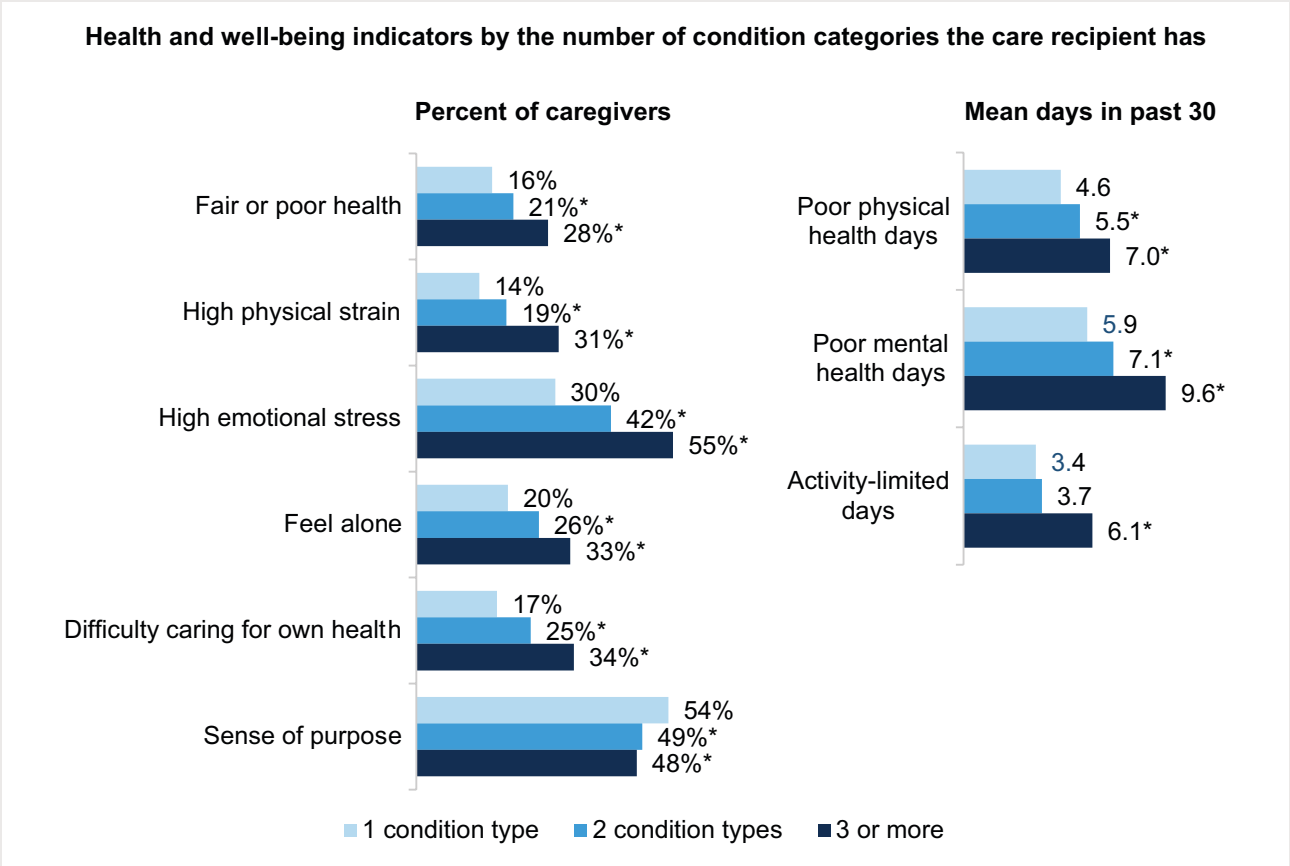
Conditions managed and caregiver health

A caregiver's overall experience may be shaped by the number of different types of conditions that they need to manage at the same time, such as short- or long-term physical conditions, memory problems, or mental health issues.

Nearly half (49 percent) of caregivers manage at least two types of health conditions for their care recipient, and nearly a quarter (22 percent) manage three or more.

There is a trend toward poorer caregiver health and well-being as the number of condition types to manage increases, in eight of the nine indicators. For example, high emotional stress is reported by 30 percent of caregivers when the recipient has one condition, 42 percent at two, and 55 percent at three or more. Sense of purpose is the exception: More caregivers caring for someone with one type of condition report a sense of purpose than do those caring for someone with two or three-plus condition types (54 percent, 49 percent, and 48 percent, respectively). See figure 11.

Figure 11. High Emotional Stress Is More Common With Each Additional Type of Condition a Caregiver Manages



Base: *n* = 2,838/1,782/1,666

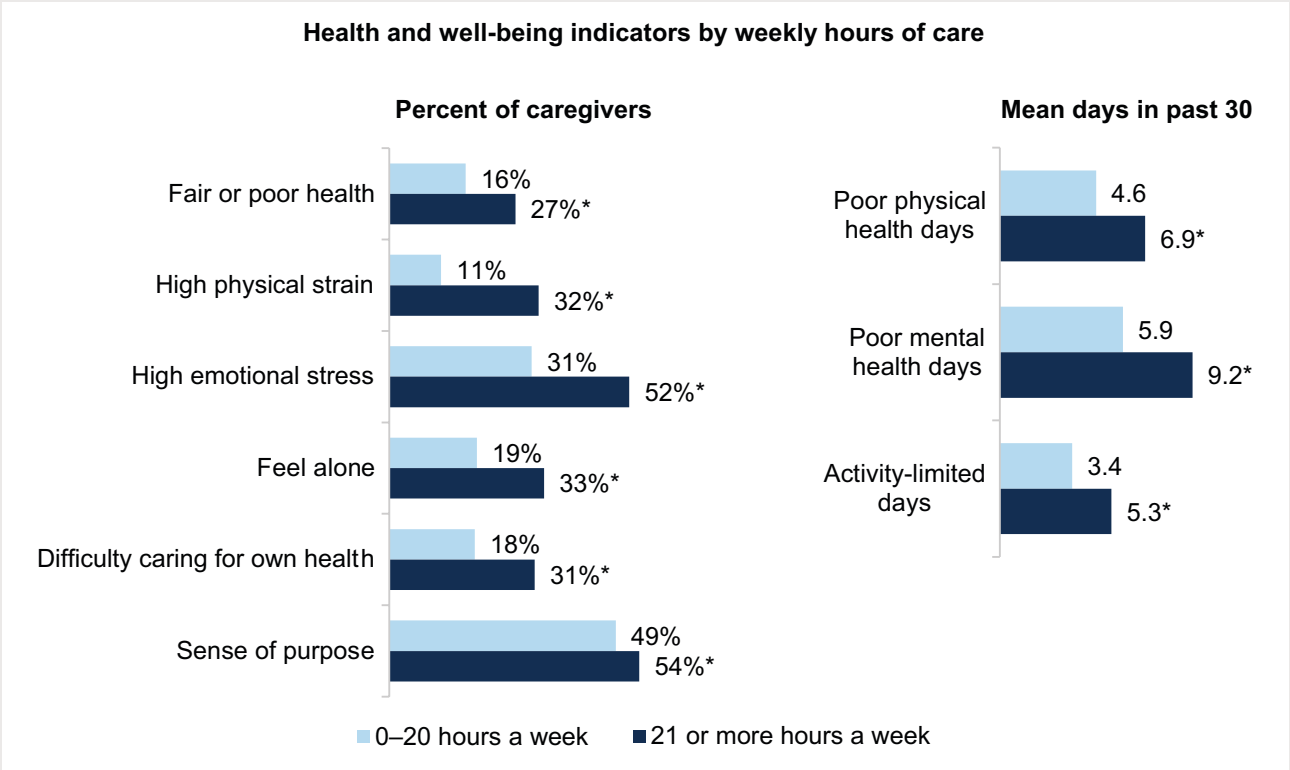
** Significantly different from caregivers managing one condition type (95%).*

Hours of care and caregiver health

The number of hours per week caregivers spend providing care varies widely. Although the median family caregiver provides 12 hours a week, about one in three (35 percent) provide 21 hours or more, including nearly one in five (19 percent) who provide constant care.

Caregivers providing more hours of care report poorer health and well-being on eight of the nine measures than those providing 20 hours or less. They are nearly three times as likely to report high physical strain (32 percent vs. 11 percent of those providing fewer hours); about 1.7 times as likely to report high emotional stress (52 percent vs. 31 percent); feel alone (33 percent vs. 19 percent); and have difficulty caring for their own health (31 percent vs. 18 percent). At the same time, more caregivers providing at least 21 hours per week of care also say caregiving gives them a sense of purpose (54 percent vs. 49 percent). See figure 12.

Figure 12. Caregivers Providing 21 or More Hours a Week Are Nearly Three Times as Likely to Report High Physical Strain



Base: *n* = 4,008/2,541

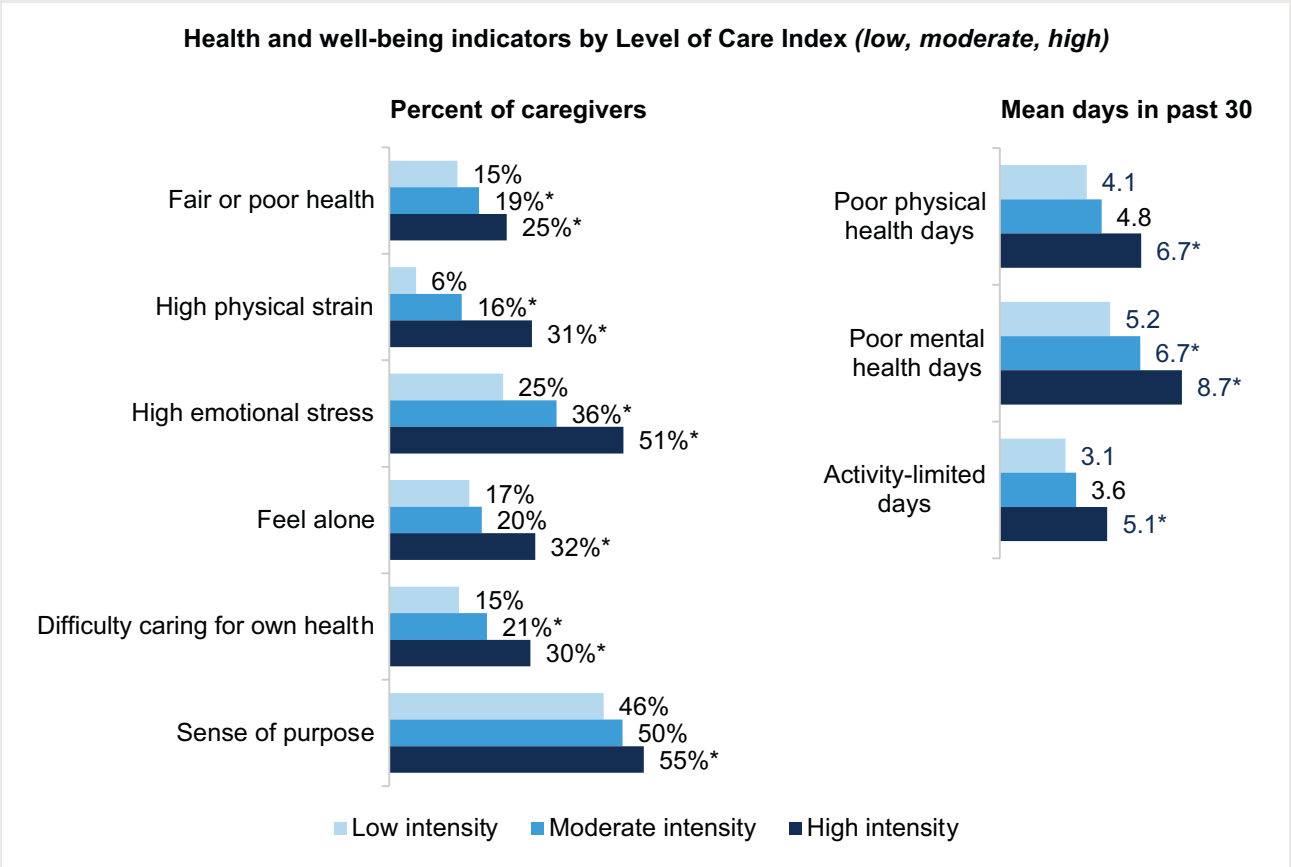
** Significantly different from caregivers providing 0–20 hours a week (95%).*

Care intensity and caregiver health

The Level of Care Index (LOCI) is a measure of caregiving intensity that combines the hours of care given as well as the number of ADLs (such as bathing, dressing, and getting in and out of bed) and IADLs (such as managing finances, preparing meals, and arranging outside services) performed.[9] Forty-four percent of caregivers are in high-intensity situations.

Caregivers in high-intensity situations report poorer health and well-being than do those in moderate- or low-intensity situations on eight of the nine indicators. The most notable differences are in physical strain and emotional stress due to caregiving. Nearly one in three (31 percent) report high physical strain compared to 16 percent of those in moderate-intensity situations and 6 percent of those in low-intensity situations. Half (51 percent) report high emotional stress due to caregiving compared to 36 percent and 25 percent in moderate- and low-intensity situations, respectively. More caregivers in high-intensity situations report caregiving gives them a sense of purpose compared to those in low-intensity situations (55 percent vs. 46 percent). See figure 13.

Figure 13. Caregivers in High-Intensity Situations Fare Worse in Eight of Nine Indicators



Base: *n* = 2,177/1,197/3,151

** Significantly different from low-intensity caregivers (95%).*

9 A more detailed methodology for calculating the LOCI is found in appendix B of the *Caregiving in the US 2025* report; AARP and National Alliance for Caregiving, *Caregiving in the US 2025*. LOCI scores range from 1 (lowest) to 5 (highest), and for the purpose of this analysis, were classified as low (score of 1 to 2), moderate (score of 3), or high (score of 4 or 5).

Medical and nursing tasks and health

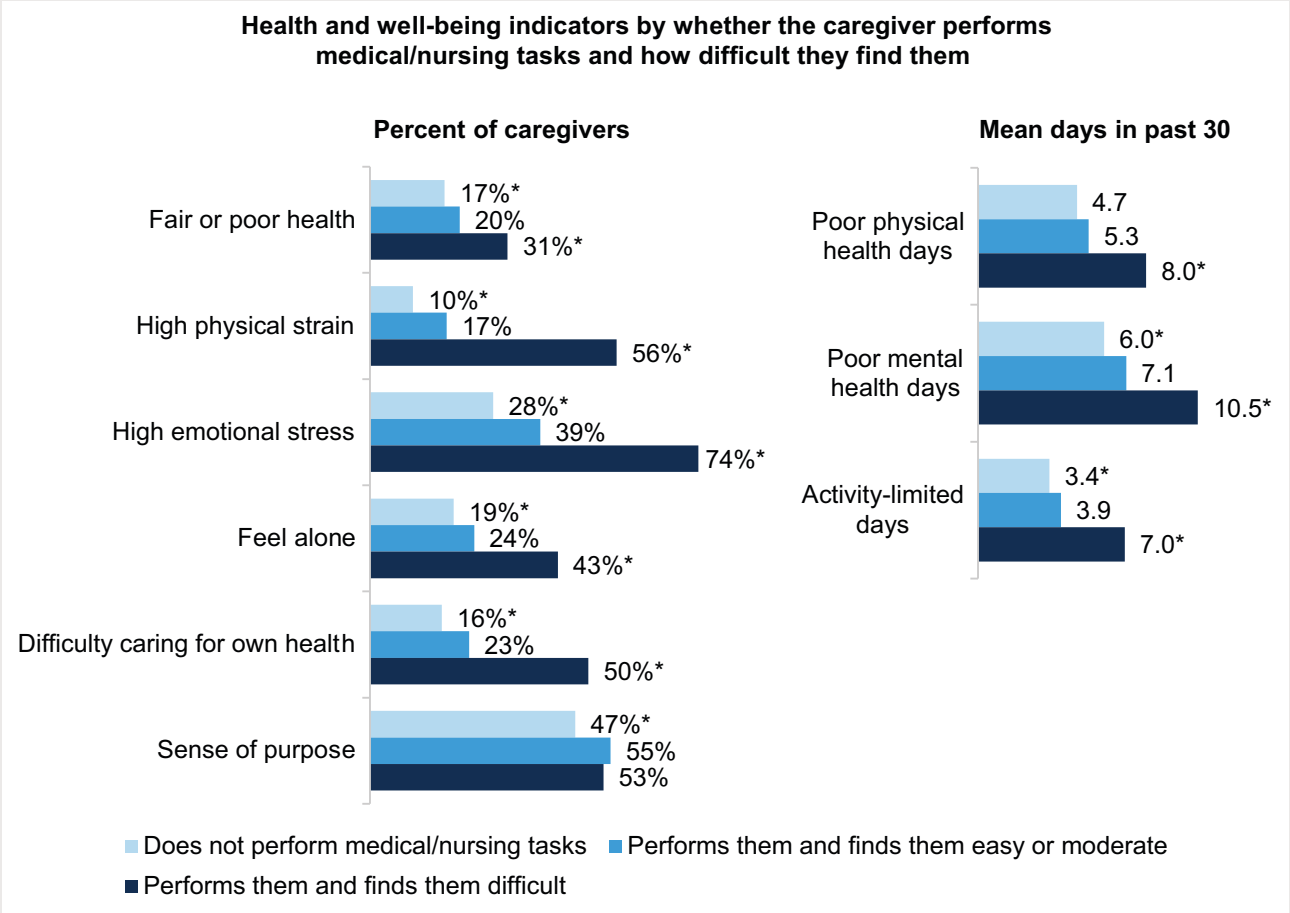
More than half (55 percent) of family caregivers take on medical or nursing tasks ranging from managing medications and preparing food for special diets to giving injections, performing wound care, helping with incontinence, and operating equipment such as oxygen tanks or feeding tubes. About one in five of those who perform medical or nursing tasks find it difficult to do so (21 percent).

Family caregivers who perform medical and nursing tasks are more likely to report worse health across eight of the nine indicators, including more days in the past 30 days when their mental health was not good (7.8 days vs. 6.0 days for those who do not provide medical tasks) and when poor health limited their activities (4.6 days vs. 3.4 days). They are more than twice as likely to report high physical strain from caregiving (26 percent vs. 10 percent) and nearly twice as likely to report difficulty caring for their own health (28 percent vs. 16 percent). At the same time, a greater share of caregivers performing these tasks report a sense of purpose from caregiving (54 percent vs. 47 percent).

This pattern of poor health is most pronounced among caregivers who report difficulty doing medical and nursing tasks; three in four report high emotional stress from caregiving. Compared with caregivers who find medical and nursing tasks to be easy or neutral, those who have difficulty are more than three times as likely to report high physical strain (56 percent vs. 17 percent) and almost twice as likely to report high emotional stress (74 percent vs. 39 percent). Those who find these tasks difficult also feel alone (43 percent vs. 24 percent) and have difficulty caring for their own health (50 percent vs. 23 percent). See figure 14.

Whether difficulty with medical and nursing tasks contributes to poorer caregiver health or poorer caregiver health makes the tasks harder cannot be determined from these data. Both are plausible but not mutually exclusive. What is clear is that caregivers who report difficulty with medical and nursing tasks stand out as needing attention and support.

Figure 14. Caregivers Who Find Medical and Nursing Tasks Difficult Stand Out: Three in Four Report High Emotional Stress



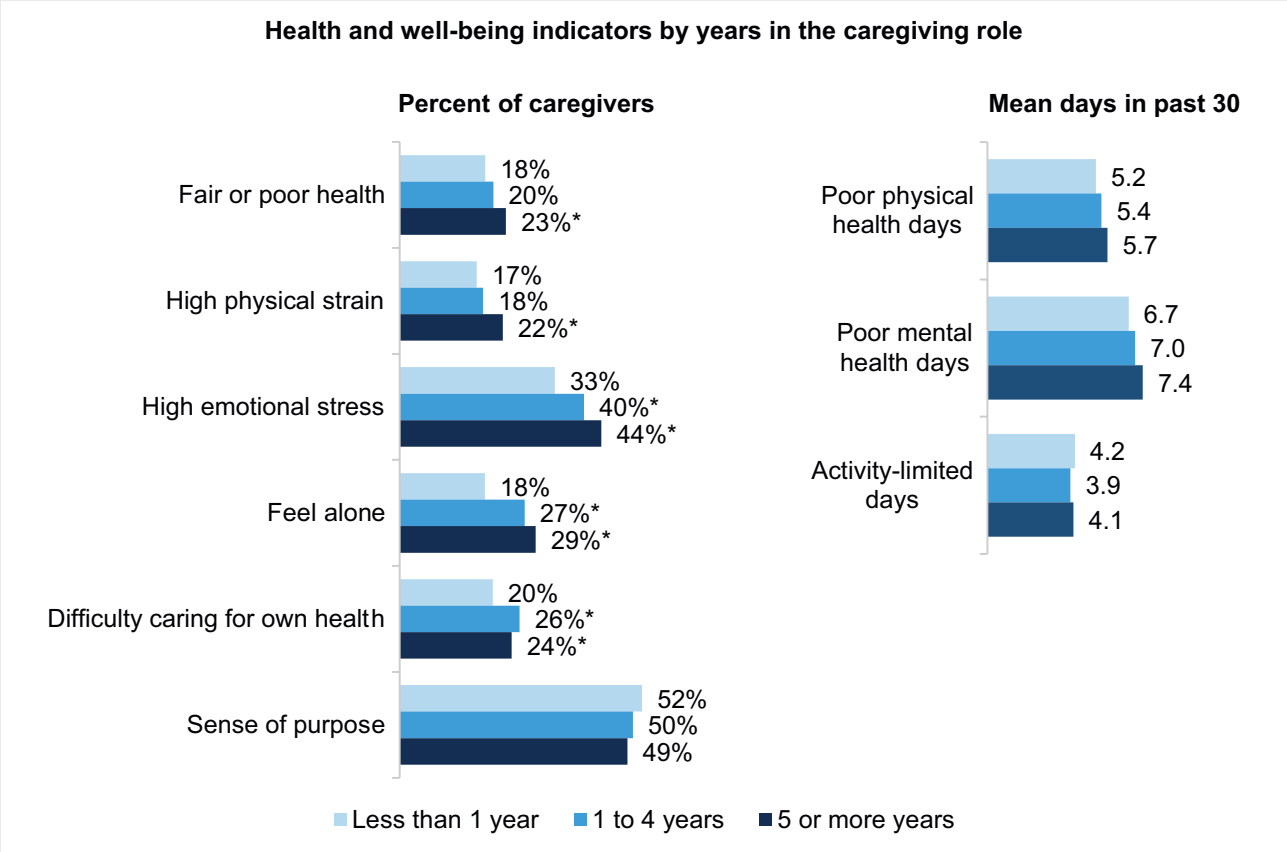
Base: *n* = 2,593/2,875/899

** Significantly different from caregivers who find the tasks easy or moderate (95%).*

Duration of caregiving and health and well-being

The duration of caregiving roles varies around a median of two years. More than four in 10 caregivers are new to caregiving in the prior year, with 28 percent acting as a caregiver for one to four years, and 29 percent serving as caregivers for five years or more. See figure 15.

Figure 15. Emotional Stress and Isolation Are More Common Among Caregivers Who Have Been in the Role for a Year or More



Base: *n* = 2,647/2,047/1,834

** Significantly different from caregivers in the role less than 1 year (95%).*

Compared with caregivers who have been in their role for up to one year, a greater share of caregivers at one to four years and at five or more years report high emotional stress (40 percent and 44 percent, respectively, vs. 33 percent); feel alone (27 percent and 29 percent, vs. 18 percent); and have difficulty caring for their own health (26 percent and 24 percent, vs. 20 percent). Caregivers at five years or more also differ from caregivers in their first year in self-rated health (23 percent fair or poor, vs. 18 percent) and high physical strain (22 percent vs. 17 percent). Despite these differences, no matter how long they have been in the role, caregivers report a similar number of days when their physical or mental health was not good or when poor health limited their activities; about half feel a sense of purpose from caregiving (49 percent to 52 percent).

3. Work, financial strain, and caregiver health and well-being

Most caregivers are in the workforce, and their health and well-being differ by employment type and employer benefits. Caregivers with high financial strain often have corresponding poorer health and well-being.

Key Takeaways

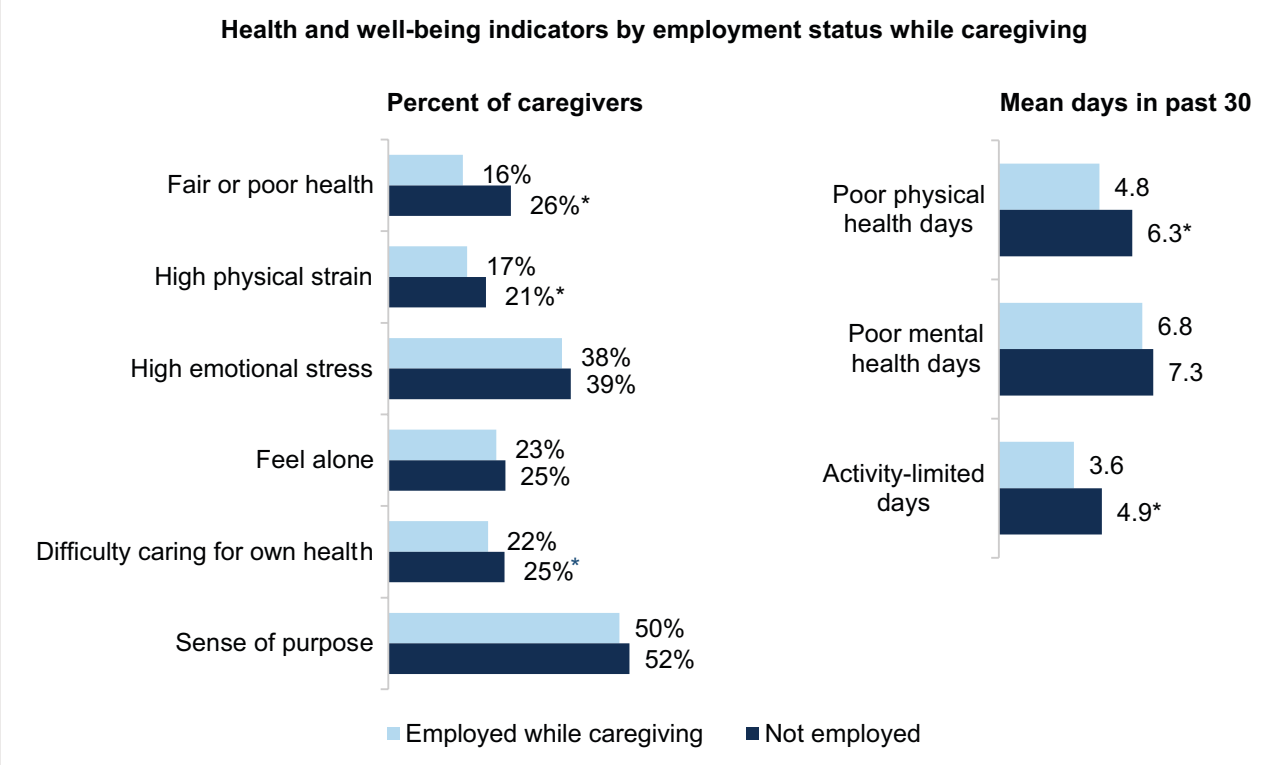
- ✓ Seventy percent of working age caregivers ages 18 to 64 are employed, most as hourly employees. Salaried full-time caregivers report the best health and well-being, whereas part-time workers, both hourly and salaried, report the poorest.
- ✓ Financial strain is common among all caregivers and is related to poorer health and well-being. Caregivers with high financial strain from caregiving report poorer health and well-being in eight of the nine indicators. More than three in four report high emotional stress, compared with 30 percent of other caregivers, and they report more days of poor mental health.
- ✓ Emotional stress is high across every employment category (from 35 percent among hourly full-time workers to 43 percent among salaried part-time workers), with no significant differences between them.
- ✓ A sense of purpose is similar regardless of level of financial strain (49 percent among those with high financial strain and 51 percent among those with low to moderate strain).
- ✓ Caregivers with two or more workplace benefits report better health and well-being than those with fewer benefits.

Work status

Among caregivers ages 18 to 64, 70 percent work for pay. Compared to employed caregivers, unemployed caregivers report worse health and well-being in five of the nine indicators: self-rated health, days of poor physical health, days in which poor health limited activities, physical strain, and difficulty caring for their own health. See figure 16.

Employed caregivers report emotional stress at rates ranging from 35 percent for hourly full-time workers to 43 percent for salaried part-time workers.

Figure 16. Caregivers Who Do Not Work Report Poorer Physical Health, but Emotional Stress Is Common Whether or Not Caregivers Work



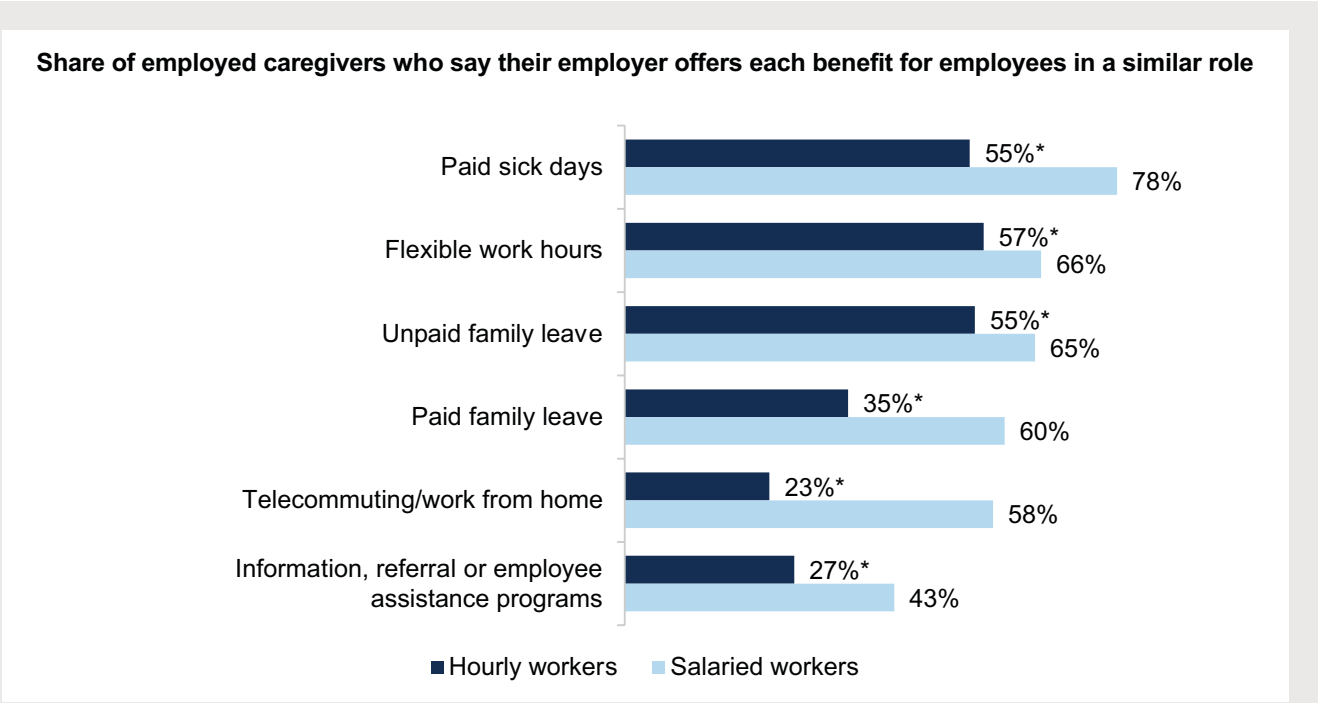
Base: *n* = 3,754/2,771

** Significantly different from employed caregivers (95%).*

Workplace benefits

Through the past decade, workplace benefits such as paid family and medical leave (PFML) programs have expanded. Since the start of the pandemic in 2020, access to all workplace benefits examined has increased: flexible work hours, paid and unpaid family leave, paid sick days, telecommuting, and information and assistance programs for caregivers.[10] Compared to workers without workplace benefits, those with two or more workplace benefits reported fewer poor mental health days (6.5 days vs. 7.7 days), fewer poor physical health days (4.4 days vs. 5.9 days), and fewer days with activity limitations due to health (3.2 days vs. 4.9 days). However, worker status, salaried or hourly, makes a difference for benefit access, with more salaried workers reporting benefits are available to them (see figure 17). This is important given the differences observed across health and well-being indicators by benefit access.

Figure 17. Hourly Workers Have Less Access Than Salaried Workers to Every Caregiver-Friendly Workplace Benefit



Base for salaried: *n* = 1,358
Base for hourly: *n* = 1,912

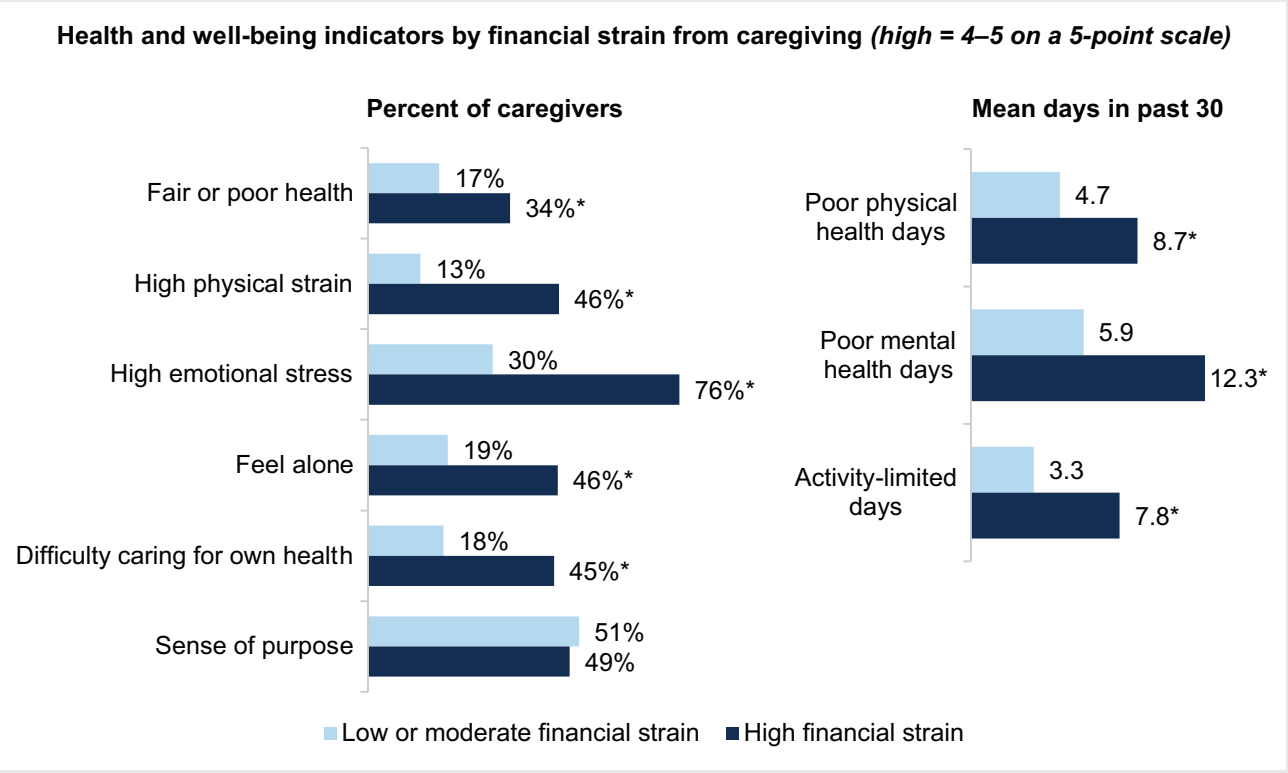
** Significantly different from salaried workers (95%).*

10 AARP and National Alliance for Caregiving, *Caregiving in the US 2025*.

Financial strain

About one in five family caregivers report experiencing high financial strain due to providing care (18 percent). In comparing caregivers who report high financial strain to those who report low or moderate strain, the difference on emotional stress is striking. Among those with high financial strain, 76 percent report high emotional stress compared to 30 percent of those with low to moderate financial strain. Similarly, those with high financial strain report experiencing over 12 days of poor mental health, more than twice that reported by those with low to moderate financial strain. The pattern is the same for eight of the nine health and well-being indicators. Those with high financial strain report a sense of purpose from caregiving at similar rates of those with low to moderate strain: 49 percent vs. 51 percent. See figure 18.

Figure 18. Caregivers Under High Financial Strain Are Two and a Half Times as Likely to Report High Emotional Stress



Base: *n* = 1,251/5,278

** Significantly different from caregivers with low or moderate financial strain (95%).*

4. Caregiver health and well-being and health care systems, services, and supports

Caregivers interact with the health care system in multiple ways, and these points of contact, from coordination to communicating with providers, are related to their own health and well-being.

Key Takeaways

- ✓ One in 10 caregivers are uninsured. They report more poor mental health days than insured peers and higher rates of physical strain and difficulty caring for their own health.
- ✓ Medicaid-covered caregivers show the worst health and well-being among insured groups, a pattern that may reflect who qualifies for Medicaid. However, more of them report a sense of purpose in their role (60 percent).
- ✓ Caregivers are doing substantial and invisible health system work: 70 percent monitor their recipient's condition, 64 percent communicate with providers, and 58 percent advocate on their recipient's behalf.
- ✓ About one in three caregivers who coordinate care find it difficult (31 percent) and report substantially worse health: 61 percent report high emotional stress compared with 31 percent of those who find it easy, averaging 9.1 poor mental health days a month compared with 6.2 days.
- ✓ Only 11 percent received training for daily care tasks, and only 22 percent of caregivers performing medical and nursing tasks were trained for them. Of those who received training, nearly all found it valuable.
- ✓ Trained caregivers fare better. Fewer of them report feeling alone, and fewer report difficulty caring for their own health. More trained caregivers report a sense of purpose from caregiving.
- ✓ Caregivers who struggle to afford services for their care recipient fare worse across the board: 30 percent rate their own health as fair or poor compared with 16 percent of those who do not find services hard to afford; 57 percent report high emotional stress compared with 31 percent; and 38 percent report difficulty caring for their own health compared with 17 percent.

Health insurance

Health insurance coverage is meaningfully associated with caregiver health and well-being. Uninsured caregivers report worse health on several key measures, including more poor mental health days in the prior 30 days (8.3 days vs. 6.9 days for insured) and more poor health days that limited usual activities (5.4 days vs. 3.9 days). Also, a greater share of uninsured caregivers report high physical strain (25 percent vs. 18 percent) and difficulty caring for their own health (29 percent vs. 22 percent).

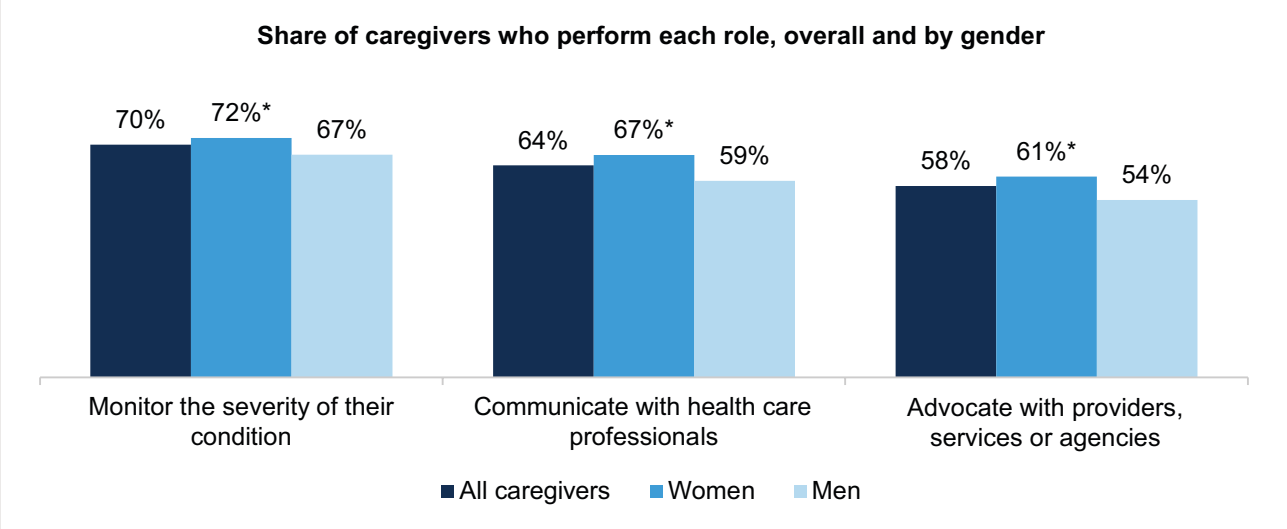
Among insured caregivers, those with employer-sponsored coverage have the best health and well-being, whereas those with Medicaid have the worst. The health and financial challenges of those qualifying for Medicaid are documented and may provide some explanation for these findings. Of note, caregivers with Medicaid coverage are significantly more likely to find a sense of purpose in their role (60 percent) than those in any other coverage category, including uninsured caregivers.

Caregiver interactions with health care providers

Family caregivers are often active participants in the health care of their care recipients. Seven in 10 (70 percent) monitor the severity of their recipient's condition to adjust care, nearly two-thirds (64 percent) communicate with health care professionals about their recipient's care, and 58 percent advocate with health care professionals, community services, or government agencies

on their recipient's behalf. These roles—monitoring, communicating, and advocating—represent informal labor that is essential to the care recipient's health and valuable for the functioning of the health system. Yet these roles are largely invisible in formal care delivery structures, and the labor may negatively affect caregivers' health. See figure 19.

Figure 19. Seven in 10 Caregivers Monitor Their Care Recipient's Condition; Most Communicate and Advocate With Providers



Base for women: *n* = 4,143
Base for men: *n* = 2,367
Base for all: *n* = 6,549

** Women significantly different from men (95%).*

Caregivers who communicate with health care professionals about their recipient's care report worse health and well-being than those who do not: 47 percent report high emotional stress, compared with 22 percent of noncommunicating caregivers, and they average 7.5 poor mental health days per month vs. 6.2 days. They also report higher rates of physical strain (23 percent vs. 11 percent); more poor physical health days (5.8 days vs. 4.8 days); higher rates of difficulty caring for their own health (27 percent vs. 16 percent); and higher rates of feeling alone (27 percent vs. 18 percent). These differences point in the same direction: Greater engagement with health care professionals is associated with worse, not better, caregiver health. This likely reflects the intensity of the care situations. Caregivers managing more complex, higher-need recipients are more likely to be in contact with providers and more likely to be experiencing health strain.

Women caregivers are significantly more likely than men to engage in these interactions, including monitoring condition severity (72 percent vs. 67 percent of men), communicating with providers (67 percent vs. 59 percent), and advocating for the recipient (61 percent vs. 54 percent). Younger caregivers ages 18 to 49 are the least likely to take on these roles—just 57 percent communicate with providers vs. 70 percent of caregivers 50-plus, and 52 percent advocate vs. 63 percent of older caregivers. This age-related gap may reflect less experience navigating health systems and different care needs as younger caregivers more often support recipients with shorter-term or episodic conditions.

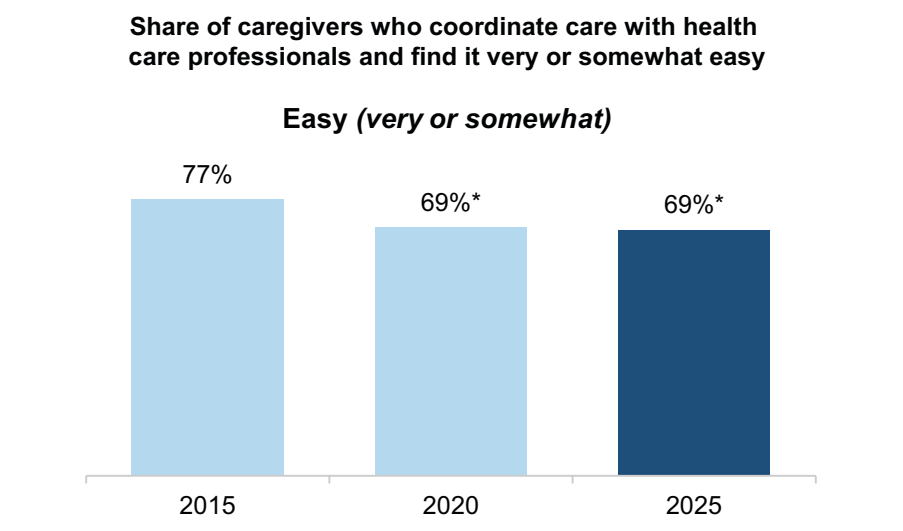
Care coordination

Coordinating care across providers, settings, and services can be one of the most complex and time-consuming tasks caregivers take on. About one in three caregivers who coordinate care with health professionals find it to be difficult (31 percent). See figure 20.

Interestingly, 41 percent of caregivers tracked their care recipient's personal health records using digital tools in 2025, an increase from 30 percent in 2020. This shift may reflect broader availability and adoption of patient portals and health apps, and it represents an opportunity for health systems to better integrate caregiver input into care planning.

Caregivers who find coordination difficult report worse health and well-being across most indicators: 61 percent report high emotional stress compared with 31 percent of caregivers who find coordination easy, and they average 9.1 poor mental health days per month vs. 6.2 days. They also report more poor physical health days (6.7 days vs. 4.8 days), and more of them report high physical strain (35 percent vs. 13 percent), difficulty caring for their own health (36 percent vs. 18 percent), and feeling alone (36 percent vs. 20 percent). But this association may reflect care situation intensity rather than coordination difficulty as an independent driver. The same caregivers managing more complex, higher-need situations struggle with coordination and carry greater health burden, making it difficult to isolate any effect of coordination itself.

Figure 20. Coordinating Care Has Gotten Harder: Among Caregivers Involved in Coordinating Care, the Share Finding It Easy Fell from 77 Percent in 2015 to 69 Percent in 2025



2015 base for caregivers involved in coordinating care: *n* = 1,042
2020 base for caregivers involved in coordinating care: *n* = 1,200
2025 base for caregivers involved in coordinating care: *n* = 4,194

** Significantly lower than 2015 (95%).*

Caregiver training and preparation

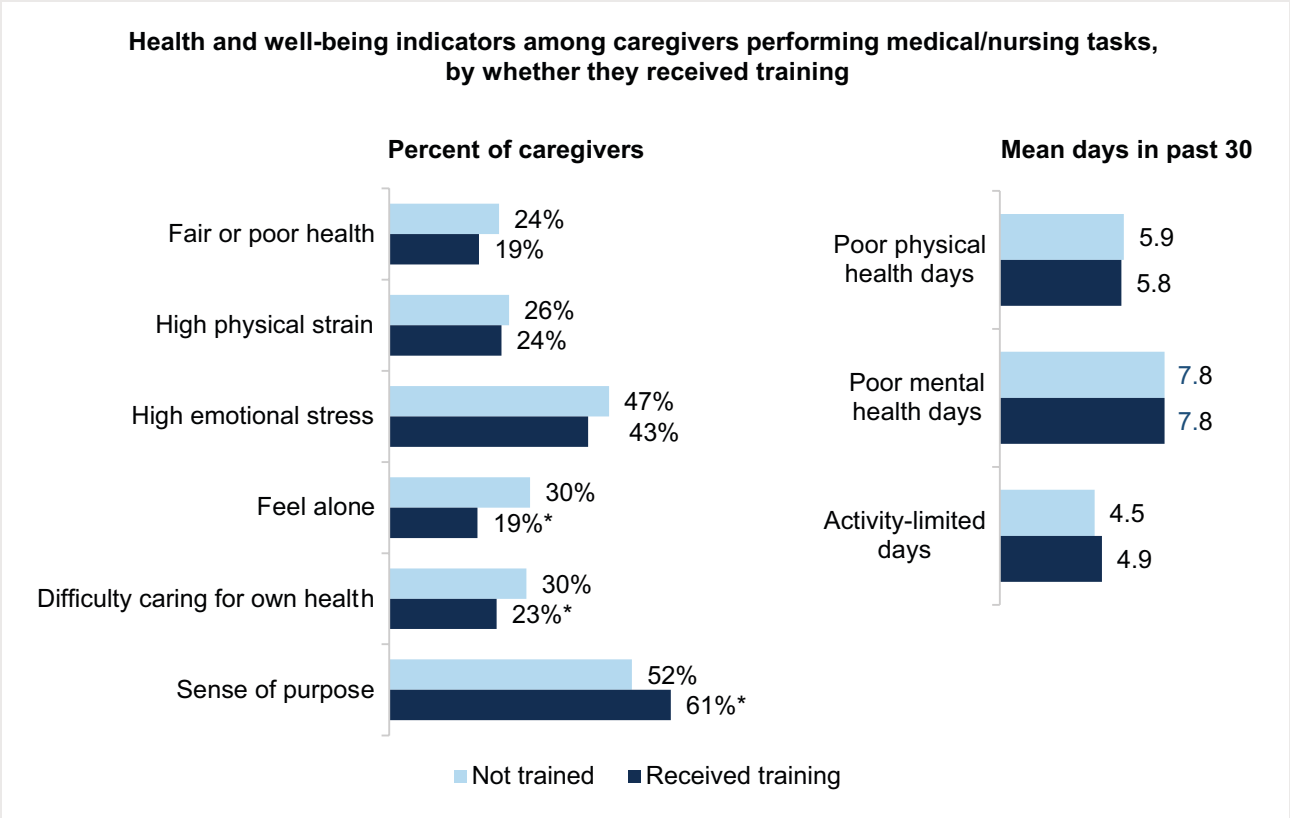
Despite the complexity and clinical significance of the tasks many caregivers perform, formal training remains the exception rather than the rule. Only 11 percent of family caregivers report receiving any training or preparation to assist with ADLs, IADLs, or behavioral management and

modification. Among the 55 percent of caregivers who perform medical or nursing tasks—including managing medications, wound care, injections, or catheters—only 22 percent received training for those tasks. When provided, it is nearly universally valued: 96 percent of trained caregivers report that it prepared them well. African American/Black family caregivers are more likely than non-Hispanic white caregivers to have received training for medical or nursing tasks. This is a pattern worth examining further to understand how it reflects different levels of need, access, and/or outreach.

Caregivers who had no choice in taking on their role are less likely to have received training (17 percent for medical or nursing tasks vs. 30 percent of those who had a choice), despite a greater number of them being in more intensive care situations on average. This gap represents a structural inequity: The caregivers who most need preparation are the least likely to receive it.

The health data offer suggestive evidence about the potential value of training. As shown in figure 21, fewer caregivers who performed medical or nursing tasks and received training felt alone (19 percent vs. 30 percent of those not trained), fewer reported difficulty caring for their own health (23 percent vs. 30 percent), and more found a sense of purpose in their role (61 percent vs. 52 percent). Trained caregivers fare better on health and well-being indicators of isolation and self-care, which points to training as a promising area for helping caregiver well-being.

Figure 21. Caregivers Trained for Medical and Nursing Tasks Are Less Isolated and Find It Easier to Care for Their Own Health



Base: *n* = 913/2,801

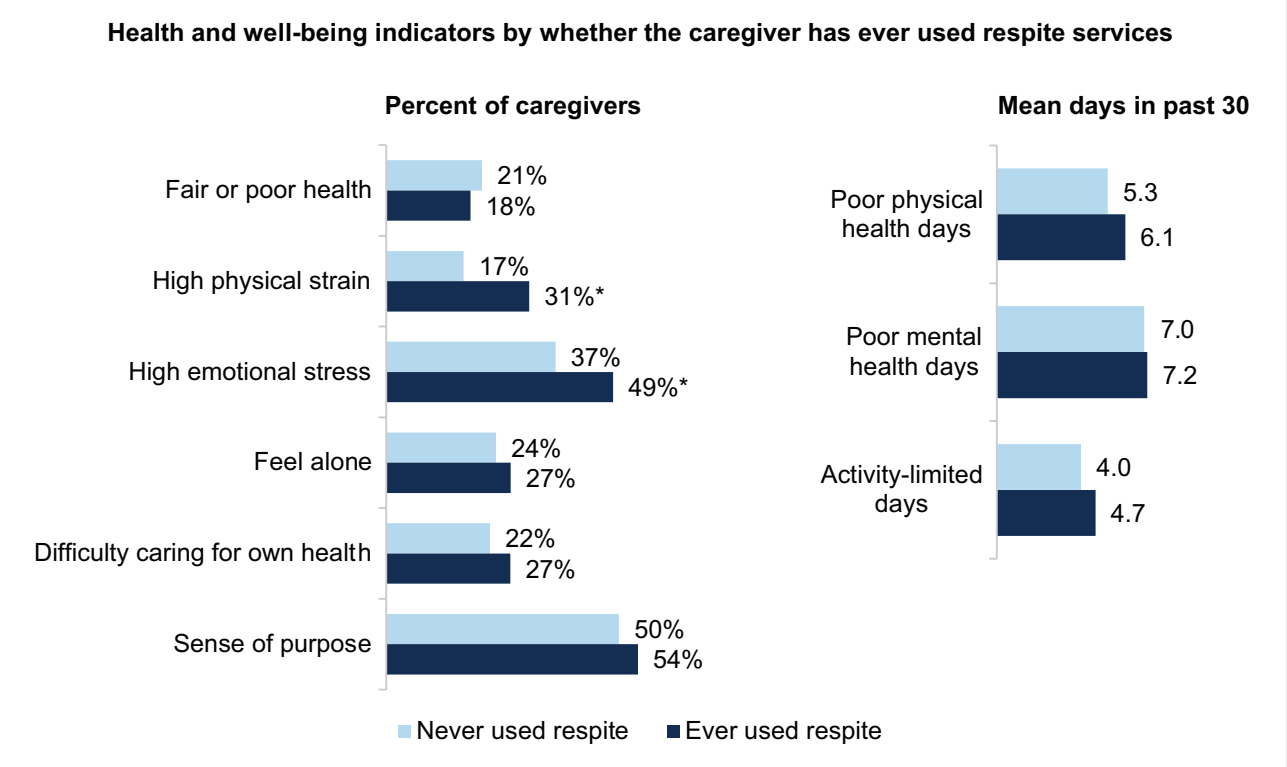
** Significantly different from caregivers who were not trained (95%).*

Caregiver health and access to support services

Respite services

Only 13 percent of family caregivers have ever used respite care, a service that provides temporary relief from caregiving responsibilities, despite 39 percent of caregivers saying respite services would be helpful. Notably, caregivers who have used respite services report higher rates of physical strain and emotional stress but show similar findings in the other health and well-being indicators, compared to those who report never using respite services. This pattern might reflect that respite is disproportionately accessed by caregivers at the highest levels of care intensity. To understand who has used respite care, see figure 22.

Figure 22. Caregivers Who Have Used Respite Care Are More Likely to Report Physical Strain and Emotional Stress but Are Otherwise Similar to Those Who Have Not



Base: *n* = 995/5,508

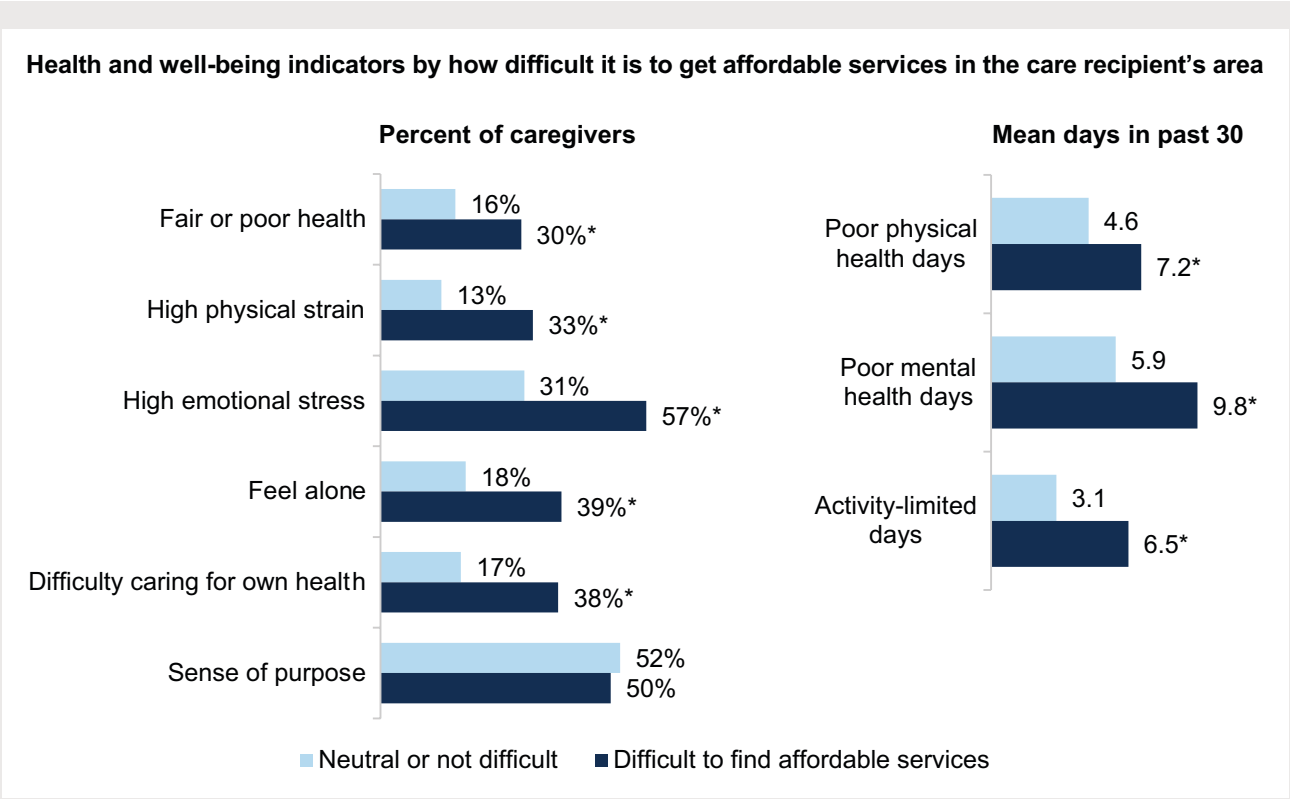
** Significantly different from caregivers who never used respite (95%).*

Affordability of services for caregivers

Affording care-related services is another increasing challenge. Since 2015, more caregivers report difficulty finding affordable services for their care recipient, including delivered meals, transportation, and in-home health services.[11] This has direct implications for caregiver health. When families cannot afford the services that support caregiving, caregiver health and well-being are put at risk, and so is the quality of care for their care recipients.

Compared to caregivers who rate affordability of services either not difficult or neutral, those who rate it as difficult demonstrate poorer health and well-being. Self-rated health was rated as fair or poor for 30 percent of those reporting difficulty compared to 16 percent for those who do not. The same goes for physical strain (33 percent vs. 13 percent) and emotional stress (57 percent vs. 31 percent). Among those who find services difficult to afford, 38 percent report difficulty caring for their own health, compared with 17 percent of those who do not. See figure 23.

Figure 23. Caregivers Who Feel Affordable Services Are Hard to Find Are More Likely to Report Worse Health



Base: *n* = 1,855/4,581

** Significantly different from caregivers who find it neutral or not difficult to get affordable services (95%).*

11 National Alliance for Caregiving and AARP Public Policy Institute, *Caregiving in the US 2015* (National Alliance for Caregiving and AARP Public Policy Institute, 2015), https://www.aarp.org/pri/topics/ltss/family-caregiving/caregiving-in-the-united-states-2015/.

Future directions for research

Caregivers provide crucial support within our society, support that spares some state and federal spending but that comes with a personal cost to caregiver health and well-being.

Differential impacts are evident by different aspects of caregiver identity and their situation. These differences emerge by age, income, sex, race and ethnicity, employment, and time spent caregiving. Each of these factors provides a starting point for outreach and for tailored programs and policies to meet the caregivers' substantial needs, needs that include training, respite, insurance coverage, and workplace supports.

Differences in caregiver age groups are instructive. The challenges to health and well-being among younger caregivers suggest that further information about interactions with other aspects of caregivers' lives could lead to actionable policy and interventions. For example, for some age groups, it may be fruitful to improve access to workplace benefits or address conditions of caregiving by age group such as sandwich generation caregiving. Policy options can be generated from the data showing that more caregivers who live with their care recipient report high-intensity care situations. More of them are also sole caregivers.

Future Research Directions

These analyses provide a detailed view yet only scratch the surface of important differences in caregiver lived experience.

1. More exploration is needed to understand the differences and opportunities they present for intervention. Age illustrates the point. Many younger caregivers ages 18 to 49 fare worse in mental health. Looking more closely, those ages 18 to 34 have the heaviest burden: 9.6 poor mental health days a month, more than double the rate among caregivers 75 and older. Interventions aimed at younger caregivers may miss the group most in need.
2. The features of caregivers' circumstances, along with their unique demographic factors, determine their health and well-being. Understanding the interplay of these factors requires more analysis and more information.
3. Further information is needed on changes during the caregiving experience over time. For example, some caregivers may be healthier than those who do not take on caregiving roles, initially. Tracking caregivers over time—from a caregiving baseline onward—and relating changes in their circumstances to their health and well-being require additional data.
4. Certain points along the care journey—entering the role, a recipient's hospitalization, changes in care intensity, end of life, and the period after caregiving ends—may be when health and well-being are most at risk and most open to intervention.
5. Respite, training, and inclusion in clinical care are all associated with caregiver health in these data, but the associations are confounded by care intensity. Studies that follow caregivers over time, or that compare caregivers who use these programs with similar caregivers who do not, are needed to show which caregivers benefit from these programs and under what circumstances.
6. The health consequences documented here carry costs to health systems and payers that have not been quantified. Linking caregiver health decline to health care use would strengthen the economic case for investing in caregiver health.

Policies and practices to support caregiver health and well-being

1. Build family caregiver support into how health care is paid for

Few caregivers get the preparation their role demands, and caregivers perform health system work that the system rarely pays to support. The Centers for Medicare & Medicaid Services' (CMS) Caregiver Training Services (CTS) codes already let providers bill for training family caregivers, but these codes are underused.[12] Health systems should provide the staff training, documentation, and billing support needed to use them. Expanding CTS use by raising provider awareness, simplifying documentation, and getting additional payers to adopt the codes is a first step in ensuring caregivers receive the training they need. When supporting caregivers becomes a billable part of care, it becomes routine rather than an exception. Other opportunities to expand CTS codes to support caregivers include reimbursement for care coordination activities similar to CMS' Guiding an Improved Dementia Experience (GUIDE) model for dementia care and reimbursement for caregiver assessments.[13] Payer reimbursement for caregiver health and needs assessments would increase use of those tools that help providers identify and address the social drivers of health that family caregivers face.

2. Treat caregiver assessment, readiness, and support as part of care quality

Care recipients' outcomes depend on their caregivers' capacity to provide care. Health systems should identify the family caregiver in the medical record, assess caregiver readiness at discharge and whenever the care plan changes, and give caregivers proxy access to patient portals when the care recipient agrees, recognizing that it is the care recipient's choice how much of their health information to share. States should enforce and strengthen Caregiver Advise, Record, Enable (CARE) Act laws requiring hospitals to identify and instruct family caregivers.[14] Quality programs for hospital discharge, home health, and care transitions should measure whether caregivers are identified and included. A structured caregiver assessment should be part of care, with assessments conducted at discharge from acute care, at the start of home health services or initiation of hospice care, and when the care plan changes significantly. Asking the caregiver what they need should be part of this process, as should connecting them to resources that can support their health and well-being.

3. Guarantee paid family and medical leave and extend caregiver benefits to hourly workers

Access to leave and other employment supports should depend on caregiving needs, rather than job type. Currently, most caregivers work, and most of those who work are hourly employees. Yet hourly workers are least likely to have employment benefits linked to better health. A national PFML program would close that gap. Employers should also offer flexible hours, paid sick days, and employee assistance programs to hourly staff using the same terms as salaried staff. Federal-level leave programs could be designed to work in tandem with employer benefits, providing incentives to employers but also ensuring coverage when employer benefits cannot meet the need.

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12 Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 88 Fed. Reg. 78818 (Nov. 16, 2023), https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other.

13 "GUIDE (Guiding an Improved Dementia Experience) Model," Centers for Medicare & Medicaid Services, last modified October 27, 2026, accessed November 4, 2026, https://www.cms.gov/priorities/innovation/innovation-models/guide.

14 "Caregiver Advise, Record, Enable (CARE) Act," AARP Public Policy Institute, accessed September 28, 2026, https://www.aarp.org/pri/initiatives/healthcare-professionals/care-act/.

4. Make respite care easier to reach

Far more caregivers want respite than use it. Although nearly four in 10 caregivers say respite would help them, few have ever used respite services. The gap reflects both availability and fit. Public respite funding is limited and tied to eligibility rules, programs can be hard to find and apply for, and the formats offered often do not match when and how caregivers need a break. Policymakers should expand funding through existing channels such as the Lifespan Respite Care Program and the National Family Caregiver Support Program as well as simplify eligibility and support flexible formats, including in-home, short-notice, and evening respite.[15] Expansion should be paired with evaluation of respite's effects on caregiver health.

5. Strengthen self-direction in Medicaid home and community-based services

Family caregivers are part of the care workforce. Many family caregivers provide the same essential services to people with serious illness or disability that paid direct care workers do. Self-direction in Medicaid home and community-based services and other public programs, such as veteran-directed care, lets people choose who provides their care, including family members, and pays those caregivers for their work.[16] Self-direction exists in every state but is offered inconsistently by population. It should be a standard option for every eligible population, broadening who can be hired, including legally responsible relatives, and simplifying enrollment for participants and caregivers. Paid family caregivers should also have access to training and respite care that other members of the direct care workforce need to sustain the work, along with the flexibility to negotiate wages in partnership with the care recipient. Strong program integrity measures, including clear safeguards when a relative is a paid caregiver, exist in self-directed programs today and should be part of any expanded access to the model. Private payers and benefit providers, such as those providing long-term care insurance, can expand offerings to meet the realities of family caregiving and a shrinking direct care workforce by modifying policies to allow for care by family caregivers.

6. Build evidence on how caregiving and health change over time

These findings describe caregivers at a single point in time. Longitudinal data collection would show how health and well-being change across the course of caregiving and how caregivers differ before and after they take on the role. Evaluating programs designed to help caregivers will support ongoing innovation and inform the efficient use of resources. For example, evaluating the impact of respite care on caregiver health and well-being, as well as on the care recipients, would enable program revision as needed. Similarly, the impact of CTS code uptake and use, caregiver assessments in health care, employer benefits for caregivers, and benefit self-direction all require careful evaluation to ensure programs work efficiently and effectively for the health and well-being of our caregivers.

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15 "Lifespan Respite Care Program," Administration for Community Living, accessed September 28, 2026, https://acl.gov/programs/support-caregivers/lifespan-respite-care-program; "National Family Caregiver Support Program," Administration for Community Living, accessed September 28, 2026, https://acl.gov/programs/support-caregivers/national-family-caregiver-support-program.

16 "Self-Directed Services," Centers for Medicare & Medicaid Services, accessed September 28, 2026, https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services.

Conclusion

This report gives policymakers, health system leaders, and clinicians a clear and measurable picture of what caregivers across the United States experience every day: a heavy burden on their health and well-being. Taken together, its findings show that caregiving is a determinant of health.

Family caregivers report poorer mental health than do other adults of the same age and income, and the pattern holds across every group examined. What sets caregivers with poorer health apart is not only who they are but also the care they provide: number of hours, caregiving tasks, number of care recipient conditions, and whether they had a choice in taking on the role. Like income, education, and employment, caregiving is a circumstance that shapes health, and it deserves the same attention.

That attention is overdue. The number of family caregivers has increased by nearly half in a decade, yet strain and stress have not eased since 2020. In fact, isolation has risen, and coordinating care has become harder. Caregivers are doing more of the work of the health care system while remaining largely invisible to it—few are asked what they need, and fewer still are prepared for the tasks they take on.

Changing that starts with recognition. For clinicians, it means seeing the caregiver in the room and asking what they need. For health systems, it means treating caregiver readiness as a matter of care quality, using the assessment and training tools that already exist. For policymakers, it means extending workplace benefits, insurance coverage, and respite care to the caregivers who have the least access to them because they are the ones in the poorest health. Family caregivers make it possible for millions to live with illness and disability. Their own health should not be the price.

Appendix. Methodology and reporting

Data from the *Caregiving in the US 2025* survey were analyzed to provide a more detailed view of family caregiver health and well-being. The *Caregiving in the US 2025* survey is a nationally representative survey of unpaid family caregivers conducted by AARP and NAC. Detailed information on sampling, recruitment, fielding dates, questionnaire design, and weighting procedures is available in appendix B of the *Caregiving in the US 2025* report.[17]

Caregiver health and well-being was quantified based on the following nine indicators:

1. Physical strain (% high: ratings of 4 or 5 on 5-point scale) [respondent asked to rate based on attribution to caregiving]
2. Emotional stress (% high: ratings of 4 or 5 on 5-point scale) [respondent asked to rate based on attribution to caregiving]
3. Feeling alone (% agree/strongly agree)
4. Difficulty caring for own health (% agree/strongly agree)
5. Sense of purpose (% agree/strongly agree) [respondent asked to rate based on attribution to caregiving]
6. CDC Healthy Days: self-rated health (% fair/poor)
7. CDC Healthy Days: physical health days not good (mean)
8. CDC Healthy Days: mental health days not good (mean)
9. CDC Healthy Days: days poor health limited usual activities (mean)

Comparisons mentioned throughout this report are statistically significant at the 95 percent confidence level unless noted. Survey results—including averages, medians, and percentages—have been weighted for accuracy. For complete details about the methodology, survey design, analysis, and weighting, see appendix B in the *Caregiving in the US 2025* report.[18]

Base population: Caregivers of adults age 18-plus (n = 6,549). Statistical testing of differences between groups is reported at the 95 percent confidence interval.

CDC Healthy Days benchmarking methodology: General-population benchmarks are drawn from the 2024 Behavioral Risk Factor Surveillance System (BRFSS) weighted with the BRFSS sample weights.[19] The overall BRFSS estimates (figure 3) were then adjusted so that the age and gender distribution matches that of the caregiver sample.

Scale definitions: Thresholds used for "high" strain/stress are 4–5 on a 5-point scale and "agree" at 4–5 on a 5-point agree/disagree scale throughout the report.

17 AARP and National Alliance for Caregiving, *Caregiving in the US 2025*.

18 AARP and National Alliance for Caregiving, *Caregiving in the US 2025*.

19 Centers for Disease Control and Prevention, "2024 BRFSS Survey Data and Documentation."

AARP and National Alliance for Caregiving.
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Washington, DC: AARP, November 2026.
https://doi.org/10.26419/ppi.00436.001

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