JAMDA 16 (2015) 900.e7–900.e10

JAMDA

journal homepage: www.jamda.com

Long-Term Care Around the Globe

Building Long-Term Care Policies in Latin America: New Programs in Chile

Mauricio Matus-Lopez PhD [a,*], Camilo Cid Pedraza PhD [b]

[a] Dpto. Economía, Métodos Cuanqtitativos e Historia Económica, Universidad Pablo de Olavide, Sevilla, Spain
[b] Departamento de Salud Pública, Pontificia Universidad Católica de Chile, Santiago, Chile

Keywords:
Long-term care policies
home-based care
day centers
nursing homes
Chile
Latin America

A B S T R A C T

Background: Little is known about long-term care policies in developing regions. Latin America is one of those regions. In less than 20 years, it will surpass Europe's elderly population. At that point, Chile will be the country with the largest share of elderly population in the region. For that reason, long-term care pilot programs have been implemented in recent years.
Objective: This article describes the long-term care policy in Chile, analyzed according to the international experience.
Method: National directors of these programs were asked to complete questionnaires with a description of each, and the results of the past year. This information was compared with interviews to experts and official information available online.
Results: Programs follow the international trends, although they are underfinanced and lack the necessary mechanisms to control service quality.
Conclusion: It is suggested that budgets should be increased, and there should be higher requirements for caregiver training. Also, mechanisms for quality control should be established, and policies should be evaluated for formal direct hiring through a cash-for-care system.

Almost all developed countries have long-term care policies (LTCP). Countries with universal regimes, such Sweden, the Netherlands, and Denmark, carried out profound reforms of their models during the 1990s. In residual care regimes, such as Spain and Portugal, new rights and systems were implemented in the first decade of this century,[1,2] while England recently reformed its system, and in the United States, Congress rejected the reform of Medicaid in 2013.

These experiences and the abundance of studies have allowed for comparisons between models and countries in past years, and have helped obtain lessons learned.[3–7] A quick search for the subject of long-term care policies in the main electronic databases shows between 6000 and 10,000 peer-reviewed articles, of which approximately 2000 are from the past 5 years. However, when the search is limited to Latin America, results are reduced to fewer than a dozen. Knowledge of reality is completely disproportionate to the distribution of the elderly population.[8] There are 603.9 million people older than 65 around the world, and only 36.4% live in developed regions. The older population in South America is equivalent to 61.8% of that of North America, and 78.5% of that of Eastern Europe. In only 20 years, it will exceed that of Europe by 16.2 million people.[9]

Previous diagnoses point out that Latin America is not prepared for this change[10] and, when this happens, most probably the countries will not have the resources that developed countries had.[11] There is certainty regarding the fact that the demand for long-term care in Latin American countries will increase significantly, as older people are reaching the last years of their lives in poor health conditions.[12,13] This is because the increase of life expectancy in the region is a result of greater coverage and the incorporation of medical technologies rather than better life conditions.[11,14]

Regional organizations have already addressed the issue of the impossibility of continuing with family care[15] resulting from both demand pressures as well as supply limitations.[16] Despite this, little or nothing is known about this neglected policy area in these countries.[8,17]

Chile is one of the most aged countries in Latin America, only behind Uruguay and Argentina. In 2015, the percentage of elderly people reaches 10.6% compared with 7.6% for the region. However, before 2035 it will become the country with the highest percentage of elderly population in Latin America, reaching 19.9%,[9] and it will be the

The authors declare no conflicts of interest.

* Address correspondence to Mauricio Matus-Lopez, PhD, Dpto. Economía, Métodos Cuanqtitativos e Historia Económica, Universidad Pablo de Olavide, Spain, Ctra. de Utrera, km. 1, 41013 Sevilla, Spain.
E-mail address: mmatlop@upo.es (M. Matus-Lopez).

http://dx.doi.org/10.1016/j.jamda.2015.07.018
1525-8610/

Organization for Economic Development and Cooperation's (OECD's) country with the highest increase in long-term care. As of 2013, this was equivalent to 1 percentage point of gross domestic product (GDP), but in 2060 it will reach 2.3%.[18] Despite this evidence, little or nothing is known about the Chilean system and its LTCP. Until a few years ago, the Chilean model rested on charity,[19] but in the past 2 years, a series of pilot LTCP programs have been implemented. The objective of this article was to present and analyze these programs. With this purpose, 3 questionnaires were sent to the Director of the National Service for the Elderly (SENAMA), the information available online was reviewed, and national experts were consulted. Following are the results.

Health and Aging in Chile

In Chile, there is a health social security system that is segmented by risk and income. The National Health Fund (FONASA, for its acronym in Spanish) is public and low-income biased, and the Health Social Security Institutions (ISAPREs) are private and high-income biased. Both are financed through obligatory contributions of 7% of the salary, plus out-of-pocket expenses, and, in the case of the public system, is financed with general taxes.[20] Thus, the public fund covers 86.1% of the 2.89 million people who are older than 60, the private system covers 7.4%, and the remaining 6.5% is covered by other systems.[21]

Although older people do not register poverty rates significantly higher than the national average, their health status and risk are segmented to FONASA. Adults who are 65 years and older register prevalence of sedentary lifestyles of 96.1%. Of this percentage, 74.6% suffer from high blood pressure, and 48.1% of high or very high cardiovascular risk.[22]

Health primary care visits and senior adult emergencies grow at rates that double the average health visits, and close to 30% of the public expenditure in health was generated by the latter; half of it resulting from hospitalizations. It is expected that in 2020 this expenditure will be 2.5 times greater.[23]

Of the elderly people in Chile, 24.1% suffer dependency to a certain degree. This is equivalent to 405,539 people who are 60 years or older.[24] In 2025 there will be close to 1 million senior adults who will require services and special care due to their functional dependency.[23] With this information, an estimate was carried out regarding the cost of a home-based care system for people 65 years or older with greater dependency. The total cost was estimated at millions of dollars annually, representing 0.44% of GDP.[25] This would place the country as the seventh with the lowest cost in the OECD, similar to the expenditure of Korea.[18]

Long-Term Care System in Chile

The Chilean model has long-term care institutions, day centers, and domiciliary care services. They are all coordinated by the SENAMA, which depends on the Ministry of Social Development. The programs have scope and organizational characteristics in common.

The 3 programs are focused by age, dependency, and socioeconomic conditions. To access the benefits, individuals must be 60 years or older, must be evaluated as moderately or severely dependent, and must belong to the first 3 quintiles of social vulnerability. Age is verified by the national identity card, whereas the evaluation of dependency is carried out by the local health services or the executing entities. The tests used are the functioning of Mini-Mental State test, Pfeffer test, and evaluation of activities of daily living. Social vulnerability is calculated using the "social protection file." This is a survey that already existed, which all homes that request social benefits such as water or electricity subsidies must fill out. Local governments manage them and they receive information regarding the structure of the family group, habitability conditions, and income. Each item is evaluated and given a value in a continuous scale. Following are the characteristics of each program.

In terms of organization, home-stay and home-based care work with contracts signed directly between SENAMA and the executing entity. Instead, for nursing homes the model is organized through competitive funds. Annually, SENAMA opens a contest to award the programs. Public law entities or private nonprofit organizations may participate, mainly local governments, religious entities, and nongovernmental organizations (NGOs). Once the proposals are reviewed and evaluated, they are awarded to the executing entities.

Long-Term Care Institutions

Long-term care institutions (ELEAM) are collective residences for senior citizens that present some degree of dependency. This program started in 2007 and is the oldest of the 3. In 2014, 12 service centers operated in 7 of the 15 regions in the country. Five of these centers were managed by local governments, 3 by religious agencies, and 2 by regional health services and NGOs. The network had a total capacity for 618 people, of which 657 senior citizens benefited throughout the year.

Financing came from the budget allocation to SENAMA, and reached USD 11.1 million for infrastructure and operations. Financing of current expenses at the center was carried out through a pay-per-beneficiary system. In 2014, the amount reached USD 138 monthly for slight to moderately dependent individuals, and USD 184 monthly for those who are severely dependent. Added to this are copayments, which have a maximum limit of 85% of the dependent's pension.

Centers had teams of 40 to 70 people, including managers, caregivers, administrators, and food and cleaning services.

With respect to the training of caregivers, they were required to have completed secondary education and have attended a course of at least 6 months regarding care for elderly people and/or sick people. The average salary of a caregiver reached USD 490 per month, which is equivalent to 61.6% of the country's average salary.

Day Centers

Day centers are spaces that offer socio-sanitary services, preventive family support, and sociocultural activities during the day to elderly people with mild dependency. The program started in 2013, and the following year it financed 25 centers in 9 of the 15 regions of the country. Of these, 21 were managed by local governments, 2 by public corporations and religious agencies, and 1 by an NGO.

The number of beneficiaries reached 1615 individuals in 2014, and the budget for the operational cost reached USD 1.32 million in the same year. The budget did not finance investment in infrastructure, and payment to the executing agencies was done through a pay-per-beneficiary system of USD $99.60 monthly. No out-of-pocket payments were allowed.

There are no exact statistics regarding the number of people who worked in the centers, nor about their working conditions. SENAMA just proposed a structure of socio-sanitary professionals and recommended that caregivers have technical studies.

Domiciliary Care

Domiciliary care is a pilot program that started in 2013. It provides support services and accompaniment for the daily activities of elderly people in their own homes.

In 2014, the service was implemented by 13 entities in 3 of the 15 regions of the country. Local governments managed the program in 7 municipalities, religious agencies in 6, and NGOs in 7. In total, 1761 elderly people benefited.