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Long-term care policies in developing countries. Early efforts of home-based care in Chile

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#### Abstract

**Background:** Over the last twenty years, almost all of the developed countries have implemented or reformed their long-term care policies. Now it is the turn of the developing countries. However, little or nothing is known of these countries. Less than 6% of the research on the subject focuses on them. Latin America is one of the most rapidly ageing regions and, among them, Chile is ageing faster than any. Almost 20% of the population will be over 65 in twenty years.

**Objectives:** This paper presents a description and analysis of a pilot home-based care programme for dependent people in Chile.

**Method:** It is based on a questionnaire consisting of fifteen questions answered by the National Managers of the programme in 2015, and expert's opinions.

**Conclusions:** The results show that the initiative is in line with the promotion of home-based services for long term care in the world. However, their extrapolation to a national policy must address in greater depth the questions of sufficient funding, means-test access and devolution problems.

**Keywords:** Long-Term Care; Health Public Policy; Demographic Aging; Chile; Latin America

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## Introduction

Over the last twenty-five years, almost all of the rich countries have created, developed or reformed their long-term care policies (LTCP). Now it is the turn of the developing countries.

Just two decades ago, 42.4% of the over-65 population was concentrated in the more developed regions. This percentage has fallen to 36.4% and the proportion in the less developed regions has risen from 57.6% to 63.2%.

Despite this, little or nothing is known about long-term care policies in these countries. Of all the research that has been done on this subject in recent years, only 6.1% studies the less developed regions (Lloyd-Sherlock, 2014).

South America is one of those regions. Several South American countries have already entered into the final stage of the demographic bonus and are now facing strong supply and demand pressure on the care of their dependent elderly population (Matus-López & Rodriguez-Modroño, 2014).

This is particularly worrying, since this region will exceed Western Europe in the number of elderly persons in less than ten years and it does not seem to be prepared for this (Cotlear, 2011).

Furthermore, it will do so with fewer economic resources than were available to the rich countries when they implemented their LTCP and studies of states of health do not show better results (Ferri et al., 2011).

Chile is a paradigm in the region. Some 10.6% of its population is over the age of 65, compared with an average of 8% in South America, and it will rise to 17.6% in 2030. It will have the most aged population in the continent, with levels similar to those of the United States and those seen today in the United Kingdom.

The specialised bibliography includes abundant information about the different LTCP models implemented today in the rich countries and many comparisons between them. Several trends can be discerned by studying this information. One of the most important is that the reforms and the new models of long-term care encourage ageing in the home. They therefore favour home-based care services (HBCS) over residential care, with only the most serious cases entering nursing homes (Alders et al 2015; Carrera et al 2013).

HBCS have therefore been expanding constantly over the last decade (OECD 2013). The incentives are bilateral. Dependent adults express their preference for living in their homes as long as possible and the administrations reduce costs, since HBCS are cheaper than nursing homes.

The purpose of this paper is to assess the pioneering home-based care model implemented by Chile in 2013 with respect to international experience. To this end, the Director of the National Service for Older Persons (SENAMA) answered an ad-hoc questionnaire of 15 questions.

The information requested included a description of the model and management, funding and results in 2014. This information was complemented by further information publicly available online.

#### Home-based care model

The model is a pilot programme, which offers home care services to elderly dependent adults, and provide a minimum of one visit per week, of two hours' duration, to the beneficiaries.

It is run by the central government through the SENAMA. Administration sign contract with public and private not-for-profit organisations (executors) to offer services.

In 2014, the programme was funded through two budgetary items. One was for the training of carers and the other was for the operational costs of care for dependent persons. In total, this annual budget came to \$630,000. The funding of the executors was by means of a pay-per-beneficiary scheme of between \$21.90 and \$36.60 per month. Out-of-pocket payments were not contemplated.

The executors were responsible for the selection of personnel, who had completed their basic education.

#### Targeted beneficiaries. Social conditions tested

Beneficiaries were required to meet three criteria: to be 60 years old or more, to belong to the 30% of households facing the greatest social vulnerability and to have moderate or severe dependency.

Social vulnerability was evaluated using a survey which has existed since 2007 and which was completed by applicants for social benefits in each municipality (local government). The survey included questions regarding family composition, housing and income. Local

administrations assessed the responses to obtain a numerical indicator and issue certificates of the condition of the families.

The level of dependency was evaluated using Mini Mental State Examination test, the Pfeffer Test and the evaluation of the activities of daily living. These tests could be run by the local health services or by the executors themselves.

## Results

In 2014, the programme was run in 17 of the 346 communes in the country, of which 11 were to be found in the Metropolitan Region of Santiago. A little under half of the executors were municipalities and the rest were private not-for-profit organisations, mainly NGOs and religious agencies.

In total, 1,761 dependent persons benefited from the programme, of whom 98.6% were 65 years old or more. 182 carers took part in the training. Not all of the carers who provided care received training. Some of the carers were voluntary personnel who were paid a small stipend.

## Discussion

The implementation of HBCS moves in the same direction as international evidence. They make it possible to prolong family life of dependent elderly persons and, at the same time, reduce pressure on public budgets.

However, there are three aspects of the programme that require further analysis. Firstly, the available funding. In the model analysed, pay-per-beneficiary only covered 9.7% of the average estimated cost of formal HBCS, calculated at \$3,603 per capita per annum (Matus-López & Cid, 2014).

This creates financial pressure on local administrations, obliging them to redistribute their budget from other items to cover the cost. If the executors are NGOs or religious agencies, this additional budget does not usually exist. For this reason, they resort to unpaid voluntary personnel who receive a small stipend.

In this context of low cost, the requirement for primary education appears insufficient to ensure the quality of long-term care. International evidence has highlighted the importance of attracting and retaining trained personnel and to do so it is necessary to create the appropriate working and economic conditions, which this funding does not cover.

A second point for discussion is the appropriateness of the means test. The families who complete the social protection form are already among the poorest. And so, the programme targets the poorest 60% of the poor. In contrast, international evidence recommends universal policies rather than means tests and uses the income to adjust co-payments, but not to exclude beneficiaries. The reason is that the cost of long-term care is extremely high and it is not only the poorest that are unable to cover such costs.

Thirdly, even though it is a pilot programme, the number of beneficiaries is low, covering less than 0.6% of the estimated 293,472 moderately and severely dependent persons in the country (González, Massad & Lavanderos, 2012). It is not just a problem of the size of the program, but the criterion of voluntarism that leads it. If a region does not have institutions interested, the service is not offered in that region. Local administrations are not responsible for the problem. Devolution and decentralization are issues that international evidence highlights in the success or failure of LTCP (Costa-Font, 2010). This also affects socio-health coordination. Certification of dependency remains in the hands of the executors, often NGOs and religious agencies, and this could cause agency problems and disconnect the programme from the local health services.

In summary, efforts are being made in developing countries to construct an LTC model to address the imminent ageing of their populations. Chile has driven forward HBCS in a low-coverage pilot model. The results appear positive, although their extrapolation to a national system requires more accurate evaluation of the financial costs, the appropriateness of income as a barrier to access and the possible devolution problems.

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