

Age ^o with Care

— Long-term Care in
Latin America and the Caribbean

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The IDB is committed to the effective and real inclusion of people with disabilities. In pursuit of a paradigm shift to understand and be understood by this group, we have worked to make this the first IDB publication that is interactive and accessible to as many people as possible.

To correctly view this interactive document, we recommend downloading it and using Adobe Acrobat Reader.

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CONTENTS

1. Why is long-term care an issue that cannot wait? 5

- 1.1. Living longer than ever 7
- 1.2. More people with chronic conditions 9
- 1.3. Assistance from family members is no longer enough 11

2. How do countries design a long-term care system? 16

- 2.1. Who to provide long-term care services to 17
- 2.2. Which services to provide 18
- 2.3. How to finance long-term care services 21
- 2.4. How to ensure quality care 24

3. What are the countries in the region doing? 28

- 3.1. Uruguay 30
- 3.2. Chile 31
- 3.3. Argentina 33

4. How much would a long-term care system cost? 35

5. Where should we start? 41

- 5.1. Choose beneficiaries based on level of care dependence rather than age 43
- 5.2. Deliver transfers that have to be spent on long-term care services 44
- 5.3. Start with home care services 46
- 5.4. Involve the private sector to create formal jobs 47
- 5.5. Train human resources and establish quality standards 48
- 5.6. Use a mix of financing mechanisms to set up a single, unified system 49

Notes 52

References 53

Today

In Latin America and
the Caribbean

By 2050

8 million

older adults
are

care-dependent



Estimates

for older adult
who are

care-dependent



This represents

12%

of people aged
over 60 in
the region

Rise to over

27

million



1.

Why is long-term care an issue that cannot wait?

In Latin America and the Caribbean (LAC), more than 8 million older people are unable to independently perform at least one basic activity of daily living (ADL), such as bathing or showering, eating, using the toilet, dressing, moving around a room, or getting in and out of bed. This situation is called care dependence, and in this region, it affects 12% of people over age 60 and almost 27% of people over age 80 (Aranco et al., 2018).

People are considered care dependent when, for an extended period of time, they cannot perform activities necessary for daily life¹ without help from others (World Health Organization [WHO], 2015a). According to the WHO, long-term care services are the activities performed by others so that care-dependent people can maintain a level of func-

tional ability compatible with their basic rights, fundamental freedoms, and human dignity (WHO, 2015a).

In the next 30 years, **long-term care for older people will become an increasingly pressing concern for LAC countries.** The population of LAC is aging rapidly and the region is far along in the epidemiological transition, so it can expect a sharp rise in the number of care-dependent older people and a consequent increase in the demand for long-term care services. Estimates show that by 2050 more than 27 million people over age 60 will be in need of long-term care. Additionally, the region's supply of informal care, typically provided by women within the family, is dropping abruptly due to smaller average family size and higher female labor force participation rates. Given this outlook, it is crucial for LAC societies and governments to prepare for future challenges.

Offering long-term care services is not just a matter of responding to growing supply and demand pressures. There are three key reasons to include this issue on government agendas. First, long-term care is essential to protecting older people's quality of life. Second, long-term care is a gender issue: women are more likely to need long-term care than men; also, developing these services gives female family caregivers more time and allows for the creation of formal job opportunities that primarily benefit women. Third, long-term care services

can bring down healthcare costs by reducing reliance on emergency and hospital services. All these reasons make long-term care an issue that cannot wait.

This publication provides key information for any country that wants to design a long-term care system, as well as specific recommendations for implementing it. **Let's begin!**

Would you like to learn more about the
concept of care dependence and the difference
between care dependence and disability?
Take a look at this video!



Video 1. Care dependence and disability

To provide quality care, a first step is to know the difference between care dependence and disability.



“ **Care dependence** and **disability**
are two different things. ”

Juan Pablo, inclusion specialist.

1.1. Living longer than ever

LAC is aging at an unprecedented rate. While the percentage of its population over age 60 (11%) is still significantly lower than that of Europe, North America, and East Asia (24%, 21%, and 17%, respectively), it is aging at a quicker rate (Aranco et al., 2018). According to United Nations estimates, 17% of Latin Americans will be older than 60 by 2030. This percentage is on track to swell to 25% by 2050. In other words, **in only 30 years, one in four people living in LAC will be over 60.** To put this statistic into perspective, it took around 65 years for a similar shift to occur in Europe, and 75 years in North America.

This aging process will impact the entire region, but not uniformly as there are major differences between countries. It will be very pronounced in the Bahamas, Barbados, Brazil, Chile, Colombia, Costa Rica, Jamaica, Trinidad and Tobago, and Uruguay. In those countries, people over 60 will make up around 30% of the population by 2050, comparable to the current level of aging in Germany, Finland, and even Japan. In contrast, Belize, Bolivia, Guatemala, Guyana, and Haiti will have a markedly lower proportion of older adults, at around 15%. This figure is similar to the current situation in China. Figure 1 shows the aging trends in LAC countries over the next 30 years.

Estimates for 2050 predict not only a higher share of older people in the population, but also a more protracted old age. People over 80,

Figure 1. Percent of the population over age 60 and over age 80 in 2015, 2030, and 2050



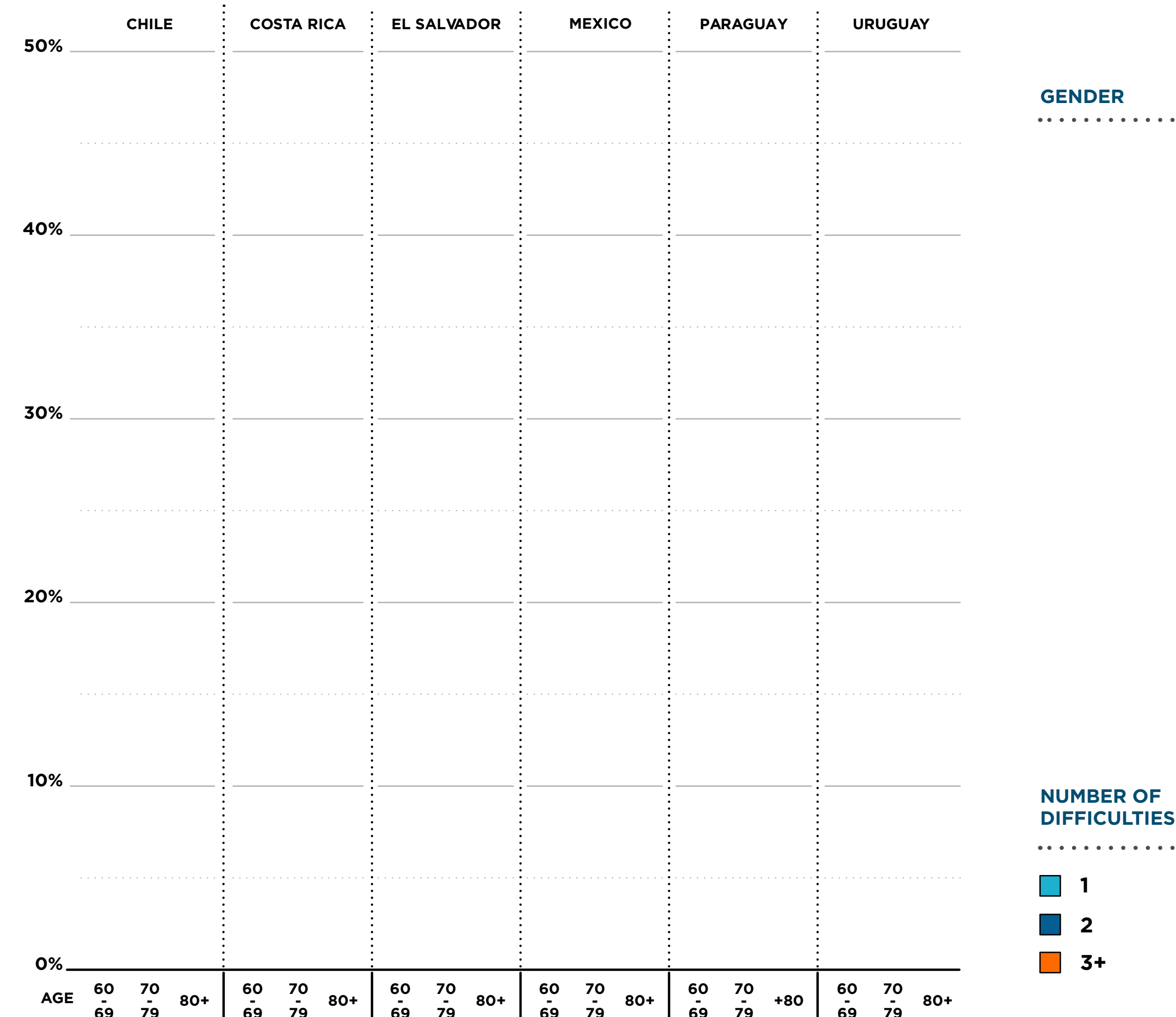
Note: The source is based on data from the United Nations, Department of Economic and Social Affairs, Populations Division, 2017. Adapted from *Panorama of Aging and Long-term Care*, by the Inter-American Development Bank, 2019 (<https://www.iadb.org/en/panorama/panorama-aging>). Copyright 2019 by the Inter-American Development Bank.

who currently represent 14.5% of the elderly in LAC, will make up an estimated 22% of the same group by 2050.

Aging is directly linked to care dependence, since **care dependence is more common among older people than in the rest of the population**. As shown in Figure 2, the proportion of people who have difficulty performing basic ADL rises with age, especially after age 80. This trend holds true for both men and women, although care dependence is more prevalent among women in all age brackets. This gender disparity is consistent with the fact that women—though longer-lived than men due to biological (Austad, 2006), social, and behavioral factors (Assari, 2017)—spend more years in poor health, since they are more prone to highly debilitating but nonfatal health conditions (Luy and Minagawa 2014).

In addition, both the number of care-dependent people and the intensity of care dependence—measured as the number of basic ADL a person needs help with—increase with age. Again, there are disparities between the LAC countries with available data. More specifically, Costa Rica, Chile, and Mexico show a high percentage of care-dependent older people, while the proportion is particularly low in Uruguay.

Figure 2. Prevalence and intensity of care dependence. Percentage of the population by age and gender

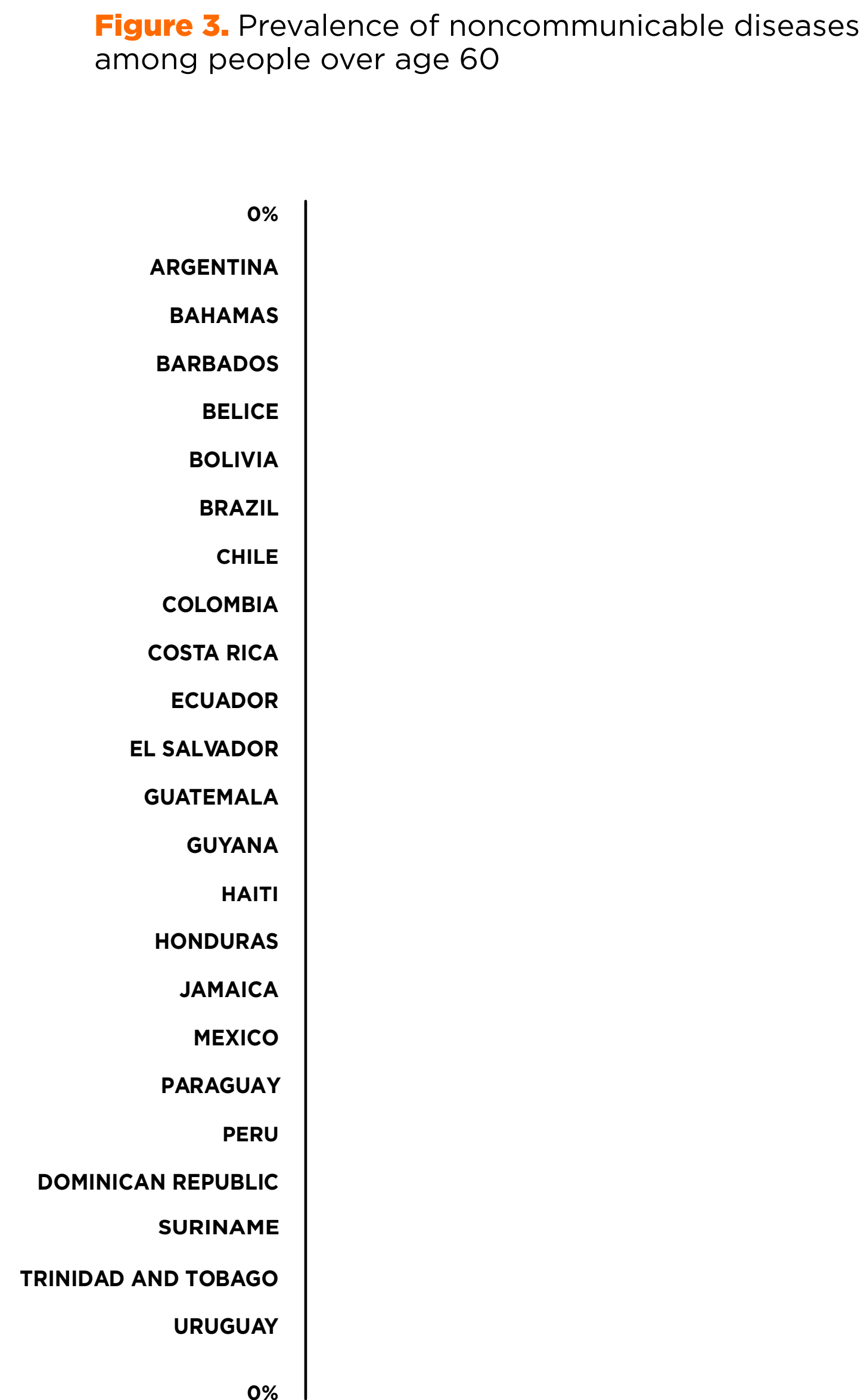


Note: The source draws on the following databases: the Longitudinal Social Protection Survey from Chile (Ministerio de Trabajo y Previsión Social, 2015), Paraguay (Secretaría Técnica de Planificación, 2015), El Salvador (Sistema de Protección Social Universal, 2013), and Uruguay (Banco de Previsión Social, 2013), as well as the Longevity and Healthy Aging Study from Costa Rica (Centro Centroamericano de la Población de la Universidad de Costa Rica e Instituto de Investigaciones en Salud, 2009); and the Health and Aging Study from Mexico (Instituto Nacional de Estadística y Geografía, 2015). For the purposes of comparison, it should be noted that five basic ADL were used in Mexico, while only four were used in the other countries. This made it more likely for survey participants to select at least one basic ADL from the list of options in Mexico. The study in Costa Rica covers people over age 62. Adapted from *Panorama de envejecimiento y dependencia en América Latina y el Caribe* (p. 24), de N. Aranco et al., 2018 (<https://publications.iadb.org/en/panorama-de-envejecimiento-y-dependencia-en-america-latina-y-el-caribe>). Copyright 2018 by the Inter-American Development Bank.

1.2. More people with chronic conditions

LAC is at an advanced stage of the epidemiological transition process. As the population ages, chronic conditions increasingly become the main causes of death and morbidity. From a biological perspective, people’s physical and mental capacities gradually diminish as they age, resulting in increased risk of chronic conditions (WHO, 2015b). This is a natural trend, but chronic conditions have also become more prevalent even within the same age group,² possibly due to changes in diet, pollution, and unhealthy lifestyles (Gakidou et al., 2017). The main cause of death and morbidity in older people in LAC is cardiovascular disease, which accounts for 25% of the total burden of disease among those over age 60 (Aranco et al., 2018). Again, there are notable differences between countries, as shown in Figure 3.

What do chronic conditions have to do with care dependence? **Care dependence is more prevalent among people with chronic conditions.** In Mexico, for example, two chronic conditions—diabetes and arthritis—are among the main determinants of whether an older person will be care dependent in the future (González-González et al., 2019). In Chile, 94.6% of older people with no chronic conditions feel they can perform all basic ADL independently. This figure drops to 80.9% for people with three or more chronic conditions. It is important to emphasize that chronic conditions cannot be equated with care dependence. In fact, only 12.5% of Chileans over age 60 with at least one chronic condition are care dependent (Aranco et al., 2018).



Note: The source uses data from the Global Burden of Disease (GBD) Results Tool of the Institute for Health Metrics and Evaluation, 2017. Adapted from *Panorama of Aging and Long-term Care*, by the Inter-American Development Bank, 2019 (<https://www.iadb.org/en/panorama/panorama-aging>). Copyright 2019 by the Inter-American Development Bank.

In short, both population aging and the epidemiological transition towards chronic conditions will lead to a rise in the number of care-dependent older people in upcoming years. Using the United Nations' population projections by age structure (2017), and assuming that the prevalence of chronic conditions and care dependence rates for each age remain unchanged, **the number of older people dependent on long-term care in LAC will more than triple by 2050, exceeding 27 million.** This figure will represent more than 3% of the population of this region and around 14% of people over age 60. If the prevalence of chronic conditions continues to grow and care dependence rates increase by 20% among older adults, by 2050 up to 17% of people over age 60 in LAC could need long-term care services.

1.3. Assistance from family members is no longer enough

The rising demand for long-term care services takes place in a context of limited supply. In 2015 in Mexico, for example, around one in four severely care-dependent older people received no type of care at all (González-González et al., 2019).

The main source of long-term care services in LAC has traditionally been informal assistance, which refers to the unpaid care that family members, primarily women, provide to care-dependent older people. But transformations in the structure of LAC families in recent decades **have eroded families' ability to directly look after their care-dependent kin.** Two transformations are especially relevant: smaller household size and women's growing labor force participation (Aguirre, 2011).

Shrinking family sizes are linked to the drop in fertility rates, the rise in divorces, and migration trends, among other factors. As a result, many older people lack a close family network that can help them carry out their daily activities. As Figure 4 shows, a significant percentage of people over age 80 in the region live alone—more than 25% in Argentina, Uruguay, the Bahamas, Jamaica, and Barbados.

Additionally, women's labor force participation in LAC jumped from 20% in the 1960s to 65% today (Marchionni et al., 2019). This undeniable progress towards closing the workplace gender gap is coupled

Figure 4. Percentage of older people who live alone



Note: The source is based on data from the Harmonized Household Surveys from Latin America and the Caribbean of the Inter-American Development Bank, 2015. The data is current as of 2017, with the exception of the information for the Bahamas (2014), Barbados (2016), Haiti (2012), Jamaica (2014), Nicaragua (2014), Mexico (2014), and Trinidad and Tobago (2014). Adapted from *Panorama of Aging and Long-term Care*, by the Inter-American Development Bank, 2019 (<https://www.iadb.org/en/panorama/panorama-aging>). Copyright 2019 by the Inter-American Development Bank.

with social and cultural shifts that are transforming the role of women within the household. The LAC region is gradually shedding the collective belief that women are the sole caregivers. But this progress has not been matched with a rise in the number of men who provide care. In the Americas, women still put in around 63% of the time spent daily on unpaid care work (Addati et al., 2018).

However, the limited availability of formal long-term care services continues to affect women's labor force participation in the region. Creating long-term care services could help more women be included in the labor market by freeing up time for female family caregivers. It could also create formal job opportunities for women as professional care providers. For this reason, together with the fact that more women need long-term care than men, **long-term care is a gender issue.**

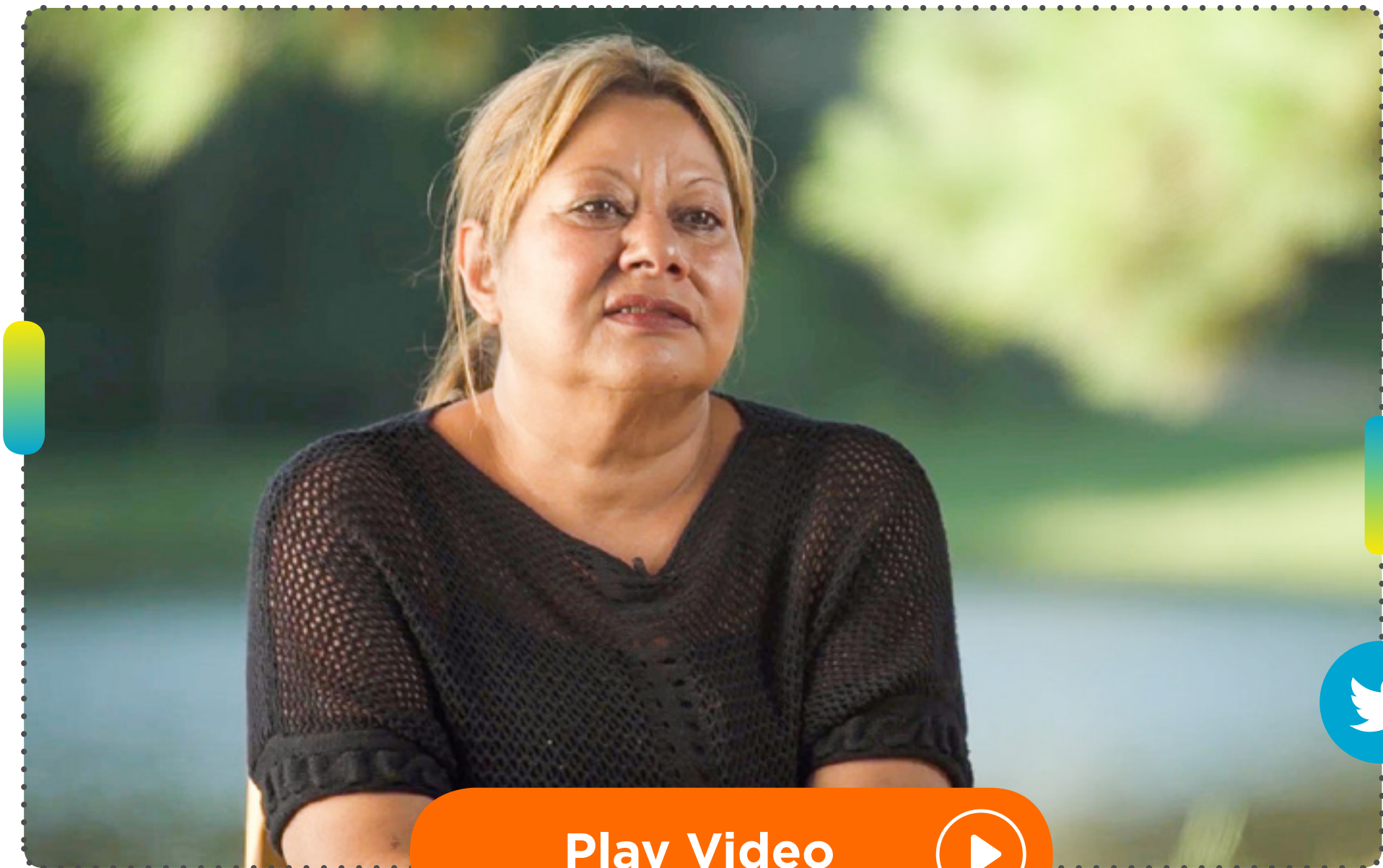
Do you know how families benefit
from long-term care?

Learn more in this video.



Video 2. Assistance from family members is no longer enough

Long-term care services help increase the well-being of families that take care of their older members.



“ I basically **never left the house.**
I couldn't leave my parents alone,
not even for a minute. ”

Delia, who takes care of her elderly parents.

In upcoming years LAC will thus face a scenario where demand for long-term care for older people will more than triple, while supply services, based primarily on informal care by women, will dwindle. LAC countries should ready themselves to meet these challenges. Informal care needs to be complemented with national long-term care systems.

And this needs to be done now.

To provide up-to-date information on the long-term care needs of older people in LAC, the Inter-American Development Bank (IDB) created the [Panorama of Aging and Long-Term Care](#) (See Box 1 for more details). In addition to the information and tools explained in Box 1, the Panorama has a [calculator](#) people can use to compute how likely they are to be care dependent in the future. To make the calculation, users just have to answer a few basic questions—about their age and current health status, for example. The calculator is based on a statistical model developed using data from the Mexican Health and Aging Study.

Box 1. The Panorama of Aging and Long-Term Care

The current context and future outlook for aging in Latin America and the Caribbean make long-term care for older people a pressing matter. The IDB created the [Panorama of Aging and Long-Term Care](#) to provide information on health conditions and current and future needs for care services for older people in order to encourage evidence-based policymaking. We aim to help the region's governments prepare to tackle the challenges of aging by creating and/or strengthening the supply of long-term care services.

Explore Panorama:

- **Want to read more about this issue?**

Have a look at the [Publications](#) section.

- **Did you know that 11.6% of people over age 62 in Costa Rica have trouble performing basic activities of daily living?**

In the [Indicators](#) section, you can find current information regarding care dependence and multiple related issues in the region's countries. We provide interactive materials that we periodically update. You will find indicators on care dependence, aging, health conditions, risk factors, disability, and socioeconomic characteristics. Additionally, all data associated with Panorama indicators can be downloaded.

- **Did you know that Uruguay has an Integrated National Care System?**

Learn more in the [Case Studies](#) section, which gives a country-by-country analysis of care dependence and long-term care services. The same structure is used to analyze each country so that information is easily comparable. The case studies contain information on the aging process, the epidemiological profile for older people, and the state of care dependence. They also describe the State's role in long-term care, how the supply of care services is structured, and the prospects for long-term care (Aranco & Sorio, 2019; López-Ortega & Aranco, 2019; Flórez, Martínez, & Aranco, 2019; Medellín, Jara, & Matus, 2019; Molina et al., in press).

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Go to the [Featured Topics](#) section. This section gives summaries of the different issues analyzed in our publications.

- **Where do I find more information on these issues?**

The [Related Resources](#) section includes a list of databases, websites, and external publications related to the Panorama.

- **Want to hear our news?**

Explore the [Panorama in the Media](#) section, where we post articles written by members of our team and published by the media. Or read through the [Gente Saludable Blog](#) entries on aging and care dependence.



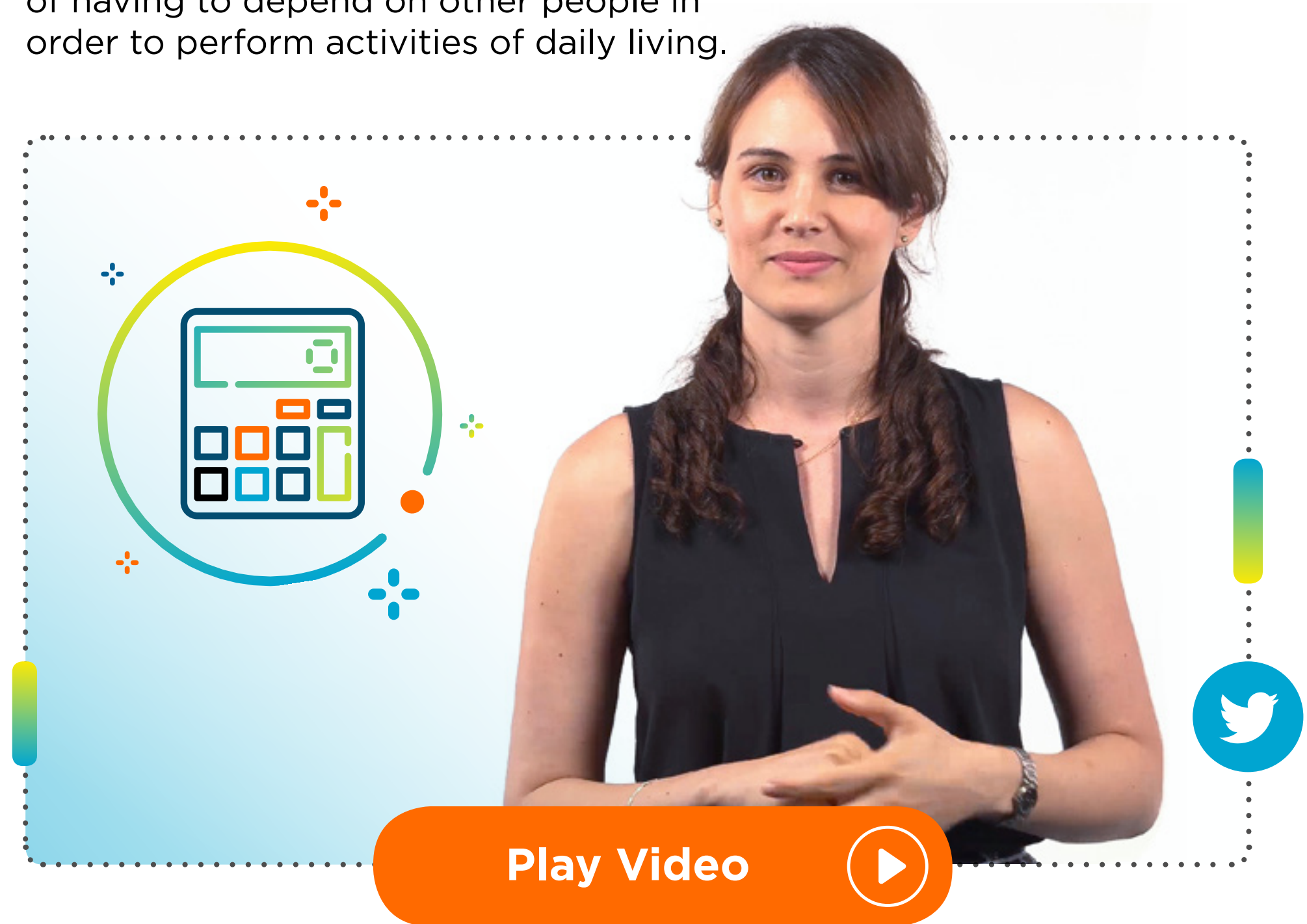
If you want to know more about
the care dependence calculator,
watch the following video.



Video 3.

Care dependence calculator

With a few simple pieces of information, this
tool can be used to calculate the likelihood
of having to depend on other people in
order to perform activities of daily living.



**“ You yourself probably have no idea
whether you will need long-term
care services in the future. ”**

María Laura, specialist in the field of social protection.

2.

How do countries design a long-term care system?

Governments in LAC face the challenge of devising public policies that give a growing number of older people access to long-term care services. Designing a long-term care system is a comprehensive solution to this challenge.³ To understand how to design such a system, it is helpful to analyze the experience of countries that are further along in the demographic transition. This analysis yields four elements that any country aiming to design a long-term care system needs to address:

1. **who** to provide care services to;
2. **which services** to provide;
3. **how to finance** the long-term care services; and
4. how to ensure **quality** care.



2.1. Who to provide long-term care services to

The first step in designing a long-term care system is to define its beneficiaries, or target population. **The most common eligibility criterion is level of care dependence.** Countries have used different tools to measure level of care dependence. Most of these tools are based on questionnaires about people's ability to perform basic and instrumental ADL on their own. In some cases, they cover cognitive capacities as well. ⁴ Usually the information collected in the questionnaires is used to generate a score that indicates whether or not a person is care dependent and their level of care dependence. Examples of this type of tool include the Katz index, the scale (*baremo de valoración*) used to assess care dependence in Spain, and the *Autonomie Gérontologique Groupes Iso-Ressource* (AGGIR) scale used by the French system. ⁵

Age is another eligibility criterion. In France, for example, only people over age 60 qualify for the personalized independence allowance (*allocation personnalisée d'autonomie*), a cash transfer for purchasing care services. Until April 2019 in Scotland, only people over 65 could receive free personal and nursing care.

Income and other socioeconomic status indicators are not usually used as an eligibility criterion. That is, if older people are considered to be in need of long-term care services, they will receive them regardless of their income, capital assets, or marital status. A

notable exception is the United States, where long-term care services are funded through a public program (Medicaid) that is exclusively for low-income people (Medellín et al., 2018).

However, many countries do use income or wealth to decide how much of the benefits will be covered by the system, as well as the recipients' copayment percentages. In France, for example, a sliding, income-based scale is used to calculate transfers; people with higher incomes receive only 10% of the maximum benefit possible for their level of care dependence.

2.2. Which services to provide

Another key element of the design of a long-term care system is the range of services offered. **The services provided by long-term care systems can be grouped into five categories:** services in residential care settings, home care services, day center services, telecare services, and services for caregivers. The services offered by most countries fall into a combination of these categories. Table 1 gives a description of each category of service.

When designing a long-term care system, it is essential to recognize that **different types of services are better suited to different contexts and levels of care dependence.** For example, services in a residential care setting are especially recommended for severely care-dependent older people, especially if they need constant medical attention and have limited family support. In contrast, day center and telecare services are usually used for older people who are mildly care dependent and to supplement other forms of service, since on their own they do not solve the need for help performing basic ADL. With this in mind, each country should assess its population’s care dependence profile and how it is predicted to evolve before defining the mix of services to be offered by the long-term care system.

Table 1. Service categories

SERVICE CATEGORY	DESCRIPTION
Services in residential care settings	Services provided in facilities that include housing. Residential care settings offer a comprehensive package of services to help people perform basic and instrumental activities of daily living. They also provide more complex healthcare services in most cases. For that reason, residential care settings are geared towards severely care-dependent people.
Home care services	Services provided in a person’s place of residence. The backbone of this category of services are personal care assistants, who help older people perform basic and instrumental activities. Housework help and food delivery services can also be included in this category. These services are intended for people who are severely, moderately or mildly care dependent.
Services at day centers	Services offered at facilities that do not include housing. Day centers usually focus on preventive and recreational activities rather than on helping people perform activities of daily living. They are thus often used in tandem with home care services. They are designed for people with little or no care dependence.

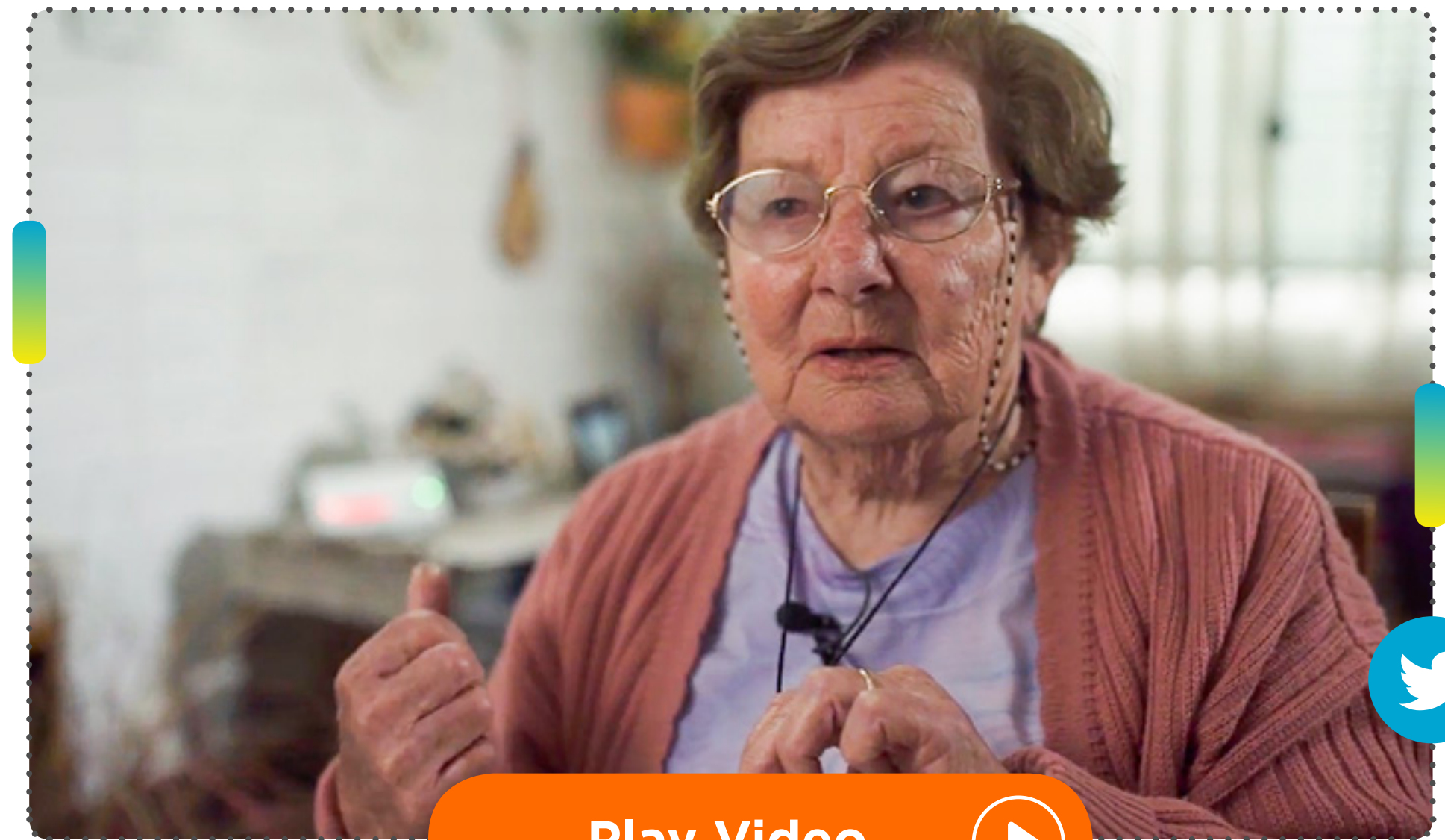
Table 1 Continued. Service categories

SERVICE CATEGORY	DESCRIPTION
<p>Telecare services ⁶</p>	<p>Remote services that use information technology. Telecare services are designed to continuously monitor a person and provide an immediate response in an emergency. Examples are emergency hotlines; personal alarms; medication dispensers; motion sensors; panic buttons; fall detectors; and temperature, smoke, and water leak detectors. Since telecare services do not solve the need for assistance for basic activities of daily living, they are usually considered a complement to home care services. They are generally meant for people who are moderately or mildly care-dependent and/or have chronic conditions.</p>
<p>Services for caregivers</p>	<p>Services designed to support unpaid caregivers (usually family members), aiming to enhance their performance and lighten their workload. These caregivers are often stressed and isolated, fail to attend to their own health, and have a hard time keeping up with their studies or work. Services for caregivers include training, advice, and respite services (where someone temporarily takes over for them so they can rest).</p>

Note: Adapted from *Cuatro elementos para diseñar un sistema de cuidados* (p. 14), by N. Medellín et al., 2018 (<https://publications.iadb.org/es/cuatro-elementos-para-disenar-un-sistema-de-cuidados>). Copyright 2018 by the Inter-American Development Bank.

Video 4. Telecare as a long-term care service

Some new technologies help older adults to live independently in their own homes for longer.



“ If I press here, **they can hear me.**
If anything happens to me
they help me. ”
Angélica, age 91.

Another aspect that could influence the combination of services offered by the system is the government's approach towards unpaid services provided by family members. Spain not only recognizes the services provided by family members, it also compensates the caregivers with cash transfers from the system. In Uruguay, on the other hand, family members are not allowed to provide services paid for by the system, which must be performed by a trained assistant. France lies somewhere between these two positions. Its rules allow family members (with the exception of spouses or partners) to provide care services as long as they have training (Medellín et al., 2018).

Long-term care can be provided in-kind, through conditional cash transfers that can only be used to purchase care services, or through unconditional cash transfers. In the first method, beneficiaries receive services from the public sector or private providers compensated by the State. In the second scenario, beneficiaries receive transfers that can only be spent on long-term care services. Under the third arrangement, beneficiaries can use the cash as they see fit. There are pros and cons to all of these alternatives. In-kind care and conditional cash transfers ensure quality control and avoid perpetuating the traditional role of women as caregivers within families (Campbell, Ikegami and Gibson, 2010). On the other hand, unconditional cash transfers are attractive because of their flexibility. They allow beneficiaries to manage resources according to their specific needs, including paying

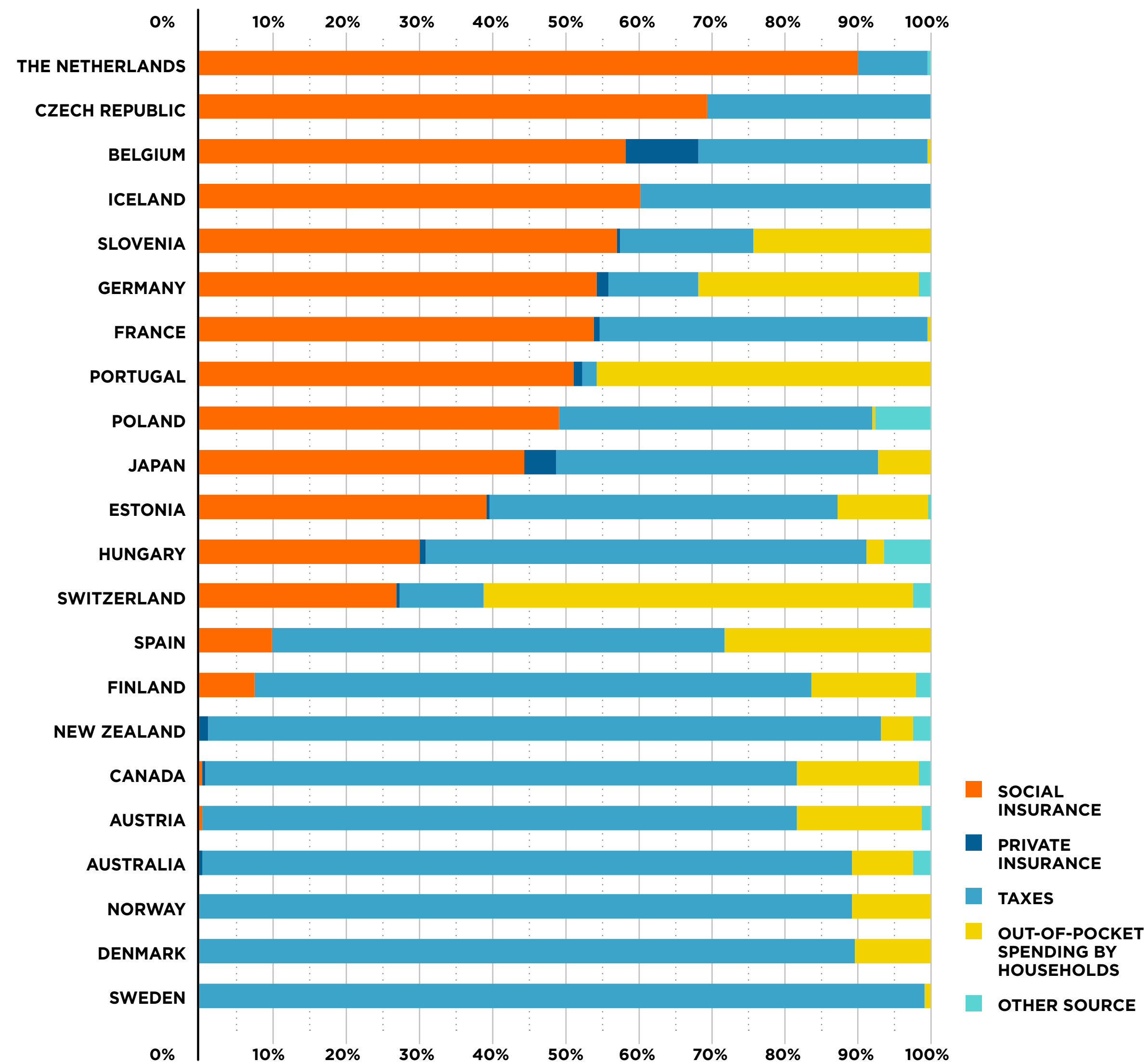
members of the household for their caregiving work. They also lower the system's administrative costs.⁷ However, they provide no guarantee that beneficiaries will receive care services. Most countries offer both in-kind services and cash transfers, whether conditional or not (Spasova et al., 2018). Japan and South Korea offer mainly in-kind services, while France and Scotland use a system based on conditional cash transfers.

2.3. How to finance long-term care services

Countries that want to design a long-term care system generally choose between funding models based primarily on either social insurance or general taxation. Although these models use mandatory contributions or general tax revenues, respectively, as their main source of funds, they can also include complementary mechanisms like private insurance and out-of-pocket payments by households (Figure 5).⁸

Under a social insurance funding model, people make mandatory contributions, generally through payroll taxes. For salaried employees, the contribution is usually split between the employee and the employer. This money goes into a fund allocated exclusively for long-term care, and only care-dependent people receive benefits. Normally countries that use this model, like Germany, South Korea, and the Netherlands, also fund their healthcare systems primarily through contributions (Organization for Economic Cooperation and Development and the European Union, 2013). This method is usually supplemented with general taxation to finance services provided to people who have not contributed to the system. Germany is an example of a country that chose a social insurance funding model. In the mid-90s, Germany introduced a payroll tax to finance a social insurance plan for long-term care. The tax rate has gradually increased from 1% at the outset to 2.55% today. Since 2004, pensioners are also required to make contributions, and people with no children have to contribute a

Figure 5. Funding mechanisms for long-term care services



Note: The source is based on data from Costa-Font, Courbage, & Swartz, 2015. Adapted from *Cuatro elementos para diseñar un sistema de cuidados* (p. 23), de N. Medellín et al., 2018 (<https://publications.iadb.org/es/cuatro-elementos-para-diseñar-un-sistema-de-cuidados>). Copyright 2018 by the Inter-American Development Bank.

higher percentage of their salary (2.85%) (Colombo et al. 2011, Federal Ministry of Health, 2017). In the case of South Korea, people were initially required to contribute 0.21% of their salary in 2008, which has increased to 0.55% in 2019 (National Health Insurance Service, 2019).

A funding model based on general taxation does not require a specific fund for paying for long-term care. The tax base is broader than that of the social insurance model, as it is not restricted to salaries and the entire population contributes. But not having a specific fund can mean the resources available to the long-term care system are less predictable or are vulnerable to changes in government criteria. The Nordic countries (Norway, Sweden, Denmark, and Finland) are classic examples of financing based on general taxation (Figure 5).

There are pros and cons to each funding model (social insurance or general taxation), and these should also be weighed from the perspective of the LAC region (Table 2). For example, high rates of informal labor can limit the implementation of a social insurance model. ⁹

To increase the amount of resources available, most systems rely on out-of-pocket payments from care-dependent people and their families as a supplemental funding mechanism. One strategy is to make beneficiaries pay in proportion to their resources and household income. In France, for example, people who receive the personalized

independence allowance (*allocation personnalisée d'autonomie*) for hiring home care services have to pay a percentage of the total cost of their care plan unless they earn less than €811 per month. This percentage can be as much as 90% of the plan for those who earn over €2,987 per month (Service-public, n.d.). Other systems establish copayments for all beneficiaries. South Korea, for example, requires beneficiaries to cover 20% of the cost of residential care and 15% of the cost of home care, unless they are living in poverty (Caruso Bloeck, Galiani and Ibarrarán, in press; National Health Insurance Service, 2019).

Table 2. Pros and cons of the two main funding models

	SOCIAL INSURANCE	GENERAL TAXATION
Pros	<ul style="list-style-type: none"> • Difficult to evade because it is based on mandatory contributions. • Predictable resources since there is a specific fund. • Connection between contributions and benefits. 	<ul style="list-style-type: none"> • Broader tax base, including capital gains and indirect taxation, and everybody contributes. • Access to benefits does not depend on employment status. • It can be easily combined with a means-tested approach.
Cons	<ul style="list-style-type: none"> • People without a formal job are not entitled to the social insurance benefits. • Restricted to wage income. • Difficult to modify the benefits. 	<ul style="list-style-type: none"> • Less predictable resources, since there is no specific fund. • Difficulty ensuring resources due to competition with other causes.

Private insurance is another funding mechanism, though it normally represents a very small portion of total expenditure on long-term care. Funding from private insurance accounts for less than 2% of the total in Organisation for Economic Co-operation and Development (OECD) countries, with the exception of Belgium (10%) and Japan (4%) (Costa-Font, Courbage and Swartz, 2015). This can be explained by the difficulty of predicting the risk of long-term care and the cost of that care, which varies immensely based on the severity and duration of a person’s care dependence (Barr, 2010; Caruso Bloeck, Galiani and Ibarrarán, in press). As a result, private insurance is not used as a sole or primary funding mechanism, but is merely supplemental long-term care financing.

Note: Authors’ elaboration based on Joshua, 2017 and Lee, 2019.

2.4. How to ensure quality care

Offering quality care is crucial because quality affects health outcomes, autonomy, and life conditions of care-dependent older people and their families. **Governments** play an important role in promoting, regulating, and supervising quality. **They have a particular impact on two areas:**

1. **training** and other human resource policies; and
2. **regulating** and **monitoring** service quality.

Human resource policies for long-term care include professional training and initiatives that foster an appreciation of care work and promote caregivers' physical and mental health. These policies cultivate better interactions between care-dependent people and their caregivers (whether formal or informal), which is essential for quality service (Malley, Trukeschitz, and Trigg, 2016). In terms of training, governments can outline the content of the programs and the skills caregivers should have, facilitate access to training courses, and oversee licenses and/or certifications. Standards for training methods (theoretical or hands-on) and duration, among other aspects, vary widely between countries (Colombo et al., 2011). Japan is a model of good practice as its laws establish a caregiver certification (*Kaigo Fukushi Shi*). The professional requirements for care workers are periodically reviewed by a national professional association (The Japan Association

of Certified Care Workers, n.d.; Lanfang, Zaaba and Umemoto, 2012). To take the certification exam, candidates must prove they have received in-person training at one of the training centers, or that they have experience at care facilities, or a combination of both. Sweden stands out as a good example of efforts to support family caregivers: the government is required by law to provide information and training, among other support services, to help family caregivers perform their tasks better, manage their caregiving responsibilities, and stay in good physical and mental health (Triantafillou et al., 2010; Nationellt Kompetenscentrum Anhöriga, n.d.). For paid caregivers, an analysis of OECD countries found that improving working conditions, including both pay and other aspects (job formality, caregiver health and safety, professional autonomy, recognition, etc.), helps enhance the quality of care (Colombo and Muir, 2016).

To promote quality care, it is essential to regulate services. This consists of:

1. **establishing quality standards** for providers; and
2. **continuously monitoring** compliance with the standards through inspections and reports, as well as applying penalties (or rewards) to boost compliance.

Governments usually set minimum standards that long-term care providers must meet. Examples include infrastructure specifications, staff ratios, and minimum training requirements. The most common tools used to ensure compliance with minimum standards are licenses and accreditations, which can be made mandatory for providers to operate or receive public funding.

Inspections to monitor compliance with minimum standards are a critical part of ensuring service quality. Almost all countries with long-term care systems conduct periodic quality inspections, most without prior notice (Mor, Leone and Maresso, 2014). In terms of penalties and rewards, the United States and England take the approach of penalizing substandard providers (Mor, Leone and Maresso, 2014). In Japan, an external entity does the inspections, creating a system with both punishments and rewards based on performance (Wiener et al., 2007).

Some countries make quality monitoring and inspection reports public. The Netherlands, for example, has a consumer-facing website that summarizes facilities' quality performance (Triemstra et al., 2010). Likewise, the United States government has a directory where people can compare inspection results and quality of care indicators for residential care settings. These indicators are calculated using a standardized tool for clinically assessing residents (the Minimum Data Set), among

other resources. The aim of these efforts is to give consumers more power to choose and motivate providers to step up their quality.

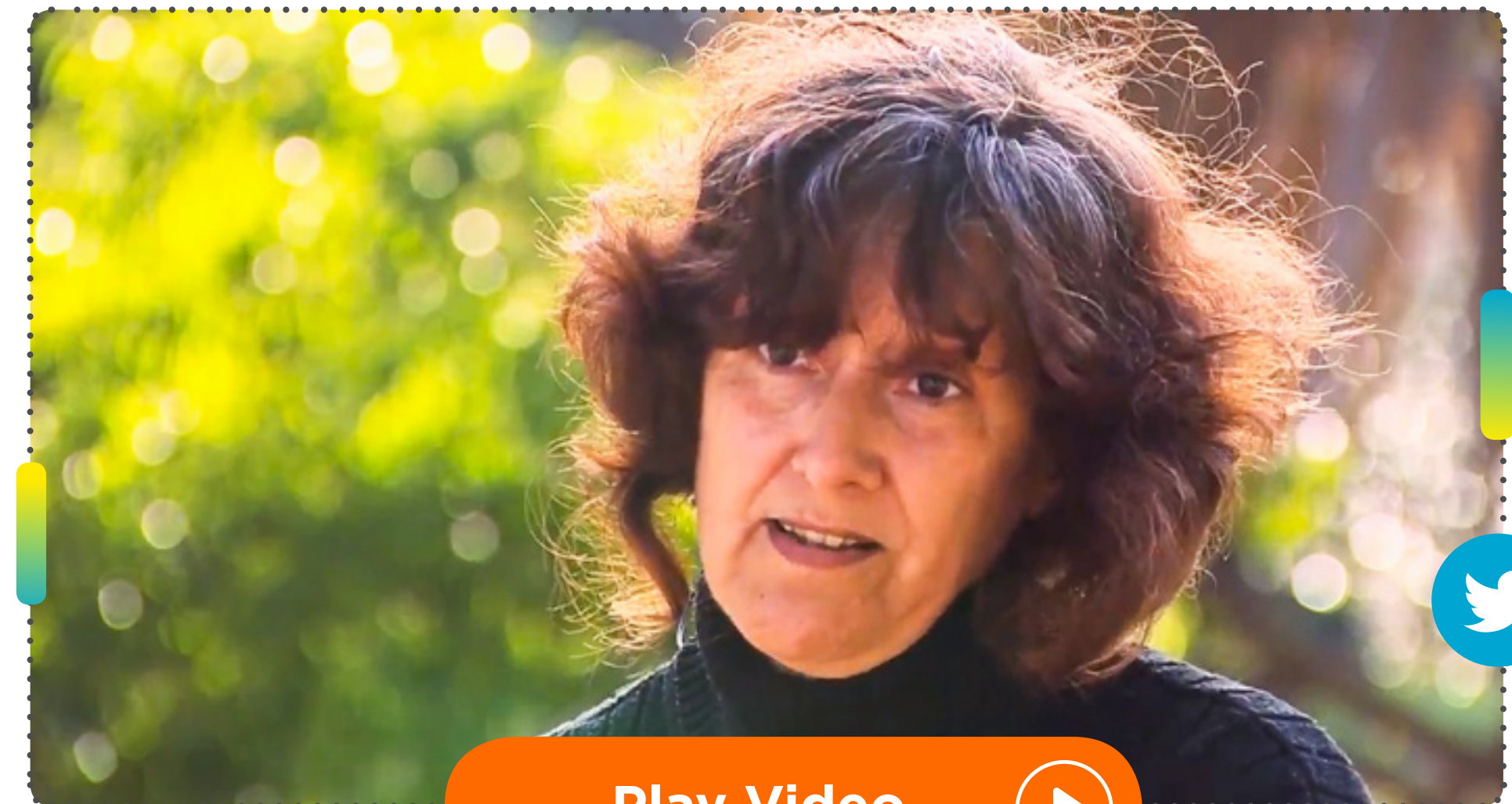
Regulation is more rudimentary for home care than for residential care. Measuring the quality of services provided in the home is more complex, although some strides have been made. The system for monitoring home care in the Basque Country in Spain serves as an interesting model that focuses on making sure that care is effective and appropriate, that work conditions are suitable, and that care is provided safely (Leturia et al., 2015).

Listen to this valuable first-person testimony from Nirley, **a trained caregiver**, in the following video.



Video 5. Training and quality of long-term care services

Ongoing training for caregivers, whether family members or formal workers, improves the quality of long-term care services. Accrediting their knowledge helps professionalize this sector.



Play Video



“ Taking a course **makes you better at your job**, and also **acknowledges the job’s legitimacy.** ”

Nirley, recipient of training on long-term care.

30 years from now

the **demand** for
long-term care services for
older adults will more
than triple



but the **supply** of
family
caregivers
will **decrease**



3.

What are the countries in the region doing?

Most LAC countries are not prepared to deal with a higher demand for long-term care services for older adults. While many countries in the region have specific institutions, laws, and programs for older people, few have designed and implemented a long-term care system. Even countries that do have a long-term care system lack strategies to address the needs of family members, particularly women, who continue to be the main source of care services.

This section **shares information on three LAC countries (Argentina, Chile, and Uruguay) that have taken steps to develop long-term care systems.** In each case study, we identify how the country addressed the four key elements in the design of a system: which services to provide, to whom, how to fund them, and how to promote quality services.



We chose Argentina, Chile, and Uruguay for two reasons. First, their experiences are already advanced enough that they can serve as examples and offer lessons to other countries in the region. Second, each case study has unique elements, thus giving various angles on how to design a long-term care system. Uruguay, for example, is the first country in the region to implement a national long-term care system, the Integrated National Care System. This system is funded chiefly through general taxation (Aranco and Sorio, 2019). Chile also uses taxes to fund its care system, *Chile Cuida*. Though currently *Chile Cuida* only operates in 20 of the country's 346 municipalities, the plan is to gradually expand its scope. *Chile Cuida's* experience thus charts a course for countries interested in instituting a long-term care system on a small scale and later expanding it. Another unique feature of *Chile Cuida* is its role in coordinating the supply of existing long-term care services, which, as in many LAC countries, are provided through a mix of different institutions and programs. Lastly, Argentina's National Institute of Social Services for Retirees and Pensioners (INSSJP), better known as the PAMI, serves as a paradigm of a funding model based on social insurance. The PAMI is also a regional model of integrated health and social services for older people.

Although this section focuses on Uruguay, Chile, and Argentina, other countries in the region (like Brazil, Colombia, and Costa Rica) are developing policies for long-term care for older people, even at the local or municipal level. In Costa Rica, for example, communities can apply for assistance from the central government to set up a network of long-term care services for older people (Progressive Care Network for the Comprehensive Care of Older People). The services can include home care, day centers, and residential care.¹⁰ At a national level, Colombia's efforts are noteworthy. It is currently in the midst of creating the National Long-term Care System (SINACU) to meet the needs for assistance of both care-dependent people and their caregivers (Flórez, Martínez, and Aranco, 2019).



3.1. Uruguay

Uruguay is the first LAC country to set up a national system to provide assistance to care-dependent people. The Integrated National Care System (SNIC) was launched in December 2015.¹¹ In addition to serving care-dependent older people, the SNIC also provides care for children and people with disabilities. Due to budget constraints, the SNIC sets coverage priorities for both the target population and the type of services offered to care-dependent older people. It uses level of care dependence and age as the criteria for defining who qualifies for each care service. Level of care dependence is determined based on a scale measuring how hard it is for people to perform basic and instrumental ADL.

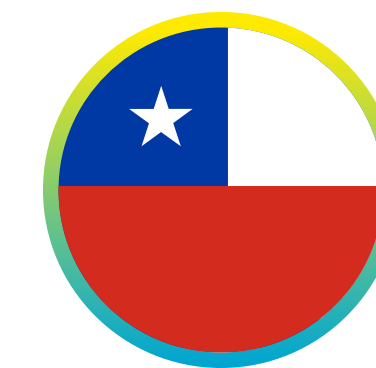
The system offers the following services to older people:

- Personal home care assistants for 80 hours per month for severely care-dependent people over age 80;¹²
- Telecare for people over age 70 who are moderately or mildly care-dependent; and
- Services at free day centers for moderately or mildly care-dependent people over age 65.

In terms of coverage, the latest data shows that 2,079 people over age 80 are receiving personal home care assistance, 1,225 people use the telecare

service, and 117 people access services from seven day centers.¹³ Only 5.9% of care-dependent people over 70 receive any type of service from the system.¹⁴ But the coverage rate jumps to 67% of people over 70 if only those who requested a service from the system are counted.

The system is primarily funded by general tax revenue. This funding is supplemented by copayments from beneficiaries, which are determined based on household income. In the case of day centers, additional funding comes from local governments and civil society organizations. For personal home care assistants and telecare, the State covers part of the cost (100%, 67%, or 33%, based on household income). Beneficiaries or their families cover the rest with a copay. Most beneficiaries have limited means and thus qualify for a high percentage of financial assistance: around 98% of recipients of both personal home care assistance and telecare have a subsidy of 67% or higher (Junta Nacional de Cuidados, 2018). In 2017, the SNIC's total budget (including services for children, care-dependent young people, and care-dependent older people) was US\$26.5 million, or 0.04% of Uruguay's gross domestic product (GDP). Almost 70% of this amount was spent on personal home care assistants (Junta Nacional de Cuidados, 2018). If services in the system were implemented for 60% of the target population, the SNIC's expenditure would equal 0.19% of the GDP, including the cost of services for older people, children, and people with disabilities (Matus-López, 2017).



3.2. Chile

To improve the quality of services, foster appreciation for care work, and increase the sector's professionalism, caregivers are required to undergo training. Additionally, the country set minimum standards for infrastructure, service, and human resources that public or private residential care settings must meet to be granted a license. As of the end of April 2019, 4,291 people were working as personal care assistants, of whom 1,380 had completed the long-term care course.¹⁵

The SNIC has also recently offered residential care facilities the option of applying for loans of up to US\$16,000 to improve the quality of their service by investing in infrastructure, equipment, and furniture, as well as staff training and education.

Toward the end of 2016, Chile created its National Assistance and Long-Term Care System (*Chile Cuida*). The system currently serves 20 of the country's 346 municipalities, with the prospect of gradually expanding to cover the entire nation. *Chile Cuida* has a double role: it provides services to care-dependent people, and it coordinates the supply of existing services in those 20 municipalities.

In the first role, *Chile Cuida* provides personal home care assistance to people who:

- are over age 18;
- are severely or moderately care dependent, according to the Barthel scale; and
- live in a household that is below the 60th percentile for vulnerability according to the Social Registry of Households.

Chile Cuida thus uses three criteria to define who qualifies for its services: age, level of care dependence, and means.

In addition to providing personal care assistants, *Chile Cuida* transfers financial resources to participating municipalities so they can adapt the homes of care-dependent people. Because of its restricted geographical scope, *Chile Cuida* currently provides limited coverage.

Chile Cuida's second role is to enhance coordination of existing long-term care services. *Chile Cuida's* services are not the only ones available; there are pre-existing services like those offered by the National Service for Older People (SENAMA).¹⁶ In the 20 municipalities where *Chile Cuida* operates, the general supply of services includes personal home care assistance, services at day centers, services in residential care settings, and services for caregivers. These services are coordinated by different programs and their application processes are not standardized. In some cases, older people or their family members apply for the services directly, while in others they are referred by the healthcare system. Through each municipality's Local Assistance and Care Network, *Chile Cuida* centralizes referrals for different programs and standardizes the qualification criteria. Referrals are managed in coordination with the Ministry of Health, which sends *Chile Cuida* a list of care-dependent people. Based on this list, a *Chile Cuida* coordinator visits these homes to assess people's needs and make the appropriate referral.

Chile Cuida is funded by general tax revenues. Its yearly budget for 2019 is US\$6.5 million, or 0.002% of Chile's GDP. The limited scale of *Chile Cuida* can explain its low cost.

Chile Cuida has various tools to promote the quality of its services. First, municipalities have to meet minimum management capability and service provision requirements to be selected to participate in the system. Second, the system inspects existing residential care facilities to make sure they meet minimum quality standards. Lastly, *Chile Cuida* municipalities are responsible for training caregivers who provide in-home services and for giving guidance to family members.



3.3. Argentina

In Argentina, the PAMI stands out as a model of integrated health and social services for older people. The PAMI currently covers more than 4.9 million people, or 88% of Argentinians over age 60. The beneficiaries are retirees and pensioners that are part of the national contribution scheme, recipients of non-contributory pensions, and Falkland War veterans and their families.

The PAMI covers both health and social services, including long-term care. Its in-kind services for care-dependent people include services at day clubs/centers and comprehensive services like gerontological nursing care in a residential care setting.¹⁷ Beneficiaries are prioritized by level of care dependence, age, medical status, and socioeconomic status.¹⁸ The PAMI pays service providers, whether public or private, according to the number of enrollees they serve.

Based on the results of a socioeconomic assessment, the PAMI subsidizes home care services and gives cash subsidies for beneficiaries whose basic needs are unmet (not enough food, housing in poor condition, lack of support from family network, etc.). Beneficiaries do not have to report how they spent the subsidies.

For older people not covered by the PAMI system and without financial resources, the National Directorate of Policies for Older People (DINAPAM) of the Ministry of Health and Social Development has

eight residential care facilities that provide comprehensive care. The DINAPAM also grants funds to strengthen community and civil society organizations that provide care to older people.

The services offered by the PAMI are funded through a contributory social insurance system based primarily on statutory deductions from the income of active employees, employers, and retirees (72% of the 2019 budget). The rest of the budget comes from transfers from the national government and from other current receipts. More specifically, employees contribute 3% of their wages to the PAMI's general budget, while employers contribute 2%. Self-employed people contribute 5%, and retirees pay 3% up to the minimum pension benefit, above which they contribute 6%. It is worth noting that no distinction is made regarding which contributions go towards long-term care and which fund the other services PAMI provides. The PAMI's budget for 2019 was 199.688 billion Argentine pesos, or approximately 1% of the GDP (PAMI, 2019). Around 5% of this amount is allocated to long-term care services.

To promote quality services, DINAPAM provides training and refresher courses for caregivers through the In-Home Caregivers Program. It partners with various institutions—like provincial governments, municipalities, universities, or civil society organizations—to provide free in-person training, which is open to anyone over age 18 with a

primary school education. Those who pass the training course receive a national certification and can be listed on the National Registry of In-Home Caregivers. The caregivers in this registry can also take advantage of job placement services that help them find employment. By the end of 2015, there were an estimated 50,000 trained caregivers (Huenchuan, 2016). Additionally, DINAPAN has created [free handbooks for in-home caregivers](#) and a [guide to self-care](#), which are available online. Day centers, when it comes to standards, must complete an accreditation process and, like nursing homes, must have a health permit and meet the requirements of the Superintendence of Health Services. The PAMI carries out compliance inspections.

“ To **prevent falls, avoid blinding glare:** don't look directly at bright lights, like car headlights when crossing the street at night. If you turn a light on in a dark room, don't look directly at it. ”

*Guide to self-care for the health of older people,
Ministry of Social Development of Argentina.*

.....

Some countries have created online handbooks for in-home caregivers and self-care guides, [like this one](#) from Argentina that encourages healthy behaviors and lifestyles for achieving as much independence as possible at this stage of life.

4.

How much would a long-term care system cost?

As the population rapidly ages, LAC governments face the triple challenge of ensuring the sustainability of social security systems, increasing the efficiency of healthcare systems, and creating long-term care systems. It is essential to have information about the cost of the systems in order to meet these challenges. Though there are multiple estimates of the cost of social security and healthcare systems, until recently there was still uncertainty about how much a long-term care system would cost.

The OECD and the European Commission (EC) both systematically track how much their member countries spend on long-term care (Organization for Economic Co-operation and Development [OCDE], 2017; European Commission [EC], 2018). Unlike the cost estimates for



LAC, the figures from these institutions include expenditure on both social services and healthcare services for care-dependent people. The OECD and EC reach similar results. In 2016, **European Union countries spent an average of 1.6%¹⁹ of their GDP, while the 2015 expenditure of OECD countries averaged out to 1.7% of GDP.**

Long-term care expenditure varies widely between countries. In the OECD, for example, Estonia and Hungary spent only 0.2% of their GDP, while the Netherlands spent 3.7%. Despite these differences, expenditure for all OECD countries from 2005 to 2015 rose at an average annual rate of 4.6% (OECD, 2017).²⁰ Projections point to a substantial upturn in spending on long-term care in upcoming years. According to the EC, the average amount spent may jump up by 73% by 2070 (EC, 2018).

In LAC, only four countries have studies on the cost of long-term care services: Chile (Matus-López and Cid, 2014), Costa Rica (Matus-López, 2019), México (González-González et al., 2019) and Uruguay (Matus-López, 2017; Colacce and Manzi, 2017). The studies simulate the potential cost of a long-term care system using different scenarios. For example, **if Uruguay were to implement all services in its system for 60%** of the target population, **it would cost 0.19% of the GDP**. But, as described above, Uruguay currently only spends 0.04% of its GDP since its care system has only been partially implemented. If Chile, Costa Rica, and Mexico were to develop long-term care systems, the cost would be 0.45%, 0.48% and 0.13% of GDP, respectively, according to the basic scenarios of these simulations.²¹ Box 2 gives a more detailed explanation of the possible scenarios that can be used to model costs and the information needed to do so. It takes the cost estimate for Mexico as an example (González-González et al., 2019).

There is a major difference between the cost estimates for LAC and the ones for the OECD and EC: LAC estimates do not include healthcare services and only focus on the cost of long-term care. It thus comes as no surprise that LAC estimates are smaller than OECD and EC ones. According to Matus-López (2019), estimates that only take into account the cost of long-term care services, like the ones for LAC, are 40% to 60% smaller than estimates that also include healthcare services. The difference in the size of the estimates can also be explained by the fact

that LAC's population is considerably younger than that of OECD and European countries. Therefore, a lower percentage of the population is care dependent and the cost of long-term care is lower. Another difference has to do with whether a top-down or bottom-up approach was used. The OECD and the EC take a top-down, or macro, approach. This means the information is collected through the national account systems of member countries. In contrast, costs for LAC countries were modeled using a bottom-up, or micro, approach. In other words, the estimates draw on information on the prevalence of care dependence and the market price of care services, and they are premised on assumptions about the target population, the categories of services provided by the system, and the level of coverage (González-González et al., 2019).

The economic effects of implementing long-term care systems are not confined to higher costs. **Long-term care systems also lead to inherent savings that contribute to economic sustainability** and are not usually taken into account in studies. **The opportunity cost of informal care underlies one of the ways long-term care systems save money.** The services provided through a long-term care system free up time in the schedules of informal caregivers, who are generally the women within the families, generating social savings equivalent to the value of the additional time available. This time could go toward increasing the labor supply or be used up as free time. According to

the model used to estimate costs for Mexico, the country would save between 0.03% and 0.05% of its GDP by implementing a long-term care system (González-González et al., 2019).

A long-term care system would also lead to inherent savings on health care, as it could lower healthcare expenditure. In Spain, for example, a reform that expanded access to long-term care services resulted in fewer hospital admissions and shorter lengths of stay, reducing hospitalization costs by 11% (Costa-Font, Jiménez-Martín, and Vilaplana, 2018). A study conducted in France found that people who receive transfers for long-term care used costly emergency services less than non-beneficiaries, leading to less spending for the healthcare system (Rapp et al., 2015). Generating more information on how long-term care systems produce social and healthcare savings should be a top priority for LAC in upcoming years.

“

In Latin America and the Caribbean there is little clarity about **how much a long-term care system would cost.** And **this information is crucial for decision-making.**”

Ferdinando, Social Protection and Health Division Chief at the IDB.

Box 2. Simulation model of the cost of long-term care systems

Using the simulation model for Mexico as an example (for details, see González-González et al., 2019), this box shares the information needed to estimate the cost of long-term care systems, as well as possible simulation scenarios.

The basic information needed to implement a simulation model includes:

1. Demand for long-term care services.

Demand is the proportion of care-dependent older people.

2. Public policy parameters.

These are the public policy decisions that need to be made in order to design a long-term care system. The model assumes that the State will fund the system through general taxation and will ensure minimum quality standards. It focuses on two parameters:

- *Who to provide long-term care services to.* This parameter defines the system's target population through criteria like level of care dependence and age.

- *What services to provide.* This parameter defines the categories of services to be provided by the system. Models usually only include long-term care services, not healthcare services. The intensity of each service, or the number of hours each service is provided, also has to be specified in the model.

Since a long-term care system is unlikely to be able to cover 100% of the target population in the first few years of its implementation, the model allows the use of different coverage scenarios for each service category. For example, it can limit home care services to 50% of the target population. The option to use limited coverage scenarios is a way of simulating governments' budget constraints. ²²

3. Service cost parameters.

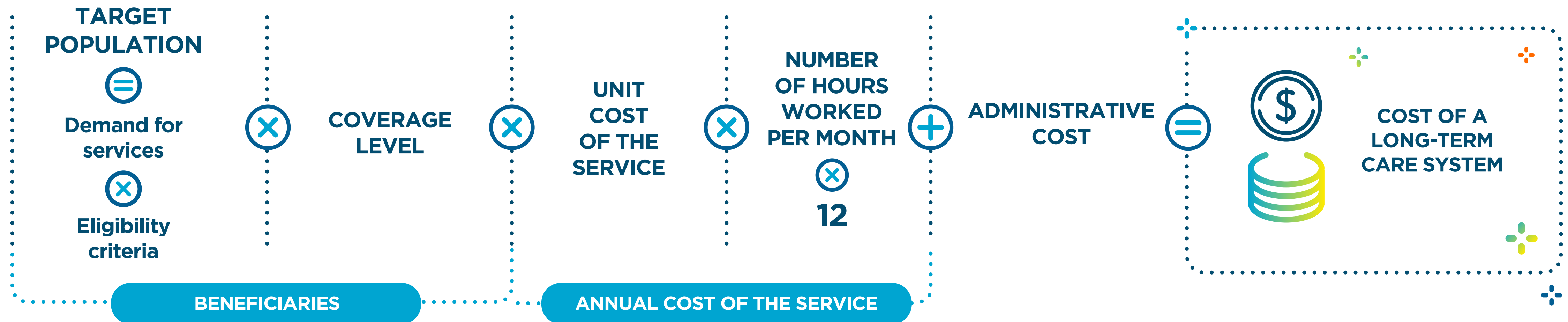
These parameters reflect the unit cost of each service (for example, the wages of personal care assistants or the monthly cost of telecare).

Box 2, continued.
**Simulation model of the cost
of long-term care systems**

Figure 6 shows how to combine these blocks of information to estimate the total cost of a long-term care system. The system’s number of beneficiaries is calculated by limiting the target population based on the coverage level set for each category of service. The cost for each service category is thus the product of the number of beneficiaries, the unit cost of each service, and the service’s intensity (i.e. the

number of hours provided per year). Lastly, the model assumes that the State bears an administrative cost that could be, for example, 10% of the system’s total cost.

Figure 6. Structure of the model for estimating the cost of a long-term care system.



Note: Adapted from *Simulaciones del costo de un sistema de apoyo para los adultos mayores en situación de dependencia en México*, by C. González-González et al., 2019. Washington, DC: Inter-American Development Bank. Copyright 2019 by the Inter-American Development Bank.

Box 2, continued.**Simulation model of the cost
of long-term care systems**

To give a specific example of the possible scenarios that could be used to set up a cost simulation model, the scenarios used for Mexico are provided below (González-González et al., 2019).

Basic scenario

- **Target population:** severely care-dependent people over age 70.
- **Coverage:** 50%.
- **Category of services offered:** 80 hours of personal home care assistance per month.

Expanded scenario

This scenario includes two target populations with different coverage levels and categories of services offered.

Target population (a):

severely care-dependent people over age 70.

- **Categories of services provided to 50% of the target population.**
 - » 120 hours of personal home care assistance per month.
 - » Telecare services.
 - » One medical appointment per month.
- **Categories of services provided to 10% of the target population:**
 - » Services in residential care settings.

Target population (b):

mildly care-dependent people over age 70.

- **Percent of target population (b) covered:** 25%.
- **Categories of services provided:**
 - » 20 hours of personal home care assistance per month.
 - » Telecare services.

5.

Where should we start?

The high cost of funding long-term care systems, coupled with the institutional governance and human resource challenges of implementing them, can be overwhelming and keep governments from acting. This is precisely what has happened in most LAC countries. A more advisable approach would be to plan and implement long-term care systems on a small scale and then gradually expand them. In other words, **start now, even if on a small scale.**

As described above, Uruguay and Chile are two examples of LAC countries that have begun to implement long-term care systems on a small scale with a view towards later expanding them. Uruguay has rolled out its Integrated National Care System, the SNIC, with limited coverage. For example, the personal home care assistants provided by the SNIC are for severely care-dependent people over age 80. Chile, on the other hand, is implementing its long-term care system, *Chile Cuida*, in



only 20 of the country's 346 municipalities, with the prospect of later scaling it up to cover the entire nation. While for Uruguay's system expansion means broadening the eligibility criteria, for *Chile Cuida* it means widening geographic coverage.

To begin implementing a long-term care system, this issue needs to be included on the political agenda. This is no small challenge, since the demand for long-term care services is higher among older people. The conditions that give rise to a favorable political environment are specific to each context. However, the experience of Uruguay and Chile, as well as that of other countries that implemented long-term care systems, can be used to identify patterns that favor the prioritization of long-term care in the political agenda.

They include:

- A.** political leaders who see long-term care as a priority because of its important gender equity implications and economic sustainability opportunities;
- B.** a civil society committed to the rights of older people, including the right to long-term care; and
- C.** the availability of technically sound local evidence that can be referenced in political debate.

Based on experiences in LAC and other regions, this section **provides concrete recommendations for countries looking to design and implement a long-term care system.** These recommendations are particularly important for countries that have limited resources but want to start implementing a long-term care system regardless, even if on a small scale.

Let's take a look.

5.1. Choose beneficiaries based on the level of care dependence rather than age

Due to budget constraints, countries often have to establish coverage priorities. As discussed previously, all countries use the level of care dependence as an eligibility criteria, though some also limit access to services based on age and/or means. Setting age as a eligibility criterion can be a way to keep costs down. This method also follows the logic that older people—especially those over age 80—generally have the highest care needs.

But the aging process is different for everyone and hinges not only on genetic variables, but also on contextual and behavioral factors. While some people enjoy good health and full functional autonomy as they age, others are relatively young when they start experiencing difficulties (WHO, 2015b). This is especially relevant in low- and middle-income countries, where the onset of chronic conditions, which can lead to limitations and care dependence (Aranco et al., 2018), occurs earlier in life than in high-income countries (Nitrini et al., 2009; Prince et al., 2015). Thus, age limits, especially when the minimum age is quite high, can exclude from the system people who experience serious difficulties performing day-to-day activities. In Mexico, for example, almost 50% of those who struggle to complete basic ADL are between 50 to 69 years old, while in Chile, 40% are between 15 to 69 years old (Instituto Nacional de Estadística y Geografía, 2015; Ministerio de Trabajo y Previsión Social de Chile, 2015).

Some countries that use age as a criterion for eligibility for long-term care services have separate coverage schemes for younger people, who switch over to long-term care systems when they reach the qualifying age. France, for example, has two separate systems: one for people under 60 and another for people over 60 (EC, 2016). In Japan and South Korea, the long-term care system covers people over age 65 but also people under that age, provided that their care dependence is the result of a condition associated with aging and included on a pre-approved list (National Health Insurance Service, 2019; Olivares-Tirado and Tamiya, 2014).

Even in countries with no long-term care system for young people, occupational accident and/or disability insurance can provide some protection against care dependence. But even where these systems based on formal employment exist, there is a coverage gap for young adults whose care dependence is not the result of a work accident.

5.2. Deliver transfers that have to be spent on care services

A long-term care system's eligibility criteria should therefore be based on the level of care dependence rather than age. If a country's budget implies coverage restrictions, it is best to tighten the minimum level of care dependence needed in order to qualify for benefits. The severity criteria should then be relaxed over time to expand coverage as the system grows.

Another way to reinforce systems' financial sustainability is to set up a scheme where users contribute. While income should not be used to determine eligibility for care, the level of benefits or copayments can be based on beneficiaries' income or wealth.

It is important to specify how long-term care services, particularly home care services, will be provided to beneficiaries. As discussed in [section 2](#), there are generally three alternatives: in-kind services, where beneficiaries are offered formal care services for a set number of hours or days; unconditional transfers that care-dependent people and their caregivers can use to pay their expenses as they see fit; and conditional transfers that can only be used for specific purposes, in the form of vouchers, reimbursements, or money for which receipts must be submitted.

Conditional transfers are the best alternative because they allow care-dependent people and their families to freely choose their service provider, while simultaneously ensuring that the resources are used for their intended purpose. Beneficiaries' freedom of choice then pushes providers to compete on quality and helps consolidate a formal personal care services market.

Personal budgets that take into account the needs of family caregivers are one way to provide conditional transfers. Staff from the system, together with the care-dependent person and his or her family, establish how the resources will be used on a case-by-case basis within a comprehensive care plan. The budgeted amount can be transferred directly to the family or care-dependent person to be used according to the plan, or it can be administered by the authorities or an

authorized intermediary that pays providers on behalf of the person who needs care. But keeping track of this type of system requires advanced administrative and monitoring capabilities. Conditional transfers can also be given in the form of vouchers that can only be used to pay for services approved by the long-term care system.

Unconditional transfers are, from an economic efficiency standpoint, an attractive option. They increase families' consumption choices and give them freedom to decide how they want to use the additional resources, thus maximizing their well-being. The reasoning behind this approach is that if families decide to keep their current care arrangements and use the resources for other purposes, that decision reflects their best interest. As Caruso Bloeck, Galiani and Ibararán (in press) argue, under certain circumstances, low-income families with poor prospects for finding well-paying jobs benefit more from receiving cash transfers than in-kind support, even if the money they receive is worth less than the market value of the hours of care provided. In terms of the cost to the system, unconditional cash transfers have the advantage of allowing benefits to be defined with certainty: the transfer does not depend on the cost of services or caregivers' wages. So when fiscal space is limited, this type of transfer can be used to cover just a part of the cost of care. In cases where there is no network of services (for example, in remote areas), cash transfers may be the only option.

Despite these advantages, there are several reasons to strike unconditional cash transfers from the list of benefit options. One is that these transfers can reinforce family gender roles and the prevalence of women as caregivers. While these transfers do give households additional resources, there is no guarantee they will be used to improve the well-being of either the intended recipient or the caregiver. They may also fail to improve the quality of services in the way that care from trained professionals would. Transfers could also be used to finance informal care, which would set back efforts to professionalize caregiving.

When Spain's System for Autonomy and Long-Term Care was created, it temporarily allowed users to choose between cash transfers and in-kind benefits. This choice was supposed to be a special measure to allow the system to quickly broaden its coverage, but moving to a system where all care is provided as an in-kind benefit has been challenging. Implementing a transfer-based system encouraged the proliferation of informal services. Additionally, a significant portion of the cash benefits ended up in family savings accounts and was not used to pay for services. In contrast, when people chose to receive in-kind benefits, no changes in savings were observed (Costa-Font and Vilaplana, 2017).

5.3. Start with home care services

Most LAC countries have public or private residential care facilities, whether for-profit or nonprofit. In general, there is neither reliable information about these facilities nor solid quality monitoring systems. These facilities often operate without authorization or certification that their services meet quality standards. Also, population census data reveals limited supply of these facilities. In LAC, 0.54% of people over 60 live in a residential care setting, with 1.9% in Chile and Uruguay, 0.89% in Costa Rica, and 0.52% in Brazil (Sanders, 2019). These percentages are low in comparison to the range of 2% to 5% in Europe or the United States (Centers for Medicare and Medicaid Services, 2015).

The limited supply of residential care, its uneven quality, and the challenge of organizing a home care services system may tempt countries to start by building new residential care facilities. But decision-makers should resist this temptation for two reasons, especially in the initial stages of implementing a long-term care system. First, most people prefer to grow old in their own familiar environment, although severely care-dependent people who need ongoing health care (for example, someone with both advanced dementia and incontinence) are best served by nursing home placement (Wiles et al., 2012). Second, it is less expensive to provide services to people with mild to moderate care needs in their homes rather than in a residential care setting.

Given these considerations, there has been a decisive shift recently

towards home care services instead of care in a residential setting. Countries designing a long-term care system should start with home care services.

But when addressing care in a residential setting, countries should first study the existing supply and develop effective regulation and monitoring systems—in addition to improving these institutions' coordination with healthcare services—before sinking resources into building new facilities. It is important to be aware that strengthening controls and possibly closing residential care facilities that fall short of minimum quality standards will affect their residents, many of whom do not have enough money to pay for a higher-quality institution. Countries should have a plan for these cases. In Uruguay, for example, the system is designed to transfer money to low-income people so they can pay for space in approved residential care facilities when their facility is shut down.

In high-income countries, assisted living is emerging as an alternative to traditional residential care settings. An assisted living arrangement has individual dwellings with shared common areas, as well as assistance services and community activities. Assisted living can be an attractive option for older people who are still relatively self-sufficient but do not have a close support network, or for people who want to live more independently but need help for some daily activities.

5.4. Involve the private sector to create formal jobs

The private sector offers most long-term care services. Generally speaking, companies and self-employed workers who provide home care services are part of the private sector, as are specialized residential care facilities and companies that develop technological solutions and offer telecare services.

The experience of the countries furthest along in the demographic transition shows that developing a long-term care market can drive job creation in a powerful way. An example is South Korea, which began setting up its system in 2008. There this sector has created jobs for almost half a million people, or around 1% of the population (Kim, 2019). This economic development opportunity associated with a longer-lived population is an important part of the silver economy, a term referring to all the goods and services consumed by older adults (Ortega Cachón, 2018; Ortega Cachón and Huertas Mejías, 2018).

Supporting companies and jobs in the long-term care sector holds huge potential for increasing labor formality, which is particularly important in a region marked by very high levels of informality. This opportunity also has a very important gender component: if there are no long-term care services on the market, women in the families are saddled with most of the caregiving burden. As the population ages, many of those women may be forced to work less hours in order to take care of a family member. Conversely, developing a service market has the

potential to multiply the number of jobs available to women. In South Korea, for example, 95% of long-term care workers are women, most over age 45, a segment that usually has fewer formal employment opportunities (Kim, 2019).

For these reasons, governments should consider incentives schemes that stimulate the creation of private caregiving enterprises. In some cases, markets are developed based on an announcement that the public sector will fund services for a significant number of beneficiaries. This was the case with telecare in Uruguay, where the SNIC promoted the formation of companies that could provide telecare technology and services. The country now has five authorized companies offering telecare services to over 1,000 people over age 70.

In other cases, countries may need to set up business incubators, credit facilities, tax breaks, or other schemes to support enterprises until they are well established. In Uruguay, for example, the system offers microloans through the State bank to residential care facilities that want to invest in improving the quality of their services. While still a nascent strategy (only three projects have been approved so far), this stimulus is meant to invigorate the private market.

5.5. Train human resources and establish quality standards

The State needs to act on two fronts to promote quality services:

1. **training** and other human resource policies; and
2. **regulating** and **monitoring** service quality.

States should foster ongoing training for caregivers (whether professionals or family members). To make the sector more professional, it should institute a skill certification system to accredit people's caregiving expertise and promote the observance of workplace health and safety standards. South Korea, for example, has a national certification system for care workers designed to ensure the quality of services. To achieve this certification, candidates must log 240 hours of training (80 hours of theory, 80 hours of practical training, and 80 hours of on-the-job training) and pass a qualification exam. Only people with this certification can work within the system.

In Uruguay, personal care assistants have to be trained and certified by the system. Given the limited training opportunities and the fact that many people were already paying a caregiver when the system started up, it was decided to implement this measure gradually to give everyone working as personal care assistants time to receive proper training. As to South Korea, it started to designate training agencies for personal care assistants five months before the system began operating.

As part of the effort to underscore the value of long-term care work, the State can organize campaigns to raise awareness about the importance of caregivers' work. The State can also encourage the development of guidance and respite services for caregivers to improve both the quality of care and the well-being of family caregivers. Some countries (Germany, France, Canada) give people who prove they are looking after a care-dependent family member more flexibility at work, like the option to work half days or take unpaid leave. The same countries have arrangements to provide personal care assistants when family caregivers go on vacation or have health problems (Federal Ministry of Health, 2017; Joël et al., 2010; Canadian Healthcare Association, 2009).

As for quality standards, the State should act as a regulator to ensure the quality of the different long-term care services (whether public or private), and it should coordinate the different actions taken by all parties involved. A public or independent entity should be designated to perform this role. It should be in charge of setting minimum quality standards for providers through licenses and certifications, and of carrying out periodic inspections to ensure their compliance and monitor their performance on quality.

5.6. Use a mix of financing mechanisms to set up a single, unified system

Securing stable and sufficient resources to implement and maintain a long-term care system is a challenge for all nations. Countries have generally adopted the same funding method they use for health care. Germany and South Korea, for example, added another payroll tax to finance their long-term care systems, in addition to the one for health care. The United Kingdom uses general tax revenue to fund both its healthcare system and its long-term care system. Uruguay is a noteworthy exception to this rule. Though it uses mostly contributions to fund its healthcare system, the majority of the money for its long-term care system comes from general taxation (Junta Nacional de Cuidados, 2015). Most countries supplement the main funding mechanism with a mix of other sources, thus adopting a combination of contributions, general taxation, out-of-pocket payments, and private insurance. But regardless of the funding sources used, they usually establish a single, unified long-term care system. Long-term care in South Korea, for example, is provided through a single system for the entire population, even though funding comes from various sources. The main funding mechanism is contributions (64% of the budget). This source is supplemented by out-of-pocket payments from beneficiaries (24% of the budget), general tax revenue (11%), and other revenue (1%) (National Health Insurance Service, 2019).

LAC countries should make it a priority to set up a single long-term care system and use the mix of funding mechanisms that brings in the

most resources, including contributions, general taxation, and out-of-pocket payments from people who can afford to pay. The advice to avoid a fragmented system aligns with what the academia and international institutions have recommended for LAC healthcare systems over the last 20 years (Montenegro et al., 2011). For healthcare services, fragmentation has given rise to two parallel systems: one financed by contributions and the other by general tax revenue. This has led to different levels of coverage and benefit quality, often at the expense of the most vulnerable people (Guanais et al., 2018).

In terms of funding, lessons that carry over from healthcare systems are how hard it is to get all workers to contribute (beyond just salaried employees) and the complexity of deciding how much someone can afford to pay, especially in the case of informal workers. This is especially pertinent in LAC, where it is thought that more than half of all jobs are still informal (Alaimo et al., 2015; Duryea and Robles, 2017).

In conclusion, these six recommendations aim to guide the process of developing long-term care systems in LAC. The verdict is clear: there is no time to lose. If the countries in this region do not act now, they will not have the financial resources and the time they need to meet the growing demand for long-term care services. The experience of countries that are further along in the demographic transition shows that it is necessary to design and implement a long-term care system gradually. These recommendations suggest how to do it.

To learn more about **how** to design and implement a long-term care system by starting small, **don't miss this video!**



Video 6. Six keys to designing a long-term care system

These six key points illustrate how to gradually design and implement a long-term care system, and then expand it more easily.



“ **There is no time to lose.**
We have to start building long-term care
systems, **and we have to start now.**

Pablo, lead specialist in social protection.

”

Road to Age with Care.

Click on the
arrow to
continue



Notes

Note 1.
In most cases, this phrase refers to the basic activities of daily living (ADL), which are the activities necessary for living independently, like eating, showering or bathing, and using the toilet. It can also include the instrumental activities of daily living (IADL), which are related to cognitive aspects and social relationships. Examples include shopping, cooking, doing housework, managing money, and using the phone.

..... ← **Back to page 5**

Note 2.
Calculations made by the authors based on the 2015 Mexican Health and Aging Study show, for example, that the prevalence of high blood pressure rose from 2001 to 2015 in each of the following age groups: 50-59, 60-69, 70-79, 80+.

..... ← **Back to page 9**

Note 3.
According to the WHO (2017), long-term care systems are “national systems that ensure integrated long-term care that is appropriate, affordable, accessible and upholds the rights of older people and caregivers alike (p.2)”

..... ← **Back to page 16**

Note 4.
Interest in measuring cognitive capacities stems from the association between cognitive impairment and care dependence among older people. Germany, South Korea, and Japan adapted their tools for measuring care dependence to incorporate or strengthen questions about cognitive impairment (Medellín et al., 2018; Campbell, Ikegami and Gibson, 2010; Jeon and Kwon, 2017).

..... ← **Back to page 17**

Note 5.
For a detailed comparison of the tools for measuring care dependence, see Medellín et al. (2018).

..... ← **Back to page 17**

Note 6.
Telecare is just one of many technological innovations with implications for long-term care. For example, artificial intelligence and social robots are expected to be used increasingly to care for, monitor, and interact with care-dependent older people, complementing the services provided by doctors and nurses. Social robots will be able to monitor vital signs, diet, and medications, as well as help older people stay active. The use of cloud-based information technology, electronic health records, electronic medication management records, and brain and physical fitness technologies is also expected to be more widespread, especially in residential care settings.

..... ← **Back to page 19**

Note 7.
LAC countries have a successful tradition of using unconditional cash transfers to alleviate poverty and accumulate human capital (Ibararán et al. 2017).

..... ← **Back to page 20**

Note 8.
Most countries use a mix of mechanisms to finance long-term care (Figure 5). In the interest of simplicity, the funding models in this publication were classified according to the two main schemes: social insurance and general taxation. For more information on funding models, see Joshua (2017).

..... ← **Back to page 21**

Note 9.
Of the four key elements in the design of a long-term care system, the funding model and the categories of services provided are particularly impacted by the informality of LAC labor markets. This dynamic is so significant that it can make it hard to draw comparisons between LAC and other regions. Regarding the type of services offered, labor informality mainly leads to an excessive use of informal home care services.

..... ← **Back to page 22**

Note 10.
For more information, visit this [website](#).

..... ← **Back to page 29**

Note 11.
The IDB provided technical and financial support for implementing the SNIC.

..... ← **Back to page 30**

Note 12.
The SNIC also provides personal home care assistants for severely care-dependent people under 30.

..... ← **Back to page 30**

Note 13.
This data was provided by the SNIC based on internal reports.

..... ← **Back to page 30**

Note 14.
The number of care-dependent people used to calculate coverage rates was taken from the Longitudinal Social Protection Survey for Uruguay of the Banco de Previsión Social (2013).

..... ← **Back to page 30**

Note 15.
The training course benefited two groups of caregivers: those working with people over age 80 and those caring for people under 30.

..... ← **Back to page 31**

Note 16.
SENAMA is a government service with separate legal status and its own resources, overseen by the Ministry of Social Development and Family. Its objectives are to promote active aging and the creation of social policies for older people, furthering their participation in society, their care and independence, and the recognition of their rights.

..... ← **Back to page 32**

Note 17.
There are three types of gerontological nursing care in a residential care setting: care in nursing or retirement homes, care in psychiatric hospitals, and 24-hour nursing care.

..... ← **Back to page 33**

Note 18.
To assess socioeconomic status, evaluators consider factors such as PAMI enrollees’ income, assets, housing quality, and family support network.

..... ← **Back to page 33**

Note 19.
This average includes all countries in the European Union, except the United Kingdom.

..... ← **Back to page 35**

Note 20.
This average includes the 25 OECD countries with available data.

..... ← **Back to page 35**

Note 21.
It is difficult to draw meaningful comparisons between the results of these modeling exercises. Each result is influenced by the underlying scenarios used and by each country’s demographic and economic characteristics.

..... ← **Back to page 36**

Note 22.
A possible alternative to limited coverage scenarios is modeling a long-term care system with universal coverage and including copayments based on the means of the people who need care.

..... ← **Back to page 38**

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