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Aging and Long-Term Care in Jamaica

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Social Protection and Health Division

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Aging and long-term care in Jamaica

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Summary

Recent estimates show that almost 15% of the Jamaican population is 60 years old or more. About 7% of this population need help with at least one activity of daily living. The demand for long-term care services is expected to rise as the country's population grows older. In a context in which family sizes are shrinking and older adults are experiencing poor health and critical socioeconomic vulnerability, the means to meet care needs privately—either by relying on unpaid care, provided by their families or close networks, or by purchasing services in the market—are scarce.

The regulation and provision of long-term care services in the country is highly fragmented and focuses mostly on those that are economically and socially vulnerable, as part of poverty-relief programs.

Residential care is the main long-term care service available in Jamaica. Public institutions target the poor, while the private sector also offers various levels of institutional care, from residential to nursing care. The nongovernmental sector is also heavily involved in the provision of residential care in Jamaica, especially through churches. All things considered, women in the family are still the main providers of care. The main conclusion of the report is that long-term care in Jamaica is still an unmet need that requires the development of comprehensive policies and programs.

JEL Classification: H5, I18, J14, J18

Key words: aging, functional dependence, long-term care, social inclusion, Latin America and the Caribbean, Jamaica.

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Introduction

This case study presents a comprehensive analysis of long-term care services in Jamaica and provides an analysis of key achievements and opportunities in the area. In this document, "long-term care" is *defined as the activities undertaken by others to ensure that the people that have lost their individual functional capacity (and those who are at risk of doing so) can receive support that is consistent with a full and dignified life and optimize their functional trajectory over time* (World Health Organization 2017). Long-term care can be provided by family members, residential care, home care services, day center services, and telecare. Services directed at supporting caregivers (be they formal or informal) are also part of the long-term care services offered in a country. Although it should be noted that integration with healthcare services is crucial to guaranteeing a comprehensive person-centered approach, this report focuses on the provision of social services, such as assistance with basic and instrumental activities of daily living.

Jamaica is the largest English-speaking island in the Caribbean, with a population of approximately 2,726,667 people that is growing older.[2]As a result, health and social services are facing the challenge of meeting the needs of an aging population, among whom chronic diseases, associated comorbidities, and physical and cognitive impairments are prevalent, which in turn increases the demand for long-term care services. Within this context, demographic changes must prompt transformations in the way that social and health services are administered, the type of services that are provided, and the way health and long-term care services are delivered.

While demographic changes provide opportunities for increased economic growth, they also create needs. One of these is the provision of long-term care services, as countries, including Jamaica, acknowledge that older people have the right to a dignified, meaningful life. Given that the oldest old (i.e., those aged 80 years or more) are the fastest-growing group of older people, long-term care needs are expected to increase in the near future. The sick and frail often rely on care, support, and assistance from others; in Jamaica, these others are predominantly the family and the community (Eldemire-Shearer et al. 2014).

The report is structured as follows. Section 1 provides an overview of the aspects determining the demand for long-term care, including the demographic transition and the health and functional characteristics of the older population in Jamaica. Section 2 describes the role of the government in meeting the care needs of older adults, the formulation and application of policies, as well as the provision of services within the public orbit. The role of the private sector, including the important contribution of family caregivers, as well as the services offered by both for-profit and not-for-profit entities is discussed in section 3. Section 4 concludes with a critical assessment of the state of the long-term care policies in Jamaica, the achievements so far, and the challenges ahead.

[2] Statistical Institute of Jamaica, Population Statistics Jamaica 2018, https://statinja.gov.jm/Demo_SocialStats/PopulationStats.aspx.

Section 1: Demand for long-term care

1.1. The aging process and its challenges

In Jamaica, older adults (those aged 60 and over) represent the fastest-growing segment of the population (table 1). The most recent Population and Housing Census for Jamaica, completed in 2011, estimated that the population aged 60 and over stood at 323,500 (i.e., 11.8% of the overall population), an increase of almost two percentage points from the previous census, in 2001 (Ministry of Labour and Social Security 2018). Population estimates from 2019 show that approximately 380,000 people were age 60 or older, representing approximately 14.9% of the overall population.[3] Furthermore, the US Census Bureau projects that in Jamaica, the population aged 60 and over will double between 2025 and 2030, while total population growth will continue on a downward trend[4] (figure 1). Finally, it is estimated that approximately 69.1% of households in Jamaica have a head who is 60 or older (Ministry of Labour and Social Security 2018).

Table 1. Older adult population by gender and age groups in 2001, 2011, and 2019

Age (years)	Male			Female		
	2001	2011	2019	2001	2011	2019
60–64	31,827	44,407	55,945	33,468	43,150	58,013
65–69	28,910	32,543	42,035	30,969	32,273	41,574
70–74	24,856	24,627	32,843	27,244	26,325	33,791
75–79	17,711	19,847	21,875	20,878	22,848	24,140
80+	19,580	23,760	28,219	29,390	35,383	40,922
TOTAL	122,884	145,204	180,917	141,869	159,979	198,440

Source: Eldemire-Shearer et al. (2014).

These changes are also reflected in the country's age dependency ratios (table 2). The youth dependency ratio (the number of children aged 0–14 per 100 people aged 15–64) has fallen while the old-age dependency ratio (the number of people aged 65 or over per 100 people aged 15–64) has risen (Eldemire-Shearer 2008, World Bank 2020). At the same time, the median age of the population has increased from 17 in 1970 to 24 in 2001 and 27 in 2011 (Eldemire-Shearer et al. 2013). It is projected to increase to 39 years in 2050 (Eldemire-Shearer 2008).

[3] Statistical Institute of Jamaica, "Population Statistics," accessed October 22, 2021, https://statinja.gov.jm/Demo_SocialStats/PopulationStats.aspx.

[4] United States Census Bureau, "International Data Base: Jamaica," accessed October 22, 2021, https://www.census.gov/data-tools/demo/idb/#/country?COUNTRY_YR_ANIM=2050&FIPS_SINGLE=JM.

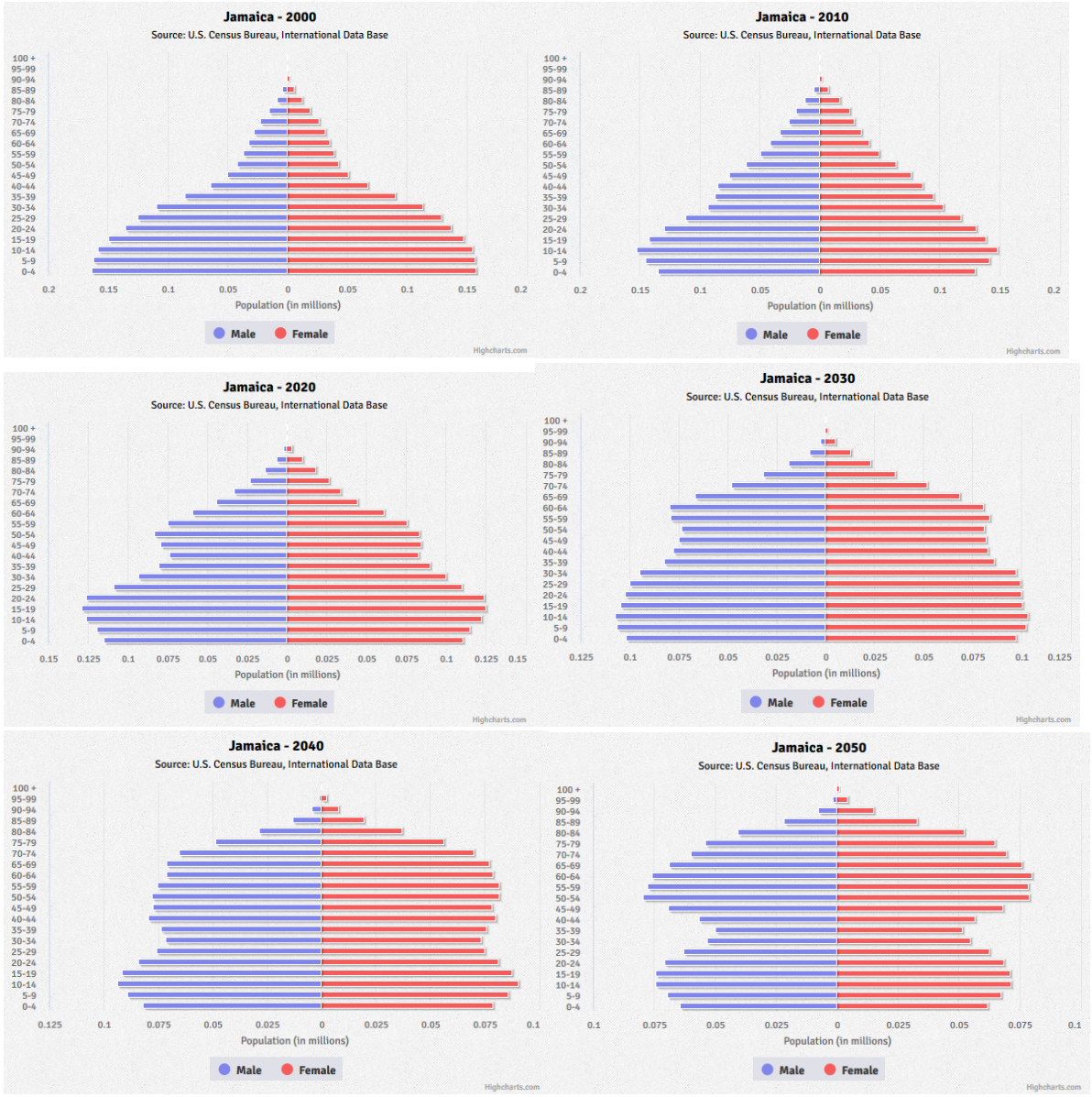
Table 2. Age dependency rates, 1975–2019

	Total	Old age	Child
1975	104.2	11.8	92.4
2000	63.1	11.8	34.2
2010	54.4	12.7	41.7
2015	49.5	12.7	36.8
2019	48.0	13.2	34.8

Source: World Bank (2020).

As in most countries, the aging of Jamaica's population has also been driven by women living longer than their male counterparts. These changes are reflected in the shifting shape of the demographic pyramid over the years, as shown in figure 1.

Figure 1. Changes in the demographic structure of Jamaica, 2000–2050



Source: United States Census Bureau.[5]

It is predicted that 1980–2030 represents a "window of opportunity" for Jamaica. During these years, young people (those under 15) comprise less than 30% of the population, there has been an increase in the working-age population, and those aged 60 or more account for less than 15% of the total (figure 1; Eldemire-Shearer 2008). This period therefore allows not only for increased economic growth but also for policy and program planning in preparation for an inevitable increase in the proportion of older adults as a share of the population (Eldemire-Shearer 2008, United Nations Department of Economics and Social Affairs 2002). Making full use of this window of opportunity and preparing for the forthcoming demographic changes is particularly important given that, as stated above, the oldest old segment is the one projected to experience the most significant growth. This will lead to increased care needs

[5] United States Census Bureau, "International Data Base: Jamaica," accessed October 22, 2021, https://www.census.gov/data-tools/demo/idb/#/country?COUNTRY_YR_ANIM=2050&FIPS_SINGLE=JM.

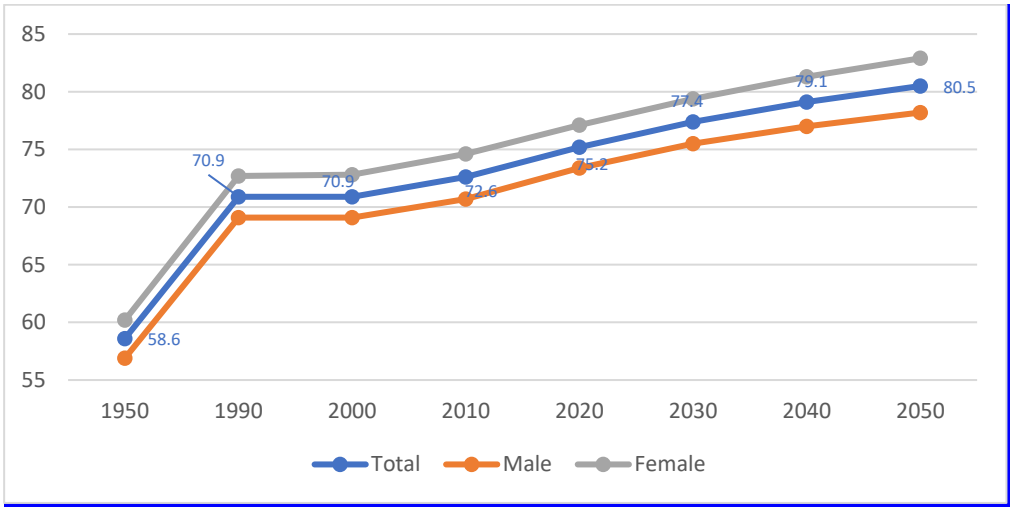
as a result of the higher prevalence of multiple morbidities and functional dependence among this segment (Eldemire-Shearer 2008).

1.2. Health status, disability, and functional dependency among the elderly

1.2.1. Life expectancy and healthy life expectancy

Life expectancy in Jamaica has steadily increased from 58.6 years in the 1950s to 75.2 years in 2020 and is projected to continue doing so (figure 2). However, as indicated above, gender differences related to longevity are worth noting: women live 3 to 4 years longer than men, on average. As a result, women outnumber men across all old-age groups, leading to a "feminization of aging," another trend that is projected to continue (Eldemire-Shearer 2008). This fact has important implications when analyzing the demand and provision of long-term care services and will be discussed later in this report, given that women are both the main demanders and providers of care.

Figure 2. Life expectancy at birth for the Jamaican population, 1950–2050



Source: Authors, based on data from Eldemire-Shearer (2008) and United States Census Bureau[6].

Increases in longevity are good news. However, they do not say much about the actual health status of the elderly and their demand for care. "Healthy life expectancy" is a summary measure that gives the average number of years that a population is expected to live free of disease or disability. In 2019, healthy life expectancy at birth in Jamaica was 67; in other words, almost 90% of people's years are expected to be lived in good health. At age 60, the number of healthy years as a proportion of remaining total life expectancy decreases to 77%, or 16.4 out of 21.3 years (WHO data for 2019).

1.2.2. Functional dependency of older adults in Jamaica

As people age, the probability that they will need the help of others to perform their daily activities increases, a state known as functional dependency. It should be noted that, although related, the concept of functional dependency is different from that of disability. Box 1 clarifies these two concepts and highlights the differences between them.

[6] United States Census Bureau, "International Data Base: Jamaica," accessed October 22, 2021, https://www.census.gov/data-tools/demo/idb/#/country?COUNTRY_YR_ANIM=2050&FIPS_SINGLE=JM.

Box 1: Definition of Disability and Functional Dependency

The International Classification of Functioning, Disability and Health (ICF) is the international standard for describing and assessing functioning and disability (World Health Organization 2001). The ICF considers the interaction between health conditions, environmental factors (i.e., the existence of barriers or facilitators), and personal factors, and views disability and functioning as existing on a continuum. According to the ICF, functioning and disability have three dimensions: body functions and structure (physiological functions, functioning of organs and limbs, and impairments), activity (ability to execute tasks/actions), and participation (involvement in life situations; World Health Organization 2001).

Disability

Disability is defined as any bodily or mental limitation that impedes a person's ability to perform activities or to engage with the outside world and considers impairments, limitations to activity, and restrictions to participation. The effect of disabilities varies widely and may be easy to see or hidden (US Centers for Disease Control and Prevention 2020). Disabilities may affect the ability to see, move, think, remember, learn, and communicate and can impede mental health and social relationships (US Centers for Disease Control and Prevention 2020).

Functional dependency

Functional dependency is linked to functional ability, that is, a person's ability to engage in the things that they value (World Health Organization 2020). Functional ability can be impaired by a person's intrinsic mental and physical capacity as well as the characteristics of their environment (World Health Organization 2020). A person who is not functionally independent requires assistance to perform the "activities of daily living" (Whitehead et al. 2015). These include the so-called basic activities of daily living and the instrumental activities of daily living. The former are considered essential for survival and comprise self-care and hygiene (such as eating, bathing, or getting dressed). Instrumental activities are more complex and involve a higher degree of cognitive effort and social interaction, such as taking care of one's own health and finances, cooking, using public transportation, and so on (World Health Organization 2004). As instrumental activities are more complex, they are usually the first to be affected (Katz et al.1983, Dunlop, Hughes, and Manheim 1997).

The most comprehensive analysis of the health conditions of older adults in Jamaica is the *Health and Social Status of Older Adults in Jamaica Study* (Eldemire-Shearer et al. 2013). The study was conducted in 2012 by the Mona Ageing and Wellness Centre and is representative of the population. No updated information was publicly available at the time of writing this report.

The study included quantitative, qualitative, and mixed methods. The sample consisted of 2,943 older people from the parishes of Kingston and St. Andrew, St. Thomas, and St. Catherine and matched the gender distribution of the census, as 52.0% of respondents were women. The participants were between 60 and 103 years old, the mean age was 72.2, and the majority (78%) of the respondents were between 60 and 79 years old. The following sections will be based primarily on the study's findings.

Among older adults in Jamaica, the rate of functional dependency is low: just 7% of those aged 60 or more have difficulties performing at least one activity of daily living (basic or instrumental; Eldemire-Shearer et al. 2013). As expected, difficulties in performing instrumental activities of daily living are more prevalent than difficulties with basic activities. In

both cases, functional ability generally decreases with age, and more women report functional dependence in all age brackets (table 3; Eldemire-Shearer et al. 2013).

Table 3. Prevalence of functional dependency by age and gender, percentages

Age (years)	Difficulties with basic activities of daily living (%)			Difficulties with instrumental activities of daily living (%)		
	Personal care	**Incontinence**	**Feeding**	**Prepare meals**	**Shopping**	**Transportation**
Women						
60–69	2.1	2.8	0.7	7.1	10.7	7.3
70–79	6.2	5.5	3.0	14.0	23.2	18.0
≥80	20.3	11.1	6.5	45.6	59.2	49.5
Total women	**7.8**	**5.7**	**2.9**	**18.9**	**26.8**	**21.3**
Men						
60–69	1.6	1.8	1.0	7.3	8.9	5.7
70–79	3.8	4.6	2.0	19.9(91)	21.3	13.6
≥80	8.1	7.4	4.5	39.9	43.9	31.1
Total (men)	**3.5**	**3.8**	**2.0**	**17.7**	***9.7**	**13.1**
TOTAL	**5.8**	**4.8**	**2.6**	**18.3**	**23.4**	**17.4**

Source: Eldemire-Shearer D. et al., 2013.

1.2.3. Impairments

The analysis of physical, sensorial, and cognitive impairments is important, as the presence of such limitations can increase the probability of dependency. A large proportion of older adults report having no impairments (61.0%). Among those with impairments, visual, hearing, and physical impairments are the most prevalent (32.3%, 8.7%, and 7.5%, respectively; table 4). As in the case of functional dependency, this prevalence increases steeply with age and is higher among women than among men.

Table 4. Prevalence of selected impairments by age and gender, percentages

	Hearing	Vision	Physical
Women			
60–69	4.2	32.3	4.9
70–79	10.2	36.1	6.5
≥80	17.4	44.2	17.4
Total (women)	9.5	36.7	8.4
Men			
60–69	4.0	20.3	5.1
70–79	7.3	32.3	6.2
≥80	18.6	37.3	10.8
Total (men)	7.8	27.5	6.5
Total	**8.7**	**32.3**	**7.5**

Source: Calculated by the authors using data from the Health and Social Status of Older Adults in Jamaica Study

More than a third of older adults have mild cognitive impairment and over 10% suffer from severe impairment (table 5). The analysis by gender shows that cognitive impairment is more likely to affect women than men.

Table 5. Prevalence of cognitive impairment among adults older than 60, as assessed by the Mini-Mental State Exam, by gender, percentages

Level of cognitive impairment	Gender		Total
	Male	Female	
None	53.6	47.4	50.4
Mild	37.3	39.7	38.5
Severe	9.1	12.9	11.0

Notes: The level of cognitive impairment was measured using the Mini-Mental State Exam (Folstein, Folstein, and McHug 1975).
Source: Eldemire-Shearer D. et al., 2013.

1.2.4. Health status of older adults

The demographic transition comes with an epidemiological transition, in that noncommunicable diseases become increasingly important as the main causes of mortality and morbidity when compared to infectious diseases. Because chronic diseases last a long time and tend not to go into remission, they can lead to functional dependence. Jamaica has completed the epidemiological transition earlier than many of its neighbors: by 1990, noncommunicable diseases were the leading cause of death and the main contributors to the country's burden of disease.

Self-reported data indicates that most older adults (76.4%) have a chronic disease and almost half have at least two. Hypertension, arthritis, and diabetes are among the most common conditions reported (table 6). Prevalence increases with age and for all conditions and is greater among women than men.

Table 6. Chronic disease prevalence by age and gender, percentages

	Age				Gender		
Condition	**60–69**	**70–79**	**≥80**	**Total**	**Male**	**Female**	**Total**
Hypertension	54.8	68.4	64.0	61.4	49.2	72.5	**61.4**
Arthritis	27.9	39.4	42.7	35.0	20.5	48.4	**35.0**
Diabetes	23.8	29.7	26.3	26.3	19.6	32.3	**26.2**
Asthma	7.4	5.4	7.4	6.7	6.0	7.4	**6.7**
Stroke	6.1	10.4	9.2	8.2	7.1	9.2	**8.2**
Coronary heart disease	4.5	5.9	6.8	5.5	3.5	7.3	**5.5**
Cancer	3.5	5.9	6.6	7.2	3.0	5.0	**5.0**
Heart failure	1.6	1.3	2.3	1.7	1.1	2.1	**1.7**
Seizures	1.5	1.4	1.6	1.5	1.6	1.3	**1.5**

Source: Eldemire-Shearer D. et al., 2013

The figures above should be interpreted as a lower bound, as clinical assessments conducted among a subsample of older adults as part of the *Health and Social Status of Older Adults in Jamaica Study* indicate high levels of underdiagnosis and poor disease control, particularly among those who live in rural areas (Eldemire-Shearer et al. 2013).

Dementia is increasingly being recognized as an important determinant of the need for long-term care. Based on data from 2014 and 2018, the prevalence of dementia in Jamaica is approximately 6% (Farina et al. 2020). Depression is another condition that is often overlooked among older people but that can take its toll on physical health as well as mental. In Jamaica, depression is more common among women, with those in the oldest old category reporting the highest prevalence rates. However, most older adults (74.1%) indicate that they are satisfied with “life as a whole.” Table 7 shows the prevalence of depression by age group and gender.

Mental health support was identified as a key area of need in the context of lockdowns and other restrictions during the COVID-19 pandemic. Several studies have identified the anxieties and fears of older adults as they practice social and physical distancing (Donaldson-Davis et al. 2020, Willie-Tyndale et al. 2020).

Table 7. Prevalence of depression among older adults, by age and gender, percentages

Levels of depression	Age				Gender		
	60–69	70–79	≥ 80	Total	Male	Female	Total
Normal	66.2	59.3	44.7	59.3	66.7	52.1	**59.3**
Mild	22.7	24.7	29.0	24.7	22.9	26.4	**24.7**
Moderate	9.2	11.9	19.3	12.3	8.1	16.4	**12.3**
Severe	2.0	4.0	7.0	3.7	2.3	5.1	**3.7**
Total	**100**	**100**	**100**	**100.0**	**100**	**100**	**100**

Source: Eldemire-Shearer D. et al., 2013

Finally, 21.7% of older adults report having a fall within the last six months—both advanced age and being female are associated with falls. Most people (89.0%) who report a recent fall are functionally independent (Eldemire-Shearer et al. 2013).

1.3 Socioeconomic characteristics of older adults

Traditional stereotypes of older people as being frail, dependent, and recipients rather than providers of care have been challenged by findings from the *Health and Social Status of Older Adults in Jamaica Study* mentioned above. These findings highlight that older adults are for the most part functionally independent despite having high prevalence rates of chronic disease (Eldemire-Shearer et al. 2013, Eldemire-Shearer et al. 2014).

The social and economic circumstances faced by older adults throughout their lives exert a significant impact on their ability to function independently in advanced age. These circumstances also influence the possibility of affording quality long-term care services when family or state-provided services are not an option.

In Jamaica, over 70% of older adults own their homes but do not live alone. Among those aged 60 or more, there is a strong connection to the local community, as most have resided in the same area for over 30 years and feel safe and comfortable there. Strong intergenerational relationships are also evident: just under 50% are involved in caring for their grandchildren, and approximately 20% in caring for older relatives. Family ties are also strong, as a majority say they have at least one family member they can rely on in difficult times (Eldemire-Shearer et al. 2013).

However, when it comes to finances, most older adults are not economically independent: more than 60% do not receive any pension and almost half rely on family sources of income (Eldemire-Shearer et al. 2013). The available research also suggests inadequate planning for retirement among the elderly (including housing, savings, and health insurance), such that children are expected to assist their parents financially in old age (Eldemire-Shearer 2008, Eldemire-Shearer et al. 2013). In 2021, the Jamaican government launched its new Social Pension Program, which focuses on vulnerable people aged 75 or older that do not have any other source of income and are not institutionalized. It is estimated that the program will reach around 30,000 beneficiaries.[7]

[7] Judith A. Hunter, "30,000 Persons to Benefit from New Social Pension Programme,"Jamaica Information Service, July 11, 2021, https://jis.gov.jm/30000-persons-to-benefit-from-new-social-pension-programme/.

Section 2: The role of the government in long-term care services

In Jamaica, the National Policy for Senior Citizens is the main policy document relating specifically to older adults and their needs. This policy is described in greater detail below. It is, however, worth noting that older people are considered by the government to be covered by all policies that speak to the rights of the population.[8] Specifically, long-term care services are coordinated and administered by the Ministry of Health and Wellness (MoHW) and the Ministry of Local Government and Community Development.

2.1 Description of the country's policies related to long-term care

Jamaica has no single policy that focuses solely on long-term care. The regulation and provision of long-term care services is highly fragmented and focuses mostly on those that are economically and socially vulnerable. In what follows, we describe the national policies that have some provisions relating to older adults' long-term care.

2.1.1 The National Policy for Senior Citizens in Jamaica (1997)

This is the main policy focusing on senior citizens in the country. It is supported by other legal documents that help to establish priorities in social development and govern how long-term care services are administered. The document provides broad guidelines "to meet the challenge of a growing, healthier and more active senior citizen population by ensuring that senior citizens are able to meet their basic human needs, that those in need are assisted, and that older persons are protected from abuse and violence and treated as a resource and not a burden. Enhance the self-reliance and functional independence of senior citizens and facilitate continued participation in their family and society" (Ministry of Labour and Social Security 1997, 3). Developed in 1997, this policy made the country one of the earliest in Latin American and the Caribbean to implement legislation with a specific focus on older adults and their current and future needs.

The National Policy for Senior Citizens is rooted in the 1982 Vienna Plan on Ageing and takes into consideration recommendations from several international meetings, such as the 1995 World Conference on Women in Beijing and the 1995 World Summit for Social Development in Copenhagen (Ministry of Labour and Social Security, 1997). Jamaica's policy emphasizes the need for older people to maintain "the maximum degree of independent living" and to be able to live socially and economically productive lives. The overall goal of the policy is "to encourage and facilitate full participation of senior citizens in the community for as long as possible, and to ensure systems of care and protection where necessary" (Ministry of Labour and Social Security 1997). The policy includes eight thematic areas: education and media, income security, family, housing and living environment, legal, research, health, and social welfare. The latter two areas specifically emphasize the goal of promoting functional independence; there is also a focus on encouraging community-based services with a multisector approach in the area of social welfare, such as by integrating the efforts of the private and voluntary sectors.

[8] There are several health-related policies that address the needs of older adults in Jamaica. These support the country's overall long-term care policy and include the National Policy on Poverty (2017), the Jamaica Social Protection Strategy (2014), the National Development Plan: Vision 2030, the National Health Insurance Plan (Green Paper), the National Strategic and Action Plan for the Prevention and Control of Noncommunicable Diseases (2013), the Food Security and Nutrition Policy (2013), and the Poor Relief Law and Draft National Population Policy (2010).

2.1.2 The National Policy for Senior Citizens in Jamaica (Revised Green Paper—2018)

In 2018, the National Policy for Senior Citizens was revised and submitted for approval by Cabinet. This revision process was prompted largely by the observed changes in the population structure (i.e., the dramatic increase in the number of people aged 60 and over) and the recognition that older adults were increasingly becoming drivers in the country's economic development. The document has been recently approved by the Cabinet and is to be tabled in Parliament for approval.[9]

The 2018 revised policy document has six goals: increased participation of senior citizens; improved income security and social protection coverage; adequate and supportive health and welfare systems; improved independence, including security and safety; enhanced family and community support systems; and strengthened institutional and infrastructural networks (Ministry of Labour and Social Security, 2018). All strategies and actions are subsumed under six thematic areas: social engagement and participation; social protection, income security, and employment; health and wellness; physical environments, protection, and safety; family integration and intergenerational transfers; governance and capacity-building. There is no explicit focus on long-term care issues; rather they are considered under the purview of the health and wellness thematic area.

The government body responsible for the development and implementation of the National Policy for Senior Citizens is the Ministry of Labour and Social Security, through one of its departments—the National Council for Senior Citizens. The majority of the funding for implementation and monitoring strategies and actions is secured from the government via ministerial/departmental and agency budgets and support provided by nongovernmental organizations (Ministry of Labour and Social Security, 2018).

2.2 The role of the government in assuring the quality of services

Jamaica has a dual system for the regulation and management of care facilities: (a) the MoHW is responsible for the regulation of private care homes (nursing homes and other private care facilities), while (b) the Ministry of Local Government and Community Development is responsible for the regulation and management of public homes.

2.2.1. Regulation of private facilities

Within the MoHW, the Standards and Regulation Division (SRD) has the overall responsibility for private care facilities in Jamaica. The SRD was formed in March 1999 as a part of the health reform process. The SRD's mission is "To improve the quality of healthcare services in Jamaica through standards development and monitoring in consultation with public and private healthcare providers; to regulate healthcare facilities, pharmaceuticals and other designated products; and to facilitate the recognition of the rights of all clients" (Ministry of Health and Wellness 2019b, para. 1).

Within the SRD, the Health Institutions and Facilities Unit (HIFU) has oversight of all facilities that fall under the Nursing Homes Registration Act and Regulations of 1934. These include (but are not limited to) nursing homes, convalescent homes, and adult daycare centers.

[9] Ainsworth Morris, "Cabinet Gives Approval For New Social Pension Programme," Jamaica Information Service, February 3, 2021, https://jis.gov.jm/cabinet-gives-approval-for-new-social-pension-programme/.

The Nursing Homes Registration Act of 1934, section 2, defines a nursing home as "…any premises used or intended to be used for the reception of and the providing of nursing for people suffering from any sickness, injury or infirmity, and includes a maternity home…" The legislation is specific as it addresses the type of staff that should oversee the facility and the different documents/records that should be kept regarding the operation of the facility. These standards refer to all facilities covered by the act, so they do not take older people's care needs specifically into account.

The Nursing Homes Registration Act outlines what are deemed offenses and determines the consequences and fines that apply in each case. The offenses in question are: (a) operating without being duly registered; (b) operating without supervision of a registered nurse/medical practitioner; (c) barring entry to inspector(s); (d) nonreporting of deaths at the facility; (e) not displaying the Certificate of Registration; and (f) failure to comply with the provisions of any of the regulations made under the act.

The Nursing Homes Registration Act also outlines different reasons for which a facility's application for registration could be refused. These include: (a) unfitness of any employee at the facility; (b) unfitness of the facility's situation, construction, accommodation, staffing or equipment, and operation, or of any premises connected with it; (c) not having a medical doctor or a registered nurse in charge, or failure to comply with the resident/staff ratios established in the act; and (d) the staff working at the facility not being under the charge of a registered nurse.

There is evidence to indicate that there are unregistered facilities providing nursing care services across the country. The operation of such facilities is of concern as the quality of care and service that they provide is unknown. Constraints faced by the SRD may partially contribute to the operation of unregistered facilities. These constraints are largely centered on governance issues. First, inadequate staffing limits the SRD's capacity to effectively monitor and regulate the facilities under its remit. For example, at the time of writing, just two officers were responsible for the registration and monitoring of facilities throughout Jamaica. As a result, enforcement initiatives are limited. Second, the Legal Services Division at the MoHW has been subsumed under the Attorney General's Chambers, which has resulted in a backlog on legislative and enforcement matters.

2.2.2. Regulation and management of public facilities

The Ministry of Local Government and Rural Development provides oversight for public care facilities in Jamaica through the Board of Supervision for the Relief of the Poor in Jamaica, which was established under the Poor Relief Act of 1886 (last amendment 1973).[10]

2.2.3. Training and accreditation of human resources

Adequate training of human resources is essential to guaranteeing good quality long-term care services. Staff caring for older adults should have the skills to understand the physical, mental, cultural, social, and family aspects of aging. More specifically, they should have the skills to evaluate the physical, psychological, and nutritional conditions of the persons they provide care for; treat health problems (i.e., frailty, sarcopenia, osteoporosis, osteoarthritis) and, identify and coordinate care for complex conditions and mental disorders such as depression,

[10] Local Authorities of Jamaica, Ministry of Local Government and Community Development, "Poor Relief," last accessed October 22, 2021, https://localauthorities.gov.jm/administration/poor-relief.

dementia, addictions, neglect, and abuse in a timely manner. In addition, social workers and health personnel must have communication skills consistent with the values and culture of older adults and be able to articulate social and health care services in such way that such care is accepted by the users.

At the moment, there are no regulations concerning the training or accreditation requirements for personnel working in the sector. Recently, so-called practical nursing schools and services have emerged, the training standards of which are neither uniform nor regulated (even though guidelines do exist). People who have completed these programs and find paid employment in the sector are referred to as "formal caregivers," but the Ministry of Labour does not legally recognize them, given that "caregivers" are not a recognized category of worker. This gives rise to two issues (1) caregivers are not protected from potentially abusive situations by their employers (most often the family) and do not generate pension rights and (2) employers are unable to verify the credentials of potential caregivers and thus are also unprotected. While Jamaica supports protection from abuse there are no formal structures for reporting elder abuse (Eldemire-Shearer et al. 2020).

2.3. The role of the public sector in the provision of services

2.3.1. Services provided under the Poor Relief Act

The provision of long-term care services by the public sector in Jamaica is part of its poverty alleviation strategy and, as such, is circumscribed to the Poor Relief Act (1886, last amendment 1973). This act provides the legislative framework for the provision of relief services to people who are "wholly destitute of the means of subsistence, and are at the same time [because of] mental or physical causes unable to work and earn the means of subsistence…" (19).

The management and regulation of long-term care services provided by the state are facilitated through the Board of Supervision (BOS), a department within the Ministry of Local Government and Community Development. The main remit of the BOS is to ensure the care, protection, and rehabilitation of the most vulnerable in Jamaica and the relief of poverty and destitution among them, in accordance with the Poor Relief Act. The BOS has been in operation since 1886 and is responsible for two main public programs, namely:

- Outdoor Relief, which assists people who may be living on the streets (homeless) or who may have a residence but are financially destitute. The total population of outdoor poor stands at 12,938, of which 6,319 (49%) are 60 or over. The services covered by the program include the education of poor children, indigent housing, unemployment benefits, medical relief, home care, transportation, and other services. The outdoor relief program also provides benefits to grandparents left to care for their grandchildren and offers night shelters, drop-in centers, and care facilities for the homeless. The program's budget in 2014 was US$76.6 million (Government of Jamaica 2017).
- The Indoor Poor Program, which is operated from the infirmaries that are in each parish and provide housing for 1,405 residents island-wide. Of this total, 941 (67%) are aged 60 or over. The program's budget in 2014 was US$296.2 million (Government of Jamaica 2017).

The indoor relief program primarily targets older adults who are unable to care for themselves (due to mental or physical causes), destitute, while not having anyone else to care for them (Poor Relief Act, section 28). The services offered are carried out by registered nurses, enrolled assistant nurses, and patient care assistants, in collaboration with other stakeholders.

In response to the COVID-19 pandemic, several safety measures have been implemented to safeguard the health of infirmary residents and indoor relief facility staff, including new screening protocols for admission and entry, the construction and refurbishing of isolation areas, staff training on infection control practices, thorough facility sanitization, and the installation of sanitation devices and additional wash handwashing areas.

2.3.2. Services provided by the National Council for Senior Citizens

The National Council for Senior Citizens is an agency at the Ministry of Labour and Social Security and is responsible for coordinating and monitoring the implementation of the National Policy for Senior Citizens. It runs several programs, including:

- Home help, consisting of the visit of a nurse aide or a volunteer that assists the older person with health-related, personal, and domestic tasks. According to the Ministry of Labour and Social Security website, nurse aides operate in just 3 out of the country's 14 parishes and are supplemented by volunteers working in rural parishes.
- Day activity centers, which offer health, educational, and recreational activities. It should be noted that functionally dependent individuals may assist only if they are accompanied by a caregiver or nurse.

2.3.3. Coverage and eligibility of public services

The coverage provided by these programs in the area of long-term care is very limited. A recent investigation finds that there are 18 public residential homes in Jamaica, two of which—known as Golden Age Homes—specifically provide care for older people in conditions of extreme poverty, while the remaining 16 receive adults of all ages.

According to Govia et al. (2021), public residential homes can meet the care demands of 0.005% of the population aged 60 and older, at most. Consequently, the need to provide support in economically constrained settings has led to more focused program planning and rationing through careful dependency/need assessment.

The process for receiving benefits under the Poor Relief Program is a streamlined one, which begins with the individual or their proxy applying to the Poor Relief Office in their parish (there is a Poor Relief Department in every parish capital). A needs assessment is conducted, which is a standardized process that takes into consideration the applicant's basic demographic details, such as age, gender, place of birth, number of people in the household, and their dependents. The applicant's average weekly earnings (if any), assets (including house or land), disability status, and general state of physical and mental health are also assessed. The application is accompanied by a medical certificate that indicates whether the applicant is able to work and earn a living. A site visit is then conducted by an Inspector of Poor to confirm the information contained in the application. The Municipal Corporation (the managers of the Poor Relief System in each parish) decides on each application and then directs the Instructor of Poor to grant relief. The Municipal Corporation also hears and decides on appeals from poor people who have been refused relief or who may consider the relief afforded them to be inadequate.

It should be noted that the first goal of the MoHW Ten Year Strategic Plan 2019–2030 underscores the intent to strengthen long-term and home care for the elderly in collaboration with the social sector, as part of the strategy to improve access to equitable, comprehensive, quality healthcare (Ministry of Health and Wellness 2019b).

2.3.2 Steps toward the integration of health and social services

In 2008, Jamaica and other countries worked with the WHO to develop the Age-Friendly Primary Health Care Centres Toolkit, which sought to improve primary healthcare responses and sensitizing healthcare workers on the specific needs of older adults.

The toolkit is used by local clinicians (especially in the public sector) to assess the functional decline of older individuals. It provides insight into how dependent older people are on mental and physical support. It contains complete protocols for measuring memory loss, difficulties in performing the activities of daily living, depression, urinary incontinence, falls, and hypertension and diabetes control.

The toolkit encourages a comprehensive yet routine approach to geriatric assessment that engages all levels of healthcare staff in the early identification of loss of autonomy/immobility, cognitive impairment, poor noncommunicable disease control, and those who live alone, which are some of the recognized predictors of functional decline (McCusker, Kakuma, and Abrahamowicz 2002).

This evaluation leads to the engagement of the attending doctor, the older person's relatives, social support services, and long-term care planning. More specifically, the primary healthcare toolkit is a screening tool that can be used by nurses to refer patients to attending doctors. Based on the nurse's screening and the doctor's assessment, a plan is developed in collaboration with the family and a decision made about whether the client can function independently at home or whether a long-term care facility (either public or private) would be in their best interest. Each clinic has its own social workers and public nurses, while community health aides are in charge of conducting home visits and inspections.

Section 3. The role of the private sector in the provision of long-term care services

In Jamaica, much like the rest of the world, family members are the main providers of long-term home-based care. Within the last few decades, however, there has been an emergence of formal establishments providing care in the private sector, run by both for-profit and not-for-profit organizations, including civil society and faith-based organizations. The objective of this section is to describe the role of each type of institution.

3.1 Informal care providers

In Jamaica, older adults residing in the community (i.e., those who have not been institutionalized) are predominantly cared for by family members (Holder-Nevins et al. 2018). Of those functionally dependent older adults, 58% receive care from a family member (James et al. 2020).

A cross-sectional, nationally representative study that interviewed 180 caregivers of older people in Jamaica showed that 77% of them were family or friends who provided long-term care without compensation. Of these, 91.6% had not received formal training. Male caregivers were more likely to be related to the recipient of the care than women (Holder-Nevins et al. 2018), and most caregivers (approximately 80%) lived with the person they were caring for. The mean number of hours spent providing care was 41.3 hours per week (Holder-Nevins et al. 2018).

It is assumed that the type of care offered by caregivers directly correlates with the needs and functional abilities of care recipients. The latter were between 60 and 104 years old, and approximately 60% were women. Over 80% of care recipients had more than one chronic condition (hypertension, diabetes, and cancers), 43.3% had restricted mobility, 41.7% were ambulant, and 15% bed-bound (Holder-Nevins et al. 2018).

3.2 Services provided by private entities

3.2.1. Residential services

There are an estimated 183 private residential facilities in operation across Jamaica's 14 parishes. Of these, only 22% (i.e., 34 facilities) are legally authorized to operate under the Nursing Homes and Registration Act of 1934 (Ministry of Health and Wellness 2019a).

Private nursing homes operate as business entities and are predominantly sole traders and partnerships. As such, financial information on them is not publicly available. The cost of care varies widely, depending on the amenities provided, location, and facility size. Generally, however, private nursing homes offer a wider range of amenities than government-run infirmaries. Another important difference is that people are admitted to infirmaries based on needs, which are assessed using a specific set of criteria (see section 2.3.1). Provisions at government-run infirmaries are basic and include shelter, medical care, meals, and clothing.

There is no government funding support or social or private insurance that covers private nursing home care, for which monthly fees are charged. Within the Kingston and St. Andrew metropolis, fees tend to be higher than in other parishes and can range from JMD75,000 (US$520) per month for triple occupancy to just above JMD200,000 (US$1,400) per month for single-occupancy dwellings. Residents are offered 24-hour supervision by registered or practical nursing staff and are assisted with activities of daily living. Other offerings include faith-based activities and entertainment (like the broadcasting of television and radio

programs) and occupational activities (such as writing, artwork sessions, and board and card game activities) organized by staff. Some facilities offer short outings to church. Some private nursing homes accommodate regular visits from family, church, and other support groups, which are an essential part of residents' psychosocial interactions and support. Physical therapy and exercise assistance ranging from short walks to structured exercise programs are also offered at some private facilities. A few residential facilities offer short-term stays as respite care.

One of the challenges facing the SRD at the MoHW is the disproportionately large number of unregistered facilities. The parishes of Kingston and St. Andrew have the largest number of these (13), while those of St. Thomas, Hanover, and Trelawny have no registered facilities (Ministry of Health and Wellness 2019b).

The main factor affecting registration status is thought to be the stringent infrastructure requirements, which tend to be more costly than the nominal registration fees and fines applied in the face of violations stipulated in the legislation.[11]

3.2.2. Other long-term care services

At present, there is no official information regarding the provision of other long-term care services by the private sector, such as daycare centers, home care assistance, or teleassistance.

However, there are some private companies and faith-based organizations that run daycare centers for retirees and parents of staff. Guided by the Nursing Home Act (1934), they provide a safe environment and appropriate activities to promote active aging. They provide a respite for families, caring for the dependent person a few hours per day, delaying institutionalization.

Personal assistance is mainly provided by the informal sector (specifically, the family). The large private entity that provided home care services (Hyacinth Lightbourne Visiting Service) stopped operating approximately ten years ago, and the market is now populated by several smaller companies. These hire a cadre of geriatric practical nurses, who are deployed at hourly rates to provide 24-hour, in-home care at various levels.

3.2.3. Services provided by NGOs

Faith-based, humanitarian, and other charitable organizations provide long-term care services for older people in Jamaica. These organizations range from well-established international/multi-country organizations to small community-based organizations and individuals. The 2020 list of Registered Charities identifies 90 organizations with a focus on the health and welfare of older people, including the provision of long-term care services.

The services offered by these organizations include full-time residential care, the distribution of care packages, and assistance with the instrumental activities of daily living. Full-time residential care services are typically offered at no or low cost to destitute people. Facilities vary regarding the level of residents' functional dependence that can be supported. Worth noting is that the services that are offered by these agencies are not supervised by the government.

[11] The Disabilities Act of 2014, the Miscellaneous Penalties Provision Act of 2011, and the Public Health Act of 1988 are the laws governing these facilities.

Older people who are in need and reside in their own homes can also benefit from services provided by faith-based, humanitarian, and other charitable organizations. The periodic distribution of care packages containing items such as food, clothing, hygiene products, medical supplies, and other personal items is one of the more common ways in which older people's needs are supported. Other important but less commonly offered services include medical assistance and assistance with performing the instrumental activities of daily living. Examples include assistance in making and attending medical appointments, filling prescriptions, grocery shopping, and paying bills.

To perform these activities, the organizations in question generally accept sundry donations that supplement their formal funding and support mechanisms. There is also heavy reliance on volunteers.

Section 4: Analysis and perspectives of the provision of long-term care in Jamaica

Long-term care services have been offered by the public sector in Jamaica for a long time, although coverage is very limited and focuses on the socioeconomically vulnerable population. The country has long recognized the need for such care, as evidenced by the many laws and programs presented in section 2, notably the National Policy for Senior Citizens in Jamaica, which was enacted in 1997. Given that Jamaica was still a low-income country at the time, the enactment of a policy to ensure that the basic needs of this population group are met was a major achievement.

Country reviews suggest that Jamaica has performed well at developing an organizational infrastructure. However, implementation has been very limited, and long-term care services are not widely available (United Nations Population Fund and HelpAge International 2011). The provision of long-term care services is even less developed in rural areas of the country, an issue that is of great concern, given that 40% of older people reside there. The lack of adequate staff and financing have been identified as the main barriers to full implementation.

The National Policy for Senior Citizens in Jamaica was based on the promotion of active aging that was first proposed by the World Health Organization in the mid-1990s. Jamaica's support for this was later reinforced by its participation in the Madrid International Meeting on Ageing in 2002. This policy, which was revised in 2018 and is awaiting approval by Cabinet, made mention of institutional long-term care to assist the most vulnerable with accessing shelter. Additionally, the policy also highlights the need for social protection for older adults and the importance of promoting universal access to quality health care.

Residential care is the main long-term care service available in Jamaica. Public institutions target the poor, while the private sector also offers various levels of institutional care, from residential to nursing care. The nongovernmental sector is also heavily involved in the provision of residential care in Jamaica, especially through churches.

While there are standards and regulations in place relating to the operation of long-term care facilities (Ministry of Health and Wellness 2012), these are inadequately operationalized, mainly due to insufficient numbers of government employees needed to conduct visits and inspections. The COVID-19 pandemic has exposed this issue and encouraged the adoption of steps to improve the services offered within facilities and increase the number of inspections. However, there is no public information to confirm that such steps have been taken.

It is important to note that there are cultural barriers in Jamaica that prevent families from placing elder members in institutions, even when they cannot provide the care these individuals need themselves. Furthermore, there is a reluctance among older people to leave their homes, which is exacerbated by the fact that most homeowners (78%) are aged 60 or more (Eldemire-Shearer et al. 2014). Older adults' preference to age at home is backed up by the evidence that remaining at home for as long as possible has beneficial effects on the health status and autonomy of older adults (World Health Organization 2015).

In this regard, the provision of home care services is an area of opportunity for both the public and private sectors, particularly given that Jamaica is currently working on primary healthcare renewal and has announced that geriatric care will be a focus. One component of the age-friendly program plans to have community health aides visit older people at home: if implemented, this could help prevent the need for institutional care by identifying opportunities for early intervention. The target groups for this program would be those who

have been recently hospitalized or recently widowed and are living alone. Extra community health aides were employed to carry out COVID-19 prevention activities, and there is now an opportunity for them to be trained to visit older people.

It should be noted that while long-term care is different to healthcare, the two are intrinsically related. Health status is a critical determinant of functional independence and of the ability to perform the activities of daily living. The health and functional status of older adults, the provision of healthcare services, and the availability of community networks are important considerations when discussing the provision of long-term care services and the design of policies and programs for older people (particularly in community settings). The integration of health and long-term care is crucial to provide high-quality services.

Investing in the training and accreditation of human resources is also key to ensure the quality of the services provided. Additionally,, as discussed, better coordination and regulatory mechanisms are needed.

The development of a long-term care system implies budget expenditure commitments from the public sector. An important step in the design of a long-term care policy is to determine its cost. In order to do this, it is necessary to have an estimation of the gap between the demand and supply of services. This implies, on the one hand, having current estimates of long-term care needs at the population level. These estimates should inform policy makers not only about total needs, but also about their characteristics, including data on dependency levels, age-composition, and socioeconomic characteristics of the dependent population, so that services and eligibility rules could be designed accordingly. On the other hand, it is necessary to have a clear understanding of the services that are already being provided and how effective these are. More research is needed in both areas. As noted thorough the report, some of the data currently available in the country is relatively dated.

In conclusion, moving toward an integrated system is key to addressing long-term care in Jamaica. Likewise, viewing long-term care as a way to maximize the autonomy of older persons and facilitate self-management is a key ingredient of development. Long-term care should include a range of services, from at-home community care to residential nursing care. Currently, very few of these services exist in Jamaica, and the limited public provision is targeted at the poorest segments of the population.

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