Capacity building for Community-based Long-Term Care

COLLABORATIVE WORKSHOP. OCTOBER 2019.

Asia Pacific Economic Cooperation (APEC)
National Institute of Geriatric Medicine (INGER)
Pan American Health Organization/ World Health Organization (PAHO/WHO)
Global Aging Research Network International Association of Gerontology and Geriatrics (IAGG)

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Content

Editorial data

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List of Participants

Table 1. Presenters and organizations represented in the opening remarks.

Ángel Villalobos Rodríguez	APEC representative, Ministry of Economics, Mexico
Luis Miguel F. Gutiérrez Robledo	Ministry of Health Mexico
Andrés de Francisco Serpa	PAHO/WHO
Cristian Morales Furihman	PAHO/ WHO Mexico
Enrique Vega García	PAHO/WHO
María del Rocío García Pérez	National System for Integral Family Development (DIF Nacional)
Nadine Gasman Zylbermann	President of the National Institute for Women (INMUJERES)
Plácido Enrique León García	Ministry of Health for Mexico City
Almudena Ocejo Rojo	Ministry of Wellness for Mexico City
Carmen Santamaria Guash	Mexican Institute of Social Security, IMSS
Shintaro Nakamura	Japan International Cooperation Agency JICA, Japanese Expert
Romina Rioja Ponce	National Older Adult Services, SENAMA, Chile
Juan del Canto y Dorador	Head of the Senior Adult Life Stage Ministry of Health, Peru
Flor Murillo Rodríguez	Ministry of Health, Costa, Rica
Caridad del Pilar Medina E.	Ministry of Public Health, Cuba
Vadim Yurievich Samorodov	Federal Center for the Russian Federation's Subjects , Russian Federation
Erna Mulati & Lisa	Ministry of Health, Indonesia
Atthaphon Kaewsamrit	Department of Health, Thailand
Noriah Binti Hajib	Cheras District Health Office, Ministry of Health, Malaysia
Sang Baek Kang	Director General of Global Cooperation NHIS, Republic of Korea.
Anne Hendry	Integrated Care Senior Associate, International Foundation for Integrated Care (IFIC). Scotland
Adelina Comas-Herrera	London School of Economics and Political Science, LSE
Pablo Ibarrarán	Inter-American Development Bank, IDB
Luis Miguel Gutiérrez Robledo	Director, National Institute of Geriatrics

Opening

The opening remarks were provided by María del Rocío García Pérez, head of the National System for the Development of the Family (DIF), Luis Andrés Francisco Serpa, director of the Department of Family, Health Promotion and Life Course of the Pan American Health Organization, Nadine Gasman, director of the National Institute for Women, Luis Miguel Gutiérrez Robledo, director of the National Institute of Geriatrics and representative of the Health Ministry of Mexico, and Ángel Villalobos Rodríguez, representative of the Ministry of Economy and also in representation of APEC.

The speakers provided highlights about the current situation of ageing and long-term care worldwide:

The demographic and epidemiological transitions have led to an increase in the proportion of older adults in most of the economies of the world. However, instead of advancing to the compression of morbidity, the burden of disease is leading to an increase in life expectancy with disability and an associated increase in care needs.

Most of the demand for long-term care (LTC) is being faced by the unpaid families and predominantly by women, thus hampering human and economic development. “Time poverty” is an emergent concept that highlights how the burden of care impacts the life course development of people, mainly woman and girls.

In a context of financial uncertainty, economies usually prioritise allocating resources to the most urgent and sensitive sectors. Long-term care costs are having an increasing impact on economies. Financial, political and implementation constraints are to be overcome in the next few years. The present workshop is aimed at sharing experiences, innovations and discussions that can shed light on the design and implementation of LTC systems in an economy-wide scale.

Day 1. How are the economies designing and implementing long-term care services and systems?

Long-term care systems in the different economies have undergone different levels of implementation, mainly related to perceived importance of the topic at the national government levels. Two relevant general topics include: reaching consensus about the definition of care dependency and reaching consensus about financing schemes.

The final program of the workshop is presented as Annex 1, and highlights of the presentations included in this block are summarized in table 3. The full presentations of each economy are available at: http://www.geriatria.salud.gob.mx/contenidos/institucional/desarrollo-capacidades-apec-inger.html

Table 3. Highlights of the case studies at the economy-level

Design	Financial	Health and social sectors and the integration or fragmentation among them	Implementation milestones
Thailand Community-based system at the sub-district level. Presented by: Nora Lisa Nordín	• Financed under the UHC financing scheme including: LTC fund, rehabilitation fund and sub-district health security fund. • Home improvement fund was mixed: Ministry of Human Development, provincial administration, local administration, but also private agencies (ie. Red Cross) • Includes community donations • Ministry of education runs an informal education centre which supports training for caregivers.	• All sectors involved with the elderly issue are part of the National Committee for Older Persons and play a role in the 20-year National Plan on the Elderly. • An agreement has been signed between four Ministries related to the LTC in 2018. • The Ministry of Public Health and the Health Security Office signed an agreement to link data about long-term care in 2018.	• Data system categorised according to the levels of functioning of older adults (ADLs) • Family care team involving the caregivers: caregiver volunteer (paid 20 USD per month), community caregiver (former volunteer plus 50 hours of training, with payment from the local administration), a care manager, but also health personnel, traditional Thai medicine and monks. • Training of trainers sessions for capacity building.
Japan's collaboration in Thailand Community-centred conferences and empowering of current resources. Presented by: Shintaro Nakamura	• Changing from a fiscal budget-only financing mechanism to a LTC insurance scheme allowed for a widening of the target population • Empowering current human resources (i.e.	• Strengths of the health and social systems that helped Thailand to start the LTC system: a) The infrastructure strength of the public health sector, b) the availability of an organization of	• Introducing care management and care managers as key features for the implementation of the LTC insurance and to make it work at the community-level. • Conforming the community care

	training for care management) allows having significant impacts without having to increase the number of employees in the public sector. • Carefully decided which kind of services can be provided by volunteers and which by professionals.	health and social volunteers designated by the health and social Ministries. • Team of Family Care: includes the visits of physicians, nurses and other health professionals to the homes. • Having community-based follow-up after discharge is fundamental	"conferences", which include police, firefighters, volunteers and private companies. Community conferences are empowered to define the most important actions to be performed. • Mobile teams to provide community-based services like direct care-providing but also deliver social benefits and training for caregivers and care managers. • Corporative governance was relevant
Chile			
Health and social sectors run in parallel but separated. Presented by Romina Rioja Ponce	• For some services, there is public funding (subventions) going to private non-profit organizations in search for improvements in the quality of the services provided. Yet, reduced coverage. • Several sources of funding aimed at fragmented programs • 40 M USD by the social sector and 117 M USD by the health sector	• SENAMA provides fully- and partially funded social benefits including residential and respite care. • Health sector services include immunization, home-based consultations and the complementary feeding program • Subsidized socio-sanitary bed program • Preventive program aimed at OA (older adults) at risk of care dependence (kinesiology and occupational therapy)	• Local networks are in charge of the integration of the services • Case managers are focused on socially isolated older adults

		• Program for dementia • Main reasons for fragmentation between health and social sectors are: different age definitions for "older adult", different methods of functional assessment, different ways of gathering the information, different target populations.	
Peru			
• Since 2016 there is legislation in place to protect older adults, but it is not operationalized yet. • Lack of professional caregivers and of formal training for caregivers • The norms and guidelines need to be updated because they are currently focused in maternal and child health • Accountability mechanisms should include a methodology to assess the cost-effectiveness of publicly funded interventions Presented by Juan del Canto y Dorador	• Pension of 74 USD every two months to 15.5% of the adults aged 65+ (those who are in extreme poverty) • The budget is assigned according to indicator-based performance. The problem is that the indicators are not comprehensive of the aging aspects and privilege maternal and child health	• Reasons for fragmentation include different inclusion criteria for benefits across programs, and divergent programs offered by each sector. • Other programs with low coverage • They have chosen to organize the community-based strategies using the local clubs of the older adults for health literacy.	• Highly frequent changes in the political posts interrupt advocacy and lobbying. • Civil society and multilateral commitments play an important role for raising awareness and place the aging topic on top of the agenda
Japan			
Mandatory insurance scheme	• Mandatory payments starting at age 40, and individuals	• The scope of the work of the case manager is the	• The municipality works as the insurance entity and

Presented by: Shintaro Nakamura	become eligible for benefits from age 65 if care dependence is certified • Currently, 18.3% of the population 65+ benefits from the insurance • Besides the contributions from younger adults and pensions (45% of total), there are transfers from the taxing system to the LTC insurance (45%); and also 10% from out-of-pocket at point of care. • Allows for a mixed functioning with additional payment if the people want to receive services from external providers. • Market management approach: the government controls the market, but 50% of the service providers are private enterprises. • The price of the services are fixed by the government each three years	home and community-based services	can deduce the insurance cost directly from the individual pensions (pension coverage around 90%) • Certificate of professional caregiver (established 1987) • The government exerts regulation of the market by fixing the prices of the services of LTC, but also by stablishing quality standards for the reimbursement of the services i.e. requiring the private and public providers a minimum number of employees available. • Comprehensive evaluating framework
Indonesia • Care management is at the centre of the conceptual model. • Three domains of actions: a) residential care for care dependent OA, b) community-based care supported by families and NGOs, c) hospital care for	• Largely relying on the family´s budget with pension coverage under 15% for women • Approximately 24% of the health resources -claimed by the insurance companies- were due to OA health care	• Estimated demand is 3.8% • 32% of OA lack a health insurance • The majority of the health service utilization by OA is for outpatient primary health care • The LTC is managed by the	• Five level training programmes for the caregivers: from pre-employment training to professional skills in 8-9 years. • Pilot integrative LTC project in areas of Yogikarta and Bali, including the

clinical conditions that deserve further attention. Presented by: Erna Mulati	• Non-contributory scheme for poor people: from taxes through the federal and local governments • Contributory scheme: financed from workers in the formal sector and informal sector • Plan to implement the LTC insurance in 2023-2024	Ministry of Social Affairs, mainly providing shelter for the homeless and conditional cash transfers. • The Ministry of Health runs a program aimed at developing LTC through payed and non-payed -family-caregivers	implementation of a special information system that gathers data from public and private entities and community based LTC services. • Accreditation for care including transitional care/ sub-acute care.
Cuba Strategy centred in the Primary-Care context. Presented by: Caridad Medina Entrialgo	• Financed by public sources only. • The payment of the pension is suspended if the older adults becomes a full-time resident at the older adult shelters.	• The estimated demand of LTC day-care services is 2.2% of 60+, and 1.3% for the shelters for older adults. • Yearly examination for people aged 60 years and older. • Caregiver schools exist at the community-level. • 1 hospital bed in the Geriatric ward for each 2,000 older adults. • Clinical protocols have been established for geriatric syndromes and other frequent pathologies in Geriatric Medicine.	• In 2018, pass an official resolution to mandate the implementation of "caregiver's schools" which should perform at least one workshop per trimester (20 hours per workshop). • The "Circles of the Older Adults" serve as a connecting entity between the health and social sectors at the community-level. • Currently, 41% of older adults are registered to the "Circles of the Older Adults".
Russia The primary health care structure is responsible for LTC. Presented by: Vadim Samodorov	• 80% of the LTC services are funded through an insurance scheme, and there are also private providers. • Taxes: 2% is paid for pensions and	• The estimated demand is 6 million and the estimated supply is 2.1 million. • Around 1 million people receive care at home or in houses	• This economy is considering the options of a) the LTC insurance and b) the creation of market niches to improve financing.

	5.1% for health insurance.	funded by the government.	
Malaysia Mixed public/private offers in the urban areas. Presented by: Noriah Hajib	• The reported welfare assistance for older adults equals approximately 21% of the GNI of Malaysia. • One of the challenges highlighted is finding an adequate scheme for financial sustainability.	• Health and social systems offer health services and social aids organised at the community-level using separate criteria (relatively low level of connection among them)	• Clear regulations for main modalities of LTC (ie. Care Centre Act 1993, Private Healthcare centres and facilities Act 1998, private Aged Healthcare Facilities and Services Act 2018)
Costa Rica National Network of caregiving and childhood development Presented by: Flor Murillo Rodríguez	• Social sector budget stipulated in the law • CONAPAM: the national council for the older adults of Costa Rica integrates public and private stakeholders who receive public funding for implementing projects.	• The LTC residences and shelters for short stay are managed by the social sector; in addition of the subsidies. • The health sector manages the day hospitals, the consultation delivered at home and the national network of palliative care, including the patient and family education. • The aim is to build 40 local networks in priority municipalities	• National Law 9220. Supporting the National Network of caregiving and childhood development • Definition of the target population: people aged 65+, living in poverty, without social support network, with care dependency or at high social risk. • Community-based geriatric unit: specialised health personnel visits the household of older adults to provide consultations, i.e. after discharge.

Day 2. A systemic approach to long-term care

The second day of the workshop started with presentations from four experts with backgrounds in the academic, policy and public health fields related to long-term care. Enrique Vega, from the Pan American Health Organization / World Health Organization; Pablo Ibarrarán from the Inter-American Development Bank; Anne Hendry, from the International Foundation for Integrated care (IFIC) and Adelina Comas-Herrera, from the Care Policy and Evaluation Centre, London School of Economics and Political Science.

Their presentations are summarized in this section highlighting the elements most relevant to the design, implementation, financing, and evaluation of LTC systems with an integrative approach. Two main ideas shared by the presentations are:

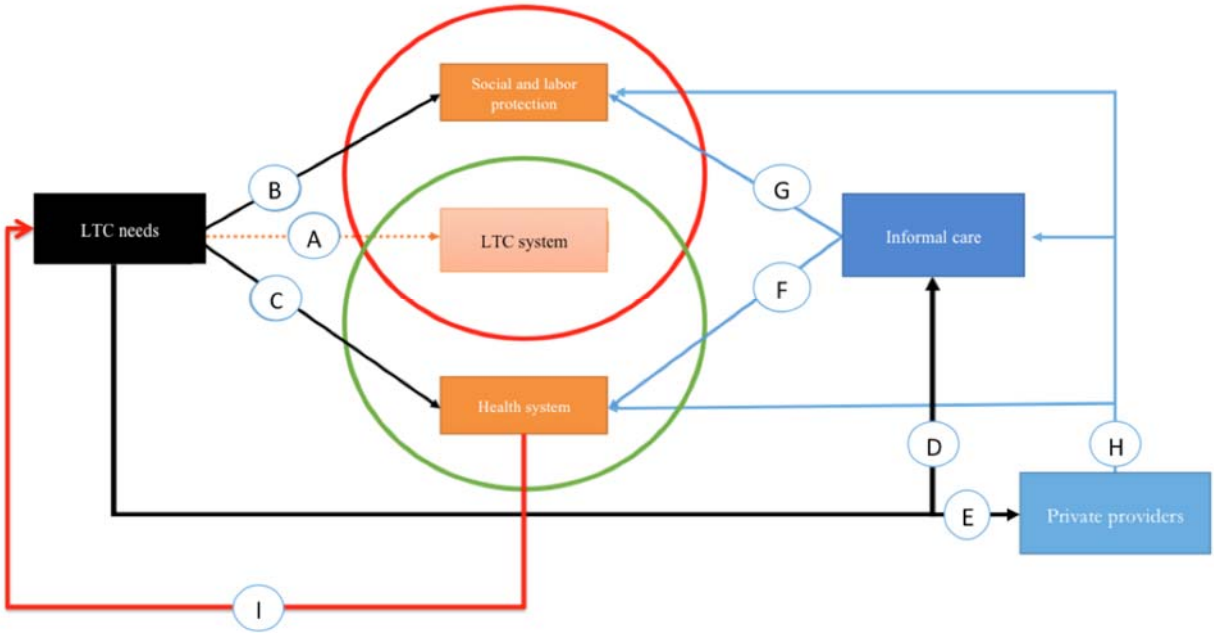
1. Economies need to shift from a family-based care provision system mainly supported by unpaid caregivers to a community-based integrated care with systemic approach.
2. The systemic approach to long-term care can be implemented by integrating elements such as information systems, budget, quality and care standards and regulations, technology, workforce capacity building and evaluation frameworks.

Summary of "Strategic vision of the Pan American Health Organisation (PAHO) for the Long-term care in the Americas" presented by Enrique Vega.

- Aging is a fact and is happening faster in the Americas than in the rest of the world.
    - Is increasing the number of people 60 years and older and their remaining life expectancy
    - It is estimated that care-dependent population will double between 2010-2050, from 349 million to 613 million
    - The dependent older adults will increase from 101 million to 227 million
    - Growth will be particularly noticeable in developing economies

- The pillars of LTC in many economies remain invisible (unpaid family care givers), but will they resist? The economic value of non-payed caregiving is higher than the total cost of Medicaid and also higher than the total out-of-pocket payments for health services in the United States.
    - Non-paid family care giving generates gender inequality by hampering the participation of caregiving women (the large majority) in the labour market and in accomplishing their own development.
- Not only the demand for care services is increasing but also the traditional ways of services supply are shrinking (changes in the conformation of families, reduction in the fertility rate)
- The boomerang of the non-paid caregiving on the health and social systems. The "wear and tear" of the family caregivers associated to non-paid caregiving may cause them health conditions which will make them eventually come back (like a boomerang) to the health system. Also, non-paid family caregivers are more prone to be impoverished by assuming the care costs of their relatives, which may eventually lead them to ask for social assistive services.

Figure 1. Investing in long-term care system is the missing piece of the social security system



Source: Villalobos, 2018. (1)

- Care dependency is not the same of poverty, reason why the assistive social policies are not enough and do not replace a long-term care system.
- Given that there are health and social policies already in place in most of the economies, the LTC does not need to start *from scratch*, but the elements already put in place should be harmonised applying a systemic integrative approach.

Summary of "Aging and Long-Term Care: the IADB's perspective" presented by Pablo Ibarrarán.

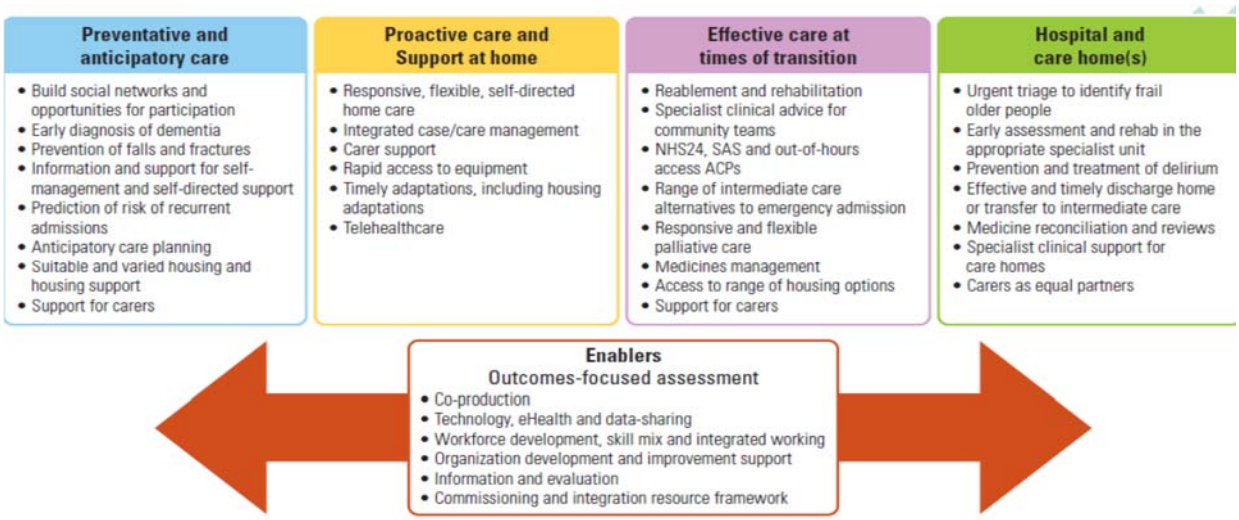
- Population ageing in Latin America and the Caribbean is a multisectoral issue with two dimensions:
    - The micro level: will the economies be able to provide basic services for older adults (pensions, health care, long-term care)?
    - The macro level: will the economies be able to fund those services without compromising financial sustainability?
- The demographic dividend that benefitted the LAC region during the last 40 years, will convert into a demographic bill in the decades to come.
- Achieving healthy ageing might extend the demographic dividend.
- Conditions of the LAC region such as fragmented health systems, weak robust welfare states, less advanced socioeconomic conditions and lower pension coverage, set up a less favourable context than in developed economies for the implementation of LTC systems.
- For some economies in LAC, the implementation of a LTC system will cost less than 1% of the GDP (baseline estimations without considering health services). The average cost for the OECD is 1.7% of the GDP. In Europe, the LTC system sector represents 2% of the employment.

- Financing issues: the determination of the benefits should consider not only the income, but also the wealth of the older adults. Greater use of community care is recommended.
- Women are the largest group contributing towards care provision.
- Six recommendations
    1. Chose beneficiaries based on level of care dependence rather than age
    2. Train human resources and establish quality standards
    3. Start with home and community-based services / respite care
    4. Most cash transfers should require buying care services
    5. Use a mix of financing mechanisms, set up a single unified system
    6. Involve the private sector to create formal jobs

Summary of: "Systemic approach to Long-term care" presented by Anne Hendry.

- A systemic approach to LTC is needed given the complexity of interactions between the stakeholders involved in the health and social interventions of many older adults.
- Guiding principles for integration of services are: preserving the continuity of care, building trusted relationships, having accessible information and advice and good communication with and between the staff.
- Continuity and coordination of care: eight priorities
    - Continuity with primary care or community of care -professionals
    - Care planning: share decision making and support for self-management
    - Case manager
    - Co-located services, hub or a single point of access
    - Rehabilitation, intermediate care and transitional care
    - Comprehensive care along the entire pathway- Including LTC and hospital care
    - Information and digital technology
    - Interdisciplinary education and workforce development
- Reshaping the care for older people means to transit from a budget highly concentrated in the hospital-based services to that allocates more resources to the community-based care services.
    - For example, 2% of the population in Scotland accounted for 50% of the acute hospital spend and community prescribing, and 77% of the bed-days.
    - Reshaping the care for older people includes capacity building at the community-level, among other strategies (See Figure 1)

Figure 2. Reshaping long-term care for older people



Source: Hendry, 2016. (2)

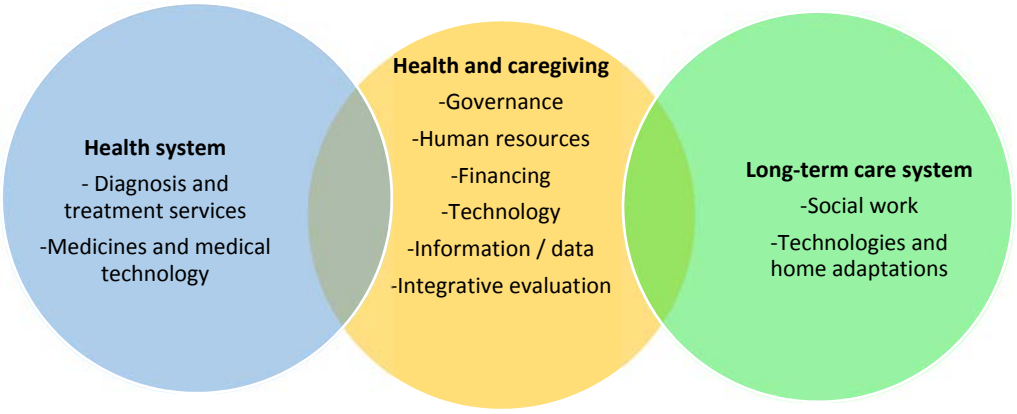
- Invest in prevention and early interventions
    - Robust: Healthy lifestyle advice
    - Pre-frail or frail: Technology enabled, support for self-management
    - Functional limitation: support, telecare, ADL advice
    - Disability: Rehabilitation, equipment, housing, care and support
    - Dependency: Care coordination, care support, palliative and end of life care
- Linking data sources, budgets and regulations are important for a systemic approach
    - The first step for the NHS Scotland was the legislation in this matter
    - The creation of a linked health and social care file was of great benefit to make the data gathering more efficient and to use it in
    - The integration of budgets, regulations and standards was crucial for applying a systemic approach to LTC in Scotland
- Networks and partnerships are ways of integrating health and social services that can help transcend classical hierarchy-based structures
    - Creative ways of networking can be adapted from previous experiences to fulfil the contextual needs
- Implementation and evaluation frameworks should be put in place to foster the integration of health and long-term care services with a systemic approach
    - Some examples are: SCIROCCO – Scaling Integrated Care in Context
    - Self-Assessment of Maturity and the Integrated Care Performance Assessment (ICPA)

Summary of: "Designing Long-Term Care systems with community-based strategies in LMICs" presented by Adelina Comas-Herrera.

- Even if the LTC policy "window" seems mostly closed, there are tasks to be done like preparing a plan for when it opens, or look for alternative topics closely related with a "more opened" window (ie. Dementia)
- The process of working a national policy for LTC is a dynamic and sometimes messy process that demands looking for consensus and often going *back and forth* with the design and implementation actions.

- The “building blocks” of the health systems will have to be adapted to an integrative system that includes the health and social sectors, plus the intersection of both.
- Families are the largest source of LTC resources (in-kind). This unpaid caregiving might not have a price, but it has a cost: cost of reduced employment, cost of heath of the caregivers and long-term costs for child caregivers. On the other hand, paid caregiving can easily become catastrophic consuming lifetime savings.
- The Public sector funding can be applied by tax-based systems or social insurance systems.
    - Tax based systems: are more susceptible to cuts. Social care systems have less political *surplus* than health or education.
    - Social insurance systems: funds are raised specifically for LTC and therefore can be protected from political interference. These systems can sometimes be regressive and depend upon narrower sources of fund.
- Private insurance schemes are not enough to cover the entire risk of LTC (USA), but can have a “topping-up” role when the public care system covers a basic care package (France / Germany).

Figure 3. Long-term care system building blocks



Source: Comas Herrera 2020 (adapted from slide #10 of her presentation).

Day 3. Challenges and resolutions ahead.

Challenges

The technical committee of the Workshop based at INGER, undertook a highly participative discussion in order to define and set a consensus around the main barriers for the implementation of long-term care systems. The group also decided to use the Café-to-go technique (3) to guide a small group discussion of the main barriers, using the background and expertise of all the participants/economies that participated in the Workshop. At the start of this session, Mariana López-Ortega from the National Institute of Geriatrics Mexico presented the guidelines for the small group discussions. In the first session, participants were

assigned to one of four groups defined by a main topic: Financing, Human Resources, Monitoring and Evaluation, and Institutional Collaborations. Each group had the opportunity to discuss a specific question from the following questions:

Main topic	Discussion question/topic
Financing	How can financing mechanisms be improved, or what other mechanisms can be successful?
Human Resources	Training for non-professional carers, implementation of standards of care for public and private long term care institutions, role of non-medical and medical personnel, role of gerontologists
Monitoring and Evaluation	¿Which are the best outcome/impact indicators to measure progress, effectiveness and performance? Innovations in data collection and information systems
Institutional collaborations	What aspects of health and social care should be integrated and strengthened? What is the role of civil society and NGOs?

In the second part of the session, within the same small groups, participants were asked to discuss the following question: What are the main barriers to implement Long-term care systems? Each group had a rapporteur that took notes and wrote main points in a flipchart. After the Workshop, part of the technical group at INGER systematised the notes and information from the flipcharts and generated a document with the main results. From the results, we classified the barriers in organizational, political, cultural, technological /research, legal, and financial.

The most frequent types of barriers mentioned were organizational (see Fig.4). Surprisingly, the financial barriers were the least frequent, as allocating funds to new programs are usually one of the main challenges. A summary of the main barriers noted are enlisted in table 1.

Figure 4. Types of barriers perceived by participants

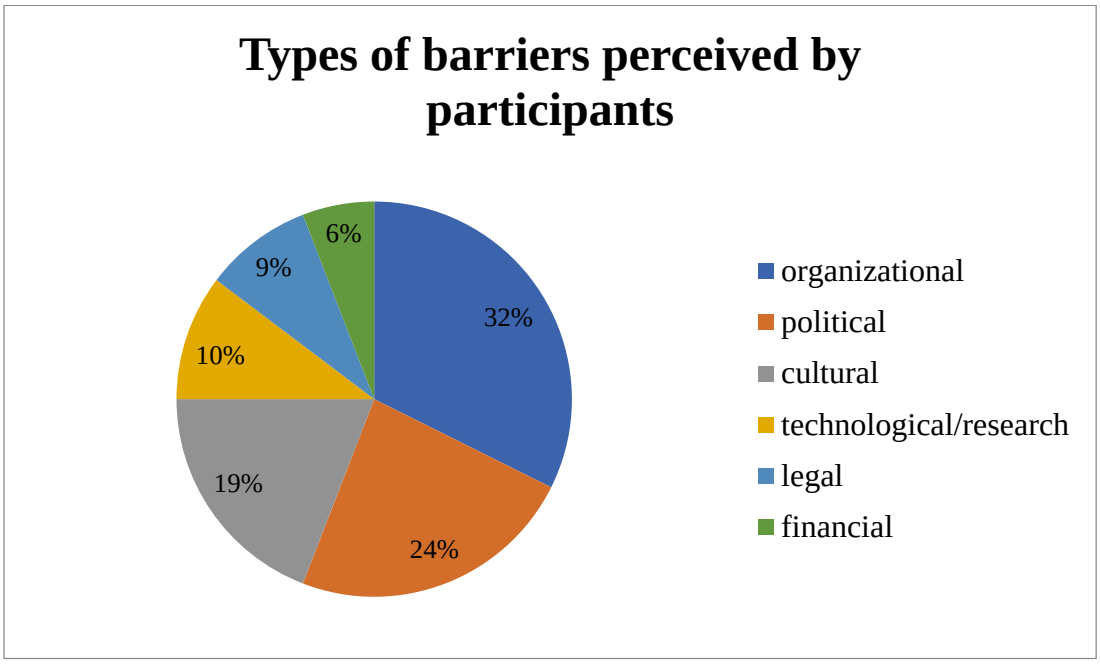


Table 4. Barriers perceived by participants

Cultural

Political inertia
Inertia in models and systems
System segmentation and fragmentation
Lack of protection for the informal workers
Absence of a comprehensive health system
Absence of long-term policies (cultural / political)
Invisibility of older people
Non-integrated budget
Administrative changes of government that block the continuity (cultural / political)

Financial

Inappropriate staff for government positions
Lack of training

Legal

Lack of information and data sharing (legal/financial)
Lack of agreement assessment tools (legal/political)
Different regulations (legal/organizational)
Gender inequality
Traditional gender roles (legal/political)

Organizational

Lack of accessible environments
Lack of rights awareness (organizational/political)
Lak of choice for the women
Lack of support systems (organizational/technological/research)
Lack of discussion of long-term care insurance
Lack of recognition of family caregiving cost (organizational/financial)
Lack of research to support decisions making (organizational/cultural)
Fragmentation or lack of legal frameworks
Lack specific data about long-term care (not monitoring neither evaluation)
Lack of empowerment of the older people (organizational/political)
Institutional mistreatment of older people including health workforce (organizational/political)
Lack of political will
Fragmentation of the systems
Lack of financing (organizational/cultural)
Lack of person-centred care models
Short-term planning
Lack of public policy of long-term care system (organizational/political)
Ageism (age discrimination)
Lack of life course policies

Political
Lack of private sector participation
Geographic challenges
Mindset of politician/decision makers (care is a private issue/gender role)
Complexity of care pathways (political/cultural)
Lack of interest from the health practitioners in geriatrics (political/cultural)
Lack of needs care assessment system
Lack of good measure of intrinsic capacity (political/organizational)
Lack of unique care policy
Technological / Research
Segmented services
Lack of strategic planning without continuity neither future foresight (very short-term vision)
Lack of long-term care definition
Lack of unique identification system
Unadapted housing for people with disability (technological/research/organizational)
Coordination problems (technological/research/legal)

Potential solutions for the challenges

In addition, the discussion among the participants lead to a series of proposed solutions, listed in table 5.

Table 5. Potential solutions proposed by the participants to overcome the barriers perceived

Cultural
To improve prevention of catastrophic diseases with a healthy lifestyle and self-care
To develop new approaches of preventative campaigns for the primary and secondary care levels
To increase awareness about long-term care at different levels (government, society, community, private sector providers, basic education, health providers and caregivers)
Community participation campaigns
To improve social engagement
Age-friendly communities and cities
Intergenerational actions to improve negative perceptions of aging and older people
Cultural change about aging and older people
Prioritize the aging theme in the political agenda with reliable data and stories
Media campaign (social marketing) directed by health ministry
Meet the caregiver's stories
Social mobilization of the care theme
Financial
To make clear that family caregiving is not free
Allocated budget for the long-term care (informal sector, formal sector, taxes)
Standardize care cost
Non-contributory pensions
Cost-effective interventions (best practice, guidelines, pathways of care)

Financing long-term care system
Strategic health purchasing

Legal

To clearly define roles and responsibilities at each level of government and harmonize the legal framework
Regulation private services of the long-term care
Care as a human right

Organizational

To increase the knowledge and skills of formal and informal human resources in the community level at health facilities
To develop a rehabilitation approach by training medical doctors, nurses and caregivers
Consensus about dependency concept
Collaboration between government, private sector and NGO´s
Consensus of comprehensive geriatric assessment
Universal health systems coordinated with social services system
To consider other alternatives to provide caregiving (for instance, young people)
Share housing for homeless people
System integration
Incorporated the aging, geriatrics and gerontology in all health professions
Training staff (competency standards)
Assessment system in place
Manpower to provide and manage care
Concept homogenization

Political

To ensure policy continuity
To develop a national long-term care system plan
Strengthen the institutions who fight discrimination
Drive state policy of aging
Establishment of long-term care national policy

Technological / Research

Implementation of an information system
Use of technology to provide long-term care
Consolidated information system
Unified clinical records
Consulting with technologies support to primary care (telemedicine, teleassistance, etc)
Outcomes monitoring (include economics data)
Including tech support

During the three days of the conference, several other ideas and concerns were discussed around the question of how to lower the burden that the families are currently facing?

The inter-sectoral policy domain:

- Recognising the right to care and develop a social protection system accordingly

- Advocating for care work as a public good that ought to be regulated out of the private space and socially acknowledged.
- Improving the quality of health care and the connectedness among the health services but also with the social care sector to foster integrated care
- Strategies to increase the level of connection between the health and social sectors

The logistical domain:

- Getting to know the magnitude of the current and future demands
- In Mexico, currently 10% of the population is 60 years or older. The proportion is forecasted to duplicate by 2050. Yet, the demand of LTC will also be affected by the prevalence of disability.
- Preserving and preventing rapid declines in intrinsic capacity is also a way to contribute to the sustainability of the LTC system.

The financial domain

- How can we meet the demand in a sustainable way?
- What mechanisms have been put in place to protect not only the poorest, but also the middle-class families who sometimes are neither candidates for social protection systems, nor can afford the private care schemes?
- The case of Japan illustrates how the health care system served as a relief for those middle-class families seeking for care services. Another contextual reason was that it was not socially accepted to put the older adults into a care shelter, but there was no problem with putting them into a hospital. The result was an increase in the “socio-sanitary beds”. The reason for restricting the care services to the poorer ones was that the source of funding was fiscal taxing.

Actions and resolutions

From the presentations and discussions, we consider that there are features of the LTC systems with the potential to be immediately put into practice.

Keys for a better implementation

- Take advantage of the window of opportunity for the policy. For example, when the politicians have had a personal experience with care dependence, dementia in particular
- Innovating in the service models or pension systems can help open those policy windows
- Working with different groups of politicians is useful. Not only with a reduced group
- Reach consensus about the funding mechanisms for the LTC
- Recognise important stakeholders: female caregivers, the State
- International experiences: Germany 20 years, Japan 13 years, Korea 8 years, UK almost for 40 years but consensus not reached yet
- Take time to design efficient and useful evaluation frameworks

We should address cross-cutting elements

1. Gender
    a. Differential burden of unpaid work on women
    b. How to take advantage of the "feminization" of aging in favour of the capacity building in LTC?
2. Technology
    a. Data collection
    b. Virtual courses (i.e. MOOC)
    c. Medical tele-assistance
3. Data-driven policy making
    a. The Korean case

Shift from a siloes and programmatic views to a systemic approach to the LTC instead of a fragmented programmatic approach.

Offering programs that solve perceived needs, for example, dancing clubs for older adults, or discounts on transportation fees, might be practical and easy to achieve within a political period of 3-4 years. Nevertheless, if it is not linked to the resolution of health needs, or other basic caregiving needs, it will not contribute to solving the long-term care needs.

Next steps for the LTC system in Mexico

The presentations and discussions during the meeting provided valuable inputs for the National Institute of Geriatric Medicine of Mexico (INGER). The INGER will use these inputs to strengthen its advocacy role as two parallel processes are taking place:

a) The review and update about the legal framework related to long-term care
b) The re-designing of the System for Social Security and Health

Also, as a result of the meeting, the INGER, as a technical reference, increased the level of inter-sectoral dialogue with other stakeholders such the National Institute of Older Adults, INAPAM as a coordinating

actor and the Ministry of Social Development (plus the DIF) as collaborators in the implementation of the LTC system.

This forum was highly relevant as it allowed to further our knowledge and understanding of LTC systems, also in addition, to learn about good practices in LTC systems from other economies. All of these aspects are relevant in the future design of a LTC system in Mexico.

Achieving the design and implementation of the LTC system in Mexico demands the transformation of some cultural and organizational structures, in addition to placing LTC on top of the public agenda; and changing the perception of LTC as charity- or a responsibility exclusive of the family-based activity, for a paradigm of LTC as a right. It is about decreasing the burden to the families and help the care givers. Also, recognising the social value of care givers who should receive a compensation and social acknowledgement for the tasks performed.

This meeting provided crucial elements to update and re-think the roadmap of the actions needed to achieve a fully-functional LTC system in Mexico.

Powerful ideas/questions emerged from the meeting

For future projects, we will focus on these three topics which deserve further discussion:

1. Opting for the long-term care insurance: how can the economies design the better financing schemes?
2. Implementing community care conferences: are they feasible for different sociopolitical contexts? How can they be adapted to suit into other economies?
3. Integration of a multinational collaborative platform: How can the multilateralism help in the capacity-building for sustainable and equitable LTC systems?

    a) Not only with academics but also with health system managers
    b) Supportive comments from Dr Seo (Korea) and from Adelina Comas Herrera
    c) Which would be the scope and objectives of the platform?

References

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Annex 1. Final program of the workshop

Capacity building for Community-based Long-Term Care

Asia Pacific Economic Cooperation (APEC)
National Institute of Geriatric Medicine (INGER)
Pan American Health Organization/ World Health Organization (PAHO/WHO)
Global Aging Research Network International Association of Gerontology and Geriatrics (IAGG)

Mexico City. October 23-25, 2019

Day 1

Time	Activities Presenter/ Coordinator
8:30	**Registration** INGER
9:00	**Welcoming remarks** Luis Miguel Gutiérrez Robledo, INGER Mexico **Opening remarks** Ángel Villalobos Rodríguez, Ministry of Economics, Mexico Andrés de Francisco Serpa PAHO/ WHO María del Rocío García Pérez DIF Nadine Gasman Zylbermann INMUJERES
9:20	**Presentation** **Updates on Long-term care translational experiences Japan – Thailand** Shintaro Nakamura Japanese International Cooperation Agency JICA Japanese Expert
10:00	Panel 1: Economy presentations Moderator: Luis Miguel Gutierrez INGER
	Each representative will use 15 minutes maximum to talk about the long-term care systems/ programs implemented in his/her economy using the slides template provided by INGER: 1. Brief description of the system / program (name, start year, institutional adscription, main barriers and facilitators during the implementation) 2. Beneficiaries (selection criteria, profile of the target population) 3. Benefits and providers (what is granted/delivered, how it is delivered, who delivers, features of integrated care) 4. Financing (major public/private sources, links to social programs, estimated amount of the health/social budget)
10:00	Chile
10:15	Peru
10:30	Costa Rica
10:45	Summary comments. Q & A
11:00	**Coffee break**
	Panel 2: Economy presentations Moderator: Mariana López Ortega
11:30	Cuba

11:45	Russia
12:00	Trinidad and Tobago
12:15	Summary comments. Q & A
	Panel 3: Economy presentations Moderator: Eduardo Sosa Tinoco
12:30	Indonesia
12:45	Thailand
13:00	Malaysia
13:15	Summary comments. Q & A
13:30	**Lunch**
14:45	**Presentation** **Community based Long Term Care Policy in Latin America** Sandra Huenchuan
15:15	**Presentation** **Long-term care from the perspective of the Inter-American Development Bank** Pablo Ibarrarán Lead Social Protection Specialist, Inter-American Development Bank
15:45	Coffee / Summary comments. Q & A
16:00	Plenary discussion Moderator: Luis Miguel Gutiérrez
16:45	Wrap up and conclusions of day 1

Day 2

Time	Activities	Presenter/ Coordinator
8:30	**Registration**	
9:00	**Presentation** **The Strategic Vision of PAHO for the Long-Term Care in the Americas** Enrique Vega Garcia Healthy Life Course Unit, PAHO/ WHO	
9:30	**Presentation** **Systemic approach to long-term care** Anne Hendry Integrated Care Senior Associate, International Foundation for Integrated Care (IFIC). Scotland	
10:00	Q & A. Plenary discussion Moderator: Enrique Vega	
10:30	**Coffee**	
11:00	Discussion Groups about the structural elements of Long-term care systems Moderator: Mariana López-Ortega (INGER team coordinates the activity and designates which participants gather for each group. After 1 hour of group discussion, each team presents their conclusions in plenary)	
	GROUP 1. Financing How can the mechanisms of financing be improved / what other mechanisms of financing have been successful? Coordinator: Mariana López-Ortega Reporteur: Luis David Jacome	
	GROUP 2. Human Resources	

	Training for non-professional caretakers; implementation of care standards for private/public facilities; participation of medical/non-medical staff; the role of the Gerontologist Coordinator: Eduardo Sosa Tinoco Reporteur: Luis Raymundo Lozano
	GROUP 3. Monitoring and Evaluation Which would be the best outcome / impact indicators to measure progress, effectiveness, performance? Innovative data gathering devices/techniques, innovation in information systems Coordinator: Carmen García-Peña Reporteur: Pamela Tella Vega
	GROUP 4. Institutional Ties Which aspects of the connection between health and social systems should be reinforced and through which means? Which should be the role of civil society/ NGO's? Coordinator: Cinthya González Reporteur: Marcos Fernando Méndez Hernández
13:30	**Lunch**
14:30	Activity: Café to go. Community-based LTC: strategies, services, systemic approaches to enhance integration and reduce fragmentation. Coordinators: 4 volunteers
	What are o would be the most important barriers to implementation?
16:00	Wrap up and conclusions of day 2

Day 3

Time	Activities	Presenter/ Coordinator
8:30	Registration INGER	
9:00	**Presentation** **Designing long-term care systems with community-based strategies for LMICs** Adelina Comas Herrera, London School of Economics and Political Science	
9:30	**Presentation** **The experience of planning and implementing long-term care services in Korea** Kyung-hwan Seo National Health Insurance Service, Republic of Korea	
10:00	Q & A. Summary comments. Moderator: Carmen Santamaria Guasch	
10:30	**Presentations** **Currently operating programs, processes and strategies that could serve as foundations for the community-based LTC strategy in Mexico** INMUJERES (15 min) Ministries of Wellness and of Health of Mexico City Government (15 min) Mexican Institute of Social Security (IMSS) (15 min)	
11:15	Q & A. Plenary discussion Moderator: Mariana López Ortega	
11:45	Coffee break	
12:00	**Presentation of the Mexico proposal for community-based long-term care for older adults framed in an integrative systemic approach** Luis Miguel Gutiérrez Robledo National Institute of Geriatric Medicine	
12:30	Concluding remarks Presenter: Luis Miguel Gutiérrez Robledo	