LONG-TERM CARE IN DEVELOPING COUNTRIES

TEN CASE-STUDIES

World Health Organization
Geneva

and

JDC-Brookdale Institute
The WHO Collaborating Centre for
Health and Long-Term Care Policy and Research
The World Health Organization
Collection on Long-Term Care

LONG-TERM CARE
IN DEVELOPING COUNTRIES
TEN CASE-STUDIES
Demographic and epidemiological transitions will result in dramatic changes in the health needs of the populations of the world. Everywhere, there is a steep increase in the need for long-term care (LTC). These trends reflect two interrelated processes. One involves the growth in factors that increase the prevalence of long-term disability in a population. The second involves the change in the capacity of the informal support system to address these needs. Both of these processes enhance the need for public policies to address the consequences of these changes.

The growing need for LTC policies is generally associated with industrialized countries. What is less widely acknowledged is that LTC needs are increasing in the developing world at a rate that far exceeds that experienced by industrialized countries. Moreover, the developing world is experiencing increases in LTC needs at levels of income that are far lower than those which existed in the industrialized world when these needs emerged.

Therefore, the search for effective LTC policies is one of the most pressing challenges facing modern society. Recognizing that such trends greatly increase the need for well-coordinated and cost-effective LTC, the World Health Organization (WHO) launched a global initiative. The JDC-Brookdale Institute, a WHO Collaborating Centre, is leading this effort.

The goal of the project is to prepare a practical framework for guiding the development of long-term care policies in developing countries. This framework will address the major issues and alternatives in designing LTC systems. The framework is not intended to provide specific prescriptions, but rather a basis for translating national conditions, values, culture and existing health and social policies into a long-term care policy.
LONG-TERM CARE

This process is based on a number of major premises:

- Previous efforts have not been successful in identifying meaningful policy guidelines that are appropriate to the unique situations of developing and middle-income countries.
- A key resource in formulating LTC policies for developing countries is their own existing experience.
- LTC policies in the developing world need to reflect each country’s unique conditions, which have to be understood in much more depth and complexity.
- There is much to be learned from the experience of industrialized countries in order to define the range of options and to identify successful and unsuccessful policy practices.
- There is a need to create a deeper and more informed dialogue between the experiences of industrialized and developing countries so that there can be a mutually beneficial learning process.

Over the course of the project, a number of steps have been taken to promote the exchange of experience. In 1998, a comparative review of the implementation of long-term care laws based on legislation and entitlement principles in five industrialized countries (Austria, Germany, Israel, Japan, and the Netherlands) was conducted and summarized in a widely distributed report entitled *Long-Term Care Laws in Five Developed Countries* (WHO/NMH/CCL/00.2). In implementing this study, a framework was developed for cross-national comparisons of long-term care policies that address the needs of policy-makers.

In December 1999, a workshop involving a group of long-term care experts from the industrialized and developing world identified specific issues in LTC provision in developing countries. Their general recommendations were submitted in a report and accepted by the 108th WHO Executive Board (*WHO Technical Report Series*, No. 898), and ratified by the 54th World Health Assembly in May, 2001.

One lesson learned from this workshop was that to go beyond previous discussions requires a more in-depth understanding of the existing situations in developing countries and the nature of the variance among countries.
Accordingly, a plan was developed to request in-depth case-studies from experts in middle-income developing countries, and in April 2001 a second workshop was organized with these experts to discuss the framework for the preparation of these case-studies.

This framework was designed to emphasize elements that would be important in the developing country context, and also to examine the more general health and social policies and service structure along dimensions that have major implications for long-term care. Case-studies of the general health system and current LTC provision in ten developing countries were written by national health care experts (People’s Republic of China, Costa Rica, Indonesia, Lebanon, Lithuania, Mexico, Republic of Korea, Sri Lanka, Thailand, and Ukraine).

A series of video conferences opened a dialogue between WHO Headquarters and the six Regional Offices on desirable directions for long-term care and priorities for WHO and country work. Furthermore, to complete and broaden the picture of patterns of LTC policies in industrialized countries, case-studies of countries without a legislative framework, including Australia, Canada and Norway, were commissioned.

An additional perspective was provided on the experience of the industrialized countries by commissioning a set of papers on key cross-cutting issues, such as:

- The role of the family and informal care, and mechanisms to support the family.
- Issues of coordination among various LTC services, and of LTC with the health and social service systems.
- Human resource strategies in delivering LTC.

The next step was to convene the group of leading experts from industrialized and developing countries who had prepared the papers, together with WHO Regional Representatives and key WHO Headquarters’ staff. Two integrative papers on the overall patterns identified and lessons learned from the case-studies of industrialized and developing countries were prepared by the Brookdale team for the meeting, convened in November 2001 in Annecy, France.
LONG-TERM CARE

The purpose of the meeting, Bridging the Limousine – Train – Bicycle Divide, was to assess what has been learned thus far from the experiences of both industrialized and developing countries that can contribute to the development of long-term care policies for developing countries.

The report of the meeting, entitled Lessons for Long-Term Care Policy (WHO/NMH/CCL/02.1), provides a broad overview of the nature of the background materials that were prepared and the issues that were discussed. It also presents some general conclusions agreed upon by the participants.

In parallel, work was proceeding to estimate current and future LTC needs globally. R. H. Harwood and A. A. Sayer analysed the 1990 WHO Global Burden of Disease data and prepared estimates for all WHO Member States. These estimates are available on the World Health Organization web site http://www.who.int/ncd/long_term_care/index.htm and are summarized in Current and Future Long-Term Care Needs (WHO/NMH/CCL/02.2).

Another complementary area of work relates to family caregiving in countries with high HIV/AIDS prevalence. E. Lindsey and M. Hirschfeld, together with co-researchers from the respective countries, completed several qualitative studies, focusing on community home-based care and its effects on young girls and older women. They summarized the findings from studies in Botswana, Cambodia, Haiti, Kenya, South Africa, and Thailand in a guideline Community Home-Based Care in Resource-Limited Settings. A Framework for Action (Geneva, WHO, 2002, ISBN 92 4 156213 7). The theoretical framework for this guideline had been developed by JDC-Brookdale for the analysis of LTC laws in five industrialized countries.

An additional area of work relates to ethical responsibilities in LTC and the ethical discussion countries need to initiate as input into the determination of the priority of LTC and the considerations in designing fair and just policies. This work was published as Ethical choices in long-term care: what does justice require? (Geneva, WHO, 2002, ISBN 92 9 156228 5.) Also in process of preparation are publications concerning a LTC Futures tool kit, case-studies from developing and industrialized countries, and a framework in which to consider these materials in the development of LTC policies in developing countries.

These and other publications in the World Health Organization Collection on Long-term Care are summarized on the following page. This volume is the seventh in this series of publications, which is designed to make more widely available the full and final materials developed through the project.
- Long-term care laws in five developed countries
  (Geneva, WHO, 2002)


- Ethical choices in long-term care: what does justice require?
  (Geneva, WHO, 2002)


- Key policy issues in long-term care: a review based on the experience of industrialized countries

- Long-term care in developing countries: ten country case-studies (this volume).


- Framework for guiding the development of long-term care policies in developing countries (forthcoming).
Contents

i Preface iii

ii Contents ix

iii Abbreviations x

iv Acknowledgements xi

1 Introduction, Jenny Brodsky, Jack Habib, Miriam Hirschfeld, and Ben Siegel 3

2 China, Fu Hua and Xue Di 25

3 Costa Rica, Paola Zuñiga, Gustavo Nigenda and Felicia Knau 69

4 Indonesia, Agus Suwandono, Qomariah Suhardi 119

5 Lebanon, Nabil M. Kronfol 171

6 Lithuania, Aleksandras Krisciunas 217

7 Mexico, Felicia Knaul, Gustavo Nigenda, Miguel Angel Ramirez, Ana Cristina Torres, Ana Mylena Aguilar, Mariana Lopez Ortega, and José Luis Torres 249

8 Republic of Korea, Chung Yu Lee and Euisook Kim 295

9 Sri Lanka, Palitha Abeykoon 333

10 Thailand, Somsak Chunharas and Kanittha Boonthamcharoen 361

11 Ukraine, Vladislav V. Bezrukov 417

12 Conclusion, Jenny Brodsky, Jack Habib, Miriam Hirschfeld, and Ben Siegel 455
LONG-TERM CARE

Abbreviations

ADB  Asian Development Bank
AIDS  Acquired immunodeficiency syndrome
ASEAN  Association of South-East Asian Nations
CCSS  Caja Costarricense del Seguro Social
CDC  Centre for Disease Control
GDP  Gross domestic product
GNI  Gross national income
GP  General practitioner
HALE  Healthy life expectancy
HIV  Human immunodeficiency virus
ILO  International Labour Organization
IMF  International Monetary Fund
LTC  Long-term care
MOH  Ministry of Health
NFP  Not-for-profit
NGO  Nongovernmental organization
OECD  Organisation for Economic Co-operation and Development
PAHO  Pan American Health Organization
PHC  Primary health care
PPP  Purchasing power parity
UNDP  United Nations Development Programme
USAID  United States Agency for International Development
WHO  World Health Organization

X
The World Health Organization gratefully acknowledges the crucial scientific and technical leadership of the JDC Brookdale Institute, Jerusalem, a WHO Collaborating Centre, both in guiding the WHO LTC Policy Initiative and in preparing this volume. Particular appreciation is expressed for the contributions of Jack Habib and Jenny Brodsky, who further acknowledge the contribution of their colleague Ben Siegel for his major role in the development of the framework of the case studies and in the final stages of this publication. WHO acknowledges the support, with particular thanks for its contributions to facilitating international meetings, of the Marshall Weinberg Fund for International Collaboration.

Authorship of the individual case studies included in this volume include Fu Hua and Xue Di for China; Paola Zuñiga, Gustavo Nigenda and Felicia Knaul for Costa Rica; Agus Suwandono and Qomariah Suhardi for Indonesia; Nabil M. Kronfol for Lebanon, Aleksandras Krisčiūnas for Lithuania; Felicia Knaul, Gustavo Nigenda, Miguel Angel Ramírez, Ana Cristina Torres, Ana Mylena Aguilar, Mariana Lopez Ortega and José Luis Torres for Mexico; Chung Yu Lee and Euisook Kim for the Republic of Korea; Palitha Abeykoon for Sri Lanka; Somsak Chunharas and Kanittha Boonthamcharoen for Thailand; and Vladislav V. Bezrukov for Ukraine.

Another in the WHO Collection on Long-Term Care, this document was produced under the direction of Miriam Hirschfeld, formerly Director of the Cross-Cluster Initiative on Long-Term Care in the Noncommunicable Disease Prevention and Mental Health Cluster of the World Health Organization. The WHO Collection on Long-Term Care was designed, and the manuscripts in this volume were language edited and harmonized, by Anne Bailey and Ross Hempstead of Creative Publications.
INTRODUCTION TO CASE-STUDIES

Jenny Brodsky
Jack Habib
Miriam Hirschfeld
Ben Siegel
Care for chronically ill and disabled persons and a steep rise in the numbers of elderly are a major and growing challenge in developing countries. The formulation of policies needs to reflect these countries’ unique conditions. As an essential element in this process, country case-studies provide an opportunity to learn from what already exists. They also help us to identify and better understand the differences that are relevant for the translation of experiences from industrialized countries to developing countries and vice versa, as well as the variations among developing countries. These include:

- epidemiology;
- available resources;
- culture and values;
- migration;
- strength of informal care; and
- stage of development of health and social systems.

This volume presents case-studies that examine the emerging needs and approaches to long-term care in ten developing countries: People’s Republic of China, Costa Rica, Indonesia, Lebanon, Lithuania, Mexico, Republic of Korea, Sri Lanka, Thailand, and Ukraine. These countries represent different levels of economic development and different stages of the demographic and epidemiological transition. The case-studies were written by national health care experts, with the professional guidance and support of the JDC-Brookdale Institute and WHO.

In this introduction, we describe the definition and scope of LTC and provide evidence of the growing need for LTC in the developing world. We also discuss the methodology used in choosing and organizing the case-studies, and provide highlights of the general characteristics of the existing LTC care systems found in the specific countries.
LONG-TERM CARE

Definition and scope of LTC

Long-term care refers to the provision of services for persons of all ages who have long-term functional dependency. Dependency creates the need for a range of services, which are designed to compensate for their limited capacity to carry out activities of daily living. Dependency also results in difficulties in accessing health care and in complying with health care regimes. It impacts on the ability of the individual to maintain a healthy lifestyle, and to prevent deterioration in health and functional status. Dependency creates additional emotional needs and strains, which must be addressed. Social needs also arise from limitations in maintaining regular social contacts.

Unique health problems arise in part from the fact that either single or multiple chronic diseases may be the source of the disability. These in themselves require complex health services and special regimes of chronic care management. Moreover, when combined with functional limitations, the challenge becomes even greater. Most obvious among these are mobility limitations and cognitive impairments which often impair a person’s self-care ability.

Central to the care of dependency is the role of the family in providing that care, and the resultant needs of the family. The need to address dependency impinges not only upon various aspects of family function, but also upon relationships within the family. Relationships between the disabled person and the family, as well as those between and among family members need to be managed by all involved. In addition to managing care, functional dependency also has emotional consequences for family members and for their relationships with one another.

Dependency requires significant needs for information, guidance, and education for the disabled person and his or her family. It also creates a complex range of needs for services. This in turn creates a need to coordinate access to and management of these multiple services. This care management function is a need in itself.

Types of long-term care services

Long-term care may be either home-based or institutional. Home-based care may occur either in the home, or in the community but outside the home.
It is useful to distinguish between two types of home-based LTC services:

- Health-related care, which we refer to as home health.
- Care related to daily functioning, such as personal care (e.g. eating, bathing) and homemaking (e.g. cooking, cleaning).

Long-term care can be provided by formal caregivers, that is paid care, or informal care that is provided by persons who do not receive pay.

Formal care services may be provided by governmental organizations; by local, national, or international nongovernmental organizations (NGOs); or by for-profit organizations. Formal care is usually provided by recognized professionals (e.g. nurses, doctors, and social workers) and/or by para professionals (e.g. personal care workers). Traditional healers may be an important additional source of care.

Informal care includes care provided by nuclear and extended family members, neighbours, friends, and independent volunteers, as well as organized volunteer work through organizations such as religious groups.

**The need for LTC policy in developing countries**

The trends in developing countries clearly indicate the growing need for long-term care. These trends reflect two interrelated processes. One is the growth in factors that increase the prevalence of long-term disability in the population. The second is the change in the capacity of the informal support system to address these needs. The need for LTC is determined by the interaction of the rate of increase in disability levels and the rate of change of the informal network and its capacity. For most countries, the development of public policies to address the consequences of these changes has become urgent.

The ageing of the populations in these countries has an impact on both of these processes. As the population ages, the percentage with chronic diseases and related disabilities rises significantly. Moreover, population ageing is caused primarily by a decline in fertility, and it is thus associated with a decline in family size and a rise in the number of elderly in relation to the younger population reflected in the elderly support ratio (the ratio of those aged 65 and over per 100 persons aged 20–64), and the parent support ratio (the ratio of those aged 80 and over per 100 persons aged 50–64). This increases the pressure on children who are a major source of support to the elderly.
LONG-TERM CARE

Provided in Table 1 on the following three pages are selected illustrative statistics for the developing countries included in this volume, which have been derived from international data bases. Although there occurs considerable variation in the proportion of elderly among the ten countries examined, each country expects a remarkable future increase in the population aged 65 and over. Most of the countries examined also expect a steep increase in the parent and elderly support ratios. In Lithuania, for example, 13.4% of the population is already 65 and over; there are approximately 22 persons over 65 to every 100 persons in the prime working age of 20–64; and the parent support ratio stands at 15.

These indicators will rise at a rapid pace. The percentage of elderly in Lithuania will increase to 19.7% by 2025, and the parent support ratio is expected to increase to 24. In Indonesia, only 4.8% of the population is 65 and over, and there are approximately nine persons over 65 to every 100 persons aged 20–64. However, the proportion of those 65 and over will nearly double in the next 25 years, as in most of the countries included in the study.

There are additional factors that are affecting the prevalence of disability in developing countries. The AIDS pandemic has had a devastating impact on the number of chronically ill and disabled adults and disabled or orphaned children. The numerous outbreaks of armed conflicts on a broad scale have had similar consequences. In many developing countries, the sharp rise in traffic accidents and other injuries is also having a significant impact on functional disability rates. Among children and young adults there are significant limitations caused by injury, blindness and the debilitating effects of tropical diseases such as malaria and schistosomiasis.

In the report of the WHO meeting, Innovative Care for Chronic Conditions, the authors write that

Table 1. Selected socioeconomic, demographic and epidemiological indicators relevant to the determination of long-term care policy in ten developing countries

<table>
<thead>
<tr>
<th></th>
<th>China</th>
<th>Costa Rica</th>
<th>Indonesia</th>
<th>Lebanon</th>
<th>Lithuania</th>
<th>Mexico</th>
<th>Republic of Korea</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Ukraine</th>
</tr>
</thead>
<tbody>
<tr>
<td>% 65+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>in 2000</em></td>
<td>6.9</td>
<td>5.1</td>
<td>4.8</td>
<td>6.1</td>
<td>13.4</td>
<td>4.7</td>
<td>7.1</td>
<td>6.3</td>
<td>5.2</td>
<td>13.8</td>
</tr>
<tr>
<td></td>
<td>13.2</td>
<td>10.0</td>
<td>8.4</td>
<td>8.7</td>
<td>19.7</td>
<td>9.3</td>
<td>16.9</td>
<td>12.3</td>
<td>11.4</td>
<td>19.0</td>
</tr>
<tr>
<td>Elderly support ratio&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>in 2000</em></td>
<td>11.4</td>
<td>9.7</td>
<td>8.9</td>
<td>11.5</td>
<td>22.4</td>
<td>9.1</td>
<td>11.1</td>
<td>10.9</td>
<td>8.9</td>
<td>22.7</td>
</tr>
<tr>
<td></td>
<td>21.3</td>
<td>17.3</td>
<td>13.7</td>
<td>13.7</td>
<td>31.5</td>
<td>15.5</td>
<td>27.4</td>
<td>20.4</td>
<td>18.2</td>
<td>29.9</td>
</tr>
<tr>
<td>Parent support ratio&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>in 2000</em></td>
<td>7.7</td>
<td>8.7</td>
<td>5.3</td>
<td>8.8</td>
<td>15.1</td>
<td>9.8</td>
<td>7.2</td>
<td>7.2</td>
<td>5.7</td>
<td>12.9</td>
</tr>
<tr>
<td></td>
<td>9.5</td>
<td>11.7</td>
<td>7.1</td>
<td>7.3</td>
<td>23.9</td>
<td>11.1</td>
<td>14.5</td>
<td>10.9</td>
<td>8.8</td>
<td>18.7</td>
</tr>
</tbody>
</table>

<sup>1</sup>Elderly support ratio: the ratio of those age 65 and over per 100 persons aged 20–64.

<sup>2</sup>Parent support ratio: the ratio of those age 80 and over per 100 persons aged 50–64.
Table 1: continued

<table>
<thead>
<tr>
<th></th>
<th>China</th>
<th>Costa Rica</th>
<th>Indonesia</th>
<th>Lebanon</th>
<th>Lithuania</th>
<th>Mexico</th>
<th>Republic of Korea</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Ukraine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life expectancy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>at birth (2001)</td>
<td>71.2</td>
<td>76.1</td>
<td>65.9</td>
<td>69.8</td>
<td>72.9</td>
<td>74.2</td>
<td>74.9</td>
<td>69.9</td>
<td>68.9</td>
<td>67.7</td>
</tr>
<tr>
<td>at age 60 (2000)</td>
<td>18.0</td>
<td>21.0</td>
<td>17.0</td>
<td>18.5</td>
<td>19.5</td>
<td>21.0</td>
<td>19.5</td>
<td>18.5</td>
<td>18.5</td>
<td>16.5</td>
</tr>
<tr>
<td><strong>HALE</strong> (2001)</td>
<td>63.2</td>
<td>64.8</td>
<td>56.7</td>
<td>59.4</td>
<td>61.1</td>
<td>63.8</td>
<td>67.4</td>
<td>58.9</td>
<td>58.6</td>
<td>57.4</td>
</tr>
<tr>
<td><strong>Mortality under age 5 (per 1000 births) (2001)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>males</td>
<td>34</td>
<td>13</td>
<td>50</td>
<td>34</td>
<td>10</td>
<td>33</td>
<td>8</td>
<td>22</td>
<td>38</td>
<td>18</td>
</tr>
<tr>
<td>females</td>
<td>40</td>
<td>10</td>
<td>40</td>
<td>28</td>
<td>10</td>
<td>27</td>
<td>8</td>
<td>18</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td><strong>% of women in labour force</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in 2000</td>
<td>55.9</td>
<td>25.2</td>
<td>39.4</td>
<td>NA</td>
<td>47.2</td>
<td>27.1</td>
<td>42.7</td>
<td>31.8</td>
<td>56.0</td>
<td>46.3</td>
</tr>
<tr>
<td>in 1960</td>
<td>43.9</td>
<td>9.7</td>
<td>20.7</td>
<td>NA</td>
<td>41.9</td>
<td>9.1</td>
<td>17.3</td>
<td>–</td>
<td>48.7</td>
<td>44.0</td>
</tr>
</tbody>
</table>

* HALE: Healthy life expectancy.
Table 1: concluded

<table>
<thead>
<tr>
<th></th>
<th>China</th>
<th>Costa Rica</th>
<th>Indonesia</th>
<th>Lebanon</th>
<th>Lithuania</th>
<th>Mexico</th>
<th>Republic of Korea</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Ukraine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GNI per capita</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>($PPP) (2000)</td>
<td>3920</td>
<td>7980</td>
<td>2830</td>
<td>4550</td>
<td>6980</td>
<td>8790</td>
<td>17 300</td>
<td>3460</td>
<td>6320</td>
<td>3700</td>
</tr>
<tr>
<td><strong>GNI per capita</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(US$) (2000)</td>
<td>840</td>
<td>3810</td>
<td>570</td>
<td>4010</td>
<td>2930</td>
<td>5070</td>
<td>8910</td>
<td>850</td>
<td>2000</td>
<td>700</td>
</tr>
<tr>
<td><strong>Health expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of GDP</td>
<td>5.3</td>
<td>6.4</td>
<td>2.7</td>
<td>11.8</td>
<td>6.0</td>
<td>5.4</td>
<td>6.0</td>
<td>3.6</td>
<td>3.7</td>
<td>4.1</td>
</tr>
<tr>
<td>per capita ($PPP)</td>
<td>205</td>
<td>411</td>
<td>84</td>
<td>696</td>
<td>420</td>
<td>483</td>
<td>909</td>
<td>120</td>
<td>228</td>
<td>146</td>
</tr>
<tr>
<td>per capita (US$)</td>
<td>45</td>
<td>273</td>
<td>19</td>
<td>590</td>
<td>185</td>
<td>311</td>
<td>584</td>
<td>31</td>
<td>71</td>
<td>26</td>
</tr>
</tbody>
</table>

\* PPP = purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries.

Sources:
LONG-TERM CARE

There is limited information on disability rates in developing countries. The existing data relate more to the prevalence of chronic and communicable diseases. However, some efforts have been made to use morbidity data to estimate disability rates. According to the World Health Report 2000, an approximately equal number of years of healthy life are lost to disability in industrialized and developing countries (7 years). This is despite the fact that people in industrialized countries live longer and “have more opportunity to acquire non-fatal diseases.”

Because of the lower life expectancies in developing countries, it can be argued that disability makes a more significant impact on the lives of people in the developing world because a higher percentage of their life years (14% versus 9% in industrialized countries, on average) is lost to disability. These estimates are based upon calculations by Murray and Lopez (World Health Report 2000).

In a recent study Current and future long-term care needs, commissioned by WHO’s Cross-Cluster Initiative for Long-term and Home-based Care (CCL), Rowan Harwood and Avan Sayer attempt to translate the increase in disability into projections that measure the need for caregiver assistance for daily needs. They find that these care needs will increase much more rapidly in developing countries (WHO, 2002).

It is important to emphasize an additional consideration that might make the issue of LTC policy especially complex in developing countries. One of the major concerns that has been expressed involves the fact that the rise in chronic disease and related disabilities is occurring in countries that are still grappling with a high burden of traditional communicable diseases. This combination creates a ‘double burden of disease’.

This double burden of disease is associated with the fact that the developing world is ageing at much lower income levels than those which characterized the same demographic transitions in the industrialized world. The extent of the double burden of disease is reflected in the indicators of chronic disease (such as the percentage of elderly) and in the indicators of the extent of communicable diseases (such as the under-5 mortality rates). Its pattern over time is affected by the rate of change in these indicators. There is the added difficulty of facing this double burden of disease at very low levels of income. As a result, countries must adopt policies which are especially cost-effective and strategic when developing LTC services.
Concomitant with these demographic and epidemiological changes, statistical evidence from the ten countries participating in the study indicates additional forces that impact on the ability of informal support systems to provide care. These factors include an increasing percentage of women in the labour force and increased migration. For example, the percentage of women participating in the labour force increased in Mexico from 9.1% in 1960 to 27.1% in 2000, in Costa Rica from 9.7% to 25.2%, and in the Republic of Korea from 17.3% to 42.7%. Therefore, there appears to be a fundamental need to develop LTC services to share these growing responsibilities with families.

**Methodology**

As mentioned in the Preface, these case-studies are part of a WHO initiative to provide guidance to developing countries as they respond to growing needs for long-term care. This effort is based on the belief that significant progress can be achieved through a case-study approach that enables one to root the discussion of policy options in an in-depth understanding of existing realities in developing countries, and to learn from what already exists.

The case-studies provide an opportunity to learn on how countries are currently responding to needs for long-term care and to identify bases for further development that build on existing health and social infrastructures.

There were a number of considerations in choosing the countries for these case-studies. An effort was made to include a range of countries at different stages of demographic and epidemiological transition and at different levels of economic development, to illustrate the diverse picture of LTC needs and service development.

A further major consideration involved geographic diversity. Included are two countries from eastern Asia (People’s Republic of China, Republic of Korea), one country from south-central Asia (Sri Lanka), two countries from south-east Asia (Indonesia, Thailand), one country from the Middle East (Lebanon), two countries from Eastern Europe (Lithuania, Ukraine), and two countries from Latin America (Mexico, Costa Rica).

We included the two countries from Eastern Europe (Lithuania and Ukraine) that reflect broader patterns found in other Eastern European countries. Both countries have low levels of economic resources and have been challenged by major macro-societal transitions during the past decade.
LONG-TERM CARE

Case-study outline

An outline for the organization of the case-studies was developed during a collaborative process involving the developing country case-study authors, the World Health Organization, and the JDC-Brookdale Institute. The outline provides a framework for understanding the general health and social systems and the current long-term care provision within these countries. It is useful to provide a brief description of this framework.

Section 1 includes a general description of the country’s social structure and information on important economic, demographic, and epidemiological trends. We make use of data available from international sources to present a standard and comparative perspective. This is important, because often these are the only data available to policy-makers in developing countries. In some cases, slight differences may exist between data in Section 1 and data obtained from domestic sources, which is presented in other sections.

In Section 2, each country’s general health and social system is described. Understanding a country’s general systems of health and social care provision and financing is important for a number of reasons. These systems reflect choices with regard to social policy principles that may influence the choices with respect to long-term care. Secondly, as LTC begins to develop, many countries may choose to develop LTC under the auspices of the general health and social systems. Therefore, background information on these systems, together with the author’s insights as to how and where LTC is developing, provides an opportunity to learn how LTC may be incorporated into existing health and social systems.

In general, the information in this section includes:

- the organization of the health and social system’s decision-making and implementation structures, including degree of coordination and decentralization;
- sources of public financial support;
- principles of coverage targeting and financing;
- the organization of the service delivery system;
- degrees of accessibility and reliability of primary health care; and
- availability of human resources in the health and social systems.
Section 3 presents information on current long-term services. Due to the various degrees of development of LTC services and systems in various countries, the information presented in this section varies from case-study to case-study. In general, the information in this section includes the following questions:

- What are the services designed for disabled persons, such as home care services (home health, personal care, homemaking, family education and training), other services in the community (such as day care services), and institutional services (nursing homes, geriatric hospitals, rehabilitation wards)?
- Have these services been developed on an integrated or non-integrated basis with the general health and social services?
- What are the respective roles of the government and nongovernmental sectors?
- What are the roles of volunteers and communal mobilization in the provision of LTC?

Section 4 addresses some general issues pertinent to LTC development. These include the present and future needs for long-term care, the author’s view of gaps between the need and provision of services, and an identification of resources (i.e. structures, human resources and organizations) at the national and local levels that may be utilized to promote LTC. It concludes with a discussion of emerging policy strategies and plans for future long-term care development, and perspectives on the preferred directions.

This common outline was intended to increase the likelihood that similar information would be collected from each case-study and facilitate comparisons. However, there was also an interest in allowing the case studies to reflect differences in the areas of expertise of the authors, the information available to them and the unique situations that exist in each country.
LONG-TERM CARE

Existing care systems in the developing world

Below, we briefly highlight the LTC policy directions that emerge from the case studies against the background of socioeconomic and epidemiological indicators as shown in Table 1.

As noted, the extent of need for long-term care is determined by the extent of disability and the availability of informal support. The extent of disability is indicated by the percentage of elderly in the population.* The percentage of elderly, the percentage of women in the labour force, and the parent support ratio are used as indications of the availability of family support. Competing resource demands are estimated by the rate of under-5 child mortality, which reflects the need to address traditional communicable diseases (acute and non-disabling diseases).

The overlap between the percentage of elderly and the rate of child mortality is used to indicate the double burden of disease. The overall resources available to address these needs are estimated by the per capita GNI (gross national income - adjusted for purchasing power parity), and the level of per capita health expenditures (also adjusted). The percentage of health care expenditures from the GNI reflects the priority given to health-related needs.

Lithuania and Ukraine

very high percentage of elderly at low income level relative to developed countries, and moderate to low burden of communicable diseases

In general, both Lithuania and Ukraine combine a very rapid rate of ageing with low income levels. The proportion of elderly in these countries is between 13% and 14%. These populations are continuing to age and in the year 2025 the proportion of elderly will reach 20% and they are confronting a large current and rapidly rising burden of chronic disease and disability.

The level of communicable diseases is low in Lithuania but is still moderate in Ukraine. The income level is particularly low in Ukraine (6980 $PPP per capita in Lithuania and 3700 $PPP per capita in Ukraine). The ageing pattern is heavily influenced by very low fertility rates. In both countries, there has been a very high proportion of women in the labour force.

* While this is a valid indicator, it ignores the fact that many elderly are themselves caregivers to their spouses, disabled children and very old parents. The caregiving roles of old people are especially important in countries with a high HIV/AIDS burden and large numbers of orphans.

14
CASE-STUDIES

Both countries have been challenged during the past decade by major macrosocietal transitions affecting all spheres of society – including their health and social systems, which have deteriorated considerably. Despite their low income level, both countries have a health system that covers the entire population. However, availability of the key services is very limited in these systems. In Lithuania, the level of expenditure on health is high relative to its economic situation compared with the other countries in the study having the same or higher level of resources.

In the past, institutional LTC services were emphasized in these countries. However, more recently they have developed home-based LTC services, including home health, personal care, and homemaking services. This broad package of LTC services, relative to the low income of these countries, may be understood in light of both the high rate of ageing and the desire to create a better balance between hospital-based and institutional-based service provision of care in the community.

The patterns described in Lithuania and Ukraine reflect broader patterns found in other Eastern European countries. Most of these countries were heavily biased towards institutional care, and only now are they moving towards services that are more community-centred.

Republic of Korea

high income and rapid ageing, low burden of communicable diseases

The Republic of Korea has the highest income (17 300 $PPP per capita) and highest expenditure on health services (in terms of total expenditures) among the countries examined. There is a very low level of under-5 mortality (8 per 1000 births) and high life expectancy.

At present, there is a moderate proportion of elderly, at 7.1%. However, the population is ageing very rapidly and by the year 2025, 16.9% will be aged 65 and over. Consequently, the Republic of Korea is concerned with the rise of chronic disease and disability.
LONG-TERM CARE

The Republic of Korea has a strong health system and a significant social service sector, both of which participate in the provision of LTC services. These services include a broad package of home health, personal care, and home-making services. It has particularly emphasized family education and training.

Trends in the Republic of Korea may be understood in light of the relatively high proportion of elderly, the decline in family size, the rise in the proportion of women in the labour force, and the availability of resources due to its relatively high-income level. Institutional LTC is very limited in the Republic of Korea, but there is an interest in developing more institutions in order to reduce acute hospital usage by individuals in need of LTC.

Costa Rica

Costa Rica has a moderate-income level (7980 $PPP per capita), but high health expenditure (per capita), and a strong health system. Under-5 mortality is low. The proportion of elderly is low, at 5%, but the proportion of those aged 65 and over will double during the next 25 years. As a result, Costa Rica is concerned with the rise of chronic disease and disability, rather than with the burden of communicable diseases.

It should be emphasized that Costa Rica’s choice – at a relatively low-income level – to spend a considerable amount of money on health care appears to have contributed to the very low communicable disease burden. In this way, it is avoiding the emergence of a double disease burden as its population ages.

Costa Rica has focused on developing home health provision, emphasizing family education and training. A broader package of LTC services, including personal care and homemaking, have not been introduced. Institutional LTC is almost non-existent. These patterns can be understood in light of the low proportion of elderly in the population and the low proportion of women in the labour force.
CASE-STUDIES

Mexico and Thailand

In general, both countries have young but rapidly ageing populations. At present, the percentage of the population aged 65 and over is 4.7% in Mexico and 5.2% in Thailand. In 2025, these percentages will reach 9.3% and 11.4%, respectively.

Accordingly, these countries are facing rapid increases in chronic disease and disability. They both have high under-5 mortality rates and are therefore still confronting the challenges of communicable diseases. In both countries, the health system provides moderate coverage of the population and their needs.

The level of development of LTC services seems to be quite similar in these countries, despite the fact that Mexico has higher resources (at 8790 $PPP per capita, as compared to 6320 $PPP per capita in Thailand). Both countries are at the initial stages of developing LTC services and are beginning to develop home health. They do not provide personal care or homemaking services.

The rate of ageing in Mexico is lower, as is the proportion of women in the labour force. These factors might have until now moderated the pressure to develop LTC services. Each country has a strong interest in health promotion, which is consistent with their emphasis on home health.

As in many other Latin American countries, Mexico strongly emphasizes highly-credentialed professions in home health care. This emphasis impacts the ability of Mexico to disseminate this service. By contrast, Thailand emphasizes personnel with much lower levels of formal credentials.
LONG-TERM CARE

Lebanon

low to medium income, low level of ageing, challenged by high level of injuries and disability caused by the civil war

Lebanon’s per capita GNI of 4500 $PPP is in the middle of countries in the study. However, total health expenditure in Lebanon represents 11.8% of GDP, the highest among the countries.

The current percentage of elderly in Lebanon (6%) also puts it in the middle of the range of countries in the study. The percentage of elderly is expected to increase to 9% by the year 2025, somewhat slower than the other countries.

Still, chronic and degenerative diseases are becoming more prevalent and represent a growing share of the country’s overall disease burden. Moreover, the problems of injuries and disability have been augmented by the civil disturbances. While the prevalence of communicable diseases has steadily declined over the last 20 years, it is still high (male mortality under age 5 stands at 34 per 1000 births).

The civil war, from 1975 through 1990, considerably weakened the institutional and financial capacity of the Government and public sector, and its role in the provision of health care services steadily declined during this period. However, health and social service development has now been resumed.

LTC services have been slower to develop, and are still provided primarily by informal caregivers. However, home health programmes are beginning to develop in the formal sector as an extension of primary care. Primary care development has been a priority for the Lebanese Government. This policy can be understood in light of the priority of the health system to develop care in the community (as opposed to hospital-oriented care) and to contain health expenditures.
CASE-STUDIES

China (with Shanghai as a more specific example)

A high percentage of elderly, low income, very large disparities between urban and rural areas

Excluding the Eastern European countries, China has a higher proportion of elderly in relation to its income level than do the other countries included in these case-studies (3920 $PPP per capita). There are huge differences between urban and rural areas with regard to demographic characteristics and health system development.

In Shanghai, for example, the proportion of elderly people is unusually high, at 15% (which is even higher than in many industrialized countries), and the health system is relatively more developed. Rural China, on the other hand, is facing the double burden of communicable and chronic diseases and has much less health coverage and infrastructure.

Home health programmes that provide a range of services, with an emphasis on family education, have begun to develop in urban areas such as Shanghai and Beijing. Despite the decline in family networks, personal care or home-making services have not developed. In these areas there is some institutional LTC provision that may be a response to rapid ageing of the population, a high rate of women’s labour force participation, and reliance on the family as the only providers of home-based personal care and homemaking.

Sri Lanka

Low income and ageing rapidly, low to medium burden of communicable disease relative to income level

Similar to China, Sri Lanka already has a relatively high percentage of elderly relative to its income level and its population is ageing very quickly. It has a gross national income of 3640 $PPP per capita. The proportion of elderly will double during the next 25 years, rising from 6% to 12% in 2025. The chronic disease burden is increasing, with a consequent increase in long-term care needs, while Sri Lanka still faces a moderate level of communicable disease burden.
LONG-TERM CARE

Sri Lanka is at the very initial stages of developing LTC services. Mainly nongovernmental organizations, together with a network of volunteers, have addressed the rapid process of ageing and the increasing need for LTC. Formal LTC services and especially home health programmes have just begun to develop (mostly by for-profit organizations, for those who can afford to pay).

The Government has played more of a role in the provision of institutional LTC, although at a low scale. Very recently, the Government has begun to sponsor clinics for the elderly, which place more emphasis on home health.

**Indonesia**

very low income, extremely high burden of communicable disease, low proportion of elderly

Indonesia represents countries characterized by a low proportion of elderly; very low economic resources (gross national income of 2830 $PPP per capita); and an extremely high burden of communicable diseases, as reflected in a high under-5 mortality rate (50 for males and 40 for females). At the same time, it is ageing rapidly – the proportion of those aged 65 and over will nearly double in the next 25 years, rising from 4.8% to 8.4% in 2025. It will therefore be confronted with a rapid increase in the burden of chronic disease and disability.

The Indonesian situation poses the basic issue, involving the question of where to begin to support the development of LTC services in the face of a low level of health infrastructure and a high communicable disease burden. Long-term care services in Indonesia, to the extent that they are available, are largely based on volunteers. This raises the question of how to strengthen volunteer roles as well as of the limits of expectations from voluntary activity.

As reflected in many other developing countries, traditional healers in Indonesia play an important role in the health system in general and already fulfil certain roles in LTC. The training of traditional healers in LTC has been identified as a way to enhance provision of long-term care.
We hope that the richness of the material presented in these case-studies will enable the reader to better understand both the factors contributing to the growing need for LTC and the unique conditions that affect the policies to address these needs in developing countries. There is much to be learned from these case-studies, including:

- existing systems of care;
- gaps between the needs and provision of services;
- potential resources that can be utilized to promote the provision of LTC; and
- emerging policy directions to care for the disabled in these countries.

These case-studies also illustrate creative efforts to address LTC needs despite obstacles. They expand the vision of the possible. Hopefully, this volume will be useful in establishing and improving long-term care policies throughout the developing world.
ACHIEVING COORDINATED AND INTEGRATED CARE AMONG LTC SERVICES: THE ROLE OF CARE MANAGEMENT

Professor David Challis
University of Manchester
United Kingdom

CASE-STUDY

CHINA

Fu Hua
Xue Di
1 General background data

1.1 Preamble

China is divided into 22 provinces, five autonomous regions, four municipalities (Beijing, Shanghai, Tianjin and Chongqing), two special administrative regions (Hong Kong and Macao) and the Taiwan Province. In 2000, the population of China reached 1.275 billion persons, 68% of whom were from rural areas. Of the people enumerated in the 31 provinces, autonomous regions and municipalities and servicemen of the mainland of China, 1,159.40 million persons or 91.9% of the population, were of Han nationality (National Bureau of Statistics).

Economic growth has speeded up, with enhanced comprehensive strength. According to preliminary estimates, the gross domestic product (GDP) in the year 2000 was 8940.4 billion yuan, up by 8% over the previous year at comparable prices. This growth rate was 0.9 percentage points higher than in 1999.

A growth of the elderly and disabled populations, the increasing public awareness of quality of life issues, and the competition in health care provision are expected to dramatically increase demand for long-term care in China. For example, of the total population in 2000, over 10% of the population were older than 60 (132 million people) and the average rate of growth of those age 60 and over was 3.2%, with an increase of more than 3.8 million people every year. Of the total population 6.96% are age 65 and over (88.11 million people), and by the year 2025 the percentage of those over 65 is expected to increase to 13.2%.

Particularly noteworthy is the growth of China’s ‘old-old’ population (those over 80 years of age). Currently, China’s old-old population is more than 5 million, or 6% of the total elderly population. However, the rate of growth of the old-old is 5.4%. This means that there will be an increase of 500,000 people over age 80 every year. By the middle of the 21st century, the old-old population will make up 6.8% of the population.
Another indicator of the growing need for government support for long-term care is the declining capacity of the informal system to provide care to the disabled elderly. Traditional Chinese culture has great respect for elders, and in the past elders’ needs were taken care of by younger family members. However, the ageing of the Chinese population (especially those age 80+), caused in part by the one-child policy that is leading to a ‘4-2-1’ family structure means that, in the future, fewer children will be available to care for their ageing parents. In other words, as the family structure is getting smaller, the informal care system is getting weaker: for every one couple, there are four or more older family members who may eventually need to be cared for.

The massive migration of individuals from rural to urban China is greatly affecting many health related issues in China, including long-term care. In 1960 about 16% of the population lived in urban areas as compared to about 32% in 2000. Many of those who have migrated to urban districts are not officially registered as local residents; as a result they do not have access to food subsidies and health insurance. Furthermore, this group often lives in densely populated, substandard living conditions, which pose threats to their health and place further demands on urban health facilities. Another implication of migration is that when working-age people leave villages to seek employment in the cities, they often leave behind elderly and other disabled relatives who they formerly were expected to care for.

Keeping these factors in mind, it is clear that China should continue preparing its long-term care system for future growth. With important economic developments occurring concurrently with these increased long-term care needs, the Chinese Government needs to be systematic in its response to the needs of its population, and in particular its elderly population, in order to have the resources and organizations ready to confront these needs.

This case-study describes the current and future needs for long-term care in more detail. It also details the current organization of the systems providing health and social services to the population (generally) and to those in need of long-term care. It is important to mention that the information provided in this case study on long-term care services generally refers to Shanghai and its environs, while the general information on China’s health and social systems refers to the entire country. Presented on the following three pages are background data concerning China, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

## 1.2 Background data from international data bases

<table>
<thead>
<tr>
<th>Demography (year 2000)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong> (thousands)</td>
<td>1,275,133</td>
</tr>
<tr>
<td><strong>Land area</strong> (sq km)</td>
<td>9,326,410</td>
</tr>
<tr>
<td><strong>Population density</strong> (per sq km)</td>
<td>133</td>
</tr>
<tr>
<td><strong>Population growth rate</strong> (% 2000–2005)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Urban population</strong> (%)</td>
<td>32</td>
</tr>
<tr>
<td><strong>Ethnic groups</strong> (%)</td>
<td></td>
</tr>
<tr>
<td>Han Chinese</td>
<td>91.9</td>
</tr>
<tr>
<td>Other</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>Religions</strong></td>
<td></td>
</tr>
<tr>
<td>Daoist (Taoist), Buddhist</td>
<td></td>
</tr>
<tr>
<td>Muslim (2%–3%), Christian (1%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total adult literacy rate</strong> (% in 1997)</td>
<td>84</td>
</tr>
<tr>
<td><strong>Age Structure</strong> (%)</td>
<td></td>
</tr>
<tr>
<td>0–14</td>
<td>24.9</td>
</tr>
<tr>
<td>15–24</td>
<td>15.6</td>
</tr>
<tr>
<td>60+</td>
<td>10.1</td>
</tr>
<tr>
<td>65+</td>
<td>6.9</td>
</tr>
<tr>
<td>80+</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Projections 65+ (%)</strong></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>13.2</td>
</tr>
<tr>
<td>2050</td>
<td>22.7</td>
</tr>
</tbody>
</table>
Demography (continued)

**Sex ratio** (males per female)
- Total population 1.06
- 15–64 1.06
- 65+ 0.89

**Dependency Ratio:**
- Elderly dependency ratio in 2000\(^2\) 11.4
- Elderly dependency ratio in 2025 21.3
- Parent support ratio in 2000\(^3\) 7.7
- Parent support ratio in 2025 9.5

Vital statistics and epidemiology

**Crude birth rate** (per 1000 population) (2000) 14.3

**Crude death rate** (per 1000 population) (2000) 7.0

**Mortality under age 5** (per 1000 births) (2001)
- Males 34
- Females 40

**Probability of dying between 15–59** (per 1000) (2001)
- Males 157
- Females 106

**Maternal mortality rate** (per 100 000 live births) (1995) 60

**Total fertility rate** (children born/woman) 1.8

---

\(^2\) Elderly dependency ratio: the ratio of those age 65 and over per 100 persons aged 20–64.

\(^3\) Parent support ratio: the ratio of those age 80 and over per 100 persons aged 50–64.
## Vital statistics and epidemiology (continued)

### Estimated number of adults living with HIV/AIDS (2001)
850,000

### HIV/AIDS adult prevalence rate (%)
0.1

### Estimated number of children living with HIV/AIDS (2001)
2,000

### Estimated number of deaths due to AIDS (2001)
30,000

### Life expectancy at birth (years) (2001)
<table>
<thead>
<tr>
<th></th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>71.2</td>
<td>69.8</td>
<td>72.7</td>
</tr>
</tbody>
</table>

### Life expectancy at 60 (years) (2000)
<table>
<thead>
<tr>
<th></th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18.0</td>
<td>16.0</td>
<td>20.0</td>
</tr>
</tbody>
</table>

### Healthy life expectancy (HALE) at birth (years) (2001)
<table>
<thead>
<tr>
<th></th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>63.2</td>
<td>62.0</td>
<td>64.3</td>
</tr>
</tbody>
</table>

### Healthy life expectancy (HALE) at 60 (years) (2001)
<table>
<thead>
<tr>
<th></th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13.5</td>
<td>12.7</td>
<td>14.2</td>
</tr>
</tbody>
</table>
**Economic data (year 2000)**

**GDP – composition by sector (%)**
- Agriculture: 15
- Industry: 50
- Services: 35

**Gross national income (GNI) ($PPP)**
- 4951 billion

**GNI – per capita ($PPP)**
- 3920

**GDP – per capita (US$)**
- 840

**GDP growth** (annual %) (1995–2000)
- 7.9

**Labour Force Participation (%)**:
- Male: 63.8
- Female: 55.9

---

**Health expenditure (year 2000)**

**% of GDP**
- 5.3

**Health expenditure per capita ($PPP)**
- 205

**Health expenditure per capita (US$)**
- 45

---

*PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries*
2 General health and social system

2.1 Basic income maintenance programmes

A minimum life guarantee system is established in all cities and towns – about 7.01 million urban and rural residents receive minimum life guarantee relief. The rural social security service network has been improved and now covers 18,855 towns, which accounts for 43.3% of the total. The basic retirement security programme, and unemployment insurance and rural social insurance are managed by the Ministry of Labour and Social Security.

By the end of 2001, 104.08 million staff and workers participated in the unemployment insurance programme, and a total of 1.37 million people received monthly unemployment insurance. Some 103.67 million staff and workers and over 31.73 million retirees participated in the basic retirement security programme.

A 1998 survey of 2000 elderly residents in Guangzhou and 1000 elderly residents in rural areas in Hunan province showed that the main source of income for elderly people in urban areas comes from pensions, while in rural areas they are more dependent on their children’s financial support (see Table 1) (Ruolian Li, 2000; Weixiwang, 2001).

Table 1. Income sources of elderly people in 1998 (%)

<table>
<thead>
<tr>
<th>Sources</th>
<th>Guangzhou</th>
<th>Hunan Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension</td>
<td>73.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Children support</td>
<td>17.7</td>
<td>67.4</td>
</tr>
<tr>
<td>Working income</td>
<td>6.5</td>
<td>25.8</td>
</tr>
<tr>
<td>Government aid</td>
<td>0.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Others</td>
<td>1.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
LONG-TERM CARE

2.2 Organizational structure of decision-making

China has a strong vertical structure in health care delivery. The central Ministry of Health (MOH), which reports to the State Council, provides policy direction, technical leadership, and supervision of disease prevention and health care provision. The structure and responsibilities of the MOH are duplicated at the provincial level within the Health Bureaux (throughout China's 22 provinces, five autonomous regions, and four municipalities) and again in Health Bureaux at the regional or city level.

There are ten departments within the MOH, three for administrative functions and seven line departments with specific programme or functional authority. Three vertical public health services operate within the ‘three-tier’ health care system. The Epidemic Prevention Service (EPS) and the Maternal and Child Health Programme (MCH) are both under the administration of the MOH, and the Family Planning and Reproductive Health Programmes are under the Family Planning Commission. At the provincial, city and county level, EPS operates epidemic prevention stations/Centres for Disease Control (CDC).

A number of other health and social functions are controlled by other ministries within the Government. The Ministry of Finance controls the central Government’s budget for health and the financing of the Government employee insurance system. The Ministry of Labour and Social Security sets policy for the entire insurance system.

A Central Price Commission sets prices for health services. Drug policy and inspection is conducted by the National Administration of Drugs. The State Pharmaceutical Agency (independent from the MOH) sets prices for drugs at the retail level. The Ministry of Civil Affairs has a Department of Social Welfare and Social Affairs, which has the function of making central governmental policies on social welfare and guiding the fulfilment of these policies.

There is some fragmentation between health and social services in terms of budget and structure, as well as between preventive and curative primary care, which are provided by different systems. The social and health systems (in general and in LTC services) at the local level are also slightly fragmented in terms of budget and structure.

LTC services are provided by both systems and integrated to different extents into the general health and social system of care. However, there is no special division for LTC as such – the social and health systems collaborate to provide LTC services, each with its own focus. Institutional LTC is provided by two different yet overlapping settings: the social system (senior citizen housing complexes which also accept disabled elderly people) and the health system (nursing homes, geriatric hospitals).
LTC facilities run by the social system are financially integrated into the national budget, and the Government allocates a certain amount of funds to support them. LTC services offered by the health system may also be integrated and costs are covered by medical insurance in some cities (such as Shanghai where some services are covered), while in other areas, they are paid almost exclusively out-of-pocket.

Traditional Chinese medicine is integrated into health care delivery at all levels, including primary care. Although the State Administration for Traditional Chinese Medicine is in charge of traditional Chinese medicine policies, it reports to the MOH. The People’s Liberation Army has its own large network of health institutions, including medical schools and hospitals.

The role of nongovernmental organizations (NGOs) is limited in the field of health care, they operate only a small percentage of health care facilities. There are some NGOs, such as the Association of the Disabled, and volunteer teams in the community that play important roles. NGOs are usually established through local initiatives. With the reform of the health system, it is expected that they will play a more important role in the future.

Every year, there are many health regulations issued by the MOH. These regulations cover the areas of disease control, health surveillance, and health care management. Health care management involves such areas as management of medical facilities and pharmacies, maternal and child health care, epidemic disease control, research and education, planning and financing, manpower, traditional medicine, and foreign affairs.

Policy-making in health care in China, however, is moving towards a more decentralized model. While the objectives of health policy are centrally defined and most health policy and planning activities occur at the national level, plans for implementation are devised at the provincial level or lower, resulting in tremendous variation across the country. In recent years, the provincial level Health Bureaux have gained much more authority over the planning and implementation of their own health services. They report directly to their local governments, but still receive technical guidance and direction from the central government.

About 10% of provincial budgets are provided by the central government. (Since fiscal decentralization in the 1980s, local governments have gained greater autonomy to raise taxes and retain revenues.) Poorer provinces continue to receive subsidies from the central government, but these have declined in real terms. Moreover, because the central government provides a small financial contribution, township health centres feel less obligated to implement laws and regulations. In this way, the system has contributed to growing inequities between the provinces.
LONG-TERM CARE

In the 1990s, the MOH introduced regional planning of resource allocation following recognition of existing inefficiencies due to the duplication of facilities and equipment and the over-supply of beds. This has enabled the central government to exercise some degree of control over health expenditures.

The Central Price Commission sets prices for health services. In most instances, fees have been less than costs. A separate State Pharmaceutical Agency sets prices for drugs at the retail level. In the case of drugs and high-tech treatments, prices are allowed to exceed costs, providing an incentive to over-prescribe high-cost diagnostic procedures and leading to rapid cost escalation.

Hospitals in China provide care on mainly a fee-for-service basis. Those owned by provinces, counties and townships have considerable authority over budgets, investment and fee collection, but not staffing.

The Government establishes basic salary scales, but hospitals provide bonuses, which can be up to two to three times regular salaries. While in governmental health facilities physicians are paid a salary, village doctors and private practitioners are paid primarily through fees from patients. Personnel are assigned to hospitals by the MOH or provincial Health Bureaux.

In December 1996, the State Council held its first National Health Policy Conference, attended by governors and representatives from relevant ministries, to discuss issues and options for the 21st century. Following the Conference, a ‘Decision of the Central Committee of the Chinese Communist Party and the State Council on Health Reform and Development’ was issued (WHO & Jianping Hu, 1999).

Since discussions of health policy reform in 1996 at the ministerial level, the MOH has emphasized the reform of Government employee and labour health insurance, the development of community health care, the establishment of a new health care framework, and the improvement of effectiveness and efficiency in health care facilities. These efforts, once implemented, will enable China to improve access, equity, and quality in health care.

In order to ensure the health system’s responsiveness to the changing needs of the population, there is a formal information system that covers the entire health care system. Every month, health institutes submit data reports to the information and statistics units in Health Bureaux. Evaluation and decision-making is done using these and other data from surveys. However, this system still needs to be improved in order to generate more useful information.
2.3 Financing of health services

The Ministry of Finance controls the central government’s budget for health and the financing of the Government employee insurance system (WHO & Jianping Hu, 1999). The Government at all levels provides financial subsidies for public health services and health care institutions in order to ensure the Government’s role in the management and surveillance of health care, in assistance to the health care sectors in providing quality public health services, and in improving the conditions of essential health care services and the health status of the public. Subsidies are set according to the responsibilities of governmental health management affairs, health surveillance, public health services, basic health care services, need for health care development, and so on (Ministry of Finance, 2000).

In general, since the early 1980s, there has been less central government contribution to health care financing and lower ‘society health payments’, and a concomitant rise in reliance on user fees and out-of-pocket expenditures. The total health care expenditure for 1997 was 337.747 billion yuans (about 273.2 yuans per capita) or 4.52% of the GDP. Of the health care expenditure, governmental budgetary health payments were 52.21 billion yuans (15.46% of the total health care expenditure), society health payments (referring to all society payments other than governmental budgetary payments, including the Governmental Insurance Scheme (GIS), the Labour Insurance Scheme (LIS), community financing, and ‘society financing’) were 93.03 billion yuans (27.54% of the total health care expenditure), and residents’ individual health payments were 192.51 billion yuans (57.00% of the total health care cost) (see Table 2) (Yuxin Zhao, 1997).

Table 2. Health financial pooling structure (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governmental budgetary health payments</strong></td>
<td>19.14</td>
<td>16.97</td>
<td>16.15</td>
<td>15.46</td>
</tr>
<tr>
<td><strong>Society health payments</strong></td>
<td>35.24</td>
<td>32.76</td>
<td>29.46</td>
<td>27.54</td>
</tr>
<tr>
<td><em>(GIS, LIS, community financing and ‘society financing’)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Residents’ individual health payments</strong></td>
<td>45.62</td>
<td>50.27</td>
<td>54.38</td>
<td>57.00</td>
</tr>
</tbody>
</table>
LONG-TERM CARE

With the health care reimbursement system shifting from mainly governmental subsidies to market mechanisms, health care institutions now have three methods of reimbursement: governmental subsidies, fee-for-service, and the sale of prescription drugs. Government subsidies account for less than 10% of the total income of health care institutions, while 90% of their total income comes from health care service provision and the sale of drugs.

For example, before economic reforms, public hospitals were financed largely by Government budgets and most physicians were salaried. After the reforms in 1978, hospital revenue from Government budgets declined. Government-owned hospitals today receive about 15%–25% of their revenues from central and/or local governments. Public hospitals are expected to cover the remainder with patient revenues.

As the health care financial pooling structure changes, the control of the Government over the health care will decrease. Instead, Government, social services, and individuals will share the responsibility for the cost of health care.

2.3.1 Pooled health care programmes

Overall about 20% of the general population in China has some form of health insurance (see Table 3) (Rao Keqin, Yi Li & Liu Yuan Li, 2000). Financing for health care differs for urban and rural areas; about half the population in urban areas, and 8% in rural areas are insured.

Because of the development of a new health insurance system in urban areas, residents are willing to share the risk with the rest of the urban population. In rural areas, the percentage of people covered by insurance (cooperatively-funded medical care) dropped from 90% in the late 1970s when the population was covered by the rural cooperative medical system (RCMS – a form of voluntary insurance that most farmers joined), to 8% in 1998.

As a result of changes from a collective to a household production system (part of the overall economic reforms), the financial basis of the RCMS began to erode. Currently, the cooperative medical system in rural areas does not cover all of the residents in these communities. There is now a renewed interest in re-establishing the RCMS system in many rural areas. In and around Shanghai, the RCMS covers a large proportion of rural residents (about 64% in 1999) (Department of Population, 2000). In other rural areas, health expenditures are mainly paid out-of-pocket.
In urban areas, there were two major insurance programmes: the Government Health Insurance scheme (GHI) and the Labour Health Insurance scheme (LHI). Due to the escalation of health expenditures in 1998, the Government decided to establish basic medical insurance and to merge both schemes into a new urban employees’ medical insurance programme (in order to increase risk pooling and to extend coverage).

This marked the beginning of an overall reform of Government employee and labour health insurance in China. Prior to the reform, about 100 million of the 400 million urban inhabitants of were covered by either the GHI or the LHI scheme.

Pilot experiments were initiated at the end of 1994 for implementing a three-tier financing system that included: (a) medical savings accounts (intended to provide consumers with incentives to be more cost-conscious in health care use); (b) out-of-pocket costs in the form of co-payments (intended to increase cost sharing by patients); and (c) social risk pooling (intended to protect persons against catastrophic expenses).

According to this new system, employers and employees share medical expenses. Employers contribute 6% of the entire staff’s salaries each year to medical insurance. Of that total, 30% goes towards medical savings accounts. The rest is set aside as a social risk pooling fund.

Employees pay 2% of their annual salaries into their medical savings accounts. When medical costs for an employee are below 10% of their average annual income, the money is either subtracted from their medical savings account (first tier) or the out-of-pocket deductible comes from their annual salary (second tier).

The social risk pooling fund, created by the employer, begins contributing to medical expenses once they exceed 10% of the employee’s average annual income (third tier). This fund does not cover expenses beyond four times the amount of the local annual average urban income (6470 yuan or US$780 in 1997) in case of serious illness, in which case patients must turn to commercial medical insurance.

Evidence from the pilot studies has shown that the three-tier finance reform has reduced cost inflation. Health spending per beneficiary decreased 27%, from 426 yuan in 1994 to 311 yuan in ZhenJiang in 1998. Total health spending declined by 24.6% from 1994 to 1995, compared with a positive growth rate of 35–40% in two neighbouring cities not under reform. Because this preliminary experience shows promise for a viable model of urban health care financing with potential for cost-containment, the central government wants to expand it to all of urban China after the amendment.
LONG-TERM CARE

Currently Shanghai is using this model, with a slight difference in the pooling and distribution of funds. This new system is expected to change life and health care for China's 400 million urban residents. Employees of non-publicly owned enterprises, mostly excluded from GHI and LHI, will now be covered under the new scheme and retirees will continue to enjoy the previous system of free medical care. The new urban employees' medical insurance will eventually be standardized at city and county levels, although no specific date for this step has been fixed (Jin Ma, 2000).

Other voluntary health insurance programmes in China include:

- health insurance for students in primary and secondary school, and in higher education mostly in urban areas; and
- ‘systematic health insurance’ for preventive and primary care services.

### Table 3. Health insurance structure in 1998 (%)

<table>
<thead>
<tr>
<th>Item</th>
<th>Total</th>
<th>Urban areas</th>
<th>Rural areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Health Insurance Scheme</td>
<td>4.95</td>
<td>16.01</td>
<td>1.16</td>
</tr>
<tr>
<td>Labour Health Insurance</td>
<td>6.22</td>
<td>22.91</td>
<td>0.51</td>
</tr>
<tr>
<td>Dependent Health Insurance</td>
<td>1.62</td>
<td>5.78</td>
<td>0.20</td>
</tr>
<tr>
<td>Medical Insurance</td>
<td>1.88</td>
<td>3.27</td>
<td>1.41</td>
</tr>
<tr>
<td>Social Health Insurance</td>
<td>0.39</td>
<td>1.42</td>
<td>0.05</td>
</tr>
<tr>
<td>Cooperative Medical System</td>
<td>5.54</td>
<td>2.74</td>
<td>6.50</td>
</tr>
<tr>
<td>Self-payment</td>
<td>76.40</td>
<td>44.13</td>
<td>87.44</td>
</tr>
<tr>
<td>Others</td>
<td>2.98</td>
<td>3.73</td>
<td>2.73</td>
</tr>
</tbody>
</table>
2.3.2 Expenditure patterns

According to a National Health Accounts Study in 1993, governmental spending (excluding the Government Health Insurance scheme (GHI)) included: 28% for hospital inpatient and outpatient care; 21% for construction; 28% for preventive care, primary care, and family planning; and 23% for all other services.

As with many other health services, preventive programmes have been under pressure to raise more of their own revenues through user fees. Some LTC services are covered in part by the national budget or through medical insurance. Much of long-term care is paid out-of-pocket in both cities and rural areas.

About half of all health expenditure goes towards pharmaceuticals (85% of all sales take place in hospital inpatient or outpatient services) and is paid primarily out-of-pocket unless the patient has insurance coverage. This high level of expenditure on drugs has been associated with the inappropriate use of drugs attributed to the incentive to overprescribe (or prescribe more expensive) drugs – the sale of which is a major component of income in health facilities and for health workers. Overall governmental allocation of funds to the health sector in the 1990’s is shown below (Table 4).

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocation of funds to health sector (Billion yuan)</th>
<th>State expenditure (Billion yuan)</th>
<th>As % of State expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>14.697</td>
<td>579.260</td>
<td>2.54</td>
</tr>
<tr>
<td>1995</td>
<td>16.326</td>
<td>682.372</td>
<td>2.39</td>
</tr>
<tr>
<td>1996</td>
<td>18.757</td>
<td>793.755</td>
<td>2.36</td>
</tr>
<tr>
<td>1997</td>
<td>20.920</td>
<td>923.356</td>
<td>2.27</td>
</tr>
<tr>
<td>1998</td>
<td>28.280</td>
<td>1,079.818</td>
<td>2.62</td>
</tr>
</tbody>
</table>
It is important to note that health care consumption is mainly in urban areas and the ratio of health care costs per capita in urban areas over that in rural areas was 3.51:1. In 1999, the average health care cost per capita in urban areas was 245.59 yuan, while it was only 70.02 yuan in rural areas. The average health care cost per capita in urban areas and in rural areas accounted for 5.32% and 4.44%, respectively, of the average individual living expenditures (see Table 5).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual health care cost per capita</td>
<td>16.71/19.02</td>
<td>110.11/42.48</td>
<td>245.59/70.02</td>
<td></td>
</tr>
<tr>
<td>Annual living expenditures for consumption</td>
<td>673.20/584.63</td>
<td>3537.57/1310.36</td>
<td>4615.91/1577.42</td>
<td></td>
</tr>
<tr>
<td>Health care cost/living expenditures for consumption (%)</td>
<td>2.48/3.25</td>
<td>3.11/3.24</td>
<td>5.32/4.44</td>
<td></td>
</tr>
</tbody>
</table>

2.4 Services delivery system

2.4.1 Health care delivery

By the end of 2000, there were 325 000 health care institutions in China (including clinics), with a total of 3.18 million beds, 2.21 million of which were in hospitals and health care centres, and 4.49 million health workers, including 2.08 million doctors in hospitals and health care centres, and 1.27 million senior and junior nurses. China also had 5441 anti-epidemic and disease prevention stations employing 211 000 health workers, and 2598 maternal and child health care institutions employing 75 000 health workers.
There were 49,000 health care institutions at township level in rural areas, with 735,000 beds and 1.03 million health workers. Rural villages with health care posts made up 89.8% of all villages in China, employing 1.32 million rural doctors and health workers. It is important to note that traditional Chinese medicine is integrated into health care delivery at all levels, including primary care.

### 2.4.2 Three tiers of health services

Health services in China are divided into three tiers. Third tier services are provided by provincial or municipal/city level hospitals. In these hospitals, emergency care, outpatient, and inpatient services are provided to patients with more complex illnesses. Generally, the physicians in these facilities are specialists. Most of the hospitals are general hospitals, but there are also those that provide specialized care, such as mental health, maternal and child health, paediatrics and oral or thoracic surgical care. Almost all of these hospitals are teaching hospitals.

The secondary tier of health services is provided by mainly district level hospitals and clinics in urban areas or county level facilities. These facilities also provide emergency, outpatient, and inpatient care. However the quality and quantity of health services provided are not of the same level as those provided by the third tier. There are also some secondary tier facilities that provide primary preventive care, mental health care, maternal and child health care, oral care or geriatric care. In some areas, the second tier will merge into either the first or third tier facilities.

Primary health services are provided mainly by community health centres (and some health posts), township health centres, or village health posts with rural doctors. In these facilities, health services include ambulatory care, home bed care, home visits, health examinations, health consultations, health education, maternal and child health care, elder care, chronic disease care, mental health, injections, and other types of care. According to a survey conducted in Beijing’s three community health centres, the top high-volume primary care services were ambulatory care, child care, and injections (Xiuyun Wu, Manchun Li & Zhenglai Wu, 2000).

The referral system between the three tiers is not enforced and has weakened with increased public awareness of their right of choice in medical care. This has led to high occupancy levels in tertiary care hospitals along with low occupancy levels in secondary hospitals and township health centres.
Traditional Chinese medicine is integrated into health care delivery at all levels, including primary care. China has hundreds of pharmaceutical manufacturers of both Western and traditional Chinese medicine, and relies minimally on imported drugs. It also has a very well developed system of drug distribution.

As in other industries in the country, formerly State-owned drug manufacturers and distributors now operate independently, resulting in increased competition in the drug market. Many people now purchase drugs without seeing a health professional at all, although most drugs are distributed by health facilities, pharmacies, or private physician practices.

The data on health expenditure by category mentioned previously indicates that about half of all health spending goes towards pharmaceuticals, with 85% of all sales occurring in hospital inpatient or outpatient settings. This high level of spending on drugs has been associated with the inappropriate use of drugs by some purchasers.

Health facilities and health workers have an incentive to over-prescribe or prescribe more expensive drugs, since they obtain much of their income from this source. Medical supplies can be bought in all drug stores and some supermarkets.

Three vertical public health services operate within the ‘three-tier’ health care system. The Epidemic Prevention Service (EPS) and the Maternal and Child Health Programme (MCH) are both under the administration of the MOH, and the Family Planning and Reproductive Health Programme, under the Family Planning Commission. At the provincial, city and county level, EPS operates epidemic prevention stations/CDC.

In rural areas, there are problems of access to medical services, especially since the decline of the collective pooling system (RCMS) and the widening gaps between urban and rural areas. Moreover, the ratio of doctors, nurses, and other health professionals is much higher in urban areas than in rural areas, and the more educated professionals tend to practice in urban areas.
### Table 6. Demands for medical care

<table>
<thead>
<tr>
<th>Survey instrument</th>
<th>Year 1993</th>
<th>Year 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total/</td>
<td>Total/</td>
</tr>
<tr>
<td></td>
<td>Urban/</td>
<td>Urban/</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Visits per 1000 inhabitants</strong></td>
<td>169.5/</td>
<td>163.9/</td>
</tr>
<tr>
<td><em>(in the preceding 2 weeks)</em></td>
<td>198.8/</td>
<td>161.9/</td>
</tr>
<tr>
<td></td>
<td>159.7</td>
<td>164.6</td>
</tr>
<tr>
<td><strong>Self-treatment patients</strong></td>
<td>–</td>
<td>28.5/</td>
</tr>
<tr>
<td><em>per 100 patients</em></td>
<td>–</td>
<td>43.6/</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>21.5</td>
</tr>
<tr>
<td><strong>Non-visits per 100 patients</strong></td>
<td>36.4/</td>
<td>38.5/</td>
</tr>
<tr>
<td><em>(in preceding 2 weeks)</em></td>
<td>42.4/</td>
<td>49.9/</td>
</tr>
<tr>
<td></td>
<td>33.7</td>
<td>33.2</td>
</tr>
<tr>
<td><strong>Hospitalizations per</strong></td>
<td>35.6/</td>
<td>35.4/</td>
</tr>
<tr>
<td><strong>1000 inhabitants per year</strong></td>
<td>50.4/</td>
<td>48.3/</td>
</tr>
<tr>
<td></td>
<td>30.6</td>
<td>31.0</td>
</tr>
</tbody>
</table>

The total number of hospital beds in China rose from 2.6 million in 1990 to 3.18 million in 2000 and the number of hospital beds per 1000 population also rose from 2.30 in 1990 to 2.39 in 1999. Yet, the utilization rate of beds declined significantly from 80.9% in 1990 to 59.8% in 1999, suggesting that the increased supply of beds led to more inefficiency (see Table 7).

### Table 7. Utilization of hospital beds at and above county level

<table>
<thead>
<tr>
<th>Year</th>
<th>1990</th>
<th>1995</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital beds (million)</td>
<td>1.85</td>
<td>2.05</td>
<td>2.14</td>
</tr>
<tr>
<td>Turnover of beds (time)</td>
<td>17.6</td>
<td>15.5</td>
<td>16.3</td>
</tr>
<tr>
<td>Average LOS (days)</td>
<td>15.9</td>
<td>14.7</td>
<td>12.6</td>
</tr>
<tr>
<td>Utilization rate of beds (%)</td>
<td>80.9</td>
<td>66.9</td>
<td>59.8</td>
</tr>
</tbody>
</table>
LONG-TERM CARE

2.4.3 Social services

Social welfare work continues to develop. There were 1.12 million beds in social welfare institutions of various types in China in 2000, with 843,000 residents. Some 201,000 community service facilities were established in urban areas, including 8,101 community service centres.

A minimum life guarantee system had been established in all cities and towns; about 7.01 million urban and rural residents received minimum life guarantee relief. The rural social security service network has been improved and now covers 18,855 towns, which accounts for 43.3% of the total towns. In 2000, 6.89 billion yuan worth of social-welfare lottery tickets were issued, raising 1.43 billion yuan worth of social funds, and donations from society reached 3.27 billion yuan.

In general, it can be said that the living standards of urban and rural households have continued to improve. With the acceleration of economic growth, the ‘three security system’ (basic living expenses for urban laid-off workers, the unemployment insurance system, and the minimum living expense assurance system in urban areas) have been further consolidated and improved.

2.4.4 Auspices of health service providers

Service providers in the health care delivery system in China fall under the following auspices:

- Government (central, provincial and county);
- State-owned enterprises, which are quasi-governmental entities with substantial autonomy (SOES);
- collective economy organizations (NGOs) including township health centres and village health posts in rural areas, and health community centres in urban areas; and
- private-for-profit entities including individual providers and an increasing number of hospitals.
While the central government has established policies governing the financing and operation of all four types of auspices, it grants considerable autonomy to the latter three to raise funds and manage their own operations, in line with market-oriented reforms in the general economy. Even its own facilities are expected to raise a substantial portion of their own revenues (WHO & Jianping Hu, 1999).

The central government, in fact, owns and operates relatively few health facilities. For example in 1996, the MOH ran 62 hospitals, 8% of which were at and above the county level. Those owned by provinces, counties and townships have considerable authority over budgets, investment and fee collection, but not staffing.

The 1980s and 1990s saw the adoption of several key pieces of health legislation. One of the most important, which significantly influenced China’s health system, was the State Council approval of the “Report on the Permission of Private Medical Practices” submitted by the MOH in 1980. In essence, it made private practice of medicine legal again.

Over the next 10 years, the percentage of village cooperative medical systems arranged through private practice increased from less than 5% to nearly 50%. By 1999, there were 163 private hospitals, an increase of 33% compared with 1995 (WHO & Jianping Hu, 1999). It was also estimated that 169,839 health practitioners worked in private practice. In Shanghai in 1999, there were 25 joint venture (Chinese–foreigner) partnership medical facilities, of which five were general hospitals, seven were hospitals with some specialty, five were multi-specialty clinics, and eight were specialty outpatient clinics. Of these 25 facilities, 15 (60%) were tertiary level and 10 (40%) were secondary level (We Zang, 2000).

### 2.5 Human resources and training

Since 1949 China has seen a considerable increase in the number of its health care workers. Health personnel include doctors of traditional Chinese medicine, doctors of western medicine, senior nurses, pharmacists, laboratory technicians, other technicians, paramedics of Chinese medicine, paramedics of western medicine, junior nurses, midwives, junior pharmacists, junior laboratory technicians, other junior technicians, other doctors of Chinese medicine, assistant nurses, assistant laboratory technicians, and other junior medical technical personnel.

The staff in health centres of urban areas includes doctors, nurses, officials and others. In general there are 50–100 staff members. The staff in village health posts includes a village doctor and one or two nurses.
LONG-TERM CARE

Some posts have only one village doctor. Most provide acute medical care, and public health nurses are responsible for preventive services. There is great variation in the length and type of education received by doctors, nurses and other health professionals (see Table 9).

More than half of all health professionals and workers in China are employed by the Government – the MOH or its provincial health bureaux, and 25% are employees of the State-operated enterprises (SOES). While there are not many private health care providers in China, the number is increasing.

Reasons for this increase may be:

- medical education reform, which creates incentives for private-paying medical students to seek private practice following graduation;
- development of a multi-ownership market, in which publicly-owned hospitals are transformed into joint-stock or partnership models.

Under joint-stock arrangements, private financing is obtained (commonly from hospital staff, but sometimes from other stockholders if publicly offered). Partnership models have also been developed with financing from foreign sources (WHO & Jianping Hu, 1999). By 1999, there were 63 private hospitals, an increase of 33% compared with 1995. Also it was estimated that 169,839 health practitioners work in private practice (WHO & Jianping Hu, 1999).

2.5.1 Doctors

In 1999, there were 1.67 doctors per 1000 inhabitants, including practitioners of Chinese medicine (see Table 8). In fact, about 20% of all doctors are practitioners of traditional Chinese medicine (TCM), both in general medical practices where they work side by side with western-trained professionals and in separate TCM institutions.

There is a much higher ratio of doctors in urban than in rural areas. As elsewhere, health professionals with more education and skills tend not to practise in rural and poorer areas since they can be better paid in health institutions in urban areas.
In 1999, there were 1.01 million village doctors and 315,000 health aides nationwide. On average, there were 1.82 village doctors or health aides per village. Seventy percent of village doctors have received formal middle-level medical education (Chang Min Li, 2001).

These village doctors and health aides play a key role in the rural health care delivery system, providing ‘first-contact’ care and referring residents to higher levels of health care if necessary. Aside from the care provided in health facilities, doctors also offer care in the homes of the disabled through a special ‘home bed programme’.

**Table 8. National hospital beds and health professionals per 1000 inhabitants**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital beds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>0.63</td>
<td>2.08</td>
<td>3.78</td>
<td>4.61</td>
<td>4.54</td>
<td>4.18</td>
<td>3.50</td>
<td>3.49</td>
</tr>
<tr>
<td>Country</td>
<td>0.05</td>
<td>0.14</td>
<td>0.51</td>
<td>1.23</td>
<td>1.53</td>
<td>1.55</td>
<td>1.59</td>
<td>1.52</td>
</tr>
<tr>
<td><strong>Health professionals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>0.93</td>
<td>1.61</td>
<td>2.11</td>
<td>2.24</td>
<td>3.28</td>
<td>3.45</td>
<td>3.59</td>
<td>3.64</td>
</tr>
<tr>
<td>Country</td>
<td>0.73</td>
<td>1.22</td>
<td>1.46</td>
<td>1.41</td>
<td>2.09</td>
<td>2.15</td>
<td>2.32</td>
<td>2.38</td>
</tr>
<tr>
<td><strong>Doctors</strong></td>
<td>0.67</td>
<td>0.84</td>
<td>1.05</td>
<td>0.95</td>
<td>1.36</td>
<td>1.56</td>
<td>1.62</td>
<td>1.67</td>
</tr>
<tr>
<td>City</td>
<td>0.70</td>
<td>1.30</td>
<td>2.22</td>
<td>2.66</td>
<td>3.35</td>
<td>2.95</td>
<td>2.39</td>
<td>2.33</td>
</tr>
<tr>
<td>Country</td>
<td>0.66</td>
<td>0.76</td>
<td>0.82</td>
<td>0.65</td>
<td>0.85</td>
<td>0.98</td>
<td>1.07</td>
<td>1.14</td>
</tr>
<tr>
<td><strong>Nurses</strong></td>
<td>0.06</td>
<td>0.20</td>
<td>0.32</td>
<td>0.41</td>
<td>0.61</td>
<td>0.86</td>
<td>0.95</td>
<td>1.02</td>
</tr>
<tr>
<td>City</td>
<td>0.25</td>
<td>0.94</td>
<td>1.45</td>
<td>1.74</td>
<td>1.85</td>
<td>1.91</td>
<td>1.59</td>
<td>1.64</td>
</tr>
<tr>
<td>Country</td>
<td>0.02</td>
<td>0.05</td>
<td>0.10</td>
<td>0.18</td>
<td>0.30</td>
<td>0.43</td>
<td>0.49</td>
<td>0.52</td>
</tr>
</tbody>
</table>
LONG-TERM CARE

China does not currently have a shortage of officially classified ‘doctors’. However, there is great variation in the length and type of training that they receive (see Table 9). Physicians practising medicine in China are required to have a medical licence whether they work in a hospital, clinic, community/township health centre, or public health facility.

Generally, after graduation from medical school (5–6 years) or medical college (3 years), one can work in a health care setting as a physician with a licence. A physician in private practice must have a licence from a Government Health Bureau.

Today, medical education in China is much closer to the international standard in terms of medical education, graduate medical education, and continuing medical education. Licensing and certification is becoming more and more formal.

In 1998, the Standing Committee of the National People’s Congress passed a new ‘Physicians Law’ with the following key elements:

- a new licensing system for physicians based on examinations, which will also help monitor private practices; and
- the designation of ‘titled doctor’ reserved for those who complete three or more years of training at a medical university or college; paramedics of Chinese medicine or western medicine (or assistant doctors) will not be allowed to become ‘titled doctors’ through seniority, as was the case in the past.
**Table 9. General education requirements for health professionals**

<table>
<thead>
<tr>
<th>Category</th>
<th>Type of health professional</th>
<th>Type of education and training</th>
<th>Length of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Doctors of traditional Chinese medicine; doctors of western medicine; senior nurses; pharmacists; laboratory technicians; and other technicians.</td>
<td>Higher education (medical or nonmedical) in a University or College.</td>
<td>At or above three years (usually four to five years).</td>
</tr>
<tr>
<td>II</td>
<td>Paramedics of Chinese medicine; paramedics of western medicine; junior nurses; midwives; junior pharmacists; junior laboratory technicians; and other junior technicians.</td>
<td>Middle medical education in a middle hygiene school, a middle nursing school, a middle pharmacy school or other middle school.</td>
<td>Three to four years.</td>
</tr>
<tr>
<td>III</td>
<td>Other doctors of Chinese medicine; assistant nurses; assistant laboratory technicians; and other junior medical technical personnel.</td>
<td>Training in hospitals, clinics or middle medical school.</td>
<td>Three months to one year.</td>
</tr>
</tbody>
</table>
LONG-TERM CARE

2.5.2 Nurses

There are 1.02 nurses per 1000 inhabitants. This rate is much higher in urban than in rural areas. Levels of nurses include: senior nurses (4–5 years of training at a university or college); junior nurses (3–4 years at a middle nursing school); assistant nurses (3 months to a year training in hospitals, clinics, or middle school).

In addition to providing care in health facilities, nurses also offer care in the homes of the disabled through a special ‘home bed programme’.

2.5.3 Social workers

‘Social workers’ in China are nonprofessionals. Some social workers are employed by family members to provide assistance to the disabled, and others are volunteers organized by the community.

2.5.4 Traditional healers

As mentioned earlier, traditional Chinese medicine is integrated into the health system at all levels. 20% of doctors practise traditional Chinese medicine, and there are also other lower levels of doctors of traditional Chinese medicine who trained for a period of 3 months to one year in a hospital or clinic.

2.5.5 Paraprofessionals

Nonprofessional home care workers are usually privately hired by families through a personnel exchange service centre. For these workers, the educational requirements are not strict and depend on the family’s preferences.

2.5.6 Volunteers

At the community level, volunteers are organized to provide services to the elderly and the disabled. In Shanghai for example, there are 3000 teams totalling one million volunteers working in the communities to help improve the quality of life of the elderly and disabled. These teams provide services such as food, escort services to hospital, and shopping.
3 Summary of LTC provision

The Chinese central government is in charge of establishing policy and regulations of LTC services, including financing of services, educational requirements for LTC staff, etc. Local governments are responsible for the administration of LTC facilities based on the policy and regulations issued by the central government. With the supervision of the central government, they may shape LTC services according to local needs and economic levels.

Enterprise-run and private LTC facilities play an important role in sharing the burden of the Government to provide care. Moreover, the increasing needs of the disabled may be better met with multiple parties involved in service provision. Nongovernmental organizations, such as the Association of the Disabled and volunteer teams in the community, also help to improve the quality of LTC services.

The social welfare and medical care systems collaborate to provide LTC services, each with its own focus, and these services are integrated into the general health and social systems to different extents. LTC facilities run by the social welfare system are financially integrated into the national budget, and the government allocates a certain amount of funds to support them. The LTC services offered by the medical care system may be integrated structurally or functionally.

Taking the ‘home bed medical service’ as an example, costs are covered by medical insurance in some cities and paid out-of-pocket in others. The central government encourages non-governmental organizations to set up social welfare services for the elderly, and has established policies for their benefit.

As mentioned previously, LTC expenses are covered in part by the national budget, and the rest is paid through medical insurance, retirement income, or family support. To help patients with serious diseases pay for costly medical expenses, various forms of supplementary medical security have emerged and commercial medical insurance and social donations have been developing.
LONG-TERM CARE

3.1 Shanghai City

Shanghai City was chosen as the specific locality to illustrate LTC services in China. However, its services, while reflective of many urban areas, should not be considered to be representative of all areas in China. In 1979, Shanghai became the first city of an ageing society in China, with 1.15 million people aged above 60, accounting for 10.2% of the city's population.

By the end of 2000, there were 2.418 million people aged above 60, accounting for 18.3% of the total population of 13.216 million. In rural areas in and near Shanghai, the population aged above 60 exceeded 15% of the total in 2000. Among the yearly increase in numbers of this ageing population, two-thirds are aged above 80.

As female elderly have more years of life expectancy (80.8 years) than males (76.4 years), the proportion of elderly females is higher, representing 55% of the population aged above 60, 63% of that aged above 80, and 86% of that aged above 100.

A population survey conducted by the Shanghai Municipal Health Bureau in 1995 showed that 74% of those over age 60 suffered from various chronic diseases. A study of physical and mental disability among 3745 persons aged 65 and older in Shanghai indicated that the prevalence of disability (the definition refers to the inability to perform independently at least one of the following five activities – eating, dressing, transferring, using the toilet, and bathing) was 8.3% (Zhang, 2001).

3.1.1 Home care (home health, personal care, home-making, family education and training)

Because of China’s traditional respect for the elderly and economic inability to provide strictly professional services for them, LTC services are mainly undertaken by the disabled person's family at home. According to a comprehensive survey in 1998, elderly individuals prefer to depend on their own family members whenever possible. Their second choice is to employ a carer. Only 5.6% of people choose supportive nursing care facilities.

In Shanghai, over 90% of dementia sufferers are cared for by their family at home. As family size becomes smaller, however, every couple must provide home care for an increasing number of elderly dependents – a task that is beyond their ability. The Government has developed a community-based social service system to take care of the elderly. With the emphasis on community-based health services, home care systems have been established to offer home-based LTC.
Home-based care is still the main LTC service provided in China, although again it is worthwhile to remind the reader that service provision varies between urban and rural areas and among different Government districts. The disabled being cared for at home may receive services from paid staff in addition to family caregivers. Such paid staff may include doctors and nurses from community health service centres (formerly community hospitals) and home care workers.

The typical service provided by the community health service centre is the ‘home-bed medical service’, which is defined as an inpatient service provided at patients’ homes. Home-bed doctors provide in-home examinations and written prescriptions. Acupuncture and other rehabilitation services can be prescribed as well.

‘Home-bed’ nurses are in charge of basic nursing tasks such as injections. Educational requirements for ‘home-bed’ doctors and nurses are the same as national regulations for medical staff. The Government has drafted a series of criteria to qualify individuals to receive the ‘home-bed medical service’ (it is intended for those who are permanently homebound due to physical or mental disability, and is available for younger as well as older disabled individuals).

The local community health service centre determines whether the condition of the patient warrants such service. An ideal, but not yet available, ‘home-bed medical service’ would include medical care, rehabilitation and psychiatric consultation.

Financial support for home care services differs by city. In Shanghai, the home-bed fee is included in the medical insurance coverage, which may cover family members through supplemental insurance packages. In some cases, NGOs may also provide funding for the service. Those who hire home care workers for assistance with daily living usually pay out-of-pocket.

Home care workers mainly provide the disabled with assistance with daily living and are usually hired by the family with private funds through a personnel exchange service centre. For these workers, the educational requirements are not very strict and depend on the preferences of the family. Alarm systems (‘bells for help’) are installed in the homes of single old people in Shanghai, and there are teams of volunteers who provide assistance to the disabled within Shanghai.

As noted above, the family provides the vast majority of care for the disabled. Family members provide assistance with activities and are the link to doctors and specialists. To date, there are no formal education/training programmes for family caregivers, but in Shanghai they may seek help through consultant hotlines or professional lectures.
LONG-TERM CARE

3.1.2 Other services in the community

At the community level, volunteers are organized for service to the elderly and the disabled. In Shanghai, as mentioned, there are 3000 teams comprising one million volunteers working in the communities to help improve quality of life for disabled individuals.

The development of many community services in China is still in its infancy. At present, day care services for the disabled are provided in many communities. These day care services fall under the responsibility of the social system and are provided by the Government (residential care services) and for-profit companies.

Payment for these services comes largely from private, out-of-pocket expenditure, although some Government money is available. Eligibility for Government money is determined by the level of family care available to the individual in need. Transportation to and from these service providers is the responsibility of the family.

‘Meals on wheels’ is a second programme provided in the community. This programme falls under the responsibility of the social system and is paid for by a combination of public and private funds. Similar to the day care services, access to Government money is determined by the level of family care available to the individual in need. Governmental and for-profit providers supply the ‘meals on wheels’ programme.

In general, it can be said that, in Shanghai, community services including hostels, welfare houses, rehabilitation houses, nursing homes, day care centres, and entertainment activity centres are being gradually popularized. ‘Bells for help’, as mentioned previously, are installed for single old people. Care teams are set up for the poor elderly to provide services such as providing food, escorting people to the hospital, shopping and prescription dispensing, etc. It has been said that elderly people can “have minor obstacles handled within the house, common services offered by the neighbourhood and big difficulties resolved within the community”.

The Ministry of Civil Affairs announced on 8 June, 2001 that the ‘Starlight Plan’ for community elderly welfare services will address the challenge of an ageing society. The tasks of the Plan are that departments of Civil Affairs at the central and local government level will support the building of elderly welfare facilities and activity places in the communities in urban areas and the building of township elderly houses in rural areas in the next three years (Ministry of Civil Affairs, 2001). This will have a great influence on the whole elderly care system in China.
3.1.3 Institutional care

Currently, there are two interconnected networks that together provide institutional care: the social welfare system, which operates senior citizen housing facilities and some psychiatric service centres; and the medical care system, which manages nursing homes, geriatric hospitals, and rehabilitation wards in general and psychiatric hospitals.

The social welfare system manages the State-owned senior citizen housing complexes at various local levels. These facilities guarantee free LTC to those who are in need and cannot afford it. Their cost depends on the financial support of the Government. The senior citizen housing complexes also accept disabled elderly who can pay in 1998 out-of-pocket.

In recent years, some enterprise-run and private senior citizen complexes have been set up to supplement the public facilities. Although these facilities charge the residents, they are basically non-profit, and their income must be invested in the maintenance of the facilities. The staff of such facilities must be licensed and provide care according to their skill level and experience.

In the medical care setting, nursing homes, geriatric hospitals and rehabilitation wards in general hospitals constitute the LTC service system. Professional and specialized LTC services for the disabled are provided in these facilities, and costs are covered to varying degrees by medical insurance. By the end of 1999, there were 47 nursing homes with 3900 beds in Shanghai alone.

These nursing homes are run by the Government and NGOs (principally the Government), and the staff in these facilities includes doctors and nurses with professional training. In a survey of 22 of these nursing homes in 1998, there were 1262 health workers (57 health workers per nursing home on average) (Xiongxiang Chen, Fei Yab & Yue Li, 2000). Adding four geriatric hospitals to the 47 nursing homes and 18 000 home beds ('home-bed medical service' mentioned above) in communities, about 40 000 to 45 000 elderly people with diseases are treated in these locations.

For the mentally disabled, psychiatric services are offered by the social welfare service or by psychiatric hospitals. The Government will pay for the cost of care for those who are unable to afford it. Otherwise, costs are covered by medical insurance to varying degrees. In some areas there is little palliative and terminal care.
4 General questions pertinent to LTC development

4.1 Present and future needs for long-term care and gaps between needs and provision of services

In keeping with traditional Chinese values, in the past younger family members had always cared for the elderly. As Table 10 below demonstrates, daughters and spouses still provide the majority of ‘daily life’ and ‘illness care’ for the elderly.

Unfortunately, the one-child policy means that, in the future, fewer younger family members will be available to care for their older family members (Keqin Rao, Li Yi & Yuan Liu, 2000). Furthermore, the growth of the elderly population in China has outpaced the present rate of economic development. With such a low GDP per capita, it is difficult for individuals and families to cope financially with caretaking issues. Moreover, the social security system in China is not well developed. With the development of the economic and social system, the system of family care will be weakened further. This challenge to the health care system must be addressed.

Table 10. Availability of caregivers for the elderly (%; n=502)

<table>
<thead>
<tr>
<th>Caregivers</th>
<th>Daily life care</th>
<th>Illness care</th>
<th>Chatting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daughter</td>
<td>88.8</td>
<td>88.2</td>
<td>48.6</td>
</tr>
<tr>
<td>Spouse</td>
<td>71.9</td>
<td>74.3</td>
<td>65.3</td>
</tr>
<tr>
<td>Old friend</td>
<td>17.1</td>
<td>11.8</td>
<td>36.9</td>
</tr>
<tr>
<td>Neighbour</td>
<td>13.1</td>
<td>3.8</td>
<td>11.6</td>
</tr>
<tr>
<td>Relative</td>
<td>12.9</td>
<td>7.4</td>
<td>5.4</td>
</tr>
<tr>
<td>Working unit</td>
<td>8.2</td>
<td>3.2</td>
<td>2.0</td>
</tr>
<tr>
<td>Neighbourhood committee</td>
<td>1.8</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Paid caregiver</td>
<td>1.2</td>
<td>1.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Community service</td>
<td>0.6</td>
<td>0.2</td>
<td>–</td>
</tr>
<tr>
<td>Social Welfare facility</td>
<td>0.4</td>
<td>0.4</td>
<td>–</td>
</tr>
<tr>
<td>Volunteer</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
</tr>
</tbody>
</table>
Between 60% and 80% of the elderly have noncommunicable chronic diseases. In 1999, the five leading causes of death in semi-urban areas were malignant tumours, cerebrovascular diseases, heart troubles, respiratory diseases, and trauma and toxicosis.

Among these diseases, the first three account for 62.34% of all causes of death. The five leading causes of death in partial rural areas were respiratory diseases, malignant tumours, cerebrovascular diseases, heart troubles, and trauma and poisoning. The first three account for 58.84% of the total causes.

In 1998, a national household survey showed that the majority of the disabled are elderly (over 65 years old) and make up 60% of the total disabled population. In one survey in Wuhan, 10.7% of the elderly (about 97,000 individuals) were ill and dependent on others for daily living.

Tables 11 and 12 indicate the health care needs of the elderly. Table 13 shows financial loss to individuals due to disability and premature death (Keqin Rao, Li Yi & Yuan Liu, 2000).
### Table 11. Forecast of the GDP, ageing population, and disease prevalence

<table>
<thead>
<tr>
<th>Year</th>
<th>GDP (billion yuans)</th>
<th>60+ years (%)</th>
<th>Illness prevalence in preceding two weeks (%)</th>
<th>Chronic disease prevalence (%)</th>
<th>Prevalence of major diseases (in 10,000s)</th>
<th>Rate of increase (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Athletic diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chronic bronchitis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Circulation</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>18 54.5</td>
<td>8.52</td>
<td>140.82</td>
<td>114.72</td>
<td>3307</td>
<td>1.96</td>
</tr>
<tr>
<td>1995</td>
<td>57 49.5</td>
<td>9.39</td>
<td>143.10</td>
<td>122.51</td>
<td>3766</td>
<td>0.46</td>
</tr>
<tr>
<td>2000</td>
<td>90 16.0</td>
<td>10.20</td>
<td>147.25</td>
<td>132.32</td>
<td>4327</td>
<td>0.10</td>
</tr>
<tr>
<td>2005</td>
<td>12 943.6</td>
<td>10.91</td>
<td>151.15</td>
<td>142.20</td>
<td>4952</td>
<td>0.26</td>
</tr>
<tr>
<td>2010</td>
<td>18 582.2</td>
<td>12.34</td>
<td>156.00</td>
<td>154.45</td>
<td>5744</td>
<td>0.51</td>
</tr>
<tr>
<td>2015</td>
<td>26 677.1</td>
<td>14.89</td>
<td>161.36</td>
<td>166.78</td>
<td>6553</td>
<td>0.39</td>
</tr>
</tbody>
</table>

Note: The table includes forecasts for GDP, ageing population, and disease prevalence from 1990 to 2015, along with the rate of increase for each year.
### Table 12. Medical care needs (survey results in 1993 & 1998)

<table>
<thead>
<tr>
<th>Survey Items</th>
<th>1993</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness prevalence in preceding 2 weeks (%)</td>
<td>140.1/ I75.2/ 128.2</td>
<td>149.8/ 187.2/ 137.1</td>
</tr>
<tr>
<td>Chronic disease prevalence (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By individual</td>
<td>124.1/ 192.7/ 102.0</td>
<td>128.2/ 200.9/ 103.6</td>
</tr>
<tr>
<td>By case</td>
<td>155.0/ 270.0/ 116.0</td>
<td>157.5/ 273.3/ 118.4</td>
</tr>
<tr>
<td>Prevalence of disability (%)</td>
<td>–</td>
<td>33.9/</td>
</tr>
<tr>
<td>Prevalence of handicapped (%)</td>
<td>–</td>
<td>42.0/</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>31.1</td>
</tr>
</tbody>
</table>

### Table 13. Financial loss due to disability, handicap, and premature death (calculated according to 1993 prices)

<table>
<thead>
<tr>
<th>Annual financial loss due to disease (billion yuan)</th>
<th>1993</th>
<th>1998</th>
<th>Rate of increase (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick leave</td>
<td>561</td>
<td>756</td>
<td>34.75</td>
</tr>
<tr>
<td>Premature death</td>
<td>1206</td>
<td>1273</td>
<td>5.60</td>
</tr>
<tr>
<td>Disability</td>
<td>1060</td>
<td>1119</td>
<td>5.57</td>
</tr>
<tr>
<td>Total</td>
<td>2761</td>
<td>3148</td>
<td>14.00</td>
</tr>
<tr>
<td>% of GDP</td>
<td>8.0</td>
<td>8.2</td>
<td>–</td>
</tr>
</tbody>
</table>
LONG-TERM CARE

The need for LTC services outside the home is growing rapidly and health care facilities, specifically for long term care services, are limited. While such services as home beds, home visits, emergency calls, hotlines, BP calls, nursing homes, day care centres, elderly apartments, elderly houses, and rehabilitation hospitals exist, they are few in number.

One survey of nursing homes in Shanghai in 1997 and 1998 shows an occupancy rate of more than 100% (see Table 14) (Fei Yan, Yue Li & Youlong Gong, 2000). The greatest need for development are for day care centres, elderly apartments, elderly houses, and nursing homes.

Furthermore, there is a need for the development of urban community health care that will offer an alternative to the inappropriate use of tertiary hospitals providing preventive and primary care. Preventive services are more difficult to finance from user fees and therefore have declined. They are currently under pressure to raise their own revenues.

**Table 14. Nursing home occupancy in Shanghai**

<table>
<thead>
<tr>
<th>Index</th>
<th>1996</th>
<th>1997</th>
<th>Jan-June 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupancy (%)</strong></td>
<td>84.7</td>
<td>103.6</td>
<td>113.2</td>
</tr>
<tr>
<td><strong>Duration (days)</strong></td>
<td>108.5</td>
<td>110.5</td>
<td>22.7</td>
</tr>
<tr>
<td><strong>Bed turnover</strong></td>
<td>2.4</td>
<td>2.5</td>
<td>1.4</td>
</tr>
</tbody>
</table>

### 4.1.1 Major education and training needs for long-term care provision

In order to develop community health care for the elderly, doctors and nurses working in community health centres should be trained in general medicine, rehabilitation and community nursing respectively, focusing on elderly care. For medical students, general medicine, rehabilitation, and community care should be included in the core curriculum.
4.2 What resources (structures, manpower, organizations) at the national and local levels may be utilized to promote LTC provision?

The programme for medical home care (‘home beds’), which includes the provision of care by doctors and nurses in homes, is integrated into primary care and is covered by social insurance in some cities such as Shanghai. Elsewhere, payment is out-of-pocket. With governmental emphasis on these types of community-based health services, home care and community-based systems will hopefully continue to develop.

4.3 Developments in LTC

Long-term care has existed in China for a long time, but rapid development has occurred in recent years. The authors believe that long-term care in China will develop at a speed higher than at any other time in the next 10–20 years. By the year 2020, the long-term care system will become more adapted to meet society’s needs.

Overall reforms in health care in recent years have, in addition to benefitting the general public, also helped to improve the life of the elderly in China. Such reforms have followed three major trends:

- revival of community financing schemes in rural areas, to alleviate problems of financial access to care and to encourage primary care delivery in villages and townships;
- encouragement of private sector investments in health care; and
- efforts to contain the costs of health insurance coverage in the two major insurance programmes, Government Health Insurance Scheme (GHI) and the Labour Health Insurance (LHI) Scheme.

The first reform mentioned above targets the vast majority of people who reside in rural areas. The other two reforms are directed at the urban population that comprises the majority of health expenditures.
LONG-TERM CARE

Furthermore, the growing economy and reform of the economic system have laid a favourable economic foundation for the development of health and social welfare. In order to focus more attention on the health status and quality of life of senior citizens and keep pace with health care needs, the municipal government has been stepping up its support in areas of institutional structure, laws, and policies, financial investment, infrastructure construction, and technical services.

One important strategy in the effort to adapt to the health needs of the community, is to promote the delivery of high-quality health care through a community-based health services approach. In the past few years, the community health service — promoted as one of the priority projects — has made steady progress.

Community health service centres and community-based comprehensive health service posts have been set up to offer an integrated comprehensive health service and most importantly to guarantee the elderly access to basic health care. In the future, community-based facilities will be the main provider of long-term care services. With the reform of the health system, it is also expected that NGOs will play a more important role in health care and social services.

Meanwhile, in Shanghai the municipal government has placed the development of health and social care for senior citizens as a priority and has already implemented reforms that benefit the elderly. The medical insurance system covers retirees’ expenses for outpatient treatment, emergency services, inpatient care and home beds under the social security system. The system regulates that individuals pay a small percentage (15%) of the medical cost. For elderly persons, the percentage is cut in half.

To help patients with serious diseases to cover high medical expenses, various forms of supplementary medical security have emerged. For example, the General Labour Union offers supplemental insurance for employees and the elderly. Commercial medical insurance and social donations are also organized. Shanghai exemplifies the ageing and health care trends in China.

At present, however, the family continues to provide the majority of care for the elderly and disabled, and is the preferred choice among caregiving options when help is needed. Home care volunteers are not popular in China. Considering the importance of the traditional family in China and the presence of the ‘4–2–1’ family structure, there will be a painful transition from predominantly family care to community care for those needing long-term care. In recent years, central and local governments have become aware of this imminent transition.
As mentioned above, many efforts have been made to reinforce health care facilities based in communities. Physicians and managers in the health care field have also called for the development of community-based care to meet long-term care needs, particularly for the elderly.

However, long-term care services are underused because there is insufficient investment, a shortage of qualified general practitioners and community nurses, a lack of confidence in the quality of the community-based health care, and an inability by many to pay the cost of care. The Government will need to make a significant financial commitment to long-term care provision in order to offset the economic status and needs of the elderly and their families.

In considering the future development of long-term care, the following measures should be taken:

- **Establishment of a long-term care network**

  The central and local government should take a leading role in establishing a long-term care network. This network should combine central and local government efforts; social welfare services, community services and health care services; inpatient care, outpatient care, and home care; and all caregivers’ work.

- **Improvement of the security system for the elderly and the poor**

  Improvement of the basic retirement security programme and the minimum living expense assurance system will help the elderly and the poor to live in a better way and to have the financial capabilities to get basic long-term care if they need it.

  The social aid system should be built using the community as the base of the communities. Long-term care, including assisted living and medical care, should be mainly provided by community service centres and community health centres.
LONG-TERM CARE

- **Development of social and health facilities for long-term care**

  Social and health facilities for long-term care should be developed to meet future needs, in which nursing homes, home beds, home care, day care centres, elderly apartments, and elderly houses should be on top of the list. According to the development of the market economy, these social and health facilities for long-term care can be operated by private organizations, collective economy organizations, government organizations and others, but the Government gives some financial subsidies, licenses the facilities, and monitors the quality of care.

- **Education and training of community health workers and caregivers**

  According to the characteristics of long-term care, community health workers and caregivers should be reoriented through education and training programmes. Medical universities or colleges, medical associations, and community health centres can play active roles in transmitting the attitudes, knowledge and skills needed for long-term care. For medical students, education on long-term care should be more heavily emphasized, especially involving skills for rehabilitation.

- **Evaluation of long-term care services**

  Evaluation of long-term care services, including needs assessment, process evaluation, and outcome evaluation, should be made in order to make sure that long-term care services are provided in the right places, with the right contents, the right amounts, and the right qualities, and by the right caregivers. Evaluation can be made by persons from government, social and health care facilities, and by long-term care receivers.
References


LONG-TERM CARE


Shen Zhenxin, Whangzhenhua. *Comprehensive study on the staged policies to deal with the problems of the aging population in Shanghai.*


CASE-STUDY
COSTA RICA

Felicia Knaul
Gustavo Nigenda
Paola Zuñiga
1 General background data

1.1 Preamble

Although considered to be a lower-middle income country and ranked 69th in the world according to GDP per capita, Costa Rica was included in 1999 among the 35 countries with the highest Human Development Index. This situation could be explained by the existence of a Welfare State and the implementation of social programmes during the second half of the twentieth century.

The social reform initiated in 1942 created a public and centralized security system managed by the Caja Costarricense del Seguro Social (CCSS). The CCSS was responsible for the provision and financing of health care services. Even though the CCSS was created in the early 1940s, the universal and compulsory character of social insurance coverage was not established by law until the 1970s.

In this decade of the 1970s, and for the first time, a National Health Plan was implemented to redefine the functions of the CCSS and the Ministry of Health. The former was more oriented towards care, and the second to public health promotion and disease prevention. All hospitals were transferred to the control of CCSS.

The Costa Rican social security system has played a principal role in the country’s human development. Comparing the health performance of Costa Rica with that of other Latin American countries, this country has the highest life expectancy for males (73.8) and the second highest for females (78.6).

The rate of malnutrition for children under five years is the lowest in the region for boys, and the second lowest for girls. Infant mortality is the second lowest, after Cuba, and health access is only superior in the Bahamas and Barbados while maternal mortality is lower only in Barbados (WH0, 1999).
LONG-TERM CARE

If these indicators are compared with industrialized countries, Costa Rica is performing well in life expectancy, ranking 26th in male life expectancy – higher than the United States, Germany, and Finland, among others. If, however, other indicators – such as child and maternal mortality – are taken into account, Costa Rica is far below countries like Japan, Switzerland, and Canada, ranking 37th and 44th respectively for these indicators (WHO, 1999).

There are still many improvements to be made. However, the relative success of the health system was in part due to a higher social public expenditure. It was also a result of centralization of health services in the Ministry of Health, the CCSS, and many other public institutions and Ministries dealing with social care and programmes particularly designed to alleviate poverty.

The provision of long-term care for the disabled has become one of the principal challenges of modern society (Brodsky, Habib and Mizrahi, 2000). In Costa Rica, provision of LTC has been affected by the wide availability of family support, especially from women (and in particular daughters and daughters-in-law) who take on most of the caregiving responsibilities towards elderly relatives.

However, with an increasing percentage of women entering the labour force and a general change in the composition of the family structure, the capacity of the informal care system to maintain such a high caregiving burden is in doubt. This trend indicates a need for more formal care structures. Currently, however, caregiving is still generally considered a family responsibility.

In Costa Rica – as in many other countries – formal care of the disabled was presented until the mid-1990’s as part of a comprehensive health care system. This was especially reflected in the creation of specialized hospitals (such as the Geriatric and Gerontology National Hospital, two psychiatric hospitals, and the Rehabilitation Hospital) and through particular programmes for target groups, even though the main objectives of the health system were to extend coverage and improve health.

The experiences of industrialized countries and the relatively rapid growth of the elderly population as a result of improvements in their quality of life, are compelling policy-makers to consider a potential increase in the demand for long-term care over the next 25 years. Some efforts to provide increased LTC at the institutional level have been implemented, in particular through the reform of the health system and the law concerning integral care of the elderly.

This case-study will explore the needs for long-term care in Costa Rica. Further, it will provide a description of the systems currently providing health and social services in the country.
CASE-STUDY: COSTA RICA

From an economic point of view, Costa Rica is considered a low–middle income country (according to the World Bank) with a GDP per capita of US$6700. Its productive structure is dominated by the tertiary sector: in the year 2000, services represented 57%. The proportion of agriculture has slightly decreased. Due to the small size of the market and an open economy, imports and exports represent 94.2% of the GDP (World Bank).

Presented on the following four pages are background data concerning Costa Rica, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

1.2 Background data from international data bases

<table>
<thead>
<tr>
<th>Demography (year 2000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong> (thousands)</td>
</tr>
<tr>
<td><strong>Land area</strong> (sq km)</td>
</tr>
<tr>
<td><strong>Population density</strong> (per sq km)</td>
</tr>
<tr>
<td><strong>Population growth rate</strong> (% 2000–2005)</td>
</tr>
<tr>
<td><strong>Urban population</strong> (%)</td>
</tr>
<tr>
<td><strong>Ethnic groups</strong> (%)</td>
</tr>
<tr>
<td>White (including mistizo)</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Amerindian</td>
</tr>
<tr>
<td>Chinese</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

**Religions (%)**

<table>
<thead>
<tr>
<th>Religion</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roman Catholic</td>
<td>76.3</td>
</tr>
<tr>
<td>Evangelical</td>
<td>13.7</td>
</tr>
<tr>
<td>Other Protestant</td>
<td>0.7</td>
</tr>
<tr>
<td>Jehovah’s Witnesses</td>
<td>1.3</td>
</tr>
<tr>
<td>Other</td>
<td>4.8</td>
</tr>
<tr>
<td>None</td>
<td>3.2</td>
</tr>
</tbody>
</table>

**Total adult literacy rate (%) in 1997** 96

**Age structure (%)**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>32.4</td>
</tr>
<tr>
<td>15–24</td>
<td>19.2</td>
</tr>
<tr>
<td>60+</td>
<td>7.5</td>
</tr>
<tr>
<td>65+</td>
<td>5.1</td>
</tr>
<tr>
<td>80+</td>
<td>0.8</td>
</tr>
</tbody>
</table>

**Projections 65+ (%)**

<table>
<thead>
<tr>
<th>Year</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>10.0</td>
</tr>
<tr>
<td>2050</td>
<td>16.7</td>
</tr>
</tbody>
</table>

**Sex ratio** (males per female)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>1.02</td>
</tr>
<tr>
<td>15–64</td>
<td>1.02</td>
</tr>
<tr>
<td>65+</td>
<td>0.87</td>
</tr>
</tbody>
</table>

**Dependency ratio:**

- Elderly dependency ratio in 2000\(^2\) 9.7
- Elderly dependency ratio in 2025 17.3
- Parent support ratio in 2000\(^3\) 8.7
- Parent support ratio in 2025 11.7

**Vital statistics and epidemiology**

**Crude birth rate** (per 1000 population) (2000) 21.9

**Crude death rate** (per 1000 population) (2000) 4.0

---

\(^2\) Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

\(^3\) Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.
**CASE-STUDY: COSTA RICA**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality under age 5</strong> (per 1000 births) (2001)</td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>13</td>
</tr>
<tr>
<td>Females</td>
<td>10</td>
</tr>
<tr>
<td><strong>Probability of dying between 15–59</strong> (per 1000) (2001)</td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>134</td>
</tr>
<tr>
<td>Females</td>
<td>78</td>
</tr>
<tr>
<td><strong>Maternal mortality rate</strong> (per 100 000 live births) (1995)</td>
<td>35</td>
</tr>
<tr>
<td><strong>Total fertility rate</strong> (children born/woman) (2001)</td>
<td>2.7</td>
</tr>
</tbody>
</table>
| **Estimated number of adults** 
  living with HIV/AIDS (2001) | 11 000           |
| **HIV/AIDS adult prevalence rate**           | 0.6                |
| **Estimated number of children** 
  living with HIV/AIDS (2001) | 320               |
| **Estimated number of deaths** 
  due to AIDS (2001) | 890               |
| **Life expectancy at birth** (years) (2001) |                    |
| Total population                            | 76.1               |
| Male                                        | 73.8               |
| Female                                      | 78.6               |
| **Life expectancy at age 60** (2000)         |                    |
| Total population                            | 21.0               |
| Male                                        | 20.0               |
| Female                                      | 22.0               |
| **Healthy life expectancy (HALE) at birth** (years) (2001) |                |
| Total population                            | 65.3               |
| Male                                        | 64.2               |
| Female                                      | 66.4               |
| **Healthy life expectancy (HALE) at age 60** (2001) |                |
| Total population                            | 14.1               |
| Male                                        | 12.9               |
| Female                                      | 15.3               |
Economic data (year 2000)

GDP – composition by sector (%)
- Agriculture: 13%
- Industry: 31%
- Services: 57%

Gross national income (GNI) ($PPP)4 30 billion

GNI – per capita ($PPP) 7980

GNI – per capita (US$) 3810

GDP growth (annual %) (1999–2000) 1.7

Labour force participation (%):
- Male: 54.5%
- Female: 25.2%

Health expenditure (year 2000)

% of GDP 6.4

Health expenditure per capita ($PPP) 411

Health expenditure per capita (US$) 273

4 PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries
2 General health and social system

2.1 Basic income maintenance programmes

The contributory retirement system is financed by employers (47.5%), by employees (25.0%) and by the State (0.25%). Until the mid-nineties, this system constituted the biggest pension regime in the country. Currently, it is the only one in existence, but it is complemented with compulsory savings. The non-contributive retirement system is financed by the State and 20% by the Fondo de Desarrollo Social y Asignaciones Familiares (FODESAF). The FODESAF is financed through a 5% tax on income and a 3% sales tax.

Even though coverage by the pension system is one of the highest in Latin America, only 36% of those aged over 60 years have a pension from the contributive regime, and about 35% of the population receive a pension from the non-contributive one. This means that about 30% of the population over 60 are not covered.

Only 55% of the economically-active population are covered by any of the pension schemes, and the possibility of savings is currently highly reduced. This fact could affect the sustainability of the system; however, a reform has been introduced in order to address these problems.

The retirement system includes a pension that is equivalent to 60% of the salary when the person has contributed the equivalent of 30 years of work (before the reform, the pension represented 100% of the salary). A pension for the disabled is provided if the individual has contributed at least 36 quotas (around three years) and she/he has lost two-thirds of working capacity.

A subsidy from the State is provided for poor people. Even if they have not contributed to the Social Security Fund, they are entitled to receive a minimum income. The goal is for every poor elderly person to have a minimum level of support. Approximately 80% of the population receive the benefit. This reform was under a law for the protection of workers.

2.2 Organizational structure of decision-making

The Costa Rican Central Government is composed of the Executive, Legislative, and Judicial branches. The Executive branch deals with social programmes, and includes the Ministry of Health, the Ministry of Labour and Social Security, the Ministry of Education, the Ministry of Agriculture, and the Office of National Planning.
LONG-TERM CARE

These programmes have a steering role in their respective fields, and they coordinate programmes between them. For example, as part of its programme the Ministry of Education provides meals in primary and secondary schools and transportation subsidies for poor people. The Ministry of Labour operates micro-enterprise programmes, temporary employment programmes, and programmes for those facing retirement.

In addition to the Central Government, the public sector is composed of public institutions such as the State Banks, The National Insurance Institute (INS) and The National Institute of Urbanism and Housing. The National Institute of Urban Affairs and Housing provides credit and conditions for housing.

There are other public institutions under various Ministries, which participate in social programmes and focus on target groups. These include INCIENSA, which has a mandate to alleviate severe malnutrition, especially among children under six years of age. The Childhood National Society (PANI) is a programme for homeless children. The Social Assistance Institute (IMAS) has a programme for family micro-enterprises, a popular housing programme, a programme for supporting small producers, and also provides subsidies for poor people.

The Bank ‘Hipotecario’ of Housing (BANHVI) provides family housing bonuses for homeless people. The Institute of Agrarian Development (IDA) awards credits for agriculture, and training for small producers. The Institute of National Learning (INA) organizes workshops, particularly for training unskilled workers. All these institutions participate in the promotion of social programmes.

The Ministry of Health, the Ministry of National Planning and Economic Policy, the Costa Rican Institute of Water and Sewage Systems, the National Insurance Institute (which provides life insurance, risk employment insurance and accident insurance, among other schemes), and the CCSS comprise what is commonly referred to as ‘the health sector’ (PAHO, 1998). The Ministry of Health supervises and evaluates health services, and is in charge of epidemiological surveillance. The CCSS is responsible for financing, insurance, and care provision through hospitals and medical centres.

2.2.1 Ministry of Health

According to the Pan American Health Organization (PAHO):

the Costa Rican Ministry of Health is a part of the Executive Branch and has a steering role. It is in charge of supervising and evaluating health service delivery. (PAHO, 1999)
However, as mentioned previously, information on financing, insurance, and the delivery of services is handled by the CCSS. This agency has an information system that is exclusively devoted to epidemiological surveillance.

Before the reform of the system in 1994–98, all health centres, health posts, mobile medical and dental units, dental school clinics, comprehensive health care centres, school lunch rooms, and comprehensive child health and nutrition centres were provided by the Ministry of Health (MOH).

Since 1995, these services have been progressively integrated into the CCSS. Other services that were transferred to the CCSS involve reproductive health and preventive oral health services provided to schoolchildren and pregnant women.

The Ministry of Health has two Institutes. The Institute for Alcoholism and Pharmacotherapy (IAFA) deals with research, treatment, and rehabilitation in those areas; and the Costa Rican National Institute of Research in Nutrition and Health (INCIENSA) coordinates programmes to alleviate severe malnutrition.

The Ministry of Health is in charge of planning and coordination policies with respect to human resources, and is responsible for accreditation. The Board of Rectors (CONARE) approves the curricula of professional programmes and establishes minimum requirements.

A public fund has been created within the CCS, and is managed by the National Centre for Strategic Development and Research in Health Services and Social Security (CENDEISS). The Fund develops programmes for training technical assistants in primary care, and also provides technical assistants for the CCSS Basic Comprehensive Health Care Teams (EBAIS) and postgraduate programmes, in coordination with the University of Costa Rica (UCR).

2.2.2 Public sector institutions

The CCSS, the National Institute of Life Insurance (INS), and the Cost Rican Aqueducts and Sewage Institute (Icaaa) are autonomous entities. The Government must approve the budget of each institution.

However, their revenue comes from normal operations. For example, an important share of the revenue of the CCSS comes from contributions to the insurance scheme (health and pensions).
LONG-TERM CARE

2.2.3.1 The Social Security Fund

The CCSS is responsible for the provision and promotion of public health services. Since 1998, it has purchased health care services through the Management Commitment, a contract signed between hospitals and the CCSS about the quantity and quality of services that hospitals will supply every year, and where 10% of the budget is subject to satisfactory performance.

2.2.4 Privatization and modernization

The highly-concentrated provision and financing of health care and the monopoly of insurance by the State constitutes a barrier to private providers, and strongly discourages their participation. As a result, the system has grown and become relatively inefficient.

During the 1980s crisis, some programmes were reorganized to incorporate the private sector into the provision of health care, especially at the ambulatory level. One innovation was 'mixed medicine', where the patient paid for medical consultation (out-of-pocket) and CCSS covered drugs and support services. Another was called 'enterprise medicine', where the strategy was for the enterprise to hire a doctor to provide health care to workers.

These measures were intended to reduce pressure on the demand for medical consultations in public institutions. Various models of care were implemented. These included the Integral Centre of Coronado, a programme of family medicine which is based on a model of community assistance and includes home assistance, home visits, and the integration of functions within the CCSS Basic Comprehensive Health Care Teams (EBAIS). The latter specializes in primary care.

Major changes began in 1992, when the Legislative Assembly passed laws 7374 and 7441. These became effective only in June 1994. The reform had various components, but among the most important was that concerning the provision and financing of services. As PAHO remarks:

> Throughout the current decade the prevailing model of health services has been a medical model to meet demand, where hospital care is predominating having few opportunities for community-based work. The emerging model seeks a more integrated approach that anticipates demand, with more community-based work. (PAHO, 1998)
2.3 Financing of services

The provision and financing of the health system in Costa Rica is primarily public. About 25% of the total health expenditure is private and paid out-of-pocket. Private insurance has not been successfully implemented. Public health expenditures are mainly financed by the CCSS, which spends 65% of the total health expenditure and 89% of public health expenditures.

Taxes in Costa Rica are levied at the national level, although only about 10% of total health care expenditure is financed through such means. A 2% sales tax, dedicated to financing the non-contributive regime of the CCSS for poor people, and a 5% income tax are also levied.

The CCSS has two insurance schemes: one contributory, the other non-contributory. The first includes insurance for the independent and self-employed through sickness and maternity insurance, pension insurance (retirement, disability and life insurance), and a voluntary insurance programme for those who are not employees. The non-contributory scheme was specially designed for poor populations. However, most people are covered by maternity and sickness insurance.

Most of the health system is publicly financed through a payroll tax. The health insurance scheme for dependent employees is financed through contributions by the State (0.25% of the total wages of workers); by the employer (9.25% of workers’ wages); and by the employee (5.5% of his or her wages). The self-employed contribute 12.75%.

Health and voluntary insurance gives ‘free access’ to the health care services provided by the CSSS. The insurance covers all economically dependent members of the family. The insured has the right to use health services, and many receive some monetary benefits and subsidies when economic conditions are bad.

The social insurance card gives no access to private health care. To use those services, a fee for service must be paid and there is no mechanism for reimbursement. However, there are systems of mixed medicine where medical care is received privately but the physician works for the CCSS. In this case, the patient pays the fee but is referred to CCSS hospitals for laboratory tests and drugs.

Health care benefits include ‘integral care’, i.e. prevention and health promotion, specialized hospital care, medical exams, and social assistance. (Access to drugs, dental services and medical supplies depends upon availability within the system.) Monetary benefits include subsidies to buy eyeglasses, and maternity leave equivalent to 50% of salary during four months. Social assistance covers transportation/lodging costs for those who cannot afford them.
Table 1. Costa Rica health expenditures

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total expenditure on health/GDP</strong></td>
<td>8.4%</td>
<td>10.5%</td>
<td>8.9%</td>
<td>8.9%</td>
</tr>
<tr>
<td><strong>Public expenditure on health/GDP</strong></td>
<td>6.8%</td>
<td>8.5%</td>
<td>6.9%</td>
<td>7.0%</td>
</tr>
<tr>
<td><strong>Private expenditure on health/GDP</strong></td>
<td>1.6%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Private insurance on health/GDP</strong></td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>External resources on health/THE</strong></td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Social security funded HE/THE</strong></td>
<td>66.7%</td>
<td>71.3%</td>
<td>66.2%</td>
<td>67.5%</td>
</tr>
<tr>
<td><strong>Private expenditure on health/THE</strong></td>
<td>19.1%</td>
<td>19.1%</td>
<td>22.6%</td>
<td>21.1%</td>
</tr>
<tr>
<td><strong>Out-of-pocket on health/THE</strong></td>
<td>19.1%</td>
<td>18.5%</td>
<td>21.9%</td>
<td>20.4%</td>
</tr>
<tr>
<td><strong>Private insurance on health/THE</strong></td>
<td>0.0%</td>
<td>0.6%</td>
<td>0.7%</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total personnel compensation/THE</strong></td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Public personnel compensation/PHE</strong></td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>External resources on health/PHE</strong></td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>THE per capita at X-rate (US$)</strong></td>
<td>157</td>
<td>266</td>
<td>245</td>
<td>255</td>
</tr>
<tr>
<td><strong>PHE per capita at X-rate (US$)</strong></td>
<td>127</td>
<td>215</td>
<td>189</td>
<td>201</td>
</tr>
<tr>
<td><strong>Private HE per capita at X-rate (US$)</strong></td>
<td>30</td>
<td>51</td>
<td>55</td>
<td>54</td>
</tr>
<tr>
<td><strong>OOPS per capita at X-rate (US$)</strong></td>
<td>30</td>
<td>49</td>
<td>54</td>
<td>52</td>
</tr>
<tr>
<td><strong>Private ins. per capita/X-rate (US$)</strong></td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>THE per capita at PPP-rate (US$)</strong></td>
<td>374</td>
<td>571</td>
<td>499</td>
<td>555</td>
</tr>
<tr>
<td><strong>PHE per capita at PPP-rate (US$)</strong></td>
<td>302</td>
<td>462</td>
<td>386</td>
<td>438</td>
</tr>
<tr>
<td><strong>Private HE per capita at PPP-rate (US$)</strong></td>
<td>71</td>
<td>109</td>
<td>113</td>
<td>117</td>
</tr>
<tr>
<td><strong>OOPS per capita at PPP-rate (US$)</strong></td>
<td>71</td>
<td>106</td>
<td>109</td>
<td>113</td>
</tr>
<tr>
<td><strong>Private ins. per capita / PPP (US$)</strong></td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: NHA-WHO.
CASE-STUDY: COSTA RICA

The budgets of hospitals and clinics are set by the CCSS. Before 1998, budgets were set on a global basis based on historical expenditures. Since 1998, part of the budget is linked to the performance of the unit. The only exemption is the Barva Clinic, which has a capitation system.

Long-term care services supplied by hospitals are included in their budget and are mainly financed by the social insurance system. However, some long-term care programmes are financed from external funds raised by foundations. Home care for poor elderly people is financed through general taxation (the tax on alcoholic beverages and cigarettes) and donors.

The last survey of income and expenditures was conducted in 1987. According to that survey, approximately 28.7% of out-pocket-private expenditures were devoted to medical and pharmaceutical products, 11.6% for medical equipment, 50.9% for medical services and diagnosis, and 8.7% for hospitalization.

According to the last Household Survey that included a health utilization module (1998), approximately 20% of the population who use health services have private medical consultations, but only about 2% are hospitalized in private institutions. According to PAHO, about 50% of drugs were supplied by the CCSS. Units (hospitals) are authorized to make cash purchases.

2.3.1 Governmental and/or NGOs health and social programmes

Social programmes

Housing, social assistance, education, and nutrition were among the programmes offered by the State. They were focused on population groups: children, the poor, and the elderly. Historically, about 20% of the GDP was devoted to public social programmes. In 1970, 47% of the social Government expenditure was allocated to health and 12.4% to social assistance. This composition changed radically in 1995, when 39.5% was provided to health and 27.8% to social assistance (World Bank, 1995).

In 1994, the Costa Rican public sector managed 31 different programmes to assist priority groups, representing 12% of social expenditure. Programmes were financed by the Fondo de Desarrollo Social y Asignaciones Familiares (FODESAF), or by other designated institutions. Those programmes were coordinated by 11 public institutions.
The main institutions which are involved in social programmes and responsible for welfare policy are the Caja Costarricense del Seguro Social (CCSS), the Instituto Mixto de Ayuda Social (IMAS), IFAM (Institute for Municipal Advisory Development), the National Institute of Life Insurance (INS), the Board of Social Protection (JPS), the Costa Rican Institute of Electricity and Telecommunications (ICE), the National Institute of Housing and Urbanism (INVU), the Costa Rican Institute of Water and Sewage Systems, and the public financial institutions.

### Social programmes and health

FODESAF finances some preventive programmes, such as the community and rural health programme. This programme divides the country into areas, with 3000 centres extending coverage to almost the entire population. Programmes are focused on various target populations, and have implemented epidemiological controls, health education, family planning, and vaccination programmes, and focalized attention, especially through CEN-CINAI centres that provide meals and milk to children and care to pregnant women.

In order to reduce malnutrition, the Ministry of Education provides food through schools to children between 6 and 12 years of age. About 54–68% of the population under the age of ten is provided food by the State (Mesalago, 1992).

### 2.4 Services delivery system

Health services are divided into three levels of care (PAHO, 1998). Primary care is provided by 103 small clinics and the EBAIS. They provide neither hospitalization nor specialist medicine. This primary care service covers 69% of the total population and more than 90% of the rural population. The secondary level is provided by seven regional hospitals, 13 peripheral hospitals and 38 clinics (type 3 and 4). Tertiary level care is provided by national and regional hospitals.

There are also three national general hospitals (San Juan de Dios, Dr Calderon Guardia, Mexico) and six specialist hospitals (Raul Blanco Cervantes: National Geriatric Hospital; two Psychiatric Hospitals: Chapuit and Chacon Paut; the Women’s National Hospital; the Children’s National Hospital; and the National Hospital for Rehabilitation).

---

5 Clinics type 1 and 2 offer ambulatory care, and the latter has pharmacy and laboratory services.

6 Clinics type 3 and 4 offer general and specialized medicine, and type 4 the four basic specializations and sub-specializations.
CASE-STUDY: COSTA RICA

As a first point of contact, people must attend the assigned clinic according to place of residence. There is a referral system from EBAIS, and from clinics to regional and national hospitals. At the end of the 1990s, the third level was spending half of health expenditures, leaving around 20% for the first level and 30% for the second level (PAHO, 1998).

Those aged 60 years and older are the main users of the health system. On average, 15% of ambulatory care is provided to this group, and in the three national hospitals this ratio is over 20%. The average length of stay is higher among people 65+ for all hospitals, and the main providers of long-term hospitalization are the two psychiatric hospitals, the Geriatric Hospital, the Rehabilitation Hospital, and the National Hospital San Juan de Dios. However, the average length of stay is higher in national general hospitals than in regional hospitals.

On the supply side, 14% of medical consultations are conducted in the national hospitals which cover the metropolitan area. The Geriatric Hospital handles only 0.28% of medical consultations and the psychiatric hospitals 0.27%. In relation to the share of beds, 58.82% are in the national hospitals – only 2.37% are in the geriatric hospital and 4.88% are for psychiatric patients. The three national general hospitals have an occupancy rate of about 90%. These data offer an idea of the importance of specialist and national hospitals in the supply of general and long-term care.

Psychiatric care is provided in all national and regional hospitals and Type 4 clinics, and in some peripheral hospitals. However, the main institution is the National Psychiatric Hospital with 800 beds – 600 for chronically ill patients – and the Chacon Paut Hospital especially for those who are non-chronically ill.

2.4.1 Auspices of health service providers

The CCSS is a monopolist supplier of health services. Services are supplied through a wide network of health care centres and hospitals, particularly at the tertiary level. The private sector has gained importance as a primary care provider. About 20% of the population receives private medical consultation.

From the point of view of demand of health professionals, the CCSS is also very important. In 1995, about 75% of physicians were hired by the CCSS. As a means of promoting private participation, the CCSS allows its employees to work part-time to facilitate the possibility of setting up their own medical clinic. Employees are paid a salary and are hired according to civil service regulations.
2.5 Human resources and training

- Role of the universities in medicine

From its inception, the CCSS has promoted the training of physicians abroad, especially through scholarships. When the Faculty of Medicine of the University of Costa Rica was established in the 1960s, the CCSS promoted the practice of those students in hospitals. In the last few years, four private universities have begun to teach medicine, and have also signed agreements with the CCSS allowing them to practise medicine within its system.

Since the Faculty of Medicine at the University was created, there has been cooperation between the University and the Social Security System. In 1974, they signed an agreement extending the use of its clinics for teaching and research postgraduate programmes to 34 clinical specialties.

The National Centre of Strategic Development and Information on Social Health and Social Security (CENDEISS) was created to provide coordination. In 1988, CENDEISS became the Centre for Development Strategy and Information on Health and Social Security. It administers all training programmes of the CCSS and the training of human resources. Among other programmes, it offers training for technical assistants in primary care (EBAIS).

All programmes of medicine include the first two years in basic sciences, plus three more years of courses and rotation internships. The number of years varies according to the university. Once the internship has been completed, the graduate must complete one year of social service in a hospital or a clinic before receiving a diploma. For the training of specialists in the field, there is a school of psychology and a graduate programme in psychiatry. A graduate programme in gerontology and geriatrics and a masters’ programme in gerontology at the State University is also offered.

The ratio of physicians to population has increased in the last nine years from 97.1 to 163 per 100 000. This ratio is lower than in countries such as France (303) Sweden (311), or Switzerland (323), but similar to the United Kingdom (164). It is also important to note that previously almost all physicians were hired by the CCSS – but that the percentage has declined from 85% in 1990 to 51% in 1999.
**Regulation**

To work as a physician, it is mandatory to be affiliated with the Physicians and Surgeons College. A further requirement is the completion of a diploma at one of the universities recognized by CONARE (Board of Rectors, which approves the curricula of professional career programmes in coordination with the Ministry of Health).

**Hiring**

In the public sector, the Budget Authority is in charge of establishing new posts, although the CCSS has its own recruitment policy. All public sector contracts are under the authority of the Civil Service, where payment is according to years of experience in the institution, on a salary basis.

However, according to the law of medical incentives, an increase in salary must be based upon the judgement of the Budget Authority as to what is fair compared with general public sector salaries. On average, the salaries of the CCSS personnel are approximately 20–40% higher than those in the public sector.

**Nursing**

Nursing is taught at the University of Costa Rica and, more recently, at three private universities. The duration of the nursing programme is approximately four years, plus eight more quarters for a bachelor’s degree and 11 more for a licenciate (considered equivalent to a Master’s degree). Studies include practice in hospitals and in the community.

The ratio of nurses to population was 109 per 100,000 in 1997. This share is very low as compared with countries such as the United States (972) or even the United Kingdom (164), but similar to Mexico (86.5). This situation reflects a severe nursing shortage. The primary employer of nurses is the CCSS (employing nearly half of Costa Rica’s nurses). In 2001, there were 5251 nurses affiliated to the Nursing Association.
National Centre of Strategic Development and Information on Social Health and Social Security (CENDEISS)

The Centre was opened in 1972. Its objective is the training of personnel, based upon new methodologies and evaluation. Another primary aim of the Centre is to promote social and biomedical research.

The University of Costa Rica and CENDEISS offer more than fifty postgraduate programmes or specialities with very high requirements.

Table 2. Health professionals per 100 000 population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>97.1</td>
<td>98.4</td>
<td>99.0</td>
<td>99.0</td>
<td>103.8</td>
<td>107.5</td>
<td>141.2</td>
<td>147.2</td>
<td>156.1</td>
<td>163.3</td>
</tr>
<tr>
<td>Dentists</td>
<td>36.6</td>
<td>37.0</td>
<td>68.0</td>
<td>37.7</td>
<td>37.2</td>
<td>37.3</td>
<td>37.1</td>
<td>37.5</td>
<td>36.9</td>
<td>39.2</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>32.1</td>
<td>32.0</td>
<td>33.8</td>
<td>32.8</td>
<td>33.0</td>
<td>33.4</td>
<td>33.8</td>
<td>33.6</td>
<td>34.5</td>
<td>36.9</td>
</tr>
<tr>
<td>Microbiologists</td>
<td>26.0</td>
<td>26.0</td>
<td>25.8</td>
<td>25.8</td>
<td>25.8</td>
<td>26.1</td>
<td>26.4</td>
<td>26.7</td>
<td>27.1</td>
<td>28.3</td>
</tr>
<tr>
<td>Nurses</td>
<td>45.0</td>
<td>46.9</td>
<td>49.9</td>
<td>48.7</td>
<td>49.1</td>
<td>49.2</td>
<td>50.0</td>
<td>48.5</td>
<td>30.2</td>
<td>30.6</td>
</tr>
</tbody>
</table>

Source: Authors’ calculations based on social indicators from Mideplan (Ministry of National Planning and Political Economy) (www.mideplan.go.cr)
3 LTC Provision

3.1 Provision and services related to LTC

3.1.1 Private institutions: nursing homes for the elderly poor, homes for the elderly, and day care centres

In Costa Rica, the care of the elderly is still considered a family responsibility, contrary to the situation in the United States and other industrialized countries. Until recently, nursing home services have not been considered an important alternative for the care of older people. Rather, housing and care institutions are available for poor older people, although financing of the services provided is not included in the benefits of the social security insurance as in the USA. These houses are privately managed, and some of them receive State support as long as they meet certain minimum requirements.

There are three kinds of private care institutions (Lizano, 2000): nursing homes for the elderly, shelters for the elderly, and day care centres. The difference between the first two is the degree of independence. To be accepted in these institutions (Laake & Morales, 1996), a person must:

- be 65 or older;
- be indigent;
- be without familial resources or family to take care of them;
- live in the community;
- not be disabled; and
- not have any communicable disease.

The nursing homes for the elderly poor offer the following services: shelter, medical and paramedical services, nursing, laundry service, nutrition, spiritual support, social workers' services, rehabilitation services, cultural and entertainment activities, a proper infrastructure, and trained personnel. In sheltered housing, only meals and social activities are provided.
LONG-TERM CARE

The day care centres complement the needs of daily life for people with economic problems or at social risk (loneliness, abuse, or nutritional problems). These centres do not provide health care.

3.1.2 Caregivers

According to Laake and Morales (1996), the majority of the managers of these centres are women between 31 and 60 years of age. However, these women are also required to fill other roles besides that of manager (e.g. teacher, secretary). Most of them have training in health or social care. There is an average of four staff for each patient.

The institutions are mainly located in the metropolitan area. They serve 4513 persons, less than 2% of the elderly population.

Another important participant in care for the elderly is the National Gerontology Association. The Association organizes activities and informational materials for elderly people. In addition, the Association Pro Geriatric and Gerontology National Hospital (APRONAGE) obtains resources – particularly through the donation of medical equipment. The National Crusade for the Protection of the Elderly (FECRUNAPA) is particularly helpful in providing training for the elderly at home.

3.1.3 Institutional participation in care for the elderly

An important characteristic of the welfare state is responsibility for the delivery of social services. Social support is important to the welfare of disabled persons. An earlier study (Ramirez, 1991) showed that social security institutions offered some assistance in the metropolitan area.

Coverage of social support services provided by the CCSS in 1991 included:

- services for people of 60+ years (personal services, such as home assistance and training of relatives);
- ‘Third Age’ clinics;
- retirement orientation courses; and
- guidance to social and community services.
3.1.4 Specialist hospitals: The Geriatric and Gerontology National Hospital

The hospital was transformed into a health centre specializing in gerontology in 1978. It offers assistance services such as medical consultation, day care centre, community care, and hospitalization.

Medical consultation includes the support of laboratory and pharmacy services. The hospital provides the following services: geriatric, internal medicine, cardiology, dentistry, special attention (pain, diabetes, high blood pressure, etc.).

The day care centre provides geriatric and nursing services, physical therapy, and psychological support. The patient is in the hospital during the day (8–16h) and returns to his/her home or to the hospitalization programme at night. In 1988, the programme had 30 patients. In 2001, the programme served 70–80 patients.

The programme of community care services provides integral care to elderly people who cannot travel to the hospital. The team is composed of a geriatrician and nurses and, as necessary, staff from the department of social work, as well as the pharmacy, and laboratory services.

3.1.4.1 Day hospital

One innovative programme is the day hospital which was started in 1973. Initially, it provided care to tuberculosis patients. It later became a service for patients at high risk – those over 60 years of age who suffer from aggression, depression, and functional disorders, and who need social support.

An interdisciplinary team is composed of a nurse, a nurse’s assistant, a part-time social worker, a psychologist, a physical therapist, an occupational therapist, a geriatrician, and a person in charge of therapeutic work who runs the occupational workshops. Four volunteers and a bus for transportation of the patients are also included in the team.

To participate in the day care hospital, candidates should be aged 60 or older, and be considered by a specialist (geriatrist) as a patient at risk. The patient is referred to the Hospital Blanco Cervantes. His or her situation is analysed by a hospital geriatrist, and finally by the geriatrist in charge of the day hospital.

Each day the programme cares for 20–25 patients. Ten to fifteen patients are hospitalized with an average length of stay of two to three months. Usually patients attend twice a week and most of them (80%) are referred by doctors from the same hospital. The most common illnesses among patients are high blood pressure and diabetes. Approximately 85% of the patients present with depression.
LONG-TERM CARE

The programme includes a medical check-up service from 8 to 8.30 in the morning. If the patient presents any problems, he/she is referred to a geriatrist. From 9.30 to 11.30, personal care therapy and physiotherapy are provided. When assisted by volunteers, patients do handicraft and cognitive exercises. A lunch break follows. From 12.30 to 13.30, there is group therapy, such as physical exercises and educational programmes, including topics such as the prevention of falls, diet, ageing, self-confidence, and depression. The programme ends with coffee. Every two months, an excursion is organized.

The board of the day care hospital meets every eight days in order to analyse the situation of patients and caregivers and consider possible discharges from the hospital. Relatives receive training for the provision of care. If there is any problem with a patient, the family is called in to seek a solution. When the family is not present, or the patient is not at the hospital, the social worker visits them at home.

The amount of hospital day care available does not meet the demand. Services are provided in a small hall, although there is a plan for the construction of a new one. The bus is not appropriate for transporting disabled people. There is a shortage of resources to improve the service and to provide individualized care. An additional problem lies in the fact that dementia is not treated because of scarce resources.

The hospital is financed through the budget of the CCSS. It also receives donations through a fund-raising programme (a telethon) promoted by the Office of the First Lady. In 2001, this fund-raising activity was carried out for the second time.

3.1.4.2 Home assistance

Services are provided to support rehabilitation and are composed of a mobile unit with a doctor, a nurse and a social worker, who give training to the family. This service is organized primarily by social workers. Some specific programmes for home care will be discussed below.

3.1.5 Community care services: home medical visits and hospitalization at home

This programme, which began in 1996, is provided for those aged 60 or older. The objective of the programme is to provide care at home for those patients who cannot attend the medical centre. Initially, patients included those with problems of readmission, or who were receiving poor care.
Currently, care is provided to all patients referred from the Hospitalization and Ambulatory Care Unit of the hospital and other medical centres in the metropolitan area (the capital and neighbouring cities). To receive this type of care, the person must have a disability that precludes his/her attendance at the medical centre. The caregiver must follow the course of basic care for the elderly (once a week for four weeks).

The basic team is composed of a doctor, a geriatrician, and a nurse. In addition, the team has the support of social workers; the pharmacy, laboratory, respiratory therapy, and dental services of the hospital; and two well-equipped vehicles for conducting approximately ten visits per day.

The programme covers approximately 550 patients in the metropolitan area. Of these, about 70% are women. Of that population, one group is visited once a month because patients need a feeding tube or are oxygen dependent; the other group is visited once every two months. Depending on the patient’s situation, he/she is followed through a telephone diary system.

During the first medical visit, a medical evaluation of the patient is conducted, and instructions given to the caregiver and family. In addition to medical services, the programme includes a service of telephone advice to the patient or relatives, as well as programmes for borrowing medical equipment, delivering drugs, and taking samples for tests. However, it does not include emergency services.

3.1.6 Calderon Guardia Hospital: hospitalization at home

The Calderon Guardia Hospital covers a population of 650,000 directly, and another 700,000 indirectly. Together, this includes approximately one third of the total population.

The programme began in 1987 and was intended for patients 60 years or older, with disabilities, familial problems, or health problems that result in long periods of hospitalization.

The basic team is comprised of a doctor, a social worker, a nurse and a volunteer, and is coordinated by a geriatrician. Services include medical consultation, delivery of drugs, laboratory examinations, nursing care, and home visits by the social worker.

The objective of the programme is to facilitate the acceptance in their home and community of a patient with psychic limitations or terminal illness.
LONG-TERM CARE

The role of the social worker was very important in the development of the programme, especially concerning support and guidance to the patient and family, types of training, and special topics connected to the care of the elderly.

3.1.7 National Centre for Rehabilitation

The National Rehabilitation Hospital (CENARE) provides care targeted to patients with medullar lesions (traumatic or congenital), tumours, infections, cranial traumas, cerebral paralysis, degenerative illness such as progressive muscular dystrophy, neuropathies, polio effects and post-polio syndrome. All of these patients require continuous medical attention.

The programme also includes patients who need therapy, especially those with problems of the skeletal muscular system. Medical attention is provided each year to approximately 50 000 patients with medullar lesions.

In addition, programmes are conducted such as ‘The Back School’ for patients, caregivers, and relatives. This three-day course is for groups of fifteen persons. During the course, participants receive theoretical training concerning the anatomy of the back, its care, and related exercises. A workshop for GPs on handling lumbar pain was begun five years ago. It convenes three times per year for 18 hours during two days.

The hospital operates a number of specialist neurological, neurosurgical and orthopaedic clinics. All of these clinics have socio-educative groups and provide services to the community.

Training for patients, relatives, and caregivers is also provide. Its purpose is to assure that patients, particularly those with brain paralysis, can follow the exercises and therapy at home.

3.1.8 Reform of mental health care

Historically, mental health problems were treated at the third level of care, and therefore no emphasis was placed upon prevention. Provision of mental health care presents some weaknesses – such as lack of resources and deficient coordination at the intersectoral, community, and interinstitutional levels. Lack of information about the demand for these services, programmes for hospitalization at home (visits at home) and psychotherapy, also presents problems.

For these reasons, a project is currently being implemented with the purpose of reforming the model of mental health care. The goal is to improve the quality of life of the patient and to integrate him/her into the community.
At the end of 2001, specific goals included:

- the provision of at least 25 units of mental health and psychiatric care;
- an inventory of personnel working in the field;
- an understanding of the epidemiological impact of problems encountered; and
- the initial stages of reform of the Psychiatric Hospital.

The Department of Mental Health of the CCSS is in charge of institutional policy and implementation of the project. The project should be completed in three years.

The concept involves each hospital and each clinic having a multidisciplinary team; decentralization of care to other residential options (with only 40% of cases treated by CCSS hospitals); and an increase in the number of beds and the number of emergencies treated in the other hospitals. A budget is to be set for human resources training, and the participation of EBAIS in the promotion of mental health is to be increased.

3.1.9 National Centre for Pain Control and Palliative Care

The National Centre for Pain Control and Palliative Care was created in July 1999 by an Executive Law. It assigned the Centre a steering role over the various entities providing palliative care in the country.

In 1990, the Committee of Palliative Care was created in the Max Peralta Hospital, which was transformed in 1993 into the Walk Together Association (Caminemos Juntos). This was the first formal group to provide care to terminal patients with cancer and AIDS.

In 1990, the first Unit of Palliative Care for children in Latin America was created in the National Children’s Hospital. One year later, a pain clinic was established at the Calderón Guardia Hospital (National Hospital), to provide support in pain management to terminal patients and to those who suffered from chronic benign pain. During the past decade, other clinics have been created in different hospitals throughout the country.
LONG-TERM CARE

The Centre’s first duty was to elaborate plans for the provision of services and drugs. Next, it was responsible for developing the organization of the clinics, and a training plan. The National Centre for Pain Control and Palliative Care team is comprised of nine specialists (physicians), three psychologists, a nutritionist, a physical therapist, four nurses, and two assistants.

Coverage is national, especially through the services of home visits. Its services comprise three specialties:

- oncology palliative care;
- non-oncology palliative care; and
- chronic benign pain care.

The first two specialties offer external consultation, home visits, and hospitalization; the last is provided only through external consultation.

The home services team is comprised of a psychiatrist, a physician (internist), a physician specializing in pain, and two psychologists. The first two specialties have a base group formed by a specialist, a nurse, and a support team of nutritionists, a respiratory specialist, a physical therapist, and a psychologist.

Home visits for oncology purposes cover the Metropolitan Area. Non-oncology visits are extended to rural areas. The total number of patients who were provided with home services between October 2000 and October 2001 was 1301. The main reasons for providing these services involved prostate gland cancer (784 cases); breast cancer (131); and stomach cancer (116). Patients were visited from one to three times per month by a nurse and a specialist. These staff also provided medical consultations to 7912 patients, and psychological consultation to 2353 patients.

In December 2001, 14 pain clinics existed in the country. There are two located in the capital, six located in the provinces and the rest are distributed in the cantons which have the highest population concentrations. Personnel who work in different areas of the country receive training (a month of internship with classes) at the Centre.
3.1.10  Golden Citizen Programme

The Golden Citizen Programme was implemented by the CCSS in July 1997. The programme covers all persons of aged 65 years or older. Golden Citizen was created with the objective of improving the physical, mental, and social conditions of the elderly through special treatment in all administrative and medical units of the CCSS and public institutions. One of its goals is to promote discounts in stores, public shows, workshops, seminars, and participation in activities. Special treatment in health care includes ambulatory care, pharmaceutical, laboratory and administrative services, and hospitalization. Currently 75 medical centres are committed to the programme.

By means of Executive Policy 26991, all public institutions are responsible for giving special treatment to the elderly. The CCSS has agreements with 34 institutions, including banks, postal services, electricity providers, ministries, and municipalities. The CCSS participates in the organization of physical training courses, taught by a professional twice per week. In 1999, 52 groups involving 1700 persons were organized. In addition, 16 cultural workshops were conducted, involving especially handicrafts. The CCSS also arranges discounts in museums, national parks, hotels, travel agencies, and the like. In 2000, approximately 84% of elderly people had a Golden Citizen Card, which permitted them to enjoy all of these benefits.

3.1.11  Other programmes for care for the elderly and disabled

- **Training for relatives**

  At least half of the health centres that answered a survey reported that they provided training on care to the relatives of the elderly. These programmes are especially prevalent in the West Pacific Region and the Metropolitan Area.

- **‘Third-age’ clinics**

  These are ambulatory care services, focusing on elderly people, which provide appointments and drugs.

- **Community services**

  These are mainly offered through the provision of medical assistance and training to the home centres.
LONG-TERM CARE

3.2 NGO’s involved in the organization of LTC services

3.2.1 NGO’s involved in the financing and provision of care for the disabled elderly

3.2.1.1 Office of the First Lady and APRONAGE

The Office of the First Lady is active in raising funds through special events. One special activity consisted of a sixteen-hour live concert by national and international artists. The objective was for businesses and individuals to make donations. The goal was to raise around US$2.2 million.

3.2.2.2 Costa Rican Gerontology Association

The Costa Rican Gerontology Association was created in 1980. The objective of the Association is to promote programmes that improve the quality of life of people aged 60 years and older. Its work focuses on education and the prevention of illness among older people, their families, and the community. Although the latter pay for some of the Association’s activities, the amount is not significant.

The Association’s main office is in San Jose, and its staff is composed of a technical team of four social workers, a public relations representative, an anthropologist, an executive director, and administrative staff. The Association maintains inter-institutional relations with the National Chain of Associations, the Permanent Forum of Abuse against the Elderly, Help Age International, the Inter-American Association of Gerontology, and the Latin-American Gerontology Commission. It is financed partly from private donors, and partly from airport exit taxes which are charged when leaving the country – these funds are then transferred to the Gerontology Association. The Association has implemented numerous programmes during the past 20 years, including:

- **Community clubs**

  Groups of no more than 25 persons are located throughout the territory, and receive technical support from the nearest health centre, the Preventive Medicine Department at the CCSS and AGECO.

- **Specialized clubs**

  Largely in the metropolitan area, these clubs organize various activities such as walking, music, handicrafts, theatre, cooking, singing, chess, and others.
CASE-STUDY: COSTA RICA

- **Physical activity clubs**

  These clubs meet twice a week, and offer yoga, gymnastics, and other courses. Each participant pays US$5–7 for each course.

- **Volunteers**

  People 50 years or older serve as volunteers in libraries, homes for poor elderly, in the Centre for National Rehabilitation, and in the Hospital Blanco Cervantes. Volunteers are provided with training and must work at least four hours per week, but may choose the location of service. The volunteer programme was begun in 1991, and 85% of the volunteers are female, and approximately 75% serve in the San José area.

- **Recreational activities**

  Trips, camping, walks, and meetings are organized, and expenses are covered by the participants.

- **Institutional training**

  This is provided especially for caregivers in homes for the elderly.

- **Loan of medical equipment to the disabled elderly**

  Equipment includes wheelchairs, beds and walking aids. The only requirement is a medical statement that the person requires the equipment. They have use of the equipment for a monthly payment of approximately US$3.

- **Ongoing training**

  The AGECO offers courses of three to six months’ duration, on subjects such as managing stress, self-confidence, training for relatives on caregiving, pensioners’ concerns, nutrition, health, physical activities, internet, and Tai Chi.
LONG-TERM CARE

- Providing information to the media

Each Monday, a space in one of the main newspapers, entitled “Golden Age” promotes these activities. Every two months, a bulletin is published.

- Orientation for new pensioners

This orientation has been provided since 1986 for the public and for institutions. Groups of 20–25 persons meet for 4–12 sessions, addressing topics such as nutrition, pensioners’ benefits, physical health care, etc.

3.2.2 NGOs’ involved in work for disabled young adults and children

The Office of the First Lady, in coordination with the foundation “A World of Opportunities”, and the National Hospital of Rehabilitation, have promoted activities, such as the provision of wheelchairs, in order to allow disabled people to lead productive lives.

The Museum of Senses with interactive displays where art works can be exhibited art works was another addition. A temporary hall for this purpose was opened in 1999.

“The Journey without Barriers” was organized in order to promote the law Equity of Disabled Persons, particularly in rural areas. Also planned is the creation of a centre to provide training and information to relatives of disabled people.

The construction of a new building in the National Centre of Special Education for children with visual and hearing impairments is part of a bigger project. Its departments for visual, audio and language deficiencies and mental problems, are funded through a donation from Proctor and Gamble.

The Foundation Pro-Unit of Palliative Care in Costa Rica was created in 1992 with the objective of supporting the Unit of Palliative Care in the Childrens’ Hospital, created in 1990. The clinic provides care for children with life-threatening illness (estimated at life expectancy of six months or less), and has already cared for eight hundred children.
CASE-STUDY: COSTA RICA

The team is composed of a doctor, a psychologist, and two nurses. Services include medical visits in the home, drugs that are not included in the basic list of the CCSS, and the loan of medical equipment.

The Foundation also trains parents in caring for the child and provides some education about cancer, pain, and dying. Psychological support is provided to parents and relatives, and a group of volunteers has been established for this purpose. The Foundation seeks to implement the first Latin-American shelter for pediatric palliative care, and has created an Education Centre for Palliative Care. The main resources are volunteers, donations by private enterprises, and proceeds from activities. Other specific projects include:

- **Pro-National Childrens’ Hospital Foundation**

  The objective of this organization is to improve the functioning and financing of the National Hospital for Children through the participation of public institutions and enterprises. Funds come from donors and a special television programme.

- **The National Centre for Prevention of Disability**

  The Foundation is currently providing support for the construction of a five-story building with laboratories for the diagnosis of genetic illness. Construction began at the end of 2001. The cost of the project will be approximately US$4.5 million. Tax-deductible resources are sought. The CCSS has committed to the operational costs, including human resources, once the centre is built.

- **National Centre of Medical Specialities of the National Hospital for Children**

  Five years ago, the authorities realized that the infrastructure of the National Hospital for Children was not sufficient, and organized a telethon to raise funds for its improvement. Now the National Centre of Medical Specialities has been constructed with the following services: psychiatry, psychology, adolescent clinics, paediatrics, endocrinology services and laboratory, haematology, oncology, immunology, neurology, cardiology and a unit for teaching and conferences. The cost of the project is US$4.5 million, and the funds are managed by the Foundation.
LONG-TERM CARE

3.3 Caregiving

One of the main problems of long-term care services involves the rapid growth of the elderly population. This places enormous pressures upon the demand for care services, while women’s participation in the labour force reduces the supply of informal caregivers. Usually, most informal caregivers are women.

According to a UN assessment, women’s participation in the labour force in Costa Rica has not significantly increased. The household survey data for Costa Rica shows that there has been only a slight increase: in 1983 the labour force was composed of 75% males and 25% females; in 1998 these shares were around 68% and 32%, respectively. In 1983, the share of employed men was 72%, and that of employed women was 27%. In 1998 the share of employed women increased to 33%, and the rate of employment was 32.7%. However, the share of employed men remained at about 72%.

This increase in women’s participation in the labour force seems to be the result of improvements in the public sector employment policy. While in 1994 only 39% of employees were women, in 1998 the share was 48%. The participation of women in the private sector and the share of women that were owners of small enterprises remained almost unchanged. There has been a slight increase in self-employment. The State is the third source of employment after the private sector and self-employment. At the household level, 25% of the heads of household were women.

In 1998, 94.8% of households included a female. This percentage was the same in 1994. The share of households with women between 12 and 60 years of age was 85% in 1998 and 87.7% in 1994. From that sample, it is possible to conclude that 62.4% (68.4% in 1994) of households were composed of at least one woman who is voluntarily or involuntarily unemployed.

Only 8% (7% in 1994) of households are composed of an older person and a woman who does not work outside the home. This means that 32% of the households with elders include a woman who works outside the household, and this ratio increases when the age range is reduced.

In 1998, 62.27% of the households had children aged between 6 and 17 years and 40.49% had children under six years old. In that year, 76.68% of households with children between 6 and 17 years included a woman not working outside the household. It seems that caregiving is associated more with the care of children. It is important to note that elderly people play an important role in the care of children in the family.
3.3.1 Training for informal caregivers

The National Geriatric and Gerontology Hospital offers courses for caregivers. The programme has been operational for more than ten years, and has been developed by social workers with the participation of nurses and psychologists. Courses are offered in particular to relatives and other caregivers of hospital patients. The course is taught each semester, twice per week in the afternoon, and enrolment is free.

In 2001, groups were comprised of approximately twenty persons, of whom an average of fifteen were women, especially housewives. The course has a social perspective, and covers topics such as family relations, ageing, family crises, the psychosocial processes of ageing, and the responsibilities of caregivers.

3.3.2 Formal caregiving

The specialized Geriatric Hospital gives training to midwives, assistant nurses, and nurses. Each year, the training is evaluated by means of a survey of the hospital personnel. As a result of the survey, conferences, seminars and workshops are organized. Personnel receive training in pathologies of elderly people, concepts of gerontology, nutrition, equipment utilization, and leadership.

3.4 Laws and legal information related to care for the disabled and elderly

3.4.1 Changes in legislation

In recent years, long-term care programmes have been developed more under the auspices of welfare institutions than that of the health services. These institutions have focused on programmes to care for the elderly, with special support from the First Lady’s Office, which strongly promoted the Integral Law for the Elderly, approved in November 1999.

The laws approved and the programmes implemented have been oriented towards the enhancement of family participation in the care of the elderly, the introduction of changes in the social perception of the elderly, and the creation of mechanisms that permit the coordination, support, and surveillance of the institutions that provide care to the elderly. Financing of the programmes is through special funds and taxes, and is separate from the health and social insurance budget.
LONG-TERM CARE

The ‘Integral Law for Elderly People’ defines the principal rights and benefits of the elderly, as related to labour conditions, housing, and well-being. It also defines the duties of the State and the Ministry of Health, and creates the National Council of the Elderly (Consejo Nacional de la Persona Adulta Mayor).

3.4.2 Integral Law for the Elderly

All the beneficiaries of the law are elderly (sixty five years or older), with a CCSS card, identity card or passport.

3.4.2.1 Programmes for incorporating the elderly into the community

The Law promotes the improvement of the quality of life of the elderly through the implementation of educational programmes and cultural activities. The programme guarantees access to a shelter or a substitute house when the person is considered at risk, or has problems in access to credit. It also promotes prompt attention in hospitals and preferential treatment in administrative offices, and facilitates pensions that help to satisfy basic needs, even when the person has not contributed. It also includes social assistance in case of disability or loss of means of subsistence.

3.4.2.2 Responsibilities of care institutions

The Law also regulates private home care in relation to the rights of the elderly. For example, older persons must not be isolated, except for therapeutic reasons recommended by a professional. They are permitted to manage their own finances, and are informed about health status, treatments, and the services of the facility. They have right to privacy during visits of their spouse, and the right of free circulation within the facility.

3.4.2.3 Responsibilities of the State

The principal institutional reform is the creation of geriatric services in all national and regional hospitals, and clinics Type 3 and 4, with the technical support of the National Geriatric and Gerontology Hospital.

The State is also responsible for integral health care, and for promoting integration in the family through training programmes for family caregivers. Institutions offering public services are responsible for giving preferential treatment to elderly people, having the infrastructure to give these issues proper attention.
CASE-STUDY: COSTA RICA

The CCSS is responsible for obtaining discounts for public transportation, public and private cultural and entertainment activities, hotels and tourism centres, and for private medical services.

3.4.2.4 National Council of the Elderly

The Council’s main objective is to encourage the family and the community to:

- participate in the development of the elderly;
- protect the rights of the elderly; and
- be responsible for their economic well-being.

The main functions of the Council are the formulation of policies to coordinate and assess the performance of the programmes, and the distribution of resources for their financing.

The Council is directed by a Board composed of the President or his representative, the Health, Public Education, Labour and Social Security Ministers, the Presidents of the Board of Social Protection (another public institution that finances social programmes), JPS, the President of the Social Assistance Institute (IMAS), Social Security Insurance, a representative of the National University, the Costa Rican Gerontology Association, the association of pensioners and the National Crusade for the Protection of the Elderly. In 2000, the President of the Board was the First Lady, acting as the President’s representative.

3.4.3 Law No.7972: Tax on alcoholic beverages and tobacco

Another important source of finance for programmes to improve the quality of life of the elderly was the implementation of Law No. 7972. This Law includes a tax of five cents per cigarette, and 10% sales tax on cigarettes and tobacco. Under the law, considerable amounts of funding from the proceeds are devoted to the Council of the Elderly and nursing homes for the poor, and to financing the non-contributive pension system.
3.4.4 Law No. 5662: Social Development and Family Allocation

This legislation finances three programmes:

- attention to the elderly poor;
- “Ageing with Quality”, encourages an active life and offers educational programmes; and
- the “institutional attention” programme that provides financial support to home care for the elderly.

Just recently begun, these programmes are not universal. For example, one part of the programme “Age with Quality” is the “Intergenerational Bridge”. This programme consists of inviting elderly people to schools to talk and share their experiences with students, in order to change their perspective of the elderly in society.

It also includes visits by groups of students, particularly from the metropolitan area, to nursing homes for the elderly poor, to share opinions with them in order to sensitize children to their needs and living conditions.

3.4.5 Law No. 7938: Protection to the Worker

The non-contributive pension scheme was created in 1974. According to the CCSS, 35% of the elderly have a non-contributive pension. By law, FODESAF finances 20% of the non-contributive scheme and another part is to be financed through the Law that imposes taxes on cigarettes.

As part of the Government plan, the President proposes to increase the monthly pension from Colones 8500 to 10 000, and to universalize pension coverage. According to the CCSS, 42 000 persons – of a total of 54 000 elderly people living below the poverty line – are assigned pensions. Coverage is nearly 80%.
4 General questions pertinent to LTC development

4.1 Present and future needs for long-term care and gaps between needs and provision of services

Although Costa Rica has the highest life expectancy in Latin America for males, and is one of the top thirty best performing countries in terms of life expectancy for females, this position changes when the concept of HALE – healthy life expectancy – is introduced. In this case, life expectancy is reduced to 65.3, and Costa Rica’s ranking in Latin America drops considerably.

Costa Rica has a relatively young population structure, as compared with industrialized countries, with approximately 7.3% of the population over 60 years of age. The high level of life expectancy and the decrease in the fertility rate, have caused the population structure to experience considerable changes.

In only ten years (1990–2000) the proportion of the population over 60 years of age increased from 6.4% to 7.3% (World Health Report, 2000). It is expected that for the year 2025 this group will represent 15% of the population (Claire, 2000). This situation will result in an increase in health costs, even though the health care reforms were to reinforce community services.

Other factors, also related to age, that may explain the potential increase in demand for long-term care services are changing morbidity and mortality patterns. The mortality rate was reduced in the last 25 years by almost half, as a result of improvements in health, health coverage, and living conditions.

In 1987, the leading causes of medical consultation were respiratory (17.8%), skin (9.3%), musculoskeletal (8.3%) and cardiovascular diseases (8.1%). However, for the population over age 60, the morbidity pattern is different. For this group, the main causes of medical consultation in 1997 were cardiovascular diseases (21.5%), endocrine disorders (14.7%), and musculoskeletal diseases (10.9%).

Endocrine disorders have increased in importance and cardiovascular diseases have decreased in the last ten years. The main causes of hospitalization are maternal conditions (32.6%) and digestive diseases (9.0%) for the population as a whole, and cardiovascular diseases (20.9%) for the elderly.
LONG-TERM CARE

The mortality pattern has changed significantly, and the rate of mortality from infectious diseases has been reduced in the last 25 years. In the 1970s there was a slight difference between the pattern of mortality of the total population and that of the elderly. Infectious diseases (97.8) and perinatal conditions (77.5) were important causes of mortality for the entire population, but for the elderly the main causes were malignant neoplasm (864.2) and cardiovascular problems (1796).

At the end of the 1990s, there was a convergence in mortality patterns. Cardiovascular and malignant neoplasm became the main leading causes for the entire population, and the mortality rate was reduced.

According to the CCSS, in the year 2000 the main causes of sickness among the elderly were, among other causes, hypertension, diabetes mellitus, and acute lower respiratory infections. The latter is one of the main causes of ischaemic cardiopathy. All these problems are related to nutrition, alcohol, and stress.

Another group requiring long-term care services comprises the mentally ill. Mental diseases represented 3% of the causes of hospitalization in 1987. By 1997, however, the percentage was reduced to 2%. In 1997, just 1% of emergencies and 4% of ambulatory care were related to mental illness. These problems are slightly greater for older people.

According to the household survey conducted in 1994, which included a sample of 2000 people aged 60 and older, only 4.39% of those who responded reported the need for help to carry out daily activities, 22.7% reported falling, but a very small proportion reported broken bones.

Of the principal diseases, approximately 13% of this age group reported suffering from diabetes, 33% from high blood pressure, and 20% from depression, with 100% of them taking drugs against those diseases. In this group, 65.2% used eyeglasses, 1.62% used hearing aids, and only 1.15% used wheelchairs. However, women tended to report suffering more than men from diseases, especially diabetes (8% of males and 16% of females) and high blood pressure (27% of males and 41% of females).

---

4 All mortality rates are by 100 000 population.
**Table 5. Percentage of elders needing help and medical equipment for daily activities, 1994**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of elderly needing help for daily activities</td>
<td>–</td>
<td>3.6</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Medical appliances</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>65.3</td>
<td>62.2</td>
<td>68.5</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>1.6</td>
<td>0.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Walking cane (baston)</td>
<td>6.1</td>
<td>6.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Walking aid (andadera)</td>
<td>0.5</td>
<td>0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Special shoes</td>
<td>0.4</td>
<td>0.7</td>
<td>0.2</td>
</tr>
<tr>
<td>Wheelchair</td>
<td>1.2</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Falls</strong></td>
<td>22.3</td>
<td>19.0</td>
<td>24.8</td>
</tr>
<tr>
<td><strong>Fractures</strong></td>
<td>–</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Medicines</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>12.8</td>
<td>8.6</td>
<td>16.9</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>33.4</td>
<td>26.6</td>
<td>40.7</td>
</tr>
<tr>
<td>Broken bones</td>
<td>36.5</td>
<td>34.1</td>
<td>39.5</td>
</tr>
<tr>
<td>Depression</td>
<td>20.0</td>
<td>14.4</td>
<td>22.0</td>
</tr>
</tbody>
</table>

*Source: Authors’ calculations from the Costa Rican household survey of 1994.*
LONG-TERM CARE

It seems that the demand for long-term care in Costa Rica is mainly determined by the care needs of the elderly. Although mental diseases are an important source of need for long-term care, the pattern has not changed over time. Diseases such as Parkinson, Alzheimer, and other dementias are considered age-related problems.

On the supply side, two main factors have reduced the provision of care for the elderly. First, the composition of families has changed – formerly parents stayed with their children, currently older people tend to live alone. Second, women have slightly increased their participation in the labour market, leaving less time to care for the elderly people in their families.

4.2 Developments that will impact on LTC

The reform of the health system is oriented towards community services and integrated care to patients. The main idea is the separation of financing and service delivery functions of the three levels of care.

Historically, the health system has been financed by a general budget, but the 1997 reform implemented Management Commitments – initially in some hospitals and health centres, and universally in 2000. These are agreements with anticipated objectives signed by the financing–purchasing entity and the health services provider.

Under this programme, a fixed percentage of the budget is established according to the performance of the unit. Accordingly, each medical unit and the CCSS are committed to achieve certain targets. The CCSS will then purchase various services from the hospital, according to the contract signed with them.

At the hospital level, under the Management Commitments 2000, the concept of the ‘day hospital’ was introduced. This concept has three components:

- daily care;
- home assistance; and
- ‘substitute transitory houses’.

Daily care is offered to ambulatory patients with mental problems, and to elderly persons and their families. Services include assistance, preventive, educational, and therapy services. The ‘substitute houses’ are temporary shelters for rehabilitation of patients with mental problems.
At the first level, the reform was implemented through EBAIS. It provided a programme of basic comprehensive care, which includes at least comprehensive care for children (0–9 years), adolescents (10–19 years), women, adults (20–59 years), and the elderly.

These ‘packages’ are universally applied. Their purpose is the prevention of diseases and the provision of health education for the entire primary care level. At the first level of care, the health team is responsible for:

- individual case finding and case management;
- detection and oversight of risk groups;
- health care; and
- rehabilitation.

### 4.3 Concluding thoughts

Costa Rica is a country with extensive health service coverage, mainly through public provision and financing. Progressively, a greater amount of coverage and financing has been transferred to the CCSS, contrary to the recent worldwide trend of privatizing health services.

Health policy is established at the national level by the Ministry of Health and the CCSS, giving the appearance of a very centralized system. However, one expression of the decentralization policy is the creation of regional offices of the Ministry and regional hospitals that belong to the CCSS.

In the latter case, each hospital receives a budget set by the CCSS but has autonomy in its allocation. Sometimes, this can create an incentive for the inefficient allocation of resources. Management Commitment agreements try to avoid these problems by setting standards through a contract drawn up between the provider of services and the CCSS as the purchaser.

Public health care in Costa Rica is mainly provided and financed by the CCSS. Most health expenditures are financed through social insurance collected at the national level as a tax on revenue. Indirect taxes used for financing health care programmes represent a small share of the health budget and are collected at the national level.
LONG-TERM CARE

This situation is made possible because Costa Rica is a small country with a relatively small population. Most of that population is concentrated in the metropolitan area.

Licensing of professionals and service providers is also established at the national level. In the case of professionals, university curricula are set by the CONARE (Board of Rectors).

The main providers of health care are the CCSS hospitals. Private providers are regulated by the Ministry of Health. Social insurance contributions are established by the Government each year according to the needs of the CCSS; and the drug list available under the Social Security Card is set by the CCSS. The CCSS is the main body responsible for the provision of health services.

However, there are some public institutions that have developed social programmes. Duplication and overlap are widespread, since inter-institutional coordination is weak and there exists no mechanism for resolving cross-jurisdictional issues.

Moreover, the wide dispersion of social programmes complicates allocations, as well as the effectiveness of alternative programmes. Health system reforms, and the according of more power to the CCSS, were attempts to solve these problems.

The provision of long-term health care services is still viewed as an improvement in the quality of health. There is no comprehensive understanding of long-term care services, except the belief that it is necessary to improve the quality of health for vulnerable groups.

At the institutional level, the CCSS, with its departments for mental health, the disabled, and the elderly, has tried to improve the quality of those services. However, it seems that there is no general long-term care plan (especially with regard to financing). Funding for programmes are raised in two ways:

- privately – especially for initial investment purposes through charitable activities managed through foundations; and
- publicly – once the programme is operational, expenses are covered by the normal budget of the institutions and the CCSS.
CASE-STUDY: COSTA RICA

There is no special insurance policy created for the purpose of supporting these new programmes, except for the Law concerning taxes on alcoholic beverages and cigarettes.

From the point of view of provision, NGOs participate in the organization of activities for improving the quality of life.

Finally, there is not much information about informal caregivers, and few incentives for them. However, it can be stated that caregiving is still considered a responsibility of the family.
References


CASE-STUDY: COSTA RICA


IICE (1985) *Costa Rica: los programas estatales de carácter social y su impacto en la distribución del ingreso familiar.* San José, IICE.


LONG-TERM CARE

Miranda G (1994) *La seguridad social y el Desarrollo en Costa Rica.* 2nd ed. EDNASS/CCSS.

OECD. *Long term care services to older people: a perspective on future needs.* Paper on social, labour market and care giving dimensions: http://www.oecd.org

http://www.paho.org


http://www.paho.org/english/sha/prflcor.html

Oficina de la Primera Dama: http://primeradama.racsa.co.cr/


Ramírez Martínez M de los Angeles (1991) *El apoyo social: gerontología aspectos generales.* San José, EDNASSS/CCSS.

Sojo A (1994) *Hacia nuevas reglas del juego: Los compromises de Gestión en salud de Costa Rica desde una perspectiva comparativa.* En serie Políticas Sociales No. 27. CEPAL, Naciones Unidas


48
CASE-STUDY: COSTA RICA

Wong R (2000) *Transferencias intrafamiliares e intergeneracionales en Mexico*


Ley No. 7972. *Creación de Cargas tributarias sobre Licores, Cervezas, Cigarrillos para financiar un plan integral de protección y amparo de la población adulta mayor.*

Ley No. 7936. *Reforma al Artículo 33 de la Ley Reguladora de Transporte Remunerado de personas en vehículos automotores.*


Interview with Dr Nuria Alvarado, Director of the Institutional (enlace). CCSS.

Interview with Dr Lilliam Gonzalez, National Centre of Rehabilitation (CENARE).

Interview with Sara Badilla, Nurse in charge of the programme of caregiving training at the Blanco Cervantes Hospital

Interview to Dr Vilma García. Geriatry of the Community Care Unit at the Hospital Blanco Cervantes.
LONG-TERM CARE

Interview with Dr Yalile Munoz, geriatrician at the Hospital Day Care Centre, Hospital Blanco Cervantes.

Interview with Dr Isaías Salas Herrera, Director of the National Centre for Pain Control and Palliative Care

Interview with Marielos Arce, psychologist at the Shelter Saint Gabriel
1 General background data

1.1 Preamble

Indonesia is one of the largest archipelagos in the world. It consists of 17,508 islands – of which about 6,000 are inhabited. The five main islands are Sumatra (473,606 sq km), Java/Madura (132,107 sq km), Kalimantan (539,460 sq km), Sulawesi (189,216 sq km), and Irian (421,981 sq km).

The country is divided into 27 provinces, 336 districts/municipalities, 4,904 sub districts and 68,988 villages. There are 300 ethnic groups (tribes), five major religions, 583 local languages, and one national language – ‘Bahasa Indonesia’.

Approximately 64% of the population lives on the island of Java, where density is nearly 700 persons per sq km. In 2000, about 41% of the population lived in urban areas. Economic growth has led to rapid urbanization. In 1980, 22% of the population was living in urban areas.

With a national history that consists of hundreds of years of Buddhist and Hindu cultural influx, 350 years under Portuguese, Dutch, British and Japanese occupation, the average Indonesian today has a very rich yet complex cultural heritage. The years under European occupation, however, produced a community with limited education and little expectation from life, as well as a paternalistic culture.

Although there is a common national language, given the overall number of languages, tribes, and religions, there is, of course, great diversity in the customs and belief systems of Indonesians. During the last few years of reformation, in which freedoms have been introduced, it is apparent that the effects of long-term disintegration in the country have been significant. These factors may significantly influence the development of long-term care services in the future.
Sociopolitics are also a factor to be weighed in future policy development. The development of the sociopolitical system of Indonesia over the last years can be described as follows:

- **Pre-1966**: multi-party system, parliamentary and presidential systems.
- **1998–2001**: multi-party system, presidential system and decentralization.

The current political system is considerably more egalitarian and has promoted more freedom and equality. It has also enabled a move towards decentralization, granting more authority to the district governments. This shift has influenced, and will continue to affect, health service provision throughout the country.

In order to improve health care provision in Indonesia, the Ministry of Health established a Special Task Force on Health Development Reform in July 1998 to examine the ongoing economic crisis and reform issues and to subsequently recommend necessary reform policies and strategies. This Special Task Force recommended that the reform of the health sector must address the issues of equity, quality and efficiency.

Furthermore, it is of vital importance that steps be taken to ensure that services reach the poor as quickly as possible. In selected areas, the full implementation of health cards for the poor has already been proposed. Based on the recommendation of the Task Force, the Ministry of Health has instituted a new and more progressive policy for health development – the Healthy Paradigm.

In March 1999, the President signed a declaration proclaiming the start of the new development policy, a Health-Oriented National Development Approach envisioned as ‘Healthy Indonesia 2010’.
The main goal of this vision is not only to deal with current weaknesses, but also to look ahead to future challenges. This policy focuses more on health promotion and disease prevention rather than on curative services.

The new goals of the National Health Development Programme are:

- to initiate health-oriented national development;
- to maintain and enhance the health of individuals, families and the community, along with their respective environments;
- to maintain and enhance quality, equitable and affordable health services; and
- to promote public self-reliance in achieving good health.

In order to achieve these aims, the following will serve as the foundation for formulating a strategy for National Health Development:

- the Healthy Paradigm, emphasizing health promotion;
- professionalism;
- the Community Managed Health Care Programme (‘JKPM’); and
- decentralization.

The main focus of the new approach and the key to health sector reform is decentralization. The Government is putting a tremendous amount of energy into such efforts, which can be seen in all aspects of the programme, including the budget.
LONG-TERM CARE

This decentralized model involves the following areas:

- integrated health planning and budgeting;
- capacity-building at the district level;
- block grants for district health services;
- stronger community involvement in health services; and
- an increased role of provincial and district governments in health programmes.

Second, the new approach will emphasize disease prevention and health promotion. Third, an effective human resources development programme, that can support decentralization, will be given a high priority. And finally, access to quality basic health services will be strengthened through the ‘JPKM’ managed care approach.

The main objective of this case study is to provide insight into the development of long-term care policies in Indonesia by learning from what already exists in the country and identifying bases for further development that build on the existing health and social infrastructure in Indonesia. The methods used for this case study are as follows: secondary data, literature and policy review, consultation, case studies, and field observation.

Presented on the following four pages are background data on Indonesia, derived from international data bases. These data involve demography, vital statistics and epidemiology, economic data, and health expenditure.

---

1 For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); US Bureau of the Census, International Data Base; WHO, World Health Report 2001; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.
### Demography (year 2000)

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands)</td>
<td>212,092</td>
</tr>
<tr>
<td>Land area (sq km)</td>
<td>1,826,440</td>
</tr>
<tr>
<td>Population density (per sq km)</td>
<td>111</td>
</tr>
<tr>
<td>Population growth rate (%)</td>
<td>1</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>41</td>
</tr>
<tr>
<td>Ethnic groups (%)</td>
<td></td>
</tr>
<tr>
<td>Javanese</td>
<td>45</td>
</tr>
<tr>
<td>Sundanese</td>
<td>14</td>
</tr>
<tr>
<td>Madurese</td>
<td>7.5</td>
</tr>
<tr>
<td>Coastal Malays</td>
<td>7.5</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
</tr>
<tr>
<td>Religions (%)</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>88</td>
</tr>
<tr>
<td>Others</td>
<td>12</td>
</tr>
<tr>
<td>Total adult literacy rate (%)</td>
<td>86</td>
</tr>
<tr>
<td>Age Structure (%)</td>
<td></td>
</tr>
<tr>
<td>0–14</td>
<td>30.8</td>
</tr>
<tr>
<td>15–24</td>
<td>19.9</td>
</tr>
<tr>
<td>60+</td>
<td>7.6</td>
</tr>
<tr>
<td>65+</td>
<td>4.8</td>
</tr>
<tr>
<td>80+</td>
<td>0.5</td>
</tr>
<tr>
<td>Projections 65+ (%)</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>8.4</td>
</tr>
<tr>
<td>2050</td>
<td>16.4</td>
</tr>
<tr>
<td>Sex ratio (males per female)</td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>1.00</td>
</tr>
<tr>
<td>15–64</td>
<td>1.00</td>
</tr>
<tr>
<td>65+</td>
<td>0.78</td>
</tr>
<tr>
<td>Dependency Ratio:</td>
<td></td>
</tr>
<tr>
<td>Elderly dependency ratio in 2000</td>
<td>8.9</td>
</tr>
<tr>
<td>Elderly dependency ratio in 2025</td>
<td>13.7</td>
</tr>
<tr>
<td>Parent support ratio in 2000</td>
<td>5.3</td>
</tr>
<tr>
<td>Parent support ratio in 2005</td>
<td>7.1</td>
</tr>
</tbody>
</table>

---

2 Elderly dependency ratio: the ratio of those age 65 and over per 100 persons age 20–64.

3 Parent support ratio: the ratio of those age 80 and over per 100 persons age 50–64.
### Vital statistics and epidemiology

<table>
<thead>
<tr>
<th>Metric</th>
<th>Measurement</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crude birth rate</strong> (per 1000 population)</td>
<td>(2000)</td>
<td>20.0</td>
</tr>
<tr>
<td><strong>Crude death rate</strong> (per 1000 population)</td>
<td>(2000)</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Mortality under age 5</strong> (per 1000 births)</td>
<td>(2001)</td>
<td></td>
</tr>
<tr>
<td>males</td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>females</td>
<td></td>
<td>40</td>
</tr>
<tr>
<td><strong>Probability of dying between 15–59 years</strong></td>
<td>(per 1000) (2001)</td>
<td></td>
</tr>
<tr>
<td>males</td>
<td></td>
<td>246</td>
</tr>
<tr>
<td>females</td>
<td></td>
<td>213</td>
</tr>
<tr>
<td><strong>Maternal mortality rate</strong></td>
<td>(per 100 000 live births) (1995)</td>
<td>470</td>
</tr>
<tr>
<td><strong>Total fertility rate</strong></td>
<td>(children born/woman) (2001)</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Estimated number of adults</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>living with HIV/AIDS (2001)</td>
<td></td>
<td>120 000</td>
</tr>
<tr>
<td><strong>HIV/AIDS adult prevalence rate (%)</strong></td>
<td></td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Estimated number of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>living with HIV/AIDS (2001)</td>
<td></td>
<td>1 300</td>
</tr>
<tr>
<td><strong>Estimated number of deaths</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>due to AIDS (2001)</td>
<td></td>
<td>4 600</td>
</tr>
</tbody>
</table>
Indonesia’s Constitution of 1945 identified health – as a means to the promotion of public welfare and the development of human capital – as a national priority. Over the years, the Government has taken various steps in this direction and has greatly improved the public health of the country. The steady decrease in infant and child mortality and the increase in life expectancy illustrate the efficacy of such efforts.

The population pyramid is increasing towards the older population; there is a life expectancy at birth of 65 years for males and 69 years for females. The Infant Mortality Rate (IMR), furthermore, is gradually declining, most likely due to socioeconomic development and improved preventive and curative health services. The IMR was 142 per 1000 in 1968, 70 per 1000 in 1986, and 39 per 1000 in 2000.
LONG-TERM CARE

Despite these figures, public health in Indonesia today still lags behind when compared to that of neighbouring countries. Moreover, there are regional and provincial disparities in health indicators. For example, in 1998 the IMR in West Nusa Tenggara was more than three times higher than the IMR in Jakarta. It is important to note these differences in order to more effectively target health services.

<table>
<thead>
<tr>
<th>Economic Data (Year 2000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GDP – composition by sector (%)</strong></td>
</tr>
<tr>
<td>Agriculture</td>
</tr>
<tr>
<td>Industry</td>
</tr>
<tr>
<td>Services</td>
</tr>
<tr>
<td><strong>Gross national income (GNI) ($PPP)</strong></td>
</tr>
<tr>
<td><strong>GNI – per capita ($PPP)</strong></td>
</tr>
<tr>
<td><strong>GNI – per capita (US$)</strong></td>
</tr>
<tr>
<td><strong>GDP growth (annual %) (1999–2000)</strong></td>
</tr>
<tr>
<td><strong>Labour force participation ( % in 2000)</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
</tbody>
</table>

In the more than 30 years under the New Order Government, Indonesia has made substantial progress, particularly in stabilizing political and economic conditions in the country. There was a period of economic growth from 1968 to 1986, when per capita income increased from about US$50 to US$385. This was primarily the result of an oil boom. However, after the drop in oil prices, the Government began to look for alternative sources of income. By 2000, the per capita income was US$570.

Despite these achievements, the country experienced a severe setback in mid-1997 when the Indonesian economy collapsed. The value of the currency plummeted, prices increased, and unemployment rose dramatically. In addition, parts of the country suffered from relatively long droughts and extensive forest fires. These sudden crises resulted in political turmoil and a change of government. Although the health status of Indonesians may not have been affected drastically in the short term, the economic crisis undoubtedly slowed the development of the health system. Furthermore, the current political instability has also had a direct impact on economic recovery.

---

*PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries*
It is feared that the effects of the political and economic crises will be felt for several more years. Even though Indonesia is taking deliberate steps to protect the health of its population, particularly through modification of policies and strategies of health development (e.g. “Healthy Indonesia 2010”), it is widely believed that the pace of progress in solving many of the health problems in the country will be slow.

With shifting politics, the economic picture continues to oscillate. The percentage of the population living in poverty dropped from 60% in 1970 to an estimated 11–13% in 1996. Most of the poor today live in rural areas, typically in the remote islands or upland areas of Indonesia. However, since July 1997, as a result of the crises that hit Indonesia, the country has faced difficult, fundamental changes that have greatly affected people’s lives.

Examples of such changes include a steep decline in buying power, an increase in prices, a deterioration in industrial productivity, and a wave of lay-offs in various industries. The economic crises have caused a drop in the Indonesian per capita income (PCI) and put Indonesia back on the list of poor countries. According to the World Bank, the national poverty level, which was successfully reduced in 1996 to 22.5 million people (11.3% of the population), bounced back to 29 million (14.1% of the population) in 1999.

The Central Board of Statistics (“BPS”) estimated this figure at 79.4 million – 39% of the population in July 1998; while the Asian Development Bank’s estimation – 80 to 100 million people, nearly 50% of the population – was even higher. It is important to note, particularly for policy development purposes, that the people who are most vulnerable to change are the marginal members of society. In urban areas, they live in slums and work as maids, construction workers, etc. In rural areas, they do not have a steady income.

### Health expenditure (year 2000)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% of GDP</strong></td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Health expenditure per capita ($PPP)</strong></td>
<td>84</td>
</tr>
<tr>
<td><strong>Health expenditure per capita (US$)</strong></td>
<td>19</td>
</tr>
</tbody>
</table>
Although the Government is committed to making health a top priority, despite the economic crisis, preliminary analysis of public expenditures shows a decreasing health budget in real terms. Intersectoral cooperation has also been inadequate and the quality of human resources is poor.

Per capita health spending dropped from US$11.4 in 1984/1985 to US$10.2 in 1986/87, increased to US$17.2 in 1994/95. In the last couple of years, due to the economic crisis, spending on health decreased dramatically. The level of per capita spending on health is significantly lower in comparison to other Asian countries with comparable per capita incomes, and in 1998 per capita public expenditure on health was US$3.00.

Experts estimate that approximately 17.5 million school-age children will have to leave school to help their parents at work, and four hundred thousand students will be unable to continue their studies, due to the economic crisis. In various large cities, the number of street children has increased. In several places, cases of child starvation are a common occurrence.

The literacy rate in 1997 for those age 10 years and older was 89.07%. Elementary school enrolment of children age 7–12 years for this same year was 95.4%.

2 General health, social and LTC system

2.1 Basic income maintenance programmes

There is no basic income maintenance programme for the elderly, except for those individuals who were career civil servants or military personnel. Some private companies have basic income maintenance programmes for their employees, although the number of such companies is very small.

2.2 Organizational structure of decision-making

In the Indonesian cabinet, according to changes as of September 2000, a decision was made to merge the Ministry of Health with the former Ministry of Social Affairs and the Ministry of Community Problems and Crisis. This merge created the new Ministry of Health and Social Welfare (MOHSW).

The new Ministry is responsible for the formulation and implementation of national health and social welfare policy and overall administration, and the coordination and management of the country’s health and welfare system.
Current roles of MOHSW include:

- developing general policy;
- providing advice, facilitation and consultation; and
- implementing monitoring schemes and supervision.

It is divided into the following seven departments:

- Community Health;
- Medical Services;
- Centre for Disease Control (CDC);
- Pharmaceutical Services;
- Social welfare Services;
- Social Welfare Development; and
- Social Welfare Problems and Crises.

The MOHSW is headed by the Minister, and its staff includes the Secretary-General, the Inspectorate-General and seven Directorates-General (one for each department mentioned above). The Bureau of Planning, under the Secretary-General of the MOHSW, is responsible for planning and budgeting health development programmes and for coordinating activities for LTC. Overall, there is a high degree of centralization in health services with control by the central government, and frequently by vertical programmes.

The Ministries of Health and Social Welfare, Education, Religion, Population Affairs and Women’s Roles are all coordinated by the Coordinating Minister for Politics, Social Affairs and Defence. The House of People’s Representatives (‘DPR’) is divided into 11 committees responsible for producing legislation. Public Health, Social Welfare and Family Planning fall under one of these committees (Committee VII).
The political institution at the highest level in Indonesia is the People’s Consultative Assembly or ‘MPR’. There are also two national institutes in the country. The National Institute of Health Research and Development – which since June 2001 has become the National Institute of Health and Social Welfare – is responsible for health and social welfare research.

As mentioned, at the ministry level the Bureau of Planning for Health, under the Secretarmey-General of the MOHSW, is responsible for planning and budgeting the health development programs. This body is responsible for coordinating activities for the development of long-, medium-, and short-term health plans. It is also in charge of channeling all foreign assistance through the Bureau and coordinates its efforts with the Central Planning Board (‘BAPPENAS’).

At the provincial level, the MOHSW shares responsibility with the provincial government, under the Ministry of Home Affairs, for administering Government health services. The dual management system comprises the MOHSW Provincial Health Office (‘Kanwil’) that is technically and administratively accountable to the MOHSW, and the Provincial Health Service (‘Dinas Kesehatan Provinsi’) that is technically accountable to the provincial administration. Specific programmes and projects are the responsibility of the project officer. The ‘Dinas Kesehatan Provinsi’ is also expected to maintain an integrated view of all provincial health services.

At the district level, the District Health Office (‘Kandep’) is a unit of the MOHSW, while the District Health Service (‘Dinas Kesehatan Kabupaten/Kota’) is technically a unit of the district administration, and is administratively responsible to the head of the district. In general, there is only one office, the ‘Dinas Kesehatan Kabupaten/Kota’, which is responsible for the implementation of all health services at the district (‘Kabupaten/Kota’), sub-district (‘Kecamatan’) and village levels. The head of this administration, the District Health Officer (‘Dokabu’), is again the focal point of the dual lines of control. The district health administration plays an important role in primary health care in supervising the district health network, organizing the distribution of drugs, and executing CDC programmes.

At the village level, the Integrated Health Posts (‘Posyandu’) provide preventive and health promotion services. These health posts are established and managed by the local community, and assisted by staff and volunteers from the health centres. In order to improve maternal and child health, midwives/nurses are now being deployed in the villages.

Since 1958, the spirit of the decentralization of health services has been acknowledged, yet efforts have not included the resources necessary for implementation. Using donor assistance (USAID, World Bank, etc.), many studies and pilot projects on health reform have been conducted since 1979.
CASE-STUDY: INDONESIA

Under the World Bank’s Health Project III (1994), reforms in the budgeting process have been initiated. Because the budget has been tightly controlled by the central government and frequently by vertical programmes, local health services have been fragmented. In response, and in line with 1995 Government reorganization and decentralization regulations, an effort was made to integrate the budgets for public and basic health services into one project at the district level.

The Ministry of Home Affairs delegated more authority to district health offices for planning, implementing and managing resources. Although this was a good idea, vertical programmes resisted this attempt to combine and simplify the district budget. More recently, a new initiative has been developed – Integrated Health Planning and Budgeting – where district planners are offering the technical skills needed to analyse their particular situation and develop interventions to solve the problems with the necessary resources.

It is also the district planners’ job to identify potential sources for resource mobilization particularly district funds, revenues from user fees, and private funds through partnerships. Responsibility for planning and budgeting of district hospitals has also now been granted to district health officers (WHO Health System Profiles Database, 2000). This new decentralized approach is considered to be one of the essential elements in building the capacity at the district level. This initiative has not been implemented extensively, but several districts have adopted the new approach to prepare for decentralization.

Decentralization has picked up more momentum in this ‘Reformasi’ era and is considered one of the main policies of the new Government. Two new decentralization laws have recently been enacted: Law no. 22/1999 that deals with provincial and local governments, and Law no. 25/1999 on fiscal equalization between central and local governments. These two laws, which impact health provision in important ways, will bring fundamental changes in the basic roles and responsibilities of the central, provincial and district governments.

Prior to the decentralization policy in January 2001, the top-down structure was clearly evident. In this structure, the Ministry of Health and Social Welfare had a very dominant role. However, after January 2001, the major decision-making roles – including health development programming – were taken over by the Governor and the District Administrator/Regent or by the City Mayor with their local health officers.
2.2.1 Budget allocation

The national budget system in Indonesia is divided into two main components: the regular budget and the development budget. Regular budgets cover operational and maintenance costs (salaries, plant maintenance, etc.), while the development budget is for investment purposes (pre-investment activities, programme development, etc.). There are several schemes under the development budget including: ‘INPRES’ (President’s Special Funds); ‘BANPRES’ (President’s Funds); Development Projects; Foreign Aid Projects; ‘SBBO’ (Operations Subsidy); and ‘OPRS’ (Hospital Operations and Maintenance). Regional and local administrative levels provide additional funds, however, and at least 90% of the public budgets come directly or indirectly from the central government.

Based on the best available data, it is estimated that the total health development budget increased from 2.4% of the annual national development budget in fiscal year (FY) 1996/97 to 3.0% in FY 1999/2000. This amounts to a growth of 0.4% of GDP in FY 1996/97 to 1% in FY 1999/2000.

Unfortunately, the available budget fails to meet current health needs. According to a significant change in the 1999–2000 budget, however, approximately 60% of the Government budget will be allocated directly to the provinces. Regional allocations will take on two forms: general subsidies and specific block grants for sectors such as health (WHO Health System Profiles Database, 2000). Although the Government is committed to making health a top priority despite the economic crisis, preliminary analysis of public expenditures shows a decreasing overall health budget in real terms, particularly for FY 1998/99. Intersectoral cooperation has also been inadequate and the quality of human resources is poor.

2.3 Financing of health services

2.3.1 Sources of finance and approximate share

Funds flow into the health sector from a variety of sources: the major sources include Government revenues (both central and local); payments by households (fees for services, drug purchases); employer contributions to health care; limited support from NGOs; and foreign loans and grants. In the period 1985–1995, an average of 30% of all health care expenditures came from government sources. The remaining 70% came from nongovernmental sources, including the organized private sector (employers and insurance companies) and out-of-pocket health expenditures by households. Table 1 presents health expenditure (in local currency, converted into US dollars according to the mean of the annual exchange rate).
Per capita health spending dropped from US$11.40 in 1984/1985 to US$10.20 in 1986/87, but increased to US$17.20 in 1994/95. This level of per capita spending on health is significantly lower in comparison to other ASEAN countries with comparable per capita incomes.

Table 1. National Health Expenditures in Indonesia (billion rupiah & US$ where indicated) 1984/85, 1989/90 and 1994/95

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public sector</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>305 700.0</td>
<td>701 286.1</td>
<td>1 821 087.7</td>
</tr>
<tr>
<td>Province</td>
<td>57 500.0</td>
<td>70 619.9</td>
<td>161 376.7</td>
</tr>
<tr>
<td>District</td>
<td>22,100.0</td>
<td>80 817.4</td>
<td>224 338.7</td>
</tr>
<tr>
<td>(%)</td>
<td>28.7</td>
<td>26.4</td>
<td>31.3</td>
</tr>
<tr>
<td><strong>Private sector</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>1 020 700.0</td>
<td>1 661 786.0</td>
<td>3 346 644.0</td>
</tr>
<tr>
<td>Private company</td>
<td>72 800.0</td>
<td>194 300.0</td>
<td>471 574.8</td>
</tr>
<tr>
<td>Parastatal</td>
<td>132 700.0</td>
<td>241 600.0</td>
<td></td>
</tr>
<tr>
<td>Insurance/</td>
<td>90 400.0</td>
<td>103 984.1</td>
<td>198 569.2</td>
</tr>
<tr>
<td>managed care</td>
<td>(%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>69.6</td>
<td>68.3</td>
<td>60.3</td>
</tr>
<tr>
<td><strong>Foreign Aid</strong></td>
<td>30 300.0</td>
<td>167 271.2</td>
<td>373 271.0</td>
</tr>
<tr>
<td>(%)</td>
<td>1.6</td>
<td>5.1</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1 891 500.0</td>
<td>3 221,664.7</td>
<td>7 028 687.5</td>
</tr>
<tr>
<td>Population (million)</td>
<td>161.6</td>
<td>179.1</td>
<td>195.3</td>
</tr>
<tr>
<td>Per capita/GDP</td>
<td>Rp11 704.8</td>
<td>Rp17 988.1</td>
<td>Rp35 989.2</td>
</tr>
<tr>
<td>Percapita/GDP</td>
<td>US$11.4</td>
<td>US$10.2</td>
<td>US$17.1</td>
</tr>
<tr>
<td>Per capita/GDP</td>
<td>Rp10,669.0</td>
<td>Rp11,289.0</td>
<td>Rp15,190.0</td>
</tr>
<tr>
<td>(at constant price 1983)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Expenditure as % of GDP</td>
<td>2.06</td>
<td>1.85</td>
<td>1.94</td>
</tr>
</tbody>
</table>

Source: Suwandono & Malik (1995)
LONG-TERM CARE

To analyse the flow of funds, Government funds can be grouped by administrative level (central, provincial and district), or by type of budget (development and routine). The principal source of funds for development expenditures at the central government level is provided from the ‘APBN’, or national development budget.

The regular or operating expenditures are allocated from the ‘APBN’, or national regular budget. Funds are also provided from the ‘INPRES’ (President’s Special Funds) budget. These funds come from the central government to the provincial and district governments for health services provision, purchase of drugs, supplements to the budgets of Puskesmases, outreach programmes, clean water and environment programs, etc.

An additional source of funds is provided by the ‘SBBO’ (operation cost subsidy fund) and ‘OPRS’ (hospital operation and maintenance costs). Both of these sources provide funds from the central government (through the Ministry of Finance) to the provincial and district governments. This budget is a special fund intended to augment hospital resources for routine costs and maintenance. Salaries for health personnel in provincial and district governments are budgeted under the Autonomous Regional Subsidy routine budget.

Aside from central government funding, there are funds provided by the ‘APBD Provinsi’, the provincial-level government budget, which consists of a general development budget that complements that of the central government development budget, and the provincial regular budget which includes ‘SDO’ (regional autonomy subsidy) for salaries and incentives for MOH manpower. Funds provided by the ‘APBD Kabupaten/Kota’ (district-level government budget) consist of funds from the central government budget and district/city regular budget.

Additionally, there are many other public departments outside the Department of Health and Social Welfare that allocate funds for health and provide health services for military personnel (e.g. ‘Hankam’ - the Department for Defence and Security). The Department of Education and Culture supports medical education and the Department of Religion provides funds for Hajj Health Services. The Departments of Transmigration, General Works, Agriculture, Mining and Energy, and Social Affairs also provide funds for health and related activities.

The largest contribution of private funds comes from direct payments for inpatient and outpatient care. This is estimated at Rp 4.6 trillion (‘Susenas 1998’) and amounts to approximately 75% of the total, beyond insurance and Government expenses. Private investments in the health sector are growing rapidly – from 251 hospitals in 1989 to 464 in 1995.
These hospitals are fully equipped with the latest technology. Foreign investors are also very attracted to private health insurance. Additionally, medical doctors are expanding their private practices into group practices and private hospitals.

As mentioned, due to economic development the insurance sector is growing at a remarkable pace. However, the development of health insurance is still slow. Only 15% of the 200 million inhabitants of Indonesia are covered by some type of health insurance. The following are important points in this area:

- Since the fiscal year 1982/1983, financial aid for health from foreign countries has been extensive. While there were at least 13 sources of funds from foreign agencies, the majority was for investment (infrastructure) and not enough was provided for system improvements. The emphasis on infrastructure development is a matter of concern as it may cause operational and maintenance costs to rise in the future.

- The national development budget for fiscal year 1999/2000 was 83.6 trillion rupiah. Of this, 30 trillion was from foreign assistance, as direct project support. Indirect support of 47.7 trillion came from foreign assistance such as general and sector loans from the IMF, World Bank, ADB and OECF. Only 6.2 trillion was from the government’s own revenues. Thus, over 90% of development expenditures was funded (directly or indirectly) through foreign assistance.

- The Government of Indonesia directly uses most of the foreign aid, and, therefore, the burden of development and sustainability will be in its hands in the future. There is a growing recognition that this responsibility should be shared between the Government and the private sector. The Government must reduce its involvement in service delivery and be more involved in public policy, regulation and in ensuring that the poor have adequate health care.

- From the perspective of decentralization, there have been significant changes in the Government’s 1999/2000 budget. Around 60% of the Government’s sectoral development budget was allocated directly to the provinces, districts, and communities, leaving only about 39% for sectoral departments.
These regional allocations consist of two types of budgets: general subsidies to local areas and specific block grants for sectors such as health. In order to protect national priorities, the block grants have specific guidelines. However, much more autonomy will be given to local staff in implementing programmes. Block grants (totaling Rp 363 billion) will be given to health centres, allocating 40% for operational costs and 60% for maintenance.

Decentralized procurement of drugs was originally proposed, but because of concerns about quality and rational drug use, it was decided to maintain the current system while expanding the local capacity for future decentralization. A total of Rp 475 billion has been budgeted for health centre drugs. Twenty percent of this amount will be procured at the provincial level and the remainder at the centre. In the next fiscal year, only very essential drugs will be procured centrally, and provinces will procure other essential drugs. This means that, in the future, less than 50% of the total budget for drugs will remain at the central level.

As a result of budget constraints, public hospitals suffer from a scarcity of resources. This condition is aggravated by the inflexibility of the budget system. The concept of autonomous hospitals or ‘swadana’ was launched in 1988. This allows hospital managers to retain hospital revenues as an additional source of operational costs.

Thus, this concept provides additional funding and, at the same time, it increases the hospital management’s responsibility for improving the quality of services. At present, 44 public hospitals have been granted autonomous hospital - ‘swadana’ status.

However, although there is some evidence that this initiative improves the quality of services, it has not achieved the objective of lowering public subsidies for these hospitals. Also, as out of pocket fees have continued to increase, access for the poor is likely to be even more difficult. In addition, during the period of high economic growth, Indonesia opened its market to foreign investment and encouraged domestic investors in health care. As a result, the private sector grew substantially. This also fostered cooperation between public facilities and private companies, and the out-sourcing of some services.
2.3.2 Pooled health care programmes, general taxation for health care provision, purchasing strategies utilized

Although in 1993 the Government attempted to promote access to health care for poor and vulnerable populations through the 'Health Card' programme, it unfortunately did not achieve its goals. Health Card holders are eligible for free health care at public facilities and can receive primary as well as secondary care.

One of the main problems has been the reluctance on the part of local (district) governments to provide free services, especially in poor districts. This issue became more conspicuous as the economic crisis hit the country and boosted the number of poor to approximately 20% of the total population. To resolve this and other problems, the Government launched the Social Safety Net Programme for Health funded by the IMF and ADB. Some evidence has shown that this programme has reached the target population and promotes essential services to the poor.

However, there are concerns regarding programme leakages and their impact on the sociocultural conditions of the community. These problems have led to questions about the programme’s sustainability and it will most likely be phased out in the coming year.

Government funds, however, are not adequate to pay for all of the health services required by the Indonesian public. While public funds will be used for priority public health initiatives and to ensure that the poor have access to services, more resources must be mobilized from the community. Overall, the non-poor will have to pay more for health services. Additionally, the establishment of effective managed care programmes (like ‘JPKM’, discussed below) will facilitate resource mobilization and ensure universal access to health services.

There are currently two voluntary health insurance programmes – ‘Dana Sehat’ and ‘JPKM’, and two statutory programmes – ‘Pt. Askes’ and ‘Jamosek’, in Indonesia. Unfortunately, the political climate of the ‘Reformasi’ era has also made compulsory schemes less attractive, and many of them have collapsed. The number of those with private health insurance, on the other hand, is still low but growing (WHO Health System Profiles Database, 2000).

Since the early 1970s the Government has promoted the ‘Dana Sehat’ village health programme. It had its origins in small NGO schemes. In 1990, the MOH issued a development strategy for this community health care insurance programme.
LONG-TERM CARE

Community organizations, such as village cooperatives or religious organizations, organize and own the funds. Some village providers organize monthly pre-finance collections from local community members (Rp1000 or US$0.10 per month) and they contract with the local health centres for certain basic health services for the villagers. Others involve external funds and are sponsored by NGOs or religious organizations.

The packages of services vary, although most cover the monthly costs of the services at the local government health centres, basic medications for emergencies, and some of the more developed care includes hospital care. There are no co-payments (WHO health system profiles database). This programme attempts to increase the coverage of health services in Indonesia by encouraging community participation in financing and in health promotion.

However, the limited funds that can be collected from villagers barely enable the village to reimburse high-cost services. This is especially true with regard to hospitalization. Limited benefits make the community less willing to participate in the scheme. However in some districts it has been successful under the management of the district head. By 1994, approximately 13% of all villages had some type of health fund (WHO Health System Profiles Database, 2000).

‘JPKM’ (‘Jaminan Pemeliharaan Kesehatan Masyarakat’) – the Indonesian version of Managed Care, was launched in 1992 under Health Law number 23/1992. This programme is focused on basic primary care (promotion, prevention, curative and rehabilitation services), as well as quality assurance, reliance on a prepaid capitation payment method, risk profit sharing and mandatory basic benefits.

It is a voluntary program that represents an attempt to unify the scattered and very different insurance programmes that operate throughout the country and integrate the insurance function, as well as health care management (similar to HMOs). Although the concept has been developed for more than 25 years, progress to date has been limited.

‘JPKM’ principles for maintaining efficiency, effectiveness and equity are summarized below and on the following page:

- prepaid capitation payment;
- risk profit sharing among the members, the ‘JPKM’ management unit and the health services institution;
contract-based agreement in ‘JPKM’;

clear mechanism and follow-up for complaints;

quality assurance;

monitoring of procedures and structure of health services;

basic compulsory package that contains promotion, prevention, and curative and rehabilitation services (including coverage for health education, immunization, maternal and child health care, treatment of diseases, outpatient, inpatient, diagnostic support, and emergency care).

The first and second principles, on the previous page, attempt to ensure budget efficiency. The third, fourth, fifth and sixth principles, above, ensure the effectiveness and quality of the services, and the last principle provides equity and basic health services for the community.

The ‘Pt. Askes’ scheme is a compulsory social security programme for public sector employees and retirees, which also has a health benefit (covering about 15 million people – 7 to 8% of the population). Due to budget deficits, efforts to contain costs include the introduction in some districts of capitation payments to health centres.

However, hospital services are reimbursed through fee-for-service. There is an extensive package of services including treatment for catastrophic to minor illnesses. A referral system was implemented to prevent over-utilization of secondary and tertiary care. This scheme is financed by a 2% payroll deduction and is additionally subsidized by the Government.

In 1993, it was expanded to include voluntary members and in five years this voluntary programme has grown to 600 000 persons, and is projected to expand rapidly (WHO Health System Profiles Database, 2000).

‘Jamsostek’ emerged in 1992 through a national law that established compulsory enrolment in the core benefits of social security, including a health component for all workers in companies of more than ten employees. (If a company can show better or at least equivalent coverage for its workers, it can opt out of this coverage).
LONG-TERM CARE

The initial aim was to include the informal sector although this never materialized. It covers only two million workers out of the 25 million workers who are formally employed. It contracts with providers and was the first to pay hospitals on a capitation basis (although it has not been consistently followed). More recently, it has established a licensed ‘JPKM’ organization that manages health benefits on behalf of ‘Jamsostek’ (WHO Health System Profiles Database, 2000).

Until 1998, only 15% of the population was covered by some sort of insurance scheme. Civil servants - 7.8% of the total population – are the largest insured group (under ‘Pt Askes’). Workers in the formal sector, 2.4% of the population, are insured by the ‘Jamsostek’ scheme, and another 2.7% of the population receives reimbursement from their employers.

These figures demonstrate that insurance coverage in the formal sector is still very low and that both employers and employees are unaware of its importance for health. Several other factors have been identified as obstacles to the implementation of the ‘JPKM’ insurance scheme, including in particular:

- poverty;
- highly subsidized user fees at public facilities;
- low community awareness;
- bureaucratic procedures;
- low technical capacity for implementation; and, most noteworthy,
- the low level of confidence in insurance providers.

Between 1992 and 1995, the initial steps of ‘JPKM’ policy development (e.g. regulation enforcement, policy application) were carried out. From 1995 to 1997 an integrated trial-and-error field study was carried out in the Klaten District that examined organizational development, local planning, unit cost, and various other related areas.

The results of this study led to programme implementation in several districts in Indonesia. In 1998, approximately 15.1% of the community was covered by ‘JPKM’ pre-paid payments. Hopefully, this will be the impetus for implementation of all ‘JPKM’ principles in the future.
### Table 2. Comparative Total Number of Members of Managed Care and Health Insurance (Comparative Data on ‘JPKM’ Members)
By Managed Care Organisation/Insurance Company and Insured/Groups 1988, 1994 and 1998

<table>
<thead>
<tr>
<th>Managed Care Organisation/Insurance Company</th>
<th>Insured/Groups</th>
<th>Total Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>’PT. ASKES IND’ (Parastatal, MOH)</td>
<td>Government employees &amp; pensioners (Civil and Army)</td>
<td>1988*</td>
</tr>
<tr>
<td></td>
<td>11 127 093</td>
<td>14 684 761</td>
</tr>
<tr>
<td>’PT. ASTEK’ (Parastatal, Ministry of Manpower) or “JAMSOSTEK”</td>
<td>Private companies employees</td>
<td>84 711</td>
</tr>
<tr>
<td>’Dana Sehat’ (Village Health Fund)</td>
<td>Farmers, fishers and students</td>
<td>6 334 320</td>
</tr>
<tr>
<td>’Dana Sehat’ w/’JPKM’ Principles Co-operation Unit</td>
<td>Farmers, fishers and students</td>
<td>–</td>
</tr>
<tr>
<td>Private Health insurance Companies</td>
<td>Members of Credit Union Unit</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Middle-high income urban residents</td>
<td>20 000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17 556 124</td>
<td>28 470 921</td>
</tr>
</tbody>
</table>

** Estimate by the Directorate General of Community Health Development, Depkes (1999)
LONG-TERM CARE

Based on the 1994 NIHRD Study, it was estimated that in 1988, 17 566 124 people - 10.6% of those who were eligible - were covered by health insurance or the village health fund – ‘Dana Sehat’. This coverage increased to about 28 470 921 in 1994 (14.8%).

However, according to the report of the Directorate General of Community Health Development in the 1999 National Health Development Workshop, the population covered by managed care or health insurance was about 15.1% or approximately 19.1 million people out of 180 million eligible ‘JPKM’ members.

Table 2 shows that the estimation of total members of ‘JPKM’ or ‘Dana Sehat’, with or without applying ‘JPKM’ principles and health insurance, numbered approximately 39 922 408. Close to 20.8 million people are ‘Dana Sehat’ members, without applying ‘JPKM’ principles.

Therefore, it is estimated that ‘JPKM’ covers only about 19.1 million people. The current enrolment in ‘JPKM’ programmes depicted in Table 3 indicates that the largest market penetrated by the ‘JPKM’ programmes is that of civil servants, retired government officials, and army personnel. Interestingly, in the formal, informal and private sectors, the market is still wide open.

Table 3. Enrolment in ‘JPKM’ and total market (1998)

<table>
<thead>
<tr>
<th></th>
<th>Number of enrollees</th>
<th>Total market</th>
<th>% Market still open</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>15 600 000</td>
<td>16 000 000</td>
<td>2.5</td>
</tr>
<tr>
<td>Formal Sector</td>
<td>1 600 000</td>
<td>40 000 000</td>
<td>96.0</td>
</tr>
<tr>
<td>Informal Sector</td>
<td>1 131 765</td>
<td>107 000 00</td>
<td>98.9</td>
</tr>
<tr>
<td>Private Sector</td>
<td>90 643</td>
<td>16 800 000</td>
<td>99.4</td>
</tr>
</tbody>
</table>

In order to increase the coverage of ‘JPKM’ consumers (‘PESERTA’), several activities were carried out at the district level. These included:

- analysis of actual and potential health problems in the district to map disease patterns; projection of district health service accessibility and ability to pay the local community; performance of health service units; managed care organization; etc.;
- promotion of ‘JPKM’ in local district administration offices, in health service units, and among candidates of managed care organizations;
- formation of advocacy and supervisory bodies at the district level;
- encouragement of managed care development; and
- education of the community about ‘JPKM’.

The following efforts will help to improve the quality of health services provided by the health service units (‘PPK’):

- family doctor training by the Indonesian Medical Association in collaboration with the local School of Medicine;
- training in ‘JPKM’ and business management, as well as quality assurance for HC’s and public hospital staff;
- comparative study in Singapore on several HCs and public hospital doctors and staff;
- development of medical service standards for ‘JPKM’ at HC’s and public hospitals; and
- improvement of medical facilities and equipment at HCs and public hospitals.
LONG-TERM CARE

The development of more ‘BAPELs’ (managed care organizations) is crucial because, until recently, there were only 20 licensed organizations and 20 others in the process of being licensed. It appears that the strategic unit for ‘JPKM’ development is the district. The reasons are as follows:

- There is a complete infrastructure of health services (basic and referral) that can be used as a ‘PPK’ network.
- The number of eligible inhabitants at this level is manageable under ‘JPKM’.
- There are government, private and community organizations that can be developed as the ‘BADAN PEMBINA’ and ‘BAPEL’ for ‘JPKM’.
- The district is the smallest possible unit with a sufficient number of qualified personnel.
- The district is the smallest autonomous area in which full decentralization will be permitted by the central government.

The following key efforts have been carried out to accelerate the establishment of ‘BAPEL’ and to strengthen those that already exist at the district level:

- Development of financing standards (capital and reserve) for ‘BAPEL’;
- Development of reporting and recording systems for ‘JPKM’;
- Development of finance management systems for ‘JPKM’.

The revitalization of ‘JPKM’ is one of the most important steps towards achieving the goals of Healthy Indonesia 2010. Additionally, the MOH has proposed that ‘JPKM’ will be one of several strategies used to reduce the public’s dependence on the Social Safety Net for the Health Sector (‘JPS-BK’) and offer an alternative form of health care support to the community. However, under ‘JPKM’ the premiums of the poor will be paid by the Government.
The MOH is now preparing 337 ‘BAPEL’ throughout Indonesia in order to hasten the enrolment of the poor in the ‘JPKM’ programme. The majority of ‘BAPEL’ are managed by Credit Unions (44.0%) and Foundations (33.8%).

Table 4 illustrates the distribution of ‘BAPEL’ which are being developed to support the integrated ‘JPS-BK’–‘JPKM’ programme.

Table 4. ‘BAPEL’ development for the integrated ‘JPS-BK’–‘JPKM’

<table>
<thead>
<tr>
<th>‘BAPEL’ of ‘JPKM’</th>
<th>Total number</th>
<th>Number of provinces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parastatal</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>Credit Union</td>
<td>147</td>
<td>22</td>
</tr>
<tr>
<td>Foundation</td>
<td>113</td>
<td>17</td>
</tr>
<tr>
<td>Company</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Pt. Askes (Insurance company)</td>
<td>25</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>26</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>334</td>
<td>63</td>
</tr>
</tbody>
</table>

The integrated ‘JPS-BK’–‘JPKM’ programme will cover the population that falls below the official poverty line, and the Government will pay for the premiums. The ‘BAPEL’ and the ‘PPK’ must work intensively to overcome the existing obstacles in order to achieve the objective of integrating ‘JPS-BK’ – ‘JPKM’.
LONG-TERM CARE

The following is a list of priority issues to be dealt with:

- Inadequate management capability in health financing among health providers.
- Insufficient regularity and sustainability of the ‘JPKM’ and the ‘Dana Sehat’.
- Lack of quality in monitoring and supervision.
- Lack of a widespread ‘JPKM’ financing system that includes pre-payment and capitation.
- ‘JPKM’ package concentrated on curative services.
- Insufficient knowledge about the concept of ‘JPKM’ by many health providers at various levels.
- Low tariff at rural health centres.
- Increasing number of poor people due to Indonesia’s economic crisis.
- Inadequate education and training for implementation of ‘JPS-BK’ – ‘JPKM’.

To revitalize reforms in the health sector, in the opening ceremony of the 1999 National Health Development Workshop, the President of Indonesia, BJ Habibie, launched “Healthy Indonesia 2010”. The strategies for achieving this vision are:

- the application of the health paradigm;
- the improvement of professionalism;
- the application of decentralization; and
- the revitalization of ‘JPKM’ (the community health maintenance insurance).
Among these strategies, the revitalization of ‘JPKM’ must be carried out immediately. This is necessary in order to keep it in line with the implementation of the Social Safety Net in Health Sector (‘JPS-BK’) in an effort to sustain the community-based health development in Indonesia.

The following parties should be involved in the implementation of the ‘JPKM’ programme:

- Defined communities as consumers (‘PESERTA’). They are members of a family, a group, or a unit of an organization who pay a certain amount to maintain their health conditions.

- Health service units (‘PPK’) as an organized health service network which can provide effective and efficient health services as packages of comprehensive health maintenance assurance (health promotion, prevention, and curative and rehabilitation services).

- Formal Managed Care Organizations (‘BAPEL’), which are responsible for the daily application of ‘JPKM’.

- Government and local professional organisations (‘BADAN PEMBINA’), which supervise, develop, encourage and support the implementation of ‘JPKM’.

The relationship between these parties can be seen in the following diagram:
2.4 Services delivery system

In the last 30 years, the Government has expanded public health care across the country by developing a system of health centres. There are about 7500 health centres in 314 districts and 21 000 sub-centres. In addition, almost every district has at least one district hospital. Each sub-district in Indonesia has at least one health centre headed by a medical doctor and it is supported by two or three sub-centres mostly headed by senior nurses. Health Centres provide 12–16 basic health services. Most are equipped with four-wheel drive vehicles or motorboats that serve as mobile health centres to provide services to under-served populations in urban and remote rural areas.

Newly-graduated medical doctors and dentists are deployed by the central administration and must serve in these public facilities. However, since 1992 the central government issued a ‘zero growth policy’ for civil servants. This restricts the availability of doctors and dentists, especially in remote areas. In response, the MOH has implemented the Contract Doctor Programme in which new graduates must serve in health centres on a contractual basis for three years before becoming civil servants. Upon completion of the service, they are free to work in the private sector or to pursue specialty training. This initiative means, however, that young doctors are uncertain about their future work status and are therefore less motivated.

At the village level, the Integrated Health Posts (‘Posyandu’) provide preventive and health promotion services. These health posts are established and managed by the local community, use a cadre of volunteers (‘kaders’), and are assisted by staff from health centres and village maternity centres. Unfortunately, due to the economic crisis, posts in some of the villages have been closed and volunteers dismissed, leaving villagers without access to this care. Those that are still in operation offer basic health care services for children under five, pregnant and lactating women, and eligible couples. They often offer spiritual support and health education as well. The services include weighing children, recording and reporting health information, distributing oral rehydration solutions, vitamin A, basic medicine for fever and influenza, and iron tablets; and providing health education for children and pregnant women. In order to improve maternal and child health and in conjunction with efforts to lower the maternal mortality rate, midwife nurses are being deployed in the villages.

---

5 Due to the decentralization policy, now if a local government (district or province) has the need and the resources to hire new personnel, they can, as long as they do not ask for additional budget money from the central government. Zero growth means the total of government officials cannot be added as before, new civil servants can replace them if they are pensioned or if it is really needed due to extreme conditions. In the past, the growth of civil servants was high; however it was not efficient, due to the low quality of the new civil servants.
Since 1995, under a similar contractual scheme as the Contract Doctor Programme, the Government has deployed these village midwives across the country. At present, about 52,000 midwives have been deployed. However, questions have been raised regarding the efficacy of this initiative and its long-term sustainability. Additionally, traditional healers are numerous in Indonesia and are an integral part of the health system.

Many people in Indonesia seek care from traditional healers who use various forms of treatment including herbal medicine, water, and forms of magic. Sometimes the healers also provide health education on such things as which foods to avoid or to consume, places to visit that may have healing usage, or body positions that may be pain alleviating. In some cases healers are paid in trade, for example with a kilogram of rice or fruit from the patient's garden, or there is always the option to pay on subsequent visits or whenever able.

Accreditation and standardization of health services, particularly in hospitals, has been conducted since the late 1980s. In addition, several groups have been working on quality issues using various approaches. The World Bank Health Project IV provides health centres with technical assistance and systems development for quality insurance in five provinces. Several public and private hospitals have also begun quality assurance processes. In general, however, the quality of health services is still substandard, reflecting a combination of low quality health personnel and poor equipment.

At present, 44 public hospitals have been granted autonomous hospital – ‘swadana’ – status. However, although there is some evidence that this initiative improves the quality of services, it has not achieved the objective of lowering public subsidies for these hospitals. Also, as out-of-pocket fees have continued to increase, access for the poor is likely to be even more difficult. In addition to the issue of cost of care is the problem of access due to the lack of adequate transportation as well as variable proximity to health facilities particularly in rural areas.

Because of the large market for drug companies and the increasing availability of drugs, there is a tendency for health providers to over-prescribe. Anticipating this problem, in the early 1980s the MOH developed the List of Essential Drugs that is revised every three years. In addition, the MOH campaigns for more affordable generic drugs by providing facilities for Government-owned and selected private manufacturer drug production.

This reform is still problematic and there is reluctance on the part of both providers and consumers to use drugs rationally. However, the decreasing ability of consumers to pay out-of-pocket prices during this current economic crisis makes generic drugs an attractive alternative.
LONG-TERM CARE

2.4.1 Auspices of service providers

During the period of high economic growth, Indonesia opened its market to foreign investment and encouraged domestic investors in health care. As a result, the private sector grew substantially. This also fostered cooperation between public facilities and private companies, and the out-sourcing of some services.

Despite a relatively large government health infrastructure, low utilization rates of health centres for primary care have continued to be a problem. Use of private sector practitioners (or public health workers who work also privately) tends to dominate the health care delivery system (WHO Health System Profiles Database, 2000).

Private clinics, hospitals and pharmacists are mostly located in urban areas. Rural areas utilize the private services of publicly employed health professionals in the ‘off-hours’. Private sector hospitals are concentrated in only a few cities (WHO Health System Profiles Database, 2000).

A number of religious missions, mostly from the Netherlands, operate small hospitals and dispensaries, and mobilize funds to support urban and rural hospitals. Many charge patients for their services, and some are subsidized by the MOH. NGOs are active in caring for specific groups such as the elderly, mentally and physically handicapped, as well as specific disease groups (WHO Health System Profiles Database, 2000).

2.5 Human resources and training

The total number of health providers in Indonesia is approximately 380 000. About 17% work at the national level and the remainder are employed as local health providers (at the provincial, district/city, sub-district and village levels).

There are more than 150 000 Government doctors, nurses, midwives, paramedics employed as salaried staff by the Government (and comprise 60% of the total health budget). Fifteen percent of health workers are employed in private settings (WHO Health System Profiles Database, 2000).
CASE-STUDY: INDONESIA

Health providers can be categorized into the following nine groups:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses and midwives</td>
<td>41.4%</td>
</tr>
<tr>
<td>Nurse assistants</td>
<td>12.7%</td>
</tr>
<tr>
<td>Non-paramedic health workers</td>
<td>25.5%</td>
</tr>
<tr>
<td>Other paramedic health workers</td>
<td>10.3%</td>
</tr>
<tr>
<td>Medical doctors (GPs)</td>
<td>4.7%</td>
</tr>
<tr>
<td>Medical doctors (Specialists)</td>
<td>1.9%</td>
</tr>
<tr>
<td>Dentists</td>
<td>1.8%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1.0%</td>
</tr>
<tr>
<td>Others</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

In 1995, there were 37,000 doctors throughout the country; one doctor for every 52,000 persons. No information is available on the number of nurses. Most nurses receive education at the junior high school level plus an additional three years of nurses training (WHO Health System Profiles Database, 2000). Nurses are also paid to make home visits.

In order to improve maternal and child health and in conjunction with efforts to lower the maternal mortality rate, midwife nurses are being deployed in the villages. Since 1995, under a similar contractual scheme as the Contract Doctor Programme described in above, the Government has deployed these village midwives across the country. At present, about 52,000 midwives have been deployed.
LONG-TERM CARE

There are also about 500,000 traditional healers throughout Indonesia. They can be divided into four categories, based on the different techniques they employ:

- healers who use traditional herbs (such as 'jamu', food, water, oil and others);
- healers who use traditional instruments (acupuncture, 'coin', glass, and other instruments);
- healers who use traditional methods (traditional birth attendance, massage, acupressure, etc.);
- healers who use supranatural powers.

The population uses these healers extensively.

Indonesia also has 39,000 social workers, who operate social welfare programmes at the provincial, district/city, sub-district, and village levels. In addition, there are around 4000 social organizations and roughly 14,000 village volunteer social workers who operate social welfare programmes throughout the country. The volunteer social workers have been trained by local social workers to assist with work at the village level. No information is available on training requirements for social workers.

Assisting the health providers, there are about 1 million village volunteer health workers ('kaders') in various fields and programmes. They are trained by local health centres, district hospitals and provincial hospitals to assist village maternity health workers, drug post health workers, integrated health post workers, and others. About 14,000 village volunteer social workers are trained by local social workers to assist in the villages. Most home visits in Indonesia are made by volunteers.
3 Summary of LTC provision

Long-term care in Indonesia has not yet been formally institutionalized, but has been carried out by players in various sectors with limited coverage. LTC services currently include:

- home care for the elderly;
- services for the mentally retarded;
- services for those needing traditional bone reposition;
- care for disabled children; orthopaedic rehabilitation services;
- care for mental illnesses; and
- cancer treatment.

Generally, LTC in Indonesia can be divided into four categories:

- **LTC in institutions by age group:**
  - geriatric homes (‘Panti Wredha’ – homes generally for the healthy elderly and those able to pay for care);
  - vocational rehabilitation camps for disabled youth;
  - disabled children’s homes, and other services.

- **LTC for those with chronic disease in hospitals:**
  - including mental illness, leprosy, heart disease, cancer, chronic lung disease, kidney disease, etc., and those needing orthopaedic rehabilitation services.

- **Community-based LTC:**
  - activities for cancer patients (including those organized by a district ‘family welfare movement’), and geriatric clubs (including a village geriatric group organized by local village health providers trained by a religious foundation).

- **Home-based LTC:**
  - mainly, home care for the elderly and care for people with chronic diseases, disabilities, mental disorders, and others who are cared for by family members.
LONG-TERM CARE

Home care is also provided for traditional bone reposition by healers who have 2–20 rooms for LTC in their homes. In addition there are paid nurses, neighbours, etc., who make home visits. Most home care (including personal care), however, is provided by family members and sometimes neighbours. Few home care programmes have been developed at the local level, and those that exist are based mainly on volunteers trained by health professionals.

LTC services provided by both institutions and individual providers vary by geographic area. Factors influencing LTC provision depend on:

- type of service;
- cultural background of patient and provider;
- socioeconomic background of patient;
- degree of seriousness of illness; and
- traditional vs. modern methods.

Another classification of LTC services is based on the type of institutions that provide the care:

- government;
- non-government;
- private; or
- community-based organizations.

Rehabilitation services can be divided into three types:

- institutional care;
- outreach; and
- community-based care.
Aside from the financial considerations, a major reason for not developing a broader package of LTC services is that traditionally people have tended to take care of the elderly, and those who suffer from chronic illness, at home. Among the LTC facilities that currently exist, geriatric institutions are the only ones that have become more popular in recent years (particularly in big cities). This is due to the fact that increasing numbers of family members who live in big cities have to work, especially women who are the traditional caregivers. Today, programmes of public health nursing, developed by the Ministry of Health and Social Welfare, assist families in caring for the elderly and chronically ill.

As mentioned previously, traditional healers provide a great deal of care in Indonesia, including long-term care. The main profession of traditional healers in Cimande Village in the Bogor District of West Java Province is bone repositioning as a result of fracture, dislocation, or injury. There are more than 100 traditional healers doing bone reposition in this village. They also provide LTC for their patients in their own (the healer’s) homes. Every traditional healer has two to twenty rooms for LTC. The average length of stay for LTC patients ranges from one month to several years. The healers use their bone repositioning expertise as well as various types of oils to treat their patients. Patients for this type of treatment are from all socioeconomic backgrounds.

Current exceptional efforts in Indonesia, that may be used as successful examples for initiating further development of LTC services in the country, include:

- Public health nursing programmes developed by the Ministry of Health and Social Welfare that encourage and assist families in caregiving for elderly relatives, or family members with disabilities or chronic illnesses.

- Village geriatric groups organized by local village health care providers trained by a religious foundation. In a village of the North Sulawesi Province there exists a primary health programme, developed by a religious foundation (‘Yayasan GIM’), that is part of the Integrated Village Health Development Project and offers such services as:
  - weighing children under-five;
  - antenatal care;
  - clean water provision;
  - village health insurance;
  - fundraising; and
  - geriatric group activities.
The geriatric group has been organized by local village providers who are trained health providers from the ‘Yayasan GMIM’. There are about 30 elderly people in the group ranging in age from 58 to 74. Some of them are disabled as a result of strokes, diabetes, cancer, chronic disease or injury, and suffer from various symptoms. Others are still very healthy. They have been divided into several small groups with five to six members in each. Most of the activities carried out by them are related to LTC. The activities include the following:

- Daily morning (except Sunday) walk around the village for approximately 30–40 minutes with additional light exercise.

- Communal breakfast in the village hall following the exercise. The menu consists of healthy food such as fruits, porridge, soy bean cake, etc., which is brought by members of the group.

- After breakfast, health providers usually lead a discussion about health or other topics. If the providers are absent, the discussion is led by the elderly themselves.

- The disabled and those with health problems are then examined by the health providers or by the elderly who have been trained by them to check blood pressure, reflexes, etc.

- Those who are sick at home or cannot participate in these daily activities, as well as those who are hospitalized, receive visits by other members of this geriatric group. Members also accompany those elderly who need assistance or request help from the families.

- Health fund programme within those elderly families are conducted.

- Fundraising activities are offered, including gardening, traditional medicine preparation, horticulture, etc.
Community participation in LTC offering activities for cancer patients through the Family Welfare Movement (‘PKK’) in Sidoarjo District, East Java Province.

The ‘PKK’ is a family movement with women in key roles. This movement has ten basic activities, including health, social welfare, education, fundraising, housing, religion, environment, and others.

One of the activities of the ‘PKK’ in Sidoarjo is LTC for cancer patients. The ‘PKK’ volunteer workers (‘kader’) are trained by local health centres, district hospitals, provincial hospitals, private foundations, and research institutions in caregiving for this population.

They learn how to provide care, palliative treatment, health education, morale boosting, spiritual care, as well as to create a favourable environment, and how to avoid secondary infections and other dangerous complications. Traditional herbs, acupressure and other traditional techniques are also used by the ‘PKK’ for palliative treatments.

‘PKK’ members encourage families of cancer patients to provide care for them at home. The ‘PKK’ also manages the village health insurance with the local hospital, and provides escorts (by the ‘kader’) for routine medical examinations and laboratory tests.

Volunteers trained by local health centres, district hospitals and provincial hospitals.

Integrated health posts (‘posyandu’) at the village level, assisted by staff from health centres, village maternity centres, and a cadre of volunteers.
LONG-TERM CARE

4 General questions pertinent to LTC development

4.1 Present and future needs for long-term care and gaps between needs and provision of services

Currently in Indonesia, the following issues need to be addressed in order to improve long-term care provision in the country:

- Lack of institutionalized programmes for LTC.
- Lack of regulation of LTC.
- Lack of decentralization of health services at the district level, so that each district does not have a specific programme for LTC.
- Low initiative of NGOs and the private sector.
- Health care programmes at the health centres and hospitals still do not function as expected.
- The integration of the Ministries of Health and Social Welfare, and Community Problems/Crises is in progress but still lacks an integrated conceptual framework.
- Health and social welfare are not perceived as investments, but rather as social and humanitarian activities with low productivity and low overall development.
- Community and private sectors are not partners in development, nor are they proactive. They still operate as the objects of development.
- Geriatric home care and other LTC services provide minimal coverage and are still not very popular. They are mainly for the very poor (government) and the rich (private) and operate without any standardization.
- Lack of clear guidance, supervision and advocacy for LTC practised by traditional healers.
- Facilities for pregnant women at high risk employ traditional birth attendants or midwife assistants, as well as midwives at the village level, and are not well standardized. There are no facilities for high-risk children under five with serious malnutrition.
4.1.1 Greatest unmet needs:

- Nursing home care for high-risk pregnant women.
- Nursing home care for high-risk children under five with severe malnourishment.
- Nursing home care for the elderly.
- Nursing home care for heart and cancer patients.

4.1.2 Major education/training needs for LTC:

For health personnel

- Additional training in LTC, home care, high-risk pregnancies, and child nutrition for midwives, traditional birth attendants, traditional healers, and nurses.
- Training of family doctors.
- Training of general practitioners in LTC, home care for patients with various diseases, care for the disabled, geriatric care, and recognition of risk factors.
- Special education for geriatric nurses.
- Additional training for health providers in treatment of heart disease, chronic illness, mental illness, cancer, and injuries.
- Community involvement in LTC.
- Management and insurance for LTC.
- Medical and social rehabilitation.
LONG-TERM CARE

For community health workers (‘kader’)

- How to motivate the local community to participate in LTC.
- How to organize LTC.
- LTC, health care and social welfare.
- Financing of local insurance for LTC.
- Medication and equipment.
- Home care.

For the community (especially mothers and families)

- Home care for babies and children under-five.
- Home care for pregnant, lactating, and high-risk women.
- Home care for the elderly.
- Management of heart disease, cancer, injuries, disabilities, mental disorders, and other chronic diseases within the family and neighbourhood.
- LTC, health care and social welfare.
- Health care and social insurance.
4.1.3 Major health concerns that lead to LTC needs:

Projected disease transition in Indonesia: (1990-2020). Disease, injury, or cause of death – year 1990 scenario based on the 1986 National Health Household Survey (NHHS)

- Lower respiratory infections
- Diarrhoea-related diseases
- Conditions arising during the perinatal period
- Unipolar major depression
- Ischaemic heart disease
- Cerebro-vascular disease
- Tuberculosis
- Measles
- Road traffic accidents
- Congenital anomalies
- Malaria
- Chronic obstructive pulmonary disease
- Falls
- Iron deficiency anemia
- Protein energy malnutrition
Year 2020 scenario, based on the 1992 and 1996 NHHS

- Ischaemic heart disease
- Unipolar major depression
- Road traffic accidents
- Cerebro-vascular disease
- Chronic obstructive pulmonary disease
- Lower respiratory infections
- Tuberculosis
- War
- Diarrhoea-related diseases
- HIV
- Conditions arising during the perinatal period
- Violence
- Congenital anomalies
- Injuries
- Tracheal, bronchial, and lung cancer
4.2 What resources (structures, manpower, organizations) at the national and local levels may be utilized to promote LTC provision?

Several laws, regulations, decrees, and guidelines for disabled community and rehabilitation programmes related to LTC have been developed in Indonesia during the last decade. They are as follows:

- Law No. 4/1997: the disabled community.
- Government Regulation No. 43 /1998: improvement of social welfare for the disabled community.
- Presidential Decree, No. 83/1999 regarding National Coordination Committee on Disability (NCCD).
- Minister of Health Decree, No. 109/1999 regarding medical rehabilitation.
- Minister of Transportation Decree, No. KM71 / 1999 regarding accessibility for people with disabilities and sick people, their vehicles and infrastructure of transportation.
- Other related Ministerial Decrees.
- Various technical guidelines related to disabled community and rehabilitation programmes.
According to the National Plan of Action for Elderly Welfare (2000), there are various policies and programmes formulated by the government related to the older population. They are as follows:

- Policy and Programme of Former Coordinating Ministry of People Welfare and Alleviation of Poverty, which contains general guidelines and standard services to institutionalize elderly in national development.

- Policy and Programme of the National Social Welfare Board by State Ministry of Community Issues/National Social Welfare Body and recently the Ministry of Health and Social Welfare, which concentrated on the management of the elderly through nursing home care and outside of nursing home care.

- Policy and Programme of Ministry of Health that focused on health services to maintain the health status and productivity of the elderly. Elderly health services that are part of family health through primary health care and referral system.

- Policy and Programmes of the State Ministry of Population/National Family Planning Coordinating Body, which basically focused on increasing elderly welfare through improvement of attention and the role of family in religious activities, healthy activities, productive life and independence.

- Policy and Programe of Other Ministries such as Ministries of Manpower, Education and Culture, Transportation, Religious Affairs, and so forth.

- Programme and activities of NGO/Private/Social and Community organizations.
4.3 Developments that will impact on LTC

As a result of the economic crisis and the political changes now taking place, Indonesia is in the midst of a transition. With steps being taken to mitigate the impact of the crisis on public health, many new developments are taking place both in public and private spheres. A new health policy and innovative approaches are being established to provide health care in an equitable and efficient manner.

Priority issues in LTC development include:

- **Equity in health care services**: This issue is growing in importance due to the economic crisis. Health care cards need to be distributed more widely. Voluntary managed care plans (’JPKM’) have been introduced and people are strongly encouraged to join the plans for better coverage of health services and protection for all.

- **Decentralization**: This is the key to total development of the health sector. In Indonesia, the current movement involves all sectors. However, necessary precautions should be taken from the beginning to prevent any adverse effects of decentralization.

- **Deregulation in drug trade**: The production of generic drugs should be encouraged to increase accessibility to those of low income. In addition, rational use of drugs must be promoted.

- **The geographic distribution of health and health-related professionals**: Major obstacles in this area include the reluctance of health personnel to work in rural areas and difficulty in placing female health workers in the periphery. One way to combat these problems would be to improve incentives for career development in remote areas. It should also be noted that, in the decentralization era, it is likely that hiring of personnel can be conducted at lower administrative levels. This policy could increase the distribution of human resources dedicated to health care and has the potential for improving performance.
LONG-TERM CARE

- **Self-financing hospitals**: ‘Autonomous’ hospitals are needed to improve efficiency in the use of funds and facilities through devolution of health programme management. There is a need to take appropriate steps to sustain the private health sector, in order to save it from collapsing in the wake of the economic crisis.

- A new policy aimed at supporting and improving health services permits the employment of physicians and medical specialists as temporary contract workers.

- Deployment of village-based midwives could reduce maternal and infant mortality through improved prenatal, delivery and postnatal care.

- Development of a population-based health information system at the district level to support managerial decision-making.

- Improvement of the quality of care in public facilities to promote higher utilization and contact rates.

- High quality governance.

The general election of June 1999 restored legitimacy to the Indonesian Government, introduced new members to the Parliament, and ushered in a new Minister of Health. While the new Health Minister has not made drastic changes in policy, the commitment for Healthy Indonesia 2010 still remains. However, until mid-2000 the political sector was still reluctant to do anything that might slow economic recovery. The Government still needs to exert major efforts to solve the economic crisis and return the country to economic growth.
The Minister of Health has emphasized specific target areas for present efforts to be used to guide health priorities:

- **Exit policies after Social Safety Net programs.** During the economic crisis, the Social Safety Net (‘JPS’) for Health has been a major initiative to protect the poor from the adverse effects of the crisis. Nonetheless, these programmes are not sustainable and must be phased out over the coming year. This will have to be planned and implemented in an efficient manner.

- **Resource mobilization and health financing.** Government funds are not adequate to pay for health services required by the Indonesian public. While public funds will be used for priority public health initiatives and to ensure that the poor have access to services, more resources must be mobilized from the community. Overall, the non-poor will have to pay more for health services. Additionally, the establishment of effective managed care programmes (‘JPKM’) will facilitate resource mobilization and ensure universal access to health services.

- **Health delivery reforms.** More complete coverage and quality health services will require significant reform of the current health delivery system. Incentive systems must be established that reward efficient and effective health services, both at primary care (‘Puskesmas’ and clinics) and secondary care levels, and that take action against ineffective and inefficient practices.

- **Human resource development.** Reforms and financial changes need to be supported by improvements in human resources. Quality training programmes are needed for all health personnel and identification of new categories of health personnel is essential for meeting the future challenges in the health care system. In addition, pre-service training must be supported by effective career development and in-service or continuing education programmes. The science of health care is developing rapidly and health personnel must keep up with the latest developments and techniques.

- **Decentralization.** This approach, as mentioned above, will be the overriding strategy for all changes in the health sector.
LONG-TERM CARE

The Government of Indonesia uses directly most of the foreign aid, and therefore, the burden of development and sustainability will be in its hands in the future. There is a growing recognition that this responsibility should be shared between the government and the private sector. The government must reduce its involvement in service delivery and be more involved in public policy, regulation and in ensuring that the poor have adequate health care.

Several laws and regulations have been passed during the last decade providing the legal basis for the improvement of social welfare for the disabled in the community, indicating a developing awareness of the needs of the disabled in Indonesia. Furthermore, the current political system during this reformation period is considerably more egalitarian and has promoted more freedom and equality. It has also enabled a move towards decentralization, granting more authority to the district governments. This shift has influenced, and will continue to affect, health service provision throughout the country. Nevertheless, for the future development of LTC, there are also several areas of conflict that should be considered:

- Signs of social and political disintegration
- Political in-fighting
- Ethnic conflict
- Religious conflict
- Misconception of democracy throughout the population
- Misconception of decentralization throughout the population.

Additionally, as a result of the economic crisis in Indonesia, there are several economic factors which must be addressed in order to develop effective LTC policy:

- Uncertain growth of economic sector in Indonesia
- Indonesian currency recently fell from Rp. 2200 to Rp. 10 500
- High international debt
- Capital outflow
- Industries moving out of Indonesia due to increasing crimes and conflicts.
CASE-STUDY: INDONESIA

Bibliography


Ministry of Health (1997) *Health Profile in Indonesia, 1997*. Jakarta


ACHIEVING COORDINATED AND INTEGRATED CARE AMONG LTC SERVICES: THE ROLE OF CARE MANAGEMENT

Professor David Challis
University of Manchester
United Kingdom
1 General background data

1.1 Preamble

Lebanon is a middle-income country with a population estimated at 3.5 million, 90% of whom live in urban areas. Before the civil war, which began in 1975, the Lebanese economy was robust, enterprise flourished, and it was the banking centre of the Middle East. The civil war led to the relocation of many service sectors out of the country, much of the industrial and agricultural infrastructure was destroyed, and the economy went into decline. Increased spending on security forces and the reduction in Government revenues from taxes and other duties led to a steep increase in public debt. The country is still recovering from the long-term effects of the civil strife.

Drained by the protracted civil disturbances that spanned the years from 1975 through 1990, the Treasury faced the extraordinary burdens of reconstruction of the infrastructure, rehabilitation of facilities, subsidies to populations displaced by the civil strife and building of its armed and security forces. The Lebanese economy is now debt-ridden, and faced with considerable and onerous burdens. It is under this scenario of economic difficulty that the reforms of the health care system are to be viewed.

The Treasury is already pressured by the existing cost of medical care from several public agencies. Therefore, one of the prime considerations to be addressed is the need to undertake reforms with a view to keeping costs under control, and perhaps within the current level of expenditures on health care.

In terms of the existing health system, the civil disturbances had a major negative impact on the current makeup of the public health care system. State facilities were often at dangerous sites in the country, and were in the majority destroyed, looted, or deserted. The staff found difficulty in reaching their workstations. The centralization of the Ministry of Health prevented the smooth flow of supplies, pharmaceuticals, systems, and manpower, and the dissemination of regulations. The Government relied on the private sector to provide care for the traumatized population.
Before the war, in 1970, only 10% of the Ministry’s budget was spent on the care of patients in private facilities, principally for advanced care unavailable in public hospitals. During the war, this budget line provided a ready opportunity for the treatment of patients. Of all sectors in the economy during the past two decades, none flourished as much as the private health sector. However, no one denies the extent to which the private hospital sector assisted in the provision of care, under duress, during that long period of strife. It is to be noted that these incentives expanded the private sector to areas of the country that were until then under-served. After the war ended in 1990, the Government began to refurbish its hospitals and to build new ones. In 1992, the Ministry decided to cover the treatment of patients undergoing complex surgeries and medical care such as cardiac surgery, cancer treatment and renal dialysis.

This chapter describes the health and social service systems in Lebanon. It analyses the components of these systems within the context of the epidemiological, demographic and economic realities that exist in the country. The chapter devotes special attention to the health and social services existing for the care of the disabled and elderly, and in particular the long-term care services available for these population groups. This chapter has drawn from many studies that have been published or produced in the past few years. Annotation and recognition of the authors have been indicated throughout.

Presented on the following pages are background data concerning Lebanon, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure. About 30% of the population in Lebanon is under age 15, and 9% over age 60. The population is growing at 2% per year, and the total fertility rate is 2.2.

Over the past 20 years, there have been steady increases in life expectancy and a steady decline in mortality rates. The life expectancy at birth increased considerably during the past two decades and reached approximately 73 years in 2000, while the infant mortality rate per 1000 live births declined significantly. The demographic transition has been accompanied by an epidemiological transition. While important health problems are still related to infectious diseases, chronic and degenerative diseases are becoming more prevalent. The causes for this are the ageing of the population, changing dietary habits, and changes in lifestyles concomitant with urbanization. Prevalence rates for hypertension and diabetes are on the rise in Lebanon. In addition there are 4000–5000 new cases of cancer each year. Concerning AIDS, there were 3.1 cases per 100 000 people in 1997.

---

## 1.2 Background data from international data bases

### Demography (year 2000)

<table>
<thead>
<tr>
<th>Demographic Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands)</td>
<td>3496</td>
</tr>
<tr>
<td>Land area (sq km)</td>
<td>10 400</td>
</tr>
<tr>
<td>Population density (per sq km)</td>
<td>336</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>90</td>
</tr>
<tr>
<td>Ethnic groups (%)</td>
<td></td>
</tr>
<tr>
<td>Arab</td>
<td>95</td>
</tr>
<tr>
<td>Armenian</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Religions (%)</td>
<td></td>
</tr>
<tr>
<td>Muslim (Sh’a, Sunni, Druze, Isma’ilite, Alawite, or Nusayri)</td>
<td>70</td>
</tr>
<tr>
<td>Christian (including Orthodox Christian, Catholic and Protestant)</td>
<td>30</td>
</tr>
<tr>
<td>Jewish</td>
<td>NEGL</td>
</tr>
<tr>
<td>Total adult literacy rate (%) in 1997</td>
<td>86%</td>
</tr>
<tr>
<td>Age Structure (%)</td>
<td></td>
</tr>
<tr>
<td>0–14</td>
<td>31.2</td>
</tr>
<tr>
<td>15–24</td>
<td>18.7</td>
</tr>
<tr>
<td>60+</td>
<td>8.5</td>
</tr>
<tr>
<td>65+</td>
<td>6.1</td>
</tr>
<tr>
<td>80+</td>
<td>0.7</td>
</tr>
<tr>
<td>Projections 65+ (%)</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>8.7</td>
</tr>
<tr>
<td>2050</td>
<td>18.9</td>
</tr>
<tr>
<td>Sex ratio (males per female)</td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>0.94</td>
</tr>
<tr>
<td>15–64</td>
<td>0.91</td>
</tr>
<tr>
<td>65+</td>
<td>0.84</td>
</tr>
<tr>
<td>Dependency Ratio</td>
<td></td>
</tr>
<tr>
<td>Elderly dependency ratio in 2000²</td>
<td>11.5</td>
</tr>
<tr>
<td>Elderly dependency ratio in 2025</td>
<td>13.8</td>
</tr>
<tr>
<td>Parent support ratio in 2000³</td>
<td>8.8</td>
</tr>
<tr>
<td>Parent support ratio in 2005</td>
<td>7.3</td>
</tr>
</tbody>
</table>

² Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

³Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.
### Vital statistics and epidemiology

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crude birth rate</strong> (per 1 000 population)</td>
<td>19</td>
</tr>
<tr>
<td><strong>Crude death rate</strong> (per 1 000 population)</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Mortality under age 5</strong> (per 1 000 births)</td>
<td></td>
</tr>
<tr>
<td>males</td>
<td>34</td>
</tr>
<tr>
<td>females</td>
<td>28</td>
</tr>
<tr>
<td><strong>Probability of dying between 15–59</strong> (per 1,000)</td>
<td></td>
</tr>
<tr>
<td>males</td>
<td>204</td>
</tr>
<tr>
<td>females</td>
<td>140</td>
</tr>
<tr>
<td><strong>Maternal mortality rate</strong> (per 100 000 live births)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>130</td>
</tr>
<tr>
<td><strong>Total fertility rate</strong> (children born/woman)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Life expectancy at birth</strong> (years) (2001)</td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>69.8</td>
</tr>
<tr>
<td>Male</td>
<td>67.6</td>
</tr>
<tr>
<td>Female</td>
<td>72</td>
</tr>
<tr>
<td><strong>Life expectancy at 60</strong> (years) (2000)</td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>18.5</td>
</tr>
<tr>
<td>Male</td>
<td>18.0</td>
</tr>
<tr>
<td>Female</td>
<td>19.0</td>
</tr>
<tr>
<td><strong>Healthy life expectancy (HALE) at birth</strong> (years) (2001)</td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>59.3</td>
</tr>
<tr>
<td>Male</td>
<td>56.5</td>
</tr>
<tr>
<td>Female</td>
<td>62.2</td>
</tr>
<tr>
<td><strong>Healthy life expectancy (HALE) at 60</strong> (years) (2001)</td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>11.5</td>
</tr>
<tr>
<td>Male</td>
<td>10.0</td>
</tr>
<tr>
<td>Female</td>
<td>12.9</td>
</tr>
</tbody>
</table>
CASE-STUDY: LEBANON

### Economic data (year 2000)

**GDP – composition by sector (%)**
- Agriculture: 12
- Industry: 27
- Services: 61

**Gross national income (GNI) ($PPP)**
- 20 billion

**GNI – per capita ($PPP)**
- 4550

**GNI – per capita (US$)**
- 4010

**GDP growth (annual %)**
- 0

### Health expenditure (year 2000)

**% of GDP**
- 11.8

**Health expenditure per capita ($PPP)**
- 696

**Health expenditure per capita (US$)**
- 590

---

4 PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries.
LONG-TERM CARE

2 General health and social system

2.1 Basic income maintenance programmes for the disabled and elderly

The income maintenance programmes for the disabled and elderly in Lebanon are not different from those provided for the rest of the population. Personal savings are the major source of maintenance. The salaried population also continues to receive monthly payments as retirement benefits.

When the salaried head of household passes away, his widow continues to receive a proportion of this pension (the proportion varies according to the adopted scheme). In most cases, the children will also receive a pension if they are disabled or unable to be employed. In general, pensions are supplemented by income from family members (sons, daughters).

2.2 Organizational structure of decision-making

The Ministry of Health is the Government ministry with the most important responsibilities with regards to the provision of health care in Lebanon. However, the Ministry’s major role is in financing and not in the direct provision of services, and most of its budget is spent on financing the hospitalization of patients in private hospitals. The Ministry of Health has not been prepared for this role in its legislation. The existing legislation, promulgated in 1961, stills defines the role of the Ministry, as a ‘public health’ entity (i.e. the provider of non-personal health services) to communities and the country in addition to its regulatory responsibilities (licensure, inspection and control). Moreover, from its original role to provide care for the poor, the Ministry has evolved to be the safety net, to cover, in principle, the medical care of all the non-insured, and to promote access and equity.

Initially, the Ministry of Health provided hospital care to the medically indigent. Hospital care was seen as a matter of ‘financial duress’ for the medically indigent, and progressively to other segments of the population. In 1992, coverage was extended to complex procedures and treatments, basically the ‘catastrophic illnesses’ that would tax any household financially. This approach has oriented care towards the hospitals, to ensure coverage and facilitate access to the satisfaction of all users and providers – and to the detriment of primary health care and its role as the gatekeeper of care.

However, the building of new public facilities leaves the private sector uneasy about its role as a partner. Will the Ministry continue its financing of the private sector to the same extent? Will these facilities remain operational? What standards of care will be mandated?
The very first component of reform will need to define the role(s) of the Ministry of Health. This is essential for the stability of the entire health care system, private and public, and to its long-term development. The delivery system must have strong and sustainable foundations on which reforms can be built and options developed.

The Ministry of Social Affairs (MOSA) also plays an important role in the provision of health and social services in Lebanon. For example, MOSA provides health assistance at public social centres. This assistance involves curative and preventive health care services, vaccinations, primary health care, reproductive health services for mothers and children, advice on reproductive health, and a set of services aimed at the disabled population.

MOSA also assists a number of centres belonging to not-for-profit and nongovernmental organizations (NFPs/ NGOs) that include health services among their activities. Geriatric homes for the elderly population are also supported by MOSA.

The Ministry of the Economy also has a role in health care in Lebanon. It is responsible for awarding licenses for private insurance.

The organization of Lebanon’s health care system can be described as highly fragmented. The war considerably weakened the institutional and financial capacity of the Government and other elements of the public sector, and its role in the provision of health care services steadily declined. Nongovernmental agencies and elements of the private sector that had undergone a rapid increase both in their numbers and their capacity filled the vacuum. Health care services have become increasingly oriented towards curative care with a rapid growth in the number of hospitals and centres for high technology services.

Today, ninety percent of hospital beds are in the private sector. The primary health care system has remained weak. The nongovernmental sector, especially NGOs, dominates this sector with governmental involvement being minimal. Nongovernmental providers include private practitioners, dentists, pharmacists, and medical laboratories.

### 2.3 Financing of health services:

There is considerable disagreement concerning the proportion of the population covered by various financing agencies. As part of the National Health Accounts (NHA) activity, an attempt has been made to estimate this coverage by obtaining information directly from the financing agencies as well as analysing data collected from the National Household Health Expenditures and Utilization Survey (NHHEUS).
LONG-TERM CARE

According to the NHHEUS, 46.8% of the population reported having some form of insurance (either social or private). If one excludes the non-Lebanese population (estimated at 7.6% of the total population), 45.6% of the Lebanese population does not have health insurance. There is considerable geographic variation in the profile of those insured by the Mohafazat or governorate. The highest proportion of the population covered is in Beirut and the Mount of Lebanon, with the lowest coverage in Bekaa and Nabatyeh.

Expenditures on hospital care by public financing agents are very high. Overall, 66.4% of public health expenditures is spent on hospital-based care, 14% is spent on ambulatory care, 7.8% is spent on pharmaceuticals, 6.8% is spent on administration, and 5% is spent on ‘other goods’ (e.g. subsidies for imaging tests, treatment abroad). In the case of the Ministry of Health, 71% of its budget is used to pay for hospital-based care. Expenditures on primary health care services are a sub-set of those on non-institutional health care providers and account for less than 5% of public expenditures. The Ministry of Health has not been able to disburse all amounts allotted to primary health care and in some cases these resources have been diverted to curative specialized care services.

There are three sources of governmental health insurance in Lebanon. This is in addition to the payments made by the Ministry of Public Health to private hospitals for the hospitalization of uninsured applicants.

2.3.1 The National Social Security Fund (NSSF)

The NSSF was established in 1964, within the programme of reforms that had been legislated after the 1958 civil disturbances. The Public Law mandated the creation of independent funds to cover workmen’s compensation, end-of-service indemnities, and maternity and sickness. The latter was implemented in 1971.

The NSSF is quite similar to the French model of Social Security. It is financed by employers, employees, and the Government. The high social costs of the NSSF have led employers to underestimate the salaries of their employees and to employ non-Lebanese.

The NSSF is managed by an independent 26-member Board of Directors: ten representing the employers, ten representing the employees, and six representing the government. A Director-General executes the decisions of the Board. Having been essentially a gain for workers, the NSSF falls under the responsibility of the Ministry of Labour and Social Affairs. The Ministry of Health has little, if any, input into its operations or decisions.

---

[5] Lebanon has six Mohafazats (sometimes the South is divided into two Mohafazats) and 24 Qadas or districts (all within the Mohafazats).
CASE-STUDY: LEBANON

The NSSF is the most important source of public health insurance in Lebanon. In principle, it covers Lebanese citizens who work in the private, non-agricultural sector, permanent employees in agriculture, employees of public institutions and independent offices who are not subject to civil service, teachers in public schools, taxi drivers, newspaper sellers and university students. Health coverage includes sickness and maternity allowances amounting to 90% of hospitalization costs and 80% of medical consultations and medication excluding dental care. To a large extent, the Fund is financed from private sources – yet, it is a public institution.

On 12 April 2000, a “project law” was approved by the Cabinet, instituting the provision of health care to the entire population above the age of 64 under the auspices of the NSSF. The “project law” has not been implemented as yet and may be revised. On 1 May, 2000, the Board of Directors announced that the following new population segments will be admitted into the NSSF Maternity and Sickness Fund: tobacco growers, fishermen, writers, poets, artists, and physicians.

Beneficiaries include the individual him/herself, the spouse, male children under the age of 16 years (up to 25 years if in formal education), and female children up to the age of 25 years. There is no age limit for coverage if the child suffers from a disability. Parents are also covered if they are over the age of 60 years, are living in the same household and cannot support themselves (there is evidence that this restriction is not strictly applied).

Hospital admission is secured through one’s physician and reviewed by the NSSF medical inspector at the hospital. Patients enter Class II, but may enter into a higher class if they pay the class difference out-of-pocket. Taxi drivers, university students and newspaper reporters do not pay any co-payment; all others pay 10% of hospital costs and 20% of outpatient care (based on the tariff).

Hospitals submit the patients’ bills to the NSSF. There is usually a delay and often bills are discounted after review. Outpatient care is paid by the patient and later reimbursed by the NSSF. Dental care is not covered as yet. There is evidence that the reimbursement procedures are tedious, time-consuming, and bureaucratic. This leads many to forego their claims. Hence, although the financial barrier is removed, the bureaucratic/administrative barrier limits the reimbursement of claims.

The household survey of 1997 revealed that only 15.2% of the sample interviewed was covered by the NSSF. In the most recent survey (March 2000), 17.8% responded that they carry the NSSF coverage. The NSSF maintains that it provides coverage for 33% of the Lebanese population, i.e. double the numbers suggested by the surveys. This information also impacts on the costs of operation and coverage, since the number of beneficiaries claimed may be double the number who receive the service (hence the cost would be halved).
2.3.2 The Cooperative of Civil Servants (Coop)

An important source of public health insurance is the Cooperative of Civil Servants. The Law instituting the Coop was issued in 1964, four months after the Law of the NSSF was implemented by the same Cabinet. An article in the Law stipulates that the Coop is to be merged with the NSSF once the latter has been developed.

The Coop insures all employees of the public sector who are subject to the laws of the Civil Service. Health insurance here covers 90% of hospitalization costs and 75% of consultations, medication and dental treatment for the employee (up to a ceiling, beyond which the Coop covers all). In addition, it covers 75% of hospitalization costs for family members of the employee and 50% of their medical consultations and pharmaceuticals.

The Coop is operated by the Office of the Prime Minister. It covers permanent civil servants. The NSSF covers staff on contracts. The Coop also covers educational costs and other family benefits. After twenty years of service, the civil servant and his dependents are covered after retirement. Coverage includes hospital care, ambulatory services, dental care and optometric services as well. Coverage is in First, Second or Third class – depending on the employment grade of the enrollee. Dental care is covered, as well as 90% of treatment abroad (up to US$10,000).

The Coop is financed by a 1% deduction from the payroll, with the balance covered by the Government. The Coop enters into a tariff agreement with providers, independent of other public funds. The Coop tariff is usually more advantageous than the other funds.

2.3.3 The Security Forces

Security forces receive coverage from multiple sources: the military is covered by the Ministry of Defense through the Military Medical Services; the Internal Security forces (ISF) have their own plan, under the Ministry of Interior; the staff of the Public Security, Customs’ employees, and those of the State Security are covered through two different funds, under the Office of the Prime Minister. All uniformed staff members are covered, as well as their dependents and parents. The dependency ratio is 3.5 persons per enrollee.

Coverage here is the most generous: 100% of hospitalization and medical expenses for the member, 75% for spouses and children, and 50% for dependent parents. Treatment abroad, cardiac surgery and renal transplantation are also covered.

2.3.4 The Ministry of Health (MOH)
In Lebanon, the Ministry of Health is the insurer of last resort, funding hospitalization costs for any citizen who is not covered under an insurance plan. This coverage is independent of the income and asset status of the individual. The Ministry of Health covers the cost of some narrow specialties such as chemotherapy, open-heart surgery, dialysis, and renal transplant, and drugs for chronic diseases.

Even as the responsibility of the Ministry of Health has grown, its share of the Government of Lebanon’s budget has declined from over 5% in the early 1990s to around 3% in 1998. The Ministry has the largest share of the total cost of public expenditures, including insurance, on health services in the country (MOH Budget).

The amount the Ministry of Health spends on hospital care in the private sector has ranged from 84% in 1993 to 72% in 1995. Many of the interventions – such as open heart surgery, kidney dialysis, kidney transplantation, and treatment of burns – affect very few people and yet consume approximately 20% of the budget of the Ministry of Health.

The Ministry of Health has been incurring deficits due to its increasing commitments to special programmes, a growing awareness among the population that the Ministry pays for hospitalization costs, and its inability to curb hospital costs. The deficit was worst in 1997 when it was equal to nearly 60% of the budget. The Ministry of Health has responded to these deficits by delaying reimbursement to hospitals for their services and by making deductions in these reimbursements.

The MOH contracts with private hospitals to provide medical services for the non-insured population. Each hospital is graded and a corresponding room rate and tariffs for tests, drugs, the use of operating theatres and other covered items are agreed with hospitals. Private hospital are supposed to admit any person with a referral note from the Ministry issued after determining that the patient had no other insurance.

At the Ministry, there is an audit committee that reviews bills presented by hospitals and that has, in addition, medical inspectors in the field to check on the identity and eligibility of patients under this plan. A number of practical problems exist, however, making the functioning of the system problematic and open to misuse. The MOH covers 90% of hospital care: the individual is expected to pay 10% of the hospital bill. Even this co-payment is frequently waived altogether, in cases of need.

There are a number of reasons to believe that control of the MOH over-billing is inadequate. Recently, the Ministry has taken steps to introduce ‘flat rate’ payments in its contracts with private hospitals. This requires studies of current practices and current costs.
LONG-TERM CARE

Table 1. MOH budget by category

<table>
<thead>
<tr>
<th>Category</th>
<th>1993 (%)</th>
<th>1995 (%)</th>
<th>1997 (%)</th>
<th>1997 (billions LL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>7.5</td>
<td>7.2</td>
<td>5.7</td>
<td>14</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>4.3</td>
<td>6.9</td>
<td>8.1</td>
<td>20.4</td>
</tr>
<tr>
<td>Subscriptions, assistance,</td>
<td>1.1</td>
<td>2.9</td>
<td>4.6</td>
<td>11.5</td>
</tr>
<tr>
<td>Contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td>83.9</td>
<td>72.2</td>
<td>77.8</td>
<td>196.6</td>
</tr>
<tr>
<td>Others</td>
<td>3.3</td>
<td>10.8</td>
<td>3.7</td>
<td>9.3</td>
</tr>
<tr>
<td>Totals</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>251.8</td>
</tr>
</tbody>
</table>

Source: MOH-As Safir Jan 04 2000

2.3.5 Private insurance companies

The private insurance market is growing rapidly in Lebanon. According to Ministry of Economy sources, approximately 70 private insurance companies provide health insurance. They provide both complementary and comprehensive health insurance policies.

The former is to complement and fill gaps in the benefits provided by the NSSF, Coop, and health insurance arrangements for the army and police. The latter refer to stand alone health insurance policies that can cover a range of benefits including inpatient and outpatient care, and coverage for pharmaceutical expenses. It is estimated that 8% of the population has comprehensive coverage and 4.6% gap insurance.

Compared to other countries in the region, Lebanon has a fairly well developed private insurance sector. The Ministry of Economy licenses private insurance.
Nearly 85% of the private policies in Lebanon are purchased by employers as an employee benefit or to fill gaps in NSSF coverage. Insurance policies in Lebanon typically cover inpatient care. Outpatient services are covered for an additional premium with co-payments of around 20%.

There is anecdotal evidence that private insurance companies transfer the burden of high cost cases to the Ministry of Health as the latter does not have the ability to verify whether applicants have insurance or not. Estimates of the breakdown of expenditures by private insurance companies by type of service show that physicians’ fees account for 30% of expenses, pharmaceuticals for 31%, hospitalization costs for 15%, and administrative expenses for 24%.

### 2.3.6 The Mutual Funds

A growing number of mutual funds are also being established, covering health expenses in the context of syndicates, associations, and other groups.

Mutual funds began in 1991. This movement is under the jurisdiction of the Ministry of Housing and Cooperatives. The Law governing this sector permits any group of 50 persons (or above) to form a mutual fund. The linkage can be professional, religious, community-based, etc.

Tax laws that provide tax-breaks to non-profit groups have lead to a proliferation of mutual funds that offer health insurance coverage to their enrollees. Recent estimates would indicate that about 65,000 individuals are covered for health benefits by mutual funds. However, the number of enrollees ranges from as low as 66 to 12,000.

Mutual funds collected 17,380,230,000 LL (US$11,586,820) in premiums and paid out 13,871,047,500 LL (US$9,247,365) in benefits. This amounts to a loss ratio of 80%.

Some mutual funds have been established exclusively to provide gap-insurance coverage, thereby negating the impact of demand side interventions aimed at controlling over consumption of high cost health services. Private insurance companies feel that the differential tax treatment distorts the playing field, and that the growth of mutual funds hampers the competitiveness of the insurance market.

Mutual funds are supported technically by the French Association of Mutual Funds. They are intended to provide for a co-insurance or a complementary insurance. Mutual funds do not pay taxes on the premium, unlike private insurance companies.
LONG-TERM CARE

2.2.7 Nongovernmental Organizations (NGOs)

There is a relatively small proportion of the total health bill that represents coverage of beneficiaries of health assistance from local and foreign not-for-profit and nongovernmental organizations (NFP/NGOs). They operate generally at the local level in poorer urban districts and underprivileged rural areas. The importance of this coverage lies in the fact that it relates to needy individuals who would have great difficulty obtaining health services from other sources.

Medical care offered through NGOs witnessed major growth during the war years. It became evident that health care was a magnet to attract the sympathies and allegiance of the population under duress. This has waned somewhat since 1990. However, it should be noted that the involvement of the community in the provision of medical care did offer some innovative models for the financing, governance and management of health services.

2.3.8 Donor assistance

In 1998, donor assistance amounted to 1.96% of total health care financing. While this is a small percentage of total health expenditures, the trends in donor assistance need attention. Donor assistance doubled between 1995 and 1996, actually declined by nearly 30% between 1996 and 1997, and rose by less than 5% between 1997 and 1998. The sharpest decline in donor assistance has been to immunization and control of diseases and there has been a significant increase in support for family planning activities.

Outlays for capital investment account for the majority of donor assistance. These rose by 174% between 1995 and 1996, declined by 23% between 1996 and 1997, and rose by 13% between 1997 and 1998. The Ministry of Health and other Government agencies are the primary beneficiaries of donor assistance. The American University in Beirut and nongovernmental providers received less than 5% of donor disbursements. With donor assistance it was difficult to reconcile the amount disbursed with the amount actually spent.

The World Bank has been supporting health sector reform as well as capital investment activities in Lebanon. The World Bank’s loan portfolio has been $38 million. Disbursements in 1998 amounted to $2.34 million and cumulative disbursements until the end of 31 March, 1999 totalled $3.91 million.
2.3.9 Out-of-pocket expenditures

Last, but certainly not least, the most important item in the total health bill is the out-of-pocket payments that consist of health expenditures borne directly by individuals, covering supplementary payments by those who are covered by insurance or the MOH, as well as full payments by those who are not covered by any insurance or are not beneficiaries of MOH assistance.

These payments are greatly affected by the economic situation and decline with recession, resulting in an increase in unmet health needs. Since this is a major item in the total health bill, this bill is bound to vary significantly with significant changes in the economic situation.

Household out-of-pocket expenditures amounted to 70% of total health expenditures. This is significantly higher than previous estimates that had placed out-of-pocket expenditures at around 53% of total health expenditures. This steep increase in household expenditures has important policy implications.

According to the National Household Health Expenditure and Utilization Survey (NHHEUS), households spent a total of 2,088,000,000,000 LL for health services in 1998. Of this, 97% was spent in the private sector, 2% in the NGO sector, and just 1% in the public sector. Per capita expenditures amounted to 522,000 LL per year. 15% of this was spent on insurance, 10% on hospitalization, 2% on one day surgery, 22% for dental care, 25% for outpatient care (excluding drugs), and 27% on drugs.

On average, households spent a little over 14% of their household expenditures on health services. However, the burden of out-of-pocket expenditures as measured as a proportion of household expenditures is not equitably distributed.

It is seen that nearly a fifth of expenditures in households in the lowest income category was allocated to health. The proportion spent on health goes down as income increases and households in the highest income group spend only 8% on health care.

Therefore, even though there might not be inequities in access, as measured by per capita use rates (as will be discussed below), certainly the burden of out-of-pocket expenditures is inequitably distributed. While the Ministry of Health pays for hospitalization costs of the uninsured, there is probably a need to develop a targeted financing scheme that assures financial access to health services for low-income families.
LONG-TERM CARE

2.3.10 Summary

In summary, Lebanon has several different Government, not-for-profit, and private for-profit financing schemes. These include:

- two employment based social insurance schemes;
- four different schemes to cover the security forces;
- the Ministry of Health financing that covers any citizen who is not covered under any other scheme;
- a growing private insurance market that is largely employment-based;
- mutual funds; and
- out-of-pocket expenditures.

It is noteworthy that the Treasury has effectively spent only US$333 million (17%) out of a total of close to US$2 billion that was spent on health in 1998. The lion’s share has been funnelled through the Ministry of Health (US$207 million or 62%).

Put differently, the Treasury has expended less than US$100 per capita for medical care only. The balance has been paid out of private sources. Hence, the basic issue in reforms is to contain the cost of medical care, as it impacts the overall economy, and specifically as it affects the private purse (of individuals, households, and private companies).

Table 2, on the following page, shows the amount spent by both private and public sources of funding for health care in 1998.
Data also show that 12% of the country’s GDP was spent on health in 1998. This compares with 4 to 6% in most developing countries (Tabbara, 2000). It should also be mentioned that, although many European countries spend approximately 10% of GDP on health care, the value-for-money, quality of care, and coverage are all far superior to the situation in Lebanon.

With universal coverage and full payment of medical bills by the public sector, the total health bill in Lebanon, under the present system of payments and costs, would probably exceed 15% of GDP. In fact, given the determinants of the health care system in Lebanon, i.e. fee-for-service, oversupply of manpower and facilities, low occupancy of hospital beds, hospital-driven care, poor control, etc., there is no reason that would prevent costs from rising to 14 or 16% or more as is the case in the USA, where control is more effective and managed care is available.
LONG-TERM CARE

2.4 Services delivery system:

2.4.1 Health care utilization

Among those surveyed by the National Household Health Expenditure and Utilization Survey (NHHEUS), individuals on average had 3.6 outpatient visits per year, with males averaging 3.1 visits per year and females 4.1 visits per year. While regional disparities exist in use rates, these do not appear to be significant. This situation probably reflects the presence of a well-developed market for health services (in the private, NGO and public sectors).

An interesting finding is that unlike many other countries lower income individuals have higher use rates than those in higher income groups. Jordan is the other country in the region where similar results have been observed. This indicates that there does not appear to be inequities in access to health services if these are measured by use rates. Looking at use rates by age group it is seen that those over the age of sixty and those under the age of five have the highest use rates. Those who have insurance have higher use rates than the uninsured.

When examining hospitalization rates, once again one does not see income-related inequities in use rates, although those with insurance do tend to have a higher use of hospital services than those who are uninsured. The age differences persist, as in the case of outpatient care.

The fact that lower income households have higher use rates than those with higher incomes quite likely reflects the fact that the Government – as the insurer of the last resort – pays for hospital care for all uninsured in Lebanon. Thus, those needing hospital care can either use insurance (social or private) or approach the Ministry of Health for financing.

The household survey reinforces the fact that the private sector dominates the health services market in Lebanon. Seventy-eight percent of outpatient visits took place in the private sector, followed by the NGO sector at 12%, with the public sector accounting for only 9% of all visits.

With regard to hospitalizations, the private sector once again accounts for nearly 86% of all admissions with the public sector accounting for 9%. The public sector fares a little better when it comes to one-day surgery, probably because it both pays for and provides these services in its facilities.

Dental care is almost exclusively the domain of the private sector. This predominance of the private sector in Lebanon makes it clear that any attempt to contain costs and improve efficiency will require the participation and commitment of the private sector. At the same time, meaningful changes in the health system cannot be achieved unless this sector is better managed.
2.4.2 **The hospital sector**

There are in Lebanon a total of 167 hospitals with 11,533 beds. Twelve per cent of the hospitals and ten per cent of the beds are in the public sector. The predominance of the private sector reflects the results of a financing arrangement where the public sector purchases services from the private sector; the lack of coordination on provider payment and rates among public sector payers, and the significant investments made by the private sector in the hospital sector. The private hospital association is a powerful lobby and controlling hospital expenditures has been a policy concern for some years.

Lebanon has 2.88 beds per 1000 population – one of the highest ratios in the Middle East. However, the beds are not uniformly distributed. For example, Mount Lebanon has 6.55 beds per 1000 population and Nabatieh has only 0.86 beds per 1000 population (NHA matrices).

Sixty-seven per cent of hospitals in Lebanon have 70 beds or fewer, 30% have between 71 and 200 beds, and only 3% have more than 200 beds. All of the hospitals with over two hundred beds are in the private sector.

The high percentage of hospitals with fewer than 70 beds – and the fact that they tend to be multispecialty facilities – make it difficult to achieve economies of scale. This leads to inefficiencies. Quality of care and financial viability in these facilities also remains a concern.

According to the Syndicate of Private Hospitals, there were 139 private hospitals in 1999 with 8297 medium stay active beds. All 14 of the private hospitals in the country with 100 to 200 beds and all 4 with 200 beds or more are concentrated in Beirut and its suburbs. A low occupancy rate adds to size inefficiency. Occupancy rates are low (59% in 1998, according to Ministry of Health sources), much below OECD norms of 80–85% needed to maximize economies of scale (girgis, 1994).

In this respect, it should be noted that the size of the hospital correlates not only with efficiency but also with the quality and cost of medical care, since larger hospitals can attract larger volumes of patients, hence improving the capabilities of the medical team and reducing the cost.

The growth of private hospitals was phenomenal during the civil war. It has been reported that close to 60% of the private hospitals were established during the war years. This expansion has been fuelled through the financing of medical care by the public funding agencies, mainly the MOH.
In terms of active beds in the public sector, there are a total of 810 beds in the 15 public hospitals that exist in various parts of the country. The average number of beds per hospital is 54, close to the average in private hospitals. There is only one hospital with 150 active beds and the numbers of beds in the remaining ones vary between 15 and 81.

The emphasis here is somewhat reversed and concentrated on the areas where the private sector has been deficient. The concentration of hospital beds in relation to population is in the needy areas of the Bekaa and the South. The North, however, remains highly neglected by the private sector and relatively neglected by the public sector.

In addition to the above, there are some 19 hospitals with 3478 long-stay beds (1998) catering basically to old-age and disabled persons (Syndicate of Private Hospitals). These hospitals receive an annual contribution from the Ministry of Public Health depending on the number of beds and the type of sickness of the patients (old age disability, mental disability, etc.). Payment is predominantly on a per diem basis.

After the end of the civil disturbances, the Government proceeded a to rehabilitate the existing public hospitals and build new ones. From 15 public hospitals with 810 beds, the number will increase to 28 hospitals with nearly 2900 beds. It should be noted that an additional 2100 beds will be added very soon to the public hospital system and that another 1000 beds are currently being commissioned in the private sector. A total of approximately 3000 new hospital beds will strengthen the Lebanese hospital system, despite the fact that – as mentioned previously – existing hospitals are currently occupied at less than 60%.

An attempt in 1978 was made to make public hospitals autonomous. The law was revised in July 1996 (Law 544/96; Law 602/97) and is currently being applied in some of the newly built public hospitals such as Nabatieh, Dahr El Bachek, and Tannourine. The driving force behind autonomy lies in promoting the efficiency of the public hospital.

It is anticipated that the Ministry of Health will contract with public hospitals in much the same manner as it does with private hospitals. In this manner, public hospitals could retrieve their operating costs through contracts with the MOH, the public agencies and private insurance, much as the private hospitals do at this time (the co-payment by the patient will be reduced to 5% instead of 15%).

It appears that public hospitals are also favouring inpatient care that is reimbursed by the Ministry of Health, thus behaving much like a private hospital. Patients, physicians, and hospitals seem to opt for hospitalization since it is covered by the MOH.
For the first time, as part of the National Health Accounts activity, a sample of hospital bills paid by Government agencies was analysed to achieve a better understanding of their breakdown. Seventy-three per cent of the reimbursements for hospital care by the Ministry of Health was spent on surgical care and the remaining 23% was for non-surgical care. The Coop spent 59% of its hospital reimbursements for surgical care, the ISF 53%, the army 51%, and the NSSF 60% (NHA Spreadsheets). This distribution probably reflects the fact that the Ministry of Health is the insurer of last resort and hence tends to pay more for inpatient admissions. With regard to the other agencies, hospitalization costs are part of the benefits available to their beneficiaries.

Hospitalization rates hovered around 7% among the population in 1984 (Beirut 1984-AUB). The household survey completed in March 2000 documented that the overall hospitalization rate was then 12% per year (1.5% of the population had more than one hospitalization per year). As expected, in the age group above 60 years it was 28%, with 4.5% having more than one episode per year.

Hospitalization episodes did not vary significantly among the regions. Hospitalization (once per year and more than once per year) was more frequent among lower income groups: 10.5% and 3.1% for households earning less than 300 000 LL per month, versus 7.8% and 2.2% for households earning more than 5 million LL per month. Evidently, hospitalization rates varied between the insured and the non-insured, 10% versus 8 % for one admission per year and 1.6 % versus 1.2% for those admitted more than once per year. Hospitalization for one day (day surgery, etc.) had similar frequencies across regions, income groups, age, and insurance status.

**2.4.3 The health centres and ambulatory services**

The primary health care system has remained weak. The nongovernmental sector, especially NGOs, dominates this sector; public involvement is minimal. Private providers include private practitioners, dentists, pharmacists, and medical laboratories. NGOs own over 80% of the 110 primary health care centres and 734 dispensaries spread across the country. NGOs have contributed successfully to joint preventive programmes carried out by the MOH and United Nations Agencies.

As an example, many centres owned and operated by NGOs are affiliated with the reproductive health programme, undertake family planning activities, and provide antenatal care. NGOs also support the health system by conducting surveys and training programmes and provide logistical support by purchasing and distributing essential drugs through a vast network of PHC centres (UNDP, 1997). Ambulatory services tend to respond to consumer demand. Follow-up and continuum of care remain weak, quality of care varies significantly across providers, and community involvement is limited.
LONG-TERM CARE

The Ministry of Public Health provides some health services in public hospitals and in a number of public health centres. The Ministry of Social Affairs (MOSA) also provides the health assistance at public social centres mentioned earlier, including curative and preventive health care services, vaccinations, primary health care, reproductive health services for mothers and children, advice on reproductive health, and a set of services aimed at the disabled population.

MOSA also assists a number of centres belonging to not-for-profit and nongovernmental organizations (NFP/NGO) that include health services among their activities. Operating in various parts of the country, some of these centres function properly and others poorly (Van Lerbergh et al., 1997).

No thorough survey of these centres has been made, so little is known about their effectiveness. Nevertheless, the decline in international donations has forced many of these centres to operate in a way not very dissimilar from the operation of private clinics—charging the patients for the services of the doctor and those of the centre itself (Van Lerbergh et al., 1997) (Tabbara, 2000).

Table 3. Distribution of outpatient facilities by region and ownership of facilities

<table>
<thead>
<tr>
<th>Mohafazat</th>
<th>MOH</th>
<th>MOSA</th>
<th>Red Cross</th>
<th>Municipalities</th>
<th>NGO</th>
<th>Closed</th>
<th>Total open</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beirut</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Mount Lebanon</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>17</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>South Lebanon</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>North Lebanon</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>1</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Bekaa</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>2</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>22*</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>68</td>
<td>6</td>
<td>98</td>
</tr>
</tbody>
</table>

*According to MOPH, in 1999 these total 28, including 4-6 that are expected to open during 2000.

Source: The World Bank (1999b)
CASE-STUDY: LEBANON

All in all, there are some 700 health centres and clinics in the country (Khoury G., 1999), but the number of persons covered by their services remains limited in relation to the national health system. However, the concentration of the centres in disadvantaged areas makes their importance in the health system greater than their number or their coverage.

In this context, it should be mentioned that health care, primarily outpatient services, witnessed a major boost during the difficult years of the war. Political, religious and community groups established clinics, dispensaries and health centres to cater to the needs of their respective populations. Health care became an effective tool to promote the image of these various groups.

Before the war, during the period 1958-75, the Office of Social Development (later to become the Ministry of Social Affairs) also encouraged the development of comprehensive health centres, based on community organization, participation and partial funding. The concept and programmes of primary health care were promoted well in advance of the Alma Ata declaration and the worldwide movement for PHC and Health for All.

The Ministry of Health has embarked on a programme to refurbish its network of health centres and build additional ones. The health sector rehabilitation programme (World Bank-MOH, 2000) has also established several task forces and programmes to promote ambulatory care, empower communities, train PHC professionals and Qada (district) physicians, introduce technology and rehabilitate health centres in both the public and NGO sectors.

Utilization of the health centres has been low. Private clinics have been the main outlet for ambulatory care for 85% of patients in Beirut (Beirut 1984) and for 79% of patients in all of Lebanon. Hospital outpatient departments were the venue for 8% of this care, NGO clinics for 10%, and other facilities for 3%. Only 20% of households had a family physician to care for their health concerns on an ongoing basis.

Reimbursement of the cost of ambulatory services in effect lies with the various public agencies, except for the Ministry of Health (MOH offers care at no or minimal cost within its own network). However, because the patient must pay first and be reimbursed afterwards, there is evidence that many prefer not to go through the process of reimbursement – which is considered tedious and time-consuming.
LONG-TERM CARE

2.4.4 The pharmaceutical sector

In 1998, pharmaceuticals expenditure accounted for over 25% of total health expenditures. Considerable uncertainty exists about the size and composition of the pharmaceutical sector in Lebanon. Of pharmaceuticals sold in Lebanon, 98% are trade names and generics account for only 2%. Imported drugs account for 94% of consumption with locally manufactured drugs making up only 6% of consumption (some studies and estimates put this as high as 14%).

Thus, Lebanon has not only high per capita expenditures on pharmaceuticals (US$120) but almost all of the drugs are trade name products that are imported into the country. Expenditures on pharmaceuticals have been increasing at 7% per annum – a figure that is higher than the rate of inflation. Household out-of-pocket expenditures account for 94% of spending on pharmaceuticals.

The growth in expenditures on pharmaceuticals has been accompanied by a rapid increase in the number of pharmacies in Lebanon. Between 1995 and 1999 that number rose by 59% and the number of registered pharmacists grew by 34%. In North Lebanon the number of pharmacies nearly doubled, in Bekaa the increase was 73%, in Mount Lebanon 55%, and even in Beirut there was an increase of 28% (NHA matrices).

2.5 Human resources and training

Table 4. Manpower and physical resources indicators (year 2000)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Per 10 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>29.2</td>
</tr>
<tr>
<td>Dentist</td>
<td>10.4</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>6.5</td>
</tr>
<tr>
<td>Nursing &amp; midwifery personnel</td>
<td>11.9</td>
</tr>
<tr>
<td>Hospital beds</td>
<td>30.7</td>
</tr>
<tr>
<td>PHC units &amp; centres</td>
<td>6.9</td>
</tr>
</tbody>
</table>
2.5.1 Physicians

The plethora of physicians in Lebanon has been an important issue for the medical profession for the past two decades. It has been exacerbated only in the past few years.

Lebanon had 14 new registered physicians in the ten-year period from 1931–40. There were a total of 800 physicians in 1946. With the rest of the world, the number of physicians continued to increase at a very rapid rate. Yet even in the decade 1961–70, there was an average yearly increase of physicians of only about 100.

In the last three decades, the annual rate of entry of new physicians into the market has been in the range of 500–700. The increase in the number of registered physicians in the past eight years alone (4918) has been close to the total pool of registered physicians in 1980 (5141).

Until the late 1970s, most physicians practising in Lebanon were graduates of the two medical schools that existed then in Lebanon, namely the American University of Beirut and the Saint Joseph University. A relatively small percentage of physicians had completed their medical education in Western Europe, mainly France.

In 1999, the graduates of Lebanese universities made up only 39% of the total pool and of the new yearly inflow. Graduates from countries in the former Soviet Bloc constituted in 1999 some 28% of the total pool and 36% of the new inflow. These graduates had received fellowships and grants to study abroad during the past three decades. Lebanese physicians who had graduated from Arab countries made up 12% of the existing pool; yet their annual increase seems to have declined (unpublished data from Beirut Order of Physicians).

The quality of doctors varies greatly from very competent to poorly trained. Generally speaking, physicians trained in Eastern European countries, including Russia, are less qualified than those trained in Lebanon, Western Europe, or the United States, as is evidenced by the degree of success in passing the colloquium examination. Lebanese ‘Foreign Medical Graduates’ are likely in the near future to outnumber physicians educated in Lebanon; it is believed that this will impact (adversely) on the character of the profession.

In mid-1999, it was estimated that the number of physicians registered in Lebanon was 8934. To this number should be added those who are (illegally) practising but not registered with either one of the two Orders of Physicians (Beirut and Tripoli). However, there are also a number of doctors who are registered but not practicing, mostly because they are working outside the country.
LONG-TERM CARE

The estimated ratio of physicians to population would thus be approximately one physician per 450 persons. In 1997, 22.1% of the pool of registered physicians were women (as compared to only 6.9% in 1946). There are two orders of physicians in Lebanon: The Order of Lebanon based in Beirut for all the country except the Mohafazat of North Lebanon (7900 registered physicians), and the Order of Physicians of the North (1069 MDs).

In the National Provider survey, released in March 2000, and financed by the MOH/World Bank/WHO, 46% of the physicians in the sample could not be contacted; of the 54% with whom contacts were established by the survey, 12% were not practicing in Lebanon. The degree of correspondence between the information available in the registries and that obtained in the survey varied to a degree between 80-85%.

Although this does not render meaningless the high number of registered physicians in Lebanon, this information indicates that the number of physicians actually practising in Lebanon may not be that high and highlights the importance of an updated database for decision-making. It is an established fact that large numbers of physicians register with the Ministry of Health (to obtain their licence) and with the Order of Physicians (to complete the practice requirements), but then elect to emigrate.

In two studies by Kronfol in 1979, only 34% of medical graduates of the American University of Beirut between 1935–1974 (40 years) were practising in Lebanon. In a follow up of that study, in 1987, only 16% of the 1960–69 medical graduates were practising in Lebanon. There is no established mechanism to update the records of physicians.

Importantly, what is clear is that there is a discrepancy in the distribution of physicians across regions, with a concentration in the Greater Beirut area. The distribution of doctors by Mohafazat is uneven, the main concentration being in the Beirut area. In November 1999, there was one registered doctor per 125 persons in Beirut as opposed to one per 417 persons in Mount Lebanon and one per 665 persons in the Bekaa.

Around 70% of physicians registered in the Beirut Order of Physicians (which includes 88% of total registered physicians) are specialists and only 30% are in the field of general or family medicine. The ratio of specialists to generalists has been increasing. In 1990, for example, the proportion of specialists was 61% of the total.
Policies should be devised to control both the quantity and quality of physicians. The level of the Colloquium should be maintained at high standards. There have been calls, particularly from the Order of Physicians, to stop the licensing of new schools of medicine and impose quotas on entrants into the existing schools.

But direct Government intervention in determining the supply of doctors is said to run into conflict with private education and the prerogatives of the private educational sector. In May 2000, licences were granted to two additional medical schools in the country: The Lebanese-American University (affiliated with the Baylor College of Medicine in Houston, Texas) and the Balamand University.

The majority of physicians practise independently and are compensated on a fee-for-service modality. The overabundance of physicians may be a factor that assists the acceptance of prepayment, capitation or employment (salaried). Similarly, the grouping of physicians into group practice schemes such as Preferred Physician Providers Group (PPPG) is likely to be more acceptable.

2.5.2 Dentists

Dentists face almost the same situation as the physicians in Lebanon. It is reported that there are currently 3471 dentists registered in the Order of Dentists of Lebanon and another 400 registered in the Order of dentists of North Lebanon (The Order of Dentists was established in 1949 but split in 1966 (Al Mustaqbal, Jan 2000)

There is a concentration of dentists in Beirut and Mount Lebanon. This is believed to be due to the effective economic demand for dental care in the more affluent regions of the country. One must remember that dental care does not have as extensive a coverage by funding agencies as medical care.

2.5.3 Nurses and paramedical personnel

The ratio of nurses to population is very low. In 1997, there were 754 nurse graduates with an undergraduate degree, 437 nurses with a “Technique Supérieure (TS)” degree, 757 ‘Baccalaureat Technique (BT)’ nurses, and 1505 nurse's aids – a total of 3453 nursing personnel (Awar, Choujaa, Papagallo, 1999).

---

6 This unpublished report, prepared by these three professionals within the World Bank-MOH Health System Rehabilitation Project, concerns the data available on health manpower, primarily nursing.
The ratio of population to qualified nurses is 1600 persons for each qualified nurse. This is one of the highest ratios in the world, and is more than ten times that typically found in industrialized countries and some two to three times that found in developing countries.

The ratio of hospital beds to nurses is 4.5 beds per nurse, which compares with a ratio of between less than 1 and 2.5 beds per nurse in most Western European countries (Tabbara, 2000). As a result of this shortage, use of nursing aids and on-the-job trained nurses aids in place of nurses has become quite common in most hospitals. The quality of service in hospitals is certainly affected by this situation.

The Lebanese University has been active in the field of nursing. The School of Public Health graduates about 80–100 BSc nurses every year in its five branches, throughout the country. In addition, schools of nursing have been in existence since the turn of the century at the American University of Beirut and the Saint Joseph University. The latter has also established a graduate degree programme (MSc).

Recently, the Balamand University has established an undergraduate nursing programme. Nursing institutes exist all over the country to prepare technical nurses at the BT and TS levels. Other nursing programmes are hospital-based. Recently, a total number of 59 institutes have been involved in the preparation of nursing personnel.

The heterogeneity of nursing education and practice has undermined efforts to ‘professionalize’ nursing. It has also impeded legislation concerning the formation of an Order for Nurses in Lebanon. A preparatory committee for the establishment of an order or an association has been in existence for the past fifteen years. It has lobbied Parliament and Government, so far without success.

It has only recently been announced that a Project Law has been submitted to Parliament to authorize an Order for professional nurses. Reform activities at the Ministry of Health include a major component for the development of the nursing profession, financed by the Italian, Swedish, and Spanish protocols of cooperation with Lebanon.
Summary of LTC provision

As an introduction to the issue of long-term care for the disabled and elderly, it is important to note that the informal support system plays the predominant caregiving role for disabled individuals in Lebanon, with family members being the primary caregivers. This has not changed, even though far more women participate in the labour force.

The family and extended support system remains strong. It should be noted, however, that hospital care for the elderly population and the disabled is primarily supported by governmental providers, unlike the ambulatory and outpatient services (including pharmaceuticals) that remain basically an out-of-pocket expenditure.

It is unlikely that these trends will change in the near future. Certainly, when a person in need of LTC becomes very disabled and family members can no longer provide needed care, the formal support system must intervene. However, the informal support system will remain the primary source of care, because of the continuing strength of the family and the community and its willingness to support its senior members.

History of care for the disabled in Lebanon

Long-term care and rehabilitation efforts were initiated in Lebanon at the turn of the twentieth century, as social concerns were raised about the plight of the blind, the deaf, and the disabled – developments that began to occur all over the world during this period. In the mid-sixties, these efforts were further accentuated due to the epidemics of poliomyelitis that left many of its victims disabled and in need of care and rehabilitation.

During the first half of the 20th century, efforts were initiated and concerns were raised by non-profit organizations in Lebanon. This was the general picture of medical care during this period. Far more technical and professional input was provided to these health care groups and to the Government by the international organizations, primarily the World Health Organization.

WHO provided training fellowships, courses, and seminars – as well as technical advice and support – for the treatment and care of these population groups. Physicians, nurses, technicians, equipment (prostheses) technicians were trained and workshops were established. Community support and public awareness rose after Lebanon’s independence, particularly with the enactment of the labour laws in the early ‘sixties, which paid special attention to the employment of people with special needs.
LONG-TERM CARE

The civil disturbances during the period 1975 through 1990 curtailed these developments as Lebanon entered a state of siege. Moreover, the plight of the injured and those disabled by the civil disturbances raised the concerns of the general public, individual local communities and the Government. 1980 was announced as the “Year of the Disabled” by the United Nations: this provided impetus to social and governmental efforts to develop the infrastructure to care for those in need of LTC.

In 1973, prior to the civil disturbances, the National Committee for the Support of the Handicapped was established in Lebanon. Its mandate was to study the causes of disabilities, the ways and means of prevention, and the availability of medical and social assistance. This Committee included most of the organizations and groups interested in the care of people with special needs. Among its responsibilities, the Commission legislated the definition of the status of the disabled (both mental and physical) and focused on insuring the livelihood of this population.

Efforts to support and further develop care for the disabled were expanded by the World Rehabilitation Fund in Lebanon, immediately after the end of the civil disturbances in 1990. Such efforts consisted of training, equipment donation and fellowships for trainers.

In 1992–93, efforts were accelerated by the Ministry of Social Affairs. In 1986, this Ministry had already conducted a national survey to identify the disabled and the causes of their impairments. This survey revealed that Lebanon’s disabled numbered close to 44,000 persons, i.e. a disability rate of 1.54% of the general population. In the same year, Caritas conducted its own survey that identified 106,355 disabled persons in the country: 39% had a physical disability, 15% were hearing and speech impaired, 14% were blind, 8% had amputations; and 24% had mental conditions.

These surveys and studies encouraged the establishment of institutions to care for persons with disabilities. It is believed that up to 60 such institutions and organizations exist in Lebanon, although they vary in their levels of sophistication.

In addition to these facilities, there are some 20 medical specialists in Lebanon for physical medicine and rehabilitation, in addition to the larger group of orthopaedic surgeons, neurologists and rheumatologists. This specialty is also recognized in Lebanon and a national association has been formed recently to promote the interests of the physicians specializing in this field.

Technicians are also educated at technical and university levels. In 1978, legislation was passed that defined educational programme requirements and their duration and content. A licensing examination is also required.
Technicians in prosthetics and orthotics are also active, as are occupational therapists (ergo-therapists).

Community-based rehabilitation services (CBRS) have been successfully implemented in Lebanon in the 1990s, after a timid beginning in the early eighties. These concepts have been supported by the WRF and by WHO. A national registry for the disabled, currently being developed by the Ministry of Social Affairs, is at an advanced stage.

In general, it can be said that both the Ministry of Health and the Ministry of Social Affairs participate in the care of the older and disabled populations. The MOH is far more concerned with medical needs, while the MOSA focuses on support at home and by family members. However, both Ministries work through programmes they develop with nongovernmental, religious organizations. Home care is primarily extended from the primary health care centres and the comprehensive care centres of the MOH and MOSA. In a similar fashion, institutional services are dominated by NGOs and the voluntary private sector that manage the long-term care centres, whether they be medical or social-supportive.

Medical personnel providing LTC are trained and provided by the Ministries and the NGOs. Family members are self-trained or are coached by the health professionals who provide care.

### 3.2 Facilities for the long-term care of patients in Lebanon

In order to provide a clearer picture of LTC in Lebanon, this section attempts to provide more details on the two main types of facility that exist for the long-term care of patients in Lebanon.

- **Long-term or chronic hospitals** are medical facilities that specialize in geriatric care or that specialize in the treatment of patients in need of LTC, such as individuals who are physically or mentally disabled. There are 22 of these facilities, with nearly 5000 beds, located all over the country.

- **Geriatric homes for the elderly population** are facilities for individuals who may still be able to carry on with activities of daily living and for others who may need more assistance. There are also approximately 22 of these facilities.
LONG-TERM CARE

Both of these facilities have been traditionally established, managed, operated and financed by charitable, usually religious, organizations. The Government supports these types of facility. However, whereas the first type is supported by the Ministry of Health, the second type is supported by the Ministry of Social Affairs. Both receive donations, gifts, and financial assistance from individuals and communities. These facilities tend to be actively supported by philanthropists.

The medical facilities, i.e. the long-term chronic hospitals, are usually large facilities. Some have evolved from being facilities to treat tuberculosis (sanatoria) or mental illnesses. They resemble monasteries and religious buildings in their design (dormitories, refectories, etc.), although newer wings have been added and the older ones have been refurbished and upgraded. These facilities are usually located outside the capital, Beirut, or in its immediate suburbs. The Ministry of Health subsidizes these facilities by paying a daily rate for each of its patients. Hence, the income they receive from the Government corresponds to the number of patient-days for individuals in the facility.

Geriatric homes represent a new addition to the social structure. The religious socio-cultural environment used to favour to a greater degree care of the older population in their homes, within their families. The more junior members of extended families almost exclusively provided support. To a large extent, this remains the case. Geriatric homes are needed for older people who may not have progeny or direct relatives to care for them, particularly if they live in the major cities.

As mentioned previously, geriatric homes are established, managed, and operated by charitable, usually religious, organizations. They receive assistance from the Ministry of Social Affairs to continue operations. The community at large also provides financial support to these institutions.

3.3 Provision of medicines

In addition to residential support, the Ministry of Health financially supports patients in need of LTC through the free provision of medicines, particularly the more expensive drugs. These are distributed through the intermediary of the Young Men’s Christian Association (YMCA), one of the larger nongovernmental organizations, to whom a contract has been awarded by the Ministry of Health to distribute medications to patients with chronic illnesses who are in need.

The value of these medications totalled US$18 million in 1999. Such medications are distributed all over the country, through 378 distribution centres. The cost per beneficiary is approximately $10 000 per year and the number of beneficiaries has been estimated at 3500.
4. General questions pertinent to LTC development

4.1 Present and future needs for long-term care

4.1.1 The older population

A major study, commissioned by the Ministry of Social Affairs, and undertaken by Dr Abla Sibai in September 1998, reviewed published and unpublished reports concerning the older population. Further analysis was also undertaken by the Population and Housing Survey conducted by the Ministry in 1996.

The sample survey of this study was a national probability sample covering all regions of Lebanon and consisted of some 70,000 households (10% of the estimated population). The study abstracted the records of all individuals above the age of 60 at the time of the survey.

The following summarizes the main findings concerning this important section of the Lebanese population. It is worth noting that the very old (80 years and above) comprise 10.6% of the old population among males and 12.1% among females. This is in accordance with the literature that asserts that women are expected to live longer than men.

- The subgroup 60–64 years of age

  Men in this age group were in the majority married (91.3%). More than two-thirds were still working (68.3%) and only 11.6% had retired. Almost half had completed only primary education, while 6% had finished university studies. Almost half were employed by others. More than four-fifths of this population group live in an apartment (70% of them actually own their apartments).

  Unlike the men, fewer than two-thirds of women in this age group were still married, and 28% had become widows. Almost 60% were illiterate and slightly over 1% had completed university studies; 90% of the women were housewives. If employed, three-quarters of women tended to be employees of others. Like men, most women lived in apartments that most of them owned.
The subgroup 65–74 years of age

Men were still in their majority married. However, only 43% were still working, while 20% had retired. When working, two thirds were self-employed. Again most men lived in apartments that they owned in entirety.

Fewer than half of women were still married by the age of 75 years. 60% had become widows.

The ‘old-old’: above 80 years of age

Even above 80 years old, two-thirds of men were still married, as compared to only 17% of women. Only 20% were still working, mainly in their own business.

In the national household health survey, 10.5% of individuals in the representative sample were over age 60. This survey was conducted in 1998, and released in December 2000. The proportion of the population above 65 years of age was 7.2%.

Almost one third of those above 60 years of age perceived their health status as poor, as compared to 6.7% for the entire population. It should be cautioned, however, that the percentage of responses characterized as ‘unknown’ in that age group were higher than 40.8%.

This poor perception of wellness was confirmed when nearly 75% of men and 84.2% of women in this age bracket (above 60 years) reported at least one chronic illness.
Two-thirds of the elderly population in Lebanon underwent a physical examination during the year that the survey was completed; almost double the rate of the general population. Most had one because of a health complaint, although 20% were for the purposes of health promotion and illness prevention.

When asked if they experienced problems with activities of daily living, such as difficulties in motion, daily care, daily functions, and depression and pain, responses seem to indicate that the proportion of those reporting problems increases with their age.

However, it is only after the age of 70 years that problems are reported by a significant majority of the population with respect to motion (72%) and in daily functions (77%). There was no reported depression in 42% of the population above 70 years of age, and no difficulty in daily care in close to 60% of respondents.
### Table 6. Problems in daily life

<table>
<thead>
<tr>
<th>Age group</th>
<th>No difficulty in motion</th>
<th>No difficulty in daily care</th>
<th>No difficulty in daily functions</th>
<th>No anxiety or pain</th>
<th>No depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-19</td>
<td>81.9</td>
<td>85.2</td>
<td>80.2</td>
<td>72.1</td>
<td>76.2</td>
</tr>
<tr>
<td>20-24</td>
<td>87</td>
<td>91.6</td>
<td>85.1</td>
<td>72.4</td>
<td>78.3</td>
</tr>
<tr>
<td>25-29</td>
<td>83.7</td>
<td>91</td>
<td>82.5</td>
<td>68.5</td>
<td>73.5</td>
</tr>
<tr>
<td>30-34</td>
<td>83.6</td>
<td>92.5</td>
<td>82.1</td>
<td>63.8</td>
<td>70.4</td>
</tr>
<tr>
<td>35-39</td>
<td>78.4</td>
<td>91.2</td>
<td>76.7</td>
<td>58.9</td>
<td>67.4</td>
</tr>
<tr>
<td>40-44</td>
<td>76.9</td>
<td>90.8</td>
<td>74.4</td>
<td>54.6</td>
<td>65.3</td>
</tr>
<tr>
<td>45-49</td>
<td>72.6</td>
<td>89.9</td>
<td>71.6</td>
<td>48.4</td>
<td>60.6</td>
</tr>
<tr>
<td>50-54</td>
<td>69.6</td>
<td>90.8</td>
<td>68.3</td>
<td>45.4</td>
<td>60</td>
</tr>
<tr>
<td>55-59</td>
<td>65.2</td>
<td>88.1</td>
<td>62.6</td>
<td>44.1</td>
<td>58.5</td>
</tr>
<tr>
<td>60-64</td>
<td>54.9</td>
<td>84.6</td>
<td>56.8</td>
<td>36.6</td>
<td>56.4</td>
</tr>
<tr>
<td>65-69</td>
<td>48.1</td>
<td>79.9</td>
<td>50.7</td>
<td>33</td>
<td>51.3</td>
</tr>
<tr>
<td>70 &amp; above</td>
<td>28.1</td>
<td>59.2</td>
<td>32.3</td>
<td>23.1</td>
<td>42.1</td>
</tr>
<tr>
<td>Unknown</td>
<td>26.1</td>
<td>26.1</td>
<td>26.1</td>
<td>26.1</td>
<td>26.1</td>
</tr>
<tr>
<td>Total</td>
<td>74.5</td>
<td>87.3</td>
<td>73.5</td>
<td>58</td>
<td>67.3</td>
</tr>
</tbody>
</table>

*Source: Household survey 2000*

As shown in Table 7 on the following page, 50% of those aged 60 and over use eyeglasses and 55% use dental prostheses. It is remarkable that only 20% use support for walking, and only 7.5% use a walker.
Table 7. Problems in the elderly population

<table>
<thead>
<tr>
<th></th>
<th>Does not use eye glasses</th>
<th>Does not use dental protheses</th>
<th>Does not use support in walking</th>
<th>Does not use walker</th>
<th>Does not use hearing aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-69</td>
<td>49.8</td>
<td>52.9</td>
<td>88.7</td>
<td>92.8</td>
<td>92.5</td>
</tr>
<tr>
<td>70-79</td>
<td>49.4</td>
<td>35.1</td>
<td>78.3</td>
<td>93.4</td>
<td>92.8</td>
</tr>
<tr>
<td>80+</td>
<td>53.6</td>
<td>32.9</td>
<td>50.6</td>
<td>89.6</td>
<td>91</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>45</td>
<td>81.4</td>
<td>92.6</td>
<td>92.4</td>
</tr>
</tbody>
</table>

*Source: Household survey 2000*

In Lebanon, 43% of those above 60 years of age are insured — the average for the general population. This should not be surprising, since most of the insurance coverage (public providers) cover individuals and dependents, including parents. Some may still be covered because of employment status, as noted earlier.

Close to 84% of men and 91% of women (above 60 years of age) indicated that they had a health problem. However, only 32.6% of men and 39% of women sought care for this health problem, i.e. only 30–40% of this age group had sought attention for a health problem at least once during the preceding month. A small proportion (5.7% of men and 8.9% of women) sought medical care more than once per month for these health problems.

However, it is important to remember that the population above the age of 60 years has a visit rate of 6.2 visits per person per year to an ambulatory health facility, almost double the national average.

The older population had a hospitalization rate of 28%, as compared to the national average of 12%. Men and women had similar rates, although men tended to be hospitalized more than once (4.9% versus 4.1%).
LONG-TERM CARE

The national health household survey attempted to seek information on lifestyles. Smoking was used as one indicator. It was found that 26% of the Lebanese population above the age of 15 years smoked. The population above the age of 60 years tended to have a higher rate of smoking: 30% between the ages of 60-70 years smoked and 16% above the age of 70 smoked (Household survey 2000).

As indicated earlier in the case study, the overall health care bill amounted in 1998 to 2994 billion LL or close to US$2 billion. Of this amount, 1 785 billion LL was spent out-of-pocket, the Ministry of Health spent 311 billion LL, the National Social Security Fund spent 297 billion LL, and all other public funds spent 189 billion LL, while private insurance spent 412 billion LL.

The population over the age of 65 years had a health care bill of 426 billion LL (US$284 million), of which 251 billion LL (US$167 million) was spent out-of-pocket. This sum (426 billion LL), was spent as follows: 199 billion LL by the insured above the age of 65 years, and 228 billion LL by the uninsured in that same age group.

If the National Social Security Fund was to become universal and cover the entire Lebanese population, actuarial studies indicated that the overall health care bill would increase to 3317 billion LL or US$2.211 billion, an increase of 10.6%. The population over the age of 65 years that would now become insured in its totality would be expected to consume 632 billion LL or US$421 million, i.e. about US $1460 per person above the age of 65 years per year, for all medical expenditures.

4.2 Developments in LTC

Services are now being developed to promote home-based care. One example includes private nursing care at home. (Two such agencies that provide nurses for home care have been established in the past two years).

Another example is physiotherapy services at home by trained and licensed physiotherapists who are normally employed in health care facilities and who ‘moonlight’ with additional work in the homes of needy clients. These contacts are developed while the patient is in the hospital, recovering from an orthopaedic condition. The ‘at-home’ physiotherapy service is usually temporary since the physiotherapist trains and teaches family members and the patient to continue exercises on their own.

Considerable interest is also developing in establishing ‘senior citizens villages’, compounds, or even new facilities. These are intended to bring together the elderly in order to combat depression and improve the quality of their lives.
Such facilities may be residential or clubs used by the individual during the day. The real issue in the development of LTC lies in the formulation of national policies for the provision and financing of LTC that is separate and well demarcated from the general health care and social services. Currently, LTC remains a component of care not targeted per se.

As noted earlier, LTC remains a component of the health care and social systems. A major breakthrough is likely to come when Parliament amends the terms of the National Social Security Fund that would provide for the care of the older population (i.e. after 65 years of age). To date, this coverage has been provided for former salaried persons. An amendment to that effect has been proposed and is currently being discussed in commissions in view of the increased financial provisions.

4.3 Major constraints to development of health care and LTC, and recommendations for future policy development

4.3.1 Sustainability

Lebanon spends approximately 12% of its GDP on health care services. The poor performance of the economy, high net public debt, and recently introduced higher pay scales for public sector employees are all bound to put increasing pressure on the Government budget.

While important health problems are still related to infectious diseases, chronic and degenerative diseases are becoming more prevalent. The causes for this are the ageing of the population, changing dietary habits, changes in lifestyle concomitant with urbanization, and issues such as diabetes and hypertension.

Unless there are significant gains in the country’s economic performance, the current pattern of health care expenditures (as a percentage of GDP) will cause a significant strain on scarce health resources. In the long-term, this will likely adversely affect the current level and quality of services provided unless there are significant reforms in the system.

4.3.2 Cost containment

In the Lebanese health care system, financing and provision functions are separated but without effective supply side controls to contain costs. Public financing agencies purchase health services from the private sector. Private sector providers are reimbursed using a combination of capitation and fee-per-service based methods, which may provide them with an incentive to provide unnecessary services. The most expensive health services (cancer treatment, dialysis, kidney transplants, open heart surgery, chronic diseases treatment, and burn treatment) are provided either free or for a minimal co-payment by Government agencies.
LONG-TERM CARE

The Ministry of Health also pays for hospitalization costs of all uninsured persons, and it is possible that private insurance shifts the burden of high cost services to the Ministry. All of these factors contribute to cost escalation. Provider payment reforms are key to cost containment. In this regard, the Ministry of Health began implementing a flat rate system for same day surgical procedures in May 1998. An analysis conducted on the potential impact of extending this system to other surgical procedures indicated that this might lead to lower costs.

Each of the principal financing intermediaries has a separate supervising Ministry (Ammar et al., 1999). This makes inter-agency coordination difficult. At a minimum, consideration should be given to setting up an institution that can coordinate payments, monitor utilization, and oversee providers across the different public financing agencies.

Centralized budgeting and managerial controls extend little authority and discretion to managers of public facilities. Hence, managers are provided with few incentives to engage in cost containment efforts. The Ministry of Health has initiated efforts to make its hospitals autonomous. This effort needs to be strengthened and expanded.

4.3.3 Rationalizing capacity in the hospital sector

The Lebanon NHA findings draw attention to the fact that 62% of public expenditures are spent on hospital care. Indiscriminate capital investment in the private hospital sector and little regulation has resulted in a surge in the number of private hospitals. With 2.88 beds per 1000 population Lebanon has the highest ratio of bed to population among MENA countries participating in the regional NHA initiative. However, 67% of these beds are in hospitals with less than 70 beds. This coupled with the multi-specialty nature of these facilities leads to inefficiencies. Quality of care and financial viability of many of these facilities remains a concern.

4.3.4 Reallocating expenditures from curative to primary health care

Under the present breakdown of expenditures, less than 10% of resources are allocated to primary health care. Not only are few resources spent on primary and preventive health care services, it appears NGO and public systems do not have the capacity to fully utilize these resources. Investments in preventive measures (including changes in lifestyle) are likely to result in substantially limiting curative expenditures in the future.

In the wake of the rapid expansion of the curative sector, the primary health care sector has languished. There is a need to both strengthen the capacity of the system to deliver primary health care services, as well as increase funding for these services.
4.3.5 Controlling capital investment in medical technology

The Lebanon NHA study reiterates previous findings that Government reimbursements for high cost services have resulted in a rapid growth of high technology centres. This in turn has contributed to cost escalation. For example, as the number of centres capable of doing open-heart surgeries grew from three to eight, the number of surgeries performed increased from 600 to 1800 and expenditures rose from 8 billion LL to 25 billion LL.

The Ministry of Health spends about 75% of its budget for curative care in the private sector. For efforts at cost containment to be effective, policies need to be developed that will control investments in medical technology.

4.3.6 Rationalizing expenditures on pharmaceuticals

As mentioned before, pharmaceuticals accounted for over 25% of total health expenditures. Ninety-eight percent of the pharmaceuticals sold in Lebanon are trade names with generics accounting for only 2%. Imported drugs account for 94% of consumption with locally manufactured drugs making up only 6%.

Thus expenditures on pharmaceuticals have been increasing at 7% per annum – a figure that is higher than the rate of inflation. Between 1995 and 1998 the number of pharmacies grew by 59% and the number of registered pharmacists grew by 34%. Further, we saw that estimates of the total size of the market vary significantly.

While some of this might be explained by the fact that households might be over reporting expenditures on drugs, there exists the possibility that drugs are either making their way into the country bypassing official channels or there is some double billing that is occurring. The high level of expenditures is also likely due to the lack of a significant policy for using generic drugs as substitutes for equivalent higher-priced prescription drugs.

Hence, to effectively contain overall health care expenditures, the Government of Lebanon should initiate policies for improving the efficiency of the system by which pharmaceuticals are imported, distributed, and sold in the country and improve its management and oversight of this sector.

4.3.7 Expanding health insurance coverage to the uninsured and limiting multiple coverage

In Lebanon health insurance is linked with employment and those in low-income households are less likely to be employed in the formal sector. Further, the presence of multiple-insurance coverage also allows for inefficiencies, double dipping, overconsumption of health services and cost escalation.
LONG-TERM CARE

It is very difficult to obtain information from private insurance companies on premiums, claims, loss ratios, and profits. The Government needs to improve its management of the private insurance market and reduce multiple-insurance coverage if it wants to control health care costs.

4.3.8 Equity

Household out-of-pocket expenditures account for 69% of health expenditures in Lebanon (National Health Accounts Study). The household survey shows that there do not appear to be inequities in access to health care. Lower income households tend to use more health care per capita than higher income households. It is only with regard to dental care that we observe inequities in access.

However, when one analyzes the burden of out-of-pocket expenditures it is appears that the burden is inequitably distributed – with lower-income households spending a much greater proportion of their incomes on health than higher income households. Even though the Ministry of Health – as the insurer of last resort – pays for hospitalization costs for all insured and uninsured (including those with low incomes), there is no formal financing mechanism for primary and preventive health services.

As part of the reform in health financing, the Government might want to consider designing a targeted programme to provide quality basic health services for those with low incomes.
Bibliography


Presentation on the Health Care System of Lebanon by Dr Riad Tabbarah (2000).

Ministry of Health reports.

Ministry of Social Affairs reports.

Dr Nabil Kronfol’s database on Lebanon.
ACHIEVING COORDINATED AND INTEGRATED CARE AMONG LTC SERVICES: THE ROLE OF CARE MANAGEMENT

Professor David Challis
University of Manchester
United Kingdom
1 General background data

1.1 Preamble

The Republic of Lithuania is situated on the east coast of the Baltic Sea. It is bordered by Belarus to the east, Latvia to the north, and Poland and the Russian Federation’s Kaliningrad enclave to the south. The capital, Vilnius, has a population of 580,000. In March 1990, Lithuania regained its independence from the USSR, and in September 1991 became a member of the United Nations.

A single chamber Parliament (Seimas) elected for a four-year term and a president elected for five years govern Lithuania. The country is administratively divided into ten districts, each of which is headed by a centrally appointed district governor. The districts are essentially administrative tiers of the central government with certain responsibilities in health and social care. There are additionally 56 local governments or municipalities, each with its municipal council, elected every three years (Lithuanian Health Programme, 1998).

The health care system in Lithuania has been in the process of a shift away from an integrated model towards a contract model of care. Significant changes in the system have been prompted by two major events: the appearance of a state health insurance system and enforcement of legislation redefining property rights and the status of health care institutions.

In Lithuania, the middle-aged population’s longer average lifespan, and the progress in the field of medicine – which enables many people to survive following complicated illnesses and accidents – have greatly contributed to an increasing number of disabled and older people who have difficulty caring for themselves. Additionally, the low fertility rate in the country, 1.3 children born per woman, has also been a prime factor leading to ageing of the population. Currently, the disabled comprise 10%, and persons over 65 years of age 13.4%, of the total population. In terms of the informal care system, it is important to note that despite a recent increase in support for caring activities by governmental and nongovernmental organizations (e.g. Caritas and the Red Cross), most care provided for the disabled and elderly is still carried out by family, neighbours, friends, and volunteers.
LONG-TERM CARE

However, demographic changes (e.g. the rapid ageing of the population) and employment changes (e.g. the increase in the percentage of women in the labour force) will make it increasingly difficult for the informal care system to continue to carry such a high burden of caring responsibilities for the disabled and elderly.

Migration from rural to urban areas in Lithuania has also become an important LTC issue in Lithuania. First, with the migration of young individuals from rural areas to Lithuania’s cities, there has been a reduction in the number of people in rural areas able to provide informal care. Secondly, because of the sudden increase in pre-retirement age employable individuals in urban areas, it is more difficult for young people in urban areas to find jobs. This has not only caused problems on the job market, but it has also encouraged elements of the young, urban population to seek the status of disabled in order to receive benefits from the Government. These factors demonstrate the growing long-term care needs in the country. This case study will attempt to look at the needs for LTC in Lithuania in more detail and will describe the health and social system currently in place. It is as yet unknown how the health and social systems will respond to the growth in needs and if this response will be adequate.

2 General health, social and LTC system

2.1 Basic income maintenance programmes

In Lithuania, all disabled and elderly people receive a disability or old-age pension. However, it should be emphasized that these pensions are insufficient to maintain reasonable living standards.

2.2 Organizational structure of decision-making

The Ministry of Health is responsible for the entire health care system policy. It is actively involved in drafting legal directives and issuing the consequent regulations for the sector. The Ministry of Health also has overall responsibility for the public health system’s performance. Through the State Public Health Centre it manages the public health network including ten country public health centres with their local branches (in total, 50 institutions). The State Public Health Centre has subordinate bodies, which deal with prevention of communicable diseases, health education and other public health functions. Presented on the following three pages are background data on Lithuania, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

1 For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); US Bureau of the Census, International Data Base; WHO, World Health Report 2001; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.
## Demography (year 2000)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands)</td>
<td>3,696</td>
</tr>
<tr>
<td>Land area (sq km)</td>
<td>65,200</td>
</tr>
<tr>
<td>Population density (per sq km)</td>
<td>57</td>
</tr>
<tr>
<td>Population growth rate (% 2000-2005)</td>
<td>0</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>68</td>
</tr>
<tr>
<td>Ethnic groups (%)</td>
<td></td>
</tr>
<tr>
<td>Lithuanian</td>
<td>80.6</td>
</tr>
<tr>
<td>Russian</td>
<td>8.7</td>
</tr>
<tr>
<td>Polish</td>
<td>7.0</td>
</tr>
<tr>
<td>Byelorussian</td>
<td>1.6</td>
</tr>
<tr>
<td>Other</td>
<td>2.1</td>
</tr>
<tr>
<td>Religions</td>
<td></td>
</tr>
<tr>
<td>Roman Catholic (primarily), Lutheran, Russian Orthodox, Protestant, Evangelical Christian Baptist, Muslim, Jewish</td>
<td></td>
</tr>
<tr>
<td>Total adult literacy rate (% in 1997)</td>
<td>100</td>
</tr>
<tr>
<td>Age Structure (%)</td>
<td></td>
</tr>
<tr>
<td>0–14</td>
<td>19.4</td>
</tr>
<tr>
<td>15–24</td>
<td>14.4</td>
</tr>
<tr>
<td>60+</td>
<td>18.6</td>
</tr>
<tr>
<td>65+</td>
<td>13.4</td>
</tr>
<tr>
<td>80+</td>
<td>2.4</td>
</tr>
</tbody>
</table>
### Demography (continued)

#### Projections 65+ (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>19.7</td>
</tr>
<tr>
<td>2050</td>
<td>28.8</td>
</tr>
</tbody>
</table>

#### Sex ratio (males per female)

<table>
<thead>
<tr>
<th>Category</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>0.88</td>
</tr>
<tr>
<td>15-64</td>
<td>0.94</td>
</tr>
<tr>
<td>65+</td>
<td>0.51</td>
</tr>
</tbody>
</table>

#### Dependency Ratio:

- Elderly dependency ratio in 2000\(^2\): 22.4
- Elderly dependency ratio in 2025: 31.5

### Vital statistics and epidemiology

#### Crude birth rate (per 1000 population) (2000)

- 8.8

#### Crude death rate (per 1000 population) (2001)

- 11.2

#### Mortality under age 5 (per 1000 births) (2001)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>males</td>
<td>10.0</td>
</tr>
<tr>
<td>females</td>
<td>10.0</td>
</tr>
</tbody>
</table>

#### Probability of dying between 15–59 (per 1000) (2001)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>males</td>
<td>270</td>
</tr>
<tr>
<td>females</td>
<td>96</td>
</tr>
</tbody>
</table>

---

\(^2\) Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

\(^3\) Parent support ratio: the ratio of those age 80 and over per 100 persons age 50–64.
### Vital statistics and epidemiology (continued)

- **Maternal mortality rate** (per 100,000 live births) (1995) - 27
- **Total fertility rate** (children born/woman) (2001) - 1.3
- **Estimated number of adults living with HIV/AIDS** (2001) - 1300
- **HIV/AIDS adult prevalence rate** - 0.1
- **Estimated number of children living with HIV/AIDS** (2001) - <100
- **Estimated number of deaths due to AIDS** (2001) - <100
- **Life expectancy at birth** (years) (2001)
  - Total Population: 72.9
  - Male: 67.7
  - Female: 77.9
- **Life expectancy at age 60 (years)** (2000)
  - Total Population: 20.0
  - Male: 17.0
  - Female: 22.0
- **Healthy life expectancy (HALE) at birth (years)** (2001)
  - Total Population: 61.1
  - Male: 56.9
  - Female: 65.4
- **Healthy life expectancy (HALE) at age 60** (2001)
  - Total Population: 12.9
  - Male: 11.0
  - Female: 14.8
The Ministry of Health develops a public health care infrastructure by establishing state programmes aimed at the achievement of key health targets (including those detailed in the National Health Programme) and by making decisions together with the Ministries of Economy and Finance, on major investment projects. Regulation and control of worker safety are the responsibility of the Ministry of Social Security and Labour, while the Ministry of Health is in charge of the performance of occupational health care providers.

### Economic data (year 2000)

<table>
<thead>
<tr>
<th>GDP – composition by sector (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>10</td>
</tr>
<tr>
<td>Industry</td>
<td>33</td>
</tr>
<tr>
<td>Services</td>
<td>57</td>
</tr>
</tbody>
</table>

| Gross national income (GNI) ($PPP) |  |
|![](https://via.placeholder.com/15x15) | 26 billion |

<table>
<thead>
<tr>
<th>GNI – per capita ($PPP)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6980</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GDP – per capita ($USP)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2930</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GDP growth (annual %) (1999–2000)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.90</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Labour force participation (% in 2000)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>57.2</td>
</tr>
<tr>
<td>Female</td>
<td>47.2</td>
</tr>
</tbody>
</table>

### Health expenditure (year 2000)

<table>
<thead>
<tr>
<th>% of GDP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health expenditure per capita ($PPP)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>420</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health expenditure per capita (US$)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>185</td>
</tr>
</tbody>
</table>

---

4 PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries.
In addition to the national health system, there are two parallel state-run health care systems that account for up to 2% of total public health care expenditure. One is run by the Ministry of Internal Affairs and serves the police and prisons. The other is run by the Ministry of Defence and provides health care services for military personnel. The Ministry of Finance funds health care delivery provided under the supervision of the Ministries of Defence and Internal Affairs.

The Ministry of Social Welfare and Labour is a separate ministry for social services and social service development. Until 1990, the main focus of social care was institutional care for the elderly and the physically and mentally disabled. During the last ten years, the number and variety of public care institutions increased, nongovernmental institutions appeared in the field, and development of non-institutional forms of care also began to receive attention.

In 1998, there were 29 nongovernmental care institutions (of a total of 90) for the elderly. Among voluntary non-governmental organizations, the Red Cross Society, the Caritas Federation, the Diabetic Association, the Association of the Blind and Visually Handicapped, and the Society of Chernobyl Victims have been influential in public debates. The church has a limited role in the health sector. The Roman Catholic Church manages a hospital in Vilnius. In addition, a few rural nursing homes are administered and financed by the Church.

Policy setting (defining priorities and types of services that should be provided) is very centralized. The Ministry of Health decides on the priorities at the national level. At the regional level, each of the ten districts has a district governor who is appointed by the Lithuanian Government and is responsible for implementation of state policy in a number of spheres including health care. The health care function is carried out by the position of District Physician. Some health care providers (district hospitals, specialized health care facilities) are governed by the district administration. Decision-making in regards to this network of providers requires participation of the Ministry of Health. The districts are in charge of implementation of the state health programmes in their respective regions.

Budget allocation in the past was controlled more on the local level. However, after the recent move towards a single payer insurance scheme, changes are developing in the control of health care budgets. This issue will be discussed in more detail in the chapter on the financing of health care in Lithuania. The licensing process has traditionally been centralized, but is moving towards being controlled more at the local level. Price setting is also very centralized. The Ministry of Health has maintained control over this aspect of the system.

In general, it can be said that the system is attempting to decentralize its functioning and control, with more provision responsibilities being allocated to local authorities. However, the results of decentralization will not be clearly evident until after a few years have passed.
LONG-TERM CARE

2.4 Financing and purchasing

Until 1997, the state health care system in Lithuania was mainly funded by taxes, with the majority of financial resources coming from local budgets and the remainder from the national (state) budget. Local budgets were (and still are) comprised of taxes collected within their respective areas (mainly a portion of personal income tax). Some taxes (e.g. property and land taxes) are collected locally. Others are transferred to the central government based on criteria such as local population size and density.

The historic rate of expenditure per capita was also an important criterion. This takes into account the actual social infrastructure within groups of municipalities. In effect, this was a situation somewhere between an incremental historical allocation and a weighted capitation formula. Municipalities decided how much of their annual budget would be spent on health care delivery. Their decision usually reflected previous spending on health care: a system of historical incrementalism. As a result of this financing mechanism, together with the application of a similar mechanism for social insurance funds that paid for rehabilitation institutions and sanatoria, geographical resource allocation was quite unequal.

A state health insurance scheme – the National Medical Social Service – was first implemented in Lithuania in 1991. The Law on State Social Insurance laid the legal foundation for a social insurance system and principles of health insurance, and increased public participation in health care costs. Between 1991 and 1995, the law was limited in scope, covering pharmaceuticals and convalescence costs that were partly reimbursed. A 1994 law on a health protection system defined the role of the state and local governments in health care administration. Laws passed in 1996 on health insurance and health care institutions created the basis for introducing health insurance and the accreditation and legal status of institutions.

National State Insurance was an obligatory, single-insurer scheme. Under this scheme, payments were made to defray expenses of preventive and curative medical treatment. These included reimbursement of the costs of pharmaceuticals prescribed during outpatient treatment, and reimbursement of the costs of sanatorium vouchers. This scheme also reimbursed blood donations and transportation, as well as health care expenses of the disabled. This scheme was administered by the State Social Insurance Council and supervised by a tripartite council consisting of representatives of the Government, the trade unions and employers’ organizations. In 1992, the State Patient Fund, a type of purchasing agency under Ministry of Health supervision was established by the Government, and was financed by the Ministry of Health. Between 1992 and 1996, the State Patient Fund’s role was to finance the current operating costs of health care institutions on the basis of contracts with prospective payments.
During the prolonged process of development of the current Health Insurance Law, various approaches to health insurance, including some of the ideas implemented between 1991 and 1996, as described above, were considered. The idea that prevailed was that of a national insurance scheme, financed through a fund that was separate from the national budget. The Law on Health Insurance was adopted in May 1996 and implemented in 1997, bringing the functions and responsibilities of the State Social Insurance Agency to the Patient Fund, alternatively known as the State Health Insurance Fund, in accordance with the 1996 Law on State Health Insurance. This law established a separate social insurance scheme covering all health care expenditures, to be administered by the State Patient Fund and its ten regional branches, the territorial patient funds (one such fund for each district), constrained by the national budget.

The State Social Insurance Agency is responsible for the provision of pension benefits, as well as maternity and sick leave benefits. In addition, it is responsible for the collection of all social insurance contributions. These contributions finance the three branches of social insurance: pensions, maternity and sick leave benefits; national health insurance administered by the State Patient Fund and the territorial funds; and unemployment benefits administered by the Labour Exchange (UNDP, 1999).

In terms of the sources of funding for the health system in Lithuania, employers transfer a certain percentage of personal income tax and contribute a certain percentage of the payroll tax. Self-employed persons contribute a proportion of their personal income tax. Farmers cover themselves and their adult family members by paying a percentage of their declared income. The exact rate of contribution is set annually by the Parliament. The State covers children up to the age of 18, students, beneficiaries of social assistance and social insurance cash benefits, and persons with certain illnesses. The state budget contributes a per capita payment (annually approved by the Parliament) on their behalf.

**Table 1. National public finance (%)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National budget</td>
<td>100</td>
<td>100</td>
<td>85</td>
<td>83</td>
<td>81</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>State insurance</td>
<td>–</td>
<td>–</td>
<td>15</td>
<td>17</td>
<td>19</td>
<td>84</td>
<td>90</td>
</tr>
</tbody>
</table>

Source: Department of Statistics (European Observatory on Health Care Systems, 2000).
LONG-TERM CARE

Although the main responsibility for payment for health care has been transferred to the State Patient Fund, general taxation also plays a major role in financing social insurance. In 1998, only about 20% of the State Patient Fund revenues were derived from payroll taxes and contributions of self-employed, as shown in Table 2 (European Observatory on Health Care Systems, 2000). The remainder involves deductions from income taxes or state budget transfers. Lithuania has therefore chosen a mixed financing system based on social insurance contributions and taxation. This financing system represents a compromise between the proponents of tax-based and those of insurance-based systems.

Financing of health care through social insurance accelerated dramatically from 1997 following implementation of the health insurance legislation. Yet, since some very important health care functions such as public health, infrastructure investments, national programmes in health protection and acute care, are still financed directly through local and national budgets, some reduction of the share of health insurance in health care financing may be expected in the future.

Table 2. Sources of state health insurance revenue (1998)

<table>
<thead>
<tr>
<th>Source: State Patient Fund Database.</th>
</tr>
</thead>
<tbody>
<tr>
<td>佩洛特·科卡尔</td>
</tr>
</tbody>
</table>

* 1 Lita = 0.25 US$
In designing the new health insurance system, a key concern was to produce an arrangement that would minimize administrative costs. The State Patient Fund is an entity accountable to the Prime Minister, while the Ministry of Health has maintained control of pricing health care services. In addition, it was decided that administrative responsibilities as well as costs related to contribution collection should stay mainly with other agencies (tax inspection and State Social Insurance Agency). The State Patient Fund is therefore responsible only for collection of contributions of the self-employed.

As this is a rather problematic area in emerging market economies, it may be changed in the near future. According to proposals under discussion, collection of contributions of the self-employed should be the responsibility of tax authorities or State Social Insurance Agency.

Table 3 shows the rough structure of total health care finance for 1998, which can be used as an approximation for sources of finance (European Observatory on Health Care Systems, 2000).

<table>
<thead>
<tr>
<th>Million Litas</th>
<th>% of total</th>
<th>% of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public</strong></td>
<td>2078</td>
<td>73.6</td>
</tr>
<tr>
<td><strong>Taxes</strong></td>
<td>209</td>
<td>7.4</td>
</tr>
<tr>
<td><strong>State insurance</strong></td>
<td>1869</td>
<td>66.2</td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td>657</td>
<td>23.2</td>
</tr>
<tr>
<td><strong>External charity</strong></td>
<td>90</td>
<td>3.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2825</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Source: Department of Statistics.*
*Sources of finance are approximated by expenditure figures for each source.*
LONG-TERM CARE

It should be noted that the figure appearing in Table 3 for ‘state insurance’ also includes taxation revenues, which have been allocated to the health insurance system. According to legislation, the Social Health Insurance Fund (SHIF) is independent of the national budget.

The ‘private’ category refers to out-of-pocket expenditures and payment of supplementary (voluntary) health insurance premiums, and amounts to nearly a quarter of the total, while external charity represents just over 3%.

The insurance scheme covers primary care, with the municipalities holding the responsibility for providing this primary health care to their local populations. Since 1997 the funding for hospitals has been by number of patients. Hospitals receive money from regional patient accounts for the number of days allocated for the treatment of a particular disease.

In 1995, changes in regulations were introduced. These regulations concern the reimbursement of registered drugs (by the government) and calculation of their reference prices (in Lithuania these are called ‘basic prices’). The Government reimburses patients for drug purchases.

2.5 Services delivery system

Until 1996, local health care infrastructure was organized and financed in a pyramidal fashion. Municipal hospitals were at the top, below which were specialized local medical institutions and village hospitals, followed by outpatient clinics and, finally, small clinics at the bottom.

The picture of the outpatient institutions network has since changed significantly as a result of the process of separation of facilities (most commonly, outpatient clinic services) from hospitals. Currently, various outpatient models are in use in the municipalities.

A decentralization process that subsumed health care facilities under district or municipality control has been under way since 1997. The municipalities are now responsible for providing primary health care to their local populations. They have been granted ownership for outpatient facilities and nursing homes.

The position of Municipality Physician has been established with supervisory and decision-making authority in the area of primary health care. Moreover, municipalities have a wide range of responsibilities in the implementation of local health programmes and improvement of public health activities.
District authorities currently lack the administrative capacity to adequately operate their care systems. Moreover, because the health system infrastructure was historically developed around the five major cities, different districts have significantly different administrative capabilities. At the same time, municipalities with increasing responsibilities in local health care provision have lost the financial tools that would allow them to implement their decisions as the newly established state health insurance fund assumed responsibility for financing health care.

As mentioned previously, the municipalities are currently responsible for providing primary health care to their local populations. The dominant pattern of primary care provision is through independent doctors and health centres/clinics. Since 1997, the majority of primary care services has been provided by primary health care centres specializing in primary health care provision, as opposed to outpatient clinics, which provide both primary and secondary outpatient services.

Additionally, primary health care services are delivered in primary health care centres, general practitioner’s surgeries, both school and community clinics (paramedical centres), out-patient clinics, women’s consultation clinics, infirmaries, as well as by the ambulance service (stations and divisions). In terms of staffing, it has been agreed that a primary health care team requires the participation of a gynaecologist-obstetrician, surgeon, and a psychiatrist, together with a general practitioner. The nurses in the primary care teams carry out the home health care. There are great disparities between health care provision in urban and rural areas.

In 1997, Lithuanian residents were asked to choose a primary health care facility where they wished to receive primary care. Through the registration process, the outpatient clinics established lists of their catchment populations. At the same time, a major portion of the population had an opportunity to make a choice upon registration of their particular general practitioner, internist or pediatrician. At present, patients have the right to choose any physician employed by the primary health care facility, and to change physicians once a year. In 1998, 92% of the population was registered with a primary health care institution.

Development of the general practitioner gatekeeping function is proclaimed to be an important goal of the new approach to primary health care. Patients require a referral signed by the physician performing the role of their general practitioner in order to receive specialist care. In 1998 more than 20% of consultations with specialists were still provided without referrals. However, this represents a significant improvement over 1996 when 70% of consultations with specialists were provided without referrals. Referrals are also required for planned admissions to hospitals. In the absence of a referral, inpatient services must be paid for out-of-pocket.
Private primary health care is still not very widespread, although there are some private gynaecologists, internists, and most of all dentists. For the most part, private primary care takes the form of single or small group physician-owned practices. In many communities, physicians often lease clinic space from public health care institutions.

There were 566 private dental practices with 1901 employees in 1998. The share of dentists working exclusively as private providers is high (697 dentists or 79% of the total), in contrast to other medical specialties (179 physicians, or less than 26% of total) (Ministry of Health, 1998).

An additional innovation within the primary health care sector involves implementation of the concept of community mental health services. Mental health centres in municipalities are currently in the process of being established. Each of these is to be staffed by a team comprised of three psychiatrists, one clinical psychologist, three mental health nurses, and two social workers.

Paramedical centres or stations are based in rural areas and employ one physician’s assistant and/or one midwife. There are about 1000 such centres in rural Lithuania. They provide some routine health care, first aid in emergencies, home nursing, perinatal obstetric care, and also supply non-prescription drugs. Most of these centres are administratively linked to an out-patient clinic.

An out-patient clinic is a group practice most commonly found in small towns, which is mostly responsible for providing unspecialized primary care. It includes a general practitioner and/or an internist, a midwife, a dentist, and a pediatrician. Currently, there are 226 outpatient clinics in all of Lithuania.

At the present time, some of the physicians working in outpatient clinics participate in general practice retraining programmes, which are provided by municipalities. Under current regulations, catchment populations corresponding to these specialties are as follows: for a general practitioner, 500–2000; for an internist, 500–2000; for a pediatrician, 200–800.

Outpatient clinics in large towns employ 10–20 different kinds of specialist physicians. They are equipped with X-ray equipment, ultrasound scanners and other diagnostic technology. There are approximately 140 such outpatient clinics throughout the country.

They are responsible for almost all primary and secondary outpatient care in the towns where they are based, and secondary out-patient care to the rural population. Recently, outpatient surgery has begun to be offered by larger outpatient clinics.
The medical/social expertise in Lithuania consists of two structural levels. The National Medical Social Expertise Commission and territorial medical social expertise commissions. The territorial commissions generally consist of an internist, a surgeon and a neurologist and function in all district centres and major towns; in addition, ophthalmologic and psychiatric territorial commissions operate in Vilnius and Kaunas. Medical social expertise commissions of general profile serve several districts each.

Municipalities have been granted ownership for outpatient facilities and nursing homes. Municipalities are engaged in operating small and medium size hospitals within their localities, in accordance with legislation, which has delegated this function to them. This process has not yet been completed because there are still discussions on who (districts or municipalities) should be responsible for medium-sized hospitals, and how administrative responsibilities should be distributed between the different levels.

According to the social services law adopted in 1996, municipalities have the major responsibility for social service provision. Social services include institutional care (for the elderly, disabled, children with special needs (e.g. orphans)) and some home care. Social workers and nurses play a leading role (especially social workers) in social service provision.

### 2.4.1 Auspices of service providers

Currently, the vast majority of Lithuanian health care institutions are non-profit. Public health care institutions are financed by the State Health Insurance Fund (SHIF). Property rights and administrative functions fall under the jurisdiction of the Central Government (Ministry of Health), its ten country branches (the country administration), and the 56 municipalities.

The vast majority of primary care provision and hospital care is governmental. Most home care providers are also governmental, with some coming from the NGO sector. In addition to publicly provided health care, a private sector has developed, providing mainly outpatient health care services which are paid out-of-pocket.

The private sector plays a significant role in dental care, cosmetic surgery, psychotherapy and gynaecology. In 1995, the private sector also accounted for 100 % of wholesale and 73 % of retail trade in pharmaceuticals. No hospitals have been privatized, and there are no official plans to privatize outpatient clinics or larger hospitals.
LONG-TERM CARE

Private health insurance is permitted. There are a few private insurance companies, mainly dealing with coverage of health care expenditures of Lithuanian citizens during foreign travel and for foreigners residing in Lithuania.

There are two competing associations of medical professionals: the Physicians Association and the Association of Medical Professionals. Specialized professional societies of physicians, dentists, pharmacists, public health specialists and others deal with professional standards and continuing education of their members.

In 1998, there were 29 nongovernmental care institutions for the elderly, while governmental public care institutions for the elderly were subordinated to municipal and district administrations. A few district care homes housed 1771 people, while 1701 elderly persons lived in 50 municipal care homes. The share of residents living in nongovernmental care institutions for the elderly doubled since 1995, accounting for 14% of the total number of persons in care institutions.

2.6 Human resources and training

2.6.1 Doctors

In Lithuania in 1998, there were 3.5 physicians per 1000 inhabitants (European Observatory on Health Care Systems, 2000). They provide care in the homes of disabled individuals who have qualified for such care.

There is a serious problem of unequal distribution of medical personnel throughout the country. The density of physicians differs by a factor of three geographically, that of paramedical personnel differs by more than five.

In 1998, about 4650 physicians, including 1168 dentists and 10 500 nurses (39% of total employed nurses) worked in public primary health care institutions (European Observatory on Health Care Systems, 2000). This constitutes about 32% of the total number of employed physicians.

Physicians are trained at Kaunas University of Medicine and Vilnius University. In 1992, the formal training of physicians was extended to include residency-training programmes following the six-year undergraduate training period.
The present programmes of medical training cover undergraduate and postgraduate levels, as follows:

<table>
<thead>
<tr>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 years</td>
<td>MD diploma after undergraduate training</td>
</tr>
<tr>
<td>1 year</td>
<td>Obligatory clinical practice for all physicians (assistant physicians)</td>
</tr>
<tr>
<td>2–4 years</td>
<td>Residency training programmes in broad specialties (primary and secondary health care provider)</td>
</tr>
<tr>
<td>2–3 years</td>
<td>Residency training programmes in narrow subspecialties (secondary and tertiary health care provider)</td>
</tr>
</tbody>
</table>

### 2.6.2 Nurses

There have been a number of ongoing changes in nurses’ training. These changes stress health promotion activities and community care. There are also curriculum changes towards increasing the role of qualified nurses. Nurses are increasingly promoted as semi-independent health practitioners, and their formal training lasts 3.5 years. There is also a university degree programme at Kaunas University of Medicine with about 20 graduates per year. There is a Nurses’ Retraining Centre in Vilnius with a few local branches throughout the country.

### 2.6.3 Social Workers

Social workers are populous in Lithuania, but increasing attention to the needs of the disabled and elderly has created a demand for more social workers. The formal training of professionals in this field has started at both university and junior college levels. The fact that social workers’ functions are as yet poorly defined remains the main obstacle to the development of this profession.

There are six junior colleges for the training of midwives and social workers in Lithuania. The Ministry of Education administers them, and together with the Ministry of Health is responsible for curriculum development. Applicants must have completed 12 years of general school education, must pass a competitive entrance examination and attend an interview.
2.6.4 Volunteers

Volunteers are often the providers of social care for the disabled and elderly. However, the system of volunteers in Lithuania is not well developed.

3 Summary of LTC provision

Community-based (non-institutional) long-term care provided by the social system is a new phenomenon in Lithuania. According to the Social Services Law adopted in 1996, municipalities have the major responsibility for social services provision.

Carers and social workers provide non-institutional home care nursing, including shopping and housekeeping services. In 1997, more than 2200 carers were involved in care delivery throughout the country, but this is undoubtedly insufficient to meet the current need.

The development of funding for community-based (non-institutional) long-term care only came into being with the adoption of the Social Services Law. Unfortunately, despite the adoption of this law, home care is only provided for the most disabled groups and the funding is currently insufficient to meet the need.

In 1998, 9 million Litas were spent on home care versus 209 million Litas for institutional care. In spite of support by nongovernmental charities (for example, Caritas and the Red Cross), social care in the community remains an activity carried out mainly by families, neighbours, friends, and volunteers.

In addition to informal caregivers, general physicians, nurses and social workers also provide care for disabled people in the home. State medical social experts are engaged in the setting of disability.

One of the main goals is to determine disability in accordance with the degree of its severity for persons starting from 16 years of age (under 16, the ability grouping is performed by institutions of children’s health care). Doctor experts evaluate the level of patients’ functional impairment, severity, causes of disability, rehabilitation needs and requirements of the disabled, integration of disabled persons into the society, and need for home care.
Long-term care services are supplied by both governmental and NGO providers. Elements of the care for the severely disabled are as follows:

- general health care and management of chronic diseases (under the auspices of the health system);
- personal care (grooming, bathing, meals);
- household assistance (cleaning, laundry, shopping);
- physical adaptation of the home to meet the needs of disabled persons;
- provision of supplies, assistive devices, equipment and drugs;
- palliative care; and
- provision of information to patient’s family

Caregivers are trained at the junior colleges and universities. Different districts have significantly different capacities for long-term care provision. Differences also exist between rural and urban populations. Community-based long-term care is provided by both the health and social systems. As noted earlier, small outpatient clinics are based in rural areas. They employ a physician’s assistant and a midwife, and provide routine health care, home nursing and supply some drugs. Social aid is provided by the municipal social workers.

In urban areas there are larger outpatient clinics. They employ a general practitioner or internist, a midwife, a dentist, and a pediatrician. They are responsible for almost all primary outpatient care, including home care. General practitioners evaluate the needs for institutional care.

### 3.1 Institutional LTC

Until 1990, the main form of long-term care was institutional care for the elderly (retired pensioners) and the physically and mentally disabled, provided only by governmental care institutions. During the last ten years the number and variety of care institutions has increased, nongovernmental care institutions have appeared and the development of non-institutional forms of care have begun to receive attention as well (see Table 4, following page).
## Table 4. Institutional Long Term Care

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Institutions for elderly</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly residents</td>
<td></td>
<td>64</td>
<td>70</td>
<td>80</td>
<td>70</td>
</tr>
<tr>
<td>Nursing homes for disabled adults</td>
<td></td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Disabled adult residents</td>
<td></td>
<td>4365</td>
<td>4678</td>
<td>4832</td>
<td>4678</td>
</tr>
<tr>
<td><strong>Infants’ homes</strong></td>
<td></td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Residents</td>
<td></td>
<td>479</td>
<td>516</td>
<td>510</td>
<td>506</td>
</tr>
<tr>
<td><strong>Boarding schools of general education</strong></td>
<td></td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Orphans and children residents without parental support</td>
<td></td>
<td>751</td>
<td>648</td>
<td>663</td>
<td>833</td>
</tr>
<tr>
<td><strong>Special boarding schools</strong></td>
<td></td>
<td>53</td>
<td>55</td>
<td>57</td>
<td>55</td>
</tr>
<tr>
<td>Orphans and children residents without parental support</td>
<td></td>
<td>968</td>
<td>965</td>
<td>928</td>
<td>831</td>
</tr>
<tr>
<td><strong>Care homes for disabled children</strong></td>
<td></td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Residents</td>
<td></td>
<td>822</td>
<td>865</td>
<td>840</td>
<td>844</td>
</tr>
<tr>
<td><strong>Child care homes</strong></td>
<td></td>
<td>46</td>
<td>49</td>
<td>57</td>
<td>64</td>
</tr>
<tr>
<td>Children residents</td>
<td></td>
<td>3528</td>
<td>3587</td>
<td>3818</td>
<td>3905</td>
</tr>
<tr>
<td><strong>Child care group centres</strong></td>
<td></td>
<td>–</td>
<td>40</td>
<td>44</td>
<td>47</td>
</tr>
<tr>
<td>Residents</td>
<td></td>
<td>–</td>
<td>1227</td>
<td>1792</td>
<td>1876</td>
</tr>
<tr>
<td><strong>Families</strong></td>
<td></td>
<td>36</td>
<td>39</td>
<td>46</td>
<td>39</td>
</tr>
<tr>
<td>Foster-children</td>
<td></td>
<td>279</td>
<td>261</td>
<td>345</td>
<td>320</td>
</tr>
<tr>
<td><strong>Temporary child care homes</strong></td>
<td></td>
<td>–</td>
<td>–</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Residents</td>
<td></td>
<td>–</td>
<td>–</td>
<td>156</td>
<td>243</td>
</tr>
<tr>
<td><strong>Lodging-houses, total</strong></td>
<td></td>
<td>10</td>
<td>11</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Lodgers per year</td>
<td></td>
<td>608</td>
<td>845</td>
<td>925</td>
<td>1089</td>
</tr>
</tbody>
</table>

*Source: Department of Statistics (European Observatory on Health Care Systems, 2000.*
As mentioned previously, in 1998 there were 29 nongovernmental care institutions for the elderly; the share of residents living in such institutions has doubled since 1995, accounting for 14% of the total number of persons in care institutions. Governmental public care institutions for the elderly were subordinated to municipal/district administrations – a few district and fifty municipal care homes housed 1771 and 1701 elderly persons, respectively.

Of 4173 residents in institutions for the elderly, 76% were over age 65. Approximately 30% of the residents in institutions for disabled adults receive intensive nursing care. State or municipal budgets cover 70% of residential institutions for the elderly. User fees cover approximately 30% of the costs of care in homes for the elderly, with residents paying 80% from their retirement or disability pensions. The remaining costs are covered by state or municipal budgets.

After treatment in a hospital for an acute event such as a stroke, an individual may receive care in an infirmary before he/she returns to the community. The cost of care in the infirmary is covered by municipal budgets for a specific period of time (i.e. three months). After this period of time expires, the infirmary services must be paid for out-of-pocket.

The share of municipal child care homes has increased relative to the number of district child care homes. In 1998, almost one quarter of the total number of children in institutions (821 children) lived in 19 municipal childcare homes. There are 17 nongovernmental child care homes, representing a fourfold increase since 1995, and housing 10% of children in institutions.

In view of the fact that many admissions in rural municipal hospitals were for nursing purposes, a network of nursing inpatient facilities began forming, based mainly in existing small hospitals in the rural areas. Some social care is provided by the health care system. At the present time, social workers are employed by the nursing hospitals. In 1997, more than 30% of the staff in social care institutions were medical personnel. Coordination of the two systems of care, subordinated to two different ministries, is still rather poor.

4 General questions pertinent to LTC development

4.1 Present and future needs for long-term care, and gaps between needs and provision of services

General morbidity, including virus and influenza type illnesses, was 498.2 cases per 1000 adults in 1997. The incidence of cardiovascular diseases in 1997 was 181.4 cases per 1000 inhabitants (MoH, 1998).
LONG-TERM CARE

The incidence and prevalence of malignant neoplasms is gradually increasing, while the number of deaths is quite stable. In 1997, 12 849 new cases of diseases were registered; 51 551 people had cancer. During the last few years, among males the incidence of lung and stomach cancer has decreased, but the incidence of prostate, skin, and oral cavity cancer has increased. The incidence of skin cancer is increasing most rapidly among women (MoH, 1998).

The incidence of tuberculosis is increasing. In 1997, 2926 new cases of tuberculosis (including relapses) were registered, i.e. 79 cases per 100 000 inhabitants. The main problems are the high rate of incidence of smear-positive lung tuberculosis and antibiotic-resistant cases, which are caused by noncompliant patients and discontinuity of treatment (MoH, 1998). Alcohol and drug abuse have a negative influence on the health of the population. The incidence of alcoholic psychosis has increased. During the last few years, it has recently stabilized, but the prevalence of drug abuse has increased significantly.

Over the last seven years, suicide has become a serious social problem for Lithuania. The overall suicide rate steadily increased from 1991 to 1996. Suicides among the rural population increased sharply in 1970–1980 (by 75%) and much less in the towns (by 20%). Since 1990, the trend has to some extent reversed; urban suicides have jumped by 64%, while the rural suicide rate grew by 75%. In 1996, the suicide rate hit a mark previously unseen in Lithuania: 46.4 per 100 000 (1723 suicides that year). This indicator was the highest in Europe and among all countries submitting data on mortality patterns to the World Health Organization (European Observatory on Health Care Systems, 2000).

A more focused estimate of the number of the disabled was calculated by analysing the following known categories of individuals:

- Persons receiving disability pensions 38.3%
- Persons receiving old-age pensions 21.5%
- Persons aged 80–84 15.6%
- Persons aged 85 and over 11.4%
- Disabled children 2.4%
- Other categories 10.8%
This analysis revealed that the total number of disabled in Lithuania exceeds 350,000 and comprises about 10% of the entire population (Kasinskienë, Klimavièius & Mikolajenko, 1998).

One of the major issues in the public agenda in relation to the care of these disabled and the elderly is defining the balance between community and institutional services both from the point of view of cost and quality of life. Currently, there is a lack of non-institutional services for those in need of LTC. Maintaining the disabled and the elderly in their homes and out of institutions as long as possible is most conducive to healthy recuperation, both physically and emotionally. It also costs both the family and the state considerably less. There also needs to be increased funding for training for LTC personnel (i.e. social workers, nurses, etc.). Long-term care of the disabled and elderly persons, their social integration, and the improvement of their quality of life is in Lithuania a complicated problem in many aspects: juridical, medical, social, economic, and ethical.

4.2 What resources (structures, manpower, organizations) at the national and local levels may be utilized to promote LTC provision?

LTC could be promoted as an important aspect of the new state medical insurance plan. Decentralizing financing leading to more spending opportunity at local levels could possibly encourage community based long-term care.

4.3 Developments that will impact on LTC and concluding remarks

Prior to the restoration of independence, the health care system in Lithuania, as part of the former Soviet system, was self-sufficient, in terms of availability of qualified and specialized medical care including microsurgery, cardiac surgery and organ transplants. Decision-making and funding were centralized. Basic requirements and guidelines were formed in Moscow, and then budgets were distributed for the entire health care system of the Soviet Union. The Lithuanian Ministry of Health was required to carry out these decisions, but it was also allowed to act independently within certain limits. Primary health care was organized on a regional-administrative principle and was carried out in outpatient facilities.

There was a nationwide network of inpatient assistance. Each region had a central regional hospital and district hospitals. There were also various types of ‘closed’ hospitals and outpatient clinics where privileged people (‘party nomenclature’) and VIPs of different departments and enterprises were treated. Quality of services in these facilities was much higher by Soviet standards.
LONG-TERM CARE

The pre-independence health care system had its positive as well as negative aspects:

- **Positive aspects**: patients received relatively free medical care on demand; employment and salaries were guaranteed for medical personnel; there were regular mass preventive health examinations for adults and children; there was free health resort treatment and strong links were developed between primary health care institutions and inpatient departments where patients received more comprehensive testing and treatment.

- **Negative aspects**: the public was given the impression that medical care was free, even though it was paid for through taxes; patients had no knowledge of the tax funds which were designated for medical care; patients’ choices of medical institutions or doctors were limited; the salaries of medical personnel were not linked to the quality and quantity of services performed; there was no competition and therefore no advancement; budgets were not used rationally and resulted in an excess of medical personnel and hospital beds and a lack of modern equipment and medicines. Primary health care was not a focal point. Instead of providing comprehensive medical care, primary care staff were dispatchers referring patients to specialists, or to the hospital when confronted with medical situations that were slightly more complex. Although the emphasis was on equal rights to health care; taxpayers’ money supported special ‘closed’ hospitals serving privileged individuals.

As such, Lithuania inherited a typical Soviet model of health care provision, featuring excessive centralization and minimal freedom and opportunity for doctors to act and patients to choose. There was a surplus of hospital beds, as well as a shortage of medicines and a lack of focus on primary and public health care. Salaries in the health sector were on the whole very low. However, in terms of access to health care, medical institutions were fairly evenly distributed throughout the country, while public transportation was cheap and well developed. The majority of the population was immunized against major diseases. There was adequate control over infectious diseases, and the Lithuanian population was in better health compared with other former Soviet republics.
CASE-STUDY: LITHUANIA

Since 1990, the first task of the health care system has been to guarantee basic medical services (immunization, children’s health care and the provision of emergency and vital assistance). In October 1991, a Lithuanian Supreme Council decision was made on the formulation and implementation of a national health model.

Processes, which are still being implemented such as insurance provision, the implementation of medical training programmes, etc., were envisaged as part of this concept. The concept included the development of an active state health care policy with emphasis on primary and preventive health care. It considers the development of a comprehensive legal framework for health care vital to successful reforms.

Difficult socioeconomic circumstances in Lithuania forecast augmentation of the numbers of disabled. The need for long term-care in Lithuania is gradually increasing.

The following key strategic steps in social policy development have been taken:

1. The act concerning protecting the rights of the disabled was adopted in 1990.
2. The law of social integration of the disabled was adopted in 1991.
3. The act concerning proclamation of the year of the disabled in 1996 was adopted in 1995.

Organizations of the disabled, particularly on the national level, began to actively participate in this process. In 1992, the Lithuanian Council for affairs of the disabled was established. The Council had two main purposes:

1. To manage several million Litas (24 million Litas in the year 2000) given directly by the Government for implementation of projects from the different members of the organizations.
2. To publicize the problems of the disabled in order to increase public awareness.
LONG-TERM CARE

According to Lithuanian rehabilitation authorities, the following model of the structure of the LTC system should be developed. It includes 13 key components that are present but need to be developed:

1. Legal support
2. Medical rehabilitation
3. Vocational rehabilitation
4. Education of specialists
5. Compensatory techniques, orthopaedic means
6. Environmental modification
7. Culture, sports, recreation, religion
8. Information
9. Transport
10. Social services
11. Benefits
12. Training of specialists
13. Medical social expertise

During the period of 1992–2000, this system began to develop. There has been disproportionate development. For instance, environmental modification has not yet been developed. Nonetheless, many rehabilitation institutions (60 units with 6000 beds) have been established, and more than 70 types of specialized technical aids and 250 types of prosthetic and orthopaedic aids have been produced. Approximately half of the municipalities have started to actively participate in this process.

The greatest progress has been achieved within the legal system. During the same period there were roughly 70 different laws and regulations adopted that all, essentially, deal with implementation of the law on social integration of the disabled.
LTC issues are more actively being dealt with in the European PHARE project, the World Bank, and other international programmes.

The major barriers to implementing long-term care services include:

- **Psychological resistance to social integration.**
  *There is a need to raise awareness about the disabled, their rights, their needs, and their potential.*

- **Financial resources are insufficient because of economic difficulties.**

- **Activities of local authorities are still insufficient.**

- **Lack of skilled specialists.**

- **Lack of experience in creating a LTC system.**

We need to work towards the provision of programmes run by multidisciplinary teams of professionals for early detection, assessment, and treatment of impairment. This may prevent, reduce or eliminate the disabling effects of some illnesses. Such programmes should ensure the full participation of persons with disabilities and their families at the individual level, and of organizations of persons with disabilities at the planning and evaluation level.

Local community workers should be trained to participate in areas such as early detection of impairment, the provision of primary assistance, and referral to appropriate services. We should ensure that individuals with disabilities, particularly infants and children, are provided with the same level of medical care within the same system as other members of the society, that persons with disabilities are provided with all standard treatment and medication needed to maintain or improve their level of functioning, and the rehabilitation services need to reach and sustain their optimum level of independence and functioning.
The priority areas in long-term care promotion in Lithuania are:

- Increasing community awareness of people with disabilities.
- Advocating for social integration in the community.
- Enacting more effective laws for people with disabilities.
- Providing enforcement mechanisms for disability laws.
- Developing a philosophy for social service delivery.
- Developing independent advocacy agencies to represent all Lithuanians with disabilities.
- Establishing Independent Living Centres.
- Developing barrier-free designs for urban and community buildings.
- Setting up group homes to enable the disabled to live in the community.
- Supporting the creation of a rehabilitation system.
- Promoting more participation of the disabled in health care decision-making.
References


CASE-STUDY
MEXICO

Felicia Knaul
Gustavo Nigenda
Miguel Angel Ramírez
Ana Cristina Torres
Ana Mylena Aguilar
Mariana Lopez Ortega
José Luis Torres
1 General background data

1.1 Preamble

As in many other developing countries, Mexico is experiencing important demographic, epidemiological, and social transitions that should guide the formation of policy in a number of areas including long-term care. From an institutional perspective, the country and the Government are open to renewal. The issues surrounding long-term care are being incorporated into the programmes and reforms that are being launched in the areas of health, social security, gender planning and the social system, but so far with limited impact.

The demographic transition, and particularly the reduction in the fertility rate and increases in life expectancy, have lead to the growth of the proportion of elderly people in the population. In 2000, only about 5% of the population was aged 65 years or older, while by 2050 the figure will be close to 20%. In the year 2020, Mexico will have a population structure similar to the post-industrial world today, with the disadvantage that this process of profound change will have occured in a shorter period – placing particularly profound demands upon society and institutions.

As part of the epidemiological transition, the profile of disease has changed and the burden of disease has shifted towards chronic and degenerative illness. Much of this change is related to population ageing. Providing adequate and appropriate care for the elderly is one of the major challenges for health services, since this age group utilizes health services much more frequently than the rest of the population and the services they use tend to be more costly. From the perspective of long-term care requirements in the future, these phenomena should be highlighted – as the ageing of the Mexican population and the emergence of new health problems will generate increased demands for care in the near future and will have an impact on large groups of the population. These changing conditions will require a prompt response from the health system in the future, that should be designed in the present. Mexico finds itself at an important junction in terms of reformulating policy for the challenges of the future and preparing itself for the middle of the century when approximately one in five Mexicans will be aged 65 or over.
LONG-TERM CARE

On the social front, female labour force participation has more than doubled in the past 30 years. This is one of the most dramatic increases in the Latin American region. Paradoxically, however, women have not been able to reach the salary standards and conditions of men, while at the same time they are still the principal individuals responsible for non-financial household duties.

Protection of the elderly and the sick continues to be a responsibility of the family and the burden of this responsibility falls primarily on women. However, the capacity of the family to respond to the needs of the elderly has been decreasing due to repeated economic crises and the challenges and changes of female labour participation, migration and the structure of families. For example, extended families are less common, and in many cases family members are living in different parts of the country or in other countries.

This decrease in the capacity of the family to provide care to the elderly and the chronically ill coincides with increases in demand for care resulting from the demographic and epidemiological transitions. These opposing forces will generate a vacuum that the health and social systems will have to either fill or react to with creative policies that respond to the changing needs of the population by reinforcing social changes and gender equity.

Presented on the following pages are background data concerning Mexico, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

---

### Demography (year 2000)

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands)</td>
<td>98,872</td>
</tr>
<tr>
<td>Land area (sq km)</td>
<td>1,923,040</td>
</tr>
<tr>
<td>Population density (per sq km)</td>
<td>50</td>
</tr>
<tr>
<td>Population growth rate (% 2000–2005)</td>
<td>1</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>74</td>
</tr>
<tr>
<td>Ethnic groups (%)</td>
<td></td>
</tr>
<tr>
<td>Mestizo (American-Spanish)</td>
<td>60</td>
</tr>
<tr>
<td>Amerindian or predominantly Amerindian</td>
<td>30</td>
</tr>
<tr>
<td>White</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Religions (%)</td>
<td></td>
</tr>
<tr>
<td>Nominally Roman Catholic</td>
<td>89</td>
</tr>
<tr>
<td>Protestant</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Total adult literacy rate (%)</td>
<td>91</td>
</tr>
<tr>
<td>Age Structure (%)</td>
<td></td>
</tr>
<tr>
<td>0–14</td>
<td>33.1</td>
</tr>
<tr>
<td>15–24</td>
<td>20.2</td>
</tr>
<tr>
<td>60+</td>
<td>6.9</td>
</tr>
<tr>
<td>65+</td>
<td>4.7</td>
</tr>
<tr>
<td>80+</td>
<td>0.8</td>
</tr>
<tr>
<td>Projections 65+ (%)</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>9.3</td>
</tr>
<tr>
<td>2050</td>
<td>18.6</td>
</tr>
</tbody>
</table>

---

2 Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

3 Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.
### Demography (continued)

**Sex ratio** (males per female)
- Total population: 0.97
- 15–64: 0.95
- 65+: 0.80

#### Dependency Ratio:
- Elderly dependency ratio in 2000: 9.1
- Elderly dependency ratio in 2025: 15.5
- Parent support ratio in 2000: 9.8
- Parent support ratio in 2025: 11.1

### Vital statistics and epidemiology

**Crude birth rate** (per 1000 population) (2000): 22.2

**Crude death rate** (per 1000 population) (2000): 5.1

**Mortality under age 5** (per 1000 births) (2001)
- Males: 33
- Females: 27

**Probability of dying between 15–59** (per 1000) (2001)
- Males: 179
- Females: 101

**Maternal mortality rate** (per 100 000 live births) (1995): 65

**Total fertility rate** (children born/woman) (2001): 2.6
## Vital statistics and epidemiology (continued)

<table>
<thead>
<tr>
<th>Description</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated number of adults living with HIV/AIDS (2001)</strong></td>
<td>150 000</td>
</tr>
<tr>
<td><strong>HIV/AIDS adult prevalence rate (2001)</strong></td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Estimated number of children living with HIV/AIDS (2001)</strong></td>
<td>3600</td>
</tr>
<tr>
<td><strong>Estimated number of deaths due to AIDS (2001)</strong></td>
<td>4200</td>
</tr>
<tr>
<td><strong>Life expectancy at birth (years) (2001)</strong></td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>74.2</td>
</tr>
<tr>
<td>Male</td>
<td>71.6</td>
</tr>
<tr>
<td>Female</td>
<td>76.7</td>
</tr>
<tr>
<td><strong>Life expectancy at 60 (years) (2000)</strong></td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>21.0</td>
</tr>
<tr>
<td>Male</td>
<td>20.0</td>
</tr>
<tr>
<td>Female</td>
<td>22.0</td>
</tr>
<tr>
<td><strong>Healthy life expectancy (HALE) at birth (years) (2001)</strong></td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>63.8</td>
</tr>
<tr>
<td>Male</td>
<td>62.6</td>
</tr>
<tr>
<td>Female</td>
<td>65.0</td>
</tr>
<tr>
<td><strong>Healthy life expectancy (HALE) at 60 (years) (2001)</strong></td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>14.7</td>
</tr>
<tr>
<td>Male</td>
<td>14.5</td>
</tr>
<tr>
<td>Female</td>
<td>14.9</td>
</tr>
</tbody>
</table>
### Economic data (year 2000)

**GDP – composition by sector (%)**
- Agriculture: 5
- Industry: 27
- Services: 68

**Gross national income (GNI) ($PPP)**
- 861 billion

**GNI – per capita ($PPP)**
- 8790

**GNI – per capita (US$)**
- 5070

**GDP growth** (annual %) (1999–2000)
- 6.90

**Labour force participation (%)**:
- Male: 55.6
- Female: 27.1

### Health expenditure (year 2000)

**% of GDP**
- 5.4

**Health expenditure per capita ($PPP)**
- 483

**Health expenditure per capita (US$)**
- 311

---

4 PPP = Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries
2 General health and social system

2.1 Basic income maintenance programmes

The financial problems of social security institutions have affected the majority of the developing nations in the world, and Mexico is no exception. The financial deficit of social security institutions makes the payment of decent pensions difficult and limits the supply of social benefits. A significant proportion of people beyond 65 years of age in Mexico (around 45%), as well as many who suffer from disability of chronic disease, have no access to social security benefits. The family provides support through monetary and material transfers, caregiving in the home, and care of health problems.

2.2 Organizational structure of decision-making (major stakeholders in decision-making)

There are a number of entities that can be considered stakeholders in Mexico’s system of care for the disabled and the elderly.

- The Mexican Institute of Security provides health coverage for employers in the formal sector and self-employed persons.
- The Social Security and Services Institute for Government Employers provides health coverage to Government employees.
- Other institutions – such as the military, the national oil company, and the national university – also contribute to the coverage of public sector workers.
- The Secretariat of Health covers the informal sector and the poorer segments of the population.

In Mexico, social policy has been a longstanding tradition of both federal and state-level governments. Various institutions are responsible for the implementation of social policy, but the Secretariat of Social Development (SEDESOL) is the only one that has responsibility in all social areas. Reorganized, SEDESOL is now clustering a whole set of institutions that were previously attached directly to the Executive Branch or to other secretariats. SEDESOL is developing a new proposal to support the elderly population through the National Institute of the Elders (INSEN). Although INSEN was created two decades ago, it is now working with a renewed spirit and developing new programmes that can respond to the increasing needs of the elderly population.
LONG-TERM CARE

Another stakeholder in the care of the disabled is the Office of Representation for the Promotion and Integration of People with Disabilities. As defined by the Presidential Office:

As a specific compromise with the population with disabilities, the new administration looks to promote and integrate this important group of the population so that their opportunities and talent are expressed in all its dimensions. To do this, the new administration created the Office of Representation for the Promotion and Integration of People with Disabilities as a way to give this population a new and valuable role within our society.

Another Governmental agency that offers care for the elderly is the System for the Integral Development of the Family (DIF), which is the main family welfare institution of the public sector.

There is a growing interest among the citizens of Mexico for volunteer participation in social problems that has had significant impact. This interest has lead to the creation of many nongovernmental organizations (Civil Society Organizations).

There are currently 3500 such institutions, and two-thirds of them have been created in the last thirty years. They perform a wide range of activities, including those supporting the interests of disabled and elderly individuals.

For example, the Mexican Foundation for Mental Health and other groups of civil society have initiated a systematic debate on the benefits of the hospital system. At the same time, the Foundation has collected data to demonstrate that the prevalent model was not responding to the needs of many of the population with mental health problems and that hospital confinement was precluding any chance of their rehabilitation.

2.3 Financing of health services and health sector expenditures

Approximately 50% of the population has health insurance. Organization of the health system is still closely linked with employment. Employees in the formal private sector and self-employed persons are covered by the Mexican Institute of Social Security (Instituto Mexicano del Seguro Social, IMSS), which is financed by tripartite or bipartite contributions from employees, employers, and the Federal Government.
Public sector workers are covered by the Social Security and Services Institute for Government Employees (ISSSTE). Such coverage is also provided by other institutions, such as the military, the national oil company, and the national university, which are financed by contributions from employees and the Government. The remainder – over 40 million people – are treated in establishments of the Secretariat of Health and under a system known as IMSS–Solidarity that is operated by IMSS in specific areas of the country. This group includes the informal sector and the poorer segments of the population. Roughly 10 million inhabitants or 10% of the population continue to lack regular access to basic health services.

In Mexico, a large proportion of the population, including both insured and uninsured, pay for private care out-of-pocket. Of the approximately 5.6% of Gross Domestic Product (GDP) spent on health in 1998, more than 50% is out of pocket spending, primarily on private sector care. Although out-of-pocket health spending is more common among the poor and the uninsured, the insured are also frequent users of private sector care primarily because of quality and long waiting times in the public sector (SSA, 2001; Frenk, Lozano & Gonzalez Block, 1994).

In 1997, several modifications to the Social Security Act went into effect. These changes were designed to revitalize the structure and practice of the pension and health care systems, by – among other provisions – reducing employer contributions and increasing Government contributions, offering family health insurance to those who wish to purchase it, and allowing the transfer of employee contributions from the workplace to other providers if employees so wish, but with IMSS retaining the collection function.

2.3.1 Expenditures and sectoral financing

In 1998, the total expenditure of the National Health System was estimated at US$23 000 million and represented 5.6% of GDP. Of this percentage, approximately 2.5% was public and 3.1% was private spending. The vast majority of private spending was out-of-pocket payments by households.

Public spending tends to be inequitably distributed both among institutions and geographically. The poorest states tend to spend less per capita, despite efforts to allocate public funds based on formulas designed according to population needs. Further, social security institutions tend to have a larger per capita allocation of public funds than the health institutions dedicated to serving the uninsured, poorer part of the population (Frenk, Lozano, Gonzalez Block et al., 1994; SSA, 2001).
LONG-TERM CARE

The majority of public funds are dedicated to curative services. In the IMSS in recent years, for example, second level and tertiary care hospitals absorb 75% of the institution’s total budget. Of the total budget allocated to health:

- 68% was directed towards curative care (including hospitalization);
- 15% to administration, policy, and planning;
- 7% to preventive care;
- 6% to infrastructure; and
- 4% to other categories.

Between 1992 and 1994, salaries consumed almost half the budget of the institutions with the greatest volume of services – 48% in IMSS and 50% in the Secretariat of Health. However, in ISSSTE the figure was only 21%, and operating expenditures were the highest (51% of total expenditure). In IMSS, operating expenditures accounted for 35% of the total, and in the Secretariat of Health they accounted for 3% of total spending for the same period.

Private expenditure is aimed predominantly at curative care, and its distribution shows that fees account for 35% of the total, drug purchases for 27%, and hospitalizations for 20%. Private out-of-pocket spending exhibited a regressive trend in all objects of expenditure – each year it represented a larger proportion than revenue.

Per capita health expenditure for 1995, estimated from the budget executed by public institutions and the total population, was MN$499. The absolute values for private expenditure in urban areas are ten times higher for the households with the highest income than for those with the lowest income (US$750 versus US$75 per quarter); in rural areas this difference may be twenty times (US$1294 versus $65).

Analysis by the national accounting system of the resources utilized between 1992 and 1994, through the so-called concentrated funds and funds utilized by the various institutions, reveals an increase in the sums used by social security institutions, private concerns, and establishments that serve the insured population. Social security handled the greatest proportion of resources (43%), followed by private concerns (42%). The institutions (largely Government entities) that treat the uninsured population, used 13% of the total resources.
2.4 Services delivery system

2.4.1 Health services and resources

The volume of public services for both the insured and uninsured populations has increased. Total medical consultations rose from 160 to 190 million between 1993 and 1996; hospitalizations increased from 3.6 to 3.8 million; and auxiliary diagnostic services rose from 123 to 137 million.

The number of outpatient clinics for the uninsured population increased from 10 443 in 1993 to approximately 14 000 in 1999. The hospital network grew from 329 to more than 500 institutions in that same period. The Secretariat of Health has ten national institutes of health in the capital, which operate in a decentralized manner and provide care at the tertiary level to patients referred from throughout the country. The social security institutes treat members through their own service networks. Outpatient clinics increased from 3029 in 1993 to 3436 in 1999, and the number of hospitals increased from 422 to 478 (SSA, 2001; OPS, 2001).

Private medicine has grown substantially, although much of this growth has taken place outside the scope of official policies and in institutions of dubious quality. Private health insurance coverage is limited, and a traditional model involving direct collection of fees for services persists, with charges being as high as the market will bear.

In 1998, it was calculated that the private supply of goods and services was responsible for half of all health expenditure. In 1995 it accounted for 30% of the bed count, 34% of employed physicians, and 32% of medical consultations.

In 1999, there were 2950 private hospitals, with a total of 31 241 beds. The majority of these are small units in urban areas, and 27% have fewer than five beds (SSA, 2001).

Traditional healing – the extent of which has not yet been effectively measured – is extremely widespread, particularly in areas with a high concentration of indigenous peoples. So-called alternative and complementary practices are more prevalent in urban areas. A recent study estimated that around 8% of the population in two mid-size cities had, in the year previous to the interview, consulted a specialist of alternative or complementary medicine in the search for therapeutic services.
LONG-TERM CARE

2.4.2 Organization of care for the population

Health promotion is a strategic approach within the priorities for disease prevention and control defined by the Secretariat of Health. Work strategies are health education and social participation, carried out along six tracks:

- family health;
- comprehensive health of schoolchildren;
- comprehensive health of adolescents;
- healthy municipalities;
- health care exercises; and
- development of educational content.

A key component is the healthy municipality strategy, which has fostered the political leadership of heads of municipalities and the organized participation of society in defining priorities and executing local programmes that deal with health promotion.

In 1997, the Secretariat of Health established a new priority disease prevention and control model. In this way, ten substantive programmes with a direct impact on the health status of specific population groups were defined:

- reproductive health;
- child health care;
- health care for adults and the elderly;
- vector-borne diseases, zoonoses;
- mycobacteriosis;
- cholera;
- epidemiological emergencies and disasters;
- HIV/AIDS and other STDs; and
- addictions.
In 1996, the country’s epidemiological surveillance system was upgraded and integrated into different public sector institutions. The unified information system for epidemiological surveillance was implemented. This system generates information from the different health services at the technical–administrative levels, backed by a software package for receiving, collecting, and analysing the information obtained.

There exists a morbidity registry, information for which comes from the Unified Epidemiological Surveillance System and reports on hospital discharges from health facilities. The information on mortality is based on death certificates, which are the compulsory legal mechanism for death certification. At the beginning of 1998, all health institutions in the country began to use the ICD-10 for their statistical records.

Health regulation activities in the past four years have been geared towards prevention and control of disease (OPS, 2001), especially for:

- the primary care level (diabetes mellitus, uterine and breast cancer, tuberculosis, HIV/AIDS, rabies);
- delivery of standardized services to special population groups (women during pregnancy, childbirth, and the puerperium; children and adolescents, to monitor their growth and development; family planning services; and psychiatric care);
- decentralization (delegation of authority to the states in public health, administration of blood banks, and issuing of authorizations and health permits); and
- the new structures and organs of the Secretariat of Health (the composition of boards of trustees in hospitals, health institutes and jurisdictions as well as the National Health Council and National Medical Arbitration Commission).
LONG-TERM CARE

2.4.3 Health sector reform prior to 2001

The 1995–2000 Health Sector Reform Programme:

- allows social security recipients to choose the physician who will treat them at the health services;
- establishes family insurance coverage in the Mexican Social Security Institute (IMSS), whereby persons able to pay may voluntarily enrol;
- transfers health services to the states to care for the uninsured population;
- fosters greater local participation in health through the healthy municipalities programme;
- expands coverage through a basic package of services for persons without access to the health services; and
- reorganizes the system, with the Secretariat of Health exercising leadership and regulatory roles, health care for the uninsured population being integrated and coordinated, and IMSS separating the functions of financing and service delivery to introduce competition among service providers (Gómez, 2001).

The first major reform policy started in 1983 in order to decentralize the structure of public services belonging to the Secretariat of Health and IMSS–Solidarity. Fourteen states, mainly the most affluent, were embarked in the process, which implied the transference of funds from the Federal to the state level to be complemented by state level funds representing around 30% of the total budget in every state. Decentralization was halted between 1988 and 1994 and begun again in 1996, but did not include the decentralization of the IMSS–Solidarity infrastructure.

In August 1996, a national agreement was signed to complete decentralization in the remaining 16 states (including the Federal District), by transferring 21,000 jobs, 7,370 pieces of property, and US$1.1 billion from the central level to the states.
The Federal Government retains the authority to set health standards; regulate services and sanitary control of goods, establishments, and decentralized services; and control professional certification and accreditation of health units, generation of national statistics, and international representation of the sector. The state and municipal agencies share responsibilities for the organization, operation, and monitoring of public and private health services; sanitary control of services to the population; and fulfilment of health promotion and orientation tasks.

In 1996, the Secretariat of Health implemented a programme to expand coverage, based on the provision of a basic package of health services for the population with limited or no access to medical services in rural areas; this programme covered 6 million people in 18 states in 1997. In addition, in July 1997, IMSS introduced family health insurance, which people may voluntarily obtain by paying a fee that is complemented by a Government contribution.

### 2.5 Human resources

In 1999, 135,159 physicians held positions in the health sector, and there were 114,845 in contact with patients. Many of these doctors perform their duties both in the private sector and in public institutions. Of these, 54,185 assisted the uninsured population (mainly from the SSA), 60,660 assisted insured workers (mainly from the IMSS or ISSSTE), and 62,102 doctors practised in the private sector.

Of all physicians, 31% were general practitioners, there were 3.6 per 1000 inhabitants, and the ratio between general doctor and specialist was 1:0.83. In 2000, the Secretary of Health had 206,408 employees: 26% doctors, 36% nurses, 10% paramedics, and the remainder consisting of other professions (DGEI-SSA, 1999; DGEI-SSA, 2001).

### 3 Summary of LTC provision

#### 3.1 Social programmes that promote health care for the elderly population

In Mexico, social policy has been a longstanding tradition of Federal and state level governments. Different institutions are responsible for the implementation of social policy, but the Secretariat of Social Development (SEDESOL) is the only one that has responsibility in all social areas. As mentioned previously, SEDESOL is, in its reorganized fashion, clustering a whole set of institutions that were previously attached directly to the Executive Branch or to other secretariats.
SEDESOL is developing a new proposal to support the elderly population through the National Institute of the Elders (INSEN). Although INSEN was created two decades ago, it is now working with a renewed spirit and developing new programmes that can respond to the increasing needs of the elder population.

INSEN operates several programmes to attain these objectives, concentrated on three main axes (INSEN, 2001):

- values;
- health; and
- employment.

The values axis contains various programmes to:

- collect information about the living conditions of elders;
- promote the value of elders and their needs through the media and other vehicles;
- help to maintain the integration of elders with other age groups; and
- provide juridical security to elders enabled to take decisions regarding their heritage.

The health axis comprises four programmes:

- The International Geriatrics Congress, which seeks to obtain and discuss frontier information on geriatrics and to learn from other countries’ experiences;
- INSEN itself, which goes into neighbourhoods to approach and care for old people in their own communities and households in order to avoid segregation and isolation;
CASE-STUDY: MEXICO

- Certifying services for elders and their quality, which seeks to unify the criteria in assistance centres in order to provide good care;

- The National Crusade against chronic–degenerative diseases, which aims at preventing and avoiding disability provoked by the most common problems.

As defined by the Presidential Office:

As a specific compromise with the population with disabilities, the new administration looks to promote and integrate this important group of the population so that their opportunities and talent are expressed in all its dimensions.

To do this, the new administration created the Office of Representation for the Promotion and Integration of People with Disabilities as a way to give this population “a new and valuable role within our society”.

What started as a presidential campaign promise of achieving total incorporation into social, work, and political life of all those Mexicans that have some type of disability now intends to be consolidated in public policies and specific programmes through this new Office. Its objective is to promote the full integration of people with disabilities, and to assure them a level of social well-being and opportunities equal to those of the rest of the population. This goal is to be pursued through the establishment of coordinated policies with other public administration agencies at the three levels of government and social organizations. (Presidencia de la Republica, 2001a)
LONG-TERM CARE

To do this, the new Office has three main functions:

- to promote necessary amendments to the legal framework of all three levels of government to improve the social well-being of all people with disabilities;
- to support and enhance inter-institutional coordination to further develop and improve all existing programmes for people with disabilities with a special emphasis on rural areas; and
- to promote the development of projects with financial support and technical cooperation at the national and international levels to improve the quality of life of people with disabilities.

In its few months of existence, the Office has established:

- The Work Integration Programme, that seeks to achieve total equality for people with disabilities in order to obtain a job and have a source of income benefiting not only themselves and their families, but society as a whole.
- The Training Scholarship for Unemployed Programme of the Ministry of Labour, with a special focus on people with disabilities who face difficulties in gaining access to the labour market.

The Office has achieved, with the help of the Ministry of Health and the National Centre for Rehabilitation, inclusion in the National Health Plan 2000–2006 of an integral programme for the prevention and rehabilitation of disabilities. Efforts will now be directed towards attaining the commitment of all states to include specific preventive programmes in accordance with Federal policies that define disabilities as a public health problem (SSA, 2001).

The objective of the National Accessibility Programme is to provide equal opportunities by a process through which the physical environment, housing, public transportation, public buildings, sanitary and social services, education, training, social and cultural life are made accessible to every person in the country.
The “Care with Quality” programme for the disabled represents a major effort within the Federal Government to achieve the mandatory actions stated in the National Development Plan 2001–2006. The Plan requires that all Federal employees promote and strengthen the development of people with disabilities, with the objective of obtaining their integration in all spheres of national life.

To achieve this goal, the programme plans to train the largest possible number of Federal employees, so that they know how to provide the best quality services to people with disabilities. This training recognizes that the physical, intellectual or sensorial condition of such disabled people require special and specific attention—not preferential attention, but equal attention, according to their needs. (Presidencia de la República, 2001b)

Finally, the Research Projects and Funds Programme aims at promoting and supporting research projects in agreement with universities, research centres, and nongovernmental organizations in order to clearly define the projects needed, and at moving ahead with their implementation. The main projects defined today are: Diagnosis of the Disability Phenomenon in Mexico and Functional Help for People with Disabilities.

Another governmental agency that offers care for the elderly is the System for the Integral Development of the Family (DIF) which is the main family welfare institution of the public sector. In 1999, the DIF cared for nearly two thousand elderly people in sheltered homes, asylums and other types of nursing home.

DIF also runs a small “Day Residence Programme” for just over 100 individuals. This programme provides medical attention, rehabilitation, occupational and recreational therapies, as well as one meal per day to each individual. The objective of the programme is to raise self-esteem and quality of life for the families of these people, in order to delay enrolment in nursing homes.

In addition to these functions, the DIF provides legal counselling to the elderly, as well as medical and psychological orientation. It also provides free courses in which the elderly can learn about the risks to which they are exposed, and preventive issues concerning their health. In other areas, it also offers training to family members on how to take care of older relatives, and on the subject of self-employment. (DIF, 2000; Mora, 2001)

Among the citizens of Mexico, there is a growing interest in volunteer participation in social problems that has had significant impact. This has lead to the creation of many nongovernmental organizations (Civil Society Organizations). There are currently 3500 institutions and two-thirds of them have been created in the last thirty years.
These organizations perform a wide range of activities. The NGOs that are of primary interest to the elderly are listed in the following table, which classifies the principal activities performed by those organizations that have been registered at the Mexican Centre of Philanthropy (CEMEFI, 2001).

**Table 1. NGOs that work on behalf of the elderly in Mexico (2001)**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Number of organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum, nursing home, shelter</td>
<td>128</td>
</tr>
<tr>
<td>Training for work</td>
<td>9</td>
</tr>
<tr>
<td>Feeding</td>
<td>14</td>
</tr>
<tr>
<td>Recreation and culture</td>
<td>5</td>
</tr>
<tr>
<td>Psychological support</td>
<td>8</td>
</tr>
<tr>
<td>Medical attention and rehabilitation</td>
<td>18</td>
</tr>
<tr>
<td>Legal counselling and human rights</td>
<td>3</td>
</tr>
<tr>
<td>Support to the elderly person’s family</td>
<td>6</td>
</tr>
<tr>
<td>Charity</td>
<td>9</td>
</tr>
<tr>
<td>Integrated support</td>
<td>28</td>
</tr>
<tr>
<td>Various activities</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>250</strong></td>
</tr>
</tbody>
</table>

*Source: CEMEFI, 2001.*
3.2 In-depth study of two initiatives in long-term care

In this section, two governmental programmes are studied in greater depth. These are projects that provide important lessons for long-term care policy in the future.

One is a programme to provide home-based care being carried out at the Mexican Institute of Social Security, the main social security institution in Mexico. The other involves an alliance between a nongovernmental organization and the Ministry of Health to develop cost-effective, de-institutionalized care options for people with mental illness. Both programmes require careful analysis in order to extend and expand services and both illustrate the efforts that the Mexican health system is making towards

- cost-containment
- improvement of efficiency, and
- strengthening of quality of care

in the provision of services for those in need of long-term care.

3.2.1 Mental care through the Ministry of Health in collaboration with nongovernmental organizations

Health care for mental illnesses in Mexico has been traditionally provided through asylums in highly institutionalized settings. Under this model, 50 hospitals were constructed throughout the country. These institutionalized settings have often lead to unnecessarily high costs for care, separation of patients from society and from family, and in some cases a lack respect of basic human rights of patients, particularly where funding was a severe problem.

Nonetheless, this is only the institutional expression of a way to perceive and respond to mental health problems in a country such as Mexico. Ranging from the household to the community levels, the mentally ill have often been seen as individuals who do not have a place or function in society. Frequently they have been abused and confined in order to keep them from participating in society (Modelo Hidalgo de Atención a la Salud Mental, 2001).
LONG-TERM CARE

The institutional health care model has been challenged since its beginnings for being an excessively medicalized and high-cost model, for not being able to establish as a goal the rehabilitation of mentally ill patients to socially valuable functions and for not providing incentives or programmes for reintegration into society. Still, the institutionalized model of care has continued to dominate in Mexico as in many other countries. Introducing elements of change into this model requires a system-wide recognition of the problem.

Pressure for change in Mexico began in the early 1990s with the participation of NGOs. Organizations such as the Mexican Foundation for Mental Health and other groups of civil society initiated a systematic debate on the benefits of the hospital system. At the same time they collected data to demonstrate that the prevalent model was not responding to the needs of much of the population with mental problems, and that hospital confinement was closing off any chance of rehabilitation.

As a result of these efforts, and within the context of health system change, the current institutional response is to develop a systemic model for the care of the mentally ill that would provide multi-level care, working with patients at all stages of illness. This model seeks to provide opportunities for reintegration into society, and to minimize the degree of institutionalization. The work towards systemic change involves collaboration between the national government, state governments, and NGOs.

An important breakthrough came in November 2000, when the Mexican Foundation for the Rehabilitation of the Mentally Ill, the Ministry of Health and the Government of the State of Hidalgo, inaugurated the Ocaranza Villages and two halfway houses in Pachuca, the capital city of the State of Hidalgo. This initial project, the Hidalgo Model, is now being adapted and developed to generate a national model that can be built into the overall health system at the state level.

The new model stresses:

- a minimum of institutionalization, based on the needs of the patient;
- step-wise reintegration into society and family; and
- the development of productive capacities that allow the maximum possible degree of independence for the patient.
CASE-STUDY: MEXICO

This model is focused on the idea that, in certain periods of their life, people can present a severe symptom or group of symptoms of a mental illness and need integral care in a hospitalized or semi-hospitalized setting, followed by work on prevention and social reintegration.

Hospitalization, when necessary, is designed to occur in psychiatric units in general hospitals. New semi-hospital structures designed to allow for group living and called ‘villages’ are being developed. These units are designed to provide specialized care under a short-term hospitalization scheme with integral medical–psychiatric care. They are also equipped for outpatient care and psychiatric emergencies. In the ‘villages’, rehabilitation programmes are intensified with visits of patients to the community, as well as workshops conducted on the premises where patients participate voluntarily in productive and paid work that will accelerate their future reintegration into the community.

Social reintegration is achieved through structures within the community that are able to support the patient in the rehabilitation process. These structures are mainly halfway houses, community residences, independent apartments, workshops, cooperatives, social clubs, etc. Community-based programmes are key to the redefinition of the traditional psychiatric model. Users have the opportunity to live within a social group and to experience a positive process of reintegration that allows them to overcome illness outside their family environment that is often dysfunctional or unsupportive.

Community-based programmes create an environment where users receive support, security, and proper care to develop their independence. Halfway houses and community residences are houses located in the community. In this space, users are housed as part of their training for independent life since in some cases, the family cannot support them. It is worth mentioning that the cost of one person in the community programme is estimated to be one quarter of the cost per bed/day in a traditional mental hospital.

Independent apartments are places within the community for which the only support to the user is the payment of rent. Residences for senior citizens will provide specialized medical psycho-geriatric care. Premises will be adequate to the population’s needs. In the workshops, users will learn an activity and will be paid for their participation. Besides these services, social clubs – meeting centres in the community – and cooperatives will be built by members of the community and users in order to create their own source of financing.

Future efforts will focus on building on the lessons learned from the Hidalgo Model, complementing some existing health structures and restructuring others. The project will be scaled-up to the national level.
LONG-TERM CARE

In order to implement new models of service provision, the Ministry of Health has created the Psycho-social Rehabilitation, Citizen Participation, and Human Rights General Directorate, the main objectives of which are to expand, promote, train, advise and supervise the development of the new forms of care throughout the country, as well as to encourage federal and state-level authorities to provide the necessary financial resources.

Through this office, the Federal government is working to organize jointly the efforts of actors at the Federal Government, state government and civil society levels, so that by the year 2006 an integrated model that focuses on stepwise care rather than on institutionalization, can be operating in the majority of the states. While progress and the final model will likely vary by state depending upon needs, funding and existing institutional structures, the goal of this administration is to introduce many aspects of the integrated, stepwise, de-institutionalized model into each of the 32 states.

This experience is an excellent example of an effort to modernize, humanize, increase the effectiveness and reduce the costs of long-term care. Further, it is a very important example of collaboration between NGOs working at the local level and the national Government. In addition to the expected improvements in the provision of care, it will be important to learn from this experience of scaling-up a local model within a decentralized health system under the guidance of a national health institution working with an NGO.

3.2.2 Home Care Programme at the Mexican Institute of Social Security (IMSS)

3.2.2.1 Background

The 1996–2000 Strategic Guidelines of the Mexican Institute for Social Security (IMSS) seek to make medical care more flexible and opportune in face of the changes that the country is experiencing. They also seek to promote the efficient use of resources throughout all activities of the health care process at the three levels of care. Within the strategy of “Improvement of Care to Vulnerable Groups” defined in the Health Sector Reform Programme, one of the specific lines of action is home medical care (Reyes, 2001).

There is a growing group of patients in the IMSS and throughout the health system that require health care that is currently offered in hospitals and that could be met using the strategy of home-based medical care. This group includes patients with noncomplicated pneumonia, cancer patients, those undergoing treatment for trauma, or pre-term births.
Many of these patients could be cared for in their own homes by a health team. However, the current trend is to keep them in the hospital. This practice imposes high costs on the health system, as well as a series of health risks.

The high costs of current medical practice have been putting pressure on the IMSS to offer hospital care only to those patients that require hospital facilities and equipment on a permanent basis. Home-care emerges as a powerful alternative within the current trends of development, since it offers quality and effectiveness at a lower cost than the hospital under many circumstances.

Furthermore, it offers other benefits that go beyond the merely economic aspects to contribute to the improvement of quality of life by not separating the patient from the household environment, which:

- guarantees the individuality of the patient;
- promotes psychological relaxation of the patient and his/her family;
- isolates him/her from hospital-born germs; and
- allows psycho-social interaction, which promotes a better and faster recovery.

As described above, IMSS is the major provider of health care services in Mexico. It provides services to around forty million Mexicans. At the beginning of 2001, IMSS had 1076 family medicine units (first level), 219 regional hospitals (second level), and 41 specialty hospitals. These were located throughout the country, but were concentrated in urban areas where most formal sector workers live. IMSS also has the largest concentration of doctors and nurses in the country.

Even though a large portion of resources is devoted to the elderly who constitute a considerable part of the institution’s population, IMSS medical staff includes very few geriatricians. In spite of this lack of technical capacity, the group aged over 65 years represents only 8% of registered users, yet accounts for 35% of the institution's budget (Table 2).

This concentration of resource utilization by elderly people will be magnified in the near future. IMSS is already experiencing the effects of this process. While the population between 15 and 44 years of age increased their utilization of services by 2% from 1994 to 1999, the group beyond the age of 65 years presented an increase in utilization of 55% in the same period.
LONG-TERM CARE

This trend is reflected in the type of health problems attended to by the institution. The reasons for consultation that had the higher increase in the same period were chronic and degenerative diseases, arterial hypertension, and diabetes mellitus.

Table 2: Users and expenditures by age group, IMSS, 1997-8

<table>
<thead>
<tr>
<th>Age/group</th>
<th>% of total users</th>
<th>% of services costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>1.6</td>
<td>10.8</td>
</tr>
<tr>
<td>From 1–4 years</td>
<td>8.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Women in reproductive age</td>
<td>26.8</td>
<td>27.4</td>
</tr>
<tr>
<td>More than 65 years</td>
<td>8.0</td>
<td>35.4</td>
</tr>
<tr>
<td>Total</td>
<td>44.7</td>
<td>77.0</td>
</tr>
</tbody>
</table>

Source: IMSS

Given this trend in resource use, IMSS has recognized the need to increase the capacity and efficiency of health care units. The “Home Care for the Chronically Ill” (ADEC) strategy was launched in 1997. This programme is intended to make medical care for chronically ill people and those in terminal phase available at the household level.

ADEC is designed for patients with chronic-degenerative diseases and temporary or permanent loss of autonomy; with dementia; with cerebrovascular disease; with severe sequela for early rehabilitation; and terminal patients in need of palliative care. Enrolment is voluntary, but a network of family and community support for the patient is a prerequisite. ADEC has proven to be able to provide high quality care, and to improve efficiency in the use of financial resources by reducing time spent at emergency wards and by reducing the number of hospitalization days.
Although an evaluation of ADEC (Muñoz et al., 2001) proved the programme to be highly cost-effective for the Institute (IMSS), there are no studies or evaluation projects that contemplate the programme’s impact, social value, or benefits to the population (such as their quality of life and general health status). The demonstrated advantages made it possible to justify the expansion of the project with the creation of a programme to care for non-chronic and non-terminal patients (Trujillo, Cárdena & Pérez, 2000). After identifying a series of non-fatal health conditions that could be cared for at the home level, the institution expanded the programme and created the Home Medical Care Programme (AMED) in 2000.

Within AMED, personnel participate in the decision-making process according to the particular situation of every health unit, following the institutional guidelines that IMSS has put in place in order to guarantee the decentralization of processes, the transfer of responsibilities, and managerial autonomy in the identification of problems, solutions, and the implementation of cost-containment. AMED encourages the participation of the family in medical care.

It has also established criteria for care given to patients with sub-acute ailments, and uses them as a guideline towards the administrative autonomy of health care units. The health team is composed of a family doctor (2nd level) or a specialist (3rd level), one general nurse, and one social worker. Depending upon the case, the team will also include a nutritionist, a rehabilitation specialist, a specialist in psychiatry, and a driver with the use of a vehicle.

AMED’s implementation is organized into four phases.

- **Phase I:** detection and selection of patients.
- **Phase II:** planning of home medical visits.
- **Phase III:** home medical visits.
- **Phase IV:** case control.

In **Phase I**, the doctor in charge of the AMED programme in the health care unit identifies the patients who, according to clinical criteria, could be included in the programme. The doctor also determines the cost–benefit of including the patient in the programme by considering transportation costs, and is responsible for informing the patient and the family about the benefits of home care and the services that will be provided, as well as about their rights and commitments.
LONG-TERM CARE

In Phase II, the responsible professional organizes a plan to carry out home visits by the health team. The patient’s needs are identified, in order to elaborate a therapeutic plan that enables the team to provide sound care at home. The plan is discussed with the family, to agree on collaboration regarding dates and times of home visits. Within the hospital, the plan must define the resources that are needed to provide the patient with adequate care.

In Phase III, the home visit is carried out. During the visit, the health team is required to:

- explain to the patient and the family the reasons for the visit;
- identify the patient’s needs according to information on the clinical record;
- identify the patient’s health status;
- develop the therapeutic actions;
- provide information to the patient and the family about the care that must provided until the next visit.

In Phase IV, case control must be undertaken. In this phase, the health team must assure that household conditions can guarantee quality of care for the patient, particularly during the periods between visits. In so doing, the health team must identify the capacity of the patient and his/her family to follow the instructions given by health team personnel regarding the intake of drugs and the application of injections, as well as the capacity of the family to deal with the care of the patient and control sources of stress. The health team must advise the family on how to handle the patient and how to collect information that could be useful for the evaluation of the programme – both at the household and population levels.

To date, the programme has been operating under difficult conditions, because of the lack of appropriate resources for and training of the personnel in charge. Despite these difficulties, the programme is demonstrating results. The index of hospital readmission is approximately 1%, with some peaks due to difficulties with transportation or overdue visits. The number of trainees is three times higher than the number of patients enrolled in the programme. Although this health care model is still not generalized within IMSS, there is an interest in training multidisciplinary teams in a number of health care units and hospitals.
IMSS is an institution still not prepared to deal with the increasing demand for health services by elderly people – the main victims of chronic and degenerative diseases. There is no organizational strategy to deal with the needs of this population group, and this is reflected clearly in some specific issues.

The most salient of these needs is the lack of geriatric specialists within the institution. Although doctors and nurses have received short-term training in some geriatric topics, their capacity to deal with problematic issues is limited. Also, this training is focused on the care of patients at the hospital level – in spite of the fact that most geriatric patients receive care at health centres. A further aspect to be considered as a limitation of the programme is that IMSS has no plan to provide integral geriatric care, to have a life cycle perspective – as recommended by WHO – nor to encourage health promotion.

The IMSS health care model continues to be excessively medicalized, and requires a more complete implementation and integration of models such as ADEC and AMED. Long-term care programmes operate within an institutional environment that is not prepared to support their development, although international experience and evidence show that such a system would save money, promote efficiency, and provide good quality care. It will be important to evaluate, adapt and promote the implementation of programmes such as ADEC and AMED within the entire health system, in order to meet the health care and economic challenges that will come with population ageing and the epidemiological transition.

As mentioned above, families have been a major asset in saving institutional resources that would otherwise be spent on hospital services. Other benefits of family support include the participation of the family in the health care of elders which tends to improve family integration, and the fact that medical consultation in the presence of a relative can help to achieve a better understanding of the treatment that the patient has to follow.

Still, it is incorrect to assume that families can bear the entire economic labour and time costs of caring for sick relatives at home. Further, the burden of the presence of a sick person is normally assigned to women – who, for cultural reasons, must accept the responsibility of dedicating time that often competes with other activities, such as salaried work or study.

Therefore, promoting wider implementation and acceptance of programmes such as ADEC and AMED will not be sufficient to effectively and equitably meet the challenges of demographic and epidemiological transitions. Reforms of the health care system must be complemented by policies and programmes to promote gender equity and wider participation in the provision of health and long-term care.
4 General questions pertinent to LTC development

4.1 Present and future needs for LTC, and gaps between needs for and provision of services

The following points summarize the findings of this case-study. They indicate the gaps between the emerging needs for long-term care and the ability of the health system to provide services for those in need:

- The Mexican population is experiencing an ageing process, whereby the elderly will represent approximately 20% of the population by 2050.

- Changes in the epidemiological profile are placing great pressure upon the utilization and cost of health services.

- Health systems are not prepared for and cannot afford the cost of long-term services according to the prevailing model, in which the hospital is at the centre of the health services structure.

- Changes in the nature of the family and in the labour force participation of women make it impossible as well as inequitable to continue to rely on ‘volunteer’ female time for the care of the majority of family health problems.

4.2 Factors affecting the need for long-term care

4.2.1 Transitions in women’s use of time, and implications for long-term care

The increases in the demand for long-term care which are associated with epidemiological and demographic transitions, are occurring alongside social transformations that are making the provision of care within the family increasingly difficult. Over the past three decades, the allocation of women’s time, the structure of families, and the profile of activities performed by women, have changed dramatically in Mexico as in many other Latin American countries. These changes are generating important questions regarding appropriate and effective policy responses to meet the long-term care needs of the chronically ill, the disabled and the elderly, in addition to those of children.
The increase in female labour force participation constitutes one of the key social transitions in Mexico as well as worldwide (Presidencia de la República, 2001b). Although women have ‘always worked’, historically the majority of this work was in unpaid, household domestic duties. In Mexico, the changes in female labour force participation have been particularly dramatic and concentrated in the past three decades.

In Latin America on average, female labour force participation increased 152% between 1970 and 1990 while that of males increased only 68%. In Mexico, the growth was the fastest in the region. Over the same period, the increases were 256% and 99% respectively (Valdés, 1995) and women now constitute approximately one-third of the labour force (INEGI, 2001).

The age distribution of the working female population has also changed significantly. In past decades, women aged 15 to 24 years had the highest participation rates, at 25%. In 1995, the highest participation rates reached 40% and spanned the age group 15 to 40 (INEGI, 1995).

While the incorporation of women into the labour market in Mexico is an important motor for economic growth and for social and human development, it is important to recognize that there are important gender inequities and implications in areas such as the provision of health care in the family. This increase in female labour participation has been accompanied by an increasing burden on women and a double or triple work day.

Apparently, women have extended their working day as part of the transition, rather than men increasing their participation in domestic duties. This has important implications for the supply of time for the care of the family and particularly for those in need of substantial daily care such as the elderly, the disabled, the acutely ill, and children. The extra burden on women also plays out in gender discrimination in wages and occupations.

The presence of adults aged 64 years or older, or children aged between 5 and 12 years, is related to the probability that women head of households join the labour market. The highest percentage of women working for pay appears in those households where there is a presence of both children and elders combined.

While several interpretations are possible, one possibility is that women in these families may have to work to support the large number of dependents. Another hypothesis is that elders act as substitute caregivers for children, enabling the mother to enter the labour market (Parker & Knaul, 1997; Levine & Wong, 1998). These data are being further analysed in regression frameworks.
4.2.2 Changes in family structure

Parallel to other social transitions, the structure of the Mexican family has changed substantially. These changes imply a rupture with traditional family organization in which extended families were common and caregiving for children, the elderly and the ill were shared responsibilities. While the extended family continues to be an important institution in Mexico, such families are increasingly less common.

The phenomenon of rural–urban migration is a factor in these changes. In 1980, 25.5% of families were classified as extended, as compared to 18.3% in 1990. Furthermore, 74.5% of families are nuclear (FLACSO, 1995).

Moreover, there has been a strong trend in Mexico towards migration away from rural areas to the country’s cities. Additionally, many Mexicans have migrated to other countries to look for work, most notably to the United States.

This migration has had important consequences for long-term care. With working age family members often moving to different parts of Mexico or to other countries to look for work, extended multigenerational families are now less common.

The presence of elderly or sick family members has a clear impact on labour force participation in the family. Based upon a national survey undertaken in 2001:

- 9% of informants (4.5 million inhabitants) that reported illness or disability declared that there was a moderate impact on family members that affected their time use:

- 3% (1.4 million inhabitants) declared that at least one family member had to withdraw from the labour market; and

- 2% (1 million inhabitants) declared that a number of family members had to modify their time use and leave the labour market.

These figures are slightly higher for older informants, but considerably higher for those who report chronic or acute illness.
The long-term economic challenges that face Mexican families are exacerbated by regular economic crises. Between 1970 and 2000, there were four economic crises. During these crises, families were forced to send as many members as possible to work in the labour market. This often implies that women, youth, and children enter the labour market – reducing the time that family members have for caring for young children, the elderly and the sick (Cutler, Knaul, Lozano, Méndez & Zurita, 2000).

In summary, the profound economic and social transitions that Mexico has gone through over the past three decades imply that the traditional supply of long-term care – women working in the home – has declined and will likely continue to do so. Other caregiving options must be sought and these require innovative policy interventions and programmes that can:

- stimulate the reorganization of responsibilities within the family;
- make female labour force participation compatible with caregiving, through flexible work options and the extension of social security coverage; and at the same time
- guarantee adequate services to those who require long-term care.

4.2.3 The epidemiological profile of the Mexican population

The demographic transition has been rapid and profound in Mexico, and is closely associated with the epidemiological transition. In 1940, children aged from 0 to 4 years represented a higher proportion of the population than adults. In 2010, this relationship will be inverted.

Further, while in the year 2000 less than 5% of the population is elderly, in 2050 one in five Mexicans will be elderly. Life expectancy in 1940 was 41.5 years and in 2000 is 74.4 years (INEGI, 1990; Partida, 1999).

This improvement is associated with a strong decline in infant mortality from 125.7 infants under one year per 1000 live births in 1940 to 28 per 1000 live births in 1995 (INEGI, 1999c). The age group with the largest number of deaths up to the middle of the century was the infant population. More than 50% of deaths occurred in age groups below 5 years, while the population older than 65 years contributed only 16% of deaths.
LONG-TERM CARE

The epidemiological transition is associated with a transition from a mortality and morbidity profile which is primarily associated with infectious and preventable diseases to one in which noncommunicable diseases predominate. This is particularly common among the wealthier and urban population.

Around the middle of the century, before the industrialization and urbanization processes, the mortality pattern was dominated by infectious diseases. The two main causes of death were diarrhoea and pneumonia, and overall infectious diseases were responsible for 60% of all deaths. Noncommunicable diseases represented 15% of all deaths, and injuries another 5%. Thirty years later, Mexico is clearly at a different stage of the epidemiological transition.

In 1998, more than 60% of deaths were caused by chronic-degenerative problems, injuries represented 12%, and infectious diseases 28%. Furthermore, the distribution of deaths according to age group is inverted. Thus, 50% of all deaths occurred in the population beyond 65 years of age and only 11% among the group aged five years or less. By the year 2010, deaths due to noncommunicable disease will represent an estimated 65% of all mortality, while injuries and infectious diseases will represent only 15% of deaths (Frenk, Lozano, Gonzalez Block et al., 1994).

The epidemiological transition has been described as prolonged and protracted. While tremendous improvement has been seen, poorer populations and states continue to suffer a backlog of preventable infectious diseases, malnutrition, and maternal mortality – while at the same time displaying increases in chronic and degenerative conditions. This presents a challenge for the health system, because the mortality and morbidity profile is complex.

In understanding the gravity of the transition to chronic and degenerative disease and disability, it is important to take into account that lacking an appropriate social infrastructure for long-term care, these health problems have a number of additional social manifestations. Illnesses that require long-term care have not only health consequences, but are also associated with social problems such as abuse, family disintegration, and exit from the labour force.

Further, catastrophic health expenditures, which have been identified as a major challenge for the Mexican health system in international as well as national studies, are often associated with disability or chronic conditions (SSA, 2001; World Health Organization, 2000; Knaul et al., 2001). These health expenditures can place a family at risk of falling into a poverty trap by forcing them to either give inadequate care to family members or put at risk their ability to finance other necessary expenditures.
4.2.4 General mortality and morbidity profile in the 1990s

In general, the most frequent causes of death continue to be cardiovascular disease (69.4 per 100 000 in 1995), followed by malignant neoplasms (52.6), accidents (38.8), and diabetes mellitus (36.4). Cerebrovascular disease was the sixth leading cause of death in 1992 (at a rate of 24.7) and moved to fifth place in 1993 (a rate of 25.5 in 1995); disorders originating in the perinatal period, which occupied fifth place in 1992, dropped to seventh place in 1995 (a rate of 22.4), and cirrhosis and other chronic diseases of the liver ranked sixth in 1995 (a rate of 23.2).

The 1993 National Survey of Chronic Diseases, which is the most recent, found a 23.6% prevalence of hypertension, a 7.2% prevalence of diabetes mellitus, and an 8.8% prevalence of hypercholesterolaemia in the population older than 20 years of age. The prevalence of these three conditions increases with age, and in the 65–69 year-old age group illnesses of this type with the highest prevalence were hypertension and diabetes mellitus. The distribution by gender was similar for diabetes mellitus and was slightly higher in men for hypertension and hypercholesterolaemia (OPS, 2001).

Mortality from chronic diseases is clearly on the rise. In 1995, cardiovascular disease accounted for 63 609 deaths (a rate of 69.4 per 100 000 population). Diabetes mellitus was responsible for 33 316 deaths in 1995 (36.4). The increase of deaths from cirrhosis of the liver was 21 245 in 1995 (23.2). The incidence of hypertension is increasing in the public health services. In 1996, 403 582 cases were reported, at a rate of 433.1 per 100 000 inhabitants. The trend is the same for diabetes mellitus.

4.2.5 Chronic and degenerative diseases and disability

Diabetes mellitus is the most salient example of an emergent disease with important consequences for the demand for health services. It is the main cause of outpatient health care demand and one of the main causes of hospitalization. In theory, diabetes mellitus should be a health problem the consequences of which can be controlled with proper medication and healthy behaviour. However, it is estimated that in Mexico out of every 100 diabetics, 14 develop nephropathies, 10 neuropathies, 7–10 diabetic feet, and 2–5 blindness.

Psychiatric disorders are an emergent problem that are not causes of death but that play an important role in decreasing the number of healthy years of life, alter the family dynamic, and represent a considerable economic burden. The absolute number of deaths registered annually from dementia, for example, has increased 20 times in the last two decades, moving from less than 40 to more than 800 per year.
Depressive disorders continue to be a health problem about which little is known. Still, it is clear that in the decades to come they will be one of the main causes of loss of healthy years of life in the world. Global prevalence is 10%, and showing a tendency to increase. Currently in Mexico, there are almost four million people suffering from depression.

Disabilities are the product of diseases or injuries, but are also the result of improvements in prevention, diagnosis, and treatment of diseases. There is only limited information available about the incidence of disabilities, but it is estimated that every year in Mexico 125,000 disabilities are produced as a result of severe bone fractures, 67,000 genetic malformations, 43,000 sequel of vascular-brain disease, 20,000 sequel of cranium-encephalic trauma, and 12,000 cases of child brain paralysis.

Mortality by perinatal brain hypoxia has been reduced, but surviving children suffer brain paralysis along with movement problems, language alterations, and epilepsy. The survival rate of children with neural tube defects has also been increased, but many of them remain paraplegic or quadriplegic with severe organ dysfunction. As mentioned above, diabetes and hypertension are common causes of death. They are also associated with complications leading to disabilities.

Life expectancy in Mexico has increased considerably, as mentioned above. One of consequences has been the increase of several disabling conditions, including mental illness. It is important to highlight the fact that the disabled suffer a lack of equity in the allocation of resources. The main example is that of almost 1000 public hospitals in the country, only 152 have rehabilitation services, which tend to be underequipped and staffed by non-specialized personnel.

To be able to care for this population with an integral perspective, it is necessary to promote multisector actions in collaboration with the private sector and civil society. These actions should be addressed to:

- prevent, treat, limit and rehabilitate disabilities;
- broaden the public infrastructure available to facilitate the mobility and care of special needs for the disabled; and
- promote and facilitate the reincorporation of the person into the family, society and the labour market where possible.
4.2.6 Health of the elderly

The demand for health services for the elderly has increased. The proportion of hospitalizations of people aged 65 years or older increased from 8.3% in 1993 to 12% in 1999. In the past year, 10.3% of that population was hospitalized against only 4.6% of the population aged between 15–64 years. Furthermore, the population over 65 years of age accounted for 43% of intra-hospital mortality.

The main reasons for hospitalizations among elderly adults are currently related to cardiac problems and cerebrovascular diseases as well as pneumonia and complications from arteriosclerosis. Little is known about the magnitude of other problems that seem to be common in this age group such as trauma, malnutrition, dementia, and depression.\(^4\)

To sum up, the decline in the extended family network greatly impacts the ability of family members to care for disabled and elderly relatives. Urbanization and industrialization over the last half century have contributed to a change in the mortality pattern in Mexico.

Around the middle of the century, the mortality pattern was dominated by infectious diseases, and overall infectious diseases were responsible for 60% of all deaths. Noncommunicable diseases represented 15% of all deaths, and injuries another 5%. Thirty years later, Mexico is clearly at a different stage of the epidemiological transition. In 1998, more than 60% of deaths were caused by chronic-degenerative problems, injuries represented 12%, and infectious diseases 28%.

\(^4\) The lack of information for the population as a whole is due to poor diagnosis as well as the lack of an adequate system for registering health problems that cause disability but not death. The transition from a predominant pattern of infectious, nutritional, and reproductive problems to a pattern of injuries and chronic conditions, will continue to place additional pressures on the health system to modify and strengthen data collection. This is a process that is well under way and assisted by recent improvements in the management of data and information. For example, a large project is under way to make widely available, user-friendly data on the provision of health care by age, gender and cause at the Mexican Institute of Social Security in conjunction with the Mexican Health Foundation. These data sets have never before been used in their entirety due to difficulty of managing such large data bases, and restricted access for reasons of privacy.
4.3 Planned or current changes in health and social services that will impact on the provision of LTC

4.3.1 National health plans and policies in 2001–2006

With the change of the federal government in January 2001, there began an aggressive and ambitious programme to reduce health gaps and health care backlogs. The National Health Programme (NHP) was published in July 2001. The main health policies are geared towards strengthening the system and generating programmes in order to meet the three key challenges that have been identified in the National Health Programme for 2001–2006: equity, quality, and financial protection.

Key objectives are to expand coverage and provide efficient, high quality services to the entire population. In addition, the issue of financial protection and avoidance of impoverishing health spending is a key component of policy for the future. Given that chronic disease and care of the elderly are important factors leading to ongoing, impoverishing health care costs for families, the search for more cost-effective solutions to these health challenges is a major issue for current policy development.

Health plans are geared to treating the disorders stemming from epidemiological and demographic profiles, rapid transitions, and the substantial degree of inequity across population groups, as well as to providing universal health insurance. These programmes and policies built on several decades of health system reform initiatives, many of which have been limited in scope to issues such as decentralization, or to particular sectors such as the insured population.

A number of new projects are being launched and several are directly relevant to the issue of long-term care. One of the most important projects is Women and Health. This project responds directly to the office of the Secretary of Health and its main goal is to develop a stronger gender focus and impose greater gender equity in all projects related to the health system. The project has four main components:

- health of women;
- research and data;
- the medical labour market; and
- the production of health within the family and the community.
A final component of this project is the one that is key for long-term care issues. Specifically, the programme seeks to develop institutional capacity, a stronger legislative framework, and social communication and education that will enable women to better combine work and other responsibilities with care for elderly and sick family members. The programme includes efforts to introduce gender equity into family and community-based care by considering policies such as extending work leave to males and females to care for family members when they are ill, newborns, and the elderly.

The National Health Programme is designed around ten major strategies. One of these strategies is to ‘confront emergent problems’ by defining priorities based on promoting healthy life-styles and early detection of health problems. In addition to implementing new health services, the strategy seeks to work with other institutions in the public and private sectors to deal with disability through rehabilitation, programmes to end discrimination, and projects to better integrate the disabled. These are described in greater detail in the next section.

Within the health sector, the strategy (SSA, 2001) on emergent problems includes intensified and enhanced programmes to:

- reduce the prevalence and consequences of diabetes;
- control cardiovascular disease and hypertension;
- provide better and more preventive care and information to the elderly;
- improve the training of professionals in the area of care for the elderly;
- promote transplants as viable health care alternatives;
- reduce addictions to tobacco and other drugs;
- care for the mentally ill;
- detect and prevent cancers;
- prevent and control HIV-AIDs; and
- prevent disability and rehabilitate the disabled.
The emergence of home-based long-term care and deinstitutionalized models is a promising option to reduce costs, to provide quality care, and to increase quality of life.

Currently, home-care and deinstitutionalized programmes face difficulties as they challenge the medicalized views of institutional health care – this needs to be overcome.

Models for providing care for the elderly and the long-term ill must be supported by specific social policy to generate models that promote gender equity.

Social policy should also encourage the participation of men in the duties of caring for family members and the community.

All programmes described in the document are still in early stages but they need to be evaluated in order to make necessary adjustments according to specific situations.

Home long-term care programmes need to be expanded, but changes need to be implemented not only at the institutional level but also at the social level – as there is still widespread rejection in society of more integrated and equitable models of caregiving.

Taking into account international experiences, such income support policies in home care programmes as direct cash supports, medical equipment needed by the patient, special beds, and the like, could be included as a component for home care programmes in Mexico. This possibility must be evaluated taking into account the needs of current and potential home care programme users, the financial condition of the programme, and how these supports would be financed, etc.
Bibliography


DGE (Dirección General de Estadística) (1970) IX Censo General de Población. Mexico, DGE.


LONG-TERM CARE


INEGI (1997) *Encuesta Nacional de Empleo Urbano*. Mexico, INEGI.


INEGI (1999a) *Encuesta Nacional de Empleo Urbano*. Mexico, INEGI.

INEGI (1999b) *Mujeres y Hombres en México*. Mexico, INEGI.

INEGI (1999c) *Sistema de Indicadores para el Seguimiento de la Situación de la Mujer en México*. Available at web site: www.inegi.gob.mx. Mexico, INEGI.

INEGI (2000a) *Diferencias de Género en las aportaciones al hogar y en el uso del tiempo*. Mexico, INEGI.

INEGI (2000b) *Anuario Estadístico 2000*. Mexico, INEGI.

INEGI (2000c) *Mujeres y Hombres en México*. Mexico, INEGI.

INEGI (2001) *Estadísticas de Empleo con Enfoque de Género*. Mexico, INEGI.


CASE-STUDY: MEXICO


Mora E (2001) Personal Communication of the “Directora del Programa de Atención a Indigentes y Personas de la Tercera Edad del Sistema Nacional para el Desarrollo Integral de la Familia”. October, Mexico, D.F.


Presidencia de la Republica (2001a) *Oficina de Representación para la Promoción e Integración Social para Personas con Discapacidad*. Available at web site: http://discapacidad.presidencia.gob.mx


LONG-TERM CARE


SSA (Secretaria de Salud) (1998) Anuario Estadístico. Mexico, SSA.


CASE-STUDY REPUBLIC OF KOREA

Chung Yu Lee
Euisook Kim
CASE-STUDY: REPUBLIC OF KOREA
by Chung Yu Lee & Euisook Kim

1 General background data

1.1 Preamble

Owing to continuous economic growth, a higher standard of living, and the advancement of medicine in Korea, the life expectancy of Koreans has increased from 69 in 1985 to 74.4 in 2000 (male: 70.5, female: 78.3). Now, Korea is on the verge of becoming an ageing society, and the speed of ageing is proceeding at a previously unparalleled rate. The proportion of people aged 65 years or older was 7.1% of the total population in 2000, and the projected percentage of elderly people will be 16.9% of the total population by 2025.

In addition to statistics that show that the rate of ageing is increasing, there is also data that indicate that chronic diseases are on the rise and that there is a change in the distribution and causes of disability (i.e. more people are developing disabilities and chronic conditions later in life as opposed to at birth).

Further, whereas family members had previously undertaken the primary caregiving responsibilities for the frail elderly in Korea (caretakers were usually wives, daughters, or daughters-in-law), realities are changing because of an increase in the number of nuclear families (79.8% in 1995), increasing urban migration and a growth in the number of economically active women (42.7% in 2000). In light of these developments, there is a need to re-examine the viability of this traditional support system for the future. Korea has thus an increasing need for professional care for people with dementia and chronic illness who previously would have been taken care of by family members.

Taken together, these trends indicate an urgent need for planning LTC services. While Korea has a well developed health and social system, better coordination of appropriate services for disabled populations with LTC needs remains a major challenge. Presented on the following pages are background data derived from international data bases.¹ These data concern demography, vital statistics and epidemiology, economic data, and health expenditure.

¹ For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); US Bureau of the Census, International Data Base; WHO-World Health Report 2001; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.
# 1.2 Background data from international data bases

**Demography (year 2000)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong> (thousands)</td>
<td>46 740</td>
</tr>
<tr>
<td><strong>Land area</strong> (sq km)</td>
<td>98 190</td>
</tr>
<tr>
<td><strong>Population density</strong> (per sq km)</td>
<td>472</td>
</tr>
<tr>
<td><strong>Population growth rate</strong> (% in 2000–2005)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Urban population</strong> (%)</td>
<td>82</td>
</tr>
<tr>
<td><strong>Ethnic groups</strong></td>
<td></td>
</tr>
<tr>
<td>Homogeneous</td>
<td></td>
</tr>
<tr>
<td>(except for approximately 20 000 Chinese)</td>
<td></td>
</tr>
<tr>
<td><strong>Religions</strong> (%)</td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>49</td>
</tr>
<tr>
<td>Buddhist</td>
<td>47</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total adult literacy rate</strong> (% in 1997)</td>
<td>98</td>
</tr>
<tr>
<td><strong>Age Structure</strong> (%)</td>
<td></td>
</tr>
<tr>
<td>0–142</td>
<td>20.8</td>
</tr>
<tr>
<td>15–24</td>
<td>16.5</td>
</tr>
<tr>
<td>60+</td>
<td>11.0</td>
</tr>
<tr>
<td>65+</td>
<td>7.1</td>
</tr>
<tr>
<td>80+</td>
<td>1.0</td>
</tr>
</tbody>
</table>

---

2 Elderly dependency ratio: the ratio of those age 65 and over per 100 persons age 20–64.

3 Parent support ratio: the ratio of those age 80 and over per 100 persons age 50–64.
Demography (continued)

Projections 65+ (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>16.9</td>
</tr>
<tr>
<td>2050</td>
<td>27.4</td>
</tr>
</tbody>
</table>

Sex ratio (males per female)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>1.01</td>
</tr>
<tr>
<td>15–64</td>
<td>1.03</td>
</tr>
<tr>
<td>65+</td>
<td>0.63</td>
</tr>
</tbody>
</table>

Dependency Ratio:

<table>
<thead>
<tr>
<th>Ratio Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly dependency ratio in 2000</td>
<td>1.1</td>
</tr>
<tr>
<td>Elderly dependency ratio in 2025</td>
<td>27.4</td>
</tr>
<tr>
<td>Parent support ratio in 2000</td>
<td>7.2</td>
</tr>
<tr>
<td>Parent support ratio in 2005</td>
<td>14.5</td>
</tr>
</tbody>
</table>

Vital statistics and epidemiology

Crude birth rate (per 1000 population) (2000) 12.8

Crude death rate (per 1000 population) (2000) 5.9

Mortality under age 5 (per 1000 births) (2001)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>males</td>
<td>8.0</td>
</tr>
<tr>
<td>females</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Probability of dying between 15–59 (per 1000) (2001)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>males</td>
<td>177</td>
</tr>
<tr>
<td>females</td>
<td>66</td>
</tr>
</tbody>
</table>
### Vital statistics and epidemiology (continued)

- **Maternal mortality rate** (per 100,000 live births) (1995) 20
- **Total fertility rate** (children born/woman) (2001) 1.5
- **Estimated number of adults living with HIV/AIDS** (2001) 4000
- **HIV/AIDS adult prevalence rate** (%) (2001) <0.1
- **Estimated number of children living with HIV/AIDS** (2001) <100
- **Estimated number of deaths due to AIDS** (2001) 220
- **Life expectancy at birth** (years) (2001)
  - Total Population 74.9
  - Male 71.2
  - Female 78.7
- **Life expectancy at 60** (years) (2001)
  - Total Population 20.0
  - Male 17.0
  - Female 22.0
- **Healthy life expectancy (HALE) at birth** (years) (2001)
  - Total Population 67.4
  - Male 64.5
  - Female 70.3
- **Healthy life expectancy (HALE) at 60** (years) (2001)
  - Total Population 14.8
  - Male 12.9
  - Female 16.7
### Economic data (year 2000)

#### GDP – composition by sector (%)
- Agriculture: 6.0%
- Industry: 41.0%
- Services: 53.0%

#### Gross national Income (GNI) ($PPP)\(^4\)
- 818 billion

#### GNI – per capita ($PPP)
- 17300

#### Gni – per capita (US$)
- 8901

#### GDP growth (annual %)
- 8.8

#### Labour Force Participation (% in 2000)
- Male: 59.4%
- Female: 42.7

### Health Expenditure (Year 2000)

#### % of GDP
- 6

#### Health expenditure per capita ($PPP)
- 909

#### Health expenditure per capita (US$)
- 584

---

\(^4\) PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries.
LONG-TERM CARE

2 General health and social system

2.1 Basic income maintenance programmes

These programmes are discussed under ‘Social welfare system’, section 2.3.

2.2 Organizational structure of decision-making

Health care can be divided into public and nongovernmental organizations. Nongovernmental health services make up the greater part of the Korean health care system.

Public health organizations include the Ministry of Health and Welfare (MOHW) at the central government level, and health centres, health sub-centres, and PHC (Primary Health Care) posts at the local government level. Nongovernmental health organizations can be classified as primary, secondary, and tertiary health care facilities based upon the scale and the level of specialization. The organizational structure of the health care system of the Republic of Korea is illustrated in Figure 1 on the following page.

The MOHW is responsible for the maintenance and promotion of national health and social welfare. To carry out these functions, the MOHW is divided into two main areas of work: social welfare; and the planning and management of general health services.

2.2.1 Health care system

The MOHW is responsible for supervising, planning, personnel management, quality assurance, budget management, and service management of health care facilities. Seven metropolitan city health centers, nine provincial health centers, and 242 district health centres are responsible for maternal and child health in each community. They also supervise community health services such as communicable disease management, nutritional health services, and health education/promotion services.

Among the nongovernmental facilities, the majority of private facilities provide curative services, while public facilities provide preventive services. The MOHW controls licensing and the number of personnel, while the Ministry of Education (MOE) controls accreditation of medical and nursing schools.
CASE-STUDY: REPUBLIC OF KOREA

Figure 1. Health care system of the Republic of Korea

<table>
<thead>
<tr>
<th>Public sector</th>
<th>Nongovernmental sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central government</td>
<td></td>
</tr>
<tr>
<td>Ministry of Government Administration &amp; Home Affairs</td>
<td>Ministry of Health &amp; Welfare</td>
</tr>
<tr>
<td>City* &amp; provincial level</td>
<td>National Medical Centre &amp; special hospitals (tuberculous, leprosy &amp; mental hospitals)</td>
</tr>
<tr>
<td>City**, county &amp; city district level (Health centres)</td>
<td>Tertiary health care facilities (general hospitals and university hospitals)</td>
</tr>
<tr>
<td>Town &amp; township level (Health sub-centres)</td>
<td>Primary health care facilities (clinics)</td>
</tr>
<tr>
<td>PHC post</td>
<td>Secondary health care facilities (hospitals)</td>
</tr>
</tbody>
</table>

City*: Seoul & the six autonomous cities.
City**: Smaller cities.
LONG-TERM CARE

2.3 Social welfare system

The current social welfare system in Korea consists of three components:

- Social insurance (health insurance, national pension, worker’s compensation, unemployment relief);
- Public assistance (livelihood protection, medical aid, veterans relief, disaster relief); and
- Social welfare services (for people who are physically and/or mentally disabled, for elderly people, children, and women).

Social insurance programmes: the national health insurance scheme was launched on 1 July 1977, and 100% of the population has been covered since 1989. The public assistance programme, in accordance with the Livelihood Protection Act enacted in 1961, provides livelihood protection services to needy persons who have no physical ability and persons with low income.

Medical Aid has been operated separately under the Medical Aid Act since 1977, and now covers 1,740,000 persons, 3.8% of the total population. According to the Disaster Relief Act, the Government offers funeral costs, consolation money, livelihood subsidies and house reconstruction cost to victims of natural disasters. There is also the patriots’ and veterans relief programme for those who were injured or killed in war and for their survivors.

The Government is striving to expand welfare institutions and improve the quality of their services, so that comprehensive protection for persons with severe and/or multiple disabilities can be provided. The Government is also expanding income maintenance programmes for persons with disabilities by providing welfare allowance and reducing taxes and fees.

Welfare policies for the disabled include:

- Providing a welfare allowance for persons with severe and/or multiple disabilities;
- Providing education aid for children of people with disabilities who are in the low-income brackets;
CASE-STUDY: REPUBLIC OF KOREA

- supporting medical expenses for disabled persons with low incomes;
- providing loans for self-support;
- reducing economic burdens, such as deduction of tax, discount fees for public facilities; and
- the National Pension Scheme (NHS) which provides its members with protection against economic distress arising from disability.

Social welfare services for elderly people include:

- provision by the NHS of lifetime pensions for those aged 60 and over;
- provision of a ‘Non-contributory Old-age Pension benefit’ for elderly people in low-income brackets who are excluded from the national pension scheme;
- support of a part or the entirety of medical costs through the Medical Aid programme;
- reduction of economic burdens, such as deduction of tax and discount fees for public facilities; and
- provision of elderly people with an opportunity to earn money through job placement programmes such as the Aged Employment Services Centre for the Elderly, the Aged Workplace and Employment Promotion for the Elderly.

At the level of the central government, the MOHW is responsible for two major social security programmes; the National Health Insurance and the National Pension Scheme. It directly carries out social insurance programmes through related associations, such as the Korean Federation of Health Insurance and the National Pension Corporation. For public assistance and social welfare services, the MOHW is in charge of planning, coordinating, budgeting, and proposing the enactment or amendment of related law.
LONG-TERM CARE

3 Financing of health services

3.1 General government finance

The health and welfare proportion of the total Government budget has been rapidly growing over recent years. This increase has resulted in strengthening various social security programmes, such as Health Insurance, National Pension, etc. The budget of the MOHW in the year 2000 amounted to 5310 billion won (approximately US$4.4 billion). This represented 5.98% of the total budget, an increase of 27.6% over that of 1999.

The breakdown of annual expenditure by programme is shown in Table 1.

Table 1. Budget of Ministry of Health and Welfare (millions of won)

<table>
<thead>
<tr>
<th>Classification</th>
<th>Budget</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Welfare</td>
<td>2 188 679</td>
<td>41</td>
</tr>
<tr>
<td>Health Care</td>
<td>236 088</td>
<td>5</td>
</tr>
<tr>
<td>Health Security</td>
<td>2 785 969</td>
<td>52</td>
</tr>
<tr>
<td>Fixed Expenditures</td>
<td>99 285</td>
<td>2</td>
</tr>
</tbody>
</table>

3.2 Government sponsored insurance with premiums

A major concern in the medical insurance scheme, like other kinds of insurance, is securing the financial resources for rendering effective benefits. The health insurance scheme in Korea is financed on the basis of ‘social insurance’, in which contributions are levied and collected in proportion to the income level of the insured.

Formerly, there were three forms of health insurance, employee health insurance, government and private school employee health insurance, and self-employed health insurance in Korea. Each insurance association was operated independently through a self-supporting system.

However, to achieve more efficiency in the operation of the insurance fund, to extend the benefit package, to meet the demand of the insured person, and to maintain equity and social solidarity among the insured, the Government passed a new National Health Insurance Act on 1 July 2000. As a result, the three insurance associations merged into one organization called National Health Insurance.
### Table 3. The health insurance financing system

<table>
<thead>
<tr>
<th>Classification</th>
<th>EHI ¹</th>
<th>GHI ²</th>
<th>SHI ³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Share of contributions by employers/employees</strong></td>
<td>2.8% of the monthly wages &amp; salaries (50% of the premium)</td>
<td>Government employees pay 3.4% (2.8% for servicemen) of the monthly wages &amp; salaries (50% of the premium)</td>
<td>Applies a flat sum system by grade (from 3 to 30 classifications according to income and assets)</td>
</tr>
<tr>
<td><strong>Employers pay 50% of the premium</strong></td>
<td>Private school employees pay 3.4% of the monthly wages &amp; salaries (50% of the premium)</td>
<td>Employers pay 30% of the premium</td>
<td></td>
</tr>
<tr>
<td><strong>Government Subsidies</strong></td>
<td>None</td>
<td>Government pays 20%-50% of the premium</td>
<td>Government subsidy covers about 36% of insurance funds</td>
</tr>
<tr>
<td><strong>Benefit package</strong></td>
<td>Non-cash benefits: health care benefits, maternity benefits, health examinations</td>
<td>Cash benefits: Maternity allowances, fixed amounts for funeral expenses</td>
<td>Co-payment</td>
</tr>
<tr>
<td></td>
<td><strong>Inpatient services</strong>: 20% of total health care charges paid out-of-pocket.</td>
<td></td>
<td>Inpatient services: 20% of total health care charges paid out-of-pocket.</td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient medical services</strong>: % paid out-of-pocket⁴ in:</td>
<td></td>
<td>Outpatient medical services: % paid out-of-pocket⁴ in:</td>
</tr>
<tr>
<td></td>
<td>General hospital: 55% of total charges</td>
<td></td>
<td>General hospital: 55% of total charges</td>
</tr>
<tr>
<td></td>
<td>Hospital: 40% of total charges</td>
<td></td>
<td>Hospital: 40% of total charges</td>
</tr>
<tr>
<td></td>
<td>Clinic: 30% of the total charges</td>
<td></td>
<td>Clinic: 30% of the total charges</td>
</tr>
</tbody>
</table>

¹ EHI: Former Employee Health Insurance
² GHI: Former Government and Private Employee Health Insurance
³ SHI: Former Self-employed Health Insurance
⁴ Temporary Medical Aid recipients (numbering 760 000) are excluded.
⁵ When the total charges do not exceed 12 000 won ($10.00), the patient pays 2200 Won ($2.00), or 2700 won ($2.50) at a dental clinic.
LONG-TERM CARE

3.3 Private insurance with premiums

A limited number of people who are willing to pay the premium have private insurance such as life insurance or cancer insurance. Some kinds of life insurance cover fees for hospitalization with predetermined injuries or diseases. Likewise, cancer insurance pays its beneficiaries fees for cancer treatment and surgery.

Expenditure for insurance as a percentage of personal income, which represents insurance penetration, reached 11.3% in 1999.

3.4 Financing for the poor

3.4.1 Recipients

The Medical Aid Programme is designed to assist people with low incomes, those receiving livelihood assistance, and those who are unable to pay for health care. It provides the poor with health care services from the national budget.

Medical Aid, as a public assistance programme, is categorized into Class I and Class II. The total number of recipients was 2,128,000 in 1999.

Table 4. Share of medical costs (1999)

<table>
<thead>
<tr>
<th>Classification</th>
<th>Outpatient services</th>
<th>Inpatient services</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>Free (Government pays all costs)</td>
<td>Free (Government pays all costs)</td>
<td>The range and level of medical services covered are equal to National Health Insurance policy holders.</td>
</tr>
<tr>
<td>Class II</td>
<td>1500 won ($1.25) per clinic visit</td>
<td>Recipient pays 20% of the total fees.</td>
<td></td>
</tr>
</tbody>
</table>
4 Services delivery system and auspices of health service providers

4.1 Primary health care

The Government promulgated a special law for Primary Health Care (PHC) in Rural and Fishery Areas in 1981 for residents where accessibility to medical care was difficult. Primary Health Care Posts (PHP) were constructed, and in 1996 the number totaled 2034. PHPs were established in rural and fishery areas, with more than 500 inhabitants (more than 300 for the islands), and where medical facilities were located 30 minutes or more away by public transportation.

The major mission of the Community Health Practitioners (CHP) is to provide PHC including preventive health care and basic medical treatment. CHP services are covered by the National Insurance System. Each PHP is operated by a committee, which is formed by the community. The CHPs are qualified nurses or midwives who are deployed to a designated area after completing on the job training for 24 weeks. To improve the quality of service by the CHPs, an annual continuing education/training has been provided.

4.2 Types of health care facilities

Public health care facilities include health centres, health sub-centres, and PHC posts. National Special Hospitals such as tuberculous, leprosy and mental hospitals are included in the public health care institutions as well.

Non-governmental clinics and hospitals make up more than 91.0% of all medical facilities, employ 88.8% of physicians, and include 91.0% of total beds. Most nongovernmental facilities are concentrated in urban areas. In Korea, while about 69.9% of the population resides in urban areas, 92% of the physicians and 85.9% of hospital beds are concentrated in the cities. This situation makes it difficult for the rural population to have access to medical care.

Nongovernmental health care facilities (medical institutions) are classified as general hospitals, hospitals, dental hospitals, oriental medical hospitals, medical clinics, dental clinics, oriental medical clinics, and midwifery clinics.

General hospitals are medical institutions where doctors and dentists give medical treatment, and are equipped with more than 100 inpatient beds with specialty doctors and more than nine medical departments such as internal medicine, surgery, obstetrics and gynaecology, paediatrics, radiology, anaesthesiology, pathology and laboratory medicine, psychiatry, and dentistry.
LONG-TERM CARE

_Hospitals_ are medical institutions where doctors, dentists or oriental medical doctors give medical treatment, and are equipped with more than 30 inpatient beds. However, _dental hospitals_ are not subject to the same requirements for facilities for inpatients. _Clinics_ are medical institutions where doctors, dentists or oriental medical doctors give medical treatment, and which have facilities for medical examination and treatment.

_Midwifery clinics_ are medical institutions where a midwife conducts child delivery, gives health education and cares for pregnant women, women in childbirth and newborn babies. The facilities are equipped for medical examination and treatment.

**Table 5. Classification of medical institutions**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Institution</th>
<th>Patient</th>
<th>Doctor</th>
</tr>
</thead>
</table>
| **Primary health care facilities** | Health centres  
Health subcentres  
PHC posts  
Clinics  
Special clinics | Outpatients residing in the area | General practitioners  
Medical specialists at special clinics |
| **Secondary hospitals** | Hospitals with 30–99 beds  
Hospitals with 100–699 beds | Outpatients & inpatients referred from PHC facilities | Medical specialists |
| **Tertiary hospitals** | Hospitals with 700 or more beds | Outpatients & inpatients referred from PHC facilities & secondary hospitals | Medical specialists in each field |
| **Special hospitals** | Psychiatric hospitals  
Rehabilitation centres  
Tuberculous hospitals  
Leprosy hospitals  
Cancer hospitals  
Communicable disease hospitals | Special disease patients | Medical specialists on specific diseases |
Several NGOs such as The Korean Red Cross, The Planned Parenthood Federation of Korea, and religious organizations exist for persons who need help from others. These organizations are operated with a fund raised through fund-raising activities, donations from NGOs, and membership fees.

Other than these organizations, professional organizations such as academic societies and associations help to promote public health by providing continuing education for members, promoting the interest and rights of members, and establishing regulations defining duties of professionals.

4.3 Health care delivery and payment system

Selection of medical institutions is usually unrestricted. Patients who receive inpatient or outpatient treatment in medical facilities, and/or prescription drugs pay 20–65% of the total cost, out of pocket. The National Health Insurance Scheme pays the rest of the medical costs. The Medical Aid programme pays a part or the entire medical costs for the recipients. However, recipients of the Medical Aid programme are not free to select any medical institution but must use health centres and designated medical institutions.

In urban areas, most people use private clinics and walk-in clinics in hospitals, while people with low income and elderly people tend to use the health centres. In rural areas 30–40% of the population uses the health centers, while in remote areas, over 90% use the CHP for health care services.

The Livelihood Protection System (LPS), developed under the anti-poverty policies in Korea, provides protection for poor people who qualified as home care and institutional care recipients according to the Livelihood Protection Act. Livelihood aid of cash grants for staple foods (rice and barley), subsidiary dishes, clothing and other necessities of life are provided to home care and institutional care recipients. The benefit level varies according to the recipient’s family income and the number of family members.

Educational aid offers educational fee assistance to school-aged children of families under the LPS. Medical aid is provided for Livelihood Protection recipients who are unable to pay for medical treatment from their own resources. Housing aid was designed to stabilize dwelling problems of low-income families. While emergency aid provides a livelihood allowance in urgent situations.
LONG-TERM CARE

4.5 Human resources and training

According to the Medical Service Act, medical persons are defined as doctors, dentists, oriental medical doctors, midwives and nurses, who are licensed by the Ministry of Health and Welfare. Besides these, there are medical technicians, medical records officers, opticians described under the Medical Technician Act and under the Medical Service Act, nurse’s aides, acupuncturists, moxibustionists and masseuses described as quasi-medical persons.

Because health related personnel are those who have special professions that deal with health, their qualifications are strictly prescribed by laws and the Government licenses only those who pass pertinent national examinations and only licensed persons can provide medical treatments and public health services. The qualification standard and licence conditions of these health related persons are determined by the degree of complexity in their services.

The number of health related personnel in Korea has increased rapidly in the last decade, but it is still comparatively low, compared to industrialized countries. The number of doctors per 10 000 persons is about 13, compared with 16–20 in industrialized countries. However, if we consider the medical demands and behaviour of people, the working hours of doctors, and the fact that there are 8714 oriental medical doctors, the above ratios seem satisfactory.

Specialists refer to those who take a training course of internship and residency at a hospital or medical institution designated by the Government after obtaining licences as a doctor or dentist. There were 26 specialties and 32 003 specialists in 1995. This represents an increase of 3.8 times the number of specialists compared to 1980.

Pharmacists and social workers are required to have four years of education after graduating from high school, and dental hygienists and physical therapists at least two years of education after high school.
**Table 6. Number of health-related persons having registered licences (1999)**

<table>
<thead>
<tr>
<th>Number</th>
<th>Educational requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>69 724 6 years after high school</td>
</tr>
<tr>
<td>Oriental medical doctors</td>
<td>11 109 6 years after high school</td>
</tr>
<tr>
<td>Dentists</td>
<td>17 193 6 years after high school</td>
</tr>
<tr>
<td>Nurses</td>
<td>150 067 3-4 years after high school</td>
</tr>
<tr>
<td>Midwives</td>
<td>8658 RN +1 year internship</td>
</tr>
<tr>
<td>Medical technicians</td>
<td>107 324 2 years after high school</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>49 214 4 years after high school</td>
</tr>
<tr>
<td>Medical records officers</td>
<td>7060 4 years after high school plus 1 year internship</td>
</tr>
</tbody>
</table>

Social workers are classified as first, second, and third grade social workers, and the required education is different for each level.

**Table 7. Number of social workers by level (2001.6)**

<table>
<thead>
<tr>
<th>Number</th>
<th>Educational requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Grade</td>
<td>28 332 4 years after high school plus 3 years of field experiences after obtaining 2nd grade certification</td>
</tr>
<tr>
<td>2nd Grade</td>
<td>13 013 3 years of field experiences after obtaining 3rd grade certification</td>
</tr>
<tr>
<td>3rd Grade</td>
<td>9181 24 weeks education after high school</td>
</tr>
<tr>
<td>Total</td>
<td>50 526</td>
</tr>
</tbody>
</table>

19
LONG-TERM CARE

Table 8 shows the number of health care workers practising in public health care institutions. Table 9 lists the number of nurses working in the field.

**Table 8. The mean number of public health care workers by institution (2001)**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Health centre</th>
<th>Health subcentre</th>
<th>PHC post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>3.1</td>
<td>1.0</td>
<td>–</td>
</tr>
<tr>
<td>Oriental medical doctors</td>
<td>0.9</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Dentists</td>
<td>0.9</td>
<td>0.5</td>
<td>–</td>
</tr>
<tr>
<td>Nurses</td>
<td>12.0</td>
<td>0.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>0.9</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Medical technicians</td>
<td>7.9</td>
<td>0.6</td>
<td>–</td>
</tr>
<tr>
<td>Nurse’s aides</td>
<td>5.3</td>
<td>1.9</td>
<td>–</td>
</tr>
<tr>
<td>Administrative workers</td>
<td>15.2</td>
<td>0.1</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45.0</strong></td>
<td><strong>4.5</strong></td>
<td><strong>1.0</strong></td>
</tr>
</tbody>
</table>

**Table 9. Number of nurses working in the field (1998)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health nurses</td>
<td>5436</td>
</tr>
<tr>
<td>Community health nurse practitioners</td>
<td>1947</td>
</tr>
<tr>
<td>School nurses</td>
<td>6156</td>
</tr>
<tr>
<td>Dispensary nurses*</td>
<td>1985</td>
</tr>
<tr>
<td>Nurses in Higher Education and Research</td>
<td>2001</td>
</tr>
</tbody>
</table>

* Number from 1994 data.
5 Summary of LTC provision

5.1 Long-term care services

Most LTC is still provided in the homes of the elderly, with most of the responsibilities falling on the eldest son. Professional LTC services can be illustrated in accordance with the type of caregivers as shown in Table 10.

Table 10. Elements of care for those in need of LTC

<table>
<thead>
<tr>
<th>Elements</th>
<th>Home care at hospital</th>
<th>Visiting nurses at health centre</th>
<th>Home helper at home</th>
<th>Hospice at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment, monitoring and reassessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health promotion, health protection, disease prevention, and disability postponement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitation of self care, self-help, mutual aid and advocacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General health care and management of chronic diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care, e.g. grooming, bathing, meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household assistance, e.g. cleaning, laundry, shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical adaptations of the home to meet the needs of disabled persons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral and linking to community resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 10. Elements of care for those in need of LTC (continued)

<table>
<thead>
<tr>
<th>Elements</th>
<th>Home care at hospital</th>
<th>Visiting nurses at health centre</th>
<th>Home helper at home</th>
<th>Hospice at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of supplies (basic and specialized), assistive devices, equipment and drugs</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Alternative therapies and traditional healing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized support (e.g. for incontinence, dementia, mental problems, substance abuse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite care (in-home or congregate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative care, e.g. pain and other symptom management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision of information to patient, family and social networks</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Counselling and emotional support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitation of social interaction and development of informal networks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of volunteer capacity and provision of volunteer opportunities for clients</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Productive activities and recreation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunities for physical activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and training of clients, informal and formal caregivers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for caregivers before, during, and after care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
and after periods of caregiving

5.2 Forms of long-term care services

- **Home care services**
  - Hospital-based home care
  - Visiting nurses at health centres
  - Welfare services for the aged at home

- **Residential care**
  - Sanitarium
  - Geriatric hospitals

- **Terminal care**
  - Hospice programme

5.3 Hospital-based home care

Targeting early discharge patients from hospitals, skilled nursing services are provided by nurses with certification in home care nursing, in consultation with the attending physicians.

- **Introduction period**
  After completing demonstration projects started in 1994, home care services were disseminated nationally in January 2001.

- **Background**
  As society has changed, traditional family support has been weakened and the number of elderly living alone has increased. The need for non-residential services for elderly people with restricted mobility, whether from chronic diseases or various kinds of accidents and disasters, has grown. Moreover, replacement services were required to decrease misuse of medical resources related to long-term and unnecessary hospitalization, and to increase efficiency of resource utilization.

- **Target population and range of services**
  Basic nursing care, patient education, and consultation are provided in the homes of early discharge patients who have National Health Insurance. Laboratory tests, medication, injections, and other medical treatment can be provided by home care nurses with diagnosis and prescription from
physicians and oriental medicine doctors.

- **Home care committee**
  Home care committees at central (The Ministry of Health and Welfare) and local (each hospital) levels of government are operated to provide support and consultation.

- **Qualification**
  Home care nurses are certified by The Ministry of Health and Welfare after completing one year of training at an authorized institution.

- **Service delivery system**
  Patients can be referred to outpatient departments of the hospital or other clinics and health care facilities if they need continuing medical supervision after completing home care services. A change in home care service institution can be achieved with a written request from the attending physician.

- **Financing**
  Fees for home care services are reimbursed via a resource-based relative value scale (RBRVS). Fees for home care visits, transportation, and fees for services are included in the reimbursement. Co-payments are made at the time of services and the National Health Insurance Fund pays the rest.

- **Coverage**
  Home care services are confined to National Health Insurance policyholders with Medical Aid and work accident compensation insurance being excluded. For hospital based home care, National Health Insurance covers up to eight home visits per month (service fee: 80% insurance vs. 20% self-paid; clients pay 100% of transportation fee). After eight home visits per month, clients are required to pay the whole service fee. Hospitals with extra beds for patients are not supportive of early discharge and home care services.
5.4 Visiting nurses at health centres

Nurses working at public health centres for disadvantaged persons in the community offer visiting nursing services. The disadvantaged populations served include elderly people, disabled people, and patients with chronic diseases.

- **Introduction period**
  In 1956, initiated by government-centred public health services, visiting nursing services were introduced. Later in 1995, legislation was created for visiting nursing services.

- **Background**
  To promote the health of the population, comprehensive services for prevention, treatment, rehabilitation, consultation, and health promotion are provided to the family as the unit of services in a cost-effective manner.

- **Target population and range of services**
  Most health centres perform needs assessments through home visiting targeting Livelihood Protection recipients among the community residents. Frequently, two to three nurses are assigned to visiting nursing services, but in some health centres visiting nursing services have been activated and provide more comprehensive services.

- **Service provider**
  When planning visiting nursing services, nurses request cooperation from other health workers within the health centre, support from the visiting nursing team, and utilization of assistant members in the community. Individual nurses constitute a support system around the team leader and services are provided using a team approach.

- **Service delivery system**
  Clinics at health centres can refer to visiting nurses if the client needs home visiting; also, visiting nurses can refer clients to dentists, oriental doctors, physical therapists, and exercise therapists at the health centres if there is a need. Visiting nurses should implement services through team meetings including physicians and social workers. They also need to cooperate with and be connected to special programmes at health centers,
cooperate with administrative and other departments, and consult with physicians and other health professionals.

5.4 Visiting nurses at health centres (continued)

- **Financing**
  
  Government supports all the expenses required.

- **Coverage**
  
  The number of people covered in 1999 was 360 744 households, which is 2.4% of total households, and 16.1% of total low-income families in Korea.

### Table 11. Comparison with home care and visiting nurses

<table>
<thead>
<tr>
<th>Classification</th>
<th>Home care</th>
<th>Visiting nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service provider</strong></td>
<td>Qualified home care nurses</td>
<td>Visiting nurses</td>
</tr>
<tr>
<td><strong>Service unit</strong></td>
<td>Individual (family)</td>
<td>Family (individual)</td>
</tr>
<tr>
<td><strong>Target population</strong></td>
<td>Early discharge patients</td>
<td>Disadvantaged family</td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>Home visiting</td>
<td>Home visiting</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>Medical treatment and examination, medication etc.</td>
<td>Treatment, education, consultation, referral, and primary health care for prevention</td>
</tr>
<tr>
<td><strong>Operation body</strong></td>
<td>Hospitals/clinics</td>
<td>Health centres</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>National Health Insurance</td>
<td>Medical Aid National Health Insurance</td>
</tr>
</tbody>
</table>
CASE-STUDY: REPUBLIC OF KOREA

5.5 Community-based welfare services for the elderly

Home help services, day care centres, and short-term care centres for elderly people are available.

- **Background**
  As society has changed, traditional family support has been weakened and the number of the elderly people living alone has increased. The need for non-residential services for those elderly people who continue living in their own home has grown.

- **Target population and range of services**
  - Home help services for low-income elderly people include homemaking services, meal services, bathing services, consultations, companion services, and visiting nursing care services. Services are performed mostly by volunteers, except for those provided for recipients who need professional care services.
  - Day care centre services are provided for elderly people who need help during the daytime because of the absence of family members to take care of them.
  - Short-term care facilities provide lodging, meals, physiotherapy and medical treatment for elderly people who need temporary hospitalization because of inadequate care by the family.

- **Service provider**
  Home-helpers must be 20–65 years old with good health and need to have one week of training.

- **Financing**
  The central government supports 88 home help services facilities, 57 day care centres, and 23 short-term care facilities. Other facilities are supported by local governments, individuals, and corporations.

- **Coverage**
  A high percentage of welfare facilities (21.8%) for elderly people are concentrated around the Seoul area, while only 16.3% of elderly people reside in Seoul.

- **Liaison System**
  Various facilities and programmes provide fragmented services,
LONG-TERM CARE

and therefore need to have organizations which have the authority to coordinate those services.

Table 12. Community-based welfare services for the elderly (2000)

<table>
<thead>
<tr>
<th>Service</th>
<th>Target population and duration</th>
<th>Number of services</th>
<th>Number of elderly per facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home help service</strong></td>
<td>Elderly people at home (Livelihood Protection recipients)</td>
<td>109</td>
<td>2645</td>
</tr>
<tr>
<td><strong>Day care centre service</strong></td>
<td>Day-time (low income elderly persons)</td>
<td>107</td>
<td>1936</td>
</tr>
<tr>
<td><strong>Short-term care facility</strong></td>
<td>2–3, or 10–15 days (Livelihood Protection recipients)</td>
<td>36</td>
<td>4990</td>
</tr>
</tbody>
</table>

5.6 Residential care

There is a lack of long-term health care facilities for elderly people who need residential care and only 0.3% of the total population of elderly people enter residential care facilities. This represents only 61.4% of elderly people who need residential care.

Free facilities and low-price facilities are provided for Livelihood Protection recipients or low-income people over 65 years old. Fee-charging facilities are provided for individuals over 65 years with income.

Residential homes are provided for healthy elderly and nursing homes for elderly with less severe health problems. Special houses are expensive condominium facilities.
Table 13. Number of welfare institutions for the elderly (1999)

<table>
<thead>
<tr>
<th>Total</th>
<th>Free facilities</th>
<th>Low-price facilities</th>
<th>Fee-charging facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential home</td>
<td>Nursing home</td>
<td>Nursing home for the severe illness</td>
<td>Residential home</td>
</tr>
<tr>
<td>229</td>
<td>92</td>
<td>73</td>
<td>21</td>
</tr>
</tbody>
</table>

5.7 Terminal care: hospice

- **Background**
  In Korea, the initial hospice programme was offered at a local clinic in 1965. As society has changed, traditional family support has been weakened and the number of elderly people and the number of patients with incurable cancers and AIDS has increased, and the need for terminal care has evolved.

- **Forms of services**
  Sixty hospice programmes existed nationally in 1998. They are not yet approved by law as a part of the health care system.

- **Service Provider**
  Tertiary health care facilities, hospitals, clinics, and other facilities.

- **Personnel**
  Physicians, nurses, social workers, clergy, volunteers, nurse aides, pharmacists, nutritionists, and medical technicians.

- **Financing**
  Donations, support from religious organizations, fees for
LONG-TERM CARE

medical treatment, and funds from health care organizations.

5.8 Major educational/training needs for long-term care provision

Strategic planning and development for recruiting public health nurses for LTC institutions is needed. Each public health nurse covers about 10,000 people in urban areas and about 1,000 people in rural areas. In order to provide comprehensive LTC in the community, more public health nurses should be recruited. Likewise, 7,000 social workers are practising in the field of social welfare. Each social worker covers about 200 families in need of help.

Systems for recruiting volunteers are needed in the community. Currently, volunteers are recruited through NGOs and churches. However, due to a lack of systematic approaches to recruiting volunteers, many women who want to serve as volunteers are unaware of these opportunities to offer services for LTC patients.

A limited amount of education, which is focused on rehabilitation, has been provided to health care workers in the community. Thus, structured continuing education for nurses, home-helpers, volunteers, and social workers working in LTC institutions, as well as family caregivers, is required.

6 General questions pertinent to LTC Development

6.1 Present and future needs for long-term care and gaps between needs and provision of services

Indicators of the present needs for long-term care:

- **An increasing population of elderly people**
  As was mentioned in the beginning of the paper, ageing in Korea is currently moving forward at unprecedented rate. Life expectancy has increased from 69 in 1985 to 75.5 in 2000. Additionally, the percentage of people aged 65 years or older was 7.1% of the total population in 2000, and the projected rate of elderly people will be 16.9% of the total population by 2025. The causes of this expected rise in life expectancy include better medical care and living environments.
Distribution of the disabled
In Korea, there were 1.05 million disabled persons as of 1995, constituting 2.35% of the total population. However, the number of disabled persons registered was only 378,323, about 36% of the total population of disabled persons. Unlike in the past, the number of people born today with a disability has decreased, whereas the number of people with a disability due to car or industrial accidents and the number of elderly people who have become disabled due to age-related diseases are on the rise. Elderly disabled people comprise 44.1% of the total population of disabled persons.

Increasing chronic illness
The Republic of Korea is now experiencing an epidemiological transition. During the last few decades, the incidence of infectious diseases has decreased, while the incidence of chronic degenerative diseases has been consistently increasing. As most chronic degenerative diseases need long-term care and have to be treated, the importance of prevention and health promotion is now being stressed. There is a distinct tendency for the mortality rates of communicable diseases to decrease, owing to improvement of the living environment and nutrition and to the development of treatment methods. However, the mortality rates of chronic diseases (or noncommunicable diseases) are rapidly increasing and it is anticipated that this tendency will be more pronounced because of the ageing of the population, changes in dietary habits, increase in smoking, and decrease in physical activity.

<table>
<thead>
<tr>
<th>Disease</th>
<th>1995</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasm of stomach</td>
<td>0.66</td>
<td>0.85</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>16.10</td>
<td>22.38</td>
</tr>
<tr>
<td>Hypertensive disease</td>
<td>26.73</td>
<td>44.73</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>5.73</td>
<td>6.48</td>
</tr>
<tr>
<td>Heart disease</td>
<td>11.55</td>
<td>18.29</td>
</tr>
</tbody>
</table>
LONG-TERM CARE

Liver disease 11.95 17.04

The number and types of persons who need long-term care services are depicted in the following tables.

Table 15. The number of communicable disease cases among total population (42 million, 1995)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>64 713</td>
</tr>
<tr>
<td>Leprosy</td>
<td>21 185</td>
</tr>
<tr>
<td>AIDS*</td>
<td>4 000</td>
</tr>
</tbody>
</table>

*Estimated number of adults living with HIV/AIDS.

Table 16. Traffic accidents and deaths 1997–1999 (per 100 000 persons)

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths</th>
<th>Injured</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>25.2</td>
<td>746.1</td>
</tr>
<tr>
<td>1998</td>
<td>19.5</td>
<td>733.5</td>
</tr>
<tr>
<td>1999</td>
<td>20.0</td>
<td>859.1</td>
</tr>
</tbody>
</table>

Table 17. Estimated number of disabled persons according to type of disability (1995)

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>696 249</td>
<td>67.67</td>
</tr>
<tr>
<td>Visual</td>
<td>73 104</td>
<td>7.11</td>
</tr>
<tr>
<td>Auditory</td>
<td>153 444</td>
<td>14.91</td>
</tr>
<tr>
<td>Speech</td>
<td>36 371</td>
<td>3.54</td>
</tr>
<tr>
<td>Mental</td>
<td>69 669</td>
<td>6.77</td>
</tr>
</tbody>
</table>
Table 18. Residents of institution for psychiatric patients (1999)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Institutions</strong></td>
<td>63</td>
</tr>
<tr>
<td><strong>Number of Residents</strong></td>
<td>12 962</td>
</tr>
<tr>
<td><strong>Residents according to disease</strong></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>11 291</td>
</tr>
<tr>
<td>Melancholia</td>
<td>214</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>254</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>476</td>
</tr>
<tr>
<td>Old age drug addiction, etc.</td>
<td>727</td>
</tr>
</tbody>
</table>

Table 19. Estimated number of elderly people with dementia (1995)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of elderly people (65+)</strong></td>
<td>2 640 205</td>
</tr>
<tr>
<td><strong>Number of elderly people with dementia</strong></td>
<td>218 096</td>
</tr>
<tr>
<td>Mild</td>
<td>129 113</td>
</tr>
<tr>
<td>Moderate</td>
<td>59 322</td>
</tr>
<tr>
<td>Severe</td>
<td>29 661</td>
</tr>
<tr>
<td><strong>Prevalence rate</strong></td>
<td>8.3%</td>
</tr>
</tbody>
</table>

6.2 Changes in the ability of the family to provide care

As was mentioned in the beginning of the paper, whereas family members had previously undertaken the primary caregiving responsibilities for the frail elderly in Korea (caretakers were usually wives, daughters, or daughters-in-law), attitudes are changing because of an increase in the number of nuclear families (79.8% in 1995), increasing urban migration and growth in the number of economically active women (49.5% in 2000). Therefore, Korea has an increasing need for professional care for people
LONG-TERM CARE

with dementia and chronic illness who previously would have been cared for by family members.

6.3 Main gaps between needs and present long-term care services

The Medical Aid programme is a government-funded programme designed to assist people with low income, those receiving livelihood assistance, and those who are unable to pay for medical care. It provides medical care services for the poor through the national budget.

The Mayor of each city or chief administrator of each county selects recipients through annual surveys of income and household assets. The criteria for selection are determined by the Ministry of Health and Welfare and may be subject to change yearly. In 1996, the recipients of the Medical Aid Programme numbered 1740 individuals and accounted for 3.8% of the population.

The greatest unmet needs for long term care service include the following:

- In Korea, there were 1.05 million disabled persons as of 1995, constituting 2.35% of the total population. However, the number of registered disabled people eligible for the Medical Aid Programme was only 378,323, about 36% of the total population of disabled persons in 1995.

- While only about 69.9% of the population resides in urban areas, 92% of the physicians and 85.9% of hospital beds are concentrated in the cities. This situation makes it difficult for the rural population to have access to medical care.

- At the district level, low-income LTC clients are placed in convalescent institutions, where district health centres and social welfare centers supervise LTC services. District health centres provide free nursing care services to low-income clients who need long-term care in their homes through visiting nurse programmes.

- Setting clear standards for selection of service recipients, as well as expansion of public LTC services to middle-income elderly people is required.

- Low-income frail and disabled elderly people who need help during the daytime because of the absence of family members have few supports from District Health Centres and Social Welfare Centres. Central and municipal government supports a fund needed for operating day care. Public health nurses, social workers, physical therapists, and nurse-aides staff this
The convalescent institutions for mentally ill elderly people and elderly with dementia are sponsored publicly and privately by churches or NGOs. Provincial health departments control and regulate convalescent institutions within the province. Medical doctors, nurses, and helpers who provide personal care are employed in convalescent institutions. Geriatric hospitals and mental hospitals provide inpatient and outpatient care like general hospitals.

6.4 **Major constraints on the development of health and long-term care**

- **Facilities**
  At present, it is so important to enhance the quality of service of welfare institutions, and to take care of elderly people who do not have the ability to pay. The government has provided mortgages to welfare foundations and charitable individuals to facilitate new construction of residential homes, nursing homes, and other LTC facilities.

- **Surveillance system**
  The registration rate of LTC cases is low. A systematic surveillance system needs to be developed at the national and district level.

- **Decreasing number of Community Health Posts**
  The Government promulgated a special law for Primary Health Care (PHC) in Rural and Fishery Areas in 1981. Primary Health Care Posts (PHP) were constructed, and in 1996 the number totaled 2034. Each PHP is operated by a committee, which is formed by the community. However, since the financial crisis and loans from the International Monetary Fund (IMF), the Government has decreased the number of Government workers. Among those, Community Health Practitioners were targeted to be decreased. Now, they have decreased from 2034 to 1750. This has affected LTC in rural areas.
6.5 Developments that will impact on LTC

- **Financing health care for elderly people**
  Financing systems for health care for elderly people include government support such as Medical Aid and budgets for health care for elderly people, National Health Insurance, private insurance and out-of-pocket payments.

  The total health care budget is very limited and does not specify a separate budget line for elderly people. The national overall health care budget for elderly people was 481 billion won (US$400million) in 2000, 0.06% of the total government budget. However, most of it was used for welfare for elderly people rather than for health care. More funds are needed to support financing health care for elderly people.

- **Health care system development for elderly people**
  To establish a health care delivery subsystem for elderly people, hospitals with 30-200 beds are encouraged to designate all or part of their beds to long-term care. Developing health care personnel for elderly people as well as reinforcing training and education for the existing health care workers is required. Utilization of existing primary health care workers through education and training is desirable.

- **Development of comprehensive health care for elderly people**
  - **Integrating acute and long-term care services**
    Provision of comprehensive health care and health promotion programmes; such as early detection and modification of risk factors, screening and early detection of diseases, prevention of complication and deformity and hospice care are required.

  - **Integrating health and social care services**
    To integrate health and social care services, collaboration between health centers and social workers’ office at local government level is required. Provision of comprehensive services through collaboration among health centers, health care facilities, and universities have been initiated. In order to provide culturally appropriate services, cooperation between local government and the private sector is
• **Balancing the delivery of institutional and community-based care services**
  Most elderly people prefer community-based care services that reduce unnecessary use of medical resources by hospitalization. In order to provide quality community-based services, expansion of home-care services as well as strengthening of day-care centers, short-term care facilities and home-helper services are needed. More long-term care facilities are needed. Thus, growth in the number of long-term care facilities as well as balance between the delivery of institutional and community-based care needs to be monitored.

• **Monitoring the quality of care**
  Establishment of inspection and evaluation systems are needed to increase quality of care and to reduce waste. These activities include:
  · Monitoring facilities and equipment
  · Monitoring quality and level of health professionals
  · Monitoring range of services and quality of care
  · Setting admission criteria
  · Evaluating results of services

■ **Professional development**
  Education and training programs for the development of health workers in this field such as geriatricians, home health aids, social workers for elderly people and case managers are needed.

### 6.6 Next LTC policy steps

As described earlier, family members have had the primary responsibilities for the care of frail elderly and disabled persons in Korea. The public and Government’s expectations were that elderly persons would be cared for in the home, and families in the past faced criticism for placing a parent in a long-term care facility. Chronically-ill patients were able to stay for extended periods in the general hospital beds. Therefore, specialized nursing homes and other LTC facilities have been slow to develop.

However, attitudes are changing as the younger generation becomes conscious of alternatives that will lessen their burden. Likewise, increases in longevity
LONG-TERM CARE

and chronic conditions have created a demand for more LTC facilities and services. Better coordination of LTC facilities is required in order to avoid duplication of services between the public and private sector. Public LTC services have concentrated on low-income families. However, the selection criteria for low-income elderly persons and disabled elderly persons are vague. Thus, setting clear standards for selection of service recipients, as well as expansion of public LTC services to middle-income elderly persons, are required. Quality of care of all services and facilities needs monitoring and continuous improvement.

Bibliography


CASE-STUDY
SRI LANKA

Palitha Abeykoon
1 General background data

1.1 Preamble

Sri Lanka is an island of approximately 62,000 square kilometres, situated in the Indian Ocean off the southern tip of India. Administratively, the country is divided into eight provinces, 25 districts and over 300 Divisional Secretariat areas.

The country has a parliamentary system of government, with the elected Parliament responsible for legislative functions, and the Cabinet of Ministers, presided over by the Executive President, vested with executive powers. The provinces have their own provincial councils, headed by a governor, and elected representatives.

The population at mid-year 2000 was estimated by the Registrar General at approximately 19 million. One of the most visible features of Sri Lanka’s age structure is the increasing proportion of older age groups.

As an indicator of the ageing of the population, the percentage of Sri Lankans over the age of 65 has increased markedly over the last 25 years and is expected to increase from 6.3% to 12.3% in the next 25 years. Correspondingly, there has been a dramatic increase in the prevalence of noncommunicable diseases in the population and, consequently, an increase in the need for long-term care.

Increased hospitalization for diseases such as neoplasms and diseases of the respiratory, genito–urinary, neurological, and digestive systems are indicative of these trends. The number of patients seeking treatment for mental disorders has also increased over the years.

A dramatic increase in hospitalization for diabetes mellitus can be attributed to urbanization, lifestyle changes, and the ageing of the population. In addition to the increase in hospitalizations for these noncommunicable diseases, there has been a substantial increase in hospitalization for poisoning and injury.
LONG-TERM CARE

At the same time that the noncommunicable disease burden is increasing in Sri Lanka, the country is still facing problems of malnutrition among children, a moderate communicable disease burden, and poverty. The demographic and health survey conducted in 1993 found that 23.7% of children suffer from malnutrition, 15.5% are acutely undernourished, and 37.6% are underweight.

Sri Lanka has done reasonably well in reducing poverty and maintaining low levels of income inequality over the years. However, poverty is still a concern, with an estimated one-quarter of the population living below the poverty line. The under-5 mortality rate for males was 24 per 1000 live births in the year 2000. Although this is a not high rate relative to Sri Lanka’s low per-capita income, it does demonstrate that communicable diseases are still an issue in Sri Lanka.

Due to the ageing of the population and the increasing noncommunicable disease burden, Sri Lanka will witness an increase in long-term care needs in the future. It is clear that policy-makers in Sri Lanka will have to plan carefully for future health and social services, in order to provide enough resources for LTC – together with malnutrition, a moderate communicable disease burden, and limited resources.

Presented on the following pages are background data concerning Sri Lanka, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

This chapter will then describe the health and social service system of Sri Lanka, focusing special attention on describing both the current and future needs for LTC and the existing LTC services. Additionally, some suggestions will be made as to how policy-planners should develop LTC in Sri Lanka.

---

1 For consistency reasons data used in this section are taken from international data sources:
UN, World Population Prospect, the 2000 revision (median variant);
WHO, World Health Report 2002; World Bank, World Development Indicators Data Base;
### Demography (Year 2000)

<table>
<thead>
<tr>
<th>Category</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong> (thousands)</td>
<td>18,924</td>
</tr>
<tr>
<td><strong>Land area</strong> (sq km)</td>
<td>65,610</td>
</tr>
<tr>
<td><strong>Population density</strong> (per sq km)</td>
<td>288</td>
</tr>
<tr>
<td><strong>Population growth rate</strong> (% 2000-2005)</td>
<td>0.94</td>
</tr>
<tr>
<td><strong>Urban population</strong> (%)</td>
<td>23.6</td>
</tr>
<tr>
<td><strong>Ethnic groups</strong> (%)</td>
<td></td>
</tr>
<tr>
<td>Sinhalese</td>
<td>74</td>
</tr>
<tr>
<td>Tamil</td>
<td>18</td>
</tr>
<tr>
<td>Moor</td>
<td>7</td>
</tr>
<tr>
<td>Burgher, Malay, and Vedda</td>
<td>1</td>
</tr>
<tr>
<td><strong>Religions</strong> (% 1999)</td>
<td></td>
</tr>
<tr>
<td>Buddhist</td>
<td>70</td>
</tr>
<tr>
<td>Hindu</td>
<td>15</td>
</tr>
<tr>
<td>Christian</td>
<td>8</td>
</tr>
<tr>
<td>Muslim</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total adult literacy rate</strong> (1997)</td>
<td>91.4</td>
</tr>
<tr>
<td><strong>Age Structure</strong> (%)</td>
<td></td>
</tr>
<tr>
<td>0-14</td>
<td>8.2</td>
</tr>
<tr>
<td>15-24</td>
<td>19.2</td>
</tr>
<tr>
<td>60+</td>
<td>9.3</td>
</tr>
<tr>
<td>65+</td>
<td>6.3</td>
</tr>
<tr>
<td>80+</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Projections 65+ (%)</strong></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>12.3</td>
</tr>
<tr>
<td>2050</td>
<td>21.3</td>
</tr>
</tbody>
</table>
### Demography (continued)

**Sex ratio** (males per 100 females):
- Total population: 0.97
- 15-64: 0.95
- 65+: 0.91

**Dependency Ratio:**
- Elderly dependency ratio in 2000\(^2\): 10.9
- Elderly dependency ratio in 2025: 20.4
- Parent support ratio in 2000\(^3\): 7.2
- Parent support ratio in 2025: 10.9

### Vital statistics and epidemiology (Year 2000)

**Crude birth rate** (per 1,000 population): 17.3

**Crude death rate** (per 1,000 population): 6.3

**Mortality under age 5** (per 1,000 births):
- Males: 24
- Females: 17

**Probability of dying between 15-59** (per 1,000):
- Males: 224
- Females: 124

**Maternal mortality rate** (per 100,000 live births) (1995): 60

**Total fertility rate** (children born/woman): 2.09

---

\(^2\) Elderly dependency ratio: the ratio of those age 65 and over per 100 persons aged 20–64.

\(^3\) Parent support ratio: the ratio of those age 80 and over per 100 persons aged 50–64.
## Vital statistics and epidemiology (continued)

### Estimated number of adults

- **Living with HIV/AIDS (2001)**: 4700
- **HIV/AIDS adult prevalence rate (%)**: <0.1

### Estimated number of children

- **Living with HIV/AIDS (2001)**: <100

### Estimated number of deaths

- **Due to AIDS (2001)**: <100

### Life expectancy at birth (years)(2001)

<table>
<thead>
<tr>
<th>Population</th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>73</td>
<td>70</td>
<td>76</td>
</tr>
</tbody>
</table>

### Life expectancy at 60 (years)(2000)

<table>
<thead>
<tr>
<th>Population</th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18.5</td>
<td>17.0</td>
<td>20.0</td>
</tr>
</tbody>
</table>

### Healthy life expectancy (HALE) at birth (years)(2001)

<table>
<thead>
<tr>
<th>Population</th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61.1</td>
<td>58.6</td>
<td>63.6</td>
</tr>
</tbody>
</table>

### Healthy life expectancy (HALE) at 60 (years)(2001)

<table>
<thead>
<tr>
<th>Population</th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13.6</td>
<td>12.5</td>
<td>14.6</td>
</tr>
</tbody>
</table>
Economic data (year 2000)

**GDP – composition by sector (%)**
- Agriculture: 38
- Industry: 17
- Services: 45

**GDP ($PPP)**

$62.7 billion

**GNI – per capita (US$)**

850

**GDP – per capita ($PPP)**

3250

**GDP growth (annual %)**

6

**Labor Force Participation (%):**
- male: 56.2
- female: 31.8

Health expenditure (year 2000)

**% of GDP**

3.4

**Health expenditure per capita ($PPP)**

99

**Health expenditure per capita (US$)**

29

*PPP = Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries*
2 General health and social system

2.1 Basic income maintenance and poverty reduction programmes

Since the 1950s, the Government’s poverty strategy has focused upon developing human resources and ensuring a minimum consumption level for the entire population. The main strategy was universal, involving free provision of health and education services to all. This strategy was supplemented by a range of income transfer programmes directed at food security (subsidies for rice and rations) and rural development.

With the introduction of market reforms in 1977, safety net programmes were implemented. These included Integrated Rural Development Programmes (IRDPs), Janasaviya, the National Development Trust Fund, the Samurdhi, and the universal wheat subsidy. In addition to these large national level programmes, a host of minor programmes have been introduced to meet the needs of specific population groups such as schoolchildren, lactating mothers, and internally displaced persons.

Despite the many economic strains faced by the country, spending on social welfare programmes has remained consistent in recent years, at approximately two to three per cent of GDP. Additional detail on these programmes is provided in subsection 2.4.3, entitled Poverty reduction and social welfare programmes in Section 2.4.

2.2 Organizational structure of decision-making

The national health policy of Sri Lanka attempts to address health inequities, with special attention to care for the disabled and elderly, noncommunicable diseases, accidents and suicides, substance abuse, and malnutrition. Both short-term and medium-term goals have been established for the performance of health services.

The health services in Sri Lanka function under a Central Ministry of Health. Since the implementation of the Provincial Councils Act in 1989, health services were devolved, with separate provincial-level Ministers of Health in the eight provinces. The Central Ministry of Health is responsible primarily for the protection and promotion of health among the people, and for providing technical support to the Provincial Ministries. In addition, the Central Ministry manages the network of teaching hospitals in the country. The key functions of the Central Ministry include the setting of policy guidelines, medical and paramedical education, management of teaching and specialized institutions, and bulk purchasing of medical requisites.
2.3 Financing of health services

2.3.1 Health finance

Health expenditures in 2000 totalled nearly 20 million rupees, which was an increase of 5.8% over the previous year. Allowing for inflation of nearly 10%, however, this figure represents a real decrease in annual expenditure.

The major portion of health expenditures is utilized by curative care services. In 2000, these services utilized 67% of the total public expenditure on health, while community health services accounted for only 9%. Of the balance, 21% was for administration and staff services and 3% was for local and overseas training. There is no separate record of expenditure on long-term care services, but with the completion of the National Health Accounts now in progress, it is likely that at least some of this information may soon become available.

The resources mobilized by the health sector of Sri Lanka have always been modest. Sri Lanka completed its demographic transition from a situation of high mortality and fertility rates to a situation of relatively low mortality and fertility within a period of 50 years, but has maintained total national health expenditure at low levels. Throughout this fifty-year period, total public expenditure on health averaged less than 2% of GDP. This is very low by international comparisons. Table 1, below, gives a breakdown of the Government expenditure by activity.

<table>
<thead>
<tr>
<th>Activity</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>29</td>
<td>37</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Prevention/public health</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Capital formation</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 1. Government expenditure by activity
Sri Lanka has been able to achieve these results and outcomes in health by adopting a resource mobilization strategy that uses available public and private funds in an effective and sustainable manner. This strategy has depended on only two resource mobilization methods:

- general taxation; and
- out-of-pocket household spending.

While the overall policy framework has not changed over half a century, the proportional contribution of these two sources has changed, with household spending increasing its share relative to general taxation. Sri Lanka has been relatively successful in increasing the contribution of private financing. User fees and private insurance have also been used for resource mobilization, but the experience to date has been that these approaches are not as effective as general taxation and direct household spending. The policy structure and framework has not changed significantly in five decades, and any changes have been gradual and incremental.

### 2.4 Services delivery system

#### 2.4.1 Organization of health services

In Sri Lanka, both the public and private sectors provide health care. The public sector provides comprehensive health care for nearly 60% of the population. The private sector provides mainly curative care for an estimated 50% of all ambulatory patients, largely concentrated in the urban and suburban areas. Ninety per cent of inpatient care is provided by the public sector. There are special service units for the armed forces and the police.

In Sri Lanka, Western, Ayurveda, Unanni, Siddha, and homeopathic medicine are practised. This allows people to seek the medical care of their choice. Of these types of care, Western medicine and Ayurvedic medicine cater to the majority of people.

Sri Lanka has an extensive network of health institutions. It is estimated that no one has to travel further than 1.4 km to reach a fixed health facility.
LONG-TERM CARE

The network of tertiary care institutions ranges from sophisticated teaching hospitals with specialized consultative services to small central dispensaries that only provide outpatient services. In 2000, there were 558 institutions with inpatient facilities, with a total of 57,000 beds – an increase of nearly 2000 beds since 1999. However, the national rate of beds for inpatient care remained unchanged, at 2.9 per 1000 persons.

2.4.2 Public health services

The main function of the public health service is the prevention of diseases, the promotion of health, and the provision of rehabilitative services – both at home and in institutions.

The programme of preventive work provides for the control of communicable diseases, sanitation, school health, epidemiological surveillance, family health, health education, and the enforcement of the Food Act. These services are delivered to the community through general community health services, as well as through specialized programmes. After the devolution of health services, functions for the control of diseases such as rabies, tuberculosis, and sexually-transmitted diseases were transferred to the provinces.

2.4.3 Poverty reduction and social welfare programmes

The following is a short description of some of the social welfare programmes that have been implemented in the past two decades.

Janasaviya

Janasaviya (JSP) was introduced in 1989, and was the Government’s primary poverty reduction programme at the time. The original purpose of this programme was to provide income transfers to about half the population for two years, but because of the high cost, it was trimmed and phased over fewer rounds and areas. Monthly cash grants were given to households, mandatory savings transferred to a specified Fund, and social mobilization was undertaken in a massive way, using 6000 mobilizers.

The World Bank provided funds for the Trust Fund in 1991, and this project worked through local NGOs. Both Janasaviya and the Trust Fund aimed at increasing the employment and income levels through rural public works and micro-enterprise development, and by improving the nutritional status of pregnant and lactating mothers and poor children.
**Samurdhi**

The Janasaviya was discontinued in 1995 after only five rounds. It was replaced by the Samurdhi programme, which then became the Government’s main vehicle for poverty reduction. Samurdhi combined the functions of the Janasaviya and the Trust Fund, which were disbanded in 1998.

The Samurdhi programme covered 50% of the population, or 1.8 million families, and had two components. The first provided direct income support in the form of food coupons, and the second aimed at promoting self-reliance and rural entrepreneurship.

This was to be achieved through training, credit, and savings schemes similar to that of the earlier Janasaviya. In 1997, Samurdhi cost the Government seven billion rupees, representing 1% of GDP. This high cost was due to the fact that it covered a large segment of the population.

**2.4.4 Emergency relief and public assistance**

Another important vehicle in the anti-poverty strategy involves assistance provided for emergency food relief needed as a result of the disruptions of civil conflict. There is also assistance to social welfare services and institutions that serve the most destitute in the country, particularly the handicapped, orphans, and the elderly with no independent means of support. However, the budgetary allocation for this is distressingly low, because of the reduction of voluntary assistance to these needy people in recent years.

**2.4.5 NGO involvement**

An overview of Sri Lanka’s poverty reduction programmes and initiatives would not be complete without explicit mention of the multitude of NGO programmes directed at socially and economically disadvantaged groups. In 1995, there were over 30,000 NGOs operating in the country, ranging from very small community-based organizations to large NGOs having several thousand full-time staff.

For example, Sarvodaya, one of the largest NGOs in the country, manages a total programme of over US$12 million a year and employs over 5000 full-time staff and an estimated 30,000 unpaid workers. While it is difficult to quantify their impact, it is certain that NGOs play an important role in long-term care and serving disadvantaged groups.
LONG-TERM CARE

2.4.6 Assessment of the poverty strategy

At least since World War II, successive Sri Lankan governments have given priority to the universal provision of basic health and education and assurance of minimum consumption levels to the population. In 1977, the strategy was expanded to include implementation of market economy reforms and specific safety net programmes. Nonetheless, income transfers have consistently accounted for a large share of government spending over the years and have been a recurrent threat to financial stability.

These policies have helped Sri Lanka achieve levels of human resource development unknown in economies of low per-capita income. There has also been considerable success in poverty reduction. There is virtually no destitution, even in the most isolated areas, and the existing poverty is neither age- nor gender-biased.

However, there is increasing evidence that the costs of these poverty programmes, especially those which are poorly targeted, are no longer sustainable and cannot be justified on the basis of their benefits. Among other conditions, significant pockets of poverty persist; more than one-quarter of the population live below the poverty line; access to safe water and sanitation is inadequate; malnutrition and stunting remain high; and alcoholism, domestic violence, and child abuse are significant social problems.

Recent assessments have indicated that although all Samurdhi beneficiaries are encouraged to develop entrepreneurial skills, the evidence shows that few have the potential for such skill development. With a few notable exceptions, few of the programmes were able to develop real micro-entrepreneurs, as external factors (such as infrastructure, marketing, and overall macro-environment) were found to be of greater importance in determining the success of new businesses.

Targeting has long been a weakness of Sri Lanka’s poverty reduction and subsidy programmes. Most poverty reduction programmes have covered 60% of the population and many general subsidies have remained in place. Paradoxically, however, assistance to the most destitute (e.g. orphans and disabled elderly) is distressingly low in Sri Lanka.

It is clear that the Government will need to review its social and poverty policies with a view to reducing the role of infrastructure development in areas with high incidence of poverty and to providing interventions aimed at promoting rural development. It will also be necessary to protect the most vulnerable through safety nets based on self-targeting.
It would appear that Sri Lanka will be seriously undermined in maintaining its record of social performance without a strong underlying economy that provides the resources to implement economic reforms and achieve growth-oriented development goals. Donor support for Sri Lankan development will remain crucial for a considerable period of time.

### 2.5 Human resources and training

In the past ten years, there has been an increase in the number of health personnel in most categories. The total number of doctors rose from 6990 in 1999 to 7960 in 2000. In a parallel development, the number of persons per doctor decreased from 2720 to 2400 during this same year. The number of nurses per 10,000 people was 76 in 2000. It is estimated that there is a shortage of over 3000 trained nurses in Government hospitals.

Also, there exists a shortage of paramedical (allied health) staff, such as pharmacists, medical laboratory technicians, radiographers, physiotherapists, and ECG technicians. There is also a wide disparity in the regional distribution of all health personnel, with the Colombo district – followed by the Kandy and Galle districts – having comparatively higher numbers of health personnel.

Training programmes address some aspects of long-term care, and the institutional objectives of most of these programmes include objectives that relate to various aspects of long-term care. However, it is the opinion of many teachers that the attention given to develop trainee competences in long-term care is inadequate and unsystematic.

It would be useful to review the curricular segments that relate to long-term care in the various health personnel education and training programmes. However, in such specific programmes of training as rehabilitative services, physiotherapy, public health nursing, and similar areas, the orientation is more adequate and these health personnel are trained in different aspects of long-term care.

The Government of Sri Lanka provides for the training of doctors, dental surgeons, assistant medical officers, nurses, and other paramedical personnel. Doctors and dental surgeons are trained in universities through regular degree programmes. Some other courses in non-degree training are also conducted in the universities. The Ministry of Health conducts all other paramedical programmes in institutions that come under the Ministry.

Postgraduate training is conducted both locally, by the Postgraduate Institute of Medicine, and abroad. The Postgraduate Institute conducts training courses in nearly 40 different specialties in clinical and community medicine.
3 Summary of LTC provision

3.1 History of LTC in Sri Lanka

Sri Lanka has a long tradition of institutionalized and non-institutionalized care for the sick. Ancient kings built hospitals as early as the 5th and 6th centuries AD, with most of these hospitals located in Buddhist monasteries. It is most likely that they catered to the needs of the monks and royalty, and to a lesser extent to the common people. The tradition of Buddhist monks taking care of long-term health care needs of their brethren continues today, with nursing for the sick being provided in temples by younger pupils.

There is also a tradition of Vedamahattayas (traditional healing practitioners), who practice a version of Ayurveda (a form of traditional medicine) providing various types of care to those in need. Vedamahattayas have family traditions of specialization including such areas as orthopaedics, nerve disease, mental disorders, and humoral disease. Generally, they have visited homes, provided medical interventions, and motivated relatives of patients to undertake activities beneficial to their health. Although this tradition is fast disappearing with the westernization of health care, it still exists in remote villages.

For the majority of the general population, Sri Lankan cultural norms tend to place the burden of long-term care on the family or village. In the case of monks, LTC is a responsibility of the younger monks ordained by the nikaya sect.

The colonial rulers founded modern institutions for long-term care in Sri Lanka. For example, the Dutch founded the Leprosy Institution and the British started the Institution for Mental Illness. Although they were initially ‘institutions of segregation’, they later became institutions of long-term care.

Epidemics of polio, internal armed conflicts, labelling of chronic mental illness, the introduction of modern life-sustaining interventions, appliances for the handicapped, the development of specialized institutions, and demographic and other epidemiological changes, have changed the current picture of long-term care in Sri Lanka.
3.2 Long-term care services

3.2.1 Governmental

The Ministry of Social Services: community-based rehabilitation

The community-based rehabilitation programme is aimed at people needing care in their communities. During the course of routine visits to families under this programme, a volunteer specially trained in principles of community-based rehabilitation (CBR) identifies people who need care. The volunteer is instructed not to proceed immediately with action, but rather to proceed slowly over a number of later visits. He/she makes several more visits over a period of time, and then, through the completion of a prepared form, tactfully assesses the nature of the disability and the needs of the person.

Following this assessment, the volunteer makes several more visits. This information is passed on to the Social Service Officer (SSO) at the Divisional Secretariat, who assists the volunteer in developing a particular action plan. Should the recipient need medical care, the local Medical Health Officer is consulted and an appropriate referral is provided. Similarly, if additional financial assistance is needed, this will also be provided by the SSO.

The wider spectrum of services will be provided to the needy through consultation with the Divisional Steering Committee, which comprises the Medical Health Officer, the Divisional Education Officer, the Divisional Samurdhi Officer, the Divisional Labour Officer and the Divisional Youth Officer. The SSO chairing this Steering Committee acts as the Secretary to the Committee.

Issues relating to social integration, which involves getting the family members to attend to the needs of the LTC patient, and social incorporation issues are handled by the volunteer. If the patient needs special appliances, NGOs are contacted for funding or the appliances are bought by funds available at the Divisional Secretary from the Provincial Government. The Divisional Steering Committee, while coordinating this service among the different government sectors, also coordinates with all NGOs working in the rehabilitation sector.

This system of community-based rehabilitation operates in 160 of a total of 304 Divisional Secretariats divisions and in 5200 Grama Niladhari divisions. Although the process has been in existence since 1994, its coverage has been limited. The Ministry now plans to start CBR in the North and East provinces, beginning with Jaffna.

The total allocation to the line Ministry for this programme is approximately 13 million rupees. After salaries, etc. are paid, only about 50 000 rupees (US$ 500) per year remain in the Divisional Secretariats for activities, including training costs.
LONG-TERM CARE

However, the provincial governments assume some of the expenses at the divisional level. Furthermore, NGOs operating in specific areas and, in some instances philanthropists contacted by the SSO, pay for appliances such as hearing aids, spectacles, wheelchairs, and crutches.

Data on individuals and families receiving assistance from the CBR are kept at all DDS offices by the SSO at the district level. Since 1994, records indicate that this programme has attended to the needs of some 89,000 individuals, with 32,000 taken off the records after having been provided care. The SSO is also responsible at the divisional levels for providing financial allowances to disabled persons and to patients with leprosy, tuberculosis, and cancer.

NGOs such as Help Age Sri Lanka, Sarvodaya, SIHA, and Plan International are assisting the CBR programme by providing appliances, and printed materials for record keeping and training, and by funding some of the local volunteer training programmes. The volunteers in this programme are individuals respected by the community (e.g., schoolteachers). Some of the volunteers are themselves disabled persons retired from the armed services.

The Ministry of Social Services: Parliamentary Act on the Rights of the Disabled

Sri Lanka also has a parliamentary act that protects the rights of the disabled (No. 28, 1996: the Act to Protect the Rights of the Disabled). The Ministry of Social Services is now revising this act so that it is more comprehensive and requires institutions to be responsive to the needs of the disabled.

The Ministry of Social Services: Parliamentary Act on the Rights of the Elderly

Parliamentary Act No. 9, enacted in 2000 provides for the establishment of a National Council of Elders with the principal function of protecting their rights. The Council, headed by the Secretary to the Ministry of Social Services, is legally entrusted with ensuring the welfare of elderly individuals rather than making policy recommendations for restructuring human resource policies for the country to harness the full potential of the elderly. The appointment of a Board for the determination of claims for maintenance by elders and the Elders’ Welfare Fund are institutions provided for in the Act.

The Ministry of Health

The Ministry of Health has not been very effective in providing the elements of care listed under LTC. Both at the national and provincial levels, the care provided by the Government is heavily institution-based. Except in situations where home visits are undertaken by midwives providing some antenatal and postnatal care, assistance to people outside the hospitals or field clinics has been minimal.
In the few instances where social workers from the main psychiatry units located in big hospitals visit families of alcohol dependents, and in some cases psychiatric patients, extension services are grossly lacking in the health sector. A recent development, however, involves clinics for the elderly operated by Medical Health Officers in the field.

A few attempts have been made by the Ministry of Health to link up with the Social Services Department at the national level. However, these efforts have only involved short-lived projects. Medical Health Officers participate as health authorities and resource persons in the CBR programme, in those districts where it is functional. Recently in one district, health authorities have undertaken another project to operate day centres for the elderly with the assistance of volunteers. At these day centers, the elderly are provided with food and other needed medical assistance. The NGO Help Age Sri Lanka has trained the volunteers for this programme.

**Sri Lanka’s Armed Forces**

Sri Lanka’s Armed Forces probably have the most elaborate long-term care services in the country. They appear to provide institutional, community based and self-help care to their members who have been affected by armed conflict. An army directorate coordinates these services. However, the release of information about the programme has been restricted.

**Nongovernmental Organizations**

Many NGOs, such as Help Age Sri Lanka and Sarvodaya, are involved at the national and provincial levels in assisting the Social Services Department’s CBR programme. Similarly, there are 155 homes for the elderly, which are run by small nongovernmental associations. The Government finances three such homes, located in Anuradhapura, Mirigama and Jaffna. In addition, several homes for the disabled are maintained by voluntary associations. The Jaipur Project provides artificial limbs to those in need.

**Help Age Sri Lanka**

One of the few NGOs that has a major impact on LTC is Help Age Sri Lanka. This organization is involved in many activities, such as providing direct monetary assistance to homes for the elderly, eye care services for the elderly, day care centres, eyeglasses, wheelchairs, and walking aids. This institution is also involved in educating school children and medical students about the needs of the elderly. They also help older people to plan their retirement.
LONG-TERM CARE

More importantly, however, their contribution to long-term care has been in the area of training personnel in needs assessments, provision of community based services, and gerontological home care. They have also assisted in intersectoral cooperation and income generation programmes for the elderly. Both the Ministries of Social Services and Health have been beneficiaries of such training programmes. Each has received assistance from Help Age Sri Lanka in training community-based volunteers and officers in the CBR and day centre programmes.

3.2.3 Private sector

Ceylinco Home Nursing Service

There are several small and large private companies that provide home-based nursing for a fee. The most organized of such companies is a subsidiary of the Ceylinco Group known as Ceylinco Home Nursing Services. This service has established branches in five large towns and employs approximately 400 trained nursing aids. Their monthly fee is US$250, and they provide a comprehensive service that includes dressing of wounds, colostomy care, catheter care, naso-gastric feeding, insulin injections, and nursing care to prevent bedsores, hypostatic pneumonia, diabetic gangrene, dehydration and accidental falls. Due to their high fees, only high-income groups can afford this service.

There are also a few other small companies that provide similar home-based nursing care services. These agencies generally provide nursing aids on a shift basis, and charge approximately US$3–5 per 12-hour shift. The quality varies very much among the various agencies. Most of them have employed individuals trained at Help Age Sri Lanka.

The most widespread private sector activity involves the off-hour service rendered by Government hospital employees. Attendants, labourers, midwives, and occasionally nurses, are involved in providing such services. Relatives of persons needing care either contact these employees through personal networks, or the services are offered when a patient leaves a hospital. In some cases, the duration of such services to a patient may extend to years.

Fee-levying homes

There also exist a few fee-levying homes for the elderly and disabled. The Mallika Home and the Jayandara Elderly Home are two such institutions. These institutions charge an admission fee of approximately 100 000 rupees (US$1000) and a monthly fee depending on the comforts provided (minimum 4000 rupees). Some individuals who have obtained such services have transferred their monthly pension payments to the institutions.
3.2.4 Private funding

Private insurance programmes are not yet popular in Sri Lanka. However, packages are available in the form of life insurance with disability coverage. Several commercial banks also offer special savings accounts for the elderly with insurance packages and medical check ups.

4 General questions pertinent to LTC development

4.1 Present and future needs for long-term care, and gaps between needs and provision of services

There has been a decline in the crude birth rate (CBR) in Sri Lanka. At first, this was due to changes in the female age structure and the rise in the age at which people marry. Thereafter, increasing use of contraceptives became the dominant reason. This declining birth rate has contributed to the overall ageing of Sri Lanka’s population. There has also been a steady decline in the infant mortality rate (IMR) with improvements in health care, nutrition, and a decrease in poverty rates. Life expectancy at birth has increased significantly.

The rapid increase in the average life span, together with the widening of the gap between the life expectancies of males and females, reflects the dramatic improvement in the survival of those groups that were most vulnerable and exposed to high risks of mortality - namely infants, children in the age group 1-4 years, and women of childbearing age.

4.1.1 Morbidity and mortality

In Sri Lanka, morbidity data are only available for patients seeking treatment as inpatients in Government institutions. Morbidity data for patients attending ambulatory care services and receiving treatment through private sector services are not routinely collected. Other than limited information collected through surveys and registers maintained by specialized campaigns for tuberculosis, malaria, cancer, and leprosy, and from notifications of communicable diseases, the Indoor Morbidity and Mortality Form (IMMR) is the most reliable source of data.

The IMMR has been in use since 1976, and is based on the 10th revision of The International Statistical Classification of Diseases and Related Health Problems (ICD). Data for the years 1995 and 2000 are presented in Table 2 on the opposite page. There are many instances in which the morbidity data in some hospitals have not been analysed. However, while this is a problem, it is likely that the data based on the hospital morbidity will give an obvious indication of the morbidity pattern in the country.
Table 2. Trends in hospital morbidity by broad disease groups (1995–2000)

<table>
<thead>
<tr>
<th>International Classification of Diseases (10th Revision)</th>
<th>1995</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious and parasitic diseases</td>
<td>1757.7</td>
<td>2431.7</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>190.1</td>
<td>260.2</td>
</tr>
<tr>
<td>Diseases of blood and blood-forming organs and certain immune mechanisms</td>
<td>152.2</td>
<td>111.0</td>
</tr>
<tr>
<td>Endocrine, metabolic and nutritional diseases</td>
<td>205.8</td>
<td>278.4</td>
</tr>
<tr>
<td>Mental and behavioural diseases</td>
<td>261.6</td>
<td>2417.0</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>172.4</td>
<td>243.4</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>276.6</td>
<td>299.9</td>
</tr>
<tr>
<td>Diseases of the ear and mastoid</td>
<td>66.6</td>
<td>86.8</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>925.5</td>
<td>1153.8</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>2088.7</td>
<td>2313.4</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>739.2</td>
<td>1056.7</td>
</tr>
<tr>
<td>Diseases of skin and subcutaneous tissue</td>
<td>529.2</td>
<td>566.9</td>
</tr>
<tr>
<td>Diseases of musculoskeletal system and connective tissue</td>
<td>627.9</td>
<td>621.3</td>
</tr>
<tr>
<td>Diseases of the genito-urinary system</td>
<td>998.9</td>
<td>124.8</td>
</tr>
<tr>
<td>Pregnancy, childbirth and puerperium*</td>
<td>2207.3</td>
<td>3122.6</td>
</tr>
<tr>
<td>Certain conditions of the perinatal period</td>
<td>4986.5</td>
<td>9108.9</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>52.8</td>
<td>54.8</td>
</tr>
<tr>
<td>Injury, poisonings, etc.</td>
<td>2552.1</td>
<td>3345.1</td>
</tr>
<tr>
<td>Other abnormal symptoms, not classified elsewhere</td>
<td>1311.6</td>
<td></td>
</tr>
</tbody>
</table>
In Sri Lanka, there has been an increase in noncommunicable diseases, which arise with the transition in the demographic profile and with increased life expectancy. This is reflected in the increased hospitalization for diseases such as neoplasms and diseases of the respiratory, genito–urinary, neurological, and digestive systems. There has also been a substantial increase in hospitalizations for poisoning and injury.

The number of patients seeking treatment for mental disorders has increased over the years. In 1970, there was a rate of 177 per 100 000 individuals receiving treatment for mental disorders – as compared with 262 and 247 per 100 000 in 1995 and 2000, respectively. This increase is attributed mainly to demographic changes, but other contributory factors are migration, alcoholism, war, and other forms of violence and stress.

There has also been a dramatic increase in hospitalizations for diabetes mellitus that can be attributed to urbanization, lifestyle changes, and the ageing of the population.

### 4.1.2 HIV/AIDS, leprosy, and trauma

Although HIV was introduced to South Asia rather late, the disease has already emerged as a serious public health and developmental problem. Sri Lanka has joined other countries in expressing its commitment to combat the expanding pandemic. The current estimates are that, in Sri Lanka, approximately 8500 persons are living with HIV, while the reported number is approximately 400. Sri Lanka is classified as a low-prevalence but high-risk country for HIV infection.

During the last two decades, Sri Lanka has made much progress in eliminating leprosy. The introduction in 1982 of multi-drug therapy, an effective, short-duration chemotherapy treatment, and the launching of the awareness campaign in 1990 to educate the general public, made a major impact. The leprosy strategy is now community-oriented and community-based. The community is educated on early signs and the need for treatment. But more importantly, education efforts are under way to reduce the stigma of leprosy, to encourage acceptance of treated leprosy patients as normal members of society, and to educate people as to how leprosy patients should be cared for in their homes.

Trauma is another major issue that often leads to the need for long-term care. Road traffic accidents, and victims of war and conflict, have been increasing in the past decade. The numbers of these victims who need long-term care have become a major health concern for the country.
LONG-TERM CARE

4.1.3 Likely target population for LTC, given current trends

Because of the lack of availability of statistics, it is rather difficult to make an accurate estimate of the population needing or receiving long-term care. However, the following indicators for the year 2000 suggest a large hidden population needing such care.

- Of 415 confirmed HIV-positive individuals, 132 have developed AIDS. However, epidemiologists estimate 6000 HIV cases in Sri Lanka.
- Approximately 50 000 patients with psychiatric disorders received treatment in government hospitals.
- Eight thousand new tuberculosis cases were detected in the year 2000.
- Another 50 000 were exposed to poisoning (most of the cases were suicide attempts).
- Similarly, 173 233 cases of asthma, 60 633 cases of ischaemic heart disease, 83 000 cases of hypertension, and 23 559 cases of liver disease (mostly following alcohol use) were reported in the year 2000.
- Additionally, 520 000 cases of traumatic injuries were reported (mostly accidents and injuries related to violence). A significant population of individuals have been disabled as a result of the armed conflict that has continued for almost twenty years.

More generally, with the reversal of the population pyramid, more and more older people are joining the population of Sri Lanka. It has been estimated that by 2050 the average age in Sri Lanka will be 50 years.

4.2 Developments in Long-term care

LTC encompasses personal care, household chores, life management, provision of assistive devices, adoption of advanced technologies, and home modifications and assistance in basic housing and subsistence needs. Access to acute and chronic care of persons who are not fully capable of self-care on a long-term basis – whether performed by themselves or provided by friends, family members, formal care givers, traditional care givers, and volunteers – are also important aspects of LTC.
In the Sri Lankan context, however, LTC activities seem to comprise the main agenda for rehabilitation, primarily in the Community Based Rehabilitation Programme of the Ministry of Social Services and in the Ministry of Defence. Therefore, ‘rehabilitation’ in Sri Lanka seems not to be limited just to medical and technological interventions for rehabilitation, but to extend beyond these interventions to incorporate all aspects of LTC.

Another area of work that seems to overlap with LTC is elderly care. Given the demographic changes expected in the future, there is more discussion about elderly care than about long-term care in general. It appears as though these two concepts, which have received attention from both politicians and professionals, are masking the realization of the goal of developing a policy on long-term care provision.

Another factor that seems to affect the conception of care needs is the idea of an inevitable sociological change from extended families to nuclear families, which for most professionals leads to thinking of institutions as becoming the providers of most care. The problem is that, in Sri Lanka, the care provided in institutions is more bureaucratic and mechanical, rather than being based on humanitarian and moral concerns. Furthermore, it is rather difficult administratively for most State-funded institutions to deploy community-oriented extension programmes.

4.3 Concluding remarks

Sri Lanka reflects current trends among most developing countries, facing the prospect of an increasing need for long-term care services that will exceed the experiences of industrialized countries. The ageing of the population will, of course, be the single most important contributor to this need. Current demographic and epidemiological profiles – particularly in relation to chronic diseases and conditions such as tuberculosis, mental illness, road traffic injuries, and violence – will dramatically increase the demand for LTC in the coming decades.

For these reasons, the country faces a number of questions that need to be addressed in a systematic manner, and cost-effective alternatives need to be identified. These efforts must be undertaken within a context in which:

- available resources are extremely limited;
- the structure of the family is in a state of flux;
- cultural and ethical values are shifting; and
- health and social welfare systems are in evolution.
LONG-TERM CARE

The following are some of the priority actions that must be set in motion in Sri Lanka.

- **Development of a rational LTC policy**

  The current policy indication is that the primary responsibility for providing LTC belongs to the family and relatives, with the informal help of the community. The government will only intercede in the event of a serious superimposed illness or in extremely dire circumstances.

  The concept that LTC is predominantly a social responsibility and that the government should take a formal, principal role and support informal caregivers has not been established in Sri Lanka. At the policy level, there needs to be support for the view that the responsibility for LTC should be balanced between society and the family.

- **Development of a set of priority areas for LTC in relation to the other needs of the population**

  This action must take into account different age groups, disease conditions and service delivery systems. With regard to service delivery systems, it appears that most countries are now moving towards developing community health care.

- **Identification of the roles of government, the private sector, and NGOs, as well as the community and volunteers**

  Specifically important will be the stewardship role of the Government in facilitating and creating the infrastructure necessary for nongovernmental sector agencies to provide an increasing quantity of services.

- **Re-evaluation of the current and future role of the family and the community in LTC and development of ways to augment these roles**
Development of the human resources capacity needed to undertake LTC at the desired level, by full-time or part-time health and social services staff, as well as such informal sector staff as volunteers.

This also requires a policy basis, after a careful consideration of the tasks – both professional and specialized, as well as caregiving tasks – that need to be performed by various persons who provide LTC. Policies in this case also have to be cognizant of efficiency and cost-effectiveness requirements, particularly in devising an appropriate personnel mix.

It is important to devise an LTC policy that is sustainable over a long period of time.
LONG-TERM CARE

References


CASE STUDY: THAILAND

ACHIEVING COORDINATED AND INTEGRATED CARE AMONG LTC SERVICES: THE ROLE OF CARE MANAGEMENT

Professor David Challis
University of Manchester
United Kingdom

CASE-STUDY THAILAND

Somsak Chunharas
Kanittha Boonthamcharoen
1 General background data

1.1 Preamble

Thailand is a developing country currently undergoing a rapid social and economic transition. In the last two decades of the 20th century, the economy has fluctuated considerably, with years of economic growth interrupted by the economic crisis of 1997. Social changes have accompanied these economic movements, with rapid urbanization and exposure to western culture being examples of two significant developments.

In recent years, there have also been important epidemiological and demographic changes in Thailand. The demographic transition includes an increasing number and proportion of elderly in Thailand’s population. The segment of the population over 65 years of age – who will require increasing amounts of long-term health care – has grown over the last twenty years and is projected to increase from 5.2% in 2000 to 11.4% in 2025.

This ageing of the population has accompanied an epidemiological transition from ‘diseases of poverty’ to ‘diseases of affluence’ that has shifted the major health burden to that of a more chronic nature. These transitions indicate increased needs for long-term care.

In recent years, there have also been important changes in financing and service provision strategies for health care in Thailand. For example, resources devoted to health care have increased markedly in recent years. While national health expenditure has increased gradually, it has done so at a faster rate than that of the gross domestic product (GDP), rising from 3.5% to 6.3% to 6.2% in 1979, 1991, and 1998 respectively. Systemic changes include a new universal health insurance system, which aims to provide health care to the entire Thai population, and a move to decentralize resources and service provision responsibility.

With regard to provision of LTC, the family has traditionally occupied the dominant role in providing care for disabled and elderly relatives. There is no systematic data on how care is provided to those with long-term health needs.
LONG-TERM CARE

However, given what we know about the current health care system and about accessibility to health services and utilization rates in Thailand, it would be fair to assume that most of those in need of LTC are receiving such care from family members. Furthermore, residential care in Thailand is not very popular because the Thai culture stresses the importance of family care for the elderly.

We also know that, in hospitals and health care centres where holistic and continuous care is being provided, family members play a crucial role in assisting members of the health teams that provide care for their relatives. There are private foundations in Thailand that assist and empower family caregivers by providing tools, regular technical supervision, and ad hoc consultation.

The State has played a lesser role in LTC provision, on the assumption that families continue to take care of their own welfare needs and are independent of outside assistance. The poor, therefore, must rely on their own families to care for older relatives.

However, looking at the growing needs for long-term care as described previously, it appears that families will need assistance and supplementation from Government sources in order to provide sufficient care for the growing populations of disabled and elderly.

In this case-study, the demographic and epidemiological changes occurring in Thailand that will impact on the need for long-term care will be examined in more depth. Additionally, the health and social services systems in Thailand will be explored to better understand how long-term care can be melded with the current and future service infrastructure.

Presented on the following three pages are background data concerning Thailand, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health

---

### 1.2 Background data from international data bases

<table>
<thead>
<tr>
<th>Demography (year 2000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong> (thousands)</td>
</tr>
<tr>
<td><strong>Land area</strong> (sq km)</td>
</tr>
<tr>
<td><strong>Population density</strong> (per sq km)</td>
</tr>
<tr>
<td><strong>Population growth rate</strong> (% 2000–2005)</td>
</tr>
<tr>
<td><strong>Urban population</strong> (%)</td>
</tr>
<tr>
<td><strong>Ethnic groups</strong> (%)</td>
</tr>
<tr>
<td>Thai</td>
</tr>
<tr>
<td>Chinese</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Religions</strong> (%)</td>
</tr>
<tr>
<td>Buddhist</td>
</tr>
<tr>
<td>Muslim</td>
</tr>
<tr>
<td>Christian</td>
</tr>
<tr>
<td>Hindu</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Total adult literacy rate</strong> (% in 1997)</td>
</tr>
<tr>
<td><strong>Age Structure</strong> (%)</td>
</tr>
<tr>
<td>0–14</td>
</tr>
<tr>
<td>15–24</td>
</tr>
<tr>
<td>60+</td>
</tr>
<tr>
<td>65+</td>
</tr>
<tr>
<td>80+</td>
</tr>
<tr>
<td><strong>Projections 65+ (%)</strong></td>
</tr>
<tr>
<td>2025</td>
</tr>
<tr>
<td>2050</td>
</tr>
</tbody>
</table>
**Demography (continued)**

<table>
<thead>
<tr>
<th>Sex ratio (males per female):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population             0.97</td>
</tr>
<tr>
<td>15–64                       0.97</td>
</tr>
<tr>
<td>65+                         0.78</td>
</tr>
</tbody>
</table>

**Dependency Ratio:**

- Elderly dependency ratio in 2000\(^2\) 8.9
- Elderly dependency ratio in 2025 18.2
- Parent support ratio in 2000\(^3\) 5.7
- Parent support ratio in 2025 8.8

---

**Vital statistics and epidemiology**

<table>
<thead>
<tr>
<th>Vital statistic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crude birth rate</strong> (per 1000 population) (2000)</td>
<td>17.8</td>
</tr>
<tr>
<td><strong>Crude death rate</strong> (per 1000 population) (2000)</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>Mortality under age 5</strong> (per 1000 births) (2001)</td>
<td></td>
</tr>
<tr>
<td>males</td>
<td>38</td>
</tr>
<tr>
<td>females</td>
<td>31</td>
</tr>
<tr>
<td><strong>Probability of dying between 15–59</strong> (per 1000) (2001)</td>
<td></td>
</tr>
<tr>
<td>males</td>
<td>272</td>
</tr>
<tr>
<td>females</td>
<td>148</td>
</tr>
<tr>
<td><strong>Maternal mortality rate</strong> (per 100 000 live births) (1995)</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total fertility rate</strong> (children born/woman) (2001)</td>
<td>2.0</td>
</tr>
</tbody>
</table>

---

\(^2\) Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

\(^3\) Parent support ratio: the ratio of those age 80 and over per 100 persons age 50–64.
**Vital statistics and epidemiology (continued)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated number of adults living with HIV/AIDS (2001)</strong></td>
<td>650,000</td>
</tr>
<tr>
<td><strong>HIV/AIDS adult prevalence rate (%)</strong></td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Estimated number of children living with HIV/AIDS (2001)</strong></td>
<td>21,000</td>
</tr>
<tr>
<td><strong>Estimated number of deaths due to AIDS (2001)</strong></td>
<td>55,000</td>
</tr>
<tr>
<td><strong>Life expectancy at birth (years) (2001)</strong></td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>68.9</td>
</tr>
<tr>
<td>Male</td>
<td>65.7</td>
</tr>
<tr>
<td>Female</td>
<td>72.2</td>
</tr>
<tr>
<td><strong>Life expectancy at 60 (years) (2000)</strong></td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>19.0</td>
</tr>
<tr>
<td>Male</td>
<td>17.0</td>
</tr>
<tr>
<td>Female</td>
<td>20.0</td>
</tr>
<tr>
<td><strong>Healthy life expectancy (HALE) at birth (years) (2001)</strong></td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>58.6</td>
</tr>
<tr>
<td>Male</td>
<td>56.4</td>
</tr>
<tr>
<td>Female</td>
<td>60.8</td>
</tr>
<tr>
<td><strong>Healthy life expectancy (HALE) at 60 (years) (2001)</strong></td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>12.3</td>
</tr>
<tr>
<td>Male</td>
<td>12.0</td>
</tr>
<tr>
<td>Female</td>
<td>12.6</td>
</tr>
</tbody>
</table>
LONG-TERM CARE

Economic data (year 2000)

GDP – composition by sector (%)  
- Agriculture: 13
- Industry: 40
- Services: 47

Gross National Income (GNI) ($PPP)  
384 billion

GNI – per capita ($PPP)  
6320

GNI – per capita (US$)  
2000

GDP growth (annual %) (1999–2000)  
4.3

Labour force participation (%)  
- Male: 65.3
- Female: 56.0

Health expenditure (year 2000)

% of GDP  
3.7

Health expenditure per capita ($PPP)  
228

Health expenditure per capita (US$)  
71

*PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries.*

8
2 General health care and social service system

2.1 Basic income maintenance programmes

2.1.1 Income support/subsistence allowance for people with disabilities

Registered disabled people who are poor, unemployed, and incapable of earning, are entitled to a 500 baht monthly subsistence allowance. The allowance is also expected to enable people with disabilities to live with their families without needing care from the Department of Public Welfare (DPW) services. In 2000, there were 15,000 persons receiving the allowance contributing to a budget of 90 million baht.

2.1.2 Income support/subsistence allowance for the elderly

Since 1993, the Department of Public Welfare has provided income support or subsistence allowances to poor elderly people living in rural areas. This policy provides cash support for elderly people who are poor, without relatives, or abandoned, and living in villages where support centres for such people are established. The amount of such allowances is very small – approximately 200–300 baht a month. Each village has a committee which decides on the selection of recipients for the allowance. In 1998, there were 318,000 recipients nationwide.

2.1.3 Welfare assistance for families

Cash assistance up to 2000 baht is provided to distressed families, whose breadwinner has died or disappeared, is chronically ill, imprisoned, disabled or unable to take care of the family for any other reason. Assistance is also provided to persons affected by HIV/AIDS (patient or family caregiver).

2.1.4 Welfare assistance for AIDS patients

The DPW provides primary family assistance and a lifelong monthly allowance (500 baht per person) to patients unable to earn their living, and who have been neglected by other people in society.

2.1.5 Cash grants for HIV-infected women

An amount of 5000 baht is provided to HIV-infected women and women affected by AIDS, for self-treatment. This cash grant is provided to those both in and outside institutional care. In 1999, grants in the amount of six million baht have been allocated to women in need.
LONG-TERM CARE

2.1.6 Workmen’s compensation

The Social Security Scheme and the Workmen’s Compensation Scheme provide monetary compensation to eligible workers covered within the two schemes, for loss of certain body parts and consequent inability to work. Such compensation is made available through the premium paid by workers enrolled in the scheme. At present there are only about five million people enrolled in the system, and there are still bureaucratic problems related to disability compensation.

2.1.7 Interest-free loans for small enterprise investment

Interest-free loans for people with disabilities wanting to become self-employed or expand their businesses, are provided from the Rehabilitation Fund. A maximum of 20,000 baht per person is set for the loan with no interest. The maximum period of repayment is five years. In 1999, 77.31 million baht has been lent to 4050 disabled people.

The DPW has also supported rehabilitation projects for disabled people operated by governmental and nongovernmental organizations. In 1999, DPW provided 5.78 million baht of financial support to 51 projects.

3 Organizational structure of decision-making

3.1 Major stakeholders

The Ministry of Public Health (MOPH) is the major provider of public health services and provides about 90% of those services. Long-term care services, on the other hand, are provided by both the Ministry of Public Health and the Ministry of Social Welfare. There is no separate division for these services. Governmental agencies, besides the MOPH, which carry out health-related activities include: the Bureau of University Affairs, the Ministry of Industry, the Ministry of Defence, the Ministry of the Interior, and the Government Pharmaceutical Organization.

The Department of Public Welfare (DPW) is the major government agency responsible for providing social welfare to the Thai people. The DPW was established in 1940 under the administration of the Ministry of Interior, and in 1993 was transferred to the Ministry of Labour and Social Welfare. The Department deals mainly with the welfare of unemployed persons, children and youth, needy families, the disabled and handicapped, the aged, the sick and injured, and ethnic minorities. It has long been criticized for its passive role in providing services to target groups.
While health and social services in the public sector lie within separate ministries – the Ministry of Public Health and the Ministry of Labour and Social Welfare, respectively – there is no intersectoral cooperation other than that for medical care covered by social security funds. Thus, there appears to be a great deal of fragmentation at the national level aside from the cooperation on this new scheme.

There are also major NGOs in Thailand that are involved in health and social service provision. There are at least 247 NGOs that have active roles in health care, and 6364 NGOs are registered as social welfare entities. They range from those working on health advocacy, to those involved in health provision of various kinds, to selected target populations.

### 2.2 Decision-making

Policy setting in Thailand is done mostly at the central level, but some local level initiatives exist. There is a general move towards more decentralization in the area of health provision, but it is unclear whether this will affect the policy-setting sphere.

Budget allocation also happens mainly at the central level but there is a move to allocate a greater share to local authorities – from 9% to 35% in the next five years (by 2006). Provision of services have long been and are currently provided mostly by the central government, but with an increase in tax revenue allocation there will be an increased responsibility for the provision of services at the local level.

Although there is an attempt to decentralize many public services, the responsibility for health and social services at the local level is limited at the present time. Variations at the local level can be seen in services provided by communities and NGOs. Licensing of professionals is generally done at the central level by the MOPH.

### 4 Financing of health and social services

The Thai health care system reflects the entrepreneurial, market-driven nature of its economy, which is exemplified by its pluralistic (mixed public and private) system of health financing. In Table 1, below, the sources of financing for health care in Thailand in 1994, 1996 and 1998 are displayed. These figures demonstrate the significant contribution of private expenditure to overall spending on health care throughout the years from 1994 to 1998.

However, the table also shows that public sector financing for health care over this period has become the dominant source of funding, with its share of the total expenditure on health services having increased from 48.77% in 1994 to 61.1% in 1998.
### Table 1. Sources of finance and approximate share (1994, 1996 and 1998)

<table>
<thead>
<tr>
<th>Sources of Finance</th>
<th>1994</th>
<th>1996</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ministry of Public Health</td>
<td>28.56%</td>
<td>28.9%</td>
<td>35.0%</td>
</tr>
<tr>
<td>2. Other ministries</td>
<td>3.8%</td>
<td>6.2%</td>
<td>5.5%</td>
</tr>
<tr>
<td>3. Local government</td>
<td>7.76%</td>
<td>3.8%</td>
<td>4.4%</td>
</tr>
<tr>
<td>4. Civil Servants Medical Benefit Compensation (CSMBS)</td>
<td>4.34%</td>
<td>8.0%</td>
<td>9.3%</td>
</tr>
<tr>
<td>5. State enterprises</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.7%</td>
</tr>
<tr>
<td>6. Social Security Fund</td>
<td>2.7%</td>
<td>3.9%</td>
<td>4.7%</td>
</tr>
<tr>
<td>7. Workmen’s Compensation Fund</td>
<td>0.31%</td>
<td>0.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Public expenditure (1–7)</td>
<td>48.77%</td>
<td>52.7%</td>
<td>61.1%</td>
</tr>
<tr>
<td>8. Private insurance</td>
<td>1.77%</td>
<td>2.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>9. Traffic accident</td>
<td>1.95%</td>
<td>1.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>10. Employer benefits</td>
<td>1.49%</td>
<td>2.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td>11. Households</td>
<td>44.38%</td>
<td>41.3%</td>
<td>33.0%</td>
</tr>
<tr>
<td>12. Non-profit organizations</td>
<td>1.63%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Private expenditure (8–12)</td>
<td>51.22%</td>
<td>47.3%</td>
<td>38.9%</td>
</tr>
<tr>
<td>Total expenditure %</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total expenditure (million baht)</td>
<td>128 305.11</td>
<td>171 470.83</td>
<td>178 129.05</td>
</tr>
<tr>
<td>Total expenditure as % of GDP</td>
<td>3.56%</td>
<td>3.72%</td>
<td>3.85%</td>
</tr>
</tbody>
</table>

Traditionally, the pluralistic nature of financing (and provision) in Thailand has made it difficult to provide equitable services, and contributes to inefficiencies and variable levels of quality of care.

**4.1 Government financing and expenditure for health and social services**

Prior to the 1997 economic crisis in the country, Government budget allocations to public health grew moderately. During the period 1992–1996, health expenditure accounted for 5.4%, 5.8%, 6.3%, 6.5% and 6.7% of the total government budget for those years, respectively. From 1977 to 1992, health expenditure, as a percentage of the GDP, expanded from 3.4% to 5.9%. Total health expenditure rose, in real terms, from 853 baht per person in 1977 to 2689 baht in 1992.

These trends demonstrate an increasing commitment of the Government to spending on health services. Figures in 1998, the last year where such statistics were available, showed that Government spending for health accounted for approximately 6% of the total Government budget and the total health expenditure was estimated at 4% of GDP.

Financing for health services through public service outlets has traditionally been through budget allocation practices based mainly on the size of health facilities, past performance and the needs of programmes. Implementation was done through agencies responsible for specific programmes. Even at the present time, budgets are hardly ever allocated to tackle the needs of well-defined population groups, but rather for problems that would affect a broad range of target populations.

As an example, even though there is a long-term plan for the elderly, the emphasis is not on developing a service system or care package aimed at them, with a special line of service delivery. Rather, on services for the elderly – health, social and clinical-Pongpanich et al. (2000) – will be integrated within the existing health and social service delivery systems.

**4.2 Government pooled programmes**

At the end of the 1990s, approximately 35-40% of the Thai population were not covered by any health insurance scheme and had to pay user fees whether they went to public or private health care facilities. The Government initially attempted to combat this problem by issuing ‘voluntary health cards’ for the near-poor and ‘low income cards’ for indigent children, the elderly, veterans, the handicapped, and certain religious and political figures. In 2001, a new reform was implemented to replace these initial attempts. This new reform is intended to provide universal health insurance to all Thai citizens.
LONG-TERM CARE

After this reform, and as things currently stand in Thailand, there are essentially four Government health insurance programmes:

- The Civil Servants' Medical Benefit Compensation (CSMBS) Programme, which covers civil servants.
- The Social Security Fund (SSF), which covers employees in firms with more than 10 workers.
- The Workmen’s Compensation Fund (WCF), which also covers employees in firms with more than 10 workers (the same population as is covered by the SSF), but which operates on different financing principles and has separate management.
- The new universal health insurance coverage, which is intended to cover the remainder of the population.

In order to clarify the coverage and financing mechanisms of these four programmes, some further details about each of these programmes will now be provided.

4.3 Civil Servants Medical Benefit Compensation (CSMB)

The CSMBS is a fringe benefit provided to civil servants. It was estimated in 1998 that this programme covered approximately 11% of the Thai population. The provider payment mechanism of the CSMB is fee-for-service, and its funds derive from general tax revenues. The CSMB is administered under the Ministry of Finance.

4.4 Social Security Act of 1990

The Social Security Act of 1990 was considered a major watershed in the history of welfare development in Thailand. In essence, it enabled participants of programmes to enjoy benefits without a sense of obligation or stigma. In other words, welfare is now perceived as an individual right rather than charity, as was once the perception.
Under the Act, the Social Security Office was established to organize and operate the programme and the Social Security Fund was assigned the administrative work. The insurance coverage includes the following seven categories:

- off-the-job accidents and sickness;
- physical disability;
- maternity;
- death and survivors;
- family allowances;
- retirement; and
- unemployment.

The Social Security Act provides for the welfare of those working in places with more than ten employees. In fact, it covers only about five million people, or slightly less than 10% of the total population. It is now being expanded to cover those workplaces with fewer employees and is expected to eventually cover around 20% of the total population. The scheme offers six different benefits, including:

- access to free medical services with a minimal exclusion list (yet it is still a poorly-defined core package);
- long-term pension benefits (old-age benefits);
- unemployment;
- maternity;
- disability; and
- death benefits.
LONG-TERM CARE

This scheme has led to competition between service providers. Aside from access to public health facilities, beneficiaries are entitled to use private facilities that contract with the Social Security Fund. Payment for such care is done through capitation. This scheme has also brought the issue of regulating quality of care in public and private hospitals into focus.

4.5 Workmen’s Compensation Scheme

The Workmen’s Compensation Scheme covers expenses for medical care arising from work-related accidents and offers compensation for loss of body parts based on physical disability. It covers the same population as the Social Security Scheme but operates on different financing principles and has separate management. Both are under the Social Security Office, which is part of the Ministry of Social Welfare and Labour.

Those covered by the Workmen’s Compensation Scheme (WCS) are reimbursed for all medical expenses up to approximately US$800 per illness episode and also receive monetary compensation for medical conditions leading to disability. The most common medical conditions covered by this scheme are injuries resulting from machine operation. Such accidents may lead to short-term or long-term disability or suffering of varying severity.

There are also cases for which eligibility is subtler, which have led to disputes between the employees and the WCS. This is especially true for medical conditions that may be attributed to the long-term exposure to hazardous agents present in the workplace. However, the lack of medical evidence and unclear information with regard to certain agents and their relation to health conditions has created a number of conflicts. This has led to a proposal to establish separate organizations to deal with such problems, the better to compensate workers in cases of severe health impact due to working conditions.

4.6 Universal health insurance plan

The 2001 reform seeks to create a large national health insurance fund to pay providers at a prospective capitation rate for inpatients within a specified budget ceiling using DRG weights as criteria for reimbursement. Such a payment method will provide the opportunity to create awareness and incentives among service providers, for meeting health needs of various population groups if an age-differential capitation rate can be properly devised.

Despite the positive ramifications that may be realized with the adaptation of the new universal financing system, there are also potential pitfalls. It is possible that the present reform will become a threat to the existing health care system if it fails to become a proper financing model and does not provide adequate funds. This will result in a lower quality of health care within the universal health insurance scheme.
4.7 Concluding thoughts

Within the present public system of health service provision, it is important that health service providers understand innovative service provision. In this way, they can more effectively address the changing health needs of the population. Even within the present health insurance schemes there are no clear benefit packages. Although beneficiaries can receive health services without having to pay for them out of pocket, the range of services available is supply-driven. If providers of health services are not capable of providing a range of health services, those services will not be available.

In the new universal health insurance scheme it is expected that the national authority or the local health purchasing bodies will be capable of specifying a range of health services (the core package) that will be made available. However, it remains a challenge for those managing the health insurance scheme to specifically identify certain health service packages and develop the necessary payment methods to ensure that they will be properly delivered within the prospective payment system.

Keeping in mind that efforts will be made to include LTC services within the financing framework of health care pooled programmes, the changes taking place in the central Government, and in the political as well as social development arenas, make it quite likely that the services for LTC – either health or supportive services – will be developed based only on an individual’s ability to pay. The LTC gap in the Thai health system then may not be adequately reduced. Those who can afford to pay can certainly have access to the available limited supply of services, while very few will be available and accessible for the poor.

In such cases, the demand for home helpers may be the only thing that will be quite obvious. It will demand clear policies on how to direct the education of such home-helpers, as well as on the changing roles of health service providers to improve outreach and home-based care.

As for those who have to depend on whatever care is available from health providers in the public system, the major challenge first involves ensuring that the central and local governments identify the needs for such services. Next, those governments must obtain the needed financial and technical support, from whatever sources of budget are available for social services in the future. This effort requires very strong leadership and good informational support from the Ministry of Health.
LONG-TERM CARE

Again, it is important to emphasize that the likely scenario for the future definitely involves serious debate about the justification of including various types of LTC within the collective financing system. However, many of the services required will be left to the individual’s ability to pay.

Financial support for certain supportive services, such as prosthetics or daily subsistence payments for the poor, may be made available through various charitable NGOs that are supported by general donations from the public. The law on the rehabilitation of the disabled will make certain prosthetic supports available, but will be unable to meet many current cases due to limited implementing capacity. This has been obvious since the first draft of the legislation was enacted in 1991.

5 Service delivery system

Under the Ministry of Public Health, there are three levels of health care provision:

- primary health care, including health centres;
- secondary care, including community and general hospitals; and
- tertiary care, including general, specialized, and regional hospitals.

A greater proportion of money is spent on curative care than on health promotion or preventive care. However, a large number of programmes have been developed in the latter areas.

Service delivery through the MOPH is comprised of health centres and community, regional and general hospitals. Health centres provide primary care at the Tambon level and referrals to higher levels of service. The centres are staffed by junior sanitarians and technical nurses and have, on average, 3.5 personnel per centre. Their catchment areas cover a population of 5000.

They deliver mostly preventive and health promotion services, e.g. nutritional, dental, and MCH programmes, mainly through an outreach community-based approach with village volunteers. The centres also provide basic curative care under supervision of community hospital doctors. Staff members are assessed through a monitoring system set up by planning departments.
CASE STUDY: THAILAND

Health centres have little autonomy, due to central planning and budgeting, although this has improved because of the new universal style health coverage that will encourage them to perform in a manner similar to high quality primary care units (PCUs) under the supervision of community hospitals. Additionally, their autonomy will be encouraged by a newly codified right to keep some of the new revenue generated by a budget allocation method that allows them to be less dependent on central department programmes and projects.

Community hospitals serve as the first referral level for curative care. The number of beds in these facilities ranges from 10 to 120. Their major roles are to provide comprehensive services to the population in their immediate catchment areas. They have a greater potential than the health centres for outreach services and innovative programme development. The main staff is comprised of doctors, nurses, dentists, pharmacists, junior sanitarians and general supportive personnel. There are no specialist posts in community hospitals.

General and regional hospitals are located at the provincial level. The number of beds in such facilities ranges from 200 to 700. Their main responsibility is to provide secondary and tertiary care. They serve as referral centres for specialized medical services. One of their roles is to provide comprehensive health services to people in the catchment area through their departments of social medicine.

Staffing is similar to that in community hospitals but includes specialists as well as physiotherapists, laboratory technicians, etc. Because these facilities have a larger pool of staff and a greater potential to generate revenue, they are more autonomous and have the ability to provide newer types of health services including outreach and institutional care. Funds from the central ministry account for 30–70% of their total revenues.

Traditional Thai medicine is practised both in and outside hospitals. Other alternative medicines also exist in the community, with supervision by the Medical Registration Division. Traditional Thai medicine and other alternative methods practised in Thailand are generally not covered by any insurance schemes and require private payment. However, in some parts of Thailand traditional healers and healing facilities (e.g. centres for traditional Thai massage) may receive financial assistance from local health centres.

In general, Thai people seek professional health care, at various facilities, for 70% of their illness episodes. Seventeen per cent of the population self-prescribes, and 14% seek treatment through traditional healers. Average utilization rates are 2.8 for outpatient visits and 0.08 for admissions per person per year.
LONG-TERM CARE

5.1 Access to care

Access to care is problematic in many parts of Thailand due to the absence of affordable public transportation and the lack of adequate facilities nationwide. People living in Bangkok and the local vicinity have better access to care than people living in other parts of the country.

In general, people living in certain big cities of regional importance, with more developed health facilities and greater levels of economic development, tend to have better service facilities in their localities. Long-term care services, on the other hand, vary from region to region.

There is also differential access to care due to the competition that has arisen between service providers under the Social Security Scheme. Beneficiaries have access to public health facilities and are also entitled to use private facilities that contract with the Social Security Fund. Payment for such care is done through capitation. This scheme has also brought into focus the issue of regulating quality of care in public and private hospitals.

As health services organizations in Thailand are mostly public, the entitlement types of health services available to the Thai population should, in theory, be relatively uniform throughout the country. In reality, however, there are differences in the types of health services available to people in various localities and to those with various levels of social status.

5.1.1 Variation due to service availability

Public hospitals in various provinces and districts vary in the range of health services they provide. Tertiary care is available to the population in only 14 of the 75 provinces. Rehabilitation services are not available in all provinces.

In certain provinces and districts, there are medical school hospitals or military hospitals where certain types of health services may be more readily available. Facilities for radiation therapy for people with cancer may not be available in many provinces as there is a total of only 36 units in the country.

Psychiatrists are also not readily available in all provinces. Facilities in Bangkok have the broadest possible range of services and expertise available in the country.
5.1.2 Variation due to entitlement among population groups

Civil servants and their dependents have the best entitlement for health care, as they are covered, as an employment benefit, by central funds from the Government. Their ability to access such care is limited only by geographic or transportation barriers.

Employers in the formal sector with more than ten employees offer the benefits of the social security system and, as previously described, have relatively generous medical and health benefits including other types of financial compensation. The indigent population has access to unlimited health services, but in practice there are various social and other financial barriers to care as a result of personnel attitudes and service availability.

5.1.3 Variation due to health services autonomy

Variation due to health services autonomy is the result of public facilities being quite autonomous in taking up new initiatives to address health problems or health service needs of the population. This is made possible through autonomy in the financial management of hospitals and also to a certain degree in the local government.

Hospitals and health centres, as well as provincial health offices, can create new programmes or health services on their own initiative if they are able to mobilize funding from various sources. The majority of financial support comes from hospital revenue through user charges.

Also, because of the lack of concrete support from the central government, many new programmes are implemented by local health authorities and hospitals according to their own priorities and standards. For this reason, there are national programmes, such as health-promoting hospitals and home health care, being implemented with a wide range of intensity and quality. High priority programmes are implemented and made available quite uniformly throughout the country.

Since LTC is quite new in Thailand, there are not yet any established programmes with concrete financial supports. Health services available to those with long-term care needs vary from one geographical area to another. The same applies to other related social services. They are made available uniformly only when they are of high priority and have concrete targets and financial support. Otherwise, service availability varies from one area to another depending on the priorities and capabilities of the staff in each locale.
5.2 Services provided by the Department of Public Welfare (DPW)

5.2.1 Types of services

As previously mentioned, there is a wide range of services available for people in need. The Department of Public Welfare (DPW) provides services for children, HIV/AIDS patients and their families, the disabled, the elderly, and immigrant workers. These services are briefly described below:

5.2.1.1 Services for children

- **Family support**
  The DPW provides financial support for poor families and those dealing with behavioural problems in children in the areas of child rearing, counselling, healthcare, and the provision of milk, stationery, school uniforms, etc.

- **Foster care placement**
  The DPW helps find foster families particularly for children in the orphanages of the Department of Public Welfare. In 1999, 654 children were placed in foster homes.

- **Residential homes for children**
  For cases lacking better alternatives, orphans and abandoned children are sent to children’s homes, children’s shelters, or child protection homes. In 1999, there were a total of 24 such children’s homes.

- **Child adoption promotion**
  The DPW arranges adoption placements and attempts to ensure the wellbeing of adopted children through regular assessments of adoptive families.
Regulation of private children’s homes and child day care centres

The DPW also supports, promotes and regulates private provision of children’s homes and child day care centres. Recently, the private sector has played a more vital role in social service provision for children. Private services are under the supervision and regulation of the Department and must meet their standards through the issuance and withdrawal of licenses. The Department also provides personnel training, meeting and seminars, and supplemental support through provision of food and toys.

Protection of children’s rights

According to the 1972 Revolutionary Decree Number 294, abused and neglected children and those being unlawfully exploited are protected under the DPW through various programmes of child welfare protection. Furthermore, the DPW works in cooperation with the National Council for Children and Youth Development and the International Programme on Elimination of Child Labour of the ILO. The DPW is also working to protect women and children according to the 1997 Measures in Prevention and Suppression of Trafficking in Women and Children.

5.2.1.2 Services for disadvantaged women

Provision of social services and vocational training in welfare protection and establishment of vocational development centres for women

Services include shelter homes, welfare and protection for women, and welfare and vocational training centres for women. In 1999, there were four shelter homes, three welfare and protection centres, and seven welfare and vocational training centres for women throughout the country.
LONG-TERM CARE

- **Welfare and vocational training for women in communities**

  Services are aimed at disadvantaged women and particularly prostitutes. The Department coordinates with the Ministry of Foreign Affairs to protect and rescue involuntary prostitutes. The DPW runs vocational training services for disadvantaged young women, unemployed, and retrenched female workers.

- **Revolving fund for women’s self employment**

  The DPW has allocated 50 million baht for setting up a revolving fund to provide loans to women who have completed vocational training courses and have become members of an occupational group.

- **Cash grants for HIV infected women**

- **Anti-prostitution campaign**

**5.2.1.3 Services for the destitute**

The DPW provides services to beggars and vagrants in the form of care in reception homes and homes for the destitute, and provides vocational training in vocational training centres.

**5.2.1.4 Services for people with disabilities**

The DPW has set up the Office of the Committee on Rehabilitation of Disabled Persons in accordance with the 1991 Rehabilitation of Disabled Persons Act. Services include entitlements, support to families of people with disabilities, provision of assistive devices, community rehabilitation programmes, subsistence allowance vocational training, disability regulation enforcement in places of employment, interest-free loans for small business investment, residential care, and various programmes protecting the rights of people with disabilities.
5.2.1.5 Disaster relief

The DPW has long provided assistance to and rehabilitation services for victims of both natural and man-made disasters, particularly those who are in need of immediate assistance. Services include five regional disaster relief centres, disaster preparedness and disaster relief programmes, and coordination with other organizations that provide assistance.

5.2.1.6 Services for families and communities

Various services include financial support and counselling for families and communities with economic and social difficulties. Many service centres are set up for particular target groups such as those living in poor areas. These service centres also work with NGOs in arranging services and programmes in the community, e.g. home visits, mobile services, and pre-school child care.

5.2.1.7 Services for older people

Services for the elderly seek to maintain well-being, particularly for those who are socially isolated and vulnerable, and to prevent homelessness, abuse, and family neglect. The DPW also initiates campaigns to support family caregiving. Services for the elderly include: residential care, social service centres, mobile units, and emergency shelters. Additionally, there are programmes specifically for older people, i.e. monthly subsistence allowance, subsistence allowance from the private sector, and service centres located in temples.

5.2.1.8 Other programmes

The land settlement development programme was initiated in 1940 to allocate uncultivated land for farming to the poor, needy, and landless people. Currently there are 44 land settlements, located in 35 provinces, under DPW auspices. Service provision ranges from financial support to technical assistance in occupational development.

In addition, services for members of the hill tribe have been developed to promote quality of life and social inclusion. Services include vocational and environmental conservation training, child development centre support, basic public utility development, and revolving funds for social and occupational development.

In addition, the DPW owns 29 lending institutions that provide loans to the needy and control the interest rates of private lenders. In 1998, the Office of Public Lending contributed 29.31 million baht to Government revenue.
LONG-TERM CARE

5.3 **Elements of the nature of health and social provision that may impact LTC**

Historically, health services in Thailand have been dominated by the development of the public sector, which has been the major provider of health care for those with low socio-economic conditions. Evolutionary health services in the public sector tend to seek alternative approaches with the aim of improving health rather than mere expansion of curative services.

Community participation, better balance of budget spending for preventive and curative services – as well as the creation of outreach services and home-based care – have been gradually receiving more emphasis from public providers. However, this has not been the case in the private sector, which grew tremendously during the economic boom period – mainly to cope with demand for curative care. This demand resulted from dissatisfaction with the crowdedness of the public sector and the relatively less pleasant attitudes encountered among public providers.

This does not mean that health services in the public sector did not also benefit from the rapid economic growth. On the contrary, during the same period the Government invested heavily in the public sector, although mostly in curative services. There was an almost threefold increase in the budget of the Ministry of Health budget in the 5-year period of the 7th Health Development Plan (1991–1995) with approximately 35% of the total budget used for capital investment in 1994. The public sector has also been able to increase its budget to cope with the increasing demand for free medical services for the indigent population, while also expanding its coverage of free services to other population groups such as community leaders.

Neither public nor private providers have focused on rehabilitative services. This could be due to a lack of explicit demand from the population. There have been no systematic approaches to identifying such population groups. All kinds of barriers to such services exist, the most important being the lack of qualified personnel and their distribution.

Although there was concern over the lack of health personnel in rural areas, that concern was focused on doctors, nurses, dentists, and pharmacists. Only these four categories were obliged to serve in rural areas, for a period of time after graduation. Such compulsory service was never extended to physical therapists, and training for auxiliary personnel in physical therapy and rehabilitation was discontinued after less than ten years.
Supportive services for those needing LTC lag behind other health services. The public welfare system is a recent concept, although various types of charitable organizations have long existed in Thai society. However, most such organizations and their services were available on a charitable basis, and all depended upon how much the supply side was willing or able to provide. There were relatively fewer explicit demands from those who needed them. People who might have benefited from a better welfare system placed themselves at the mercy of Government machinery, or sought help from the more prosperous population.

Thailand took fifty years to decide upon the first Social Security Act – the first attempt to systematically institutionalize the social welfare system and to move away from the charitable approach. The Department of Public Welfare was moved into the new Ministry of Labour and Social Welfare, when this Ministry was established after the passage in 1992 of the law on the social security system.

There are still programmes which are operated on charitable basis. They tend to be very passive and limited in scope, and they lack the flexibility to deal with the needs of target populations with different socioeconomic backgrounds. The fact that these programmes and organizations are in a ministry separate from that of Public Health make it difficult for them to be well coordinated in responding to the need of their priority target population groups. LTC needs tend to partially met, on either the health or the social aspect of the services required.

5.4 Auspices of service providers

As mentioned previously, there is a pluralistic system of health care provision in Thailand. Accordingly, services are organized and provided by both the public and private (for-profit) sectors. Among the numerous changes taking place is the increasing presence of the private sector in the provision of health services.

The Ministry of Public Health is the major organization responsible for care and provides about 90% of public services. The private for-profit sector accounts for 70% of all hospitals and hospital beds, and most of the primary care services. There are also private for-profit clinics and pharmacies. This sector is rapidly expanding, particularly in Bangkok and other urban areas. Thirty per cent of hospital care is public. Overall, public health care services have been extensively developed by the various governments during the past 40 years.
LONG-TERM CARE

Generally, services for those requiring long-term care are provided through a mix of public and private institutions. However, public outlets are still serving the needs of the majority of those requiring long-term care.

The majority of health facilities outside Bangkok are under the MOPH. The average number of general hospitals, community hospitals and health centres per province (with an average population of 700 000) are 1.2, 10.2, and 100 respectively. These facilities provide services at the primary through tertiary levels of care. Health volunteers assist health personnel in health centres, community hospitals, and general hospitals in all villages outside Bangkok. Medical schools and private hospitals provide mostly curative services, with no specific catchment population. Private clinics/polyclinics provide ambulatory services for drop-in patients.

There are various private providers of medical services including physicians, dentists, hospitals, drug distributors, and traditional healers. Although private health services have increased rapidly throughout the past decade, medical practitioners are still scarce. Forty percent of the urban population uses private services, whereas 50% use public health centres. Most private providers are also employed by Government health programmes and work only part-time in private practice. Their earnings as private practitioners are normally much higher than their salaried Government positions.

The balance between public and private contractors under the Social Security Scheme has changed over time and the share of the private sector has increased. In 1994, the private sector comprised 32% while in 1999 it held 45% of contracted health facilities. Furthermore, the share of registered workers in private facilities has also changed according to the same trend. The private sector more than tripled in market share during the first three years of this scheme. It rose from 16% in 1991 to 53% in 1993. By April 1999, the private sector covered 58% of approximately 5 million beneficiaries.

Many NGOs in Thailand are also involved in health care and social services. At present, a coordinating committee for NGOs is attempting to establish links to and a communication network with the Government health sector. Most notable among the thousands of NGOs are those working with the disabled. Sources of income vary from one NGO to another. Some organizations depend on domestic donations, while others receive external funding.

The Ministry of Public Health provides an annual budget of approximately US$1 million to support various NGOs including a Government fund dedicated to NGOs working specifically with HIV infection. There are also ‘private foundations’ that assist and empower family caregivers providing them with certain tools as well as regular technical supervision and ad hoc consultation.
Health care and social services are provided not only by formal institutions but also by traditional informal institutions. The family and religious institutions have also played an active part in providing welfare for the populace. The State has played a lesser role, on the assumption that families will continue to take care of their own welfare needs. Since the Social Security Act of 1990, however, the role of the state in welfare provision has gradually increased.

5.5 Human resources and training

Doctors, nurses, pharmacists, dentists, and other health care personnel must have professional licences in order to practise in Thailand. In addition to these providers, health volunteers work at the village level, with roles centred on health education and information distribution rather than care provision. There is no specific training required for paraprofessionals, although there are assistant nurses and technical nurses who are trained mainly for work in hospitals.

The MOPH also employs community health personnel, including technical nurses, midwives, and health personnel. Since 1991 the educational requirements for health personnel have included secondary school education and two years of training. In 1996, there were an average of 3.08 health personnel per health centre. Recent interest has also been expressed by a private caregiver agency in caregiver training for the elderly, in a health school located in Chonburi.

5.5.1 Doctors

There are about 20,000 doctors throughout Thailand. The doctor to population ratio widely varies from 1:900 in Bangkok to 1:9000 in the north-east region. Although the number of new medical school graduates has increased faster than has population growth, a total of about 2000 doctors in the community hospitals serve 60% of the population. The ratio of GP to specialist was 45:55 in 1998. Doctors do not provide care in the homes of disabled patients.

5.5.2 Nurses

There are about 57,000 nurses throughout the country. The nurse to population ratio ranges from 1:400 in Bangkok to 1:2000 in the north-east of the country. The majority of nurses work for the MOPH and only 10% work in the private sector. The annual graduation of nurses is about 6000. Recently, the MOPH’s nursing colleges have been pressured to reduce this annual rate of production. However, such pressure does not exist at university nursing faculties. Nurses working at selective local health centres provide care in the homes of disabled patients.
LONG-TERM CARE

5.5.3 Social workers

Social workers require four years of training and receive a bachelor’s degree from the Department of Social Administration or Social Science at various universities. Special training is optional as is professional practical training in various service settings. Generally, there are two types of social workers: professional social workers who provide counselling and social therapy for support, adjustment, rehabilitation, prevention, and development programmes; and general social workers who provide general management services.

5.5.4 Psychologists

Psychologists require special training beyond graduation. They provide general and specialized counselling. Basic training requirements range from degrees in education, to social work, to professional nursing.

5.5.5 Physical therapists

Physical therapists are crucial health personnel in the provision of long-term care. They number about 650 at the present time. Seven faculties in seven universities – five public and two private– train physical therapists, with an annual production rate of 240–330 per year. There has been no immediate plan to train more than this number, nor to introduce policies requiring service in the public sector and particularly in rural areas. There are also medical doctors who specialize in rehabilitation, but their numbers are fewer than physical therapists and it has not been a popular specialty among medical school graduates.

5.5.6 Alternative health care providers/Traditional healers

Thailand offers training at specialized schools for Ayurvedic practitioners. Those who undergo informal training can also apply for licensing from the Medical Registration Division. This is an example of a traditional practitioner who receives systematic training and licensing. Like other types of traditional healers, they have no systematic support for training but are allowed to take licensing exams and qualify for practice.

There are also various types of spiritual healers, most commonly found in the north-east region, who practise locally and are therefore not regulated as are other health providers. Generally, Thai traditional healers provide services in rural areas. Health care in urban areas is dominated by modern medical practitioners. In some cases where good relationships exist between local health centres and local traditional healers, healers may receive financial support from the health centres.
5.5.7 Paraprofessionals

There are many different types of paraprofessionals trained to work solely in MOPH facilities but they are few in number. Paraprofessionals include technical nurses, dental assistants, dental nurses, junior sanitarians working at the health centre level, pharmacist assistants, cytologists, lab technicians, radiation technicians, and others.

Training for technical nurses generally involves two years following high school. However, there currently fewer trainees due to an increase in this training time from two to four years in an attempt to upgrade them to professional nursing.

Common problems of most paraprofessionals include the lack of clear career paths/ladders, coupled with low job status and low morale. The length of the career of a paraprofessional is relatively short. There are only a few categories of paraprofessionals who are permitted to work independently in order to augment service provision to the rural population. Because the Ministry of Public Health is undergoing reform and has been mandated to reconsider its manpower production and health service provision, many of the Ministry schools that train paraprofessionals are in a transition period involving reorganization and redefinition of their roles.

With the recent migration of young women from rural areas into urban settings to seek jobs, there has emerged a new pool of paid home helpers for those with chronic health conditions. This has given rise to a self-initiated school focusing on the training of young men and women in the care of children and the elderly. Although this approach has expanded gradually, the duties of these home-helpers have been somewhat limited as a result of resistance by certain professional organizations to their employment in this area of work.

5.5.8 Support staff in social welfare services

Support staff are employed as permanent public employees, not as civil servants. Education beyond a secondary education, that is higher than matayom 3, is required of these support staff. They provide assistance to residents in various welfare homes.

5.5.9 Volunteers

Health volunteers work at the village level, with roles centred on health education and information distribution. They are not involved in the provision of care.
LONG-TERM CARE

3 Summary of long-term care provision for the elderly and disabled

Broadly speaking, people requiring long-term care fall within three categories, based on problems affecting their health status:

- chronic diseases;
- disability; and
- ageing

Clearly, overlaps occur among these categories. As mentioned previously, the number of people with chronic health conditions, both from communicable and noncommunicable diseases, has increased progressively within the Thai population.

The proportion of elderly (those over age 65) is also projected to reach 11.4% of the total population by 2025 – a large increase from today’s estimated 5.2%. The number of people with disability has been estimated at approximately 5%, according to the latest national survey. The total estimated number of people within these three categories may be as high as 30% of the total population.

In general, there is as yet neither a systematic approach nor any concrete policies concerning LTC. Accordingly, it is difficult to identify clearly the service infrastructure for these population groups. In addition, few human resources are dedicated solely to providing LTC.

However, these conditions present both a disadvantage and advantage of the Thai health system. That system tends to integrate services, rather than to specifically single out particular problems or the needs of particular population groups and to establish dedicated facilities to deal with them.

Generally, however, services for those requiring long-term care are provided through a mix of public and private institutions. Public outlets are still serving the needs of the majority of those requiring long-term care. Although the types of service and support provided are both medical and supportive in nature, those available are still far from meeting the real needs of the target groups.

On the whole, LTC for those in need of such care is still far from adequate. There exists a wide gap between demand and existing supply of services – medical as well as supportive.
3.1 Identification of target population groups

Age and degree of dependence on others are two important criteria that can help to target more effectively the various population groups that may require long-term care. Using these two criteria, it is possible to map various types of conditions that may pose needs for long-term care within the Thai context.

These types of conditions are as follows:

- Those with common chronic illnesses such as tuberculosis, hypertension and diabetes mellitus, and HIV infected people. These are mostly people in the active working age group, with some in the elderly age bracket.

- The elderly population, especially those without proper family support.

- Those with disabilities ranging from sensory limitations such as blindness or severe hearing loss (two among the top five groups of disabled people in the country) to limitations in movement due to accidents or severe neurological conditions. These people are also mostly among the active age group, with some being children. People with long-term mental and neurological disorders include children who are mentally handicapped as a result of the mix of preventable and unavoidable congenital defects.

- The elderly population with disabilities of various types, especially those without proper family support. These disabilities may result from diseases such as cerebrovascular, accidents, or injuries without proper rehabilitation, or they may be simply degenerative conditions.

- Those providing care to people requiring long-term care of various kinds are also target group for LTC development. These caregivers range from family members, to those working in charitable organizations (including temples), to health professionals and support staff. This target group requires special attention to ensure that caregivers can effectively carry out their roles and functions, crucial to improving long-term care.
## Table 2. Summary of target population groups

<table>
<thead>
<tr>
<th>Target population</th>
<th>Size of group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1: people with chronic illness</strong></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>31,081&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hypertension</td>
<td>4.3 million&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.8 million&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Living with HIV</td>
<td>670,000&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Group 2: elderly people</strong></td>
<td></td>
</tr>
<tr>
<td>Living alone</td>
<td>4.3% of elderly population&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Without proper family support</td>
<td>15.8% of elderly population&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Group 3: disabled people</strong></td>
<td>1.02 million&lt;sup&gt;f&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Group 4: elderly people with disability</strong></td>
<td>108,000&lt;sup&gt;g&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Group 5: care provider</strong></td>
<td></td>
</tr>
<tr>
<td>Professional/formal care provider</td>
<td></td>
</tr>
<tr>
<td>Informal/family care provider</td>
<td>Unclear</td>
</tr>
</tbody>
</table>

<sup>a</sup>Notification report, Epidemiology Division, 1999

<sup>b</sup>Only working population, Chuprapawan 2000

<sup>c</sup>Estimated people living with HIV under heterosexual risk reduction scenario

<sup>d</sup>1995 data from Chayovan’s unpublished paper (1999)

<sup>e</sup>Using (Chayovan’s) survey data assuming all elderly people reporting dissatisfaction with no adequate indirect support are those living without proper family support

<sup>f</sup>NSO, 1996 Health and Welfare Survey (all people with impairment – may overestimate the disabled)

<sup>g</sup>Derived from 1996 HWS
Among those with health conditions that require long-term care, the third and fourth groups are those traditionally considered to be the more relevant targets for long-term care development. However, one should not focus only on organizing long-term care based on the present estimate.

Rather, it is interesting to note that many of those causes that may lead people to ultimately require LTC or depend on others for help can be prevented or averted through various types of preventive efforts and programmes. These programmes can be conducted through various sectors of society and not necessarily the health sector.

Among the various target population groups in need of long-term care we can assign the type of services required according to the specific needs of the various population groups. Such services consist of both health care and social service support and are not necessarily rendered by health professionals only.

### 3.2 Description of current long-term care services

#### 3.2.1 Hospital-based services

- **Rehabilitation services**

  Rehabilitation services are part of hospital services, although not all hospitals have such services available. All of the hospitals at the provincial level, and approximately 80 community hospitals offer such services.

  There is a national centre for rehabilitation in the Ministry of Public Health. However, its scope of services and coverage is limited by its location near Bangkok, as well as by the limited budget and personnel available. Its mandate has been somewhat broadened by the legislation on the rehabilitation of the disabled introduced in 1990, but its capacity still remains quite limited.

  Even though auxiliary personnel for physical therapists exist in the Thai health system, their numbers are few. Moreover, most work with professional physical therapists rather than in the rural areas, where professional personnel may be lacking.
3.2.2 Home-based care

- **Home care**
  
  Home-based care is a recent development in the Thai health system. These services – offered through targeted development projects – are organized and managed by two different divisions of the Ministry of Public Health. One home care programme covers exclusively public hospitals of the Ministry of Public Health. All 92 provincial hospitals, but fewer than 10% of community hospitals, provide home-based care.

  One of the initiatives emphasizing home-based care is the ‘health promoting hospital’. The aim is to reorient hospitals so that they build a continuum of services that range from health promotion to rehabilitation. The key strategies consist of public mobilization as well as system development for identification of patients for early discharge along with continuous home-based care. Although the initiative does not target people with needs for long-term care as the primary objective, it has the potential to develop a system for public hospitals that can evolve and meet the health needs of such target groups. Currently, there are 350 MOPH hospitals enrolled in the health promoting hospitals programme.

  A second initiative emphasizes proactive care provision aimed at the development of health teams that provide continuous health care to people with a wide range of health problems such as tuberculosis, hypertension, diabetes mellitus, cerebrovascular accidents, etc. This initiative also has the potential to address more effectively the health needs of those requiring LTC.

- **Emergency care service**
  
  An emergency home service exists for elderly people who are experiencing severe family stress and want to separate themselves temporarily; for elderly people from the provinces who need to go to hospitals in Bangkok but have no accommodation there, for elderly people who are waiting for their relatives to return home after medical treatment in hospitals in Bangkok; for elderly people who are waiting to enter institutional care, and for elderly people from regional provinces who come to stay in Bangkok. The funded length of stay does not exceed 15 days and the basic maintenance and social work services are provided.
CASE STUDY: THAILAND

- **Caregiving services**

There are many agencies providing trained caregivers to look after older people in their own homes. Usually, these services are costly, so users are middle to upper class. The poor must rely on their own families to look after their older relatives.

Care providers in private home-based care for the elderly (and children) have special training provided by their own schools. The Ministry of Education is entrusted to register and oversee the performance of the training schools for these care providers. However, the nursing council is not in favour of this type of school, and cites concern over quality of care and violation of professional nursing standards under the jurisdiction of the council.

3.2.3 **Community-based support programmes**

- **Community self-help groups and civic groups working in health care**

Health service providers in rural areas working under the Ministry of Health have been quite instrumental in creating social groups of various types working to improve the health of people in local communities. The two most notable groups are those dealing with the elderly and people with HIV infection. Although historically this approach began with the training of village health volunteers, the number and types of community groups have expanded with changing health needs.

At present, there are village health posts operated by village health volunteers who provide simple care for common health conditions. There are also clubs and groups for the elderly organized by health personnel in almost all provinces, covering about 5% of the villages (approximately 4000 clubs in a total of 80,000 villages throughout the country).

In addition, a large number of community groups working with HIV infected people are supported by the network of health personnel and other local NGO’s. Some of these are supported by the budget from the Ministry of Public Health.
Community involvement in support programmes also includes community-based outreach by village volunteers working through MOPH health centres which provide primary care – mainly prevention and health promotion services – at the Tambon level.

**Mobile units – Ministry of Social Welfare**

A mobile unit service consists of social workers, nurses and specialists who visit the elderly in the community, and disseminate information about health and social care. The unit serves as a medical check-up and scan point for health and social problems of older people in the community. The service operates at least once a month. In 1992, the work of the mobile unit was operated at the Din Daeng Elderly Social Service Centre in Bangkok and the Lop Buri Elderly Social Service Centre in Lop Buri, another province in central Thailand.

**Temples**

In 1998, recognizing the important role of temples in Thai communities, the DPW launched a community-based project for older people in temples throughout the country. It is hoped that these centres will enable older people to continue living at home rather than in institutional care. In 1999, DPW received funding of 43 million baht from the Miyazawa loan project to provide revolving funds for these centres. Currently, there are 200 centres nationwide and they are allocated 50,000 baht in revolving funds. Another 140,000 baht will be provided to each of them to purchase materials and equipment for physiotherapy, exercise, and office appliances, etc.

**Rehabilitation services in the community**

DPW has encouraged families and the community to participate in the rehabilitation of disabled people in the community using locally-available resources and community wisdom. DPW has cooperated with village welfare assistant centres and other Government and nongovernmental agencies in care provision.
Social service centres for the elderly

The Department of Public Welfare established the first social service centre for the elderly in 1979. It provides non-resident services to males and females over sixty years of age who live in nearby areas. By the year 2000, 17 centres serving 207,800 elderly people had been established.

Services provided include medical check-ups, physical therapy, occupational therapy, activities of interest to members, recreational activities, exercise and sports, social work services, counselling, problem solving, study visits, information, and annual religious ritual participation in various festivals.

Social organizations

There are two types of social organizations, those that emerge from the people themselves, and those which are supported by the government.

The two principal Government-supported organizations are described here. They are the Village People Welfare Centres and the Tambon Administrative Organizations (TAO).

Village People Welfare Centres are run by the Centre Committee, comprising the head of village, the assistant head of a village, and the head of the relatives of the village. The Department of Public Welfare provides the first endowment of 12,500 baht. In 1999, there were 67,884 centres throughout the country, and provincial social workers support the operation of the centre.

Tambon Administrative Organizations are the smallest local administrative organizations. Their administrative committees are elected by local people. Some of the functions of the Department of Public Welfare are considered suitable for allocation to the TAO. Among these functions are provision of subsistence allowances to older and disabled people, social service centres, and Village People Welfare Centres.
LONG-TERM CARE

3.2.4 Institutional and residential Care

Homes for the Elderly

Under the Ministry of Labour and Social Welfare, several residential services for the elderly have been developed. The Department of Public Welfare has operated homes for the elderly since 1953 with the main purpose of providing residential care to needy persons who meet the following criteria: over 60 years for females and 65 for males; homeless; no relatives to live with or unable to live happily with their own families.

Services provided include lodging and food, clothing, personal and therapeutic activities for physical rehabilitation, recreational activities, traditional festival activities, social work services, and traditional funeral services. In response to the increasing demands of an ageing population, large numbers of homes for the elderly were established in the 1990s. Many nursing homes for older people are also provided by private sector.

There are three types of homes for the elderly, those provided free-of-charge, hostel-types, and private houses. Free-of-charge services are provided for poor elderly people in all homes. The hostel-type service is provided for elderly people who can afford monthly charges, and provides individual rooms to recipients. A private house is provided for elderly people who are financially able to own houses built in the compound of the institution and which conform to the house designs of the Department. The houses become the property of the Department of Public Welfare after the death of the owners and their spouses.

Services provided in these homes include health services, medical treatment, physical therapy, appropriate sports and exercise for the elderly, informational and educational activities, nutrition, social work, recreational and religious activities, and funeral assistance for elderly who have no relatives.

Residential care is provided for persons with disabilities who have been abandoned or neglected by their families. In 1999, nine homes accommodated 3779 persons. In 2000, the total number of elderly receiving residential care was 2807 (Department of Public Welfare, 2000). This small number of places reflects the limited provision of governmental residential homes. The number of places is insufficient to meet demand, and there is still a waiting list – despite the fact that residential care is not popular in the Thai culture, which stresses the importance of family members caring for elderly relatives.

Services in the homes comprise basic necessities, medical rehabilitation, educational rehabilitation, vocational rehabilitation and social rehabilitation. Although the homes provide medical services for their residents, those who need long-term medical care usually are not appropriate for this kind of facility.
### Table 3. Number of elderly in public institutions in Thailand

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of elderly in institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>1675</td>
</tr>
<tr>
<td>1987</td>
<td>2144</td>
</tr>
<tr>
<td>1989</td>
<td>2150</td>
</tr>
<tr>
<td>1991</td>
<td>2144</td>
</tr>
<tr>
<td>1999</td>
<td>2631</td>
</tr>
<tr>
<td>2000</td>
<td>2807</td>
</tr>
</tbody>
</table>

*Source: Department of Public Welfare.*

#### 3.2.5 Other services

**Provision of assistive devices**

Assistive devices (e.g. hand-operated tricycles, wheelchairs, artificial hips, eye lens replacements, etc.) are provided free of charge to impoverished disabled people. Funding is provided by the Government budget and public donation. In 1999, DPW distributed devices to 1497 persons, from a budget of 4.8 million baht. The law on the rehabilitation of the disabled has made a substantial contribution to increasing the budget available for the provision of assistive devices. However, the available budget and the ability to provide needed devices are still far from meeting the demand.

**Vocational training**

The DPW provides vocational training courses to disabled people. These courses are offered in seven vocational rehabilitation centres for people with disabilities, and in a vocational training centre. Furthermore, DPW cooperates with the Ministry of Education to provide those who have completed vocational training with both vocational and mainstream education certificates.
LONG-TERM CARE

3.3 Linkage between the health services and other supportive services

In reviewing the situation concerning the need to support certain population groups, it becomes obvious that support for living expenses – or at least for travel and other expenses related to care-seeking – is crucial. The low socioeconomic status of many requiring LTC makes it very difficult if not impossible for them to gain access to health services even though they do not have to pay for them. In terms of general support by family members, the issue is not whether they are willing to assist the patient but whether they can afford it. In many cases, the family cannot even afford the daily living expenses of its members, let alone the time to care for those needing LTC. In such instances, the need to earn money for daily living is more pressing to family members. Without such opportunities, other support rendered to the target population will not be as useful as it might be.

In the Thai context, such support exists through the work of the DPW. However, the scope of supports is limited, and the possibility of reaching those in need must be further improved. For example, seed money to support the disabled seeks to make it possible for disabled people to resume normal activities that can also generate income for them. Where the disabled person cannot be expected to work, and must be cared for by family members, the fund cannot be made available to non-disabled family members. Such support violates the principles set forth by the Department. As a result, family members who are poor remain without job opportunities. If the objectives of such funds could be broadened to include the general welfare of the disabled, it would be possible to make such funds available. Accordingly, family members supporting the disabled could also take better care of themselves.

3.4 Concluding thoughts

In general, social services for population groups needing LTC may seem broad. However, there are a number of limitations in the services provided. First, there are fewer than 100 social workers per province, and they are posted only at the provincial level. These social workers have a broad target population and those needing LTC are just a small proportion in their priority target groups.

Another limitation involves linkage with the health service sector. Most health personnel work at levels below the provincial level, and therefore do not have close communication with social workers. In addition, traditional bureaucratic organizational boundaries do not facilitate such close communication. If health and social workers were at the same level, the smaller work settings of the districts and sub-districts would automatically facilitate the collaboration across agencies. A further limitation involves a lack of flexibility to meet the various types of demands of those in need.
4 General questions pertinent to LTC development

4.1 Assessment of the main gaps between needs and present long-term care services available.

The gap between needs and services available for long-term care exists for almost every group of target populations. Most of the gap is due to shortages of qualified personnel, coupled with barriers to care which are due either to physical remoteness or financial limitations. Also, most people will be seen and their needs assessed only when they seek services at outlets. Even then, their needs may not be properly assessed. Outreach health services are available only in certain localities (districts or tambons or municipalities).

However, the range of health services provided and the ability to assess those needing LTC also vary from one area to another. Welfare workers conduct home visits, and community development or agricultural workers serve at the village level, and they may come across those needing LTC. However, such initiatives are random and can only identify the more severe cases.

NGOs that work with the community may help in identifying certain cases. Annual surveys have begun to attend to specific population groups, mostly those with disabilities of various kinds. Such surveys may provide a beginning for finding those with needs for services. However, these surveys are based on statistical sampling and are not intended to search for those with LTC needs.

Generally, this identification stage is still very much fragmented. The most reliable agents would be health workers in various localities, if properly reoriented and trained to understand the needs of such target groups.

4.1.1 Gaps in needs by service type

4.1.1.1 Rehabilitation services

The most pressing need involves minimizing the gap between supply and demand for physical rehabilitative services. Such services are particularly inadequate for the poor. Even those with injuries from traffic accidents – young people with a high potential for recovery if given continuous care in the critical early stages – suffer from lack of continuity of care.

In most instances, this is due to the lack of qualified manpower and an effective follow up system. With increasing life spans and more people suffering from, for example, cerebrovascular accidents, there are growing numbers of patients who have not received appropriate rehabilitation services.
LONG-TERM CARE

These services are highly inadequate, due to limited infrastructure and manpower. Physical rehabilitation is the most widely available service, although only 650 physical therapists and 187 physicians are working in rehabilitation medicine. There are even fewer health professionals working in occupational rehabilitation – only 60 in the entire country – in rehabilitation of various sensory capabilities such as hearing, speech, and vision.

Even when cases are identified they have to be sent to specialized centres located only in certain cities and provinces. Most of these centres are in Bangkok or in large cities with medical schools, and are operated by public agencies and NGOs.

4.1.1.2 Prosthetics and accessories for the disabled

Supportive utilities such as wheelchairs, crutches and prosthetics that could help to reduce dependence are not widely available and should be considered as high priority. They are provided mainly by NGOs for the lower socioeconomic population or even the middle class. However, since 1991 the legislation on rehabilitation for the disabled has mandated that the public sector provide essential prosthetics and accessories for the disabled. It also mentioned the need to modify buses, roads, and buildings to facilitate travel by the disabled.

However the true capacity to fully implement the law is still very limited. In 1997, less than 15% of disabled gained access to the devices they needed. Few changes have been made in public facilities, and few services are available to help families or community groups in modifying the living environment in the household or in the community.

4.1.1.3 Holistic and continuous health care

This area includes counselling, emotional support, and palliative treatment, provided through private and public health service facilities. Most are provided on a passive reactive basis, i.e. only to those who gain access to health service facilities and only in those facilities where services are made available, and are quite limited in number. Counselling services are normally not available as a part of the comprehensive health services in either the public or private sectors.

However, many district hospitals and health centres have helped to organize community groups – such as women’s groups and elderly groups – who could be used to provide some general support for certain target groups. At present, the emphasis has been on health for the elderly and children rather than on those with LTC. In those hospitals and health centres where wholistic and continuous care is provided, family members play crucial roles – working with health teams led mostly by nurses.
4.1.1.4 Alternative health care

As has been mentioned throughout this chapter, people requiring long-term care or people with chronic health conditions seek help from many types of alternative health care providers. These include Thai traditional healers, folk healers, spirit healers, and the use of macrobiotics.

Most of the services sought are related to either physical or mental health conditions, and are normally used as a supplement or even a replacement for western medicine. However, they are rarely employed on a long-term basis except for certain types of care such as traditional massages or certain types of food supplements and special dietary practices.

4.1.1.5 Supportive services

A considerable gap also exists in the provision of essential services to help parents take better care of children with conditions of mental retardation and delayed development. Existing institutions and manpower are scarce, staff are overstretched, and admissions are limited. Although the total additional number needed to better cope with the existing identified cases may not be high, there is a general lack of concern and commitment to fill that gap. Incentives to attract people to work in this field are also lacking. Self-help groups among families suffering from similar conditions exist, but are not widely known and accessible to those of lower socioeconomic status.

4.1.1.6 Home help for those that require regular support for daily activities

With more elderly people suffering from cerebrovascular accidents, LTC at home has become a higher priority. It is unreasonable to expect that family members will be able to provide continuous care. Home helpers help share the burden of family members. However, the lack of acceptance from the nursing profession of such personnel has caused difficulties in the expansion and increase of training programmes.

Most of those doing this work are family members. Community members or neighbours can be mobilized to help, as in the case of villages where HIV infection is endemic. There are as yet no examples of community mobilization for other types of health conditions where long-term care is needed.

Those who are prosperous can hire home-helpers who are trained by schools (six-months of training is required for general care and help) endorsed by the Ministry of Education. Some middle class families may employ self-trained home helpers. These are normally girls from rural areas who came to the cities to perform housework and were recruited and trained by the employing family to attend to the daily needs of family members with LTC needs.
LONG-TERM CARE

4.1.1.6 Long-term institutional care

Long-term institutional care is quite rare. Monks serving in temples in certain areas may play significant roles through establishing hospices, such as for those with HIV infection and cancer. There are also nursing homes for the elderly established by the public sector, such as the Department of Welfare. An increasing number of private nursing homes and even private hospitals provide such care for the elderly. However these are affordable only for the prosperous. (One hospital advertises its services at approximately US$2000 per month, excluding medication). A limited number of beds in public hospitals are available for those who are long-term bedridden. Most must be discharged and cared for at home, regardless of their condition and home situation. Only a few hospitals are beginning to provide continuous care at home after discharge.

4.1.1.7 Information systems

Information systems are fragmented and routine information collected by service providers barely captures the changing needs of the people. Staff at the local level gather information according to assignments, following centralized planning efforts. Population and demographic data is neither up to date nor accurate. Therefore, much-needed information is lacking for policy formulation.

4.1.2 Gaps in education and training for personnel

There is a great need to increase the number of various types of personnel if LTC needs are to be met. Training personnel to provide physical rehabilitation services will benefit from two different strategies. First is the use of Thai traditional massage to cope with the needs of certain population groups, especially those suffering from cerebrovascular accidents. Thai traditional massage is growing in popularity, and has been well documented in its ability to help people suffering from paralysis.

The other strategy to increase the number of trained personnel for physical rehabilitation could involve the training of auxiliary personnel. Courses for training auxiliary physical therapists in the Ministry of Public Health were discontinued due to lack of continuous support. There is also a need to change the law on practice of the healing arts, which governs various professional practices of health providers, to allow wider use of auxiliary personnel in the private sector.

Training for those with a loss of special sensory capabilities, such as sight and hearing, should also be more widely available and accessible to those who need them. However, there is a shortage of trained personnel and institutions that could become the basis for providing such services. Many blind people must depend on their family members or neighbours for help, rather than being properly trained to become independent.
CASE STUDY: THAILAND

Well-supported programmes and institutions to train teachers to help children with delayed development and mental retardation, and their parents, could improve the quality of life of many with such conditions. The same approach could be applied to the training of teachers for the blind and hearing impaired.

With the prospect of the new health insurance system promising to eliminate financial barriers to essential health services, those needing LTC will still lack the necessary services if the supply of qualified personnel remains limited and if the system does not specifically identify such services as mandatory. However, the new insurance system may not explicitly address these gaps because of the limited availability of financial resources. It may even delay the improvement of such services, if greater attention is directed towards meeting other and more pressing needs.

4.2. Planned or current changes that will impact LTC.

4.2.1 Overall health system reform

The reform focuses on creating a health-oriented system, rather than one that focuses only on improving access to health services. This approach involves the mobilization of all sectors working towards improving the health status of the Thai population.

Various components are crucial to the system, and certain mechanisms can enable broad-based participation and development of sound public policy. Key components include health care financing as well as these policy development mechanisms. The overall health system reform seeks to develop national health system legislation that will serve as a master plan for the development of the health system of the future.

4.2.2 Reform of health care financing

The principal approach to health care financing reform involves making health services accessible to all – to achieve universal coverage. This approach will have implications for various insurance schemes. Present financing sources include CSMBS, Low income scheme, Voluntary health card, Social Security scheme, Workmen’s Compensation, and Traffic Accident Fund. Each scheme has its contribution system and benefit package, and focuses mainly on health services.

Changes in the health care financing system under the new government health policy are at an early stage of development. There is not yet any specific reference as to how to deal with LTC. The emphasis is still on proactive preventive and health promotion services, and conventional curative care.
LONG-TERM CARE

However, there is an ongoing debate about certain types of services which tend to be very costly and disagreement about whether they should be included. These services involve chronic hemodialysis and the long-term provision of anti-retroviral drugs. An exclusion list specifies services to be excluded. Those services that are not mentioned on the list are assumed to be included. However, providers who are paid on a prospective capitation basis, with the mandate to pay for referred patients, will be forced to develop cost-effective ways to provide needed services.

Both opportunities and threats lie in the future of LTC during this development. On the one hand, the needs of those requiring LTC will become more obvious and there will be more demand for services. On the other hand, the existing supplies are limited and providers may tend to ignore the need to improve and include additional services due to the need to increase investment.

Such tensions between the new undeclared entitlement and the shortage of supply will eventually create a broader societal debate. The alternative is to wait until the tension has developed and then introduce the debate. That debate will involve the prospect and feasibility of including services for LTC and specifying the range of feasible packages to be included – the same way that the debate was conducted in connection with the provision of anti-retroviral drugs and hemodialysis.

4.2.3 Decentralization

The overall decentralization movement requires that the cabinet develop a national decentralization plan. This plan will follow constitutional requirements which transferr decision-making to the local level. Health and welfare services are considered public services for which local administrative organizations must be responsible. Decentralization will include the allocation of a greater share of the government’s revenue to the local authorities, from 9% to 35% by 2006. Such an increased allocation is coupled with the increased responsibility of the local government for the provision of social services.

It is not yet clear how the local government will accept such added responsibility in health services, with the changes in the health care financing system of the country. However, it is very likely that the local government will have more decision-making authority concerning expenditure of money from the new health insurance system and be able to direct health service providers. Local governments should also be able to determine local health needs, and to use part of the money to create the necessary environment for other needed supportive services. The outcome will definitely depend on the awareness of the local authorities and the local population. However, it is expected that the central Government, through MOPH, will still have considerable influence on how the local government performs and decides on local health problems.
With the delegation of more responsibility and authority to local governments for social services provision and the allocation of more government revenue to the local government, more attention will be devoted to meeting the needs of the disabled through the improvement of public facilities.

4.2.4 Development of a national long-term policy and plan for the elderly

The development of the new national long-term policy and plan for the elderly is an ongoing development that will be finalized soon. Although the means to implement the proposed policies have not yet been fully identified and developed, the draft policy could serve as the platform for debate on the possible development of LTC. This will be especially important for elderly groups, both those with and without chronic illnesses and conditions.

The policy focuses upon promoting the health and well-being of the elderly through various types of supports and intervention, including the establishment of pension systems and family supports. Although it does not refer specifically to the development of LTC, the future policy towards the elderly, if realized, may contribute to the improvement of the quality of life of those with LTC needs. The elderly will not have to rely totally on the development of the health insurance system, which will tend to be limited in its scope of coverage and unable to deal with issues beyond health care.

4.2.5 The attempt to use professional workers and family members for homecare

Another changing trend involves an attempt to create a better interface and interaction between professional care and family care, using both professional and family members for care at home. This has been made possible through both governmental and private facilities. There are private foundations that work with family members to empower them to better take care of their family members, providing the families with certain tools as well as regular technical supervision and ad-hoc consultation.

Some of these efforts involve self-organized self-help groups of family members. Some are charitable organizations funded through public donation. Public hospitals are also creating programmes and services that extend to the family and community level, as in the case of health promoting hospitals, home-based nursing care programmes in selected provinces, and district hospitals and teaching hospitals.

The Ministry of Health is also demanding that health service providers under contract for the new health insurance scheme provide active home-based health services provision. However, there is no specific reference to and requirement for them with regard to provision of LTC. However, it made a good starting point for future development of this important major health policy change.
LONG-TERM CARE

One important component of the effort to combine professional and informal services in the home is the development of the ‘home-helper’. This approach has resulted from the migration of young girls from rural areas into urban settings looking for jobs. The increasing demand for home-helpers has also been a result of the ability of some people to pay for care for those with chronic health conditions. This has given rise to a self-initiated school for home-helpers focusing on training young boys and girls to care for small children and the elderly. This has expanded gradually, and is now extending to serve the demand from abroad for home-helpers for LTC.

4.2.6 Reform of public hospitals

The reform of public hospitals and health service facilities is another crucial component that will help to better incorporate and improve the services needed for LTC. Public health facilities will become more autonomous with the future health system reform. They will be monitored and required to be output-oriented and to respond to the demands of their target population. Thus, their management and the decision on the use of financial and human resources will be made to be more cost-effective and productive.

Use of existing trained manpower could be improved under the reform, although the number may not differ much at the beginning. On the other hand, there will be a greater willingness to accept and implement innovative services and programmes directed to outreach and home-based care, which may contribute to better interaction and supervision of the family members with relatives needing LTC. Such possibilities for the health facilities to use their personnel more properly will not only contribute to the provision of LTC but also to other types of health services. However, how this will proceed depends very much on the financing system provided to these health facilities. It depends upon whether the need to provide LTC will be properly identified and highlighted, or if these health facilities will be asked to focus only on prevention and the provision of conventional curative services.

4.2.7 Changes in private hospitals

There have been important changes in the private hospital business in recent years. Such enterprises have been in excess supply since the beginning of the economic crisis. There has been a gradual shift to use the excess beds and capacity to care for those with chronic conditions, with minimal services from professional medical and nursing personnel. As noted above, some private hospitals even advertise in newspapers, offering such services at the rate of US$2000 a month for accommodation, food, and general supportive services, with medical services and medication at extra charge. The private sector is even planning to extend LTC services to other countries. These services would be packaged with Thai traditional health care and herbal medicines.
4.2.8 Development of legislation for the disabled

The development of legislation to improve the quality of life of the disabled is being advocated by NGOs working with the disabled, especially the blind and the hearing impaired. This is a continuation of the effort to modify existing legislation which tends to focus mainly on providing assistance to the disabled and was seen as overpatronizing. Some of the improvements from this legislation will certainly contribute to the enhancement of the quality of life of those needing LTC, especially those with physical handicaps who require assistance from others for daily living activities, and who may be trained and rehabilitated to become more independent.

4.2.9 Development of organizations, working conditions, and services for workers

The development of an organization and institutions for the safety and better quality of life of workers is another ongoing effort that may contribute to the improvement of LTC. Workplace injury has been one of the common causes of disability among the active young. Attention to the improvement of workplace safety as well as compensation to workers will not only prevent injuries, but will also help to provide the means to better support those who incur work-related injuries/handicaps. This could be in the form of financial compensation, or by the establishment of service facilities, or by the provision of a specific entitlement for services that will better address LTC needs.

4.3 Public concern about LTC

It is not easy to gauge how the public sees the need for the future development of LTC. It is fair to say that the health and quality of life of underprivileged groups have become the concern of society in general. This has always included concern for those with LTC needs. If the media can be used as a proxy to reflect public opinion, it is reasonable to conclude that there is growing interest in LTC.

If political campaigns can be used as another proxy for public concern on societal issues, it can be noted that the latest political campaign barely referred to the needs for LTC. The closest to such concerns was the demand from disabled groups that political parties clearly specify their policies towards them. The fact that Thai athletes did quite well in an international competition among disabled people might have contributed to the increased concern over their well-being. However there was no reference to the needs for better development of LTC for the disabled. The emphasis was more on providing supportive facilities in public places and job opportunities.
LONG-TERM CARE

However, such concerns can be judged as being only superficial. While there were debates and criticism about HIV-infected people being discriminated against, headlines about drug abuse, and articles about poor quality of health care in general, there was hardly any serious debate about the lack of LTC within the Thai health care system.

Although political parties drew up policies concerning the welfare of the disabled, there is hardly anything concrete taking place so far. Those in need of LTC also tend to be passively waiting for support to be rendered.

This could partly imply that Thai society in general may accept that people with LTC needs are the responsibility of the individual family, and that those needs do not correspond to the types of care that can be demanded from the system or society in general. For the poor family, it is up to those who are better off to offer any help they deem possible. Otherwise, it is up to family members to take full responsibility for the care of their relatives.

4.4  Key strategies for the future

The future of LTC in Thailand is at a very interesting phase of development with the ongoing reforms on all sides. On the one hand, the new financing system for health presents a highly promising opportunity to better address the health needs of those requiring LTC. On the other hand, the limited budget makes it quite impossible to specifically meet all the service requirements.

One key strategy should be aimed at informing the general public and various levels of decision-makers, national and local, about LTC needs and the potential to reduce the future burden through preventive activities. This might be more effective than proposing essential LTC services at this time.

Perhaps the best approach is to work with other developmental sectors, those involving both social and economic policy, to assure that serious attention is devoted to empowering family and community networks. These networks are the very foundation of societal fabric that will help to enhance self-reliance, in health as well as comprehensive and holistic development. It is imperative that all sectors work to strengthen the family and community as the basis for better health and quality of life, not only for those needing LTC but for the health and well-being of the population in general.

Together with all of these opportunities, and with the identification of some of the crucial partners and entry points for the improvement of LTC, it will still be essential to develop broader strategies to better address the future needs for long-term care.
Some of these strategies should include:

- **Involving and supporting family members as active participants in LTC**

  Direct financial supports or external group supports must be limited to those who require assistance and who cannot afford such assistance through personal sources of income. Involving families in LTC requires technical supports as well as indirect financial incentives, and a system that helps to share the burden of family members. Most supportive and facilitating systems should be developed to supplement families’ efforts, rather than creating a separate subsystem aimed at replacing the role of the family.

- **Development of understanding, concepts and capability among service providers and managers of service facilities**

  Under the new financing system, service providers will be required to make decisions about service mixes for their target populations. The new system will be on a prospective payment basis, using a capitation rate for well-defined target population groups. Unless the needs for and benefits of LTC are seen in terms of both improving the quality of life of the target population and the potential savings in costs, then service providers will continue to deliver services through the conventional passive mode of operation that they have adopted in dealing with acute conditions in the past.

- **Defining LTC as one of the requirements in the service packages to be included in the future health insurance system**

  This will make it obvious to providers that such services will have to be made available, rather than their provision being left to the discretion of providers and their managers. Conceptually, this is easy to say. In practice, it is impossible to define it down to the final detail — so a strategy to develop the understanding and capabilities of providers and their managers is still necessary in order to create more awareness and to bring more innovative ideas into the future development of LTC.
- **Strengthening and involving local governments and civic groups in local health planning and management**

Local governments, with their mechanisms to deal with health problems and needs of the population, will afford another important approach to making decisions on the use of resources in the future. They should be able to plan properly and provide support to appropriate civic groups to take active roles in providing LTC, or even to carry out activities that may reduce the need for LTC.

- **Capacity development of civic groups and communities to be active partners in carrying out LTC for those in need in the community**

- **Working with religious groups and various religious establishments in different localities as a basis for the provision of LTC to certain types of patients through semivoluntary workers.**

- **Promoting the role of the private sector in the training and development of LTC providers in the home**

The private sector can serve the LTC needs of people who can afford to pay for them. Further, they can develop various kinds of packages of care, through which they can work with both family members and supplement the existing health service provider network.
Bibliography


LONG-TERM CARE


CASE-STUDY
UKRAINE

Vladislav V. Bezrukov
1 General background data

1.1 Preamble

Ukraine belongs to the cluster of countries currently having a large elderly population. Therefore, it is essential to the process of reforming the health care and social service systems in the country that current demographic changes are taken into account. Population ageing will have a direct impact on the country’s socioeconomic status. In 1939, the number of persons 60 and over in the total population was 6.2%. In 2000, this figure reached 20.5%. It is predicted that it will grow to more than 25% by 2025. With these increases in both the relative and absolute numbers of elderly people, the morbidity level has also risen. The main incapacitating diseases in Ukraine include those of the circulatory system, nervous system, sensory organs, bones and joints, as well as cancer and psychiatric disorders. For these reasons, the greatest proportion of the population in need of long-term care is the elderly (who comprise two-thirds of the total number of those in need).

The capacity of the informal care system is already very limited. The country displays a clear process of reduction in its population (the natural population loss coefficient is approximately seven (the birth rate is 7.8, and the death rate 14.8, per 1000). The demographic burden per 1000 people of working age is 896 children and persons of the retirement age. In rural areas, the number of persons who are not able to work exceeds the number of those who are able to work. In this context, the role of the family in caring for those with long-term illnesses - primarily the elderly – will not become the dominant mode in LTC. The key role in the organization of long-term care should therefore be shifted to the State.

Presented on the following pages are background data concerning Ukraine, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

---

## 1.2 Background data from international data bases

### Demography (year 2000)

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands)</td>
<td>49 568</td>
</tr>
<tr>
<td>Land area (sq km)</td>
<td>603 700</td>
</tr>
<tr>
<td>Population density (per sq km)</td>
<td>82</td>
</tr>
<tr>
<td>Population growth rate (% 2000–2005)</td>
<td>-0.94</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>68</td>
</tr>
<tr>
<td>Ethnic groups (%)</td>
<td></td>
</tr>
<tr>
<td>Ukrainian</td>
<td>73</td>
</tr>
<tr>
<td>Russian</td>
<td>22</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Religions (%)</td>
<td></td>
</tr>
<tr>
<td>Ukrainian Orthodox, Ukrainian Catholic</td>
<td></td>
</tr>
<tr>
<td>Protestant, Jewish</td>
<td></td>
</tr>
<tr>
<td>Total adult literacy rate (% in 1997)</td>
<td>100</td>
</tr>
<tr>
<td>Age Structure (%)</td>
<td></td>
</tr>
<tr>
<td>0–14</td>
<td>17.8</td>
</tr>
<tr>
<td>15–24</td>
<td>14.9</td>
</tr>
<tr>
<td>60+</td>
<td>20.5</td>
</tr>
<tr>
<td>65+</td>
<td>13.8</td>
</tr>
<tr>
<td>80+</td>
<td>2.2</td>
</tr>
<tr>
<td>Projections 65+ (%)</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>19</td>
</tr>
<tr>
<td>2050</td>
<td>28.7</td>
</tr>
</tbody>
</table>
### Demography (continued)

**Sex ratio** (males per female):
- Total population: 0.86
- 15–64: 0.91
- 65+: 0.49

**Dependency Ratio:**
- Elderly dependency ratio in 2000\(^2\): 22.7
- Elderly dependency ratio in 2025: 29.9
- Parent support ratio in 2000\(^3\): 12.9
- Parent support ratio in 2025: 18.7

### Vital statistics and epidemiology (year 2000)

**Crude birth rate** (per 1000 population) (2000): 8.1

**Crude death rate** (per 1000 population) (2000): 15.4

**Mortality under age 5** (per 1000 births) (2001):
- males: 18
- females: 13

**Probability of dying between 15–59** (per 1000) (2001):
- males: 376
- females: 140

**Maternal mortality rate** (per 100 000 live births) (1995): 45

**Total fertility rate** (children born/woman) (2001): 1.1

---

\(^2\) Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

\(^3\) Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.
### Vital statistics and epidemiology (continued)

**Estimated number of adults living with HIV/AIDS** (2001)  250 000

**HIV/AIDS adult prevalence rate**  1

**Estimated number of children living with HIV/AIDS** (2001)  –

**Estimated number of deaths due to AIDS** (2001)  11 000

**Life expectancy at birth** (years) (2001)
- Total Population  67.7
- Male  62.2
- Female  73.3

**Life expectancy at age 60** (2001)
- Total Population  17.0
- Male  14.0
- Female  19.0

**Healthy life expectancy (HALE) at birth** (years) (2001)
- Total Population  57.4
- Male  52.9
- Female  61.8

**Healthy life expectancy (HALE) at age 60** (2001)
- Total Population  10.5
- Male  8.8
- Female  12.2
**CASE STUDY: UKRAINE**

### Economic data (year 2000)

**GDP – composition by sector** (%)
- Agriculture 12
- Industry 26
- Services 62

**Gross national income (GNI) ($PPP)**

- 183 billion

**GNI – per capita ($PPP)**

- 3700

**GDP – per capita (US$)**

- 700

**GDP growth** (annual %)

- 5.8

**Labour force participation** (%):
- Male 55.8
- Female 46.3

---

### Health expenditure (year 2000)

**% of GDP**

- 4.1

**Health expenditure per capita ($PPP*)**

- 146

**Health expenditure per capita (US$)**

- 26

---

*PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries*
LONG-TERM CARE

2 General health, social and LTC system

2.1 Basic income maintenance programmes

The sources of income support for disabled and elderly persons include:

- monthly pension payments for all State pensions (labour pensions, old age pensions, and incapacitation and loss of breadwinner pensions) and social pensions;
- allowances for services to low-income families, e.g. drug provision, sanatorium-and-spa treatment, and prostheses;
- one-time payment to pensioners; and
- free meals for low-income, single disabled persons.

Also, in the majority of towns in Ukraine, certain national committees release funds for the financing of home-based medico-social services for the needy.

2.2 Organizational structure of decision-making

2.2.1 Major stakeholders

The State plays a principle role in the planning, financing and development of health care services through two separate ministries that function within the Cabinet of Ministers of Ukraine: the Ministry for Public Health and the Ministry for Labour and Social Policy.

The Ministry for Public Health is composed of a number of departments, each dealing with a particular sphere of management: organization of medical care for the adult population, sanitary and epidemiological management, science and international relations, personnel, educational institutions management, social development, etc. Likewise, public health care departments exist at the regional and local levels, functioning within the regional (‘oblast’), municipal and district state administrations.
The Ministry for Labour and Social Policy has a number of departments, such as social services for the elderly, legal control, employment, etc. Respective departments also exist at the regional and local levels for the social protection of the population that function within the regional (‘oblast’), municipal and district state administrations.

Overall coordination of the activities of the two Ministries is accomplished at the levels of the Prime Minister and the Cabinet of Ministers. Coordination is conducted in localities by the first deputy chief of local administration or by special coordination commissions dealing with care provision for those who are in need. Despite the fragmentation of health and social services at the local level, the district doctor plays an important role in determining care plans for home care services provided by the department of social services.

The NGOs involved in health care provision are relatively new associations that deal with Parkinsons disease, Alzheimers disease, diabetes mellitus, cerebral paralysis, and the Red Cross, that provide education and training for families of long-term care patients. There are also NGOs (religious and charitable organizations) that operate at the local level and provide additional funding for LTC provision. For example, geriatric hospitals have opened in several regions under the auspices of local NGOs. NGOs are also involved in the provision of home care for the frail elderly and the disabled.

LTC services, mainly for the single elderly and disabled, are provided by special divisions in both the Ministry of Public Health and the Ministry for Labour and Social Policy and are financed from the State budget. A special department of social services for the elderly at the Ministry for Labour and Social Policy provides care mainly to these single elderly and disabled.

Services are provided in various housing facilities and at home. A special subdivision for long-term health care within the Ministry of Public Health provides:

- care in geriatric hospitals and units for long-term care of chronically-ill patients;
- nursing care units in multi-profile hospitals;
- hospices; and
- home assistance for the disabled in district outpatient facilities.
LONG-TERM CARE

2.2.2 Decision-making

In a general sense, it can be said that the health and social service systems in Ukraine are fairly centralized. For many years, there existed a State-controlled, centralized system of medical and social services, funded predominantly by the State budget.

As a result of the complex socioeconomic and demographic situation in the last few years, there is now an urgent need to change the policy of the national and regional administrations. This change in policy is needed with regard to health care and social protection in the country.

Currently, Ukraine is undergoing a process of decentralization, financial restructuring, restructuring of medical and social services, and expansion of services. The concept of health care and social welfare reform envisages an improvement of the forms and methods of managing these branches at the national, regional and local levels through:

- decentralization of institutions – transfer of a number of institutions to local administrations;
- financial restructuring – increasing local budget expenditures;
- restructuring of medical, social and daily living service – changing the internal structure of practical health care institutions and services;
- changing the forms of their interaction and subordination;
- creating new types of services that would more adequately meet the needs of the people; and expanding the infrastructure of services.

The bases of the reform measures include:

- adequate financing;
- reorientation of priority development of primary medical care (introduction of family medicine, strengthening of the rehabilitative and geriatric fields).
standardization of services and introduction of estimated rates for different kinds of medical, social and daily living services, and organization of a system of quality control of these services;  

creation of an up-to-date information base; and  

enhancing continuity and an interaction between the medical, social and public structures in addressing the issues of support for patients in need of long-term care.

3 Financing of health services

Public health care and social protection services in Ukraine are funded through the national budget. Allocated from the total 1999 budget of Hr 32 876.4 billion (about US$6 billion) was:

- Hr 3808.7 million (approximately US$700 million, or 11.5% of the total budget) for public health care; and  
- Hr 4147.1 million (approximately US$755 million, or 12.6% of the total budget) for social protection and social welfare.

Also, in the majority of towns, certain national committees release funds for the financing of home-based socio-medical services for the needy. Other sources of funding are the local municipalities, private donations, and out-of-pocket payments.

In accordance with the main law of Ukraine (the Constitution adopted in 1996), each citizen has the right to health care and medical aid, provided through State financial support and available free of charge at State and communal institutions (Article 49).
LONG-TERM CARE

However, because of the gap between budgetary allocations and the real cost of medical services, some of the services that require technical or material means (including dental care, laboratory diagnostic analyses, highly specialized consultations, tomography (CT), x-rays, and dressing materials) as well as drug provision, are partially or fully paid by the patients themselves. Subsidized coverage (free or at reduced prices) is provided for specified medical care and drug provision for specific population groups, such as those suffering from diabetes, tuberculosis, AIDS, etc.; the disabled of all categories and ages; and low-income citizens. Also, disabled war veterans are given privileges to buy drugs within the system of specialized (e.g. veterans) pharmacies.

In addition, disabled persons of all categories, victims of the Chernobyl disaster, low-income pensioners and families, all have privileges to pay reduced housing-communal payments. The State pays part of the cost of the sum exceeding 20% of total family income. Furthermore, local administrations provide material aid for persons in need (in cases of childbirth, illness, death of a spouse, extraordinary situations, natural or man-made disasters, etc.). The amount of aid varies.

4 Services delivery system

Medical care is provided by a network of general and specialized health care services in the following types of facilities.

- Treatment institutions. These include district, central district, central town and regional hospitals; hospitals for World War II disabled veterans; and emergency aid hospitals.

- Specialized hospitals. These include psychiatric, psycho-neurological, physiotherapeutic, and geriatric clinics at research institutes

- Dispensaries. These include oncological, cardiological, anti-tuberculosis, endocrinological, and psycho-neurological dispensaries.

- Ambulatory-polyclinic institutions. These include medical-obstetric stations, village medical ambulatory centres, town, central district and district polyclinics, stomatological, and physiotherapeutic polyclinics.
First aid and emergency medical stations.

Resort houses, sanatoriums, rest homes, prophylactic centres, medicinal baths/springs.

The system of social protection of the population includes various kinds of assistance as follows:

- pension provision;
- material (pecuniary) aid;
- privileges;
- full board plus socio-medical service at stationary institutions; and
- various kinds of domestic social and daily living services.

The social (medico-social and social/daily living) assistance for the population is provided through the following institutions:

- Homes for the aged and disabled, including nursing homes for elderly and disabled persons; geriatric nursing homes; special boarding houses for elderly and disabled persons who have been released from prisons.
- Homes for mentally ill persons.
- Boarding houses for agricultural workers.
LONG-TERM CARE

- Territorial social service centres for pensioners and single disabled citizens, including informal care units; social and daily living rehabilitation units; socio-medical rehabilitation units; stationary units for temporary/permanent residence; units providing material aid/assistance in kind to low-income disabled persons; domestic social care units within district departments for social protection; and special residential houses for single pensioners (sheltered housing).

As of 1 January 2000, there were a total of 3300 medical institutions in Ukraine. The number of beds was 96.1 per 10,000 population. The number of medical ambulatory-outpatient institutions was 7200. The number of visits per one working shift was 195.5 per 10,000.

Primary ambulatory medical care is provided by a network of ambulatory polyclinic institutions at municipal and district medical centres, trauma centres, rural medical ambulatory and medical-obstetric services, and through private clinics. Primary medical care is delivered by a district physician and a medical nurse. Currently, emphasis in health care is being placed on the development of family medicine. In the case of home care, the district doctor, or other specialist from a polyclinic or the first-aid team, is called on to conduct home visits. All equipment/supplies to care for a chronically ill person in her/his home environment are procured at the patient’s expense, from the hiring stations at territorial social service centres for pensioners, pharmacies, special community funds, etc.

For the treatment of acute diseases and depending on severity, the patient can visit a district doctor at an outpatient department or call a first-aid medical team to visit him/her at home. If need be, the patient will be admitted to a profile hospital division. All the listed services are provided free of charge.

In a number of towns there exists an informal sector offering alternatives to formal sector services, such as emergency medical aid, inpatient and outpatient treatment, including stomatological and rehabilitative services. However, these services do not meet the health care needs, either in volume or in quality, of chronically ill patients (such as those with cancer, diabetes, or emphysema).
Inpatient care is provided at multi-profile or specialized (cardiological, geriatric, psychiatric, etc.) hospitals and dispensaries. Rehabilitation units have been opened at some hospitals.

Drug provision within the primary care system is at the expense of patients themselves. At the same time, invalid patients and war veterans are given privileges to buy drugs within the system of general or specialized pharmacies (e.g. those for veterans). There are also privileges for patients suffering from illnesses specially listed (diabetes, tuberculosis, etc.), to buy drugs free of charge or at reduced prices.

There are regional differences in the provision of health care and social protection services in the Ukraine. Some regions and localities have more developed infrastructures of these services owing to additional financing by local administrations, public funds and religious bodies.

The present-day health care reform is focused on improving primary medical care and long-term care, with a strong emphasis being placed on strengthening secondary prevention. Further reform envisages the replacement of district therapists by family doctors and general practitioners. In the health care institutions, the quality of care is evaluated on the basis of selective check-ups by the respective administrative bodies. One of the main directions of health system reform is the development of quality standards for health services.

### 4.1 Auspices of health service providers

The provision of health and social care is through a system of state-owned institutions affiliated with the Ministry of Public Health and the Ministry of Labour and Social Policy at regional, district and municipal levels. The work of all medical institutions is controlled by the State, by special departments within the oblast, municipal and district administrations.

The majority of medical institutions are State-owned and financed from national and local budgets. In addition, there are private clinics such as, for example, stoma clinics.

The Red Cross, other public organizations, and charitable funds (both religious and secular) also play an important role in the provision of care.
LONG-TERM CARE

5 Human resources and training

Medical professionals are trained within the system of State-owned and private secondary and higher educational institutions. Ongoing improvement of professional knowledge and skills is conducted within the system of advanced postgraduate education, at special schools on a local basis and at work sites in leading clinics. All State-owned and private medical institutions are subject to licensing and accreditation.

5.1 Physicians

After receiving a medical degree (six years of study), all medical doctors undertake a specialized intern course (one year). In addition, physicians in polyclinics pass an advanced training study course at the Chair of Gerontology and Geriatrics of the Institute for Postgraduate Education (three months study). Every fifth year, physicians in all specialties must take a three-month continuing education course.

The role of the physician includes assessing diseases, deciding on treatment, and coordinating the work of medical personnel, social workers, and other personnel involved in care for patients. Despite the fragmentation of health and social services at the local level, the District Doctor plays an especially important role in determining care plans for home care services provided by social services.

5.2 Nurses

Medical nurses and Red Cross nurses must have earned diplomas from secondary medical education (3 years). They improve their qualifications at special courses (1–4 weeks) and schools (ongoing courses, each with one lecture per month).

Medical nurses fill doctors’ prescriptions, monitor patients’ health, conduct rehabilitative measures, and instruct/educate the patient’s relatives/carers.

5.3 Other health/social care providers

Junior Red Cross nurses, social workers, and alternative servicemen have various terms of educational and training requirements for specific positions.
Social workers receive short-term training courses in management and care of chronically ill persons, held on a local basis. As an element of their training, social workers receive weekly courses for familiarization with the specifics of care for frail patients, their psychology, and issues pertaining to their legal protection. In the course of their working life, they receive necessary in-service training at special training centres (once a month).

An important role of the junior Red Cross nurse, the social worker and the alternative servicemen is to help the doctor/nurse in providing various kinds of services for chronically ill patients.

For example, social workers can provide the following kinds of services:

- purchase and delivery at home of supplies and food;
- cooking meals;
- delivery of prepared meals, medications, newspapers;
- calling a doctor at home;
- rendering assistance with periodical medical examinations, hospitalization;
- help with house cleaning, laundry, all kinds of repair work, fuel provision;
- preparation of documents in order to receive pensions, subsidies, and other kinds of payments;
- preparation of documents in connection with sanatorium–spa treatment, move to a boarding home, or admission to an inpatient unit of the territorial social service centre;
- writing applications to receive services from food/daily living/telephone/housing organizations and agrarian enterprises;
- establishing and maintaining linkages with former employers in order to receive moral and material support;
- creating conditions for doing a job; and
- solving other problems for persons living alone, when asked to do so.
The volume of services provided to persons with disabilities living alone varies depending upon the severity of the condition. For those who never leave their home, the above-listed services are provided in full. Among those living alone, full care is required by 12.5% of the urban and 1.1% of the rural population. Those who need partial assistance to perform daily living activities comprise 10.4% of the urban and 4.6% of the rural population.

5.4 The role of the volunteer

There has been a long-standing tradition in Ukraine to render assistance to disabled, frail old people on a voluntary basis. In recent years, this type of public activity has grown into a voluntary movement among all layers of society. In different regions of the country there are centres, where the training of volunteers to perform various kinds of activity is carried out. The volunteers work in social service centres, in the medical-sanitary centres and Red Cross rooms, at inpatient institutions of the public health service, and in the welfare service system.

6 Summary of LTC provision

A unified, single LTC system does not exist in Ukraine. LTC-type services do exist in the systems of the Ministry of Public Health and Ministry of Labour and Social Policy. Within the system of social protection for the population, LTC is one of the most significant points of focus. This focus is expressed in financing services and in planning and allocating budget resources at both the national and local levels.

At the same time, the practical health care network, which provides long-term care for specific population groups, is developing at a slower rate, and financing at national/local levels is not a priority. The long-term treatment of patients suffering from tuberculosis, diabetes, bronchial asthma, cancer (certain groups) and AIDS, as well as Chernobyl victims, is provided by national and local budgets. However, financing of long-term health and social care for old chronically ill persons is mainly at the expense of local budgets and on the initiative of local administrations.

The main set of services is regulated by Ukrainian laws and by the respective documents (such as orders, resolutions, decrees, recommendations) of the Ministry of Public Health and the Ministry of Labour and Social Protection. Fulfilment of legislation is regulated by relevant documents issued by local state administrations in consideration of local conditions, followed by a control of the respective administration commissions at the town and district levels.
These commissions are composed of public officials, representatives of the industrial sector, businessmen, and heads of public organizations and foundations. They participate in discussions concerning the fulfilment of the regional social programme and may even release additional funds to finance elements of the programme, and not infrequently, long-term care.

Overall, long-term care services are paid by the State. In the case of those who are not eligible to receive social care free-of-charge (e.g. those living in a family with a total average income higher than a subsistence level defined by the Government) may, under existing legislation, receive services upon partial or full payment of their costs. Many of those receiving public services also need to supplement them with out-of-pocket payments.

The district physician–therapist plays a key role in the organization of long-term health and social care for chronically ill persons in their homes. He/she determines the whole complex of measures, including the volume of required services to be delivered by social services. With further development of long-term care, the role of paramedical personnel with special training in rehabilitation and geriatrics will be enhanced.

This chapter will first consider LTC services according to whether they are provided in the health or the social system, with additional information about the participation of religious groups. Next, this discussion will examine target populations receiving various types of services (e.g. institutional, home-based) together with exceptional programmes in various regions. Finally, LTC services in a specific region, the Ternopil oblast, will be described.

6.1 Care provided in health and social care systems

Within the health care system, separate structural subdivisions, fully financed from the budget, provide long-term health care, including:

- Geriatric hospitals and units (based on multi-profile hospitals) for long-term treatment of chronically ill patients.
- Nursing care units as part of multi-profile hospitals.
- Hospices.
- Medico-social divisions providing home assistance for disabled individuals living alone (district territorial outpatient facilities).
LONG-TERM CARE

Within the social system of care, priority is given to long-term care of elderly citizens living alone and to disabled persons. This is a budget-restricted form of care, which is provided at:

- boarding homes of various types;
- inpatient care units of the territorial social service centres for pensioners; and
- domestic service units.

To provide long-term care for disabled citizens living alone, special geriatric hospitals were opened under the auspices of religious bodies in several regions (L’viv, Ternopol, etc.). The parishioners of different religious groups also provide home care for fragile elderly and disabled individuals. In the majority of towns, ethnic communities release funds for financing home-based medico-social services for the needy.

6.2 Target populations for LTC provision

LTC targets:

Chronically ill persons, including persons with disabilities and elderly citizens living alone, who are receiving care in nursing and LTC multi-profile hospitals, at hospices and in their homes.

Chronically ill persons with infectious diseases, who are being cared for in the infectious disease hospitals and in specialized inpatient dispensaries.

HIV-infected persons and patients with AIDS who are registered and undergo treatment in specialized medical institutions at the regional and national levels (mainly in general wards of infectious disease hospitals).

Persons disabled as a result of injuries who are placed initially in the specialized traumatology units of multi-profile hospitals or emergency aid hospitals. Rehabilitation of such patients is carried out under ambulatory conditions in rehabilitative units of the territorial polyclinics. Patients with complicated traumas and their consequences are sent to specialized clinics at the research centres.
To date, there has been no decision as to the organization of care for elderly persons with hip fractures and other complicated injuries who become functionally disabled as a result. In recent years, the Government has allocated funds for the development of national production of protheses and other necessary equipment and devices for rehabilitation of disabled persons. However, these funds do not fully meet existing needs. Many patients who are in need of prostheses have to pay, partially or fully, their costs.

**Persons with sensory limitations** generally belong to community associations, which are responsible for arranging their social rehabilitation. Medical care for these persons is provided within the ambulatory-polyclinic network or by physicians within specialized inpatient divisions.

**Mentally ill persons** are treated by physicians–psychiatrists at polyclinics, specialized hospitals, units, and dispensaries. There are ursing homes for the psychically chronically ill within the welfare system, and inpatient specialized geriatric units for **persons with dementia**. There are no arrangements for long-term home care for those with severe psychiatric disorders.

**Persons with substance (alcohol, narcotics) dependence** are registered and undergo courses of treatment with narcologists at polyclinics and specialized dispensaries.

**Aid for victims of man-made and natural disasters** is provided within the general health care system network and in specialized ambulatory and inpatient institutions funded by the Cabinet of Ministers, the Ministry for Extraordinary Situations, international funds, and the Red Cross. Informal care for these population groups is provided by family members, neighbours, and volunteers. The significant role of volunteers in LT for patients in rural areas must be stressed.

### 6.3 Types of long-term care services

**Disability prevention** occurs at all stages of primary and secondary health care provision. The central figure in this work is the district physician–therapist of the polyclinic. He/she arranges for observation of those patients who are in need of long-term follow-up and rehabilitation. The district physician is obliged to conduct a medical examination of every elderly person at least once a year. However, only a few elderly persons actually receive such examinations.

Disability and chronic disease prevention are handled in the rehabilitative units (rooms) in polyclinics, inpatient institutions, and territorial social service centres. However, only 30% of the need for well-elaborated programmes of socio-medical and preventive rehabilitation for different groups of people are being met, and such structures are developing slowly.
LONG-TERM CARE

In Ukraine, there is no education/training for families of patients who require long-term treatment and care. However, the appearance of new associations (such as Parkinson’s disease, Alzheimer’s disease, diabetes mellitus, cerebral paralysis), is bringing together patients, their relatives and carers, and other personnel. The activities of these associations focus on education and training of patients’ relatives/carers.

Programmes for education of pensioners at ‘third age’ universities include special classes on issues of care for chronically ill persons in home conditions. In addition, Red Cross activists and district physician nurses educate family members in specific diseases, and how they should take care of the particular patient. The municipal and district Centres of Health regularly publish booklets on the concerned topics, which are also dealt with in special television and radio programmes.

_Inpatient facilities_ include

- hospitals and nursing care units for long-term chronically ill persons,
- hospices,
- social inpatient facilities attached to district village hospitals,
- religious community-based long-term care hospitals,
- boarding homes for the elderly and invalid persons,
- geriatric nursing homes;
- nursing homes for mentally ill persons;
- inpatient units for temporary (up to six months) and permanent residence of disabled citizens living alone at social service centres, boarding homes for collective agricultural enterprises; and
- specialized dwelling houses with medico-social services (sheltered housing).
In many regions, such structures as hospices, long-term and nursing care hospitals are only now coming into existence and have not been widely used. Over 15,000 elderly patients were treated at day inpatient facilities in hospitals and polyclinics in 2000.

**Home-based services** are provided by polyclinics (not universally) and social service units. In the case of home care, the district doctor/other specialist from a polyclinic or the first-aid team may be called to visit a patient at home. The principal health professional teams who organize home-based LTC are:

- a district physician – therapist;
- a district physician – nurse assistant;
- a nurse – physiotherapist;
- a Red Cross nurse – nurse assistant.

Home care is provided by social workers of the 19 territorial social service centres and domestic social service units, as well as by those performing alternative (i.e. non-military) national service and volunteers. In 2000, the total number of single non-working citizens in need of home social care was 266,000. This service was delivered to 215,000 people (77%), while 51,000 people (mainly in rural areas) received home care from their neighbours or volunteers.

The work load (i.e. the number of individuals served) of social workers in the staff structure of home-based service units is from four to twelve persons. The number served depends upon the severity of the patient’s condition (as for example in the case of a person living alone who has lost self-care abilities) and on the location of his residence (in a town or village). The number of visits by a social worker to an individual living alone (at least twice a week) is determined by the chief of the home-based service unit. These social workers are assisted by nurses of the Red Cross and volunteers.

A specific form of home care involves an ‘in-home hospital’ for a long-term stay. Medical care for in-home hospital patients is delivered by physicians and nurses of the polyclinic and by Red Cross nurses. Social care and assistance in daily living activities are provided by social workers of social domestic service divisions and by volunteers. A patient living in the family is cared for by members of the family. In 2000, there were about two thousand pensioners in such in-home hospitals.
LONG-TERM CARE

Formal care (including that in the structures listed above) is funded through budgets at the national and local levels. In addition to this formal care should be added LTC activities of the Red Cross organization and ethnic communities (Joint-Hessed, etc.). Formal care is delivered generally by qualified medical professionals (physicians, nurses and social workers) and their assistants.

Informal care is delivered by family members, neighbours, friends, and religious community volunteers, etc.

In organizing LTC services, assessments of need and monitoring of the quality of service provision are made by health care services – namely, the district doctor (physician’s assistant in rural area) – and by social welfare services – namely, the employees of domestic and social protection service divisions of local administrations. Public organizations, such as councils of veterans, also have some control over the quality of services.

A number of State-owned and cooperative enterprises throughout the country manufacture approximately a hundred products for invalid persons, in order to facilitate their motor abilities and self-care. However, the volume of this production, its cost and sometimes its quality, do not meet their needs.

6.4 Exceptional LTC-type programmes directed to specific target populations in specific regions of Ukraine

These programmes include populations in:

- **Kiev**

  An International Medical Rehabilitation Centre for the victims of wars and totalitarian regimes has been established, which provides long-term medical, psychological and social-daily living assistance for sufferers and their family members in their homes.

  If necessary, the Centre refers patients for long-term inpatient treatment. The Centre is financed from the funds of local administrations and international foundations (grant-supported projects).
CASE-STUDY: UKRAINE

- **The Ternopil Oblast**

  Under the auspices of a men’s orthodox monastery, a hospice with a capacity of 50 places for frail old persons needing LTC and treatment was opened. In the Zolotnik District of the same oblast, a social care inpatient institution with 30 beds and elements of medical rehabilitation was organized using as a base the village district hospital at the expense of private donations.

- **In a residential district of Kharkov**

  Using as a the base the Territorial Centre for social services for pensioners, an information-consultative centre was opened. In this establishment, any citizen can obtain consultative assistance on all questions of medical and social care, and receive substantive LTC support.

- **In a number of villages of the Kupiansk district (Kharkov Oblast)**

  Social care and assistance with activities of daily living for elderly people living alone and who are in need of long-term care has been organized. This work has been undertaken under the auspices of the district people’s deputy council, the council of veterans, and volunteers, financed from a local budget and donations from private individuals.

6.5 **Long-term care in a specific Ukrainian region: Ternopil**

Ternopil oblast is located in the western region of Ukraine, and most of its population lives in rural areas in which the religious traditions of Orthodox and Catholic faiths are preserved. Accordingly, the church community plays a central role in providing care for elderly and disabled persons.

This factor has also an impact on the formation of intergenerational family relationships. These relationships are exemplified by the spirit of responsibility which is assumed for a frail and/or disabled close relative.
LONG-TERM CARE

These same attitudes are naturally shown by neighbours and volunteers. The latter provide free assistance for long-term care, along with the more common forms of LTC such as caregiving (variously from pensioner to pensioner, pensioners to children, and children to pensioners).

Inpatient/institutional long-term care is provided in the following institutions:

- Town hospital No. 1: A geriatric long-term care unit for chronically ill persons (30 beds) and a day geriatric inpatient hospital (20) beds have been established.

  Six teams (four therapeutical, one neurological, and one surgical) have been established, in the organization of a centralized in-home service for chronically-ill persons and funded through the town budget.

- Specialized long-term care wards on the premises of town and district hospitals (predominantly funded by local budgets covering 40-60% of the cost of treatment, as well as by the central budget and by private and public donations).

- District village hospitals, geriatric long-term care wards have been opened. During the autumn-winter season, more than 300 elderly people, who are in need of social care rather than treatment, are placed in these wards for two to four months.

  One such hospital has been converted to a socio-medical in-patient facility with 30 beds. It is funded by partial donations from the Ukrainian diaspora, with a large portion of the money coming from Canadian diaspora members.
7 General questions pertinent to LTC development

7.1 Present and future needs for long-term care and gaps between needs and provision of services

Any discussion of LTC provision in Ukraine must include statistics concerning the need for such services. The results of a socio-medical investigation of the retirement age-population, conducted by the Kiev Institute of Gerontology, show that:

- among the total elderly population, 4.3% of urban and 9.5% of rural residents are in need of prolonged hospitalization (institutionalization) at social care facilities for patients who have lost the ability for self-care, or at divisions for long-term stay of chronically-ill persons, or at nursing care units.

- 13.2% of urban and 6.6% of rural residents aged over 70 years and living alone are in need of partial outside assistance with activities of daily living; when such assistance cannot be organized in their homes, these persons must be transferred to general wards (units) of boarding homes for the aged.

- 13.8% of town and 2.7% of village residents aged over 70 years and living alone are in need of everyday social, daily living, and medical service to the full extent of that care; alternatively, they need to be placed in hospital wards (units) of boarding/nursing homes for war and labour veterans, when such kinds of services cannot be organized in their own homes.

The main task of socio-medical services is to promote the option of keeping an elderly person in his own health/needs class for as long as possible. A comparative longitudinal study has shown that living at one’s own house or in special apartment houses with an adequate number of residents and provided with a set of socio-medical services appears to be the most favourable option. By contrast, excessive help produces an equally negative effect. Moreover, the ‘clusterization’ of individuals with marked psychic and physical disorders in nursing homes accelerates the process of dependence development.
LONG-TERM CARE

The acuteness of rises in dependence indices is significantly higher for men than for women. These findings provide evidence of poorer reserves among men of the mechanisms for adaptation to limitations imposed by ageing.

Indices of dependence according to physical capability, social activity, and psychological status show the greatest rise in old age. Analysis of data has shown that the accelerated rate of rise of the dependence is influenced by an increased frequency of acute and exacerbation of chronic illnesses, motor passivity, excessive weight, and ‘social uselessness’ among the elderly.

However, despite the heterochronicity of ageing of organs and systems, and the peculiarities of rises in indices of the dependence upon outside assistance relative to gender and other individual characteristics, the main negative breakdown occurs on average within the same age interval – after seventh decade of life. This should be defined by medical services as a super-risk period, during which an intensive long-term health care and rehabilitation – including preventive measures – are required to reduce the acuteness of this process.

Among other groups of patients who are in need of long-term care (including those with cancer, tuberculosis, psychic disorders, HIV/AIDS, alcoholism/drug addiction) morbidity levels have risen constantly. For example, morbidity from various causes rose as shown in Table 1.

Table 1. Cases of morbidity per 100 000 population

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1995</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasms</td>
<td>1297</td>
<td>1525</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>190</td>
<td>239</td>
<td></td>
</tr>
<tr>
<td>HIV-infected cases</td>
<td></td>
<td>2.9</td>
<td>52.9</td>
</tr>
<tr>
<td>AIDS</td>
<td>0.1</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Psychic disorders</td>
<td>1946</td>
<td>2425</td>
<td></td>
</tr>
<tr>
<td>Drug addiction</td>
<td>6.6</td>
<td>21.5</td>
<td></td>
</tr>
</tbody>
</table>
In promoting long-term care at the local level through existing infrastructures of the health or social care system, the challenge is to:

- introduce geriatric patronage medical nurses into the staffs of outpatient clinics;
- increase the number of Red Cross nurses;
- increase interactions between the respective State and public structures;
- provide medical personnel to deliver care for patients in their homes, with portable diagnostic and physiotherapeutic equipment;
- develop industries to manufacture necessary appliances for caring for patients in their home environments; and
- establish locations for obtaining such devices.

Throughout the country, a wide gap exists between the care needs of elderly people and the satisfaction of those needs. Ambulatory-polyclinic services (therapeutic and specialized) needs are met at an average rate of only 53%; rehabilitative out-patient treatment 19%; home care 29%; emergency medical care 67%; in-patient treatment 74%; and social care of single persons 80%.

Generally, health and social care remains inaccessible to the greatest degree among elderly people who reside in rural areas. For example, the needs of rural people of retirement age for ambulatory/outpatient care are met at an average rate of only 39%; emergency medical aid 42.7%; and in-patient treatment 67.3%. This last need is met predominantly at the expense of using the beds of district rural hospitals, rearranged for purposes of LTC and care of chronically-ill persons. Medical rehabilitation and home-based care have an incidental character, or may never be used in the community.

Results of experts’ evaluation of LTC provision have revealed significant inadequacies in the diagnosis and treatment of elderly patients, as a result of insufficient personnel qualification and violation of the stages of service provision. Wrong diagnoses were registered in every tenth case, and overdosing and multi-morbidity in every second case, while the continuity in treatment between separate medical sub-units was totally absent.
LONG-TERM CARE

From a cost–effectiveness perspective, the most advantageous were either those institutions with home-based long-term health and social care units and rehabilitation units within their structures or those which used non-traditional forms of long-term hospitalization (in-home hospitals and day centres). These were able to reduce the number of emergency aid calls by 2.5 times and the number of expensive hospitalizations by 3 times.

The principal shortages in meeting LTC can be summarized as follows:

- Absence of a State-coordinated long-term health and social care system.
- Absence of specialized home care at night, much required for single disabled persons and oncological patients.
- Shortage of staff specially trained in rehabilitation; lack of portable equipment to conduct diagnosis, treatment, and rehabilitation in the home; shortage of medical supplies to care for patients (particularly bedridden persons); and devices for moving around in and outside the home.
- A slow rate of development of a network of LTC hospitals, nursing hospitals, and hospices (only 10% of this need is met). There are almost no daytime in-patient facilities for psychochronically-ill persons, or clinics for social-psychological rehabilitation.
- The unresolved question as to the method of payment for medications for various groups of chronically-ill persons – primarily for expensive medication for chemical therapy for oncological patients.
- Urgent need for special educational programmes for training medical and social personnel engaged in LTC service, including: physicians, medical nurses, and social workers, as well as staff dealing with rehabilitation (preventive, medical, social, and psychological).
- A need to develop special programmes for education of patients’ relatives (carers) on the specifics of care, and for training schools at territorial medical and social centres.
7. 2 Planned or current changes/reforms which are likely to affect the provision of LTC.

From an understanding of the socioeconomic and demographic situation of Ukraine, and of its potential for developing national medical services, there emerges an urgent need for radical reform measures. A systematic approach towards long-term and geriatric care organization is also needed.

Successful reform of the organization of health and social care for chronically ill and disabled persons lies in the creation by the State of a well-coordinated service system. Such a system can be organized at a high and modern scientific-technical level, based on a concept that has been developed by the Kiev Institute of Gerontology in the course of its long-term research.

This concept has two fundamental bases – it must be:

- purpose-oriented (assessment of the position of geriatric care within the general health care system, its essence and goals and its major objectives, priorities, and principles of activity); and
- legal (assessment of the legislative basis for socio-medical protection of the population beyond the working age, and forms of management, use of staff, resources, financing, and planning).

The concept also relates to the organizational and structural information bases for the development of health and social care for elderly people. Priorities in the staged development of medical-sanitary and stationary care are determined. These are linked, with an enhancement of the district geriatric activity and an introduction of rehabilitation structures.

Particular emphasis is placed upon:

- the need for arranging annual medical examinations for people of retirement age;
- free choice of a doctor by these people; and
- proper equipment for and financial incentives to medical personnel serving primarily the elderly.
LONG-TERM CARE

Considered in detail are:

- the prospects for the organization of geriatric care at home;
- development of a nursing service, polyclinic socio-medical units, mobile gerorehabilitation teams; and
- the specifics of providing consultative and medical first-aid to elderly patients.

Modern trends in the development of inpatient care services are defined. These trends include – on the one hand – geriatric hospitals, units, wards, nursing care hospitals and hospices, and – on the other hand – non-traditional in-patient forms of care (e.g. day inpatient hospitals and in-home hospitals).

A very important question concerns the need to enhance geriatric assistance to rural residents, based in village district hospitals, village medical ambulatory hospitals, medical-obstetric stations, and specialized mobile services.

Special attention is given to consideration of the new forms of geriatric care to be developed in Ukraine. These include such innovations as geriatric centres, geriatric polyclinics, nurse screening teams, crisis centres, night services providing health and social care for the elderly, information-referral phone services, gerorehabilitation centres for mentally ill persons, gerotechnical equipment and manufactured goods centres.

An additional component of the concept is devoted to the need to:

- revise the norms for the provision of the principal kinds of health, social, and daily living services (estimated standards) for the elderly;
- assess the position of the elderly in medical insurance; and
- determine average resource costs and insurance risks, in accordance with terms and degree of dependence upon assistance.
The key element in the organization of assistance to elderly people involves substantiation of the necessary guaranteed level and volumes of services, with differentiation according to the degree of functional capabilities. Adequate assistance will prove both effective for the individual’s health, and cost-effective for society.

Such establishment of LTC for chronically ill and disabled people would reflect the State’s responsibility for the health of its citizens. It would serve as an additional guarantee that citizens can realize their constitutional right to health and to sound care in old age.

Home health programmes are an integral part of primary care, and initiatives are provided for the integration of personal care and homemaking services into the system (mainly for those who live alone). Physicians at primary health clinics receive a three-month course of special training in geriatrics, and nurses also receive some special training in this field.

Reform is also focused on improving both primary medical care and long-term care. Strong emphases is placed upon strengthening the role of secondary prevention.

Important reforms aimed at improving the medical and social branches of this effort are in progress. The Ukrainian parliament has passed several decrees, including laws on:

- Social care
- Health insurance
- The status of war veterans and the guarantee of their social protection
- Social protection of the disabled
- Main directions of social protection of labour veterans and other groups of elderly citizens in Ukraine

Mention should be made of the amendments to a Ukrainian law on pension provision. Also notable are existing laws and normative Acts concerning issues of health and social care of the population.
8 Concluding thoughts

Once again, it should be stressed that Ukraine has no nationwide, unified system of health and social long-term care. At the same time, this type of service is being more highly developed in certain regions which have greater opportunities for additional financing from their local budgets.

It is noteworthy that the Ministry for Labour and Social Policy has been highly effective in enabling the development of infrastructure services involved in LTC provision. Conversely, the Ministry for Public Health has shown greater conservatism in the development of long-term health care and rehabilitation services, and this process is therefore proceeding very slowly.

The coordination of activities of separate services, and the rational use of available budget and extra-budgetary funds, are in large measure controlled by the regional administrations. Accordingly, such coordination depend upon the extent to which local authorities are aware of the significance and financial expediency of investing in primary and long-term care for the chronically ill and invalid persons in their homes. Such an approach would make it possible to save money spent on expensive various kinds of inpatient medical services and emergency medical services.

Generally, the complexity and problems associated with providing LTC arise not only from inadequate financing and limited resources, but also as a result of the absence of a coordinated organizational structure – that is, of a specialized system able to satisfy long-term care needs. The situation is even more complicated – and the quality of care provided even lower – as a result of the absence of service standards responsive to the real needs of a population which is undergoing economic transition. This, in turn, hampers control of the quality and cost-effectiveness of the proposed services.


LONG-TERM CARE


Voronenco Yu.V, Moskalenko VF, eds. (200) Social medicine and public health organisation. Ternopil, Ukrmenedniga.


CONCLUSION TO CASE-STUDIES

JDC-Brookdale Institute
Conclusion

In the introductory chapter of this volume, we demonstrated the scope of the increase in long-term care needs in the developing world. We also highlighted emerging LTC policy directions in ten developing countries against the background of key socioeconomic and epidemiological indicators. In this concluding chapter, we describe broad patterns emerging in the countries examined.

There is a wide range of LTC development in the countries included in this volume. In Indonesia, there are not yet any formal initiatives for the provision of LTC, and care is dependent on the mobilization of volunteers. In Sri Lanka, while also relying mainly on volunteers, some forms of community care are beginning to develop in response to the ageing of the population. In the Chinese cities of Shanghai and Beijing, unusually high rates of ageing have contributed to the development of home health provision.

A number of countries are still relatively young but have also prioritized the development of home health care, such as Costa Rica, or are beginning to do so, such as Lebanon, Mexico, and Thailand. In Lithuania and Ukraine, the ageing of the population has created a great incentive to prioritize LTC provision and develop a range of services despite low incomes. Finally, the Republic of Korea has a relatively lower rate of ageing as compared with Lithuania and Ukraine, but a much higher level of resources and a relatively more highly developed range of LTC services.

The case-studies reflect broad general trends emerging in developing countries:

- Important efforts are being made to provide home-based LTC in a number of countries. Some provide a broad package of services that include home health, personal care, and homemaking (Lithuania, Republic of Korea, Ukraine); and some are more narrow and focused on home health only (urban China, Costa Rica, Mexico, Thailand). Publicly-funded LTC is not provided or only provided to a very limited extent in Indonesia, Lebanon, and Sri Lanka.
Where it exists, home health is linked to the health system (financially and organizationally). There are some very good examples of integration of home health into primary care (Costa Rica, Republic of Korea, and to some extent China, Lithuania, Mexico, and Ukraine).

Family guidance and counseling is highly emphasized in a number of countries. There seems to be a strong emphasis on this education and counseling through home health systems, which have become neglected in the home health systems of industrialized countries (Costa Rica and Republic of Korea).

Where it exists, personal care and homemaking services are targeted towards the very poor and those without families. None of these countries provides publicly funded personal care services to the non-poor population. Home health, on the other hand, is not necessarily targeted towards the poor, and health conditions and disability are more of a criterion.

Institutional LTC is provided by a number of countries. It is provided more extensively in Lithuania and Ukraine, and to some extent in China, Lebanon, the Republic of Korea, and Sri Lanka. In the other countries, publicly-financed institutional LTC is hardly provided. In countries that do provide institutional care, an issue that requires greater clarification involves the degree of coordination between home-based and institutional LTC.

Countries with a broader package of services have not integrated all their LTC services into one system. These countries generally split such services between the health and social systems. Therefore, fragmentation between health and social services and among LTC services is a general problem, similar to that which exists in most industrialized countries. In the Republic of Korea, for example, despite the fact that one ministry is responsible for health and social services, there is fragmentation of service provision and some overlapping. On the other hand, in some countries like Ukraine, even though there are two ministries and a division responsible for the care of the elderly in each of them, there is a coordinating mechanism at the level of local service provision (district physician).
The degree of age integration seems to vary. In general, home health is age-integrated. Other home care services are often but not always age-integrated. Age segregation is more typical of institutional LTC.

Most health systems are making special efforts to develop community health care. This health policy seems to be compatible with the development of home-based LTC, especially in Lithuania and Ukraine, where there is an objective to shift the relatively high emphasis on institutional LTC to community care. In some countries with hardly any institutional services, such as the Republic of Korea, there is also emphasis on developing institutional LTC to avoid utilization of more expensive acute hospital services by patients whose primary need is LTC.

In some countries, such as in Mexico, Sri Lanka, and Ukraine, NGOs are playing an important role in the development of LTC.

The level of volunteerism seems to vary, as does the degree to which volunteers receive training. The role of volunteers in the LTC arena was emphasized in China, Indonesia, Sri Lanka, and Ukraine. Indonesia, Sri Lanka, and Ukraine provide training to volunteers. In Ukraine, training is provided in formal training institutions and in Sri Lanka, NGOs have played a major role in this area.

The volunteer issue was further elaborated in the cross-cutting paper entitled *Key issues, options, and considerations on the role of volunteers and community development in least developed countries*. This paper outlines the key issues and presents the option of community-based volunteers as a necessary component that should be nurtured and strengthened.

There is a great deal of variation in human resource patterns. There is a clear pattern showing that as economic resources increase, countries have staff with higher levels of formal professional credentials. However, one finds a broad range of educational levels among staff in primary health care and in the various types of LTC. In many countries, there is a sense that more training of various staff levels in LTC is needed.
These general patterns give rise to questions that need further exploration, such as whether there is a trend towards the overprofessionalization of LTC roles, and to what extent general health personnel can play more of a role in LTC. While highly-trained nurses lead many home-care programme initiatives, such as those in the Republic of Korea and Thailand, in general we do not find that they provide more basic personal care services, as is the case in some industrialized countries.

There seems to be a hierarchy in the development of home-based LTC. The first priority is for home health with an emphasis on training and educating families, while personal care and especially homemaking develop later. That is, most countries do not provide publicly-funded personal care or homemaking services, and these services have remained a family responsibility or a service provided by volunteers. However, despite the appearance of these stages, it is important to emphasize that this pattern need not be prescriptive, and it may not describe the order of development of home-based LTC in all countries because of local cultural factors and national priorities.

As mentioned in the introduction to this volume, these case-studies are part of a WHO initiative aimed at providing guidance to developing countries as they respond to growing needs for long-term care. This effort is based on the belief that it is possible to make real progress through a case-study approach, that will enable one to root the discussion of policies in an in-depth understanding of existing realities in developing countries and to learn from that which already exists.

This process is also based on the premise that although there is much to be learned from the experience of industrialized countries, LTC policies in the developing world need to reflect their unique conditions. Therefore, one major question that accompanies this process involves the identification of the key factors that distinguish industrialized and developing countries, which are relevant to the translation of experiences from industrialized to developing countries and vice versa, as well as among developing countries. These factors include epidemiology; resources; culture and values; educational levels; strength of informal care; stages of development of health and social care systems; and obstacles to the accessibility of LTC such as geographic spread, internal migration, transportation, and infrastructure.
One of the most important lessons to be leaned from the case-studies is that there are a number of basic factors in developing countries that affect the relative significance of the key policy issues that are relevant to LTC policy development, as compared to those in the industrialized countries. We can highlight some of these factors:

- In industrialized countries, the need for a broad range of LTC services is taken for granted. Indeed, in the industrialized world this range continues to increase as new services emerge.

  In developing countries, the provision of a broad array of LTC services is not taken for granted. The development of a specific package of LTC services is affected by both the resources available and by the rate of development of needs.

  The change in needs is affected by underlying demographic, epidemiological and social forces. These translate into changes in the disability burden and in the potential role of the family. At the same time, local cultural and political values, and especially the priority given to health and social services in general, and to LTC services in particular, affects the development of LTC.

- Due to tight budget constraints, developing countries focus upon publicly-subsidized services for the poor. As a result, major policy issues emphasized for industrialized countries, such as universal entitlements, are much less of a source of controversy or deliberation.

- The nature of the existing health and social service infrastructure plays a much more critical role in shaping the provision of LTC in developing countries because of cost-containment concerns and other difficulties related to establishing new service infrastructures. Thus, the issue of integration, particularly with the health system, looms even larger for developing countries.

- In developing countries, much more attention is given to extended family networks, and the role of the broader community as sources of support, including communal structures of volunteer support.
A human resource issue that is especially relevant in developing countries is the possibility of mobilizing traditional healers to play a role in the provision of long-term care services. In many societies, traditional healers fulfil roles that may be considered long-term care, and are often available at local levels in even the most remote areas. These healers are often respected and trusted members of the community, and in some parts of the world they are now receiving special training in collaboration with the general health system and are required to meet a certain set of qualifications.

Because of the larger gaps in conditions between urban and rural areas in developing countries, there appear to be significant differences in the strategies applied to addressing the needs of the urban and rural population in the developing world.

In conclusion, the developing country case studies in this volume reveal that significant beginnings in addressing LTC-related issues have been made (as, for example, through home health, mobilizing communal organizations, and specialized training). Additionally, it is apparent that important initiatives, from which we can learn, are emerging in these countries. We need to continue to learn more about the experience of various developing countries and identify the ingredients that are the seeds for further success. At the same time, there is also evidence that low- and middle-income countries are repeating some of the same mistakes that industrialized countries are now attempting to correct, highlighting the importance of developing better guidance now.
This volume of ten case-studies from developing countries can serve as a foundation resource for the World Health Collection on Long-term Care.

Considered together, these case-studies provide examples to illustrate many of the lessons learned, key policy issues confronted, and current and future needs discussed in other volumes in this series.

Represented in this first of two volumes are case-studies of China, Costa Rica, Indonesia, Lebanon, Lithuania, Mexico, Republic of Korea, Sri Lanka, Thailand, and Ukraine. Each has been prepared by LTC experts from that country, in close collaboration with the World Health Organization and its Collaborating Centre for Research on Health of the Elderly, JDC-Brookdale Institute.
CONCLUSION TO CASE-STUDIES

JDC-Brookdale Institute
In the introductory chapter of this volume, we demonstrated the scope of the increase in long-term care needs in the developing world. We also highlighted emerging LTC policy directions in ten developing countries against the background of key socioeconomic and epidemiological indicators. In this concluding chapter, we describe broad patterns emerging in the countries examined.

There is a wide range of LTC development in the countries included in this volume. In Indonesia, there are not yet any formal initiatives for the provision of LTC, and care is dependent on the mobilization of volunteers. In Sri Lanka, while also relying mainly on volunteers, some forms of community care are beginning to develop in response to the ageing of the population. In the Chinese cities of Shanghai and Beijing, unusually high rates of ageing have contributed to the development of home health provision.

A number of countries are still relatively young but have also prioritized the development of home health care, such as Costa Rica, or are beginning to do so, such as Lebanon, Mexico, and Thailand. In Lithuania and Ukraine, the ageing of the population has created a great incentive to prioritize LTC provision and develop a range of services despite low incomes. Finally, the Republic of Korea has a relatively lower rate of ageing as compared with Lithuania and Ukraine, but a much higher level of resources and a relatively more highly developed range of LTC services.

The case-studies reflect broad general trends emerging in developing countries:

- Important efforts are being made to provide home-based LTC in a number of countries. Some provide a broad package of services that include home health, personal care, and homemaking (Lithuania, Republic of Korea, Ukraine); and some are more narrow and focused on home health only (urban China, Costa Rica, Mexico, Thailand). Publicly-funded LTC is not provided or only provided to a very limited extent in Indonesia, Lebanon, and Sri Lanka.
Where it exists, home health is linked to the health system (financially and organizationally). There are some very good examples of integration of home health into primary care (Costa Rica, Republic of Korea, and to some extent China, Lithuania, Mexico, and Ukraine).

Family guidance and counseling is highly emphasized in a number of countries. There seems to be a strong emphasis on this education and counseling through home health systems, which have become neglected in the home health systems of industrialized countries (Costa Rica and Republic of Korea).

Where it exists, personal care and homemaking services are targeted towards the very poor and those without families. None of these countries provides publicly funded personal care services to the non-poor population. Home health, on the other hand, is not necessarily targeted towards the poor, and health conditions and disability are more of a criterion.

Institutional LTC is provided by a number of countries. It is provided more extensively in Lithuania and Ukraine, and to some extent in China, Lebanon, the Republic of Korea, and Sri Lanka. In the other countries, publicly-financed institutional LTC is hardly provided. In countries that do provide institutional care, an issue that requires greater clarification involves the degree of coordination between home-based and institutional LTC.

Countries with a broader package of services have not integrated all their LTC services into one system. These countries generally split such services between the health and social systems. Therefore, fragmentation between health and social services and among LTC services is a general problem, similar to that which exists in most industrialized countries. In the Republic of Korea, for example, despite the fact that one ministry is responsible for health and social services, there is fragmentation of service provision and some overlapping. On the other hand, in some countries like Ukraine, even though there are two ministries and a division responsible for the care of the elderly in each of them, there is a coordinating mechanism at the level of local service provision (district physician).
The degree of age integration seems to vary. In general, home health is age-integrated. Other home care services are often but not always age-integrated. Age segregation is more typical of institutional LTC.

Most health systems are making special efforts to develop community health care. This health policy seems to be compatible with the development of home-based LTC, especially in Lithuania and Ukraine, where there is an objective to shift the relatively high emphasis on institutional LTC to community care. In some countries with hardly any institutional services, such as the Republic of Korea, there is also emphasis on developing institutional LTC to avoid utilization of more expensive acute hospital services by patients whose primary need is LTC.

In some countries, such as in Mexico, Sri Lanka, and Ukraine, NGOs are playing an important role in the development of LTC.

The level of volunteerism seems to vary, as does the degree to which volunteers receive training. The role of volunteers in the LTC arena was emphasized in China, Indonesia, Sri Lanka, and Ukraine. Indonesia, Sri Lanka, and Ukraine provide training to volunteers. In Ukraine, training is provided in formal training institutions and in Sri Lanka, NGOs have played a major role in this area.

The volunteer issue was further elaborated in the cross-cutting paper entitled *Key issues, options, and considerations on the role of volunteers and community development in least developed countries*. This paper outlines the key issues and presents the option of community-based volunteers as a necessary component that should be nurtured and strengthened.

There is a great deal of variation in human resource patterns. There is a clear pattern showing that as economic resources increase, countries have staff with higher levels of formal professional credentials. However, one finds a broad range of educational levels among staff in primary health care and in the various types of LTC. In many countries, there is a sense that more training of various staff levels in LTC is needed.
These general patterns give rise to questions that need further exploration, such as whether there is a trend towards the overprofessionalization of LTC roles, and to what extent general health personnel can play more of a role in LTC. While highly-trained nurses lead many home-care programme initiatives, such as those in the Republic of Korea and Thailand, in general we do not find that they provide more basic personal care services, as is the case in some industrialized countries.

There seems to be a hierarchy in the development of home-based LTC. The first priority is for home health with an emphasis on training and educating families, while personal care and especially homemaking develop later. That is, most countries do not provide publicly-funded personal care or homemaking services, and these services have remained a family responsibility or a service provided by volunteers. However, despite the appearance of these stages, it is important to emphasize that this pattern need not be prescriptive, and it may not describe the order of development of home-based LTC in all countries because of local cultural factors and national priorities.

As mentioned in the introduction to this volume, these case-studies are part of a WHO initiative aimed at providing guidance to developing countries as they respond to growing needs for long-term care. This effort is based on the belief that it is possible to make real progress through a case-study approach, that will enable one to root the discussion of policies in an in-depth understanding of existing realities in developing countries and to learn from that which already exists.

This process is also based on the premise that although there is much to be learned from the experience of industrialized countries, LTC policies in the developing world need to reflect their unique conditions. Therefore, one major question that accompanies this process involves the identification of the key factors that distinguish industrialized and developing countries, which are relevant to the translation of experiences from industrialized to developing countries and vice versa, as well as among developing countries. These factors include epidemiology; resources; culture and values; educational levels; strength of informal care; stages of development of health and social care systems; and obstacles to the accessibility of LTC such as geographic spread, internal migration, transportation, and infrastructure.
One of the most important lessons to be learned from the case-studies is that there are a number of basic factors in developing countries that affect the relative significance of the key policy issues that are relevant to LTC policy development, as compared to those in the industrialized countries. We can highlight some of these factors:

- In industrialized countries, the need for a broad range of LTC services is taken for granted. Indeed, in the industrialized world this range continues to increase as new services emerge.

In developing countries, the provision of a broad array of LTC services is not taken for granted. The development of a specific package of LTC services is affected by both the resources available and by the rate of development of needs.

The change in needs is affected by underlying demographic, epidemiological and social forces. These translate into changes in the disability burden and in the potential role of the family. At the same time, local cultural and political values, and especially the priority given to health and social services in general, and to LTC services in particular, affects the development of LTC.

- Due to tight budget constraints, developing countries focus upon publicly-subsidized services for the poor. As a result, major policy issues emphasized for industrialized countries, such as universal entitlements, are much less of a source of controversy or deliberation.

- The nature of the existing health and social service infrastructure plays a much more critical role in shaping the provision of LTC in developing countries because of cost-containment concerns and other difficulties related to establishing new service infrastructures. Thus, the issue of integration, particularly with the health system, looms even larger for developing countries.

- In developing countries, much more attention is given to extended family networks, and the role of the broader community as sources of support, including communal structures of volunteer support.
A human resource issue that is especially relevant in developing countries is the possibility of mobilizing traditional healers to play a role in the provision of long-term care services. In many societies, traditional healers fulfil roles that may be considered long-term care, and are often available at local levels in even the most remote areas. These healers are often respected and trusted members of the community, and in some parts of the world they are now receiving special training in collaboration with the general health system and are required to meet a certain set of qualifications.

Because of the larger gaps in conditions between urban and rural areas in developing countries, there appear to be significant differences in the strategies applied to addressing the needs of the urban and rural population in the developing world.

In conclusion, the developing country case studies in this volume reveal that significant beginnings in addressing LTC-related issues have been made (as, for example, through home health, mobilizing communal organizations, and specialized training). Additionally, it is apparent that important initiatives, from which we can learn, are emerging in these countries. We need to continue to learn more about the experience of various developing countries and identify the ingredients that are the seeds for further success. At the same time, there is also evidence that low- and middle-income countries are repeating some of the same mistakes that industrialized countries are now attempting to correct, highlighting the importance of developing better guidance now.
This volume of ten case-studies from developing countries can serve as a foundation resource for the World Health Collection on Long-term Care.

Considered together, these case-studies provide examples to illustrate many of the lessons learned, key policy issues confronted, and current and future needs discussed in other volumes in this series.

Represented in this first of two volumes are case-studies of China, Costa Rica, Indonesia, Lebanon, Lithuania, Mexico, Republic of Korea, Sri Lanka, Thailand, and Ukraine. Each has been prepared by LTC experts from that country, in close collaboration with the World Health Organization and its Collaborating Centre for Research on Health of the Elderly, JDC-Brookdale Institute.
Conclusion
In the introductory chapter of this volume, we demonstrated the scope of the increase in long-term care needs in the developing world. We also highlighted emerging LTC policy directions in ten developing countries against the background of key socioeconomic and epidemiological indicators. In this concluding chapter, we describe broad patterns emerging in the countries examined.

There is a wide range of LTC development in the countries included in this volume. In Indonesia, there are not yet any formal initiatives for the provision of LTC, and care is dependent on the mobilization of volunteers. In Sri Lanka, while also relying mainly on volunteers, some forms of community care are beginning to develop in response to the ageing of the population. In the Chinese cities of Shanghai and Beijing, unusually high rates of ageing have contributed to the development of home health provision.

A number of countries are still relatively young but have also prioritized the development of home health care, such as Costa Rica, or are beginning to do so, such as Lebanon, Mexico, and Thailand. In Lithuania and Ukraine, the ageing of the population has created a great incentive to prioritize LTC provision and develop a range of services despite low incomes. Finally, the Republic of Korea has a relatively lower rate of ageing as compared with Lithuania and Ukraine, but a much higher level of resources and a relatively more highly developed range of LTC services.

The case-studies reflect broad general trends emerging in developing countries:

- Important efforts are being made to provide home-based LTC in a number of countries. Some provide a broad package of services that include home health, personal care, and homemaking (Lithuania, Republic of Korea, Ukraine); and some are more narrow and focused on home health only (urban China, Costa Rica, Mexico, Thailand). Publicly-funded LTC is not provided or only provided to a very limited extent in Indonesia, Lebanon, and Sri Lanka.
Where it exists, home health is linked to the health system (financially and organizationally). There are some very good examples of integration of home health into primary care (Costa Rica, Republic of Korea, and to some extent China, Lithuania, Mexico, and Ukraine).

Family guidance and counseling is highly emphasized in a number of countries. There seems to be a strong emphasis on this education and counseling through home health systems, which have become neglected in the home health systems of industrialized countries (Costa Rica and Republic of Korea).

Where it exists, personal care and homemaking services are targeted towards the very poor and those without families. None of these countries provides publicly funded personal care services to the non-poor population. Home health, on the other hand, is not necessarily targeted towards the poor, and health conditions and disability are more of a criterion.

Institutional LTC is provided by a number of countries. It is provided more extensively in Lithuania and Ukraine, and to some extent in China, Lebanon, the Republic of Korea, and Sri Lanka. In the other countries, publicly-financed institutional LTC is hardly provided. In countries that do provide institutional care, an issue that requires greater clarification involves the degree of coordination between home-based and institutional LTC.

Countries with a broader package of services have not integrated all their LTC services into one system. These countries generally split such services between the health and social systems. Therefore, fragmentation between health and social services and among LTC services is a general problem, similar to that which exists in most industrialized countries. In the Republic of Korea, for example, despite the fact that one ministry is responsible for health and social services, there is fragmentation of service provision and some overlapping. On the other hand, in some countries like Ukraine, even though there are two ministries and a division responsible for the care of the elderly in each of them, there is a coordinating mechanism at the level of local service provision (district physician).
The degree of age integration seems to vary. In general, home health is age-integrated. Other home care services are often but not always age-integrated. Age segregation is more typical of institutional LTC.

Most health systems are making special efforts to develop community health care. This health policy seems to be compatible with the development of home-based LTC, especially in Lithuania and Ukraine, where there is an objective to shift the relatively high emphasis on institutional LTC to community care. In some countries with hardly any institutional services, such as the Republic of Korea, there is also emphasis on developing institutional LTC to avoid utilization of more expensive acute hospital services by patients whose primary need is LTC.

In some countries, such as in Mexico, Sri Lanka, and Ukraine, NGOs are playing an important role in the development of LTC.

The level of volunteerism seems to vary, as does the degree to which volunteers receive training. The role of volunteers in the LTC arena was emphasized in China, Indonesia, Sri Lanka, and Ukraine. Indonesia, Sri Lanka, and Ukraine provide training to volunteers. In Ukraine, training is provided in formal training institutions and in Sri Lanka, NGOs have played a major role in this area.

The volunteer issue was further elaborated in the cross-cutting paper entitled *Key issues, options, and considerations on the role of volunteers and community development in least developed countries*. This paper outlines the key issues and presents the option of community-based volunteers as a necessary component that should be nurtured and strengthened.

There is a great deal of variation in human resource patterns. There is a clear pattern showing that as economic resources increase, countries have staff with higher levels of formal professional credentials. However, one finds a broad range of educational levels among staff in primary health care and in the various types of LTC. In many countries, there is a sense that more training of various staff levels in LTC is needed.
These general patterns give rise to questions that need further exploration, such as whether there is a trend towards the overprofessionalization of LTC roles, and to what extent general health personnel can play more of a role in LTC. While highly-trained nurses lead many home-care programme initiatives, such as those in the Republic of Korea and Thailand, in general we do not find that they provide more basic personal care services, as is the case in some industrialized countries.

There seems to be a hierarchy in the development of home-based LTC. The first priority is for home health with an emphasis on training and educating families, while personal care and especially homemaking develop later. That is, most countries do not provide publicly-funded personal care or homemaking services, and these services have remained a family responsibility or a service provided by volunteers. However, despite the appearance of these stages, it is important to emphasize that this pattern need not be prescriptive, and it may not describe the order of development of home-based LTC in all countries because of local cultural factors and national priorities.

As mentioned in the introduction to this volume, these case-studies are part of a WHO initiative aimed at providing guidance to developing countries as they respond to growing needs for long-term care. This effort is based on the belief that it is possible to make real progress through a case-study approach, that will enable one to root the discussion of policies in an in-depth understanding of existing realities in developing countries and to learn from that which already exists.

This process is also based on the premise that although there is much to be learned from the experience of industrialized countries, LTC policies in the developing world need to reflect their unique conditions. Therefore, one major question that accompanies this process involves the identification of the key factors that distinguish industrialized and developing countries, which are relevant to the translation of experiences from industrialized to developing countries and vice versa, as well as among developing countries. These factors include epidemiology; resources; culture and values; educational levels; strength of informal care; stages of development of health and social care systems; and obstacles to the accessibility of LTC such as geographic spread, internal migration, transportation, and infrastructure.
One of the most important lessons to be learned from the case-studies is that there are a number of basic factors in developing countries that affect the relative significance of the key policy issues that are relevant to LTC policy development, as compared to those in the industrialized countries. We can highlight some of these factors:

- In industrialized countries, the need for a broad range of LTC services is taken for granted. Indeed, in the industrialized world this range continues to increase as new services emerge.

  In developing countries, the provision of a broad array of LTC services is not taken for granted. The development of a specific package of LTC services is affected by both the resources available and by the rate of development of needs.

  The change in needs is affected by underlying demographic, epidemiological and social forces. These translate into changes in the disability burden and in the potential role of the family. At the same time, local cultural and political values, and especially the priority given to health and social services in general, and to LTC services in particular, affects the development of LTC.

- Due to tight budget constraints, developing countries focus upon publicly-subsidized services for the poor. As a result, major policy issues emphasized for industrialized countries, such as universal entitlements, are much less of a source of controversy or deliberation.

- The nature of the existing health and social service infrastructure plays a much more critical role in shaping the provision of LTC in developing countries because of cost-containment concerns and other difficulties related to establishing new service infrastructures. Thus, the issue of integration, particularly with the health system, looms even larger for developing countries.

- In developing countries, much more attention is given to extended family networks, and the role of the broader community as sources of support, including communal structures of volunteer support.
A human resource issue that is especially relevant in developing countries is the possibility of mobilizing traditional healers to play a role in the provision of long-term care services. In many societies, traditional healers fulfil roles that may be considered long-term care, and are often available at local levels in even the most remote areas. These healers are often respected and trusted members of the community, and in some parts of the world they are now receiving special training in collaboration with the general health system and are required to meet a certain set of qualifications.

Because of the larger gaps in conditions between urban and rural areas in developing countries, there appear to be significant differences in the strategies applied to addressing the needs of the urban and rural population in the developing world.

In conclusion, the developing country case studies in this volume reveal that significant beginnings in addressing LTC-related issues have been made (as, for example, through home health, mobilizing communal organizations, and specialized training). Additionally, it is apparent that important initiatives, from which we can learn, are emerging in these countries. We need to continue to learn more about the experience of various developing countries and identify the ingredients that are the seeds for further success. At the same time, there is also evidence that low- and middle-income countries are repeating some of the same mistakes that industrialized countries are now attempting to correct, highlighting the importance of developing better guidance now.
This volume of ten case-studies from developing countries can serve as a foundation resource for the World Health Collection on Long-term Care.

Considered together, these case-studies provide examples to illustrate many of the lessons learned, key policy issues confronted, and current and future needs discussed in other volumes in this series.

Represented in this first of two volumes are case-studies of China, Costa Rica, Indonesia, Lebanon, Lithuania, Mexico, Republic of Korea, Sri Lanka, Thailand, and Ukraine. Each has been prepared by LTC experts from that country, in close collaboration with the World Health Organization and its Collaborating Centre for Research on Health of the Elderly, JDC-Brookdale Institute.
Conclusion
In the introductory chapter of this volume, we demonstrated the scope of the increase in long-term care needs in the developing world. We also highlighted emerging LTC policy directions in ten developing countries against the background of key socioeconomic and epidemiological indicators. In this concluding chapter, we describe broad patterns emerging in the countries examined.

There is a wide range of LTC development in the countries included in this volume. In Indonesia, there are not yet any formal initiatives for the provision of LTC, and care is dependent on the mobilization of volunteers. In Sri Lanka, while also relying mainly on volunteers, some forms of community care are beginning to develop in response to the ageing of the population. In the Chinese cities of Shanghai and Beijing, unusually high rates of ageing have contributed to the development of home health provision.

A number of countries are still relatively young but have also prioritized the development of home health care, such as Costa Rica, or are beginning to do so, such as Lebanon, Mexico, and Thailand. In Lithuania and Ukraine, the ageing of the population has created a great incentive to prioritize LTC provision and develop a range of services despite low incomes. Finally, the Republic of Korea has a relatively lower rate of ageing as compared with Lithuania and Ukraine, but a much higher level of resources and a relatively more highly developed range of LTC services.

The case-studies reflect broad general trends emerging in developing countries:

- Important efforts are being made to provide home-based LTC in a number of countries. Some provide a broad package of services that include home health, personal care, and homemaking (Lithuania, Republic of Korea, Ukraine); and some are more narrow and focused on home health only (urban China, Costa Rica, Mexico, Thailand). Publicly-funded LTC is not provided or only provided to a very limited extent in Indonesia, Lebanon, and Sri Lanka.
Where it exists, home health is linked to the health system (financially and organizationally). There are some very good examples of integration of home health into primary care (Costa Rica, Republic of Korea, and to some extent China, Lithuania, Mexico, and Ukraine).

Family guidance and counseling is highly emphasized in a number of countries. There seems to be a strong emphasis on this education and counseling through home health systems, which have become neglected in the home health systems of industrialized countries (Costa Rica and Republic of Korea).

Where it exists, personal care and homemaking services are targeted towards the very poor and those without families. None of these countries provides publicly funded personal care services to the non-poor population. Home health, on the other hand, is not necessarily targeted towards the poor, and health conditions and disability are more of a criterion.

Institutional LTC is provided by a number of countries. It is provided more extensively in Lithuania and Ukraine, and to some extent in China, Lebanon, the Republic of Korea, and Sri Lanka. In the other countries, publicly-financed institutional LTC is hardly provided. In countries that do provide institutional care, an issue that requires greater clarification involves the degree of coordination between home-based and institutional LTC.

Countries with a broader package of services have not integrated all their LTC services into one system. These countries generally split such services between the health and social systems. Therefore, fragmentation between health and social services and among LTC services is a general problem, similar to that which exists in most industrialized countries. In the Republic of Korea, for example, despite the fact that one ministry is responsible for health and social services, there is fragmentation of service provision and some overlapping. On the other hand, in some countries like Ukraine, even though there are two ministries and a division responsible for the care of the elderly in each of them, there is a coordinating mechanism at the level of local service provision (district physician).
The degree of age integration seems to vary. In general, home health is age-integrated. Other home care services are often but not always age-integrated. Age segregation is more typical of institutional LTC.

Most health systems are making special efforts to develop community health care. This health policy seems to be compatible with the development of home-based LTC, especially in Lithuania and Ukraine, where there is an objective to shift the relatively high emphasis on institutional LTC to community care. In some countries with hardly any institutional services, such as the Republic of Korea, there is also emphasis on developing institutional LTC to avoid utilization of more expensive acute hospital services by patients whose primary need is LTC.

In some countries, such as in Mexico, Sri Lanka, and Ukraine, NGOs are playing an important role in the development of LTC.

The level of volunteerism seems to vary, as does the degree to which volunteers receive training. The role of volunteers in the LTC arena was emphasized in China, Indonesia, Sri Lanka, and Ukraine. Indonesia, Sri Lanka, and Ukraine provide training to volunteers. In Ukraine, training is provided in formal training institutions and in Sri Lanka, NGOs have played a major role in this area.

The volunteer issue was further elaborated in the cross-cutting paper entitled *Key issues, options, and considerations on the role of volunteers and community development in least developed countries*. This paper outlines the key issues and presents the option of community-based volunteers as a necessary component that should be nurtured and strengthened.

There is a great deal of variation in human resource patterns. There is a clear pattern showing that as economic resources increase, countries have staff with higher levels of formal professional credentials. However, one finds a broad range of educational levels among staff in primary health care and in the various types of LTC. In many countries, there is a sense that more training of various staff levels in LTC is needed.
These general patterns give rise to questions that need further exploration, such as whether there is a trend towards the overprofessionalization of LTC roles, and to what extent general health personnel can play more of a role in LTC. While highly-trained nurses lead many home-care programme initiatives, such as those in the Republic of Korea and Thailand, in general we do not find that they provide more basic personal care services, as is the case in some industrialized countries.

There seems to be a hierarchy in the development of home-based LTC. The first priority is for home health with an emphasis on training and educating families, while personal care and especially homemaking develop later. That is, most countries do not provide publicly-funded personal care or homemaking services, and these services have remained a family responsibility or a service provided by volunteers. However, despite the appearance of these stages, it is important to emphasize that this pattern need not be prescriptive, and it may not describe the order of development of home-based LTC in all countries because of local cultural factors and national priorities.

As mentioned in the introduction to this volume, these case-studies are part of a WHO initiative aimed at providing guidance to developing countries as they respond to growing needs for long-term care. This effort is based on the belief that it is possible to make real progress through a case-study approach, that will enable one to root the discussion of policies in an in-depth understanding of existing realities in developing countries and to learn from that which already exists.

This process is also based on the premise that although there is much to be learned from the experience of industrialized countries, LTC policies in the developing world need to reflect their unique conditions. Therefore, one major question that accompanies this process involves the identification of the key factors that distinguish industrialized and developing countries, which are relevant to the translation of experiences from industrialized to developing countries and vice versa, as well as among developing countries. These factors include epidemiology; resources; culture and values; educational levels; strength of informal care; stages of development of health and social care systems; and obstacles to the accessibility of LTC such as geographic spread, internal migration, transportation, and infrastructure.
One of the most important lessons to be learned from the case-studies is that there are a number of basic factors in developing countries that affect the relative significance of the key policy issues that are relevant to LTC policy development, as compared to those in the industrialized countries. We can highlight some of these factors:

- In industrialized countries, the need for a broad range of LTC services is taken for granted. Indeed, in the industrialized world this range continues to increase as new services emerge. In developing countries, the provision of a broad array of LTC services is not taken for granted. The development of a specific package of LTC services is affected by both the resources available and by the rate of development of needs. The change in needs is affected by underlying demographic, epidemiological and social forces. These translate into changes in the disability burden and in the potential role of the family. At the same time, local cultural and political values, and especially the priority given to health and social services in general, and to LTC services in particular, affects the development of LTC.

- Due to tight budget constraints, developing countries focus upon publicly-subsidized services for the poor. As a result, major policy issues emphasized for industrialized countries, such as universal entitlements, are much less of a source of controversy or deliberation.

- The nature of the existing health and social service infrastructure plays a much more critical role in shaping the provision of LTC in developing countries because of cost-containment concerns and other difficulties related to establishing new service infrastructures. Thus, the issue of integration, particularly with the health system, looms even larger for developing countries.

- In developing countries, much more attention is given to extended family networks, and the role of the broader community as sources of support, including communal structures of volunteer support.
A human resource issue that is especially relevant in developing countries is the possibility of mobilizing traditional healers to play a role in the provision of long-term care services. In many societies, traditional healers fulfil roles that may be considered long-term care, and are often available at local levels in even the most remote areas. These healers are often respected and trusted members of the community, and in some parts of the world they are now receiving special training in collaboration with the general health system and are required to meet a certain set of qualifications.

Because of the larger gaps in conditions between urban and rural areas in developing countries, there appear to be significant differences in the strategies applied to addressing the needs of the urban and rural population in the developing world.

In conclusion, the developing country case studies in this volume reveal that significant beginnings in addressing LTC-related issues have been made (as, for example, through home health, mobilizing communal organizations, and specialized training). Additionally, it is apparent that important initiatives, from which we can learn, are emerging in these countries. We need to continue to learn more about the experience of various developing countries and identify the ingredients that are the seeds for further success. At the same time, there is also evidence that low- and middle-income countries are repeating some of the same mistakes that industrialized countries are now attempting to correct, highlighting the importance of developing better guidance now.
This volume of ten case-studies from developing countries can serve as a foundation resource for the World Health Collection on Long-term Care.

Considered together, these case-studies provide examples to illustrate many of the lessons learned, key policy issues confronted, and current and future needs discussed in other volumes in this series.

Represented in this first of two volumes are case-studies of China, Costa Rica, Indonesia, Lebanon, Lithuania, Mexico, Republic of Korea, Sri Lanka, Thailand, and Ukraine. Each has been prepared by LTC experts from that country, in close collaboration with the World Health Organization and its Collaborating Centre for Research on Health of the Elderly, JDC-Brookdale Institute.