

The Future of Health and Health Care in an Ageing World:

A Focus on Brazil, the Dominican Republic and the United States of America



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Introduction

Appropriate health services are an essential adjunct to extending life and preserving functional capacity and quality of life at all ages. Throughout the course of our lives all of us may require disease prevention, curative procedures, treatment of injuries, rehabilitation, control of chronic conditions, supportive management of disability and palliative services. Services required in younger life typically focus on prevention and cure through medical services and hospital care. The care needed by older persons are much more varied, both because the health status of older people is more heterogeneous and because needs change with advancing age. Health services for older adults can be more complex; timely intervention is more critical to prevent a downward spiral of problems that could be irreversible; and “care” that is as much social as medical becomes increasingly more important than “cure”. The ideal health system for an ageing world is a comprehensive and coordinated continuum of care – that is, care that “continues” over a person’s health trajectory (prevention, treatment, rehabilitation, control, palliation) and that “continues” across settings. This complete network of health services is essential to preserve the health and facilitate the contributions of older people, and to manage a society’s health care expenditures cost-effectively.

Achieving this ideal range of health services is a policy challenge facing all countries. Systems and practices have emerged in several countries that can provide ideas to be adapted by other countries. Yet most developed countries still face problems in delivering equitable, effective and sufficient health services for an ageing population, owing to entrenched models of care delivery and financing, and inappropriate workforce composition and training. Developing countries are striving to establish health care systems that meet the diverse needs of their entire populations in ways that are economically, socially and politically sustainable. Many of them are now fast ageing and while also dealing with still prevailing infectious diseases: the double burden of infectious and chronic disease within a context of large health inequalities.

This paper examines the overall health status and the status of health care for older adults in two “moderately ageing” (ECLAC, 2010) developing countries, Brazil and the Dominican Republic, who have remarkably similar estimates of life expectancy, both at birth and at age 60 (UNDESA, 2012). The situation in these countries is compared with that in the United States of America (USA). This country faces common as well as unique challenges compared to other developed nations, at the same time as it offers some examples of excellent care practices for older persons which, unfortunately, are not available for most. This report draws largely on the responses provided by the ILC member organizations in these countries to a short questionnaire, as well as on other background reference material.

Health Status of Older Adults

World-wide demographic changes are reflected in a major epidemiological transition, with chronic, non-communicable diseases (NCD) common in later life becoming a major health priority. In Brazil, chronic disease accounted for 74 percent of all deaths in 2008 (World Health Organization, 2011). Progress has been made in reducing smoking-related cardiovascular and respiratory disease deaths, as a result of highly successful anti-tobacco measures and improvement in access to primary health care (Gragnotati et al, 2011). However, as Brazilians have become more urbanized and wealthier, an increasing number of them have adopted the unhealthy life styles common in developed countries which are leading to higher rates of diabetes and hypertension (Schmidt et al, 2011). Negative changes in health behaviours are now resulting in increasing disability in later adulthood for both men and women: new findings from the SABE study in the city of São Paulo show that from 2000-2010 persons aged 60-64 years gained two years of life, but lost three years of life expectancy in good health (Colluci, 2013).

Older Brazilians experience considerable health inequalities owing to large disparities that are reflected largely between the poorer Northeast states and the more affluent Southern states (Kalache, 2010). Within cities, both infectious and chronic diseases are more prevalent in low-income neighbourhoods (Riley et al, 2007; Schmidt et al, 2011).

The Dominican Republic is one of the poorer countries in Latin America, and the epidemiological transition is less advanced here than in Brazil or the United States. In Santo Domingo, the capital of the Dominican Republic, many chronic illnesses are as prevalent among older persons as in the United States; however, rates of obesity, diabetes and hypertension were associated with greater affluence, while anemia and physical impairments were inversely related to income (Acosta et al, 2011). Also, most chronic conditions were more prevalent among women than men.

About 80 percent of older US Americans live with at least one chronic condition (Centers for Disease Control and Prevention, 2011) and one in nine individuals aged 65 years old or more lives with Alzheimer's Disease (Alzheimer's Association, 2013). Obesity, paralleled by diabetes, has risen steadily over the last two decades (Barnes, 2011), resulting in health problems for increasing numbers of ageing Americans. Also, as in Brazil, race, gender and related economic disparities are the major predictors of health inequality throughout life (Komisar, Cubanski & Neuman, 2012). Older persons "of colour" (black and Hispanic) are experiencing disproportionately higher rates of chronic illness and disability than whites, and lower incomes to pay for needed care. Women typically live longer than men but have less economic capacity to obtain needed health services. Socio-economic disparities in access to health care

may increase as health costs in the US escalate as a result of factors such as the high costs of new technologies and a payment structure that rewards both more and more costly services (Farrell et al, 2008).

Existing Health Care Policy Framework

Both Brazil and the Dominican Republic have enshrined the rights of older persons and have specified measures to ensure their protection in national legislation. However, these countries differ in important ways in the implementation of the legislation and the net effect. In the Dominican Republic, the rights of older persons and the measures to ensure their protection by the State are guaranteed by law since 1998 (law 352-98) (HelpAge International and UNFPA, 2012). The Social Security System was established in 2002, with a three-tiered health care regime (contributory, partially-contributory, non-contributory) based on employment category. The right of older persons to health care is recognized through the provision of non-contributory health care to persons who are older, disabled or unemployed. However, although the legislation is already 10 years old, the non-contributory component of the Social Security System has not yet been implemented. The interim measure – a National Health Insurance Card – is distributed selectively based on political affiliation, and covers about 52 percent of older Dominicans only.

Since 1988, Brazil has a two-tiered health care system which guarantees the right to publicly-funded health care for all citizens through the Single Health System (Sistema Único de Saúde – SUS) while allowing a parallel private health care system. About 75 percent of Brazilians of all ages rely on the SUS (Lima-Costa et al, 2011). The right of older Brazilians to health care, including preferential treatment, was instituted in the 1996 National Policy on Older Persons, and later reinforced in the 2003 Statute of the Older Person (which is equivalent to a Bill of Rights of older persons). In addition, the Government of Brazil enacted a National Policy on the Health of Older Persons (2006) with the objective to restore, maintain and promote the autonomy of older persons. The National Health Plan (2012-2015) renews this commitment. Thus Brazil has in place a more stable and encompassing health policy framework in favour of older persons than the Dominican Republic.

The Dominican Republic does not have a universal public health system such as Brazil, but provides public health care coverage through the federally-funded Medicare program for persons over 65 years of age and for younger persons with permanent disabilities. Older adults with sufficient incomes supplement Medicare with private health insurance. Medicare is comparable to the Dominican health insurance system, although Medicare does not cover all of the costs for hospitalization, physician visits and other medical services. For

low-income American older persons, state-funded Medicaid helps with expenses not covered by Medicare. Nevertheless, health care constitutes a large and growing portion of personal expenses for older Americans as both Medicare premiums and the cost of non-insured health services increase.

Primary Care Health Services

All three countries have given priority in their public systems to primary health care services. The introduction of public primary care in developing countries in recent decades has yielded clear benefits to the health of older persons.

Through the Health Insurance Card, older Dominicans have free access to medical attention and to prescription medications. Older Brazilians similarly have free access to a physician and to medication for chronic conditions through the Statute of the Older Person, plus other health promotion and disease and injury prevention services provided in the National Policy on the Health of Older Persons, including targeted vaccination campaigns, booklets to support self-care, education to prevent osteoporosis and falls and subsidies to purchase other medications and continence supplies. These ageing-specific service provisions build upon the Family Health Care Program established in 1994 that registers all SUS beneficiaries with a local health administration and provides home visits by a multi-professional team (Gragnotati et al., 2011). State and municipal governments in Brazil follow federal policies and add measures of their own. For example, the Municipality of Rio de Janeiro has a free mobile eye clinic offering eye examinations and free prescription glasses for persons aged 40 and older as well as referrals for ophthalmological care.

In the Dominican Republic and Brazil the increase in primary care services has reportedly improved the health and quality of life of older people. Nevertheless, these services are far from perfect. As mentioned earlier, the Dominican Health Insurance Card is only an interim measure, and coverage is incomplete and politically biased. In Brazil, accessing the SUS services can be difficult, for reasons such as inaccessible transport, poor physical infrastructure of the neighbourhood, difficulty in making appointments, lack of priority treatment, long waiting times and a lack of home visits by health professionals (Amaral et al., 2012).

US Medicare provides access to many medical services, including prevention and diagnostic services, outpatient and post-acute care and prescription drug benefits. Nevertheless, there are deductibles for these services. Concerns about paying medical bills and accumulating medical debt lead some low and middle-income persons to delay or forego medical treatment

(Komisar et al., 2012). Another issue of concern is the dearth of primary care physicians to meet the needs of ageing Americans (Sussman & Altman, 2009).

An effective model of primary care in the US is Guided Care® (Boult et al., 2008) which helps primary care practices meet the complex needs of patients with multiple chronic conditions. In this evaluated model, a trained nurse works closely with patients, physicians and other providers to provide coordinated, patient-centered care (www.guidedcare.org).

Concerns about rising Medicare costs are driving authorities to support disease prevention and health promotion among older adults. One example is the Pioneer Accountable Care Organisations initiative, which encompasses 32 healthcare organizations nationwide and aims to improve health for Medicare patients through status assessments, controlling blood pressure and diabetes and scrutinizing immunization rates and take-up of preventive services (EIU, 2012).

Geriatric Services

Geriatric specialists are required to assess and treat more complex health problems of older persons but especially to educate and to guide general medical practice. All three countries report a shortage in the supply of geriatricians and in geriatric services.

The need for geriatric specialists and for better general medical training in geriatrics has prompted action recently in both the Dominican Republic and in Brazil. After relying for many years on foreign-trained geriatricians, the Dominican Republic has established a specialization in geriatric medicine in the country's two medical schools. It is reported that the presence of trained geriatricians in hospitals has led to an improvement in the care of older persons and consequent reductions in costly hospital admissions. Brazil's 2012-2015 National Health Policy has committed to providing training in geriatric care to health care professionals through distance education. Geriatric reference centres have been established in many states, especially in the richer southern states. As part of the broader, comprehensive Age-Friendly State of Sao Paulo initiative, a significant initiative underway is the transformation of one hospital in the State of Sao Paulo into the largest medical centre in Latin America specialized in the care of older patients and make 10 large private and public hospitals "age-friendly hospitals". While it is too early to evaluate the effectiveness of this initiative, it is already being replicated.

In the United States, only approximately 1 percent of physicians specialize in geriatrics and the numbers are decreasing, notwithstanding the increase in the older adult population (Sussman & Altman, 2009). Both the

supply and the demand of geriatric specialists are low. Demand for geriatricians in institutions and medical practices is low in part because the procedures performed by geriatricians are not highly reimbursed. Supply is low partly because the negative stereotypes of older adults and lower income relative to other specialties make it a less attractive choice for physicians.

Home Care/Home Support

As in the vast majority of countries, the Dominican Republic, Brazil and the United States strongly favour care within the older person's home. However all three provide minimal public assistance to control disease and maintain functional wellbeing. Mostly, older persons remain in the community, whatever their condition, with only the help of family either for lack of support services or for lack of income to pay for available services.

In the Dominican Republic, 81 percent of older persons live in extended families and only 14 percent live alone. Thus, the Solidarity Card, which provides a meagre food allowance to about 28 percent of poor older persons, contributes a little to the budget of families that support an older person. A very small number of older people benefit from domiciliary visits by a team composed of a geriatrician, a geriatric nurse and a social worker of the two medical schools offering geriatric training. Voluntary service organizations are virtually non-existent, private home care services are unaffordable for the vast majority of older people and there are no public home care services. A few public adult day centres provide community support, but they are insufficient to meet current and growing needs.

In Brazil, the old-age pension (both the rural pension and the Benefit of Continued Provision) is also indirectly subsidizing home support of older adults because the income gives older people the capacity to share resources with family members in exchange for services. Some municipalities or private health services include geriatric day centres among their services. Another public service available is caregiver training programs and educational materials offered to enhance the care provided by informal and formal caregivers. Nevertheless, the mainstay of care at home, i.e., family caregivers, is eroding, as the number of women available to provide care at home is declining (Camarano, 2008). Many of the initiatives implemented as part of the Age-friendly State of Sao Paulo are aimed at promoting the health of older people.

In the United States, Medicare covers post-acute home care, but long-term care is not a service insured by Medicare and few people have private insurance to help cover costs of home care. Informal care and support, by family and friends is the norm. It is reported that 65 percent of older persons in the community rely solely on unpaid help (Stone, 2000, cited in He et al., 2005).

Outside the formal health system, a number of “ageing-friendly” community initiatives have developed to strengthen community support to enable ageing in place and access to needed local services have emerged in recent years (Scharlach, 2012). The AARP has recently become involved in working with officials and partners to facilitate and guide communities to become more age-friendly, in alliance with the WHO Global Network of Age-Friendly Cities.

An example of an innovative project within the health system is the nurse-driven model “Living Independently for Elders” (LIFE), which was established in 1998 by the University of Pennsylvania School of Nursing. Under this model, all aspects of a patient’s care are coordinated by a team that includes nurse practitioners, a geropsychiatric nurse, a home health nurse practitioners, home care nurses and day centre triage nurses (Sussman & Altman, 2009).

Institutional Care

The Dominican Republic and Brazil differ somewhat with respect to long-term institutional care provisions. As in developed countries, the Dominican Republic counts some 5 percent of older adults living in 46 long-term care residences most of which are private philanthropic or private for-profit. This surprisingly high percentage of older people living in institutional facilities may be related to the fact that many young people are emigrating. These institutions are regulated, although it is claimed that in many instances, regulation is limited to administrative measures (HelpAge International and UNFPA, 2012). Institutional care in Brazil is rare and policies in this area are very timorous. An estimated 0,5 percent of older Brazilians reside in care institutions, which also comprise public, private philanthropic and private for-profit facilities (IPEA, 2011). Institutional care is available in only 28.8 percent of Brazilian municipalities (over 6000). According to the National Policy and the Statute for Older Persons, older people are eligible for institutional placement only if they are indigent and completely lacking family support.

In the United States, approximately 4 percent of persons aged 65 and older live in nursing homes, and another 2.5 percent reside in housing that provides supportive services; the vast majority are aged 80 and older (Department of Health and Human Services, 2011). Medicare does not cover institutional care, and few Americans have private insurance for long-term care costs. Thus, the majority of nursing home residents rely on state support through Medicaid because they either have low incomes, or they have spent down their assets (Komisar et al, 2012).

Conclusions: Looking to the Future

Disease trends in the three countries examined here do not portend significant improvements in the health of the increasing older populations in the near future. The current landscape of health policies and services suggests that both the Dominican Republic and Brazil will be the victims of their own success as improved primary care services increase the number of older persons living longer who will eventually require care and support for disability and frailty. However, there is a dearth of services required to support and care for older persons with chronic or increasingly complex needs as they age. In the Dominican Republic and in Brazil, both service infrastructure and financial coverage are lacking for care beyond primary and acute care. In the US, major barriers include a system that is organized around the provider rather than the patient, as well as inadequate public health care coverage. Meeting the needs of older persons in the US health care system will entail adjusting existing laws, financing and reimbursement mechanisms, insurance policies and practice models that protect existing provider practices and constrain innovations in health care delivery.

Taking into account the variations in service capacity among the countries examined here, some directions are proposed to guide policy for the future.

- Strengthen health promotion and disease prevention and self-care programs for older adults.
- Continue to strengthen primary care by improving the gerontology and geriatrics training in all streams of medicine and in all health professions.
- Implement proven care practices to favour comprehensive and flexible management of health service offered by health professional teams.
- Foster local coordinated networks of community support services. This includes creating more age-friendly settings and services to prolong and enhance functionality and wellbeing. These services should support both the older person and the informal caregiver.
- Increase the availability of affordable/subsidized good quality institutional care based on assessed levels of individual health needs. This will include adopting cost-effective models of public/private long-term care financing that exist already in some countries.
- Invest in research to evaluate the implementation and the impacts of new health policies and practices on wellbeing and on health system costs. Because Brazil has a particularly strong capacity for data collection and research, this country can contribute significantly to the evidence base for policy in countries with emerging economies.

In conclusion, there has been significant progress in some developing countries such as the Dominican Republic and Brazil to establish access to health care, and to develop health care services targeted to older persons. It is

necessary for these countries now to keep building the care continuum as these older adults advance in age, and to do so in tandem with the creation of age-friendly environments. In the United States (and other developed countries with similar problems of entrenched health care delivery and financing), the challenge is to create sufficient incentives to allow the full implementation of effective models of care.

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