Special Article

Progress Toward Long-Term Care Protection in Latin America: A National Long-Term Care System in Costa Rica

Mauricio Matus-López PhD*, Alexander Chaverri-Carvajal MSc

Department of Economics, Quantitative Methods and Economic History, Universidad Pablo de Olavide, Seville, Spain

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Abstract

The aging of the world’s population is a reality. People are living longer, not just in high-income countries, but it remains unclear whether their extra years will be lived in better health. In fact, an increasing number of older adults will probably require help to perform activities of daily living. Within the framework of its Global Strategy and Action Plan on Ageing and Health, the World Health Organization has called on all countries to create suitable and equitable long-term care systems that meet the needs of older people. The challenge is particularly acute in Latin America. The region is aging faster than other areas in the world, and its less-prepared social protection systems suffer from limited economic resources.

Costa Rica is one of the first middle-income countries to create a national long-term care system. This article describes the main characteristics of this system and discusses it from an international perspective. The results show that it has been designed to prioritize severity of dependency and cost containment, and to reinforce the formalization of care. The outcome of its implementation will affect the decisions of neighboring countries and those with similar economic conditions concerning the development of their own long-term care systems.

The forecasts turned out to be true. The world’s population has rapidly aged, and the process has spread to less developed countries. In 2000, the percentage of the population aged 65 and older exceeded 15% in 19 countries. Now it does so in 104 countries.1

This is, of course, an important achievement, but living longer does not necessarily mean healthier living. There is no guarantee that those extra years will be lived in better conditions.2 Some studies are optimistic on the matter,3,4 although most only analyze the situation in high-income countries, and yet they confirm a higher incidence of multimorbidity in socioeconomically disadvantaged populations.5 This is relevant because 3 of 4 older adults will not be living in high-income countries by 2050.

The World Health Organization (WHO) is clear about it. All countries will need a long-term care system (LTCS), and governments must take on the responsibility of ensuring its implementation.6,7 Long-term care was included as 1 of the 4 action areas of the United Nations Decade of Healthy Ageing, 2021–2030.7 Nevertheless, reality is lagging far behind. In 2020, fewer than 30 countries had a national LTCS, most of them in Western Europe and North America.

The circumstances of Latin America are particularly worrisome. In 2050, the number of people aged 65 and older will have multiplied by 2.5 and that of people older than 80 by 3.5 times.7 In addition, this population often suffers from obesity, diabetes, depression, and dementia.9,10 The economic context is not positive either. Only 4 countries have a gross domestic product (GDP) per capita exceeding USD 10,000, and Latin America remains the most inequitable region in the world,11 a combination that points to an increase in long-term care shortfall.12

In 2018, the Economic Commission for Latin America and the Caribbean urgently called on these countries to adjust their social protection systems to account for the anticipated demographic profiles.13 But only a few Latin American governments have undertaken the development of an LTCS. Uruguay included these services in its National Care System in 2016,14 and Costa Rica is doing so now.

In the past 2 years, other countries have expressed their willingness to implement this kind of system. Chile has conducted several studies15,16 and in 2019, the government announced its intention to create a dependency care system.17 Colombia is working on a national care system within the framework of the United Nations 2030 Agenda.18 Mexico has proposed reforming its political constitution in

* Address correspondence to Mauricio Matus-López, PhD, Department of Economics, Quantitative Methods and Economic History, Universidad Pablo de Olavide, Ctra. de Utrera, km. 1, 41013 Seville, Spain.

E-mail address: mmatlop@upo.es (M. Matus-López).

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2020 to incorporate the right to dignified care.19 Finally, Ecuador is also working on a proposition for an LTCS as part of its 2030 Agenda.20

Costa Rica’s LTCS provides pragmatic evidence of the feasibility of implementing those systems in middle-income countries. No other country with this level of income has done it before. Therefore, it is important to know how the Costa Rican government is planning to carry it out: how the system has been designed, what services it includes, and how it compares with the international framework. To this aim, this special article describes the main characteristics of the Costa Rican system and discusses it from an international perspective.

Key Elements of LTCSs

There is no specific theoretical framework that defines what the key elements of an LTCS are and what are not. However, a review of the research in the field shows that the aspects considered coincide in most of the studies. This section presents which elements or groups of elements are considered in the evidence, grouped into 3 approaches: exploratory-descriptive, clustering, and comparative.

The main objective of the first approach (exploratory-descriptive) is to describe an LTCS. The European Commission21 published a series of studies on 35 national LTCSs. Each document contains information on governance, type of financing, balance between institutional and home care service, cash for care versus in-kind benefits, levels of informal and formal care, evaluation of needs, and eligibility criteria. Similarly, the Organisation for Economic Co-operation and Development (OECD),22,23 analyzed some elements of the LTCSs of 10 countries, including benefits and eligibility criteria, benefits for caregivers, funding and coverage, delivery, and workforce. Becker and Reinhard23 contributed a legal analysis of the precedents, legal framework, administrative organization, and service supply of the system in 15 European countries. Ranci and Pavolini24 undertook a more comparative analysis in which they described the LTCS reforms implemented in 10 countries. The elements selected varied with each national reform, but most were characterized by their home-based orientation, cost containment, and private provision of services.

The main objective of the second approach (clustering) is to classify the systems according to their characteristics. For this purpose, the methods of cluster analysis, main-components analysis, and multiple factor analysis are used. In one of the first studies, Kraus et al.25 selected 2 sets of elements—organizational and financial—to analyze the LTCSs of 21 countries. The first set included aspects as access, entitlement, choice, quality, and coordination. The second set comprised cost sharing and public expenditure. Later, Halásková et al.26 limited the scope to 2 sets of elements related to expenditures and beneficiaries in 13 OECD countries. The last work in this matter, conducted by Ariaans et al.,27 focused on 26 OECD countries and highlighted 4 groups of variables: supply, public/private mix, access, and performance.

The third approach (comparative) is most widely used. Authors who chose this approach compared 2 or more systems to draw out lessons. In this line, WHO28,29 analyzed elements identified in international experiences that may be useful for countries that do not yet have an LTCS. The study highlighted the scope of potential demand, the health standards of the older adult population, eligibility, services, and expenditure. Other works have identified the key elements for countries with an emerging LTCS. For instance, Kim and Jeon30 elucidate lessons learned for developing a performance assessment of the Korean LTCS. The domains selected in this case were coverage, service quality care, health and quality of life, and financial sustainability. From a more global perspective, Spasova et al.31 analyzed 4 elements that represent challenges for those systems: access and adequacy, quality of care, employment, and financial sustainability.

The evidence of those 3 approaches allows the identification of 5 key areas in LTCS analysis: (1) access and eligibility, establishing who has access to the benefits and specifying the recipients; (2) services and benefits, describing the balance between home care and residential care, and the role of cash for care; (3) organization and governance, that is, the centralization or decentralization of the system, the relationship between health care and social services, and the quality control mechanisms; (4) cost and financing scheme, which establishes the amount of economic resources and the sources of funding for the system; and (5) impact and results, reflecting the impact on life expectancy and the real or self-perceived health status of the beneficiaries (Figure 1).

This research proposes a framework that highlights 4 of these 5 key elements of LTCS. Impact is excluded because implementation of the system is still in process, and there are no results to analyze. We will now refer to the precedents of the Costa Rican LTCS and then proceed to describe the system.

Costa Rica and the Road to an LTCS

Costa Rica shares many characteristics with the other countries in the region, but it also has its own particularities. Its income per capita is higher than the regional average and close to the threshold of high-income countries. It is 1 of 5 Latin American countries ranking high in the United Nations’ human development index.32 Its health care data are better than those of other countries, and it has a universal health care system.31 Its life expectancy is the highest in the region (80.4 years), and it is expected to have the highest percentage of people older than 65 (>30%) after 2065. This is of concern, because this group is expected to consume 27.5% of the total health care expenditure in 2030.34

Preliminary studies for the development of an LTCS began several years ago. The diagnoses revealed the existence of fragmented and duplicated plans managed by different public institutions.35,36 These plans included provision of long-term residential services and daycare facilities, mainly staffed with volunteer workers, and designed for older or disabled adults living in poverty.36,37

Survey results found that an estimated 13% of the population aged 65 and older requires help to perform basic activities of daily life (walking, as well as Katz activities like bathing, feeding, transferring, dressing, and toileting). In 89.8% of the cases, help was provided by relatives, and only in 2.1% of them was it remunerated.37

These studies led to cost projections of different models and coverage. In most scenarios, costs ranged from 0.3% to 1.1% of the GDP.38 In parallel, it was estimated that savings in hospital expenditure could be achieved by reducing long stays. These savings could amount to 28% of the initial cost of the LTCS.

On this basis, on March 3, 2021, the Costa Rican government issued a presidential decree for implementation of the National Care Policy for 2021–2031, which aims to carry out “the progressive implementation of a system to promote autonomy, support care, and provide care for the population in a situation of dependence.”39 The system is currently being initiated, procedures are being defined, and it is expected that by the end of the year, the first services will begin to be provided. The timeline for its implementation is presented in the following section.

The Costa Rican LTCS

Access and Eligibility

The Care and Dependency Support System (Sistema de Apoyo a los Cuidados y Atención a la Dependencia) is based on 2 principles: Universality and equality of opportunities. It has established 5 main objectives concerning services, viability, and equity (Figure 2).38

Beneficiaries are defined as adults who have lost their physical, mental, intellectual, or sensorial autonomy, preventing them from
performing activities of daily living (ADLs) on their own, whether permanently or for an extended period. Caregivers are also included as beneficiaries of the system. Eligibility criteria are based on the person’s need for help in performing ADLs. How these criteria will be applied has not yet been determined. The government is designing an assessment tool that will rank applicants into 4 levels depending on their degree of dependency: nondependent, moderate, severe, and major.

**Benefits and Services**

The National Care Policy considers 3 types of benefits: care services, cash for care, and caregiver training (Figure 3). Four care services will be developed between 2022 and 2031. Among them, home care is established as the principal service. It consists of formally trained care to support beneficiaries with their daily routines for a maximum of 80 hours per month; the coverage target is 80% of those categorized as major dependents. The second type of service is residential care, which involves day and night stays in a domestic-style environment providing 24-hour functional support and care. The coverage target is 20% of major dependents. The third type, telecare, is remote care provided through video conference or telephonic devices installed in the dependent’s home and connected to a monitoring center. The coverage target is 100% of major dependents and 70% of the severely dependent. It is envisaged that a new telehealth service will be incorporated before 2031, but it is not yet clear which type it will be. Finally, daycare facilities provide supervision and care to older adults during the daytime. The coverage target is 10% of the major and severe dependents. It is projected that by the end of the period 2021 to 2031, 55% of the dependent population will be receiving some kind of care service.

The system includes a cash-for-care scheme only in specific cases. The recipient must meet the following 3 eligibility requirements: (1) being entitled to home care service, (2) their relative caregiver probably cannot access the job market, and (3) living in extreme poverty. The amount allocated has not yet been determined.

**Fig. 2.** Objectives and strategies for the implementation of the long-term care system in Costa Rica.
Finally, formal training for caregivers will be provided. A certification procedure for care workers will be created, the curriculum of which is currently being defined, and training will have a duration of 810 hours. The Ministry of Labor will coordinate the recruitment and training of these workers. For those who continue doing family care, self-care training will be offered, and relief care will be facilitated through access of dependents to short residential stays.

Organization and Governance

The Ministry of Human Development is responsible for establishing the guidelines and organizing the system. For this purpose, a secretariat will be created to coordinate the functioning of the system, establish who is eligible for benefits, and determine how much the providers will be reimbursed.

The system will be implemented by different public institutions working in social, health care, labor, and educational areas. These institutions will integrate an Interinstitutional Committee. For this purpose, 4 working groups will be organized: service provision, quality and employability, economic resources, and information management. Disability and older adults' institutions are included in the service provision group. The Ministry of Health is responsible for monitoring the quality of care, and a formal educational institution oversees training care workers. The administration of the social fund is integrated into the economic resources group, whereas statistical and social security institutions take part in the data management group (Figure 4).

Monitoring the system is the responsibility of an inter-ministerial council that will meet every 2 years. This council is integrated by the Presidency, the Ministry of Human Development, and the Ministry of Planning.

The system is centralized, but it is expected that local governments will participate in the development of complementary programs during the next 5 years.

Cost and Financing Scheme

The system is funded through general tax revenues and copayment. Its estimated cost is USD 235 million, which is equivalent to 0.48% of the GDP. Its implementation should be completed within 5 years, and the initial investment is estimated at 43.8% of the total cost. Initially, it will be sustained through budget reallocations. The fiscal space will be progressively expanded through increased tax revenue because of economic growth. The creation of new taxes or raising current taxes are not envisaged, and copayment rates are yet to be defined.

Timeline

The development of the system began with issuance of the decree. The first steps currently being taken are setting up the dependency assessment scale, development of the curriculum of formal training for care workers, and the development of quality control procedures and instruments. Over the next year, implementation of telecare and
home care services will begin. It is expected that within the next 5 years, all services will be fully available. In the same period, residential care services will be gradually expanded to attend to 20% of the most severe cases. The introduction of new telehealth tools and joint programs with local governments is also envisaged, but not yet defined.

Discussion

During the past decade, the international evolution of LTCSs has followed certain trends, such as expansion of home-based care services, the introduction of cash-for-care schemes, the integration of new technologies, the diversification of funding sources, and cost containment. The Costa Rican system follows most of those trends, but with certain differences.

Access and Eligibility

Like most international systems, it is declared to be universal, but its design is clearly focused on the population suffering from major dependency. For instance, the French and Spanish systems are defined as universal, but benefits are provided only to those who have a certain degree of dependency. The Costa Rican system applies the same logic and does not offer benefits to 2 of the 4 levels of dependency. Therefore, the expected coverage of the system is limited and falls below the OECD average; it contemplates less than half the coverage of the highest-income countries, such as Sweden and Norway.

Services and Benefits

The system is oriented toward home-based care. The main services provided will be telecare and domiciliary care. However, in contrast with Uruguay, the other existing system in Latin America, it also includes residential care from the start. When the model is fully implemented, it is expected that 4% of the population aged 65 and older will receive residential care. This percentage is lower than the OECD average, but close to that of most countries. On the other hand, the system includes a cash-for-care scheme only for specific cases. It is a marginal benefit, as it is in Denmark and other Nordic countries, in contrast with its counterparts in France, Spain, and Italy. Certified training for caregivers is like the basic courses offered in Japan, and is focused on home-based care, like elder-care courses given in Germany.

Organization and Governance

The system is centralized. Local governments do not participate in the design or financing of the program, unlike the cases in most international systems. Quality control is the responsibility of the Ministry of Health, which seeks better social and health care coordination. Toward this objective, social and health care databases are integrated.

Cost and Financing Scheme

It is expected that the cost of the system, when fully implemented, will be limited. The budget is lower than the OECD average and is equivalent to one-third of those in high-income countries like the Netherlands, Denmark, or Norway. Funding is scarcely diversified. It is based on general tax revenues and complementary copayment, the same financing model as those implemented in Spain, Scotland, and Sweden, but Costa Rica’s fiscal capacity is significantly lower. Taxes amount to barely 24% of the GDP (it averages 34.3% in OECD countries).

Analysis of these elements reveals 2 challenges that the Costa Rican LTC model will face. First is the reorientation of the social protection system. Traditionally, social programs for disabled and older adults have been designed for people living in poverty. Although copayment is part of the LTCs, the beneficiary’s income is no longer an eligibility criterion—the main criterion is the severity of dependency. This new system entails a change in organizational culture.

The other challenge relates to public funding. The government has low tax revenue, and the economic indicators are not promising. Amid the pandemic, the budget deficit amounts to 8.3% of the GDP, and the economy fell by 4.8% in 2020. Shortage of funding may be overcome following the example of Spain in 2012. In the long term, the system will probably need to diversify its funding sources, as has been done in other countries.

Implications for Practice, Policy, and Research

Costa Rica is the second Latin American country to implement a national LTC, and one of the first middle-income countries to do so, in response to the call from international organizations to create sustainable and equitable LTCs in less developed countries. The case is relevant because it refers to a country located in a region that is rapidly aging and faced with a difficult health situation, limited economic resources, and an incomplete social protection system. In the face of these barriers, the Costa Rican system is being implemented at a slow pace and with emphasis on cost containment, starting with a plan that focuses on the most severe cases, formalizes care work, and reorganizes its public programs. The outcome of this effort will determine the decisions of other middle-income countries to design their own systems.

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