

**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 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.

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- 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.

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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.